

The Compass

Staying the Course Through Service and Education



Volume XIV, Issue 3, Fall/Winter 2012

January 2013 CALAOMS Meeting Dedicated to Dr. Gerald Gelfand

The CALAOMS Board of Directors has dedicated the January 2013 CALAOMS Meeting at La Quinta Resort to Gerald Gelfand, DMD. There is no one more deserving of this CALAOMS honor than Dr. Gelfand.

Jerry graduated from Rutgers University in 1967 and The University of Medicine and Dentistry of New Jersey—New Jersey Dental School in 1971. He completed his oral and maxillofacial surgery residency at Michael Reese Hospital and Medical Center in Chicago in 1974. Following residency, Jerry spent two years of active military duty in the U.S. Air Force as Chief of oral and maxillofacial surgery at George Air Force Base in Victorville, California. He has practiced in Woodland Hills since 1976, and has volunteered tirelessly his entire career for the betterment of dentistry and oral and maxillofacial surgery. Jerry has been an important figure in helping to guide California and national dental and oral and maxillofacial surgery organizations for many years. His counsel has been sought by many in these organizations because of his clear and logical thinking, his mild manner, his



flawless integrity, and his willingness to work and follow through with projects.

Recognizing the importance of oral and maxillofacial surgery being a specialty of dentistry, Jerry has—throughout his career—participated in leadership positions in both organized dentistry and oral and maxillofacial surgery. He has helped bring the perspective of occasional opposing viewpoints to the table to help resolve conflicts—to the benefit of all. Among the many leadership positions held by Jerry over the years include: President of the San Fernando Dental Society, CDA Trustee, Delegate to the CDA House of Delegates, Chairman of the CDA Council on Legislation, Chairman of the CDA Screening Committee, Cal-D-PAC Board of Trustees, Delegate to the ADA House of Delegates, ADA Council on Government Affairs, President of the Southern California Society of Oral and Maxillofacial Surgeons, President of the SCSOMS Foundation, Chairman of SCSOMS Anesthesia Committee, President of California Association of Oral and Maxillofacial Surgeons, President of the CALAOMS Health Foundation, Chairman of the CALAOMS Risk

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Richard E. Anderson, MD, FACP
Chairman and CEO, The Doctors Company

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Editor's Corner



Jeffrey A. Elo, DDS, MS
Editor of the Compass

More Health Law Changes Coming in 2013—Know Your Plan

Health care reform is here to stay—for the foreseeable future. So for the millions of Americans with health insurance at their workplaces, this season's "open enrollment" period will be one of the most important in years.

2013 will see some of the many significant changes brought on by the Affordable Care Act, including easy-to-read plan summaries and caps on flexible spending accounts. The ability of health insurers to place limits on annual spending is also on its way out, while earlier reforms such as adding adult children to their parents' plans offer new options to consumers.

Most of the really big changes—including health-insurance exchanges and tax credits to help people buy coverage—aren't coming into play until 2014. Still, the provisions going into effect in 2013, along with

those that have already been introduced, can affect any changes you might want to make to your own health coverage.

"This year's enrollment season is really the calm before the storm of health-plan reforms that will come in 2014," says Tom Richards, Cigna's president in charge of reform implementation. "There's some uncertainty among employers because of the political dynamics they are watching, nevertheless they continue to move ahead to implement the changes that were part of reform."

Here are five things you need to know as you sift through your own or your office's plan options over the next few weeks.

1. HIGHER PREMIUMS

First, the bad news: You will likely be paying higher premiums next year, with 13% of companies planning to raise their employees' contributions to health-care costs by five percentage points or more, and 42% planning premium increases of one to five percentage points, according to a July survey of employers by benefits consultant Towers Watson. Some good news: The pace of that growth is slowing. Employer health-care costs are expected to rise by 5.3% in 2013, compared with 5.9% this year, according to the survey.

Premium increases have been held down thanks to the requirement that insurers give rebates to consumers if insurers spent less than 80% of premiums on medical care. Some 13 million consumers got rebates worth \$1.1 billion this year, according to the Obama administration.

2. STRAIGHTFORWARD SUMMARIES

The most visible change in your packet of insurance options for 2013 is a new (required) form called a "Summary of Benefits and Coverage." The summary is meant to be a simple, easy-to-read description of how a plan works; what it covers and doesn't cover—there

is no fine print allowed. Every health plan must have one, allowing you to compare two different plans side by side. The form also will include examples to show you what each plan would generally cover in some common medical situations.

3. FSA LIMITS

For 2013, the amount you can put into a workplace flexible spending account will be capped at \$2,500. Previously, the limits, if any, were set by the employer. FSAs let you set aside tax-free money that can be used to pay for qualifying out-of-pocket expenses, such as copayments for doctor visits and prescriptions. It can't be used for premiums. Keep in mind that if you don't use the full amount that you set aside, you will lose it. So it's important to estimate your out-of-pocket expenses wisely.

4. DEPENDENT COVERAGE

Dependent coverage has gotten a boost from the health-law provision allowing many adult children up to age 26 to remain on their parents' policies. Keep in mind that a few plans were grandfathered in—or exempted from the requirement—when the provision was enacted, if they made minimal changes to their existing design. Also, be aware that companies are often not eager to pay for additional dependents if they aren't required to do so or if the insured has other options, such as a spouse who already has coverage as well.

5. HIGHER SPENDING CAP

If you suffer from a chronic or costly medical condition, it may come as some relief that annual limits on how much an insurer will pay for care will be going up next year—and on their way out—for many plans. For 2013, the cap rises to \$2 million, from \$1.25 million this year. The cap goes away entirely in 2014. Before the health-care law, health plans could set an annual limit on how much they would spend on your covered benefits. Still, despite the higher limits, insurers can still limit services that aren't considered "essential." ●

Continued from page 1

Management Committee, Co-Chair of CALAOMS Council on Government Affairs, CALAOMSPAC Board of Directors, Delegate to the AAOMS House of Delegates, and current CALAOMS Long-Term Delegate to the AAOMS House of Delegates, Chairman of OMSPAC Board of Directors, Chairman of AAOMS Committee on Governmental Affairs, and current President of the Western Society of Oral and Maxillofacial Surgeons.

Jerry was the recipient of the 2009 CALAOMS Distinguished Service Award and the recipient of the AAOMS 2010 Presidential Achievement Award in Oral and Maxillofacial Surgery for his work in the political and governmental affairs arena.

In addition to the many organizational leadership positions held by Jerry and running a successful private practice these many years, he also found time to volunteer at the UCLA School of Dentistry, Department of Oral and Maxillofacial Surgery teaching residents and students about our specialty. Jerry also volunteered at the Los Angeles Free Clinic. He also coached Little League for the L.A. County Department of Parks and Recreation for over 20 years. Jerry received the Woodland Hills Small Business Person of the Month Award by the Woodland Hills Chamber of Commerce in 1993.

