

# ODA Today

A publication of the Ohio Dental Association focusing on dentistry in Ohio

## QuickBites

### Still time to register for Day at the Statehouse

It's not too late to sign up for the Ohio Dental Association's 2011 Day at the Statehouse on Wednesday, April 13 at the Hyatt on Capitol Square in downtown Columbus.

The annual event is free to ODA members and dental students and provides attendees with the opportunity to speak one-on-one with state legislators and advocate for issues that impact their patients, their dental practices and oral health in Ohio.

Registration for the 2011 ODA Day at the Statehouse begins at 11 a.m. on Wednesday, April 13, and the luncheon for attendees starts at 11:30.

During the luncheon, a briefing on current topics affecting dentistry in Ohio will be given by ODA President Dr. Thomas Matanzo; ODA Executive Director David J. Owsiany, JD; ODA Director of Legal and Legislative Services, Keith

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## ODA "cautiously optimistic" on proposed state budget

Liz Long Downey  
Staff Writer

While Gov. John Kasich's budget released Wed., Mar. 15 does not specifically detail covered services and reimbursements for optional Medicaid services, it appears the Kasich administration's initial budget proposal includes funding for adult dental Medicaid services.

"We are cautiously optimistic," said ODA Executive Director, David Owsiany, J.D. "We have confirmed with multiple sources within the Kasich administration that they want to avoid making cuts to services within the dental Medicaid program. While their initial proposal appears to achieve that goal, it is important to remember that this is only the first step in the process."

The governor's budget proposal will now be turned into legislation and introduced in the Ohio House of Representatives and then will move to the Ohio Senate. The budget must be adopted by June 30 and will go into effect July 1 of this year.

"As the legislation is introduced and the legislative process moves forward, the ODA will get additional details and inform members of changes, if any, to the dental Medicaid program being considered, including the possibility of reimbursement cuts, changes to covered services, or other so-called 'savings' within the Medicaid budget," Owsiany said.

Over the last decade, the Ohio Dental Association and its members have worked extensively and successfully to maintain funding for the dental Medicaid program, as in recent years, it has been suggested that eliminating adult dental services will save the state money.

During Gov. Bob Taft's eight-year tenure as governor from 1999-2007, he proposed complete elimination of the adult dental Medicaid program on multiple occasions. Each time, the ODA advocacy team and grassroots dentists worked with the Ohio Legislature to retain the program. However, in 2006, Taft was successful in cutting roughly a third of the adult dental Medicaid program, which included cuts to many adult dental services and across the board fee cuts for all children's and adult services.

In March 2007, then-Gov. Ted Strickland recommended the Medicaid budget include a restoration of coverage for dental services and dental fees and an increase in reimbursement for community providers, including dentists, physicians and clinics. The General Assembly passed the state budget, including funding to restore the dental Medicaid program, effective Jan. 1, 2008. However, in November 2007, the Strickland administration announced plans to delay the restoration of Medicaid benefits.

In January 2008, Strickland announced he would reinstitute all the fee and service cuts made during the Taft Administration to their levels in 2000 and it became effective July 1, 2008. Additionally, in 2010, while other providers were having three percent across

See BUDGET, page 2

### AN APPLES TO APPLES COMPARISON

#### With the Adult Dental Medicaid Program

##### Patient with abscessed tooth seeks treatment in a dental office.

Emergency dental exam	\$22.58
X-ray	\$ 5.00
Extraction of tooth	\$52.45

**TOTAL COST TO MEDICAID: \$80.03**

##### Result:

- Problem is resolved.

Based on 2010 Medicaid fee data.

#### Without the Adult Dental Medicaid Program

##### Patient with abscessed tooth seeks treatment in the local hospital emergency room.

Hospital ER fee	\$220.65
Physician fee	\$ 59.35
X-ray	\$ 49.32
Radiology review	\$ 22.28
Antibiotic injection	\$ 13.82

**TOTAL COST TO MEDICAID: \$365.42**

Depending upon a patient's presentation and the hospital's capabilities, these costs could rise to \$850 or more.

##### Result:

- Pain and infection medication is prescribed to treat symptoms.
- Problem with tooth is not resolved and will reoccur.
- Multiple return visits to ER likely.

Based on 2010 Medicaid fee data.

## Statehouse insider Ross McGregor a featured speaker at ODA Leadership Institute

### ODA Staff

State Representative Ross McGregor (R-Springfield) will be a keynote speaker at the ODA's 2011 Leadership Institute to be held at the Hilton Hotel at Easton in Columbus on May 20-21.

McGregor is in his fourth term in the Ohio House of Representatives, representing the 72nd House District, which encompasses portions of Clark County, including Springfield.

He was a primary co-sponsor of the recently-enacted ODA-backed House Bill 190, which creates new flexibility for dentists supervising their dental hygienists in public health settings in order to better facilitate access to dental care for underserved populations. He has also been a leading advocate for the adult dental Medicaid program and other dental care initiatives.

Keith Kerns, ODA's Director of Legal and Legislative Services, said McGregor is a "champion" in the General Assembly for dentistry and dental patients. "He really understands our issues," Kerns said.

McGregor is chair of the Joint Committee on Agency Rule Review, which oversees the rules and regulations promulgated by various state agencies, including the Ohio State Dental Board. He also serves on several other important committees, including the House Finance and Appropriations Committee and the Commerce and Labor Committee.

McGregor is the recipient of the Watch-

dog of the Treasury Award and the National Federation of Independent Business Guardian of Small Business Award.



In addition to his duties Ohio Rep. Ross McGregor at the Statehouse, McGregor works as the Manager of Business Projects for his family's business, Pentaflex, Inc., and as President of the Champion City Development Company, both located in Springfield. He received his Bachelor's Degree in Business Administration from Urbana University and is married to ODA member dentist, Dr. Catherine Crompton.

"Rep. McGregor's background is in business so he focuses on trying to get things done, not on politics," said ODA Executive Director David J. Owsiany. "These are turbulent times for Ohio so it will be interesting to hear his perspective on the current condition of our state."

Rep. McGregor will speak at the Leadership Institute at 4 p.m. on Fri., May 20.

See page 2 for additional information on the 2011 ODA Leadership Institute.

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## Day at the Statehouse

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**BUDGET, from page 1** — The board fee cuts, the Ohio Department of Jobs and Family Services limited adult dental services to one cleaning and one exam per year in lieu of fee cuts.

As Ohio's economy declined in 2008-2009 and hundreds of thousands of Ohio workers lost their jobs and the demand for social services grew, the General Assembly passed the state budget for fiscal years 2010-2011, which included funding for the dental Medicaid program.

In signing the state budget into law, Strickland announced a portion of the monies formerly contained in the tobacco cessation endowment fund from the state's settlement with the tobacco companies would be utilized for necessary social services and Medicaid coverage. Included in the expenditure was approximately \$129 million for optional Medicaid services, including dental coverage for adults.

However, the Washington, DC-based American Legacy Foundation, which expected to receive approximately \$190 million from the settlement funds for tobacco use prevention efforts in Ohio, filed a lawsuit challenging the state's expenditure of the tobacco settlement funds.

In August 2009, the Franklin County Court of Common Pleas ruled in favor of the Legacy Foundation and invalidated the state's attempt to utilize the disputed funds for anything other than tobacco use prevention efforts. The court's ruling

effectively put the funding for adult dental Medicaid coverage in jeopardy.

The state of Ohio immediately appealed and the ODA led a coalition of health care organizations, including the Ohio Association of Community Health Centers and the Ohio Optometric Association, in filing an amicus (friend of the court) brief with the appellate court.

On Dec. 31, 2009, the Tenth District Court of Appeals reversed the trial court's decision and ruled in favor of the state, agreeing with the ODA's position that the General Assembly and governor have broad authority to determine the state's budgetary priorities.

While the court of appeals' decision was positive from the ODA's perspective, the future of the dental Medicaid program remained in limbo because the Legacy Foundation appealed the case to the Ohio Supreme Court.

On May 24, 2010, the ODA again filed an amicus brief – this time with the Ohio Supreme Court – in support of the state's position. On Dec. 22, 2010, the Ohio Supreme Court unanimously upheld the state's decision to utilize tobacco settlement funds for important state priorities, including adult dental Medicaid services.

The court's decision was critical to the ODA's continued efforts to preserve dental coverage for adults in Ohio's Medicaid program through fiscal year 2011; however, the state is facing an \$8 billion budget shortfall for fiscal years 2012-2013.

Owsiany reminds members that attendance at the ODA's Day at the Statehouse on Wed., April 13 will be important in the advocacy efforts to retain funding for the program and encourages members to participate.

"While Gov. Kasich's initial budget proposals do include funding for the dental Medicaid program, it is important for us to continue our advocacy efforts throughout the budget deliberations to secure the dental Medicaid funding in the state's budget for fiscal years 2012-2013," Owsiany said.

Owsiany said the ODA fully appreciates the financial constraints the state of Ohio is currently facing with the state's operating budget and it appears the ODA's message is resonating with lawmakers.

"Providing coverage for Medicaid dental services ensures that Ohio's most vulnerable patients are being treated in the most cost-effective setting – the dental office – instead of costlier settings like hospital emergency rooms," Owsiany said. "To eliminate adult dental Medicaid would be penny-wise and pound foolish."

Continued coverage of the status of the dental Medicaid program will be included in future issues of *ODA Today* and updates will be sent to members in the ODA's e-newsletter and posted online at <http://www.oda.org>.

To register for the 2011 ODA Day at the Statehouse, contact Liz Downey, ODA government affairs assistant, at (800) 282-1526 or [liz@oda.org](mailto:liz@oda.org).

## Learn the ABC's of a strong practice at ODA Leadership Institute

### ODA Staff

Sharing some professional, personal and life experiences, ODA member Dr. Ron Arndt will speak of lessons learned in his keynote presentation, *Kindergarten for Dentists ... the ABC's of Running a Successful Dental Practice* at the ODA Leadership Institute this May.



Arndt is founder and CEO of The Dental Coach in North Ridgeville, OH, a business through which he has long coached dentists on how to create and maintain a strong balance between personal and professional life.

In addition to a BA in communications and his DDS from The Ohio State University, Coach Ron has an MBA from Baldwin Wallace College, and an MAGD from the Academy of General Dentistry. In his keynote address, Arndt will share how dentists can create "Kindergarten Magic" in their own practice. In this interactive presentation, which begins at 11:05 a.m. on Fri., May 20, Arndt will help attendees learn how to not just increase, but catapult profits, reduce staff turnover and make serving patients more enjoyable and fun.

