



The Future is Minimally Invasive:

Expanding Access, Preserving Teeth,
and Improving Practice
Sustainability

Jonathan Norris, DDS • Diplomate ABPD

www.MontshirePD.com



The Paradigm is Shifting...

**This is the greatest
opportunity in the history of
dentistry to do the right thing
for the right reason...**



Objectives

- 1 Educate on the benefits of minimally invasive practices in dentistry.
- 2 Discuss how MID fits into the future landscape of dentistry and healthcare transformation.
- 3 Describe the financial benefits and improved patient outcomes when prioritizing minimally invasive dentistry.

Disclosure Statement:

Financial & Professional Affiliations:

I have a financial interest in Montshire Dental, PC and Equity Dental, LLC.

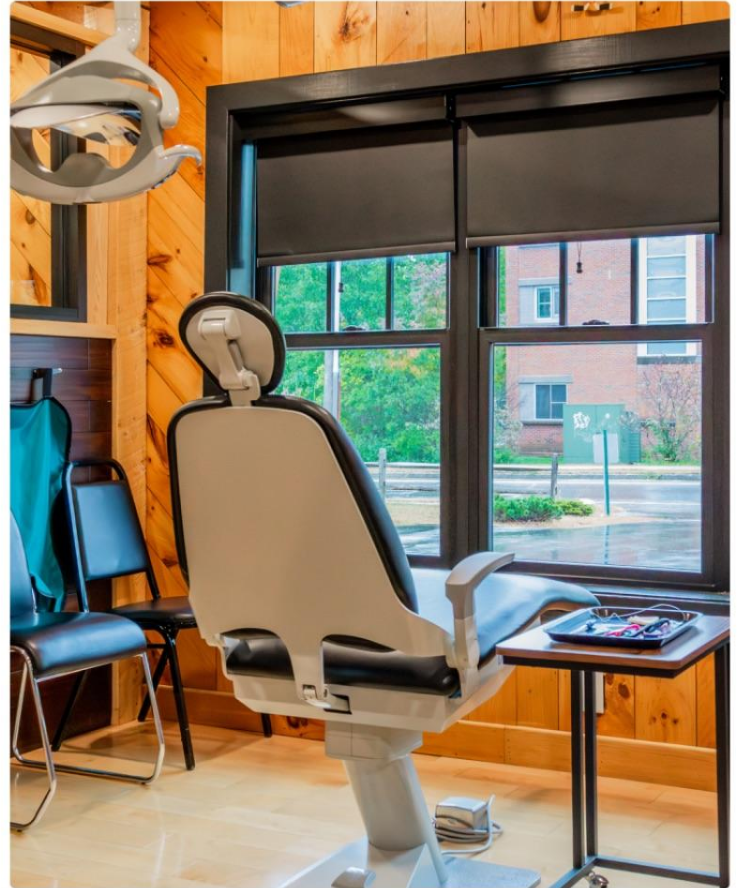
I also serve as a CAMBRA board member, and the New Hampshire APD Sec/Treasurer + President Elect

Disclaimer:

The opinions I express are my own and not necessarily representative of the organizations I am a part of.

I don't consider myself an expert – I am just a person trying to practice ethically based on science and evidence.

Research on these topics is on-going, and best practices are constantly evolving.





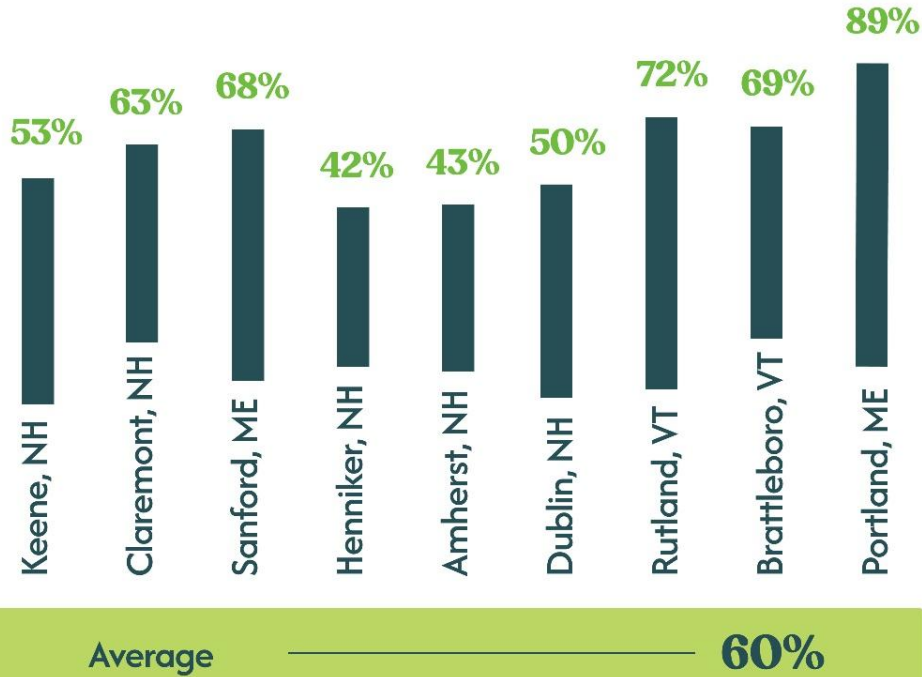
Overview

- Introduction
- Problem - Caries & Medicaid Cuts
- Solution = Dentistry's Penicillin Moment (MID)
 - Historical
 - "The New Dentistry"
- Medicine
- Model
- Benefits



“Every Child is Welcome”

Montshire Medicaid Percentage



*As of 10/01/2025

The Problem

Congress targeting \$600-880 billion in Medicaid cuts over the next decade

Medicaid dental covers 78 million Americans

47% of Medicaid children receive annual dental care

Only 1 in 3 dentists accept Medicaid

Medicaid reimburses at rates 34% below commercial insurance for children and 46% below for adults

Most practices view this as an unsolvable equation:

1. Accept Financial Losses
2. Limit or outright exclude these populations

What if the problem is NOT Medicaid but our approach to serving Medicaid Patients? What if we could design a practice model where public insurance becomes not just viable BUT profitable in an era of reduced federal funding???

The Oral Health Ecosystem

Dentistry Is Not A Monolith

DENTIST ASSOCIATIONS

American Dental Association (ADA)

American Academy of Pediatric Dentistry (AAPD)

American Association of Orthodontists (AAO)

American Association of Oral and Maxillofacial Surgeons (AAOMS)

American Academy of Periodontology (AAP)

American Association of Endodontists (AAE)

American College of Prosthodontists (ACP)

American Board of Oral Medicine/Oral Pathology

American Association of Public Health Dentistry (AAPHD)

...

DENTAL HYGIENIST ASSOCIATIONS

American Dental Hygienists' Association (ADHA)

National Dental Hygienists' Association (NDHA)

...

DENTAL ASSISTANT ASSOCIATIONS

American Dental Assistants Association (ADAA)

Dental Assisting National Board (DANB)

...

DENTAL LAB TECHNICIAN ASSOCIATIONS

National Association of Dental Laboratories (NADL)

...

DENTAL EDUCATION ORGANIZATIONS

American Dental Education Association (ADEA)

Commission on Dental Accreditation (CODA)

...

PUBLIC HEALTH & ADVOCACY ORGANIZATIONS

Association of State & Territorial Dental Directors (ASTDD)

American Public Health Association (APHA)

...

PAYERS

Delta Dental Plans Association, etc.

Managed Care Organizations

...

PUBLIC

Patients & Families

Community Advocacy Organizations

...

CMS

Centers for Medicare & Medicaid Services (CMS)

State Medicaid Agencies

...

**SPACE
WHERE WE
CAN
ACTUALLY
GET
THINGS
DONE**

**PUBLIC
INTEREST**

CMS

*PUBLIC HEALTH &
ADVOCACY
ORGANIZATIONS*

**POLICY &
PAYMENT**

PAYORS

PUBLIC

*DENTAL
EDUCATION
ORGANIZATIONS*

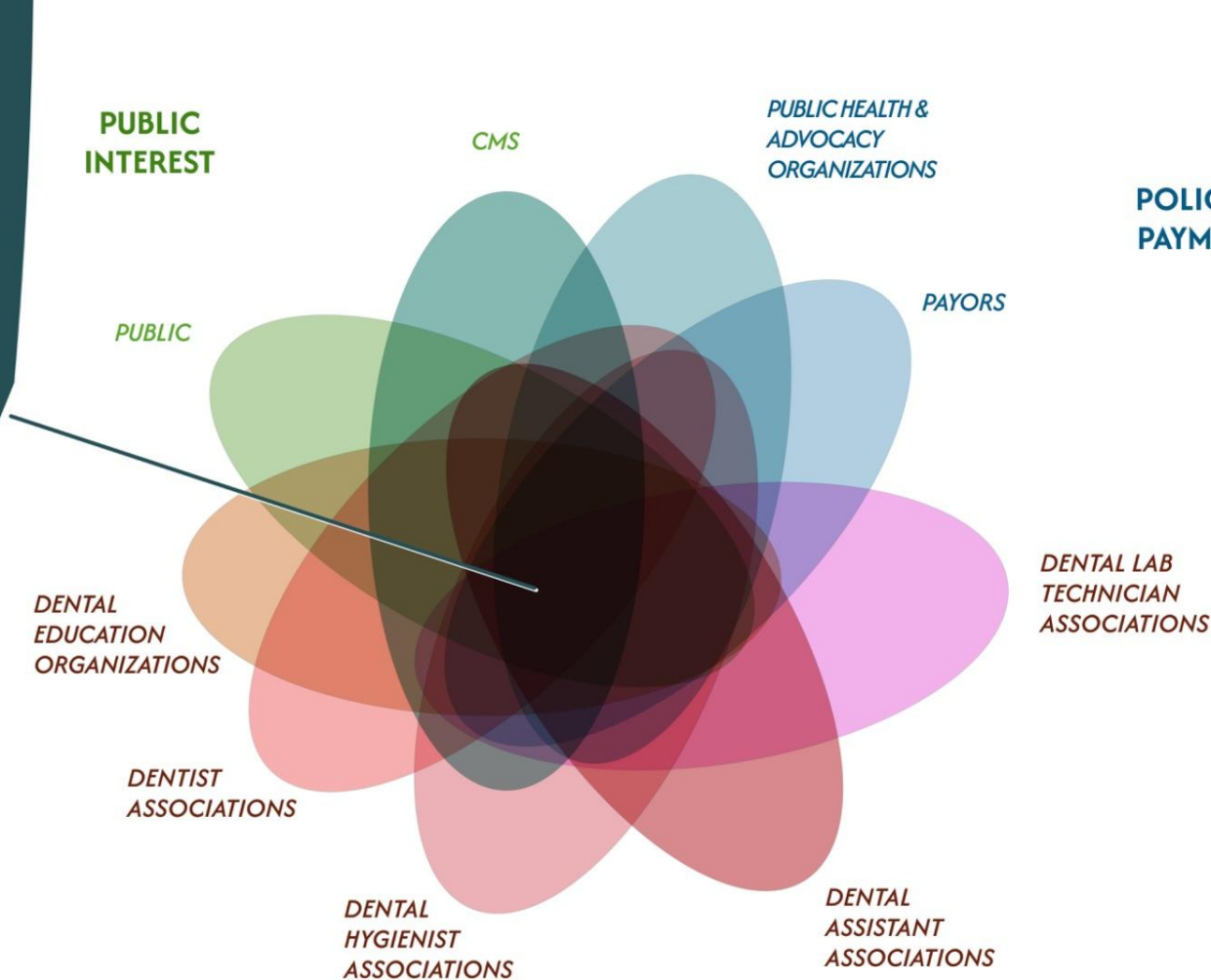
*DENTAL LAB
TECHNICIAN
ASSOCIATIONS*

*DENTIST
ASSOCIATIONS*

**CARE
DELIVERY**

*DENTAL
HYGIENIST
ASSOCIATIONS*

*DENTAL
ASSISTANT
ASSOCIATIONS*



Historical Response

Surgery-first approach



Standard response for 100+ years



Focuses on repair of damage



Can be effective, but...



