A Look at the Future of Dentistry:
From Curing Lights to Current Issues

Jed M. Best
Welcome to the Greater New York Dental Meeting

Greater New York Dental Meeting™
Executive Headquarters
200 West 41st Street, Ste. 1101, New York, NY 10036
Tel. (212) 398-6922, Fax. (212) 398-6934
E-mail: victoria@gnydm.com
www.gnydm.com
Sponsored by New York County & Second District Dental Societies

All programs and exhibits are held at the Jacob K. Javits Convention Center (unless otherwise indicated) 11th Avenue between 34th and 39th Street, New York City

General Registration Hours
Friday, November 29 12:00 Noon - 4:30 P.M.
Saturday, November 30 8:00 A.M. - 4:30 P.M.
Sunday, December 1 - Tuesday, December 3 8:00 A.M. - 5:30 P.M.
Wednesday, December 4 8:00 A.M. - 4:30 P.M.

Exhibit Hall Hours
Sunday, December 1 - Tuesday, December 3 9:30 A.M. - 5:30 P.M.
Wednesday, December 4 - 9:30 A.M. - 5:00 P.M.

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COURSE REGISTRATION
Pre-registration is required for all continuing education courses with the exception of the “Live” Dentistry and Affiliated Groups. Your seat will be held for 15 minutes after the start of the course; after that, those without tickets will be seated according to space availability. When the room is filled, no additional people will be admitted due to fire department regulations. If you have not pre-registered, please be prepared to select an alternate session to attend.

Tickets
Tickets are required for all courses excluding Live Dentistry. Tickets for all functions can be purchased at all general registration booths located in the Registration Area on the Upper Level in the Crystal Palace and online.

6 Days of Education Seminars, Hands-on Workshops & Essays
Friday - Wednesday
4 Days of Exhibits
Sunday - Wednesday

FREE “Live” Dentistry
Hi-Tech 450 Seat Arena

SUNDAY
9:45 - 11:45
VOCO America, Inc.
Drs. Ron Kaminer & Marc Geissberger
Restorative

9:45 - 11:45
Shofu
Dr. Ron Kaminer
Restorative

MONDAY
9:45 - 12:00
Millennium
Dr. Sunil D. Thanik
Laser

1:30 - 2:45
First Fit
Drs. Frederick E. Solomon
Cyrus Tahmasebi
Digital

3:30 - 5:15
Align 
Dr. Karla Soto
Invisalign
Itero
Christian Coachman
Restorative

TUESDAY
9:45 - 12:00
Apa / CareCredit
Drs. Michael Apa
Aesthetic

2:00 - 4:15
Glidewell
Dr. Justin Chi
Digital

WEDNESDAY
9:45 - 12:00
Benco / Vatech
Dr. Aeklavya Panjali
Implant

3:30 - 5:15
3Shape
Dr. Sundeep Rawal
Digital

 огромные гости

Celebrity Luncheon Speaker
John Quiñones
Monday, December 2nd
12:00 - 2:00 - Ticket 4010
$125.00

3D Printing & Digital Dentistry Conference
Dental Laboratory
Technicians Programs
Sleep Apnea Symposium
Oral Cancer Symposium
GREATER NEW YORK DENTAL MEETING
DECEMBER 1, 2019

SHINING A LIGHT
CLINICAL TO CLINIC

ABOUT ME
PRIVATE PRACTICE EXCLUSIVE TO PEDIATRIC
DENTISTRY FOR 38+ YEARS
CLINICAL ASSOCIATE PROFESSOR AT CASE,
COLUMBIA AND NYU
FELLOW AMERICAN COLLEGE OF DENTISTS
FELLOW INTERNATIONAL COLLEGE OF
DENTISTS
AND YES, PAST RACER

DISCLAIMER
I HAVE FRIENDSHIPS WITH MANY OF THE R & D PEOPLE AT VARIOUS DENTAL COMPANIES
2017: MATERIAL THE EQUIVALENT TO $15 FROM ULTRADENT
2018: PHILIPS ELECTRONICS - $14
2019: MATERIAL, THE EQUIVALENT OF $125 FROM GC AMERICA

Top Companies Making General Payments

Top Companies Making Clinical Payments
TOPICS

- Light Curing
- Side Effects of Light Curing
- Restorative Considerations re: Light Curing
- Outcome Assessments - Manpower

BEWARE IF STUDY IS NOT!!

