Additions to NDA Library

Give the NDA Office a call if you’d like to checkout these booklets.

Financial Management in the Successful Dental Practice

This publication helps you develop sound financial policies for the day-to-day operations of your practice. Addresses important monetary aspects and the steps to developing a financial support system. Topics include:

- practice finance basics
- cash flow management
- fee determination
- developing financial policies
- managing patient insurance

Building Successful Associateships

Learn how to successfully hire or become an associate in dental practice. Formulate your plans with information on:

- reasons for becoming an associate
- reasons for adding an associate
- various working arrangements
- forms of compensation
- impact of new tax laws and IRS regulations
- sample agreements

Includes sample advertisements, checklists, C.V. outline, and agreement examples.

Personal and Professional Success Through Strategic Planning and Goal Setting

Gain insights into your practice needs and chart a course for action. Learn to:

- develop a mission statement
- analyze the state of your practice
- set goals
- create a strategic plan
- resolve conflicts
- manage time effectively

Successful Valuation of a Dental Practice

If you’re in the market for buying or selling a practice, prepare your negotiating position by becoming familiar with:

- fair market value
- setting prices
- legal and tax considerations
- third party appraisal
- alternate valuation methods
- using advisors

and much more. Case examples with sample computations give you clear direction on how to ensure a successful purchase or sale.

Health Care Reform: Nebraskare

by T. Bassett

Another new word for our growing vocabulary is Nebraskare. It could become Nebraska's answer to national health insurance. A blue ribbon panel of 33 people were appointed nearly 18 months ago (by Gov. Nelson) to create a method of providing a basic health insurance package to all citizens in our state.

An early guess is that the program being considered for recommendation to the Governor will be more physician and hospital oriented. Dentistry will likely not be included in the basic coverage. However, the panelists realize that dental services to Nebraska's thousands of medicaid recipients can not simply be eliminated. Their task seems to be to create some program similar to Medicaid to wrap around the basic insurance program and thereby keep impoverished citizens from being denied dental care.

In 1992, Medicaid provided 55,000 Nebraskans with dental care at a cost of nearly $7 million. Thanks to a matching formula the federal coffers paid for $4.4 million and the State's treasury anted up the other $2.6 million.

The NDA will stay in touch with members of the panel and we will keep you informed. They are looking at dozens of options and ideas and seem receptive to our input. They are months away from completing their work.

We will keep you informed. However, if you would like a copy of their initial report give the NDA a call. It's a rather lengthy document, so be prepared to do a lot of reading and not see much of anything on dentistry.

Radiology Inspections: Unofficial “Survey”

by Tom Bassett

Well, how's it going? If your office has been visited by an inspector from Nebraska's Department of Radiological Health we'd like to hear about it — good, bad or otherwise.

The intent of the inspection is to offer protection for all members of the dental team and to patients. If this goal is not being met or if an office is being disrupted we believe the Director of Radiological Health would like to know.

You can call Julie at the NDA office, (800) 234-3120 or drop the NDA a note. This is very unofficial but we believe it's in everyone's best interest to gather some feedback.
A Message From the President

Several months ago, I was seeing a person for a consultation and in passing, asked about his position with the insurance company for which he worked. His answer was a bit unsettling, "I'm in health care delivery, the managed-care end of it." What was unsettling was the "matter-of-fact" tone of his voice. He was not trying to shock me; nor, trying to confront me; just, informing me. He really and truly believed he is part of the system. Dummy me was shocked! Dummy me felt threatened! Dummy me grew-up thinking the system consisted of the patient and the provider.

I had not thought too much of that incident until today when another person, also in the insurance industry, asked me if I would consider joining a dental HMO. I told her that my wife had dental insurance through her employer and that was sufficient. She said it was not for protection, but, as a provider. I was shocked. I was threatened. Dummy me again.

Saturday morning, June 19, 1993, Omaha World Herald headlines front page reads "2 Health Plans Innovate Early: Good Care, Costs Key In Concept". "Rx for Future: Managed Health Care". Plans were revealed discussing alliances of insurance companies, hospitals and physicians to help control health-care costs while maintaining high standards of care.

NEWSWEEK magazine, June 28, 1993. Page 38, "Why Wait For Hillary?: Thanks to competition, business has started the health care revolution without Washington". The article discusses the pressure being put to bear by the purchasers of health-care benefits on the insurance industry to cut the high costs of health benefits. Indemnification programs have dropped from 71% of the insurance market to 45% in six years. The conversion is to programs that have some form of managed care.

The key is to create competition! The up-side is potential for lower costs of prescription drugs and equipment. Great! The downside is the end to the archaic notion that the Patient-Doctor relationship is sacrosanct. Dummy me again. Shocked? Threatened? According to the "ADA Washington Report" (June 11, 1993) the White House Task Force will recommend that dental benefits be part of the basic benefit package of health services.

Is this the end to life on earth as we know it? Probably not. It may change the look of the neighborhood a little bit though. With every challenge comes an opportunity for growth. Just what we need! I am sure everyone is done stretching from the wake-up call from OSHA, the CDC and other governmental entities. Now, on to the fun stuff as the insurance industry gets in on the act!

William Corcoran, D.D.S.
President, Nebraska Dental Association

FDA to classify TMJ Implants

The Food and Drug Administration expects by July to issue regulations classifying temporomandibular joint implants as devices requiring pre-market approval, reports the May 14 ADA Washington Report.

The final rule would place in a Class III category for regulatory purposes TMJ prosthesis, including the interarticular disc prosthesis (the interpositional implant), the mandibular condyle prosthesis and the glenoid fossa prosthesis.

"This action would allow FDA to require manufacturers of these devices to submit pre-market approval applications demonstrating the safety and effectiveness of these devices," according to a notice in the April 26 Federal Register, the official record of government business.

"The devices present a risk of implant loosening or displacement; degenerative foreign body reaction; degenerative changes to the natural articulating surfaces; infection; and loss of implant integrity," the notice said.

Rag Dolls To Riches

Last year, children around the world received $54 billion worth of toys. Children in Germany got the most - an average of $441 worth of toys per child. Per capita, children in Belgium got $355 worth, the children in the United States $348, and children in Japan $280.