Frequently requires sedation in certain communities
(children, special needs, etc.)



Often traumatic, leading to dental hesitancy



Are there more opportunities for prevention?

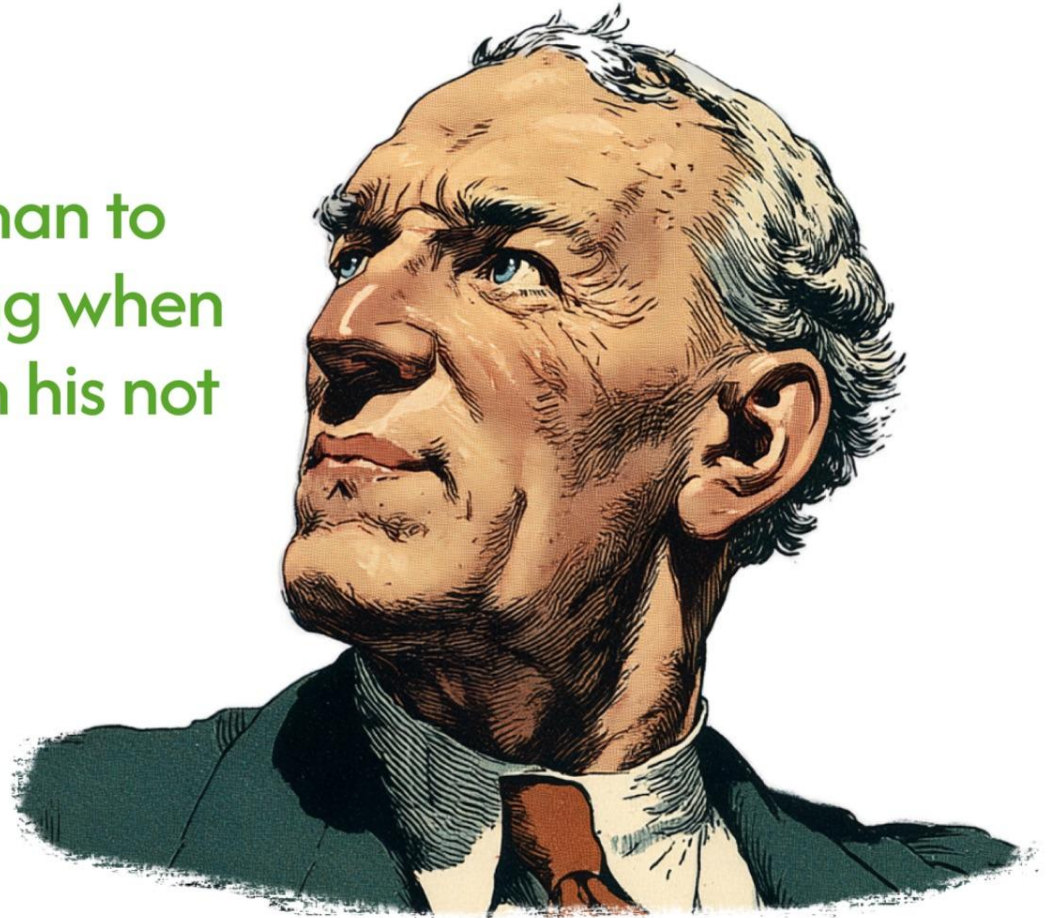


Can we treat tooth decay as the infection it is?



“ It’s difficult to get a man to understand something when his salary depends on his not understanding it. ”

— UPTON SINCLAIR



Dental Public Health



“The science and art of **preventing and controlling dental diseases** and promoting dental health through organized community efforts. It is that form of dental practice which serves the community as a patient rather than the individual. It is concerned with the dental **health education of the public**, with applied dental **research**, and with the administration of group dental care programs as well as the **prevention and control of dental diseases on a community basis.**”

Dental Public Health Definition from the ADA
<https://ncrdscb.ada.org/recognized-dental-specialties>

A New Tool in Dentistry

Incorporating Medical Management



Education



Prevention



Research



“Less Invasive”



Shift from doctor based treatment
to team approach

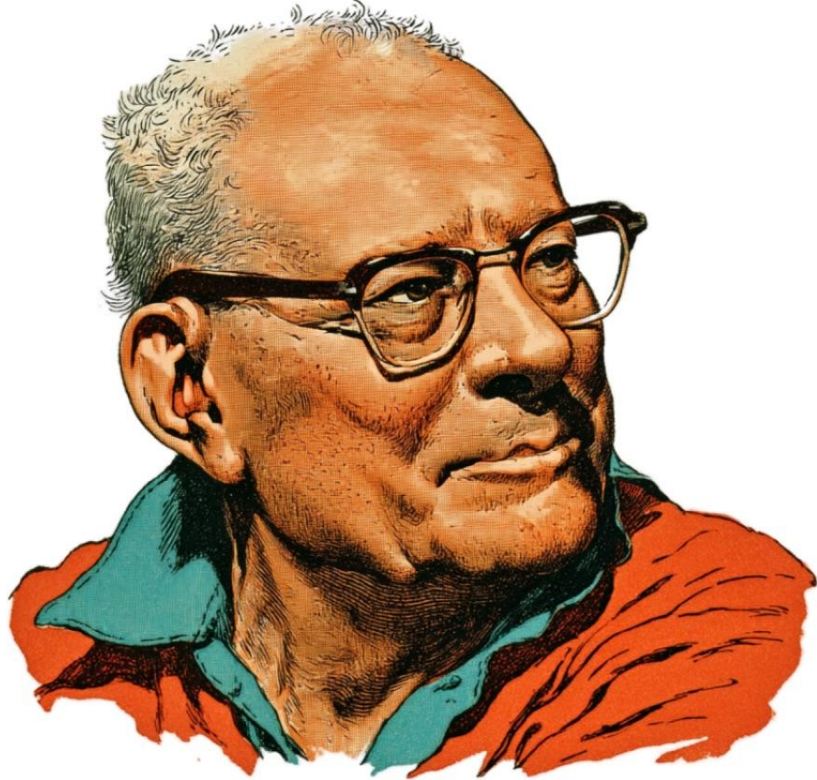


The Dentist's Dilemma: **How Individual Incentives Conflict with Optimal Care**

The dental industry suffers from a fundamental misalignment: dentists are trained as medical specialists but must operate as small business owners, typically without business education and carrying massive debt loads. State laws requiring dental practice ownership by licensed dentists, combined with dental boards composed of practicing dentists, create a unique industry structure where clinical and business decisions remain concentrated within the profession. This creates a self-governing system where treatment decisions naturally reflect the financial and operational realities of individual practices, rather than broader healthcare efficiency or population health objectives.

Traditional practices are perfectly optimized for their current model. Small teams (6 employees on average), manageable patient loads (average of 1500 patients - 250 patients/teammate), high-margin procedures that justify extensive surgical investments. **While minimally invasive dentistry benefits patients and payers, it requires dentists to transform from skilled technicians into high-volume business operators, serving more patients for potentially similar income.** Since dentists ultimately control treatment protocols, external stakeholders cannot force this transition. This structural resistance creates significant first-mover advantages for practices willing to make the transition.

Montshire averages 370 patients/employee with a target of 500+ patients/employee and Montshire dentists traditionally manage the care of 7000 patients each.



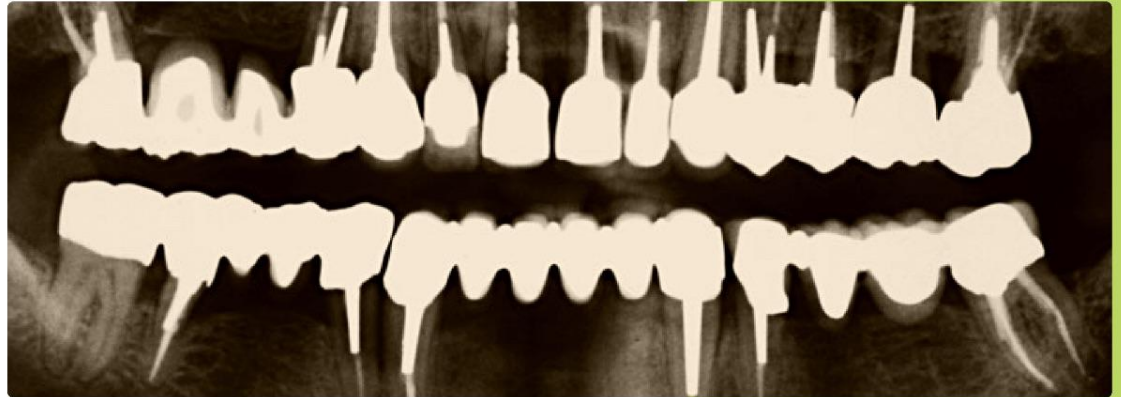
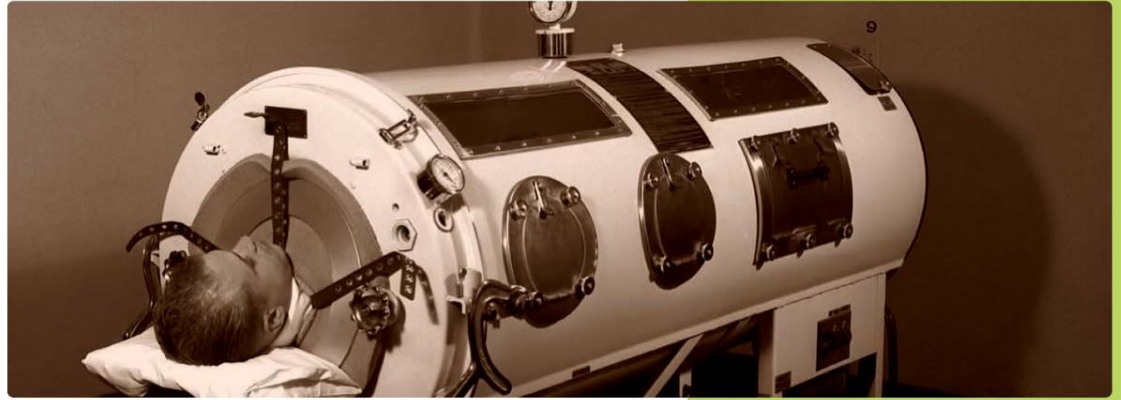
“ Each system is perfectly designed to give you exactly what you are getting today. ”

— W. Edwards Deming

A mechanical respirator (aka - iron lung) used to treat patients with respiratory paralysis, during the polio era.

The End Stage of Infection

A full mouth dental rehabilitation with crowns, root canals, and bridges used to treat patients with dental decay.