- Refereed Journal
- In Vitro vs In Vivo, is it in SBF (Simulated Body Fluid) if In Vitro, often In Vitro delivers different values than In Vivo
- Statistically Study Sample
- Randomized Clinical Trial
- Meta Analysis

MUCH OF WHAT YOU DECIDE TO BUY IS OFTEN BASED ON MANUFACTURER'S DEFINITION OR SALESPERSON OR FRIEND WHO JUST TOOK A COURSE?

JOURNAL CIRCULATIONS - TAKE ADS

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<thead>
<tr>
<th>JOURNAL</th>
<th>CIRCULATION</th>
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<tr>
<td>JADA</td>
<td>147937</td>
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<td>DENTALTOWN</td>
<td>128195</td>
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<td>INSIDE DENTISTRY</td>
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JOURNAL CIRCULATIONS - NO ADS

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STANDARDS

- ADA
- ANSI
- ISO
- FDA

• Bioactivity
• Potential Obstacles
• No Standard Definition Covering All Materials and Treatments (ISO Standard)
• There is substantial misuse of the word
• Used as a marketing buzzword
• Standards like Underwriter's Lab, FDA, ISO, ANSI, ADA
WHAT IS ISO

PREMARKET NOTIFICATION (510(K))

ISO 23317

WHAT IS ISO

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WHAT IS ISO

PREMARKET NOTIFICATION (510(K))

ISO 23317
ISO standards are reviewed every five years and revised if needed. This helps ensure they remain useful tools for the marketplace. The challenges faced by business and organizations today are very different from a few decades ago and ISO 9000 has been updated to take this new environment into account.

EBAY DISCLAIMER (AMAZON – VERBAL YES, (AS WELL) BEWARE!! DISCOUNT HOUSES MAY BE SELLING GRAY MARKET LIGHTS THAT DO NOT MEET ISO STANDARDS

DEFINITIONS

BEWARE OF MISUSE

DEFINITION AFFECTS

• AFFECTS TREATMENT DECISIONS
• EXPECTATIONS
• OUTCOMES

BIOCOMPATIBILITY

• BIOCOMPATIBILITY IS RELATED TO THE BEHAVIOR OF BIOMATERIALS IN VARIOUS CONTEXTS, THE TERM REFERS TO THE ABILITY OF A MATERIAL TO PERFORM WITH AN APPROPRIATE HOST RESPONSE IN A SPECIFIC SITUATION.
• DOES NOT ELICIT A NEGATIVE HOST RESPONSE [18]

BIOACTIVITY

• BERYLLIUM HAS THE AVAILABILITY OF “BIOACTIVE” RESTITUTIVE MATERIALS NOW FOR SEVERAL DECADES IN THE FORM OF FLUORIDE-RELATING MATERIALS”

FIRST BIOACTIVE MATERIAL

• BIOGLASS 45S5
• DISCOVERED 1969
• LARRY HENCH PhD
• NA2O-CaO-P2O5-SiO2
• BONE REPAIR, IMPLANTS
LIGHT CURING REQUIREMENT

Minimum = 6-48 J/cm² or higher

Modly Dependent Upon:
- LCD and Photoinitiator Match

INTRODUCTION

Curing Light Performance
- LED
- Light Emitting Diode

Energy Requirements of Polymer-based Restorative Materials
- LCD: Light Curing Dispenser

Clinical Technique
- Self-polymerizing resins

SEVERAL PROBLEMS

- LIGHT'S THEMSELVES:
  - PHOTOINITIATOR-BANDWIDTH MISMATCH
  - LED'S AND HOT SPOTS
  - HEAT
  - LIGHT POSITION (MARC), SHAPE OF CURING TIP
  - INFECTION CONTROL

IRRADIANCE ACROSS THE TIP

WHAT ACTUALLY REACHES THE TARGET?
IT ISN'T JUST 3M THAT SHOW THE DIFFERENCES OF BEAM DIMENSIONS


THE ROLE OF CURING LIGHT POSITION OVER THE LONG AXIS OF THE TOOTH

DISTANCE EQUALS LOSS OF ENERGY

High Intensity Shutter Curing Times

Time x Intensity = Constant Energy

Equivalent Cure or Commission?

