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By Dr. Bruce R. Terry  
Editor

## It's All in the Numbers

Almost a year ago the ADA published "Breaking Down Barriers to Oral Health For All Americans: The Role of Finance."<sup>1</sup> This report is peppered with important statistics that everyone should learn. It would be especially good for lay people and lawmakers to review, but I doubt that will happen.

It should come as no surprise that dentistry is a major component of our health care needs, but is poorly supported financially. Even in good times, Americans are accustomed to medical coverage through employer sponsored health benefits or public assistance (80 percent) vs. private pay (<10 percent). Dental coverage is mostly financed through employer sponsored dental coverage (45 percent) and private pay (45 percent). Less than 10 percent of dental benefits are paid with public money vs. 50 percent of medical benefits.

While dental benefits comprised only 4.2 percent of all health care expenditures in 2009 (\$102 billion), patients covered more expenses personally when compared to medical costs (50 percent dental vs. 10 percent medical). In 2000, 70 percent of employers offered some form of dental benefits. In 2010, only 58 percent of employers offered dental benefits. This simple fact explains why many patients postpone dental treatment. Compound this with factors like a recession and high unemployment and one can easily understand why many dental problems are not being treated.

In 1997 the federal government created the Children's Health Insurance Program (CHIP) to help families who don't qualify

for Medicaid but can't otherwise afford health care. The program was reinforced in 2009 as part of the American Recovery and Reinvestment Act. But this is still temporary and only addresses children. With the current federal budget under the knife it's only a matter of time before this benefit will need to be trimmed to support other more important budget items.

So, the Pew Foundation and the Kellogg Foundation sponsored studies and reported that there is a lack of access to dental care. Are they right or wrong? I guess it depends on how you look at the numbers. If you say that more Americans lack adequate dental care you may be partly correct if you are looking at the number of people that don't see a dentist regularly, or go to the E.R. for a dental problem. Does that mean that we need more dentists? Again, that depends. If you look at a geographic area and report that 10 percent of that population sees a dentist regularly you may be factually correct, but if the reason is that the population in question can't afford the 50 percent out of pocket expense then available dentists are not the problem.

There are studies that say if cost is the barrier, then why don't we have mid-level providers available to help with the access issue. Is this the correct answer to the problem? Again it depends. If cost is an issue, how much less do services need to be valued for someone to accept treatment? 50 percent? 75 percent? In some communities people won't access dental care unless it's free. Citing economic difficulties, many low income patients can't even afford a discounted crown or root canal treatment.

In 2010 and 2011 several states, citing economic difficulties, limited access to dental care within the Medicaid system. Eliminated adult restorative services, including root canal treatment, essentially barred many patients from adequate dental care. Oral surgery or no treatment were the only options.

Could we improve the oral health literacy and thereby improve one's dental health? Probably. We can have an army of public health hygienists deliver the message to everyone. Whether in schools, community center or health clinics, the message of proper dental care and nutritional obstacles can be reinforced. Dental sealants can be applied. Hopefully with measured studies we can see if these interventional efforts help.

Unfortunately, there are still many obstacles. Poor dietary choices lead the list. Sugary drinks, high sugar and carbohydrate snacks will make all other efforts less effective. Can we change the overall habits of Americans? Probably not! While dental disease is considered the number one epidemic in the pediatric population, it's usually not life threatening like heart disease and cancer and so it gets less attention and less concern.

Can we get there through charity? Probably not. In 2007, the ADA reports that over \$2 billion in donated dental care was delivered by dentists through the U.S. In response to the need for dental care to the underserved, the American Dental Cares Foundation (ADCF) brought dental equipment to needy areas where dentists can provide charitable dental care. Since 2000, the ADCF estimates that more than 100,000 dental patients have received more than \$50 million in donated dental services. Since the economic crisis began in 2008 these Mission of Mercy (MOM) events have grown nationally. Local news reports tell of patients waiting all night for the chance to have dental work for free. With the current economic situation this trend is likely to continue.

What do experts say about the future of dental services? It depends on who you call an expert. There are many studies that give current statistics and future projections. If they are generated by the government we get one conclusion. If sponsored by Kellogg or Pew we get

different information. And, if we read the reports from the ADA we get a third set of information. Basically, everyone is right from their frame of reference. It's like looking at an object from different vantage points. Each observer is likely to see that object differently while still being factually accurate.

How do we in the trenches process this information? I think we need to rely upon logic and what we see and hear at the ground level. For those that work in affluent communities the biggest obstacle to care is the available disposable income needed to offset dental expenses. When the economy is good and people are employed they seek dental care. When the economy is bad patients avoid costly dental care. That's not an access issue due to lack of providers. It's just a lack of dollars!

In less affluent communities there are indeed fewer providers, since it's not financially feasible to support a business in such an environment. With government Medicaid reimbursements at incredibly low levels, it's a business decision not to practice in an economically depressed community. When Connecticut raised its Medicaid dental reimbursement in 2009 it saw a ten-fold increase in providers. When Georgia decreased Medicaid benefits in 2006 it tracked a 70 percent decrease in providers.

The issues surrounding access or barriers to dental care are complex but ultimately come down to available money. Government money, insurance benefits and private pay all play an important role in determining who can receive dental care. Yes, there are issues like available providers, dentist's fees etc., but these issues exist due to financial concerns. So you can read any study you want, at the end of the day it not as much about how much it costs but who is paying for it.

—BRT

#### REFERENCES

1. [http://www.ada.org/sections/advocacy/pdfs/7170\\_Breaking\\_Down\\_Barriers\\_Role\\_of\\_Finance-FINAL4-26-12.pdf](http://www.ada.org/sections/advocacy/pdfs/7170_Breaking_Down_Barriers_Role_of_Finance-FINAL4-26-12.pdf)



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# Where are the Dental Homes?

## A Challenge to Dentistry

By Bernie Dishler, DDS, PDA President

In November I received an email from, Dr. Marie Tacelosky, a member of the Fourth District, asking me if I knew that pediatricians are referring year-old infants to dental offices for treatment and are being told, "We do not treat children until age three."

And, I said, "That is what we do in our practice." Thus began an education of your president that resulted in this issue of the *Pennsylvania Dental Journal*.

I learned that, for the last several years, the ADA has been advising parents to have their children examined by a dentist when their first tooth appears. It certainly was not the cover story in *JADA*, but it is **the standard of care**. I also learned that the Pennsylvania section of the American Academy of Pediatrics has been teaching physicians how to examine an infant's teeth, do a risk assessment, paint fluoride varnish on their teeth and refer the child to a dental home. Thus, the call for help from Marie. Where are the dental homes?

I turned to a friend of mine Lisa Schildhorn, RDH, who recently earned a degree in Organizational Psychology and had been working with the Academy of Pediatrics with their DentaQuest grant. She introduced me to all the "players" who are transforming oral care for young children in Pennsylvania. Lisa arranged to have the feature articles that you see on pages 19-31 written.



The age one exam is not your traditional exam. It is a "knee to knee" exam with the child being held by a parent and the dentist looking in the mouth. There is no problem getting the children to open their mouth. They are often crying! An assessment can be done rapidly, followed by a quick varnish application, and you are done. Thanks to the staff at Kids Smiles in Philadelphia, even I can do it now!

*continued*

## Where are the Dental Homes?



The most important aspect of the age one exam is the education of the parent. The dentist or hygienist can point out areas being missed in tooth brushing. Talk about good habits, like only putting water in the child's sippy cup, eliminating fruit rollups and dried fruit.

I urge you to learn how to do the age one exam if you are not already doing it. There has been a dramatic increase in caries in children under the age of three. I encourage you to take a look at two YouTube videos (<http://www.youtube.com/watch?v=OIZnfCTjIBw> and [http://www.youtube.com/watch?v=4hNRu3\\_fvsM](http://www.youtube.com/watch?v=4hNRu3_fvsM)) that demonstrate the exam. Let's give the pediatricians more dental homes where they can refer their patients and we can help stem this rise in caries.

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### Non-Covered Services Update

PDA scored a major victory in October when the General Assembly passed SB 1144, which mandates that an insurance company cannot force its participating dentists to accept carrier allowances as the maximum amount that they can bill their patients for services not covered under the patient's contract. The bill went into effect on December 25, 2012. The following points are intended to offer some clarification to this bill:

- Dentists may opt to sign a Participation Agreement which stipulates that they accept the insurance carriers' allowances for non-covered services, but they may **not** be forced to do so.
- Dentists can remain Participating Providers with an insurance carrier and elect **not to sign** the addendum requiring them to accept the carrier's allowance for non-covered services.
- The Act applies to **insurance policies** that are written or renewed after Dec 25, 2012. Insurance policies are those issued by insurance carriers to their covered members, **not** the Participation Agreements between dentists and the insurance carriers.
- Determination of non-covered services is based on **each patient's insurance policy**. If it is not a covered service under the terms of that patient's policy, a dentist may bill his or her fee for the service. But if it is a covered service that has gone over the patient's maximum, or the patient has not satisfied his/her deductible, the dentist can be held to the carrier's allowance.

### Where Things Stand

Governor Tom Corbett delivered his budget proposal in February, setting the stage for Senate and House Appropriation meetings that address his priorities for Fiscal Year 2013-2014, which begins on July 1. Among the bills PDA actively monitors include our 2013/14 legislative priorities:

#### **Assignment of Benefits — SB 520**

In December, PDA met with Sen. Dominic Pileggi, State Senate Majority Leader, to discuss Assignment of Benefits legislation and address other legislative priorities for the 2013-14 session. Attendees at this initial meeting received an assurance from Pileggi that he would recommend a sponsor for this legislation. In January, Pileggi asked Sen. Kim Ward to introduce SB 520, which will require insurers to make payments directly to the providers of professional health care services, regardless of whether they participate with the patient's insurance plan.

SB 520 was assigned to the Senate Banking and Insurance Committee. In March, president Dr. Bernie Dishler accompanied PDA's lobbyist and staff members to a meeting with chairman White to provide information and request a committee vote.

#### **Donated Dental Services (DDS) — SB 290**

Funding for the DDS program, which helps facilitate care for the elderly, disabled and medically compromised, has a significant chance of getting back in the budget for 2013-14. Sen. Edwin Erickson intends to re-introduce his bill to reinstate the \$150,000 for the two regional offices and coordinators needed to oversee care between volunteer dentists and patients.

Funding was cut in 2009, resulting in the closure of both offices and the laying off of one coordinator. Subsequently, the program is currently not accepting new applicants in many counties. PDA held meetings with key Appropriation members in January to request this line item be placed back into the budget. We are hopeful the Administration will either reinstate funding on its own or that Sen. Erickson's bill will pass this session.

