Coverage from the Most Important Dental Industry Conferences

Dentist's MONEY DIGEST

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BLACK & GRAY Markets

Shedding light on how counterfeit products are hurting your patients.

PLUS

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Beware Gray- and Black-Market Goods: Products of Negligence

When was the last time you looked through your supply closet? Moreover, when was the last time you reviewed the inventory your staff has been ordering? You may know how much those supplies cost, but what you don’t know about them may cost you more dearly.

We’re talking disciplinary charges dearly. If you’re like most dentists, you’re not the one stocking that supply closet – you’re simply signing the check to keep it full. And if that check happens to be smaller than it was the month prior, you’re a happy dentist. But what accounts for the sudden cost-savings? Where are those cheaper products coming from? They may have been purchased on the black or the gray market.

The worst part in all of this is, the product-purchaser in your practice likely has only good intentions. They’re trying to save you some money. Maybe they found the composite you prefer or self-adhesive resin cement you like on eBay or Amazon, or the Chinese equivalent, Alibaba, for a lower price. It looks the same in real life as it does online, and when it arrives at your practice, it passes muster, so into the closet it goes.

The trouble starts when it’s taken out of the closet and put into a patient’s mouth. Say the product fails, complicating a patient outcome. You lose time or money redoing your work. Or worse, the treatment causes harm to a patient, leaving you to answer to a state panel for negligence. Our experts say, “I didn’t know” won’t be an adequate defense.

As you’ll learn in this month’s cover story, experts estimate that about 15 percent of all dental products are acquired from outside of secure supply lines – black or gray markets. The threats associated with black-market products (often made of inferior components and under less- rigorous manufacturing standards) are obvious.

Gray-market products, however, are far more insidious. Unlike their black-market counterparts, gray-market products are legal here in the United States. Often, these look the same as legitimately manufactured and shipped goods, but experts say gray-market products are usually intended for foreign markets and, as a result, may sit in non-climate-controlled environments, or exceed their use-by dates – compromising their efficacy. Luckily, there are steps you can take to avoid this nightmare scenario. The experts we’ve interviewed in this issue provide useful information that you can absorb, and then impart to your staff to protect your business.

First and foremost, they say, if it looks too good to be true, it probably is. But ultimately, solving the problem of black- and gray-market dental products is a matter of education. With your name on the line, how can you afford not to?

Mike Hennessy, Sr.
Chairman and CEO

Meeting Minutes SUMMARIES AND STATS FROM INDUSTRY EVENTS

Yankee Dental Congress
Jan. 25-29, 2017
New England’s largest gathering of dental professionals brought droves from across the region to exchange ideas and hone their skills in an unseasonably warm Boston. The meeting included more than 450 exhibitors, offered more than 30 free continuing education courses, and hosted 28,000 dental industry workers. Our coverage begins on page 23.

Chicago Dental Society Midwinter Meeting
Feb. 23-25
The theme for this year’s meeting, now in its 152nd year, was “Leadership: Cornerstone for Success.” Educational opportunities abounded for business-minded dentists. The conference kicked off with an all-day learning track on the Business of Dentistry on Feb. 23. The next featured “The Basics Express: Things They Didn’t Teach You in Dental School.” Our recap begins on page 23.

Mid-Atlantic Dental Meeting
May 5-6
Spring is lovely time to be in Washington, D.C. If the Mid-Atlantic meeting will be bringing you to town, you’ll want to make time to see the District’s sites and museums. And if the family is coming along with you, you’re in luck – many of the areas attractions are free. Just plan and ticket your visits in advance, because they tend to fill up quickly. Your travel guide begins on page 24.
What to Consider When Purchasing Practice Real Estate

Brandy Keck, a brokerage liaison at Carr Healthcare Realty, says these points are what you must bear in mind.

By DMD Staff

Hire representation. Do not talk to the seller directly. The dentist will want representation in the form of a team of experts. “Dentists are really great about bringing in their team,” Keck says, including contractors, dental-specific CPAs and attorneys. A real estate broker, Keck says, is essential to deal with the confrontational aspect of the transaction.

Let the experts do the talking. “Something that can be challenging for dentists can be the confrontational piece of what it’s like to work with a landlord or a seller directly,” Keck explains. This can be especially difficult in lease-renewal situations where the dentist knows and may have a good working relationship with the landlord.

See as many properties as you can. Even if you love it, don’t buy the first practice that you see, Keck says. Look at multiple properties in the same market. Have all the information about the advantages and disadvantages of each at your fingertips. “There really needs to be a posture and an education on multiple properties at one time, separating the dentist from the transaction.”

Know the demographics. Keck recommends working with a demographics firm to determine the demand for dentistry in each area. Dentists need to know if a given market is growing. “If there’s a market that’s booming right now and a lot of population moving into an area, there’s going to be a need for dentists coming up.”

It’s not always better to buy. When weighing their options, Keck says dentists should consider the stage of their career. Straight out of school, a dentist’s debt load might be too large to take on added real estate costs. Additionally, buying gets complicated if a dentist is considering relocating in the future.

Is that office vacant for a reason? You need to know if there’s a demand for dentistry in your desired location before you buy.

Quick Tips

Advice for revisiting the tried-and-true investing strategy of buy-and-hold; fixed-income options for retirement and asset-protection strategies.

Buy-and-Hold
Sometimes a classic just needs some freshening up. For buy-and-hold, assemble a diversified stock portfolio, then leave it alone for years. You build wealth and minimize exposure. By buying a core group of companies and holding them for 10 to 15 years. What’s different is that today, you should have a group of satellite stocks that revolve around a core selection and are changed more frequently.

Fixed-Income
When looking for fixed-income investments to fund your retirement, don’t forget about fixed-rate annuities. You get a set rate of interest for a set period of time, usually three to 10 years. Annuities, unlike bonds, are not subject to rate fluctuation. The insurance company bears all the underlying investment risk, protecting owners from market volatility.

Plan for Asset Protection
The right time to come up with your asset-protection strategy was yesterday. Most doctors don’t even think about asset protection until after a lawsuit has been filed. Laws vary from state to state, so you’ll want to check with your CPA or CFP, but in general there are three basic asset-protection structures: 1) retirement accounts: the easiest and most tax-advantaged way to shield your assets from creditors; 2) domestic asset-protection trusts: in 16 states, anyone can set one up, even nonresidents; 3) annuities and life insurance: did we mention annuities?

Keep Calm
Just because conditions in the market created a recent downturn or upswing doesn’t mean those conditions are here to stay. But the cognitive bias of recency makes us think that they will. We’re all prone to pay undue attention to recent news, either good or bad, and under emphasize long-term trends. Performance in the recent past is arguably the least useful information about an investment. But while recent performance data is easy to understand and dramatic, it’s not necessarily accurate.

Eric C. Jansen, ChFC; Ken Nuss; Trey Smith, CFP; and Benjamin Sullivan, CFP, contributed to this report.
Your Money

Pick the Retirement Plan that Fits You Best

Different-sized offices have different needs.

By Palmer Price

When you're running a business, the daily demands keep you plenty busy. Not only do you have to worry about your patients, but you also have to pay bills and balance the books.

Along the way, don’t forget about planning for your future.

That means you need a retirement plan.

“These plans can be great for owners who want to save money for retirement and save money on taxes,” said Amy Noel, a Boulder, Colorado-based certified financial planner.

Whether you're a solo practitioner or you have a practice with dozens of employees, and whether you want to save a lot or a little, there’s a plan to suit your needs.

Here’s some help to get you started.

SEP IRA

SEP IRA is short for simplified employee pension individual retirement account.

It is funded solely by employer contributions and provides the employer flexibility so that in lean years, the contribution can be skipped, said Andrew Samalin, a certified financial planner with offices in Chappaqua, New York, and New York City.

He said for the SEP IRA, an employer can contribute up to 25 percent of compensation — which is about 20 percent of the Internal Revenue Service (IRS) Schedule C net income and based on maximum compensation of $270,000 for 2017 — with a maximum of $53,000 per participant.

A SEP IRA must be offered to all employees who are at least 21 years old, employed for three of the last five years and who had compensation of $600 for 2015 and 2016.

So, if you have a lot of part-timers, they’ll probably be eligible for the plan.

Because part-time employee wages would presumably make up a small percentage of overall wages, a SEP IRA would not be too expensive for the business owner, he said.

“Contributions must be based on the same percentage for all participants and are immediately vested,” he said. “An employer may use IRS Form 5305-SEP to set up the plan but the costs to administer are low.”

And a bonus? Tax benefits. The business owner can deduct no more than 25 percent of aggregate compensation for all participants.