I first met Jerry in 1993 when we served together as rookies on the Board of Directors of the Southern California Society of Oral and Maxillofacial Surgeons. It has truly been my great honor to have him as my close friend all these years and to watch him serve our profession and his community with great distinction. Congratulations, Jerry, for all that you do and have done for us; this is an honor well-deserved!

by P. Thomas Hiser, DDS, MS
Past President, CALAOMS

President's Message



*W. Frederick Stephens, DDS
President, CALAOMS*

As Time Goes By

Growing up, my elders always told me that as you get older, time would seem to accelerate at an ever-increasing rate. Well, I am beginning to realize the truth in this concept more and more, especially after a recent birthday. For example, it seems that it was just a few months ago that I began my 2012 term as CALAOMS President, and now I am writing my last President's Message. In spite of several important and time-consuming issues that came to our Board this year, my tenure has somehow passed quite rapidly for me. In retrospect, this also seems to be coming true of my professional career.

Through my tenure with the CALAOMS Board, I have evolved to understand our position as one that not only represents our members, but also protects our specialty in California from a seemingly endless onslaught of issues which constantly threaten the way we practice. These issues come not only from outside our specialty as might be expected, but also more and more from within our profession of dentistry.

As an example, at the very beginning of this year we were faced with an important issue concerning the development of mid-level providers to treat children in California. This issue (which is supported by the CDA) has been legislatively tabled for the time being but is likely to once again appear in 2013 and will consume more valuable time and funds from our specialty. As another example, a returning bid to recognize a specialty of dental anesthesia within the profession of dentistry was stopped at the ADA House of Delegates in October, but required significant energy from our specialty at national and state levels to defeat. This issue will also most definitely reappear sometime in the future.

For most of us, our specialty of Oral and Maxillofacial Surgery has changed significantly over the years. When I completed training in 1985, my practice immediately became a full scope practice with major reconstructive surgery and trauma being the bulk of my surgical care. Dentoalveolar surgery and dental implant reconstruction was a smaller part of my practice scope at that time. Now 27 years later, major reconstructive surgery and orthognathic surgery has become a smaller and smaller part of my practice, with dentoalveolar surgery and dental implant reconstruction increasingly dominating my schedule. I am sure this is true now for many of our members, whether you are beginning your career or you are one of the "older dogs" in our specialty.

Our venue and model of practice is also rapidly changing. I have practiced my entire career as a private practitioner; sometimes solo, and currently with an associate. Recent data reported by our current ADA President Dr. Bob Fiello stated that "corporate dental practice" currently involves 2.9% of all dental practices, but predictions suggest that this number will rise to 15% as early as 2015. This implies that the private practice as we understand it may become a rarity in the future and perhaps even eventually become extinct. In addition, a decreasing trend in dental utilization began in 2005—before the economic downturn. This means that our services are (seemingly) in less demand for, perhaps, more than economic reasons.

Currently, itinerant specialty practice is increasingly pervading dentistry and is raising issues about the quality and continuity of patient care across all dental specialties. This model of practice, which spawned from various economic stresses, also encroaches into and negatively affects the established specialty practice model. Oral and Maxillofacial Surgery is especially affected with respect to the safe delivery of anesthesia services in nonpermitted offices. As a result, these offices are not equipped or prepared to adequately provide safe anesthetic care or manage anesthetic emergencies. Any such adverse outcomes occurring in these nonpermitted offices will affect all of our practices negatively and reflect poorly on dentistry.

Itinerancy also creates issues of inappropriate patient coverage in the absence of the specialist. Coverage by "unqualified" general providers in the absence of the specialty provider can (potentially) place a patient somewhere below the "standard of care" for these specialty services. We all understand that specialty care is not only about the performance of a specific specialty service, but also includes appropriate pre- and post-procedural care. Certainly, if a general provider is not qualified to provide the specialty service, they then in turn are not qualified to provide pre-procedural consultation or post-procedural care and the management of complications. If we as a specialty are to allow this model of practice to exist, parameters for its safe practice must be established and, most importantly, regulated.

Oral and Maxillofacial Surgery also has an image problem. Many lay people and even our fellow dental professionals still do not seem to know who we are or what we do. This is apparent when a patient accepts the performance of surgical procedures by the general practitioner. The generalist may initiate the treatment, but the patient—who simply does not know the difference between the generalist and the specialist—ultimately accepts it. The patient, therefore, needs to be educated to understand the difference in a specialist's education, skill, and experience when accepting such care. The state of Utah has had good results with

marketing and educating directly to the public about our specialty. This may be a concept that we as a specialty need to revisit. If not, Oral and Maxillofacial Surgery will become increasingly marginalized.

Finally, the elephant that recently entered the room and will be here for a long time is the Affordable Care Act. The effects of this confusing and questionably wise legislation are yet to be fully appreciated. Oral and Maxillofacial Surgery may or may not be heavily affected, but it certainly will have effect on the future of our practices and our reimbursements, and probably our patient's access to our specialty care.

These are just a few issues which are currently affecting our specialty and will be on the agenda for our current and future specialty leaders. So how do we deal with these and other issues potentially affecting our practice and specialty? First, we certainly need to be vigilant and proactively recognize the issues. Second, having friends and relationships in the appropriate places is also important. This, unfortunately, is the way the game is played and requires funding. This can be done through our political action committee (CALAOMS/PAC) and is the only way we can effectively enable any change at the legislative level. In addition, research, which will result in better patient care and establish Oral and Maxillofacial Surgery as the leaders in the field, is also necessary. This can be done through contributions to our Oral and Maxillofacial Surgery Foundation. The problem is that very few in our specialty contribute to these entities. This must change. Third, we need a constant flow of new, energetic, and interested leaders both at the state and national levels. Without these committed people, new ideas to adapt to the changing field we play in will be more difficult. As result, I urge you to step up to the plate and get involved!

The health of any organization certainly is based upon the number and quality of its membership, but the direction of the organization is dependent upon a group of strong leaders who can make wise and insightful decisions for the betterment of the organization. I have been quite fortunate to work with such

a group of professionals who have made my position as President much easier this year. Our Board is an example of the leadership I referred to above. CALAOMS is fortunate to have such a diverse group of professionals volunteering their time for the betterment of our specialty, and I am privileged to have had the opportunity to benefit from their guidance. I am sure that your President-Elect, Dr. Alan Herford, will

continue to lead CALAOMS into the future with great insight and wisdom.

In spite of my tone, the future for Oral and Maxillofacial Surgery remains bright, but we must continue the fight. Thank you for all your support this year. It is greatly appreciated.

American Board of Oral and Maxillofacial Surgery

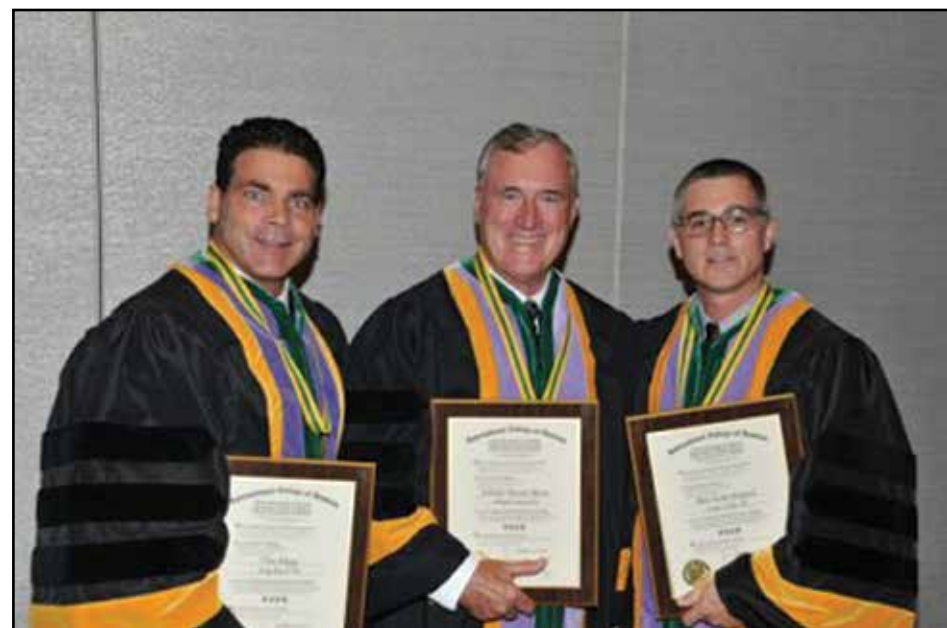
In the Summer 2012 issue of the Compass, we published a list of our members that just completed their certification to become a Diplomat of the American Board of Oral and Maxillofacial Surgery. Due to an oversight on our part, we inadvertently left a member off that list. We would now like to take this opportunity to recognize and congratulate that member.

