

Journal

CALIFORNIA DENTAL ASSOCIATION

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Oral Health Infrastructure: The Value of State Oral Health Programs

Lewis N. Lampiris, DDS, MPH



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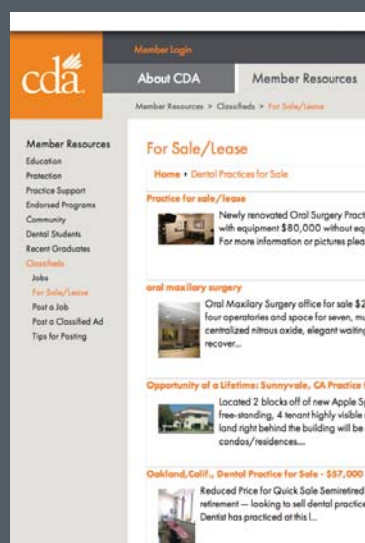
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Dentistry's Changing Landscape

I'd like to commend CDA's leadership and thank the contributing writers ("Controversies in Dentistry" and "Dentistry at the Crossroads" by Richard T. Kao, DDS, PhD, "The Perfect Storm" by Marc B. Cooper, DDS, and "Decision Dilemmas and Opportunities for the New Graduate Dentist" by Natasha Anne Lee, DDS) in the February 2014 *Journal* for providing an in-depth review of dentistry's changing landscape. The articles presented a thoughtful description of the current state of the dental industry, showcasing the varied, alternative practice models that have evolved and how they offer diverse options for both new and seasoned dentists.

I'm co-president of the Dental Group Practice Association (DGPA), an industry trade group that brings together dental support organizations (DSO) and industry partners to share best practices and support dental professionals to improve access and provide quality dental care. DGPA represents more than 25 DSOs in 44 states, including the California-based company I founded and lead, Pacific Dental Services. In total, DGPA member companies support more than 7,000 dentists who serve more than 27 million patients annually, including nine DSOs in more than 200 locations throughout California.

It is true that today's dentists will encounter a changing business landscape that is much different than the ones professionals were confronted with in the past; yet we must not let our current comfort with the traditional models

deter us from embracing the beneficial changes our industry needs to continue, grow and flourish in the future. As the son and grandson of two proud dentists, I've experienced firsthand on both a professional and personal level the shift highlighted in these articles. And I've seen how the existence of varied practice models can be a solution to the challenges many professionals, young and old, face — financial, regulatory and personal.

The articles noted how the number of dentists supported by DSOs is increasing and that increase has not occurred without questions from

within the dental industry, and even some from lawmakers. DGPA members abide by a code of ethics that affirms our primary objective to "support dentists so that they may improve access and the quality of dental care for their patients, as well as the quality of life for themselves and their dental professional colleagues." As CDA and other professional organizations explore the role of DSOs in supporting dentists to expand and optimize the delivery of oral health care, we encourage an open dialogue to improve the understanding of how the DSO model benefits dentists, patients and the community.

To learn more about DSOs, visit thedgpa.org or contact me at info@thedgpa.org.

Stephen Thorne, BS, MHA
Co-president, DGPA
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The *Journal* welcomes letters

We reserve the right to edit all communications. 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 should be submitted at editorialmanager.com/jcaldentassoc. By sending the letter, the author certifies that neither the letter nor one with substantially similar content under the writer's authorship has been published or is being considered for publication elsewhere, and the author acknowledges and agrees that the letter and all rights with regard to the letter become the property of CDA.

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Diversity Today

By Brian Shue, DDS, CDE

What is diversity? “I believe that diversity is appreciating and being open to understanding and respecting people for who they are,” Kathleen Roth, DDS, said in an interview during her term as ADA president-elect. “We all have unique cultures, religions, backgrounds, families and opinions. When each of us takes the time to connect with our friends and colleagues openly, we can appreciate fully who we are and value what we all bring to discussions.”¹

Though diversity means many things, no one can dispute its significance in the direction and future of our dental organizations. Look no further than its prominence in our current ADA mission statement: “The ADA is the professional association of dentists that fosters the success of a diverse membership and advances the oral health of the public.”

The challenge of diversity involves addressing factors like inclusion, participation and leadership. The ADA Institute for Diversity in Leadership is one successful program that covers all of these facets.

Created in 2003, the Institute selects 12 dentists each year who are “members of racial, ethnic and/or gender groups that have been traditionally underrepresented in leadership” and provides leadership training at ADA headquarters in downtown Chicago with faculty from Northwestern University’s Kellogg School of Management and Duke University. Those selected also develop a project of their own that focuses on a community-related issue.

The Institute participants attend at no cost and all travel expenses — transportation, lodging and meals — have been provided since the beginning by ADA and corporate sponsors P & G and Henry Schein Dental. Note that



The challenge of diversity involves addressing factors like inclusion, participation and leadership.

this program is different from the ADA/Kellogg Executive Management Programs for Dentists, which is tuition-based.

ADA President Charles Norman, DDS, explains the importance of the Institute:

“It provides a valuable opportunity for leadership training to those colleagues from diverse backgrounds. The experience gained at the Institute will hopefully hasten their involvement in organized dentistry and stimulate them to become mentors to other dentists with similar diverse communities. The complexion of the current dental school enrollment is a testament to how quickly the membership of the ADA is going to change, and we need young graduates to see their contemporaries as active participants in their professional organization.”

And so far, it has had an impact on our direction as a professional organization. “The Institute alumni are a growing national network of dentists committed to serving the profession and the public,” said ADA Director of Dental Society Services Joe Martin. “Thirteen alumni were delegates or alternates in the 2013 ADA House of Delegates; and alumni are active volunteers with constituents and components across the country.”

“They support each other in their leadership efforts, mentor other dentists going through their Institute year and recruit more dentists to be actively involved with their dental associations,” Martin said. Always looking for inspiration for the Institute, he has already incorporated the 2013 CDA House

of Delegates speech on leadership by Arthur Dugoni, DDS, into the program.

Don’t think you could ever be picked to participate in this national endeavor? It can happen. I participated in the Institute in 2004-2005. I learned much about myself and leadership; it helped develop my skills, which I have applied in organized dentistry as well as in my community health center practice.

Regardless of one’s previous experiences and background, taking that first step is never easy. I became a member of the San Diego County Dental Society in 1994 and always wanted to write for its newsletter. But I never did, remaining a silent member for 11 years. That all changed as the Institute strengthened my determination to move forward and contribute to my profession. I joined the SDCDS editorial board in 2005 and became its editor the following year. I have been reaching for leadership opportunities ever since.

I have three great mentors from my Institute program: Alan Felsenfeld, DDS, Gene Sekiguchi, DDS, and Carol Summerhays, DDS, who all remain instrumental to me. I found another, Dr. Roth, immediately after my Institute program ended. And many leaders throughout California have encouraged me along the way: Kerry Carney, DDS, Bruce Donald, DDS, Douglas Gordon, DDS, and Ron Mead, DDS, as well as San Diego County’s Clayton Fuller, DDS, John Geis, DDS, Barbara Kabes, DDS, MS, and David Richards, DDS, PhD, to name just a few.

And this is not unique to me. CDA whole-heartedly embraces its members who attend the Institute. And there are many of us — out of the 129 dentists selected to the Institute nationwide, 24 are California dentists. There could be an Institute participant in your local component. Or you may already know one. After all, ADA reports 44 percent of all IDL participants have served or currently serve in a leadership position at the local and/or state level. Institute participants from California have served in many leadership roles, including component president, CDA Board of Trustee, delegates to the ADA and CDA Houses, as well as in leadership

positions in other dental organizations.

CDA members who have attended the Institute have been invited to speak at CDA in Sacramento and have participated in CDA Leadership Education Conferences. Some have been appointed “guests of the CDA Board of Trustees,” which are nonvoting positions that allow participation in CDA governance at the board level. “It’s been inspiring to see how the CDA and California components reach out to actively engage California dentists from the Institute community,” Martin said.

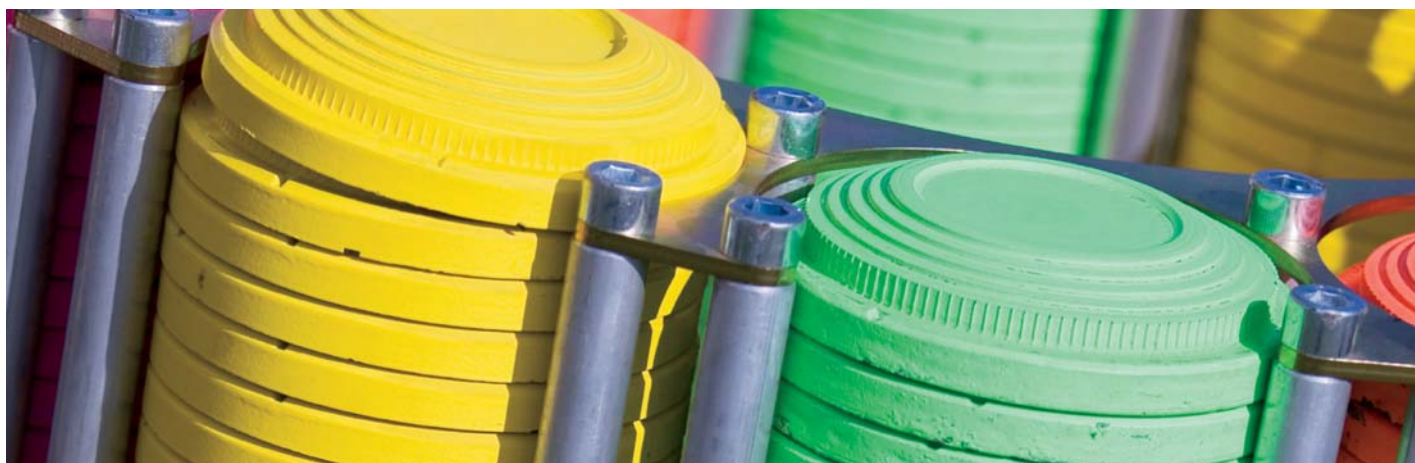
“Diversity to the ADA means that we as an organization strive to reflect the varied membership which we represent,”

Roth said. “This means opportunity for representation at all levels of our tripartite and a true voice for all members.”

The deadline to apply is April 30, 2014, and application information can be found at ada.org/5402.aspx. If you have questions, contact ADA at 800.621.8099, x4699 or starsiaks@ada.org.

The Institute has been dynamic in striving to improve our profession. You could be among the next class. To quote a famous doctor and author, “Oh, the places you’ll go!” ■

1. Shue BK. Diversity: 10 Questions With ADA President-elect Dr. Kathleen Roth. SDCDS Facets; Feb. 2006:12-13.



CDA Foundation Sporting Clays Fundraiser

Help the CDA Foundation in its efforts to improve the oral health of all Californians by joining us for camaraderie, fun and a fundraising opportunity at our fifth annual Targeting Smiles Sporting Clays Tournament May 3. This event is set in the Northern California county of Solano, north of the Sacramento Delta.

For details and to register, visit cdafoundation.org/targetnorth





The nub:

1. Look to commercial concerns only after completely satisfying all professional obligations.
2. "Others are worse" is an ethical dodge.
3. "Drafting," remaining silent while benefiting commercially from the cover provided by the really bad, is hypocritical.

David W. Chambers, EdM, MBA, 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*.

Commercial Cover

David W. Chambers, PhD

For most of the 20th century, the industrial elite ruled over the poor of South America, often by getting favorable laws passed and sometimes using thug tactics. When the drug cartels came, the privileged class did not turn nice. They upped their game, buying better politicians and outfitting a paramilitary. In commercial competition, one group provides cover for the others.

When one airline raises its fares, others follow, often just short of matching. Each summer, hospitals hire a crew of consultants to survey what other hospitals are charging so that they can set their fees "competitively."

It is human nature and good business sense to be slightly ambivalent about competitors who are blatantly commercial and successful. If the rising tide lifts all boats, it is a very comfortable position to sit in a stronger second place while taking the moral high ground of gently complaining about the crassly commercial.

Dentistry is a business and a profession. Recently there has been a lot of grumbling about commercialism, especially about corporate ownership business models. I would have expected a massive, indignant repudiation of everything using dollars as the measure of what is good in dentistry. The silence is worrisome. True, the American College of Dentists has issued several position papers challenging commercialism and the intrusion of third-party values and the Academy of General Dentistry has also begun raising important questions. But the voice of the leaders in the profession could be stronger.

Dentistry is a regulated business like real estate, requiring a license from the state. In California, the Department of Consumer Affairs sets minimal standards for commercial enterprises. Removing the license of a practitioner who conspicuously damages patients is a difficult process, as the lawyers will remind us, because it deprives the bad actor of his or her livelihood. Removing a license for maximizing financial gain, as long as some minimal standards are maintained, would be unthinkable.

It is not okay to switch between commercial and professional standards to suite the circumstances. The profession sometimes campaigns for important patient benefits that happen to coincide with commercial interests for dentists. The legislature and the public have difficulty understanding which is the operative motive. Promoting fluoridation and other public health actions would be less ambiguously worthy. Some practitioners feel inoculated from ethical matters because they are following the law. The uneasy quiet of the profession on the dangers of commercialism could be interpreted by those with suspicious minds as evidence that all dentists are benefiting from standards that are drifting toward economic measures of success.

The American College of Dentists has a simple rule for removing the commercial cover on dentistry. Dentistry is answerable to two standards: a commercial one and a professional one. Where there is conflict, the professional standard takes complete precedence. ■

Chairside Screenings Could Save Health Care Costs

A recent study in the *American Journal of Public Health* has found that if dentists screen for the most common chronic medical diseases, it could save the American health care system as much as \$102.6 million annually.

According to the Centers for Disease Control and Prevention, 7.8 percent of the U.S. population has undiagnosed hypertension, 2.7 percent has undiagnosed diabetes and 8.2 percent has undiagnosed high cholesterol. Screening for these conditions in dental offices could lead to savings of up to \$102.6

detecting chronic, systemic disease. This study shows that dentists can contribute to reduced health care costs in the U.S. by screening for chronic conditions.”

According to the Centers for Disease Control and Prevention, about half of all American adults suffer from chronic illnesses, which account for more than

75 percent of health care costs and 70 percent of deaths each year in the United States. Chronic diseases are estimated to cost the country \$153 billion annually in lost productivity.

For more information, see the study published Feb. 13, 2014 in the *American Journal of Public Health*.



million, or \$33 per person screened, and healthier outcomes for patients.

“As many as 27 million people visit a dentist but not a physician in a given year,” said Kamyar Nasseh, PhD, lead author of the study conducted by the ADA Health Policy Resources Center (HPRC). “This presents an opportunity for dentists to be part of an integrated health care team working to combat chronic illnesses.”

“We have long known that the mouth is the window to the body,” said ADA President Charles H. Norman, DDS. “But we have an increased understanding about roles that dentists can play in

Scientists Begin to Uncover Mystery of Oral Bacteria

Scientists have begun to chip away at the mystery of bacteria in the mouth by piecing together sections of DNA from 12 individual BU063 cells to sequence the genome of a bacterium known to live in healthy human mouths.

BU063 is closely related to the pathogen *Tannerella forsythia*, a bacterium linked to periodontitis. But despite being related, the new research from The Ohio State University revealed that they have clear differences in their genetic makeup.

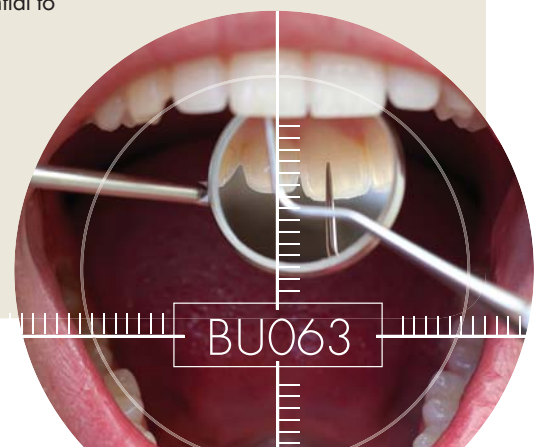
Those genes lacking in BU063 but present in *for*sythia — meaning they are a likely secret behind *for*sythia’s virulence — are now identified as good targets for further study, researchers said.

“One of the tantalizing things about this study was the ability to do random searches of other bacteria whose levels are higher in periodontitis,” said Clifford Beall, lead author of the study. “We looked for genes that were present in these bacteria and *for*sythia and not in BU063. There is one particular gene complex in a whole list of these periodontitis-related bacteria that could be involved with virulence.”

The study, published in the journal *PLOS ONE*, found that while BU063’s genome is more similar to *for*sythia’s than any other known genome, the two have a 44 percent difference in gene content.

This research also supported an existing theory that three genes could be related to *for*sythia’s ability to cause disease because these genes are missing from BU063. Two have potential to damage tissue and inactivate the immune response and the third is a cell-surface molecule that interacts with human cells.

For more information, see the study published online in the journal *PLOS ONE* Feb. 14, 2014.



Facial Injuries in the Elderly Result in Longer Hospitalizations, Increased Care and Death

According to projections from the United Nations Population Division, by 2035 one in five people is expected to be 65 or older. This may signal an increase in the number of traumatic facial injuries in this population. Our bones become less dense and injuries do not heal as easily as we age. In addition, some chronic diseases, such as diabetes, affect the healing of bone fractures.