The 'New Dentistry'

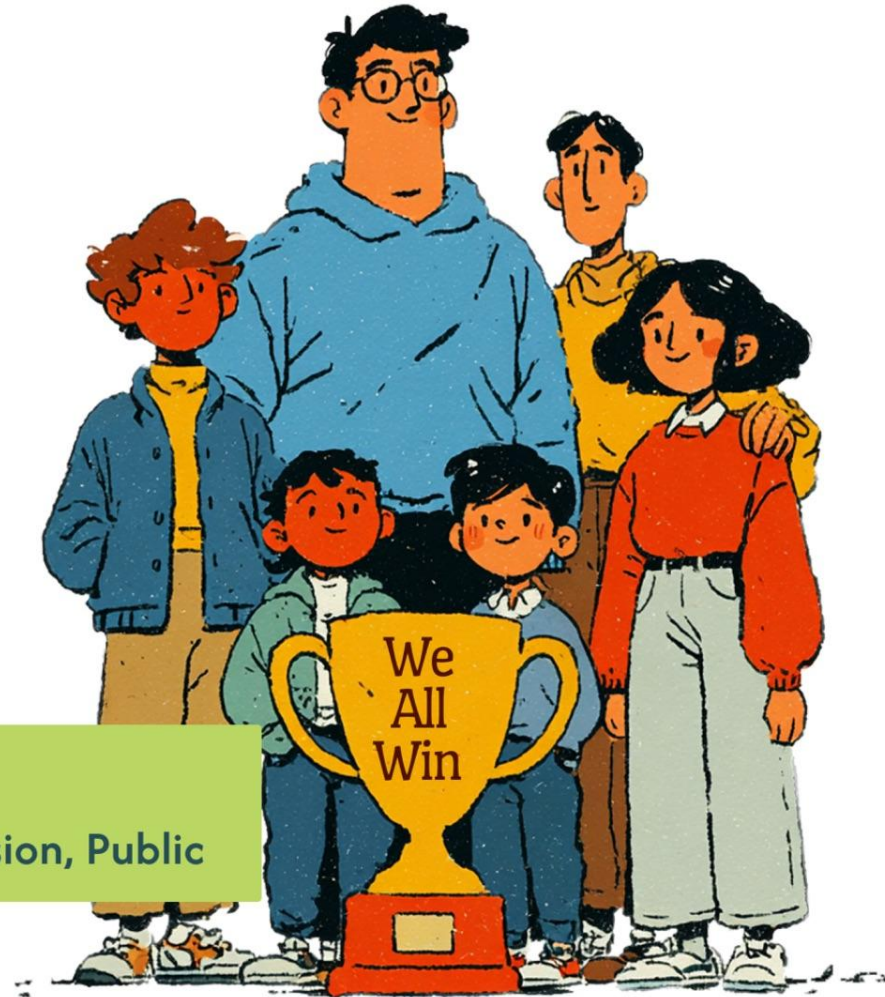
A type of "medical dentistry"...

That is minimally invasive...

And emphasizes putting the mouth back in the body.

Winners = 6 Ps:

Patients, Parents, Payors, Providers, Profession, Public



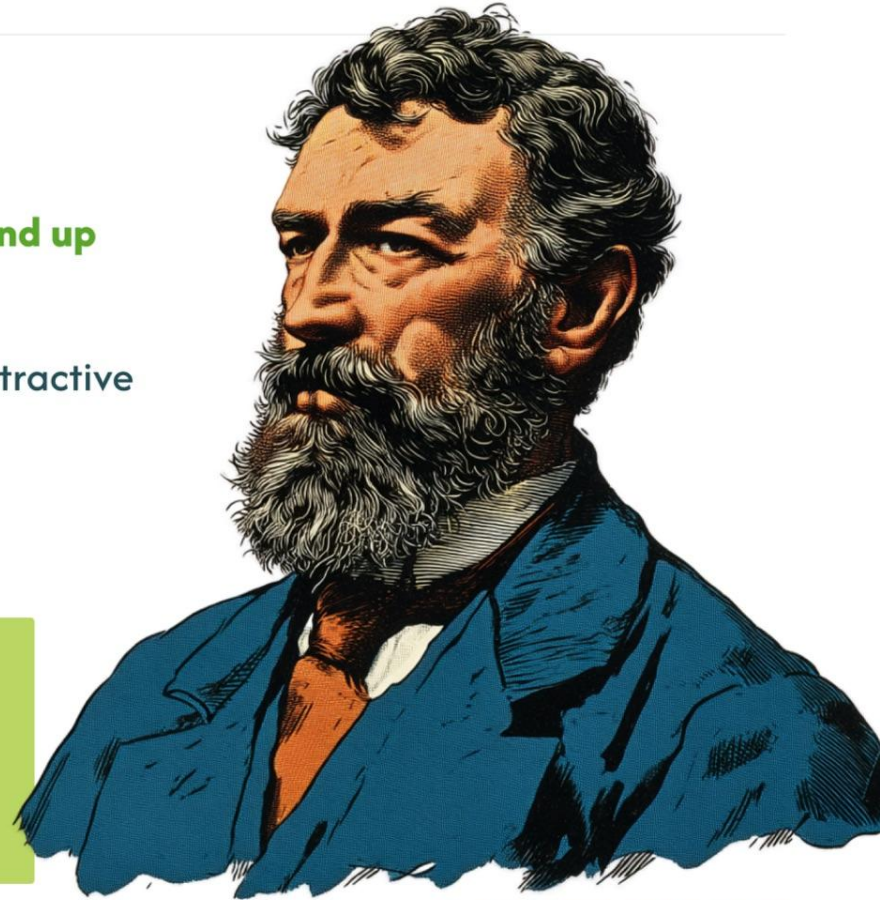
Jevon's Paradox

When we make something more efficient, we often end up using more of it, not less.

Efficiency reduces costs, making the resource more attractive and accessible, which drives up overall consumption.

This is the new dentistry.

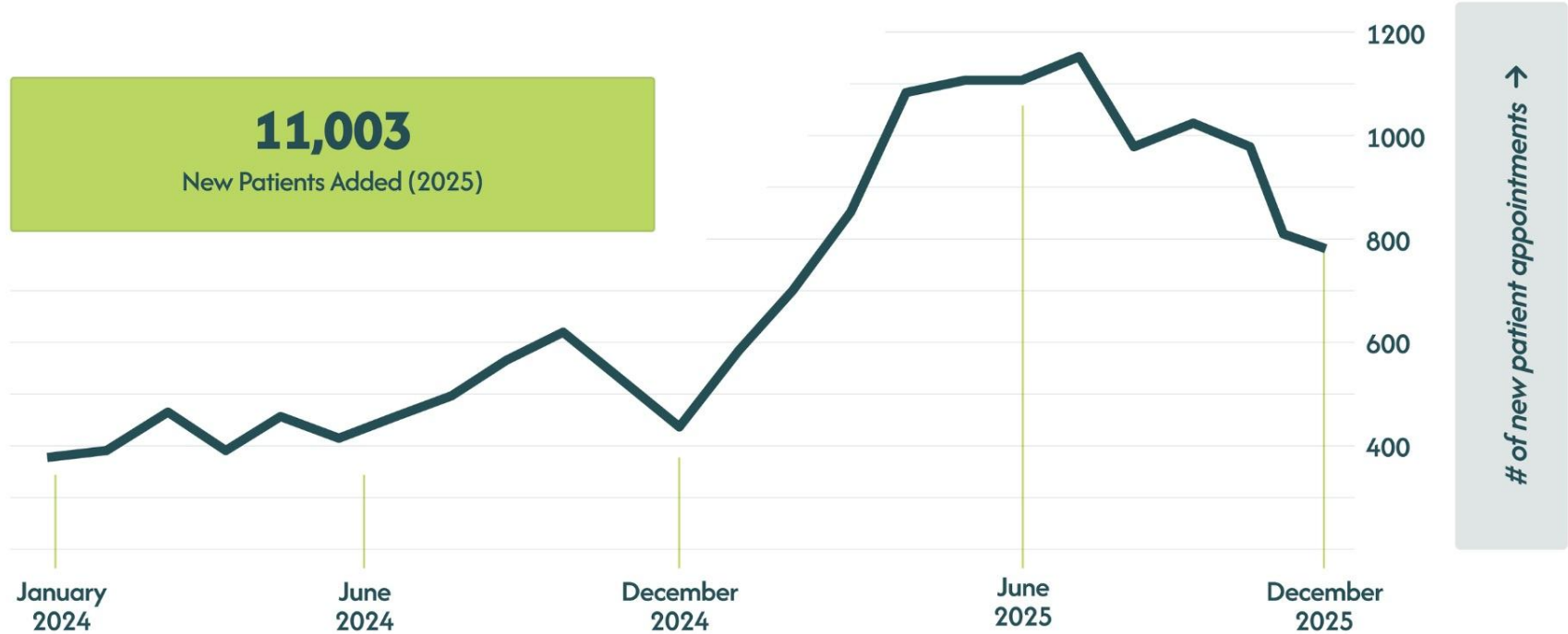
Tooth Decay remains the most common chronic disease in humans, but only about half of all Americans will receive dental care this year. We don't have enough dentist with the existing paradigm...



WILLIAM STANLEY JEVONS

Montshire Pediatric Dentistry Growth: 2024-2025

Number of New Patient Appointments Per Month





Surgical Management



Medical Management

Two Tools, One Goal

Do we need to choose between surgical and medical management, or can we use both tools wisely?

Let's expand our options.

Research-Science-Based Action

THIS IS NOT COMPREHENSIVE



Silver Diamine Fluoride (SDF)



GreenMark



Fluoride Varnish



Glass Ionomer Cement (CIG)



Nano Hydroxyapatite



Arginine



PapaCarie Duo



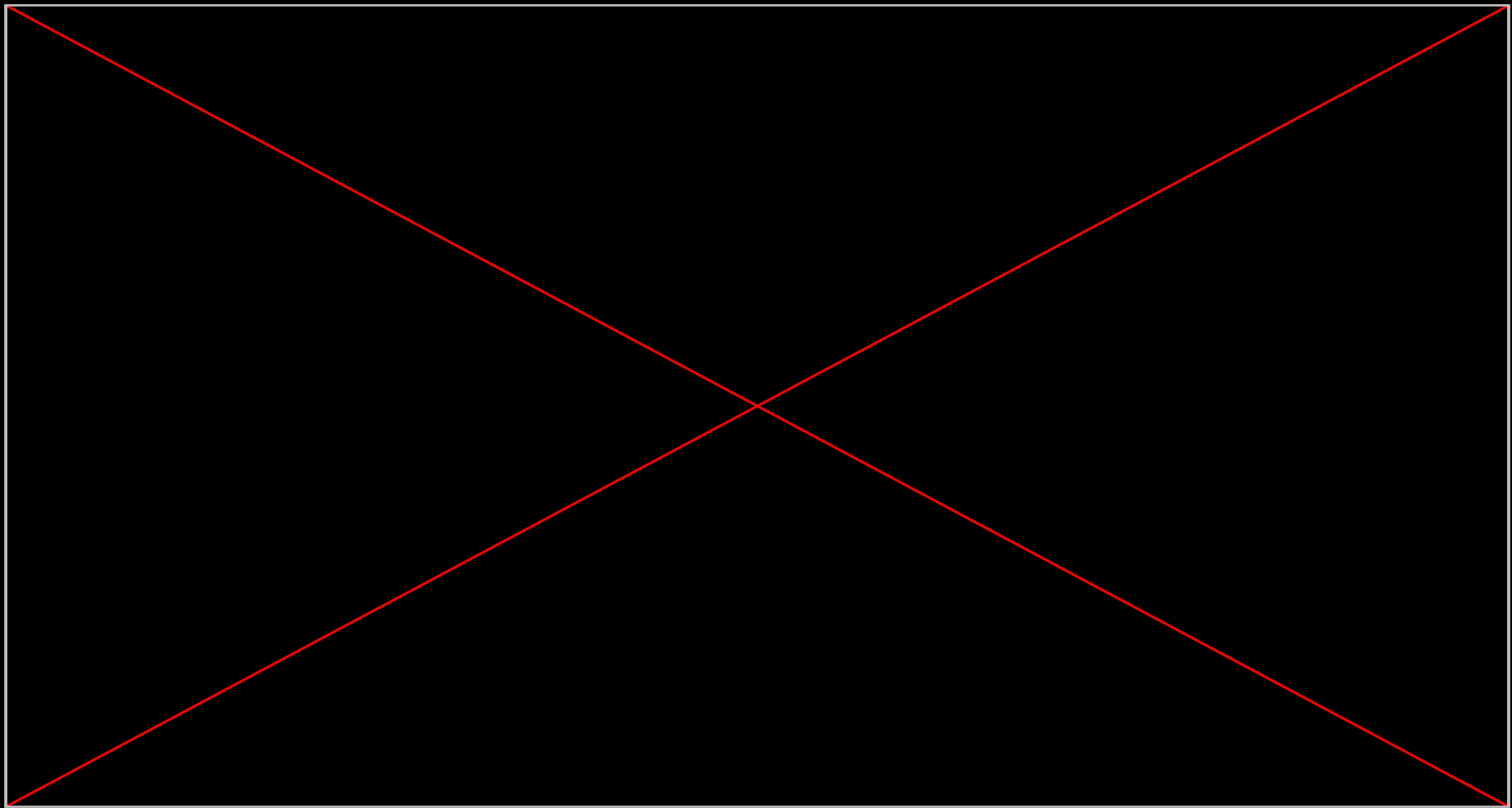
Blue Check



Curodont



Povidone Iodine (PVP-I)



