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California CareForce Coachella Valley a Huge Success

Pamela Congdon, CAE, IOM, CCF President and Volunteer; Executive Director, OFSOC

Early in the morning on April 6th, a group of us volunteers left the parking lot from the headquarter offices of the OFSOC and CCF with a box truck and a semi fully loaded with equipment for 70 dental stations, sterilization, dental, vision, and medical supplies, along with enough equipment for 10 vision lanes and production of 250 pairs of glasses per day. We were headed for Coachella Valley to set up our free health clinic. This would be our fourth clinic in Indio. As it turned out, it would also be our best one yet.

Why was this clinic the best, to date? Here are my top 5 reasons:

1. On October 1, 2015, Governor Jerry Brown signed into law AB 880. This bill was sponsored by Assemblymember Sebastian Ridley-Thomas at the request of OFSOC to allow California dental students, in their final year of training, the privilege of participating and providing dental treatment under indirect faculty supervision at free

CONTINUED ON PAGE 5

A Patient at the California CareForce Clinic in Coachella prior to receiving a partial denture.

The same patient overjoyed upon seeing her new smile thanks to her partial denture she had just received.

CALIFORNIA JOURNAL OF ORAL & FACIAL SURGERY
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in this issue:

CALAOMS also does business as:
* Oral & Facial Surgeons of California
* Southern California Association of Oral and Maxillofacial Surgeons
* Southern California Society of Oral and Maxillofacial Surgeons
* Northern California Association of Oral and Maxillofacial Surgeons
* Northern California Society of Maxillofacial Surgeons
* California Society of Oral and Maxillofacial Surgeons
* Southern California Oral and Maxillofacial Surgeons

EDITORIAL

A good name should be esteemed higher than riches

by Jeffrey A. Elo, DDS, MS

Who we are matters. It matters to us as individuals. It matters to our spouses. It matters to our kids. It matters to our patients. It matters to our staff. What is the status of your name in the circles you belong to? Would you, or others, say it is good? Do you even care how those around you view your name? I'm not talking about the actual name. There is nothing fancy about my actual name as nearly one million people in the U.S. share it. Statistically, my name is the 46th most popular first name.

I'm talking about what your name implies. When people in your community hear it what do they think of you? A good name really speaks to your integrity. It's about your reputation and the character you have inside. It identifies who you are from a moral and ethical standpoint. Essentially, it's what you are all about.

A well-known Proverb states that "a good name is to be chosen rather than great riches…" Let's think about that—a good name is better than riches. Better than all the money in the world is what people think when your name comes up. Does that seem odd or even possible? I mean I'm pretty sure that I could find some pretty positive ways to use great riches. It sure would set my mind at ease knowing I'd never need to worry about money again.

While that might be true, a good name, I believe, still provides more value. I can think of a few reasons why a good name is better than great riches: A good name provides stability.

When you have a good name people can trust you, and that trust is a stabilizing factor in your relationship with them. They know what to expect from you and can lean on your decisions with absolute surety, knowing they were made with pure motives. Those whose good name has been tarnished have a difficult time building trust. Their motives will always be questioned as insincere. They are often seen as looking out for themselves only and taking little consideration for the needs of others. And how often do you question the motives of those who throw their great wealth around? Doesn't it seem like there are often strings attached? That there might be an ulterior motive for using their money?

A good name is eternal. Riches are fleeting. Money could be with us one minute and gone the next. And of course we know that we can't take riches with us once we leave this world. A good name, however, can be eternal. How many great men and women of history are still being spoken of in a positive light? Wouldn't you agree that you know more people of history for who they are and what they did rather than what they owned or how much money they had? Wouldn't it be special if that could be you? How will your legacy be remembered and portrayed by family, friends, or colleagues once you are gone? Will they focus on the value of your good name or only remember that you cared about money? One of those will provide fonder memories and produce more positive future dialogue than the other.

A good name brings loving favor. The ending phrase of the above mentioned well-known Proverb continues with "… loving favor rather than silver and gold." As we are to seek a good name instead of riches, so we are also to seek loving favor over riches. And I can think of no better way to garner loving favor than to have a good name. People will favor you for having integrity. They will appreciate you for showing kindness, mercy, and attention to their needs. They will stand up and support you when you are bombarded with unwarranted attacks.

And let's be honest…wouldn't we all prefer to be favored first and foremost? Riches we could live without. A life that doesn't experience favor would be devastating. Riches are not evil and there is nothing wrong with having them. But a good name is better than riches—than all the riches of the world. It provides more value in the present and the future. Do you need to start working on yours today?

CCF COACHELLA CONTINUED FROM PAGE 1

medical/dental clinics throughout the state. This bill was heavily supported by our OFSOC (CALAOMS) board of directors, the deans of each of the 6 California dental schools, as well as multiple medical and dental specialty organizations, and went into effect January 1, 2016. This was the first event where students got to participate. On the first day of the CCF clinic in Indio, 8 senior dental students from Western University of Health Sciences (WesternU) College of Dental Medicine (Pomona) volunteered and provided treatment under faculty supervision from CCF Board Director, OFSOC Vice President, and WesternU faculty OMS, Dr. Jeff Elo. The students were so jazzed and honored to have been invited to participate in our event.

2. Dr. Peter Scheer recruited Glidewell Laboratories who helped provide removable partial dentures at this clinic. Tears of joy from both patients and volunteers were seen throughout the dental section. Having this service at our clinic was really a life changer for many patients. Dr. Craig Bloom, our dental lead, CCF Board Director, and OFSOC member, summed it up this way: "This clinic was a fantastic experience - truly a blessing for all."

3. Volunteers from the Coachella Valley community formed a committee and rallied together to perform outreach for patients and volunteers. Dr. Peter Scheer and Dr. Milan Jugan's office were instrumental in heading these outreach efforts by performing interviews, writing articles, etc. The committee was a wonderful example of professional camaraderie, and its passion succeeded in getting the word out about the clinic.

4. We saw more patients at this fourth clinic than the previous three and provided more services. (Patients seen: 1,937; Services provided: 5,923; Value of services: $648,390)

5. Volunteers and patients alike were grateful for the opportunity to be part of this wonderful event.

Our next California CareForce clinic will be October 28-30, 2016 at Cal Expo in Sacramento. There are other organizations that have free clinics (e.g., Care Harbor and CDA Cares), but California CareForce is the outreach of OFSOC/CALAOMS. It started with us and continues with us. I hope that you will all consider volunteering. The experience will be so rewarding. We need your help, as well as your passion to help others. We always need help in dental. Please encourage your staff, your dental colleagues, and family members to volunteer. Everyone will be glad they did!

