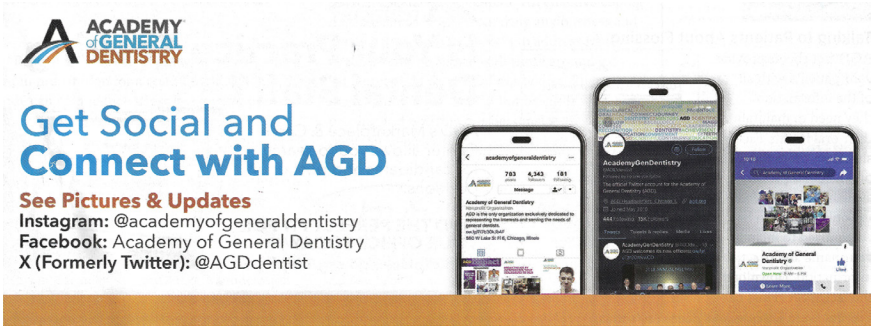
FLORIDA FOCUS

June 2025

the publication exclusively for the general practitioner

FLORIDA ACADEMY of GENERAL DENTISTRY

Dr. Francisco Marcano lectures at the Northeast Florida Component meeting in April



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President's Message

From our human perspective, time has a way of getting away from us. Here we are, near the end of April at the time I'm writing this. Already a third of the year has passed, and soon we'll be getting into that time of the season that we've all come to know and love – Christmas decorations on sale at Hobby Lobby. What does any of that have to do with dentistry? It's all about looking toward the future.

A lot has changed since I graduated dental school in 1992. Digital radiographs. Multiple computers in the office and the operatories. CAD/CAM dentistry. One day crowns. Geesh, more like one hour crowns. 3-D printing. I presented a digital dentistry lecture to the dental assisting and hygiene class at my local state college not long ago, and I showed them the placement of an implant by the Yomi robot in Japan. Technology moves forward at a frightening pace.

One thing that seems to stay the same is the steadfastness of the human attitude. Once again, we seem to be in that dilemma of fluoride or no fluoride. Sealants or no sealants. Why can't I just clean my teeth myself? Why does that filling cost so much? It's all about perspective.

In dentistry, we see it from a research and education side, reading our dental journals every month or at least reading *Dental Abstracts*, and knowing that our costs, inventory and payroll are going to be balanced by our fees and hopefully a decent insurance reimbursement. But our responsibility to our patients is not just limited to drill and fill, but to informing them about the research and education and to helping them understand the true benefit of what we do in dentistry. We place our trust in the advocacy of our dental government leaders to stand up for what is best for our profession, but we also have to trust that those leaders are standing up for what is best for our patients.

That's one of the reasons why I love the Academy of General Dentistry. Dentistry is a profession that centers its efforts not only on those who pay the dues, but toward those who need the care. Yes, in this age of social media, directed advertising, and whatever in God's Name an influencer is, it's difficult to trust that our patients are getting both sides of a story or that they're even getting correct information. That's why we need to do our part, as well: reading our journals, doing our research, and striving to understand both sides of the conversation so we can present our patients with information that will benefit them, not only now but years down the road. So, as you're walking through the "Christmas in April" aisle at Hobby Lobby, I hope that you'll maybe, possibly, hopefully, think about the future of our patients in our practices and how we can benefit them with the best dentistry we can provide, through education, openness, and developing trust in our well-established profession. I wish you all well in this fast-paced year.

Ray A Morse, DMD

Panama City, FL

Editor's Note

According to the great sage David Bowie, "Aging is an extraordinary process where you become the person you always should have been." I came across this quote recently after celebrating a birthday, and it startled me to realize how much time I've been spending lately on crosswords, cryptograms, Sudoku, reading, and of course, the computer. Should we become *this* sedentary as we age?

When I retired from full-time practice, I realized it was time to ramp up my community involvement, which included chairing the Jacksonville Dental Society's Give Kids A Smile event in 2019 and then serving as the JDS President. Last year, I added a slew of other commitments; and for over five years, I've been the editor and designer of this journal, which I love doing. As always, thank you to the generous authors who have contributed to this issue!

However, with my latest birthday behind me, I decided that I should start cutting back on community involvement and focus on the steps we need to take as we age, such as banishing the excessive *stuff* from our house. But which groups should I desert? I keep thinking of another quote, a famous one attributed to Rabbi Hillel in the *Ethics of the Fathers*, compiled in the second century C.E.: "Do not separate yourself from the community." Why is that so important now?

Like me, the world's population is aging. According to the U.N., the number of people over 65 is expected to more than double to 1.6 billion by the year 2050! With this surge in longevity, there's also been a surge in books, articles, videos, and podcasts telling us how to make old age healthier and more satisfying. We've probably all heard the slogan "Age is just a number!" That number is increasing.

In his book *The Great Age Reboot*, author Michael Roizen predicts that with medical advances and healthier lifestyles, people could soon start living to 120 or 130.

One important factor of a healthy old age is social connection. There are probably 1.6 billion studies showing that seniors who maintain a social network usually live longer, have a lower risk of depression and dementia, and have better cardiovascular health and mobility. In one small study, Finnish researchers interviewed residents of an independent living community about why social engagement was so important to them. The residents' answers indicated that they wanted social participation that was meaningful and allowed them to feel significant as individuals. The main goal of their interactions was to help them feel that "I matter."

So, dropping most community involvement probably isn't a great idea, even though I still need to clean out our house. I thought about my communities and realized that there are several I shouldn't abandon until I'm truly decrepit.

The first is the AGD, this extraordinary professional organization composed of dentists who are constantly working to improve their skills, their patients' lives, and the world. I feel privileged to participate on the Florida AGD Board and on the AGD Self-Instruction committee, and I encourage all Florida members to attend our meetings and invite other general dentists to join us!

Continued on page 25

Florida AGD Update

Congratulations to the 2025 graduating classes of Florida's three schools of dentistry at the Lake Erie College of Osteopathic Medicine, Nova Southeastern University, and the University of Florida! We know that they have chosen an extraordinary profession and wish them the utmost success and happiness as they improve their patients' lives every day!

Six outstanding senior students received the 2024-2025 AGD Future Leader in General Dentistry Award, which provides them with a complimentary one-year membership in the AGD and the Florida AGD. Congratulations again!

LECOM

Jacob Burton, DMD

Taryn Arendsen, DMD

Nova Southeastern

Sara Geib, DMD

Dayli Guzman Vidal, DMD

University of Florida

Megan Wilgus, DMD

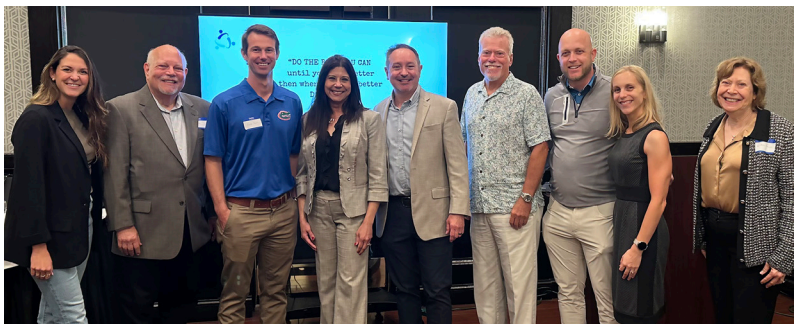
Alec Simonson, DMD

Drs. Wilgus and Simonson receive their awards from Dr. Raj Gohel of the UF College of Dentistry. The photos from the awards ceremonies at LECOM and Nova were unavailable when this issue went to press, but warmest congratulations to Drs. Burton, Arendsen, Geib, and Vidal, as well!

Component News

Florida is one of the few states fortunate to have local AGD chapters, our four components. On March 5 in Altamonte Springs, members of the Central Florida Component enjoyed dinner and a 2 CE presentation on "Pursuing Perfection, Achieving Excellence in Restorative Dentistry," by Dr. Steven Hochfelder. The course referenced the facially generated treatment plan pioneered by Dr. Frank Spear in seeing the larger picture to achieve the desired results. It also incorporated photography to enhance the experience for all involved and discussed the benefits of using pink porcelain in certain situations to support the cosmetic results, as well as the use of provisionals to guide the final result and highlight the benefit they provide as a "test drive" to final restoration.

The Northeast Florida Component met on April 4 in Jacksonville for breakfast and a 3 CE course by Drs. Francisco Marcano and Maribel Santos-Cordero on "Wake Up to the Signs: A Practical Guide to Obstructive Sleep Apnea Screening." The dental spouses shared their personal story of their son's obstructive sleep apnea, explored the critical role of dental professionals in identifying the early signs and symptoms of OSA, and emphasized the unique presentations of OSA in children vs. adults, the importance of interdisciplinary collaboration, and the potential for dental interventions to improve airway health. To learn more about OSA, please read the article by Drs. Marcano and Santos-Cordero on pp. 10-11.



Photos, clockwise from top left: Drs. Marcano and Santos-Cordero; Dr. Steven Hochfelder; a few of the attendees at the Northeast Component meeting.

Spring 2025 Legislative Update: Impacts on Dentistry in Florida and Beyond

by Florida AGD Legislative Chair
Dr. Hector Cabrera

Executive Summary

Spring 2025 has brought a flurry of legislative activity affecting dentistry, particularly in Florida. The Florida Legislature is advancing significant measures that could reshape dental practice in the state – from authorizing a new mid-level dental provider (dental therapists) to expanding what dental hygienists can do and improving access via mobile dental clinics. These state initiatives aim to address provider shortages and improve oral health access, although they have sparked debate within the dental community. At the national level, new federal bills and regulatory trends are poised to impact dentists across the country. Congress is considering reforms to insurance practices and support for oral health programs, while multiple states have joined a licensure compact to facilitate dentist mobility. This report provides an overview and analysis of these 2025 developments, examining their immediate implications and long-term potential effects on the dental profession.

Florida Legislative Developments in 2025

Dental Therapy Legislation in Florida

One of the most significant proposals in Florida's 2025 session is the creation of a licensed dental therapist role. House Bill 21 (and its Senate companion SB 82) would establish dental therapists as mid-level providers who can perform certain procedures under a dentist's supervision. This includes routine restorative care and extractions of primary teeth, among other duties defined by national accreditation standards. The bill also creates a Council on Dental Therapy to oversee licensure and practice standards. If enacted, Florida would join 14 other states in authorizing dental therapists, becoming the 15th state to do so. Proponents argue that dental therapists are a proven way to expand access to care. The bill's sponsor noted that the model has bipartisan support nationally and a decades-long track record abroad with no major safety issues reported.

HB 21 gained momentum in the Florida House, passing by a 78–32 vote on April 23, 2025. As of this report, the measure is awaiting final approval in the Senate. If it becomes law (effective July 1, 2025), dental therapists in Florida would be required to work under the supervision of a licensed dentist. In certain settings – for example, public health clinics or mobile units serving underserved communities – a supervising dentist could authorize a dental therapist to provide services under general supervision (dentist off-site), provided the dentist has examined the patient at least once. In traditional office settings, dental therapists would likely practice under direct supervision, meaning a dentist is on premises and responsible for overseeing care. This tiered supervision approach is intended to increase flexibility for community-based programs while maintaining close oversight in private practices.

Analysis – Potential Impact: The introduction of dental therapists could have far-reaching effects on Florida dentistry. In the long term, this new provider type may help alleviate the state's dentist shortage in underserved areas. Florida has 49 counties designated as Dental Health Professional Shortage Areas, needing an estimated 1,256 additional dentists to meet current needs. Dental therapists – who require less training time than dentists (often around 3 years post-high school) – might help fill critical gaps by providing basic care in public health programs, schools, and rural clinics. Advocates believe this can free up dentists to perform more complex procedures, thereby improving overall productivity of the dental team.

However, many in the dental profession have expressed concerns. The Florida Dental Association opposed HB 21, warning that allowing practitioners with substantially less training to perform irreversible procedures could endanger patient safety. They point out that dental therapists may have as little as three years of post-secondary education focused on limited-scope practice, whereas dentists undergo 8+ years of comprehensive training. Some dentists worry that the quality of care could suffer if supervision protocols are not rigorous. There are also questions about how dental therapists will be integrated into practice – for example, how their services will be billed and whether they will primarily serve public health settings or enter private practice teams. It may take several years before Florida sees a significant workforce of dental therapists, as training programs will need to be established and licensure processes put in place. In the immediate future, the mere possibility of this new provider type is prompting Florida dentists to consider how their practice models might adapt. If implemented successfully, dental therapists could expand access for Medicaid and uninsured patients, potentially drawing more people into regular care. The Legislative Council will be closely watching the rulemaking and implementation (through the new Council on Dental Therapy) to ensure patient care standards remain high.

Enhanced Roles for Dental Hygienists

In tandem with creating a new provider tier, Florida lawmakers also moved to expand the scope of practice for dental hygienists. A provision in the 2025 health care legislation authorizes licensed dental hygienists to use a dental diode laser for specific periodontal therapy tasks. Under the new law, hygienists who complete the proper training will be permitted to use diode lasers for bacterial reduction and disinfection of periodontal pockets (the gingival

sulcus), provided that no hard or soft tissue is incised or removed except for incidental curettage. In practice, this means hygienists can perform laser bacterial reduction during deep cleanings or periodontal maintenance – for example, using the laser to reduce bacteria around teeth and promote healing in cases of gum disease. The law includes safeguards: any hygienist using lasers must complete at least two hours of continuing education on laser technique and safety in each license renewal cycle, and the procedures must be within a dentist's overall treatment plan.

