BULLETIN OF THE SAN FERNANDO VALLEY DENTAL SOCIETY

Dental DimensionS

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Fall 2014

- Bridging the Diversity Gap

- Tobacco Cessation Training for Dentists
- Leadership Conference Review
- Afternoon Tea
- Overlapping Issues in Dentistry and Medicine: Endothelial Function

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In This Issue

Fall 2014

Volume XLVIII Number 4

Call for Submissions

Do you have an unusual case study or an interesting article you would like to have published? Dental Dimensions is looking for articles from our members so we can share our collective knowledge. Articles should be 500-1000 words with references where applicable and photos if possible. Send your submissions to:
shukandds@gmail.com
or contact the dental society office at 818-576-0116

On The Cover.....

(on the cover): Angel City executive director, Katrina Eagilen, DDS (l) receives a certificate of appreciation from SFVDS president, Mahrouz Cohen, DDS for her contribution at this year's 'Bridging the Diversity Gap' forum.

From the Desk of the Editor

Dear Colleagues,

A very warm welcome to the final quarter of our editorial; yes we are nearing that festive time of the year again! The year went by in the blink of an eye; especially with our lives so full with professional and familial responsibilities. In addition, some of us choose to go above and beyond these to volunteer our time to make the SFVDS the wonderful society that it is for our member dentists!

I have had a wonderful year in my career as a pediatric dentist with love and gratitude from my little patients and their parents, outstanding support from my staff, and also at home with my lovely family helping my young children with their school and extra-curricular activities! We are also blessed to be surrounded by a circle of friends who we can count on, come rain or shine, and also share some fun times together.

I have enjoyed every moment serving as the Editor of the SFVDS this year and being involved with the SFVDS board of directors. While my availability is often limited by responsibilities at home, I have learned valuable lessons about the workings of the organization.

I hope you all have been receiving Dental Dimensions as an email attachment in addition to the printed version. If not, please send me or Andy your email address so that we can update it. I welcome your feedback and suggestions to make the newsletter better, so please do not hesitate to drop me a line or two! I hope your year has been just as enriching and fulfilling as mine.

Wishing you all the hope, wonder and joy that the season will bring!

Cheers,
Shukan Kanuga DDS, MSD.
Diplomate, American Board of Pediatric Dentistry
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SAVE THE DATE
SFVDS HOLIDAY SOCIAL

CENTRAL OFFICE
9205 ALABAMA AVE, STE B
CHATSWORTH, CA 91311
DECEMBER 12, 2014
6PM UNTIL ?
RSVP TO 818.576.0116

From the Desk of the President

The best thing I did this past summer was to sign up for a bus tour vacation of Poland and the ex-Soviet countries. I have come to realize that if I want to practice dentistry long term, I must have these breaks so that I can disengage from the physical and mental stress the job brings. I left with a bad backache and amazingly enough, I came back with no pain!

The tour bus drove us through the outskirts of Poland. The guide pointed out to a distant forest called Treblinka, where millions of Jews, Muslims, Armenians, Arabs, Turks, Asians, Africans, and Gypsies along with some other minorities, were innocently killed and then sent to the ovens. As we passed through Lithuania, the guide pointed out yet another forest and said the Lithuanians had been getting rid of their minorities in this area even before Hitler's army made it there. This tour took place in the middle of summer, but the intense cold weather made us wear layers and a heavy jacket on top. I cannot imagine if the summer was so cold, how bitter the winters must have been and how these people stayed alive before they were exterminated.

I thank God for the opportunity to live in the United States where diversity is not considered a disadvantage, but an asset.

Thanks to our supporting staff, the diversity forum held at the Airtel Plaza Hotel on September 13, 2014 was very successful. This gathering consisted of the following entities, each representing a different ethnic group. I must say; I felt privileged and honored to be included in such a distinguished group of people. The following is the list of the attendees who attended. I sincerely thank everyone for taking the time to participate.

Dr. Gist- Past – president, ADA
Dr. Weber - CDA president-elect
Dr. Mito - UCLA Dental School, Associate Dean
Dr. Trivedi--Indian DS
Dr. Barbosa---Hispanic DS
Dr. Lozada--Filipino DS
Dr. Gereis---Arab American DS
Dr. Kim---Korean DS
Dr. Katrina Eagilen-Angel City DS
Dr. Namazikah--Persian American DS
Dr. Lindsey Robinson- Immediate Past- president, CDA

Regardless of our ethnic backgrounds, we were all under the same roof. Our goal was to help unite our profession and improve the welfare of our patients. Without a shadow of doubt, as one, we would have more clout and an even stronger voice if all dentists would join the Tripartite ADA. I am eager and looking forward to increasing one membership and the unity and strength of our society. The steps we all took by attending the diversity forum will lead to a more definitive and very positive future for all of us.

The third annual afternoon tea party took place on September 27, 2014 at the Porter Valley Country Club. Once more, it was humbling to be in the company of accomplished female dental leaders such as Dr. Feinberg (President elect ADA), Dr. O'loughlin (ADA Executive Director), Dr. Marcos (CDA Leadership Chair) and Dr. Robinson (Past CDA President, ADATrustee).