Journal Dissects the Uninsured

(New York) Before turning one-eighth of the U.S. economy upside down to help the 37 million uninsured, "perhaps someone would try to distinguish between an intriguing problem and a crisis," urged a Wall Street Journal editorial. The uninsured, according to a study produced for the Urban Institute, tend to be young and low on the earning curve, but not necessarily poor. Nearly half have household incomes above $20,000, and 17 percent earn more than $40,000, according to the Employee Benefit Research Institute. "What this suggests is that many young workers are turning down health coverage from their employers. They'd rather have the cash wages and funnel the money toward rent, car payments or a savings account," the editorial explained. "In affect, these workers opt to self-insure, which means that they reach into their own pockets when they need a doctor." So instead of Clintons insistence on "bold, persistent experimentation," policy-makers should consider smaller-scale experiments to address the problem, the editorial said. (The Wall Street Journal, April 15)
Where Do New Patients Come From?

Your Executive Director guessed “the stork” and “the cabbage patch.” Further research proved him wrong, however, one point was awarded for spelling his wild guesses correctly. From the June 1993 issue of Practice Smart we learn the correct answers.

This chart shows the breakdown according to the ADA. Whether you’re a G.P. or specialist, it’s more important than ever to cultivate referrals from your existing patient base. One of the best ways to get referrals is simply to ask. If you’re unsure as to your best patients, or when you would like to ask, start by identifying your best patients. Some criteria include those who:

- pay on time
- show up on time
- have good insurance
- are great dental “successes” (they will become great missionaries for your practice – just ask them!)
- have outgoing personalities
- have lots of friends
- own their own businesses.

Another way to put it is: Your best source of new patients is your best patients!

**Sources of New Patients**

**General Practitioners**

- 72.7% Existing Patients
- 1.6% Referral Services
- 2.4% Other Gen. Practitioners
- 3.5% Capitation Plans
- 3.9% Physicians/Other Professionals
- 4.3% Other
- 5.1% Specialists
- 6.5% Advertising

**Specialists**

- 55% General Practitioners
- 1.8% Advertising
- 1.9% Other
- 1.1% Referral Services
- 1.5% Capitation Plans
- 4.4% Physicians/Other Professionals
- 5.1% Other Specialists
- 28.1% Existing Patients
Dr. Thiemann Visits South Dakota

One of the most enjoyable aspects of visiting South Dakota for their annual meeting was seeing the enthusiasm of the membership and their commitment to organized dentistry. The meeting started on Friday with a Trustees meeting, Saturday with a scientific session, Sunday with a House of Delegates, again on Monday with another House meeting and ending on Monday afternoon with a Trustees meeting. This truly is a commitment by the delegates to the business of organized dentistry in South Dakota!

The concerns of the dentist in the Dakotas mirrors our own including putting the state organization on firm financial footing, providing quality C.E. to their membership, access to qualified auxiliaries in the office, OSHA, and especially the unknown health care proposals by Hillary Clinton.

Addressing the House of Delegates was the 10th District Trustee Dr. Michael Till and the Second Vice President of the ADA Dr. Richard Lewis.

Dr. Till’s address centered around the ADA’s response to OSHA which is a two pronged approach: First being in the legislative arena and second in the courts. Both of these will be ongoing for quite some time.

Dr. Lewis’ report dealt with health care reform. Dr. Lewis stressed that we cannot afford to stand back and not become involved. Dentistry has a very good record in cost containment, quality of services involved and providing preventive care. South Dakota responded to Dr. Lewis’ appeal by passing resolutions to form an ad hoc committee to promote health care policy in South Dakota, urge component districts to meet with their legislators and resolve to oppose a health care provider tax as instituted in Minnesota.

On a personal note, my wife Cindy and I would like to thank all of those who made our visit to South Dakota so pleasant. All of those involved went out of their way to make us feel a part of their annual session.

Bill Thiemann, DDS
Vice-President

They’re Still Free

The response to our offer of the Joe Montana - mouthguard posters has been great. We only have a hundred or so left. The NDA’s Mouthguard Committee purchased these colored posters to help promote the use of mouthguards.

We would like one displayed in every members’ office. To get your poster just contact the NDA office. If you know a coach who will display one or two at school, order several. They’re free to NDA members and won’t do Peggy, Julie or Tom much good in the NDA storage room. We wear our mouthguards darn near everyday.

Call us at 800-234-3120.

Moved?
New Phone #?

Let the NDA know your new address/phone #. Call Julie or Peggy at 1-800-234-3120 or 476-1704, or write us at 3120 “O” Street, Lincoln, NE 68510.

Need answers? Call the NDA toll free at 1-800-234-3120.

Fax it! Dial (402) 476-2641.

*Please note that the NDA’s Membership Directory goes to the printer on July 15th. Please call us with changes in phone numbers, addresses, etc. ASAP.

During the Past Decade:

- The number of Americans in prison doubled.
- There was a 20 percent drop in death from residential fires (thanks to smoke detectors).
- The number of fast-food stores increased by 78 percent.
- Sales of gospel music tripled – it’s now a $500 million industry.
- The number of children injured by falling out of shopping carts more than doubled.
- Divorce rates dropped ten percent.
- The percentage of Americans who know someone with AIDS rose to 15 percent.
Dr. Vigna Visits Iowa

During the last week of May, I had the pleasure of attending the 131st Annual Session of the Iowa Dental Association in Des Moines. As is the case with all our 10th District neighbors, I was hosted in fine fashion and had a nice time. The Iowa Association is organized in a more traditional structure with two Board sessions, and two sessions with reference committee meetings held between the sessions. The business of the Board and House was a routine nature, and not any real controversy (which we all appreciated). The resolutions of most interest called for a study of the number of delegates each district has or should have, the establishment of a dental foundation; the reorganization of their councils and committees and one addressing the method of selection of the ADA president-elect. Action on these issues were as follows:

- The resolution to study the delegate numbers from each district was defeated;
- The establishment of a dental foundation was passed (in fact, they took a page out of our book and held a celebration fund-raiser event like ours to raise funds for the new foundation. I guess they were pretty sure the concept was going to be approved, or at least had wishful thinking!);
- The reorganization plan for the councils was approved and was a good effort to help make the Association more efficient.
- The resolution dealing with the ADA president-elect selection passed and will be taken to the ADA House in San Francisco by the delegates. This resolution calls for simple rotation of the ADA president-elect between the 16 districts of the ADA thus eliminating the costly campaigns.

