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Journal

NOVEMBER 2011

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Vol 39 No 11

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Journal

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Obvious and Natural

KERRY K. CARNEY, DDS

On the evening of Oct. 10, 1911, the polls closed on the third attempt to enfranchise the women of California. When the first results came in, it did not look good. Based on the early returns from the heavily industrialized San Francisco Bay Area, the constitutional amendment appeared to have failed to gain a majority. That evening it appeared to have been soundly defeated.

Two more days would pass before all the votes from the nonindustrial and agricultural areas around the state were reported. By Thursday, it was clear that the men of California had voted by a slim margin to grant California women the right to vote.

California became the sixth state to grant women suffrage 100 years ago.

The history of the women's suffrage movement in the United States is a great case study in American politics. It is full of grassroots organizing, undaunted enthusiasm, dirty tricks, heroic bravery, special-interest manipulation, and ferocious optimism. Winning the right to vote in 1911 seems ridiculously late, but once it finally happened, people quickly started to think of it as obvious and natural. We forget how hard it was to win.

Now it seems obvious and natural to see more and more women involved in every aspect of dentistry. But there was a time, not long ago, when a woman dentist was a rara avis. This was brought home to me while attending my first American Dental Association convention in San Francisco. When I took advantage of the free health screening nothing seemed out of the ordinary until I got in line for the EKG test. There, it suddenly dawned on me that I was the only one in line with my shirt on. Bare-chested men were lined up in front of me and behind me, and there was not another woman to be seen. I felt unusually out of place.

There was a time, not long ago, when a woman dentist was a rara avis.

In 1984, women represented about 2 percent of practicing dentists. Our class had the greatest number of women students up to that time in our school (about 20 percent of the class).

There is scant mention of women in dentistry before the mid-1800s. There were a few women who apprenticed to the trade before dental school certificates were required. Lucy B. Hobbs Taylor graduated from Ohio State Dental College in 1866. She was the first woman to graduate from a dental college though she had already apprenticed and been practicing in Iowa for a number of years before she was accepted into the dental college. (Her Iowa colleagues had to rally to her support before she was granted admission to the college.) It was another six years before Fanny A. Rambarger graduated from the Pennsylvania College of Dental Surgery in 1872.[1]

"Ida Gray Rollins was the first African-American woman to receive a dental degree in the United States … She matriculated at the University of Michigan Dental School in 1887 and graduated in 1890."[2]

M. Evangeline Jordon entered the school of dentistry at the University of California and graduated in 1898. "She went into general practice, but soon began to limit her practice to children. She thus became the first pediatric dentist in the United States."[2] In 1900, Dr. Jordon developed a lecture course for the University of Southern California on children's dentistry. She also "… encouraged Dr. Samuel D. Harris to form a pediatric dental society, the American Society of Dentistry for Children, in 1927."[2]

By 1945, there remained only four dental schools in the United States that barred women as students. Harvard, Georgetown, St. Louis University, and the University of Kansas City were the last to open their doors to women.

The 2009 first-year U.S. dental school enrollment figures show the makeup as 54.3 percent men and 45.7 percent women. In Canada, the percent was just about the reverse. Slightly more women applied to dental school in Canada in that year.

The 2009 U.S. dental school graduate profile showed 53.8 percent of the graduates were men and 46.2 percent were women. This represents a steady increase for women from 39.5 percent in 2000. Though women are approaching the 50 percent mark in graduates, they still represent only 20.8 percent of the practicing dentists according to the ADA's 2008 report.[3]

Enrollment and graduation figures are more reliable since they are based on actual reported enrollment and graduation. There should be no sample bias to consider. Any self-reported, small sample like the ADA practice survey probably suffers from some sampling bias but the fact that women still represent a significantly smaller percentage of practicing dentists is not disputed.

As an aside, in 2009, both first-year

and graduating numbers showed that in African-American, Hispanic, and Asian categories, women outnumbered men by a significant figure.

In advanced education, women represent 39 percent of advanced dental trainees and 31.33 percent of full-time dental faculty. Women hold 15 percent and 20 percent of department chairs and dental school dean positions, respectively.

During its 152-year history, the ADA has elected only two women presidents, and those two took office in the last 21 years. Since 2009, a woman dentist has held the position of ADA executive director.

The present-day California Dental Association has existed since the 1973 merger of the two original state organizations. During that time the number of women in leadership has increased markedly.

A cursory look at the component records shows that Marlene Shultz from Western Los Angeles in 1979 was the first and, for a long time, only woman trustee to serve on the CDA Board of Trustees. There were no other women trustees until 2001 when Santa Clara, Tri-County, and Western Los Angeles elected the first women in 22 years to serve on the CDA Board of Trustees. In the last 10 years, 20 women have served as trustees. Of the incoming cohort of trustees, 10 out of 43 are women (23 percent).

There remains only one component that has yet to elect a woman to the position of president. San Francisco holds the record of nine women presidents. Of the total of 114 component women presidents, 108 have been elected since 1990. It must have been a little lonely for those six women who served as component presidents between 1895 and 1990. (Dr. Emma T. Read of San Diego Dental Society served as president five times beginning in 1895.)

In its 38-year history, CDA has elected three women to the leadership ladder that leads to the office of president.

It seems obvious and natural that women should play a significant role in all aspects of dentistry today. However, higher levels of leadership are slow to reflect the diversity of the dentists practicing in California. It will be nice when the numbers of women in the top leadership roles in organized dentistry are too great to count on one hand. Then it may seem obvious and natural that strong leadership is diverse and inclusive and that is a powerful "Welcome" sign. ■■■■

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Just a Thought on Volunteerism

Editor:

I've had this thought in my mind for some time now, and I can't seem to shake it. Nor do I want to. It's an idea, I think, whose time has come. With the very tough economic times so many of our friends, neighbors, and families are having, I think it is time the profession of dentistry becomes proactive and leads by example to help the less fortunate.

Specifically, I have this idea concerning our continuing education requirements and volunteering. Let me be blunt and straightforward. Why don't we require, as part of our C.E. requirements, that dentists volunteer one day of dentistry every license renewal period? That is eight hours every two years. That would certainly not break, nor overburden, anybody. And, it would help so many people.

I read somewhere that there is something like 30,000 actively licensed dentists in California. That's 30,000 volunteer days EVERY two years. Awesome! (We would probably have to create new dental free clinics to accommodate everyone!) Can you imagine how much that would help so many of our friends and neighbors?

When a person loses their job, they lose not only their income to pay for rent/house payments, food, clothes, gas, etc., but also their medical and dental benefits (if they even had them in the first place). With no more Denti-Cal for adults, what are these unfortunate people to do? Especially families with kids. And let's not forget the handicapped, special needs people, and the elderly. I sincerely think it's time we all step up to the plate and help. Like I said before, I really don't think volunteering eight hours every two years is going to kill anybody. If anybody still can't, or won't (for whatever reason), volunteer, let's give them an option of buying their way out by donating some money to a local dental free clinic. (Say $200 to $300, about the average cost of an eight-hour seminar.)

Wouldn't this be a win-win situation? I mean, first off, we would be helping out so many people. How great is that? It would also be great PR for the dental profession and help us regain some of the public trust I personally feel we have lost over the past few years (a putting-our-money-where-our-mouth-is kind of thing). But, MOST IMPORTANTLY, isn't it just the "right thing to do"?

That's it. That's my thought. If anybody knows how to further this idea to the powers that be, I'd love to hear from you. Thank you.

MICHAEL HANRAHAN DDS
Garden Grove, Calif.

P.S. By the way, I'm talking to you hygienists, too!

Editor:

I read the July 2011 issue of the *CDA Journal,* and your editorial, with great interest. I have been a practicing dentist and a member of CDA for the past 20 years, yet this is the first time that I have written to the *Journal*. The theme of the issue was access to care and, in particular, children's access.

It is sad that in this day and age, and in such a prosperous state as California, we are still faced with issues like this. However, I feel very strongly that organized dentistry has failed to be on the forefront of many critical issues and has been less than effective in dealing with contemporary matters, such as access to care.

One example is the Healthy Families Program. I think the principal foundation of this program, and similar programs, is wonderful. However, Healthy Families is being administered by for-profit insurance companies, which are primarily concerned with their own financial benefit. They are restricting access to specialty care by designating provider offices as "full risk," whereby referral to any specialist is restricted. In addition, the reimbursement schedules created by these insurance companies are so low that it is impossible to treat these patients and be able to sustain a viable business at the same time. Therefore, what I have seen during the past few years is that these patients are transferring from office to office because no dentist can afford to treat them at the rates that these plans are reimbursing the providers.

A similar situation is created by certain insurance carriers and HMO providers, where the cost of treating a patient and the financial compensation is making it cost-prohibitive for the dentist. This, in my opinion, is creating a

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Timothy G. Giroux DDS/Broker

ASK THE BROKER

Question:

What about a practice in which the doctor also owns the real estate?

Great Question!!! My advice is to speak with your accountant first on whether buying a building with your practice or selling the building with your practice makes financial sense. Generally, in the S.F. Bay area, we do not see too many practices where the doctor also owns the building. The vast majority of our practices are sold without real estate; which then just simply involves a landlord negotiation. Before I sold my practice and moved to California, my next dental career consideration was to partner up with several dentists to build our own building. In hindsight, I wish I would have considered owning my own real estate after 5 years of practice instead of waiting, especially since the practice was growing successfully.

Let's break down this discussion for Sellers who own their building and then for Buyers who have the opportunity to buy the real estate with the practice.

Sellers: Generally, we advise sellers to consider selling the building with the practice. ***Sometimes this opportunity is what may attract a serious buyer***. While it sounds enticing to be collecting rent while sipping pina coladas on the beach, should the dentist move out of that "single-use" space, it can be very difficult to sell or rent that space out again. It sometimes works out best for both parties to consummate the real estate portion of the transaction a year or two after the practice sale. Again, after consulting your accountant, it may be best to sell the building in a different tax year than the practice transaction. If the buyer is adamant on purchasing the real estate at the same time as the practice purchase, it is generally better to sell the real estate and not risk owning an empty dental space in the future.

Buyers: Generally, it is better to own than to rent. Again, you must first consult with your accountant on the tax ramifications, as the rent is completely deductible. However, most of the time, the 20-25 yr loan on the real estate is less than the rent payment and remains constant while the rent payment usually increases 3% per year. It may seem "spooky" to purchase the real estate if you focus on the debt burden of your investment. However, an astute businessman realizes that rent is also a debt burden that will continue to increase. Owning the building gives you an opportunity for a return on your investment. Even if the property never increased in value, eventually it is a fully "paid for" asset that you can sell in the future. Worse case scenario: it is a forced savings account. Possible scenario: it doubles in value in the 20 years you own it.

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

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population where oral health neglect by dentists is becoming extremely prevalent. Furthermore, it is creating ethical dilemmas for dentists on how to treat patients optimally and still be able to run a viable business.

California has one of the highest dentist populations in the country. I do not think the main issue is that of access. Dentists are willing and able to treat these patients, including children. However, many dentists have passed the tipping point where it is no longer viable to treat certain types of patients.

I, and many of my colleagues, feel that organized dentistry has failed to challenge some of these more relevant economic issues. If CDA can, for example, bring these matters to the attention of the Managed Risk Medical Insurance Board, perhaps this would be a start. I do not believe that the answer to access to care is just to bring in midlevel practitioners. Many of these issues can be solved if the existing practitioners can see an economic viability in providing care to the underserved.

NAME WITHHELD BY REQUEST
California

Thanks to generous donations to the CDA Foundation, nearly 85,000 underserved Californians received oral health care in 2010, reflecting more than $12 million in services.

The Foundation that started with a single employee and a sole purpose celebrates its 10th anniversary of transforming lives across California.

The Foundation's significant achievements include its work in community water flouridation, CAMBRA, the development of Perinatal Oral Health Guidelines and the Student Loan Repayment Program, which awards grants to new dentists in exchange for a commitment to provide services to underserved communities that are most in need.

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Matt Mullin

Billy Budd, Sailor

BY DAVID W. CHAMBERS, PHD

Omniscience means knowing everything. Naturally, it would come in handy in the "Whose smartest at the table" kinds of competitions. But it is generally recognized that the number of truly omniscient individuals is very small and phony know-it-alls are real pains.

Surprisingly, we are slower at recognizing that the same sort of limitations apply in the ethical domain. If a genie offered me the gift of knowing what everybody else should do, I would be sorely tempted to turn it down.

Consider the case of *Billy Budd, Sailor.* This is the title of Herman Melville's posthumously published novella, now a standard text in high school. Budd is a merchant sailor pressed into the British Navy (kidnapped at sea) in 1797. Described as "beautiful Billy," Melville

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New Implant Therapy Developed

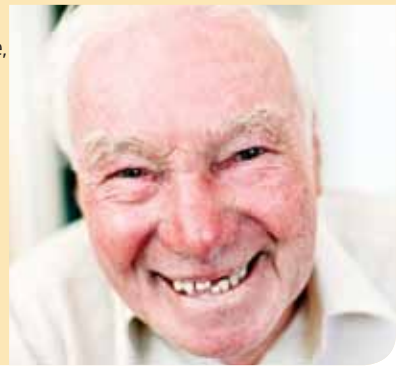
With a swell in the older adult population, more and more people are facing a reduced quality of life due to edentulism. It is estimated that 37 million Americans will need dentures by 2020.

According to clinical studies, in a comparison of patients who had implant therapy, they fared better than their denture-wearing counterparts who showed only a minor improvement in their quality of life. Denture-wearers reported discomfort, poor stability, pain, and trouble eating.

In a report recently published in an issue of the *Journal of Oral Implantology,* there is an alternative treatment to dentures: "All-on-Four" therapy. This approach uses four implants to support a fixed prosthesis and the patient's new teeth can be put in place the day of surgery.

In the All-on-Four approach, two implants are placed near the front and two implants are placed near the back of the dental area. These implants support a fixed, full-arch prosthesis that is put in place the same day as the surgery.

The authors evaluated the survival of the All-in-Four treatment for a 29-month period using the NobelActive implant from Sweden's Nobel Biocare, according to a news release. This implant features a tapered body and variable thread design. Other All-on-Four implant designs have reported high survival rates between 92 percent and 100 percent.



In the study, 165 participants received 708 implants. (The mean age was 59.) No significant difference was found between the survival rates of implants in the maxilla and mandible jaws. The survival rate was 99.6 percent, with only three implants failing.

Advances Made in Next-Generation Organ Replacement Regenerative Therapies

A research group in Japan has tested for "bioengineered mature organ replacement as a future regenerative therapy."

Led by Takashi Tsuji, PhD, a professor in the Research Institute for Science and Technology, Tokyo University of Science, and director of Organ Technologies Inc., the research group reported an additional development in which a bioengineered tooth unit comprising mature tooth, periodontal ligament and alveolar bone, was successfully transplanted into a correctly sized bony hole in the alveolar bone through bone integration by recipient bone remodeling in a murine transplantation model system, according to a news release in an online version of the U.S. scientific journal *PloS ONE*.

The bioengineered tooth unit restored enough alveolar bone in a vertical direction into an extensive bone defect of murine lower jaw. The engrafted bioengineered tooth displayed physiological tooth functions such as mastication, periodontal ligament function for bone remodeling, and responsiveness to noxious stimulations. According to a news release, this study represents a substantial advance and demonstrates the real potential for bioengineered mature organ replacement as a next-generation regenerative therapy.

Tsuji is a research team member in "Health Labor Sciences Research Grant: Research on Regenerative Medicine for Clinical Application" under Akira Yamaguchi, DDS, PhD, of Tokyo Medical and Dental University. The study was combined with other research conducted by Teruko Takano-Yamamoto of the Division of Orthodontics and Dentofacial Orthopedics, Graduate School of Dentistry, Tohoku University, Japan, and Professor Shohei Kasugai of the Oral Implantology and Regenerative Dental Medicine Graduate School, Tokyo Medical and Dental University, Japan.

To read the article, which was published July 12 online, go to http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0021531.

Green Tea Lozenge May Help to Remedy Dry Mouth

Researchers at Georgia Health Sciences University are conducting a clinical trial using an all-natural green tea lozenge to treat dry mouth, a condition that affects an estimated 40 percent of Americans.

In a recent article in *Word of Mouth,* the journal of the university's school of dentistry, Stephen Hsu, PhD; Douglas Dickinson, PhD; Stephen Looney, PhD; and Kalu Ogbureke, DDS, DMSc, are hoping that their research will show that the lozenge can provide relief without the side effects of prescription medication.

"With green tea polyphenols, we have an agent that's helping to correct the salivary gland's abnormal behavior," said Dickinson in the article.

For their research, Dickinson, Hsu, Looney, and Ogbureke have received one of three International Innovation in Oral Care Awards sponsored by the International Association of Dental Research and GlaxoSmithKline. The award amounts to $75,000.

According to the paper, a green tea lozenge could be available to the public by the end of this year.

Novel 'Magic' Fluid May Replace Filling Teeth

University of Leeds researchers have developed a new way to treat the initial signs of tooth decay: a peptide-based fluid and paintbrush, which then stimulates regeneration of the tooth defect.

"This may sound too good to be true, but we are essentially helping acid-damaged teeth to regenerate themselves. It is a totally natural nonsurgical repair process and is entirely pain-free too," said Jennifer Kirkham, PhD, of the University of Leeds Dental Institute, who led the development of the new technique.

Designed by researchers in the University of Leeds' School of Chemistry, the "magic" fluid contains a peptide known as P 11-4 that — under certain conditions — will assemble together into fibers, according to a news release. When applied to the tooth, the fluid soaks into the micropores caused by an acid attack and then forms a gel that provides a scaffold or framework that attracts calcium and regenerates the tooth's mineral from within, providing a natural and pain-free repair.

The technique recently was tested on a small group of adults whose dentist had identified initial signs of decay. The results from this showed that P 11-4 can reverse the damage and restore tooth tissue.

Still Too Few Young Athletes Wearing Mouthguards

Despite vociferous and repeated recommendations by dental professionals that sports-playing youths wear mouthguards, a large number of children are still ignoring the warnings, according to a survey conducted on behalf of Delta Dental Plans Association.

"Mouthguards do more than protect young athletes' teeth. They can also help prevent concussions by acting as shock absorbers," said William Kohn, DDS, vice president of dental science and policy for Delta Dental Plans Association. "Studies show that concussions can cause serious, long-term consequences for athletes, and the majority of at-risk athletes are children."

An estimated 68 percent (seven in 10 Americans) of parents reported their child eschews mouthguards when playing baseball, basketball, softball and soccer. Studies have shown that basketball players are 15 times more at risk sustaining an orofacial injury compared to their football-playing counterparts. Since wearing mouthguards became mandatory in football, orofacial injuries have dropped. Mouthguards have also become mandatory for some youth sports such as lacrosse and ice hockey; however, dental professionals recommend mouthguards for all athletic sports at games as well as practices.

The U.S. Centers for Disease Control and Prevention estimates 300,000 people get sports-related concussions a year, with children and teens at the highest risk. Safe Kids USA said most organized sports-related injuries occur during practice rather than games.

"Parents need to encourage their young athletes to get in the habit of wearing mouthguards whenever they participate in sports, whether it's for practice or a game," Kohn said.

The three types of mouthguards are listed below. And if cost is a consideration, any mouth protector is better than none.

- The least costly, stock mouthguards have a preformed shape. Because the fit can't be adjusted, they're less effective than a fitted option.
- Mouth-formed mouthguards are shaped to fit the wearer by boiling the mouthguard in hot water to soften the plastic.
- Fabricated by one's dentist, custom-made mouthguards are considered the best option as they fit securely and properly to the wearer's teeth. They also are the most expensive option.

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Dentists, Pharmacists Team up to Increase Awareness of Medication-Induced Xerostomia

In an effort to promote oral health and educate the public on xerostomia due to medications, leading pharmacy and dental organizations have joined forces. It is estimated that least 25 million Americans have inadequate salivary flow or composition and lack the cleansing and protective functions provided by saliva.

"Each day, a healthy adult normally produces around one-and-a-half liters of saliva, making it easier to talk, swallow, taste, digest food and perform other important functions that often go unnoticed," said Fares Elias, DDS, president, Academy of General Dentistry. "Those not producing adequate saliva may experience some common symptoms of dry mouth."

The AGD joined the American Dental Association, American Academy of Periodontology and the American Pharmacists Association on this public education campaign.

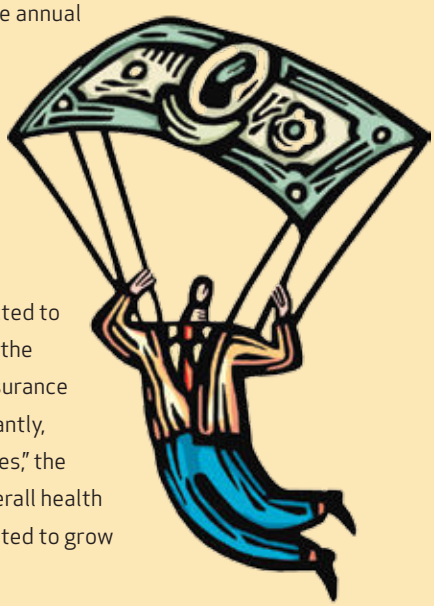
Antihistamines, anti-hypertensive medications, decongestants, pain medications, diuretics, and antidepressants are among the 500 medications that contribute to dry mouth. Nearly half of all Americans take at least one prescription medication a day regularly. But for older adults who frequently take one or more medications (an estimated 90 percent for those over the age of 65), this group is considered at a significantly higher risk of experiencing xerostomia.

Dry mouth also is commonly associated with autoimmune conditions such as Sjogren's syndrome. Radiation treatment for head and neck cancer also is an important cause of severe dry mouth. The treatment can produce significant damage to the salivary glands, resulting in diminished saliva production and extreme dry mouth in many cases.

Symptoms include trouble eating, speaking and chewing, burning sensations, or a frequent need to sip water.

Rapid Increases Anticipated in National Health Costs

For the period of 2010 through 2020, national health care spending is expected to grow 5.8 percent per year, about 1.1 percentage points faster than the expected average annual rise in gross domestic product.



And, according to recent study published in and issue of *Health Affairs,* health spending will go from accounting for 17.6 percent of the GDP to 19.8 percent in 2020 in response of this growth. National health care spending reached $2.6 trillion in 2010, reflecting a growth rate of 3.9 percent over the previous year, the slowest growth rate for that sector of the economy ever recorded.

The study's authors noted that health spending growth is expected to jump to 8.3 percent in 2014, when major coverage expansions from the Affordable Care Act begin. "The expanded Medicaid and private insurance coverage are expected to increase demand for health care significantly, particularly for prescription drugs and physician and clinical services," the authors stated. They note that, concurrently with an increase in overall health spending, the federal government's share of that spending is expected to grow from 27 percent in 2009 to 31 percent by 2020.

BILLY BUDD, CONTINUED FROM 783

makes him a Christ-like paragon of virtue: an able seaman, loyal, popular, and even gifted as a peacemaker. His only flaws include a touch of righteous indignation and stammering under emotional pressure. Never in the novella is there even a hint the reader learns of that Budd is anything less than pure virtue. The fact that he is hanged, and even Budd praises the captain who orders it, makes for a nice ethical discussion.

The plot unfolds like this: John Claggart, the master-at-arms (shipboard chief of police), is jealous of Billy Budd and fabricates circumstantial evidence of his being involved in a mutiny plot. Claggart reports Budd to Capt. Vere and the captain calls in Budd to confront his false accuser. In complete disbelief and unable to express himself otherwise, Budd lashes out at Claggart and lands a single, fatal blow.

The moral challenge is what should Capt. Vere do? Budd is guilty of three breaches of the British Articles of War: failure to report the attempts by Claggart to frame him, making a threat to a superior officer, and committing murder. Striking a superior officer (regardless of the effect) normally called for summary execution. There are no doubts about the facts. Vere saw it with his own eyes.

Melville really piles it on Vere. He and Budd were the only witnesses. Budd's ship, with the absolutely inappropriate name Bellipotent, had pursued a French warship and become separated from the fleet so that Vere could not appeal to others. The story is set a few years following the well-publicized mutiny on the ship Bounty and several notorious navy uprisings in English ports, creating a climate hypersensitive to organized insubordination.

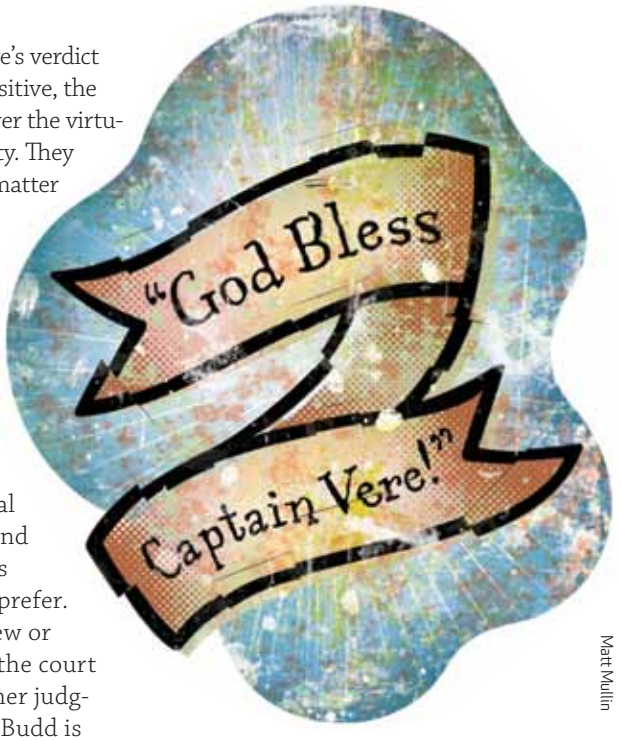
In his heart, Vere "knows" Budd was set up. He convenes a drum head court of his officers. They hear the testimony and condemn Budd to be hanged the next morning. Just before Budd is raised on a yard arm with a rope around his neck to suffocate, he cried out "God bless Captain Vere."

Modern readers regard Vere's verdict as wrong-headed, harsh, insensitive, the triumph of a callous system over the virtuous individual, or simple cruelty. They regard Budd's opinion on the matter as mockery or irony.

Such a judgment can only be justified based on omniscience. The reader is sucked into a position of false moral superiority by being given a view of the situation that no one in the novella actually had. That is a common ethical trap. We like easy answers, and are tempted to make up facts that justify the outcome we prefer. Knowing only what Vere knew or what the officers who sat at the court martial knew, there is no other judgment that could be reached. Budd is truly prescient in praising Vere: He saw that Vere did what he had to do and that armchair second-guessers would not even have been allowed to give testimony. Melville has pulled a dirty trick on the reader by making him or her seem morally superior by taking a position that no one could actually take.

In years of leading students and practicing dentists through ethics cases involving second opinions and justifiable criticism of colleagues, I am struck by the assumptions that are added to the case by participants. The best way to get out of a dilemma is to assume some additional facts that justify our conclusion: "The patient may just be shopping for a lower price," or "Perhaps this is the kind of patient who is mad at the world in general."

