ORACLE

NAPA–SOLANO DENTAL SOCIETY NEWSLETTER

June 2017

Inside This Issue:

Current status of CDA's major legislative issues and priorities

Updated May 9, 2017

Medi-Cal/Denti-Cal – Proposition 56 Funding. More than half of children and 33 percent of adults – 14 million Californians – now rely on the state's Medi-Cal/Denti-Cal programs for health care. However, there are not enough providers able to treat them, so patients continue to face significant barriers to care, including long delays for appointments, trouble finding specialists and traveling long distances to receive care. According to a recent state audit, more than half of enrolled children are not receiving any dental care; and the majority of counties have an insufficient number of Denti-Cal providers. The state's Little Hoover Commission also recently completed a review of Denti-Cal and called it one of state government's "greatest deficiencies" that has "thoroughly alienated the dental profession with reimbursement rates among the nation's lowest, an abundance of restrictive rules and reliance on outdated paper-

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From the President

An unusual scenario played out in our office a few weeks ago. May you learn from our misfortune. Don't be alarmed; this is not a story of physical injury.

Because I have a referral-based practice, it is not unusual to see a patient for only one procedure. A sense of the patient's personality and character are not developed as one might from multiple contacts over time. Complications do not usually arise.

A patient was referred through normal channels requiring initial endodontic treatment. The patient mentioned they were new to the area and spoke with an accent consistent with their home region in the United States. Examination and treatment proceeded without incident.

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As the patient was dismissed, a credit card was presented, we attempted to scan the card, and our terminal prompted an error message. The patient immediately said that they had experienced the problem before and that they had yet to inform their credit card company of their relocation. The patient suggested we call the credit card company, "the number is listed on the back of the card." With the credit card and out-of-state driver's license in hand, the credit card contact number printed on the card was contacted. The credit card representative asked staff, and patient through the staff, to verify the driver's license and other data and then walked my staff through entering a verification code on our credit card terminal to complete the transaction. The patient left after they advised us that a restorative appointment had already been scheduled with the referring office.

The following day, our merchant services bank (credit card payment processing bank) phoned stating a fraudulent transaction had occurred and that we would not receive payment for the sale — we had been scammed.

In discussion with our merchant services bank ("vendor"), local law enforcement (police), and law enforcement friends, what did we learn?

If there is a problem with a transaction, e.g., a card won't "read," call your vendor, whose number is typically listed on the terminal. Since they are responsible for processing the transaction and ultimately reimbursing you, they are responsible for the transaction. Follow their directions, and they are responsible. The patient's credit card company does not directly pay you. Think of it this way: Your vendor has to go get your money on your behalf.

Local law enforcement will take a report then apologize saying your dollar loss does not warrant an investigation.

We were scammed first rate! I can take solace in knowing we were No. 1 in something. An Olympic Gold Medal would have been preferred. It is quite unusual for a fraud to include a convincing out-of-state driver's license, a convincing fake credit card complete with a "Customer Service Number" printed within the typical text on the card back, and an appropriate-sounding credit card associate to answer the call and who knows how to instruct our staff on bypassing our specific terminal commands so that it looked like a legitimate transaction occurred.

Consider having a patient photograph as part of the chart record. Our "fake" patient was tall and blonde, but it turns out that the person the name belonged to was much shorter, brown haired, and lives in San Clemente. We have no way now to identify the person. Their address correlated with an Oakland warehouse district that is "out of the jurisdiction" of local law enforcement.

If there is a problem with a transaction, ... call your vendor, whose number is typically listed on the terminal.

Our patients can use password-protected registration and medical questionnaire documentation. They are advised that we have access to that information, and it is their choice if they wish to use that service under those conditions. Our law enforcement friends had us check that information. Let's just say the patient's password instructed us to a certain location in the afterlife. Our friends advised, "Oh, that's not good" – an immediate red flag.

Learn from our misadventure. Your bank vendor is your ally in such schemes. Staff felt bad the day of treatment, "What did we do to that poor patient's card?" Staff felt bad the day after — How could we have avoided the scam? This fraud was fancy, complex, but not all that different than being advised "I left my checkbook at home" followed by "Don't worry, I'll mail it in." That always makes me worry.

