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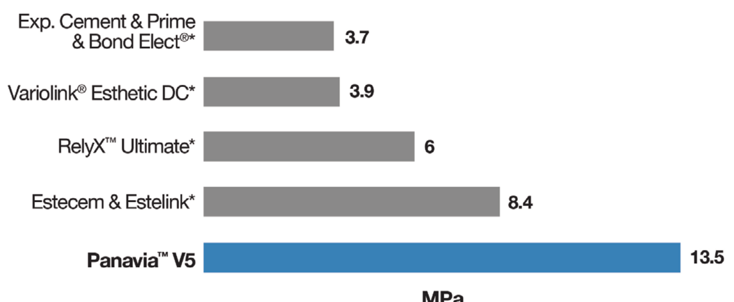


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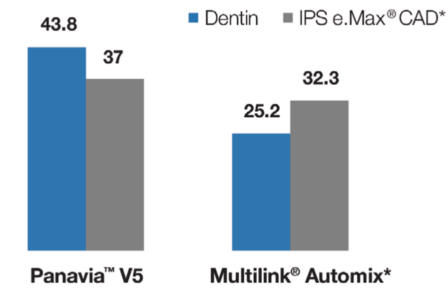


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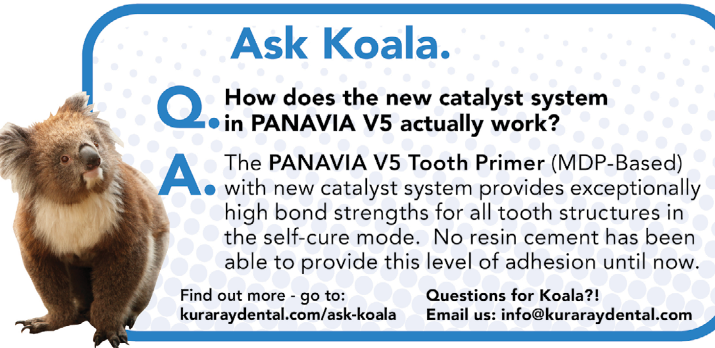


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# CDA *essentials*

*2016 • Volume 3 • Issue 5*


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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.

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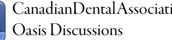
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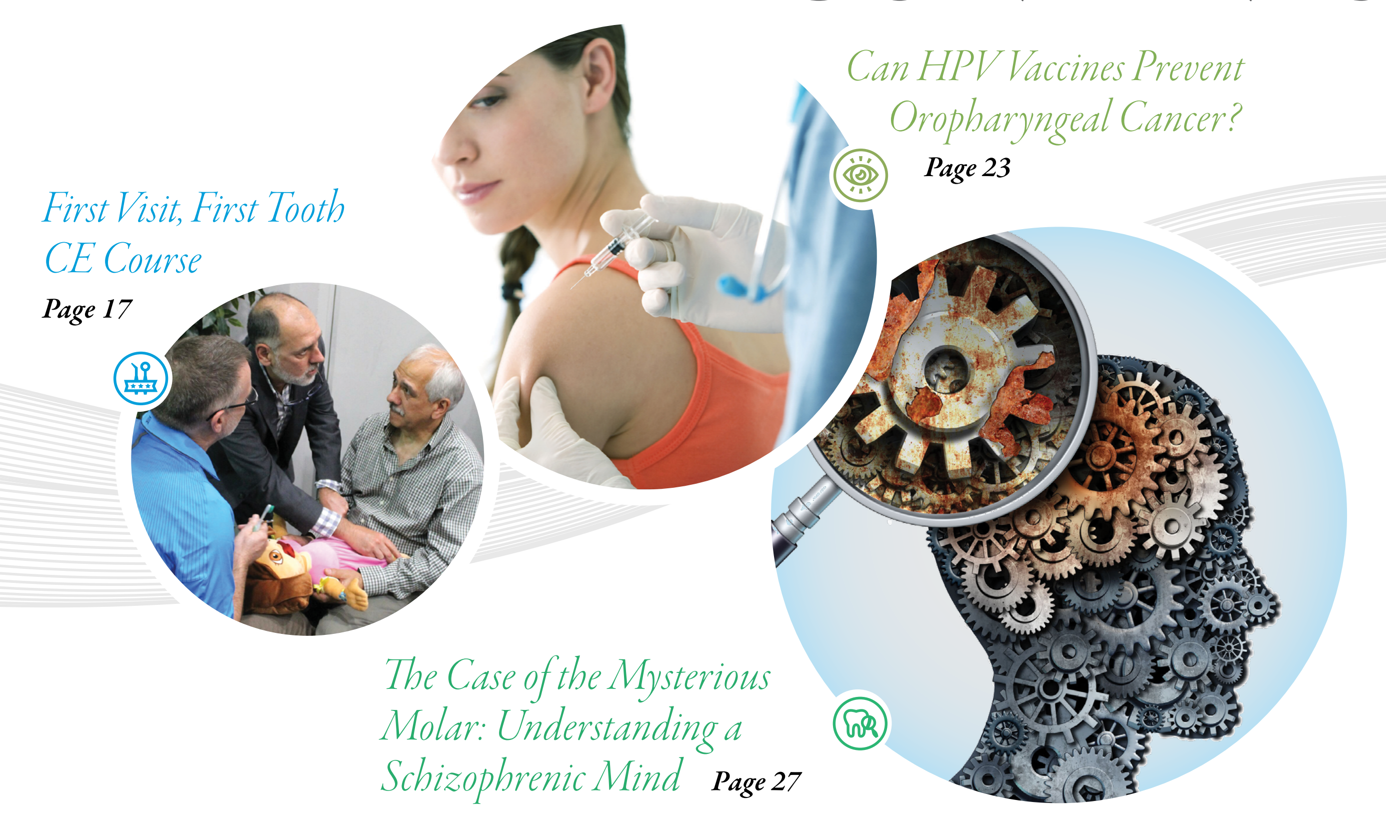

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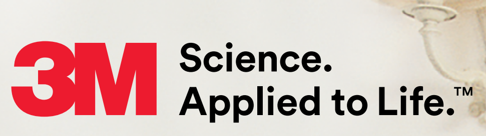


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# *Heeding our call on* Sugar Reduction

This May, I was proud to be a part of the CDA delegation for this year's Days on the Hill event (see p. 9). Over the course of two days packed with meetings, the CDA delegation (which included 8 practising dentists like myself) focused on 3 important matters with parliamentarians and policy makers:

- reducing Canadians' sugar consumption
- refining the small business tax rate
- improving refugee oral health care

It was a truly invigorating experience that showed me why advocacy initiatives are so meaningful: our efforts can bring about positive changes for our profession and for our patients.

I believe we made a compelling case for support on all of the issues we raised, but in particular discussions on sugar reduction resonated very deeply with the MPs whom I spoke with. They are hearing more about the dangers of too much sugar from other health care providers as well. Canadians are consuming too much sugar in their diets and this is putting them at a greater risk for such conditions as oral disease, heart disease, stroke, diabetes, obesity, high blood cholesterol and cancer. Although dentists have long understood that reducing sugars is going to reduce the prevalence of caries that we see every day, recognition of these other serious health consequences has resulted in governments all over the world reckoning with high-sugar diets as a significant problem.

CDA believes that Canadians need better information on how much sugar is found in their food and drink. Most Canadians rank their sugar intake as average, but few even know what the average is! In 2001, Statistics Canada reported that an individual's average consumption of sugar is 26 teaspoons a day: is that too much, and if so, by how much? According to the World Health Organization, the recommended intake is no more than 10% of an individual's daily calories—that's about 12 teaspoons of sugar for an average 2,000-calorie-a-day diet. The average Canadian, then, is consuming over 200% of the recommended sugar intake. To be clear, these recommendations are based on sugars considered to be "free sugars" (those added to food or drink and naturally present in honey, syrups, fruit juices and fruit juice concentrates) but not the sugars found in fruit, vegetables and dairy products.

Sugar intake might be so high in Canada because the average person simply isn't aware of how much sugar they are consuming. That's why CDA is supporting an initiative that would make it mandatory for all food and drink to have a "percentage daily value" declaration for sugars. CDA is also recommending measures that would restrict the marketing of sugary food and drinks to children, and restrictions to the use of the "no added sugar" claim on products like fruit juices, fruit concentrates, and fruit strips.

Getting people to consume less sugar isn't easy; dentists are well aware of this. But the collaborative spirit of this year's Days on the Hill event left me feeling hopeful—as a Canadian and a dentist—that our government is ready to listen to and act upon our advice.

RANDALL CROUTZE, BSC, DDS

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## *CDA Days on the Hill*

# BUILDING NEW BRIDGES

*The winds of change blew over Parliament Hill last fall, bringing close to 200 new members of parliament (MPs) to the House of Commons. To help forge a strong foundation with these new influencers and inform them of issues affecting dentistry, CDA held its annual Days on the Hill event on May 10 and 11.*

This year's discussions focused on three key topics: sugar reduction, changes to the small business tax rate, and the oral health care of Syrian refugees. All of these matters also appear on the new Liberal government's agenda, making them great opportunities to collaborate on nation-wide initiatives and policies.

## Sugar Reduction

The previous Conservative federal government had made the reduction of sugar intake a priority and had consulted with several organizations, including CDA, on how to improve nutrition labelling regulations. To CDA's great relief, sugar consumption is also a topic of concern of the new government. "We are pleased to see that while a new party is in office, the significance of the issue is not fading," says Dr. Randall Croutze, CDA President.

Minister of Health Jane Philpott's mandate letter mentions the importance of "introducing new restrictions on the commercial marketing of unhealthy food and beverages to children" and of "improving food labels to give more information on added sugars and artificial dyes in processed foods."

CDA's message resonated strongly with parliamentarians, and all of them confirmed they would support CDA's position, including Bill Casey, chair of the House of Commons Standing Committee on Health. Many Days on the Hill discussions revolved around the negative impact of sugar on overall health, and on oral health in particular. "It was important for us to clearly underline for new MPs the direct connection between sugar consumption and tooth decay," explains Dr. Tom Raddall, chair of the CDA Advocacy Committee.

CDA recently commissioned research to gauge the population's awareness of sugar consumption and oral health. The vast majority (87%) of respondents mentioned supporting warning labels on foods and beverages with high sugar content. "Better information on sugar content in processed food is likely to lead to better health decisions. CDA will continue to advocate on behalf of the Canadian population, together with like-minded organizations, to see such changes happen," promises Dr. Raddall. In addition to improved iterations of Canada's Food Guide and nutrition labelling regulations, CDA supported measures to restrict marketing of food and beverages with added sugar to children, similar to the Quebec Consumer Protection Act which prohibits advertising directed at children under the age of 13.

## Changes to Small Business Tax Rate

Many small business owners—including physicians, lawyers and dentists—took note of Prime Minister Justin Trudeau's election promise to review the eligibility rules for the small business tax rate.