SIMPLE IRA

Another option is the SIMPLE IRA, which stands for Savings Incentive Match Plan for Employees Individual Retirement Account.

“The SIMPLE includes anyone who makes over $5,000 as an eligible participant,” Noel said.

Employees can defer $12,500 — or $15,500 for those over age 50 — and the employer is required to contribute each year by matching employee contributions up to 3 percent of compensation. Or, the employer can make a non-elective contribution equal to 2 percent of employee compensation up to annual limit of $270,000 ($5,400) in 2017.

Samalin said this plan may be less expensive than a SEP IRA because some of the employees may choose not to participate.

SAFE HARBOR 401(k)

The Safe Harbor 401(k)/Profit Sharing Plan has a higher cost of administration and a higher potential cost of funding for employees, but also allows for high contribution limits. You can use employee salary deferrals for these plans, and they’re easier to administer than a traditional 401(k).

Samalin said you can offer employee-vesting schedules to incentivize long-term employment and lower turnover.

Anyone who works more than 1,000 hours a year would be eligible, Noel said.

“So, if you have part-timers that work less than 20 hours a week, a 401(k) can be an option,” she said. “Typically, most employers will choose a Safe Harbor plan which mandates a 4 percent match for participants or a 3 percent non-elective contribution for all eligible employees.”

SOLO 401(k)

If you have no employees, or only your spouse works with you, you could consider a Solo 401(k).

These plans allow the business owner and spouse to contribute elective deferrals up to 100 percent of compensation as the employee, up to $18,000 for 2017, plus there’s a catch-up contribution of $6,000 for those over age 50.

Then as the employer, the business owner may also contribute up to 25 percent of compensation or earned income.

“Total employee and employer contributions, not counting catch-up contributions, may not exceed $54,000 for 2017,” Samalin said. “Business owners must file Form 5500 after plan assets exceed $250,000.”

With this plan, you can still contribute to a traditional or Roth IRA every year, too.

GETTING STARTED

Consider meeting with a certified financial planner who has expertise in small business retirement plans.

You can search for an adviser in your area on the websites of the Financial Planning Association at www.plannersearch.org or the National Association of Personal Financial Advisors at www.napfa.org.

You can also contact a plan custodian such as Vanguard or Fidelity.
Late in 2015, Congress made permanent a tax law that allows a taxpayer aged 70.5 or older to take an up-to-$100,000 annual gross income exclusion for otherwise taxable IRA distributions. The IRA distribution must be made directly to an eligible charitable organization. These distributions are not subject to the charitable contribution percentage limits and cannot be included in gross income. Because the distributions are not included in gross income, it will not increase adjusted gross income (AGI) for purposes of the phase-out of any deduction, exclusion, or tax credit that is limited or lost when AGI reaches certain levels. Having a lower adjusted gross income could mean less tax may be paid on Social Security benefits, and Medicare B and D premiums may be lower.

Even though a direct distribution from an IRA to a charity is not included in a taxpayer’s gross income, it is considered in determining a taxpayer’s required minimum distribution (RMD) for the year. To constitute a qualified charitable distribution, the distribution must be made after the IRA owner reaches age 70.5, and it must be made directly by the IRA trustee to a qualified charitable organization. Also, to be excludable from gross income, the distribution must otherwise be entirely deductible as a charitable contribution deduction. Amounts transferred are not taxable, but no deduction is available for the amount given to charity. Consult your tax adviser to see if this is a good opportunity for you.

**States with the Highest Personal Income Growth**

By Sarah Handzel, BSN, RN

Since the start of the Great Recession in late 2007, personal income levels have grown at a slower rate than usual. But the good news is, income levels have still been increasing. Nationwide, personal income is estimated to have grown by 1.7 percent annually since the fourth quarter of 2007. This compares with an average growth rate of 2.8 percent over the last 30 years.

In a recent report, the Pew Charitable Trusts collected data about personal income growth for all 50 states. The report examined compound annual growth rates for each state since the fourth quarter 2007, in addition to income growth rates over the past year.

Here are the 10 states where income has grown the most.

- **North Dakota**
  - North Dakota enjoyed the fastest rate of personal income growth compared to the other states. Personal incomes in the state grew at a rate of 4.7 percent since 2007. In the past year, incomes dropped by 1.8 percent, largely due to declining petroleum prices.

- **Texas**
  - Incomes grew at a rate of 3.1 percent since 2007.

- **Utah**
  - The growth rate for incomes was 2.6 percent. Over the past year, incomes have risen more than the state average since the recession, growing at 3.7 percent.

- **Colorado**
  - For nearly nine years, state personal incomes have grown by 2.4 percent.

- **California**
  - The Golden State has had a 2.2 percent average state personal income growth rate since 2007.

- **Oregon**
  - The average income growth rate held steady at 2.1 percent.

- **Washington**
  - Residents have seen their personal incomes rise at a rate of 2.1 percent since 2007.

- **South Carolina**
  - South Carolina had an average personal income growth rate of 2.1 percent.

- **Alaska**
  - The state personal income growth rate was 2.1 percent.

- **Florida**
  - The state personal income growth rate was 2.1 percent.

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**Donate to Charity and Ease IRA Distribution Bite**

Potential tax savings are waiting for those 70.5 and older.

By Kristi Harris, CPA

Late in 2015, Congress made permanent a tax law that allows a taxpayer aged 70.5 or older to take an up-to-$100,000 annual gross income exclusion for otherwise taxable IRA distributions. The IRA distribution must be made directly to an eligible charitable organization.

These distributions are not subject to the charitable contribution percentage limits and cannot be included in gross income. Because the distributions are not included in gross income, it will not increase adjusted gross income (AGI) for purposes of the phase-out of any deduction, exclusion, or tax credit that is limited or lost when AGI reaches certain levels. Having a lower adjusted gross income could mean less tax may be paid on Social Security benefits, and Medicare B and D premiums may be lower.

Kristi Harris is a principal at Fluence, a dental CPA and consulting firm that represents more than 200 dentists, located in Portland, Oregon. Harris is a member of the Academy of Dental CPAs, which is an organization that represents over 9,000 dentists.
Ask the Expert

How to Take Your Business from Ordinary to Extraordinary

Randy Fine and Mayer Levitt sat down with Dentist’s Money Digest at the 2017 Yankee Dental Congress in Boston, to discuss their continuing education lecture, “Ideas and Strategies to Take Your Dental Practice from Ordinary to Extraordinary.” Here’s what they had to say.

Q: How does a dentist attract top-tier talent to his or her practice?
Levitt: I think that in order to be able to attract that kind of staff, you’ve got to offer state-of-the-art benefits. People are not going to come and work for you if you’re not providing health insurance, if you’re not eventually going to be able to give them a pension or 401(K). Don’t be penny-wise and pound-foolish. If you’re paying people, I’d like to see you be paying more at the top of the scale because I don’t want these people looking every month on Craigslist, asking “Where should I go?”

Q: How should dentists set attainable financial goals?
Fine: Our strategy is, if you have a dollar, you want to put a certain percentage of that dollar into short-term, a percentage into midterm, and a percentage in long-term savings. You’re not just putting that one dollar away into one of those areas and letting the other two suffer. A short-term strategy would just be money in the bank, money available for personal and business emergencies. The long-term strategy would be retirement or saving for a child’s education. Somewhere in the midterm would be maybe their second home, or saving for their second practice.

Q: How does a dentist create a practice that his or her peers will admire?
Levitt: A dental practice has to have a very strong commitment to continuing education. I think you would also be impressed if you were a peer and did a Google search and saw that the practice came up near the top, that it’s very prominent in the rankings. I think that the practice needs to also have a prominent position on Facebook. Social media and the internet are extraordinarily important and I think that those are the kinds of things that would impress somebody coming to see a practice.

Q: When considering the myriad financial priorities dentists should have, does the order of how dentists address those priorities matter?
Fine: My company uses a financial engineering model that we put together for our clients. The model focuses on getting core protection components – such as life and disability insurance, estate planning, wills, trusts, and health care proxies – in place first to make sure that one bad day doesn’t wipe out everything that you’re trying to create and do. The model ensures that all of your limits on your property and casualty insurance and your life, health and disability insurance are maxed out. Once maximum protection is in order, now you can get a little more creative with your finances toward savings. When you’re more comfortable in savings, we go more into the growth area. It’s really a combination of understanding the philosophy and the foundations to a good, strong financial plan, and then building upon that.

Q: How important is it for a dentist to be working on staff development?
Levitt: As the doctor and as the owner, you need to be continually coaching and praising your staff. This is what they want to hear. I think if you can do that and be a great manager, which you don’t learn in dental school, you’re going to be quite successful.

