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NEWS FOR THE GENERAL DENTIST

NOVEMBER 2019
VOL. 47, NO. 10



The Need to Screen

Diabetes in the Dental Office

New CDT Codes for 2020

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The Need to Screen

Diabetes in the Dental Office

By Jennifer Gibson

Diabetes is a chronic, incurable illness and a growing epidemic in the United States. According to the Centers for Disease Control, more than 30 million Americans have diabetes. In addition to serious health problems such as heart disease, kidney disease and vision loss, diabetes also has negative effects on oral health. Dentists are in a unique position to help detect this disease early by using simple, safe and inexpensive testing.

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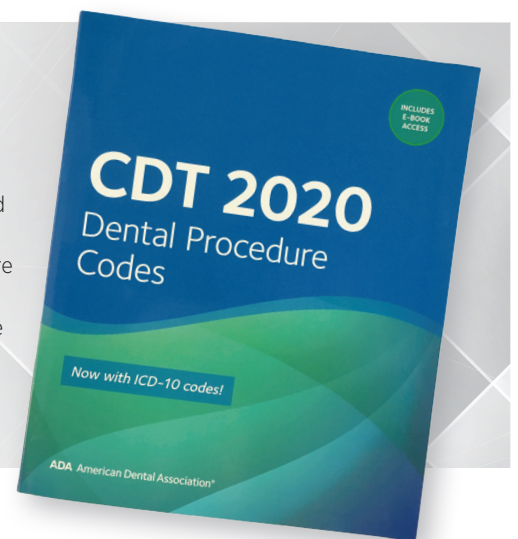
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By Caitlin Davis

A new year means a new edition of the American Dental Association Code on Dental Procedures and Nomenclature (CDT Code), and dentists have just two months left to review this year's updates before the new version takes effect. Learn about new codes pertinent to general dentists, how they were proposed and the process behind the CDT Code.



The Fight Against Diabetes

My battle with diabetes began 10 years ago. My brother, who is also my physician, discovered it during a routine checkup and started me on oral medications. This regimen worked well until I needed cardiac bypass surgery. Afterward, my surgeon prescribed injectable insulin to increase my body's healing ability. The artificial quadrupling of my body's insulin wrought havoc on my own insulin production. Subsequently, after a few months, a small infected hole in the plantar region of my foot became a major, painful and time-consuming undertaking. Sixty days of early-morning, two-hour barometric chamber therapy sessions and thrice-weekly wound care appointments gave me ample time to contemplate the importance of early prevention and diagnosis of diabetes.

“As healthcare providers, we must be cognizant of this disease and ready to refer our patients to their physicians for any life-threatening situations.”

I thought open-heart surgery was severe, but dealing with diabetes and all of its ramifications and sequelae has been a nightmare. As you can imagine, I am now adamant that we dentists can do more to combat this insidious disease. I have conferred with our AGD communications team to bring you articles about diagnosis, prevention, pharmaceuticals and the latest knowledge about diabetes in future issues of *AGD Impact*



and *General Dentistry*. As healthcare providers, we must be cognizant of this disease and ready to refer our patients to their physicians for any life-threatening situations.

This mission kicks off with this month's cover story, which addresses one important way we can prevent and manage diabetes: screening and subsequent referral. Diabetes was not prevalent when I

matriculated, but now we need all the tools in our arsenal to diagnose and refer patients for treatment. In future articles, I would like to provide our membership with more insight into this disease to empower you to help address this crisis.

Knowledge is powerful, and searching for knowledge from others is a basic principle of professional life. Helen Keller said, "Alone we can do so little; together we can do so much." As such, we must collaborate with physicians to gain a solid understanding of diabetes.

My emphasis on this struggle with diabetes may appear personal, but, every week as I receive treatment at the wound care clinic, I observe an increasing number of diabetic patients struggling with their healing. The clinic staff reports a twofold increase in diabetic patients in the last year — an alarming trend. As dentists, our goal has always been prevention, and we must extend this goal as much as possible for our patients' well-being. As we've stressed time and again in *AGD Impact*, we should think of ourselves as physicians of the mouth. So let's go a step further and join the fight against diabetes.

A handwritten signature in black ink that reads "Roger D. Winland". The signature is fluid and cursive, with the first letters of the first and last names being capitalized and prominent.

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Letter to the Editor

Don't Single Out DSOs

I am disappointed with a column in the July issue of *AGD Impact*, "How to Compete with Discount Dental Practices."

I understand the message the author is conveying, but I don't feel it was appropriate to single out "corporate" dental service organizations (DSOs) as the only practices advertising discounted, "subpar" services. Further, it was very offensive for the author to make the following generalization: "Most patients don't know the difference between a private, quality dental practice and corporate dentistry."

These patently false, divisive and inflammatory comments are not promoting unity in organized dentistry, and, in my opinion, they go against the mission of AGD. The dental practice model is evolving, and it's important for us to work together to ensure that we continue to maintain high standards in the profession, despite the setting in which we work.

The quality of a dental practice is not based on the business model "private vs. DSO." Generalizations about one being superior to the other are inappropriate. I have worked for my group for over eight years since finishing dental school and an advanced education in general dentistry program. My organization prides itself in providing high-quality, personalized patient care with modern technology. It provides abundant resources for continuing education, mentorship and practice management.

This is a good reminder for AGD to remember its member base is diverse, and further division of this nature may cause

dissatisfaction and loss of membership. I am proud to be a member of AGD, but I would like to see more respect for various practice models.

William G. McBride, DDS, MAGD

Iowa City, Iowa

Response from the Author

Hi Dr. McBride,

I'm sorry to hear of your disappointment with our article on competing with discount dental practices. You are absolutely correct that corporate DSO practices are not the only ones offering discount dentistry and, just like in private practices, the quality of the practice can run the gamut.

It's getting increasingly difficult to attract new patients across the board — for both private and DSO practices. In our experience working with private practices, we've seen many instances of DSO practices getting aggressive with discount dentistry as a tool to attract new patients, making it hard for experienced, high-quality private practices to compete. While not being clinicians ourselves, the feedback we generally receive from private practices — whether right or wrong — is that patients just aren't treated with the same care and competency as their corporate counterparts. This certainly isn't absolute, but it is what we hear more often than not.

The biggest point I'd like to make is that — whether you're a private practice or a DSO — the more we use aggressive offers to attract new patients in our industry, the more we're teaching these patients that looking for a new dentist is no different than price-shopping for any product they can buy from 100 different retailers, when this can't be further from the truth.

Jackie Ulasewich Cullen

Co-Founder of My Dental Agency



Awards

Fellowship, Mastership, Lifelong Learning and Service Recognition, and the 2021 Dr. Thaddeus V. Weclaw Award

Applying for AGD Fellowship, Mastership or Lifelong Learning Service and Recognition is a clear way to reflect your ongoing commitment to providing quality care to patients through the pursuit of continuing education. Download the applications at agd.org, or contact awardapp@agd.org. Applications must be postmarked by Dec. 31, 2019.

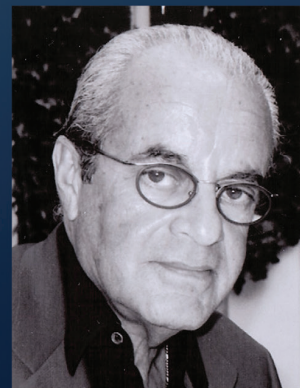
AGD is also accepting nominations for the 2021 Dr. Thaddeus V. Weclaw Award. Named for founder Thaddeus V. Weclaw, this prestigious award is given to an individual who has made outstanding contributions to the art and science of dentistry or has enhanced AGD's principles and goals and made exceptional efforts in promoting these ideals. To nominate a deserving colleague or educator, contact education@agd.org, and request a nomination form. The nomination deadline is Dec. 1, 2019.