*PDA also continues to monitor the Governor's budget priorities, as well as legislation impacting health care contracts, prescription drug plans, and licensing in Pennsylvania.*

#### **Restricted Faculty Licensing — HB 272**

Rep. Bernie O'Neill plans to reintroduce legislation that would amend the Dental Law (Act 76 of 1933), allowing most dentists licensed in other states or countries to obtain a restricted faculty license, which will authorize them to teach in dental schools indefinitely while working toward obtaining a Pennsylvania state license. Currently, these dentists have four years in which to obtain a Pennsylvania license, a requirement that the dental school deans have identified as a barrier to retaining qualified faculty. This legislation would allow them to renew their temporary license every two years indefinitely. The restricted license would permit them to teach in the dental school where they hold a faculty position, but would not allow them to practice dentistry outside of the school. The deans believe legislation would be beneficial for Pennsylvania's dental schools as they seek to recruit distinguished faculty from other U.S. or foreign dental schools. HB 272 applies to foreign-trained dentists who have passed a CODA-approved specialty course.

### **Loan Forgiveness Program for Dentists — HB 542**

Rep. William Kortz reintroduced his legislation to establish the Loan Forgiveness for Dentists Program in the Pennsylvania Higher Education Assistance Agency (PHEAA). This legislation would allow PHEAA to forgive up to 50 percent of a dentist's loan, not exceeding \$100,000. The recipient would be subject to a four year contract with PHEAA and the award would be forgive over a four year period at an annual rate of 25 percent.

The Department of Health currently administers the only loan forgiveness program available to dentists. Applicants accepted into the program must practice in an underserved area for four years in order for them to receive student loan forgiveness up to \$64,000.

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It's time to register for PDA's Day on the Hill, scheduled for June 4, in Harrisburg. All members, spouses and dental students are encouraged to attend. PDA will assign you to a team to visit with General Assembly members who are in positions of leadership, or who sit on a key committee that votes on PDA's legislation. PDA will arrange the meetings in advance, provide you with background information and talking points on PDA issues and arrange your transportation to the Capitol.

Your participation in dentistry's advocacy efforts is more needed than ever. Consider joining your colleagues and speaking with legislators about important oral health care issues that not only affect you as dentists, but your patients as well. How else can dentistry make an impact at the state and national Capitols without your insight and expertise?

**To register for Day on the Hill, please visit PDA's website at [www.padental.org/dayonthehill](http://www.padental.org/dayonthehill) by May 14, 2013. You must register online by the deadline.** For more information or if you need assistance with online registration, please contact Marisa Swarney at (800) 223-0016, or [mss@padental.org](mailto:mss@padental.org).



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**"21st Century Marketing: How Dentists Can Thrive in the New Economy"**

*Presented by Dr. Leonard Tau:*

*The internet has become the main way that potential patients search for a dentist. Dr. Tau will teach you the ways your office can become the "go to" office in your area during this content rich course. Dr. Leonard F. Tau maintains a full time private practice in northeast Philadelphia focusing on general, cosmetic, reconstructive, and implant dentistry. Dr. Tau lectures nationally to fellow dentists on Internet marketing and social media.*

**Fall Dine Around: Wednesday, November 7, 2012**

**Paloma, 763 South 8th Street, Philadelphia, PA**

*"Practice Transitions"*

*Presented by Phil Cooper, DMD, MBA*

*Founded American Practice Consultants in 1985 to provide guidance for dentists in practice appraisals, practice sales, and partnership agreements. He has worked with hundreds of dentists throughout all types of practice transfers over the years and is well known and respected within the greater Philadelphia and New Jersey region.*

**Winter Entertainment Event: Thursday, January 17th, 2013**

**Del Frisco's Steakhouse 1426 Chestnut Street, Philadelphia, PA**

*Come and join us in "The Vault" at Philadelphia's premier steakhouse with a night of fine fare, music, drinks and entertainment.*

**Spring Dine Around: Wednesday, March 20, 2013**

**La Veranda, 30 North Columbus BLVD, Philadelphia, PA**

*"Cement Retained vs. Screw Retained Implant Restorations"*

*Presented by Jeff Carlson CDT*

*A noted international speaker, trainer, and author. He teaches dental technicians and dentists how to "simplify the complex". He is the co-creator, along with his wife Kathi, of The Implant Consortium, a patient centered group of dental professionals dedicated to the advancement of tooth replacement. Jeff will discuss the criteria for determining which option is best securing implant restorations for the patient based upon: the patient's expectations, the doctor's expectations, biomechanical factors, and overall physiologic considerations.*

**Spring All Day Program: Friday, May 3rd, 2013**

**The Buck Hotel, Feasterville, PA**

*"STEP: A Predictable Protocol for Treating the Worn Dentition"*

*Dr's Wooddell and Passaro graduated from the University of Maryland Dental School, Class of 1981. They have practiced together for over thirty years and maintain a practice of Restorative and Esthetic Dentistry in Davissonville, Maryland. In 2010, Drs. Wooddell and Passaro launched the Chesapeake Dental Education Center where they teach other practitioners how to achieve more efficient and predictable treatment outcomes with greater case acceptance.*

**Annual Golf Outing: June, 2012**

**Philmont Country Club**

For more information on Eastern Dental Society,  
please contact Dr. Michael Salin at [Info@Eastern-Dental.org](mailto:Info@Eastern-Dental.org) or  
**(215) 322-7810**, or visit us online at [www.Eastern-Dental.org](http://www.Eastern-Dental.org)

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The classifieds see an additional increase in traffic during the spring and summer months. More specifically, the opportunities available for dentists are viewed more as dental students are graduating and seeking employment. If you're looking for a new hire, place an ad in the upcoming May/June or July/August editions of the *Journal*.

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If you have any questions or would like to place a classified ad, please contact Linda Platzer at [llp@padental.org](mailto:llp@padental.org) or (717) 234-5941.



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## NEW MEMBERS

### Welcome New Members!

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

Erin M. Adamson, DMD  
University of Pittsburgh '10  
Boiling Springs

Timothy P. Adamson, DMD  
University of Pittsburgh '10  
Boiling Springs

Avanti Agrawal, DMD  
University of Pennsylvania '12  
Chadds Ford

Nicole M. Armour, DMD  
University of Connecticut '09  
Cherry Hill, NJ

Ramon T. Arreola, DMD  
University of Pennsylvania '80  
Bethlehem

Thanh T. Bang, DMD  
Temple University '12  
Philadelphia

Charles L. Barber, DMD  
Temple University '86  
Bridgeville

Mindy Joy Benjamini, DMD  
University of Pennsylvania '00  
Merion Station

Rae M. Calcote, DMD  
Temple University '12  
Allentown

Julie Cha, DMD  
University of Pennsylvania '12  
Lancaster

Evan C. Chalk, DMD  
Temple University '08  
Doylestown

Jenna S. Chalk, DDS  
University of North Carolina '11  
Doylestown

Bilal Chaudhry, DMD  
University of Pennsylvania '08  
Breinigsville

Grace Chen, DDS  
University of the Pacific '12  
Philadelphia

Ann Chernyak, DMD  
University of Pittsburgh '07  
Philadelphia

Lisa M. Ciabattoni, DMD  
Temple University '06  
Wyomissing

Matthew J. Conquest, DMD  
University of Pittsburgh '05  
Owego

Gina M. De Marco, DDS  
West Virginia University '81  
Pittsburgh

Pankaj K. Dhingra, DDS  
New York University '12  
Muncy

Ryan N. Dobbs, DDS, MD  
Creighton University '06  
Ardmore

Michael A. Dobos, DMD  
University of Pittsburgh '79  
Bethel Park

Snigdha Fnu, DDS  
University of California,  
San Francisco '12  
Coraopolis

Ruth Fremont, DDS  
Temple University '79  
Bala Cynwyd

Dustin J. Getz, DDS  
West Virginia University '12  
Morgantown, WV

Anna Grinberg, DMD  
University of Pittsburgh '09  
Pittsburgh

Eric T. Grunow, DMD  
University of Pittsburgh '10  
Erie

Ryan T. Hartle, DMD  
University of Pittsburgh '11  
Oil City

Elizabeth P. Heindel, DMD  
University of Pennsylvania '12  
Philadelphia

Jason T. Herres, DMD  
Temple University '07  
Elizabethtown

Jessie E. Hoffman, DMD, MS  
Harvard University '10  
Pittsburgh

Sookie Hwang, DDS  
New York University '11  
Philadelphia

Michael V. Jaconski, DMD  
Temple University '87  
Allison Park

Ankur Johri, DDS, MD  
University of Toronto Faculty of  
Dentistry '03  
Macungie

Melissa Karski, DMD  
University of Pittsburgh '12  
Cranberry Township

Kamaljit Kaur, DDS  
New York University '10  
Ephrata

Christie S. Kim, DMD  
University of Pennsylvania '10  
Philadelphia

Hee Sun Kim, DMD  
Temple University '12  
Fort Washington

Jee-Eun Kim, DMD  
University of Pennsylvania '12  
West Chester

Lucy Kim, DMD  
University of Pennsylvania School  
of Dentistry '12  
Philadelphia

Ericka Klein, DMD  
Temple University '02  
Malvern

Victor W. Lapkowicz, DMD  
University of Pittsburgh '77  
Beallsville

Eun Young Lee, DDS  
Foreign Trained '92  
Bryn Mawr

Hyejin Lee, DMD  
University of Pennsylvania '12  
Philadelphia

Julie Lee, DMD  
Case Western Reserve  
University '05  
Philadelphia

Robert D. LeNoir, DDS  
Virginia Commonwealth  
University '12  
Allentown

Catherine Dulay  
Lichtenstein, DDS  
University of Illinois at Chicago '07  
Maple Glen

Lynda Mabene, DMD  
University of Medicine and  
Dentistry of New Jersey '97  
Mechanicsburg

Matthew J. Makuta, DMD  
Temple University '09  
Freeland

Fareeha Malik, DMD  
University of Pennsylvania School  
of Dentistry '12  
Philadelphia

Surinder K. Masown, DDS  
University of Colorado '11  
Pittsburgh

Christina M. McGorty, DMD  
Temple University '12  
Bensalem

Cynthia I. McNeil, DMD  
University of Pittsburgh '90  
Pittsburgh

Jessica R. Meier, DMD  
University of Pennsylvania '12  
Philadelphia

## NEW MEMBERS *continued*

Raha Mozaffari, DMD  
University of Pennsylvania  
School of Dentistry '12  
Philadelphia

