BULLETIN
CALIFORNIA SOCIETY OF PEDIATRIC DENTISTS

Summer 1997 Vol. XXIII, No. 2

PRESIDENT'S MESSAGE

Dr. Ray Stewart

This is truly an exciting time for the specialty of Pediatric Dentistry. As a number of events unfold, both nationally and here in California, it is clear that the future of our specialty is generally bright. The children's oral health policies which have

been adopted by the leadership at AAPD and within our CSPD component over the past several months have positioned us in a very favorable light in both the public eye and in the eyes of our health care colleagues. We are, in most cases, the "guys in the white hats" leading the charge when it comes to advocating for the underserved children in our society and championing the cause of elevating the status of oral health in our nation's children. (See *Statement on Children's Oral Health* elsewhere in this issue.) Although things look rosy on most fronts, there are two critical areas of concern which need to be addressed by CSPD, as well as, AAPD.

The first issue of concern is the looming manpower shortage facing our specialty in the next 10 - 15 years. Dr. Tom Buch's manpower survey of pediatric dentistry in California (see last issue of Bulletin) reveals that the number of practitio-

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Dental Care Report

IPA's potential impact on Pediatric Dentistry

IPA's are continuing to grow across the state of California. Presently, at least five new IPA's are in various states of formation. They are located in Los Angeles county, Fresno county, Monterey county, the Bay area, and the Sacramento area. Most are presently engaged in the formation of their networks. Fresno is furthest along, having already a significant book of business.

Most new IPA's are essentially EPO networks (Exclusive Provider Organizations). This means there is an additional financial benefit to the employee, if they go to one of these PPO providers. None, with the exception of Fresno, are presently planning to do any capitation business.

In a PPO environment, patients are free to choose any PPO network provider. There is no gate keeper dentist involved in this process. This means that patients are free to choose a Pediatric dental office that participates in the network, and the Pediatric Dentist will be reimbursed on an agreed upon fee schedule. As long as these IPA's don't choose to engage in capitation business, they should not impact the status of Pediatric Dentists as primary care providers, because there is no gate keeper to prevent access to Pediatric dental offices.

Paul Reggiardo, AAPD Trustee mentions in his report that GMC in Sacramento has 140,000 patients enrolled. In it, he concluded that, based on his data and oversight by the courts, he believes, "it is unlikely we will see a statewide dental capitation program in California any time soon."

I do not agree with Paul's conclusions. Presently, there are over 300,000 Denti-Cal recipients enrolled in dental managed care in Los Angeles County. Up until now, the population was capped at 350,000 participants. The Department of Health Services this week removed that cap.

This is presently a voluntary program, but all it would take is a change in policy and approval by the federal government to remove the voluntary component of this program and mandate all eligible Denti-Cal recipients into dental managed care.

The state is also looking to expand this voluntary program to other counties in the state.

Respectfully submitted,

Scott Jacks
Dental Care Committee

This Bulletin...

PRES. MESSAGE, continued from page 1

ners retiring or reducing the number of patient treatment hours will not be adequately replaced by "new" pediatric dentists currently in training. There is also an inadequate number of young specialists choosing to pursue an academic career to replace the large numbers of pediatric dental faculty who will be retiring in the next decade. The situation looks pretty grim, however, AAPD and CSPD are engaged in "new approaches" to the problem.

Roger Sanger, as the Chairman of the Manpower Ad Hoc committee, is organizing two meetings, one in the Los Angeles area and one in the San Francisco area, to assemble the program directors from the California pediatric dental programs to discuss, in an open forum, the ways in which CSPD can help to convince the school to; (a) increase the numbers of residents being accepted, (b) increase the numbers of qualified faculty to participate in the training programs, (c) broaden the funding options and training opportunities available to the schools, (d) encourage residents finishing programs to stay in California and to consider establishing practices in rural communities.

The second area of concern is how to increase the number of members who play an active role in CSPD. There are still a significant number of pediatric dentists who do not participate in society affairs and as such, do not let their voices be heard on issues vital to the welfare of both CSPD and the children of this state.

Much to our surprise, the Board recently learned from David Perry, Chairman of Credentials and Membership, that there are currently 66 members of AAPD who do not belong to CSPD! Conversely, there are 118 members of CSPD who are not members of AAPD! Further, there are currently 16 Diplomates of the American Board of Pediatric Dentistry (out of 101 practicing in California) who do not belong to CSPD! Less than 35% of our membership (currently 438) attends the Annual Business Meeting and Scientific Session.

What is wrong with this picture? If an organization as small as CSPD is to have any significant effect in dealing with important issues concerning our specialty and the future of children's oral health policy at local, state and national levels, we must speak as one voice. The old adage "together we stand; divided we fall" could not be more true than it is in our case.

CSPD has an aggressive Governmental Affairs Program to monitor and respond to legislative issues affecting children's oral health care in California. This will only be strengthened by the development of an active and informed "grass roots program" designed to have our members be proactively involved with their own local representatives to the State Assembly and State Senate to present CSPD's views and position on critical legislative issues as they arise.

Similarly, your Board of Directors has outlined an aggressive and highly visible program to position CSPD at the forefront of Child Health and Welfare Advocacy in California. We are working hard to assure that "oral health" is included in any language or legislation concerning child welfare, medical care and health care in this state.

The success of all of CSPD's programs and initiatives depends on broad support and participation by our members. This means each and every one of us must play a role. I am told that direct participation by members is often impeded by their reluctance to interact with what they perceive to be a "good old boys' club". Nothing could be further from the truth when it comes to CSPD. The Officers and Board of Directors would welcome enthusiastically, any requests to be considered for committee appointments, board positions, etc.

I encourage you (no, I implore you) to GET INVOLVED. If there is a particular committee on which you would like to serve or have some area of expertise which would be beneficial, please contact me directly or call the chairman of that committee and ask to be included.

