Summer 2012

APEX

BULLETIN OF THE STANISLAUS DENTAL SOCIETY

MARK YOUR CALENDARS!

JUNE

1 **Friday**
CPR Renewal

1 **Friday**
SDS Goes (to the) Nuts!

JULY

4 **Wednesday**
Independence Day — ADA/CDA/SDS offices closed

5 **Thursday**
SDS Board Meeting

13 **Friday**
CE - Pearls of the Practice, 8:00 am - 1:30 pm, Jacob's Fine Dining

AUGUST

16 **Thursday**
SDF Annual Dinner, 5:30 - 8:00 pm, Jacob's Fine Dining

24-25 **Friday-Saturday**
CDA Cares - Sacramento Cal Expo

President's Message

Dr. Corey R. Acree, 2012 SDS President

Stanislaus Dental Society has a lot going on this year. CDA held a special session of the House of Delegates to further discuss the support for Senator Padilla's Bill 694. The discussion centered around the section of the bill that calls for a study that would research the effects of non-dentists providing a certain level of care on California's children which would include irreversible dental procedures. This is being viewed as a possible means of meeting the needs of the 30% of Californians that do not have access to care, according to the Access Report filed at the 2011 HOD. This is a crucial time for the future of dentistry and I would encourage each member to be informed and voice your thoughts as dentistry, and possibly our work force model, is redefined in the years to come. Following is the resolution that resulted from the special HOD as well as a letter of response from Senator Bill Emerson.

2012 Unofficial Actions of the CDA Special House of Delegates

1S6. Whereas, CDA is an evidence-based organization and makes decisions based on pertinent scientific evidence, and no such evidence currently exists regarding the safety of non-dentists performing expanded duties as proposed in the CDA Access Plan.

Whereas, public leaders are concerned about barriers to access to oral health services in their communities and seek to overcome these barriers for their citizens.

Whereas, barriers to care are multiple and multi-factorial, and no single solution will resolve these barriers to access that an estimated 30 percent of Californians experience.

Whereas, CDA has concluded and filed its 2011 Access Report further identifying and enumerating the various barriers to accessing oral health services for approximately 30 percent of the population of California.

Whereas, legislation has been introduced in an attempt to improve access by creating a statewide office of oral health to create and administer a comprehensive statewide oral health program aimed at meeting the needs of the population, including those that do not have access to services. CDA has shaped and endorsed the legislation, and thus has a leadership role and visible stake in the legislation. CDA, as an association of learned professionals, has the ability and duty to provide guidance to the state in proposed matters aimed at overcoming access barriers to those needing oral health services that are not able to access the current existing private-practice or public health models of dental service delivery in California.

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President's Message continued from page 1…

Whereas, the proposed legislation includes a study of the safety, effectiveness, quality, cost-effectiveness and patient satisfaction of a not-yet-finalized set of expanded dental procedures performed by non-dentists under various forms of supervision.

Whereas, some CDA members have expressed deep concern about various aspects of the proposed legislation, and seek to encourage CDA to rescind support heretofore given by CDA to the bill.

Therefore be it

Resolved, that CDA continue to support and endorse legislation, such as SB 694, so long as any amendments or revisions made during the legislative and rulemaking processes result in legislation that is consistent with CDA policy that the dentist remain the head of a single dental delivery system; and be it further

Resolved, that the study referenced in Phase 1, Objective 8 of the 2RC-2011-H, as approved to be pursued, be further defined as a study limited to California licensed RDHs and RDAEF2s receiving modular training on specified new duties, and be it further

Resolved, that in order to support any legislation that calls for a study, as defined, the following parameters be included:

- The study must be conducted by a California university under the auspices of its internal review board with all instruction conducted under the oversight of a dentist.
- The study must limit the duties to be studied to the following: administration of local anesthesia; tooth preparation for, and placement and finishing of, direct restorations; interim therapeutic restoration; stainless steel crown placement; therapeutic pulpotomy; pulp cap, direct and indirect; and extraction of primary teeth.
- The study must focus on safety, quality, patient satisfaction and cost effectiveness of the care for children delivered in a public health setting under the direct, general and remote supervision of a dentist.
- The final design and implementation criteria of the clinical study must be carried out and approved by a committee to include dental school faculty, state dental board members and both public health and private practice dentists.
- The additional duties permitted for those providers participating in the study are only permitted for the purposes and the duration of the trial, which is not to exceed five years.
- Recognition that any permanent scope of practice changes would require separate legislative action in the future.

And be it further

Resolved, that at the conclusion of any such study, CDA analyze the results and take a position on any proposed changes to the dental practice act only after presentation and approval by the House of Delegates; and be it further

Resolved, that in addition to these workforce activities, CDA fully implement the other phase I strategies from 2RC-2011-H so that multiple efforts to overcoming barriers to care are occurring simultaneously and the need to introduce alternative workforce members is reduced.

Resolution 1S1 (as submitted by the San Diego County Dental Society) was substituted for Resolution 1. Resolution 1S6 (as submitted by the Alameda County, Berkeley, Redwood Empire, Southern Alameda and Tri-County Dental Societies) was substituted for Resolution 1S1. Resolution 1S6 was amended and subsequently adopted.

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President's Message continued from page 2…

Senator Bill Emmerson Reflects on Special Session of HOD

Three days into March, 2012, the CDA held a special session of the House of Delegates (HOD) in Oakland to reconsider a resolution regarding a study on mid-level providers that was passed in the regular HOD last November of 2011. After much discussion, a resolution was passed, co-authored by three components – including Tri-County Dental Society.— to affirm support for the study outlined in SB 694 with some important changes and conditions. (Unofficial actions of this Special House can be found at cda.org.)

Tri-County Dental Society member Senator Bill Emmerson wrote his reflections regarding this historic event. He said that "Being a Republican in the legislature, I am accustomed to holding the minority opinion. It is never fun when your colleagues don't agree with your perspectives and I feel compelled to say how much I continue to respect my colleagues even though some perspectives were not consistent with mine.

"After adjournment, I took the opportunity to speak directly to many of those who came up short to thank them for standing up for their beliefs. There is only honor in fighting for what you believe in, and I have only admiration for everyone who did so in Oakland."

With dissent, there is always the potential of hurt feelings and of those who do not prevail in their stand to end up either intentionally or unintentionally hurting the organization to which all participants are a part. I imagine this is what concerned Bill.

Bill went on to write, "While I was uncertain about the eventual outcome, I was deeply worried about the affect the debate would have on the CDA, its membership, and our future. Fortunately, I witnessed a level of disclosure rarely seen in the Capitol and I remain as proud of our members and our organization as I ever have been.

"Going forward, please know that I will work doubly hard to ensure that as SB 694 moves through the Assembly that the direction the House approved will remain. I will continue to work directly with Senator Padilla to ensure that your objectives will be met.

"Finally, I want to reinforce what I said on the floor of the House. Namely, that I will do nothing that in my mind will harm Dentistry. If anything changes in SB 694 that is not in the best interest of our profession or harms Dentistry, I will move from support to opposition."

Senator Emmerson wrote that he does "not expect that to happen, but given the amount of energy each of you put into this issue in Oakland, you deserve nothing less than that commitment."

He then thanked all involved for their "time and commitment to Dentistry."