Analysis – Potential Impact: Allowing hygienists to utilize diode lasers is expected to enhance the effectiveness of non-surgical periodontal therapy. Lasers can significantly reduce pathogenic bacteria and inflammation in gum tissue, adjunctive to traditional scaling and root planing. For patients, this could mean improved outcomes (like reduced pocket depths and better gum health) without needing more invasive surgical treatments. In the near term, dental offices may need to invest in laser equipment and training for their hygiene team. Many Florida practices are already familiar with laser technology, but this legislative change formally clears the way for hygienists to use it, rather than limiting lasers to dentist-only use. Dentists will want to ensure any hygienist performing laser procedures is proficient and follows safety protocols (e.g., using proper eye protection and appropriate power settings). Over time, this expanded function could become a standard of care in managing periodontal disease, much as the administration of local anesthesia by hygienists (approved in Florida in earlier years) has become routine. The dental community largely views this change as a positive, collaborative step – it enables the hygiene team to leverage modern technology for better patient care. As with any new function, there may be a learning curve and a need for clear practice guidelines from the Board of Dentistry, but the long-term outlook is improved periodontal health outcomes and possibly more efficient perio maintenance programs within practices.

Access to Care Initiatives: Mobile Dentistry and Provider Incentives

Florida's 2025 legislature not only focused on workforce roles but also on how and where dental care is delivered. In an effort to reach vulnerable populations, lawmakers approved measures to support mobile dentistry. Notably, HB 21 (the dental therapy bill) includes language to allow Medicaid reimbursement for dental services provided via mobile dental units . Previously, regulatory and funding hurdles made it difficult for mobile clinics (such as dental vans that visit schools, health fairs, nursing homes, and rural areas) to sustain operations, since Medicaid would not directly reimburse many services delivered outside of fixed clinics. The new provision removes these barriers by explicitly authorizing Medicaid to pay for care provided by mobile units that are owned or operated by (or contracted with) approved health access organizations . This change dovetails with Florida's broader push to improve rural and underserved area healthcare. It was also reflected in a larger health care package (HB 1427) aimed at bolstering rural health infrastructure, which among other things creates grant programs and may expand loan forgiveness to encourage providers (potentially including dentists) to practice in high-need communities .

Analysis – Potential Impact: These access-oriented initiatives could have an immediate positive impact on Florida's underserved patients. By making mobile dental care financially viable, Florida is empowering public health departments, nonprofit clinics, and even private practices with mobile outreach programs to expand their services. We may soon see more dental vans visiting Title I schools to provide children with exams, cleanings, sealants, and fluoride treatments – services that can now be billed to Medicaid when applicable. Similarly, mobile units can serve homebound seniors or residents of long-term care facilities who struggle to travel to a dentist's office. In the short term, dental providers who operate or partner with mobile programs will need to navigate Medicaid billing procedures for these units, but the state's clear support signals fewer administrative hurdles than before.

Longer-term, improving access via mobile dentistry could lead to better preventative care and earlier intervention in communities that historically had limited dental services. If successful, this can reduce the burden of advanced dental disease that often ends up in hospital emergency rooms. Additionally, by expanding loan repayment and rural grant programs for health professionals, Florida is addressing one root cause of access gaps: the maldistribution of providers. For dentists, expanded incentive programs (like loan forgiveness for serving in a rural county or a financially depressed area) can make it more attractive to practice in those areas. Over time, this could gradually increase the dentist-to-population ratio in high-need regions. From a dentist's perspective, these programs may offer both an opportunity to reduce student debt and a pathway to build a practice in a less saturated market. However, the effectiveness of such incentives will depend on adequate funding and awareness – the

state will need to promote these programs so that new dental graduates and even mid-career dentists are aware of the support available for relocating to underserved communities.

Licensure and Practice Regulations

The Florida Legislature also addressed professional regulation in 2025 to ensure quality and accountability in dental practice. One update came in the form of tweaking the requirements for licensure by endorsement for out-of-state dentists and hygienists. Legislators passed a bill (HB 509) amending the criteria under which Florida will grant a license to an applicant already licensed elsewhere in the U.S. The new language requires that any dentist or hygienist seeking Florida licensure by endorsement must be a graduate of an accredited dental or dental hygiene program (i.e., accredited by the American Dental Association's Commission on Dental Accreditation or a successor recognized by the U.S. Department of Education). This seemingly small change closes a loophole and ensures that Florida does not issue licenses by endorsement to individuals who attended non-accredited programs (for example, some foreign-trained dentists without U.S.-accredited credentials). By enforcing the accreditation requirement, Florida's lawmakers aimed to uphold high standards for competence and training in the profession.

Allowing hygienists to utilize diode lasers is expected to enhance the effectiveness of non-surgical periodontal therapy... Over time, this expanded function could become a standard of care in managing periodontal disease, much as the administration of local anesthesia by hygienists (approved in Florida in earlier years) has become routine.

Another notable provision in the dental therapy legislation is a clause that restricts the ownership and employment relationships involving dental therapists. The bill explicitly prohibits anyone who is not a licensed dentist from employing a dental therapist in the operation of a dental office. In other words, only a dentist-owned entity can hire and oversee dental therapists. This aligns with Florida's existing stance that dental practices should be owned or controlled by licensed dentists – a policy intended to keep clinical decisions in the hands of practitioners rather than corporate or purely business interests. By extending that principle to the new dental therapist role, the legislature has maintained consistency in Florida's professional practice rules.

Analysis – Potential Impact: The tightening of licensure-by-endorsement requirements will help ensure quality control as more dentists move into Florida. Florida is an attractive state for many practitioners (due to its growing population and lack of state income tax), and the endorsement pathway allows experienced dentists licensed elsewhere to obtain a Florida license without re-examination, provided they meet certain criteria. Requiring accredited education is a safeguard that protects patients and the profession from individuals who might circumvent the standard U.S. training pipeline. The immediate impact on the workforce is likely small – relatively few applicants come from non-accredited backgrounds – but it sends a message that Florida will not compromise on educational standards. Legitimate foreign-trained dentists typically must still go through accredited U.S. programs or examination routes to practice in Florida, so this legislative tweak essentially codifies the status quo as law. In the long run, this helps maintain public trust that any dentist or hygienist practicing in Florida met rigorous training benchmarks equivalent to U.S. grads.

The ownership restriction for dental therapists is also significant. In the short term, it assures dentists that the new mid-level practitioners will remain firmly under dentist supervision and practice management. This could alleviate concerns about potential independent practice or outside entities using dental therapists in ways that undercut dental offices. By requiring a dentist to be the one hiring/supervising, the law fosters a team model where the dentist is ultimately responsible for patient care delivered by the therapist. Long-term, this may forestall any drift towards independent practice for therapists, unless future laws explicitly change that. For now, Florida's approach mirrors that of other states like Minnesota and Vermont where dental therapists must practice in collaboration with dentists. This regulation should encourage a collaborative implementation of the dental therapist model – dentists can incorporate therapists into their practice settings to expand services, but always with the dentist guiding treatment planning and maintaining oversight. From a practice management perspective, Florida dentists can view dental therapists (if the law passes) as a potential extension of their team rather than a competing parallel practice. Of course, maintaining compliance with these rules (e.g., ensuring any business employing a therapist has a dentist owner) will be important; the Board of Dentistry will likely develop rules or guidance to enforce this, and violations (such as a non-dentist-owned clinic attempting to employ a therapist) would carry penalties under unlicensed practice or similar statutes.

National Legislative and Regulatory Updates

Federal Dental Legislation to Watch

Several federal initiatives in 2025 could impact dentists nationwide. A top priority for organized dentistry is addressing burdensome insurance practices. In late February 2025, the Dental and Optometric Care Access Act (known as the DOC Access Act) was reintroduced in the U.S. House of Representatives. This bipartisan bill, strongly backed by the American Dental Association (ADA) and Academy of General Dentistry (AGD), aims to prohibit dental insurance plans from dictating fees for services that the plan doesn't even cover. Many dentists are familiar with this scenario: an insurance contract sets a maximum charge for certain procedures, even if those procedures are not included as benefits under the patient's plan – effectively a "non-covered services" fee cap. The DOC Access Act would outlaw such clauses in insurance contracts at the federal level, ensuring that dentists can set fair fees for services when the insurer isn't paying for them. This would apply primarily to employer-sponsored (ERISA) dental plans that state laws currently can't reach. If enacted, it would complement laws in over 40 states that have already banned non-covered services fee caps in state-regulated dental plans. Dental organizations argue that this reform will help patients in the long run: it prevents insurers from pushing unrealistically low fees (which can limit what services dentists offer) and thus preserves patient access to a full range of treatment options. While the fate of the bill in the current Congress is uncertain, its introduction is a positive sign. The legislative effort has gained notable support – it is seen as a common-sense fix to an unfair insurance practice

– and the hope is that 2025 could finally be the year this consumer protection becomes law.

Another federal bill important to dentistry is the Ensuring Lasting Smiles Act (ELSA). Though not new to Capitol Hill, ELSA continues to be a focal point in 2025 as dental advocates urge its passage. This act would require all private group and individual health plans to cover medically necessary dental procedures related to congenital anomalies or birth defects. For example, children born with cleft lip/palate or other craniofacial conditions often need a series of dental and orthodontic treatments as part of their reconstructive care. ELSA would guarantee that insurance

A top priority for organized dentistry is addressing burdensome insurance practices... The Dental and Optometric Care Access Act aims to prohibit dental insurance plans from dictating fees for services that the plan doesn't even cover.

cannot deny these claims on the basis that they are "dental" in nature. The ADA and AGD have championed ELSA for several years, and it has previously passed one chamber of Congress with broad bipartisan support. In the new Congress, the bill is expected to be reintroduced and hopefully advanced further. If ELSA becomes law, it will relieve a significant financial burden for affected families and ensure patients receive the comprehensive care they need for full rehabilitation. For dental practitioners, this would mean fewer insurance obstacles when providing care to patients with congenital conditions, as medically indicated dental services (such as restorations for missing teeth, bone grafts, implants, and orthodontics related to a congenital defect) would be clearly covered. While as of Spring 2025 ELSA has not yet been enacted, its continued progress is a key national legislative update to monitor.

Beyond these specific bills, there remains ongoing discussion in Washington about expanding oral health coverage in public programs. Notably, the idea of adding a dental benefit to Medicare continues to be debated. No consensus legislation has emerged in early 2025 on a comprehensive Medicare dental benefit, largely due to cost concerns and differing views on scope. However, there have been incremental moves: for instance, recent policy changes now allow Medicare to cover certain medically necessary dental services (such as extractions or exams prior to organ transplants or cancer treatment). Additionally, some lawmakers have floated more limited proposals (like a Medicare dental benefit restricted to low-income seniors or specific services). While no new federal dental coverage law is in place yet, the landscape is shifting toward greater recognition of oral health in overall health policy. Dentists should be aware that in the coming years, we may see Medicare or other federal programs inch toward including more dental care – a development that could significantly impact practices serving older adults. If and when such proposals gain traction, the AGD and ADA will undoubtedly be involved to ensure any program is implemented in a way that is sustainable for both patients and providers.

Interstate Licensure Compact Gains Momentum

Dental licensure portability is another area of progress in 2025 that has implications for the profession. The Dentist and Dental Hygienist Licensure Compact – a newly created interstate agreement – is rapidly gaining adopters. In April 2025, Nebraska became the 12th state to enact legislation joining this compact. Other states that have signed on include Colorado, Ohio, Washington, Tennessee, Virginia, and several more across the Midwest and South. Under the compact, dentists and hygienists licensed in one member state would be able to obtain a privilege to practice in other member states more easily, without having to go through the full, traditional state-by-state licensure process. Essentially, the compact creates a pathway for license portability: a dentist could apply for a compact privilege to practice in another compact state, provided they meet eligibility criteria (such as being free of disciplinary actions, having a valid license in good standing, etc.). This system is expected to reduce administrative burdens and delays for dentists relocating or wanting to practice across state lines (for example, dentists who live near state borders or those who move due to family or military assignments).

The ADA and AGD have both endorsed the licensure compact as a means to modernize the profession and address regional workforce shortages. The idea is that if dentists can more readily move to where patients need them, it will improve access to care. It can also benefit spousal employment for those in the military or others who frequently relocate – a dentist moving into a compact state could start practicing much sooner than if they had to wait for a new license by the usual endorsement methods. From a long-term perspective, if the compact continues to catch on (most compacts become operational once a threshold number of states join – often around 7 to 10 states, which has now been met), we could see a more nationalized dental labor market. Dentists might pursue opportunities in other states without the deterrent of licensure exams or red tape, and hiring processes for multi-state dental groups could be streamlined.

It's important to note that Florida has not yet joined the Dentist Licensure Compact. Florida dentists moving elsewhere, or out-of-state dentists moving to Florida, must still go through the conventional licensure or endorsement procedures in the meantime. Given that Florida often attracts practitioners from around the country, the state's participation in the compact would be significant. However, Florida regulators and the dental board may be evaluating how the compact's requirements align with our state's standards. There may be concerns to address, such as ensuring that any incoming dentist via the compact meets Florida's criteria (the compact has built-in standards, but states can add certain requirements like a jurisprudence exam). For now, the Legislative Council will monitor this trend. As more states (potentially including neighboring states in the Southeast) adopt the compact, there could be growing interest in Florida following suit. Joining an interstate compact would ultimately be a decision for a future legislative session, likely with input from the Board

of Dentistry and dental associations. If Florida does consider it, the profession will need to weigh the benefits of easier mobility against any possible risks (for instance, ceding some control of licensure processes to a multistate commission). In the short run, Florida dentists should simply be aware that this change is on the horizon nationally – and if they hold licenses in one of the compact member states, they might soon have expanded practice options across state lines.

Other Notable Regulatory Developments

Outside of legislation, a few regulatory updates in 2025 are worth mentioning, as they could affect dental practices:

- **Insurance and Billing Regulations:** The Centers for Medicare & Medicaid Services (CMS) has been working on rules to improve transparency and fairness in insurance. While mainly targeted at medical plans, some changes trickle down to dentistry. For example, CMS is implementing stricter requirements for Medicare Advantage plans and Medicaid managed care plans regarding prior authorization processes. These rules, expected to be finalized in 2025, will likely mandate more timely responses and greater disclosure of approval rates. If a dental service (such as an oral surgery or a medically necessary dental procedure) falls under one of these plans, dentists and patients could see a modest improvement in how quickly treatment gets approved or denied. Additionally, there is ongoing discussion at CMS about network adequacy – ensuring health plans have enough providers, including dentists, in their networks. Stronger network adequacy standards in Medicaid or exchange dental plans could benefit dentists by reducing overly narrow networks and ensuring more patients have in-network options for care.