Congratulations *Todd Sumner DDS, MD*

Congratulations, Fellows!

CALAOMS would like to congratulate Dr. Tim Silegy (CALAOMS Board Director), Dr. Charles Hasse, and Dr. Alan Herford (CALAOMS President-Elect) for their recent installation as Fellows in the International College of Dentists. Membership (Fellowship) in the International College

of Dentists is by invitation only, an honor bestowed upon those dentists who have made significant contributions to the profession, the community, and their families, and have successfully completed a thorough peer review process. Congratulations on jobs well done!



Pictured left to right Dr. Tim Silegy, Dr. Charles Hasse, and Dr. Alan Herford

NEW REQUIREMENT for Licensed Dentists (Effective November 28, 2012)

Notice to Consumers of Licensure by the Dental Board

On November 28, 2012 a new regulation, required by Business and Professions Code Sections 138 and 1611.3, will go into effect requiring licensed dentists engaged in the practice of dentistry to provide conspicuous notification to consumers that dentists in California are licensed and regulated by the Dental Board of California. The notice is required to be prominently posted in a conspicuous location accessible to public view on the premises where the dentist provides the licensed services. The notice is required to be in at least 48-point type font and include the following statement and information:

NOTICE TO CONSUMERS
Dentists are licensed and regulated
by the Dental Board of California
(877) 729-7789
www.dbc.ca.gov

**TITLE 16. PROFESSIONAL AND VOCATIONAL
REGULATIONS**
DIVISION 10. DENTAL BOARD OF CALIFORNIA
CHAPTER 2. DENTISTS
ARTICLE 9. MISCELLANEOUS

**Section 1065. Notice to Consumers of Licensure by the
Dental Board.**

(a) A licensed dentist engaged in the practice of dentistry shall provide notice to each patient of the fact that the dentist is licensed and regulated by the Board. The notice shall include the following statement and information:

NOTICE TO CONSUMERS
Dentists are licensed and regulated by the Dental Board of
California
(877) 729-7789
www.dbc.ca.gov

(b) The notice required by this section shall be provided by prominently posting the notice in a conspicuous location accessible to public view on the premises where the dentist provides the licensed services, in which case the notice shall be in at least 48-point type font.

Note: Authority cited: Section 1614, Business and Professions Code. Reference: Sections 138 and 1611.3, Business and Professions Code.

FREQUENTLY ASKED QUESTIONS

Where should the signage be posted?
The notice shall be provided by prominently posting the notice in a conspicuous location accessible to public view on the premises where the dentist provides the licensed services, in which case the notice shall be in at least 48-point type font.

How do I comply if my practice setting is not a traditional dental office?
Dentists are responsible for the implementation of this regulation. This means you must make sure, regardless of practice setting, that the regulation is being complied with. Probably, the easiest way is to make sure the necessary sign is posted in an area where patients are likely to see it, e.g., waiting room, discharge location.

Are there any exceptions to the requirement?
There are no exceptions to this requirement.

Must disclosure be made in other languages?
No.

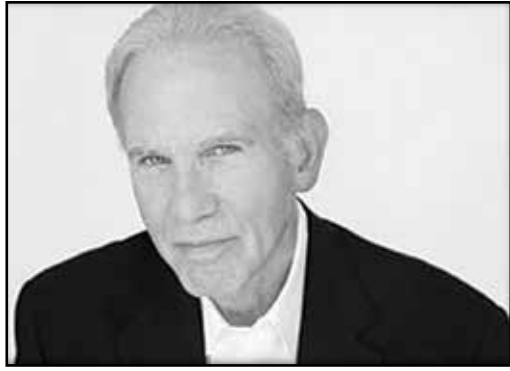
Can I post the sign or provide the wording for the permissible options in another language?
Yes. Although the sign or other permissible notification must be in English in order to meet the requirements of the regulation, we encourage you to provide that same sign or information in other languages as well if it will better assist your patient population.

Does the regulation apply to hospital and clinic settings?
Yes. Again, this regulation applies to every location where dental work is practiced in California, and that includes hospitals, nursing homes and dental clinics. It is the responsibility of the dentist who practices there to see that this regulation is complied with.

Does the dentist's name have to be disclosed along with the other, mandated information?
No. The only information required is the exact language in the regulation.

Are we still required per Business and Professions Code, Section 1700 (c) to display the name of each person employed in the practice of dentistry?
Yes. The new regulation only refers to the Notice to Consumers of Licensure by the Dental Board.

If a California dentist is offering dental services outside of California, is he/she required to provide this notice to out-of-state patients?
No, the Dental Board of California only has jurisdiction over what occurs in California.



Q AND A WITH DR. MARC B COOPER

by Jeffrey Elo, DDS, MS

I have been reading Dr. Cooper's blogs for several years now and he has been a prior contributor to *The Compass*, so I decided to ask him a few questions that may be on all of our minds regarding practice trends taking place within oral and maxillofacial surgery (OMS).

Dr. Cooper, where do you think OMS is going? Do you feel like it is moving in the direction of the system in England where there are Oral Surgeons (essentially exodontists) and Oral and Maxillofacial Surgeons—those doing the “big” cases, which are fewer in numbers and are more hospital-based?

Dr. Cooper: Yes. In the next decade or so, dentistry will “tier out” as it has in the U.K.; actually, in all European countries. There is strong evidence to support this assertion.

The context (paradigm) has shifted and is no longer “fee-for-service.” Fifty-seven percent of employees in the U.S. have some form of dental (insurance) benefits. Eighty-plus percent of this

fifty-seven percent *actually seek* dental treatment. PPOs dominate the landscape which is a total game-changer. So, like the NHS (National Health Service) in the U.K. that controls reimbursements, here in the U.S. we have 3rd parties. In the U.K., eighty percent of the dentists practice within the NHS system. I believe the same thing will happen here.

The system has shifted. In the “old” system, the patient was the decision maker and the provider (dentist) was the driver. In the old system, the purchaser (employer or government) was passive; as was the payer (3rd party). In the new system, the provider and patient are passive; and the purchaser is the driver while the payer is the decision maker.

Corporate competitors can do dentistry for less than solo practitioners or small specialty groups with their more favorable economies of scale, purchasing power, negotiating power, greater efficiencies, greater marketing, and ability to recruit new dentists and graduating residents with their heavy debt load. Corporate, as a model, can operate much more efficiently in the new context and the new system. The fastest growing segment in dentistry is “Corporate.”

