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Dear Editor,

The article titled, “Dental Treatment and Prosthetic Joints: No Evidence for Antibiotic Prophylaxis” by Dr. Thomas J. Greany, published in the Journal of the Colorado Dental Association, Vol. 89, No. 1, Winter 2010 is inaccurate for the information given. The author states that “antibiotic prophylaxis for dental patients having total joint replacement has not been updated by the ADA or AAOS since 2002.” This is not true. Both the AAOS and ADA updated this subject in 2009. (1-2) All dental clinicians should read these updates and form their own opinions along with the patient as to whether our patients should be covered or not.

Dr. Greany’s points are, however, well taken and questions about the efficacy of antibiotic usage must be asked and answered if possible, but in the meantime until better information is available, it is my opinion that total joint patients should be covered for those procedures likely to cause a bacteremia and for the reasons given by the AAOS in their 2009 statement.

References:

Sincerely,
Richard Zallen, D.D.S., M.D.
Denver Health Medical Center

---

Dear Editor,

Dr. Zallen correctly points out that the position of the AAOS was updated in 2009 – after my article was written. Its position is clearly summarized on the ADA’s Website, and is significant in its directive that clinicians “…consider antibiotic prophylaxis for all total joint replacement patients prior to any invasive procedure that may cause bacteremia.” This is a significant departure from the 2003 advisory statement, which recommended prophylaxis for all patients within the first two years after replacement surgery, and thereafter only for those with co-morbidities that may place them at higher risk of hematogenous total joint arthroplasty (TJA) infection. Disappointingly, the current AAOS update does not introduce any new studies as evidence in support of its position.

Sincerely,
Thomas J. Greany, D.D.S.

---

Dear Editor,

Our experience this year with Give Kids a Smile Day was fabulous. My staff and I saw 25 kids and provided $14,700 worth of dental care to these patients who never would have gotten it otherwise. With three hygienists, three dental assistants (two who spoke Spanish) and two front desk support staff, we were able to smoothly make it through the day. The day was rewarding for all of us and was the best team building experience I ever imagined. We all came to work ready to give it our all and by the day’s end we were exhausted and proud to have been able to give back to the community.

This program is such a plus for dentists as a vehicle to give back and involve the whole staff. It creates public awareness about how dentists are willing to help those who need it most in the community. The kids all showed up and were very cooperative. The parents were really grateful and even went outside to clean up trash around my building while we worked on their kids. Once again, the main problem we found was a complete lack of nutritional knowledge resulting in the kids having a very high sugar diet and a large number of caries. Many of them drink large quantities of pop and eat a lot of fast food. We were able to spend some time with the parents discussing better nutrition, which would result in fewer caries. Many of the kids had never been to the dentist and were somewhat apprehensive, but we were able to provide a positive experience and hope they will seek more routine dental care. Thanks to the CDA for doing such a great job coordinating this program. We look forward to next year’s event.

Sincerely,
Mitch Friedman, D.D.S. and team
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Greetings!

We are excited about the CDA’s 124th Annual Session coming up June 10-13 in Crested Butte, Colo. This is the first time that the CDA has had a meeting in this location and I know that you will find lots of things to do, whether part of our official program or just wandering around the town or trails in the area.

A former coal mining town now called “the last great Colorado ski town,” Crested Butte is a destination for hiking, mountain biking and a variety of other outdoor activities.

Since one of my passions that I hope you will share is promoting not just good dental health but overall wellness and fitness, we have on tap some world-class athletes who have found a niche helping non-athletes become beginners, and helping beginners advance to intermediate, advanced and beyond. Sara Ballantyne, three-time world champion mountain biker and adventure racer (along with being a mom), will give a brief talk on finding balance in personal and professional life before taking folks out on the trails. Marcel Vifian, a former U.S. triathlon champ, will help guide folks with their nutrition and exercise programs.

No, this isn’t all about working out. We actually have CE for dentistry! We are thrilled that Dr. Terry Tanaka will be lecturing on Thursday, June 10 about complex restorative dentistry while being sensitive to the trying economic times that our patients (and we, ourselves) are having. Dr. Tanaka has lectured worldwide on restorative dentistry and TMD-TMJ.

Dr. Rob Roda will be presenting on endodontic emergencies and the vexing problems of good anesthesia during endodontic procedures. Dr. Roda has lectured extensively in the U.S. and Canada. Other seminars include The Challenge of Behavior Change for Your Patients, Chairside Digital Imaging and 3D Prep Review, Finance Management – Recovering from the Perfect Storm, and a Discussion with the State Board of Dental Examiners.

You don’t want to miss this fantastic weekend. Kick your summer off with this conference in beautiful Crested Butte. It’s a great location with plenty of summer activities including hiking, biking, backpacking, rafting, fishing and more! See the insert in this issue of the Journal for details and to register for this year’s Annual Session. Bring your toys and enjoy!
After eight years, Give Kids a Smile Day has produced more than $3.2M in donated dental care for underserved children in Colorado. Year after year, even despite tough economic times, hundreds of dentists and dental professionals volunteer to give back to their communities and these families who need it most.

2010 was no exception with over 375 dentists and dental team members committed to GKAS on Friday, Feb. 5. These volunteers donated treatment in their private offices, volunteered in dental clinics, and took time to visit schools for presentations, screenings and sealants.

GKAS was created by the American Dental Association to accomplish two things: to help children who need it most with their dental needs and to draw attention to the access-to-care crisis that families face locally and throughout the nation.