- **Workforce and Training Programs:** On the federal front, funding for dental workforce development continues through HRSA (Health Resources and Services Administration) grants. In 2025, Congress is expected to consider reauthorization of programs under the Public Health Service Act that include support for dental training, such as pediatric dentistry residencies, general practice residencies, and the National Health Service Corps (NHSC) loan repayment program for dentists. Thus far, no new major funding boosts have been passed, but maintaining these programs is crucial. The NHSC, for instance, has placed many dentists into underserved communities with loan repayment incentives. The AGD and ADA are advocating not only to preserve such funding but also to expand it, as part of the solution to the access gaps.

- **Employment and Practice Management:** A significant regulatory proposal currently pending is the Federal Trade Commission's (FTC) proposed ban on non-compete clauses in employment contracts. While this is not specific to dentistry, it has drawn attention in the healthcare arena. Many dentists, especially new associates, sign contracts with non-compete provisions that restrict them from practicing within a certain radius if they leave their employer. The FTC's proposal (introduced in 2023 and still under review in 2025) would prohibit most non-compete agreements nationally as an unfair restraint of trade. If this rule (or similar legislation such as the bipartisan Workforce Mobility Act) moves forward, it could profoundly affect dental practice owners and associates alike. Immediate impact: none yet, as the rule is not finalized; but dentists may want to review how they structure employment agreements in anticipation. In the long run, eliminating non-competes could lead to greater competition for patients and staff in local markets – on one hand benefiting young dentists by giving them freedom to change jobs or start practices, but on the other hand, challenging practice owners to focus on retention through positive workplace culture rather than enforceable contracts. The dental community is keeping a close eye on this issue, and we will update if a final rule is issued. It's worth noting that some states, independent of the FTC, have already moved to limit non-competes in healthcare employment to promote patient access and continuity of care.

- **Public Health Initiatives:** Lastly, it's notable that organized dentistry remains engaged on public health regulations that indirectly affect dental practice. For example, the ADA in 2025 joined a coalition supporting community water fluoridation nationwide, in response to localities considering fluoridation rollbacks. Also, the U.S. Food and Drug Administration is progressing on tobacco control measures (such as potential bans on menthol cigarettes and new rules for e-cigarettes) which the dental profession largely supports due to the oral health implications. While these are not legislative acts per se, they underscore the broader regulatory environment in which dentists operate – one that increasingly recognizes oral health as integral to overall health. Keeping abreast of such developments enables dentists to align their patient education and advocacy efforts with current public health priorities.

Conclusion

The spring of 2025 has proven to be a dynamic period for dental legislation. In Florida, lawmakers are on the verge of enacting substantial changes – introducing dental therapists, expanding hygienists' capabilities, and boosting access to care through mobile dentistry and provider incentives. These efforts reflect innovative strategies to tackle longstanding issues like provider shortages and untreated disease, even as they raise important questions about implementation and oversight. Florida's dental community, including the AGD's Legislative Council, has been actively engaged, voicing support for what works and caution where needed. As these state initiatives take shape, their real-world impact will become clearer: Will Florida see more patients reached and better outcomes, and how will dentists and team members adapt to the new professional roles?

Nationally, the legislative and regulatory landscape continues to evolve in ways that will influence dental practice in the Sunshine State and beyond. Federal insurance reforms like the DOC Access Act could shift the balance in dealings with insurers, empowering both dentists and patients. Momentum on the licensure compact hints at a future with fewer barriers for dentists practicing across states, which could benefit a transient workforce and areas in need. Meanwhile, ongoing advocacy for measures like ELSA shows a determination to ensure coverage gaps are filled for our most vulnerable patients. Dentists should remain informed and engaged on these fronts – contacting their representatives when support is needed and adjusting their practices proactively as new rules come into effect.

In summary, 2025's legislative developments carry significant promise for improving oral health access and the practice environment, but they also require careful navigation. The Florida AGD will continue to monitor these changes, provide input to policymakers, and update our members. By staying adaptable and informed, general dentists can turn many of these changes into opportunities – to broaden the reach of our care, to strengthen our professional teams, and to better serve the oral health needs of our communities in Florida and across the nation.§

Screening for Obstructive Sleep Apnea With Dr. Francisco J. Marcano and Dr. Maribel Santos Cordero

Passionate about sleep and its correlation to TMD, Dr. Francisco Marcano has done extensive specialized education training in this area. From over-the-shoulder courses to mini-residences, and anything in-between, Dr. Marcano has transformed his knowledge into a mission: addressing life-threatening medical conditions rooted in dental causes.

A graduate of the University of Puerto Rico School of Dental Medicine, Dr. Marcano has been practicing dentistry since 1994. Dr. Marcano is an alumnus of the University of Kentucky College of Dentistry's TMD, Orofacial Pain Management and Sleep Medicine Mini Residency and has earned Diplomate status from the American Board of Dental Sleep Medicine.

An active leader in his profession, Dr. Marcano is a proud member of the American Dental Association, the Academy of General Dentistry, the American Academy of Dental Sleep Medicine, Spencer Study Club, and the Florida Dental Association. He also serves as a Board Member and Delegate-at-Large for the Florida Academy of General Dentistry. Dr. Marcano has lectured in the US as well as internationally on Dental Sleep Medicine and the dentist's role in helping patients with Sleep and TMD problems.

Dr. Maribel Santos-Cordero's personal journey and relentless pursuit to find solutions to her son's struggles drove her down the path of specialized training in tethered oral tissues, oral myology, and pediatric dental sleep medicine. She has now made it her mission to provide each patient with the necessary tools to achieve optimal growth & development.

As an Affiliate of The Breathe Institute, Dr. Santos is very passionate about the need to create awareness of the potential health problems in children with lip & tongue ties and sleep related breathing disorders. She often engages in a team approach with other healthcare professionals to provide her patients with treatment options that will help them thrive.

Dr. Santos-Cordero earned a DMD degree from the University of Puerto Rico School of Dental Medicine with high honors and has been practicing dentistry since 1994. She completed her residency program in Pediatric Dentistry at The Children's Hospital of Buffalo, NY, and a Pediatric Dental Sleep Medicine residency at Tufts School of Dental Medicine. A certified laser surgeon, she is also trained in oral myology.

Dr. Maribel Santos has earned privileges to practice dental surgery at Johns Hopkins All Children's Hospital in St. Petersburg, FL, and has been on staff since 2002. Dr. Santos is a Diplomate of the American Board of Pediatric Dentistry, a Fellow of the American Academy of Pediatric Dentistry, and a Fellow of the American Laser Study Club. She is a member in good standing of the Florida Academy of Pediatric Dentistry, the Academy of Laser Dentistry, the International Affiliation of Tongue-Tie Professionals, the International Consortium of Ankylofrenula Professionals, and the American Dental Association.

Educating dentists and their teams about obstructive sleep apnea screening isn't only a professional mission for both of you; it's personal, too. Could you please tell our members about why screening for OSA became so important to you?

Our journey into airway health started from a deeply personal place as we searched for answers to our son's struggles. As a child, he showed signs of sleep-related breathing disorders: restless sleep, mouth breathing, snoring, gasping for air, night terrors, hyperactivity, and stunted growth.

At the time, we didn't understand how these symptoms were connected, or that we, as parents and dental professionals, could play a role in addressing them. We sought help from multiple specialists, but were repeatedly told, "He'll grow out of it." Unfortunately, he didn't. By his teenage years, he was diagnosed with mild obstructive sleep apnea.

Our determination to help him led us down an intensive path of education. Through countless hours of continued learning in areas like children's oral and craniofacial growth, functional orthodontics, oral myofunctional therapy, dental sleep medicine, and surgical treatment for tethered oral tissues, we started connecting the dots. We began to understand how oral function, tongue posture, and early growth patterns all are linked to airway health.

We've come to accept a powerful truth: *you can't recognize what your mind hasn't been trained to see.* Once we began to understand the connections, it became clear that dental professionals have a critical role in identifying and addressing these root causes, especially during a child's early developmental years. Many underlying causes of sleep-related breathing disorders in children are treatable, particularly when detected early.

Our story ends well. Our son is now a professional soccer player, breathing well and thriving. We still reflect on how different his story might have been if we had known what we know now. This experience has become our purpose. It fuels our commitment to early screening, interdisciplinary collaboration, and helping other families find answers sooner. What once was a personal quest has now become our professional mission.

How prevalent are obstructive sleep conditions among adults and children?

Sleep-related breathing disorders in children represent a spectrum ranging from mild symptoms like mouth breathing to severe conditions like obstructive sleep apnea (OSA). Prevalence increases as severity increases along that spectrum. It is estimated that 30-60% of children are habitual mouth breathers. About 10-30% may have snoring without OSA and 5-10% may suffer from OSA.

In adults, obstructive sleep apnea is very common and often underdiagnosed. According to a 2022 study published in the *Journal of Clinical Sleep Medicine* by Nosetti and colleagues, the global burden in the adult population is even more significant — it's estimated that over one billion adults between the ages of 30 and 69 may be living with OSA. Considering that the adult world population is approximately 5.25 billion, that is a very significant statistic. In the US, roughly 18 to 30 million Americans are estimated to have OSA, with about 80% of cases going undiagnosed.

What are the primary causes of OSA in children, and what are the signs?

In children, one of the main causes of OSA is nasal airway obstruction, often due to enlarged tonsils or adenoids, or frequent nasal congestion from allergies or upper respiratory infections. These blockages can lead to habitual mouth breathing and a low tongue posture. It's also common to see low tongue posture in kids with tongue-ties or prolonged oral habits like thumb sucking or pacifier use. When the tongue doesn't rest against the palate, it can fall back and partially block the airway during deep sleep.

In your practices, when do you begin screening for OSA? What questions & observations should dentists include in our patient examinations of children & adults?

As part of our routine pediatric dental exams, we always look for clues that might point to sleep-disordered breathing; things like mouth breathing, teeth grinding, unfavorable jaw growth, myofunctional issues, and tongue-ties. We've also created a questionnaire highlighting common signs and symptoms in children. It helps us start meaningful conversations with parents and allows them to connect the dots between airway health and their child's overall well-being.

In our adult dental practice, we screen every patient for obstructive sleep apnea. Our approach includes validated screening tools, a thorough review of the patient's medical history, and one-on-one discussions to explore sleep-related concerns.

As dentists, it's crucial that we pay close attention to oral and craniofacial indicators that may signal OSA. These include signs like nighttime grinding or daytime clenching, limited tongue mobility or a large tongue (macroglossia), tenderness in the facial muscles, recurring broken or failed dental work, and visual evidence of a narrow airway. We also take note of posture compensations that can hint at long-term airway challenges. This comprehensive, team-based approach helps us identify at-risk patients and work collaboratively with other healthcare providers for proper diagnosis and treatment.

Which sleep questionnaires do you prefer to use, and why?

Over the years, we've worked with a variety of established screening tools and have also developed our own comprehensive questionnaire, drawing elements from instruments such as the Epworth Sleepiness Scale, Berlin Questionnaire, STOP-BANG, Lamberg Questionnaire, and the Fairest 6. Our goal has been to create a thorough screening process that captures a broad spectrum of risk factors and symptoms.

That said, it's important to recognize that questionnaires are simply tools and valuable components in our clinical toolbox, but not diagnostic instruments. They cannot determine the type or severity of obstructive sleep apnea. Rather, they serve as starting points for meaningful conversations with patients and parents, helping us piece together the clinical picture.

As dental professionals, we play a critical role in screening and identifying potential indicators of OSA, but we are not licensed to diagnose the condition. Diagnosis must come from a qualified physician, typically following a sleep study. Once a diagnosis is made, we collaborate within a multidisciplinary care team to help manage and treat the patient appropriately.

Could you please tell us a little about comorbidities between OSA and other chronic illnesses?

In children, sleep-related breathing issues often show up as more than just snoring or restless sleep. We frequently see signs like delayed growth, ADHD-like symptoms, bedwetting, frequent allergies or upper respiratory infections, poor emotional regulation, learning difficulties, and underdeveloped upper and lower jaws.

Dr. Steven Lamberg notes that over 170 medical conditions have been directly linked to sleep-related breathing disorders. In adults, some of the most common ones include atrial fibrillation, type 2 diabetes, cognitive decline and Alzheimer's disease, certain cancers, high blood pressure, stroke, obesity, erectile dysfunction, GERD (acid reflux), coronary artery disease, high cholesterol, cardiovascular disease, depression, anxiety, chronic fatigue, and excessive daytime sleepiness.

What are the best practices for good sleep hygiene?

Good sleep starts with good habits. It's all about creating routines that help your body wind down and get into a healthy rhythm. One of the most important things? Going to bed and waking up at the same time every day, even on weekends. That helps your internal clock stay on track.

Screens are a major sleep disruptor. Try turning off TVs, phones, and computers at least one hour before bed. The blue light from screens can mess with your melatonin levels (that's the hormone that helps you fall asleep). It's also a good idea to use caffeine drinks in the morning only; having it too late can keep you up at night.

Your sleep space matters, too. A cool, dark room is ideal - aim for around 65 to 67 degrees Fahrenheit. Even tiny lights (like those little LED dots) can throw things off, so try to block them out. And try to keep your bed just for sleeping. Using it for reading, working, or scrolling can confuse your brain and make it harder to fall asleep.

Also, taking naps, especially in the afternoon, can make it tougher to fall asleep later on.