The CDA delegates explained to MPs that dentists are first and foremost health care providers, focused on the oral health of their patients. Yet dentists recognize that they need to organize their offices as efficient businesses if they are to provide that care. "We wanted to explain to parliamentarians what the Canadian-Controlled Private Corporation (CCPC) status represents for dentists," says Dr. Croutze. This was echoed by Dr. Raddall: "Most of us are self-employed small business owners, meaning that we employ staff and run a business in addition to providing oral health care. We wanted to emphasize that dentists incur significant startup costs and ongoing financial responsibilities just like any other small business owner."

The CDA delegation also highlighted the contribution of dental practices to the Canadian labour market and economy. "Direct employment in dental practices is estimated to be more than 80,000, the vast majority of whom are skilled and trained professionals," explains Dr. Croutze, "not to mention the economic spin-off to the dental and medical supply industry—virtually all of our purchasing is done in Canada from Canadian suppliers."

CDA representatives discussed the 2017 federal budget with the Honorable Wayne Easter, chair of the House of Commons Finance Committee. They recommended that any review of the tax system, especially one that would alter the CCPC framework, only be undertaken after a comprehensive consultation with businesses and professionals who would be affected, including dentists. Mr. Easter indicated that most members of the committee are supportive of the current regulations regarding small business tax obligations, and he encouraged CDA to submit a pre-budget submission to the committee with recommendations on how to achieve better economic growth.

## Health Care for Syrian Refugees

The recent arrival of a large number of Syrian refugees has put the Interim Federal Health Program (IFHP) under considerable strain, and the program's shortcomings quickly became evident. The limited manner in which oral health is covered under the IFHP creates challenges for patients and care providers alike. "The window of services offered via the IFHP is too narrow to appropriately treat these patients," says Dr. Raddall. "The program limitations are not in line with accepted best practices of care. In cases of advanced oral

disease, the IFHP offers limited ability to save teeth, and no ability to replace them if they need to be extracted."

Dr. Croutze made sure to highlight the incredible generosity and empathy shown by the dental community. "Many dentists from across the country have stepped forward to help these new refugees," he says. "I however wanted MPs to understand that relying exclusively on pro bono services would not be sufficient to address the oral health needs of this cohort of new arrivals."

CDA representatives met with both vice-chairs of the House of Commons Standing Committee on Citizenship and Immigration, David Tilson and Jenny Kwan. These meetings led to an invitation to appear before the committee to discuss the settlement of Syrian refugees, and more specifically the IFHP. On May 31, Dr. Croutze provided an overview of the program coverage and limitations, feedback from members of the provincial associations using the IFHP, and suggestions on how to address inefficiencies. The presentation was well received, and the committee requested that CDA follow up with a brief outlining current issues and suggestions for improvement. "This truly summarizes the importance of building bridges with parliamentarians—by offering clinical guidance and sharing practical knowledge, we were able to advocate on behalf of both the Syrian refugees and the dental profession," concludes Dr. Croutze. ✦

❶ Members of the CDA delegation on Parliament Hill. (L. to r.) Dr. Thomas Raddall, chair of CDA's advocacy committee, Dr. Larry Levin, CDA president-elect, Dr. Randall Croutze, CDA president, and Kevin Desjardins, director of CDA public affairs.

❷ CDA delegates discussed the oral health of Syrian refugees with Jenny Kwan, vice-chair of the House of Commons Standing Committee on Citizenship and Immigration and NDP MP for Vancouver East.

❸ Members of the CDA delegation with the Honorable Wayne Easter (l.), chair of the House of Commons Finance Committee and Liberal MP for Malpeque.

❹ Drs. Croutze and Levin met with Kamal Khera (c.), parliamentary secretary to the Minister of Health and Liberal MP for Brampton West.

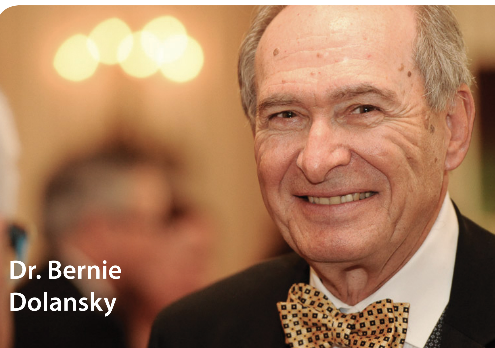
❺ Dr. Lynn Tomkins, CDA Board member from Ontario, with David Tilson, vice-chair of the House of Commons Standing Committee on Citizenship and Immigration and Conservative MP for Dufferin-Caledon.

❻ Dr. David Zaparinuk discussed sugar reduction initiatives with Senator Nancy Greene Raine, an Olympic medalist in alpine skiing.

❼ Dr. Harold Albrecht (l.), Conservative MP for Kitchener-Conestoga and a retired dentist, with Dr. Levin.

❽ Dr. Croutze with Bill Casey (r.), chair of the House of Common Standing Committee on Health and Liberal MP for Cumberland-Colchester.

CDAnet™ 25 YEARS



1 The trailblazers of CDAnet were honoured on the 25th anniversary of this service that transformed Canadian dental offices. (L. to r.) Dr. Toby Gushue, Dr. Don Gutkin, Dr. Alastair Nicoll, CDA past-president, Susan Matheson, CDAC past-director, Dr. Bernie Dolansky, Dr. Don MacFarlane.

# *CDAnet* 25 YEARS LATER

CDAnet benefits almost all of us. It's time we say thank you to its founders.

It's a CDA service used over 100,000 times a day in Canada. But ask a member of your dental team what they think of CDAnet and you may be met with blank stares. But the fact that dental offices might take CDAnet for granted could be seen as evidence of its enduring success and seamless integration into Canadian dental practices. Since its introduction in 1991, CDAnet has become an indispensable part of the everyday workflow involved in sending patients' dental claims to insurance companies.

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 electronically.

In 1987, three dentists conceived a plan to develop CDAnet: Drs. Toby Gushue from Newfoundland, Don Gutkin from Manitoba, and Don MacFarlane from British Columbia. Two years later, Dr. Bernie Dolansky from Ontario joined the group. In interviews with these men, it's astonishing to realize

*Most people at the time didn't know what to do with a computer. The idea of CDAnet seemed so far-fetched that it was a challenge to convince people that this was the way we were headed.* — Dr. Don MacFarlane

how much they accomplished as volunteers of the CDA Third-Party Dental Plans Committee.

The sacrifices they made in the process were significant: considerable time spent away from their families and their practices, and even lost friendships. "It's really difficult to convey just how tense and emotional those years (of developing CDAnet) were," recalls Dr. Dolansky, who describes his role in CDAnet's creation as politician, "arm-twister" and negotiator. "Unfortunately, I lost friendships over this. At times, it got to me. I thought, 'Why am I doing this, it's not worth what it's doing to me, my family and my practice.' But I could never bring myself to quit."

"The number of hours that Drs. Gutkin and Gushue (who both had the technical expertise needed to guide CDAnet's development) spent away from family and out of their practice was unbelievable," says Dr. MacFarlane. "But the enthusiasm and desire to volunteer was true of everybody that worked on the committee and not only did we enjoy the fact that we were accomplishing things, but we had a great time together."

To appreciate the barriers facing this group, it's useful to remember that the idea of CDAnet was in its infancy in the mid-80s—before the Internet, debit cards or cell phones were mainstream. Dr. MacFarlane led the discussions with the insurance company representatives and remembers their initial skepticism. "Most people at the time didn't know what to do with a computer. The idea of CDAnet seemed so far-fetched that it was a challenge to convince people that this was the way we were headed," he says. The first time they pitched the idea of electronic processing of dental claims to the leaders of the insurance companies, Dr. Gushue recalls a brief, incredulous silence and then, "I remember the president of one of the big insurers saying, 'You people are dreamers, you're talking about the next century!'"

But the four men shared an enthusiasm for seeing their vision to completion—a transmission standard for dental claims owned by Canadian dentistry, "by dentistry, for dentistry"—and they were not deterred by doubters.

The CDAnet pilot project launched with 18 dental offices in 1991. It was simple to use, significantly sped up the reimbursement process from several weeks down to a few days, and virtually eliminated procedure code errors. Drs. Gushue, Gutkin, MacFarlane and Dolanksy attended every provincial and national dental meeting to sell the idea of CDAnet to dentists. Talk of CDAnet spread rapidly by word of mouth and drove an increase in the number of computerized dental offices, which constituted roughly 30% of all Canadian dental offices in 1991. Dentists across the country began to sign up soon after the pilot was completed, and continue to do so 25 years later.

Today in Canada more than 18,500 dentists, representing about 86% of licensed dentists, subscribe to CDAnet (Réseau ACDQ in Quebec). It's difficult to calculate the exact cost savings per claim by using CDAnet compared to systems used in dentistry in other countries but conservative estimates suggest that CDAnet saves each Canadian dentist thousands of dollars each year.

For the persistence and vision of these four men, Canadian dentistry says a heartfelt thank you.

## Celebrating 25 years of CDAnet

Visit **Oasis Discussions** to watch Drs. Gushue, Gutkin, MacFarlane and Dolansky discussing the early days of developing CDAnet:

Drs. Toby Gushue and Don Gutkin: oasisdiscussions.ca/2016/04/21/cdanet-2

Dr. Don MacFarlane: oasisdiscussions.ca/2016/04/19/cdanet

Dr. Bernie Dolansky: oasisdiscussions.ca/2016/04/22/cdanet-3

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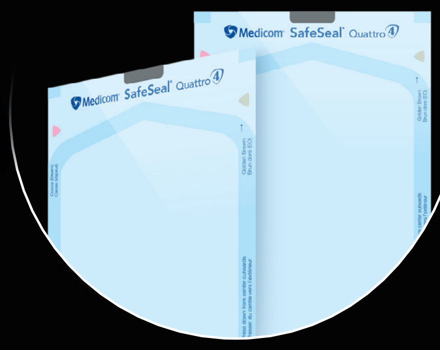


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*From my perspective*

# CDANET AND ITRANS ARE BENEFITS EXTRAORDINAIRE!

*I attended the 2016 CDA Annual General Meeting (AGM) in April, where the 25th anniversary of CDAnet was celebrated. Attendees recognized the efforts of dentists and other folks who worked diligently to create CDAnet, despite the doubts of a lot of skeptics. CDAnet was created to allow dental offices to send dental claims seamlessly to third parties. The AGM chairman remarked that those younger than age 50 would be unaware of the reason for this CDA member benefit. Since I was there when it all happened, here are my perspectives on life before CDAnet.*

In the "olden days" my front office procedures for submitting dental claims for patients were complicated. Every insurance company had its own forms that were completed by the patient and then mailed by the dental office. The carrier processed the form by transferring the codes from the claim to the adjudication engine. Eventually a cheque was mailed to the patient or the office, along with a printout of all the patient's transactions for that month. The process consumed significant staff time and was a liability because of the potential for errors and delays. My office had to keep hundreds of claim forms or pay to print forms that more than one insurance carrier would accept.

