2015 • Volume 2 • Issue 5

CDA essentials

The Canadian Dental Association Magazine

CDA Days on the Hill

Advocating for Canadian Dentists

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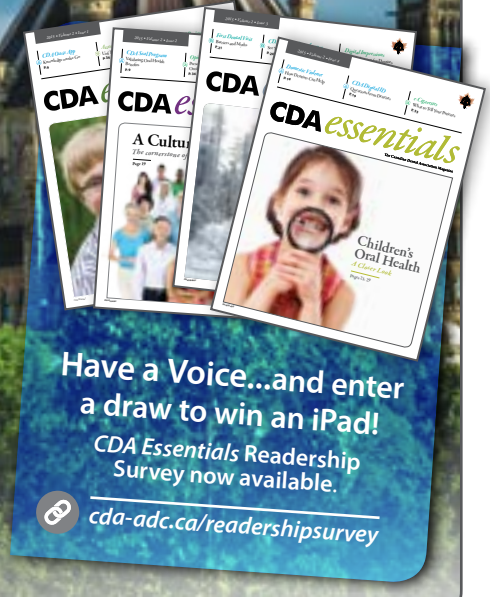

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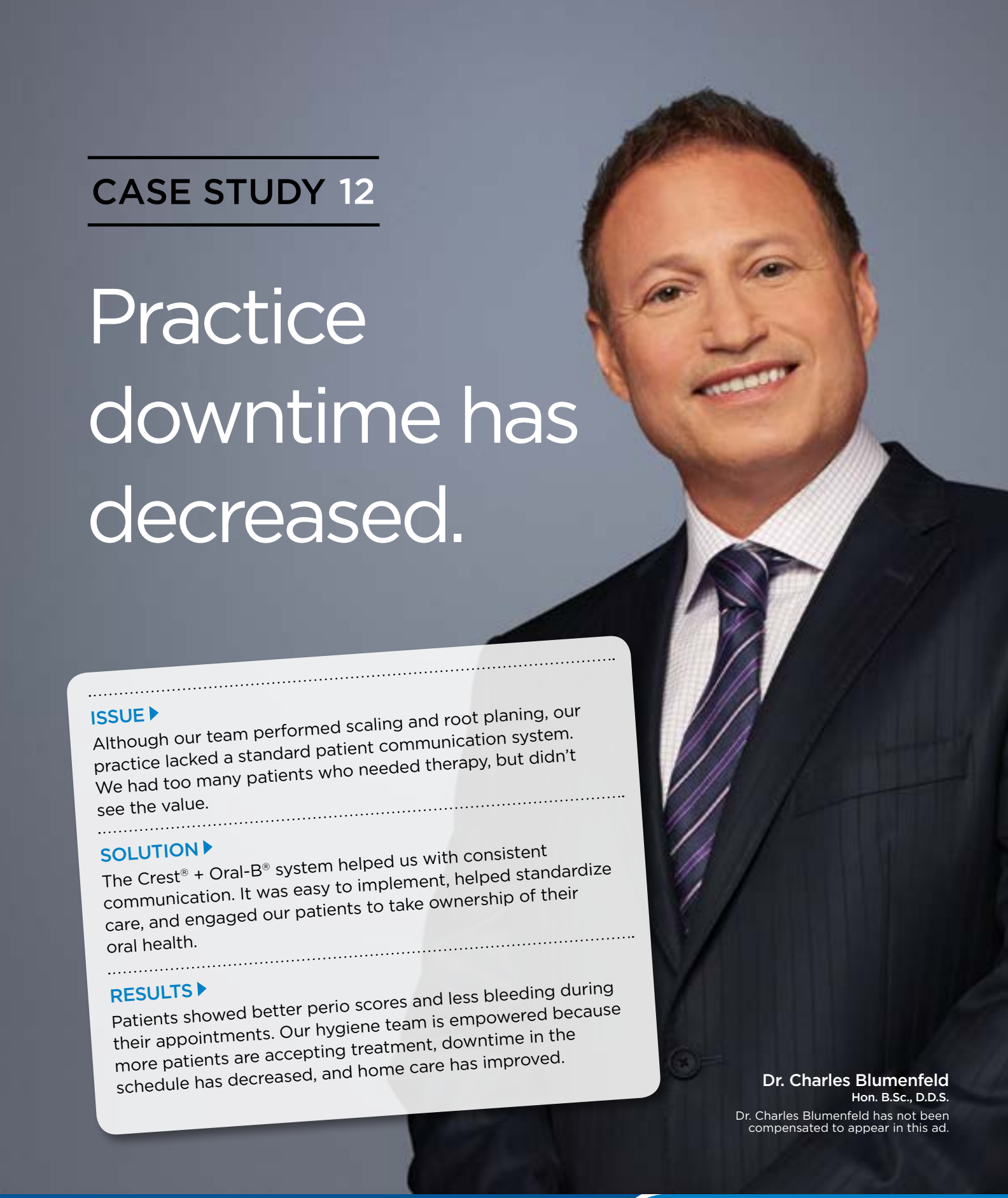

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CDA essentials

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CDA *essentials* is the official print publication of CDA, providing dialogue between the national association and the dental community. It is dedicated to keeping dentists informed about news, issues and clinically relevant information.

CDA BOARD OF DIRECTORS

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INTRODUCING

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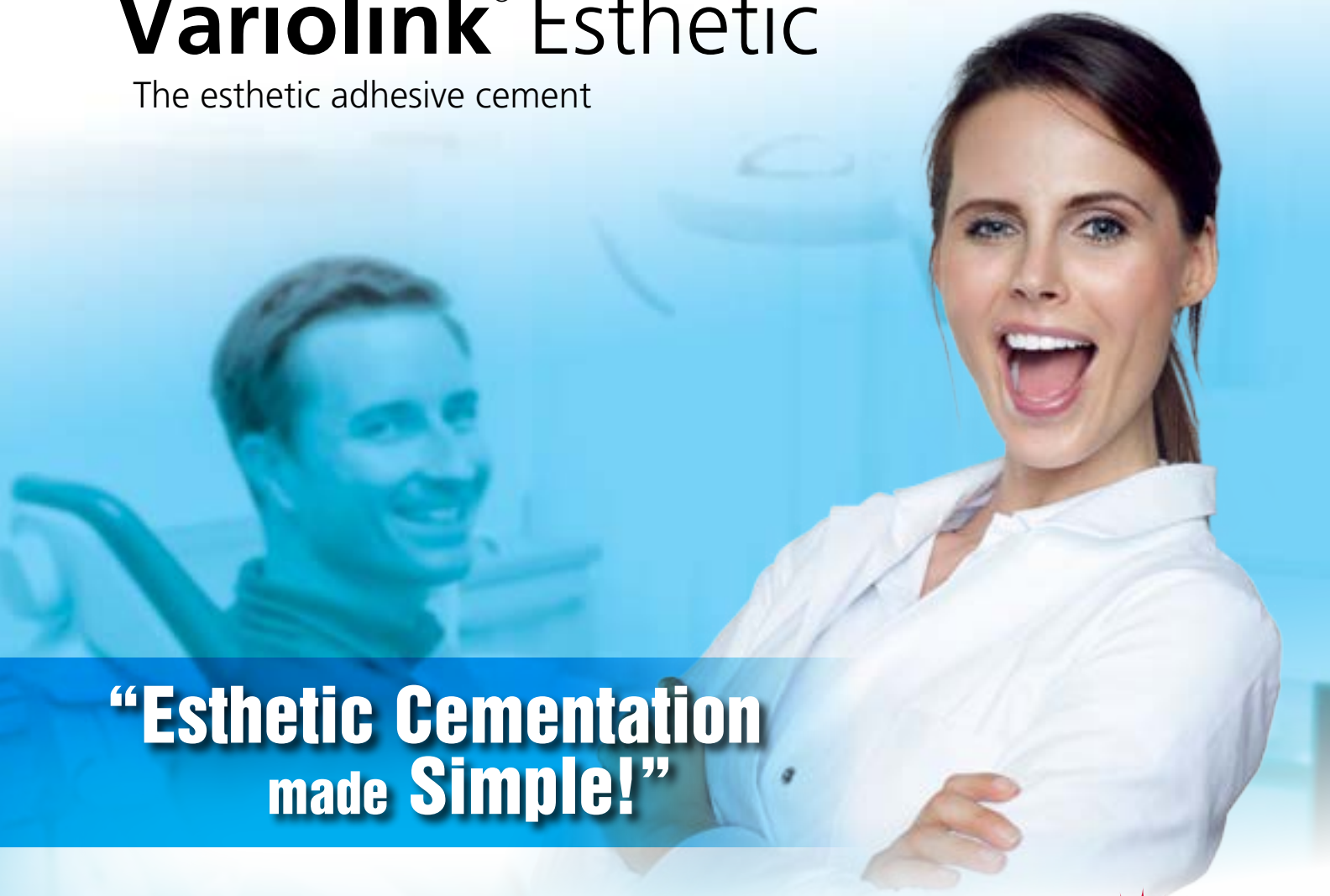

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Preparing for an uncertain future: A Fireside Chat

CANADIAN DENTAL ASSOCIATION

It's impossible to predict the future, but we should pay attention to prevailing trends and prepare accordingly. I think it's generally accepted that the breadth of skills required for a career in contemporary dental practice can't all be covered in 4 years of dental school; new dental graduates will need to seek additional training.

If I could have a fireside chat with these new dentists, based on my 30 years of experience and a watchful eye on our professional environment (aided by CDA's ongoing environmental scan of the social, political, economic and health trends affecting dentistry) here's what this one dentist would say are key skills to acquire.

First are business skills. I don't think it's enough to engage an accountant and attend a marketing seminar, nor do I believe that teaching these skills can be easily integrated within dental school curricula. I'm talking about basic practice management skills that should be acquired from a trustworthy organization, such as your provincial dental association (PDA). To determine what the provinces are offering in practice management education and to identify gaps in training, a CDA Working Group has been formed with contributors from CDA and the PDAs. University-based business schools are another option; at least one that I'm familiar with, the UBC Sauder School of Business, offers a program in dental practice management.