Pooja D. Mukhatyar, DDS  
University of Minnesota '11  
Bryn Mawr

Brian Musetti, DMD  
UMDNJ '11  
Hanover

Abigale P. Neville, DMD  
Temple University '04  
Holland

Michel R. Obaid, DDS  
New York University '12  
Allentown

Sungbum Park, DDS  
SUNY Buffalo '08  
Olean, NY

Ashley L. Parks, DMD  
Temple University '11  
Philadelphia

David A. Pechersky, DMD  
University of Pittsburgh '09  
Aspinwall

Jakub P. Pelka, DMD  
University of Pennsylvania  
School of Dentistry '10  
Philadelphia

Christopher Scott Perrie, DDS  
University of Southern California '02  
North Wales

Noelle M. Peters, DMD  
University of Pittsburgh '11  
New Castle

Gregory D. Petrilla, DMD  
University of Pittsburgh '12  
Apollo

Samuel C. Pollina, DMD  
Ligonier

John P. Popernack, DMD  
Temple University '08  
Abbottstown

Mohammed O. Qahash, DDS  
Virginia Commonwealth  
University '96  
Harleysville

Dorothy M. Ramos, DDS  
University of Michigan '12  
Conshohocken

Christian M. Reinecker, DMD  
Temple University '11  
Wyomissing

Kevin Risko, DMD  
University of Pennsylvania '91  
Lititz

Erin K. Rose, DMD  
Temple University '11  
Erie

Haritha Sambaraju, DDS  
New York University '06  
Easton

Judith Samselski, DMD  
Temple University '05  
Sewell, NJ

Jacqueline N. Scott, DMD  
University of Pittsburgh '12  
Murrysville

Anjali Shah, DDS  
New York University '10  
Harrisburg

Dhaval R. Shah, DDS  
New York University '12  
Souderton

Brianne N. Shanley, DMD  
University of Pennsylvania '10  
Lancaster

Yuchen Sheng, DMD  
University of Pennsylvania '12  
Allentown

Ashutosh A. Shrivastava, DMD, BDS  
University of Pennsylvania '11  
Plainsboro, NJ

Natalie M. Sorbello, DDS  
University of Maryland '12  
Lancaster

Reeme K. Sreedharan, DMD  
Boston University '11  
Exton

Joseph H. Troupe, DMD  
University of Pittsburgh '11  
Pittsburgh

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Temple University '84  
Montrose

Neil E. Uffner, DMD  
University of Pennsylvania '11  
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Anthony G. Wach, DMD  
University of Louisville '03  
Pittsburgh

Ronald J. Walker, III, DMD  
University of Pittsburgh '12  
Walston

Xiang Wang, DDS  
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West Virginia University '12  
Six Mile Run

# PARAGON

## DENTAL PRACTICE TRANSITIONS

**Mark H. Buzzatto, D.D.S.**  
has acquired and merged his practice into the practice of  
**Raymond V. Tomb, D.M.D.**  
Bethel Park, Pennsylvania

**Mark G. Cherewka, D.M.D.**  
has acquired the practice of  
**Salch A. Malik, D.M.D.**  
Enola, Pennsylvania

**Zachary S. Sisler, D.D.S.**  
has acquired an equity position in the practice of  
**John A. Franklin, Jr., D.M.D.**  
Shippensburg, Pennsylvania

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In December, Governor Corbett announced that Pennsylvania would not pursue a state-based health insurance exchange. The administration will continue to seek guidance from the U.S. Department of Health & Human Services on the costs and impact involved in the options for Medicaid expansion, but Governor Corbett maintained that implementation of an exchange under the Affordable Care Act (ACA) will be operated at the federal level. Pennsylvania joined 28 other states in this decision. By law, Governors can re-evaluate their decision to establish a state-based exchange on a yearly basis.

Since its passage in Congress in 2010, many questions remain about how the ACA will impact health insurance, health care providers and patients. The expansion of medical insurance coverage and changes to how health care is financed could have a transformative impact on dentistry in Pennsylvania and across the country. Aspects of the ACA impact dentists not only as health care professionals, but also as small business owners and consumers of medical care. The full impact of the ACA on dentistry remains uncertain at this stage, but PDA can highlight some of the potential changes that will most likely occur in the near future:

### Medicaid

- The ACA expands Medicaid coverage to people with incomes up to 133 percent (138 percent, net of income disregards) of the federal poverty level (FPL). The taxpayers will initially provide 100 percent cost coverage for this population and 90 percent of the cost long term. According to policy experts, the number of children and non-elderly adults added to the Medicaid rolls as a result of these changes could be as low as 11 million or as high as 24 million, depending on how many states accept the ACA funding and expand their Medicaid programs. Beneficiaries enter and leave Medicaid as their financial circumstances change, so the actual increases in monthly enrollment could be lower than these numbers.

### Health Care Delivery/Financing

- The ACA seeks to better integrate and coordinate health care delivery and financing through expansion of health care provided under the Accountable Care Organizations (ACO) umbrella. ACOs were designed to improve the infrastructure of care delivery by aligning provider reimbursements to health outcomes and quality. ACO models currently focus on health care services for the Medicare population. There are very few ACO type models of care that include any dental services, with the exception of a proposed Medicaid pilot program in Oregon.

### Health Insurance Exchanges

- Exchanges must be established to begin enrolling beneficiaries by October 2013. The exchange will initially be limited to individuals and small businesses, allowing the purchasers to select from various private health care plans. People with incomes between 100 and 400 percent of the FPL are eligible to receive federally subsidized coverage through the exchange.
- Stand-alone dental plans must offer the **pediatric oral essential health benefit** without annual and lifetime limits. This is to ensure consistent level of consumer protections. These stand-alone dental plans will also likely have to adhere to certain marketing regulations, ensure a sufficient choice of providers and possibly meet performance quality requirements. Dental plans may also be required to use a single enrollment form and a standard format for presenting options under health benefit plans.

- An estimated 3 million children will gain dental benefits through the health insurance exchanges by 2018, which is an estimated five percent increase over the current number of children with private dental benefits. Children will also gain dental benefits outside the health insurance exchanges through employer-sponsored dental benefits with dependent coverage, in addition to other insurance options. The impact of exchanges on dentistry could be greater if the ACA-required essential pediatric dental benefit is inadequate or too costly, or if plans with inadequate dental networks comprise a large part of the exchange marketplace.

### Dentist Employers

- Under the ACA, small businesses with 50 or fewer employees are **NOT** required to provide health insurance. More than 99 percent of dental practices have 50 or fewer employees. Small business employers who pay at least 50 percent of the premium for coverage may qualify for a small business tax credit. In order to qualify, the employer must have fewer than 25 full-time employees whose average annual wage does not exceed \$50,000 per employee. These tax credits will be available on a sliding scale to assist in purchasing health insurance. They will disappear after 2016.

### Taxes and Limits on Tax Preferred Accounts

- Flexible spending accounts allow employees to set aside tax-free money to pay medical and dental bills. Beginning this year, the FSA set-aside will be limited to \$2,500 a year and increased annually by a cost-of-living adjustment.

### Dentists as Consumers

- Insurance plans in the individual and small group market are prohibited from imposing pre-existing condition limitations, excessive waiting periods and copayments or deductibles for certain preventive care. Coverage must also be guaranteed, renewed, and cannot be rescinded. Age, tobacco use, location and family composition will also be used by insurance plans to calculate premiums and coverage for dependents up to age 26.

In addition to these policy and regulatory changes under the ACA, the public health infrastructure will also impact dentistry. ACA provides for increased funding for Centers for Disease Control and Prevention (CDC) oral health programs and national oral health surveillance programs; increased grant opportunities for general, pediatric or public health dentists; funding for National Health Service Corps loan repayment programs; and

CDC initiation, in consultation with professional oral health organizations, of a five-year national public education campaign focused on oral health prevention and education. PDA will continue to monitor and report how the ACA will affect dental providers and their patients in the coming months.

### Impact of Medical Excise Tax on Dentistry

As of January 1, a new 2.3 percent federal excise tax went into effect. The medical device excise tax, which is part of the Affordable Care Act, is raising numerous questions from dentists nationwide. Based on current information obtained by the American Dental Association (ADA), here are a few points that can help dentists, their staff and patients understand the tax:

- Dentists will not be responsible for collecting, reporting or paying the 2.3 percent tax. Dentists will not be considered “manufacturers” of dental

devices merely because they perform restorations or assemble and adjust prosthetic devices.

- The tax on “devices” specific to dentistry will, in many cases, be applied to the materials that dental devices are manufactured from, rather than to the items supplied by a dental laboratory, regardless of whether or not a device is adjusted and adapted by the dentist for a patient.
- The tax will result in some increased costs for dentists and patients.
- Dentists should review manufacturer and vendor price lists and invoices to insure that the 2.3 percent tax is not being applied as a general cost increase for all items, but is only applied to devices as required by law. There are 130 items that appear on the Food and Drug Administration’s (FDA) list of dental devices. A compiled list is available on ADA’s website at <http://www.ada.org/8054.aspx>.



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FDA regulations do not create a carve-out for dental devices. Dental Devices subject to the 2.3 percent tax are listed by the FDA in the Code of Federal Regulations at 21 CFR 872- DENTAL DEVICES. The FDA list places dental devices into Class I, Class II, or Class III. ADA has a compiled list that includes any item designated as a “Dental Device” by the FDA, as well as the devices FDA subcategory. All devices listed are subject to the excise tax unless they fall under an exclusion.

A major exclusion from the tax is provided by the “retail exemption.” Items that are available “over the counter” are not subject to the medical excise tax, even if they appear on the FDA’s list. Devices that apply to the “retail exemption” are

noted on the FDA’s list with the letters “OTC” in front of the devices name.

It is safe to assume that other devices, such as power and manual toothbrushes, dental floss and teething rings are not subject to the tax. The Internal Revenue Service (IRS) itself may not be sure what products fall under the “retail exemption.” The IRS has said that it will take a “facts and circumstances” approach to determining whether or not the retail exemption should apply in particular cases.

The first device excise tax deposit from manufacturers was due January 29, however the IRS offered temporary relief to device manufacturers from timely deposits for the first three calendar quarters of 2013 in consideration of the time

frame between the effective date and the first deposit due date.