No one was physically injured, and it is a sunny day outside. Life goes on.

Trustee Report

Delta settlement: Average allocation will be $2,500

James Sanderson, DDS

The CDA Board of Trustees met on Friday, May 19, and Saturday, May 20, in Sacramento. The following key subjects were discussed:

DELTA SETTLEMENT

The following summary of events in the Delta settlement were provided:

April 21 – Order granting preliminary approval of proposed settlement

May 11 – Court-approved Notice of Proposed Settlement mailed to all class members

June 12 – Motion for attorney fees/service awards to be filed

June 26 – Deadline to opt-out or object (DO NOTHING to opt-in)

Aug. 31 – Hearing for final approval in San Francisco

Monetary settlement

There are 13,462 members eligible to receive allocations under the settlement. It is estimated that 7,263 will be allocated the minimum amount of $350. The remaining members will receive from $351 to $228,875. The average allocation will be approximately $2,500.

Delta letter

Providers are currently receiving amendment letters that include the following amendments:

- Fee Setting – Delta will control fees up or down. (Can file yearly.)
- Tax ID Numbers – If there are multiple dentists in one practice location, the rate of pay will be the lowest filed at that address/practice.
- Mechanism for Challenging Conduct – See contract.
- Contracted Fee vs. Submitted Fee – If a submitted fee is less than contracted fee, the lower fee could become new contracted fee.
- Notice – Delta is obligated to provide 120-day notice under Knox-Keene prior to lowering fees.
- Delta's FAQ document shows no current reduction in reimbursement fees.
- Effective date will be Sept.15

It is estimated that CDA's litigation with Delta Dental saved providers/members $500 million by not having fees lowered.

SILVER DIAMINE FLUORIDE

Dr. Jeremy Horst, a UCSF researcher, gave trustees an update on silver diamine fluoride. Currently, approximately 8% of dentists use it. SDF has been shown to arrest caries (~90%), prevent caries, and decrease dentin hypersensitivity. The downside is that it turns lesions black.

Billing codes

1354 – Caries Arrest
1208 – Topical Fluoride
9910 – Desensitization

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based administrative processes."

Last year CDA co-sponsored Prop. 56, a tobacco tax increase approved by 64 percent of voters that contained dedicated funding to improve access to care in the Medi-Cal program. Prop. 56 included language to increase Medi-Cal funding "by providing improved payments" for services that was meant to supplement, not replace, existing funding sources. Gov. Jerry Brown's recent 2017-18 budget proposal disregards this provision and instead directs these funds to pay for general cost increases in the program, simply adding more patients to the back of the line and maintaining the status quo. Medi-Cal reimbursement rates for dentists and physicians are among the lowest in the nation (lower than Alaska, Mississippi, Texas and West Virginia), failing to cover the cost of care and severely limiting their ability to serve Medi-Cal patients. As a result, the number of dental providers across the state has declined 16 percent since 2008; and a majority of counties have an insufficient number of dental providers, while the number of Californians enrolled has increased nearly 75 percent. CDA and the California Medical Association have developed a proposal that uses Prop. 56 funding as intended, to expand access and improve payments to providers by tying increased payments directly to increased access to care.

Health Care Reform. Over the past several years as the federal Affordable Care Act took effect, California created the country's largest and most robust state health insurance exchange (Covered California), which includes standalone family dental plans, and established the largest expansion of Medicaid program beneficiaries, resulting in the enrollment figures noted above. Approximately 20 percent of the state's current health care budget comes from increased federal funding under the ACA. Discussions in Congress continue on repealing and replacing the ACA, and CDA is working to protect California's current Medi-Cal funding at both the federal and state levels, to maintain state flexibility to provide coverage, to prevent erosion of networks, and to protect the overall dental safety net. Concerns about a rollback of the ACA have prompted efforts in the Legislature to insulate California from any federal action, including a proposal – SB 562 (Lara) – to create a single-payer government-run health insurance program for the state. CDA has numerous concerns with such a proposal, including lack of choice for providers and patients, and providing more coverage without the funding to ensure access to care, as is the case in the current Medi-Cal/Denti-Cal system.