**Re-write of Senator Bill Emmerson's official letter is provided by the Tri-County Dental Society.*

As a member of SDS, will you consider being a part of a committee such as the Continuing Education committee or Community Health committee? We want to hear from you as this is your local dental society. SDS will only be as good as what you are willing to put into it. You can call me at my office, 529-0674 or cell, 402-9810. Thank you for your consideration.

by Dr. Corey Acree

Editor's View

by Michael P. Shaw, DDS – SDS APEX Editor

It really doesn't matter what capital letters are associated after our names, D.D.S. or D.M.D. or what segment of dentistry we are most interested in and enjoy most in our practice of dentistry, I have to believe that most of us entered into this profession in order to help others achieve oral, and in some cases, total physical health. Sure there may be a few who wandered into the profession for various other reasons but in the end, our goal is to provide oral health care to all ages and with that, the positive social and personal benefits associated with our care. This is why, when I see a journalist and their team compile and present a story like the one aired on KOVR Channel 13 in Sacramento, I become so enraged. Not so much at the specific journalistic team but because of the mistrust and questions it invokes in the general public viewing the segment. In my humble opinion, dentistry is an art and a science. We all offer treatment plans based on our past outcomes of specific therapy. I have to believe that nearly all keep the patients' well being paramount and the final treatment is usually a partnered plan of both practitioner and patient. Be all that as it may, the dark cloud of confusion created in some patients by this type of information is disconcerting. It was so significant that it stimulated the CDA to offer "talking points" to assist in dealing with patients who viewed this piece. We should never be too busy (especially in these economic times) not to offer all our knowledge in order to perfect the patient-doctor relationship. In this time of "bad press" we do have a chance to shine locally.

Photo Page…

This is Logan Poblete born August 19, 2011 to Dr. Nicholas and April Poblete.

Congratulations on a beautiful baby!

Dr. Corey Acree, SDS President, representing your dental society at the special House of Delegates 2012.

Dr. Abbas Raissi presents at the April General Membership Meeting.

Periodontal Preparation of the Orthodontic Patient: A Consideration for the Primary Care Provider*

by Eileen Zierhut, DDS

As dentists, we all know the importance of a coordinated, multidiscipline approach to the care of dental patients. Ideally, the general dentist should be the primary care provider who then coordinates the involvement of other dental specialists. Unfortunately, in reality there is frequently a disconnect between the various aspects of a patient's treatment and the dental professionals involved in this care. One of the areas for which this is true is the periodontal preparation of the orthodontic patient. Orthodontics has much to offer in the esthetic improvement of smiles as well as an indispensable adjunctive tool in restorative treatment and other aspects of dental care. When performed on patients who are free of inflammation and active periodontal disease, orthodontics can be accomplished without significant periodontal risk. However, in the presence of inflammation (poor oral hygiene) and other periodontal disorders, orthodontic treatment can pose a significant threat to the health of the periodontium. Therefore, for the safety of our patients, a periodontal evaluation and necessary treatment must be completed prior to engaging in any orthodontic tooth movement and good communication between the patient's dental providers is essential in this process.

During orthodontic treatment, both the orthodontist and the general dentist are responsible to ensure that the optimal care is provided to their patients. If a general dentist does not feel comfortable making the initial periodontal evaluation, diagnosis, and prognosis, then the patient should be referred to the periodontal specialist. It can be a delicate issue between orthodontist, periodontist, and general dentist as to who provides the periodontal evaluation, any needed preparatory periodontal care, and maintenance and monitoring during orthodontic treatment. This should be determined based on the difficulty of the periodontal situation and the expertise of the general dentist. Out of professional courtesy, a discussion of these issues should occur between the general dentist and the orthodontist. However, if the general dentist fails to provide the required preliminary periodontal diagnosis and documentation, the orthodontist may be forced to refer the patient directly to a periodontist.

Adult orthodontics is one of the most important applications of this multidisciplinary approach. Adequate periodontal care is usually even more critical for the adult patient undergoing orthodontic treatment. As more and more adults engage in orthodontic treatment, this becomes a more prevalent issue in the practices of the dental professionals involved. Prior to undergoing orthodontic treatment, each adult patient must have a periodontal evaluation. This includes a complete hard and soft tissue evaluation, full periodontal probing, and a periodontal diagnosis and prognosis. In order to safely begin orthodontic movement, the patient (of any age) must be:

- Free of active periodontal disease
- Free of calculus
- Free of inflammation: This is the most significant factor contributing to periodontal tissue destruction with or without orthodontic movement

In addition they must have:

- Adequate bone support, including the resolution of vertical defects when not caused by malalignment of the teeth.
- Adequate soft tissue support: Thin, friable tissue may need reinforcement; however, there is debate regarding the importance of a band of attached tissue (Sanders); The need for (or benefit of) gingival grafts in these circumstances depends also on the direction of tooth movement and should be considered on an individual basis with treatment goals in mind (Wennström).

The presence of these problems during active orthodontic movement will very likely result in an accelerated deterioration of the periodontium. Therefore, orthodontic treatment should be postponed until these problems are resolved. Further consideration should be given to the patient's medical history looking for factors that contribute to periodontal problems. These include smoking habits, diet, bisphosphonate drugs, anti-seizure medications, stress levels, immune deficiencies, diabetes, osteoporosis, certain blood dyscrasias, and polymorphonuclear leukocyte disorders, as well as other diseases and medications. These periodontal and health history findings are then put together with the findings and objectives of the orthodontist and general dentist to make the best and most well-informed decisions about the patient's treatment.

Whereas the decision to treat with orthodontics is much easier in the absence of periodontal problems, the practitioner is often faced with the decision whether or not orthodontics should be performed in the presence of a compromised periodontal condition such as significant bone loss. The good news is that the presence of bone loss alone is not a reason to exclude a patient from orthodontic treatment. Most studies demonstrate that in the absence of inflammation, orthodontic movement can be accomplished with minimal to no further bone loss or tissue destruction (Eliasson, et al). In fact, in some studies, improvement in the periodontal condition was seen using both traditional braces (Corrente, et al.) and clear aligner therapy (Lee, et al). If there is no active periodontal disease and no inflammation present, a patient can undergo comprehensive orthodontic treatment without any further significant loss of bone. However, tissue thickness and

attachment levels need to be addressed and treated as necessary prior to orthodontic treatment to prevent fenestration and dehiscence. Each case should be considered individually and the periodontist brought in to consult as to whether a patient has an adequate level of bone and soft tissue support for this treatment.

Adults are not the only ones who should have periodontal evaluations and treatment prior to orthodontics. Frequently, children have periodontal issues that should be addressed before placing braces or other orthodontic appliances. One of the most prevalent of these is the presence of thin, friable tissue or minimal or absent attached tissue. It is not uncommon for these children or adolescents to require pre-orthodontic grafting, although the pre-orthodontic grafting purely for improving tissue attachment is controversial. If retrusion or reclination of the tooth is planned, gingival grafting may have no benefit (Ngan, et al). However, if any potential for protrusion (or further labial movement) exists, then grafting may be advisable (Wennström, Sanders). Even if no grafting surgery is recommended, it is still recommended that these areas be carefully monitored throughout orthodontic treatment.

