

Bulletin



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President's Message Controlling Our Destiny

Dennis Paul Nutter, DDS



In the pursuit of any goal, it is useful to pause, and ask if what you are doing will get you where you want to go. If you don't, you could end up like Johannes Kepler.

In order for Kepler to solve the orbital riddle of the Copernican model, he desperately needed to get his hands on the observational data of the legendary astronomer, Tycho Brahe. But, Brahe was not giving out his life's work to

just anyone. He had spent the last 30 years making accurate, repeated observations of planetary movement and he guarded that data jealously. Kepler needed to prove himself first. But without pausing to think things out, he made a strategic error. In an effort to further his reputation and thus gain Brahe's respect, he wrote a letter to the Imperial Mathematician asking his opinion on certain computational ideas and praised him as "the greatest mathematician of all time". The Imperial Mathematician then took Kepler's written praise and published it as an endorsement of his own work; work that was critical of Brahe!

After that, Brahe never really trusted Kepler. For years, Brahe reluctantly dribbled out data to him. Brahe only consented to give Kepler full access when Brahe was literally on his deathbed. A brief pause to look at the forces he was contending with might have saved Kepler years of grief.

Unlike Kepler, this past September the CSPD Board of Directors paused to scan our environment, think about where we want to go and created a plan to better control our destiny. They noted that we are at a watershed time for the profession of pediatric dentistry. There will be pressure to reduce the cost of dental care from government, employers and patients. Dental plans will increasingly use more selective networks and demand more accountability in the form of data and performance measures. Recently graduated pediatric dentists, under pressure from debt, will likely follow the trend toward multi-site, corporate practices. The drive to reduce healthcare costs will compel exploration of alternative care delivery models.

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Vice President	Dr. David H. Okawachi	dokawachi@sbcglobal.net
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APPOINTED OFFICERS		
Editor	Dr. Jung-Wei (Anna) Chen	jwchen@llu.edu
Website Editor	Dr. Steven Niethamer	sniethamer@compuserve.com
Public Policy Advocate	Dr. Paul Reggiardo	reggiardo@prodigy.net
DIRECTORS		
Director North (2015)	Dr. Aparna Aghi	aparna.aghi@vcsf.edu
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Director South (2016)	Dr. Daniela Silva	drsilva@dentistry.ucla.edu
STAFF		
Executive Director	Dr. Ray Stewart	drstewart@aol.com
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California Society of Pediatric Dentistry

BULLETIN

CSPD members are encouraged to contribute to the Bulletin. Articles, Letters to the Editor, or other items of interest are welcome. Items for publication may be submitted to Jung-Wei (Anna) Chen, DDS by email at jwchen@llu.edu.

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MISSION OF THE BULLETIN

The Bulletin of the California Society of Pediatric Dentistry shall be to examine and identify the issues that affect the specialty of Pediatric Dentistry and the oral health of teenagers and children. All of our readers should remain informed and participate in the formulation of public policy and personal leadership to advance the purposes of the Society. The Bulletin is not a political publication and does not knowingly promote the specific views at the expense of others. The views and opinions expressed in the Bulletin do not necessarily represent those of the California Society of Pediatric Dentistry.

President's Message

Controlling Our Destiny (continued from page 1)

Dennis Paul Nutter, DDS

In a series of meetings and breakout sessions the directors reevaluated and retooled CSPD's strategic plan to prepare us for these challenges. The board focused on three areas in order to shape our future – Policy/Advocacy, Membership and Governance.

One of the strategic aims to come out of those discussions was for CSPD to bring in outside expertise so that our decisions are based on relevant data. The board would also like to be able to be more proactive in communicating to membership our policy stances. Another aim is to increase our collaborations with other healthcare entities. Along this line, the CSPD board has already initiated development of a Recertification Course in collaboration with the College of Diplomates. Many thanks go to **Jonathon Lee** for his efforts in planning this course. Leveraging other association strengths with ours will help us serve our members better.

The board also wants to better understand CSPD's membership needs and values. They want our decisions to be data driven so that we can deliver "true and effective representation of membership." Kudos are given to **Jeff Huston** who, as Membership Chair, has been relentless in trying to get data on our members.

In common with past strategic plans, the board wants to take firm steps to secure a sustainable development of leaders in pediatric dentistry. **Suzy Tavana** who is slated to become CSPD's Secretary in March, is an example of how CSPD has endeavored to do this in the past. She is a former Warren Brandli Intern who attended board meetings as a part of that leadership development program's itinerary of duties.

Lastly, the board rejected any plan to compliment Imperial Mathematicians! Speaking of compliments...

Many Thanks:

My sincere thanks goes to **Paul Reggiardo**, our Public Policy Advocate, for his succinct and wise counsel. At the recent board meeting, he was declared a national healthcare treasure by CDA Vice President for Government Affairs **Carrie Gordon**. For Paul, this is actually not hyperbole. And I've checked, he has nothing against Brahe.

My sincere thanks go to **Ray Stewart** for your sage counsel, patience and diplomacy. There is a vast constituency in the profession that knows of your splendid contributions of service and advocacy.

I would also like to thank **Oariona Lowe**, chair of the annual meeting. Your organizational talent is impressive. Under your stewardship, the CSPD Annual Meeting has been taken to a higher level. Ora you are a master at keeping all those plates spinning. I keep expecting a call from Cirque du Soleil asking for you!

Thank you **Kenneth Szymanski** for your stentorian viewpoint and authoritative financial guidance.

Thank you **Mel Rowan** for keeping the CSPD ship of state upright and driven by clear and concise bylaws language. Your counsel on leadership, while not always translated by me into effective action, was nonetheless welcome and cherished.

Thank you **Steven Niethamer** for your dedication to our website and online continuing education. It is because of your attention to CSPD's digital presence that we can offer CE online and communicate to membership through the website – a strategic objective!

Thank you **Jung-Wei Anna Chen** for guiding the *Bulletin* through an important transition and launching the column of scientific abstracts.

Thank you **Donald Schmitt** for taking care of dues and finances for us and all those other tasks that you took up without being asked.

Thank you **David Okawachi** for delivering judgment and assessment with a palliating demeanor. Thank you for a great Dana Point annual meeting.

Kudos to **Sharine Thenard** for finding us a well qualified Executive Director nominee! Not an easy task.

Thank you **Rebecca Lee** for running the baton that last mile and **La Juan Hall** for carrying the baton the first mile.

Thank you **Aparna Aghi** (another Warren Brandli Intern) and **Jacob Lee** for your inspiring work on CSPD Continuing Education.

Thank you **Eric Dixon**, **Daniela Silva**, **Rick Nichols** and **Nancy Hsieh** for your integrity and perspective.

Lastly, thank you **Stacie Lewis** and **Catherine Smith** for taking CSPD operations to a higher level of service to our members.

And to all a good night!

Trauma-Related Root Fractures

Diagnosis and Treatment

Leif K. Bakland, DDS

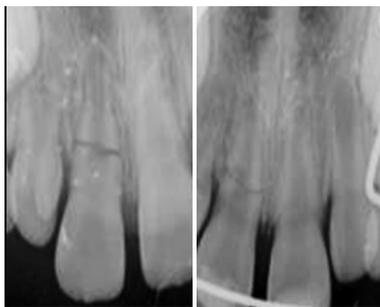


Fig. 1A Fig. 1B



Fig. 1C Fig. 1D

Introduction

Traumatic root fractures are relatively uncommon in both primary and permanent dentition and constitute less than 8 percent of all dental injuries (1). The low incidence may explain why dentists sometimes select treatment options that are not consistent with current information (Fig. 1). Today, up-to-date guidelines are readily available both electronically (2) and in dental journals (3).

Most trauma-related root fractures occur in the maxillary anterior teeth (1). For that reason, the description of diagnostic techniques and treatment options will be described for that group of teeth. Slight modifications may be applied to teeth in other parts of the mouth.

The purpose of this short review is two-fold: (1) To describe diagnostic techniques that can reduce the risk of missing a trauma-related root fracture; and (2) to describe treatment options associated with good outcomes.

Diagnosis

Acute trauma, such as blows to the teeth can result in many different injuries including root fractures (1). Frequently there is a combined injury in which the coronal part of the tooth (coronal to the fracture line) is both luxated and displaced along with adjacent alveolar bone fracture. If there has been coronal displacement, diagnosis is relatively easy to make, since the examination radiograph will demonstrate the fracture space in the root. If the displacement has been extrusive, the coronal segment will also have increased mobility (Fig. 2). Lateral displacement can result in a 'locking in' of the coronal segment when displaced into the alveolar bone, giving the impression that the tooth is ankylosed.



Fig. 2

When the fracture does not include coronal displacement, radiographic diagnosis can be difficult and the presence

of a root fracture can easily be missed, especially if the fracture direction is diagonal (oblique). How can one identify teeth with diagonal root fractures? With conventional radiographic equipment, one reliable technique is to add at least one additional x-ray beam angulation, approximating a 45° angulation to the long axis of the tooth. This can be accomplished by placing the x-ray film or sensor on the patient's lower teeth, have the patient close the jaws gently to hold the film/sensor in place, and then aim the x-ray beam in an occlusal direction (Fig. 3). This allows the x-ray beam to run approximately parallel to the diagonal fracture line and will appear clearly on the exposed film (4, 5).

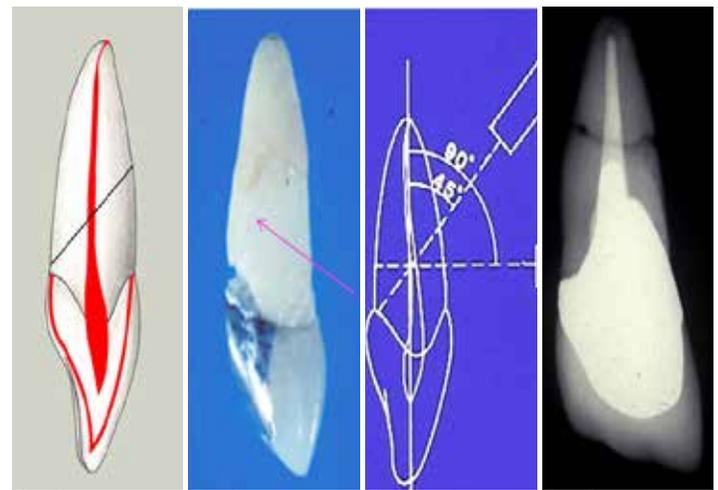


Fig. 3A

Fig. 3B

Fig. 3C

Fig. 3D

The new radiological era of cone-beam computed tomography (CBCT) has provided diagnostic opportunities unmatched with previous technologies. Anatomical abnormalities and variances can now be relatively easily identified using this modality. Root fractures of any direction and angulation are clearly observable on CBCT images. Dentists have been enthusiastic in incorporating CBCT in their practices, and when used in cases of dental trauma, increased accuracy in diagnosis can be expected (6). One must however, be aware of the concern about the increased use of CBCT and carefully weigh risks and benefits when choosing this diagnostic modality (7).

