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### DEPARTMENTS

- 741 The Associate Editor/Some Have It All: The State of Medi-Cal's Adult Dental Benefits
- 743 Letter to the Editor
- 745 Impressions
- 793 Regulatory Compliance/Required and Recommended Vaccinations for Dental Health Care Workers
- 795 RM Matters/Lag in License Renewal Can Spell Trouble
- 798 Periscope
- 800 Tech Trends

# DENTAL ETHICS

### FEATURES

- 755 One Million More Children Knocking on the Dental Door An introduction to the issue. Paul Reggiardo, DDS
- 757 Dental Workforce Capacity and California's Expanding Pediatric Medicaid Population *This study assesses the dental workforce capacity to serve children eligible for Medicaid dental coverage in California.* Carrie Tsai, DMD, MPH; Cynthia Wides, MA; and Elizabeth Mertz, MA, PhD
- 769 Expanding Public Coverage for Dental Services: Pathway to Improvements or Hollow Promise? This paper contrasts the performance of California's Medicaid dental program with progress in other states, outlines major reasons for performance gaps and raises concerns about recent policymakers' decisions. James J. Crall, DDS, ScD
- 779 Educating General Dentists to Care for U.S. Children: How Well Are We Doing and What Can We Do Better?

This commentary attempts to put the debate over the care of children by general dentists in perspective with a review of salient issues, discussion of preliminary new information in relation to existing literature and proposals for improvement.

Paul S. Casamassimo, DDS, MS, and N. Sue Seale, DDS, MSD

785 Pediatric Dentistry for the General Practitioner: Satisfying the Need for Additional Education and Training Opportunities

This article discusses the Pediatric Oral Health Access Program, widely recognized as the first large-scale effort to provide advanced education and training in pediatric dentistry to general dentists.

Ray E. Stewart, DMD, MS, and Roger G. Sanger, DDS, MS

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February 2015: General Topics

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# Some Have It All: The State of Medi-Cal's Adult Dental Benefits

Brian Shue, DDS, CDE

edi-Cal's adult dental services have returned to California. That's old news, right? After all, Assembly Bill 82 authorized this back on May 1, 2014, giving Denti-Cal beneficiaries 21 years of age and older access to some dental benefits such as exams, prophylaxes, restorations, anterior root canals, prefabricated crowns, dentures and other key services.

But adults with Medi-Cal were actually entitled to receive full dental benefits — not just partial benefits — beginning September 26, 2013. And it had nothing to do with AB 82, the California legislature or even the governor. In fact, this return of full dental benefits was permanent and immune to any future Sacramento budget crisis; however, it depended on who exactly was providing the treatment. All because a Northern California health center and a rural care association took legal action against the \$46,600,000,000-a-year California Medicaid system.

What began as a lopsided battle akin to fighting a heavily fortified giant while only armed with a sling, a rock and a prayer — actually wreaked havoc everywhere as it lumbered through the legal system. The end result? The fragile safety net clinics and the very patients it serves emerged victorious.



It all began when California cut adult health services described as "optional benefits" to balance the budget in an economy more wobbly than a primary mandibular central incisor in a 7-year-old.

It all began when California cut adult health services described as "optional benefits" to balance the budget in an economy more wobbly than a primary mandibular central incisor in a 7-year-old. The Department of Health Care Services (DHCS), which oversees the Medicaid program in California, thus eliminated reimbursements for dental, podiatry, chiropractic, optometry and other critical services on July 1, 2009. Of course, those adults with Medi-Cal could still have dental care, but would have to pay out of pocket. Unfortunately, many complained they could not access affordable care. What adult benefits remained included emergency services such as extractions and periodontal treatments for pregnant patients. But not too much else.

That resulted in "California Association of Rural Health Clinics and Avenal Community Health Center versus David Maxwell-Jolly, Toby Douglas and the California Department of Health Care Services," the legal action in March 2010 that opposed the elimination of these benefits, specifically at federally qualified health centers (FQHCs) and rural health clinics (RHCs). The following ensued:

- October 2010: U.S. District Court orders DHCS to begin to reimburse California's FQHCs/RHCs for the provision of these optional benefits, because the actual process to remove them was improper. Full adult Medi-Cal dental care immediately resumed at the clinics, but was not available in the private sector.
- May 2011: U.S. Centers for Medicare and Medicaid Services finally approved California's State Plan Amendment, which was the correct process to use before removing benefits. However, it was made retroactive to July 2009. Full adult Medi-Cal dental care immediately stopped at the clinics. DHCS announced its right to take back all the Medi-Cal reimbursements for adult dental care made to the FQHC/ RHCs from October 2010 through May 2011 because the elimination was made retroactive — even though the clinics provided this care because said benefits were restored. Clinics waited in fear that their not-for-profit operations would be hit for hundreds of thousands of dollars, possibly leading to clinic closures across the state.

**Brian K. Shue, DDS, CDE**, is the dental director of a federally qualified health center. He is a certified dental editor, the San Diego County Dental Society editor and is a fellow of the American College of Dentists and the Pierre Fauchard Academy.

- June 2013: The 2014 California budget was approved. It was a major success, as private Medi-Cal dentists would be able to provide some adult dental benefits starting in May 2014.
- September 2013: U.S. 9th Circuit Court of Appeals reversed the previous decision and determined adult Medi-Cal dental services by FQHCs and RHCs were required by federal law and were improperly removed. Full adult Medi-Cal dental care immediately resumed at these clinics. Clinics also breathed a sigh of relief, as this final court decision removed the threat of retroactive actions against the clinics for the sevenmonth period in question.
- April 2014: The monthly Denti-Cal bulletin states "services provided to beneficiaries ages 21 and older at an FQHC or RHC would be limited to those restored adult dental services pursuant to AB 82," which was essentially the same reduced set of procedures that would be provided by the private Denti-Cal providers.1 Full adult Medi-Cal dental care would again stop at the clinics on May 1.
- May 2014: DCHS reversed its own decision and rescinded the April Denti-Cal bulletin. DCHS clarified it would abide by the 9th Circuit Court decision and adult dental services at FQHCs and RHCs "would remain unchanged" from the pre-July 2009 full allowable reimbursable services. Full adult Medi-Cal dental care was not interrupted at the clinics and continues today.
- May 1, 2014: Finally, after almost five years, the private sector Denti-Cal providers began to provide some dental services to the adult Medi-Cal population.

Problem solved? Not exactly. What are these "unchanged pre-July 2009" dental benefits? DHCS has not answered this question. Clinics do not want to run the risk of erroneously billing Denti-Cal for noncovered procedures, but on the other hand, patients want to receive the full scope of treatment that are supposed to be available to them. Such unchanged adult dental benefits may include such procedures as scaling/root planing, partial dentures and even PFM crowns on certain teeth — procedures not reimbursable to Denti-Cal providers outside of the community clinic system. The California Primary Care Association recommends that each and every FQHC/ RHC seek its own legal assistance to

> Almost 8 million adults and children in California are eligible for Medi-Cal benefits.

determine these dental benefits.

Anyone with Medi-Cal can receive care at one of California's 129 FQHCs and RHCs. The Health Resources and Services Administration reported in 2012 that 44.6 percent of the 575,524 dental patients of the California clinics had Medi-Cal and that was a year "optional benefits" were not provided.

But a majority of Denti-Cal patients depend on the private sector for their care. In 2007, of the \$583.7 million total Denti-Cal fee-for-service reimbursements made to providers, only 13.9 percent (\$81 million) of the reimbursements went to California's community clinics.<sup>2</sup>

Almost 8 million adults and children in California are eligible for Medi-Cal benefits. Because of the Affordable Care Act, this total will rise to 11.5 million by 2015, which will be almost 30 percent of California's population. Fortunately, the 2014-2015 FY budget continues the partial restoration of adult Denti-Cal services for the private sector by including \$75.6 million — a mere drop in the bucket — about one-half of one percent of the current \$16.9 billion to be paid out of California's general fund for Medi-Cal.<sup>3</sup> That amount doesn't count federal funding, which actually makes up more than half of the whole Medi-Cal budget.

Besides adult benefits, there are other major Denti-Cal problems: the 10 percent rate cut on top of the already low reimbursement rate for dentists (one of the lowest in the nation), the low percentage of dentists participating in the program (only 24 percent back in 2007) coupled with the increase in new Medi-Cal beneficiaries, and the low utilization of services sought by the Denti-Cal population (only 25 percent with benefits accessed dental care).

There is much renewed interest to meet the needs of this underserved population. This was most recently seen at *CDA Presents* in Anaheim this May, when Denti-Cal representatives delivered the course "Adult Denti-Cal Services: Navigating the Renewed Program" and latecomers saw the sign posted outside of the classroom with the three most dreaded words: Room Is Full. Fortunately, the Denti-Cal course returned to the September San Francisco *CDA Presents*.

The state of Medi-Cal's adult dental benefits continues forward, hopefully addressing one more barrier to care.

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# Treating TMD

read with great interest your recent series of TMD articles in the August issue of the *Journal*. Thank you for putting together so many views. I can tell from your credentials and background which camp I would probably find you in. The divergent views of four highly respected experts in this field is quite thought-provoking and has inspired me to present the following comments.

At the age of 80, I am the youngest practicing dentist in the town of Cedarville, Calif. I have been here for more than 10 years; prior to this, I was a bush pilot dentist in Alaska for more than 40 years. I was issued the last Alaska Territorial dental license. When I arrived in Alaska with a new license and an education to be proud of, I thought I knew it all. It did not take long for me to recognize, however, that the centric occlusion was not always where I had been taught it was. Every dentist that I knew had his or her own special technique. I used various methods and bites for 40 years.

When I moved to California in 2003, I discovered Myotronics in Seattle and finally became aware that there was a jaw position that could be identified repeatedly. After being introduced to the neuromuscular concept, I became an avid student and studied the works of Bernard and later Robert Jankelson, read the works of Witzig and Spahl, listened to the lectures by Norman Thomas, Bill Dickerson, Clayton Chang and others and I became a true believer.

While in Alaska, I had two very good friends whose wives had severe TMD. They begged me to help — and I couldn't. They both had nice-looking teeth. An orthodontist had treated one. They were miserable and I could not help them. With just the little I have picked up in the past 10 years, I feel now that with my simple J-5 Myomonitor I could have made them



both comfortable. I do not have a K-7 but have been exposed to the fine-tuning that can be accomplished with one. I have treated several dozen cases using the J-5 with good results. Please tell me if I would do that much better with the K-7. I always TENS them until I can get three bites that are identical. Sometimes I need to put them in a temporary orthotic between TENS sessions, but eventually I will get three bites that are identical.

I agree with Dr. Fricton that cybernetics and his newly termed HST provides a framework that without doubt contributes to the problem. And Witzig and Spahl essentially discussed Dr. Simmons' emphasis on orthopedics before the J-5 was developed. Dr. Gelb could get to the Gelb 4/7 position quickly with a J-5 and I agree that airway is so important — I use a CPAP machine every night. I will not comment on Dr. Raman as I may see him sometime at the LVI when I can afford to attend.

My overall term for my limited TMD treatment would be pragmatic. I know that there are cases so complex that they

are way beyond my J-5 and me. No matter how complicated or esoteric any of these cases may be, they are all dependent upon attaining homeostasis and neuromuscular balance. But I think Einstein would agree that the pragmatic designation would describe all conditions of TMD imbalance, including the simple as well as the most theoretical situations.

> JIM HARROWER, DMD Cedarville, Calif.

### The Journal welcomes letters

We reserve the right to edit all communications. Letters should discuss an item published in the Journal within the past two months or matters of general interest to our readership. Letters must be no more than 500 words and cite no more than five references. No illustrations will be accepted. Letters should be submitted at editorialmanager.com/icaldentassoc. By sending the letter, the author certifies that neither the letter nor one with substantially similar content under the writer's authorship has been published or is being considered for publication elsewhere, and the author acknowledges and agrees that the letter and all rights with regard to the letter become the property of CDA.

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The nub:

1. Power is often a substitute for ethics.

2. We may have had enough of soapbox ethics.

3. Those who are most likely to bring ethics to dentistry are dentists.

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

## **Power Ethics**

David W. Chambers, EdM, MBA, PhD

There are approximately 75 ethics journals published in English. Bioethics is the largest specialty focus in health. Medicine has five journals. The professions are well represented, with multiple journals in business, law, education and nursing, and specialty publications for ethics in agriculture, engineering, research, the environment, information technology, media, sports and the military. A typical single issue of the *Journal of Business Ethics* contains 200 pages of peer-reviewed, referenced papers quarterly.

But there are no journals for dental ethics. *The Journal of the American Dental Association* began publishing the "Ethical Moment" in 2006. But the title suggests something less than the kind of in-depth discussions that would build a discipline. The Academy of General Dentistry and some other journals give advice. Ethics is a favorite topic for editorials, especially of the "we should all do better" type. The *Journal of the American College of Dentists* has a journal-within-a-journal called *Issues in Dental Ethics* and has been the richest source of writing about dental ethics, with an average of 40 pages of material each year.

There are two troubling characteristics of the literature on dental ethics. The obvious worry is the small amount of detailed and cumulative thought being given to the topic. Additionally, the articles typically address ad hoc issues, often with ad hoc opinions about how the writer would respond. It might be accurate to characterize much of dental ethics writing as well-meaning personal opinion rather than scholarship.

A study in one of the management ethics journals may shed some light here. In the research, individuals were given an ethical dilemma, and the outcomes of interest were how certain the decision-makers were regarding their choices and how much they consulted those affected by the decision. Decisionmakers' sense of power was subtly manipulated. Subjects first took a management quiz and a "high technical sense of power" group was created by giving falsely inflated feedback on the results. A low power group was created by faking poor scores.

Subjects who mistakenly believed they were powerful (about management) were less likely to consider the views of others and were more confident in their choices (about ethics).

Dentists are high-powered folks. They pretty much define what is so in their day-to-day worlds. Medicine is hospital based; business and law are played out in give and take among equals. Professions where expertise is open to frequent, knowledgeable scrutiny are more likely to have ethics journals.

Likely, we can begin to expect to see some journals in dental ethics. Group practice and corporate dentistry are growing. I recently polled informally a dozen leaders in dentistry and asked about the big ethical issues in the profession today. None mentioned patients; no one said anything about staff. All comments were about differences of opinion regarding how dentists should treat each other.

### Research Finds Patients Prefer Dentures Made From Silicone Impressions

Researchers recently conducted a study in order to provide evidence for best practice in prosthodontic impressions by comparing two impression materials and found that patients prefer dentures made from silicone impressions.

In the double-blind, randomized, crossover, controlled, clinical trial, the authors utilized 78 patients and provided each patient with two sets of dentures made using either alginate or silicone impressions, the study notes. The researchers found that 53 patients (67.9 percent) preferred dentures made from silicone impressions while 14 (17.9 percent) preferred alginate impressions. Four patients (5.1 percent) found both dentures equally satisfactory and seven patients (9 percent) found both equally unsatisfactory.

From their research, the authors made the following conclusions:

- Dentures made from silicone impressions were preferred by patients over dentures constructed from alginate impressions, both before and after the dentures were adjusted.
- Overall, patients preferred the experience of having impressions taken in silicone, finding silicone impressions more comfortable; however, there was no preference for the taste of either material.
- Patients' oral health-related quality of life was better after wearing dentures made from silicone impressions.
- Unadjusted dentures made from silicone impressions were more comfortable, stable and efficient for chewing.
- After adjustment, the dentures made from silicone impressions remained more stable and efficient for chewing.

### More Young Adults Have Dental Coverage Under ACA

Researchers from the ADA's Health Policy Institute found that the Affordable Care Act's (ACA) expanded dependent coverage provision increased access to dental care for young adults.

This according to a new report published in *Medical Care* that set out to "assess the effect of the Affordable Care Act's dependent coverage policy on private dental benefits coverage, utilization and financial barriers to dental care."

Although the ACA allows parents to keep their children on their medical plans up to age 26, there is no similar requirement for dental coverage.

According to the study's abstract, "The Affordable Care Act included a dependent coverage policy that extends parents' or guardians' health insurance to adults aged 19-25. This policy does not apply directly to private dental benefits. However, for various reasons it could still have an indirect 'spillover' effect if employers voluntarily expand dental coverage in conjunction with medical coverage."

Analyzing two years of postreform data, the study found that private dental benefits coverage among adults aged 19-25 increased by 5.6 percentage points in 2011 and 6.9 percentage points in 2012 compared with adults aged 26-34. Dental care utilization among adults aged 19-25 increased by 2.8 percentage points in 2011 and 3.3 percentage points in 2012 compared with adults aged 26-34. Adults aged 19-25 experienced a 2.1 percentage point decrease in 2011 and a 2.0 percentage point decrease in 2012 in financial barriers to dental care compared with adults aged 26-34.

The conclusion, according to the abstract, is "The dependent coverage policy

was associated with an increase in private dental benefits coverage and dental care utilization, and a decrease in financial barriers to dental care among young adults aged 19-25." For more information, visit ada.org/ en/press-room.



However, the adjustment of the dentures resulted in no detectable difference in comfort between the dentures.

The authors suggest, "Given the strength of the clinical findings within this paper, dentists should consider

choosing silicone rather than alginate as their material of choice for secondary impressions for complete dentures."

For more information, see the study in the *Journal of Dentistry*, vol. 42, issue 8, pp. 895–901, August 2014.



### Survey: Tooth Fairy Cutting Back in 2014

A recent "Tooth Fairy" survey, conducted annually by Visa, has found that American children are receiving an average of \$3.40 per lost tooth this year, down 8 percent from 2013. For a full set of 20 baby teeth, American kids will be getting a slightly more modest, but still hefty, \$68, down from \$74 last year, according to a news release.

The survey also found that the Tooth Fairy may be giving just what she happens to have in her pocket, as more than 50 percent of kids will get either \$1 or \$5. This year, 33 percent of respondents reported that the Tooth Fairy left a dollar, while only 3.6 percent of survey participants said the Tooth Fairy left \$20 or more, down from 6 percent in 2013.

Also according to survey results, fathers reported a far more indulgent Tooth Fairy, saying that the Fairy left 45 percent more than moms said she did: \$4.20 versus \$2.90. Kids in Canada are receiving the equivalent of \$2.60 in U.S. dollars on average with the exchange rate, which is the same amount the Tooth Fairy was leaving kids in the U.S. in 2011.

Last, the survey found that the Tooth Fairy spoiled kids in the West the most, leaving her most generous \$3.60 per tooth while children in the South and Northeast will each receive an average of about \$3.50. The Tooth Fairy was at her most thrifty in the Midwest, leaving an average of only \$3.10.

For more information, see the survey results at practicalmoneyskills.com/ about/press/releases\_2014/0821.php.

### ADA Addresses Triclosan Safety

The American Dental Association recently issued a statement on the safety of triclosan, an ingredient in Colgate Total, which is an ADA Sealapproved toothpaste.

Triclosan is the antibacterial, active ingredient in Colgate Total that fights plaque and gingivitis, and according to the ADA, Colgate Total — with a concentration of 0.3 percent of triclosan — is the only "ADA-Accepted" toothpaste that contains the substance.

According to the U.S. Food and Drug Administration's website, animal studies have shown that triclosan alters hormone regulation. However, the FDA notes that data showing effects in animals don't always predict effects in humans. Other studies in bacteria have raised the possibility that triclosan contributes to making bacteria resistant to antibiotics.

