THE NUGGET

A PUBLICATION OF THE SACRAMENTO DISTRICT DENTAL SOCIETY

JANUARY 2008

ACCESS TO CARE
PART 2

Inside:

Access to Care Revisited

PLUS: Welcome 2008 Executive Committee, Board & Committees!

Sacramento District Dental Society presents the 28th Annual MidWinter Convention & Expo

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PRESIDENT'S MESSAGE

ACCESS TO CARE: A SUBJECT THAT DEMANDS OBJECTIVE RESEARCH

By **Robert D. Shorey, DDS**

While I was gathering research and reading for this issue of the *Nugget* (Access to Care II), I became aware of a modern change in strategic ideology within our public health systems. This concept was brought forward in the book Politically Correct M.D. (Basic Books, Copyright 2000). Originally public health's mission has been responsible for three noble revolutions that have vastly improved the lives of modern man. These three health revolutions were in the following areas:

1. **Sanitation** has lead society to clean water, sewage systems, cleaner air and methods of disease isolation.
2. **Biology of Disease** has brought us antibiotics, vaccines, fluoridation and knowledge of the human genome.
3. **Healthier Lifestyles** protect us from dangerous work habits, diseases of social habits, bad nutrition and unhealthy exercise habits.

Most recently, some public health proponents have been seeking a fourth revolution that perceives the need to **engineer social justice as a means to improve the health of all Americans**. Healthcare is now perceived as the new civil rights battlefront. This newest direction of public healthcare focus has therefore become a **mixture of political ambitions and healthcare science**. Unfortunately, the results of such a mixture are dubious and some of the principles upon which science depends are being eroded through the promotion of political social agendas.

The accomplishments of science are a product of its emphasis to strive for absolute objectivity. Our "scientific method" is a metaphor for **blind neutrality**. When political agendas infect and contaminate scientific conclusions, they become the ***fruit of their preconceptions*** and can be an obstacle to uncovering truth. In a word this is what we referred to in school as "dry labbing" – the research to support the initial study hypothesis. The current political strategy invading public health research is the subject of the books Politically Correct M.D. and Storm over Biology: Essays on Science, Sentiment, and Public Policy (Prometheus Books, 1986). If these books are an accurate assessment of some of the research in public health, then the future of healthcare and its decision making processes will be compromised. In a time when many of our own professional organizations pride themselves on reaching conclusions structured on knowledge based governance, the filtering of information and promotion of preconceived conclusions contaminate and undermine the entire non-bias research concept. The process of reliance on scientific research and its fundamental principles is a necessary component to achieve progress in medicine. Having even small amounts of research that are suspect makes everyone of our lives as healthcare providers more difficult. We must be able to arrive at factual assessments of information upon which people of different cultures can objectively agree, separate from political agendas.

Healthcare is now perceived as the new civil rights battlefront.

While the basis of much of our scientific papers supporting social disparities have very strong emotional underpinnings, ultimately **emotional perspectives must be set aside to rely only on objective fact finding**. Some would argue the "end" justifies the "means." Allowing politics to contaminate the pursuit of truth undermines the unbiased scientific approach to problem solving that has rewarded healthcare with solutions that actually reach the root of many of mankind's problems. The scientific method has provided an ultimate factual dividend for all mankind to share. We must embrace the process of research on any and all issues facing healthcare. Scientific studies are the pillars of our dental profession and we must be strident concerning our responsibility to safeguard scientific objectivity. ■

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FROM THE EDITOR'S DESK

"ACCESS TO CARE" REVISITED

By **Alexander H. Malick, DMD**

In defining the term Access to Care, three aspects of the word care must be evaluated:

1. Is there a perceived NEED for the care?
2. Are resources available to meet the needs?
3. Is there a WANT for the care?

At the University of Connecticut, I was told that the World Health Organization ranked gum disease and caries as the number one world health problems. As I began to practice dentistry, I realized almost everyone needed my services in one way or another: on an emergency basis, urgent basis (deep caries pending pulpal infection) or preventive basis. Most of my friends and relatives encouraged me to hurry up and finish school so they could come to me. With this in mind, I thought, wow, in a few years, I should be a millionaire! When I graduated, I never saw them. (I did, however, get phone calls asking me to write prescriptions for pain, antibiotics for sinus infections, bronchitis and ear aches, Valium and even diet pills!) Of those that did visit me, they left when they found out they had to pay just half of my fees! The truth was that although everyone needed my services, few actually made appointments, with me or any other dentist. When I was in the Army, dental care was a 100% FREE, yet we had no shows, cancellations and failure to follow through with treatment. (It was interesting though, that once the soldiers were about to leave the Army into civilian life, they suddenly showed up for care and expected full mouth dentistry in less than two weeks, including ortho!) I also worked in a state funded clinic in San Jose, where the majority of the patients were MediCal. I was usually scheduled three patients per hour at the same time (24 per day), yet on average I saw 8-10 patients per day, some of which did not have an appointment (especially on Fridays). I could not understand why people did not get the care they needed. I knew they had the time and the means. I attended many classes focusing on how to convince people to do what they needed in the first place. I was confused. These people had "access to care," yet they did not SEEK it, or better yet, they did not seem to WANT it. I can't tell you how many of my patients told me they could not afford the co-pay for their necessary care and in the same breath inquired about Zoom Bleaching!

So, in my own 25 years of experience, I think I have answered all three questions. I know there is a need. I almost always dealt with a population that had available resources and providers, yet they didn't all seem to want the care, unless they were influenced by some outside factor (such as insurance ending, leaving the military, or cosmetics).

Most of you responded to a recent survey I took during one of the SDDS meetings. By far, the majority felt that Access to Care referred to patients' ability to pay for services.

So what does Access to Care really mean in dentistry? Well, just like all other complex human conditions (drug problems, family breakdowns, crime), Access to Care is multi-factorial including financial, physical/geographical, cultural, ethnic, political and social structural factors. I think Needs vs. Wants should also be on the list. ■

Have something to say?

LET'S HEAR IT!

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CATHY'S CORNER

THE *NUGGET*... *Another Member Benefit!*

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

Several months ago, SDDS did a survey of the membership. What came back was the incredible vote of confidence that the *Nugget* was considered the "#1 Member Benefit" in the Society!

So, as I am proof-reading this issue of the *Nugget,* it gives me another chance to assess just why the members feel this way.

If you take an extra moment while you are reading the *Nugget,* consider the information that you can glean from just this issue of the magazine. Not only will you read some very thought-provoking articles written and assembled by our guest editor, Dr. Malick, but you will also find the following important information in this month's issue:

1. **Meet next year's leadership —** these wonderful volunteers bring a wealth of knowledge and experience to the SDDS Board of Directors. They are your representatives; let them know what you think!
2. **MidWinter Convention sign-up —** there is still time to sign up for this great opportunity for doctors and staff members to get lots of CE units, licensure renewal courses and OSHA requirements!
3. **New members —** meet them in the *Nugget.* Give them a call to welcome them! New members – read the information about the FREE DINNER in February for all new members!
4. **Foundation —** Thank you, thank you, thank you to EVERYONE who has contributed to our Foundation. Hopefully we didn't miss anyone. This is YOUR Foundation, and every member of SDDS is a member of the SDDS Foundation. Please support it!
5. **Committees for 2008 —** WOW! What a huge group of volunteers who have committed to working on next year's committees. Thank you!
6. **YOU: the Dentist... the Employer —** this is a very important feature of every month's *Nugget;* this month, in particular, explains all of the new laws that affect how you run your business… it's worth the read!
7. **Vendor Members —** we are so blessed to have the support of our Vendor Members; they are there for our members to use as resources — call them!
8. **Blowing Your Horn —** the "newsy-news" of the Society's members! Do you have a horn to blow? Please let us know.

So, as I have illustrated, the *Nugget* is much more than just a newsletter! Thanks for your continued support and contributions to its "award winning excellence!"

Happy New Year!

Cathy

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March 28, 2008

Ann Eshenaur Spolarich, RDH, PhD

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THE POLITICAL WINDS OF ACCESS TO CARE: ORIGINS & DESTINATIONS

By **Barry B. Hoffman, DDS**

We all believe that a Democracy is the best form of government for protecting our personal freedoms in a responsible society. In his book, Eat the Rich (*Atlantic Monthly Press,* 1998), P.J. O'Rourke details in humorous fashion various forms of government sanctioned economic structures and the long term effect on their respective societies. He compares the untamed capitalism of Hong Kong to the tempered democratic capitalism of the United States and on down to the destitute countries of the world which only survive by the grace of the United Nations largesse. Capitalism, socialism, communism or dictatorships, all have their benefits. But it is the people's imprimatur on our government's actions that creates democracy's strength in America. Our government is only as strong and effective as the involvement of the people. Democracy, as favorable a system as it is, has an Achilles Heal. That is, in our democracy, we the people can vote for ourselves anything we want.

Our liberal society now demands that somebody else be responsible for everything that occurs to us in life. Many want the cigarette companies to be responsible for our personal behavior of smoking; dying from lung cancer or cardiovascular disease 39 years later. Others want the fast food industry to be responsible for our being overweight after eating the food they serve. A significant effort is being made to hold gun manufacturers responsible for all murders committed with guns even though an individual pulled the trigger. Somebody else must financially pay for all the destruction from Hurricane Katrina, even though protective insurance had been rejected…

When society fails to hold its fellow citizens accountable for their personal life choices, both good and bad, the seeds of our own destruction are sown. Failure to educationally prepare ourselves for the uncertainties of the future leave us ill equipped to provide ourselves the basic necessities of life, much less those comforts that make life enjoyable. By default, we ask our governments to do many of the jobs we should be doing for ourselves. In the end, governments, at all levels, ultimately determine how we live. We become a people "of the government, by the government, and for the government." So government, and worse yet, the uncontrolled bureaucracies within government that nobody elects, write the legislative mandates telling us what we must and must not do from birth until death. We the people, being preoccupied in our own lives and uninterested in being involved citizens, are given a free ride as long as somebody else is willing to look out for us.

The political mantra is to cater to affected groups: "the poor," "the elderly." or "the disenfranchised." Whenever a politician speaks, one should always insert the word "voter" for the affected group under discussion. California Governor Gray Davis talked about the "rate payer" who must be protected from the predatory power companies during the energy crisis of 2001. Insert the word "voter" and his political position on the issue is all too transparent. Politicians are deathly afraid and unable to hold their "constituents" (voters) personally accountable for the unwise choices they make in their daily lives. In light of this cowardice (political savvy?), giving the people what they want, no matter the wisdom, maintains job security. "Politicians can deal with public opinion in three ways: Ignore it, change it or pander to it. Politicians who choose the first often become ex-politicians. The second is hard. The easiest course is to pander." (Robert Samuelson, *Newsweek* Nov 1, 2006). With this recognition, we can understand why government decisions regarding spending and program expansion (politically driven decision making) usually do not match projected revenue with required allocations. This always results in accelerating deficits. Since we don't hold ourselves accountable, we shouldn't hold elected officials responsible for their decision making either. They are, after all, not statesmen but politicians; lifetime employees who make sure they get re-elected before they look out for you.