DR. CARL F. GUGINO

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Orthodontics and Myofunctional Therapy, Pontarlier, France
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The Raphael Center for Integrative Orthodontics, Clifton, NJ
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Advocacy

AGD Attends Two National Legislative Conferences

AGD leadership and staff exhibited at two national conferences in August — the annual National Conference of State Legislatures (NCSL) Legislative Summit and the American Legislative Exchange Council (ALEC) Annual Meeting — where state legislators from across the country discussed current legislative issues.

AGD government relations staff members were joined by AGD congressional liaison Mike Bromberg, DDS, at the NCSL Legislative Summit and Gordon R. Isbell III, DMD, MAGD, at the ALEC Annual Meeting to provide general information about AGD, speak with legislators about matters relating to oral health and general dentistry, and discuss specific issues legislators may have in their state and how AGD can be a partner to help solve them.

Both events are opportunities for legislators to gather and discuss state policy and potential solutions to



Dr. Bromberg (right) with New Jersey Assemblyman Herb Conaway.

prominent issues. Organizations and other parties of interest attend to share information, network and connect. AGD values these opportunities to interact with elected officials and discuss the significant role AGD member dentists play in local communities as well as work to solve issues related to oral healthcare. Between both conferences, AGD representatives spoke directly with hundreds of legislators and staff from more than 30 states.

Partnerships

AGD, AAFP and AADE Developing Diabetes Toolkit

AGD is developing an online toolkit to help members access resources related to diabetes awareness and diagnosis. It includes a series of videos to educate members on when and how to perform a blood sugar (A1C) test on patients at risk for diabetes or prediabetes. The effort, supported by a Colgate educational grant, is the result of a partnership with AGD and the American Academy Family Physicians and the American Association of Diabetes Educators. The organizations have been working to identify those at risk and to improve outcomes. To learn more, go to agd.org/diabetes.



AGD Foundation

AGD Foundation Hosts Interdisciplinary Oral Cancer Summit

On Aug. 16, the AGD Foundation hosted an Oral Cancer Summit at AGD headquarters in Chicago. The summit was facilitated by AGD Foundation Immediate Past President W. Mark Donald, DMD, MAGD, and included representatives from participating organizations in dentistry and medicine. The aim of the summit was to share information regarding the treatment and management of oral cancer patients from the perspective and knowledge base of each organization. Another goal is the development of a standardized interdisciplinary toolkit for dental and medical providers to use in oral cancer case management.

During the summit, each representative was given the opportunity to share current advances and obstacles facing their fields. Attendees brainstormed solutions to shared problems and volunteered to share information-based resources to fill gaps in each organization's capabilities. Throughout the day, the discussion focused on how to better serve and provide for patients through better interdisciplinary cooperation, optimized information-sharing, standardized timelines and protocols, and, above all, increased oral cancer awareness throughout the dental and medical professions.

The efforts of this group are ongoing, and AGD will continue to share updates and pertinent information with the general dentist community. The group will continue to meet in person or via teleconference, and representatives from other pertinent organizations will be added as they are identified. Attendees at the



summit included AGD Foundation President Carol A. Wooden, DDS, MAGD; Wanda C. Gonsalves, MD, of the American Academy of Family Physicians; Derrick T. Lin, MD, FACS, of the American Academy of Otolaryngology — Head and Neck Surgery; Ann-Christine Nyquist, MD, MPH/MSPH, of the American Academy of Pediatrics; Mohammed Qaisi, DMD, MD, FACS, of the American Association of Oral and Maxillofacial Surgeons; Karen Pitman, MD, FACS, of the American Head and Neck Society; Alexander T. Pearson, MD, PhD, of the American Society of Clinical Oncology; and Dena Fischer, DDS, MSD, MD, of the National Institute of Dental and Craniofacial Research.

NEXT YEAR, INVEST IN YOURSELF

Here are some of the speakers you can
look forward to seeing at AGD2020:

Janice A. Townsend, DDS, MS
Pediatric Dentistry

Thomas A. Viola, RPh, CCP
Pharmacology

Jim Grisdale, DDS
Periodontics

Timothy F. Kosinski, DDS, MAGD
Implant Placement and Laser Dentistry

Joshua Austin, DDS, MAGD
Social Media and Restorative Dentistry

David L. Roberts, DDS
Oral Surgery

Jessica Wilson, MPH
Infection Control

Gigi Meinecke, DMD, FAGD
Facial Esthetics, Botox and Dermal Fillers

Steve Carstensen, DDS
Sleep Medicine and Special Patient Care

Please note that speakers are subject to change.



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AGD Foundation

AGD Foundation Continues to Fight Oral Cancer

The AGD Foundation is strongly committed to promoting oral cancer awareness, risk factor prevention and diagnostic training for general dentists that uses the best technology and clinical judgment. Oral cancer can be devastating if it is not diagnosed and treated in its early stages. Dentists are uniquely positioned to serve as the first line of defense against this potentially life-altering disease. Here's how you can help.

AGD Foundation Grants Available

Since 2012, the AGD Foundation has awarded grants totaling \$216,109. We are proud of the support we have provided and look forward to supporting AGD constituencies, regions and nonprofit organizations across the United States and Canada.

The AGD Foundation Grant Program offers financial support to community-based outreach programs in the United States and Canada that provide free oral cancer screenings and education to the public. Grant applications for 2020 are available online at agd.org/agd-foundation/our-programs/agd-foundation-grant-program, and the application deadline is Dec. 1, 2019. AGD constituencies are encouraged to apply. Applicants will be notified of award decisions in March 2020. If you have questions, contact the AGD Foundation at foundation@agd.org.

Share Your Plans for Oral Cancer Awareness Month

We want to know how you will promote Oral Cancer Awareness Month in April 2020 and throughout the year. Send photos or stories about your events to foundation@agd.org, and we will share your efforts with AGD membership. If you're interested in learning how to host an oral cancer screening in your community during Oral Cancer Awareness Month, email foundation@agd.org.

Support the Mission of the AGD Foundation

Your donation will help expand low-cost educational offerings to AGD members that cover early detection techniques for cancers of the mouth, tongue and throat. Your gift will also help

enhance public awareness of the general dentist's role as the first line of defense against this deadly disease through public service announcements and patient education tools. Please make a tax-deductible donation with your AGD membership dues renewal or online at agd.org/donate/foundation.

The AGD Foundation is a 501(c)(3) charity; gifts to the AGD Foundation are fully deductible for federal income tax purposes, subject to the limitations placed on charitable gifts by the IRS. Check with your tax professional or attorney for specific, allowable deductions in your state.



Leadership

Donald Elected ADA Speaker of the House

W. Mark Donald, DMD, MAGD, from Louisville, Mississippi, was elected Sept. 9 as speaker of the American Dental Association's (ADA's) House of Delegates. Donald's installation took place in San Francisco at the ADA FDI World Dental Congress 2019. Donald is immediate past president of the AGD Foundation, a past AGD president and a past AGD speaker of the house.

The House of Delegates, as the ADA's legislative and governing body, is the organization's highest authority. The 473 voting members of the House of Delegates are chosen

by the 53 constituent societies, the five federal dental services and the American Student Dental Association. As the speaker, Donald will preside over the legislative body.

Donald has served as a delegate in the ADA's House of Delegates and on the ADA Council on Dental Practice. He is also a past speaker and president of the Mississippi Dental Association and was named its Member of the Year in 2009.

Donald earned his dental degree from the University of Mississippi School of Dentistry in 1988.



Dental Assistants

AGD Dentists Weigh in on Value of Dental Assistants to the Dental Practice

AGD members were among the nearly 3,000 participants who recently weighed in on the value of dental assistants to the dental practice as part of new research commissioned by the Dental Auxiliary Learning and Education Foundation, an affiliate of the Dental Assisting National Board. The results of the survey, "The Value of Dental Assistants to the Dental Practice," highlight the many ways assistants contribute to the dental practice.