Respectfully,

Ray Stewart
President

Membership News

CSPD Membership Status

Active	351
Associate	26
Life (inc. ret.)	27
Retired	5
Student	24
Honorary	1
Faculty	8
Total	442

CSPD Board Meetings

Officers and members of the Board of Directors for CSPD meet quarterly. The membership of CSPD is encouraged to provide input to it's leadership. Our next regularly scheduled meeting is **October 4, 1997.**

Board meetings are open to the membership, and you are welcome to attend. In the alternative, written communication should be addressed to Dr. Ray Stewart.

BULLETIN
California Society of Pediatric Dentists

CSPD members are encouraged to contribute to the *Bulletin*. Articles, Letters to the Editor, or other items of interest are welcome. The next deadline for submission is October 18, 1997. Items for publication may be submitted by e-mail (editor@cspd.org), in computer format on a 3.5" disk or double spaced, typewritten and of reproducible quality for Xerox.

Product and informational content presented in the *Bulletin* by contributing authors are not necessarily supported by the Executive Board of CSPD.
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Editor
James M. Yee, DDS

Children's Oral Health AAPD Statement

The American Academy of Pediatric Dentistry believes that all children have a right to quality oral health care. Oral health is an integral part of total health and future success. Healthy mouths together with bright smiles are the foundation for healthy children. During the last decade, due to the combined efforts of government and organized dentistry, the oral health of the majority of our nation's children has improved significantly. Unfortunately, a significant number of children have not benefited from this change. Without federal and state support, access to care is still unavailable to two groups of children, those in low income families and those with special needs.

We endorse the following principles:

1. Add dentists to the list of providers in Medicaid (OBRA 1989) and ensure that regulations and report language explicitly include, oral health within the terms "medical care" and "health care".

2. Support child health coverage that provides care to as many children as possible. Include treatment in any plan accepted and/or maintain EPSDT.

3. The decline in the number of pediatric dentists is an accelerating problem. Support programs that train dentists to competently treat children through the use of Graduate Medical Education funds (GME) to support pediatric dental training at all sites.

4. Recognition of pediatric dentists as primary care providers by including them in the primary dental care cluster as part of the Health Professions Training Act.

5. Congressional action to eliminate abuses in managed care, as addressed in PARCA legislation, especially maintaining the patient's freedom of choice as well as access to all providers.

6. Allow deduction of interest on student loans for dental students and those in residency programs. New practitioners need relief from educational debt repayment so they can afford to treat the neediest patients.

7. In all program planning, maintain coverage for quality oral care for those children with access and provide provisions for children with special needs, realizing that deductibility of dental benefits by employers is the key to maintaining access for middle class children.

We urge you to join us as we work toward our vision of

Optimal Oral Health for All Children

Office Based Research

The foundation for all advances in the Science of Pediatric Dentistry is basic research The observations made in the process of conducting a well designed and controlled experimental protocol are the basic elements of all of our diagnostic and treatment decisions.

We, as practicing pediatric dentists, have access and contact with large numbers of patients of diverse racial and socioeconomic backgrounds. Collectively, we have the potential of very large experimental or study populations. If we are successful in developing a program where, as a group, we can make observations, record data and process that data in a standardized and controlled fashion it is possible that the results and conclusions of these efforts would be significant and valuable.

The heretofore missing link in the equation has been the presence of persons with the skill, experience and willingness to design a protocol, data collection instrument, and data processing which a busy practitioner could embrace and agree to be a participant in a project without imposing undue delays or interferences with his usual office routine We now have such a team in the form of faculty members at UCSF and UCLA who have expressed an enthusiastic willingness to participate in a CSPD office based research project.

The next step in the process is to identify areas or topics of interest which our members feel would be worthy of investigation. Please fill out the attached questionnaire and return promptly to Dr. Richard Udin for consideration by the committee. Don't delay. Do it now!

!!! SAVE THESE DATES !!!

For the fifth year in a row, CSPD will present a day of continuing education designed exclusively for pediatric dental auxiliaries.

This year's course entitled, "Bumps, Scratches, Blisters, and Bruises– Recognizing Medical Conditions in our Pediatric Patients" will be held on **Saturday, November 15, 1997** in Newport Beach, and on **Saturday, November 22, 1997** in Oakland. This course will discuss common childhood conditions including skin lesions, allergic reactions, childhood diseases, and congenital syndromes. Signs and symptoms of child abuse will also be reviewed.

Detailed registration material for your staff will be mailed in September. Mark your calendars now!

AAPD Legislative Update

Late in July, a bill introduced through the efforts of the Louisiana Academy of Pediatric Dentistry passed both houses of the state legislature and was signed into law mandating third party reimbursement for hospitalization and general anesthesia costs associated with dental care. The law takes effect January 1. Louisiana now joins Minnesota, Texas and Tennessee in prohibiting the denial of medical insurance reimbursement for otherwise covered medical procedures when dental treatment is provided.

The Louisiana component utilized the Academy protocol in drafting this bill with the cooperation and support of the Louisiana Dental Association in all phases of the legislature process.

Our colleagues in Louisiana should be congratulated for their success on behalf of the children and parents in their state, for whom needed care may now be more affordable and accessible.

Paul Reggiardo
Trustee, District VI, AAPD

AAP Liaison Report

Dr. Parvethi Pokala, San Diego Chapter 3, is working with the Care committee of the Local AAP and is currently reviewing the School system care manual to ensure that the dental recommendations contained in it correspond with those of the AAPD and the CSPD.

She is also working to help coordinate a 1/2 day seminar at Children's Hospital for Pediatricians, Peds. residents, Peds. nurse practitioners, nurses, and other caregivers on the topic of Pediatric Dentistry. Although dates have not yet been set, it will be held on a Saturday morning hopefully late summer or fall.

The AAP chapter 3 would like to sponsor a joint evening meeting with the AAP and the local Pediatric Dentists. She would like to use the CSPD as the sponsoring dental group. So it would be a jointly sponsored meeting of the AAP and the CSPD. The meeting is being scheduled for sometime in November.

