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

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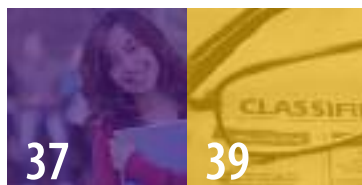


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By Dr. Bruce R. Terry
Editor

Happy Birthday

Did you know that the Internet turned 25 years old this March? It seems that a whole generation has grown up without ever knowing what it was like before the Internet. Recent dental school graduates never had a time when they didn't search the Web for information and answers. Those of us "older" practitioners remember when computers were a novelty for the dental office. Big businesses and multinational corporations needed computers and a way to send information, but what did the solo dental office need with the Internet? We had a one-write pegboard accounting system and a paper scheduling book. We were off the grid and could survive a power failure better than today's modern offices.

To be clear, the Internet existed before 1989. In-the-know people would have connected through a bulletin board system (BBS) or, later, through an email or forum with a service like CompuServe, but the idea of pulling up a website was foreign.

It wasn't until Sir Tim Berners-Lee proposed an "information management" system that would allow people to access pages hosted on computers across the globe that the world would ultimately be connected. Berners-Lee received a knighthood for his work, originally created on March 12, 1989. By 1990 he released his code to the world for free, turning the "Internet from a geeky data-transfer system embraced by specialists and a small number of enthusiasts into a mass-adopted technology," according to the

Pew Research Center.

In 1993, Mosaic, the first popular Web browser, was born. In 1995 only 14 percent of American adults were using the Web and only 42 percent had heard of the Web. Connection speeds were painfully slow compared to today's speeds. Most material was better viewed as text rather than picture and certainly not as video.

Compare that with the statistics today where nearly every American has heard of the Internet and 87 percent are online regularly. Of course as these changes were taking place, businesses both large and small were adjusting to the "new information age."

I was a geeky kid who enjoyed computer programming languages in the 1970s. Having learned Basic, Fortran and Cobol, I enjoyed writing computer programs and even managed to get college credit while writing database programs for the football team and the resident ornithologist.

When I started my first office I decided that we would modernize beyond the traditional accounting system on paper and move to a computer based system. Computerization would allow us to better look at our information as well as to streamline the tasks of sending out statements and tracking production and collections. At first this was a hobby. Born out of interest, lack of busyness and mostly being cheap, I did all of the programming and setup myself. Many of you did the same thing and can relate to this story. Many evenings and weekends I would update and improve the system that I created. At first it was just one computer at the front desk connected to the printer. I must have spent a few hundred hours getting statements to print correctly. I ordered multipart statements that ran through the printer and could be mailed by just adding postage. No writing addresses, no sealing and folding envelopes.

Next I needed to connect these computers to access information at the same time. Before Ethernet, I ran coaxial cable between the workstations in my office and those at the front desk. At that time, circa 1989, I had three computers. Later I would have to replace all of the co-axial cables with Ethernet cables. Exciting, huh? But, I still was not connected to the Internet.

Computer technology in my dental office was a revolution at the beginning. Pretty soon I was a slave to it. I remember one evening when I was running a batch of monthly statements for the eighth or ninth time, because of a paper jam, I nearly grabbed the printer and threw it at the wall. At other times my receptionist would say that she couldn't do this or that, and I would have to find time to fix problems that were becoming more difficult as well as more numerous. As more options, such as electronic claims, became available, I quickly became overwhelmed by the programming necessary to keep up. It was at this point that I reluctantly agreed to hand over control to a software management company.

Again there are those of you who might relate to my DIY story. Like many of you I thought I was as smart as the programmers, but the reality was I was just stubborn and cheap. It was around this time that we not only embraced dental office management software, but the IT professional to manage it all for us. With the introduction of the Internet we began to process claims electronically, check benefits electronically, send and receive information electronically, etc.

Like the younger dentists reading this, most of us old-timers can't work without the Internet today. With all that is available it's not only an enhancement but a necessity. That's why a power failure today is much more dramatic than in the

past. In the past a patient could come in for an impression or cleaning and pay cash without the need for power. Just a battery operated headlamp is all you would need. But, today you need your electronic schedule to know who's coming in, your computer to read your notes and record the payment, and your credit card terminal to accept payment.

And while the Web has transformed our lives at work as well as at home, I think Berners-Lee captured the essence of his creation with the following: "Anyone who has lost track of time when using a computer knows the propensity to dream, the urge to make dreams come true and the tendency to miss lunch." The Internet is not just for business anymore!

Happy Birthday to the Web.

—BRT



SAVE THE DATE 2nd Annual MOM-n-PA

The second MOM-n-PA dental mission will be held in Allentown on Friday, September 12 and Saturday, September 13, at the Agri-Plex at the Allentown Fairgrounds. Last year the MOM-n-PA mission provided more than \$850,000 in free dental services with more than 1,000 volunteers taking part in the event. You can help with the 2014 effort by volunteering your services or making a donation. For more information, visit the website at www.mom-n-pa.com.

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GOVERNMENT RELATIONS

In March, PDA made headway with House of Representatives leaders and staff on moving our assignment of benefits bill through the House. We expect that a companion bill to SB 520, the assignment of benefits legislation introduced in the Senate, will soon be introduced. This remains PDA's legislative priority for the 2014 session. We continue to advocate for legislative proposals aimed at improving access to care, including loan forgiveness for dentists practicing in designated shortage areas, continued funding in the Donated Dental Services program and reforms to the Medical Assistance program, such as increased provider reimbursement and centralized credentialing.

For the past two months, the primary focus in Harrisburg has been Governor Corbett's proposed budget for fiscal year 2014-2015, which begins July 1. The House and Senate Appropriation Committees held public hearings, at which they grilled secretaries for all of the executive agencies responsible for implementing the Governor's budget. The General Assembly and Administration will now undergo months of negotiations before the budget is voted on at the end of June. PDA will continue to monitor these developments for any impact they will have on dentists and the delivery of dental services in Pennsylvania.

Governor Corbett's 2014-15 Executive Budget Summary

In February, Governor Tom Corbett presented his 2014-15 budget to the General Assembly, telling lawmakers that the \$29.4 billion spending plan continues to drive the values of strategic investment and prudent fiscal management to address the commonwealth's core funding needs.

Corbett's proposed budget focuses on three key areas: education, jobs and health and human services.

Health and Human Services

In September 2013, Governor Corbett launched his "Healthy Pennsylvania" proposal aimed at increasing access to quality, affordable health care for all Pennsylvanians. Healthy PA has three key priorities: improving access; ensuring quality; providing affordability. The Governor's message to lawmakers is that his proposed budget "advances the Healthy PA plan while reaffirming a commitment to preserving the safety net for individuals with intellectual and physical disabilities, seniors, children and low-income families."

To further support the Governor's Healthy PA and human services agenda, the 2014-15 budget outlines the following initiatives:

Reforming Pennsylvania's Medicaid Program — The Administration's claim is that Healthy PA is needed to ensure that the commonwealth can provide sustainable access to quality, affordable health care coverage well into the future. Healthy PA includes reforms to Pennsylvania's MA program and increases access to health care coverage for more than 500,000 low-income residents through its Private Coverage Option.

The 2014-15 budget includes \$125.4 million in savings from the implementation of the Medicaid Reforms and Private Coverage Option within the Healthy PA Medicaid waiver. This budget assumes approval of the waiver by the federal government.

PARAGON

DENTAL PRACTICE TRANSITIONS

RECENT TRANSACTIONS

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Angela C. Resavage, D.M.D.
Forty Fort, Pennsylvania

David L. Gordley, D.D.S.
has acquired and merged his practice
into the practice of
F. Roger Landfair, D.D.S.
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Increasing Support for Community Health Centers and Health Care Clinics — The budget provides \$4 million of new funding to provide grants for four new health care centers and to 36 existing health care entities to increase access to preventative primary care services for uninsured individuals in underserved areas of the state.

Expanding Access to Primary Care Services in Rural and Underserved Areas of Pennsylvania — The budget increases funding by \$4 million to provide loan repayment assurance to health care practitioners who commit to working in primary care in rural and underserved areas of the commonwealth. This funding will provide an additional 70 awards to physicians, dentists and other practitioners. To help address the growing primary care shortage in our rural areas, this budget also provides funding to create 12 new residency slots for medical school

graduates who are legal Pennsylvania residents or who have completed their medical school education in Pennsylvania and who commit to providing primary care in a rural Pennsylvania community upon completion of residency training.

