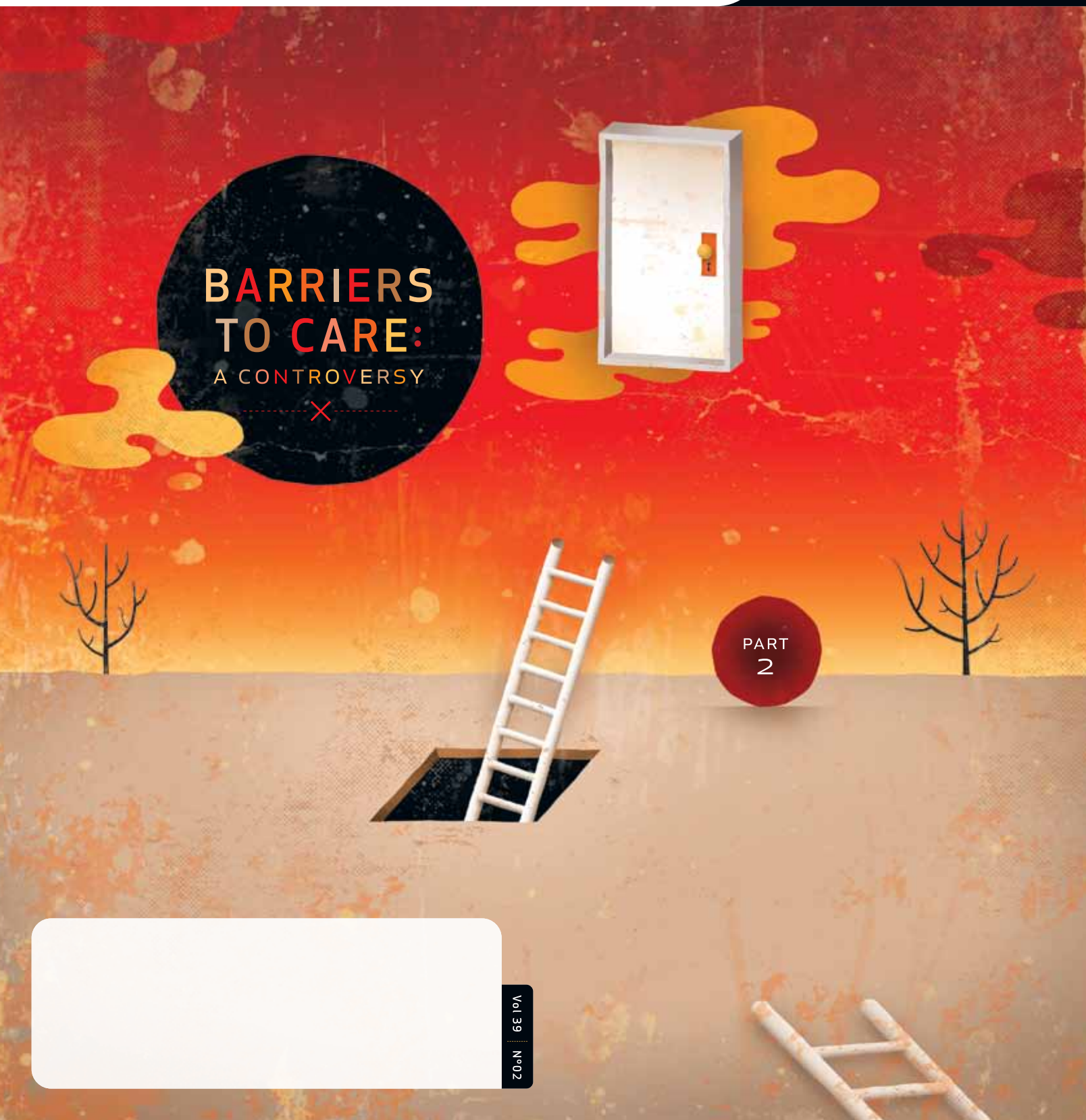
OF THE CALIFORNIA DENTAL ASSOCIATION

# Journal

FEBRUARY 2011






Vol 39 No 02

# Protecting dentists.

# It's all we do.[SM]

- Professional Liability
- Office Property
- Employment Practices Liability
- Workers' Compensation
- Life/Health/Disability
- Long-Term Care
- Business Overhead Expense
- Home & Auto

**800.733.0633 tdicsolutions.com CA Insurance Lic. #0652783**

Coverage specifically underwritten by The Dentists Insurance Company includes Professional Liability, Office Property and Employment Practices Liability. Workers' Compensation, Life, Health, Disability, Long-Term Care, Business Overhead Expense, Home and Auto products are underwritten by other insurance carriers, brokered through TDIC Insurance Solutions.

tdic®

## DEPARTMENTS




69

## FEATURES

OF THE CALIFORNIA DENTAL ASSOCIATION

# Journal

CDA Journal
Volume 39, Number 2
FEBRUARY 2011

cda

**Journal of the California Dental Association**

**published by the California Dental Association**
**1201 K St., 14th Floor**
**Sacramento, CA 95814**
**800.232.7645**
**cda.org**



## Reader Guide:

**Upcoming Topics**
MARCH: *General Topics*
APRIL: *Recession Erosion*
MAY: *Somnology*

**Manuscript Submissions**
Patty Reyes, CDE
ASSISTANT EDITOR
Patty.Reyes@cda.org
916-554-5333
Author guidelines are available at cda.org/publications/journal_of_the_california_dental_association/submit_a_manuscript

**Classified Advertising**
Jenaé Gruchow
COMMUNICATIONS ASSISTANT
Jenae.Gruchow@cda.org
916-554-5332

**Display Advertising**
Corey Gerhard
ADVERTISING MANAGER
Corey.Gerhard@cda.org
916-554-5304

**Letters to the Editor**
Kerry K. Carney, DDS
Kerry.Carney@cda.org

**Subscriptions**
The subscription rate is $18 for all active members of the association. The subscription rate for others is as follows:
*Non-CDA members and institutional:* $40
*Non-ADA member dentists:* $75
*Foreign:* $80
*Single copies:* $10
Subscriptions may commence at any time. Please contact:
Jenaé Gruchow
COMMUNICATIONS ASSISTANT
Jenae.Gruchow@cda.org
916-554-5332

**Permission and Reprints**
Jeanne Marie Tokunaga
PUBLICATIONS MANAGER
JeanneMarie.Tokunaga@cda.org
916-554-5330

*Journal of the California Dental Association* (ISSN 1043-2256) is published monthly by the California Dental Association, 1201 K St., 16th Floor, Sacramento, CA 95814, 916-554-5330. Periodicals postage paid at Sacramento, Calif. Postmaster: Send address changes to *Journal of the California Dental Association*, P.O. Box 13749, Sacramento, CA 95853.

*The Journal of the California Dental Association* is published under the supervision of CDA's editorial staff. Neither the editorial staff, the editor, nor the association are responsible for any expression of opinion or statement of fact, all of which are published solely on the authority of the author whose name is indicated. The association reserves the right to illustrate, reduce, revise, or reject any manuscript submitted. Articles are considered for publication on condition that they are contributed solely to the *Journal*.

CDA JOURNAL, VOL 39, Nº2

# Partners

RUCHI K. SAHOTA, DDS, CDE

**In terms of a business model, partnerships work when one partner compliments the other. Each partner contributes to the other's goals.**

What was the plan? Build a practice? Build a family? Build a house? Did you plan to do it in that order? Would you do it alone?

Years ago, dentists finished school, passed boards, and set up solo shop. That was the most prominent reality we knew.

A 2007 ADA survey showed that "independent nonsolo dentists accounted for 28.3 percent of all dentists ... (and among this group), 46.2 percent were less than 50 years old." The West Coast was also identified as the area with the highest number of nonsolo dentists — or partnerships.

In terms of a business model, partnerships work when one partner complements the other. Each partner contributes to the other's goals. We understand each other's weaknesses and are inspired by each other's strengths. But at the same time, we are not threatened by our own vulnerabilities.

A friend is in a three-dentist partnership. Each partner just gravitated to what he enjoyed doing most, or, in my friend's words, "what each of us could stand doing the most." One partner manages the financial accounts and statements. One partner deals with staff issues. And the third partner administers other outside-the-box tasks like staff trips, meetings with consultants, continuing education management, scheduling, etc.

The big costs — the overhead, property rent/loan payments, and marketing — are shared. A partnership may give a practice the opportunity to offer a larger range of services or rent a bigger office. The risk of a business loan is shared. This can make a loan application more attractive to a bank as well.

To be by yourself, to face all that we face as business owners every day on your own is difficult. Bill Gates, who started Microsoft with his friend and partner Paul Allen, asserted, "You've got to have somebody, one person who you can really open up with, and be weak with, and be afraid with, and be out of control with, or be screwed with."[1]

But there is another type of partnership: one that handles disparate functions, owns separate responsibilities, and does not wander along the border of their black-and-white divisions of partnership. The famed "Last Emperor" of the fashion industry, Valentino, had Giancarlo Giammetti by his side and behind the runway so that he could concentrate solely on his creativity and that was it.

In dentistry, we see business models that include a nondentist partner, perhaps a spouse who handles all of the finances, staff, marketing, and other business aspects of the practice. This allows the dentist partner to concentrate on his skills and the patients.

But how do we choose the best partner? Warren Buffett holds a few workshops a year about the ethics of business. Each student is supposed to select a classmate. They will take 10 percent of the classmate's earnings for the rest of their life. Even though they are prompted to consider grades, IQ, etc., students inevitably use generosity, kindness, and integrity as their gauge to pick their partners for life. Buffet's lesson to his students: "Everyone here has the intelligence and energy, but the integrity is up to you. You weren't born with it; you can't learn it in school." He urges students to find what they want to develop in themselves in the partner they choose.[1]

So partnerships also bring risks. They require trust. There are more than a few gambles: loan defaults, unequal production to meet overhead, and malpractice/liability risks.

CDA's Practice Support Center (cdacompass.com) notes that mutual respect and a common business plan are the foundation for a partnership. The legal reference guide outlines some partnership options, "The dentists may consider establishing a general partnership, under which the partners share decision-making as well as financial risk. However, a general partnership may increase a dentist's risk. While the sole proprietorship format involves unlimited liability, a dentist in a general partnership is exposed to potential liability for the actions of each of the partners as well as for his or her own actions."[2]

The guide addresses risks, legal considerations, and factors that should be taken into account with regard to business partnerships. Like any friendship or even marriage, disagreements, miscommunications, deviations from the original visions and passions occur.

A written agreement and involvement of an attorney is imperative.

My partner set up "shop" in a farming township, which would eventually grow to become one of the commuter suburbs of Silicon Valley and the fourth-largest city in the San Francisco Bay Area. Almost 30 years ago, she found an open office space in the town of Fremont and she started her practice from scratch. Was it good planning and intuition, just luck, or the benefit of having established her business in simpler times that made her successful?

This is not a common story these days. California has undergone immense growth and thus incredible urban saturation as well. The new economic situation presents barriers to practice growth. A recent ADA Health Policy Resources Center (HPRC) report noted emerging challenges and strategies with respect to the current economy:

- Existing patients, because of economic uncertainty and job loss, are reluctant to accept treatment plans.
- Patients are reluctant to use their discretionary dollars for dental services, except for acute care.
- Reimbursement issues with insurance carriers/managed care plans are increasing.
- New patient volumes are down.

According to the HPRC, dentists across the country are reviewing and lowering expenses and trimming down overhead. We are wracking our brains. How do we help our patients? How do we help them understand the cost of delayed treatment? If our schedules lay open and patients cancel their appointments, how do we stay afloat?

These are hard questions. It is hard to sit in that office alone and come up with answers. Our minds work at an electrifying pace, especially when times are tough. Expression. Interaction. Digestion. It is nice to have someone to bounce off ideas and learn from.

A business partner. A dental society colleague. A friend. A spouse. A partner can help enlarge our vision but contain our egos. A partner can shield us from embarrassment in the case of a potential wrong decision. And a partner can also push us toward the right direction in the case of a possible life-altering decision. ■■■■


**REFERENCES**

1. Eisner M, Cohen A, Working together: why great partnerships succeed, first ed., New York, N.Y., HarperCollins, 2010.
2. CDA Compass, Legal Reference guide, 2010. cdacompass.com.


*The* Journal of the California Dental Association *welcomes letters from readers on articles that have appeared in the* Journal. *We reserve the right to edit all communications and require that all letters be signed. Letters should discuss an item published in the* Journal *within the past two months or matters of general interest to our readership. Letters must be no more than 500 words and cite no more than five references. No illustrations will be accepted. Letters may be submitted via e-mail to the* Journal *editor-in-chief at kerry.carney@cda.org. By sending the letter to the* Journal, *authors acknowledge and agree that the letter and all rights of the letter's author become the property of the California Dental Association.*

Academy of General Dentistry™

# AGD 2011 San DieGO!

Annual Meeting & Exhibits

**July 26 to 28, 2011: AGD House of Delegates**
**July 28 to 31, 2011: AGD Annual Meeting & Exhibits**

## Courses

Go to San Diego and experience more than an entire year's worth of continuing education in one great location. Quality courses will be offered every day from Thursday, July 28, to Sunday, July 31, 2011.

## Speakers

- Gordon J. Christensen, DDS, MSD, PhD ("The Christensen Bottom Line")
- David S. Hornbrook, DDS, FAACD ("Hot Topics in Restorative and Esthetic Dentistry")
- Terry T. Tanaka, DDS, MAGD ("Treatment Planning Guidelines for Fixed and Removable Prosthodontics")
- Pascal Magne, PhD, Dr.Med.Dent. ("Biomimetic Restorative Dentistry")
- Howard S. Glazer, DDS, FAGD ("What's Hot and What's Getting Hotter")
- Harold L. Crossley, DDS, PhD ("What's the Real Deal About Street and Prescription Drug Abuse" and "The 30 Most Physician-Prescribed Medications")
- Karl R. Koerner, DDS, MS ("Surgical Extractions Using New High-tech Devices")
- Louis Malcmacher, DDS, MAGD ("Total Facial Esthetics for Every Dental Practice")
- Joseph J. Massad, DDS ("Dentures and Implant Overdentures: How They Have Improved the Quality of Life")
- Russell A. Baer, DDS ("Basic Implant Surgery for the General Dentist")

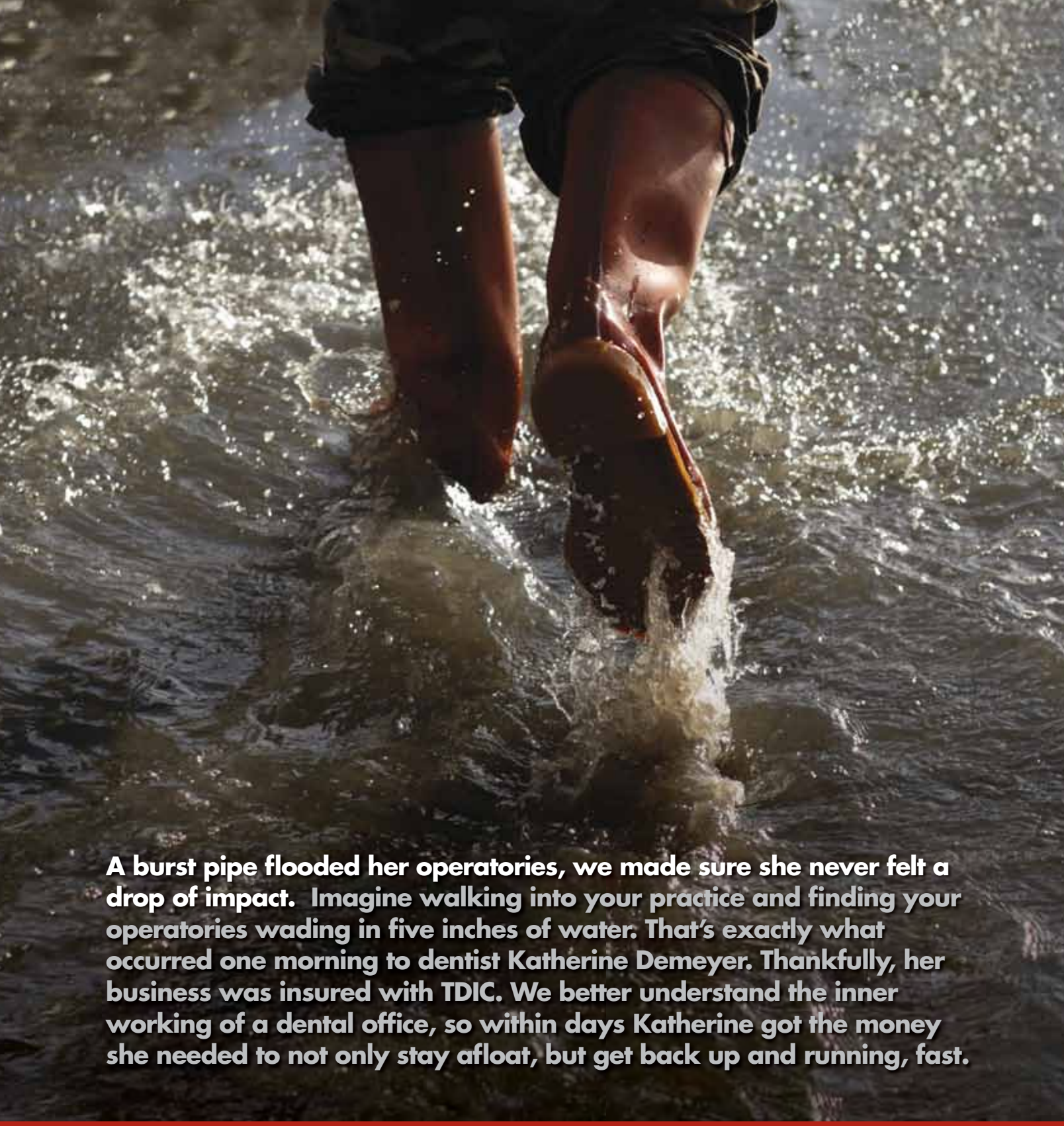
## AGD Headquarters Hotel

**San Diego Marriott Hotel & Marina**
**333 West Harbor Drive**
**San Diego, CA 92101**

## Registration

**Registration is now open!**
**Visit *www.agd.org/sandiego***
**and click on "Register Now" today.**

GO



**A burst pipe flooded her operatories, we made sure she never felt a drop of impact.** Imagine walking into your practice and finding your operatories wading in five inches of water. That's exactly what occurred one morning to dentist Katherine Demeyer. Thankfully, her business was insured with TDIC. We better understand the inner working of a dental office, so within days Katherine got the money she needed to not only stay afloat, but get back up and running, fast.

**Protecting dentists.**
**It's all we do.**[SM]

800.733.0634 thedentists.com

tdic®

CDA JOURNAL, VOL 39, Nº2


Matt Mullin

## Dental Care Is Not a Right

BY DAVID W. CHAMBERS, PHD

The study of rights is a branch of ethics. But it is not mainstream, so the branch office is small. There is almost no one there working in the "Health as a Right" department.

Rights exist to the extent that someone declares they should have something and others agree. Sometimes the rights are positive, as in free public education, and sometimes they are negative, as in freedom from unwarranted search or seizure. Rights are claimed, they are not earned. Human rights belong to all people, without qualification. Civil rights belong to members of national groups, and that is why habeas corpus is a civil right in the United States but not in Iran. Entitlements are benefits or protections written into law for the advantage of specific groups, such as Medicaid, Indian gaming, or environmental protections.

CONTINUES ON 71

**Brush Buddies** ↑

Ashtel Dental allows kids to pick the character of their choice with Brush Buddies. Using Brush Buddies teaches children healthy brushing habits. The unique toothbrushes feature an animated voice recording that guides kids through proper brushing techniques. The toothbrush also plays a melody that lasts two minutes, the recommended brush time. For more information, go to ashteldental.com.

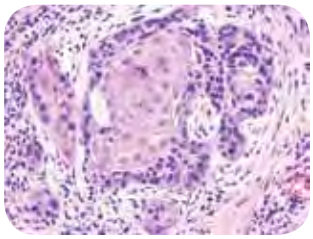
## Primary Treatments Studied for Bilateral Cleft Lip and Palate

A study published in an issue of the *Cleft Palate-Craniofacial Journal* recently examined two primary treatments for bilateral cleft lip and palate: orthodontic space closure and prosthetic replacement, primarily with resin-bonded bridges.

Twenty-seven adults with a bilateral cleft lip and palate participated in the study. The treatment methods of these Netherlands-residing patients were evaluated on the basis of aesthetics and mandibular function. A professional panel and patients were asked to rate the aesthetics of the both procedures. The two groups did not find a significant aesthetic difference between orthodontic space closure and prosthetic replacement. However, the method of treatment made a difference in jaw function. Patients used a questionnaire to evaluate specific functions: prosthetic replacements were found to result in significantly more impairment of the jaw.

The number, shape, and position of teeth can be affected, frequently the permanent lateral incisor is misshapen or missing in those who have cleft lip and palate. Different dental treatment options for bilateral cleft lip and palate can result in similar aesthetic appearance, but they produce definite differences in jaw function.

To read the full text of the article, "Orthodontic Space Closure Versus Prosthetic Replacement of Missing Upper Lateral Incisors in Patients With Bilateral Cleft Lip and Palate," go to www2.allenpress.com/pdf/cpcj-47-06-591-596.pdf.



"More people in the UK die each year from mouth cancer than from cervical and testicular cancer combined."

NIGEL CARTER, DDS

## HPV Status May Determine Odds for Surviving Cancer

According to a new study, monitoring cancer tumors for the human papilloma virus may help health experts predict a patient's survival chances.

Researchers monitored 198 patients with mouth cancer following surgery or radiotherapy for two years. It was discovered that those with HPV positive cancer were four times less likely to die than those who were HPV negative, according to a news release. Additional information showed that cancer was three times less likely to reoccur at the primary site in patients with HPV positive cancer.

"Our study, which focused on a group of patients with advanced oropharyngeal cancer, found that those with cancer caused by HPV had a significantly better chance of survival than cancer which was not caused by HPV. And this beneficial HPV effect was seen regardless of the type of treatment they had," said Angela Hong, MBBS, MMed, PhD, of the University of Sydney, who conducted the study.

"HPV status is now the strongest predictor of whether a patient will survive oropharyngeal cancer or whether the disease will return. Various clinical trials are now in development to tailor treatment according to HPV status of tumors," she said.

In the United Kingdom, mouth cancer is currently one of the fastest growing cancers and is responsible for one death every five hours.

"Mouth cancer is a devastating disease, and this study is another step forward in the battle against it," said Nigel Carter, DDS, chief executive of the British Dental Health Foundation. "More people in the UK die each year from mouth cancer than from cervical and testicular cancer combined, which is wrong considering this disease can be treated and cured if caught in the early stages."

## First International Conference on Dental and Craniofacial Stem Cells

The inaugural gathering of the world's most leading scientists in dental and craniofacial stem cells will be held April 27-29 at the New York Academy of Sciences in New York City.

An estimated 300 individuals from scientific research, industry, government agencies such as National Institutes of Health and the U.S. Food and Drug Administration, and researchers from the emerging field of regenerative dental medicine are expected to attend the event to advance dental and craniofacial stem cell research.

"The teeth and the face harbor stem cells, just like virtually all other regions of the body. However, stem cells from the teeth and the face have special properties that make them unusual, if not unique, in some cases," said Jeremy Mao, DDS, PhD, one of the conference leaders. "Dentistry is undergoing a transformation from restorative, such as drilling and filling, to regenerative. This conference represents the first dedicated gathering of stakeholders from the scientific community, industry, and government officials who fund and regulate regenerative technologies."