History

Silver Diamine Fluoride (SDF)

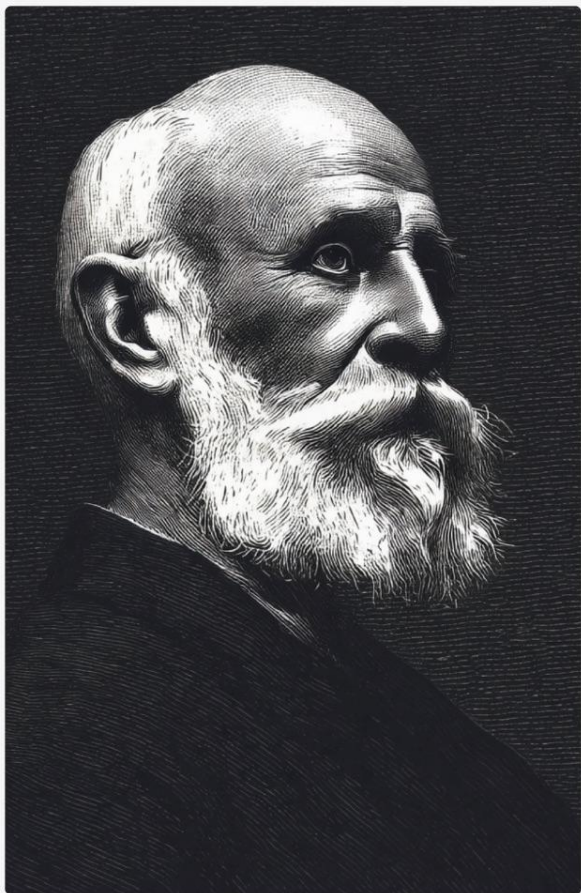
First Pharmacological treatment governmentally approved for use against dental caries (ex Japan in 1970, Canada 2017).

The effectiveness of treating individual cavitated lesion is estimated by meta-analysis to be 81% (Gao Et Al., 2016).

Similar to composite fillings placed in similar high caries rate public health situation (Bucher et al., 2015).

Outperforms all other modalities besides sealants, approximately 61% fewer new lesions throughout the mouth (Horst & Hieme, 2019).





History

Greene Vardiman Black

Leave the decayed material in the dentin where it is. Do not disturb it or attempt to remove it. The removal of this is particularly painful to the child.

...if some decay is left or some dentin is exposed, it should be treated with silver nitrate. ...

The object in this treatment is to fill the part of the dentin softened by decay with the insoluble salt of silver ... and incidentally to destroy the organisms in it.

Generally decay is effectually (sic) stopped by this treatment. ... and the teeth, although mutilated and out of shape, will be useful to the time of their shedding.

We may, if decay is again starting up in some part of a surface that has been treated in this way, treat it again and stop it again, and again, if necessary.

A Work on Operative Dentistry, Vol. One, The Pathology of the Hard Tissues of the teeth, Management of Children's Teeth, pp. 235-257.

Case Study

SDF Cost vs Revenue Generated

Missouri reimbursement one application of SDF (D1354) = \$16.87

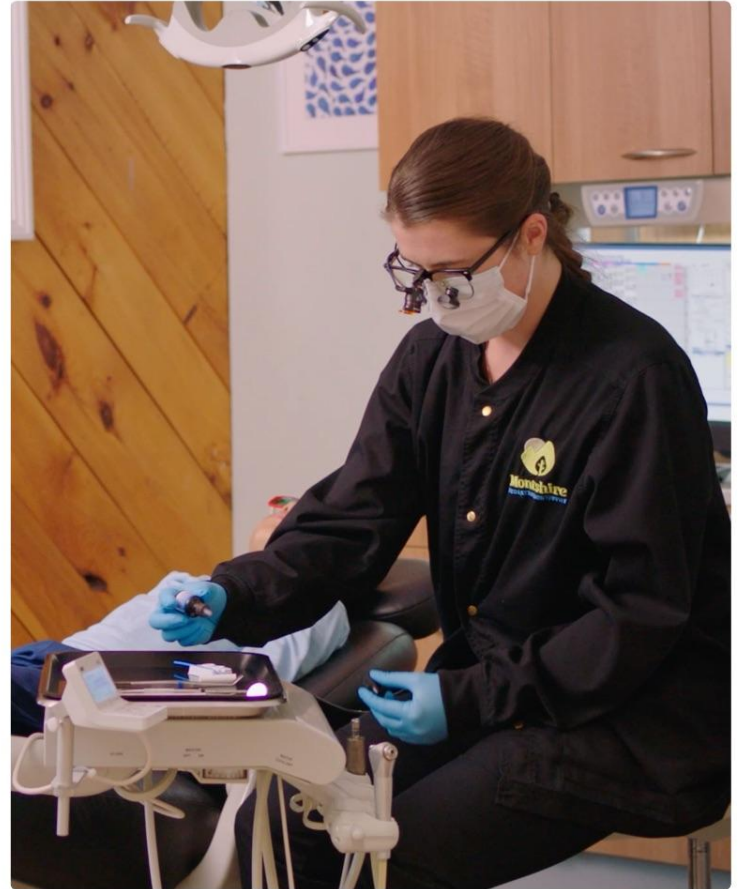
Advantage Arrest Cost = \$0.92 per drop • \$230 per bottle

250 drops in one bottle • One drop can treat 5 teeth

Best case scenario = 250 drops x 5 teeth x \$16.87 = \$21,087.50

Worst case scenario = 250 drops x 1 tooth x \$16.87 = \$4217.50

In 2024 Montshire spent \$21,340 on SDF and we generated \$926,212.53 in revenue (NH, VT, ME reimbursement rates)



Montshire Pediatric Dentistry Outcomes: 2025

Example of MID Treatment Performed

Applications of SDF/PVP-I (D1354)

Keene, NH	20,183	Dublin, NH	3549
Claremont, NH	14,152	Rutland, VT	9182
Sanford, ME	17,141	Brattleboro, VT	8702
Henniker, NH	5165	Portland, ME	5250
Amherst, NH	3845		

TOTAL APPLICATIONS OF SDF:

87,169

ANNUAL EXPENSE FOR SDF:

\$30,784

PRODUCTION GENERATED:

\$2,731,719

ROI:

8770%



Glass Ionomer Cement

Let's Talk Glass

Glass ionomer cement (GIC) was first synthesized in 1965 by Dr. Alan Wilson and Dr. Brian Kent at the British Laboratory of the Government Chemist. The first commercially available GIC was produced in 1975.

Wilson and Kent synthesize glass ionomers by mixing silicate glass with poly-acrylic acid. They establish that the setting mechanism is an acid/base reaction.

GICs are unique among dental materials because they: Release fluoride, Physically and chemically bond to tooth structure, and Adhere to untreated dentine and enamel.

Glass Ionomer Cement

Development

Glass Ionomer really Introduced in 1976

Resin Based

Composite

(GIC)

Glass Ionomer Cement

Inert

Biocompatible

Hydrophobic

Hydrophilic

Micromechanical

Chemical

Photoinitiation

Chemical

Glass Ionomer Cement

GIC

Has been suggested as a chemical delivery device to prevent and treat caries rather than solely as a restorative material (Christensen, 2000)

Ideal for root protection in the elderly as well as coronal protection in the elderly as well as coronal protection on a newly erupted tooth in a child (Forsten, 1994)

Successfully sealed occlusal pits and fissures (Mount 2002) (Mount & Hume, 2005)

Unlike resin-based materials, glass ionomer will chemically bond equally well to both prismatic and aprismatic enamel (Yoshida et al., 2000)

Effects of GIC suggest an anti-cariogenic biofilm is correlated with GICs fluoride release (Chau, Pandit, Cai, Lee, & Jeon, 2015)

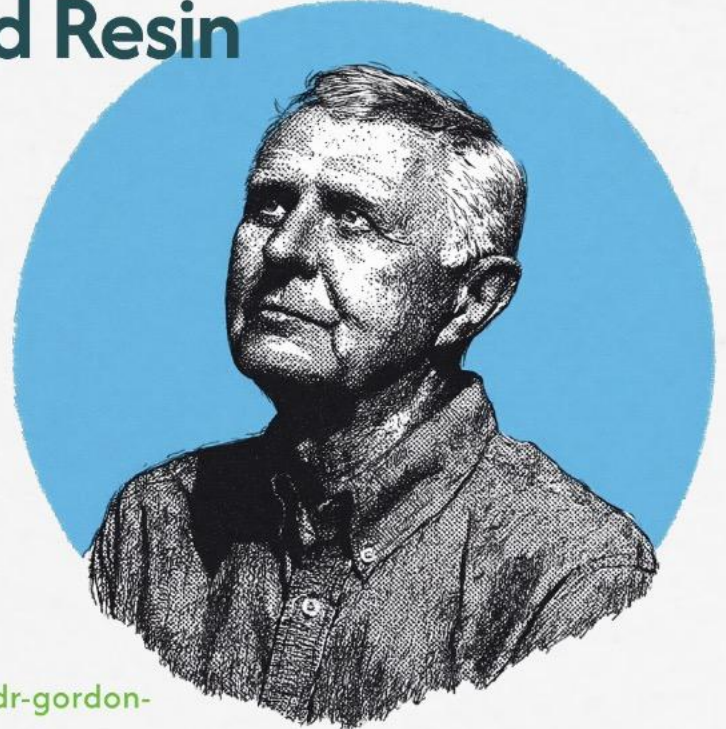


Glass Ionomer Cement

Gordon Christensen: GIC and Resin

"I'm partially responsible for it, but let's say straight forward about whether or not we've really done a wonderful job to throw plastic in everybody's mouth. Amalgam is slightly cariostatic*, composite is, you don't want to hear this, slightly cariogenic."