Psychologists such as Nobel laureate Daniel Kahneman and Amos Tversky have studied what people make up in order to make sense of ambiguous situations. A common scenario used in their research is a college professor driving home and diverting his normal route to run an errand for his wife. He is struck by a truck and dies. Virtually, no one is willing to leave the story as told, accepting the facts as random events. Human nature requires that we invent "if onlys" in order to make the story meaningful to us. Here are some of the common characteristics of makeup explanations: Bad things require explanatory stories; there is something that needs fixing in the world if things do not turn out as we would like. Good outcomes are accepted as one's due. The explanations are simple, single changes in the world — the brakes failed — not the truck took the wrong turn, and the professor started late, and the brakes failed. The best fix is that the other guy should have acted otherwise.



Matt Mullin

The nub:

1. There is no view from nowhere. It is unethical to presume ethical omniscience.
2. Moral courage means deciding based on everything that is known, not what is imagined.
3. Be humble about what you do not know.

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

ADA: Dental Safety Net Needs More Attention, Repair

The American Dental Association recently released the second in a series of papers analyzing the challenges and solutions to bringing good oral health to millions of Americans, including the growing population whose only possible source of dental care is the so-called oral health safety net.

"Major improvements in the dental safety net will not occur until the nation places much greater value on oral health," said Raymond F. Gist, DDS, ADA president. "Treating disease that could have been easily prevented or treated in its early stages but has progressed to the point of chronic infection, and lost teeth, gum tissue or bone is one of the major reasons why these clinical delivery systems remain overwhelmed."

The paper, "Breaking Down Barriers to Oral Health for All Americans: Repairing the Tattered Safety Net," highlights the lack of a coordinated, systematic approach to treating underserved populations, according to a news release. It also draws attention to common sense remedies that can improve safety-net programs even though major funding increases are not likely during the current economic times.

Among the principles presented in the paper are:

- **Prevention is essential.** A public health model based on the surgical intervention in disease that could have been prevented after that disease has occurred is a poor model.
- **Everyone deserves a dentist.** The existing team system of delivering oral health care in America works well for patients in all economic brackets and can be expanded to accommodate millions more.
- **Availability of care alone will not maximize utilization.** In too many cases, people are unable or unwilling to take advantage of free or discounted care. This often can be remedied through better attention to social or cultural issues, oral health education, and assistance with child care, transportation or securing permission to miss work in order to receive treatment.
- **Coordination is critical.** Too many government or government-administered programs suffer from a failure to manage and exchange information about best practices for safety-net operations.
- **Treating the existing disease without educating the patient is a wasted opportunity,** making it likely that the disease will recur. Anyone who enters a dental operatory for restorative care should leave that operatory with an understanding of how to stay healthy and prevent future disease.
- **Public-private collaboration works.** Absent a highly unlikely population boom among dentists practicing in community-based and public health settings, private practice dentists will continue to deliver the hands-on care to most of the population. Better coordination between the public and private dental communities can help maximize existing resources.
- **Silence is the enemy.** Virtually every shortcoming in the safety net has at its root a failure to understand or value oral health.

UPCOMING MEETINGS

2011	
Nov. 6–12	United States Dental Tennis Association, Palm Desert, Calif., dentaltennis.org
Dec. 16–17	First Dental Conference, Scientific Dental Committee at the Palestinian Dental Association in Lebanon, Beirut, Lebanon, 916-780-1955
2012	
March 29–April 1	CSPD/WSPD Annual Meeting, Portland, Ore., drrstewart@aol.com
April 22–28	United States Dental Tennis Association's 45th Annual Spring Meeting, Kiawah Island, S.C., www.dentaltennis.org or 800-445-2524
April 26–28	World Federation for Laser Dentistry, 13th Annual World Congress, Barcelona, Spain, wfldbcn2012.com
May 3–5	*CDA Presents the Art and Science of Dentistry,* Anaheim, 800-CDA-SMILE (232-7645), cdapresents.com
Oct. 18–23	ADA 153rd Annual Session, San Francisco, ada.org

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

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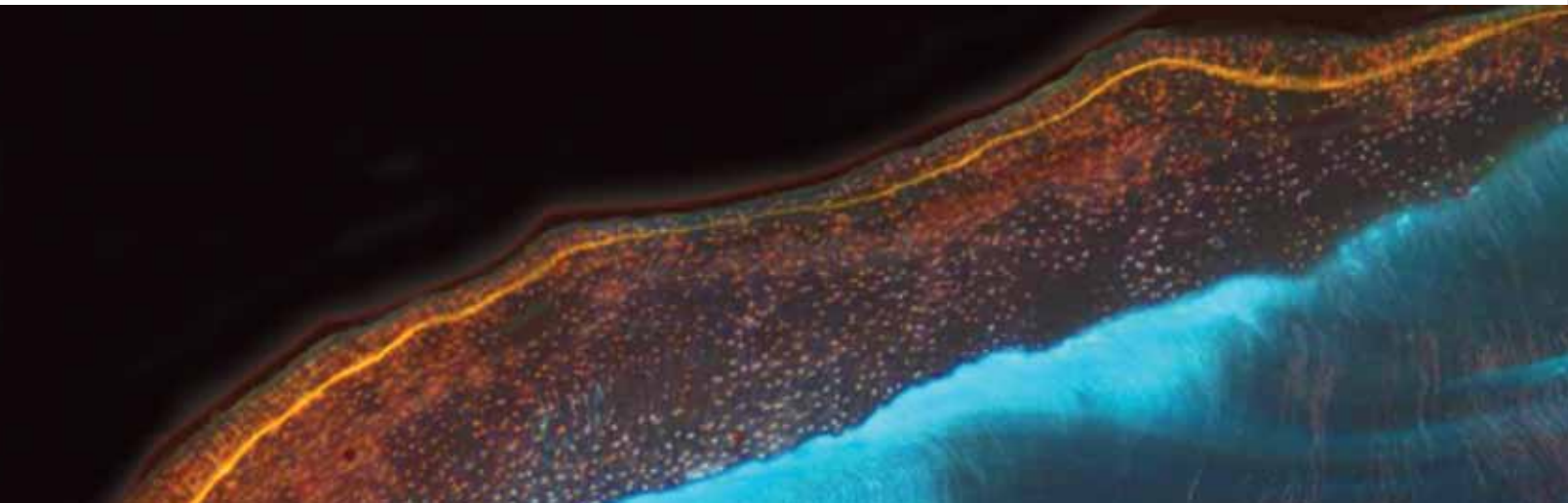


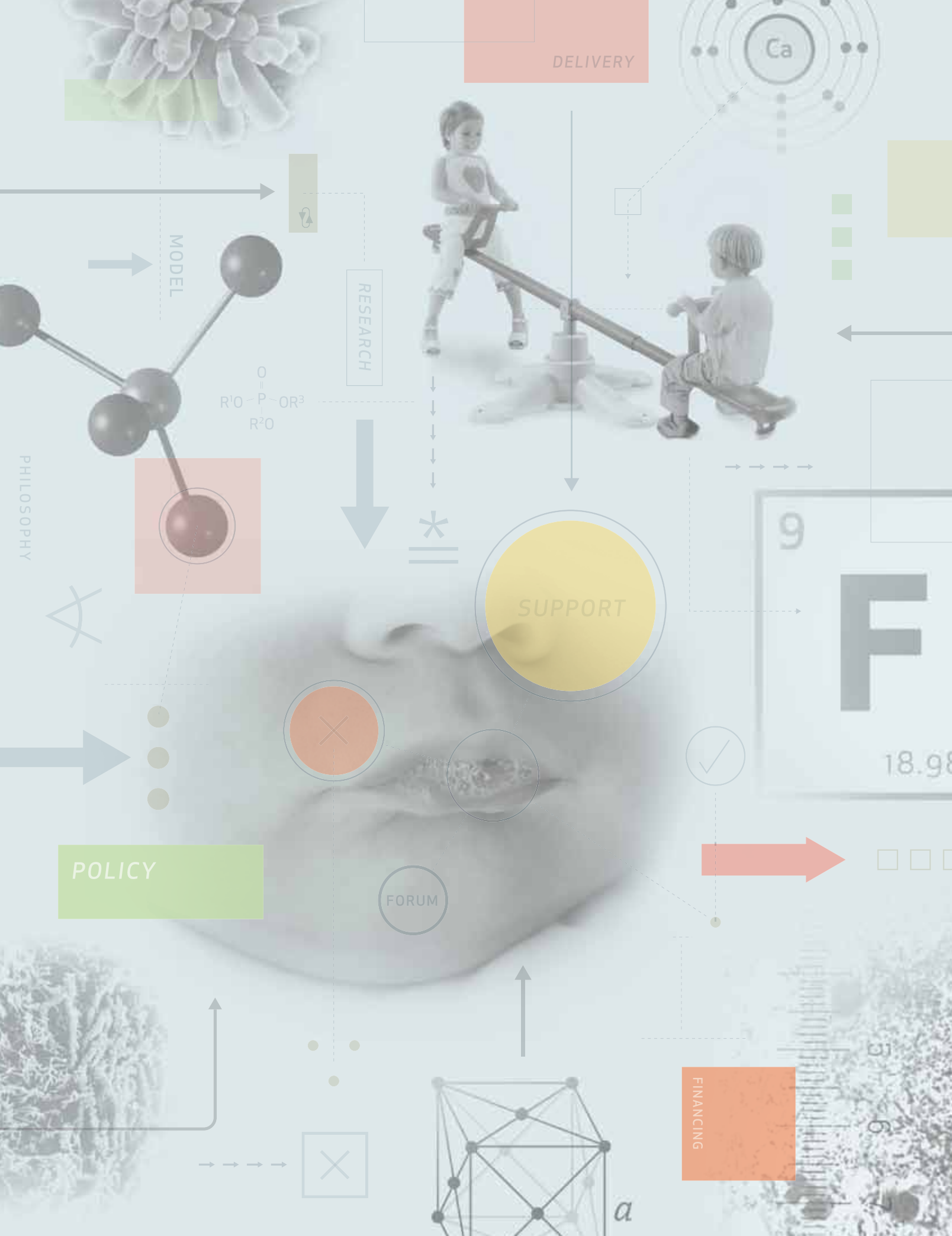
Cool Products

cda PRESENTS

If you're looking for the latest technology, products and services in dentistry, look no further than *CDA Presents*. Check out these Cool Products.

	Company/Product	Product Description
	Colgate's® Sensitive Pro-Relief™ Toothpaste	New Colgate® Sensitive Pro-Relief™ Toothpaste provides over 30% more relief vs. the leading sensitivity toothpaste based on clinical studies at 2, 4 and 8 weeks.[1] Patients also prefer the taste of Colgate® Sensitive Pro-Relief™ toothpaste over Sensodyne® Extra Whitening.[2] 1. Faster vs. Sensodyne® Extra Whitening toothpaste at 2, 4 and 8 weeks in clinical studies. Lasting relief with continued use. 2. Data on file. Vs Sensodyne® Extra Whitening Toothpaste, Colgate-Palmolive, 2011.
	Kerr Corporation's SonicFill Composite System	SonicFill is the only sonic-activated, single-step bulk fill composite system that makes posterior restorations practical and efficient. Go from placement to a polished restoration in less than 3 minutes. Effortless placement and superior adaptation greatly reduce procedure time.
	Philips Sonicare's DiamondClean Toothbrush	Philips Sonicare has long been a leader in Oral Healthcare innovation, and is taking its tradition of innovation even further with the introduction of Sonicare DiamondClean. With an advanced new handle and high-density, diamond-shaped bristles, DiamondClean provides better plaque removal and whitening than any Sonicare to date.
	SurgiTel's MicroLine LED Headlight: All Day Illumination	As a companion product to SurgiTel's MicroLine loupe family, SurgiTel has created a new generation LED headlight based on a patented beam-forming concept. The combined weight of MicroLine loupe and MicroLine LED headlight is much less than traditional loupes alone. The quality of beam is superior to other traditional LED headlights, which use a single lens or reflector.
	Ultradent's VALO Curing Light	VALO, the award-winning curing light from Ultradent, now has a cordless companion! Featuring the same trusted technology as VALO, VALO Cordless also offers total freedom of mobility. Its environmentally responsible rechargeable batteries were specifically chosen for their optimal power output, life expectancy, and affordability.

CDA Presents. The home for dental innovation.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Implementing CAMBRA Protocols Into Practice

ROLANDE LOFTUS, MBA

In a continued effort to promote caries management by risk assessment, the CDA Foundation hosted a symposium in January 2011 to advance the practice of dental disease management by engaging researchers, clinicians, insurers, and policy-makers in a practical discussion on caries management, the impact of caries on access to care, and financial implications and current policies that inhibit widespread adoption of the protocols.

GUEST EDITOR

Rolande Loftus, MBA, is a program director, California Dental Association Foundation, in Sacramento.

The goal of the conference was to disseminate research findings that support comprehensive change in the delivery and financing of preventive dental care by educating and gaining the support of professional organizations, policy-makers, and insurers. It was designed to provide a forum to address the barriers to widespread adoption of a disease-management model in clinical dental practice from different points of view. A multidisciplinary panel of experts presented recent research findings or trends in their assigned topic area and were followed by reactors to support or challenge the presentation's content. Each panel session concluded with open dialogue between the audience and presenters and the collection of written feedback. Presenters and reactors met in private session to discuss audience feedback that then was incorporated into the articles that make up this two-part issue.

This month, we continue the dialogue with articles from practitioners, payers, and private philanthropy outlining each party's role in bringing about change and their own experiences with implementation of CAMBRA protocols in practice. We will learn about one payer's experience with designing a plan to reimburse for risk-based, patient-centered services, and how some practices are finding success implementing the CAMBRA model in the current environment. The differences in CAMBRA implementation in private practice versus community health centers will be explored, and the potential for CAMBRA in federal programs including the Patient Protection and Affordable Care Act and the advocacy efforts around designing the essential benefits package for children within the health exchanges. ■■■■

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Successful Business Models for Implementation of Caries Management by Risk Assessment in Private Practice Settings

YASMI O. CRYSTAL, DMD, FAAPD; JEAN L. CREASEY, RDH, DDS; LINDSEY ROBINSON, DDS; AND FRANCISCO RAMOS-GOMEZ, DDS, MS, MPH

ABSTRACT This article describes how to implement caries management by risk assessment successfully in private practice, detailing the formats used in a pediatric dental practice and in a general dentistry practice. The authors discuss the barriers for implementation as well as how they overcame these obstacles to achieve patient satisfaction, improve health outcomes, provide optimal patient care, advance their professional success, and expand the economic viability of their practices.

AUTHORS

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Francisco Ramos-Gomez, DDS, MS, MPH, is a professor, University of California, Los Angeles, School of Dentistry, Section of Pediatrics, and researcher for the University of California, San Francisco's Center to Address Disparities in Children's Oral Health.

Caries management methods in the last 60 years have yielded major successes. Public health care measures such as water fluoridation and the widespread use of fluoride toothpaste have resulted in major decreases in caries rates.[1] The advent of new clinical technology, techniques, and materials have improved the delivery, longevity and tissue compatibility of restorative and prosthetic treatment. Surgical improvements have restored function in patients who have had tissue loss from either caries or periodontal disease. However, although caries rates have declined significantly among most adults and school-aged children since the early 1970s, oral health disparities remain across some population groups and dental caries continues to be the most prevalent chronic disease of childhood.[1] We need to recognize this as a warning sign since research confirms that caries in the primary dentition is the best predictor for caries in the permanent dentition.[2,3]

Even though surgical methods for restoring cavities and delivering prosthesis are successful strategies to maintain function, efforts to implement preventive care are falling short. To maintain long-term dental health, we need to concentrate on improving preventive techniques as well as developing, learning, and teaching complex surgical techniques. This shifts the treatment paradigm from exclusively restorative to a proactive, preventive approach based on individual risk. For this, the rationale of health care delivery among practitioners, third-party payers, and patients needs to be altered.

Risk assessment is an accurate indicator of future disease patterns.[4] Numerous publications have described the caries management by risk assessment (CAMBRA) protocol, its scientific basis, its implementation, and its measurement in academic settings.[5] However, it is still not the standard of care in private practice and it involves extra time during new patient visits or recall exams. However, prevention resonates with patients because it leads to fewer restorative treatments and maintains health, function, and esthetics. As patients gain more access to dental health information, they will begin to seek preventive measures. By empowering patients to have greater control over their caries rates, a more successful dentist-patient relationship is established, ultimately contributing to the long-term success of the practice.

Patient-centered, individualized care requires adoption of new procedures and practitioners who have departed from the current systems of treatment delivery and compensation, have achieved professional, economic, and personal success. The following describes implementation in a pediatric dental and a general dentistry practice, illustrating that CAMBRA can help achieve better health outcomes, optimal patient care and patient satisfaction, which, in turn, results in professional success, practice growth, and economic viability.

Implementing Caries Management by Risk Assessment

The following description of CAMBRA implementation refers to two well-established dental practices. The first one is a pediatric dental office in a suburban setting with multiple providers and a large staff that treats mostly private insurance patients and a small number of government-funded insurance patients. The other is a three-dentist group general dentistry practice in a rural area where approximately half of the patients have private insurance and the other half do not have coverage and are self-funded in a competitive dental marketplace. The common denominator for both practices is that their philosophy and goals have been to provide optimal comprehensive care to their patients based on specific needs with a strong emphasis on prevention. To provide this kind of welcoming and friendly patient-care environment, it is imperative for the staff be committed, adequately trained, and have a harmonious, rewarding, and secure work place.

PREVENTION RESONATES with patients because it leads to fewer restorative treatments and maintains health, function, and esthetics.

Incorporating Caries Risk Assessment Into Examinations: Determining the Level of Risk

Assessing a patient's risk for caries can be easily accomplished at the new patient exam; when relationships are being established and it is appropriate to review past dental experiences, oral health literacy levels, overall health, medications, diet, familial dental health patterns and attitudes.

The CAMBRA protocol, introduced and revised over the last several years, includes forms formatted to be compatible with current record keeping systems.[6-8] These forms help staff and families become familiar with and identify the risk factors that make them susceptible for developing new carious lesions, the protective factors of preventive and restorative measures, and other specific disease indicators according to the patient's individual case. The CAMBRA information is the basis for a restorative treatment plan, prescription of chemotherapeutic aids, hygiene recommendations, personalized counseling, the establishment of tailored, age-appropriate anticipatory guidance, and recall periodicity. By assessing the factors in a typical comprehensive oral exam, an analysis of caries risk can be made simultaneously. Areas of heavy biofilm accumulation, active caries and decalcification are obvious signs of a patient at moderate to high risk for caries. Subtler signs, such as lower saliva levels or the use of certain medications, are also important predictive factors and indicate a need for a more aggressive prevention protocol. A past decay and restorations history provides a dialogue that reveals a patient's level of oral health literacy and awareness.

Once these factors have been identified and recorded, a patient's risk can be categorized into low, moderate, high or gradations thereof. An example is a patient at low risk who has not had a carious lesion in more than two years, has little biofilm, few or no areas of demineralization, and healthy saliva levels. This categorization of risk determines the next steps to be taken in establishing an individualized prevention plan. Details are described in Ramos et al. 2010 for ages 5 and younger http://www.cda.org/library/cda_member/pubs/journal/journal_1010.pdf and Featherstone et al. 2007 for ages 6 years through adult.[6,7]

In the pediatric private practice, the typical patient visit starts with viewing educational videos in the waiting room, which has been well-received by the patients' parents, as it allows them to acquire some background knowledge prior to talking to the doctor. The video messages cover the mechanisms of dental caries, prevention of cariogenic bacteria transmission, and specific diet and

hygiene recommendations. The use of entertaining mediums, animation for example, and bilingual audio when required, makes the information easy to understand for the children and their parents.

Once the parent and the child enter the treatment area, a member of the multicultural staff, usually a hygienist, sits with the parents to ask the questions that reveal the exact details of the risk and protective factors.[9,10] For example, it is important to note if the child frequently drinks sweetened beverages or eats refined carbohydrate snacks and to specify the kind of beverages and food as well as the frequency and pattern of ingestion. A mother, when asked if her child drinks sweetened beverages often, may answer NO because she has been told that apple juice has no added sugar and is all natural. The mother may be unaware that the child has a greater caries risk through continual exposure to the natural sugar in the juice all day long.

All CAMBRA protective factors should be recorded with the same attention to detail, capturing as much information as possible on the form (**TABLES 1 AND 2**).

The dentist should then conduct a clinical examination, recording disease indicators and risk factors. To better understand their child's oral health conditions: gingivitis, plaque accumulation, deep fissures, existing decay lesions, etc., parents are invited to look into their child's mouth during the exam. X-rays are taken when indicated.[11] The evaluation is completed by establishing the level of risk and formulating a treatment plan that includes: preventive (sealants) and restorative treatment required, recommendations for antibacterial and fluoride products for home use, and establishing periodicity of in-office examinations and fluoride varnish applications.[12]

For patients found to be low risk for caries, prevention strategies can be reviewed and reinforced but less time is required for counseling since their preventive routines are working. The recall interval can be determined based on their overall oral health needs (i.e., patient may be categorized at low risk for caries but at high risk for developing periodontal disease, oral cancer, or other problems). Low-risk patients typically will have two examinations and one fluoride treatment per year; those at moderate risk may receive two examinations and two fluoride treatments per year.

A MOTHER, WHEN ASKED if her child drinks sweetened beverages often, may answer NO because she has been told that apple juice has no added sugar and is all natural.

Patients at moderate or high risk require a strategic prevention plan and they (or their parents) should specifically receive information that includes:

- Insurance benefits are the same for everyone who joins a certain plan but that benefit coverage has little to do with dealing with their specific needs;
- Cavities are only a consequence of a disease, and dental caries is an infectious, transmissible disease that is entirely preventable;[13]
- Just because the parents have "bad teeth" doesn't mean their children are doomed to live the same reality and painful consequences;
- Placing restorations on the cavities alone does NOT ensure that their child will have no new cavities in the near future;[14]
- Lifestyle changes, similar to those required to control other chronic diseases like diabetes, will be necessary to control dental caries;[15] and
- It makes economic sense to make an effort to try to stop the disease progress, hopefully before the eruption of permanent teeth.[16,17]

For children at high risk, who include any of those who required restorative treatment, those whose mother's or caregivers have active decay, those with white spot lesions, etc., additional recall visits are added at three month intervals. Most insurance companies do NOT cover the additional visits and staff must convince parents to the benefits of more frequent preventive care. Recommendations for these families are to have two examinations a year that include examination, prophylaxis, and fluoride treatment that are typically covered by their insurance plan; and then two visits at the three-month intervals that include re-evaluation of the home-care protocols and fluoride varnish treatment that is paid for by the parents.

For children at extreme high risk, monthly visits for re-evaluation of risk factors are recommended in addition to support with home care and therapeutic treatment compliance, and fluoride varnish applications until their level of risk is lowered. The parents need to understand and agree to pay for the additional fluoride varnish applications in excess of what is covered by their insurance plan.

All patients have a new risk assessment form completed at every recall visit regardless of the level of risk, as an evaluation is a snapshot in time.[18] A patient's caries risk status can change dramatically between visits due to changes in health, medications, or life situations. Adjustments to home-care routines should change accordingly. Hygienists play a key role in detecting risk level changes but the entire staff should be well-trained in caries prevention

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TABLE 1

CAMBRA — Caries Risk Assessment Form for Age 0 to 5 Years

Patient Name:_____ ID#_____ Age: _____ Date: _____

Assessment Date: _____ Please circle: Baseline, three-month follow-up or six-month follow-up

	1	2	3	
NOTE: Any one Yes in Column 1 signifies likely "High Risk" and an indication for bacteria tests	Yes =CIRCLE	Yes =CIRCLE	Yes =CIRCLE	Comments:
1. Risk Factors (Biological Predisposing Factors)				
(a) Mother or primary caregiver has had active dental decay in the past 12 months*	Yes			
(b) Bottle with fluid <u>other</u> than water, plain milk and/or plain formula		Yes		Type of fluid:
(c) Continual bottle use		Yes		
(d) Child sleeps with a bottle, or nurses on demand		Yes		
(e) Frequent (>3 times/day) between-meal snacks of sugars/cooked starch/sugared beverages		Yes		#Times/day:
(F) Saliva-reducing factors are present, including: 1. medications (e.g., some for asthma [albuterol] or hyperactivity) 2. medical (cancer treatment) or genetic factors		Yes		
(g) Child has developmental problems/CSHCN (child with special health care needs)		Yes		
(h) Caregiver has low health literacy, is a WIC participant and/or child participates in Free Lunch Program and/or Early Head Start		Yes		
2. Protective Factors				
(a) Child lives in a fluoridated community or takes fluoride supplements by slowly dissolving or as chewable tablets (note resident ZIP code)			Yes	
(b) Child drinks fluoridated water (e.g., use of tap water)			Yes	
(c) Teeth brushed with fluoridated toothpaste (pea-size) at least once daily			Yes	
(d) Teeth brushed with fluoride toothpaste (pea-size) at least 2x daily			Yes	
(e) Fluoride varnish in last six months			Yes	
(f) Mother/caregiver chews/dissolves xylitol chewing gum/lozenges 2–4x daily			Yes	
3. Disease Indicators/Risk Factors – Clinical Examination of Child				
(a) Obvious white spots, decalcifications enamel defects or obvious decay present on the child's teeth*	Yes			
(b) Restorations present (past caries experience for the child)*	Yes			
(c) Plaque is obvious on the teeth and/or gums bleed easily		Yes		
(d) Visually inadequate saliva flow		Yes		
(e) New remineralization since last exam (List teeth):				

Child's Overall Caries Risk* (circle): High Moderate Low

Child: Bacteria/Saliva Test Results: MS: LB: Flow Rate: ml/min: Date:

Caregiver: Bacteria/Saliva Test Results: MS: LB: Flow Rate: ml/min: Date:

Self-management goals:

1)_____

2)_____

VISUALIZE CARIES BALANCE

*Assessment based on provider's judgment of balance between risk factors/disease indicators and protective factors.

