THE NUGGET
A PUBLICATION OF THE SACRAMENTO DISTRICT DENTAL SOCIETY
MAY 2008

PAY FOR PERFORMANCE

Inside:

Is dental pay for performance on the horizon?

PLUS: Smiles for Kids 2008 — Highlights & Stats

DON'T MISS OUT ON THESE EVENTS!

FOUNDATION NIGHT!

GENERAL MEETING

May 13, 2008 • 6:00pm–9:00pm
Sacramento Hilton — Arden West

What Your Corporate Pharmacy Won't Tell You Today... & Other "Compounding" Concerns!

John C. Richards IV, PharmD
Barbara Dace, PharmD

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- What types of unique products are available to the dental team

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Marcella Oster, RDA & Diane Morgan
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California Dental Practice Act meets the CE requirements for California Dental Practice Act education, discussing information and updates to the Dental Practice Act regulations and other statutory mandates relating to the dental practice.

THESE COURSES REQUIRED FOR 2008/09 LICENSURE RENEWAL

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SDDS GOLF TOURNEY

May 9, 2008
Timber Creek Golf Course
(Roseville, CA)

See insert to sign up!

HR AUDIO CONFERENCE

12:00noon–1:00pm • Register & we will confirm with call-in information

Presented by California Employers Association (CEA)

May 20, 2008

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- Documenting performance — good & bad
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NEED MORE INFO? Fliers for May 2008 Events are available in the center of this issue or online at www.sdds.org. We'll see you there!

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** featured on cover*

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GOLDEN PEN HONORABLE MENTION AWARD

OUTSTANDING COVER AWARD

OVERALL NEWSLETTER AWARD

PRESIDENT'S MESSAGE

EVIDENCE-BASED DENTISTRY

By **Robert D. Shorey, DDS**

Dedicated toward the aim of improving the quality of dentistry there is an international electronic journal titled "Evidenced Based Dentistry." It is founded on the concept of helping us (dental professionals) sift through dental research to comprehend appropriate clinical procedures supported by the compilation of factual peer reviewed studies. I find it particularly interesting that it is an international publication, when you consider the difference of opinion across international lines for dental procedures. I wonder what areas of clinical consensus can be reached with the existing international diversity of thought. Knowing Sweden has banned amalgam; stainless steel inlays are prevalent in Japan and root canal obturation procedures vary throughout the world, there is clear evidence for international variation of teaching and preferred dental procedures. I can only imagine the complexity of assembling a publication seeking the "right" answers; the difficulty of defining the "right" clinical procedures. Would a wonderfully executed amalgam filling be automatically dismissed as poor quality service in such a publication? By the way, what is a "wonderfully executed amalgam" anyway? Is it proper to consider a root canal treated tooth as an implant placeholder?

I can only imagine the complexity of assembling a publication seeking the "right" answers.

Within the discussion of evidence based dentistry, there is a fundamental discussion about quality dentistry. Seeking answers often involves breaking the problem down into smaller elements. In this case we might start with the definition of quality. A consumer definition might be, "The quality of a product or service refers to the perception of the degree to which the product or service meets the customer's expectations." A technical scientific definition might be, "The degree of non-conformity of a product or service to its ideal specifications." The first question might be which definition to use; or whether both or neither may apply to dental services. Several things become evident to me as I examine these definitions: Who is the customer and what is the appropriate weight given to his/her perception? Is the customer the patient, an insurance company or our peers? When we speak about conformity we might examine how stridently relevant such a concept is to the human condition, as we realize the variations in mankind of our anatomy and individual psychology.

Our profession has always been concerned about and continues to debate and strive to establish fundamentals of quality dental care for the maintenance of optimal oral health. This is a healthy process, but lacking definitive **divine** intervention, this is an ongoing process and a difficult mortal task. As a mortal dentist we might rely on the lessons of those who have preceded us, as I think they still apply. I think they would agree with the following:

The professional journey of dentists is called a "practice" for good reason.

The professional journey of dentists is called a "practice" for good reason. Dentists have a professional obligation to be continual scientists seeking new knowledge and substantiated clinical options. We must always be willing to learn new things and we must be open-minded. Dentistry is currently still a technical human endeavor and comprises elements of **art and science which is both subjective and objective** in its very nature. Character is as important as skill. Character traits of honesty, integrity, pride and thoughtful caring are necessary traits to the delivery of quality dental services. What do you think? *robusc83@inreach.com* ■

FROM THE EDITOR'S DESK

PAY FOR PERFORMANCE

By **James M. McNerney, DMD, FAGD, FACD, FPFA**

"What's that?" was the response I most often got. Mine too, when I first saw it in print. Nevertheless, it is a fairly recent concept in medical reimbursement which will likely be applied in some fashion to dental. Of the three articles which accompany this editorial, Dr. Guay, a dentist, gives a most complete explanation while Dr. Epstein, a physician, both explains and offers a dissenting view. From the latter: "It is hard to dispute the rationale behind realigning payment incentives… to encourage higher quality and more efficient care." On the other hand: "Because the rationale behind pay for performance is so compelling, it may seem surprising that the evidence base… is thin." The third article, on a different but relevant subject, by Dr. Chambers appeared in the *Journal of the American College of Dentists.*

Why is this happening now? Probably it is just a natural evolution in the tweaking of the reimbursement process due to the conflict between two opposing forces, such as Democrat vs. Republican. Here we have fee for service which, un-monitored, has a tendency to reward greed, against capitation/salary which, left to its own devices, can reward sloth. Here speaking is an insurance actuary:

"In the fee-for-service world, we rewarded time and activity. The system penalized initiatives that would reduce the intensity or length of healthcare. Then we moved to capitation, which rewarded efficiency but didn't reward for innovation or systems requiring additional revenue. We also had the staff model, which used salary. This really made it stable but did nothing for over- or under-utilization. On a salary, providers became sort of bureaucratic, which discouraged innovation. Current providers don't get rewarded on quality."

Perhaps we ought not to be surprised that such a concept has finally surfaced. To my knowledge, there are no dental schools that grade on a pass-fail system. Full disclosure, time to 'fess up here: I was not an A student. Though able to drill an above-average tooth, I was not one those who "really had the hands." Consequently, after my Air Force time, I never really expected to be compensated at the highest end of the scale: be happy with Bs, disappointed with Cs, try to avoid Ds and Fs. My neighbor is a finish carpenter by trade who is capable of fabricating cabinets and other objects of wood that would satisfy even a dentist. I never really appreciated that skill until I attempted to build a stereo case. It was pretty simple, really, except that I wanted something more aesthetic called "dado joints." I had the full Mather AFB wood shop at my disposal, including expert docent craftsmen. Still, the shelves had large and quite noticeable gaps… "open margins," if you will. However, the item has remained functional after all this time.

So what of the difference in skill? Does an "A" margin crown last longer than a mere "pass?" Aesthetics aside, does it really matter except to us? Note that pay for performance links quality to outcomes. This is an insurance-driven concept which can only work at all because it is those insurance entities which have the very large databases to track the large sample sizes which are needed to overcome individual variations. Your John and Mary Does won't brush their teeth so their crowns get recurrent decay; is that your fault? No, of course not; even Frank Spear could have that problem. So an individual dentist could not even be looked at until he or she had a significant number of procedures on file. Does this seem oppressive, even Orwellian? As a solo "private practitioner," I could think so. However, in my Air Force experience, we were subject to constant peer review: records were reviewed monthly, questionable outcomes were actually looked at in vivo. Those of us who have experience as part of third-party payers can attest to the fact that not every doctor is a saint. Did you have any idea, for example, that there are practitioners among us holding valid current dental licenses who routinely replace perfectly functional crowns that they themselves have placed and do so every five years whether they need it or not? Why is that? My own experience as a member of our Peer Review committee revealed that untoward events were almost never intentional. For the individual dentist, especially a young one, such an experience early on can be devastating. For most with some longevity under the belt, it falls under the category: "shit happens." Wide experience among many tends to exonerate the innocent while snaring the bad guys.

Whether we will see pay for performance widely implemented in dentistry remains to be experienced. But it's out there, so you might want to be aware of it. ■

Have something to say?

LET'S HEAR IT!

Join the *Nugget* Editorial Committee to help decide the topics covered in future issues of the *Nugget*.

Contact SDDS (446-1227) for more information.

CATHY'S CORNER

RECAP-TO-CAP

By **Cathy B. Levering**
SDDS Executive Director

In early April, I had the great pleasure and honor to represent the small businesses of the Dental Society members at the Sac Metro Chamber's Cap to Cap Trip to Washington, D.C. What a great experience; thank you so much for sending both Dr. Wai Chan and me. Dr. Chan sat on the healthcare committee and I represented small businesses. This trip is the largest chamber of commerce trip in the nation, and many cities are envious of the event, which brings together more than 350 local business owners, city representatives, politicians, educators and experts in their various fields — from the six counties in the Sacramento region.

During this four-day quicktrip, we both met with our local Congressional representatives and their staffs. My small committee of seven business owners met with Congresswoman Doris Matsui *(photo above),* Congressman Dan Lundgren, the senior staffs of Senators Dianne Feinstein and Barbara Boxer, as well as Congressman Wally Herger and the Governor's office in Washington. While my group was lobbying for small business, Dr. Chan's group was addressing healthcare and SCHIP. Other platforms were transportation and air quality issues, flood control and water resources (Dr. Bill Marble represented the Woodland City Council on this issue), Clean and Green technology, workforce development and economic development.

I am happy to report to you that BOTH sides of the aisle were in agreement about the small business issues we brought forth:

1. Americans with Disabilities Act (ADA) compliance issues and inconsistencies; frivolous lawsuits regarding small businesses and ADA compliance
2. Tort reform issues and frivolous lawsuits
3. Small Business Tax Relief
4. Full Funding for the SBA

Small businesses represent approximately 80% of the Sacramento regions' job growth. Our dental society members employ nearly 8000 employees. The Economic Growth and Tax Relief Reconciliation Act of 2001, which is set to sunset in 2011, allows up front deductions for certain qualifying investments. This puts money back in the hands of small business owners so they can hire new workers, circulating more money through the regional economy. Similarly, the Jobs and Growth Act of 2003, which accelerates the income-tax-rate reductions from the 2001 bill, increases small-business-expensing limits, lowers capital-gains and dividend taxes. This is due to sunset as well.

In a short summary (and I will provide more information in the next issue of the *Nugget!*), did you know that, in the new economic stimulus package, you can depreciate 50% of new equipment purchases with no cap? Did you know that you can expense up to $400,000 in new purchases? If not, talk to your CPA — soon!

I met many wonderful people on this trip. I was honored to be a big part of the small business community of Sacramento. And, proudly, I am the third generation of my family to attend Cap to Cap – all representing small business! ■

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Special to the ADA News

UNDERSTANDING PAY FOR PERFORMANCE

By **Albert H. Guay, DMD**

Health care costs in the United States are among the highest in the industrialized nations of the world, while the health status of Americans in several areas falls below that of citizens of other nations who spend less. That's the driver for the "spend less and improve the quality of health care" quest by both governmental and private third party payers. We have seen many efforts in the past that attempted to accomplish this, managed care and consumer driven health plans being recent examples.

A new initiative has been introduced with strong backing by the federal government that, if successful, will have a major impact on the delivery of dental care; an impact far beyond that which is evident at a casual glance. This initiative is called pay for performance (P4P) — a reimbursement plan built upon the philosophy that those who perform well should be reimbursed more than those who perform at a lower level.