The Exchange Programs and the Accountable Care Organizations, both part of the Affordable Health Care Act, will have direct influence on dentistry and certainly increase the patient pool for exodontia. Additionally, Senator Sanders’ “Comprehensive Dental Act” will increase the patient pool for exodontia if the law gets enacted. But the fees for exodontia will be tightly controlled.

Dr. Elo: *If an OMS does not participate in these larger groups, would you foresee GPR-trained exodontists working with dental anesthesiologists to provide the care that traditionally has been provided by the OMS?*

Dr. Cooper: Yes, of course. Eighty percent of dentists are GPs, unlike medicine where that ratio

is the opposite -- 80 percent of physicians are specialists. Check out the CE programs – they aren't geared to specialists. They are given *by* specialists to GPs. Your customer is turning into your competition.

Dr. Elo: *When recruiting a partner about six years ago, I knew a colleague who found it difficult to find a surgeon who wanted to participate in a full-scope practice which included ~100 trauma cases a year. All that the new grads wanted to do was, as he said, “teeth and titanium.” The “titanium” practice is crowded now with GPs placing and misplacing a lot of implants. Where are we going?*

Dr. Cooper: There are several paths OMSs can take in the future.

Become highly premier so that you are sought after by dentists to work on the most difficult cases; ones they can't possibly handle. That means presentations at conferences and study clubs, writing articles...generating a personal brand. It's a tremendous amount of work and only a few will be able to reach this “premier” status. But it is an option.

Seek an MSO/DSO that matches your core values and become their resident OMS.

Create a group of OMSs that will be itinerant and go to dental offices to do your work.

Work for entities like Clear Choice.

Dr. Elo: *I know that our membership, at this point, is screaming and shaking their heads loudly at the text in front of them, as am I. Are the changes that have taken place in the dental workplace reversible, or is there hope that we can get back to the “traditional model” of dental practice?*

Dr. Cooper: The changes that have occurred in the dental industry are irreversible. The soufflé

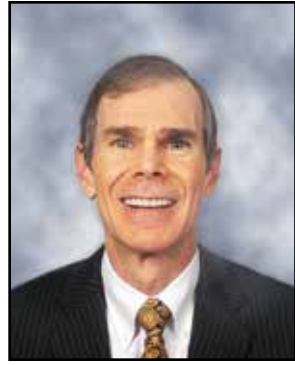
can't be put back in the oven – it's baked. You need to play the cards you are dealt and stop living in hope. OMSs have enormous talent and that is a valuable asset. Reposition this asset so it is transferable.

There are many choices now for OMSs. Investigate the choices available, look at which ones will allow your assets to appreciate, and choose where to go.

Caveat – We see the future as MSOs and DSOs, so we are producing a conference on the roadmap of how to build a DSO and an MSO. www.dental-summit.2013.com

Dr. Marc Cooper's professional career includes periodontist, private practice, academician, researcher, teacher, practice management consultant, corporate consultant, coach, trainer, seminar director, futurist, board director, author, entrepreneur, and inventor. His consulting company has been in existence since 1984. Dr. Cooper's client experience includes numbers of health care entities, from numerous solo private practices to a large hospital system, from Silicon Valley start-ups to Fortune 500s. His weekly blog has readers in 31 countries.

Dr. Cooper works with clients throughout North America with a few select clients in Europe, New Zealand, Singapore, and the U.A.E. Dr. Cooper has studied with masters in numbers of disciplines, participated in formal business educational programs, worked as an independent contractor with several top flight consulting companies, and developed a suite of online business assessment tools. Dr. Cooper has authored six books, two of which are top sellers in his field, *Mastering the Business of Practice and Partnerships in Dental Practice*. Recently, Dr. Cooper was recognized a master coach by being selected as a coach for the prestigious TED Fellows Program www.masterycompany.com



by Richard Boudreau, MA, MBA, DDS, MD, JD, PhD

Treating an Expanding Population and Medical Malpractice: A Doctor's Point of View

INTRODUCTION

One of the inevitable consequences of Obama's Affordable Care Act is that millions of Americans who did not have access to health care in the past may be seeking care, and physicians and medical facilities will have to address the needs of growing patient populations. From a physician standpoint, this growing population poses a number of issues, including care management, increasing workforce needs, increasing costs, and the potential for an increased number of malpractice lawsuits. This last issue, the problem of medical malpractice and the increase in the cost of malpractice insurance, has many physicians debating the viability of their practices in light of expanding costs.

One of the immediate assumptions is that a growing patient population will result in an increased number of malpractice claims. Malpractice claims

more frequently extend from the treatment of patients requiring significant levels of care and often reflect the impacts of a lack of primary care that results in the onset of illness. In assessing the views related to both malpractice and increasing patient populations, physicians also need to balance off the cost savings that may result from patients obtaining preventative care, living healthier lifestyles, and not requiring complex treatments that are more likely to foster malpractice claims.

A GAP IN REFORM

Obama's health care reform measures were designed to address the needs of the generally underserved in this country, including a large population of people who do not have access to health care services on a regular basis. The uninsured and underinsured in this country were the basic focus of the reform measures, with the belief that health care costs could be reduced significantly by implementing methods by which health care services could be paid and individuals could seek preventative care. The measures were implemented in order to increase access to quality health care while reducing costs, but the lack of a clear directive for reducing medical malpractice costs left physicians feeling like they were left out of the reform process. Physicians have called for a number of legislative measures, including reductions in liability limits as a means of addressing the financial costs of healthcare across the board. Excessive awards, high costs of premiums for malpractice insurance, and identified high-risk populations have influenced the decision-making of many physicians, especially in light of healthcare reform changes.

Though reform measures have been proposed, researchers have indicated that physicians still fear the impacts of malpractice claims, including claims that can alter their capacity to continue their practice. The Patient Protection and Affordable Care Act of 2010 (PPACA) will have a significant impact on the decision-making of many practicing physicians. The Act is likely to affect the coverage of about 32 million Americans, resulting in millions of added

patients who require services. If all other variables remain unchanged, an influx of patient populations would result in an increase in the number of malpractice claims that are made and this would create a considerable burden to practicing physicians. Medical malpractice claims more frequently arise from surgical procedures or more complex treatments, but medical errors can occur at every level of care. One of the gaps in health care reform is to reform medical malpractice laws, creating some response to the issue before the problem fully manifest. Rothstein maintained that there is an increase in populations will lead to an increase in injured patients, and even balancing for potential improvements due to preventative care, physician errors leading to malpractice claims may not significantly decrease. Attempts to predict the behavior of injured patients in the new healthcare environment would be impossible to assess, but there is some evidence that these behaviors would not change significantly. The underlying reason is that regardless of the type of injury or the reason for the injury, people seeking malpractice lawsuits generally have reasons to attempt to sue for monetary damages that can include the need for money for long-term care; the need for continued medical care, the desire to deter future errors, and the need to mitigate for lost earning potential and lost livelihood. Often, patients have reported the decision not to file a malpractice claim even when admitted medical mistakes have occurred, based on a number of factors, including how they were informed about the error.