To try and fix this mess, a CDA committee was formed. With the insurance carriers, the committee solved two major problems: (1) they eliminated the problem of too many forms by creating the Standard Dental Claim Form, and (2) they ended the dependence on "snail mail" by creating CDAnet, which defined the standards and protocols for sending claims electronically to the insurance carriers. Dental software vendors implemented CDAnet standards to allow the creation of an electronic equivalent to the paper claim form. The practice management system could now accept patient information, dental procedure codes and fees. Now, a completed claim form could be sent electronically to the insurance carrier, where the information fed directly into their system and facilitated payment. To imagine the impact of this improved process, try taking a patient treatment record and then manually fill in a paper claim form!

The claims process has evolved as technology evolves. Twelve years ago, CDA introduced ITRANS to allow dentists to send CDAnet claims securely over the Internet; until then, modems and phone lines were the only way to transmit claims electronically. Two years ago, the dental benefit industry began a new communication protocol that allows for transmission of claims on the Internet without going through ITRANS. The software that implements this protocol is called CCD-WS and is now included in a number of practice management software packages. Is ITRANS still needed? In my opinion—YES! It offers services to dentists that CCD-WS cannot, including the ability to send claims to ALL carriers and support from a reliable Help Desk. ITRANS is supported by all software vendors and I know that I would insist that ITRANS be the primary protocol on my practice management program.

Now, compare this to the U.S., where the lack of standardization has resulted in individual carriers adopting their own solutions, creating a tangle of procedures that are difficult to manage for dental practices. Offices must use clearinghouses to send their claims at costs that vary between $0.50 and $1.25 per claim, depending on the services selected. The most recent statistics show that roughly 30 million dental claims are sent annually in Canada. At $0.50 a claim, that's a savings of $15 million for dentists each year. One of the biggest reasons to thank CDA every day is the fact that we use CDAnet and ITRANS *free of charge as a CDA member benefit.*

You can see that these old guys who didn't have an iPad or Cerec machine were still pretty sharp, and we should be very thankful that they, and CDA, took the chances they did 25 years ago. They've saved us hundreds of millions of dollars over the years, so if you happen to meet some of these visionaries, shake their hand. ◆

**Dr. Brian Barrett**

*Dr. Barrett is executive director of the Dental Association of Prince Edward Island.*

*The most recent statistics show that roughly 30 million dental claims are sent annually in Canada. At $0.50 a claim, that's a savings of $15 million for dentists each year.*

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## *CE Course Gaining Momentum*

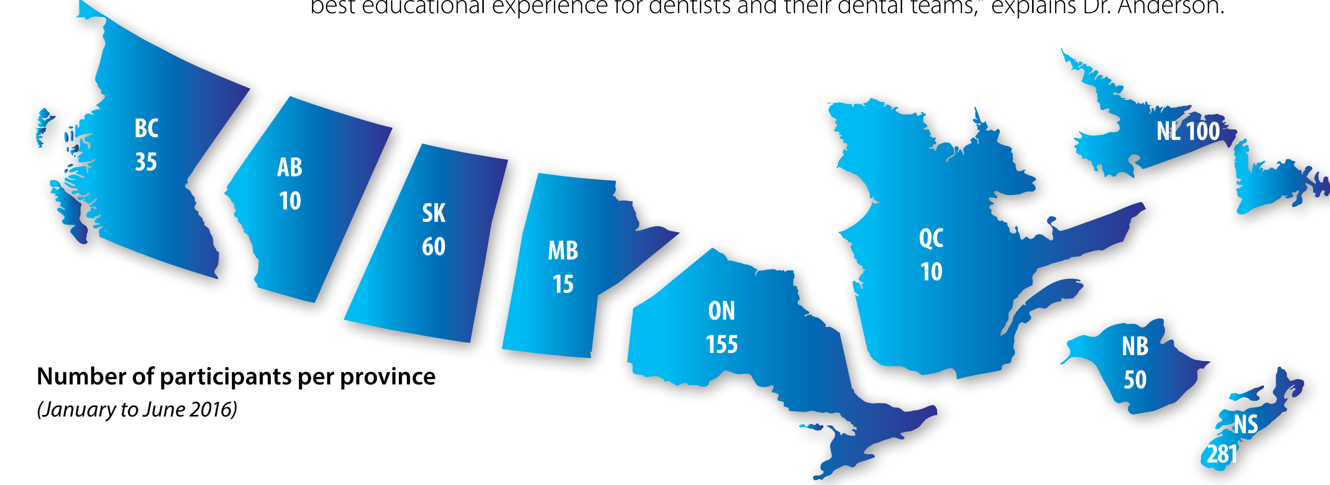
As part of CDA's *First Visit, First Tooth* *(FVFT)* initiative promoting first dental visits by 12 months of age (or within 6 months of first tooth eruption), CDA launched its *FVFT* continuing education (CE) course in January 2016.

Dr. Ross Anderson (c.) lends his expertise during a hands-on examination session.

Dr. Ross Anderson, head of pediatric dentistry at Dalhousie University and chief of dentistry at the IWK Health Centre, and also a member of the CDA Access to Care Working Group, developed the course to reinforce the first visit as a best dental practice to help reduce early childhood caries (ECC).

According to a 2013 report from the Canadian Institute for Health Information, dental surgery to treat ECC accounts for about one-third of *preventable* day surgeries in preschoolers.[1] "Seeing the dentist by 12 months of age is essential," stresses Dr. Anderson. "The consequences of untreated ECC can be serious. We too often see infants with pain, trouble eating and sleeping which can have an impact on normal growth and development in an infant or toddler."

The *FVFT* course is customizable and can be adapted to suit the presenter's own material and presentation style, and to focus on locally relevant issues. It is also interactive and comes with supplies (including brushes, varnish and a doll) to simulate hands-on examinations. The course content goes beyond examination procedures to outline key conversations dentists should be having with caregivers about topics such as diet and oral health habits. "The course incorporates both knowledge transfer and experiential learning to offer the best educational experience for dentists and their dental teams," explains Dr. Anderson.




**Number of participants per province**
*(January to June 2016)*

**CDA BEST PRACTICE**

First visit to the dentist by age 1, or within 6 months of eruption of first tooth.

Dr. Heather Carr, chair of the CDA Access to Care Working Group, underlines the importance of raising awareness on this issue: "Even within our dental community, there can be hesitations or misconceptions about treating infants. Each time the *FVFT* course is given, we reinforce the notion that first dental visits by 12 months of age are best practice," she says.

Since its launch, the *FVFT* course has been delivered to over 700 oral health professionals across Canada. Dr. Anil Joshi of Moncton, New Brunswick, has led *FVFT* sessions for over 200 dental team members. "Many were overwhelmed by the extent of ECC in our province and in Canada, and they found the tools to be very helpful," says Dr. Joshi. "They also clearly expressed the need for continued support from CDA and the provincial associations to keep this program at the forefront," he adds.

REFERENCE

1. Canadian Institute for Health Information. *Treatment of Preventable Dental Cavities in Preschoolers: A Focus on Day Surgery Under General Anesthesia.* 2013

## *New CDC Summary Guide on* INFECTION PREVENTION IN DENTAL SETTINGS

In March, the Centers for Disease Control and Prevention (CDC) updated its recommendations on infection prevention in dental settings. The newly published summary guide discusses current recommendations for dental settings, stresses the crucial role of strong preventive practices, and offers a comprehensive list of resources that support this evidence-based approach to infection prevention and control.

The guide is accompanied by an easy-to-use checklist. The *Infection Prevention Checklist for Dental Settings: Basic Expectations for Safe Care* allows for a thorough assessment of compliance with current best practices through a review of the policies in place in any given dental setting and an evaluation of personnel compliance with those policies.

Topics covered by the summary guide and checklist include:

- Administrative measures
- Education and training
- Dental health care personnel safety
- Program evaluation
- Hand hygiene
- Personal protective equipment
- Respiratory hygiene/cough etiquette
- Sharps safety
- Safe injection practices
- Sterilization and disinfection of patient-care items and devices
- Environmental infection prevention and control
- Dental unit water quality

The CDC Summary of Infection Prevention Practices in Dental Settings: Basic Expectations for Safe Care can be downloaded at **cdc.gov/oralhealth/infectioncontrol/guidelines**

### Want to learn more about operatory disinfection?

Visit *Oasis Discussions* to learn more about disinfectant selection. Don't forget to scroll down to the Comments section to see which products your colleagues are using: **oasisdiscussions.ca/2015/06/02/do**

See *CDA Essentials*, Issue 2, 2016 to learn more about the cleaning and disinfection process from start to finish: **cda-adc.ca/essentials/disinfectants**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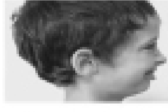

After

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# *Dr. Jack McLister* Appointed ODA President

*Dr. Jack McLister has been appointed 2016–17 president of the Ontario Dental Association (ODA) for a 1-year term.*

The London dentist has been a member of the ODA for the past 41 years, and he has been involved in organized dentistry ever since graduating from the University of Western Ontario in 1975. He has served on many committees and task forces with the ODA and sat on the association's Board of Directors. He was also president of the London and District Dental Society twice, and has been involved with the National Dental Examining Board of Canada. Dr. McLister is currently co-chair of the Constitution and Bylaws Committee with the International College of Dentists as well as one of the college's international councilors.

A part-time adjunct professor at the Schulich School of Medicine and Dentistry, Dr. McLister has been teaching and mentoring students for close to 40 years. He also maintained a family practice for 38 years. Each year, Schulich Dentistry presents the Dr. John C. McLister Award to a graduating student in recognition for their commitment, leadership and service to their community and profession.

Dr. Jack McLister

# Dr. Renée Delaquis Named *Acting Dean at University of Montreal*

*Dr. Delaquis will serve as acting dean of the University of Montreal faculty of dentistry for a 2-year term, starting on June 1, 2016.*

Dr. Delaquis was a clinical instructor for many years within the faculty before being appointed secretary in 2014. She has also acted as assistant director of the dental clinics and assistant vice-dean of clinical affairs.

Dr. Delaquis commends the work carried out by the previous management team, especially with regard to access to care for vulnerable people. These efforts will continue during her term. "We have to offer a top-level education at the cutting edge of scientific advances for our students and provide high quality care to patients at our dental clinics. Research, therefore, plays a pivotal role and knowledge translation must be carried out in a timely fashion."

Both a dentist and a lawyer, Dr. Delaquis practised dentistry for almost 15 years before earning an undergraduate law degree and a master's degree in health laws and policies.

She is currently president of the Professional Liability Insurance fund of the Order of Dentists of Quebec (ODQ), and she sits on the Fund's Claims and Prevention Committee. Dr. Delaquis has also been a member of the Disciplinary Committee and an associate trustee with the ODQ.