Next I would encourage any new practitioner to acquire skills in implant dentistry. We frequently examine patients with heavily restored, failing dentitions. Obtaining informed consent from these patients, for even simple restorative treatment, requires a comprehensive discussion of the patient's treatment needs. These discussions need to address occlusion, options for fixed and removable prosthodontics, (including the use of dental implants), cost implications, and the potential need for bone augmentation or sinus grafts. A practitioner must have a sound understanding of implant dentistry, whether or not the practitioner intends to place or restore implants, or refer the patient to a colleague.

Cone beam computed tomography (CBCT) is another technology that is rapidly becoming part of the mainstream as it becomes more affordable and as the risk/benefit ratio improves with diminishing radiation levels used in the newer units. Although many dentists don't have direct access to CBCT, all of us need to understand its value and risks. Even if another office acquires the image or another practitioner formally reads the scan, practitioners should develop skills to interpret these CBCT scans.

Finally, I would highlight the changing dentist-to-population ratios in Canada. In many regions, a surplus of dentists means it will be difficult to become established and meet modest financial expectations. Although roughly two-thirds of Canadians have good access to dental care, other segments are underserved, such as seniors in long-term care, people with special needs, individuals living in remote First Nations communities, and new immigrant families. These individuals have diverse treatment needs and face multiple barriers to care that go beyond affordability. By acquiring the skills to provide care and developing a business model for one of these vulnerable groups, a practitioner can generate additional income while also providing a much needed service.

Dentistry is and will remain a great vocation, but all of us must be prepared to move with the times.

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CDA Adds its Voice to Debate on Sugars and Nutrition Labelling

CDA recently joined with several other health organizations in asking Minister of Health Rona Ambrose to refine the federal government's proposed updates to food labels

In 2014, Health Canada held consultations with health organizations and Canadian parents to explore how nutrition labels could be improved to help consumers make healthy choices. While CDA and other health organizations applauded the government's initiative, they expressed concerns that the ministry's proposed changes could be confusing and unintentionally lead to poor food decisions.

The government's proposed changes include placing a threshold on daily consumption of total sugars. Yet this could "confuse consumers, possibly deterring them from consuming more healthy foods that contain naturally occurring 'bound sugars', such as whole unprocessed unsweetened vegetables, fruits, nuts, legumes, and lower fat milk, yogurt and milk alternatives," CDA and its fellow health organizations explained in a joint letter to Minister Ambrose.

"CDA recognizes the impact of poor nutrition on both oral health and overall health," says Dr. Gary MacDonald, CDA immediate past-president. "That is why we are committed to partnering with government and other health organizations, to empower consumers so they can make healthy food choices."

The group of health organizations also suggested that the definition of added sugars be extended to include free sugars, so consumers do not assume that packaged foods sweetened with fruit concentrates, for example, are de facto healthy choices.

The letter suggested an approach to Minister Ambrose to address both the issues the group previously raised and the government's concerns about compliance, enforcement and trade issues. This approach was defined as follows:

- Having a single line in the nutrition facts table for sugars, which would focus on the presence of added/free sugars only. This would exempt naturally occurring "bound sugars" that can be found in packaged unsweetened vegetables and fruits (frozen or canned); unsweetened milk, yogurt and milk alternatives; and unsweetened nuts and legumes (dry or canned).

- Having accompanying %DV declaration for sugars based on a reference value that is low enough to promote limited consumption of free sugars—so Canadian don't limit their vegetable intake for fear of exceeding the suggested value, for example. This value should be in line with the World Health Organization's target of a maximum of 10% daily energy intake from added/free sugars.
- Restricting the use of the "no sugar added" claim. This claim could still be used for healthy foods that are exempted from declaring sugars (i.e., unsweetened foods with naturally occurring "bound sugars").
- Opting for a more intuitive reporting of sugars on the ingredient list which captures added/free sugars, as proposed by Health Canada. The health department has suggested that all sugars be grouped under the common name "sugars" and then listed in parenthesis, explaining that "this approach would give consumers an idea of how much added sugar there is in their food compared to the other ingredients."

Letter signatories

- Bariatric Medical Institute
- Canadian Dental Association
- Canadian Diabetes Association
- Canadian Medical Association
- Canadian Nurses Association
- Dietitians of Canada
- Heart and Stroke Foundation
- University of Toronto, Department of Nutritional Sciences

To learn more about Health Canada's proposed changes to food labels, visit **health.gc.ca/nutritionlabelling**

CDAnet™

A LOOK BACK

Many dentists will remember when sending dental claims was a time-consuming, paper-based process.

Once the patient was billed for treatment, if they had dental insurance, the dental office would complete and sign a claim form and the patient would mail the dental claim form to their insurance provider. The insurance provider entered the information on the claim form into their computer systems, adjudicated the claim and—if there were no errors in the paperwork and no further clarifications required—the patient waited up to 8 weeks before receiving a cheque!

But in 1991, an innovation significantly reduced the time needed for reimbursement and changed the way dental offices and patients communicated with insurance companies from that year forward.

The idea was born in the plainly named CDA committee, the Third-Party Dental Plans Committee, which was formed in 1984 in response to criticism that CDA needed to improve communication between dentists and insurance companies. The challenge was taken on by the committee's founding members: Dr. Toby Gushue from Newfoundland, Dr. Don Gutkin from Manitoba, Dr. Bill Leggett from Ontario, and Dr. Don MacFarlane from British Columbia.

At first, the committee's main goals were to develop a standard dental claim form (at that time different forms were used by each insurance company) and develop a new system that would standardize the way dental procedures were coded and defined across the country. Each province had its own set of procedure codes, which created a complicated and inefficient system of administration for the bigger insurance companies with clients in more than one province.

"The provinces did not want to change their systems," says Dr. Gushue. "They were happy with their own definitions." It took several years of closely working with the provincial associations and various specialty groups, but a national system for identifying the dental services provided to patients, the CDA's Uniform System of Codes and List of Services (USC&LS)—now the basis of all fee guides and code lists—was implemented in 1990.

To hear an interview with Dr. Toby Gushue on CDAnet, visit **oasisdiscussions.ca /2015/04/28/tg-2**

> *An important feature of CDAnet is that it was developed by dentists for dentists.*

These days, it is hard to imagine a dental office without a computer, but Dr. MacFarlane remembers the committee discussing the untapped benefits of using a computer in the office. "Don Gutkin was frustrated that the office computer was not contributing more to office efficiency and said, 'Shouldn't we be able to send dental claim information digitally to the dental plan companies?'"

Bringing this idea to fruition took about 4 years. Consultants were hired to explore the technical requirements of the project and discovered that the technology was already being used by financial institutions. The heads of major insurance companies initially doubted it could be done, but soon came to be convinced of its possibilities and potential cost savings. Software developers were hired, software vendors notified, and eventually the concept was promoted to dentists. The task of negotiating legal agreements between CDA and various interested parties—provincial associations, network providers, insurers, and software vendors—was managed by Dr. Bernie Dolansky of Ontario, who joined to committee to lead this crucial work.

In 1991, the system they called "CDAnet" was officially launched. Technically defined, CDAnet is "the agreement between the dental profession and the insurance carriers on the format in which the information normally found on dental claims will be forwarded to the respective carrier electronically." Practically speaking, CDAnet opened the doors for dentists to send patient insurance claims online.

An important feature of CDAnet is that it was developed by dentists for dentists. "In our negotiations with the insurers, we insisted that CDA would retain all rights to the system and it was CDA ownership that gave the dentists of Canada a feeling of security in joining," recalls Dr. Gushue.

"As someone who spent many days promoting CDAnet to dentists, I can tell you that the fact that it was owned and controlled by CDA was a comfort to many of them."

Today in Canada, with the exception of Quebec, all provincial fee guides and code lists are based on the USC&LS and more than 14,500 dentists, representing about 85% of licensed dentists, subscribe to CDAnet. "These days, for young dentists coming out of dental school, CDAnet has always just been there," says Dr. Gushue. "But I look at it as a crowning achievement for CDA and it was my pleasure to have been a part of it."


Canadian Dental Association

Communiqué

A CDA Member Service

ELECTRONIC DATA INTERCHANGE

EDI = Every Dentist's Interests

CDA's *Communiqué* magazine featured information on CDAnet in anticipation of its launch in1991.

What if we didn't have CDAnet?

To imagine alternative solutions to CDAnet, consider how dental offices transmit claims in the U.S. using EDI (Electronic Data Interchange). Dentists in the U.S. must select at least one EDI dental clearinghouse, such as DentalXChange, and pay an annual fee for services that "simplify business processes, increase productivity and enhance the management side of your dental practice by providing streamlined connectivity that bridges the gaps between payers, patients and providers." There are roughly 15 companies that provide these services in the U.S.

Each EDI dental clearinghouse has connections with individual dentists and providers. Unlike in Canada, where every dentist can transmit to every carrier, in the U.S. a dentist can only transmit to the carriers that are also signed up, or connected to, the same EDI dental clearinghouses as the dentist. It's a fragmented system where dentists have little influence, and where there are greater costs for the dentist.

It's difficult to calculate the exact cost savings per claim by using CDAnet compared to a system used in the U.S., because there are many factors to consider. However, conservative estimates suggest that CDAnet saves Canadian dentists thousands of dollars each year.

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A National Meeting Place *for the Profession*

In April, CDA held its Annual General Meeting where representatives of Canadian dental organizations gathered to focus on current and emerging issues in dentistry.

Participating organizations included the provincial dental associations (PDAs), the Association of Canadian Faculties of Dentistry (ACFD), the Canadian Dental Specialties Association, and the Canadian Dental Regulatory Authorities Federation (CDRAF), to name just a few.