Arndt will also lead a breakout session Friday afternoon, *Killing the Practice Before it Kills You: How Throwing Out my Business Model Saved My Life*. In this session, Arndt will share his personal experiences of mistakes made as a young dentist and driven business owner, and **See COACH page 6**

## Have a question? Contact the Ohio Dental Association!

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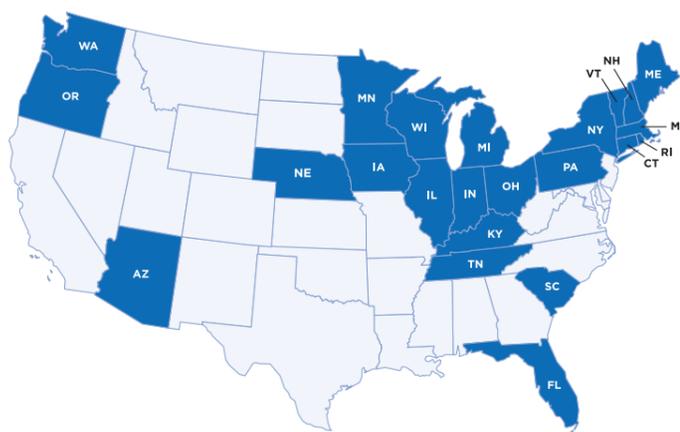
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## Reagan's legacy may impact health care reform



The  
Director's  
Chair

David J. Owsiany,  
ODA Executive Director

I received several comments on my February column on the 100th anniversary of Ronald Reagan's birth and my March column on health care reform. This month's column builds on both of those previous columns by looking at how Reagan's legacy related to the federal judiciary may impact the new health care reform law.

### Reagan and the courts

When Reagan was elected in 1980, the federal judiciary was far different than today. From the New Deal through Reagan's two terms as president, many federal judges felt that the provisions of the Constitution had no fixed meaning. In their view, judges were to interpret the Constitution in light of "contemporary values," which often times was just a substitute for their own personal policy preferences.

For example, in the 1960s and 1970s, the federal judiciary regularly hampered law enforcement by inventing new constitutional protections for criminal defendants that had little basis in the text or original meaning of the Constitution. Some judges found a constitutional right to government assistance thereby restricting the ability of states to cut off welfare payments. Some federal judges openly questioned the constitutionality of the death penalty and whether private citizens had a right to own guns. Never mind the fact that capital punishment is specifically contemplated in the Constitution and the Second Amendment provides for the "right of the people to keep and bear arms."

In reaching these constitutional interpretations, activist judges referred to a "living" Constitution, which was really a code word liberal judges used to push their own personal beliefs under the guise of constitutional interpretation. Reagan had a different view of how the judiciary should operate. In cases involving constitutional issues, Reagan believed judges were to follow the text and the framers' original understanding of the constitutional provision at issue.

Reagan appointed many judges who shared his philosophy.

In a widely noticed speech to the American Bar Association in 1985, Reagan's Attorney General, Edwin Meese, ignited a debate about the proper role of the federal judiciary and constitutional interpretation. Meese explained Reagan's belief that "the only reliable guide for judgment" was "the original meaning of constitutional provisions."

Reagan believed that judges were to be independent arbiters that interpret the Constitution in a neutral manner, without regard to their own personal policy biases. In essence, judges were to follow the law no matter where it led them. They were not to make the law up from the bench, as had become the norm.

In response to Reagan and Meese, then-U.S. Supreme Court Justice William Brennan rejected this "originalist" approach to constitutional interpretation, stating that the meaning of the Constitution should not be frozen in a world that is "dead and gone."

Similarly, former Justice Thurgood Marshall contended that he did not find the "wisdom, foresight, and sense of justice exhibited by the framers particularly profound." He said the framers devised a government that was "defective" from the start. For advocates of the "living" Constitution, the founding generation was unsophisticated and backward. The activists believed it was incumbent upon enlightened federal judges to actively promote their agenda from the bench.

Today, Reagan's philosophy is winning. Some are more faithful to the concepts of originalism than others, but judges and legal scholars of all persuasions – left, right, and center – regularly cite the framers' understanding of the Constitution in making their decisions. While determining the original understanding of various constitutional provisions can be difficult and reasonable minds can differ in their interpretation, the fact that the framers' views matter so much is a dramatic change from the 1970s.

Seth Stern, who is co-author of the recent biography *Justice Brennan: Liberal Champion*, says that the "great debate" between the advocates of a "living" Constitution and the advocates of originalism, which started with the debate between Brennan and the Reagan administration, was "remarkable and unprecedented." Twenty-five years later, the result of the debate, according to Stern, is that liberal legal scholars and judges "have intentionally distanced themselves from the idea of a living constitution as

they grope for a new way of talking about constitutional interpretation."

### Reagan's legacy and its impact on health care reform

What does Reagan's legacy regarding the federal judiciary and constitutional law have to do with health care reform? Last year, several states filed a lawsuit in a federal court in Florida challenging the constitutionality of the health care reform law signed by President Barack Obama in March 2010. Ohio joined the lawsuit in January 2011 bringing the total number of states participating in the lawsuit to twenty-six. Shortly thereafter, U.S. District Judge Roger Vinson of the Northern District of Florida issued a decision finding the health care reform law was unconstitutional. Vinson was appointed to the federal bench by Reagan in 1983 and, based on his written opinion in the health care reform case, it appears that Vinson favors an originalist approach to constitutional interpretation, just as Reagan envisioned.

Vinson began his opinion by quoting James Madison's statement that the federal government's powers are "few and defined" while the powers that remain with state governments are "numerous and indefinite." Vinson's analysis of Congress's commerce power, which is the authority Congress relied upon in enacting the health care reform law, began with the text of the Constitution. He noted that the Commerce Clause states that Congress has the authority "to regulate commerce...among the several states." Vinson's written opinion included a discussion of the history of the Commerce Clause, including the understanding of the commerce power at the time of the ratification of the Constitution. Vinson specifically discussed Madison and Alexander Hamilton's view of the commerce power and quoted the definition of the term "commerce" from a dictionary published in 1773.

Vinson explained that power under the Commerce Clause was originally intended to permit the federal government to regulate the trade or exchange of goods and to eliminate trade barriers erected by and between states. Vinson explained how "for most of the first century and a half of Constitutional government," the Commerce Clause was "narrowly construed" and, accordingly, the reach of the federal government remained limited. Vinson then described how, following the New Deal, the U.S. Supreme Court took a much broader view of the commerce power. This expansive view led the

Supreme Court to hold that even activities that are entirely local in nature may be regulated by the federal government if the cumulative impact of such activities would have a substantial effect on interstate commerce.

Vinson acknowledged that the Commerce Clause's reach had been "expanded" over the years to permit the federal government to exercise broad powers well beyond the original understanding of the commerce power. However, Vinson concluded that to allow the federal government to penalize an individual's decision not to buy health insurance would exceed Congress's commerce power under the Constitution. Accordingly, he held that the health care reform law was unconstitutional.

In reading Vinson's opinion, I am struck by his willingness to reach back to the founding era to show what the original understanding of the commerce power was. He then meticulously showed how far away from that understanding we have gotten as the federal government's power exponentially increased over time. By finding that the health care reform law was unconstitutional, Vinson seemed to be saying that "enough is enough." Vinson's written opinion demonstrates that there must be some limit on the federal government's authority or the Constitution's original design – dividing powers between the states and the federal government – means nothing at all.

Vinson's decision will not be the final word on this issue. The fate of the health care reform law will likely be decided by the U.S. Supreme Court. The outcome of the case will ultimately be determined by whether a majority of the justices take a broad "living" view of the Constitution with a willingness to accept essentially unlimited federal power.

Alternatively, a majority of the court could look to the original understanding of the commerce power and recognize that the reach of the federal government does indeed have limits and, in enacting the health care reform, Congress exceeded those limits. If the court does so, it will be a fitting legacy for Reagan, who had the courage to challenge the prevailing liberal orthodoxy that dominated the federal courts from the 1940s to the 1980s.

And it would be another example of how Reagan continues to influence American society, more than two decades after leaving office and six years after his death.

For a reprint of the Feb. 2011 column on Reagan, visit [www.oda.org](http://www.oda.org).

### Adjunct Instructor Cincinnati Children's Hospital Medical Center

The Division of Pediatric Dentistry at Cincinnati Children's Hospital Medical Center, one of the top-ranked children's hospitals in the world, is seeking candidates with a DDS/DMD from an accredited dental school in the U.S. and completion of an accredited pediatric residency training program. Additional requirements include Board certification and Ohio licensure (or eligibility for both).

This position is responsible for providing clinical care in the outpatient office and OR settings including supervision of residents, on a part-time basis. A demonstrated commitment to clinical scholarship through participation in clinical research will also be necessary.

Interested candidates should send CV to: Stephen Wilson, DMD, MA, PhD, Cincinnati Children's Hospital Medical Center, 3333 Burnet Avenue, MLC 2006, Cincinnati, OH 45229 or email: [stephen.wilson1@cchmc.org](mailto:stephen.wilson1@cchmc.org)

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### Legal Briefs

Keith Kerns, Esq. ODA Director of Legal & Legislative Services

On March 15, 2011 Governor John Kasich announced his proposed state budget priorities for state fiscal years 2012 and 2013.

The proposal, dubbed the "Jobs Budget" by the administration, provides \$34 million in job-creating tax incentives and creates other initiatives in an attempt to improve the business climate in Ohio.

Members of the General Assembly appear to share the Governor's goal and have spent a large portion of the first few months of the legislative session discussing proposals to improve Ohio's economic outlook. In fact, the House of Representatives created a new standing committee called the Economic and Small Business Development Committee to study these issues exclusively.

Many of the proposals under consideration are aimed at fostering small business growth and development and could have a positive impact on dental practices if adopted.

## State policy makers debate initiatives designed to help Ohio's small business professionals

### Increased oversight of administrative agency rules

Senate Bill 2, sponsored by Sen. Jim Hughes (R-Columbus), was the first bill signed into law by Gov. Kasich. It makes several changes to the administrative rulemaking process in an attempt to make the state's regulatory framework more inviting to new businesses and less cumbersome for existing businesses.

S.B. 2 creates new oversight for agency rules that could negatively impact small businesses with the help of a Small Business Advisory Council comprised of small business representatives. The Common Sense Initiative Office housed within the Governor's office will evaluate rules that may have an adverse impact on businesses. These new entities will establish standards for administrative agencies on transparency, consistency and flexibility of rule implementation and making new regulations "easy to understand."