Aside from the routine business, the topic of greatest interest in both formal meetings and informal conversation was health care reform and how it would affect dentistry. Mike Till, 10th District Trustee gave a report on the latest position of the ADA. As you know, the position of organized dentistry has been that we have done a good job of providing care, and access and with our emphasis on prevention, a reform of our delivery system is not needed.

As always there was a nice mix of social events. One of the most interesting was the PAC luncheon. I am well aware of the controversy surrounding the PAC concept. However, the speaker was a dentist who is a member of the Iowa House. His message was outstanding about the specific ways the dental PAC really makes a difference. We have all heard the message before and it is a simple one. Whether it is on a state or national level there are people with many ideas of how we should practice our profession and deliver care to our patients. If we like to be told what to do and how, then we should sit on the sidelines and watch, but don’t complain when one day our practice lives are being dictated from an outside source. If we want to preserve our profession, then we should get involved, and stand up and be heard. As a profession, we are well-respected. Legislators will listen and want to hear from us. As an active player he felt strongly that PAC activity was the way to get the voice of the profession heard the loudest.

Respectfully submitted, Ed Vigna, President-Elect
OSHA Stats: Dental Office “Visits”

Federal and State Occupational Safety and Health Agencies inspected 195 dental offices and clinics between July 1 and February 26 - a rate of 25 a month.

An ADA Washington office analysis shows that 80 percent of the dental inspections were based on employee complaints. The rest were random inspections or references from other agencies.

Dental inspections were reported in Alabama, Alaska, Arizona, California, Colorado, Connecticut, the District of Columbia, Florida, Hawaii, Illinois, Indiana, Iowa, Louisiana, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Nevada, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Tennessee, Texas, Virginia, Washington, and Wisconsin. Inspectors visited dental facilities in Kentucky, Minnesota and West Virginia, but did not conduct inspections. Other states not mentioned above also may be conducting inspections, but did not show up in OSHA’s records.

Nearly 40 percent of the dental inspections occurred in California, one of 25 states and territories enforcing their own occupational safety and health standards, which must be at least as effective as federal OSHA requirements. California OSHA is phasing in a state bloodborne pathogens standard that will be fully effective May 8.

Of the 195 inspections nationally, 71 were in federal OSHA states, and 124, including 75 in California, were in “state-plan” states.

Inspectors issued 628 citations for alleged violations at 124 dental facilities, an average of five per facility. Bloodborne pathogens and hazard communication regulations were cited most often, although general safety violations occasionally were cited.

Federal and state compliance officers proposed penalties for dental facilities totaling nearly $256,000. Penalties ranged from $50 in Los Angeles to $48,400 for a Colorado dental practice.

Negotiations and settlement agreements reduced the total to just over $212,000. Three dental practices filed legal contests to their OSHA citations.

Reports provided by federal OSHA and analyzed by the ADA Washington office covered dental inspections between July 1, 1992, when the federal bloodborne pathogens standard took effect, and February 26, 1993.


(Thanks to the South Carolina Dental Association for this information).

3rd International Computer Conference

The most up-to-date computer systems and technology will be displayed and discussed at the Third International Conference on Computers in Clinical Dentistry, held September 17-19 in Los Angeles.

The meeting is sponsored by the University of Southern California School of Dentistry and co-sponsored by GC America and Quintessence International.

Over 25 top lecturers from around the world including Dr. Ronald Goldstein and Dr. Marilyn Miller. Also, 65 exhibitors will present the latest computer-related applications for dentistry and offer participants the opportunity to determine which system best suits their needs.

Registration information can be obtained by calling (213) 740-1591 or by writing to the USC School of Dentistry, Dept. of Continuing Education, Room 304A, University Park MC 0641, Los Angeles, CA 90089.

Note to lawmakers: health reform needs in medicine, dentistry differ

(Editor’s note: We seldom use an article from the ADA News feeling that you saw it in that publication. Here’s an exception. The NDA Newsletter has asked members on more then one occasion to educate legislators at all levels of government to the fact that there are some big differences between dentistry and medicine. The following appeared in ADA News, June 7, 1993.)

Dr. Albert Guay, director of the ADA Division of Dental Practice, has been keeping a close eye on state health care reform initiatives.

“It’s very important,” says Dr. Guay, “that state dental societies make their views known when health care reform legislation is proposed. It’s important for them to educate legislators about the key differences between medicine and dental care.”

Those differences, Dr. Guay continues, include facts such as:

- Dental disease is almost entirely preventable, at a minimum of cost and effort.
- Unlike general disease, dental disease is not an insurable risk; it does not have the essential characteristics of an insurable risk, since: there is near-universal incidence of dental disease; apart from trauma and pain, the patient has total control over when, and if, treatment, and has considerable effect on the outcome of treatment; and the financial implications of dental treatment are not catastrophic;
- Competition exists in the dental marketplace, since most dental care is not of an acute nature, enabling patient to seek out the best value in dental care.
- High-tech advances in dental care generally are not very costly, add to the efficiency and capability of care and have not resulted in severe inflation of dental costs.

These facts have certain implications for health care reform initiatives, says Dr. Guay:

- The cost for a dental plan can be planned for quite accurately, so dental plans are really not insurance plans, but prepayment plans.
- Preventative services should be reimbursed at 100 percent of costs, and should be an essential part of every plan, especially for children.
- The health maintenance concept of health care delivery does not apply to dental care; dental health must be established in most people before it can be maintained.
- There need not be an aggregation of dentists into groups to introduce competition into the dental marketplace.

Calling All Hams

No, not swine or stand-up comedians. The Japan Dental Ham League (JDHL) was founded in 1975 and has 130 dentists in their personal computer dental network, “JDHL NET.”