1 second x 5000 mW/cm² = 5.25 cm²
5 seconds x 1000 mW/cm² = 5.00 cm²
10 seconds x 500 mW/cm² = 2.50 cm²
5000 seconds x 1 mW/cm² = 5.00 cm²

IRRADIANCE VS. DISTANCE

There is not one irradiance number. Many major lights drop 65-75% over 10 mm.
Poor quality control. More than 30% delivered less than 12 J/cm² only 33% of curing lights from 400 offices met the composite manufacturer’s recommended minimum energy requirements.

Conclusions:
- 23% emitted less than 800 mW/cm²
- Negative correlation between LCU radiant exitant (RE) value and age and light tip damage
- No statistically significant difference between average radiant energy for mono and multiwave LCU
- LCU older than 4 years had more light tip damage which reduced their ability to emit 800 mW/cm²

New study published 9/2019:

800 mW/cm² = 16 J/cm² when LCU used for 20 seconds

113 LCU in Toronto area (32 multi and 81 mono LED) used check MARC by Blue Light Analytics to measure.
KEY POINT: "INCREASE EXPOSURE TIME SEEMS TO BE THE FACTOR MOST LIKELY TO CAUSE TISSUE DAMAGE."
WHERE ARE MY LED’S?

Uneven Light Output

VALO VS 3M DEEP CURE

<table>
<thead>
<tr>
<th>Feature</th>
<th>VALO</th>
<th>3M Deep Cure</th>
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<tbody>
<tr>
<td>Effective Tip Width</td>
<td>...</td>
<td>...</td>
</tr>
<tr>
<td>Power Output</td>
<td>...</td>
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Valo recommends using high-intensity light sources capable of curing under varying thicknesses without compromising light output.

“Throughout the RBC, the nanohardness and elastic modulus across two RBC materials were found to change differently according to the orientation of the violet and blue LED emitters with the curing light.”


Resin polymerization was not uniform.

If you use a PolyWave light, don’t expect there to be any violet light at the bottom at 4MM. This is especially important if you are trying to cure both the composite and bonding agent simultaneously.


Bulk composites are now showing comparable results to incremental placement.

For camphorquinone-based bulk-filled composites, photopolymerization with monowave light-emitting diode lights may be more efficient than PolyWave one. Despite manufacturer’s claims, e.g. Elipar Deep Cure (JB).

Not all bulk-fill composites can be effectively cured to depths of 4-5 MM.

Real-time light transmittance monitoring for determining polymerization completeness of conventional and bulk-fill dental composites.

Real: time light transmittance monitoring for determining polymerization completeness of conventional and bulk-fill dental composites.

• Key: short curing times of 10-20 seconds may be insufficient for an optimal polymerization, especially under nonideal conditions.

BULK FILL RESIN COMPOSITES

• Bulk composites are now showing comparable results to incremental placement.

Undercuring a resin does not provide the manufacturer’s intended results.

Bulk-Fill does not generate Bulk-Cure!
• ROLE OF THE LIGHT POSITION

• RANDOM POST-OP SENSITIVITY CONCERNS

• MARC® PS WAS IN HER DENTAL CHAIR

• FOCUSED, CAREFUL AND NOT RUSHED

• BELIEVED THE TESTS SIMULATED ATTENTIVE CARE

CLINICAL IMPLICATIONS

• 37 OPERATORS
• SAME LIGHT, SAME TOOTH, SAME TIME

RADIOMETERS ARE INACCURATE

Actual Output = 986 mW/cm²
DAMAGE AND DEBRIS!