Doctor signature/#: _____ Date:_____

TABLE 2

Caries Risk Assessment Form — Children Age 6 and Over/Adults

Patient Name: _____Chart #:_____Date:_____

Assessment Date: Is this (please circle) Baseline or Recall

Disease Indicators (Any one "YES" signifies likely "High Risk" and to do a bacteria test)**	YES = CIRCLE	YES = CIRCLE	YES = CIRCLE
Visible cavities or radiographic penetration of the dentin	YES		
Radiographic approximal enamel lesions (not in dentin)	YES		
White spots on smooth surfaces	YES		
Restorations last 3 years	YES		
Risk Factors (Biological predisposing factors)		YES	
MS and LB both medium or high (by culture**)		YES	
Visible heavy plaque on teeth		YES	
Frequent snack (> 3x daily between meals)		YES	
Deep pits and fissures		YES	
Recreational drug use		YES	
Inadequate saliva flow by observation or measurement (**If measured, note the flow rate below)		YES	
Saliva-reducing factors (medications/radiation/systemic)		YES	
Exposed roots		YES	
Orthodontic appliances		YES	
Protective Factors			
Lives/work/school fluoridated community			YES
Fluoride toothpaste at least once daily			YES
Fluoride toothpaste at least 2x daily			YES
Fluoride mouthrinse (0.05% NaF) daily			YES
5,000 ppm F fluoride toothpaste daily			YES
Fluoride varnish in last 6 months			YES
Office F topical in last 6 months			YES
Chlorhexidine prescribed/used one week each of last 6 months			YES
Xylitol gum/lozenges 4x daily last 6 months			YES
Calcium and phosphate paste during last 6 months			YES
Adequate saliva flow (> 1 ml/min stimulated)			YES
****Bacteria/Saliva Test Results: MS: LB: Flow Rate: ml/min. Date:**			

VISUALIZE CARIES BALANCE
(Use circled indicators/factors above)
(EXTREME RISK = HIGH RISK + SEVERE SALIVARY GLAND HYPOFUNCTION)
CARIES RISK ASSESSMENT (CIRCLE): EXTREME HIGH MODERATE LOW

Doctor signature/#: _____ Date:_____

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and risk assessment so consistent messages are delivered throughout a dental visit. Ideally, a form of saliva bacterial testing should be included in the initial and periodic examinations as a predictor for caries risk for all ages, but the cost for currently available products not usually covered by third-party payers have prevented both practices from using them routinely.

An oral evaluation for a child ends with anticipatory guidance that includes growth and occlusion development, trauma prevention and changes the parents may see in their child's mouth until the next re-evaluation visit.[19] At this time, any member of the staff can review the CAMBRA findings with parents or, on high-risk patients who require a subsequent visit, it can be done while their child is receiving restorative treatment.[20]

Formulating a Treatment Plan Based on CAMBRA

A treatment plan based on individual risk should include preventive treatment (sealants and in-office fluoride treatment), restorative treatment required, individualized counseling to target specific risk factors, recommendations for antibacterial and fluoride products for home use, and establishing periodicity of in-office examinations and fluoride varnish applications.[6]

There is a high level of evidence proving the effectiveness of interventions such as fluorides and sealants, and for that reason they form the foundation for current therapeutic recommendations.[21,22]

Restorative treatment is an integral part of caries management since it can limit tissue damage and restore function, avoiding emergency situations. It is unrealistic to expect a child with open cavities to allow the brushing of the teeth when contact with cold water and a toothbrush elicits pain. Performing restorative treatment in young children is often complicated because cooperation is usually limited depending on the age, the child's disposition, and their treatment needs. Delivering optimal treatment on an uncooperative young child is not an easy task and patients may require behavior modification techniques or the aid of nitrous oxide analgesia, sedation, or general anesthesia to complete the required work.[23]

Often, young patients with advanced decay have been "treated" at other clinics with fluoride varnish or failed forms of intermediate therapeutic restorations (ITR). Unfortunately, when this disease is left to advance, the infection spreads so much into surrounding tissues that extraction is the only treatment option. When evaluating a child's restorative needs, consider conservative, preventive, and minimally invasive treatment by contemplating "What do we need to do as a team to make sure this is the one and only time we have to perform restorative treatment on this child?" This means that whatever behavioral modality is required to deliver adequate, conservative, and durable restorations should be used with the expectation that chemotherapeutic and behavioral treatments will prevent or at least reduce the need for future restorative treatment.

RESTORATIVE TREATMENT is an integral part of caries management since it can limit tissue damage and restore function.

In adults as well as in children, the patient's overall medical status, and the family's social and economic situation are always considered to establish the course of action for the restorative portion of the treatment. However, the goal of restorative measures is always to prevent further tissue destruction and interventions. The use of ITR is limited as a temporary means to limit tissue destruction.[24]

Individualized counseling is an integral part of the treatment plan. By utilizing a "motivational interviewing" approach instead of traditional "advice-centered" strategies for patients or the parents of patients, one can attain higher incidences of behavior change.[2] Change comes from internal motivators, not external, and patients will change behaviors only when they hear themselves talk about the need for change. A traditional prevention approach is, "Mrs. Jones you really need to brush better or you're going to continue getting cavities. You also need to eat less sugar." A motivational interviewing style is, "Mrs. Jones, would you be interested in lowering your decay rate? We now have a better understanding of how you can control your tendency of getting cavities. Let me know if you want me to share some of these techniques with you." The advantage of this approach is it clearly establishes that the patient is ultimately responsible for their dental health status.

Staff trained in motivational interviewing skills will prove invaluable for successful patient counseling.[3] A successful prevention discussion should take no more than about 10 minutes. Simple illustrations can help communicate the concepts of mineral leaving the tooth structure in an acidic environment, saliva eventually neutralizing acids, and how the frequency of fermentable carbohydrate ingestion can influence mineral loss. Phrases such as "You wouldn't think of replacing the roof on a burning building until you extinguished the flames" provide useful analogies to restoring decayed teeth before patients take control of their caries status.

Trained staff ensures parents have a clear understanding of the disease process, the caries balance concept, and their individual risk factors, guiding them to realize the need to change their routines.[25] Counseling is targeted toward modifying the patient's specific risk factors.[26] The nuances of diet and the effects of refined carbohydrates on tooth structure are essential to reducing caries risk. Patients must understand that the nature and frequency of carbohydrate ingestion as the key to controlling acid challenges on their teeth. They should be encouraged to become "diet detectives," analyzing their food choices and eliminating "caries-risk" foods. They need to realize that a food can be nutritional but also creates a caries risk. Since diet can play a major role in caries risk, both dental practices focus efforts in assessing a patient's intake of fermentable carbohydrates. Performing a diet analysis for the patient can be of benefit since patients may be unaware of the amount, frequency, or type of carbohydrates they consume until they are compelled to write them down. The general lack of knowledge on the acid level of many commonly consumed beverages can be an eye-opening exercise for the patient.[27]

Other counseling topics include demonstrating to patients and parents supervised toothbrushing with a smear (for under age 2) or pea-size amount (from 2 to 6 year olds) of fluoride toothpaste.[28,29] Effective oral hygiene is important and recommendations for brushing three times a day with a fluoride-containing toothpaste on extreme high-risk patients are helpful to overcome frequent acid attack. Always review the proper techniques for plaque removal to prevent accumulation.

At this time, recommendations for chemotherapeutic home-care products for slowing down and reversing the demineralization cycle include home fluoride preparations, prescription-strength fluoride toothpastes or a combination product containing both fluoride and calcium phosphopeptide, 0.12 percent chlorhexidine rinse, xylitol products, and/or MI paste with or without fluoride.[30-37] High-risk patients aged 6 through adult should be advised to use high concentration (5,000 ppm) fluoride-containing prescription toothpaste at bedtime and not to rinse with water after spitting out the excess. These prescription toothpastes can also be used instead of regular toothpaste two or three times daily. The appropriate combination of the above products depends on age and risk level, and are chosen as per guidelines given in Jensen et al. for ages 6 years through adult and in Ramos-Gomez et al. 2010, for children 5 years and younger.[6,8]

THE NUANCES of diet and the effects of refined carbohydrates on tooth structure are essential to reducing caries risk.

If the family has a prescription plan, a prescription detailing use may be given, or products can be purchased directly in the office to facilitate compliance. At these practices, products are sold at a minimum price for the purpose of encouraging use and being easily affordable to all patients. This is not expected to be significant extra income for the office, but it builds trust and a sense of partnership in health with the families. However, costs can also be recovered by building the expense into the fee schedule, or in different patient settings, the sale of preventive products can be an additional form of revenue. Written instructions on the proper use of all products should accompany dispensing since patients often do not remember verbal chairside instructions.

The unit cost to the dentist for 5,000 ppm fluoride toothpaste is approximately $7 per tube. The use of 0.12 percent chlorhexidine mouthrinse for one minute/one time a day/one week per month is appropriate for high-risk patients who need to modify the acid producing bacteria dominating their oral flora. The approximate cost of chlorhexidine mouth rinse is $7 per 8-ounce bottle. MI paste is recommended to patients who have decalcified areas, for those too young to be on additional fluoride therapy, or for those who are against using fluoride-containing products. It should be applied for three to five minutes, twice a day. MI paste plus, which contains 900 ppm of fluoride can be recommended as an additional therapy for extreme risk patients. The cost is approximately $14.40 per tube.

The benefits of xylitol gum are well-documented and most adult patients find it easy to comply with the recommendation of chewing xylitol gum three to five times per day.[38,39] Sharing facts about xylitol gum such as the natural sources that it is found in, that acid-producing bacteria cannot metabolize it and that the increase in salivary flow aids in remineralization, all help to encourage the patient to increase compliance. Xylitol gum can be purchased for approximately $1.20 per package of 10 pieces from different sources.[40-43]

Practice Management Integration

CAMBRA calls for customizing a patient's prevention plan according to individual risk. However, dental benefits are not customizable by age or risk to fit each patient's needs. Yet, dental coverage is the most significant factor in motivating patients to use oral health care services and their covered benefits influences the

specificity and frequency of procedures that are available. A typical benefits plan allows for two cleanings, two periodic exams, and two fluoride treatments per year, but increasingly, plans are only covering one topical application of fluoride per year. A patient deemed at moderate or high risk for caries would be required to pay for recommended supplemental office visits as well as home-care products out of their own pocket. Therefore, the practice must "sell" these patients on the concept that some up front out of pocket expenses can lead to greater cost savings down the road for preventable restorative care. A recently added CDT code — D0145 — oral evaluation for a patient under age 3 and counseling with a primary caregiver, is meant to encourage early intervention and the establishment of a dental home within six months of the eruption of the first tooth. The code descriptor ideally reflects CAMBRA principles as it includes the following:

- Recording and oral and physical history;
- Caries risk assessment;
- Development of a plan to reduce the risk of caries;
- Instructions for cleaning the child's teeth;
- Fluoride recommendations;
- Diet recommendations; and
- Recommendations to reduce transmission of bacteria.

More diagnostic codes like this combined with an individualized, flexible benefits package will be necessary to reimburse for and encourage these activities across a patient's life span.[44] Provider reimbursement in the private sector dental delivery system is procedure-based. The filing of claims to third-party payers is based on a set of CDT codes and includes procedures performed on a particular date of service. In contrast, the medical delivery system uses medical diagnostic codes (ICD-9) for filing medical claims that are used to describe the patient's health and condition at the time of service and validate the procedure performed on a date of service was medically necessary. Diagnostic codes in dentistry do not exist, therefore it is not possible to bill for changes in a condition through time or track the impact of a particular intervention based upon the patient's risk category. The current reimbursement structure provides no incentive to the clinician for improving and maintaining the patient's oral health.

STUDIES SHOW THAT children and adults at the highest risk tend to remain at that level and develop further problems with traditional restorative treatment only.

Normal business operations in private dental practice do not readily support CAMBRA implementation. None of the most widely used dental office software systems provide an off-the-shelf means of recordkeeping for caries risk status, patient compliance, and outcomes of recommended preventive interventions. As an example, there is no validated risk assessment form programmed into a clinical software package. This places a burden on private dental practices to develop their own means of implementing CAMBRA into the daily delivery of care either by scanning into the system their own risk assessment form or using a separate form to place in a paper chart. With the movement toward adoption of electronic health records, it will be essential to develop software components compatible with CAMBRA principles that integrate with electronic billing of dental insurance. Practice management companies and consultants would provide a great service for clients by encouraging business models supporting CAMBRA implementation.

Overcoming the Barriers of Implementation

The most significant barriers to the implementation of caries management by risk assessment in private practice are first, the current system of remuneration that is based on corrective procedures performed rather than on preserving health from the start. The second is the public's mentality that has unquestioningly become used to this kind of remuneration system, and the third is the great difficulty for everyone to make and maintain significant lifestyle changes.[45]

These practices overcame these barriers by educating patients on the benefits of promoting and preserving their oral health. In general, it is easier for patients to understand the benefits of prevention when they see themselves or their children struggle with extensive restorative needs; the trick is to convince everyone to act before the problem arises. This is still one of the easier problems to overcome when treating children since parents at all levels of the economic spectrum want the best for their offspring. Most of the parents in both practices have no problem paying out of pocket for additional fluoride varnish applications or sealants on primary teeth, which they see as a "fix" for their children's high risk. However, it is hard to change behaviors and routines, and studies show that children and adults at the highest risk tend to remain at that level and develop further problems with traditional restorative treatment only. Sometimes adult patients are just not ready to make the lifestyle changes that will help them and their families be healthier.

To increase the likelihood of patient behavior change, use of a counseling approach such as motivational interviewing has been of great value in the general and pediatric dental practices described here, but the clinicians admit that "although you can lead a horse to water you can't make it drink." Studies on compliance with medication regimens show that nearly 20 percent of prescriptions are not filled and roughly one-half are taken incorrectly.[46] In-office dispensing of home-care products and simple, clearly stated written directions for use will encourage proper utilization. In general, home regimens that require considerable patient attention will have worse compliance. Prioritizing recommendations to the few with the greatest impact is best. To enhance a patient's knowledge of caries risk factors it would be advisable to provide a written copy of the patient's caries assessment form, and where applicable, clinical intraoral photos of demineralized areas.

The aid of fluoride to overcome extreme caries risk only goes so far.[47] With the limitations of the current chemotherapeutic agents available for use on young children, behavior modification techniques that have shown improved outcomes of health have become a crucial part of treatment.[48] Sadly, these very effective but time-consuming procedures are not only never covered by traditional insurance plans, but also are services that parents are not receptive to pay for. Furthermore, it may take a long time to change this mentality. This barrier has been overcome by training all of the dental assistants and receptionists to do the bulk of the counseling, so then the hygienists and the doctors only have to reinforce the main points. Cross-training all auxiliary personnel into doing motivational interviewing and the concepts of the caries balance has the added benefit that patients' backgrounds and/or styles can be matched with someone who can establish a better rapport with them. Patients can have any questions answered in the operatory, during the counseling session, or before they leave the front desk. Everyone in the staff is on the same page, and all information required is easily accessible in the caries risk assessment form. The auxiliaries, empowered with the knowledge they share with patients, many times members of their communities, realize the importance of their contribution to keeping patients healthy that gives them an added sense of achievement, which in term adds strength to the team.

Advantages Gained From a CAMBRA Practice

These practices are viewed as highly successful by all standards. In times of economic turmoil, patient volume has remained for the most part unchanged; total revenues have increased when most other practices report reductions in income; staff needs have grown when most other practices nearby have had staff reductions; and the referral base remains large and loyal, including former patients, general dentists, pediatricians, and other specialists for the pediatric practice. In the general practice, patient satisfaction is demonstrated with heartfelt acknowledgment, long-term

commitment, and in-house referrals.

The doctors' top parameter for success would be to cite better health outcomes for all patients. However, that is very hard to quantify in clinical practices like these. Patients and referral sources certainly have the perception of the high standards of care: they refer their friends because families with high restorative needs will be treated kindly and efficiently, and, with the parents' cooperation, will be kept from requiring further treatment. The entire dental team benefits when patients improve their oral health and reduce their caries rates. Hygiene visits are more comfortable for patients and the dentist's restorative work lasts longer in a healthy oral environment. Patients have the obvious benefit of requiring less restorative treatment and ultimately the practice benefits because these patients develop strong loyalties and refer friends to the dental team that helped them achieve improved dental health.

Finally, the success in the team's stability, determined by the low attrition rate of personnel, and the positive working atmosphere, is based on the whole staff's attitude in methodology and practice by providing optimal care to individuals and the community while having job security, financial rewards, and recognition for their efforts.

As outlined in the two practices presented, expenses can be reduced by training and calibrating lower salaried staff to perform the risk assessment data gathering, oral health education to patients and parents, and application of the risk-based preventive protocols. This in turn empowers staff as they share in the satisfaction of knowing they have played a significant role in improving the oral health of patients. The pediatric dental practice optimally utilizes a multicultural staff to accommodate an ethnically diverse and economically disadvantaged patient population enrolled in government-funded insurance programs, such as Medicaid and CHIP, who typically present as high risk. Patients, and especially parents, are prepared to pay to prevent further decay and to improve their oral health of themselves and their children.

Conclusions

The general and pediatric practices described here join others (www.dentaquestohc.com) to illustrate how CAMBRA principles can be successfully established in private practice even with the current barriers, and that by starting very early in life, beginning at age 1, we have the potential to positively impact an individual's oral health into adulthood, and improve patient/provider satisfaction, economic viability of the dental practice, and, most importantly, the maintenance of oral health.[45] ■■■■

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Bringing CAMBRA Into Federally Qualified Health Centers

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ABSTRACT Federally qualified health centers serve a high volume of patients vulnerable to caries. This article examines how caries management by risk assessment, an evidence-based risk assessment tool and caries disease intervention approach, can be incorporated into federally qualified health center dental delivery systems, the potential obstacles to doing so, and the rationale for overcoming those obstacles.

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Caries management by risk assessment (CAMBRA), an evidence-based risk assessment and caries disease intervention approach, is supported in clinical practice by Western, Central, and Eastern CAMBRA Coalition dental schools, the American Dental Education Association Cariology Special Interest Group, World Congress of Minimally Invasive Dentistry, the California Society of Pediatric Dentistry, and the American Dental Association, among other organizations.[1] Clinical use of CAMBRA also aligns with a chronic disease focus of federally qualified health centers (FQHCs). They are engaged in preventing, delaying, detecting, and controlling chronic disease. Nationally, chronic disease is among the most common, costly, and preventable health problems. In 2009, it was reported that almost 133 million — one out of every two adults had at least one chronic medical disease and their management accounted for 75 percent of all health care costs.[2]

Dental caries is even more prevalent than the most common chronic medical diseases. It is the most prevalent pediatric chronic disease.[3] Moreover, in the past decade, dental caries has increased in children aged 2 through 5.[4] Nationally, it affects one-fourth of children in this age range.[5] Half of the children in the United States aged 12 through 15 have caries. By age 19, more than two-thirds of U.S. residents have dental caries.[6] Sixteen percent report untreated caries, according to data collected 2005-2008.[7] Black and Hispanic (or Latino) persons have a disproportionately high incidence of caries and untreated caries compared to their non-black and non-Hispanic counterparts.[8] Low-income individuals below 200 percent of the federal poverty level also have a disproportionately high incidence of caries compared to individuals at 200 percent or more of the federal poverty level.[8]

FQHC's Role in Chronic Disease Management

The demographics cited above by the National Center for Health Statistics align with the demographics of the patients served by FQHCs. In 2009, approximately 92 percent of FQHC patients lived below 200 percent of the federal poverty level

and more than half of the FQHC patients were black or Hispanic.[8] All but 15 percent were uninsured or had public insurance. As safety-net providers, FQHCs serve the most vulnerable populations — individuals who are isolated from traditional health settings because of where they live, personal factors, the languages they speak, their income levels, the public insurance they possess, or their lack of insurance.

FQHCs are structured to deliver affordable, coordinated, family centered, culturally competent, and effective care aimed at reducing health disparities and improving outcomes. As mandated by federal law, and despite increasing resource constraints, FQHCs offer an "open door" to children and adults by accepting public insurance and providing a sliding-fee scale for the uninsured.

FQHCs are health care organizations receiving grants under the Public Health Service Act (PHSA) Section 330. They include consolidated health centers, migrant health centers, health care programs for the homeless, and health centers for residents of public housing. Additionally, they include Healthy Communities/Schools, the Office of Tribal Programs and urban Indian organizations. Non-PHSA Section 330 grantees, identified by the U.S. Health Resources and Services Administration (HRSA) and certified by the Centers for Medicare and Medicaid Services (CMS) as operating in compliance with the FQHC program requirements are also eligible to participate in the FQHC program. This category of health centers is commonly referred to as "FQHC look-alikes."

FQHC's Role in Oral Disease Prevention

CAMBRA does not align so neatly with the oral disease prevention model of the largest FQHC payer, Medicaid. The Medicaid rules and regulations for reimbursement to providers do not reward an evidence-based approach to prevent or halt the progression of the underlying caries disease. Although the Medicaid scope of dental services includes preventive services, it fosters a "surgical" or "reparative" model for the delivery of care, rather than a prevention-oriented "health" model.[9] The Medicaid scope of preventive dental services — oral examinations, radiographs, fluoride applications, oral prophylaxes, and sealants — at the allowable Medicaid frequency help to prevent dental caries up to a point. If there are repeated acid attacks and the acidogenic bacterial challenge is sufficiently high, the beneficial effects of fluoride can be overcome. Then antibacterial therapy becomes necessary.[10] Caries progression or reversal is an ongoing and changing balance between pathological factors, risk factors, and protective factors.[11]

FQHCS OFFER AN "open door" to children and adults by accepting public insurance and providing a sliding-fee scale for the uninsured.

Evidence suggests that providing therapeutic and preventive services to patients according to their caries risk levels yield better oral health outcomes and greater cost-effectiveness than performing the same services to all patients equally, independent of caries risk.[12]

Bringing CAMBRA Into FQHCs — the Cost

Some FQHCs incorporate the costs associated with CAMBRA as part of their prospective payment system (PPS) rate. New FQHC dental programs that expect to furnish CAMBRA therapeutics may include the cost of CAMBRA therapeutics in the reasonable cost calculation. PPS is the methodology Medicaid uses to reimburse FQHCs. It is based on the assignment of a prospectively determined rate per encounter that approximates the FQHC's reasonable cost per visit. Existing FQHCs can decide whether or not to submit a change in scope-of-service request (CSOSR) based upon whether they will meet the criteria for an adjustment in the PPS rate.

In California, CAMBRA therapeutics are not a therapeutic classification on the Medi-Cal (California State Medicaid Program) contract drug list, Medi-Cal's formulary. CAMBRA therapeutics are not a 340(b) federal drug pricing program therapeutic category either and therefore, do not qualify for purchase at up to 80 percent off the cost of retail prices. Existing FQHCs may opt to write prescriptions for prescription therapeutics, absorb the cost, or require patients to pay a share of the cost. Caries susceptibility tests to monitor caries activity are not a Medicaid benefit either. The options are to absorb the cost or require patients to pay a share of the cost. While chemotherapeutic agents and caries susceptibility tests are not covered by Medicaid, the visit is reimbursable when services that qualify for Medicaid reimbursement are provided.

Bringing CAMBRA Into FQHCs — the Reimbursement

Medicaid FQHC reimbursement is key to the FQHCs ability to serve low-income, uninsured individuals as the provider of last resort. In 2008, 36 percent of FQHC visits were made by Medicaid beneficiaries.[2] Thirty-six percent of Medicaid reimbursement can equal as much as 60 percent of a dental program's revenues. Medicaid revenues help cover the cost of providing care to the uninsured.

As a result, FQHCs are attentive to following Medicaid rules and regulations for reimbursement. A FQHC visit must be a face-to-face encounter between a Medicaid patient and any health professional whose services are reimbursed under Medicaid for the purpose of diagnosis or treatment.[13] In addition to cost-based reimbursement for dentist encounters, California FQHCs may seek Medicaid independent reimbursement for dental hygienist services through an alternative payment methodology (APM). The California Department of Health Care Services finalized the APM this year.

The oral examination by the dentist and the anticipatory guidance by the dentist or dental hygienist with patients at the initial visit are critical. Some aspects of caries activity monitoring and most aspects of self-management support can be performed by dental assistants. However, at a minimum, the dentist or dental hygienist should reinforce the importance of caries protective factors at every visit, thereby making each and every visit a "prevention" visit.

Bringing CAMBRA Into FQHCs — the Dental Delivery System

Nationally, in 2008, 74 percent of the 8,000 delivery sites at 1,200 FQHCs delivered preventive dental care.[3] (A single FQHC may deliver dental services at multiple sites.) FQHCs can and should utilize CAMBRA in all levels of prevention: primary, secondary, and tertiary.

Primary prevention focuses on measures that prevent the actual occurrence of caries such as breaking the chain of infection from mother to child. It is well-known that dental caries is an infectious and transmissible disease.[6]

Secondary prevention focuses on early detection and management of noncavitated lesions by reversing caries lesions or halting their progression.

Tertiary prevention takes the minimally invasive restorative dentistry approach to cavitated lesions at the same time as measures are taken to reduce the cariogenic bacterial loading in the remainder of the mouth.

Primary Prevention With CAMBRA

Mutans streptococci (MS) transmission from mother to child is the primary route of MS inoculation in early infancy. Studies have shown that MS in early childhood is a major risk factor for caries during early childhood and later in life.[14] Caries in the primary dentition is a strong predictor of caries in the permanent dentition. However, many parents remain unaware that they can transmit caries-causing bacteria to their newborns. Therefore, it is critical that the CAMBRA strategy during pregnancy continue postnatally in infancy with the newborn.

IT IS CRITICAL that the CAMBRA strategy during pregnancy continue postnatally in infancy with the newborn.

Instituting CAMBRA protocols for the benefit of our prenatal patients will not only improve the mothers'-to-be own oral health but also greatly impact their babies' dental health outcomes. Because the incidence of early childhood caries (ECC) has increased significantly in recent years, it is crucial that dental delivery sites, including FQHCs, adopt caries primary prevention protocols because they offer real opportunities to improve oral health outcomes.[15] Protocols include fluoride varnish applications, anticipatory guidance, and parental counseling. Dental personnel would have the opportunity to collaborate with parents concurrently about primary caregiver's and the child's caries prevention even as a dual mother/child visit.[16]

In California, FQHCs receive Medicaid FQHC reimbursements for up to five topical fluoride applications per year for children under the age of 6, which is beneficial for children at high or extreme risk for caries. Cavitated lesions in the 0-5-year old patient population are the most challenging at FQHCs. It is very difficult to find pediatric dental specialists who are willing to work at FQHCs with this patient population. Moreover, there is very limited hospital operating room time available at which to provide treatment.

In addition to dental personnel, FQHC and community pediatricians can play a key role in primary prevention during well-child visits by screening for visible signs of caries, providing anticipatory guidance, applying fluoride varnish applications, making referrals to dental homes, and advising parents. Research has shown that physician advice is an effective driver in persuading patients to change high-risk behaviors.[17] According to the National Academy for State Health Policy, 34 states have mechanisms in their state Medicaid dental programs to reimburse primary care physicians for providing early oral care.[9] In California, physicians are legally permitted to apply fluoride varnish up to three times in a 12-month period to children under the age of 6. If they establish protocols, physicians may delegate fluoride varnish applications to nurses and other medical personnel.