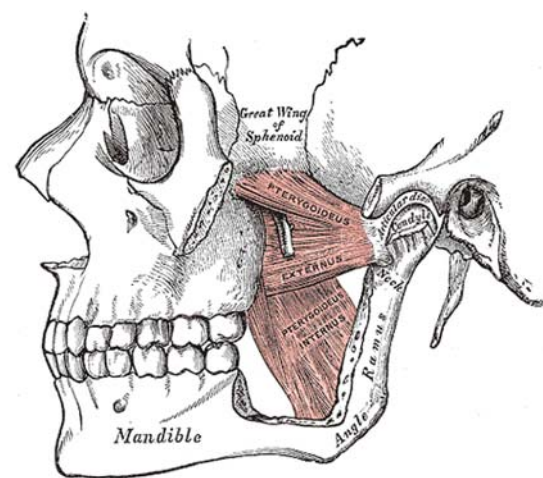
The authors of "Defining Predictable Patterns of Craniomaxillofacial Injury in the Elderly: Analysis of 1,047 Patients," which appeared in the February 2014 issue of the *Journal of Oral and Maxillofacial Surgery*, found that patients 65 years of age and older who experienced traumatic injuries of the skull, face and/or jawbone were hospitalized longer, had increased critical care needs and suffered higher death rates than younger patients.

During their study, the authors reviewed patient records from February 1998 through December 2010. To be included in the study, patients had to be at least 60 years old, had to have experienced head and/or facial fractures and had their injuries confirmed by CT scanning.

Of the 11,084 patients who experienced facial fractures during the study timeframe, 1,047 were older than 60 years and 59 percent were males. Falls accounted for 50 percent of these fractures, differing greatly from the causes of facial fractures in younger age groups. Areas commonly fractured included the nose (43 percent), upper jaw bone (30 percent), cheek bone (30 percent), eye socket (27 percent) and lower jaw bone (18 percent). This again differs greatly from younger patients.

The authors concluded that their data support the move for improved national medical readiness to better anticipate the needs of elderly patients who experience traumatic head and facial injuries.

Read the complete study findings in the *Journal of Oral and Maxillofacial Surgery*, February 2014.



"We've had diagnostic criteria for years," said Eric Schiffman, DDS, a co-lead author. "What is unique here is instead of a panel of experts empirically deciding best practices, we relied on science as a methodology to test our best assumptions and see if we were actually correct."

"A common language allows clinicians to communicate more easily to researchers about their daily diagnostic challenges," said Richard Ohrbach, DDS, PhD, a co-lead author of the publication. "Conversely, a common language allows research findings to be more easily integrated into a clinical setting and improve patient care."

Published in the *Journal of Oral and Facial Pain and Headache*, the authors conclude that the new evidence-based protocol for Diagnostic Criteria for TMD (DC/TMD) "is appropriate for use in both clinical and research settings."

For more information, see the criteria published in the *Journal of Oral and Facial Pain and Headache*, 2014;28:6–27.

First Evidence-based Diagnostic Criteria Published for TMD

The first evidence-based diagnostic criteria have been developed to help health professionals better diagnose temporomandibular disorders (TMD), which affect an estimated 10 to 15 percent of Americans.

Supported in part by the National Institutes of Health, the new criteria comprise an improved screening tool to

help researchers and health professionals, including dentists, more readily differentiate the most common forms of TMD and reach accurate diagnoses that are grounded in supportive scientific evidence. Previously, diagnostic criteria for TMD were based on a consensus of expert opinion and often reflected a shared clinical perspective.



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ADA: Use Fluoride Toothpaste as Soon as First Tooth Arrives

The American Dental Association's Council on Scientific Affairs recently updated its guidance to caregivers — now recommending children's teeth be brushed with a fluoride toothpaste as soon as the first tooth appears.

CSA previously recommended using water to brush the teeth of children younger than 2 years old and a pea-sized amount of fluoride toothpaste to brush the teeth of children 2 to 6 years old. CSA updated the ADA's guidance based on a review of scientific evidence and now suggests caregivers use a "smear" of fluoride toothpaste (about the size of a grain of rice) for children younger than 3 years old and a pea-sized amount for children 3 to 6 years old.

Based on a systematic review of the evidence, CSA concluded that following these new recommendations helps prevent cavities and is less likely to cause fluorosis.

"For half a century, the ADA has recommended that patients use fluoride toothpaste to prevent cavities, and a

Study: Obesity and Survival in Tongue Cancer Patients

Recent efforts from cancer experts at Memorial Sloan Kettering Cancer Center and Weill Cornell Medical College have generated interesting findings: obesity prior to diagnosis is associated with a five-fold increase in the risk of death from early-stage squamous cell carcinoma (SCC) of the tongue.

Published in the Jan. 21, 2014, issue of the journal *Cancer*, their findings are the first-ever to link obesity and diminished survival in any head and neck cancer.

"Most prior research investigating the interaction between body mass index and head and neck cancers included multiple tumor sites and disease stages. Due in part to these confounding factors, it previously has been difficult to clearly understand the role of obesity in head and neck cancers," said Neil Iyengar, MD, the study's first author. "By focusing on a single site and a more select patient population, we designed our study to better identify new and relevant prognostic factors for this particular type of cancer, which could lead to further refined and tailored treatment strategies down the road."

Data was included from more than 150 patients diagnosed with SCC of the tongue. The experts looked at the relationship between a patient's body mass index and how long he or she survived after surgery. The researchers found that at the three-year mark, 68 percent of obese patients were alive, compared with 87 percent of normal-weight patients.

"Now that we've discovered an association between obesity and poor survival in this particular subset of patients, we're investigating whether inflammation has a role there as well," Iyengar said. "If such a connection is confirmed, it could lead to the possibility of testing anti-inflammatory treatments, including specific diets, as well as interventions aimed at weight loss to improve outcomes in these patients."

For more information, see the study first published online in the journal *Cancer*, Jan. 21, 2014.



review of scientific research shows that this holds true for all ages," said Edmond L. Truelove, DDS, chair of the CSA. "Approximately 25 percent of children have or had cavities before entering kindergarten, so it's important to provide guidance to caregivers on the appropriate

use of fluoride toothpaste to help prevent their children from developing cavities."

For more information, see the report published in the February 2014 issue of *The Journal of the American Dental Association*.

Health Coaching Helps Improve Oral Health in Diabetes Patients

Researchers at the University of Copenhagen recently helped a large group of people with diabetes to markedly improve their oral health through motivational health coaching, according to the university.

Those with diabetes face an increased risk of oral health problems, including periodontitis, caries, dry mouth, fungal

infections and poor wound healing.

The new study, published in the journal *Clinical Oral Investigations*, included 186 patients with Type II diabetes and, according to the authors, was the first study intended to evaluate the impact of health coaching compared to health education on oral health and diabetes management among



Rise in Oropharyngeal Cancer in Young Adults

Researchers at Henry Ford Hospital in Detroit have found an “alarming” increase in oropharyngeal cancers among young adults, according to a study in *Otolaryngology-Head and Neck Surgery*, the official journal of the American Academy of Otolaryngology-Head and Neck Surgery.

The new retrospective, population-based study used data from the Surveillance, Epidemiology and End Results (SEER) 9 database from 1973 to 2009 to evaluate 1,603 patients under 45 years old with oropharyngeal squamous cell carcinoma.

According to the researchers, there was an overall 60 percent increase between 1973 and 2009 in cancers of the base of tongue, tonsils, soft palate and pharynx in people younger than age 45. While the exact cause for this phenomenon is unknown, “the rising incidence within recent decades is thought to be related to human papillomavirus transmission and changes in sexual practices,” the authors wrote.

“We were interested in looking at people born during that time period and incidence of oropharyngeal cancer. Not only were we surprised to find a substantial increase in young adults with cancer of the tonsils and base of tongue, but also a wide deviation among Caucasians and African Americans with this cancer,” said lead author Farzan Siddiqui, MD, PhD.

Among Caucasians, there was a 113 percent increase, while among African Americans the rate of these cancers declined by 52 percent during that period of time. But compared to Caucasians and other races, the five-year survival rate remains worse for African Americans.

For more information, see the full study published online before print in *Otolaryngology-Head and Neck Surgery*, Jan. 22, 2014.



patients with Type II diabetes.

Patients were divided into two groups, with one group receiving traditional health information, for example a brochure on good dental hygiene, while the other group was offered three to six sessions of motivational health coaching over a six-month period, focusing on personal guidance related to diet, stress management and dental care.

“In the group of patients who were given personal health coaching, biological markers for periodontitis were reduced by as much as 50 percent over a six-month period,” said authorized coach and study author Ayse Basak Cinar. “The patients in the trial group saw a significant decline in long-range blood sugar levels, whereas figures for the control group were unchanged. Moreover, the patients in the coaching group expressed markedly increased self-efficacy in relation to handling illness and health issues.”

At postintervention, the study noted, the group that received health coaching had significantly lower community periodontal need index and HbA1C than the group that received health education.

The findings imply that health coaching has a significantly higher impact on better management of diabetes and oral health when compared to formal health education, the authors concluded.

For more information, see the study published online Dec. 21, 2013, in the journal *Clinical Oral Investigations*.

Increased Incidence of Thyroid Cancer Associated With Increased Diagnosis

The increased incidence of thyroid cancer appears to be associated with an “epidemic of diagnosis” and not disease, according to a study by Louise Davies, MD, MS, of the VA Medical Center, White River Junction, Vt., and H. Gilbert Welch, MD, MPH, of the Dartmouth Institute for Health Policy & Clinical Practice, Hanover, N.H.

An increase in thyroid cancer previously has been reported, largely due to the detection of small papillary cancers, a common and less aggressive form of the disease, according to the study background.

The authors analyzed data for patients diagnosed with thyroid cancer from 1975 to 2009 in nine areas of the country using the Surveillance, Epidemiology and End Results (SEER) program: Atlanta, Connecticut, Detroit, Hawaii, Iowa, New Mexico, Utah, the San Francisco-Oakland area in California and the Seattle-Puget Sound area of Washington.

Since 1975, the incidence of thyroid cancer has nearly tripled from 4.9 to 14.3 per 100,000 people, with virtually the entire increase due to papillary thyroid cancer (from 3.4 to 12.5 per 100,000 people). The absolute increase in thyroid cancer among women (from 6.5 to 21.4 = 14.9 per 100,000 women) was almost four times greater than for men (from 3.1 to 6.9 = 3.8 per 100,000 men). The mortality rate has remained stable since 1975 at about 0.5 deaths per 100,000 people, according to the results.

“The jump in incidence is due to



Parents Need Education on Dosing Accuracy

Parents often make dosing errors when administering over-the-counter pain medication to their children for postoperative dental pain. Dentists can improve pain management in these patients by educating parents about accurate measuring devices, weight-based dosing and correct interpretation of medication dosing charts.

In a study in the February 2014 issue of *The Journal of the American Dental Association*, authors compared the dosing accuracy when parents used various measuring devices and aimed to identify risk factors associated with dosing errors.

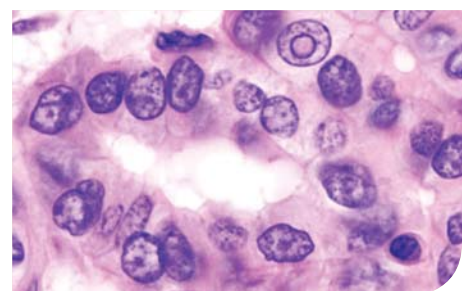
According to the study, 120 parent-child pairs participated. The results of a McNemar test revealed a significant difference in parents' ability to measure accurate doses using the various devices. Medicine cups, which parents reported using most frequently, had a higher occurrence of dosing errors when compared with the other devices. The results of a Pearson χ^2 test showed no statistically significant difference between the control and study groups for dosing accuracy. The χ^2 analysis results showed no significant differences in risk factors that could be associated with dosing errors.

For more information, read the complete study in *The Journal of the American Dental Association*, February 2014;145(2):141-149.

an increase in diagnosis and possibly overdiagnosis of papillary thyroid cancer, which can be present in patients without symptoms,” according to the authors. Overdiagnosis occurs when a person is diagnosed with a condition that causes no symptoms and may cause them no eventual harm. Responses to the overdiagnosis could ultimately include active surveillance without treatment of the asymptomatic cancers, relabeling some of them as other than cancer, and more closely investigating risk factors for cancer, the authors write in the study. They also suggest that physicians explain to patients that many of these small cancers will never grow and cause

harm to the patient, although it is not possible to know which diagnosed cancers will fall into that category.

For more information, see the study published online first Feb. 20, 2014 in *JAMA Otolaryngology Head and Neck Surgery*.





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PRESENTS

The Art
and Science
of Dentistry



CDA Presents schedule-at-a-glance

Thursday, May 15, 2014

■ Anaheim Convention Center (ACC)

■ Hilton

* Repeated Course ➤ Continued Course

Thursday Exhibit Hall Hours

9:30 a.m.—5:30 p.m.

Required Courses — Ticket Required

7 AM	8 AM	9 AM	10 AM	11 AM	Noon	1 PM	2 PM	3 PM	4 PM	5 PM	6 PM
Infection Control Arns, ACC Ballroom C/D										California Dental Practice Act Thomason, ACC Ballroom C/D	

The Spot — The Smart Dentist Series, Free Lectures in the Educational Theater

				Regulatory Compliance Pichay	Manuals and Policies Thomason	Mobile Marketing McCollough	Critical Decisions Tyson	Dental Benefits Milar	Leadership Opportunities Leadership Develop- ment Committee	• Coltene Sponsored Program								
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Workshops — Ticket Required

				Exquisite Anterior Provisionals* Brady, ACC 213 A				Exquisite Anterior Provisionals* Brady, ACC 213 A											
				TDIC Risk Management* Sahota, Curley, Hilton California A				TDIC Risk Management* Sahota, Curley, Hilton California A											
				Anesthesia and Maxillofacial Human Cadaver Dissection* Hawkins, Paxton, ACC 213 D				Anesthesia and Maxillofacial Human Cadaver Dissection* Hawkins, Paxton, ACC 213 D											
				Implant Overdenture Methods* Massad, ACC 213 B				Implant Overdenture Methods* Massad, ACC 213 B											
				Social Media and Online Marketing* Mele, ACC 303 C/D				Social Media and Online Marketing* Mele, ACC 303 C/D											
				Intraoral Radiographs and Digital Images* Johnson, et al., ACC 213 C				Intraoral Radiographs and Digital Images* Johnson, et al., ACC 213 C											
				Equipment Care and Repair* Yaeger Sr. & Jr., ACC Exhibit Hall D				Equipment Care and Repair* Yaeger Sr. & Jr., ACC Exhibit Hall D											
				Laser-assisted Dentistry* Cardoza, Riley, ACC 210 C				Laser-assisted Dentistry* Cardoza, Riley, ACC 210 C											

International Symposia of Dental Learning

				Integrating Restorative Natural Teeth and Implants Diez Gurtubay, ACC 204 C				Treatment of the Edentulous Maxillary Diez Gurtubay, ACC 204 C											
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Express Lectures — Speakers New to the Podium

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Air Techniques Corporate Forum (C.E. Exhibit Floor Hall D)

7 AM	8 AM	9 AM	10 AM	11 AM	Noon	1 PM	2 PM	3 PM	4 PM	5 PM	6 PM
			Infection Control Menage Bernie		Digital Diagnostics Kachalia		Digital Imaging Diagnostics Jablow		EMPOWERing Your Practice Morilla		
Lectures											
	Dental Hygiene Lasers Cardoza, Riley, ACC 209 A/B										
	Battling Biofilm and Inflammation* Wu, ACC 303 A/B			Battling Biofilm and Inflammation* Wu, ACC 303 A/B							
	Essential Core Oral Pathology Achterberg, ACC 210 A/B			Prebiopsy Diagnostics Achterberg, ACC 210 A/B							
	Restorative Materials Update 2014> Brucia, ACC Ballroom E			>Restorative Materials Update 2014 Brucia, ACC Ballroom E							
	Oral Surgery/Pediatric Patient> Borris, Hilton Pacific A			>Oral Surgery/Pediatric Patient Borris, Hilton Pacific A							
	Smile Design, Interdisciplinary and Occlusal Update> Chiche, ACC Ballroom B			>Smile Design, Interdisciplinary and Occlusal Update Chiche, ACC Ballroom B							
	TMD Made Easy Spencer, ACC 304 C/D			Sleep Apnea and Snoring Spencer, ACC 304 C/D							
	Restorative and Whitening Products Osuna, ACC 204 B										
	All Ceramic Restorations Etchable and Non-etchable> McLaren, ACC 207 C/D			>All Ceramic Restorations Etchable and Non-etchable McLaren, ACC 207 C/D							
	Eat Well, Live Well, Age Well Smith, Hilton Pacific B			Building a Healthier You Smith, Hilton Pacific B							
	Diagnosis/Treatment/Oral Trauma Soxman, Hilton California B			Pediatric Alpha Pup Soxman, Hilton California B							
	Functional Anterior Esthetics> Hooper, ACC Ballroom A			>Functional Anterior Esthetics Hooper, ACC Ballroom A							
	Life of a Top-gun Dental Team Hyman, Hilton California D			Top Game Changers of 2014 Hyman, Hilton California D							
	Skills for Difficult Conversations Osborne, ACC 208 A/B			Move Patients/Dental to Action Osborne, ACC 208 A/B							
	Women's Oral Health – Part I Steinberg, ACC Ballroom C/D			Women's Oral Health – Part II Steinberg, ACC Ballroom C/D							
	What's Up With Whitening? Wallace, ACC 209 A/B			Everyday Adhesives Tips Wallace, ACC 209 A/B							
				CAMBRA Creasey, ACC 204 B							
				Dental Electronic Health Records Uretz, ACC 303 A/B							
				Colgate Corporate Forum – Diagnosis and Management of Dentin Hypersensitivity Li, ACC 205 A/B							
				PPO Mastery Straine, ACC 210 A/B							
7 AM	8 AM	9 AM	10 AM	11 AM	Noon	1 PM	2 PM	3 PM	4 PM	5 PM	6 PM

CDA Presents schedule-at-a-glance

Friday, May 16, 2014

■ Anaheim Convention Center (ACC)

■ Hilton

*Repeated Course ➤ Continued Course

Friday Exhibit Hall Hours

9:30 a.m.—5:30 p.m.