Once a patient has had a comprehensive periodontal evaluation, communication should occur between the periodontist or general dentist and the orthodontist. This communication should consist of a written periodontal diagnosis, prognosis and treatment plan, as well as provide any radiographs made. If there is not any indication for any preparatory periodontal treatment, a clearance should be provided in writing to the orthodontist stating that it is okay to proceed with orthodontic treatment. Any maintenance recommendations should be included in that letter. If periodontal treatment is recommended, a written statement of that plan should be provided to the orthodontist. Both the orthodontist and the general dentist should follow up to ensure that this treatment has been completed. When periodontal treatment is completed, the orthodontist should be provided (in writing) a summary of treatment completed, the prognosis, a clearance to start orthodontic treatment and when to start, and maintenance recommendations (including frequency of scaling, root planing, and periodontal evaluations for adults or periodontally-compromised adolescent patients). This communication and follow-up should continue throughout active orthodontic treatment and retention to ensure the excellent oral hygiene of the patient, the absence of inflammation, and no exacerbation of any periodontal condition. Prevention of periodontal disease during and after orthodontic treatment is an equally important consideration and is facilitated through this communication.

As seen, good initial and continued communication between dental professionals is critical for excellent orthodontic care. This is especially true for the periodontal preparation and follow-up care of orthodontic patients. When we work together as professionals, we provide a level of service that is deserved by our patients and maximizes our combined abilities and knowledge.

This article is in no way designed to be a comprehensive review of the literature or the periodontal problems or issues that arise with orthodontic care. A very comprehensive review of the literature on this subject by Dr. Norman Sanders can be found in the Journal of the American Dental Association ("Evidence-based Care in Orthodontics and Periodontics: A Review of the Literature").

*This article is reprinted with permission of the San Fernando Valley Dental Society.

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Bio: Dr. Eileen Zierhut, is a native of the San Fernando Valley and has practiced in the San Fernando and Santa Clarita Valley communities for 26 years. She has specialized in the field of orthodontics for more than 18 years.

Her bachelor's and dental degrees were earned from UCLA, and her Master of Science degree in Dentistry and Orthodontics specialty were earned from the University of Washington in Seattle. Dr. Zierhut has taught at the UCLA School of Dentistry in both the Fixed Prosthodontics Department and in the Orthodontic Department, as well as at the University of Washington Department of Orthodontics. Presently, she maintains two private orthodontic practices in the San Fernando and Santa Clarita Valleys.

If We Offer It, Will They Come?

Access to Care Requires More Than Just Making Treatment Available

BY ERIC K. CURTIS, DDS, MA, MAGD

My first attempt to stage an in-office charity-care day was a disaster. I called nurses in eight school districts across two counties and asked them to send deserving children my way for complimentary dental care. Among several dozen kids who showed up for exams and radiographs, I identified a raft of cavities and even a few fistulae. I treatment-planned restorations, stainless steel crowns, and extractions, while my assistants gave home care instructions, passed out toothbrushes and toothpaste, and spoke to parents and guardians. The front office triumphantly scheduled everyone into a full day of free work.

But when the big day came, about half of my charity cases didn't. I was astonished at the number of no-charge no-shows. My staff called to find out why so many people turned up their noses instead of opening their mouths. The answers were pedestrian. Moms forgot. Kids were sick. One family decided to attend a soccer game instead. "We didn't think we needed to come," another mother said, "because nothing was really hurting."

Some days, I realized, you just can't give dental care away.

The number of U.S. dentists who provide free or reduced-fee care these days is astounding. News stories bubble with details of free dental days, charity projects, and indigent clinics, as well as scholarships, grants, and awards for dentists who provide services to those in need and in high-need areas. Mobile clinics are mushrooming. Yet in an era of unparalleled provision, critics charge that dental care remains out of reach for many who need it most. The term "access to care" has moved from mere description to political rallying cry in the last few years. But is the problem really that patients can't find care—or that they choose *not* to access the care that's available, or are unhappy with the ways in which it is currently being offered?

Dental access by the numbers

Much has been made of the notion that there are too few dentists. June Thomas, for example, writing in the 2010 *Slate* article series "The American Way of Dentistry," rounds up the usual suspects. She points out that, in recent years, dental schools closed and downsized because they were expensive. She calculates that, currently, approximately 600 to 800 more dentists enter the profession than retire from it each year, but starting around 2014, as the baby boomer dentists who graduated in larger classes start to retire, the number of practicing dentists will decline while the U.S. population continues to grow. What's more, she notes, dentists enjoy abbreviated work weeks. In 2006, 12.1 percent of U.S. private dentists worked fewer than 30 hours per week, which Thomas speculates may be related to the growing number of female dentists with children. She says fewer dentists are now chasing more teeth. The U.S. population has grown from 227 million in 1980 to 307 million in 2009, and people are often keeping their natural dentitions into old age.

But such numbers don't tell the whole story, and they may not tell any story. According to the American Dental Association (ADA) Survey Center, as of 2008, 174,204 dentists were in private practice in the United States, including 134,204 general dentists, 5,114 pediatric dentists, and 34,598 other specialists. That's one dentist for every 1,762 people and one general dentist for every 2,288 people in the country—ratios that don't make dentists seem particularly scarce.

According to the American Dental Education Association website, 61 dental schools are currently accredited in the United States. In 2010, 4,947 dentists graduated across the country, representing a steady increase in both schools and graduates in the last decade. The ADA thinks the trend is toward continuing the expansion of the dentist population. The ADA's 2011 paper, "Breaking Down Barriers to Oral Care for All Americans: The Role of Workforce," concludes that "the available supply of active dentists will not suffer the major reduction that is commonly predicted." The paper cites workforce studies showing the number of both dental schools and graduates increasing steadily through 2030, resulting in a rise in dentist numbers to as many as 220,000. "Although many factors can affect so large an undertaking as opening a dental school," the ADA paper cautions, "some observers estimate that there will be as many as 20 new schools by 2020." The ADA also anticipates that the dental workforce will be more robust because baby boomer dentists will retire at older ages than their predecessors.

"The assumption seems to be that dentists won't go where they are needed, and where they are needed is in rural areas. But, in fact, the opposite is true. The most needy demographic is the urban poor."

At any rate, the supply of dentists isn't everything. In the 2002 *Journal of the American Dental Association (JADA)* article, "The importance of productivity in estimating need for dentists," the authors argue that the need for dentists is determined not just by supply but by dentist productivity (which they estimate to have been increasing by 1.4 percent annually for the last several decades), technological innovations, and "well-trained and managed" personnel.

Access-to-care critics and analysts also often cite not only a shortage, but a perceived maldistribution, of dentists. There aren't enough dentists, they worry, in underserved areas. "It's hard to know what access to care really means," says Gerald Woodworth, DMD, from Rupert, Idaho. "Does it mean that there aren't enough dentists? That dentists are too expensive? That dentists don't go where they are needed?" Dr. Woodworth points out that legislators and policy makers tend to assume that rural areas need dentists the most, because more dentists live in bigger cities. "The assumption seems to be that dentists won't go where they are needed, and where they are needed is in rural areas," he says. "But, in fact, the opposite is true. The most needy demographic is the urban poor."

Brent T. Schvaneveldt, DMD, of Aberdeen, Idaho, believes that the idea of rural underserved dental patients is a myth. "In Idaho," he says, "a map of the state with locations of dental providers showed that every state resident lived within 30 miles of a dentist."

Robert J. Gherardi, DMD, from Albuquerque, N.M., tells a similar story. "People like to quote numbers that say there are counties in New Mexico with no dentists within the county," he says. "What they fail to say is that the whole county only has 718 or 1,991 residents spread over a vast area, and that many of those residents access dental care just 40 miles away in Texas."