This year, thanks to Colorado GKAS volunteers:

- 3,937 kids received dental education at 37 locations in 18 cities
- 2,054 kids received $765,301 in donated treatment at over 98 locations in 43 cities. (This is an average of $373 in treatment per child.)

GKAS was full of grateful families. Here are just a couple testimonials from parents who contacted the CDA following the event.

"When I took my four-year-old son to the dentist last week, I felt very worried about a number of things. I knew his cavities were serious and I knew he had a very difficult appointment at a local dental clinic. They referred us to a pediatric dentist because they thought he would require going under general anesthesia to get the work done. In my mind, I was calculating the possible costs of even a simple operation, and thinking it would likely be thousands of dollars. Even though I run a small non-profit that serves homeless people in Boulder, I have struggled financially for years as a single mother with the high costs of housing and daycare. I do not have dental insurance and cannot afford it even though I work two jobs.

The dentist was so kind and all of the staff were very knowledgeable about working with kids. Not only did my son have a great appointment, I was surprised and pleased when I found out the dental..."
work could be done in the office and wouldn’t require general anesthesia. No one could have been more shocked to find out that the work is free through the Give Kids a Smile program. I almost cried when the dentist gave me the news. I am so very grateful to this program, for the financial help and the truly excellent care my son received. The patience of the staff was what made the difference and they understood how to allay his fears. I have worked for two and a half years to get out of debt; I am not there yet, but Give Kids a Smile gave me and my family enormous assistance.”

-Joy, GKAS parent

“Today at the University of Colorado School of Dental Medicine, my 10-year-old son was treated by your Give Kids a Smile program. I can’t begin to find words to thank your organization, the wonderful staff that treated him today and any others involved with this program. Today was not just about my son getting some beyond horrible dental issues taken care of (he had six extractions and two fillings), it was about giving my son confidence, self esteem, a smile, a new outlook on life, and a brighter future. I pray that you know what dental care can do for a child who has not had it available and how incredibly grateful we are to everyone. You’ve changed his life with your mission and generosity and I wanted to make sure you knew this. Please feel free to share this with dentists, students and donors. If there is a single way I can help this program continue, please let me know. Again, thank you deeply, and God bless you.”

-Michelle, GKAS parent
Thank You GKAS Volunteers!

Dr. Gary Field with a GKAS patient.

