GP NEWS

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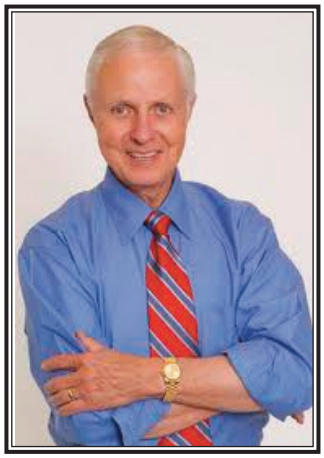
Mid-Level Practitioners ARE THEY NEEDED IN DENTISTRY?

GORDON J. CHRISTENSEN, DDS, MSD, PhD
Diplomate, American Board of Prosthodontics



DR. CHRISTENSEN

The following expresses my candid opinions on the now in-vogue concept among politicians—mid-level dental practitioners. As a long-time educator, practitioner and researcher, I have watched opinions vary as history has repeated itself for over the last one-half century.

At this time, we are in yet another movement to satisfy the "access to care" challenge by saturating the dental manpower marketplace. Several factors are evident currently that relate to this movement. There is no question that auxiliary dental staff persons can accomplish some oral preventive and treatment procedures. I am well-known to be a proponent of dentist-supervised staff persons accomplishing many clinical tasks.

Does dentistry need another category of practitioner? *In my considered, strong opinion*—**DEFINITELY NOT...!**

As I provide courses around the country—eighty programs in 2012—I see THOUSANDS of dentists in major financial distress. There are dentist bankruptcies in almost all cities. Although the recession appears to be slightly recovering, dentist financial challenges are still present. Many specialists have nothing to do, since GPs are not busy and are accomplishing specialty procedures. There is NO dental manpower need, and there will be none in the foreseeable future. Many dentists are unemployed. New dental schools are opening across the country. Most of them are NOT in conventional research and service-based universities. These schools are further saturating the dental marketplace with dentists. Numerous other dental schools are in the planning stages.

New dentists have school debts that average between $250,000 to $300,000. They are financially stressed and forced to do anything to survive. Many new dental hygiene schools have opened in recent years. In numerous geographic locations, dental hygienists cannot find employment.

(continued on page 4...see CHRISTENSEN)

The G.P. NEWS

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How Large Is the Dental Workforce in California...?

John S. Bettinger, DDS, FAGD, *Santa Monica*

As Dental Professionals, we are concerned about the underserved and those facing barriers to care. The California Dental Association's 2011 Access Report estimates that 30% of Californians, or about eleven million including four- to five-million children, face barriers such as distance and isolation to accessing dental care. Many of California's isolated areas can be reached with mobile dentistry. The recent growth of large Federally Qualified Health Center (FQHC) Community clinics with associated Dental Residents demonstrates significant expansion of our dental infrastructure. Without citing how they arrived at this assumption, the CDA Access Report states, "Capacity to provide care to these additional children does not currently exist within the dental delivery system in California." *The facts that follow dispute that claim.*

Dental workforce totals in California:

Active Dental Licenses—Dentists.....37,494
(from the Dental Board of California as of 1/1/12)

Active RDA, RDAEF Licenses.....35,342
(from DBC as of 1/1/12)

Unlicensed Dental Assistants (DAs) *estimated*.....50,000

The total Dental Workforce in California 141,039
(total of all the above)

The Ratio of Total Dental Workforce to Californians....1 to 268
(dividing 141,039 into 37,800,000). Counts all hygienists all assistants and all dentists.

The Ratio of Dentists to Californians.....1 to 1008
(dividing total of licensed Active Dentists into population of California—37,800,000). Does not include those licensed but retired, or account for part-time dentists.

The number of Licensed Registered Dental Hygienists *(all categories)* has increased from 12,486 in 2002 to 18,203 on March 30, 2012 *(Dental Hygiene Committee of California----DHCC) (DBC and UCLA Center for Health Policy Research 2005)*

The number of Licensed Registered Dental Assistants *(all categories)* has increased from 31,372 in 2002 to 35,342 at the end of 2011 *(DBC and UCLA Center for Health Policy Research 2005)*

The number of Active Licensed Dentists has increased from 26,533 in 2002 to 37,494 at the end of 2011 *(DBC)*

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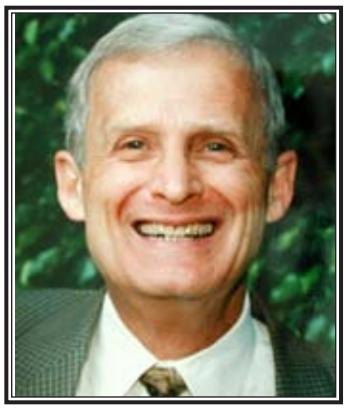

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Dr. Bob Garfield reports on SCAGD's Annual 2012 Ski & Learn trek to Park City with a look forward to the 2013 trip to be held at Snowmass /Aspen in Colorado

CHRISTENSEN *(continued from page 1)*

The misguided plan that saturating the market with dentists, mid-level practitioners, dental hygienists and others will satisfy the access to care problem has been disproven numerous times in recent history, in the U.S. and in other countries.

Practitioners of any type choose the place they prefer to practice, and market saturation has NOT improved access to care in those locations where others have tried it.

A few months ago, I made a survey of the profession relative to the challenges "real world" practitioners see, and I provided that survey to the ADA Board of Trustees. **A copy of it is included in this communication**. The survey supports my points made above.