Vendor Spotlight

OFSOC Wishes to Thank the Vendors That Graciously Sponsored the 2016 January Anesthesia Meeting: The Palace Hotel San Francisco

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PRESIDENT'S MESSAGE

Oral Surgeons Face Anesthesia Debate

by Leonard M Tyko II, DDS, MD, FACS

On February 18, 2016, California Assembly Member Thurmond introduced AB 2235. This legislation was the direct result of the tragic death of a 6 year-old boy, Caleb, who underwent an anesthetic at an OMS office. While specific details of the tragedy remain unknown, the terrible result sadly remains the same.

Initially the intent of the bill was to significantly revamp the OMS anesthesia delivery model. However, because the Senate Business and Professions Committee requested the California Dental Board to immediately establish an ad hoc committee to study the administration of dental anesthesia specifically to juveniles, the bill was amended to mirror and codify that request. Unfortunately the bill at one point was amended to require the OMS to provide an anesthetic consent form to state that patients have a "greater risk of death when the surgeon provides both the anesthetic and the surgery" Additionally the bill called for the use of the pediatric dental model as the best anesthetic practice. OFSOC and CDA opposed that version of the bill because we believe that facts do not support those assertions.

Currently, AB 2235 no longer contains such inflammatory and unsubstantiated language. The bill currently calls for the Dental Board to study incident reports related to pediatric anesthesia in dentistry from 2011 to 2016. The bill also requires the following verbiage for informed consent:

> *All sedation and anesthetic medications involve risks of complications and serious possible damage to vital organs such as the brain, heart, lung, liver, and kidney, and in some cases use of these medications may result in paralysis, cardiac arrest, or death from both known and unknown causes.*

With these changes, OFSOC and CDA withdrew opposition, and AB 2235 passed unanimously out of its first committee and ultimately out of the Assembly.

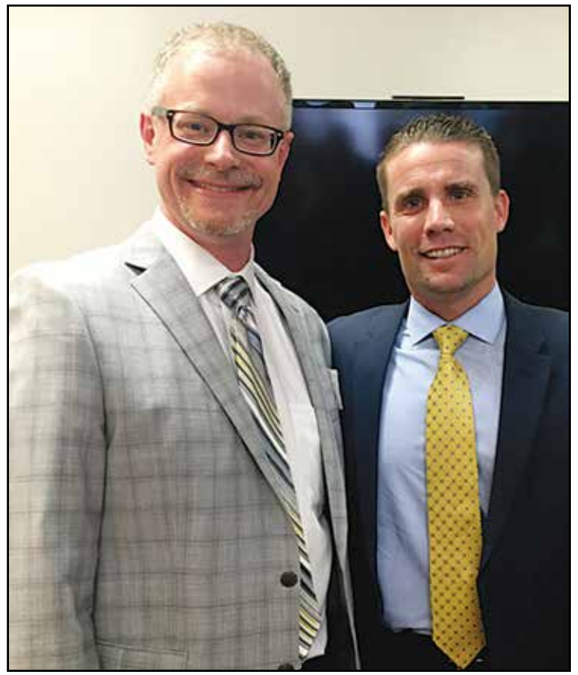
In order to educate lawmakers and to attempt positive change of AB 2235, our hardworking lobbyist, Mr. Gary Cooper worked tirelessly. Several members of the OFSOC Board visited with lawmakers. Even AAOMS president, Dr. Lou Rafetto, journeyed to California to speak on our behalf. Thus far, I have made five trips to Sacramento.

On April 5, 2016, I went to Sacramento to testify at AB 2235's first committee hearing. I was joined by Dr. Larry Moore, who presented our excellent anesthesia safety record within the team model, and by Dr. Tom Indresano, who explained how OMSs are trained and how our practices are monitored. I spoke about access to care issues and of the need to make changes only after consideration of the Dental Board's findings. All of us addressed the emotion surrounding this bill and expressed our condolences to Caleb's family. CDA stood with us and testified eloquently about the implications of AB 2235 on oral health care delivery.

OFSOC is confident that OMS deliver anesthesia safely. The evidence shows this - as does our long history. Dentistry is the pioneer of pain and anxiety control.

In addition to Assemblyman Thurmond and Caleb's family, a long line of stakeholders presented testimony in favor of a stronger, more restrictive bill. They repeatedly stressed the need to rein in OMS and end our anesthesia delivery model. In addition to lay members of the public, the list of professionals who testified included dental anesthesiologists, anesthesiologists, pediatricians, and other physicians - one of whom works directly attending OMS residents during their anesthesia rotation.

OFSOC is confident that OMS deliver anesthesia safely. The evidence shows this - as does our long history. Dentistry is the pioneer of pain and anxiety control. And though our model of care differs from that of medicine, our model is not inferior to theirs. In many ways, our care is safer and more cost effective.



OFSOC President Leonard Tyko, DDS, MD with State Senator Mike McGuire

A great deal of work lies ahead of us. Though we have an anesthetic model with an exemplary record, we face confusion within the legislature, with many of our medical colleagues, and with the average citizen about who we are and what we do. If we are to maintain the ability to care for our patients, we must also maintain our anesthetic abilities. If the Dental Practice Act changes, as some would desire, we will be forced to adopt the medical model of anesthesia. Imagine if all of your patients who require sedation or general anesthesia are funneled into the hospital or surgery center. Imagine how unprepared the medical system will be to care for so many more patients. Imagine the skyrocketing costs and the delay or refusal of care. Imagine the catastrophic effect on oral health in your communities.

Members of OFSOC, this is a call to action. We need each of you to rally to protect the autonomy of dentistry and the autonomy of your specialty. Please make appointments to speak with your state assembly member and senator. Endeavor to educate them about who we are, how we are trained, and our safety record. OFSOC can provide you with talking points and scripts. And once you've done that, call other dentists in your area and ask them to advocate on our behalf as well. It is only through a loud and united effort that we can make our voices heard.

Respectfully yours,

Leonard M Tyko II, DDS, MD, FACS

OMSA

Oral & Maxillofacial Surgery Assistants Course Still Packs Them In!

OFSOC's OMSA course is still as popular as ever. For the last 5 years in a row, we have filled the course to capacity and have had a sizable wait list for each course.

Not wanting to rest on its laurels, the OMSA committee has been updating the course content to reflect the most recent trends and protocols in office based anesthesia. In addition the committee is close to completing the videos needed to supplement the course with an online presence.

OFSOC recommends that every member of your anesthesia team be certified as an Oral and Maxillofacial Surgery assistant. We also encourage that certified assistants renew their certification every 3-5 years.

The OMSA course is one of the many safeguards that helps ensure that OMS offices throughout California continue to provide a safe environment for patients undergoing Conscious Sedation and General Anesthesia.

In addition, OMS offices can take further safeguards by running in-office emergency simulations not only with the anesthesia team, but with the entire office staff. Having every office staff member trained to respond in an emergency can save valuable seconds, which are crucial if a medical emergency were to arise in the office.