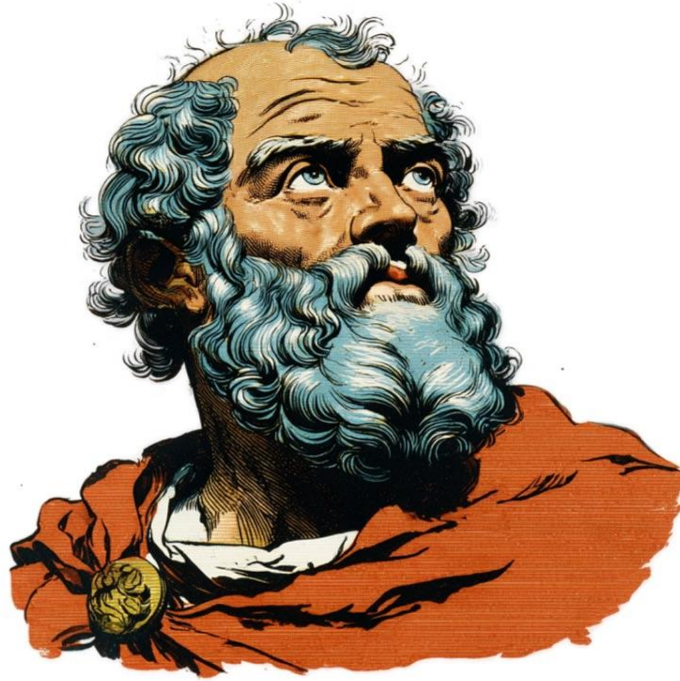
* GIC = Cariostatic



📺 www.youtube.com/watch?v=7g_O25kf5aM

🔊 www.dentaltown.com/blog/post/1902/dentistry-update-with-dr-gordon-christensen-howard-speaks-podcast-45

Starting at 41:45



“ First Do No Harm. ”

— Hippocrates

Montshire Pediatric Dentistry Outcomes: 2025

Example of MID Treatment Performed

Applications of Glass Ionomer Cement

(D2940, D1351, D2391, D2392, D2393, D2394, D2330, D2331, D2332, D2335)

Keene, NH	10,031	Dublin, NH	2080
Claremont, NH	6389	Rutland, VT	4087
Sanford, ME	10,756	Brattleboro, VT	4125
Henniker, NH	3120	Portland, ME	6563
Amherst, NH	2039		

TOTAL APPLICATIONS OF GIC:

49,190

ANNUAL EXPENSE FOR GIC:

\$75,283

REVENUE GENERATED:

\$2,976,231

ROI:

5,950%

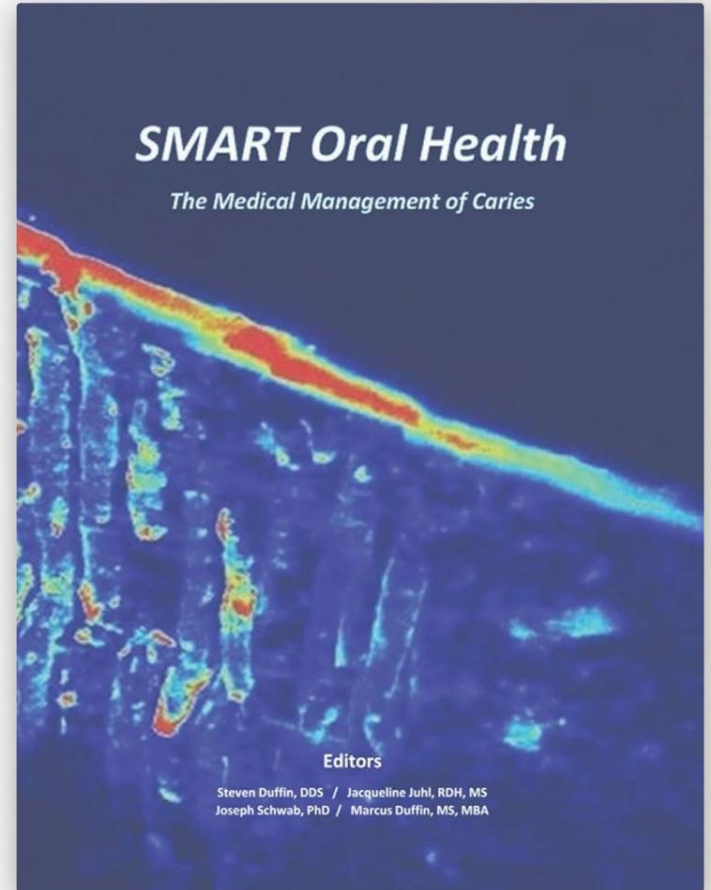
Combination Therapy

SDF + GIC = SMART

“Silver Modified Atraumatic Restorative Technique”

Efficient, Preventative, & low-cost

Anti-microbial and remineralizing effects of
GIC/RMGI



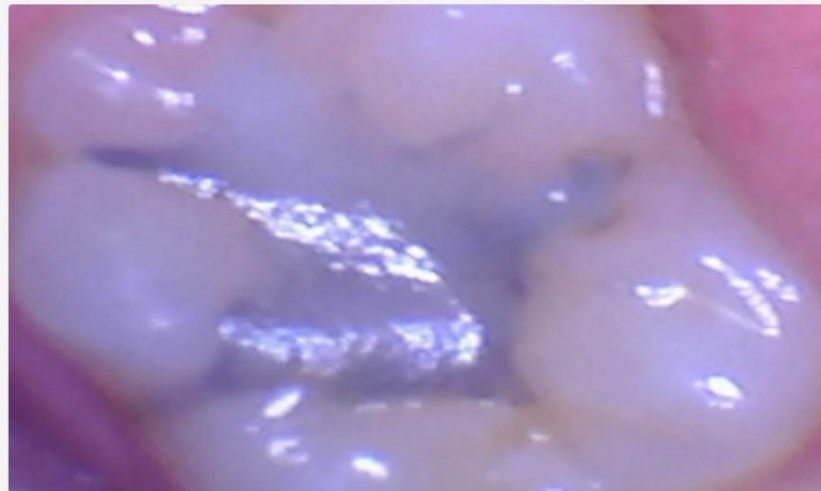
SMART

SMART Case Study - 1

Michelle Pinders RDH, CPHDH



SMART placed 9/23



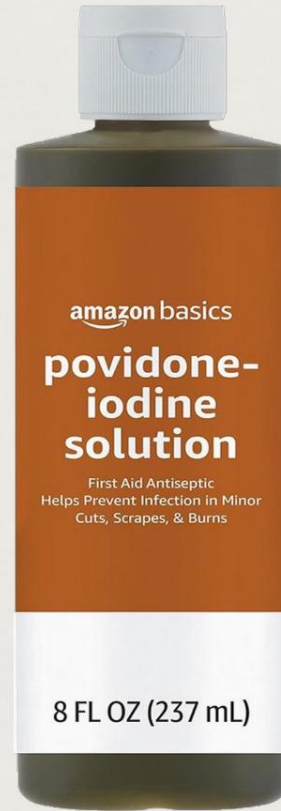
Post OP 5/24



Povidone Iodine

What is it?

Who's heard of it?



Povidone Iodine

Povidone Iodine in Oral Health Care

Being safe, effective, and inexpensive has placed it on the World Health Organization (WHO) List of Essential Medicines. Povidone iodine has a broad spectrum of clinical activity against bacteria, yeasts, parasites, and viruses.

Tanzer concluded that among various dental plaque bacteria iodine differentially targets cariogenic bacteria.

Recently, in vitro studies have elaborated the mechanism of action of povidone iodine to show that at low concentrations it specifically inhibits the extracellular polysaccharide synthesis that is required for both adhesion and niche formation of *S. mutans* and similar cariogenic organisms.



PROFESSIONAL APPLICATION IN THE OFFICE AND DISPENSING TOPICAL POVIDONE IODINE FOR HOME USE TO MANAGE DENTAL CARIES IN CHILDREN AND ADULTS

(Horst and Milgrom)



Apply 10% Povidone-Iodine

for Caries Prevention

1 Dispense



Dispense 8 drops of 10% povidone-iodine.

2 Saturate



Saturate one end of a cotton swab.

3 Dry



Help the patient remove excess saliva. Keep moist. For example ask the patient to swallow, use cotton, or use a saliva ejector.

4 Apply



Roll the swab and push to release more iodine into high risk areas, like contact points and exposed roots.

Note: To avoid too much iodine, **do not re-dip** after applying to teeth.

5 Cover



Continue across all teeth. Keep mouth open for 10 seconds.

Help the patient remove any pooled saliva by swallowing or spitting, or using cotton or a saliva ejector.

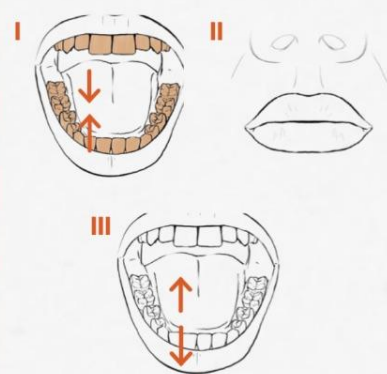


6 Optional fluoride varnish



Fluoride varnish may be applied immediately. Help the patient avoid eating or drinking for 30 minutes.

Myths about Povidone-Iodine



Myth: It stains teeth.

No! The temporary color will disappear after closing. However, it can stain cloth.

Myth: Shellfish allergy = iodine allergy

No! There is **no cross-reactivity** between shellfish and iodine.

Myth: Bad taste

No! A little bit of iodine **does not taste bad**.

A Dispense



Screw the brush together.

B Dry



Ask the patient to swallow. Use gauze or suction to remove excess saliva.

C Squeeze



Squeeze to move the iodine into the brush.

D Apply



Brush on, focusing on high risk areas like contact points and exposed roots.

E Cover



Continue across all teeth. Keep mouth open for 10 seconds.



F Optional fluoride varnish



Fluoride varnish may be applied after 10 seconds. Wait 30 minutes to eat or drink.

Povidone Iodine

PVP-I Case Study - 2



7/09/2024 - 6,7



7/09/2024 - 9, 10



7/09/2024 - 10, 11



7/09/2024 - 27, 28



7/09/2024 - 7, 8, 9, 10, 11



7/09/2024 - 27, 28

Hall Crown

Dr. Norna Hall: Scotland/1980s

Early Controversy - Now 5 RCTs showing Hall to be superior to other methods of managing decay in primary teeth (Innes et., al., 2019)

Generally, Hall crowns have better long-term outcomes with less pain and infection and with less need for replacement compared with standard fillings (Gilchrist et al., 2011)

One study, Hall was shown to provide a 97% success rate (Ludwig, Fontana, Vinson, Platt, & Dean, 2014)

Only CI = Clinical signs and symptoms of irreversible pulpitis or dental abscess



Number of MID Treatments Performed

Previous 12 Months
(Feb 2025 - Jan 2026)



Opened
January 2026

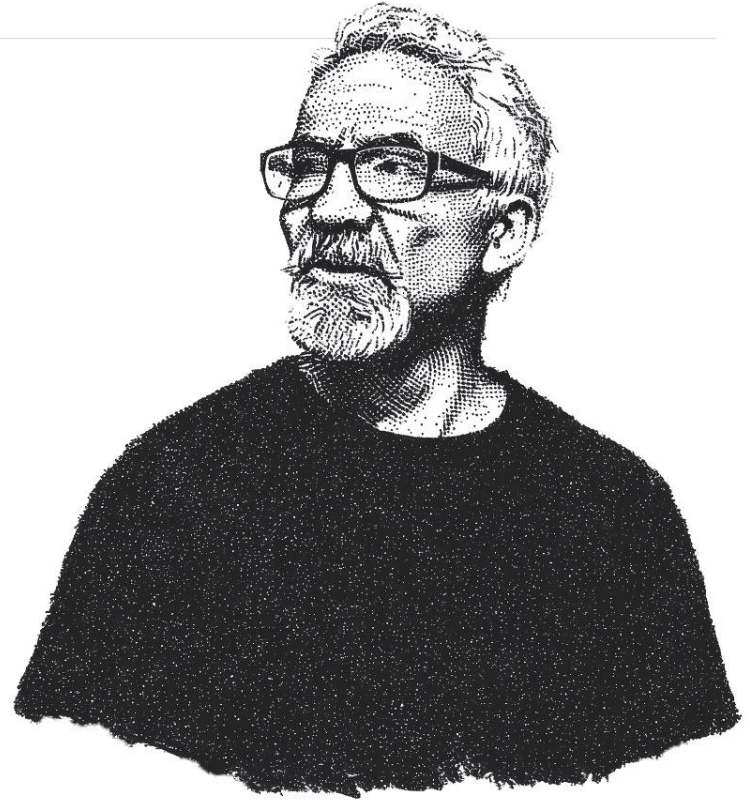
	D1354 (SDF/PVP-I)	D1351 (Sealants)	D2940 (Protective Restoration)	D2930 (Stainless Steel Crown / Hall Technique)
Keene, NH	19,038	7171	2375	1470
Claremont, NH	13,647	3743	2173	673
Sanford, ME	17,074	7615	2977	554
Henniker, NH	5150	2258	672	411
Amherst, NH	3845	1551	388	283
Dublin, NH	3330	1620	417	—
Rutland, VT	9693	2647	1422	427
Brattleboro, VT	9442	2935	1445	307
Portland, ME	6118	5324	1807	405
W Springfield, MA	414	502	54	15
Total	87,751	34,864	13,730	4545