I think that in order to be able to attract that kind of staff, you’ve got to offer state-of-the-art benefits.
You just finished building your dream dental office: eight treatment rooms and brand-new equipment in a great location. Although it was one of your biggest investments it will bring in new patients, allow you to do the dentistry you want to do and make the balance of your dental career enjoyable.

Now that the office is completed, potential income-tax savings will be on your mind. Hopefully, your CPA knows how a cost segregation study works. Here’s an overview for the uninitiated.

Constructing a dental office requires spending in the following categories:

• Dental equipment, computer equipment, furniture, and fixtures. Equipment and computers are depreciated over five years. Furnishings are depreciated over seven years. You also have the option of expensing them under Section 179 up to a maximum of $500,000 per year.

• Leasehold improvements (i.e., structure, plumbing, electrical wiring) and the internal structure of the dental office (i.e., carpet, walls, ceilings). Generally, the structural components of a building are depreciable over 39 years. Qualified improvement property is usually depreciable over 15 years.

Upon reviewing the depreciation schedule of a new client, a dental CPA notes leasehold improvements written off over 39 years and that triggers a recommendation that the client consider a cost segregation study.

Cost segregation studies came about in the 1980s. A company called Hospital Corporation of America was advised by its accountants, engineers and attorneys that instead of writing off the cost of the majority of their hospitals over 39 years, the company should come up with a method to “segregate” portions of the construction costs that could be written off over five, seven or 15 years.

Instead of writing off construction costs over 39 years, qualifying construction might be written off over five, seven or 15 years.

The Internal Revenue Service (IRS) audited Hospital Corporation of America and disallowed the segregation of the costs, taking the company to court. Several times. And the IRS lost.

The IRS acquiesced, subsequently creating rules regarding exactly how an engineered cost segregation study must be prepared and documented, giving birth to the cost segregation industry.

Cost segregation studies can be used when a tenant builds out an office, or when a dentist builds or buys a new building. They can even be used by a dentist who built an office anytime after 1987 (yes, that’s correct —1987).

Here’s an example: In 2016, for $1.2 million, the fictional Dr. John Jones purchased a free-standing building, a shell in which he then built a dental office. The project cost him $2 million, not including the cost of equipment, furnishings or computers. Dr. Jones then set up a separate limited liability company (LLC) to own the building, which then rents the building to the J Corporation, the operator of his practice. >>
Dr. Jones has a sharp CPA who suggests performing an engineered cost segregation study. Bill Sheridan, principal of Cost Segregation Consultants in San Diego, California, and J. Curt Gautreau, who is a certified cost segregation professional from Baton Rouge, Louisiana, provided the sample you see with this article of a cost segregation study for a $2 million building.

As you can see, out of the $2 million, which would have normally been depreciated over 39 years, 15.3 percent is depreciated over five years, 4.2 percent over seven years, 8.7 percent over 15 years, and the balance of 71.8 percent over 39 years. Depending on the situation, this could save tens of thousands of dollars in income tax in the first year.

Had the entire project cost of $2 million (assume this is the cost of the building and improvements, and that land costs were additional) been depreciated over 39 years, the first year’s depreciation deduction would have been $2 million divided by 39, or $51,282.

With the cost segregation study, the amount of depreciation allowed is as follows in year one:
- Of the five-year property ($306,930), Dr. Jones can deduct 50 percent bonus depreciation ($153,465); he can also deduct 20 percent of the remaining $153,465, or $30,693. Total deduction: $184,158.
- Of the seven-year property ($83,927), he can deduct 50 percent bonus depreciation ($41,963); he can also deduct 14.29 percent of the remaining $41,963, or $5,997. Total deduction: $47,960.

Assuming the 15-year property qualifies as a qualified improvement property under Internal Revenue Code Section 168(k)(3), this, too, qualifies for 50 percent bonus depreciation. So, of the $173,233 allocated to 15-year property, Dr. Jones can take $86,617 in bonus depreciation and $8,662 in additional depreciation for a total of $95,279 in year one.

Finally, he receives depreciation on $1,435,910 over 39 years, which comes to $36,618 per year.

So the total first-year depreciation deduction with the cost segregation study is $364,215, compared with a first-year deduction of $51,282 without a cost segregation study. This gives

Dr. Jones an additional depreciation deduction of $312,933, which, at a 40 percent marginal tax rate (federal and state), saves him $125,173 in taxes.

Now let’s assume Dr. Jones built the exact same building in 1999 and has filed tax returns through 2016. Federal tax law states that he can have a study done for his 2017 returns, file the proper paperwork with the IRS, and make a retroactive adjustment to his tax return, called a Section 481(a) adjustment. In 2017, he can take a one-time deduction based on the difference between the depreciation he would have taken had he done the study in 1999 and the amount he has taken without the study.

In this case, he has done the study in 1999, he would by this time have taken all of the depreciation on the five-year property of $306,930; on the seven-year property of $83,927; on the 15-year property of $173,233; and seventeen-thirty-ninths of the $1,435,910 taken over 39 years on the structure, which comes to $625,909. So the total amount of depreciation using the cost segregation study numbers is $1,189,999.

Without the study, he has taken depreciation of seventeen-thirty-ninths multiplied by $2 million, which is $871,795. So the difference between the $1,189,999 and the $871,795 is the one-time deduction, which comes to $318,204. At a 40 percent marginal tax rate, that is a one-time savings of $127,282.

If you are planning on building a new office, whether it includes the purchase of a building or not, or if you have built one anytime after 1987 and did not do a study, the implementation of a study can save you tens of thousands of tax dollars.

It is important that you use a company that specializes in performing engineered cost segregation studies. In addition, you have until the due date of your tax return including extensions to have the study prepared plus file the required IRS form, Form 3115. Finally, if you generate the large depreciation deduction, which throws your Schedule E (this is the form on your personal tax return that will be filed if you own the building in a single-member LLC) into a loss for the year, it is very important that your CPA makes what is called a “grouping election” pursuant to Treasury Regulation Section 1.469-4 on your corporate tax return and on your personal return. This avoids what is called the passive activity loss rules, which would disallow the loss created from the depreciation deduction created by the cost segregation study.

Be sure to consult your tax professional about this as the rules are very complex.

Art Wiederman is a CPA and managing partner of Wiederman and Chamberlain, a CPA firm that works with about 250 dentists in Tustin, California. He is a frequent lecturer at local, state and national dental meetings and is a founding member of the Academy of Dental CPAs (ADCPA), which comprises 26 dental CPA firms across the country, servicing more than 9,000 dentists.
Obtain, develop and retain talented employees.

By Miriam T. Furlong, D.M.D.

**Being an employer is the most difficult aspect of owning a dental practice and assembling the right team to keep your practice running is also no easy task. However, following these guidelines can help you find and keep your dream team, setting your practice up for continued success.**

1. **KNOW WHERE TO SEARCH, AND BE SELECTIVE.**
   Consider contacting local vocational schools, checking work-study programs for high school seniors and posting free help-wanted ads on social media and CraigsList. Then, as you develop these less-experienced employees, you can encourage them to grow, taking on more senior roles within the practice.

   If you place paid help-wanted ads or look to hire more experienced employees, you may only find potential employees who expect higher starting salaries and are less adaptable. When you hire individuals at the beginning of their careers, you can more easily mold their attitudes, habits and work methods to meet your expectations.

   When you begin the hiring process, scrutinize applicants’ résumés and conduct phone interviews. Check their references and look over their social media profiles.

   If you’re still interested after your initial assessments, invite applicants in for interviews to evaluate their communication skills, appearance and demeanor.

   You may want to administer some type of personality or a skills test. I find the Personality Evaluation Test by Dean C. Bellavia, Ph.D., M.S., to be a useful assessment. Next, invite strong candidates to a working interview with your team.

   If they pass muster, hire them for a specific trial period during which you or the employee may terminate employment without penalty.

2. **BE CLEAR AND HONEST ABOUT WHAT YOU EXPECT AND WHAT THEY CAN EXPECT. THEN STICK TO IT.**
   Have written job descriptions with pay ranges, hours, expectations and responsibilities for each position.

   Select the right person for the job, rather than the right job for the person. Avoid creating a position for someone or tailoring the work to suit an employee’s needs. Don’t hire someone you can’t fire, such as a friend or family member, and do not hold onto problem employees no matter how short-handed getting rid of them will leave you.

   Have a fair and systematic protocol for warning and firing employees. Document everything in an employee’s file with dates and signatures, and have a witness present (your office manager, for example, in addition to you and the employee). Do not make empty threats. Stick to your word.

3. **MAINTAIN PEAK PERFORMANCE.**
   Hold productive team meetings with a specific agenda on a regular basis: morning and evening huddles (10 minutes each) and monthly meetings (half-day).