Dr. Renée Delaquis

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*Exciting developments in research and technology are making it possible to re-imagine how we will practise dentistry in the future. From patient risk assessment and disease diagnosis to materials selection, transformative changes are on the near horizon. In a series of interviews on Oasis Discussions (**oasisdiscussions.ca**), CDA reached out to leaders in various disciplines to seek their insights on how their particular fields might be transformed in the next 10 years.*

# What do the next 10 years hold for dentistry?

## Dental Materials

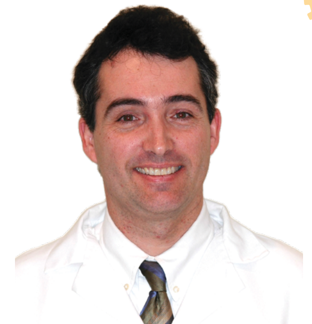
Dr. Rick Carvalho, professor in the faculty of dentistry, University of British Columbia

**Materials will be bioactive:** "I see a shift away from inert materials toward materials that have some sort of activity. For example, materials that release drugs, like antibacterial drugs or anti-inflammatory drugs, to target localized and maybe systemic diseases as well. These bioactive materials are already in place, but product development will take time."

**Care will be tailored to the patient:** "Advances in genomics, proteomics, and metabolomics are driving research toward personalized care. The idea is to develop a chairside system where you can create a patient profile from saliva or blood, in terms of biomarkers, proteomics or metabolomics. Biomarkers can identify the presence of disease. Proteomics and metabolomics, by determining a patient's risk of getting a disease, can help in prevention."

*Listen to the full interview with Dr. Carvalho:* ***oasisdiscussions.ca/2016/05/24/fdm***

## Oral and Maxillofacial Pathology



Dr. Paul Edwards, professor, department of oral pathology, medicine and radiology, Indiana University school of dentistry

**The focus of general dentistry will expand:** "The biggest change I'm hopeful for in the practice of dentistry is a much larger focus on clinical oral pathology, oral medicine, management of head and neck lesions, and other non-dental, non-periodontal aspects of dental medicine. Dentists can really take ownership of these areas, and there isn't a better trained group to really care for these patients."

**Care will become more personalized:** "With the decreasing costs of genome sequencing, there are a number of international efforts to try and identify genetic variations that are associated with disease. These studies look at single nucleotide polymorphisms and their association with disease susceptibility, response to therapies and pharmakogenetics. As the database increases, dentists can take advantage of this growing body of knowledge to tailor our management of patients to what is going to be most effective for them."

**In vivo microscopy will improve diagnosis of oral lesions:** "In oral pathology, I think we're going to see a move toward in vivo microscopy for assessing certain oral lesions.

As the technology improves, live microscopy on a patient to better assess certain conditions will have a significant impact."

*Listen to the full interview with Dr. Edwards: oasisdiscussions.ca/2016/05/24/omfp*

## Oral Cancer Management

Dr. Ross Kerr, clinical professor, oral and maxillofacial pathology, radiology and medicine, NYU college of dentistry

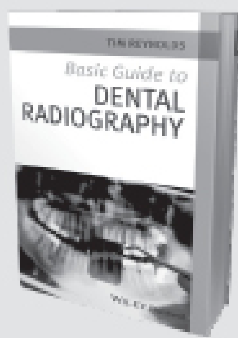
**Therapies will target cancer pathways:** "There have been tremendous advances in radiotherapy and chemotherapy directed to cancer cells. In 10 years, it looks promising that we'll be able to look at the cancer, understand the pathways driving it, and offer the patient targeted therapies directed to particular pathways in cancer development."

**Biomarkers will improve early detection of oral cancer:** "Most oral abnormalities found by dentists have a relatively low likelihood for malignant transformation but it's important to identify which patients have a lesion with malignant potential—those with the genetic mutations that increase the likelihood of it transforming into an aggressive cancer. I think biomarkers will allow us to make great advances in that domain."

**Lab results will be in real time:** "We have traditionally relied on biopsy and histopathology results to determine if lesions have malignant potential. And patients wait about one week to get the lab results. In the future, I think this process will be replaced by live biopsy and optical techniques that can tell you what is going on in the tissue without cutting into it—we can get real-time results and provide patients with the information they need."

*Listen to the full interview with Dr. Kerr: oasisdiscussions.ca/2016/06/13/ocm*


# Comprehensive guides for all members of your dental team

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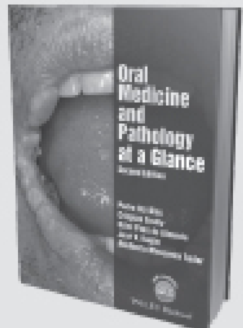
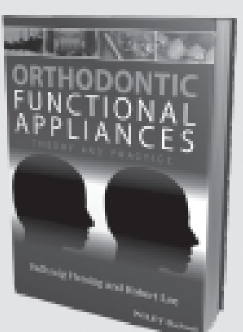



An updated overview of essential aspects of oral medicine and pathology with an emphasis on oral health care provision in general practice, including new clinical photographs and featuring a companion website with interactive MCQs, further reading and downloadable images.

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# Can HPV Vaccines Prevent Oropharyngeal Cancer?

*Dr. Anna R. Giuliano is a professor and director of the Center for Infection Research in Cancer at the Moffitt Cancer Center in Tampa, Florida. Her research focuses on HPV-related carcinogenesis, including head and neck cancers. She gave a presentation at a Pan-American Health Organization (PAHO) consultation meeting on HPV-associated oropharyngeal cancer in July 2015. CDA talked to Dr. Giuliano to learn more about the current state of knowledge regarding the efficacy of vaccines in preventing HPV-related oropharyngeal cancer.*

Watch the full interview with Dr. Anna Giuliano at **oasisdiscussions.ca/2016/02/19/hpv-4**

> *Given how important this vaccine is in preventing so many of the other HPV-related diseases, I think it's quite appropriate to give a strong recommendation for vaccination of the target population.*

### Can you talk about your lecture at the PAHO consultation meeting?

I was asked to do a summary of the studies that have shown the efficacy of HPV vaccines for preventing related diseases in both females and males. I was able to show that there is a very strong prevention efficacy against cervical, vulvar and vaginal cancers in females. The one HPV vaccine trial conducted among males showed very strong efficacy against the infection as well as the lesions that HPV causes at the genitals and anal canal in young men.

### How effective are vaccines in preventing HPV-associated oropharyngeal cancer?

Let's start with the data we do have. Among males and females, the prevention of anal-genital infections and related cancers is nearly 100% if we vaccinate at a young age among individuals who have never been exposed to the virus. So it's incredibly effective in preventing HPV-related diseases in both men and women. However, the vaccine has never been tested in a trial designed to evaluate whether the vaccine will prevent oral HPV infections or oropharyngeal cancer. So this remains an unanswered question.

### Is there a message that dentists should be giving to their at-risk patients?

The vaccines are approved for use in the United States and in Canada the same way: for vaccination of young adolescents, 11 and 12 years of age, with a catch-up depending on where you are in the Americas of up to age 26 for both males and females.

I think the message dentists can give to families, as well as to young adults, is how effective the vaccine is in preventing HPV infection. We don't have the evidence to make a statement directly about the prevention of oropharyngeal cancer, but given how important this vaccine is in preventing so many of the other HPV-related diseases, I think it's quite appropriate to give a strong recommendation for vaccination of the target population.

### What were the recommendations that came out of the consultation meeting?

The oral health providers who attended the meeting felt very strongly that without definitive evidence, they could not draft a policy statement or recommendation to vaccinate to prevent oropharyngeal cancer. They felt that there is a tremendous need for a trial to be conducted to definitely provide the evidence, in which case recommendations and policy statements could be made by the various health authorities.

### Any final thoughts for dentists?

I feel very positive that if we can conduct this phase-3 trial to test the efficacy against these oropharyngeal lesions, we will likely see that the vaccines work. But until we conduct the trial, we're in a standstill. So research must continue. I'd say that within a decade we'll have the information we need to cover all of these cancers.

## *A Risk Management Approach to*

# EARLY CHILDHOOD CARIES

*Early childhood caries (ECC) continues to take a heavy toll on Canadian children. While many parents now understand and appreciate the importance of early oral care—both at home and in-office—, some struggle to find a dentist willing to see their infants.*

*"My philosophy of care is one geared toward providing empathetic care, growing the relationships with the families and establishing a dental home for the children.*

— Dr. Ian McConnachie

Dr. Ian McConnachie, a pediatric dentist from Ottawa, sees this as a crossroad for the profession. "I believe that the profession, the leadership and the educators need to develop programs and opportunities for our members to develop skill sets. And at the same time, our members need to feel comfortable that they can develop those skills and establish a dental home early on—to the mutual benefit of the families and the profession."

## Road map to ECC risk assessment and management

Dr. McConnachie developed a basic strategy for treating young patients. "My philosophy of care is one geared toward providing empathetic care, growing the relationships with the families and establishing a dental home for the children," he explains. "It focuses on developing a true collaboration with the parents, and helping them in making choices. That effective collaboration really is the key to success."

### *Risk assessment*

It all begins with the first exam by age 1 or within 6 months of first tooth eruption, says Dr. McConnachie. Early visits are an opportunity to assess risk for ECC and to put in place a specific plan for the child, in collaboration with an informed parent. "The actual exam is a very small part of the overall visit, what I call my 30-second special," he explains. "Most of the visit is done without the child in the chair and in conversation with the parent."

The elements of the first dental visit are broad and build important links:

- ✓ Parent interview
- ✓ Assessment of parental motivation
- ✓ Visual exam to assess risk
- ✓ Development of a risk management protocol
- ✓ Oral hygiene instructions
- ✓ Application and dispensation of preventive therapies

"Having examined the child and taken in the relevant information, we can position them into the most appropriate risk category using one of the assessment models available, with the 3 general categories being low risk, moderate to high risk (non-cavitated lesions), and high risk (cavitated lesions)," adds Dr. McConnachie.

## *Risk management*

"As care providers, we need to first decide how far into the algorithm we are comfortable going, and at what point we need to refer to another clinician—and this obviously includes building a relationship with the pediatric specialist, consistent with our own philosophy of care," emphasizes Dr. McConnachie.

Dr. McConnachie encourages dentists to take the plunge and treat young patients: "Start slowly. Get comfortable with the lower-risk patients. Start with the first exam by first birthday. Build skills. Always have a plan B, and be prepared to enjoy the experience!"

Visit **Oasis Discussions** to watch a video interview with Dr. McConnachie.

The video includes an overview of Dr. McConnachie's algorithm for ECC risk assessment and management, and the presentation of ECC risk-management cases.

**oasisdiscussions.ca/2015/06/09/eccp**

## Early Childhood Caries Risk Management Algorithm

*Decision to treat or refer can come at any stage.