Stick with these habits, and you'll probably notice a big difference in how well you sleep and how you feel during the day.§

Pediatric Dentistry for the General Dentist:

What You Need to Know

by Dr. Shana Capra

Introduction

Dental caries remains the most common chronic childhood disease in the United States. Despite overall improvements in oral health, early childhood caries is still highly prevalent. More than half of U.S. children ages 6 to 8 have had caries in a deciduous tooth, and over half of adolescents ages 12 to 19 have had caries in a permanent tooth. In Florida, for example, roughly one in four preschool children in Head Start programs have untreated tooth decay, illustrating that many young children suffer from preventable dental disease. These untreated cavities can cause pain, infection, and difficulty eating or learning, underscoring the importance of early prevention and treatment.

General dentists play a critical role in pediatric oral health, especially in communities with limited access to pediatric specialists. Most general dentists do treat pediatric patients, but historically some have been reluctant to see very young children. A survey found that 73% of general dentists did not treat children under 18 months old, and 28% would not see children aged 18 months to 3 years. This delay in care conflicts with current guidelines: the American Academy of Pediatric Dentistry (AAPD) and American Dental Association recommend establishing a dental home by age one or within 6 months of the first tooth's eruption. If a general dentist is not comfortable seeing infants or toddlers, it is essential to refer the family to a pediatric dentist rather than postponing care. Early dental visits set the foundation for a lifetime of oral health and allow providers to educate parents, implement preventive measures, and address issues before they become severe.

Caries in Children: Prevalence and Why Early Treatment Matters

Dental caries is not only common but also largely preventable. It is often cited that childhood caries is five times more frequent than asthma in children. The high incidence is concerning because untreated caries in primary teeth can have serious consequences. Besides pain and infection, infected primary teeth can affect a child's nutrition, speech development, and self-esteem. Untreated caries in primary molars may also spread infection that impacts overall health. Children with significant dental disease can suffer impaired growth and miss school days; in fact, American kids 5 to 7 years old miss an estimated 7 million school hours annually due to dental problems.

Importantly, treating caries in primary teeth is critical, even though these teeth will eventually exfoliate. Primary teeth serve as natural space holders for permanent teeth and are vital for proper chewing and speech in early years. It also curtails the child's caries risk going forward – a history of caries is the strongest predictor of future caries in both primary and permanent dentitions. In summary, general dentists should not adopt a "wait and see" approach for primary teeth. Restorations, silver diamine fluoride (SDF) treatment, or interim therapeutic restorations can stop the disease process and preserve the tooth's function until natural exfoliation. By intervening early, we avoid more complex treatment later and break the cycle of disease.

First Dental Visit by Age One

Many pediatric dentists and informed general dentists follow the axiom "First visit by first birthday." This early visit is primarily educational and preventive. The dentist can perform a quick exam (often with the child on a parent's lap), demonstrate proper oral hygiene for an infant, and discuss dietary habits. Seeing a child at age 1 allows the dentist to assess caries risk (e.g. are there white-spot lesions, is the child routinely put to bed with a bottle, etc.) and to counsel parents on fluoride, toothbrushing, and nutrition. It also helps the child become acclimated to the dental environment. The Centers for Disease Control and Prevention emphasizes that an early dental visit helps spot problems early and gives parents guidance on preventing cavities.

Unfortunately, some families are still told to delay the first dental visit until age 3, an outdated practice that can lead to missed prevention opportunities. If a general dentist chooses not to see children under 3, it is imperative to refer those patients to a pediatric dentist rather than delay care. Early exams can reveal issues like enamel demineralization or early childhood caries before they progress. For instance, a small lesion in a 1-year-old's front tooth can often be arrested with fluoride varnish and behavior changes, whereas waiting until age 3 might result in a large cavity requiring restoration or extraction and even sedation in order to treat. The AAPD has long advocated that "the age-one dental visit" become the norm, and pediatricians likewise are encouraged to refer infants for dental evaluations by 12 months of age. Establishing

a dental home by age one means the child has an ongoing place for comprehensive oral health care, be it with a general dentist comfortable with infants or a pediatric dentist. This proactive approach significantly lowers the risk of extensive disease and costly intervention down the road.

Consequences of Delayed Care

One of the starkest illustrations of why early dental care matters is the prevalence of very young children needing extensive dental rehabilitation under general anesthesia. When toddlers and preschoolers present with severe early childhood caries affecting multiple teeth, treating them in the dental chair can be very challenging due to their age and limited cooperation. The result is often treatment in an operating room under general anesthesia. While general anesthesia enables comprehensive care in one visit, it carries medical risks and significant cost. Many of these hospital dental cases could have been prevented by earlier intervention – timely exams, fluoride treatments, and restorations before the caries became rampant.

Studies show alarming trends in the need for dental general anesthesia among young children. In one U.S. hospital-based study, "tens of thousands" of preschool-age children undergo dental treatment under general anesthesia each year. Similarly, a New York State review found that from 2004 to 2008, the percentage of children with early childhood caries being treated under general anesthesia in hospitals more than doubled (from ~35% to 75%), indicating a growing reliance on general anesthesia for preschool dental cases. International data echo this concern: in Canada, dental surgery for early childhood caries was the single most common day-case surgery for children under age 5, accounting for 31% of all day surgeries in 1–5-year-olds. In the United Kingdom, dental extractions under anesthesia are a leading cause of hospital admissions for children ages 5–9. These sobering statistics highlight that too many children are reaching a point of advanced dental disease that requires surgical intervention.

The strain on healthcare resources is significant – dental OR cases tie up operating rooms and anesthesia personnel, and the financial burden can be high. Estimates put the cost of pediatric dental general anesthesia cases in the thousands of dollars each, often covered by Medicaid or other insurers. Beyond cost, there are child health considerations: the FDA has warned about repeated or prolonged anesthesia in children under 3 and potential side effects, although a single short dental general anesthesia is generally considered safe. The bottom line for general dentists is that prevention and early management of disease is far preferable to surgery under general anesthesia. By seeing children early (age 1) and every 6 months after that, applying fluoride varnish, counseling on diet, and restoring teeth conservatively as needed, we can intercept disease before a child ends up in the OR. If a toddler already has extensive decay, prompt referral to a pediatric dentist for advanced behavior management or general anesthesia may be warranted – but our goal should be to minimize children's exposure to general anesthesia by preventing severe early childhood caries. As one paper noted, aggressive preventive measures for high-risk children are less costly and safer than repeated treatment under general anesthesia, freeing up hospital resources for other pediatric cases.

Radiographs and Early Caries Detection

A crucial component of early dental visits is appropriate use of radiographs to detect interproximal caries. These carious lesions in young children are not visible to the naked eye, especially once the child's molars contact each other. Bitewing radiographs are the standard for detecting interproximal caries in posterior teeth. The general rule is to take the first posterior bitewings once the primary molars are in tight contact – typically around age 3½ to 4 years for an average child. According to pediatric dental guidelines, about one year after molars begin touching is the right time for a child's first set of bitewings. In practical terms, many children will have their second primary molars erupted by age 3, and by age 3 or 4 these teeth contact the first molars. If a child is cooperative at that point, obtaining bitewings can reveal early enamel caries between molars that cannot be seen otherwise and can allow for early treatment to stop or delay the progression of caries with minimally invasive treatments.

If bitewings show incipient proximal lesions, the dentist can employ measures like fluoride varnish, dietary counseling, and monitoring – or use silver diamine fluoride (SDF) to arrest the lesions before they cavitate. Silver diamine fluoride is an effective topical agent that can stop caries progression in primary and permanent teeth, buying time until the child is older or the tooth naturally exfoliates. For example, a small cavity between toddler molars might be arrested with SDF applications as indicated for the child, preventing pain and infection and potentially obviating the need for a filling on an uncooperative 3-year-old. Some state Medicaid programs have even incentivized SDF use – recognizing that arresting decay can avoid the need for general anesthesia in young children. General dentists should familiarize themselves with SDF and consider it a valuable tool for managing early enamel caries, particularly when treating very young or anxious children.

In summary, don't wait for large cavities to form. Take radiographs as soon as appropriate, and intervene early. A small approximal "shadow" on an x-ray of a 5-year-old's primary molar can often be treated with a simple restoration or arrested with silver diamine fluoride, rather than becoming a toothache at age 6 that requires pulpotomy and crown or extraction and space maintainer. Early detection and conservative treatment protect the child's health and comfort.

Orthodontic Referrals by Age 7

While caries prevention is a major focus in pediatric patients, general dentists should also be attentive to the developing occlusion. The American Association of Orthodontists (AAO) recommends that children have an orthodontic evaluation by age 7. By around age 7, most children have a mix of primary and permanent teeth, and an orthodontist can spot subtle problems with jaw growth or tooth eruption that may benefit from early intervention. As a general dentist, you don't need to initiate orthodontic treatment at this age (and many children will simply be placed on observation), but you should know when to refer to an orthodontist for an expert opinion. Common guidance is to refer by age 7 for any of the following: anterior or posterior crossbite, moderate to severe crowding, habits causing malocclusion (thumb sucking), open bite, or significant skeletal discrepancies. An early orthodontic consult does not commit the patient to treatment, but it ensures that if interceptive measures are indicated, they can be done at the optimal time.

Delayed orthodontic referral can lead to avoidable complications. For instance, one notorious problem is impacted maxillary canines. The permanent upper canines typically erupt around ages 11–12. If there is severe crowding or a misdirection, they can become impacted in the palate or side of the arch. An impacted canine that goes undetected until adolescence can cause displacement and even resorption of adjacent teeth roots (often the lateral incisors). Studies have found lateral incisor root resorption in a significant percentage of cases of canine impaction, sometimes affecting the central incisors as well. If a general dentist waits until age 12 or 13 to assess tooth eruption and then discovers an impacted canine, the child may require a complex surgical exposure and

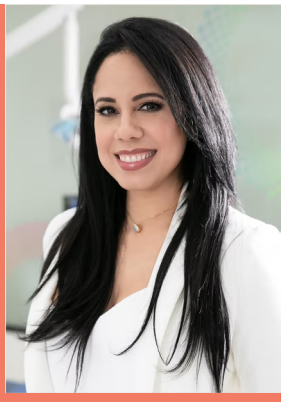
orthodontic traction, or worse, might lose the adjacent incisor due to root damage. Early referral at age 7 can catch early warning signs (such as lack of canine bulges, asymmetric eruption patterns, or crowding) and allow the orthodontist to intervene – often by removing over-retained primary canines or using expanders – to prevent full impaction.

Another consequence of late referral is that severe crowding may necessitate serial extractions of permanent teeth that could have been avoided. For example, a child who could have benefited from a palatal expander might, if untreated, end up needing extraction of permanent premolars as a teenager to alleviate crowding. According to the AAO, interceptive treatment like a palatal expander in a growing child can widen the upper jaw and reduce crowding, often eliminating the need for permanent tooth extractions or jaw surgery later on. Early correction of a developing crossbite or improper bite can also guide jaws as they grow and minimize the severity of problems in adulthood. The AAO's new campaign highlights that addressing issues in mixed dentition (ages ~7–10) can shorten treatment time or complexity in the teen years.

General dentists should therefore incorporate orthodontic screening into routine exams for school-age children. By age 7, assess the occlusion: look for crossbites, check if all permanent first molars and incisors are present, evaluate spacing. Educate parents that an orthodontic consult by 7 is a precaution – much like a well-child check – even if you don't see glaring issues. For children you continue to monitor in your practice, keep an eye on the canine eruption paths around age 10-11; if you note palatal blanching or prolonged retention of primary canines with no sign of permanent ones, refer to the orthodontist sooner rather than later. Also, don't hesitate to refer older kids who have obvious malocclusion even if they are past 7. While earlier is ideal, referring a 12-year-old who has an apparent malocclusion is still very beneficial. Timely referral and interdisciplinary cooperation can save the patient from more invasive procedures and ensure the best outcome.

Preventive Strategies: Oral Hygiene and Nutritional Counseling

Preventive dentistry is the cornerstone of pediatric oral care. General dentists must emphasize proper oral hygiene practices and diet from the first visit onward, educating both the child (as appropriate for their age) and the parents or caregivers. Effective oral hygiene for young patients requires parental involvement. Children lack the dexterity to brush and floss effectively until at least age 8 and sometimes even beyond. Parents should brush their child's teeth for them or with them until around age 7 or 8, and continue to supervise and check the quality of brushing until the child is about 10 years old. Encourage parents to make brushing a fun, consistent routine – for example, using a timer or a children's song, letting the child pick a toothbrush, or using disclosing tablets periodically to show missed spots. Reinforce the use of fluoridated toothpaste in appropriate amounts (a smear layer for under age 3, pea-sized for age 3-6), and caution parents to avoid rinsing immediately after brushing so the fluoride can work.



Dr. Shana Capra brings both deep local roots and international experience to The Kids Dental Practice. Born and raised in Hollywood, Florida, Dr. Capra knew she wanted to be a dentist from the time she was just 8 years old. She earned her D.D.S. from Pontificia Universidad Católica Madre y Maestra, a renowned university in Santiago, Dominican Republic, and completed her pediatric dental residency at Nova Southeastern University in Fort Lauderdale, Florida, where she served as Chief Resident.

In December 2019, Dr. Capra opened The Kids Dental Practice with a mission to provide high-quality, prevention-focused, and minimally invasive care in a fun, nurturing environment to the children of Delray Beach, Boca Raton, Boynton Beach, and surrounding cities. She believes early dental experiences shape a child's long-term relationship with oral health and is committed to making each visit positive, empowering, and educational.

Dr. Capra is a Diplomate of the American Board of Pediatric Dentistry, a Fellow of the International College of Dentists, and serves as a delegate for the Atlantic Coast District Dental Association and a Florida delegate to the American Dental Association. A passionate advocate for giving back, Dr. Capra participates in annual mission trips internationally and locally, volunteers at the Florida Mission of Mercy, supports the Special Olympics, and contributes to the ADA's Give Kids a Smile Day.

When she's not in the office, you'll likely find her traveling with her husband and their five kids, playing beach tennis or pickleball, or educating parents on social media.