AGD dentists overwhelmingly agreed that dental assistants were integral to their practices. Over 90% agreed that assistants contribute to productivity, team synergy and patient retention. In addition, 88% agreed or strongly agreed that an effective assistant helps them not become burned out, and 90% agreed or strongly agreed that an effective assistant makes it more likely that a patient will accept dentist-recommended treatment.



Not surprisingly given AGD's mission, 87% of AGD dentists agreed or strongly agreed that continuing education (CE) is critical to maintaining assistants' skills and that assistants who complete CE are more likely to contribute to the profitability of the practice. AGD dentists also said the five most important qualities in assistants are having good patient care skills, being a team player, being willing to learn, taking ownership of their work and showing initiative.

To view the full report, visit dalefoundation.org/research.

AGD Fact Sheets

Talking to Patients About Periodontal Disease

AGD fact sheets provide your patients with all of the information they need to maintain their oral health. Fact sheets on more than 25 oral health topics are available for downloading online and can be customized to include your name and practice contact information.

Download the fact sheet "What You Should Know About Periodontal Disease" at agd.org/factsheets.



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Practice-Building in Small-Town and Rural America

By Roger P. Levin, DDS

Big cities often hold the allure of big success — more people means more money, right? While an urban environment can be lucrative, certain realities hold true about practice-building regardless of location. Although small-town and rural practices don't see the constant stream of potential patients walking past their doors, that doesn't mean they can't enjoy success. By maximizing connections within their communities, these practices can devise strategies that will allow them to thrive.

Small-Town and Urban Similarities

Worldwide, all dental practices share some similarities. I have visited dental practices in 26 countries, and, in every practice, dentists must get to the office on time every day, hire staff, treat patients, address emergencies, deal with dental insurance, pay bills and order supplies. This means that the systems to address these issues also have similarities. The number of new patients; active patients; cases accepted; average production per patient and per new patient; and several other key statistics will all determine a practice's level of success.

Advantages of the Small-Town Practice

While urban practices may benefit from a greater influx of new patients, small-town practices can hope to maintain more long-term patients. There are factors that only small-town or rural dental practices can take advantage of, including:

- **Easily building strong relationships with patients.** Urban populations are generally more transient. In my observation of many small-town and rural practices, I have found that many patients have lived in communities for generations. Therefore, the active patient attrition rate is much lower. Levin Group data indicates that the larger the active patient base, the higher the practice production.



- **Staying involved in their communities.** Many urban practices aren't located where the dentists and staff members live, making it more challenging for them to be involved in their patients' community. In small-town and rural dental practices, dentists and staff often live in the same community as the practice, and they already know people and business owners and are familiar with local schools. As the dentist and team become better known in the community, they should have a comprehensive marketing plan regarding community interaction. Many practices achieve this by participating in health fairs, supporting and sponsoring school activities, making presentations at senior centers and working with active charities in the community.
- **Getting to know patients on a deeper personal level.** When many people work and live near the dental practice, it becomes easier to get to know patients on a personal level. I recommend that practices maintain a personal information form for every new patient that includes topics for conversation such as occupation, hobbies and interests, community involvement, travel and favorite restaurants. Many patients will have friends and family members who also come to the practice, which further increases the opportunities to deepen relationships and earn referrals.
- **Focusing on internal marketing.** It is often easier for patients in small-town or rural areas to refer others to the practice because they know many others in a reasonable proximity to the dental practice. Let patients know on a regular basis that you appreciate referrals, and reference this in all marketing communications.
- **Maximizing on the potential for positive reviews.** Because of the deeper relationships small-town and rural practices often have with patients, asking for reviews is often all it takes to get patients to follow through. I find it is easier to motivate patients to leave reviews in these practices versus those in large urban areas, where people are more likely to be inundated with requests for reviews by other businesses.

The distinct advantages that allow small-town and rural practices to market and communicate with patients differently than their urban counterparts create brand penetration in the community and increase referrals. Never underestimate their potential for success. ♦

Roger P. Levin, DDS, is the founder and CEO of Levin Group, a dental management consulting firm. To comment on this article, email impact@agd.org.



The Value of the Dentistry You Deliver is Much Greater than Patients Realize

By Gary Kadi

This column is sponsored by CareCredit.

It wasn't until my father had a heart attack and survived quintuple bypass surgery that I began to truly understand the incredible impact oral health has on the body overall as well as the real value proposition of dentistry. Two days after my father's surgery, I walked into a client practice, and the hygienist said, "I'm sorry about your dad. How is his periodontal health?" This single question changed the trajectory of my personal and professional life, and I became passionate about understanding the oral-systemic connection. The more I learned, the more I realized I didn't have a big enough vision for the value that dentistry provides.

When the dental team and patients are committed to the bigger picture — the patient's overall health and longevity — attaining and delivering oral health becomes much more important and rewarding. Dentistry is a proactive healthcare specialty, meaning most patients know to go to the dentist or the hygienist on a regular basis; they go to their general medical doctor reactively, or when they have symptoms. Because so many diseases often begin in the mouth, the dental practitioner should be a whole-body health practitioner dedicated to proactive prevention. Dentists and hygienists cannot replace physicians, but they can become the filter for educating and transforming how the patient relates dentistry to their overall health.

To transition to a whole-health practice, you have to change the mindset of your team and your patients. You should start from the patient's current mindset. You can't just start taking blood pressure measurements and talking about medical history forms. You have to begin by educating them from the initial contact and throughout their dental journey. You should also give them a choice about how they want to receive care.

I've found using the four P's — positioning, pleasing benefit, proof story and permission — is very helpful.



- 1. Positioning:** "Hello, Ms. Johnson. I want to let you know that we are a whole-health dental practice."
- 2. Pleasing benefit:** "What this means is that we don't just look at the health of your teeth and gums and the appearance of your smile; we also look at the overall impact the health of your mouth has on chronic disease. So, we'll look at your medical history form and see how we can help you prevent any issues you're predisposed to, such as high blood pressure or osteoporosis."
- 3. Proof story:** "I'd like to share a story about a 55-year-old patient with periodontal disease who had pancreatitis and whose grandfather had pancreatic cancer. Pancreatitis is connected to periodontal disease, and, when we took care of the periodontal disease, we were able to arrest the pancreatitis. This is an example of the systematic processes we can impact and the value we can provide for you."
- 4. Permission:** "Would you like to be treated traditionally or from a whole-health perspective? It's up to you." When people have a choice, they usually choose the smarter one. If the patient says, "No, I would just like to get my cleaning done," then we treat them that way.

Once you've generated interest, your team can connect your patients' overall health with their oral health through education. Then, all that's left is to enable and empower patients to get on the schedule and get healthy. ♦

Gary Kadi is founder and CEO of NextLevel Practice, a dental consulting firm. To comment on this article, email impact@agd.org.

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Dr. Owocki Combines a Love of Dentistry with a Love of Photography

Modern dental photography is a far cry from the slide photography Dennis C. Owocki, DDS, MAGD, used in his practice for most of his career. Now, digital cameras offer invaluable convenience, enabling the clinician to take and present intraoral photos to the patient immediately. Owocki's history with film, however, made him reluctant to embrace digital photography.

"My interest in photography began while I was still in elementary school," said Owocki, now retired. "Like most households in my neighborhood, we had a simple Kodak Brownie camera, and we used that to take photos of family and friends and my mother's rose garden. During those years, itinerant photographers would visit the neighborhood, just walking up and down the street to provide portraits at your home. I had five sisters, and, every two or three years, my parents would invite one of these photographers into our home to take portraits of all of us kids. The photographer had a large-format camera and a big wooden tripod with two very large lights for illumination. You can imagine how impressive this setup would be to a group of young people."