Trauma-related root fractures are with few exceptions of the horizontal/diagonal type; it is possible that vertical fractures may occur, but that is more likely in posterior teeth and will not be discussed in this review.

(Continued on next page)

Trauma-Related Root Fractures:

Diagnosis and Treatment (continued from page 5)

Leif K. Bakland, DDS

Treatment

In spite of all the information available about root fractures, there seems to be a lack of information among many dentists about both treatment and expected outcomes. This is particularly disturbing considering the fact that most dental injuries, including root fractures, occur in young patients who are still undergoing orofacial growth and development. Failure to provide optimal treatment impacts on the continued development of the alveolar structures resulting in difficult dental conditions both immediately and long term.

Correct diagnosis provides the opportunity to develop various treatment options, keeping in mind the desired outcomes. The two primary treatment goals are healing of the injured periodontal ligament (PDL) of the coronal segment of the root, and revascularization of the coronal segment of the pulp (8, 9).

The location of a root fracture can be anywhere along the length of the root, but as long as the entire fracture is within the alveolar bone the tooth can be treated (8).



Fig. 4A Fig. 4B

In spite of the fact that the injury is referred to as 'root fracture,' and giving the impression that treatment should be directed toward hard tissue healing as in a long bone fracture, it may be more useful to look at it as a 'luxation'

injury of the coronal segment. So just as with a luxated tooth, the treatment consists of repositioning the coronal segment, if it has been displaced, and then splinting it with a non-rigid splint (Fig. 4A) to allow PDL healing (3). Such PDL healing typically requires no more than four-six weeks of stabilization (10). If the fracture location is close to the cervical area of the root (but still within the alveolar bone), longer splinting time periods may be beneficial (11); in some cases it may even be advisable to consider permanent splinting (similar to the fixed retention done in some orthodontic cases).

Since the purpose of the splint is to stabilize the root for PDL healing, rigid splinting is not recommended (3, 10). A semi-rigid, functional splint promotes healing of the PDL; a popular splint is made using a thin orthodontic wire bonded to at least one tooth on either side of the injured tooth by using composite resin.

Repositioning of a displaced coronal segment has two purposes. The first is self-evident - namely to return it to its natural position for function and esthetics. The second reason, often overlooked, is to provide an opportunity for revascularization of the coronal pulp tissue segment. During a traumatic event leading to root fracture, the blood supply to the coronal pulp will be either totally severed or severely compromised, depending on the extent of coronal segment displacement. If the coronal segment can be repositioned in its natural position, or close to it, there is a good chance that revascularization can take place even in teeth with relatively small diameter pulp canal spaces (12).

The benefits of revascularization are several. The first is that a vital pulp is less likely to be invaded by bacteria because of the natural immune system defense present in vital tissues. The second benefit is that in the presence of a revitalized pulp, hard tissue repair may take place between the two fragments along with hard tissue ingrowth into the coronal segment. This is particularly beneficial in a young, immature tooth to strengthen the root walls (13). One may also consider it a benefit that with a vital pulp, further treatment such as root canal therapy will not be needed.

Root fractures have a good prognosis in most cases (10 - 12). In fact, many such injuries have resulted in uneventful healing and the patients were unaware of their injuries until they were incidentally discovered on routine dental radiographic examination. Often such cases tend to be root fractures located in the apical area with no displacement of the coronal segments.

Root fractures managed as described above may result in one of several outcomes. The ideal one is hard tissue repair between the apical and coronal segments keeping the two segments connected (Fig. 4); often there may also be some fibrous tissue connection between the two segments. While radiographically one may continue to see what appears to be a fracture line between the segments, clinically the fracture line will be filled in with hard tissue resembling cementum. Such teeth need no further treatment with respect to the fracture (8, 10, 12, 14).

A less ideal outcome, but nevertheless a positive one, is when bone grows in between the coronal and apical segments (14). The result is a tooth with a short root – the coronal part – and an apical root segment unconnected with the coronal part (Fig. 5). As long as the coronal segment has healthy periodontal tissue providing adequate support for the tooth, it can function satisfactorily.



Fig. 5

It is important to point out that the apical segment, disconnected from the coronal segment, does not need to be removed surgically.

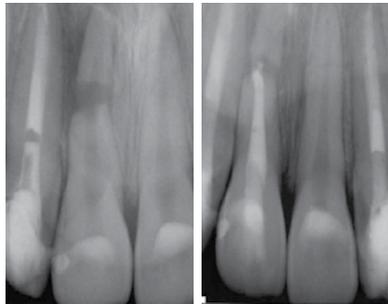


Fig. 6A

Fig. 6B

The least desirable outcome is when the coronal pulp tissue becomes infected. This situation is recognized by clinical symptoms and radiographic lesions surrounding the fracture site (8, 10, 12, 14). The apical pulp segment

is usually vital so root canal therapy is confined to the coronal part only (Fig. 6), and the results are good (15). The use of mineral trioxide aggregate (MTA) has been recommended for root canal treatment in such cases (16).

Conclusion

The prognosis for trauma-related root fractures is good, particularly if the injury is optimally managed as mentioned above. Extraction is a treatment option that is rarely needed and root canal treatment is indicated only when infected pulp necrosis in the coronal segment can be confirmed. In young patients with developing dentition it is especially important that serious consideration be given to preserving traumatized teeth.

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FIGURE LEGENDS

Figure 1. A. Bicycle accident three days earlier, visited two dental offices and was offered the option of surgical extraction. Parents wanted a second opinion and came to the pediatric dentistry clinic. Examination: Slight mobility, sensitive to percussion and palpation. Root fracture within alveolar bone. Splinted with wire and resin. Patient indicated that the tooth felt better immediately after being splinted. B. four weeks later the tooth was asymptomatic; splint removed. C. two years later the tooth continued to be asymptomatic. D. Photo showing that the tooth has normal color and the gingiva is normal. (Courtesy, Dr. Jung-Wei Chen)

Figure 2. Radiograph of a tooth with root fracture in which case the coronal part was displaced extrusively. The optimal outcome of treatment requires repositioning of the coronal segment with short-term non-rigid splinting.

Figure 3. A. Graphic illustration of a tooth with a diagonal root fracture; conventional radiographic angulation will miss such fractures. B. Extracted tooth showing diagonal (oblique) fracture (arrow) that was not recognized on the original examination radiograph. C. Adding an additional angulation (approximately 45° to long axis) will allow x-ray beam to travel through the fracture line, highlighting the fracture. D. The extracted tooth in 3B was radiographed bench-top at a 45° angulation – the fracture can now easily be seen. E. Clinical illustration showing how the film/sensor can be placed on the lower teeth with the patient closing gently to hold it in place while the x-ray beam will be directed in an occlusal direction.

Figure 4. A. Radiograph taken after repositioning of the coronal segment of a root fractured tooth followed by splinting with a non-rigid splint. B. Radiograph taken 2 years later shows good healing.

Figure 5. Healed root fracture with bone interposing between segments. The coronal segment has a good prognosis in spite of the short root, the apical segment does not need to be removed surgically.

Figure 6. Treatment recommended for root fractures that do not heal due to coronal pulp infection. A. Radiograph shows lesion of endodontic origin surrounding the fracture site. The absence of an apical lesion indicates that the apical pulp segment is vital and uninfected. Root canal treatment can be confined to the coronal segment. B. Radiograph taken one year following root canal treatment shows good healing.

Receive CE Units for This Article!

CSPD is offering members continuing education units for reading the Trauma-Related Root Fractures: Diagnosis and Treatments article on pages 5 through 7. Complete the five question multiple-choice quiz on page 35. Mail complete quiz back to the CSPD Office at 1215 K Street, Suite 940, Sacramento, CA 95608. One hour CE unit will only be offered to those members who get a score of three or more on the quiz.

Executive Director's Message

Keep Your Head Down and Your Eye on the Ball

Ray E. Stewart, DMD



Many years ago my high school baseball batting coach pounded this concept into our heads to the point that more than five decades later I can still hear his voice in my sleep. This same lesson can be applied to many things in life, not the least of which are our business and professional lives. If we do not maintain a constant vigilance of the driving forces determining the course and future of our profession

and the specialty of pediatric dentistry, we are likely to be overcome and overwhelmed by the changes which are inevitable.

Pursuant to this admonition, there are two subjects that are, in my opinion, very important and have the potential of being real “game changers” for those of you in the early or mid-stages of your careers.

Pediatric Dentistry Dental Service Organization (DSO)

The majority of pediatric dentists practicing in California are acutely aware of the growing presence of large “corporate” practices which are opening office dedicated to providing comprehensive dental care for children at an electrifying rate. The majority of these “corporate” practices are being operated under the centralized management of a Dental Service Organization (DSO). The business models of these practices can vary greatly but they have one thing in common. They offer an economy of scale in terms of practice management services and purchasing power which is difficult, if not impossible, for the solo practitioner or small group practice with a single or two or three office locations to compete. All practicing pediatric dentists know and understand that the largest contributors to our cost of doing business are (in no particular order), staff salaries and benefits, supplies and materials, equipment purchase and maintenance, marketing and practice promotion, rent or mortgage debt service. We also understand that if we are to be successful in the business of our chosen profession, we should plan on spending at least as much time managing our practice as we do providing services at the chair. Especially in the early phases of building a successful practice, the mid-night oil requirements of managing a successful practice can be daunting to say the least.

So...just what is it that a DSO can provide in the way of management, marketing and other services which may provide operational and competitive advantages that may be attractive to a dentist that would cause him/her to consider utilizing DSO services?

- Human resource (HR) services where the DSO “owns” the employees and handles everything from payroll services, training, etc, and leases the employees to the practitioner.
- Billing and collection services
- Marketing and practice promotion services
- Group purchasing advantages for purchase of equipment, supplies, materials and maintenance services.
- Rent/Lease negotiation. Possible expanded financial service affiliations.
- Contract negotiation with insurance and other third party payers based on the existence of a network of providers and location throughout a geographic area.

The reason that this is something that each and every one of you should be thinking about is that this Pediatric Dentistry DSO concept may be more than “a pipe dream.” The California Dental Association (CDA) is currently in the investigative and due diligence process of exploring the feasibility and desirability of forming a DSO business entity which would offer member dentists the opportunity to join a DSO wherein they could pick from a menu of services that they would choose to engage and/or purchase. This may be something as limited as individual services such as marketing and promotion, or group purchasing. Others may choose a more comprehensive package of services which would include combined services such as HR, billing and collection, and network contract negotiation.

The DSO concept is foreign to most who have been practicing for a decade or more. It is not however foreign to recent graduates who have been recruited by one or more of the large, in many cases, multi-state corporate practices who may have hundreds of locations. They have recognized the many advantages these practices offer in terms of a good income coupled with a lifestyle free of many of the management responsibilities that comes with the traditional private practice. The DSO option may not be for everyone, but the CDA/ DSO hybrid business model may offer the possibility of the “best of both worlds.” Keep your head down, your eye on the ball and stay tuned for possible developments and opportunities in the coming year.

