

# Bulletin

Fall 1999

Vol. XXV No. 2

## PRESIDENT'S MESSAGE



Wayne Grossman

challenge at hand.

Such was the case recently when several concerned members called about pending legislation that they thought would have a very harmful impact on the state MediCal program. The legislation was intended to stop fraudulent practices among dentists and under certain circumstances it would require radiographs when the case was submitted for payment.

The situation that called for x-ray submittal was one of those commonly encountered by pediatric dentists. Many of us recall the problems with the MediCal program in the past when inappropriate use of x-rays was used to deny claims and that has driven many dentists out of the program for good. This kind of claim administration had a detrimental impact on access to care for youngsters throughout the state. Years of litigation reduced the documentation levels and under certain circumstances marginally increased the fees. Those changes partially mended the program but there were still many access problems. Indeed, the design of this new legislation seemed to once again create the risk of driving out a number of providers.

CSPD sprang into action. Since CDA had initially introduced the bill, we had a good channel of communication to relay our concerns. Through a series of faxes, e-mails, and conference calls, we were able to develop our strategy and outline our objections. We presented remedies that were adopted by legislators. What had been a "done deal" was able to be modified into a bill that not only may catch a few crooks, but one that will protect the honest providers and preserve access to care. Although the bill is still in the works, our remedies and amendments have been built into the legislation. I would like to acknowledge the work of Paul Reggiardo, Andy Soderstrom, Dave Perry, and Larry Luke for spearheading this successful effort. An added benefit of this cooperative effort is the prospect of a closer working relationship between CSPD and CDA when legislation that impacts our patients and our practices is considered.

I can state proudly that CSPD's Officers and Board of

Directors are actively addressing many issues that confront our professional lives. CSPD is an advocate of fluoridation in battles throughout the state. We are assessing changes in the reimbursement policies by public and private insurance carriers. We are orchestrating efforts to enable properly certified and trained RDA's to place sealants under direct supervision. We are monitoring the State Board and are assisting them in devising new mandated regulations such as those dealing with the use of oral sedation in our offices. We are consolidating our position relative to issues such as reciprocity, licensure by credential, and specialty licensure. CSPD is working on programs to assist the new Pediatric dentist and to increase the number of trained Pediatric dentists who will be able to practice or teach in California.

As already mentioned, CSPD is working closely with CDA and other groups on the legislative front. We are supporting the effort of Francisco Ramos-Gomez to pass AB 1065 which would initiate early-treatment preventive programs in areas of California modeled after a successful program in Washington. We are involved in efforts to provide training for general dentists so that they may better serve their pediatric patients. We maintain linkages to agencies and organizations such as the AAP, CHDP, Children's Defense Fund, Dental Health Initiative, LA Care, Healthy People 2010, and others.

All of these efforts as well as membership services, CE programs for auxiliaries, website and e-commerce, annual meeting programs, executive director, membership directory, and more underline the importance of a strong and participatory membership. If you would like to take a more active role, please contact me or the Executive Director, Mel Rowan. If you have a concern about an issue, like the one outlined above, don't hesitate to write or call me. You can help to change the world. In fact, as a Pediatric Dentist, you do it every day!

*Wayne Grossman*

*Drs. David Good,  
Ray Stewart,  
Mel Rowan, &  
John Groper at the  
AAPD Meeting  
in Toronto.*



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# PRACTICAL APPROACH TO EVIDENCE-BASED MANAGEMENT OF CARIES

D.K. BENN, BDS, PhD; T.D. CLARK, D. D. DANKEL II, PhD; S.H KOSTEWICZ, MS.

For an in depth multi-media tutorial with a spoken text regarding the icons and charts, please see <http://www.cise.ufl.edu/~shk>.

The purpose of this paper is to discuss: (1) the changes which are needed to adopt evidence-based methods, (2) barriers to change, and (3) possible solutions to assist in changing work practices. To limit the scope of the paper, we will concentrate on the application of evidence-based methods to caries management.

## CHANGES NEEDED IN WORK PRACTICES

Despite the significant decline in caries during the last twenty-five years the disease should not be thought of as having been conquered. Although 50% of children aged twelve in the USA have caries-free adult teeth, by the age of seventeen this decreases to 33% of adolescents. With increasing age, almost 95% of adults have experienced one or more carious lesions. However, most people develop few lesions over a lifetime. Only 25% of the children and adolescents aged five to seventeen account for 80% of caries in permanent teeth. To put it another way, the majority of people suffer from very few lesions during their lives. Even the development of a smooth surface lesion does not mean the disease will definitely progress since in one study, 40% of smooth surface lesions in seven-to-nine-year-olds remineralized to sound. If the lesion does not repair itself, then progression is usually slow. In a group of adult teeth radiographically surveyed over ten years, only 20% of the interproximal lesions at the baseline examination would reach the junction between the outer and middle one thirds of dentin, requiring restoration.

From the preceding paragraph, there is evidence in the literature to show that individuals experience different degrees of caries attack (incidence) and progression rates. As a consequence, the population can be divided into three different groups for risk of developing new or recurrent caries: low, medium, and high. The expected incidence of new lesions for a child or adolescent in one year, or for an adult over three years, would be none for the low risk group (approximately 70% of population), one for the medium risk group (10% of population), or two or more for the high risk group (20% of population). Therefore, for low risk individuals who form the majority of our patients, there is no scientific support for their six-monthly attendance and a yearly recall would provide the same outcome.