We now have representatives in District 1, 2 and 3. Our chapter was recognized at the AAPD meeting as one of the most advanced components with respect to relationships with the AAP. I was asked to present a plan to help other components develop their relationship with the local pediatric chapters and presented the developed material to the AAPD workshop at the annual meeting..

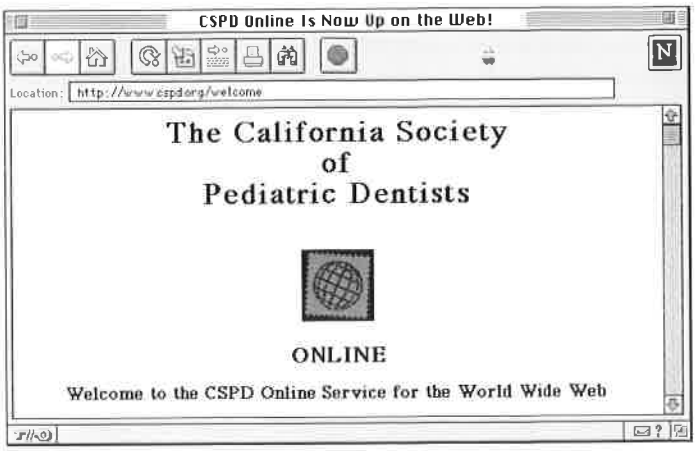
California Pediatrician Report. The Spring issue contains a report by Richard Sobel on oral trauma. The next issue will contain an article on the big brother program written by Ed Sharp. This article is currently under editorial review.

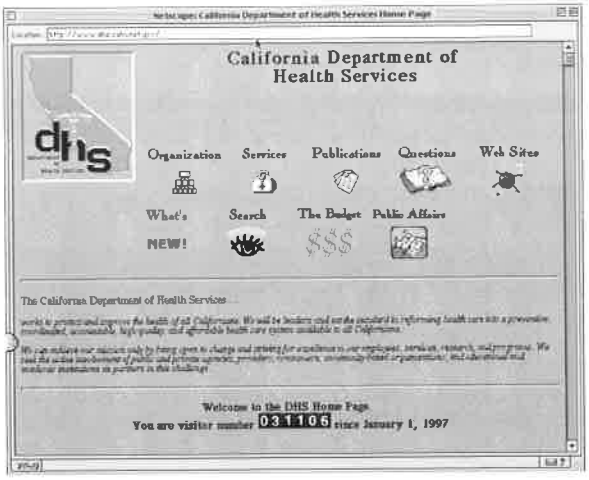
Respectfully submitted,

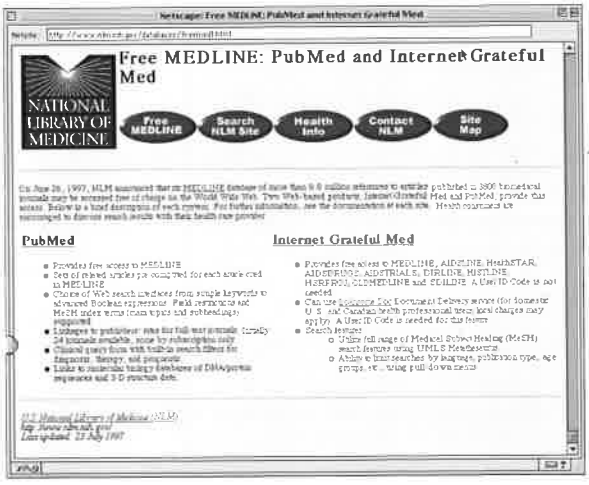
D. F. Duperon
California AAP Liaison

On the Net...

www.cspd.org







CDA Interdisciplinary Affairs Committee-Sacramento, May 1, 1997

The Executive Director and I attended the CDA Interdisciplinary Affairs Committee meeting in Sacramento on May 1, 1997. This meeting was attended by the presidents of the state specialty organizations which included: Pediatric Dentistry, Endodontics, Oral and Maxillofacial Surgery, Periodontics, Orthodontics, Oral Pathology-Oral Medicine and Public Health. Also in attendance were the Executive Director, President and President-Elect of CDA, a representative from TDIC and various CDA staff persons.

The agenda was very full so I will only touch on the subjects which in some way, impact us as pediatric dentists. What follows are excerpts from the minutes of the meeting.

Managed Care Issues

Managed Care Organizations Referral Policy to Specialists: Dr. Stewart advised the committee that pediatric dentists are seeking recognition by managed care organizations as "a" primary care provider for children (similar to medical pediatricians), in addition to the general dentist. Dr. Stewart added that insurance companies have created a process that virtually rewards general dentists to limit referrals, sometimes with potential risk to the patient. It was noted that the problem of referrals by general dentists is not limited to the pediatric specialty, but is of paramount concern to all specialties. Upon discussion, it was suggested that: (1) Dr. Sekiguchi appoint a task force comprised of volunteers; 2) CDA support the concept of pediatric dentists as a primary care provider, and the topic of protecting professional discretion to refer when appropriate; (3) the task force to interact with the Council on Legislation and Liz Snow; (4) an article on this subject be considered for publication in a future CDA *Update*.

Oral Pathologists and HMO's: Dr. Handlers expressed concern regarding evaluation of biopsies being performed by large contract laboratories exclusive of confirmations or oversight by an oral pathologist. It was noted by Dr. Handlers that, although biopsy readings conducted by an oral pathologist are not reimbursable by most insurance programs, the risk involved in a misdiagnosis easily justifies additional expense incurred by the patient. Upon discussion, Dr. Handlers volunteered to contact the American Academy of Oral Pathology to determine the level of interest at the national level specific to this issue. It was further recommended that this topic be considered for publication in a future CDA *Update*.