- At the Dentistry Leaders' Forum, participants focused on the federal government's studies of prescription drug abuse and antimicrobial resistance. The objectives of a working group established to examine the need for dentists who are qualified to provide special care dentistry and to recommend strategies for increasing their numbers, were also discussed. The working group is a collaboration between CDA, the ACFD and the Royal Canadian Dental Corps.
- CDRAF reported on the pending free-trade agreement between Canada and the European Union. The Comprehensive Economic and Trade Agreement (CETA) was signed by Canada and the EU in 2014 but has not been ratified. One of the CDRAF's main concerns with CETA is a clause that requires regulators to provide temporary licenses and suitable training to applicants who do not initially meet licensure requirements. CDRAF is seeking an exemption from this clause from the federal government.
- Canadian representatives are among the founding members of the International Society of Dental Regulators, formed in 2014. The 3rd International Conference of Dental Regulators will be held in Boston on September 16, 2015.

Working collaboratively with the PDAs, academia, government and specialists, CDA acts as a facilitator to ensure the profession works together on issues of national scope:

- CDA established a national task force to contribute to the joint Health Canada and Assembly of First Nations review of the Non-insured Health Benefits (NIHB) program.
- CDA established a national task force to support internationally trained dentists in adapting to professional life in Canada. The task force developed information and resources that are now available on the CDA website: cda-adc.ca/internationallytrained
- The CDA Board of Directors approved a new CDA Principles of Ethics document. The document serves as a foundation for defining a dentist's responsibilities to patients, society, the profession and self.
- The CDA Board officially installed its new executive branch: Dr. Alastair Nicoll, president; Dr. Randall Croutze, president-elect; and Dr. Larry Levin, vice-president. Dr. Lynn Tomkins of Toronto was elected as the newest member of the Board.

① Dr. Graham Conrad, immediate past-president of the Nova Scotia Dental Association.

② Nazanin Hojjati (McGill '15), Federation of Canadian Dentistry Student Associations, regional councillor for Eastern Canada.

③ Col Kevin Goheen, director of dental services, Royal Canadian Dental Corps.

④ Dr. Kelly Manning, immediate past-president of the New Brunswick Dental Society with Dr. David Peters, CDA president 1972–73.

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[1] Clinicians Report, October 2014, Volume 7, Issue 10. [2] Data on file.

WHAT'S NEW *in Electronic Claims?*

By Geoff Valentine, CDA Manager of Health Informatics Services

The transmission and administration processes for electronic dental claims (e-claims) are always evolving. Driven by a variety of factors—claims processors' desire to reduce costs, retirement of old technology, and CDA's goal of making e-claims simple for dental offices—the following industry developments could have an impact on the way your dental office processes claims.

Great-West Life introduces bundled payments and statements

Starting in July 2015, Great-West Life is enhancing the payment process for all dentists by offering weekly direct deposit payments instead of individual cheques per visit. Payments will include an easy-to-read electronic statement with details—breakdowns by family name and patient, service codes, tooth numbers and more—to help you reconcile payments.

Great-West is working with TELUS Health to make signing up for direct deposit and electronic statements fast, easy and secure. Dentists who do not sign up for direct deposit will receive a cheque and statement by mail twice monthly. Go to **telushealth.com/directdeposit** for more information and to sign up.

Sun Life Financial accepts coordination of benefit claims

Sun Life has upgraded to CDAnet version 4 and now accepts co-ordination of benefits e-claims. This change improves service by reducing claim processing time and cost.

When a patient has coverage from two different carriers and Sun Life is the secondary carrier, the dental office can transmit the explanation of benefits from the first claim to Sun Life for electronic processing. Both claims can often be settled while the patient is still in the office.

If your office is not familiar with the coordination of benefits claim transaction, contact your software vendor for information on how to process them with your software.

Alberta Blue Cross accepts X-rays electronically

Alberta Blue Cross now accepts X-rays and other documents in support of claim transactions using the CDAnet version 4.1 attachment transaction feature. Dental offices can transmit supporting information electronically, saving postage and improving turnaround time.

Currently, Maxident and Gold Dental Office Software are the only software systems that fully support attachment transactions, although others are looking into adding this feature. Find out if your vendor supports or will soon be supporting this transaction.

More Online

For more information about **CDAnet**, including a link to a document that lists the types of transactions supported by the networks and insurance carriers, visit **cda-adc.ca/en/services/CDANet**

Dentists Meet with Parliamentarians on NIHB and Seniors Issues

DAYS ON THE HILL

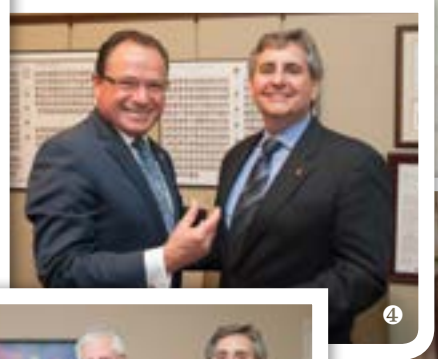
CDA's Days on the Hill event—an annual initiative that connects dentists with federal parliamentarians to discuss issues affecting dentistry—was an opportunity to advocate for policy change to help improve the oral health of Canadians.

The main focuses of this year's meetings, held on May 5 and 6, were the review of the Non-Insured Health Benefits (NIHB) program and oral health standards for veterans in long-term care (LTC) facilities. The CDA delegation held 35 meetings with parliamentarians over the course of two days in May, including ministers, officials in the Prime Minister's Office, senior officials, senators, and other Members of Parliament. Other key topics of discussion were food labelling as it pertains to sugar consumption and prescription drug issues.

CDA was joined by representatives of the Assembly of First Nations (AFN) to discuss the review of the NIHB program with key parliamentarians. "We wanted to reiterate our strong support of the current joint review of the program by AFN and Health Canada, which we are hopeful will lead to an effective and patient-focused program," says Dr. Alastair Nicoll, CDA president.

"We also emphasized that the program review must be seen through to its conclusion to ensure it is both adequately funded and administratively efficient. First Nations and Inuit populations need and deserve an NIHB program that is based primarily on client needs and focused on improving client outcomes."

With regard to the oral health care needs of veterans in LTC facilities, CDA wanted to underline the capacity of Veteran Affairs Canada (VAC) to show leadership on standards of care for seniors. "The Department plays a vital role in providing care for a segment of Canada's elders. And because of its contractual relationships with close to 200 care facilities across the country, VAC can positively influence the quality of oral health care offered to all seniors in LTC facilities," explains Dr. Thomas Raddall, chair of CDA's advocacy committee.



The CDA delegates recommended that VAC include in its contracts with LTC facilities the minimum requirements of an oral health screening upon admission, an annual examination by a dentist, a daily mouth care plan, and suitable infrastructure to support the appropriate delivery of needed dental care. "We are thrilled that several MPs responded positively to our call to action and offered to help immediately by reaching out to their relevant ministers and caucus colleagues," adds Dr. Raddall.

The event was also an occasion to have fruitful discussions with Minister of Health Rona Ambrose. "The meeting with Minister Ambrose was particularly positive," says Dr. Nicoll. "She was very appreciative of CDA's responsiveness on many issues; she even mentioned that we stand as a good example for our willingness to understand and address issues with prescription drug abuse." CDA delegates covered several topics with Minister Ambrose, and she committed to raising the issue of oral health standards for veterans in LTC facilities with Minister of Veteran Affairs Erin O'Toole.

Furthermore, the CDA delegation thanked Minister Ambrose for the opportunity to participate in several roundtable meetings this past year, including those on health care innovation, prescription drug abuse, and domestic violence and child abuse. "By having representation at those meetings, CDA can ensure that the oral health care needs of the Canadian population are understood by government and other relevant stakeholders, and that they are taken into consideration when developing policies and initiatives," concludes Dr. Raddall.

❶ (L. to r.) Marie Frawley-Henry, AFN representative; Dr. Jason Noel; Laurie Hawn, Conservative MP for Edmonton Centre; Dr. David Zaparinuk.

❷ Members of the CDA delegation with Carol Hugues (c.), NDP Aboriginal Health Critic and MP for Algmoa–Manitoulin–Kapuskasing.

❸ (L. to r.) Dr. Thomas Raddall, chair of CDA's advocacy committee; Senator Daniel Lang, member of the Senate Subcommittee on Veteran Affairs; Dr. Alastair Nicoll, CDA president; Dr. Randall Croutze, CDA president-elect.

❹ CDA president-elect Dr. Croutze (r.) presented a Royal Canadian Dental Corps centennial pin to Dr. Harold Albrecht, Conservative MP for Kitchener-Conestoga and a retired dentist.

❺ Liberal Party of Canada leader Justin Trudeau chats with CDA president Dr. Nicoll.

❻ The CDA delegation including Mr. Kevin Desjardins (far left), director of public affairs at CDA, and Dr. Chris Robinson (far right) met with Minister of Health Rona Ambrose.

❼ Kim Elmslie, assistant deputy minister at the Public Health Agency of Canada, with Dr. Nicoll.

❽ CDA president Dr. Nicoll on Parliament Hill.

❾ Carolyn Bennett (r.), Liberal Party of Canada Aboriginal Affairs Critic and a retired physician, and Dr. Lynn Tomkins (l.), CDA Board member.

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Royal Canadian Dental Corps Celebrates 100 Years of Service

In May 2015, the Royal Canadian Dental Corps (RCDC) celebrated its Centennial, marking a century of Canadian military dental service, with several events in Ottawa.

The events included a two-day international military clinical symposium (sponsored by CDA, with generous support provided by Henry Schein Canada and KaVo Kerr Group), an RCDCA/CDA golf tournament, Centennial Parade and unfurling of the Royal Banner, a wreath laying ceremony at the National War Memorial, and the official opening of an exhibit at the Canadian War Museum, "Oral History – A Century of Canadian Military Dentistry"—open to the public until November 11, 2015.

"The RCDC thanks CDA for the key role it played in commemorating the RCDC Centennial, reflecting CDA's role in establishing a military dental service in Canada and the close partnership between CDA and RCDC since that time," says Colonel James Taylor, Regimental Head of RCDC.

A formal RCDC Centennial Gala was held on May 13 at the Fairmont Château Laurier in Ottawa. CDA sponsored the Gala, with generous support provided by CDSPI and QuikCard.