Specific human services funding includes:

- Expanding Services for Older Pennsylvanians and Individuals with Physical Disabilities —** This budget provides an increase of \$41.5 million to serve:
- o An additional 1,764 older Pennsylvanians through the Medicaid Home and Community-Based Aging Waiver (\$11.6 million)
 - o An additional 800 individuals in the LIFE program (\$9.4 million)
 - o An additional 500 individuals on the Options waiting list (\$1.1 million)
 - o An additional 204 individuals who transfer from the Department of Public

Welfare's Attendant Care Program at age 60 (\$1.4 million)

- o An additional 1,599 individuals with physical disabilities in community settings (\$18 million).

Expanding Services for Individuals with Intellectual Disabilities and Autism — The budget includes an additional \$23.5 million to provide home and community-based options for an additional 1,200 individuals with intellectual disabilities and autism:

- o 700 young adults who are graduating from the special education system to continue to live independently in the community
- o 400 individuals who are on the emergency waiting list to access crucial services to keep them in their home and community
- o 100 individuals receiving service in the Autism waiver

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Moving Individuals from Institutional Care to Community-based Care — The budget includes an additional \$5.4 million to increase community placement for individuals currently in state mental hospitals and state intellectual disability facilities. This funding will enable the transition of 90 clients from state mental hospitals to progressive mental health treatment in home-like settings and 50 clients from state intellectual disability facilities to home and community-based settings.

Domestic Violence and Rape Crisis — The budget provides \$2.2 million, a 10 percent increase in funding, for services dedicated to victims of sexual and domestic violence.

Early Learning Challenge Grant — This budget provides \$15.8 million in federal Race to the Top Grant Program funds to support high-quality early childhood education programs across the commonwealth. This four-year grant supports the commitment to providing high-quality early learning opportunities for Pennsylvania's youngest students by:

- o Enhancing access for children with high needs to high-quality early learning and development programs
- o Developing stronger relationships between early childhood education programs and school districts
- o Developing strategies focused on increasing family supports and engagement
- o Improving access and delivery of high-quality professional development for early learning educators

Child Care Assistance and Improving the Quality of Child Care Programs — This budget provides \$15 million in federal funds to allow an additional 2,895 children currently waiting for services to receive child care assistance and continues the commitment to high quality child care and assures that more than 210,710 children of low-income families have access to and can receive affordable child care.

For more information on the Governor's 2014-15 Executive Budget, including a summary of education and jobs proposals, visit www.pa.gov.

Medical Assistance Reforms: Pennsylvania Submits Healthy PA Waiver to U.S. Department of Health & Human Services

Governor Tom Corbett submitted Pennsylvania's plan to the U.S. Department of Health and Human Services to reform the state's Medical Assistance (MA) program, with the promise that it will provide increased access to quality affordable health care for more than 500,000 uninsured Pennsylvanians. By this formal step, Pennsylvania is seeking federal approval to implement the Healthy Pennsylvania plan.

The Healthy Pennsylvania MA modernization plan includes reforming the current Medicaid program and offering a private coverage option for uninsured Pennsylvanians. The proposed plan, anticipated to begin in January 2015, encourages personal responsibility, provides benefits that match individuals' health care needs and promotes healthy behaviors.

Currently, one in six Pennsylvanians receive MA benefits and the costs of the program account for 27 percent of the Commonwealth's entire general fund budget. These costs continue to grow by hundreds of millions of dollars each year.

The submitted plan includes numerous modifications based on feedback DPW received during seven statewide hearings, two webinars and submitted comments. Some of the changes include modifying cost sharing criteria, providing coverage for the period between the presumptive eligibility application date and the effective date of the private coverage option coverage, and including locally-based federally qualified health centers in plan networks under the private coverage option.

The proposed plan would:

- Increase access to private market health insurance through the *Healthy Pennsylvania* Private Coverage Option for Pennsylvanians 21 years of age or older, but under 65 years of age, with incomes less than 133 percent of the Federal Poverty Level (\$15,282 in a household of one);
- Modify the existing Medicaid benefit designs to be consistent with the private health insurance market, with the intent of providing long term sustainability of the program and a safety net when individuals are in their greatest need; and
- Promote healthy behaviors and increased independence through cost sharing and encouraging employment.

For more information about Governor Corbett's entire Healthy Pennsylvania plan, visit www.pa.gov. For more information about the Healthy Pennsylvania Medicaid modernization plan, visit www.dpw.state.pa.us/healthypa.

WHAT IS THE PA COALITION FOR ORAL HEALTH?

By Dr. Bernie Dishler, *Chair, PCOH Steering Committee*



Seven years ago, the Pennsylvania Dental Association helped form a coalition of several groups and foundations to work for a bill before the Pennsylvania State Legislature that would require communal water suppliers to adjust the fluoride content in their water to provide optimum caries prevention. The group was called Fluoride Now. Although it made great inroads, after several attempts, the coalition was not able to convince the legislators to pass the bill.

Even though the groups were disappointed, they realized that there were other issues concerning oral health, especially for the underserved. Several other states have oral health coalitions that help promote education and policy projects. Each state is slightly different, but all of the coalitions advocate for better oral health. They concern themselves with preventive measures as well as delivery of quality services to all citizens. They often advocate to state government officials, legislators, management care organizations and third party payers.

PDA realizes that our ability to influence the decision makers is often limited by our inability to work on many issues at once. And, we realized that when we are in a coalition with the Pennsylvania Chapter of the Academy of Pediatrics, the Head Start Association, the Pennsylvania Association of Community Health Centers, the Pennsylvania Dental Hygienists Association, several community foundations, dental manufacturers, insurance companies, and managed care organizations, we speak with a much more powerful and influential voice.

The Pennsylvania Coalition for Oral Health (PCOH) spent a year or so organizing itself to make it sustainable. This of course included raising funds. PCOH was successful enough to hire a part-time executive director, a person known to many dentists: Lisa Schildhorn, formerly on the staff at the University of Pennsylvania School of Dental Medicine and the owner of Dental Power, a dental employment agency.

We are embarking on a campaign to educate legislators and government agencies regarding the needs of Pennsylvanians. We are trying to have the state and the MCOs consider reforming the Medicaid system to make it more "user friendly" for dental providers. Some of the issues to be discussed are the credentialing and fees. We are helping to see that families and dentists are aware of the need for Age One Dentistry. We are hoping to try to upgrade the loan repayment program to encourage young dental graduates to practice in underserved rural areas of PA. These are just a few of the immediate planned activities.

Although we have our PDA staff involved in the coalition, when I realized there were no dentists involved, I chose to volunteer. I think I can provide a perspective that only a practicing dentist can. The chair of the Steering Committee changed his professional job and the chair position became open. The Steering Committee asked me to become the chair. I would be very happy to answer any questions you might have. And, if you are interested in attending any of the quarterly meetings of PCOH please let me know.

Dr. Dishler can be reached at dishyork@aol.com





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SOCIETY

2013/2014

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Upcoming Events

Fall All Day Program: Friday, September 20, 2013

The Buck Hotel, Feasterville, PA

"Staging Comprehensive Treatment"

John Nosti D.M.D. practices full time with an emphasis on functional cosmetics, full mouth rehabilitation, and TMJ dysfunction. His down to earth approach and ability to demystify occlusion has earned him distinction among his peers. In his lecture, participants will learn how to stage comprehensive treatment to meet their patient's budgetary limitations while providing functional and stable dentistry.

Fall Dine Around: Wednesday, November 6, 2013

Toscana 52, Feasterville, PA

"The Five W's of Xylitol"

Lisa Stillman, RDH, BS is the Northeast Xylitol Educator. She teaches dental health professionals the general and dental health benefits of quality xylitol products with presentations and literature to assist dental offices to incorporate xylitol into the dental hygiene protocol. Lisa has practiced dental hygiene in Maryland and Virginia and currently has a position specializing in Periodontics. The Five W's of xylitol; the Who, What, When, Where, and Why will become clear upon completion of this course. In addition, attendees will gain a greater appreciation for the many preventive and therapeutic benefits of xylitol.