Photo of the OMSA Fall 2015 Course Courtesy of Vincent Farhood, DDS

NEWEST ACD FELLOWS

Oral and Facial Surgeons of California congratulates its newest ACD Fellows!

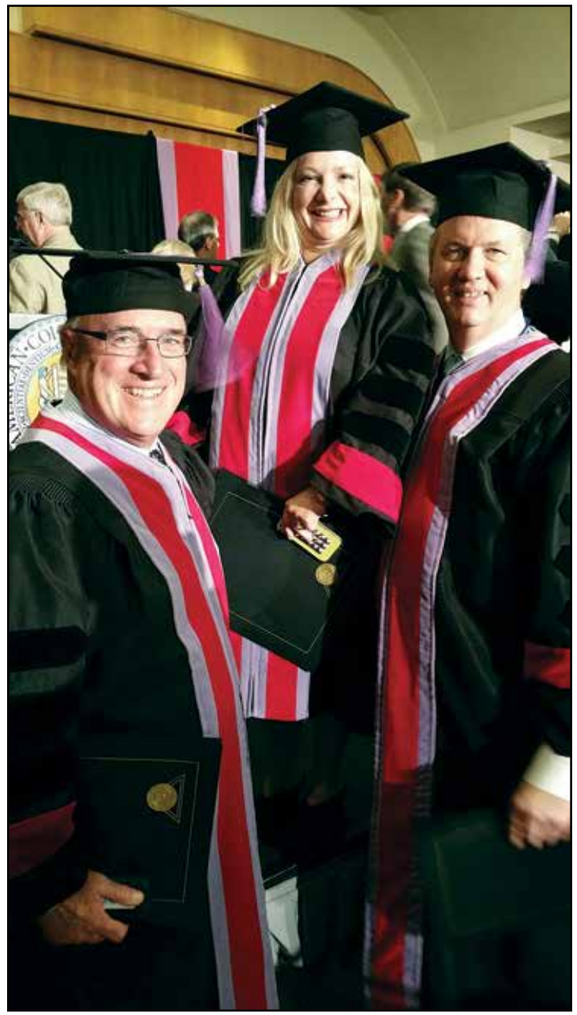
On November 5, 2015 in Washington, D.C., the American College of Dentists inducted into Fellowship the following OFSOC members:

- John M. Allen, DMD, FACD (Pomona)
- Simona C. Arcan, DMD, MD, FACD (Huntington Beach)
- Charles D. Hasse, DDS, FACD, FICD (Irvine)

Fellowship in the American College of Dentists is by invitation and is based on a proven, confidential, peer-review system that has remained intact since the inception of the College in 1920. The College was founded by the president, vice president, and secretary of the American Dental Association (then called the National Dental Association) and by the president of the National Association of Dental Faculties (forerunner of the American Dental Education Association). At the time of its founding, dentistry was plagued with a variety of problems, particularly in the areas of education, journalism, and research. The College was specifically conceived "to elevate the standards of dentistry, to encourage graduate study, and to grant Fellowship to those who have done meritorious work." Fellowship was instituted to promote excellence within the profession by recognizing it. Outstanding dentists were singled out and honored as positive role models to the profession. Fellowship reinforced the highest ideals of dentistry. Fellowship was not designed to circulate honors among a small clique.

Fellowship in the American College of Dentists is a distinct honor and it is often the high point in a dental career. Only about 3.5% of dentists in the United States have been granted Fellowship in the College. Fellows of the American College of Dentists truly are an elite group. Fellowship is bestowed only if the accomplishments of the nominee are truly outstanding and epitomize excellence.

Congratulations, Fellows, on a job well done! OFSOC is proud of you!



From left to right: Charles D. Hasse, DDS, FACD, FICD; Simona C. Arcan, DMD, MD, FACD; John M. Allen, DMD, FACD

MEANING IN ETHICS

The Relevance of 'Meaning' in Clinical Ethics

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

While preparing for a lecture involving Kantian epistemological ethical decision making, I had a moment of anamnesis triggering reflection on the 'meaning' in medicine. Most of us recall reading Frankl's 'Man's Search for Meaning' while in college; the same philosophical principles can translate to medicine which has historical roots, including epistemology, ontology, metaphysics, and, more recently, bioethics. According to Plato, anamnesis is the closest that human minds can come to experiencing the freedom of the soul prior to its being encumbered by matter. Health care clinical ethics can be viewed through the prism of the anamnesis of meaning, not only for medicine per se, but, more importantly, for ethical decision making itself.

Moral reflection, especially in the existentially charged realm of clinical ethics, does not necessarily begin with the application of normative principles, nor can it be sustained by an attitude of resignation strictly toward the pursuit of 'the good'; rather, it begins with a free and open confrontation with the meaning of the experiences we all face as a continuum in day-to-day life. Attending to the moral meaning of concrete situations entails recognizing that formal modes of logical argumentation are only derivative functions of the moral language; thus, an ethicist's involvement is a work of ongoing circumstantial understanding.

Clinical ethics can also be viewed as a form of mindfulness that impels the practice of medicine towards its own telos; to wit, the ends to proper ethical decision making. Because it articulates the ends of medicine in the context of a communal ethos, with attendant needs, values, and priorities, clinical ethics is perhaps better understood as a function of critical analysis that borrows from the anthropological and epistemological milieu in which it operates.

Therefore, the function of clinical ethics can be viewed as articulating a commitment to the search for 'meaning'; a search that is hindered by the limited vision of positivist natural sciences, and by excessive preoccupation with normative dimensions. The former is a recurring temptation of medicine, most visible, of late, in discussions regarding, for example, aid-in-dying and genetic research. It is not enough to keep such a conversation open to the latest normative integration in an endless exercise of reflective equilibrium if this paradigm fails to address the deepest matters of humanity. Indeed, without an appreciation for the profound nature of humanity and meaning, one will not be able to fully comprehend how *caring* is an integral part of medicine when *curing* is not an option.

> ***"Brilliant moral theories might come too late, when ethics has already lost its soul."***

According to philosopher Edmund Husserl, "Fact minded science excludes in principle precisely the questions which man finds the most burning: questions of meaning or meaningless of the whole of human existence." Similarly, bioethicist Leon Kass insightfully opined that "Brilliant moral theories might come too late, when ethics has already lost its soul." My message is that we should be mindful that strategies for solving moral problems need to be addressed beyond the scope of normative principles and, in fact, rely on the larger questions of humanity and 'meaning.'

ORAL & FACIAL SURGEONS of CALIFORNIA

Legislative Update

by Gary Cooper
Legislative Advocate, OFSOC

Oral and Facial Surgeons of California (OFSOC) again has been very engaged in the legislative process during the early months of the 2016 legislative session. On March 2, 2016, five members of the OFSOC board and Executive Director Pamela Congdon spent the entire day in Sacramento with me meeting twelve different members of legislature. These meetings were very beneficial in educating the legislators on the complexities of the current practice of oral and maxillofacial surgery in California. This proved to be necessary and very timely due to an Assembly bill moving through the legislature, AB 2235 (Thurmond).