IT IS TIME FOR THOSE WHO ACTUALLY DELIVER ORAL HEALTH CARE AND SEE THE CHALLENGES ON A DAILY BASIS TO SPEAK UP…!

CURRENTLY, MID-LEVEL PRACTITIONERS ARE NOT NEEDED AND HAVE NOT BEEN IN THE PAST, AND WILL NOT BE IN THE FUTURE, TO SATISFY THE ACCESS TO CARE PROBLEM!

GORDON J. CHRISTENSEN, DDS MSD PhD
CEO Clinicians' Report; Director, Practical Clinical Courses
Diplomate, American Board of Prosthodontics
Adjunct Professor, University of Utah and
Brigham Young University

Welcome To Our New Members

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Dr. Prerna Aggarwal, *San Francisco*
Dr. Nikhil Anand, *San Francisco*
Dr. Olga Antipova, *Los Angeles*
Dr. Sahil Arora, *San Francisco*
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DR. JAY THOMPSON
Trustee, Region 13, CAGD
San Diego

HOW I SEE SB-694:

Unethical Experimentation on the Vulnerable

I was watching television in February and saw a California Senate Committee holding hearings on SB-694; the bill that will establish a California Dental Director and give him/her the authority to conduct a study which would develop a mid-level dental provider or dental therapist. Testifying before the Committee were several dentists, a spokeswoman for the California Dental Association *(not a dentist)* and State Senator Padilla, the author of the bill.

What struck me as the committee questioned the witnesses and made comments, was that they appeared to place great faith in the proposition that a RIGOROUS SCIENTIFIC STUDY would be able to answer the question of whether or not a minimally trained dental therapist would be able to satisfactorily overcome the barriers to dental care for the underserved, poor, minority children in the State of California. Because of this I wanted to list some RIGOROUS SCIENTIFIC STUDOIES which were done since 1960 to answer LEGITIMATE SCIENTIFIC QUESTIONS but, in hindsight, missed the question of whether or not they were ethical, which is really the question about the study proposed in SB-694.

Here are just two RIGOROUS SCIENTIFIC STUDIES which sought to answer legitimate scientific questions, but should not have been conducted because they were unethical experimentation on human beings:

1. The Stanford Law Review reports in the Jewish Chronic Disease Hospital Case in which in July of 1963, twenty-two debilitated patients were injected with live cancer cells without the patient's voluntary informed consent. The experiment was financed by the American Cancer Society and the United States Public Health Service as part of a project to evaluate ways to fight cancer. This research was recognized as among the "most promising of all lines of cancer research." The web address for the introduction to this case is:
http://www.jstor.org/pss/1227417

2. From 1963 to 1966, the Willowbrook Study involved a group of children diagnosed with mental retardation, who lived at the Willowbrook State Hospital in Staten Island, New York. These innocent children were deliberately infected with the hepatitis virus; early subjects were fed extracts of stools from infected individuals and later subjects received injections of more purified virus preparations. Investigators defended the injections by pointing out that the vast majority of them acquired the infection anyway while at Willowbrook, and it would be better for them to be infected under carefully controlled research conditions. The web address below has the article (Historical Cases of Unethical Research):
http://www.und.edu/instruct/wstevens/PROPOSALCLASS/MARSDEN&MELANDER2.htm

It is my position that the study outlined in SB-694 which allows someone who is inadequately trained to perform irreversible surgical procedures on poor and minority children is the same type of RIGOROUS SCIENTIFIC STUDY which should not be conducted because it is unethical experimentation on the vulnerable.

Currently, dental hygienists and dental auxiliaries with expanded functions are allowed to: Clean teeth; take dental radiographs; place and remove surgical dressings; size and place orthodontic bands and brackets; place dental liners and bases; size, fit and place stainless steel crowns; polish, place, cure, shape and adjust dental restorations once the dentist has prepared the teeth. *The ONLY treatment currently denied to dental auxiliaries is the ability to perform irreversible surgical procedures.*

The Dental Board of California currently investigates and prosecutes individuals who practice dentistry without a valid dental license when they perform irreversible surgical procedures even with direct supervision by a dentist. Have we come to the point that this last standard will be removed in order for the State of California to reduce what it wants to pay for dental care for the children of California?

If you agree with me that the State of California is proposing to authorize unethical human experimentation, please contact your State Assemblyperson and urge them to vote against SB-694.

"It is my position that SB-694 allows someone who is inadequately trained to perform irreversible surgical procedures on poor and minority children is... unethical experimentation on the vulnerable."

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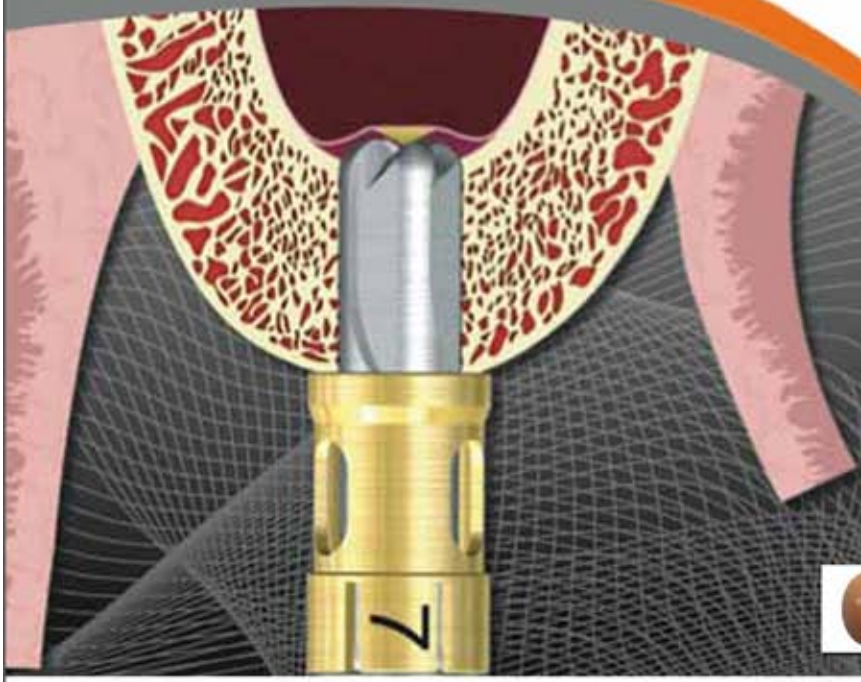