Spring Dine Around: Wednesday, March 12, 2014

The Refinery at Sugarhouse Casino, Philadelphia, PA

"The Many Faces of Facial Pain"

Alan Stiles, D.M.D. is an Instructor in the Department of Oral and Maxillofacial Surgery at Thomas Jefferson University. His clinical practice is limited to the management of head, neck, and facial pain. Following his completion of his DMD at Temple University, he completed a residency in Orofacial Pain and Dysfunction at UCLA School of Medicine and Dentistry. He then completed his fellowship in headache at the Jefferson Headache Center in the department of neurology at Thomas Jefferson University in Philadelphia.

CPR: Friday, April 25, 2014

The Buck Hotel, Feasterville, PA

Spring All Day Program: Friday, May 9th, 2014

The Buck Hotel, Feasterville, PA

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Bruce Baird, D.D.S.: The business of dentistry is changing as rapidly as new technology is changing how we treat patients. To succeed in today's challenging economic environment, we have to re-evaluate our current processes and symptoms. Learn several key strategies that will effectively change your thinking on the business of dentistry, challenge many of the beliefs that prevent practices from realizing their full potential, and offer solutions to your most challenging business issues. Dr. Baird, is a preeminent cosmetic dentist in the Dallas / Fort Worth area at Granbury Dental Center. Dr. Baird specializes in cosmetic makeovers, full mouth rehabilitation, and dental implants.

Annual Golf Outing: June, 2014

Philmont Country Club

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

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.

Leyla A. Abdulhay, DMD
University of Pennsylvania '08
Orefield

Yasmin N. Ali, DDS
The University of Michigan '12
Orefield

Stephanie C. Berg, DMD
University of Pennsylvania '12
Lancaster

Diane Yi-Chia Chen, DMD
The University of Connecticut '13
Philadelphia

Chun-Hsi Chung, BDS,DMD,MS
University of Pennsylvania '86
Bryn Mawr

Dan D. David, DMD
University of Pennsylvania '10
Philadelphia

Diana M. Dongell, DMD
University of Pittsburgh '07
Pittsburgh

Kyle Dumpert, DMD
University of Pittsburgh '13
Bedford

Gary Todd Fishbein, DMD
University of Medicine and
Dentistry of New Jersey '08
Jersey City

Sarah Goldstein, DMD
NOVA Southeastern University '12
Bethlehem

Justin C. Hollingshead, DMD
Temple University '97
Greencastle

David Kopecki, DMD
University of Pennsylvania '90
Chester Springs

LynAnn Mastaj, DMD
University of Pennsylvania '88
Bryn Mawr

Kathryn Faye Mucha, DMD
University of Pittsburgh '13
Venetia

Dmitry I. Nurminsky, DMD
University of Maryland '13
Lutherville

Rakhee Patel, DMD
Arizona School of Dentistry '12
East Brunswick, NJ

Erik J. Smith, DMD
Arizona School of Dentistry '10
Gettysburg

Alicia P. Stoutland, DDS
University of Maryland '08
Ardmore

Joanne M. Tovissi, DMD
University of Pittsburgh '87
Pittsburgh

Karin C. Trotta, DMD
University of Pittsburgh '00
Orefield

Joseph J. Wawrzeaniak, DMD
University of Pittsburgh '76
North Huntingdon

Christine J. Yu, DDS
Columbia University '06
South Abington Township

At Your Fingertips — Classified Advertisements padental.org/classifieds

Did you know that our Classified Advertisements are consistently one of the most visited sections of our website? Not only do the ads appear on our website, but they also are printed in the *Journal*. We accept ads from PDA members, dental laboratories, product manufacturers, financial institutions and other businesses that serve member dentists.

Visit padental.org/classifieds to view listings for:

- Opportunities available for dentists
- Practices for sale
- Office space for sale or rent
- Equipment for sale
- Professional services

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 May/June edition of the *Journal*.

In addition, the *Pennsylvania Dental Journal* is posted on our website and available for download. Simply visit padental.org/journal to download and read past issues.

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





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

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Eligibility: Offer expires 6/15/2014. Electricity service offer valid for Pennsylvania residents serviced by Met-Ed, PECO, Penelec, PPL Electric Utilities Corporation, or West Penn Power only. Limited-time offer only available to first-time Energy Plus residential and small commercial customers. Previous and existing Energy Plus customers are not eligible. Offer is non-transferable, cannot be combined with other Energy Plus offers, is subject to change or cancellation and is not available for all rate classes, customer types or in all areas. Additional eligibility requirements, terms and conditions may apply. Please see our Terms of Service for full details which can be found online via the web address listed above and in your Welcome Email/Letter.

Rewards Information: A \$25 Enrollment Bonus for residential accounts and a \$50 Enrollment Bonus for business accounts will be awarded after completing two months of active service with Energy Plus. Active accounts are defined as those (i) that are billing more than \$0 and (ii) for which we have not received a request to discontinue service. You will earn 3% Cash Back for residential accounts and 5% Cash Back for business accounts for every \$1 spent on the supply portion of the monthly electric bill. Your Cash Back rebate will be mailed automatically after the close of your twelfth billing cycle which means you must have an active Energy Plus account for 12 billing cycles to receive the Cash Back rebate.

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D-MMEX assigns values based on the London precious metals market and prices can be checked daily at www.easyrefine.com. Our endorsed refiner provides a generous payment on the values of metals:

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In addition, **PDA members receive a 5 percent bonus on the full value of the metals submitted.** And, you receive the written assay that shows the basis of your compensation. D-MMEX *EasyRefine* pays you with a cashier's check in about 10 days from the date of submission.

"I wanted to create a process that was completely transparent so dentists could readily see why they were compensated as they were," David Morris, D-MMEX president, says. "Our process is simple. It is fast and accurate and it has inherent integrity. I cannot say that we are better than any of our competitors; only you can judge that based on the results you get. But I can say that we have many repeat clients among PDA dentists and from dentists in 12 other state dental associations or their affiliates who endorse D-MMEX. I invite you to give us try."

For a free shipping kit or to get more information on the EasyRefine program, call D-MMEX at 800.741.3174.

To receive the PDA member 5 percent bonus on the value of metals submitted, specify that you are a PDA member on your submission form.

For more information on our endorsed vendors, visit www.pdais.com/vendors or call (877) 732-4748.



WHY THE FUSS OVER Encrypting Email?

By Todd Schorle, TS Tech Enterprises

Email is such a fast, convenient and cheap way to communicate. It's easy to believe it is foolproof. Just type in a message, hit send, and poof! It is almost instantly delivered to your recipient's inbox. What happens during that transmission has generally been unknown to the public, and of no concern as long as the email is delivered. The reality is, your email message travels vast distances over many networks, crossing many servers at the speed of light. As it passes through so many hands, a second is all it takes for your email to be intercepted and, since it is still delivered successfully, you would never know anything had happened. Now imagine your intercepted email contained patient information and protected health information (PHI)...here is the crux of the email "fuss."

Email is not the direct and private mode of communication that most people assume it is. Once you hit the send button, you relinquish control of your email to an insecure journey. It is no different from a postcard with the recipient's address, attachments and content of the message exposed and vulnerable, in this case to a malicious or compromised mail server.

Whether a patient has ever been harmed by the exposure of his or her information through unencrypted email isn't even the issue any longer. It is now your responsibility to protect your patients' information, and "harm," meaning size of exposure, or even personal damages, are no longer the primary concern. If you send patient information via unsecure email, you are endangering your patients' **right** to privacy and putting yourself at risk.

So, how can you use email, as an easy and inexpensive communication tool, and still protect your patients' information?

Email Encryption is the Answer.

The security rule of HIPAA states that "a covered entity must identify and analyze potential risks to e-PHI, and it must implement security measures that reduce risks and vulnerabilities to a reasonable and appropriate level." (HHS.gov)

Assuming that you have completed your required annual risk assessment, and you send emails which might include e-PHI, you almost certainly need encrypted email. Hypothetically, you

WHY THE FUSS OVER **Encrypting Email?**

could simply adopt a policy that your office is not going to send patient information through email...At all! Ever! Even if this were an option, however, a policy cannot actually prevent the disclosure of PHI; it merely provides an indicator for when you should discipline someone who breaches that policy.