More than 100 health plans and some dental benefit plans across the nation have introduced pay for performance reimbursement incentive programs under a variety of names and with varying provisions. In some cases, consortia of insurers with P4P programs have been formed to pool data and to study the effects of those incentives on the cost and the quality of care.

The U.S. government, as the largest purchaser of health care in the nation, is actively investigating the implementation of P4P programs for Medicare and Medicaid. Although the exact nature of the programs is not yet known, it is a certainty that some sort of a P4P program will be adopted. It can be assumed that, with such an economically powerful program as Medicare taking the lead, P4P programs will be adopted by most payers.

What is pay for performance?

Pay for performance in health plans is a generic term for programs that provide incentives to providers to meet evidence-based performance criteria in clinical care and who document that care through office management systems that track services provided, patient satisfaction and clinical outcomes. Data from such programs should lead to consumer "value-based purchasing" of health care by differentiating among providers based on the quality of their care and their efficiency of operation.

There are essentially two categories of incentives that have been employed in P4P programs to encourage providers to increase the quality of the services they provide: financial incentives and reputational incentives. Financial incentives provide increased reimbursement for preferred behavior — the "carrot" approach to behavior change. The public release of provider performance data affects the reputation of the provider in the community — the "stick" approach to behavior change.

It can be assumed that, with such an economically powerful program as Medicare taking the lead, P4P programs will be adopted by most payers.

Pay for performance programs have four essential elements, the details of which vary form program to program. Emphasis on any particular element can be an indication of the primary goal of the administrator employing the program. The essential elements are performance measures, data collection, performance targets and performance incentives.

Performance measures

Performance measures for most categories of provider activity have either already been developed or should be fairly easy to develop. Utilization or cost measures are not new, nor are patient satisfaction measures. Patient safety measures (for example, the percentage of patients who were questioned about allergic drug reactions) are easily understood and will probably not be controversial. Administrative efficiency measures are new to health care and will be related to the level of implementation of information technology.

The most difficult area of performance measurement will be in the area of evidence-based clinical quality or the effectiveness of care – meaning outcomes. This area has been the focus of a great deal of activity for many years and one that is rife with controversy. Because of the great variation in patients and the many complications from co-morbidities commonly seen, data individualized to specific patients are not a reliable basis upon which to draw conclusions. Cross-sectional data may be more useful, but only with a very large sample so that patient variations cancel each other out.

Measures of clinical outcomes must be developed by providers, or at least with provider input, in order to be valid, reasonable and acceptable to the practitioner community. Interpretation of the outcomes' measures should also be done by practitioners or under practitioner supervision. The American Medical Association Physician Consortium for Performance Improvement has developed almost 100 performance measures that are now in use in physicians' offices and in government P4P demonstration projects.

Data collection

In order to facilitate the process, data collection should be easily accomplished with a minimum of effort and cost on the part of practitioners. Claim forms and the administrative data generated by the plan administrator provide the lease intrusive method of generating data, but they may not provide data adequate for the purposes of administering P4P programs. Encounter forms completed at the time of service can provide a greater depth of data, but require

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PAY FOR PERFORMANCE AT THE TIPPING POINT

By **Arnold M. Epstein, MD**

It is hard to dispute the rationale behind realigning payment incentives in health care to encourage higher quality and more efficient care. Indeed, across the country and beyond, the number of "pay for performance" programs, as such realignment is called, has reached a tipping point. In the United States, more than half the health maintenance organizations (HMOs) in the private sector have now initiated such programs, covering more than 80% of the country's HMO enrollees. Congress has mandated that the Center for Medicare and Medicaid Services (CMS) develop plans to introduce a pay-for-performance program in Medicare. The British have gone a league further, introducing their own version of pay for performance that puts 25 to 30% of the income of family practitioners at stake.

Because the rationale behind pay for performance is so compelling, it may seem surprising that the evidence base linking such programs to a better quality of care is thin (at least, according to two recent review articles). Most previous studies have looked at incentives to physicians and medical groups. The data showing efficacy are inconsistent, and some studies have revealed unintended effects, such as improvement in documentation without much change in the underlying quality of care. Only one previous study examined cost-effectiveness.

Given this dearth of solid evidence, it seems apt to compare our adoption of pay for performance with our adoption of new surgical procedures or medical therapies. Many of my clinical colleagues would insist on hard evidence documenting efficacy before endorsing a new therapeutic approach. They cite sobering stories of what can happen when we introduce new approaches prematurely. Consider, for example, the numerous surgical procedures or medical therapies — including radical mastectomy for women with early-stage breast cancer and hormone-replacement therapy for postmenopausal women — that were diffused widely before solid evidence of their relative efficacy was available, only for us to learn later that they were, at best, no more effective than alternative therapies, or, at worst, harmful. If pay for performance were a therapy, its rapid diffusion thus far would have to be considered premature.

The study by Lindenauer et al. in this issue of the *Journal [New England Journal of Medicine]* begins to address this information gap on pay for performance. The authors report the initial results of a three-year program in which more than 200 hospitals participating in a quality-benchmarking database maintained by Premier volunteered for a Medicare demonstration in which payments would be allocated partially on the basis of quality performance. Hospitals performing in the top decile received a 2% increment in Medicare payments, whereas hospitals in the second decile received a 1% increment. Hospitals that underperformed by failing to exceed the performance of hospitals in the lowest two deciles (as established during the program's first year) were liable for a 1% or 2% financial penalty in the third year.

> *If "pay for performance" were a therapy, its rapid diffusion thus far would have to be considered premature.*

Lindenauer et al. matched these hospitals with 406 hospitals that were providing the CMS with a subgroup of the same quality-performance data. The latter data were intended for public reporting but no for additional payments. The pay-for-performance hospitals showed significantly greater improvement than the hospitals that engaged in public reporting alone. However, after adjustments for confounders, the overall differential was only 2.9%, and that number probably overestimates the effect of the program, since the participating hospitals were a self-selected group whose administrators probably thought their performance would exceed the payment threshold.

Besides gauging the effect of pay for performance, the study by Lindenauer et al. also challenges the leading rationale for providing financial incentives. For years we have assumed that rewarding higher quality with higher payments directly motivates physicians and hospitals to invest in personnel and systems to improve the quality of care. However, the data from this study suggest that the causal chain may be more complicated. If gaining financial reward were indeed the primary impetus for hospitals to improve performance, one might expect that pay for performance would have its largest effect relative to public reporting in the hospitals with the best chance of rising above the quality threshold (i.e., those in quintiles one and two). One might also expect the smallest relative improvement in hospitals that are farthest away from the threshold (in quintile five). However, the study by Lindenauer et al. does not show such patterns. Perhaps the findings are idiosyncratic, reflecting the low level of payments, the voluntary nature of the Premier demonstration, or the penalty that low-performing hospitals potentially suffer in year three. However, at least one other similar study also showed behavior equally incompatible with expectations. Perhaps the explanation is that improvements in quality performance are easier to make at the low end and that the additional attention that financial rewards draw to performance catalyzes professional ethos. These explanations, if true, would be good news for those who are concerned about budget constraints undermining pay-for-performance programs.

Because of the federal sponsorship of this study and the vast resources required to

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HOVEY-BEARD

By **David W. Chambers, EdM, MBA, PhD, FACD**

Alex Bavelas is the father of marketing research. He invented the focus group and successfully launched instant coffee after its initial stillbirth. One of the companies Bavelas consulted for, or at least knew in detail, was Hovey and Beard, a small outfit in the rural South that manufactured wooden children's toys. The case study he developed became a staple in MBA programs. (I used it for years when I taught.)

Here is the general outline of the case. The company targeted its semi-automated painting function for improvement. Teams of about a dozen women worked in a shed where an endless loop chain brought nearly finished toys along. The women removed a toy, spray painted it according to a predetermined pattern and placed it back on the chain to be transported into the dryer. A team of quality control engineers studied the process and established an optimal chain speed. A pay incentive plan was put in place to reward the women for exceeding the target rate. (At this point in the case, as Bavelas wrote it, students are invited to discuss what they thought might happen next. You might want to try your own hand.)

The women grumbled quite a bit. Because the bonus was limited by the speed of the chain, some wanted to be able to control it themselves. Their biggest gripe was about the heat in the shed, and they wanted some fans installed. Productivity dropped slightly and management regarded the grumbling, especially the part about fans, as a dodge. A foreman who had only nominal involvement in the painting function became a spokesman for the women. He requisitioned a few fans and conducted some experiments after hours to determine that a quicker pace could be maintained without a drop in quality. Armed with these data, the women and the foreman convinced management to allow a general experiment. A rheostat was installed that allowed the head lady to vary the speed of the chain. (Now, what do you think happened?)

The women varied the speed of the chain according to a schedule they established themselves. At the beginning of the morning and afternoon shifts, the chain ran "slow." Near breaks and at the end of the day it was set on the "normal" setting. The rest of the time it ran hot. Quality was not an issue; morale was high. Virtually all of the women qualified for the highest level of bonus established under the original plan and were actually making as much money as some of the men working in other operations at the company. The productivity from the operation put the Hovey and Beard Company in the black economically for the first time in years. (At this point a good teacher in an MBA course is able to develop with his or her students many lessons about group incentive programs, work design, decentralization and worker control of processes, management responsiveness and the importance of the work environment. Then, the question becomes what happened next. Here is what Bavalus reported.)

Success is suspicious, or even intolerable, if it is not achieved by the correct means or by the right people.

The foreman was summarily fired. The chain was reset to the original pace. All of the women quit, over a period of a few weeks, and turnover remained high thereafter. Productivity lapsed to the level before any innovations were attempted, and Hovey-Beard continued to lose money until it folded in bankruptcy.

Success is suspicious, or even intolerable, if it is not achieved by the correct means or by the right people. That is the Hovey-Beard effect. When people say they would be happy if a groups of patients could be served, an amount of money raised, or a particular goal accomplished, watch for the unspoken condition that states, "as long as it's done my way."

Here is an example of how the Hovey-Beard effect works in dentistry. Some years ago an experiment was conducted in the clinic at the school where I teach. I believe, and I think most dentists do as well, that there is a benefit in having a small enough group that the dentist in charge feels responsible for patients. Size matters. Two groups of twelve students, instead of forty, were randomly selected and, based on faculty nominations, the best teacher in school was assigned to one group and the worse teacher to the other. There was nothing else done to promote quality of care other than telling the two faculty members that they were responsible and that we would be measuring four outcomes: (a) financial productivity, (b) educational accomplishment, (c) patient satisfaction and (d) improvements in patient health. Dental health was measured by a few quick indices such as number of untreated carious teeth, periodontal condition, number of unopposed teeth, etc.

After six months the results showed a great success: satisfaction and learning up, measured improvements in patient oral health. And 8% better clinical income compared to other students in the general clinic — and that was for the worst teacher's group. The results among the best teacher's students were about half again as good all around. (Now, in the spirit of an Alex Bavelas sequential case, can you guess what happened next?)

The results were greeted with scorn. They were labels as "inaccurate examples of the 'new math' " by a top administrator in a public memo. Following several meetings to review the data in detail, the administrator accepted the outcomes as valid, but no corrective memo was ever sent and the project has never surfaced again.