Required Courses — Ticket Required

7 AM	8 AM	9 AM	10 AM	11 AM	Noon	1 PM	2 PM	3 PM	4 PM	5 PM	6 PM
California Dental Practice Act Curley, ACC Ballroom C/D										Infection Control Arns, ACC Ballroom C/D	

The Spot — The Smart Dentist Series, Free Lectures in the Educational Theater

				Art of Getting to "Yes" Hyman	Regulatory Compliance Pichay	Patient Reviews and Reputation Management McCollough	Managing Patient Conflicts Alvi			Wine FUNdamentals Ticket required	
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Workshops — Ticket Required

Ultrasonic Technology* Wu, ACC 210 C		Ultrasonic Technology* Wu, ACC 210 C									
		Anterior and Posterior Etched Ceramic Restorations> McLaren, ACC 213 B				>Anterior and Posterior Etched Ceramic Restorations McLaren, ACC 213 B					
		Social Media and Online Marketing* Mele, ACC 303 C/D				Social Media and Online Marketing* Mele, ACC 303 C/D					
		Oral Biopsy Techniques – Cadaver* Achterberg, Paxton, ACC 213 D				Oral Biopsy Techniques – Cadaver* Achterberg, Paxton, ACC 213 D					
		TDIC Risk Management* Kodama, Weiss, Hilton California A				TDIC Risk Management* Kodama, Weiss, Hilton California A					
		Quality Panoramic and 3-D Images,* Johnson, et al Cancelled				Quality Panoramic and 3-D Images,* Johnson, et al Cancelled					
		Stainless Steel and Esthetic Crowns* Soxman, ACC 213 A				Stainless Steel and Esthetic Crowns* Soxman, ACC 213 A					
		Equipment Care and Repair Yaeger Sr. & Jr., ACC Exhibit Hall D									
						Guide to Suturing and Soft Tissue Management Borris, ACC 210 C					
						Great Dental Photographs Henderson, ACC Exhibit Hall D					

Air Techniques Corporate Forum (C.E. Exhibit Floor Hall D)

				Instrument Processing Menage Bernie		Caries Detection Abilities Jablrow		Imaging 2.0 Kachalia		EMPOWERing Your Practice Morilla	
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Lectures

	Dentoalveolar Surgery Borris, ACC 207 C/D										
	CAMBRA Creasey, ACC 303 A/B										
	Adult Denti-Cal Services Holloway, Murthy, Prabhu, ACC 204 C										
	Posterior Bonded Porcelain> Brady, ACC Ballroom B					>Posterior Bonded Porcelain Brady, ACC Ballroom B					
	International Volunteer Serio, Rollofson, ACC 206 A/B										
7 AM	8 AM	9 AM	10 AM	11 AM	Noon	1 PM	2 PM	3 PM	4 PM	5 PM	6 PM

Lectures (continued)

7 AM	8 AM	9 AM	10 AM	11 AM	Noon	1 PM	2 PM	3 PM	4 PM	5 PM	6 PM
		Implant Restoration Syndrome <i>Simon, Hilton California C</i>				Passive Fit in Implant Dentistry <i>Simon, Hilton California C</i>					
		Forensic Dentistry <i>Cardoza, ACC 304 C/D</i>				Mass Disaster Scenario <i>Cardoza, ACC 304 C/D</i>					
		Role of Vital Pulp Therapy <i>Trope, ACC 208 A/B</i>				Update in Modern Endodontics <i>Trope, ACC 208 A/B</i>					
		Peer Review <i>Hansen, ACC 205 A/B</i>									
		Functional Posterior Esthetics> <i>Hooper, ACC Ballroom A</i>				>Functional Posterior Esthetics <i>Hooper, ACC Ballroom A</i>					
		Posture, Pain and Productivity <i>Caruso, Hilton California B</i>				Primer on Posture <i>Caruso, Hilton California B</i>					
		Practice Ownership> <i>Christie, Pryor, Mostofi, Chamberlain, Hilton Laguna A</i>				>Practice Ownership <i>Christie, Pryor, Mostofi, Chamberlain, Hilton Laguna A</i>					
		Implant Therapy and the RDH <i>Hempton, Hilton California D</i>				Practical Periodontal Therapy <i>Hempton, Hilton California D</i>					
		Anterior Bonded Restorations <i>Magne, ACC Ballroom E</i>				Posterior Bonded Restorations <i>Magne, ACC Ballroom E</i>					
		Removable Prosthodontics> <i>Massad, ACC 209 A/B</i>				>Removable Prosthodontics <i>Massad, ACC 209 A/B</i>					
		Eat Well, Live Well, Age Well <i>Smith, ACC 207 A/B</i>				Building a Healthier You <i>Smith, ACC 207 A/B</i>					
		Common Dental Materials* <i>Wallace, ACC 204 B</i>				Common Dental Materials* <i>Wallace, ACC 204 B</i>					
		Affairs of the Heart...With Dentistry> <i>Johnson, ACC 210 A/B</i>				>Affairs of the Heart...With Dentistry <i>Johnson, ACC 210 A/B</i>					
		Endodontic Diagnosis and Access Preparation <i>Ruddle, ACC Ballroom C/D</i>				Glide Path Management and Shaping Canals <i>Ruddle, ACC Ballroom C/D</i>					
				Great Dental Photographs <i>Henderson, ACC 303 A/B</i>							
				Help Your Patients Say "Yes" <i>Brown, ACC 207 C/D</i>				How to Be a Rock-star Team! <i>Brown, ACC 207 C/D</i>			
				Health Care Reform <i>Short, ACC 204 C</i>							
						Pacific Dental Services <i>Rodgers, ACC 204 A</i>					
						Ethics <i>Kiger, et al.</i>	Cancelled				
						Perio Protect Corporate Forum <i>Keller, ACC 205 A/B</i>					
						Practice Assessment <i>Perry, Thomason, Fornelli, ACC 206 A/B</i>					
							HIPAA, HITECH, and CMIA <i>Pichay, Zreikat, ACC 204 C</i>				
							Head and Neck Anatomy <i>Gremillion, ACC 303 A/B</i>				
								Carestream Dental Corporate Forum <i>McAllister, ACC 206 A/B</i>			
7 AM	8 AM	9 AM	10 AM	11 AM	Noon	1 PM	2 PM	3 PM	4 PM	5 PM	6 PM

CDA Presents schedule-at-a-glance

Saturday, May 17, 2014

■ Anaheim Convention Center (ACC)

■ Hilton

* Repeated Course ➤ Continued Course

Saturday Exhibit Hall Hours

9:30 a.m.—4:30 p.m.

Required Courses — Ticket Required

7 AM	8 AM	9 AM	10 AM	11 AM	Noon	1 PM	2 PM	3 PM	4 PM	5 PM	6 PM
Infection Control Arns, ACC Ballroom C/D			California Dental Practice Act Curley, ACC Ballroom C/D								

The Spot — The Smart Dentist Series, Free Lectures in the Educational Theater

						How to Handle Negative Online Reviews Corum	Manuals and Policies Thomason	Characteristics of Ethical Dental Professionals Ryan	Dental Benefits Milar		
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Workshops — Ticket Required

		Modern Endodontics: Theory to Practice* Trope, ACC 213 A					Modern Endodontics: Theory to Practice* Trope, ACC 213 A				
		Crown Lengthening Hempton, ACC 213 B					>Crown Lengthening Hempton, ACC 213 B				
		Team Fabulous! Wallace, ACC 303 C/D					>Team Fabulous! Wallace, ACC 303 C/D				
		Anatomy of the Masticatory System: Clinical App./Human Cadaver Dissection Gremillion, Hawkins, ACC 213 D					>Anatomy of the Masticatory System: Clinical App./Human Cadaver Dissection Gremillion, Hawkins, ACC 213 D				
		TDIC Risk Management Kodama, Weiss, Hilton California A									
							Great Dental Photographs Henderson, ACC Exhibit Hall D				

International Symposia of Dental Learning

		New Restorative Strategies in Pediatric Dentistry – Part I Krämer, ACC 204 C					New Restorative Strategies in Pediatric Dentistry – Part II Krämer, ACC 204 C				
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Air Techniques Corporate Forum (C.E. Exhibit Floor Hall D)

			Digital Imaging Diagnostics Jablow	Digital Diagnostics Kachalia	Environmental Surface Management Menage Bernie	EMPOWERING Your Practice Morilla					
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Lectures

		Treating Back and Neck Pain Caruso, ACC 304 C/D					Fitness & Function in Dentistry Caruso, ACC 304 C/D				
		Optimal Aging — Living to 100 Steinberg, ACC Ballroom A					The Four "S's" of Optimal Aging Steinberg, ACC Ballroom A				
		Strategic Exit: Succession Planning for Dentists Formelli, Oromchian, Murphy, ACC 207 A/B									
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Oral Health Infrastructure: The Value of State Oral Health Programs

Lewis N. Lampiris, DDS, MPH

GUEST EDITOR

Lewis N. Lampiris, DDS, MPH, is an associate clinical professor and director of the Dentistry in Service to Communities program at the University of North Carolina, Chapel Hill, School of Dentistry. He practiced general dentistry for 17 years before redirecting his efforts toward public health. He is a fellow of the American College of Dentists, past president of the Association of State and Territorial Dental Directors, served as chief of the Illinois Department of Public Health's Division of Oral Health and as director of the American Dental Association's Council on Access, Prevention and Interprofessional Relations. *Conflict of Interest* Disclosure: None reported.

In November 2011, the California Dental Association released a report entitled *Phased Strategies for Reducing the Barriers to Dental Care in California*.¹

The report recognized the critical importance of oral health leadership within state government as being essential to improving the oral health of not only underserved and vulnerable populations but of all Californians. This could best be accomplished by establishing a state oral health program, appropriately staffed and led by a state dental director who is strategically placed to impact oral health policy development at the state level.

This issue of the *Journal* will help readers understand the value of having a vibrant state oral health program and how it will directly benefit both the public and the profession. A state dental director is the person to contact if and when you have a question about state oral health policies. A state program serves as the “go-to” place and focal point for policy development when there are multiple state agencies addressing dental and oral health issues.

State dental directors, when they are strategically located within the state structure, provide expertise and guidance to the many others in state government who directly impact dental interests. These include, but are not limited to, staff in departments of professional

regulation, maternal and child health programs, state Medicaid agencies, environmental protection agencies, agencies focused on the health of seniors and those with developmental disabilities, those who regulate nursing homes, and departments of justice and juvenile affairs.

They know how to leverage the resources available from these various entities and direct those toward improving the oral health of the public. When properly staffed and supported, they can successfully apply for grants from federal agencies, leverage general revenue funds at the state level, garner resources from philanthropic organizations and identify and tap into special funds that can be used to promote the oral health of the public.

A well-positioned office of oral health can build and foster partnerships between these many agencies and dental providers. A recently published tip sheet prepared by the Association of State and Territorial Dental Directors (ASTDD) and the American Dental Association (ADA) describes the opportunities for collaboration between state oral health programs and state dental associations.² Another, developed by ASTDD and the Medicaid SCHIP Dental Association (MSDA) provides and describes examples of the natural synergy between oral health programs and state Medicaid agencies.³

A state dental director and private

practitioner share many commonalities in terms of carrying out their professional responsibilities. The key difference between the two is that for a dental director, patients are communities rather than individuals. For example, an “examination” is done through the regular collection of data specific to the community’s oral health status and its capacity to improve health, which we in public health call surveillance. This information is then analyzed and interpreted so that a “diagnosis” may be established and the findings shared with the multiple stakeholders who impact a community’s health, including the private practice community.

A “treatment plan” is developed, which describes the policies and programs needed to improve the community’s oral health. A vibrant state oral health program could be responsible for spearheading the development of a state oral health plan, which would clearly articulate what needed to be done, by whom, how it would be done and how success would be measured. This could include, but certainly would not be limited to, legislative initiatives, changes to rules and regulations, creating coalitions, establishing loan repayment programs for dentists and dental hygienists and implementing population- and evidence-based preventive interventions, such as community water fluoridation and school-based sealant programs. Finally, and most important, “treatment” would occur. Programs would be implemented, funded and evaluated.

In this issue, Jayanth Kumar, DDS, MPH, New York’s state dental director, and Hiroko Iida, DDS, MPH, director of the New York State Oral Health Technical Assistance Center, describe the various systems that are in place that can be used to assess both population oral health and the capacity of the delivery system

to provide care. In their article, “State-based Oral Health Surveillance Programs in the United States,” they provide data specific to California, yet clearly state that “data for many indicators were five to seven years old.” They conclude that “in order to elevate oral health issues to be included in the state’s health agenda, data needs to be not only current but also should be available at the local level.”

This article is followed by one written by Harry Goodman, DMD, MPH, Maryland’s state dental director and the president of ASTDD. The article describes Maryland’s experience and the critical roles Maryland’s state oral health program, in collaboration with the state’s dental association, played in developing policies to improve the oral health of the residents of the state. It would seem that California is currently on the same path that Maryland was on back in the 1980s when, as described by Dr. Goodman, the Maryland State Dental Association had “been responsible through its advocacy efforts to reinstate the state oral health program/state dental director in the state health department when previous budget cutbacks had abolished the program.” He goes on to describe the benefits that were derived by private practitioners when the program was reinstituted.

Finally, U.S. Public Health Service Chief Dental Officer RADM William Bailey, DDS, MPH, who also serves as the spokesperson and programmatic lead on water fluoridation at the Division of Oral Health within the Centers for Disease Control and Prevention, describes how public-private partnerships can assure that programs are implemented to improve population health. His focus is on national efforts that can have impact on states and communities. He describes how the CDC and the Health Resources and Services Administration (HRSA) are funding states to implement or expand dental

sealant programs in rural or low-income schools, thus reducing the disease burden and decreasing the demand for dental care in these communities. Of particular interest to California are the resources available through the CDC and HRSA to support key oral health positions within state health departments. ■

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State-based Oral Health Surveillance Program in the United States

Jayanth V. Kumar, DDS, MPH, and Hiroko Iida, DDS, MPH

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Conflict of Interest
Disclosure: None reported.

The Institute of Medicine in its 1988 landmark report highlighted assessment as one of the three core functions of public health, along with policy development and assurance.¹ These functions are akin to diagnosis, treatment planning and carrying out treatment of patients in a practice setting. In a community setting, assessment efforts evaluate and monitor the health status and needs of communities and populations; policy development provides an environment to promote better health; and assurance activities improve the access and availability of quality health care, including prevention services. Public health surveillance is defined as “the ongoing systematic collection, analysis, interpretation and dissemination of health data for the planning, implementation and evaluation of public health action.”^{2,3} Its goal is to support action for public health policy and prevention programs in order to reduce morbidity and mortality and to improve the health of the public. Public health surveillance

is different from epidemiologic research as it emphasizes “ongoing collection” and “timely dissemination” of data and uses data “for action.”³

Public health surveillance in the United States has evolved from monitoring infectious diseases to tracking the occurrence of many noninfectious conditions, such as cancers, birth defects, oral diseases and risk factors. Until the late 1990s, oral health surveillance was primarily the domain of the federal government⁴ and was based on episodic national surveys. While data from national surveys have demonstrated important changes in the prevalence and severity of dental diseases over several decades, state-based data were largely lacking for promoting policies and programs at the local level.

While there are many reasons for the slow adoption of policies to support dental sealants in the early 1980s, the lack of data at the state level was probably a major contributing factor. National survey data from 1986-87 showed that most children were experiencing fewer caries (zero or few

decayed, missing, filled surfaces [DMFS]) relative to the 1979-80 epidemiological data of U.S. school-aged children.⁵ Among children ages 5 to 17, the mean number of DMFS declined from 4.77 in 1979-80 to 3.07 in 1986-87.⁵ Furthermore, by 1987, 88 percent of all decayed or filled surfaces in the permanent teeth of children ages 5 to 17 were in pit and fissure surfaces.^{5,6} Another national survey conducted in 1988-1991 showed that nearly 80 percent of decay was experienced by just 25 percent of U.S. school-aged children.⁷ These findings from the national surveillance led to the concept of targeting dental public health prevention programs, such as dental sealant programs for the highly affected minority and promotion of the insurance coverage under Medicaid and other insurance plans. However, the coverage for sealants under Medicaid and other insurance plans lagged the epidemiological findings at the national level because such data were not available in a timely fashion at the state level to advocate for its coverage. This suggests the importance of developing the capacity at the state level for data collection, analysis and interpretation. In addition, it has been emphasized that states should develop a mechanism for timely dissemination of the information derived from data to people who can undertake effective prevention and control activities. This helps to focus on tracking health outcomes and making suitable adjustments in the programs and policies, rather than program activities like the number of people served.