Secondary Prevention With CAMBRA

As noted, a high proportion of FQHC patients exhibit multiple caries risk factors and early lesions at their first dental visit. Caries lesions are reversible if detected early enough. It is clinically demonstrated that the noncavitated caries lesions can be arrested if the caries challenge is reduced sufficiently or eliminated, or if the protective factors are increased.[18] Depending upon the severity and activity status (progressing or reversing) of caries lesions, a preventive intervention or a combination preventive/minimally invasive dentistry intervention may be sufficient. Both types of interventions are options if CAMBRA protocols are followed.

Failure to use preventive measures defaults to combating caries in later-stage treatment when caries lesions are more advanced, which then results in a more time-consuming and costly treatment. In comparison, early receipt of dental care is more cost-effective. A 2004 study that examined the effects of prevention on subsequent utilization found that average dental-related costs for low-income preschool children who received their first preventive dental visit by age 1 were less than one-half ($262 compared to $546) of the average cost for children who received their first preventive visit at age 4 through 5.[19]

Tertiary Prevention With CAMBRA

FQHCs exist to reduce barriers to access to care. Yet, a significant number of patients present for initial FQHC visits with substantial treatment needs, characterized by high caries activity and rampant cavitated lesions. They will have acute care needs that must be addressed before the comprehensive oral exam and treatment plan. Patients with frank, moderate-severe symptomatic caries lesions require palliative care such as removal of tooth decay and the placement of adhesive transitional fluoride-releasing restorative material. The return appointments for oral examinations are an optimal time to perform the caries risk assessment, teach self-management skills, and perform the caries bacterial tests. The caries risk category should be factored into treatment planning caries lesions. For the high- and extreme-risk patient requiring restorative treatment, it is recommended that periodontal care, fluoride varnish applications, preventive dental services, oral hygiene instruction and chemotherapeutic agents be administered before restorative treatment with the placement of final restorations as rapidly as possible.[20] With CAMBRA, the use of cariostatic modalities becomes part of the evidence-based treatment for noncavitated lesions, as opposed to "watching" them or treating them surgically.[18]

NONCAVITATED CARIES lesions can be arrested if the caries challenge is reduced sufficiently or eliminated, or if the protective factors are increased.

Bringing CAMBRA Into FQHCs — the Support

Organizational support at each level is key to the successful clinical use of CAMBRA. Staff roles may change, tasks may increase, and some visits may take longer affecting productivity. Scheduling adjustments may need to be made. CAMBRA's viability in FQHC settings requires staff commitment to learning the CAMBRA approach, endorsing the principles, and applying them in their patient encounters. Motivational interviewing techniques move patients beyond ambivalence to making changes.[21] Self-management support helps patients to sustain changes. Both motivational interviewing techniques and self-management support are behaviors that can be learned and improved with practice. Staff training is necessary although it requires time away from patient care. And, of course, CAMBRA needs a champion, whether it is the dental director or another staff member who is willing to take the initiative to keep the dental clinic staff motivated and contemporary with CAMBRA because CAMBRA is an evolving strategy.

A main principle for CAMBRA implementation is informed patient participation.[10] And it is a necessary prerequisite to obtaining patients' commitment to follow-through. CAMBRA requires commitment by patients to: 1) attend to dental visits for monitoring the changes in their caries disease activity status; 2) develop self-management behaviors to reverse or halt caries; and 3) understand that daily behaviors determine the course of their caries disease. Sustaining a patient's commitment to manage their risk factors at home requires the support of all members of the dental team; regular follow-up to check plaque removal effectiveness; chemotherapeutic product adherence; and maintenance of a low frequency of fermentable carbohydrate snacking.

Monitoring Caries Activity

Regular monitoring to assess positive or negative changes in the caries activity status is the most important aspect of caries management.[12] For moderate-, high-, and extreme-risk patients age 6 years through adult, recall exams are

recommended every three months.[19] However, this frequency poses logistical challenges for the FQHC dental program receptionist/scheduler. Even if monitoring visits are incorporated into restorative and preventive visits, the wait for an appointment often exceeds three months in some dental clinics. FQHC patients are often unaccustomed to frequent dental visits and may defer a dental visit in the absence of symptoms. After FQHC patients with acute care needs receive treatment and symptomatic relief, they are less likely than patients who present initially with nonacute needs to return for follow-up care.[22]

Even when patients intend to return for follow-up appointments, difficulties in taking time off from work, arranging transportation, and finding child-care may preclude keeping the appointments. Those factors inform the urgency for all dental staff to be supportive in the patients' education and self-management.

Designated access scheduling, called "scheduling by design" can help dental programs by apportioning appointment slots more equitably based upon caries risk category.[23] For example, scheduling by design could be used to reserve quarterly return restorative/monitoring appointment slots for high-risk patients with high-caries rates. Combined restorative/caries activity monitoring visits would likely appeal to patients because clinicians who follow the chronic care model report that patients do not prefer separate, planned visits for chronic disease management.[22] As patients are reassessed to a low-risk category and their restorative treatment is completed, research shows that a single dental visit annually is sufficient to maintain their optimum oral health.[23]

Of course, having a good scheduling system does not mean all patients will keep the appointments for some of the reasons noted above. In addition, the medical literature suggests that low health literacy levels lead to poor compliance with routine medical visits.[24] It is likely that low health literacy levels also lead to poor compliance with dental visits. CAMBRA gains are threatened when patients drop out of care or experience significant gaps in visits. Patients with low knowledge and low literacy levels may drop out of care because they do not understand what it means to have a high caries risk level. Low literacy levels are known to impede patients' ability to process, understand, and make appropriate health care decisions.[24] It has been shown that dental programs that hold patients accountable for remembering appointments are more efficient and have low no-show rates.[23] Taking the time to give very basic explanations about what the caries monitoring visits will accomplish could significantly overcome patients' low literacy levels and help them patients to prioritize those visits amid other commitments.

IT HAS BEEN SHOWN that dental programs that hold patients accountable for remembering appointments are more efficient and have low no-show rates.

Supporting Self-Management

Low oral health literacy levels also affect patients' self-management success. The Institute of Medicine defines self-management support as "the systematic provision of education and supportive interventions to increase patients' skills and confidence in managing their health problems, including regular assessment of progress and problems, goal-setting, and problem-solving support.[25] Self-management support is designed to engage patients and dental team members in a partnership to agree on specific self-management goals and steps.

Self-management support is integral to treatment plans designed by using CAMBRA. For some patients, it is a matter of coaching patients to develop the habit of taking the therapeutics as directed. For others, it is coaxing them to seek refills as needed. The cost of therapeutics may be a positive or negative factor. For some patients, if they have to pay a share of cost for therapeutics, they may be more likely to use them. For other patients, paying for them may be a barrier to acquiring them. Understandable verbal and written instructions aid adherence. These factors need to be considered when engaging patients around self-management.

Supporting the Team

Caries activity monitoring and self-management support are key to achieving successful health outcomes for patients. They require that dental staff work together as a team. Teams perform well when there is good leadership, a clear division of labor, and staff training both in their individual role and in team functioning.[26] Adopting evidence-based CAMBRA treatment guidelines as standard clinical protocols ensures that each patient in the same caries risk category receives the same evidence-based management. CAMBRA protocols guide the delivery of the appropriate comprehensive sessions including the: parent/caregiver and/or patient interview; oral examination; caries risk level assignment; bacterial testing; oral health education; motivational interviewing if indicated;

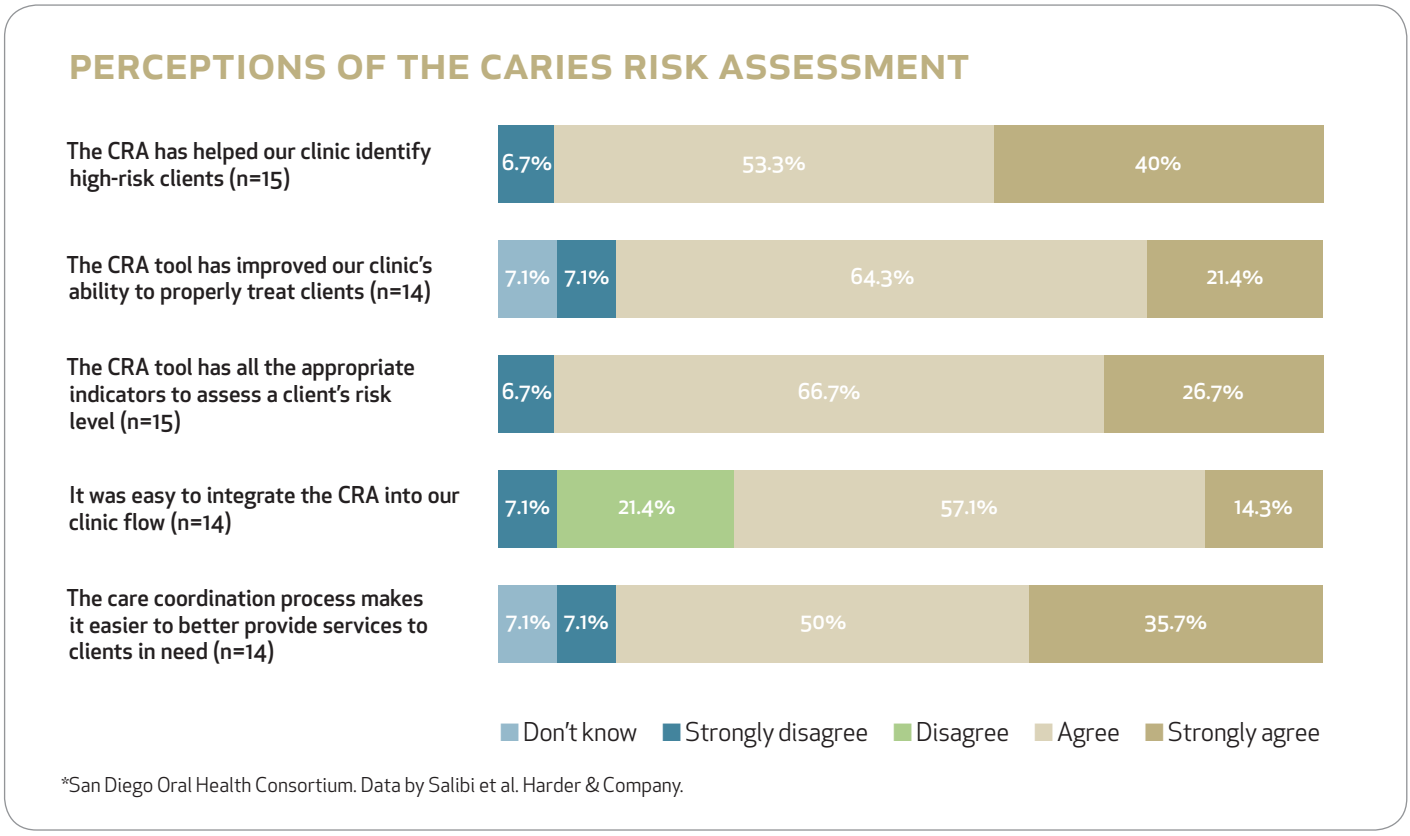

FIGURE 1. Perceptions of the caries risk assessment.*

and age-specific anticipatory guidance. When these sessions are standardized according to dental program protocols, the added time component to oral examinations and other types of visits becomes predictable, inconsistencies are eliminated, and productivity guidelines can be adjusted to maximize visit productivity.

Dental programs that develop templates for progress notes facilitate efficient and complete documentation in conformity with the billing rules for Medicaid FQHC reimbursement. Well-organized and user-friendly CAMBRA treatment guideline tables in journals can be copied and laminated for easy reference. The American Dental Association, the American Academy of Pediatric Dentistry, and the California Dental Association, among other organizations, have posted noncopyrighted downloadable and reproducible caries risk assessment tools (CAT) on their websites that can be adapted to FQHC use.

CAMBRA protocols also function to define aspects of care that can be managed by nondentist team members. With training, and given sufficient time, dental assistants can maximally conduct portions of caries monitoring and self-management sessions within the scope of authorized duties in the state Dental Practice Act. In medicine, it is acknowledged that some aspects of chronic disease management may be performed better by nonphysician staff members if they possess special skills such as linguistic competency, cultural competency, teaching, and motivational interviewing techniques.[26] These skills can also be taught and with practice, they improve. Like the medical field, some aspects of caries chronic disease management may be better performed by dental assistants. The extent to which dental team members' cultural competence and sensitivity builds patient trust and rapport enhances favorable long-term outcomes.

Oral Health Initiative

Fiscal year (FY) 2009-10 marks the fifth year for the oral health initiative (OHI) of First 5 Commission of San Diego County. OHI addresses the oral health needs of young children 1-5 years and of pregnant women in San Diego County. FY 2009-10 is also the second year in which OHI has implemented the care coordination process — the caries risk assessment (CRA) — a national best practice. This method is administered to patients during oral health screenings or exams to assess their risk level for dental disease and other oral health problems. Those patients diagnosed as high risk with the CRA are coordinated to receive careful follow-up by care coordinators to guarantee thorough and seamless treatment.

In May 2010, the dental staff from OHI-funded clinics involved in the care coordination process were sur-

veyed to assess their opinions on the CRA's impact. A total of 15 dental staff consisting primarily of care coordinators, dental managers and administrative staff completed a survey.

Overall, respondents felt the use of the CRA brought positive changes to their clinics as shown in **FIGURE 1**. Results indicate that the CRA assists their clinics to identify and treat clients, contains all the appropriate domains to assess a client's risk level, and serves as a useful tool in the care coordination process by providing the appropriate services to meet patient needs. The single exception was when dental staff were asked whether they agreed that integrating the CRA into their clinic was an easy process; 28.5 percent stated they disagreed with that statement. Preliminary findings suggest that reasons for this dissonance may be a result of the additional paperwork and the need to remind dental staff to complete the CRA, as noted by several respondents.

Summary

There are many examples of how care plans incorporating CAMBRA result in positive benefits to patients as well as satisfaction to dental personnel. The hope for managing the burgeoning, vulnerable FQHC population with caries disease and containing the treatment costs is through a shift to effective prevention. FQHCs have varying organizational capacities. Each FQHC is encouraged to examine its unique workflow, resources and constraints to determine the most efficient way to integrate the CAMBRA approach into patient care. Despite the cost that is associated with all prevention, including CAMBRA, the long-term positive benefits make this a practice decision that needs to be adopted by all FQHCs with dental programs. ■■■■

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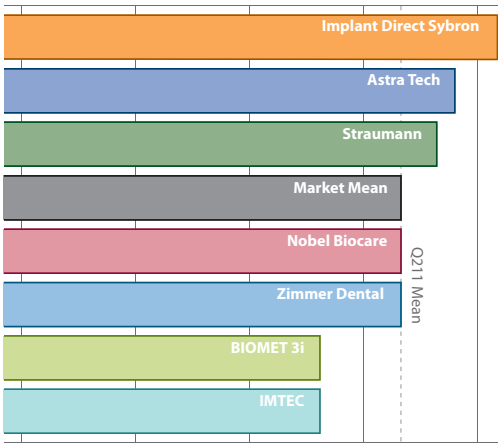

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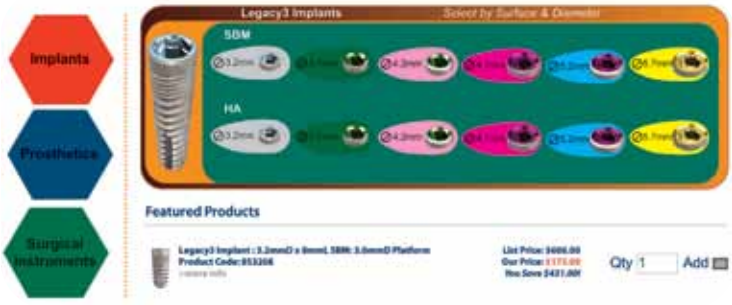

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This I Believe: A Reaction to CAMBRA and its Effects on Access to Care

STEVEN P. GEIERMANN, DDS

ABSTRACT This article suggests opportunities to incorporate new preventive paradigms, such as CAMBRA and motivational interviewing, into current pre-existing government and organizational programs and offers resources in order to increase access to care for those most in need.

AUTHORS

Steven P. Geiermann, DDS, is senior manager, Access, Community Oral Health Infrastructure and Capacity, Council on Access, Prevention and Interprofessional Relations, American Dental Association, in Chicago.

One of my favorite segments on National Public Radio is "This I Believe," which is based on the series made popular by Edward R. Murrow in the 1950s. Consider this my audition and your reaction.

Not so long ago, a new day was dawning. Health care reform had passed, sufficient funding to support its initiatives was only a pen stroke away, and access to good oral health care through prevention and treatment for the underserved was right around the corner.

Fast forward through the elections. Dark clouds not only gather on the horizon, they are here. The pendulum has swung from Mother Teresa seeing her God in the faces of the poor to Ebenezer Scrooge looking to decrease the surplus population. With a November shellacking and a strident call for more accountability and less government, the hope of securing appropriations to put flesh upon health care reform is fading. Medicaid budgets are stripped bare. Fiscal watchdogs are on the prowl. An emboldened House is calling for the repeal of health care reform. Here in California, your new/old governor is telling people to tighten their belts and get ready to make sacrifices. Dark clouds indeed ...

Yet, there is hope. Though challenged, I am encouraged. One door closes and another opens. Walk through and three others welcome you forward. Call it six degrees of separation, connecting the dots, or putting the pieces of the puzzle together. Regardless, it is building upon what already exists, what is already funded, and what is currently making a difference.

I believe one and one can equal three.

Whether it is moving dentistry to embrace a medical model of prevention across all lifecycles, using motivational interviewing to build patient trust and compliance, or generating sufficient advocacy to secure needed health care appropriations, the resources are here. For example, here are 12 pieces of the puzzle to illustrate these opportunities:

1. Consider $11 billion to expand health centers over the next five years to meet the needs of those populations most at risk with oral health as an integral part of an interdisciplinary approach to patient care. This is in addition to the 1,200 new access points funded during the last administration.

This is an opportunity to provide guidance and mentoring for the young dental directors and uninformed executive directors at these health centers, emphasizing quality outcomes and effectiveness. Health Resources and Services Administration's last guidance issued in March 1987 is no longer sufficient.

This is an opportunity to expand practice-based research networks. Convince HRSA to invest in CAMBRA pilots, validate the findings, adjust payment systems to reimbursement, and regulate it.

Demand sane expansions as two-chair clinics are not optimal. Insist upon adequate numbers of operatories and support staff.

2. HRSA is increasing its funding for school-based health centers. Many of the recommendations Dr. Milgrom suggested for 6-7 year olds could be implemented in these settings. Include screenings and supervised school toothbrushing in these settings. Could motivational interviewing and listening be part of regular parent-oral health professional group meetings that mirror or augment parent-teacher gatherings?

3. With an increasing acceptance of the Centers for Disease Control and American Dental Association's sealant guidelines, there is a growing realization of the importance of school-based sealant programs. Kudos to those programs that track kids to completion, utilizing both private practitioners and safety-net clinics as referrals.

4. There is a renewed HRSA, ACOG, and ADA effort to bring to the fore the importance of perinatal oral health. This collaboration seeks to educate both the public and providers by formulating national perinatal oral health guidelines that build upon five strategic priorities put forth by a 2008 Maternal and Child Health Bureau convened expert panel, while fully acknowledging the excellent work demonstrated within the New York and California state guidelines.

KUDOS TO THOSE programs that track kids to completion, utilizing both private practitioners and safety-net clinics as referrals.

Offer prevention at the right time for the right people. Something is not working when a mother brings in her fifth child with severe early childhood decay and there is oral health education documented with the previous children. What are the social determinants at work here?

If we expect others, such as midwives, OB-GYNs and pediatricians, to preach our prevention gospel, we must be prepared to preach theirs. With an electronic health record, oral health professionals should be advocating for immunizations and Pap smears.

5. There is a growing appreciation of the importance of health literacy and using social marketing to get the message out to the public in a manner that can be understood and embraced. I applaud HRSA's Maternal and Child Health Bureau for their use of "Text4Babies."

6. The National Health Service Corps has increased scholarship and loan repayment opportunities, including a part-time loan repayment option. New graduates can reduce their debt and practice as part of an interdisciplinary team, while building their own practice if they choose. If they decide to leave after finishing their obligation, health centers are not losing a provider; they are gaining a collaborator, an ally in the community. These young dentists now know that kids are not aliens and the elderly with multiple comorbidities are not to be feared. Their personal skill sets have been enhanced and they are now ambassadors promoting greater familiarity between dentists practicing in health centers and those in private practice.

7. Community-based dental education is becoming the norm thanks to the RWJF Dental Pipeline program and the additional work done in California. More students are exposed to high-risk populations as part of their training and many are introduced to the basic tenets of public health, especially the value of assessment. They begin to understand and appreciate that being a health professional means more than simply addressing the immediate needs of the person in the chair in front of them. It is being part of a community and addressing its needs as well.

8. Oral health coalitions are increasing in both numbers and effectiveness. Thanks to the CDC for funding 19 states with oral

health infrastructure grants encouraging diverse stakeholders to come to the table and finding common ground. Public/private collaboration is growing in support of the public health infrastructure. A recent survey of state dental societies found that more than 80 percent participated in their state oral health coalition and not simply in a watchdog capacity.

Organized dentistry and dental hygiene are at the table finding common ground. They should embrace CAMBRA and promote it.

9. More than 50 pediatricians recently completed chapter advocacy training on oral health (CATOOH) agreeing to coach their peers in their state about risk assessment, anticipatory guidance, and fluoride varnish. In advocating for a dental home for their patients, they are establishing referral networks to facilitate medical/dental collaboration. These advocates often ask their own dentist to "invite" them to present at the local dental society meeting. Once there, they share their enthusiasm, promote risk assessment within a medical model of intervention, and have their "ask" ready as they invite all present to be part of the solution to the problem at hand. It is about building sustainable medical and dental homes.

10. Not to be outdone by their pediatrician colleagues, the Society of Teachers of Family Medicine offers their "Smiles for Life" oral health modules to educate internal and external partners. Providers are training their medical and dental assistants to recognize what is "normal" and to utilize motivational interviewing to build credibility and trust with patients. These auxiliary staff members are our first line of offense and defense. They come from the community, already have connections, and they know how to listen before giving advice. Empower them and build upon their work.

11. Prevention starts at home but not necessarily in "our dental homes." Women, Infants and Children, Head Start, and senior citizen centers are ideal places to spread the oral health gospel, along with churches, beauty salons, and big-box stores. Be creative and equip those who are most likely to bear good fruit with the tools they need to evangelize. Partner with these community groups and practice motivational interviewing. Get their insights. They know their populations and what approaches are most likely to be acceptable and successful. Just as there are four gospels in the New Testament, each written for a different population and its particular needs, the oral health gospel, evidence, and best approaches may differ for different communities, yet there is always that fundamental element of truth.

COMMUNITY-BASED dental education is becoming the norm thanks to the RWJF Dental Pipeline program and the additional work done in California.

12. Coordination and communication are essential to connecting the dots. Case management makes a tremendous difference. Promotoras and community health workers enable patients to better navigate the health care system while bringing prevention home. Continuity of care is the goal. Risk assessment, a prevention emphasis and effective oral health education are fundamental elements. Timely and affordable access to quality care follows and completes the picture.

In conclusion:

- Connect your dots;
- Get your pieces of the puzzle on the table;
- Build upon what already exists;
- Utilize what is already funded;
- Make a difference;
- There is hope.
- I believe! ■■■■

TO REQUEST A PRINTED COPY OF THIS ARTICLE, PLEASE CONTACT Steven P. Geiermann, DDS, Access,Community Oral Health Infrastructure and Capacity, Council on Access, Prevention and Interprofessional Relations, American Dental Association, 211 E. Chicago Ave., Chicago, Ill., 60611.

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The Business of Prevention

RONALD INGE, DDS

ABSTRACT Providing good oral health care is the goal of both the dental profession and the dental benefits industry. Dentists are well-trained to provide appropriate care. Unfortunately, that training offers little insight into the business of delivering care. Dental benefits companies must invest heavily to create a structure that allows for appropriate care to be delivered.

AUTHORS

Ronald Inge, DDS, is vice president of Professional Services and dental director for Washington Dental Service in Seattle. He also is executive director for the Institute for Oral Health.

Dentistry takes pride in describing itself as a profession made up of both art and science. There is a third component that even though just as important as the art and the science receives far too little recognition of its contribution to the profession. That component is business. Without the business aspects of dentistry it can be argued that there would be no art or science.

The art of caries control has been defined by the beauty of a well-placed restoration. The science of caries control now tells us that a beautiful restoration is akin to placing a new roof on a house that is still on fire. But we continue to build our beautiful roofs on houses that continue to burn. Why? The reason is simple. Dentists get paid to fix teeth. They do not get paid to prevent the problem.

Therein lies the problem. What is the business case for prevention? Philosophically it makes good business sense to think that preventive services will prevent or at least reduce more costly services from occurring. That statement is good enough for dentistry but those who contract to pay for dental services need more than a philosophical statement. What is needed is a business case with a predictable return on investment (ROI). Or is it more than that? Let's explore an example of one company's attempt to build a business case around prevention.

Let's first start with the company, Washington Dental Service. A key ingredient is the company's history and mission. Washington Dental Service was one of the first dental benefits companies founded in 1954 to provide dental care to the children of the International Longshoremen and Warehouse Union members. Its mission statement is the "Washington Dental Service will revolutionize the oral health industry and improve overall health." Washington Dental Service has a history of innovation and leadership in the dental benefits industry. A few firsts by Washington Dental Service: (1) first to cover fluoride vanish as a standard benefit; (2) first to establish periodontal

guidelines to govern benefits; (3) first to cover implants as a standard dental benefit; and (4) first to cover antimicrobial rinse as a benefit for at-risk patients.

A foundational philosophy of Washington Dental Service is the science drives change. With this in mind, the executives at Washington Dental Service sponsored the Institute for Oral Health. The Institute for Oral Health was founded with a mission to advance oral health care by identifying effective and efficient guidelines for treatment, access, and delivery, and to promote best practices by serving as a central resource for shared practical knowledge and collaboration to benefit the dental profession and the public. For its inaugural conference the Institute for Oral Health chose "Early Childhood Dental Care" as its topic. The conference was highlighted by four prominent speakers. Dr. Burton Edelstein focused our attention on caries as a disease; Dr. John Featherstone explained the "caries balance" and the role bacteria plays in dental disease; Dr. Joel Berg spoke of innovations in caries detection and diagnosis; and Dr. Rob Compton introduced the concept of risk assessment in determining cost-efficient, effective care. The impact these four speakers had on the executives of Washington Dental Service caused them to immediately begin developing a dental benefits plan that incorporated elements from each speaker.

A concept was born, "The appropriate care for the appropriate patient at the appropriate time." This was such a revolutionary idea. It was so forward-thinking. It was prescient. Like all new dental benefits products or plans it now had a name – prescient. But the name prescient was already taken. So to make it unique, the marketing minds at Washington Dental Service changed the spelling to "Preshent."

