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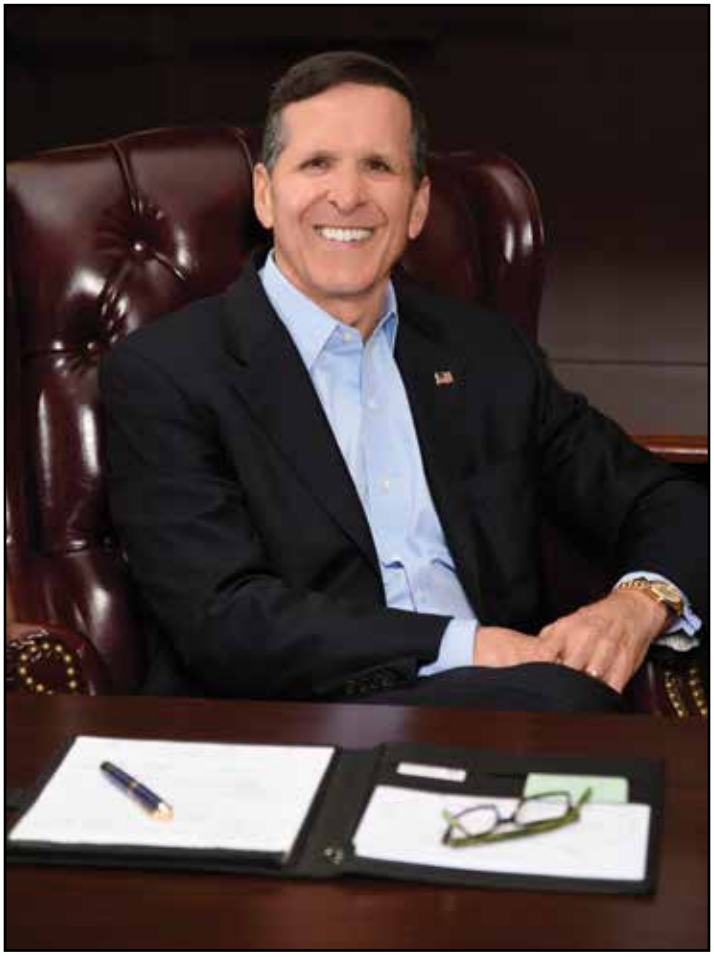
An Interview with Roger P. Levin, DDS



Roger P. Levin, DDS - Founder & CEO of Levin Group Inc.

The California Association of Oral and Maxillofacial Surgeons (CALAOMS) is pleased to have Dr. Peter Krakowiak, one of our contributing members, interview Dr. Roger Levin, the CEO of Levin Group, a leading OMS management and marketing consulting firm. Dr. Levin has worked extensively with our specialty and has contributed his vast knowledge and expertise to the enhancement of successful management of all types of dental practices in North America and Europe over the past 40 years. He is one of the most sought after speakers in the area of dental economics and practice management in the United States. He has been a key business advisor in the aftermath of the COVID-19 epidemic for thousands of dental providers in the United States, generously dedicating his resources and time to help our profession weather the storm. Today, he joins the CALAOMS membership for a candid interview and timely advice.

Dr. Krakowiak: *Dr. Levin, welcome and thank you for joining me in this interview for The California Journal of Oral & Maxillofacial Surgery. It's truly a unique opportunity to have you directly share your invaluable insights with hundreds of our association's specialist members. I know all of our members will really appreciate this segment of our Journal. Thank you, once again.*

Dr. Levin: It is my pleasure to be with you and I look forward to our conversation.

Dr. Krakowiak: *I have known you personally now for almost two decades and certainly a lot has changed in the past 20 years. It certainly is not getting any easier to operate our practices. What do you see as the single most difficult challenge for traditional referral-based OMS practices in the next decade, and what is the preferred strategy to take it on?*

Dr. Levin: That is a really great question. It's always hard to predict exactly what will happen in the future, especially with the advent of COVID-19. But my general belief is that oral and maxillofacial surgeons, who are currently

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EDITORIAL

by Jeffrey A. Elo, DDS, MS, FACS

Epidemics Collide

Recently, I watched *The Perfect Storm*, the 2000 American biographical disaster drama film based on the 1997 non-fiction book of the same name by Sebastian Junger. The phrase 'perfect storm' is a bit of an oxymoron if you consider its true definition. There is nothing perfect about a storm which creates a calamitous situation other than that the storm is the perfection of the elements which came together to create it. I couldn't help but think about the current state of affairs and how they remind me of a 'perfect storm.'

Beginning in mid-March, the entire nation was placed on government-ordered lockdown. Businesses deemed *non-essential* were forced to close their doors, and workers were furloughed or laid off. Sadly, many of those businesses have not yet reopened and many of the workers continue to be unemployed or underemployed. Dental offices were not immune. They also soon closed after temporizing and stabilizing patients of record; and most OMSs either closed their offices temporarily or dramatically decreased their patient volume – only treating emergency patients.

Society was paralyzed in an unprecedented effort to "stop" or "slow down" the spread of the coronavirus. Business owners and citizens were told to close and stay home for "two weeks" to "flatten the curve" so we would all "be safe."

Often, on the 'road of good intentions,' there is a detour route that takes the travelers down the 'highway of unintended consequences.' In addition to the ongoing challenges presented by the COVID-19 pandemic, the nation's opioid epidemic has grown into a much more complicated and deadlier drug overdose epidemic. Take San Francisco, for example. San Francisco is on track to lose more than 700 people due to drug overdoses in 2020 (*source: San Francisco Chronicle*), while so far in 2020, 123 deaths have been attributed to COVID-19 in San Francisco County. Many publications track and monitor every death linked to the coronavirus, but few seem to devote similar resources to track deaths attributable to drug overdoses.

The American Medical Association has stated its great concern over an increasing number of reports from national, state, and local media suggesting increases in opioid- and other drug-related mortality – particularly from illicitly manufactured fentanyl and fentanyl analogs. More than 40 states have reported increases in opioid-related mortality as well as ongoing concerns for those with a mental illness or substance use disorder.

The unintended consequences from the states' reactions to the coronavirus look to be undoing the advances made against a drug epidemic that has claimed close to 600,000 lives in the U.S. over the past two decades. Worse, it's also laying the foundation for a long-term resurgence of addiction by exacerbating many of the conditions – including unemployment, underemployment, low incomes, and social isolation – that contributed to the rise of the opioid epidemic and deaths of despair.

There are certain anticipated emotional and psychological reactions that happen as a result of a stressful event, such as a pandemic or a stock market crash. Anxiety and depression increase, suicides increase, and people's use of harmful substances goes up. The number of opioid overdoses has been increasing and doesn't appear that it'll be easily turned back. Once the tsunami wave of the coronavirus pandemic finally recedes, it seems clear that we're going to be left with the social conditions that enabled the opioid crisis to emerge in the first place; and those are not going to swiftly go away.

So, what is happening? Many moving parts have contributed to and compounded the problem. Social distancing – with its resultant loneliness, dramatic increases in unemployment or underemployment, and widespread economic woes lend themselves to common substance abuse triggers: isolation and anxiety. Those in the medical community, specifically those who regularly deal with substance abuse disorders, often describe addiction as a "disease of isolation." Given the continuation of states' lockdown orders in various parts of the country, many more people have assumed a higher risk of drug abuse, even those who did not misuse opioids previously.

At just the end of April, 28% of Americans reported worsening mental health and 34% reported worsening emotional well-being. How much worse do you think these have gotten in the six months since?

From 1999–2018, almost 450,000 people died from an overdose involving any opioid, including *prescription* and *illicit* opioids.1 In the last twenty years, 200,000 people have died from *prescription* opioids.2 CALAOMS has been the leader in dentistry's efforts in California to proactively advocate recommendations that focus on clinical practice, providing evidence and guidance to improve how these medications are prescribed; ultimately resulting in improved patient care outcomes.

The rise in opioid overdose deaths can be outlined in three distinct waves (Figure 1).

1. The first wave began with increased prescribing of opioids in the 1990s, with overdose deaths involving prescription opioids increasing since at least 1999.3

2. The second wave began in 2010, with rapid increases in overdose deaths involving heroin.4

3. The third wave began in 2013, with significant increases in overdose deaths involving synthetic opioids, particularly those involving illicitly manufactured fentanyl.5,6,7 The market for illicitly manufactured fentanyl continues to change, and it can be found in combination with heroin, counterfeit pills, and cocaine.8

Although states like California remain under the national average for overdose deaths, the state has still been hit particularly hard. The statistics released by the National Institute on Drug Abuse (NIDA) describe 2,199 overdose deaths that involved opioids in 2017 in California. This translates to a rate of 5.3 deaths per 100,000 persons, which is lower than