EFFECT OF INFECTION CONTROL

CURING LIGHT SPECIFIC

ON PACKAGING

IN SUMMARY

OCULAR DAMAGE
• THE YOUNG EYE HAS ANTIOXIDANTS THAT PROTECTS THE EYE FROM INTENSE AMBIENT LIGHT
• AFTER MIDDLE AGE, THESE ANTIOXIDANTS DECREASE IN PRODUCTION
• CUMULATIVE EFFECT TOWARDS EXPOSURE IS SIGNIFICANT IN CAUSING DAMAGE
• 5 MIN EXPOSURE OR BUT 3 TO 4 5 MIN EXPOSURES AND FOLLOWED BY A ONE HOUR DARK INTERVAL DID LEAD TO DAMAGE

• RETINAL DAMAGE CAUSED BY BLUE AND VIOLET LED LIGHT VIA A PHOTOCHEMICAL PROCESS
• PHOTORETINITIS CAUSED BY SHORT WAVELENGTHS (BLUE AND VIOLET)
• CAN WORSEN CATARACT GENESIS

• AMERICAN CONFERENCE OF GOVERNMENTAL INDUSTRIAL HYGIENISTS HAS RECOMMENDED A THRESHOLD LIMIT FOR BLUE LIGHT HAZARD OF 100J/CM² OVER A TOTAL VIEWING TIME OF 367 MINUTES IN AN EIGHT HOUR DAY
• BLUE LIGHT IS ABSORBED BY THE RETINA
• LENS OF THE EYE ABSORBS WAVELENGTHS LESS THAN 400NM

WHAT TO DO?
• REMEMBER REFLECTIVE LIGHT ALSO CAUSATIVE
• ORANGE BLUE BLOCKERS POTENTIALLY REDUCE TO LESS THAN 0.1% OF THE RADIATION AT ANY WAVELENGTH BETWEEN 400NM AND 525NM.
• MUST BE LARGE ENOUGH TO PROTECT DR AND STAFF

A BRIEF CHAT ABOUT RESTORATIVES
• SIMILAR TO COMPOSITES
• DECREASE MARKET SHARE
• GIOMERS = IMPROVED COMPOSITES

• ADVANTAGES
• VERY ESTHETIC
• NEW TECHNOLOGY
• 2012 – 261 MILLION WORLDWIDE
• CONSERVE TOOTH STRUCTURE
• SLOT PREP

• DISADVANTAGES
• TECHNIQUE SENSITIVE
• PRONE TO SECONDARY CARIES
• PRONE TO BULK FRACTURE
• SUFFICIENT ENERGY TO CURE
• POSTPOLIMERIZATION SHRINKAGE
• MOISTURE CONTROL, “FIGURE 8 ISOLATION”
• TROUBLE (IF MANAGE WP ON THERE IS DEEP STAINS IN DENTALS)
ACID BASE REACTION

• BOTH HAVE THERMAL EXPANSION PROPERTIES SIMILAR TO DENTIN
• BOTH “BOND” CHELATE TO DENTIN
• INDIRECT PULP THERAPY
• ONE: GLASS IONOMER AND CALCIUM WITHIN TOOTH
• BOTH CAN “RECHARGE”

INDIRECT PULP THERAPY

• IONIC BOND BETWEEN GLASS IONOMER AND CALCIUM WITHIN TOOTH
• BOTH CAN SELF CURE
• ACID BASE RXN

SELECTIVE REMOVAL TO FORM DENTINE.


GIC / RMGIC

• BOTH CAN SELF CURE
• POOR WEAR
• POOR PHYSICOMECHANICAL PROPERTIES
• SLOW SETTING TIMES (CAN BE MODIFIED)
• KETAC MOLAR/UNIVERSAL (HIGH P/L RATIO)
• FUJI IX (HIGH P/L RATIO)
• RIVA, KETAC SILVER, MIRACLE MIX
• RIVA HV
• CHEMFIL ROC (SLOW SETTING)
• EQUIA FORTE