The people's desire for universal access to health care is no exception.

California Governor Arnold Schwarzenegger and Democratic legislative leaders have said their top priority will be expanding access to health care, not reducing it. Currently, state expenditures for the Medi-Cal program are $13.8 billion and are projected to rise to $15.9 billion over the next three years. This is a 5% increase per year, although inflation is running around 2% per year. To reduce this growth rate, either services have to be eliminated or payments to providers must be cut. Although cutting payments to providers is politically more attractive, the business overhead of the provider remains the same and increases with inflation. Just ask the Nurses Union if they will accept a pay cut because the State Legislature and Governor want to contain expenditures on healthcare. Are infrastructure companies from telecommunications to malpractice insurers going to take a cut in reimbursement rates? How about construction companies that build the new health facilities needed by a growing population? Will they cut the cost of labor, concrete and steel or the land itself?

In California, nearly 800 citizens defined what constitutes "Basic Benefits" in a computer simulation project called Just Coverage. Although extremely thorough, thoughtful and insightful as to what the people want, it failed to place an absolute dollar cost on basic coverage. Instead, the project abstractly assumed a 66% cost parameter compared to an employer based health plan. The panel was then charged with limiting the cost to the recipient in terms of deductibles and co-pays [(De)constructing 'Basic' Benefits: Citizens Define The Limits Of Coverage, *Health Affairs,* November/December 2006; 25(6): 1648-1655, Marjorie Ginsburg, Susan Dorr Goold and Marion Danis]. Dental

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ETHICAL APPROACHES TO IMPROVING ACCESS TO ORAL HEALTH CARE

By **Frank Catalanotto, DMD**
University of Florida College of Dentistry

In 2002, the American Dental Education Association (ADEA) established a Presidential Commission on the "Roles and Responsibilities of Academic Dental Institutions in Improving the Oral Health Status of All Americans."[1] The Commission proposed several guiding principles with respect to access to oral health care including: 1) access to basic oral health care is a human right, 2) the oral health care system must serve the common good, and 3) the oral health of vulnerable populations has a unique priority. While there is no legal right to health care in the United States, many Commission members agreed that there is a natural right to health care for all members of society and that health care for the underserved and indigent is a societal problem that must be addressed by the public at large.

Should / how can the profession reframe the ADA Code of Ethics to reflect these concepts related to the ethics of access to care?

Other papers on this issue adequately document the nature and extent of the access crisis in this country. In this paper, I would like to focus on the ethics of access to care. One question we should ask is how we as health care professionals are responding to the challenges of access to oral health care. Several reports suggest that dentists are, generally speaking, not treating Medicaid and other underserved patients, frequently because of low fees and administrative burdens [2–4]. What about philanthropic care? While dentists provided about 1.3 billion dollars in uncompensated care in 1998, this was only 2.4% of total dental expenditures compared to a rate of 5% uncompensated care of total physician expenditures.[5] Data from the American Dental Association demonstrates that while dentists mean net income increased approximately 35% from 1996 to 1999, free dental care provided by dentists decreased 6.6% and discounted dental care decreased about 10% [6,7]. Hopefully, improvements in Medicaid reimbursement rates and new programs such as Give Kids a Smile may result in increased awareness and increased philanthropic care and participation in Medicaid programs.

The Medicaid and philanthropic data prompt another question — what are some of the reasons we in the dental professions may not be adequately responding to the access challenges? Several responses come to mind but I would like to focus on the ethical framework of the profession, especially within the context of the ADEA Commission recommendations (1).

There is a legitimate perspective that practicing dentistry is a business — one must pay for rent, supplies, salaries, etc. The long term position of the American Dental Association (ADA) is that oral health care is a commodity that must be viewed in normal market or business terms, ie, demand and supply issues will determine fees, etc.

The ADEA Commission proposed an alternative perspective. First, oral healthcare should be treated differently than marketplace economies in "the good society" (8, 9). Second, oral healthcare should be accessible to all members of society and social and economic institutions of the society should be arranged to maximally benefit the worst off in society, as proposed by Rawls (10). Third, and this is most critical, health professionals have a moral obligation to provide care to the underserved and vulnerable, as described by Pellegrino (11,12).

These three terms, "the good society," "social justice" and "moral responsibilities" led me to review the ADA Code of Professional Conduct and Principles of Ethics (13). These documents do not contain any language similar to concepts of the "good society" but do address the general principle of doing good. While they address the concept of justice, I would describe the usage as more legalistic than reflecting the values of social justice. Finally, there is little in the ADA documents that address moral responsibilities of health care professionals, but the Code does address issues such as serving the community.

This leads to the question — should / how can the profession reframe the ADA Code of Professional Conduct and Principles of Ethics to reflect the concepts noted above related to the ethics of access to care? To initiate this discussion, we organized a workshop in the summer of 2005 attended by ethicists, dentists and other interested parties (14). One of the most interesting papers in the workshop, prepared by Dr. Donald Patthoff — a private practicing dentist, and Dr. Bruce Corsino — a professional ethicist, discussed a proposal for an ethical principle that our profession may consider incorporating into the dental Ethical Principles (15, 16). The authors named this principle Acceptance and/or Universal Patient Acceptance (UPA).

Acceptance can sometimes be lost in the process of diagnosis and treatment.

Corsino and Patthoff state that there are four steps in the process of becoming a patient including acceptance, diagnosis, treatment and payment. Acceptance is the conversation that needs to take place between the dentist and the potential patient to determine the need for care and the possible methods through which that care can be obtained as a patient. They express concern that acceptance can sometimes be lost in the process of diagnosis and treatment. The authors also

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By **Beth Mertz, MA**
UCSF Center for Health Professions

& **Irene Hilton, DDS, MPH**
San Francisco Department of Public Health

ACCESS TO CARE — WHAT DOES THIS MEAN?

Access to oral health care services is problematic for millions across California. But what does this really mean? Is it really a problem for a given individual to get oral health care? How is access defined and what are some of the factors that influence the ability of an individual or population to achieve access to care?

The Institute of Medicine defines access to care as "the timely use of personal health care services to achieve the best possible outcomes" (IOM, 1995). Traditionally, access to care is measured by the visits an individual has to a dental office. However, access to care as we think of it in today's complex health care environment must also include consideration of whether the care received was appropriate and of high quality, as well as whether one has access to the knowledge needed to effectively prevent disease and even access to environmental factors such as water fluoridation. This article explores issues surrounding access to care by categorizing the various barriers individuals might encounter and overcome in order to access care. Understanding the structure of barriers can inform the development of practical and innovative solutions for improving the oral health of society.

Barriers to Accessing Dental Care

There are a plethora of factors that contribute to an individual's (or population's) inability to access dental care. In this article, factors that can be considered barriers to accessing care are grouped into four general areas. The first set of barriers to access can be considered **"physical barriers"** to care. The most obvious is a lack of dentists in the area where a person lives. While the supply of active, patient care dentists in California has not kept up with the pace of population growth, resulting in declining dentist to population ratios, the overall ratio in California (71:100,000) still far exceeds the national ratio of 59 per 100,000. More importantly, studies have shown that there is a mal-distribution of dental providers across the state, with rural, low-income, and inner city communities tending to have the least number of providers available. The federal government designates these communities as "Dental Health Professional Shortage Areas (HPSA's)." The last study identifying California HPSA's found that out of 487 Medical Service Study Areas — geographic regions defined by state agencies for the administration of various programs — **97, or 2%, were at or below the federal standard of one primary care dentist for every 5,000 people**. Of the 97 shortage areas, 66 were rural and 31 were urban. Thirty-two Medical Service Study Areas, most of which are rural, did not have any dentists at all.

> *Nationwide, the rate of dental insurance coverage is much lower than the rate of medical insurance coverage.*

While some individuals may be able to overcome the distance barrier and get to services that can be up to 100 miles away, other individuals lack the resources to overcome the geographic barriers because, for example, they have no transportation, are handicapped, have child or elder care responsibilities that keep them from leaving their homes for extended periods or have language differences and are unable to communicate with dental offices. These factors can be exacerbated by dental offices that have limited hours or long waits for appointments.

As well as shortages of general practice providers in specific geographic locations, there are also shortages of types of providers — for example there are fewer pediatric providers in California compared to other states (though California is projected to be one of the youngest states in the nation) and not all providers accept Medi-Cal or Health Families insurance. All of these types of "shortages" can hinder access to dental care.

The second set of barriers to accessing care are **"financial barriers."** The cost of dental services is a barrier to access for many individuals. Nationwide, the rate of dental insurance coverage is much lower than the rate of medical insurance coverage, and approximately **40% of the CA population lacks dental coverage.** Medi-Cal and Healthy Families do cover dental care. However, as noted above, low reimbursement rates cause many providers to choose not to accept these programs. Medicare does not cover dental benefits, an issue that may be of increasing importance as the baby boomers, most of whom have all their teeth, retire. Out of pocket payment for regular routine preventive services (~$100) is cost prohibitive for poor individuals, and treatment, if severe (~$25,000 for a child with rampant decay needing hospital treatment) is unaffordable for even those with modest incomes. An adult who has not received dental care for several years may require thousands of dollars of procedures to control disease and return to a level of functionality that allows employment. Additionally, some individuals do not have sick leave benefits and cannot afford missed work time to get to a dentist during the traditional 9–5, M–F work week. As the disparities between rich and poor in the country continue to expand, the issue of affordability will increasingly become an issue to accessing care.

A third set of barriers to access to care can be considered **"attitudinal barriers"** — these are barriers that arise when there is discordance between the beliefs and expectations of the dentist and patient. Dentists hold a relatively uniform set of beliefs about the "norms" of providing and utilizing dental care in the US. Not all individuals may share this value set, creating a tension between the dental care system and the individuals. California is undoubtedly the most diverse state in nation, which exacerbates this disconnect for many communities. Many people do not speak English, are born in foreign countries where

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SOCIAL DISPARITIES IN HEALTH CARE AMONG CHILDREN IN CALIFORNIA

By **Ming Wen, PhD**
University of Utah

Social inequalities in health and health care have increasingly received attention from researchers, health practitioners and policy makers. The persistent gap in health across social groups poses moral and ethical dilemmas that challenge health systems and professionals. The federal *Healthy People 2010* initiative has established an over arching goal of eliminating health disparities across social-demographic groups *(http://www.healthypeople.gov/).* Differential access to health care across social groups is a plausible pathway, partly explaining health disparities. Because differences in health markers and social conditions in early life play a significant role in contributing to social inequalities in health across the life span, one crucial step in the process of achieving the goal of eliminating health disparities is to advance our understanding of the current situation and mechanisms of disparities in health care in early life.