(Continued on page 18)

ABOUT

The *Joey Board* is an immobilization system used for the pediatric, adult, and special needs patient. Designed by a pediatric doctor to symbolize that of a baby kangaroo, or "Joey" in a pouch for protection, not restraint. Its revolutionary design increases safety and has been tested extensively. The unique engineering keeps the patient's head more stable, in a "chin up" position protecting the airway. It provides ideal use for oral conscious sedation and operating room procedures.

The *Joey Board* enhances Doctor/Assistant efficiency because of its improved design, allowing for quick immobilization and less readjusting of head position. It also allows for improved ergonomics for the doctor and decreases chair time. The *Joey Board* provides the answer to a patient that needs to be immobilized quickly so that the treatment can be completed in a timely manner.

Joey Board

Patent Pending

The *Joey Board's* unique design is visually pleasing with design options to help ease anxiety for parents and patients making it less intimidating than all other immobilization devices. The *Joey Board* is offered in an appealing Blueberry color. There is no need to purchase multiple accessories to make the system usable.

The *Joey Board* is also easier to clean due to its durable vinyl wrap. It allows for quick cleaning with a common disinfectant of your choice such as Cavicide. (The wrist wraps and head straps require machine washing.)

Caution: The *Joey Board* should only be utilized under the direct observation of a licensed medical or dental practitioner. It is important that the doctor monitor for risk of aspiration, impaired breathing, injuries, and overheating. Furthermore, the *Joey Board* should not be used for extended restraint.

F.A.Q.'S

Why is the *Joey Board* the most parent friendly restraining device?

The *Joey Board* was designed by a pediatric doctor for the safety and security of the patient. Parents are very impressed with the comfort of the *Joey Board* as well as the vibrant attractive colors.

Why is the *Joey Board* economical for my practice?

The *Joey Board* features all in one pricing and most accessories such as the shoulder roll, head strap and nitrous hose loops are included.

How does the *Joey Board* improve efficiency in the workplace?

The *Joey Board* was designed to improve patient stabilization. It is also very ergonomic and because of the proper positioning that is established during treatment the *Joey Board* enables the doctor to concentrate on simply treating the patient versus having to constantly reestablish patient positioning. The *Joey Board* is also comfortable for the patient and so patients are not continuously trying to readjust positioning.

How do I clean the *Joey Board*?

The *Joey Board* can be cleaned with Cavicide (TM) products, Ethyl alcohol based cleaners, Isopropyl alcohol based cleaners, Lysol (TM) disinfectant or other non-bleach, non abrasive cleaners. Simply wipe the *Joey Board* following OSHA protocols. Do not submerge the *Joey Board* in any of these substances.

Is there a discount if I buy more than one *Joey Board*?

Absolutely. In fact, many offices are purchasing the *Joey Board* for each treatment room and our sales team is very happy to discuss different pricing options for multiple *Joey Boards*.

Why is the *Joey Board* ideal for Oral Conscious Sedation or Operating Room procedures?

The *Joey Board* can be used during routine in-office procedures as well as Oral Conscious Sedation or Operating Room procedures. The shoulder roll helps to establish proper airway positioning by placing the patient in a head tilt chin up position. The Nitrous Hose Loops are also ideal for securing the Nasal Hood during Nitrous Oxide procedures.

Does the vinyl wrap cause the patient to overheat?

The *Joey Board* has been extensively tested in Lake Havasu City, AZ. Lake Havasu is one of the hottest cities in the United States and patients have not reported concerns regarding temperature. There have been no significant differences between the *Joey Board* and its competitors.

Is there a guarantee offered with the *Joey Board*?

Yes, The *Joey Board* is guaranteed against manufacturer defects for one year.



Quit Running Like a Dentist!

Jeff Huston, DDS, MS, FAAPD



Hurray for our side! *U.S. News and World Report* (1) named dentistry the #1 best job of 2015. They correctly perceived our “marathon of training and testing.”

Pediatric specialists invest at least two additional competitive years of time, effort and money into our education. We aim our expertise and skills at improving the oral health of California’s children. Many of us want to work as long as possible. Our brains tell us, “Go, go, go!” But, if we’re not prudent, our bodies could signal “No.” The above article neglects to mention the heavy toll multiple repetitive hand movements and prolonged awkward sitting postures take on wet-gloved dental surgeons.

So, what’s the best way to care for our physical health? The Earl of Darby (1799-1869) inspires us to keep active with, “Those who do not find time for exercise, sooner or later will have to find time for illness.”

Most would agree and think swimming a mile almost every day a week for 20 years would have kept me at the chair forever. However, an underlying skeletal brittleness surfaced when I ventured out of my league.

About 15 years ago, I started working out with a friend who was a nationally ranked triathlete. With no running or cycling in my background, we began training for an Olympic triathlon. A few months later, my right hip started acting up. My buddy counseled, “No pain, no gain. If it’s not killing you, it’s making you stronger.”

Jumping into the pool a few weeks later, the heel of my right foot slammed into the concrete. Flipping at the end of the lane, something snapped deep in my rear. Instantaneously, an excruciating electric shock zapped my entire nervous system.

Looking at the x-ray on the emergency room view box, the on-call orthopedist grimly prognosticated, “Sorry, you’ll

never run again.” He diagnosed a stress fracture of my acetabulum and a severely torn gluteus minimus muscle. Apparently, the cumulative musculoskeletal impact (actually, lack of impact) of practicing pediatric dentistry, swimming, no resistance training and not routinely stretching weakened my pelvic bone.

Since I ignored my body’s not so subtle pain messages, it shut me down. The hospital admission forced me to take time to read the proverbial writing on the wall. During three long days lying in the unfamiliar bed counting little dots in the ceiling paneling, training errors preoccupied my mind.

Recovery started with crutches, slow walking and then Tai Chi. After six months of weekly teaching, the master stepped in front of me, tilted my chin down, pushed my head back, gently judo chopped my shoulders and said, “Jeff, you’re way too tight. You don’t need Tai Chi, you need yoga.”

Shortly afterwards, I found an excellent article (2) targeted at improving dentists’ flexibility and range of motion. It described a morning ritual I still follow. Together with basic push-ups and crunches, the well-illustrated yoga-like stretching moves reverse the deleterious effects of excessive sitting.

Long walks gradually turned into slow jogs. Still aching to figure out crucial elements which factor into a dentist’s ideal fitness equation, I became a certified personal trainer. My client base totaled two, my son and me.

After several years, I participated in a few sprint triathlons always dreading my weakest link, the ending run segment. In due course, I completed an Olympic triathlon including jogging the entire 10K. November of 2012, I finished the Big Sur 13.1 marathon without stopping. Pain in my calves indicated persistent poor biomechanics and spurred on further technique research.

The book “Run Less Run Faster” (3) mentioned a runner’s retreat at Furman Institute of Running and Scientific Training. I signed up and flew to Greenville, SC. The last thing I expected hearing at the pricey program was a PhD physical therapist yelling, “QUIT RUNNING LIKE A DENTIST!” A million questions raced through my mind: “what did he mean by that? was I... hunched over? shoulders up to my ears? leaning too far forward? clenching my teeth? stomach flaccid? not tightening my glutes? hands and forearms too tense? elbows sticking out or not at 90 degrees? neck bent? stiff? squinting? head bobbling? looking down? breathing too fast? too slow? not at all? What did dentistry have to do with the ergonomics of running?”

After in-depth gait video inspection and range of motion measurements, the PT doc strongly recommended focusing on three things, “core, core, core.” Another expert at gait analysis prescribed a detailed strengthening program which precisely addressed my weak spots. Our office manager posted one of these recommendations on Facebook (4) as the “Best oral health tip of the year!” It’s a pic of me brushing my teeth on one leg. Suffice it to say, knowledge reaped from studying kinetics benefits our practices in numerous ways.

Although noticing most everyone else in class could do it, I had never seriously contemplated my clumsiness while attempting to perform yoga’s tree pose (one leg stance). In hindsight, this signposted an unstable core and foreshadowed the cracked hip and torn glute.

Flamingo style brushing and one-legged track drills exemplify applying functional strengthening of specific body parts used in an athlete’s chosen sport. Unlike walking, running is a one-legged endeavor. To run fast and without injuries each leg must stand on its own. “Chi Running” (5) and “Running Revolution” (6) provide additional thought provoking postural and biomechanical concepts.

The necessity of coping with dentistry’s physical challenges will persist as long as we’re sitting behind the chair. A one-size fits all generic workout won’t satisfy every dentist’s unique fitness requirements. Bottom-line, there’s no best way. Personally, decreasing race times provide some credence to my on-going rehabilitation approach. It’s a process.

My quest for translating sports wisdom into every day dental practice continues. I strive to listen acutely and respond timely to my body’s messages. Regardless of age, worthwhile activities include consistently performing balanced anti-sitting routines, daily static and dynamic stretching, bilateral movement cross-training and enhancing core stabilization.

These words haven’t touched upon other significant quality of life issues like nutrition, sleep or psychological, emotional and spiritual well-being. Indeed, they barely scratch the surface of how to preserve our musculoskeletal systems. Hopefully, they remind us to move smarter and allow us to play the intense game of pediatric dentistry a little longer. The children of California need us to stay healthy and keep smiling!

1. <http://money.usnews.com/careers/best-jobs/rankings/the-100-best-jobs>
2. http://www.cda.org/Portals/0/journal/journal_022002.pdf (page 170)
3. <http://www.furman.edu/sites/first/Pages/RunningRetreat%28Adult%29.aspx>
4. <https://www.facebook.com/LodiKidsDentistry?ref=hl>
5. <http://www.chirunning.com/what-is-chirunning>
6. <https://posemethod.com>

2015 CSPD Fun Run!



Tie up those sneakers, grab a sweatband, pull out that warmup suit and join the 2015 CSPD Fun Run!

On Saturday, March 28 starting at 6:30 a.m., runners, joggers and walkers will gather in the hotel lobby and head out for a lovely tour around the Laguna Cliffs Marriott. Pick your speed, all are encouraged to participate.

Ready to rumble...either register on-line at www.cspd.org or email Dr. Jay Golinveaux at jaygolinveaux@gmail.com and ask him to count you in for the 2015 Fun Run! It will be groovy.



Report of the Meeting of the Dental Board of California

Prepared for the California Society of Pediatric Dentistry

Paul Reggiardo, DDS, Public Policy Advocate



The Dental Board of California met November 6-7, 2014, in Studio City. The following report summarizes actions and issues coming before the Board pertinent to pediatric oral health. CSPD is represented at each meeting of the Dental Board and updated reports are posted in the Advocacy, Legislation and Regulatory Matters (ALARM) section of the CSPD Website.