Centennial Highlights

1. The Honorable Jason Kenney, Minister of National Defence, (second from right) was on hand to help officially open the "Oral History – A Century of Canadian Military Dentistry" exhibit at the Canadian War Museum.
2. Members of the RCDC and Canadian dental profession attended a wreath laying ceremony at the National War Memorial in Ottawa in May 2015.
3. (L. to r) Dr. Alastair Nicoll, CDA president; General Tom Lawson, Guest of Honour and the Canadian Forces' Chief of the Defences Staff; and Colonel James Taylor, Regimental Head of RCDC; at the RCDC Centennial Gala.
4. Dr. Alastair Nicoll, CDA president (r.), accepts the Canadian Forces' Medallion for Distinguished Service on behalf of CDA, from General Tom Lawson, Guest of Honour and the Canadian Forces' Chief of the Defences Staff at the RCDC Centennial Gala.
5. Dr. Alastair Nicoll, CDA president, presents Colonel James Taylor, Regimental Head of RCDC, with a commemorative sword on behalf of the Association at the RCDC Centennial Gala.

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CDA AWARD WINNERS: RECOGNIZING EXCELLENCE

Exceptional individuals were recognized for their contributions to the dental profession, the dental community or the oral health of Canadians at the annual CDA award ceremonies held in Ottawa in April 2015.

Medal of Honour

The Medal of Honour is the highest award conferred by CDA. It is given to a dentist in recognition of a lifetime of outstanding service and professional achievement to the benefit of the dental profession, the dental community and society at large, and to whom significant change can be attributed. The breadth and scope of achievement are significant factors in granting this award, as are the individual's contributions to the goals and objectives of CDA. This year's recipient was ***Dr. Gordon Thompson*** *of Edmonton.*

Dr. Thompson has devoted his career to advancing the dental profession in Canada and abroad. In his distinguished academic career, he served as associate dean in the faculty of dentistry at the University of Toronto, and as dean of the faculty of dentistry at the University of Alberta. He has been a major influence in organized dentistry as past-president of many national organizations, including the Association of Canadian Faculties of Dentistry and the Canadian Dental Regulatory Authorities Federation, and as executive director and registrar of the Alberta Dental Association and College—a role he has performed for the past 21 years. Dr. Thompson is widely respected for his leadership in guiding the profession through complex issues over the years and for the inspiration and mentorship he has provided to many dentists.

> *"I would like to thank CDA for making the Medal of Honour award possible and honouring me in this way. It is a signal honour to receive the support and recognition of one's peers. Receiving this award underscores the support of family, colleagues and staff."*

Honorary Membership

The Honorary Membership award is given to an individual (dentist or non-dentist) who has made an outstanding contribution to the dental profession, the dental community, or the oral health of Canadians over a sustained period of time at the academic, corporate, specialty society, council, commission or committee level. An outstanding contribution at the national level is a principle consideration. The breadth and scope of achievement is a significant factor in determining this award. The CDA Honorary Membership was presented this year to ***Dr. Gilles Lavigne*** *of Montreal.*

Dr. Lavigne, dean of the faculty of dentistry at the University of Montreal, has made exceptional contributions to the dental profession. As a researcher, he is internationally recognized in the field of bruxism and sleep disorders and leads the field of orofacial pain research. Admired by colleagues as an inspiring leader and excellent communicator, Dr. Lavigne has guided the work of international, national, and provincial research-related organizations and has made outstanding contributions to dental education at the University of Montreal. On top of his many commitments in research, teaching, and university administration, he also remains a dedicated practitioner. In his acceptance speech, Dr. Lavigne talked about the importance of collaboration.

> *"Our goal is interdisciplinary, we have to work all together. I always remind the dean of medicine that about 70% of Canadians, of all ages, are seeing one health care provider once a year—it's us. We have an important role in screening, detection, and in guiding patients."*

Oral Health Promotion Award

The Oral Health Promotion Award recognizes individuals or organizations who have improved the oral health of Canadians through oral health promotion. This may involve creating public health policy or supportive environments, strengthening community action, developing personal skills, and/or increasing the prevention of oral diseases and disorders. The Oral Health Promotion Award was awarded to ***Dr. Pamela Glassby*** *of Vancouver.*

Dr. Glassby has dedicated her career to improving the oral health of young children in British Columbia (BC), especially those in low-income families. She created Smile to Smile/Knee to Knee (S2S/K2K), a program for vulnerable children and their families that assesses a child's caries risk and helps parents develop the skills they need to provide their children with good oral care. She also created educational resources on managing the first dental visit for dentists and dental students. Through her many successful oral health initiatives, Dr. Glassby has influenced the lives of many BC families.

> *"Pamela is a wonderful public health dentist in BC — she's a trailblazer, and thousands of children have benefitted from her efforts," said Ms. Jocelyn Johnston, executive director of the British Columbia Dental Association, who accepted the award on Dr. Glassby's behalf.*

Distinguished Service Award

The Distinguished Service Award is given to recognize outstanding contributions to the dental profession, the dental community or the oral health of Canadians at large, in a given year or for outstanding service over a number of years. It may also recognize outstanding contributions at the academic, corporate, specialty society, council, commission or committee level. The Distinguished Service Award was presented to 2 recipients: ***Dr. Blaine Cleghorn*** *of Halifax, and* ***Dr. Amil Shapka*** *of St. Paul, Alberta.*

Dr. Cleghorn, assistant dean of clinics and building services in the faculty of dentistry at Dalhousie University, is a leader in dental education at the local, provincial, national and international levels. His excellence in teaching has been recognized with a number of prestigious awards, including twice winning the W.W. Wood Award from the Association of Canadian Faculties of Dentistry (ACFD) and the ACFD National Teaching Award. Through his educational innovations and leadership roles with ACFD, the Commission on Dental Accreditation, and the National Dental Examining Board of Canada, Dr. Cleghorn has made a lasting impact on the dental student experience and the professional membership in Canada.

> *"It's been privilege for me to have been involved in many provincial, national and international organizations. I've had incredible mentors and teachers along the way, who have influenced and guided my life and career choices."*

Dr. Shapka is a practising dentist in St. Paul, Alberta, and founder of the Kindness in Action Society (KIA), a non-profit organization that provides dental care to people living in poor and remote regions of the world. For 21 years, Dr. Shapka has been committed to sustaining and expanding KIA's work, an operation that involves over 250 volunteers each year. His efforts have made a tremendous difference, not only for the thousands of people around the world who have benefited from the dental care and pain relief provided by KIA volunteers, but also for the hundreds of KIA volunteers whose lives have been enriched by the experience.

> *"Working selflessly from the heart is a life-changing, life-affirming experience for most and my experience is no exception. Perhaps most importantly, it has been a humbling and gentle reminder that we all have much to be grateful for. As dentists we are privileged to be able to contribute to the well-being of others and, above all else, dentistry is a helping profession."*

Award of Merit

The Award of Merit recognizes an individual who has served in an outstanding capacity in the governing or service of CDA over a sustained period of time, or who has made similar outstanding contributions to the dental profession, the dental community, or the oral health of Canadians and/or society at large. This year, there were 2 recipients of the award: ***Dr. Michael Brown*** *of Moncton, New Brunswick, and* ***Dr. Edmund O'Neill*** *of Kingston, Ontario.*

Through his engagement with the dental community at the provincial and national levels, **Dr. Brown** has served his profession with distinction. He was president of the New Brunswick Dental Society in 2000-01, chair of its Board of Directors from 2001-08, and member of the Mediation and Discipline committee for many years. At the national level, Dr. Brown represented the interests of New Brunswick dentists on the CDA Board of Directors for 6 years. In 2014, he was awarded Honorary Membership in the New Brunswick Dental Society, its highest level of recognition. In his acceptance speech, Dr. Brown thanked his wife, Dr. Mary Ann Wiseman, president of the National Dental Examining Board of Canada, whose commitment to organized dentistry matches his own.

> *"Mary Ann has been involved in organized dentistry almost as long as I have so she understands the time commitments, but more importantly, how rewarding it is to contribute to the profession."*

A practising orthodontist in Kingston, Ontario, **Dr. O'Neill** played an instrumental role in establishing the Crawford Dental Collection as a permanent collection within the Museum of Health Care in Kingston. Dr. O'Neill was involved in bringing Dr. Ralph and Olga Crawford's collection of dental artifacts and memorabilia out of storage and ensuring it would be preserved and made available to the public. To find a permanent home for the collection, he mobilized support from the local dental and medical communities and chaired a committee of the Kingston Dental Society dedicated to this goal. He also ensured that the stories behind many of the artifacts, as told by Dr. Crawford, were captured for future generations. Through these efforts, Dr. O'Neill has made an invaluable contribution that honours the history of the dental profession.

> *"The love and support of one's spouse and family, the appreciation of our care by our patients, and recognition of our efforts by our peers—these are life's rewards."*

Announcements

Dr. Victor Kutcher

Ontario Dental Association

New president for Ontario Dental Association

Dr. Victor Kutcher of Stoney Creek, Ontario, has been installed as president of the Ontario Dental Association (ODA) for 2015-16.

He has served as a member of the ODA Board of Directors since 2010.

Dr. Kutcher has an MBA from York University and graduated from the University of Toronto faculty of dentistry in 1981. He maintains a general private practice in Hamilton.

Literature search service *for Canadian dentists*

The University of Toronto Dentistry Library is offering a Literature Search Service for Canadian dentists and dental organizations.

By request, University of Toronto dentistry librarians will use advanced search strategies to conduct a literature search on a given topic. Service users will receive a list of article citations and abstracts with links to PubMed. The list of article citations can also be delivered through a citation management system, like RefWorks, by request.

For more information, or to request a literature search, visit **dentistry.library.utoronto.ca/content/literature-search-service** or contact Helen He, Head of the Dentistry Library, **library.dentistry@utoronto.ca**

Laval University *Appoints New Dean*

Dr. Cathia Bergeron of Quebec City, has been appointed dean of the Laval University faculty of dentistry. Her 4-year term officially began in July 2015.

Dr. Bergeron is the former associate dean of undergraduate studies at Laval University, where she also teaches operative dentistry. Her main areas of focus are biomaterials and composite restorations, and she has a keen interest in health sciences education.