AB 2235 (Thurmond) is a bill that was introduced at the request of a family whose six-year old son tragically died while under anesthesia in the office of an oral and maxillofacial surgeon (OMS). Originally, the intent of the bill was to require two anesthesia providers in the room while an OMS performed any procedure requiring anesthesia. The bill was originally introduced to require the Dental Board of California to create a committee to evaluate the use of anesthesia by dental professionals and report back to the legislature. OFSOC supported that version of the bill. However, the family of the young boy wanted more and the bill was amended to require an informed consent form be created to indicate that if the same person was performing the procedure and administering the anesthesia, there was 'a greater likelihood of death.' OFSOC and CDA strongly opposed this language. OFSOC asked AAOMS president Dr. Lou Rafetto to come to California to speak in opposition of the bill in this form. Dr. Rafetto, along with OFSOC president Dr. Leonard Tyko and I, met with many members of the Assembly Business and Professions Committee to oppose the bill. The chair of the Assembly Business and Professions Committee agreed with our position and required the bill to move forward without the offensive consent form language and with a more robust data collecting process by the California Dental Board.

While the bill passed with more moderate provisions, it is very evident that there are many healthcare providers who would like see the current oral and maxillofacial surgery team anesthesia delivery model altered. This was made clear by testimony at the Assembly hearing. At the time of this writing, AB 2235 (Thurmond) is moving through the Assembly with the requirement that a comprehensive study of the dental professions' delivery model of anesthesia to juveniles be completed before any scope of practice changes be enacted. That is the strong position of OFSOC. However, as the bill continues to move, the bill could change in an undesirable way and OFSOC will continue to be very engaged.

SB 994 (Hill) specifies that a covered licensee, which includes dental professionals, must adopt and implement an antimicrobial stewardship policy before applying for a renewal license. This policy is defined as efforts to promote the appropriate and optimal selection, dosage, and duration of antimicrobials for patients. The stated goal of the bill is to reduce antimicrobial overuse and misuse and minimize the development of antimicrobial-resistant infections. OFSOC will continue to monitor this measure as it moves forward.

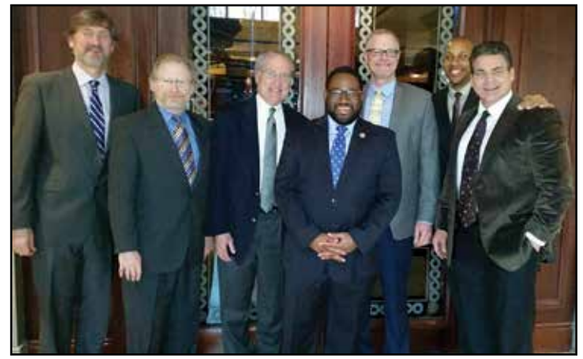
AB 533 (Bonta) remains a "well intentioned" bill sponsored by several of the healthcare insurance plans with the stated goal of addressing the long-standing balance billing issue. Under the balance billing scenario, patients may receive unexpected billing amounts after receiving care at a facility that is part of their insurance plan's network but from an out-of-network provider who contracts with the facility. OFSOC, along with CDA, continued to watch this bill until the last week of the session last year. Amendments added to the bill over the Labor Day weekend would have limited payments to Medicare rates for out-of-network providers. In addition, providers would be required to adhere to a dispute resolution process that has yet to be determined to collect additional payments. AB 533 would apply to dentists and OMSs practicing in hospitals, surgery centers, or offices that provide care under general anesthesia. The Medicare rates amendment raised enough concerns, particularly in the dental care arena, that OFSOC joined with CDA, California Medical Association, and other provider groups to oppose the current version of the bill. Ongoing discussions continue among the stake holders, including OFSOC, to get the bill into an acceptable position.

OFSOC Day at the Capitol

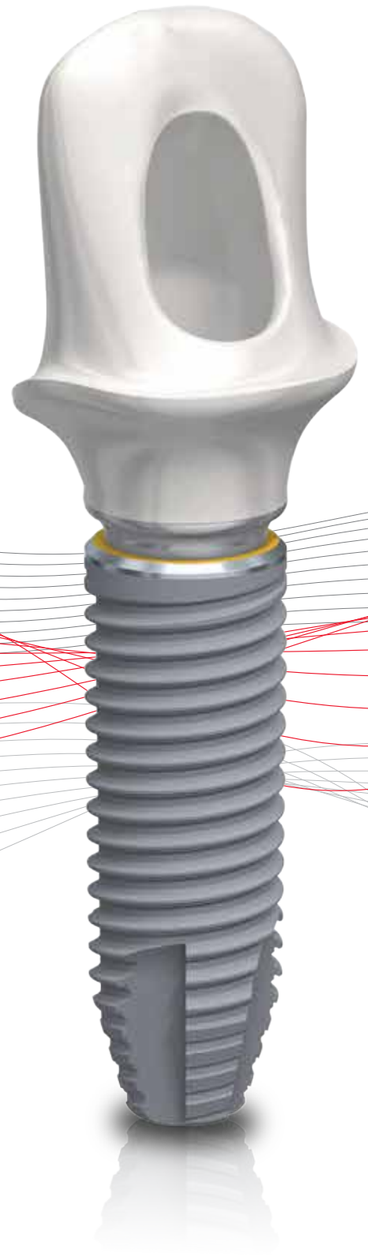
On March 2, 2016, several members of the OFSOC board of directors and legislative committee, along with Mr. Gary Cooper (lobbyist for OFSOC) and Executive Director Pam Congdon, convened in Sacramento to meet with several key state legislators. The purpose of the day was to introduce ourselves as a specialty and an organization, and to educate lawmakers on our training, standards, and everyday practice. The day's busy schedule included meetings with the following Assemblymembers and Senators:

- Assemblymember Sebastian Ridley-Thomas (D-Los Angeles)—*the author of OFSOC's AB 880 which was signed into law on October 1, 2015*
- Senator Ed Hernandez, OD (D-West Covina)—Senate Health Committee Chairman
- Senator Jerry Hill (D-San Mateo)—Senate Business and Professions Committee Chairman
- Assemblymember David Hadley (R-Torrance)
- Assemblymember Marc Steinorth (R-Rancho Cucamonga)
- Assemblymember Marc Levine (D-Santa Rosa)
- Assemblymember Tony Thurmond (D-Oakland)
- Assemblymember Susan Eggman (D-Stockton)
- Assemblymember Mike Gatto (D-Burbank)
- Senator Hannah-Beth Jackson (D-Santa Barbara)
- Assemblymember Matt Dababneh (D-Van Nuys)
- Assemblymember Jim Wood, DDS (D-Eureka)—Assembly Health Committee Chairman

OFSOC lobbyist Gary Cooper (left) with OFSOC board director Tim Silegy, president Len Tyko, president-elect Alan Kaye, and vice president Jeff Elo pause to take a photo in the state capitol rotunda.