Additionally, S.B. 2 provides expanded authority to the Joint Committee on Agency Rule Review (JCARR) in its administrative rule review process. Currently, JCARR may recommend that a rule be invalidated for being in conflict with legislative intent or another rule, if the agency has exceeded its authority in

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proposing the rule or if the agency did not meet certain notice requirements.

Under the provisions of S.B. 2, JCARR will also be able to recommend invalidation if the agency fails to demonstrate that the regulatory intent of the rule justifies its adverse impact on businesses.

State Representative Ross McGregor (R-Springfield), current chairman of JCARR and a featured speaker at the upcoming ODA Leadership Institute, recently commented that the change increases the power of JCARR "exponentially" and may need to be clarified further so as not to insert too much subjectivity into the rule review process.

### Small business loans

If adopted, House Bill 44, sponsored by Reps. Jay Goyal (D-Mansfield) and Nancy Garland (D-Gahanna), would authorize the Department of Development to establish a small business working capital loan program to create or preserve jobs in locations throughout the state.

The program would establish criteria for loan eligibility, which would include the economic needs of the area in which the business is located, the number of jobs to be created or preserved and other factors deemed to impact the overall economic welfare of the state as determined by the director of the department.

The bill is under consideration in the House Economic and Small Business Development Committee.

### Improved customer service and access to information

In addition to the rule review procedure outlined earlier, S.B. 2 also requires each state agency to develop customer service performance standards for employees of the agency whose duties include a significant level of interaction with the public. Employees and the officers of the agencies will be required to comply

with the newly established standards and compliance will be evaluated as part of the employee's periodic performance reviews.

House Bill 144, sponsored by Reps. Mike Divolla (R-Berea) and Nan Baker (R-Westlake), would require the Department of Development to create a web-based "small business resource center" to serve as a primary source for information related to small businesses.

The resource center would provide information on:

- the steps to starting a small business in Ohio
- workforce availability
- regulatory requirements
- licensure and permit requirements
- loan and financing opportunities
- tax requirements
- Workers' Compensation requirements and other information

H.B. 144 is also pending in the House Economic and Small Business Development Committee.

The ODA will continue to monitor these and other small business proposals contained in the state operating budget for the potential impact on dental practices.

For more information on these or other legislative issues, contact the ODA department of governmental affairs at (800) 282-1526.

Legal Briefs is intended to offer information and general guidance but should not be construed as legal advice and cannot be substituted for the advice of the dentist's own legal counsel. Dentists should always seek the advice of their own attorneys regarding specific circumstances.

### STATEHOUSE, from page 1

Kerns; and ODA consulting lobbyists Darryl Dever and Adam Hewit.

Topics of discussion will include the state budget, including adult dental Medicaid funding, insurance reform and mid-level providers. In addition, attendees will be provided with an outline on how the political landscape has changed in Ohio and be briefed on the Ohio Dental Political Action Committee (ODPAC).

Following the lunch and briefings, dentists will hold one-on-one meetings with their legislators to discuss these issues.

This year's Day at the Statehouse will see the continuation of the mentoring program initiated in 2008. The program matches newcomers and dental students with experienced attendees from their area, allowing first-time attendees and dental students to ask questions and get advice from a mentor. Mentors will provide direction to new attendees prior to their meetings with legislators.

To register for the 2011 ODA Day at the Statehouse, contact Liz Downey, ODA government affairs assistant, at (800) 282-1526 or [liz@oda.org](mailto:liz@oda.org).

Members interested in participating in the mentoring program or who need assistance scheduling meetings with state legislators may also do so through the ODA office. If meetings are scheduled through other means, the ODA asks that members contact Liz Downey to avoid conflicting meeting times.



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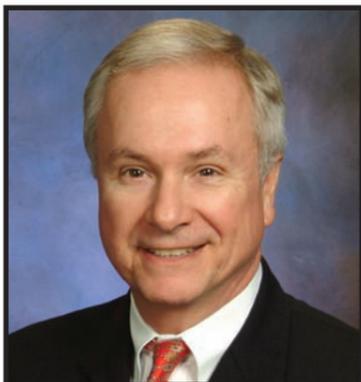
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Frank R. Recker & Associates Co., LPA  
Law & Finance Bldg.  
85 E Gay Street, Suite #910  
Columbus, OH 43215

1850 San Marco Road  
Marco Island, FL 34145

800.224.3529 (p)  
888.469.0151 (f)  
[recker@ddslaw.com](mailto:recker@ddslaw.com) (e)

Frank R. Recker has practiced general dentistry for 13 years and served as a member of the Ohio State Dental Board before entering the legal profession. Areas of practice include:

- Administrative Law before State Dental Boards
- Dental Malpractice Defense
- Practice-related Business Transactions

Dr. Recker also represents multiple national dental organizations and individual dentists in various matters, including First amendment litigation (i.e. advertising), judicial appeals of state board proceedings, civil rights actions against state agencies, and disputes with PPOs and DMSOs.

A sampling of various cases can be obtained online. Questions regarding representation can also be addressed to Dr. Recker via e-mail at [recker@ddslaw.com](mailto:recker@ddslaw.com).

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## The standard of care – a clinical concept with risk connotations

Kathleen M. Roman, M.S.

Standard of Care: In medical, legal, etc., malpractice case ... the traditional standard for doctors is that they exercise the average degree of skill, care, and diligence exercised by members of the same profession, practicing in the same or a similar locality in light of the present state of medical and surgical science.

– Black's Law

The term "standard of care" can sometimes be confusing for dentists because it may have both legal and clinical connotations. Examples:

- Clinical connotation: Is it within the standard of care for a dentist to refuse to extract a third molar when a new patient won't agree to an X-ray?

Dentists have little difficulty understanding the clinical elements that come into play as they decide on a clinical standard of care. In the scenario above, the patient may refuse to have an x-ray for fear of radiation exposure or because he simply doesn't want to pay for a test

he doesn't understand. Dentists are educators as well as practitioners.

In this case, the patient needs an explanation of the limited risks associated with this technology. The doctor will also want to point out the substantial risks the patient may face without the X-rays. These risks would include the potential for damage to bone, other teeth, nerves, etc.

Most dentists would agree that an x-ray is a standard of care element of a third molar extraction – and, in keeping with the Black's Law definition, this majority view thus determines the clinical standard.

- Non-clinical connotation: Is it within the standard of care for a dentist to refuse to extract a third molar if a new patient can't afford to pay for the x-ray?

In this case, the decision of whether or not to provide a specific service is being influenced, not by the patient's clinical need, but by the doctor's financial policy. "Payment is expected at the time service is rendered" is not about patient safety or about clinical standards. It is a

business policy and, as such, may have legal ramifications if its enforcement contributes to a patient's injury. While some dentists may believe that this is an acceptable business decision, others will not.

In fact, the ADA Council on Scientific Affairs advises doctors that payment issues cannot cancel a doctor's obligation to provide emergency dental care for a patient of record or to carry through with treatment already begun if failure to do so would put the patient at risk. A payment policy may not always nullify the dentist's duty to provide treatment to a patient.

### The nature of misunderstandings or disputes

Doctors are often surprised to learn that the standard of care isn't carved in stone. It may be influenced by outside factors:

- State laws and courts' interpretations of the laws.
- Currently accepted methods for performing a specific procedure.
- The types of services typically provided by the dentist or group.
- The location of the practice and the

location of service.

- The state of current research and technology related to the procedure.
- The dentist's ability to make decisions based on the patients' best interests in keeping with professional standards, e.g., ADA ethical guidelines.

Not all unanticipated outcomes can be prevented. But doctors can establish policies and procedures that reduce the likelihood that an unanticipated outcome will turn into a dispute. Doctors who are sensitive to the current local professional standard of care, and who factor it in to their own policies, will be more comfortable with the professional decisions they make – and potentially reduce the risks of patient dissatisfaction that sometimes trigger lawsuits. While considering policies related to the standard of care, dentists might include such issues as:

- Has the doctor stayed current with generally accepted practices?
- Has the doctor ventured into what could be considered experimental practice? If so, has the patient been advised that the proposed treatment is experimental in nature?
- Do the doctor's credentials reflect training and experience sufficient to indicate that the care was responsive to accepted standards? This is especially important in dentistry where some generalists provide types of care that are also provided by "certified" specialists. When the generalist offers treatments that a patient might obtain from a specialist, the onus is on the generalist to be able to show that he can safely and effectively perform the same procedure that specialists perform. Or, the generalist needs to determine which patients and which types of conditions he will treat; e.g., minor cosmetic straightening and which cases he will refer, such as cross-bites.

The generalist has a greater obligation to "triage" his cases because any unexpected outcome or patient complaint will hold the doctor to the standard of care that would have been in place had a certified specialist performed the procedure.

### Conclusion

Typically, the standard of care doesn't require that a dentist be perfect in the treatment of patients. It anticipates that the dentist will make the kind of reasonable and prudent decisions that other doctors, similarly trained and practicing in the same area and specialty, would also make. That provides each doctor with leeway for a variety of different but equally-acceptable treatment options.

But, as dentists know from their training and from their professional guidelines, the foundation for the standard of care is the assumption that doctors will have their patients' interests at heart when making treatment recommendations. And this may include the decision to refer a patient or to refuse to comply with a treatment request that the doctor feels may deviate from appropriate standards of care; e.g., failure to take x-rays preceding extraction of a third molar.

**About the author:** Kathleen M. Roman is Risk Management Education Leader for The Medical Protective Company, founded in 1899. She can be reached at [kathleen.roman@medpro.com](mailto:kathleen.roman@medpro.com).

Editor's note: The opinions expressed in this article are those of the author, and not necessarily the views or opinions of this publication or the Ohio Dental Association.

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## 2011 ODA Annual Session to offer course on monitoring nitrous oxide

### ODA Staff

A course meeting the Ohio State Dental Board's (OSDB) new regulations to allow properly trained dental auxiliaries to monitor nitrous oxide under the direct supervision of a dentist, will be given during the ODA Annual Session in Columbus on Fri., Sept. 16, 2011. The cost of the course for staff is only \$135.

The course is for dental assistants, CDAs, EFDAs, hygienists and other auxiliaries and provides the lecture and testing components needed to be in compliance with the OSDB's new regulations. Topics covered include, but are not limited to:

- The history, philosophy and psychology of N<sub>2</sub>O-O<sub>2</sub> minimal sedation.
- Definition and descriptions of the physiological and psychological aspects of pain and anxiety.
- Concepts and management of pain and anxiety.
- Indications and contraindications for N<sub>2</sub>O-O<sub>2</sub> minimal sedation.
- Anatomy and physiology of respiration.
- Medical assessment of the patient

prior to administration of N<sub>2</sub>O-O<sub>2</sub> minimal sedation.