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AFTERTHOUGHTS FOLLOWING BY-PASS SURGERY

3 Days Post-Op

By **Bevan M. Richardson, DDS**

Now that I am on the other end of cardio-vascular surgery (a four way, coronary artery by-pass, as it turned out) I think I would have written my previous history (April 2008 *Nugget*), a little differently. But, rather than re-write that history, "most" of which would remain unchanged, here are my more current thoughts, post surgery, on the whole experience.

I went into the hospital at 5:30am on Monday morning. For the next three days I couldn't help but think this was a big mistake. What could I have been thinking? I spent two days in the ICU, and then three days in the Sutter Telemetry Unit. Being in the hospital is no fun. Although I met an army of wonderful, dedicated people (who I hope I never see again), coming out of that environment gave me a sense of overwhelming relief.

By 7:30 on Monday, I was being wheeled down the hallway on a gurney. Entering the Surgical arena, I was introduced to many of the attending staff and surgeons. My very next recollection was in the ICU with a tube coming out of my throat, another tube coming out of my chest, some significant discomfort almost everywhere above the waist and an offer for "more morphine." *Gladly*. Four and one half hours had passed. I have very fuzzy recollections of the ICU but removing the chest tube was unforgettable. I had at least four RN's in the ICU, each one of them exceptional in their focus and attention to detail. They worked in a twelve hour shift. Each RN had the responsibility of one patient full time.

Since one isn't an intensive care patient for long, I was eventually transferred to what is referred to as the telemetry unit. In telemetry I had a room-mate. In this unit each RN had two rooms and it appeared that four patients provided a full time job for our RN. In the telemetry unit each patient is attached by electrodes to a pocket sized transmitter. This provides a constant feed of electronic information to a central location where records are being made, supervision is occurring and decisions are made. If something goes wrong, lots of people are alerted simultaneously and action can be coordinated. While in this unit my attitude was adjusted from "having made a big mistake" to "maybe I just should have waited a little while longer." Of course my room-mate, who is just a couple of years older than I, had waited. He got there on the previous Friday, was still there when I left, was much more incapacitated, was the recipient of several visits from telemetry central and is probably still there today, three days after my release.

It appears that they don't want you to sleep in the hospital. There are several teams that seem to spring into action if telemetry central thinks you are sleeping. One specialist takes your vitals every 12 hours. Another team comes in and takes a blood sample every day. Another team appears with pulmonary re-conditioning therapy every 6 hours. Then there is the exercise therapist, better known as the Drill Instructor, at least twice a day. During all of this time the RN is coming and going constantly checking your oxygen infusion, lung volume, measuring your fluid out-go, and recording everything. Three times a day a meal is delivered. Not bad food, but who's interested?

They always enter with a healthy "Good Morning," as if 2:00am or 11:00pm is morning. Upon leaving the staff would often forget to turn off the light, or close the door. Since the hallway was a pretty good representation of Interstate 80 at rush hour, there wasn't a whole lot of sleeping going on anyway. By Thursday, I wasn't sure I felt well enough to accept a release, but by Friday I was convinced that a good sleep was more of what my body needed than anything. When offered, I signed the early release papers that had been issued as a result of my good behavior.

So now in retrospect, would I do this again without first having a serious indicator? Considering all of the pros and cons, "probably." Post-operatively, I have significant pain in my chest which really registers high when I cough. The finger tips on my right hand have been numb ever since I came out of surgery. This is probably due to a constraining device that was too tight. The hope is that this numb feeling will resolve itself. Surgery left a major footprint in my chest. Muscle beach will never be the same.

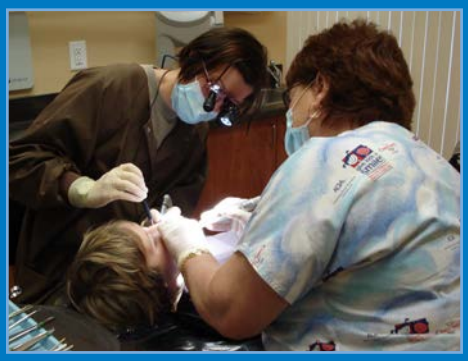
There is an anticipated recovery time. The first cardiologist said I would need to take three months off. The surgeon said, "Aw, that's what state workers do. I recommend two months. Some self employed people try to go back after six weeks, but I recommend two months." In that first couple of days I was thinking three months wouldn't be enough. Now I'm thinking the two months will be good enough. We'll see how this is going as I approach the six week mark. Hopefully, by then, the right hand fingers will resolve themselves. I use them quite a lot in the work that I do.

Other post-op issues: When you go on the heart lung machine, your lungs collapse. After four hours they are somewhat dehydrated and almost non-functional. We measured lung volume prior to surgery and soon after. After surgery I was functioning at below 20% of my normal lung volume. I am now up to 30%. A walk of twenty yards is a long walk. I expect to see gradual improvement over the next few weeks. Also, I have a few TMJ issues that I have not experienced in the past. I hope to see these resolve also.

I came out fast because I was young and healthy going in. I had not suffered any long term damage to the heart muscle, nor even any short term damage. Best of all, I hadn't died before making this decision. Had I waited, the outcome could have been much worse in a variety of ways. The fact is, none of the choices I had were very good. For everyone else, I would say, "It would be good to know your choices." How can you make choices if you don't know what they are? In fact, that's what I always tell my patients when I refer them to a specialist. ■

Smiles for Kids 2008

FEBRUARY 2, 2008



Smiles for Kids gives me an opportunity to give something to a child in need. I have been participating in this event for four years and every year it touches my heart in a special way. The children I have met during this event are truly grateful for the care they receive. Each year I adopt at least two children and they never miss an appointment. I look forward to next year.

Julianne Digiorno, DDS, RD

The Smiles for Kids Event was a pleasing and memorable experience! It was fantastic giving back to children who needed dental care! Pure Dentistry was able to provide the children with dental education and getting back to great oral health! I am grateful to have been a part of this amazing event. It brought me a sense of warmth and peace giving back to the community! Thank you!

Connie (Practice Admin, Pure Dentistry)

It is the Super Bowl for our uninsured kids ... it's been on Super Bowl weekend for a few years now. Like the Super Bowl, it has the most impact on game day/ treatment day. All season, countless hours have been devoted to making sure it is a BIG hit... with the kids, of course.

Sang Tran, DDS

We don't have to go to a foreign country to be in the "mission field." 45 children, with their parents, in the reception room all at once, WOW! We have been helping kids like this for 23 years. Our staff works harder than ever on this day, donating their time and loving it. We are so proud of our giving staff, doing and feeling good about helping the children right in our community."

Ron Ask, DDS

Smiles for Kids is a tradition in our office. It is the one day of the year when you open-up your dental doors simply to help others. There is a fun, party atmosphere that develops because we are all there serving the special needs of children who might not otherwise be treated. Many of these little ones are in pain and have been for a while. You supply a little of your professional skills and make these guest patients feel better. The rewards are immediate to all concerned. Along the way you meet some nice people and make new friends. Everybody wins! I love it.

Jan Work, DDS

Our office has been involved with Smiles for Kids and a program similar for 23 years. This is such a rewarding time for all of us, giving us the opportunity to give back to our community. We are making an impact one child at a time. It is very exciting to go beyond screenings, by providing restorations, orthodontic treatment, oral surgery etc. Thank you for all the dentists and their staffs who have made this possible. Also, let's invite other dentists and teams to make this even larger next year.

Craig Kinzer, DDS

SMILES FOR KIDS 2008 STATISTICS

Over 350 doctors participated — 27% of our membership!

FALL 2007 SCREENINGS

21,000+ kids screened

55+ DOCTORS DID SCREENINGS

SFK DAY TREATMENT SITES

803 kids scheduled for treatment

99 doctors volunteered

326 staff and other volunteers worked

425 TOTAL VOLUNTEERS

28 treatment sites in **31** private offices

ADOPT-A-KID PROGRAM

302 kids referred for GP treatment

60 kids referred to Ortho Program

95 kids referred to other specialities

457 total Adopt-a-Kid cases

204 total doctors volunteered to take Adopt-a-Kid cases

SFK DAY (February 2, 2008)

Total # of kids scheduled	803
Total % of "no shows" *(great improvement!)*	18%
Total # of "walk-ins"	31
Total # of kids treated	691
Total % of kids needing additional treatment through the Adopt-a-Kid Program	76%
Total dollar value of pro bono services donated on SFK day	$314,078

ADOPT-A-KID

Dollar value of pro bono services donated to Adopt-a-Kid Program cases (estimate — NOT FINAL*)	$260,000
Dollar value of pro bono services donated to Ortho Program cases (estimate — NOT FINAL*)	$334,750
Estimated total dollar value of pro bono services donated to 2008 Adopt-a-Kid & Ortho Programs (NOT FINAL*)	**$594,000+**

*FINAL NUMBERS AVAILABLE JUNE 30, 2008

TOTAL DOLLAR VALUE OF DENTAL CARE FROM ALL SOURCES: $908,000+*

THANK YOU TO OUR GENEROUS SMILES FOR KIDS 2008 SPONSORS

Sierra Health Foundation

Cover the Kids — First 5 Sacramento

Rotary Club of Sacramento

CDA Foundation

Patterson Dental Supply

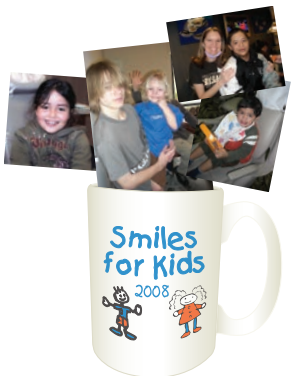
Henry Schein Dental — Corporate

Rotary Club of Roseville • Sacramento Regional Community Fund (Knapp Fund & Give Something Back Fund)

THANK YOU TO THE FOLLOWING FOR THEIR GRACIOUS DONATIONS:

Bel Air — *Arden & Eastern*
Blue Northern Builders — *Marc Davis*
CDA — *Molly Woodward*
CSUS Pre-Dental Club — *Project Backpack*
Dentsply North America — *Jason Imrie*
diSeta, LLC — *Paige Chatfield*
GC America — *Lauren Chavez*
Noah's Bagels — *Fair Oaks*
Nugget Market — *Greenhaven*
Pro2 — *Thuy Tran*
Procter & Gamble — *Sherrie Everhart*
Safeway — *Jackson*
Starbuck's Coffee — *Elk Grove*
Sullivan-Schein — *Chuck Coppage*
Ultradent — *Christina Vetter*

THANK YOU TO ALL WHO MADE CONTRIBUTIONS OR RAN AS TEAM SFK IN THE 2007 CALIFORNIA INTERNATIONAL MARATHON!



OUR CUPS RUNNETH OVER WITH SMILES!

Thanks to all (425 TOTAL VOLUNTEERS!) who volunteered their time to make this year's Smiles for Kids project a huge success!