   Put systems in place for every aspect of the practice: Write them down, review them frequently and modify them as the practice changes. Conduct training sessions and plan continuing education on a regular basis.

4. **MAINTAIN A FILE ON EACH EMPLOYEE.**
   Keep an updated employee handbook that contains your policies about conduct, dress code, attendance and social media, and review this handbook with your employees annually. Have them sign it after reviewing it.

   Follow state labor laws. When in doubt, consult an attorney to make sure that your policies are legal.

5. **GIVE MEANINGFUL FEEDBACK.**
   Praise publicly and criticize privately. When possible, sandwich negative feedback between positive feedback. Hold private meetings one to two times annually, or as needed, with each team member.

   Show your team members you appreciate them. Institute a bonus system, and every now and then, give small, unexpected gifts. Your employees will likely exceed your expectations.

**Focus on bringing in people who are new to the workforce so you can develop them to suit your office’s needs.**

Miriam T. Furlong, D.M.D., is the chief clinician and administrator at Jackson Orthodontics in Jackson, New Jersey. She can be reached at mfurlong@jacksonorthodontics.com or at 732-942-8400. You can find more information about her and her practice at www.jacksonorthodontics.com.
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Each day at your practice must begin with a morning huddle. The morning huddle sets the tone for the day and informs all team members about production and collection goals, as well as potential problem areas in the schedule. Moreover, the morning huddle motivates you and your team. I guarantee that you will see performance improve as a result of it.

First and foremost, the huddle must always start on time. Every team member must be present. No excuses! All charts – especially the schedule, and the Pick Huddle Sheet – must be on hand. Every team member must have a copy of the schedule and the huddle sheet. These should be prepared the night before.

During the huddle, a designated team member will review the doctor’s schedule with the doctor, who knows how much time each patient and procedure requires. The entire team reviews each patient’s treatment plan, avoiding confusion chairside.

Hygienists must review their charts prior to the huddle to determine who needs bitewings or a full-mouth series. Missed radiograph and treatment opportunities are missed revenue opportunities. The doctor is made aware of pending radiographs so he or she can re-explain any necessary treatment or direct patients as needed during the hygiene check.

A critical component of this team meeting is the daily review of your practice’s progress on production goals.

The second document covered during the huddle is the aforementioned Pick Huddle Sheet. The office manager or scheduling coordinator must ensure that the form is completed and handed to the doctor and team at the start of the meeting. This form allows everyone to see where the office stands in terms of total production for the day and the month, the projection for the next month, and relative to last year’s numbers. Also, the production is broken down per clinical provider for not only the day but for the month to date. It further shows collections and new patients for the month. Most importantly, the Pick Huddle Sheet also lets you know how much you have to produce and collect daily in order to meet your goals.

And what are those goals, by the way? You should review them with your team each morning during the huddle. Each month, a different employee takes a turn reading the goals and also provides the group with a motivational quote. These goals and their affirmation become a part of your office’s culture. This is also a good moment to review the practice’s mission, vision and culture statement.

But there has to be some levity, too. In my practice, each Monday and Wednesday, I hold a drawing for the staff. A random team member will receive an envelope that includes a gift card and a motivational note. After the raffle, it’s time to kick things off. Think of a sports team before a big game. All staff members put their hands in, and an appointed staff member give an NFL-caliber shout-out. It may seem silly, but the enthusiasm will carry you through the day.

For you, the doctor (and the team as well), the morning huddle does this one critical thing: It motivates you. If you know you are behind on your revenue goals, you will spend that extra 10 minutes with a difficult patient who needs a restoration on the lower right first molar.

There is a lot more to all of the above, but these basics are enough to get you going. For these practices to be effective, they must become part of your daily ritual. They must become an automatic habit. If done correctly, they will be one of the many business practices that will elevate your practice above the rest.

Robert Pick, D.D.S., is a full-time practitioner in Aurora, Illinois, and the CEO of his own consulting firm, The Pick Group. He can be reached at 773-402-8933. If you would like a copy of the Pick Huddle Sheet mentioned in this article, please email diana@progressiveperio.com.
Shedding light on the BLACK & GRAY Markets for dental products.

By P. Croatto
Bernie Teitelbaum, former executive director of the Dental Industry Association of Canada (DIAC), had just finished a talk in Vancouver about the risks dentists run using dental products purchased on the black and gray markets.

A dentist stood up: “Name me one dentist who’s ever been brought up before the disciplinary committee for using non-compliant product?”

Before Teitelbaum could offer his retort – “you want to be the first?”—another audience member rose to his feet. “I’m counsel for the British Columbia College of Dental Surgeons,” Teitelbaum remembers the man saying, “And I can tell you categorically that you will never be brought up on disciplinary charges for using non-compliant products. You will be brought up on disciplinary charges for professional negligence. And we won’t let you hide behind the product.”

That dentist probably stopped frequenting the gray and black markets. Plenty of others have not.

“We’re well aware that (the gray market) hasn’t been cleaned up,” says Tim Rogan, vice president of marketing for merchandise at dental product and technology distributor Patterson Dental.

Simon Hearne, 3M Oral Care’s international vice president, admits awareness of the risks of using black- and gray-market products is “very low.”

What are the differences between the two categories?

“When we talk about gray market, we are talking about genuine products sold through an unsecured supply chain,” Hearne says. “These products include inferior goods that have been diverted from the manufacturers’ secured supply chain. Counterfeit goods or black-market goods are fake products that are often sold alongside gray market goods.”

The sale of gray-market products is also legal in the United States, says Gordon J. Christensen, D.D.S., MSD, PhD, CEO of Practical Clinical Courses and Clinicians Report Foundation, who has written on gray and black market dental products. “I have repeatedly asked the major dental companies about the amount of their products that are gray or black, and I always get the same answer,” he says. “The percentage of gray- and black-market products is estimated to be about 15 percent of total product sales.”

Rogan of Patterson Dental says a distributor must have “the ability to say no” to tempting offers from gray-market dealers. Doing so means leaving “a fair amount of margin dollars on the table. But when you say yes to gray marketers, you put yourself at risk that you’re buying product that could be harmful to our customer’s customer, the patient.”

These products, Christensen adds, are “commonly consumable dental products” such as cements, composites and bonding agents.

“The only motive to buy these products is price,” he says. That can stem from good intentions.

Many dentists, Teitelbaum says, “don’t have a clue” what they’re buying.

Ira Newman, D.D.S., who practices on Long Island, New York, and previously worked for a dental supply company, says a dentist “involved in doing his purchasing has way too many empty spots in his appointment book.” A hygienist or an assistant is usually assigned that task. That employee wants to look good. The dentist, Newman says, only has time for the headlines. “We’re busy, you saved me money, we’re profitable. It’s a good day.”

Some dentists, Teitelbaum says, “are absolutely convinced they’re getting ripped off” and will pursue bargains outside accepted channels – such as Amazon, eBay, or, as Newman recalled, an endodontist selling supplies from his garage.

Discounted dental goods come with a hidden cost: putting your patients and practice at risk.

By P. Croatto

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**Cover Story**

**Though legal,**
**there’s no guarantee a gray-market product will work the way it’s supposed to.**

It’s a gamble, says Christensen. A dentist has no guarantee if the project is legitimate or if it will do what it is intended to do. “If some treatment fails and the failure can be related to a deficient product,” he says, “the legal implications are obvious.”

What’s even more troubling? “The dentist doesn’t see the product until he uses it,” Teitelbaum says.

The sense of doom extends beyond the black market. “Many gray-market goods bought by dental practices have often changed hands numerous times since they were diverted from the manufacturer-secured supply chain,” Hearne explains. “Often they have not been handled and stored under required climate-control conditions, and then they may no longer meet the manufacturer’s original specifications.” Typically, these products do not comply with U.S. regulatory requirements either. Sometimes, gray-market goods are even relabeled or repackaged with phony expiration dates. In some cases, products may be sold years past their expiration date, which can lead to problems like improper curing or bonding.

Buying from a manufacturer’s authorized dealers – which Teitelbaum says he believes “a big percentage of the market” does – comes with security. “If I have a problem, I have full recourse,” he says. “If my patient sues me because there’s a problem, I can go after the manufacturer and the dealer. I’m protected. The entire chain of custody was as recommended by the manufacturer.”

There’s also the small matter that dentists may not be saving as much as they think by using the black or gray markets. “For most dental offices, expenses for supplies is about 5 to 7 percent of gross revenue,” Hearne says. “Saving on the supply expense is minor when considering risks to patient safety and productivity and financial loss to redo treatment and manage complaints or even lawsuits brought by dissatisfied patients. The damage to a dental practice’s reputation is much more of a significant loss compared to a few dollars of saving on supply expense.”