Evidence shows that children of ethnic minority background, from immigrant families, with low family socioeconomic status and living in single-parent families are disproportionately represented in children lacking access to health care services. Social status also matters for the quality of care received. Data collected from California confirm some of these national trends.

Table 1 (opposite) presents evidence of social disparities in several indicators of access to health care and quality of care among children in California. Data are from the 1999 and 2002 National Survey of America's Families (NSAF) *(http://www.urban.org/center/anf/nsaf.cfm).* The NSAF is nationally representative of the non-institutionalized, civilian population of persons under age 65 in the United States. Weighted statistics of children age 0 to 17 living in California are shown here.

The first column shows that children with disadvantaged background were more likely not to get dental care when they needed it although the disparity by social status seemed to have somewhat dwindled from 1999 to 2002. For example, in 1999 10.81% of children who experienced financial hardship in terms of food and housing insecurity due to lack of money had delayed dental care when needed compared to 3.92% of those without financial hardship. The corresponding figures in 2002 were 9.15% for children in hardship and 3.88% for children without hardship. Moreover, parental education indexed by high school diploma was only protective in 1999. Interestingly, white children had much higher rates of delayed dental care than minority children in 1999, whereas in 2002 they were the least likely to have delayed dental care. What contributed to their rapid improvement in access to dental care is worth further investigation. In short, the general trend for dental care for children in California is that social status is an important determinant of children's access to dental care although the significance of social status has decreased to some extent from 1999 to 2002.

The next three columns indicate that Hispanic children (many of whom are immigrants) had the highest rates of uninsured. Immigrant children were about three times as likely as US-born children to be uninsured. Children whose parents had not received high school diploma, who were from low income or immigrant families and who experienced food and housing insecurity had significantly higher rates of being uninsured than those with more adequate family and socioeconomic resources. For example, in 1999, 37.44% of foreign-born children were not covered by any insurance versus 10.67% of the US-born being uninsured; in 2002, 25.85% of foreign-born children were not covered by any insurance compared to 9.41% for US-born children.

Similar trends were found for having usual source of care except the racial/ethnic differences (Table 1, fifth column). Hispanic children (14.21% in 1999 and 13.78% in 2002) had the highest rates of not having a usual source of care among all groups. Asian children's rate of having no usual source of care greatly reduced from 13.53% in 1999 to 7.03% in 2002.

The sixth column presents statistics on having had no well child visits in the past year. Social status still matters to this outcome but to a much lesser extent than to other access indicators. For example, in 2002, 36.40% of children whose parents had not received high school diploma had no well child visits last year compared to 30.88% of those with higher parental education. These differences, however, were not as dramatic as those we observed in delayed dental care, insurance coverage and usual source of care. This pattern may partly reflect the importance of parental attitudes towards well child care disregarding social background.

The last column provides data tapping parental satisfaction with quality of care as a proxy of quality of care received by children. Foreign-born and financial hardships are huge deficits in perceived satisfaction with health care. In 2002, 19.57% of the foreign-born versus 13.21% of the US-born had parental report of not being satisfied with quality of care; and 19.39% of children in financial hardship compared to 9.67% of those not in hardship had parental report of dissatisfaction with quality of health care. There is also some evidence to suggest that disparities in quality care might have increased in a degree from 1999 to 2002 in California. For example, in 1999 and 2002, respectively, 15.53% and 19.39% of parents in financial hardship reported not being satisfied with quality of care, compared to 10.67% and 9.67% of parents not in financial hardship.

Taken together, these data suggest that social disparities in access to care and quality of care exist by race/ethnicity, family socioeconomic status, immigrant background and family structure among children in California. For some aspects of care, these disparities decreased from 1999 to 2002 but for others they remained constant or even increased.

California is a unique state, given that its concentration of recent immigrants and ethnic minorities particularly characteristic of the state's youth population. About 47% of California's children are immigrants. Data presented here show that family socioeconomic and immigrant background play a role in contributing to disparities in access to and perceived experiences of health care. These factors are not easy to manipulate from a policy point of view, however. Across the nation, the number of children living in non-intact families is growing, the number of immigrant children is growing, and the number of children living in poverty is growing. Without having effective solutions to tackle social disparities at their sources that are inherent in our social stratification system, one possible way to deal with disparities in child health might be to implement universal health coverage in American children and adolescents to structurally reduce disparities in access to care by social status. Several states have already started state-level efforts to ensure access to care across all segments of their populations. It would be an exciting endeavor if similar measures to improve access of the poor are put in place in California so that children of disadvantaged social background are not to be deprived of good care at their early stages of life. Moreover, efforts to reduce disparities in health care should also keep disparities in quality of care in mind and may thus need to take different forms for different racial/ethnic and immigrant groups. The benefits of these targeted interventions are potentially invaluable to our next generation and to the general welfare of our increasingly diverse nation.

Ming Wen is a medical sociologist and a social demographer. She obtained an MS in statistics in 1999 and a Ph.D. in sociology in 2003 from the University of Chicago. She worked as a biostatistician at the University of Chicago from 1999 to 2003. Since she finished her graduate training in sociology in 2003, Wen has been an assistant professor in sociology at the University of Utah. Her research interests center on how multilevel social, economic, political, cultural, behavioral and psychological factors affect population and individual health-related outcomes. Around this general theme, she has been working on a series of funded projects that investigate multilevel antecedent conditions of health status, behavior, and care across the life course. ■

Table 1: Social Disparities in Access to Care among Children in California

1999

	Delayed dental care	*Currently not insured*	*Public insurance*	*Private insurance*	*No usual source of care*	*No well child visits last year*	*Not satisfied w qual of care*
Ethnic background							
White	7.85%	4.44%	7.72%	87.84%	2.73%	36.99%	13.67%
Black	3.13%	2.44%	24.89%	72.66%	4.83%	28.52%	5.12%
Hispanic	5.32%	25.10%	19.36%	55.54%	14.21%	38.77%	10.99%
Asian	2.95%	4.72%	5.38%	89.90%	13.53%	38.01%	14.04%
Immigrant status							
US-born	6.08%	10.67%	13.16%	76.17%	6.58%	37.24%	11.44%
Foreign-born	6.46%	37.44%	13.86%	48.71%	29.92%	39.91%	19.05%
Family structure							
Non-intact	7.78%	13.79%	20.45%	65.76%	13.53%	54.97%	9.86%
Intact	5.82%	13.32%	11.94%	74.74%	8.14%	34.39%	12.64%
Family income*							
Lowest	9.71%	33.94%	48.93%	17.13%	26.32%	40.83%	12.02%
Medium	6.93%	17.90%	14.26%	67.84%	7.94%	38.13%	13.09%
Highest	5.23%	2.12%	1.19%	96.69%	4.00%	36.62%	11.89%
Financial hardship							
Yes	10.81%	21.22%	26.04%	52.74%	15.29%	40.32%	15.53%
No	3.92%	9.74%	7.26%	83.00%	6.00%	36.20%	10.67%
Parental education							
No HS diploma	8.01%	30.17%	24.11%	45.72%	18.72%	42.22%	13.13%
Above HS	5.40%	7.05%	9.12%	83.83%	5.26%	35.73%	11.87%

2002

	Delayed dental care	*Currently not insured*	*Public insurance*	*Private insurance*	*No usual source of care*	*No well child visits last year*	*Not satisfied w qual of care*
Ethnic background							
White	5.29%	4.74%	15.86%	79.41%	3.99%	32.89%	11.93%
Black	6.94%	6.17%	47.75%	46.07%	6.54%	23.06%	19.21%
Hispanic	6.07%	18.41%	38.23%	43.36%	13.78%	35.18%	15.35%
Asian	6.00%	3.98%	10.45%	85.57%	7.03%	23.72%	8.51%
Immigrant status							
US-born	5.57%	9.41%	28.13%	62.46%	7.65%	31.14%	13.21%
Foreign-born	7.96%	25.85%	32.16%	42.00%	20.13%	39.85%	19.57%
Family structure							
Non-intact	7.05%	12.31%	43.72%	43.98%	11.71%	32.90%	16.78%
Intact *(2-parent)*	5.24%	10.66%	21.04%	68.31%	7.72%	31.70%	12.50%
Family income*							
Lowest	5.85%	16.80%	66.47%	16.74%	16.81%	32.09%	18.66%
Medium	7.53%	16.76%	31.53%	51.71%	10.83%	39.34%	17.71%
Highest	4.53%	3.58%	4.47%	91.95%	2.65%	28.22%	7.98%
Financial hardship							
Yes	9.15%	16.47%	46.82%	36.72%	14.25	32.71%	19.39%
No	3.88%	7.45%	16.43%	76.12%	4.81	30.45%	9.67%
Parental education							
No HS diploma	5.69%	20.81%	42.86%	36.33%	14.58%	36.40%	15.05%
Above HS	5.88%	8.42%	24.42%	67.16%	7.46%	30.88%	13.59%

*** Family income:** *lowest (at or below federal poverty level), medium (greater than federal poverty level and lower than 4 times of federal poverty line), highest (at or above 4 times of federal poverty line).*

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LATINO VALUES & ACCULTURATION: WHAT DO THEY HAVE TO DO WITH DENTAL CARE?

By **Lucy M. Delgadillo, PhD**
University of Utah

Awareness of cultural variations among families of different origins has applications relevant to dental prevention and treatment programs. No program can be effective if it does not take into account the cultural values most important in a targeted population. How do cultural values affect visits to the doctor? In what way do these cultural values affect people's behaviour regarding dental care? Identification of Latino family values, and levels of family acculturation, are just a few issues to be considered by successful health providers.

Latinos are often viewed as a homogenous group. In reality, Latinos are not only different from the white and non-white population by most demographic and socioeconomic measures but they also differ among themselves in national origin, English fluency, and economic status. Low-income Latinos may not be grouped with high income Latinos, or with low income non-Latinos.

Understanding Cultural Values and Frame of Reference

Although it seems like an easy task, the potential for stereotyping makes it a challenge to provide precise descriptions of Latino values. The collective identities recognized by researchers (Falicov, 1998; Falicov & Karrer, 1980; Ginorio & Huston, 2000; Pine, 1976) are more social conceptualizations than a true picture of the complexity of Latino culture and behavior. Therefore, generalizations made about Latinos in this article should not be taken so rigidly as to ignore individuality and idiosyncrasies of cultural heritage. The best way to tap into values is by conducting focus groups with the targeted population.