Dr. Courtney Collings  Dr. David Collins  Stephanie Cope  Dr. Arnold Cullum  Dr. Andrea D’Addario  Dr. Matt D’Addario  Dr. Ryan Davis  Dr. Jill Decker  Dr. Ronald DesMarleau  Tammy Do, RDH  Dr. Dick Dobbin  Dr. Anastasia Dodson  Diana Dorantes-Mendez  Dr. G. Bruce Douglas  Dr. Dennis Driscoll  Dr. David Dunn  Dr. Charles Durbin  Dr. Cecilia Edwards  Dr. Gerlinde Ehni  Dr. Jason Ehlessabian  Dr. Jack Emmons  Dr. Geoff Engelhardt  Dr. Josh Erickson  Dr. Greg Evans  Sharon Fabrizius  Dr. Rebecca Facy  Dr. Bob Fauccett  Dr. Lisa Feheley  Tavita Ferrer  Dr. Gary Field  Dr. Marcy Flack  Dr. Karen Foster  Dr. Mark Frank  Dr. Kelly Freeman  Dr. Mitch Friedman  Dr. Alison Fronzczak  Dr. Dana Fujita  Dr. Randolph Geoghan  Dr. Louis Gerkin  Penni Gibson, RDH  Dr. Mike Gilbert  Dr. Ron Gilligan  Andrea Glover  Dr. Sabrina Goff  Dr. Frank Gold  Dr. Michael Golinvaux  Dr. Steve Gould  Dr. Jeff Gourley  Marcy Greenburg  Dr. Jerome Greene  Dr. Sonia Greval  Dr. Frederick Guerra  Dr. Joe Guido  Dr Scott Hadley  Michelle Hair  Dr. David Hamula  Dr. John Hanck  Dr. Russell Hanson  Susan Hanson, RDH  Dr. Jennifer Hargleroad  Dr. Katie Harmon  Dr. Michael Harms  Dr. Ashleigh Harrison  Stephanie Harrison, RDH  Dr. Dayle Hartgerink  Dr. Karl Hegglund  Dr. Jay Heim  Dr. Jim Henry  Dr. John Hildebrandt  Dr. Doxiades Hill  Dr. Jonathan Hill  Dr. Judith Hill  Dr. Todd Hill  Dr. Gary Holt  Dr. Mark House  Dr. Keaton Howe  Dr. Makala Hubbell  Dr. Don Hull  Dr. Miles Humble  Dr. Autumn Hurst  Dr. Jeffery Hurst  Dr. Nadine Hutchins  Dr. Aliafayz Ibrahim  Dr. Anil Idiculla  Dr. Dave Ishley  Dr. Michael Israelson  Dr. James Jack  Dr. Steven Jacobsen  Dr. Matthew Janda  Dr. Jesse Jenkins  Dr. Rossynet Jimenez  Dr. Carl Johnson  Dr. Cory Johnson  Dr. Scott Johnson  Dr. Michael Jones  Dr. Greg Jungman  Dr. Jeff Kahl  Dr. Jennifer Karaskevicus  Dr. Julia Kasper  Dr. Susan Kasper  Dr. Remindier Kaur  Dr. Jim Kearney  Dr. Wade Kennedy  Dr. Ethan Kems  Dr. Mi-Lee Kim  Dr. Derek Kirkham  Dr. Kristy Klemm  Dr. Randy Kluender  Steven Klyn  Dr. Darrel Kneupper  Brittany Kolling, EDDA  Sahel Korshidian  Dr. Nelson Krum  Dr. Jim Kuhar  Dr. Randall Kumm  Dr. Jennifer Kurth  Karen Laughlin  Dr. Wm. LaVelle  Dr. Tom Lavery  Dr. Steven Law  Dr. Pamela Lerfald  Ryan Lewis  Sharon Lillpop  Dr. Shiloh Lindsey  Dr. Cliff Litvak  Denise Lopez, RDH  Dr. Mike Lovato  Dr. Mark Lucas  Dr. Dave Lurye  Dr. Carol Lybrook  Dr. Scott Lybrook  Dr. John Lydiatt  Dr. Les Maes  Erin Major  Dr. David Maki  Dr. David Maloley  Dr. Shawn Maloy  Sharyn Markus  Julia Martin, RDH  Jean Martinez  Dr. Michele Mathews  Marie Matthews  Dr. Christina Mazzola  Brittany McDonald  Dr. John McFarland  Dr. Kareen McIntosh  Sue McIntosh, RDH  Brenda McNulty  Dr. Jose Mena  Dr. David Mershon  Dr. Peter Mertz  Dr. Roger Meyer  Dr. John Meyers  Dr. Debbie Michael  Dr. Eric Miller  Dr. Michael Miller  Dr. Miles Miller  Dr. Jerry Minick  Dr. Scott Minnich  Dr. Rebecca Misner  Dr. Mark Moller  Dr. James Monk  Pam Moore  Lisa Morales-Campbell  Dr. Damian Mulvany  Dr. Bob Murphy  Dr. Melissa Musolf  Dr. Tim Nary  Dr. Leo Nassimbene  Dr. Jeff Nelson  Dr. Hilary Nieberg Baskin  Dr. Joe Nieters  Dr. Carol Nilorato  Dr. Mark Novelen  Dr. Kent Obermann  Dr. John Offerdahl  Dr. Eugene Oja  Dr. Mike Onstad  Dr. Brian Ozenbaugh  Dr. Rachel Parker  Dr Ronald Palmer  Dr. Alexander Park  Dr. Kevin Patterson  Dr. Ken Peters  Andrea Peterson  Dr. Tyr Peterson  Dr. Candace Pfister  Dr. Todd Pich  Dr. Eva Poulson  Dr. Sally Preston  Dr. Derrick Price  Dr. Michael Purcell  Teresa Ramirez, RDH  Dr. Salvador Ramirez  Dr. Bill Rankin  Liz Ransom, RDH  Dr. George Ranta  Dr. Jeff Ranta  Dr. Ryan Reposo
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The American Academy of Pediatric Dentistry (AAPD) and the American Academy of Pediatrics (AAP) adopted new guidelines stating that children should have their first dental visit “within six months of the first tooth erupting or by age one.” This guideline also accompanies the introduction of a new concept in dentistry, the dental home.

The dental home is based on the medical home concept and proposes that every child should have an “ongoing relationship between the dentist and the patient, inclusive of all aspects of oral healthcare delivered in a comprehensive, continuously accessible, coordinated and family-centered way.” According to the AAPD, this should happen no later than age one for all children, regardless of risk status. With dental decay being the number one chronic illness in children today, five times more common than asthma, this guideline comes at an opportune time to help decrease caries rates in children.

Early Childhood Caries

In a Colorado School Survey conducted by the Centers for Disease Control and Prevention (CDC) in the 2006/2007 school year, 23% of kindergarteners began school with untreated decay and 53% of third graders had either treated or untreated decay. Early childhood caries affects approximately 30% of lower income children in the U.S.; these children often arrive for their first dental visit presenting with rampant caries. They may be experiencing pain and infection, demonstrate lowered ability to concentrate in school and miss more school days than healthy children. If they are pre-cooperative and cannot endure conventional treatment in the dental chair, they must undergo costly and extensive full mouth rehabilitation in the operating room under general anesthesia.

Another issue that compounds the problem is that of access-to-care. There is a national shortage of general and pediatric dentists willing to see children less than three years old, and even fewer willing to accept Medicaid, CHP+ and other public insurances. According to a Colorado Health Institute report, 12% of Colorado dentists accept Medicaid, with only 3% being classified as “significant providers.” More recently, data from the State of Colorado has estimated the number of dentists accepting Medicaid to be less than 10%. Accordingly, only 30% of Colorado children eligible for Medicaid received dental care in 2006. These alarming results support the need for developing more progressive oral health initiatives for children.

Implementing the Age One Dental Visit

General dentists can play an integral role in preserving the health and well-being of children. Here are some guidelines for dentists to consider when implementing the Age One Dental Visit in their office:

- Offer dental care for children upon eruption of the first tooth or by age one.
- Train front desk and reception staff to inform parents calling the office that waiting until age three or older is no longer the standard of care.
- Infant oral health exams typically require 30 minutes of chair time.
- Healthy patients with primary teeth, no pathology, open contacts or who may be pre-cooperative do not require radiographs.
- The dental assistant or dental hygienist can perform a risk assessment followed by anticipatory guidance counseling, toothbrush prophylaxis and fluoride varnish application.
- The dentist completes the visit with an intraoral and extraoral exam to ensure the teeth and gingiva are healthy.
- Low risk children can be seen every six months like adults. Moderate and high risk children should be seen every three months.
- Billing for low risk visits: Comprehensive Oral Evaluation (D0150) for
the first visit, Periodic Oral Evaluation (D0120) for six month recall visits, Dental Prophylaxis (D1120) and Fluoride Varnish (D1206).