They’re looking for more dentists to join in this exchange of ideas and information. If you’re into amateur radio and/or computer systems drop a note to the group’s president. Contact: Osamu Tamazawa, D.D.S., Ph.D. 23-9 Oohara 2-chome Setagaya, Tokyo Japan, 156

Better put an extra couple stamps on the envelope.
Your Colleagues

by Julie Berger

This month's featured Young Professional is Dr. Mark Ebers of Lincoln. Mark is a 1990 graduate of UNMC and is a general dentist. He and his wife Cathy have been married for 2 1/2 years.

Mark loves recreation time including everything from volleyball to cycling, skiing and softball. He hopes to develop a taste for golf if he learns to get his drives off the grass! Good Luck!

Dr. Ebers hopes to keep his career in perspective and enjoy the dental profession as much over the next 35 years as he is today.

Outside of just graduating from dental school, he tied for the 11th place on the still rings at the '86 NCAA Gymnastics Championship! Wow – way to go!

Best of luck to you Dr. Ebers!

Dr. Mark Ebers

Congrats, Thanks, Etc.

Congratulations to Dr. William "Skip" Gist of Omaha. Skip recently qualified for the Nebraska men's golf championship. He was seated third. Skip won the 1st match, but lost in the 2nd round. But, hey, you didn't want to be a pro golfer, did you? We thought so! Congrats and keep on swingin'!

Three Cheers to Sheri Uher, a dental hygienist who works for Dr. Nick Kentopp in Omaha. Sheri was in the right place at the right time and saved a man's life. A man had collapsed in a paint store and Sheri was there to help. She performed CPR on him until the paramedics arrived. The paramedics stated that the man would not have made it without her help.

Kudos to Dr. Arthur Croft of Augusta, Georgia. He recently has been promoted from Assistant Professor to Associate Professor at the Medical College of Georgia's School of Dentistry. What a significant achievement! Dr. Croft has retained his NDA membership. Thanks, Congrats and Best Wishes!

Surgeon General Warns of Increased Use of Smokeless Tobacco

U.S. Surgeon General Dr. Antonia Novello, who relinquished office last month to Arkansas' health director Dr. M. Jocelyn Elders, continues to warn the public about tobacco abuse.

Novello recently told USA Today, "Tobacco is tobacco whether you smoke it, chew it or spit it."

In another interview she said tobacco use falls when the price goes up.

"What we have to watch very closely is what I see in the community – since the EPA (Environmental Protection Agency) proclaimed that passive inhalation could result in cancer of the lungs – that there is this perception that smokeless tobacco might be less dangerous because it has no smoke," she said.

"And I am very concerned because I'm seeing a lot of young people starting to use chewing tobacco under the assumption that it is no problem," she said.

One of five males 17 to 19 years old is chewing tobacco, Novello said. The mean starting age is nine. Smokeless tobacco, she said, has never been taxed equally; taxes are three cents a pouch for smokeless tobacco and 24 cents a pack for cigarettes.

Novello warned of a potential oral cancer epidemic if the smokeless tobacco trend continues.
Consent for Minors

What is adequate consent?

Dentists must obtain informed consent before providing dental care to adult and minor patients. Failure to obtain consent may result in a malpractice action against the treating dentist if patients allege they were treated without an adequate explanation of treatment.

Before giving permission to the dentist to perform the procedure, patients have the right to be properly informed about health risks, complications, alternatives and benefits of the proposed treatment. Being given a clear explanation of these issues allows the patient to ask questions and give informed consent.

Can a minor give consent?

Generally, patients who have not yet reached the age of majority (18 years of age in most states) cannot legally give informed consent for dental care. Minor patients generally have similar rights as patients who, due to some disability, cannot represent themselves competently in legal proceedings.

Who can provide consent for minors?

In most cases, parents (or legal guardians) represent minors' interest in legal issues, including consent authorizations.

Parents provide consent for the majority of minor patients. Children of divorced parents may be represented by one or both parents, depending upon the divorce decree. Generally, one divorced parent is appointed guardian, even if joint-custody is granted. However, there may be exceptions requiring the consent of both divorced parents.

Minors who do not live with or are not dependent upon their parents usually will have a court-appointed legal guardian provide consent. Some minors may have the right to give consent for themselves if the state has recognized them as "emancipated" minors. Minors who support themselves, live independently or are married generally qualify as emancipated minors.

Risk management aspects of consent for minors

Dentists should discuss all dental treatment required for minor patients with the parents or legal guardian. If it is unclear who has the responsibility to authorize the minor's dental care, obtain a copy of the legal documents that identify the guardian or that designate the minor as emancipated. This information should become part of the dental record.

The parents or guardian should be asked to give consent for treatment of minor patients after discussion of each procedure to ensure conformance with informed consent requirement. If there is an unanticipated change in the treatment plan, obtain consent again before proceeding with treatment. This requirement can be completed through a telephone call, if necessary, and if the telephone discussion is clearly documented in your file.

Because minor patients may be accompanied to the dentist's office by a person who does not have the legal authority to give consent for treatment, dentists should be careful to obtain consent from a person with the proper authority.

Additional consideration in treating minors

Minors eventually reach the age of majority. As minors become mature enough to participate in the decision-making process, dentists should include them in the discussion of treatment with the parents/guardian.

These discussions which include mature minors can improve communication and enhance the dentist-patient relationship. In addition, a review of certain medical history questions in private with the minor could uncover important facts that may influence dental treatment. There may be issues concerning oral contraception, drug abuse or pregnancy that minors may not have yet discussed with the parents/guardian.

Take time to protect your practice

It takes time and effort to properly and effectively provide dental treatment to minors. However, it is time and effort well spent.

(Thanks to CNA for providing this article)

Congratulations to Dean Leeper!

The Juvenile Diabetes Foundation (JDF) International announced the election of Dr. Stephen Leeper, Dean of the UNMC College of Dentistry, as the President of JDF International.

Dr. Leeper has been a member of JDF's International Board since 1987 and has served on its Executive Committee. For three years he was Vice President of Research, responsible for overseeing the review of grants, career development awards and postdoctoral fellowships. He also played an integral role in JDF's Medical Student Workshops and other scientific meetings. Prior to his research involvement, Dr. Leeper was very active in JDF chapter development and fundraising making visits to chapters all around the country. JDF is no small group, in 1992 they provided $20 Million for research.