Dr. Bergeron serves on the Academy of Operative Dentistry's research committee and the Association of Canadian Faculties of Dentistry's academic affairs committee, and she participates in the National Dental Examining Board of Canada's question selection and review workshops. She has also been involved with the American Dental Education Association, *Journal of Esthetic and Restorative Dentistry* and *Journal of Dental Education*.

Dr. Cathia Bergeron

Université Laval



The Royal College of Dentists of Canada *Appoints New Registrar*

The Royal College of Dentists of Canada (RCDC) appointed Dr. Keith Morley as its new Registrar, effective April 1, 2015.

Dr. Morley is a graduate of the faculty of dentistry at the University of Manitoba and completed his pediatric dental residency at the University of Toronto and the Hospital for Sick Children in Toronto. He also obtained an MBA degree in 2013.

Dr. Morley has worked in the Canadian Armed Forces Dental Services, where he was honorably discharged with the rank of Lieutenant Colonel, and maintained a private practice in pediatric dentistry.

He has held senior leadership positions in organized dentistry, including president of the American Academy of Pediatric Dentistry, and served as chief of dentistry and deputy chief of surgery at the Royal Victoria Hospital Regional Health Centre in Barrie, Ontario.

As RCDC Registrar, Dr. Morley will work with a variety of stakeholders to set the standards for dental specialty education, practice and certification.

Dr. Keith Morley

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CHANGING THE CULTURE OF PATIENT SAFETY IN DENTISTRY

New initiatives within the Dental Services at Canadian Forces Health Services Group have the potential to improve patient outcomes

See also:
"Optimizing Patient Safety: Can We Learn From the Airline Industry?" by Drs. Richard Speers and Christopher McCulloch
jcda.ca/article/e37
or
CDA Essentials
Issue 4, 2014
p.26

For all health care professionals, a primary goal is the delivery of safe care to produce better patient outcomes. But ensuring patient safety requires knowledge of the risks—an area that has not been well studied in dentistry. At the Canadian Forces Health Services Group (CFHSG), new initiatives promise to shed some light on patient safety in dentistry, starting with military dental clinics.

The Knowledge Gap

Much of the research to date on patient safety focuses on medicine and, in particular, patients seen in acute care hospital settings where it's easier to track errors and their potential impacts. In comparison, a systematic approach to patient safety in dentistry and other forms of health care provided in ambulatory care settings has been limited.

(L. to r.): Shoba Ranganathan, Chief Quality and Patient Safety Officer, Canadian Forces Health Services Group (CFHSG) and Lieutenant Colonel (Dr.) Brenda Joy, Directorate of Dental Services, CFHSG.

However, strategies and initiatives to enhance patient safety in these sectors are becoming more common, says Shoba Ranganathan, Chief Quality and Patient Safety Officer within the CFHSG. "For several years, I worked as a quality improvement manager in the Canadian Armed Forces medical clinics," she says. "When I was given the opportunity to manage the program for the entire CFHSG, involving the dental services was a new and exciting component. The dental personnel were very interested and willing to engage in the patient safety program, knowing the impact it could have on their patients."

As for why dentistry lags behind medicine in its approach to patient safety, Lieutenant Colonel (Dr.) Brenda Joy, from the Directorate of Dental Services within the CFHSG, adds, "The medical world has also had accreditation activities push the patient safety agenda. Formal accreditation of dental clinics is a newer concept, so directing efforts to develop a strong organizational culture of patient safety is not something that is as apparent within the greater dental community."

Ms. Ranganathan stresses the importance of understanding patient safety from a dentistry-specific perspective. "In outpatient-type health care settings, patient safety incidents that occur are different than in acute care settings; many of them centre on communication and documentation errors,"

> *Very rarely is an error deliberate or the result of incompetence. Usually, an error occurs because of a system failure or process breakdown.*
>
> – Shoba Ranganathan

she says. "Unfortunately, there's not a lot of research on patient safety incidents that occur in dental settings. There is some information on wrong-site extractions, or needle sticks, but nothing necessarily about documentation errors in patient charts or contraindications of medications."

Learning from Medicine

As part of a CFHSG initiative, the Dental Services are embarking on an ambitious project that aims to adapt patient safety measures used in medicine to the dental setting. "As a military organization, a great benefit is our system-wide approach," says Lieutenant-Colonel Joy. "We have 42 dental clinics that function like individual dental practices but are integrated with primary medical care as part of the overall organizational structure for the CFHSG. With this kind of system, we can implement different processes and measure their effectiveness; we can promote best practices and advance dentistry not only for our own patients and but also as a test bed for the rest of the country."

Integrating medicine and dentistry in the CFHSG's approach to patient safety also supports the overall health of patients. "Within our organization, we have the ability to make connections between the family physician and the family dentist," says Ms. Ranganathan. "And if we can establish that as being a best practice, it could improve the integration of oral care into an individual's overall health care."

Learning from the Air Force

Drawing parallels between safety in dentistry and in aviation can be instructive: both share a team environment, a systematic approach to processes, and benefit from crew (team) resource management. By adapting the processes and reporting framework used in the Royal Canadian Air Force (RCAF) Flight Safety program to a health care environment, CFHSG hopes to foster even safer, more reliable care. "We have the benefit of having the RCAF in our backyard. Their flight safety program is very well established and respected, says Ms. Ranganathan. "So we've been able to take best practices from their flight safety program and are applying them to health care."

To illustrate how flight safety principles apply to health care, Lieutenant-Colonel Joy cites the use of patient safety officers at every medical and dental clinic across the CFHSG, mirroring the use of unit-level flight safety officers, and the implementation of an incident reporting system informed by the RCAF system. CFHSG also hopes to examine and learn from RCAF's highly successful, deep-rooted culture of safety.

Changing Attitudes

It's the intangible aspects of a patient safety program—those that help define a workplace culture—that are perhaps most difficult to establish. Developing a culture of safety involves encouraging openness to reporting mistakes, a move that many clinicians may be unwilling to make because of perceived negative implications. But shifting the emphasis away from blame is a key part of ensuring a strong culture of patient safety, says Ms. Ranganathan. "Very rarely is an error deliberate or the result of incompetence. Usually, an error occurs because of a system failure or process breakdown. We need to help patients feel confident that we're going to do something about preventable errors. It's really about a cultural shift, at arriving at the understanding that what makes me a better clinician is that I'm doing something about my mistake."

To help further enhance the culture of patient safety within the military health services, the CFHSG is partnering with the Canadian Patient Safety Institute (CPSI) to implement a patient safety education program across the organization. The goal of the program is to train enough patient safety trainers to sustain a peer-to-peer system of education for all levels of health care workers, based on a curriculum that develops attitudes, knowledge, specific skills, and behaviours around patient safety. For this work, the CFHSG was awarded CPSI's Innovation in Patient Safety Education Award for 2014.

Although the education program is still in its infancy, it has the potential to change how patient safety is considered and managed in military dental clinics. What the military Dental Services learns from this work could inform discussions about patient safety in Canadian dentistry and health care, in general. Ultimately, it has the potential to improve patient care.

Patient Communication Scenario: HOW WOULD YOU HANDLE AN ANGRY PATIENT?

On Oasis Discussions, we presented dentists with the following scenario:

An angry patient is dissatisfied with treatment received in your office and refuses to leave a full waiting room. How would you handle this situation?

We received a lot of responses from Canadian dentists and asked a communications expert for advice. Dr. Sheela Raja is a licensed clinical psychologist and assistant professor at the University of Illinois at Chicago, where she teaches health communication and behavioural medicine.

Dr. Sheela Raja
BS, MA, PhD

How do you think this scenario could be handled?

It's the kind of situation that health care workers are most worried about—what do I do with somebody who gets angry? But there are several general strategies that dentists can use to de-escalate the situation:

- **Listen.** The first defence is good listening. Reflect on what the patient has said and what they are upset about. Try to show empathy, if you can.
- **Avoid.** This doesn't mean avoiding the patient—it means giving them 5 or 10 minutes to cool down, and then telling them, "I'm in the middle of seeing a patient right now but I'll come back and we can talk about this in 10 or 15 minutes." Don't let them stew so long that it makes things worse, but also use this time to gather your own thoughts.
- **Oblige.** Ask the patient: "What can I do to make this situation better?" It's about figuring out what they want and what's behind their anger.
- **Integrate.** This approach is a collaboration between your interests and the patient's interests. Ask the patient, "How can we come together and figure out something that works for both of us?"
- **Compromise.** Closely related to integrating, the compromise approach is where everyone gives a little bit on either side, which allows you to come up with short-term solutions.
- **Dominate.** You could say, "I'm the boss, it has to be done my way." Sometimes it works, but other times it just escalates the situation. Of all the strategies, the dominating approach should be used the most sparingly.

It's also a good idea to have any of these discussions with the patient in a private setting, away from the crowded waiting room.

What stood out for you in the responses from dentists?

First off, it was great to see how strongly this question resonated with dentists—they had so much to say! Some specific suggestions stood out to me as good approaches:

- **Use a mediator.** Some people said they would invite the patient back for a discussion and use a mediator, usually another staff member who was not involved in the conflict.

> *It's the kind of situation that health care workers are most worried about—what do I do with somebody who gets angry?*

Oasis discussions.ca

To see the full interview, visit **oasisdiscussions.ca/2015/04/20/sr-2/**

To read the full scenario that was presented to dentists, visit **oasisdiscussions.ca/2015/04/02/cc1/**

To see the replies from dentists, visit **oasisdiscussions.ca/2015/04/14/fbcs/**

- **Review notes prior to meeting with the patient.** Be prepared and informed as you don't want to retrigger an angry patient by making them think, "You really don't know what's gone on with me?"
- **Provide opportunity for written and verbal complaints.** This gives the patient a lot of choice, which is really good; anything that gives the patient some choice will de-escalate the anger.
- **Call the police.** The number of people who suggested this tactic suggests that health care providers, understandably, don't like to engage in conflict. However, this should be considered an option if the person has a prior history of violence or if their behaviour is threatening. Trust your judgement.
- **Train staff in prevention.** Work with staff ahead of time by talking about similar scenarios and the importance of good communication with patients.
- **Fulfil an ethical obligation.** Some talked about an ethical obligation to complete unfinished care and be available for the patient. Even if you do dismiss the patient, let them know that until they find a new dentist, you are available for emergency care.
- **Keep good documentation.** Dentists talked about the importance of keeping good documentation and reporting to your malpractice or licensing body if an incident has taken place in your office.