Dental stem cells, according to current research, are poised to significantly impact treatments that run the gamut from dental implants to reconstructive surgery, as researchers have been able to regrow both teeth and jawbone, according to a news release. Moreover, dental stem cells demonstrate tremendous promise in advancing the field of regenerative medicine, which continues to make important strides in addressing degenerative conditions, disease, congenital anomalies, trauma, and organ repair and replacement.

To register for the conference go to dental.columbia.edu/ICDCSC/ or e-mail mmw7@columbia.edu.

## Things Your Staff Is Telling You That You Need to Hear

Intelligence from the front line is crucial to winning wars, and Theodore Schumann believes staff in the dental office is a dentist's "front line."

In a recent issue of the *Michigan Dental Association*, Schumann wrote that staffers in a dental office are "likely to have some worthwhile opinions and suggestions you can take advantage of in managing your office."

Some of the things staff may bring to your attention are:

- You give away too much free or discounted care. Often staff is aware of how much your charity is hurting your bottom line.
- A specialist you refer to doesn't get great reviews from patients. Patients are more likely to complain of a specialist to your staff than to you.
- Your staff needs more training. It takes bravery for staff to admit they need training. When they acknowledge this, follow up on it.
- A patient is ready for a more comprehensive treatment plan. Often a patient will communicate more openly with staff than with the dentist.
- Your attitude has changed for the worse. Don't get defensive. Listen to your staff. They care about you and the practice.
- An item needs to be replaced. The person who uses a piece of equipment knows it best. Use that knowledge in developing a long-term capital budget plan.
- There's a better way. Sometimes we get too comfortable in our routines. Listen to your staff. They bring a number of different perspectives.

**CARE IS NOT A RIGHT,** CONTINUED FROM 69

Rights create obligations. Somebody must provide the resources that make positive rights possible and guarantee that negative rights are protected against encroachment. There are no free rights, they are always transfers from one segment of a group to another.

The United Nations' Declaration of Human Rights lays out rights such as fair remuneration for one's work, political assembly, and no slavery. Health is mentioned, but not as many people would imagine. Article 25 states that "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family." But that is different in nature from free public education: it is a test standard for economic development. It is not a right to health, but a right to choose health.

Leading philosophers today such as John Rawls and Norman Daniels state specifically that health is not a right. Jeremy Bentham, the late 18th century English jurist and philosopher, said, "Rights are utter nonsense, nonsense on stilts."

I count myself among those who boggle at the prospect of health care as a right. It is a bottomless opportunity to consume resources. There are more researchers developing health innovations than there are folks creating resources. America's health bill is now at 18 percent of the GDP and on its way up. And if an individual believes that somebody else owes them health care, who will say they have enough of it?

The alternative is to consider health, including oral health, as a social good. The public is damaged by children who miss school and employees who miss work because of toothache. Emergency rooms, by law, cannot turn patients with oral complications away despite this being an inefficient system. To the extent that the public chooses to avoid these social costs by subsidizing dentistry it should enact entitlements, but not more than that.

The nub:

1. No one is entitled to everything they want just because they want it: try sharing your own list with others.
2. When evaluating proposals for entitlements, ask whether the burdens as well as the benefits are being justly distributed.
3. Try to answer the question for yourself: How much oral health care is enough?

*David W. Chambers, PhD, is professor of dental education, Arthur A. Dugoni School of Dentistry, San Francisco, and editor of the* Journal of the American College of Dentists.

Rotadent Plus

The Rotadent Plus, by Zila, a TOLMAR Company, is a rotary-powered toothbrush. The toothbrush features three speeds, brushing timer, and charging base. The Rotadent Plus still retains the same characteristics as the classic Rotadent toothbrush – a 360-degree sweeping-action brush head and a limited lifetime warranty. The rotary-powered toothbrush improves oral hygiene more effectively than the average toothbrush. For more information, contact (970) 212-5861.

## Consider Carefully When Opting for Elective Angioplasty

While the advances in angioplasty can be lifesaving, it does not fix the real source of the issue of atherosclerosis, the spread or damage from the disease, nor does it lessen the risk of future heart attacks or survival, according to an article in the *Harvard Heart Letter*.

A new study of women and men planning on having elective angioplasty showed that 60 percent didn't necessarily need the procedure and would have been better off with intensive medical and making lifestyle changes. An estimated five in every 100 people who undergo the procedure have complications ranging from kidney damage and an abnormal heart rhythm to stroke, heart attack, or prolonged bleeding.

An astonishing 88 percent said they believed that the procedure would help protect them from having a heart attack down the road, according to a news release. It is widely believed that people think of the procedure that uses a small, wire-tipped balloon to enlarge a cholesterol-choked arteries, as a cure; however, according to the study, it is not. Although angioplasty can ease chest pain brought about by stress or physical activity, it does not address atherosclerosis.

Timely angioplasty can limit damage to the heart and can prevent a heart attack from turning into a deadly cardiac arrest. In the throes of a heart attack, the benefits of angioplasty outweigh the risk. But in cases of infrequent angina or in instances when a narrowed coronary artery isn't causing major health troubles, angioplasty adds little or nothing to intensive medical therapy and lifestyle changes, according to the study.

To read the full article, "What can angioplasty do for you?" go to health.harvard.edu/newsletters/Harvard_Heart_Letter/2010/December/what-can-angioplasty-do-for-you?utm_source=heart&utm_medium=pressrelease&utm_campaign=heart1210.


Xylishield

Ultradent Products' Xylishield is the perfect addition to the take-home hygiene routine for patients. The product comes in the form of gum, mints, mouthrinse, and toothpaste. Each contains high levels of xylitol, an all-natural sweetener that helps to protect teeth from cavity-causing bacteria. For more information, contact Ultradent's customer service at (800) 552-5212.

## UPCOMING MEETINGS

**2011**

| | |
|---|---|
| April 7–10 | California Society of Pediatric Dentistry 36th annual Session/Western Society of Pediatric Dentistry ninth annual session, San Francisco, 831-625-2773, drrstewart@aol.com. |
| April 10–16 | United States Dental Tennis Association, Tampa, Fla., dentaltennis.org. |
| May 12–14 | *CDA Presents* the Art and Science of Dentistry, Anaheim, 800-CDA-SMILE (232-7645), cdapresents.com. |
| June 16–18 | ADA New Dentist Conference, Chicago, (800) 621-8099, ext. 2779, ada.org/goto/newdent. |
| Sept. 22–24 | *CDA Presents* the Art and Science of Dentistry, San Francisco, 800-CDA-SMILE (232-7645), cdapresents.com. |
| Nov. 6–12 | United States Dental Tennis Association, Palm Desert, Calif., dentaltennis.org. |

*To have an event included on this list of nonprofit association continuing education meetings, please send the information to Upcoming Meetings, CDA Journal, 1201 K St., 16th Floor, Sacramento, CA 95814 or fax the information to 916-554-5962.*

Periscope offers synopses of current findings in dental research, technology, and related fields.

## PERIODONTICS

GERALD I. DRURY, DDS

### Dental Plaque and Gastric *H. Pylori* Infection

**Jia CL, Jiang GS, et al, Effect of dental plaque control on infection of *helicobacter pylori* in gastric mucosa. *J Periodontol* 80(10):1606-9, 2009.**

**BACKGROUND:** The aim of this study was to evaluate the potential relationship between dental plaque control and gastric *H. pylori* infection.

**METHODS:** Patients with gastritis or a peptic ulcer were recruited and submitted to a C urea breath test to determine their gastric *H. pylori* status. The following parameters were assessed in the oral examinations: GI, PD, CAL, BOP, suppuration (SUP), and oral hygiene status. The urea breath test was used to confirm that *H. pylori* had been eradicated from all subjects' gastric mucosa after their systemic anti-*H. pylori* treatments. One-hundred and ten (110) subjects were divided into two groups: 59 subjects received dental plaque control (test group), and 51 subjects did not receive dental plaque control (control group). The test group was brought to a healthy periodontal state by SRP. Home care for the subjects in the test group included brushing three times a day and the use of a mouthrinse twice a day. A dental examination was performed every other week in both groups. At six months, all patients received the C urea breath test to detect the prevalence of *H. pylori* in gastric mucosa. The prevalence of *H. pylori* in gastric mucosa was evaluated by the x2 test; any difference of $P < 0.05$ was considered statistically significant. Three patients from the test group were excluded due to poor compliance. At six months, the C urea breath test showed that 11 of 56 patients in the test group were positive for *H. pylori* (19.64 percent). Forty-three of 51 subjects in the control group had *H. pylori* infection (84.31 percent). The prevalence of gastric *H. pylori* infection in the test group was significantly lower than that of the control group ($P<0.05$).

**CONCLUSIONS:** The authors concluded that long-term professional plaque control was associated with lower gastric reinfection by *H. pylori*, and that it is necessary to control dental plaque in the treatment and prevention of *H. pylori*-associated gastric diseases.

**BOTTOM LINE:** Plaque control might improve *H. pylori* gastric diseases.

## ORAL AND MAXILLOFACIAL SURGERY

D.D.R. YAMASHITA, DDS

### Third Molars and Periodontal Health

**Moss K, Oh E, et al, Third molars and periodontal pathologic findings in middle-age and older Americans. *J Oral Maxillofacial Surg* 67(12):2592-8, December 2009.**

**AIM:** To determine whether the presence of clinically visible third molars is a predictor of the periodontal health of the other teeth in the same patient.

**METHODS:** 6,793 patients (2,035 who possessed at least one clinically visible third molar), from four different centers were subjected to oral examination which included periodontal probing and calculation of CAL.

**RESULTS:** Significant differences in CAL and periodontal probing depth in the first and second molars were found in the visible third molar and nonvisible third molar groups. The percentage of patients with periodontal probing depths of 4 or more (in molar teeth) in the visible third molar group was 17.94, and, in the group without visible third molars, the percentage was 15.28. The probing depths in premolar and anterior teeth were not significantly different in the two groups.

**CONCLUSIONS:** The presence of visible third molars is a negative predictor for the periodontal condition of first and second molar teeth.

**CLINICAL RELEVANCE:** Clinicians have long observed that the third molar tooth is prone to periodontal disease, pericoronitis, and caries. This is most likely due to a combination of the difficulty of cleaning and unfavorable relationship with pericoronal soft and hard tissue. This study provides evidence that the presence of visible third molars has a measurable effect on the CAL/probing depths of the other molar teeth. Patients should be well-informed when considering extraction, including all the potential risks and benefits of the procedure, a potential benefit being decreased risk of increased CAL in other molar teeth.

CDA JOURNAL, VOL 39, Nº2

TECHNOLOGY

JIN-HO PHARK, DDS, DR.MED.DENT.

## Efficacy of Resin Infiltration

**Paris S, Hopfenmuller W, Meyer-Lueckel H, Resin infiltration of caries lesions: an efficacy randomized trial. *J Dent Res* 89(8):823-6, 2010.**

**AIM:** The purpose of this clinical study was to assess whether infiltration of proximal caries lesions with a special resin is more efficacious than nonoperative measures alone with respect to the inhibition of caries progressions.

**METHODS:** Twenty-two young adults with 29 pairs of interproximal caries lesions with radiological extension into the inner half of enamel or the outer third of dentin were enrolled in this randomized split-mouth placebo-controlled clinical trial. From each pair, one lesion was randomly assigned to a test and one to a control group. The test group received treatment with resin infiltration (Icon pre-product, DMG, Hamburg, Germany) and the control group was treated with a placebo (water). Patients received fluoridation, oral hygiene, and dietary instructions. The primary outcome after 18 months was radiographic lesion progression (assessed by digital subtraction radiography).

**RESULTS:** No adverse effects were observed. After 18 months, significantly less lesions (p=0.021) had progressed in the resin infiltrated test group (2 out of 27 lesions (7 percent)) in comparison to the control group (10 out of 27 lesions (37 percent)).

**CONCLUSIONS:** This study supports that infiltration of interproximal caries lesions is efficacious in reducing lesion progression.

**CLINICAL RELEVANCE:** Resin infiltration is a noninvasive approach to arrest progression of caries lesions. For this purpose the carious lesion is etched with a 15 percent HCl gel, followed by infiltration with a special resin. Application of this treatment can prevent or delay invasive treatment in permanent teeth.

IMAGING

SOTIRIOS TETRADIS, DDS, PHD, AND
SANJAY M. MALLYA, BDS, MDS, PHD

## Vertical Root Fracture Detection

**Hassan B, Metska ME, et al, Detection of vertical root fractures in endodontically treated teeth by a cone beam computed tomography scan. *J Endod* 35(5):719-22, 2009.**

**THE CLINICAL PROBLEM:** Vertical root fractures often pose a diagnostic challenge. Clinical features are often nonspecific. Because of their inherent two-dimensional nature, periapical radiographs are of limited value to demonstrate the presence of these fractures. Detection of these fractures is crucial to the prognosis and treatment options.

**AIM:** This study compared the accuracy of cone beam computed tomography (CBCT) scans versus periapical radiographs to detect vertical root fractures. The study also examined whether the presence of radiopaque root canal filling material would alter the accuracy.

**METHOD:** Forty premolars and 40 molars were endodontically prepared, manually fractured or left undisturbed and divided into four groups. Group 1: no root canal filling and no vertical fracture; group 2: no root canal filling plus vertical root fracture; group 3: root canal obturated and no vertical fracture; group 4: root canal obturated plus vertical root fracture. Teeth were imaged by CBCT at a voxel size of 0.25 mm and by periapical radiography using storage phosphor plates. Four observers, who were blinded to the status of root fracture, scored images.

**RESULTS:** Sensitivity of CBCT for vertical root fracture detection was significantly higher than that of panoramic radiographs (79 percent versus 37 percent, respectively). Both techniques had a high specificity (92.5 percent and 95 percent, respectively). Overall, CBCT was more accurate than periapical radiographs for detection of vertical root fractures (86 percent versus 66 percent). Interestingly, the presence of radiopaque root canal filling material (which causes artifacts on CBCT images) did not significantly decrease the accuracy of CBCT. In contrast, the presence of the radiopaque root canal filling further decreased the accuracy of periapical radiographs, with more false negative results.

**CONCLUSIONS:** CBCT is more accurate than periapical radiographs for detection of vertical root fractures.

**BOTTOM LINE:** When clinical indications suggest the possibility of a vertical root fracture, the dentist should consider requesting a high-resolution CBCT scan.

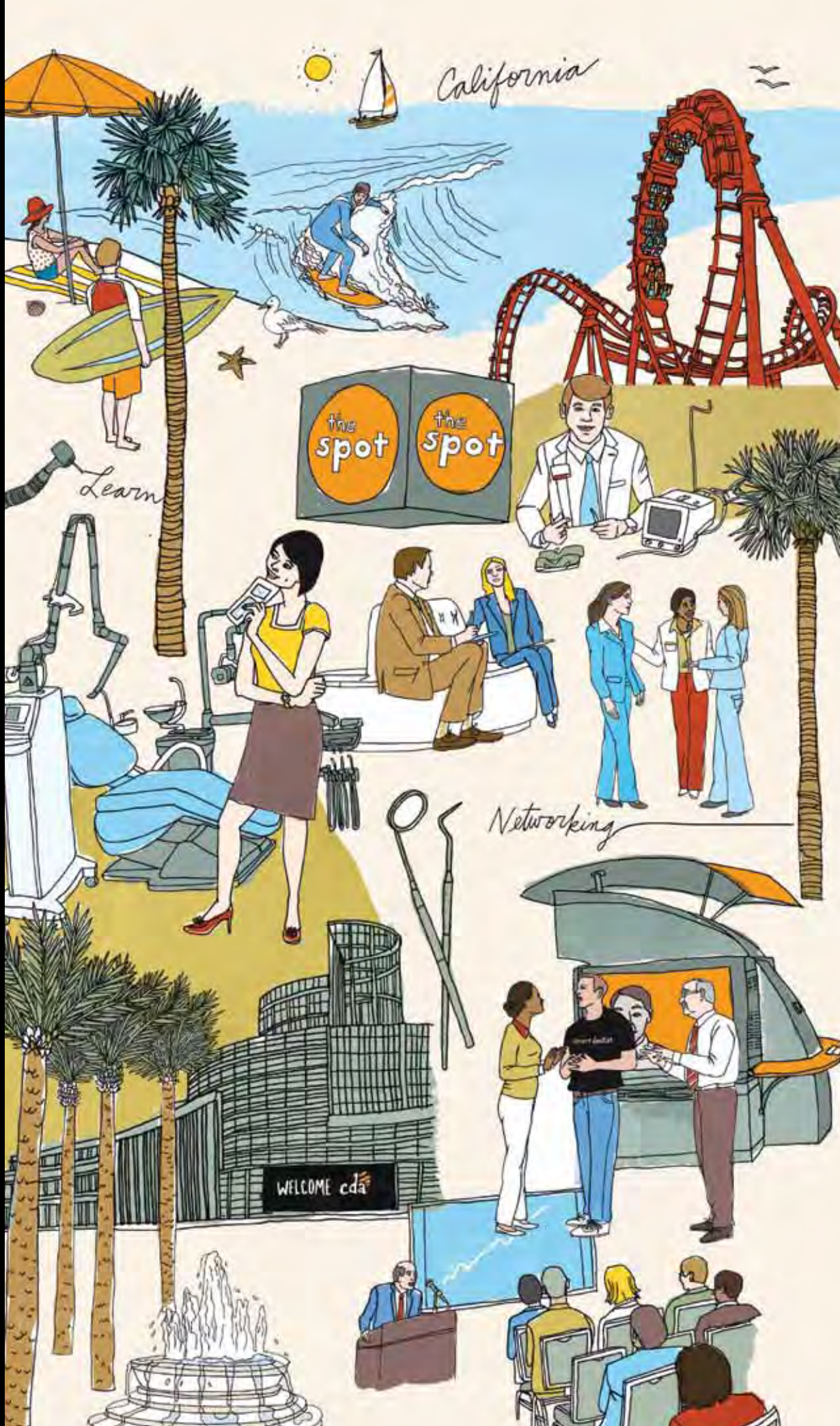
cda PRESENTS

# The Art and Science of Dentistry

## Anaheim, California

May 12-14, 2011

**New days:** Thursday-Saturday



# HEADLINING SPEAKERS

## Newton Fahl, DDS

### Cosmetic Dentistry

Mastering Anterior Composite Restorations ..... Thursday lecture

Class IV and Direct Veneer — Solving Challenges With Composites ..... Friday workshop

## Pascal Magne, DMD, PhD

### Cosmetic Dentistry

Bonded Restorations in the Posterior Dentition: Evidence-Based Clinical Approach..... Saturday lecture

## Joseph J. Massad, DDS

### Removable Prosthodontics

Dentures and Implants in Today's Dental Practice ..... Thursday lecture

The Ultimate Prosthetic and Implant Impressioning Experience..... Friday workshop

## Clifford J. Ruddle, DDS

### Endodontics

Creating Endodontic Excellence..... Friday lecture,

ProTaper Shaping and Cleaning Workshop..... Saturday workshop

## David S. Hornbrook, DDS, FAACD

### Restorative Dentistry

Hot Topics in Esthetic and Restorative Dentistry..... Friday lecture

## Jon B. Suzuki, DDS, PhD, MBA

### Periodontics

Clinical Contemporary Periodontics, Part I — Diagnosis and Treatment Planning..... Friday morning lecture

Clinical Contemporary Periodontics, Part II — Periodontal and Implant Therapy..... Friday afternoon lecture

Ridge Preservation for Esthetics, Prosthetics and Implant Placement..... Saturday workshop

## Douglas L. Lambert, DDS, FACD, FASDA, FASD, ABAD

### Esthetic Dentistry

Smile Design: Something Old, Something New, Something Borrowed and Something RED?..... Thursday morning lecture

Less Is More — Practical Concepts for Changing Times..... Thursday afternoon lecture

Addition by Subtraction — Conservative Veneer Preparation Works ..... Friday morning workshop

Basic Solutions to Acidic Problems — Restoring the Erosion Patient with Composite Resins..... Friday afternoon workshop

## Olya Zahrebelny, DDS

### Insurance

Maximizing Patient Dental Benefits..... Friday morning lecture

An Introduction to Medical Billing in the General Dental Practice ..... Friday afternoon and Saturday morning lecture

Correctly Completing the Medical Claim Form CMS-1500 (08-05) ..... Saturday afternoon workshop

## Derek Mahony, BDS

### Orthodontics

Patients' Nasal Breathing Problems and How This May Influence Dental Crowding and Facial Morphology..... Thursday morning lecture

The Truly Invisible Aligner Alternative (Social 6 Technique) ..... Thursday afternoon lecture

How to Diagnose and Treat Impacted Canines, Plus Tips to Prevent Canine Impaction ..... Friday morning lecture

Correction of Common Oral Habits in Young Children To Prevent Orthodontic Problems ..... Friday afternoon lecture

**Visit cdapresents.com for more program information.**

*CDA Presents* will feature more than 550 exhibiting companies showcasing the latest in dental technology, products and services. Stay ahead of the curve by exploring the innovative new products being launched in the exhibit hall.

## Please note new days:

**Thursday–Saturday,**
**May 12–14, 2011**

### Grand Opening

**Thursday, 9:30 a.m.**

### New Exhibit Hall Days and Hours

**Thursday, May 12, 9:30 a.m.–5:30 p.m.**
**Friday, May 13, 9:30 a.m.–6 p.m.**
**Saturday, May 14, 9:30 a.m.–4:30 p.m.**

### Family Hours

**Daily, 9:30 a.m.–noon**

## Visit cdapresents.com to maximize your tradeshow experience.

## Registration/Ticket Sales/ Tote Bag and Lanyard Pickup

**Anaheim Convention Center**

Thursday, 6:30 a.m.–5:30 p.m.
Friday, 6:30 a.m.– 6 p.m.
Saturday, 6:30 a.m.–4:30 p.m.

## Bag and Lanyard Pickup

**Hilton Anaheim Hotel**

Thursday, 7 a.m.–3 p.m.
Friday, 7 a.m.–3 p.m.
Saturday, 8 a.m.–noon

## Programs

**Anaheim Convention Center and Hilton Anaheim Hotel**

Express Lectures Thursday, various times

Lectures/Workshops Thursday–Saturday, various times

## Table Clinics

**Anaheim Convention Center**

Public Viewing Friday, noon–2 p.m.
Dental Student
Dental Hygiene Student
Dental Assisting Student

Public Viewing Saturday, noon–2 p.m.
Military
Resident

## Exhibit Information — Anaheim Convention Center

**Grand Opening of the Exhibit Hall**

Thursday, 9:30 a.m.

**Exhibit Hall Hours**

Thursday, 9:30 a.m.–5:30 p.m.
Friday, 9:30 a.m.– 6 p.m.
Saturday, 9:30 a.m.–4:30 p.m.

**Family Hours**

Daily, 9:30 a.m.–noon

**Kid Zone Hours**

Thursday, 9:30 a.m.–5:30 p.m.
Friday, 9:30 a.m.–6 p.m.
Saturday, 9:30 a.m.–4:30 p.m.

## Special Events

**Hilton Anaheim Hotel**

Child Care
Thursday and Friday, 7 a.m.– 6 p.m.
Saturday, 7 a.m.– 4:30 p.m.

**CDA Beach Party**

Friday, May 13, 7–10 p.m.
Arena Plaza, Anaheim Convention Center
All attendees invited, ticket required

**Register online at cdapresents.com.**

## Prepaid Early Bird Parking

To make your parking experience easier, CDA is offering the opportunity to purchase parking vouchers in advance for the Anaheim Convention Center. Tickets will also be available at on-site registration for next day(s) use only. If you arrive by 8:30 a.m., this will guarantee a parking space with the added convenience of not worrying about having cash on hand. Purchase the tickets along with your registration.