National statistics seem to draw parallel conclusions. A 2007 *JADA* article, "The urban and rural distribution of dentists, 2000," reported that, although dentists in the United States were more concentrated in urban areas, 84.7 percent of the population living in the nation's most rural counties had at least one practicing dentist in the county.

Access to funding: The problems with Medicaid

Dentistry, according to Thomas in her 2010 *Slate* article series, is "the branch of medicine the affluent use most." The extensive knowledge and skills needed to provide dentistry come at a cost. Even if there are enough dentists, there aren't enough of them willing to see low-income and Medicaid-enrolled patients, especially children. Just as poverty breeds caries, funding undoubtedly encourages people to see the dentist.

The U.S. Department of Health & Human Services (HHS) Agency for Healthcare Research and Quality (*Research in Action*, issue 13, available online) reports that 36.8 percent of poor children ages 2 to 9 have one or more untreated decayed primary teeth, compared to 17.3 percent of non-poor children. Uninsured children are half as likely as insured children to receive dental care.

Thomas cites numbers from the National Association of Dental Plans (NADP) showing that the 157 million Americans who had dental insurance in 2007 were 49 percent more likely to have visited the dentist for a checkup or cleaning in the previous six months and 42 percent more likely to take their children to the dentist twice a year. But a third-party payer's support isn't all-motivating. The NADP also indicates that fewer than 5 percent of people with dental coverage reach their annual maximum.

In the United States, 129 million or so Americans have no dental coverage; the remaining 21 million have some form of Medicaid or one of its state equivalents. Thomas lists several reasons that Medicaid patients have a hard time getting in to see the dentist. For one thing, the fees are too low, a situation especially untenable for new dentists facing high educational debt loads. Noting that Idaho Medicaid reimbursements run about 30 percent of normal fees, Dr. Schvaneveldt describes a recent study indicating that the majority of Idaho dentists would provide care to those in need if reimbursement rates were within 60 to 70 percent of normal fees. "We don't have an access to care problem," he says. "We have a state funding problem."

Yet a March 2008 Issue Brief from the California Healthcare Foundation, "Increasing Access to Dental Care in Medicaid: Does Raising Provider Rates Work?," concluded that adequate reimbursement alone is not enough to induce dentists to participate. According to the report, "The research concludes that reimbursement rate increases were a necessary, but insufficient, part of making Medicaid dental reforms succeed. Experts in each state indicated that ... Medicaid agencies must also revamp program administration and build partnerships with dental societies."

On the other hand, Donald E. Patthoff, DDS, MAGD, from Martinsburg, W.Va., warns of regulation capture, an economic concept that describes the propensity for any regulation to be eventually captured by the agencies it was intended to regulate, so that it operates to their benefit. "If the partnerships only promote *bigger* government and *bigger* business," he says, "such partnership revamping can itself become another level of concern."

A second Medicaid snag, then, is administrative red tape, and a third is patient unreliability. "Many people only live moment to moment,"

Dr. Patthoff explains. Thomas also alludes to "cultural disconnects"—dentists are often uncomfortable integrating poor patients with their otherwise middle-class clienteles.

"We don't understand the mindset and motivations of the poor," says Gregory M. Pafford, DDS, a dentist from Phoenix, Ariz. "If they just had the door to a dental office opened to them, would they step inside?"

But when people living in poverty do step inside, dentists tend to first tell stories of Medicaid patients out to milk the system. "I had a Medicaid patient who came in wearing an ill-fitting denture," Dr. Schvaneveldt says. "The denture teeth were in good shape, and a reline would solve her problem. When I explained this, her response was, 'They'll pay for a new denture, and I want a new denture.' She didn't care that I was going to lose money on the procedure."

Indifference to care: Not all needs are wants

Most often, however, dentists are left scratching their heads at patients' seeming indifference to care. "Twenty-five years ago," Dr. Pafford says, "in an effort to give back to the community, the Arizona Dental Association sponsored a donated dentistry day every third Friday. But the program failed. Dentists got tired of paying their staff members to sit around while no patients showed up." As a result of a lack of adult participation, he says, the dental association now focuses most charitable efforts on children and the elderly.

Every adolescent with an allowance to spend faces the inevitable lesson that not all wants are needs. But the inverse, while rarely acknowledged, is also true: Not all needs are wants. Availability alone is simply not enough to ensure that care gets delivered. Put a dentist on every corner, throw open the doors of the office, even make treatment free, and patients will still stay away in droves. So what motivates people to go the dentist? What keeps them away? And, on the other side of the coin, what motivates dentists to offer charity care or to participate in Medicaid?

When examining access to care issues, a distinction can be made between cultural and structural factors. Cultural factors arise from internal, personal, and emotional (subjective) impulses, while structural factors involve external, societal, and circumstantial (objective) pressures. In a 2010 *Slate* essay, "The 'Culture of Poverty' Myth Returns," Alyssa Battistoni argues that poverty is not cultural. People are not poor because they are lazy. She says that poverty springs from external socioeconomic considerations: "Poverty is first and foremost a result of structural forces, from economic growth and job opportunities to segregation and discrimination." In sociologic terms, lack of patient care may be considered either a structural issue (there are not enough dentists) or a cultural one (people want to avoid perceived unpleasantness).

The most commonly cited barriers on the patient's part are money and fear; the most cited motivators are pain and vanity. Dentists recognize that people will usually show up if they have a toothache or if a front tooth is broken. People hate needles and drills and may skip treatment if they have to pay. Such explanations, facile and self-evident, have become stereotypes, and stereotypes may obscure as much as they reveal. "People tend to frame access to care as an economic issue—they may say that doctors cost too much," says Dr. Patthoff. "But that's far too simplistic."

Observations about accessing care: Why people avoid the dentist

Three broad approaches may help an analysis of the perplexities of patient participation—the observational, the theoretical, and the philosophical. "I live in The Rio Grande Valley in south Texas, on the border of Mexico," says Joe D. Zayas, DDS, of Brownsville. According to Dr. Zayas, it is "a poor and underserved area. I have often asked my patients who have had dental benefits for many years, 'Why are you just now using your benefits?'" Dr. Zayas cites nine reasons people don't show up for dental care. One, he says, is money. "Even for reduced fees or low-cost dentistry, many patients still don't have the co-pay, no matter how small it may be." The second reason is fear. "People are afraid of the unknown, or what they have been told, or possibly [they are haunted by a] previous bad experience with a dental visit."

Dr. Zayas says the third reason people avoid dental care is lack of transportation: "Many patients don't have a car. That's why many offices that cater to Medicaid-type patients have vans or cars to pick up patients for their appointments." The fourth reason is embarrassment. "Many patients," he observes, "are ashamed of the condition of their oral cavity and don't want others to know." The fifth is invasion of privacy: "Some patients simply do not want others looking in their mouths, much less placing instruments, materials, or fingers in there."

A sixth reason is lack of education or low dental IQ. "Many patients just don't know the importance of dental health and how it relates to their overall health," Dr. Zayas says. The seventh reason is lack of knowledge of dental plans. "Many patients are aware that their company has provided some form of dental benefits, but they never inquire about them," he observes. "Just last week, a couple argued in my office because the husband told his wife that the dental plan he had from his place of employment only covered 'cleanings,' so he was sending her into Mexico to have all her restorative work done. She was upset to have to risk her life to go into Mexico under the current cartel situation. The couple actually has great dental benefits but never used them, and the husband just assumed they had weak benefits."