Pediatric Dental Anesthesia. The use of general anesthesia during a dental procedure is necessary in certain cases, and California has long required a variety of safeguards, along with written informed consent of the associated risks. The Dental Board of California recently completed a review of existing state policies on pediatric dental anesthesia and issued a number of recommendations to improve patient safety, including creating new permit categories and additional training, further strengthening enforcement and data collection, and codifying specified personnel that must be present during the procedure. The Dental Board also recommended "that there be an analysis of the effects of any proposed new legislation or regulation on access to care for pediatric dental patients prior to the implementation of any changes." CDA is supporting SB 501 (Glazer), which adopts the Dental Board's recommendations and calls for a study from the board on cost and access implications of requiring a separate anesthesia provider during general anesthesia for children younger than 7. CDA is also supporting SB 392 (Bates), which also calls for this study and requires the board to develop a course on pediatric life support. We are continuing to monitor and work with stakeholders on the latest version of AB 224 (Thurmond), as amended by the Assembly Business & Professions Committee, which adopts many of the Dental Board's recommendations.

Dental Plan Reporting and Accountability. Californians deserve to know the value of their dental insurance plans and receive the same protections that apply to medical plans. Under the federal Affordable Care Act and current state law, all medical insurance plans must adhere to a medical loss ratio requiring at least 80 percent of premium revenue to be spent on patient care, as opposed to administrative costs. However, no dental loss ratio (DLR) standard exists for dental insurance plans. Prior to the enactment of CDA-sponsored legisla-

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tion in 2014 (AB 1962), dental plans were self-reporting spending as little as 38 percent of premium revenue on patient care. AB 1962 created a standardized reporting system for dental plans to annually and uniformly disclose how they spend premium revenue. The data reported for 2014 and 2015 shows a wide range of premium revenue spent on patient care, with the average DLRs ranging from 52 percent for individual plans, to 60 percent for small group plans, and 72 percent for large group plans. Some dental plans, however, fall as low as 10 percent; and these egregiously low DLRs raise serious questions about what value these plans provide to consumers for their premium dollars. CDA is exploring opportunities for establishing a suitable DLR standard for dental plans. While the state must be cautious moving forward at a time of great uncertainty around health care reform at the federal level and its impact on the health insurance market, dental plans ultimately need to be held accountable for providing adequate value to their enrollees.

Dental Waterline Infection Control – AB 1277 (Support). This legislation improves infection control safety in dental offices by changing the minimum standards to require water to be sterile or contain disinfecting or antibacterial properties when performing dental procedures that expose dental pulp. The legislation is a response to infections that recently occurred after treatment at a dental clinic, believed to have been caused by bacteria introduced through water used during dental pulp procedures. AB 1277 (Daly) sets a clear standard for infection control and establishes it as a standard of care within dentistry, and CDA is in support of the bill.

Kindergarten Oral Health Assessment – SB 379 (Support). A key goal of the state Oral Health Plan overseen by the dental director is to establish an ongoing oral health data collection system to assess needs and monitor progress statewide. CDA sponsored legislation in 2005 (AB 1433) to establish the Kindergarten Oral Health Assessment, which aimed to ensure a dental check-up for all children by the end of their first school year. Participating schools provide a form to students to take to their dentist, who will perform the assessment and send the form back to school with the student for the schools to report the data. Reorganization of K-12 funding has made the program optional. However, as the assessment can be an important data collection tool for the state, working in collaboration with the dental director, we have identified some changes to improve this tool. CDA is sponsoring SB 379 (Atkins) this year to: add "caries experience" (cavity history) to the reported data (this is currently collected in the assessments, but not reported), make on-campus assessments easier for schools to conduct by allowing passive consent for screenings (consistent with hearing and vision screenings), and streamline data analysis by directing schools to report data directly to the Department of Public Health.