Dentists may have received letters from dental laboratories attempting to explain the tax and its implementation. At this point, there may be some difference of opinion as to how the tax will work, but it is important to keep in mind that dental labs and supply companies will likely pass the tax along to their customers. ADA plans to reach out to vendors in order come to a consensus on how the tax should be applied and collected.

ADA has urged Congress to repeal the medical excise tax and will continue to track information on its implementation.

## How much should a dentist charge for reproducing and transferring dental records?

State Board of Dentistry regulations require that record reproduction in a private office should be provided either gratuitously or for a “reasonable” fee reflecting the cost of reproduction within 30 days of a patient’s request. Charges made to patients for the reproduction of records should not be more than the cost of the reproduction of the records.

In cases involving reproduction of records by request or subpoena for a legal matter, the Department of Health recently announced new fees that dentists may be charged by health care facilities and health care providers. Effective January 1, 2013, the following fees may be charged by a health care provider or facility for the reproduction of patient records needed in a legal proceeding only. In addition to the below costs, a provider may charge the patient for the cost of postage and shipping of patient records.

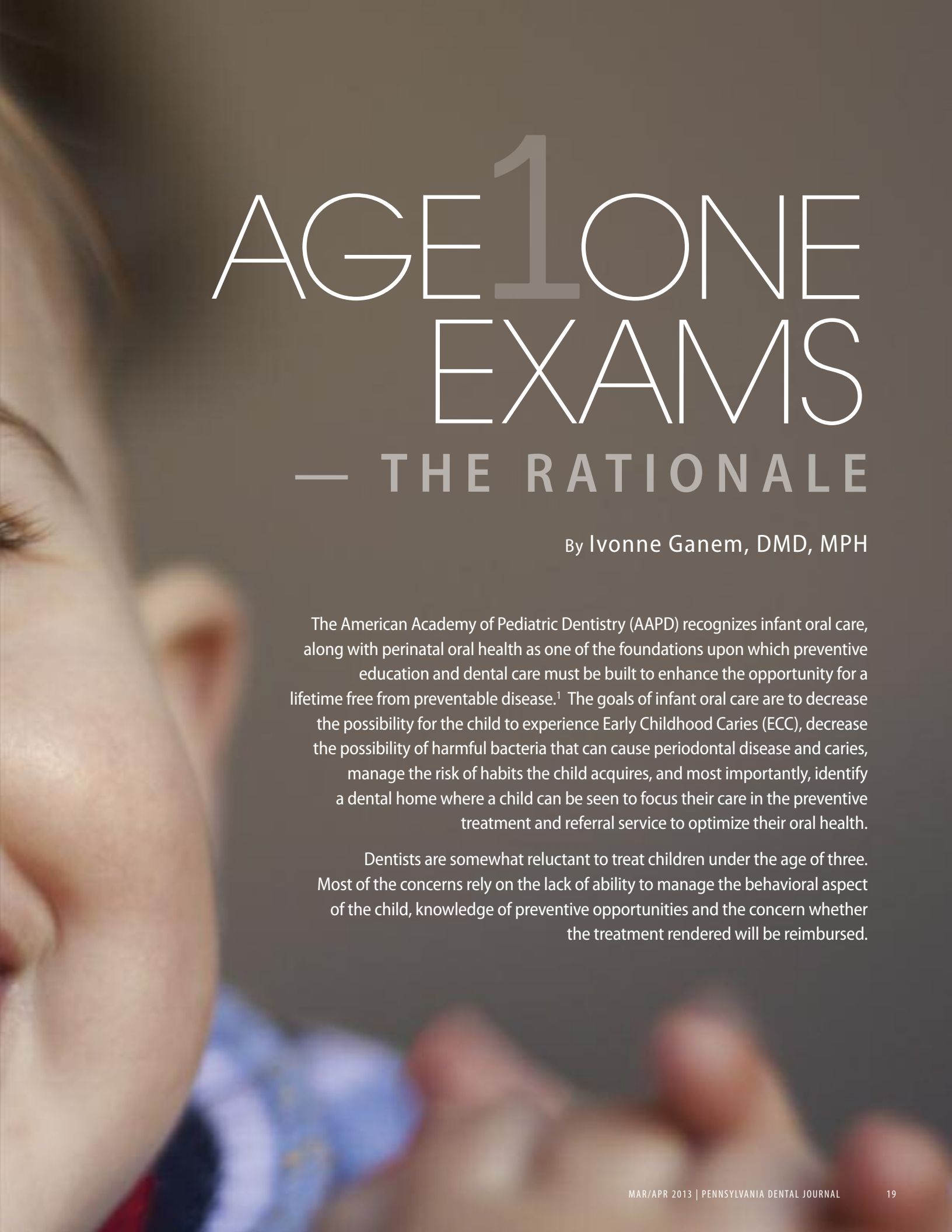
- Amount charged per page for pages 1—20 \$1.42
- Amount charged per page for pages 21—60 \$1.05
- Amount charged per page for pages 61—end \$.35
- Amount charged per page for microfilm copies \$2.09
- Flat fee for production of records to support any claim under Social Security or any Federal or State financial needs based program \$26.70
- Flat fee for supplying records requested by a district attorney \$21.08
- Search and retrieval of records \$21.08

The charges listed above do not apply to an X-ray film or any other portion of a medical record which is not susceptible to photostatic reproduction.

These flat fees apply to amounts that may be charged by a health care facility or health care provider when copying medical records either for the purpose of supporting any claim or appeal under the Social Security Act, any federal or state financial needs based program, or for a district attorney.

ADA advises members that upon a patient’s request, records should be provided to the patient or the patient’s new dentist either gratuitously or for a fee reflecting the cost of reproduction within 30 days. Dentists may use the Department of Health’s fee schedule as a guide. However, when furnishing records for a legal matter, dentists should charge patients using the Department of Health’s fee schedule.



A close-up, slightly blurred photograph of a young child's face, showing the eye, nose, and mouth. The child is looking towards the right. The background is a dark, solid color.

# AGE 1 ONE EXAMS

## — THE RATIONALE

By Ivonne Ganem, DMD, MPH

The American Academy of Pediatric Dentistry (AAPD) recognizes infant oral care, along with perinatal oral health as one of the foundations upon which preventive education and dental care must be built to enhance the opportunity for a lifetime free from preventable disease.<sup>1</sup> The goals of infant oral care are to decrease the possibility for the child to experience Early Childhood Caries (ECC), decrease the possibility of harmful bacteria that can cause periodontal disease and caries, manage the risk of habits the child acquires, and most importantly, identify a dental home where a child can be seen to focus their care in the preventive treatment and referral service to optimize their oral health.

Dentists are somewhat reluctant to treat children under the age of three. Most of the concerns rely on the lack of ability to manage the behavioral aspect of the child, knowledge of preventive opportunities and the concern whether the treatment rendered will be reimbursed.

### DENTAL HOME

The AAPD supports the concept of a dental home for all infants. Children that belong to a dental home are more likely to receive appropriate preventive services and routine oral health care. It is recommended a dental home be established by the age of 12 months since it will institute appropriate caries preventive strategies, dietary recommendations and oral hygiene instruction as the primary teeth begin to erupt.

Previously, many thought a dental visit by the age of 36 months was appropriate, but it has changed because by that time it was already too late and caries were already present in many children. A dental home also provides the child with comprehensive oral care, acute care and preventive services. It should include, and be able to provide a comprehensive assessment for oral diseases and conditions, and assess the risk for developing caries.

Individualized preventive dental programs based upon caries risk are extremely important to tailor a correct prevention plan and periodic reevaluation intervals for the child. The dental home will provide a structured referral system if necessary.

An oral health risk assessment for infants by six months of age allows instituting appropriate preventive strategies as the primary dentition begins to erupt.

### CARIES RISK ASSESSMENT

Caries risk assessment is defined as the identification of factors associated with a condition or disease for purposes of further diagnosis, prevention or treatment. If those risk factors are eliminated before the diseases occur, the disease process can be prevented.

Risk factors that can be evaluated include:

- Presence of caries
- Presence of plaque
- Gingival condition
- Caries history
- Fluoride exposure
- Carbohydrate exposure – frequency, amount
- Socioeconomic status
- Dental care exposure
- Caregiver dental literacy

The American Dental Association (ADA) developed a caries risk assessment form for children 0-6 that evaluates three areas and includes:

1. Contributing Conditions
2. General Health Conditions
3. Clinical Conditions

All of them are evaluated in the following three categories: High, Moderate or Low risk.

### INITIAL EXAM – RATIONALE

An initial exam should happen as early as six months of age, or six months after the first tooth erupts and no later than 12 months of age. Thorough medical histories of the infant and dental histories both of the mother/caregiver and infant should be recorded. It is important to educate the caregivers in infant oral care, provide a caries risk assessment and determine an appropriate prevention plan. Referral to specialists should be evaluated if needed.

The initial visit should consist of the following:

- Thorough medical (infant) and dental (mother or primary caregiver and infant) histories

- Thorough oral examination
- Assess the child's risk of developing oral disease using a caries risk assessment
- Providing education on infant oral health
- Providing anticipatory guidance regarding dental and oral development, fluoride status, non-nutritive sucking habits, teething, injury prevention, oral hygiene instruction and the effects of diet on the dentition
- Determining an appropriate prevention plan and interval for periodic reevaluation based upon that assessment
- Planning for comprehensive care in accordance with accepted guidelines and periodicity schedules for pediatric oral health
- Referring patients to the appropriate health professional if intervention is necessary

There are several techniques used for this initial exam. The one recommended is the lap-to-lap/knee-to-knee where oral hygiene practice is demonstrated and the parent is asked to participate. Usually the child will cry and this will help in keeping the mouth open. The parent/caregiver should be aware of what is being performed so they understand what the practitioner will be doing as they can be surprised.

### EARLY CHILDHOOD CARIES (ECC)

ECC begins usually soon after tooth eruption and can be a predominantly virulent form of caries. It usually affects children that come from a low socioeconomic status that consume a high sugar content diet whose caregivers/mother have a low educational level. Preventive strategies and appropriate therapeutic interventions guided by oral health risk assessments should be utilized by the dental professional in order to educate the mother and assist with the prevention and treatment of disease for children at higher risk for developing infections.

It develops in smooth surfaces and progresses rapidly. There is usually a pattern seen in this disease in which it affects — maxillary anterior ⇒ maxillary posterior ⇒ mandibular post ⇒ mandibular anteriors. The mandibular anteriors are protected by the tongue.

Children with significant levels of *Mutans Streptococci*, and any level of lactobacilli are at a higher risk. It affects the general population but is 32 times more likely to occur in infants who are of low socioeconomic status, who consume diets high in sugar and whose mothers have a low educational level.