GIC - RMGIC

• BOTH CAN SELF CURE
• POOR WEAR
• POOR PHYSICOMECHANICAL PROPERTIES
• SLOW SETTING TIMES (CAN BE MODIFIED)
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• RIVA, KETAC SILVER, MIRACLE MIX
• RIVA HV
• CHEMFIL ROC (SLOW SETTING)
• EQUIA FORTE

GIC / RMGIC

• INDIRECT PULP THERAPY (SCALE)
• PHASE VS ACTIVE (“TRIMMERS VS DISC BRAKES”)
• INDIRECT PULP THERAPY
• ONE: GLASS IONOMER AND CALCIUM WITHIN TOOTH
• BOTH CAN “RECHARGE”

GIC VS RMGIC

• RMGIC
• ADHESION OF WATER SOLUBLE PHOTOPOLYMERIZABLE RESIN MONOMERS
• PROPRIETARY RESINS IN EXTREMELY SLOW SETTING
• HARDER SETTING
• HAS BETTER AESTHETICS
• HAS BETTER WEAR
• LESS WEAR

GIC VS RMGIC

• RMGIC
• ADHESION OF WATER SOLUBLE PHOTOPOLYMERIZABLE RESIN MONOMERS
• PROPRIETARY RESINS IN EXTREMELY SLOW SETTING
• HARDER SETTING
• HAS BETTER AESTHETICS
• HAS BETTER WEAR
• LESS WEAR
• VITREMER - 3M
• KETAC NANO - 3M
• Fuji II LC - Fuji
• Riva - SDI
• Ionomax - VOCO
• Activa – Pulpdent (?)

RMGIC

ACTIVA STUDY

• "It can be concluded that the use of the biocactivity claiming adhesive, application a short phosphoric acid pretreatment but without an adhesive system, resulted in an unacceptable high failure frequency after a one year period."

• 78 pairs of class II and 4 pairs of class I

STUDY

25% Failure of Material

Van DIJKEN JWV, PALLESEN U, BENETTI A. DENTAL MATERIALS. 35. 2019 P335-343

NO BONDING AGENT NECESSARY

TO PONDER!

WHEN YOU USE AN ISOLITE?

• DOES YOUR MIRROR FOG?

• DO YOU USE COMPOSITE AND NOT A GC OR RMGIC?

• SO YOU ARE USING A HYDROPHOBIC MATERIAL IN A MOIST ENVIRONMENT?

• PLUS YOU HAVE SULCULAR INFILTRATION UNLESS THE MATRIX IS AIR TIGHT AGAINST THE TOOTH!

INTO THE UNKNOWN VOID

FUTURE

Present Day

MARCHING TO A PARADIGM SHIFT!!
MAINTENANCE OF PULP VITALITY IS PARAMOUNT

NONSELECTIVE REMOVAL TO HARD DENTINE - FORMERLY KNOWN AS COMPLETE CARIES REMOVAL (TECHNIQUE NO LONGER RECOMMENDED)

SELECTIVE REMOVAL TO FIRM DENTINE


FEDERAL CHANGE WILL CERTAINLY ALSO PROPEL STATES TO EXPERIMENT WITH PAY-FOR-PERFORMANCE TO REPLACE FEE-FOR-SERVICE, ENGAGE RISK-BASED FORMULAE TO APPLICATION OF SERVICES.

HOW WE MANAGE THEIR ORAL HEALTH NEEDS WILL LIKELY BE VERY DIFFERENT. MANY WILL COME TO US CARIES-FREE IF PEDIATRICS AND GENERAL DENTISTRY EMBRACE INFANT ORAL HEALTH.

DATA ALLOWS FOR LESS AGGRESSIVE TREATMENT

• LESS REMUNERATION FOR MORE CONSERVATIVE TREATMENTS

THOSE ESTABLISHED IN PRACTICE AND THOSE STILL IN RESIDENCY MAY HAVE DIFFERING FUTURES, BUT SHARopyright the decision to care for children as their career path.