The following conditions apply:

- Tickets are $12 per day and are available for Thursday, Friday and Saturday.
- Arrive by 8:30 a.m. — prepaid parking spaces will not be honored after that time.
- Parking passes are nonrefundable. Refunds cannot be given for lost or forgotten passes.
- Original passes must be used.
- Passes must be surrendered upon entry to the lot.
- Passes are only valid at the Anaheim Convention Center. They cannot be used at off-site parking or Disney lots.

## Traffic and Parking Recommendations

If you are driving to the Convention Center, traffic is anticipated to be heaviest on Thursday and Friday mornings. To minimize any inconvenience, early arrival is strongly recommended. The peak traffic and parking time is projected to be from 8 to 11 a.m. Please watch the traffic control signs as you exit the freeway for the most updated parking information.

## Off-Site Parking

CDA is working to secure off-site parking near the freeway exits with complimentary shuttle service to the Anaheim Convention Center. Due to scheduling of events at these venues, this can only be confirmed within a few weeks of our meeting. Please watch for additional information in your badge mailing, attendee e-mails or visit us at cdapresents.com for updated instructions the week prior to the meeting. The morning of, traffic signage will also provide direction.

## Prepaid Food Vouchers

Treat your staff to lunch with vouchers for the Anaheim Convention Center concession areas. Available in increments of $10, vouchers allow a prepaid, hassle-free option to grab something quick or sit down and enjoy a meal with your team while attending the exhibit hall or between C.E. courses. Menu options include specialty coffee and breakfast items, Grab 'n' Go for lunch, Mexican taqueria, made-to-order sandwiches, All American Grill, barbecue, rice bowl and pizza. Exact locations and food selections will be included in your registration packet and on cdapresents.com. These vouchers are nonrefundable and must be used for amount shown. Change cannot be given if purchase is less than $10.

## Purchasing Vouchers

Purchase prepaid food and parking vouchers when you register online at cdapresents.com or by submitting the advance registration form.

## Prepaid Parking Voucher

**Fee:** $12

**Event #:** 059 Thursday
060 Friday
061 Saturday

## Prepaid Food Voucher

**Fee:** $10

**Event #:** 062

CDA JOURNAL, VOL 39, Nº2

# A FORUM

In this issue, the *Journal* acts as a forum for three distinct voices in the controversy surrounding the issue of barriers to oral health care in the United States.

KERRY K. CARNEY, DDS

Dr. Neil Croucher has worked as a public health dentist since qualifying at Guy's Hospital Dental School, London in 1986. For 16 years he worked as a special care dentist in the south of England. In 2003, Dr. Croucher emigrated to New Zealand to become clinical director of Dental Services, Northland District Health Board (NDHB) where he is responsible for the quality of clinical services delivered by the primary and secondary public dental services. He also fulfills the role of oral health adviser to NDHB. In the summer of 2010, Dr. Croucher addressed the CDA Workforce Taskforce and became a valuable resource for information on the New Zealand dental therapist model.

Dr. James Crall has a long and illustrious academic career. He is a board-certified pediatric dentist and earned a doctorate in health policy and management from the Harvard School of Public Health. For the past 15 years, he has been actively involved in national, state, and professional oral health policy development, and has served as an adviser for numerous organizations including the American Academy of Pediatric Dentistry, American Academy of Pediatrics, American Dental Association, National Committee on Quality Assurance, Pew Health Professions Commission, Robert Wood Johnson Foundation, U.S. Department of Health and Human Services and U.S. General Accounting Office. In the summer of 2010, Dr. Crall addressed the CDA Workforce Taskforce and became a valuable resource for information on regional efforts that have been effective in addressing barriers to care.

Dr. Paul Casamassimo is professor and chair of the Division of Pediatric Dentistry at the Ohio State University College of Dentistry and chief of Dentistry, Department of Dentistry, Nationwide Children's Hospital. He is a board-certified pediatric dentist, past president of the AAPD and has devoted his career to care of exceptional children and adults for the past 30 years. Dr. Casamassimo practices as a hospitalist at Columbus Children's Hospital where he served as president of the medical staff in 1999. He has authored or edited more than 300 publications in the areas of pediatric dentistry, care of children with special health care needs, dental education, and oral health disparity. He is a nationally recognized voice questioning the validity of the dental therapist model to improve access to care for children in the United States.

Our final article presents an overview of how the CDA Foundation programs and projects have been addressing some of the many variables that contribute to barriers to oral health care in California.

Implant Direct®
simply smarter.
Sybron Dental Specialties

www.implantdirect.com
Implant Direct Sybron International
1-818-444-3333 • 1-888-NIZNICK

AOA · Axis · Kerr · TotalCare · Attachments International · Implant Direct Sybron Int'l · Metrex · SybronEndo · Ormco · Orascoptic
a DANAHER company

## Legacy™3 All-in-1 Packaging

INCLUDES: Cover Screw, Healing Collar, Transfer and Straight Preparable Abutment. Surgically and Prosthetically Compatible with Zimmer's Tapered Screw-Vent®

Legacy3 USA price = $175

*Tapered Screw-Vent USA price = $584

* Includes similar components provided with Legacy3 Implant

**INTRODUCTORY LEGACY OFFER**

Try a 13mmL Legacy1, Legacy2 and Legacy3 implant at no charge with purchase of required instruments

US List Price for 3 Implants Abutments and Prosthetic Components

Legacy = $620

Zimmer Dental = $1797

**FREE Introductory Offers at www.implantdirect.com**

Terms and Conditions Apply

## Three Implant Designs and Packaging Options

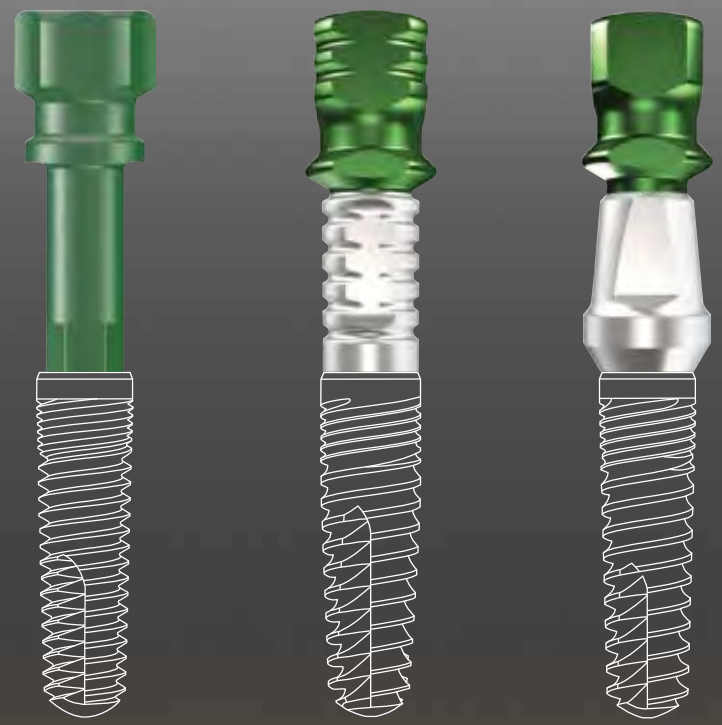
**Original Conical Connection (GNiznick US Pat.#4,960,381)**

**Implants include Cover Screw and Healing Collar**

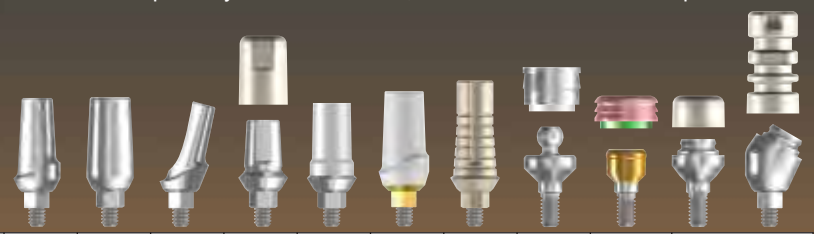
**Select Implant based on Price, Packaging and Thread Design**

**Legacy1: $125 Original "V" Thread with Plastic Carrier**
**Legacy2: $150 includes Temporary Abutment/Transfer**
**Legacy3: $175 includes Preparable Abutment/Transfer**

| Legacy1 | Legacy2 | Legacy3 |
|---|---|---|
| Standard "V" Threads Matches Screw-Vent | Spiral Threads for Increased Stability | Buttress Threads for Increased Surface |



Prosthetic compatibility with Screw-Vent, BioHorizons® and MIS Implants



| Compare US List Price | Straight Contoured | HLA Abutment | 15° Angled Contoured | Straight Snap-On | Gold/ Plastic | Zirconia Abutment | Plastic Temporary Abutment | Ball Attachment | GPS™ Attachment | Multiple-Unit w / Cap & Transfer Straight | Angled |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Implant Direct | $85 | $75 | $85 | $85 | $100 | $120 | $35 | $107 | $100 | $85 | $100 |
| Zimmer Dental | $158 | $152 | $179 | $203 | $180 | $232 | $52 | $168 | $166 | $167 | N/A |
| Cost Savings | 46% | 51% | 53% | 58% | 44% | 48% | 33% | 36% | 40% | 49% | N/A |

List prices as of April 2010

Screw-Vent® is a registered trademark of Zimmer Dental

CDA JOURNAL, VOL 39, Nº2

# A Letter From New Zealand: Improving Access to High Quality Dental Services for All Children

NEIL CROUCHER, BDS, MCCDRCPS, DMS, FICD

**ABSTRACT** As a career-long public health dentist spanning 25 years, I have had the privilege of working in two very different service delivery models providing dental care for children in the United Kingdom and New Zealand. Neither model is perfect, but what is clear is that the facilities and workforce model that does exist in a country can have a profound impact on which children end up accessing that care and which children do not.

AUTHOR

**Neil Croucher, BDS, MCCDRCPS, DMS, FICD,** is the oral health adviser to the Northland District Health Board in New Zealand.

The United Kingdom has prided itself in free medical and dental care for children since the National Health Service's (NHS) conception in 1948. There are two main service delivery models in the United Kingdom within which primary care dentists work. The largest workforce group are the 32,000 general dentists working in their own private practices. All general dentists in the private sector have the option, as independent contractors, to sign up to become a provider of free NHS dental care for children and subsidized dental care for adults. The other service model is the publicly funded community dental service (CDS), employing nationwide about 1,600 salaried general and specialist dentists. The CDS provides a full-range of dental services to children and adults with special needs, including those who may find it difficult to access care within a private dental practice. The CDS is mainly delivered out of dental clinics located close to or within primary medical and health services and other central community settings.

Two years prior to March 2010, 69.9 percent (7,694,000 children) of the child population aged newborn-17 years received free NHS dental care, either by general dentists in private practice or by general and specialist pediatric dentists within the CDS.[1] It is my understanding that in the United Kingdom, very few specialist pediatric dentists provide care under the NHS dental contract, rather, working in either specialist private fee-paying practice or as salaried employees in the hospital and community dental services.

Most private dentists locate their dental practices in areas where there is sufficient economic affluence and patient support base to run their businesses and make a reasonable living. Community dental services in the United Kingdom, on

the other hand, tend to have their clinics located in areas of higher social economic deprivation, and hence capture a higher proportion of children from more socially and economically deprived communities. By having two different but complementary service delivery and facility models, there is opportunity for most families and children to access free dental care in a variety of different ways through a private dental practice or community dental clinic. A 69.9 percent child utilization rate for a publicly funded dental service isn't too bad, and I feel a reasonable assumption can be made that due to these two complementary service models facilities working together, children from both affluent and poorer communities are accessing care. Of course, the missing 30 percent who did not receive an examination under the free NHS dental system in the last two years need to be found, although some, of course, will be going to private fee-paying dental practices.

One of the CDS' strengths is that 42 percent of the 1,600 dentist workforce has a specialist and/or postgraduate qualifications in one or more of the dental specialities.[2] With the first 16 years of my career spent in the CDS, I can personally testify that this experienced and highly specialized clinical team is able to provide very high quality pediatric care to its client group. Overall, however, the CDS sees a relatively small minority of the whole-child population, perhaps no more than 10 percent. The remaining primarily access care with general dentists in private dental practices, and the bonus in doing so is that general dentists can also offer subsidized NHS dental care to the parents of those children, hence, allowing the whole family to visit the dentist together.

At a recent conference I attended, Monty Duggal, a pediatric dental professor from Leeds University Dental School in the United Kingdom, said that the restorative care index for 5-year-old children in some areas of the United Kingdom is currently only 12 percent. The restorative care index is the proportion of teeth with caries experience that have been filled, derived by taking the number of filled teeth and dividing by the total number of dentinally decayed ($D_3$), missing (M) and filled (F) teeth and converting to a percentage ($FT/D_3MFT$). Looking at the latest NHS oral health surveys of 5- and 12-year-old children, the respective restorative care indices was 14 percent for 5 year olds and 47 percent for 12 year olds.[3,4] Also at the time of examination, 2.3 percent of 5 year olds and 3.4 percent of 12 year olds were actually experiencing acute sepsis. That means there is a lot of decay that has either not been treated yet or has been left untreated. There is, of course, a school of thought that is promoting a noninterventional and preventive approach for the treatment of dentinal caries in deciduous teeth.[5] However, it is my belief and experience that this noninterventional approach, in its purest form, is bordering on being unethical, and would significantly increase the numbers of children experiencing toothaches and acute and chronic sepsis in any given population. This then becomes a "quality of life" issue for each individual child who develops pain or sepsis, and, in the more severe cases, a few children will end up being admitted to hospital for treatment of a severe and debilitating acute infection.

**DUE TO THESE TWO** complementary service models facilities working together, children from both affluent and poorer communities are accessing care.

My experiences in the United Kingdom have made me ask the question on several occasions as to whether general dentists can consistently provide high quality pediatric dental services to all children. Most general dentists are excellent at treating adults and adolescents, but when it comes to children, we all know it is not necessarily the complexity of the care required that is the problem. More so, the necessity for dental clinicians to have the full range of behavioral management and sedation skill sets, coupled with some understanding of child development and psychology, that allows dental treatment to become a possibility for the more difficult and challenging children. Whether in the United Kingdom the very low restorative care index is due to a noninterventional approach to the treatment of dental caries in deciduous teeth or due to the lack of the more higher level pediatric skill sets, I don't know, but clearly while the utilization rate of 69.9 percent is reasonable, the treatment outcomes in terms of the current restorative care index of this service model could, in my opinion, be significantly improved.

New Zealand also has a long, proud history of public dental service provision for children, this time since 1921. New Zealand's model has been quite different, but is like the United Kingdom attempts to provide universal access to dental and preventive care to all enrolled schoolchildren aged 0-17. The care for the 0-12-year-old age group is almost exclusively provided by dental therapists at the schools where these children are attending. Dental care for the 13-to-17-year-old age group is primarily provided by contracting general dentists

in a private practice setting with dental therapists and dentists in school dental services complementing and improving access as and where capacity allows.

For the last 90 years, school dental clinics have been based within the school grounds of most primary schools. However in the last six or seven years, a "Hub and Spoke" facility model has emerged in some areas, made up of new modern community dental clinics (hubs) supported by a fleet of new mobile dental clinics (spokes). Some of the "hub" clinics are based in large schools but others have been built in strategically placed locations near health centers and town centers. Meanwhile the new state-of-the-art dental mobile units (the spokes) are providing diagnostic and/or treatment services at schools and preschool settings in the more rural communities. At the same time, there has been a greater emphasis on the New Zealand School Dental Service enrolling and examining preschoolers from birth. This has facilitated earlier detection of enamel decalcification and early dentinal caries in preschoolers, allowing opportunities for appropriate and timely preventive interventions such as fluoride varnish applications and the opportunistic delivery of oral health education to the caregivers and families. This more recent focus on preschoolers in New Zealand can only be a good thing.

There is no doubt in my mind that the New Zealand dental facility and service model eliminates almost all the physical and financial barriers that exist to children accessing dental care. Under this model, nearly all children are receiving high quality dental and preventive care, irrespective of their family's or their community's social economic status or circumstances. This is backed up by the recently released New Zealand 2009 Oral Health Survey, which shows the proportion of children who had visited a dental professional in the last year was highest among children aged 5–11 (90.3 percent).[6] The proportion was lower among 12-17-year-olds (79.9 percent) and lowest for preschool children aged 2-4 (59.7 percent). These figures show very good utilization rates, especially in the 5-to-11-year-old age group who almost exclusively receive care from dental therapists within the school based fixed and mobile dental clinics. The same survey shows that 1 in 6 (17.3 percent) 5-to-11-year-olds had untreated coronal decay in at least one primary tooth and only a very small proportion (2.7 percent) had untreated coronal decay in one or more permanent teeth. In the 12-17-age group, about 12.7 percent had untreated coronal decay on at least one permanent tooth.

**THE NEW ZEALAND** dental facility and service model eliminates almost all the physical and financial barriers that exist to children accessing dental care.

Whilst the detailed database from the New Zealand 2009 Oral Health Survey is not accessible yet, the exact restorative care indices cannot be calculated as a comparison with the United Kingdom figures. However one can make a reasonable assumption that if only 17.3 percent of 5-to-11-year-old New Zealand children have one or more untreated coronal dentinal lesions, that in fact the majority of children that have experienced caries in the past have accessed care and are now enjoying a restored and functional dentition.

There are about 550 registered dental therapists in New Zealand. Training programs for dental therapy have recently changed from a two-year diploma course to a three-year combined dental therapy/hygiene degree course, which has moved the focus of dental therapy away from a mainly restorative/operative training program to a dental training program firmly grounded on the principles of evidence-based dentistry, preventive strategies, and sound research. Also the combined dental therapy/hygiene degree means that new graduates can now fulfill a number of roles in the dental sector, perhaps working as hygienists in private practice for two or three days a week, and the rest of the week as a public sector dental therapist. Graduate numbers have doubled in the last five years from about 30 annually to 60, which is currently supplying the existing demand for both dental therapy and hygiene in both the private and public sectors within New Zealand.

New Zealand dental therapists since 2004 have been able to register as dental professionals with the Dental Council of New Zealand and are slowly evolving and promoting the profession of dental therapy in a very responsible and professional manner. New Zealand dental therapists are highly experienced and competent at delivering high quality basic dental care to children, their behavioral management techniques of children are exemplary, and, at times, I stand in awe at the skill sets the more experienced dental therapists have developed over the years. Dental therapists can examine, diagnose, and treatment plan independently within their scope of practice and must have a professional relationship with a named dentist for access to timely advice and clinical support. They have a defined "scope of practice," which allows

them to perform all basic pediatric dental and preventive care other than pulpectomies, the treatment of trauma-related injuries and permanent teeth root canals and extractions.[7] They are not authorized to prescribe any form of sedation and so any dental care required outside the scope of practice of a New Zealand dental therapists is referred to either community dentists in nearby community dental clinics or private dentists holding a public dental service contract for children's care. This equates to only about 10 percent of children each year requiring referral to a dentist for more complex care, or put it another way, 90 percent of pediatric dental care is provided by dental therapists to children in New Zealand at or near where that child goes to school or lives.[8]

I have observed barriers to accessing dental care quickly surfacing for some children from more deprived socioeconomic and rural areas who have been referred to a dentist for more complex care. The reality is many of these children just don't make it to the dentist due to travel difficulties or the inability to afford the financial costs of getting there. In some areas this problem is being addressed by the employment of dentists working out of the new modern community dental clinics. Another weakness of the New Zealand system may well be the fact that, while children mostly receive care at their own schools, the parents of those children have to access care elsewhere within a private dental practice model. This does not embrace the desirable concept of the whole family going to receive dental care together.

But what would you rather have, a service delivery model that reaches more than 90 percent of New Zealand children or a service delivery model that means only children who can access a private dental practice model will benefit?

The New Zealand dental therapists' approach to treatment planning is highly preventive with fissure sealants and fluoride varnish applications being applied across the board to children with moderate to high caries risk. Active dentinal caries is generally treated either by extraction, fillings, or stainless-steel crowns. This means that most children, while having high numbers of filled or missing teeth, do have very little untreated decay and, hence, enjoy the status of having functional, pain- and sepsis-free aesthetic dentitions. This level of dental fitness I believe contributes to the children's ability to function and learn well at school and at home, exhibit more self-confidence, have happy smiles, and an ability to eat and speak well.

**WHILE CHILDREN MOSTLY** receive care at their own schools, the parents of those children have to access care elsewhere within a private dental practice model.

It is only recently that New Zealand has started to measure the decayed component of the decayed (d or D), missing (m or M) and filled (f or F) teeth indices ("dmf" for deciduous teeth and "DMF" for permanent teeth), because historically, the New Zealand school dental service has consistently converted most decayed surfaces to a missing or filled surface. For those who may think New Zealand child oral health services might be overtreating, I would like to reassure the reader that there are many inactive carious lesions that are not restored and/or active lesions that are treated preventively or just left because the tooth is close to exfoliation. That aside, I would like to ask the question at this point, what statistics would you like to see in your child population? A restorative care index that might be close to 75 percent for an average 5-year-old child in New Zealand or 14 percent in the United Kingdom?

Program costs for these two different models from the New Zealand and the United Kingdom would vary enormously. However, what can probably be assured is that the New Zealand model in regard to workforce is probably significantly less expensive. Dental therapists in New Zealand earn (all converted to U.S. figures) between $30,000 and $45,000 per annum; a community dentist's salary in New Zealand is between $75,000 to $120,000 per annum; and most private dentists in New Zealand earn about $120,000 and $150,000 per annum. With 90 percent of basic pediatric dental care for 0-to-12-year-old children being provided by dental therapists, it is clear this workforce model is more cost effective than a dentist-only workforce model.

The service and delivery models for dental care to children in California are not well-known to me. I believe currently 75 percent of children are accessing high quality pediatric dental care within a private dentist practice model, with some of those children eligible for subsidized care at those same facilities. If 75 percent of the population is receiving the care they need, and, if that care is being delivered by experienced pediatric dentists and specialists, that is great news.

But what about the 25 percent who aren't accessing care at the moment? It is well-known that there is a very close correlation between the dental decay prevalence and severity in a commu-

nity and the deprivation status of that community. Lifestyle factors have been shown to have a significant bearing on general well-being and health, include warm and dry housing, income, social and occupational class, employment and educational achievement.[9] The close relationship between socioeconomic status, ethnicity and health needs is particularly well-documented within New Zealand and elsewhere.[10-12] It would be my prediction, therefore, that the majority of these 25 percent of children in California not accessing dental care are probably living in areas of either urban or rural social economic deprivation.