To classify a patient into one of the risk categories, it is necessary to identify certain risk factors such as the presence of existing lesions, their depth and change over time, high DMFT index, a restoration

placed in the last year, frequent sugar intake, poor oral hygiene, reduced saliva production, inadequate exposure to fluoride, plaque traps around restorations, high *S. mutans* saliva count, and a lack of patient compliance. The collection of risk factor data is simple to perform and could be delegated to a hygienist.

Some dental schools still provide traditional teaching that enamel lesions or shallow dentin radiolucencies should be restored. However, the scientific literature has shown that non-cavitated enamel lesions and outer one third dentin radiolucencies have the potential to remineralize and should not be restored in low or medium risk people. Indeed, an eleven-year longitudinal study of seventy-five large occlusal cavitated lesions showed that soft dentin caries, with a caries free enamel margin, can be safely sealed in preventing lesion progression. The evidence is demonstrating that conventional early operative treatment is wrong. The emphasis should now change in dental offices from immediate surgical removal of carious tissue to risk assessment, lesion detection, and monitoring of lesion depth and activity over time. Treatment plans should be devised which vary according to risk estimates. High-risk patients should have their caries infection controlled through modification of their life-style and the use of chlorhexidine.

To summarize, the new evidence-based method of working will require patients to have a caries risk assessment producing a risk classification, the recording of lesion severity and activity, a treatment plan with clinical/radiographic intervals which will vary

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*Even the development of a smooth surface lesion does not mean the disease will definitely progress since in one study, 40% of smooth surface lesions in seven-to-nine-year-olds remineralized to sound.*

## CALIFORNIA SOCIETY OF PEDIATRIC DENTISTS Bulletin

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 Oct. 4, 1999. Items for publication may be submitted by e-mail ([editor@cspd.org](mailto:editor@cspd.org)), in computer format on a 3.5" disk or typewritten in double space format.

Product and informational content presented in the Bulletin by contributing authors is not necessarily endorsed by the Executive Board of CSPD.



Published 4 times annually  
Editor, Roland Hansen, DDS, MS  
Member Publication  
American Association of Dental Editors

# Annual Meeting Photo Contest Winners

## 2nd Prize

By George or Cynthia Lyman of native dancer near the Bufadoro (blow hole). Awarded a pair of matching photo albums.



## 1st Prize

By Randall Wiley of wife Gloria giving a brushing demo in an alternate setting, pose and dress. Awarded the Louis Melamed choice of magic packages.



## 3rd Prize

By Sponsor Louis Melamed of dinner partner Sponsor Marsha Freeman demonstrating alternate uses of bread products in a dietary regimen. Awarded matching albums.



## 4th Prize

By George or Tamar Mednick of Donna Wolkstein profiled in the setting dusk of the Pacific. Awarded matching albums.



# CALIFORNIA CHILDREN'S BUDGET

The Children's Advocacy Institute recently issued the "California Children's Budget 1999-2000," a huge (600 page) document that analyzes spending in major child accounts of the State budget, using 1989-90 as the starting year.

The California Children's Budget 1999-2000 divides the State budgetary accounts into eight subject areas: poverty, nutrition, health, special needs, child care, education, protection (from abuse and neglect), and juvenile justice.

The purpose of the annual California Children's Budget is to facilitate the examination of the Governor's formal proposed budget submitted to the legislature in January and as revised in May. The California Children's Budget allows the legislature and public to review the Governor's proposed budget in light of relevant trends and data affecting children before final budget vote in late June.

The proposed budget also includes a discus-

sion of the State Children's Dental Disease Prevention Program and The Dental Health Foundation's Oral Health Needs Assessment of Children. Among the report's recommendations are: 1) All of California's [water] supplies should be fluoridated immediately; and 2) The expanded Medi-Cal system [proposed in the report] should include dental sealants as a required benefit for all covered children.

You can find the entire document at:  
[www.acusd.edu/childreissues/toc/title.html](http://www.acusd.edu/childreissues/toc/title.html)

## WELCOME NEW MEMBERS

Dr. Robert Belfon  
201 Cruz Alta Road  
5519 NDCBU  
Taos, NM 87571

Dr. Gary Sabbadini  
1500 Tara Hills Dr.  
Suite 100  
Pinole, CA 94564



Dr. Wayne Grossman confers with  
Dr. Leticia Mendoza-Sobel.

## ASSAYS OF FLUORIDE CONTENT IN DOMESTIC WATER WITH "FLUORICHECK"

Omni Products in West Palm Beach, Florida will provide assay kits (sample bottle, box, labels) for fluoride content in water samples. The assay is performed using an electronic ion analyzer with fluoride specific electrode. Results are reported by mail in parts per million to the patient and the dentist.