** Volunteered their office for Smiles for Kids Day*

SFK DAY VOLUNTEER DOCS

Kreston Anderson, DDS*
Ron Ask, DDS*
Andrea Azevedo, DDS
Matt Campbell, DDS
Christopher Cantrell, DMD*
Adrian Carrington, DDS*
Erin Carson, DDS
David Cernik, DDS*
Andrea Cervantes, DDS
Christopher Chan, DDS*
David Crippen, DDS
G. Curtis Croft, DDS
Jaime Curtis, DDS
Bob Daby, DDS*
Jerome Daby, DDS
Jennifer Datwyler, DMD
Paul Denzler, DDS*
Anthony Digiorno, DDS*
Julianne Digiorno, DDS*
Shaina DiMariano, DDS
Shellie Edwards, DDS
Lora Foster, DDS
Kasi Franck, DDS
Jennifer Goldman, DDS*
Holley Gonder, DDS
Victor Hawkins, DDS*
Marsha Henry, DDS*
Nam Hoang, DDS
Chester Hsu, DDS*
Alice Huang, DDS*
Horia Ionescu, DDS*
Ralph Jacobs, DDS*
Daniel Juarros, DDS
Craig Kinzer, DDS*
Diane Liberty, DDS
Timothy Lyons, DDS
William Marble, DDS
Michell Matsuda, DDS
Candy Tan-Chi McComb, DDS
Jeffrey McComb, DDS
Warren McWilliams, DDS
Kenneth Moore, DDS
Sydney Moore, DDS
Kenneth Moore, II, DDS
Megan Moyneur, DDS*
Greg Owyang, DDS
Elizabeth Park, DDS*
Eric Park, DDS*
Jun Park, DDS
Sireesha Penumetcha, DDS
Dennis Peterson, DDS*
Michael Phelps, DDS*
Dexter Quiggle, DDS
Brian Ralli, DDS
Robert Ramirez, DDS
Gabrielle Rasi, DDS*
Roger Reich, DDS*
Sean Rhee, DDS
Sean Rockwell, DDS
Leon Roda, DDS*
Christy Rollofson, DDS
Don Rollofson, DMD*
Nick Rotas, DDS*
Jason Roth, DDS
Sean Roth, DDS*
Maryam Saleh, DDS*
Elaheh Samsani, DDS
Dean Sands, DMD*
Sahil Sethi, DMD*
Cindy Shen, DDS
Stefanie Shore, DDS
Dwight Simpson, DDS*
Darce Slate, DDS*
Charles Smurthwaite, DDS
Oladimeji Sorunke, BDS*
Jeff Sue, DDS
Victoria Sullivan, DDS*
Joelle Taves-Speed, DDS*
H. Scott Thompson, DDS
Robert Tilly, DDS
Amy Tran, DDS*
Sang Tran, DDS*
Allison Trout, DDS*
Kelvin Tse, DDS
Garri Tsibel, DDS
Wayne Tsutsuse, DDS
Stuart Wakeman, DDS*
Kim Wallace, DDS*
Brigid Walsh, DDS
Russ Webb, DDS
Cindy Weideman, DDS*
Mike Weideman, DDS
Joel Whiteman, DDS
Kristy Whiteman, DDS
Rae Whitten, DDS*
Mark Wong, DDS*
Janice Work, DDS*
Karl Zander, DDS
Siri Ziese, DDS

SFK DAY STAFF VOLUNTEERS

Kristen Adams, RDA
Gwendolyn Aguila
Stephen Aguirre
Alejandra Alatorre, DA
Katy Allen, RDH
Melissa Allen, RDA
Melissa Allen, RDA
Kristen Alvis
Venessa Amparan
Vanessa Anaya
Alyssa Anderson, RDA
Stacey Arnett, RDA
Michelle Arntson, RDA
Samantha Arriola, RDA
Lawryn Ask
Rachel August
Sharron Austin
Jenn Axtell, RDA
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Sharlee Bates, RDA
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Sunday Bogart, RDA
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Korbi Brizendine, RDA
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Michelle Bruce
Sylvia Buentipo, RDH
Mona Buksh, RDA
Jenner Bull, RDA
Alla Burlaka, RDH
Leah Busich, RDA
Sara Campos
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Alexis Carrington
Azra Carrington
Alex Caster, DA
Angelica Cedeno
Sharon Cervantes
Sheri Chambers, RDA
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Pat Chang, RDH
Lauren Chavez
Alejandra Cheesman, RDA
Helena Chew
Caroline Collins, DA
Tanjia Collins, RDH
Melissa Conklin-Allen, RDH
Mary Contreras, OSA
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Lisa Cornelius, RDAEF
Sallie Craig, RDH
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Jill Daby, RDA
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Candis Dastmalchi
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Amitash Dhillon, RDA
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Teri Emry, RDH
Pam Essandiary, RDH
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Liana Feoktistova, DA
Andie Fink, RDA
Martha Flores
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Mia Fraser, RDA
Erly Gaiser, DA
Stephanie Galvan, RDA
Nayelli Garcia, RDA
Roberto Garcia
Rosalva Garcia, RDA
Sandy Garcia
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Jill Goard
Bivian Gomez, RDA
Holly Gommeringer
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Trisca Grasse
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Alma Gutierrez, RDH
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Sarah Hannah
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Monika Henderson
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Becky Herrera, RDA
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Michaela Hertoghe
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Mallorie Hogan
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Jackie Hyland, DA
Corina Jackson, RDA
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Jenny Jacobs
Stacy Jacques
Jennifer Jedlicka, RDA
Jackie Jellesed, RDA
Gail Jennings, RDA
Rose Jimenez
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Cindy Johnson
Holly Johnson, RDA
Jennifer Johnson, RDH
Judi Johnson
Megan Johnson
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Erin Jones
Mike Jones
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Chuck Joy, RDAEF
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Lindsey Joyce, RDA
Lillie Juarros
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Janet Marin, RDH
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Sandi Martin, RDA
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Jaime McAdams, RDH
Mona McConville, RDH
Keri McKinney, RDA
Jessie McVey, RDA
Patricia Meehan, RDA
Letticia Melgoza, RDA
Yelena Melnichuck, RDA
Yolanda Mendoza, RDA
Sharon Moe
David Monjaras, DA
Don Moore
LuAnn Morrison
Heather Moustakas, RDH
Lisa Murphy
Jackie Najarro, RDA
Maricela Navarrete, RDH
Nolan Negrete
Amy Neto, RDA
Lisa Ngo
Thanh Nguyen
Veronica Nieves
Danette Ocegueda
Joel Oliquiano, RDA
Carmen Olivas
Krystle Onsted, RDA
Christine Ontiveros, RDA
Melissa Orth
Riley Osborn
Maryam Osmanova, DA
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Christina Paquin

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Rachel Paul, RDA
Sandy Paul
Abigail Pearson
Myla Pelito, RDA
Janet Percevic
Menchu Perez, RDA
Lois Perisho, RDH
Kendell Perry
Caitlin Peterson
Deb Peterson
Holly Pfeifer, RDH
Beth Phillips
Justin Pope
Eryka Powers
Lisa Purves, RDA
Mahshid Rafat
Olga Rahardja
Melodi Randolph, RDAEF
Marcella Raper, RDH
Stephanie Reeve, RDA
Allison Reinig, RDA
Alissa Repec, RDA
Tiffany Ribble
Allysun Rice
Nancy Richardson
Teila Rifa, RDH
Tina Rios, RDH
Beth Robles, RDA
Emily Rodriguez
Bryan Rollofson
Madelyn Rollofson
Cyndee Rosca, RDA
Lynn Ross
Karen Roth, RDH
Carol Roudebush, RDA
Dan Rusen
Becky Rust, RDA
Sam Sabri
Joanna Salton
Daneille Scott, RDA
Marcie Scroggins, RDH
Cris Severson, RDAEF
Barbara Shepherd, RDH
Natalya Shpak, DA
Tatyana Shpak, DA
Michelle Shrader-Nopens, RDA
Preetkamal Sidhu
Emily Sierck
Sandy Silva, RDAEF
Kandice Simpkins, RDH
Megan Simpson
Shannon Simpson, RDH
Shaneka Sims, RDA
Bethany Sisemore, RDH
Majel Small, RDH
Mary Smith
Renee Smith, RDA
Lori Solden
Sylvia Solis, RDA
Gail Souligny, DA
Brenda Sparks, DA
Buffie Stenback, RDA
Angela Stevens, RDA
Laura Stewart, DA
Amy Strand, RDH
Jo Stromberg, RDA
Kymberly Suarez
Bonnie Sutherland, RDA
Byron Tam
Deanna Taylor, RDA
Brooke Thaler, RDA
Lori Thompson, RDH
Zina Thruelsen, RDAEF
Noel Tonn, RDH
Mary Lou Torres
Kelli Tran
Dana Trepagnier, RDA
Alanna Trevino, DA
Dena Trotter, RDH
Kima Trotter, RDA
Tameka Tucker, RDH
Jaynie Ulm, RDA
Ying Vang, RDA
Carmen Venegas
Jennifer Verplancken, RDH
Beth Waklee, RDA
Krista Walker
Sandy Wallace
Kristi Wasyluka
Kathi Webb
Jamie Wehr, RDA
Donna Weideman
Roxie Weideman
Penny Wells, RDA
JoEllen Werner, RDH
Tra-Shell Westbroook, RDA
Nikole Westty, DA
Kim Whil
Emily White
Nona Wilborn
Dianna Williams
Marsha Williams, RDA
Cassandra Wilson
Susan Wilson
Nicole Winkler
Jenny Wisterman
Marissa Wisterman
Rosalva Wisterman
Megan Witt
Jodi Wright, RDA
Theresa Wright, RDA
Bonnie Yarbrough, RDA
Della Yee
Melissa Young
Rosalia Young, RDH
Sharon Young, DA
Nasim Zamani
Valerie Zinola, RDH

ADOPT-A-KID VOLUNTEER DOCS

Endodontists

John Fat, DDS, MS
Bruce Holt, DDS
Kevin Keating, DDS, MS
Loc Tran, DDS
Clifford Wong, DDS, MSD
Timothy Wong, DDS

General Dentists

Gary Ackerman, DDS
Hanan Amini, DDS
Kreston Anderson, DDS
Todd Andrews, DDS
Ron Ask, DDS
Nazila Bagheri, DDS
Forrest Bond, DDS
Lenna Bright, DMD
Arthur Burbridge, DDS
Matthew Campbell, Jr., DDS
David Cernik, DDS
Jayson Chalmers, DDS
Christopher Chan, DDS
Regina Cheung, DDS
Lawrence Chu, DDS
Darrell Chun, DDS
Scott Churchill, DMD
James Cope, DDS
Paul Cripe, DDS
Kenneth Curry, DDS
Robert Daby, DDS
Jerome Daby, DDS
Paul Denzler, DDS
Pamela Di Tomasso, DMD
Friz Diaz, DDS
Julianne Digiorno, DDS, RD
Lisa Dobak, DDS
Timothy Durkin, DDS
Thomas Eaton, DDS
Michelle Edwards, DDS
Gwendelyn Enriquez, DMD
James Everhart, DDS
Volkmar Felahy, DDS
Rikard Forsberg, DDS
Kasi Franck, DDS
Arlenita Gomez-Croddy, DDS
Holley Gonder, DDS
Edi Guidi, DDS
Elizabeth Harmon, DDS
Victor Hawkins, DDS
Marsha Henry, DDS
Timothy Herman, DDS
Chester Hsu, DDS
Horia Ionescu, DDS
Craig Johnson, DDS
Terrence Jones, DDS
Daniel Juarros, Jr., DDS
Richard Kiholm, DDS
Craig Kinzer, DDS
Mark Kujiraoka, DDS
Diane Liberty, DDS
Yen Lieu, DMD
David Lopes, DDS
Douglas Lott, DDS
Thomas Ludlow, DDS
Alexander Malick, DMD
William Marble, DDS
Kevin McCurry, DDS
Robert Meaglia, DDS
Fanhua Meng, DMD
Ken Ngo, DDS
Minh Nguyen, DDS
Thanh-Truc Nguyen, DDS
Jeffrey Olson, DDS
Brian Orcutt, DDS
Deborah Owyang, DDS
Virenchandra Patel, DDS
Radoslaw Peliks, DDS
Hanh Pham, DDS
Anh Phan, DMD
Vinh Phan, DDS
Alan Rabe, DDS
Robert Ramirez, DMD
Gabrielle Rasi, DDS
Paul Raskin, DDS
Leon Roda, DDS
Sean Roth, DDS
Jared Ruminson, DDS
Stephen Saffold, DDS
Allen Sanders, DDS
Dean Sands, DMD
Christopher Schiappa, DDS
Alvin Seevers, DDS
Dwight Simpson, DDS
Charles Smurthwaite, DDS
Oladimeji Sorunke, BDS
Brian Steele, DDS
Cynthia Stuart, DDS
Charles Su, DDS
Jerard Trombka, DDS
Allison Trout, DDS
Glen Tueller, DDS
Sergio Vicuna, DDS
Jonathan Vongschanphen, DDS
Kim Wallace, DDS
Wen-li Wang, DDS
Glen Warganich-Stiles, DDS
Jerard Wilson, DDS
Kelly Wilson, DDS
H Yee, DDS
Raj Zanzi, DMD