Oral Health Objectives

For three decades, Healthy People has provided a set of national goals and objectives for guiding health promotion and prevention efforts and has monitored the progress through regular reviews. These initiatives are intended to encourage collaborations

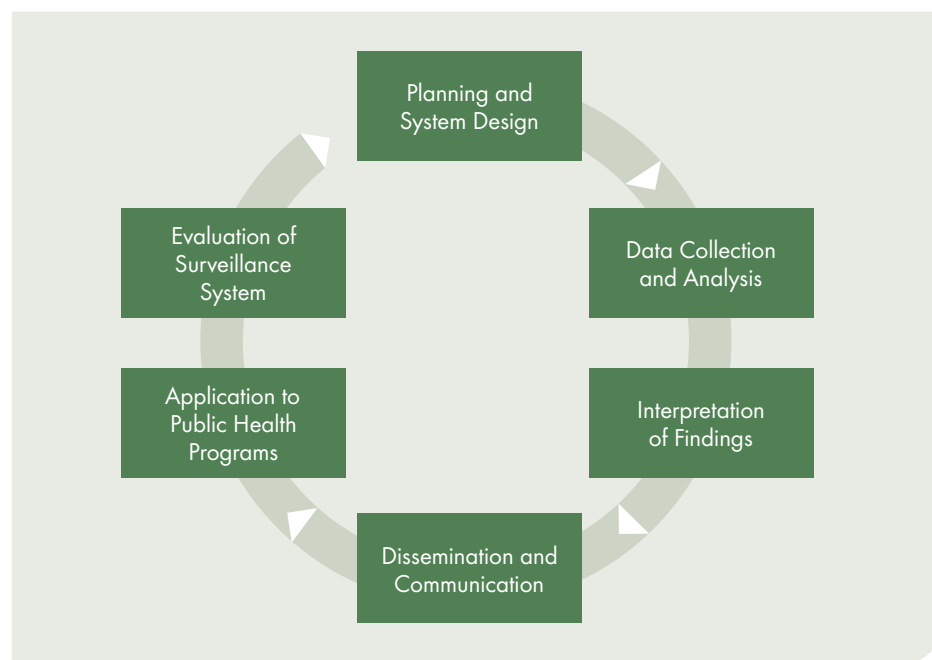


FIGURE 1. The surveillance cycle.⁴

across communities and sectors, empower individuals toward making informed health decisions and measure the impact of prevention activities. In the Healthy People agenda, there are 17 oral health objectives and other related objectives in cancer, diabetes and tobacco use.⁸ In addition, several federal health agencies have specific objectives, performance measures and benchmarks.⁹ For example, the Maternal and Child Health (MCH) Title V Block Grant program has set a target that 50 percent of third-grade children should have received protective sealants on at least one permanent molar tooth. The Centers for Medicare and Medicaid Services has also set a 2015 goal to increase by 10 percent, from fiscal year 2011, the number of children ages 1 to 20 enrolled in Medicaid for at least 90 continuous days who receive a preventive dental service. Many states have also established their own state-specific targets.

National Oral Health Surveillance System

The Centers for Disease Control and Prevention (CDC) plays a major role in the U.S. oral health surveillance. The

National Center for Health Statistics (NCHS) of CDC collects oral health data of the U.S. population through the National Health and Nutrition Examination Survey (NHANES) and the National Health Interview Survey (NHIS).¹⁰ The oral health component of the NHANES is a massive undertaking that includes comprehensive clinical examination of oral conditions and diseases such as edentulism, dental sealants and dental fluorosis, as well as dental caries and periodontal diseases among the nationally representative sample of U.S. children and adults.¹¹ In addition to the examination component, oral health interviews covering topics on dental utilization, quality of life, health promotion/disease prevention and periodontal health are conducted, producing sufficient data to monitor several key oral health objectives in the Healthy People.¹¹

In response to the growing need for state-specific data for local public health agencies to successfully achieve national goals, CDC collaborates with state health departments in surveillance programs such as the Behavioral Risk

TABLE 1

Oral Health Indicators in the National Oral Health Surveillance System*

	Description	Data Source
Dental visit	Adults age 18 and older who have visited a dentist or dental clinic in the past year	BRFSS
Teeth cleaning	Adults age 18 and older who have had their teeth cleaned in the past year (among adults with natural teeth who have ever visited a dentist or dental clinic)	BRFSS
Complete tooth loss	Adults age 65 and older who have lost all of their natural teeth due to tooth decay or gum disease	BRFSS
Lost six or more teeth	Adults age 65 and older who have lost six or more teeth due to tooth decay or gum disease	BRFSS
Fluoridation status	Percentage of people served by public water systems who receive fluoridated water	WFRS
Caries experience	Percentage of third-grade students with caries experience, including treated and untreated tooth decay	Statewide BSS
Untreated tooth decay	Percentage of third-grade students with untreated tooth decay	Statewide BSS
Dental sealants	Percentage of third-grade students with dental sealants on at least one permanent molar tooth	Statewide BSS
Cancer of the oral cavity and pharynx	Oral and pharyngeal cancer comprises a diverse group of malignant tumors that affect the oral cavity and pharynx	SEER

Abbreviations: BRFSS - Behavioral Risk Factor Surveillance System; BSS - Basic Screening Survey; WFRS - Water Fluoridation Reporting System; SEER - Surveillance, Epidemiology and End Results.

*Source: CDC National Oral Health Surveillance System.¹⁸

Factor Surveillance System (BRFSS) and the Pregnancy Risk Assessment Monitoring System (PRAMS). BRFSS and PRAMS are both population-based telephone interview surveys. BRFSS became a nationwide surveillance system in 1993 and provides state-specific estimates of health risk behaviors among the U.S. adult population 18 years of age and older.¹² BRFSS includes oral health questions regarding dental visits and previous episodes of extraction.¹² PRAMS identifies a sample of women who have had a recent live birth from the state's birth certificate file and collects information on maternal attitudes and access to and experience of health care, including oral health care before, during and shortly after pregnancy.¹³ The National Survey of Children's Health and the National Survey of Children with Special Health Care

Needs (SHCN) are part of the State and Local Area Integrated Telephone Survey (SLAITS) conducted by the NCHS of the CDC.¹⁴ These survey data examine the physical, oral and emotional health as well as access to medical homes and adequate health insurance among U.S. children ages 0 to 17 years with and without SHCN. The data also provide critical information for local and state policymakers and public health and health care professionals concerning children's health. NCHS and NSCSHCN surveys are generally conducted every four years.

In addition to the CDC, the HHS agency that conducts national surveillance involving oral health data is the Agency for Healthcare Research and Quality (AHRQ). AHRQ conducts the Medical Expenditure Panel Survey and collects information on oral health

care needs, access and expenditures through household interviews.¹⁵

State Oral Health Surveillance Programs

The National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) of the CDC supports many states in monitoring oral diseases and risk factors and developing state oral health plans through cooperative agreements. Between 2009 and 2013, 19 state oral health programs were supported by NCCDPHP, and 21 states (California is not one of these states) currently receive grant funding designed to support state infrastructure development. Funding provides support for state oral health surveillance and the implementation of prevention programs for a five-year period of time.¹⁶ Developing a state oral health surveillance program begins with planning and system design (FIGURE 1).⁴ This provides the necessary framework to identify resources as well as skill sets and expertise to carry out data collection, analysis, interpretation and the timely dissemination of data. Technical aspects of surveillance programs include, but are not limited to, ensuring validity and reliability of questionnaires, calibration or standardization of examiners and developing sampling methodologies, such as calculating sample size, response rate and representation of the population. The State Oral Health Program, in collaboration with multiple stakeholders throughout the state, utilizes data from ongoing surveillance in the development of a State Oral Health Plan. The plan should include goals, objectives and strategies covering a broad spectrum of issues related to policy, prevention, access, workforce, surveillance and research in order to address the burden of oral diseases in the state.

In order to monitor the key indicators

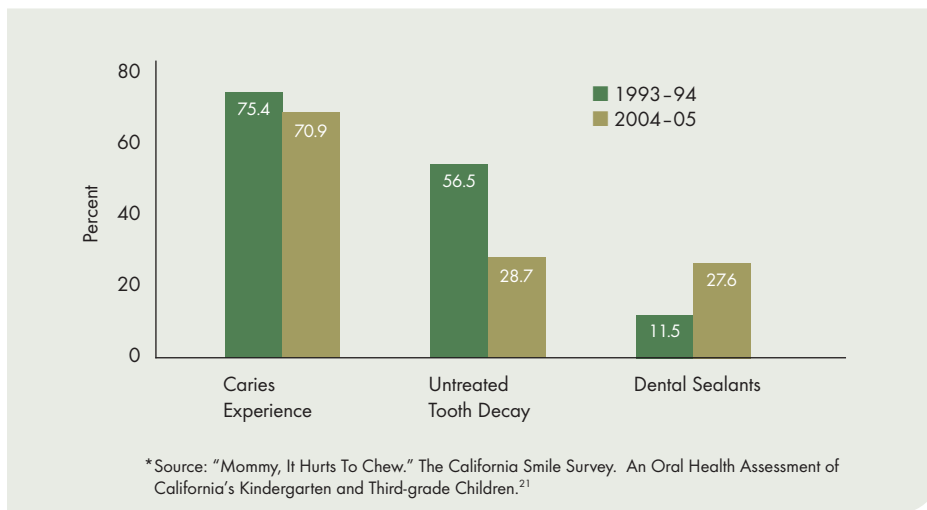


FIGURE 2. Oral health of California's third-grade children by year of survey.*

TABLE 2

Oral Health Status of California's Third-grade Children Stratified by Participation in the Free and Reduced Lunch Program (Unadjusted), 2004-2005*

Variable	Does not Participate (n=2,099)	Participates (n=2,491)
Percent with caries experience	60.8	78.8
Percent with untreated decay	22.0	32.2
Percent with rampant caries	15.4	26.7
Percent with dental sealants	28.1	27.9
Percent needing treatment	21.0	30.6
Percent needing urgent treatment	2.3	5.3

Note: The majority of parents did not return a parent questionnaire; therefore, this information is probably not representative of the state and should be viewed with caution.

* Source: California Smile Survey: An Oral Health Assessment of California's Kindergarten and Third-grade Children.²²

suggested in the National Oral Health Surveillance System (NOHSS), most states use the combination of primary data collection and existing surveillance systems such as BRFSS and cancer registries (TABLE 1).^{4,17,18} The Basic Screening Survey (BSS) provides data on the prevalence of caries experience, untreated decay, need for dental treatment and dental sealants in a cost-effective manner, and is usually used to monitor the oral health status of Head Start, kindergarten and third-grade children.¹⁹ Such data from school surveys, if done in

a consistent manner, provide useful trend information for decision-making by various groups in the community. Data on oral and pharyngeal cancer as well as orofacial clefts are available in the Surveillance, Epidemiology and End Results (SEER) program of the National Cancer Institute and state birth defect registries, respectively.¹⁷ Several states, including California, maintain a cancer registry. The Water Fluoridation Reporting System (WFRS), an online data reporting tool for water systems to monitor fluoridation quality, is the basis for the state and

national surveillance on community water fluoridation in the U.S.²⁰ Data from the WFRS help update the consumer-friendly database on fluoridation status of local water systems in the U.S., called "My Water's Fluoride," available at apps.nccdc.cdc.gov/MWF. Many states monitor the number of licensed dentists, hygienists and dental assistants to track the adequacy of states' dental workforce. These state surveillance data are reported in the National Oral Health Surveillance System's State Oral Health Profile (apps.nccdc.cdc.gov/nohss/bystate.asp?stateid=6), which provides oral health summaries for each state and territory.

Data for California: Prevalence and Trends

In California, two surveys of third-grade children, conducted over a decade apart by the Dental Health Foundation (now the Center for Oral Health) using the BSS, provide insight into children's oral health (FIGURE 2). In 2004-05, more than seven out of 10 third graders had experienced tooth decay, and more than 25 percent of them had untreated decay.²¹ While the decline in the prevalence of tooth decay was not notable, improvements were observed with respect to untreated decay and the use of dental sealants.²¹ Furthermore, the disparities by income as reflected in children's participation in the free or reduced school lunch program is apparent (TABLE 2).²² Additionally, fewer children in California have excellent/very good condition of teeth compared to the nation as a whole (TABLE 3).²³

The data from the BRFSS are presented in TABLE 4. These data show that while dental visits and visits for teeth cleaning among California residents are similar to the national data, there is an observable difference with respect to complete tooth loss among older adults.

TABLE 3

Overall Health of Children's Teeth and Oral Health Problems*

	Condition of children's teeth percent (95 percent CI)			Children reportedly had oral health problems in the past 12 months, percent (95 percent CI)	
	Excellent/ very good	Good	Fair/poor	No oral health problems	One or more oral health problems
U.S.	71.3 (70.6–72.0)	21.1 (20.5–21.8)	7.6 (7.2–8.1)	81.3 (80.6–81.9)	18.7 (18.1–19.4)
California	64.2 (60.8–67.7)	25.3 (22.1–28.5)	10.4 (8.3–12.6)	77.9 (74.9–80.9)	22.1 (19.1–25.1)

Abbreviation: CI - confidence interval. Note: Percentages are weighted to population characteristics.

*Oral health problems: toothache, decayed teeth or unfilled cavities in the past 12 months among children ages 1 to 17 years, California versus nationwide. Source: 2011-12 National Survey of Children's Health Survey.²³

TABLE 4

**National Oral Health Surveillance System Indicators,
California versus Nationwide***

Behavioral Risk Factor Surveillance System 2008	California	Nationwide
Dental Visit Adults (18+) visited the dentist or dental clinic within the past year	67.6%	68.5%
Teeth Cleaning Adults (18+) had their teeth cleaned by a dentist or dental hygienist within the past year	68.8%	69.0%
Complete Tooth Loss Older adults (65+) who have lost all of their teeth.	10.1%	18.1%
Lost Six or More Teeth Older adults (65+) who have lost six or more teeth.	33.6%	33.6%
Water Fluoridation Reporting System 2010	California	Nationwide
Fluoridation Status Population on public water systems receiving fluoridated water	62.5%	73.9%

*Sources: National Oral Health Surveillance Report. Behavioral Risk Factor Surveillance System, 2008¹² and CDC Water Fluoridation Reporting System.²⁰

authored AB 733, the Fluoridation Act, which mandated the fluoridation of water systems with 10,000 service connections or more when funding was available. Prior to the implementation of AB 733, California was ranked 48th in the nation for percent of residents receiving community water fluoridation (15.7 percent of the population on public water supplies in 1992). Subsequent to the Fluoridation Act, the California Endowment allocated \$15 million to increase the number of Californians receiving fluoridated water. To develop local support for community water fluoridation projects and to allocate capital funds, the Fluoridation Advisory Group was created, which included the California Dental Association, California Department of Health Services, Dental Health Foundation and the California Fluoridation Task Force. Because of this project, the cities of Sacramento, Los Angeles, Santa Maria, Escondido, Mountain View and other communities now fluoridate their water supplies. The Metropolitan Water District has also fluoridated its water supplied to most of Southern California.²⁵

Benefits of Oral Health Surveillance and the Future

Oral health surveillance is not only important for public health agencies but is also useful for practitioners and the profession. It helps if they understand disease prevalence and access to care issues at the local level. With the mapping programs now available,²⁶ practitioners could work with local health departments, foundations or other partners to create maps and spatial interpretations to understand unmet needs and availability and accessibility of dental care in the community. For example, a community health assessment of children's dental care needs in Los Angeles County found that 81 percent of children needed dental

Whether this difference is real or an artifact due to differences in age, race/ethnicity, gender, income distribution or treatment effects needs further study.

In 2010, there was a total of 3,869 cases of cancer of the oral cavity and pharynx in California.²⁴ FIGURE 3 shows that there has been a modest decline both in incidence and mortality rates in males and females. Data are also available

by race and ethnicity and region.

California has made steady progress with respect to water fluoridation coverage, with 62.5 percent of the population on public water systems receiving fluoridated water in 2010. This progress is largely attributable to a policy intervention to promote water fluoridation. In 1995, Jackie Speier, then in the California State Assembly,

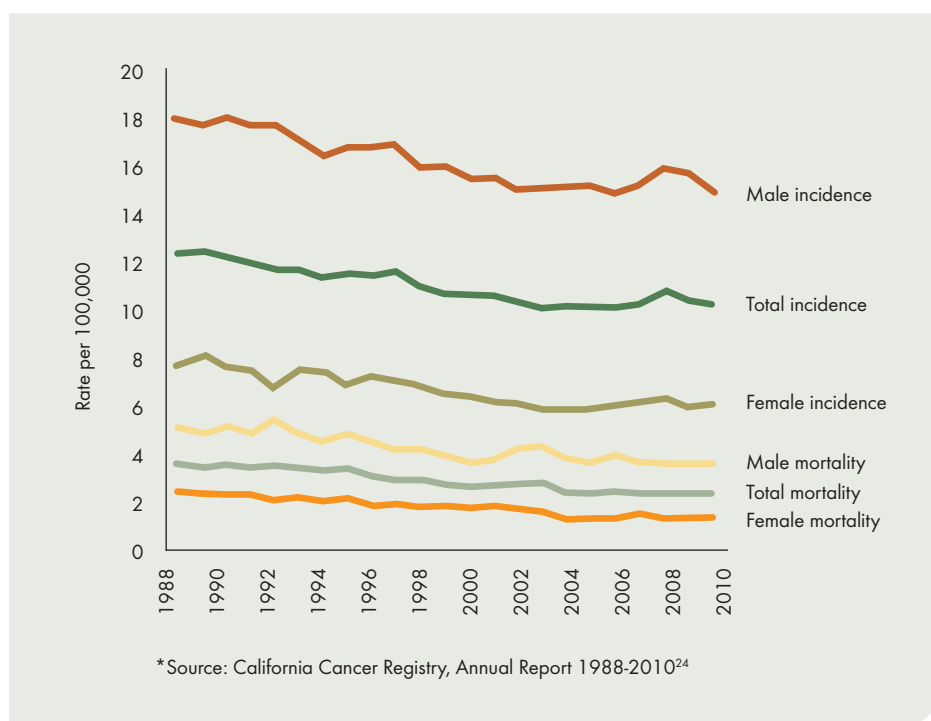


FIGURE 3. Incidence and mortality age-adjusted (2000 U.S. population) rates per 100,000 persons by year and gender, 1988-2010.*

care.²⁶ Seventy-two percent needed early dental care (within 15 days) and 9 percent needed urgent care (within 24 hours).²⁷ Where local data are not available, it is possible to obtain local area estimates utilizing a statistical method called synthetic estimation. A synthetic estimate is defined as a prevalence estimate for a local area that is calculated by using descriptive or demographic data for local areas combined with state prevalence values.²⁸ Such data could be combined with workforce data to identify dental health professional shortage areas (for a map of Dental Health Professional Shortage Areas in California, see gis.oshpd.ca.gov/atlas/topics/shortage). Using such data, practitioners could identify areas to establish practices, expand their services or advocate for innovative solutions. The Kansas Initiative for New Dentists (KIND) program, for example, was created as an incentive for new dental school graduates to move to and practice in a “Dental Care Service Desert” that the Kansas State Bureau

of Oral Health identified in its *Mapping the Rural Kansas Workforce* report.²⁹

Survey data also help dental professionals to effectively communicate problems and solutions not only to their patients but also to policymakers and the community. Tracking disease rates and progress toward health objectives can help oral health professionals to advocate for essential health benefit coverage, including coverage for adult dental health benefits and to target volunteer efforts such as Give Kids a Smile and/or Mission of Mercy dental projects. Furthermore, understanding oral and other chronic diseases and common risk factors affecting individuals within the community can empower local dentists and dental hygienists to better communicate with nondental health professionals in the community, establish referral networks for high-risk populations, promote healthy lifestyles, collaboratively address modifiable risk factors such as tobacco use and serve as oral health leaders in the community by serving on boards of health,

school health advisory committees and other community groups. Data can be used for advocating and strengthening programs such as mandated dental examinations, creating linkages with a source of care and case management, reimbursement for tobacco cessation counseling and other services in dental offices, and practice support and loan repayment programs for dentists.