2014-2015 REGULATORY PRIORITIES

Passage of legislation which requires implementation by the Dental Board of California involves a structured process by which the Board formally develops and adopts regulations to the Dental Practice Act under the statutory authority of the governing bill. The Board in August considered the order in which they would address pending regulatory issues for the fiscal year 2014-15 and voted the following priorities:

1. Update of Continuing Education Requirements
2. Mobile and Portable Dental Unit Regulations
3. Elective Facial and Cosmetic Surgery Permit Regulations
4. Comprehensive Package of Dental Assisting Regulations

Comment: The Board next year will develop more comprehensive regulation of mobile and portable dental providers regarding provisions for follow-up and emergency care and for maintenance and availability of provider and patient records under the authority of SB 562 (Galgiani) passed in 2013. These regulations will also govern implementation of AB 1174 (Bocanegra), passed this year, which establishes an expanded scope of practice for Registered Dental Hygienists and Registered Dental Assistants in Expanded Functions in remote settings under teledentistry provisions. CSPD intends to be actively engaged in the development and approval of these regulations.

The update of continuing education requirements will finally allow implementation of AB 836 (Skinner), also passed in 2013, which would reduce the continuing education licensure requirements for retired dentists providing only uncompensated care to no more than 60% of those hours required for an active license.

APPROVAL OF WESTERN UNIVERSITY OF HEALTH SCIENCES COLLEGE OF DENTAL MEDICINE

The California Code of Regulations requires that a new dental school in California apply for provisional approval in its first academic year and apply for final approval when its program is in full operation. Western University of Health Sciences College of Dental Medicine obtained initial provisional approval from the DBC in 2009 and applied this year for final approval. The law provides that the board may accept the findings of a commission or accreditation agency approved by the Board and adopt those findings as its own, in lieu of conducting its own investigation. Western University Health Sciences, College of Dental Medicine received the highest accreditation status from the Commission on Dental Accreditation (CODA) – “approval without reporting requirements” --- earlier this year. Accepting the CODA accreditation, the Board unanimously voted final approval of Western.

Comment: The “approval without reporting requirements” status means that the school’s dental education program achieves or exceeds the basic accreditation requirements.

PORTFOLIO PATHWAY TO DENTAL LICENSURE

Final approval of the Portfolio Pathway to Dental Licensure regulations was granted November 5 by the Office of Administrative Law (OAL) and become effective immediately as an “urgency provision” upon filing with the Secretary of State. This clears the last administrative hurdle for implementation of Portfolio licensure by the California Dental Schools. It is now possible, at the discretion of the schools, to license the first dentists under the portfolio pathway at the close of the 2015 academic year.

Comment: Of the six California dental schools, only UCSF and The Arthur Dogoni School of Dentistry at UOP have indicated they will immediately implement the portfolio examination. Western University has stated it will not participate in the program and the remaining three schools are evaluating future implementation. It remains to be seen how great will be student interest in this licensure pathway.

Public Policy Advocate's Report (continued from previous page)

REGIONAL EXAMINATIONS AS PATHWAYS TO DENTAL LICENSURE

At the August meeting of the Board, there was discussion regarding satisfaction of the examination requirement for California dental licensure by achievement of a passing score on the clinical and written examination administered by the North East Regional Board of Dental Examiners (NERB) or an examination developed by the American Board of Dental Examiners (ADEX). Currently, this requirement may be satisfied only by passage of the Western Regional Examination Board (WREB). California no longer administers its own clinical licensure examination. The ADEX examination is currently administered by the NERB. Similarly, the ADEX examination could be administered by the DBC.

Before either approach may be considered, the Department of Consumer Affairs must first conduct an occupational analysis of the dental profession and the ability of any proposed examination to reflect the current practice of dentistry. The Office of Professional Examinations (OPES) indicates that an OA will take approximately 12 months to complete, cost between \$50,000 and \$100,000, and, at the direction of the Board will tentatively take place in fiscal year 2015-16.

Comment: The adoption of the NERB and/or the APEX exam (in addition to the WREB) is another step in an inexorable march toward a single national licensure examination. As a side note, the APEX can be administered as a "curriculum integrated examination", something similar to licensure by portfolio examination.

RDA PRACTICAL EXAMINATION

While the pass rate for the RDA written examination still hovers around 65 percent (71 percent for first time candidates), the pass rate for the practical examination has dropped precipitously this year from over 90 percent to barely over 20 percent. This alarming trend was addressed by the Board in an extended discussion with stakeholders and a content expert regarding the grading criteria, the examination itself, and the equipment requirements among other issues. As a result of these discussions there appeared to be consensus that the largest contributor to the increased failure rate was the result of greater examiner calibration and resultant attention to clinical (typodont) performance. In other words, lack of minimal competency in clinical performance that was being overlooked in the past, is no longer being missed or ignored. The three procedures currently being tested are as follows:

1. Place, adjust, and finish a direct provisional restoration on tooth #19 or #30
2. Fabricate and adjust an indirect provisional restoration on tooth #8
3. Cement an indirect provisional restoration on tooth #8

The three most common reasons for failure are open contacts, open margins, and poor occlusion.

As a result of the discussions, the Board voted to appoint a two-member subcommittee of the Board to examine the issues and to make recommendation to the Board for any changes in the examination allowable by change in regulation or statute..

Comment: This presents an interesting conundrum and potentially intractable problem. Dental assisting educators testified that candidates are adequately prepared by training for passage of the clinical examination, but logistical problems associated with the process are resulting in the high failure rate. While these factors may contribute to the problem, and should be addressed, they have not changed in the last year. Unless examinations standards are relaxed, not an attractive solution, then elimination or significant overhaul of the RDA practical examination may be the only resolution.

PRESCRIPTION DRUG ABUSE

In May, the DBC voted that the President would appoint a committee of the Board to explore the issue of prescription drug abuse, how dental prescribing and dispensing practices may contribute to this public health problem, and to make recommendations to the Board as to regulatory and statutory action. Since the fall of 2013 the president and staff of the Board have been participating in a *Prescribing Task Force* convened by the Medical Board of California (MBC) to identify ways to "approach and find solutions to the epidemic of prescription drug overdoses through education, prevention, best practices, communication, and outreach by engaging stakeholders" in common efforts. In May the Dental Board became part of an intergovernmental consortium --- *The Prescription Opioid Misuse and Overdose Prevention Workgroup* --- with the purpose of improving collaboration among state agencies working to find solutions to this increasing recognized public health problem. In October the MBC adopted a revised document, *Guidelines for Prescribing Controlled Substances for Pain*, which will be released this month and which may have significant implication for dental prescribers. In a related activity, in August the Drug Enforcement Administration announced it was reclassifying all Hydrocodone Combination Products (HCP) from Federal Schedule III to Schedule II, effective October 6 of this year.

(Continued on page 17)

Warren Brandli Internship Report

My Year as a Warren Brandli Leadership Intern

Patricia McClory, DMD, MPH - Pediatric Dentist, Los Angeles, CA



As a 2014 Warren Brandli Leadership Intern, I was so fortunate to experience the large scope of skills, resources and mentorship of the CSPD. Through the year with my fellow Intern and friend, Sahar Hamedani, a second-year resident at USC, we witnessed organized dentistry firsthand as well as its deep impact on pediatric dentistry in California. I view the Warren Brandli Leadership

Internship Program as one in which we will be able to better understand, utilize and ultimately direct systems that have the possibility of impacting many more than we could otherwise touch as clinicians alone.

The objective of the program is to introduce the interns to the inner workings of CSPD, including the organization's ongoing involvement in public policy. Last April, in collaboration with the California Dental Association, the interns were fortunate to attend an Advocacy Day in Sacramento to meet California's Assembly Members. Here, I was inspired by the CSPD's influence on the political process, as well as the mentorship they provided the Interns. I was deeply touched by the passion these leaders show in order to make such an impact on the oral health community as well as in educational programs for Residents. I saw how organized dentistry allows professionals to become leaders within their fields and draw on knowledge from different resources to assess and resolve public health issues.

Additionally, my attendance at the CSPD Board and Foundation meetings gave me a great appreciation of the preparation and dedication of the members and staff, as they collaborate to solve the profession's most difficult challenges. Witnessing the detailed operations of organizational governance, I could appreciate the organization's strive towards efficiency, transparency and justice as they generate ideas and advance goals. I feel fortunate to be a pediatric dentist in California with so many advocates to support my profession.

As interns, we are working with the CSPD Board on a Millennial Member Data Gathering Project, in which we are conducting interviews with the newest generation of pediatric dentists in California. Through this feedback, we hope to better understand the unique needs of the younger segment of the organization and convey this perspective to the CSPD Board. As a result of this project, we hope that the CSPD can better support newer graduates in their professional development and provide a targeted value to them as members.

Looking forward, I hope to serve patients on a larger scale, not just through sound clinical skills but also through advocacy, policy implementations and project planning. The Warren Brandli Leadership Internship Program has allowed me to train in a well-designed scope and sequence dealing with all aspects of dentistry in California. This training has given me the context for not just the clinical skills, but also the entire scope of services I hope to deliver, as well as those of colleagues with whom I will work over time.

The Warren Brandli Leadership Internship Program is more than dental health. It is more than managing an office. It is working with colleagues to understand the policies, philosophies and systems that can either limit or enhance what services we provide to our communities. It has given me perspectives that may serve as a vision of all I can do to impact the lives of my patients and perhaps touch others who never receive treatment from me. Through my experiences with the Warren Brandli Leadership Internship program, I hope to continue my involvement in organized dentistry to improve our profession as well as the health of pediatric populations.

30th Annual Charles A. Sweet, Sr. Pediatric Dentistry Memorial Lecture

Saturday, April 25, 2015

Diagnosis and Treatment of Oral Trauma

A routinely followed format for a post-trauma examination provides a more organized approach, along with the assurance of a thorough evaluation. Other areas of injury to the head or oral cavity may be missed if we concentrate only on the most obvious injury or chief complaint. This lecture instructs participants in the examination, diagnosis and the treatment of oral trauma in the pediatric patient. Timing and inclusions for follow-up examination, radiographic techniques and antibiotic recommendations are included. Many accidents lead to legal intervention, and findings that appear to be irrelevant or minor may ultimately be of significance. The thoroughness and organization of your dental records will not only insure excellence in treatment, but may be significant for medical-legal support.



Dr. Jane Soxman

You Will Learn

- To obtain information and documentation for accurate and complete dental records
- To perform emergency treatment with an organized approach for assurance of timely and appropriate intervention and provide appropriate follow-up
- To gain confidence for treating the various presentations of dental trauma
- The need for collaboration with other specialists along with determining the provider who will assume primary responsibility for treatment continuity and follow-up
- Current guidelines and review the dental literature

Becoming the Pediatric Alpha Pup

Treating the challenging child today requires a new approach for behavior guidance. Aversive techniques are no longer acceptable. Developmental stages, the multiple factors that influence a child's behavior and recommendations for intervention are discussed. Methods to engage and involve parents and ultimately bring them to "our side" are presented. Potential problems are identified with specific recommendations that can result in more successful and less stressful visits for all.