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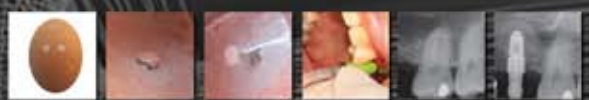

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Watchdog REPORT

Dr. Guy Acheson, DDS, MAGD, *Watchdog Committee Chairman, CAGD President Elect, Fair Oaks*

THE CALM BEFORE THE STORM

Our efforts have been directed to SB694. Drs. Langstaff and Acheson have met with Sen. Alex Padilla's staff two times to present the CAGD position of being opposed to non-dentists providing any surgical or irreversible procedures. We have used the AGD Whitepaper's list of alternatives to mid-level providers as ways to address the access to care problem of the low income and uninsured population. Our strongest suggestion is expanding the general dental residency programs and siting them in federally designated underserved areas. We also expressed support for requiring all Federally Qualified Health Care Facilities to have a dental component. This dental component can take the form of having a dental treatment facility on site or by contracting with private practice dentists in the area.

The CAGD was invited to a stakeholders' meeting by Sen. Padilla on SB694. Drs. Acheson, Langstaff and Seldin were present and the CAGD was given the foot of the table, directly opposite Sen. Padilla. We maintained our position of being opposed to any non-dentist providing surgical and irreversible dental procedures to children. Incredibly, the CAGD and the California Association of Oral and Maxillofacial Surgeons were the only voices at the table clearly opposed to non-dentists providing surgical services to children.

As you all know, SB694 has breezed through the senate and is about to be presented to the assembly. Sen. Padilla is delaying presentation of SB694 to the assembly until reconciling his bill with the recent decisions by the CDA and consulting with stakeholders. He is expected to call a second stakeholders' meeting within the next couple of weeks. The CDA House of Delegates, in a very rare special session, has voted to support the study of mid-level providers as long as the providers are an extension of the existing RDAEF program. Incredible. The major dental organization in California endorsing the concept of non-dentists working as pediatric dentists.

The California Academy of General Dentistry position is that only dentists should provide surgical and irreversible procedures. When it comes to children, the most vulnerable people in our population, the risks provided by non-dentists delivering these services is just too great to entertain the concept of non-dentists being surgical providers. The major reason that many general dentists decline to provide care to young children is because of the challenges presented by young children in behavior management. Indeed, for a provider to be deemed truly competent to treat exclusively young children we have created a specialty of Pediatric Dentistry that requires two to three years of training beyond the DDS/DMD degree. With that as the recognized minimum training to provide care exclusively to children, it is very difficult to consider high school graduates with two years of training as being a good choice. After that thought exercise we can move on to the concept of creating a two tiered healthcare delivery model with poor people receiving care in a parallel system with lesser trained providers with cost containment as the primary guiding principal. Then we can continue this thought exercise with the fact that the majority of poor people in California are people of color and you now have decided to provide a different type of healthcare to poor minority populations as compared to the majority populations. *Does that sound like the healthcare model that you were trained in?* I was trained that there is **one standard of care** and that all people deserve to have access to the same high quality providers and therapeutic options.

The primary argument for creating mid-level dental providers is that there are not enough dentists in California to provide dental care to the 1.2 million children who are expected to obtain dental benefits when the Affordable Care Act (ACA) becomes fully implemented in 2014. The Children's Partnership is the sponsor of SB694 and the first paragraph of their paper arguing for mid-level providers ends with, "There are not enough dentists to serve these populations." In my opinion, this is magical thinking on the part of proponents of SB694. California has more dentists per population than any other state in America. We have had more dentists per population for a very long time and the trend is that the number of licensed dentists per population is growing and the growth rate is accelerating.

Some statistics are in order to support this statement. In 2000 the population of California was 33,871,648 and the number of licensed dentists was 28,800. So in 2000 there was one dentist for every 1,176 persons. In 2008 the population of California was 36,756,666 and the number of licensed dentists was 34,142 for a dentist to population ratio of 1:1,077. In 2011 the population was 37,691,912 and there were 37,494 licensed dentists for a ratio of 1:1,005. Up through the mid-2000s the number of new dental licenses every year roughly matched the number of graduates from the California dental schools at 520. Since then the number of new dental licenses issued has increased dramatically so that in 2011 there were 982 new dental licenses issued. This dramatic increase is the result of many changes in pathways to licensure in California. These include the PGY-1 dental residencies that qualify graduates for a California license, the increase in Federally Qualified Health Care dental facilities that utilize dental residents, the new dental school that just opened and rumors of a seventh dental school on the horizon, the use of Western Regional Dental Boards instead of just a California board examination, as well as the pathway to licensure that is afforded graduates of University De LaSalle in Mexico. There is no shortage of dentists in California and the density of dentists is increasing rapidly.