DROPS IN MALPRACTICE RATES

Another significant factor that may help to reduce concern about medical malpractice in a growing population is that national statistics suggest that malpractice cases have decreased in the last decade. This means that the number of payments made for physicians by their malpractice insurers have decreased, even though some findings suggest the overall payout per case has increased. Some of the factors that have generally led to a reduction in the number of claims include an increased diligence to reduce medical errors and increased preventative care services, which lead

to fewer cases of long-term problematic health issues that can result in complicated treatments and surgeries in which medical errors are more likely to occur. In some cases, though, the number of case filings has decreased because physicians are less willing to work in areas and with populations that are at higher risk of filing medical malpractice claims. These findings suggest a need to consider broader reaching legislative changes that reduce the claims or reduce the cost of claims in order to maintain the directive for access to care inherent in the PPACA.

REFORM MEASURES

A major issue noted by physicians is that while health care reform has focused on methods of reducing costs while improving services, medical liability has gone relatively unaddressed, even though this is one of the major issues impacting costs. There is a "striking contrast to its prominence in previous federal health policy debates," and the malpractice insurance "crisis" which has led to expanding costs across the board. The call for linking medical liability reform with health care reform is based on the belief that these two issues are inextricably linked and that physicians who are responsible for caring for the growing population of people accessing health care should be able to manage their costs more effectively through reductions in liability insurance payments.

Specific reform measures have been proposed, including disclosure-and-offer programs, administrative tribunals, and "safe harbor" options. Disclosure-and-offer programs are one approach to reform for malpractice that has fueled considerable debate. These programs are designed to support transparency and allow physicians to identify medical errors that have occurred while also providing a settlement offer in order to reduce the need for expensive lawsuits and protracted processes that result in exorbitant claims. The advantages of this kind of system is that it would promote transparency, improve reporting of medical errors, and reduce the volume of lawsuits, while also reduce the adversarial nature

Continued on page 16

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January 19-20, 2013

RESIDENTS' NIGHT PRESENTATIONS (NORTH)
January 30, 2013

RISK MANAGEMENT (SOUTH)
February 20, 2013

RISK MANAGEMENT (NORTH)
February 27, 2013

ACLS SPRING
March 16, 2013

ANNUAL MEETING
May 4-5, 2013

RESIDENTS' NIGHT PRESENTATIONS (SOUTH)
September 11, 2013

ACLS FALL
October/November, 2013 - TBD

MEDICAL EMERGENCIES (NORTH)
November 6, 2013

CONTINUING EDUCATION AND GENERAL MEETINGS

2013 Anesthesia Symposium

JANUARY 19-20, 2013
La Quinta Resort & Club, La Quinta, CA

SATURDAY TOPIC: "Meeting Today's Challenges in Anesthesia for Oral and Maxillofacial Surgery"
SPEAKER: Andrew Herlich, DMD, MD, FAAP

SUNDAY TOPIC: "Office-based Ambulatory Anesthesia: Benchmarks and Outcomes"
SPEAKER: Thomas B. Dodson, DMD, MPH

SUNDAY TOPIC: "Laryngeal Mask Airway's (LMAs) as a Routine Airway"
SPEAKER: Frank L. Pavel, DMD

Residents' Night Presentations (North)

JANUARY 30, 2013
Holiday Inn Hotel & Suites, Oakland Airport

TOPIC: Orthognathic Surgery

CALAOMS/The Doctors Company

Risk Management Seminar (South)

FEBRUARY 20, 2013
Marriott Burbank Airport

CALAOMS/The Doctors Company

Risk Management Seminar (North)

FEBRUARY 27, 2013
Holiday Inn San Francisco Airport

ACLS Spring

SATURDAY, MARCH 16, 2013
Solano Community College, Suisun

13th Annual Meeting

MAY 4-5, 2013
The Westin San Francisco Market Street

SATURDAY TOPIC: "Creating Natural Soft Tissue Emergence Profiles Around Dental Implants in the Esthetic Zone through the Immediate Restoration/Loading of Dental Implants at Placement"
SPEAKER: Paul S. Pettrungaro, DDS, MS

SUNDAY TOPIC: "Social Media Marketing Success Strategies for Oral and Maxillofacial Surgeons"
SPEAKER: Rita Zamora

Residents' Night Presentations (South)

SEPTEMBER 11, 2013
Location to be determined

Topic: TBD

ACLS Fall

OCTOBER/NOVEMBER 2013 (TBD)
Solano Community College, Suisun

Medical & Anesthetic Emergencies in the OMS Office (North)

NOVEMBER 6, 2013
Location TBD

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• Please note that the complete OMSA course is scheduled to be offered online in 2013. Visit the Home Page of the CALAOMS website for updated information.

• The Dental Board of California will host the Calibration Training courses as Webinars in 2013. Dates to be determined.

• We invite you to visit our website for current, up-to-date information on Continuing Education course offerings and to register online at: www.calaoms.org/events

• TBD = To Be Determined

Continued from page 13

of the malpractice process. The disadvantages is that this type of program would probably be opposed by trial lawyers because it would reduce their role, and it would involve risk for health care providers because of the immediacy at which providers would have to inform their patients of the errors that occurred and the reasons for those errors. In addition, these programs have not had proven outcomes in relation to the program's success in reducing costs.

Another type of reform is the use of administrative or specialized tribunals, rather than a court-based legal process, which would reduce the costs involved in litigation. The advantages include an increase in the predictability of the process and the use of specific guidelines designed to reduce conflicting testimony. Because the tribunal would be conducted by medical professionals, it would place the error within a context and evaluation process that would improve understanding and reduce costs. At the same time, this type of approach may also be opposed by trial attorneys who would lose work, and it might be opposed by patient groups who may feel that this type of process unfairly supports the physician. Subsequently, this type of procedure might also be brought into question on the grounds of its constitutionality in terms of the right of the individuals to the trial process (Mello & Brennan).

Finally, researchers have outlined the claims of "safe harbors" in which physicians who adhere to evidence-based practices can maintain the value of this kind of knowledge. This is perceived as a method of promoting physician dedication to research and practices of evidence-based care and could result in improved outcomes relative to the costs of malpractice suits. The disadvantages are that physicians may not use this kind of approach and costs may continue to skyrocket. Of the three potential areas of reform, this is the least likely to show immediate benefits in reducing the cost for a growing patient population.

STATE REFORMS

Though states like Texas and California have applied reform measures to issues of medical malpractice, and have had some success in capping the costs involved, there are issues with doing this on a state-by-state level. Specifically, if some states implement malpractice liability reform, including caps on liability levels as a means of increasing the number of doctors who work in that state, they may actually increase the risk of malpractice by attracting high risk physicians. In other words, state-by-state reforms of liability insurance, including caps for malpractice suits, can result in a movement of high-risk doctors to states where reform measures have been put into place. When addressing the needs of a growing patient population in specific areas, states like Texas have implemented reform to address this growing population. This seems like a lose-lose proposition, though, with increasing patient numbers and increasing high-risk doctors being matched together, thereby increasing the overall chances that malpractice will occur. Researchers have maintained that there is a statistically significant increase in the number of high-risk physicians in states that have implemented malpractice liability reforms. This is one of the underlying reasons that physicians have championed liability and malpractice reform measures at a national level.

CONCLUSIONS

There are two essential questions that must be considered when evaluating the call for malpractice reforms and the issue of a growing population of patients seeking health care services under the PPACA: 1. Does research support a link between the increased population and increased malpractice suits? 2. If reform is necessary, should it be applied at a state or national level? These two questions are at the crux of the debates and underscore the need for greater discourse on this issue.