You Will Learn

- The developmental stages for age-appropriate expectations for behavior
- To recognize potential behavioral problems with instruction in techniques for modifying various forms of behavior
- To provide information for parents regarding limitations due to behavior and treatment objectives
- To determine the pros and cons of parental presence for treatment
- To review the dental literature with updates using evidence-based recommendations

Who Should Attend

This informative program is open to pediatric dentists, general practitioners, dental hygienists, dental assistants and dental office managers.

- Tuition:** \$365 Dentists; \$285 Allied Dental Professionals
(includes continental breakfast and lunch)
- Program:** 9:00 am – 4:00 pm
- Check-in:** 8:30 am
- Location:** Arthur A. Dugoni School of Dentistry, 155 Fifth Street, SF
- Credits:** This activity is designated for 6 units of continuing education credit.

Faculty

Jane Soxman, DDS, is a diplomate of the American Board of Pediatric Dentistry, a fellow in the American College of Dentists and on the board of advisors and a column contributor for the journal, *General Dentistry*. She is a seminar instructor for three general practice residencies, a chapter contributor on dental trauma for a pediatric-orthodontic textbook and is currently editing *The Handbook of Clinical Techniques in Pediatric Dentistry*. Her lectures incorporate more than 30 years of private practice experience, including a review of the dental literature. A conversational style, fact-filled lectures and numerous publications have earned her recognition as a leader in continuing education.





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Be
the expert.

New Warren Brandli Leadership Interns



Drew Colantino was born and raised in Springfield, Illinois. Drew graduated with honors from Georgetown University with a bachelor's degree in business. After working in the world of marketing and advertising in New York City, he decided to redirect his career path, choosing dentistry for its unique integration of science, art and hand skills in a manner that improves the lives of others.

Drew received his DMD degree from Harvard University, where he was involved in outreach programs to assess and provide care to underserved and underrepresented sub-populations throughout Massachusetts and Vermont.

His post-doctoral training includes completing a general practice residency at the Jesse Brown VA Medical Center in Chicago, Illinois where he focused on treating the diverse oral health needs of medically compromised veterans. He is currently a second year pediatric dental resident in San Diego through Lutheran Medical Center. He is currently looking for employment opportunities in California.



Amita Ruehe is a third year pediatric dentistry resident at UCSF. She completed her undergraduate studies at UCSD and studied abroad in England while she was in college. Amita decided to become a dentist through her volunteer work at free dental clinics in San Diego. She graduated from the UCSF School of Dentistry in 2010 and was inducted into the Omicron Kappa Upsilon

dental honor society. Amita realized her desire to become a pediatric dentist during her General Dentistry Residency (GPR) program at the Community Regional Medical Centers in Fresno, CA. Upon graduation from the GPR program, she worked in Central California and in the Bay Area providing dental care to the under-served and low-income pediatric patients. She hopes to continue providing quality care to the under-served pediatric population after she becomes a pediatric dentist. In November 2014, Amita and her husband Eric welcomed their beautiful baby girl, Iyla, into their family.

Public Policy Advocate's Report (continued from page 13)

This "up scheduling" will have major impact in California, where over 1 billion dosage units of HCPs were dispensed last year.

With this as background, the newly-formed Prescription Drug Abuse Committee of the Dental Board adopted the following mission statement:

Our mission is to respond to the rise in prescription drug overdoses by developing strategies for safe but effective prescribing methods within the practice of dentistry.

Comment: These strategies may include adopting the MBC's revised "Guidelines for Prescribing Controlled Substances for Pain" or developing similar guidelines of its own, establishing mandatory continuing education requirements, and/or establishing a policy statement, guidelines or regulation on in-office dispensing of pain medications.

ACCESS TO CARE

At the February meeting of the Board, an Access to Care committee was appointed, with an unclear agenda. The committee at this meeting adopted the following mission statement:

The Committee will maintain awareness of the changes and challenges within the dental community and serve as a resource to the Dental workforce by identifying areas where the Board can assist with workforce development, including the dental loan repayment program, and publicizing such programs to help underserved populations, exploring methods for promoting diversity within the dental community through surveys and workforce data to inform the Board as to existing workforce capacity.

The committee then pledged to meet "whenever any of the above issues arise and require the Board to address and make recommendations."

Comment: It is difficult to envision the actions the Board will take under this still ambiguous mandate.

Executive Director's Message (continued from page 8)

Managed Care: A Near Certain Future for Denti-Cal

As I write this column, a new director of the Department of Health Care Services has just been announced. Her name is Jennifer Kent. She is an experienced health care bureaucrat and is more familiar with oral health issues than most. She and Governor Brown are avowed advocates of a conversion of the Medicaid dental services in California (Denti-Cal) to a managed care system, statewide rather than only in Sacramento and Los Angeles as it now exists. This trend toward some form of managed care is, in my opinion, virtually assured following the release of the recent scathingly critical audit report of the current system that is administered by Delta Dental (<http://www.californiahealthline.org/articles/2014/12/12/audit-dental-failing-to-serve-half-of-children-in-program>). The same system that we all know has been so helplessly and irreparably broken for decades.

Given this extremely likely policy change, I believe that it is essential that dentistry, particularly pediatric dentistry, must be knowledgeable and aware of the various possibilities and directions that can be anticipated with respect to the direction that this managed care train may take.

The first and, in my opinion, the most onerous possibility is that dental care could be simply made a part of ("embedded") one or more of the existing medical health care plans that are operating in California. This would ultimately result in a very real possibility of dentistry (oral health care) being relegated to an insignificant, low priority (pimple on a elephant's rump) status. Under the "embedded" structure the Medical plan would most likely take a 2-3 percent profit off the top and contract with Delta Dental or other similar Third Party Administrator (TPA) to manage the program. Delta Dental, or other TPA entity would take their 2-3 percent profit off the top and what would be left over would be "business as usual" with limited access and low provider participation. Do we really want or need that? I think not!

It is time that we, (CDA and CSPD) take a look at what has occurred in other parts of the country where states have met with varying degrees of success in making the conversion from fee for service to "managed care" for dental services. We must be acutely aware of the fact that such a conversion is first and foremost driven by the state's desire to put a limit on its potential costs (a cap on its expenditures) for providing federally mandated oral health services to its indigent and underserved populace. (Governor Brown is steadfast in his demand that no programs under his administrative control will see increased budgets or current expenditures. He has summarily refused to consider a revocation of the

10 percent decrease in Denti-Cal reimbursements to providers that was implemented last year. Bottom line is that there will be no increases in the Denti-Cal budget for the duration of his administration which is 3 ½ years.) The first conclusion that we can make from observing the results experienced from managed care conversions in other states is that dentistry (Oral Health Care) should not be embedded in Medical Health plans. The second conclusion is that whatever managed care option is chosen it cannot be one which capitates the provider as a means of compensation or reimbursement. The Insurance companies may be capitated however in all of the systems around the country which have met with acceptance by the provider (adequate networks) and satisfactory access and utilization by beneficiaries have been based on a reasonable and fair fee for service reimbursement for services rendered.

I would strongly suggest that CSPD work with CDA to exert all of our combined influence and advocacy efforts to assure that these two provisions be central to any legislation or policy development that would lead to and authorize the conversation of Denti-Cal services to a managed care model:

1. Dentistry must be a separate program (carved out) and not be embedded (carved in) to any Medical Health Plans.
2. Provider reimbursement must be based on a fee for service system, (not capitated to the provider)

We all, collectively and individually, need to practice the old sports adage: Keep your head down and eye on the ball. Do not fall victim to the temptation to close your eyes and swing for the fence. Odds are that nine times out of 10 you will strike out!

Meet CSPD's New ED at Annual Meeting

Dr. Andy Soderstrom is the new CSPD Executive Director!

ED Selection Committee



After CSPD's current executive director Dr. Ray Stewart announced his plans to retire from the leadership position, the CSPD Board of Directors launched a nationwide search for his replacement. CSPD's leadership began looking for the next executive staff leader for this dynamic organization facing new challenges and opportunities in the pediatric dental profession. The goal was to

select a visionary individual with the skills to lead CSPD, strategically partner with the Board of Directors, staff, and members to provide excellent service to CSPD members while being a vocal advocate for California's pediatric dentists and their quest to provide exceptional oral health care to the state's children.

CSPD received interests in the executive director position from both within California and outside of the state. After interviewing a number of candidates, the Executive Director Search Committee unanimously selected Dr. Andrew P. Soderstrom as the new CSPD Executive Director.

For those of you who don't know Dr. Soderstrom, his CV is impressive. He is a current resident and pediatric dentist in Modesto, California, where he has been practicing for over 30 years. He has been a CSPD member his entire career.

He earned his undergraduate degree from the University of California Berkeley and he received his D.D.S from the University of the Pacific and his certificate in pediatric dentistry from the University of California, San Francisco. He is an educator, advocate, author, and recognized leader in California's dentistry community. He is a member of the American Academy of Pediatric Dentistry, California Dental Association, California Society of Pediatric Dentistry and the Stanislaus Dental Society. He is very involved with CDA Cares and giving back to the community. Most notably, Dr. Soderstrom is Past President of CDA. He continues to be involved in numerous volunteer leadership positions on state and local dental societies, including the CDA Foundation. He is not only a practicing pediatric dentist but has gone beyond his practice to commit his time and expertise to the profession through volunteer efforts.

Dr. Soderstrom shared in his letter of interest on being selected as CSPD's next executive director, "It would give me the opportunity to give back in a way I had not expected."

Be sure to attend the CSPD 2015 annual meeting and met the new CSPD executive director in person. Share your thoughts for CSPD's future and support of his new leadership.

Dr. Soderstrom will officially take the helm of CSPD later this year. Dr. Stewart, the CSPD Board and staff will be working closely together to ensure a smooth transition.

Annual Meeting Update

Oariona Lowe, DDS, MA, Annual Meeting Chair

Please join us in Dana Point for CSPD's 40th Anniversary! Whether you are new to CSPD or have been a loyal member since the beginning - join in on the fun to celebrate 40 years of smiles.

The Annual Meeting promises a variety of educational and scientific sessions with topics, such as: Esthetic Full Coverage Restorations for Primary Teeth, A Discussion of Business Topics Affecting Pediatric Dentists, Access to Care in California: Meeting the Challenge and Innovative Solutions, Pediatric Advanced Life Support (PALS) and more. Visit the program page on the CSPD meeting website to see what other topics will be presented.

The meeting will take place at the magnificent Laguna Cliffs Marriott Resort and Spa, located in the city of Dana Point in Orange County. The city is named after Richard Henry Dana Jr., author of the famous literary "Two Years before the Mast." The harbor at Dana Point is home to a marina,

shops and restaurants and is a point of departure for the Catalina Express. A fun-filled trip to Catalina Island awaits you! Dana Point is OC's best year round whale-watching destination. Migrating gray whales can be spotted from November through April.

Dana Point is also a popular destination for surfing and sailing. Nearby is the historical, famous Mission San Juan Capistrano, founded by Father Serra. Make reservations now for the annual meeting and plan some remarkable side trips. Don't miss the action!