**Low Risk**

Anticipatory Guidance
- Diet
- Growth and development
- Commitment to appropriate periodicity of office care
- Motivational interviewing

Reduced periodicity and treatments:
- Annual visits
- Introduction to prophylaxis as child development progresses
- X-rays required at a later date

Patient status deteriorates? — Yes → Moderate to high risk (Assess for); No → Resume comprehensive risk management care

**Moderate to high risk: non-cavitated lesions**

Assess for:
- Antimicrobials
- Topical fluoride
- Sealants
- Appropriate periodicity

Patient becomes high risk? — Yes → Staged care; No → Restoration needed?

Restoration needed? — Yes → Permanent restoration with or without sedation; No → Resume comprehensive risk management care

Staged care:
- Systematic desensitization
- Antimicrobials
- Topical fluoride
- Atraumatic restorative treatment (ART)
- Glass ionomer (GI) sealants
- Appropriate periodicity

(May include initial sedation visit(s) to control pain and infection.)

Unstable clinical situation? — Yes → Treatment under general anesthesia; No → Permanent restoration with or without sedation

Permanent restoration with or without sedation → Resume comprehensive risk management care

**High risk: cavitated lesions**

Staged care while waiting for general anesthesia → Treatment under general anesthesia → Completion of restorative treatment

*Printed with permission of Ian McConnachie, DDS, MS, FRCD(C)*

### Share Your Experience

Do you see infants in your practice?
Have you adopted a risk management approach to ECC?
Send your feedback to **oasisdiscussions@cda-adc.ca** or call 1-855-716-2747.

*For our readers in Ontario, further information on this topic was recently featured in* Ontario Dentist *magazine:*

McConnachie, I. New solutions for general practitioners in treating early childhood caries. *Ontario Dentist.* 2016;93(2):23-25.

McConnachie, I. Staged care – new solutions for treating early childhood caries. *Ontario Dentist.* 2016;93(3):32-36.

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Oasis Discussions

*The following Case Conference originally appeared on the Oasis Discussions website at* ***oasisdiscussions.ca****. This site answers your clinical questions, discusses issues related to the profession, and showcases interesting clinical cases with an educational component for dentists and the entire dental team.*

# The Case of the Mysterious Molar

## Understanding a Schizophrenic Mind

*How would you treat such a case?*

Watch the case conference at

**oasisdiscussions.ca/2016/03/21/mm-3**

*When treating a patient diagnosed with a mental illness, the treatment plan must be developed with that condition in mind to ensure the best possible outcome for the patient. Dr. David Clark, clinic director of dental services at the Ontario Shores Centre for Mental Health Sciences, treats patients living with complex and serious mental illness on a daily basis. He recently discussed the case of a patient diagnosed with paranoid schizophrenia, and how his approach focused on both optimal oral health and risk mitigation.*

### Case presentation

In 2008, a 23-year-old male patient was hospitalized at the Ontario Shores Centre for Mental Health Sciences for the management of paranoid schizophrenia. He presented to the dental clinic for a routine examination. He had no tooth decay and only needed cleaning. It was noted that he was congenitally missing both lower second bicuspids and as a result he had retained primary teeth 75 and 85. The patient was discharged shortly after his admission.

In 2014, the patient was readmitted to the hospital. Dr. Clark was asked by the patient's psychiatrist to assess his oral health and provide comments, as he had expressed a clear concern with tooth 85. The psychiatrist wanted to know if it was solely a direct manifestation of a current delusional thought process or if the patient actually needed dental care. While it was not incapacitating him, the tooth was nonetheless preoccupying him a majority of the time.

### Investigation

The patient was examined at the hospital's dental clinic. He was very personable and pleasant, and he engaged in good conversation with the team. It was noted that tooth 75 had been extracted since the patient was last seen in 2008; the patient was however unable to provide a good prior history explaining the reason for the extraction. The team performed a thorough oral examination and took two

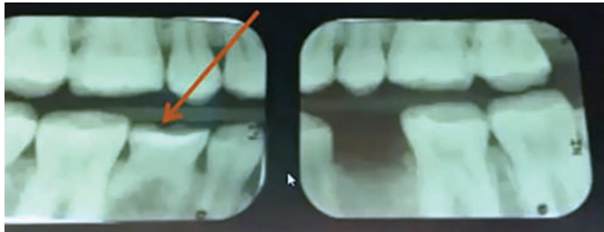

*Figure 1: Bitewing radiographs showing the presence of retained tooth 85, and the absence of clinical findings explaining the patient's concerns.*

bitewing radiographs to rule out any new tooth decay or other conditions. There were no significant findings upon clinical examination and no causes for concern were identified.

It is common for patients diagnosed with schizophrenia to require readmission to hospital for stabilization as a result of non-compliance with medication and deterioration of their condition. While a concurrent history of polysubstance abuse might have precipitated the patient's readmission to the hospital, substance abuse was not an issue at this particular time in his treatment.

The patient told Dr. Clark he felt "divided in half" because of his one remaining primary molar. The side with no primary teeth felt like an adult. The other side, the one with the retained primary 85, rendered him feeling like a child or infant. He was having difficulty dealing with these conflicting feelings, and he indicated only feeling able to chew on the "adult" side of his mouth.

## Diagnosis

As the investigation did not reveal any significant clinical findings that could explain the patient's discomfort with tooth 85, it was determined that it was solely a manifestation of the patient's delusional thought process.

"Delusions are a common feature of the positive symptom complex of schizophrenia, meaning that they are observable while they should not be," explains Dr. Clark. "The other two symptom complexes are disorganized and negative symptoms. This patient displayed primarily positive symptoms in his overall diagnosis of the disease, which does carry a better prognosis with treatment, and often a better response to antipsychotic medications that are prescribed for these patients."

## Treatment Plan

"In my experience, retained primary molars in adult patients can survive quite well for many years, and there's no indication that we have to intervene and extract them. They are an inexpensive way to retain space and provide some function—while perhaps limited for this individual," says Dr. Clark. He explained this reasoning to the patient. "He was very pleasant and he listened while we explained the pros and cons of both tooth retention and extraction," Dr. Clark remembers. "I presented him with my recommendations and explained that I declined to extract his tooth for the reasons that I had just given him. While it wasn't what he wanted to hear, he was accepting of it."

The patient returned to the dental clinic to see the hygienist, and was certainly motivated to look after his teeth. He was discharged from the hospital shortly after that time.

Dr. David Clark

### *Could extraction have been the solution?*

*Could tooth extraction have eliminated the delusional thought process? "Sure, we could easily have extracted the tooth," recognizes Dr. Clark. "Yet should another practitioner have later recommended the use of an implant or another prosthetic replacement, there would have been the potential for it to trigger further delusional thinking or thought processes typical of this positive symptom complex." For example, the patient could eventually have perceived the implant as something foreign to him. It could also have resulted in the delusion of thought broadcasting—another very common delusional thought process that occurs in patients with this diagnosis—, creating a whole new area of conflict for this patient. "The simplest approach, and the one I was quite comfortable with, was to decline to remove the tooth for him at that time," Dr. Clark concludes.*

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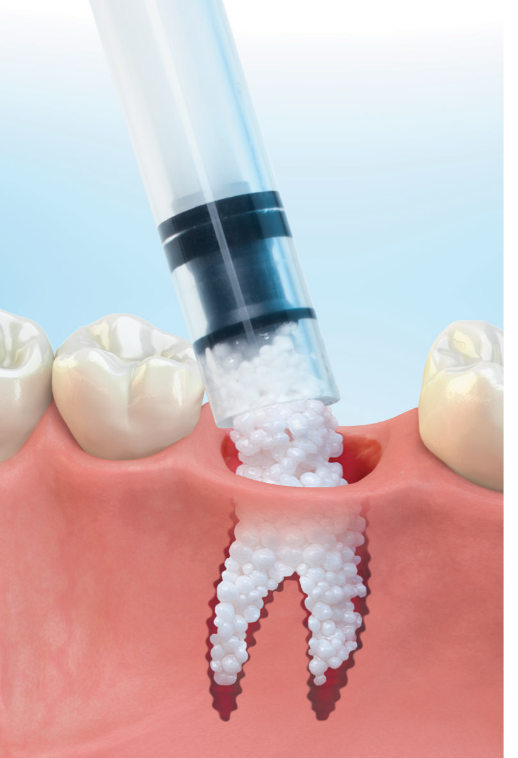

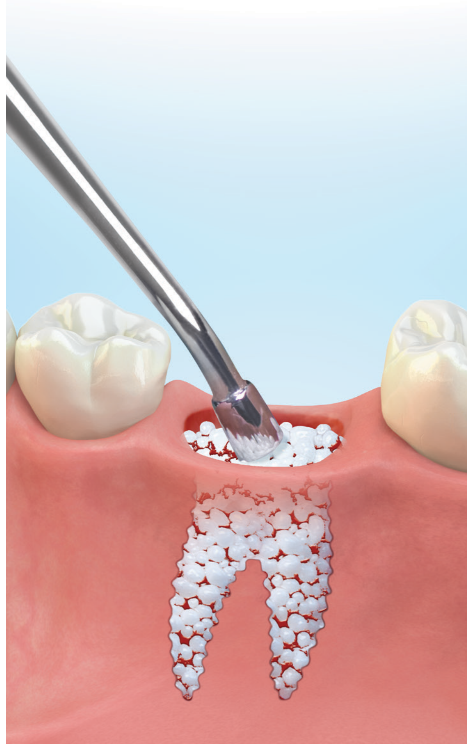

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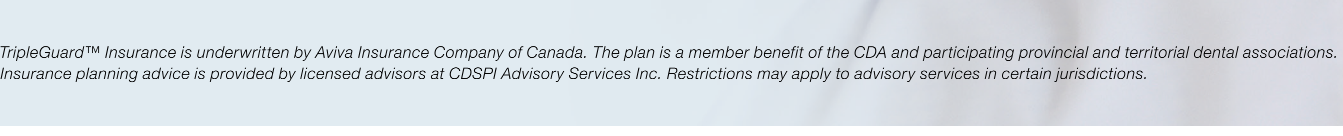

Research Summary

*The following is based on a research article originally published in the "Applied Research" section of JCDA.ca—CDA's online, open access scholarly publication that features articles indexed in Medline, Journal Citation Reports and Science Citation Index.*

# What are Canadian Dental Professional Students Taught about Infant, Toddler and Prenatal Oral Health?

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*Despite the fact that many professional organizations, including CDA, recommend a first visit coinciding with the eruption of the first tooth or no later than 12 months of age,[2-4] only a limited number of dentists are willing to see infants and toddlers.[6,11] A recent survey revealed that some general dentists are willing to see low-risk infants and toddlers, but not those with obvious dental disease.[12] Parents who attempt to obtain an early consultation for their child may become discouraged, as some practitioners refuse to see any children under 3 years of age.[13] The purpose of this study was to determine how accredited dental and dental hygiene programs in Canada prepare students in the areas of infant, toddler and prenatal oral health.*

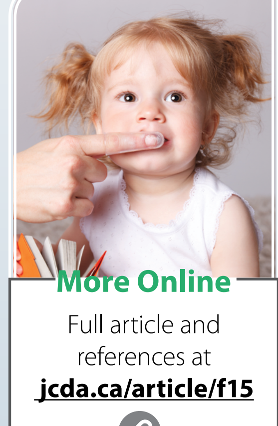
An electronic questionnaire was sent to associate deans (academic), program directors or curriculum directors of accredited dentistry and dental hygiene programs in the country. Respondents included representatives of the 10 accredited dentistry (100%) and 25 dental hygiene programs (64.1%) in Canada. The questionnaire was developed to collect information on whether, and to what extent, programs were educating students in infant, toddler and prenatal oral health. Specifics explored methods used, hours dedicated to each method and materials used to educate students.