- Billing for moderate and high risk visits: Oral Evaluation for Patients Under Three Years of Age (D0145) may be used at the three month and nine month visits in place of Periodic Oral Evaluation.

Research has shown that the strep mutans bacteria causing caries are transmitted from primary caretaker to children. Therefore, the idea of “family dentistry” provided by general dentists in the community is more important now than ever. Dentists should stress the importance of treating the entire family to decrease the spread of bacteria leading to high caries rates in children.

There is a wealth of educational materials on the American Dental Association’s Website (www.ada.org) and the American Academy of Pediatric Dentistry’s Website (www.aapd.org) that are available to help dentists implement the Age One Dental Visit.

**Cavity-Free at Three**

The Children’s Hospital Dental Clinic in conjunction with the University of Colorado Denver School of Dental Medicine has created the Cavity-Free at Three clinic to help address the need for preventive dental care in young, underprivileged children.

The program serves children less than three years of age with the primary goal of preventing dental decay by educating caretakers about the best oral healthcare practices for their children. At each appointment a board certified pediatric dentist, together with the child’s primary caretaker, reviews oral hygiene practices at home, fluoride exposure, diet considerations, and general anticipatory guidance principles. The child also receives a toothbrush prophylaxis, dental examination and fluoride varnish application.

Currently the Cavity-Free at Three Program sees children on Thursdays and Fridays at The Children’s Hospital Dental Clinic and has enrolled more than 300 children since July 2009. The program also offers seminars and clinical-based CE courses to the general dentist community to train them to conduct effective Age One Dental Visits as part of their practice.

The Cavity-Free at Three Program is funded by the Delta Dental of Colorado Foundation and is under the directorship of Elizabeth Shick, D.D.S., M.P.H.

For more information about the program and how to implement the Age One Dental Visit in your practice, please contact the author, Dr. Elizabeth Shick at The Children’s Hospital Dental Clinic, at 720-777-6788. More information is available at www.cavityfreeatthree.org.
Commercial Real Estate in 2010: The Upside of a Down Market

By Christian Gile

In commercial real estate, one of the top questions asked in 2009 was, “If my lease expires in 2010, will I still be able to take advantage of this aggressive market?”

The answer to that question is “yes.” If your lease is expiring in 2010 or even 2011, you do have the opportunity to capitalize on the current market conditions. As the economy has struggled, real estate values have gone down as well. This in turn has created an opportunity for those who are prepared. The following information will put you in a position to capitalize on the current market conditions.

What is the commercial real estate forecast for Colorado in 2010?

Current research indicates that 2010 is lining up to be another strong year for both prospective tenants and buyers throughout Colorado. This is particularly true for the healthcare industry. On the leasing side, vacancies have increased and rental rates have decreased in both office and retail properties. According to CoStar Group Inc., one of the nation’s top commercial real estate research companies, local office vacancies were up to 14.6% at the end of the fourth quarter of 2009, as compared to 13.6% at the end of the fourth quarter in 2008. Additionally, in 2009 CoStar cited a near 2% decrease in rental rates from the third to the fourth quarter alone. Similarly, in Colorado, we have observed a 15% to 20% decrease in rental rates and sales prices over the past year from 2009 compared to 2008. Many owners are continuing to cut prices in an attempt to eliminate excess inventory and reduce debt.

Although the U.S. economy is showing signs of economic recovery, predictions are the commercial real estate market will likely continue to struggle through 2010. This is due in part to a lack of demand for space caused by tightened credit conditions for many borrowers. This situation provides tremendous opportunities to tenants and buyers in the market who are credit worthy. The good news is that dentists are still at the top of the list for many owners are continuing to cut prices in an attempt to eliminate excess inventory and reduce debt.

How can I take advantage of the market conditions?

1. Get representation – it's FREE.

Don’t underestimate the impact of being professionally represented. Whether you desire to stay in your current space by negotiating new terms for your lease or if you are interested in relocating or purchasing, every dentist should contact a dental specific commercial real estate representative. The majority of landlords understand the market and have professionals negotiating on their behalf. To level the playing field, it’s imperative that you also use a skilled negotiator that only represents your interests. Your representative should specialize in representing tenants, have extensive knowledge of the dental industry, and be able to provide you with a thorough resume and list of current dental references.

One of the many benefits to being a tenant or buyer is that real estate commissions are paid by the landlord or seller; which means as a dentist you are not paying out-of-pocket for the real estate representative’s services.

2. Determine whether it would be better to stay, relocate or purchase.

In order to make this decision, you need market knowledge. What are the top options available if you were to relocate or purchase? What are the bottom line numbers of a purchase compared to a lease? What is the best rate and terms you could achieve if you were to stay at your current space and renegotiate? Don’t make decisions without all the information. The slightest difference in rental rates, build-out allowances and additional financial terms can impact you financially by hundreds of thousands of dollars, as well as expose you to additional liability. A market expert can answer all these questions and then help you implement a game plan of securing financing and beginning the appropriate process to move forward.