Medical Management of Caries (MMC) Evidence

“System level interventions to reduce utilization of general anesthesia to treat dental caries: a practice brief”, Ludwig, et al, Journal of Public Health Dentistry, 2020. **Conclusion: 70% less general anesthesia necessary with MMC vs. with conventional care across many 0-5 year olds while also treating 6-18 year olds non-invasively.**

“Effectiveness of SDF in arresting caries- oral health related quality of life”, Sirha, et al, Journal Canadian Dent Assoc, 2020. **Conclusion: SDF +FV arrests tooth decay by 96%. (Nothing in dentistry has ever been 96% effective against caries before!)**

“SDF Helps Prevent Emergency Visits in Children with Early Childhood Caries”, Thomas, et al, Pediatric Dentistry, May 2020. **Conclusion: SDF helps reduce ER visits for children with EEC and dental emergencies were approximately 80% lower in the SDF group.**



Courtesy of Dr. John Frachella 🙌

The Model

High-volume, Minimally Invasive

Clinical Efficiency

Redefined Team Roles and Capacity

Operational Efficiency Through Technology

Focus on Patient Experience

The Future of Dental Practice



General Binh		General Laura / Treen		General Sam / Bryden		General Kristen / Hollie	
11y 9m Miller Ortho Extra \$210.60	General Binh Here - --NO ADULT TOOTH EXTRACTI ON --EXAM - Infant HYG: 30mins - Older kids HYG: 40mins - Emergency: 40mins --HALL CROWN - F3 kiddo: 40mins --FILLING - 50mins --EXTRAC TION - baby teeth: 40mins (50mins if F2 kiddo)	Ins1: 8y 1m Dental \$0.00 New Je \$0.00	\$0.00 3y 2m \$ HOW eligible	Ins1: 5y 10m Ins1: CIGNA Does g \$0.00	Ins1: 14y \$0.00 NorHOW Ap Miller Ortho	Ins1: 10y 1m NorHOW Ap DelHOW Ap	
Ins1: N 7y 2m Medica \$0.00 #K-SSCPri \$		Ins1: N 3y 3m Medica \$0.00	Ins1: N 3y 7m Medica \$0.00	Ins1: 10y 10m Medica \$	Ins1: 11y 7m Dental \$0.00 -BW Wilson	Ins1: 12y 0m NorHOW Ap DelHOW Ap	Ins1: 9y 3m NorHOW Ap DelHOW Ap
Referr 7y 9m \$105.00		Ins1: 14y 9m Dental \$0.00 ORT WILSON	Ins1: 16y 4m Dental BW \$157.50	Ins1: N 10y 10m Medica \$	Ins1: \$41.60 Medica \$	Ins1: 6y 4m NorHOW Ap DelHOW Ap	Ins1: 4y 1m NorHOW Ap DelHOW Ap
9y 2m \$0.00		Ins1: 10y 9m NorHOW Ap DelHOW Ap	Ins1: 15y 0m Medica BW \$0.00	Ins1: N \$0.00 Medica \$	Ins1: 13y 3m Medica POE, F \$0.00	Ins1: N 4y 3m Medica \$0.00 -Try OCC a \$	Ins1: 5y 10m Medica \$0.00 -BW \$
Ins1: 5y 10m \$0.00					Ins1: 13y 3m Medica POE, F \$0.00	Ins1: 12y 0m NorHOW Ap DelHOW Ap	Ins1: 12y 0m NorHOW Ap DelHOW Ap
Ins1: Vermont Me \$						Ins1: 12y 0m NorHOW Ap DelHOW Ap	Ins1: 12y 0m NorHOW Ap DelHOW Ap
Staff Meeting			Staff Meeting	Staff Meeting	Staff Meeting	Staff Meeting	Staff Meeting
Team Meeting - Jonny Admin Day			Team Meeting - Jonny Admin Day	Team Meeting - Jonny Admin Day	Team Meeting - Jonny Admin Day	Team Meeting - Jonny Admin Day	Team Meeting - Jonny Admin Day
Ins1: 7y 1m Vermont Medica \$0.00		Last 14y 11m Mon \$388.00 Miller Ortho	Ins1: 12y 1m NorHOW Ap HOW eligible	Ins1: 14y 7m Dental \$0.00	Ins1: 1y 11m Medica \$0.00	Ins1: N 5y 0m Medica -SDF 1 \$0.00	
Ins1: 7y 0m Vermont Medica cl pt p \$0.00		Ins1: 6y 7m Vermont \$0.00	Ins1: 12y 2m Medica POE, \$41.60	Ins1: 11y 2m Medica in full a \$0.00	Ins1: N 8y 9m Medica POE, F \$0.00	Ins1: N 5y 1m Medica BW \$0.00	
Ins1: 1y 11m Medica \$0.00 10/22-Pt ord \$		Ins1: 11y 4m Vermont Medica \$0.00	Ins1: 11y 8m Medica BW \$0.00	Ins1: N 6y 5m Medica \$0.00	Ins1: 14y 10m Medica POE, F \$0.00	General -- SINGLE WITH KRISTEN	
Ins1: 11y 4m Vermont Medica \$0.00		Ins1: 11y 4m HOW eligible Active Miller		Ins1: 13y 1m Medica No xray \$0.00	POE, 10y 0m ProChi \$0.00	Ins1: Age: 18 Medica -Not du \$0.00	
15y 8m Ins1: NH Medica \$0.00		Ins1: M 9y 3m Dental \$6.00			Ins1: 5y 2m NorHOW Ap DelHOW Ap	Ins1: 7y 2m Medica -See h \$0.00	

Quadrant Dentistry vs “The Bundle”

Provide Comprehensive Care

- Trauma care
- Ortho Evaluation
- Extractions
- Space Maintenance
- Caries Management

Clinical Efficiency Evident Chairside

- SDF → 1-2 minutes
- PVP-I → 20-30 seconds
- GIC → 2-3 minutes

Same Day Treatment During Routine Hygiene Visits

- Gentle nature and speed of these treatments allows multiple quadrants to be treated in one visit

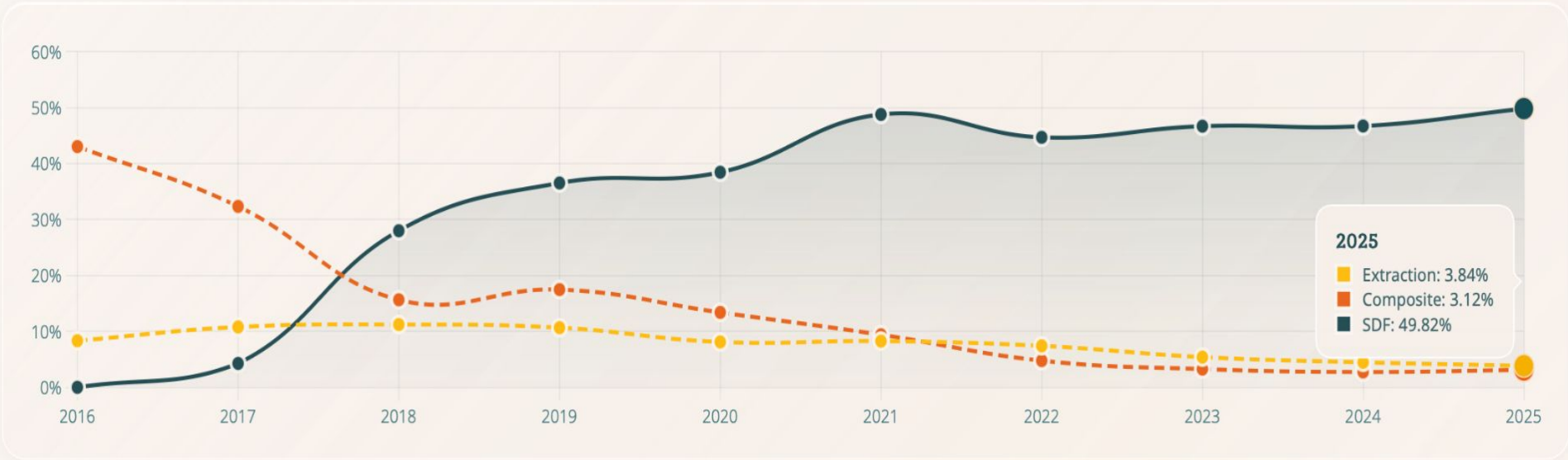


Dental Caries affects 46% of children ages 2- 19
Medical Management creates an outsized impact
on our overall efficiency

This Is What Comprehensive Care Looks Like

Ten years of patient data from our Claremont location shows what a truly comprehensive medicine-first practice actually produces: not fewer treatments, but earlier ones, before the disease progresses far enough to require surgery at all.

— SDF - - - Composite - - - Extraction



SDF introduced in 2017. Composite restorations peaked at 43% of patients seen in 2016. By 2025, SDF reached 49.8% while composites and extractions each fell below 4%.

The Key Players

Dental Hygienists, Assistants,
RNs, NPs, Dental Therapists,
and Doctors

“The heroes”= The team

MMC is within their scope (varying
degrees)

Huge impact



Dental assistant scope of practice varies by state and changes over time. It is your professional responsibility to understand which techniques and procedures are you are legally permitted to perform in your jurisdiction and to stay informed of regulatory updates.

Dental Assistant Scope

Functions delegable to a dental assistant possessing a board-issued permit to perform expanded functions are divided into five (5) categories: restorative I, restorative II, removable prosthodontics, fixed prosthodontics, and orthodontics and are listed below by category.

Restorative I

- Sizing and cementing of prefabricated crowns;
- Placing, condensing, carving, and finishing amalgam for Class I, V, and VI restorations;
- Placing and finishing composite for Class I, V, and VI restorations; and
- Minor palliative care of dental emergencies (place sedative filling).

Restorative II

- Sizing and cementing of prefabricated crowns;
- Placing, condensing, carving, and finishing amalgam for Class I, II, III, IV, V, and VI restorations;
- Placing and finishing composite for Class I, II, III, IV, V, and VI restorations; and
- Minor palliative care of dental emergencies (place sedative filling).

Orthodontics

- Preliminary bending of archwire;
- Removal of orth. bands and bonds;
- Final cementation of any permanent orth. appliance other than bands;
- Making impressions for the fabrication of any orth. or fixed prosthesis/appliance; and
- Placement and cementation of orth. brackets and/or bands.

Prosthodontics – Fixed

- Apply tissue retracting material prior to impression of a fixed prosthesis;
- Extra-oral adjustments of fixed prosthesis;
- Final cementation of any permanent appliance or prosthesis;
- Making impressions for the fabrication of any removable or fixed prosthesis/appliance; and
- Sizing and cementing of prefabricated crowns.

Prosthodontics – Removable

- Placement of temporary soft liners in a removable prosthesis;
- Extra-oral adjustments of removable prosthesis during and after insertion; and
- Making impressions for the fabrication of any removable or fixed prosthesis/appliance.