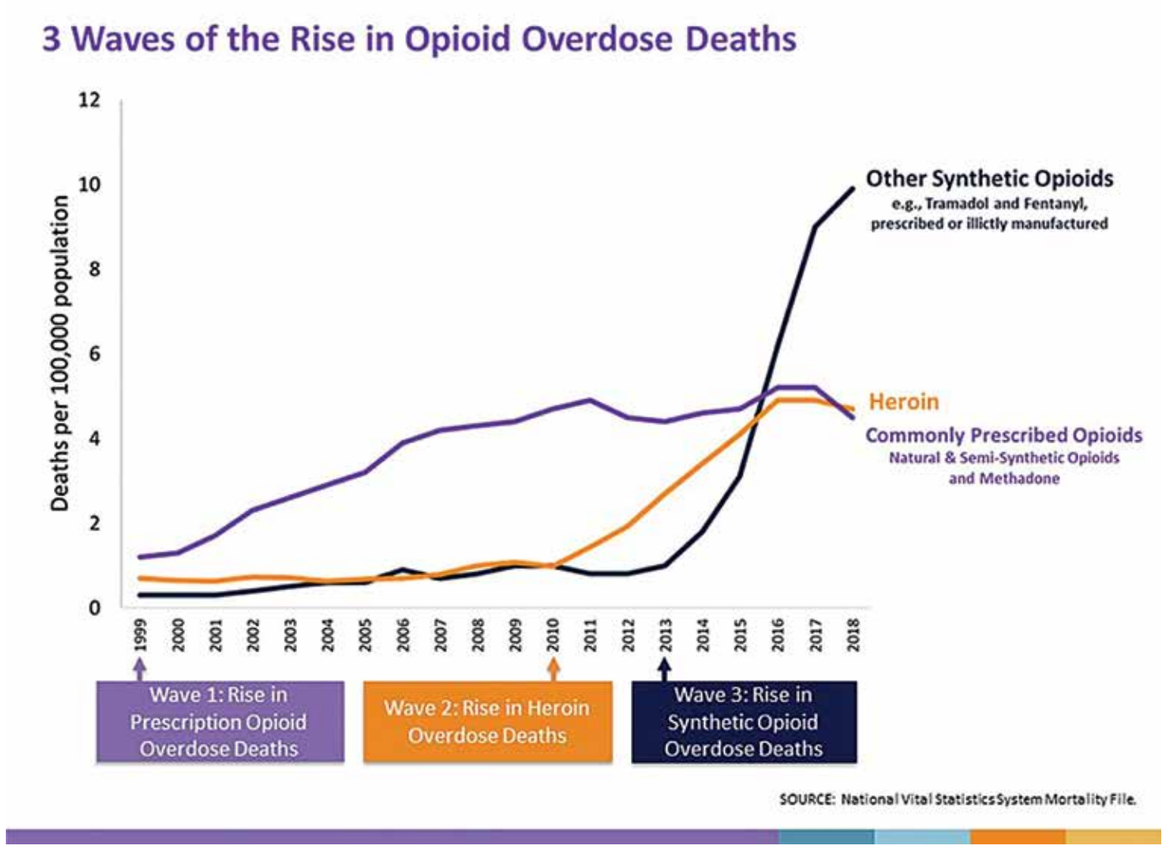

Figure 1.

the national rate of 14.6 deaths per 100,000 persons. The primary driver behind overdose deaths involved *prescription* opioids, with 1,169 deaths in 2017. Unfortunately, the most significant increase in overdose deaths involving opioids stemmed from synthetic opioids (mainly fentanyl). It accounted for a more than twofold rise from 229 to 536 over a span of two years. Heroin overdose deaths also increased in the same period from 593 in 2012 to 715 in 2017. In 2017, doctors in California wrote 39.5 opioid prescriptions per 100,000 persons. It was the lowest prescribing rate in the United States and significantly lower than 58.7 per 100,000 person prescriptions, which is the national average. These numbers showed a positive correlation, however, and the lower opioid prescriptions accounted for a decrease in deaths from 2014 to 2017.

CALAOMS has been committed to doing our part to combat the opioid overdose epidemic. CALAOMS supports our members with data, tools, and guidance for evidence-based decision-making to improve opioid prescribing and patient safety. Through outreach efforts with high schools around the state, CALAOMS members have increased public awareness about prescription opioid misuse, abuse, and overdose; and have taught hundreds of teenagers to make safe choices about opioids. Collaboration is essential for success in preventing opioid overdose deaths. Medical personnel, emergency departments, first responders, public safety officials, mental health and substance use treatment providers, community-based organizations, public health, and members of the community all bring awareness, resources, and expertise to address this complex and fast-moving epidemic. Together, we can better coordinate efforts to prevent opioid overdoses and deaths.

In 2017, during Dr. Alan Kaye's CALAOMS presidency, he brought a proposal to the board that CALAOMS should take a proactive stance against the government's narrative (*that falsely stated that dentists, specifically OMSs, were a big part of the opioid prescribing problem*) and carry a message to all California high school students about who we – as oral and maxillofacial surgeons – are and how we are seriously responding to the opioid epidemic. As surgeons, and more to the point – as surgeons being accused of being part of the problem – we need to bring a positive and educational message to all high school-aged students that OMSs can and do offer very effective non-opioid pain medications for post-operative discomfort. That doesn't mean we won't prescribe an opioid when absolutely necessary, but we do not view them as first-line or solo medications for the treatment of post-operative discomfort.

Our current CALAOMS Board continues to embrace the importance of this encouraging message. We have composed a short and powerfully educational PowerPoint presentation for high school-aged students that contains important statistical information, as well as the consequences of opioid misuse and abuse.

Prior to the COVID-19 shutdown, this presentation had been delivered to several groups and organizations, including many high schools in California, several police and fire departments, and Rotary Clubs. Each audience responded favorably and with gratitude for our willingness to share our time and expertise.

As members of our communities and as individual surgeons who are part of a bigger collective – CALAOMS – as schools begin to open up again, we again need to pick up where we left off and carry this message statewide - and hopefully nationwide - to let our young people know that oral and maxillofacial surgeons care about them and their well-being.

This is where all of you, our members, come into play. What began as a pilot project to determine how this message would be received can once again blossom into an explosion of excitement in our communities. It will take all of us participating to get this message out. As busy as we all are with our practices and family and life events, this is a message that strongly demands and deserves our time. Working together as one body, we can blanket the state's high schools with this life-saving information.

By delivering this presentation in person (or even via Zoom, if that's all that is allowed in your communities), you will be helping students on their journey to understand the dangers of opioid misuse and abuse, and at the same time will be teaching them about who we (OMSs) are, what we do, and why we care. Well-respected oral and maxillofacial surgeons demonstrating care and concern for vulnerable and influenceable youth in their community is extremely powerful and deeply impactful. Our state legislature is taking notice and will applaud both our association and each of you for the proactive nature of this program.

Though our efforts were placed on government-mandated pause seven months ago, as schools and society now open back up, this is our moment to step back up to the plate and really do something at the grassroots level that will deliver incalculable goodwill and benefits. As surgeons who can prescribe opioids for post-surgical care, we have an obligation to help people understand the potential for misuse and dependency, so they are better prepared for pain management after a procedure. They need to be made aware of good alternative pain relief medications.

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PRESIDENT'S MESSAGE

by Chan M Park, DDS, MD, FACS
CALAOMS President

It does not matter how slowly you go so long as you do not stop.
— Confucius

Year 2020 has been an interesting year to say the least. I find my daily routine fundamentally changed. The ways I interact with family and friends have changed. My children's daily routines have changed. All the sports, various activities, meeting with friends, and schools have all changed. For us oral and maxillofacial surgeons (OMSs), many things have changed, as well. The way we interact with patients, the way we deliver treatment, who we treat, the way our office flows, referral patterns - they've all changed. It is safe to say that things will never quite be the same as they used to be. As individuals, we all face challenges; we grow from them, adapt to circumstances, and eventually overcome. That is what makes us strong.

Many of CALAOMS' important agenda items have been put on hold this year, but they haven't disappeared. There is still the need to continue advocating to preserve our anesthesia team model. The MICRA (Medical Injury Compensation Reform Act) battle is once again looming on the horizon. The Delta Dental fee reduction is imminent, it seems.

The good news is that your CALAOMS leadership team has been diligently working silently in the background. We have plans in place for 2021 to re-introduce legislation (that was

withdrawn in 2020 due to the pandemic) to proactively promote our anesthesia team model that contains the same safety measures we advocated for in SB 501 (pediatric anesthesia safety bill passed in 2018) to also apply to patients over 13 years old. We have established a special task force committee that has been communicating with Delta Dental representatives on behalf of California OMSs. We are working with our lobbyist to continue advocating our stance on MICRA; thankfully, the entire medical community stands united on this issue. We have successfully launched - for the first time ever - the online OMSA (oral and maxillofacial surgery assistant) course.

CALAOMS will be promoting and encouraging all OMSs and their OMS assistants to renew their OMSA training every two years instead of every five years.

The OMSA course will be completely online, beginning soon in 2021. At that point CALAOMS will be promoting and encouraging all OMSs and their OMS anesthesia assistants to renew their OMSA training every *two* years instead of every five years. This past September, the AAOMS House of Delegates voted to pass a similar requirement as a condition for membership – this proposal still requires one year for policy/language review before returning to the House for final vote. So, just as we have always done in California, we are once again taking the lead on this very important anesthesia-related item.

The CALAOMS Board believes the 5-year interval between recertification of the anesthesia assistants is too long for meaningful retention of skills needed by OMSAs. California Law will require, beginning in 2022, that OMSAs who assist in Moderate Sedation and Deep Sedation/General Anesthesia (DS/GA) on children under 7 years of age must be currently certified in PALS (or a Dental Board-approved course of equal or superior quality). With our proposed legislation in 2021, the board also desires to enhance the training of OMSAs who assist in anesthesia delivery for adult patients by requiring ACLS certification.

OMSA recertification every 2 years coincides with the renewal of all other state healthcare licenses and permits on a two-year cycle. Bringing OMSA training and recertification into line with professional licensing norms enhances the professionalism of the OMSA program. The OMS Anesthesia Team Delivery Model, consisting of a three-person team for DS/GA, with the surgeon in command, a dedicated monitor trained to assist in the anesthesia, and a dedicated surgical assistant, is the standard for anesthesia safety in dentistry.