Dietary counseling is equally important in preventing caries. Frequent consumption of sugary foods or drinks is a primary driver of caries in children. Educate families on the concept of limiting sugar frequency (frequent snacking) even more than quantity. For example, sipping juice or sweetened beverages throughout the day or allowing a toddler to carry a sippy cup of milk or juice can be far more cariogenic than an occasional treat given with a meal. Advise that children should not be put to bed with a bottle of milk or juice, as this habit bathes the teeth in sugar overnight and leads to severe early childhood caries. If a bottle is needed at bedtime for comfort, it should only contain water. Similarly, limit sugary snacks and instead offer teeth-friendly alternatives like cheese, veggies, or fruits like apples. For infants, counsel parents to avoid sharing saliva in ways that can transmit *Streptococcus mutans*. For instance, parents should not clean a dropped pacifier with their own mouth or use the same eating utensils.

A helpful strategy is to discuss the child's typical daily diet with the parent and identify "problem" items (e.g., frequent gummy snacks, juice intake, sticky candies) and propose substitutions or limitations. Emphasize the importance of water as the primary drink between meals. Many parents are unaware that even 100% fruit juice, despite being marketed as healthy, contains natural sugars that can promote decay; thus, juice should be limited to small amounts with meals per pediatric dietary guidelines. It's also worth reviewing any medications the child takes, as sticky or sweet liquid medications (like certain vitamins or syrups) can contribute to caries, so rinsing with water or brushing after dosing is prudent.

During hygiene instruction, tailor your advice to the child's age. For toddlers, demonstrate brushing on a puppet or have the parent sit knee-to-knee with you to practice brushing the child's teeth. For older children, consider using disclosing solution to show them the plaque they missed and turn it into a learning game. Make sure to cover flossing once any teeth touch. Often by age 3-4, some primary molars contact, and parents should begin flossing those for the child. By age 6-8, the child can start learning to floss with supervision.

Lastly, underscore the benefit of topical fluoride and other preventive measures. Explain to parents that in-office fluoride varnish treatments reduce cavity risk and that dental sealants

on permanent molars can prevent caries on these molars. When families understand the "why" behind brushing, flossing, and dietary rules, they are more likely to comply. The general dentist should aim to create a team atmosphere with the parent and child – everyone working together to keep the child cavity-free.

Space Maintainers After Early Tooth Loss

Despite our best efforts, sometimes children do lose primary teeth prematurely – whether due to severe caries or trauma. When a primary molar is lost years before the permanent tooth is ready to erupt, the result can be unwanted movement of adjacent teeth. The space left by the primary tooth tends to narrow as the neighboring teeth drift or tip into it, which can cause impaction of the permanent successor or lead to crowding. To prevent this, use space maintainers like a band and loop, upper nance or lower lingual holding arch when indicated.

> *"Through preventive education, early intervention, and collaboration with pediatric specialists, general dentists can ensure that children get the right care at the right time."*

General dentists should be familiar with the indications for space maintenance. As a rule of thumb, loss of a primary molar before the eruption of the first permanent molar (around age 6) usually warrants a space maintainer. If a primary second molar is lost before the 6-year molar comes in, the space can close rapidly, and the 6-year molar may drift mesially, impeding the eruption of premolars. Even loss of a primary first molar can cause the back teeth to shift forward and reduce arch length. Premature loss of primary canines (for example, due to ectopic eruption of lateral incisors) can lead to midline shift and anterior crowding; in such cases, a bilateral maintainer like a lingual holding arch may be indicated once lower incisors erupt. The consequences of not maintaining space include malocclusions that might have been avoidable, such as impacted premolars or permanent canines, need for extractions, or orthodontic problems that are more complex down the line.

Clinical evidence supports the use of space maintainers to preserve arch integrity. Space maintainers effectively prevent the drifting of teeth and the loss of arch length that happens after early tooth loss. By doing so, they help ensure there is adequate space for the succedaneous permanent teeth to erupt in alignment. Once the permanent tooth begins to erupt into the space, the space maintainer can be removed. Also, practitioners must balance the caries risk – sometimes the tooth used to anchor a space maintainer (like a band around a tooth) can accumulate more plaque. Emphasize to the parent and child the need for excellent hygiene around the appliance. With proper care, space maintainers are highly effective in preventing orthodontic complications following premature tooth loss.

Collaboration with Pediatric Specialists and Building Patient Trust

General dentists do not have to manage pediatric patients in isolation. Developing a good working relationship with local pediatric dentists can greatly enhance the care for children in your practice. Pediatric dentists can serve as a valuable resource for consultation on difficult cases. For example, if you are unsure about how to manage a child's behavior, how to treat an unusual lesion in a toddler, or when to consider general anesthesia, a quick call to a pediatric colleague can provide guidance. Establishing a referral network means you can confidently refer infants or children with extensive needs (or special health care needs) to a specialist when appropriate, and conversely, the specialist might refer patients back to you for general dental care as they grow older or if they live far from the specialty office. This team approach ensures the patient gets the right care at the right time.

Many rural or underserved areas have no pediatric dentist in the immediate vicinity, meaning general dentists are truly the frontline (and sometimes the only line) for kids' oral health. According to a Florida dental workforce survey, 83% of Florida dentists reported treating children in their practice, reflecting that the majority of general practitioners do see pediatric patients. By embracing this role and seeking additional training or mentorship when needed, general dentists can effectively care for pediatric patients and expand access to care, especially in communities without specialists.

For every young patient, the dentist should also focus on building trust and a positive experience. Children may be fearful or fidgety in the dental chair; employing behavior guidance techniques such as Tell-Show-Do, distraction, and lots of positive reinforcement can help put them at ease. A warm, patient approach and a child-friendly office environment (with simple touches like sunglasses, cartoons, or a prize after the visit) go a long way. The goal is to make dental visits non-threatening – even fun – so that the child develops confidence in the dentist. When children have pleasant early dental visits, they are more likely to cooperate in future appointments and less likely to develop dental anxiety. Positive parental involvement can further improve the experience. Additionally, by educating parents about their critical role in daily oral care, we ensure that the prevention message carries over into the home. Parental enforcement of regular brushing, flossing, and healthy diet is essential.

In conclusion, pediatric dentistry is a vital aspect of general dentistry, and staying informed on current best practices allows general dentists to provide excellent care for their youngest patients. Caries remains epidemic in childhood, but it is preventable with early and regular dental visits, fluoride, and good home care. General dentists should welcome children by age one (or refer them to a pediatric dentist) to establish a dental home early. By doing so, we can intervene before minor issues become major ones – preventing the need for extensive treatment or general anesthesia whenever possible. Likewise, being attentive to growth and development (with orthodontic referrals by age 7 and space maintenance when needed) will set children up for a healthy functional occlusion. Through preventive education, early intervention, and collaboration with pediatric specialists, general dentists can ensure that children get the right care at the right time. The reward is seeing our pediatric patients grow up cavity-free, without dental fear, and with smiles that last a lifetime.§

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Full Mouth Adhesive Rehabilitation of a Worn Dentition

by Drs. Vanessa Schussler,
Patrica N. R. Pereira,
and Alex J. Delgado

Introduction

Tooth wear (TW) refers to the progressive loss of dental hard tissues from mechanisms unrelated to caries, trauma, or developmental disorders. While a degree of tooth wear is considered a normal physiological process—averaging between 18 to 38 micrometers per year—it becomes excessive when it leads to functional or esthetic concerns, occurs at a rate disproportionate to the patient's age, or is accompanied by symptoms such as pain or sensitivity.[1-3] The etiology of TW is multifactorial, with contributions from erosion, abrasion, attrition, and abfraction. Erosion can be intrinsic, resulting from conditions such as gastroesophageal reflux disease (GERD), eating disorders like anorexia or bulimia, chronic alcoholism, rumination, and dehydration, or extrinsic, caused by dietary acids (carbonated drinks, fruit juices), medications (aspirin, vitamin C, asthma inhalers), or environmental exposures including occupational hazards and swimming. Abrasion arises from mechanical factors such as aggressive tooth brushing, habitual biting of hard objects, or iatrogenic causes, while attrition is characterized by the flattening of occlusal and incisal surfaces, cupped lesions, and dentoalveolar compensation, often resulting from parafunctional habits like bruxism.[3]

A comprehensive evaluation to determine the cause involves recognizing clinical indicators such as hypertrophic masseter muscles, buccal keratosis, cheek biting, tongue scalloping, loss of canine guidance, and the presence of wear facets.[3] The Basic Erosive Wear Examination (BEWE) is a standardized index that assists in assessing the severity of erosion, guiding both diagnosis and treatment planning. The score which ranges from zero to four, is based on the most severely affected tooth in the sextant. Management strategies should aim to recognize and monitor the wear, grade its severity, and diagnose the underlying causes. Restorative intervention should be considered when patients experience esthetic or functional concerns, pain, unstable occlusion, or when the rate of wear poses a risk of pulp exposure.[2,4] A multidisciplinary approach is often required, with orthodontic treatment playing a pivotal role in creating interocclusal space and aligning teeth for optimal restorative outcomes. In cases where excessive gingival display is present, crown lengthening may be indicated to enhance esthetics and function.[3,5]

Clinical Case

A 56-year-old Caucasian male presented with the chief complaint of a 'broken tooth.' A thorough temporomandibular joint (TMJ) assessment revealed no clicking, popping, or crepitus. The patient experienced no pain upon palpation of the TMJ or muscles of mastication. Mandibular movements were within normal limits, with a range of motion of 50 mm and no deviation on opening.

Occlusal analysis revealed a Class II Division 2 malocclusion, with a 2 mm overbite and 3 mm overjet. Anterior guidance was present during protrusion, while bilateral canine guidance was observed during lateral excursions. Generalized tooth wear was noted throughout the dentition. Given the extent of wear and the patient's desire for functional and esthetic improvement, the treatment plan involved an adhesive full mouth rehabilitation approach.

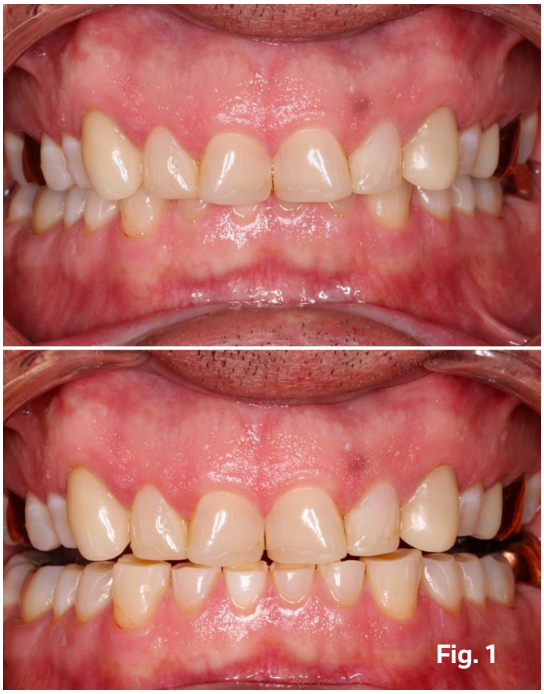


Fig. 1

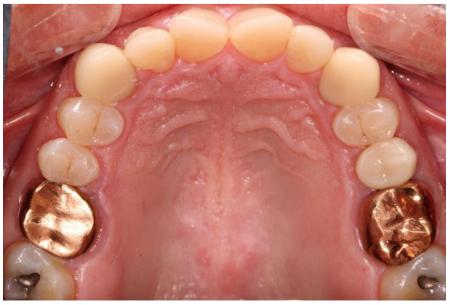
Treatment Approach

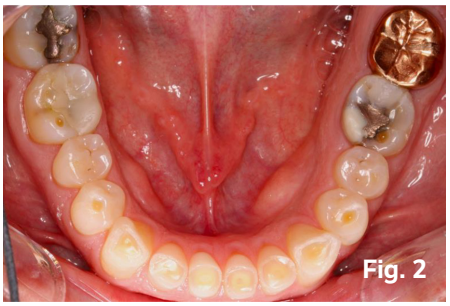
Over the past two decades, there has been a paradigm shift in the management of tooth wear, favoring adhesive approaches over traditional full coverage crowns. Adhesive restorative techniques support a minimally invasive and additive method, preserving as much natural tooth structure as possible. This is especially relevant in cases of severe wear, where further removal of already compromised enamel and dentin can lead to pulpal damage.[3]

The goals of the restorative intervention included protecting remaining tooth structure, managing symptoms, and stabilizing the occlusion. Minimally invasive treatment is preferred for severe tooth wear when increasing vertical dimension, especially in young patients.[3] Restorations do not prevent wear processes; they merely modify the rate, location, and nature of the wear.[4] By opting for conservative, minimally invasive restorations, clinicians preserve more natural tooth structure, which helps slow the restorative cycle and allows for more treatment options in the future. When the patient eventually requires recare, the teeth are more likely to remain restorable and suitable for further intervention—unlike cases where treatment begins with aggressive full coverage restorations, which may limit future options and lead to more invasive procedures such as extractions, implants, or dentures.[6]

Conventional, full coverage restorations have been associated with high risks of loss of pulp tissue vitality, with studies showing that approximately 19% of crowned teeth develop radiographic signs of peri-radicular disease. This risk is particularly relevant in teeth affected by wear, where pulpal tissues may already be compromised, a concept referred to as the "stressed pulp".[7] Furthermore, crown preparations are inherently invasive, often requiring the removal of 63% to 75% of coronal tooth structure, which further diminishes the tooth's structural integrity and long-term viability.[8,9]

Given the patient's occlusion, wear patterns, and bruxism history, lithium disilicate was chosen for its ability to be etched and silanated, allowing for strong adhesive bonding. The rehabilitation involved an increase in vertical dimension of occlusion (VDO) to create restorative space, correct esthetics, and establish anterior and posterior guidance without invasive procedures.