Oral & Maxillofacial Surgeons

Craig Alpha, DDS
Henry Bennett, DDS
Steven Brown, DDS
Vincenzo Castaldo, DMD
Margaret Delmore, MD, DDS
Brian Fong, DMD, MD
Louis Gallia, MD, DMD
Gregory Hailey, DDS
Jagdev Heir, DMD, MD
Gregory Heise, DDS
Richard Jackson, DDS
Loche Johnson, DDS
Christopher Kane, DDS
Grace Lee, DMD, MD
Richard Moorhouse, DDS
Franklin Niggebrugge, DDS
Michael Phelps, DDS
Michael Preskar, DDS
Nicholas Rotas, DDS
Brian Royse, DDS
John Tomaich, DDS, MD

Orthodontists

Gregory Adams, DDS, MS
Robert Alexander, DDS, MS
Crystal Anderson, DMD, MS
Steven Anderson, DDS
Robert Andresen, DDS
Joseph Atkinson, DDS
Thais Booms, DDS, MS
Paul Cater, DDS
Vincent Chiappone, DDS, MSD
Thomas Chin, DDS
Douglas Church, DDS, MPH
Brian Crawford, DMD
Kent Daft, DDS
David Datwyler, DDS
Jason Dorminey, DMD
Mark Douglas, DDS, MSD
Jennifer Drew, DDS, MSD
J. Patrick Dunbar, DDS
Marc Dunn, DDS
Jeffrey Elenberger, DDS
Gregory Evrigenis, DDS
P. Scott Favero, DMD
Patricia Fong, DDS
Steven Frank, DDS, MS
Donna Galante, DMD
Richard Gere, DDS
Kelly Giannetti, DMD, MS
Stuart Greenberg, DDS
Michael Guess, DDS
Daniel Haberman, DDS, MS
Mark Holt, DDS, MS
Nicole Jane, DDS, MS
Darryl Johnson, DDS
Yan Kalika, DMD, MS
Robert Kelleher, DDS
Richard Kilmer, DDS
Stephen Kineret, DDS, MS
Timothy Lyons, DDS
David Markham, DDS
George Mayweather, DDS
Robert McClurg, DDS
Dwight Miller, DDS
Matthew Molitor, DDS
Robert Nisson, DDS
Gloria Nollie, DDS
Jack Oates, DDS
John Oshetski, DDS
Ronald Otto, DDS, MS
Michael Payne, DDS, MSD
Wilmonte Penner, DDS
Richard Portalupi, DDS, MSD
Donald Rollofson, DMD
Benton Runquist, DDS
Bryan Scott, DMD
Annie Shih, DDS, MPH
Charles Stamos, DDS
Sam Stassi, DDS
Russell Sutliff, DDS
Robert Sutter, DDS, MS
Damon Szymanowski, DMD
Richard Talbot, DMD, MS
Alan Tan, DMD
Binh Tran, DDS, MSD
Garri Tsibel, DDS
Melvin Walters, DDS
Sidney Wisdom, DDS
Peter Worth, DDS
Timothy York, DDS, MS

Pediatric Dentists

Wayne Grossman, DDS
Sydney Moore, DDS
James Musser, DDS
Dennis Peterson, DDS
Jeffrey Sue, DDS
Victoria Sullivan, DDS
Monica Tavallaei, DMD
Joelle Taves-Speed, DDS, MS
H. Scott Thompson, DDS
Cynthia Weideman, DDS

Periodontists

Nicky Hakimi, DDS, MSD
Sean Rhee, DDS
Shaunda Thomas, DDS

Prosthodontists

Herlin Dyal, DDS

SCREENING DOCS

Ashkan Alizadeh, DDS
Todd Andrews, DDS
Donald Boatman, DDS
Gary Borge, DDS
Chris Cerceo, DDS
Andrea Cervantes, DDS
Christopher Chan, DDS
Wai Chan, DDS
Andrew Chen, DDS
Wayne Cheng, DDS
Vincent Chiappone, DDS, MSD
Jennifer Choi, DDS
Clifford Chow, DDS
Tracey Cook, DDS
Paul Cripe, DDS
Robert Daby, DDS
Jennifer Datwyler, DMD
Paul Denzler, DDS
Shaina DiMariano, DDS
Lisa Dobak, DDS
Mark Douglas, DDS, MSD
Kathleen Duncan, DDS
Timothy Durkin, DDS
Gwendelyn Enriquez, DMD
Kimberly Fong, DDS
Donna Galante, DMD
Arlenita Gomez-Croddy, DDS
Walter Griffin, DMD
A. Grivas, DDS
Kirk Hanson, DDS
Gordon Harris, DDS
Brenda Ho, DDS
Alice Huang, DDS
Lindsay Johnson-Hart, DDS
David Kanas, DDS
Mark Kujiraoka, DDS
Warren McWilliams, III, DDS
Ken Ngo, DDS
Siamak Okhovat, DDS
Mark Olson, DDS
Virenchandra Patel, DDS
Hanh Pham, DDS
Mark Porco, DDS
Robert Ramirez, DMD
Jeffrey Rosa, DDS
Ronald Rott, DDS
Maryam Saleh, DDS
Dean Sands, DMD
Jonathan Szymanowski, DMD, MMSc
Ricky Tin, DDS
Sang Tran, DDS
Kim Wallace, DDS
Melvin Walters, DDS
Daniel Woodson, DDS
Janice Work, DDS

Volunteer names as of April 15, 2008

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additional efforts on the part of practitioners. Electronic data collection and transmission is the ultimate goal of P4P programs.

Retrospective data gathering, such as from chart reviews, is generally shunned in P4P programs. Data are gathered on a contemporary basis at the time of service. The mere fact that performance data are recorded at each patient visit in itself tends to enhance performance.

Performance targets

Performance targets are the essence of P4P programs. They are the "standards" the plan seeks to have its providers achieve. They also indicate what the administrator's real goals are in establishing a P4P program; for example, if the goal is to reduce the per patient expenditures for care, the performance targets will reflect that.

It is important that practitioners are part of the establishment of performance targets. Absent that, "performance" could be defined as just about anything a health plan says it is, with the concomitant effect on providers' compensation and/or reputation.

Performance incentives

When incentives, positive or negative, are the driving force behind attempts to change providers' behavior in health care plans, one can expect considerable discussion of the incentives and how they are sued.

Financial incentives should be of sufficient magnitude to change behavior. A small compensation bonus will have little effect in changing a behavior that has resulted in a significant increase in practice revenue particularly in plans that already are driving down compensation. The amount of compensation bonuses in private P4P programs currently is in the five to 20 percent range. It is a matter of debate whether practitioners should be eligible for incentives only upon achieving performance targets or also for making significant progress toward achieving those targets. In order to be effective, P4P programs must design incentive programs that reward both performance and improvement at levels significant enough to motivate practitioners to modify their behavior.

There are two basic schemes that are being discussed to fund P4P programs: a redistribution of exiting funds and the infusion of additional money beyond that already being expended. The revenue neutral redistribution of existing funds is accomplished by withholding a specific amount of practitioners' revenue, usually in the two to five percent range, and those monies are used to fund the incentive bonuses. The "poor" performers are subsidizing the "good" performers, in essence. Obviously, there must always be a pool of " poor" performers to provide this subsidization.

When new money is put into the system to fund incentive bonuses, there is usually no absolute penalty imposed upon "poor" performers; "good" performers are rewarded for their behavior. Although they do not lose any money, "poor" performers may consider receiving no bonus as a penalty. They may look at their situation as reduced compensation compared to the "good" performers.

Pay for performance can evolve into such an all-encompassing program that it has the potential for significant unintended negative consequences.

If P4P programs actually reduce the costs of health care, some feel the "new money" required to finance bonus incentives should come for those savings rather than from reimbursement reductions to "poor" performers. If quality of care improvement is the real goal of P4P programs, actual costs may increase, at least in the short run, since many of the performance measures at this stage of development are measures aimed at identifying areas of under use of diagnostics or treatment. Relying on saved money to fund bonus incentive may have the effect of having cost experience become a significant part of performance targets established for the plan.

Information technology

The operation of a full pay for performance program will depend greatly on the use of information technology, both for administrative purposes and for the individual patient record. A great deal of information must be reported and analyzed in order to make a fair determination of the quality of care provided by a practitioner. This would be prohibitively expensive both for the provider and the administrator without the use of electronic technology.

This poses a significant problem for practitioners, especially individuals and small groups. With the amount of bonus money available in most programs, it is difficult to realize an adequate return on the investment in information technology required for participation in these programs. The cost of establishing an electronic record system is high and its operation is estimated to cost between $12,000 and $24,000 per year. In addition, the successful implementation of electronic records is difficult at this time, adding to the costs, frustrations and disruptions in office administration. It is important that there be significant incentives or cost sharing for practitioners to employ electronic technology if these programs are to reach their full potential for improving health care.

Potential concerns

Pay for performance can evolve into such an all-encompassing program that it has the potential for significant unintended negative consequences. Probably the greatest risk is gaming of the system, a phenomenon frequently seen in P4P programs not related to health care. Individuals with the highest chances of success are preferentially selected for participation. In prospective payment health plans, physicians and hospitals have been found to attempt to enroll healthier patients in order to maximize net revenues. Other potential unintended consequences are decreased access to care for marginal populations, reduction in the quality of care to cut expenses, minimization of treatment in areas not targeted for financial rewards or in areas not included in performance measures.

There are also some concerns about using claims-based information for quality determination, particularly for individuals and small groups. Because of the tiny size of the sample of patients from an individual practitioner, quality determinations may be difficult and the conclusions invalid.

In dentistry, using claims data is even more of a problem since diagnoses, modifying conditions and co-morbidities are not reported. Reporting only "what was done" for consideration of the quality of care provides only one-third of the quality determination equation: what was the diagnosis, what treatment was provided and what was the outcome?