Generally speaking, family, collaboration, mutual dependency, present orientation, external locus of control, fatalism and religion are core values for Latinos. Of these, the value of *family* is very important. When Latinos talk about family they could mean nuclear or extended family; Latinos do not distinguish between the two. Why is this important to know? For example, if your goal is to promote oral hygiene among children, you have to keep in mind that the children's habits are going go be influenced by their parents' habits, who are in turn influenced by the grandparents, and all of them (child-parent-grandparent) may be living in the same household. In this scenario, the challenge health providers face is to educate three generations at once. Because of this strong family orientation, which is a major source of social and emotional support, it would not be unusual for other family members to accompany a patient to the doctor's office to support the recipient of the medical treatment.

How do cultural values affect visits to the doctor?

Another salient value among Latinos is respect for others and deference to authority. Latinos rarely challenge an authoritative response by a well educated professional, even when the service is being offered in poor Spanish by an Anglo provider. Lack of control, and perhaps immigration status, may result in Latinos being more accepting of poor outcomes.

Longer social protocols are the norm and are highly valued. A light chit-chat prior to a discussion about science, teeth or other health concerns is always appreciated and seen as friendly and reassuring. Good social relationships with patients precipitate confidence, strong bonds of loyalty, and good referrals. Other broad cultural differences reflecting the average features and values of the Latino culture and middle-income Americans are listed in Table 2.

Acculturation Journey (see Table 2)

Acculturation refers to the changes that occur when one group acquires some of the characteristic values or behaviors of the other without giving up its own values or behavior (Ginorio & Houston, 2000). Acculturation of immigrant groups can be measured in a variety of ways, such as years or generations of residence in the United States, use of the English language (spoken at home; spoken with friends; ability to think in a second language), educational attainment and number of non-Latino friends (Cuellar, Arnold, & Maldonado, 1995; Ginorio & Huston, 2000; Gordon, 1964; Medina & Chau, 1998; Olson, Zuiker & Montalto, 2000). English language has been the best determinant of acculturation among Latinos. Conversely, researchers measure attachment to Latino culture by use of the Spanish language, participation in Latino traditions, and constructed scales of "Hispanicness" (Valencia, 1985; Valdes, 2000), among other indicators. It is important to recognize that acculturation has different stages and may not be experienced uniformly among all Latino groups. Table 3 provides a summary of the interrelationship between length of residence, acculturation levels, value systems, and preferred language.

Interrelationship Between Length of Residence, Acculturation Levels, Value Systems and Language Preferred (see Table 3)

Latino children and teenagers who go to school are believed to be more acculturated than their parents because they come into contact more often with mainstream Anglo values portrayed by their peers, teachers, and the media. Educational and socialization processes learned at school sometimes conflict with their home cultural values. For example, for Latino children, dependency and cooperation are nurtured at home, while independence and competition are valued in school. Similarly, an authoritarian style prevalent at home — with a clear family stratification by gender and age (father, mother, children) and generational hierarchy (grandparents, children, grandchildren) — is contrasted with a more democratic style taught in school (Ginorio & Huston, 2000). Shultz (1976) reports that the integration of native

and traditional values with the dominant culture's current values is a conflictive process that takes at least three generations.

Since culture, values and language are intertwined, should one address the Latino population in English or in Spanish? The answer depends upon the demographic characteristics of the group, length of residence in the U.S., and preferred language. Once the Latino group is defined, the most effective strategy can be weighed against those factors. For example, if the target audience is the children and youth of adult Latino immigrants, they may feel comfortable communicating in English. If the target audience is recent immigrants and adults, which is a high probability because about 66% of all Latino adults in the U.S. were born abroad, they are more likely to be predominantly Spanish-speaking. Because of the varying degree of acculturation among Latino families, a Spanish-only or English-only strategy may not be effective in reaching Latinos. In many cases, a cross-over communication strategy that combines both languages may be the best option. Effective communication with audiences who have Limited English Proficiency (LEP) also involves developing a marketing strategy that integrates traditional and non-traditional outreach methods. ■

Table 2: Family & Cultural Values

Latino Culture	Anglo Culture
Group oriented, collectivism, emphasis on familism	Self oriented, emphasis on individualism
Larger families (extended family), physical closeness	Smaller families (nuclear family); personal space respected
Family interdependency or dependency, collaboration	Individualistic behavior; independence is encouraged
Sources of authority are respected and trusted	Sources of authority are respected but questioned
Fate determines future; external locus of control.	Hard work determines future; internal locus of control
Spontaneous, relaxed about time; time is to be enjoyed.	Planners, adhere to schedules; time is as valuable as money
Longer social protocols	Brief, concise, and to the point
Stress cooperation, participation, being part of a group	Stress competition, achievement, motivation and self-competence
Present oriented	Future oriented
Appreciate being given all the needed time (the more the better) when interacting with service providers	Appreciate efficiency and efficacy

Sources: Valdes (2000); Noble & Lacasa (1991).

Table 3: Interrelationship between Length of Residence, Acculturation Levels, Value Systems & Language Preferred

Length of Residence and Education	Value System and Acculturation	Language Preference
New immigrants (foreign born), from a few months to a few years of residence, and low educational attainment	Traditional Latino value system from country of origin	Spanish only
New immigrants with a few years of residence in the U.S., who consider English their second language	Latino value system with beginning stages of acculturation	Spanish preferred
Immigrants with either long years of residence in the U.S., high educational attainment, or both	Intermediate state of acculturation	True bilinguals
Immigrants' children (first generation/second generation)	Hybrid culture, bi-culturalism	English preferred
U.S. born Latino third generation	Main stream Anglo values fully adopted, behave like middle class Anglo	English only

Cervantes, J. (1980), Falicov, C.J. (1998), Ginorio, A.B., & Huston, M.M. (2000), Perez, W., & Padilla, A.M. (August 2000), Valdes, M. I. (2000), Valencia, H. (1985).

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ACCESS TO CARE: A DIFFERENT PERSPECTIVE

By **Steven K. Kirkpatrick, DDS**

Upon landing at La Mesa International in San Pedro Sula, Honduras after a red eye flight from San Francisco with an overnight stopover in San Salvador, I began to adjust to my new surroundings. My senses were on high alert as I collected my bags containing my instruments and supplies and prepared to clear customs. I was in a foreign country, this was not a tourist destination, there was no one else of my color around and I didn't want to loose anything. My next concern was to transport all my "stuff" to the hotel where I would meet the rest of the ACTS group traveling independently from the east coast. ACTS (Americans Caring Teaching Sharing), as I was soon to learn, is a small loosely knit, incredibly effective organization of very committed people who have been providing medical and dental care, as well as assisting with public health infrastructure improvements for the people of El Rosario (Pop. 700) and its surrounds for about 25 years. The road to town was crowded with cars passing on the right and left dodging the wary pedestrians carrying their produce or pushing it in carts. My taxi driver took all this in stride as we drove to the hotel. In the center of town I noticed that every bank or major business had at least two heavily armed (M16 or shotgun) guards wearing ballistic protective vests.

Our group of nine included two dentists, one dental student, one physician, one medical student, one chiropractor and two "lay" people. We rented two four-door Toyota 4wd trucks, loaded all our supplies including enough food and bottled water for 10 days and took off for El Rosario, three and a half hours away. After two hours or so of mostly paved road we turned on to a deeply rutted dirt road that wound and climbed up into heavily forested and I might add stunningly beautiful mountains. We crossed through several streams that were small on this day only because it wasn't raining.

El Rosario at last. Slowly making our way through town I noticed that there were no stores, shops, power or phone lines. Pigs, chickens, goats and a few cattle were scattered throughout the town. The pens meant to contain the cattle and pigs often were not adequate unless a large forked branch was tied to the animal's neck effectively making the animal much larger and unable to penetrate the fence. People were busy going about their daily lives. Upon arrival in El Rosario, Dr. Jim Gold — East Thetford VT, my connection to the group whom I had met at the Pankey Institute the previous year, Beth Kulic —– then a fourth year dental student, now practicing in NYC and I were anxious to assess the status of the clinic. It had been two years since a dentist had been there and we also wanted to assemble our "new" dental chair. The new chair was fabricated from a stamped steel tractor seat with legs and a back rest. The floors were concrete, the walls were block and the roof was tin. There was a sink in one corner with water that ran cold but was now, thanks to ACTS, also clean. For many years the people of El Rosario had suffered from repeated GI infections due to contaminated water. ACTS volunteers helped redo the water system, helped every home build a sanitary latrine and put an end repeated GI infections. This clean water supply was now the envy of all the surrounding villages. Clearly, this was going to be a life altering experience — clorox for sterilization, 2X2 gauze and a cardboard box for removal of saliva and blood — x-rays would be something for the world we left back home.

> *Clearly, this was going to be a life altering experience.*

Adjustment to this new world was abrupt and wrenching. Word of our arrival spread rapidly. Soon people started to show up for treatment: men, women, children, families — people of all ages presenting with small medium and large carious lesions, red swollen gingival and not one of them had ever had any restorative dental treatment. The difficult decisions – what to extract, what to leave (there was a remote chance that somehow somewhere and soon this person would get restorative treatment before the pain started) — were made rapidly as there were lots of people waiting. There was a continuous stream of patients, quiet, resolved, stoic, friendly and polite, dressed in their very best. Families with freshly scrubbed kids walked, sometimes several hours, to get help and would return home often after dark, mouths stuffed with red stained gauze, with only the stars and moon to light the way.

We brought hundreds of toothbrushes to dispense along with our instructions for use and diet counseling. In retrospect this feeble prevention effort, though well intended, would not be nearly enough to make much of a dent in the problem.

SO! Access to Care! What does that mean to me in the current context of my smug, comfortable life in California? Several thoughts come to mind. It is no wonder why millions of people leave their friends and family south of the border and have flooded into the USA. Further it is no mystery why, statistically speaking, California has so many children with untreated dental problems. What I do wonder is why some California politicians are pushing for a single payer program they claim will solve all the dental care problems and yet they are unwilling to fund universal fluoridation, the one investment that would dramatically cut the need for dental restorative treatment. That makes as much sense as continuing to treat repetitive GI infections but being unwilling to help clean up the water supply. If you clean up the water supply you no longer have a dependent population. Similar benefits accrue with fluoridation. Why, for instance would El Dorado County, in the 90s, use grant money (can you say free?) to start a dental clinic to treat Denti-Cal patients but be unwilling to use available resources (donated labor) to keep it in the black and operating.