First, the assumption cannot be made or easily supported that simply because there will be increased numbers of patients nationwide, that there will be

an increase in the number of malpractice cases. In fact, increasing use of preventative medicine and the decreased need for interventive and surgical procedures could continue to support the decline in malpractice suits that has already been noted in the research. Second, even if reform measures are perceived as a necessary part of maintaining a lower average of malpractice claims per capita, there is generally little consensus about how this type of reform should be implemented. States like Texas have introduced tort reform measures and methods of capping malpractice suit outcomes, but these efforts may result in more claims, rather than fewer. Critics argue that in the absence of a federal mandate for malpractice reform, states with reform measures in place will see an influx of high-risk physicians and potentially have to bear the brunt of increasing malpractice suits.

Clearly, there is still need for additional discourse and research into the issue, but the flawed assumption that the PPACA will immediately result in increased malpractice suits and increased costs for care may never come to fruition. In fact, it is likely that over the next decade, malpractice suits may continue to decrease and this may correspond with the increasing access to preventative care services. In the meantime, physicians and health care facilities can make their own decisions about implementing methods to reduce malpractice, including individualized reform measures. Physicians and health care facilities, for example, can implement disclosure and offer approaches in which physicians are encouraged through administrative directives to disclose medical errors when they occur and work with internal counsel or hospital administration to determine what kind of offer can be utilized as a means of reducing the potential for malpractice suits. Assessing how this kind of approach can be introduced would be an essential part of hospital/primary care office planning. Though reform in medical malpractice was not a part of the current PPACA, the identification of the potential problem and the introduction of debate may serve as a foundation for additional national reforms in the future.

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Viewpoint: A Letter to the Country from an Emergency Physician

by Michael E. Jacobson, DO

(This letter was reprinted with permission from the author and publication; its views and opinions represent those solely of the author and not CALAOMS); Emergency Medicine News. 34,(11A): 1 November 2012. doi: 10.1097/01.EEM.0000422901.91264.53

Dear America,

I am an emergency physician with an apolitical message in this rather politically charged, polarized time in our country. I have worked for some time in this profession, and have noticed a disturbing trend about which I must speak out — the growing number of emergency department scenarios in which the selfishness and entitlement of those without real emergencies drown out the quiet suffering of those in real need.

This morning a middle-aged woman came into the emergency room in cardiac arrest. ACLS was performed to keep her alive. Other patients were in the ED before she even arrived, certainly with what they felt were emergencies, but treatments for these individuals were placed on hold as this event took precedence. After 75 minutes of continual heroic measures and life-saving interventions, with her grief-stricken husband crying, holding her hand for the last time, and stroking her face, she died.

This was no movie, no reality TV show. This was as real as it gets. Real life and real death. Family huddled around the bed to say their

goodbyes and wished they or we could have done more.

I walked to my office, emotionally drained and exhausted, and from across the emergency department another patient, upset that she had to wait, spoke out brashly in tones that carried to every room in the department. “I know someone’s dying and all, but I am in real pain here.”

What most of America don’t know is the emergency department staffs are graded with a nationally-based report card by hospital administration. A survey is sent only to those who are discharged from the ED, not to those who actually needed admission to the hospital for an emergency

Now everyone is equal, everyone is the same — the broken physically, the broken emotionally, the broken spiritually, the broken psychologically, and even the broken culturally.

or to those, like this new widower, whose loved one passed. This survey is a customer service tool used to see if people like coming to our ED and asks whether we did a good job. The ED staff know this survey is skewed because of the population to which it is sent, and certainly it is not the only tool hospital administrators use to evaluate us. That is another topic for another time.

But you must understand, the real emergencies are rarely graded or surveyed; they only go to those vast hoards of folks who were sent home, many of whom did not get their narcotic medication refilled, like Ms. “I’m-in-real-pain-here” who screamed her needs for all to hear, just within earshot of a new widower.

Mitt Romney recently was secretly taped speaking to his party base about the 47 percent

of the nation that feels entitled to health care, to homes, to handouts, and to ever-present help from the government. If this lady represents that 47 percent, I have a few things to say.

The widower and his wife were also in need of care and financial aid. They came to the hospital for emergency care and received it. He was gracious about it, even when the scenario ended in a way he did not want. He and his family were thankful for the care. They will not be asked how they felt the care was, but screamer lady will be. It is doubtful that screamer lady would have been happy short a lifetime supply of narcotics, free ambulance rides, meals, and immediate gratification of all perceived needs. In fact, she and her friend raided the refrigerator for food and beverages without asking permission of staff or being cleared for eating or drinking prior to her labs and tests returning.

This widower and his family behaved in a way that acknowledged that there were others in the ED. They realized a limited but adequate number of doctors and staff were available. They were calm in the face of a real emergency, but never acted as though the world should stop for them, even though it ended tragically. They knew how to play fair even though their real emergency was not fair.

We live in a society that David McCullough Jr. describes as rewarding mediocrity because everything fairness and equality. Everyone is special, so nobody is. Everyone should get a prize for participating. And even though Johnny didn’t win, we’re going to give him a trophy for trying because he is special, too. Competition is bad because there is a winner and loser, and that’s not fair. This fundamentally wrong notion breeds false equality and ultimately false fairness and entitlement. We do no one a favor by preaching this. We are lazy parents if we can’t find a constructive way to celebrate the winner and help our children be happy for him. Instead, we have chosen an easier road: to

make all things fair and equal. If nothing can rise above, be more important, or be first, then all must be mediocre. If all must be fair and equal, all will assume the position of being just as important and just as entitled as everyone else despite the real emergency or the real need.

The government mandates I evaluate and treat everyone who steps foot in our emergency department, regardless of the ability to pay or the acuity of the complaint. The government has passed health care legislation that makes it so everyone must have insurance. Now everyone is equal, everyone is the same — the broken physically, the broken emotionally, the broken spiritually, the broken psychologically, and even the broken culturally. Many have primary care doctors, but they storm the ED at 2 a.m. with the Burger King entitlement of having it their way rather than waiting for their own doctor to see them the following day. They will demand to be treated equally regardless of the acuity of their emergency. And you know what? They will probably get it because we don’t want a bad report card from the feel-goods upstairs intent on establishing great PR or the lawyers who will use government mandates to take away your pain and make the other guy pay.

Were I to say something to screamer lady about her behavior, she likely would fall back on the clichéd finger-pointing canard, and say, “You’re a doctor. You are well off. You don’t understand. You can’t relate. And you are the one responsible for the high cost of health care. It’s your fault.”

As a young, married medical student, my family and I participated in Medicaid because having insurance was a requirement for my rather expensive medical school. I felt grateful, not entitled, to be able to sign up for the program. I know poverty in America because I lived it for a decade despite help from family. Government programs can help for a time. But know this, I spent my high school years working on grades and homework and at a job. I went to four years of college, working on grades

and a job. I went to four years of medical school working on grades and leaning on the government for help, which I am now paying back. Then, I worked four years as a resident on call, on 12- or 36-hour shifts with just enough sleep to go back and start again. Now I work. And I work. Work and making good life decisions result in prosperity. No one — I repeat, no one — becomes prosperous on government programs. Student loans, food stamps, Medicaid, and unemployment benefits are there to help temporarily, but for heaven's sake, government aid is not a right and living your life like you are entitled to eternal government care is not right.