Dental hygiene scope of practice varies by state and changes over time. It is your professional responsibility to understand which techniques and procedures are you are legally permitted to perform in your jurisdiction and to stay informed of regulatory updates.

Dental Hygienist Scope

Section (3): A hygienist may perform the following procedures under general supervision:

1. Scaling and polishing teeth (prophylaxis);
2. Applying dental sealants;
3. Periodontal root planing, debridement, and curettage;
4. Nonsurgical periodontal procedures;
5. Administering local anesthesia, as outlined in sections (9), (10), and (11) of this rule; and
6. All procedures delegable to a dental assistant or certified dental assistant, except the expanded functions in section (5) of this rule.

Section (4): A hygienist may perform the following procedures under indirect supervision:

1. Administering nitrous oxide analgesia, as outlined in section (8) of this rule;
2. Procedures deemed appropriate by a dentist as outlined in section 332.091, RSMo; and
3. All procedures allowed under general supervision as outlined in section (3) of this rule.

Section (5): A hygienist may perform the following procedures under direct supervision:

1. All procedures allowed under general supervision and indirect supervision as outlined in sections (3) and (4) of this rule; and
2. Expanded functions in 20 CSR 2110-2.120 after receiving a board-approved expanded functions permit issued by the Missouri Dental Board. Neither a Missouri basic skills test nor certification in dental assisting is required for a dental hygienist to take expanded functions courses. The board shall issue the appropriate expanded functions permit upon receipt of a completed application form, payment of the appropriate fee specified in 20 CSR 2110-2.170, and proof that the dental hygienist has completed a board-approved expanded functions training course. The requirements of this section must be completed within one (1) year of the date of submission of the application form. The board-issued expanded functions permit must be displayed in plain view in any facility where the dental hygienist will be providing expanded functions prior to delegation of expanded functions to that dental hygienist. Dental hygienists shall renew expanded functions permits in accordance with the requirements in 20 CSR 2110-2.120. A licensed dental hygienist may use continuing education hours obtained for license renewal to renew an expanded functions permit.

Operational Efficiency Through Scale and Technology

- AI Tools (i.e. OverJet)
- Automated Scheduling and Billing Systems (i.e. NexHealth)
- Teledentistry Tools and Platforms (i.e. MouthWatch)



*Future unlikely to look anywhere near this cool

Montshire Pediatric Dentistry Outcomes: 2018 - 2024

Building Patient Trust Through Better Care

📍 Keene, NH Location

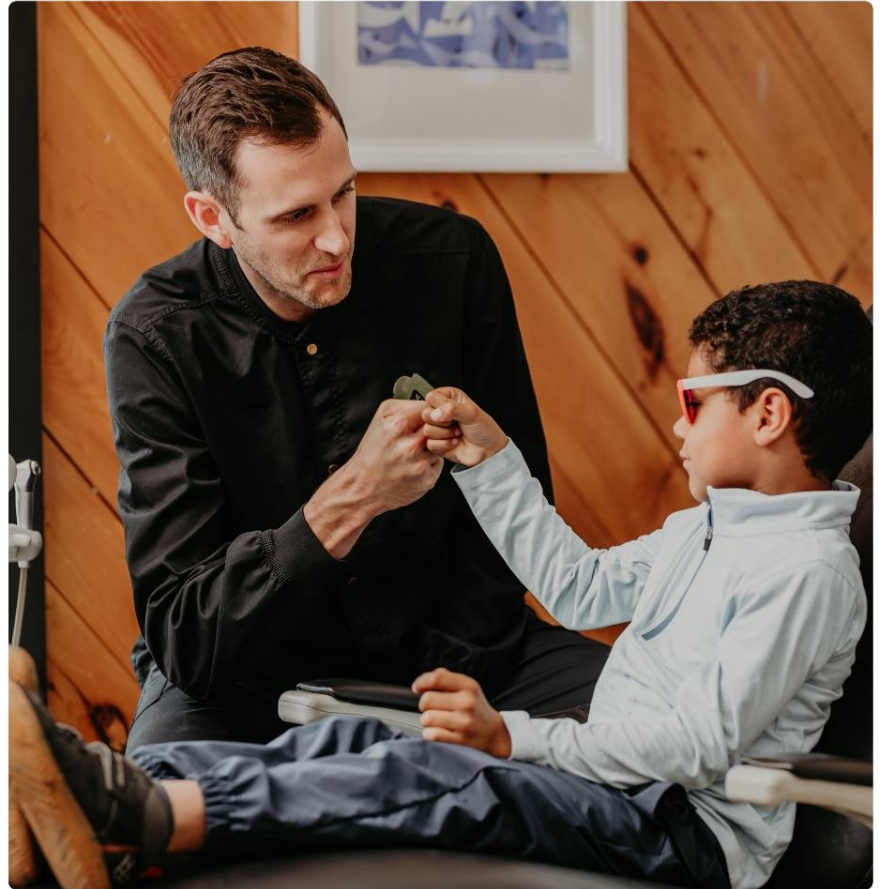
50,695 Scheduled Appointments

49,834 Completed Appointments

861 Broken Appointments

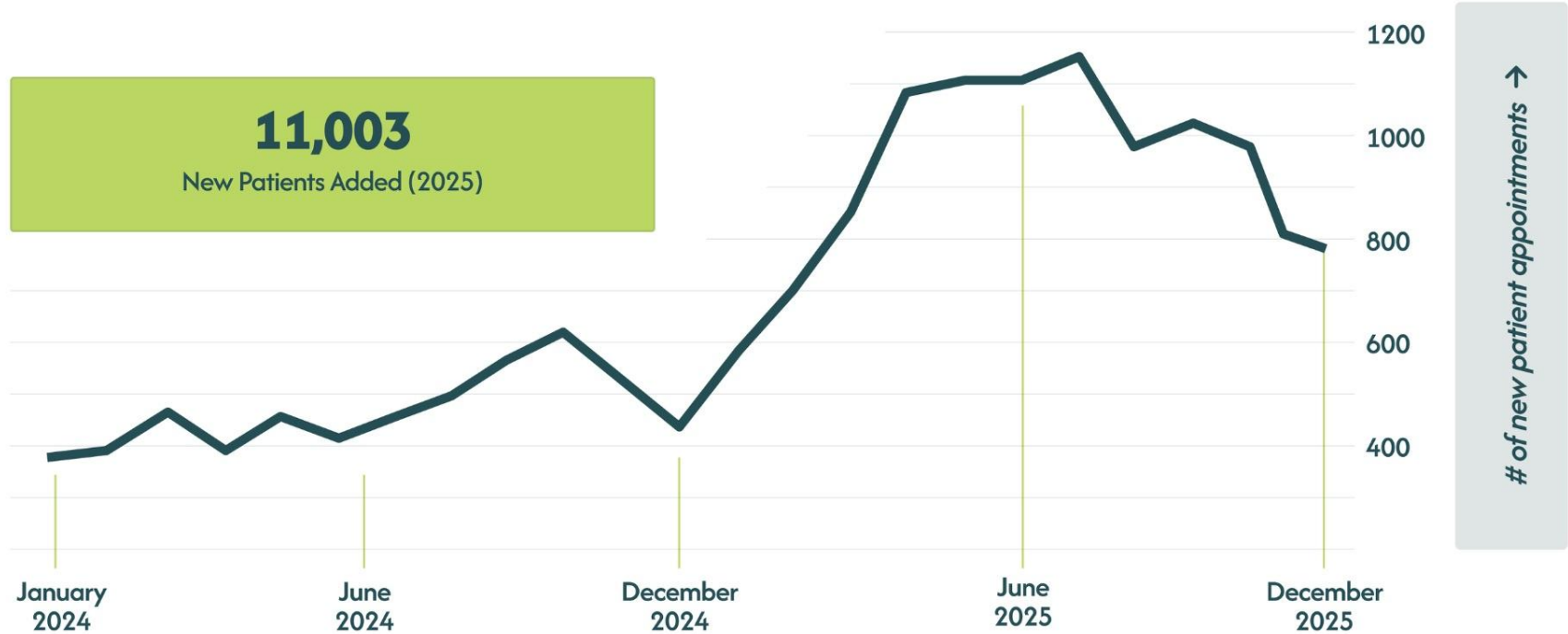
1.7% Broken Appointments / No-Show Rate

When patients feel valued and respected, they commit to their care.



Montshire Pediatric Dentistry Growth: 2024-2025

Number of New Patient Appointments Per Month



Benefits of Minimally Invasive Dentistry

Pain-free treatment, reduced anxiety and trauma: Eliminates need for injections and drilling in 90% of cases that require them in a traditional model

Faster appointments: From hour-long procedures to treatments completed in minutes.

Fewer appointments: Can treat multiple areas in single appointment, many issues can be addressed during routine hygiene visits

Better outcomes: Addresses root cause of disease rather than just symptoms, prevents recurrent decay, and repairs that last longer and assist in natural healing

Cost-effective: Treatments cost a fraction of traditional alternatives

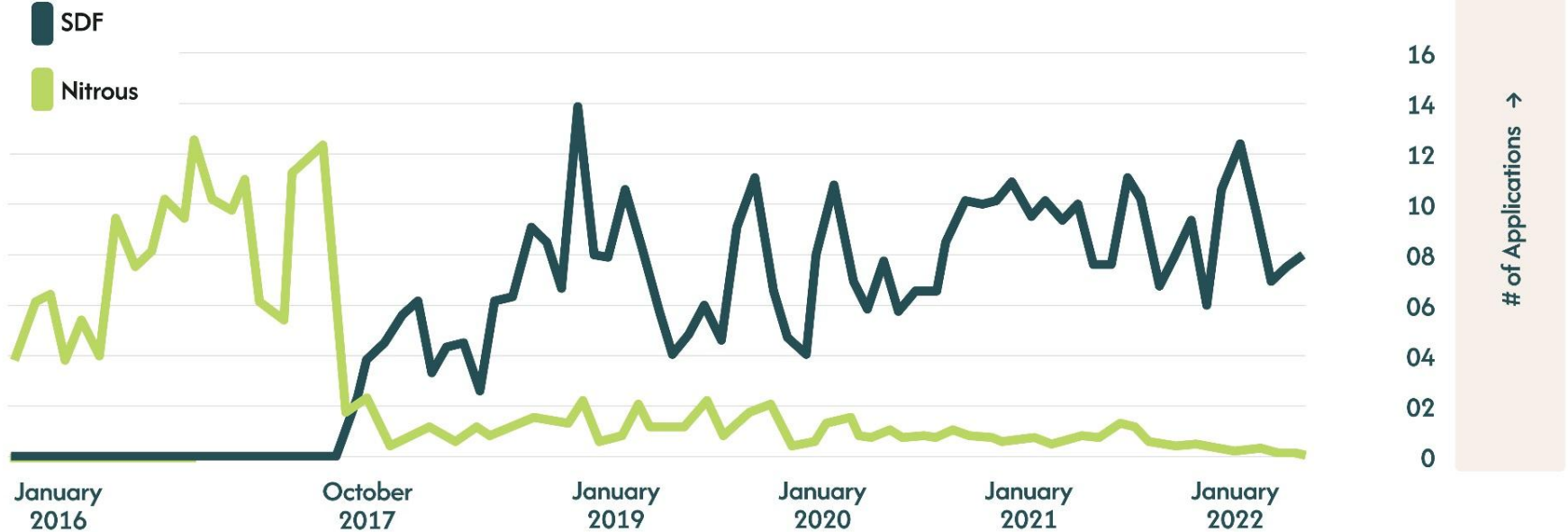
Better utilization of dental team: Allows for Dental Hygienists and Dental Assistants to treat many issues that previously required a dentist (and in a fraction of the time)

Minimally invasive dentistry represents a rare healthcare innovation that benefits everyone: superior patient outcomes independent of insurance status, enhanced efficiency that insurers value, and clinical excellence that has earned endorsement from premier dental institutions and researchers as the new standard of care.