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BABY NUGGET

BROUGHT TO YOU BY YOUR DENTAL HEALTH COMMITTEE

HOW TO BOOST YOUR CHILD'S GPA THE DENTAL WAY

By **Victoria K. Sullivan, DDS**

As dentists, we are constantly trying to improve our patients' nutritional habits. With pediatric patients this is especially challenging. Children have immature immune systems, they eat a high carbohydrate-high frequency diet, their hygiene efforts are not ideal, their enamel is thinner than that of permanent teeth, and Early Childhood Decay is especially virulent. In the education process, we must provide information on the decay cycle, hygiene tips and, most particularly, improved nutrition.

We can interest our busy parents in improved nutritional efforts in a crafty way by linking improved nutrition with improved school performance. The average American child is absent 3.1 days per year due to decay-related pain and may miss more school days to restore damaged teeth. All children need accessible brain sharpening equipment. The easiest source for an improved G.P.A. is located in the family refrigerator of our busy children. Improved cognitive function, better math skills, verbal skills and creativity have been linked to eating healthy balanced meals and good hydration. Children need to keep hydrated, as hydrated bodies are bodies better able to absorb nutrients effectively.

To "brain boost," children need to concentrate their snacking in more healthy directions such as: meat or fish, eggs, peanut butter, whole grain bread, low-fat frozen yogurt, popcorn, chocolate, hummus, fruit, veggies and cheese. Parents need to avoid stocking their pantries and refrigerator with "brain busting" foods such as: juice and soda, French fries or chips, cake, cookies, doughnuts, white flour, white rice, sugar cereals and sticky candies.

The number of times which a child eats also contributes to decay. Ideally children would eat no more than four times a day. Children should not "graze" all day long on either sugary drinks or foods. Grazing results in lowered PH within the mouth and gives bacteria the natural "foothold" to begin and develop decay. Ideally parents will brush the teeth of their children through age 7 and floss their children through age 9. Use of topical rinses such as A.C.T. and fluoridated toothpastes can also contribute to improved health and school performance.

In an on-going effort to improve our treatment with children and adapt to the emerging "evidence-based" treatment direction, nutrition and disease process counseling for our parents is essential and will need to be a continuing growth area in our practices. ■

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THANK YOU DONORS!

If you're interested in donating to the Foundation, contact SDDS at (916) 446-1227.

Donors listed as of 12/17/07

THANK YOU, RUNNERS & SPONSORS!

TOTAL MILES: 234 MILES!

Proceeds from our sMILES for Kids runners go to Sacramento District Dental Foundation's Smiles for Kids program. Thank you, Dr. Rollofson, for organizing this event. We've raised **$18,465** to date and the money's still rolling in!

SDDS MEMBER MARATHON FINISHERS:

Dr. Donna Galante	*26 MILES!*	*4:36:00*
Dr. Kang Lee	*26 MILES!*	*5:40:00*
Dr. Dwight Miller	*26 MILES!*	*2:56:41*
Dr. Don Rollofson	*26 MILES!*	*4:43:00*
Dr. Benton Runquist	*26 MILES!*	*3:30:20*

RELAY RUNNERS:

Dr. Dan Thu Nguyen	*Relay*	*Finished!*
Weideman Pediatric Dentistry	*Relay*	*3:55:52*
Dr. Cindy Weideman		
Dr. Candy Tan-Chi McComb		
Dr. Brigid Walsh		
Dr. Dave Trent		
Wells Fargo Bank	*Relay*	*4:43:00*
Janet Percevic	*13 miles*	
Leo Hamel	*13 miles*	

GREAT JOB, SMILES FOR KIDS ORTHO DOCS!

At the end of 2007, Smiles for Kids treated its 500th orthodontic patient!

I love marathons, Smiles for Kids and the Sacramento District Dental Society. How can those three be put together?

I completed the CIM full marathon today in 5 hrs 40 min, so I was unfortunately unable to see any SDDS member or give my sponsoring check to anybody.

I put the check of $1,310.00 (one thousand three hundred and ten dollars) in my mail box today so it will arrive to Ms Cathy Levering (Executive Director) in a few days.

Thanks, as always, for your professional service for the Society.

— Dr. Kang Lee, South Lake Tahoe

EVENT HIGHLIGHTS

SDDS HOLIDAY PARTY 2007

December 3, 2007 • Thanks to Drs. Shorey, Sorunke & Hakimi for contributing to the photos below!

CONVERSATION, LIBATION, FOUNDATION!

The 2007 SDDS Holiday Party and Silent Auction provided a festive venue for members and their guests to spend time together in celebration of the holiday season. This year's silent auction was a huge hit, raising $6,035 for the Foundation!

The merry men and women, from left to right: *(top row)* Drs. Bevan Richardson and Kim Wallace • Elaine Ferrasi and Dr. Bellamy • Drs. George Koch and Jerome Dobak • Darlene and Dr. Herb Hooper • Dr. Jim and Joyce Oates • Susan Neal and Dr. Walter Winfrey • Drs. Ken and Diana Fat *(bottom row)* Linda and Dr. Henry Bennett • Tamara and Dr. Jeff Rosa • Dr. Jim and Ann Peck • Dr. Emmanuel and Zhanna Kandkhorov • Dr. Don Rollofson and Janet Percevic (one day post-marathon!) • Christopher and Dr. Thais Booms • SDDS staff and Phil Waelbrock (Zimmer)

Photos *(left to right):* 2008 SDDS Executive Committee — Drs. Wai Chan (Secretary), Terry Jones (Treasurer), Adrian Carrington (President Elect), Kevin McCurry (Immediate Past President) and Robert Shorey (President) • Dr. Kevin McCurry shows his Past President gift from SDDS — a limited edition duck print stamp

(more info on award recipients on page 34)

HOLIDAY PARTY SPONSOR: Drs. Nicky Hakimi, Brad Townsend & Justin Gee • **AUCTION ITEM DONORS:** Dr. Henry Bennett • Ms. Mari Bradford (CA Employers Assn) • Ms. Anne Brown, First U.S. Community Credit Union • Dr. Matthew & Irene Campbell • Ms. Judy Couch (Citibank) • Drs. Paul Cater & Donna Galante • Ms. Charlene Davis (Sacramento Hilton Arden West) • Dr. Kent Farnsworth • Dr. Louis Gallia • Dr. Kelly Giannetti & Family • Dr. Bob & Mary Lou Gillis • Dr. Nicky Hakimi, DDS, MSD & Melissa Owen, RDH • Mr. Mark Hansen, ChFC, CSA (CFP, Hansen & Associates) • Dr. Greg Heise • Mr. Ernie Jimenez (Ernesto's, Mas & Zocalo Restaurants) • Mr. Creighton Kahoalii (RiverCats) • Ms. Yvonne Kreck (Mill Creek Vineyards) • Bruce & Cathy Levering (Levering Company) • Mr. Milton Lobato (California Fleet Mobile Detailing) • Maloof Sports & Entertainment • Dr. George W. Oatis, Jr. • Mr. Chris Poulos (Turkey Creek Golf Course) • Dr. Donald P. Rollofson • Ms. Ulrich Samutz (Hyatt Regency Sacramento) **THANK YOU!**

Photos *(left to right):* Dr. Kevin McCurry presents the Distinguished Alliance Member Award to Irene Campbell • Dr. Glen Tueller receives the Distinguished Member Award, as Dr. Kevin McCurry and Cathy Levering look on • Dr. Bob Gillis recognizes outgoing Foundation Board Members, Drs. Nicky Hakimi and Terry Jones • Outgoing SDDS Board Members, Drs. Nicky Hakimi, Wai Chan, Henry Bennett and Glen Tueller show their plaques • Life Members, Drs. Bevan Richardson, Henry Bennett, Wesley Honbo, Gordon Douglass and Robert Tilly receive their certificates and Life Member pins • Dr. Adrian Carrington raises a glass to 2007

SDDS PAST PRESIDENTS: *(left to right)* Dr. Kevin McCurry (2007), Dr. Bevan Richardson (1991), Dr. James Peck (1994), Dr. Nicky Hakimi (2006), Dr. Marty Rosa (1989), Dr. Don Rollofson (2002), Dr. John Orsi (2000), Dr. Walt Skinner (1988), Dr. Bob Gillis (2003), Dr. Jerome Dobak (1987), Dr. Jim Oates(2004), Dr. Kent Farnsworth (1992), Dr. Herb Hooper (1983), Dr. Glen Tueller (2001), Dr. Matt Campbell (1998), Dr. Donald Hagy (1982), Dr. Kevin Keating (2005), Dr. Ken Fat (1979), Dr. George Koch (1972), Dr. Gordon Douglass (1990), Dr. Gordon Harris (1979), Dr. Kent Daft (1995–96) and Dr. Bob Daby (1997).

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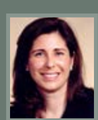

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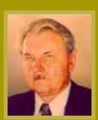

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- Advisory & Ad Hoc Committees
- Special Event Committees
- Work Groups
- Miscellaneous Committees

See page 23 for 2008 Committee Meeting Schedule

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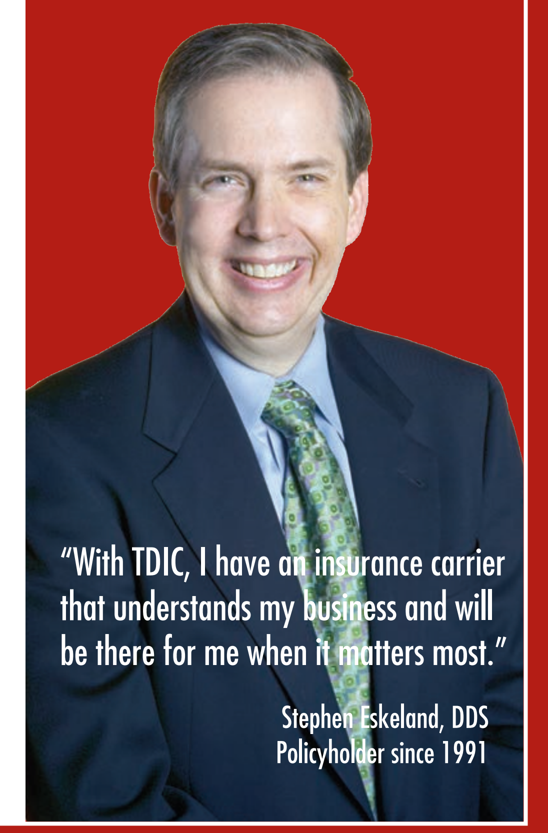