Just like in any industry, information and implementation are catalysts to leveraging opportunity. The economy may be down, but opportunity in commercial real estate is at a near all time high!

Christian Gile is vice president of Carr Healthcare Realty; a Colorado-based commercial real estate company that specializes in representing dentists with all their real estate needs. Christian can be reached at 303-960-4072 or christian@carrhr.com.
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Although 2009 was one of the worst years for the economy, data in the form of credit card transactions indicates that dental practices in Colorado may be more resilient than other small businesses and are better able to tread the turbulent waters. The graphs below paint a picture of how Colorado dental practices performed when compared to their counterparts in five states: Texas, Washington, Oregon, Montana and Nevada. The first graph compares the dollar amount processed per month on credit cards in 2009 versus 2008; the second graph shows the number of transactions involving credit cards; and the last graph shows dollar amounts per credit card transaction in 2009 versus 2008. Overall, Colorado practices outperformed the GDP and other dental practices in a five-state region by .6% and nearly 2% respectively.

In 2009, the monthly average dollar amount processed by credit cards in Colorado practices was $16,262 – a 1.8% decrease from the $16,561 average in 2008. Despite this, Colorado dental practices still managed to outperform the GDP, which declined 2.4% in the same period. Furthermore, Colorado practices bested their counterparts in the five-state region that saw a 3.68% decline. Most practices receive 25% to 33% of their dental payments via credit card transactions so this data represents only a portion of the entire picture.

Overall, there has actually been a slight increase in the total number of credit card transactions for dental
The average Colorado dental practice ran 63.4 credit card transactions per month in 2009 compared to 60.8 transactions per month in 2008. This may seem counterintuitive given the condition of the economy. However, the reasons for this could be attributed to more people relying on credit to pay medical bills or more people paying for their own dental procedures instead of paying with dental insurance. Colorado compares favorably to the five state averages of 59.3 in 2009 as compared to 58.3 in 2008.

The most significant change in credit card processing for dental offices has been the 5.5% decrease in the average amount per transaction. In 2008, the average amount per credit card transaction was $270.82 compared to $255.79 in 2009. Considering the number of transactions and the drop in the amount of the average ticket, this could imply that dental offices are still maintaining much of their business but their patients are declining or postponing certain procedures/treatment.

While you can always do marketing to increase revenues, you also want to make sure that you’re effectively managing costs to maximize your net profit margins. A simple method to evaluate your credit card processing fees is to divide your monthly processing fees by your dollar volume processed (i.e. fees $262.12 / processed $9,973.14 = 2.63% effective rate charged). A good rule of thumb: if you are paying more than 2.2% you should reassess the rates charged by your current processor – now is a great time since most processors are increasing rates in April.

Jennifer Nieto is a co-owner of Best Card. Best Card is endorsed by the Colorado Dental Association for credit card processing. You can reach her at 303-482-2773 or 877-739-3952.

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The More Things Change, the More They Stay the Same

By David Lurye, D.D.S., CDA President

W e are almost a third of the way through 2010. I ran for office because I felt I could serve many of the needs and wishes of our members. I ran because I hoped that my perspective may rub off on others. I ran because I wanted to make a difference.

Have I served you well? I hope so. As I suggested to an unresponsive state legislator, “if I wanted to run against you all I would have to say in an ad is ‘I may disagree with you but I WILL call you back’.” I trust I have returned your calls and listened.

Has my perspective rubbed off? I think so. I have managed, with the help of colleagues from the 14th District, to introduce bills at the ADA having to do with subjects as diverse as correcting restrictions by insurance companies to dealing with humane treatment of lab animals, along with bills addressing obesity and wellness in our patients and for ourselves and our staffs.

Have I made a difference? Time will tell. Some things seem to never change, like our getting defeated by the insurance industry over an issue in the legislature recently. Unflattering things were said about you and me by one of the industry’s CEOs, implying that dentists double or triple fees once someone’s annual max has been reached. Though I have never heard of any of us doing that, it was implied and then believed by enough legislators for our bill to be defeated. That’s what the insurance industry thinks of you and me; that we are money-grubbing, dishonest, opportunistic cheats.

To listen to the actual hearing for this bill, please go to www.cdaonline.org/replay (click on the Jan. 27, 2010 audio file near the bottom of your screen).

With that in mind, I present to you an article that I wrote in the ADA News four years ago, edited for reasons of space in this newsletter.

Dear Editor, responding to an article that you ran in January of 2006, once again we have an article in our own newsletter explaining how to make a particular managed care plan fit in your practice if you are so inclined. The author goes to great lengths to explain that we must constantly review our systems to make sure that we are managing the managed care in our practice.

He asks if your practice can absorb these patients without affecting your current patients. My answer is “NO.”

Anytime we make a financial decision to give a group a break on fees, it is going to impact the remaining pool of patients. Back in the old days, before discounted plans came along, this was an honorable way of shifting costs. We gave discounts or even free work to those most in need.

Now, instead of financial need prompting cost shifting, we have an employer’s group plan putting pressure on our practices.

We live in a system where a human resource manager’s choices can affect not only the level of medical or dental care that someone gets, but also affects our practices by pressuring dentists for fear of losing a substantial pool of patients.

In a bizarre twist, you could have an executive at Microsoft and their “insurance plan” reimbursing a dentist at a lower rate than someone with far less means walking in off the street with little money and no third-party payer.