Pay for performance in dentistry

As is frequently the case, innovations in the health care delivery system come to dentistry only after having been developed and tried in the general medical-surgical-hospital sector. We know from long experience that there is often little general transferability of these effects and experiences between medicine and dentistry, notwithstanding the fact that transfer is still attempted regularly.

There are several examples of P4P programs in commercial dental plans, although they may not be identified with that terminology. In Minnesota, Delta Dental participating dentists are classified according to the total cost of oral health care they provide, with the "good" performers receiving a higher level of reimbursement than the "poor" performers. In Rhode Island, Delta Dental will pay participating dentists a bonus per claim if they submit claims electronically directly to Delta. Note that neither of these incentive programs are related to the quality of dental care provided, but are cost related.

In Colorado, Delta has begun a model P4P which provides financial bonuses to dentists whose practice patterns suggest, according to Delta standards, efficiency, comprehensiveness and compliance with professional standards. Providers whose claims patterns suggest they are providing continuing, comprehensive, prevention-oriented care that does not suggest over treatment are financially rewarded, while others are encouraged to modify their practices to qualify for the incentives. Practitioners whose claims suggest inappropriate care can be identified and removed from the network should they not modify their practice patterns to better meet professional standards.

Overall, in dentistry there are no generally accepted/universal quality guidelines or measures developed by the profession, other than some preventive or process measures. Quality guidelines in use in dentistry have mostly been developed by insurers.

In the absence of credible quality guidelines, dental plans wishing to incorporate P4P programs will have to focus their attention on financial goals, patient satisfaction, processes or IT employment. Quality improvement, one of the cornerstones of the rationale for employing P4P programs, most likely becomes unattainable except through very indirect means. This will most likely not be a significant barrier to implementation of P4P programs by insurers, since reduction of their costs is a strong incentive (some would argue, the primary incentive) for insurers to pursue P4P programs, and financial performance measures and targets are very easily calculated from data the carriers already possess.

Pay for performance is an urgent situation for medicine, now.

Although the same level of urgency does not now exist for dentistry, it may be the time to get ready for that eventuality.

Where does dentistry go from here?

The implementation of mature and full-blown pay for performance programs in both the private and public sectors will take some time to occur in medicine and, most likely, even longer in dentistry. There is little doubt that they will eventually come, going through an uncertain evolutionary process. They will start with financial considerations and cost reduction, and most likely will progress to true quality of care issues.

When considering the role the ADA should play in this area, it might be well to consider a recent statement by Nancy H. Nielsen, M.D., speaker of the AMA House of Delegates: "There's not a good evidence-based way for most conditions to measure what is exactly the right thing to do — no less and nor more. And that's where our profession really needs to be involved because, if we're not there, frankly, the bean-counters are going to decide what the issues and measures are."

Pay for performance is an urgent situation for medicine, now. Although the same level of urgency does not now exist for dentistry, it may be the time to get ready for that eventuality.

The ADA 2006 House of Delegates adopted principles for Pay for Performance or Other Third-Party Financial Incentive Programs to be used by payers as guidance in the development of P4P and other similar programs that do no compromise patient care or interfere with the patient-doctor relationship.

For a look at what the government is saying about pay for performance, do a search for that term on the following Web sites: Centers for Medicare and Medicaid Services, www.cms.hhs.gov, the Agency for Healthcare Research and Quality, www.ahrq.gov, Health resources and Services Administration, www.hrsa.gov.

Dr. Guay is the ADA chief policy advisor. This is a summary of an analysis he presented to the Board of Trustees in December 2006. ■

YOU: THE DENTIST... THE EMPLOYER

You are a dentist — you've been to school, taken your Boards and settled into practice. End of story?

Not quite. Employee evaluations, hiring and firing, labor laws and personnel files are an important part of being an employer. Are you up on the changes that happen nearly EVERY January 1st?

In this monthly column, we will offer information pertinent to you, the dentist as the employer.

RECORDS RETENTION REQUIREMENTS

FOR A COMPLETE LIST, CALL THE HR HOTLINE AT 800.399.5331

By **California Employers Association (CEA)**

Personnel Data Category	Laws Requiring Retention & Retention Periods	Longest Req. Retention Period
Recruitment, Hiring & Job Placement Records • Job applications including applications for temporary positions • Resumes • Other job inquiries sent to employer	Title VII: 1 year from date record was made/employment action taken, whichever is later (recommend 3 years as actions under ADEA or Title VII can be filed long after the 1 year period is expired) ADA: Same as Tile VII FEHA: 2 years from date record was received/created; minimum of 2 years after action taken.	2 years (or duration of any claim/ litigation involving hiring practices)
Payroll Records • Name, employee number, address, age, sex, occupation, Social Security number, birth date	FLSA: 3 years. Federal Unemployment Tax Act: 4 years	4 years
Employee Wage Records • Time cards • Wage rate calculation tables for straight time and overtime	FLSA: 2 years. Service Contract Act of 1965 (Public Contracts)Service Contracts Over $2,500: 3 years from end of contract. Department of Industrial Relations, Division of Labor Standards: minimum of 3 years.	3 years
Unemployment Documents • Social Security account number	Federal Unemployment Tax Act: 4 years	4 years
Tax Records	Internal Revenue Code: 4 years	4 years
Child Labor Documents • Certificates and Notices • Work Permits	FLSA: 2 years Walsh Healey Public Contracts Act (Public Contracts) Government Supply Contracts over $10,000: period of employment of minor	3 years
Union and Employee Contracts • Union Agreements • Job Orders given to Union	FLSA: 3 years Equal Pay Act of 1963: 3 years ADEA: 1 year from date of personnel action.	3 years
Employment Eligibility Verification (I-9) Forms • INS I-9 Employment Eligibility Verification Form. Must be completed for all Employees hired on or after November 7, 1986	Immigration Reform and Control Act: minimum of 3 years; if employed more than 3 years, 1 year after termination	later of 3 years from hire date or 1 year from termination
Employee Personnel Files • Disciplinary notices • Promotions and demotions • Job Accommodations • Performance evaluations • Job Descriptions	Title VII - 1 year from date record was made/employment action taken, whichever is later (recommend 3 years as actions under ADEA or Title VII can be filed long after the 1 year period is expired) FLSA: 2 years Equal Pay Act of 1963: 2 years Rehabilitation act of 1973: recommend at least 2 years	2 years
Employee Benefits Data • Records supporting all required plan descriptions, including vouchers, receipts, worksheets, etc.	ERISA: minimum of 6 years after the filing date of documents these support Internal Revenue Code: recommend at least 6 years per ERISA requirements	6 years (at least 1 year following plan termination)
Employee Health and Safety Records	Cal/OSHA: 5 years.	5 years

CEA HR HELPER: UNPAID INTERNSHIPS

This spring weather reminds us that students all over will soon be wrapping up their academic year. Many employers establish their own internship programs to help out high school and college students or to help non-students who may be new to the employer's business or industry. While the idea is a good one, and often mutually beneficial for both the employer and the intern, all internships do not qualify as exempt under the state's minimum wage and overtime laws.

A person hired as a true, unpaid "intern" must be a student enrolled in an accredited academic program and receiving academic credit for the internship or be in a program approved by a public agency to provide training. Otherwise, the employer must pay the "intern" at least minimum wage for all hours worked.

Before hiring an intern or creating an internship program, check with your regional director to see if the proposed internship complies with the Division of Labor Standards Enforcement (DLSE) guidelines, four pieces of criteria must be met. And, if you are in a hurry, we can ask the DLSE for an advanced ruling as to whether your proposed program constitutes an employment relationship. ■

Pay for Performance ... Tipping Point

CONTINUED FROM PAGE 8

carry it out, the results of the Premier demonstration have been eagerly awaited. However, the findings still leave us with many uncertainties concerning the level of financial incentives needed and the optimal formulas for payment that might be used for attaining high levels of performance. Returning to the medical-advances analogy, we have learned through the years that medical therapies and procedures are not cost-effective per se but, rather, are more or less cost-effective for various populations and for various medical indications. Policymakers need similar fine-grained information about different aspects of pay for performance. The reality, however, is that we are at the tipping point with pay-for-performance programs, and such information is unlikely to be forthcoming before political pressure forces policymakers to act.

In this situation, the CMS may have much to gain from recognizing that pay for performance is fundamentally a social experiment likely to have only modest incremental value. Broad demonstration and evaluation will probably be helpful. Rather than adopt a single new payment system for all of Medicare, a series of regional models could accelerate learning and allow Medicare officials to find out more about the effect of differing levels of incentives and formulas for payment. No matter what the course, timely evaluation of any policy we adopt seems critical to ensure that we achieve high performance without unintended consequences.

Arnold M. Epstein, MD, MA, is a John H. Foster Professor and chairman of the Department of Health Policy and Management at Harvard University School of Public Health http://www.commonwealthfund.org/bios/bios_show.htm?doc_id=236233

Reprinted from The New England Journal of Medicine: Volume 356:515-517 — February 1, 2007 — Number 5 ■

Hovey-Beard

CONTINUED FROM PAGE 9

The Hovey-Beard effect is not about people who are dim or devious; there are very sound reasons why we must preserve our identity by discounting the success others achieve in pursuing our goals. Sometimes we try to scare others away, sometimes we work to establish monopolies without serving all who are required to seek only our care. That is just survival. But we need to be careful not to talk too loudly about seeking the best oral health outcomes if there are hidden rules for how these results can be obtained.

Dr. Chambers is a mathematician and statistician by background, a professor of dental education at the Arthur A Dugoni School of Dentistry and editor of the Journal of the American College of Dentists.

Reprinted with permission from the Journal of the American College of Dentists. ■

ABSTRACTS

Biophosphonate treatment: An orthodontic concern calling for a proactive approach

J. Zahrowski
Am J Ortho & Dentof Orthoped 131:3 2007

Biophosphonates are drugs used to treat bone metabolism disorders such as osteoporosis, bone disease and bone pain from some types of cancer. Because they work by inhibiting bone resorption by osteoclasts, they can have side effects in dental treatment, including inhibited tooth movement, impaired bone healing, and induced osteonecrosis. Examples are; Fosamax, Fosamax Plus D, Didronel, Boniva, Aredia, Actonel, Skelid, and Zometa.

Effect of rinsing with an essential oil-containing mouthrinse on subgingival periodontopathogens

D. Fine, et al
J Perio 78:10 2007

After 14 days of twice-daily rinsing with Listerine Antiseptic, the level of each of the target subgingival organisms was significantly lower in the essential oil group than in the control group with percent reductions ranging from 66% to 79%. Additional studies on non-prescription antimicrobial oral care products may lead to new regimens for decreasing the burden of periodontal disease in the population.

New shade guide for tooth whitening monitoring: Visual assessment

R. Paravina, et al
J Pros Dent 99:3 2008

A shade guide that has tabs arranged from the lightest to the darkest in accordance with visual findings may increase reliability of monitoring tooth whitening and provide results that are more meaningful and easier to compare. The study found the new Vita Bleachguide 3D-Master superior to the Vitapan Classical and the Trubyte Biofrom shade guides.

RTB

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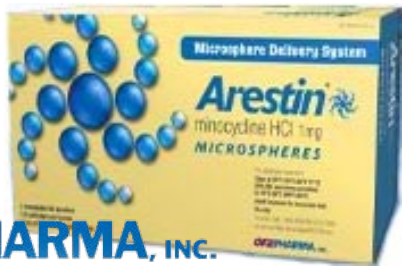

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Please support SDDS Vendor Members any way you can!