The United States Census Bureau estimates California's population at the end of 2012 will be 38,100,000. If 2012 has the same number of new licenses as 2011 (982) there will be roughly 38,476 *(cont'd on pg. 9...WATCHDOG)*

KEYS TO
Esthetic Anterior Implant Restorations

DR. DiPONZIANO

John DiPonziano, DDS, MAGD, DICOI, CDT, *San Leandro*

In addition to the usual standards of surgery in implant placement: sharp drills and chilled irrigation to reduce thermal damage, there are other key points which promote a favorable esthetic outcome and long-term success in anterior implants.

1. Keep your distance—horizontally and vertically

In an immediate implant placement case, i.e., extraction of the tooth and fixture placement at the same appointment, it is important to position the fixture at least 1.5 mm from the facial bone of the extraction socket. This maintains a blood supply to the fragile facial plate and allows osteoprogenitor cells to populate the area which ultimately surround the implant with viable, healthy bone. (FIGURE 1)

Gone are the days of filling the extraction socket with the largest implant possible. That philosophy, which was prevalent several years ago, lead to many problematic cases where the facial wall of bone disappeared in a short time leaving fixture threads exposed, leading to esthetic and/or periodontal problems.

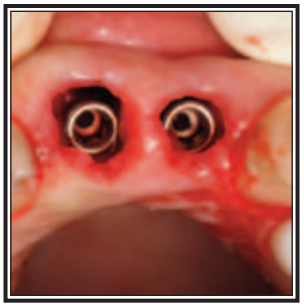


FIGURE 1

A space of 2 mm or more is preferable, but not always achievable, especially in a maxillary lateral or lower anterior situation. But with the availability of small diameter one and two-piece implants, (3mm or less), it is now easier to avoid the encroachment on the facial plate.

The technique for placement is to start the osteotomy favoring the palatal wall of the socket, keeping the drill from sliding into the apical root tip area. (FIGURE 2)

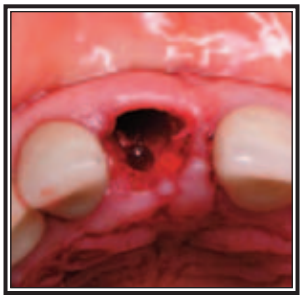


FIGURE 2

If this palatal placement is not followed, the implant position will be dictated by the shape of the socket which will cause the fixture to be placed too far facially with all the problems mentioned above.

The caveat to the palatal placement is that the angle of placement cannot be so acute that the gingival portion of the fixture encroaches on the facial plate.

This can be avoided with the use of a simple surgical guide with maintains the facial aspect of the tooth to be replaced. This allows the surgeon to visualize where the final facial profile of the crown needs to be, so as to position the gingival aspect of the fixture lingual to that facial profile. (FIGURE 3)

This lingual positioning of the implant is important, whether or not it is an immediate placement or a site that is edentulous.

FIGURE 3

A labially positioned implant can result in the final crown being too long and/or too bulky—generally not very esthetic. In addition, a labially positioned implant can have a compromised gingival architecture and very little or no keratinized tissue, leading to chronic periodontal problems. With regard to the vertical placement of the fixture, a good rule of thumb is to have the coronal end of the fixture 2.5 to 3 mm from the anticipated cervical contour of the crown. (FIGURE 4)

This 2.5 to 3 mm distance allows the abutment some "running room" to enable a more natural emergence profile of the crown.

2. Think Small

If the position of the fixture is correct, then the next item that needs to be addressed is the implant abutment and its relationship to the emergence profile of the crown.

Several studies have shown that the most favorable long-term esthetic results for an anterior implant restoration were related to the health of the gingival tissue at the fixture/abutment/crown area.

Placing a small diameter abutment allows the gingiva between the crown and implant body to have a better blood supply and therefore less tendency to recede or have an abnormal color. (FIGURE 5)

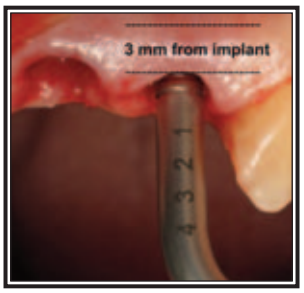


FIGURE 4

In some instances—even with the implant in the proper position—a connective tissue graft is an important adjunct to bulk up this critical facial area. This can provide a more natural looking emergence profile and gingival color, as well as add keratinized tissue for better long-term gingival health.

(continued on the next page. . . see KEYS)

WATCHDOG *(continued from page 7)*

licensed dentists at the end of 2012. Therefore, an estimate of the dentist to population ratio at the end of 2012 would be 1:990. We could pass through the one dentist per 1000 ratio. *Another first for California!* ***Too few dentists?***

There is a distribution problem of dentists, but the distribution of dentists reflects the ability of dentists to run a viable business. Private practice dentists must be able to generate enough income to support a business and provide an adequate income to the dentist. Just one example brought forward as proof of an inadequate number of dentists is that there is not a single dentist in all of Alpine County. True, but the total population of Alpine County is 1,200 people spread out over 743 square miles and the median income is $24,431. There is just not enough density of population to support a private dental practice. Twenty-five percent of the population lives below the poverty level. It is very hard to see how any dental practice could be viable in that environment. It will take subsidized business models such as Federally Qualified Health Care Facilities to fill the voids.