2008 SDDS COMMITTEE MEETINGS:

Auxiliary Ad Hoc • SDDS • 6:30pm
2008 meetings TBA

Board of Directors • SDDS • 6:00pm
Jan 15 • Mar 4 • May 6 • Sept 2 • Nov 4

CE Committee • SDDS • 6:30pm
Jan 14 • Mar 31 • May 19 • Oct 6 • Dec 1

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

Dental Health Committee • SDDS • 6:30pm
Feb 4 • Apr 21 • Sept 30 • Dec 9

Ethics Committee • SDDS • 6:00pm
Jan 29 • May 19 • Oct 6

Foundation (SDDF) • SDDS • 6:30pm
Jan 23 • Apr 21 • Sept 30 • Nov 19

Golf Committee • SDDS • Times TBA
Jan 28

Leadership Dev. Committee • SDDS • 6:00pm
2008 meetings TBA

Legislative Committee • SDDS • 7:00pm
Apr 14

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

Membership Committee • SDDS • 6:30pm
Jan 23 • *New Member Dinner: Feb 6, 2008*
Mar 10 • May 27 • Sept 22

***Nugget* Editorial Committee • SDDS • 6:15pm**
Feb 26 • June 3 • Oct 28

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

SacPAC Committee • SDDS • 6:00pm
Apr 14

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

House of Delegates 2007 *(left to right): New CDA President, Dr. Brian Scott; Current SDDS Trustees, Drs. Glen Tueller and Don Rollofson; Outgoing SDDS Trustee, Dr. Glen Tueller; Incoming Trustee, Dr. Kevin Keating*

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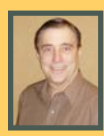

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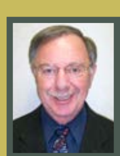

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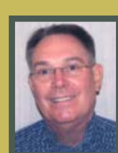

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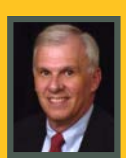

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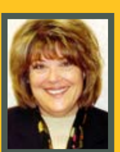

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YOU: THE DENTIST... THE EMPLOYER

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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.

NEW LAWS AFFECTING BUSINESSES IN 2008

By **California Employers Association (CEA)**

AB 1835 (enacted in 2006) CA Minimum Wage Increase This law allowed for a state minimum wage increase for all industries from 7.00 to 7.50 to 8.00 over 3 years. Whether you have hourly, salaried or a combination of hourly and salaried employees — this law affects you.

New I-9 Form (December 26, 2007) All US employers must start using the Department of Homeland Security's (DHS) revised Form I-9, *Employment Eligibility Verification* and M-274, *Handbook for Employers, Instructions for Completing the Form I-9* on or before December 26, 2007, to verify the employment eligibility of their employees hired after November 6, 1986, who are eligible to work in the US in order to prove that their identities match their work authorization documents. (This can be found on the CEA website under resources, government resources.

New IRS Mileage Rates

- 2008 rate increase for operating an automobile for business, charity, medical or moving purposes
- 50.5 cents/mile for business miles driven;
- 19 cents per mile driven for medical or moving purposes; and
- 14 cents per mile driven in service to a charitable organization.

No Social Security Number on Pay Stubs

- Enacted in 2005, this law becomes effective 1/1/08.
- Employers will be required to list only the last four numbers of an employee's Social Security number, or an employee identification number that is not the employee's Social Security number.
- Employers who knowingly and intentionally violate the provisions of Labor Code Section 226 could be subject to misdemeanor charges and civil penalties

SB 1613 Driving While Talking on a Cell Phone Makes it an infraction to drive a motor vehicle while using a wireless telephone unless the telephone is designed and configured to allow hands free listening and talking and is used in that manner while driving.

AB 650 Employer Required Notification — Earned Income Tax Credit Effective Jan. 1, 2008, California employers who are required to provide unemployment insurance must notify all employees that they may be eligible for the federal Earned Income Tax Credit (EITC) within one week before or after, or at the same time, the employer provides an annual wage summary including but not limited to a Form W-2 or Form 1099. Employers are encouraged to consult with their payroll service, accountant and/or legal counsel regarding compliance with tax laws.

AB 338 Temporary Disability Payments Effective Jan. 1, 2008, AB 338 changes how temporary disability (TD) is paid to injured workers. Under current law, an injured worker can receive 104 weeks of TD benefits. However, those benefits have to be paid within 104 weeks of the first date that temporary disability is paid. AB 338 removes the requirement that the TD benefits be collected within two years of the first date that TD is paid. Instead injured workers are eligible for 104 weeks of temporary disability as long as those benefits are paid within five years of the date of injury. Benefits are still capped at 104 weeks, but the injured worker has a longer period of time in which to collect those benefits.

AB 392 Urgency Legislation, Military Spouse Leave Governor Arnold Schwarzenegger signed AB 392 on October 9, 2007, which requires employers with 25 or more employees to give qualified employees as many as 10 unpaid days off when their spouse is on leave from military deployment. A qualified employee is one who works for more than 20 hours per week whose spouse is a member of the Armed Forces, National Guard or Reserves who has been deployed during a period of military conflict. The employee must provide the employer with notice within at least two business days of receiving official notice that their spouse will be on leave from deployment that s/he wishes to take leave. The employee must also provide the employer with written documentation certifying the spouse will be on leave from deployment. This is an urgency statute, so it is effective immediately for all employers with 25 or more employees.

AB 14 Civil Rights Act of 2007 The Unruh Civil Rights Act entitles all people in California to full and equal accommodations, advantages, facilities, privileges or services in all business establishments regardless of sex, race, color, religion, ancestry, national origin, disability, medical condition, marital status or sexual orientation. This bill expands these protections to include a number of groups and individuals previously not specifically listed.

AB 102 Name Change, Domestic Partnership & Marriage License Requires the state Secretary of State to amend domestic partner registration forms to include an option for either or both parties to change their middle and/or last names. The Secretary of State, when preparing the Certificate of Registered Partnership, must include the name used by each party before registration and any new name(s). *Employer note: A person engaged in a trade or business of any kind or in the provision of a service of any kind is prohibited from refusing to do business with or refusing to provide the service to, or imposing a specified requirement upon the use of the name, as a condition of doing business with or providing the service to, a person who uses a name adopted upon the solemnization of marriage or registration of a domestic partnership.*

SB 869 Workers' Comp Authorizes the Labor Commission to systematically identify unlawfully insured employers and prioritize targets for the workers' compensation (WC) program in consideration of available resources. This bill requires the report to be posted on the Labor Commissioner's Web site. The funds will come from the WC revolving fund in the state treasury. The bill directs the Director of Employment Development to share information with the

Labor Commissioner so she can more readily identify unlawfully insured employers.

AB 632 Health Care & Whistleblower Protection This bill prohibits a health facility from discriminating or retaliating against any patient, employee, member of the facility's medical staff or any other health care worker of the facility because that person has (1) presented a grievance, complaint or report to an entity or agency responsible for accrediting or evaluating the facility or to any other governmental agency; or (2) has initiated, participated or cooperated in an investigation or administrative proceeding related to the quality of care, services or conditions at the facility.

An employee who has been discriminated against in employment in violation of this law shall be entitled to reinstatement, reimbursement for lost wages and work benefits caused by the employer, or to any remedy deemed warranted by the court, as well as lost income and legal costs.

AB 1302 Health Insurance Portability and Accountability Act Extends the Act's duration to July 1, 2010. ■

The Political Winds... Destinations

CONTINUED FROM PAGE 7

and vision coverage was deemed "basic." Responsible planning always begins with a fixed budget before deciding on structural elements and cost shares.

The Oregon Health Plan, developed in the 1980s, was once viewed as the wave of the future. Originally designed to provide funding for those medical procedures deemed most cost effective (top 709 condition and treatment pairs), it never fulfilled its promise of dramatic savings. As a rationing scheme disguised by euphemisms of "prioritization" or "resource allocation," it never had a chance. It simply became politically impossible for the public, legislators and health professionals to agree on a sensible plan for state financed medical care. Ultimately it devolved into a traditional government program with expanded services for more people through managed care contracts and increased funding from general treasury contributions and targeted taxes on cigarettes. The political weight of the task proved too heavy to lift. We now have the Massachusetts Health Plan and a California version being developed as I write. The egregious California plan intends to force all businesses to provide health insurance or pay a penalty to the State, even if the employee freely chooses not to have coverage.

As with all demands, the people's "want" ultimately becomes an unbearable pressure to create a new "right." Dr. Thomas Sowell, senior fellow at the Hoover Institution, Stanford University says, "The political answer is to create 'rights' to things, equally available to all, regardless of what they did or didn't contribute to society and regardless of whether they behaved responsibly or irresponsibly in schools, at work or in life" ("Unfair" Advantages, 5-05-00). The people are entitled! Once "rights" are created, the government requirement is to provide endless funding for the equalization process. We want somebody else to pay our health care costs when it is often personal behaviors that create the problem in the first place; principally tobacco use, but also alcohol and drug abuse, and the lack of basic hygiene for dental problems. In 1993 California spent $1.7 billion out of a total $10.5 billion (16.2%) Medicaid budget for smoking related diseases. Substantial documented evidence is available concerning irresponsible personal spending habits of eligible beneficiary groups for consumer electronics, dietary preferences and other discretionary items. Individual or family eligibility is a tangled maze of qualifiers that can not be determined by anyone other than a social services expert whose bottom line criteria is non-discriminatory "means testing." Personal responsibility must be eliminated from consideration.

Access to Care is certainly noble and good and in no way should benefits be denied to the truly needy. But all services must eventually be paid for, since there is no such thing as a free lunch. Robert Kiyosaki, author of Rich Dad, Poor Dad, says "…I knew the politicians running our country would not stop spending, would not stop borrowing, and would not stop printing money. It was the financial incompetence of our leaders that was predictable. They do not solve problems. They simply push the problem forward and make the problem bigger." An honest assessment of what California can afford in total dollar expenditures must be made before basic benefits are decided upon and is essential to any plan of integrity and fiscal responsibility. May a divine entity help us when the day of financial reckoning hits. We can shake our collective heads and wonder how it ever got this way. The obvious answer is "We only have ourselves to blame." ■

ABSTRACTS

Immediate dentin sealing supports delayed restoration placement

P. Magne, et al
J Pros Dent 98:3 2007

The authors state that the results of the in vitro study indicate that freshly cut dentin surfaces (inlay, veneer, and crown preparations) may be sealed with a dentin bonding agent immediately following tooth preparation, prior to impression making. Three-step etch rinse or 2-step self etching DBA's are recommended, and the bond of the definitive restoration to the resin-coated dentin can still be obtained following extended placement of provisional restorations up to 12 weeks. Also, the sealed dentin is protected from bacterial leakage and the risk for postcementation sensitivity is reduced.