OFSOC legislative committee chair Jim Jensvold, OFSOC lobbyist Gary Cooper, president-elect Alan Kaye, president Len Tyko, and board director Tim Silegy meet with Assemblymember Sebastian Ridley-Thomas (center, front) and Mr. Ridley-Thomas' legislative assistant Embert Madison (second from right, back)



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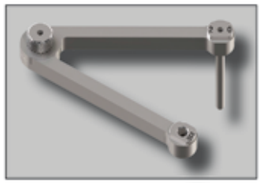

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Incorporating digital intraoral scanning technology into surgical implant practice

by Peter Krakowiak, DMD, FRCD(C)

Every few years I find that we inevitably introduce new technology into our practices, and after several years the new technology becomes both a routine and an indispensable part of our everyday operations. This is not to say that it is always a seamless process. The typical tribulations of most new technology implementation are usually the initial financial expenditures, especially if you are one of the early users in the market, the ongoing and recurring need for training of operators and support staff and connecting the capabilities of our technology into a therapeutic collaborative with our referring doctors. The cost issues of new technology usually become less pronounced after the first two to three years after product entry as competition for the marketplace quickly occurs and multiple vendor companies will rapidly provide similar products and technology. The second hurdle is likely the most difficult to overcome as it truly does take the commitment of the entire team to embrace the new technology. Surgeons, assistants, and ancillary support staff have to be enthusiastic, motivated, and excited with the implementation strategies and show commitment to getting the technology in place. No small task at hand. Finally, getting our referring partners to take advantage of our new technological resources takes a lot of marketing, initial assistance, and sustained re-exposure to the new service or product at our disposal.

2016 is my 21st year out of dental school and I have seen these new technological spheres and enlightenment opportunities present to us several times now with each and every new technological advance we have embraced. In 1990, I remember my mother, a GP dentist in Canada, getting her first workstation-based practice management computer in her general dental office. It was really exciting to be entering the new era of IT. The system sat in the box until 1992, however, due to procrastination and a perceived difficulty at mastering the system's functions. In 1995 when I finished dental school and joined her practice, the system was only being used for treatment plans and we finally threw away the paper appointment book in 1996. It took us four years to only partially implement the system. We much later started using computerized insurance/patient billing and appointment records, and then came full electronic medical records (EMR) keeping in 2005.

In 2006 as now an OMS owner/practitioner I started with my CBCT imaging collection (at $180k it was my first "pre-owned" Ferrari 512TR that I did not buy). Since then I have acquired two additional CBCT scanners in 2013 and 2015 for our new satellite offices. These were a bit less costly by that time ($85k so maybe an E class Mercedes and the other for $59k or a 5 series BMW). Then in 2007 we added Simplant-based CBCT-guided surgical implant planning.

This evolving and highly advanced computer-based digital armamentarium has been a constant and faithful companion to our generation of practitioners.

Then we added computerized pharyngometry and rhinometry to evaluate and treat sleep apnea in 2011; and in 2014 I added Materialise/Synthes software in orthognathic virtual surgical planning.

This evolving and highly advanced computer-based digital armamentarium has been a constant and faithful companion to our generation of practitioners. In 1986, I saw my first computer—the Radio Shack TRS 80 not knowing that this novel medium would be something even remotely useful to a surgeon. But digital computerized technology has been a lynch pin of progress in this constantly morphing and adapting field, and has given us the opportunity to stay in the "hunt." It continues daily to offer growth and challenge opportunities; some well above and beyond the standard surgical care and human resource challenges we face and enjoy (especially those of us who are crazy enough to still be in private practice). Whether we like it or not the challenge of staying relevant in our surgical specialty is always to stay ahead of this curve, of course in addition to already being a competent and compassionate doctor.

The most recent addition to my own practice's gadgetry has been a Carestream CS3500 optical scanner. The digital intraoral impressions technology appeared on the dental market in 1997 with Siemens and Cerec1. Having learned from my CBCT purchases I waited til early 2015 to get some skin in this game as I wanted to have some better and more cost effective options to choose from. I started looking at the early implant fixture compatible scanners in 2011. The early players included Biomet Encode, Lava COS from 3M, iTero from Cadent, IOS FastScan, Sirona's Cerec, and newer True Definition from 3M, E4D Dentist from D4D Technologies and Carestream CS3500, amongst the few. Early versions of the systems were priced upward of $45k (so around a baseline Ski Nautique boat).

When it comes to buying things for the office, I like to price items in terms of things I could have bought with the same funds but did not. Fortunately, the price point is now south of $15k for even the more advanced scanning systems. When choosing my system I wanted an open platform scanner which was free to work with all premier implant systems and all commercial milling sites so that I would not be limited to any one specific implant line by my scanner. I wanted something that would not charge me for each product use or have maintenance fees up the wazoo. Also, I waited for refinements that would allow for much faster scan times, the smallest camera size, defogging capabilities, portability of the unit to multiple work stations, smaller unit/CPU size, and the ability to capture structures without "dusting" in the normal wet/humid intraoral environment. I also looked for a scanner that would be most compatible with my existing CBCT software. I finally settled on a Carestream product CS3500.

Part of my decision was of course based on already owning two of their CBCT scanners and having great support and software familiarity with Carestream software. The company has so far provided us with tremendous support and repeated a la carte training of our team for the past year (all-inclusive in the product price). This ongoing chairside support feature has been critical to us being able to implement the technology since its capture involves all of our team members. Also, as new members joined our team they had access to this training opportunity as well, courtesy of our Carestream representative.

In current OMS practice, the optical scanners allow us to get cost effective, rapid, and highly precise renditions of soft tissues, dental structures, and implant position circumventing the need for traditional elastomeric PVS, polyether, or alginate-based impressions and stone cast modalities. The scanners, and especially the software, are improving annually, as well, and I believe we will eventually see the complete demise of elastomeric dental impressions perhaps within the next ten years. Price point and economics of dental practice will drive this train, as they do with most things. Just look at video rental stores or phone books. Online technology has driven them out of the marketplace for the same reasons.

The cost of traditional dental impression materials is quite significant and may accrue to be well over $50 per case. Also the staff/operator time needed to take traditional impressions is over 10 minutes per case, not including the time generated to set up, pour, set, trim, and mount the models. Never mind the lab space clean-up and then shipping costs to the lab. Patients were never big fans of the process in my past experience; in fact, in some places in the world these techniques can be considered as enhanced integration techniques similar to water boarding! I know for a fact that my staff members are rarely happy to clean up the mess left after the impressions and models are made. I am usually the one making most of the mess.