“Dentists’ net income, adjusted for inflation, is at 1997’s level, according to Christensen,” he says. **Though legal, there’s no guarantee a gray-market product will work the way it’s supposed to.**

Dentists can still be thrifty and buy supplies from authorized dealers. “If they’re really clever, they demand a high level of service from that dealer that they’re working with, because they know they’re paying a premium price,” Teitelbaum says.

Christensen offered other options for practitioners: joining “dental cooperatives” that “have programs discounting products up to 25 percent,” negotiating with local retailers or buying distributor private label brands, which typically carry “significantly lower prices.”

“Just because a retail price is written in a catalog,” Newman says, “doesn’t necessarily mean you have to pay that price.” Here’s the logic: “Supply houses don’t want to lose business,” he continues. “So if they have to discount a little to keep the business, they’re (still) profitable. It’s when that person doesn’t buy at all – and does buy in gray market – that they’re losing money. So there is a pressure on them to give on price point to a degree.”

Teitelbaum says he believes “90 percent of the profits that are missing in a dental practice are in the patient charts.” In other words, patients need additional work, but turn it down. Or it gets forgotten about.

“The office manager doesn’t know anything about dentistry, but she’s out there saving money for you,” Teitelbaum says. “The problem is why isn’t she taking a course on how to reduce the number of cancellations? Or why isn’t she taking a course on patient acceptance so she can help a patient with payment options for additional work? Teitelbaum says that the extra money for buying products from a reputable channel can be recouped (and more) with “one crown a month.”

“I think if the manufacturers made a better effort at somehow educating staff as to the purchasing process and why they should buy from authorized sources, that might help,” Newman says. “I don’t think you’re going to find a practitioner sitting there checking shipping lists to see who you’re buying from.”

With 3M.com/BuyDental and dentistupply.com, 3M and Patterson Dental, respectively, are among the major dental players doing just that. Education also extends to the dentists compelled to roll the dice, who should “at least have the common sense to check the product when it comes into the office,” Teitelbaum says.

In 2016, DIAC developed “A Suggested Protocol for Checking Product,” a checklist that could be posted in the office. “One knowledgeable person” should review all product purchases that arrive. Among the questions to ask: does the product have the same name as advertised – and is it in English? Is the product in its original package or crammed in a plastic baggie? Does the package, or its contents, have markings indicating it might have been rerouted?

Initially, it might take 15 minutes to vet a shipment, but Teitelbaum says repetition will turn the examination into a “nonissue” within six months. “Because at the point,” he says, “if they are buying from unauthorized sources, they’re going, ‘This isn’t worth it. Too much of what we’re getting is garbage.’ ”

Teitelbaum and Newman would like the business education to start even earlier – in dental school. Maybe, Teitelbaum says, a dentist takes a practice-management course or eventually hires a consultant. Then they open their doors for business and “they haven’t got a clue how to run a dental practice.”

Aside from continuing education, collaboration is key.

“The black- and gray-market products put patient safety at risk, and it is up to the entire industry, manufacturers, distributors and dental professionals to do their part to keep patients safe,” Hearne says. “By working together, we can all help protect the integrity of the industry that we’ve worked so hard to build.”

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April 2017
Early in my career, I realized my best referral source wasn’t the direct-response mailers, new-resident programs, website, care-to-share programs, signage or even location. To my surprise, it was the orthodontist and two other general dental practices down the street.

In a town of 19,000 people, 35 miles north of Dallas, we were getting 15 to 20 new patients per month from our competitors. How could that be? Why would so many patients in a town where everyone knew one another decide to leave their long-time dental practice to come to the new kid on the block?

Maybe what I had been taught in dental school wasn’t true, that patients will bond to a dental practice for life. In fact, Fortune found that 87 percent of patients will change their physician over a $5 difference in fee. Is it any surprise that they would leave a dentist for money, lack of concern, poor hours, location, lack of competence or a single bad experience?

Welcome to the era of Donor and Recipient Dental Practices. Fail to inspire your patients, and you will see them seek treatment elsewhere. Make every step of the patient experience perfect, except for the last one, and they’re gone. Patients today vote with their feet. If you are seeing the back of their heads, you are doing it wrong.

**DENTAL TRUTH #1**
There is no way to get better at giving patients what they don’t want. The worst thing you could ever do is to push treatment on patients without happily giving them what they want. Let that small fact elude you and you will find yourself on the fast track to a mediocre, unfulfilling career.

You need to realize that if you are not growing, then you are not meeting your patient’s needs. If you cannot inspire your patients or if you are not growing, then you become the Donor Practice in your area. Take a moment and see if you can name a practice in your area that is a Donor Practice. If you can’t think of one, then it’s you. The Donor practice has no idea that they have this effect on their patients. It is always the poor economy, terrible location, poor dental IQ, or the inability to find quality staff that is blamed for lack of growth.
I expect that all of my practices should grow regardless of the economy, and they do. The Recipient Practice grows, inspiring their patients to refer everyone they know.

**DONOR PRACTICE SYMPTOMS**  
**An increase in cancellations and no-shows.** Your goal should be less than 10 percent. What’s causing this? You are not convenient and did not sound caring and compassionate over the phone. Maybe you have poor hours or days. Or your fees create such a hassle that patients make an appointment never intending to keep it.

**Receiving few or no direct referrals.** Your goal should be 60 percent minimally. This is the one black-or-white symptom. Few referrals spell disaster.

**Patient's want second opinions.** This is usually the result of being too assertive, instead of giving a balanced case presentation. If you want the treatment more than the patient, you have crossed the line. There should be no selling in dentistry. Give them what they want and tell them what they need.

**You're over-emphasizing marketing.** You spend a greater and greater portion of your income on external marketing in order to maintain your numbers. Recipient Practices do not need to market and Donor Practices should not market. Don’t look for an external solution for an internal problem. Spend money and time on marketing when you have few internal referrals.

**Patients complain about price.** You must keep comparables comparable when it comes to fees. Stay in the 80 to 90 percent for your area. Always give the patient what they want first, then, work at giving them what they need. Bundling your fees and treatment plan incorrectly make you look like a dentist turned time share salesman.

**High staff turnover.** Our office was fortunate to average more than 14.5 years for each employee. High turnover is a symptom of lack of leadership and systems. Get it right and the patients and staff will stay. If your patients see a different face every six months, they will wonder why, and they are right.

**Assisted hygiene.** Assisted hygiene does work to ramp up the hygiene department, but make sure you have the right assistant in that role. It should be the best assistant in the office. Maybe even the one you can’t work without. If done incorrectly, you will see fewer patients following thru with treatment plans because of a lack of trust that was once created by your hygienist spending the time to adequately explain treatment and listen to what the patient came in for. I have seen few offices that do this correctly.

**Poor financial arrangements.** The largest and most-used health care patient financing company is not the best just because they pay the ADA hundreds of thousands of dollars a year to receive their endorsement. Add Wells Fargo and Chase to your options, and watch the acceptance rate sore.

**FIXING DONOR PRACTICES**  
**Routing slips.** These can be produced by most dental software and allow you to follow each patient through the office. Patients may first contact you by phone and then arrive at the office for the first time. The routing slip follows them through your office. At some point, you will find a point at which the patient does not go to the next treatment step. Identify this point and you can correct the system or staff member and eliminate the blockage. Don’t and it is “Donor Doomsday.”

**Exit interviews.** Whether it is with a staff member that does not work out, or a patient who goes down the street, you can benefit by taking the time to call and find out why. Great leaders find the problem and deal with it immediately.

**Comment cards.** These anonymous cards allow you to learn of potential problems from every patient you see. Email me (abernathy2004@yahoo.com) and I will send you one. Assume that if one patient mentions a problem, there are a 100 more patients who were silent and felt the same way. Ninety-six percent of patients will leave without saying a thing if dissatisfied. Learn of and deal with the problem and most will stay.

**Create a system for cancellations and no-shows.** Email me and I will send you our cancellation and no-show system we have used for more than 30 years.

**Record and monitor your calls.** This applies to calls inside and outside of your office. The number-one piece of technology in your office is the phone. If the staff does not come across as caring and compassionate, the patient will never show up to let the doctor mess up the relationship.

Spend the time to create great systems and inspire your patients and staff, and there is no limit to practice growth.  

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Michael Abernathy, D.D.S., is the founder of Summit Practice Solutions in Dallas, Texas. He founded Summit Practice Solutions in 1991 to help other dentists duplicate his success. He can be reached at abernathy2004@yahoo.com or (972) 523-4660.
Late-night parties, exam-cramming or Netflix marathons that extend into the wee hours of the morning may be why so many patients seem ready to doze off in the operatory — or not. Instead, it could very well be obstructive sleep apnea (OSA) that’s to blame.