Efficacy of an automated flossing device in different regions of the mouth

A. Hague & W. Carr
J Perio 78:8 2007

The study found that the automated flossing device (Ultra Flosser, William Getgey Co.) removed significantly more interproximal plaque in molar, premolar, and anterior teeth compared to manual floss at days 15 and 30.

Current ceramic materials and systems with clinical recommendations: A systematic review

H. Conrad, et al
J Pros Dent 98:5 2007

Results of the study indicate there is not a single all-ceramic material or system for all clinical situations. The successful application is dependent upon the clinician to match the materials, manufacturing techniques, and cementation or bonding procedures with the individual clinical situation.

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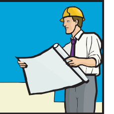

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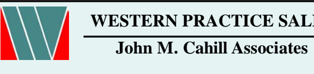

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CONTINUED FROM PAGE 8

express concern about practice patterns or styles of Acceptance that might cause barriers to access. "Random acceptance is practiced when providers do not specifically plan their actions to determine which persons will be seen for discussion and perhaps treated… For example, an office that is wheelchair-inaccessible leads to exclusion and reduced access to care… Selective acceptance is an intentional process that specifically seeks to limit who can be seen and treated. … Providers who refuse health welfare recipients exclude patients based on finances and ability to pay … Universal acceptance intends to remove barriers that accidentally or intentionally keep people from being accepted for a dialogue with a health care professional. Universal Patient Acceptance (UPA) is a practice based on an ethical commitment to speak with every prospective patient who contacts a provider to learn if he or she should become a patient, the type of care needed, and options for how that care can be provided. UPA does not imply an obligation to diagnosis, treat or be held accountable for abandonment, nor does it necessarily require that doctoral providers be the ones who individually meet with patients." The authors clearly recognize that "Full access to care requires multidisciplinary support from many parts of society and a reform of existing public policy, law and financing." They also recognize that "fuller access to care appears somewhat dependent on changes in professional provider education and behavior." They strongly suggest that thorough discussion, debate and then hopefully adoption of Acceptance and UPA by the profession could lead to improved access to oral health care.

Two additional papers in the workshop are worth suggesting as additional readings on this topic. Dr. Beverly Largent, a pediatric dentist and member of the ADA Council on Ethics, provided the perspective of a private practicing dentist and pointed out a number of parallels between the concepts of UPA and components of the ADA Principles of Ethics and Code of Professional Conduct (17). The author also explores the difficulties that might be encountered if private dental practitioners were to embrace the concepts of Acceptance and UPA. Bruce Peltier, a faculty member at the University of the Pacific, describes UPA as "innovative and important, even brilliant," but also recognizes the need for clear discussion of its meaning and implications of implementation (18). This author also points out parallels to the existing ADA Code and Principles.

Many participants in the workshop believe that Acceptance and UPA could be very helpful in dealing with components of the access problem in this country. However, this short paper does not provide enough space to adequately discuss these concepts. My goal has been to present these concepts to the reader and hope that he/she will read the original papers. Our profession can then engage in a vigorous and open discussion that might lead to the inclusion of these concepts in our ethical codes, and eventually to improved access to oral health care for all members of society. In closing, I want to state clearly that many of us who want to see the dental profession take a stronger role in solving the access to oral health care crisis do not necessarily believe that this problem is the dental profession's sole responsibility. It is clear to us that this is a societal problem of immense proportions, intertwined with general health care access, education and oral health literacy of the public, employment status, availability of adequate dental insurance and a host of other societal problems. ■

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MEDI-CAL DENTAL GEOGRAPHIC MANAGED CARE (GMC) PLANS IN SACRAMENTO COUNTY

Bryan Quattlebaum, DDS & Steve Forsberg
Medi-Cal Dental Services Branch • Dec 2007

Commencing April 1, 1994, the Department of Health Services (DHS) entered into contracts with four dental managed care plans to cover that portion of the Medi-Cal population in Sacramento County eligible for dental services on a mandatory enrollment basis. This program became known as the Sacramento County Geographic Managed Care (GMC) Pilot Project. As of June 2007, 162,000 Medi-Cal beneficiaries were enrolled in Sacramento GMC dental plans.

The GMC Dental program is designed to provide a reasonable choice of dental managed care plan alternatives, all of which are contracted by the California Department of Health Care Services (DHCS) to assure access to primary care dental services (including preventive dental care) and dental care provided by dental specialists. GMC dental contracts provide for performance-based contracts. The dental plans are required to meet specific "Conditions Precedent to Payment" and up to 7% of their monthly payments from DHCS are not paid until such conditions were met. "Conditions Precedent to Payment" include:

- Annualized Utilization Rate of 38%
- Benchmarks relating to the service rate per 1000 members in preventive and basic restorative services
- Quality Assurance & Access to Care standards
- General Operations standards (timely and accurate deliverables and submissions)

Currently (December 2007) the California Medical Assistance Commission (CMAC) is in the process of negotiating new dental GMC contracts with five (and potentially six) dental managed care plans. These contract negotiations are expected to be completed in January 2008 and to go into effect on May 1, 2008. Those dental managed care plans who are awarded GMC contracts will be seeking providers in Sacramento County to join their plan's network of providers.

If you have any questions or concerns regarding the Medi-Cal dental GMC program in Sacramento County, please contact the Medi-Cal Dental Services Branch at (916) 464-3888. ■

GMC (GEOGRAPHIC MANAGED CARE) **PLANS** IN **SACRAMENTO** COUNTY

SEE INSERT TO REPORT A PROBLEM WITH GEOGRAPHIC MANAGED CARE

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Access to Care — What Does This Mean?

CONTINUED FROM PAGE 9

environments and systems are different, or may simply have a different level of health literacy. Language access research shows that patients are both more comfortable and tend to have better experience in the system with a provider that is language concordant. Even among populations that do not share the American middle class "dental values" there is still a high value for health — however the "definition" of what health is, as well as the cultural traditions on attainment of that health (i.e., only going to the ER when acute issues arise) may vary greatly. Culture influences both an individual's beliefs about disease causation, as well as expectation of how to treat disease and access external sources of care when needed. The accompanying article in this issue, by Degadillo, discussing Latino values and acculturation, explains some aspects of this for one ethnic group. Finally, fear from previous experiences may impact individual's expectations and behavior. These attitudinal barriers may be the most difficult to address, but also may be some of the most important challenges faces by the dental care delivery system today.

The final set of barriers are **"process barriers"** — simply put these are the barriers preventing an individual from navigating the dental care system. This may include lack of knowledge about available and/or existing dental insurance options, difficulty navigating the system (finding a provider, understanding the protocol, benefits) or factors associated with lifestyle such as being a migrant farm worker who moves from place to place (making record portability difficult). While highly educated and acculturated individuals may not feel that the dental system is difficult to manage, many individuals, particularly those who have language or literacy challenges, can become discouraged when trying to figure it all out.

Access to care is a complex issue — addressing it involves responsibilities at many levels: the individual, the community, the dental providers and the state. Dentists may feel they can only impact access at their point of service. However, they have the ability to influence the individual as well as societal factors that impact access to care though community education and involvement and political activity promoting oral health system improvements. Understanding the issues involved in access to care is the first step in creating solutions for California's future.

Beth Mertz is a program director at the UCSF Center for the Health Professions. Irene Hilton is a staff dentist for the San Francisco Department of Public Health and at La Clinica de la Raza Community Health Center in Oakland, CA and is President-Elect of the San Francisco Dental Society.

For additional reading, please see http://futurehealth.ucsf.edu/CDAP/whatwedo.html. ■

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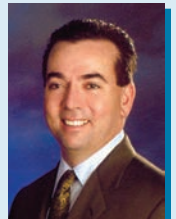

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CONGRATULATIONS TO...

Dr. Sean Roth, on his service dentistry trip to Mozambique. *(photo at right)*

Dr. Ronald Blanchette, whose daughter, Dominique, is one of the Sacramento Bee's *15 Players to Watch* in basketball.

Drs. Jeff and Alan Chantry, for their work at a clinic in Elk Grove that caters to women and children from the Wellspring Womens Center. They treated over 40 children.

Don McAdams (Sac State pre-dental student and big time SDDS supporter), who was just accepted to UOP Dental School!

Dr. Benton Runquist, who qualified for the Boston Marathon at the California International Marathon this December! (3:30:20!)

Dr. John Orsi, who taught a three and a half day continuum called ID3 (Advanced Interdisciplinary Care) at the Pankey Institute with Dr. Irwin Becker last month. It went so well, he was asked to speak at "A Gathering of Eagles," an international symposium scheduled for November 2008 in Miami.

Dr. Robert Shorey, who had a photography article published (as a cover story!) in *X-Ray Lab & Imaging Currents,* the national journal of the American Association of Dental Maxillofacial Radiology Technicians. ■

Dr. Sean Roth helped provide oral hygiene presentations to over 1,300 children in Maputo, Mozambique.

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.

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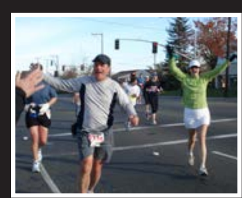
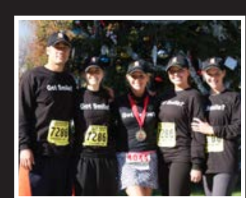
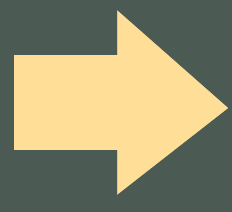




Proceeds from our sMILES for Kids runners go to Sacramento District Dental Foundation's Smiles for Kids program. Thank you, Dr. Rollofson, for organizing this event. We've raised **$18,465** to date and the money's still rolling in!

The runners (column 1): Dr. Don Rollofson & Janet Percevic take the miles in stride, (column 2): Karen Roth & her team are looking great, (column 3): Drs. Kelvin Tse & Cindy Weideman run as Dr. Jeff & Tamara Rosa help Bruce Levering cheer them on.

WELCOME
to SDDS's new members, transfers and applicants.



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NEW MEMBERS

JANUARY **2008**

Celeste Eckerman, DDS
General Practitioner
2074 Lake Tahoe Blvd
South Lake Tahoe, CA 96150
(530) 541-4640
Dr. Celeste Eckerman graduated from USC School of Dentistry in 2007 with her DDS. She is currently practicing and living in South Lake Tahoe.

Sapna J. Hayes, DDS
General Practitioner
7 Main St
Winters, CA 95649
(530) 795-5200
Dr. Sapna Hayes graduated from Louisiana State University in 1997 with her DDS. She is currently practicing in Winters and Vacaville and living in Winters with her husband, Samuel.