Frequent bottle-feeding at night, ad-lib breast-feeding, and extended and repetitive use of sippy/training cups are associated with ECC.

ECC can have a lasting and detrimental impact on dentition.

The NHANES report, *Trends in Oral Health Status: United States, 1988–1994 and 1999–2004* states the following regarding dental caries in infants and children:

- Overall, the prevalence of dental caries in primary teeth (dft) increased from approximately 40 percent from 1988-1994 to 42 percent during 1999-2004. However, among 2-5 year-olds, the prevalence of dental caries in primary teeth significantly increased from approximately 24 percent to 28 percent.
- The mean number of decayed and filled primary dental surfaces significantly increased from 2.94 to 3.63 from 1988-1994 to 1999-2004.
- For 2-4 year-olds, prevalence of dental caries in primary teeth has increased from approximately 18 percent to 24 percent between 1988-1994 and 1999-2004.

- The prevalence of untreated primary dental decay increased from approximately 16 percent in 1988-1994 to nearly 19 percent in 1999-2004 for 2-4 year-olds
- The prevalence of dental caries in permanent teeth significantly increased for 6-8 year-old non-Hispanic black persons from approximately 49 percent in 1988-1994 to 56 percent in 1999-2004. The prevalence of untreated tooth decay in permanent teeth for 6-8 year-olds remained unchanged.

The above data reflects how important it is to prevent dental caries in children that are affected by the disease in such a young age.

#### OTHER ISSUES AFFECTING INFANTS

Caries and periodontal disease are not the only conditions that affect infants. The following are important areas to discuss with parents/care-givers as part of anticipating and preventing injury or disease.

##### **Teething** - Can cause systemic distress

Increased temperature, GI irritation, diarrhea, dehydration, increased salivation

Treatment:

- Maintain/increase fluid consumption, analgesics, palliative care, teething rings
- Avoid topical meds (Ambesol)

##### **Non-nutritive Habits**

- Arise from psychological needs and physiologic need for nutrition
- Non-nutritive oral habits (e.g., digit and pacifier habits, bruxism, abnormal tongue thrusts) may apply forces to teeth and dentoalveolar structures that result in occlusion and facial developmental changes
- Early dental visits provide an opportunity to encourage parents to help their children stop habits by age three years or younger, before malocclusion or skeletal dysplasias occur.

It is important to discuss the need to wean from the habits before malocclusion or skeletal dysplasias occur. For school-aged children, counseling regarding habits is appropriate. It occurs in 70-90 percent of children.

Digit habits are harder to break than pacifier habits. Conventional pacifiers are the same to orthodontic pacifiers in their effects to orofacial structures.

Habits of sufficient frequency, intensity, and duration can contribute to:

- Reduced overbite, increased overjet
- Protrusion of maxillary incisors
- Anterior open bite
- Narrowing of the maxillary arch width, widening of mandibular arch

#### **Injury Prevention**

An age-appropriate injury prevention counseling for parents/care-givers should be put in place for potential orofacial trauma accidents. Discussions with parents would include play objects, pacifiers, car seats, and chewing of electric cords. Little ones love to put things into their mouths.

#### **CONCLUSION**

For most Americans, oral health status has improved since 1988-1994. Dental caries continues to decrease in the permanent dentition for youths, adolescents and most adults. Among seniors, the prevalence of root caries decreased, but there was no change in the prevalence of coronal caries. However, the prevalence of dental caries in the primary dentition for youths aged 2-5 years increased from 1988-1994 to 1999-2004.

Adult general health, especially oral health starts with infant oral care. An array of factors contributes to the oral health status of a child. Finding a dental home and having a formal preventive care plan can decrease the likelihood of the infant to experience dental disease. Educating the parents and/or caregivers on the infant's oral health, on bacteria transmission, injury prevention and the importance of having regular scheduled visits at appropriate intervals, plays an important role to maintain a healthy child.

#### **REFERENCES**

- 1 *American Academy of Pediatric Dentistry Reference Manual V32/No 6 10/11*
  - Policy on Oral Health Care Programs for Infants, Children and Adolescents pg. 24
  - Policy on Use of Fluoride pp. 34-35
  - Policy on the use of Xylitol in Caries Prevention pp. 36-38
  - Guideline on Infant Oral Health Care pp. 114-118
  - Guideline on Fluoride Therapy pp. 143-146
- 2 Pinkham, et al, *Pediatric Dentistry – Infancy through Adolescence*, Fourth Edition, Elsevier, pp.198-233
- 3 *NHANES* April 2007 DHHS Publication No. (PHS) 2007-1698

#### **About Ivonne Ganem, DMD, MPH**

Dr. Ivonne Ganem graduated from Universidad Javeriana School of Dentistry (Bogotá, Colombia) in 1999. In 2001 she completed her Masters in Public Health, majoring in Policy and Management, at Emory University in Atlanta, Georgia. Dr. Ganem joined the faculty at Temple University Kornberg School of Dentistry in 2002. She serves as Chair (Interim) for the Department of Pediatric Dentistry and Community Oral Health Sciences, Director of Community Outreach Programs and Director of the Infant Care Program at Temple University Kornberg School of Dentistry.

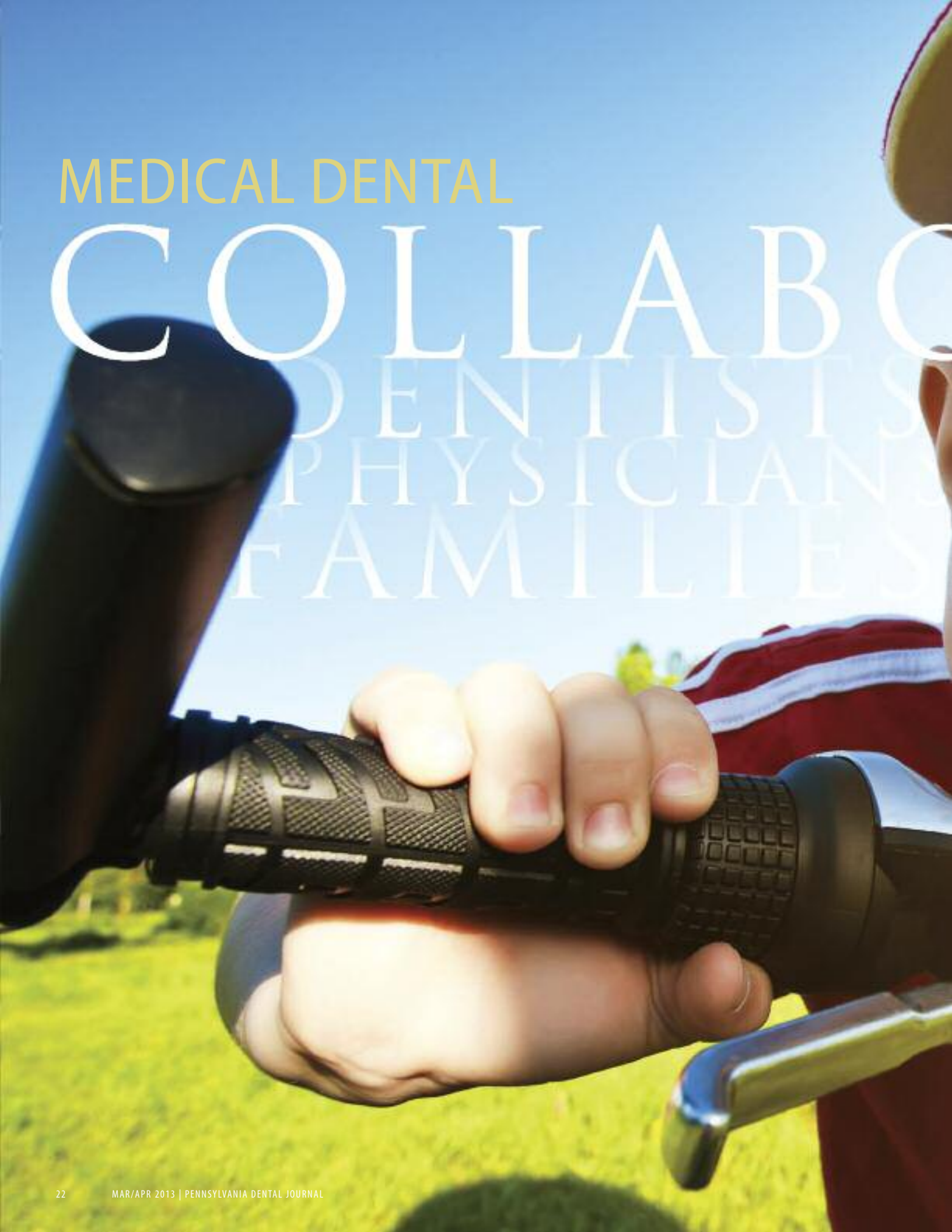
Dr. Ganem has been involved in access to care policy and research. Her interests include policies that affect access to care in underserved communities and access to dental education of underrepresented minorities. Dr. Ganem has also been involved in teaching both the graduate and pre doctoral levels in areas of Dental Ethics and Public Health. She has been an invited grant reviewer for governmental and private organizations and presents on topics relating to school-based dental clinics, community outreach and dental care delivery systems and workforce.



MEDICAL DENTAL

# COLLABO

DENTISTS  
PHYSICIANS  
FAMILIES





A close-up, low-angle shot of a young boy with a joyful expression, wearing a tan baseball cap and a red shirt. He is riding a bicycle, with the handlebars and front wheel visible in the foreground. The background is a bright, sunlit field with trees in the distance under a clear blue sky.

# OPERATION

QUALITY, COST EFFECTIVE HEALTH CARE

By C. Eve J. Kimball, MD

## A STORY - DO YOU HAVE A SIMILAR ONE?

*Sunday, Nov. 1, 2008 – R.M., a 22-month-old boy was in his hospital room surrounded by five (yes, FIVE) half empty sippy cups containing water to which “a little bit” of apple juice had been added “for flavor.” He was recovering from strep viridans sepsis and meningitis. His two maxillary primary central incisors each contained one millimeter brown spots and his left upper primary molar had a similar problem. His teeth were pointed and conically shaped. A medical and family history revealed that his mother had lost all of her permanent teeth when her braces were applied as a teenager. He had staphylococcal sub-scapular fasciitis at age 18 months at another institution.*

A call for help to one of our three local pediatric dentists, Preciosa Perez (due to deliver her infant in two weeks!) resulted in her appearance within the hour to examine him. Our plan of action was that he would have his PICC line placed on Tuesday and then she would repair his teeth in hospital on Wednesday and send him home to continue his antibiotics.