In a statement, the ADA reiterated that its Council on Scientific Affairs monitors and evaluates the safety of Colgate Total toothpaste on an ongoing basis. "If the council's evaluation determines sufficient scientific evidence exists that an ADA Seal-Accepted product poses a health risk, the council has the authority to withdraw the Seal from that product," the ADA statement said. In a later addition to the statement, the ADA noted that "at this time there is no clinically relevant scientific evidence indicating that the Seal should be removed from the Colgate Total product."

The ADA statement also said that the Council on Scientific Affairs will continually monitor and evaluate existing and new scientific information on the issue and recommended that consumers continue to follow the FDA's recommendations on the use of oral health care products that contain triclosan, according to a news story from the ADA. As the statement pointed out: "The FDA's November 2013 Consumer Update states that the FDA does not have sufficient safety evidence to recommend changing consumer use of products that contain triclosan at this time."

For more information, see the ADA story at ada.org/en/publications/ada-news/2014-archive/ august-2014/ada-issues-statement-on-triclosan-intoothpaste.



### Commonly Used Depression Drug and Dental Implant Failure

Selective serotonin reuptake inhibitors (SSRIs), the most widely used drugs for the treatment of depression, have been reported to reduce bone formation and increase the risk of bone fracture. Because osseointegration is influenced by bone metabolism, a recent study investigated the association between SSRIs and the risk of failures in osseointegrated implants. According to the study, published in the *Journal of Dental Research*, the authors found the primary outcome was that compared with nonusers of SSRIs, SSRIs usage was associated with an increased risk of dental implants failure.

The retrospective cohort study was conducted on patients treated with dental implants from January 2007 to January 2013 with a total of 916 dental implants in 490 patients (94 implants on 51 patients using SSRIs) used to estimate the risk of failure associated with the use of SSRIs, according to a news release. After three to 67 months of follow-up, 38 dental implants failed and 784 succeeded in the nonusers group while 10 failed and 84 succeeded in SSRIs-users group. The failure rates were 4.6 percent for SSRI nonusers and 10.6 percent SSRI users, respectively, the authors wrote, noting that SSRI users and nonusers were comparable in terms of age, sex, bone augmentation, smoking habit, implant diameter, implant length,

# Facial Fracture Injuries in Children and Adolescents by Cause

A recent study in the Journal of Oral and Maxillofacial Surgery detailed a multicenter study using national data of hospital-based emergency department visits to identify the prevalence of facial fracture injuries in children and adolescents by cause.

During the study period, 336,124 emergency department visits were for facial fractures in those no older than 21 years, according to the study. The authors found that "late adolescents" (18 to 21 years old) accounted for 46 percent of all emergency department visits, "middle adolescents" (15 to 17 years old) for 27 percent. They also found male patients comprised 75 percent of emergency department visits.

According to a description of the study, facial fractures most commonly found were those of the nasal bones and mandible. While these injuries in younger children were more likely to have been caused by falls and pedal cycle accidents, those in older children were more likely to have resulted from such occurrences as firearm injuries, motor vehicle accidents and assaults, according to a news release.

Those residing at low annual income household levels were at a high risk for having firearm injuries, motor vehicle traffic accidents and transport accidents, the authors

wrote, adding that late adolescents, middle adolescents and male patients comprise a significant proportion of these emergency department visits.

"Age, gender and household income levels are significantly associated with the causes of facial fracture injuries," authors concluded.

For more information, read the complete study findings in the Journal of Oral and Maxillofacial Surgery, September 2014, vol. 72, issue 9, pp. 1756-1765.



implant torque and follow-up period.

The retrospective study also found that small implant diameters (<4 mm), bone augmentation and smoking habits also seemed to be associated with an increased risk of implant failure while patient's age, sex, bone augmentation, follow-up period, implant length and torque had no significant association with implant survival rate.

"Within the limits of this study, these findings indicate that treatment with SSRIs is associated with an increased failure risk of osseointegrated implants," the authors concluded.

For more information, see the study in the *Journal of Dental Research*, published online before print Sept. 3, 2014.

### AAP Issues New Dental Recommendations

The American Academy of Pediatrics recently issued new children's oral health recommendations, beginning with a recommendation that all children start using toothpaste with fluoride when their teeth appear, regardless of cavity risk level. According to a news release from the AAP, children age 3 and younger are advised to use a small amount of toothpaste, equivalent to a grain of rice, and for those 3 and up, a pea-sized amount may be used. Parents should

### Bacterial Growth on Hollow-head Versus Solid-head Toothbrushes

According to researchers at The University of Texas Health Science Center at Houston School of Dentistry, solid-head power toothbrushes retain less bacteria compared to hollow-head toothbrushes.

In the recent study, published in the *Journal of Dental Hygiene*, the authors found that microbial counts were lower in the solid-head toothbrush group than in the two hollow-head toothbrush groups in nine out of 10 comparisons.

"Toothbrushes can transmit microorganisms that cause disease and infections. A solid-head design allows for less growth of bacteria and bristles should be soft and made of nylon," lead author Donna Warren Morris, RDH, MEd, said in a news release. "It is also important to disinfect and to let your toothbrush dry between uses. Some power toothbrushes now include an ultraviolet system or you can soak the head in mouthwash for 20 minutes."

The study was conducted over a three-week period where participants brushed twice daily with one of three randomly assigned power toothbrushes. Participants used non-antimicrobial toothpaste and continued their flossing routine throughout the study, but refrained from using other dental products like mouthwash.

During the study, the brush heads were exposed to five categories of oral microorganisms: anaerobes and facultative microorganisms, yeast and mold, oral streptococci and oral enterococci anaerobes, *Porphyromonas gingivalis* and

Fusobacterium species.

"The solid-head power toothbrush was found to have significantly less microbial contamination than either of the two hollowhead power toothbrushes for all the bacteria tested and less than one of the hollow-head brushes for yeast and mold," the authors wrote.

For more information, read the complete study in the Journal of Dental Hygiene, August 2014, vol. 88, no. 4, pp. 237-242.





dispense toothpaste for young children and supervise and assist with brushing.

The new recommendations also state that fluoride varnish is recommended in the primary care setting every three to six months starting as soon as the first tooth emerges; however, over-the-counter fluoride rinse is not recommended for children younger than age 6 due to a risk of swallowing higher-than-recommended levels of fluoride.

Because fluoride is available in many sources, including food and tap water, and may be administered at home and professionally applied, the AAP says, "pediatricians should be aware of the risks and benefits of various fluoride modalities to appropriately advise families to achieve maximum protection against dental caries, and to help counsel patients about proper oral health."

As tooth decay remains the most common chronic disease in American children, health officials hope this new information can prevent future cavities from forming.

For more information regarding the changes, see the report, "Fluoride Use in Caries Prevention in the Primary Care Setting," in the journal *Pediatrics*, vol. 134, no. 3, September 2014.



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### New Shape-memory Polymer Could Help Reconstruct Faces

Researchers recently developed a "selffitting" material that expands with warm salt water to precisely fill bone defects and can act as a scaffold for new bone growth, according to a news release. This research, which was presented at a meeting of the American Chemical Society, could help reconstruct faces by filling gaps in bone that are too large to heal naturally.

Currently, the most common method for filling bone defects in the head, face or jaw is autografting.

"The problem is that the autograft is a rigid material that is very difficult to shape into these irregular defects," said study leader Melissa Grunlan, PhD, in the news release.

Another approach is to use bone putty or cement to plug gaps, but according to the news release, these materials aren't ideal because they become very brittle when they harden and they lack pores that would allow new bone cells to move in and rebuild the damaged tissue.

To develop a better material, Grunlan and her colleagues created a shapememory polymer (SMP) that molds itself precisely to the shape of the bone defect without being brittle, and according to the news release, also supports the growth of new bone tissue.

Upon heating to 140° F, the SMP becomes very soft and malleable, which would allow a surgeon to fill in the defect with the softened material. Then, as the SMP cooled to body temperature, it would resume its former stiff texture and "lock" into place.

The researchers also coated the SMPs with polydopamine to help lock the polymer into place by inducing

formation of a mineral that is found in bone. It may also help osteoblasts, the cells that produce bone, to adhere and spread throughout the polymer. The SMP is biodegradable, so that eventually the scaffold will disappear and leave only the new bone tissue behind.

For more, see the study in the journal *Acta Biomaterialia*, published online ahead of print July 24, 2014.

### Improved Appearance and Psychological Factors

A recent issue of Angle Orthodontist included a study on the relationship between satisfaction with dental esthetics and oral health-related quality of life among treated adults. According to a study summary from the American Dental Association, authors also compared patients' esthetic satisfaction and quality of life when appearance evaluations were performed by people other than the patients themselves – three panel groups: 30 laypersons, 30 dental students and 10 orthodontists.

The study utilized 52 patients between the ages of 18 and 61 with severe malocclusion who were treated in Oulu University Hospital. Of these, 38 patients underwent orthodontic/surgical treatment and 14 patients underwent orthodontic treatment. A questionnaire and dental photographs were collected before and after treatment and the 14-item Oral Health Impact Profile (OHIP-14) was used to measure oral health-related quality of life.

According to the study, dental photographs were presented to the three panel groups who rated the photographs using the Aesthetic Component of the Index of Orthodontic Treatment Need. The authors found oral health-related quality of life and esthetic satisfaction improved after the treatment.

The most unsatisfied patients reported oral effects more often both before and after treatment, the study found. Authors also noted that changes in oral health-related quality of life components of severity, psychological discomfort and psychological disability correlated positively with the changes in esthetic satisfaction. Orthodontists graded the situation before treatment as worse and the outcome as better than the laypersons did. The level of grading by dental students fell between these two groups.

The study concluded,

"Improvement in esthetic satisfaction due to the treatment of severe malocclusion improves oral healthrelated quality of life, particularly by decreasing psychological discomfort and psychological disability."

For more, see the study in Angle Orthodontist, July 2014, vol. 84, no. 4, pp. 594-599.



# Dignity

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# One Million More Children Knocking on the Dental Door

Paul Reggiardo, DDS

### **GUEST EDITOR**

Paul Reggiardo, DDS, is the public policy advocate for the California Society of Pediatric Dentistry. He is a past president of the CSPD and the American Association of Pediatric Dentistry. Dr. Reggiardo practices pediatric dentistry in Huntington Beach, Calif. Conflict of Interest Disclosure: None reported. arly last year, I was struck by a headline in the *California Health Report*, an independent nonprofit journalism project with a mission of informing Californians about public health and community health issues, which read, "After reform, a million more kids will be insured — but will they be able to find a dentist?"

The article went on to report that the state would transition more than 850,000 Healthy Families children to fee-for-service Denti-Cal delivery in 2013, and by the end of 2014, through expanded entitlement under the Affordable Care Act, the number of children eligible for Denti-Cal benefits would exceed 5 million — slightly more than 50 percent of the state's childhood population. In addition, more children from low-income households would be gaining dental benefits under commercial programs sold in the state health insurance exchange, Covered California, as a result of health care reform.

At about the same time, Carrie Tsai,

DMD, MPH, then a pediatric dental resident at the University of California, San Francisco, was completing her research thesis on the capacity of the pediatric dental safety net in California to meet the needs of these low-income children. Her study, co-authored by Cynthia Wides, MA, and Elizabeth Mertz, MA, PhD, which is reported in this issue, is the first to examine the dental workforce for low-income pediatric patients in California in the context of the 2014 implementation of the Affordable Care Act. She concludes, not surprisingly, that the likely increase in the Denti-Cal population and the concurrent decrease in the number of dentists willing or able to treat this population is reason for concern.

James Crall, DDS, ScD, chair of the Division of Public Health and Community Dentistry at the University of California, Los Angeles, takes a larger view in this issue of our national and state commitment to improving the oral health of disadvantaged children by expanding enrollment in public programs without removing or correcting chronic Medicaid dental program shortcomings. He notes that California ranks among the lowest-performing Medicaid dental programs for children in the nation and has shown only meager, sporadic signs of improvement over the last 14 years. He chronicles program deficiencies, cites examples of other state improvements in Medicaid dental performance and makes specific suggestions for Denti-Cal reform.

If part of the problem of an inadequate supply of willing providers for these 1 million additional children is programmatic, another part may lie in the educational preparedness of our graduating dentists to treat those children with the highest burden of dental disease — who are predominately poor, minority and young. Paul Casamassimo, DDS, MS, professor and chair of the Division of Pediatric Dentistry at The Ohio State University and chief of dentistry at Nationwide Children's Hospital in Columbus, Ohio, and N. Sue Seale, DDS, MSD, professor emeritus and former chair of the Department of Pediatric Dentistry at Baylor College of Dentistry at Texas A&M University, report on their 2014 survey of dental educators regarding predoctoral educational experience and propose some novel training directions. Their proposals include suggestions for partnering with corporate dentistry, increasing community-based dental education, expanding curricular hours and clinical experiences in predoctoral education and raising Medicaid fees.

Lastly, Ray Stewart, DMD, MS, and Roger Sanger, DDS, MS, report on the Pediatric Oral Health Access Program (POHAP), a joint project of the California Dental Association and the California Society of Pediatric Dentistry to address the shortcomings of predoctoral dental education with the first large-scale effort in the nation to provide intensive advanced education and training in pediatric dentistry to general dentists. Dr. Stewart is the executive director of CSPD and a professor in the Division of Pediatric Dentistry at the University of California, San Francisco. Dr. Sanger is director, Pediatric Sedation Curriculum, DOCS Education, Seattle. They report that this effort by the dental profession, supported by grants from the CDA Foundation, Delta Dental of California, L.A. Care, The California Endowment and Western Dental, to increase access to oral health care for children by general dentists in private

practice and community health centers, has reached close to 450 dentists, treated more than 82,000 children and rendered a collective treatment value of more than \$34 million. What is less clear is the long-range change in practice patterns by POHAP graduates and the modification in POHAP training required to adequately prepare dentists to competently provide pediatric oral conscious sedation.

What is clear is that by the end of this year, something slightly more than 1 million additional children will be knocking on the California dental door. Who will let them in?





# Dental Workforce Capacity and California's Expanding Pediatric Medicaid Population

Carrie Tsai, DMD, MPH; Cynthia Wides, MA; and Elizabeth Mertz, MA, PhD

ABSTRACT The number of children eligible for Medicaid dental coverage in California will increase to nearly 5 million because of the Affordable Care Act (ACA) and the transition of nearly 880,000 children from California's Children's Health Insurance Program (CHIP) to Medicaid. This study assesses the dental workforce capacity to serve this population. Supply projections indicate that provider deficits are likely in rural and urban counties after the CHIP population is transitioned and the ACA is fully implemented.

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Thank you to Jenny Kattlove at the Children's Partnership and Stuart Gansky and Joanne Spetz at UCSF for their thoughtful review of this manuscript. n California, Medicaid and the Children's Health Insurance Program (CHIP) have provided the backbone of dental coverage for low- and moderate-income children whose families' incomes are at or below 250 percent of the federal poverty level (FPL). During 2013, approximately 880,000 low-income children were transitioned from the Healthy Families Program (HFP, California's CHIP program) to Medicaid.

Most dental providers who treat children in Medicaid (Medi-Cal in California) are reimbursed by Denti-Cal, a fee-for-service (FFS) payment system under which dentists are paid for each procedure. Providers who treat Medicaid children in federally qualified health centers (FQHCs), Native American or rural health clinics are typically salaried or on contract with the clinic, which is reimbursed under a

prospective payment system (PPS) — an encounter-based reimbursement structure. In 2011, approximately 13.2 percent of the enrolled Denti-Cal population who also had a dental procedure were treated in such clinics.<sup>1</sup> Children in Sacramento and Los Angeles counties are covered through dental managed care (DMC) plans, which operate through a capitated payment system and constitute about 5 percent of the enrolled Medicaid population.<sup>2</sup> While DMC is mandatory in Sacramento County, parents in Los Angeles County may choose to enroll their children in either dental managed care or fee for service. In 2013, the HFP mandated that children in Sacramento County enrolled in HFP plans move to one of the capitated payment DMC plans. In Los Angeles County, children covered by HFP plans were given the choice of moving into one of the DMC plans or finding an FFS provider.

Effective January 2014, the Patient Protection and Affordable Care Act (ACA) requires all health insurance (public and private) to include dental benefits as part of the essential benefit package for children under age 19 with the exception that a qualified health plan in the exchange is not required to include the pediatric dental benefit if a stand-alone dental plan providing those benefits is available. (Under federal rules, individuals purchasing coverage through exchanges are not required to purchase pediatric dental coverage. Rather, the requirement is to offer coverage.)<sup>3-5</sup> The federal government has also funded CHIP through 2015 with plans to maintain the program until 2019. Under the ACA in California, dental insurance coverage for the pediatric population will be expanded by increasing enrollment in Medicaid, which already covers pediatric dental care, and by mandating pediatric dental coverage through both the staterun insurance exchange and private market products. The influx of publicly and privately insured children, as well as newly insured adults, into the dental marketplace raises questions about the capacity of the pediatric dental safety net in California to meet the needs of lowincome children. This paper provides an analysis of trends in pediatric Denti-Cal and HFP enrollment and utilization of dental services from 2006-2011, as well as estimates of current and future capacity of the dental workforce to provide dental services to children enrolled in Medi-Cal.

### **Methods**

### Data Sources

Medi-Cal fee-for-service dental (Denti-Cal) pediatric enrollment and dental utilization data were obtained for the California fiscal years (FY) 2006, 2008 and 2011 from the California Department of Health Care Services (DHCS), and included claims by procedure type for only unduplicated users enrolled for at least 11 of the most recent 12 months with no more than a one-month break in eligibility ("continuously enrolled").<sup>6</sup> Enrollment and utilization data for continuously enrolled children in HFP were obtained by averaging the monthly enrollment reported in Annual Enrollment Reports as well as dental quality reports prepared by California's Managed Risk Medical

Under the ACA in California, dental insurance coverage for the pediatric population will be expanded by increasing enrollment in Medicaid ...

Insurance Board (MRMIB) for 2006, 2008 and 2011.<sup>7,20-22</sup> Data on encounters and utilization rates of children in clinics were also obtained from the DHCS. Utilization data for children under managed care were not readily available.

Data on Denti-Cal provider practice location and number of patients seen were obtained from the DHCS for FY 2011 and included all providers.<sup>8</sup> Membership lists and practice locations for pediatric dentists in California for calendar year 2012 were obtained from the American Academy of Pediatric Dentistry (AAPD) and the California Society of Pediatric Dentistry (CSPD).<sup>9,10</sup> These lists include licensed pediatric dental specialists who were members of AAPD and/or CSPD in 2012, but are not inclusive of all licensed pediatric specialists in California.

Demographic data on children ages

0-19 years of age separated by income bracket and median household income for each county in California were obtained from the U.S. Census Bureau for the calendar years of 2006, 2008 and 2011.<sup>11</sup> Data on California counties were obtained from the Office of Statewide Health Planning and Development (OSHPD), which designates rational services areas in California as Medical Service Study Areas (MSSA). MSSAs incorporate the U.S. census total population as well as socioeconomic and demographic data to classify one or more complete census tracts as frontier (fewer than 11 persons per square mile), rural (fewer than 250 persons per square mile not exceeding 50,000) or urban (population range of 75,000-125,000) within each county in California.<sup>12</sup>

### Methodology

This study estimates California's ability to meet current and future demand for Medicaid pediatric dental services by examining trends in dental enrollment and utilization by the pediatric Medicaid population, trends in the number and distribution of California's Medicaid and pediatric dental providers and current and future capacity of the Medicaid dental workforce to treat pediatric patients. All analyses were performed using descriptive statistics.