Owocki began at the University of Detroit as an engineering student, but soon changed to a liberal

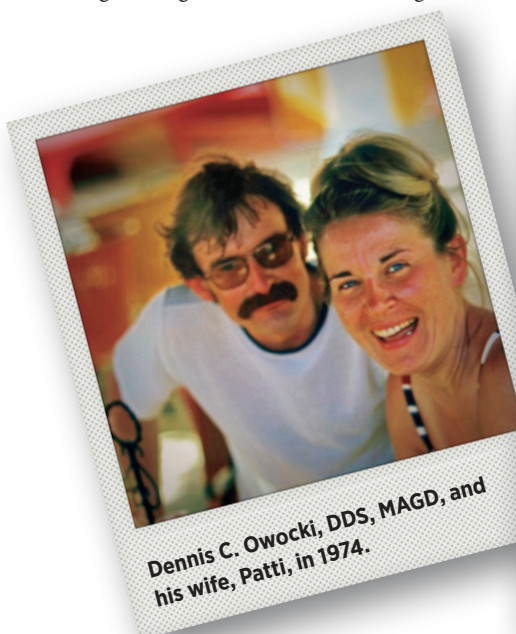
arts curriculum, then finally to a pre-med/pre-dental focus. He later enrolled in the University of Detroit School of Dentistry. "In dental school, I noticed some of the instructors were using Nikon Medical-Nikkor lenses," said Owocki, "which allowed the photographer to make superb intraoral images and also some pretty good portraits, too. This always intrigued me."

When Owocki was in dental school, the military draft was in force, so he signed up for service with the U.S. Army and began after graduation. He was stationed in Schwäbisch Hall, Germany, for three years and arrived on Aug. 13, 1961, the day construction began on the Berlin Wall. "A few months after arriving, I asked my commanding officer if I could attend a weeklong photography program at the nearby Leica Camera factory using their cameras and lenses. I emphasized that this additional training could help me take better intraoral photographs, which would increase the quality of care we could give to our troops. He agreed with me."

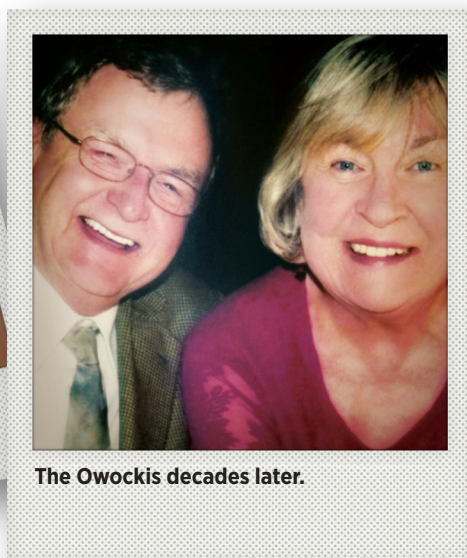
But that wasn't the only opportunity Owocki had to sharpen his photography skills while stationed in Germany. "Even though we were a small post," Owocki said, "we had a photography program offered to all of the troops after regular work hours. The person running that program was a former German soldier who



Advances in technology can help motivate those in the profession to do the best they can and help the patient be healthier and happier.



Dennis C. Owocki, DDS, MAGD, and his wife, Patti, in 1974.



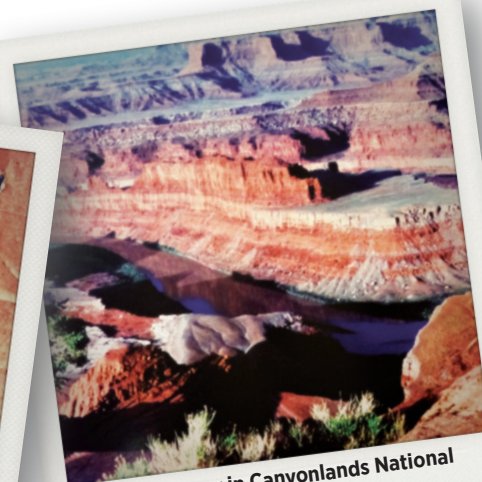
The Owockis decades later.



An example of Owocki's film photography from Bodie, California, a mining ghost town.



Another shot from Bodie.



The Green River in Canyonlands National Park, Utah.

was well versed on the nuances of photography. I was very fortunate to have him help me perfect my darkroom techniques as well as develop my knowledge of composition and the art of photography."

When he returned to the United States in 1964, Owocki settled in the small town of Fenton, Michigan, to open a private practice. Eventually, he purchased a Nikon camera system with a Medical-Nikkor lens like the ones he had admired during dental school. "This allowed me to show my patients more dramatic results," he said. "It actually gave me the confidence to advise patients to seek more comprehensive care if needed. At that time, we made our images with slide film. You would put the photograph slides on a carousel and project them on a screen." The film had to be developed first, so the photographs would be taken and presented at separate appointments.

Owocki joined AGD in 1968 after meeting founder Thaddeus V. Weclaw, DDS, MAGD, and became more motivated to seek meaningful continuing education in dentistry. "Anytime I took dental courses," he recalled, "I was also motivated to take more photography workshops. Photography helped me enjoy dentistry more, and it helped me enjoy my life outside of dentistry."

The pursuit of photography education led Owocki to many interesting places. "I studied the work of some expert landscape photographers, several of whom used the large-format cameras that I remembered from my childhood. I took a few weeklong courses in the use of that format but found it wasn't for me — it was too cumbersome. But taking these courses encouraged me to seek out some of the photographers who did use that format, and I began to take workshops on both the East and West coasts as well as in many of our national parks in the West, including a workshop in Yosemite with Ansel Adams. I really enjoyed the respite from the office, and, when I'd return home after having

been inspired by the beauty of nature, I would be even more inspired to help my patients improve their smiles."

Having used film for so long, Owocki took longer than many of his peers to make the switch to digital. "I saw some digital images by other students that were of beautiful subjects but had been so overly processed that the image looked unnatural, and this turned me off," said Owocki. "I did buy a small point-and-shoot camera in the early 2000s, but I kept using my slide camera in the office. After a while, I saw I was the only guy still using film, so I finally took the plunge. I bought my first full-time digital camera — a Nikon — in 2009. It took this old guy that long. There's been no looking back since then. Digital is the way to go. Actually, digital is easier for me than working in a darkroom with all of those chemicals, and I'm getting too old to have any more back or neck aches."

Although it took Owocki a while to transition to digital photography, he is not averse to technology. In fact, when Owocki and his son David practiced together, David purchased a Zeiss operating microscope for their office — not for endodontic procedures, but for restorative dentistry. "I know virtually all endodontists use microscopes, but I know very few restorative dentists who do," Owocki said. "When a patient sees an intraoral image from a microscope on a large-screen monitor, it makes quite the impression. You can see the good, the bad and the ugly. And if that doesn't motivate the patient, I don't know what will."

"Advances in technology can help motivate those in the profession to do the best they can and help the patient be healthier and happier. Achieving this high level of care requires building great relationships with staff and with patients. There's no question that digital photography is here to stay, but it's not the technology alone that gets the job done. I can't say enough that when you develop trust with people, you don't have to sell. Everything just seems to flow." ♦



The Need to Screen

Diabetes in the Dental Office

By Jennifer Gibson

Diabetes is a chronic, incurable illness and a growing epidemic in the United States. According to the Centers for Disease Control (CDC), more than 30 million Americans have diabetes. Eighty-four million more have prediabetes — and the vast majority, up to 90%, don't even know it.¹ If current trends continue, the CDC predicts that one in three Americans will have diabetes by 2050. The good news is that diagnosing prediabetes gives patients an opportunity to take steps to prevent the development of full-blown diabetes.

Type 2 diabetes is the most common form of the disease and represents more than 90% of diabetes cases in the U.S.¹ Patients with Type 2 diabetes aren't able to properly control their body's production of insulin; insufficient levels of insulin lead to a buildup of glucose in the blood. High blood sugar can cause serious health problems such as heart disease, kidney disease and vision loss.