Legislative Issues

Legislative Priority of General Anesthesia - Deep Sedation Medical Insurance Coverage: Dr. Stewart reported that the subject of deep sedation medical insurance coverage is still a priority legislative agenda item. Ms. Snow added that the issue is timing and whether to move on a one-year or two-year time frame. No additional action was taken.

Legislative Update: Liz Snow provided a legislative update to the committee as follows:

Hygiene and Diagnosis: AB 560 (Perata) has been amended to require diagnosis by a dentist prior to hygiene treatment; the hygiene treatment would be authorized by prescription. The bill

See CDA INTERDISCIPLINE, page 8

CDA Liaison Report

CDA Sponsorship on P.A.N.D.A. Program: Effective July 1, 1997, Delta Dental of California will no longer financially support the statewide Prevent Abuse and Neglect through Dental Awareness (P.A.N.D.A.) program. As of that date CDA will sponsor the statewide program with the Council on Community Health serving as the coordinating entity.

Voluntary Continued Competency Assessment: Name has been changed to QUILL, Quality Improvement through Lifelong Learning. The AMA and the American College of Dentists have prepared very similar quality assessment programs for use by their members. Changes realized due to leadership feedback include the program's restructure to be totally self-administered/graded and to include a manual and didactic exam, that emphasis be placed on an individual quality improvement concept, and that this program support dentists pursuing the case-based national board, part II didactic exam.

A second trial program review will be given at the 1997 San Francisco Scientific Session. Our Board of Directors should be encouraged to take the test. To date there has not been any discussion about specialty assessment programs but CSPD should be ready to give input when the time comes. The CDA House of Delegates will vote on the QUILL program this November.

Vendor-Sponsored Mouth Guard Train-the-Trainer Program: The Council on Community Health will coordinate a day-long mouth guard "Train-the-Trainer" program for member dentists wishing to make mouth guard presentations to coaches and trainers.

Council on Legislation

Hygiene Legislation-Assembly Bill 560 (Perata). CDA removed opposition to the independent Dental Hygiene bill after amendments were adopted that require a physical examination by a physician or dentist prior to the issuing of a prescription for dental hygiene services. This bill passes the Assembly and is now in Senate committees. CSPD has expressed its concern that schools are included as underserved areas with nursing homes and the home bound elderly.

Assured Diagnosis-SB 1014 (Brulte). Sponsored by CDA, this bill would make it unprofessional conduct for a dentist to allow treatment on a new patient who is not yet a patient of record, as defined.

Outpatient Settings-AB 745 (Thompson). This bill would allow any M.D. anesthesiologist to go into a non-permitted and unaccredited dental office and administer anesthesia without either the physician or the office having to submit to an inspection. CSPD's president wrote a letter stating its opposition to this bill unless amendments were made to have some permitting process in place similar to the dental GA permitting system.

Respectfully submitted,

David Perry
CDA Liaision

The Dental Health Foundation Children's Dental Heath Initiative-Summary

The Children's Dental Health initiative (ODHI) is a multifaceted project aimed at improving underserved children's access to dental services, and is comprised of the following components: 1) determination of which children's dental services are most needed and where new resources should be targeted; 2) development of a strategic plan for improving oral health of children, based on the recommendations from our Oral Health Needs Assessment of Children and with specific action proposals targeted to the Legislature, government agencies, the private sector, and the philanthropic sector; and 3) funding 10 school-based projects that will: a) screen children, prioritize their need for dental treatment, and refer them, if necessary, to an accessible source of dental care; b) provide sealants and other preventive dental services in school-based facilities using portable dental equipment, and assure the provision of other necessary dental treatment for those determined to need it and who lack their own dentist; c) coordinate and promote collaboration between all dental health education, preventive, and treatment resources available in the community, and take steps to add additional ones, if necessary; and d) enhance existing data and management information systems to: enable tracking the use and non-use of dental services by children served by the program; allow consistent and uniform tracking of services arid reporting by local programs; provide timely information for local program and case management; and provide aggregate data needed for evaluating the services provided, including oral health outcomes and utilization of dental services.

Identifying gaps in the availability and use of dental health services by underserved children

The Dental Health Foundation (TDEF) recently completed the first statewide oral health needs assessment (OHNA) of California children ever conducted, providing a wealth of data on the prevalence of oral disease, use of preventive dental services, and access to dental care of preschool, elementary school, and high school children. However, funding constraints precluded an assessment of the extent to which existing resources are addressing children's oral health needs, which we believe is an essential prerequisite to determining and prioritizing what services are needed by which children which locations. In other words, knowing what children's oral health needs are, qualitatively and quantitatively, is a necessary precursor to developing solutions to address those needs, but without the ability to access the availability of local resources and the extent to which they are able to address those needs, one cannot adequately determine which services should be targeted to which children in which geographic areas.

Much of the OHNA data have not yet been analyzed, including data on which teeth require which types of dental services and the expected costs of dental treatment. Further analysis of these data is essential to help determine how and where preventative and dental treatment resources should be allocated. Further analysis of these and other data on needs from the OHNA, existing resources as described above, and utilization from Medi-Cal and community clinics will enable us to develop criteria for determining: 1) what types of oral health services are needed most, by which children, and in which part of the state, and 2) whether these needs can best be met by coordination of existing resources or (in the case of treatment services) if new clinical facilities are indicated. The results of this analysis will enable the California Endowment, government, and other funding agencies to target their limited resources for improving children's oral health much more effectively, and will help avoid situations in which expensive clinical facilities are funded when what is needed is simply better coordination of the resources that already exist in a community.

Strategic plan for improving the oral health of children

The full report of findings from the OHNA remains in draft form. A summary report of the OHNA, which includes recommendations approved by the OHNA's Professional Advisory Committee, is now available and will be broadly distributed to policy makers, children's advocates, funding agencies, etc. The fall report with all supporting data is expected to be available to a more limited audience in several months.