State Office of Oral Health – Proposition 56 Funding. CDA's Access Plan to reduce barriers to oral health care prioritizes the need for a comprehensive state oral health program led by a state dental director. The state began providing ongoing funding for a dental director and office of oral health (based in the Department of Public Health) in the 2014-15 budget for the first time in decades; and Jay Kumar, DDS, MPH, was appointed to the position in 2015. Dr. Kumar came to California with more than 25 years of experience in the New York State Bureau of Dental Health, where he also held the position of state dental director and developed the first comprehensive state oral health plan for New York. During the past year, Dr. Kumar and stakeholders including CDA have been developing a state oral health plan for California, which includes objectives such as building community-clinical linkages, expanding access to water fluoridation and dental coverage, and developing programs that promote oral health literacy and healthy habits. These efforts will receive a strong boost from the passage of Proposition 56, which includes an annual $30 million for the state oral health program – a tenfold funding increase and the first time the program has ever had a dedicated revenue source. CDA is advocating for flexibility with the Proposition 56 funding that will allow the office of oral health to enter multi-year contracts and to contract directly with local entities.

For more information on CDA's legislative priorities, contact Todd Roberson at **todd.roberson@cda.org** or 916.554.4982 or Brianna Pittman at **brianna.pittman@cda.org** or 916.554.7340.

Silver Diamine Fluoride – Dentistry's Silver Bullet

Shukan Kanuga DDS, MSD
Board-Certified Pediatric Dentist
Editor, San Fernando Dental Society

Introduction

While most of us have heard about t from various sources, including patients/parents, some of us are still wondering what all the buzz is about. The use of silver in dentistry dates back to the early 20th century. Case studies of silver nitrate use date back to the 1800s in the literature; however, there was no mention of it in ADA Council on Scientific Affairs reports on Non-Fluoride Caries Preventive Agents or Managing Xerostomia and Salivary Gland Hypofunction. Silver nitrate application was sequentially combined with fluoride varnish in the past for caries arrest.

In 2014, the Food and Drug Administration approved SDF to reduce tooth sensitivity; and since April 2015, SDF has been available in the U.S. marketed as Advantage Arrest by Elevate Oral Care LLC (West Palm Beach, Fla). SDF (38% w/vAg(NH3)2F, 30% w/w) is a colorless topical agent comprising 24.4-28.8%(w/v) silver and 5.0-5.9% fluoride at pH 8-10. Currently, the use of SDF for caries prevention or arrest is off-label, similar to fluoride varnish.

Mechanism of Action

Caries arrest results because cariogenic bacteria are killed by the silver compounds with their antimicrobial properties, and colonization is reduced because the pathogens are unable to form a biofilm on SDF-treated dentinal surfaces. The fluoride ion facilitates remineralization with formation of fluorapatite from the original hydroxyapatite crystals. The insoluble crust, which forms after treatment, also serves as a fluoride reservoir for reducing the impact of acid challenges and increases dentin hardness.

Based on some randomized clinical trials, SDF appears to be almost twice as effective as fluoride varnish for caries arrest as it is unique in both killing the bacteria and hardening the teeth, thus both arresting and preventing caries. SDF presents the highest fluoride delivery system available at 44,800ppm of fluoride. The caries lesion stains black due to the release of silver oxide.

Following are clinical examples of its indicated application:

• A pre-cooperative child with early childhood caries (See **Figure 1**) who either is too young to undergo treatment under IV sedation or has parents who do not want IV sedation.

Figure 1. Early caries in a 14-month-old, and 6 months post SDF treatment, showing caries arrest.

SDF becomes a cost-effective and viable alternative to buy time in such a case in contrast to monitoring with frequent fluoride varnish applications combined with diet modification and improved home care, or even interim therapeutic restoration. Studies have shown that SDF-treated demineralized dentin is more resistant to caries bacteria than treated sound dentin.

• A special-needs or medically fragile patient who cannot undergo extensive restorative treatment in an office setting.

• A teenager with multiple interproximal caries lesions that would benefit from caries arrest prior to definitive treatment in the future.

• Hypoplastic molars with caries to reduce sensitivity prior to restoring the tooth.

Countless patients would benefit from conservative treatment of asymptomatic active carious lesions.