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Source: Omni Products

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West Palm Beach, FL 33409

800-445-3386 • FAX 561-689-1159

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*Congratulations to Shahram Taheri, a former resident at UCSF who won a set of golf clubs donated by Space Maintainers Laboratories. The support of our sponsors at the Annual Meeting aboard the Viking Serenade was superlative. The members and officers of CSPD are very appreciative of the continuing support of our sponsors.*

## CONFERENCE ANNOUNCEMENT FOR THE NEW PEDIATRIC DENTIST

FRIDAY, AUGUST 20, 1999 IN LOS ANGELES

Dr. Roger Sanger, Dr. John De Lorme, and Mr. Randall Berning will coordinate a special conference for the new pediatric dentist that will be held in the Los Angeles area on Friday August 20, 1999. The goal of the conference will be to assist the pediatric dentist who has graduated from a postdoctoral program within the last five years to learn creative methods in strategic planning for a career in private practice. More information is forthcoming in a mailing to all CSPD members.

For more information, please contact Dr. Roger Sanger at 831-443-9696.

*The purpose of the annual California Children's Budget is to facilitate the examination of the Governor's formal proposed budget submitted to the legislature in January and as revised in May.*

# NEW TECHNOLOGY TAKES CITY SPECIALTIES TO THE COUNTRY

West Coast dentists who practice in remote areas can soon consult with specialists at the UCLA School of Dentistry, thanks to a new software jointly developed by UCLA and Houston-based PhysiTel Inc. Called TeleDiagnosis, the teledentistry software enables dentists to automatically encrypt and e-mail patient information over the Internet. The program digitizes intraoral camera images, X-rays, voice mail, on-screen notations and paper-based records, then compresses them into a single electronic patient chart. The information travels in seconds over ordinary phone lines, enabling UCLA faculty to review the patient's history, diagnose the problem and formulate a treatment plan.

"Teledentistry is a whole new way of providing dental care," said Jeff Bimbach, PhysiTel's chief executive officer. "It eliminates geographic boundaries and non-productive travel time. Now people living in remote areas can benefit from the same high level of dental care as patients in Los Angeles. "UCLA specialists will be able to provide timely consultation services at an affordable price to patients who are otherwise beyond UCLA's service area," Bimbach added. Other universities offer Web-based consultation services in medical specialties, but UCLA is the first to venture into the mouth.

"UCLA is the first dental school in the United States to launch a teledentistry program," Bimbach said. The

director of UCLA's Oral Medicine and Orofacial Pain Faculty Group Dental Practice said that the software will help rural dentists by enabling consultation with experts.

"This is designed for the general dentist in rural California who does a fine job providing routine care, but possesses limited experience in treating unusual oral disease," said Glenn T. Clark, DDS. "Practitioners now have the advantage of consulting with UCLA faculty, whose clinical care and expertise is shaped by the latest research findings in the field." PhysiTel put the finishing touches on TeleDiagnosis in August. UCLA plans to distribute 10,000 complimentary copies of the program to potential customers, who will be invited to try the service on a free trial basis. UCLA will charge an hourly consultation fee thereafter. The address on the World Wide Web will be <http://www.diagnosis.dent.ucla.edu>.

TeleDiagnosis can be used on virtually any PC, laptop or notebook computer running Windows 95 or Windows NT. Users may also access the software from a cellular phone to create a mobile health care program. Bimbach said that MediWorks, the program from which TeleDiagnosis was developed, will be used for a number of different types of applications, from UCLA's project, to one that will end up being used on NASA space projects.

Excerpted from an article that appeared in the CDA Update, September 1998.

## CALL FOR TABLE CLINICIANS AT 2000 ANNUAL MEETING

Table clinicians are being sought to participate in the program at the 2000 Annual Scientific Meeting of CSPD. This meeting will take place March 30-April 2, 2000 at the Marriott Laguna Cliffs Resort Dana Point, California. Clinics are especially being sought on information technology and clinical topics however research, practice management, and community service topics are most welcome. If you would like to participate, please contact Dr. Larry Luke at [larryl@dent.ucla.edu](mailto:larryl@dent.ucla.edu) or David Perry at [dperry3459@aol.com](mailto:dperry3459@aol.com).

## PROFESSIONAL OPPORTUNITIES REGISTRY

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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

### NOW IS THE TIME

Looking for an Associate or Partner? The Chair of this committee has listings for 15 Pediatric Dentists who will finish their residency in the near future. Complete this form and return it to Douglas McGavin, DDS and their name and phone number will be returned.

*"UCLA is the first dental school in the United States to launch a teledentistry. TeleDiagnosis can be used on virtually any PC, laptop or notebook computer running Windows 95 or Windows NT*

# NEWS BRIEFS

The UCLA Pediatric Dentistry Alumni will meet at the Olympic Connection on Friday, August 6. Featured speaker will be Dr. Shane White on "Current Endodontic Therapies of Interest to the Pediatric Dentist." Resident Research Presentations will follow Dr. Shane's presentation. This is the 25th anniversary of the class of 1974 that graduated Dr. Lonnie Lovingier, Dr. Michel Bonin, Dr. David Suttie, Dr. Noushin Morshed, and Dr. David Taylor. For further information contact: Pat Stafford at the UCLA School of Dentistry (310-825-0691)

## DR. LARRY LUKE WINS CSPD RESEARCH AWARD

The professional activities committee of the CSPD is pleased to announce that Dr. Larry Luke is the recipient of the \$1500 member research grant. Dr. Luke heads the Section of Orthodontics and is a Clinical Professor of Pediatric Dentistry and Orthodontics at UCLA.