Currently, my new scanner-based impression appointments involve an easy setup of my plug and play scanner wand into any of my workstations' dedicated gaming-caliber laptops. Having 4 office locations, my scanner readily travels with me and can go easily from operatory to operatory in a small handgun-sized case. Since the scanner is powderless there is no need for dusting which is a huge plus when working in surgical fields.

The typical modern optical scanner can be used to capture images to facilitate several procedures. Standard crown and bridge dentistry preps, full arch study and working models, models for orthodontic tray aligners and bite correlations, and implant-related planning for surgical guides, including corresponding custom abutments/ temporaries and even final crowns can be completed all ahead of the surgical appointment. An important point to make is that at this point very few local labs are truly proficient at handling these digital cases in the entirety from model to restoration. So most will still delegate at least some parts of the process to stereolithic model manufacturers and milling centers, but increasingly more and more will do all the work in-house given the access to this costly laboratory-based technology.

Over the past decade I have partnered with Sunrise Dental Laboratories in Yucaipa and have worked exclusively with John Wilson, CDT. John has a similar zest for technology on "his side of the bench" and we both have been able to grow together with all the ongoing updates and advances. Choosing someone that has years of experience with early CAD/CAM technologies such as John, has been paramount to our success in incorporating the new scanner data acquisition into the surgical implant practice mix. His sound knowledge and ability to communicate with our entire collaborative care team, especially our restorative team, has been invaluable.

Fig. 1 Staff member takes initial scan of surrounding hard and soft tissues

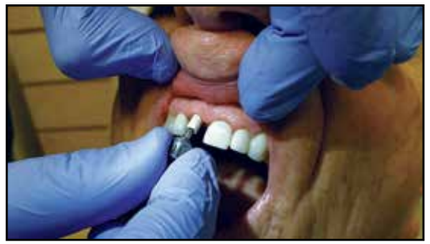


Fig. 2 Fixture specific scan body placed

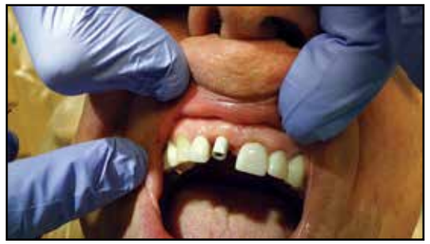


Fig. 3 Scan body oriented with facial bevel

Fig. 4 Scan body registration

Fig. 5 The scan body final and bite impression done by doctor

Currently, our typical scans are mostly used to generate custom restorative abutments and milled screw-retained restorations. I will briefly present a simple single unit case to illustrate the basic work flow which can also be similarly applied to a multi-unit case or even a full arch restoration with small adaptations for occlusal coupling.

Essentially, just as with stone models, we will generate two virtual soft tissue and teeth models of the areas of interests. For most single unit restorations we aim to capture at least three teeth (facial, occlusal, and lingual) on either side of our implant fixture and the majority of soft tissues extending on the facial into the vestibule. We then will capture the opposing dentition and facial soft tissues in the corresponding sextant. Our staff will perform this part of the data acquisition in most cases (Figure 1). Once the scans are completed, a bite relationship capture is made which relates the arches and occlusal schemes of the two virtual segment models together. This occlusion/bite registration is completed by the doctor to ensure the highest precision of record. In my experience, this modality of bite correlation is much more accurate than traditional wax wafers or flowable bite registration material technique as the exact fit of the bite is directly verifiable and maximal intercuspation is readily visible without impression materials in the way of our eyesight. Also patients are most intercuspated without intervening materials this way.

If the virtual model is to be made ahead of surgical placement, the digital impression can be sent to the lab or to an in-office milling unit to manufacture the planned surgical guide, abutment, temporary, or even the final restoration. Alternatively, we usually will scan the implant once it has integrated in non-immediate load cases. To capture the implant position the technique requires two separate scans. The initial scan will visualize the soft tissue contour of an exposed implant with its tissue molding/healing abutment removed. The immediately captured sulcular contour image will provide the lab with the desired emergence profile information for the abutment/restoration contours as they were developed by the healing abutment. Alternatively, these images can be altered in CAD/CAM design software rendition of the restoration if needed during production to change the desired tissue contour. Subsequent to the initial image capture, a system specific scan body (Figs. 2 and 3) is placed into the implant for a second scan of the site (Fig. 4). This part of the process is completed by a licensed dentist as it is analogous to the final impression (Fig. 5). A shade selection is taken to assist with restoration of the site (Fig. 6). It is important to use scan bodies that are manufacturer specific and can be readily identified by third party software used by the milling labs (Fig. 7). Some labs can supply you with their preferred implant scan bodies. They can be sterilized and used several times, further reducing the cost of providing this service. Once the scan body is captured with the scanner, the software will then marry the image of the scan body with the initial virtual scan of the arches in their articulated setting (Fig. 8). The files are then approved for export and digital impressions can be uploaded to the lab via third party portals or sent by standard email as a zip file. The lab will receive the digital data in seconds and can start on the process of generating stereolithic lab models (Fig. 9) and setting in implant analogs (Fig. 10), correlating occlusion and designing the final abutment and/or restorations (Fig. 11). Soft tissue thickness is often evident in the scans and appropriate emergence profile can be planned for the subgingival connecting elements of the abutment (Fig. 12) and restoration (Fig. 13). From there the standard CAD/CAM process is completed and the

models, abutment, and/or crowns are milled or printed (Fig. 14). In some cases labs can create virtual models of tissues and implant connections and then use this hybrid approach to design and/or fabricate any components in standard lab top fashion, if so desired. The traditional layered ceramic restorations may still be desired by some in high esthetic demand cases.

In our community, many of our referring GP doctors already have a vast expertise with the use of Cerec milling technology and have been using the Cerec scanners to mill their inlays, onlays, and crowns for well over a decade. They have also been able to scan prefab and custom abutments and mill crowns over these components over the past several years (Figs. 15 and 16). Most recently, now with the introduction of implant specific titanium connected zirconia milling blocks for custom abutments, they have also been able to use technology to mill all prosthetic based components and crowns in their own offices. Even multiunit restorations are possible with the newer Cerec machine paradigms.

Not all offices and doctors, however, have embraced this technology and we still have the ability to assist the other restorative practitioners with the delivery of advanced prosthodontic and implant care in the virtual paradigm to their patients using our own scanners. We are always relying on our partner laboratories to provide the milling/casting and crown restoration fabrication capabilities which employ optimal collaboration and will result in the highest caliber of outcomes for their referred patients. The optical scan is now also a base for developing occlusal appliances, surgical guides, and orthognathic splints in our practice. The scans are capable of registering arches for denture fabrication and tray fabrication for aligner-based orthodontic therapy.