The eighth reason, Dr. Zayas says, that patients avoid care is lack of interest. "Some patients don't care about their physical health, much less their dental health." The ninth reason is lack of pain. "Many patients feel that they are doing well just the way they are if they don't have any warning signs. Their attitude is, 'If nothing is bothering me, why check it out? If it ain't broke, don't fix it.'"

Availability alone is simply not enough to ensure that care gets delivered. Put a dentist on every corner, throw open the doors of the office, even make treatment *free*, and patients will still stay away in droves.

A theory about accessing care: The health belief model

As a guide to better understanding patient behavior, Dr. Patthoff suggests familiarity with the health belief model (HBM). One of the first theories of health behavior, the HBM was initially developed by researchers in the U.S. Public Health Service in the 1950s to understand people's health choices. Known as a "value expectancy" theory, the HBM analyzes patients' reasons for seeing a health care professional. It describes the thoughts and circumstances that influence a patient to seek care by enumerating five conditions of action—perceived susceptibility, perceived severity, perceived benefits, cues to action, and self-efficacy.

Perceived susceptibility generally involves a person's interest in his or her own health, and a sense of vulnerability or the likelihood of illness. *My gums are hurting.* Perceived severity involves a person's beliefs about how dire the consequences of an illness, and leaving it untreated, might be. *I'm worried about missing work.* The perceived benefits part has to do with weighing the costs and benefits of seeking treatment. *I'll get my gums checked out before I leave town so things won't get worse on the road.* Cues to action are triggers that stimulate actual behavior, such as physical stimuli and advice from others. *I have a bad taste in my mouth. My dad thinks I should go in.* Self-efficacy has to do with a patient's confidence in the ability to successfully act. *This can't be worse than the colonoscopy I had done last year.*

Dr. Patthoff points out that additional theories exist, such as those of the various health education models, which further demonstrate that wanting, searching for, and getting good health involve complex factors. The assumptions, he says, that "bad choices, bad genes, and bad rearing" underlie poor health "serve more to preserve the status quo than the human desires to care and to be cared for."

Access to care as philosophy: The importance of value in an age of distraction

For David E. Houten, DDS, of Kelso, Wash., money is high on the list of reasons why people avoid dental care. "People don't want to pay for anything that's not immediately gratifying or fun," he says. "No one wants to pay for their own health care. People want to spend their money on things that are more immediately, emotionally rewarding, things that don't remind them of their own mortality."

Another reason people skip dental care is fear, not just of needles or drilling, but of embarrassment, and of getting bad news. "You can pretend everything is OK if you don't know about it," he says. Still another factor, Dr. Houten says, is inconvenience. Schedules are more hectic today. There are many more choices now about how to spend one's time, and many more demands on time. People are frazzled and frenzied. "Some of my patients only make it to their dental appointments by sheer luck," he says.

Dr. Houten also describes a public seized by a shopper's mentality. "We are used to getting everything on demand," he says. "Want a burger, or a box of cereal, or a tank of gas, or an inflatable life raft at 3 a.m.? Someone will be there to sell it to you right away. So people become indignant that they can't see the dentist whenever they want, without waiting." Dr. Houten suspects that the public has little sense of how difficult dental care is to provide. People want to think dentistry is easy, he says, and dentists, eager to entice people into their chairs, have encouraged public notions of dental procedures as the most routine of surgeries.

Dr. Houten also sees a commitment issue in the avoidance of dental care. Nowadays, people text and Tweet and Facebook and email incessantly, but they have fewer social contacts. "Dental appointments commit people to specific behavior at specific times with specific, real people in face-to-face interactions," he says. "We shy away now from things that require specific response and direct contact."

In the end, Dr. Houten believes that any discussion about access to care necessarily hinges on value. Issues of money and fear, convenience and commitment, are really issues of value. What is the value of dentistry to a given patient? What does dental care mean to that person's life? "We keep telling ourselves that we have to do a better job educating our patients," Dr. Houten says. "But I don't know how to teach value. I know what's valuable to me, but it's subjective and personal, based on my education and life experience, and I can't tell you what's valuable to you."

Education must produce behavioral change to have value. "We say we need to teach people better prevention," Dr. Houten says, "but the public already knows about prevention. It's not a matter of knowledge, but of bringing actions up to the existing level of knowledge. People know the routine, but they don't *own* the routine. A minister came into my office the other day. The first words out of his mouth were, 'I know I should brush and floss better, so don't lecture me.'"

Dental plans themselves may contribute to dentistry's lack of value. "Employees don't see the value of dental coverage," Dr. Houten says. "People are not sophisticated about their plans. No one ever asks, 'How much of my day do I spend earning my dental care?' They don't see the money that pays for their coverage, don't feel it coming out of their check, so it has no value. If dental care costs nothing, and demands no

responsibility on the patient's part, it often has no value to the patient."

Dr. Houten thinks that people just don't know how to go to the dentist anymore. "In this generation, it doesn't enter people's minds that dental care is routine and repetitive," he says. "Dental visits are not really part of the social system now. In a society bent on convenience, we somehow have to create value."

What dentists can do

Dr. Patthoff notes that decisions about who gets what dental care often occur at an intersection of market forces, government decisions, and professional problem-solving. Markets are very good at achieving efficiency, he says, but not excellence. Markets tend to get cheaper things to more people who can pay for them. Governments, on the other hand, are not really about efficiency *or* excellence. Instead, they aim at social basics, which might be just doing *something* for everyone.

"The government thinks that any care is better than no care," says Dr. Pafford, "but inadequate or delayed care inevitably becomes more expensive care. It's not just about getting care. It's about getting adequate, good-quality care. It's up to the dental profession to encourage both efficiency and excellence."

Changing patients' minds about dentistry even now depends on education. "People are still surprised to hear that caries is a disease," says Dr. Patthoff. In an effort to teach patients one-on-one, New Mexico recently became the first state to authorize Community Health Care Coordinators (CDHCs) in its dental practice act. "These practitioners will have a mix of 'social work' skills and dental skills," explains Dr. Gherardi. "Their job will be to go into communities—hopefully where they are from—and educate residents about the importance of dental care. They will be able to coordinate care for those patients at a local dental facility. If they can increase utilization and efficiency of a dental office, such as reducing no-shows, then those lonely counties with only a few thousand residents will be able to support a dentist."

Dr. Pafford believes that charity care can also enhance dentistry's value. "Consistent, ongoing, sustainable charity care has an important place," he says, "both to offer underserved populations care they wouldn't otherwise get and to show the public and lawmakers that the profession thinks dentistry is extremely important. We may not be able to adequately tell them how important dentistry is, but we can show them."

Joseph G. Mirci, DDS, MAGD, of Salt Lake City, Utah, is developing a statewide access-to-care program involving vouchers. "We would work with county health departments," he says. "They would qualify the patients." Once individuals are identified as having dental needs, the voucher system would be accessed by dentists who have volunteered to see five such patients in a year's time. The dentists, including specialists, would be specific in the type of care they are willing to provide; having provided treatment, they would report to the voucher system about the procedures accomplished and the dollar amount donated.