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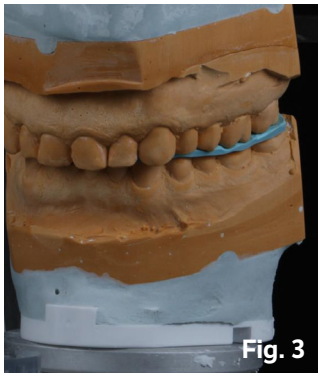
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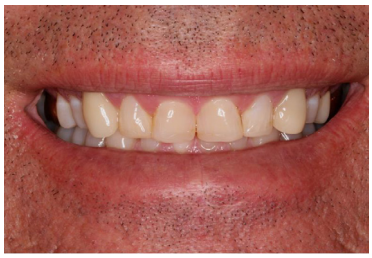
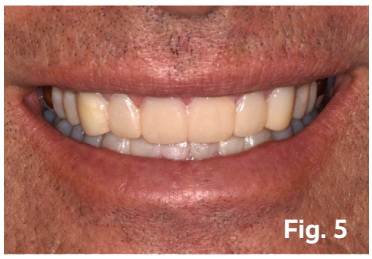
Fig. 4

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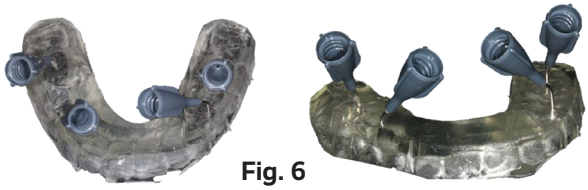
Fig. 6

Treatment Sequence

The process began with a diagnostic mounting in centric relation, followed by a full-contour wax-up. An esthetic mock-up was created to evaluate visual outcomes and phonetics, followed by a functional mock-up to test the new occlusion. Once adjusted intraorally, the mock-up was scanned. 3D printed models from the scan were used to fabricate clear PVS matrices. A CBCT scan was taken with the teeth apart and lips retracted to assess bone levels and evaluate its relation to the proposed margin placement.

Using the clear PVS matrix, bonded functional esthetic prototypes (BFEP) were created via an additive technique. Flowable composite was layered over natural teeth and existing restorations, increasing VDO and testing function. After that, crown lengthening surgery was performed using a flapless technique. This approach allowed minimal tissue trauma, faster healing, and improved patient comfort. One-week post-surgery, cervical contours were refined using flowable composite to prevent tissue rebound.

Following two months of successful function with the BFEP and no signs of fracture of the restorations and no symptoms reported by the patient, the fabrication of the final restorations was started. The restorations included a combination of onlays, crowns, and veneers. A protective occlusal splint was fabricated for nighttime use.

Conclusion

This clinical case demonstrates the successful management of severe tooth wear through a minimally invasive, adhesive full mouth rehabilitation. By preserving natural tooth structure, improving esthetics, restoring function, and stabilizing the occlusion, long-term success and patient satisfaction were achieved. The integration of diagnostic tools, modern materials, and an additive approach ensured an outcome that is both functional and biologically respectful.§

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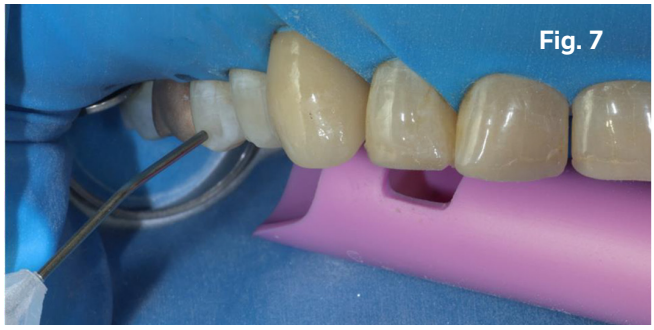
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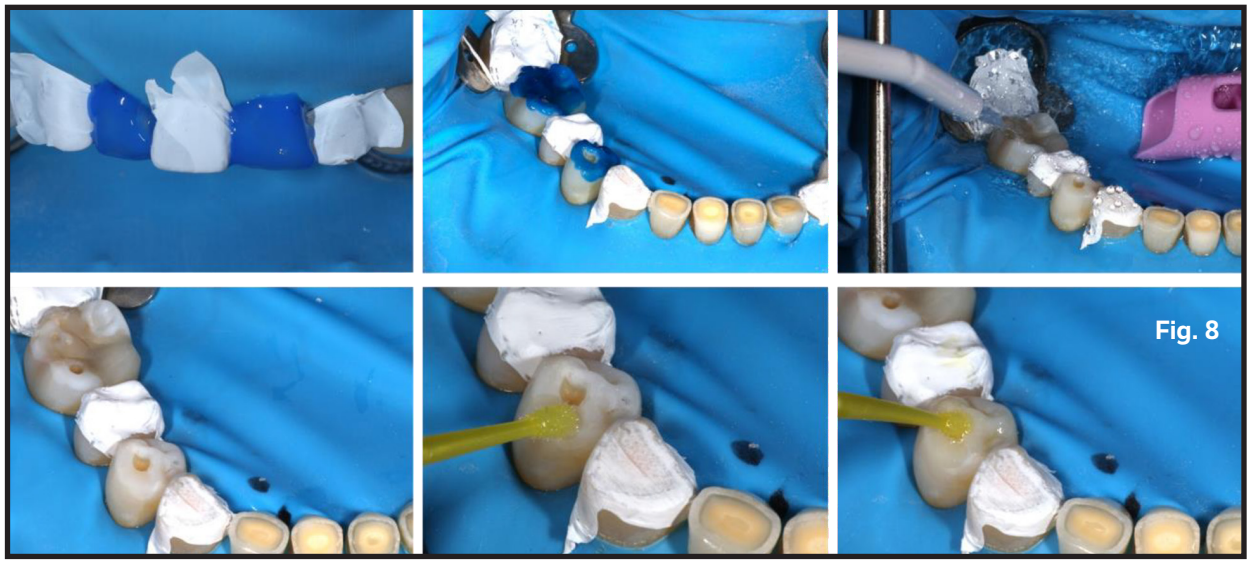

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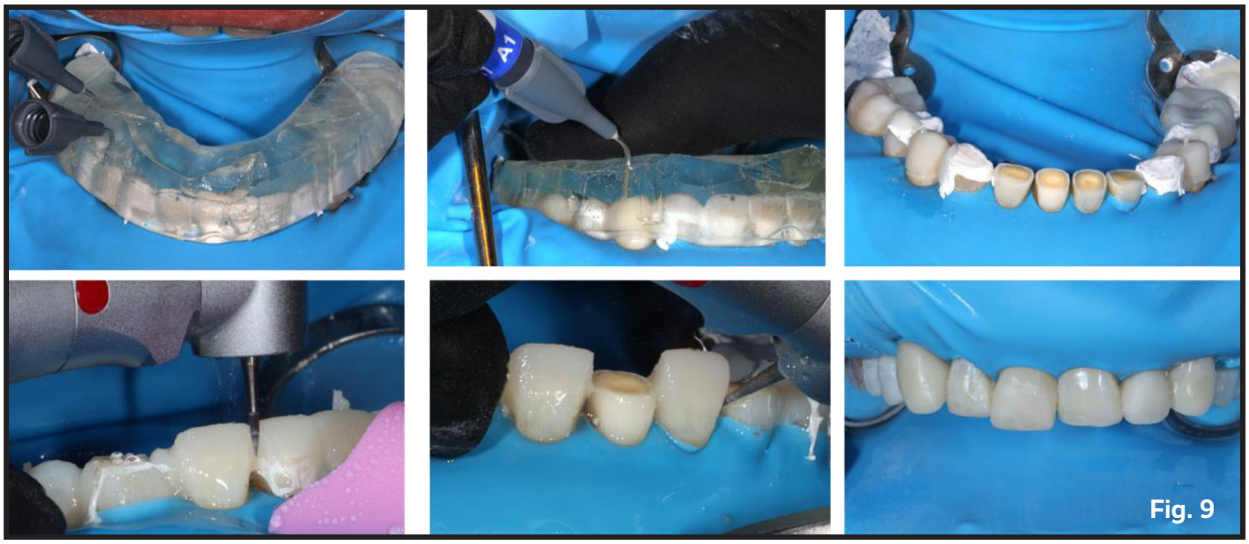

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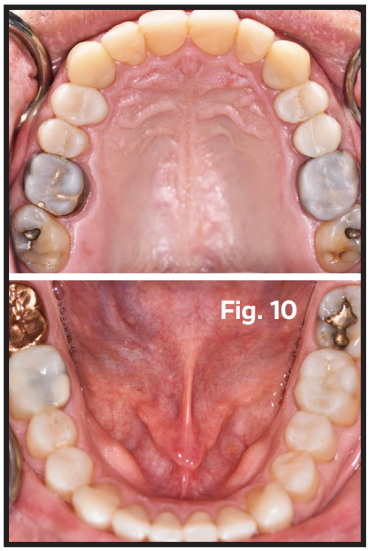

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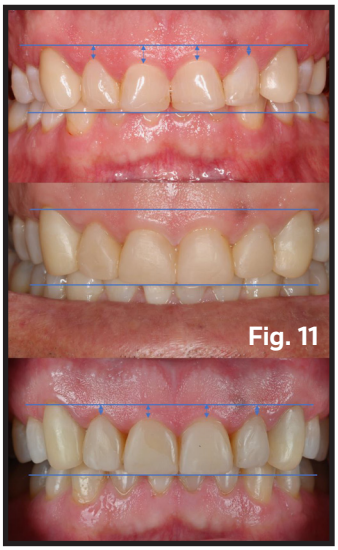

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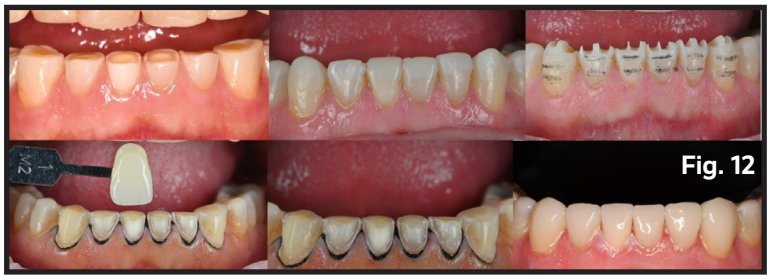

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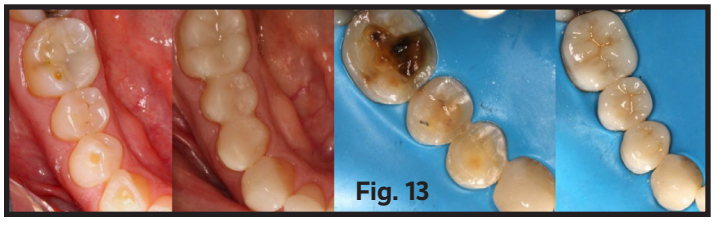

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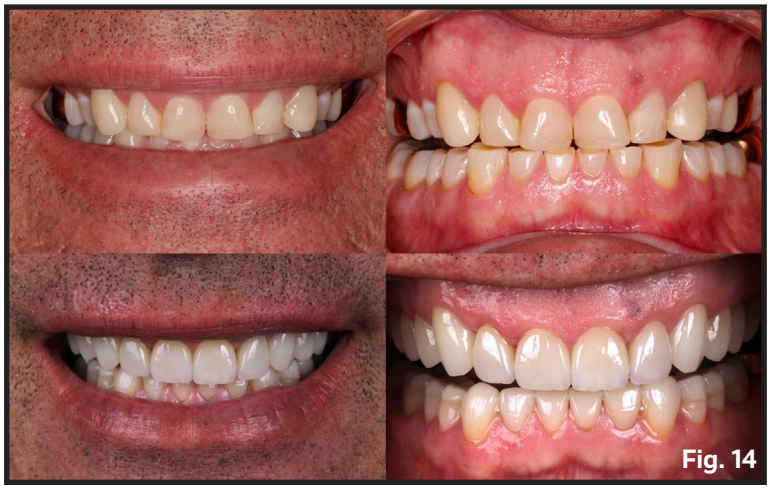

Fig. 14

10 Top Management Tools for a Successful Practice

by Lois Banta

It has been said for years that it takes a village to raise a child. In the case of dental practice management… it takes a "total team" to run a "practice". This article will reveal the 10 key management tools for running a successful dental practice. There is a domino effect that takes place in running a practice. Key systems need to be in place which leads to excellent communication which leads to knock your socks off customer service while maintaining positive attitudes. All these tools are essential for a successful practice. I have outlined these key management tools in this article.

1. **Design systems and protocols for a good foundation of production and collections.** Strategically plan the success of the practice by designing effective systems for Production (total office and individual providers), Net Collections (gross collections minus refunds), Adjustments (excluding bad debt), Accounts Receivables Ratio, open time, and treatment acceptance. Additionally, keep in mind that Gross Production drives overhead and Net Collections pay the overhead. Therefore, Gross and Net production must be tracked. Listed below are recommended statistics to track monthly. This gives the dental practice an opportunity to easily identify trends happening. A statistic that goes in a specific direction three months in a row is a trend. One of the most important statistics to track is the Accounts Receivables Ratio. A recommended ratio is less than 1.0. This means that the average one- month production does not exceed the accounts receivables balance.

2. **Hire and train for a positive attitude and acquire great teams with dedication towards customer service and effective communication.** If a practice wants team members with great attitudes, write the ad to attract the person with the best attitudes. Then, inspect what is expected of the team by checking in with them often. I call this PPI's (Personal Performance Interviews). This is a sit-down conversation that wouldn't take more than 5 minutes. Typical questions are: "What can I do to help you be more effective?," "How are things going?," "What challenges and celebrations do you wish to share with me?" Additionally, positive reinforcement plays a key role in keeping the team motivated and feeling appreciated. A simple thank you for the hard work, great job and positive recognition for a job well done will go a long way in reducing turnover and can add longevity in a team.