## Results

### *Infant and Toddler Oral Health Curriculum*

While all dentistry programs recommend that a child's first dental visit take place by 12 months of age, only 56% of dental hygiene programs recommend it. Most respondents indicated that infant and toddler oral health is an explicit component of their curriculum, and all indicated that time is designated in their curriculum for this topic. Only 1 dental hygiene and 4 dentistry schools reported offering additional elective training on the topic, which most commonly take place in community programs, public health clinics and pediatric dentistry clinics, with considerable variation in hours of exposure.

In terms of the time devoted to various teaching methods, lectures and seminars were the most common didactic approaches followed by clinical care and clinical observation only. Less than a third of programs reported that all students receive hands-on experience in performing infant and toddler examinations. Most responding programs rely on their institution's clinic to provide these opportunities, while others send students to primary care clinics, daycares and public health settings. Of those who provide hands-on experiences to some or all of their students, most dentistry programs reported that fewer than 50% of their students receive hands-on experiences, while most dental hygiene programs reported that ≥ 75% of their students have such opportunities.



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Key policies and clinical guidelines related to infant and toddler oral health appear to be present in curricula. Other concepts related to infant oral health, such as the use of fluoride toothpastes and varnishes, infant feeding practices and caries diagnosis, are also taught. Most programs recommend fluoridated toothpaste for infants and toddlers (dentistry 80%, dental hygiene 65.2%). Nearly all respondents said that their program discusses professional recommendations for a first dental visit and were aware of CDA's position statement on early childhood caries.[2] All respondents indicated that their curriculum teaches students about the relationship between bottle feeding and oral health, and the majority reported teaching students about breastfeeding and oral health.

### *Prenatal Oral Health Curriculum*

Respondents noted that in most dentistry and dental hygiene programs, prenatal oral health is a component of the curriculum. Time is designated in the curriculum of 40% of dentistry and 69.6% of hygiene programs for teaching prenatal oral health. Educating students about the relation between periodontal disease during pregnancy and premature birth and low birthweight was commonly reported (dentistry 70%, dental hygiene 95.7%). Most respondents also reported that their program informs students about the role of prenatal nutrition in infant oral health. All mentioned teaching about bacterial transmission from mother to infant.

## Discussion

A search of the Commission on Dental Accreditation of Canada's (CDAC) accreditation requirements for a graduating dentistry student found none specifically addressing infant oral health. CDAC requires that Doctor of Dental Surgery and Doctor of Dental Medicine program graduates "be competent in the management of the oral health care of the child, adolescent, adult and geriatric patient."[15] The document does not identify management of infant oral health as a separate requirement, although its inclusion is implied. Similarly, there is no mention of specific requirements relating to infant oral health for a graduating dental hygiene student; these graduates must be "competent to manage health promotion and oral health care for a range of clients within the life cycle, including children, adolescents, adults, and seniors."[16] Because dental development and progression of dental disease during childhood vary greatly from birth to adolescence, the lack of specific inclusion of the infant and toddler age groups may lead to their omission from curricula.

*Based on our findings, we propose that curricula consider didactic, clinical domain and system-wide changes.*

So how best can we assist educators to prepare dental professionals to care for pregnant women and young children? Based on our findings, we propose that curricula consider didactic, clinical domain and system-wide changes.

### *Didactic Teaching*

The amount of didactic teaching in prenatal and infant oral health reported by dentistry (70% and 100%, respectively) and dental hygiene (82.6% and 100%, respectively) programs is encouraging. Although responding dental hygiene programs reported more time dedicated to didactic teaching in infant and toddler oral health than dentistry schools, 44% of them do not recommend a first visit by 12 months of age. This suggests the need for re-acquaintance with current clinical practice guidelines. A survey of Manitoba dentists found that only 58% were aware of the recommendation for a first dental visit,[6] but this proportion appears to have increased following a health promotion campaign by the profession (Free First Visit program).[7,21] It was reported that a First Dental Visit campaign by the British Columbia Dental Association (BCDA) that included hands-on workshops and an online learning tool has also led to increased numbers of dentists welcoming infants and toddlers to their offices.

With limited human resources for education,[23,24] innovative ways to disseminate knowledge about current guidelines on prenatal and infant oral health could be helpful. Time could be better devoted to promoting clinical experiences in this area, a barrier noted by educators in our study. Development of standardized curricula using innovative web-based teaching methods, similar to that developed by BCDA, may provide students with a foundational level of knowledge.[25] Evidence suggests that web-based delivery can produce learning outcomes equal to face-to-face education.[26]

### *Clinical Experience*

Our study found that, although many programs teach about the timing of a first visit, less than a third offer hands-on experiences in performing assessments. This lack of clinical experience increases the possibility that students will not engage in these activities following graduation.[24,27] Unfortunately, most of the hands-on clinical experience that students receive is with children 4 years of age and over.[24,27]

A recent Cochrane review found that combining interactive and didactic formats is a more effective approach than either alone.[28] Specific to dental education in early childhood, evidence suggests that comfort is a significant predictor of general dentists' stage of readiness to deliver preventive oral health services to this cohort. Strategies to promote comfort and self-efficacy through clinical experiences during dental education have been shown to improve knowledge

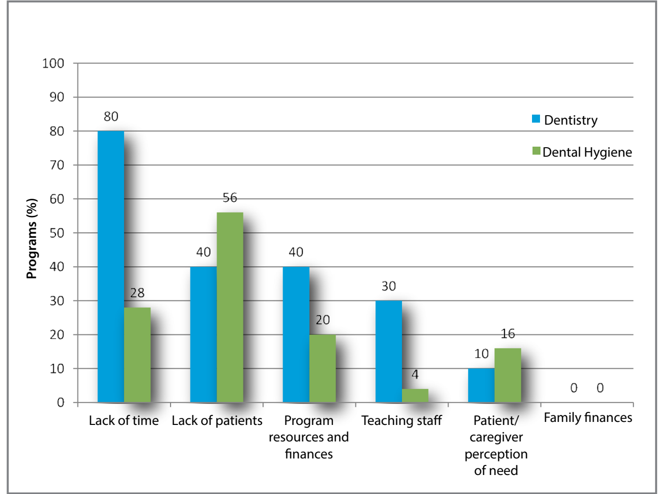


Figure 1: Barriers to teaching or providing clinical experience in infant and toddler oral health in dentistry ($n$ = 10) and dental hygiene ($n$ = 25) programs.

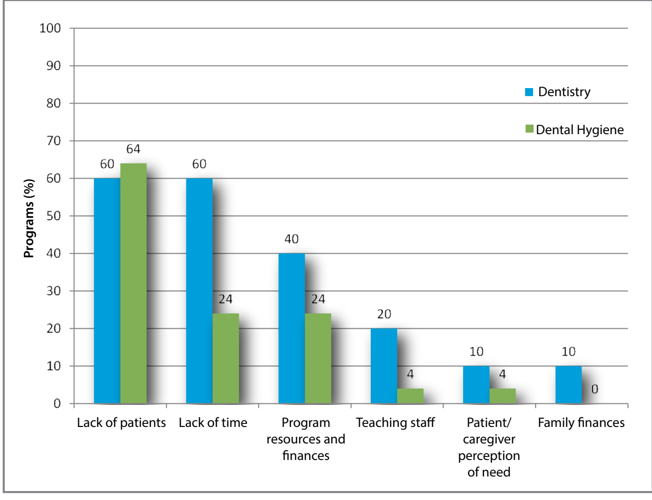


Figure 2: Barriers to teaching or providing clinical experience in prenatal oral health in dentistry ($n$ = 10) and dental hygiene ($n$ = 25) programs.

and confidence in performing these services for young children.[30] In other areas of health care education, multiple exposures to procedures have been linked with increased student confidence.[31]

Lack of patients was mentioned as 1 of the top 2 barriers to teaching and providing clinical experience in prenatal and infant and toddler oral health (**Figs. 1** and **2**). Interprofessional educational opportunities in primary care settings with pediatrics, obstetrics and family medicine components may expose students to these populations. Not only could this enhance training, but it may also foster oral health awareness among non-dental professionals and lead to better coordination of care and establishing and maintaining dental homes.

## *Systems-Based Issues*

To ensure that comprehensive education in prenatal and early childhood oral health is part of dental programs, CDAC's accreditation requirements should be reviewed and amended to include pregnant women and infants and toddlers. Another useful approach may be to supplement each program's curriculum with an innovative online module on infant and toddler oral health. The evolution of dental education beyond the traditional surgical to a more preventive approach and the increased emphasis on the medical rather than the surgical management of caries should lead to more universal adoption of early intervention. Consideration of developing pediatric dentistry rotation opportunities for senior students interested in general dentistry may assist with workforce issues, as such "super" general dentists will provide the greatest safety net for pregnant women and children.[24,30,32]

National oral health campaigns can help address the perception, as identified in our study, that parents lack awareness of the need for early dental care. This finding is consistent with pediatric dentists citing parents' diminished value on infant oral health as the main barrier for not caring for young children.[33] A public campaign of CDA, CDHA or provincial dental organizations promoting the first dental visit could help change perceptions and have an impact on all aspects of clinical practice. In 2009, the *Journal of the Canadian Dental Association* published an article along with a complementary PowerPoint presentation to teach dentists how to perform a first visit for a toddler.[34] In the context of social media, platforms such as Twitter and YouTube may facilitate awareness of these practice guidelines.

CDA has launched a website to help promote the importance of the first dental visit: **firstvisitfirsttooth.ca**

Although profit should not shape clinical decisions, appropriate reimbursement may convince some dentists and hygienists of the usefulness of early dental care, as the absence of reimbursement is a known barrier to caring for young children.[11] A specific code for first dental examinations exists in Canada (code 00010), but providers may be unaware of this and it is uncertain whether insurance plans accept this code. Advocacy by CDA and CDHA to promote proper reimbursement may increase its use.

# Conclusions

Many, but not all, dentistry and dental hygiene programs are teaching their students about the recommended age for a first dental visit. Better adherence to national guidelines will require programs to address current barriers impeding learning about this important topic and to provide creative opportunities for students regarding prenatal and infant and toddler oral health.