• Difficult-to-treat caries lesions such as those at a bridge margin or root caries.

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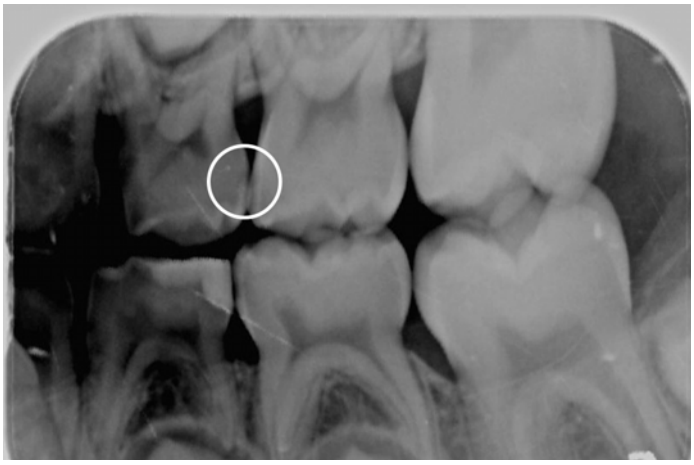

Figure 2. This caries lesion can be arrested by SDF application in a tooth close to exfoliation.

Figure 2 shows a caries lesion than can be arrested by SDF application.

Of course, SDF would not be the treatment of choice in deep caries lesions close to the pulp with symptoms of irreversible pulpitis as it is a pulpal irritant. It is being used either as a stand-alone treatment or followed by future restorations including resin modified glass ionomer or composite resins.

Application Protocol

The most effective treatment was 38 percent SDF twice per year, which led to a nearly 80 percent reduction in both caries progression and subsequent caries on treated teeth based on a review of multiple randomized controlled trials. The famous UCSF study published in the *CDA Journal* in January 2016, which brought SDF into the limelight nationwide, recommends twice per year application, only to carious lesions without excavation, for at least the first two years.

The CDT code for treatment is D1354 (Interim caries arresting medicament application)

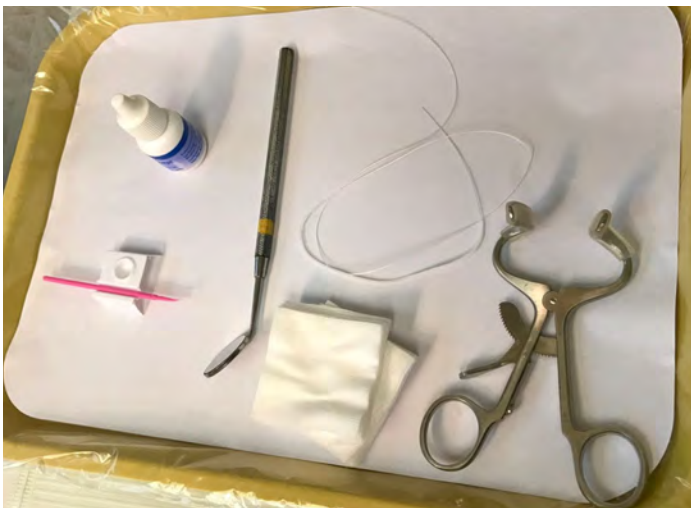

Figure 3. Clinical set-up for SDF treatment.

The Set-Up

Figure 3 shows the clinical set-up for SDF application.

Informed Consent

A thorough informed consent is the key to this treatment just like any treatment plan in dentistry. It is important for parents to understand that carious lesions will be stained black after treatment with SDF and that is an indication of the effectiveness of the treatment. Including pictures as visual aids helps reiterate and set the expectations correctly. While some parents may object to the black discoloration in their infant or toddlers' anterior teeth, the choice is to put up with the staining but control the disease or face the consequences of untreated progressive dental caries like abscesses and eventual extractions, and/or extensive treatment with sedation.

Figure 4 is a sample consent form, courtesy of the UCSF School of Dentistry, that you can modify for use in your own practice.