There is a global search going on and the final solution probably lies in a hybrid solution, by taking the best ideas and solutions offered up and adapting them to suit the California demographics and deprivation mapping. Whatever the model that is finally decided upon, I would suggest that the following principles should underpin that final model:

- In areas of high deprivation and high dental needs, take the service delivery model close to where these children live or go to school.
- Engage or train a dental workforce that have proven and specific pediatric skill sets.
- Make the service free at the point of delivery of that care. ■■■■

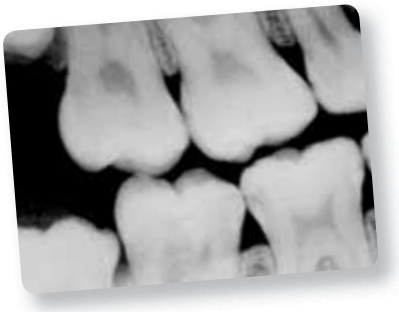

**REFERENCES**

1. NHS Dental Statistics for England, quarter 3. Dec. 31, 2009, report. The Dental and Eye Care Team. NHS Health and Social Information Centre.
2. Blinkhorn FA, Blinkhorn AS, Tickle M, A profile of the dentists working in the community dental service in the United Kingdom in 1999. *Br Dent J* 190, 266-8.
3. NHS Dental Epidemiology Programme for England Oral Health Survey of 5-year-old Children 2007/2008. NHS Health and Social Information Centre.
4. NHS Dental Epidemiology Programme for England Oral Health Survey of 12-year-old Children 2008/2009. NHS Health and Social Information Centre.
5. Levinne RS, Pitts NB, Nugent ZJ, What happens to unrestored carious deciduous teeth? *Br Dent J* 93:99-103, 2002.
6. Our Oral Health: key findings of the 2009 New Zealand Oral Health Survey. Ministry Of Health, Wellington, New Zealand.
7. Dental Council of New Zealand. Notice of scopes of practice and prescribed qualifications for Dental Therapists. Wellington, Dental Council of New Zealand, 2004.
8. Croucher N, Ackermann J, Bridging the gap: A dental access initiative for Northland children. *N Z Dent J* 102(1):10-4, March 2006.
9. Salmond C, Crampton P, Heterogeneity of deprivation within very small areas. *J Epidemiol Comm Health* 56(9):669-70, 2000.
10. Public Health Advisory Committee. Improving child oral health and reducing child health inequalities. Wellington, National Advisory Committee on Health and Disability, 2003.
11. Jamieson LM, Koopu PI, Child use of dental services and receipt of dental care in New Zealand. *J Paediatrics Child Health* 43:732-9, 2007.
12. The social determinants of health: The Robert Wood Johnson Foundation, USA.



**TO REQUEST A PRINTED COPY OF THIS ARTICLE, PLEASE CONTACT**
Neil Croucher, BDS, neil.croucher@northlanddhb.org.nz.

Spotting caries is a piece of cake.



CDA JOURNAL, VOL 39, Nº2

# Improving Oral Health and Oral Health Care Delivery for Children

JAMES J. CRALL, DDS, SCD

**ABSTRACT** National and state-level evidence has documented ongoing disparities in children's health and utilization of oral health care services, prompting a re-examination of factors associated with poor oral health and low use of oral health services. These efforts have yielded a wide array of proposals for improving children's oral health and oral health care delivery. This paper offers a perspective on the current context of efforts to improve children's oral health and oral health care delivery.

AUTHOR

**James J. Crall, DDS, SCD,** is a professor, pediatric dentistry, at the University of California, Los Angeles, School of Dentistry.

Despite overall positive trends in the oral health status of American children, significant disparities persist. Analyses of national survey data reveal higher prevalence rates of dental caries and unmet dental treatment needs in children of low-income families compared to their more affluent counterparts, and in black and Latino children compared to non-Hispanic whites.[1,2] Studies also have substantiated high rates of dental disease in Native American children and an increase in early childhood caries among 2-4 year olds between 1988-1994 and 1999-2004.[2,3] Statewide assessments of California children mirror national findings with respect to sociodemographic disparities and indicate that California has the fifth-highest rate of caries experience in third-grade children among all states and ranks in the bottom third of states with respect to the percentage of third-grade children with untreated caries.[4,5]

Significant disparities also exist in children's use of dental services. Findings from the Medical Expenditure Panel Survey (MEPS) for 2004-2005 showed that the percentage of U.S. 2-18 year olds who received dental services in the previous year was 55 percent for privately insured children, 37 percent for children covered by Medicaid — the predominant source of dental benefits for children from low-income families — and 26 percent for uninsured children.[6] Utilization of dental services by children in Medicaid has improved nationally from 18 percent of all eligible children in 1993, to 31 percent of 2-18 year olds in 1996-1997 and 37 percent in 2006-2007, with most states demonstrating increases (some quite substan-

tial) in the percentage of Medicaid children receiving dental services, even with growing numbers of children enrolled in Medicaid.[6,7]

California, on the other hand, is among a small number of states that have reported declines in the percentage of Medicaid children using dental services. Data reflecting the use of dental services by California 1-18 year olds in Medicaid showed that utilization reached a high of 34.5 percent in 2003, but declined to 31.3 percent in 2006 and 2007.[8] California also was one of 15 states selected for on-site reviews by the Centers for Medicare and Medicaid Services (CMS) in 2008 because of overall dental utilization rates of <30 percent of all Medicaid-eligible children.[9]

These and other observations have prompted a wide range of public and private entities to re-examine factors associated with poor oral health and low use of oral health services by children for the nation as a whole and within California. The findings, conclusions and recommendations of these various efforts have yielded a wide array of proposals for improving children's oral health and oral health care delivery — some of which call for bolstering the performance of current systems based on lessons learned in other states, and others which call for major reforms and system redesigns based on approaches that have been applied to a very limited extent in the United States. Absent from virtually all of these assessments and proposals, however, is delineation of a strategic framework and process for identifying broad goals and major strategies, or for developing and evaluating related courses of action to achieve desired improvements in oral health and oral health care delivery across diverse community settings. Also generally absent are credible cost comparisons for various approaches and analysis of what steps are likely to be feasible and optimal in the current socio-politico-economic context.

This paper offers a perspective on the current context of efforts to improve children's oral health and oral health care delivery, outlines a broad strategic approach, highlights lessons learned from prior experience with public and private-sector stakeholders in other states, and examines options for expanding the availability of children's oral health care services, including recent proposals for expanding the dental workforce and increasing services through the dental safety net.

**RECURRING** state budget shortfalls also pose a challenge for oral health improvement programs in California.

## Important Contextual Factors

### *State Oral Health Leadership*

The situation summarized above with respect to children's oral health and oral health care delivery — especially as it relates to California children in low-income families — clearly presents considerable room for improvement. Despite numerous examples of active coalitions, successful local programs and private-sector initiatives, the lack of strong oral health professional leadership within state government has long been recognized (at least by those outside state government) as a critical structural shortcoming with respect to oral health improvement efforts in California. Although no single individual can be expected to produce the kind of changes necessary to improve children's oral health in a state as vast and diverse as California, the lack of high-level oral health professional leadership within state government, i.e., a dentist with suitable background, experience, and support serving as the state government point person for oral health issues, is undoubtedly a factor in California's lack of progress in advancing oral health.

In addition to the observations provided in the introduction, tangible indicators of the deficit in oral health leadership in California state government include the absence of an official state oral health plan, the lowest ranking among all states for the percentage of the population on public water systems receiving fluoridated water, Medicaid dental reimbursement rates that rank third-lowest in the country relative to dentists' prevailing fees, and the eighth-lowest rate of third-graders with dental sealants.[5,8]

### *State Government*

Recurring state budget shortfalls also pose a challenge for oral health improvement programs in California. The loss of adult Medicaid dental benefits (Denti-Cal) in 2009 without any corresponding enhancement to California's dental Medicaid program for children represents a setback whose direct consequences for adult oral health and indirect impact on children's oral health, dentists' participation in Medicaid and the financial stability of safety-net program operations are yet to be fully realized.[10]

### *Federal Government*

At the federal level, a sluggish national economy and growing political pressure to reduce the federal deficit portend little in the way of future enhanced funding for federal oral health initiatives. Reauthorization of the Children's Health Insurance Program (CHIP) in 2009 and

CDA JOURNAL, VOL 39, Nº2

enactment of the Patient Protection and Accountable Care Act (PPACA) in 2010 will add an estimated 5 million-plus children nationally and hundreds of thousands of children in California to Medicaid and CHIP program enrollments beginning in 2014.[11,12] Initially, this expanded enrollment will be paid for largely with federal funds; however, states will be required to assume greater responsibility for the ensuing costs of larger Medicaid enrollments within a relatively short time period, placing additional demands on already strained state budgets.[12]

*Demographics*

A paper published nearly eight years ago in this journal summarized data indicating that a high proportion of California children live in poverty (≤100 percent of the federal poverty level or FPL) or in low-income families (≤200 percent of the FPL).[13] More recent data reported by the Centers for Disease Control and Prevention (CDC) in 2009 indicate that 42 percent of California's 9,992,000 children under age 18 live in low-income households (similar to the national average) and 25 percent live in households with incomes below 125 percent of the FPL.[14] More than 4.2 million California children were enrolled in Medicaid for at least one month in 2009 and another 895,000 were eligible for the CHIP (Healthy Families) program.[14] California also has high proportions of children from racial/ethnic groups who are at higher risk for dental decay. Having such a high proportion of children covered by public programs underscores the importance of recognizing that meeting their needs — which are greater than those of more socioeconomically advantaged segments of the population — must include and rely heavily on "mainstream" approaches to oral health care delivery, not on some patchwork or disorganized conglomeration arrangement that offers little in the way of sustained support for the millions of children enrolled in Medicaid and CHIP or accountability for program expenditures.

*Workforce*

The size of California's dental workforce has remained relatively stable in recent years according to CDC data and other sources, with approximately 31,500 dentists licensed by the state in 2008, of which approximately 26,400 (84 percent) actively practice in California.[14] California's dentist-to-population ratio is higher than the national average, with one dentist for every 1,440 persons.[15] California's dental workforce includes approximately 450 full-time equivalent (FTE) dentists practicing in 256 community clinics that are geared primarily toward providing services for underserved populations.[8] Nearly 12,000 California dentists submitted at least one Medicaid claim in 2009; however, data provided by the CDC indicate significant reductions in the number of dentists who provided "significant levels" of Medicaid services (defined as seeing more than 50 Medicaid patients <21 years of age or being paid for at least $10,000 in Medicaid claims).[14]

**CALIFORNIA'S DENTIST-to-population ratio is higher than the national average, with one dentist for every 1,440 persons.**

Other sources note that 49 percent of California dentists in private practice report providing care on a sliding-scale basis to low-income patients; however, the extent of those discounts is unknown.[15] CDC data also indicate that there were 49,000 state-licensed dental hygienists in 2009 (data on hygienists practicing in California were not reported).[14]

According to data provided by the Health Resources and Services Administration (HRSA), less than 4 percent of California's population lives in designated dental health professions shortage areas and thereby is considered to be underserved with respect to established dentist-to-population criteria.[8] HRSA data indicate that California's dentist workforce would need to be increased by 1.5 percent to 2 percent to remove the shortage area designations from these areas.[16]

## Adopting a Strategic Approach

Efforts to improve children's oral health and oral health care delivery often suffer from a failure to adopt a strategic orientation to establish broad goals and priorities, identify targeted approaches geared toward the needs of diverse communities, and implement and evaluate chosen courses of action. Recognition of this common shortcoming led the National Governors Association (NGA), with funding from HRSA and CDC, to sponsor a series of oral health policy academies in 2000-2001 to help 21 selected states bolster their ability to serve the oral health needs of vulnerable segments of their respective populations, including low-income children.[17] The objectives of the academies were to:

- Help state policymakers develop an oral health action plan that could be realistically implemented in their respective states;

- Learn about innovative solutions states have employed to address critical policy questions and improve program design; and
- Create and reinforce relationships between governors' offices, state legislators, key public program directors, and stakeholders from the private sector.

As expected, the strategies and courses of actions that various states chose to pursue as a result of their involvement in the NGA policy academies varied in scope and the intensity with which they were subsequently pursued. Nevertheless, the process employed and outcomes of the experience were widely regarded as extremely beneficial by participating stakeholders.[17]

Private foundations and quasi-governmental organizations also have served as important catalysts for development and implementation of statewide oral health strategic plans in several states. Prominent examples include the work of the Connecticut Health Foundation, Washington Dental Service Foundation, and North Carolina Institute of Medicine. Common features of these successful ventures include active involvement of prominent stakeholders — including representatives from state government, health professions groups, oral health advocates and community leaders — in both the planning and implementation phases of the work, and a sustained commitment to help ensure the resources and buy-in necessary to carry out proposed recommendations.

## Proposed Strategic Framework

Choosing a strategic framework is a critical step in developing and implementing plans to improve children's oral health and oral health care delivery on a statewide basis. A framework that has proven to be useful in previous involvements with various state-level children's oral health initiatives organizes strategies and activities within two broad goals: 1) reducing the burden of oral disease in the population(s) of interest, and 2) ensuring access to and utilization of appropriate diagnostic, preventive, treatment, and disease management services.[18] Use of this framework helps to delineate and assess the potential value of various strategies geared toward achieving each of the two complementary goals, promotes a more broad-based approach to improving oral health, and fosters buy-in and collaboration among stakeholders with limited or more narrow interests.

**STRATEGIES FOR** reducing the burden of oral disease can and should involve multiple types of health care providers.

A publication illustrating the use of this framework to develop strategies for improving oral health and delivery of care for children and for fostering system reform in Connecticut is available from the Connecticut Health Foundation.[18] One of the more interesting findings from the application of this approach in Connecticut was that 54 percent of Medicaid-eligible children lived in five metropolitan areas where only 18 percent of the state's dentists practiced. The remaining 46 percent of Medicaid children lived in 164 cities and towns with 82 percent of the state's dentists. Application of this finding led to two fundamentally different approaches for improving access for these two groups of Medicaid children — one emphasizing greater reliance on expanding so-called "safety-net operations" and developing broad-based community collaboratives to help enhance local systems of care in areas with low dentist-to-population ratios, and the other relying on Medicaid dental benefit program improvements to increase Medicaid participation by dentists where adequate supplies of dentists existed.[18] A similar analytic and strategic approach was used in the design, development, and implementation of the Michigan Healthy Kids Dental program that has successfully increased access to dental services for children enrolled in Medicaid.[19]

### Reducing the Burden of Oral Disease

Strategies for reducing the burden of oral disease can and should involve multiple types of health care providers (e.g., oral health professionals and primary medical care providers) along with an array of organizations, programs and individuals involved in family support and community development activities (e.g., Head Start and WIC programs; early child care and education programs; state, county and local health departments; home visitation programs; prenatal and perinatal education programs). A central thrust of these activities should be geared toward educating high-risk children and families about the causes of dental disease (primarily dental caries in children) and practical, effective ways to avoid or minimize its destructive consequences, e.g., sound nutrition, healthy habits including daily brushing with fluoride toothpaste, and regular use of dental services.[20] Approaches also may include providing clinical preventive services, which should be applied according to professional guidelines based on assessment of risk for disease (i.e., caries risk assessment) and may be provided in settings other than traditional clinical settings, e.g., in family support or nonclinical community program settings.

CDA JOURNAL, VOL 39, Nº2

## Ensuring Access and Appropriate Utilization of Comprehensive Oral Health Care Services

The principal focus of this goal is to ensure that children, particularly high-risk children, establish a dental home relationship with a dentist capable of meeting the full range of criteria and expectations delineated in the American Academy of Pediatric Dentistry (AAPD) Definition and Policy on the Dental Home, ideally by the time of their first birthday.[21,22] Within the context of Medicaid, a dental home should provide all medically necessary dental services, including diagnostic and preventive services according to the state's Medicaid Early Periodic Screening, Diagnostic and Treatment (EPSDT) Dental Periodicity Schedule.[23] (Within the context of Medicaid EPSDT programs, "dental services" are defined in Medicaid regulations at 42 CFR 440.100 (for the purpose of determining if federal match is allowed for the service) to mean "diagnostic, preventive or corrective procedures provided by or under the supervision of a dentist in the practice of his profession ..." and "dentist" means "an individual licensed to practice dentistry or dental surgery.")

Guidelines for EPSDT oral-health related services to be provided by medical providers should be delineated in a separate general or medical Medicaid EPSDT Periodicity Schedule developed by each state's Medicaid program. (The requirement for a separate EPSDT Dental Periodicity Schedule was established as part of OBRA'89 federal legislation. However, states have been slow in developing these schedules; and some officials may be unaware of the necessity for and details of their state's EPSDT Dental Periodicity Schedule.)

Experience gained in programs such as the Washington Access to Baby and Child Dentistry (ABCD) program and the AAPD Head Start Dental Home Initiative highlight the need for information and support services to help low-income families understand the importance of oral health care for young children and what it takes to establish and maintain a dental home relationship with community-based providers. Programs that provide caretaker education, oral health assessments and preventive services on-site (i.e., outside dental clinics or offices) can be an effective way to increase the "comfort level" of at-risk children's caregivers with dental professionals and begin the process of establishing ongoing relationships between families and dental care providers (i.e., dental home relationships). However, additional efforts are necessary to help at-risk children and families become comfortable and knowledgeable about obtaining ongoing care in more traditional community-based settings (dental clinics and private offices) given that low-income children and families will require care in these settings beyond the time when they are enrolled in early childhood or school-based programs.

**ADDITIONAL EFFORTS** are necessary to help at-risk children and families become comfortable and knowledgeable about obtaining ongoing care.

## Large-Scale Program Innovations With Demonstrated Promising Results

As noted earlier, ongoing concerns about persistent disparities in children's oral health and utilization of dental services have produced a wide range of proposals for program and/or policy changes from diverse interested parties. This section provides a brief synopsis of Medicaid program innovations that have been carried out on a large scale and reported results. Several of these approaches were included in a recent report and set of recommendations for improving the performance of the California dental Medicaid (Denti-Cal) program.[24]

## Washington Access to Baby and Child Dentistry (ABCD) Program

ABCD program benefits beyond routine dental services for children covered by Medicaid include:

- Up to three dental fluoride varnish treatments per year for children with high caries risk. (Additional fluoride varnish treatments can be provided by primary medical care providers for high-risk young children);
- Coverage for glass ionomer sealants and fillings;
- Parental orientation focusing on the importance of preventive dental visits and program expectations (e.g., being on time for dental appointments and waiting room etiquette);
- Short-term professional training for dentists and staff on pediatric dental techniques;
- Community outreach and program marketing; and
- Increased Medicaid reimbursement for dental services provided by ABCD-trained dentists.[24]

Evaluations have reported that Medicaid-insured children <6 years of age from ABCD program counties have higher rates of preventive dental visits compared to those from non-ABCD counties (45 percent versus 36 percent) and U.S. children with continuous private insurance.[25]

The ABCD program also has been shown to reduce the prevalence of

decayed or filled primary teeth compared to non-ABCD counties at an annual cost of approximately $13 per child using Medicaid dental services.[25]

## Michigan Healthy Kids Dental Program

The State of Michigan initiated its Healthy Kids Dental (HKD) Program in 2000, contracting with Delta Dental of Michigan to provide dental benefits for Medicaid children using Delta Dental commercial dental plan designs, arrangements (minus requirements for co-pays) and networks of dentists. Implementation of the HKD program began in 22 counties and has expanded to 61 of Michigan's 83 counties with the following results:

- Dental visits for HKD children are 50 percent higher than in the traditional Medicaid program;
- Geographic access to dentists has improved for HKD children (travel distances cut in half);
- Parents report high satisfaction with the HKD program; and
- 92 percent of parents report improvements in their children's health from the HKD program.[24]

## State Medicaid Reimbursement Increases and Program Administration Improvements

Using a combination of momentum from the enactment of SCHIP, strong state revenue flows in the late 1990s and participation in NGA Oral Health Policy Academies, states such as Delaware, Michigan, Alabama, South Carolina, Georgia, Indiana, and Tennessee were able to significantly increase Medicaid reimbursement for dental services to "market-based rates." A 2008 report by the National Academy of State Health Policy concluded that in the six states it examined, provider participation increased by at least one-third and sometimes more

than doubled following rate increases to market-based levels.[26] Not only did the number of dentists enrolled in Medicaid rise, so did the number of Medicaid children they were willing to treat.

Consequently, Medicaid children's use of dental services increased significantly following rate increases. Connecticut and Texas also have documented substantial increases in dentists' participation in Medicaid and utilization of dental services by Medicaid children following rate increases to market rates (50th percentile of dentists' prevailing fees for a range of common pediatric dental procedures) following settlements of federal litigation proceedings.[9,27,28] Streamlining Medicaid program administration processes to make them more consistent with processes used by mainstream commercial dental benefit plans also has been acknowledged as an effective way to increase dentists' participation.[24]

## North Carolina Into the Mouths of Babes (IMB) Program

North Carolina initiated a program in 2000 that provides training and reimbursement that enables physicians to provide preventive oral health services for young children enrolled in Medicaid. The IMB program reimburses providers for up to six visits of preventive oral health services in primary care medical settings for children up to age 3. IMB services include assessments of dental caries and risk, topical application of fluoride, and parental counseling on the proper care of children's oral health. All three services must be delivered at a single visit by trained physicians and physician extenders to claim reimbursement. Implementation of the IMB program included training programs for primary medical care providers and led to a net statewide increase in preventive oral health services to young Medicaid-enrolled children, with almost 30 percent of all well-child visits at the targeted age including preventive oral health services. A small increase in visits to dentists also was observed.[29]

## Rhode Island RIte Smiles Program

Rhode Island implemented a statewide program in 2006 following recommendations of a state senate commission and involvement in the Robert Wood Johnson Foundation State Action for Oral Health Access (SAOHA) program. RIte Smiles is designed to increase utilization of dental services by young children, including early preventive services to minimize the impact of dental disease, and reduce emergency room use for dental conditions. Medicaid children from birth to age 6 were enrolled initially to maintain Medicaid program budget neutrality; however, age limits subsequently were raised annually to expand the scope of the program and avoid children losing RIte Smiles program eligibility. Dentist participation increased from 27 to 217 providers, including every pediatric dentist in the state. Within the first program year, 34 percent of RIte Smiles enrollees had visited a dentist, compared to 21 percent of traditional Medicaid program enrollees.[24]

**NOT ONLY DID** the number of dentists enrolled in Medicaid rise, so did the number of Medicaid children they were willing to treat.

## Proposals for Expanding the Dental Workforce

Numerous groups have offered a variety of workforce strategies for expanding the availability of dental services for underserved segments of the population. More traditional proposals include increasing the number of dentists and/or dental hygienists, either through class size expansions of existing programs or the addition of new schools. Five new U.S. dental schools have opened since 2000, the most recent being Western University School of Dental Medicine in Pomona, Calif. Three additional new schools are scheduled to accept their inaugural classes in 2011, with several others in various stages of planning. The number of dentists graduating from U.S. dental schools increased 20 percent over the past two decades, from 3,995 in 1991 to 4,796 in 2008, while graduates of dental hygiene programs increased 59 percent from 4,229 in 1991 to 6,723 in 2008.[30]

Other strategies involve expanding dental hygienists' scope of services, creating new categories of expanded function/expanded-duty dental assistants (currently are utilized in at least 24 states) and creating new categories of dental workforce providers (e.g., community oral health coordinators and dental therapists). The most controversial of these approaches concerns the proposed creation of new categories of midlevel dental providers, e.g., dental therapists, with the most contentious issue involving scope of practice, level of supervision and the potential for migration to independent practice arrangements, i.e., without dentist supervision. Of significant concern are the potential negative effects of the confluence of underfunded and weakly monitored public programs, workforce policy changes, and the "corporatization" of dental care in light of recent examples of dubious

business and clinical practices involving dental care for low-income children.

More than 50 countries utilize dental therapists, largely as part of dental teams headed by dentists, with most therapists employed by government programs (although recent changes in Australia, Britain, Canada, and the Netherlands allow use of therapists in private practices, with resultant increases in private-sector employment).[31] Despite widespread global usage, the total number of dental therapists worldwide is only on the order of 14,000, with fewer than 1,000 therapists working in most English-speaking countries.[31] Dental therapists tend to be used more extensively in countries that employ nationalized approaches to health care delivery and financing. Dental therapist use in the United States thus far has been limited to Alaska, where 14 therapists work in conjunction with dentists to provide dental services to remote areas.[32]

Minnesota has authorized use of dental therapists, but none have yet completed their initial training.[32] Evaluations of the effectiveness, cost-effectiveness and sustainability of employing dental therapists in U.S. settings therefore are extremely limited.