- Moderate and deep sedation/general anesthesia versus minimal sedation
- Pharmacological and physiological effects of nitrous oxide.
- A description of the stages of drug induced central nervous system depression through all levels of consciousness and unconsciousness with special emphasis on the distinction between the conscious and unconscious state.
- Monitoring of N<sub>2</sub>O-O<sub>2</sub> minimal sedation.
- Management of complications and medical emergencies.
- Legal and ethical considerations.
- Occupational exposure.
- Successful completion of a written examination, provided by the board-approved permanent sponsor.

To monitor nitrous oxide in the dental office, dental team members must also have appropriate CPR certification. The American Heart Association Basic Life Support for Health Care Providers certification will be offered at Annual Session on Sat., Sept. 17.

*Note: The ODA does not plan to offer a course to meet the OSDB's criteria for hygienists to administer nitrous oxide under the direct supervision of a dentist.*

Look for complete Annual Session registration information in the mail and online at [www.oda.org](http://www.oda.org) by May 15.

### Information for dental team members seeking to monitor nitrous oxide (N<sub>2</sub>O-O<sub>2</sub>) minimal sedation

Dental team members (dental hygienists, EFDAs, CDAs, and dental assistants) must satisfy the following requirements unless otherwise noted:

- Be at least 18 years of age.
- Have at least two years and 3,000 hours of experience in dental assisting (note: dental hygienists are exempt from this requirement).
- Complete a basic life-support training course certified by the American Heart Association, the American Red Cross or the American Safety and Health Institute and remain current at all times when monitoring N<sub>2</sub>O-O<sub>2</sub> minimal sedation.
- Complete a six-hour course in the

monitoring of N<sub>2</sub>O-O<sub>2</sub> minimal sedation provided by an OSDB-approved permanent sponsor of continuing education.\*

- Successfully complete a written examination provided by the course sponsor.
- Document completion of basic life-support training and N<sub>2</sub>O-O<sub>2</sub> training received on the form obtained from the OSDB. The form and documentation should be maintained in the office(s) in which the dental team member practices.
- Monitoring of N<sub>2</sub>O-O<sub>2</sub> may only be performed under the direct supervision of a licensed dentist. Direct supervision requires that the supervising dentist be present in the facility at all times during performance of the task.
- A satisfactory initiation phase of N<sub>2</sub>O-O<sub>2</sub> may only be administered by the supervising dentist.
- Under no circumstances may the dental team member administer, adjust, or terminate the N<sub>2</sub>O-O<sub>2</sub>. These functions may only be performed by the supervising dentist.
- The dental team member may not monitor more than one patient at a time and must physically remain with

See NITROUS, page 7

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### COACH, from page 2

how he survived a heart attack at age 41.

He will speak of how this near-fatal event helped him regain control of his life, and learn to live and live well.

Married for 37 years to his wife Trish, he is also a member of Toastmasters International and served 12 years as trustee with the ODA Foundation.

There are four one-hour breakout sessions offered at this year's Leadership Institute, and each is held twice Friday afternoon. Participants choose two.

Breakout sessions begin at 12:35 and again at 1:45 and include:

- Killing the Practice Before it Kills You ...
- Update on the Ohio Dental Practice Act (offers 1 CDE to attendees)
- ADA Membership Outreach Training
- E-Marketing and Your Dental Practice

### ODA Leadership Institute Schedule of Events

#### Friday, May 20

- 10:00 Registration begins
- 11:00 Welcome by ODA president Dr. Thomas Matanzo
- 11:05 Keynote presentation, Dr. Ron Arndt, The Dental Coach
- 11:45 Buffet lunch
- 12:35 Breakout session I
- 1:45 Breakout session II
- 3:00 Legislative update
- 4:00 Rep. Ross McGregor
- 4:45 Closing remarks, Dr. Matanzo
- 5:00 Reception hosted by the Delta Dental Foundation of Ohio

#### Saturday, May 21

- 7:45 Registration and breakfast buffet
- 8:40 Welcome and introductions, Dr. Thomas Matanzo
- 8:45 Disney's Approach to Leadership Excellence
- 10:15 ODA Foundation update
- 10:30 Executive Committee Town Hall
- 11:45 Adjournment

Additional information on the Leadership Institute has been mailed and is online at <http://www.oda.org>. This event is free to ODA members and sponsored by the Delta Dental Foundation of Ohio.

## ODA Meeting & Event Calendar

### Apr.

- 1 Callahan Commission Meeting
- 6 OPTIONS Steering Committee Meeting
- 7 Executive Committee Meeting
- 8 Ad Interim Committee Meeting
- Executive Committee Meeting
- Strategic Planning Committee Meeting
- 9 Strategic Planning Committee Meeting
- 12 Council on Dental Care Programs and Dental Practice Dinner Meeting
- 13 ODA Day at the Statehouse
- Council on Dental Care Programs and Dental Practice Meeting
- Dental Education and Licensure Committee Meeting
- 15 Annual Session Committee Meeting
- 22 ODA Office Closed for Holiday
- 29 ODA Foundation Board of Trustees Meeting

### May

- 6 Forensic Dental Team
- 19 Executive Director's Forum
- Council on Access to Care and Public Service Meeting
- Council on Membership Services Meeting
- 19-20 Executive Committee Meeting
- 20 Dentists Concerned for Dentists Meeting
- 20-21 ODA Leadership Institute (Hilton Columbus/Easton)
- 30 ODA Office Closed for Holiday

### ODA Today correction

In the March 2011 *ODA Today* Give Kids a Smile list, dentists from the Northeastern Ohio Dental Society that were inadvertently listed with the North Central Dental Society volunteers. These dentists are:

Richard Cavolo  
Kim Gardner  
Cary Goldstein  
Mitch Henn  
William Nelson  
Lisa Richards

In addition, the name of Dr. Evan Tetelman of the Greater Cleveland Dental Society was misspelled. We apologize for the errors.

## New policies set by Ohio State Dental Board

The Ohio State Dental Board recently released information on the following new policies:

### Dental hygienists providing periodontal maintenance

This policy addresses whether a dental hygienist can perform periodontal maintenance on a patient when the supervising dentist is not present in the office.

Periodontal maintenance for the purposes of this policy is defined as procedures performed at regularly scheduled intervals to assist the periodontal patient in maintaining oral health. As part of periodontal therapy, an interval is established for periodic, ongoing care.

Maintenance procedures are under the supervision of the dentist and typically include:

- an update of the medical and dental histories;
- radiographic review;
- periodontal evaluation;
- removal of the bacterial flora from crevicular and pocket areas;
- limited scaling and root planing where indicated; polishing of the teeth;
- and a review of the patient's plaque control efficiency.

Periodontal maintenance procedures following active therapy is not synonymous with a prophylaxis.

The performance of periodontal maintenance as described above is permissible on a patient when the supervising dentist is not present, as long as there is compliance with Ohio Administrative Code 4715-9-05. The supervising dentist must have evaluated the patient within the past seven (7) months, and prescribed the periodontal

maintenance as part of ongoing care for the patient.

Periodontal maintenance is NOT a permissible duty in the care provided in the Oral Health Access Supervision Program.

### Utilization of non-dentist licensed healthcare providers

The second policy is on non-dentist licensed healthcare providers and states the Board's position on a dentist using non-dentist licensed healthcare providers (RN, LPN, etc.) to assist in the performance of patient treatment within the scope of the practice of dentistry while in a dental office.

The Ohio Revised and/or Administrative Codes delineate procedures/tasks/duties a licensed healthcare practitioner can perform.

Non-dentist, licensed healthcare practitioners may perform those procedures/tasks/duties in a dental office only when all of the following conditions are met:

- Non-dentist, licensed healthcare practitioners may perform procedures/tasks/duties only within the scope of their license.
- Non-dentist, licensed healthcare practitioners may perform procedures/tasks/duties only under the direct supervision of a licensed dentist.\*
- Non-dentist, licensed healthcare practitioners may perform procedures/tasks/duties only during the performance of dental procedures.

\*This does not apply to a licensed physician anesthesiologist.

Additional information on OSDB policies is available online at <http://www.dental.ohio.gov>.



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### NITROUS, from page 6

the patient at all times.

- The supervising dentist must approve the discharge of the patient. Dental hygienists engaged in monitoring of N<sub>2</sub>O-O<sub>2</sub> must document the supervising dentist's approval for discharge of the patient.

### Limited exemptions to training requirements:

- Dental team members who graduated from an ADA Commission on Dental Accreditation-approved program on or after Jan. 1, 2010, and received equivalent training as part of that program are exempt from the training requirements outlined above. However, these team members must still complete and maintain the basic life-support training requirements.
- Dental team members who hold a current license or credentialing issued by another state for the

monitoring of N<sub>2</sub>O-O<sub>2</sub> minimal sedation may be exempt from the training requirements outlined above if the training received is substantially equivalent to the training required by Ohio. Dental team members seeking such an exemption should contact the state dental board to obtain a determination on the equivalency of their training.

\*A permanent sponsor of continuing education includes the following: the American Dental Association, Ohio Dental Association and component dental societies; the National Dental Association and its affiliated societies; the American Dental Hygienists Association and its affiliated societies; dental specialty organizations affiliated with the ADA; accredited schools of dentistry or dental hygiene and hospitals, among others.

## Dental Insurance Corner

## Dental insurance and identity theft

Christopher A. Moore, MA  
ODA Director of Dental Services

*This is the second column of a two-part series. In the March ODA Today, this column addressed the impact of dental benefit fraud on the dental office.*

## Action steps

To better prevent the dental office from being a victim of identity theft-related dental insurance fraud, dentists should implement patient authentication practices as part of their office policies.

A good example of this, particularly with new patients, is to request to see a separate form of identification, such as a driver's license or other photo ID, in addition to the patient's dental insurance card. Comparing the photo ID with the dental insurance card can help verify an identity while also deterring potential subterfuge. This method of patient authentication is most effective when the demographics, such as race, gender or age, of the identity thief do not match those of an existing record.

The dental office may need to ask additional questions of potential patients who provide a dental insurance number but fail to produce an actual dental insurance card. An alert office staff that questions the lack of actual physical documentation may thwart the efforts of

an individual who has obtained another person's dental insurance number or other information.

Some sources recommend that dentists make a copy of the patient's photo ID and keep it in the patient's chart. They similarly recommend that the patient's dental insurance card be copied, dated and also placed in the patient's chart.