### Medicaid Pediatric Eligibility, Enrollment and Utilization Trends

We estimated *potential eligibility* based on income levels of children's families in California counties obtained from the U.S. Census Bureau.<sup>11</sup> This estimate is based on the Medicaid family's income level, where coverage is available for children younger than 1 year of age up to 200 percent FPL, ages 1 to just under 6 years of age up to 133 percent FPL and ages 6 to just under 21 years of age up to 100 percent FPL. HFP provides coverage of children ages 0 to 19 years of age up to 250 percent FPL, but does not take into account other eligibility factors such as immigration status. To be eligible in the infant category, a child must not have reached his or her first birthday; to be eligible in the 1-to-5-years-of-age category, the child is 1 year of age or older, but has not yet reached his or her sixth birthday. To be eligible in the 6-to-19-years-of-age category, the child is age 6 or older, but has not yet reached his or her 19th birthday.

Descriptive trends for each measure from 2006 through 2011 were computed to examine trends over time, while the difference between eligibility and enrollment was computed to determine the enrollment increase possible under the ACA.

Pediatric Denti-Cal utilization was measured as the rate of enrolled children who accessed either diagnostic, preventive or restorative dental services in each fiscal year. Utilization by HFP enrollees was measured through the occurrence of an annual dental visit from 2006 to 2011, along with rates of utilization for evaluation (diagnosis), preventive and dental treatment procedures (including fillings, crowns, root canals and oral surgery).

Medicaid and pediatric dental provider trends and distribution. Trends were calculated from Medicaid provider data for the years 2006, 2008 and 2011. We analyzed all providers (not just those seeing pediatric patients) to determine overall trends in provider participation and distribution.

The membership lists of specialty trained pediatric dentists were obtained from AAPD or CSPD for calendar year 2012, and were cross-referenced with those who participated in Denti-Cal for FY 2011 to calculate the number of pediatric Denti-Cal providers.

To assess distribution of providers, all



\* Denti-Cal data are fiscal years (July-June) while Healthy Families data are the average for the months in the calendar year.

**FIGURE 1.** Number of children potentially eligible and enrolled in Denti-Cal (Medicaid) and Healthy Families (CHIP).

Denti-Cal dentists, Denti-Cal pediatric dentists and AAPD/CSPD pediatric member dentists were categorized into counties based on practice locations or cities reported to AAPD and/or CSPD directories. Counties were classified as majority rural if all MSSAs were more than or equal to 75 percent frontier or rural, and classified as majority urban counties if all MSSAs were less than 75 percent rural. Counties were also classified by wealth quartile using median household income data from the U.S. Census Bureau.<sup>13</sup>

Dental provider capacity estimates. Provider-to-population ratios are commonly used to estimate workforce supply, although no clear guidance as to what ratio represents adequacy is provided in the literature or by any regulatory or advocacy organization. The Health Resources and Services Administration (HRSA) classifies dental shortage areas as those with a ratio of less than 1:5,000. The Knox-Keene Act, used to determine provider adequacy for dental managed care programs, is set at a 1:2,000 ratio; however, both of these ratios include adults and all payer sources as part of the population.

For this study, we took into consideration that very few dentists have patient panels comprising at least 10 percent Medicaid recipients, and only one in six dentists who accept Medicaid receives \$10,000 or more in Medicaid payments per year.<sup>14</sup> Further, many Medicaid general dentists do not treat children or may limit the number of children they see. In fiscal year 2009-2010, 25 percent of California dentists who treated children enrolled in Denti-Cal saw 80 percent of all Denti-Cal children.<sup>15</sup> The actual ratio of all dentists for the total population in California was 1:1,050 in 2011.<sup>16,17</sup> We chose a conservative benchmark of "adequate" capacity for this study — a county Denti-Cal providerto-eligible-pediatric-population ratio of 1:1,000. A sensitivity analysis was then conducted using higher and lower ratios of 1:800 and 1:1,200. For the final capacity analysis, we restricted the data to those Denti-Cal providers who had seen at least 100 Denti-Cal pediatric patients (0-20 years of age) in the last fiscal year. We did not include any HFP providers in our

estimates beyond those who already meet the Denti-Cal restriction criteria. As of November 2012, the DHCS reported that the Healthy Families network contained 9,398 individual providers, 82 percent (n=7,706) of whom also participate in Denti-Cal.<sup>18</sup> Recent reports from the DHCS show that about 4.1 percent of former HFP providers went on to enroll in the Denti-Cal program.<sup>19</sup>

### Results

### Denti-Cal and HFP Pediatric Enrollment and Dental Service Utilization 2006-2011

Trends in pediatric Denti-Cal and HFP eligibility and enrollment. Medicaid pediatric enrollment increased by 18.5 percent, from 2.22 million to 2.63 million, from FY 2006 to 2011, while HFP enrollment increased by 11.6 percent, from 763,844 to 852,291 in calendar years 2006-2011. During the same period, the pediatric Denti-Cal population potentially eligible for enrollment increased by 18.8 percent from 2.39 million to 2.84 million, and the HFP potentially eligible population decreased by 3.7 percent from 2.45 million to 2.36 million (FIGURE 1). These numbers indicate that between 2006 and 2011 the number of children who were potentially eligible for, but not enrolled in, Denti-Cal had increased from 170,000 to 210,000. In the HFP during the same time period, the difference between potentially eligible and enrolled decreased by 178,000, yet more than 1.5 million potentially eligible children were not enrolled in the HFP.

Trends in pediatric Denti-Cal and HFP utilization. Overall utilization by Denti-Cal-enrolled children increased during the study timeframe. In FY 2006, 881,213 children of the 2,215,883 enrolled (39.8 percent) received at least one diagnostic procedure, and the number of procedures



\* Annual Dental Visit (ADV) was used as proxy for diagnostic visits in the Healthy Families Program. \*\* Years for Denti-Cal graph are fiscal years (July-June) ending in written year. Years used here for Healthy Families were calendar years ending in December.



TABLE 1

Mean Dental	Procedures	Per Enro	llee of De	nti-Cal (Med	icaid) for	Fiscal	Years
2006-2011							

	Diagnostic	Preventive	Restorative
2005-2006	7.8	2.1	3.9
2006-2007	7.9	2.1	3.9
2007-2008	8.0	2.2	4.0
2008-2009	8.0	2.2	4.0
2009-2010	8.4	2.3	4.2
2010-2011	8.5	2.3	4.1

per user averaged 7.8. By FY 2011, the share receiving at least one diagnostic procedure had increased to 45.7 percent and the average number of procedures rose to 8.5 per user. (FIGURE 2 and TABLE 1).

In 2006, 473,585 (62 percent) of the 763,846 children enrolled in HFP had at least one annual dental visit.<sup>20,21</sup> This percentage dipped to 56 percent in 2008

and then rebounded to 59 percent in 2011.<sup>17</sup> From 2008 to 2011, utilization of preventive dental services increased from 51 percent to 54 percent while the rate of restorative services decreased from 31 percent to 30 percent (**FIGURE 2**).<sup>22</sup>

From 2006 to 2011, the number as well as proportion of Medi-Cal-enrolled children seen in dental clinics (FQHCs, Native American and rural health clinics) increased steadily from 79,546 (3.6 percent of total Medi-Cal enrollees) to 192,358 (7.1 percent). The average of 2.7 dental encounters per user in clinics remained the same from 2006 to 2011.

### Denti-Cal and HFP Dental Provider Participation 2006-2011

Trends in Denti-Cal general and pediatric dental provider participation. California had approximately 32,800 licensed dentists in 2006.<sup>23</sup> Of these, 12,101 (36.9 percent) participated in Denti-Cal. By FY 2011, the raw number of dentists participating in Denti-Cal had decreased by 5.9 percent (n=710) to 11,392 dentists, while the percentage of all dentists in the state participating in the program dropped to 31.6 percent (of 36,058 total dentists). Among pediatric dental specialists in 2012, 364 (41 percent) of all members of either AAPD or CSPD had participated in the Denti-Cal program in FY 2011. This indicates that pediatric dentists who were members of their specialty organizations in 2011 participated in Denti-Cal at higher rates than did all dentists.

Trends in geographic distribution of Denti-Cal and pediatric providers. Of California's 58 counties, we classified 40 percent (n=23) as primarily urban according to their MSSA composition and the remaining 60 percent as primarily rural (n=35). In FY 2006, a majority (93 percent) of Denti-Cal dentists (n=11,257) were located in urban counties with 7 percent (n=844) in rural counties. In FY 2011, 94 percent (n=10,704) of Denti-Cal dentists were practicing in urban counties with only 6 percent (n=688) in the state's 35 rural counties (**FIGURE 3**).

Of all dentists participating in Denti-Cal in FY 2011, 3.2 percent (n=365) were pediatric specialists who belonged to AAPD or CSPD in calendar year



FIGURE 3. Distribution of the Medicaideligible pediatric population (2011), all Medicaid dentists and all pediatric dentists by county according to rural versus urban designation.

2012. Of these Denti-Cal pediatric specialists, 92 percent were in urban counties (n=335). Examining all pediatric specialists, including those who did not participate in Denti-Cal, reveals that the majority was located primarily in urban counties (94 percent) (n=833), mirroring the overall distribution of Denti-Cal providers (**FIGURE 3**). The population distribution of poor children (family income less than 250 percent FPL) was less urban, with 87.8 percent (n=2,496,090) residing in urban counties and 12.2 percent (n=345,808) residing in rural counties in 2011 (**FIGURE 3**).

Based on median county income, 86 percent (n=7,282) of practices accepting Denti-Cal in FY 2011 were located in the wealthiest half of California's counties, and 37 percent (n=3,095) were located in the wealthiest quartile (FIGURE 4). The distribution of pediatric specialists was even more skewed to higher income areas with 95 percent (n=841) located in the wealthiest half of counties and



FIGURE 4. Distribution of the Medicaid-eligible population into county quartiles based on median household income compared to distribution of all Medicaid dentists and all pediatric dentists that practice in those quartiles of counties.

40 percent (n=357) located in the top quartile of counties by median income (FIGURE 4). This means there were only 47 (5 percent of total) pediatric specialists to treat all of the Denti-Calenrolled children in the 29 counties that make up the lower half of the wealth distribution and almost 20 percent of the low-income pediatric population.

Dentists exiting the Denti-Cal program between FY 2006 and 2011 resulted in a 5-percent loss of providers in urban counties compared to a 19-percent loss of providers in rural counties, and the poorest quartile of counties saw disproportionately higher losses of

### TABLE 2

### Change in Geographic Distribution of Medicaid Dentists From 2006 to 2011

	2006 Count of Dentists	2011 Count of Dentists	Percent Change
Urban Counties	11,257	10,704	-5%
Rural Counties	844	688	-19%
Highest Quartile of Counties	3,363	3,094	-8%
Lowest Quartile of Counties	455	386	-15%

### TABLE 3

Medicaid Dentists Required to Maintain a 1:1,000 Provider-to-Population Ratio (range of 1:800 to 1:1,200) for the 2011 Medicaid-eligible Pediatric Population

	1:800	1:1,000	1:1,200
Urban	-628	-3	413
Rural	-192	-106	-48

### TABLE 4

Medicaid Dentists Required to Maintain a 1:1,000 Provider-to-Population Ratio (range of 1:800 to 1:1,200) for the 2014 Medicaid-eligible Pediatric Population

	1:800	1:1,000	1:1,200
Urban	-3,284	-2,129	-1,359
Rural	-481	-337	-214

Denti-Cal dentists (15 percent) than the wealthiest quartile (8 percent) (TABLE 2).

### Denti-Cal and HFP Dental Provider Capacity to Meet Future Demand for Pediatric Services

Projected pediatric Denti-Cal enrollment. By the end of 2013, HFP's 880,000 enrollees were slated to be shifted to Medicaid, increasing total enrollment in Denti-Cal to roughly 3.5 million children. With the January 2014 enactment of the ACA mandate under which all children were offered insurance coverage that included a dental benefit through private or public insurance, the pediatric Denti-Cal population likely further increased, given that 1.7 million children were already eligible for but not enrolled in Denti-Cal or HFP during 2013. As a result, more than 5.2 million children over half of all California children — are Denti-Cal eligible as of January 2014.<sup>24</sup>

2011 Denti-Cal provider capacity. The provider-to-population ratios computed for the capacity analysis included only Denti-Cal providers who treat more than 100 children per year (n=2,733) and the estimated eligible pediatric population in 2011 (TABLE 3). In 2011, using the benchmark ratio of 1:1,000, urban counties had a shortfall of only three Denti-Cal providers, while rural counties had a shortfall of 106 providers. The sensitivity analysis using a low-end ratio of 1:800 and a high-end ratio of 1:1,200 produced estimates that ranged from a shortfall of 628 providers to a surplus of 413 Denti-Cal providers in urban areas, while rural counties' capacity is lacking at both ends of the sensitivity analysis

with shortages from 192 to 48 dentists.

Projected Denti-Cal provider capacity, post 2014. To project provider capacity for 2014, provider-to-population ratios were calculated assuming an estimated total eligible Denti-Cal pediatric population of 5.2 million and the 2011 number of Medicaid dentists who treated children (TABLE 4). Both urban and rural counties are expected to have Medicaid dentist shortfalls with urban counties requiring 2,129 Denti-Cal providers, and rural counties requiring 337 providers in order to meet the 1:1,000 ratio. The sensitivity analysis using a low-end ratio of 1:800 and a high-end ratio of 1:1,200 produced estimates that ranged from a shortfall of 3,284 to 1,359 Denti-Cal providers in urban areas and a shortfall range of 481 to 214 dentists in rural counties. Urban counties are projected to require 20 percent (n=2,129) more Denti-Cal dentists than currently participate and rural counties will require an additional 50 percent (n=337) to maintain a 1:1,000 ratio in 2014. No counties would be able to meet the provider-to-population ratio of 1:1,000 in 2014 with the 2011 number of Denti-Cal providers. FIGURE 5 graphs the estimated dentists needed to meet the 1:1,000 ratio with the range (1:800-1:1,200) by county using 2011 dentists counts for both 2011 (green lines) and 2014 (yellow lines). The four counties that experience the largest supply of dentists (>40 Medicaid dentists who see children) in 2011 are all urban counties: Orange, Los Angeles, San Bernardino and Santa Clara.

### Discussion

Our study shows that the capacity of the dental workforce to address the needs of the pediatric Denti-Cal population is likely to be stressed if Medicaid enrollment swells to the projected levels under the Affordable Care Act in



\*Each line represents where a county stands in terms of having enough dentists for given size of pediatric population. Counties shown above zero are projected to have more dentists than will be necessary using 1:1,000 as a referent, while counties below zero are projected to have insufficient numbers of dentists. The length of each line shown (error bars) designate the boundaries of the sensitivity analysis for provider-to-population ratios from 1:800 to 1:1,200. Some rural counties had to be combined because their populations were smaller than the U.S. Census can classify.

FIGURE 5. Medicaid dentist estimated supply: Numbers of Medicaid dentists available for the estimated 2011 Medicaid-eligible pediatric population and for the projected 2014 Medicaid-eligible pediatric population.

2014. Our conservative estimate is that urban counties will require a 20 percent increase in the number of dental providers participating in Denti-Cal, while rural counties will require a 50 percent increase. Poor counties already fare worse than wealthier counties in provider supply. The maldistribution of pediatric specialists, who are few in number to begin with, is especially severe. The policy environment shaping the pediatric dental care supply and demand landscape is guite volatile at the moment; however, the possible pressures on the system that would push these estimates in a positive or negative direction can be anticipated.

Our examination of demand for dental care indicates that enrollment, utilization and procedure use for the pediatric Denti-Cal population in California have been on the rise and may continue to increase. The payment plans participating in the HFP in California report a higher utilization rate for the enrolled population than claims data show for the Denti-Cal program.<sup>25</sup> Therefore, if the HFP population maintains a higher demand for care, moving these individuals to Medicaid may inflate Medicaid utilization rates, despite the flat HPF utilization trends. It is not known how close the final enrollment numbers in Medicaid will come to the projection of 5.2 million children or what percent of those newly enrolled children will ultimately seek dental care. This will depend on many unpredictable policy and social factors.

Another confounding issue is the ongoing economic recovery, which may lead to a decrease in the percent of children covered by public insurance programs. It is possible that the growth in Denti-Cal eligibility and enrollment we see in our data, and concurrent downturn in HFP numbers, was sparked by low-income families shifting into an even lower (Denti-Cal eligible) income bracket during the recessionary period and availing themselves of Denti-Cal benefits in lieu of their former HFP coverage. As the economy recovers, we would expect to see more families' incomes increasing to levels ineligible for Medicaid, decreasing demand for Denti-Cal services.

Trends in the supply of dental care for Denti-Cal eligible children show that dentist participation in Denti-Cal has declined in the state, even as the overall dentist population grows. It is unclear to what extent there may be a future inflow of Denti-Cal providers beyond 2013. A 2012 survey of Healthy Families providers indicates that 92.1 percent of Healthy Families members will continue to receive care from their same provider post-transition,<sup>26</sup> and the DHCS is making efforts to enroll HFP providers that did not formerly accept Denti-Cal. However, recent data show that from January 2013 to November 2013, while there were 448 newly enrolled Denti-Cal providers (278 providers also inactivated their

enrollment), only 66 were former HFP providers, representing an enrollment of only 3.9 percent of the targeted former HFP provider population.<sup>27</sup> The recently implemented 10 percent reimbursement cut<sup>28,29</sup> may further erode Denti-Cal's provider participation that was already challenged by low reimbursement rates and significant administrative burdens.<sup>30</sup> Many dentists who participate in both HFP and Denti-Cal place limits on the number of Denti-Cal patients they treat<sup>31</sup> in any given year, so, ultimately, rate cuts combined with increased bureaucracy may result in an even lower rate of provider participation in Denti-Cal in the immediate aftermath of the HFP transition and the implementation of the ACA pediatric mandate.

An additional policy issue that will impact supply is the scheduled partial reinstatement of adult dental benefits in conjunction with expansion of Medi-Cal coverage to formerly ineligible adults under the ACA.<sup>32,33</sup> In July 2009, Denti-Cal eliminated coverage for optional adult Medicaid dental benefits for most adults. Previous studies have shown that policy changes reducing or eliminating optional adult Medicaid dental benefits have resulted in Medicaid dental providers shifting their focus to the provision of care to the pediatric Medicaid population.<sup>34</sup> This trend is born out in our data, which show a jump in pediatric utilization after 2009. However, private providers were not always able to replace the income lost from their adult patients by treating more pediatric patients.<sup>35,36</sup> Therefore, the reinstatement of these benefits may actually decrease the safety net's capacity to care for children as providers reinstate adults into their practices. Alternatively, it may result in an increase in overall dentist participation in Denti-Cal, many of whom could be expected to treat pediatric patients.