# What are the main drivers that make a dental practice valuable?

**Bernie Dolansky**

*Dr. Dolansky practised as an endodontist for over 35 years. He also served as president of CDA, the Ontario Dental Association and the Dentistry Canada Fund.*

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*This interview has been condensed and edited.*

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

It's a seller's market for dental practices according to Dr. Bernie Dolansky, transition consultant, partner and sales representative at Tier Three Brokerage, a firm specializing in the evaluation and sale of dental practices. In most areas of Canada, having more buyers than sellers is driving an increase in dental practice values. But what factors are the best predictors of dental practice value in today's market? We spoke with Dr. Dolansky, a CDA past-president in 1992-93, to get his perspectives.

## The most valuable commodity

As evaluators of dental practices, we have to look at all the factors that any reasonably well-informed buyer would want to know about a practice. By far the most valuable part of a general dental practice in today's market is, quite simply, **its patients**. Active patients, defined as patients on regular recall who have been seen in the last 12–18 months, are particularly valuable. In most parts of Canada, we have too many dentists and not enough patients, and that's what is driving the market.

## Traditional views of practice evaluations are changing

For a general dental practice, cash flow is related to the patient lists or charts. Up until about four years ago, we based our evaluations of dental practices on past gross revenues—usually an average of the previous three years. But buyers today are more sophisticated and are interested in **future projections of cash flow**. Today, the possible future cash flow that can be derived from those valuable patients is the major determinant of value for an informed buyer.

## The challenge of predicting revenue

Future cash flow seems like a simple concept: it's future revenue minus future costs. But how do you predict future revenue per patient per year? Well, current revenue can be a very good

*By far the most valuable part of a general dental practice in today's market is, quite simply, its patients.*

indicator of future revenue. Based on the last 100 valuations of Ontario practices we've done at Tier Three Brokerage, the **average revenue per patient, per year, is $620** (excluding lab) for a general dental practice. But there are outliers. One practice averaged $1300 per patient, per year, and some average barely over $100. So the question for potential buyers of those dental practices is, how reliable are estimates of current revenue in predicting future revenue?

## Components of revenue

To understand revenue contributions in a general dentist practice, you have to consider the three typical components of revenue: **hygiene, dentistry, and lab**. Lab is a flow-through cost because Canadian dentists do not markup lab fees. So we have to look at revenue from hygiene and dentistry to understand their potential future contributions to the practice.

To watch the full interview with Dr. Dolansky, visit: **oasisdiscussions.ca/2016/02/02/pv-2**

## Buyers can count on hygiene revenue

Revenue from hygiene is a transferrable asset of the practice—this means that when you buy a dental practice, patients will predictably keep coming to see that hygienist so **average revenue from hygiene per patient is reproducible**. For example, if a practice is doing over $550 per patient, per year, in hygiene services, even though the average for general dental practices is $220, some portion of that higher-than-average revenue can probably be maintained. On the other hand, if a practice is doing $65 per patient, per year, in hygiene, then unfortunately that relatively low revenue will also be maintained unless the buyer is able to bring revenue up. And that underperformance in hygiene can represent a possible upside in predicting future cash flow and thus the value of that practice.

## Dentistry revenue is less predictable

On the other hand, r**evenue from dental services tends to be specific to the dentist** selling the practice. So if a dentist produces over $1300 per patient, per year, in revenue from dental services, chances are a new dentist is not going to be able to reproduce that. In general, if we see a practice producing way above average in terms of dentistry revenue, we decrease our projections of future cash flow because a new buyer will probably not be able to reproduce those numbers. This would then represent a possible downside in predicting future cash flow and thus the value of that practice.

## More than a business

Increasing revenue is consistent with good oral hygiene and patient satisfaction—to a point. To be blunt, the point at which it stops being consistent is overtreatment. Overtreatment is not going to add to the value of a practice. The best way to increase your patient satisfaction—and thus new patient flow and retention—is to **keep your patients happy**. And the best way I know of doing that is by delivering excellent oral health care.

*The best way to increase your patient satisfaction—and thus new patient flow and retention—is to keep your patients happy.*

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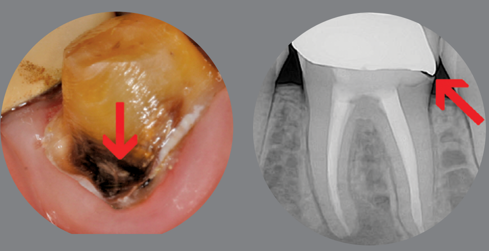

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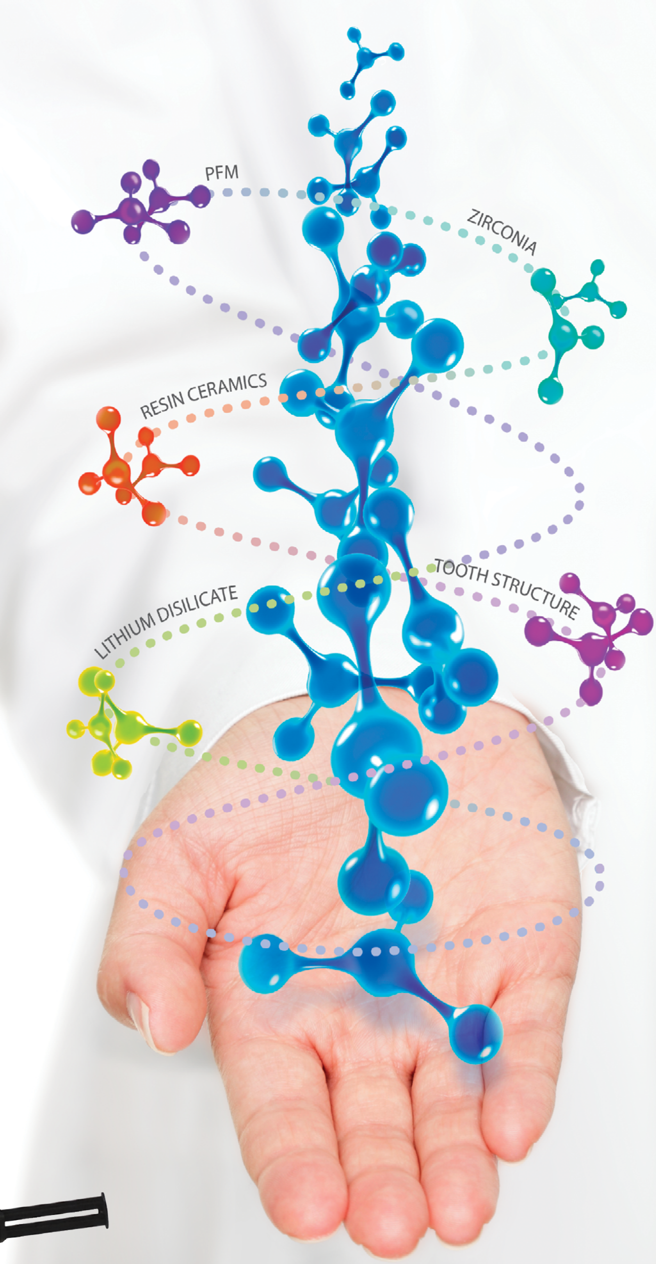

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# The Masked Dentist

## *Denture Patients' Stories*

**THE MASKED DENTIST**

*Anonymous by choice, the "Masked Dentist" will provide his/her personal experiences about practising dentistry in Canada from time to time.*

*This interview has been condensed and edited.*

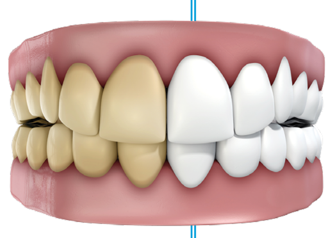
*The views expressed are those of the author and do not necessarily reflect the opinions or official policies of the Canadian Dental Association.*

Dr. John O'Keefe, CDA director of knowledge networks, spoke with a dental colleague who had recently retired and they were reminiscing about denture patients they had seen over the years. Some of these clinical experiences brought back a smile when remembering them with the privilege of hindsight! Here are a few short vignettes that they recounted.

"I did an externship in the late 70s between my 3rd and 4th year in dental school. It was with a dentist (let's call him Bob for this story) who is to this day a real hero of mine. It was an amazing experience that allowed me to do so much dentistry, that I found my 4th year in dental school to be a breeze!

He had a patient arrive with no teeth who wanted a set of dentures. I never got to see the patient. Bob explained that it would take several visits, the patient told him he was only coming back one more time and that was to pick up his dentures. Bob took a set of alginate impressions and estimated the bite, etc. The patient had hard ridges that showed little bone loss because the patient had all his teeth removed and never had dentures, but claimed he could eat everything—except Brazilian nuts.

When the patient came back for the denture fit appointment, he put the teeth in and Bob did a few adjustments. Then, the patient put the dentures in his pocket. When Bob asked why he was getting dentures, the patient responded that he was going to wear them at his eldest daughter's wedding and that he had four daughters and planned to wear them only 4 times! "



"Another story from that same externship was about a patient who arrived at Bob's office with an older set of dentures that he had taken a pair of pliers to and removed all the teeth. When Bob asked why he'd done that, the patient said that set (made by another dentist) weren't white enough.

Bob made a set with the whitest colour possible—and the patient loved it. He introduced me to the patient on the street one day and the patient had great praise for Bob—and for his very white teeth!"

"In my early days in practice, I did extensive work with seniors and their dentures. I did some challenging work with stroke victims who needed special dentures because of changed bites and sagging faces. But my next story relates to a lady, who hadn't suffered a stroke. I examined her and clearly she had a set of dentures that were two sizes too big! I made her a new set, but she was reluctant to give up the ones she was wearing because they were her late husband's."

"My final story comes from a nurse who worked in seniors' care for years. This nurse one-upped my previous story and related an incident in which a lady arrived in care and when her husband came to visit he made a stink because they had "lost" her dentures. He phoned to apologize the next day because he found them when he took his shirt off and they fell out of his back where they had been lodged. They figured he had rolled on to them in bed and did not notice them."