2008 SDDS COMMITTEE MEETINGS:

Auxiliary Advisory • SDDS • 6:30pm
Future meetings TBA

Board of Directors • SDDS • 6:00pm
May 6 • Sept 2 • Nov 4

CE Committee • SDDS • 6:30pm
May 19 • Oct 6 • Dec 1

CPR Committee • SDDS • 6:30pm
May 7 (yearly calibration)

Dental Health Committee • SDDS • 6:30pm
Sept 30 • Dec 9

Ethics Committee • SDDS • 6:00pm
May 19 • Oct 6

Foundation (SDDF) • SDDS • 6:30pm
Sept 30 • Nov 19

Golf Committee • SDDS • 6:30pm
Future meetings TBA

Leadership Dev. Committee • SDDS • 6:00pm
Future meetings TBA

Legislative Committee • SDDS • 7:00pm
Sept 15

Mass Disaster / Forensics Committee • 6:30pm
Sept 17 (yearly calibration)

Membership Committee • SDDS • 6:30pm
May 27 • Sept 22 • Dec 1

***Nugget* Editorial Committee • SDDS • 6:15pm**
June 3 • Oct 28

Peer Review Committee • 6:30pm
May 8 • June 12 • July 10 • Aug 14
Sept 11 • Oct 9 • Nov 13 • Dec 11

SacPAC Committee • SDDS • 6:00pm
Sept 15

For dates & times not listed above, visit the SDDS calendar at www.sdds.org/calendar.htm

LETTER TO THE EDITOR

RE: Can't Medicine & Dentistry Work More Closely?
May 2008 issue

...Another insightful and helpful issue of the *Nugget*. My favorite insights were:

- "...medicine and dentistry germinated from separate and dissimilar seeds..." from Dr. Paul Raskin. Way to go, Paul, in dissecting the differences to understand our similarities and explore harmony.
- "American health care is fragmented, compartmentalized, parochial and non-universal..." from Dr. Richard Raskin. I think we can all relate to that description and be grateful that our profession is mostly comprised of efficient little entrepreneuralships.

Dr. Chester Hsu's article on Children with Special Needs hit home for me having just seen a boy with severe cerebral palsy with cognitive impairment requiring hospitalized dental care and the mother not knowing where to turn. Dr. Hsu is one of many unsung heros in our profession, asking us to 'open our hearts,' as he and many others serve the needy. Being in the same shoes- — having a quad spastic cp child (fortunately with intact mental ability), I know first-hand how grateful a parent is when a professional is caring and competent in providing medical/dental care to a handicapped child.

I believe that the *Nugget* is one of the most valuable services we provide to SDDS membership. Great job, folks.

James C. Cope, DDS

ADVERTISER INDEX

COMMITTEE CORNER

Submitted by **California Dental Association**

Gabrielle D. Rasi, DDS
Legislative Committee Chair
(pictured)

Legislative Committee: CDA BILL BECOMES LAW

January 1, 2008, Assembly Bill 895 became law. This CDA-sponsored bill clarifies and places new requirements in law on how dental plans coordinate paying for patients' benefits.

CDA sponsored AB 895 to address the issue of dual dental coverage and the inability of spouses and domestic partners to receive the benefit for which they or their employers have paid. CDA often heard complaints from dental offices of patients with dual coverage who were unsure what each plan would pay when coordinating payments. Some dental plans do not declare their coordination of benefits policies to their enrollees and, until AB 895's enactment, such declarations were not required by law. In addition, increasingly over the past few years, many dental plans adopted non-duplication of benefit clauses. These clauses declared the plan would pay nothing as a secondary payer if the primary payer paid what it would have if the secondary payer had been primary. The result has been plans using primary payers to cover their obligations to their enrollees, resulting in a situation where the employer or employee pays dual premiums for dual coverage while getting the benefit of only one coverage plan. With the changes in law established by AB 895, secondary payers have responsibility

> *CDA sponsored AB 895 to address the issue of dual dental coverage.*

to pay something — they can no longer claim no responsibility because of "non-duplication of benefit" clauses in contracts with enrollees.

Since the enactment of the bill, CDA has received numerous inquiries from member dentists about the scope of AB 895's requirements. In response, we published a "Frequently Asked Questions" article on AB 895 in the March UPDATE, and are placing key information about the bill and its provisions on the CDA website (www.cda.org). These inquiries have also prompted a good number of faxed responses to educate member dentists about the provisions of the bill and to provide informational assistance in dealing with payers denying payment for "non-duplication of benefits" policies. CDA has also approached plans about their appeal to "non-duplication" provisions.

As part of our response to the need that members have for information about this bill, the following information is provided on the CDA website (www.cda.org):

- Copy of AB 895
- AB 895 Fact Sheet
- Frequently Asked Questions about AB 895 and coordination of benefits
- Filing Complaints for non-payment by secondary payers

CDA members and office managers should familiarize themselves with the requirements of the new law and use the information to challenge a secondary payer who claims nothing is owed in a coordination of benefits situation. Members and office managers are also encouraged to contact CDA about non-payment by secondary payers so that we might know which plans are claiming the law doesn't apply to them. ■

WE'RE BLOWING YOUR HORN!

CONGRATULATIONS TO...

Dr. Ron Rasi, on his daughter (and **Dr. Gabrielle Rasi,** on her niece), Isabella "Ella" Gianna, born April 5, 2008.

Dr. Dean Ahmad, on his Fellowship for the International Congress of Oral Implantologists.

Dr. Alfred Nickel, on his Congressional Medal of Distinction for his work on cancer in 2008.

Dr. Craig Alpha, on his board certification as a Diplomate of the American Board of Oral & Maxillofacial Surgery.

SDDS Executive Director, **Cathy Levering,** on her sightings of both Tony Bennett and Angela Lansbury during a recent trip to New York City. *(photos below)* ■

Cathy mingles with the "who's who" of NYC.

Have some news you'd like to share with the Society? New babies, achievements, retirements, new offices — we'll report them all! Please send your information to SDDS via email (melissa@sdds.org), mail (915 28th St, Sacramento, CA 95816) or fax (916-447-3818). Call SDDS at (916) 446-1227 for more information.

OUR CONDOLENCES TO...

Dr. Herb Hooper, on the loss of his mother, Ethel Marlow (Parker) on March 20, 2008. Ethel was 109 years old.

WELCOME

to SDDS's new members, transfers and applicants.

IMPORTANT NUMBERS:

SDDS *(doctor's line)* . . . . . (916) 446-1227

ADA . . . . . (800) 621-8099

CDA . . . . . (800) 736-8702

CDA Contact Center . . (866) CDA-MEMBER *(866-232-6362)*

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Denti-Cal Referral . . . . . (800) 322-6384

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The more accurate information we have, the better we can serve you!

NEW MEMBERS

MAY 2008

NEW TRANSFER MEMBERS:

Sarwandeep Bath, DDS
Transferred from Butte-Sierra District Dental Society
General Practitioner
7141 Fair Oaks Blvd
Carmichael, CA 95608
(916) 482-7188
Dr. Sarwandeep Bath graduated from an international dental school in 1995 with her DDS. She is currently practicing in Carmichael and Yuba City and living in Sacramento.

James D. Meinert, DDS
Transferred from Orange County Dental Society
General Practitioner
604 3rd St
Davis, CA 95616
(530) 756-2160
Dr. James Meinert graduated from UCLA School of Dentistry in 1993 with his DDS. He is currently practicing and living in Davis with his wife, Laura.

Purvak Parikh, DDS
Transferred from Redwood Empire Dental Society
General Practitioner
125 Ascot Dr, Ste D
Roseville, CA 95661
(916) 782-3129
Dr. Purvak Parikh graduated from Government Dental College — Ahmedabad located in India in 1999 with his DDS. He is currently practicing in Roseville and Merced.

James Rocel G. Pugeda, DDS
Transferred from Los Angeles Dental Society
General Practitioner
2518 L St, Ste A
Sacramento, CA 95816
(916) 446-7768
Dr. James Pugeda graduated from USC School of Dentistry in 2007 with his DDS. He is currently practicing in Sacramento and living in Elk Grove.

Paulyn C. Rodriguez, DDS
Transferred from Los Angeles Dental Society
General Practitioner
Office Address Pending
Dr. Paulyn Rodriguez graduated from USC School of Dentistry in 2007 with her DDS. She is currently living in Elk Grove.

NEW APPLICANTS:

Alexander Antipov, DDS
Daniel Harvey Lee, DDS
Mark Macaoay, DDS

SDDS "FUN TIMES" HAPPY HOUR

May 15, 2008 (6:30pm • No host)

BJ'S BREWHOUSE (2730 E BIDWELL, FOLSOM)

NO RSVP NECESSARY! JUST SHOW UP!

PRESENTED BY THE SDDS MEMBERSHIP COMMITTEE

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SUPER FUN • EXTRA FUN • EVEN MORE FUN THAN THE LAST ONE. IF YOU CAN BELIEVE IT • LET THE GOOD TIMES ROLL • TIME FLIES WHEN YOU'RE HAVING FUN

CLIP OUT this handy NEW MEMBER UPDATE and INSERT it into your DIRECTORY under the "NEW MEMBERS" tab.

TOTAL MEMBERSHIP (AS OF 5/1/08): 1,539

TOTAL ACTIVE MEMBERS: 1,305
TOTAL RETIRED MEMBERS: 184
TOTAL DUAL MEMBERS: 3
TOTAL AFFILIATE MEMBERS: 8
TOTAL STUDENT MEMBERS: 4
TOTAL CURRENT APPLICANTS: 3
TOTAL DHP MEMBERS: 33

TOTAL NEW MEMBERS FOR 2008: 21

2007 SURVEY OF CURRENT ISSUES IN DENTISTRY

Jon D. Ruesch — Director, Survey Center

The Survey Center recently compiled data on a number of issues affecting private practitioners. A few of the findings follow:

- Close to two-thirds (63.4%) of dentists currently use amalgam restorations in their primary practice. Among dentists who use it, more than half indicated that the number of patients on whom they use amalgam restorations had decreased in the past 12 months. 46.4% indicated the number of patients had stayed the same and 2.4% stated the number had increased.
- About one in four (26.7%) dentists indicated their primary practice currently treats Medicaid-insured patients. Dentists whose primary practices do not treat Medicaid-insured patients were split when asked whether they would treat such patients if the fees were raised to meet their overhead; 47.8% said yes and 52.2% said no.
- Regarding physical well-being, close to six in ten (57.1%) dentists indicated they regularly experience pain in an area of their body, but 84.8% of those indicated that the pain has not limited their work.

LINK OF THE MONTH

New required poster!

Print the addendum to the Federal Family & Medical Leave Act at:

www.dol.gov/esa/whd/fmla/NDAAAmndmnts.pdf

Find the entire list of required postings at:

www.cda.org/page/Required_Postings_in_a_Dental_Office

Stumbled upon a great link?
Email it to melissa@sdds.org, to submit it as a possible link of the month!

EVENT HIGHLIGHTS

MARCH & APRIL GENERAL MEMBERSHIP MEETINGS

March 11, 2008 — Alliance / Spouse Night • April 1, 2008 — Back to School / Recruitment Night

March: Olga Rahardja (a CSUS Pre-Dental student) enjoys pre-dinner conversation with Drs. Tracey Cook & J. Michael Gains.