Patient care shouldn't be reduced to a battle between government and the market, with charity left mopping up the casualties. People need care, and dentists need to care for them. Dentistry's goal is patients' well-being. "Our job is to show that we are ready to work and open to change," Dr. Pafford says. "We need to learn from our patients and each other. I think we can continue to deliver high-quality care, even in the face of patient negligence, if we remain vigilant, enthusiastic, and engaged." ◆

Eric K. Curtis, DDS, MA, MAGD, is an adjunct associate professor at University of the Pacific. Dr. Curtis holds a certificate in professional writing from the University of Arizona and is certified by the Board of Editors in the Life Sciences. He maintains a private general dental practice in Safford, Ariz.

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Making the Most of Your CDA Leadership Application

So you've been actively involved in component leadership for several years and you're now ready to take the leap and volunteer your time and talents as a member of a CDA council, committee or board. You've logged into the CDA website and are on the leadership page at **cda.org/volunteer**. You see the link to apply for leadership, but you hesitate before clicking. You think: "With just a handful of positions available each year and close to 200 candidates vying for them, what can I do to make sure my application stands out?"

Well, first and foremost, make sure to read the qualifications for the position you are interested in, as well as the expectations for members of that committee. This may seem basic, but you would be surprised how often applicants overlook this important first step. Understanding what is required of volunteers is the foundation of an effective leadership application.

Once you're familiar with the duties of the committee for which you are applying, make sure you use that knowledge in crafting your application. There is an area on the application for you to indicate five areas in which you have skills, experience or training. Make sure you select the competencies you possess that match the needs of the committee you're interested in.

Next, take full advantage of the short-answer essay questions as opportunities to highlight the experience and skills you can contribute as a CDA leader, especially those which relate to the positions for which you're applying. This is also an area on the application where you can differentiate yourself from other candidates. Take your time formulating your responses to these questions. Speak to your passions – what is your motivation for being involved? Since answering these questions will take more than just the few minutes you have between patients, the form includes a save button so you don't lose your progress if you cannot complete your application in one sitting. Just make sure to complete and submit your application by the June 1 deadline.

Lastly, carefully select your references. Make sure to follow the guidelines and do not list any Executive Committee, Leadership Development Committee, or Committee on Volunteer Placement members or CDA staff as a reference. Your references should be individuals who have seen you in action as a volunteer and can speak to your strengths and experience.

Even the most well-thought out application won't guarantee your selection for a CDA council, committee or board, but it can go a long way in getting you consideration as a serious candidate for a leadership position.

Questions? Please contact CDA's Leadership Development Committee at **ldc@cda.org**.

How Do I Handle a Drug-Seeking Patient?

Dental offices can be the target of individuals looking for an easy prescription for controlled substances. For this reason, limit issuing prescriptions to patients of record.

Many times, a patient will call and ask for a prescription. Have a method to determine if a caller is a patient of record. If you are taking calls for a colleague, determine how you can confirm whether the caller is your colleague's patient. If the caller is not a patient of record of your or your colleague's practice, then you must use your professional judgment in determining the necessity of providing the caller with a prescription. If a caller states he or she is in severe pain and in need of medication, offer to meet him or her at your office or at an emergency room in order to conduct an exam. If the caller is looking for a quick prescription, they will almost always decline the exam. In all instances, when someone calls to request a prescription, record the details of the contact and subsequent action.

For more information on dispensing and administering prescription drugs to potential addicts please refer to California Health and Safety Code section 11156.

In the event you suspect that a patient or prospective patient is seeking drugs, you may do one or more of the following:

- Follow up on suspicious stories, such as treatment begun by another dentist in another community.
- Notify local pharmacies of any suspicious actions regarding prescription abuse.
- Contact a supervisor at the Bureau of Narcotics Enforcement CURES Program (916.319.9062) to ask if it is possible the patient is doctor-shopping. Alternately, real-time access to CURES information is available to individuals and organizations registered with Bureau of Narcotics Enforcement.
- Identify other treating health care providers and contact them to ensure that the health care providers coordinate prescription of medications.

Another issue to keep in mind is confidentiality. Dentists are often privileged to know their patients over a long period, and treat many members from the same family. This may make a dentist want to take additional steps when they suspect a patient's alcohol or drug use is out of control, such as expressing concern to a family member. The importance of keeping confidentiality and privacy laws in mind before traveling this path cannot be understated.

When voicing your suspicions remember that typically it is only suspicions. Cast them as such, rather than fact. Anything more can trigger allegations of slander and or/libel if your suspicions are incorrect.

Addendum:
Prescription Drug Monitoring Program
The California Department of Justice has a Prescription Drug Monitoring Program (PDMP) system which allows pre-registered users including licensed healthcare prescribers eligible to prescribe controlled substances and pharmacies to access timely patient controlled substance history information at the point of care therefore reducing prescription drug abuse. The state's database known as the Controlled Substance Utilization Review and Evaluation System, C.U.R.E.S, For more information on the C.U.R.E.S. program, http://oag.ca.gov/cures-pdmp. Registration information is on the bottom with an electronic application included.

Uh-Oh! Unpaid Taxes = License Denial/Suspension

Effective July 1, 2012 the Dental Board of California is required to deny new license applications or suspend licenses if you have an outstanding tax obligation due to the Franchise Tax Board (FTB) or State Board of Equalization (BEO) and your obligation appears on either the FTB or BEO certified lists of top 500 tax delinquencies over $100,000. The law prohibits the DBC from refunding any application fees once paid, regardless of denial of license as required by AB 1424.

To determine if you are on the list, visit the FTB at www.ftb.ca.gov/individuals/txdlnqnt.shtml or BEO at www.boe.ca.gov/cgibin/deliq.cgi.

RM Matters

Policyholder Expectations: Professional Liability v. Workers' Compensation

By Taiba Solaiman
Risk Management Analyst

Professional Liability policyholders should expect excellent claims service from their carrier. For example, once a TDIC policyholder opens a claim under a professional liability line of coverage, an assigned claim representative acts as the policyholder's advocate by keeping him or her informed and engaged throughout the claim process. On the other hand, Workers' Compensation insurance provides protection for injured employees. The carrier designates a claims examiner to investigate the claim made by the injured worker. The examiner must remain impartial throughout the investigation to determine the extent of the injury and provide benefits to the injured employee in accordance with state regulations.

"Workers' compensation laws provide money and medical benefits to an employee who has an injury as a result of an accident, injury or occupational disease on-the-job. Workers' compensation is designed to protect workers and their dependents against the hardships from injury or death arising out of the work environment. It is intended to benefit the employee and employer alike. The employee receives money (usually on a weekly or biweekly basis) and medical benefits in exchange for forfeiting the common law right to sue the employer. The employer benefits by receiving immunity from court actions against them by the employee in exchange for accepting liability that is limited and determined."
---www.workerscompensation.com

All states require employers to promptly report work related injuries. It is not at the discretion of the employer to determine whether or not an employee should receive a medical evaluation following an incident. Failure to report an injury is a violation of the workers' compensation regulations and can result in substantial penalties to the employer.

Most dental office workplace injuries result in medical treatment only and do not result in the employee taking time off from work. If the injury does require the employee to remain off the job, the workers' compensation claims examiner will request a copy of the employee's payroll information to calculate disability payments that may be due. The examiner also coordinates the employees' return to work. Be prepared to give the claims examiner a copy of the injured employee's job description. The treating physician advises the examiner about which regular job tasks the employee can perform and which tasks need modification. Check with your workers' compensation carrier for state-specific information.