In addition, oral health and other health professionals need to know whether their patients live in a community with an optimum level of fluoridation or not in order to assess their risk for dental caries and develop effective disease management plans. Community water fluoridation is a key protective factor for all patients in the community. Dental professionals can play a significant role to educate community members regarding the benefit of water fluoridation and partner with the public sector to maintain it in the community they serve.

The availability of data in a timely manner is crucial for the dental and public health communities. As illustrated in this paper, data for many indicators were five to seven years old. Furthermore, for oral health issues to be included in the state’s health agenda, data need to be not only current but also should be available at the local level. With the increased competition for limited public health funding, alternative data sources for oral health surveillance should be considered. The proliferation of electronic information systems like electronic health record data systems, rapid advances in information sciences and the availability of new tools like diagnostic codes in dentistry present opportunities for collaboration to meet the needs of public health surveillance programs. Public health agencies and professional organizations should explore ways to use the data collected from such novel data sources. ■

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Policy Development Collaboration Between State Dental Associations and State Oral Health Programs: The Maryland Experience

Harry S. Goodman, DMD, MPH

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A principal recommendation that was part of the framework in *Oral Health in America: A Report of the Surgeon General* (2000) was to “use public-private partnerships to improve the oral health of those who still suffer disproportionately from oral diseases.”¹ Reducing, if not eliminating, oral health disparities demands a response from the members of a diverse group of disciplines who can weave their own unique talents, networks, interests and policies into shared strategies that effectively address all aspects of this complex issue.

While it may not be very apparent, successful oral health partnerships do exist between private practice and public health dentistry because of a shared vision of improving oral health for all Americans. In fact, there are many similarities between the two disciplines as highlighted in an American Dental Association (ADA) education module on dental public health.² Many such partnerships exist at the national level between nonprofit dental professional organizations such as the ADA, National Dental Association and Hispanic

Dental Association, among others, and professional dental public health organizations such as the American Association of State and Territorial Dental Directors (ASTDD), American Association of Public Health Dentistry, the Medicaid/SCHIP Dental Association and the National Network for Oral Health Access. Many members of these public health groups also belong to the dental professional organizations.

ADA and ASTDD, in particular, share a unique partnership as both represent respective associations and programs at the state and local levels throughout the country. Whereas the ADA represents dental practitioners and their specialty organizations (that includes dental public health) through their respective constituent (state) dental associations, ASTDD represents public health state dental directors who oversee state oral health programs. It is this partnership at the state and local levels that has the potential to make the most impactful contributions toward reducing oral health disparities.

State oral health programs (SOHPs) are generally located in public health

agencies and work with a diverse group of partners to promote and support evidence-based programs, policies and activities. State dental associations (SDAs) are a leading voice for a state's dental profession and are an important resource for member services, education and advocacy, including legislation. While their paths may be different, both SDAs and SOHPs share a similar vision, and partnering with one another can benefit the public as well as provide value to each organization in terms of brand recognition, experience and leveraged resources. SDAs and SOHPs already collaborate on many important activities that benefit low-income families, such as ADA's Give Kids a Smile, Oral Health America's Smiles Across America, Mission of Mercy and Special Olympics.³

However, as was demonstrated in Maryland after the death of a 12-year-old local boy due to an untreated dental infection, it is perhaps in the area of policy development where both partners can create the greatest effect. Policy development is one of three core public health functions (in addition to assessment and assurance) and utilizes data and evidence-based information to develop multidimensional policies aimed at enriching decision making, planning and activities that help a population achieve health goals.⁴ The purpose of this paper is to highlight one state's experience in utilizing its public-private partnerships to develop key policies that enabled it to effectively respond to a preventable tragedy and steer it on a course to successfully engender positive change and reform in its oral health care delivery system.

It has been said that "a disaster can often do in an instant what years of interest group activity, policy entrepreneurship, advocacy, lobbying and research may not be able to do: elevate an issue on the agenda to a place where

it is taken seriously in one or more policy domains."⁵ The tragic and preventable death of Deamonte Driver in February 2007 due to an untreated dental infection was the galvanizing force that resulted in formative oral health policy development that resonates to this day and which brought into full view many partners, including the Maryland Office of Oral Health (OOH) and the Maryland State Dental Association (MSDA). However, what is generally not known is that OOH and MSDA had already been working together out of the spotlight, along with

While their paths may be different, both SDAs and SOHPs share a similar vision, and partnering with one another can benefit the public as well as provide value.

many others (such as the Maryland Academy of Pediatric Dentistry and the University of Maryland Dental School) on a legislative agenda to develop new policies well before this disastrous event.

As far back as the late 1980s, MSDA had already been responsible through its advocacy efforts for reinstating the SOHP/state dental director in the state health department when previous budget cutbacks had abolished this program. The state dental director was issued an ex officio, nonvoting seat on the MSDA executive committee, which exists to this day. Subsequently, both OOH and MSDA worked together along with their other partners to develop policy in the 1990s that resulted in the first meaningful reforms in the Medicaid dental program, a requirement for enhanced oral health

surveillance efforts and establishing the OOH in statute, among other key initiatives.⁶ Other legislation ensued in the early 2000s, including a statewide oral cancer prevention campaign, loan repayment to dentists who treated Medicaid children in their practices, state dental licenses issued to pediatric dentists with undergraduate foreign dental school degrees who provided dental services in Maryland public health clinics, increased support for Maryland dental safety-net clinics and a requirement that the state have a full-time dental director in its oral health office.⁶

While these policies enabled OOH to garner needed support to institute new and important education, prevention and access initiatives, more importantly, dentistry finally had a permanent voice at the state health department "policy table." This period also created an atmosphere of trust and credibility and formed a bond between MSDA and OOH that lasts to this day. This connection didn't mean that both were in agreement on every issue, only that when there was disagreement, each side understood and accepted the rationale and perspective of the other. This mutual understanding would be critical during the ensuing period when Maryland was thrust into the public spotlight over the death of Deamonte Driver. Trust and credibility would be crucial since it was apparent to all involved that Maryland had reached a tipping point regarding its ability to provide ample access to oral health care services and truly address oral health disparities. And it was this bond among OOH, MSDA and other partners that resulted in the oral health delivery system policy reform measures and recommendations of the newly convened Dental Action Committee (DAC), of which both MSDA and OOH were members.⁶

In essence, the DAC, which had been charged by the secretary of health with developing system-level recommendations to improve oral health access in the state, would be working with a “shovel-ready plan” that resulted from the previous deliberations between OOH, MSDA and others. The plan consisted of provocative reforms in the Medicaid program, including having dentistry being “carved out” from the rest of the system, a request that had been made for many years by the private and public dental communities. In addition, Medicaid dental rates were increased to the median fees charged by local dentists, and nonmonetary Medicaid issues, such as expediting credentialing, simplifying application processes and timelier turnaround in claims processing and complaint resolution, were also addressed. Again, what is significant about these recommendations is that they dutifully addressed the exact complaints that dental practitioners had been expressing for years.

As a result of this inclusive environment that demonstrated both respect and openness to dentists’ views, buy-in for the dental community was achieved. Such buy-in likely enabled other presumably more controversial DAC recommendations at the time to be approved by DAC membership with minimal resistance. Such recommendations included the establishment of public health dental hygienists and enabled medical practitioners to be reimbursed by Medicaid to apply fluoride varnish for their well-child patients (the full DAC report can be found at phpa.dhmdh.maryland.gov/oralhealth/docs1/DAC_report.pdf). The DAC cemented the public-private partnerships and collaborative spirit that had been created earlier; everyone gave up something to achieve the greater good. While the death of Deamonte Driver

was certainly the spark that lit the fire to establish policies to achieve shared oral health goals in Maryland, the fire may have quickly been extinguished if the less formal public-private partnership between OOH, MSDA and others had not been established. Even after the DAC recommendations were eventually accepted and approved by the Maryland governor, both the MSDA president at that time and the OOH director felt compelled to conduct a series of state dental component society site visits to secure membership support and

As a result of this inclusive environment that demonstrated both respect and openness to dentists’ views, buy-in for the dental community was achieved.

improve the chances that more dentists would cooperate and participate in the state Medicaid dental program.

As a result of the DAC recommendations and the commitment of MSDA leadership to the access reforms, approximately 1,000 new dentists joined the Medicaid dental program between August 2009 (first year of the dental carve-out) and August 2012.⁷ Access to dental services for Medicaid children increased from 49.3 percent in calendar year 2007 (the year of Deamonte Driver’s death) to 66.4 percent in calendar year 2011.⁷ Further, OOH was able to augment the dental public health safety net system and ensure that residents in every region of the state had access to at least one jurisdictional or regional safety net dental clinic. And public health dental hygienists

and medical practitioners were applying timely and needed preventive services in “nontraditional” settings to targeted children and then referring high-risk kids to dental offices. As a result of these collective efforts, Maryland, which once had one of the poorest records in oral health in the nation, was ranked in 2011 by the Pew Center of the States as the top state in the country for oral health.⁸

Since the DAC proceedings, MSDA, OOH and others have continued their collaboration and have partnered to successfully challenge proposed cuts in certain Medicaid dental services, as well as to oppose legislation that would have curtailed community water fluoridation and dental amalgam use in the state. These groups also partnered to support legislation enabling temporary dentist and dental hygienist volunteer licenses in order to better support activities such as Mission of Mercy events and, along with the Maryland Dental Hygienists’ Association (MDHA), supported legislation that permitted dental hygienists to administer local anesthesia. While not in complete agreement on the expanse of legislation involving other dental hygiene scope-of-practice changes, MSDA and OOH eventually worked with MDHA on “compromise” legislation that enabled eligible licensed dental hygienists to provide prevention services in venues such as long-term care facilities and community health fairs without direct supervision and the need for dentists to first see the patients.

Another significant collaboration is the annual “Access to Care Day” that MSDA sponsors at its annual membership meeting and which is partially supported by OOH. The purpose of the meeting, which has grown significantly over the past five years, is to provide training in pediatric and perinatal oral health care as well as to assist dental providers

in successfully participating in and navigating the Medicaid oral health delivery system. MSDA also sponsors an annual Dental Leadership Roundtable that consists of leaders from all state dental organizations, including OOH, to discuss policies and other activities aimed at resolving issues confronting dental practitioners. Finally, both MSDA and OOH are members of the Maryland Dental Action Coalition (MDAC), the independent state oral health coalition that morphed from the DAC. The MDAC office is located within MSDA and as a result, MDAC and the state's dental public health partners, including

OOH, are afforded some of the resources of MSDA, including meeting space.

In summary, there are many other states where the public-private partnership of the SDA, SOHP and other private and public health groups work successfully together to best serve their oral health interests. In fact, ADA and ASTDD are currently working together on a tip sheet that provides many examples of successful collaborations between SDAs and SOHPs. The tip sheet does not gloss over the reality that there will be differences in opinion between the organizations, as was the case at times in Maryland, but that with mutual respect,

credibility and trust, both partners should be able to give up something in order to work collaboratively.

Mike Rutherford of the rock group Genesis once said that making music as part of a band was "always a compromise. Provided that the balance is good, what you lose in compromise, you gain by collaboration." State oral health programs and state dental associations also can strike the right note when singing from the same hymnal. Each partner brings unique skill sets and toolboxes that, when working together and with others, can become an important voice for oral health and the populations they conjointly serve. ■

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Public-Private Partnership: Complementary Efforts to Improve Oral Health

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RADM William Bailey, DDS, MPH, is the chief dental officer of the U.S. Public Health Service and senior advisor for oral health at the Centers for Disease Control and Prevention in Atlanta. He has a master's in health policy and administration and is a diplomate of the American Board of Dental Public Health. In his 32-year career with the U.S. Public Health Service, he has worked with vulnerable and underserved populations in diverse settings during assignments with the National Health Service Corps, Bureau of Prisons and the Indian Health Service.

Conflict of Interest

Disclosure: None reported.

All dental professionals, whether they work in private practice or public programs, have the same ultimate goal — achieving the best oral health for patients, families and communities. The best way to meet this goal is through collaborative action. Effective collaborations depend on making sure professionals in both sectors know what their colleagues are doing and on making the best use of available resources.¹ This article is designed to increase practitioner knowledge of key public health activities at the federal level. It briefly describes efforts to improve oral health literacy, increase the number of dental visits and support effective state oral health programs.

Public oral health programs at the federal level, such as those managed by agencies and offices of the U.S. Department of Health and Human Services (HHS), provide a wide range of services. These services include helping increase access to dental care for vulnerable populations, providing

training grants to improve the skills of oral health professionals and conducting surveillance of oral health diseases and conditions.² HHS priorities include expanding access to high-quality clinical preventive services, linking community-based policies and programs to support and supplement clinical prevention efforts, and supporting prevention programs that increase the quality of care delivered by both public and private systems.³

Collaborations between private practice and public programs can help to support efforts to improve oral health across the United States. These efforts include the following three goals.

Improving Oral Health Literacy

Improved oral health literacy is a stated goal of the California Dental Association and is important to private practitioners.⁴ Federal programs are also taking steps to improve oral health literacy, which is defined as a person's "capacity to obtain, process and use basic oral health information and services needed to make appropriate health

decisions.”⁵ In 2010, HHS published the *National Action Plan to Improve Health Literacy*, with the underlying assumption that all patients have the right to health information that helps them make informed decisions and that the delivery of health services should be done in ways that are “understandable and beneficial to health, longevity and quality of life.”⁶

Research indicates that adults with proficient health literacy skills are more likely to have a yearly dental visit (77 percent) than adults with less than adequate health literacy skills (44 percent).⁷ In addition to increasing the number of dental visits, proficient oral health literacy is associated with knowledge about preventive measures such as water fluoridation and greater appreciation for oral health-related quality of life.⁸

Early health literacy studies focused on patients’ reading skills but did not adequately account for the importance of the written and verbal literacy skills of health care providers.⁹ To enhance the health literacy skills of dentists and other providers, federal agencies have developed and distributed resources and encouraged providers to take steps to improve their communication skills and approaches to ensure patients’ understanding.¹⁰ For example, the Agency for Healthcare Research and Quality (AHRQ) developed the *Health Literacy Universal Precautions Toolkit* for primary care providers.¹¹ The “universal precautions” in the title refer to “specific actions that minimize risk for everyone when it is unclear which patients may be affected.” A survey of U.S. adults found that more than one-third had limited health literacy.¹² Because health care providers cannot easily identify which of their patients have low health literacy, the AHRQ recommends the use of proven communication techniques with all patients.

The *Health Literacy Universal Precautions Toolkit* includes information about how to improve both oral and written communication between providers and patients, empower patients to manage their own conditions and build supportive systems to improve patient compliance. It describes methods such as asking patients to repeat back instructions to ensure understanding, developing and using easy-to-read materials, making follow-up telephone calls to patients, creating action plans for patients and connecting patients to community resources.

Public-private collaboration will help give dental professionals, patients and community leaders the literacy skills and resources they need.

Another new resource for oral health professionals is the oral health e-learning program on the Think Cultural Health website. This free, online educational program offers continuing education credits on how to deliver culturally competent care.¹³ In addition, a range of expert guidance is available on how to develop easy-to-understand health education information for websites, including a guide from HHS’s Office of Disease Prevention and Health Promotion.¹⁴

Public-private collaboration will help give dental professionals, patients and community leaders the literacy skills and resources they need to enhance the health care delivery system and improve oral health. By increasing the health literacy of patients, we can help them

understand the importance of oral health, improve their ability to find the services they need and navigate the health care system and adopt more healthy behaviors (such as self-management practices) to prevent and control oral disease.