## 1999-2000 CSPD DIRECTORY

The new Directory contains numerous errors in the home phone numbers only.

There are no known errors in the rest of the Directory. This occurred during the setup, the numbers are correct in the CSPD database and will automatically be corrected in the next Directory. Please remember to notify the Executive Director with any address or phone changes during the year.

## CSPD WEB SITE SELECTED

The CSPD website has been selected to be included on Mioti, debuting in August of 1999! Mioti (medical information on the Internet) is a new website dedicated to providing timely and useful information to physicians and their staff.

## "MANY DENTISTS WON'T FIX POOR CHILDREN'S BAD TEETH"

Look for this article from the New York Times on the CSPD web site.

## LEAD BLOOD LEVELS & DENTAL CARIES

A recent JAMA article examines the relationship of dental caries and blood lead levels. Analyzing data from the Third National Health and Nutrition Examination Survey (NHANES III) conducted by the National Center for Health Statistics from 1988-94, researchers found statistically significant associations between blood lead levels and status of dental caries. Higher blood lead levels were associated with higher rates of tooth decay, which are more prevalent among poor individuals.

The researchers suggest that the association between poverty and dental caries may partially be explained by lead exposure. Several ecologic and cross sectional studies, conducted in the 1960s and 1970s, implicated lead as a risk factor for dental caries. Studies have found that dental caries rates are higher among lead-exposed animals, although a direct association has not been established in humans.

The authors of the JAMA study suggest that a causal association between environmental lead exposure and dental caries would have important public health implications. In addition to modifying dietary habits, improving personal oral hygiene behaviors, and increasing fluoride exposure in high-risk groups, health interventions for dental caries would also need to address environmental factors.

Visit the JAMA website to download a copy of the report: <http://www.jama.com>

## MAKE CSPD YOUR HOMEPAGE

When you log on to the internet you may not see the home page of CSPD. Your browser has the option to define the homepage address when you log on. Please make CSPD your homepage. That simply means that when you log on to the internet our page is loaded. If members are logging on to any other site first, we lose a hit up front. You may change the log on address by accessing General Preferences under Options in Netscape Navigator. Type in <http://www.cspd.org> as your home page location

*The authors of the JAMA study suggest that a causal association between environmental lead exposure and dental caries would have important public health implications.*



(left)  
President Wayne Grossman,  
Executive Director  
Mel Rowan & Roland Hansen,  
Editor/Webmaster at the  
AAPD meeting in Toronto.

(below)  
Past Presidents  
Don Duperon & Ray Stewart  
at the AAPD meeting in  
Toronto.



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by risk group. The evidence-based management strategy is very different compared to conventional dental practice. What are the practical barriers to adopting these new practices?

### BARRIERS TO CHANGE

The barriers can be considered as: (1) collection of data, (2) consistent decision-making, and (3) the complexity of the decisions.

### COLLECTION OF DATA

There is a broad agreement amongst researchers regarding the need to collect a wide range of risk indicators (listed above), from the patient demographics, medical, dental, social histories, as well as from the clinical examination. However, there has been little consideration given to the extra time required to collect the data, whose role it should be to collect

it, and the validity of the data collected.

To prevent increased staff costs, it may be necessary to develop automated methods. A patient could telephone an office and engage in a computer dialogue, to provide as much as possible of their history directly into a digital chart using speech recognition technology. Current natural language recognition accuracy is approximately 95%, which may reduce receptionist time, even though more data is collected.

Existing caries charting methods do not record in a systematic way the severity or activity of individual caries lesions. Usually a lesion is recorded as new or recurrent with the surfaces involved. Ideally a chart record for a single lesion should give you the following information:

- Cavitated or non-cavitated-essential if remineralization is to be attempted.
- The depth of the lesion judged clinically as enamel only, enamel and dentin, or enamel, dentin, and pulp-the depth is one factor in determining whether monitoring alone, fissure sealants, restorations, or endodontic therapy is needed.
- The lesion activity as progressing, static, or remineralizing-superficial static/remineralizing lesions may be monitored while deeper progressing lesions will require restoration. The radiographic depth divided into outer and inner halves of enamel and the dentin into thirds to allow monitoring of lesion activity so that shallow lesions can remain unrestored preventing the creation of a repair destruction cycle.

The importance of the limitations of the current charting representations is shown in Figure 1, where there are three occlusal lesions. The lesion severity varies from a stained non-cavitated enamel-only lesion, to a small cavitated enamel lesion, and lastly to a large cavity in enamel and dentin with probable pulpal involvement. However, the conventional chart symbol is a circle, which is the same for all three lesions despite the clinical differences. As a possible solution to the problem of inadequate lesion detail, we have developed at the University of Florida a new pictorial classification of lesion severity and activity. Figure 2 shows a series of pictorial icons for non-cavitated or cavitated lesions involving the crowns or roots. The lesions are colored green for stasis or remineralization are red for progression. The lesion depth varies from enamel only; enamel and dentin; or enamel, dentin, and pulp.