Using an encrypted email system will help safeguard your patients' information, help protect you from possible lawsuits, and help you avoid breaking the law.

The Ostrich Approach

It is frightening to me how many dental offices have an "ostrich" approach to HIPAA, HITECH and Omnibus. An example of real feedback I've heard from more than one dental practice is, "There are no HIPAA Police; I don't need to worry about this!" Unfortunately, putting your head in the sand and ignoring the laws will not make HIPAA, HITECH and Omnibus go away.

Motivated Enforcement

One very significant change under the HITECH act is that the state attorneys general are now responsible for enforcement of HIPAA. They are motivated to investigate claims of privacy breach because it's the law and because the state can keep the fines it levies. Data breaches are occurring, being reported, and fines are being levied. Take a look at the HHS.gov site for breaches at <http://1.usa.gov/1dn3XDD> to see some examples.

What Should You Buy (and Do)?

First off, conduct a risk assessment. There is no magic bullet for solving this issue. Currently, HIPAA has not defined specifically how an email should be encrypted, and there are many methods available to encrypt email.

Unfortunately, this leaves a lot of wiggle room for the interpretation of the law. What one office uses may sound good on paper but fall short of truly protecting an organization's data. Rather than providing a broad technical overview of acceptable encryption or a narrow focus on one specific solution, I am going to describe what I feel you should have in place from a security and compliance standpoint that encompasses email as well as a few other aspects:

1. Individual user accounts:

Each user who has access to patient information is a steward of that information, and therefore needs to be accountable for their actions. This means each user who sends email from the practice should have his or her own encrypted email address.

2. Policy documents:

There needs to be a policy that instructs users how to treat PHI and when and how it may be transmitted. Perhaps not all users have permission to send patient records. I personally recommend that each user have an encrypted account even if you don't authorize them to send patient information because it protects you against accidental disclosure.

3. Block 3rd party email:

If the "official" method of communication is documented to be the company's encrypted email system, then it should be the only method of communication. I personally believe there is no reason an individual should be checking personal email on the company computers.

4. Automatic:

Users make mistakes, so I prefer to leverage technology wherever possible to aid in protecting the organization. This means that email should automatically encrypt if it detects a key word or phrase or message format. For example, if you say "treatment" or "patient" in your email, it should encrypt.



5. Easy to use:

I hate programs that require additional plug-ins or require complicated steps. Sending an email should be easy. If it requires a 14-step process, it is unlikely to happen each time. I also feel email encryption should occur on the email server, preventing a user from accidentally sending the email from outside the encryption service. The unfortunate side of encryption is that often the recipients must go through a few steps to receive an encrypted mail; that is a “price” worth paying to ensure the safety of patient information.

6. Training:

A system is only as good as the last time you trained your people on how to use it. Training on how to safely communicate patient information should occur at least once a year and any time a new staff member joins the team.

7. Retention & Destruction:

It is important that PHI being transmitted has a limited window where it can be retrieved by the recipient, and after that it is automatically deleted. Alternatively, you may wish to keep a history of all sent records for a specific duration, like seven years, on an archive system. Each of these items can be handled automatically, and should be discussed during your risk assessment.



Building a “Culture of Security”

The issue of email encryption, high-tech privacy and compliance exists across the entire medical community; however, most physicians are only just now becoming technologically advanced and moving to EMR, so they are able to incorporate the requirements at the same time. The “dawn of the digital age,” however, came very early to the dental profession.

Dentists were pioneers of paperless, using a computerized scheduler, paperless chart, digital X-ray and email to send patient records long before others in the medical community. A few years ago I would have said that most small dental practices had adopted more unified technology than some larger hospitals. The problem is, advanced tools were adopted without a culture of security. Technology was cheap and easy to implement, and security was often an afterthought. Now an essential game of catch-up is required.

Today’s challenge is not simply to identify a specific and appropriate product to buy for encrypted email. Cost, ease of use and speed must take a back seat to security. The more difficult (and perhaps more important) challenge is also to shift your entire practice mindset to include a **culture of security first**.



ABOUT THE AUTHOR

Todd Schorle is the President of TS Tech Enterprises, a technology consulting firm based in Wyomissing. Todd’s passion is helping small business owners solve problems through the use of technology. TS Tech supports small businesses and dental practices with 10 to 100 computers by providing computer security, support, network management and cloud services, including encrypted email, online backup and more. Visit www.ts-tech.com.com to learn how TS Tech’s solution can protect your practice.

The following item appeared in the **ADA News** (February 3)



Microsoft to discontinue support for Windows XP Could expose some dentists to security risks and lead to HIPAA violations

By Kelly Soderlund, ADA News staff

Microsoft will discontinue its technical support for Windows XP as of April 8, which could put dental practices that still use the operating system at increased risk of serious security problems.

For dental practices that use Windows XP and that are covered under the Health Insurance Portability and Accountability Act, it may be prudent to review and, if appropriate, revise their HIPAA Security risk assessment and security measures.

Security updates that help protect PCs against newly discovered vulnerabilities will no longer be provided for Windows XP as of that date. The operating system will still work after April 8 but computers may become more vulnerable to security risks, according to Microsoft.

The antivirus software for Windows XP called Microsoft Security Essentials will continue to receive regular updates until July 14, 2015.

Other antivirus vendors are also expected to continue to provide updates.

These security risks could lead to data breaches that would require dental practices to notify their patients and government officials, and could expose them to liability for violating state data security laws. They could also be at risk of violating the Payment Card Industry Data Security Standards, a set of standards developed by the payment card industry to protect credit

and debit card data.

But it may be an oversimplification to state that any covered health care provider using an XP work station or server after April 8 is automatically violating the HIPAA Security Rule, according to Dr. Mary A. Licking, chair of a working group of the Standards Committee on Dental Informatics.

The HIPAA Security Rule includes two standards that should prompt covered dental practices that are currently using Windows XP to develop a transition plan to Windows 7 or 8, Dr. Licking said. The "Risk Analysis" standard requires a covered dental practice to conduct an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity and availability of electronic protected health information held by the covered practice. The "Security Management Process" standard requires covered practices to implement security measures sufficient to reduce risks and vulnerabilities to a reasonable and appropriate level to comply with general requirements of the Security Rule.

"These requirements basically mean that covered entities must be aware of privacy threats and adjust their policies, procedures, and, sometimes, their office computer networks to respond to changes in their threat environments in an appropriate manner," Dr. Licking said. Older

computer operating systems, like Windows XP, may be more vulnerable to hacking attacks over open networks and to computer viruses, Dr. Licking said. They can also crash without warning, exposing data to possible loss, she said. Once a developer like Microsoft stops offering support for an operating system, no more security patches or bug fixes will be available.

"Vendors of products that run on the old operating system, like dental practice management software, may cease support for those products as well, exposing the client to the risks posed by bugs, crashes, data loss and other security problems," Dr. Licking said. "It's more prudent to use a reasonably current operating system that's supported so that the organization can continue to receive security patches, software updates and technical support necessary for meeting the HIPAA Security Rule's technical requirements."

Microsoft encourages its customers to upgrade their operating system to Windows 8.1, if their PC can handle it. Windows 7 is also an option. Dental practices that are planning to transition away from Windows XP should consult with their technology vendors to devise a prudent and appropriate migration path.

For more information on HIPAA requirements, visit ADA.org/8753.aspx. The Office for Civil Rights also has information on the law at hhs.gov/ocr/privacy. To learn more about the Payment Card Industry Security Standards Council, visit pcisecuritystandards.org.

The ADA Complete HIPAA Compliance Kit (J598) is available from the ADA Catalog, catalog.ada.org, and includes a manual, the training CD-ROM and a three-year update service. The kit is \$300 for members and \$450 for nonmembers.