It is very important to note that simply copying or scanning and storing a patient driver's license and/or insurance information may create other problems if this documentation is not properly maintained and secured. The information contained in these documents represents a treasure trove to the identity thief and must be safeguarded by the dental office. It is for these reasons that some advisors and commentators express concern or caution about keeping copies of this information in the dental office.

Patient authentication is not a panacea however. In addition to the critical need to keep personally-identifiable patient information confidential and secure, there are concerns if the initial patient record is not accurate.

The 2008 Medical Identity Theft Environmental Scan from the United States Department of Health and Human Services reported "in one case, the thief had stolen the individual's driver's license

Editor's note: Dental Insurance Corner is intended to offer information and general guidance but should not be construed as legal advice and cannot be substituted for the advice of the dentist's own legal counsel. Dentists should always seek the advice of their own attorneys regarding specific circumstances. ODA members who would like to submit a dental insurance related question, problem or concern may do so by sending the appropriate information to the ODA Dental Insurance Working Group, 1370 Dublin Road, Columbus, OH 43215, or 614-486-0381 FAX, or [chrism@oda.org](mailto:chrism@oda.org).

as well as her insurance information.

Once the victim discovered the theft, she had difficulty in proving that she had not received the services because the health care facility had a scan of her driver's license on file and believed that the victim had provided it at the time of care.

At that time, medical staff could have discovered the medical identity theft if they had taken a closer look at the license photo. This incident illustrates that patient authentication must be implemented effectively, so it does not contribute to the complexities of the problem. More specifically, it illustrates the frequently observed principle that policies, procedures, and technology are only effective in combating medical identity theft if providers and staff receive and adhere to appropriate training and awareness.

The following action steps can also help deter and/or prevent dental identity theft:

- Check patient eligibility status at each visit. Online patient eligibility information, such as enrollee and family member names, birth dates and family member-enrollee relationships can be used to compare with the in-office information provided by the patient.
- A careful review of dental insurance explanation of benefits can be a valuable tool in detecting medical identity theft. Inaccuracies that are contained on the EOB relative to services provided, dates of service, patient and/or subscriber names, addresses or amount of annual maximums expended are possible indicators that a theft has been committed. While patients can be invaluable in identifying fraud, dental offices should not rely solely on them to catch EOB inaccuracies as patients may be unfamiliar with the

dental and insurance terminology commonly utilized on EOBs. The patient's ability to identify EOB discrepancies may also be compromised by having to rely on their memory since they typically will not have ready access to their dental chart.

- Patients should be encouraged to contact the dental office when they see items on their billing statements that do not look right or when they receive an unexpected bill, statement or collection notice. Such reports oftentimes represent the first opportunity to spot medical identity theft.
- Paper and electronic records must be properly guarded to prevent unauthorized access to sensitive patient information by those both inside and outside of the dental office. This includes taking steps to digitally safeguard electronic records that are taken outside of the office; e.g., portable memory devices or on a laptop computer.
- Dentists should restrict dental staff access to sensitive patient and insurance information to a need-to-know basis and to only provide enough access to ensure team members can properly do their assigned duties. Knowing who does and does not have access to certain information can serve as a deterrent to insider theft since those staff members with access to it will be limited and easily identifiable. Some experts recommend that employers conduct employee background checks both before hiring employees and regularly after as a means of detecting those possibly susceptible to committing a crime or being an accomplice to one.
- Paper and electronic records should be destroyed or made inaccessible when they are no longer useful.

A dentist who believes his or her office has been a victim of identity theft should immediately report concerns to law enforcement authorities and the affected insurance companies. He or she should then follow the authorities' instructions relative to informing the affected patient(s) of the theft in as timely a manner as possible.

## Additional resources

- Federal Trade Commission  
[www.ftc.gov/bcp/edu/microsites/idtheft](http://www.ftc.gov/bcp/edu/microsites/idtheft)
- Fight Identity Theft,  
[www.fightidentitytheft.com](http://www.fightidentitytheft.com)
- Privacy Rights Clearinghouse  
[www.privacyrights.org/identity-theft-data-breaches](http://www.privacyrights.org/identity-theft-data-breaches)
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## ODA Foundation highlights grant/scholarship opportunities for 2011

### ODA Staff

The ODA Foundation (ODAF) expects to achieve a significant milestone later this year – awarding more than half a million dollars in grants and scholarships in Ohio since 1995.

The philanthropic arm of the Ohio Dental Association, the ODAF helps fund dental education programs through grants, and with scholarships to future dental professionals, primarily dental students, at ADA-accredited schools in Ohio. In 2010, \$58,900 was given to students and programs throughout Ohio, bringing the total since 1995 to \$477,920. It is anticipated that the Foundation will again award between \$50,000 and \$60,000 this year.

“This scholarship assistance has helped hundreds of future dental professionals offset the cost of their dental education,” said Dr. Ron Stanich, chairman of the ODA Foundation. “Additionally, thousands of Ohioans have benefited from the services provided through community oral health education programs, including many dental residency program clinics that have received grants from the Foundation.”

The amount of student loan debt is significant, according to estimates provided by the dental schools at The Ohio State University and Case Western

Reserve University. For the graduating class of 2010, the median student loan debt for the OSU College of Dentistry was \$184,000 while at the CWRU School of Dental Medicine, it was \$275,000.

Matt Lemke, D-4 at the OSU College of Dentistry, is a four-year scholarship recipient, having received a total of \$11,000 in financial assistance from the ODAF. To Lemke, who in 2010 received the highest single scholarship ever awarded by the ODAF – \$5,000 – the money definitely makes a difference.

“It’s half my tuition for an entire quarter and when I start payments on my loans, that amount will probably be two months of student debt I don’t have to pay.”

In addition to the dental career scholarships that are available in 2011, there is a one-time scholarship this year, the Burton P. Siegel Scholarship for Dental Students.

This special scholarship is for \$8,035 and will be awarded to a single dental student recipient from either OSU or CWRU who is in the third or fourth year of dental school. This scholarship amount was raised through a special fundraiser hosted by Dr. Stephen Simpson, immediate past president of the ODA, in 2010 in honor of Dr. Siegel, who passed away suddenly in late 2009.

The Bowers Essay scholarship is again available for dental students, with one award each of \$1,000 and \$500 available for successful applicants. This scholarship is a written historical essay and judged on accuracy and style of writing; specific criteria is included in the application.

Applicants for the dental career and dental student scholarships must be residents of Ohio for at least three years, and demonstrate financial need and academic ability, and meet all other application-specific criteria.

There are two grant opportunities available as well – the community Program Grant Application and the Research Grant Application. Members of the ODA, community groups and other dental-related professionals are encouraged to apply for the community program grant; the research grant is open to dental students and dental residents. Both applications detail specific criteria and eligibility.

Links to information and individual applications for all scholarship and grant opportunities offered by the ODA Foundation are online at <http://www.oda.org/abouttheoda/foundation.cfm>.

Funding for the ODAF scholarships and grants comes from member dentist’s contributions to the annual raffle fundraiser.

The 2010 raffle was the most successful to date, with 668 tickets sold (out of 700) and \$33,323 in proceeds – \$6,000 more than in 2009 and over \$9,000 higher than five years ago.

Tickets for this year’s raffle are available from any Foundation trustee or member of the ODA Executive Committee, by calling Denise at the ODAF at (800) 282-1526 or by downloading the order form online at <http://www.oda.org/abouttheoda/foundation.cfm>.

Visit the web site to learn more about donating to the ODA Foundation or to view the 2010 Annual Report and Case for Support, or phone Kathy L. Woodard, Foundation Director at the number listed above.

### Designated funds within the ODA Foundation are:

- Akron Dental Society (Dr. James) Claypool Fund
- Faith Barlow Fund
- (Dr. Donald) Bowers Fund
- Nancy Siegfried Burgess Fund
- Cincinnati Dental Society Fund (Bev Fortner)
- Dr. John Harris Fund
- (Dr.) Bob & Peg Hinkle Family Fund
- (Dr. James) Mercer Fund
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## Dental therapy: another tongue in the Babel of dental access for children

Paul S. Casamassimo, DDS, MS

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Below is an edited version of an article that appeared in the February 2011 *California Dental Association Journal*. The author, Dr. Paul S. Casamassimo, is the Secretary of the Ohio Dental Association and Chair of Pediatric Dentistry at The Ohio State University College of Dentistry and Chief of Dentistry for Nationwide Children's Hospital in Columbus.

**Abstract**

*The debate over midlevel dental care providers, such as dental therapists, is intense in emotion but light on facts and data. This opinion paper questions the applicability of dental therapy in the United States and offers a prediction for its very limited acceptance. More importantly, this paper suggests that the debate on dental therapy in the United States ignores crucial issues and will delay the likelihood of improvement in children's access to oral health care.*

Never in my recollection has an issue in dentistry ignited such fervor, but most curiously, in the almost total absence of relevant data and ignorance or misrepresentation of those existing data. True, there are examples of dental therapists worldwide, but no real evidence of its applicability in a country with a third of a billion people, a highly developed, overwhelmingly dominant private practice-based dental care system, an extremely high standard of care, expectations of the populace across all socioeconomic strata for a singular high quality of care, a dental education system hard-pressed to either finance and repopulate itself, and a dental public health infrastructure in significant decline with little hope of salvation on the horizon.<sup>1</sup>

Having worked to improve access for so many years, and having the mixed blessing of seeing medicine confront this same issue over the last quarter century, I can, with some confidence, make these predictions about the future of dental therapy in the United States:

- Dental therapy will gain a foothold in this country. Indeed, it already has in Minnesota and Alaska, and the seeds are planted in other states.
- In spite of efforts by the public health community, government, legislators seeking easy fixes to dental access and other advocacy groups with agendas, dental therapy will ultimately reach the same status as independent dental hygiene practice—possible but impractical.
- Access will not be improved by dental therapy; more so, the impact of dental therapy on access will pale in comparison with community-based dental education, incentivized indigent care by existing providers, and other dentist-based approaches.

Unfortunately, these solutions already within our grasp will be delayed as we squabble over dental therapy.

There should be no confusion among those concerned about the headlong rush to enable dental therapists that some states will create pathways to implementation. The seeds have been sown.