The ongoing economic recovery combined with expanded dental insurance coverage for all children under the ACA, not just those in public assistance programs, may increase demand from the privately insured marketplace. Reimbursement rates in California's Denti-Cal program are one-third to onehalf of the usual fees charged for selected dental services,<sup>37</sup> one of the lowest reimbursement rates in the nation.<sup>38</sup> Dentists may prefer to provide dental

Therefore, the reinstatement of these benefits may actually decrease the safety net's capacity to care for children ...

services to the newly insured health exchange patients if they garner higher reimbursement rates than Medicaid patients. This may crowd out the growing Denti-Cal enrolled population given the limited supply of dentists accepting Medicaid, further reinforcing the need for policies that support an adequately funded and staffed dental safety net for vulnerable and underserved populations in California.

### Study Limitations

This study relied on eligibility estimates including the population data for various age and income level groups that were obtained from the U.S. Census Bureau, not from the DHCS, based on census sampling, and not actual eligibility tests\* therefore the eligible population may be overestimated. Further, Census data is reported by calendar year, while data from DHCS correspond to California's fiscal years.

The Denti-Cal pediatric population projections are underestimated because general population growth was not accounted for using 2011 data as the most recent data. Groups eligible for Denti-Cal and HFP grew by 27.9 percent and 1.7 percent, respectively. In reality, provider-to-population shortfalls will likely be more severe than projected.

The number of Denti-Cal providers may be overestimated due to dentists who either retired or otherwise stopped practicing in the area listed. Alternatively, the estimate could be under target depending on how many current HFP providers transition to Denti-Cal. In short, due to a lack in data collection coordination, there were challenges in finding numbers of users, actual providers and other performance measures that are necessary for real and effective surveillance to identify and improve shortfalls within Medicaid.

### Conclusion

This study is the first to examine the dental workforce for low-income pediatric patients in California in the context of the 2014 implementation of the Affordable Care Act. Our findings are consistent with other states' findings that there is currently an inadequate dental workforce to care for the pediatric Medicaid population.<sup>39,41</sup> The complexity of policy changes that are driving these trends, the scarcity of clear data on future provider inflow to the Medicaid program and lack of consensus on what an appropriate provider-to-population ratio,<sup>42</sup>

<sup>\*</sup>The estimates used the 2006, 2008 and 2011 American Community Survey One-Year Public Use Microdata Samples (PUMS) with varying margins of error based on county size. Some counties were combined, since the smallest geographic area available on the PUMS is the PUMA (Public Use Microdata Area, which are statistical geographic areas defined as consisting of whole, geographically contiguous census tracts with a total minimum population of 100,000 persons.



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make supply adequacy projections difficult. When viewed against the backdrop of the historically poor performance of the California Denti-Cal program in terms of its provider participation and patient utilization, the likely increase in size of the Denti-Cal population and concurrent decrease in the number of dentists to treat these patients is reason for concern.

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# Expanding Public Coverage for Dental Services: Pathway to Improvements or Hollow Promise?

James J. Crall, DDS, ScD

ABSTRACT Growth in public sector dental benefits following passage of the Affordable Care Act extends a national trend of expanding publicly funded benefits programs. This paper contrasts the performance of California's Medicaid dental program with progress in other states, outlines major reasons for performance gaps, raises concerns about recent policymakers' decisions and questions whether expanding coverage without addressing long-standing shortcomings represents a step forward or a catalyst for program deterioration and untoward consequences for millions.

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n estimated 8 million American children will gain dental benefits coverage over the next five years as a consequence of enactment of the Affordable Care Act (ACA).<sup>1</sup> Projected increases include more than 3 million additional children enrolled in Medicaid, approximately 3 million covered through health insurance exchanges or marketplaces operated by federal or state governments and 2.5 million covered through employersponsored benefits. The increased enrollment in public benefit programs resulting from the ACA extends a trend that has produced substantial growth in public dental benefits program enrollments by children over the past

two decades, most notably in Medicaid.

**TABLE 1** shows the growth in the number of individuals under age 21 covered by Medicaid over the past 25 years — i.e., over the second half of the period following enactment of Medicaid in 1965. The data demonstrate variable, but substantial, increases over that time span with enrollment increasing from approximately 9 million in 1989 to 23.5 million in 2000 to approximately 37 million by 2012.<sup>2</sup> Increases over the past 15 years are partially the result of enactment (1997) and reauthorization (2009) of the Children's Health Insurance Program (CHIP), which contained provisions that allow states to choose Medicaid as a coverage option. However, a larger portion of the growth in Medicaid

### TABLE 1

Growth of Medicaid Enrollment for Ages 0-20 and Percent of Population Enrolled in Medicaid

Fiscal Year	Medicaid EPSDT* enrollment ages 0-20 (million)	Percent of U.S. population ages 0-20 enrolled in Medicaid
1989	8.9	13.6
1990	14.7	
1995	23.4	
2000	23.5	27.7
2005	30.8	
2010	30.1	
2012	37.0	42.6

\*Early and Periodic Screening, Diagnostic and Treatment (EPSDT). Data sources: U.S. Census, CMS-416 EPSDT National Reports.

### TABLE 2

### States With Highest Utilization of Dental Services by Medicaid Enrollees Ages 1-18 in 2009

State	Percent of 1- to 18-year-old Medicaid enrollees receiving any dental services 2000	Percent of 1- to 18-year-old Medicaid enrollees receiving any dental services 2009
Idaho	29.9	67.7
Texas	42.8	59.8
Vermont	48.9	57.3
Arkansas	24.5	57.1
New Hampshire	34.1	54.2
lowa	35.1	53.8
Nebraska	42.0	52.5
Washington	46.7	52.4
Massachusetts	33.8	52.3
North Carolina	24.6	52.1
South Carolina	31.3	51.9
New Mexico	24.7	49.8

Data source: PEW, 2011.

enrollment of children stems from increased levels of childhood poverty in the U.S. combined with elevation of Medicaid household income eligibility thresholds over time. The aggregate effects of these changes have not only been manifested in growing numbers of children covered by Medicaid, but also in growing proportions of the overall population of children ages 0-20 covered by Medicaid — from 13.6 percent in 1989 to 27.7 percent in 2000 to 42.6 percent in 2012.<sup>3</sup>

From a historical perspective, it is worth noting that the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) helped to clarify federal expectations regarding Medicaid dental benefits for children — which, although required as part of the Early, Periodic Screening, Diagnostic and Treatment (EPSDT) federal provisions of Medicaid, are largely administered according to budgetary parameters and operational arrangements established by states, subject to broad federal oversight.<sup>4</sup> The renewed emphasis on dental services in the provisions of OBRA '89 reflected concerns about limited enrollment and use of dental services by Medicaid-eligible children in the 25 years following enactment of the original Medicaid legislation in 1965.<sup>5</sup>

Seven years later, the release of a 1996 report from the U.S. Department of Health and Human Services (HHS) Office of the Inspector General (OIG) highlighted the broad failure of Medicaid programs to secure dental services for eligible children as evidenced by the finding that only 18 percent of Medicaideligible children received dental services in 1993.6 The 1996 OIG report is widely acknowledged as a watershed antecedent to a series of federal and state activities - including, but not limited to, a landmark 1998 HHS-sponsored conference in Lake Tahoe titled Building Partnerships to Improve Children's Access to Oral Health Services (1998), the U.S. Surgeon General's Workshop and Conference on Children's Oral Health (1999), the Surgeon General's Report on Oral Health in America (2000), a series of Oral Health Policy Academies sponsored by the National Governors Association (2000-2002), a formal joint federal agency oral health initiative and actions by many states (sometimes as a result of actual or threatened litigation in federal courts) that resulted in improvements in the use of dental services by children enrolled in Medicaid.

TABLES 2 and 3 provide data compiled by the Pew Center on states showing changes in the utilization of dental services by children ages 1 to 18 enrolled in Medicaid for the 12 states with the highest levels of utilization in

### TABLE 3

States With Utilization of Dental Services by Medicaid Enrollees Ages 1 to 18 of Less Than 40 Percent in 2009 and Percentage Point Change From 2000 to 2009

State	Percent of 1- to 18-year-old Medicaid enrollees receiving any dental services 2000	Percent of 1- to 18-year-old Medicaid enrollees receiving any dental services 2009	Percentage point change 2000 to 2009
Florida	25.9	25.7	-0.2
Montana	26.5	29.9	3.4
California	32.4	38.9	6.5
Wisconsin	22.2	30.1	7.9
Missouri	20.4	30.3	9.9
New York	27.3	38.4	11.1
Michigan	22.8	36.8	14.0
Pennsylvania	23.2	37.3	14.1
North Dakota	13.8	36.9	23.1

Data source: PEW, 2011.

2009 (TABLE 2) and the nine states with the lowest levels of utilization of dental services in 2009 (TABLE 3), including California.7 Readers should note that the rates reported by Pew do not include two age groups (< 1 year old and 19-20 years old), which historically have had lower rates of utilization of dental services, and thus are slightly higher than reported data that include the entire population of individuals covered by Medicaid EPSDT benefits (ages 0-20).

The data compiled by Pew for all 50 states and the District of Columbia demonstrate substantial improvements in dental utilization by children enrolled in Medicaid between 2000 and 2009 for the nation as a whole — from just under 30 percent in 2000 to nearly 44 percent in 2009. The Pew data also show substantial improvements in utilization in many states, with 50 percent or more of Medicaid enrollees ages 1-18 receiving dental services in the top quartile of states in 2009. Twentyseven states demonstrated increased utilization of at least 15 percentage points between 2000 and 2009 - 11 states had increases of 15-19 percentage

points, eight had increases of 20-24 percentage points, four had increases of 25-29 percentage points and four had increases of more than 30 percentage points. These substantial increases are particularly noteworthy because they occurred during a time when the overall U.S. economy was experiencing limited growth and many states were experiencing significant budgetary challenges.

The Pew data also show relatively little in the way of substantial progress for several low-performing state Medicaid programs, including California, which had the third lowest increase (6.5)percentage points) among all states between 2000 and 2009. The variability and inconsistency in performance across states raise questions regarding previously voiced concerns about whether efforts to expand enrollment in public benefits programs represent a broad commitment to improve access to services (and ultimately children's oral health status) or a hollow illusion of progress whereby coverage is expanded, but access remains constrained by chronic Medicaid program shortcomings.5,8-10 The lack of improvement in lowperforming states also raises questions about the consistency of federal oversight of state Medicaid programs.

With the above overview, related data tables and cited references as a broad introductory synopsis of achievements in many states and lack of progress in others toward expanding coverage and use of dental services by children enrolled in Medicaid, the remainder of this paper explores examples of where and why state Medicaid programs have substantially succeeded in effecting improvements in utilization and, alternatively, possible reasons why other states have fallen short of federal performance expectations. Subsequent sections examine possible explanations for the observed performance gaps among state Medicaid programs and the perceived potential of various strategies to contribute to enhanced program performance. The final section provides an assessment of current circumstances in California and suggestions for addressing the challenges California and other states face in light of recent trends that have contributed to expanded Medicaid enrollment, including decisions made subsequent to enactment of the ACA.

### Improvements in Medicaid Program Performance

The top quartile of states based on the 2011 Pew report on Medicaid dental utilization data for 1- to 18-year-olds includes Alabama, Arkansas, Idaho, Iowa, Massachusetts, Nebraska, New Hampshire, New Mexico, North Carolina, South Carolina, Texas, Vermont and Washington. Among these states with the highest levels of utilization, five states (Alabama, Arkansas, Idaho, New Mexico and North Carolina) achieved increases in utilization of dental services by children enrolled in Medicaid of at least 25 percentage points — an observation that

is made all the more impressive by the fact that the number of children enrolled in Medicaid over the course of that decade increased substantially in all states. Other states that increased utilization of dental services by children enrolled in Medicaid by at least 25 percentage points include Maryland, North Dakota and Oklahoma. As noted above, an additional eight states had increases of 20-24 percentage points and four states had increases of more than 30 percentage points.<sup>7</sup>

Multiple factors are likely to be involved in achieving improvements of this magnitude over a relatively short period of time. And, while there is a general consensus that there are no simple formulas or one-size-fits-all solutions for improving Medicaid program performance, a number of critical components have been highlighted in various peer-reviewed literature publications and government reports, which are summarized below. Additional details can be found within the corresponding references cited in those documents.

A series of briefs published by the American Dental Association (ADA) identified four broad critical components that contribute to high performance in state Medicaid dental programs:

- Using public program administration policies and procedures or contracting arrangements that are consistent with practices commonly employed by "mainstream" private commercial dental benefits programs.
- Using market-based reimbursement principles to ensure an adequate provider network.
- Employing effective outreach programs to inform and educate beneficiaries.
- Developing and sustaining effective partnerships with key stakeholders, including organizations representing important provider groups.<sup>11-14</sup> Recommendations contained in these

briefs reflected strategies commonly used by 23 selected states that participated in a series of Oral Health Policy Academies sponsored by the National Governors Association from 2000 to 2002 to increase the performance of their Medicaid dental programs.

The Centers for Medicare and Medicaid Services (CMS) subsequently conducted eight state Medicaid dental program reviews between December 2009 and March 2010, and reported on practices and program innovations that have been used to successfully increase dental utilization in those states.<sup>15</sup> Major program features or innovations identified by CMS as contributing to higher performance included:

- Partnerships and collaborations among state partners and stakeholders (used by five of eight states).
- Collaboration with dental schools and loan repayment programs (used by five states and six states, respectively).
- Increased reimbursement (used by six states).
- Simplifying administrative processes (four examples cited).
- Grant funding (three examples cited).
- Educating families (five examples cited).
- Targeting young children (four examples cited).
- Dental home initiatives (two examples cited).<sup>15</sup>

A great deal of similarity exists between the practices, innovations and key program features identified as being important to high performance in these reports. The 2011 CMS report also reaffirmed the importance of efforts geared toward early establishment of dental homes during the preschool years for children at high caries risk - building on recommendations in the updated CMS Guide to Children's Dental Care in Medicaid and a growing body of literature and guidelines issued

by professional dental, medical and public health organizations.<sup>16-19</sup>

### Major Reasons for Gaps in Medicaid Dental Program Performance

Looking beyond critical components and program features that distinguish between states that have achieved relatively high levels of performance in their Medicaid dental programs and those that have not, several broad internal and external factors appear to be particularly salient. A brief synopsis of both categories appears below.

Prominent internal factors affecting the performance of state Medicaid dental programs (i.e., factors influenced by stakeholders within respective states) include:

- The strength of Medicaid program leadership.
- The strength and persistence of the commitment by key stakeholder groups to improve children's oral health (particularly for those who are historically underserved and at greatest risk of dental disease).
- The existence of an effective strategic plan and corresponding action plan that have broad-based support among key public and private stakeholders and incorporate a practical, prioritized number of actionable elements that have been shown to produce substantial, reproducible improvements in delivery of services and health outcomes in generally comparable contexts.

Space constraints do not allow for expounding on details concerning these critical internal factors or examples of strategic approaches taken by other states to improve the performance of their Medicaid dental programs. Interested readers can find additional information of this nature in previous

### TABLE 4

Fiscal Year	California Medicaid EPSDT enrollment ages 0 to 20	California Medicaid enrollees ages 0 to 20 using dental services	California Medicaid dental utilization rates ages 0 to 20 (percent)
1995	3,743,022	652,987	17.4
2000	3,217,206	958,490	29.8
2005	4,231,177	1,302,932	30.8
2010	4,697,466	1,588,344	33.8
2012	4,868,984	1,866,228	38.3

### Trends in California Medicaid/EPSDT Enrollment and Dental Utilization: 1995-2012

Source: CMS-416 Medicaid EPSDT State Reports.

 Sustained or extraordinary media attention and/or attention from external advocacy groups highlighting poor state program performance.
 External tackpiage assistance.

specific directions or recommendations from CMS, or litigation or plans to initiate litigation in federal courts).

publications and related references.<sup>20-25</sup>

Major external factors influencing the performance of state Medicaid dental program performance include: Actions emanating from federal oversight of Medicaid programs (e.g.,

External technical assistance opportunities that help guide the development and implementation of strategic plans and corresponding action plans.

A notable example of federal regulatory agency action to address poor performance by state Medicaid programs include a review undertaken by CMS in 2008 of states with less than 30 percent utilization of dental services by Medicaid EPSDT enrollees, findings of which were published in the 2008 National Dental Summary.26 Recent examples of program changes emanating from federal judicial branch activities include improvements in Medicaid dental programs in Texas and Connecticut. The Texas case was settled in favor of plaintiffs who sued the state of Texas on the basis of unequal access to care. Included in the provisions of the settlement was a requirement for the state to provide an additional \$150 million in funding for Medicaid dental benefits for children.<sup>15</sup> The additional funding was used to raise reimbursement rates for a core set of basic pediatric dental procedures to market-based benchmark percentile levels (doubling reimbursement rates for 35 common dental procedures for children) and to initiate a program aimed at increasing the early establishment of

dental homes for preschool-age children enrolled in Medicaid. Connecticut followed a similar strategy combined with an approach that reduced the use of managed care organizations for administration of their Medicaid EPSDT dental benefits program. The results in both cases were substantial increases in Medicaid participation by dentists in both states and substantial increases in utilization of services by children covered by Medicaid dental benefits.<sup>26,27</sup>

### California and Perspectives on Prospects for Meaningful Improvements

As noted above, California's Medicaid dental program for children ranks among the lowest-performing Medicaid programs in the nation and has shown only meager, sporadic signs of improvement since 2000. TABLE 4 shows California trends regarding the number of children covered by Medicaid and utilization of dental services by children enrolled in Medicaid since 1995 using data obtained from CMS-416 reports. The number of children under age 21 covered by Medicaid increased by more than 50 percent between 2000 and 2012, from 3.22 million to 4.87 million enrollees. The number of Medicaid enrollees under age 21 who received dental services increased from about 960,000 in 2000 to 1.87 million in 2012, but

this represented only an 8.5 percentage point increase in utilization in large part because of the significant increase in the number of California children covered by Medicaid between 2000 and 2012.

California was one of 15 states reviewed by CMS in 2008 due to low reported utilization of dental services for Medicaid EPSDT enrollees approximately 28 percent of the 4.5 million Medicaid-eligible children ages 0-20 received a dental service in the reference year 2006.<sup>26</sup> The CMS review team identified two findings of noncompliance with federal regulatory and statutory requirements and issued the following recommendations for the state:

- The state must provide, or require its contractor or health plans to provide, information to all enrollees about how and where to access Medicaid benefits that are not covered under the managed care contract, including dental benefits.
- The state must ensure that Treatment Authorization Requests (TARS) for children under age 21 are adjudicated accurately, using EPSDT medical necessity criteria, regardless of whether the provider is familiar with or requests "EPSDT Supplemental Services."
- The state should provide families with a single, clear document that explains Medicaid dental benefits for children, including information on the importance of preventive and routine

dental care and how they can get assistance finding a dental provider.

- The state should conduct an assessment of each county's Medicaid EPSDT informing procedures, provide feedback and share best practices.
- The state should ensure that contractor oversight includes verification of the accuracy of the referral lists it compiles.
- The state should monitor the number of dentists accepting new patients by geographic area and recruit new providers as necessary in order to ensure that dental benefits are provided to eligible EPSDT beneficiaries who request them.
- The state should review its transportation policies to assure that the mandatory assurance of transportation exists for Medi-Cal beneficiaries. The state should consider providing, or reimbursing for the provision of, transportation for EPSDT beneficiaries who need it to access medically necessary services, including dental services.
- The state should take a more active role in coordinating dental "programs" for children in order to reduce duplications of effort.
- The state should monitor the impact that the reduction in dental payment rates has on access to dental services.
- The state should ensure that beneficiaries receive reminders regarding the need for periodic dental services either from the state Medicaid agency as part of the annual EPSDT informing requirement or directly from dental service providers.