That old law of physics saying, “for every action, there is an equal and opposite reaction” applies to business as well. Don’t fool yourselves. Unless you are giving that same generous financial break to patients in need as those who happen to participate in a plan, you are greatly

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affecting your other patients, and I would like to remind dentists of that each and every time they do an analysis.

Just yesterday, I spoke with a dentist whose son was on oxygen at $1,000 per month billed to insurance. When he asked the oxygen company what he would pay without insurance, they told him $250! I have implored him to write letters to the editor, and to essentially “go public” because when outrage comes from healthcare practitioners themselves, people may tend to notice more.

We need to all be outraged at our screwed up system. On one hand we have costs being driven up to patients by insurance companies driving down reimbursement to dentists. On the other hand we have insurance premiums going through the roof when we hear stories about quadruple charges for oxygen.

It takes outrage and action on our parts – healthcare professionals writing letters, calling legislators and “going public.” Someone else isn’t going to do it, and it carries so much weight when you or I act, especially if we voice ourselves in numbers.

I don’t know how to fix healthcare. I do, however, know how not to fix it: don’t recognize the problem, and if you do, don’t talk about it and don’t take action.

I’m a brawler. I don’t have the subtle political maneuvering mind that seems to be so popular in politics. I do recognize problems, I am willing to take action to try to change them, and I am not content with politics as usual. Are you? Take action. Make calls. Write letters. Many individuals acting on their own will be heard more loudly than just the institutional voice of this organization. I urge you to get involved and vocal before our profession is run by third party payers.

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Jerry Weston, MBA

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1. the favorable or prosperous termination of attempts or endeavors.


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Looking to Increase your Retirement Savings?  
For the first time, you may be able to use a Roth IRA

By Scott Brookes, A.I.F.

The Roth IRA conversion rules changed in 2010. Before this year, taxpayers with adjusted gross income greater than $100,000 were not eligible to make a Roth IRA conversion. The new rules eliminate that income limit, now allowing anyone to convert.

With this new opportunity, you may be able to add additional dollars to your retirement savings using a little known Roth IRA conversion strategy.

Non-deductible IRAs are the secret. If you aren't eligible to make a tax-deductible or Roth IRA contribution this year and if you have no money in existing IRAs, SEP-IRAs and Simple IRAs, then you should consider making a non-deductible IRA contribution. (There are no income limits for contributions to non-deductible IRAs.) You can then make a tax-free conversion of this non-deductible contribution to a Roth IRA. If you are married, you can do the same for your spouse. This is a great way to double your tax-free IRA savings.

Individuals under age 50 can contribute up to $5,000 ($6,000 if age 50+) in 2009 and 2010 to an IRA.

Considerations to be aware:

Pro-rata tax treatment for existing IRA assets – In calculating the taxes due on a Roth IRA conversion, you must include the proportionate amount of tax-deferred money relative to the amount held in all of your IRAs (including SEP and Simple IRAs). You cannot specify to convert only the after-tax IRA money to a Roth IRA.

Roll your traditional IRA into your 401(k) – Because of this tax treatment, if you have IRA assets, a good strategy may be to roll your pre-tax (deductible) IRA money to your company's 401(k) or profit sharing plan if your plan allows it. This leaves your IRA accounts holding only after-tax (non-deductible) dollars, which can then be converted tax-free to a Roth IRA. This strategy is most effective if you complete this rollover the year prior to initiating any Roth conversions. Your Certified Financial Planner or tax advisor can assist you with the timing and details of this strategy. Also, make sure you like the investment options in your 401(k) before you move a large sum of dollars into it. You may have to separate from service to get the money back out again.

Check your plan to see if in-service rollovers are allowed.

How it Works:
1. If you have pre-tax money in your IRAs, roll it to your 401(k).
2. Assuming you have $5,000 or more in taxable wages, make a non-deductible contribution to an IRA for the prior year by April 15.
3. Convert your non-deductible IRA to a Roth IRA immediately so as to avoid garnering any growth prior to conversion (this way the conversion remains tax-free and any subsequent growth is tax-free as well).

Call your Certified Financial Planner or tax advisor to review your situation and initiate a plan of action.

Scott Brookes, AIF®, is director of Retirement Plan Services at Sharkey, Howes & Javer, Inc., a Denver-based, fee-only, financial planning and investment management firm and a supporter of the Colorado Dental Association. Visit SHWJ.com or call for more information at 303-639-5100.

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Tips When Selling Your Practice

By Tom Abood, J.D.

Selling your practice is certainly one of the most significant events in your life, both professionally and emotionally. The following tips should help make your practice transition a more pleasant and satisfying experience to both you and the buyer. Please note, this article focuses on the sale of 100% of your practice and will not discuss issues relating to an associate buy-in transition.

Tip #1: The sale of your practice should not be the primary source of your retirement funds. Save, save, save, invest wisely and don’t count on the sale of your practice to primarily fund your retirement years. The proceeds from the sale of your practice should be a nice supplement to your retirement funds but not the cornerstone.

Tip #2: Assemble a professional team: Selling your dental practice is truly a team approach. The first decision you will need to make in assembling your team is whether you will list your practice with a practice broker or sell your practice without a practice broker. Regardless of whether a practice broker is involved, the remaining members of your team should be an attorney and an accountant experienced in dental practice sales, and your financial planner, if you use one. If you are not using the services of a practice broker to list your practice, then you will need to have your practice valued by an experienced, qualified dental practice appraiser, who may or may not be a practice broker. Remember, there is no such thing as a seller selling his/her practice alone, it always should be a qualified team approach.