IN MEMORIAM

Dr. Guy E. Fessler, Jr.
Lansdale
University of Pennsylvania (1954)
Born: 1929
Died: 1/10/2014

Dr. Ronald C. DiLeo
Allentown
Creighton University (1959)
Born: 1932
Died: 2/23/2014

Dr. Carl H. Bell
Hermitage
University of Pittsburgh (1974)
Born: 1949
Died: 2/14/2014

Dr. Julius Victor
Philadelphia
Temple University (1943)
Born: 1921
Died: 2/5/2014

Dr. Alice M. Amsterdam
Bala Cynwyd
University of Pennsylvania (1978)
Born: 1950
Died: 12/22/2013

Dr. Stephen B. Ollock
Mainesburg
Temple University (1976)
Born: 1949
Died: 1/5/2014

Dr. Curtis G. Martin
Hilton Head Island
Temple University (1969)
Born: 1943
Died: 5/8/2012

Dr. Frank P. Palermo
Orwigsburg
Temple University (1968)
Born: 1933
Died: 1/19/2014

Dr. Eugene W. Shuke
Six Mile Run
Temple University (1958)
Born: 1929
Died: 11/22/2013

Dr. Harold J. Ebersole
Palmyra
Temple University (1954)
Born: 1928
Died: 1/26/2014

Dr. Jack B. Metzger
Lancaster
Temple University (1951)
Born: 1925
Died: 12/6/2013

Dr. John D. Grant
Lititz
Temple University (1951)
Born: 1921
Died: 12/2/2013

Dr. Henry A. Segatti
Bethlehem
Temple University (1950)
Born: 1922
Died: 12/11/2013

Dr. Seymour Finkelstein
Stamford
Temple University (1946)
Born: 1923
Died: 1/1/2014

Dr. Thomas H. Leininger
Mohnton
Temple University (1945)
Born: 1923
Died: 1/11/2013

Dr. Elmer R. Lipp
Beaver Falls
University of Pittsburgh (1950)
Born: 1925
Died: 2/7/2014

Dr. Ralph E. Palmer, Jr.
Monessen
University of Pittsburgh (1943)
Born: 1917
Died: 1/5/2014

Dr. Daniel A Bomberger
Myerstown
University of Pennsylvania (1955)
Born: 1928
Died: 11/23/2013

Dr. Dillman C. Sallada, Jr.
Jamison
University of Pennsylvania (1951)
Born: 1924
Died: 10/27/2013

Dr. Eugene G. S. Adams
Lewisburg
University of Pennsylvania (1950)
Born: 1922
Died: 12/15/2013

Dr. Jeffrey J. Kasander
Bangor
Boston University (1987)
Born: 1959
Died: 2/2/2014

Dr. Joseph F. Eckman
Kennett Square
Balt. Coll. of Dent. Surgery (1968)
Born: 1941
Died: 11/29/2013

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WHICH BROKERAGE FIRM IS TRULY LOOKING OUT FOR YOUR INTERESTS WHEN SELLING YOUR PRACTICE?



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Brokerage Firms?*



*Dental Supply Companies
Who Also Act As Brokers?*



*Your Accounting Firm Who
Offers Brokerage Services?*

Is it a dual-rep brokerage firm? NO You cannot serve two masters. Dual-rep firms charge buyers hefty fees, and as a result, their strategies usually negatively affect the final selling price and/or terms the owners agree to when selling. In addition, if a buyer has to choose between two similar practices- where one requires a substantial fee to a dual-rep firm, and the other does not- which practice and brokerage firm will they choose?

Is it the equipment/supply companies who are also brokering practices? NO In most cases, the owner is selling and retiring. The supply companies want to please the buyer in order to gain or retain their business post-closing. Whatever the terms, their priority is to get the deal done in order to pick up the buyer as a new client, at whatever cost to the seller.

Is it your accounting firm that also owns a practice brokerage company? NO This could be the biggest conflict of interest that exists. Sellers look to their accountants for advice asking, "Is the price or tax structure acceptable?" Will the accountant advise their client against a "bad" deal if a large commission is on the line to their firm, or to a brokerage company they are partners with or are profiting from?

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How to lessen the risk of

DENTAL MALPRACTICE

By Evan Edward Laine M.A.J.D.



You are a defendant in a malpractice action. You are angry, nauseous and silently wish you did not have that second cup of coffee in the morning. You are now involved in a long process where you will be subjected to humiliation, impatience, anger, stress, boredom and frustration. Elisabeth Kubler-Ross in her book, *On Death and Dying*, described the process of grief over a loved one's death as similar to that, which many physicians experience when facing a lawsuit. The above nightmare scenario is not rare; roughly one out of 10 dentists will have a claim against them in any given year and typically, a dentist is sued once in their career. Suits can be filed for a variety of reasons. Studies reveal that the usual claims concern endodontic overfills, implant failures, paresthesia following injection, failure to diagnose and lack of informed consent. Crown and bridge, root canal and extraction procedures make up nearly half of all filed claims.

However, a filed claim does not necessarily equal a successful one; rather 75 percent of dental claims did not result in a payment to the patient because the case was dropped voluntarily, dismissed by the judge or a defense verdict was entered. Therefore, according to Dr. John Vaselaney (National Director of Dental Risk Management for CNA HealthPro) "it is apparent that bad dentistry is not the primary reason patients are alleging malpractice." Logically then the question becomes what is the cause of most claims and how can you avoid them? It is not possible to completely avoid the risk of a claim, however in the following, I will present you with various different strategies to lessen that risk.

Be Likable

The common motivation for a patient seeking a lawyer is that the dentist *pissed them off big-time* (a legal term). It is difficult to take a day off to go to a lawyer and it is not a pleasant experience. Furthermore, patients generally do not like to sue their medical providers because they want to believe doctors have all the answers. So why do they sue? The simple answer is that they do not like you! Unfortunately, in most cases the medical provider caused this anger, and most of the time unnecessarily. The following are common complaints:

"My physician barely looked at me when I came into the room and didn't even listen to me."

"My dentist didn't even ask me my name when I came in and then he demanded that I open my mouth without even considering me, it was obvious that I was nothing more than a piece of meat."

"There's nothing wrong with you, you're just getting old."

Here is a simple idea. Introduce yourself to every patient; ask them a little about themselves. Ask them if they have kids; people love to talk about their kids. If you have kids talk about them. Establish a bond before you start working. It is amazing how many medical providers ignore this extremely effective way to lessen the risk of malpractice. Place pictures of your family around the office. If your patient understands that you are like them, they will be reluctant to try to hurt you in a lawsuit. Make sure those photos are not of expensive vacations or pictures of your yacht or fancy shore house. Avoid wearing expensive jewelry; the patient does not have to see your Rolex in their face. The best protection against litigation lies in

the way that patients feel that their physician treats them. Respect breeds respect. Avoid the long waits. Patients hate that! I implore every dentist to make the effort to treat each patient with respect and dignity. **People do not sue people that they like.** This is a proven fact!

Don't Practice Avoidance

You have encountered or will encounter bad results. Bad results do not mean malpractice; rather a successful malpractice action requires that there must be a breach of the standard of care. Breach is defined as negligent care, treatment or misdiagnosis or a failure to get informed consent. Patient anger often results from some type of bad result and **the subsequent avoidance or complete lack of communication by the dentist.** Often, the cause of a malpractice suit lies in the patient's feeling of being ignored.

It is understandable that one of the most powerful human emotions is denial, but this will get you into trouble. You must communicate a bad result to your client and take their calls. Put yourself in the patient's place for moment. They have a bad result; they are hurt and upset and need information from someone they trust. If you avoid the call, they will perceive you are abandoning them. Further, the patient will assume you are ignoring them because you did something wrong. **This is the worst thing you can do!** By avoiding your patient, you are practically forcing them to the attorney's office. TDIC's Risk Management Director Robyn Crimmins, recommends that you "respond immediately to complaints; tell patients immediately when injury or mishaps occur." Avoiding the denial syndrome however, is easier said than done and be careful what you say.

■ **WARNING: CHOOSE YOUR WORDS CAREFULLY**

You have an ethical duty to report bad results to your patient, and obviously, you will tell the truth; however, this is not confessional time. You can apologize for a bad result, you can indicate how the bad result occurred; you can refer them for a second opinion. However, the word **malpractice** is a legal one, which you are not qualified to define or understand. Further, when you are apologizing make sure you are not apologizing for malpractice, but rather that they have a bad result. Give information **BUT do not admit to liability**; again, you do not understand that legal concept and should not venture into those dark dangerous woods.