There are many uncertainties that lie ahead of us. The full economic impact of COVID-19 to individual OMS practices is still unknown. As we head into the flu season, we don't fully know how the concurrent flu season with the underlying pandemic will affect our business. Will there be a second wave? Will there be another shelter-in-place? Will the PPE shortages persist? Is there going to be a recession next year? There are more questions than answers at this point and it will likely be that way for a long time. Despite how long it takes, we will overcome this pandemic. I am confident that the changes that occurred both personally and professionally will be for the better.

As I write this last President's Message of farewell, I am honored to have served as your President in the year 2020. It was certainly a challenging year. I would like to thank our Executive Director, Pam Congdon, CAE, IOM, for her dedication and hard work this year. It has been a tough year for her both professionally and personally, yet she has given her full attention to CALAOMS to cope with all the challenges this year, such as PPE, finances, and numerous conference calls, to name just a few. I would like to also thank Teri Travis and Steve Krantzman from our CALAOMS headquarters. They have all worked tirelessly behind the scenes with hotels, CE courses, and COVID-related issues. Their efforts truly need to be recognized and congratulated. I would like to thank Dr. Vivian Jui for chairing the COVID task force to help OMSs get back to opening their practices. Dr. Jui and the task force need to be congratulated and recognized for their efforts. She has also spearheaded the OMSA committee to bring the OMSA course fully online. In my six years serving on the board, I have never met a first-year board director as dedicated and hardworking as she is. CALAOMS is in good hands for years to come. Lastly, I would like to thank the rest of the board members: Drs. Larry Moore, Jeff Elo, Dave Cummings, Sam Khoury, Ash Veeranki, George Maranon, Shama Currimbhoy, Alan Kaye, and Fred Stephens for their dedication and efforts spent on behalf of CALAOMS. Thank you for allowing me to serve our wonderful profession and great state association as your President; it has been a great pleasure.

Sincerely,

Chan Park, DDS, MD, FACS, FACD
CALAOMS President

AAOMS DISTRICT VI TRUSTEE REPORT

by Mark Egbert, DDS, FACS
AAOMS District VI Trustee

Greetings from the District VI Trustee

I am grateful to CALAOMS – and to all of District VI – for the support and confidence shown me as your AAOMS Trustee. I will continue to bring hard work, dedication, and a love for the specialty to the AAOMS Board table from our district. California possesses an important voice in leading the district and AAOMS.

The 2020 Virtual AAOMS Annual Meeting recently concluded. Despite the many challenges it takes to host such a large event completely online, we had a successful meeting! AAOMS thanks the many attendees, speakers, exhibitors, and guests who contributed to the success of the first-ever Virtual AAOMS Annual Meeting. Attendees have access to the meeting education platform until December 10, 2020. In addition, you can also view the latest products and services in the Virtual Exhibit Hall. The last day to received continuing education credit is January 31, 2021. The virtual format combined high-quality educational content from the traditional Annual Meeting and the Dental Implant Conference into one distinctive meeting. Attendees received world-class presentations and a community-oriented platform that allowed for peer-to-peer engagement. The President's Event featured a presentation by special guest Dr. Anthony S. Fauci as well as a conversation between AAOMS President Dr. Victor Nannini and Jay Leno, former host of NBC's "The Tonight Show."

The President's Event featured a presentation by special guest Dr. Anthony S. Fauci...

The House of Delegates completed the work of the association and elected a new slate of officers. Dr. B.D. Tiner (San Antonio, Texas) is AAOMS' new President, Dr. J. David Johnson (Oak Ridge, TN) ascended to President-Elect, and Dr. Paul J. Schwartz (Pittsburgh, PA) was elected Vice President. Dr. Victor L. Nannini will serve as Immediate Past President and will continue to provide counsel to the board.

I encourage you to read the AAOMS Member Alerts and President's Message, and to visit the AAOMS website frequently for new information as it comes available. I also encourage you to read the letter from AAOMS President Dr. Victor Nannini to CNN's Jake Tapper, who on October 2, 2020, made an on-air intentional slight against oral surgeons in his discussion with Dr. Sanjay Gupta regarding President Trump's health. A link to the letter will be provided in Dr. B.D. Tiner's next President's Message coming soon. Dr. Nannini's very professional response provided Mr. Tapper with an education as to who OMSs are, what we do, and discussed how so many of us have been on the front lines with the pandemic response.

I am honored to serve as your District VI Trustee. I am confident that we will continue to get through this trying time. Please do not hesitate to reach out with your suggestions, comments, or concerns.

ROGER P LEVIN, DDS - CONTINUED FROM PAGE 1

reasonably successful, will continue to enjoy success over time. However, I do not think success will be as evenly spread for all doctors and practices as it is today. We are facing several changes ranging from the continuing growth of DSOs to lower reimbursements by many insurance carriers. The OMS practices that will achieve and maintain the highest levels of success will be the ones that continually work with the referring doctors to maintain a steady stream of referrals. I can't emphasize enough how important this is. Today's practices can build a strong, steady stream of referrals by implementing a consistent relationship-oriented referral marketing program. This will be the solution for many years to come, but it will also be necessary to continually add new referral sources to protect the practice and its future. The days of simply having lunches or occasional contact with referring doctors and maintaining a strong loyal group of referring doctors will most likely not continue. It will be the practices that have ongoing relationships that are continually reinforced with contact and value that are able to maintain and increase referrals. Any practice with enough referrals will be, by definition, successful. And interestingly, I just spoke to the president of a multi-billion dollar national medical group and they have a department dedicated strictly to increasing referrals from other doctors.

Dr. Krakowiak: *With the announced substantial reduction in fee reimbursement from Delta Dental, what are the considerations for restructuring our billing systems and continuing our global insurance relationships that you can recommend to us?*

Dr. Levin: Unfortunately, as we have always predicted, dental insurance will continue to lower reimbursements. We have gone from a high-fee reimbursement with indemnity insurance to watching those fees be reduced. Then we had the introduction of PPOs which continue to reduce reimbursements. This is the role of the dental insurance carrier. During COVID-19, we are already seeing carriers in certain areas reducing reimbursements as more dentists have enrolled to participate in plans. For the OMS practice, there are opportunities. Unbundling procedures and codes, where allowable, will be of help. Many OMS procedures also include aspects that have not been viewed as warranted for separate codes and charges. For example, a number of bone and tissue procedures are often included rather than being separately coded and billed. It will also be necessary to work under medical coding as much as possible to identify additional opportunities for higher reimbursements. To be clear, we never endorse anything that is not completely legitimate, but the future of reimbursements should be to itemize all aspects of the procedure and bill accordingly. Another recommendation is to submit a new fee schedule twice a year to the insurance carriers which, in many cases, will result in raising the fee profile of a specific doctor. But in terms of any larger changes it will be beyond the scope of an individual practice. This is where societies and organizations like CALAOMS, AAOMS, ADA, and CDA must work together to have any impact.

Dr. Krakowiak: *What have been the best strategies and most return-on-investment (ROI) methods you have seen for direct patient marketing by traditional OMS practices?*

Dr. Levin: Direct patient marketing is a science, but an extremely inexact science. As a dentist, I receive the same solicitations from marketing companies that promise to do the most amazing things. My first point would be that prior to entering any type of extensive marketing program, be careful about signing long-term contracts. Always make sure there is an out clause. A long-term, unproven marketing program can become extremely expensive regardless of the results.

Still, direct marketing can be effective. Right now, social media is the big focus of many practices, and in many cases, it works extremely well. But with any effective marketing technique you must remember this marketing concept: "Whatever works today will not work tomorrow." It is most likely that if only one approach is taken it will lose effectiveness over time. The same concept is true for social media. There is no one platform or one approach that works consistently, and many times does not work at all.

Naturally, the days of postcards are coming to an end. Direct mail was once highly effective; however, it has become too expensive and difficult to produce the same results. I know of one direct mail marketing company in medicine and dentistry that recently completely switched to social media. The biggest problem with social media is that its competition is growing rapidly, and results are somewhat inconsistent.

Finally, we have seen practices that have success with television and radio for dental implants. The challenge here is that it can be extremely expensive and must be continually funded in order to keep the practice at a certain level.

Dr. Krakowiak: *What are the top five KPIs all surgery practice owners must assess on weekly, monthly, and annual basis, and when do you need to get concerned about changes or maybe lack of changes in these?*

Dr. Levin: That is a great question. Peter, as you know I love KPIs (key performance indicators) or anything that can be measured. At Levin Group, we have a large data center and share data with national organizations. Data is critically important in any business and will very quickly provide important trend analysis to demonstrate how the practice is performing. If I had to pick the top five KPIs out of the 25 that we track monthly with our OMS clients, they would be: production, collections, referrals, overhead, and income. It is not that these are necessarily the five most important, but they are the five that best determine practice performance and impact. If I was allowed to have a sixth, it would be accumulated cash as a reserve and protection for the future.

When you look at the five or six that I have selected, if any one of those is below the target, then the practice is in danger. Additionally, they all integrate. For example, if production were to decline, then collections, cash, and income would also decline. The same effect occurs if overhead were to dramatically rise. These five or six KPIs provide practices with enough information to quickly identify any changes or trends that are taking place. The other KPIs that we will skip over for this interview will then help to reveal why some of those changes were happening.

I would also like to point out that it is just as important to know why a practice is declining as it is to know why it's growing. In a funny way, I've always believed that it may be even worse not to know why a practice is successful than why it is declining. When you know why your practice is successful you can continue to focus on those few key aspects that are contributing to success.

Dr. Krakowiak: *What are typical collection/overhead ratios you have seen in the top 10% performing OMS clients in California?*

Dr. Levin: As you know, we have a 30-year ongoing study of top 10% performing practices in the different specialties, including OMS. Although we do not have separate California data, the concept will generally apply to most OMS practices. But to be clear, it is not about a top 10% practice as much as a top 10% doctor. If we don't break each practice down by the number of full-time equivalent OMS doctors, then we won't have data driven comparative information. In our research, we define a top 10% OMS doctor as producing over $2.8 million per year.