Actively involved in community projects, Dr. Leeper and his wife, Jan, co-founded the JDF Lincoln Chapter in 1974.

Congratulations and best wishes!
Between Hillary Clinton and about a dozen federal agencies, the words and phrases used in connection with national health care plans sound like a Martian’s version of pig latin. It’s time to review this new vocabulary.

**ACCOUNTABLE HEALTH PLANS (AHP):** AHPs are mechanisms for provision of health care services, accredited according to guidelines established by the National Health Board (NHB). They must offer standard, nationally defined uniform health benefits. An AHP will have to require providers to report medical outcomes and have to meet quality and cost standards. Furthermore, AHPs will not be able to “cherry pick” healthy individuals, charge extremely high rates for persons with costly medical problems, or deny coverage for a pre-existing illness.

**ALL-PAYER SYSTEM:** “All payers” of health care bills – the government, a private insurer, a big company or an individual – pay the same rates, set by the government, for the same medical service. The uniform fees would bar providers from shifting costs onto those more able to pay.

**COMMUNITY RATING:** Setting health insurance premiums based on the average cost of medical services to all people in a geographic area, without adjusting for each individual’s medical history or likelihood of using such services.

**FEE FOR SERVICE:** An arrangement under which patients pay doctors, hospitals or other health care providers for each service rendered. Most then seek reimbursement from a private insurer or the government.

**GLOBAL BUDGET:** A system through which the federal government sets a national health care budget, thus placing federal caps on health care spending. The cap would cover both public and private spending.

**HEALTH INSURANCE PURCHASING COOPERATIVE (HIPC):** HIPCs would act as purchasing agents for small businesses and individuals, giving them the same leverage as big companies. They would shop for the highest quality health plan at the lowest price. They would service defined regions, states or classes of customers.

**HEALTH MAINTENANCE ORGANIZATION (HMO):** A prepaid health care plan under which people enroll by paying a set annual fee. Patients then receive all the medical services they need through a group of affiliated doctors and hospitals, often with no additional co-payments or fees.

**MANAGED CARE:** A general term for organizing networks of health care providers, such as doctors and hospitals, to enhance the cost-effectiveness of their work. An HMO is a common form of managed care.

**MANAGED COMPETITION:** A proposal for financing and delivering health care that attempts to meld government regulation and market competition. The basic idea is to blend employers into large purchasing networks to shop for the highest quality health coverage at the lowest price. The government would require any insurance company, HMO or other health plan bidding for their business to offer a standard package of benefits. The hope is that the networks huge buying power would generate competition among health plans, lowering prices and improving quality. All employers would be required to contribute to the cost of health coverage for their employees and the government would subsidize the cost for the working poor.

**NATIONAL HEALTH BOARD (NHB):** The NHB is a federally appointed board similar to the Securities and Exchange Commission or Federal Reserve Board, with carefully defined authority to oversee the implementation of an American health care system modeled on the development of managed competition. The board would define a basic benefits package, establish standards for reporting prices, technical arrangements, health outcomes and quality. In addition, the NHB would ensure availability of consumer information on the quality of accountable health plans.

**PREFERRED PROVIDER ORGANIZATION (PPO):** An arrangement under which an insurance company or employer negotiates discounted fees with networks of health care providers in return for guaranteeing a certain volume of patients. Enrollees in a PPO can elect to receive treatment outside the network but have to pay high co-payments or deductibles for it.

**PAY-OR-PLAY:** A proposal for restructuring the health care system so that all employers would be required to either provide health insurance for their workers or pay a tax to finance a government plan to cover them and everyone else.

**SINGLE-PAYER:** A system whereby one entity, probably the government, pays for all health care. Canada has the best-known single-payer system. It is financed by taxes, and people go to the doctor or hospital of their choice and bill the government.
Chemical Dependency and the Dental Patient

by Dr. Dennis Miers
Assistant Professor
Louisiana State University
School of Dentistry

Doctor, have you ever administered nitrous oxide, diazepam, or an opiate to a recovering alcoholic? Have you ever administered lidocaine to a patient whose hepatic or vascular systems have been damaged by alcohol or other drugs? Have you ever given a mouthwash or medicament containing alcohol to a patient who is taking disulfiram? Could you have prescribed an agonist-antagonist narcotic to a patient who has been taking an agonist narcotic for an extended period of time? Do you know how many patients in the United States are or have been treated for chemical dependency? Do you know how many patients in the United States have active, or a predisposition to, chemical dependency. Yet, in dental school we had little, if any, training concerning one of the largest health problems in America.

The American Association of Dental Schools has developed the following resolution which states the "Provision of Dental Care for Patients Who Are or Have Been Chemically Dependent":

1. In the treatment of any dental disease, the general well-being of the patient must be a primary focus for comprehensive dental care. All disease states, either active or in remission, should be identified and considered in the overall dental treatment planning.

2. Chemical dependency (alcohol, nitrous oxide and other drug dependencies) is a primary chronic and progressive disease that can affect every aspect of a patient's life.

3. The use of certain therapeutic agents in dental treatment may have effects on the health and relapse potential of the recovering chemically dependent patient.

4. It is the professional responsibility of the practicing dentists of the United States to be aware of chemical dependency as an illness and to address the issues of appropriate dental care in the chemically dependent population.

5. Confidentiality must be respected and maintained at all times.

The ADA has adopted "Oral Health Care Guidelines for the Chemically Dependent Patient." The purpose of these guidelines is to educate the profession to the fact that the use of, abuse of, or addiction to alcohol and other drugs of dependence may constitute an additional risk factor in the provision of dental care. The extent of this risk factor will vary greatly, even among patients with the same level of substance use, abuse or addiction and who exhibit similar symptoms. Therefore, there are many options for dealing with chemically dependent patients and until such time as definitive standards of care may be developed in this area, the appropriate course of action must be left to the professional judgement of the treating dentist. The objective of these guidelines is for the dentist to be able to:

1. Describe the difference between the use, abuse and dependence upon a psychoactive substance.

2. Describe the disease precept of chemical dependency.

3. Identify the most commonly-used psychoactive substance among the United States's population in general and in one's own locale.