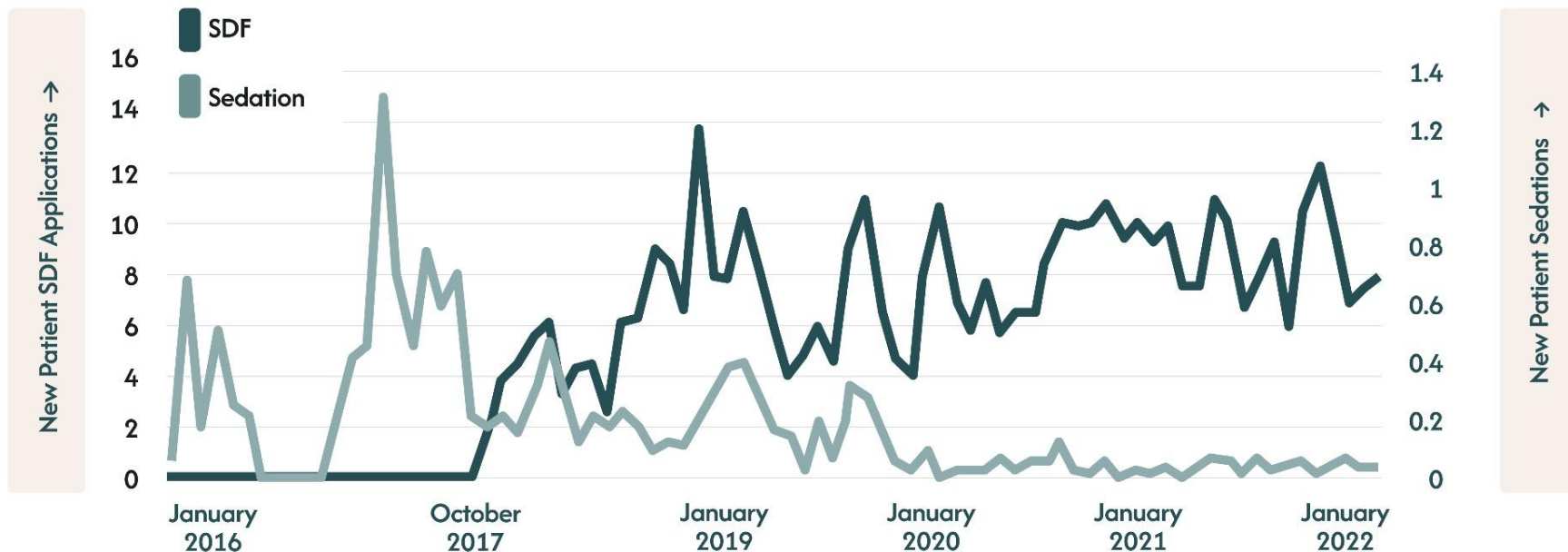
Montshire Pediatric Dentistry Outcomes: 2016-2022

SDF & Decreased Use of N2O



Montshire Pediatric Dentistry Outcomes: 2016-2022

New Patients: SDF & Decreased Sedation



The Investment

How to Transition

Education - Evidence Based

Unwavering Conviction = Trust the Science

Calibration - SOPs

Materials

Equipment

Teledentistry

DeNovo

Acquisition / Conversion



You May Lose Money Transitioning Initially

Form **8879-S**

IRS e-file Signature Authorization for Form 1120S

OMB No. 1545-0123

2018Department of the Treasury
Internal Revenue Service

For calendar year 2018, or tax year beginning _____, 2018, and ending _____.

Name of corporation

Employer identification number

Montshire Pediatric Dentistry, PC

Part I Tax Return Information (Whole dollars only)

1	Gross receipts or sales less returns and allowances (Form 1120S, line 1c)	1	58,284.
2	Gross profit (Form 1120S, line 3)	2	2,149.
3	Ordinary business income (loss) (Form 1120S, line 21)	3	-145,288.
4	Net rental real estate income (loss) (Form 1120S, Schedule K, line 2)	4	
5	Income (loss) reconciliation (Form 1120S, Schedule K, line 18)	5	-145,538.

Part II Declaration and Signature Authorization of Officer (Be sure to get a copy of the corporation's return)

Under penalties of perjury, I declare that I am an officer of the above corporation and that I have examined a copy of the corporation's 2018 electronic income tax return and accompanying schedules and statements and to the best of my knowledge and belief, it is true, correct, and complete. I further declare that the amounts in Part I above are the amounts shown on the copy of the corporation's electronic income tax return. I consent to allow my electronic return originator (ERO), transmitter, or intermediate service provider to send the corporation's return to the IRS and to receive from the IRS (a) an acknowledgement of receipt or reason for rejection of the transmission, (b) the reason for any delay in processing the return or refund, and (c) the date of any refund. If applicable, I authorize the U.S. Treasury and its designated Financial Agent to initiate an electronic funds withdrawal (direct debit) entry to the financial institution account indicated in the tax preparation software for payment of the corporation's federal taxes owed on this return, and the financial institution to debit the entry to this account. To revoke a

But if you do the right thing for the right reason,
the money will follow...

MONTSHIRE PEDIATRIC DENTISTRY PC
Statement of Income and Expenses - Modified Cash Basis
Dec 1-31, 2024

Ordinary Income/Expense	Dec 1-31, 2024		Jan 1-Dec 31, 2024	
		% of Income	(YTD)	% of Income
Income				
Fee for Service	324,658.72	100.08%	4,167,976.17	100.49%
Refunds	-286.38	-.08%	-20,394.86	-.49%
Total Income	324,372.34	100.00%	4,147,581.31	100.00%
Cost of Goods Sold				

Montshire Pediatric Dentistry Outcomes: 2015 - 2024

Better Care Reaches More People

📍 Claremont, NH Location

2015 - 2017

- 1741 Active Patients
- 4.5 Doctor Days

2022 - 2024

- 5599 Active Patients
- 1 Doctor Day

Grew 321% while reducing Doctor time by 78%



Does it work?

Results:

The Oregon model demonstrates sustainability despite capitation rate decreases since 2021, maintaining 40-60% patient utilization. The Northern New England model achieves operational efficiency through high-volume care.

Conclusions:

Practices utilizing minimally invasive techniques, medical management of caries, and population health approaches demonstrate resilience against policy changes and funding cuts. High-volume Medicaid participation enables economies of scale.

Serving Rural Communities, Coping with Medicaid Cuts, and Having a Successful Practice: Case Studies from Oregon and Northern New England

Jonny Norris, DDS, Diplomate ABPD ^a, Mike Shirtcliff, DMD ^b, and Peter Milgrom, DDS ^c

^aMontshire Pediatric Dentistry, Keene, New Hampshire, USA; ^bEquity Dental, Redmond, Oregon, USA; ^cDepartment of Oral Health Sciences, University of Washington, Seattle, Washington, USA

ABSTRACT

Background: Medicaid dental programs face potential challenges with anticipated federal funding cuts. Traditional fee-for-service models have struggled to serve all Medicaid populations effectively.

Case Description: This case study examines two successful dental practice models serving Medicaid populations: Equity Dental in Oregon operating under capitation-based care for 65,000 enrollees across 15 counties, and Montshire Pediatric Dentistry serving 28,000 children across Northern New England, 59% of whom are Medicaid enrollees. Both practices provide minimally invasive dentistry and medical management of dental caries as core strategies.

KNOWLEDGE TRANSFER STATEMENT

These case studies demonstrate that dental practices can successfully serve large Medicaid populations through minimally invasive techniques and medical management of caries. The models provide practical frameworks for improving access to care, reducing treatment costs, and maintaining practice sustainability despite funding challenges. Clinicians can apply these population health approaches to enhance care delivery efficiency while improving patient outcomes and satisfaction across all patient populations.

ARTICLE HISTORY

Received 4 September 2025

Revised 18 November 2025

Accepted 6 February 2026

KEYWORDS

Medicaid dentistry;
minimally invasive dentistry;
medical management of
caries; rural health;
population health; dental
access; capitation; silver
diamine fluoride; case study

Introduction

Medicaid is a state-federal program that is operated at the state level under guidelines established by Congress and with joint funding. By standard measures, whether the practices operate in states with primarily fee-for-service or capitation payment, payments have never been enough and bureaucracy has been problematic. This has resulted in relatively few dentists in each state serving the majority of enrollees. The percentage of dentists who are Medicaid providers masks the reality that few actually see more than a few enrollees in any given year. In Oregon, for example, 30% of citizens are enrolled in Medicaid, but only 12% of dentists in the state care for the entire enrolled population.¹ Similarly, in a 2023–2024 survey conducted by the American Dental Association, two-thirds of New Hampshire dentists reported they had seen a Medicaid patient in the last 12 months while state administrative data showed that only 16% actually saw a beneficiary.² The changes passed by Congress in 2025 and rescissions ordered by the Executive Branch raised new concerns about the viability of

be impacted as the states are forced to adjust to changes in the federal share of funding. Specific provisions that are designed to reduce enrollment include eligibility redeterminations, work/community engagement requirements, and co-pays.

This commentary provides two case studies of established practices serving Medicaid enrollees, who most often live in rural, underserved communities, and their approach to grow and prosper in an era of scarce resources. In both examples, the practices utilize the clinically proven and effective principles of minimal intervention dentistry (MID) and non-operative caries treatment/management/control/care as defined by the Consensus Report of the Organization for Caries Research and the Cariology Research Group of the International Association for Dental Research.⁴ This approach is the key to the practices' success, because it delivers care more efficiently than traditional methods and satisfies both patients and funders.

Discussion

Does it work?

IMPLEMENTING MINIMALLY INVASIVE DENTISTRY IN A CONTEMPORARY PRIVATE PEDIATRIC PRACTICE

Objective: Minimally invasive dentistry has increased across the world. A primary goal is to preserve tooth structure and arrest caries progression. Current evidence suggests that this approach can delay or even avoid the need for advanced dental procedures. For children, these trends are highly relevant. While most work in implementation science examines public health clinics, the objective of this descriptive study was to evaluate a minimally invasive program in a private pediatric practice in the northeastern United States.

Methods: Child-level demographic and visit-level procedure data were collected from Montshire Pediatric Dentistry's electronic health record from August 16, 2018, through June 30, 2025. For each child with one or more clinic visits, every treatment visit was categorized into one of three categories: disease management, restoration, or significant treatment. Children were stratified by their caries subtype classification described by Gormley et al. (2022),

ranging from Class 1 (pit and fissure disease on second primary molars) to Class 5 (lesions on nearly every primary tooth). Summary statistics for continuous variables were described as means and standard deviations (SD) and categorical variables as frequencies and percentages.

Results: A total of 8857 children were included. The mean number of disease management procedures ranged from 6 (SD=5) for Class 1 children to 15 (SD=13) for class 5 children, and the mean number of restorations ranged from 0.26 (SD=0.68) for class 1 patients to 1.91 (SD=2.21) for class 5 patients. Only 4.6% of class 1 children required treatment escalation (mean=661 days after initial treatment) whereas 27% of class 5 children required treatment escalation (mean=652 days after initial treatment).

Conclusions: This minimally invasive treatment program provided children with a successful alternative to treating their dental caries. Fewer than one-quarter of all children required subsequent treatment following disease management. Additional research using implementation science frameworks could scale this model of care delivery.



Objectives

- 1 Educate on the benefits of minimally invasive practices in dentistry.
- 2 Discuss how MID fits into the future landscape of dentistry and healthcare transformation.
- 3 Describe the financial benefits and improved patient outcomes when prioritizing minimally invasive dentistry.



Questions?

feedback@montshirepd.com

Jonny Norris
165 Winchester St, Keene NH 03431
603-354-3895