To answer your specific question, I also want to mention that we separate out trauma from other OMS services, as the reimbursements are generally very low, as are collections. In a top 10% performing OMS practice, collections are typically around 93% which is lower than other specialties in dentistry. However, overhead is typically around 54% in OMS practices, but drops down to 47% in the top 10%. This is understandable because top 10% performing practices have higher production and revenue which drives down the overhead percentage. Believe it or not, many of these practices still have pockets of waste that go unidentified due to the level of production and busyness.

Dr. Krakowiak: *How do you feel about selling private OMS practices to "silent" partners and venture capitalists at various stages of one's career?*

Dr. Levin: This is a great question. In essence, should an oral and maxillofacial surgeon or practice consider what is commonly referred to as "taking money off the table?" This simply means that there would be a buyer for all or part of the practice at different points in an oral and maxillofacial surgeon's career. There is no single or clear answer to this question because it is a financial and economic decision. For example, having the right investor in a practice will allow the practice owner or owners to take money off the table. That money can be used for a person's lifestyle, retirement funding, investments, or other important life factors. But there's also the scenario where selling part of the practice to the right investor could lead to the practice expanding, and the remaining smaller percentage still owned or controlled by the oral and maxillofacial surgeon may be worth more than the original total value of the practice when it was smaller. In other words, the oral and maxillofacial surgeon will have a smaller piece of the pie, but the pie itself will be much bigger.

There's also a factor of autonomy. Will the investor have a majority or minority share, and who controls decision-making? Some oral and maxillofacial surgeons would find it very difficult to have anyone else dictating how they practice or making fundamental practice decisions. And then there are other surgeons who might be comfortable with that. So, once again, it is an individual decision based on financial, economic, and practice control-related issues.

Dr. Krakowiak: *What are the easiest methods to prevent embezzlement and keep financial security in your practice?*

Dr. Levin: Embezzlement is a real issue. According to the Levin Group Data Center (the data collection arm of Levin Group Consulting), 65% of dental practices are the victims of embezzlement at least once and 35% are embezzlement victims at least twice. This doesn't really represent the entire picture because these are only the instances that we know about. Every practice should have a strong set of controls to prevent embezzlement which should be worked out with their CPA firm. If their CPA firm is unable to properly implement the necessary controls, then the practice will need to determine if they are working with the right firm.

Preventing embezzlement is a complex area, but there are standard methods that practices can use that will either prevent or identify embezzlement. For example, the person who

writes the checks should not be the person who signs the checks, and there should be spot checking of any charges by staff members with access to the practice credit card. Another effective monitoring strategy requires that all individuals that deal with practice finances or insurance take vacations. Many embezzlement crimes are often discovered when another team member must step in during the perpetrator's absence. Finally, any system of checks and balances should include an audit every year or every few years.

There is an old statement which we often find to be true in these matters: The person embezzling from you is often the last person you would expect. This makes sense to me because this is the person you trust a great deal, so you don't monitor them as closely.

Dr. Krakowiak: *How do you gauge growth and demise of the practice in today's realities? What are your current benchmarks?*

Dr. Levin: Another great question. Growth of the practice is simple. We look at production, collections, profit, and overhead. If production is rising, this is a positive sign for growth. If collections are rising, as they should with any production increases, this is also a positive sign for growth. If overhead is rising, this is a negative sign for growth unless the overhead has contributed to increasing practice profitability. Ultimately, profit is the metric that determines if the practice is growing or declining. Simply expanding a practice by creating rising overhead and lower profit would not be considered positive growth unless it is for a short period of time in an investment phase.

Ideally, an OMS practice should grow by a minimum of 4-5% per year. We know that most have at least a 30% growth potential by reorganizing and implementing excellent systems. So, it should not be a major challenge for most practices to achieve 4-5% growth at this time. However, practices can also decline and any decrease in practice production or collections signals descent. The true danger zone is a decline of over 25%. This is the level of decline where a practice may not be able to sustain itself. Still, we rarely see OMS practices that cannot continue to exist and when we do it's often related to personal issues in the life of one or more doctors in the practice.

I do, however, have concerns about insurance carriers continuing to lower reimbursements. When large carriers make significant reductions in reimbursements, it has an immediate impact on the practice's adjusted production and collections. Every OMS practice should assume that at some point reimbursements will be lowered and take the necessary steps to implement the right strategies for maximizing all of the best reimbursement scenarios.

Dr. Krakowiak: *What is the future of generating referral streams?*

Dr. Levin: As you know, this is one of our core consulting areas. We believe that the future of generating referrals for OMS practices will be very similar to what it is today. Most patients making appointments in the OMS practice will be by referral from other doctors that are, for the most part, general dentists. The traditional referral stream process that has worked for so many years will continue with other opportunities emerging, as well. We have seen examples of direct-to-consumer marketing by OMS practices that have been very successful, but it's important to recognize that they can also be hit or miss. The one referral marketing program that can always be counted on will be referrals from other doctors where the OMS practice has built strong relationships.

When we reviewed some of the most successful OMS practices in California, we found that their patient bases are 75-80% made up of referrals from other doctors. These practices also tend to have strong referral marketing programs

Peter Krakowiak, DMD's Lakeshore Oral and Maxillofacial Surgery Office and its staff.

using multiple relationship building strategies in categories that include education, social, referral doctor relationships, staff relationships, and interdisciplinary care. It is important for an OMS practice to build strategies in each of these categories and have a highly-skilled professional relations coordinator, or PRC, to implement them, measure results, and make necessary modifications.

The professional relations coordinator is the individual responsible for handling almost the entire referral marketing program. He or she becomes a liaison and customer service representative to referring practices, while also administrating and implementing all selected strategies within an annual calendar. The PRC may be the single most valuable OMS practice team member when it comes to maintaining a strong stream of referrals.

Dr. Krakowiak: *Should an OMS practice consider a sale to a DSO or other capitalized corporation? What parameters should be considered in this decision? What is the future of OMS private practice?*

Dr. Levin: This is a great question and one that practices frequently ask us. The real answer about deciding to sell all or part of the practice or sell to a DSO depends on how the OMS doctor wants to practice for the remainder of their career. Many OMS doctors simply want to control their own practice and lives and not be employees of other organizations. Enticed by large compensation packages and sale prices, some doctors feel that it is in their best interest to sell at this time. The danger is that once a practice is sold, the doctor is no longer in control, and despite what they are told changes will occur. Many OMS doctors don't have the temperament to be employees in a cooperative corporate environment. This is not a positive or negative character trait, but it is important for every doctor to evaluate the level of control and independence that they want in their own practice.

I also find that most OMS practices are performing well. There is still a 30% plus typical growth potential in most OMS practices, so when practices are strong and performing well, it might not be the right time to consider a sale. Although the sale price might be higher, the profit and income spun off by the practice year after year will eventually outpace the sale price and far beyond. Each individual and practice must make its own determination about its future, but I always recommend not to think short-term unless you only have a few years left to go.

CALAOMS CE State of Affairs

by Steve Krantzman, CALAOMS Associate Director

Like almost every business in the world, COVID 19 has had an effect on how CALAOMS operates on a daily basis. One of the biggest impacts to the association has been on CALAOMS CE Events.

Early on, like many of you, CALAOMS waited the spring out trying to identify how COVID would affect us. Once we determined that it was not going to be possible to hold large in-person gatherings any time soon, we set out to identify options and alternatives. It is no surprise that Zoom Meetings and Zoom Webinars ended up at the top of our list of options.

Since the spring CALAOMS has utilized Zoom Meetings to hold both Board and Committee meetings with success. The problem with CE was that we were still in contract with several hotels to hold CE events. Eventually, these hotels relented and released us from our contracts for those meetings. Once released, we added Zoom Webinars to our online lineup for CE events. Our Zoom package allows us to hold webinars for up to 500 attendees, which should be more than sufficient to hold any type of webinar for our membership.

As of this writing, CALAOMS has successfully held two separate full weekend webinars for Oral and Maxillofacial Surgery Assistants (one in September and one in October), as well as an abbreviated afternoon 20th Annual Meeting Webinar in November. We have plans to continue holding virtual events through 2021 for CALAOMS CE including the January 2021 Anesthesia Meeting (January 16th) and the 21st Annual Meeting (May19th.)

Although our OMSA attendees' response to the webinar format was very positive, we may be moving away from the weekend webinar format in favor of a fully online OMSA course. The benefit to our members will be that they can register new hires as soon as they need, instead of waiting months for a new OMSA course to open for registration.

CALAOMS will continue to further identify areas that we can adapt/improve for our membership, during COVID and well into the post COVID era.

LEGISLATIVE UPDATE

by Gary Cooper
Legislative Advocate, CALAOMS

Legislation in The Time of Covid-19

It is clearly an understatement to say that 2020 – year two of the 2019-20 California legislative session – was unique. It was far more than unique. It was complicated and very stressful for all those involved. That included legislators, staff, lobbyists, members of the public, and all stakeholders.

Due to the COVID-19 crisis, the legislature had to suspend all activities several times, which played havoc with the normal schedule of activities. When the process did resume, most procedures were significantly altered and "virtual" became the new "normal." Yet through all the disruption and chaos, the California Legislature managed to conduct business and many bills were passed and sent to the governor for his signature. This year however, as the COVID-19 pandemic took its toll on the health and economy of all Californians, much of the legislation enacted was COVID-19 related. There were other meaningful bills that were not directly related to the virus but that were beneficial to the well-being of Californians.