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Figure 4. A sample consent form. *Courtesy of UCSF School of Dentistry.*

UCSF Dental Center Informed Consent for Silver Diamine Fluoride

Facts for consideration:

- Silver diamine fluoride (SDF) is an antibiotic liquid. We use SDF on cavities to help stop tooth decay. We also use it to treat tooth sensitivity. SDF application every six to 12 months is necessary.
- The procedure: 1. Dry the affected area. 2. Place a small amount of SDF on the affected area. 3. Allow SDF to dry for 1 minute. 4. Rinse.
- Treatment with SDF does not eliminate the need for dental fillings or crowns to repair function or esthetics. Additional procedures will incur a separate fee.
- I should not be treated with SDF if: 1. I am allergic to silver. 2. There are painful sores or raw areas on my gums (i.e., ulcerative gingivitis) or anywhere in my mouth (i.e., stomatitis).

Benefits of receiving SDF:

- SDF can help stop tooth decay.
- SDF can help relieve sensitivity.

Risks related to SDF include, but are not limited to:

- The affected area will stain black permanently. Healthy tooth structure will not stain. Stained tooth structure can be replaced with a filling or a crown.
- Tooth-colored fillings and crowns may discolor if SDF is applied to them. Color changes on the surface can normally be polished off. The edge between a tooth and filling may keep the color.
- If accidentally applied to the skin or gums, a brown or white stain may appear that causes no harm, cannot be washed off, and will disappear in one to three weeks.
- You may notice a metallic taste. This will go away rapidly.
- If tooth decay is not arrested, the decay will progress. In that case, the tooth will require further treatment, such as repeat SDF, a filling or crown, root canal treatment, or extraction.
- These side effects may not include all of the possible situations reported by the manufacturer. If you notice other effects, please contact your dental provider.
- Every reasonable effort will be made to ensure the success of SDF treatment. There is a risk that the procedure will not stop the decay, and no guarantee of success is granted or implied.

Alternatives to SDF, not limited to the following:

- No treatment, which may lead to continued deterioration of tooth structures and cosmetic appearance. Symptoms may increase in severity.
- Depending on the location and extent of the tooth decay, other treatment may include placement of fluoride varnish, a filling or crown, extraction or referral for advanced treatment modalities.

I certify that I have read and fully understand this document and all my questions were answered:

_____ (signature of patient) _____ (date)

_____ (signature of witness) _____ (date)

Pound foolish: Cost as a factor in treatment

By TDIC Risk Management Staff

Responsible consumers understand the importance of cost when making a purchasing decision. Whether a house, a car or even a pair of shoes, cost is usually one of the most important factors that influence the decision to buy. But when it comes to dental care, cost shouldn't be the determining factor. Unlike housing, transportation or footwear, postponing or forgoing dental treatment can result in irreparable damage. All too often, patients fail to follow treatment recommendations due to expense, putting their oral health at risk. In addition, dentists sometimes make their treatment recommendations based on what a patient's insurance plan will cover.

The Dentists Insurance Company reports calls to the Risk Management Advice Line from dentists whose patients have refused care based on the cost. While budgetary limitations are certainly a reality of life, dentists are advised to proceed with caution when allowing patients to dictate care. In doing so, they can set themselves up for allegations of supervised neglect.

In one case reported to TDIC, a patient presented for a crown and buildup on a tooth that the dentist had previously treated with a root canal. The patient made a partial payment at the end of his appointment and sent a check for the remainder of his balance a few days later. The check bounced. The office called the patient to advise him of the issue with the bounced check and informed him that the dentist could not deliver his permanent crown until he took care of the outstanding balance.

A few months later, the office received a request for records from another dental office, stating that the patient was being treated for an extraction and an implant for the same tooth. Subsequently, the patient sent an email to the original dentist, demanding that the office pay for the additional treatment. In an effort to compromise with the patient, the dentist offered the patient a refund, which the patient refused. The patient retained an attorney and demanded $10,000.

The dentist's lack of follow up, failure to disclose the risks associated with delaying treatment, and decision to withhold care led to the case being settled for $3,500.

"When a patient remains in a temporary crown for an extended period of time, the chances of something adverse happening to that tooth increase," says TDIC Risk Management analyst Taiba Solaiman. "The dentist could be responsible for replacement of that tooth if treatment was withheld due to an unpaid bill."