Visit our website at conference.cspd.org and read more about our fantastic program. See you in the surf!





CSPD/WSPD Schedule at a Glance

Laguna Cliffs Marriott Resort & Spa • March 25-29, 2015

Wednesday, March 25, 2015

PALS® (Pediatric Advanced Life Support) by Jeff Laabs, RCP-ALS

Time: 8:00 a.m. - 4:00 p.m.

6 CE Units for Recertification

8 CE Units for Full Certification

Course Description: To Be Announced

Thursday, March 26, 2015

CSPD FOUNDATION LECTURE

Meeting the Challenge and Innovative Solutions for Access to Care

Time: 1:00 p.m. - 5:00 p.m.

4 CE Units

Panel:

Jared Fine DDS: Scope of the Problem.

Liz Snow: Managed Care vs. Fee for Service: What works and what doesn't.

John Fehmer: A Practice and Business Model allowing access to care.

Ariane Terlet DDS: The Role of the Federally Qualified Health Centers as a Partial Solution to the Access to Care Problem.

Richard Mungo: Wrap-up and Summary.

Friday, March 27, 2015

Esthetic Full Coverage Restorations for Primary Teeth by William F. Waggoner, DDS, MS

Time: 8:00 a.m. - 11:00 a.m.

3 CE Units

An Update on Restorative Dental Care for Children

by Kevin Donly, DDS, MS

Time: 2:00 p.m. - 4:30 p.m.

2.5 CE Units

NEW DENTIST LECTURE

Employment Law: Wage and Hour Rules and Pitfalls by Anita York

Time: 2:00 p.m. - 4:00 p.m.

2.5 CE Units

Saturday, March 28, 2015

Oral Pathology of the Pediatric Patient by Darren P. Cox, DDS, MBA

Time: 8:00 a.m. - 11:00 p.m.

3 CE Units

AUXILIARY COURSE

Relationships 101: Enhancing Personal Interactions with Your Patients, Team and Family by Linda Waggoner accompanied by William Waggoner, DDS, MS

Time: 8:00 a.m. - 10:00 a.m.

2 CE Units

Utilizing Practice Management Systems and Teamwork for a Successful Practice by Debra Quarles

Time: 10:00 a.m. - 12:00 p.m.

2 CE Units

Saturday, March 28, 2015

STRING OF PEARLS by Various Presenters

Time: 8:00 a.m. - 11:00 a.m.

3 CE Units

Details for this course are not yet available



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A Continuing Education Opportunity for CSPD Membership



By Jacob K Lee, DDS, Chair, Continuing Education Committee

For the last few years, our society has been concerned with providing the most convenient and reliable means of registering the earned CE credits for our Annual Meeting attendees. The Continuing Education Sub-Committee and the Annual Meeting Committee were charged with instituting a simple, cost-effective and less labor-intensive process for our volunteers and staff. Smart-reg international, Inc. is a company that provides registration and lead retrieval services to trade shows and meetings such as the annual meeting. In 2013 Dr. Aparna Aghi, CE Committee chair at the time, and CSPD staff set out to use Smart-reg as a tool to elevate the annual meeting and tracking CE units for our attendees.

Many of you may ask, why do we need to do this? While we are part of our mothership AAPD in being credentialed in our continuing education process, we must adhere to the California Board of Dental Examiners criteria of “trust but verify” towards our licensure requirements.

Dr. Paul Reggiardo, our liaison to the Dental Board of California, cogently commented:

“The purpose of the individual certificates is to protect the integrity of the process. The one-sheet listing is subject to fraud/abuse and we do ourselves a disservice if we do not demonstrate adequately to the public that our continuing education is sufficient to allow us to be relicensed every two years without renewed demonstration of competency (i.e. reexamination)”.

The specific section of the Dental Practice Act covering issuance of the Certificate of Completion of CE also states:

“(1) A provider shall furnish a written certification of course completion to each licensee certifying that the licensee has met the attendance requirements of the course. Such certification shall not be issued until completion of the course and shall contain the following:

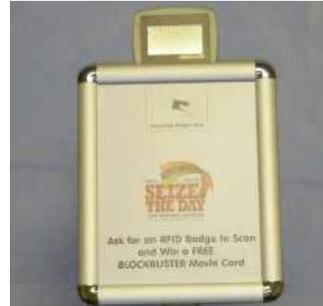
(A) The licensee’s, name and license or permit number, the provider’s name, the 11-digit course registration number in the upper left hand corner of the certificate, date or dates attended, the number of units earned, and a place for the licensee to sign and date verifying attendance.

(B) An authorizing signature of the provider or the providing entity and a statement that reads: ‘All of the information contained on this certificate is truthful and accurate.’

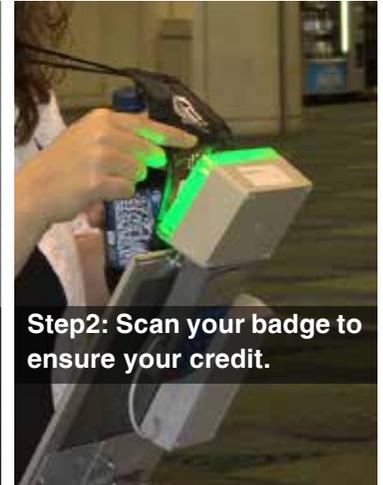
(C) A statement on each certification that reads: ‘Completion of this course does not constitute authorization for the attendee to perform any services that he or she is not legally authorized to perform based on his or her license or permit type.’”

Since the law does not require even a simple written pass/fail quiz at the end of each continuing education offering to demonstrate learning (or that the person was not asleep), the least we should be doing as a CE provider is demonstrating that the licensee was at least in the room.”

There are just 2 simple steps in registering to receive credits for the programs that you attend:



Step1: Locate the SmartReg stand in front of the lecture room that you would like to attend.



Step2: Scan your badge to ensure your credit.



Once you have scanned your name badge successfully, enter the session and never worry about losing your CEU certificates again!

There will be a Smart-reg staff member, members of the CE Committee and the members of the Annual Committee available at each station to assist you with this process.

Two weeks after the meeting you will receive an email notifying you that your certificates are ready to download. Click on the link provided in the email. Once there, enter your badge ID number that is on your name badge. Your certificates from the sessions you attended will be displayed after logging in. You will be able to save and print your certificates.

Should you forget your badge ID number after the meeting, call the CSPD office at 916-231-2142 and they will assist you.

The Continuing Education Committee and Annual Meeting Committee are confident the Smart-reg system will prove to be an easy way to track CE units and help attendees to enjoy the scientific sessions.

Treasurer's Report

CSPD Second Quarter - Fiscal Year 2014-15

Don Schmitt, DDS, CSPD Treasurer



First of all I would like to thank Ken Szymanski for his dedication to both CSPD and our Foundation. Ken has been a tremendous asset to the organization as a whole and has been invaluable in my transition into the Treasurer position. Thank you Ken!

CSPD continues to be in sound financial health. The **2014-15 budget** calls for total expenses of \$463,750 with total revenues of \$477,750. Thanks to conservative budgeting our expenses were 9 percent under budget and our income was 5 percent over budget for the 2nd quarter. We expect the positive trend seen in the 2nd quarter to carry through the rest of the fiscal year.

By now you all should have received your dues statements for the first six months of 2015. Since CSPD decided to accept AAPD's offer of free dues billing, this is a transition year for us. In the past CSPD has operated on calendar year membership but we are now aligning with AAPD's July 1 to June 30 membership year. This necessitated two separate billing statements for the 2015-16 membership year. The billing statement you previously received from CSPD covers from January 1 to June 30, 2015. In May, you will receive your second billing statement directly from AAPD which will cover from July 1, 2015 to June 20, 2016. There will be some cash flow considerations this fiscal year since CSPD will not receive any dues from AAPD billing until October. CSPD's robust reserves put the Society in a strong financial position and we do not foresee any significant problems during the transition.

The addition of Smith Moore and Associates (SMA) as our association management company (AMC) has been a tremendous benefit to our Society. Catherine Smith and her team (particularly Stacie Lewis and Sandy Goree) have taken on a large majority of the administrative tasks that used to fall to the volunteer leadership. But as with anything in life, added benefits come with added costs. CSPD's leadership has worked to reduce costs and increase non-dues revenue where possible. Online continuing education

under the direction of Steven Niethammer is one area of significant membership benefit and non-dues revenue. Another area of non dues revenue is the Annual Meeting.

At the January Board meeting, CSPD's leadership reviewed the current policy of a revenue neutral Annual Meeting. The way CSPD currently operates with an Executive Director and an AMC, a revenue neutral Annual Meeting is not possible without a significant increase in membership dues. Therefore CSPD's leadership elected to change the policy such that the Annual Meeting is designed to be both a membership benefit and to generate non dues revenue for the Society.

Reserves: CSPD's policy and procedure manual calls for a Reserve Fund equal to an average of the last two years operating expenses. The current mandate amount is \$400,854. The Reserve Fund requirement has increased substantially over the past three years due to the increased operating expenses incurred with the addition of SMA.

Investments: Following the Financial Policy outlined in the Policy and Procedure Manual, all of CSPD's assets are in fixed return products. These include both savings and money market accounts. The Finance Committee discussed the status of CSPD investments recently. Though the committee is disappointed in the paltry investment returns it was determined that the safety and capital preservation of CSPD's assets is paramount. The committee did vote to move \$81,490.77 from a Smith Barney money market account that was losing money due to high fees to another existing money market account at California Bank and Trust.

Thank you for allowing me to serve as your Treasurer. If you have questions about the finances of our Society please do not hesitate to contact me. I look forward to seeing you in Dana Point in March.

Foundation President's Message

Steve Gross, CDT



Everyone Benefits

Thanks to you, the CSPD membership and your generous donations, the Foundation continues its mission to enhance and expand educational opportunities for faculty and students with research grants, travel grants, support for student groups, lunch and learns and sponsoring residents to attend Annual Meetings. Over the last four years **The Bridging the Gap** program as been an overwhelming

success, with over \$250,000 provided to California's pediatric dentistry programs to help with faculty recruitment and retention. The Foundation also supports the annual meeting as a Diamond Sponsor as well as the SCLDC program and the Warren Brandli Leadership Intern program, with an additional \$20,000 per year. These programs will ensure that there will always be a strong corps of leaders for CSPD in the years to come.

While we will continue the funding of these programs, we will now open up for consideration a wide variety of additional grant options. **Our new Program Enrichment Grant** will fund innovative program enhancements, with each grant funded up to \$8,000. (Read more in the article below)

Access to Care in California: Meeting the Challenge and Innovative Solutions

This year in Dana Point we will be co-sponsoring (with Healthy Smiles Healthy Children) an impressive panel of experts for an in-depth discussion on an issue that affects a growing number of California's children. A lack of access to care for a substantial segment of the population including low income and special needs patients, as well as the under-insured, has led to an environment where we will no longer be able to conduct "business as usual." Please join us for this informative informational presentation and discussion around a problem that will have a very direct effect on every dental practice. (See announcement on page 27.)