■ **WARNING: THE APOLOGY AND ITS IMPLICATIONS**

Apology programs in Pennsylvania (Liebman & Hyman, 2004, 2005) claim that effective apologies and disclosure of mistakes can dramatically reduce malpractice claims, **BUT remember** that apology will be heard by a jury and will be very powerful. This dilemma leads to the 500-pound gorilla in the room, malpractice coverage and the unbelievable disaster of your company denying coverage! Most medical malpractice insurance policies contain a clause requiring cooperation with the insurer's efforts to defend against a claim. **A common stipulation in this clause forbids the insured from "admitting liability."** This clause may have a chilling effect on the truthful disclosure of medical error, thus conflicting with the fundamental ethical requirement that a physician should at all times deal honestly and openly with patients. If a medical malpractice insurer denies coverage on the above grounds, the physician is likely to have a strong argument in court that they had a moral obligation under the Code of Ethics, but do you want to take that chance of being responsible for the litigation cost and the ultimate verdict?

The solution? Contact your insurance carrier immediately before you speak to that patient and make sure you have advised them of the situation and that you will be speaking to the patient and telling them the truth about that bad result. A conversation with an insurance company that is not completely documented in an immediate email or letter of some kind of missive **does not exist**.

Bad Recordkeeping

A 2005 survey by the ADA seeking to determine the frequency, severity and causes of dental malpractice claims revealed that poor record-keeping was a significant cause of claims. Your records ARE your protection, they should not be the source of your downfall. The ADA suggested that information in the record should primarily be clinical in nature and should be very meticulous and thorough. All information should be clearly written, and the person responsible for entering new information should sign and date the entry. The information should not be ambiguous or contain many abbreviations. In practices with more than one dental practitioner, the identity of the practitioner rendering the treatment should be clearly noted in the record.

If a mistake is made, do not correct it with "white-out." A single line should be drawn through the incorrect info, the new corrected info added, and again, the entry should be signed and dated. We will be getting into the issue of informed consent herein, however you must keep something in mind when you are writing records; they are your friend, they could save you, or they could sink you if you are lazy. Physician Dr. Gregory House wisely stated, **"Everyone lies!"** He is right. From now on assume that any patient (even the sweetest one, you know the one that brings you cookies at Christmas and muffins in the morning) will lie. They WILL claim that you:

- Did not discuss the risks and benefits of a procedure.

- Never told them that if they do not follow up in future appointments that they could do further damage to themselves.
- Did not explain to them that if they did not undergo recommended procedures or studies that they can suffer from further damage.
- Never asked about their medical history.
- Never offered them any alternatives.
- Never recommended a specialist.
- Guaranteed treatment.
- Never prescribed medications.
- Never informed them about proper dosage and when to take medications.
- Never informed them of symptoms or problems to look out for after a procedure.
- Abandoned them.

Your records are your shield against these claims. You might have a problem making immediate notes but that is dangerous especially when you are floating from one patient to the other and attending to emergency phone calls. Take out your digital recorder and document the facts; this takes a lot less time than weeks of horror endured in medical malpractice claim.

Failing to Get Informed Consent

The particular pitfall of informed consent is that the medical provider will be responsible for all damages following a procedure performed without informed consent, **even if he performs that procedure flawlessly**. The purpose of the Pennsylvania informed consent doctrine is to ensure that a patient is provided with the material information necessary to determine whether to undergo the given procedure. For consent to be informed and valid, it must be **clear that the patient understands the reasonably possible, as well as the expected, results**. Therefore, you must inform the patient of the material known risks of ANY procedure and the likelihood of their occurrence. The patient need not show that they would have chosen differently had they possessed the missing

information, but only that the missing information would have been a substantial factor in their decision. Remember you could completely and accurately explain the risks and benefits and alternatives of any medical procedure to a patient, BUT if you do not document that discussion in your notes and in addition have a signed consent form listing all dentists who will be involved, if that patient brings a lawsuit the jury almost always will find against you.

Informed Refusal

When patients refuse the proposed care or plan for care, the dentist must inform the patient about the consequences of not accepting the treatment and get a signed informed refusal which states very clearly that you have recommended a plan of treatment and that the patient refused. You must also indicate and document the risks of non-treatment and note that the patient understood these risks and still refused.

Conclusion

The risk of a claim cannot be completely eliminated, however simple strategies that include bonding with the patient, being upfront with them about bad results and most importantly using your records as a shield will lessen your risk of being the unfortunate one of every 10. Good luck!



ABOUT THE AUTHOR

Evan Laine was a trial attorney for 28 years, licensed in both Pennsylvania and New Jersey and specializing in complex civil litigation, which included dental and medical malpractice claims. Mr. Laine is currently an Associate Professor of History at Philadelphia University and serves as their Director of the Law & Society program.

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The

RESTRICTIVE

COVENANT

MYTH DISPELLED

By Gary Baumwoll, Esq.

As an attorney who works almost exclusively on dental employment and transition issues, I am frequently asked by dentists whether a restrictive covenant is enforceable.

One of the biggest misconceptions regarding employment contracts is that restrictive covenants are not enforceable. Restrictive covenants are difficult to enforce. Judges do not like to curtail an individual's freedom to work or to hinder the free market. However, restrictive covenants are enforceable and are a very effective tool to protect a valid business interest.

The Court's Position on Restrictive Covenants

The courts look at restrictive covenants with skepticism because they curb competition and employment opportunities; however, restrictive covenants are enforceable as long as they are reasonable as to time and distance. Reasonable as to time and distance has no universal meaning as it is likely different in almost every employment or practice purchase situation.

Reasonableness is a combination of many factors, including but not limited to, (i) density of population where the practice is located; (ii) number of other dentists with the same skill set in the area (this is specific to the type of dentist - general, periodontist, orthodontist, endodontist, etc.); (iii) amount of time associate worked at the practice; (iv) how much money dentist paid for the practice; and (v) the particular judge that presides over the case.



It is this last factor that is really the most important. The American legal system is based on precedent (past decisions of other judges with more weight given to higher court decisions). The issue with restrictive covenants for a dentist is that it is unlikely that your particular fact pattern has come before the court. There are two reasons this is the case. The first is that it is just unlikely that another dentist in the same town or a town adjacent with the same skill set and working the same amount of time violated a restrictive covenant. The second reason is that in the unlikely event the first reason occurred it is again unlikely that such a case would ever get to a judge's decision. The unlikelihood of a restrictive covenant case being decided by a judge is the essence of why a restrictive covenant is "enforceable."

Enforcing a Restrictive Covenant

An employer will initially obtain an injunction against the employee who is allegedly violating the covenant. The employer seeking to enforce the covenant must show that the employee is violating the restrictive covenant as it is written in the contract. If the court grants the employer an injunction, the employee must obey the court's injunction or risk being held in contempt of court.

Why would an employer want to obtain an injunction or pursue litigation? Sometimes it is to punish the employee who is leaving to compete against the employer. Sometimes it is to set an example for the other employees who may be contemplating doing the same thing. Other times it is to protect a legitimate business interest of the employer that the restrictive covenant was designed to protect. Both parties need to weigh

the cost of contesting or enforcing a restrictive covenant against the outcome they hope to achieve.

When the court wants to define reasonableness, it usually interprets the restrictive covenant strictly as written and as narrowly as possible. Even so, when an employer feels there are grounds to enforce a restrictive covenant, the employer may decide to pursue an employee for violating the covenant. This often sets up a “battle of the checkbooks.” Even if the employee’s claim that he or she has not violated the restrictive covenant has merit, the employee will still have to prove there was no violation of the restrictive covenant. This can be very costly and time consuming for the employee, who may be less well capitalized than the employer. Even if the employee prevails, the cost of challenging a restrictive covenant contained in an employment agreement may be so prohibitive that the reward of winning does not offset the price of doing so. However, that is not even the biggest problem. The biggest problem is that fighting the validity of a restrictive covenant takes time. Because it takes time, the job the employee was looking to take or the practice the employee was looking to purchase is no longer available once the injunction is lifted if the employee wins. Therefore, in most scenarios, even if the employee wins the case he or she loses because they spent money and the opportunity that was the impetus for the restrictive covenant dispute is no longer available.

The consequences of this reality are that very few employees will fight the injunction invoked by the employer. Therefore, if an employer wants to “enforce” a restrictive covenant, they will likely be able to and prevail in stopping the employee from the competing without the case ever reaching the merits of reasonableness. Due to this reality, an employee should always have the mentality that the employer will be able to enforce the restrictive covenant as it is stated in the signed employment agreement.