While the professional liability policyholder participates in the decision making process on how a claim is handled, workers' compensation gives employers (policyholders) limited rights. They can obtain general information regarding the status of a claim such as the employee's anticipated return to work date and any necessary job modifications. Privacy laws do not allow specific medical information about the employee to be disclosed to the employer.

For more information or advice on workplace injuries, please call TDIC Insurance Solutions at 800.733.0633.

The Dentists Insurance Company
a California Dental Association company
1201 K Street, 17th Floor, Sacramento, CA 95814 | t. 800.733.0634 | p. 916.443.4501 | f. 916.443.4468 | thedentists.com
MOVING FORWARD. TOGETHER.

Admitting Liability
Is Saying "I'm Sorry" an Admission of Guilt?

By Taiba Solaiman
Risk Management Analyst, TDIC

What do you say to a patient when you discover that the treatment outcome did not turn out as planned? How should you inform a patient when the unexpected has happened? Comments such as, "That should not have happened," or "I'll pay whatever it takes to make this right," may seem innocent, but may also lead to malpractice claims.

Typically, patients file lawsuits because they believe they have been wronged or feel abandoned. Providing an explanation and answering their questions, may be enough to quell their anger and anxiety. Conveying your concern about a poor outcome, without accepting or placing blame, may help improve your relationship with the patient as well as reduce the likelihood of litigation.

"I'm sorry" may be the most difficult words a dentist will ever have to say to a patient. If you experience untoward results, expressing sympathy without admitting liability to the patient and his/her family may help soften an emotional situation. Patients may also appreciate your candor and recognize that your primary concern is achieving their optimal dental health. When unexpected outcomes occur:

- Talk to the patient or family as soon as possible.
- Inform them, in a professional and solution-oriented manner, about what has occurred.
- Be compassionate, but avoid using terms that can be construed as admitting guilt such as, "I'll do whatever it takes to fix this error." "That should not have happened." "This is my fault."
- Document what happened, your course of action to resolve the problem and what you discussed with the patient.
- Notify your professional liability carrier for advice on managing the situation. (Do not put notes from these calls in the patient record; keep them in a separate file.)

How to apologize:

- Describe the incident and medical or dental response in brief, factual terms to the patient and/or his/her family.
- Show concern for the patient's condition.
- Offer options for a solution or improvement of the outcome.
- Do not criticize yourself or other caregivers for a poor outcome.
- Do not brainstorm about what happened or why.
- Document the incident, the patient's condition and plans for further follow up, if indicated.

Do say…

- I understand how difficult this is.
- I'm sorry this has happened.

Do not say…

- I'm sorry I did this.
- I wish I had handled this differently.
- I'm sorry; this is all my fault.

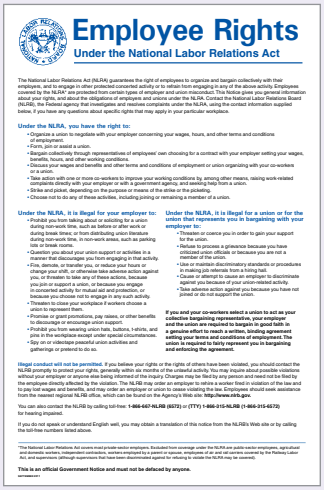
Currently, approximately 35 states have pending or passed laws allowing or declaring apologies inadmissible as evidence. The other states do not have statutory provisions allowing doctors to apologize or express condolences without fear of being subject to additional liability. These states follow the Federal Rule of Evidence 801 (d) (2) which "may construe an apology made by a healthcare provider as a statement against interest and thus subject to admissibility under the exception to hearsay."

The following table lists the applicable state statutory provisions pertaining to TDIC's policyholders.

State	Statutory Provision
Alaska	No provisions. Federal admissibility laws apply.
Arizona	Apologies and similar gestures by healthcare providers are not admissible in court as admission of liability or admission against interest.
California	Apologies are inadmissible as evidence of liability. However, statements concerning negligence or culpable conduct that are part of or in addition to the apology are admissible.
Hawaii	Statements or gestures that express sympathy, commiseration or condolence are not admissible to prove liability.
Illinois	Apologies are not permissible in the court as admission of liability.
Minnesota	No provisions. Federal admissibility laws apply.
Nevada	No provisions. Federal admissibility laws apply.
North Dakota	A statement, affirmation, gesture or conduct of a healthcare provider, or healthcare provider's employee or agent, that expresses apology, sympathy, commiseration, condolence, compassion or benevolence to a patient or to a patient's relative or representative is not admissible as evidence of liability .
New Jersey	No provisions. Federal admissibility laws apply.
Pennsylvania	No provisions. Federal admissibility laws apply.

It is important to be open and honest with the patient if an untoward event happens. Taking immediate steps to resolve the situation ensures the patient's dental needs are met and may help sustain the doctor-patient relationship. Offering a sincere apology may allow you to control the direction of the outcome.

Important Labor Law Updates!



Employee Rights
Under the National Labor Relations Act

The National Labor Relations Act (NLRA) guarantees the right of employees to organize and bargain collectively with their employers, and to engage in other protected concerted activity or to refrain from engaging in any of the above activity. Employees covered by the NLRA* are protected from certain types of employer and union misconduct. This Notice gives you general information about your rights, and about the obligations of employers and unions under the NLRA. Contact the National Labor Relations Board (NLRB), the Federal agency that investigates and resolves complaints under the NLRA, using the contact information supplied below, if you have any questions about specific rights that may apply in your particular workplace.

Under the NLRA, you have the right to:

- Organize a union to negotiate with your employer concerning your wages, hours, and other terms and conditions of employment.
- Form, join or assist a union.
- Bargain collectively through representatives of employees' own choosing for a contract with your employer setting your wages, benefits, hours, and other working conditions.
- Discuss your wages and benefits and other terms and conditions of employment or union organizing with your co-workers or a union.
- Take action with one or more co-workers to improve your working conditions by, among other means, raising work-related complaints directly with your employer or indirectly through a union, or seeking help from a union.
- Strike and picket, depending on the purpose or means of the strike or the picketing.
- Choose not to do any of these activities, including joining or remaining a member of a union.

Under the NLRA, it is illegal for your employer to:

- Prohibit you from talking about or soliciting for a union during non-work time, such as before or after work or during break times; or from distributing union literature during non-work time, in non-work areas, such as parking lots or break rooms.
- Question you about your union support or activities in a manner that discourages you from engaging in that activity.
- Fire, demote, or transfer you, or reduce your hours or change your shift, or otherwise take adverse action against you, or threaten to take any of these actions, because you join or support a union, or because you engage in concerted activity for mutual aid and protection, or because you choose not to engage in any such activity.
- Threaten to close your workplace if workers choose a union to represent them.
- Promise or grant promotions, pay raises, or other benefits to discourage or encourage union support.
- Prohibit you from wearing union hats, buttons, t-shirts, and pins in the workplace except under special circumstances.
- Spy on or videotape peaceful union activities and gatherings or pretend to do so.