Virtual study models do not occupy room on shelves and are not subject to chipping when moved around. Of course as anything in digital media they are prone to file loss or corruption if not stored properly. Since there are multiple companies in the market place there is always some concern about compatibility. However the majority of systems use an open platform STL file analogous to DICOM files for CT scanners which allow for extrapolation and application of the data in numerous settings and third party software applications. The savings in materials, staff time, two-way shipping costs, and improvement in accuracy of the working models is significant when using digital impressions. The elastomeric impressions can always be distorted, are subject to time-based deterioration, and stone model materials experience setting and thermal distortions as well. These are not the case with digital impressions. Recent literature on the use of digital fixture level impressions in implant cases has shown them to be superior to the traditional open tray and closed tray impression techniques. With a lot of products on the market this may be a very good time to consider adding optical scanning capabilities to your practice if you have not done so, or implement them now if you have had this technology on board but have not implemented it to its full potential.

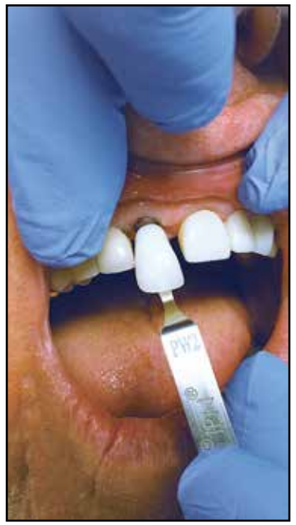


Fig. 6 Shade match is made

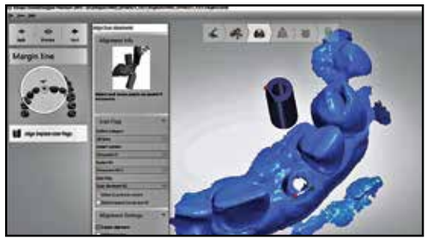


Fig. 7 3-point referencing of scan body

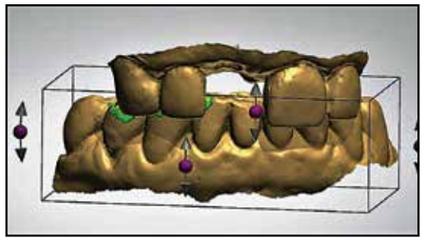


Fig. 9 Lab virtual model is mounted and articulated in 3D

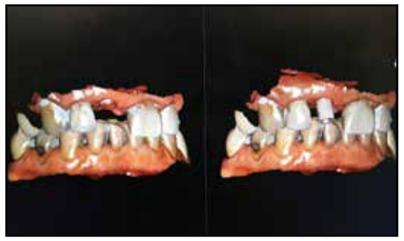


Fig. 8 Scanner-derived virtual tissue scan images with bite registration

Fig. 10 Virual lab model with implant analog

FIGURES 11-16 CONTINUED ON PAGE 17

Fig. 11 Abutment design

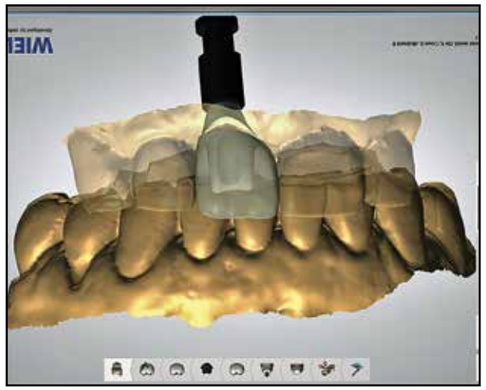


Fig. 13 Final crown contour design

Fig. 12 Abutment and crown emergence planning

Fig. 14 Milled model with custom anodized titanium abutment and interim crown ready for delivery

Fig. 15 Prefab abutment scan on Cerec

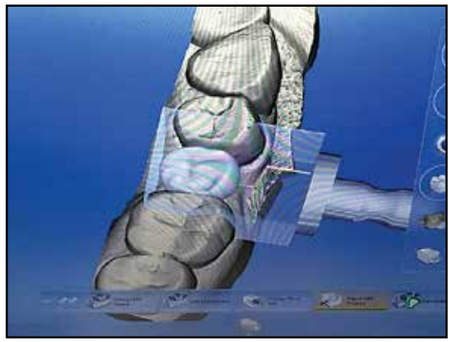


Fig. 16 Milling plan for Cerec milled crown (courtesy Dr. Charles Drury)

RISK MANAGEMENT

The Three Options in a Ransomware Attack: Restore If Possible, Pay, or Lose Patient Information

by Craig Musgrave, Senior Vice President, Information Technology, The Doctors Company

The news made national headlines: Hollywood Presbyterian Medical Center's computer systems were down for more than a week1 as the Southern California hospital became yet another victim of ransomware—an attack where a business or individual's computer system is held hostage by cybercriminals until a ransom is paid. Hollywood Presbyterian Medical Center ended up paying $17,000 to restore its systems and administrative functions.

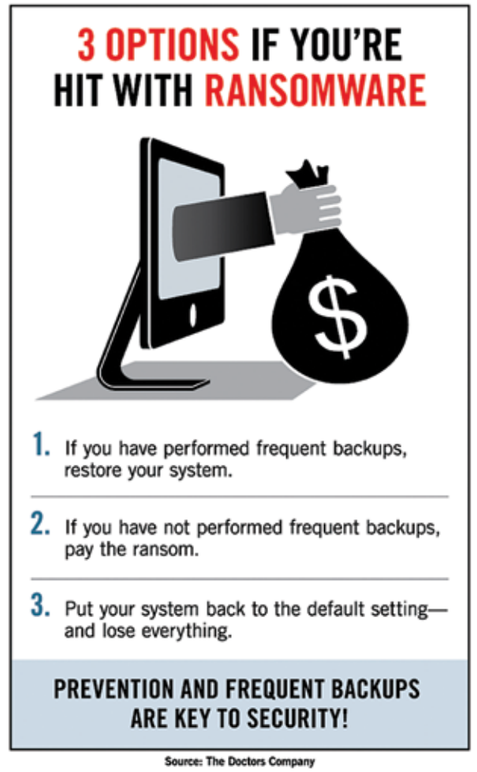
Once ransomware is in your medical practice or hospital system, there are only three basic options:

1. *If you have performed frequent backups, restore your system.*
2. *If you have not performed frequent backups, pay the ransom.*
3. *Put your system back to the default setting—and lose everything.*

If before the attack you've performed incremental backups, you can restore the areas affected, with minimal data loss (for example, an hour). If you have point-in-time backups, you can restore with increased data loss (for example, a week). If you have no reliable backups, you can reset the technology back to its "out-of-box," or default, state and lose all the data, if no paper records exist. The only other option would be to pay the ransom.

Besides loss of business, inconvenience to patients, and damage to reputation, a ransomware attack also poses liability risks. The possibility of adverse events and subsequent claims for professional negligence increases when computerized systems necessary for various functions such as CT scans, documentation, lab work, and pharmacy needs are offline. If hospital systems are down for any significant period of time, certain patients should be transported to other hospitals.