Negotiating a Restrictive Covenant

When a young dentist is presented with an employment contract, he or she usually focuses on the compensation terms. While compensation is very important, the restrictive covenant is equally important. The long-term ramifications of agreeing to a restrictive covenant can greatly affect a young dentist’s career path and aspirations. Young dentists need to look carefully at the terms of the restrictive covenant being agreed to and negotiate them with the same vigor they do their compensation.

The most obvious aspects of the restrictive covenant to negotiate are the time and distance components. The reasonableness of the time and distance restrictions depend upon the location of the practice. The more populated the area, the shorter the time period and the smaller the proscribed area. In an urban area, a reasonable restricted area might be measured in blocks; in a rural area a twenty-mile or larger restrictive covenant might be reasonable to the court.

Restrictive covenants also contain non-solicitation clauses. The clause can restrict indirect and/or direct solicitation of patients. An example of indirect solicitations is sending out a mailer to zip codes where many patients of the former practice reside. An example of direct solicitation would be contacting former patients by phone or mail using addresses obtained from the practice’s patient list. Even in the absence of a non-solicitation clause, direct solicitation as a result of the unauthorized use of a patient list is likely a violation of the law and may be grounds for a civil suit. A patient list is protected proprietary business information. A former employee is not entitled to take such information when employment is terminated.

Two other terms that show up in many restrictive covenants are restrictions on hiring employees of the practice and soliciting referrers of the practice. These terms, too, should be negotiated if the employee feels that these issues could affect them in the future.

When the time comes to negotiate the restrictive

covenant, the employer and employee should assess what their outcomes and objectives are in their business relationship. The senior doctor will want to protect the practice he or she spent years building. The junior doctor will not want to foreclose any potential opportunities by agreeing to an overly broad set of restrictive covenants. Each party should negotiate the restrictive covenant so it will not be an obstacle in the pursuit of his or her opportunities, goals and dreams.

Non-Legal Ramifications

As an attorney, I am often presented with a scenario to review an agreement for an employee that is looking to leave his or her current job for another opportunity that is within the restricted area. The employee asks if the covenant will hold up in court. My usual answer is, I do not know but it does not matter. While the above describes why the covenant is likely enforceable in order to stop an employee from pursuing the opportunity, I often advise against violating the covenant from a business perspective.

As we all know the dental world is a small community and word travels fast and sticks with you for a long time. You do not want to be known as the dentist that violated your covenant and tried to compete against your former employer. This never looks good. If the employer is well liked then you most certainly will be looked down upon. Even if the employer does not have a good reputation you will still be perceived as someone only out for yourself. It will be hard to get another job in the area. If you buy or start a practice in the area, you will start the business with a bad reputation that will be hard to shake. If the restrictive covenant makes you uneasy then it is worth discussing and revising. It is unlikely you will be able to amend the covenant to where all of your concerns are extinguished, but every little bit could help. You cannot predict the future of your career so always try to protect against every foreseeable scenario.

About the **AUTHOR**



Gary Baumwoll is an attorney who has focused his practice on the legal issues surrounding dentistry since he began his law career. His wife, Heather Baumwoll, DMD, is an orthodontist, providing him with unique insight into the specific issues that face dentists. This insight and experience provides Gary with an exceptional understanding of how to best advise and protect his dental clients.



By Gilbert R. Davis
PDAIS President & CEO

INSURANCE

THE ADVANTAGES OF Claims-Made Professional Liability Coverage

Purchasing professional liability insurance can be a complex and confusing process. Dentists need to determine if a claims-made and reported policy or an occurrence policy will work best for them. Due to the heightened resurgence from our competitors in marketing and selling the occurrence policy, we thought it beneficial to inform PDA members of the advantages of a claims-made policy.

Claims-made and reported professional liability policies offer several key advantages to the policyholder:

- Limits can be predicated on today's exposures, ensuring that the policyholder will not be underinsured. Claims-made and reported policies do not require the policyholder to project 20 years or more into the future when setting limits. Policyholders have today's limits for claims. In addition, purchasing a claims-made policy can help eliminate the concern policyholders may have as to whether their previous occurrence carrier remains in business. If an insurance company would go into receivership (the insurance equivalent of bankruptcy) you can move your coverage to a financially stronger insurance company. If the carrier for an occurrence policy goes into receivership, switching to a new financially stronger carrier will not remedy the problem with the former carrier.
- Claims-made and reported policies contain a retroactive date, which indicates when the policy is in-force. In many cases, the retroactive date serves as the effective date of the policy period to cover prior acts at **NO** additional premium. Most claims-made and reported policies contain a provision for free lifetime tail coverage after full retirement, death or disability.
- With a claims-made policy, the insured can move coverage from one carrier to another carrier. If you have an active claims-made policy, you can apply to another insurance company that offers prior acts coverage for claims-made policies. Under this scenario, the new company takes the retroactive date from the old policy and endorses it onto the new policy.

The new policy with the retroactive date from the previous policy now covers the same period of time as the old policy. Also, this means that as long as the new carrier is providing prior acts coverage there is no need to purchase "extended reported period" (commonly known as the tail).

- If a dentist owns an occurrence policy and renews on a claims-made and reported form, the first few years of premium can offer SUBSTANTIAL savings in premium. The claims-made and reported form does not have to pick up prior acts, as the occurrence form will continue to protect against incidents that may have occurred during the time the policy was in effect. This enables many insurance carriers to offer discounted premiums on claims-made

and reported policies the first few years of the policy.

- From a pricing viewpoint, occurrence policies are more expensive than comparable claims-made policies because they provide coverage for incidents that occurred during the policy year regardless of when the claim is reported. And the occurrence policy provides a separate limit for each year protection is purchased. On average, a dental professional liability policy costs about **10 percent** more a year than a claims-made policy.
- Claims-made and reported policies give the insurer the ability to monitor how much money will be needed to adjust claims in a particular year, giving them the flexibility to adjust premiums accordingly.

- In years when claims experience is especially favorable, insurers may return excess premiums (those not needed for purposes such as claims expenses, operations or capital growth) in the form of policyholder dividends. Insurers offering claims-made and reported policies can declare dividends earlier than those that offer occurrence policies.

Whether shopping for a new professional liability insurance policy or deciding whether or not to renew an existing one, it's important to consider the advantages of a claims-made and reported policy before making a final decision.

For more information or a quote on a professional liability or claims-made policy, please contact a PDAIS representative at (877) 732-4748 or visit the website at www.pdais.com.

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Clinicopathologic Review: Multiple Radiolucencies of the Jaw Bones

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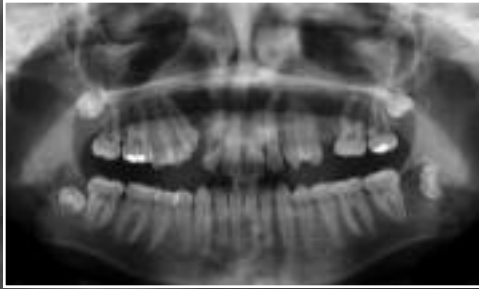


FIGURE 1. Panoramic radiograph taken in 2011.



FIGURE 2. Follow up Panoramic radiograph 8 months later, showing enlargement of the lesions.

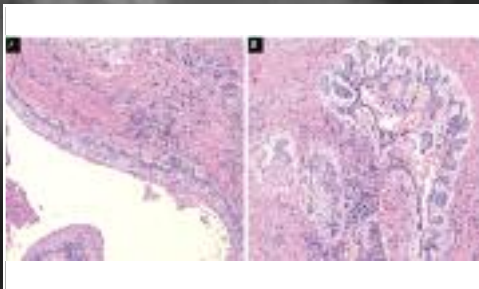


FIGURE 3. Representative histopathologic photomicrographs of the lesions of the jaws (H&E x100).



FIGURE 4. Panoramic radiograph taken one year post-operatively.

CLINICAL HISTORY

A fifteen-year old male presented to his dentist for a routine examination on June, 2011. A panoramic radiograph was taken, which revealed three well-defined, sclerotic unilocular homogeneous radiolucencies. Two were associated with the crowns of the unerupted third molars #17 and 32, and one was located in the maxilla between teeth #6 and 7, causing displacement of these teeth (Figure 1).