For radiographic lesions, Figure 3 shows the pictorial icons, and Figure 4 radiographic examples of lesions in the outer or inner halves of enamel (E1, E2), and thirds of dentin (D1,D2, and D3). Unlike the clinical caries, where the operator selects the lesion activity as red or green, the software automatically chooses this by looking for previous radiographic information. If a lesion has been recorded currently as D1 and it was previously E2, the lucency is colored red, indicating progression. No change or



## CALIFORNIA SOCIETY OF PEDIATRIC DENTISTS ANNUAL MEETINGS

**2000**

March 30-April 2

Marriott's Laguna Cliffs Resort • Dana Point, CA



Program: Computers

-featuring Drs. Paul Rhodes, Robert Schultz, Pam Den Besten

Celebrating our 25<sup>th</sup> Anniversary.

The program also includes group seminars with:

Mike Null, "Filmless Dental Office"

Dr. James Yee, "E-mail for the Office"

Shaun Halladay, "Internet and Intranet"

Mark Brown, "MS Word" (Beginner & Advanced)

**2001**

March 29 - April 1

Sacramento Hyatt Regency at Capital Park

Sacramento, CA

**2002**

Anaheim Disneyland

**2003**

April 3 - April 6

Empress Hotel Victoria • British Columbia, Canada

Officers and members of the Board of Directors for CSPD meet quarterly. The membership of CSPD is encouraged to provide input to the leadership. Our next regularly scheduled meeting will be held in Los Angeles on September 25, 1999. Board meetings are open to the membership, and you are welcome to attend. Address your written intention to attend to the President, Dr. Wayne Grossman.

*The scientific literature has shown that non-cavitated enamel lesions and outer one third dentin radiolucencies have the potential to remineralize and should not be restored in low or medium risk people.*

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# ORAL HEALTH & INCOME DISPARITY

For every child in America who does not have medical insurance there are 2.6 children who do not have dental insurance. According to the National Health Interview Survey (1995) 36% of US children —about 27 million— have no dental coverage. In a recent New York Times article, pediatric dentist and national authority Dr. Burton Edelstein notes, "There are profound disparities in the oral health status of children in the United States. Dental diseases, tooth decay in particular, are overwhelmingly concentrated in a small subset of kids," primarily among 5 to 10 million poor and immigrant children.

In fact, Dr. Edelstein says, federal data show that the percentage of children who experience tooth decay has stayed pretty steady over recent years, but the percentage of children with decay who get it repaired has dropped. So, for the biggest sufferers, the problem is

actually getting worse.

While the overall level of dental caries (cavities) in U.S. children has dramatically declined since the introduction of fluoride in public water supplies, a startling 80% of all decay can be attributed to just 25% of all children.

Many of the poorest children lack access to dental care, even those enrolled in Medicaid. Relatively few dentists take Medicaid patients because of inadequate reimbursement rates and cumbersome bureaucratic requirements.

## SOURCES:

The New York Times, 6-26-99, C. Goldberg, section A, pg. 8, col. 1.;

Unpublished NHIS data provided by Dr. Burton Edelstein, director of the Children's Dental Health Project, Washington, D.C.

## PEER REVIEW OPPORTUNITY

The Peer Review system is a wonderful benefit for all CDA members as well as their patients. All peer review claims brought against Pediatric Dentists are handled through CSPD and the reviews are done by three trained reviewers meeting to clinically examine and discuss the merits of the complaint. At this time, I am making a plea for volunteers that would be willing to aid in this review process. We need examiners in all geographical parts of the state so that we can keep travelling to a minimum and so that we are all sure to be judged by our peers. The time requirement would be very minimal since our specialty has the least number

of reviews per year and each exam requires about two hours of commitment and is always accomplished after regular office hours.

There is a one time training process which will be organized by the local dental society or by special arrangement requiring about 3-4 hours. Please contact me with your interest as soon as possible by e-mail [pwolkstein@aol.com](mailto:pwolkstein@aol.com) or by phone at night (408) 268-5479. Please help make our peer review committee as good as it can possibly be.

Phil Wolkstein, Peer Review Chairman

## CALIFORNIA SOCIETY OF PEDIATRIC DENTISTS

### Sponsors

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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Safety Compliance Services  
111 N. Jackson St., Ste. 200  
Glendale, CA 91206  
818-552-2114

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9129 Lurline Ave.  
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135 Duryea Road  
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1888 Century Park East, Ste. 200  
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*Dental diseases,  
tooth decay in  
particular, are  
overwhelmingly  
concentrated in a  
small subset of  
kids," primarily  
among 5 to 10  
million poor and  
immigrant children.*

decrease in depth is shown in green. If no previous radiographs are available, the lucency has small red and green blocks to show that we do not know what the lesion activity is, since we have nothing to compare over time.