Can you recommend good resources on communicating in health care settings?

These websites and books have great tips for dealing with angry people:

- hpso.com/resources/article/3.jsp
- mindtools.com/pages/article/dealing-with-angry-people.htm
- *Tough Questions, Great Answers: Responding to Patient Concerns About Today's Dentistry*, Edition 1, by Robin Wright (Quintessence, 1997).

This interview has been edited and condensed.

The views expressed are those of the author and do not necessarily reflect the opinions or official policies of the Canadian Dental Association.

Ask Your Colleagues

Do you have any burning clinical questions related to your everyday practice? Are you facing a challenging clinical case and need advice? Send your queries to Oasis Discussions for expert guidance. The following question was submitted to Oasis Discussions by a general dentist. Drs. Michael Casas and Suham Alexander provided a response.

Erratum

CDA Essentials did not reference the source JCDA article where the images shown in Case 1 originally appeared. The images presented in Case 1 were adapted from:

Raldi DP, Mello I, Habitante SM, Lage-Marques JL, Coil J. Treatment options for teeth with open apices and apical periodontitis. *J Can Dent Assoc* 2009 Oct;75(8):591-6.

CDA Essentials apologizes to the authors for this oversight.

Question

What are the current standards for treatment of permanent teeth that have had trauma and require apexification?

Response

Apexification
is the process of inducing apical root closure in a necrotic immature tooth. For traumatically induced pulp necrosis, the tooth requiring apexification is most commonly an incisor. Traumatic injuries account for approximately 5% of the dental treatments sought by patients.

Treatment options

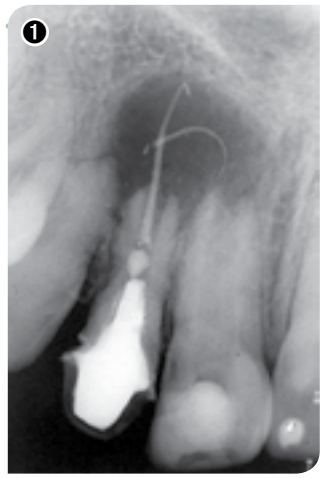
Frank Technique

In this traditional approach, calcium hydroxide is placed in a lightly cleansed canal to induce apexification. The calcium hydroxide is replenished every 3–6 months within the canal. It has been shown that it requires approximately 18–24 months of active treatment to gain adequate apical closure before gutta percha obturation can be performed.

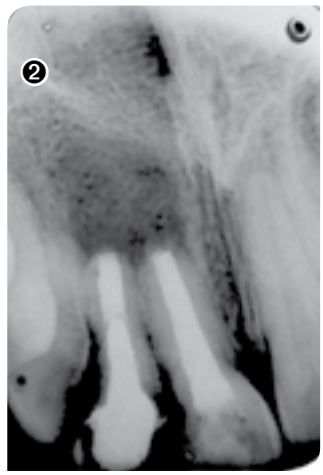
However, this long-term treatment can be unpredictable with respect to the formation of an apical seal. Also, the treatment period required to achieve an apical seal is variable and can lead to difficulty in appropriate follow-up (see ❶, ❷).

Apical Plug

Mineral Trioxide Aggregate (MTA) has been effective in inducing apexification of roots when used as an apical plug. Treatment with MTA has the advantages of a shorter treatment time, fewer patient appointments, and more predictable outcomes in creating an apical barrier, especially in immature permanent teeth with necrotic pulps. However, similar to treatment with calcium hydroxide, MTA only addresses the creation of an apical seal and not root formation along the length of the root.



Preoperative diagnostic radiograph showing teeth 11 and 12 with open apices and periapical radiolucencies.



Follow-up radiograph taken 24 months after completion of treatment.

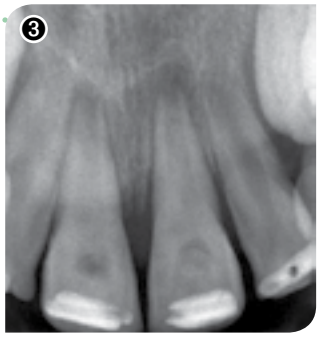
Case 1

Antibiotic Therapy in Revascularization/Revitalization

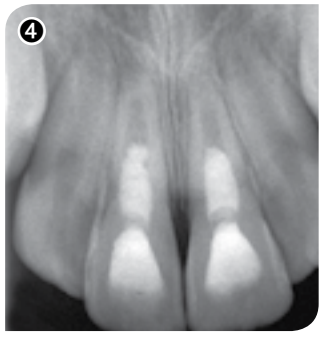
The use of antibiotic mixtures as intracanal medicaments to cleanse and "sterilize" the canal has become increasingly popular. The necrotic tooth is commonly filled with a combination of metronidazole, ciprofloxacin and minocycline. After 3 months, the canal is accessed again, bleeding is induced to fill the canal with blood, and the canal is sealed with a collagen plug, MTA and then amalgam.

The blood clot creates a biological scaffold to aid in the growth of new tissue within the canal space. Additionally, the growth and differentiation factors within the blood clot support the healing process. More recently, some techniques utilize blood that is drawn from the patient and centrifuged to isolate platelet-rich plasma (PRP) or plasma-rich growth factor (PRGF), which is then injected into the canal. Although the treated tooth appears radiographically to develop a typical root shape, animal studies suggest that the new tissues are not dentin and pulp but rather cementum with bony islands and connective tissue (see ❸, ❹).

The views expressed are those of the authors and do not necessarily reflect the opinions or official policies of the Canadian Dental Association.



❸ Radiographic view after intracanal application of calcium hydroxide paste; periradicular radiolucencies are evident in both roots.



❹ Radiographic view at 18 months follow-up, demonstrating narrowing of root canal in the apical third and thickening of the lateral walls. A normal bony architecture at the periradicular region is evident.

Case 2

THE AUTHORS

Dr. Michael Casas

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Dr. Suham Alexander

Dr. Alexander is in private practice in Ottawa and is a clinical editor for Oasis Discussions at CDA.

Send us your comments or clinical questions.

oasisdiscussions@cda-adc.ca
or use the CDA Oasis App.

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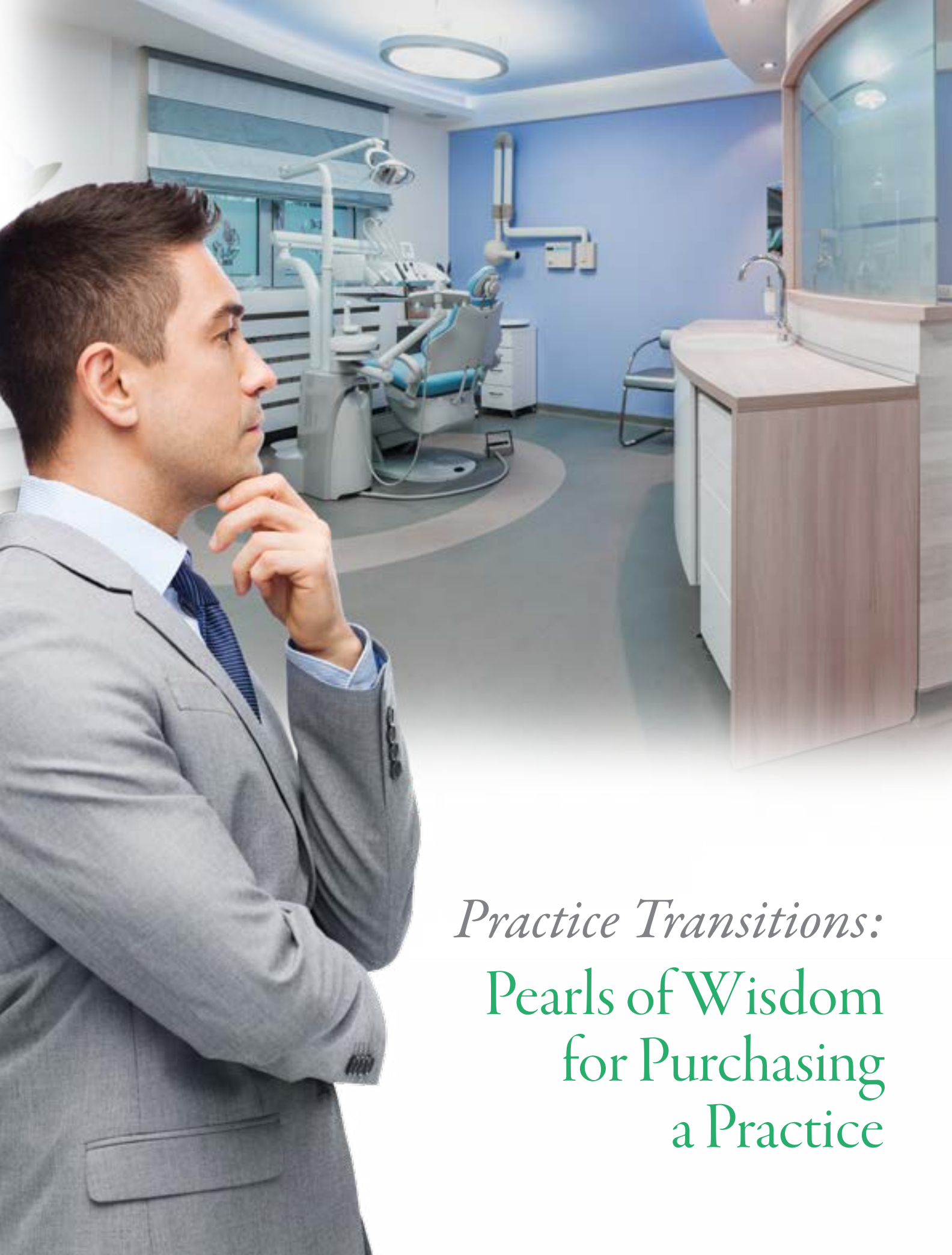

Practice Transitions:

Pearls of Wisdom for Purchasing a Practice

David Chong Yen

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To watch an interview with David Chong Yen on purchasing a dental practice, see:
oasisdiscussions.ca/2015/05/14/pdp/

Practice ownership is a major life decision for a dentist. There are generally 2 options: buy an existing practice or open one from scratch. Although it may be more costly, many dentists choose to buy an existing practice because it is usually less risky and provides immediate access to a patient base and cash flow that allows the practice to repay its debts and fund the clinic's operating expenses. To help you purchase and evaluate a practice, here are some considerations that could save you unnecessary financial and mental stress.