SB 793 (Hill): After much debate and significant and costly opposition advertising by tobacco companies, the legislature passed and Governor Newsom quickly signed a statewide ban on the retail sale of flavored tobacco products. The ban includes e-cigarettes, menthol, and small cigars. This newly enacted piece of legislation made national headlines as one of the country's strongest anti-tobacco laws. As with most contentious bills, amendments were required to move SB 793 successfully through the process. Several tobacco products were exempted from the bill, including loose leaf pipe tobacco, premium cigars, and flavored hookah tobacco. Nevertheless, the bill is very large step forward in protecting minors and adults from getting involved in the addictive habit. As California oral and maxillofacial surgeons who are concerned about the oral health of the citizens of the state, CALAOMS is proud that Senator Hill was able to get this bill passed into law. The measure takes effect January 1, 2021.

SB 1383 (Jackson): Requires employers of 5 or more employees to provide up to 12 work weeks of protected unpaid leave that can be taken for the birth, adoption, or foster care placement of a child or for the employee's own serious health condition or that of a child, parent, or spouse. While CALAOMS made the case that the bill was too expansive and oral surgery offices could be negatively impacted, Governor Newsom signed SB 1383 on September 17, 2020.

AB 685 (Reyes): On September 17, 2020 Governor Newsom signed AB 685 which will require that employers notify employees if they could have been exposed to COVID-19 while at the workplace. If notified that an employee has tested positive, the employers would be required to provide written notification to their other employees within one business day, including notification of specified COVID-19 related benefits and options. Also included in that notification would be the employer's disinfection and safety plans. This bill sunsets on January 1, 2023.

SB 653 (Chang): This bill was approved by Governor Newsom on September 24, 2020. The measure will permit Registered Dental Hygienists to apply fluoride varnish without the supervision of a dentist and provide services in medical offices through the virtual dental home (VDH) model of care. SB 653 expands the settings where RDHAPs can provide local anesthesia and soft tissue curettage when following specified safety protocols, including collaboration of a dentist to increase access to dental care in underserved areas of California. This piece of legislation had no opposition.

2020 clearly has been an unusual and difficult year for all members of the healthcare profession. Members of the dental profession have seen unprecedented drops in the number of patients treated. Oral and maxillofacial surgeons have continued to be on the frontlines treating emergency cases while ensuring that their patients are safe and receive quality care. 2020 was going to be the year that CALAOMS revisited the pediatric anesthesia issue by making it even safer than it already is. However, due to the pandemic, that legislative endeavor had to be briefly sidelined. Rest assured that CALAOMS continues to view that issue as a high priority and will be back in 2021 to continue our efforts to guarantee the safest possible care for children and adults.

CALIFORNIA ASSOCIATION OF ORAL & MAXILLOFACIAL SURGEONS UPCOMING CE EVENTS

2021 Meetings

- **January Anesthesia Meeting** - Webinar — January. 16
- **ACLS/BLS Spring 2021** - TBD — Spring TBD
- **OMSA Spring 2021** - Weekend Webinar — March, 6 - 7
- **21st Annual Meeting** - Webinar — May. 19

VENDOR SPOTLIGHT

CALAOMS Wishes to Thank the Following Vendor That Graciously Sponsored CALAOMS' 20th Annual Meeting Webinar Held on November 4th, 2020

Webinar Sponsor:

THE DOCTORS COMPANY

MEANING IN ETHICS

by Richard Boudreau, MA, MBA, DDS, MD, JD, PHD, PSYD

Morality & Happiness

Why be moral? The answer is that it is the best kind of life. It is the most fulfilling life that leads to happiness that is indestructible. The world is a rational place. It is important to mull things over, come up with the right thing to do and so forth. Man is capable of making rational decisions; indeed, some philosophers claim that the reason why man is superior to beast is his ability to reason. Living a virtuous life is not only possible but also preferable. Of course, this theory, as relayed in *Rational Man* by twentieth century philosopher Henry Babcock Veatch, is something that is aligned with Aristotle's ideas. One may sift through theoretical models but in the end, Aristotle's is the one worthwhile.

The idea that moral theory is important and that man should live an ethical life presents a conundrum. An attitude of ethical relativism and skepticism is untenable, because of inconsistency. We have not as yet done anything in the way of directly undermining its two foundation stones: the factual relativity of moral norms and the logical impossibility of grounding such norms on scientifically observable facts. Nor do we even propose to do anything of the sort, at least not just at present. Just shoving the problem aside for the time being is one approach; however, it is something that cannot be ignored and is the basis for opposition to this line of thinking. The problem is, how does anyone know anything? What is moral and what is immoral? The idea that there is an intrinsic monitor in each and every individual is one idea and others come from religion. Yet, Aristotle's virtue ethics seems to be something usable here.

One important point is that according to Aristotle, it is important for people not to be in the dark and think they are in the light. In other words, people who follow others' ideas, even those of a religious leader, are not really in the light. What is the answer to this? The individual should lead an examined life and should live intelligently; however, in some way, this answer is not practical. It is almost predetermined. People live on this planet for some purpose. As Aristotle sees it, the examined life is a goal or end toward which any and every human being is naturally oriented, regardless of whether they know it or not, and regardless of whether they actually attain it or not, much as an acorn is ordered by nature to its own complete development and protection as a full-grown oak.

Aristotle's ideas go to the concept that man is destined to live an ethical life and that just may be man's purpose. It is not only that man is destined to accomplish this goal on the planet, but also that there is something within man that prompts him to do so. The nature of man is essentially why man should lead a moral life. His nature is not something outside of one's self. Rather, man is made of something that is a part of the larger consciousness and the goal of every individual is to live a good life, for which the contemplative life is the best type.

For the most part, people strive for happiness in their lives. They do things that will make them happy and try to avoid painful experiences. At least, that is what psychologists say. But happiness may be equated with virtue. Leading a moral life can be consistent with leading a happy life. Aristotle sees virtue as necessary to secure happiness. Again, it appears that Aristotle's conception of happiness is not simply tied to the feeling of bliss or well-being. People can, for example - using contemporary examples, indulge in drugs and alcohol and feeling good, but one would not say that they are happy. That kind of "happiness" is fleeting. Rather, many look towards leading a virtuous life where one can manifest happiness as being relevant and aligned with a 'life purpose and meaning.' Aristotle held a similar view and rejected hedonism as man's highest good. In other words, feeling good is not the only thing necessary for a happy and content life, but virtue is.

Virtue is intrinsic, indescribable and innocent. It stands on its own and while it is hard to pin down with particulars it is not arbitrary. It is not that everyone just does what they think is right or what society tells them is right, but what comes from within. It is assumed that the wisdom is real. Hence, there exists an objective, intrinsic morality. This is the point relayed in Aristotle's ideals. So, we can ask: Why people should be moral? It is their birthright. Based on these premises, there is an objective sense of right and wrong after all. Of course, determining what that is can be difficult, but the fact that it exists suggests something beyond whim and culture.

RISK MANAGEMENT

Providing Dental Services in the Hospital Setting

by Amy Wasdin, RN, CPHRM, Patient Safety Risk Manager II, Department of Patient Safety and Risk Management, The Doctors Company

Lack of familiarity with hospital systems can pose serious risk management implications for dental professionals.

Patients present to an acute care facility for a variety of reasons, such as emergency care, admission for ongoing treatment, surgical procedures, and specialized nursing care. Unfortunately, appropriate dental care is often overlooked or not identified as a priority at the beginning of a patient's course of hospitalization.

Good dental care is an important component of maintaining overall health and well-being. When unchecked and untreated, bacteria that forms in the mouth can lead to more serious health problems. Poor oral care has been known to contribute to cardiovascular disease, respiratory infections, and other serious health conditions.

Dentists and oral surgeons are often appointed to a hospital's medical staff to provide dental services to emergency department patients and inpatients when needed. They do not routinely provide general dental services but frequently provide emergent treatment indicated by oral trauma or infection.

Because of the infrequency of providing dental care in the hospital setting, many dentists are unfamiliar with hospital and medical staff requirements that apply to the providers who examine and treat inpatients. The lack of familiarity with hospital systems and medical staff rules can pose serious risk management implications for the dental care provider.

Risk Management Strategies

- **Be wary of the "curbside consultation,"** an informal collaboration that may find its way into the medical record. Dentists have been sued by patients they did not meet or examine because another provider documented inaccurate information in the medical record. If you are asked for input on a specific patient situation, it may be best to request a formal consultation so that you can document your thoughts and opinions in your own words.
- **Communicate clearly with other providers on the expectations regarding your involvement in patient care.** Once you become part of the care team, the lines can become blurred among providers regarding who is responsible for each aspect of care. Key information can get lost during the transitions that occur among caregivers in a hospital. Clarify your role in the record and communicate with other caregivers when confusion or cause for concern occurs.
- **Familiarize yourself with the medical record in advance—and ask for training.** Electronic health records (EHRs) present special challenges to users who are not familiar with the system and its unique nuances. You may need to use templates or designated sections for your documentation. The EHR may not be easy to navigate, so it is helpful to take the time to learn about the sections that you will need to use. The EHR can be a powerful tool for provider collaboration if you know where to access information.
- **Understand your documentation requirements.** How often are you required to document your care of the patient? When does your documentation need to be finalized and available in the medical record? What do you need to include in your consultation notes? These questions should be answered at the time of your appointment to the medical staff.
- **Request updates and revisions to processes and systems.** Hospitals regularly update and revise facility operations as well as clinical policies and processes. Make sure that you periodically request updated information regarding any changes related to the facility or patient care. Notices about physical plant changes may prove extremely helpful to you when locating your patient to provide dental services. Notices of process changes will help you fulfill your obligation to follow current policies and procedures as a medical staff member.