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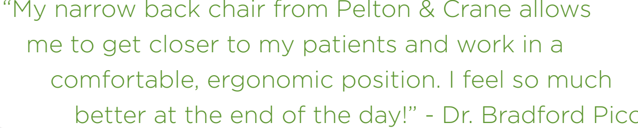


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**ONTARIO - Toronto:** Oral maxillofacial surgeon needed for multi-disciplinary specialty practice. This is an excellent opportunity for an oral maxillofacial surgeon to join a busy downtown Toronto and Etobicoke practice. Please email CV to: raquel@profilesds.com. Direct inquiries call Raquel at: (416) 924-2424. D11810

**ONTARIO - West of Toronto:** Part-time periodontist required for large, well-established dental practice. Newly renovated, modern office with a value-driven environment is waiting for that unique person with a positive attitude. Email resume to: foxteeth14@gmail.com. D11804

**ONTARIO - West of Toronto:** Full-time/part-time dentist needed for large, busy dental practice. Schedule fully booked from day one. Exposure to all specialties. Email resume to: toothdds14@gmail.com. D11807

**PRINCE EDWARD ISLAND:** Associate dentist required immediately for a busy family practice. Enjoy a full schedule while working in a newly constructed, bright and spacious clinic with an exceptional team. Clinic houses 3 dental and 2 hygiene operatories and is home to over 6500 patients. Located in beautiful western PEI, one can enjoy a variety of leisure activities as world-renowned golf and breathtaking scenery are within arms reach. Perfect opportunity for either a new grad or seasoned practitioner. For more information please contact: dr.r.ramsay@gmail.com or (902) 859-2366 (West Prince Dental Clinic). D11743

**SASKATCHEWAN - Regina:** Locum required for busy general practice. Hours Monday - Friday 9am - 5pm. Flexible start date. Renumeration discussed at time of meeting. Email: cathedraldental@sasktel.net. D11772

**SASKATCHEWAN - Regina:** Full time, guaranteed salary. Campus Dentist in Regina is currently looking for an outgoing, enthusiastic dentist to join our team. This truly is a very unique opportunity for a sole full-time dental associate in a modern university setting. The facility is bright, modern with paperless charting and digital x-ray. The ideal candidate will be self-motivated, have strong communication skills, be highly organized, have a positive attitude and a sense of humour. If you are someone who wants join Campus Dentist dynamic team please email: marzena@campusdentist.com. D11755

**UNITED STATES:** Familia Dental has great opportunities for general dentists and orthodontists in Wisconsin, Illinois, Texas, New Mexico, Indiana, and Iowa. We show our doctors how much we value their skills by offering high compensation with earning potential over $300,000 annually & $500,000 for orhtodontists. Other benefits include sign-on bonuses, relocation bonuses, vacation packages, health insurance, malpractice insurance, continuing education, and H1B and Permanent Residency sponsorship. For more information contact: (847) 915-3019 or send your resume to: Doctor@familiadental.com. D11788

## Equipment Sales & Service

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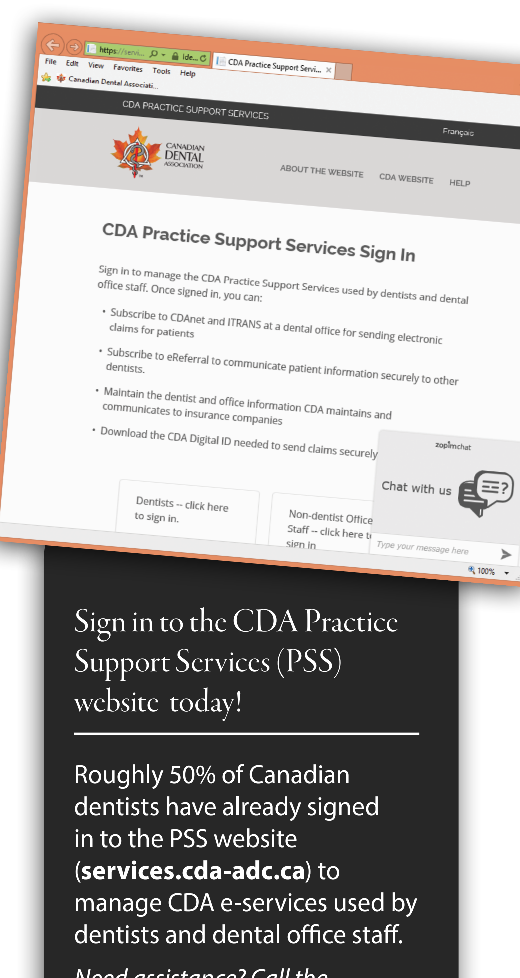


# CDSPI Funds Performance

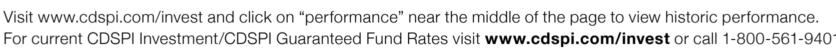
## Period ending May 31, 2016

CDSPI Funds can be used in our RSP, TFSA, RIF, Investment Account, RESP and IPP.

| Canadian Equity Funds | MER | 1 YEAR | 3 YEARS | 5 YEARS | 10 YEARS | MORNINGSTAR RATING* |
|---|---|---|---|---|---|---|
| Aggressive Equity Fund (Fiera Capital) | 1.00% | -1.4% | 14.4% | 6.6% | 5.3% | ★★★★ |
| Canadian Equity Fund (Trimark) | 1.50% | -19.2% | -3.0% | -0.4% | 1.6% | ★★ |
| Common Stock Fund (Fiera Capital) | 0.99% | -3.6% | 9.3% | 2.6% | 4.4% | ★★★ |
| Dividend Fund (PH&N) | 1.20% | 0.3% | 6.7% | 5.4% | 4.4% | ★★★ |
| High Income Fund (Fiera Capital) | 1.45% | -3.3% | 3.9% | 4.0% | 3.9% | ★★★ |
| TSX Composite Index Fund (BlackRock®) | 0.67% | -4.1% | 6.0% | 2.7% | 4.1% | ★★★ |
| **International Equity Funds** | | | | | | |
| Emerging Markets Fund (Brandes) | 1.77% | -7.7% | 1.3% | 0.1% | 5.1% | ★★★★ |
| European Fund (Trimark) | 1.45% | 4.6% | 13.3% | 13.5% | 6.4% | ★★★★ |
| Global Fund (Trimark) | 1.50% | 5.4% | 15.3% | 14.0% | 6.4% | ★★★★ |
| Global Growth Fund (Capital Intl) | 1.77% | 0.4% | 13.3% | 11.8% | 7.0% | ★★★★★ |
| Global Real Estate Fund (Invesco) | 1.75% | 6.0% | 12.5% | 11.7% | N/A | N/A |
| International Equity Fund (CC&L) | 1.30% | -4.8% | 9.5% | 8.5% | 3.0% | ★★★★★ |
| Pacific Basin Fund (CI) | 1.77% | -8.3% | 6.9% | 5.7% | 3.0% | ★★★★ |
| S&P 500 Index Fund (BlackRock®) | 0.67% | 5.4% | 18.8% | 17.3% | 8.1% | ★★★★★ |
| US Large Cap Fund (Capital Intl) | 1.46% | 4.1% | 16.1% | 14.3% | N/A | ★★★★ |
| US Small Cap Fund (Trimark) | 1.25% | -1.9% | 11.6% | 13.0% | 9.2% | ★★★★ |
| **Income Funds** | | | | | | |
| Bond and Mortgage Fund (Fiera Capital) | 0.99% | 0.3% | 1.2% | 1.6% | 2.7% | ★★★★ |
| Bond Fund (PH&N) | 0.65% | 2.7% | 4.0% | 4.4% | 5.2% | ★★★★★ |
| Fixed Income Fund (MFS) | 0.97% | 1.5% | 3.3% | 3.8% | 4.4% | ★★★★★ |
| **Cash and Equivalent Fund** | | | | | | |
| Money Market Fund (Fiera Capital) | 0.67% | 0.3% | 0.4% | 0.4% | 1.2% | N/A |
| **Equity and Income Funds** | | | | | | |
| Balanced Fund (PH&N) | 1.20% | 0.2% | 8.5% | 6.2% | 4.7% | ★★★★★ |
| Balanced Value Fund (MFS) | 0.95% | 1.7% | 9.7% | 7.5% | 5.5% | ★★★★★ |
| **Corporate Class Funds** | | | | | | |
| Canadian Bond Fund Corporate Class (CI) | 1.10% | -3.1% | 8.3% | 7.3% | 5.2% | ★★★★★ |
| Canadian Equity Fund Corporate Class (CI) | 1.65% | -5.4% | 7.2% | 5.6% | 5.8% | ★★★★ |
| Corporate Bond Fund Corporate Class (CI) | 1.25% | -0.6% | 3.8% | 4.9% | N/A | ★★★ |
| Income and Growth Fund Corporate Class (CI) | 1.45% | -6.3% | 5.4% | 5.3% | 5.7% | ★★★★ |
| Short-Term Fund Corporate Class (CI) | 0.75% | -0.2% | 0.4% | 0.5% | 1.2% | N/A |
| **MANAGED RISK PORTFOLIOS (WRAP FUNDS)** | | | | | | |
| **Index Fund Portfolios** | | | | | | |
| Aggressive Index Portfolio (BlackRock®) | 0.85% | -0.8% | 8.9% | 7.1% | 5.3% | ★★★★ |
| Conservative Index Portfolio (BlackRock®) | 0.85% | 0.9% | 6.3% | 5.9% | 5.2% | ★★★★★ |
| Moderate Index Portfolio (BlackRock®) | 0.85% | 0.1% | 7.6% | 6.5% | 5.3% | ★★★★★ |
| **Income/Equity Fund Portfolios** | | | | | | |
| Aggressive Growth Portfolio (CI) | 1.65% | -3.8% | 9.3% | 7.8% | 5.1% | ★★★ |
| Balanced Portfolio (CI) | 1.65% | -1.9% | 7.2% | 6.6% | 5.2% | ★★★★ |
| Conservative Growth Portfolio (CI) | 1.65% | -2.5% | 7.7% | 6.9% | 5.3% | ★★★★ |
| Income Portfolio (CI) | 1.65% | 1.3% | 5.7% | 5.7% | 5.7% | ★★★★★ |
| Income Plus Portfolio (CI) | 1.65% | -0.8% | 6.2% | 5.7% | 5.2% | ★★★★ |
| Moderate Growth Portfolio (CI) | 1.65% | -3.1% | 8.3% | 7.3% | 5.2% | ★★★★ |

Listed are annual compound rates of return with all fees deducted for one-to-ten-year performance for the period ending May 31, 2016. The figures are historic results based on past performance and are not necessarily indicative of future performance. Returns are after the deduction of management fees, and so may differ from those published by the respective fund management companies. MERs are subject to applicable taxes. BlackRock is a registered trade-mark of BlackRock, Inc.

* 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.



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## Shape Matters PART I - Curved Inserts for Perio

### FURCATION ADAPTATION

Implement better ultrasonic techniques immediately!
Curved ultrasonic instruments can enhance clinical outcomes as they offer superior access in furcations, concavities and curved root surfaces. This online tutorial will guide clinicians through the principles of left and right insert selection and adaption in furcations.

## Shape Matters PART II - Curved Inserts for Perio

### POSTERIOR SEXTANT DEBRIDEMENT

Implement better ultrasonic techniques immediately!
Curved ultrasonic instruments are more perio suited than straight ultrasonic or manual instruments. These instruments can enhance clinical outcomes as they offer superior access in furcations, concavities and curved root surfaces. Building on the principles from Part 1, this tutorial will guide clinicians through extensive adaption of left and right inserts on posterior teeth.

## Shape Matters PART III - Curved Inserts for Perio

### FULL MOUTH DEBRIDEMENT

In this final webinar in the series, the unique benefits of curved ultrasonic instruments in anterior sextants will be addressed. The previously addressed concepts of curved inserts in furcations and posterior sextants will be built upon as full mouth sequencing of these periodontal gems will be the focus. Suggestions for client-operator positioning are also highlighted.

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