Watchdogs and CAGD leadership have been very successful in getting the CAGD recognized as a spokesperson for general dentists. Our opinion has stimulated dentists to take notice of the issues raised by SB694 and to take a position. Many CDA dental societies are now actively seeking participation of CAGD members in their delegate deliberations and have specifically chosen CAGD members as delegates to provide the CAGD perspective. There was significant CAGD presence at the CDA HOD special session. This is all very new for the CAGD. Dr. Mike Bromberg must be acknowledged as the person who has worked tirelessly for years to provide education and training in legislative matters for CAGD members, indeed for AGD members at large. His efforts have provided us with the tools to become involved and to become effective.

The mid-level provider issue will not go away. There are issues regarding corporate dentistry, licensure, and auxiliary regulation that all would benefit from CAGD input. *The Academy of General Dentistry is the only pure voice by and for general dentists.* The CDA/ADA perspective must represent all specialties in dentistry and the many dental auxiliaries that are members. General dentists need to support the only organization that represents their interests. Urge your fellow general dentists to join and to make their concerns known so that the AGD can have an even stronger voice in all matters dental.

Every general practitioner needs to be aware of the fact that the AGD is the only organization that speaks solely for the general dentist. State and national associations represent all specialties in dentistry.

We have been and are very much about advocacy for the GP. Urge your non-member colleagues to join with us in our efforts to have an even stronger voice in dentistry. Numbers carry the day.

KEYS *(continued from the adjacent page)*

3. Provisionalization

Another item that can aid in the proper emergence profile and gingival contour of the final implant restoration is the placement of a provisional crown and allowing the tissue to mature around it. This can be done either immediately after surgical placement using a pre-made or stock abutment, or after second stage surgery. (FIGURE 6)

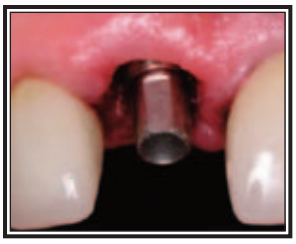


FIGURE 5

The challenge of placing a provisional at the time of fixture placement—especially in an immediate extraction case - is the initial stability of the fixture. As a general rule, an implant needs to have a stability of at least 40 Ncm at time of fixture placement in order to provisionalize. Even then, the provisional should be designed so there are no occlusal or excursive interferences.

If this 40 Ncm stability is not achieved, then a provisional restoration should not be placed until second stage surgery. Then, following at least six weeks of tissue maturation, final impressions can be made.
In summary, esthetic anterior implant restorations can be predictable, and have long-term esthetic stability, provided the above techniques are given proper consideration.

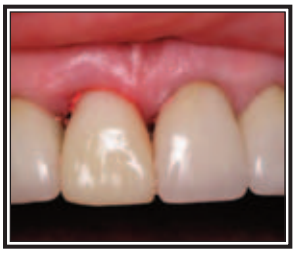


FIGURE 6

Dr. John DiPonziano has been placing and restoring dental implants since the mid-eighties. He is a Diplomate of the International Congress of Oral Implantologists and Chaired the AGD Implantology Task Force, which formulated dental implant educational guidelines in 2009. He lectures on surgical and restorative implantology and maintains a full-time private practice in San Leandro, California. Dr. DiPonziano can be contacted at jdiponz@aol.com

Sacramento-Sierra AGD News

Howard Chi, DMD, MA., MAGD, *President, SSAGD, Stockton*

The SSAGD hosted its annual continuing education course on May 12, 2012 at the UOP Health Science facility in Stockton, California. The course was on Restorative Implant Procedures with a lecture and a hands-on workshop with Dr. John DiPonziano. He is well known for his implant presentations, and brings a very comprehensive and clear understanding about the procedures of implant density to general practitioners. The course was sponsored by Hiossen Implants. Pacific's Stockton AEGD residents were invited guests of the SSAGD. Their attendance at the course furthered our outreach to inform about the AGD. Additionally, it creates future interest and possible leaders for our organization.

The SSAGD also hosted two successful study club dinner meetings. The first one was on Treatment Planning, presented by Dr. Guy Acheson. The second meeting was on Cracked Tooth Syndrome, presented by Dr. Samer Alassad. These study club meetings offer a relaxing atmosphere where participants can have lively open discussions about the given topics. Attendees learn not only from the presenter, but also from fellow participants.

In July, we will be hosting our third study club dinner meeting. The topic for that day is 3D and Cerec Integration on Virtual Implant Placement and Implant Treatment Planning. *Look for details on this meeting on the SSAGD Facebook and/or in a mailer. Plan to be there and invite a colleague to come along with you...!*

2012 is well on its way with many continuing education opportunities for the Sacramento-Sierra areas. We are also busy with planning and ground work for 2013. Being at the helm for the past three years has been rewarding for me. It is time to move on. My successor, Dr. Erin Carson, is working diligently to ensure that her year will continue the success and growth that we've had in the past several years.

Our board has grown tremendously with many individuals eager to participate with the SAGD and the CAGD.

SSAGD's future is certainly bright!