Diabetes also has negative effects on oral health. Patients with hyperglycemia, or high blood sugar, can be three times more likely to develop periodontitis than those without diabetes.² Patients are more likely to have infections in the gingiva and underlying bones, while diabetes also reduces blood flow to these areas. Patients with diabetes can be affected by other oral health problems, including alveolar bone loss, abscess formation and poor healing. This necessitates careful treatment planning, making identification of diabetes even more important.

Diabetes doesn't just lead to periodontal disease — the two have a bidirectional relationship, meaning the presence of one condition can impact the other.² Studies show that patients with severe periodontitis have higher blood sugar levels and may be at a higher risk of developing Type 2 diabetes or, if already diabetic, have a harder time controlling their Type 2 diabetes.³

Gary D. Hack, DDS, believes dentists are in an ideal position to help identify diabetic or prediabetic patients. An associate professor at the University of Maryland School of Dentistry, Hack says periodontal patients and those with diabetic risk factors should be screened.

Other Types of Diabetes

While Type 2 is the most common form of diabetes, 5%–10% of patients have Type 1 diabetes, a chronic condition in which the pancreas produces little or no insulin. Although Type 1 diabetes usually appears in children, it can develop in adults. Regardless of the type of diabetes, increased blood glucose also increases the risk of developing caries, gingivitis, periodontitis, thrush and dry mouth.

Gestational diabetes occurs in women with high blood glucose levels during pregnancy. It is found in about 7% of all pregnancies. For patients with gestational diabetes, proper monitoring is necessary. The condition is temporary and usually reverses after the woman gives birth, but she will be at a higher risk of developing diabetes later in life. Studies have shown a relationship between gestational diabetes and periodontal disease. Dentists should be careful to help these patients avoid dental infections and manage any sources of acute or chronic inflammation to help control the diabetes.

Source: Novak, Karen E, et al. "Periodontitis and Gestational Diabetes Mellitus: Exploring the Link in NHANES III." Journal of Public Health Dentistry, vol. 66, no. 3, 2007, pp. 163-168.

there is attachment loss of the gingiva from the root surface, which is one of the key signs of periodontal disease," said Cassis. "The other widely recognized sign of periodontal disease is bleeding of the gingival tissues while probing. It is those two signs that we use to screen patients for periodontal disease. If a patient has signs of periodontal disease, then we are going to do a blood glucose screening at the same appointment."

Most screenings are handled by hygienists and assistants in Cassis' practice, and he said patients have come to expect the additional test. If blood glucose is found to be elevated, then the patient's physician is notified immediately.

"The idea is to make the screening routine so patients expect it," said Cassis. "Patients appreciate that we are concerned

"Many people will see a dentist in a year and not their physician," said Hack. "Periodontal disease is one of the earliest signs of diabetes, and who better to diagnose this condition than a dental professional?"

Hack teaches students how to measure blood glucose levels in dental patients. He's been diabetic for more than 30 years.

"I know how hard it is for diabetic patients," he said. "If 90% of prediabetic people don't know they have it, they are not going to change their lifestyle, and many will convert to diabetes. If you know you're prediabetic, you can take some action to minimize the risk of converting."

Knowing the blood glucose level of diabetic patients also can impact treatment planning for dental procedures in order to prevent diabetic emergencies.

Screening Dental Patients

Testing for diabetes can be simple, safe, inexpensive and enlightening. A study of 1,022 patients found that screening for diabetes during regular dental visits led to the diagnosis of diabetes and prediabetes in 12% and 23% of patients, respectively.⁴

Dentists should first be aware of the common risk factors for developing prediabetes or Type 2 diabetes. They include being overweight, having a family history of diabetes, being 45 years or older, being physically inactive and having high blood pressure or high cholesterol.⁵ Certain ethnic groups also are more likely to develop diabetes.⁵ Providers should also evaluate for oral symptoms of uncontrolled diabetes, which include a dry mouth or burning sensation in the mouth, delayed wound healing, more frequent and severe

infections, thrush, parotid salivary gland enlargement, gingivitis and periodontitis.⁶

Patients with these risk factors or symptoms can be screened to test either their hemoglobin A1C level, which is the patient's average blood sugar level over the past two to three months, or their blood glucose level, which is the amount of glucose in the patient's blood at the time of testing.

Blood glucose and A1C levels both can be tested with a finger-prick blood test. Research has found that blood collected from the gingiva at a dental visit can also be used for screening with similar results. Another study found gingival blood collection for testing to be the preference of patients and dentists.^{7,8} Hack teaches second-year dental students how to use a glucose meter to test blood glucose levels.

"It's a very simple procedure," explained Hack. "A drop of blood on a strip, the strip goes into the machine, and, in a matter of minutes, the machine will give you the glucose or A1C level. I encourage students to do this with any at-risk patients."

His students are very receptive to the program, and Hack says most of them plan to incorporate diabetes screening into their practices.

"The students realize that they can play a major role in addressing this epidemic," Hack said. "Diabetes is a life-threatening disease, and they can identify at-risk patients who have prediabetes and get them to a physician."

AGD Vice President Bruce L. Cassis, DDS, MAGD, of Fayetteville, West Virginia, screens patients with signs of periodontal disease.

"If the periodontal probing measurement is greater than 3 millimeters, then we know

for their total health and that we are dedicated to discovering potential health risks, and they tend to refer other like-minded patients to us.”

“**Without intervention, this epidemic will bankrupt our healthcare system.**”

– Gary D. Hack, DDS

For dentists who aren’t sure whether a patient is at risk for developing diabetes, Susan Maples, DDS, worked with an endocrinologist to develop a survey that essentially enables patients to self-identify as being at risk. The questions are based on the known risk factors for diabetes, symptoms of hyperglycemia and diabetic complications, and they enable a dentist to identify at-risk patients without weighing them or calculating a body mass index, which is a common tool to diagnose prediabetes.⁹

To develop the survey, Maples randomly tested the A1C levels of 500 adult patients who did not have a history of diabetes or prediabetes. The patients answered a 14-question proposed risk assessment for diabetes that was built on existing screening

methods, and the responses were statistically compared to the blood results. Maples and her coauthors retained the questions that were or were close to being statistically significant.

The aim of the screening survey is to be used before chairside testing. Interestingly, 19% of the patients in the study tested positive for prediabetes, and 1% tested positive for diabetes.⁹

“As dentists, we’re in a wonderful position to help people predict and preempt diabetes,” Maples said. “This can be a huge wake-up call for patients. You can actually tell someone, ‘In three to five years, if nothing changes, you could become diabetic.’ This stimulates a personal impetus for change.”

In a study of patients screened for diabetes and prediabetes at the dental office, some respondents said it led to a new way of interacting with a dental provider, viewing the dental visit and thinking about their healthcare. They also reported a better understanding of the increased risk of diabetes among patients with periodontal disease and the opportunity to improve their health.⁸

Collaborating with Physicians

Dentists cannot diagnose prediabetes or diabetes, so referral to a physician is necessary if the patient’s A1C level is 5.7 or greater, says Maples. Dentists should document the referral and have the patient sign an information release form. This can be an opportunity to better integrate oral and general health — however, it may take some effort from both sides. In a study of dental students who screened patients for diabetes and referred them to their physicians, the authors assessed how the medical doctors communicated back to the dental students. They found that, despite requests, none of the physicians provided written information about the patient’s diabetic condition. After phone calls, all of the doctors provided data on the patients’ additional testing.¹⁰

A task force of representatives from AGD, the American Academy of Family Physicians and the American Association of Diabetes Educators convened in 2018 to develop resources for both dentists and physicians. One of the goals of the task force was to simplify the referral process by creating dentist-to-doctor and doctor-to-dentist referral forms, thereby improving communication between healthcare professionals and facilitating more patient referrals. Based on the framework of the first task force, AGD formed a diabetes communication task force in 2019 to create an online toolkit for dental offices. Part of the toolkit is a multipart video series that aims to educate dentists about when and how to perform an A1C test. The first video will feature Cassis demonstrating how to use a glucometer during a dental visit. To view it, visit agd.org/diabetes.