The release of the OHNA report will be the first step of a year-long strategic planning process aimed at developing specific recommendations and action steps for each of the three major sectors we believe should be involved in addressing children's oral health issues—the public sector, the private sector, and the philanthropic sector. This project will enable us to continue the momentum we have already established, which we are confident will lead to major policy decisions that will improve children's oral health status. It will also allow the strategic planning process to be guided by the additional information from the needs and resources assessments, and funding decisions—especially potentially costly ones involving clinical facilities—to be guided by both the additional data analysis and the deliberations of the strategic planning process.

As noted previously, the OHNA was guided from its outset by a Professional Advisory Committee (PAC) comprised of

continued next page...

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representatives of dental professional organizations, community clinics, children's advocacy organizations, dental schools, local health departments, and state health department agencies. Because of their long-term involvement in the OHNA process, some members of the PAC have been invited to continue as members of the Advisory Committee for this project, which will also be supplemented with additional members, including representatives from the communities in which local programs will be conducted

School-based dental programs

During the first year of the project, we plan to begin at least 5 school-based dental programs, with the remaining 5 programs added during the second year. Each program will be responsible for either providing directly or arranging for the following: 1) oral health screening of children, prioritization of their need for dental treatment, and referring them, if necessary, to an accessible source of dental care; 2) provision of a dental examination, sealants, and other preventive dental services, as appropriate, in school-based facilities using portable dental equipment, and assuring the provision of other necessary dental treatment for those determined to need it and who lack their own dentist; 3) coordination and promotion of collaboration between all dental health education (including parent education), preventive, and treatment resources available in the community, and taking steps to add additional ones, if necessary.

We view these programs as demonstration programs that will provide us the opportunity to refine and "fine-nine" the school-based dental delivery system model and learn what works best given different community dynamics. The knowledge and insight we gain from our first year's experience with these programs, when combined with the detailed analysis of children's dental care needs and resources that will be available by the end of the first year, will provide us with the best possible information from which the most appropriate decisions can be made in the future with respect to the types of programs to fund and their locations. By the end of the first year, then, we expect to be able to better predict those factors that contribute to the success of school-based preventive dental programs; those that indicate when community resources are sufficient to care for its underserved children, given appropriate coordination; and those that indicate that supplemental resources will be needed.

CSPD members **Francisco Ramos-Gomez** and **President, Ray Stewart** have been appointed to the Advisory Board.

The support our sponsors contributes to the success of the annual meeting and helps to underwrite the projects of our society throughout the year. Please let our sponsor know we appreciate their continued support.

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CSPD Annual Meetings

1998	1999
April 2-5	March 26-29
Tropicana Hotel	Royal Carribbean Lines
Las Vegas, NV	USA & Mexico

CDA INTERDISCIPLINE, continued from page 5

passed the Assembly Health Committee and is awaiting hearing in Appropriations; discussions on this issue will continue.

MICRA/Tort Reform: At least two major tort liability bills will need to be fought this year. AB 250 (Kuehl) would eliminate the $250,000 Medical Injury Compensation Reform Act (MICRA) cap on non economic damage awards in specific instances, such as when the provider caused injury due to consumption of alcohol or drugs, the provider has had three or more disciplinary actions against him/her, the provider committed sexual abuse, etc. AB 103 (Figueroa) would delete the $30,000 threshold for reporting to the Medical Board malpractice settlements and arbitration awards against physicians. While that bill does not presently affect dentists directly, many feel it would set a dangerous precedent.

Uniform Licensure Standards: AB 1116 (Keeley) is co-sponsored by CDA and a coalition of ethnic minority dental associations to, among other things, sunset the restorative technique exam for foreign dental graduates in 2003 and instead require applicants to have a degree from a state-approved foreign dental school or two years of additional education, while allowing all California licensed dentists to use the letters DDS after their names. This bill has passed the Assembly Health Committee and is awaiting hearing in Assembly Appropriations.

MD Anesthesiologists: AB 745 (Thompson) creates an exemption for M.D. anesthesiologists from the requirements provided for by a general anesthesia permit. Currently M.D. anesthesiologists cannot go into a dental office to administer anesthesia unless the dentist in the office has a general anesthesia permit.

Proposition 65 and Dentistry: Mr. Alcorn provided an update regarding the California Safe Drinking Water and Toxic Enforcement Act of 1986, also known as Proposition 65. Proposition 65 requires posting of warnings in dental offices where the public may be exposed to chemicals known to the State of California to cause cancer or reproductive toxicity. In 1990, mercury and mercury compounds were added to the Proposition 65 reproductive toxicity list, although not on the cancer list. Mr. Alcorn reported that CDA supports the removal or modification of the mercury and mercury compound listing if scientific research is inconclusive or does not support the causal relationship between mercury and the alleged toxicity. he further added that, CDA opposes the posting of specific warnings to consumers about dental amalgam because it seriously misleads patients about the safety of dental amalgam.

Specialty Representation and Participation at CDA House of Delegates: The subject of coordinating efforts between CDA and specialty organizations was introduced by Dr. Stewart. Dr. Rowan suggested that representation of specialty societies at the House of Delegates meeting would provide an excellent opportunity to caucus with other dentists and CDA leadership. Upon discussion, it was recommended that: (1) the president and president-elect of each specialty organization attend the next house of delegates meeting; (2) a caucus meeting (Thursday evening suggested) and second IAC meeting (Saturday morning suggested) be held in conjunction with the CDA House of Delegates meeting; (3) Drs. Rowan and McCartney to serve as host and contact regarding meeting preparations.

Specialty Peer Review Issues: Judith Babcock updated the committee regarding efforts to create greater consistency in the peer review process, and indicated that specialty calibration workshops will be conducted 5-6 times throughout the year to affect this desired outcome.