Solaiman warns that withholding treatment due to a patient's inability or unwillingness to pay may constitute patient abandonment. Even if patients have not fulfilled their financial obligation, dentists should complete the treatment and then pursue the unpaid balance in accordance with office policy.

TDIC reports some cases in which a patient offers to sign a form relieving the dentist of liability based on the patient's own decision to decline the treatment recommendation. However, no such form exists, and patients cannot sign away their right to receive appropriate treatment or to prohibit themselves from later filing a claim.

Oftentimes, patients use the cost of treatment as a way of delaying necessary care or attempting to negotiate a discounted price for a procedure. TDIC recommends keeping clinical and financial discussions separate and to defer any discussion of payment options to administrative staff. Rather, dentists should focus on clinical treatment needs, including any potential health risks of noncompliance. For patients who delay or refuse treatment based upon financial considerations, the following responses can be helpful:

"My treatment recommendations are made regardless of a patient's payment source or financial status. With respect to the cost of care, I would encourage you to speak with my patient account representative regarding possible payment options."

"I certainly understand that expense is a concern. We have many different financing options. Perhaps we can find something that meets your needs."

"While I can appreciate your financial position,

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NSDS Continuing Education 2017

For registration and more information, contact Gail Grimm, CAE, Executive Director, 707.428.3894 or exec@n-sds.org.

DATE	TIME	TOPIC	LOCATION
Thursday, Sept. 21	6 p.m.	Tissue Banking – 2 C.E. units Douglas Dixon, DDS	Hiddenbrooke Vallejo
Thursday, Oct. 13	9 a.m.	An Overview of New Technology & Materials Changing Dentistry – 7 C.E. units Dr. Parag Kachalia	Ramekins Sonoma
Thursday, Nov. 30	1 p.m.	OSHA/Infection Control/ Dental Practice Act (6 hour session) – 6 C.E. units Diane Arns	Chardonnay Napa

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it does not change my diagnosis and treatment recommendation. I would strongly encourage you to do what you can to receive the treatment without delay as our goal is that you maintain optimal dental health."

Alternatively, dentists can refer patients to a clinic or dental school, where the optimum treatment may be able to be obtained at a lower cost. Provide these referrals in writing and document all conversations in the patient's chart.

Should a patient become argumentative or attempt to dictate treatment, or if the patient fails to obtain treatment by an established date, TDIC recommends dismissing him or her following a formal dismissal protocol. These conversations should be documented thoroughly.

Dentists are professionally and ethically responsible to present treatment options that are most appropriate for patients' clinical needs. While cost is certainly a factor in any decision, it should not be the only factor, and dentists should educate patients on the risks associated with failing to complete recommended treatment. When all else fails, it is appropriate to dismiss noncompliant patients from care in order to protect yourself and your practice from risk.

Questions? Call TDIC's Risk Management Advice Line at 800.733.0633.

New Members

The Napa-Solano Dental Society welcomes the following new members:

Paul Menges, DDS
General Practice
Vacaville

Michael Kuscera, DDS
Retired Military,
Delta Dental Employee
Suisun City

Katarzyna Glab, DDS
General Practice
Vacaville

Gianna Ligouri, DDS
General Practice
Vacaville

Verna Schuetter, DDS
General Practice
Fairfield

IN MEMORIAM

Hugh L. Reat, DDS
02/20/1924 to
12/08/2016
General Practice
Napa

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CDA PRESENTS IN ANAHEIM

The recent CDA convention in Anaheim was the largest and most attended CDA Presents ever, with 26,500 attendees.

CDA CARES SAN MATEO

CDA Cares San Mateo provided nearly 2,000 patients with almost $1.6 million in care. Since 2012, CDA Cares has held 11 events treating 122,000 patients and providing $18.1 million in care. The next event will be held Oct. 6-7 in Bakersfield.

You are also not a sales goal or a market segment. You are a dentist.
And we are The Dentists Insurance Company, TDIC.

It's been 35 years since a small group of dentists founded our company.
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