## Proposals for Expanding Dental Safety-Net Services

The term "'dental safety net" typically is used to denote dental clinics operated by public and voluntary sector organizations to provide services to populations that are unable to purchase private-sector care. Although private practices play a critical role in caring for the underserved, providing care to approximately two-thirds of all patients from underserved segments of the population who obtain care, they are not considered part of the safety net system.[33]

The primary components of the dental safety net for noninstitutionalized, underserved populations in the United States are clinics located in community health centers, community hospitals, public and parochial schools, public health departments, dental schools, and other social service agencies.[33]

Calls for expansion of the dental safety net to enhance the availability of dental services for underserved segments of the population have prompted an examination of the current capacity and potential for expansion of prominent components of the safety net, individually, and in the aggregate. Findings from a recent analysis by Bailit et al. indicated that current U.S. dental safety-net operations provide care to approximately 7.4 million patients, or approximately one-third of the underserved children and adults who obtain dental care annually.[33] The majority (59 percent) of patients treated in safety-net dental clinics are seen in federally qualified and community health centers (FQHCs and CHCs) with one-third of the total being children and two-thirds adults. The balance of care provided to patients seen in safety-net programs occurs in dental schools (24 percent), community hospitals (14 percent), and school-based dental clinics (3 percent).[33]

**DENTAL THERAPISTS** tend to be used more extensively in countries that employ nationalized approaches to health care delivery and financing.

Projections based on changes that are likely to require 5 to 10 years to implement — expansion and increased productivity in FQHCs, residency program expansions in community hospitals and dental schools, and increased use of dental student rotations in community-based settings — suggest that the dental safety net could potentially serve an additional 2.5 million people annually.[33] CHCs and school-based clinics are viewed as unlikely sites for expansion of safety-net services because of a host of contextual constraints. e.g., challenges related to securing public funding, space and other resources needed to build dental treatment facilities in elementary and high schools; recruitment of dentists and other clinical staff; and, most importantly, the ability to generate adequate revenues to cover operating expenses. Projections based on increasing dental service utilization by currently underserved segments of the population to levels comparable to levels observed in middle-income families suggest that the proportion of individuals served by safety-net facilities would likely decrease slightly, from approximately 33 percent to 30 percent, due to the limited potential for safety-net programs to expand their service delivery capacity.[33]

## Key Overarching Considerations

Questions concerning what can and should be done to reduce disparities in oral health status and utilization of oral health services within the social, political, legal, economic, and organizational contexts that prevail in the United States as a whole or within any particular state are complex. As such, they merit careful analysis, strategic planning, collaborative action, rigorous and robust unbiased evaluation, and sustained commitment on the part of responsible

stakeholders to achieve improvements. Key considerations concerning the central focus of this paper within the above contexts are summarized below.

*Social Considerations*

America's demographic makeup is undergoing profound changes as a result of immigration, differential birth rates, and increased life expectancy. Immigration and differential birth rates among racial/ethnic groups are rapidly altering the characteristics of the U.S. child population. Nowhere is this more apparent than in California, where, in 2009, 50 percent of children had at least one foreign-born parent (a rate 50 percent higher than in Florida, New Jersey, Nevada, and Texas, and twice the U.S. average).[34]

Immigrants, especially those with low levels of education and/or income, are more likely to need assistance to learn how to navigate the highly complex and varied U.S. health care system effectively, and may place additional strains on already fragile public programs and safety-net operations. Also, often forgotten in debates about access to care is the need to educate vulnerable populations about the determinants of oral health and reshape attitudes about oral health care.[35] Increased life expectancy has a more indirect impact on children's health and health care in that it contributes to greater demands for resources and programs designed to provide health services for seniors.

*Political Consideration*

The two most significant recent political actions concerning children's oral health include reauthorization of the CHIP program in 2009 and enactment of federal PPACA legislation in 2010. Current estimates suggest that these two legislative actions will increase enrollment in publicly funded health care programs by more than 5 million children nationally. California, with an estimated 1.5 million uninsured children, of which 700,000 are eligible for Medicaid and CHIP, will see the largest state-level expansion of public program enrollment.[12] Providing coverage is a necessary first step toward reducing financial barriers to health care. However, public funding for children's oral health programs in the United States historically has accounted for only about 5 percent of all spending on children's dental care even though nearly 30 percent of all children are covered by publicly funded programs and despite the fact that dental expenditures comprise 18 percent of all health care expenditures for all children under age 18.[36] Incredibly, analyses suggest that public funding provides less than 30 percent of all expenditures for the poorest segment of U.S. children, those in households with incomes below the federal poverty level.[37] Coverage without adequate funding compromises the availability of services in both the public and private sectors. Political "fixes" and "reforms" that fail to adequately address fundamental underlying problems and balance the interests of major stakeholders generally produce unintended consequences that surface as new problems and/or larger versions of old problems.

**AMERICA'S DEMOGRAPHIC** makeup is undergoing profound changes as a result of immigration, differential birth rates, and increased life expectancy.

*Legal Considerations*

The Early Periodic Screening, Diagnostic and Treatment (EPSDT) provisions of federal Medicaid statutes require that states provide dental services (defined as services provided by or under the supervision of a dentist) to all eligible children promptly and at reasonable intervals that, at a minimum, include relief of pain and infections, restoration of teeth, and maintenance of dental health.[23] Additional statutes require states to develop separate EPSDT dental periodicity schedules in conjunction with organizations involved in providing dental care to children.[23] The states' failure to adhere to EPSDT requirements have been repeatedly and often successfully challenged in federal courts; however, achieving successful outcomes in the legal arena depends not only on getting a favorable settlement or judgment, but also on obtaining substantive relief thereafter. Another key legal consideration when contemplating models developed in other countries is the more aggressive medical malpractice environment in the United States compared to other countries.

*Economic Considerations*

Numerous actuarial analyses have calculated the level of funding necessary to provide medically necessary dental benefits to children covered by Medicaid and CHIP programs.[9] Additional analyses have compared Medicaid dental reimbursement rates to distributions of dentists' fees (percentile analysis) and reported costs of providing dental services.[9,38] The results of such analyses have been used to highlight the inadequacy of Medicaid payments relative to other payment sources and the cost of providing services in private and/or nonprofit settings, and to guide reimbursement rate setting in deliberations geared toward enhancing dentists' participation in Medicaid.[9]

*Organizational Considerations*

Estimates suggest that dental care for the majority (two-thirds) of individuals in underserved segments of the population who currently obtain services is provided by private dental practices.[33] Safety-net providers constitute an important part of the dental care delivery system; however, significant expansion of safety-net operations in the United States is likely to be limited by a combination of financial, physical, and workforce constraints.[33] Adopting fundamentally different arrangements for providing children's dental care on a scale necessary to make a meaningful impact on oral health disparities, such as the school-based programs employed in New Zealand or Australia, would require modification of state workforce policies; substantial capital expenditures for facilities and equipment plus maintenance costs; training, recruitment, retention and supervision of an adequate workforce; and augmentation of current meager state and local dental public health infrastructures — a rather daunting undertaking, even in good economic times and a supportive political climate.

## Conclusions and Recommendations

In conclusion, national- and state-level evidence have clearly documented the existence and consequences of ongoing overarching considerations and an increasingly diverse population underscore the need for approaches that are innovative, solidly evidence-based, targeted, and coordinated in order to maximize effectiveness and efficiency. Major initiatives geared toward overcoming structural deficiencies in current systems should be carefully designed, introduced as demonstration programs and subjected to thorough, unbiased evaluation of their effectiveness, costs, potential for widespread use, sustainability and potential adverse unintended consequences. Given the typical protracted timeline required to implement major system

changes and workforce initiatives and the uncertain and imprecise impact of major policy changes, initial efforts should be directed toward identifying and implementing strategic program enhancements that have been demonstrated in other states to produce substantial improvements in existing programs, starting with Medicaid and CHIP. ■■■■

**REFERENCES**


1. Vargas C, Crall J, Schneider D, Sociodemographic distribution of pediatric dental caries: NHANES III, 1988-1994. *J Am Dent Assoc* 129(9):1229-38, 1998.
2. Dye BA, Tan S, et al, Trends in oral health status: United States, 1988-1994 and 1999-2004. National Center for Health Statistics. *Vital Health Stat* 11(248):1-92, 2007.
3. U.S. Department of Health and Human Services, Office of Minority Health. Racial and Ethnic Specific Oral Health Data: Fact Sheet. minorityhealth.hhs.gov/templates/browse.aspx?lvl=3&lvlid=209. Accessed Dec. 20, 2010.
4. Dental Health Foundation. Mommy, it hurts to chew: the California smile survey: an oral health assessment of California's kindergarten and third-grade children, 2006.
5. Center for Disease Control and Prevention. National oral health surveillance system: oral health indicators. cdc.gov/nohss/index.htm. Accessed Dec. 20, 2010.
6. U.S. Government General Accountability Office. Medicaid: extent of dental disease in children has not decreased, and millions are estimated to have untreated tooth decay. Publication, GAO-08-1121. Washington, D.C., September 2008.
7. U.S. Department of Health and Human Services, Office of the Inspector General. Children's dental services under Medicaid: access and utilization. San Francisco, Calif., 1996. Publication OEI-09-93-00240.
8. Pew Center on the States. The cost of delay: dental programs fail one in five children. Washington, D.C., February 2010.
9. U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. 2008 National Dental Summary, January, 2009.
10. California Medi-Cal Program. Elimination of most adult dental services beneficiary frequently asked questions (FAQs).
11. Henry J. Kaiser Family Foundation. Financing new Medicaid coverage under health reform: the role of the federal government and states. Washington, D.C., May 2010.
12. Lavarreda SA, Brown ER, et al, Number of uninsured jumped to more than 8 million from 2007 to 2009. UCLA Center for Health Policy Research, March 2010.
13. Crall JJ, California children and oral health: trends and challenges. *J Calif Dental Assoc* 31(2):125-8, February 2003.
14. Center for Disease Control and Prevention. National oral health surveillance system: state oral health profile: California. apps.nccd.cdc.gov/nohss/bystate.asp?stateid=6. Accessed Dec. 20, 2010.
15. Pourat N, Nicholson G, Distribution and characteristics of dentists licensed to practice in California, 2008. UCLA Center for Health Policy Research, June 2009.
16. U.S. Department of Health and Human Services, Health Resources and Services Administration. Designated health professions shortage areas (HPSA) statistics. ersrs.hrsa.gov/ReportServer?/HGDW_Reports/BCD_HPSA/BCD_HPSA_SCR50_Smry&rs:Format=HTML3.2. Accessed Dec. 20, 2010.
17. National Governors Association. Policy academy: improving oral health care for children. nga.org/portal/site/nga/menuitem.9123e83a1f6786440ddcbeeb501010a0/?vgnextoid=19ae5aa265b32010VgnVCM1000001a01010aRCRD. Accessed Dec. 20, 2010.
18. Crall JJ, Edelstein BL, Elements of effective action to improve oral health & access to dental care for Connecticut's children and families. Connecticut Health Foundation and Children's Fund of Connecticut, Inc., 2001.
19. Eklund SA, Pittman JL, Clark SJ, Michigan Medicaid's healthy kids dental program: an assessment of the first 12 months. *J Am Dent Assoc* 134(11):1509-15, 2003.
20. Crall JJ, Optimizing oral health throughout childhood: the importance of caries risk assessment and strategic interventions. *Int Dent J* 57 (suppl. 2):221-6, 2007.
21. American Academy of Pediatric Dentistry. Definition of dental home. aapd.org/media/Policies_Guidelines/D_DentalHome.pdf. Accessed Dec. 20, 2010.
22. American Academy of Pediatric Dentistry. Policy on the dental home. aapd.org/media/Policies_Guidelines/P_DentalHome.pdf. Accessed Dec. 20, 2010.
23. U.S. Department of Health and Human Services, Centers for Medicare and Medicaid services. A Guide to Children's Dental Care in Medicaid, October 2004.
24. Davis C, Brown G, Managing California's Medicaid dental program: lessons from other states. California HealthCare Foundation, July 2009.
25. Kobayashi M, Chi D, et al, The effectiveness and estimated costs of the access to baby and child dentistry program in Washington state. *J Am Dent Assoc* 136(9):1257-63, 2005.
26. Borchgrevink A, Snyder A, Gehshan S, The effects of Medicaid reimbursement rates on access to dental care. National Academy for State Health Policy, March 2008.
27. U.S. District Court, State of Connecticut. Carr vs. Wilson-Coker settlement agreement. ct.gov/dss/lib/dss/pdfs/carrsettlement.pdf. Accessed Dec. 20, 2010.
28. Personal communication with Dr. Joanna Douglass. Results: number and percentage of Medicaid clients receiving any services. Connecticut Dental Health Partnership, November 2010.
29. Rozier RG, Stearns SC, et al, How a North Carolina program boosted preventive oral health services for low-income children. *Health Aff* 29(12):2278-85, 2010.
30. American Dental Hygienists Association. Dental hygiene education: curricula, program enrollment and graduate information. adha.org/downloads/edu/dh_ed_fact_sheet.pdf. Accessed Dec. 20, 2010.
31. Nash DA, Friedman JW, et al, Dental therapists: a global perspective. *Int Dent J* 58(2):61-70, 2010.
32. U.S. Government General Accountability Office. Oral health: efforts under way to improve children's access to dental services, but sustained attention needed to address ongoing concerns. Publication GAO-11-96. Washington, D.C., November 2010.
33. Bailit H, Beazoglou T, et al, Dental safety net: current capacity and potential for expansion. *J Am Dent Assoc* 137(6);807-15, 2006.
34. Annie E. Casey Foundation National KIDS Count Program. Children in immigrant families: 2009. datacenter.kidscount.org/data/acrossstates/Rankings.aspx?ind=115. Accessed Dec. 20, 2010.
35. Patrick DL, Lee RSY, et al, Reducing oral health disparities: a focus on social and cultural determinants. *BMC Oral Health* 6(suppl. 1):S4, 2006.
36. Kashihara D, Carper K, National health care expenses in the U.S. civilian noninstitutionalized population, 2008. Statistical Brief No. 301, December 2010. Agency for Healthcare Research and Quality, Rockville, Md. meps.ahrq.gov/mepsweb/data_files/publications/st301/stat301.shtml. Accessed Dec. 20, 2010.
37. Wall TP, Brown LJ, Manski RJ, The funding of dental services among U.S. children 2 to 17 years old: recent trends in expenditures and sources of funding. *J Am Dent Assoc* 133(4):474-82, 2002.
38. Schneider DA, Crall JJ, Medicaid reimbursement: Using marketplace principles to increase access to dental services. American Dental Association, Chicago, Ill., 2004.


**TO REQUEST A PRINTED COPY OF THIS ARTICLE, PLEASE CONTACT**
James J. Crall, DDS, ScD, University of California, Los Angeles, School of Dentistry, CHS 23-020A, 10833 Le Conte Ave., Los Angeles, Calif., 90095-1668.

CDA JOURNAL, VOL 39, Nº2

# Dental Therapy: Another Tongue in the Babel of Dental Access for Children

PAUL S. CASAMASSIMO, DDS, MS

**ABSTRACT** The debate over midlevel dental care providers, such as dental therapists, is intense in emotion but light on facts and data. This opinion paper questions the applicability of dental therapy in the United States and offers a prediction for its very limited acceptance. More importantly, this paper suggests that the debate on dental therapy in the United States ignores crucial issues and will delay the likelihood of improvement in children's access to oral health care.

AUTHOR

**Paul S. Casamassimo, DDS, MS,** is a professor, chair and chief of dentistry, Ohio State University and Nationwide Children's Hospital. He also is secretary of the Ohio Dental Association.

Never in my recollection has an issue in dentistry ignited such fervor, but most curiously, in the almost total absence of relevant data and ignorance or misrepresentation of those existing data. True, there are examples of dental therapists worldwide, but no real evidence of its applicability in a country with a third of a billion people, a highly developed, overwhelmingly dominant private practice-based dental care system, an extremely high standard of care, expectations of the populace across all socioeconomic strata for a singular high quality of care, a dental education system hard-pressed to either finance and repopulate itself, and a dental public health infrastructure in significant decline with little hope of salvation on the horizon.[1]

Our profession, unfortunately, chose early on the strategy of challenging the technical quality of dental therapists, which has been demonstrated with some consistency to be acceptable. Unfortunately, we did not address the profound implications of changing our dental health care system, nor did we quantify the wastefulness of ignoring existing expert workforce capacity, nor the overwhelming economic and human cost of a drawn-out conversion to a dental therapist system, nor confront the moral and ethical implications of delaying for many years, real solutions to dental access.

Sadly, neither side of the argument has done an unbiased thorough analysis.

Having worked to improve access for so many years, and having the mixed blessing of seeing medicine confront this same issue over the last quarter

century, I can, with some confidence, make these predictions about the future of dental therapy in the United States:

- Dental therapy will gain a foothold in this country. Indeed, it already has in Minnesota and Alaska, and the seeds are planted in other states.
- In spite of efforts by the public health community, government, legislators seeking easy fixes to dental access and other advocacy groups with agendas, dental therapy will ultimately reach the same status as independent dental hygiene practice — possible but impractical.
- Access will not be improved by dental therapy; more so, the impact of dental therapy on access will pale in comparison with community-based dental education, incentivized indigent care by existing providers, and other dentist-based approaches.

Unfortunately, these solutions already within our grasp, will be delayed as we squabble over dental therapy.

There should be no confusion among those concerned about the headlong rush to enable dental therapists that some states will create pathways to implementation. The seeds have been sown. Sadly, implementation of dental therapy may be a necessary step to allow us to eventually move past this distraction and focus on real solutions to access to dental care.

## The Danger of Dental Therapy to Real Access Solutions

No one can foresee what a dental therapy system will ultimately mean to access for children, but its creation will clearly be a distraction, if for no other reason that concurrently while pilot programs in health care reform will be implemented and evaluated, the training time it will take to create a meaningful therapist workforce, and the slow assessment of their effect.[2] This will keep oral health advocates for children from unifying and moving closer to real solutions to access to care while we wait for this experiment to unfold. While groups like the Pew Foundation rush to promote dental therapy as a bona fide solution to access, more thoughtful and fiscally pressed entities will wait until data emerge while children continue to suffer in the ensuing years or decades.[3]

I am also concerned that results of demonstrations will be used to color the argument in much the same way that proponents of potential U.S. dental therapy tend not to report problems or issues with programs such as New Zealand's and Canada's.[4-6] To accept most papers in our domestic literature supporting dental therapy in the United States is a matter of faith over fact.[7-10]

**DENTAL THERAPY MAY** be a necessary step to allow us to eventually move past this distraction and focus on real solutions to access to dental care.

The failure of New Zealand's program to adequately address minority oral health, oral health in young children, and to have health outcomes no better than those of the United States after almost 100 years, are not reported (except, thankfully, by the New Zealand government).[4,5] Canada's now truncated program is never mentioned in terms of its failure to overcome financial problems.[6] The recent Kellogg study of the Alaska program was published in late 2010.[11] The concerns of organized dentistry and the numerous qualifications and limitations of the impartial Kellogg-contracted research group, RTI, are ignored. Numerous groups opposed to a DHAT model have expressed the scientific honesty to say they would look fairly at meaningful data, but to date, that kind of information remains elusive.

## What Is a Likely Scenario for Dental Therapy?

Imagine the following scenario. A state creates a pathway for dental therapists. Training programs spring up not only in that state, but perhaps in adjacent states, based on the argument that there is fertile ground for employment and need for increased access. However, a small dispersed rural population, a crumbling dental safety-net infrastructure, high poverty in urban areas and poor overall economy limit employment opportunities. Therapists are initially locked by statute into public health service, some find employment, but the state's financial woes cause rationing of care in the public sector, and shrinking opportunity. Even with the lower cost of the dental therapist, the mix of uninsured and Medicaid patients dooms any permanent solution, because of inadequate reimbursement. Cost shifting that would be available in a private practice, dentist-based system is not possible.

Cultural obstacles to care (i.e., beliefs and attitudes about dental care, care-seeking behaviors) continue and dental therapists sit idle or revert to simple low reimbursement hygiene procedures. Ultimately, the therapists challenge their servitude to public health and the state acquiesces, as did New Zealand and Canada, allowing dental therapists to migrate to the highest-paying employers in the private sector. Even here, they remain underutilized due to the small size of most practices, patient desires to see a dentist, and the necessary service mix

to maximize revenue. As with expanded function dental assistants, only larger practices will look to employ dental therapists.[12] Training programs will contract or close. Like the independent dental hygienist, the dental therapists in the state will spend a few years in practice and slowly disappear. Access will not have improved.

Unfortunately, for this scenario to play out, it will take a couple of decades that will delay a real solution to dental access for children. In medicine, physician extenders have found a place, but have not solved access-to-care issues. We may be doomed to repeat the experience of medicine.

## A National View of Access: the Alchemy of Dental Therapy

Most states will never allow dental therapists because of the financial and political capital expenditure needed to implement and the absence of the geographic imperative that supports dental therapy in Alaska. The limited penetration of expanded-duty dental assistants (EFDAs) in the United States and the anemic performance of independent dental hygiene practice predict the failure of dental therapy. There is even question whether the state Department of Education would bless an educational program without likelihood of employment of its graduates.

The history of access to dental care is really the story of Medicaid, public funding and the cultural abyss separating the dental profession's view of oral health and desired health behaviors, and the reality of being poor in America. Address these three issues and one can fix access, but that is easier said than done. Medicaid's problems will ultimately doom solutions to oral health care access — with or without dental therapists. In many states, the Medicaid monster has devoured large parts of budgets, often to the detriment of higher education.[13] The appetite of states for dollars has already affected

many dental education programs.[14] It is difficult to foresee the ultimate mutation of Medicaid, but clearly, its reliance on a bankrupt federal government, and with a majority of states in dire and perhaps intractable financial straits, it doesn't take much to see what will happen, particularly as health care reform kicks in, throwing more high disease-acuity patients into the underserved pool, a problem medicine dreads, and which is equally daunting for dentistry.[15]

Idaho recently disenfranchised (then recredentialed under pressure) 140 large Medicaid dental providers and adult dental services, caught up in the tsunami of service reduction.[16] Medicaid fees will not increase appreciably, services will continue to be rationed, and the percentage of participating dentists will continue to decline. Even the best-intentioned states will continue to attempt "access alchemy" to increase care by contracting Medicaid operations in order to save money to HMOs that ration care and siphon precious care dollars for administrative profit. Some states may even choose to seek other options because the federal contribution to Medicaid, while alluring, is being seen more and more as a millstone rather than a blessing. This is all happening in spite of unprecedented use of emergency departments for dental infection and emerging linkages between child and maternal caries status, and the science pointing to the associations between oral health and systemic health.

The bottom line on access is money. The alchemy of improving access to dental care without increasing Medicaid dental expenditures has drawn dental therapy into its formula, but ignores the real issue related to improved access and, as such, we divert attention from the really difficult work of finding sustainable funding solutions.

## Lingering Questions, Few Answers in the Dental Therapy and Access Debate

The Pew Foundation's determination of the pivotal role of dental therapy as an indicator of state grades for access, when dental therapists have been in place for one to two years in the state, perhaps, is the most egregious example of the confusion of the dental therapy discussion.[3] There are many others. For example, Minnesota's model requires that therapists treat special needs patients.