March: Dr. Steve Leighty (new affiliate member — current Butte-Sierra Dental Society President); Dr. Wai Chan (Secretary); Drs. David Amid and Robert Groesbeck (new members for March)

March: Dr. Michael Payne (left) receives a CDA Award in recognition of his extraordinary effort & testimony on dental assisting education regulations & legislation. (presented by SDDS President, Dr. Shorey)

April: Represented by Rob Bausman, Dockstader Dental Lab sponsored the evening's program.

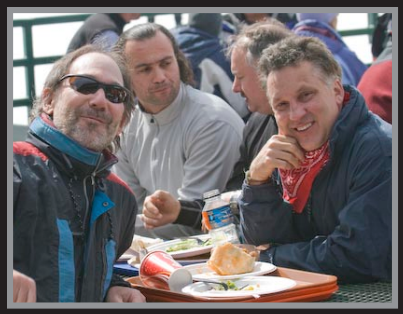
April: Dr. Dennis Wong (right) accepts a Fluoridation Award from the CDA Foundation on behalf of Dr. John Orsi & himself.

April: Alice Penney (Western Career College) receives the CDA Foundation's Allied Dental Health Scholarship Award for Hygiene from CDA Foundation President, Dr. Bruce Toy (right).

April: Christopher Hicks (center — San Joaquin Valley College) receives the CDA Foundation's Allied Dental Health Scholarship Award for Assisting.

April: CSUS Pre-Dental student, Jesse Manton, reminds attendees of their wine tasting event on April 4, 2008.

April: Dr. Ladi Sorunke spends time with his staff members, Monica Vargas & Cassaundra White, at the close of the evening.



PRESENTED BY

FUN TIMES!

SDDS MEMBERSHIP COMMITTEE

TIME FLIES WHEN YOU'RE HAVING FUN • SUPER FUN • EXTRA FUN • EVEN MORE FUN THAN THE LAST ONE! IF YOU CAN BELIEVE IT • LET THE GOOD TIMES ROLL •

Pictured (left to right): Drs. Robin Berrin, Jason Bandani, Robert Shorey

SKI TRIP • AUGUST 3, 2007

PART OF THE SDDS MEMBERSHIP COMMITTEE "FUN TIMES" PROGRAM

THANKS TO DR. JENNIFER GOSS FOR ORGANIZING THIS FUN EVENT!

JOIN US MAY 15 • 6:30PM

BJ'S BREWHOUSE (FOLSOM) • NO HOST

Nugget Classifieds

Positions Wanted

ENDODONTICS: In your office 2–3 days/month or ? 30+ yrs experience. References upon request. Contact Dr. Koett, Sr. (916) 337-6202. *02-07*

HAPPIER PATIENTS • Anesthesiologist will minimize stress for you and your patients • Industry recognized • Board certified • 20 years experience • Call (800) 853-4819 or info@propofolmd.com. *05-07*

I AM RETIRED AND ABLE TO SUPERVISE YOUR OFFICE, do exams and treat emergencies, while you vacation or take leave. Dr. Leif C. Overby, FAGD, MAGD. Ph (916) 434-7033. *05-08*

SEEKING ASSOCIATESHIP — AEGD trained; available FT/PT (June '08). Proficient in molar endo, extractions (full bony impactions), prosth, minor ortho (invisalign), more. Comprehensive treatment with exceptional service. Email ryan.grandpre@cvn68.navy.mil. 05-08

Practices For Sale

NORTHERN CALIFORNIA COAST — Well established 5 op GP located in a high traffic area. Long-term, dedicated staff and loyal patient base. 2007 collections exceeded $1 million. Building is also available. Practice Transition Partners, (888) 789-1085, www.practicetransitions.com. 03-08

BEAUTIFUL, FULLY EQUIPPED DENTAL OFFICE SPACE available, Campus Commons area. Doctor moving to new location, to sell all equipment and leasehold. Turnkey: 6 operatories, 2 in-office restrooms, pano, intra-oral camera, artwork. Please contact John Pacelli at Patterson Dental (916) 595-3005. *05-08*

Employment Opportunities

A GREAT OPPORTUNITY! If you are planning or considering opening a practice in El Dorado Hills, give me a call!!! Dr. Linssen (916) 952-1459. *02-07*

DENTIST — RURAL HEALTH CLINIC — in Corning, twenty minutes north of Chico. Good salary percentage. Part/Full time. Serving mostly Medi-Cal patients. Opportunity for partnership. Call James at (530) 321-2927. *06/07-07*

CALIFORNIA DENTAL ASSOCIATE — MALE/FEMALE. Placerville, CA — Fee for service, long established practice. Great, professional, sophisticated, expanded function staff. 12 day hygiene week. Family oriented, great schools, friendly community, in gold country. $600/day + production, PT start / FT future. Experience requested. Resume to: drsands@jps.net or Dr. Sands, DMD; 2900 Cold Springs Rd; Placerville, CA 95667. *10-07*

ASSOCIATE — Kids Care Dental Group is looking for a pediatric specialist who loves working with kids to help us take care of our growing patient base. Great private practice with tons of potential for growth. Call Derek at (530) 263-2454 or fax your resume to (916) 290-0752. *11-07*

PEDIATRIC DENTAL PRACTICE located in Folsom seeks dentist. Excellent opportunity for skilled dentist to join our practice. Please fax resume to (916) 983-9012. *08/09-06*

ORTHODONTIST NEEDED for a well established busy 4-practice in Sacramento area. Excellent starting salary, incentive bonus plan and benefits, including medical and 401(k). Send resume to marissamcclurg@gmail.com. *05-C1*

PERIODONTIST needed for busy Roseville general dentistry practice. 2 to 3 days per week. Growth opportunity in well-established, friendly, fee-for-service practice. Send resume to mckinleyk@interdent.com. *05-C1*

STATE OF THE ART DENTAL PRACTICE in Roseville, California. Excellent compensation. One to two days a month. Email CV to rockyridgedental@surewest.net or call Art at (951) 217-6749. *05-08*

For Lease

EL DORADO HILLS! 1490 SqFt. for lease, Build to Suit. Perfect for Specialist! Adjacent to Endodontist/Owner. Close to new Town Center. Professional buildings have beautifully landscaped courtyard (waterfall, putting green, creek). Rent will be reasonable, with modest TI allowance to help build to suit. eldoradoendo@yahoo.com (916) 205-8825. *05-05*

SUITE FOR LEASE — 2 OPERATORY: Sacramento Dental Complex — Midtown. Possible to purchase existing equipment. Great for new practice. Please call (916) 448-5702. *03-07*

HIGHLY VISIBLE LINCOLN OFFICE SPACE — Divisable up to 8,000 sq ft for lease or purchase. Ground up built by a dental contractor specialist. Call (916) 772-4192 for details. *01-08*

DENTAL OFFICE SPACE AVAILABLE FOR LEASE in professional building. Located in Elk Grove. 1800 sq feet, 5 operatory spaces, large reception room, business office, laboratory and private office. Ph Mel Bell (916) 479-1827. *03-08*

DENTAL SPACE FOR LEASE — 2 nicely appointed spaces in established Carmichael Dental Building. 820 sf and 955 sf with 3 patient areas and private office in each. $1.35 psf plus utilities. Agent (916) 443-1500. *04-08*

FOLSOM DENTAL OFFICE FOR LEASE: Creekside Drive, five operatories, TI complete, excellent location. Won't last long. Dr. Rufo (916) 521-7730. *05-C1*

TURNKEY DENTAL PRACTICE — 3 operatories, remodeled, new equipment. 1355 Florin Dental Bldg. Reasonable rent, ample parking, storage. $95K, terms (916) 730-4494. *05-08*

Equipment For Sale

MERGING PRACTICES — Too much stuff! Dental equipment, instruments, office furniture. What do you need? Chairs, vac former, file cabinet, cure lite, surveyors, forceps and more — Just ask, I may have it! kguyellis@aol.com. *05-C1*

SDDS Members Can Place Classified Ads For FREE!

Selling your practice? Need an associate? Have office space to lease? Place a classified ad in the *Nugget* and see the results! SDDS members get one complimentary, professionally related classified ad per year (30 word maximum; additional words are billed at $.50 per word). Rates for non-members are $45 for the first 30 words and $.60 per word after that. Add color to your ad for just $10! For more information on placing a classified ad, please call the SDDS office (916) 446-1227. Deadlines are the first of the month before the issue in which you'd like to run.

SDDS CALENDAR OF EVENTS

MAY

1–4 **CDA Scientific Session**
Anaheim, CA

6 **Board of Directors Meeting**
6:00pm / SDDS Office

7 **CPR Committee Calibration**
6:30pm / SDDS Office

8 **Peer Review Committee**
6:30pm

9 **SDDF Golf Tournament**
Timber Creek Golf Course (Roseville)

13 **General Membership Meeting**
What Your Corporate Pharmacy Won't Tell You Today… & Other "Compounding" Concerns!
John Richards
(Owner, Professional Village Pharmacy)
Foundation Night
Sacramento Hilton — Arden West
2200 Harvard Street, Sacramento
6:00pm Social
7:00pm Dinner & Program

14 **Alliance Board Meeting**
Noon / SDDS Office

14 **Licensure Renewal Course**
California Dental Practice Act & Infection Control
Superior Office Safety
Sacramento Red Lion Inn
1400 Arden Way, Sacramento
8:30am–12:30pm

19 **Ethics Committee**
6:00pm / SDDS Office

CE Committee
6:30pm / SDDS Office

22 **Continuing Education**
HR Audio Conference
An HR Question-fest!
California Employers Association
Noon–1:00pm

27 **Membership Committee**
6:30pm / SDDS Office

29 **Phantom of the Opera**
8:00pm / Sac Community Center

JUNE

3 ***Nugget* Editorial Committee**
6:15pm / SDDS Office

6–7 **CDA Board of Trustees**
Sacramento, CA

11 **Alliance Board Meeting**
Noon / SDDS Office

12 **Peer Review Committee**
6:30pm

19 **RiverCats Game**
7:05pm / Raley Field

JULY

4 ***Independence Day***
SDDS Office Closed

9 **Alliance Board Meeting**
Noon / SDDS Office

10 **Peer Review Committee**
6:30pm

MARK YOUR CALENDAR FOR THE **29TH ANNUAL MIDWINTER CONVENTION**
FEBRUARY 19 & 20, 2009 • TONS OF CE & A GREAT TIME! SEE YOU THERE!

Loads of CEU!

FOUNDATION NIGHT

May General Membership Meeting

Earn 3 CE units!

MAY 13, 2008

WHAT YOUR CORPORATE PHARMACY WON'T TELL YOU TODAY... & OTHER "COMPOUNDING" CONCERNS!

Speaker: John Richards *(Owner, Professional Village Pharmacy)*

When it comes to medication… "One size fits all" doesn't work. Many patients have unique problems that require unique answers. Compounding pharmacists often times can help you solve these issues.

Attendees will discover: How compounded medication can help their patients, how the compounding pharmacist can be a valuable member of the dental team, what types of unique products are available to the dental team

6pm: Social & Table Clinics / 7pm: Dinner & Program
Sacramento Hilton — Arden West / 2200 Harvard Street / $52 Member price

SACRAMENTO DISTRICT DENTAL SOCIETY

915 28th Street
Sacramento, CA 95816
916.446.1211
www.sdds.org