- **Have a go-to person to contact for assistance when needed.** Despite taking appropriate steps to be prepared to care for your patient, unexpected challenges may occur. Get to know your medical staff department coordinator and the facility risk manager. They can prove to be great resources when you need quick access to information. Also, if you cannot find someone to assist you outside of regular hours, ask the on-call hospital administrator to connect you with someone who can assist.

The guidelines suggested here are not rules, do not constitute legal advice, and do not ensure a successful outcome. The ultimate decision regarding the appropriateness of any treatment must be made by each healthcare provider considering the circumstances of the individual situation and in accordance with the laws of the jurisdiction in which the care is rendered.

COVID-19 Is Changing Liability Risks and Litigation in Healthcare

by Bill Fleming, Chief Operating Officer, The Doctors Company

Across the spectrum of care, healthcare delivery is changing as the COVID-19 pandemic continues, creating additional pressures to maintain patient safety and shaping new liability risks for hospitals, group practices, and solo physicians.

Understanding how these new risk exposures are unfolding—and how adverse events may be litigated in a courtroom environment also under strain—is the first step to taking protective measures.

Mr. Fleming offers his expert insights:

Q) What kinds of lawsuits do you expect to see linked to the COVID-19 pandemic?

A) Extraordinary circumstances and a steady stream of directives (and revisions thereto) from state and local governments have pressed physicians, practices, and hospitals to practice medicine in ways they never have before—or to not practice medicine, when certain elective forms of care have been suspended by government action, often to conserve PPE and other resources. In spite of reasonable efforts under difficult conditions, it's likely that some adverse events will be traced to this time.

It is important to note that "elective" in this context does not mean unnecessary or optional. It includes important screening and diagnostic procedures such as colonoscopies, some cancer and cardiac surgeries, and most dental procedures. Delay of elective procedures may be a source of increased litigation—many biopsies for cancer, for instance, have lately been delayed, and delay in diagnosis was already one of the most expensive areas of litigation pre-COVID-19.

Other delays in care many be linked to access issues. Telemedicine has been a lifesaver for many during this crisis, but some vulnerable patients may lack access. Infrastructure can also present a barrier to telemedicine care, as some do not have sufficient internet bandwidth for video visits.

Moreover, circumstances have forced physicians to use telemedicine in ways they usually might not. Telemedicine is ideally an adjunct to in-person care, and therefore not the best option for a first visit with a new patient, but during peak infection risk, exceptions had to be made.

Among our infrequent telemedicine claims pre-COVID-19, misdiagnosis of cancer was the top allegation, and I can't imagine that risk of misdiagnosis has decreased, given the spike in telemedicine usage under nonoptimal conditions.

Also, I anticipate that some COVID-19-related cases will focus on shortages of personal protective equipment (PPE)—those claims may come from patients or employees.

Q) As you've said, providers are delivering care differently during COVID-19. How do these changes diminish or increase risks?

A) In the crush of managing a public health crisis, many hospitals and practices have had to take temporary measures that impact patient safety: Some of these measures mitigate certain risks but may amplify others.

Healthcare providers in hard-hit areas are working longer hours, sometimes with insufficient PPE, sometimes in large tents put up in parking lots or other overflow sites. In surge locations, staff from other departments may be covering in the emergency department (ED) or intensive care unit (ICU)—this is could increase the risk of communication gaps. All of these resource-stretching measures, taken together, may add up to a risk profile that is more than the sum of their parts.

While responding to health directives from state and local

governments, as well as advisories from the Centers for Disease Control and Prevention (CDC) and other trusted sources, hospitals and practices will continue to experience unavoidable delays in treatment to all patients. Testing delays do not help.

In addition, by patient preference, many routine checkups and tests have been delayed, not to mention routine procedures. Adverse events linked to these delays could affect physician liability.

Q) What can physicians and practices do to protect themselves during the pandemic?

A) Conscientious documentation becomes a witness for the physician in the courtroom. In the COVID-19 era, practices may benefit from documenting not only individual patient interactions, but how the practice is following CDC infection control guidelines and recommendations from state and local health authorities at particular points in time. This could be as simple as jotting a daily note in an electronic calendar.

Q) How are courtroom changes during the pandemic challenging defense teams?

A) In a recent medical malpractice suit, a physician member of The Doctors Company, with assistance of counsel and The Doctors Company's support, secured a defense verdict despite many changes in the courtroom environment that could have posed problems if we had not been prepared to adjust.

We've seen firsthand how physicians facing a court hearing during COVID-19 need a legal team that is prepared for changes in depositions, jury selection, and the trial itself. For instance, depositions may be completed by video, with multiple screens for the attorneys, parties and exhibits, and jury selection may take place partly via written communication. During trial, showing evidence must be done differently, so defense teams need solid technology skills in settings where counsel can publish exhibits to the jury using large screens.

Some courts are taking 15-minute breaks every hour for better ventilation and cleaning. This breaks the momentum when an attorney is speaking with a witness, reduces the overall trial time per day, and prolongs the trial duration. Taking time out of a practice to participate in an extended trial can further stress a stretched practice.

Q) Litigation stress places a burden on physicians at any time. How is this different during the pandemic?

A) Individual trials are taking longer, compounding delays from the existing backlog. This keeps physicians in limbo—and could even affect their credentialing. As previously reported by RAND, pre-pandemic, on average, physicians were already spending more than 10 percent of their careers living under the shadow of an open malpractice claim.

It is true that at any time, even the best of physicians could find themselves facing an unexpected lawsuit. And states around the country handle cases differently. That's why our members are supported by legal teams with deep roots and expertise in members' local venues. In addition, knowing that the stress of malpractice litigation affects physicians deeply, and knowing that preparation is the key to victory, we support our members through in-depth litigation preparation.

Like the COVID-19 pandemic itself, pandemic-related risk exposures are fluid. Physicians, practices, hospitals, and systems are facing rapid changes in liability exposures at the same time as the day-to-day business of healthcare is changing under their feet. The Doctors Company is prepared to assist our members through lawsuits during these unprecedented times so that, even with changes in the courtroom, members can present their best defense.

The guidelines suggested here are not rules, do not constitute legal advice, and do not ensure a successful outcome. The ultimate decision regarding the appropriateness of any treatment must be made by each healthcare provider considering the circumstances of the individual situation and in accordance with the laws of the jurisdiction in which the care is rendered.

THE DOCTORS COMPANY

IN MEMORIAM

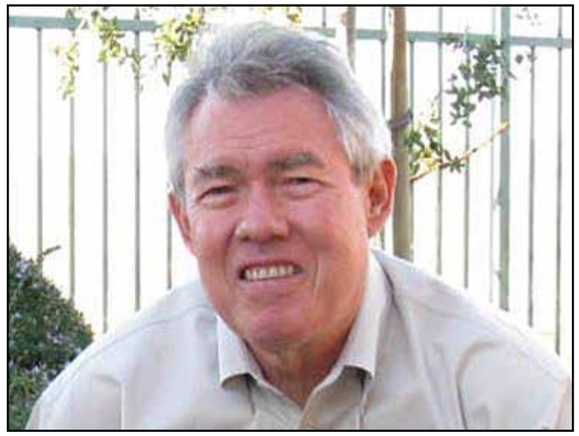
John Sullivan Bond

November 1, 1946 – April 6, 2020

John Sullivan Bond, DMD, 73, surrounded by his family, entered into eternal rest after a courageous year-long battle with pancreatic cancer. He touched many lives with his generous spirit and adventurous outlook on life.

John was born in Moscow, Idaho, to Bill and Virginia Bond. Graduating from Burley High School in Burley, Idaho, he then went on to earn dual degrees (pre-med/chemistry) from the University of Idaho, where he met his wife Diana and was a member of Sigma Alpha Epsilon. Following Navy Officer Candidate School, John became an aviator, flying A-6's as a bombardier navigator in squadrons VA-95 and VA-128. He had 125 aircraft carrier landings to his credit. Next, he went to Washington University in St. Louis for his dental degree and completed his oral and maxillofacial surgery residency at Cook County Hospital in Chicago, Illinois in 1981. Continuing in the Navy, he worked as an oral surgeon in San Diego, California and Yokosuka, Japan.

In 1988, John moved his family to Los Gatos, California where he opened a private oral surgery practice while continuing in the U.S. Naval Reserves, retiring as a captain. He served as president of Northern California Society of Oral and Maxillofacial Surgeons (NCOMS), California Association of Oral & Maxillofacial Surgeons (CALAOMS), and Western Society of Oral Maxillofacial Surgeons (WSOMS). He enjoyed supporting the Los Gatos Lions Club, attending Saratoga Federated Church, traveling the world, and outdoor activities including skiing, boating, and chopping wood. He especially enjoyed the time he spent at his Idaho home, feeding the birds and sitting around the campfire with the grandkids.



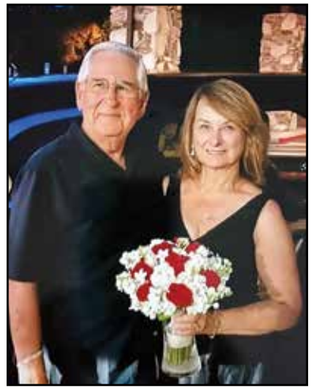
John is survived by his wife of 50 years, Diana; children Jeffrey Bond (Rebecca) of San Jose, California and Chelsea Allen (Cory) of Mt. Pleasant, South Carolina; grandchildren Brent and Brooke Bond, Kirkland, Barrett and Ferris Allen; sister Carol Bowie (Ralph); brother-in-law Garth Douglass; four nieces and one nephew. He is preceded in death by his parents, Bill and Virginia Bond; and his brother, Joe Bond.