Increasing the Number of Dental Visits

The American Dental Association’s Health Policy Resources Center recently reported that Americans are making fewer visits to the dentist and spending less money on oral health.¹⁵ HHS is working to counter this trend by increasing the percentage of Americans who have an annual dental visit. For the first time, oral health was chosen as a Leading Health Indicator, which is a high-priority health objective with specific actions that can be taken to address it.¹⁶ As part of the Healthy People 2020 national health agenda, HHS is monitoring trends for the following indicator: “Persons aged 2 years and older who used the oral health care system in the past 12 months.” Currently, just over 40 percent of people see a dentist each year, and the HHS objective is to increase this percentage to almost 50 percent by 2020.¹⁷

To support these efforts, several federal agencies have developed strategic objectives and are working with private practitioners to increase access to clinical and preventive services and reduce health disparities, especially among vulnerable populations.^{3,18} Some progress has been made. A recent analysis by the Centers for Medicare and Medicaid Services found that the percentage of children enrolled in Medicaid and the Children’s Health Insurance Program who were using any type of dental services increased from 29 percent in 2000 to 46 percent in 2010. The percentage who received dental treatment during this period increased from 15 percent to 23 percent, and the percentage who received preventive

dental services increased from 23 percent to 41 percent. Despite this improvement, these children still visited the dentist less often than children with private dental insurance (53 percent).¹⁹ In addition, only about 16 percent of children ages 6 to 14 years who were enrolled in Medicaid had a dental sealant placed in 2010.¹⁹

As stated previously, delivery of preventive services is a priority for federal agencies like the Centers for Disease Control and Prevention (CDC).^{2,3} One of the four core focus areas of CDC's National Center for Chronic Disease Prevention and Health Promotion is to explore strategies to improve community-clinical links to promote health and prevent disease.²⁰ CDC is playing a leading role in tracking the delivery of dental sealants and other preventive services to children as part of Healthy People 2020.¹⁷ In addition, CDC and the Health Resources Services Administration (HRSA) are funding states to implement or expand sealant delivery to students in low-income or rural schools in accordance with evidence-based recommendations that were developed through public-private collaborations.²¹⁻²³

Supporting State Oral Health Programs

Organized dentistry works with federal and state oral health programs in many different ways to improve the nation's oral health. Examples of these efforts include increasing awareness about oral disease prevention, fostering population-based prevention programs, ensuring a skilled workforce and the necessary infrastructure to assess and address a community's oral health needs, and improving health outcomes through collaboration.²⁴

Strong state oral health programs are needed to coordinate these efforts and promote active public-private partnerships at the state level. Examples

of these partnerships include work with state and local dental associations, state dental boards, educational institutions, philanthropic organizations and primary care associations.²⁵ State oral health programs are also performing the core functions of public health: assessment, assurance and policy development. These functions include assessing and analyzing oral health needs, setting priorities, developing policies to address the most urgent needs and implementing, managing and evaluating programs.²⁶

Federal programs support state oral

Strong state oral health programs are needed to coordinate these efforts and promote active public-private partnerships at the state level.

health programs in various ways. For example, CDC and HRSA currently provide funding and technical assistance to states to support key oral health positions and build or maintain effective public health capacity to set up, evaluate and share best practices to prevent oral disease and improve oral health. Funded states use this support to develop state surveillance systems, generate data reports, create and maintain partnerships and oral health coalitions, and develop state oral health plans.^{21,22}

Public-private collaboration on oral health is occurring at federal, state and local levels. At the federal level, officials are working to improve oral health literacy, increase the number of dental visits and support effective state oral health programs. These efforts benefit

dentists in private practices, just as the efforts of private practitioners enhance public programs. The efforts of those in private practice include participating in the Dental Practice-based Research Network,²⁷ volunteering in school-based sealant programs²⁸ and helping with statewide oral health surveys.²⁹ Maintaining and expanding public-private collaboration is essential to achieving optimal oral health for all Americans. ■

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Differentiating a Good From a Great Dental Practice

Michael Perry, DDS

The popular business book, *Good to Great*, by Jim Collins is highly recommended for current and prospective practice owners. Many of the ideas he expresses about corporate America also apply to private dental practices.

There are different ways to measure success. The primary theme of *Good to Great* is the difference between businesses that achieve good results and those that achieve extraordinary results.

I see Collins' "doom loop" model occurring frequently in dental practices. When disappointing results occur in a practice, an early reaction is often "reaction without understanding." This reaction by the leader is often "a new direction, program, fad or acquisition" that often leads to "no accumulated momentum" in the practice, which leads back to disappointing results.

Collins advocates replacing the doom loop with the "flywheel model." The components of this model are:

- Level 5 leader
- First who, then what
- Confront the brutal facts
- Hedgehog concept
- Culture of discipline
- Technology accelerators

Read the book to obtain a detailed description of each of these components. Two of the more compelling are "confront the brutal facts" and the "hedgehog concept."

The brutal facts don't have to be brutal, but they must be truthful to be of value. Just as we dentists find value in the objective facts about our patients' health, it is valuable for us to seek the objective facts concerning the conditions of our businesses. To obtain these facts on a consistent basis, easy-to-use monitoring and reporting systems must be in place. An outside assessment is often very helpful as well.

The hedgehog concept is the confluence of the answers to three business questions:

1. What am I passionate about?
2. What can I be the best at in my community?
3. What drives my economic engine?

Determining the hedgehog concept for a practice requires a confrontation of the brutal facts followed by creative energy on the part of the leader. Collins states that great companies follow a simple mantra: "Anything that does not fit within their hedgehog concept, they will not do!"

Utilizing the flywheel model creates the "flywheel effect." This effect starts with

"steps forward consistent with the hedgehog concept." This leads to "accumulation of visible results." Team members are then energized by those results. This creates "momentum within the flywheel." This facilitates more steps forward consistent with the hedgehog concept and so on. ■

Michael Perry, DDS, is a former member of the California Dental Association Council on Membership and the Dental Benefits Research Task Force. He is also the chair of the CDA Practice Support Center Task Force. Dr. Perry is a practicing general dentist in Santa Rosa, Calif., and a dental business consultant.

PARAGON

DENTAL PRACTICE TRANSITIONS

RECENT TRANSACTIONS

Tina S. Fariba, D.D.S.

has acquired an equity position in the practice of

Russell E. Haag, D.D.S.

San Diego, California

PARAGON is proud to have represented both parties in this California transaction

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How You Can Help

To help provide oral health care services to the large number of expected patients, we need volunteer dental and health professionals including general dentists, oral surgeons, dental hygienists, assistants, lab technicians, nurses and pharmacists. Additionally, community volunteers are needed to assist with registration, clinic setup, data entry, escorting patients, translating and much more. Patients receive cleanings, fillings, extractions, oral health education and assistance in finding a dentist for follow-up care.



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Address Harassment Complaints Immediately

TDIC Risk Management Staff

The Dentists Insurance Company says it receives repeated calls to its Advice Line about the harassment of dental staff by patients or vendors.

Federal and state laws forbid harassment of employees, and dentists have an obligation as employers to maintain a safe workplace. Further, dentists can be held liable if a harassment situation is not addressed, according to attorney Christopher Yeh.

"Dentists can be liable because their duty is to provide a harassment-free workplace," said Yeh, a Honolulu-based attorney specializing in labor and employment law. "Their responsibility is

to protect employees from harassment by an individual in the work environment, whether it is a co-worker or a third party such as a patient or vendor. Once dentists have notice of harassment, such as a complaint, it is their duty to take reasonable steps to prevent it."

The U.S. Equal Employment Opportunity Commission states that it is "unlawful to harass a person (an applicant or employee) because of that person's sex. Harassment can include "sexual harassment or unwelcome sexual advances, requests for sexual favors and other verbal or physical harassment of a sexual nature." The commission also notes that "harassment does not have

to be of a sexual nature, however, and can include offensive remarks about a person's sex. For example, it is illegal to harass a woman by making offensive comments about women in general."

When it comes to harassment of employees, Yeh said every situation is different. Dentists must apply proportional corrective action depending on the circumstances. If a co-worker, vendor representative or patient tells an off-color joke, the corrective action should be reasonable, based upon the severity of the situation.

The Equal Opportunity Commission specifies that the "law does not prohibit simple teasing, offhand comments or isolated incidents that are not very serious." However, harassment is illegal when it is so frequent or severe that it creates a hostile or offensive work environment. The commission also notes that harassment can happen to either a man or a woman, and the harasser can be the same gender.

Yeh said that the best action for dentists is to have an office policy that defines and prohibits inappropriate behavior. This is best included in your office's employee manual. "The policy should include a definition of harassment as well as examples of unprofessional and rude behavior," he said. Yeh emphasized that there should be at least two people in the dental office to whom employees can report harassment, and that employees must be assured there will be no retaliation for reporting harassment.

Once a dentist or office manager has notice of harassment, either by an employee reporting the situation or by observation, the harassment must be investigated as soon as possible. "Dentists must determine the facts of the situation and if office policy was violated," Yeh said. Office managers must be trained to take immediate corrective action in the event of employee harassment.

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QUESTIONS MOST OFTEN ASKED BY SELLERS:

1. Can I get all cash for the sale of my practice?
2. If I decide to assist the Buyer with financing, how can I be guaranteed payment of the balance of the sales price?
3. Can I sell my practice and continue to work on a part time basis?
4. How can I most successfully transfer my patients to the new dentist?
5. What if I have some reservation about a prospective Buyer of my practice?
6. How can I be certain my Broker will demonstrate absolute discretion in handling the transaction in all aspects, including dealing with personnel and patients?
7. What are the tax and legal ramifications when a dental practice is sold?



QUESTIONS MOST OFTEN ASKED BY BUYERS:

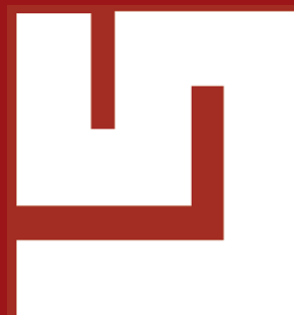
1. Can I afford to buy a dental practice?
2. Can I afford not to buy a dental practice?
3. What are ALL of the benefits of owning a practice?
4. What kinds of assets will help me qualify for financing the purchase of a practice?
5. Is it possible to purchase a practice without a personal cash investment?
6. What kinds of things should a Buyer consider when evaluating a practice?
7. What are the tax consequences for the Buyer when purchasing a practice?



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ANAHEIM: General Dentistry Practice. 3 Ops. Nicely appointed and modern. GR \$423K with Adj. Net \$140K. Refers out specialty procedures. Retiring. Growth potential! #CA101 - **In Escrow**

BAKERSFIELD: General Dentistry Practice. 3,650SF. 8 Ops. 7 equipped. Digital X-rays and intra-oral camera. GR \$1.3MM with Adj. Net \$431K. Growing area. #CAM554

BAKERSFIELD and SMALL FARM COMMUNITY: Two Practices 30 mins. apart. Strong patient bases. Staff and doctor work both practices. Underserved communities with room for growth. GR \$588K with Adj. Net \$278K. #CAM557

BISHOP: General Dentistry Practice & Building. 1,800SF. 5 Ops. GR \$1MM with Adj. Net \$387K. #14390 - **In Escrow**

CENTRAL COAST: Prosthodontic Practice. 4 Ops. Full in-house lab. GR \$1.1MM. Near shopping. #CAM535

CERRITOS: General Dentistry Practice. 1,500SF. 7 Ops. 6 equipped. 1 plumbed. Digital X-rays. Strong area near shopping, residential and freeway. GR \$408K with Adj. Net \$140K. Est. 39 years. Room to grow. #CA100

CHULA VISTA: General Dentistry Practice. 4 Ops. 3 1/2 days of hygiene. Dentrix. GR \$528K. #CA109.

CLAREMONT: General Dentistry Practice. 6 Ops. 8 days of hygiene/week. GR \$581K with Adj. Net \$147K. #CA114

COALINGA: General Dentistry Practice. 1,100SF. 3 Ops. Remodeled in 2011. 1,000 active patients. Excellent opportunity for new dentist or established dentist looking for satellite office. #CA564

COASTAL ORANGE COUNTY: General Dentistry Practice. 4 new Ops-High-end chairs, cabinetry and tenant improvements. Dentrix, Dexis, Digital Pan. Close to the ocean-Dream location! Doctor is retiring. GR \$600K in '11, \$500K in '12. #CAM566

COASTAL ORANGE COUNTY: Periodontal Practice. 5 Ops. Retiring doctor works 3 days/wk with 4 days of hygiene. Great location near freeway/hospital. GR \$450K+. #CAM533

FOLSOM/EL DORADO HILLS: General Dentistry Practice. 1,200SF. 4 Ops. 2 1/2 days hygiene/wk. Dentrix, Laser, Digital X-rays, Intra-oral camera. GR \$405K. #CA103

FREMONT: General Dentistry Practice. 3,000+SF. 10 Ops. Digital X-ray, Pan. 4,000 active patients. PPO/HMO. GR \$1.2MM w/ Adj. Net \$300K. #CA553 - **In Escrow**

GRANITE BAY: General Dentistry Practice. 5 Ops, 3 equipped. Newly remodeled office. Dentrix, Digital X-rays. GR \$236K+ on 8 days/month. Owner relocating out of country. #CA128 - **In Escrow**

GREATER SACRAMENTO: Orthodontic Practice. Like-new 2,300SF office with extensive leasehold improvements and 6 chairs. 220 active patients, Phase 1. #CA551

GREATER SACRAMENTO: General Dentistry Practice and Condominium. 4 Ops. 1,300SF office in professional bldg. Eaglesoft software, Fiber Optics. GR \$679K. Owner retiring. #CA138

GREATER SACRAMENTO/ROSEVILLE: Partnership Position in General Dentistry Group Practice. Each partner has own patients. Intra-Oral, Digital X-Rays (Dexis), Digital Pan. Excellent Mgmt team. Owner financing w/acceptable down payment. Subject to approval by current partners. #CA126

HAWAII (MAUI): General Dentistry Practice. Approx. 1,200SF w/4 equipped Ops. GR \$636K #20101

HENDERSON, NV: DECEASED DENTIST. Pediatric Practice. 2011 GR \$875K; 2012 GR \$1.1M; 2013 GR in first 9 months \$68K. 6 Ops, Dentrix, Pano. Available for immediate sale. #NV100

HOLLISTER: FACILITY ONLY. 1,800SF. 3 Ops w/ 2 add'l plumbed with cabinets. Adec chairs, units, lights, Dexis, Easy Dental, Pano X-ray. Owner relocating to own building. #CA563

HUNTINGTON PARK: Retiring General Dentist with a large group practice that was started in 1984. 15 Ops and Dentrix/Dexis with 25 computer workstations. E4D CAD/CAM machine. GR \$1.1MM+. #CA113

INDIAN WELLS: General Dentistry/TMJ Practice. 4,000SF. 6 Ops. GR \$350K+ on 1 doctor-day/wk. #CAM530

LA MESA: General Dentistry Practice. 3 Ops. 2,000SF. Professional bldg. GR \$396K with Adj. Net \$155K. Dentrix, Laser, Digital X-rays. #CA127

LANCASTER: General Dentistry Practice. 2,300+SF. 4 Ops. GR \$676K with Adj. Net \$174K. #CA14376 - **In Escrow**

LOS ANGELES: General Dentistry Practice. 5 Ops. Professional bldg downtown. #CA141

MILPITAS: General Dentistry Practice. 1,440SF. Professionally designed office in major business district. 4 Ops. Intra-oral camera/computers in each Op. Pano X-ray. Owner retiring. #CA562 - **In Escrow**

NEWPORT BEACH: General Dentistry Practice. 3 Ops. Newer high-end equipment. GR \$350K on 3 1/2 days/wk. #CAM534

NORTH EAST BAY: General Dentistry Practice. 7 Ops. 2,324SF. Dental Mate software, Intra-oral Camera, Pano X-ray, Digital X-ray. GR \$885K with 70% OH. Building to be sold with practice. Owner retiring. #CA108

NORTH OF SACRAMENTO: General Dentistry Practice. 4 Equipped Ops, 5 available. Newly remodeled office. Approx. 1,500 active patients. GR \$515K on 32 hr/wk., 37 wks/yr. EZ Dental, Pan, Fiber Optics. 20 hrs. hyg/wk. Bldg. available for purchase. #CA558

NORTH OF SACRAMENTO: General Dentistry Practice. 4 Ops. 1,650SF. GR \$521K with low 52% OH. #CA528.

NORTH OF SACRAMENTO: General Dentistry Practice. 5 Ops. 2,050SF. Dentrix, Intra-oral Camera, Digital X-ray, Imaging System, Pano. GR \$1.2M+ with only 54% OH. #CA106

NORTH ORANGE COUNTY: Endodontic Practice. 5 Ops, fully equipped. 3 Zeiss wall-mounted microscopes. Established 30 yrs. GR \$370K with Adj. Net \$172K on 3 Days/wk. #CAM561

NORTH SAN DIEGO COUNTY: Large legacy practice. 4 Ops. HMO practice with a great check in a desirable area in North County. #CAM555

ORANGE: 3 Op practice specializes in Dentures and Partials. Established for over 14 years in a retail location. #CA142

ORANGE COUNTY: General Dentistry Practice. Located in a retail center in a desirable area of Orange County. GR \$900K+ with Adj. Net \$393K. #CA132

PITTSBURG: General Dentistry Practice. 5 Ops. 1,400SF. Pano, Fiber Optics. 12 New patients/month. Favorable rent. GR \$236K with 60% OH. Owner is retiring. #CA133

POWAY: General Dentistry Practice. 4 Ops. 1,100SF. Dentrix, 6 workstations, digital X-rays, intra-oral camera. Established 1985. Equipment only 5 years old. GR \$720K with Adj. Net \$241K. #CA139 - **In Escrow**

RIDGECREST: General Dentistry Practice/Dental Building. 4 Ops. 1,500+SF. Small practice with GR \$175K 2012. #CA523

RIVERSIDE: General Dentistry Practice/Building. 5 Ops. Emphasis on Implants. Established over 50 years. GR \$500K+. #CA120

SOUTH LAKE TAHOE: General Dentistry Practice. 5 Ops, 1 add'l available. 1,450SF. High visibility. 15 new patients/month. 4 days/hygiene. Avg. collections over last 3 years \$733K. #CA134

SOUTH ORANGE COUNTY: General Dentistry Practice. 4 Ops. 1,350SF. Dentrix. Coastal location. #CA119 - **In Escrow**

SACRAMENTO: General Dentistry Practice. 8 Ops, 7 equipped. 2,400SF office/bldg. Low 54% OH. GR \$642K. #CA549

SAN CLEMENTE: General Dentistry Practice. 3 Equipped Ops, 2 add'l plumbed. Established ~10 years. PracticeWorks, digital X-rays, Pano. #CA129

SAN DIEGO: General Dentistry Practice. 5 Ops. 1,200SF EagleSoft, digital X-rays, Established 22 years. GR \$442K with Adj. Net \$161K. #CA130

SAN JOSE: FACILITY ONLY: 6 Ops. 3,700SF. Digital X-ray, sterilization, computer workstations in every room. Reception w/flat screen TV. Equipped business office/conference room. #CA565

SANTA ANA: General Dentistry/Pedo/Ortho Practice. 11 Ops. Established 20 years. Free-standing building. Pano, intra-oral camera. GR \$424K with Adj. Net \$138K. Denti-Cal makes up ~35% of business. #CA136

SANTA CRUZ: Endodontic Practice. 2 Ops. 850SF. Schick Digital X-rays. Ideal for a satellite practice. Owner will work for new buyer 1-1 1/2 days/wk. GR \$350-\$400K. 55% OH. #CA102

SANTA CRUZ COUNTY: General Dentistry Practice. 3 Ops. 1,100SF. Professional bldg. near Hwy 1. 2,200 active patients. 10 new patients/month. Schick Digital X-ray, Dentrix software. GR \$338K on 2 days/wk. Moving. #CA550

SHERMAN OAKS: General Dentistry Practice. 4 Ops. Professional bldg near freeways. SoftDent. Established 40 years. GR \$740K with Adj. Net \$220K. #CA135

THOUSAND OAKS: General Dentistry Practice. 6 Ops. 7 Days hygiene/wk. Dentrix/Dexis. GR \$576K with Adj. Net \$163K. Retiring. #CA118 - **In Escrow**

THOUSAND OAKS: FACILITY ONLY. 4 Ops. 1,325SF. Move-in ready. Office features modern design, Dentrix with 4 workstations, Equipped business office, Sterilization area. Great start-up location or satellite office. Full inventory and photos available. #CA137

TURLOCK: General Dentistry Practice. GR \$950K with Adj. Net \$443K. #CA506 - **In Escrow**

TUSTIN: General Dentistry Practice. 3 Ops. CEREC 3D Machine. GR \$300K with Adj. Net \$103K. #CA131 - **In Escrow**

WALNUT CREEK: PRICE REDUCED! Prosthodontic Practice. 3 Fully-equipped Ops. Full lab. GR \$399K with Adj. Net \$143K. #CAM540

WEST LOS ANGELES: General Dentistry Practice. 4 Equipped Ops, 1 plumbed, not equipped. Great LA location on the west side. GR \$342K 2 doctor days/week. Room to grow! #CA117

YORBA LINDA: General Dentistry Practice. 5 Ops. Laser, Intra-oral camera, digital X-rays. 3 Hygiene and 3 doctor days/wk, Great location! #CAM531

CONTINUED FROM 258

To investigate a harassment complaint, talk to the employee who filed the complaint and guarantee that he or she is safe from retaliation. Reassure the employee that he or she did the appropriate thing by reporting the incident. Inform the employee that you need to know immediately about any retaliation or ongoing harassment. Ask the employee to recount the situation while you take notes about dates, times, situations and witnesses. Clarify any vague or unclear comments.