3. **Hold a "morning huddle" every day to check in on the pulse of the practice and address day to day concerns before they become major issues.** Many times, the morning huddle or morning meeting becomes a chart review. It is important to address all areas of the practice to avoid unpleasant surprises during the day.

4. **Strategize each week by holding team meetings. Set a theme for each week:**

- **Week 1: Cross training** – Set aside this team meeting to cross train departments. Some possible clinical cross training opportunities: Heat sterilizing instruments, ordering clinical supplies, re-stocking operatory, pre-discussion with patients, post op instructions, charting. Possible administrative cross training opportunities: Scheduling an appointment, discussing financial arrangements, handling objections, confirming appointments, finalizing appointments, New Patient phone call, estimating dental benefits.
- **Week 2: Analyzing monthly numbers** – Each department would take a section of the monthly monitor and reveal the previous month's statistics, percentage of goal, and trends identified. It is also helpful to understand the overhead in the practice for optimal understanding of what it takes to run a successful practice.
- **Week 3: Continuing Education** – This team meeting would address continuing education opportunities. You could review a recent conference attended, invite a specialist to the practice to review their specialty, invite a product or services organization to review new and updated products and services, in-office training on dental software in the practice.
- **Week 4: Role play** – practice communication for patient questions. This is very helpful in improving communication in the practice with patients. It is also an opportunity to identify and problem-solve patient concerns and questions. List patient questions for one entire week, bring the questions to the team meeting, and discuss optimal responses to improve communication.
- **Week 5:** Sometimes there will be a fifth week in the month. During these weeks, hold an "attitude adjustment" lunch. The rules for this meeting…don't talk work. This is an opportunity for the practice to bond and increase their effectiveness through fellowship.

Design these team meetings to be productive, not complaint sessions. Hold the team meetings at a set time each week for 1.5 hours. The first 30 minutes would be lunch and the second 60 minutes would be for the team meeting itself. Develop written action plans. Bring these action plans to every team meeting. The action plan would have four columns:

- Column 1: Item to be addressed
- Column 2: Name of facilitator taking on the project…a project coordinator
- Column 3: Target completion date
- Column 4: Celebration/Completion date

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I recommend bringing lunch in and holding the team meeting in a location where there would be the least amount of interruption. As for concern that the production would be less on these days, I recommend setting the production goals as if it were a full day, which means raising the hourly goal slightly to accommodate for the one hour less seeing patients. This way, the productivity is not reduced.

5. **Choreograph schedule for optimal productivity.** There are many ways to achieve a productive schedule. It is as stressful to produce a high production day as it is to produce a low production day. Choreograph the schedule in blocks of time based on the preferences of the producers in the practice. Key communication skills are also needed to predict optimal success. This means not asking "yes" or "no" questions and always offering "two options." Asking "yes" or "no" questions puts the practice at risk for the patient not accepting optimal dentistry. Offering the patient two options puts them in control; however, the "practice" is actually in control because they offer the two appointments that work best in the schedule. It is imperative to utilize good communication and great customer service.

Another consideration is how the actual appointments are scheduled and how many columns are being utilized. "X" scheduling is a method of compartmentalizing the appointment into Anesthetic/Doctor/Assistant time. Once a determination is made for each procedure on how many time units are needed for each section of the appointment, predictable results ensue. It will be important to create a master sheet of all appointments detailing how many time-units are needed for each procedure offered in a practice for optimal non-verbal communication in the practice. Written protocols need to also be in place for confirming and handling short notice cancellations and failed appointments. This can also be the nonverbal skill in your text confirmations and email confirmations.

- Do say: "We are calling to let you know you are on our schedule." Don't say: "Remind" or "confirm."
- If the patient needs to cancel, never offer them the very next appointment. Instead, schedule them in 2 to 4 weeks. Then, offer to place them on the "priority list" if a "change in schedule" happens sooner. This retrains the patient and doesn't give them the idea that the practice is always available on short notice.
- Have a "2 to 3 strikes and out" failed appointment guideline. If the patient fails 2 or 3 appointments in a row, release them formally from the practice. Send a letter by priority mail with a delivery confirmation releasing them from the practice. Failed appointments are one of the most costly aspects of a practice. If the fee for a hygiene appointment is $150, and there is one appointment per day unfilled because of a failed or canceled appointment, then over the course of 220 days in a practice year, the loss would total $33,000, and that is for only one hygienist in the practice!

6. **Get the money off the books and into the bank quickly.** Collection strategies are a crucial element of a successful practice. Getting the money "on" the books is one thing. However, if the money isn't collected…it can't come "off" the books. Detailed strategies and systems must be in place.

- First, when scheduling dentistry for patients, careful attention must be paid to financial arrangements. Be sure all financial arrangements are in place and patients understand fully their responsibility. Obtain signed treatment acceptance and financial agreements. Collecting the patient's portion at the scheduling of the appointment insures patient compliance, and paid-for dentistry rarely fails.
- Second, have a written protocol in place for following up on overdue accounts. Send statements in a timely way. Call on all overdue accounts for balances over 30 days overdue.
- Third, set aside private time to consistently follow up on accounts that need phone calls and special overdue balance communication.
- Fourth, take action on all accounts deemed uncollectable. If the patient hasn't paid or acknowledged an overdue balance in 4 statement cycles, they are probably not going to pay, and collection action is recommended. Refer accounts for collection after approval from the dentist. Once final collection action is taken and the account is referred for collection…write it off as uncollectable as a bad debt, inactivate the account, and release the patient formally from the practice.

7. **Utilize excellent customer service…the patient's impression of you begins on the phone.** Patients make decisions about the quality of their care by how they feel treated when they walk through the doors of a dental practice. Of all the top management tools in a practice, this is one of the most important tools. Excellent customer service can be revealed in many ways: how the patient was treated on the phone when they called the office, how the patient's questions were answered, if they felt able to ask questions, make informed decisions, if the practice included the patient and their partner/spouse/family member in the decisions regarding their dentistry. Giving the patient a tour of the office translates to great customer service for the patient. Don't put the patient in a position to have to repeat their story when handed off to another team member to assist them. This is another great example of good customer service.

8. **Sharpen your clinical and practice management skills often by attending and participating in select continuing education.** The practice that invests in learning together is a team that grows in the right direction. Attending continuing education together reinforces consistency. The team that stops learning… stops growing. Continuing education doesn't mean having to leave the practice to learn. There are many learning opportunities that will offer many concrete pathways to grow a practice to a health level. Seek out these opportunities, involve the team, and seize the moment!

9**. Inspect what you expect.** There are many ways to inspect what you expect in an office, and they have been addressed in this article. The most important thing to remember is to lead by example and stay checked in to the practice. Create an infectious environment to keep learning and growing. Involving the team in this process creates a sense of ownership and offers a practice ultimate success. Leaders are created by setting the example and then reinforcing the result in great leadership with the team. This leads to positive results, better communication and less stress. Identify trends and challenges early. Then, be sure to tweak the challenges, turn weaknesses into strengths and celebrate the successes.

10**. Have more professional fun and find your "internal giggle."** Remember to have good, professional fun in the practice. Patients pick up on body language and what they see visually very quickly. Patients make judgments about the quality of the care they receive by what they see and hear. Look for opportunities to make a positive impact in your practice by treating your patients and team with respect, care, and empathy. Find your "internal giggle" and keep the focus about positive results.

Success is a choice… What you choose to do with your choices is up to you.§

The Secret to Sustainable Growth in Dentistry? Marketing Smarter.

by Christion Hatch, DMD Dental

Every dentist wants more new patients, but not every practice knows where they're really coming from—or how to consistently bring them in. In today's digital world, the answer isn't in billboards, radio ads, or local coupon books. It's online, where nearly all patient journeys begin.

Where New Patients Actually Come From

According to BrightEdge Research, **a staggering 76% of new business comes from organic search**. That means when people need a dentist, they're not looking through mailers or magazines—they're searching online, primarily on Google.

To put this into perspective, **Google alone holds over 90% of the U.S. search engine market share**. If your practice isn't showing up on the first page, you're essentially invisible to most prospective patients.

"96% of all clicks happen on the first page of Google. If you're not ranked, they're finding your competition instead."

The ROI of SEO vs. Traditional Ads

Let's talk numbers. SEO may sound like a buzzword, but the return on investment (ROI) is anything but vague.

- A dental practice bringing in just 20 new patients per month, with each worth about $400, generates $8,000/month or $96,000/year in new patient revenue.
- With the average SEO cost around $700/month, your monthly profit is $7,300—an ROI of 1,042%.
- Even in a conservative scenario (10 new patients), your ROI is still over 470%.

Now compare that with traditional marketing:

- Billboard ROI: $0.04 per $1 spent
- Coupon books, magazine ads, and radio spots? Often worse.

The difference is staggering: $1 on SEO returns over $10; $1 on a billboard barely breaks even.

Marketing Practices vs. Non-Marketing Practices

Practices that embrace marketing consistently outperform those that don't:

- **New Patients:** Marketing-focused offices often see 30–50 new patients per month, while those relying on word-of-mouth average 10–15.
- **Revenue Growth:** With a solid digital strategy, practices grow revenue by 10–20% annually, compared to 0–5% (or even decline) without one.
- **Retention:** Practices using patient engagement tools—automated reminders, follow-ups—retain 60–70% of patients. Others drop to 40–50%.

Online Presence Is Your Reputation

Your Google Business Profile isn't just a listing—it's your first impression. Nearly 64% of patients use it to find contact info, and practices with optimized profiles are 94% more likely to be seen as reputable. If your listing is unclaimed or outdated, you're sending patients straight to a competitor.

Digital = Scalable Growth

The average new dental patient spends $700–$1,250 in their first year, and thousands

over a lifetime. With digital tools—especially SEO, Google Ads, and local listings—you can increase that number without constantly increasing ad spend.

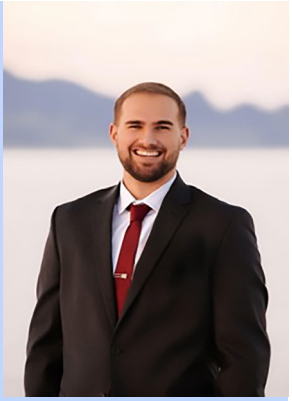
Even better? Organic traffic converts at 3.5%, often outperforming paid channels. Combine that with proper keyword targeting and content strategy, and you're setting your practice up for long-term, compounding growth.

Let's Be Honest — You Don't Have Time for This

Dentists are busy. Between taking care of patients, managing staff, and running a business, most don't have the bandwidth to manage marketing too.

That's where we come in. At DMD Dental, we help general dentists like you dominate their local market. From unranked to front page on Google in just 90 days, we've helped hundreds of practices consistently grow their patient base—and we'd love to help you, too.

You focus on dentistry. We'll make sure people can actually find you.§



Christion Hatch is a Sales & Growth Partner at DMD Dental, where he helps dental practices across the country grow through results-driven marketing. With over 5 years of experience in the industry and a Business Marketing degree from Brigham Young University–Idaho, Christion combines creative insight with data-backed strategy to help clients not only get noticed—but get results. He's passionate about making dentists more money while taking the stress of marketing off their plates.

Outside of marketing, you'll find Christion out in nature—white water rafting, fishing, playing football, or exploring new hiking trails.

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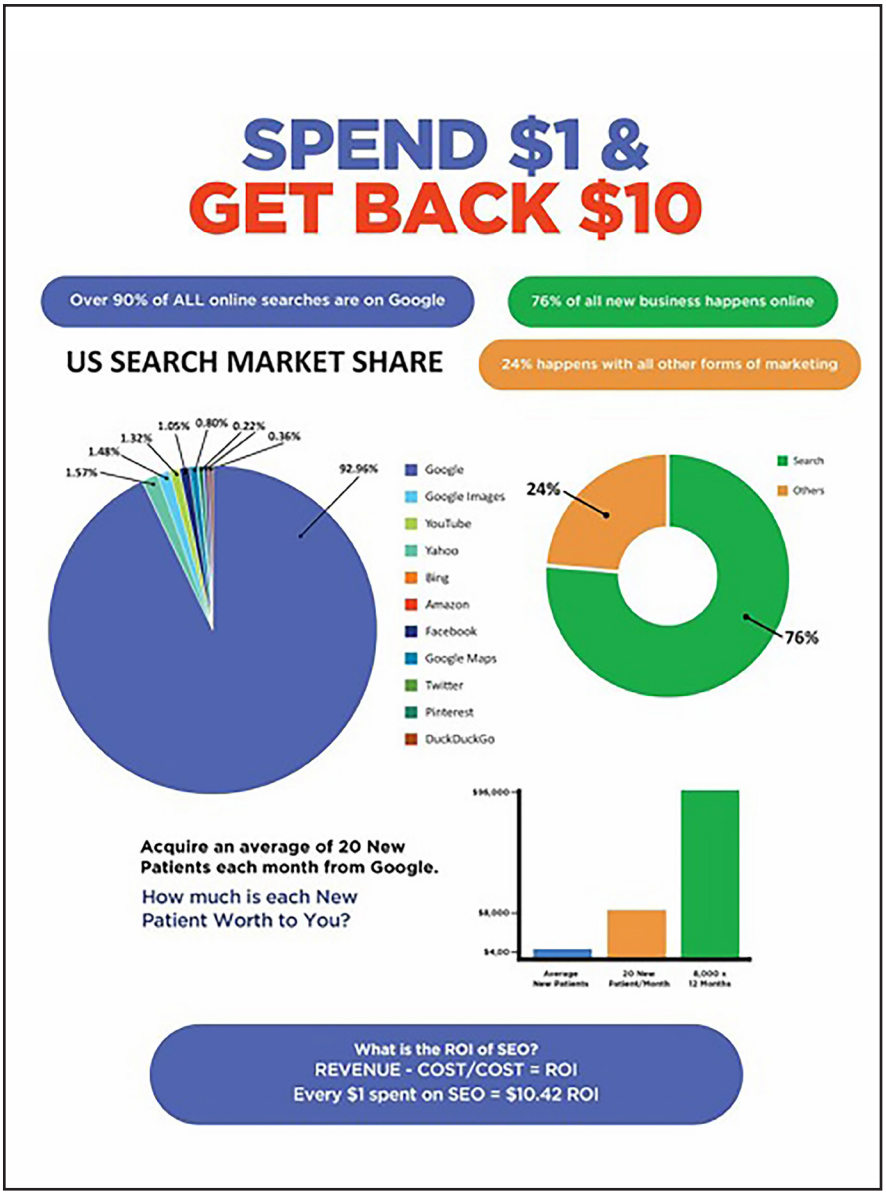
DMD Dental has been helping dental practices grow for over 15 years. From SEO, social media, video production, and app development to custom websites and ad campaigns, DMD Dental is your all-in-one partner for growth. We do the work so you can focus on your patients.