4. Identify appropriate chemical dependence resources for personal continuing education purposes.

5. Identify appropriate chemical dependency policies enacted by the ADA House of Delegates which have a bearing on one's practice of dentistry.

6. Identify the signs, symptoms and complicating factors for each of the categories of psychoactive drugs.

7. Intelligently review his/her prescribing practices and make any necessary or appropriate changes.

8. Modify, if necessary, the personal/health history form to include appropriate questions about alcohol, nicotine and other drugs.

9. Implement courses of action to enhance risk management while treating this special population.

10. Describe the actions and interactions of various psychoactive drugs used by patients and/or administered by the dentist.

It may seem that those who adhere to the disease model of addiction are implying that the chemically dependent person is not responsible for his/her condition. Addiction and recovery should be perceived as being on a continuum. Some people become dependent more easily than others and some recover more easily than others. Also, some are more likely to relapse if exposed to mood altering chemicals. For this reason, we take precautions with all recovering, predisposed, or active chemically dependent patients.

Table 1 lists some of the drugs that could be hazardous to the sobriety of a recovering patient. A few of these drugs are not physically addictive, however, they can alter the mood of a chemically dependent patient. In turn, this could trigger drug ideation and the compulsion to use.

At a minimum, the dental health information form should include the question, "Are you recovering from the disease of chemical dependency?" Recovering patients are more likely to identify themselves if they perceive that you and your staff are non-judgemental and recognize chemical dependency as a treatable disease. At least part of our responsibility is reduced if we ask this question.

Recovering patients should not have to endure intolerable pain. If non-mood altering drugs are not sufficient, then one should resort to using stronger analgesics provided that certain guidelines are followed. (Table 2)

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Cont'd on Pg. 11
Chemical Dependency and the Dental Patient

Although it is true that no one decides to become chemically dependent, at one time or another they have made a decision to drink or use a mood altering drug. They are responsible for that choice unless of course the drug was prescribed by a dentist or physician. They are not responsible, however, for losing control of that consumption. The loss of control or compulsivity is due to complex changes in the neurochemistry of the brain. We now understand that the sometimes repulsive, manipulative behavior of the addict is due to changes in brain chemistry brought on by exposure to the drugs.

The behavior did not necessarily precede the exposure and when the patient is detoxified that dmg-induced behavior tends to cease. Once the patient is detoxified and in a recovery program, he/she is responsible for his/her own recovery.

Just like periodontitis, chemical dependency is a disease. They are both classified as diseases because they (a) have recognizable signs and symptoms; (b) they follow a predictable and progressive course; (c) they produce consistent anatomic and/or physiologic alterations; (d) their cause or causes may not yet be known; (e) they are primary conditions not merely symptoms of some other disorder. Behavior modification is an essential element of recovery for both diseases. Like periodontitis, chemical dependency is a highly-treatable disease with a good prognosis if treatment recommendations are followed. Both diseases are chronic and progressive. If the patient neglects his/her recovery responsibilities, the diseases will become active again. Relapse is common to both diseases, however, chemical dependency is fatal if not treated.

Table 1. Drugs which may be hazardous to the sobriety of a recovering chemically dependent person.

| A. Narcotic (opioids) such as codeine, morphine, hydromorphone, meperidine, oxycodone, Hydrocodone, pentazocine, propoxyphene, nalbuphine hydrochloride, butorphanol tarrate. |
| B. All sedatives, including the barbiturates and synthetic sedatives such as chloral hydrate, glutethimide, and ethchlorvynol. Any medication which contains alcohol, such as cough syrups or cold medications. |

Dentistry on TV

"Dentistry Update," a 30-minute television program for dentists, airs Sundays on the Lifetime Cable Network. Check local listings for airtimes.

- "Dentistry Update" is produced by the ADA and Lifetime Medical Television and funded by Dr. and Mrs. Lampshire.

July 4: Pain Control in Dentistry and TM Disorders
July 11: Computers and Imaging in Dentistry
July 18: Dental Forensics and Child Abuse
July 25: Esthetics in General Practice
August 1: Adult Orthodontics and New Technologies in Endodontics
August 8: Pediatric Dentistry
August 15: Periodontology
August 22: Microsurgery and Arthroscopy of the TM Joint
August 29: Maxillofacial Prosthodontics and Oral Cancer

The Lifetime Channel can be viewed on the following channels:

- Lincoln – 33
- Omaha – 28
- Holdrege – 16
- Grand Island – 30
- North Platte – 18
- Scottsbluff – 21

Table 2. Guidelines for the use of mood altering drugs with recovering chemically dependent patients.

1. Inform the patient and a family member of the type of dmg being used and its possible side effects.
2. Consult the patient's primary physician and/or after-care personnel of your treatment plan and intended dmg therapy.
3. If a prescription is indicated, a family member, A.A. or N.A. sponsor should fill and dispense the dmg. (A sponsor is someone in the program of A.A. or N.A. in whom the recovering person can confide. They usually have a greater length of sobriety than the person whom they sponsor.)
4. Suggest that the patient identify his/her activity in A.A., N.A. or other group therapy that may be associated with the aftercare program.
5. Prescribe only the amount of dmg necessary to cover their acute pain and do not give refills.
6. Reassure your patient that you will do everything possible to make him/her comfortable.
7. If mood altering drugs are required, the primary physician may recommend that dmg therapy and subsequent detoxification occur within the hospital environment.

Condolences to Dr. Lampshire

Dr. Earl Lampshire of Lincoln, a past president of the NDA, suffered the loss of his home on June 9th. One of Lincoln's worst residential fires in memory swept through the Lampshire home causing nearly a total loss of the property.

Earl suffered burns on his head, neck and back. He was taken to a hospital but released the same day. His wife was not home.

The real estate was not insured and losses are estimated to be in the $350,000 range. We extend our sympathy to Dr. and Mrs. Lampshire and wish them a speedy recovery from this tragic accident.

References:

Note: This list is not exhaustive and is meant only to be a guide.