Investigating a harassment complaint against a patient is a delicate situation, and TDIC advises that the dentist interview the patient accused of harassment with the same respectful approach given the employee and any other witnesses. Ask open-ended questions, seek specific facts and take objective notes.

Once you have interviewed all parties, consider the degree of the offense. If it is not a completely offensive situation, such as inappropriate jokes or comments, talk to the offender. Provide examples of the inappropriate behavior and what will happen if the behavior continues. If the offender is a patient, advise him or her that dismissal from the practice will occur if the behavior does not stop. Note the situation in the patient's chart using objective language and facts.

If the offense from a patient or vendor is more serious, such as sexually explicit language or touching, TDIC advises dentists to dismiss that patient or stop doing business with that vendor. The dentist can also consider calling the vendor and requesting a different representative. In this situation, call TDIC's Advice Line to discuss the situation with an analyst before taking the next step. ■

The Dentists Insurance Company offers policyholders a free advice line at 800.733.0634 for assistance with questions or concerns about potential liability. TDIC risk management analysts will work with policyholders to develop a solution.

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AC-243 SF Facility: Occupies the entire 8th Floor of this beautiful Professional Building in Downtown SF's Financial District. ~2500 sf w/ 7ops & plumbed for additional ops. **\$150k**

BC-221 EAST CONTRA COSTA: Well Respected w/ loyal patients, Seller is retiring! 1900 sf w/ 4 ops **\$325k**

BN-183 HAYWARD: *Kick it up a notch by increasing the current very relaxed work schedule!* 1,300 sf w/ 3 ops **\$150k**

BN-233 ALAMEDA: Real Estate and Practice Available! ~ 3,139 sf w/ 8 ops. **\$275k, RE: \$825k**

BN-248 NORTHEAST BAY: Big Town Care with Small Town Feel! Opportunity to own Building also! ~ 1,160 sf w/ 3 ops + room for 1 add'l. **\$195k, RE \$250k**

CC-151 SANTA ROSA: Stable patient base, well-respected, close to Memorial Hospital. 2,262 sf w/ 6 ops **\$875k Real Estate avail.**

CC-170 SOLANO COUNTY: Near Wine Country! 950 sf w/3 ops **\$225k**

CN-189 RIO VISTA: In the heart of the beautiful California Delta! 3 ops **\$275k**

CN-262 PETALUMA: Looking for an HMO practice? This practice is located in a very desirable area. ~1202 sf w/ 3 ops. **\$475**

DC-257 SAN JOSE: Highly Motivated Seller! GP in desirable Silicon Valley. Office is 900 sf w/ 3ops in single-story bldg. **\$300k**

DG-116 SALINAS AREA: Large, loyal & stable patient base! 1,400 sf w/5 ops. State-of-the-art Equipment **\$195k**

DG-124 MILPITAS: Highly visible. Desirable area. 960 sf w/ 2 ops + 1 add'l **\$130k**

DG-156 SAN JOSE: Hardwood Floors & plenty of windows! 1,160 sf w/ 3 ops (+2 add'l) **REDUCED! \$125k**

DG-222 SAN JOSE: High traffic Retail Shopping Center with unbeatable signage. 2,847 sf w/ 7 ops **\$925k**

DG-223 SUNNYVALE: **Seller Relocating!** Popular Retail Shopping Plaza with major anchor tenants. 2,000 sf w/ 6 ops +1 **\$450k**

DG-212 FREMONT: Courtyard Garden welcomes patients. Your talent and skill keeps them! 2,181 sf w/ 3 ops **\$175k**

DG-232 SANTA CRUZ: Large, well-established Medical/Dental Prof complex! 1,063 sf w/ 3 ops **\$345k**

DG-239 PALO ALTO: Amazing Location! Pristine practice. "Top-of-the-line" Pelton Crane . 2000 sf w/5 + 1 add'l **\$1.05m**

NORTHERN CALIFORNIA

EG-198 SACRAMENTO: Tucked in well established "Pocket Area" in highly desirable corridor. 1,112 sf w/3 ops **Now Only \$115k**

EG-237 ROCKLIN: State-of-the-art, top-of-the-line equipment. 1,000 sf w/ 2 ops. Plumbed for 2 add'l **\$245k**

EN-245 SACRAMENTO: Immaculate! Long established warm and inviting practice! ~1,335 sf w/ 3 op + 1 add'l. **\$150k**

FN-181 NORTH COAST: Well respected FFS GP. Stable patient base. 1,000 sf w/3 ops **SELLER MOTIVATED! \$150k (25% int. in bldg. avail.)**

FN-185 UKIAH: 900 sf w/ 3 ops. Seller Willing to Negotiate! **\$250k**

GN-149 YREKA: Quality FFS, Warm & Caring. 900 sf w/ 3 ops. Now Only: **\$180k/Real Estate \$110k**

GN-201 CHICO: Beautiful practice , major thoroughfare, stellar reputation! 1,400 sf w/ 4 ops & room for another **\$425k**

GN-228 CHICO/PARADISE AREA: A reputation built on quality care and personalized service in a warm and caring atmosphere. Office ~ 898 sf w/ 3 ops. **\$250k**

GN-244 OROVILLE: Must See! Gorgeous, spacious 2500 sf office w/5 ops! Collections over \$450k in 2013. **Only \$315k**

GN-249 YUBA CITY: This FFS practice sets the bar for all dentists! With an opportunity to own your building. ~1,750 sf w/ 5 ops. **\$465k./Real Estate \$TBD**

HN-213 NORTH EAST CA: Close to the Oregon Border, this FFS practice is ~2,200 sf w/ 3op +1 add'l **\$145k**

HN-197 EAST LODI FOOTHILLS: Two practices for one great price! Call today for details! **\$595k**

HN-242 YOSEMITE (Charts Only): Increase your Patient Data Base with this incredible opportunity to procure 500+ charts ! **\$75k**

CENTRAL VALLEY

IG-067 STOCKTON: Fully computerized, paperless, digitalized. 5,000 sf w/10 ops **Now \$425k**

IG-165 TURLOCK: Well established Shared/Solo Group Practice. 10 ops (shared) **\$428k**

IN-193 Modesto Facility: Recently remodeled! High foot traffic! Can be purchased with or without new equipment. 2,300 sf w/6 ops (4 fully equipped) **\$169k equipped or \$85k w/o equipment**

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SALES

CENTRAL VALLEY CONTINUED

IN-205 STOCKTON Facility: Desirable professional corridor. Newly remodeled. 1,565 sf w/ 4 ops **\$169k equipped or \$69k w/o equipment**

IN-211 MODESTO: Seller Motivated! Located in a single story, multi-unit Professional building, 1,500 sf w/ 4 ops. **\$230k**

IG-253 NORTH MODESTO/RIPON: Professionally & custom-designed. 2,012 sf w/ 3 generous-sized, fully equipped ops. + 2 add'l ops. **\$245k**

IG-247 ATWATER: Stunning practice! Cash flows well and profits better than most! 1090 sf w/ 3 ops. State of the Art & Top of the Line! **\$645k**

JN-251 FRESNO: Dedicated to delivering the highest quality of care! ~ 1,565 sf w/ 4 ops. **\$140k**

JN-254 FRESNO: "Retro-vintage-designed". All this practice needs is you! Office is ~ 2,159 sf w/ 4 ops. **\$140k**

JN-259 FRESNO Facility: Newly Remodeled! Low rent & overhead would cost much more to duplicate! ~ 1,197 sf w/ 3 ops + 1 add'l. Seller Motivated! **\$45k**

SPECIALTY PRACTICES

DC-246 PLEASANTON Pediatric: Highly Motivated Seller! Pediatric Practice/Facility Only. 1700 sf w/ 4 ops. Plumbed for additional ops. **Practice \$325k or Facility only \$250k**

EG-131 ROSEVILLE Ortho: Reputation, loyal patient base, seasoned staff & beautiful, spacious facilities. 1,100 sf w/ 4 chairs **REDUCED! NOW ONLY \$65k**

I-7861 CENTRAL VALLEY Ortho: 2,000 sf, open bay w/ 8 chairs. Fee-for-Service. **\$370k**

I-9461 CENTRAL VALLEY Ortho: 1,650 sf w/ 5 chairs/bays & plumbed for 2 add'l **\$180k**

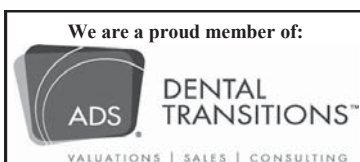
EN-203 SACRAMENTO Oral Surgery: This highly efficient office occupies ~ 3,000 sf w/ 4 fully equipped ops **\$325k**

GN-209 SACRAMENTO VALLEY Endo: 1,400 sf w/ 3 ops **\$350k**

BC-230 CENTRAL CONTRA COSTA Perio: Loyal patients @ 2 locations! **\$650k**

EG-225 SACRAMENTO Ortho: Well-maintained, single-story Medical/Dental complex. 1,200 sf w/ 4 chairs **\$95k**

DN-229 EAST BAY Endo: Strong referral & patient base. Attractive tree-lined street, mature landscaping and curb appeal. High foot traffic. 975 sf w/ 2 ops **\$245k**



ASK THE BROKER

Can a dental practice be sold without a "covenant not to compete"?

Great question! Yes it can, but the "covenant not to compete" is one of the most precious aspects of most practice transitions. We often sell completely furnished "facility only" practices that contain no patient charts or records, so there is no "covenant not to compete" in those circumstances. However, practices that do contain patient charts and records are usually valued primarily for the revenue that the patients have generated over the past 1-2 years.

Most dentists understand that a practice sells for certain "rules of thumb", such as a percentage of collections or a multiple of NET profit. These "rules of thumb" vary from location to location, but the "covenant not to compete" is the promise or the security that assures the buyer that they will have the same opportunity to produce those numbers with the same patient base. Nobody can guarantee similar results of production because we are all different in our skill sets, clinically or communication-wise.

Amazingly, the sales price only varies approximately 10% between a practice that has all the bells, whistles, and newer equipment as compared to an outdated practice in the same neighborhood. This underscores that the value of most practice sales is in the patient base.

While the court system has placed a premium on the mileage component of the "covenant not to compete", obviously the intent of the covenant is that the buyer has every expectation that the seller will not treat the patients who were "promised" to remain as part of the transaction. The reason for this is mostly practical. It would be very difficult to audit the patient base of any practice to prove a seller was violating the covenant if he was practicing nearby. It is much easier to place a mileage restriction that can be simple to enforce. This is why we see smaller mileage restrictions in congested urban areas compared to rural areas where people are accustomed to driving greater distances for services.

This is a particularly good question as there are more dentists and businessmen who are buying and selling dental practices. They need to be aware that buyers are rightfully concerned about the future plans of the seller. In addition, most dental lenders also have some minimum expectations when financing dental practice transitions.

Bottom Line: There is always an expectation that a "covenant not to compete" will be part of any transition that involves patients.

Timothy G. Giroux, DDS is currently the Owner & Broker at **Western Practice Sales** and a member of the nationally recognized dental organization, **ADS Transitions**. You may contact **Dr Giroux** at: **wps@succeed.net** or **800.641.4179**

Cal/OSHA Written Plans

CDA Practice Support

Year after year, Cal/OSHA cites dental practices for failure to have written safety plans. Dental practices must have at least three written plans — injury and illness prevention, exposure control (blood-borne pathogens) and hazard communication. CDA provides sample written plans that members can customize and implement in their practices. The sample plans are part of the *Regulatory Compliance Manual* available at cda.org/member-resources/practice-support/regulatory-compliance-manual.

Injury and Illness Prevention (IIP)

A written plan must:

1. Identify the person(s) with authority and responsibility for implementing the injury and illness prevention program.
2. Describe a system for ensuring employees comply with safe work practices, such as a recognition program, disciplinary actions and training.
3. Describe how safety information is communicated to employees and how employees can inform employers of workplace hazards.
4. Include procedures for identifying and

evaluating workplace hazards, including scheduled periodic inspections.

5. Include a procedure to investigate occupational injury or illness.
6. Include methods or procedures for correcting unsafe conditions or work practices.

If a dental practice claims exemption from the Cal/OSHA Aerosol Transmissible Disease (ATD) regulation, the practice's IIP plan must include procedures for screening patients for ATDs and management of patients suspected of having an ATD.

Exposure Control

A written plan must contain the following elements:

1. Identify by individual name or job category whether employees are exposed to blood, saliva or other potentially infectious material (OPIM).
2. A schedule and method of implementation for each of the five subsections of the blood-borne pathogens regulation.
3. Description of procedure to evaluate circumstances surrounding exposure incidents.
4. Description of an effective procedure for gathering information required by the sharps injury log.
5. Description of a periodic procedure to determine the frequency of use of the types and brands of sharps involved in exposure incidents documented on the sharps injury log.
6. Description of a procedure to identify available "engineering controls" (i.e., safety devices).
7. Description of a procedure to document patient safety determination when using an exemption from the requirement to use an engineered safety device.
8. Description of a procedure to actively involve nonmanagerial

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employees in reviewing and updating the exposure control plan.

Hazard Communication

A written plan must:

1. Describe how the practice will implement the requirements for labeling, warning notices, safety data sheets and employee information and training.
2. Include a list of hazardous substances known to be present at the workplace.
3. Describe the methods the employer will use to inform employees of the hazards of nonroutine tasks and the hazards associated with substances contained in unlabeled pipes in their work areas.

Other

An ergonomics/repetitive motion injury (RMI) prevention plan is required when RMI has occurred to more than one employee under certain conditions.

A fire and emergency action plan has instructions and procedures for employees to follow in the event of a fire or emergency that occurs at the dental practice when employees are present. A written plan is not required of employers with 10 or fewer employees and who verbally communicate the information to employees.

A general office safety plan augments the other written plans with instructions on maintaining a safe workplace and performing safe work practices. ■

Regulatory Compliance appears monthly and features resources about laws and regulations that impact dental practices. Visit cda.org/practicesupport for more than 600 practice support resources, including practice management, employment practices, dental benefit plans and regulatory compliance.



PRACTICE SALES AND LEASING



Paul Maimone
Broker/Owner

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BAKERSFIELD #26 – 3,500 sq ft free stand. duplex bldg. w a (5) op fully equipped turnkey dental office. Located on a main thoroughfare w signage. Move in condition. **SOLD**

CALABASAS – Highly sought after but seldom found, upscale Shop. Ctr. location w excellent exposure, visibility, & signage. Newer build out. Mostly Fee for Service. (4) ops of newer eqt. Digital Pano & X-rays, Central Nitrous, & Dentrix s/w. Annual Collections of \$525K+. **NEW**

CENTRAL VALLEY/So. FRESNO COUNTY – (3) op comput. G.P. in smaller town w ltd. competition. Newer eqt. Networked & digital. Dentrix & Dexis. Gross Collect \$40K+/mos.

CORONA – Dental Spa & Free Stand. Bldg. for sale. (5) op comput. G.P. w (2) spa rooms; one for facials & one for massage. Drop dead gorgeous facility w all the special touches. New eqt. Digital X-rays. Pano eqt'd. Previous Production of \$1.0M+. Partnership dissolution. **NEW**

EAST VENTURA COUNTY #2 – Free Standing Bldg. & (3) op comput. G.P. 2013 Collections of \$561K+. Cash/Ins/PPO/HMO pt. base. Mos. Cap. Ck. of \$2K+. (28+) new pts./mos. **NEW**

ENCINO – (4) op compt G.P. in a well-known, recently remodeled prof bldg. on a main thoroughfare. Magnificent panoramic Valley views in (3) ops. Cash/Ins/PPO. Gross Collect \$600K/yr on a (4) day week. Digital X-Rays & laser eqt'd. 34+ yrs of Goodwill. **SOLD**

HOLLYWOOD – Excell. Starter or Satellite Office. (3) ops. Comput. Collect \$100K+ p.t. **NEW**

MANHATTAN BEACH – (4) op comput. G.P. located in a prof. bldg. w ample free parking. 2013 Gross Collect \$508K+. Cash/Ins/PPO. Digital X-rays. Dentrix & Dexis. Nice Eqt. **NEW**

OXNARD #7 – (5) op turnkey G.P. No pts. In a free stand bldg. on a main thoroughfare.