How do you go from a concept to practical application? This truly was in keeping with the mission of Washington Dental Service to "revolutionize the dental benefits industry." Dental benefits based on the needs of the individual. This was a paradigm shift in the business model for a dental benefits company. Dental benefits have been based on group benefits. The predictability of a group influenced pricing, what type of benefits were covered, the utilization patterns expected. Everything was based on a group concept. Shifting to individual benefits created an increased level of uncertainty. Every familiar process had to be rethought.

A CONCEPT WAS BORN,

"The appropriate care for the appropriate patient at the appropriate time."

The first challenge to the business model was in the area of technology. The company had invested millions of dollars over the past five years in developing a system that was state-of-the-art for dental benefits. This system was coded to make a complex decision without input from a live person. It could handle information for millions of enrollees in the plan. It could automatically adjudicate millions of claims based on coded policies. All that had to change. The system would be required to capture data that it had never encountered before—an individual's risk of disease. Risk of disease had to be codified in the system. The new coding had to be mapped to the decision-making processes in the system. The decision-making processes had to be remapped to benefits based on the risk of disease. This was a very complex and complicated process, also very costly — about $500,000 in system development costs.

The foundational piece of this revolutionary idea was a risk assessment tool. There was a number of risk assessment tools designed for use in the dental office each having its own strengths and weaknesses. There was no accepted standard for risk assessment by the dental profession. So the company created its own risk assessment tool. The design of the tool had three basic principles:

1. Credibility;
2. Dentist user friendly; and
3. Data capture.

With the understanding that most dentists are skeptical of any actions taken by a dental benefits company, dental experts from a prominent university dental school were sought out to help develop the risk assessment tool. To be dentist user friendly, the tool could not be disruptive of the norm routine of a dental practice. For that reason the risk assessment was binary — either high or low risk. The tool itself consisted of only the most relevant risk indicators for caries and periodontal disease. The assessment tool was to be used as a guide for dentists to help them in their determination of a patient's risk for disease. In no way did the tool make the determination of risk. The determination of risk was left solely to the dentist.

The next challenge was communicating the patient's risk to the dental benefits company. A copy of the risk assessment tool was to be sent to the dental benefits company as an attachment either electronically or by mail. Based on the determination of risk by the dentist, the adjudication system would make benefits available to the patient for reimbursement under the patient's plan. The benefits af-

fected by the patient's risk of disease were limited to diagnostic and preventative benefits. These individualized benefits for diagnostic and preventative services were based on guidelines recommended by the dental profession. An example of one such benefit was coverage for four applications of fluoride varnish for an individual with a reported high risk for caries.

Due to the absence of diagnostic codes, a determination of high or low risk had to be codified for delivery and recognition by the dental benefits company. Since the tool dealt with risk factors for only two diseases, caries and periodontal disease and the risk could only be high or low, there were only four possible combinations of risk for the two diseases. So for simplification, each combination was assigned a number from 1 to 4. This codification was placed as a legend on the assessment tool. Dentists were instructed to place the appropriate number corresponding to the patient's risk in the narrative field on the American Dental Association claim form. As an example, a patient with a low risk for caries and a low risk for periodontal disease would have an assessment code of "1." A patient with a high risk for caries and a high risk for periodontal disease would have an assessment code of "4."

The claim adjudication system for the dental benefits company was enhanced to recognize each number and activate the appropriate corresponding benefit set for the patient. The adjudication system would also initiate a reimbursement to the dentist for providing the risk information. Both the risk level and a copy of the information from the risk assessment tool were captured and stored in a data warehouse for future analysis.

With a process now in place, the next challenge would be to communicate the process to the dental community. First, dentists were in need of a foundational understanding of risk of dental disease. To accomplish this, the dental experts from University of Washington School of Dentistry developed a full-day seminar on the risk for caries and the risk for periodontal disease. The dental benefits company sponsored several sessions across the state offering a full day of continuing-education credits at no charge to the dentists. The sessions were well-attended. The information from the sessions was also made available to dentists online.

IT WAS EASY
to accept that high-risk patients needed more care but it was not acceptable that low-risk patients needed less care.

The next hurdle to clear was the business part of the equation. The first challenge was the sales force for the dental benefits company. Since this was such a revolutionary product, no one seemed to know just where it fit. Was it a limited network of dentists that attended the seminars? If so, then it would never sell because employers want more choices. It was determined the Preshent product would be a subset of the company's PPO product offering. From a business standpoint it allowed the company to price the new product in a similar fashion to its other PPO products. It is important to note that any savings from this new product would not materialize for a number of years. So, without the promise of savings to an employer, selling the new product did not look good. The other challenge to selling the product was that it was somewhat difficult to explain. Employers and the brokers and consultants who represent employers were not familiar with individualized benefits based on individual need. It was easy to accept that high-risk patients needed more care but it was not acceptable that low-risk patients needed less care.

Dental benefits have become an entitlement in our current fee-for-service environment. It was seen as a take-away not to provide a second cleaning to a patient who was at low risk for disease. The elevator pitch for Preshent was, "the appropriate service for the appropriate patient at the appropriate time."

What was needed was a proof of concept. What was needed was the "right" employer to pilot this new plan. The right employer was one that was truly concerned about the health of its employees and the appropriateness of their benefit utilization. The obvious first choice was the dental benefits company. If the dental benefits company would not offer this new product to its own employees how could they expect another employer to offer the product? A large government employer that had launched a wellness program that included a health assessment chose to offer the new product and pay the additional cost for the risk assessment.

It seemed that dentistry was on the verge of a major shift in how treatment as well as benefits would be provided to patients. It seemed that the interest of the patient, the dentist, the dental benefits company and the employer were in alignment.

So what happened? The key to the success of this concept was the dentists. Even though many supported the concept in theory, it was a different story in practice. Dentists pushed back saying they did not

want to be responsible for what benefits a patient was going to receive. It was fine when the conversation was with high-risk patients and the dentist explained that additional benefits were available. The difficulty came with the low-risk patients. Even though many dentists claimed to schedule recall appointments based on need, they found it a very difficult conversation to tell a patient they did not need to return for another 12 months. Without the support of the dental community, what had such potential for change became another failed attempt at change.

In hindsight, too few of the critical stakeholders embraced the change. Even though the dental benefits company invested time, money, and resources that alone was not enough to overcome the traditional notion of how dental benefits are delivered. Even though risk for dental disease is taught in dental schools and seminars across the country, it was not enough to overcome the dental professions traditional view for the delivery of dental services. ■■■■

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The Evolving Role of Insurance Carriers in Caries Prevention in Children

JOHN R. LUTHER, DDS, AND MICHAEL D. WEITZNER, DMD, MS

ABSTRACT This article suggests opportunities to incorporate new preventive paradigms, such as CAMBRA and motivational interviewing, into current pre-existing government and organizational programs and offers resources in order to increase access to care for those most in need.

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Today, approximately 54 percent of the total population has access to dental health benefits through private and public benefit programs and those with benefits are significantly more likely to access dental care than those without.[1] Although access, the ability to obtain and utilize dental benefits, is critical, the benefits to which patients have access must be appropriate to meet individual patient needs, keeping pace with scientific and technological advancements. We are experiencing a paradigm shift from a surgical, procedure-based dental care model that primarily manages the downstream impact of disease through restoration of irreversibly damaged teeth, to one focused on the identification of individual patient's risk for disease and the management of disease itself. As evidence based guidelines continue to be introduced, Dentists will see their primary role evolve from detecting existing carious lesions and restoring teeth to managing oral diseases before they cause irreversible damage and prescribing preventive treatments for those diseases.

Carriers must also keep pace, by playing an integral role in developing benefits appropriate to the new model and then appropriately administer financial resources that align incentives. The importance of developing strategies that encourage prevention and early intervention to improve population outcomes and control costs cannot be underestimated.

To maximize their contribution, carriers must expand their role of simply administering benefits for dental procedures to one in which they partner with dentists, physicians, and other key stake-

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holders to take a more active role in the management of patient's total health and wellness, with an emphasis on education, prevention, and early intervention Carriers are in a unique position to identify at-risk populations, provide outreach to caregivers and patients, coordinate disease management and wellness programs, and collect and analyze medical and dental data used to improve outcomes.

For a paradigm shift of this magnitude to occur, all of the key stakeholders will have to collaborate. Although insurance carriers play a key role in dental benefit plan design and administration, benefit decisions are not made solely by insurance carriers but depend on the support and interrelationships of multiple players, including health care professionals, consumers, patients, caregivers (i.e., parents and others who take care of children), employers, and state and federal government. Plan design features, including benefit selection, plan limitations and exclusions, and even the degree of oversight, are determined by a complex interrelationship between all of these stakeholders and are influenced by many factors such as group demographics, geography, and the degree to which employees are responsible for premiums.

In this paper, the authors will explore how dental benefits are currently determined and their basis for reimbursement. There also will be discussion on the carrier's evolving role in supporting the paradigm shift from a surgical, procedure-based reimbursement model to a risk-based, patient-centered model focused on disease prevention.

How Are Dental Benefits Determined and What Is the Basis for Reimbursement?

Dental benefit determination, plan design, and reimbursement are integrally linked. All are developed to create a value proposition for the customer by improving quality and outcomes while, at the same time, reducing costs. Taking a long-term perspective, utilizing the caries management by risk assessment (CAMBRA) approach accomplishes both objectives. In this section, the authors will briefly outline the current environment before moving on to describe the opportunities dental insurance carriers have to promote caries prevention, while acknowledging the short- and long-term gaps.

Historically, dental benefits have been chosen for inclusion in a benefit package based primarily on employee preference, cost, historic norms, customer desires, administrative ease, and competitive intelligence. Additionally, plans have traditionally relied on group underwriting with little reliance on individual risk assessment. Consequently, benefit packages tend to be one-size-fits-all, failing to support a strategy of focused attention on high-risk individuals. Due to limited availability of evidence-based guidelines and the absence of universally accepted diagnostic codes and quality measures, it has been difficult to unify standards and best practices across the industry. Consequently, benefit selection and frequency limitation have been based primarily on tradition, experience, and cost-control considerations.

BENEFIT PACKAGES tend to be one-size-fits-all, failing to support a strategy of focused attention on high-risk individuals.

The value proposition of any plan design has traditionally reflected the tension between the inclusion of richer benefits, including newer technologies, and cost-effectiveness. The value of any benefit package, i.e., insurance product, must then be sold to plan purchasers, including employers, individuals, and government in a competitive environment.

Reliance on CDT Codes

Understanding the current world of dental benefits and how these might evolve to support the principles of new paradigms such as CAMBRA also requires an awareness of coding (with all of its complex and sometimes confusing nomenclature), and how it supports the dental plan structure. It should be noted that all covered benefits included in any plan design must be selected from the code as published in the most current version of American Dental Association's dental reference manual, *Current Dental Terminology*. Federal regulations and legislation from the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all payers to accept HIPAA standard electronic transactions, including dental claims. One data element on the electronic dental claim format is the dental procedure code that must be from the CDT.[2]

The procedure codes, as incorporated into the CDT, are maintained by the Code Revision Committee (CRC). Any changes, including additions, modifications, and deletions must go through the CRC's review process and be approved/disapproved for acceptance based on a majority/supermajority vote. The CRC is comprised of equal representation by carrier representatives and organized dentistry.

Diagnostic Codes

Although dental billing systems are almost entirely designed around dental procedures codes, no diagnostic code set has been established as a standard in the United States. Lack of universally

accepted diagnostic codes restricts carriers and researchers access to information relative to the patient's clinical condition. Although diagnostic information is often recorded by the dentist in the treatment record, that same information must be standardized and codified to be easily used by the dental benefits industry. The introduction and universal acceptance of a robust diagnostic code set has the potential to allow clinicians and researchers to track and compare clinical outcomes, demonstrate effectiveness in individuals and populations, track oral health status over time, and to more easily identify and treat high-risk groups.

As risk-based clinical guidelines become available, diagnostic codes could facilitate the linking of the patient's clinical condition, risk category, and treatment with outcomes assessment. Thus, with the introduction of diagnostic codes, CAMBRA's value proposition could more easily be proven to stakeholders, including plan purchasers. Specific to CAMBRA, the precise diagnostic classification of cavitated and noncavitated lesions must be included in whichever diagnostic code set is chosen for widespread use.

One such diagnostic code set is the ADA's *Systematic Nomenclature of Dentistry* (SNODENT), which the ADA has been working to update for the last several years to be interoperable with ICD-9 (*International Classification of Diseases,* ninth revision) and support dental procedures codes. To date, there has been no release of SNODENT for general use today, most dental procedure codes are submitted for authorization or payment without a supporting diagnosis. To fully support disease management by risk assessment, a robust caries classification system must be available to enhance clinical documentation of disease status and to allow identification of risk status.

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Evidence-Based Guidelines

Carriers look to evidence-based guidelines and best-available scientific evidence as a basis for sound benefit decisions. True evidence-based guidelines, however, are in short supply. Evidence-based guidelines are also sometimes slow to be adopted in clinical practice due to resistance by some who see their introduction as the first step into "cookbook dentistry" and the loss of autonomy by individual dentists and patients.

Nevertheless, organized dentistry has taken a leading role in promoting evidence-based dentistry and in the development of specific evidence-based recommendations. This has been done by balancing clinically relevant scientific evidence "with the dentist's clinical expertise and the patient's treatment needs and preferences."[3] Evidence-based guidelines incorporate individual risk assessment components into the decision-making process. It should be noted that the radiographic guidelines were the first widely accepted guidelines to incorporate individual risk assessment into treatment recommendations.

In addition to radiographic guidelines for which they have always taken a leading role, the ADA recently published evidence-based clinical recommendations on topical fluoride, pit and fissure sealants, and oral squamous cell carcinoma screening. Specialty organizations such as the AAP, AAPD, and AAOMS have also researched and published evidence-based guidelines. Specialty guidelines, such as those published by the AAP, are also increasingly risk-based, Additional evidence-based reviews can be accessed through organizations such as the Cochrane Oral Health Group and National Guideline Clearinghouse, but, unfortunately, many of these reviews do not provide definitive guidance to clinicians due to a lack of strong evidence.

Evidence-based guidelines, as they become available, are increasingly being considered in plan design, new clinical product development, claims and utilization criteria, and underwriting guidelines. Evidence is slowly evolving to facilitate a better understanding of the oral-systemic relationship and serves as the foundation for clinical innovations in disease management and wellness programs, including the management of early childhood caries.

EVIDENCE-BASED guidelines all incorporate individual risk assessment components into the decision-making process.

Risk Assessment in Plan Design

As noted, evidence-based guidelines incorporate individual risk assessment in the determination of treatment needs. Yet, most plan designs do not currently build effective individual risk assessment tools into the determination process, but rely on the one-size-fits-all approach to benefit administration. This is primarily due to administrative complexities (such as reliance on group underwriting), an inability to collect information related to patient risk, challenges in defining risk and determining specific criteria, and inertia due to an inability to prove value, either in terms of increased quality or decreased cost. Additional impediments include the potential reluctance of individuals to provide information for fear of being labeled "costly," as well as concerns that any benefit changes made will be perceived as a reduction in benefits.

Nevertheless, these challenges are not insurmountable. UnitedHealthcare Dental is participating, through the California Dental Association, in the CAMBRA Practice-Based Research Network (PBRN), which is looking at the use of CAMBRA principles in the private practice setting. This includes understanding how dentists can incorporate risk assessment in private practice and recognizing the potential barriers.

Cost

Procedure-based historic norms and emerging evidence-based guidelines are not the only drivers in plan design. Dental benefit purchasers are also looking for value by offering adequate benefits at reduced cost to employees, while further looking to lower cost of care by keeping employees healthy through disease management and wellness initiatives. In the current economy, it is fair to say that cost is the primary driver in benefit design. Employers and plan purchasers are often reluctant to change benefit offerings without evidence that costs will be reduced and employee health will be maintained or improved.

As medical costs escalate, government, employers and individuals are continually looking for ways to reduce health care expenses; although, it is important to maintain tight control of administrative cost, the great majority of dollars go to provider payments for services rendered. Savings in plan design is most easily achieved by reducing the cost of care that can be achieved by decreasing the number and frequency of benefits, shifting costs to employees, managing fraud, waste and abuse, and shifting care from complex restorative treatment to prevention and early intervention. Over time, it is in the areas of

prevention and early intervention that carriers should see a win-win situation in the adoption of the new preventive model. Not only should emphasis on prevention and early intervention lead to improved outcomes, but it should also lead to reduced cost. One model conservatively estimates a 7.3 percent savings from screening and early intervention. The model suggests that not only should effective treatment of early childhood caries lead to decreased dental cost, it should also significantly reduce medical costs by keeping children out of the operating room and emergency room.[4]

Carriers also look to provide value to their customers to avoid commoditization. The desire to provide added value leads to innovation in utilization management, patient and provider education, administrative simplification, prompt payment, as well as clinical programs involving disease management and wellness, all in an effort to grab a larger share of a shrinking employee pool. To stay one step ahead carriers also utilize marketplace intelligence to remain competitive.

PPACA

In the near future, benefit design will also be significantly impacted by recent health reform legislation, also known as PPACA (the Patient Protection and Affordable Care Act). Under PPACA, small businesses and individuals without access to viable health insurance options will be able to purchase them through insurance exchanges run by the states. Plans will include specific essential benefits that include dental benefits for children. The extent of those children's dental benefits has not been determined.

In addition to the essential benefit package, PPACA contains numerous provisions regarding prevention, education, demonstration projects for wellness and disease management and increases in the dental workforce designed to improve access. Disease management and wellness incentives in particular, could further drive innovation as described earlier, giving benefit companies further opportunity to differentiate themselves and to positively impact the health of the populations they serve.

What is the Carrier's Role in Caries Prevention?

Ultimately, the role of carriers must expand from administering cost-effective, procedure-based benefits to ensuring the health and wellness of its covered populations. This will require the development of strategies that focus on risk-based, patient-centered health care, based on measurable outcomes. Successful management will require that provider incentives are aligned with the new model and that clinicians are adequately compensated for providing care based on prevention and disease management using both nonsurgical and surgical approaches.

Until such time as plan design can fully incorporate these principles, benefit companies, including UnitedHealthcare Dental, are actively involved in disease management and wellness initiatives within the confines of the existing benefit structure. Disease management pro-

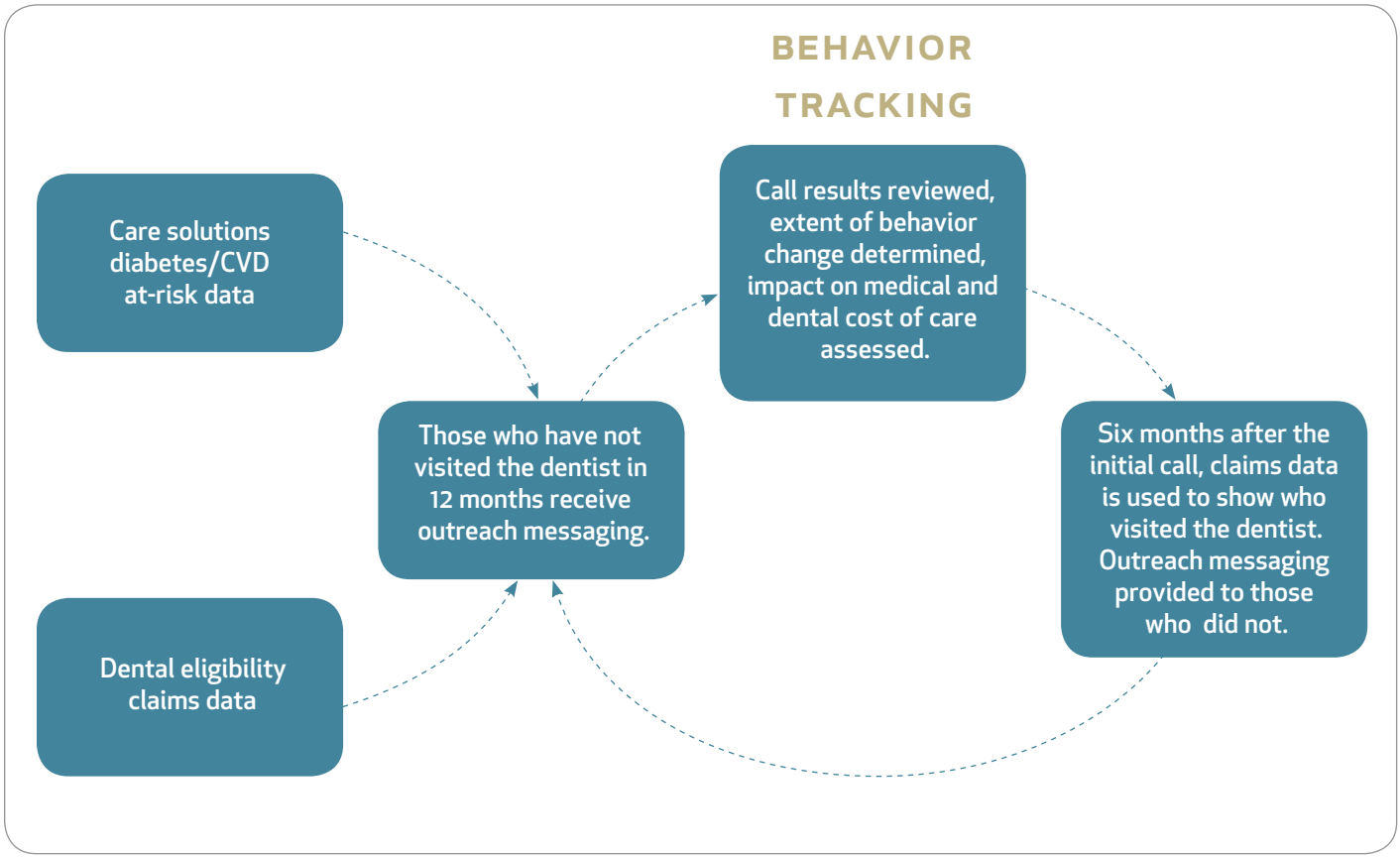

FIGURE 1. UnitedHealthcare Medical-Dental Integration Program.

grams typically involve a level of dental and medical data integration and have been commonly associated with programs linking periodontal disease and systemic conditions such as diabetes and cardiovascular disease. For instance, at UnitedHealthcare, patients with diabetes and cardiovascular disease who have not seen a dentist in the previous 12 months are identified. These members are given information on the link between oral and overall health, and, through a series of questions, are encouraged to visit their dentist for follow-up. The objective is to change member behavior and improve health outcomes. Those who do not follow-up receive additional outreach, claims are then monitored and the message adjusted to improve engagement (**FIGURE 1**).

In addition to disease management programs focusing on periodontal diseases, there is increasing emphasis on strategies addressing early childhood caries (ECC). In addition to simply developing and administering dental benefits, carriers are identifying at-risk populations, providing outreach to caregivers and patients, participating in the dissemination of provider and patient education, and helping direct patients to health homes.

Regardless of their specific focus, disease management programs sponsored by dental carriers can be instrumental in translating science into practice. To achieve optimum results, programs must be developed and continually refined based on best available scientific evidence. Additionally, carriers can benefit by developing strong partnerships with academia to further their understanding of existing research, to help develop educational materials for clinicians (both dentists and physicians) and patients and to validate outcomes.

Carriers also have a unique opportunity to disseminate educational materials and develop communication strategies to help give at-risk patients and their caregivers the tools they need to better manage their own health, and to positively impact behavior through better hygiene, improved nutrition, and appropriate professional care. UHC Dental is developing and implementing a variety of strategies, using written educational material, the web and interactive voice recognition, (IVR), to provide messaging on the etiology of early childhood caries (including the role of mothers and other primary caregivers in transmitting the disease) and specific strategies for prevention and treatment.

Health care professional education and communication are also extremely important. Though dentists are educated in caries etiology and treatment,

benefits companies are in a position to share information on the latest research and treatment recommendations. UHC Dental regularly reaches out to dentists through its provider newsletter and website. Physicians, since they are the first to treat very young patients, are also increasingly targeted to apply fluoride varnish, conduct simple dental screenings and risk assessments, and make appropriate referrals to a dental home. Carriers can be instrumental in the coordination of activities to train physicians to apply fluoride varnish, reimburse physicians for the application of fluoride varnish, and to direct the patient to a dental home.

Insurance carriers are well-equipped to effectively reach large patient populations by providing both general and targeted outreach. General outreach can provide the larger population with information on caries prevention and treatment (as well as other vital messaging on oral health including the links between periodontal disease and overall health, the importance of oral cancer screening, etc.). UHC Dental has utilized the web and other strategies in providing its general population with oral health messaging including caries prevention and child wellness.

Carriers with access to both medical and dental patient information can specifically target at-risk patient populations to provide more focused communication, for example, targeting pregnant mothers with information on the importance of good oral health during pregnancy, including the potential risks of transmitting caries causing bacteria to their infants.

Finally, program success is dependent upon outcome measurement. Data analysis is vital in seeking to define best practices, and demonstrate value through improved clinical outcomes (increased frequency of prevention, decreased frequency of complex restorative care as well as endodontics, oral surgery, and anesthesia as they relate to caries), and lower costs (lower dental costs as well as medical costs in the form of decreased use of operating rooms, emergency rooms etc.). As stated earlier, outcomes measurements, particularly clinical, could be greatly enhanced if a standardized diagnostic code set was available. As the value of disease management is demonstrated through outcomes analysis, the trend toward the new paradigm will be accelerated.

THROUGH EARLY
identification of at-risk children, referral, and rigorous management, we can help those children avoid a lifetime of disease.

Disease Management and Early Childhood Caries

Disease management strategies can be applied to ECC programs. The goal of managing early childhood caries is to move beyond the historical model of surgically treating the damage caused by caries, to treating caries as a disease through prevention, early detection, and conservative treatment. In order to accomplish this, programs need to be structured to first identify children at risk through screening (both children and their caregivers) including risk assessment, member education, and outreach. Secondly, to get that child into a dental home, be it a private dental office, health center, school-based setting, or hospital outpatient clinic. Thirdly, to treat that child through a combination of rigorous prevention, nonsurgical treatment, and minimally invasive restorative care; and, finally, to engage in long-term maintenance.

Through early identification of at-risk children, referral, and rigorous management, we can help those children avoid a lifetime of disease. Additionally, there is a significant cost impact, not only in reduced dental care but lower medical costs through reductions in operating room and emergency room expenses.

It is well-known that ECC takes its greatest toll on children in disadvantaged populations, many of whom participate in government programs. UHC Dental is focusing attention on developing programs in those states in which they participate in Medicaid and/or CHIP. UHC is also looking to build relationships with nonprofit groups, industry partners, and organized dentistry, in an effort to develop demonstration projects where innovative approaches to reaching those in need can be developed and implemented.