The American Dental Association, Washington, D.C. (202) 501-2200
**NEBRASKA DENTAL ASSOCIATION**

**NDA MEMBERSHIP**

**What’s In It For You?**

**SAVE MONEY**... Take advantage of NDA endorsed insurance plans!

**DISABILITY INCOME**
- Up to 80% of earned income.
- “Your occupation” covered.
- Economical premiums.
- Partial disability included.
- Survivor benefit up to 3 times your monthly benefits.
- $25,000 loss of use of hands benefit in addition to your regular monthly benefit.
- Monthly benefits can never be reduced because of income received from other disability policies, social security, or worker’s compensation benefits.
- Local claim service.

**HOSPITAL CASH PLAN**
- Pays up to $200 a day for every day you are hospitalized for 365 days. Will help ease the cost of waiting for your disability waiting period to be satisfied.
- Pays in addition to your health insurance plan.

**OFFICE OVERHEAD INCOME**
- Reimburse your office expenses when you are disabled, so you can keep your staff intact.
- Benefits are paid retro active to the very first day of disability, after the waiting period has been satisfied.
- Premiums are tax deductible.

**PROFESSIONAL PROTECTOR PLAN**
- Consolidate all your office insurance requirements within a unique Dental practice policy offering $1,000,000 limits of liability plus “replacement cost” property coverage, Dental liability package, and worker’s compensation insurance.
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To take advantage of the above insurance programs contact:
Harold Diers & Company
Administrators NDA Endorsed Insurance Plans
805 S. 75th St.
Omaha, Nebraska 68114
391-1300
1-800-444-1330

**Term Life Insurance**
- Very reasonable rates for ADA members!
Call Great-West Life 1-800-568-2001

**Travel Arrangements**
AAA Travel offers NDA members a 3% rebate. Their statewide toll free number is 800-222-6327. Be sure you tell them you’re an NDA member.

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**Washington’s Crystal Ball**

Oral health care is emerging as an issue of renewed importance in the debate on health care reform. Association lobbyists have learned that the White House Health Care Task Force will recommend that dental benefits be included in the basic benefit package of covered services.

During a recent speech to consumer groups, First Lady Hillary Rodham Clinton confirmed that she wanted a children’s dental program, along with coverage for acute dental care for adults, included in the Clinton health plan’s mandatory package of benefits.

Speaking for the ADA, as quoted in the *New York Times*, ADA Executive Director John S. Zapp responded by saying, “We would support a preventive dental health care program for children and comprehensive coverage for all indigent people. But for the nonindigent adult population we prefer the current private-sector benefits program, including private health insurance negotiated in the workplace, which has a good record of cost containment.”

This is the message that ADA President Jack H. Harris, Dr. Zapp and Dorothy Moss, Director of the ADA Washington office, delivered when they met June 2 with representatives of the President’s Health Care Task Force. In addition to being supportive of prevention and care for children, the elderly and those who are indigent, they advocated the preservation of the current dental care delivery system provided through tax-deductible employer plans.
UNIVERSAL HEALTH CARE MAY TAKE 3-7 YEARS

(Washington) President Clinton's advisers are considering phasing in health insurance coverage for the 37 million uninsured Americans over three to seven years, according to an official familiar with the deliberations. Clinton has publicly pledged his reform measure would provide universal coverage by the end of his term, which ends in January 1997. But the official, who discussed the matter on the condition of anonymity, said the timetable may be slowed because of the huge sums needed to extend coverage to the uninsured. "You can't do it overnight. You can't say to every small business in America, 'Cover your people next year,' " the official said. Under one scenario, universal coverage would be phased in as early as 1996, but other proposals would push it back as late as the year 2000, the source said. (The Associated Press, April 29, 1993)

KERREY SAYS HEALTH CARE EFFORT MUST BE AUSTERE BUT UNIVERSAL

(Washington) Sen. Bob Kerrey, D-Neb., said that President Clinton should lean toward austerity in proposing health insurance for 250 million Americans. "I don't think you should have an open-ended system like we have now," Kerrey said in an interview. "An open-ended system will bust the bank." "States will have the principal responsibility for determining the details of health care legislation," Kerrey said at a health care forum he addressed at the University of Maryland. He said he would favor federal legislation that would pre-empt the 1975 Employee Retirement Security Act (ERISA), which prohibits states from regulating benefit plans provided by employers. Recent newspaper stories, reportedly based on unattributed information from the president's health-care task force, said health benefits provided by large employers will be exempt from the national program. Kerrey said he would oppose these exemptions if they appeared in the final version of the plan. "All Americans should participate on at least one level," he said. (Omaha World-Herald May 4, 1993)

HEALTH REFORM COST PUT AT $100 BILLION OR MORE

(Washington) Government financial experts have told the White House that President Clinton's health reform plan may require $100 billion to $150 billion a year in new public and private spending by government, business and consumers, the New York Times reported.

The estimates, which some administration officials contend are too high, come at a time when Congress is anxious about new taxes needed to pay for a major overhaul of the nation's health system. They are included in confidential work papers from the President's task force on national health care reform.

Financial experts have been working on cost analysis for months, but only recently, as the administration's thinking has crystallized, have estimates of the overall cost begun to circulate.

The financial experts, from the health care financing administration, estimated the cost of three possible packages of benefits. The least generous would cost $99.5 billion a year, while the most generous would cost $150.6 billion, they said. (The New York Times, May 3, 1993)

Quotes of the Month

"[The federal government should] have a tax system which looks like someone designed it on purpose."

William E. Simon (former U.S. Treasury Secretary), 1977.

"I think it an object of great importance ... to simplify our system of finance, and bring it within the comprehension of every member of Congress."

Thomas Jefferson, 1802.

"The race is not always to the swift, nor the battle to the strong, but that's the way to bet."

Damon Runyon
The NDA’s prepayment program has proven to be very popular. For many, 5 monthly payments from July through November are a lot easier to make than 1 biggie in December or January. Over 200 members have been taking advantage of this program and you’re invited to join them.

Fill-out, clip and mail in the following form. If you have questions give us a call at 800-234-3120.