**The danger of dental therapy to real access solutions**

No one can foresee what a dental therapy system will ultimately mean to access for children, but its creation will clearly be a distraction, if for no other reason that concurrently while pilot programs in health care reform will be implemented and evaluated, the training time it will take to create a meaningful therapist workforce, and the slow assessment of their effect.<sup>2</sup> This will keep oral health advocates for children from unifying and moving closer to real solutions to access to care while we wait for this experiment to unfold. While groups like the Pew Foundation rush to promote dental therapy as a bona fide solution to access, more thoughtful and fiscally pressed entities will wait until data emerge while children continue to suffer in the ensuing years or decades.<sup>3</sup>

I am also concerned that results of demonstrations will be used to color the argument in much the same way that proponents of potential U.S. dental therapy tend not to report problems

or issues with programs such as New Zealand's and Canada's.<sup>4-6</sup> To accept most papers in our domestic literature supporting dental therapy in the United States is a matter of faith over fact.<sup>7-10</sup>

The failure of New Zealand's program to adequately address minority oral health, oral health in young children, and to have health outcomes no better than those of the United States after almost 100 years, are not reported (except, thankfully, by the New Zealand government).<sup>4,5</sup> Canada's now truncated program is never mentioned in terms of its failure to overcome financial problems.<sup>6</sup>

The recent Kellogg study of the Alaska program was published in late 2010.<sup>11</sup> The concerns of organized dentistry and the numerous qualifications and limitations of the impartial Kellogg-contracted research group, RTI, are ignored. Numerous groups opposed to a DHAT model have expressed the scientific honesty to say they would look fairly at meaningful data, but to date, that kind of information remains elusive.

**What is a likely scenario for dental therapy?**

Imagine the following scenario. A state creates a pathway for dental therapists. Training programs spring up not only in that state, but perhaps in adjacent states, based on the argument that there is fertile ground for employment and need for increased access. However, a small dispersed rural population, a crumbling dental safety net infrastructure, high poverty in urban areas and poor overall economy limit employment opportunities.

Therapists are initially locked by statute into public health service, some find employment, but the state's financial woes cause rationing of care in the public sector, and shrinking opportunity. Even with the lower cost of the dental therapist, the mix of uninsured and Medicaid patients dooms any permanent solution, because of inadequate reimbursement. Cost shifting that would be available in a private practice, dentist-based system is not possible.

Cultural obstacles to care; i.e., beliefs and attitudes about dental care, care-seeking behaviors, continue and dental therapists sit idle or revert to simple low reimbursement hygiene procedures. Ultimately, the therapists challenge their servitude to public health and the state acquiesces, as did New Zealand and Canada, allowing dental therapists to migrate to the highest-paying employers in the private sector. Even here, they remain underutilized due to the small size of most practices, patient desires to see a dentist, and the necessary service mix to maximize revenue. As with expanded function dental assistants, only larger practices will look to employ dental therapists.<sup>12</sup> Training programs will contract or close. Like the independent dental hygienist, the dental therapists in the state will spend a few years in practice and slowly disappear. Access will not have improved.

Unfortunately, for this scenario to play out, it will take a couple of decades that will delay a real solution to dental access for children. In medicine, physician-

extenders have found a place, but have not solved access-to-care issues. We may be doomed to repeat the experience of medicine.

**A national view of access: the alchemy of dental therapy**

Most states will never allow dental therapists because of the financial and political capital expenditure needed to implement and the absence of the geographic imperative that supports dental therapy in Alaska. The limited penetration of expanded-duty dental assistants (EFDAs) in the United States and the anemic performance of independent dental hygiene practice predict the failure of dental therapy. There is even question whether the state Department of Education would bless an educational program without likelihood of employment of its graduates.

The history of access to dental care is really the story of Medicaid, public funding and the cultural abyss separating the dental profession's view of oral health and desired health behaviors, and the reality of being poor in America. Address these three issues and one can fix access, but that is easier said than done. Medicaid's problems will ultimately doom solution to oral health care access — with or without dental therapists. In many states, the Medicaid monster has devoured large parts of budgets, often to the detriment of higher education.<sup>13</sup>

The appetite of states for dollars has already affected many dental education programs.<sup>14</sup> It is difficult to foresee the ultimate mutation of Medicaid, but clearly, its reliance on a bankrupt federal government, and with a majority of states in dire and perhaps intractable financial straits, it doesn't take a genius to see what will happen, particularly as health care reform kicks in, throwing more high disease-acuity patients into the underserved pool, a problem medicine dreads, and which is equally daunting for dentistry.<sup>15</sup>

Idaho recently disenfranchised 140 large Medicaid dental providers and adult dental services are caught up in the tsunami of service reduction.<sup>16</sup> Medicaid fees will not increase appreciably, services will continue to be rationed, and the percentage of participating dentists will continue to decline. Even the best-intentioned states will continue to attempt "access alchemy" to increase care by contracting Medicaid operations to save money to HMOs who ration care and siphon precious care dollars for administrative profit. Some states may even choose to seek other options because the federal contribution to Medicaid, while alluring, is being seen more and more a millstone rather than a blessing. This is all happening in spite of unprecedented use of emergency departments for dental infection and emerging linkages between child and maternal caries status, and the science pointing to the associations between oral health and systemic health.

The bottom line on access is money. The alchemy of improving access to dental care without increasing Medicaid dental expenditures has drawn dental

therapy into its formula, but ignores the real issue related to improved access and, as such, we divert attention from the really difficult work of finding sustainable funding solutions.

**Lingering questions, few answers in the dental therapy and access debate**

The Pew Foundation's determination of the pivotal role of dental therapy as an indicator of state grades for access, when dental therapists have been in place for one to two years in the state, perhaps, is the most egregious example of the confusion of the dental therapy discussion.<sup>3</sup> There are many others. For example, Minnesota's model requires that therapists treat special needs patients. Nash, a leading proponent of dental therapy, stated that therapists should treat children because they are, by and large, healthy, while adults have more medical problems.<sup>17,18</sup> The reality is that about one in six children has a special health care need. Nash also maintains that most services needed by children are preventive, which is true, but these can be addressed in most states by dental hygienists, questioning the need for dental therapists.

No one in this country has adequately addressed the shortcomings of the New Zealand experience and how a U.S. system would address the failure to adequately care for the very young and minority children. In the United States, the caries problem is clearly cited in these populations.<sup>19</sup> No one has proposed how a therapist system would be able to address restorative care for preschool children with treatable caries needing sedation and hospitalization.

Perhaps more perplexing, and a problem the New Zealanders seem to have recognized recently, the nature of dental caries, once established, becomes difficult to eradicate.<sup>4,20</sup> Ironically, a fact widely touted in promotional U.S. literature about the New Zealand system is that by the end of the school year, all the carious lesions in children have been restored. Am I the only one asking the question why there is so much new decay every year in this highly touted oral health care system?

A dental therapist system, whether in the United States or New Zealand, based on restoration of teeth of older manageable children, perhaps in schools, will not improve oral health. The experience of the Indian Health Service and its failure to restore away early childhood caries should be a warning for those who believe dental therapy will improve oral health in high disease children.<sup>21</sup>

While we dream about restoring away early childhood caries, we fail to address the growing realization that the solution to dental caries in children is not biological but systemic in its broadest sense. Recent caries initiation models and large-scale studies suggest that we need to delve deeper into all strata of society to cure this ill.<sup>22,23</sup> The dental therapy debate only distracts us from a concerted effort to alter behaviors and truly prevent disease.

Finally, no one appears to be addressing the convergence of dental therapy with problems funding oral health services, a very weak and rapidly deteriorating safety net, rapidly declining dental faculty numbers, up to 20 proposed new dental

**See DENTAL THERAPY, page 11**

The dental therapy debate only distracts us from a concerted effort to alter behaviors and truly prevent disease.

**DENTAL THERAPY, from page 10**  
schools, placement of thousands of dental students in community settings, the shifting of public dollars away from higher education, dramatic and ever-increasing dental student debt, and growing poverty in this country.<sup>24,25,13</sup>

Even the esteemed Institute of Medicine appears to be content to look only where it wants to as it reviews the U.S. oral health care system. Truly, the discussion on access to dental care for children is a tower of Babel.

My work and that of my faculty colleagues and residents every day is caring for poor, minority and special needs children and adults — about 50,000 patient visits for our small department each year, about as many as a mid-sized dental school. For us, the dental therapy debate is a distraction at best and at worst, a threat to the vulnerable children in our dental home.

In Ohio, in 2009, a taskforce commissioned by the state's director of health, comprising public health and private practice dentists, dental hygienists, physicians, child advocates and other stakeholders, relegated the study of midlevel practitioners to its lowest priority among a host of strategies to improve access.<sup>26</sup>

Nationally, we should follow that lead and move on to real solutions.

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## The Explorer

Matthew J. Messina, DDS  
Executive Editor

### The right answer's been there all along

I spent a great deal of time talking to reporters recently concerning access to care issues in Ohio and nationally. One particular reporter was well versed in the proposal of UHCAN-Ohio to push for a mid-level provider position, commonly known as a Dental Health Aide Therapist (DHAT). This effort is being strongly supported in Ohio and four other target states by the Kellogg Foundation.

This reporter certainly meant well. She had heard that there were people in Ohio, many of them children, who suffered from dental disease. This is painful, and is a known risk to their overall health. It is sad that this should be the case in a country as prosperous as the United States. She had a big heart, and she wanted to have us "do something" to make it better.

The more I talked to her, I realized that I was having the same type of discussion I always seem to have with people on most of the issues in dentistry.

*"Well Doctor, what's the best way to prevent cavities and gum disease?"*

*"Research has shown that brushing, flossing and seeing your dentist twice a year is the most effective way to prevent decay and periodontal disease."*

*"But Doc, isn't there some kind of pill (or new laser procedure, or herbal remedy) ... that will prevent the problem?"*

*"As exciting as emerging research is*

*on the connection between good oral health and overall health, we know that excellent oral hygiene – that is brushing and flossing and seeing your dentist at the proper interval – is the key to success."*

*"And Doc, I saw on TV that there is this new diet (or pill, or whatever) that will make weight loss easy. What do you think?"*

It's not sexy, but the right answer sometimes is right in front of us. **"Well, we believe that eating less and exercising more is the most successful way to weight loss and a healthy life."**

My reporter friend was trying to help, but in her world, and the world of many in Columbus and Washington, DC, when a problem is identified, you have to find a solution. That solution almost always involves creating a new program to fix it. In this case, creating something new is exactly the wrong thing to do.

The American public today expects the highest level of dental care in the world. They are not ready to accept a two-tier system, one in which a part of the public will receive a lesser standard of care and private pay patients will get to see the dentist and have a higher level of treatment. Any way you cut it, a DHAT is a lesser trained professional by definition, and will provide services that the patient will perceive as being of a lower quality. If they could see the dentist, they would choose to do so, which will make them resent their situation if they are forced to see the DHAT. That's not a good place to be, and luckily, that's not a choice we have to make as a society.