A Special Thank You to Our Corporate Sponsors My Kids Dentists – Prophecy Magic

Please remember that these sponsors not only pay to come our Annual Meeting, they have also stepped up to become our corporate sponsors. They deserve your support!

Special Thanks to Our Brandli Sponsor Donors

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At this point I would like to speak directly to you, the membership of CSPD. It is only through your donations that this Foundation can keep our dream alive. To those who have given, **THANK YOU!** There are many of you out there who are at or approaching the completion of your life pledge, so I ask you to join many of your colleagues in the same position who have pledged to continue giving at the same or even higher level.

There are over 700 members of CSPD and only about a hundred who support the Foundation. Just think what a force we would be if we **ALL** kicked in as little as a hundred dollars a year. (\$8.50 a month) What a difference it would make! PLEASE JOIN US!

Finally, I want to extend my gratitude to our Foundation Board – it is only through their hard work that we continue to accomplish great things for pediatric dentistry in California.

Thank you for listening; if you have any comments or suggestions, please don't hesitate to contact me at steveG@SMLglobal.com.



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CONGRATULATIONS
to this year's Grant Recipients!



**JOIN US FOR THIS YEAR'S CSPD FOUNDATION
ANNUAL "HOT TOPIC" PRESENTATION:**

2015

Access to Care

Formidable Challenges and Innovative Solutions

March 26, 2015, 1:00pm -5:00pm

CSPD/WSPD Annual Meeting: MARCH 26-29, Dana Point, CA

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Enhancing Pediatric Dental Education at All Levels

Bridging the Gap Program

CSPD Foundation has provided more than \$250,000 in financial support to California's pediatric dentistry programs over the past three years. For the 2015-16 funding cycle, the Foundation will continue to make available grants up to \$25,000 to support faculty recruitment and retention.

Announcing Program Enrichment Grants: A New Funding Opportunity!

In addition to providing funds that directly go towards the cost of hiring faculty, the Foundation is pleased to announce a new category, titled Program Enrichment Grants (PEG). This program will provide additional opportunities to enhance pediatric dental programs. Program Enrichment Grants will fund up to a maximum of \$8000. The Foundation encourages Program Directors and Department Chairs to apply for funds that will enhance their programs in innovative ways, such as:



- Volunteer and/or part-time faculty "perks", such as parking, travel expense, meals for staff meetings, etc.
- Strategic Planning Retreats which include both volunteer and paid faculty
- "Transportation Fund" which might improve patient access to clinics and reduce missed appointments

Thank you Foundation Donors!

Your support has funded BTG and PEG programs, Lunch and Learns, Brandli Interns, Special Projects with CSPD and AAPD, Leadership Development Committee Activities, Undergraduate Dental Student Groups, Foundation Presentations, Research Grants, CSPD Meeting Support and more.

2015 CSPD Foundation Presentation

Access To Care In California: Meeting The Challenge With Innovative Solutions

The CSPD Foundation will again focus its presentation on a key "Hot Topic" for 2015

This presentation will offer important information to CSPD members, addressing the challenges and presenting innovative solutions.

Pediatric dentistry is currently experiencing a marketplace, which is undergoing profound fundamental changes, inevitably affecting the way we practice. These same changes, which occurred in medicine in the 1990s, have forever transformed the way health care is administered and delivered. Dentistry is not far behind, with the growing problem of access to care for a substantial segment of the population including low income and special needs patients. This has led to an environment where we will no longer be able to conduct "business as usual." The introduction and implementation of the Affordable Care Act (ACA) in 2010 and the rapid transition to universal care has all but assured us that our world is in the process of evolving in a direction and with a speed that is difficult to comprehend.

Please join us and a panel of experts as we explore key issues and solutions to this ever-growing challenge.

Panel:

- Jared Fine DDS: Scope of the Problem.
- Liz Snow: Managed Care vs. Fee for Service: What works and what doesn't.
- John Fehmer: A Practice and Business Model allowing access to care.
- Ariane Terlet DDS: The Role of the Federally Qualified Health Centers as a Partial Solution to the Access to Care Problem.
- Richard Mungo: Wrap-up and Summary.

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Faculty Spotlight

Dr. Amit Shah, DDS, Associate Clinical Professor at USC

Interview by Sahar Hamedani, DDS, Warren Brandli Intern



Q: As a recent graduate, what motivated you to enter teaching?

A: When I graduated, I still could remember the feeling of not being sure how to do something. I always appreciated when an attending took the time to teach me. I also had a lot of experience teaching in my last year of residency, and I felt I could take that and contribute in a positive way to new residents.

Q: What would you say to other new or recent graduates who are thinking about going into academics?

A: I would encourage new and recent graduates to dip their feet into academics. It is rewarding to see residents become more confident and capable clinicians.

Q: What has been the biggest challenge you have faced as a recent graduate and what advice would you give to new grads?

A: The biggest challenge for me was figuring out what type of working environment I want to be in for the long run. When you first graduate, you are still learning so much; what you think you want when you graduate usually evolves into something different one to five years in practice. The advice I always tell residents to give a chance to every opportunity they receive. I either learned something or made a new friend at each place I worked.

Q: What do you enjoy most about being an attending?

A: I enjoy getting to meet new residents every year and hear their experiences. Discussing academic material, clinical care, and what we heard at the latest meetings also keeps me sharp while teaching and working in private practice.

Q: Aside from pediatric dentistry, what are some of your passions?

A: I love trying new restaurants and traveling to new places. In the last couple years I have been to Cambodia, Turkey and Brazil, and I'm looking forward to going to Iceland.

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Student Activity Report for California Pediatric Dental Residencies University of California, Los Angeles

UCLA SCAAPD has been hosting events that continue to promote pediatric educational and service opportunities as well as events that harbor relationships between the members of our club. Some of the highlights of the events that happened over the past few months include: Gingerbread House Decorating Competition between dental students and the UCLA Pediatric Dentistry Faculty and Residents, Balloon Animal Making workshop, Kids Enjoy Exercise Now (KEEN), and Reading to Kids.

KEEN allowed our students to spend a Sunday morning with special needs children, teaching the children that being outside and being active is just as fun as being inside and playing with electronics. We also spent one Saturday morning with Reading to Kids where our students read to children to promote that reading is fun. We are looking forward to our biggest event of the year in February 2015: Give Kids a Smile at The Children's Dental Center of Greater Los Angeles. We have many exciting events in the next few months and we look forward to watching our students learn more about pediatric dentistry!



Loma Linda University

Adi Genish, President of LLU CSPD Student Chapter. Mentor: Jung-Wei Chen DDS, MS, PhD.



This past fall Loma Linda's CSPD chapter has been organizing events while our new residents are hard at work and doing an incredible job. This quarter we had an incredible opportunity to have a five-year reunion party for all of our patients that have had the Presurgical Nasoalveolar Molding Appliance that we utilize for cleft lip and palate infants prior to their surgical corrections. All of our faculty members were presents to provide their support, as well as all residents and staff.

Drs. Jung-Wei (Anna) Chen and Bonnie Nelson did an incredible job organizing the event and the residents were involved in providing free oral screenings for all the patients and their siblings. In addition, several individuals serving on these patients' craniofacial team were in attendance. It was an incredible day for our department and for the families. Further, our second year residents presented their case presentations.

Ava Chung presented a case on Epidermolysis Bullosa, Adi Genish presented a case presentation on her patient with Van der Woude Syndrome, Pooyan Nasibi gave a very informative presentation on Cherubism and Mike Young did an excellent job on presenting a case report on Dental Whitening in the Pediatric Patient. Several of our residents also participated in Clinic With a Heart in which free dental services were provided to pediatric patients. We have several events planned for our Winter quarter and look forward to sharing them!



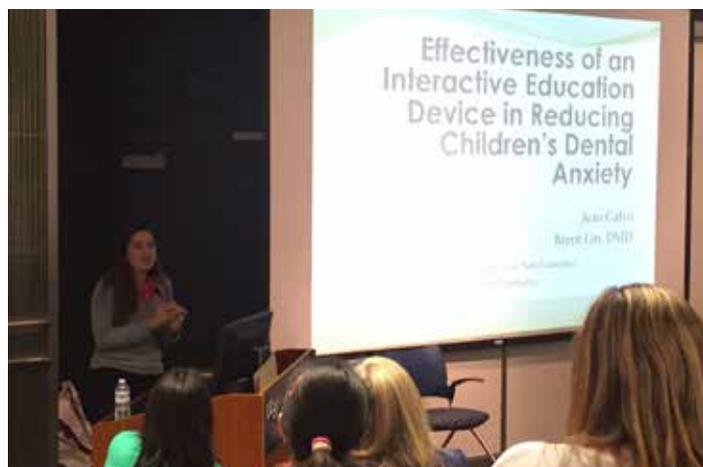
University of California, San Francisco

The Student Society of Pediatric Dentistry (SSPD) at UCSF has initiated and organized a scientific symposium in collaboration with the Center for Children's Oral Health Research (COR) on November 20, 2014. The inaugural event has brought the research scientists with interest on children's oral health together with the pre-doctoral students and post-graduate students. Award-winning presentations on basic and clinical sciences and global oral health research were given by the student researchers and faculty scientists. Kei Katsura (third-year DDS/PhD student), under the guidance of Dr. Pamela Den Besten, presented her research, "The Maturation of Enamel Development: Investigating Wdr72 gene". Jean Calvo (third-year DDS student), under the mentorship of Dr. Brent Lin, presented her clinical research on utilization of an interactive education device in reducing children's dental anxiety. The scientific findings of a global oral health project for children in Honduras was presented by Dr. Ling Zhan. The symposium was concluded with closing remarks from Dr. Den Besten, Director of COR, and Dongkook Lim, Vice-President of SSPD.

A new pediatric dentistry elective course is created and implemented on January 1, 2015 with the focus on literature review and case presentation. Under the guidance of the course director, Dr. Brent Lin, and the third-year pediatric dental resident and former CSPD Warren Brandli Intern, Dr. Alex Malebranche, the course was designed and planned to elicit critical thinking and encourage students to learn and to practice evidence-based dentistry in pediatric dentistry. The course is well received by the students, with nearly 30 students signed up for the first course.

UCSF has successfully placed 6 students this year into pediatric dentistry residency program around the country, with the immediate past-president, Michael Hong, heading to Boston Children's Hospital/Harvard Program. The SSPD and its student officers have continued to play an active role in community engagement and have raised fund to support programs promoting children's oral health. The current SSPD secretary/treasurer, Jason Kowk, is working on a scientific project, under the guidance of Dr. Brent Lin and in collaboration with a foundation, looking at the special needs children and promoting care for this vulnerable population, and Julia Ma, a third-year dental student and SSPD member, has coordinated and conducted a very successful global children's oral health project in an underserved, rural elementary school at Guangdong, China in December 2014. SSPD is currently taking on the leadership role in organizing the upcoming "Give Kids a Smile Day" at UCSF.