The conventional one-row tooth chart per jaw would not be able to display sufficient data, so we designed a four-row chart (Figure 5). The first row shows the Existing Condition with either new lesions, restorations, or restorations with recurrent caries. The crowns are shown as four or five surface structures. The second row, Clinical Data, contains the icons for the clinical severity and activity of caries. The smiley faces are an attempt to communicate that healthy teeth without caries or fillings are the ideal to aim for. You lose the smiley faces when caries or restorations are recorded. The next row, X-Ray Depth, displays the radiographic severity and activity of lesions. The last row, Possible Treatment, contains an automatically generated suggestion for managing the lesions, which will be discussed later.

Although at first sight the new chart may appear complicated to use, initial standardized testing with twenty-four users found the error rate to be less than 3% for recording ninety-nine pieces of information. An example of a test lesion to be recorded was "Tooth #2, occlusal, new lesion, pit and fissure enamel only, cavitated, demineralizing, with an outer one third dentin lucency." This example contained five basic pieces of information. Test subjects used only the tutorial program with no other assistance. It is reasonable to assume that with further use, the error rate will decrease.

### CONSISTENT DECISION-MAKING

Dentists have considerable difficulty in producing similar treatment plans, even when presented with identical information. In one study of nine dentists, two dentists correctly diagnosed one in seven lesions, while only one dentist recognized more than half the lesions. Consistent correct decision-making is of the utmost importance but the literature shows that this is a major problem area for our profession.

Compared to conventional treatment planning, evidence-based caries management will be more complicated since there are many new factors to consider. Hence, we should expect a larger variation in the decision-making given the current performance with traditional caries management. For this reason, we decided to develop a computer program, which has a digital patient chart and a large set of rules to automatically suggest a treatment plan. The rules were created by a group of teachers at the University of Florida and are based on the research literature. The objective of the program is to examine the data as they entered for risk factors, and if there are any, increase the risk score until the patient becomes classified as medium or high risk for developing caries. As each lesion is recorded in the caries chart, the program examines the rules and based on the patient's current risk level, recommends a spe-

cific management for each lesion, which appears in the Possible Treatment row.

### COMPLEXITY OF THE DECISIONS

A review of the decision rules, needed for managing an individual lesion, shows the process to be complex. To produce a detailed treatment plan for all lesions, plus general recommendations such as chlorhexidine rinses and appropriate recall intervals, requires at least fourteen pages of flow charts. Such complex decision-making would be too great for a dentist or supporting staff to perform in a consistent and comfortable manner using a paper system. Our hope is that by providing a computer based system, we can hide the complexity of the decisions needed and at the same time reduce treatment variability.

### SELECTION OF CLINICAL AND RADIOGRAPHIC EXAMINATION INTERVALS

A patient who is initially classified as at risk of developing caries, will be required to return at three-monthly intervals for *S. mutans* measurement until the count is below 100,000 colony forming units. A further low count will be sought after an additional three months. Assuming the other risk factors are reduced to a low score, a reassessment after six months is required. Finally, a further low risk assessment leads to a twelve-monthly recall. A radiographic examination interval can vary between six to thirty-six months depending on the age, risk category, and date of previous exposure.

### DISCUSSION

Many readers may have developed an opinion by now that the evidence based approach to managing oral health may be very difficult or too complex for routine office use. We believe this to be true if dentists wish to continue with paper-based methods for recording patient data. There may also be some anxiety that control of decision-making is being taken away from the profession by a computer. This is not correct since the computer is only making a suggestion, based on the findings from the scientific literature. If a dentist does not agree with the computer recommendation, it is a very simple process to choose an alternative procedure so that control still remains with the clinician. Nevertheless, we believe the complexity of the decisions has reached a point where support systems are needed to reduce the wide treatment planning variations, which have been observed.

Our goal is to design a computer system which simplifies the collection and use of data, while hiding the complexity of the decision-making. However, dentists will need to understand and support the new way of working, which in turn will require the creation of new continuing education courses.

Excerpted from the Journal of the American College of Dentists, Spring 1999 issue. Refer to [www.cise.ufl.edu/shk](http://www.cise.ufl.edu/shk) for a tutorial. Bibliography on request.

*The new evidence-based method of working will require patients to have a caries risk assessment producing a risk classification.*

# BOARD BRIEFS

JUNE 26, 1999 • CROWN PLAZA LOS ANGELES AIRPORT

The 100th meeting of the Board of Directors of the California Society of Pediatric Dentists was called to order by Dr. Wayne Grossman on Saturday, June 26, 1999 at 9:18a.m.

In attendance were: Drs. Duperon (Past President), Rowan (Exec. Director), Grossman (President), Luke (President-Elect), Perry (Vice President), Lovingier (Secretary), Reggiardo (District VI Trustee), Lisagor (AAPD Liaison), (Directors) Soderstrom, Huene-Christensen, DeLorme, Ramos-Gomez, Chiang and Ms. Marian (Secretarial Assistant). Special Guests: Ms. Jan Moffett, USA Executive Services (meeting planner), and Dr. Ray Stewart .

Members Absent: Drs. Mungo (Treasurer), Hansen (Editor), (Directors) Jacks, Cortez and Aspis.

ACCESS TO CARE THROUGH GENERAL DENTISTS - DR. STEWART would like to see CSPD and CDA team up to train general dentists to treat more children. We have the opportunity to team up with CDA in a request for \$100,000 from the Sierra Heath Foundation. This is also a very important charge at the academy level on a nation wide basis. If CSPD plays a key role in this, it will serve as a model and a pilot project that could be expanded to a national level. Dr. Stewart requested board support for a joint CDA/CSPD \$100,000 dollar application.