IT REMAINS TO BE SEEN HOW CHANGES SUCH AS INDIRECT PULP-CAPPING, SILVER DIAMINE FLUORIDE, FLUORIDE VARNISH, DENTAL THERAPY, ICD-10 CODES, LARGE SCALE ADOPTION OF ELECTRONIC RECORDS AND DATA MANAGEMENT BY PAYERS, AMONG OTHER THINGS, WILL SHAPE THE FUTURE OF PEDIATRIC DENTISTRY PRACTICE.
Milton Friedman, University of Chicago and Nobel Prize Winner

- "Preached a Gospel of Profits as Purpose"
- Goal of corporation, & insurance companies, was to return the highest possible dividend to shareholders, not the insured.

New York Times August 16, 2009, p16

This decrease is due to an expansion of Medicaid coverage, which mandates extensive dental benefits for children. Combine with other reforms, the change has helped drive increased utilization of dental care among low-income children.


Between 2000 and 2010, the number of ER visits has doubled. This increase has been driven almost entirely by young adult’s ER use for dental conditions, which is wasteful and expensive and which often simply relieves pain and not the underlying conditions.

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In contrast, the ACA is expected to expand the number of children with dental benefits. Research carried out in 2012 indicates that up to 8.7 million children are expected to gain dental benefits by 2018.

This expansion would reduce the number of uninsured children in the United States by approximately 15 percent.

However, since this analysis was done, the way the ACA is being implemented has watered down the impact on dental benefits coverage for children. As a result, this estimate of additional number of children expected to gain coverage should be viewed as an upper bound.

The trend toward larger, consolidated, multisite practices is expected to continue, driven by changes in the practice patterns of new dentists, a drive for efficiency and an increase competition for patients.

The percentage of dentists who are in solo practice is declining steadily and this trend is expected to continue. - Growth in dental and this trend is expected to continue. - Interest in solo practice is likely to continue. - Growth in dental and this trend is expected to continue. - Interest in solo practice is likely to continue. - Commercial plans increasingly will use selective networks and will demand increased accountability. - Premiums will be placed on good practice management.

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Background. Childhood caries is a major oral and general health problem, particularly in certain populations. In this study, the authors aimed to evaluate the adequacy of the supply of pediatric dentists.

Methods. The authors collected baseline practice information from 2,546 pediatric dentists of pediatric dentists.

Results. If production of new pediatric dentists and use and delivery of oral health care continue at current rates, the pediatric dentist supply will increase by 4,030 full time equivalent (FTE) dentists by 2030, whereas demand will increase by 140 FTE dentists by 2030. Supply growth was higher under hypothetical scenarios with an increased number of graduates (4,690 FTEs) and delayed retirement (4,320 FTEs). If children who are underserved experience greater access to care or if pediatric dentists provide a larger portion of services for children, demand could grow by 2,100 FTE dentists or by 10,470 FTEs). If children who are underserved had oral health care use patterns similar to those of the population with fewer access barriers.

Conclusions. The study results suggest that the supply of pediatric dentists is growing more rapidly than is demand. Growth in demand could increase if pediatric dentists captured a larger share of pediatric dental services or if children who are underserved had oral health care use patterns similar to those of the population with fewer access barriers.
THERE WILL BE MORE COMPETITION FOR PATIENTS AND INCREASED PRESSURE TO DO MORE WITH LESS IF REIMBURSEMENT CONTINUES TO DECLINE AND DEMAND FOR DENTAL CARE REMAINS SLUGGISH

VUJICI M, JADA 148(9) COMMENTARIES

PRACTICE OWNERSHIP IS DECLINING, http://jada.ada.org 2017 P1690-691

PROVIDERS HAVING STRONGER FINANCIAL INCENTIVES FOR PREVENTION

VUJICI M, COMMENTARY, OUR DENTAL SYSTEM IS STUCK, JADA 149(3) HTTP://JADA.ADA.ORG 2018 P167-169

SHIFTS THAT ARE UNDERWAY:
FROM VOLUME TO VALUE
FROM FEE FOR SERVICE TO ALTERNATIVE PAYMENT MODELS
INDIVIDUAL TO POPULATION-LEVEL CARE
DISEASE-CENTERED TO PERSON-CENTERED
UNACCOUNTABLE TO ACCOUNTABLE HEALTH OUTCOMES