Under the NLRA, it is illegal for a union or for the union that represents you in bargaining with your employer to:

- Threaten or coerce you in order to gain your support for the union.
- Refuse to process a grievance because you have criticized union officials or because you are not a member of the union.
- Use or maintain discriminatory standards or procedures in making job referrals from a hiring hall.
- Cause or attempt to cause an employer to discriminate against you because of your work-related activity.
- Take adverse action against you because you have not joined or do not support the union.

If you and your co-workers select a union to act as your collective bargaining representative, your employer and the union are required to bargain in good faith in a genuine effort to reach a written, binding agreement setting your terms and conditions of employment. The union is required to fairly represent you in bargaining and enforcing the agreement.

Illegal conduct will not be permitted. If you believe your rights or the rights of others have been violated, you should contact the NLRB promptly to protect your rights, generally within six months of the unlawful activity. You may inquire about possible violations without your employer or anyone else being informed of the inquiry. Charges may be filed by any person and need not be filed by the employee directly affected by the violation. The NLRB may order an employer to rehire a worker fired in violation of the law and to pay lost wages and benefits, and may order an employer or union to cease violating the law. Employees should seek assistance from the nearest regional NLRB office, which can be found on the Agency's Web site: **http://www.nlrb.gov.**

You can also contact the NLRB by calling toll-free: **1-866-667-NLRB (6572)** or **(TTY) 1-866-315-NLRB (1-866-315-6572)** for hearing impaired.

If you do not speak or understand English well, you may obtain a translation of this notice from the NLRB's Web site or by calling the toll-free numbers listed above.

*The National Labor Relations Act covers most private-sector employers. Excluded from coverage under the NLRA are public-sector employees, agricultural laborers, supervisors, independent contractors, and workers employed in the airline and railroad industries (covered by the Railway Labor Act, and supervisors (although supervisors that have been discriminated against for refusing to violate the NLRA may be covered).

This is an official Government Notice and must not be defaced by anyone.

WH1088rev1

NLRA Poster: For the third time, the National Labor Relations Board (NLRB) has suspended enactment of its notice-posting rule, which means that employers will not have to meet the April 30 posting deadline. CEA will continue to follow this situation and will let you know when and if you need to post the NLRA poster, which informs employees of their union.

Brinker Decision: On April 17th, the California Supreme Court released its long-awaited decision in Brinker Restaurant Corp. v. Superior Court. As a result of the decision, employers have to provide meal breaks, but do not have to ensure employees actually take their meal breaks. The ruling is a win for California employers, but not without possible pitfalls. Employers will need to examine their meal and rest policies and shore up their timekeeping practices.

It is important to have an employee handbook that is in accordance with the Supreme Court decision. CEA has updated the Sample Employee Handbook. The Brinker decision does not resolve every employer's issue with meal and rest breaks.

Wage Theft Protection Act: On 1/1/12, AB469 added a new labor code section which requires employers, at the time of hire, to provide non-exempt employees with a written notice containing specific wage and contact information. As of April 12, 2012, the DLSE has updated this Notice to Employee form. Any employees you hire after 4/12/2012 should receive the updated form, Wage Protection Act.

You can download these forms to include with your existing Labor Law posters from the SDS website, stanislausdental.org. Hold your mouse over Pearls of Dentistry under the heading Public on the left of the front page and you will see Labor Law Updates. You can download your forms from here.

Stanislaus Dental Society

Biomimetic Dentistry

David S. Alleman, DDS

5 Hours / Units of Category 1 Continuing Education Credits

Friday, September 27, 2012

8:30am – 1:30pm

Jacob's Fine Dining Restaurant
2501 McHenry Blvd. – Modesto

8:00am – Full Breakfast/Registration

8:30am to 1:30pm – Presentation

David S. Alleman has been practicing dentistry for 32 years since his graduation from the University of the Pacific in 1978. In 1995 he started studying adhesive dentistry with Dr. Ray Bertolotti. In 1999 he started studying with Dr. John Kois. These two mentors guided him through a 10 year/10,000 hour review of the literature on which advanced adhesive (Biomimetic) dentistry is based. He is currently partnering with Dr. Simone Deliperi from Sardinia, Italy to teach these techniques to practicing dentists at his educational facility in Salt Lake City, Utah. He is a member of the Academy of Operative Dentistry & the International Association for Dental Research. He has published articles on advanced adhesive techniques that focus on reducing stress, increasing long-term bond durability and tooth conservation. He currently mentors over 200 dentists nationwide in his practice based research group.

COURSE OBJECTIVES:

Adhesion Dentistry is a relationship between stress & bond strength. If the bond strength can withstand the stresses then the restorations will be successful. This course will give scientific evidence on how to control stresses, which maximize bond strengths. This maintains the seal, prevents secondary caries, eliminates post-op pain & preserves pulp vitality.

After Taking This Course You Will Know:

- How to Find Caries Infected & Affected Dentin & Guidelines for Removal
- How to Choose the Best Type of Restoration Based on Risk Assessment
- Immediate Dentin Sealing: How to Seal Preparations before Taking Impressions
- C-Factor & Polymerization Stresses & How They Affect Bond Strength & Durability
- How to Double Your Bond Strengths with Stress Reduced Layering Techniques & Curing
- How to Adjust Occlusion by Finding Lateral Interferences with Unterbrink's 3-Paper Technique
- How to Conserve Tooth Structure & Double or Triple The Life of Restorations

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SDS Membership Status Update

262 Total members	37 Lifetime Retired
212 Active Members	5 Retired
4 Permanent Disability	3 Affiliates
11 Lifetime Active	5 NEW!

SDS Welcomes Its Newest Members!

Christina Lee, DDS: GD - Graduate of UOP, 2010
Golden Valley Clinic, Los Banos

Teresa Lee, DDS: GD - Graduate of UCLA, 2007
Pediatric - Graduate Herman Ostro School of Dentistry, 2009

Marinello Manuel, DMD: GD - Returning Member
Associate of Dr. Glenn Takenaga
3801 Pelandale Suite B-9, Modesto • (209) 575-2400

Shamiram Melko, DDS: GD - Graduate of UOP, 2010
Looking for an associate position

Prakash Sojitra, DDS: GD - Graduate of USC, 2011
Smile World Dental, 4925 Sisk Road, Salida • (209) 543-0555

SDS 2012 CALENDAR

JULY

July 4	Wednesday	Fourth of July – office closed
July 5	Thursday	Board meeting
July 13	Friday	CE – TBA

AUGUST

August 16	Thursday	SDF Annual Dinner

SEPTEMBER

September 3	Monday	Labor Day – office closed
September 6	Thursday	Board meeting
September 20	Thursday	Staff Appreciation

OCTOBER

October 18	Thursday	General Membership meeting
October 19	Friday	CE – Biomimetic Dentistry, Dr. David Alleman

NOVEMBER

November 1	Thursday	Board meeting
November 9-11	Friday-Sunday	HOD – Newport Marriott – office closed including Thursday Nov 8 for Exchange

DECEMBER

December 6	Thursday	Installation/Spouse Night
December 24-31	Monday-Monday	Winter Holiday – office closed

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Editor: **Michael P. Shaw, DDS**
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Your contributions in the form of articles, photos and/or ideas are greatly appreciated. The APEX Staff is currently accepting articles of general membership interest. This can include an accomplishment, interesting hobby, innovative idea, volunteer effort, etc. Please feel free to submit an article or call for an interview. All articles are subject to editorial review. Requests for donations may be made by members but must be limited to 50 words or less.

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