DOC Draft Quality Guidelines: In 1996, the Department of Corporations (DOC) formed a Dental Quality of Care Working Task Force to advise the DOC on what additional steps the Health Plan Division might undertake to satisfy its regulatory responsibility to ensure that Californians enrolled in dental health plans are being provided appropriate dental care. Copies of the DOC draft *Quality Guidelines, as* recommended by this task force, were distributed as a matter of information.

Dental Specialist Agency: Dr. Freed informed the committee that an entity identified as Dental Specialist Agency (DSA) is functioning as an agent between general dentists and periodontists. Concern was expressed that referral to a periodontist may be made on the basis of a contract rather than patient choice, and that patients are not being informed regarding the existence of a fiduciary relationship between the general dentist and the pedodontist. Upon discussion, it was suggested that a copy of the DSA contract used to delineate the conditions of the financial arrangement be submitted by Dr. Freed to the CDA legal staff for review.

Improving Access to Dental Care: Dr. Zakariasen reported that efforts are underway regarding ways to increase access of care and improve the oral health status of underserved populations in California. Dr. Zakariasen added that he has been meeting with the dental schools who have organized task forces to consider methods to enlist greater support from educational institutions and volunteers, and investigate avenues to obtain additional funding. Upon discussion, it was suggested that a network of statewide dental volunteer opportunities be developed and publicized via CDA *Online* to promote participation from health care providers as well as donations of education materials and supplies.

Respectfully Submitted,

Ray Stewart
President

Professional Opportunities Registry

Name _____

Address _____

City _____ ZIP _____

Telephone (_____) _____

Opportunity Offered: (Associate, Partnership, Employment or Sale)

Date Available: _____

Mail Confidential form to:

Douglas J. McGavin, DDS
17300 Yorba Linda Blvd., Suite G
Yorba Linda, CA 92686

Medical Savings Accounts: Good for Cash Flow Good for Patient Relationships

For years, dentists have been shoved into accounting roles they never really auditioned for. The time you spend in accountability and as a managed care negotiator slows the payment process, increases administration, and interferes with cash flow. But dentists are discovering recent legislation that reduces paperwork, provides immediate payment, eliminates billing, claims, and hassles. Medical Savings Accounts (MSAs) are turning the tide against the conformity and restrictions that have come to envelope the dental community.

MSAs Are Similar To IRAs

In many ways, MSAs are similar to tax-favored Individual Retirement Accounts (IRAs). MSAs, created by the Health Insurance and Portability Act of 1996, are a combination of high-deductible health insurance (required) and a tax-favored health care savings account. A patient who owns an MSA account gets a tax deduction for money contributed to the account each year. That person can withdraw funds to pay for dental and medical expenses without paying a penalty.

If eligible expenses exceed the insurance policy's high-deductible threshold, the policy kicks in and pays the additional costs. If account holders spend less than the amount contributed, the difference stays in the account, earns tax-deferred interest, and is carried over to the next year. The MSA holder does not lose any contributed funds.

MSAs Help Restore the Patient-Physician Relationship

In the last 10 years, patients complained that their insurance plans had forced them to select dentists from "preferred provider" catalogs. MSA holders are not restricted to a particular network and can once again select the dentist of their choosing. MSAs also minimize payment fatigue from both patient and doctor. There are no claims, no billings, no hassles with an MSA. The doctor is paid at the time of service. This reduces the paper shuffling, price fixing, and accountability that has been imposed by the health-insurance system.

MSAs Represent Big Benefits to Small Business Owners

Most dentists are self employed and can only deduct 40 percent of their health-insurance premiums. Medical savings accounts offer a 100 percent tax deduction from the first dollar and this allows dentists even more resources to use in the business however they see fit.

How to Set Up and Manage Your MSA

1) Call your insurance agent and request a medical savings account.
2) The agent will describe several high deductible plans to you. Find a policy that fits your personal and family needs, and also stays within your deductible limits.
3) Ask your agent about administration costs (fees and monthly fees).
4) Ask about "Hassle Factors" that make transactions simple or tedious.

- Is payment electronically processed?
  - Can you deduct actual charges or is a minimum balance ($50, $100) deducted from your balance?
  - Are there support telephone "hotlines" to answer financial or medical questions or provide information about the status of your MSA?

Wanted: CSPD Editor

The Editor serves as a Member of the Board of Directors which requires attendance at quarterly Board Meetings.

Anyone interested in being considered for the position should contact a member of the search committee or the Executive Director Mel Rowan.

Dr. Tom Barber
Dr. Suzanne Berger
Dr. Lonnie Lovingier

This job is an opportunity for some creative person to serve our society in an extremely important role.

What is a MSA?

Who is eligible?

- Self-employed persons – either a sole proprietor or an owner in a partnership.
- Employers of small employers with fewer than 50 employees during either of the two preceding years. Contributions may be made by either the employer or the employee, but not both in the same year.

What is the required deductible?

- Single coverage: annual deductible between $1,500 and $2,250. Out of pocket expenses may not exceed $3,000.
- Family Coverage: annual deductible between $3,000 and $4,500. Out-of-pocket expenses may not exceed $5,500.

What if I am covered by another health plan?

Even if you meet all the other qualifications, and even if you are covered by a spouse's health plan, you are not eligible for an MSA. You may, however, have compatible policies such as: accident and disability, dental and vision, long term care, specific illness coverage, or long-term care.

How large is my tax write-off?

Single – you may contribute 65% of the deductible amount. Married – you may contribute 75% of the deductible amount. MSA contributions can be made for those months you are enrolled.

What is a Qualified Withdrawal from my MSA?

Anything that is allowed on your 1040 Federal income tax form, including glasses, orthodontics, massage therapy, prescriptions, dental work, long-term care premiums, chiropractic care. (For a complete list, call 1 800-TAX FORM, order IRS Publication 502).

What isn't covered?

Insurance premiums, cosmetic surgery, over-the counter drugs, travel for improved health are the major nondeductibles.

What is the penalty for withdrawing an MSA for non-medical expenses?