The biggest risk in the DHAT proposals is that they divert scarce resources in funding from where they can produce the best results. In an effort to do something good, the DHAT program will siphon away millions of dollars that otherwise would be used to provide the care for the populations at risk for dental disease.

The DHAT training programs do not exist in Ohio, and would need to be developed. That takes time and money. Students would then need to be attracted to enroll in the DHAT programs, and be trained. In a perfect world, it would take at least two years to create the curriculum and develop the training programs to begin to enroll the first DHAT class.

Adding the training time of about two years, we are now into more than four years, and we have yet to place the first person to alleviate the "access crisis" that exists now.

We have an existing system in place to meet the needs of the citizens of Ohio. Dentists are willing and able to treat patients. Expanded function dental assistants (EFDA) and registered dental hygienists (RDH) are trained and currently available as members of a well organized dental team. Existing training programs for EFDAs and RDHs have sufficient capacity to increase the number of auxiliaries if the needs increase. Hygienists are allowed by Ohio law to treat patients in public health settings. All the pieces we need are currently available. All we lack is proper funding for dental care for the public assistance population, and a reduction in the burdensome bureaucracy administrating that care.

I guess it is a good thing that we dentists have become very talented at

**See MESSINA, page 13**

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## It's Your Choice

Robert Buchholz, DDS  
Guest Columnist

### Revolution

*"This country with its institutions, belongs to the people who inhabit it. Whenever they shall grow weary of the existing government they can exercise their constitutional right of amending it, or their revolutionary right to dismember or overthrow it."*  
Abraham Lincoln

These words, and for me that's all they are, may or may not have been Lincoln's. I haven't seen the document or any other evidence that verifies the quote's authenticity. Nonetheless it's out there in cyberspace.

Indeed, cyberspace is garnering credit for hastening the changes of several governments of late. Those cyber elements receiving revolutionary recognition include Google Earth, Facebook, YouTube, and Twitter.

Years from now, hopefully the Egyptian child supposedly named "Facebook" by her revolutionary parents will mature, and can have her own mini-revolution by changing her name to something more practical.

Patients constantly inquire if I'm on Facebook. I facetiously answer, "What drug is that?"

I finally yielded to their requests. I was listed for less than 24 hours when I had a family revolution on my hands.

My youngest daughter informed my wife, myself, and her sisters that she was pregnant with her third child and most importantly my fifth grandchild. That night I proudly posted my first Facebook entry, "Pop Pop is going to be a Grandpa again. Ain't life grand?"

Being on Facebook is like handling nitroglycerin – always read the instructions before using. I had no idea that depending on my particular settings, any post I make can be like playing the game "Five Degrees of Kevin Bacon."

Other people could find out before my daughter could tell them by her preferred means of communication. I'm so ancient, she probably wished I had used Morse Code. Indeed, looking back, perhaps that was the first use of cyberspace?

Facebook was also responsible for an office insurrection a few years ago. I added an addendum to the office handbook which stated that Facebook and other online activities would be limited to non-office hours, and continuing such activities could lead to termination.

An oral surgeon colleague of mine recently dismissed an employee whose typical eight-hour work day consisted of four hours of Facebook surfing. He stated that she truly believed her behavior was normal and acceptable. Get used to asking references of potential new hires about their employee's cyber habits.

A decade ago who would have expected this type of chaos in the office?

Revolutions thrive on chaos.

Little did I know when I wrote about mid-level providers, that the Kellogg Foundation had targeted Ohio to be one of five states incorporated into their dental provider revolutionary model. Nor did I know about a website, www.xtranormal.com, until my nephew sent

me a YouTube video titled *Typical Dental Hygiene Patient*.

This Canadian company's motto is "If you can type, you can make movies" (and chaos). They claim to have helped in the creation of over 10 million projects. I have to admit at first blush the video made me laugh. The company is very careful to state that even though you make the movie, "all content is the property of xtranormal." And by the way, "they have very limited control", if any, over the "quality, safety, morality, legality, truthfulness, or accuracy of the various aspects of the service."

I used to think dental insurance companies had strong "Hold Harmless" clauses!

Obviously, just like dental insurer's contracts, members of our profession have no problem with this company's hold harmless clause and proceed with abandon to expose themselves to risks.

Other dental YouTube movies include: *Periodontist vs. Dentist, Specialists vs. General Dentists, Dentist vs. Doctor, Endo vs. Endo, Ortho vs. GP, The Average Patient (viewed as of this writing 131,000 times), Ghetto Patient, If Dentists Spoke Their Minds, and OS vs. Perio*. The author of the latter project did it because it is the most obvious "rivalry in dentistry."

I'd be naive to state that the content of these videos hasn't been or won't continue to be topics of discussion at a bar, country club, CE course and other professional settings. I'm not going to prevent it from happening because it's human nature. If there's any venue for this type of gossip, let it be there. I'd rather it be nowhere.

These attempts at contemporary humor would be X-Rated by any movie critic other than Charlie Sheen.

I'm amazed at how well we manage

**See BUCHHOLZ, page 13**

## ODA Today

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## Between the Lines

Ken Jones, DDS, JD  
Guest Columnist

### Duck waddle

*"Orthodox medicine has not found an answer to your complaint. However, luckily for you, I happen to be a quack."*

Richter cartoon caption

The Internet is wonderful. There is a ton of great information out there, just waiting for the right search engine to find it. There's also a ton of total crap, and, for our patients, it's sometimes difficult to tell the good from the bad.

Actually, some dentists have the same difficulty – and a number of them contribute to the problem as well.

Here are some Web advertising headlines (the perpetrators of which shall remain anonymous unless you want to search them out) patients asked about:

"Mercury Removal Protocol ... Mercury Free Practice. Mercury Removal Detox, Applied Kinesiology, mercury filter & Living air filter (ion generator & ozone generator)." "TMJ Kinesiology ... Dental Homeopathy. Safe removal of toxic fillings, crowns and root canals. Biocompatibility testing for new materials. Alternative root canal treatment. Headache therapy."

"Aromatherapy, acupuncture, reiki, massage chairs." "Multi-disciplined health care model that has been influential in improving autoimmune diseases such as MS, Lupus, Parkinson's, and Alzheimer's. Other symptoms such as chronic fatigue, depression, and memory and digestive

problems have also responded."

"Cavitation surgery, Root canals causing cancer. Sterilize jaw bone with a magnet pulser ..." "Dentistry extends into the bedroom. It affects your sex life and sexuality. Extended to the uterus, breasts and testicles, male and female are both vulnerable to toxic invasion. Menstrual cycles, pregnancy and birth defects are a package deal under the control of your dentist - and he hasn't the first clue."

At least one of these website dentists has lost his license to practice dentistry over his outrageous claims. However, he's still out there, spreading his garbage, but now with a disclaimer that says he isn't giving dental or medical advice.

Others – including some in Ohio – continue to prey on the hopes and fears of a gullible and desperate public by using the very same tactics. And why not? It's profitable; very. Then again, it pays very well, too. And did I mention that you can make a lot of money selling this point of view to unsuspecting patients, usually under the guise of "alternative" or "holistic" dentistry?

Just because it's called alternative and holistic, it still needs good science behind it – not just a self-published and self-promoted point of view, totally out of the mainstream of good research and independent review. Things like mail order diagnosis of almost any disease by "analysis" of hair, blood, and other body fluids, (even when it's chicken blood), promised cures of MS, Parkinson's and Alzheimer's diseases, and badmouthing good dental treatment just don't fit those necessary criteria.

A wise man once told me, "If it walks like a duck, and looks like a duck, and smells like a duck, it probably sounds like a duck, too." And what you hear is what you get: "Quack, Quack!"

Dr. Jones may be reached at [jonesdds@aol.com](mailto:jonesdds@aol.com).

MESSINA, from page 12

giving correct, but boring, answers to questions. In this case, if the question is "What can we do to resolve the problem of getting children and adults access to proper dental care," the right answer is to do what we have been telling people all along. "Let the current system work. It's the best in the world. We have the people and training in place that we need. All we need is the proper funding – it works wherever it is tried! Don't spend money and waste time reinventing the wheel."

It may not be sexy, but sometimes the right answer is so simple, it's been there all along.

Dr. Messina may be reached at [docmessina@cox.net](mailto:docmessina@cox.net).

BUCHHOLZ, from page 12

to poke ourselves in the eye and aren't aware we've done it. Technological innovation doesn't necessarily result in products that lend themselves to truth or fact.

Xtranormal Inc. couldn't care less about the survival of the dental profession or any other profession. They'll enjoy idiotic projects and profit from them. And if these projects produce chaos, well ... I believe someone once said, "a little revolution every now and then can be a good thing."

Right?

Dr. Buchholz may be reached at [rbuchh@windstream.net](mailto:rbuchh@windstream.net).



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## Bureau of Worker's Compensation announces quarterly training courses

Dentists and their staff can attend one of the more than 60 occupational safety, health and ergonomics courses offered by the Ohio Bureau of Workers' Compensation Division of Safety & Hygiene.

These courses are offered through the training center in Pickerington at the Ohio Center for Occupational Safety and Health (OCOSH), as well as at branch sites and BWC service offices across the state, including Toledo, Cincinnati, Canton, Cambridge, Portsmouth, Youngstown and Cleveland. Employers may enroll any number of employees at no additional cost. A number of courses are also available as online learning opportunities.

The division offers courses at no extra cost to Ohio employers with active workers' compensation policies. To enroll or learn more about the courses available April - June 2011, including the online courses, visit the BWC Learning Center at <http://www.ohiobwc.com/employer/programs/safety/SandHEducation.asp>. For a listing of courses, more information or to register, call 1.800.OHIOWBC or visit the Website listed above.

## In other BWC news

The BWC Provider Relations area is doing a recruitment effort and mailing a flier to nearly 6,000 Ohio dentists, with some limited phone follow-up as well. The recruitment efforts will be strongest in Coshocton, Hocking, Jackson, Noble and Vinton counties where there are no dentists certified with BWC in Ohio.

Additional information on provider services is available online at [www.ohiobwc.com/provider/default.asp](http://www.ohiobwc.com/provider/default.asp) or by phoning provider relations at (800) 644-6292 and choosing option 0-3-0.

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## First Ronald McDonald Care Mobile dental unit in state helping underserved children in northeast Ohio

**Kathy L. Woodard**  
Staff writer

A partnership between the Irving and Jeanne Tapper Pediatric Dental Center at University Hospitals Rainbow Babies & Children's Hospital in Cleveland and the Ronald McDonald House Charities® (RMHC) of Northeastern Ohio is well underway and hundreds of underserved children in northeastern Ohio counties are getting needed dental care.