Tip #3: Provide buyers a thorough practice valuation prospectus: The practice valuation prospectus you provide to prospective buyers should be a thorough, detailed evaluation and valuation of your practice. It should clearly state the selling price, or range of price, and most importantly, the methodology of how the appraiser arrived at the selling price. In addition, the prospectus should include the following: tax returns for the practice for at least the previous three years; practice and doctor characteristics; facility information; copy of the lease; patient information and demographics (including the number of active patients, insurance patients, new patients per month, hygiene, etc); staff information; treatment and insurance information; fee schedule and other relevant information on the practice. When the seller does not have a thorough practice valuation prospectus with supporting documents and information, the sales process is delayed and buyers oftentimes become frustrated and look elsewhere. Be organized, professional and present a thorough prospectus with supporting data to prospective buyers.

Tip #4: Keep your practice information confidential: It is important to keep all the information you are providing prospective buyers confidential. All prospective buyers should enter into a confidentiality/non-disclosure agreement before you provide them with your practice information.

Tip #5: Position your office lease for the sale: The office lease is one of the most valuable practice assets that you will transfer to the buyer. While you need to make sure you have a lease to transfer, you also need to plan ahead so that you can minimize your risk and liability under the lease after you sell your practice. The ideal lease scenario for you, the seller, is having an existing term with an option to renew and selling your practice toward the end of the existing term before you exercise your option to renew. For example, let’s assume you have four years remaining on your existing lease term with one option to renew for an additional five-year term. It is best to sell your practice toward the end of your existing lease term and before you exercise the option to renew. This will provide more incentive for the landlord to enter into a new lease with the buyer and completely release you from liability under the lease after closing. If you sold your practice in the first year of a five-year lease term, the landlord
would probably require you to assign
your lease to the buyer and the landlord
would probably also require you to
remain liable under the lease for the
remainder of the five-year term.
Therefore, you need to plan ahead and
coordinate the sale of your practice
with the end of your lease term but
prior to exercising any options to
renew.

Tip #6: Don’t plan to work in the
practice after closing: Once you sell
your practice, you should be prepared
to ride into the sunset and not look
back. Very few one doctor practices
have enough cash flow and a large
enough facility to support both the
buyer, with his/her debt service after
buying your practice, and the seller
after closing. In addition, it is never
truly the buyer’s practice until the seller
is no longer engaged in the practice.
Some of the most difficult transitions
occur when the seller has remained in
the practice for an extended period
after closing. For general practices, the
seller should plan on completely exiting
within a month or two after closing, or
earlier if the seller has completed all
treatment started prior to closing. For
specialty practices, the period after
closing could be considerably longer if
there was no transition period or
relationship between the seller and
buyer prior to closing. Therefore,
practice until you are ready to exit, sell
your practice and move on.

Tip #7: Sell your accounts receivable
to the buyer at closing: Your
accounts receivable should be manage-
able, collectable and ideally sold to the
buyer at closing for a reasonable
discount. This will provide the buyer
with cash flow and you will not have to
worry about collecting your receivables
after closing.

Tip #8: Cash out at closing: If
possible, obtain the entire practice sales
price in certified funds or wire transfer
at closing from the buyer. While it may
be attractive for you to finance all or
part of the sales price because you
believe you can obtain a better interest
rate/return than investing elsewhere
(plus you can pay the taxes generated
from the sale over time) there can be
significant risks in your financing the
sales price. Once you close on the sale,
you have lost all control over the
practice and there is no guarantee that
the staff or patients will remain. If the
buyer is unable to pay you after closing
because revenues are down as a result
of the employees and patients having
left the practice, you will not be in a
very enviable position. If a prospective
buyer needs to obtain a loan to pay the
purchase price, which is the case with
most buyers, pre-qualify the prospective
buyer so you know that he/she can
obtain the necessary loan to buy your
practice, before you take the practice
off the market and spend too much
time, energy and money drafting
documents for the buyer. If a third
party lender is not willing to loan the
buyer the entire purchase price, then
you will have to make a decision as to
whether you will finance the balance of
the purchase price with that buyer.

While there are many additional legal,
business and tax issues related to the
sale of a dental practice that need to
be addressed, the above tips should
help you in the transition of your
practice.

Tom Abood received his law degree from
the University of Denver and has special-
ized in representing dentists involved in
practice transitions since 1980. Tom is a
member of the Colorado Bar Association,
the Denver Bar Association and is also a
clinical assistant professor at the Univer-
sity of Colorado School of Dental Medicine
in the Department of Applied Dentistry.
Contact Tom at 303-793-3200 or
tabood@dsl-mail.com.
OPPORTUNITIES WANTED

Opportunity Wanted: Very interested in supporting the general dental population in TMJ-related therapy. Have diploma in the Academy of Pain Management and extensive clinical experience with occlusal driven TMJ dysfunctions. These are normally associated with head and neck pain. Services will be available early summer, hopefully, in two locations. For more information please e-mail me: tnjsupport@hotmail.com.

Opportunity Wanted: 2009 U at Buffalo grad and current advanced education in general dentistry resident seeks associate position in northern Colorado. Residency complete 6/30/10. NERB certified. CV upon request. Contact LeahChI17@gmail.com.