SAN JOAQUIN VALLEY – G.P. & Bldg. in small town w ltd. competition. (4) op comput. office. Cash/Ins/PPO. Annual Gross Collect \$500K+. Low overhead. Seller retiring. **REDUCED**

SANTA CLARITA VALLEY – Gorgeous (6) op state of the art G.P. w digital X-rays & pano, CEREC, Dentrix & Dexis! Mostly Fee for Service w a few of the better PPOs. 2013 Gross Collections \$800K+. (12-14) new patients/mos. **NEW**

VAN NUYS/SHERMAN OAKS – (4) op comput. G.P. located in a free stand. bldg. on a main thoroughfare. Cash/Ins/PPO. 50+ yrs of Goodwill. 2013 Collect \$425K+. Seller retiring. **NEW**

WEST SAN FERNANDO VALLEY PEDO/ORTHO OFFICE – Comput. Pedo/Ortho office. (3) op open bay & (1) op quiet room. Pano eqt'd. Digital X-rays. Cash/Ins/PPO small % Denti-Cal. 30+ years of Goodwill. Annual Gross Collect \$600K+. Seller retiring but will assist with transition and/or stay to do Ortho.

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3088 SAN JOSE GP & BUILDING

Offering well-est. practice and 20 year old, 3,500 sq. ft. professional building. Office space is 1,755 sq. feet with 4 fully equipped ops. New laser, and Dexis digital x-ray, digital camera, intra oral camera, and panorex. Approx. 1,200 active pts. and 3.5 doctor days/week. Call for details.

4022 PALO ALTO FACILITY

Premiere dental practice facility only located on the 1st floor of modern University Circle building in Palo Alto w/ convenient freeway access, ample parking + commuter shuttle service. This is a terrific opportunity to practice in the heart of Silicon Valley blocks from downtown Palo Alto. Seller leaving the area and offering beautiful 3 op, 1,059 sq. ft., turn-key, fully-equipped office. Lease expires 2015, has 4 five year options to renew & is assignable. Asking \$160K.

4015 LOS ANGELES COUNTY GP

Quality East San Gabriel Valley, Foothill Community practice. Retiring seller working 4 doctor-days, approx. 1,600 active pts., seasoned & loyal staff. 1,103 sq. ft. modern office w/4 fully-equipped ops. Prominent, well-travelled street corner in desirable neighborhood surrounded by healthcare professionals with large daytime population draw. Recent equipment upgrades. New computers and new cabinets. 2012 GR \$877K+ Asking \$722K.

3096 NORTH BAY PERIO

Step into quality practice with established referral base. 2,200 sq. ft. office w/6 fully-equipped ops. Modern facility kept updated with recently purchased chairs, lights, Pano & lasers. Seller will grant a fair market lease and would consider selling the office space. 5 year avg. GR \$1.2M+ Asking \$825K.

4013 STANISLAUS COUNTY GP

Well-managed GP with regularly increasing revenue. State-of-the-art 1,600 sq. ft. well-equipped office w/4 ops. Digital x-ray, Dexis, 4 x-ray machines, laser, pano and recent leasehold improvements. 2012 GR \$883K+, 2013 on schedule for \$968K+ as of Oct. Located near hospital in well-travelled area. Asking \$604K+.

4007 FREMONT PERIO

Seller retiring from 30 year est. Periodontal practice in 3 op facility located in medical/dental building on well-traveled avenue in commercial neighborhood. Strictly Perio - no implants. Great starter practice opportunity, turnkey operation with equipment and no construction hassles. 2012 GR \$133K+ w/just 1 Dr. day/week. Avg. 8 new pts. per month, 6 pts. per Dr. day & 7-8 pts. per hygiene Asking \$75K.

4011 SANTA ROSA GP

Seller is changing careers and offering a well-established and successful practice. No insurance contracts, 4 doctor day/week & attractive 1,700 sq. ft. office close to downtown. 2012 \$576K+, 2013 on schedule for \$612K+ as of June. Asking \$450K.

4014 SAN FRANCISCO GP

Seller has a sterling reputation throughout the community, and is ready to retire. Facility has 3 fully-equipped ops, reception area, business office, private office, lab + sterilization area, x-ray room, dark room + storage and bathroom. Asking \$125K.

4018 NAPA COUNTY GP

Seller retiring from a profitable, well-established Napa County practice w/large & loyal patient base. Located in 2,750 sq. ft. office w/6 modern fully-equipped & upgraded ops. including digital x-ray in each op. 2012 GR 1.7M+ & 2013 GR on schedule for 1.8M+ as of October. Asking \$1.4M.

3094 NORTH BAY PERIO

North Bay Perio now available. Seller retiring from well-est. practice with seasoned staff and active referral base. 1,300 sq. ft. very nice office with 4 fully-equipped operatories. 2012 GR \$450K+ with just 3 1/2 doctor days and 5 days of hygiene per week. Great upside potential since owner does few implants. Asking \$271K.

4020 MID PENINSULA GP

Well est. practice with modern recently upgraded equipment in 2 op. facility. Located in professional & residential area close to downtown, convenient to 101, public transportation, shops, restaurants, and hospitals, in neighborhood known to the community for health care professionals. Seller willing to help for a smooth transition to a dentist with a similar philosophy of complete dental care. 2.5 doctor days/wk. Asking \$134K.



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PERIODONTICS

Bacterial changes that occur following periodontal therapy

Socransky SS, Haffajee AD, Teles R, Wennstrom JL, Lindhe J, Bogren A, Hasturk H, van Dyke T, Wang X, Goodson JM. Effect of periodontal therapy on the subgingival microbiota over a two-year monitoring period. I. Overall effect and kinetics of change. *J Clin Periodontol* 2013;40:771-780.

Background: Periodontal treatment is rendered in hopes of improving various clinical parameters and altering the subgingival microbial flora to one that will support periodontal health. The aim of this article was to determine the bacterial changes that occur following periodontal therapy for up to two years.

Methods: This randomized, single-blinded, prospective clinical trial consisted of 178 chronic periodontitis patients assigned to eight groups treated by scaling and root planing alone or with one, two or three adjunctive periodontal therapies (systemic amoxicillin and metronidazole, local tetracycline and/or surgery). A total of 27,710 subgingival biofilm samples were collected and subjected to checkerboard DNA-DNA hybridization for the analysis of 40 bacterial species. Patients were evaluated at three, six, 12, 18 and 24 months postperiodontal therapy and data was analyzed using the Friedman and Wilcoxon ranks tests to determine statistical significance.

Results: Overall, the mean counts of 30 of the 40 tested species, including red and orange complex bacteria, were significantly decreased post-therapy except for *Streptococcus oralis*, which was significantly increased at two years. Although the kinetics surrounding the bacterial reductions differed among species, a general trend was observed with all of the categories of baseline pocket depths in which a rapid reduction of the DNA probe counts was observed at three months followed by a rebound at six months and a slow decline up to 24 months.

Conclusion: Changes in the subgingival microbiota as a result of periodontal therapy leads to an overall decrease of the total number of bacteria, which can be maintained for up to two years.

Clinical significance: The best strategy to maintain periodontal attachment is to reduce periodontal inflammation. Reduction of bacterial biofilm and total number of bacteria can help to reduce inflammation and achieve periodontal health. Various therapeutic approaches are effective in reduction of bacterial biofilm over a period of time that can help to control periodontal inflammation and attachment loss.

— Kian Kar, DDS, MS, and Diane Anthony

IMAGING

Guidance for imaging in dental implant treatment planning

Tyndall DA, Price JB, Tetradis S, et al. Position statement of the American Academy of Oral and Maxillofacial Radiology on selection criteria for the use of radiology in dental implantology with emphasis on cone beam computed tomography. *Oral Surg Oral Med Oral Pathol Oral Radiol* 2012;113:817-28.

The clinical problem: Implants are widely used in everyday dental practice. However, clear guidelines for utilization of various imaging modalities in evaluation of the edentulous alveolar ridge prior to implant placement have not been updated since 2000. This is particularly important due to the widespread utilization of cone beam computed tomography (CBCT) that enables three-dimensional visualization of the maxillary and mandibular alveolar ridge with relatively low radiation exposure to the patient.

Aim: To provide a research-based, consensus-derived clinical guidance for practitioners on the appropriate use of imaging modalities in dental implant treatment planning.

Method: Literature relevant to treatment decision and outcome assessment studies during dental implant treatment planning was reviewed.

Results: Anatomic considerations of various sites, advantages and disadvantages of imaging modalities, including intraoral (periapical and occlusal projections) and extraoral radiography (panoramic, tomography, CBCT, multislice CT), radiation dose considerations and principles of imaging for dental implant assessment, were discussed. A series of recommendations for appropriate imaging at initial examination, preoperative site-specific imaging and postoperative imaging were provided.

Conclusions: Familiarity with advantages and disadvantages of various imaging modalities, utilization of selection criteria and adherence to as low as reasonably achievable (ALARA) principles for radiation exposure should be the guiding principles during the evaluation of the implant patient.

Bottom line: The American Academy of Oral and Maxillofacial Radiology (AAOMR) recommends that "cross-sectional imaging be used for the assessment of all dental implant sites and that CBCT is the imaging method of choice for gaining this information."

— Sanjay M. Mallya, BDS, MDS, PhD, and Sotirios Tetradis, DDS, PhD

ENDODONTICS

The battle against biofilms

Persoon IF, Hoogenkamp MA, Bury A, Wesselink PR, Hartog-Ing AF, Wever R, Crielaard W. Antimicrobial Effect of a Modified Vanadium Chloroperoxidase on *Enterococcus faecalis* Biofilms at Root Canal pH. *J Endod* 2013;39(8):1035-1038.

Aim: The purpose of this study was to examine the antimicrobial effect of a fungus-derived enzyme, vanadium chloroperoxidase, on *Enterococcus faecalis* biofilms at the pH level encountered in a root canal.

Methods: Native vanadium chloroperoxidase activity is optimum at pH 5.5, and at physiologic pH the activity decreases by one-thousand fold, so a modified vanadium chloroperoxidase (mVCPO) was developed to exhibit full activity at physiologic pH that would be encountered with the root canal space. Biofilms of *E. faecalis*, allowed to mature for 48 hours, were incubated with the mVCPO, bromide and hydrogen peroxide for five and 30 minutes. Following this incubation, colony-forming units were determined. A biocompatibility assay was also performed using fibroblasts in cell culture to determine if there was any cytotoxic effect of the mVCPO.

Results: Biofilm inactivation was significant at both time intervals: 99.73 percent at five minutes and 99.99 percent at 30 minutes at pH 7.7. The biocompatibility assay showed only a mild effect on fibroblast

cell culture, observed to be much less than the effects of sodium hypochlorite and calcium hydroxide, the most common irrigant and intracanal medicament respectively.

Conclusions: The capability to inactivate a biofilm within the root canal space is a highly desirable property in an intracanal medicament. The mVCPO enzyme examined in this study demonstrated the potential to accomplish this goal. Nearly complete inactivation occurred at 30 minutes, which makes this material more suited to serve as a medicament than an irrigant. The observed biocompatibility relative to fibroblasts would indicate postoperative symptoms/complications due to the medicament should be minimal.

Clinical relevance: Persistent microorganisms are a significant contributor to endodontic failures. Formation of biofilms is an effective mechanism of persistence employed by some organisms found in the root canal space. Elimination of these biofilms during endodontic treatment should, theoretically, increase the success rate. The organism employed in this study is one often found associated with failure of endodontic treatment, but its pathogenicity is questionable. Repeating this study using a biofilm of *Fusobacterium nucleatum* would be of interest, as this organism is a much more potent pathogen in both primary endodontic disease and failure.

— Craig Noble, DDS, MS, FACD, FICD

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- 6055 VACAVILLE** Great foundation for Next Owner. Strong reputation. 3-days of Hygiene. 3-ops. 2013 collected \$515,000 on 3-day week.
- 6054 TRACY** Great launching pad waiting for opportunistic buyer. Best location. Beautiful 4-Op office. Digital and paperless. Part-time management collected \$189,000 in 2013. Will do well with full-time attention. Full Price \$125,00.
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- 6047 STOCKTON** Best location outside Brookside Community on West March Lane. 2013 collected \$535,000. Attractive 3-Op office. Package sale includes condo.
- 6046 PINOLE** Collected \$500,000 in 2012. 4-days of Hygiene produced \$178,600. Beautiful office. Refers Endo. Lots of Goodwill here. **SOLD**
- 6043 EL SOBRANTE** 3-day practice collected \$184,000 in 2013. 3-ops. Building optional purchase. Full price \$50,000.
- 6041 PLEASANT HILL** Collected \$365,000 with Profits of \$142,000 in 2012. Owner is moving down. Previous 3-years averaged collections of \$415,000 and Profits of \$180,000. **SOLD**

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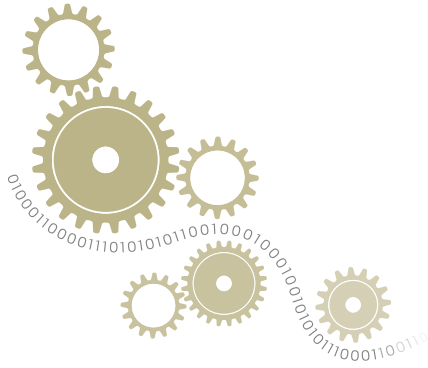
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- SOUTHERN CALIFORNIA** \$4,500,000 Practice. HMO. Prestigious hi identity.
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- TORRANCE - GARDENA** Conservative Chinese DDS. Refers lots of work. Chinese/American Successor will do \$600,000 first year. Bargain at \$185,000.
- VICTOR VALLEY** Hi identity. Grosses \$650,000. 8 Ops low overhead. Full Price \$550,000.
- YUCCA VALLEY** Hi identity 600 sq.ft. 2 op building on .44 acres, zoned for additional home plus apts. Full Price \$110,000.



A look into the latest dental and general technology on the market

ADA Oral Pathologist

(American Dental Association, \$59.99)

Experience with oral pathology greatly varies among dental practitioners. Some are comfortable with the diagnosis of pathology, while others find it difficult.

ADA Oral Pathologist is a mobile app that efficiently assists dentists in obtaining their differential diagnoses of common oral and maxillofacial conditions.

Users will immediately notice the innovative user interface of the app. Users simply swipe from right to left on the main screen to start a diagnosis. Each swipe reveals a major category that includes patient information such as gender, age, location, clinical observation, pain level and color of the pathological condition. From every category, users select from items that describe the patient and the condition by checking applicable boxes, scrolling from lists or tapping on diagrams. Once users have entered information in all the categories, a button labeled "See Possible Conditions" appears at the bottom of the screen. Tapping it will reveal all the possible conditions from the given information with detailed descriptions and images. Users have the option of saving conditions, which can then be easily recalled from the main screen.

From start to finish, users can potentially reach differential diagnoses within seconds. With its simple and fast interface, users will find this app remarkably refreshing, but perhaps still lacking in some areas. Radiographic pathology would make this tool highly comprehensive but is not included in this initial release. In addition, items to select within certain categories may be confusing. For example, selecting the color of a lesion may be difficult with overlapping choices such as red and bright red or pink/red and pink. Because of this, users may end up second-guessing their selections and going back to change their input to see if different possible conditions might be revealed. ADA Oral Pathologist is a useful and efficient app to assist dentists with the diagnosis of oral pathology conditions, but is not intended to replace the knowledge and skill of a trained specialist.

— Hubert Chan, DDS

Would you like to write about new technology?

Dentists interested in contributing to this section should contact Tech Trends Editor Blake Ellington at blake.ellington@cda.org.

Paper—Stories from Facebook

(Facebook Inc., Free)

Facebook recently launched a new mobile app called Paper that provides an entirely new interface for Facebook users to browse content from their News Feed. The interface is very different from the standard Facebook interface and is definitely a "mobile-first" application, as a user flips through content via thumb gestures (up and down and side to side). Essentially, Paper is a story reader that delivers content from a user's News Feed in the top half of the screen while also displaying content "cards" in the lower half with subjects such as top headlines, tech news, cute animals and more. This coincides with Facebook's recent changes to the News Feed to give more prominence to recent and popular news stories shared by users. Standard Facebook features such as photo viewing, friend requests, notifications and messaging are all included within the app, which is interesting as that sets Paper up as a strong replacement candidate for the standard Facebook mobile app. Ultimately, the choice will come down to how each individual user prefers to consume their Facebook news and updates.

— Blaine Wasylkiw, director of online services, CDA

Flipagram

(Cheerful Inc., Free)

With so many moments captured on a daily basis on cell phones, the need to package these photos and make them presentable becomes evident. Insert Flipagram, an app for iOS and Android that lets users create their own video "stories" of their favorite photos from their Facebook and Instagram accounts or their photo gallery in their phones. Flipagram lets the user select multiple photos to add to their video story. Double tap any photo to crop or move it. Once the photos are selected, users can choose to add music (songs from a personal library or full songs available for purchase) and a title with a specific font. Flipagram offers a more personalized option for \$1.99 that allows users to choose their own separate watermark and font. After all of this, click "OK" and Flipagram compiles the video. Though Flipagram is simply a tool to create videos and not a social network in and of itself, the app does allow for the final version of the created video to be shared on Google+, Tumblr, Facebook, LinkedIn, Twitter, Instagram and more. Users also can text or email the video.

— Blake Ellington, Tech Trends editor

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