**THE DENTAL** therapy debate only distracts us from a concerted effort to alter behaviors and truly prevent disease.

Nash, a leading proponent of dental therapy, stated that therapists should treat children because they are, by and large, healthy while adults have more medical problems.[17,18] The reality is that about one in six children has a special health care need. Nash also maintains that most services needed by children are preventive, which is true, but these can be addressed in most states by dental hygienists, questioning the need for dental therapists.

No one in this country has adequately addressed the shortcomings of the New Zealand experience and how a U.S. system would address the failure to adequately care for the very young and minority children. In the United States, the caries problem is clearly cited in these populations.[19] No one has proposed how a therapist system would be able to address restorative care for preschool children with treatable caries needing sedation and hospitalization. Perhaps more perplexing, and a problem the New Zealanders seem to have recognized recently, the nature of dental caries, once established, becomes difficult to eradicate.[4,20] Ironically, a fact widely touted in promotional U.S. literature about the New Zealand system is that by the end of the school year, all the carious lesions in children have been restored. Am I the only one asking the question why there is so much new decay every year in this highly touted oral health care system? A dental therapist system, whether in the United States or New Zealand, based on restoration of teeth of older manageable children, perhaps in schools, will not improve oral health. The experience of the Indian Health Service and its failure to restore away early childhood caries should be a warning for those who believe dental therapy will improve oral health in high disease children.[21]

While we dream about restoring away early childhood caries, we fail to address the growing realization that the solution to dental caries in children is not biological but systemic in its broadest sense. Recent caries initiation models and large-scale studies suggest that we need to delve deeper into all strata of society to cure this ill.[22,23] The dental therapy debate only distracts us from a concerted effort to alter behaviors and truly prevent disease.

Finally, no one appears to be addressing the convergence of dental therapy with problems funding oral health services, a very weak and rapidly deteriorating safety net, rapidly declining dental faculty numbers, up to 20 proposed new dental schools, placement of thousands of dental students in community settings, the shifting of public dollars away from higher education, dramatic and ever-increasing dental student debt, and growing poverty in this country.[24,25,13] Even the

esteemed Institute of Medicine appears to be content to look only where it wants to as it reviews the U.S. oral health care system. Truly, the discussion on access to dental care for children is a tower of Babel.

My work and that of my faculty colleagues and residents every day is caring for poor, minority and special needs children and adults — about 50,000 patient visits for our small department each year, about as many as a midsized dental school. For us, the dental therapy debate is a distraction at best and at worst, a threat to the vulnerable children in our dental home.

In Ohio, in 2009, a taskforce commissioned by the state's director of health, comprising public health and private practice dentists, dental hygienists, physicians, child advocates and other stakeholders, relegated the study of midlevel practitioners to its lowest priority among a host of strategies to improve access.[26]

Nationally, we should follow that lead and move on to real solutions. ■■■■


**REFERENCES**

1. Nash D, The international experience. In: National Academy of Sciences. The U.S. oral health workforce in the coming decade: workshop summary. Available at: nap.edu/catalog/12669.html. Accessed Dec. 7, 2010.
2. American Dental Association. Health Reform Legislation: side-by-side comparison, March 23, 2010.
3. The PEW Center on the States. The Cost of Delay, State Dental Policies Fail One in Five Children. Washington, D.C., Pew Charitable Trusts, 2009.
4. New Zealand Ministry of Health. Good oral health for all: the strategic vision for oral health in New Zealand. Wellington, Ministry of Health, August 2006.
5. DHBNZ. 2006. National School Dental Service Review: final report, December 2004. Wellington, Ministry of Health.
6. Quinonez CR, Locker D, On the pediatric oral health therapist: lessons from Canada. *J Public Health Dent* 68(1):53-6, 2008.
7. Nash DA, Developing and deploying a new member of the dental team: a pediatric oral health therapist. *J Public Health Dent* 65(1):48-55, 2005.
8. Nash DA, Developing a pediatric oral health therapist to help address oral health disparities among children. *J Dent Educ* 68(1):8-20, 2004.
9. Nash DA, Adding dental therapists to the health care team to improve access to oral health care for children. *Academic Pediatrics* 9(6): 446-51, 2009.

*Timothy G. Giroux*
*DDS/Broker*

# ASK THE BROKER

**Question:**
What do you predict in the way of practice sales for next year?

**Hu C, DDS**

The last two years have been slow for practice transitions. Most doctors are holding onto their practices for a few extra years since they are uncertain about the future of our economy. Some have lost equity in their homes and realize that the stock market could experience another 4000 point drop as it did in 2008. The net proceeds on the sale of their practices only result in about two years' worth of income, so why not work a little longer if your health is still good?

Unfortunately, the economy has also reduced gross receipts for most dentists. Not only are lower revenues another reason a doctor may defer retirement, but this also translates into fewer and lower paying associate positions. I remember hearing "doom and gloom" predictions for my graduating class of 1983 due to 15+ % interest rates. Eventually the economy pulled us out of those times. I look back now and feel that my class experienced some of the best times of dentistry. Hopefully the same will be true of the young dentists out there struggling to find a job in these tough economic times.

While the "rule of thumb" multiples for pricing practices remain fairly constant, decreasing revenues translates into lower prices. Lenders are not averaging multiple years to determine value, but are using the standard multiples on the last year's tax return. If the revenues have increased, the lenders are very generous with the loan amounts. If the revenues have decreased by more than 15%, not only will the price reflect the corresponding decrease, they may not even be interested in lending on the practice until the receipts have stabilized.

The good news is there is currently a backlog of dental work being created by patients who are putting off dental care. This corresponds to the backlog of practices that eventually will make their way to the market.

My New Year's wish is that the economy turns around, patients once again seek dental care and doctors decide it is time to retire. If it does not happen this year, hopefully it will happen next year!!! Who knows? This group of graduating dental students may eventually be as lucky as my generation of graduates.

**Timothy G. Giroux, DDS** is currently the Owner & Broker at **Western Practice Sales (westernpracticesales.com)** and a member of the nationally recognized dental organization, ADS Transitions. Do you have any **Questions? Email them directly to *Dr Giroux at:* wps@succeed.net** or Call **800.641.4179**

10. Nash DA, Nagel RJ, Confronting oral health disparities among American Indian/Alaska native children: the pediatric oral health therapist. *Am J Public Health* 95(8):1325-9, 2005.
11. Wetterhall S, Bader JD, et al, Evaluation of the dental health aide therapist workforce model in Alaska. Final report. Research Triangle Institute International, October, 2010.
12. American Dental Association. An economic study of expanded duties of dental auxiliaries in Colorado. ada.org/goto/economics. Accessed Dec. 7, 2010.
13. Orszag P, A health care plan for colleges. NY Times, Week in Review, page 10, Sept. 19, 2010.
14. Valachovic RW, Charting progress: looking for the silver lining among storm clouds, *ADEA Newsletter* October 2010.
15. O'Reilly KB, Health reform's next challenge: who will care for the newly insured? Amednews.com. ama-assn.org/amednews/2010/04/12/prl10412.htm. Accessed Dec. 7, 2010.
16. Galewitz P, States cutting Medicaid benefits as they stagger under economic downturn. Kaiser Health News. kaiserhealthnews.org/Stories/2010/September/30/medicaid-cutbacks.aspx. Accessed Dec. 7, 2010.
17. Glasrud P, Embertson C, et al, A history of Minnesota's dental therapist legislation, or … what the heck happened up there? Minneapolis, Minnesota Dental Association, 2009.
18. Nash D, Williard WR, On why the dental therapists' "movement" in the United States should focus on children not adults. *J Public Health Dent* July 28, 2010.
19. Beltran-Aguilar ED, Barker LK, et al, Surveillance for dental caries, dental sealants, tooth retention, edentulism, and enamel fluorosis — United States, 1988-94 and 1999-2002. MMWR 54:ss-3: 1-43, Aug. 26, 2005.
20. O'Sullivan DM, Tinanoff N, The association of early childhood dental caries patterns with caries incidence in preschool children. *J Public Health Dent* 56:81-3, 1996.
21. Council on access, prevention, and interprofessional relations, American Dental Association. Symposium on early childhood caries in American Indian and Alaska native children, panel report, November 2009.
22. Fisher-Owens SA, Gansky SA, et al, Influences on children's oral health: a conceptual model. *Pediatrics* 120:e510-20, 2007.
23. Larson K, Russ SA, et al, Influence of multiple social risks on children's health. *Pediatrics* 121:337-44, 2008.
24. Edelstein B, The dental safety net, its workforce and policy recommendations for its enhancement. *J Public Health Dent* 70:532-9, 2010.
25. ADA Survey Center. 2007-2008 survey of dental education: faculty and support staff, volume 3, April, 2009. Chicago, American Dental Association.
26. Ohio Department of Health, director of health's task force on oral health and access to dental care, Columbus, Ohio, 2009.

**TO REQUEST A PRINTED COPY OF THIS ARTICLE, PLEASE CONTACT**
Paul S. Casamassimo, DDS, MS, Department of Dentistry, Nationwide Children's Hospital, 700 Children's Drive, Columbus, Ohio, 43205.

CDA JOURNAL, VOL 39, Nº2

# Addressing Barriers to Care: 10 Years of Meeting Community Needs

ROLANDE T. LOFTUS, MBA, AND JON R. ROTH, CAE

**ABSTRACT** The California Dental Association founded the California Dental Association Foundation in 2001 as its philanthropic affiliate, with the express mission to "improve the oral health of all Californians by supporting the dental profession in its efforts to meet community needs." This mission is evident as the CDA Foundation celebrates its 10th anniversary of identifying and addressing barriers to care through innovative programs, scholarships, and grant-making.

AUTHORS

**Rolande T. Loftus, MBA,** is program director for the CDA Foundation.

**Jon R. Roth, CAE,** is the former CDA Foundation executive director.

Oral health disparities in the United States were brought into sharp focus in 2000 with the publication of a first-ever report on oral health from the U.S. Surgeon General's office, *Oral Health in America: A Report of the Surgeon General*.[1] The report identified significant incidence of oral disease in the United States with large disparities in certain populations, including low-income families, those living in rural communities, racial or ethnic minorities, children, the elderly and the developmentally disabled. The surgeon general described the situation as a "silent epidemic" that affects millions of adults and children throughout the United States. The response to this report set several activities in motion. On a national level, the American Dental Association, the Centers for Medicare and Medicaid Services (CMS), and the Health Resources and Services Administration (HRSA) conducted national summits for the purpose of addressing the issue of access to care, and identifying and recommending action steps.

During this period of attention, the CDA Foundation's new emergence on the oral health landscape brought further attention to health professionals and stakeholders beyond dentistry. This attention also leveraged additional funding and interest in understanding the oral health crisis and deployed a number of innovative strategies to reverse the trend.

## Managing the Disease

One of the most exciting CDA Foundation projects has involved research into effective oral disease prevention strategies. Since 2003, the CDA Foundation has partnered with the University of California,

San Francisco (UCSF) School of Dentistry in the development of caries management by risk assessment (CAMBRA) protocols.[2] CAMBRA represents a paradigm shift in dental science from the surgical/restorative treatment of caries to a medical model of disease prevention and management. CAMBRA main principles are[3]:

- Caries is a bacterially generated, transmissible disease that results in tooth decay.
- A patient's risk for caries is different in each individual.
- The caries process is most effectively managed by assessing each patient's individual risk factors (the balance/imbalance of protective factors and pathological factors), and providing interventions that will "tip the scale" to favor health.
- A restorative approach alone will not eliminate the underlying disease of caries.

Following up on initial research, the CDA Foundation has recently expanded its efforts with a multiyear collaboration with the UCSF School of Dentistry to conduct translational research in dental offices to attempt to replicate results of a clinical study to assess caries risk and determine appropriate nonsurgical interventions to manage the disease. With funding from PacifiCare/United Health, and under the direction of co-principal investigators — John D.B. Featherstone, MSc, PhD, UCSF dean, and Peter Rechmann, DDS, PhD — the CDA Foundation has assembled a network of 18 dentists in private practice dentists and community health centers to collect data on changes in risk level and disease status as a result of nonsurgical caries prevention interventions.

## Reducing Barriers to Care for Children

There is little debate that children are the most vulnerable to adverse socioeconomic and health disparities since children are dependent on caregivers to make choices for them and provide the services needed to maintain optimal health. In order to expand services to low-income children, in 2004, the CDA Foundation collaborated with the California Society of Pediatric Dentistry to develop and implement an innovative program to increase access to dental care for very young children.

This program, known as pediatric oral health access program (POHAP), is a statewide workforce development effort supported by a $1.2 million grant from the California Endowment and grants from L.A. Care Health Plan. The program increases access to dental services for underserved children by training general dentists to provide treatment to infants and young children. General practice dentists gain clinical and patient management skills to serve infants and young children over the course of an intensive 32-hour training program that offers didactic lectures, case presentation, hands-on bench training, and advanced local anesthesia and nitrous oxide training. Lectures cover such topics as diagnosis and treatment planning, restorative materials, children with special health care needs, behavior management, and oral disease and injury prevention. In exchange for the free course, dentists agree to regularly accept young patients into their practices and to provide no-cost treatment to 20 low-income children within the first 12 months after completing the program.

**THERE IS LITTLE** debate that children are the most vulnerable to adverse socioeconomic and health disparities

Training sessions have targeted all California geographic regions. Since the program's inception, 414 dentists have been trained throughout the state in private practice and community health center settings. Program evaluation reveals that more than 4,100 children received pro bono treatment valued at more than $3.5 million, and nearly 71,000 children under age 12 received care from POHAP-trained dentists during the 12 months following completion of their training.

## Medical-Dental Integration

Many barriers exist between the medical and dental delivery systems that have historically limited the medical community's involvement in identifying and referring infants and young children with mild oral health disease to their dental colleagues. The CDA Foundation has engaged in numerous projects to strengthen the partnership between dental and medical in an effort to ensure children receive the care they need as early as possible.

### *First Smiles*

With a goal to reduce the incidence of early childhood caries among California children under the age of 5 and those with special health care needs, the CDA Foundation was awarded one of the largest oral health grants ever provided in California from the California First 5 Commission. This four-year $7 million project charged the CDA Foundation and its joint venture partner, the Center for Oral Health (then-known as the Dental Health Foundation), with developing the First Smiles Education and Training Project. First Smiles increased dental, medical and early childhood education professionals' knowledge of early child-

hood preventive oral health strategies, reaching more than 16,000 dental and medical professionals through continuing education courses, and in-office and online training opportunities.[4]

Other major First Smiles accomplishments include the publication of manuscripts in peer-reviewed and scientific oral health journals, the creation of a series of articles in dental trade media, and the development and distribution of more than 1 million parent education brochures in the 10 languages most commonly needed in California dental practices. The First 5 Oral Health website (first5oralhealth.org), an online clearinghouse is accessed by more than 20,000 visitors each month, offers on-demand training, archived webcasts that feature experts in the field, trainer materials, the latest science and research on early childhood caries prevention, a resource guide for parents and caregivers, and tools for dental and medical professionals.

### *Perinatal Oral Health Guidelines*

In early 2009, the CDA Foundation collaborated with the American College of Obstetricians and Gynecologists District IX to convene a consensus conference of experts to develop practice guidelines to assist medical and dental professionals in providing appropriate evidence-based oral health care to pregnant women and young children. The resulting guidelines and companion policy brief were completed in February 2010 and published in the June 2010 issue of the *Journal of the California Dental Association*.[5] To assist health care and social service professionals who work with pregnant women, patient education materials were created as a tool to engage in conversations about the importance and safety of dental care during pregnancy. "Cavity Keep Away" was developed with simple messages for lower literacy populations. It is available as brochures in English and Spanish, and as a double-sided poster in both languages.[6]

Integration of medical and dental care for pregnant women and the establishment of a dental home for the child by age 1 is key to successful implementation of the guidelines. To this end, the CDA Foundation has developed a pilot project to introduce the guidelines into clinical practices, identify barriers to clinical implementation and provide a quality improvement methodology to overcome identified barriers. Project sites may include co-located (medical/dental) community health centers, health maintenance organizations, and private practices. Alameda County has been selected as a pilot site due to a strong existing infrastructure and current programs under way to serve this population.

**CURRENTLY, THERE** is much research under way nationally to understand health literacy's relationship to dentistry.

### *Oral Health Literacy*

Health literacy has been defined as "the ability to obtain, process and understand basic health information to make appropriate health decisions."[7] Currently, there is much research under way nationally to understand health literacy's relationship to dentistry. Given the complex nature of health literacy and the diverse population of California, improving oral health literacy must begin with assembling a broad coalition of stakeholders to create a statewide action plan to accomplish that goal.

The CDA Foundation has begun exploring various efforts around oral health literacy that are occurring across the nation with a goal of developing and seeking funding for a program that will increase the public's knowledge of oral health, its importance to overall health, and the causes of dental disease. A meeting was convened in June 2010 by Robert Reed, DDS, a CDA trustee, Kern County Dental Society, to discuss a demonstration project that would connect oral health and nutrition/obesity prevention through educational sessions in elementary schools in Kern County. The project would conduct a longitudinal study to track oral health status and height/weight to determine the effectiveness of the intervention. The studies' underlying assumption is that children's diet affect both their teeth and weight, specifically as it relates to the frequency and duration of sugar and fermentable carbohydrate consumption; the studies' goal is to test the hypothesis that children and parents who are educated on the issue through targeted and age-appropriate education will make better dietary choices than those who do not receive this education.

## Supporting Dentists in Underserved Communities

New dentists graduate from dental school with an average student debt of $250,000, which is a tremendous burden to a health professional just starting out in practice, particularly those who have a passion and desire to practice in public health settings. The burden of debt limits their options for choosing community health. In 2002, the CDA Foundation created the Student Loan Repayment Grant Program to provide financial assistance toward student debt in exchange for three

years of service in a California practice setting providing dental care to underserved populations. An initial three-year award provides recipients with $35,000 per year for three years ($105,000 total) if educational loans amount to $105,000 or more. If educational loans amount are less than $105,000, recipients will receive up to the total of their qualified educational loan amount. A competitive application process seeks to provide grants to dentists who are likely to remain in an underserved area beyond the terms of the required contract. Recent research shows that health professionals who come from minority backgrounds and rural areas are more likely to return to serve in those areas. As such, preferences in grant awards are given to applications who have a disadvantaged background with economic, social, or other obstacles (as documented by academic institution); lived in a rural, highly minority or health professional shortage area (HPSA) community for an extended period of time, particularly from birth to age 18 and/or; demonstrate an initiative to develop cultural and linguistic competencies reflecting one or more diverse socioeconomic or ethnic communities in California.

Since the program's inception, 11 new dentists have benefited from the program, but most importantly the communities they serve benefit tremendously. Through rigorous reporting, we have learned that each loan recipient provides an average of $500,000 worth of care in their community, or $1.5 million over the course of their three-year commitment, which is a significant return on investment.

This brief review of some of the organization's most recent projects highlights the CDA Foundation's ongoing commitment to improve the public's oral health. With evidence that oral health disparities continue to grow, the CDA Foundation will continue efforts to educate the public and advocate the importance of oral health, and identify programs, projects and guidelines that improve the oral health of California's most vulnerable populations. ■■■■



**REFERENCES**

1. U.S. Department of Health and Human Services. Oral health in America: a report of the surgeon general. Rockville, Md., U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, pages 2-3, 2000.
2. Featherstone JDB, Adair, SM, et al, Caries management by risk assessment: consensus statement, April 2002. *J Calif Dent Assoc* 31(3):257-69, 2003.
3. Young DA, Featherstone JDB, et al, Caries management by risk assessment: implementation guidelines. *J Calif Dent Assoc* 35(11):799-805, 2007.
4. Aved BA, First Smiles education and training project: final evaluation report, March 2008. first5oralhealth.org/. Accessed Dec. 20, 2010.
5. cdafoundation.org/guidelines. Accessed Dec. 20, 2010.
6. cdafoundation.org/cavitykeepaway. Accessed Dec. 20, 2010.
7. U.S. Department of Health and Human Services. Healthy People 2010: understanding and improving health, second ed., Washington, D.C., U.S. Government Printing Office, November 2000.

**TO REQUEST A PRINTED COPY OF THIS ARTICLE, PLEASE CONTACT**
Rolande T. Loftus, MBA, California Dental Association Foundation, 1201 K St., 15th Floor, Sacramento, Calif. 95814.

# Professional Practice Sales, Inc.

**Specialists in the Sale and Appraisal of Dental Practices**

***Serving California Dentists since 1966***

***Where turning "For Sale" into "Sold" is a practiced art!***

## PPS NORTH (415) 899-8580 ~ (800) 422-2818
## www.PPSsellsDDS.com

**5991** **San Francisco's Financial District** Perfect facility. $750,000 in revenues. Busy Hygiene schedule.

**5993** **San Francisco's Financial District** 3-Op office. 3-days of Hygiene. Collects $325,000.

**5994** **California's Lake Tahoe** $800,000+ in collections, Profits of $430,000. Great staff, beautiful office.

**5997** **Fremont** Collected $355,000+ on part-time schedule with $143,000 in Profits.

**5999** **Pleasanton** 2010 collected $690,000+. Profits of $360,000. Digital radiography, computers in Ops.

**6000** **Millbrae** Perfect facility. Downtown sidewalk location. Digitized, computerized. 2010 collected $720,000.

**6002** **San Jose's Silver Creek** Busy Hygiene schedule. Generates $600,000/year. 4-Ops.

**6003** **Western Contra Costa County** Collected $700,000. Busy Hygiene Department. Attractive location and suite.

**6004** **San Jose's Santa Teresa Area** Beautiful 3-Op office. Digital & paperless. Opened 11/09, collected $277,000 in 2010 with $190,000 in Profits.

**6005** **Fairfield – West of I-80** Generates $500,000/year on 2-day week. Strong Profits. Shall do better with more attention.

**"COMING UP" – Filipino Practice – San Francisco's South Bay** Send email to Ray@PPSsellsDDS.com if you would like to learn more.

## PPS SOUTH (714) 832-0230 ~ (800) 695-2732
## www.PPSDental.com

**3164** **Temecula/Murrieta Area** Collects $30K/mth. 5 Ops. Located in shopping center with AAA tenants. FP $385,000.

**3193** **Palm Desert** Grossing $400,000+. Great Location.

**3220** **Temecula** Merger candidate. Spacious office grosses $1 Million - $6,000/mth Cap checks. Develop into contiguous specialty center.

**3226** **Corona** New hi identity shopping center. Grosses $400,000. HMO $3K+/mth & growing. 4 Ops room for more. Bargain price.

**3237** **Anaheim Hills** Group member wanted. Hi identity. GP has space to share with Specialist. Pedo/Ortho/or?

**3240** **Redlands** 5 Ops. Shopping center. Great lease @ $1.00 sq. ft. Grossing $300K. FP $250,000.

**3245** **Arcadia/Monrovia Area** Location only. Million dollar location. 2,500 sq.ft. with 8 Ops, 4 equipped. Very busy shopping center.

**3247** **Glendora** Super shopping center. Established 15 yrs. Like new. Grossing $45K to $60K/month.

**3248** **Small Town near Palmdale** Previous Seller grossed $800K in hi identity shopping center. Available for $250,000.

**3250** **Anaheim – NW Disneyland** Part time, 2 days wk. Hi identity corner. Grossing $362K in '09. 1,800 sq.ft.. 6 Ops equipped.

**3251** **Anaheim** 1,700 sq.ft. rents for $2,400/mth. Established 1967. Conservative Senior. Gross $240K. FP $150K.

**3253** **Porterville/Tulare** Gross $1 million in state of art building first year. 6 Ops, ADEC equip, digitized x-rays. Bargain price. Net $500K first year. Seller referred $250K in Endo. Still produced near $1 Million.