Reimbursement rates for dental services were not a specific part of the CMS state dental reviews. However, low reimbursement rates were noted by providers and others interviewed as one reason there is low provider participation in Medicaid in the CMS report and recent reports conducted by independent consultants.<sup>23,25,26</sup> A comparison of Denti-Cal reimbursement rates for a commonly monitored mix of dental procedures for children to median fees charged by dentists in a three-digit ZIP code area of Southern California revealed that Denti-Cal reimbursements averaged only about 30 percent of median fees charged by dentists, making Denti-Cal reimbursement levels among the lowest, if not the lowest, payments for

> The state should take a more active role in coordinating dental "programs" for children in order to reduce duplications of effort.

Medicaid dental services in the nation.<sup>25</sup>

Additional analyses of average Denti-Cal expenditures per EPSDT-eligible enrollee indicate that annual expenditures for the Denti-Cal fee-for-service program (which covers approximately 96 percent of EPSDT beneficiaries) averaged \$75.26 per 0- to 20-year-old enrollee in FY2007. That translates to approximately \$6.25 per child covered by Denti-Cal per month, a small fraction of the amounts recommended by previous actuarial studies for funding levels for Medicaid and CHIP dental benefits programs for children — 43 percent of the actuarially based funding level (1999 dollars) for children enrolled in Medicaid from a report by the Milbank Memorial Fund, 29 percent of the funding level (1998 dollars) recommended for California rural CHIP enrollees by a 1998 American Academy of Pediatrics (AAP) actuarial study,

21 percent of the funding level (1998 dollars) recommended for California urban CHIP enrollees by the 1998 AAP actuarial study, 21 percent of the funding level recommended for California rural areas in a 2004 American Academy of Pediatric Dentistry (AAPD) actuarial analysis, 16 percent of the funding level recommended for California urban areas in the 2004 AAPD analysis, less than one-third of the actuarial rates approved for California state health insurance exchange (Covered California) plans<sup>28</sup> and approximately 15 percent of the amount currently allocated per child for dental benefits by Medicaid in Texas.<sup>29</sup>

Appendix D of the CMS 2008 National Dental Summary<sup>26</sup> also contains sections on financing and reimbursement for dental services due to increased interest in information regarding these topics. Issues addressed in Appendix D include:

- Funding levels for public dental programs for children.
- Actuarial estimates of necessary funding levels for publicly financed children's dental benefits programs.
- Historic funding levels in public pediatric dental care programs.
- Reimbursement for dental services.
- General financing considerations for Medicaid children's dental program improvements.

Given the concerns identified by the CMS 2008 site visit and the wide discrepancy between current Denti-Cal funding levels for children and actuarially based recommendations, it is rather astounding that CMS approved a 10 percent reduction in reimbursement rates for dental services covered by Denti-Cal, and California policymakers recently decided to discontinue the state's Healthy Families (CHIP) dental benefit program and transfer the approximately 850,000 children who were enrolled in that program to Denti-Cal coverage.<sup>30</sup>

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The end result of that decision to transfer children from the Healthy Families program to Denti-Cal coverage combined with projected increases in Denti-Cal enrollment subsequent to the ACA is that more than 50 percent of California children are projected to be covered by Medicaid in 2014 — a program that currently is remarkably under-resourced in terms of program financing.<sup>30</sup>

The striking projected increases in enrollment of California children in Medicaid come at a time of unprecedented rapid expansion of publicly financed health benefits coverage. For example, Medi-Cal will see an estimated total increase of 1 million or more enrollees because of the ACA — including 680,000 people in 2014, the first year of Medi-Cal expansion under health reform;<sup>30</sup> Covered California (the state's health insurance exchange) will offer pediatric dental benefits to large numbers of previously uninsured children (presumably with resources and terms that dentists will likely find preferable to those currently offered by Medicaid/Denti-Cal;28 and state policymakers have decided to reinstitute some (optional) dental benefits for adult Medicaid dental enrollees.<sup>31</sup>

These actions raise serious questions about the prospects that children with Denti-Cal coverage will be adequately served by a program that could well be experiencing declines in provider participation because of dentists' growing dissatisfaction with Denti-Cal payments and other actions involving Medicaid program operations — e.g., ongoing 10 percent reductions in Denti-Cal payments, threatened "clawback provisions" of previous Denti-Cal payments that were approved by CMS, but ultimately not implemented by the state, and Medicaid provider audits authorized by provisions of the ACA.<sup>25,32</sup> And while reinstituting some coverage for adult Denti-Cal benefits

(an optional Medicaid benefit) will have some direct benefits for those adults who are able to find a participating dentist, the allocation of state funds for adult services will do nothing to stem the continuing erosion of Denti-Cal's purchasing power for federally mandated children's dental services — all at a time when the state has additional projected revenue of \$1 billion over previous budget projections.<sup>33</sup>

All of this points to the fundamental question raised in the title of this paper

Have the children of low-income families in California been given a hollow promise and only an illusion of access ...

— is there a commitment on the part of the state of California and the federal officials responsible for overseeing the performance of the Medicaid program to honor the requirements that have been laid out in federal statutes and regulations? Or have the children of low-income families in California been given a hollow promise and only an illusion of access to care at levels that they, those interested in their welfare and those charged with protecting their rights should expect?

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# Educating General Dentists to Care for U.S. Children: How Well Are We Doing and What Can We Do Better?

Paul S. Casamassimo, DDS, MS, and N. Sue Seale, DDS, MSD

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he care of children by general dentists has been a topic of interest in dental education for several decades and recently given new life with the announcement from the Centers for Disease Control and Prevention that dental caries in young children has increased.1 Current angst over the ability and willingness of the general dental community to treat children who need care the most has taken center stage with the highly anticipated pediatric oral health mandate in the Affordable Care Act<sup>2</sup> and publicity over what the media and federal government have called controversial care of children by the corporate dental industry.<sup>3</sup> This commentary attempts to put the debate in perspective with a review of salient issues, discussion of preliminary information in relation to existing literature and proposals for improvement.

### Not a Simple Problem

The debate continues about the preparedness of graduating dentists to treat children, particularly those with the most dental caries - those who are poor, minority and younger than 5 years of age. That shift from a pandemic to a focused epidemic begins the saga. Dental schools historically served many with limited access to dental care, but were never a major source of care. Often based deep in urban campuses and with a main emphasis on education rather than health care provision, dental schools relied on a steady stream of patients, but sorted out patients based on financial ability, disease patterns and behavioral compatibility. In institutions with predoctoral and postdoctoral training programs, children were often assigned by need. Those most severely affected by caries and those with the most demanding medical and behavioral needs were seen by pediatric dentistry specialty trainees. The predoctoral student tended to see those who remained in the pool, often children with minimal needs. In most dental schools, it would be safe to say that the sieve of acceptability for predoctoral education yielded a pool of well-behaving, low disease complexity and adequately financed children for learning purposes. Three decades ago, those requirements provided enough patients and some were even turned away or placed on waiting lists. Today that is no longer true.

### Who Turned Off the Tap?

No one factor can be blamed for the feast-to-famine shift in patient availability, but the following factors, among others, seem to have contributed to today's empty dental school clinics:

- More alternatives to dental school care exist in community settings where children can be seen more quickly and without the oft-daunting challenges of parking and accessing dental schools in a campus-based medical center.
- Busier families that may have tolerated half-day dental visits no longer want to miss work and school and shepherd children.
- Dental school faculty that may be less willing to take on a more challenging patient pool and opt for low complexity child patients.
- A reverse disease polarity has created an increase in dental disease in the very young child who requires advanced behavior management and a decline in permanent tooth caries in the older, more manageable child.
- Corporate competition offers community-based care with acceptance of government payment plans.
- Declining allocation of curricular hours for pediatric dentistry creates a de facto low priority as compared to

adult care in today's education model.

These factors, which have been catalogued in previous work,<sup>4,5</sup> have all contributed to a heightened concern about the willingness and ability of the general dental community to address the dental ills of children.<sup>6</sup> The tipping point focusing the concern of dental educators today is not so much the revelation of the general dental community's reluctance to treat, but rather the belief by dental educators that

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recent graduates working for corporate entities are not trained well enough to render appropriate care to children. The paradox inherent in this new concern by dental educators should escape no reader.

### How Well Are We Doing – Yesterday Versus Today

In an effort to gain new information about possible changes in preparedness of newly graduated general dentists, we updated a survey published in 2004 reporting on predoctoral pediatric dentistry education and its impact on access to dental care<sup>5</sup> and resurveyed dental educators in 2014. Survey questions directed to predoctoral pediatric dentistry program directors were modifications of those used in the earlier publication. We inquired about the adequacy of the pediatric patient pool, factors impacting its adequacy, the presence and location of external rotations, supervision of dental students, types and location of essential pediatric dental experiences, methods of teaching pediatric dental skills and program directors' opinions on the adequacy of the preparedness of the new dental graduate to treat children.

### What's New and What's Not?

Predoctoral pediatric dentistry educational programs have changed since the survey published in 2004. Many changes relate to patient pools and locations of clinical educational experiences dental students receive in pediatric dentistry.

- In 2004, more than half of respondents reported their pediatric patient pool was adequate to provide predoctoral students sufficient patients to permit achievement of program competencies. By 2014, that number had been reduced by half, with only about a quarter of programs reporting adequate patients.
- Reasons given for inadequacy were much more diverse and evenly distributed in 2004 than today, with the most frequently given reasons as "lack of patients requiring restorative care" (56 percent), followed by "inadequate numbers of patients to screen" (47 percent), "clinic fees too high" (41 percent), "location of dental school" (39 percent) and "insufficient faculty to cover clinics" (29 percent). In 2014, in contrast, almost all programs identified "inadequate numbers of patients to screen" as the cause of insufficient patient pools, twice the number reporting that reason in 2004. The location of the dental school almost doubled as a factor contributing to patient shortages from 39 percent in 2004 to 72 percent in 2014. Lack of patients requiring restorative care (58 percent) remained consistent with 2004's response (56 percent).

- The lament of insufficient faculty to cover clinics by respondents in 2014 declined to a fifth of the 29 percent in 2004, and high fees as a factor dropped to almost half of that reported in 2004 (22 percent versus 41 percent respectively).
- Comments in the "other" category included the following reason that has come into play since the 2004 data were collected, "competition via other well-marketed and available and efficient offices — some corporate and some general dentists." Ironically, this suggests that general dentists are assuming more of a role in caring for the dental needs of children.
- Comparing responses from 2004 with 2014, the number of available patients had decreased three-fold but the amount of decay had nearly doubled.

### Has Dental Education Helped Itself Since 2004?

The simple answer is yes. Choosing to go where the need exists is a major element of today's health care. Our 2014 data reveal external rotations outside of the dental school predoctoral program had increased by about a third since 2004. Federally qualified health centers (FQHCs) and clinics for patients with disabilities or special needs increased, while hospital clinic rotations and clinics for women, infants and children decreased. Mobile clinics and school-based programs were reported in 2014 as being commonly used, but not reported in 2004.

Dental educators may have also learned other lessons from the medical education model, that is, student comfort with treatment comes from seeing similarly trained providers be successful. This apparently has translated into allowing general dental supervision in external rotations. Today, pediatric dentists and general dentists are almost equally represented as supervisors in mobile clinics and private practices, but general dentists now are more likely to be the supervising dentists in community health centers and in city/public health clinics and clinics for patients with disabilities or special needs. Unfortunately, obstacles remain in placing students where disease is most common, these include insufficient faculty full-time equivalents (FTEs), location/distance to travel, loss of income to the school, lack of off-site

> A blend of schoolbased and communitybased education may offer some solutions.

locations and transportation issues that preclude more community experiences.

A blend of school-based and community-based education may offer some solutions. We found that experiences that hold promise to address caries, such as infant oral health and treatment of advanced decay were similar in both sites, but slightly more in the community. Community sites offer a better menu of special needs experiences, opportunities for higher volume care and more advanced behavior management, all of which should instill confidence in the dental learner.

### There Is Still Work to Do

Rather than seek live patient clinical experiences, dental education has opted for simulation in some cases. Most educators have maintained live patient encounters for stainless steel crowns and pulpotomies, infant oral examinations and nitrous oxide/oxygen analgesia, which are positive. However, advanced forms of behavior management, such as protective stabilization and voice control, were less often taught with live patients.

Ironically, half of faculty graduating new general dentists said their students were not ready to provide stainless steel crowns or pulp therapy and a third said their graduates were not ready to provide infant oral exams, nitrous oxide/oxygen analgesia and space management. Nearly two-thirds believed their students were not ready to treat dental alveolar trauma or special needs patients. Many who responded to our 2014 questionnaire were unable to quantify the procedures accomplished by their students in community-based care experiences.

### What Can We Do About It?

Like most complex issues and the ACA itself, the solutions to providing quality care to an increased population of children are complex and probably involve both upstream and downstream change in the educational delivery system. Fixing predoctoral education in pediatric dentistry is but a piece of a national mosaic of needed change. The remainder of this paper proposes directions that would yield a more prepared workforce and thus an enabled care system. These are listed in no particular order, but offered as significant changes that can lead to better access to care for children in the general dental community.

### Common Needs Make for Strange Bedfellows

Earlier in this paper, we report that corporate dentistry has been implicated in the decrease in child patients available to traditional dental educational institutions. In spite of its occasional unsavory public image in the media,<sup>3</sup> corporate dentistry is a growing

player in delivery of dental care in the United States to patients of all ages. The attention of government has prompted reinvention of the business model of care as it affects children.<sup>7</sup> Certain practices have, for some corporate entities, yielded closer scrutiny and documentation of the provision of care by the corporation itself. Application of guidelines of the American Academy of Pediatric Dentistry to corporate treatment protocols is one example of self-improvement. The shift in corporate care to mainstream methods opens the potential for interaction with educational institutions in several ways. As traditional campus-based dental programs struggle to provide students with adequate experiences, corporate entities enjoy populations with the very characteristics that are desired by dental faculty. One can envision the benefits of closer liaisons between the dental education system and a corporate care system with the infrastructure to monitor performance, outcomes and quality of care. Longstanding is the observation that the presence of students is associated with a higher quality of care in facilities where education is a part of the mission. Literature that is more recent points to the positive impact on student attitudes toward the underserved when they participate in well-structured, community-based dental education.<sup>8,9</sup>

Maybe now is the time for a look at partnerships with corporate dentistry to place students in that environment with benefits to both dental education and the world of corporate dentistry. One might argue that corporate dentistry has little to gain from this marriage, but aren't their dentist-employees often the very same graduates who educators lament are marginally competent due to patient shortages in dental schools? Wouldn't corporate care benefit from closer scrutiny, affiliations with educational institutions with established protocols for care and the opportunity to recruit the very best graduates, now beginning to graduate with exposure and practice previously unavailable? Wouldn't dental education benefit from a ready source of patients, the extensive resources of corporate care and the opportunities for research? New predoctoral standards require exposure to a diverse patient pool and the corporate systems more often than not engage patients and families who meet those

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requirements. It seems like untapped opportunities exist here for both dental education and the corporate dental world if only both would see them.

### Evacuate the lvied lvory Towers

Many dental schools have embraced community-based dental education (CBDE), but much more could be done to engage community sources of care and begin a more meaningful and deliberative emptying of the campus-based, big-box dental schools that have dominated dental education for a century or more. As clearly identified by the Institute of Medicine in its 2011 report, entitled *Improving Access* to Care for Vulnerable and Underserved Populations,<sup>10</sup> the community is where the patients are and where care delivery and education should be. It should be of no surprise that major health centers have for decades been creating community presences, buying practices of health providers and offering ancillary services such as laboratory and mental health. The proliferation of institution-affiliated and freestanding urgent care facilities and care clinics in pharmacies, as well as community-based corporate dental clinics should be ample warning to dental schools to figure out how to make CBDE a meaningful contributor to dental students' overall education and competencies, especially related to pediatric dentistry.

The challenge to accomplish a major sea change in education is with the institutions and their faculty, all of whom were birthed from an educational model where patients were used to teach skills, rather than the medical model where patient care provides opportunity to learn real-world care. It will take a major shift in attitude, education and business models to see dental education take advantage of the opportunities to engage community-based faculty, tap into a patient base with both dental and real problem-based challenges and downsize traditional dental schools or retask them to more advanced skill sets.

### Give Appropriate Value to Care of Children in Dental Education

The current Commission on Dental Accreditation (CODA) educational standards for predoctoral dental education (Standard 2-22) specify that graduates must be competent in caring for patients of all ages within the scope of general dentistry.<sup>11</sup> Because general dentists comprise the largest source of care providers for the population, it seems reasonable to expect that they have the same curriculum time and clinical experiences related to care of children as they do for adults. Unfortunately, the amount of educational capital provided to pediatric dentistry pales in comparison to that given to adult care. Sadly, dental

education continues to assign low value to the care of children, if clock hours of clinical and didactic education are compared to those addressing adults. The expectation that graduates emerge competent in provision of real-world pediatric dentistry is naïve at best. Until dental education parcels out curricular hours to balance competency across ages rather than by tradition, source of income or rigid clinical admissions criteria, the graduate will continue to be nominally competent.

### Raise Medicaid Fees Nationwide

In states where Medicaid fees have risen, all provider groups have gravitated toward care of children. One might question whether this shift is to quality care versus just an increase in quantity. However, if we accept the vision of pundits of health care change and if we look to what has happened to corporate purveyors of pediatric dental services, it should be clear that quality will win over, perhaps not in the short run, but eventually. If care of children becomes economically beneficial, providers will want to treat them, and treat them well, to maintain practice market share. Factors such as proposed dental quality assurance measures, the Internet's unabashed popular rating systems and continuing audits by government will drive quality care. If that means some type of quality continuing education in pediatric dentistry, certification such as the Academy of General Dentistry's mastership or some other measure of the quality of a dentist's care, who knows, but that is the direction health care is headed.

### Mandate Early Dental Intervention

Only about half of dental schools expose predoctoral students to infant oral health and seemingly, the association of this type of clinical experience with enhanced competency in care of children may escape some reading this report. Numerous health associations recommend a first dental visit by 1 year of age, and so a national acceptance of this policy unfolds over time like this. General dentists see children and establish prevention in dental homes, having learned those skills in dental school. Prevention reduces the number of children with early childhood caries. Participation in the

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dental home allows the general dentist to identify early carious lesions and act with minimal invasiveness. The number of children with severe early childhood caries declines and becomes manageable in existing referral patterns to pediatric dentists. The challenge to the general dentist to provide extensive behavior management and restorative care decreases dramatically. Can this happen? Certainly, it can. The shift in pediatric health care illustrates this well, with its refocusing on millennial morbidities<sup>12</sup> from a preoccupation on managing infectious disease.

### Conclusio

The general dental community remains tentative about providing care to those children who need it most and some of their reluctance goes back to inadequacies in predoctoral dental education in pediatric dentistry. Dental faculty we surveyed largely agree that factors have worked against provision of adequate training of dental students to manage young children with extensive dental caries. Yet, in spite of the warning signs of an inadequate system, dental education continues to impart competency to its graduates in care of children.