Anyone who wants to can go to school for 12 more years after high school and work, incur student loan debt, drive a 14-year-old car for 12 years, and study (while passing on TV, movies, parties, conversation, family life, sleep, and eating to study some more). They can then make a living that buys a nice home, clothes, insurance for family, and, hey, a new car. Anyone who can work can do this. And I'm all for government help for those who, through no fault of their own (and not their poor choices), can't work.

This woman, however, would reach into my pocket and take my hard-earned money while tapping impatiently on my watch to give her more of my immediate time and attention when others need it more, still claiming I am a cold-blooded heartless rich guy intent on robbing her of all the government assistance that is her due while simultaneously stiffing the hospital for what she considers an unconscionable medical bill. I am not cold-blooded or heartless, just tired and beat from the work I do and proud and gratified that I can do it. The same is possible for anyone here in the land of opportunity.

Are we so far gone as a society, in the name of popular progressivism, that we now don't view work as something to be valued, specifically when the work requirement is removed from the welfare bill? Are we so far gone as a nation that we vilify

someone for their hard-earned wealth and elect a national leader who believes in taking that away to pay for those who would act as drains and not aquifers to the national pool of prosperity? Have we developed a national mindset that makes it normal to expect others to take care of us?

I think we develop a self-absorption that is callous in the face of anyone else's need when we rely on the government to handle our every need. No respect. No decency, no restraint, no responsibility, and no apology for it.

Frankly, our government cannot fix this, they cannot mandate a solution to this, and they cannot legislate against this. Nor should they. The solution to selfishness and entitlement can only be fixed with a mother and father (who know how to model character) teaching a child that work is hard and rewarding, that life is not fair and never will be, and that the freedoms you enjoy in this life are because someone else paid the price. Get up and get fixing.

Sincerely,

Michael E. Jacobson, DO

AUTHOR INFORMATION:

Dr. Jacobson is a graduate of Kansas City University of Medicine and Biosciences and the emergency medicine residency at Henry Ford Macomb Hospital in Warren, MI. He lives with his wife and four children in Omaha, NE.

CALIFORNIA CORRECTION HEALTHCARE SERVICES SOON TO OPEN AN INVITATION FOR BIDS

The California Correctional Healthcare Services (CCHCS) is in the process of developing an Invitation for Bid (IFB) for Oral Maxillofacial Surgery Services for patient-inmates/wards housed at the 33 California Department of Corrections and Rehabilitation (CDCR) adult institutions and three juvenile facilities located throughout the state of California. The IFB has not yet been advertised for bidder's response, but it is anticipated to be advertised sometime shortly after the first of the year. When the IFB is released for advertisement, it will be listed on BidSync.com for a minimum of ten (10) business days. Once advertised, all contractors/providers who meet the qualifications specified in the bid documents are encouraged to submit a response. The response submittal instructions will be specified in the IFB.

In order to be notified of the release of the upcoming IFB for Oral Maxillofacial Surgery Services, you must register with BidSync. Registration is free and done by logging on to www.bidsync.com. BidSync is an application that all California state agencies are required by the California Department of General Services (DGS) to use to advertise their bids. If any of your information changes from the date you register, you will need to log in to www.bidsync.com to make updates as necessary. The system attempts to notify individuals/companies when a bid is released for the type of services indicated during registration. However, being registered in BidSync is not a guarantee of notification and it is ultimately the individual or company's responsibility to check BidSync.com regularly to see all bids currently advertised, and to check on any addendums issued to the original bid solicitation.

Provided below are the registration instructions for BidSync.

Go to www.eprocure.dgs.ca.gov

Click Access eProcurement (eP)

Login to your registered eProfile with your BidSync user name and password

Click the Tools button

Under Account Profile Setup:

- click Regions: only California should be checked.
- click Notifications: Include BidSync Links Plus Bids in my Bids of Interest email and Send me exclusive offers and promotions should be checked Never.
- click Agency Types: only State should be checked.

If you have any questions regarding the BidSync registration please contact DGS, for any bid solicitation process questions for Oral Maxillofacial Surgery services, you may contact me at the phone number provided below, or via e-mail at Stacie.Kincaid@cdcr.ca.gov.

2013 January Meeting and Anesthesia Symposium

Friday, Jan. 18 - Sunday, Jan. 20, 2013

Saturday Topic: "Meeting Today's Challenges in Anesthesia for Oral & Maxillofacial Surgery"
Speaker: Andrew Herlich, DMD, MD, FAAP



"Office-based Ambulatory Anesthesia: Benchmarks and Outcomes"
Speaker: Thomas B. Dodson, DMD, MPH

Sunday Topics

"LMA's as a Routine Airway"
Speaker: Frank L. Pavel, DMD



CALAOMS Launches "Value Added Program" As a Benefit of Membership

In August 2012, CALAOMS added a new benefit of membership, "The CALAOMS Value Added Program." CALAOMS has established a group purchase program through McKesson Medical Corporation, tailored to the OMS practice.

CALAOMS members are able to purchase items listed in the program formulary at discounts ranging from 5% to 50%. The program features on-line medical supply ordering, cost management programs, and weekly updates on Rx Medication status. This program is offered exclusively to CALAOMS and its members.

By now you should have received a flyer in the mail outlining this program. If you did not receive

the flyer you may contact CALAOMS to find out more, or better yet, go to www.calaoms.org and look for the "Value Added Program" link.

To take advantage of the program, all you will have to do is setup a "Ship To" account under CALAOMS' parent account. You will then be able to make purchases online and pay for them with your credit card.

Members who took part in the pilot program were able to see average savings of 27.5% on their purchases. Enough to recoup your annual CALAOMS dues in as little as a few months.

Do yourself a favor and look into this program!



Risk Management Corner

Damage Control: Dealing with Online Patient Complaints

By Susan Shepard, MSN, RN, Director, Patient Safety Education, The Doctors Company, and Lois Kemp, MA, RN, Director, Patient Safety Intervention Program, The Doctors Company

Although the Internet provides a plethora of useful information, it becomes problematic when patients post unfavorable opinions about medical or dental care providers and/or their services. It is very difficult to prevent negative comments from being posted to a blog or online message board. It can be equally difficult to obtain a retraction or have a negative comment removed once it has been posted.

Even if you can find the person posting the negative comments and persuade him or her to stop, the existing comments remain in the public domain and might even be perpetuated inadvertently or intentionally by others. As we have all come to appreciate, it is difficult to completely eradicate comments once they are on the Internet.

THERE IS NO EASY REMEDY

The Doctors Company frequently receives requests from members asking for information on how they can hold patients accountable for posting negative comments. It is common for providers to ask for insurance coverage or want an attorney to pursue a defamation case—even though no malpractice is involved.

If you are considering pursuing a defamation suit, you might need to retain private counsel to assist you. Proving damages and recovering them from a former patient can be a difficult and expensive undertaking.

Keep in mind that many lawyers are not interested in prosecuting these types of claims. Both federal and state courts have repeatedly held that individuals and Internet service providers are protected by the First Amendment in exercising their right to free speech.

Some medical or dental care providers hire reputation management companies. The companies might promise to remove negative posts, but this claim can be misleading. It is more likely that the search engine results will simply be manipulated to move the posts further down in the result pages.