If you would like to honor him with a donation, please consider the Pancreatic Cancer Action Network https://www.pancan.org/ or the American Society for the Prevention of Cruelty to Animals (ASPCA) https://www.aspca.org/.

Dr. George W. Oatis, Jr.

June 25, 1938 – May 13, 2020

Dr. Oatis was born in Danbury, CT on June 25, 1938, the son of George W. Oatis, Sr. and Ruth Niland Oatis. He attended public schools and graduated from Danbury High School in 1956. He graduated from the University of Maryland, College Park, MD, receiving a B.S. Degree in Zoology in 1960. From there, he attended the Baltimore College of Dental Surgery, University of Maryland Dental School, graduating in 1963 with a Doctor of Dental Surgery degree.



He interned in oral surgery at the Johns Hopkins Hospital from 1963-1964. He entered active duty in the Navy in July 1964, instrumental in treating maxillofacial injuries. From 1967-1968, he was a resident in Oral and Maxillofacial Surgery at the University of Alabama, Birmingham. He completed his residency at the Naval Hospital, Philadelphia, PA, in 1970. He received diplomatic status in Oral and Maxillofacial Surgery in 1973.

During his active duty, Dr. Oatis received the following: Armed Forces Expeditionary Medal, Second Meritorious Unit Commendation, Republic of Vietnam Meritorious Unit Citation Civil Color (1st Class), Vietnam Service Medal, National Defense Service Medal, Republic of Vietnam Armed Forces Meritorious Unit Citation (Gallantry Cross). In 1988, Dr. Oatis received the Navy Commendation Medal for Meritorious Service from October 1983 to August 1984 at the Naval Hospital, Bethesda, MD. He retired from the Navy in 1984 after 20 years with the rank of Captain.

Dr. Oatis entered private practice of Oral Maxillofacial Surgery in 1984 in Roseville and Folsom. He was a member of numerous professional societies, including being a Fellow in the American College of Dentists, International College of Dentists and Pierre Fauchard Academy. An author of over 29 professional articles, he retired in 2014.

Dr. Oatis was preceded in death by his parents, wife Elma Powell Oatis, son Wayne Francis Oatis, and sister Nancy Lou Kratky. Dr. Oatis was an active pilot for 61 years, avid golfer, and skier. He was a volunteer at the California Air Museum and member of Valley Springs Presbyterian Church. Dr. Oatis leaves his wife Elsie of Roseville, CA; son George William III of Buckeye, AZ; daughter Diana Winans of Orangevale, CA; and daughter-in-law Cindy Oatis of Huntington Beach, CA; 4 stepdaughters, 9 grandchildren, 7 step-grandchildren, and 12 step-great grandchildren. George was loved very much. In lieu of flowers, please consider a donation to the American Cancer Society.

Dr. Jeffry E. Persons

June 27, 1948 - March 6, 2020

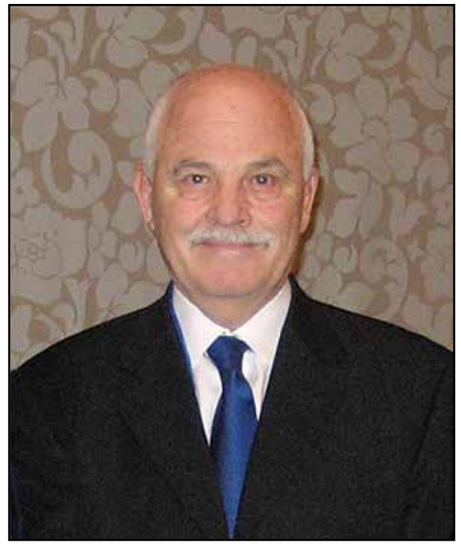
The California community of oral and maxillofacial surgeons lost an esteemed colleague when Dr. Jeffry E. Persons passed away on March 6, 2020.

Dr. Persons grew up in the Inland Empire and attended the University of Southern California (USC) for both his undergraduate studies and for dental school. Following dental school, he completed his oral and maxillofacial surgery training at USC + L.A. County Medical Center. Dr. Persons then established a two-location practice in Orange County (Tustin and Irvine) in 1977 and practiced for over 40 years.

Dr. Persons was a constant and dynamic presence in organized oral and maxillofacial surgery and dentistry. He served as President of the Southern California Society of Oral and Maxillofacial Surgeons (SCOMS) in 1997 and spearheaded the union of the two California societies into CALAOMS.

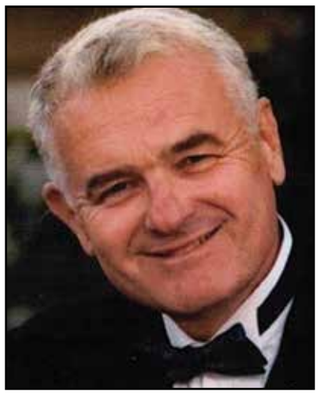
In addition to serving AAOMS on numerous committees and as a delegate, he also held leadership positions in the CDA and ADA on the local, state, and national levels.

Dr. Persons is survived by Anna, his wife of nearly 50 years, and his four daughters - Angelee Willis, Lisa Mondello, Lauren Persons, and Lindsey Persons.



Remembering Lawrence W. Stark, DDS 1931-2020.

123 Atlantic Ave., Long Beach CA



The minute I saw the concrete, navy-gray building at 123 Atlantic Ave., I was infatuated with it. Little did I know, it was home to the oral surgeon who would become one of mymost-respected mentors. This was the summer of 1995, where I first met the humble and friendly Dr. Stark, welcoming me to start my own practice. Dr. Stark, the previous owner of the location, told me this was the place where many renowned oral surgeons revolutionized and initiated office-based general anesthesia--the reason Dr. Stark was drawn to the location in the first place. The building was built in 1945 for the practice of oral surgery by Dr. Adrian Hubbell, a pioneer in office-based general anesthesia. The building is built like a fortress, with an underground bunker that grants access to 10 portable beds, as well as showers and drinking water. It is painted in a Navy gray color, just like a battleship. Fittingly enough, Dr. Stark, who practiced here from 1970 to 1995, was a veteran of the Navy, as was his mentor Dr. Adrian Hubbell. Dr. Stark in turn became a mentor to myself and the Long Beach community for 25 years. He brought life to this unique space and passed down his legacy through not only his professional practice, but his kindness and optimism.

In the 50s to 90s, Dr. Hubbell pioneered the intravenous office-based general anesthesia technique with sodium pentathol, using the "Hubbell Bubble," a device he invented for initiating general anesthesia before starting surgical procedures. Today, office-based general anesthesia for dental procedures is commonplace. Dr. Stark was hired by Dr. Hubbell in the summer of 1970, and then purchased the practice seven years later. Dr. Stark continued using Dr. Hubbell's anesthesia technique, modifying it to make office-based anesthesia more safe and efficient in patient care. I learned from Dr. Stark and watched him perfect Hubbell's techniques.

Dr. Stark dedicated himself to a life of service to his community. Besides running his practice and hospital calls, he dedicated himself to Harbor Dental Society for many years as a board member and president (1983). With his combat-casualties experience serving in Vietnam in 1968, he covered oral maxillofacial trauma cases for four Long Beach hospitals, caring especially for underserved populations. He also helped Cal State University, Long Beach establish their pre-dental program. With his mentoring, all 30 students were accepted to dental or medical schools, and today, many of them practice in the Long Beach area. He also founded hospital-based dental care for mentally-disabled children at the St. Mary Medical Center, as well as creating an after-hours emergency dental clinic. In addition, he remained active in the Navy Reserves, practicing part-time at the naval base dental clinic until he reached the age of 65.

What I have learned from Dr. Stark is his balance of care and dedication to his family, patients, dental community, and Navy community throughout his life. He told me of his lifelong appreciation for the Navy, which provided him the NROTC scholarship that enabled him to attend Duke University for his undergraduate education. He trained as a Navy aviator, and was called to serve in his last year of college during the period of Cuban missile crisis. Dr. Stark later graduated from Harvard Dental School and completed his oral surgery training at the University of Alabama. Soon after his oral surgery training, he was called to serve in Vietnam. He served as the Navy oral surgeon at the Da Nang Navy hospital. That's how he got his trauma experiences -- treating casualties of the war. After he sold his practice, he and his wife, Cathy, moved to Bakersfield, where he continued working at North Kern State Prison to establish the first oral surgery facility to treat inmates for their oral surgery needs.

In 2009, Dr. Stark and Cathy then retired in San Clemente, where he spent ample time with family and friends, as well as traveling and notably visiting his ancestral land of Sweden. In his book, *A Life Worth Sharing*, Dr. Stark wrote, "I intend to continue moving forward with much more to learn, much more experience, and much more to enjoy." To his mentees and grandchildren, he said, "Continue pursuing your dreams, work hard, and never give up." Dr. Stark always had the most sensational stories to tell and endless wisdom to share.

Dr. Stark passed away on 5-15-2020. We truly miss him. But his journey left in many words allows us to share, to learn, and to appreciate life -- just as he did through his optimistic and warm-hearted care for everyone around him. His legacy remains in the spirit of 123 Atlantic Ave, Long Beach.