1. Average Revenue Per Patient

It is not enough to just look at the gross billings or number of active patients. Consider the average billing per patient as a benchmark for evaluating whether a practice is over- or underperforming. In Ontario, the average billing per patient per year is approximately $670. A practice generating higher billings per patient may not be sustainable once you replace the principal dentist. A practice generating lower billings per patient could represent untapped potential—perhaps services that could be done in-house are being referred elsewhere. As a starting point, use the appraisal's estimate of active patients and the latest set of financial statements to determine the average revenue per patient. After your chart audit, you can verify this figure using data collected first hand. Keep in mind that the type of services provided will also affect the average revenue per patient. For example in Ontario, the optimum hygiene production is about $220 per patient, per year.

2. Co-payment Collection

Consider whether a practice has difficulties collecting fees from patients. Warning signs include a high accounts receivable balance (i.e., patient fees not yet collected) and a high number of write-offs/adjustments. If there is smoke, there may also be a fire and a detailed investigation could result in finding co-payment collection issues. Buying a practice with co-payment issues means you could lose a significant portion of the patient base once co-payment collection is enforced.

3. Number of Active Charts

The primary driver of a practice's value is the active number of patients, usually defined as regular (i.e., not emergency) patients who have attended the practice within the past 12 months.

In most cases, the practice appraisal will state the number of active charts. However, prospective buyers should verify this number by performing a chart audit. Since it is not

practical to count every chart, most buyers audit a sample of all the charts (i.e., 1 out of every 10 charts). While going through the charts you can get an idea of the type of clinical work being performed by asking:

- Are the current treatment plans consistent with my clinical philosophy?
- Are there opportunities to provide comprehensive dentistry—including crowns, root canals, complete oral exams—and some of the work referred to specialists which you believe your clinical skill set allows you to perform?

4. Cash Flow Forecast

Cash flow, and not necessarily profit, is the lifeline of any business. At the outset, it is important to ensure that a practice's cash flow allows you to repay the loan and provide personal financial stability. Buyers should prepare a monthly cash flow forecast to help answer the following questions:

- How much money is required to purchase and pay for practice expenses such as salaries, rent, utilities and dental supplies?
- How much cash will be in the practice or how much debt will I owe at the end of each month?
- How much profit will be generated each month? *Note that profit generated may be different than the amount of cash in the bank account. Loan repayment is not considered an expense and does not reduce profit, but will reduce the amount of cash in your bank account.*
- How long will it take to repay the bank loan? *If it will take more than 10 years to repay the loan, you might question whether this practice is suitable for you.*

5. Review the Vendor's Numbers

As a potential buyer, your advisors should perform due diligence and inform you of any unusual items, exceptions and opportunities associated with the practice in question. This could include potential tax liabilities, co-payment issues or ways to structure the transaction/agreement to save you money.

6. Lease Agreements*

Read and review lease agreements thoroughly.

- Relocation/Demolition Clause

  The presence of a demolition or relocation clause allows the landlord to terminate the lease and destroy or relocate the dental office with short notice. This can be very disruptive and under more severe circumstances, could cost you the entire practice.

- Length of Lease Agreement

  Banks are looking for a lease term and renewal options of at least 7 years (preferably, 10). If the lease term and renewal options are under 7 years, the term of the loan may be adjusted to the length of the lease. This means the loan will have to be repaid much faster, thereby reducing cash flow.

- Assignment or Transferability

  Ensure that the practice's premises lease can be transferred or assigned to another buyer.

** Note that in situations where the vendor intends to sell only "patient charts and goodwill" not all content in this section will apply.*

7. Employee Severance and Termination

In ideal circumstances, employees of a dental practice are retained when the practice is sold to a new owner. However, in some situations the buyer may terminate a staff member. Work with your advisors to ensure that the purchase agreement defines who will pay the costs associated with the termination of a staff member.

8. Patient Retention

Minimizing the loss of patients once ownership changes hands is important. When the buyer and seller collaborate for an effective transition, the practice is more likely to be successful in retaining patients. However, you should prepare yourself for at least a 10% loss of patients under normal circumstances. This loss should be built into your cash forecast so you understand its impact on your financial situation.

Buying a practice is not an exact science. For most buyers, the perfect practice does not exist, but the challenges can be made easier by understanding what is most important to you and where you are willing to compromise.

The views expressed are those of the author and do not necessarily reflect the opinions or official policies of the Canadian Dental Association.

> *At the outset, it is important to ensure that a practice's cash flow allows you to repay the loan and provide personal financial stability.*

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1 Delaurenti M, et al. An Evaluation of Two Toothbrushes on Plaque and Gingivitis. Journal of Dental Research. 2012, 91(Special Issue B):522.
2 Data on file, 2010

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How to Manage "CLOSED LOCK" DISC DISPLACEMENT WITHOUT REDUCTION WITH LIMITED OPENING

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"Closed lock:" disc displacement without reduction with limited opening

- *Functional disorder of the temporomandibular joint (TMJ) included within the broad category of derangements of the condyle disc complex.*
- *In the closed-jaw position, the disc is anterior to the condylar head, and the disc does not reduce with jaw opening. Medial and lateral displacement of the disc may also be present. This disorder is associated with limited jaw opening because the disc mechanically obstructs translation of the condyle.*
- *Derangements of the condyle disc complex are considered a subgroup of temporomandibular disorders (TMDs).*

Presentation

Population

- More common in young and middle-aged adults.
- Approximately twice as common in women than men.
- Often remitting, self-limiting or fluctuating over time.
- Disc displacement without reduction with limited opening is relatively uncommon.
- Progression to chronic and disabling intracapsular TMJ disease is uncommon.

Signs

- Maximum assisted opening (passive stretch) is less than 40 mm, including the vertical incisal overlap.
- Deflection of the mandible to the ipsilateral (involved joint) side on opening and protrusion.
- Restriction of movement to the contralateral (normal joint) side.
- No intracapsular sounds (click or pop) identified unless chronic and associated with change in bony surfaces.

Symptoms

- Patients often report:
  - Precisely when the "closed lock" occurred and can relate it to a specific event.
  - History of intracapsular sounds (click or pop), but this sound has ceased.
- Pain may or may not be present. If present, pain is often localized to the preauricular area.
- Pain may be described as sharp, sudden and (sometimes) intense and is closely associated with joint movement, particularly at the point of limitation of movement.

Dental Emergency Scenario

This article was originally created for the JCDA Oasis searchable database. Visit Oasis Help at **jcdaoasis.ca** to access this and other point of care clinical consults.

- If inflammation develops, the pain may be constant, dull or throbbing, even at rest, and be accentuated by joint movement and joint loading.
- Patient displays concern regarding the sudden decrease in mandibular movement as a result of the "closed lock."

Investigation

1. Obtain thorough medical and dental history, including details related to pain and dysfunction.
2. Perform head and neck examinations (cranial nerve, muscle and joint tenderness, joint sound, range of motion of jaw) and intraoral (teeth, gingiva, oral soft tissue) to rule out local pathology or other sources of pain and to assess joint function.
3. Downward force applied to the mandibular incisors produces minimal, if any, increase in range of opening (hard end feel).
   a. Restricted mouth opening (maximum interincisal opening) as a result of muscle disorders is usually variable in terms of range of opening. However, mild passive force applied to the mandibular incisors will usually result in an increase in range of opening (soft end feel).
4. Loading of the involved joint is often painful.
5. Confirm the diagnosis on a magnetic resonance imaging (MRI) scan of the TMJ.
   a. In the maximal intercuspal position, the posterior band of the disc is located anterior to the 11:30 position and intermediate zone of the disc is anterior to the condylar head.
   b. On full opening, the intermediate zone of the disc is located anterior to the condylar head.
6. Determine whether the disc displacement without reduction with limited opening (closed lock) is acute or chronic.
   a. The clinical picture becomes less clear if disc displacement is chronic, as the ligaments become further elongated and the morphology of the disc becomes altered, thus allowing a greater range of movement. This may mistakenly be considered as a disc displacement without reduction without limited opening.

Diagnosis

A diagnosis of disc displacement without reduction with limited opening is based upon patient history, clinical examination and related tests.

Differential Diagnosis

Common conditions

- Masticatory myalgia
- Myositis
- TMJ osteoarthritis (degenerative joint disease)
- Temporalis tendonitis

Less common conditions

- TMJ ankylosis
- Coronoid hyperplasia
- Tendon/muscle contracture
- Synovial chondromatosis
- Capsular fibrosis
- Polyarthritides
- Connective tissue disorders
- Neoplasm
- Trauma/fracture

Treatment

Approaches to acute cases may be different from chronic cases.

Common Initial Treatments

Acute cases

- Patient experiencing closed lock for 1 week or less.
- Consider referring the patient to an oral medicine specialist or oral and maxillofacial surgeon.
- Consider attempting manual manipulation to regain the normal disc–condyle relationship. If this is successful, then the patient could wear an anterior positioning appliance for the first 2–4 days followed by nighttime use only. Once stability has occurred, a stabilization appliance may be considered for nighttime use.
- If patient's condition is not responding to the above recommendations, then a minimal invasive surgical procedure (arthrocentesis/arthroscopy) could be considered to return the disc to a normal functional relationship with the condyle. This will need to be followed by conservative supportive therapies.
- Conservative supportive therapies:
  - Advise the patient to avoid chewing/biting hard foods, stop parafunctional habits (tooth clenching and grinding, gum chewing, nail biting) and generally avoid activities that aggravate the condition.
  - Counsel the patient to perform gentle, controlled jaw exercises within a pain-free range, as this may be helpful in regaining range of opening.
  - Consider application of moist heat or ice to symptomatic preauricular area. After an acute injury (<72 hours) heat should not be used.
  - Prescribe a short course of NSAIDs for pain control and resolution of inflammation.
  - Fabricate a stabilization appliance for nighttime use.
  - Involve a physical therapist knowledgeable in TMDs to assist with pain control and regaining range of opening.