Pacific's Stockton AEGD residents attending a SSAGD study club dinner meeting held at the 33rd Street Bistro in East Sacramento

SSAGD 2012 OFFICERS

President: Howard Chi
President-Elect: Erin Carson
Secretary: Maryam Saleh
Treasurer: Smita Khandwala
Immediate Past President: Sireesha Penumetcha

Dr. Kevin Kurio, Dr. Alan Golshanara and Dr. Eric Wong reviewing study materials during a SSAGD study club dinner meeting also held at the 33rd Street Bistro

FellowTrack South ✶ Lunch and Learn

University of Southern California

DR. GOLDASICH

CHERYL GOLDASICH, DDS, FAGD, *CAGD Advisor, Herman Ostrow School of Dentistry of USC*

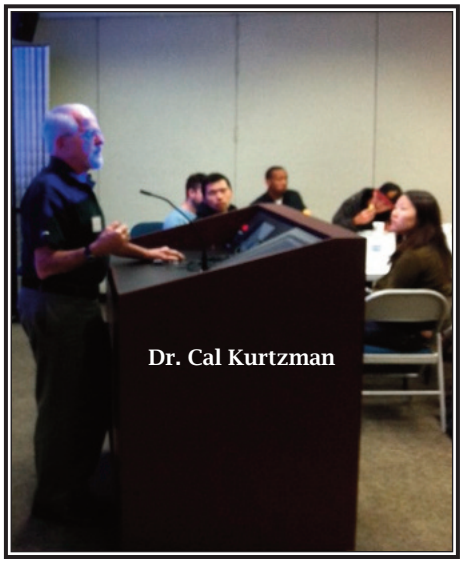
The USC FellowTrack program has been very active this year. We started out with an orientation last Fall and have since had five "Lunch and Learns" as well as an all-day implant workshop. Implant workshops are, by far, the most asked for by students. The most recent implant workshop had twenty-eight USC students as contrasted with two at from UCLA. Students have asked for practice management, oral surgery and even "what to do when we get out of here." Last March was "March Madness." It seems to have become a tradition at USC, where we had a "Lunch and Learn" every Friday during the month.

Students are currently discussing the events they would like to have for the Summer 2012 trimester. It is an exciting program and it is my ongoing pleasure to work with such motivated students. I see them transitioning into active, full members of the AGD and continuing on to achieve their Fellowship over time.

I am pleased and very lucky to be able to work with Dr. Garfield on the FellowTrack. He submits the student AGD numbers to "National" and keeps track of how many CEs have been achieved by FellowTrackers.

We are now an official club of the University of Southern California. Because of this, USC has been paying for most of our activities and I have not used up my FellowTrack stipend from the CAGD. ❑

Dr. Cal Kurttzman speaking about starting private practice



Dr. Cal Kurtzman

Especially attentive students

Academy of General Dentistry's

FellowTrack

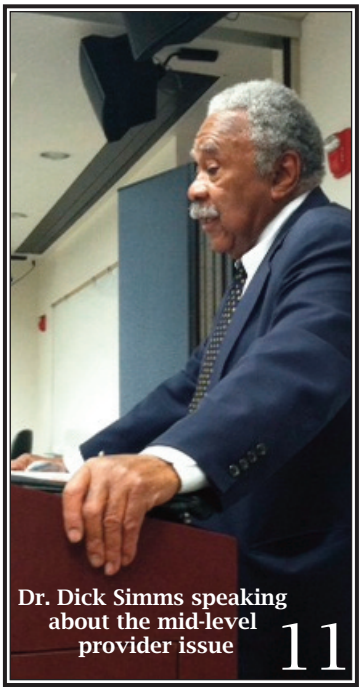
"LUNCH AND LEARN"

at the

Herman Ostrow School of Dentistry

of the

University of Southern California



Dr. Dick Simms speaking about the mid-level provider issue

Northern California AGD Update

Chitra Shikaram, DDS, *Editor, NCAGD, Campbell*

The Northern California Academy of General Dentistry presented two participation courses in November and December of 2011. These include a Social Media course and a PerioProtect Certification course. All classes were held at the Sobrato Center in San Jose.

Edward J. Zuckerberg, DDS, FAGD, presented "Social Media and Your Dental Practice: Strategies for effective Online Marketing." During the four-hour course, Dr. Zuckerberg helped create a Facebook page for Dr. Shanthi Madireddi's practice. He walked the participants through step-by-step, helping them create a Facebook page for their respective practices. Dr. Zuckerberg shared the many benefits of using social media, while sharing his own Facebook page as an example. Key features included practice growth by attracting new patients, reactivating old patients, maintaining relationships with existing patients, and new ways to motivate current our patient base. In addition, how to boost revenues during slow months, etc.

Dr. Zuckerberg maintains a private practice in New York. His son, Mark, is the founder and CEO of Facebook, Inc. The attendees were given a $50 gift voucher from Facebook to use toward their professional Facebook page. The course was sponsored by NetIP, DemandForce, Henry Schein, Smile Reminders, and Comcast. The co-sponsors were the NCAGD and Advocates for Access, Inc.

The PerioProtect Certification Course was presented by Duane Keller, DDS, founder of the PerioProtect Therapy program. This lifetime certification in PerioProtect method was offered to the AGD and non-AGD members for a special discounted rate. Dr. Keller explained the science behind oral biofilms, periodontal pathogens, how they cause refractive periodontal disease, and influence the presence of systemic diseases. Attendees learned how to manage periodontal disease and decrease unfavorable oral microbes using PerioProtect, in conjunction with non-surgical therapy. Dr. Keller speaks extensively nationwide. The course was sponsored by NetIP, DemandForce, Henry Schein, Smile Reminders, and Comcast. The co-sponsors were the NCAGD and Advocates for Access, Inc.