Tony T. Chi, D.M.D.
Diplomate of American Board of Oral and Maxillofacial Surgery

ASSOCIATE/PARTNERSHIP OPPORTUNITIES

Bay Area, California: Well respected, busy and established oral surgery practice in search of a board certified or board eligible, motivated, hard-working and efficient oral surgeon for a full time position in the Bay Area, CA. Our office provides a full scope of Oral & Maxillofacial surgery including IV-sedation, Extractions, Bone Grafting and PRP, Implant placement, Biopsies and more. Applicant should have CA license, GA permit and Medical Malpractice Insurance. Medical Degree is a plus. Candidate must be able to provide excellent surgical services, establish and maintain relationships with existing and new referring doctors and be interested in growing the practice. Candidates should reply via email with their CV attached to: apply.oralsurgery@gmail.com

High-end Northern California Oral and Maxillofacial Surgery practice is seeking an associate. Full or part time position available. Stunning newly built building on waterfront property with state-of-the-art equipment, CBCT imaging, digital scanners, and more. Full scope office is grossing $2.2 million on 3 days a week with 50% of procedures from implants. Excellent opportunity for growth and buy-in option is available. Hard-working, experienced auxiliary staff currently employed with good referral rapport. Candidates should reply via email with their attached CV to: drdan73@protonmail.com.

Kids Care Dental & Orthodontics is hiring a talented oral surgeon to join our team. KCD&O is a northern California based pediatric practice that offers comprehensive services including preventive dental care, orthodontics and oral surgery for our patients. We currently have 17 practices throughout Central California and the Bay Area (primarily in Sacramento, San Joaquin, Alameda, Contra Costa and Solano counties). You will work with an experienced practice management staff and have the opportunity to collaborate and share insight with our orthodontists and pediatric dentists. The scope of practice includes routine dentoalveolar surgery and benign pathology. Our surgeons enjoy competitive compensation with high earning potential with group benefits including group health, dental, vision, life/AD&D and professional liability insurance, a non-qualified deferred compensation plan, and a 401(k) savings plan. We are currently looking for skilled oral surgeons to join our team in Sacramento, Stockton, and northern California locations as we are growing. Requirements are a CA license and a GA permit. If you are interested a drtalent@kidscaredental.com

Northern California Premier OMS practice for sale. Partnership leading to full ownership. Motivated and flexible. Seller will stay on to facilitate a smooth transition. This is a prominent OMS practice in one of Northern California's most desirable communities. Our long-established practice enjoys an excellent reputation and exclusive referrals from the majority of dental practitioners in our community, and the region. Collections $1.75M, pre-tax income $1.2M. Full scope oral surgery practice that includes all phases of dentoalveolar surgery, implants, orthognathic surgery, and pathology. CBCT imaging on site. State of the art care for full arch rehabilitation implant/prosthetic treatments. Seller intends to immediately reduce his work load sufficiently to allow the new associate adequate patient flow, and sufficient net earnings to afford the purchase, to fulfill lifestyle requirements and student loan obligations, while facilitating a hand-off of the important community and professional goodwill. Opportunities abound for an active outdoor lifestyle including, hiking, cycling, boating, skiing, and more. Send inquiries with a letter of interest and a C.V. to: bizdocjay@mac.com.

Placerville (Northern California) Premier full scope OMS practice, has partnership or associate, opportunity available. State of the art CBCT, EMR Practice Management software. This is an established practice with continued growth and a wide referral base. Routine office based practice that includes: dentoalveolar surgery, bone grafting, implants, IV general anes., orthognathic surgery, and All on four/five implant cases. Located at the base of the Sierra foothills. Please contact: jstraw@edoralsurgery.com 916-990-3644

Santa Barbara OMS Associate wanted to practice in Santa Barbara. Leading to partnership/owner position. Please contact Yvonne at 805-692-8500 or Email at drwelsh.oms@gmail.com

San Diego Well-respected oral surgery practice located in central San Diego. 25 years in practice and one of the most successful, busy practices in the city. Very active Seattle study club sponsor for over 21 years with 50 members. Scope of practice includes all dentoalveolar surgery, implants, bone grafting, PRF/PRP active use, orthognathic and TMJ surgery, sleep apnea treatment with MRD and bi-maxillary advancement and facial trauma. In house OR capable of supporting single jaw orthognathic/TMJ surgeries. Active hospital practice for more complex cases.

We are looking for a board certified/eligible surgeon with active skills in orthognathic/TMJ/Trauma surgery comfortable with outpatient anesthesia and dentoalveolar surgery that is interested in becoming a partner in this practice. Comfort with public speaking is a big plus. Outgoing personality with excellent patient care skills is mandatory. Interested parties, please contact via email at info@mvoms.com, or office phone at 619-298-2200 and ask for Kim, office manager

San Francisco We are seeking an OMFS single or dual degree for a part/full time position. Our practice is located in the heart of San Francisco Peninsula. The practice has been established over 50 years with excellent reputation in the community. The facility is state of the art with the latest technology. Our practice emphasizes office-based dental-alveolar and implant surgery but can expand to full scope if desired. Ideal candidate should have excellent interpersonal skills with good patient care and ethics. Salary will be negotiable and competitive. Reply with CV to sfpeninsulaomfs@gmail.com

Southern California's Inland Empire Immediate full-time oral maxillofacial surgeon wanted in Southern California's Inland Empire. We promote a workplace with a supportive and efficient staff, individual growth and personal achievement. The right individual should demonstrate creativity, interpersonal skill and have a team player attitude. We emphasize dentoalveolar surgery, dental implants, and pathology but also practice orthognathic, TMJ and trauma surgery. Compensation includes competitive salary, incentive bonus system, health insurance stipend, and relocation advancement. Interested applicants should call (909) 331-0227 or email MDudziak@ieomfs.com.

Seeking Oral & Maxillofacial Surgeon Established oral surgery office in San Francisco is looking for a part time oral and maxillofacial surgeon to join our practice with the possibility of partnership. Our practice is a state-of-the-art facility with advanced technology like digital X-Ray, 3D Scanner and CT scan machine.

The ideal candidate must be a team player looking for a long-term position with the desire to grow professionally. We are seeking someone who works independently, has excellent clinical skills, great chair-side manners and high ethical standards. Candidates should be able to perform the full scope of oral maxillofacial surgery.

Please respond to this ad with your cover letter and resume.
Faces of The Mission
2480 Mission Suite 219
San Francisco, CA 94110
Phone 415.285.0526

OMS SEEKING WORK

UCSF Fresno OMFS Graduate looking for an associateship/partnership position in Southern California, with potential for buy-out down the road. omidniav@gmail.com 714-624-7634

Seeking Part Time OMS Job Between San Francisco and Sacramento. Oral and maxillofacial surgeon retired with 40 years of experience in private practice seeking part time job. Grad of UOP and Highland Hospital. Reason, full time retirement is boring. Experience includes teaching at Highland Hospital. Contact John Kiesselbach at (530) 613-7833 or email jekiesselbach@gmail.com

PRACTICE FOR SALE

Long Beach: Oral and Maxillofacial Surgery Practice for Sale Great location and opportunity for a specialty practice of Oral and Maxillofacial Surgery in Long Beach, California. Established practice located in professional medical building, freeway close to level 1 trauma center. Digital X-ray, paperless office with outstanding, long-term staff. Seller will stay for transition. Long-term lease is assumable. Please call 714-335-0987 or email bowronmary@aol.com if you are interested

Los Angeles: Turn-key oral and maxillofacial surgery practice available for sale, with transition if buyer desires, in west Los Angeles. 1200 sq. ft. office in quality hi rise medical/dental building. Newer CBCT, centrifuge, two surgical operatories, consultation room, recovery room. On 3 ½ days per week, collections averaged 500K for the past three years. Owner selling to return to teaching. Interested parties please contact cell phone 310 415-7816

Southern California: Well established OMS practice in desirable location in sunny suburb of Southern California for sale. Same location in a professional medical building close to hospital and freeways for over 20 years with great referral base. The owner surgeon is moving out of State and is motivated but will stay for a smooth and stress free transition as long as desired by the prospective buyer surgeon to insure continuation of great service to referral base and community. The owner surgeon has a study club that meets 4 t o5 time a year providing CE credit for referral doctors. The gross Production for the last year was over $1M (break down for each procedure is available) with collection of $900K on 3 ½ days a week! The practice procedures is summarized as full scope of implantology, dentoalveolar, pathology, TMJ. No HMO insurance. There is a lot of potential for expansion of services for an enthusiastic new surgeon. The office has a fully equipped and functional operating room in full operation for general anesthesia with intubation and anesthesiologist. The office was certified as surgery center. It only needs renewal. If you love great climate and outdoor activities, great schooling system, safety, close to airport, beach life style in Southern California, this is your opportunity. For confidential detailed information please contact us at sylviamini@hotmail.com.

WOULD LIKE TO BUY

Greater Sacramento Area. I am looking to purchase a practice with transition in Sacramento or surrounding areas. I am currently practicing in Northern California and I am looking for an OMFS practice with an emphasis on Dentoalveolar and implant surgery. Please contact me at omfspractice43@gmail.com if interested

Southern California: I am currently out-of-state and would like to relocate to California. I am looking for an OMS practice for purchase with transition. Southern California preferred (Greater Los Angeles, Inland Empire or Greater San Diego) / mid-size city or suburban community. 1,500-2,000 sq. ft. 2-3 operatories. Please email me @ surgeryoms@gmail.com

Supporting the Resilience of the OMS Community.

Throughout the pandemic, your OMS colleagues are here to help. Dr. Guyette and Dr. Bournias are managing practices and treating patients while also guiding OMSNIC company decisions as Board Directors. Their input, along with that of many other OMS, gives OMSNIC the unique ability to respond effectively to your practice needs during this stressful time.

OMSNIC is the only professional liability insurance company owned by oral and maxillofacial surgeons where practicing colleagues represent your interests and advocate for the Specialty. As part of your OMS community, OMSNIC is committed to the safety and success of every OMS practice.

800-522-6670 omsnic.com

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Photo: Robert F. Guyette, DMD, MD, Guyette Facial & Oral Surgery, Scottsdale and Avondale, Arizona and Nicholas J. Bournias, DDS, Michigan OMS, West Bloomfield and Richmond, Michigan.