Sirisha Krishnamurthy, DDS
General Practitioner
1258 Coloma Way
Roseville, CA 95661
(916) 784-1144
Dr. Sirisha Krishnamurthy graduated from UCSF School of Dentistry in 2007 with her DDS. She is currently practicing in Roseville and living in Folsom with her husband, Anandarao.

Sahil Sethi, DMD
General Practitioner
3001 P St
Sacramento, CA 95816
(916) 736-6750
Dr. Sahil Sethi graduated from Tufts College Dental School in 2004 with his DMD. He is currently practicing and living in Sacramento.

Kenneth Silva, Jr., DDS
General Practitioner
16985 Placer Hills Rd, Ste D
Meadow Vista, CA 95722
(530) 878-0704
Dr. Kenneth Silva graduated from Indiana University in 1985 with his DDS. He is currently practicing in Meadow Vista and living in Applegate with his wife, Tamara.

NEW TRANSFER MEMBERS:

E. Thomas Casselman, DDS
Transferred from Santa Clara County Dental Society
General Practitioner
Not Currently Practicing
Dr. E. Thomas Casselman graduated from UCSF School of Dentistry in 1968 with his DDS. He is currently retired and living in Rocklin.

Jennifer S. Goss, DDS
Transferred from Santa Clara County Dental Society
General Practitioner
125 Ascot Dr, Ste A
Roseville, CA 95661
(916) 786-7070
Dr. Jennifer Goss graduated from UCSF School of Dentistry in 1996 with her DDS. She is currently practicing in Roseville and living in Dublin.

Roxanne Gould, DDS
Transferred from Alameda County Dental Society
General Practitioner
3945 Marysville Blvd
Sacramento, CA 95838
(916) 464-4100
Dr. Roxanne Gould graduated from University of Nebraska Medical Center in 1982 with her DDS. She is currently practicing in Sacramento and living in Gold River.

Denisse Montalvo, DDS
Transferred from San Francisco Dental Society
General Practitioner
8909 Madison Ave
Fair Oaks, CA 95628
(916) 536-5151
Dr. Denisse Montalvo graduated from UCSF School of Dentistry in 2007 with her DDS. She is currently practicing in Fair Oaks and living in Folsom.

Brigid A. Walsh, DDS
Transferred from San Francisco Dental Society
General Practitioner
7916 Pebble Beach Dr, Ste 101
Citrus Heights, CA 95610
(916) 962-0577
Dr. Brigid Walsh graduated from University of Illinois at Chicago in 2006 with her DDS and later completed her residency at VA Medical Center in San Francisco in 2007. She is currently practicing in Citrus Heights and living in Sacramento.

NEW APPLICANTS:

Brian Crawford, DMD

Justin Gee, DMD

Peter Kim, DDS

Taha Shoreibah, DDS

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

TOTAL MEMBERSHIP (AS OF 1/1/08): 1,531

TOTAL ACTIVE MEMBERS: 1,295
TOTAL RETIRED MEMBERS: 184
TOTAL DUAL MEMBERS: 3
TOTAL AFFILIATE MEMBERS: 7
TOTAL STUDENT MEMBERS: 3
TOTAL CURRENT APPLICANTS: 4
TOTAL DHP MEMBERS: 35

TOTAL NEW MEMBERS FOR 2007: 123

Access to Care: A Different Perspective

CONTINUED FROM PAGE 14

The County Health Department's "commitment" ended as soon as the grant money was spent. It seems that anyone who objects to the creation of a new, likely wasteful, layer of government with the stated purpose of care for the poor is labeled socially unaware, uncaring or worse "racist." That is just not necessarily true.

Fast forward three years. El Rosario now has electricity. One additional adjacent community now has clean water to drink. Another ACTS group is going back for two weeks in February of 2007. In addition to treating patients we will be "drawing up" plans to begin offering restorative care. The hurdle, as I see it, is huge. The additional equipment and supplies needed, though a big issue, are only parts of the puzzle. Prevention does work. How can we fluoridate the kids — how can we help them to get frequent "sugar" out of the children's diets? Can we teach them to brush and floss effectively? Can we improve the staffing frequency? All these parts are needed to insure that our restorative efforts are well placed and have sustaining value.

We face some of the same issues here at home. I know for a fact that there are others in our community who have traveled the same road as I, thankfully lots of them. Some have also devoted time and energy attempting to create a treatment facility and organization able to provide quality care — preventive and restorative - for those with minimal ability to pay — one that would be staffed mostly with volunteers. One would think that there would have been broad support for such efforts from "government" agencies. I sense that "government" has been less than supportive of these efforts. I believe it can happen without government money and it probably should. ■

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Kent Williams, DDS

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March 27, 2008

John Eby (Greenbook Financial)
Eugene Hsu (AIG Financial)

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Prescription Drugs & Herbal Therapies that Increase Bleeding Risk & Osteoporosis: Assessment, Prevention & Pharmacotherapy

March 28, 2008

Ann Eshenaur Spolarich, RDH, PhD

RDA SPECIALTY **LICENSURE** PROGRAM

NEW RDA SPECIALTY LICENSURE PROGRAM DEFERRED UNTIL JANUARY 1, 2010

SB 1049, signed by the Governor on October 13, 2007, deferred implementation of the new RDA specialty licensure program until January 1, 2010. This law also extended the current RDA licensing program setting September 1, 2009 as the final application date for licensure under the current RDA licensing program.

Currently: An RDA licensed on or before December 31, 2009 may apply pit and fissure sealants only if he or she has provided evidence to the board of having completed a board-approved course in the application of pit and fissure sealants.

Starting January 1, 2010: Dental assistants will be allowed to place sealants:

1. if they have taken a board approved course
2. after completing a formal education program for the Registered Restorative Assistant (RRA) or Registered Dental Assistant (RDA), as it will be included in their curriculum, OR
3. after completing the RRA program through a work experience pathway, trained by a dentist approved by the Dental Board.

Please be advised that dental sealant courses that do not meet the requirements stated above and are not Board approved do not meet the requirement.

If you have any further questions, you may visit COMDA's website at: www.comda.ca.gov

You may also contact SDDS at (916) 446-1227. ■

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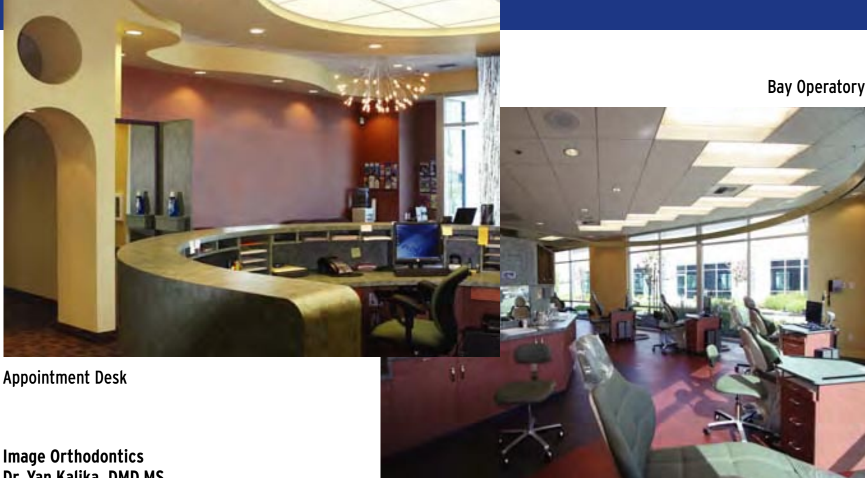
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NORTHERN CALIFORNIA COAST — Well established 5 op GP located in a high traffic area. Long-term, dedicated staff and loyal patient base. Collections $780,000+. Building is also available. Practice Transition Partners, (888) 789-1085, www.practicetransitions.com. 01-08

Equipment For Sale

FILM PROCESSOR A/T 2000 XR — less than 2 years old. Like new / well maintained. $4,000. (916) 736-6757 / Sharon. *10-07*

SONY COLOR VIDEO PRINTER (Mavigraph) — Welch Allyn Dental System IntraOral camera — Valpex-Intra-x Fully Automatic Film Processor — Amalgamaters (Vivadent silamat) — portable nitrous oxide (Porter MXR). For major sale contact (916) 300-4396 or (916) 276-6009. 01-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

JANUARY

1 *New Years Holiday*
SDDS office closed

8 **General Membership Meeting**
How Vital & Effective is Your Hygiene Department?
Kim Miller, RDH
Hygiene Night
Sacramento Hilton — Arden West
2200 Harvard Street, Sacramento
6:00pm Social
7:00pm Dinner & Program

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

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

Fun Times "Happy Hour"
6:30pm / Center Court (Natomas)
No host

14 **CE Committee**
6:30pm / SDDS Office

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

16 **Continuing Education**
The Doctor as CEO
Virginia Moore & Debbie Castagna
Sacramento Hilton — Arden West
2200 Harvard Street, Sacramento
6:30pm–9:00pm

21 *Martin Luther King Jr Day*
SDDS office closed

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

Foundation Board Meeting
6:30pm

28 **Golf Committee**
6:30pm / SDDS Office

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

FEBRUARY

3 **Smiles for Kids Day**

4 **Dental Health Committee**
6:30pm / SDDS Office

6 **New Member Dinner**
6:30pm / Old Spaghetti Factory

8 **Alliance Crab Feed**
Dante Club

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

15 **Executive Committee Meeting**
7:00am / Del Paso Country Club

21–22 **28th Annual MidWinter Convention**
Sacramento Convention Center

Remember, the **April General Membership Meeting** date has been changed to **April 1st**

THIS IS NOT A JOKE!

MARK YOUR CALENDAR FOR THE **28TH ANNUAL MIDWINTER CONVENTION**
FEBRUARY 21 & 22, 2008 • TONS OF CE & A GREAT TIME! SEE YOU THERE!

Loads of CEU

JANUARY 8, 2008

HOW VITAL & EFFECTIVE IS YOUR HYGIENE DEPARTMENT?

HYGIENE NIGHT!

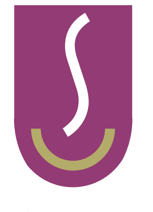
January General Membership Meeting

Earn 3 CE units!

Speaker: Kim Miller, RDH

This one hour program will explore the parameters of a profitable and effective hygiene department that focuses on patient care. Attendees may want to bring a computer generated year to date report by provider (each RDH) by procedure code (4341, 4341, 1110, 4910) for comparison purposes.

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



SACRAMENTO DISTRICT DENTAL SOCIETY

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