A call to Dr. Margaret Fisher, our pediatric infectious disease specialist, confirmed that strep viridans is an oral flora and a brain MRI would be a useful diagnostic study. On Tuesday, while groggy from PICC line placement anesthesia, the brain MRI revealed a left temporal abscess. Oops! Off to the Tertiary Care Children’s Hospital before the teeth could be fixed, diagnosis by the pediatric dental resident of NEMO syndrome (an X-linked variant of ectodermal dysplasia with a systemic immune deficiency syndrome and involvement of teeth which are pointed or conical). The parents were instructed to call for a dental appointment at the Children’s Hospital to repair his teeth. An appointment was made for June 2009 (seven months later), he had a consultation with pediatric immunologist, no fluoride varnish applied and he was discharged home on I.V. antibiotics.

I contacted Dr. Perez, who was willing to repair his teeth in Reading but anesthesiologists at two local hospitals refused to perform the anesthesia “because he had a brain abscess.” The distant dental appointment was moved up to March after more than two hours of telecommunications. The brown spots grew to 3 mm diameter in one month despite twice daily brushing with fluoride toothpaste and water only between meals. Another pediatric dentist suggested that I apply fluoride varnish every two weeks in the office from December to March and the brown spots decreased in size. His mother brushed his teeth twice daily, put only water in his sippy cups and kept his March dental appointment at the Children’s Hospital, where the teeth were repaired under general anesthesia.

R.M. is now six years old. He has all of his primary teeth, and is able to receive his dental care locally. His immune deficiency is managed with IVIG, and his later episode of osteomyelitis was diagnosed early and treated - all because the dental resident made the appropriate diagnosis and coordinated care with his medical team.

### U.S. health care setting

- In its World Health Report: Health Systems: Improving Performance, 2000, the U.S. Health Care System is ranked No. 38 in the world by the World Health Organization, and in expenditure per capita we are ranked No. 1! In 2010, a Gallup poll noted 62 percent of Americans rated quality and 39 percent rated coverage of their health care as good or excellent. We all must pay attention to both quality and cost of the care we provide.
- July 13, 2011, the Institute of Medicine published Improving Access to Oral Health Care for Vulnerable and Underserved Populations stating “Access to oral health care across the life cycle is critical to overall health, and it will take flexibility and ingenuity among multiple stakeholders...to make this access available...improve Medicaid and CHIP reimbursement rates...non-dental health care professionals can acquire the skills to perform oral disease screenings and provide other preventive services...dental schools...expand opportunities for dental students to care for patients with complex oral health care needs in community-based settings in order to improve the students’ comfort levels in caring for vulnerable and underserved populations...states...allow health care professionals to practice to their highest level of competence...”
- Families with two working parents have limited time (and yes limited financial resources).
- Access to medical and dental care for children on Medicaid is limited.
- Access to oral health care for children from 1-3 years old and for children with special health care needs is even more limited and frequently requires long travel distances for families to reach care.
- Early childhood caries is the number one chronic infectious disease in children (causes PAIN) and obesity is the number one chronic health problem in children in the U.S. Both have excessive sugar intake as root causes.
- In 2009, the American Academy of Pediatrics Leadership Council passed (in their top 15 resolutions) a resolution recommending (fluoridated) tap water as the beverage of choice between meals and at bedtime for all children over 12 months of age.
- The American Academy of Pediatrics Oral Health Section (dentists are welcome) noted the connection between obesity and oral health and promotes education through their Chapter Oral Health Advocates.
- The Dentaquest Foundation began Oral Health 2014 in 2011 with six focus areas: Prevention and the Public Health Infrastructure, Oral Health Literacy, Medical and Dental Collaboration, Metrics for Improving Oral Health, Financing Models and Strengthening the Dental Care Delivery System.

## Oral Health Care in Pennsylvania

- Forest County in Pennsylvania has NO DENTIST OF ANY KIND - Robert Wood Johnson County Health Ranking - 2012
- Medicaid services throughout the state are provided by four dental insurers and eight medical managed care organizations.
- Medical billing/reimbursement for Fluoride Varnish application (D1206) to children from >1 and <5 years old by primary medical care providers, accompanied by risk assessment, education, and referral to dentist was approved in April, 2010.
- Dentaquest foundation has funded three grantees in the state of Pennsylvania. We are working collaboratively, meet at least quarterly and have learned much from each other's efforts:
  - o PA Association of Community Health Centers to pilot improving access to oral health care in CHC settings - five clinics last year and five more this year
  - o PA Head Start Association is using the DentaQuest grant with Massachusetts Head Start Association to build successful collaborative oral health consortiums and to educate Head Start staff, children, and families using the Cavity Free Kids curriculum. Also, they are working to "Connect the Dots" between medical and dental providers to improve oral health services and access to care for vulnerable children through the PA Healthy Smiles Oral Health Task Force.

### OVERALL GOAL OF THE TASK FORCE:

To improve oral health outcomes for Pennsylvania's most vulnerable children under five and their families

### TASK FORCE OBJECTIVES

- Establish a dental home for every child by age one
- Educate adults to prevent oral diseases in children by starting early
- Forge local collaborations that benefit at risk children in Head Start and beyond
- Build collaborative and lasting relationships with the dental community statewide

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Healthy Children**  
A Pennsylvania Medical/Dental Partnership

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**You and your office staff can prevent pediatric tooth decay!**

American Academy of Pediatrics  
DEDICATED TO THE HEALTH OF ALL CHILDREN  
Pennsylvania Chapter

## Healthy Teeth, Healthy Children (HTHC)

HTHC is based at the PA Chapter of the American Academy of Pediatrics. They have been funded for planning and implementation to work on Medical/Dental Collaboration, Access to Care, and Oral Health Literacy. They are:

- working with PAAAP Early Childhood Education Linkage System revising the oral health curriculum for childcare providers,
- developing low literacy oral health handouts and poster,
- collaborating with PACHC to develop models of medical/dental collaboration in CHCs,
- developing best practices for oral health curricula for medical and dental education (both allopathic and osteopathic),
- implementing the Educating Practices in their Communities (EPIC) model (developed at the PA Chapter in 1994 teaching Early Intervention, followed by Immunizations, Child Abuse, Clean Air, Medical Home, Obesity, and Oral Health). A pediatrician or nurse practitioner and a community partner (dentist or dental hygienist) go into practices and teach them the following:
  - o Risk assessment and prevention plan
  - o Examination (positions, techniques) done by a trusted provider, in a familiar place, without pain at 6, 9, 12, 15, 18, 24, 30, and 36 months (Medical provider can be the primary health home until 24-36 months. After that the dental provider sees the children twice yearly and can report problems to the physician)
  - o Fluoride varnish application to teeth and recommendations for fluoridated water intake and brushing twice daily (we do not recommend fluoride supplement because of variability of fluoridation of water sources and because less than 10 percent are compliant with that recommendation)
  - o Education
    - Mechanism of development of early childhood caries (Oral bacteria + sugar = acid which destroys teeth)
    - Water in night-time bottles
    - Only water in sippy cups between meals - no adding juice "for flavor"
    - Age appropriate nutrition counsel - minimize sugar, utilize [www.choosemyplate.gov](http://www.choosemyplate.gov), and the low literacy handout pictured here in English and Spanish

**Healthy Mouth!**

**Healthy Food!**

**Healthy Children!**

Brush twice daily, floss once a day, and drink fluoridated water to help prevent cavities and tooth decay.

DentaQuest | American Academy of Pediatrics | Pennsylvania Chapter

**¡BUCA SAN!**

**¡DIETA SAN!**

**¡NIÑOS SANOS!**

¡Cepíllate dos veces al día, usa hilo dental una vez al día y bebe agua fluorada para ayudar a prevenir caries y enfermedad de las encías!

DentaQuest | American Academy of Pediatrics | Pennsylvania Chapter

- Brush twice daily
- Floss once teeth touch
- Role of fluoridated water
- What to expect from the dentist and what to look for in a dentist
- Trauma prevention

o Referral

- Create a list of available local dentists who are comfortable and competent with treating 1 year olds and children with special healthcare needs
- Encourage medical professionals to call dental professionals and develop shared context for future collaboration

o Skills

- Multiple positions are possible: knee/knee; supine on table, cradled in parent arms, sitting
- Utilize otoscope light
- Varnish application - bend the brush, just coat teeth - no need to use it all, accumulate supplies in plastic bag to speed the process
- Understand the role of fluoride in water, varnish sealants; Emphasizing that fluoride in recommended doses is "micro (0.7 ppm)" and toxicity only occurs with "macro (>4 ppm)" doses; Anti-fluoride promoters are quoting problems from areas where fluoride occurs naturally in the water in concentrations >20-90 ppm in Colorado, Mexico, India, China, and some parts of Africa. The problems they mention don't occur with the "micro" doses that promote healthy teeth
- Role of sealants
- Efficient, effective office flow
- Billing a dental code

- Medical/dental referral and collaboration skills (I just had a call this week from a local family dentist who needed a preop exam done quickly for a child needing oral rehab quickly.)

**What's to do? The Executive Summary!**

- Sippy cups will not go away. Therefore parents should be taught that only fluoridated tap water should be placed in sippy cups between meals and that no juice or sugar should be added.
- There is a connection between dental caries and obesity. That connection is sugar. By teaching healthy diet habits we can prevent two diseases.
- Medical-dental collaboration is a cost-effective way to improve both care and access to care for oral health. In addition both physicians and dentists learn more about each other's professional knowledge.
- Physicians see children every 2-6 months through the first 3 years of life. They are perfectly positioned to provide preventive oral health counsel, treatment, and referral. If trained, they can provide appropriate oral health risk assessment, varnish application, and referrals as needed. Dentists see children every six months and can be observers who refer back to the pediatrician between checkups for the older children - a health partnership.
- Having physicians apply varnish when the first tooth appears is a cost effective way to prevent early childhood caries. Training dentists to see children at 12 months of age is important if we are to stop the epidemic of early childhood caries.