Chronic cases

- Refer the patient to an oral and maxillofacial surgeon if he/she presents with a chronic "closed lock" and if previously applied conservative supportive therapies have failed. The oral and maxillofacial surgeon will explore definitive surgical approaches.
- Involve a physical therapist knowledgeable in TMDs to assist with pain control and regaining range of opening.

Alternate Treatments

- An auriculotemporal nerve block may be attempted to differentiate a primary diagnosis of joint pain from muscle pain.

Advice

- Patients are managed following principles of orthopedic, musculoskeletal and rehabilitative medicine that require experience in management of TMDs.
- Patients need to be educated about this condition, as many patients attempt to force their mouths to open wider, thus aggravating the intracapsular tissues and potentially producing more pain.
- Patients need to be reassured that the long-term consequences of this condition are minimal, with the majority of patients regaining at least some of their original range of opening. ◆

Suggested Resources

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SOUTHWESTERN ONTARIO: OMFS Associateship. A well established group practice in Southwestern Ontario is seeking an Oral and Maxillofacial Surgeon for associateship leading to partnership. Our full scope modern surgicentre and hospital based practice provides dento-alveolar, implant, orthognathic, reconstructive, TMJ and trauma surgery under deep sedation or general anesthesia. We enjoy partnering with a very supportive dental, medical and specialist referral network in our community. We are seeking a personable, energetic, ambitious, caring individual who wishes to be part of a large dynamic team and further its reputation. The candidate must be eligible for licensure to practice as a specialist in oral and maxillofacial surgery in Ontario, includ-ing Fellowship in the Royal College of Dentists of Canada (RCDC). Our diverse university community has many amenities and provides an excellent environment in which to raise a family. Its high living standards and easy access to recreational and cultural activities make it a top community in Southwestern Ontario. Forward CV and inquiries to resumesoralsurgery@gmail.com. D10805

SASKATCHEWAN: Full-time or part-time associate needed for a busy office less than 2 hours east of Regina in a beautiful farming community. Full schedule from day one! 45% paid commission, accommodation provided. More amazing incentives to the right individual. New grads welcome and mentoring is available! Our associates make on average 300 - 400K a year! Email resume or for more information to: northerndentaltoday@gmail.com or by phone at: (647) 444-1336. D11102

Advertisers' Index

CDSPI Funds Performance

Period ending June 30, 2015

CDSPI Funds can be used in your Canadian Dentists' Investment Program RSP, TFSA, RIF, Investment Account, RESP and IPP.

Canadian Growth Funds	MER	1 YEAR	3 YEARS	5 YEARS	10 YEARS	MORNINGSTAR RATING*
Aggressive Equity Fund (Fiera Capital)	1.00%	0.5%	20.5%	12.4%	7.7%	★★★★
Canadian Equity Fund (Trimark)	1.50%	-13.8%	9.2%	8.2%	4.1%	★★
Common Stock Fund (Fiera Capital)	0.99%	3.5%	13.3%	6.8%	6.0%	★★★
Dividend Fund (PH&N)†	1.20%	-3.3%	10.4%	9.3%	4.8%	★★★
High Income Fund (Fiera Capital)†	1.45%	-9.2%	9.5%	9.5%	N/A	★★★★
TSX Composite Index Fund (BlackRock®)††	0.67%	-1.9%	10.3%	7.5%	6.2%	★★★★
International Growth Funds						
Emerging Markets Fund (Brandes)	1.77%	-8.4%	7.6%	4.1%	7.3%	★★★
European Fund (Trimark)†	1.45%	13.2%	22.6%	17.5%	7.4%	★★★★
Global Fund (Trimark)	1.50%	16.3%	19.9%	15.9%	6.2%	★★★★
Global Growth Fund (Capital Intl)†	1.77%	17.3%	20.7%	16.4%	N/A	★★★★★
Global Real Estate Fund (Invesco)†	1.75%	15.4%	14.7%	N/A	N/A	
International Equity Fund (CC&L)	1.30%	13.4%	18.5%	12.9%	4.0%	★★★★
Pacific Basin Fund (CI)	1.77%	17.4%	15.2%	9.3%	5.3%	★★★★
S&P 500 Index Fund (BlackRock®)††	0.67%	24.5%	24.1%	19.8%	6.9%	★★★★★
US Large Cap Fund (Capital Intl)†	1.46%	17.0%	21.8%	16.1%	N/A	★★★
US Small Cap Fund (Trimark)	1.25%	15.2%	20.6%	19.4%	N/A	★★★★
Income Funds						
Bond and Mortgage Fund (Fiera Capital)	0.99%	1.8%	1.5%	1.9%	2.5%	★★★★
Bond Fund (PH&N)†	0.65%	5.8%	3.5%	4.6%	N/A	★★★★★
Fixed Income Fund (MFS)†	0.97%	5.0%	3.2%	4.1%	4.0%	★★★★★
Cash and Equivalent Fund						
Money Market Fund (Fiera Capital)	0.67%	0.4%	0.5%	0.4%	1.3%	
Growth and Income Funds						
Balanced Fund (PH&N)	1.20%	8.3%	11.4%	8.5%	5.0%	★★★★★
Balanced Value Fund (MFS)†	0.95%	9.3%	12.8%	9.6%	5.7%	★★★★★
Corporate Class Funds						
Canadian Bond Fund Corporate Class (CI)†	1.10%	4.9%	3.1%	4.1%	N/A	★★★★
Canadian Equity Fund Corporate Class (CI)†	1.65%	5.1%	13.3%	N/A	N/A	★★★★
Corporate Bond Fund Corporate Class (CI)†	1.25%	4.8%	6.5%	6.9%	N/A	★★★★
Income and Growth Fund Corporate Class (CI)†	1.45%	5.6%	11.4%	9.8%	N/A	★★★★★
Short-Term Fund Corporate Class (CI)†	0.75%	0.3%	N/A	N/A	N/A	
MANAGED RISK PORTFOLIOS (WRAP FUNDS)						
Index Fund Portfolios						
Aggressive Index Portfolio (BlackRock®)†	0.85%	8.9%	12.8%	10.4%	N/A	★★★★
Conservative Index Portfolio (BlackRock®)†	0.85%	8.0%	7.6%	7.7%	N/A	★★★★
Moderate Index Portfolio (BlackRock®)†	0.85%	8.4%	10.2%	9.1%	N/A	★★★★
Income/Equity Fund Portfolios						
Aggressive Growth Portfolio (CI)†	1.65%	9.5%	16.7%	12.5%	N/A	★★★
Balanced Portfolio (CI)†	1.65%	8.4%	12.0%	9.9%	N/A	★★★★
Conservative Growth Portfolio (CI)†	1.65%	8.3%	13.2%	10.7%	N/A	★★★★★
Income Portfolio (CI)†	1.65%	7.3%	9.4%	8.4%	N/A	★★★★★
Income Plus Portfolio (CI)†	1.65%	5.8%	7.5%	7.6%	N/A	★★★★
Moderate Growth Portfolio (CI)†	1.65%	8.5%	14.6%	11.4%	N/A	★★★★★

Figures indicate annual compound rate of return. All fees have been deducted.
As a result, performance results may differ from those published by the fund managers.
Figures are historical rates based on past performance and are not necessarily indicative of future performance.
MERs are subject to applicable taxes. BlackRock is a registered trade-mark of BlackRock, Inc.

† Returns shown are for the underlying funds in which CDSPI funds invest.

†† Returns shown are the total net returns for the funds which track the indices.

* Morningstar ratings are based on analysis by Morningstar, Inc. of CDSPI funds with performance records of one year or more. For more details on the calculation of Morningstar ratings, please see www.morningstar.ca.

To speak with a representative, call CDSPI toll-free at 1-800-561-9401.

For online fund data or more recent performance figures, visit www.cdspi.com/invest.

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Your Everyday Panavia *IMPROVED!*

PANAVIA SA Cement Plus combines the features of Glass Ionomer with Kuraray's legendary **MDP** technology.

Just like its predecessor, **PANAVIA SA Cement Plus** offers fast clean-up, ease of use and fluoride-release.

This next generation of the original **PANAVIA SA Cement** offers stronger shear bond strengths; faster light-curing time; and room temperature storage.

Improved features include:

- **NEW** Translucent Shade
- **NEW** Chemistry
- **Even Stronger** Bonds
- **No** Refrigeration Required
- **Choice** of Easy-to-Use Automix and Cost-Saving Handmix

ALSO AVAILBLE IN A COST-SAVING HANDMIX

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Q. **Can PANAVIA SA Cement Plus chemically bond to Zirconia?**

A. Yes. Obtaining a strong, durable bond to zirconia can be difficult. **PANAVIA SA Cement Plus**, with its high concentration of **MDP**, bonds to zirconia chemically, as well as micro-mechanically, which provides you with additional strength and confidence.

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Questions for Koala?! Email us: info@kuraraydental.com

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... TO ACHIEVE LONG TERM SUCCESS!

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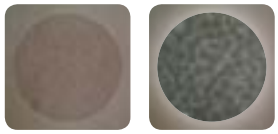
Rebilda Post

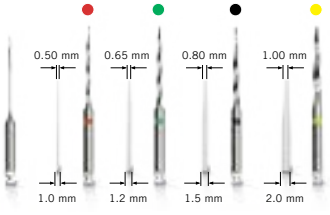
- High transverse strength
- High radiopacity (350% Al)
- Translucency like dentin
- Anatomical shape
- Adhesive luting



Cross-sections show even distribution of the glass fibers

Highly radiopaque

Great light conduct



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