I would like to pre-pay my 1994 Membership Dues in five monthly installments, July through November, 1993. Please enroll me in this program.

Name ________________________________
Address ______________________________
City __________________ State ______ Zip ______
Phone (_____ ) ___________ District _____
Signed ____________________________
Date _______________________________

Please return this form to: Nebraska Dental Association
3120 “O” Street, Lincoln, NE 68510
FOR SALE: Dental office building 900 square ft. with 3 operatories and 3/4 basement lab-equipped. Also, good operatory and lab equipment plus many dental supplies selling. Dr. Robert Crownover, 803 Box Butte, P.O. Box 705, Alliance, NE 69301 (308) 487-3706, evenings.


FOR SALE: Western Nebraska: long established, centrally located 900 sq. ft. 2 chair office and general practice. Good growth potential in a progressive community of 5000. Send inquiries to NDA Box 408, 3120 "O" St., Lincoln, NE 68510.

ILLINOIS GENERAL PRACTICE FOR SALE -- Established 12 years. Equipped with Computer, 3 Operatories with modern equipment. Clean modern office. Good recall system. Practice oriented toward fine quality and preventative dentistry. Reply to NDA box 914.

FOR SALE: Good Serviceable Equipment. 1 Dental EZ Chair, 2 Ritter Chairs, 1 Dansereau Chair, 2 Ceiling Lights (1 Pelton Crane, 1 Ritter), 1 Pelton Crane Executive Unit, Dental EZ Dual Vac Suction, One H.P. Compressor with air dryer, Caulk Varimix Amalgamators, Torit Model Trimmer, Alabama Carts, Cabinetry, and various other items. (402) 493-6063.

WANTED: Lab Technician for gold and porcelain work. Will work for group of doctors and will be offered a partnership position. Lincoln/Omaha area. Send resume to NDA Box 623.

FOR SALE -- Costal chair and dental unit with Peloton Crane light. Unit looks and is like new. Factory reconditioned Weber power lounge chair with articulating headrest. All for $750.00, Lite alone worth the price. Located Omaha. Dr. Croft (706) 868-0674 Evenings.

All ads with an NDA box number should be mailed to: Nebraska Dental Association NDA Box # 3120 "O" Street Lincoln, NE 68510

CLASSIFIED ADVERTISEMENTS: Must be submitted in typewritten form. Indicate the number of issues in which the ad is to be published. Rates for NDA Members (per issue): $6.00 for 30 words or less; 20 cents for each additional word. For replies to NDA box number, an additional $1.00. For Non-NDA Members add fifty percent to these rates. NOTE: Advanced payment for classified ads MUST accompany order. For Display Advertising rate card, contact the NDA office. Send classified ad with remittance to: Nebraska Dental Association 3120 "O" Street Lincoln, NE 68510

DEADLINE: Four weeks before publication.

From Summers Past

In honor of summer and pleasant memories of bygone days, here's a selection of those famous signs by the roadside created by Burma Shave. If you're under 35 you may have to ask an older person what the heck this is all about.

WE CAN'T PROVIDE YOU WITH A DATE BUT WE DO SUPPLY THE BEST DARN BAIT.

TRAIN APPROACHING WHISTLE SQUEALING PAUSE! AVOID THAT RUNDOWN FEELING!

WE'VE MADE GRANDPA LOOK SO TRIM THE LOCAL DRAFT BOARD'S AFTER HIM A CHIN WHERE BARBED WIRE BRISTLES STAND IS BOUND TO BE A NO MA'AMS LAND

HEAVEN'S LATEST NEOPHYTE SIGNALLED LEFT THEN TURNED RIGHT PROPER DISTANCE TO HIM WAS BUNK THEY PULLED HIM OUT OF SOME GUY'S TRUNK

New Members, Phone #'s, Addresses

Please keep us updated re: new addresses, new phone numbers, or corrections in the membership directory.

New Members
Dr. Tarnjit Saini
825 Driftwood Drive
Omaha, NE 68128-4728
(402) 597-2970

Dr. Claris L. Sell
P.O. Box 416
Gibbon, NE 68840
(308) 468-5500

Dr. Derek A. Fender
1209 Harney Suite 200
Omaha, NE 68102
(402) 392-3901

New Addresses
Dr. Donald B. Weddington
5405 Bancroft Ave.
Lincoln, NE 68506-4419
(402) 477-8423

Dr. William Ahrens
5515 S. 73rd St.
Lincoln, NE 68516-4318
(402) 489-5943

Dr. Michael Nedley
908 N. Howard, Suite 110
Grand Island, NE 68803
(308) 381-0151

Dr. Lee A. Dahl
P.O. Box 97
Laurel, NE 68745-0097
(402) 256-3231
WANTED:

County Dental Consultants

We are currently in need of dentists willing to fill vacancies of County Dental Health Consultants in the following Counties:

Arthur
Banner
Box Butte
Burt
Dakota

Dawes
Dixon
Grant
Kimball
Lincoln

We still need a few good NDA members to serve as County Dental Consultants.

Here are guidelines regarding the position.

1. Consultant must be a dentist licensed in the State of Nebraska;
2. Must have experience in private dental practice and should be able to demonstrate through such mechanisms as continuing education, familiarity with current clinical procedures and practices;
3. Should be in a position to maintain a private practice at least on a part time basis to remain current with the trends in treatment, fees, etc. ;
4. The consultant should be a general practitioner rather than a specialist;
5. Should have demonstrated knowledge of contract interpretation laws and regulations governing dental practice in those jurisdictions affected by his consulting activities.
6. Should be aware of the resources available from the dental profession that are intended to assist carriers in prepayment matters such as peer review committees and dental care councils;
7. Should be active in organized dentistry and have the respect of peers;
8. Should possess the administrative ability to deal tactfully with situations in which differences of professional judgement may arise;
9. Should be sensitive to the importance many patients and dentists place on the doctor-patient relationship and take care that it is not unjustifiably disturbed.

If you have questions or need further encouragement, please call Peggy or Tom at the NDA office.

It is important that we have NDA representatives in each of our counties. If you are willing to represent one or more of the above listed counties as a Consultant, please phone the NDA. Your support of this program will be appreciated.