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*Dr. Kenneth Wolnik recently acquired the Broadview Heights practice of Dr. Dan Keehn. PI would like to congratulate both doctors on a successful transition!*

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- Two excellent detailed curricula are available online for pediatricians and family practitioners who desire to improve their knowledge of oral health. Family dentists who are uncomfortable with seeing children can also expand their knowledge with these curricula:
  - o Smiles for Life at [www.smilesforlifeoralhealth.org](http://www.smilesforlifeoralhealth.org) (8 CME hours)
  - o Protecting All Children's Teeth (PACT) curriculum at [www.aap.org/oralhealth](http://www.aap.org/oralhealth) (11 CME hours)
- The EPIC curriculum is designed to assist practices in the implementation of risk assessment, examination of teeth, fluoride varnish application, education, and referral while providing basic education about early childhood caries and other oral health conditions common to the care of children and adolescents.
- Cooperation between organized medicine and dentistry at the state and ultimately at the national level would be extremely beneficial in promoting oral health education and proper care of teeth
- Children with special health care needs should be seen at 12 months and every 6 months thereafter if their teeth are to be kept free of caries and plaque.
- Both medical and dental providers need to increase the services that they provide to children who have PA Medicaid insurance HMO.

## ACTION NEEDED!

### Please consider:

- Medical dental collaboration - talk to your local physicians and encourage them to call you with questions.
- Improving access to care - find out how you can participate in Medicaid and receive additional meaningful use dollars from CMS through the state of PA.
- Become comfortable with seeing 12 month olds - educating their parents and giving them time to get used to you in the dental office without pain is good practice - some

dentists schedule them one each hour to compensate for missed appointments by others. Other dentists have a time set aside for doing small children as a group for education followed by examination.

- Focus on educational materials that everyone can understand - see Picture 1 here for your use if you find it useful. It is in both Spanish and English.
- Membership in the AAP Oral Health Section is available to dentists interested in oral health care for children. You are welcome to join us! The section is currently lead by a Pediatric Dentist. For information contact Lauren Barone at [lbarone@aap.org](mailto:lbarone@aap.org) for information.
- Finally, contact us at [hthc@paaap.org](mailto:hthc@paaap.org) to find out how we can work together or call me at (610) 463-8775 if you have questions.

## ONE FINAL STORY - 1971 Location: Silver Spring, Maryland

Our private pediatric dentist, on the faculty of Georgetown Dental School gave me a challenge: If I was willing to look at teeth on my way in to examine the pharynx, he would give me free dental care for our three children. He taught me how to evaluate a dentist, what to expect as good oral health care, to refer children for his care at age two (that was before the guidelines were revised 25 years ago), the importance of fluoride, to give 16 ounces of fluoridated tap water daily, and never to put babies to bed with a bottle! He also taught me to expect that the dentists caring for my patients would be willing to receive a call from me when I had concerns - AND CONVERSELY, for me to expect calls from them when they saw oral health problems that might be related to the child's overall health. What a gift that was! My medical career (1970-present) has been enriched hundreds of times. And, by the way, he is now caring for three of my grandchildren and is teaching my pediatrician daughter to refer at one year old.



### About Dr. Kimball

Dr. Kimball has been looking at teeth and talking to dentists for more than 40 years and has found that it enriched her medical career and served her patients well.

Dr. Kimball is the managing partner at All About Children Pediatric Partners in Reading. She founded this practice in 1991 and has built it from solo practice to eight MDs and eight NPs. All About Children Pediatric Partners was trained in oral health risk assessment and varnish application in April 2009 and has been applying varnish since October 2009.

Dr. Kimball became Chapter Oral Health Advocate for the PA Chapter of the AAP in December 2009 and was awarded PA AAP Chapter Pediatrician of the Year for 2009 in 2010.

She considers Douglas Pincock, DMD, Norman Tinanoff, DDS, Hugh Silk, MD, and Amos Deinard, MD to be her oral health mentors!

# BENEFITS OF THE AGE ONE EXAM

By Cheryl Janssen, CEO, Kids Smiles and Health Care Management Solutions Inc. and Allison Rose, DMD

*Communications regarding good oral health care can help families develop positive, lifelong habits. Over time, this will produce a larger population of people with good oral health, and given the connection between oral health and overall health, this will ultimately reduce health care costs.*

*To be most effective, communication promoting oral health as an integral part of overall health should begin early in a child's life.*

*The American Academy of Pediatrics (AAP) recommends referral to dental care by a primary care physician as early as six months of age, six months after the first tooth erupts, and no later than 12 months of age. This provides time-critical opportunities to implement preventive health practices and reduce the child's risk of preventable dental disease.*





*Engaging the provider community is essential as they are the primary source of oral health information for people. Insurers like DentaQuest programs follow the Early Periodic Screening Diagnosis and Treatment (EPSDT) guidelines, which require that services be available to children from birth to age 20.*

*The AAP states that a professional prophylaxis can be performed using toothbrush, rubber cup, flossing, or mechanical instruments. In the absence of stain or calculus, a manual toothbrush and non-abrasive paste may fulfill the goals of a professional prophylaxis. Additionally, the AAP recommends that children at moderate risk for caries should receive a professional fluoride treatment at least every six months. MassHealth supports these recommendations.*

## **PREVENTIVE PEDIATRIC DENTAL CARE**

### ***Birth to Early Adulthood***

The American Academy of Pediatric Dentists (AAPD) publishes recommendations for preventive pediatric dental care and periodicity and anticipatory guidance recommendations for children from birth through early adulthood. The oral health of a child is ultimately the responsibility of the child's parent/caregiver, but as a provider you can counsel your patients on the preventive treatments/procedures available to them, along with other healthy habits.

The first step is the initial patient exam, which should take place at the eruption of the child's first tooth (and no later than 12 months). Counseling on several topics including: oral hygiene, injury prevention, healthy eating and snacking habits, and other lifestyle habits, can be beneficial to the overall oral health of your patients, and should be continued throughout all stages of a child's development.

The AAPD recommendations also cover fluoride supplementation, pit and fissure sealants and radiographic assessments. Please remember to refer to the benefits tables for benefits and limitations before treating your patients.

### ***Incorporating Age One or Early Childhood visits into the general dental practice.***

Treating young children in the general dental office is important in the reduction of early childhood caries and developing good oral habits that will help reduce more significant oral health issues in the future. Providing these services can also help the patient flow, increase the number of services offer by a practice and enhance the dental practice business model.

Providing an age one exam can be easily incorporated into a dental office schedule alongside of other patients or during open schedule times. Frequently mid-morning hours are in less demand for appointments. These appointment times are ideal for young patient visits. Specific appointment time can be allocated for the visit, or the appointment can be double booked in a busy schedule. If the practice has a number of young

children, setting aside specific mornings and allotting blocks of time for several young child visits is productive. If the practice only has a few young children, streamlining them into the day-to-day schedule is the best strategy.

The actual age one to age three appointment takes approximately 10 to 15 minutes and is conducted in a knee to knee exam style (technique below). The exam consultation with mom or dad is another five minutes because a majority of the consultation occurs in conjunction with the exam process. If behavior permits, a tooth brush prophylaxis and or fluoride varnish can be administered. It is often easiest for the dentist to offer these services while conducting the exam. However, key auxiliary can perform these services and address the oral health education given to parents to aid them in the at home oral health process. The exam and prophylaxis or placement of fluoride varnish is charged under the normal ADA dental codes.

Providing care to toddlers aligns with clinical and business best practices. As an early intervener in the oral care model this practice reduces the incidence of early childhood caries, future oral health complications and helps reduce dental anxiety. These services also increase practice revenue and maximize chair utilization. Dentists should work with their team to design an efficient and impactful system to advance the oral health care model and help meet the AAPD in this call for oral health action among our children.

### ***Standard Procedure used when providing a knee to knee exam with the parent or caregiver:***

1. Introduce yourself to parent and child.
2. Review the medical and dental history.
3. If the child is NOT crying or being difficult, give child time to "check out" the place and go over anticipatory guidance with parent (appropriate info about child's health to prepare for child's milestones).
4. If the child is crying, do clinical exam first (get it out of the way) and then do discussion with parent as child calms down in their lap.



Anticipatory guidance:

- A. Dietary education and feeding practices/counseling
  - B. Fluoride assessment/status
  - C. Oral hygiene instructions and home care instructions (brushing and floss needs if applicable)
  - D. Age appropriate injury prevention
  - E. Importance of dental care and routine checkups every six months or sooner. Making a dental home.
  - F. Non-nutritive habits (digit, pacifier)
5. Clinical exam to assess oral growth, pathology, injuries and oral development to provide a diagnosis. (Radiographs if clinical findings or dental history warrants them) removal of plaque and application of fluoride varnish.
  6. Discuss treatment needs or referrals and consults with MD if needed.
  7. Also should do a caries risk assessment. This involves a combination of factors including diet, fluoride exposure and susceptibility of decay, social and cultural and behavioral factors.
    - A. You are determining the likelihood of the incidence of caries (# of new cavitated or incipient lesions during a period of time).

B. You are categorizing a patient into a high/moderate/low or protective risk.

Your factors involve:

- biological: family history, socioeconomic, diet, bottle, special health care needs.
- protective: fluoride, home care, dental visits/home, routine dental care
- clinical: white spots, enamel defects, cavities, fillings, plaque.

**About Cheryl Janssen**

Cheryl Janssen is the CEO of Kids Smiles, the non-profit dental center serving poor children that she has led since 2000. She is also founder and CEO of Health Care Management Solutions. Cheryl's work resulted in the *Philadelphia Business Journal's* 2012 Health Care Innovation Award for Kids Smiles. She was named *Philadelphia Business Journal's* "Woman of Distinction" in 2011.

**About Dr. Allison Rose**

Dr. Rose graduated from the University of Pittsburgh School of Dental Medicine in 2000, after earning a Bachelor of Science degree from Pennsylvania State University. She was a Pediatric Dentistry Resident at Temple Hospital in 2002, and she has been a board certified Diplomate of the American Board of Pediatric Dentistry since 2005. Dr. Rose loves spending time with her husband Josh and two wonderful boys, Jake and Max. She also enjoys cooking, reading and working on home improvements.

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# Save the Date!

## Affordable Care Act Webinar — May 14

PDA and PDAIS are hosting a 90-minute webinar on the new federal health care law, Tuesday May 14, from 11:30 a.m. to 1:00 p.m. Learn how the Affordable Care Act impacts dentists during this free webinar. We will have several panelists who are nationally recognized experts on health care and dental insurance. Visit [padental.org/ACA](http://padental.org/ACA) for more information, including how to register for this special event.