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# **QUESTIONS MOST OFTEN ASKED BY SELLERS:**

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

# **QUESTIONS MOST OFTEN ASKED BY BUYERS:**

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

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Pediatric Dentistry for the General Practitioner: Satisfying the Need for Additional Education and Training Opportunities

Ray E. Stewart, DMD, MS, and Roger G. Sanger, DDS, MS

ABSTRACT The Pediatric Oral Health Access Program is a joint project of the California Dental Association and the California Society of Pediatric Dentistry. The results have been remarkable in terms of the number of underserved children who have received oral health services. What is less certain is the number of general dentists who, as a result of the training, have been able and willing to provide routine comprehensive care to more and younger children.

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Roger G. Sanger, DDS, MS, is the director of Pediatric Sedation Curriculum, DOCS Education in Seattle. Conflict of Interest Disclosure: None reported. he California Society of Pediatric Dentistry is a professional association of dentists who have a special interest in the delivery of comprehensive oral health care for infants, children and persons with special health care needs. Although the majority of CSPD members are dentists who have received two or more years of accredited postdoctoral specialty training, its membership is also open to general dentists (as affiliate members) and other health care workers (as allied professional members) who have an interest in pediatric oral health.

The problem of access to oral health care experienced by many lowincome families throughout the nation has been chronic and widespread.<sup>1</sup>

According to the 2007 report by the Centers for Disease Control and Prevention (the most current report to date), cavities have dramatically increased for toddlers and preschoolers. Cavities in children 2 to 5 years of age increased from 24 percent to 28 percent between 1988-1994 and 1999-2004.<sup>2</sup> The high-risk, high-prevalence, highseverity group, which currently represents nearly 20 million children, is largely comprised of low-income children (nearly all of whom are eligible for Medicaid or State Children's Health Insurance Program (SCHIP)), with higher levels of caries found in African-American and Hispanic groups at all ages.<sup>3</sup>

A similar situation exists in California. The reasons for this problem are many and varied but the fact remains that less than 37 percent of children under age 6 visited a dentist or received oral health services in the past year.<sup>4</sup> This disparity is all the more striking when one focuses on that portion of the pediatric population who are eligible for Medicaid services. Among that demographic, the statistics are even more significant. A mere 20 percent of Medicaid children ages 0-6 have ever received oral health services.<sup>4</sup>

It is estimated that there are fewer than 500 specialty trained pediatric dentists in California who are practicing full time (full-time practice is defined as four days per week) and an estimated 150 who practice part time (one to three days per week).<sup>5</sup> With an estimated 9,150,549 children in California between 0 and 20 years of age, it is clear that the potential demand far exceeds the capacity for pediatric dentists alone to provide even the minimum required preventive services for this population.<sup>6</sup>

Approximately 50 percent of these children are covered by Denti-Cal but often have difficulty accessing care because of the dismally low reimbursement rates for providers who participate in the program. California is among the lowest of all states with respect to Medicaid reimbursement, ranking 42nd for reimbursement for a periodic exam and 41st in reimbursement for a two-surface restoration.<sup>4</sup> Because of this, there will be a continuing challenge for recruiting and retaining a workforce to deliver comprehensive care to this ever-growing population of underserved children.

The obvious conclusion is that a majority of healthy children, regardless of their socioeconomic status, are or will be treated by general dentists who are truly "family practitioners." It is also clear that there are extreme variations in these practitioners' backgrounds and predoctoral training experiences in pediatric dentistry. It is not unusual for a dental student to graduate without completing a single class II restoration let alone a pulpotomy and stainless steel crown procedure on a young child. Considering the constant pressures on dental schools created by new curriculum requirements without the extension of the traditional three- or four-year predoctoral program, this trend toward a reduced number of pediatric clinical experiences will likely continue.

With this check on reality and with fewer than 650 practicing pediatric dentists in the state, it is clear that pediatric dentists are simply not able to satisfy the oral health needs required of those children. Under this scenario, each pediatric dentist would be responsible for

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the care of more than 15,000 children and adolescents to achieve our stated goal of providing "optimum oral health for all children." We believe that there is general agreement that there should not be two tiers of quality or standards of care when it comes to the provision of care for the children we serve. If that is indeed the case, shouldn't we be advocating for the elevation of the standards for the education and clinical training of our predoctoral dental students and providing expanded opportunities for postdoctoral continuing education for those general dentists who desire to see more children and younger children in their practices? CSPD has and should advocate for a venue wherein general dentists could acquire the basic preventive, diagnostic and restorative skills that would enable them to provide safe, high-quality care for the majority of healthy children who have no special needs or extensive restorative needs complicated by behavioral issues.

It is also a well-recognized fact that there are significant numbers of dental students and general practitioners who, for a variety of reasons, have been unable to find positions in an accredited two- or three-year specialty training program but who have a strong desire to focus on children as the primary beneficiaries of their professional services. In spite of no formal training, many general dentists have effectively and ethically limited their practices as "general dentists for children and adolescents." We acknowledge that there are many general dentists in California and across the nation who limit their practices to children and adolescents who provide services at a standard of care consistent with trained pediatric dentists. Conversely, we also recognize that there are significantly larger numbers of general dentists who limit their practices but do not clearly state their services as being "provided by a general dentist," rather choosing the ethically questionable approach of representing themselves as "pediatric dental specialists." These practitioners frequently do not have the training or experience that would provide the skills necessary to deliver comprehensive services consistent with the standard of care. Although access to care may be improved by both categories of "ethical" and "not so ethical" dentists, the quality of care provided by the latter is often an issue.

To assure that general dentists motivated to solve the access to care problem and dedicated to improving the quality of care for children and adolescents have access to educational programs, CSPD, in partnership with the California Dental Association and Delta Dental of California, initiated the Pediatric Oral Health Access Program (POHAP) in 2000. Other programs followed in the Los Angeles area (LAPOHAP) in 2003, 2004 and 2008 sponsored by the CDA Foundation and funded by L.A. Care. Subsequently, with a \$1.3 million grant provided by The California Endowment, the CDA Foundation conducted additional POHAP trainings in the greater Sacramento region, San Francisco Bay Area and Orange County in 2007 and 2008. Two additional POHAP trainings (2009 and 2013) were funded by and provided to 79 Western Dental dentists.

The goal of the program was to increase access to oral health care for children, particularly the underserved, by providing the skills and knowledge general dentists need to administer oral health services to children younger than 12 years of age, including those with special physical and behavioral needs. At the completion of the tuition-free training program, which provided 40 hours of continuing education credits, each participating general dentist agreed to regularly treat young children in his or her practice and to provide pro bono dental care to at least 20 underserved children over the ensuing 24 months. Underserved children were defined as those who require urgent, extensive treatment, have no private/government benefits and have no viable means to pay for dental services.

In addition, dentists accepted into the POHAP program were asked to sign an agreement, which included the following terms:

- Commit to attending all lectures, laboratory courses and mentoring sessions on the scheduled days.
- Expand the scope of their practices to include routinely providing dental care to children younger than 12 years of age and children with special needs.
- Provide oral conscious sedation (OCS) where appropriate following completion of the necessary training

and earning an OCS permit from the Dental Board of California.

- Equip their practices with the necessary instruments, supplies and equipment to routinely provide care to young children, especially the underserved.
- Report dental services provided as a result of the program.

The POHAP training programs consisted of the following educational components provided by volunteer CSPD pediatric dentists:

- Fourteen hours of didactic seminars, which included subjects such as diagnosis and treatment planning, behavior management, pulp therapy, restorative techniques, dental materials and space management.
- Four hours of facilitated case review seminar.
- Seven hours of "hands-on" pediatric restorative techniques on simulated human primary dentition.
- Fifteen-hour seminar in nitrous oxide/oxygen analgesia.
- Six hours of facilitated video presentation on pediatric practice management.
- Optional 25-hour accredited OCS; dentists could then apply for an OCS permit issued by the Dental Board of California.

The overall results of the California POHAP programs over the past decade (TABLE) reveal some interesting and significant data. The number of clinicians trained and the number of children who have benefited from the POHAP program are remarkable.

### **POHAP Project Summary**

- Through 2012, 448 dentists had completed the training program, resulting in 82,389 children (ages 0-12) receiving care, including 1,329 children with special needs and 4,138 pro bono cases.
- The California Endowment provided a \$1.3 million grant for statewide

implementation that will result in the training of an additional 300 dentists, 36,000 children receiving care and 6,000 pro bono cases.

- The services rendered had a collective treatment value of more than \$34 million.
- Participants include approximately 50 percent private practice and 50 percent community health center dentists.

The POHAP programs in California have been widely recognized as the first large-scale organized educational programs designed to enhance the pediatric diagnostic and treatment skills of general dentists. However, they have also revealed several shortcomings and the need for refinement and expansion of the educational, mentoring and overthe-shoulder learning experience. There is no substitute for observing and then performing clinical procedures under the direct supervision and mentoring of an experienced clinician. We have also learned that it is not realistic to expect that a general dentist who attends a 25-hour didactic course and one observational experience (which in California would qualify him/her for an OCS permit) will be competent to routinely perform restorative dental procedures using oral conscious sedation on children younger than 13 years of age.

Postdoctoral students training for a specialty in pediatric dentistry are required to perform a minimum of 25 oral conscious sedation procedures under the direction of supervising faculty. This experience imparts the confidence and ability to effectively and safely manage the behavior of very young and/or marginally cooperative children in need of invasive restorative or surgical procedures. This skill set, along with the training, knowledge and experience to effectively manage the risks and potential complications

### TABLE

### **Quarterly Report Data**

	LAPOHAP I 2003	LAPOHAP II 2004	LAPOHAP III 2008	тсе ронар 2007-2008	Western Dental POHAP 2009	Southern California Safety Net 2010 (0-5 year olds only)	Western Dental POHAP 2011	Total	Average Fee	Treatment Value (tx)
Number of participants	50	50	49	187	34	33	45	448		
Patients 0-12 years old (tx value: exam and X-ray)	1,303	5,346	5,967	56,815	2,436	10,522		82,389	\$162	\$13,347,018
Special needs patients (tx value: exam and X-ray)	116	576	192	445	N/A	N/A		1,329	\$162	\$215,298
Referred out (because of complexity of case)	98	292	172	1,631	N/A	N/A		2,193		0
OCS (utilized oral conscious sedation)	219	428	N/A	N/A	N/A	N/A		647	\$203	\$131,341
Nitrous oxide (utilized nitrous oxide)	N/A	N/A	2,061	3,412	205	N/A		5,473	\$48	\$262,704
Prophies	1,908	4,804	5,741	29,382	1,145	16,125		59,105	\$55	\$3,250,775
Fluoride varnish	N/A	N/A	5,589	28,670	1,065	11,843		34,259	\$28	\$959,252
Fillings*	3,475	7,600	12,430	42,512	5,258	5,276		76,551	\$102	\$7,808,202
Stainless steel crowns	908	2,142	4,105	5,749	2,586	330		15,820	\$246	\$3,891,720
Pulpotomies	1,059	2,765	4,085	7,080	2,602	341		17,932	\$145	\$2,600,140
Extractions	960	2,331	1,385	8,125	551	408		13,760	\$11 <i>7</i>	\$1,609,920
								Pro	aram total:	\$34,076,370

\*Children with insurance, including public programs and sliding scale.

### Pro Bono Reporting Form Data

	lapohap I	lapohap II	lapohap III	tce Pohap	Western Dental POHAP	Southern California Safety Net	Western Dental POHAP	Total	Average Fee	Treatment Value (tx)
	2003	2004	2008	2007-2008	2009	2010	2011			
Total pro bono patients (tx value: exam and X-ray)	346	647	492	2,653	N/A	N/A		4,138	\$162	\$670,356
Prophies	317	591	N/A	N/A	N/A	N/A		908	\$55	\$49,940
Fillings**	1,329	2,182	1,646	8,569	N/A	N/A		13,726	\$102	\$1,400,052
Stainless steel crowns	458	732	422	1,249	N/A	N/A		2,861	\$246	\$703,806
Pulpotomies	465	890	505	1,394	N/A	N/A		3,254	\$145	\$471,830
Extractions	290	454	232	1,586	N/A	N/A		2,562	\$117	\$299,754
							Pi	ro bono tre	atment tota	l: \$3,595,738

\*\*No insurance or financial means.

Source: CDA Foundation POHAP statistics through Oct. 24, 2011.

of oral conscious sedation, are what pediatric dentists spend an additional two to three years training to attain.

In summary, we feel justified in making the following observations

and recommendations:

Nine million children (ages 0-18) reside in California, and that number is increasing.

More than one-half of these children

are on the Medicaid (Denti-Cal) program where the caries crisis is an epidemic and the number of recipients and their caries rate is increasing.<sup>5</sup>

The reimbursement rate for dental

services provided by Denti-Cal is among the lowest in the U.S. and that rate is decreasing.<sup>4</sup>

- Access to dental care for children and adolescents on the Medicaid program (Denti-Cal) is hindered by the low number of providers, both pediatric and general dentists. This situation becomes more critical as reimbursement rates decline.
- Of the general dentists who do treat children and adolescents, many lack the diagnosis, treatment planning, pulpal therapy and restorative care skills necessary to provide services at levels consistent with the standard of care and that are in compliance with AAPD guidelines.
- Of the general dentists who treat young children, children with special needs or those with behavior management issues, few have the training, credentials or experience to provide safe and efficient oral conscious sedation. Although the number of postdoctoral positions in pediatric dentistry is increasing, many general dentists are unable to assume the additional debt of specialty training. Or if they do apply for postdoctoral training, they do not match but wish to limit the scope of their practices to children and adolescents. They may also obtain employment in corporate or community health centers where onthe-job training is all that is available.
- The usual one-day continuing education course offered at a university, dental society or private provider does little to improve the diagnostic and clinical skills necessary to treat the child who has extensive restorative or behavior management needs.
- There is an acute need for more comprehensive educational programs for general dentists with hands-on skill training in clinical pediatric dentistry.

A funding mechanism needs to be identified for the general dentist already burdened with high student debt and working in a first-time associate salaried position to obtain the additional training needed to provide dental services consistent with the standard of care equivalent to that of the pediatric dental specialist.

### Conclusion

There is an obvious need for quality, practical postdoctoral education training

Pediatric dentistry is currently the most soughtafter postdoctoral dental specialty training program...

opportunities for general dentists who wish to enhance their skills and confidence in treating children. The demand is high and the competition is rigorous for postdoctoral residency training positions across the nation. Pediatric dentistry is currently the most sought-after postdoctoral dental specialty training program, surpassing the previously first- and secondranked popular specialties of oral and maxillofacial surgery and orthodontics.7 According to the Survey Center of the American Dental Association, in academic year 2010-2011, 76 pediatric dental postdoctoral programs enrolled a total of 763 students that included 382 first-year positions.<sup>7</sup> This indicates that there is a large number of recently graduated dentists who would like to have access to educational and mentoring opportunities to upgrade their pediatric

dentistry skills. It remains to be seen how this demand will be met, but it is clear that there is a need and an opportunity to focus on children and adolescents in their careers. Although California's POHAP program has made some inroads, there is an obvious need and incentive to develop expanded and widely available opportunities, expanded curriculum and clinical experiences wherein general dentists are able to develop and sharpen their skills so they feel comfortable and confident providing preventive and basic restorative care for younger children and children with special needs. The glass is either half full or half empty. It will surely be interesting to see what entrepreneurial enterprises are created to fill this need.

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

HN-280 NORTHEASTERN CA: "Only Practice in Town" 900 sf w/ 2 ops \$110k

HN-290 PLACERVILLE: Embrace the lifestyle and build your success story here! FFS. 1,400 sf w/ 4 ops \$210k

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# SALES

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

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JN-295 VISALIA: Practice & Real Estate 2,000 sf w/ 5 ops PR: \$185k RE: \$300k

JN-316 CLOVIS: "The best of all worlds!" Huge, like new Practice! 2,501 sf w/10 ops **\$700k** 

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<u>GN-304 NORTHERN SACRAMENTO Pedo:</u> Well established, highly esteemed. 1,800 sf w/ 4 ops **\$595k** 

DN-293 LIVERMORE Perio: Specialty of Periodontics, Dental Implantology and Oral Medicine. 2,200 sf w/ 5ops + 1 add'l. PR: \$650k RE: TBD

<u>AC-325 SAN FRANCISCO Endo:</u> Associate + Buy-In Opportunity in warm and caring environment. **Call for details!** 

BC-336 CONTRA COSTA CO Perio: 1,440sf, 4 ops +1 Great Location! Call for Details!





### ASK THE BROKER How much should I pay in a simple chart sale?

The answer to *every* practice transition value question comes back to "Return on Investment." While a normal practice sale is valued at local market conditions, it has to make financial sense also. The key point starts with an assumption that the buyer can replace the selling doctor and maintain the same revenue stream in the practice. There is a return on investment assumption which is why the dental lenders will normally lend more than 100% of the asking price as long as the asking price is less than 85% of the collections.

If one applies this accepted business principle of "Return on Investment" to a chart sale, the value of a practice merger opportunity is worth more than the value of a straight sale. In a practice merger, the buyer already has the facility and staff. He can usually eliminate many overlapping expenses such as rent, utilities, and some of the staff. The elimination of these expenses alone sometimes results in twice the "Return on Investment" as compared to a practice sale where the buyer needs the office space and equipment.

While this logic that the *value* of a merger compared to a normal sale is indisputable, every dentist I have ever run into will insist that a reduction of purchase price be given to them if they don't need the additional equipment. This may be a natural assumption but obviously flawed if considered from a pure business or "Return on Investment" perspective. The only logical conclusion is that a buyer who has the opportunity to purchase a practice into which he can merge should be happy to pay more than the buyer who does not have that opportunity!

Unfortunately we dentists are not trained to look at the "Return on Investment" in this manner so it *seems* to make sense that we should pay less if we do not need the used equipment. However, the real value is in the transfer of patients to the new location, assuming that the buying dentist is capable of performing the dentistry that was being performed by the selling dentist.

Sometimes just a simple letter from the retiring dentist is enough. Other times seeing patients in the current location for a short period of time or just keeping the same key front office person is a good idea. Normally patients will return to where their records are kept because they do not want new x-rays! Call it a chart sale or a merger, but the answer lies on what "Return on Investment" you can expect from the patients you will incorporate into your practice.

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



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### 4013 STANISLAUS COUNTY GP

Well-managed GP with regularly increasing revenue. State-of-the-art 1,600 sq. ft. well-equipped office w/4 ops. DigiNGx-ray, Dexis, 4 x-ray machines, IDEN Bano and recent leasehold improvements. 2012 GR \$883K+, 2013 on schedule for \$968K+ as of Oct. Located near hospital in well-travelled area. Asking \$560K.

### 4033 PETALUMA GP

Owner retiring looking to transition 41 year-old practice to conscientious & dedicated dentist. ~1,000 active pts., avg. 7 new pts./month, 3.5 doctor days **\$6** year-old days per/wk. 2013 GR \$683K+. Asking \$477K.

### 4032 SOUTHERN PENINSULA GP

Well established GP located in highly desirable area. Beautiful 4 op office in lovely professional bldg. with excellent sibility on major cross street. 3 Dr. days & Shygiene days/week. 4 year average GR \$391K. Great upside potential. Asking \$300K.