Edelstein B. Private Communication

FACTS

IN THE CASE OF PEDIATRIC DENTISTS THERE IS A SUBSTANTIAL INCREASE IN THE PER CAPITA SUPPLY FROM 2001 TO 2015 PER CAPITA IN THE US:
1.4 PER 100,000 IN 2001
2.2 PER 100,000 IN 2015

GUPTA N, VUJICIC M, MUNSON B, NASSEH K, RECENT TRENDS IN THE MARKET FOR ORAL SURGEONS, ENDODONTISTS, ORTHODONTISTS, PERIODONTISTS AND PEDIATRIC DENTISTS, ADA HEALTH POLICY INSTITUTE, FEB 2017

HOWEVER, IF YOU CONSIDER THE POPULATION OF THOSE UNDER 19 PER CAPITA IN THE US:
4.9 PER 100,000 IN 2001
8.7 PER 100,000 IN 2015

GUPTA N, VUJICIC M, MUNSON B, NASSEH K, RECENT TRENDS IN THE MARKET FOR ORAL SURGEONS, ENDODONTISTS, ORTHODONTISTS, PERIODONTISTS AND PEDIATRIC DENTISTS, ADA HEALTH POLICY INSTITUTE, FEB 2017

DENTAL COVERAGE FOR CHILDREN IS COMPULSORY BOTH IN MEDICAID AND CHILDREN’S HEALTH INSURANCE PLAN, WHICH TOGETHER COVER OVER 40% OF THE CHILDREN IN THE US

A RECENT STUDY REVEALED THAT IN EVERY STATE EXCEPT ONE, LOW-INCOME CHILDREN ARE “CATCHING UP” TO HIGH-INCOME CHILDREN IN TERMS OF THEIR DENTAL CARE UTILIZATION

COMMON TO THESE PROGRAMS IS TO DEMONSTRATE BETTER HEALTH OUTCOMES ARE ACHIEVABLE AT LOWER COST, WITH BETTER POPULATION HEALTH AND PATIENT EXPERIENCE IF CARE SYSTEMS ARE REDESIGNED WITH A FOCUS ON EFFICIENCY AND EFFECTIVENESS TO YIELD MEASURABLE HEALTH OUTCOMES.

OUTCOME ASSESSMENTS

THE GOAL IS TO GO FROM CATEGORY 1 > 4 ALTERNATIVE PAYMENT MODELS
1. FEE FOR SERVICE: NO LINK TO QUALITY OR VALUE (2018)
2. FEE FOR SERVICE-LINK TO QUALITY AND VALUE
3. APM’S BUILT ON FEE FOR SERVICE ARCHITECTURE
4. POPULATION-BASED PAYMENT

OUTCOME ASSESSMENTS
WHY:
DISTRIBUTION OF DENTAL EXPENDITURE BY SOURCE OF FINANCING
FROM: 1990-2016

OUT OF POCKET (FEE FOR SERVICE)  48% TO 40%
PRIVATE INSURANCE  48% TO 50%

U.S. DENTAL EXPENDITURES 2017 UPDATE. ADA HEALTH POLICY INSTITUTE

IT REMAINS TO BE SEEN HOW CHANGES SUCH AS INDIRECT PULP CAPPING, SILVER DAMARIE FLUORIDE, FLUORIDE VARNISH, DENTAL THERAPISTS, ICD-10 CODES, LARGE SCALE ADOPTION OF ELECTRONIC RECORDS AND DATA MANAGEMENT BY PAYERS, AMONG OTHER THINGS, WILL SHAPE THE FUTURE OF PEDIATRIC DENTISTRY PRACTICE.

CASAMASSIMO, P. PEDIATRIC DENTISTRY, GUEST EDITORIAL. WHAT WE CAN COUNT ON, V40 NO. 1, 2018 P8-9

• WITH LARGE STUDENT DEBT
• WITH THE INCREASE IN CORPORATE DENTISTRY OWNING PRACTICES
• WHO WILL BE ABLE TO BUY OUT THE OLDER PRACTITIONERS?

THANK YOU!