FEEDBACK CAN BE CONSTRUCTIVE

One study indicated that 88 percent of the comments posted about health care providers are positive.¹ The remaining 12 percent may appear disproportionately hurtful and vindictive, but negative feedback also creates an opportunity for a provider to become a better practitioner or improve the practice.

Consider conducting your own research to determine how the negative comments have affected the practice. Have patients left the practice? Is the patient load decreasing? Do patients call about or comment on the negative posting? Answering these questions will provide reliable evidence to help you determine if there are areas within your practice that could be improved.

PATIENT SAFETY TIPS TO HELP YOU GUARD YOUR REPUTATION

- Discuss with all new patients your commitment to answering their questions and keeping them informed.
- Allow patients to have a voice by conducting patient satisfaction surveys. Discuss the survey

results in regular staff meetings, and address any patient concerns.

- Consider posting in the patient reception area or treatment rooms select survey results and your actions to improve.
- Ensure that you and your staff communicate with patients and family members in a respectful and friendly manner. When patients have a positive experience with the practice, they are likely to tell others, and when patients in a community consistently rave about a medical or dental provider, negative postings tend to lose their intensity.
- Consider sending a letter to new patients after their first visit, thanking them for choosing the practice and hoping to see them in the future.
- Do not respond to a negative post. Responding might draw more attention to it.
- If you want to write off all or part of a dissatisfied patient's fee, contact your malpractice insurer for help evaluating the situation from professional liability and compliance standpoints.
- If there is any demand for money from a dissatisfied patient, contact your liability carrier immediately.

ADDITIONAL RESOURCES

For more about blogs and rating and review sites, read "The Internet: Friend or Foe to Physicians" under Communication at www.thedoctors.com/articles.

A sample patient satisfaction survey is provided in the Additional Resources section at www.thedoctors.com/patientsafety.

Avoid potential liability risks associated with new technologies by visiting the Electronic Health Record and Telemedicine Resource Center at www.thedoctors.com/ehr.

¹ Lagu T, Hannon NS, Rothberg MB, Lindenauer PK. Patients' evaluations of health care providers in the era of social networking: an analysis of physician-rating websites. *J Gen Intern Med.* 2010;25(9):942-6. Accessed September 28, 2011.



RAM
California



REGISTER NOW!

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CALAOMS Once again will work with RAM California in 2013 to provide care to the under and uninsured people in our state.

The clinic will be held in Coachella Valley at the Indio/Riverside Fairgrounds in Indio, CA on April 4-7, 2013.

This clinic is being hosted by the Goldenvoice a music concert promotion company who is responsible for the world renowned Coachella Music Festival. The clinic is being held one week prior to the start of the festival.

We are hoping for a large turnout of oral and maxillofacial surgeons, so please register today and volunteer a day or two of your time.

Upcoming 2013 CALAOMS CE Events

<p>2013 Anesthesia Symposium January 19-20, 2013</p> <p>Residents' Night Presentations January 30, 2013</p> <p>Risk Management February 20, 2013</p> <p>Risk Management February 27, 2013</p> <p>ACLS March 16, 2013</p>	<p style="text-align: center;">La Quinta</p> <p style="text-align: center;">Oakland</p> <p style="text-align: center;">Burbank</p> <p style="text-align: center;">San Francisco</p> <p style="text-align: center;">Solano</p>	<p>13th Annual Meeting Mar 4-5, 2013</p> <p>Residents' Night Presentations September 11, 2013</p> <p>ACLS Oct./Nov. 2013 - TBD</p> <p>Medical Emergencies* Nov. 6, 2013</p> <p>OMSA Online Classes - Status Still Unknown We will update the membership when we have more information in late winter.</p>	<p style="text-align: center;">San Francisco</p> <p style="text-align: center;">Southern CA</p> <p style="text-align: center;">Solano</p> <p style="text-align: center;">Northern CA</p>
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** The Medical Emergencies course will be alternating between Northern and Southern California Locations.*

Classified



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EQUIPMENT FOR SALE

Reduced! iCAT EXCELLENT CONDITION, used Next Generation Platinum with Extended Field of View. Includes monitors, Codonics medical printer and supplies. Warranty available and selling due to lack of utilization. Asking \$95,000. Please contact Frank A. Portale DDS at 209-481-9307.

REDUCED! RITTER SURGICAL TABLE, Model F-Type 75, \$500. Call Doug Fortney at 858-485-1783 or email doctorfortney@hotmail.com

BAXTER INFUSO.R. SYRINGE PUMP w/ Propofol Smart Label. Like new. New \$1800, Sale \$500. If interested, email roger.kingston@att.net.

PRACTICES FOR SALE

LOOKING TO PURCHASE an OMFS office in Southern California (LA and surrounding areas). Please email me at omfsbuyer@gmail.com if interested.

RIVERSIDE COUNTY, Oral Surgery Practice. Nicely appointed, 3 operatory oral surgery practice in a prime location with easy freeway access. The spacious facility is efficiently designed. A well trained, dedicated staff work with the oral surgeon and patients in this long established business. 2011 collections exceeded \$900,000. The seller is retiring. Contact Practice Transition Partners: (888) 789-1085, contact@practicetransitions.com, www.practicetransitions.com.

PREMIER ORAL AND MAXILLOFACIAL SURGERY PRACTICE available in a highly desirable and prosperous community of the San Francisco North Bay Area. Practice historically produces \$1.7 Million with excellent net income. Excellent opportunity for a new practitioner, or a seasoned professional wishing to build his or her professional career. If buyer wishes, owner will remain available on a regular basis to introduce to referring doctors, and to mentor the new owner, but will not be available to contribute any significant amount of surgical time due to disability. For additional details, interested parties please contact Jay M. Hislop, DDS, Esq., who represents the owner, at jayhislop@mac.com, or leave a voicemail message at 209-406-6314. A confidentiality and non-disclosure agreement will be required before release of practice information.

ASSOCIATE/PARTNERSHIP OPPORTUNITIES

CALIFORNIA, Full time position with opportunity for buy-in. Position includes two practice locations. Clear Choice Dental is located in San Jose and our private practice is located in beautiful Santa Cruz. Full scope practice specializing in Orthognathic surgery, implants and wisdom teeth. Please e-mail resume to Dr. George M. Yellich at gmyell@aol.com, or call Dr. Yellich at Clear Choice Dental (408) 556-9587, or Santa Cruz Oral and Maxillofacial Surgery at (831) 475-0221.

GREATER SACRAMENTO multi-specialty office seeks associate Oral Surgeon for 1 day a month to start; eventually trying to expand program to 2-3 days per month. Dental Practice has great modern facilities and equipment, with an experienced support staff. Please email CV to smiles4abetterlife@gmail.com or fax to 916-817-4376.

LOS ANGELES, Immediate opening in a busy, well-established Los Angeles-area OMS practice. Amazing opportunity for a hard-working and outgoing OMS to develop a successful career. We are seeking an associate who is passionate about their work and strives for excellence. Position will lead to partnership and/or practice buy-out. Please email jobopp@live.com with inquires.

NORTHERN CALIFORNIA Oral Surgery office north of the Golden Gate Bridge with easy access from Highway 101 seeks full time associate for this high-volume practice leading to buyout and/or partnership. Interested prospects should send a CV and cover letter to molinelli@aol.com or call Stephen Molinelli of Northern California Practice Sales at 650-347-5346.

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