Whoa! –15 percent penalty PLUS regular income taxes (similar to IRA's).

How Can I Obtain an MSA?

Call your insurance agent, carrier. or broker. To find one near you who offers MSAs, call 1-888-EASY MSA.

ABC's of Infant Oral Health

A Comprehensive Program Instructional Video & 8 Components

The ABCs of Infant Oral Health comprehensive early intervention program provide the beginning steps to integrating early infant oral health into your daily practice and can be easily modified to suit your practice needs.

Incorporating this program into your practice will strengthen the coalition with parents and other healthcare practitioners in the quest for disease-free children.

The ABCs of Infant Oral Health involves **A**ssessing Risk **B**uilding Relationships, and **C**ontinuing Care

Program components:

Instructional Video
- Acquaints dentist and staff with the concepts of early intervention
- Demonstrates the use of the program

Tent Card
- Designed for the reception area
- Triggers questions from parents/caregivers

Risk Assessment Interview Form
- Provides the basis for the interview process with the parent/caregiver
- Details questions in each of the seven risk assessment areas

Anticipatory Guidance Reference Card
- Pinpoints discussion topics specific to a child's stage of growth and development

Patient Education Flip Chart
- Laminated, full-color, patient education flip chart detailing the seven risk assessment topics

Parent Information Form
- Correlates to the seven topic areas of risk
- Provides take-home information for parents/caregivers to reinforce compliance and a second copy becomes a permanent record for the chart

Infant Oral Smilestones Wall Poster
- 18x24 full-color wall poster for reception area or treatment room
- Focuses on infant oral health issues from birth to 36 months of age

1st Dental Exam Bookmark
- Practical parent/caregiver take home piece
- Reminder to schedule their child's first dental examination by the first birthday

Reference Card
- 8x10 full-color for professional-to-professional communication
- Space provided for inclusion of your business card
- Easily mailed to other healthcare providers

Please send me _____ copy(ies) of **ABC'S of Infant Oral Health** materials and it's instructional video for only $125 each

Shipping Address _____

Name _____

Address _____

City _____

State _____

Zip _____

Telephone (_____) _____

Payment by: Check enclosed Payable to: **American Academy of Pediatric Dentistry**

❑ MasterCard ❑ Visa

Card No. _____ Exp. Date _____

Signature _____

All orders in the United States will be shipped via UPS. Please allow ample time for delivery.

Foreign order: Additional shipping charges will be applicable for orders outside the US. Orders to foreign destinations will be sent a ***pro forma*** invoice indicating shipping charges. The order will be shipped promptly upon receipt of remittance.

Please complete this form and mail ***or fax*** it to:

American Academy of Pediatric Dentistry
211 E. Chicago Avenue - Suite 700
Chicago, IL 60611-2616
Phone: 312-337-2169
Fax: 312-337-6329

Board Briefs - Board Of Directors Meeting June 28, 1997
Crown Plaza Hotel - Los Angeles

The 91st meeting of the Board of Directors of the California Society of Pediatric Dentists was called to order by Dr. Ray Stewart on Saturday, June 28, at 9:10 a.m.

Correspondence: Dr. Stewart received a letter from Dr. Barber to Dr. Stewart and Dr. Lisagor about the smooth transition of the Executive Director to Dr. Rowan; a letter from Dr. Bogert to Dr. Buch complimenting him on the his work on the manpower report; a letter from Dr. Lovingier to several members of the Board and members of CSPD thanking them for accepting responsibilities for the 1998 AAPD meeting in San Diego.

Officer's Reports

President Dr. Stewart: A written report was submitted. Dr. Stewart reported on the CDA Interdisciplinary Affairs Committee meeting that he and Dr. Rowan attended in Sacramento, May 1, 1997. The Interdisciplinary Affairs Committee will meet twice a year. Dr. Stewart reported on the Office Based research meeting that Dr. Stewart chaired at UCSF School of Dentistry on May 9, 1997. The purpose of the meeting in San Francisco was to discuss the feasibility of developing a plan of implementation for an Office Based Research Project utilizing the CSPD membership as a source for data collection and the faculty at University of California to process and analyze the data. Dr. Stewart asked Dr. Udin to poll the membership as to what research should be undertaken and asked Dr. Perry to provide Dr. David Noel with AAPD Guidelines on Sedation. Dr. David Noel expressed an interest in reach on oral sedation in the office since Medi-Cal is considering making oral sedation a covered benefit.

MOTION: 06.28.97.01: LISAGOR/SANGER: I move that the President appoint an Ad-Hoc Committee to review the societies current committee structure and to make recommendations regarding any needed changes. ..... PASSED

Dr. Lisagor to chair Ad-Hoc Committee on Committee Structure.

MOTION: 06.28.97.02: DUPERON/ENRIQUEZ: I move that the sub committee investigate the possibility of standardizing our accounting and reporting procedures. ..... PASSED

MOTION: 06.28.97.03: SANGER/BUCH: I move that the Executive Director develop an orientation program for new board members. ..... PASSED

Dr. Lisagor wrote a letter to Dr. Jasper Lewis, AAPD President, requesting a leadership development program for components be held at the AAPD annual meeting. Dr. Reggiardo recommended that the idea be brought to Dr. Susie Seal of AAPD requesting that the Trustees of AAPD consider a leadership development program.

District VI AAPD Trustee Dr. Reggiardo: Academy is effective with Child Advocacy role. The Academy is looking at 3 major areas, Health Care Legislation, Consumer Protection Legislation, and continued support for graduate training programs. The Academy is trying to leverage advocacy, capitalize on relationships in Congress, activate own membership towards legislation, and develop an advocacy manual. AAPD membership is at all time high. Future sites for AAPD meetings are San Diego (1998), Toronto (1999), Nashville (2000), Atlanta (2001), Denver or Houston (2002), New York Marriott Marquis or Washington D.C. (2003), and the New Western region (2004 to be picked at the 1998 meeting). The AAPD's Infant Oral Health Care program (the ABCs of Infant Oral Health Care) was discussed and the following recommendations were made; make space available at annual CSPD meeting for Infant Oral Health Care tapes.