“We need to work in conjunction and collaboration with physicians to control glycemic levels,” said Maples. “Dentists can prescribe antibiotics that specifically target the patient’s bacteria while we work in coordination with anti-glycemic medication to reduce hyperglycemia.”

Maples routinely monitors A1C levels for her periodontal patients and those at high risk for developing

Managing the Diabetic Patient

Patients with diabetes present challenges that dentists need to be aware of and prepared for. If you know your patient is diabetic, inquire about their diagnosis, blood glucose monitoring and medications, as well as any complications. Be prepared to monitor patients’ blood glucose during long procedures. According to Gary D. Hack, DDS, if their insulin begins to drop, it could be life-threatening. Hypoglycemia can lead to a loss of consciousness. Try to schedule your diabetic patients early in the day, keep

them comfortable to reduce stress and have juice or glucose tablets on hand in the event their blood sugar drops.

Understanding the patient’s diabetic condition can also help with treatment planning. Knowing the patient is at increased risk for infection, delayed healing and periodontal disease will impact how he or she is managed. If the patient does have periodontal disease, proper treatment and deep cleanings may improve glycemic control, improving health beyond the oral cavity.

diabetes. She notes that periodontal maintenance prophylaxis intervals are every three months — the same interval recommended for A1C monitoring.

Recently, the National Academy of Sciences published proceedings of a workshop on integrating oral and general health through health literacy.¹¹ The workshop discussed the gap between oral health and medical health and the need for improved collaboration and care. The proceedings described a potential model for future collaboration, where physicians in Oregon educated diabetic patients about periodontal disease and referred them to a dentist if they had not recently seen one. Meanwhile, a dental clinic identified at-risk patients and referred them to a physician if they had not seen one in the past year. The program increased the level of partnership between doctors and dentists and educated patients about the relationship between diabetes and oral health.

Integrated electronic health records have also made steps to improve collaborative care. The Marshfield Clinic Health System in Wisconsin synchronizes medical and dental records so dentists are alerted when seeing a diabetic patient, and medical staff members are alerted about diabetic screenings of at-risk patients in the dental office.

AGD supports the role of general dentists in the identification and management of diabetes and has issued a policy stating: “General dentists should be provided the ability, training and resources to screen for diabetes, and to collaborate with the patient’s primary care physicians, as deemed appropriate, to identify and manage diabetes.”¹²

Reimbursement for Diabetic Screening

It is increasingly accepted that screening for diabetes is within the dentist’s scope of practice; however, it is important to check with your state’s dental licensing board. The American Dental Association Code on Dental Procedures

and Nomenclature (CDT Code) recently approved codes for reporting A1C and blood glucose level testing. Code D0411 is for point-of-service A1C level testing, and D0412 is for reporting in-office blood glucose testing using a glucose meter. Coverage also varies, so it is important to check with the insurance companies you contract with. You can also consider submitting the test to the patient’s medical insurance.

Dentists should be aware that the U.S. Food and Drug Administration considers finger-stick screenings to be simple tests and therefore waives the licensing requirements of laboratories to conduct the procedures. Dentists must apply for a Clinical Laboratory Improvement Amendments of 1988 Certificate of Waiver.¹⁴

Complete Healthcare

Dentists are in a unique position to identify at-risk prediabetic patients who can then take steps to prevent progression to full-blown diabetes. Proper diet, increased exercise, monitoring and treatment of high blood pressure, good oral health and smoking cessation can all lower the risk of developing diabetes.

Maples hopes more dentists utilize her survey, which can be found at selfscreen.net/1/diabetes, or conduct in-office screenings.

“Our profession is slow to adapt to new evidence, but we have to change our thinking around the complicated nature of this disease,” she said. “Open your minds and think about addressing this disease with a different toolbox than you’ve been using.”

Hack agrees, and he points to the \$327 billion annual cost of treating diabetes as another cause for concern.

“Without intervention, this epidemic will bankrupt our healthcare system,” said Hack. “Dentistry is in an ideal position to contribute to addressing the epidemic of diabetes.” ♦

Jennifer Gibson is a freelance writer based in the Chicago area. To comment on this article, email impact@agd.org.

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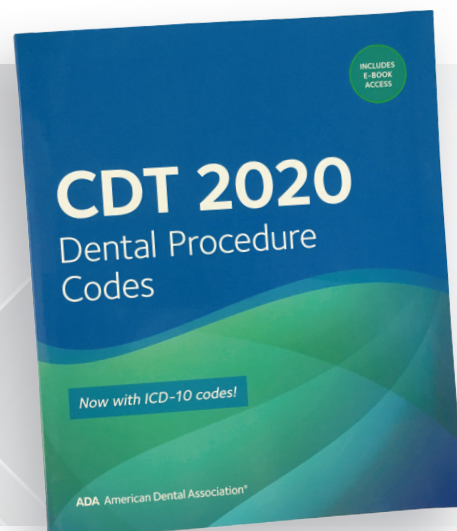
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Glucose monitors can be purchased through AGD’s discount program, AGDVANTAGE. Visit agd.org/agdvan tage for more information.

What to Expect in 'CDT 2020'

Plus the Process Behind the CDT Code



By Caitlin Davis

A new year means a new edition of the American Dental Association (ADA) Code on Dental Procedures and Nomenclature (CDT Code), and dentists have just two months left to review this year's updates before the new version, "CDT 2020," takes effect Jan. 1, 2020. There are 63 changes in "CDT 2020" — 37 additions, five revisions, six deletions and 15 editorial changes.¹ "CDT 2020" is available now, and below are three of the code additions dentists will be able to use starting Jan. 1.

New to 'CDT 2020'

| Code | Description |
|-------|--|
| D0419 | Assessment of salivary flow by measurement |
| | This procedure is for identification of low salivary flow in patients at risk for hyposalivation and xerostomia, as well as effectiveness of pharmacological agents used to stimulate saliva production. |

Code D0419 was submitted by Allen Wong, DDS, EdD, professor and director of the advanced education in general dentistry and hospital dentistry programs at the University of the Pacific Arthur A. Dugoni School of Dentistry, on behalf of the Caries Management by Risk Assessment (CAMBRA) Coalition, of which he is the president.

"CAMBRA's purpose is to educate dental professionals on the prevention of and — more importantly — the management of caries," Wong explained. "We recognized that more data and research was needed to document and track treatment for caries risk reduction and diagnoses and that a supplement to the current CDT Code was needed. The concept of caries risk assessment emphasizes a deliberate evaluation and recording of data when needed. The recording of salivary flow assessment is a process that is currently taught in dental schools and is a specific procedure that many dentists may be performing. Having a code to track deliberate salivary assessment will be useful in evaluating the usage of this method and possible health outcomes."