Mayo Clinic defines obstructive sleep apnea as “a potentially serious sleep disorder” that “causes breathing to repeatedly stop and start during sleep.” And it’s far from rare: According to the American Academy of Sleep Medicine (AASM), more than 25 million American adults have OSA. Harold Smith, D.D.S., president of the American Academy of Dental Sleep Medicine (AADSM), estimates that 20 percent of a dentist’s general practice is composed of patients with undiagnosed OSA.

“If a dentist is oriented to looking and screening for OSA, he’s going to be a very productive dentist in helping his patients have better qualities of life, catching serious comorbidities early, and possibly saving a life or two along the way,” Smith says.

GROWING AWARENESS
Smith recalls that in 1993, the field of dental sleep medicine was in its infancy. There were no studies or evidence-based literature for dentists to rely on. Education was anecdotal, based mostly on talking to practitioners who had begun treating...
patients. But over the last 25 years, Smith says, there has been “a virtual explosion” of literature, evidence-based studies, and clinical trials.

“We’ve come a very long way,” he says. “We’ve come to the point where oral appliance therapy is recognized as a viable option” for treating adult patients with OSA who are intolerant of continuous positive airway pressure therapy.

Oral appliance therapy features a custom-fit oral sleep appliance that fits into a patient’s mouth, much like a sports mouthguard or an orthodontic retainer. It supports the jaw in a forward position to help maintain an open upper airway.

Medical studies have helped physicians understand that oral appliance therapy is a modality of treatment they can consider for patients who are diagnosed with OSA. But what has lagged, says former AADSM president B. Gail Demko, D.M.D., with Sleep Apnea Dentists of New England in Weston, Massachusetts, is an adequate number of educated dentists to fill the need physicians are creating.

**IMPORTANCE OF EDUCATION**

Demko explains that OSA treatment is not an extension of what dentists learn in school. Crafting an appliance might be, but by engaging in oral appliance therapy, dentists are treating a medical disease, that falls outside of the typical dentist’s comfort zone.

“It’s incumbent upon us to understand that disease at the level of the physician, and dentists aren’t used to that,” Demko explains. “Any dentist can make one of these devices, but that isn’t the issue. The issue is understanding when to use them, when not to use them and how the medical concerns of the patient play into it.”

Smith echoes those thoughts. OSA is not the usual type of profit center dentists bring into their general practice. Continuing education for many dentists, Smith explains, is going to a weekend course in periodontics, picking up a few pearls and bringing them back to their practice, and on Monday morning, putting those pearls to use.

“Dental sleep medicine is an entirely different thing,” Smith says. “Dentists need to understand that obstructive sleep apnea and snoring are medical conditions, and we as dentists are treating these medical conditions. So the important thing for dentists to understand is they must be a valued part of the medical team in their community. And to become a valued part, you need to be properly educated.”

**PROACTIVE ROLE**

Patients with OSA must first be diagnosed by a physician, and the patient can then be referred to a dentist. But dentists can play an important primary role in terms of screening. Smith points out that a dentist often sees a patient more frequently than does that patient’s primary care physician.

“Standard care for every patient who comes into a dental office for an examination is an oral cancer screening,” he says. “And an extension of that … is screening for obstructive sleep apnea.” During an oral cancer screening, a dentist can look for the anatomical markers that are fairly common in most OSA patients.

He cautions, too, that it’s important not to pre-judge patients. “All of us have patients who you would never think have sleep apnea because they’re fit, thin, active and young,” Smith says. “But anatomically, their airway closes at night.”

Demko is also an advocate for screening, favoring a method called the STOP-Bang Sleep Apnea Questionnaire that’s used by physicians. It takes into account a range of criteria, including snoring, fatigue, blood pressure, and body mass index.

“There are no studies supporting that a physical examination of a crowded oral pharynx leads to sleep apnea,” Demko says. “But the STOP-Bang Questionnaire is highly indicative of obstructive sleep apnea, and it’s used by anesthesiologists screening patients prior to general anesthesia.”

**COLLABORATIVE EFFORTS**

In July 2015, the AASM and the AADSM issued the first joint clinical practice guidelines for oral appliance therapy. The guidelines are a pathway for sleep physicians and dentists to work together to treat OSA.

It’s not the only collaborative effort underway. In February, the AASM held Sleep Medicine Trends 2017 in Phoenix, Arizona, and dentists were invited to collaborate with physicians in a day-and-a-half work-
About 20 percent of a dentist’s patients have undiagnosed obstructive sleep apnea, the American Academy of Sleep Medicine estimates.

shop, “Oral Appliance Therapy: A Model for Physician-Dentist Collaboration.” Demko was one of the participants.

“It was huge,” she says of the first-of-its-kind collaborative workshop. “The more that physicians understand that we are there to give them another modality for treating their patients that may be more acceptable, more comfortable, and that improves compliance, the better.”

Demko notes that in Europe, about half of all patients with mild to moderate sleep apnea receive oral appliances as a first-line therapy. “It’s nowhere near that in this country because physicians give us two pushbacks,” she explains. First, physicians worry that dentists may not understand the fine points of adjusting devices, as well as the related medical aspects. Second, they’re afraid of losing patients to dental offices, and that patients won’t return for proper follow-up.

It’s up to the dentist to allay physicians’ fears, says Demko. “In the past, dentists haven’t been playing as team members,” she admits. “And I think now with Trends, where the AASM is giving us a true chance to come in and be a part of the team on an equal standing with physicians, that’s going to make a huge difference in how physicians perceive oral appliance therapy.”

FINANCIAL CONSIDERATIONS
Smith believes that because so many people have OSA, providing treatment can be profitable for dentists who are willing to undertake the proper educational steps. “If a dentist can position himself — through proper education, through networking with his community physicians, through being proactive in screening and finding out about local sleep centers — he can create a network of physicians who respect the fact that he is prepared, he is educated,” Smith explains. “And physicians will refer patients to him. Then, if you create a significant number of people coming in for your services, it can be very financially rewarding.”

Demko, though, offers a caveat. She found that she was unable to work oral appliance therapy into her general practice because it’s essentially different from the way a restorative dentist works. A restorative dentist may be working three rooms at once, doing very technical procedures and working with patients who are extremely nervous. There isn’t time for much education.

For patients with OSA, however, education is imperative. “All of the big studies show that the biggest dropout rate for patients using oral appliances is in the first month,” Demko explains. “So for me it’s about educating the patient to take it slowly, that it’s not going to be easy. And because insurance demands it, they all have 90 days of follow-up in the original fee. If I can get them back for those three months I know I’m already past that big hump where we lose patients to compliance. So, for a dentist who says I’m going to take this course, increase my bottom line by $100,000, it’s not going to happen.”

Demko says the AASDM offers sleep medicine courses for dentists. There’s an introductory course, a full-day clinical course, even podcasts on everything from billing to oral exams. The goal is to guide dentists through the steps necessary to fully understand OSA, but also “to try to explain to them that they can’t go into this for bottom line,” says Demko. “If they go into this for bottom line they will fail. I don’t want to see 25 new patients and none of them have a device made for them. But to have four new patients and all of them have a device made, that’s the difference between understanding what you’re doing, and not.”
The Business of Saving Lives:
What Dentists Should Do in the Fight Against Oral Cancer.

Sarah Handzel, B.S.N., RN
Dentists, whether they realize it or not, are on the front line of the war against cancer. With the prevalence of oral cancer on the rise, dentists are positioned to provide patients with critical diagnostic care. Suddenly, dentists find themselves not in the business of cavities and crowns, but saving potentially countless lives.

In the United States, oral cavity squamous cell carcinoma is the most common cause of malignancy in all head and neck cancers, accounting for about 90 percent of cancers that are diagnosed in this anatomical region.1 It’s estimated that about 49,670 people in the U.S. will be diagnosed with a form of oral cancer in 2017. Worldwide, oral cancer is the sixth most common form of cancer; most often diagnosed in male patients and typically appearing after it has metastasized.1 Diagnosis of this form of cancer typically occurs about age 62, although slightly more than one-quarter of these types of cancers develop in younger patients.1 Recently, there has been an increase in public awareness efforts regarding oral cancer and the role dentists play in screening for the disease.

“We’re in a place in history that is unique: Americans, in general, have never been more interested in their own health,” says Brian Hill, founder and executive director of The Oral Cancer Foundation. “The interest in cancer screenings has become a normal part of our lives, and things that we normally didn’t think about 20 years ago, we’re regularly getting screened for now.”