MOTION: 06.28.97.04: LUKE/DUPERON: I move that CSPD appoint a Ad-Hoc committee to prepare a proposal for California to host the AAPD annual sessions in the year 2004. ..... PASSED

Dr. Stewart appointed Dr. Good to chair the Ad-Hoc Committee on AAPD annual session 2004. Dr. Reggiardo, Dr. Wiley and Dr. Duperon were appointed to the committee also.

Standing Committee Reports

Public and Professional Relations: Dr. Stewart reviewed the Dental Health Initiative in the State of California. Dr. Stewart will appoint a representative to serve as an advisor on the Dental Health Foundation panel. Dr. Stewart asked the Child Advocacy Sub-Committee to put CSPD at the front of Children's Oral Health. Dr. Francisco Ramos-Gomez to chair Child Advocacy Sub-Committee. Committee to plan and produce symposium that will deal with Child Advocacy issues with Oral Health being the focal point.

MOTION: 06.28.97.05: Perry/Lisagor: The California Society of Pediatric Dentists Sponsor a Infant Oral Health Care Resolution to the California Dental Association House of Delegates and that the following resolution be forward to CDA Council on Community Health for consideration by the 1997 CDA House of Delegates.

Resolved, that California Dental Association endorse the policies and guidelines on Infant Oral Health Care as adopted by the American Academy of Pediatric Dentistry and as recommend by the National Center for Education Maternal and Child Health that a child should be seen with in six months of the eruption of the first primary tooth and no later than 12 months of age, and be it further

Resolved, that the California Dental Association Encourage educational programs on Infant Oral Health to educate dentists dental students, other health care providers, and the public that the objective oaf the firs dental visits be to counsel the child's caregiver regarding oral development, fluoride usage, oral health, and oral hygiene, nutrition and diet, oral habits, injury prevention, and perform an oral examination developing a caries risk assessment plan: and be it further

Resolved, that the California Dental Association recommend that Infant Oral Health Care guidelines be published in the California Dental Association Journal. ..... PASSED

MOTION: 06.28.97.06: SANGER/LISAGOR: The Editorial Committee explore alternative options for publishing our quarterly newsletter. .... PASSED

MOTION: 06.28.97.06: Perry/Wiley: AAPD members that are not currently members of CSPD be actively recruited to join CSPD. ..... PASSED

Annual Meeting Site Selection (2000) - Larry Luke:

MOTION: 06.28.97.07: LUKE/WILEY: The Vice President assume responsibility for the Annual Meeting. In the year 2000, both the President Elect and Vice President will share responsibility as a transition year. ..... PASSED

MOTION: 06.28.97.08: LUKE/JACKS: Marriott-Laguna Cliffs be selected for the site of the CSPD meeting in the year 2000. ..... PASSED

Dr. Perry to look at Sacramento site for the year after 2001.

MOTION: 06.28.97.09: LUKE/GROSSMAN: The Executive Director of CSPD investigate the cost of contracting with Patterson Travel for serving as a meeting planner for the meeting in the year 2000. ..... PASSED

MOTION: 06.28.97.10: SANGER/BUCH: Manpower issues sub-committee organize and execute meetings between CSPD and Dental School Deans, advanced Pediatric Dentistry Program Directors and other interested parties. (One meeting in Northern California-San Francisco and one meeting in Southern California-Los Angeles.) ..... PASSED

Continuing Education Dr. Good:

Dr. Good to report on continuing education course offered for members at the strategic planning meeting.

The Ad hoc Legislative Committee will consist of Dr. Perry, Dr. Chan, Dr. Pedersen and Dr. Stewart (non-official member).

Respectfully submitted,
David Perry, Secretary

CALIFORNIA SOCIETY OF PEDIATRIC DENTISTS
P.O. BOX 6396
SAN PEDRO, CA 90734-6396

Officers and Members of the Board of Directors - 1997-1998

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Jac Pedersen (a.l. '99) Michael McCartney
(a.l. '00) Ann Azama

Public & Professional Relations...(Robert Fisher)
Thomas Buch
Frank Enriquez
Mark Lisagor (AAPD Liaison)

Sub-Committee Child Advocacy...
Francisco Ramos-Gomez, Chair
Stephen Blain
Wayne Grossman

Editorial.....(James Yee)
Donald Duperon
John De Lorme
Roland Hansen - Webmaster

Constitution & Bylaws.....(Mark Lisagor)
Weyland Lum
Richard Sobel

Dental Care.....(Scott Jacks)
Roger Sanger
John De Lorme
Randall Wiley

Sub-Committee Dental Anesthesia, Sedation Access
Jac Pedersen
David Perry

Credentials & Membership.....(David Perry)
Douglas McGavin (Student Liaison)
Melvin Rowan (ex off.)

Peer Review.....(Philip Wolkstein)
Douglas McGavin

Professional Activities.....(Richard Udin (USC))
Randall Wiley
David Rothman (UOP)
Pamela DenBesten (UCSF) - Office Based Research
Donald Duperon (UCLA)
Todd Milledge (L.L.U.)
David Perry - Legislative
Steven Chan

Membership Services.....(Tom Buch)
Victoria Sullivan
Nina Mandelman

Sub-Committee on Manpower Issues
Roger Sanger, Chair
Wayne Grossman
John De Lorme
Randall Wiley
Scott Jacks

Annual Meeting Site Selection (2000).....(Larry Luke)
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Catherine Huene
Larry Luke
Paul Reggiardo

Continuing Education.....(Lori Good)
Weyland Lum
Roger Sanger

Ad Hoc Strategic Planning Retreat.....(David Perry)
Mark Lisagor

Ad Hoc Editor Search Committee
Suzanne Berger
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Lonnie Lovingier

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