## IN MEMORIAM

Dr. Sidney R. Bridges  
Bryn Mawr  
Temple University (1954)  
Born: 1931  
Died: 12/1/2012

Dr. Philip D. Corn  
Mays Landing  
Temple University (1948)  
Born: 1925  
Died: 1/4/2013

Dr. John L. Cullen  
Leechburg  
University of Pittsburgh (1968)  
Born: 1942  
Died: 3/22/2011

Dr. Raymond L. Detz  
Nanticoke  
Temple University (1954)  
Born: 1927  
Died: 1/1/2013

Dr. Norman A. Dinnerman  
Levittown  
University of Pennsylvania (1952)  
Born: 1919  
Died: 1/16/2013

Dr. C. Douglas Ebling  
York  
Temple University (1955)  
Born: 1929  
Died: 8/19/2012

Dr. Paul E. Farrell  
Virginia Beach  
University of Pennsylvania (1951)  
Born: 1926  
Died: 10/19/2012

Dr. Louis H. Guernsey  
Audubon  
University of Pennsylvania (1947)  
Born: 1923  
Died: 12/6/2012

Dr. Clinton L. Hoffman  
Etters  
Temple University (1953)  
Born: 1926  
Died: 11/3/2012

Dr. Theo H. Kirrstetter, Jr.  
Lansdale  
University of Pennsylvania (1948)  
Born: 1925  
Died: 12/8/2012

Dr. Edmund H. Lange  
Pocatello  
Temple University (1949)  
Born: 1925  
Died: 1/5/2013

Dr. Heather M. Raymond  
State College  
Temple University (2000)  
Born: 1969  
Died: 12/19/2012

Dr. Michael C. Ritter  
Wyomissing  
Temple University (1970)  
Born: 1943  
Died: 12/7/2012

Dr. John L. Salines  
Allentown  
Temple University (1947)  
Born: 1923  
Died: 1/24/2013

Dr. James S. Williams  
Hatboro  
University of Pennsylvania (1954)  
Born: 1927  
Died: 12/1/2012

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## CONTINUING EDUCATION

### University of Pittsburgh

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Administrative Secretary  
(412) 648-8370

#### **April 6-7 - Part 1 and April 20-21 - Part 2**

Local Anesthetics for the Dental Hygienist  
*Matthew Cook, DDS, MD, MPH*  
*Paul Moore, DMD, PhD, MPH*  
*Angelina Riccelli, RDH, MS*

#### **April 27**

Dental Radiography: DANB Exam Prep course  
*Gayle Ball, RDH, MA*  
*Victoria Green, RDH, BS*

#### **May 4**

What's Hot and What's Getting Hotter (T. F. Bowser Memorial Lecture)  
*Howard S. Glazer, DDS, FAGD, FACD, FICD, FASD*

#### **Off Campus Courses**

##### **Altoona**

#### **April 25**

Update on Caries, Vital Pulp Therapy, Ceramics and Cements  
*Jan K. Mitchell, DDS, MEd, MAGD*

##### **Bradford**

#### **April 25**

Restoration of the Complex Denture, Fixed, and Implant Patient: Pitfalls to Avoid  
*Carl F. Driscoll, DMD*

#### **September 26**

Modern Endodontics - From Theory to Practice  
*Martin Trope, BDS, DMD*

#### **October 24**

New Modalities in the Treatment of TMD  
*John E. Pawlowicz, DMD*

##### **Butler**

#### **April 18**

Treating Patients with Cardiovascular Disease: What To Know and What To Do - Plus Treating Yourself to a Healthier Life  
*James Lichon, RPh, DDS, NCCM*

##### **Erie**

#### **April 18**

Dental Caries Update: It's About More Than Just Filling Holes!  
*John Maggio, DDS*

##### **Greensburg**

#### **April 19**

Treating Patients with Cardiovascular Disease: What To Know and What To Do - Plus Treating Yourself to a Healthier Life  
*James Lichon, RPh, DDS, NCCM*

##### **Johnstown**

#### **April 24**

The Latest Spin on Rotary Instrumentation  
*George Just, DDS, JD*

#### **October 16**

Drugs in Dentistry - Including Herbals and Natural Products: Most Current Information Affecting Your Practice  
*Richard L. Wynn, PhD*

#### **November 14**

Can I Do That, and Get Paid, and Enjoy It?  
*Robert N. Obradovich, DMD*

##### **Pittsburgh (VAMC)**

#### **April 24**

Understanding All-Ceramics: Techno-Clinical Perspectives and Tips for Success  
*Damon C. Adams, DDS*

#### **May 17**

Treatment Planning Occlusal Wear Cases  
*Joseph C. Passaro, DDS*  
*James B. Wooddell, DDS*

##### **Pottsville**

#### **April 11**

Drugs in Dentistry - Including Herbals and Natural Products: Most Current Information Affecting Your Practice  
*Richard L. Wynn, PhD*

##### **Reading**

#### **April 12**

Drugs in Dentistry - Including Herbals and Natural Products: Most Current Information Affecting Your Practice  
*Richard L. Wynn, PhD*

#### **May 10**

What's Hot and What's Getting Hotter!  
*Howard S. Glazer, DDS, FAGD, FACD*

#### **September 13**

Options for the Restoration of the Dental Implant  
*Steven J. Kukunas, DMD*

#### **October 11**

Porcelain Laminate Veneers - The Whole Story!  
*Steven P. Weinberg, DMD*

##### **Scranton**

#### **April 17**

What's Hot and What's Getting Hotter!  
*Howard S. Glazer, DDS, FAGD, FACD*

##### **Steubenville, OH**

#### **April 18**

Update on Caries, Vital Pulp Therapy, Ceramic, and Cements  
*Jan K. Mitchell, DDS, MEd, MAGD*

##### **Titusville**

#### **April 24**

Nonsurgical Periodontal Therapy  
*Jennifer Zavoral, DMD*

##### **Williamsport**

#### **April 3**

Restoration of the Complex Denture, Fixed, and Implant Patient: Pitfalls to Avoid  
*Carl F. Driscoll, DMD*

### Temple University

Contact: Nicole Carreno  
(215) 707-7541  
(215) 707-7107 (Fax)  
[ncarreno@temple.edu](mailto:ncarreno@temple.edu)  
Register at  
[www.temple.edu/dentistry/ce](http://www.temple.edu/dentistry/ce)

#### **April 19**

Porcelain Laminate Veneers  
*Dr. Steven Weinberg*

#### **June 17 - 21**

Surgical and Prosthetic Oral Implantology — A 5 Day Introductory Course  
(Part 2 in September, see site for info)

### Greensburg

Giannilli's II Restaurant & Banquet Facility  
Contact: Rebecca Von Nieda, PDA  
(800) 223-0016, ext. 117

#### **April 12**

Salvaging Hopeless Teeth  
*Edward M. Feinberg, DMD*

#### **May 10**

Dose Response Relations & Avoiding Adverse Drug Interactions  
*Elliot V. Hersh, DMD, MS, PhD*

Brookville	Wellsboro	PDA & PDAIS Sponsored Courses	Lancaster County Dental Society
<p>Gold Eagle Inn Contact: Rebecca Von Nieda, PDA (800) 223-0016, ext. 117</p> <p><b>April 19</b> Oral Cancer and Medically Complex Dental Patients <i>Andres Pinto, DMD, MPH</i></p> <p><b>May 10</b> Medical Emergencies in the Dental Office: The Six Links of Survival <i>Larry J. Sangrik, DDS</i></p>	<p>Tokishi Training Center <b>(New Location!)</b> Contact: Rebecca Von Nieda, PDA (800) 223-0016, ext. 117</p> <p><b>May 17</b> Current Concepts in Salivary Gland Disease <i>Scott S. De Rossi, DMD</i></p> <p><b>September 6</b> Salvaging Hopeless Teeth <i>Edward M. Feinberg, DMD</i></p> <p><b>October 4</b> Advanced Technology Update: Emerging Options in Materials, Diagnostics and Devices for Dentistry <i>Steven R. Jefferies, MS, DDS, PhD</i></p>	<p>Contact: Rebecca Von Nieda, PDA (800) 223-0016, ext. 117</p> <p><b>Erie</b> <b>May 8</b> Medical Emergencies in the Dental Office: The Six Links of Survival <i>Larry J. Sangrik, DDS</i></p> <p><b>Bedford</b> <b>November 22</b> Medical Emergencies in the Dental Office: The Six Links of Survival <i>Larry J. Sangrik, DDS</i></p>	<p>Lancaster Country Club Contact: Alycai Billy, Executive Secretary <a href="mailto:LCDentalsociety@yahoo.com">LCDentalsociety@yahoo.com</a> or (717) 606-6534 for registration and fee info</p> <p><b>May 3</b> The Joy of Oral Pathology: You are the Object of My Infection <i>Dr. John Svirsky</i></p>
<p><b>Berks County Dental Society</b></p> <p>The Highlands at Wyomissing Contact: Marie Erlandson (610) 987-0143 <a href="mailto:berkscountydentalsociety@yahoo.com">berkscountydentalsociety@yahoo.com</a></p> <p><b>April 12</b> Are Your Patients Dying To Breathe? <i>John Pawlowicz, DMD</i></p>			<p><b>Dental Society of Chester County and Delaware County</b></p> <p>DKU Continuing Dental Education Springfield Country Club Delaware County Contact: Dr. Barry Cohen (610) 449-7002 <a href="mailto:DKUdental@aol.com">DKUdental@aol.com</a></p> <p><b>May 22</b> Achieving Financial Independence <i>John McGill, CPA, MBA, JD</i></p>



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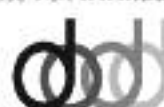
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Please contact Bob Septak at (724) 869-0533 or email [bob@udba.biz](mailto:bob@udba.biz), [WWW.UDBA.BIZ](http://WWW.UDBA.BIZ).

As always, we treat these matters with the highest amount of confidentiality and any contact with United Dental Brokers of America will be kept completely confidential.

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**SoNet**  
PDA's Social Network

### Connect with Your Colleagues PDA's Social Network (SoNet)

If you haven't yet logged on to the PDA Social Network, we encourage you to do so. This network gives you the ability to have increased communication with PDA leaders and staff, as well as endless opportunities to connect with your colleagues. Some highlights of the network include:

- Open forums for discussing dental office equipment and products, legislative topics and practice management issues.
- A library for you to search and share documents, as well as provide product reviews and share testimonials.
- Public and private groups that serve as an electronic mailing list.
- A personal profile for sharing and connecting with colleagues.

There is all of this and much more. The new communication possibilities provided by the social network are endless. To get started, visit [www.community.padental.org](http://www.community.padental.org) and download the first time user instructions by clicking on the link on the homepage.

If you have any questions about the Social Network, please contact PDA at (717) 234-5941.

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