Adverse events can occur when healthcare workers do not have access to EHR systems. However, if this type of case



was litigated, the patient would have to prove that something in the records may have had a bearing on the treatment being provided. In the case of emergency care, the claimant would have to successfully argue that the staff should not have undertaken the care until the medical records could be accessed.

Hospitals, medical practices, and businesses should take full precautions to prevent a hack that results in ransomware being installed. Prevention strategies include:

- Provide security awareness for all employees. Over 80 percent of attacks are made possible by human error or human involvement. Train staff members to avoid downloading, clicking on links, or running unknown USB on computer systems.
- Block the malware at the firewall, by using intelligent firewalls to stop the malware from downloading.
- Install intrusion detection software to monitor illegal activities on computer networks.
- Stop the malware from executing on desktop computers by installing application whitelisting software, anti-virus, or anti-malware.

- Perform regular system backups.
  - Ensure that critical systems and business data are backed up—even backed up hourly for critical systems.
  - Test that the backup restore process works.
- Avoid relying solely on encryption. Encryption does not protect a business from a ransomware attack. If a cybercriminal has your login, encryption doesn't do anything to stop the hacker.
- Perform penetration testing on a regular basis to determine any existing vulnerabilities that should be patched.

Reference

[1]Dangerous escalation in ransomware attacks. *CBS News*. February 20, 2016. http://www.cbsnews.com/news/ransomware-hollywood-presbyterian-hospital-hacked-for-ransom/. Accessed March 21, 2016.

There's an App for That: Benefits and Risks of Using Mobile Apps for Healthcare

by Robin Diamond, MSN, JD, RN, Senior Vice President, Patient Safety and Risk Management, The Doctors Company

With over 100,000 mobile health apps now available—in addition to many new tools that allow physicians to remotely monitor their patients' conditions—physicians now have to handle an increasing amount of constant data and patient information that they did not have in the past. Patients are using mobile apps to monitor their activity levels, track weight loss, improve medication adherence, and even track their blood pressure or blood sugar levels. Only 16 percent of healthcare professionals currently use mobile apps with their patients, but 46 percent plan to do so in the next five years.[1]

Mobile apps offer many potential benefits to doctors and patients:

- Mobile apps can help patients self-monitor their conditions and can alert them and their physicians to problems before they become serious medical issues.

Source: The Doctors Company

- Some of these apps are regulated by the FDA. For example, patients can monitor their heart rhythms with an FDA-approved device that wraps around their iPhone.
- Mobile apps can be a tool for patient education:
  - A better-informed patient is more likely to understand risks and, if there is an adverse event, may be less likely to file a lawsuit.
  - Mobile apps help patients remember important information about their healthcare. Patient pamphlets and other educational materials are often lost or forgotten. Patients forget 80 percent of the information they are told and *inaccurately* remember an additional 10 percent, leaving patients with just 10 percent of the information remembered correctly.
- Mobile apps can engage patients in their healthcare:
  - Many patients today are interested in becoming as involved in their care as possible.
  - One patient engagement platform that connects patients and physicians, Healthloop, markets its product as a way to have very satisfied patients who will publicly share their experience. This platform monitors compliance and adherence to the treatment plan; checks in with patients, thus eliminating phone calls; collects outcome data; educates and reinforces education; and identifies at-risk patients quickly to reduce readmissions.

But not all of the apps currently on the market are approved or regulated by the FDA, and the use of mobile apps does not come without liability risks. The Doctors Company has not yet seen malpractice suits that involve mobile apps because the use of these apps to monitor patients is fairly new. Malpractice lawsuits may not be filed for several years after the adverse event, so with the increased use of mobile apps for healthcare, we expect there will be lawsuits involving mobile apps in the future.

Physicians could face allegations of failing to educate the patient/family about the risks and limitations of the app or failing to act appropriately if the app goes offline or malfunctions. Product liability, negligence, contract law, and even malpractice tort law could be applied to possible causes of action in lawsuits brought because of an injury connected to use of a mobile app. Injuries could occur if:

- The physician receives information from a mobile app and does not act on this information. Physicians have a legal duty to review real-time data direct from the patient and respond. Mobile apps raise patient's expectations of how a physician will act—the patient/family expect that the patient is monitored 24/7 and the physician will respond "within a moment's notice." When an adverse event occurs, if a patient believes the physician failed to act on information from a mobile device, the patient might sue. If physicians don't respond to information from an app, this will be recorded in the metadata, which can be used in court.
- The readings received from a mobile device are wrong and treatment is prescribed based on the wrong data. There are a lot of untested apps on the market that may be unreliable or even dangerous. Apps are also vulnerable to being hacked, resulting not only in potential loss of personal health information (PHI) but also in potential malfunctioning of the app.
- Patients rely on technology alone, leading to decreased phone contact with the physician when symptoms arise or there are changes in the condition that require immediate action.

These apps can be useful tools to support a comprehensive care plan, but physicians need to be knowledgeable about these apps so they can educate their patients about the apps' limitations and potential risks.

Consider limiting your patients to one mobile app that you agree to monitor. This will make it easier to control the incoming data and help make the best use of the app. Other important considerations include:

- Consider whether the two-way communication between you and your patient is secure and, therefore, HIPAA/HITECH compliant. Ask the vendor for assurance that the app is HIPAA-compliant and that data is encrypted for security.
- Know the app:
  - Vendor information, such as updates, downtime, and critical value alerts.
  - How will it interface with your EHR?
  - Is the device regulated by the FDA as a medical device?
  - Will you get alerts by e-mail or a phone call from the vendor when the app isn't working?
- Beware of the possibility of lack of security when using public Wi-Fi with the app.
- Clearly communicate and educate the patient/family about the purpose of the app and how and when the data is transmitted to the clinician.
- Avoid assuring the patient that the app will "take care of everything." Educate the patient/family about the limitations of app, with specific examples of instructions for the patient to follow. For example, can the algorithm be changed for specific patient needs?
- Identify a contact person within your organization to troubleshoot and be available to address technical problems.
- Have the patient/family sign a consent form that describes the risks, benefits, and purpose of the app.
- Do not do this alone! Avoid utilizing medical apps without support from your organization.

References

[1]Easy on those mobile apps: Mobile medical apps gain support, but many lack clinical evidence. *Modern Healthcare*. November 28, 2015. http://www.modernhealthcare.com/article/20151128/MAGAZINE/311289981/easy-on-those-apps-mobile-medical-apps-gain-support-but-many-lack. Accessed December 16, 2015.

THE DOCTORS COMPANY

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2016 Meetings

- **ACLS** - Solano — October TBD
- **OMSA Fall 2016** - Foster City — October 15 – 16
- **Medical Emergencies** - Southern CA TBD — November 2

2017 Meetings

- **January Anesthesia Meeting** - Berkeley — January 14 – 15
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