“The good news is that the American public is receptive to screening. Our government is also realizing that treatment is way more expensive than early discovery. Right now, we have an audience that wants information.”

CANCER RATES ARE INCREASING

Since the mid-1970s, the incidence of oral cancer has increased about 15 percent,2 with a 0.5 percent annual increase in positive diagnoses.3 According to some data, privately insured insurance claims in the U.S. related to oral cancer diagnoses rose by 61 percent from 2011 to 2015.6

“There are publications that show the rate of oral cancer — not oropharyngeal cancer — in young patients is increasing,” says Brian Schmidt, D.D.S., M.D., Ph.D., an ADA spokesper-

son. “It’s hard to get exact numbers on this, but it seems oral cancers are increasing. We don’t yet understand the etiology of this.”

The term “oral cancer” can be misleading since it is often used as a single diagnostic term when discussing all cancers of the head and neck. It is important to distinguish between true oral cancers — those occurring in the oral cavity on the tongue, gums, buccal mucosa or floor of the mouth — and oropharyngeal cancers that occur on the soft palate, the base of the tongue and the tonsils.1 Squamous cell carcinoma can certainly develop in this region independently of any growth in the mouth itself.1,4

A NEW CANCER RISK FACTOR

Infection with human papillomavirus (HPV) has recently emerged as a major risk factor for the development of oropharyngeal cancers.2 Most commonly, HPV infection is associated with squamous cell carcinoma of the tonsils and the base of the tongue.2 In the U.S., HPV infection has been shown to account for more than 60 percent of all oropharyngeal cancers.1

There is now some debate over whether HPV infection could be a causative factor in the development of oral cavity squamous cell carcinomas. HPV colonization within the oral cavity can be identified in 2 to 8 percent of the healthy adult population, but studies suggest these infections typically resolve within a year.4

In individuals engaging in frequent high-risk oral sexual behavior, or those with weakened immune systems, HPV infections are more likely to persist and may be a critical factor for the development of HPV-related cancers.4 In the body, HPV infects basil epithelial cells and can remain latent within these tissues. Research has shown HPV can infect gingival tissue, invading the periodontal pocket where basil cells are exposed to the environment.4 In individuals with periodontitis, chronic inflammation leads to increased basil cell proliferation, which in turn leads to higher viral loads in the oral cavity and saliva. There is some speculation that this process could create a reservoir within the oral cavity, leading to sustained HPV infection and the development of oral cancers.4

However, there is still no clear association between HPV infection and the development of oral cavity squamous cell carcinoma.4 As Hill says, “At the end of the day, the ubiquitousness of this virus is unlike anything that we’ve had to deal with in the dental community ever before.”

WHY IS IT SO HARD TO DETECT ORAL CANCERS EARLY?

Unfortunately, oral and oropharyngeal cancers often remain undetected until later stages, when treatment is difficult and often unsuccessful. For individuals with cancer that is diagnosed after metastasis, the 5-year relative survival rate is about 38 percent.7 This rate hasn’t improved substantially for many years.

Traditionally, dentists have used oral examinations, including visual inspection and palpation, to screen for oral cancers, but it is possible for smaller, more subtle lesions to remain undetected, especially in the oropharyngeal region.

“It’s a difficult area to examine. Dentists are formally trained to examine both the inside and outside of the mouth, and part of the examination of the inside of the mouth would be the base of the tongue and the tonsils,” Schmidt says. “However, it’s hard to see those areas — sometimes directly examining the base of the tongue and the tonsils can be difficult.”

Unfortunately, many dentists do not encounter patients until the cancer has metastasized. “Many of the oropharyngeal cancers that are related to HPV present with metastasis to the neck,” Schmidt says. “These patients will often present with a lymph node in the neck that the dentist can palpate. They might not show anything in the mouth.”

“Dentists are very good at picking up oral cancers early, but for certain populations —
Under current guidelines, dentists are encouraged to perform head and neck exams, as well as collect tobacco and alcohol use data, during routine visits.

VELscope uses a wireless, handheld scope that uses natural tissue fluorescence to enhance the way (we) can visualize oral mucosal abnormalities that might not be apparent or even visible to the naked eye,” Wei says. “We have implement this into our dental practice and it has become routine during exams.”

As Hill says, “Screening for oral cancer is a very small part of your daily practice. It’s not going to be hugely time consuming, and you don’t have to go back to school to learn how to do it. It just requires engagement, and saying ‘I believe this is important in my practice. I am the custodian of these patients’ mouths.’ I think if every dentist approaches their patients with that mentality, they will take the time to do what’s right, and we’ll start finding this stuff earlier.”

REFERENCES:
Turn On the ‘New-Patient Faucet’
Your practice from the patient’s perspective.
By Darcy Lewis

It may seem harder than ever to build a steady flow of new dental patients, but they’re still out there for dentists who have drive and marketing know-how. “The ability to literally turn on the new-patient faucet is still a reality,” Michael Abernathy, D.D.S., told attendees at the Chicago Dental Society Midwinter Meeting.

“The problem,” he said, “is that most of us just don’t know how.” Abernathy, who runs a multioffice dental practice based in McKinney, Texas, and is the founder of Summit Practice Solutions in Dallas, started his talk by reminding colleagues that successful marketing is an outgrowth of what is already happening in a healthy practice.

“There’s an old marketing axiom that applies to dentistry beautifully: Good practices that are receiving many new patients don’t need to market, but they should do it anyway,” he said. “Poor practices who are losing patients to better practices need to market, and yet they shouldn’t, because the basics aren’t in place.”

MAKE SURE YOUR PRACTICE IS IN ORDER.
Abernathy suggested evaluating your practice the same way prospective patients judge a dentist. Key attributes include hours and location, of course. But go beyond these factors: evaluate how clean and up-to-date you are, the quality of your office, the clarity of your treatment plans and payment options, he said.

DEVELOP A CONSISTENT REFERRAL MECHANISM.
A simple postcard has generated good results for his practice, Abernathy said. Each patient receives it at the end of their visit. It includes three key questions: How did you learn about us? What did you like least about your visit? Would you refer your family or friends to our office?

The postcards can either be completed on the spot or they can be returned via business reply mail, so the practice only pays postage on the cards that it receives.

He also encourages current patients to generate referrals by offering $50-off certificates. When a current patient makes a referral, both the current and new patients receive a $50 discount on their next dental visits.

REACH OUT TO NEW RESIDENTS.
When people move to your area, that’s a prime time to add them to your practice. Abernathy suggests contacting a mailing-list broker. “Ask for new residents in a 3- to 5-mile radius from your office,” he said. “Choose an appropriate income level for the demographic area and then send them your best new-patient offers.”

ENGAGE IN MEANINGFUL COMMUNITY OUTREACH.
Abernathy and his colleagues have long prioritized outreach to children at schools and in other organized settings. He shared a flyer that goes home to the parents of each participating child.

It reads: “Your child had a terrific time today. There were films, balloons, toothbrushes, a dental poster contest and brushing instructions. As a public service, your child was also given a free dental exam. Areas marked in red (on the accompanying diagram) on permanent and baby teeth require attention. Please call your dentist at your earliest convenience. Provided as a public service by [insert practice name].”

The practice also had a huge success by offering a free dentistry day. It took out a newspaper ad that read, in part, “We will be donating our services to anyone who cannot afford dentistry. … We consider this a mission project; no money will be accepted. … If you or anyone you know needs dental treatment that can be completed in one day, please be at our office on [date, time].”

Two-hundred people received care, and the local paper ran an article about the event, even sending a photographer to capture the scene.

Above all, be consistent in your marketing approach and efforts. “Practice growth is the natural result of practice health,” he said. “Growth occurs when our message and our methods are balanced.”

Five Takeaways
1. Social media is more than just Facebook.
   “The biggest social media blunder that I see dentists making is they think of social media as [just] Facebook,” said Larry Emmott, D.D.S., president of Emmott On Technology. Emmott sat down with Dentist’s Money Digest at the Chicago Midwinter Meeting. What’s more important, according to Emmott? “Claiming your Google business site, claiming your Yelp site.”

2. Your website is the face of your practice.
   In her continuing education session at the Yankee Dental Congress, Alicia Owens, a Dentrix profitability coach, discussed how an updated website can help a patient discover your practice. A website should also let patients know what procedures you offer. She suggested creating a patient resources section with accurate information about the procedures they will be undergoing. This may save some WebMD-induced anxiety.

3. Are practice leaders born, or can they be trained?
   “Thinking that leadership is an ability that either a dentist or anybody else is born with is a bit of a misconception,” said Amy Morgan, CEO and owner of the Pride Institute. Morgan sat down for an interview with Dentist’s Money Digest at the Chicago Midwinter Meeting. “No matter what your personality style is, one can and should aspire to higher-level leadership.”