Duane Keller, DDS, founder of the PeripProtect Therapy program, speaking

The Northern California AGD Board for 2012:

Dr. Craig Crispin, *President*
Dr. Mina Levi, *President Elect*
Dr. Ralph Hoffman, *Treasurer*
Dr. Kinnari Ghia, *Secretary*
Dr. Chitra Shikaram, *Editor*
Dr. Shanthi Madireddi, *Immediate Past President*

We would like to remind all our members to look us up on Facebook. We request that you "Like" the California AGD.

Dr. Mike Lew, Dr. Edward Zuckerberg, Dr. Tim Verceles, Dr. Chitra Shikaram, Thorn, Dr. Shanthi Madireddi, Dr. Brian Chun

Dr. Shanthi Madireddi, 2011 President of the NCAGD with Dr. Duane Keller, Founder of the PerioProtect Therapy program

NCAGD President's Message

Craig D. Crispin, **DDS**, *President, NCAGD, Point Reyes Station*

Under the strong organizing and administrative skills of our Past-President, Shanthi Madireddi, the NCAGD began 2012 with a new Board in place, ready to start the agenda for the year.

In January, the NCAGD sponsored our first course, "How To Be a Success in Dentistry" at the Hyatt Regency Hotel in Monterey, California. Five seasoned AGD members made presentations and shared their experiences and advice. Forty dentists attended the course which was made possible by the generous sponsorship by HiOssen *(see ad on page 6),* Henry Schein and Delta Dental.

Our second program, held in March, was an excellent presentation by Dr. Harry Albers, entitled "Esthetic Dentistry and the Latest Materials." The venue was the UCSF and was combined with FellowTrack North for dental students. Almost 100 dentists and students attended, with generous sponsorship by HiOssen *(again)*, Henry Schein and Image Dental Studio.

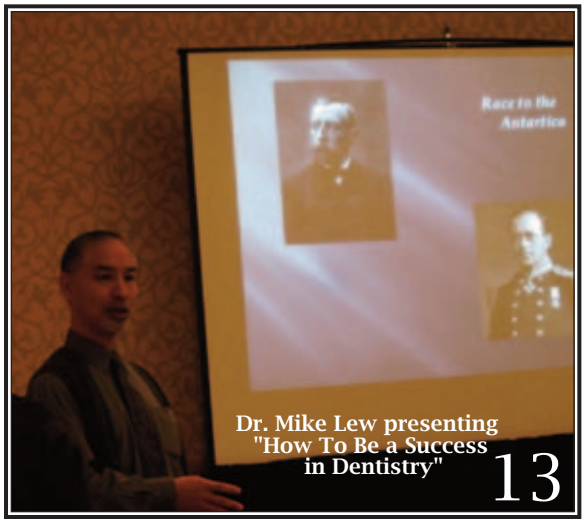
Our first face-to-face Board meeting followed with sixteen members and student-leader guests for dinner. A networking discussion was held afterward.

Our third program was in April, again at the UCSF, and was combined with FellowTrack North. Forty dentists and students attended "Keys To Your Practice Success." JoAnne Tanner, MBA; Haden Werhan, CPA; and Jernnifer Ellis, attorney, presented current legal, good practices and ethical advice for practice management to the attendees.

On behalf of the Board of the NCAGD, I thank attendees and sponsors for allowing the NCAGD to provide excellent continuing education courses for 2012. *Watch for our future course offerings.*

Participants keenly listening to Dr. Zuckerberg as he shares the various benefits of Social Media

Drs. Mina Levi, Chitra Shikaram, Mehtab Sadrameli, Dinu Grey, Craig Crispin, Sun Costigan, Harry Albers and Shanthi Madireddi, and Rich Ringrose



Dr. Mike Lew presenting "How To Be a Success in Dentistry"

Dental Workforce Size in California *(continued from page 2)*

The above numbers show a significant rate of growth of our dental workforce. Credit for this growth goes in part to the new pathways for dental licensure including licensure by credential and licensure by residency. Ten years ago, the average yearly number of new dental licenses issued in California was closely tied to the number of graduates from the five California dental schools, approximately 520. With the addition of a sixth California dental school, plus approval of the dental school program at the Universidad De La Salle Baijo, the yearly licensing total has increased.

In 2011, the Dental Board of California issued **982** dental licenses, **up from 520** in 2002. That number will continue to increase due to strong demand for increasing slots for California's PGY-1 residency pathways. There has also been a rapid increase in the number of large FQHC-approved Community Clinics, often utilizing Dental Residents who, on successful completion of their one-year residency, qualify to apply for licensure. The FQHCs or clinics are located in underserved areas. The Dental Hygiene Committee of California (DHCC) issued a total of **790** Hygiene licenses from 4/11 to 4/12 and their **rate of licensing** more than compensates for increasing population figures.

The California Office of Statewide Health Planning and Development (OSHPD) has a system for assessing the **dental workforce** that vastly underestimates that workforce. OSHPD converts the number of selected dentists to **Full-Time Equivalent (FTE) dentists**. To arrive at one FTE dentist, General Dentists and Pediatric Dentists are counted and their hours of providing clinical practice are added then adjusted. There is a formula to reduce the weight of older dentists to account for less productivity. A dentist who works four out of five days is eight-tenths of a dentist. If the General Dentist refers out procedures to a Specialist such as an Endodontist, Orthodontist, Oral Surgeon, Prosthodontist, Periodontist or a dental school, those hours don't count. In fact, no other dentists or providers count except General Dentists and Pediatric Dentists. If you are a specialist in a field other than Pediatric Dentistry, your clinical hours don't count in the workforce count. The hours worked by Hygienists don't count. Also on the no count list are Full-time Faculty, Residents, Students and Indian Health Service Dentists. There is even an adjustment regarding the number of assistants a dentist employs. What all this means is that data used in calculating the FTE dentist is incomplete and/or does not exist (may be estimated), and yet such suspect data is factored into the number and the ratio is published. Without verifiable and accurate data, the FTE may not be reliable.