MOTION: 06.26.99.03: SODERSTRON/PERRY: I move that CSPD work with CDA to develop a program to train general dentists and their staff in a comprehensive pediatric update and further work to obtain a grant from the Sierra Health Foundation to fund this program. PASSED

CDA FLUORIDATION TASK FORCE - DR. STEWART reported that the Department of Health Services will go to Santa Cruz and enforce the state fluoridation code. Anti-fluoridation forces have been active in the community.

DISTRICT VI TRUSTEE NOMINEE - DR. STEWART noted that Dr. Reggiardo's three year tenure as our District VI trustee will end at the next annual meeting in Nashville. Dr. Stewart asked for the board's support for his candidacy for District VI Trustee Nominations are due by July 30, 1999.

## OFFICER'S REPORTS

PRESIDENT - DR. GROSSMAN reported that it is appropriate to fund the Executive Director's attendance at the AAPD Annual Meeting.

MOTION 06.26.99.04 PERRY/LOVINGIER: I move that the Executive Director of CSPD should be strongly encouraged to attend the AAPD Annual Meeting. To facilitate his attendance the E.D. shall be reimbursed for standard airfare, lodging, and registration fees in an amount not to exceed \$2,000.00 annually.

FINANCIAL IMPACT: \$2,000.00

PASSED.

PRESIDENT-ELECT - DR. LUKE reported that he has been named to the newly established California Dental Offices, Denti-Cal External Quality Review Committee. The purpose of this committee is to ensure that our professional consultant team is applying program criteria mandated by the state consistently and that program guidelines are appropriate to the current standard of care.

VICE PRESIDENT - DR. PERRY reported on the Strategic Plan update. He reviewed the purpose of the strategic plan for the new members present. He highlighted each goal and objectives. CSPD is on target with almost all of these objectives.

SECRETARY - DR. LOVINGIER reported there is no rea-

son to highlight or explain any information listed in the board packet.

TREASURER - DR. MUNGO was absent. Dr. Lisagor stated that e-commerce on our web site is ok; we are permitted to make money on this project. It just can not be the primary purpose of the organization and the money has to be expended to fulfill in part the mission of the organization.

Dr. Rowan requested that CSPD's computer equipment be upgraded.

MOTION 06.26.99.05: DUPERON/SODERSTROM: I move to budget \$2,400,000 as requested by the executive director to replace necessary hardware, software, printer and answer phone/ fax.

FINANCIAL IMPACT: \$2,400.00

PASSED

AAPD TRUSTEE REPORT - DR. REGGIARDO reported that in Toronto the AAPD board elected to increase the advocacy activities in Washington with an additional 100,000 to 120,000 dollars. Dr. Reggiardo reported that the AAPD Constitution and Bylaws are undergoing revision.

MOTION: 06.26.99.06: LOVINGIER/RAMOS-GOMEZ: I nominate Ray Stewart as the CSPD nominee for AAPD District VI Trustee.

CHILD ADVOCACY - DR.SODERSTROM reported that there is no provision for compliance in the general anesthesia bill 2003. The insurance companies are not required to inform anyone. Dr. Soderstrom will ask Dr. Santos if it would be reasonable to ask for CSPD approval of the pediatric dentist on staff at Delta. Dr. Soderstrom and Dr. Stewart attended the Fluoride Symposium April 30, 1999 at CDA. The opposition is starting to take a different tact on how they are attacking the issues. They are getting the message that their junk science is not holding up and people can see through that. They are getting into more "green" issues like those seen in Santa Cruz. They don't ban fluoride but they ban anything being added to water. Emphasis to be placed on "clean water." The state law will supercede any local ordinances and it is just a matter of when and who is going to mount the challenge.

AAPD LIAISON - DR. LISAGOR feels that this liaison is not worth the cost of this position. After much discussion it was concluded that even though you don't influence votes we have the ability to respond to what the board decrees. It was the decision of the board to continue this role.

CAL OSHA - Dr. Grossman reported on the new regulation concerning "Sharps" that will be effective on July 1, 1999. At that time we are required to use a safety needle or safety syringe. There is going to be a publication in the CDA journal that contains a study of the dental safety needles. The position paper was adopted at the last trustees meeting. There are exceptions to the regulation. 1) Lack of market availability 2) Health care professional has determined that the use of the safety needle will jeopardize the success of the dental procedure 3) the production evaluation criteria have shown that safety needles are not safer than alternatives used by the employer. CDA has suggested that you can document this in your chart and not have to use your sharp if you don't feel it is proven. CDA has also contacted the FDA and written them a letter stating that you have inadvertently approved the safety needle under the criteria of the needle and have not had any demonstration that is effective.

The president adjourned the meeting at 4:57PM

Respectfully submitted  
by Dr. Lonnie Lovingier, Secretary.