4. Taking the spoon from practice pot-stirrers.
   The dynamics of each practice may be unique, but employee problems often stem from a common root. “Usually the dentist hasn’t set clear standards as the practice grows, especially when problem employees have good technical skills or are good with patients,” Judy Kay Mausolf, a practice consultant, told Dentist’s Money Digest at the Chicago Midwinter Meeting. “Dentists may be reluctant to address problems.”

5. Is your practice HIPAA compliant?
   According to Danielle Sheer, vice president and general counsel at Carbonite, an automated data storage company, the three most common HIPAA compliance errors doctors and dentists are making are: 1) using an external hard drive to back up data, 2) using public software, such as Google Docs, and 3) using a program that syncs data instead of backing them up.

Reporting by Sarah Anwar, Darcy Lewis and Joe Hannan
A planned city, Washington, D.C., was built to embody the new country’s aspirations. The broad boulevards and wide circles, laid out when horse trails marked the town, show the breadth of the Founding Fathers’ dreams. The District unfolds as a graceful mix of monuments, memorials, museums and neighborhoods. There’s always more to see, whether you visited last year or toured with your high school buddies decades ago.

If the Mid-Atlantic Dental Meeting brings you to town from May 5-6, you’re in luck. Spring is the best time to explore. The mild weather makes walking a joy and the profusion of tulips, dogwood and azaleas sweeten the scenery.

**MUSEUMS, MONUMENTS AND OFFICE BUILDINGS**

D.C. is a feast for the eyes. No other city has the White House, the Capitol, and the National Archives, where the Declaration of Independence, the Constitution, and the Bill of Rights are on view. The scores of monuments and memorials pay official homage to our country’s heroes, and the Smithsonian Institute’s 19 museums and the National Zoo offer free access to U.S. treasures.

The newest Smithsonian museum, the National Museum of African American History and Culture, which debuted last September, presents the African-American experience in the United States. The multilayered story starts with slavery, winds through segregation and protests, and culminates with triumphs in sports, stage, movies and other arts. Because of the museum’s popularity, visitors must obtain free timed-entry tickets. Check the Smithsonian website.

Find out about bugs, bones, blue whales and much more at the National Museum of Natural History, home to the 45.5-carat Hope diamond. At the Hall of Human Origins, you can merge your face with that of a prehuman, and visit the Insect Zoo for the tarantula feeding. The National Museum of American History houses such favorite and eclectic finds as the flag that flew over Fort McHenry (the original Star-Spangled Banner), first ladies’ gowns, Thomas Jefferson’s lap desk and Dorothy’s ruby-red slippers from “The Wizard of Oz.”

At the National Air and Space Museum, peruse the history of aviation from the dreams of the Wright brothers to space flight. A swirl of curves, the 250,000-square-foot National Museum of the American Indian, constructed of yellowish Kasota limestone, glows softly like an adobe-built kiva at sunset. The facility presents artifacts and cultural information about native nations hailing from the Arctic Circle to Tierra del Fuego.

Three non-Smithsonian facilities well worth touring are the U.S. Holocaust Memorial Museum, which tells the somber story of the millions of Jews and other victims of Nazi brutality in World War II; the International Spy Museum, which delivers the lowdown on espionage; and the Newseum, whose scores of theaters, galleries and interactive stations demonstrate how free speech, supported by newsgathering and distribution, is essential to democracies.

Take advantage of spring’s warm weather to walk or bike the National Mall and adjacent areas, pausing at the Lincoln, Jefferson, Martin Luther King Jr., Franklin Delano Roosevelt, Vietnam War, Korean War, and World War II memorials, as well as the Washington Mon-
To tour the U.S. Capitol or the White House, obtain tickets well in advance by contacting your senator or representative. The Capitol Visitor Center distributes a limited number of same-day tickets. Even without passes, allow time to explore the exhibits at both the Capitol and the White House visitor centers.

At Arlington National Cemetery, across Memorial Bridge in Virginia, hundreds of thousands of U.S. service members are buried. Watching the changing of the guard at the Tomb of the Unknown Soldier always re-enforces the solemnity and seriousness of war. Other famous gravesites there include those of former President John F. Kennedy, former first lady Jacqueline Kennedy Onassis and former U.S. Attorney General Robert F. Kennedy.

**DINING AND NIGHTLIFE**

The District blooms with interesting places to eat, ranging from Michelin two-star dining rooms to spicy cheap eats at food trucks. The recent Michelin Guide awarded stars to 12 area restaurants, and an additional 19 eateries made Michelin’s Bib Gourmand list, which features the best moderately priced eateries.

Chef Aaron Silverman, known for his playful and unlikely combinations of ingredients, features a 13-course tasting menu at two-Michelin-starred Pineapple and Pears. At his casual, one-starred Rose’s Luxury, tables can be had only by lining up in advance. Usually, you need to be there by about 3 p.m. for the beginning of the dinner seating at 5 p.m. Professional line sitters – yes, they exist – hold the places of those who can’t or won’t queue up.

Chef Fabio Trabocchi’s Fiola, a noted Italian restaurant, received one Michelín star. His Fiola Mare, even without a Michelín star, rates as one of the District’s best restaurants and the dining room comes with a Potomac River view. The one-star Blue Duck Tavern serves seasonal and innovative American cuisine. Chef Nick Stefanelli’s Masseria, also the recipient of one Michelín star, plates memorable Italian cuisine. Diners choose either a four- or five-course meal or a six-course tasting menu. Zaytinya, among Michelin’s Bib Gourmand recommendations, serves savory Greek/Mediterranean tapas near the Verizon Center.

Sometimes when exploring a museum, it’s most convenient to eat there. Mitsitam Cafe, at the National Museum of the American Indian, and Sweet Home Café, at the National Museum of African American History and Culture, rate as two of the best Smithsonian cafeterias. Mitsitam (which means “let’s eat” in the language of the Piscataway and Delaware peoples) serves Native American tacos, fry bread, squash, grilled salmon and other traditional foods.

To stretch your budget, get lunch at one of the many food trucks. Fill up on homemade stuffed pockets at DC Empanadas, tasty pizza at DC Slices, and for snacks, try the ice cream sandwiches, and cookies and milk from Captain Cookie and the Milk Man. Track the moving feast online at Food Truck Fiesta (foodtruckfiesta.com).

For D.C. nightlife, think theater. Two noted companies offer innovative takes on the Bard, as well as other productions. The Shakespeare Theatre hosts “Macbeth” April 25 - May 28, and the intimate Folger Theatre presents a program of medieval troubadours’ songs and poetry April 28-30, followed by Shakespeare’s “Timon of Athens,” May 9-June 11.

But it’s not all Shakespearean classics in the capital. Arena Stage has been at the forefront of nurturing new plays and updating definitive American plays since its founding in 1950. The facility hosts “A Raisin in the Sun” on its main stage (March 31-May 7) and “Smart People,” billed as a “controversial and fiercely funny new play,” is in the Kreeger Theater (April 14-May 21).

Along with hosting plays, the Kennedy Center is home to the National Symphony Orchestra and the Washington Ballet. The boxy building on the Potomac provides Washington with an extraordinary artistic menu of theater and musicals, dance and ballet, and multimedia performances, as well as chamber, jazz, orchestral, popular and folk music. The Millennium Stage offers a free performance every evening.

**ESPECIALLY FOR CHILDREN AND TEENS**

Cool off by running through the synchronized sprays with your kids at Georgetown Waterfront Park, an oasis at the foot of M Street NW. Nearby, concrete steps lead to the river, getting you close enough to feed the ducks. The recommended treats for the quackers aren’t crackers or bread. Instead, bring birdseed, barley or oats to toss.

Little ones like riding the carousel on the Mall near the Arts and Industries building. At the National Museum of American History, hands-on activities captivate tots through 6-year-olds at Wegmans Wonderplace, and budding inventors, ages 6 to 12, craft musical instruments, create fashion from trash or try their hand at being a disc jockey at the museum’s Draper Spark!Lab. Turn your grade-schoolers and teens into secret agents by taking part in Operation Spy, a one-hour, hands-on secret mission at the International Spy Museum.

Want great city views? Then paddle the Potomac River with a rented canoe or kayak from Thompson Boat Center, something that is likely to please the entire family, even teens. If your child is 16 or older, consider ending your day together with an evening glide on a Segway past the illuminated monuments. Companies include City Segway and Segs in the City.

Whatever your age or your politics, you are sure to discover many engaging experiences in Washington, D.C.
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