With opening of the new UCSF Children's Hospital on February 1, 2015 at the Mission Bay, UCSF students are excited and will have an opportunity to involve in caring of the special needs children in an interdisciplinary setting and observe general anesthesia cases in operating room with the state of art facility.



CDA Cares - Pomona

Santos Cortez, DDS - CDA Cares, Pediatric Dentistry Lead



The Pomona Fairplex was the site of the CDA Cares dental clinic in 2014 where more than eighteen hundred patients were treated on Friday, November 21 and Saturday, November 22.

Future CDA Cares Events:

Sacramento, Cal Expo: March 27, 28, 2015
 Fresno, Convention Center: October 2, 3, 2015

Visit the CDA Cares website for more information in the coming months.

Volunteers participated in setting up the clinic the Thursday before patients were seen and others helped close it up on Sunday morning. Once again, pediatric dentistry was well represented as we had over 20 volunteers and we treated over 200 pediatric patients and over 250 patients altogether, as we also treated some adult patients in the pediatric department.

We all appreciate the teamwork of the 1,700 dentists, hygienists, dental assistants, lab technicians and community volunteers who came together to provide care for nearly 1,900 people who would otherwise have gone without dental care. Once again, CDA Cares made a difference; pain was relieved, infections were treated and smiles were restored.

I know as volunteers, we received as much or more than we gave. The CDA Cares clinics provide free dental treatment for people that will drive hundreds of miles and wait many hours in line to receive care. Restorations, extractions, x-rays, dental prophylaxis, root canals, partial dentures and much more were procedures that were rendered in those two days of intensive work.



Pediatric dentists volunteering at CDA Cares Pomona November 21-22: David Okawachi, Santos Cortez, Dora Lee, Jared Nation and Ora Lowe.

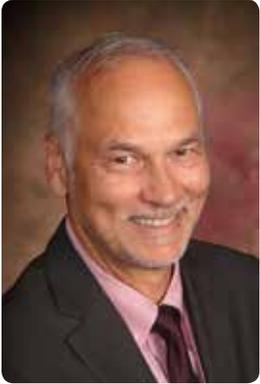
CDA Cares Pomona Statistics:

- \$1.66 million in dental services
- 1,752 volunteers
 - 826 dental professionals
 - 10 medical professionals
 - 22 lab techs
 - 727 community volunteers
- 1,861 patients
- 12,204 procedures

Pediatric procedures: Comparison	Solano 2014	Pomona 2014
Children's Services (0-18 years old)*	Quantity	Quantity
Sealant (per tooth)	104	76
Prophylaxis - Child	73	59
Topical Fluoride - Child	60	11
Therapeutic Pulpotomy (Excluding Final Restoration)	39	8
Extraction, Coronal Remnants - Deciduous Tooth	4	45
Prefabricated Stainless Steel Crown - Primary Tooth	9	3
Prefabricated Stainless Steel Crown - Permanent Tooth	5	4
Amoxicillin 250 mg (#21)	5	3
Acetaminophen 80mg Chewable (#6)	13	0
Total	312	209

Western Society of Pediatric Dentistry WSPD President Letter

John L. Gibbons, DMD



This year the Western Society of Pediatric Dentistry has submitted to the AAPD Constitution and Bylaws Committee two (2) proposed amendments to the AAPD Bylaws.

We requested that the Constitution and Bylaws Committee draft an amendment to extend the existing notification of Constitution or Bylaw changes from thirty (30) to

sixty (60) days.

Current AAPD Bylaws provide that members be notified thirty (30) days prior to any vote on Constitution or Bylaw amendments by membership. This is viewed as being inadequate notice to evaluate the change, elaborate a response and even schedule to be in attendance to cast a vote at the General Assembly. What we are advocating is that every member be given adequate notice when there is a major constitutional or bylaw change.

We also requested that the Constitution and Bylaws Committee draft an amendment to modify the existing voting provision that allows absentee voting for all eligible voting members to include absentee voting on Constitutional and Bylaw amendments.

The General Assembly is where you have the right to cast your vote on the future path that our organization will take. It is estimated that only three percent (3%) of our membership attend this important meeting. To allow every member the right to vote on important issues such as leadership change, constitutional and bylaws changes, the WSPD introduced a bylaws change that will require that every member be allowed to vote in abstention when these issues are voted on.

“We believe that every member regardless of his or her circumstances should have the ability to vote on the direction of our organization.”

We believe that every member regardless of his or her circumstances should have the ability to vote on the direction of our organization. Currently our bylaws allow a member to request an absentee ballot for the annual leadership change; what we are advocating is that every member also be allowed to vote in abstention when there is a major constitutional or bylaw change up to thirty (30) days following the General Assembly.

The General Assembly is where a sometimes robust debate of the pros and cons of the proposed Constitutional or Bylaws changes takes place. It is our belief that by thirty days following that debate a final version of any last minute changes to the proposed amendments, along with the debated pros and cons will be able to be distributed to and voted on by the membership. This insures that the members will be casting an informed vote.

The WSPD invites you to please arrange your schedule to come to Seattle, AAPD meeting the morning of May 24th (Sunday) and cast your vote at the General Assembly on these very important proposed amendments.

Significant Approved Motions from the January CSPD Board Meeting

- Move to approve the 2017 Annual Meeting to be held at the Green Valley Ranch Resort in Las Vegas, Nevada.
- Move to approve Drs. Drew Colantino and Amita Ruehe as the Warren Brandli Interns for 2015-2016.
- Move to approve Drs. Trang Pham and Stephen Kim as the Santos Cortez Graduate Student Legislative and Advocacy Interns for 2015-2016.
- Move to approve to offering Drs. Angela Lee and Arina Hartunian the additional openings for the Santos Cortez Graduate Student Legislative and Advocacy internships.
- Move to approve the Endorsement of AAPD oral health policy and clinical guidelines positions with acknowledgement that the policy is not constitute a “standard of care”, but rather are meant to act as guidelines.
- Move to approve the removal of Section IV, Line 1665: “After sponsorship income is taken into consideration, registration fees should be set so as to balance expenses and produce a “break even” meeting” from the Policy and Procedure Manual.

NEW CSPD MEMBERS

Active Members

David Cottrell..... Atascadero, CA
Richard Spaulding..... Torrance, CA

Affiliate

Suzanne Clift..... Vallejo, CA
Bryan Randolph Folsom, CA
Maryam Mohsenzadeh..... Napa, CA

Post-Doctoral Student Members

Sanjeeta Shergill Lutheran Medical Center,
Springfield MO
Drew Colantino..... Lutheran Medical Center -
San Diego
Julie Nguyen Lutheran Medical Center -
San Diego
Shanan Brown..... University of Florida-
Naples
Tesha Waggoner..... Queens Medical Center

CALENDAR OF EVENTS

CSPD

March 26-30, 2015: CSPD’s 40th Annual Session at Laguna Cliffs Marriott Resort, Dana Point, CA

April 20-24, 2016: 2016 Silverado Resort, Napa, CA

AAPD CE Meetings

May 21-24, 2015: 68th Annual AAPD Meeting, Seattle, WA

May 26-29, 2016: 69th Annual AAPD Meeting, San Antonio, TX

See www.cspd.org and www.aapd.org for more courses

Do You Have a Story to Share?

Is your practice doing something unique? Whether it’s a great new program or how you managed a complex issue, we want to hear about it. The CSPD Bulletin is distributed to members statewide and pediatric dentists located throughout California. If you have news to share, contact Stacie Lewis, slewis@cspd.org.

Letter from the Editor:

By Dr. Jung-Wei Chen

Dear CSPD Members,

It is great to have another new issue of the bulletin published. You will find there are various resourceful and interesting contents in this issue. We still have the reports from the leaders of CSPD, WSPD and CSPDF. The important legislation details legislative updates of bills and Annual Meeting of 2015, student activity reports and faculty of Spot Light are also included. There is an article about wellness and exercise. We also added one new benefit with this issue which was earning one CE unit by reading scientific article that is related to pediatric dentistry. In this issue, we invited the internationally known expert in Dental Traumatology, Dr. Leif Bakland, to write an article for Bulletin. After reading the article, simply answer the quiz you can earn one CE unit. I hope you enjoy reading it!

CSPD Professional Opportunities



Opportunities
Wanted

Opportunities
Available

Faculty Positions
Available

Practices for Sale
Offices for Lease

Have you been thinking about hiring an associate, but just aren’t sure where to look? Or are you finishing your residency soon, and aren’t sure where you’d like to live and practice? The answer is right on the CSPD website. To look at these opportunities and others, go to www.cspd.org.

Sincerely,
Don Schmitt, DDS



Winter CE Quiz

Trauma-related Root Fractures: Diagnosis and Treatment

Leif K. Bakland

- 1) Root fractures occur most frequently in
 - A. mandibular anterior teeth
 - B. maxillary anterior teeth
 - C. mandibular molars
 - D. maxillary premolars
- 2) Which type of trauma-related root fractures is most likely to be missed radiographically?
 - A. Horizontal fractures.
 - B. Diagonal fractures.
 - C. Vertical fractures.
 - D. Cervical fractures.
- 3) Which of the following clinical examination procedures provides the most definitive information about a root fracture?
 - A. Pulp vitality testing
 - B. Percussion sound
 - C. Periodontal probing
 - D. Multiple angles radiographs
- 4) Favorable treatment outcomes for root fractures are related to
 - A. timely repositioning of the coronal segment
 - B. rigid splinting
 - C. immediate root canal treatment
 - D. use of antibiotics for 7-10 days
- 5) The tissues that form between root segments in root fractures include the following, except:
 - A. Cementum.
 - B. Dentin.
 - C. Bone.
 - D. Fibrous tissue.

Licentiate's Name: _____ **License Number:** _____

I certify that I completed the above course for continuing education credit.

Licentiate's Signature

Date



The California Society of Pediatric Dentistry (CSPD) is an ADA CERP Recognized Provider Approved by the American Academy of Pediatric Dentistry. ADA CERP is a service of the American Dental Association to assist dental professionals in identifying quality providers of continuing dental education. ADA CERP does not approve or endorse individual courses or instructors, nor does it imply acceptance of credit hours by boards of dentistry. Concerns or complaints about a CE provider may be directed to CSPD at (916) 231-2142 or to ADA CERP at www.ada.org/cerp.

These California, Florida and AGD continuing education activities have been planned and implemented through joint efforts between American Academy of Pediatric Dentistry and California Society of Pediatric Dentistry.

Florida Registration Number: PP072

AGD Approved National Sponsor Number: 214685

One hour CE unit will be granted to members who answer more than three questions correctly.



Return by mail:

California Society of Pediatric Dentistry
1215 K Street, 940
Sacramento, CA 95814



California Society of Pediatric Dentistry

1215 K Street, Suite 940
Sacramento, CA 95814

The mission of the California Society of Pediatric Dentistry is to serve its membership and the public by advocating for the optimal oral health of infants, children and adolescents.



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