"The AGD Dental Practice Council (DPC) initially opposed this addition, arguing that codes already existed for saliva collection and for analysis of the sample," said Ralph A. Cooley, DDS, FAGD, AGD's representative on the ADA Code Maintenance Committee (CMC). "However, after hearing the arguments at the meeting, we realized that a gap in the code existed where collecting saliva and determining the amount produced was concerned. The arguments were persuasive enough for me to change my initial thoughts and vote in favor."

| Code | Description |
|-------|--|
| D9997 | Dental case management — patients with special health care needs |
| | Special treatment considerations for patients/ individuals with physical, medical, developmental or cognitive conditions resulting in substantial functional limitations, which requires that modifications be made to delivery of treatment to provide comprehensive oral health care services. |

Code D9997 was submitted by Delta Dental Plans Association, which is a dental payer member of the CMC. The rationale for the code as submitted by Delta stated: "Currently there is no method for identifying dental services provided to patients with special needs. This non-clinical administrative code would facilitate the processing of claims and documentation of services directed at this high-need population. It would also facilitate payment under government and other third-party payer systems where specific fee schedules are provided for services to these patients. One example is the State of Wisconsin, where state legislation provides for a higher payment for Medicaid dental services to qualifying providers, but there is currently no method for providers to identify which patients are eligible for those fees. There is also a lack of data in general on the existing provision of care for patients with special needs due to inability to identify these patients in claims and electronic records."

“This adjunctive general services code is an example of several recent new codes that reflect important, complex nonclinical aspects of patient care,” Cooley explained. “This code will be beneficial in clarifying to both third-party payers and dentists what treatment is actually performed and why it is necessary for the patient, as well as improving data analysis on the services provided to this population.”

| Code | Description |
|-------|--|
| D7922 | Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site |
| | This procedure can be performed at time and/or after extraction to aid in hemostasis. The socket is packed with a hemostatic agent to aid in hemostasis and or clot stabilization. |

“Code D7922 that will definitely impact the general dentist,” said Cooley. “General dentists do a large portion of oral surgery involving tooth extraction, so this procedure is not at all limited to oral surgeons. While codes may be categorized under specialties, there are no limitations on who can use which codes, and general dentists can certainly use this one. The discussion concerning this code addition was whether this constitutes a standalone procedure or whether it is part of a surgical code. The placement of this dressing is not done routinely for every case, though, so the committee determined an additional code was warranted. Having this code allows the dentist to accurately reflect what happened with each particular surgical situation.”

Creating the Codes

The CDT Code was first published in 1969. In the 2000s, it was regularly updated by the ADA’s Code Revision Committee, which consisted of six dentists appointed by the ADA and six members representing third-party organizations. In 2012, the ADA enlarged the committee and renamed it the Code Maintenance Committee. The CMC includes five representatives from the ADA, one of whom serves as chair; one representative from each of the ten recognized dental specialty organizations; one representative from AGD; one representative from five major third-party payer organizations, including the Centers for Medicare and Medicaid Services; and one representative from the American Dental Education Association.

Cooley has represented AGD on the CMC for four years and previously represented the ADA on the Code Revision Committee. “When the structure of the committee changed to include many different groups in dentistry, including AGD, the process became more cohesive and collegial,” Cooley said. “It also allowed for greater discussion on why certain new codes are truly needed by the dental community. The voting members of the CMC are all committed to the core purpose of the CDT Code, which is to achieve uniformity, consistency and specificity in accurately documenting dental treatment for patient health records, claims submission and other purposes.”

“The CMC is a decision-making body, and the majority vote rules,” explained Christopher Bulnes, DMD, chair of the March 2019 CMC meeting. “The goal in expanding the CMC was to add more representation from the dental professionals and practice side as well as the educational side and the dental payer side. With rare exception, the individuals on the committee representing the member organizations are all dentists, and we do have some very engaged discussions based on the variety of backgrounds represented by the individuals who come to the table.”

The CDT Code is updated yearly, with the CMC reviewing more than 100 action items from all sectors of the dental community in order to ensure the code set accurately reflects current dental practice.

“A robust CDT Code is one that enables a dentist to easily and clearly document services provided,” said Bulnes. “Having a specific code for each service eliminates the writing of a narrative report, which is required when an unspecified procedure code is the only option available. Changes that fill gaps in the code set or bring greater clarity to an existing entry support more accurate electronic patient record-keeping.”

The annual cycle of the CDT Code revision process begins Nov. 1 each year, which is the due date for all action requests to be submitted to the ADA for CMC consideration. The action requests are then compiled and distributed to the CMC members by Dec. 1.

“This starts what we call the ‘due diligence period,’ when every CMC member organization begins their review of the action requests to determine their positions on each one prior to the convening of the CMC in March for discussion and deliberation,” Bulnes explained. “How each member organization performs its due diligence is up to that organization, but I know from experience and conversations that each organization has a committee that reviews the action requests on the agenda. Within these groups, there is deliberation back and forth and sometimes up and down. The ADA, for example, will often contact submitters and other members of the CMC during the due diligence period as part of the process of forming a position on each action.”

AGD’s due diligence process involves two levels of review for each submission. First, Cooley and AGD staff review all submissions and make recommendations to AGD’s DPC. The DPC then discusses and votes on the recommendations at its January meeting.

“This thorough process has earned AGD the respect of the ADA and the dental specialties, which often seek out AGD’s input as they make their own evaluations,” Cooley said. “As AGD’s representative on the CMC, I vote based on the recommendations of the DPC with leeway to exercise discretion if changes are made to a code change the DPC initially opposed.”

The CMC’s deliberation occurs in March, at which point each action is voted upon.

“During the meeting, submitters will often be present to argue for and address any questions about their specific requests,” said Bulnes. “Sometimes these deliberations will lead to a revision on the floor before a final vote is taken to accept or reject. For those who offer persuasive arguments, the expected outcome is acceptance. Those action requests and arguments that the committee deems not persuasive will be rejected with a reason why and — often — a recommendation to try again next cycle.”

After the decisions have been made, the CDT Code moves through the publication process, with the new edition available in early fall the year before it takes effect.

The Purpose of the Code

Unfortunately, the existence of a specific dental code does not guarantee reimbursement for that service. Nevertheless, because the CDT Code has been named a HIPAA standard code set, all claims submissions and patient records must utilize the correct and current CDT codes.¹

"In the preface to the CDT manual, there is a statement that the CDT Code exists to provide a means to document services being delivered by dentists in the course of practice," Bulnes explained. "There is also a clear statement that just because there is a CDT code for a service, that doesn't mean the service will be reimbursed. Reimbursement is based on the provisions of the dental benefit plan against which the claim is filed."

While getting paid is important — and coding correctly is instrumental in getting timely reimbursement from a benefits plan — the CDT Code also serves a greater purpose.

"The main purpose of the code is not for third-party payment," said Cooley. "It is a tool to allow the dentist to accurately reflect

treatment that is performed. As AGD's representative, I take this mindset into each meeting of the CMC, and, for every submission, I ask myself, 'Will this be of benefit to dentists and patients, and will it clarify treatment decisions and outcomes?'"

"The concept of 'code for what you do, and do what you coded for' really is the mantra," said Bulnes. "This links to the ADA's Principles of Ethics, specifically No. 5: veracity, or 'truthfulness.' It really is incumbent that the dentist accurately record what was done. Whether or not that's going to be reimbursed is not particularly germane. The point is that the patient record should be complete and accurate."

AGD members can contact AGD at practice@agd.org for inquiries into specific matters regarding the CDT Code. AGD cannot offer legal consultation or representation; the information provided will not replace consultation with an attorney licensed in your state. ♦

Caitlin Davis is associate editor of *AGD Impact*. To comment on this article, email impact@agd.org.

References

1. "Code on Dental Procedures and Nomenclature (CDT Code)." *American Dental Association*, www.ada.org/en/publications/cdt. Accessed 5 Sept. 2019.

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If you are in the market for a simple, versatile and easy-to-use bonding agent, look no further than All-Bond Universal™ from Bisco. All-Bond Universal is a light-cured bonding agent that combines etching, priming and bonding all in one step. It comes in bottles or unit-dose delivery systems and is compatible with dual-cured, light-cured or self-cured materials. And, unlike many single-bottle adhesive systems, All-Bond Universal does not require the use of an activator. Another attractive feature is that it is truly universal in its use

among multiple materials. According to the manufacturer, it has high bond strengths with materials such as metal, zirconia, lithium disilicate, glass ceramics, silica-based porcelains and alumina.