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tions. I can be reached at darthexdog@aol.com.

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Opportunity Wanted: Seeking an office wanting an in-house lab w/o the expense! Gain an edge over your competition. Save money with an exclusive 20% discount. Please email me: tmjsupport@hotmail.com.

OPPORTUNITIES WANTED

Opportunity Wanted: Very interested in supporting the general dental population in TMJ-related therapy. Have diploma in the Academy of Pain Management and extensive clinical experience with occlusal driven TMJ dysfunctions. These are normally associated with head and neck pain. Services will be available early summer, hopefully, in two locations. For more information please e-mail me: tnjsupport@hotmail.com.

Opportunity Wanted: 2009 U at Buffalo grad and current advanced education in general dentistry resident seeks associate position in northern Colorado. Residency complete 6/30/10. NERB certified. CV upon request. Contact LeahChI17@gmail.com.

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Practice: Denver/Lakewood, Colo. Collected $467,000 in 2009, established team willing to stay on with transition, nice facility. Good location. Owner retiring and ready to sell! Susan Spear, MPB, Inc., 303-973-2147 or susan@practicebrokers.com.


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Practice: Small pediatric practice for sale. Share space with an orthodontist. Great starter location near Park Meadows Mall. Shannon at 303-792-0345.


Seller/Buyer Services: If you would like more information on how to buy, sell or associate in a practice, please call Larry Chatterley at 303-795-8800 or visit our website for practice transition information and current practice opportunities at www.ctc-associates.com.

Practice: Steamboat Springs/Craig, Colo. Busy practice in small town near ski area. Collecting $750,000 with $260,000 profit! Call Jerry Weston, 303-526-0448, Professional Marketing and Appraisal.


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Space Sharing: Dentist in upscale Belmar area looking for dentist to share office space. E-mail inquiries to: drchristiwinner@comcast.net.


Spare Sharing: Space share in GP office in Aurora. Six treatment rooms, fully-equipped with latest ergonomic concept, administration support, fully digital office, pleasant professional location. Call 303-369-1069.

Office Space: Centennial, Colo. Ortho/pedo space for lease. 1,800 sq. ft. plumbed for five open-bay ops. Located across from Newton Middle School on the busy corner of Arapahoe and Colorado. Approx. one mile from new Streets of Southglenn development. General dentist located in the same building. 303-221-3044 or irene@ButtermansDental.com.

Office Space: Colorado Springs, Briargate. Turn key, one year free rent w/10 yr. lease. $16/sq. ft. NNN. 2,000-18,000 sq. ft. available. 100% Class A medical use building. on-site surgical center, building signage, easy accessibility w/unobstructed Front Range and Pikes Peak views. Skip Graham, Sovereign Capital Management, 719-634-8225.

Office Space: Colorado Springs, Briargate area by major intersection. 2,095 sq. ft.

first floor modern bldg., four ops. Plumbing, cabinetry, data lines, etc. present. Call 719-266-4848 or derdds@yahoo.com.

Office Space: Boulder, Colo. 1,350 sq. ft. Four plumbed ops. for lease or lease purchase. Great central location. 303-818-2787, drbeedo1@hotmail.com.

Office Space: 1,100 sq. ft., near Park Meadows mall. Plumbed for nitrous, includes one fully-equipped operatory, x-ray, air and suction lines. Shared space with orthodontist. Ideal for oral surgeon or pediatric dentist. Automatic referrals. Call Shannon at 303-792-0345.


Office Space: Build/Relocate/Remodel: Foothills Commercial Builders has specialized in building dental offices for more than 20 years in Colorado. Bring us on board early to help you minimize construction costs by choosing a space that best meets your needs. We promise to go the extra mile to provide you with the highest quality craftsmanship at an exceptional value. See some of our work at www.foothills-builders.com or call us at 303-755-5711 x300.

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Office Space: Dental offices in Lakewood, Colo. 26th and Kipling area. 850 sq. ft. built-out, four ops., full service $15/ft. 1,900 sq. ft., owner will assist w/tenant finish per your specs., full service $12/ft. 2,000 sq. ft., owner will assist w/tenant finish per your specs., full service $12/ft. Three months FREE with three year lease. Call Jack, 303-919-0813.


SERVICES/ANNOUNCEMENTS/MISC.

For Sale: CEREC milling and acquisition unit, $24,000, Lakewood. Contact 720-635-1922 or cgdentist@yahoo.com.


For Sale: Schick digital panorex machine. Great quality images, five years old, with computer. Serviced by Patterson. $19,000, call Jeff Bailey, 303-579-9882.

For Sale: Assorted chair mounted, gently used operating lights, Pelton and Crane, Ritter, Super Star ($200 each your choice). If interested, please contact Shannon at str@teeth2000@yahoo.com.

For Sale: Planmeca ProMax digital cephalometric x-ray unit w/ separate sensor. Brand new in the box. Fits ProMax panoramic digital unit. Please call 719-358-3755 or e-mail jmr.ddswatt.net.

CLASSIFIEDS continued on page 32
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Sedation CE: Conscious Sedation Consulting provides continuing education, training and consulting services to non-anesthesia dental providers on the administration of sedation. Visit www.SedationConsulting.com. We are hosting a two-day event in Denver, Colo. on May 15-16, 2010. This course will meet the new requirements to administer minimal sedation by dentists. Seating is limited, pre-registration is required. Register online or by phone at 888-581-4448 x2.

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