For those of you who want to learn more about how OSHPD calculated FTE, go to the following link to see a power point presentation by OSHPD.

http://www.oshpd.ca.gov/HWDD/pdfs/app/4-RatioofDT.ppt

OSHPD is supposed to collect workforce data and disseminate information about California's healthcare infrastructure. The last detailed study done by OSHPD on the Dental Workforce was in 2002, and in that study they stated that the estimated dentist-to-population ratio was one full-time equivalent dentist to 1700 Californians. OSHPD projected that the number of FTE dentists would stay about level or drop by 2012. OSHPD made two ten-year projections based on two scenarios:

Scenario 1: The number of FTE dentists stays the same for ten years resulting in a ratio of 1(FTE) to 2000, *and*

Scenario 2: Number of FTE dentists declines resulting in a ratio of 1 to 2350.

By 2012, the opposite occurred. The number of dentists **increased more than predicted.** OSHPD is an important part of our state government, but they did not predict the major legislative changes that vastly changed our workforce numbers in a positive direction. The link to their study is:

www.oshpd.ca.gov/HWDD/pdfs/AB668Rpt.pdf

Since the OSHPD study in 2002, I know of no other detailed study on Dental Workforce with updated ratios of Dentists to Californians or Dental Workforce to Californians. There have been several updated maps of California showing underserved areas, however the sources of the information *(raw data)* is not verifiable.

CONCLUSION: ***The numbers of dentists, dental hygienists and dental assistants have outpaced projections and have outpaced population growth in California. OSHPD's dental workforce predictions have proved inaccurate. The existing dental workforce is adequate to address dental access. Other factors, not addressed here, are responsible for barriers to care.***

Disclaimer: Dr. John S. Bettinger is the immediate past-president of the Dental Board of California and is currently a Board Member. His opinions are his personal opinions only and are not necessarily those of the Dental Board of California. He is also in full-time general practice in Santa Monica. He can be contacted at: jbett256@aol.com

2012 Ski and Learn Held at Park City

PARK CITY PHOTOS BELOW AND ON THE PAGE THAT FOLLOWS

Dental continuing education and festivities mix very well at the SCAGD-WSP Ski Seminars. Our 2013 Ski and Learn Seminar will be held in Aspen-Snowmass, Colorado, February 9th through February 16th, 2013. *See details on the following page.*


An old silver mine near a ski trail


Brunch Break


Ski Luxury


Brunch on the Slope


Lori Anderson


"CE" Credit Time


Mountain Lunch


Dicussion of Wine and Caries


Lunch-up and Ski


More "CE" Credit


Jin Kim Family at Dinner


Welcome Wine and Cheese Event


Welcome Wine and Cheese Event

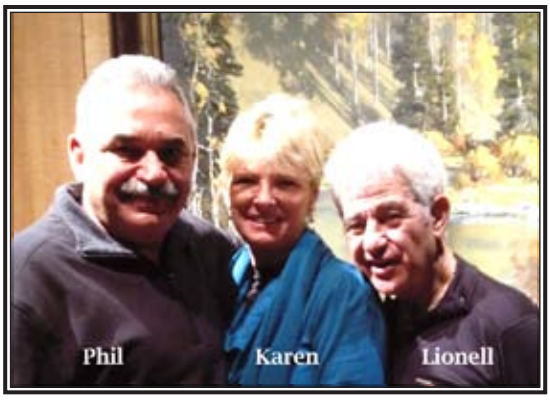

Hotel Lobby

California Academy
of General Dentistry
2063 Main Street, PMB 418
Oakley, California 94561-3302

Presorted Standard
U.S. POSTAGE
PAID
Concord, California
Permit No. 530

Ski and Learn *(continued from previous page)*


2012 Park City Skiiers


Phil Karen Lionell

Ski 2013 with the SCAGD and the WSP for the Lowest Fee in the Ski Industry


Martha *"Ski.com"* Perez, Don and Jan


Phil Mendelovitz
Linda Osborn

Our Thirty-third Annual Winter Ski Seminar will be held from Saturday, February 9 through Saturday, February 16, 2013 in Snowmass Village near Aspen, Colorado, sponsored by the Southern California Academy of General Dentistry and the Western Society of Periodontology.

The package includes:

- Round-trip airline from LAX directly to Aspen
- Ground transportation from Aspen to Snowmass lodging
- 7 nights lodging at Top of the Village Condominiums
- 5 days of skiing at all mountains in Aspen and Snowmass
- All taxes, Welcome Reception, Farewell Banquet and NASTAR race
- 16 units of CE credit for full attendees

Estimated cost per person for the seven-night total package is $1699 *plus* $255 for dentists or medical personnel who wish to partake in the continuing education units to make the package a business expense. *This is the top value in the educational ski seminar industry.*

For more information or to register please contact either:

Robert Garfield, DDS, *Executive Director, SCAGD* drrobertgarfield@aol.com 310-471-4916
Martha Perez, *Group Sales Manager* mperez@ski.com 818-802-0373