The result of this collaboration is a 42-foot, 32,000 pound, 3-chair mobile dental unit – the first Ronald McDonald Care Mobile in Ohio. Awarded in 2010, this unit is the 40th given since 2000 through the worldwide Ronald McDonald Care Mobile program.

Dr. Gerald Ferretti, Chair of the Pediatric Dentistry Department at the Case Western Reserve University School of Dental Medicine and Chief of Dentistry at Rainbow Babies & Children's Hospital, was instrumental in making this happen. Components of the mobile unit were planned for and designed by Ferretti and others involved with this project, and took about 18 months to complete.

"I've had an affiliation with the Ronald McDonald global charities for about 10 years, and had the opportunity to 'build' two other units when at the University of Kentucky."

Ferretti, who oversees general operations of the new dental unit, said when he arrived at the Case dental school five years ago, his vision was to have a mobile dental unit there by 2010. "We were able to accomplish that goal."

The cost of the Ronald McDonald Care Mobile (RMCM) was funded primarily through a \$355,000 grant from the global Ronald McDonald House Charities. Its operating budget is funded through RMHC of Northeastern Ohio and Rainbow Babies & Children's Hospital.

Children are seen in this unit at no cost to the family or guardian. For those with third party insurance such as Medicaid, the staff does submit reimbursement requests from the insurance provider accordingly.

In addition to providing care to underserved populations, the mobile unit is a training mechanism for dental residents and fourth-year dental students at the CWRU School of Dental Medicine. The mobile unit's attending dentist, whose hire is underway, will also be a faculty member at the CWRU dental school.

Supplementing the sizable grant from RMHC, other funding for operation of this mobile unit included a \$38,000 donation from an anonymous source; \$25,000 from Allen Smith, a private owner in the McDonald's® Restaurants of Northeastern Ohio; and \$10,000 from Charter One Bank. The remaining funding needed, nearly \$65,000, came from Rainbow Babies & Children's Hospital. In addition, significant donations and discounts of dental equipment and materials were provided by Henry Schein Dental and the dental division of Midmark Corp.

The unit is designed to meet the needs of 3-6 year old children – mostly in HeadStart programs, as well as individuals with special needs in northeast Ohio, Ferretti said. "This is part of our outreach programs and ties into access to care." According to Ferretti, treatment provided by fourth year dental students will provide them with training most dental schools in the U.S. don't offer: hands-on experience treating young children.

"This can hopefully encourage them to see younger kids when in their own practices," he explained.

Nadine Hayes, RN, BSN is the clinical manager with the care mobile and with Rainbow Babies & Children's Hospital, and has been involved with the project from its inception. She is also trained to drive the unit if the regular driver would not be available.

The mobile unit serves counties in northeast Ohio.

In addition to complete exams and preventive care, services provided in the three-operator unit include stainless steel crowns, extractions, space maintainers, pulpotomies, composite restorations and digital x-rays. The unit is designed for routine cleanings, as well, but according to Hayes, that is not its primary focus.

Since its first trip May 28, 2010 to a HeadStart school in Barberton, Ohio through the end of February 2011, Hayes estimates approximately 420 children have received treatment in the RMCM.

Children seen for treatment in the RMCM are first screened and diagnosed through CWRU or other outreach programs, after which the mobile unit is scheduled for treatment.

One such site recently was the Pro Football Hall of Fame during the ODA's Give Kids a Smile kickoff to treat children pre-screened and diagnosed in need of dental care. Fifteen children received restorative care that day, including 14 extractions, 1 crown and several multiple-surface composite restorations. The nearly \$6,300 in dental treatment was provided for free that day by residents Dr. Brian Hatch and Dr. Larry Kalke.

Ferretti said having the unit at the Stark County event was a great opportunity to showcase what it can do.

"We want to let individuals know what our purposes and goals are so that it can provide open access to children who don't have that access."

Providing care to special needs children is also an important part of the RMCM's mission, Hayes said. The mobile unit can travel to schools that serve special needs children and provide exams, cleanings and restorative care. This helps the children immensely, she said, in that taking this population out of their own environment to a private dental office or clinic can be cumbersome to them.

During the summer months, the unit will continue to partner with special needs schools, and serve programs such as the YMCA and year-round HeadStart schools, and other areas of need.

The Ronald McDonald Care Mobile is



Photo by ODA staff

Onsite at the Pro Football Hall of Fame during the ODA's GKAS kickoff event, the Ronald McDonald Care Mobile is on track to provide dental care to thousands of underserved children in northeast Ohio annually.

expected to be operating in northeast Ohio five days a week and treating a minimum of 6,000 children a year by 2013.

"We are on track and anticipate that we will be there meeting the needs of the community," Hayes said.

Below is a listing of Ohio's active mobile dental units posted online by the Ohio Dept. of Health at <http://www.ohiodentalclinics.com/database/piecharts.html>.

- Ohio State University Dental H.O.M.E. Coach (central and southeast Ohio)
- Dental Center of Northwest Ohio Smile Express Mobile Dental Center & HomeBound/Senior Mobile Unit (Toledo and Northwest Ohio)
- Humility of Mary Health Partners "The Smile Station" Mobile Dental Clinic (Mahoning County)
- Ronald McDonald Care Mobile (Northeast Ohio)
- Summit County Health District Mobile Dental Clinic (Akron)
- Third Street Community Clinic Mobile Dental Clinic (Mansfield)
- Zanesville City Schools Mobile Dental Clinic/Dental Health Program
- CincySmiles Foundation Mobile Dental Unit (Cincinnati)



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## Ohio Dentist Loan Repayment Program contract awards now in excess of \$560,000

**Liz Downey**  
Staff Writer

Several dentists across Ohio will provide care to underserved Ohioans and receive dental student loan repayment assistance through the Ohio Dentist Loan Repayment Program (ODLRP) and the Dentist Workforce Loan Repayment Program (DWLRP) this year.

### Ohio Dentist Loan Repayment Program

Created through an Ohio Dental Association legislative initiative in 2003, the ODLRP encourages dentists to practice in underserved areas in Ohio in return for loan repayment assistance. The program is funded by a \$20 surcharge on Ohio dentist license renewals.

A total of \$566,000 in loan repayment has been awarded since the first contracts for the program were signed in 2005.

Late in 2010, \$116,000 in loans were awarded through the ODLRP and \$40,000 in matching State Loan Repayment Program funding was awarded, totaling

\$156,000 in new and renewed contracts through the ODLRP.

Any dentist who meets the eligibility requirements may apply and if selected, could contract for a maximum award amount of up to \$25,000 per year for the first and second years participating in the ODLRP, and up to \$35,000 per year for the third and fourth years.

New two-year contracts were awarded to the following ODA member dentists for 2010-2011:

- Dr. Lawrence Gamby, working at the Clinton Memorial Hospital Dental Clinic in Wilmington.
- Dr. Eva Meszaros, in private practice in Zanesville.
- Dr. Rachael Michalak, working at the Dental Center of Northwest Ohio in Toledo.
- Dr. Gabriel Russo, with the Tuscarawas County Health Department Dental Clinic in Dover.

In addition, program contracts were renewed for the following dentists:

- Dr. Andrew Aderman, employed

at the Henry County Health Department in Napoleon, and

- Dr. Kyle Hensley, who is with the Dayton Pediatric Clinic in Dayton.

ODLRP contracts are awarded to dentists who agree to practice in dental health resource shortage areas as determined by the Ohio director of health, or federally designated dental health professional shortage areas (HPSAs). Areas with high population-to-dentist ratios have the greatest priority.

Other considerations include the applicant's background, career goals, length of time he or she is willing to provide dental services in a dental health care resource shortage area and amount of educational expenses for which reimbursement is being sought.

Applicants must be licensed general or pediatric dentists. Persons currently receiving National Health Service Corps (NHSC) tuition or loan repayment are not eligible.

ODLRP payments are made once yearly to the appropriate lending institutions.

Expenses eligible for repayment include all or part of the principal and interest of a government or commercial educational loan taken by an individual for expenses incurred while the individual was enrolled in an accredited dental college or residency program, including tuition, fees, books and laboratory expenses, as well as room and board in amounts determined to be reasonable by the director of health.

Clinicians must provide dental services at the dental health site(s) they have agreed upon, practicing a minimum of 40 hours per week.

Participants must agree to provide dental services for Medicaid-eligible persons and to provide dental care without regard to a patient's ability to pay.

Clinicians who fail to complete their service obligation according to the terms specified in their contract will incur a penalty.

The next ODLRP application process will begin in January 2012. For more information, visit the ODH Web site at <http://www.odh.ohio.gov/> or contact Mona Taylor at (614) 466-4180 or [mona.taylor@odh.ohio.gov](mailto:mona.taylor@odh.ohio.gov) or Sandy Brado at (330) 643-1300 or [sandy.brado@odh.ohio.gov](mailto:sandy.brado@odh.ohio.gov).

### About the Ohio Dentist Loan Repayment Program

- Since 2005, 17 Ohio dentists have contracted with ODLRP to treat Ohioans regardless of ability to pay.
- 10,870 patients were seen through ODLRP in 2010, for a total of 22,088 office visits.
- From 2005 through the end of 2010, more than 69,500 Ohioans in need of dental care have been seen through the ODLRP.

### Dentist Workforce Loan Repayment Program

The Ohio Department of Health also has offered an additional six dentist contracts totaling \$150,000 in loan repayment through the Dentist Workforce Loan Repayment program for the year. The contracts are for one year and can be renewed for two additional one-year terms – for a total of 3 years in the program.

The Dentist Workforce Loan Repayment Program (DWLRP) – differs from the Ohio Dentist Loan Repayment Program and the National Health Services Corps loan repayment program – as it was created and funded as a result of a three-year HRSA Workforce Grant awarded to the Ohio Dept. of Health last fall.

According to the ODH, the DWLRP was created as another program to help more dentists pay off their student debt and help underserved Ohioans.

The DWLRP awards contracts in the amount of up to \$25,000 per year (renewable to \$85,000 maximum) to general and pediatric dentists who work full-time in either a private practice setting or a Safety Net dental clinic in a federally designated dental health professional shortage area (DHPSA) in Ohio. The dentist must provide services to Medicaid-eligible persons and to all persons regardless of their ability to pay.

For more information on the DWLRP, visit the Ohio Department of Health Bureau of Community Health Services Web site at <http://www.odh.ohio.gov/> or contact Sandy Brado at [Sandy.Brado@odh.ohio.gov](mailto:Sandy.Brado@odh.ohio.gov) or (330) 643-1300.



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