### 4030 MODESTO GP

Well-established & well run general practice available immediately. 2,500+ active pts. 4 year avg. GR approx. \$1,275,000. Seasoned staff, 10 hyg. days/wk, 4 Dr dat wk. Beautiful 2,293 sq. ft. dental office in seller owned building with 6 fullyequipped ops. digital x-ray & regular dental equipment upgrades. Asking \$837K.

### 4054 MID-PENINSULA ORTHO

This established orthodontic practice is located in desirable centrally located area with a solid economic base, numerous amenities & diverse residents. Average GR \$700K+ with only 2.5 doctor days/week & genuine potential for growth. The practice is offered with newly re-modeled, gorgeous free-standing professional building w/ private garden & dedicated parking surrounded by dental & medical professionals in a commercial & residential mix neighborhood. The office is state-of-the-art with 5 (open bay) ops in approximately 1,600 sq. ft not including an additional 300-400 sq. ft. of storage space. Both practice and building are for sale. Asking \$591K practice, \$937K building.

### 4050 SANTA ROSA GP

Seller retiring & ready to transition well est. GP w/focus on restorative care. Spacious 2,100 sq. ft., elegant & modern office in seller owned building located on preprior of a well-traveled intersection close to shopping areas. 6 fully-equipped ops. Dedicated parking. Excellent leasehold improvements. Approximately 1,900 active pts. \$1.1M+ avg. GR w/66% overhead & 4 doctor days. Asking \$751K.

### 4051 CENTRAL COAST PROSTHO

Well-established practice located in California's gorgeous Central Coast area. Beautifully appointed, spacious 1,568 sq.ft. office with 4 fully equipped ops, pros lab and other amenities. Situated just minutes from the ocean and <5 miles away from **GOLO** California's historic Mission Cities, this practice is nestled in a highly desirable community. 2013 gross receipts were \$1.2M+ and 2014 is annualized at \$1.3M+ on a 4 day doctor workweek, w/4 days of hygiene/week. Approx. 15 new patients a month and ~1,500 active patients (all fee-for-service). Owner/doctor is willing to help Buyer for smooth transition.

### 4040 FAIRFIELD GP & BUILDING

Well-established GP located in excellent, upscale area. 4 fully equipped ops in 1,615 sq. ft. 2013 GR \$335K. 2014 annualized GR \$433K with adj. net of \$183K. Approx. 700 active patients, all Fee-for-Service (no PPOs/HMOs). Retiring doctor willing to help Buyer for smooth transition. Practice listed at \$210K. Beautifully appointed building is also listed for sale, appraised value and listing price \$410K.

### UPCOMING:

### 4046 SAN JOAQUIN VALLEY ENDO & GP

**4056 SOLANO COUNTY GP** 









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# Required and Recommended Vaccinations for Dental Health Care Workers

CDA Practice Support

he Cal/OSHA blood-borne pathogens regulation requires employers to offer the hepatitis B virus vaccination series to employees within 10 days of initial assignment to tasks that will potentially expose them to blood or saliva. Employers are not required to offer the vaccination to employees who have previously received the vaccination series, who are already immune as revealed by appropriate tests for HBV antibodies or who are prohibited from receiving the vaccine for medical reasons. An employer may not condition hiring on whether a job candidate has been vaccinated. The employer is responsible for paying for the vaccination series and post-exposure evaluation and follow-up series, and the employee should have these done during regular work hours. An employee's refusal to be vaccinated should be documented. If an employee who refused the vaccination later decides to proceed with the series, the employer is responsible for paying for the vaccination series, post-exposure evaluation and follow-up series.

Cal/OSHA and local public health agencies require other vaccinations in specific circumstances. Cal/OSHA's aerosol transmissible disease (ATD) regulation requires certain employers offer occupationally exposed employees the influenza, measles, mumps, rubella, Tdap and chicken pox vaccinations. Dental practices are exempt from this requirement if they meet the conditions for exemption established in the regulation:

- 1. The dental practice does not perform dental procedures on patients with ATDs or who are suspected ATD cases. (A common occurrence in a dental practice is the presentation of a patient with influenza. The patient should be rescheduled in this case and can be treated once the patient no longer presents a possible ATD exposure risk.)
- 2. The dental practice's Injury and Illness Prevention Plan includes a written procedure for screening patients for ATDs that is consistent with current Centers for Disease Control and Prevention (CDC) guidelines for infection control in dental settings, and this procedure is followed before performing any dental procedure on a patient to determine whether the patient may present an ATD exposure risk.
- 3. Employees have been trained in the screening procedure. (This can be easily incorporated into existing infection control or Cal/OSHA training and does not require a separate class dedicated to ATDs.)
- 4. Aerosol-generating dental procedures are not performed on a patient identified through the screening procedure as presenting a possible ATD exposure risk unless a licensed physician determines that the patient

does not currently have an ATD.

A dental practice that does not meet the conditions for exemption from the ATD regulation is required to comply with the regulatory requirements, including the requirement to offer and provide vaccinations to employees.

Local public health departments have authority to order vaccination of health care workers. In the last two flu seasons, a few local agencies ordered all health care workers, including those in dentistry, to get flu shots. For the continued health of your patients, your employees and yourself, keep aware of local public health advisories on ATDs such as whooping cough and the flu. With Nov. 1 being the start of flu season, dental professionals are advised to check for health alerts on the websites of respective county public health departments.

The CDC makes vaccination recommendations for health care workers. You can find more information on its recommendations as well as links to other information resources at cdc.gov/vaccines/adults/rec-vac/hcw.html.

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



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6071 FRESNO Shopping Center location. Has strong history. Last 2-years have averaged \$482,000 in collections and \$275,000 in Profits. 4-ops.
6070 VISALIA Table is well set for the future. Best location with island building at busy stop light intersection. Custom designed 6 op office with best technology (digital, Panorex and Ceric). 6-days of Hygiene. 2013 produced \$826,000 and collected \$794,000 with Profits of \$274,500. Office opened to patients 3-days per week. Successor should open doors 5.5 days a week. \$335,000 invested in technology and equipment. Full price \$485,000. Building also available if desired.
6068 KINGSBURG Great family community south of Fresno.
averaged and a constraint of the stress of the st

Long established. Owner works relaxed schedule doing basic restorative dentistry. Endo and OS referred. 2013 collected \$293,000 with \$154,000 in Profits. 3 Ops. 6067 MONTEREY - ADVANCED RESTORATIVE PRACTICE

Strong foundation for Dentist desiring quality restoration practice in mature and affluent demographic. \$310,000 invested in leaseholds, delivery systems and technology. Digital office includes Panorex and paperless charting. Great location, 3- Ops. 2013 Produced \$525,000 and Collected \$458,000. This is an "out-of-network" practice. Seller available to offer considerable transition assistance. Full price \$185,000.

**6065 SOUTHERN ALAMEDA COUNTY** Collected \$480,000 in 2013. Attractive 3-Op office with tranquil views of garden setting. Digital radiography includes Panorex.

**6064 BERKELEY'S ALTA BATES MEDICAL VILLAGE** Strong performer on Owner's 24 hour week. Current year tracking \$750,000+. 4-days of Hygiene. Lots of work referred out. Renowned Medical Village has regional draw.

**6062 SAN FRANCISCO'S MISSION DISTRICT** Ground floor office in Los Portales Medical Building. SF's hi tech work force is moving into The Mission and transforming area. Client moving into purchased building 12-blocks away. Has been \$900,000/year office. 4-ops fully equipped. Full price \$75,000.

**6061 LODI** Beautiful digital 5-ops with Panorex and paperless. 16+ years left on Lease. 2-day week shall collect \$160,000 in 2014. Will see immediate improvement with Successor who devotes full attention here. \$340,000 invested here. Full price \$200,000.

**6059 MODESTO** Coffee Road. 3-Ops. Collections have averaged \$295,000 with Profits of \$155,000+ last two years. Successor shall see pop in New Patients by becoming PPO provider.

**6055** VACAVILLE 3-days per week with 3-days of Hygiene. Hygiene booked 6-months out. Collected \$565,000 with Profits of \$241,000+ in 2013. Great transition arrangements available.

**6043 WESTERN CONTRA COSTA COUNTY'S EL SOBRANTE** Highly visible in stand-alone building on Appian Way. Has been \$200,000/year on 3-day week. Successor shall see growth. 3-ops. Building optional purchase.

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California DRE License 324962 ANAHEIM HILLS Group member wanted. Hi identity. GP ANAHEIM 2 days wk. Hi identity. Grosses \$20,000-to-\$30,000/month. New digital x-ray. Full Price \$225,000. BAKERSFIELD Lady DDS Grosses \$800,000. Great profits. Shopping center. Full Price \$585,000. BAKERSFIELD 1,000's of patients. Low overhead. Can do \$1 Million. Bargain. BAKERSFIELD - NORTH Gross \$1.5 Million working four 6 hour days. BAKERSFIELD - SOUTH Practice & RE. 1,800 sq.ft. 5 ops and apt. Full CORONA - NORCO Averages \$90,000/month. Will do \$1.2 Million in 2014. DOWNEY Historic Center. 50,000+ autos pass/day. 5 op. FP \$250,000 HEMET Beautiful 10 ops. Will be \$1 Million office. Buy 50% for \$300,000. HMO 2 practices grossing \$4.5 Million. Call Tom Fitterer at 714-832-0230. HUNTINGTON PARK 98% Hispanic. Grosses \$600K. Low overhead. 4 ops. HUNTINGTON PARK Hi identity. 50,000 autos/day. 3 ops. Full Price \$195,000. INDIO 4,600 sq.ft. building across from City Hall. 2 op office ready to expand. IRVINE Low overhead. Quality 5 op. Great Lease. 3 days of Hygiene. LAKE FOREST 7 ops located across street from major employer. LONG BEACH Established 40 years. Includes dental condo. Bargain. NEVADA RESORT AREA Grosses \$600,000 on 3 Days, 30 Denture patients/day. Perfect for Implant Specialist. FP \$600,000. PALMDALE Bank Sale. 4 ops. Great hi identity location. PALM DESERT 5 ops. Grosses \$800,000. Bargain. PASADENA AREA HMO Grosses \$900,000. Storefront, 5 ops. Real Estate available. **REDLANDS** Bank Repo run by Internet Marketing DDS. 4 ops low overhead Grosses \$30,000/month. Full Price \$285,000. RIVERSIDE HMO Grosses \$850,000, low overhead. 9 ops. \$1.5 Million potential. SAN BERNARDINO \$1.5 Million potential. SAN DIMAS HMO Hi identity center. Seller refers a lot. SAN FERNANDO VALLEY Hispanic practice grossing \$1.25 Million. Real estate available. SAN FERNANDO VALLEY Part-time grossing \$300,000. Full time will do \$500,000. SANTA ANA Emergency! Seller says discount and sell. Low overhead strip center. 3 ops. SANTA ANA LOCATION - COMING UP! Hi identity. SOUTH ORANGE COUNTY Prestigious Plaza. Modern 1,450 sq.ft. Will be \$1.5 Million in 3 years.

SOUTH ORANGE COUNTY \$950,000 in 2013. Gorgeous 5 ops. Full Price \$795,000.

SOUTHERN CALIFORNIA Grosses \$4.5 Million. Prestigious hi identity.

**TORRANCE** Prestigious Asian Center. High tech, gorgeous. Full Price \$350,000.

TORRANCE Grossing \$300,000+. Next to hospital.

- TORRANCE/GARDENA Chinese DDS. Very profitable. Grosses \$200,000. Lots referred out.
- **YUCCA VALLEY** Hi identity (huge sign) 600 sq.ft. 2 op dental building. Full Price \$110,000.

# Lag in License Renewal Can Spell Trouble

TDIC Risk Management Staff

Of all the things needed to practice dentistry, a license is the most crucial. However, when it comes to renewing a dental license, the task can get lost in the demands of daily practice.

Forgetting to renew a dental license, or waiting until the last minute to renew, can create unintended consequences. The Dentists Insurance Company advises dentists to plan ahead for required continuing education and promptly renew dental licenses and required certificates. TDIC also strongly recommends that dentists keep copies of current staff licenses on file.

A lapse in dental licensure because of delinquent renewal means that the dentist is practicing without a license, which is a criminal act, according to John J. Sillis, a Northern California attorney specializing in professional liability.

"If there is any problem or lawsuit, practicing without a license is indefensible," Sillis said. "If a dentist practicing without a license commits battery, there is no 'work around' in this situation."

Dental license requirements differ slightly from state to state, but all states make it a crime to practice dentistry without a license. In California, the Business and Professions Code lists the first offense of practicing without a license as a misdemeanor, punishable upon conviction by a fine of up to \$3,000 or imprisonment in a county jail for up to six months or both. A second or subsequent offense is considered a felony punishable by a fine up to \$6,000 or a fine and imprisonment as outlined in the Penal Code.

Sillis cited cases he has handled in which dentists were liable for not having an active license or required certificate. In one instance, a dentist failed to apply for an oral conscious sedation certificate, but performed extensive treatment on a patient under sedation. When the dentist called the patient later to see how she was doing, the patient's husband informed the dentist that the patient had died. While the cause of death was found to be an aneurysm unrelated to dental treatment, the Dental Board investigated the case due to the death of a patient within 24 hours of dental work. When the Dental Board discovered the dentist was practicing without an active certificate, the dentist was required to give up oral conscious sedation privileges and placed on probation for five years.

In another case, a patient claimed he was injured by a hygienist's instrument during a prophylaxis. The investigation uncovered that the hygienist was unlicensed. "If the person is unlicensed, there is no defense," Sillis reiterated. The case settled with a sharp monetary fine. "The dentist hiring and supervising must, at the very least, make sure to have proof of staff license and insurance," he added. "That is the minimum.

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Additionally, before hiring staff, run a background check and call references."

TDIC risk management analysts report ongoing calls about unlicensed staff and emphasize dentists' responsibility to document active licenses because of vicarious liability for staff. The legal concept of vicarious liability holds employers responsible for the acts and oversights of their employees. Regarding dental assistants, if an assistant is not licensed, care must be exercised to ensure the assistant does not perform RDA duties.

To keep ahead of the licensing curve, savvy dental professionals should prioritize continuing education and act quickly when it comes to renewal. License renewal time frames vary by state and depend upon the renewal method. In California, online renewal is the fastest, with license status updated within 48 hours and the pocket license issued within two to three weeks, according to the Dental Board website. California dentists are eligible to renew online if their license expires within the next 85 days and they have no outstanding fines or license delinquencies. If renewing by mail, an update of license status and arrival of pocket license takes six to eight weeks. Do not assume that because you have mailed the renewal paperwork, the process is completed. You can feel confident of license renewal when you receive notification from your dental board or you see your license status updated online.

Outside of California, consult your state dental board, as time frames vary and online renewal may not be available.

Dental professionals cannot rely entirely on receiving a renewal notice. The Dental Board of California website states: "Renewal notices are mailed approximately 60 days before expiration. A dentist is responsible for renewing the license regardless of having received the renewal notice or not." California dental licenses expire on the last day of the birth month of the licensee every two years, according to the Dental Board. If the licensee's birth year is an even number, the license will expire during evennumbered years. If the licensee's birth year is an odd number, the license will expire during odd-numbered years.

Regarding license renewal, the Dental Board of California notes in bold on its website that "there **is no grace period** for a dentist in active practice, although a delinquency fee will not be assessed until the renewal is more than 30 days late. A dentist who practices after the expiration date without renewing is considered to be practicing without a license."

Do not wait until you are questioned whether you have an active license. Uncertainty could lead to an unpleasant discovery and that can spell trouble.

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

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BALDWIN PARK: General Dentistry Practice. 5 Ops, 4 Equipped. 2013 GR \$286K w/Adj Net \$133K. Dr. is moving out of state. #CA176

BANNING: General Dentistry Practice. 6 Ops w/Room for expansion. Paperless, Digital, EagleSoft. 8 Days hygiene/week. 2013 GR \$1.5MM+.

BAY AREA: Periodontal Practice, 6 Ops. 2120 SF. Digital X-rays, Pulse Oximeter Endoscope, Piezosurgery, Dentrix. #CA167

CHULA VISTA: General Dentistry Practice. 4 Ops. Dentrix. 3<sup>1</sup>/<sub>2</sub> Days hygiene. 2012 GR \$528K. #CA109

COASTAL ORANGE COUNTY: General Dentistry Practice. 4 New High-End Ops. Dentrix, Dexis, Digital Pan. 2013 GR \$511K. Close to Ocean-Dream Location! #CAM566

EASTERN SIERRAS: General Dentistry Practice. 4 Ops. 1650 SF. 2012 GR \$521K. Low 52% OH. #CA528.

FOLSOM/EL DORADO HILLS: General Dentistry Practice (Dp D200 SF. Dentrix, Laser, Digite Stores, antra-oral Cameras. 2012 GR \$46-7K. #CA103

**FREMONT:** General Dentistry Practice. 10 Ops. 3000 SF. Digital X-rays, Pan. 4000 Active patients. PPO/HMO, 2012 GR \$1.2MM w/ Adj Net \$300K. #CA553

FRESNO: General Dentistry Practice. 5 Ops, 2000 SF. 5 Days hygiene. 23 New patients/ month. 2013 GR \$789K, #CA171

GREATER LINCOLN/ROSEVILLE: General Dentistry Practice. 3 Ops, 2 Add'1 plumbed. 2150 SF. Intra-Oral, Digital X-ray Laser, Eaglesoft. 2013 GR \$528K+. #CA165

GREATER LOS ANGELES: Periodontal Practice. 5 Ops, 34 Years goodwill. Call for more information. #CA173

GREATER ROSEVILLE/ROCKLIN/ **LINCOLN:** General Dentistry Practice. 2 Ops, 3 Add'l plumbed. 1887 SF. Eaglesoft. 3 Days hygiene. 2013 GR \$350K+. #CA154

GREATER SACRAMENTO: PRICE **REDUCED \$50K!** General Dentistry Practice/Condo. 4 Ops. 1300 SF. Eaglesoft. 2013 GR \$679K. #CA138

GREATER SACRAMENTO: General Dentistry Practice. 7 Ops. 3079 SF (Shared w/2nd DDS-Separate practices). Digital X-Ray, Pano, Datacon. 2013 GR \$974K. #CA140

GREATER SACRAMENTO: General Dentistry Practice. 5 Ops, 1 Add'l plumbed. 1600 SF. Eaglesoft, E4D, Intra-Oral, Pano. 9 Days hygiene/week. 2012 Fiscal Year GR \$888K+. #CA156-IN ESCROW!

Βι

GREATER SACRAMENTO/ **ROSEVILLE** Partices in Position in General I metric Coup Practice. Each partner has own patients. Intra-Oral, Digital X-Rays. #CA126

HAWAII (MAUI): General Dentistry Practice. 4 Ops. ~1200 SF. GR \$636K. #20101

HUNTINGTON BEACH: General Dentistry Practice. 6 Ops, 3 equipped, 3 plumbed. Established 18 years. Spacious. #CA155—IN ESCROW!

INDIAN WELLS: General Dentistry/TMJ Practice. 6 Ops. 4000 SF. 1 Doctor Day/wk, GR \$350K+. #CAM530

LA MESA: General Dentistry Practice. 3 Ops. 2000 SF. Dentrix, Laser, Digital X-Rays. 2012 GR \$396K w/Adj Net \$155K. #CA127

LOMA LINDA: NEW LISTING! General Dentistry Practice. 4 Ops. Intra-Oral, Digital X-Rays, Pano. 2013 GR \$631K #CA185.