In one of these programs, UHC Dental, in partnership with its sister company UnitedHealthcare Community Plans (formerly AmeriChoice) and New York University College of Dentistry, has recently developed an ECC program intended to meet the requirements of Take Care New York, a new quality improvement mandate requiring managed care companies participating in government programs to increase dental visit rates among children and adolescents aged younger than 21, and pregnant women enrolled in the plan, to promote the establishment of dental homes, (i.e., sources of regular dental care) for these members and increase the application of fluoride varnish by primary care physicians (PCP) among children aged younger than age 7. NYU serves as a referral "center of excellence" as well as a resource for educating both dentists and physicians on the

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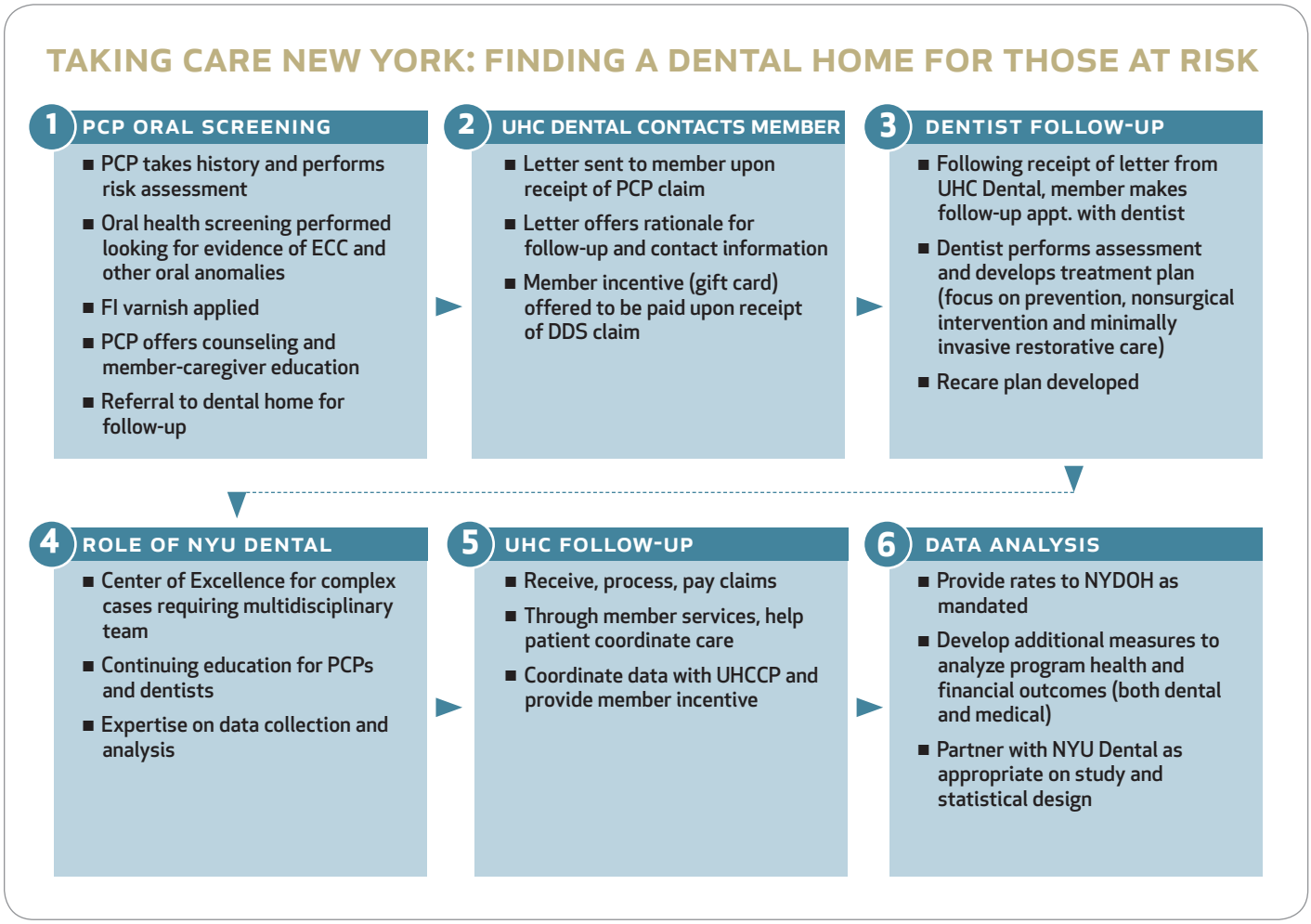

FIGURE 2. UnitedHealthcare Early Childhood Caries Program for New York.

importance of early prevention, referral and treatment in early childhood caries.

Specific goals are to improve dental care for children and their caregivers enrolled in the plan, increase the rate of fluoride varnish application by PCPs, educate PCPs on the importance of dental risk assessment, referral to a dental home, application of fluoride varnish, develop member education, outreach and facilitation, offer PCP incentives for members to obtain dental care and apply fluoride varnish, and finally develop process and outcome measures including rates of fluoride varnish application. Although community physicians and dentists will be utilized, UHC will also partner with NYU to treat more complex cases, help to provide provider education, and to help with data collection and analysis (FIGURE 2).

Coordinated with the well-baby exam, a participating PCP will perform a simple oral health screening looking for ECC and other oral health concerns. The primary care physician will apply fluoride varnish, provide dental counseling, and refer the child to a dentist for follow-up. UHC Dental then contacts the child's caregiver by mail reinforcing the need for a follow-up by a dentist, providing information concerning how to locate dentists near the patient's home, and an incentive for visiting the dentist. The dentist is able to establish a relationship with the patient at a very young age and provide appropriate treatment and maintenance. UHC will aid in the coordination of care between patient, dentist and physician, help ensure follow-up, manage claims and patient incentives, and perform follow-up data analysis.

Data analysis will initially focus on the metrics established by the TKNY initiative, such as how many children are visiting the physician, how many are getting fluoride treatments, the rates of follow-up visits to dentists, and dental disease rates (using procedure codes as proxies for outcome measurement). Ultimately, there will be a focus on health improvement as well as cost savings, both dental and medical.

Cooperative programs such as the one just described are a step toward more pa-

tient-centered, prevention-oriented care.

Carriers are increasingly utilizing best evidence, identifying and reaching out to at-risk populations, developing disease management and wellness strategies, and communicating more effectively with patients and clinicians. Nevertheless, there are still gaps, in promoting utilization of efficacious diagnostic tools, aligning incentives, measuring outcomes and most importantly, building individual risk assessment into plan design.

Although innovative disease management programs are having a growing impact, they continue to supplement more traditional existing benefit models and are slow to replace them. A more significant shift from the current procedure-based model to a patient-focused, preventive model will require collaboration by medical and dental practitioners, organized dentistry, academia, government, not-for-profits and the benefits industry to change the focus (and the incentives) from treating cavities to treating caries. Despite the challenges, the prospect of eradicating dental caries presents a real opportunity to improve the lives of children and future generations. ■■■■

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Federal Policy-Making in Support of CAMBRA Implementation

BURTON L. EDELSTEIN, DDS, MPH

ABSTRACT For caries management by risk assessment to become broadly institutionalized in practice, dental professionals need to be trained, the public needs to be informed, research needs to develop and test best practices, payment incentives need to be aligned, health informatics systems need to be developed, and integrated, accountable systems of care need to be advanced. This contribution details how recent federal and state governmental actions support these advances through legislation, regulation, and program administration.

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Caries management by risk assessment (CAMBRA) seeks to change caries management from the currently predominant one-size-fits-all approach (e.g., every patient followed for "preventive care" every six months) to individualized risk-based care that focuses on controlling caries risk factors. Among the many agents that can drive such progressive change are the health professions, insurers, foundations, educators, researchers, advocates, and government. Each holds specific opportunities and unique clout. Yet, among these players, government is most potent as it serves many functions and can influence each of the other agents.

Governmental influence is exercised through licensure, law, regulation, and taxation; through financing of research, education, and direct delivery programs; and through direct payments to medical and dental providers under government employee plans, active-duty military insurance, Medicaid, Children's Health Insurance Program, and Medicare. Under health reform, the federal government also regulates an "essential benefits package" that must be provided by private insurance offered through purchasing "exchanges." This package, which eventually mandates "pediatric services, including oral care," in all individual and small group health plans, provides an ideal opportunity to promote a progressive dental benefit design.[1] Additionally, government, by way of its judicial functions, plays the role of arbiter — a role critical to dealing with change.

This article considers a subset of these governmental roles as they relate specifically to various federal supports for

FIGURE 1. Action steps identified by the U.S. Surgeon General's Workshop on Children and Oral Health to improve the oral health of children, Washington, D.C., 2000.

caries management — and by extension, CAMBRA — in children. Children are highlighted because they are universally regarded as vulnerable and therefore in need of the special protections offered by government. Historically, federal policy-making has been scant on adult oral health care as evidenced by the lack of mandatory dental coverage in Medicaid, exclusion of dental coverage in Medicare, and optional inclusion of dental services (other than limited prevention services) in federally sponsored safety-net facilities.

The federal government has at its disposal a variety of means to address oral health and dental care. The administration manages a host of dental initiatives, direct service programs, grants, and surveillance activities across its departments of Health and Human Services, Defense, Veterans Administration, and Justice (through the Bureau of Prisons).[2] Most such programs are either administered by states or by nonprofit grantees or contractors. Others are direct federal-to-local programs like Head Start and federally qualified health centers (FQHCs). Each such executive branch action begins as a congressional authorization and appropriation of funding. In addition, Congress conducts oversight hearings on oral health and dental care, conducts investigations either by its own committees or by the Government Accountability Office (GAO), and establishes commissions, like the Medicaid and CHIP Payment and Access Commission (MACPAC) to assist it in formulating policy.

Principles of caries management articulated by CAMBRA and by guidelines of the American Academy of Pediatric Dentistry include (1) addressing the caries disease process that leads to cavities separately from the repair of cavities; (2) initiating preventive care and disease management early in life; and (3) tailoring the intensity of intervention to the risk-level of each individual patient.[3,4] Ensuring that these principles guide actual clinical practice requires that dental personnel be trained to provide them, that payment systems incentivize their delivery, that the public is aware of this approach and accepting of it, that programs targeting the youngest and most at-risk children incorporate oral health, and that larger tangential systems impacting health and health care are leveraged. Such tangential systems include government-sponsored primary medical care, medical insurance, medical training, social services, home visitation programs, nutrition programs, early education programs, and early inter-

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vention programs. A model for integrating these various "moving pieces" to advance children's oral health was developed by the Surgeon General's Workshop on Children and Oral Health (**FIGURE 1**).

Federal Legislation Supportive of CAMBRA

CAMBRA principles and their support systems have been well-incorporated into major federal legislation starting with the 2002 Healthcare Safety Net Amendments to the Social Security Act and continuing through passage of the Child Health Insurance Reauthorization Act of 2009 and the Patient Protection and Affordable Care Act (aka "health reform") in 2010.[1,5,6]

The 2002 law, developed by senators Collins (R-ME) and Feingold (D-WI) authorizes "Grants to States to Support Oral Health Workforce Activities" program to pursue one of 13 specified activities including expanding dental residency training, delivering distance continuing dental education, supporting teledentistry, and offering community-based preventive services. Since initial funding in 2006, the funding agency reports that 24 states supported distance learning and continuing education, some of which focused on education on prevention and disease management. Thirty-two states elected to provide community-based prevention services including development of public education websites. These grants, which require partial matching with state dollars, are competed annually pending congressional appropriations and allow three-year project periods. This program offers CAMBRA advocates the opportunity to partner with states in promoting concepts of caries management.

The 2009 Children's Health Insurance Program Reauthorization Act, builds on and corrects many deficits in the original 1997 State Children's Health Insurance Program (SCHIP) with regard to children's oral health by 1) mandating dental benefits that are reasonably comprehensive and are at least equivalent to benchmark plans; 2) authorizing states to offer dental coverage to income-eligible children who have medical but no dental insurance; 3) requiring performance reporting on preventive services including sealants and other dental services; 4) developing quality measures pertinent to children's oral health services; 5) expanding access to private dental offices for people who seek primary care in health centers; 6) providing consumers with a description of the dental services provided under the plan; 7) establishing the Medicaid and CHIP Payment and Access Commission (MACPAC) that must include at least one dental expert; and 8) providing new parent education on early childhood caries risk and prevention.[7,8]

THIRTY-TWO STATES elected to provide community-based prevention services including development of public education websites.

A closer look at these provisions, suggests a number of specific opportunities to leverage the law in favor of CAMBRA-principled interventions. These include:

- The benefit: The law states that the dental coverage must include coverage for services "necessary to prevent disease and promote oral health." CAMBRA advocates can influence states to design their dental coverage in ways that institutionalize and incentivize principles of individualized, risk-based, evidence-supported care.
- Preventive care accountability: The law requires that states report to the federal government "For children within each … age grouping, information [on] … the number of enrolled … children who receive any, preventive, or restorative dental care." This expanded level of oversight provides advocates the opportunity to highlight the importance of CAMBRA principles in promoting preventive and disease-management services.
- Sealant tracking: The law specifies that states must report "for the age grouping that includes children 8 years of age, the number of such children who have received a protective sealant on at least one permanent molar tooth." As sealants are a mainstay of prevention and consistent with CAMBRA philosophy, this enhanced level of federal oversight can similarly be leveraged by advocates.
- Quality initiative: The law requires federal reports on quality measures that build on "identifying gaps in existing pediatric quality measures and establishing priorities for development and advancement of such measures" and that include "status of efforts to improve dental care." Differences between current one-size-fits-all preventive practice and CAMBRA approaches to disease management represent such a "gap" for which CAMBRA advocates can develop and promote new quality measures and respond to the call for improvements in dental care.
- New parent education: This is perhaps the single strongest provision for advancing CAMBRA's value for early intervention and risk-based care. After a plan is developed by the Secretary of Health and Human Services, payers of birth services to Medicaid and CHIP beneficiaries (about 40 percent of current U.S. births) will be required to provide "oral health educational materials that inform new parents about risks for,

and the prevention of, early childhood caries and the need for a dental visit within their newborn's first year of life."

- Public-private contracting: This provision allows patients of FQHCs, including those covered by Medicaid, to obtain their dental services from private practice dentists, whether or not those dentists are Medicaid providers. CAMBRA-affiliated dentists in private practice who contract with FQHCs are well-poised to provide risk-based disease management services to such patients.
- MACPAC: Early in its work, MACPAC identified shortcomings in Medicaid and CHIP dental care as a problem worthy of its attention.[9] The legislation charges MACPAC to examine "Medicaid and CHIP payment policies and interaction of Medicaid and CHIP ... with health care delivery generally." As MACPAC considers improvements in these programs, it can be encouraged by CAMBRA advocates (through a public input process) to promote progressive science-based interventions that hold potential to improve oral health outcomes at lower costs.

Passage of health reform in 2010 as the Patient Protection and Affordable Care Act (PPACA) further advanced pediatric oral health reforms and expansions, providing additional opportunities to advance CAMBRA principles of practice. Most directly related to CAMBRA, the law authorizes a national grant program to "demonstrate the effectiveness of research-based dental caries disease management." This program, to be administered by the Centers for Disease Control and Prevention (CDC), allows such demonstrations to be conducted by a very wide range of entities including health centers, health departments, Indian Tribal Organizations, publicly owned hospitals, dental schools, and for-profit and nonprofit agencies. The goal of this demonstration program is to facilitate translation of science to practice while discovering and validating approaches that work on the ground. This provision recognizes that in modern evidence-based caries management is an emerging practice, that the scientific base for caries management is already well-established but that the practice is not now widespread.

Other provisions seek to prepare practitioners and the public alike to accept and engage in caries management practices. To prepare clinicians, the Title VII Health Professions Training Program, which is reauthorized by PPACA, includes a new authorization that allows the program to engage an entity "to provide technical assistance to pediatric training programs in developing and implementing instruction regarding ... risk-based clinical disease management of all pediatric populations with an emphasis on underserved children." To prepare the public, the law authorizes a five-year "oral health public education campaign" through the CDC. That campaign, to be constructed during a two-year planning period and to be targeted to specified high-risk populations, is to "utilize science-based strategies to convey oral health prevention messages" to the public.

THE GOAL OF THIS demonstration program is to facilitate translation of science to practice while discovering and validating approaches that work on the ground.

The single greatest opportunity that PPACA provides to CAMBRA advocates is a redesign of the pediatric dental benefit to feature individualized risk-based care that is focused on prevention. All health insurance to be sold to the uninsured and those in small group plans through the exchanges must provide, at a minimum, for coverage of an "essential benefits package." That package includes "oral health care" within the larger context of "pediatric services." Thus, dental services are conceived as a subset of pediatric services that are intrinsically variable according to children's unique needs while being consistent with overall pediatric health care guidance outlined in the *Bright Futures: Prevention and Health Promotion for Infants, Children, Adolescents, and their Families* and American Academy of Pediatrics guidelines. Indeed, with regard to prevention, the law implicitly references *Bright Futures,* mandating that preventive services must include "evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration."[10]

Recognizing that coverage is inadequate if payments to providers are not sufficient, the law charges MACPAC with a review and report to Congress on payments to dental professionals in state Medicaid and CHIP plans.

To address the problem of not all children having ready access to private practitioners, the law authorizes expanded dental capacity in both FQHCs and school-based health centers and expands school-based dental sealant programs.

To support the role of state oral health agencies in encouraging progressive oral health care, the law expands cooperative agreements between CDC and states, providing CAMBRA advocates yet another leverage point for promoting risk-based care.

Recognizing that metrics are critical to evaluating the impact of reform

efforts, the law expands oral health surveillance systems, allowing CAMBRA advocates to track progress in caries reductions (or at least slowing of caries increments in young children).

To address the need for additional oral health care providers whose affinity for underserved populations may position them well for promoting individualized prevention for U.S. subpopulations that experience highest disease rates, the law authorizes development and testing of a variety of new dental personnel, specifying a list that includes "community dental health coordinators, advanced-practice dental hygienists, independent dental hygienists, supervised dental hygienists, primary care physicians, dental therapists, dental health aides, and any other health professional that the Secretary (of the Department of Health and Human Services) determines appropriate." This provision supports the principle of many CAMBRA advocates that risk assessment, counseling, and monitoring of caries risk can be well-provided by a variety of dental and non-dental personnel in addition to dentists.

As noted, authorizations are sterile until funded through the appropriations process. Only upon funding of these various PPACA provisions will they become available to CAMBRA advocates to leverage. Among those that have already received funding are the Title VII training programs (but not the technical assistance provision), the FQHC and school-based health center expansions, and a partial expansion of the cooperative agreements between CDC and state oral health programs. Among those that do not require additional appropriations are the charge to MACPAC to evaluate payment issues in dental Medicaid and CHIP, and the as-yet-undetermined pediatric oral health benefit definition.

Incentivizing CAMBRA Practice in Health Reform

Charged with establishing regulation for the implementation of the Health Insurance Exchanges where uninsured individuals and small businesses will access coverage, the federal Centers for Medicare and Medicaid Services (CMS) established the Center for Consumer Information and Insurance Oversight (CCIIO). Its responsibility, in part, is to oversee operationalizing the essential benefit package in the state exchanges. CCIIO will additionally establish one or more alternative national exchanges on behalf of states that elect to not develop their own. As such, CCIIO will be a significant player and influential standard setter for all exchanges. CAMBRA advocates can actively promote a progressive pediatric dental benefit with CCIIO and with their state authorities for design the various exchanges.

CAMBRA ADVOCATES can actively promote a progressive pediatric dental benefit with CCIIO and with their state authorities for design the various exchanges.

One potential impediment on such innovation, however, is the requirement that policies offered in the exchanges reflect current practices in the private insurance markets as determined by the Department of Labor (DOL). With regard to dental plans, no major carrier at the time of DOL's investigation offers a risk-adjusted individualized pediatric dental benefit despite interest by many plans. Rather, DOL described the typical "100-80-50" plan in which 100 percent of costs for preventive dental services, 80 percent of costs of "basic restorative" services, and 50 percent of costs for "advanced restorative services" are covered by dental plans within their allowances and limits.[11] Recognizing that current benefit designs may not adequately reflect best practices, PPACA charged The Institute of Medicine (IOM) with making recommendations for benefit design. The Children's Dental Health Project, the sole dental group invited by IOM to provide testimony, called for dental benefits designs that reflect CAMBRA principles.[12] A concerted effort by CAMBRA advocates, educators, scientists, foundations, practitioners, and insurers will be needed to promote a progressive pediatric dental benefit design formulated to reduce disease while lowering costs — a design that will be sensitive to individual children's needs, workable, accountable, and acceptable to patients and their dental providers.

CMS is also actively engaged in an effort to improve oral health care for children. One component of that effort is to identify potential innovations that hold promise to improve health outcomes at lower costs for Medicaid and CHIP through program improvements. CMS's new Center for Medicare and Medicaid Innovation (CMMI) is collecting initial suggestions that may lead to opportunities to test innovations in CMMI-sponsored projects. Among ideas that have been promoted and are consistent with CAMBRA are four that relate specifically to risk-based caries management:[13] 1) evaluate CAMBRA for persons with intellectual and developmental disabilities; 2) test a risk assessment and referral guideline tool for use by primary medical care providers of young children; 3) test

cost-effectiveness of disease management/caries risk assessment; and 4) apply a chronic disease management model to early childhood caries (ECC). Others, with strong potential to advance CAMBRA practice include: 5) use of systems dynamics modeling of prevention options; 6) test a dental home concept using distance technologies; and 7) use financial incentives to encourage physicians and dentists to follow best practices and collaborate in the prevention of symptomatic ECC. Since CMMI's work will inform implementation of PPACA over time, each of these ideas, whether or not they are supported by CMMI, holds potential to promote a more rational pediatric dental benefit.

Overview of Additional Agency Efforts Relevant to CAMBRA

Everywhere that federal agencies interface with pediatric oral health and dental care, opportunities arise to promote CAMBRA principles. Many oral health activities that are consistent with CAMBRA are cited above, including those administered by CMS for payment and innovation, Agency for Health Care Research and Quality (AHRQ) for quality measures, and CDC for public health and education efforts. Among additional activities administered by the U.S. Department of Health and Human Services are those at the Health Resources and Services Administration. They include:

- The Maternal and Child Health Bureau (MCHB), National Maternal and Child Oral Health Policy Center, and National Maternal and Child Oral Health Resource Center. The policy center partners with national organizations of state policy-makers to advance progressive caries management approaches while the resource center catalogues and disseminates caries management resources including

Bright Futures Oral Health materials for health professionals and parents.[14-18]

- The MCHB Leadership Training in Pediatric Dentistry Program supports three pediatric specialty residencies to interweave public health values represented by CAMBRA with clinical training.
- The Bureau of Health Professions (BHPr) Title VII Training Programs for general, pediatric, and public health dentists and for hygienists can promote risk-based caries management in training.
- The BHPr program of Grants to State to Support Oral Health Workforce Activities, described above, can inform health professionals and the public about CAMBRA principles and approaches.
- The HIV/AIDS Bureau (HAB) which directs the Ryan White direct-care delivery programs and the Community-Based Dental Partnership Program links universities with community-based care sites.
- The Bureau of Primary Health Care (BPHC) manages the national FQHC program.

In addition to support for FQHCs, the federal government is actively involved in direct delivery of dental services to active-duty military and their dependents, to veterans served by Veterans Administration hospitals, and to inmates in federal prisons. It is indirectly involved in the financing of dental services for Head Start enrollees and for military dependents. As such, CAMBRA holds promise to both improve outcomes and lower costs and would therefore be appropriate targets for advocates.

Among the National Institutes of Health opportunities to advance CAMBRA principles are the National Institute of Dental and Craniofacial Research sponsored Centers for Research to Reduce Disparities in Oral Health, some of which have been building the scientific base for caries management since 2001, and various smaller efforts, including a bio-behavioral caries management project sponsored by the National Center on Minority Health and Health Disparities. Each of these is consistent with the Department of Health and Human Services 2003 National Call to Action to Promote Oral Health which, in part, calls for "Building the science base and accelerating science transfer."[19]

The Indian Health Service has developed a comprehensive approach to ECC prevention through its "ECC Initiative" that seeks collaborative engagement of health care and nutrition professionals, Community Health Representatives, Head Start staff, and others to prevent ECC and to promote "early intervention focusing on "caries stabilization."[20] Similarly, the Administration for Children and Families Office of Head Start supports a Dental Home effort "that links oral health with early learning and development programs."[21]

Growing interest in health information technology, stimulated in part by the Health Information Technology for Economic and Clinical Health Act (HITECH), can stimulate CAMBRA proponents to develop and implement electronic health records (EHRs) that highlight caries management and can be shared among health care professionals.[22,23] HITECH provides a financial incentive program adoption of EHRs that meet "meaningful use" requirements. Leaders in developing such interoperable and multiuse records that include oral health risk factor considerations are the Veterans Administration and the Marshfield Clinic in Wisconsin.[24,25]

Conclusion

The U.S. federal government, through legislation, regulation, and programs, has established a wide variety of options and opportunities for CAMBRA advocates to advance their promotion of individualized, risk-based, evidence-supported dental care. Leveraging these will require concerted and sustained effort as policymakers continue to implement health reform and related programs. Development of regulations that implement the "essential benefits package" in health insurance exchanges provides the single greatest opportunity to align financial incentives with progressive dental care delivery. ■■■■

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TO REQUEST A PRINTED COPY OF THIS ARTICLE, PLEASE CONTACT
Burton L. Edelstein, DDS, MPH, Columbia University Medical Center, 622 West 168th St., PH18-360, New York, N.Y., 10032.

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LOS ANGELES COUNTY

BEVERLY HILLS - Fee for service practice located in a multi story professional building with great window views to the city. ID#4081
CASTAIC - Modern design office located in busy shopping center .Excellent traffic flow w/ great street visibility. Net of $121K. **SOLD**
ENCINO - Leasehold & Equip Only! - Corner location w/ good window views. A great starter opportunity / 3 spacious eq. ops. ID#3971.
GLENDORA - Long established general practice with 44 years of goodwill located in 2 story building.4 ops. Net of $404K ID #3041
LOS ANGELES - Leasehold & Equip Only! Excellent for a 1st time Buyer. Neat office w/ 3 eq ops in a multi story bldg. ID#4025.
LOS ANGELES -Turn-Key office w/ 2 eq. ops. in the Westchester area. Established in 1972. Fee for service. ID#4039.
LOS ANGELES - Fee for service office w/ over 12 yrs of goodwill. In 2 story Med / Dent bldg w/ ample parking. ID #4057 **SOLD**
MONTEBELLO - Located in a free standing building w/ over 25 yrs of gdwll. Great street visibility, signage and foot traffic. ID #4051.
PALOS VERDES ESTATES (GP Group Solo) - 40 years of gdwll in a 3 story prestigious bldg w/ ocean view. Fee for service. ID #4059.
SAN GABRIEL - Leasehold & Equip Only! Great opportunity for GP or Specialist, located in single story building w/ 2 eq ops. ID#3161.
WOODLAND HILLS - Well equipped Pedo office with 3 chairs in open bay area. 31 years of goodwill. NET OF $261K. ID#3661.