The patient returned eight months later and a follow-up panoramic radiograph was taken, which showed that the lucencies had increased in size. The radiolucency associated with tooth #32 extends into the ramus of the mandible. The radiolucency associated with tooth #17 now extends in the body of the mandible to the mesial of tooth #18; both lesions were expanding anteroposteriorly with minimal bucco-lingual expansion on clinical examination. The radiolucency in the maxilla had also increased in size, extending from apices of the teeth to the crest of the alveolar ridge. No new radiolucent lesions of the jaws were found (Figure 2).

On clinical examination of the patient, pitting of the palmar surface of the hands was noticed; this finding was also present in the mother. There was no contributory dental or medical history and no other significant findings on examination.

The patient was referred to an oral and maxillofacial surgeon for further management. All three lesions were curetted and sent for histopathologic evaluation. The histopathologic examination of the specimens revealed cysts lined by parakeratinized stratified squamous epithelial with corrugation on the luminal surface and prominent basal hyperchromatic, palisaded cuboidal to columnar cells. Budding-off of satellite cysts was noticed from the basal layer into the connective tissue stroma (Figure 3). A year later, a follow-up radiograph was taken, which showed no new or residual pathology (Figure 4).

What is the diagnosis?

- A. Dentigerous cysts
- B. Enlarged/hyperplastic dental follicles
- C. Keratocystic odontogenic tumors
- D. Unicystic ameloblastomas

The answer:

C. Keratocystic odontogenic tumors in a patient with nevoid basal cell carcinoma syndrome (Gorlin syndrome).

INTRODUCTION

Keratocystic odontogenic tumor (KCOT), initially called odontogenic keratocyst, is a developmental odontogenic cyst arising from remnants of the dental lamina epithelium. In 2005 odontogenic keratocyst was rechristened by a panel of head and neck pathology experts of the World Health Organization as a neoplastic process, and renamed “keratocystic odontogenic tumor”, based on its aggressive nature and molecular/genetic features.¹⁻³ Clinically, KCOT presents as a unilocular or multilocular radiolucency of the jaw. It may be solitary or multiple, with a locally destructive potential. KCOTs are usually discovered in the 2nd and 3rd decade of life.¹

Nevoid basal cell carcinoma syndrome (NBCCS) is also known as Gorlin syndrome, Gorlin-Goltz syndrome or basal cell nevus syndrome.^{4,5} It is an autosomal dominant disorder caused by mutation of *PTCH1*, a tumor suppressor gene, the human homologue of the *Drosophila patched* gene.^{6,7} Keratocystic odontogenic tumor is one of the major manifestations of this syndrome and can also be one of the first presenting signs in this syndrome.⁸ One should suspect NBCCS with the manifestation of a KCOT in a patient younger than 20 years of age or multiple recurrences of KCOT of the jaws in a young patient. Nevoid basal cell carcinoma is characterized by many different clinical and radiologic findings (Table 1), some of which can be identified by a general dentist, raising the suspicion for a suspected nevoid basal cell carcinoma syndrome. Various clinical features associated with this syndrome are categorized into major or minor criteria based on the frequency of presentation of these pathologies in patients with NBCCS. Pathologies that are frequently seen in patients with this syndrome are categorized as “major”, with the exception of medulloblastoma, included as a major criterion because it usually manifests in children 2 years of age, which might aid with the early detection of the syndrome.⁹ Clinical features that are less associated with the syndrome are categorized as “minor”. The various pathologies associated with NBCCS are presented in Table 1.

Studies by V. E. Kimonis et al. in 1996 and 2012 shows that palmar/plantar pits, KCOT, basal cell carcinoma and lamellar calcification of the falx cerebri are the most common features of presentation in patients within the 0-19 years age group.^{10,11} Panoramic radiographs taken for initial examination and/or

evaluation of eruption pattern in children will help in the identification of cysts of the jaws. Basal cell carcinomas associated with the syndrome are usually found on the face, sun exposed areas of the skin, and also on non-sun exposed areas of the skin. With the increased use of a wide-field view cone-beam computed tomograms in dental practices, calcification of the falx cerebri can be identified. Pitting of the palmar and plantar surfaces of the hands and feet can be identified on physical examination if the syndrome is suspected. This patient fulfilled the criteria for the diagnosis of NBCCS, having multiple KCOTs and palmar/plantar pits. Genetic/molecular testing was done, and a mutation was found in the *PTCH1* gene. The patient is maintaining close periodic follow-up by his pediatrician and dentist for evaluation of any new lesion or recurrence of lesions associated with this syndrome.

TABLE 1.

Adapted from the consensus statement from the First International Colloquium on basal cell nevus syndrome.⁹

MAJOR CRITERIA

- 1) Basal cell carcinomas <20-year old or excessive numbers of basal cell carcinomas out of proportion to sun exposure
- 2) Keratocystic odontogenic tumor of the jaw <20-year old
- 3) Palmar or plantar pitting
- 4) Lamellar calcification of the falx cerebri
- 5) First degree relative with NBCCS
- 6) Medulloblastoma, desmoplastic variant

MINOR CRITERIA

- 1) Rib anomalies
- 2) Skeletal malformations (kyphoscoliosis, vertebral anomalies, polydactyly)
- 3) Macrocephaly
- 4) Micrognathia
- 5) Cleft lip/palate
- 6) Meningioma
- 7) Ovarian/cardiac fibroma
- 8) Lymphomesenteric cyst
- 9) Ocular abnormalities (glaucoma, coloboma, strabismus, hypertelorism, congenital cataracts)

Diagnosis of NBCCS can be made by a combination of:
A. Two major criteria. B. One major criterion and molecular confirmation. C. One major and two minor criteria.

Clinicopathologic Conference: Multiple Radiolucencies of the Jaw Bones



FIGURE 2. Follow up Panoramic radiograph 8 months later, showing enlargement of the lesions.

DISCUSSION

Choice A. Dentigerous cysts. The radiolucencies associated with these unerupted mandibular third molars make a dentigerous cyst a clinical differential diagnosis. Dentigerous cyst is a developmental cyst which arises as a result of fluid accumulation within the reduced enamel epithelium of an unerupted tooth, presenting as a unilocular radiolucency with a sclerotic border, usually associated with the crown of the tooth, and arising from the cemento-enamel junction of the tooth. The crown of the tooth projects into the cyst lumen with the reduced enamel epithelium forming epithelial lining of the cyst. Dentigerous cysts associated with impacted/unerupted mandibular third molars are relatively common. However, the rapid growth of the lesions, and the maxillary lesion, which is not associated with the crown of a tooth, argues against dentigerous cyst as a diagnosis. It is important to note that KCOT could present as a dentigerous cyst radiographically.^{12,13}

Choice B. Enlarged dental follicles. An enlarged/hyperplastic dental follicle also presents as a unilocular pericoronal radiolucency of the jaws. A pericoronal radiolucency < 4-mm is consistent with an enlarged follicle. Any radiolucency greater than that is suggestive of a cyst.^{13,14} The lesions seen in this case are much larger than 4mm. This also does not account for the maxillary lesion.

Choice D. Unicystic ameloblastomas. Ameloblastoma is a benign aggressive odontogenic tumor usually presenting as a multilocular radiolucency of the jaws; however, a unicystic variant does exist. Radiographically, it presents as a unilocular radiolucency which could be associated with the crown of an unerupted tooth in the jaw. Unicystic ameloblastomas are usually discovered in patients in their 2nd decade of life.¹⁴ However, multiple unicystic ameloblastomas within the jaws of a patient are rare.

Histopathologically, the proliferation of epithelium from the cyst wall does suggest ameloblastoma, but the other histopathologic features of this case are distinct and specific to KCOT, which is different from any of these clinical differential diagnoses.

In conclusion, a good clinical history and physical examination, in combination with appropriate imaging, is crucial in the identification of this condition. Clinical examination may reveal the palmar/plantar pitting and basal cell carcinomas. A wide-field of view cone-beam computed tomography may identify calcification of the falx cerebri. Identification of one or more jaw cysts in patients younger than 20 years of age should raise suspicion of a diagnosis of nevoid basal cell carcinoma syndrome.

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- How to avoid scaring off new patients with the wrong message (just like bad breath, nobody will tell you if you have this problem)
- Why dumb criminals can be extremely profitable for your practice. And more ...

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