MENDOCINO COAST: General Dentistry Practice. 4 Ops. 2376 SF. Dentrix, Intra-Oral, CAD/CAM. 2013 GR \$1.025M. #CA181

MILPITAS: General Dentistry Practice. 5 Ops. 1650 SF. Pano, Intra-Oral, Laser. 7 Days hygiene/week. GR \$935K. #CA180

MURRIETA: General Dentistry Practice. 7 Ops. CEREC, Dentrix, Schick. 2013 GR \$1.4MM+ w/Adj Net \$521K. #CA163 -IN ESCROW!

NEWPORT BEACH: PRICE REDUCED! General Dentistry Practice. 3 Ops. High-End Equipment, 2012 GR \$350K. #CAM534 -IN ESCROW!

NORTH EAST BAY: PRICE REDUCED \$77K! General Dentistry Practice, 7 Ops. 2324 SF. Dental Mate, Intra-Oral, Pano X-ray, Digital X-Ray. Bldg to be sold with practice. 2012 GR \$885K. #CA108

NORTH HOLLYWOOD: NEW LISTING! General Dentistry Practice. 6 Ops, 5 Equipped, 1 Plumbed. Dentrix, Digital X-Rays, Pano, Laser, Paperless. 2013 GR \$845K. #CA187

NORTH OF SACRAMENTO: General Dentistry Practice. 5 Ops, 2050 SF. Dentrix, Intra-Oral, Digital X-Ray, Imaging System, Pano. GR \$1.2M+. #CA106-IN ESCROW!

NORTH ORANGE COUNTY: Endodontic Practice. 5 Ops. 3 Zeiss wall-mounted microscopes. Established 30 yrs. 3 Day/wk. GR \$370K w/Adj Net \$172K. #CAM561

NORTH ORANGE COUNTY: NEW LISTING! General Dentistry Practice. 7 Ops. 6 Equipped. 2700 SF. 3 Days/wk. GR \$601K w/Adj Net \$244K.

NORTHERN CALIFORNIA: Periodontal Practice. 6 Ops. 1500 SF. Dentrix. Partnership Position. Owner Financing Available. #CA168

NORTHERN CALIFORNIA: Endodontic Practice. 3 Ops, 1 Add'l plumbed. 1200 SF. Two microscopes. Digital. 2013 GR \$319,865. #CA158-IN ESCROW

NORTHERN CALIFORNIA: Endodontic Practice. 4 Ops, 1 Add'l available. 1021 SF. Dentrix. 2013 GR \$337K. Owner Retiring. #CA169

ORANGE COUNTY: Oral Surgery Practice. 5 Ops. 2013 GR \$1.3MM+ w/Adj Net \$870K. #CA164-IN ESCROW!

**ORANGE COUNTY:** Periodontal Practice. 6 Ops, 5 Equipped. Great Location. 2013 GR \$479K w/Adj Net \$164K.

**ORANGE COUNTY: NEW LISTING!** Ortho Practice. 4 Chairs. 1200 SF. #CA188

PLUMAS COUNTY: PRICE REDUCED! General Dentistry Practice. 5 Ops, 4 equipped. EZ Dental, Pan. ~1500 Active patients. 32 Hours/wk. 2012 GR \$515K. #CA558

**REDLANDS:** General Dentistry Practice. 3 Ops. Established 48 years. 3 Dr Days and 3 Hygiene Days/wk. \$364K. #CA160

RIDGECREST: General Dentistry Practice & Building. 4 Ops, 1500+ SF. Small Practice. 2012 GR \$175K. #CA523

**RIVERSIDE:** General Dentistry Practice & Building w/ emphasis on Implants. 5 Ops. Established 50+ years. 2012 GR \$500K+. #CA120

ACRAMENTO: General Dentistry Practice. 7 Ops, 1 Add'1 plumbed. 2400 SF. Intra-Oral, Digital X-Ray, Pano, Softdent. 2013 GR \$711K. #CA182

SAN BERNARDINO: General Dentistry Practice. 4 Ops. 30+ Years goodwill. GR \$265K. Dr. retiring. #CA150

SAN CLEMENTE: PRICE REDUCED! General Dentistry Practice. 3 Ops, 2 Add'l plumbed. Practice Works, Digital X-Rays and Pano. Established 10 years. #CA129 -IN ESCROW!

SAN DIEGO: General Dentistry Practice 5 Ops. 1200 SF. EagleSoft, Digital X-Rays Established 22 years. 2012 GR \$442K w/Adj Net \$161K. #CA130

SAN DIEGO: General Dentistry Practice. 3 Ops. FFS, PracticeWorks. Located in a Central Area of San Diego. 2014 GR \$187K. #CA161

SAN FERNANDO VALLEY: General Dentistry Practice. 3 Ops. EagleSoft, Schick Digital X-Rays. Established 30 years. 2013 GR \$177K #CA159

SAN FRANCISCO: General Dentistry Practice. 4 Ops, 1 Add'l plumbed. 1744 SF. Pano, Digital X-Ray, Intra-Oral, Softdent. 177 Dr. Days. 2013 GR \$906K w/ Adj Net \$338K. #CA162

SAN JOSE: General Dentistry Practice. 3 Ops. 1200 SF. Pano, Eaglesoft. 30 Hour/ wk, 2 Days hygiene/wk. 2013 GR \$370K #CA178

SAN MATEO: General Dentistry Practice. 4 Ops, 1 Add'l plumbed. 2150 SF. Dentrix, Digital X-Ray, Film-based Pano, Intra-Oral. 5 Days hygiene/wk. 2013 GR \$708K. #CA179—IN ESCROW!

SANTA CRUZ COUNTY: General Dentistry Practice. 3 Ops. 1100 SF. Schick Digital X-Ray, Dentrix. GR \$338K. #CA550

SANTA MARIA: General Dentistry Practice. 4 Ops. 1500 SF. Easy Dental, Dexis, Digital X-Ray, Intra-Oral. 5 Days/ hygiene. 2013 GR \$523K. #CA166

SOUTH COUNTY SAN DIEGO: General Dentistry Practice. 3 Ops. 1100 SF. Easy Dental, Digital X-Rays w/ 3 Sensors. 2014 GR \$195K. Great Office location w/ growth potential. #CA175

TEMECULA: General Dentistry Practice. 6 Ops. EagleSoft w/ 14 Workstations, Digital, CEREC, Pano. Established 26 years, Wellestablished hygiene program and dedicated, long-term staff. #CA174

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VICTORVILLE: General Dentistry Practice. 3 Ops, 3 Add'1 plumbed. 2150 SF. SoftDent. Established 34 years. 2013 GR \$313K w/Adj Net \$147K. #CA149

WALNUT CREEK: PRICE REDUCED! Prosthodontic Practice, 3 Ops. Full lab, 2013 GR \$399K w/Adj Net \$143K. #CAM540

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

### IMPLANTS

# Do materials matter for ridge preservation?

Chan HL, Lin GH, Fu JH, Wang HL. Alterations in Bone Quality After Socket Preservation With Grafting Materials: A Systematic Review. Int J Oral Maxillofac Implants 2013;28:710-720.

**Purpose:** The purpose of this study was to conduct a systematic review of data comparing the proportion of vital bone and connective tissue between grafted and naturally healed sockets so that the quality of a grafted bone socket can be better understood.

**Methods:** An electronic search of five databases (from 1965 to November 2011) and a hand search of peer-reviewed journals for relevant articles were performed. Human clinical trials that compared histologic components of soft and hard tissues in augmented sockets and naturally healed sites, with at least five samples per group, were included.

**Results:** Eight studies (five randomized controlled trials and three controlled clinical trials) were reviewed. The mean percentages of vital bone and connective tissue in natural healing sockets were 38.5 percent  $\pm 13.4$  percent and 58.3 percent  $\pm 10.6$  percent, respectively. Limited evidence (one to two articles for each material) implied that vital bone fraction was not different with demineralized allografts and autografts and increased by 6.2 percent to 23.5 percent with alloplasts in comparison to nongrafted sites. Four studies investigating the effect of xenografts were available, with equivocal results. The difference in the mean percentage of vital bone ranged from -22.2 percent decrease to 9.8 percent increase. Connective tissue content decreased with the use of the aforementioned bone substitutes. Considerable residual hydroxyapatite and xenograft particles (15 percent to 36 percent) remained at a mean of 5.6 months after socket augmentation procedures.

**Conclusions:** Based on a limited number of prospective comparative studies, the use of grafting materials for socket augmentation might change the proportion of vital bone in comparison to sockets allowed to heal without grafting.

Whether these changes in bone quality will influence implant success and peri-implant tissue stability remains unknown.

**Clinical relevance:** Attaining better bone quality and quantity after regeneration are key outcomes in grafting bone for implant placement. The authors' systematic review analyzed three key outcomes (soft tissue fill, vital bone fill and remnant graft particles) that contribute to a better understanding and comparison of the application of bone grafting materials. Among the grafting materials used, autogenous bone and demineralized freeze-dried bone aggregate did not produce a significant change in percentage of vital bone, whereas alloplasts such as bioactive glass, calcium sulfate and hydroxyapatite obtained a significant increase in vital bone. Results for xenograft were mixed. These results are somewhat unexpected, as allografts and autogenous grafts are the most widely used products in clinical practice, with the latter being considered the gold standard. Considerable heterogeneity did exist among the studies, with all estimated to be at moderate risk of bias with the exception of one at high risk. Future studies should be completed with the goal of reducing heterogeneity in order to further investigate the histologic outcome of regeneration.

– Craig Noblett, DDS, MS, FACD

### IMAGING

# Calcified carotid atheromas: recognition and appropriate referral

MacDonald D, Chan A, Harris A, et al. Diagnosis and Management of Calcified Carotid Artery Atheroma: Dental Perspectives. Oral Surg Oral Med Oral Pathol Oral Radiol 114: 533-47, 2012.

**Clinical problem:** Anatomic structures of the neck can calcify and present as incidental findings on radiographic images of dental patients. Some of these calcifications are normal variants that do not require further evaluation, while others, such as carotid atheroma calcifications, do demand further evaluation. Proper identification of and appropriate referral for these calcifications are important for dental patient management. **Aim:** To present various calcifications of the neck and discuss the clinical, diagnostic and management algorithms for dental practitioners when calcified carotid artery atheromas (CCAAs) are identified radiologically.

**Method:** A review of the dental and medical literature on diagnosis and management of cervical CCAAs was performed.

**Results:** A diagnostic flow chart to characterize the appearance of lateral neck soft tissue calcifications on the panoramic radiograph is provided. Proper differentiation among anatomic variants, such as laryngeal cartilage or stylohyoid ligament calcifications, and pathologic processes, such as carotid calcifications and sialoliths, are discussed. An algorithm for the management of dental patients with suspected carotid calcifications identified on maxillofacial imaging, taking into consideration the patient's blood pressure status, is presented.

**Conclusions:** A medical consultation should be requested for all patients who present with CCAA on dental images. This is particularly important for patients who have sustained elevated blood pressure and no cardiovascular history.

**Bottom line:** Several soft tissue calcifications of the neck can appear as incidental findings on maxillofacial images, such as panoramic and cephalometric radiographs and cone beam computed tomography. Proper identification and differentiation of these opacities is important for appropriate management.

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

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### Tech Trends



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

### 9 Billion Mobile Connections by 2020

Smartphones are everywhere, and that trend is only going to increase over the next six years. According to GSMA, a telecommunications industry body, by 2020, there will be 9 billion mobile connections around the world, with 1 billion new smartphone connections coming in the next 18 months. Part of the reason for this projection is the expanding use of smartphones in developing countries. In fact, by 2020, the GSMA expects emerging countries to account for four in five smartphones connections. Sub-Saharan Africa is expected to become the fastest-growing region thanks to more affordable devices and expanded network availability. The GSMA points out that the price difference between standard phones and smartphones is decreasing, with \$50 (or less) smartphones becoming available.

- Blake Ellington, Tech Trends editor

### iPhone 6 (Apple, pricing begins at \$199 with cellular contracts)

Keeping with what has now become an annual tradition, Apple chose September to release the latest version of its iPhone. In fact, the company released it in two flavors: the 4.7-inch iPhone 6 and the "phablet"-size 5.5-inch iPhone 6 Plus. The new model is not simply a larger version of previous iterations, but delivers significant changes to the form factor, size and features within. The display screen of both models is much larger as well as sharper in terms of color and detail, thanks to the new Retina HD display technology. The phone is thinner and lighter, with curved edges and a power button relocated to the right side of the phone. Under the hood, the camera has also been upgraded, with better autofocus capabilities, 60-frame-per-second video, 240-frame-per-second slowmotion video and time-lapse video mode. Download speeds are now made faster by upgraded LTE capabilities as well as support for the 802.11 ac Wi-Fi standard, which is three times faster. Finally, Apple has delivered on the long-rumored NFC technology integration, which allows iPhone 6 users to use Apple Pay to quickly, easily and securely pay for purchases at participating merchants with only a scan of their thumbprint on their phone. The phone is noticeably fast, including speedier thumbprint recognition on the Touch ID sensor. I have not experienced any instances of the phone bending, as has been reported in the media. The frame is made from long strips of thin aluminum. Bending is possible, just as it is with any other phone, but Consumer Reports has extensively tested it and found the new phones to be far less prone to bending as some initial reports have indicated.

- Blaine Wasylkiw, CDA director of online services

### SwiftKey (SwiftKey, Free)

With the recent release of iOS 8, users can now take advantage of third-party add-ons to enhance their user experiences. SwiftKey can be downloaded for any iOS device running the latest operating system. Upon launching, users are given easy instructions to activate the keyboard through iOS Settings. Once the instructions are complete, users are able to switch to the SwiftKey keyboard by tapping on the globe icon whenever text input is available. The keyboard layout not only provides a standard interface for input but also contains a powerful feature that is sure to capture users averse to typing on a touchscreen keyboard. Users can simply type as they normally would on the standard touchscreen keyboard. Suggestions appear above the keyboard and users can choose to continue typing or select a suggestion that will automatically complete their word or phrase. The other text entry method utilizes SwiftKey Flow, which is a powerful feature enabled by default that will change a user's typing experience dramatically. Most users will easily find SwiftKey to be an invaluable tool that deserves a permanent place on their mobile device.

– Hubert Chan, DDS

### Social Media Leading in Obesity Fight

A new study suggests that social networking programs designed to help people lose weight might help fight against obesity globally. The Imperial College London has released the results of a study that found social network programs designed for weight loss are cutting down on obesity numbers. The finding comes from the data results of 12 studies conducted around the world (U.S., Europe, East Asia and Australia) that included 1,884 participants. Social networking services geared toward weight loss were examined and a decrease in body mass index of 0.64 was discovered among participants. The study, which was published in the journal *Health Affairs*, cited the cost-effective nature and convenience of the apps as a reason for the success, as well as the feeling of being "part of a community" when participating.

- Blake Ellington, Tech Trends editor

### Would you like to write about new technology?

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



Is this the logical extension of the color madness that swept the dentifrice industry in the last few years, giving us a rainbow of choices?

> Robert E. Horseman, DDS

> ILLUSTRATION BY VAL B. MINA

The following Dr. Bob column was originally printed in the February 1995 issue of the Journal.

Will the person responsible for the flowing please step forward and identify himself or herself: 1. Clear soft drinks; 2. Clear mouthwashes; 3. Clear deodorants; 4. Clear toothpastes, gels and lotions; and 5. Clear anything else.

Why this deplorable state of affairs was allowed to get this far without major consumer revolt is anybody's guess. I presume powerful forces got together in secret someplace, fedoras pulled low, and, perhaps after a night of heavy controlled substance abuse, decided that what the public really wanted was transparency in its consumables. Working under the industry motto of "Never underestimate the taste of the American public," it was an easy step to begin leaving the color out of everything they could think of.

There's something terribly wrong about quaffing a clear root beer. It's ok to alter the color with a scoop of vanilla ice cream, but to leach out the rich, brown hue of root beer is sacrilege and must not be tolerated. Is this the logical extension of the color madness that swept the dentifrice industry in the last few years, giving us a rainbow of choices? A backlash that a colorsaturated public might have anticipated?

Some thing, but not necessarily toothpaste, are just meant to have certain colors. Meat, for example, is supposed to be red, not green. That's how we relate to most things in our daily lives. Don't tell me that taking the caramel coloring out of Coke or a Pepsi does not affect its taste. We must never admit this, even if it's true. What'll the attempt next, clear cherry Jell-O? Pellucid coffee? Are these the same people who brought us white chocolate and now they are working on mayonnaise that looks like rubber cement?

What is the point of these

depredations? Financial? Is this like the health-conscious soup manufacturers who managed to charge more for producing reduced-sodium products? Or the rest of the food industry busy leaving out the fat, so we could pay a premium for reducedfat foodstuffs? At least these products still look pretty much the same and we've not yet been conned into drinking warmed water pretending to be bullion from which they've considerately extracted the yellow.

What are we supposed to feel as we behold a transparent product? Boy, this looks so clear, so clean, so free of adulteration? Nonsense! You experience the same revulsion a steak man feels when confronted with tofu, or a vegetarian presented with a slab of prime rib.

I offer my patients a cup of clear mouthwash, hastening to warn him not to drink it.

"Why not?" he asks.

"Because I don't want to clean up the mess you'll make when you belatedly discover it's not water," I explain.

"What's happened to the blue, green or red stuff I always had before?" he questions.

"I dunno," I confess. "It's the latest thing: clear is in, color is out. It's not my fault."

Then suddenly I'm struck by an idea so revolutionary, so delicious, I'm nearly rendered senseless. As amalgam is slowly being phased out by assorted resins and porcelains, why not — oh my Lord, this is so exciting! — why not place clear posterior fillings? Surely, the advantages of this are instantly apparent (or transparent!). No more wondering what's happened under your restoration. You could peer right down to the pulpal floor and check it out.

The composite people will go crazy when this catches on. So will the cement people. Imagine, clear porcelain cemented with clear cement! Clear bonded resins that can be transilluminated to show everything you ever wanted to know about the interior of a tooth. You could almost sell your X-ray machine and get a Lexus.

You remember when pit and fissure sealants first were introduced? They were clear and you could look right through them and see the underlying groove or pit. So we had to save some titanium dioxide or essence of potrizebe incorporated in the mix so we could tell if it was still there later on. The pit and fissure makers had a fantastic thing and didn't even know it!

Well, the handwriting is clearly on the wall now and I offer my idea to the composite and cement and porcelain people ... freely and without any desire for recompense other than a modest request to have the restorative department of any prominent and certified dental school named after me.

However, I join with Snoopy and Bill Mauldin in refusing to quaff any root beer that's transparent, no matter what it tastes like! Is that clear?

### We're Taking Your Requests

If you have a favorite Dr. Bob column you want to see again, send an email to Publications Specialist Andrea LaMattina at andrea.lamattina@cda. org. We will oblige by reprinting those requested favorites interspersed with any new Dr. Bob submissions.





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Dpalescence BOOST

# NO LIGHT NEEDED

# FOR A BRIGHT, WHITE SMILE!

Opalescence Boost is chemically activated, so no light is needed to quickly achieve the smile your patients want! With its powerful 40% hydrogen peroxide formula, Opalescence Boost can deliver stunning results in less than one hour in the dental chair.

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