The company provides easy-to-use technique cards for direct and indirect restorative applications with the product and on its website. Indications for use include direct restorations such as composites, core buildups and resin-modified glass ionomers. Indirect restorations include gold, porcelain fused

to metal, zirconia and glass ceramics. All Bond Universal also has great value as a desensitizing agent, a protective varnish for glass ionomer restorations, orthodontic bracket bonding, and prefabrication or direct post-and-core bonding. I can say from personal use that, since using All-Bond Universal, my incidence of post-operative sensitivity has been all but eliminated.

If you are looking for a simple way to standardize your bonding protocol and supplies, check out All-Bond Universal.

A Powerful Electric Handpiece

NLX Nano

NSK America

nskdenal.us

In our practice, we try to provide treatment for the patient at the time of diagnosis if possible. “Same-day dentistry” is great for patients because it saves them a trip back and frees up that time in our schedule for other patients. We even do it in our hygiene rooms. But, to do this, you need to have your hygiene rooms fitted for high- and low-speed handpieces. If you purchased an existing practice as I did, sometimes the hygiene rooms were designed for hygiene only, or sometimes you can only get an air-driven turbine in there. What if you wanted a state-of-the-art electric handpiece but didn’t want to pay the price of outfitting more than one room?

The NLX Nano is a portable, practical and high-performing motor and handpiece system. It is a great system that is easy to carry and hook in from room to room. Offering a wide range of applications, the Nano can accept 16:1, 1:1 and 1:5 handpieces, as well as some existing contra-angles you may already have

(check with the manufacturer). I personally like design features such as the reduction in weight of the micro-motor attachment to the handpiece, which makes it feel lightweight compared to other electric micro-motors. If you have a longer case, you can appreciate the reduction in fatigue afterward. NSK has also taken into account where the balance point is between the top of the handpiece and the motor, making it evenly weighted so it feels similar to an air-driven handpiece.

Some other features of the Nano system include a powerful LED fiber optic light — most electric lights are halogen bulbs. The power setting of the light is also adjustable. The Nano’s control panel display offers a digital speed readout, programmable settings you can store for quick access and even a reverse cutting mode.

If you are looking to add to your existing electric armamentarium, or are looking for your first system, you can’t go wrong with the NLX Nano from NSK.





Jump-Start Your Cavity Prep

Danville PrepStart™
Zest Dental Solutions
zestdent.com

Looking to expand your bag of tricks for cavity/sealant preparation, crown and bridge prep and indirect restoration inserts? The PrepStart™ air-abrasion system from Danville is the perfect solution.

The PrepStart utilizes air pressure with 27- or 50-micron aluminum oxide particles to quickly and painlessly prepare the tooth surface. The PrepStart is great for treating incipient Class I–VI lesions without the need for a local anesthetic. The unit allows you to vary the amount of pressure and the air/powder ratio. For deeper Class I occlusal caries and sealants, we often start off with a fissurotomy bur to open the grooves and fissures and then painlessly finish preparing the dentin with the PrepStart.

Different size tips (0.015-, 0.019- and 0.026-inch nozzles) allow varying degrees of pressure for more efficient cutting.

The PrepStart is also versatile in its application for indirect restorations. The air abrasion can be used to help increase retention of crowns, onlays and bridges by air abrading the tooth preparation before insert. You can prep the intaglio of certain restorative materials where hydrofluoric acid etching is not advisable such as porcelain fused to metal, gold and porcelain. When removing older composites, it is helpful to delineate between where composite and tooth structure begin and end. Studies have shown that air abrasion followed by phosphoric acid etching help increase bonding retention more than just etching alone.

The PrepStart also comes in PrepStart H2O if you prefer an air/water/powder slurry, and additional accessories such as the PowerPlus air pressure booster can help increase the power when an older compressor may not deliver enough.

Patients have always been amazed at how fast, easy and painless dentistry can be with the PrepStart.



Matt Giulianelli, DMD, FAGD, is a fellow of the International Congress of Oral Implantologists and has served as a peer reviewer for *General Dentistry*. He and his wife have a private practice in South Burlington, Vermont. Giulianelli has confirmed to AGD that he has not received any remuneration from the manufacturer(s) of the product(s) reviewed or their affiliates for the past three years. All reviews are the opinions of the author and are not shared or endorsed by AGD *Impact* or AGD. To comment on this article, email impact@agd.org.

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What medical conditions do you screen for in your dental practice?



Larry J. Melo

We routinely take pulse and blood pressure measurements on all of our adult patients. With the known prevalence of hypertension in the general population and its association with serious systemic consequences, including heart attack and stroke, I feel strongly that dental professionals are in an ideal

position to screen for this condition and thus significantly impact their patients' overall health. On several occasions, we have identified severe hypertension in individuals who were completely unaware of their dangerously high blood pressure, and we referred them for immediate medical evaluation prior to beginning

any dental treatment. In addition, we counsel our hypertensive patients on related topics such as diet, smoking cessation, stress and anxiety, and medication-related side effects such as dry mouth.

Larry J. Melo, DDS, MAGD, is based in Herkimer, New York.



Randolph A. Coffey

Every patient examination should include a detailed medical history with a clinical head, neck and oral cancer screening. In over 31 years of continuous clinical practice, I have performed these medical screenings for every single patient exam, without exception. One memorable case began in 2011 during an annual examination of a 35-year-old male patient serving in his final duty station of a full military career. He reported a 15-plus-year history of smokeless tobacco use (STU). He dipped continuously while at work and presented with a chief complaint of a dull burning sensation on the right posterior lateral border of his tongue. Upon examination, I noted an erythematous lesion measuring approximately 5-by-8 millimeters. The oral cavity revealed marked leukoplakia — also known as “snuff dipper’s keratosis” — bilaterally in the mandibular vestibules. I immediately referred him to an oral and maxillofacial surgeon (OMS). He was initially reluctant to comply with the mandated referral to present for exam, and I had to ground him from his flight duties until he followed through. The OMS performed a soft tissue biopsy, and histopathologic diagnosis revealed dysplasia with clear margins. When I brought the patient back for follow-up with a verbal and

signed review of his histopathologic report, he seemed concerned but opined that STU was his safer alternative to his previous habit of cigarette smoking. I provided extensive counseling on the severe risks associated with STU and placed a referral for further tobacco management programs. The patient complied with three-month follow-ups and had no signs or symptoms of pathoses until 18 months later, when he presented with a new, highly indurated 3-by-4-mm ulcerative erythematous lesion. He admitted to continued STU. The OMS biopsied the site, and histopathologic diagnosis revealed squamous cell carcinoma in situ with normal soft tissue margins and no neurovascular involvement. The patient lost close to 10% of the lateral right border of his tongue. Afterward, the patient was quite emotional and promised himself that he would remain tobacco free for life; he stated that he had been given a “second chance.” The patient has been free of recurrence with no new pathology since I last examined him in 2016 shortly before my retirement.

Randolph A. Coffey, DMD, MS, MAGD, FICD, ABGD, is based in Richmond, Virginia.



Kyle Pelkey

As an active-duty Air Force dentist, I use the Air Force’s Form 696 (Dental Patient Medical History). We review this questionnaire at every appointment with our patients. Using the form, we screen for many medical conditions, including heart conditions, chest pain, high blood pressure, and

diseases such as diabetes, AIDS, HIV and various venereal diseases. We also ask about medications or supplements, allergies to medicines or materials, reactions to local anesthetics, complications after dental treatment, inability to be a blood donor and antibiotics prior to dental care. We screen for all of these conditions to ensure all

treatment is provided while taking into account the specific medical conditions of each patient. We want our patients to be as healthy as possible so they can serve whenever and wherever our nation calls.

Col. Kyle Pelkey, DMD, FAGD, ABGD, is based in Colorado Springs, Colorado.

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