ORANGE COUNTY

ANAHEIM - Leasehold & Equip Only! - In colonial style medical plaza w/ large French windows near Medical Cntr. 4 ops. ID #4061.
GARDEN GROVE - Turnkey practice w/ over 20 years of gdwll located in one story free standing building w/ ample parking. ID #3988.
IRVINE - Leasehold & Equip Only! Well laid out office in a multi story professional medical building. Great views. 7 eq ops. ID #4019.
IRVINE - Located in busy shopping cntr w/ lots of foot traffic. Modern designed w/ 4 eq. ops. Over 10 years of goodwill. ID #4053.
IRVINE - Great opportunity for GP or Specialist!! Leasehold & Equip Only! 5 eq. ops. located in busy large shopping center. ID #3401.
LAKE FOREST - PRICE REDUCED! Modern design office with State-of-the-Art equipment. Leasehold & Equip Only. ID#3631.
RANCHO STA MARGARITA - Leasehold & Equip Only! In modern single story med prof. bldg w/ mountain views. ID #4079.
SANTA ANA - Absentee owner. Long established practice located a single standing bldng w/ ample parking. 4 ops.NET $82K. ID#4071
TUSTIN - State-of-the Art practice located in a 2 story Med/Dent bldg. Incredible build out. Potential for a multi specialty off. ID #4069.

RIVERSIDE / SAN BERNARDINO COUNTIES

HEMET GP- Established in 2004, located in a single story strip mall. Consist of 4 computerized eq. ops., w/ Easy Dental soft.ID #4077
LA QUINTA - Leasehold & Equip Only! Office consist of 3 fully eq. ops., 1,000 sq. ft. suite located in a strip shopping center**.** ID#4063.
MURRIETA - Price Reduced! Leasehold & Equip w/ some charts. Well design office with 4 fully eq. ops., 1,350 sq. ft office. ID #3221.
RANCHO CUCAMONGA - Leasehold & Equip Only! 6 eq. ops., 1,800 sq. ft. ste located in 2 story med/dent prof. bldg. ID #3191.
TEMECULA - Fee for service practice in nice strip mall. Established late 2007. Beautiful office. Proj. approx $292K for 2011. ID#4075.
UPLAND - Established in 2005. GP located in busy shopping center w/ excellent signage & visibility. 3 ops., 1 pmbd not eq. ID#4065.

SAN DIEGO COUNTY

DEL MAR - Beautiful Décor office located in a one story medical dental building w/ ocean view. 3 fully eq. ops. Lots of traffic. ID #4083.
SAN DIEGO - Over 27 yrs of gdwll. Fee for service. Located busy shopping cntr. Great visibility and signage and foot traffic. ID#4059.

SANTA BARBARA & KERN COUNTY

SANTA MARIA GP - Established over 13 years this practice is located in a Medical plaza. 4 eq. ops, with Eagle Soft software. ID #4007.

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The *Journal* has changed its classified advertising policy for CDA members to place free classified ads online and publish in the *Journal*. Only CDA members can place classified ads. Non-CDA members can place display ads.

All classified ads must be submitted through cda.org/classifieds. Fill out the blank fields provided, including whether the ad is to appear online only or online and in the *Journal*. Click "post" to submit your ad in its final form. The ad will be posted immediately on cda.org and will remain for 60 days.

Classified ads for publication in the *Journal* must be submitted by the fifth of every month, prior to the month of publication. Example: Jan. 5 at 5 p.m. is the deadline for the February issue of the *Journal*. If the fifth falls on a weekend or holiday, then the deadline will be 5 p.m. the following workday. After the deadline closes, classified ads for the *Journal* will not be accepted, altered or canceled. Deadlines are firm.

Classified advertisements available are: Equipment for Sale, Offices for Sale, Offices for Rent or Lease, Opportunities Available, Opportunities Wanted, and Practices for Sale.

For information on display advertising, please contact Corey Gerhard at 916-554-5304 or corey.gerhard@cda.org.

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

OFFICES FOR RENT OR LEASE

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

DENTAL OR MEDICAL SUITE FOR LEASE — Starting in January 2012, prime office space of 2150 sq. ft. is available in Salinas, CA. This office suite is located across the street from Salinas Valley Memorial Hospital. This is a great opportunity to start a new practice or relocate an existing practice. Office comprised of 5 plumbed operatories, lab, reception, sterilization, conference or lunchroom, and additional upstairs storage with two private offices. No patient records or dental equipment included. All operatories have cabinets and sinks. Contact Dr. John Hirasuna at hi2jtsumo@gmail.com or 831-484-9439.

DENTAL OFFICE FOR LEASE/RENT — Modern and professionally designed dental office for lease/rent. Three partially equipped dental operatories. Contact 408-839-4090.

CONTINUES ON 842

CLASSIFIEDS, CONTINUED FROM 841

DENTAL OFFICE FOR LEASE/RENT — Stunning lakeside setting. Custom designed 5 ops. Office is 2,500 sq. ft., no improvements necessary. Plug and play. Some equipment may be available. Contact 925-838-8793.

DENTAL OFFICE FOR LEASE ESCONDIDO, CA — Newly renovated, freestanding 2000 sf. single story dental building in heart of downtown, Escondido. Good visibility and ample parking. Plumbed for six operatories and two labs. Private office, staff room, two restrooms and beautiful reception area with bay window. Call Dr. Vern Blaney at 760-739-1312, blaney@cox.net or Nancy Murphy at 760-839-0272, nmurphy@cdccommercial.com.

DENTAL OFFICE FOR LEASE/RENT — Office suite for lease in quiet North Natomas neighborhood. Gorgeous, move-in ready suite originally built for ortho, but will work for pedo as well. 1600+ square feet. Open bay layout with space for 4-5 chairs. Signage visible from I-5. Plenty of on-site parking. Contact Dave Herrera 916-821-9866 or Chris Chan 916-285-9678.

OFFICES FOR SALE

DENTAL OFFICE FOR SALE — Beautiful beach town practice in Grover Beach in 1,800 sq. ft. office with four ops with two others available. Average growth $1.2M, 50+ new patient per month. Fee-for-service, no HMO. Owner retiring and motivated. Five year renewal lease. Practice purchased from previous owner established 34 years, one mile from beach on highly visible main road in small shopping center. Comfortable mild weather year round. Ideal place to retire or to raise family in quite neighborhood. Email gethealthy528@yahoo.com.

CONTINUES ON 846

WESTERN PRACTICE SALES

John M. Cahill Associates

BAY AREA

A-8941 SAN FRANCISCO– Move-In Ready! Two Fully Equipped ops/plumbed for 1 add'l **Only $65k**

A-9991 SAN BRUNO – Facility- Ready to Move in Perfect for GP or Specialist! 1,500 sf w/3 ops and plumbed for 1 add'l **REDUCED! $48,800**

B-9791 OAKLAND Historic building 2,050 sf w/ 4 fully equipped ops **$275k**

B-9851 SAN RAMON Facility—This remarkable opportunity will not wait for the hesitant buyer! Office ~ 1,700sf w/ 3+ ops **$219k**

B-9941 Central Contra Costa-Stellar reputation - Strong, loyal patient base. 863 sf w/3 ops **$675k**

C-8901 SANTA ROSA– Residential area. 40+ new pats/mo. Highly Visible! 1291sf & 3 + 1 op. **$468k**

C-976 PETALUMA—Prestigious area! ~ 800 sf w/2 fully equipped ops **$295k**

C-989 SANTA ROSA - Foot traffic generates new patients & continuous growth for this modernly equipped office. ~ 2,500sf w/ 5ops. **$325k**

C-1016 MARIN CO-Well-established w/wonderful patient base! 800 sf w/3 ops **$280k**

D-877 LOS ALTOS -Pristine Professional plaza. Office is ~ 2,400sf - 6 ops **2009 Collections - $819k!! Reduced to $350k to offset rent amount**

D-9091 ATHERTON -Turnkey operation 969 sf & 3 ops ***Call for Details!***

D-960 *Facility only* SAN JOSE - *Reasonable rent and great lease*. **Opportunity to purchase condo suite also!** 1,158sf w/3 ops **$85k**

D-965 WATSONVILLE - Office ~ 2,400 sf, w/ 4 equipped ops + plumbed for 4 add'l ops. **$420k**

D-967 SAN JOSE – FACILITY— Beautiful! Office ~1,600+ sf w/ 4 ops **Only $135k Seller fin. avail. to qualified buyer w/10% down!**

D-982 SUNNYVALE Facility - 2 ops & space to add an add'l op & business office - Rent only $1,750 including triple-net! **$128k**

D-1003 CENTRAL CONTRA COSTA CO - Quality practice with a wonderful patient base! 1,550 sf w/ 4 fully equipped ops **$575k**

D-991 SANTA CRUZ-Practice by the beach! 1,050 sf w/ 3 ops + plumbed for more! ***$195k***

D-9921 SANTA CRUZ CO - Professional center, good design for patient flow. 1,140 sf w/3 ops **$225k**

D-1015 SAN JOSE - 1,160 sf w/3 ops w/ plumbing and space for 2 additional ops **$250k**

BAY AREA CONTINUED

D-997 SAN JOSE -Well established, FFS practice. ~ 1,008 sf w/ 3 ops + 1 add. **$230k**

D-1020 CASTRO VALLEY - Quality, fee-for-service practice. 1,784 sf w/5 ops w/ plumbing for 1 add'l op **$545k**

NORTHERN CALIFORNIA

E-8641 SACRAMENTO-FACILITY - 2,100+ sf w/ 3 ops & plumbed for 1 add'l **$50k**

E-969 FAIR OAKS Everyday will be a joy to come to work. Office is ~ 600sf w/2 ops. **$250k**

E-995 ELK GROVE -Quality, FFS practice. $900k+ in 2010! ~1,692sf w/ 5 ops. **$600k**

E-1007 ELK GROVE— Great Location with excellent signage and visibility. ~800sf w/ 3ops **$200k**

E-1018 *Facility Only* FOLSOM—Sparkling! Medical/Dental building. ~2305sf w/ 5ops**. $150k**

F-1013 FORTUNA-Well respected FFS GP. Loyal stable patient base. 1,000 sf w/ 3 ops **$195k**

G-875 YUBA CITY–Estab. 30 + years, GP, FFS, 3,575sf /9 ops, great location. **$1.63m w/Cerec ~ Assoc Buy-In Op!**

G-883 CHICO VICINITY – Quality FFS GP. Attractive Prof Plaza. 1,990 sf w/ 5 ops **$495k**

G-998 CHICO/PARADISE—Surrounded by breathtaking natural beauty! ~898sf, 3 ops. **$275k**

H-856 SOUTH LAKE TAHOE Over 50 new patients/mo Respected & Growing! 1568 sf & 4 ops **$325k**

G-1019 CHICO AREA—Small Community practice! ~1,600sf w/ 2 ops. **$215k**

SOUTHERN CALIFORNIA

K-986 NEWPORT BEACH - Attractive, multi-story Medical/Dental Professional building. 1,000 sf w/2 fully equipped ops + 1 hyg op **$195k**

CENTRAL VALLEY

I-945 TRACY - Young, growing, highly motivated patient base. 1,300 sf & 4 ops **$350k**

CENTRAL VALLEY CONTINUED

I-923 MODESTO—1495sf/ 4op+1, Newer, All digital. **$310k**

I-966 MODESTO - Facility Newly renovated, w/ prof. décor and floor plan~ 700sf w/2 ops, **$89k**

I-9721 STOCKTON –Prof. complex on major thoroughfare. 1,450 sf w/3 ops & plumbed for 1 add'l op. **$75k.** Partial Bldg Buy-out available

I-974 MODESTO FACILITY – Newly Remodeled / Reasonable Rent! 950sf w/3ops **NOW ONLY $79k**

I-1005 SAN JOAQUIN VALLEY - Seller Retiring. Long-established High-End Restorative Practice. 2,500+ sf w/ 6 fully equipped ops **$650k**

I-1012 MANTECA - Location, growth & high profitability! Well equipped w/ high-tech amenities! 780 sf w/2 ops **$479k**

J-1000 TULARE— *Real Estate Available too!* Great highly visible location! ~ 1650sf w/ 4op. **$349k and R.E. $249k**

J-1001 LINDSEY— All American City! Conveniently located ~ 3,380sf w/5 ops $325k

J-928 ATWATER - Established & respected for gentle treatment. 1,313 sf w/3 spacious ops **$230k**

J-1009 VISALIA- Buy 50% or 100%! Prof Bldg. Desirable area. 4 ops. **$250k /$500k**

SPECIALTY PRACTICES

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

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

I-9461 CENTRAL VALLEY/ORTHO - Strong referral base and happy patients! .~ 1,650 sf w/5 chairs/bays + (2) add'l plumbed. **$140k**

E-980 SACRAMENTO VICINITY ORTHO – ***4 for the price of 1***! Sold as cluster of satellite offices in multiple locations, grab this w/ no regrets! **$1.5M**

J-983 CENTRAL VALLEY ORTHO - Practice focuses on service and comfort! Attractive, single-story building . ~1,773sf w/ 6 chairs/bays. **$325k**

G-975 CHICO ORTHO—Providing quality qualifying Denti-Cal patient base. ~ 900 sf w/ 2 + ops . **$90k**

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- **CORONADO:** *For Sale*-General Dentistry Practice. Gross Receipts in 2010 $405K. Office space 1,400 sq. ft., 4 operatories, Laser, Intra-Oral Camera. 1,000 active patients. 2 hygiene days a week. Practice has operated in its present location for 40+ years. Owner retiring. #14366
- **EL DORADO HILLS:** *For Sale*-General Dentistry Practice. 2009 GR $790,758, adjusted net income of $312K. Intra-oral camera, pano, Softdent software, 4-equipped ops. 6-hygiene days. Practice has been in its present location for past 18 years. Owner retiring. SOLD
- **EL DORADO HILLS:** *For Sale*-General dentistry practice. Gross Receipts of $834K with adj net of $389K, 53% overhead. Office has five equipped operatories in 1485 sq.ft. Pano, Intra-oral Camera, Dentrix, 5 days of hygiene. Owner retiring. SOLD
- **FOLSOM:** *For Sale*-General Dentistry Practice. Gross Receipts in 2010 were $703K with an adjusted net income of $300K. 5 days of hygiene and approx 1500 active patients. Leased Office is 2,000 sq ft with 4 equipped operatories-5 possible. Patient Base software. Owner to retire. SOLD
- **FOLSOM:** *For Sale*-General Dentistry Practice 2009 Collections $513K. Adjusted net income $184K. 4 ops (plumbed for 5), Intra-oral camera, fiber optics in all ops. Patient base software. Owner retiring. SOLD
- **FOLSOM:** *For Sale*-General Dentistry Practice. Gross Receipts in excess of 1.5M the past three years. Adjusted Net of $550K. 2,700 sq. ft. office with 7 ops, Digital, Dentrix, Intra-Oral Camera, Laser, 5+year old equipment, 8 days hygiene. Beautiful office, great location. Owner retiring. #14336 SOLD
- **FRESNO:** *For Sale*-General Dentistry IV Sedation Practice. (MERGER OPPORTUNITY) Owner would like to merge his practice into another high quality general dentistry or IV sedation practice. The merger would be into Buyers office. Seller would like to continue to work as either a partner or associate after the merger. 2010 collections were $993K with a $422K adjusted net income. There are 7 days of hygiene. #14250.
- **GLENDALE:** *FACILITY SALE*-General Dentistry Office Space & Leasehold Improvements Sale- Office located in a medical plaza, 1760 sq. ft. 7 operatories, computerized equipment approximately 5 years old. Two 5-year options available.
- **GRASS VALLEY:** *For Sale*-General Dentistry Practice. GR of $307,590 (3 days/wk) with adjusted net income of $105K. 3 Ops. refers out most/all Ortho. Perio, Endo, Surgery. Intra-Oral Camera, Diagnodent, EZ Dental Software. Good Location. Owner retiring. #14337.
- **GRASS VALLEY:** *For Sale*-General Dentistry Practice. GR 545K 3 days/wk (4 avail). 3 hygiene days/week. 5 Ops (6 Avail) 1,950 sq ft. Refers out most/all Ortho, Perio, Endo, Surgery. Office has Laser, Intraoral Camera, Pano, & Dentrix Software. Owner retiring.
- **GRASS VALLEY:** *For Sale*-General Dentistry Practice. Owner retiring. Gross Receipts $89K. Practice has been in the same location for the past 33 years. 2 equipped operatories, 3-4 available. Panoramic X-ray. Doctor owns building, which is available for purchase. This practice can also be combined with another Grass Valley practice also listed for sale. #14362.
- **GREATER CHICO:** *For Sale*-General Dentistry Practice. Gross receipts in 2010 were $584K, with an adjusted net income of $152K. Approx 1,100 active patients. 4 operatories, Pano, Intra-Oral Camera. Easy dental software. Leased office 1,200 sq. ft. Owner is retiring. #14359.
- **GREATER SAN JOSE AREA:** *For Sale*-General Endodontic Practice. 2009 Collections were $1,187MIL with an adjusted net income of $696K. There are 4 ops in this nicely decoreated 1,400 sq. ft. office space. 4 microscopes. Owner has been in same location for 26 years with long-term employees. Owner is retiring but will continue to work 1 ½ to 2 years through the transition with the buyer. SOLD
- **HAWAII (MAUI):** *For Sale*-General dentistry practice. Gross Receipts of $636K. Office has four equipped operatories in 1198 sq.ft. Pano, Laser, I.O. Camera, Fiber Optics, 2 ½ days of hygiene. Owner retiring: Don't miss this opportunity to live and work in paradise. #20101
- **IRVINE & COSTA MESA:** *For Sale*-General Dentistry practice combined. Gross receipts combined $781K with adjusted net of $396K. Both office spaces are leased with 4-5 ops in each. Both are 1,600 sq. ft. Irvine is equipped with Intra-Oral Camera, Pano & Dentrix. Costa Mesa is equipped with Laser, Intra-Oral Camera, Pano and Dentrix. #14355.
- **LAGUNA NIGUEL:** *For Sale*-General Dentistry Practice. 2010 gross receipts were $503k. 4 operatories, Pan, computerized with EZ dental software. 1,500 sq. ft. lease. 10 years in present location. Owner retiring. #14352
- **LAKE COUNTY:** *For Sale*-General Dentistry Practice. Gross Receipts 904K with adjusted net $302K. Practice has been in same location for past 23 yrs, and 25 yrs in previous location. 2,600 sq ft with 8 equipped treatment rooms. Intral-Oral Camera, Pano, and Data Con software. Owner to retire. #14338
- **LINDSAY:** *For Sale*-General Dentistry Practice & building. Gross Receipts $330K with adjusted net income of $219K. Owner has operated in present location for 27 years. Office space 1,489 sq. ft., 3 operatories available (2 equipped), Intra-Oral Camera, Soft-Dent software. 3-hygiene days a week. Owner retiring. #14363.
- **LIVERMORE:** *For Sale*-General Dentistry Practice. 2009 Collections were $688K with an adjusted net income of $287K. There are 4 ops in this nicely updated 1,082 sq. ft. office space. Dentrix software, 6-days/wk hygiene. Owner has been in same location for 36 years with long-term employees. Owner is retiring. #14326 SOLD
- **LOS ANGELES:** *For Sale*-General Dentistry Practice.1,200 sq ft 4ops, 29 yrs in present location. Gross Receipts $274K with adjusted net income of $89K. Owner to retire. #14348
- **MARIN COUNTY:** *For Sale*-General Dentistry Practice. This is a small 650 sq.ft. office with three treatment rooms. The practice has a very low overhead of only 48%. 2010 gross receipts were $179,000 with $90,000 adjusted net. Practice includes Panoramic X-ray and Easy Dental Software. Refers out O.S., Perio., & Endo. Practice has been in its present location for 30 years. This is an ideal practice for the new grad or satellite practice for the established dentist. Owner is retiring. #14370
- **MODESTO:** *For Sale*-General Dentistry Practice. 5 operatories, 32-years in practice. Gross Receipts $884K w/adjusted net income of $346. Dentrix, Cerec, and Intra-Oral Camera. Owner to retire. #14308 SOLD
- **NAPA:** *For Sale*-General Dentistry Practice. Gross Receipts $800K, with adjusted net income of $250K. Fee for Service. 1300 sq ft 4 ops 6 hygiene days/ 38 yrs in present location, 30 yrs in previous location. Owner to retire. SOLD
- **NEWPORT BEACH:** *For Sale*-General Dentistry Practice. Practice has operated at its present location since 1986. Located in a highly affluent Newport Beach community. Three (3) hygiene days per week. Leased office space with 4 ops. in 1,450 sq. ft. Pano & Practice Works software. #14354. SOLD
- **NEVADA CITY:** *For Sale*-General Dentistry Practice. Gross Receipts $491K with an adjusted net income of $130K. Overhead 73%. Office leased 1,555 sq ft. 4 equipped operatories

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5 available. Laser, Intra-Oral Camera, Cerac, & Eaglesoft software. Owner would like to retire.

- **NORTHERN FRESNO:** *For Sale*-General Dentistry Practice. This is a perfect starter or satellite practice. Excellent location in North Fresno. Gross Receipts in 2010 were $173K. Approximately 450 active patients. 3 operatories. Dentrix software. Leased office 1,200 sq. ft. Owner has been accepted to an Endodontic Residency after starting practice 1 1/2 years ago.
- **NORTHERN CALIFORNIA:** *For Sale*-Endodontic Practice. This Endodontic practice is located in an upscale professional office complex. The owners condominium occupies 1,770 sq ft, There are 4 equipped treatment rooms with an additional 5th room available. Gross Receipts were $638K with $239K adjusted net income. Owner will stay for transition to introduce buyer. Owner is retiring. #14251
- **NORTHERN CALIFORNIA:** *For Sale*-Pediatric practice. Owner has operated in same location for 32 years. Approx 1,760 active pts, 1,160 sq ft, panoramic X-Ray, Dexis Digital and Dentrix software in this 5–chair office. 2009 Gross Receipts $713K with 48% overhead. Owner retiring. Call for Details. SOLD
- **OCEANSIDE:** *For Sale*-Modern looking office. 4 op, office space and equipment only. Belmont chairs. Gendex x-ray system, intraoral camera, approx 1200 sq ft. Low overhead-Rent is $1,900/month, and it's a 5 year lease. Staff is available for rehire-front desk $15/hr, assistant 13/hr. Update all the computer systems after purchasing the office in 07. Computers and monitors in every room. #14346 SOLD
- **PLEASANTON:** *For Sale*-General Dentistry Practice. Owner has other practice in Bay Area only in Pleasanton 1 day/wk. 300 active patients. Excellent location-beautiful 1600 sq.ft. 5-op office. Equipment like new, intra-oral camera, pano, Easy Dental software. Must See. #14364.
- **PLUMAS COUNTY:** *For Sale*-3 equipped ops. Space available for 4th op. 1,245 sf office in good location. Gross Receipts $475K. Practice in present location over 50 years. Owner is retiring. #14318
- **RENO:** *For Sale*-General Dentistry Practice and Dental Building: 2009 Gross Receipts $517K with adjusted net income of $165K. 4 ½ hygiene days/week. 1, 800 sq. ft. with 6 equipped ops. (7 Avail). Dentrix software, Pano. Practice has been in its present location for 40 years. Owner retiring SOLD
- **ROCKLIN:** *For Sale*-General Dentistry Practice. Gross Receipts $593K in 2010 with $240K adjusted net income. Office is 1,630 sq. ft., with 4 operatories equipped with fiber optics. Owner has been in present location for the past 13 years. 3 1/2 days hygiene. Intra-Oral Camera, Dentrix software. Owner to retire. SOLD
- **ROSEVILLE:** *For Sale*-General Dentistry Practice. Great Location. 2009 GR $900K with adjusted net income of $300K. 1,975 sq. ft. with 4 ops, 3 days hygiene/wk. Digital, Intra-Oral Camera, Dentrix, Trojan, fiber optics, P & C chairs - all less than 5 years old. Owner is retiring. #14327 SOLD
- **SACRAMENTO/ROSEVILLE:** *For Sale*-One of many partners is retiring in this highly successful General Dentistry Group Practice. Intra-Oral Camera, Digital Pano-Dexis, electronic charts, owner Financing. Call for further information. #14334
- **SAN DIEGO:** For Sale-General Dentistry practice. Gross Receipts $414K. Practice has been operated by the same owner for the past 6 years. Leased 950 sq. ft. office with 3 equipped operatories. Dentix software, Intra-Oral camera, Panoramic X-Ray. Owner to relocate. #14356.
- **SAN DIEGO:** *For Sale*-General Dentistry Practice. 6 ops, Intra-Oral camera, Eagle Soft Software. Office square feet 2,300 with 3 years remaining on lease. 2009 Gross Receipts $1,448,520, with an adjusted net income of $545K. Doctor would like to phase out then retire. #14331
- **SANTA BARBARA:** *For Sale*-General Dentistry Practice. This excellent practice's 2009 gross Receipts $891K with steady increase every year. Practice has 6 days of hygiene. 1,690 sq. ft., 5 ops, Laser, Intra-Oral Camera, Schick Digital X-Ray, Datacon software. Doctor has been practice in same location for the past eleven years of his 31 years in Santa Barbara. Doctor is retiring. #14333 SOLD
- **SAN LUIS OBISPO:** *For Sale*-Two Doctor General Dentistry Practice. Gross receipts $1,537,142 for 2010 with an adjusted net income of $691K. The office has 2,331 sq. ft. with 8 equipped operatories. Pano, E4D, and Dentrix software. Practice started in 1990 and has been in its present location since 1998. Approx. 3000 active patients. Great location with nice views. #14353.
- **SANTA CLARA:** *For Sale*-BUILDING ONLY: This building is located just west of Westfield Mall and Santana Row. The building has two units. One side is designed and plumbed for dentistry and the other was a law office. There is 3,776 sq. ft. of office space. The dental office is approximately 2,500 sq. ft. with 6 operatories. The building is presently being re-roofed. Excellent opportunity for a startup practice or for the dentist that needs more space. Financing available through various dental lenders. #14368
- **SANTA CRUZ:** *For Sale*-General Dentistry practice. Gross Receipts $300K with a 57% overhead. Office is 1,140 sq. ft. 3 equipped operatories. Intra-Oral Camera, Pano, Digital X-Rays, and Dentrix software. Practice has been in its present location since 1980. Owner retiring. SOLD
- **SANTA CRUZ:** *For Sale*-General Dentistry practice. This excellent practice is centrally located in a professional complex. Office is approx. 1,885 sq. ft., 4 operatories with room for one additional. There are approx. 2000 active patients with 6 days of hygiene per week. Practice Pano, Intra-Oral Camera and Easy Dental software. Owner is retiring. Reasonable lease available. #14361
- **TORRANCE:** *For Sale*-General Dentistry practice. This excellent practice is centrally located in a professional complex. Office is approx. 1,885 sq. ft., 4 operatories with room for one additional. There are approx. 2000 active patients with 6 days of hygiene per week. Practice Pano, Intra-Oral Camera and Easy Dental software. Owner is retiring. Reasonable lease available. #14320 SOLD
- **TORRANCE:** *For Sale*-General Dentistry Practice. Gross Receipts $413K with an adjusted net income of $203K. 50% overhead. Practice has been in its present location for the past 25 years. The office has been tastefully remodeled. Office is 800+ sq. ft. with 3 equipped operatories. 4 -hygiene days per week. Doctor is to retire. #14369
- **TRACY:** For Sale-General Dentistry Practice. Gross Receipts $832K adjusted net income $504K. 3 operatories, Pano, Patient Base software, leased office space 1,100 sq. ft. Practice in same location for 33 years. 22 new patients seen a month. Owner would be willing to come back 1-2 days a week. SOLD
- **TRACY:** For Sale-Equipment, furnishings, and leaseholds only. In the Central Valley. Fully equipped including 4 Belmont Accutrac chairs, 2 Midmark chairs, 6 DCI rear delivery units, 3 Gendex x-ray units, 1 Sci-Ced digital x-ray processor, 1 Statim 5000, 1 Harvey autoclave. 2,800 Sq ft, 6 Ops. New lease available from landlord. SOLD
- **VISALIA:** For Sale- General Dentistry Practice. Gross Receipts $616K with an adjusted net income of $ 321K. Office is 1,380 sq ft with 3 equipped operatories. Intra-Oral Camera, Digital X-Rays, Mogo software, equipment & leaseholds look new. 5 years in present location. Owner to relocate. #14347 SOLD

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CLASSIFIEDS, CONTINUED FROM 842

DENTAL OFFICE FOR SALE — Four operatory dental building In the beautiful mountain town of Dunsmuir, located in far Northern California on the I-5 corridor, we offer this modern four operatory dental building for sale or lease. The building is well maintained; the seller is motivated and can carry paper, all terms negotiable. Dunsmuir is in dire need of a dentist who uses modern techniques and materials. Dunsmuir, located seven miles south of Mount Shasta, on the Sacramento River, and offers a wide variety of outdoor recreational opportunities. Please contact seller at info@dunsmuirdental.com or Brett at Doris Moss Realty at brett@mtshastarealty.com. For additional details, please visit our website at dunsmuirdental.com.