**3255** **Partner Sought for Temecula** Grossing $550K. Absentee. Seller wants working Partner. Outstanding shopping center. Hi identity location.

**3265** **Rowland Heights/Diamond Bar** GP Gross $1.4 million. Absentee. No HMO, No Medi-Cal. 57/60 Area, 8 Ops, 4,000 sq. ft.

**3270** **Downtown** Beautiful 3 Op office in prestigious area of Downtown. Ultra modern. Gross $500K your first year.

**3271** **Costa Mesa** Hi identity office. 1,400 sq. ft., 4 Ops, Pelton crane. 5th Op plumbed. Grossed less than$1 million in past. Proven location @ $125,000.

**3273** **Downtown Alvarado** Beautiful office. 3 Ops. 50% Hispanic, 50% Korean. Free standing building. Grosses $400K part time.

# Professional Practice Sales, Inc.


**Northern California**
**Ray and Edna Irving**
**(415) 899-8580 ~ (800) 422-2818**
**Ray@PPSsellsDDS.com**
**www.PPSsellsDDS.com**

**Southern California**
**Tom Fitterer and Dean George**
**(714) 832-0230 ~ (800) 695-2732**
**PPSIncnet@aol.com**
**www.PPSDental.com**


***110+ years of combined experience and expertise!***

***3,000+ Concluded Sales***

## Call "PPS" Today

**This shall be the best decision you make regarding this important change in your life!**

**CA DRE License #00324962**

# Specializing in the Selling and Appraising of Dental Practices

**CALIFORNIA PRACTICE SALES INC.**


**Serving California Since 1974**

**"Your local Southern California Broker"**

**Phone (714) 639-2775**
**(800)697-5656**
**Fax (714) 771-1346**
**E-Mail: jknipf@aol.com**
**rpalumbo@calpracticesales.com**
**WWW.CALPRACTICESALES.COM**


***John Knipf & Robert Palumbo***

## LOS ANGELES COUNTY

**BEVERLY HILLS** – Leasehold & equip only! Located in multi story historical med/prof. building with parking options. ID #3601
**CENTURY CITY GP** – Well established practice located in a multi story med/prof. building. Project approx. $496K in 2010. ID #3581
**CLAREMONT/ UPLAND Ortho** – Long established practice located a 2 story med/dent building with low rent. ID #3681
**DIAMOND BAR** – Leasehold & equip only! Great opportunity for a GP or Specialist. Located in a 2 story bldg w/12 eq ops. ID #3721
**ENCINO GP** – Price Reduced! 3 fully equipped ops., 1,200 sq. ft. suite, 7 story professional building. NET OF $115K. ID #2631
**HOLLYWOOD** – Equipment & some charts! Located in general purpose building with 5 fully equipped ops. Good exposure. ID #3761
**LOS ANGELES GP** – Building for sale! Well established practice with 32 yrs of goodwill. Excellent signage. Great staff. ID #3771
**LOS ANGELES GP** – Located in a 2 story busy shopping center with great exposure & valet parking. Equip with charts only. ID #3861
**LOS ANGELES** – Over 20 years of goodwill. Turn-key practice is located in a 7 story med/dent building. Low sale price! ID #3791
**LOS ANGELES** – Long established practice located in a shopping center with heavy traffic flow. NET $58K. ID #2771
**MALIBU GP** – Located in a very desirable upscale area w/excellent exposure. Fee for service practice. High quality dental care. ID #3651
**MONTEBELLO** – Price Reduced! Long established practice in a single story busy shopping center. Leasehold, equip. & charts. ID #2701
**SAN GABRIEL GP** – 4 fully eq. office located in a single free standing building. Excellent exposure and signage. NET $178K. ID #3701
**VALENCIA GP** – State-of-the-art office with condo suite available for purchase. Projecting approximately $707K for 2010. ID #3741
**WHITTIER PERIO** – 5 eq. ops., plmbd for N2O2. Single story free standing building for sale. 70 yrs of goodwill. NET $153K. ID #3521
**WOODLAND HILLS PEDO** – Well equipped pedo office with 3 chairs in open bay area. Fully computerized. NET $308K. ID #3661

## ORANGE COUNTY

**ALISO VIEJO** – Beautiful spacious practice with 4 fully eq. ops. Great opportunity for GP or Spec. Leasehold & equip only! ID #3831
**GARDEN GROVE GP** – Turn-key, 3 fully eq. ops., located in a 2 story professional building. Good exposure. Low sales price! ID #3561
**GARDEN GROVE GP Group Solo** – Two offices under one location. Both listings are to be sold together. Condo for sale. Retiring sellers. Great location. Great staff. 72 years of goodwill combined. Excellent potential. ID #3591
**IRVINE** – Price Reduction! Leasehold & equip. only. 5 eq. ops., 1,450 sq. ft suite located in busy Ralph's shopping center. ID #3401
**LAKE FOREST** – Modern design office w/state-of-the-art equip., 4 fully eq. ops, and 2 plumbed eq. ops. Leasehold & equip. ID #3631
**ORANGE GP** – Well established practice located in a single story medical center with 4 fully eq. ops., 1 plumbed not eq. ID #3531
**ORANGE GP** – Established in 1994, the practice consists of 3 eq. ops, in a 1,200 sq. ft. suite located in a 2 story prof. building. ID #3841
**TUSTIN** – Great starter practice for GP or Specialist located in a busy shopping center. Leasehold & equip only! ID #3481
**YORBA LINDA** – Turn-key practice located in a free standing building w/heavy traffic intersection & excellent street visibility. ID #3711

## RIVERSIDE / SAN BERNARDINO COUNTIES

**HEMET** – Established 30 yrs ago this beautiful practice consists of 3 eq ops & 1 plmbd not eq located in a busy shopping center. ID #3851
**MORENO VALLEY GP** – Turn-key w/5 eq. ops & X-ray room w/pano located in free standing bldg. ID #6341
**MURRIETA** – Leasehold, equipment & some charts only! 4 eq. ops., 1,350 sq. ft office located in a single story condo. ID #3221
**TEMECULA** – Turn-key practice located a 2 story building with 4 eq. ops. Easy access to freeway. Low Sales Price! ID #3731
**VICTORVILLE** – Fee for service practice, located in a single standing building w/over 55 years of goodwill. Building for sale. ID #3861

## SAN DIEGO COUNTY

**SAN DIEGO COUNTY** – Busy shopping center with major anchor tenants. 4 fully eq. ops., 1,178 sq. ft. suite. Absentee owner. ID #3341
**SAN DIEGO** – Price Reduced! Located on a major thoroughfare in the heart of San Diego 30 yrs of goodwill. NET $241K. ID #3501
**VISTA** – Well established practice w/31 years of goodwill. Consists of 3 computerized eq. ops, & 2 plmbd not eq. NET $107K. ID #3781

*** UNDER OFFER**

***Call us about Debt Consolidation & Retirement Planning***

**VISIT OUR WEBSITE WWW.CALPRACTICESALES.COM**

**CA DRE #00491323**

John Knipf
President

(Neff)

**Also serving you: Robert Palumbo, Executive V. P. /Partner, Alice C. King, V.P., Greg Beamer, V.P., Tina Ochoa, V.P., & Maria Silva, V.P.**

# Classifieds



## OFFICES FOR RENT OR LEASE

**BAKERSFIELD PEDIATRIC DENTAL OFFICE FOR RENT/LEASE —** Long established pediatric dental office. Four plumbed operatories. Newly remodeled. Quiet room. 1,000 sq. ft. office. Tremendous amount of underserviced young families in the area. $1,250 a month. Please call 661-871-0780.

**DENTAL SUITE IN SANTA ROSA —** Renovated 1,500 sq. ft. office. Has some new equipment and furnishings. Very reasonable rent. Contact 707-494-8498 or e-mail jsmuthy@aol.com.

**DENTAL SUITES FOR LEASE IN SILICON VALLEY —** Renovated ortho, pedo, and general space with views in Los Gatos, an affluent community. Close to schools, downtown and freeway. Contact Trask Leonard at 650-282-4620, e-mail at tleonard@baysiderp.com or e-mail owner at 2340akmeadow@sbcglobal.net.

**EXCLUSIVE DENTAL SUITES FOR LEASE —** Short/long term lease, state-of-the-art equipment and accommodations. Conveniently located off the 101 freeway. Laura Miller 818-758-3557.

**NEW DENTAL BUILDING IN ALBANY —** Prime Albany/Solano Ave. Approximately 1,500 sq. ft. on 2nd floor. Elevator, spectacular design, high ceiling and glass wall. Includes vacuum and compressor. Plentiful parking. Orthodontist landlord on ground floor. Contact Dr. Immi Song at 510-325-9321.

**SANTA CLARA OFFICE FOR RENT OR LEASE —** Fully equipped, six operatories, ample parking, free standing one story building, approximately 1,800 sq. ft. Close to Santana Row. Option to buy. Call 619-644-2906.

**SF BAY AREA/VALLEJO PROFESSIONAL BUILDING —** 1,000-5,000 sq. ft. existing dental/orthodontic office. Inquiries call 707-994-1218.

## OPPORTUNITIES AVAILABLE

**DENTAL ASSISTANT PROGRAM DIRECTOR WANTED —** Program director wanted to develop curriculum/teach at new center in Tarzana, California. Experience required. Call Laura 818-758-3557.

**DENTAL JOBS AVAILABLE —** Aspen offers tremendous earning potential and a practice support model that empowers dentists. We eliminate obstacles for dentists to own their own practice. Call 866-745-5155 or visit aspendentaljobs.com. EOE

CONTINUES ON 114

## How to Place a Classified Ad

For information on placing a classified, contact Jenae Gruchow at 916-554-5332 or Jenae.Gruchow@cda.org.

The deadline for classified advertising is the first day of the month, prior to the month of publication. After the deadline closes, ads will not be accepted, altered or canceled. Deadlines are firm.

Licensed agents and brokers may not place classified ads. For information on display advertising, please contact Corey Gerhard at 916-554-5304 or Corey.Gerhard@cda.org.

CDA reserves the right to edit copy and does not assume liability for contents of classified advertising.

**CLASSIFIEDS,** CONTINUED FROM 113

**OPPORTUNITIES AVAILABLE —** If you're looking for a long-term commitment and desire to be productive, the opportunity is yours! Seeking FT managing dentists to join large group practice in Lancaster, Palmdale, Los Angeles, Orange County, Inland Empire, San Diego and any doctors looking to relocate to Arizona. Steady patient flow in high volume HMO environment. Must have 3-5 years experience and be proficient in molar endo RCT. A comprehensive benefits package is offered including malpractice coverage. Competitive pay! For available positions please call: 714-428-1305, submit your resume to: kristin.armenta@brightnow.com or fax to: 714-460-8564.

**OPPORTUNITIES AVAILABLE —** Virginia Commonwealth University, School of Dentistry is seeking dentists for a full-time faculty position in the Department of General Practice. Ideal candidates will have experience in dental practice management and operations. Responsibilities will include teaching and mentoring undergraduate dental students in preparation for private practice. Methods will include clinical and didactic teaching, course directorship, curriculum development, scholarly activity, mentoring and patient care. Participation in faculty practice and research is encouraged. Demonstrated experience working in and fostering a diverse faculty, staff and student environment or commitment to do so as faculty member at VCU. Applicants must have a DDS or DMD degree and eligible for licensure in Virginia. Required are strong leadership skills, expansive clinic experience and expertise in practice management. Salary and rank will be commensurate with experience and qualifications. Send curriculum vitae and a list of at least three references to: Dr. Alfred Certosimo, Chair of Search Committee, Department of General Practice, School of Dentistry, Virginia Commonwealth University, PO Box 980566, Richmond, VA 23298. Virginia Commonwealth University is an equal opportunity/affirmative action employer. Women, minorities, and persons with disabilities are encouraged to apply.

CONTINUES ON 118

# WESTERN PRACTICE SALES

## John M. Cahill Associates

### BAY AREA

**A-817 BELMONT-** Surrounded by dental specialties in 2-story Prof. Bldg. 860sf w/2 ops +1 **$210k**

**A-8911 SAN FRANCISCO—** Don't hesitate! One of the areas most prestigious addresses! 2,073 sf, 4 ops + plumbed for 1 add'l op. **$585k**

**A-8941 SAN FRANCISCO–** Ready to Move In. Fully Equipped. 2 ops. Plumbed for 1 add'l **$75k**

**A-9361 SAN FRANCISCO–** Blocks from Union Square! 17 story building. 975 sf w/4 ops **$550k**

**B-9381 OAKLAND** - GP in Bustling Area! 1148 sf w/2 ops. **Only $75k**

**C-7811 SOLANO CO -** 2,997 sf w/6 ops + 2 Hyg ops + 1 add'l op! Buy the whole practice for $1.3m or only 50% for $650k. **Call for Info!**

**C-880 PETALUMA—** HMO practice in a Professional medical plaza. Doctor averages 10 patients per day. 800sf and w/ 2 ops, **$295k**

**C-8901 SANTA ROSA–** Residential area. 40+ new pats/mo. Highly Visible! 1291sf & 3 + 1 op. **$475k**

**D-842 PLEASANTON** –1,488sf w/ 2 ops **$295k**

**D-845 SAN JOSE - *Facility* -**Attractive office. Traditional décor. Retail Plaza. 2,240 sf & 5 ops. **$150k**

**D-877 LOS ALTOS -**Pristine Professional plaza. Office is ~ 2,400sf - 6 ops **2009 Collections - $819k!! Asking only $425K**

**D-9091 ATHERTON -**Turnkey operation – no construction hassles, equipment purchase. Would cost nearly twice our asking price to duplicate. 969 sf & 3 ops ***Call for Details!***

**D-912 SALINAS -** Doctor averages 8 patients w/ 8 Hygiene patients per day and generates ~20+ new patients per month. 1,200sf 3 ops. **$275k**

**D-925 SANTA CLARA -** Family-oriented office. 35+ new patients/month by internal marketing: word-of-mouth referrals of quality care and relationships. Retail Shopping Center in the heart of the Silicon Valley. 1,500 sf & 3 ops **$499k**

**D-939 SAN JOSE -** Doctor averages 5 patients daily. Office is ~1,522 sf w/5 ops **Only $195k**

### BAY AREA CONTINUED

**D-926 FREMONT -**Tucked among busy commercial, desirable area is this remarkable opportunity. ~2,000sf w/ 4 ops. **$500k**

**D-9331 SARATOGA– FACILITY ONLY -** Open to General Dentistry & Specialists! State of the Art Equipment in excellent condition 1,187sf w/3 ops **Offered at only $98k**

### NORTHERN CALIFORNIA

**E-729 AUBURN -** Busy retail shp ctr w/excellent signage & good traffic flow. 1750sf, 4ops. Plumbed for 2 add'l ops **$250k**

**E-7121 SACRAMENTO AREA –** Largely FFS. 1800sf, 4ops (+2 add'l plumbed). . **$695k**

**E-818 SACRAMENTO-**Increase the part-time, relaxed workweek & watch the practice grow! 2007 Collections $350k+. 1,200sf & 4 ops. **$315k**

**E-881 SACRAMENTO-**State-of-the-art Practice with growing patient base. 2,400 sf & 3 ops. Plumbed for 3 add'l. Seller flexible w/ transition plans **$250k**

**E-915 ELK GROVE—**Averages 8 patients w/ approx 5-6 new pats/month. Located in an attractive professional building. 1,200sf / 4 ops. **$650k**

**E-8641 SACRAMENTO-FACILITY** Fast Growing Area w/easy access to Tahoe and SF Bay! Single Story office near county buildings. 2,100+ sf w/ 3 ops & plumbed for 1 add'l **$50k**

**G-751 RED BLUFF/CHICO-** Complete remodel ~5 yrs ago. FFS GP. 2350sf /4 ops. Plumbed for 2 add'l. **Practice $175k / Real Estate $250k**

**G-875 YUBA CITY–**Estab. 30 + years, GP, FFS, 3575sf /9 ops, great location. **$1.5m**

**G-883 CHICO VICINITY –** Quality FFS GP. Attractive Prof Plaza. 1,990 sf w/ 5 ops **$535k**

**H-668 NORTHEASTERN CA–**4 ops 1600sf office. 2007 gr rcpts exceed $650k! **$395k**

**H-856 SOUTH LAKE TAHOE** Over 50 new patients/mo Respected & Growing! 1568 sf & 4 ops **$425k**

### CENTRAL VALLEY

**I-685 TURLOCK -** 1700sf, 7 ops. Recently remodeled. Free standing bldg. Mostly Adec Eqpmt. **REDUCED! NOW ONLY $305k**

**I-772 *Facility* STOCKTON-**Desirable, affluent health care area. 2,140sf/4 ops **$150k**

**I-889 MERCED-** Heart of town, bustling with activity & foot traffic. 3 ops **$265k**

**I-923 MODESTO—**1495sf/ 4op+1, Newer, All digital. **$295K**

**J-928 ATWATER -** Well-established & respected for gentle treatment. Prof Bldg in desirable area. 1,313 sf w/3 spacious ops **$230k**

### SOUTHERN CALIFORNIA

**K-887 ESCONDIDO-**Beautifully landscaped dental prof bldg 1,705 sf w/5 ops **$175k**

**K-916 SANTA MARIA—**Location and reputation are only two of the winning attributes of this stunning practice! 1,545 sf, w/ 4 fully equipped ops, **$300k Real Estate also available!**

### SPECIALTY PRACTICES

**I-7861 CTRL VLY ORTHO-** 2,000sf, open bay w/8 chairs. Garden View. 45 years Goodwill. FFS. 60-70 patients/day. Prof Plaza. **$370k**

**D-892 MORGAN HILL ORTHO-** Remarkable Oppty! Floor to Ceiling windows—wooded courtyard. 1900sf & 6 chairs in open bay. **$275k**

**H-913 Orthodontics SIERRA FOOTHILLS –** Strong, loyal base referral base. Practice averages 30 – 60+ pats/day. Pristine, remodeled building w/ ample parking. 2,600 sf w/ 5 chairs/bays **$500k**

**K-929 SANTA MARIA – PROSTHODONTICS -** Where "the patient comes first". Professional building w/large floor-to-ceiling, picturesque windows. 1,400+ sf & 3 ops **$450k**

**Timothy G. Giroux, DDS**

**Jon B. Noble, MBA**

**Mona Chang, DDS**

**John M. Cahill, MBA**

**Edmond P. Cahill, JD**

# 800.641.4179

**View all of our available practices at:**

**westernpracticesales.com**

CARROLL & COMPANY

**"MATCHING THE RIGHT DENTIST TO THE RIGHT PRACTICE"**

Complete Evaluation of Dental Practices & All Aspects of Buying and Selling Transactions

*Serving you: Mike Carroll & Pamela Gardiner*

**3047 WEST SAN JOSE GP**

Owner retiring from well-established practice in professional dental building with 3 ops in 950 sq. ft. office. Ideal location near O'Connor Hospital, Town & Country Village and Valley Fair Shopping Center. Avg. GR $169K+ w/ 60% overhead. Asking $95K.

**3045 VACAVILLE GP**

Turn-key, traditional dental practice with loyal staff and sense of community. Well maintained 900 sq. ft. tastefully decorated office with 2 fully-equipped ops. 2009 GR 224K+, 2010 projected GR as of Aug. $270K+ with 50% avg. overhead. Owner retiring and willing to help for a smooth transition. Asking $172K.

**3006 MONTEREY COUNTY ORTHO**

Est. Ortho practice in 2,668 sq. ft. office with 5 open bay chairs in a professional dental complex. Panorex and Cephlometric X-ray machines. Stable and loyal referral base. Annualized GR as of Oct 2009 are $335K+. Owner retiring and willing to help for a smooth transition. Asking 227K.

**3028 NAPA-SOLANO COUNTY GP**

Owner retiring from well-est. practice in 1,400 sq. ft. facility with 5 ops. All fee-for-service pts. with great word-of-mouth reputation. 2009 GR $731K+, June 2010 FY on schedule for $771K+ with just 4/doctor-days. Asking $518K.

**3041 SOUTH BAY GP**

Well est. & successful practice in gorgeous state-of-the-art facility located in a most desirable area. Modern equipment updated in 2007 and near paperless office. Equipment includes Gendex digital x-rays, Panorex, Cerec & Dexis. 1,653 sq. ft. facility w/6 fully-equipped ops. Avg. GR for past 5 years 1.6M w/59% overhead. 2010 GR as of Aug. on track for 1.5M+. Quality staff. Long term lease available. This is an outstanding opportunity for the experienced dentist looking for a high quality practice. Asking $1.3M.

**3040 MID-PENINSULA GP**

Golden opportunity to own an established mid-peninsula practice and building. Located in professional and residential neighborhood in a charming 1,168 square foot facility w/3 fully-equipped ops. + a hygiene op. Seller retiring and working just 3 doctor days/week. Consistent 4 Year avg. GR $417K+ w/an avg. net of $153K+ & 2010 GR on schedule for $412K+ as of June. Practice Asking Price $297K, building available to purchase; or lease at fair market rent.

SOLD

**3037 PLACER COUNTY GP**

Well est. Placer County General & Cosmetic Practice. 6 fully-equipped state-of-the-art ops., in single story 2,700 sq. ft. stand alone professional building. Avg. GR for past 4 years $1.4M+ with 61% overhead and just 4 doctor-days/week. Approx. 1,954 active patients, all fee-for-service. Seller is re-locating out-of-state but will help for smooth transition. Seller owns the building and will provide buyer with a fair market lease or sell the building to buyer. Asking $1,134,000.

SOLD

**3030 NORTH BAY AREA PERIO**

Owner retiring from well established periodontal practice with excellent referral sources in a 2,411 square foot state-of-the-art office facility with 4 fully equipped operatories and a dedicated staff. Looking for buyer with high ethical standards and great clinical skills. Great location and owner willing to help for a smooth transition. Asking $600K.

PENDING

**Upcoming: Alameda County Perio**


**Contact Us:**
Carroll & Company
2055 Woodside Road, Ste 160
Redwood City, CA 94061

**Phone:**
650.403.1010

**Email:**
dental@carrollandco.info

**Website:**
www.carrollandco.info

*CA DRE #00777682*

# HENRY SCHEIN®
## PROFESSIONAL PRACTICE TRANSITIONS

# "DENTAL PRACTICE BROKERAGE"
## Making your transition a reality.

More information is available on our website regarding practices listed in other states, articles, upcoming seminars and more.