*Dr. Grossman reported on the new regulation concerning "Sharps" that will become effective on July 1, 1999.*

## LEGISLATIVE NEWS

Dr. Reggiardo reported on the Meeting of the State Board of Dental Examiners May 1999. Regarding advertising of Non ADA-Recognized Credentials, the BDE adopted proposed regulatory language governing announcement and promotion of education and credentials in non ADA-Recognized specialty areas of practice. Basically the board is not recognizing other new specialties. The board does not have clearly defined parameters by which they could enforce current regulation. Dr. Reggiardo also reported on the Recommendation for Additional RDH and RDAEF duties. It was the general feeling of the board that they are comfortable with letting CDA take the position in regard to the expansion of duties.

AB 2006: Dr. Reggiardo said at the Regulatory Hearings in August, the Board will accept public comment and approve final wording for regulations to implement AB 2006, passed last year, granting statutory authority to the BDE to regulate oral conscious sedation of minor dental patients. After a lengthy discussion the CSPD Board felt the regulations met their intended purpose.

AB1065 Children's Dental Care Pilot Project - Dr. Ramos-Gomez reported that the final draft of AB1065 was sent as amended. It has passed the health and budget committees unanimously. HHS will send the bill to the governor where it is expected to be vetoed. Dr. Ramos-Gomez sent out a mass mailing encouraging support.

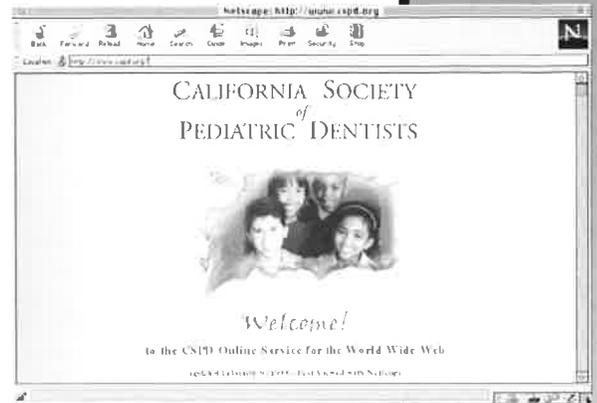
SB856 Dr. Reggiardo reported that this bill as was originally drafted would have discouraged participation and thus limited access to care. Four concerns were brought to CDA regarding this bill. The bill was going to require submission of pretreatment radiographs, when more than six teeth were treated at one visit or more than 10 teeth in a six-month period. The idea was to identify fraudulent providers. This would have increased the expenses of those providers who were treating Denti-Cal effectively lowering the reimbursement rate. There was the potential that radiographs could be used to deny payment. The bill then had a number of other amendments added in addition to addressing these concerns. The amendments that were added changed it from a bill to find Medi-Cal fraud to a bill for dental reform.

SB552 - Dr. Perry reported that this bill is the Thompson bill that allows the MD anesthesiologist to function in the dental office. The first bill that allowed the medical anesthesiologist was for 1 year. This bill extends it for 2 more years. The MD anesthesiologist may work in the dental office provided he obtains a certificate from the Board of Dental Examiners.

# WEB NOTES

## RECENT POSTINGS ON THE CSPD WEBSITE - WWW.CSPD.ORG

In What's New see the:  
Photographs from the Annual Meeting Aboard the Viking Serenade  
Reprints from the Fall Bulletin  
President's Message  
Legislative News  
Sponsors & Links  
News Briefs  
California Children  
Evidence Based Dentistry  
Teledentistry  
Peer Review Request  
Web Notes & Internet Buying  
New Members  
Conference for the New  
Pediatric Dentist



## DENTAL SUPPLIES VIA THE INTERNET

The Internet is fast becoming a major player in business to business (B2B) transactions. Last year activity in the United States amounted to an estimated \$12 billion dollars. That total amounted to 79% of the total worldwide activity. Medical and dental supply ordering is a small portion of this total, however experts agree that over the next few years B2B will encompass many health care organizations. Health care information technology and emerging companies will provide solutions to connect providers, health care practitioners, and suppliers.

A recent survey commissioned by the Dental Manufacturers of America and the American Dental Trade Association revealed that most dentists nationwide depend on the telephone to place orders. Nevertheless, dental manufacturers are interested in expanding their ability to market their products using the Internet.

The vice-president of Information Systems for Henry Schein, Inc., recently reported that 10% of their business was conducted via the internet. He notes that "Last year we did in the neighborhood of 10 percent of total sales electronically. We've been in the electronic world for the last few years and were the first to get into Internet ordering about 18 months ago."

Dental practitioners like using the Internet because ordering may be accomplished at any time of the day either in the office or at home. The computer program keeps track of everything that is ordered and after the account is set up new orders are processed expediently. Using the Internet to order supplies also saves money. Prices are somewhat less and some companies give additional discounts for ordering online. Next day delivery of supplies is common duplicating the speed of telephone orders.

Online ordering via the Internet has found new adherents since it is a time-saver, reduces costs, and it is logical. If you are computer literate it makes sense to explore the B2B concept.

Excerpted from the CDA Journal, April 1999.

The Online Store is not currently in service. Until the contractual arrangements are reviewed, the links with Amazon.com, Barnes and Noble.com, Beyond.com & Xoom.com cannot be accessed through the CSPD web site.



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