DENTAL OFFICE FOR SALE — Newly equipped three operatory dental office for sale in Sunnyvale, CA. Contact 408-839-4090.

OPPORTUNITIES AVAILABLE

ASSOCIATESHIP OPPORTUNITY IN SANTA ROSA — Associate with ownership potential. State-of-the-art general dentistry practice with all private pay/indemnity insurance patients. Fabulous team and facility. Seeking personable, quality oriented GP with 2 years experience or GPR for 3-4 days/wk. Email resume to roberte@fountaingrovedentistry.com.

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

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

CONTINUES ON 848

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3060 SACRAMENTO COUNTY GP

General & Cosmetic practice located in the charming, picturesque town known as "The Jewell of Sacramento County". For those who enjoy cycling, running and other outdoor activities. The American River parkway winds through this town and can be ridden all the way to Folsom Lake.

Beautifully & thoughtfully designed, this well appointed office has 6 fully equipped ops with state-of-the-art equipment and facility. The practice is located in a single occupancy, free standing, single story professional building of approximately 2,000 sq. ft. The building's lot has ample on-site parking and is located on a major thoroughfare with fantastic visibility. Approximately 1,500 current/active patients (all fee-for-service) with an estimated 16 new patients a month. 2010 GR $1.6M with an adjusted net income of almost $500K. Asking price $1,105,000.

3059 SANTA CRUZ COUNTY GP & BDG

Charming practice tucked among soaring redwoods in Santa Cruz County. Located in a single level professional building in the heart of town. Well established and part of the small community landscape. 2010 GR $595K+ w/3 doctor days. All fee-for-service. Owner retiring and willing to help for a smooth transition. This is a great turn key practice and opportunity to own a hidden gem. Practice asking price $373K, building is also available.

3006 MONTEREY COUNTY ORTHO

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

3061 SAN JOSE ORTHO FACILITY

Located in desirable Evergreen area in a two-story, handicap accessible, high profile, medical and professional building. Gross lease with utilities included expires July 2013 with 5 year option to renew. Modern, tastefully designed, approximately 1,321 square feet. Office space includes: fully-equipped open bay with bay support cabinets and 4 chairs setup for right-handed delivery, exam/consult room with patient chair, reception area, private office, business office, lab area, sterilization area, and bulk storage area. Asking $95K.

3049 SAN JOSE GP

Well-located, across from O'Connor Hospital, general practice in 2,118 sq. ft.state-of-the-art facility w/ 3 fully-equipped ops. 2 pvt. offices (1 can be plumbed for 4th op.). This office is beautifully designed and is stunning. In addition to his general practice, owner treats sleep apnea patients. He is selling just the general operative portion of the practice and is willing to help for a smooth transition. Ideal for an experienced dentists looking to merge an existing practice. Asking $285K.

3045 VACAVILLE GP

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

PENDING

3057 SAN JOSE GP

Priced to sell. Located in 2 story professional building w/3 fully-equipped ops. in 990 sq. ft. office. Part of historic Rose Garden neighborhood, block from the Alameda, & near a well travelled intersection. Seller transitioning due to health reasons. FY 2010 GR $415K. Asking Price $120K.

SOLD

3052 PETALUMA GP

Well-established 3 Dr. day practice in 2,268 sq. ft. office w/6 ops. Avg. gross receipts for past 3 years $315K. Located just a mile from the Petaluma River in the historic town of Petaluma. Centrally located 32 miles north of SF in the Sonoma County Wine Country. Bldg. is available for purchase. Ideal for merging with an existing practice in the area. Owner retiring and wiling to help for a smooth transition. Asking $145K.

Upcoming: San Jose GP & Fremont GP

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CLASSIFIEDS, CONTINUED FROM 846

SEEKING MANAGING DENTISTS — If you're looking for a long-term commitment and desire to be productive the opportunity is yours! Seeking full-time, managing dentists to join large group practice in the following areas: Los Angeles, Orange County, Inland Empire, San Diego and doctors willing to relocate to Arizona. Steady patient flow in high volume HMO environment. Required: 3-5 yrs experience and proficient in molar endo. Benefits include: medical, dental, vision, 401K, malpractice coverage and competitive pay! For available positions please call: 714-428-1305, submit your resume to kristin.armenta@smilebrands.com or fax to 714-460-8564.

SUN VALLEY/KETCHUM, IDAHO — Traditional, established, profitable fee-for-service dental practice looking for versatile experienced person with successful record to buy practice. General, cosmetic, endo, implant surgery, Invisalign, prosthetics. Excellent staff, fantastic lifestyle, incredible environment. World-class skiing, fishing, hunting, golf, hiking, water sports, culture, dining and weather. Contact sunvalleydentalpractice@gmail.com.

DENTAL OFFICE SEEKING OFFICE MANAGER — Office manager with 3 yrs minimum experience in Marketing. Candidate must be Bilingual, self-motivated, organized, and capable of multi-tasking several projects/assignments at a time. Must have experience in the front office with managing self/staff/doctors/patient schedules and be able to maintain business operations with efficiency and accuracy. Must have knowledge and skill set to handle, date entry, multiple phones lines/general office duties, treatment planning, billing and claims aging. Travel is a must for this position, but gas reimbursement is provided. Candidates will be required to learn pre-existing client base as well as acquire new clients thru strategized marketing. Previous sales experience is a plus for the marketing aspect of this position. Serious candidates that feel you fit this job description, please contact me for an interview. $16-21/hourly plus monthly bonuses, negotiable based on experience. Must be bilingual in Spanish. Contact 310-780-5278.

OPPORTUNITIES WANTED

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

OPPORTUNITY WANTED — I am a new graduate of the University of Louisville School of Dentistry who has recently relocated to San Francisco, CA. I have 2 years of patient-based experience at the university clinic, 5 weeks of externship at the private dental office, and hours of volunteering, which gave me the current in-depth knowledge of general dentistry (feel confident with posterior root canals and surgical extractions). I have a current California dental license, DEA number, CPR training, malpractice, and disability insurance. If you are looking for quality-

CONTINUES ON 850

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If you want your practice "For Sale", we are not the firm for you.
If you want your practice "SOLD", contact us!

5999 **"SOLD" PLEASANTON** Adjacent to Hacienda Business Park. 2011 tracking $900,000. Strong profits. Digital radiography with computers in Ops. Great visibility.

6002 **SAN JOSE'S EVERGREEN VALLEY - FILIPINO PRACTICE** Near Highway 101 and East Capitol Expressway. Housed in new building and suite. Busy Hygiene schedule. 2011 tracking $715,000+ with $350,000 in profits. Shall be best year ever!

6003 **"SOLD" PINOLE - HERCULES AREA** 4-days of Hygiene. 90%+ effective Recall. Produced $740,000 and collected $709,500. Low AR balance. Endo referred.

6004 **"SOLD" SAN JOSE'S SANTA TERESA AREA** Asking slightly more than what it would cost to replicate this office today. Digital & paperless 3-Op suite. 2010 produced $385,000 with collections of $277,000 and Profits of $190,000+. Gorgeous facility. Lease allows occupancy thru 9/30/2024.

6008 **MENDOCINO COAST - FORT BRAGG** Nestled in desirable cultural haven creates attractive lifestyle. 4-days of Hygiene. 2011 shall top $700,000 in collections making this its best year ever. Owner works 3-day week and states he could work more if desired. Computerized Ops and digital radiography.

6010 **"SOLD" BERKELEY – ALTA BATES MEDICAL VILLAGE** Attractive revenues. Last 2-years Profits have averaged $225,000. 2011 doing better!

6011 **"SOLD" SAN JOSE – WEST OF I-280** Long established practice off Saratoga Avenue. Has averaged $400,000 per year in collections. 3-Ops with 4th available in 1,000 sq. ft. suite.

6012 **"SOLD" FREMONT** Well established practice as evidenced by 6+ days of Hygiene. Fantastic Recall System. Great location. Collects just shy of $900,000 per year. Total Available Profits in 2010 were $360,000. 5-Ops.

6013 **"SOLD" LIVERMORE** Not yet 4-years old, tracking $430,000+ in collections 2011. Attractive 4-Op suite fully networked, employs computer charting and digital radiography.

6014 **SAN FRANCISCO** Located in "Heart" of the Mission. Owner does not speak Spanish. 2011 tracking $425,000+ with $185,000 in Profits on 3-day week. 3-Ops. Great opportunity for Successor who shall devote more attention. Building has private garage for tenants.

6015 **SONOMA COUNTY'S HEALDSBURG** Vibrant economy and great small town atmosphere. Anchored by 4-day per week Hygiene schedule and great Office Manager. Revenues tracking $540,000 with Profits of $225,000 in 2011.

6016 **BERKELEY** Collecting $30,000/month on 3-day week. Did better when Owner was able to devote more time here. Profits tracking $140,000+ for 2011.

For complete details on any of these opportunities, go to www.PPSsellsDDS.com

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"I listed with a competitor for 12 months. Had two people visit my practice. First weekend PPS had my listing, I had 3 people visit and an offer by the end of the first week. Thank you for allowing me to move on to the next step of my life."

"It was a pleasure to work with PPS. I had to sell because of health complications. Mr. Irving listed my practice on Jan 1st, we closed escrow on Feb 27th. It took him less than 60 days to complete the sale as promised."

"When I decided to sell my ortho practice, I sought the services of a large company. Over the 12-month contract, I had one buyer visit. Word was out. It had a devastating effect on my bottom line. Fortunately, I found Ray and Edna Irving! When I finally sold, I choose between two good offers. My regret was the time and money lost with the other guys."

"When I signed the Listing on June 1st, Ray stated he would have the practice sold by Labor Day. The sale was concluded on Sept 1st, two days before Labor Day. Wow!"

"I will always remember your statement when I questioned your contract being only four months. You stated: 'If I can't sell your practice in that time, you should get someone else.' Well, you did with time to spare!"

"Before I called Ray, I had a listing with another prominent Broker. After eleven months without a sale, I called Ray. He sold it in about a month! Would I recommend Ray? Yes!"

"In April, I asked Ray Irving to sell my practice. At the same time my friend decided to sell his practice. He employed another firm. My practice sold June 22. My friend's practice still hasn't sold and he was putting his dreams on hold."

PPS of The Great West's reputation is built upon grounded ethics and effectiveness. Our trademark "client services" include accurate assessments, impeccable marketing plans, complete transparency, generating quick responses, realizing multiple Offers, securing 100%+ financing in days, expert papering of our transactions and sound counsel. Everything is done to protect our Client and to effect a successful transfer. Our intent is simply to provide the best service imaginable for this very important engagement.

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PRACTICE SALES AND LEASING

Paul Maimone
Broker/Owner

HAPPY THANKSGIVING!

BAKERSFIELD #21 - (10) op G.P. & Bldg. on a main St. (3) ops fully eqt'd. (3) ops part eqt'd & (4) add. Plmbd. Store front. Collects ~$500K/yr. Cash/Ins/PPO/small % Denti-Cal. **NEW**.

BAKERSFIELD #24 - (4) op computerized G.P. 2 ops eqt'd w 2 additional plumbed not eqt'd. Cash/Ins/PPO pt. base. Collect $200K+/yr. 3- 4 days/wk. In a strip ctr. Seller retiring.

CENTRAL VALLEY/So. FRESNO CTY. - (3) op compt. G.P. Newer eqt., digital x-rays & Dentrix s/w. Limited competition. Cash/Ins/PPO. New bldg out in 2009. **SOLD**

COVINA #2 DUPLEX BLDG. & PRACTICE - (4) op comput. G.P. & Bldg. (3) ops eqt'd 4th plmbd. Mixed pt base. 2010 Gross Collect $250K on a 3 day wk. 2,150 sq ft bldg. **REDUCED**

COVINA #3 - (3) op compt. G.P. Cash/Ins/PPO. Gross Collect $242K+ on an easy (3) day wk. Located in a small prof/medical/dental bldg. w off street parking. Seller retiring. **NEW**

GLENDALE #6 – (5) op state of the art comput. G.P. 4 ops eqt'd, 5th op plumbed. Digital x-ray & networked. Mixed pt base. In a free stand bldg. Annual Gross Collect.~ $500K. **NEW**

NEWPORT BEACH - (5) op comput. G.P. 4 ops eqt'd/5th plmbd. In a prof. bldg. on the Marina. Cash/Ins/PPO small % cap. Dentrix & Shick. Collects $400K+ on a (2) day wk. **NEW**

No. COUNTY SAN DIEGO - (4) op comput G.P. in a shop ctr. w excell exposure & signage. Cash/Ins/PPO/HMO pts. Dentrix s/w, paperless & digital. Gross Collections $900K+/yr.

OXNARD #5 BLDG. & PRACTICE – (4) op comput G.P. in a free stand bldg. w a pole sign. On a very busy main road. Mixed pt base. 2011 Project Gross Collect $447K. **NEW**

RESEDA #6 - (3) op comput G.P. located in a well know, easily accessible prof. bldg. Cash/Ins/PPO pts. Annual Gross Collections ~ $150K on a p.t. schedule.

SANTA BARBARA #2/GOLETA - (4) op computerized G.P. located in a garden style prof. bldg. w St. frontage. (3) ops eqt'd/4th plumbed. Cash/Ins/PPO pt. base. (4) days of hygiene/wk., approx. (20) new pts/mos. Pano eqt'd. Collects. $400K+/yr. on a (4) day wk.

SANTA BARBARA #3 - (3) op comput. G.P. in a prof/med/dental bldg. Cash/Ins/PPO. 8-10 new pts/mos Gross Collect. $250K+ on a (4) day wk. Digital x-ray. Seller retiring.

UPLAND #3 - (5) op comput G.P. & Speciality Pract. in a free stand bldg. Gross Collect $525K-$625K/yr. Digital x-ray. Excell opp. for G.P. who likes to do Endo. **BACK on MARKET**

VACAVILLE – (3) op compt. G.P. turnkey w charts. Shunted 5 mos. Great start up op. **NEW**

WEST HILLS - (3) op compt G.P. in a prof. bldg. Newer leaseholds. Cash/Ins/PPO. Digital x-rays & Dentrix s/w. 2010 Gross Collect. ~ $305K part time. Seller retiring. **BACK on MARKET**

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CLASSIFIEDS, CONTINUED FROM 848

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PRACTICES FOR SALE

COASTAL EUREKA PRACTICE FOR SALE OR LEASE — Family practice in beautiful semi-rural area with fantastic outdoor recreation. Production/collection average 80,000/month with high net, a FFS practice with no capitation and doctor only working 14 days/month. Large loyal patient base would support two dentists. Great growth potential by adding endo, perio, and oral surgery and increasing work schedule. Priced at $625K. Building available for favorable lease or purchase. Owner considering adding associate dentist while transitioning to retirement. Call after 6pm Pacific Time 707-499-9799.

PEDIATRIC PRACTICE IN EUREKA, CALIFORNIA — Don't miss this opportunity! Perfect situation for one or two pediatric dentists looking for an exceptional life style, higher than average income/benefits working in a state-of-the-art facility with six bays, one quiet room and lots of extras! Revenues of $1.5M with low overhead and limited competition. Owner retiring and motivated. Check it out! Email growingsmilesdds@sbcglobal.net.

EQUIPMENT FOR SALE

DENTAL EQUIPMENT FOR SALE — A/T 2000 film processor, still in the box, brand new $3,500 OBO. Contact 310-654-1098.

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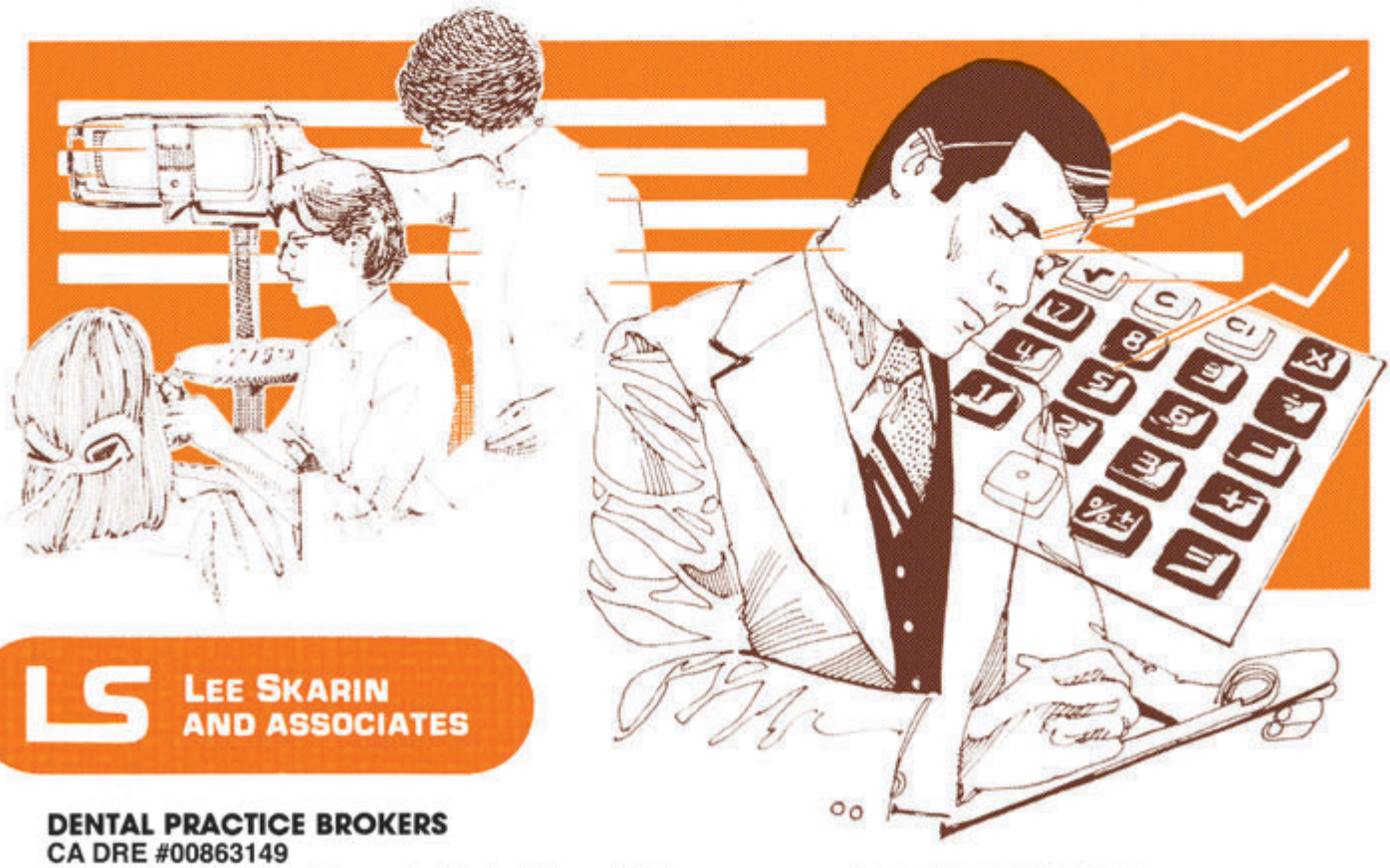
Lee Skarin & Associates has scores of Buyers in their computer. The Buyers' profiles in practice interest and financial ability, have been categorized to expertly select the right Buyer for your practice. Expert Buyer selection solidifies a deal, eliminating that overzealousness to sell that can cause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



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DR. BOB, CONTINUED FROM 854

We have had well over 200 years to study Washington's teeth because their owner, feeling that things had to be better in the Great Beyond, gladly left them behind. There are only four sets of Washington's dentures known to exist; one of which resides in a classy glass cube at the Samuel D. Harris National Museum of Dentistry in Baltimore. The whereabouts of the other three sets is questionable. Perhaps John Greenwood, Washington's dentist sent them out to the lab for a reline and they've not returned yet.

George had only one remaining natural tooth when he was elected president. It was not thought fitting for the Father of our Country to deliver the State of the Union address looking like Ollie from the *Kukla, Fran and Ollie* show popular at the time. All the other heads of state around the world, many of whom had as many as four or five teeth of their own, would have poked fun at George. Potentates and kings can be so cruel.

John Greenwood was commissioned to make full upper and lower dentures with Delta picking up 50 percent of the fee after a six-month qualification period and the meeting of the deductible. Delta wanted a radiograph of Washington's one remaining tooth, but the X-ray hadn't been invented yet, so the tooth was posted to them in a little green box with an image of the Tooth Fairy engraved on the cover, along with suitable documentation and a request for an estimate of benefits. George's portion, after deductible, came to $3.79.

With that background, you will understand why we decided to make a replica of the Washington dentures and maybe go into the museum business ourselves.

Fortunately, we have an ideal patient, one Filbert Fischbyne. We have made Mr. Fischbyne at least six sets of teeth, none of which have been satisfactory, but he liked the notion of being part of history when we explained our plan. After taking the necessary impressions in alginate because we didn't have any beeswax, or whatever was in vogue in 1778, the models were sent off to the lab with detailed instructions. Shortly after, the phone rang.

We have never seen a picture of President Washington with his mouth open, a presidential condition not noted since the departure of Calvin Coolidge in 1929.

Lab: Doc, couple questions on this Fischbyne case.

Us: Shoot.

Lab: Lessee (reading from lab slip), you're asking for cast gold base, hippopotamus bone, elephant ivory, eight assorted human teeth and a couple springs, right?

Us: No, the base is swaged, whatever that is and the teeth are to be attached with little wooden pegs.

Lab: Attached to what, Doc? The hippo bone or the elephant ivory? And how come only eight teeth? What about the other 20?

Us: We'll get back to you.

This is going to be tougher than we thought. A study of pictures of Washington's teeth reveals little, except the anterior teeth are square, like Chiclets, and it's hard to tell whether they are composed of real enamel, hippo bone or ivory. We can see the springs pretty clearly, but the mechanics of their use is puzzling. Would they stretch upon opening the jaws, creating a tension, that then would cause the dentures to snap together whether George was ready to close or not?

We have never seen a picture of President Washington with his mouth open, a presidential condition not noted since the departure of Calvin Coolidge in 1929.

Us (to lab): How you coming with the Fischbyne case? It's been six weeks.

Lab: Had a little trouble with the springs, Doc. We could only find garage door and screen door springs. So we cut down the screen door springs a bit and if this Fischbyne guy has enough Fixodent he can probably get his teeth open about a quarter inch. Also, elephant ivory is a prohibited import, so we cut up some pool balls. You may have a little shade match problem, but the numbers won't show.

The Fischbyne/Washington case is in. When Filbert dons the powdered wig, there's a remarkable resemblance. The nose isn't quite right, but he's got the grim look down pat. He says it's because the "Dang things don't fit," but we think it's because Delta denied payment based on the fact that he's had a half dozen other dentures inside their five-year limit. Also they said our $9,745 fee falls outside the 90th percentile range for our area.

If you are interested in obtaining an exact replica of the famous George Washington teeth (with a spare set of springs), please contact Mr. Fischbyne or this office. ■■■■

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Replicas and Copycats

We have had well over 200 years to study Washington's teeth because their owner, feeling that things had to be better in the Great Beyond, gladly left them behind.

Robert E. Horseman, DDS

ILLUSTRATION BY DAN HUBIG

A $17 million replica of Capt. Cook's historical ship The Endeavour sailed into Newport Harbor the other day. Had Capt. Cook been standing at the bow like that DiCaprio kid in the $200 million movie *Titanic*, he would have been amazed at how much growth and commercialization has taken place there since 1778. Or maybe not, since he had never seen it in the first place. Instead, he got into a hassle with some natives on the Big Island of Hawaii (formerly the Sandwich Islands, named after the Earl of McDonald) over the theft of a boat, so they killed him. So much for the aloha hospitality. He'd have been better off dealing with the natives of Newport Bay and might have ended up buying Balboa Island for a couple bucks worth of beads and getting in on the ground floor of the frozen banana concession.

The point is, the fabrication of replicas is Big Business. Whether it is The Endeavour, the Spirit of St. Louis, Dolly Parton's bra or Archie Bunker's chair, make an exact replica and the world will beat a path to your door and your coffers will runneth over. If you are unable to acquire any suitable coffers, the money can be deposited directly into your account.

From a historical point of view, what dental artifact would be most likely to lend itself to replication? The answer, of course, is George Washington's teeth. Information about the dentition of all succeeding presidents is sparse, historians preferring to delineate the boudoir proclivities of our leaders instead. An inquisitive reporter recently asked a recent president about the state of his teeth, only to have him equivocate stating, "Depends on your definition of teeth."

CONTINUES ON 853

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