Want to see how your practice could grow with better marketing? Click here to book a 1-on-1 Google Meet with Christion.

Or feel free to email: **christion@dmddental.com**.§



Protecting What You've Built: A Dentist's Guide to Long-Term Care Insurance

by Adam Chubb

Adam Chubb is the Founder and Managing Partner of Pinnacle Life, LLC, a boutique insurance firm specializing in helping high-achieving professionals protect their wealth, families, and future through customized long term care and life insurance solutions.

A graduate of the Wharton School of Business and former professional athlete, Adam brings a disciplined, team-focused approach to financial protection and risk management. He understands the unique financial pressures and planning opportunities that come with running a practice, managing staff, and planning for retirement.

Dentistry is a profession built on precision, foresight, and trust. Over the course of your career, you've likely invested significant time, energy, and resources into building a thriving practice, planning for retirement, and securing your family's financial future. That kind of long-term planning is second nature in clinical and business settings.

Yet, despite careful financial preparation, many professionals overlook one important area of their future: long-term care. This isn't about being pessimistic it is about exploring the importance of long-term care insurance as a practical tool for preserving independence, protecting loved ones, and safeguarding the legacy you've worked hard to create. Do you think it's possible that, at some point, you may need help taking care of yourself?

Understanding Long-Term Care: A Broader Definition

The term "long-term care" often make us think of images of elderly individuals in nursing homes. In reality, long-term care refers to a large range of support services for individuals who can no longer perform essential daily activities without assistance. These activities include bathing, dressing, eating, and others.

The need for long-term care can result from a range of factors: chronic illnesses, accidents, cognitive decline such as dementia or Alzheimer's, or the general effects of aging. Importantly, long-term care is not something that happens later in life — health events or accidents at younger ages can also trigger the need for sustained support.

According to the U.S. Department of Health and Human Services, nearly 70% of individuals over the age of 65 will require some form of long-term care in their lifetime. We see now more and more people are now turning to long-term care insurance to help plan for the future and handle the costs.

The Rising Cost of Care

Long-term care services, whether delivered at home or in a facility, come with considerable financial implications. As of the 2024, the average costs in Florida include:

- Private nursing home care: $138,700 annually
- Assisted living community: $63,885 annually
- Home health aide services: $62,400 annually
  (Source: Genworth Cost of Care Survey, 2023)

These figures don't include medical bills, transportation, or other out-of-pocket costs. Many families are surprised to find out how quickly care expenses can drain savings or retirement accounts. Without a plan, that burden may fall on your spouse or children—both financially and emotionally.

Most of us look forward to extra free time with family but often overlook what is need in the way of resources need for aging. For some, these numbers can be surprising. And without a strategy in place, the burden of care often falls on loved ones, either financially or personally.

Imagine your partner suddenly stepping into the role of full-time caregiver. Or your adult children navigating complex care decisions while balancing their own families and careers. From a business continuity perspective, these expenses can also affect your ability to maintain your dental practice, support your staff, or preserve your retirement timeline.

What Long-Term Care Insurance Provides

Do you plan on living a long life: until 80, 85, or even 90? Long-term care insurance is designed to help with the cost of care when a person cannot perform a certain number of basic daily activities or has a severe cognitive impairment. The policies typically provide tax-free monthly benefits that can be used to pay for services in:

- In-home care
- Assisted living facilities
- Memory care
- Skilled nursing or rehabilitation facilities

Unlike traditional health insurance or Medicare, long-term care insurance covers custodial care—the kind of support most needed during extended periods of disability or aging. This includes non-medical help with daily living activities, which gives you options. Importantly, having this type of coverage gives individuals and families more choice in how and where care is delivered. It provides the flexibility to receive care at home for as long as possible and reduces the likelihood of needing to rely on loved ones as primary caregivers.

Early Planning

One of the most effective times to start looking into long-term care insurance is before you need it. Health and pre-existing conditions can limit some of the options available. The delay in action can also increase not only the financial cost but also the risk of becoming uninsurable altogether.

As a dental professional, the principle of preventive care is already familiar. You encourage patients to address oral health proactively rather than reactively. The same logic applies here: looking into long-term care insurance before it's needed ensures access to coverage when it matters most.

Balancing Risk: What If It's Never Used?

One common hesitation around long-term care insurance is the possibility of never needing it. While this outcome would indicate excellent long-term health, it does not negate the value of having coverage in place. Modern policies have made some changes to address this concern. There are now many different options and ways to tackle these concerns. This shift in policy design means you can customize the plan to fit your needs and concerns.

Protecting the Practice and Legacy

For many dentists, the practice you've built is both a livelihood and a source of pride. It represents decades of effort, patient relationships, and community engagement. However, unexpected care needs can sometimes change the course of things.

If long-term care becomes necessary and no financial plan is in place, you may be forced to make changes to the practice prematurely or use business or retirement reserves to pay for care Long-term care insurance can serve as a financial firewall, allowing you to protect your income, your retirement, and your practice. It gives you breathing room to make thoughtful decisions rather than reactive ones in a stressful situation.

The Human Element: Easing the Burden

While long-term care insurance is a financial tool, its value also lies in what it helps prevent — namely, the emotional burden on those who would have to step in and help as caregivers. Without a plan, family members frequently become the default solution. Spouses, adult children, or close relatives may assume the role of caregiver.

A policy can allow your family to support your care without having to become your full-time caregiver. That distinction matters. It preserves relationships and ensures that care is provided in a professional, consistent, and respectful way.

Planning Is Professional

In an increasingly aging population with rising healthcare costs, long-term care planning is something to consider when planning for the future. Integrating long-term care insurance into your financial plan ensures that your future care will be delivered with choice, dignity, and confidence. You protect your family from the strain of urgent decision-making. And you protect both the professional and personal legacy you've worked so hard to create.

Planning for long-term care isn't about assuming the worst. It's about choosing to lead with preparation.§

Editor's Note, continued from page 3

The second organization is Toastmasters International, which really has changed my life. I became enchanted with Toastmasters at my very first meeting way back in 2001. Who knew public speaking could be fun? While it took me years to overcome my panic attacks, I threw myself into club activities, serving in various officer roles and eventually as an Area Governor (today, it's called an Area Director), visiting other clubs, and attending Toastmaster conventions and district meetings. Toastmasters isn't just a public speaking organization; it's a wonderful community of diverse and occasionally brilliant people. I urge our Florida AGD members to discover the benefits of Toastmasters and realize why it became so successful that we're now celebrating its 100th year.

Since I'm writing this on Mother's Day, the last two commitments I'll mention are to religious groups in memory of my parents. One is being a "minyanaire," attending at least one weekday service every week. We're needed, because unless there are ten adults (a minyan) present at a service, mourners aren't permitted to recite the prayer of mourning. The Jewish philosophy of mourning is that it shouldn't occur only in solitude; the mourner needs the opportunity to be consoled by the presence of others and to express gratitude to God. I'm grateful to the minyanaires who were there when my parents passed away, and I can't abandon other mourners now. The other community is the Chevra Kaddisha, the Jewish burial society. About once a month, I join three or four other women to wash a deceased woman, dress her in her white shroud, place her in her plain wooden coffin, and say some prayers. I feel privileged to be able to care for these women at the end of their lives and plan to do this for many more years.

I hope I've given you a greater appreciation of how crucial community involvement becomes as we age! As time passes, it's tempting to watch TV on the couch or sit in front of the computer. But your most meaningful and beneficial pastimes will be the conversations and community interaction you have with other human beings for the rest of your life.§

Millie Tannen, DDS, MAGD

Behind the Breakdown – What's Really Happening Inside Your Handpiece

By Rick Ball, Summit Handpiece Express

> *"The handpiece is the heartbeat of a dental practice—until it skips a beat and everything stops."*

Handpieces are easily one of the most relied-on tools in any dental practice. They're also one of the most taken for granted. Used dozens of times a day, they're expected to perform flawlessly, quietly, and powerfully—until they don't. And when they don't, productivity stalls, procedures are delayed, and repair bills start piling up.

This first installment of the "Handpiece Lifeline" series looks beneath the surface of these precision instruments. Why do even the best handpieces start breaking down sooner than expected? What factors are shortening their lifespan? And most importantly, what can dentists do to spot issues early and keep their handpieces working at peak performance?

About the Author

Rick Ball is the owner and CEO of Summit Handpiece Express, a family-owned dental handpiece repair company trusted by practices nationwide.

Since 2009, Rick has helped dentists extend the life of their equipment through expert repairs, fast turnaround, and straightforward advice.

Summit Handpiece Express is known for its personal service, affordability, and commitment to helping dentists keep their schedules running smoothly.

Need a hand with your handpieces? Let's talk.

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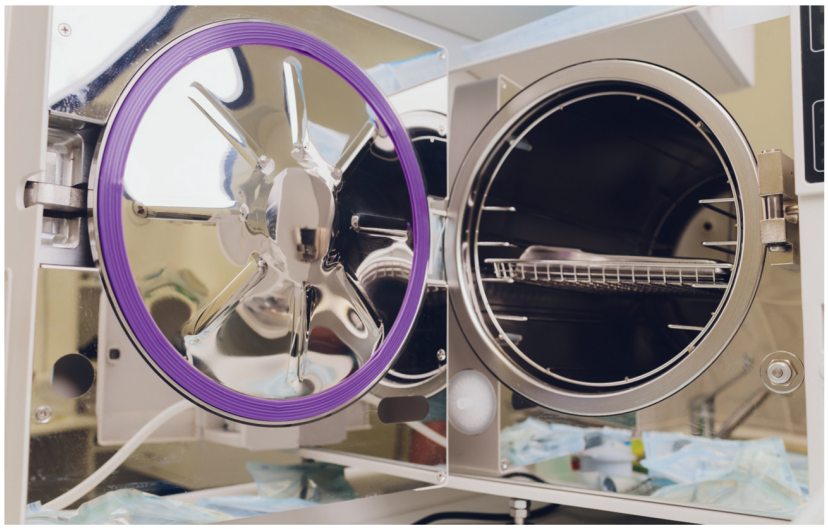
The Hidden Cost of Sterilization



Routine sterilization became the standard of care following critical infection control updates in the early 1990s. It was a much-needed shift in protecting patients—but it also came with unintended consequences for dental equipment.

Modern handpieces are engineered to handle heat and moisture, but the autoclave environment is harsh. High-pressure steam cycles subject turbines, bearings, O-rings, and even the internal optics to repeated thermal stress. Over time, this leads to gradual but significant deterioration.

What does this look like in the operatory? Subtle performance issues—less cutting power, more vibration, occasional bur slippage—are early signs that sterilization is doing its damage. If left unchecked, these issues compound, often resulting in complete turbine failure and costly repairs or replacements.

Turbines: Precision Components Under Pressure

At the heart of every highspeed handpiece is the turbine—a finely balanced assembly of bearings, impellers, and chucking mechanisms spinning at 300,000 to 450,000 RPM. These speeds make dental procedures faster and more efficient, but they also demand perfect balance and lubrication.

Sterilization can weaken the turbine's bearings over time, especially when lubrication routines are inconsistent or skipped. As bearings begin to wear or dry out, they no longer support smooth, concentric motion. This leads to poor bur retention, increased chair time, rougher margins, and greater operator fatigue.

What many dentists don't realize is that most handpiece failures don't happen instantly. It's a slow decline, often masked by compensating with more pressure, swapping burs, or simply adjusting technique. But these workarounds don't fix the core problem—they just delay the inevitable.

Internal Corrosion: The Silent Saboteur

Moisture is a powerful corrosive force—especially inside the narrow, uncoated air and water lines of a handpiece. Repeated exposure to steam without thorough drying leads to oxidation, which gradually narrows channels and blocks exhaust ports.

This backpressure reduces turbine speed and power, even if the bearings themselves are still intact. Many dentists report this as a "sluggish handpiece" or "intermittent performance," not realizing the internal architecture is slowly deteriorating.

Practices using sterilizers with recirculated water are particularly vulnerable, as contaminants in the water supply accelerate corrosion. Newer autoclaves with fresh distilled water per cycle mitigate this risk, but drying protocols are just as critical. Moisture left in the handpiece post-cycle creates the perfect environment for rust, especially if it sits unused overnight.

Telltale Signs of Trouble

Recognizing early signs of handpiece issues is key to avoiding emergency repairs. Some red flags to watch for:

- **Reduced cutting efficiency** – Procedures take longer, even with new burs.
- **Vibration or noise** – A "whining" or "rattling" sound could indicate bearing damage.
- **Loose or drifting burs** – Indicates possible chuck or autochuck failure.
- **Heat at the head** – Excessive friction inside the turbine.
- **Increased chair time** – Subtle performance issues that slow your workflow.

If your handpiece isn't performing like it used to, trust your instincts. These signs don't just indicate normal wear—they signal an opportunity to intervene before the issue worsens.

A Smarter Approach

Understanding what's happening inside your handpiece isn't just about avoiding breakdowns. It's about creating a proactive maintenance mindset that saves time, protects your investment, and keeps your practice running smoothly.

In the next article, we'll unpack the repair vs. replace decision. What really happens during a turbine rebuild? When is it smarter to salvage your current handpiece, and when does full replacement make more sense?

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