For more information regarding the listings below:
VISIT OUR WEBSITE AT:
WWW.PPTSALES.COM
(Practice Opportunities)

Practice Sales • Mergers
Partnerships • Appraisals
Patient Record Sales

- **APTOS:** *For Sale* - General Dentistry Practice. Highly desirable location. 2008 Gross Receipts over $1Mil. w/adjusted overhead at 51%. 3-operatories in 1,000 sq ft. Pano & Modi computerized software. 9-hygiene days per week. Practice operated for past 33 years in same location. Open 5 days a week. Owner willing to work back for new owner 2 days/wk. #14305 SOLD
- **BIG BEAR CITY:** *For Sale* - General Dentistry Practice. 26 years at current location. Gross Receipts $428K. 3-equipped operatories. Doctor owns the building. New lease available or option to purchase.
- **EL DORADO HILLS:** *For Sale*-General Dentistry Practice. 2009 GR $790,758 adjusted net income of $312K. Intra-Oral camera, Pano, Softdent software, 4-equipped ops. 6-hygiene days. Practice has been in its present location for past 18 years. Owner retiring. #14324 SOLD
- **FOLSOM:** *For Sale* - General Dentistry Practice. Gross Receipts in excess of 1.5M the past three years. 2009 Adjusted Net of $550K. 2,700 sq. ft. office with 7 ops, Digital, Dentrix, Intra-Oral camera, Laser, 5+year old equipment, 8 days hygiene. Beautiful office, great location. Owner retiring. #14336
- **FOLSOM:** *For Sale* - General Dentistry Practice 2009 Collections $513K. Adjusted net income $191K. 4 ops (plumbed for 5), Intra-Oral camera, fiber optics all ops. Patient base software. Owner retiring. #14329 SALE PENDING
- **GRASS VALLEY:** *For Sale*-General Dentistry Practice. 2009 GR of $307,590 (3 days/wk) with adjusted net income of $105K. 3 Ops. refers out most/all Ortho. Perio, Endo, Surgery. Laser, Intra-oral camera, Diagnodent, EZ Dental Software. Good Location. Owner retiring. #14337
- **GRASS VALLEY:** *For Sale*-This Periodontal Practice is located in a very desirable growing community. Practice has been in its present location for the past 28 years. Office consists of 1,500 sq. ft. 3 ops, Intral-oral camera. Practice has 5 days of hygiene. #14272 SOLD
- **GREATER SACRAMENTO AREA:** *For Sale*-Gross Receipts in excess of $1.1 Million dollars for the past three years. Adjusted net $450K. 2,400 sq ft office-5 ops. Hygiene days-6, Owner works 32 hours per week. Eagle Soft, Laser, Pan, Intral Oral camera, fiber optics. Owner retiring. #14343
- **LAKE COUNTY:** *For Sale*-General Dentistry Practice. Gross Receipts 904K with adjusted net $302K. Practice has been in same location for past 23 yrs, and 25 yrs in previous location. 2,600 sq ft with 8 equipped treatment rooms. Intral-Oral camera, Pano, and Data Con software. Owner to retire. #14338
- **LIVERMORE:** *For Sale* - General Dentistry Practice. 2009 Collections were $688K with an adjusted net income of $287K. There are 4 ops in this nicely updated 1,082 sq. ft. office space. Dentrix software, 6-days/wk hygiene. Owner has been in same location for 36 years with long-term employees. Owner is retiring. #14326 SOLD
- **LOS ANGELES:** *For Sale* - General Dentistry Practice.1,200 sq ft 4ops, 29 yrs in present location. Gross Receipts $274K with adjusted net income of $89K. Owner to retire.
- **LOS ANGELES:** *For Sale* - General Dentistry Practice: This practice 80% Dentical and has approximately 2000 active patients. Owner has operated in same location for 31 years. 2009 receipts were $709,000.-6 equipped ops, 4 rms, laser, Intra-Oral camera Pano and Ceph. Call for details. #14319 SALE PENDING
- **MODESTO:** *For Sale* - General Dentistry Practice. 5 operatories, 32-years in practice. Gross Receipts $884K w/adjusted net income of $346. Dentrix, Cerec, and Intra-Oral camera. Owner to retire. #14308 SOLD
- **NAPA:** *For Sale* - General Dentistry Practice. Gross Receipts $800K, with adjusted net income of $250K. Fee for Service. 1300 sq ft 4 ops 6 hygiene days. 38 yrs in present location, 30 yrs in previous location. Owner to retire. SOLD
- **NORTHERN CALIFORNIA:** *For Sale* - Pediatric practice. Owner has operated in same location for 32 years. Approx. 1,760 active patients, 1,160 sq. ft., Panoramic X-ray, Dexis Digital and Dentrix software in this 5-chair office. 2009 Gross Receipts $713K with 48% overhead. Owner retiring. Call for details. #14322
- **OCEANSIDE:** *For Sale* - Modern looking office. 4 op, office space and equipment only. Belmont chairs. Gendex x-ray system, intraoral camera, approx 1200 sq ft. Low overhead-Rent is $1,900/month, and it's a 5 year lease. Staff is available for rehire-front desk $15/hr, assistant 13/hr. Update all the computer systems after purchasing the office in 07. Computers and monitors in every room. #14346
- **OROVILLE:** *For Sale* - General Dentistry Practice. Owner dentist recently deceased. 2009 collections $770K. Very nice stand alone dental building with basically 7 ops digital x-ray 5 days of hygiene. Bldg 3,000 sqft Basement 540 sq ft. Temporary Dentist in place. SOLD
- **PALM SPRINGS:** *For Sale* - General Dentistry Practice. Fee for Service. 2009 Gross Receipts $282K with adjusted net income of $157K. 1,280 sq. ft., 3 equipped operatories. Intra-Oral camera, Pano, Practice-NEB software. Doctor willing to transition by working 1-2 days a week. #14332
- **PLUMAS COUNTY:** *For Sale*-3 equipped ops. Space available for 4th op. 1,245 sf office in good location. 2009 gross receipts $475K. Practice in present location over 50 years. Owner is retiring. #14318
- **REDDING:** *For Sale*-Owner looking for Assoc. trans. into Partnership w/Buy-Out. GR $1 Million dollars income $436K. 5.5 days hygiene, 2,200 sq. ft. #14293
- **RENO:** *For Sale* - General Dentistry Practice and Dental Building: 2009 Gross Receipts $517K with adjusted net income of $165K. 4 ½ hygiene days/week. 1, 800 sq. ft. with 6 equipped ops. (7 Avail). Dentrix software, Pano. Practice has been in its present location for 40 years. Owner retiring. SOLD
- **ROCKLIN:** *For Sale*-General Dentistry Practice. Gross Receipts: $560K in 2010. Office is 1,630 sq ft, with 4 operatories equipped with fiber optics. Owner has been in present location for the past 13 years. 3 ½ days of hygiene. Intra-Oral camera, Dentrix software. Owner to retire.
- **ROSEVILLE:** *For Sale* - General Dentistry Practice. Great Location. 2009 GR $900K with adjusted net income of $500K. 1,975 sq. ft. with 4 ops, 8 days hygiene/wk. Digital, Intraoral camera, Dentrix, Trojan, fiber optics, P & C chairs, all less than 5 years old. Owner is retiring. #14327 SALE PENDING
- **SACRAMENTO/ROSEVILLE:** *For Sale* - One of many partners is retiring in this highly successful General Dentistry Group Practice. Intra-Oral camera, Digital Pano-Dexis, electronic charts, owner Financing. Call for further information. #14334
- **SAN FRANCISCO:** *For Sale-Patient Base for Sale*-Owner passed away last June and the practice has continued on 4 days a week with an associate. Lease can't be signed. There are approx. 1,000 acive patients in the practice. The patient base can be purchased at no risk to buyer since the purchase price is paid according to the receipts collected on the patients that transfer. #14312 SOLD
- **SAN DIEGO:** *For Sale*-General Dentistry Practice. This office is plumbed for 4 ops. 3 ops. are equipped with Promo Equipment. Lease is $2,200 per month. 2009 receipts were $185,645. PPO and Fee for service practice. #14315 SALE PENDING
- **SAN DIEGO:** *For Sale*-General Dentistry Practice. 6 ops, Intra-Oral camera, Eagle Soft Software. Office square feet 2,300 with 3 years remaining on lease. 2009 Gross Receipts $1,448,520, with an adjusted net income of $545K. Doctor would like to phase out then retire. #14331
- **SAN DIEGO/CITY HEIGHTS:** For Sale-General Dentistry practice. Owner has operated in same location for 12 years. Approx. 1,000 active patients, Panoramic X-ray, Intra-Oral camera, in this 3-chair office. #14321
- **SANTA BARBARA:** *For Sale* - General Dentistry Practice. This excellent practice's 2009 gross Receipts $891K with steady increase every year. Practice has 6 days of hygiene. 1,690 sq. ft., 5 ops, Laser, Intra-Oral camera, Schick Digital X-Ray, Datacon software. Doctor has been practice in same location for the past eleven years of his 31 years in Santa Barbara. Doctor is retiring. #14333 SOLD
- **TORRANCE:** For Sale- General Dentistry Practice: Owner has operated in same location for 20 years. Approx. 1,000 active patients, 1,080 sq. ft., Brican System, and Camsight software in this 2 equipped, 3 available-chair office. 2009 Gross receipts $434K with 38% overhead. Owner relocating. #14320
- **TRACY:** For Sale- Equipment, furnishings, and leaseholds only. In the Central Valley. Fully equipped including 4 Belmont Accutrac chairs, 2 Midmark chairs, 6 DCI rear delivery units, 3 Gendex X-ray units, 1 Soridex digital x-ray processor, 1 Statim 5000, 1 Harvey autoclave. 2,800 sq. ft., 6 Ops. New lease available from landlord. #14335
- **VISALIA:** General Dentistry Practice. Gross Receipts $616 with an adjusted net income of $ 321K. Office is 1,380 sq ft with 3 equipped operatories, Intra-oral camera, Digital X-Rays, Mogo software, equipment & leaseholds look new. 5 years in present location. Owner to relocate. #14347

## CALIFORNIA / NEVADA REGIONAL OFFICE


**HENRY SCHEIN PPT INC.**
California Regional Coporate Office
**DR. DENNIS HOOVER, Broker**
Office:(800) 519-3458 Office (209) 545-2491
Fax (209) 545-0824 Email: dennis.hoover@henryschein.com
5831 Stoddard Road, Ste.808 Modesto, CA 95356

**Henry Schein PPT Inc., Real Estate Agents**
and Transitions Consultants
Dr. Tom Wagner (916) 812-3255 N. Calif.
Mario Molina (323) 974-4592 S. Calif.
Hallie Johnson-Nelson (209) 545-2491 N. Calif.
Thinh Tran (949) 533-8308 S. Calif.

CLASSIFIEDS, CONTINUED FROM 114

**OPPORTUNITY AVAILABLE IN NORTHWESTERN WASHINGTON —** Seeking experienced dentist for busy, established, rapidly growing, fee-for-service group dental practice. Excellent immediate income opportunity ($180K to $375K + per year) depending on productive ability and hours worked. Secure long-term position. You can concentrate on optimum patient treatment without practice management duties. Newly equipped, modern office with excellent staff and lab services provided. If you are bright, energetic with a desire to be productive, very personable, people oriented and have great general and specialty clinical skills, please fax resume to Otto J. Hanssen at 425-484-2110.



**OPPORTUNITY AVAILABLE IN OXNARD —** Seeking a production driven dentist to work full-time at busy dental office in Oxnard, CA. Spanish speaking required. For more info e-mail afocil@law.cwsl.edu or call 805-340-9893.

## OPPORTUNITIES WANTED

**IN HOUSE PERIODONTIST/IMPLANT SURGEON AVAILABLE FOR YOUR PRACTICE —** In the Greater San Francisco Bay Area. Implant Surgeon/ Bone Grafting/Perio Surgery/3rd Molar Extractions. Email bayareaperio@gmail.com or call 617-869-1442.

**TEMPORARY DENTIST —** Very experienced, available to cover your practice in case of illness, injury or vacation. S.F. Bay Area, Northern California. Contact 925-757-1383.

## PRACTICES FOR SALE

**GENERAL PRACTICE IN EL CAJON/SAN DIEGO FOR SALE —** Mainly cosmetics, C&B, implants. No pedo, no HMOs. All PPOs and cash. Collected over $650K in the last three consecutive years. Reduced price from $525K to $395K. Buy directly from owner. Options of long term-lease or buy the building as well. Call 619-401-0444.

**GP FOR SALE NEAR BERKELEY —** Doctor has to leave state due to spouse transfer. Twenty years in practice, three operatories plumbed for four. Growth potential, currently working 32 hours. Asking $190K. If interested call 925-207-7976 or e-mail ddsdeb@mac.com.

**STOCKTON PRACTICE FOR SALE —** Visible and easily accessible 1,100 sq. ft. practice. Ideal opportunity for a dentist looking to start a practice or for someone looking to expand. Great location, next to shopping. Equipment/charts included. Buyer would take over building lease. Selling dentist is retiring. Contact 209-957-0765 or 209-598-1640.

# PRACTICE FOR SALE...

## . . . and have the right buyer?

**Lee Skarin and Associates will "Package" your sale efficiently and at low cost.**

**It's easy when you know how! Knowing how, means doing all of the following—with precision!**

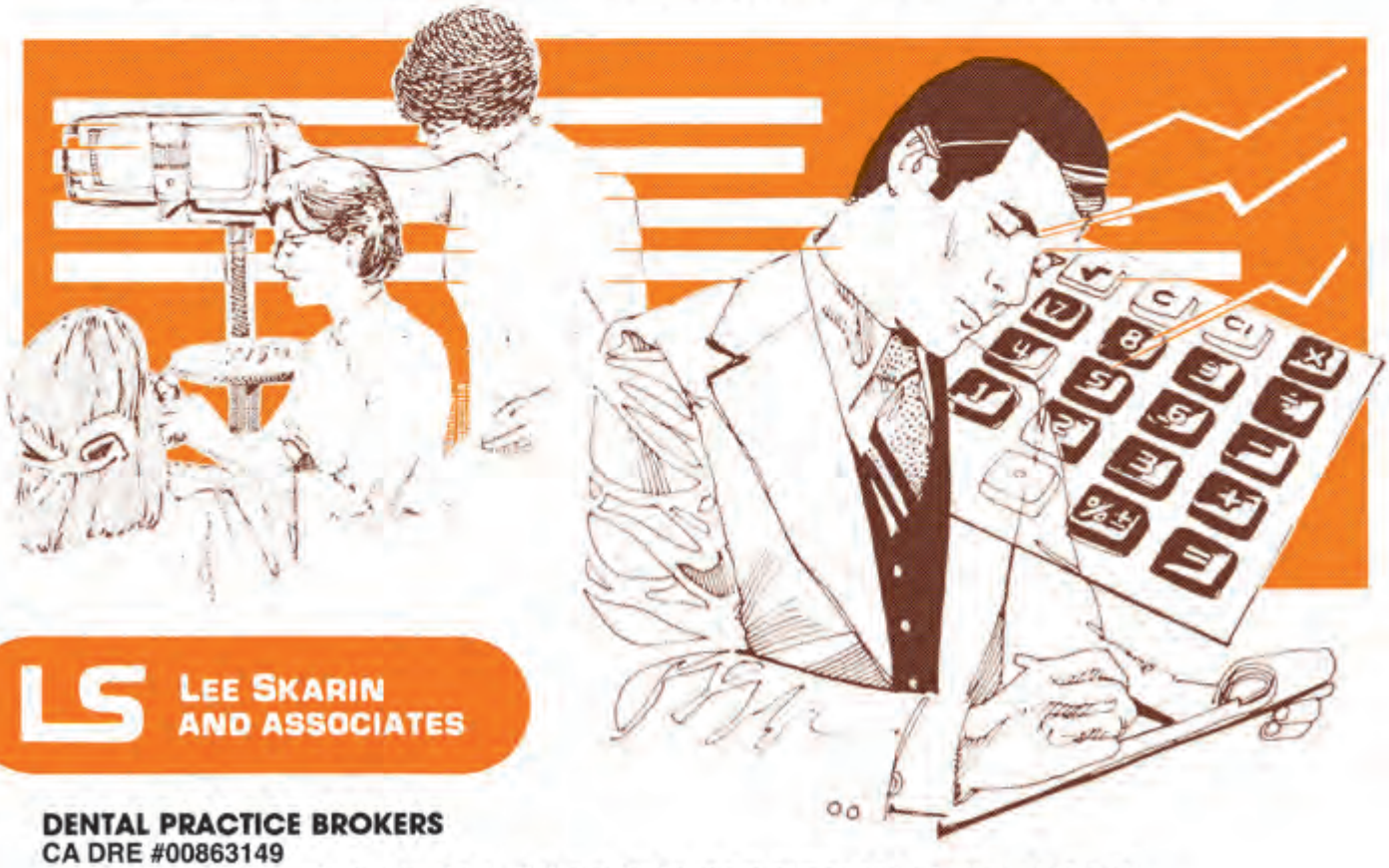
1. Valid practice appraisal;
2. Contract preparation and negotiations, including critical tax allocation consideration;
3. Bank financing or Seller financing, with proper agreements to adequately protect the Seller and make the deal close – realistically and expeditiously;
4. Performance of "due diligence" requirements, to prevent later problems;
5. Preparation of all documentation for stock sale, when applicable;
6. Lease negotiations;
7. With Lee Skarin & Associates, all of the above occurs on your behalf—WORRY-FREE—from beginning to end.

**ALL SEVEN OF THESE SERVICES COSTS NO MORE. MAYBE EVEN LESS!**

Lee Skarin & Associates, is California's leading Dental Practice Brokers. Their in-house attorney, Kurt Skarin, Ph.D., J.D., specializes in these matters. He does all of the above, and more. He is the catalytic agent that makes the sale happen, quickly, and smoothly.

**Any Questions? Call Kurt Skarin, now at** **(818) 991-6552**

**Lee Skarin & Associates has scores of Buyers in their computer. The Buyers' profiles in practice interest and financial ability, have been categorized to expertly select the right Buyer for your practice. Expert Buyer selection solidifies a deal, eliminating that overzealousness to sell that can cause lasting harm. Lee Skarin & Associates services all of Southern California from three strategically located offices — one is near you.**



**LS LEE SKARIN AND ASSOCIATES**

**DENTAL PRACTICE BROKERS**
**CA DRE #00863149**

**Your calls are invited. Put our thirty years experience to work for you!**

(805) 777-7707 (818) 991-6552 1-800-752-7461

## ADVERTISER INDEX

| | | |
|---|---|---|
| A. Lee Maddox, A Professional Law Corporation | maddoxpracticegroup.com | 66 |
| Academy of General Dentistry | agd.org/sandiego | 67 |
| Aspen Dental Management | aspendentaljobs.com | 105 |
| California Practice Sales | calpracticesales.net | 112 |
| Carroll & Company Practice Sales | carrollandco.net | 116 |
| D&M Practice Sales and Leasing | dmpractice.com | 118 |
| Golden State Practice Sales | 925-743-9682 | 114 |
| Implant Direct | implantdirect.com | 82 |
| Lee Skarin and Associates, Inc. | leeskarinandassociates.com | 119 |
| Leslie Canham and Associates | lesliecanham.com | 87 |
| Maddox Practice Group | maddoxpracticegroup.com | 110 |
| Midwest Dental | midwest-dental.com | 103 |
| Professional Practice Sales | ppsdental.com | 111 |
| Professional Practice Transitions | pptsales.com | 117 |
| Select Practice Services, Inc. | betterobin.com | 123 |
| The Dentists Insurance Company | tdicsolutions.com | 62, 68 |
| TOLD Partners, Inc. | told.com | 113 |
| Ultradent Products | ultradent.com | 124 |
| US Bank | 951-296-3357 | 99 |
| Western Practice Sales/John M. Cahill Associates | westernpracticesales.com | 95, 106, 115 |
| Wood and Delgado | dentalattorneys.com | 114 |

FOR ADVERTISING INFORMATION, PLEASE CONTACT COREY GERHARD AT 916-554-5304.

**DR. BOB,** CONTINUED FROM 122

Not that there haven't been products that needed recalling. Dentists have shelves of these in their labs and stashed away in closets, but since nobody ever offered to recall them, dentists just bit the bullet and eagerly bought the next gadget or modality that was so new and improved, they simply couldn't practice without it.

But — just supposing that, say, Acme Oral Products, Inc., a subsidiary of Acme International GmbH, famous for supplying all the high-tech products used by Wile E. Coyote in his incendiary pursuit of the Road Runner, decides to recall their widely used silver amalgam product "I Can't Believe It's Not Sterling." Tens of millions of restorations have been successfully placed by dentists over the years using this product. The only complaint ever recorded was that, esthetically, they were on a par with homemade soap. Suddenly that changes, according to our scenario. During DC101's annual Chili Cook-Off held in Washington, D.C., to benefit The National Kidney Foundation, tragedy strikes. At the zenith of the festivities featuring the rock band Puddle of Mudd, 17 musically challenged youths simultaneously complained of fractured amalgam fillings. Initially this phenomenon is attributed to the decibel rating of the band that is comparable to a B-58 using its reverse thrusters. Later, the blame falls on the chili submitted by Edith Mae Flithers of Lubbock, Texas. A hastily conducted examination of her entry reveals an unacceptable ratio of goat gristle to pinto beans whose sell-by date has been exceeded by 18 years.

Within 24 hours, a busload of trial lawyers materializes. A class-action suit is immediately filed naming Ms. Flithers, Acme International GmbH and, by default, every dentist who ever placed an amalgam made of Acme's alloy as defendants. This is promptly amended when it is discovered that Edith Mae hasn't a pot to cook in, nor a window to throw it out of, but the dentists and Acme are retained as deep-pocket targets of opportunity.

A forensic laboratory hired by the lawyers on behalf of themselves and their star plaintiff, 20-year-old Sylvester (Sly) Buttinski, discovers the fractured amalgam restorations all contain trace amounts of the rare metal potrezebie that has been suspected of causing early onset pregnancy in Rhesus monkeys. Acme, in deposition, assures the court that it gave full disclosure to the dentists, claiming it had no idea they were going to put their product in peoples' mouths. With billable hours amounting to hundreds of thousands of dollars, each dentist's attorney counter-claims that Acme did no such thing. Plaintiff Buttinski demands that all his fillings be replaced with white "stuff."

During the next nine years, 7 million patients cheerfully join in the class-action suit with the proviso that "if it don't cost me nothin,' I'm in!" The delays, continuances, requests for mistrial and plea bargaining continue with the speed of continental drift. Eventually, everybody dies and history records the trial with the same respect accorded the Scopes Monkey Affair.

The point is, there are *recalls* and there are recalls. With one, parties show up defining themselves as victims and expecting to get a piece of the settlement, sometimes as much as $2 or $3; with the other, appearance is iffy because there could possibly be discomfort in terms of an unfavorable diagnosis and a fee. Read the fine print. If there is a legal person who appears to come out better than you do, act accordingly. ■■■■

CDA JOURNAL, VOL 39, Nº2

# Total Recall

Obviously, there are certain differences between Toyota's recalls and our own.

Robert E. Horseman, DDS

ILLUSTRATION BY DAN HUBIG

*New York (CNNMoney.com) Toyota, the world's No. 1 automaker, recalls 5.3 million cars because of potentially sticking accelerator pedals.*

The above headline caused dismay among distraught Camry, Corolla, Avalon, Tundra and Sequoia owners, some of whom had already altered the symmetry of their garages after applying brakes that were ineffective when confronted by a stubborn gas pedal.

Even more discomfited were the thousands of Toyota franchises, normally quite comfortable with the variations of "sticking" as in "sticker price" or "sticking it to you." Dealers were forced to reconsider the possibility of acquiring Yugo dealerships as they pulled their brand-new inventory of cars off their lots pending news from the Kentucky base of the mother corporation's engineers that the solution to the vexing problem might be a squirt or two of WD-40.

Aloof from all this disquietude was the entire dental profession. This conscientious group has promulgated a recall system since the time of Pierre Fauchard. It advised King Louis XIV that his lower denture had a defective peripheral extension problem and he should pop in for a rebase whenever affairs of state permitted. No waiting, no charge — it's good to be the king, it said.

Obviously, there are certain differences between Toyota's recalls and our own to the extent that a successful recall system in dentistry is mandatory and pegged at six-month intervals to discourage the "if it don't hurt, don't fix it" attitude held in lofty disregard by many patients.

CONTINUES ON 121

*When you want your practice sale done right.*

# BetteRobin, DDS, JD

**DENTIST ATTORNEY BROKER**

Loma Linda Dental 83  Southwestern Law 95


**Select Practice Services, Inc.**
Dental Practice Sales and Transitions
877.377.6246 • www.BetteRobin.com
17482 Irvine Blvd., Ste E • Tustin, CA 92780