Please do not forget to vote No on prop 46 on November 4, 2014. As you are aware, trial lawyers are trying to increase the statutory cap on pain and suffering awards from $250,000 to $1.1million for all dentists and medical doctors. This will astronomically increase the dental/medical malpractice insurance premium and consequently will increase the cost of running a practice. Do not be surprised if a number of us, as difficult as it may be, would have to hang up the white coat for good and look elsewhere to make a living if the risks of practicing outweigh the benefits.

Please also do not forget to be part of the Foundation Fundraiser party on October 24, 2014 at Porter Valley Country Club. Our staff and our board members have worked extremely hard since the beginning of the year to make this a delightfully fun evening. As mentioned in the past, we are honoring USC Dean Emeritus Landesman. Gary Bryan (The host of Kearth-101) graciously donated his time by being our master of ceremony. Our staff has arranged for a photo booth, raffle tickets, and great entertainment. You can dance the night away in your seventies costume and you can win a cash prize for having the best costume. One should feel honored that all these proceeds will be used to give much needed dental attention to low income and uninsured children and adults within the boundaries of our component. Let's help the needy together.

In closing, I thank all the board members and our trustees and members at large for donating their precious time, attending the board meetings and offering their invaluable input to make the SFVDS the best component in the tripartite.

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From the Desk of the Executive Director

By: Andy Ozols
Executive Director

By the time you receive and read this magazine, the year will be almost over. Seems like just yesterday that we started 2014 with big expectations and lots of activities planned for the year.

I am happy to report that everything planned took place and we again can lay claim to one of the most active dental societies in the country. We held a wide variety of member events during the year, our membership numbers grew for the second year in a row and our dental society took center stage on the national level.

I want to recount our major activities for this year in hopes that by doing so, you will be encouraged to attend our 2015 events, which will repeat 2014's successes and add still more programs and events based on your feedback as members. If in the following list, we have missed an activity or event you think would benefit you and the membership, please send me an email.

1. We held CPR recertification classes almost every month at the reduced rate of only $35 per student, $5 of which is donated to the SFVDS Foundation.
2. We held eight, hi-powered CE courses, and offered a two-for-one deal for the June and November courses
3. We held three hands-on courses at the central office: Lasers, Botox, & Crown Lengthening
4. We held Yoga and Reiki classes at the central office
5. We conducted two job fairs to help members looking for associates and members looking for work as dentists in Chatsworth and Santa Clarita
6. We held three Schlep and Shred events in Palmdale, Chatsworth and Glendale
7. We held two speed pairing events to help members buy and sell their practices in Sherman Oaks and Granada Hills.
8. We held a new member orientation at the Chatsworth office
9. We held a new dentist/student social event at Magic Mountain
10. We held a new dentist social in Burbank
11. We participated in a joint new dentist social with the West LA Dental society in Beverly Hills
12. We held four zone meetings in Glendale, Santa Clarita, Sherman Oaks and Palmdale
13. We conducted a leadership conference for members interested in ascending to leadership positions within organized dentistry in Chatsworth
14. We held a 'Diversity Forum' with all SoCal ethnic dental societies participating
15. We held an 'Afternoon Tea' social for our female members
16. We held our second successful annual fundraiser for the SFVDS Foundation at the Porter Valley Country Club
17. We will finish the year with our annual holiday social at the central office in Chatsworth on Dec. 12th.

As I mentioned above, the SFVDS is back on center stage at the national level. In addition to the SFVDS winning two 'Golden Apple' awards from the American Dental Association for its diversity and women's issues programs, this past July, I ascended to the presidency of the Association of Component Society Executives, the national association of nearly 500 component society executives in the United States. This gives me a seat on ADA executive director, Dr. Kathy O'Loughlin's Executive Director's Advisory Council, where we meet with our state executive director counterparts and the ADA executive director to give advice and plan ADA's strategy for all of organized dentistry throughout the country.

However, I and the office staff, Wendy Zaslove and Bella Penate, could not have achieved so much without the support and help of your board of directors, its committee chairs, especially Dr. Anette Masters our 2014 membership chair, and you the members who participated in our programs.

I hope you will all be able to join us at our annual holiday social at the society's central office in Chatsworth on December 12, 2014 at 6:30 PM so that the office staff and board members may wish you a happy holiday season in person! There will be plenty of food, wine, beer, music, dancing and camaraderie to help us all close out the year with our SFVDS friends.

Legislative Committee Report

By: Jim Mertzel, DDS

The CA Legislature has recessed until after the November elections. Governor Brown has signed the following bills and budget inclusions relating to dentistry.

AB 1962 Dental Patient Premium Protection

This bill was sponsored by CDA. The bill should provide increased transparency for patients and employers regarding dental insurance plans. Under the Affordable Care Act and current state law all medical plans require that at least 80% of patient premium revenue be spent directly on patient care. There is no requirement that exists for dental insurance. Some dental insurance plans were reporting that only 38% of the premium was being spent for dental care, the balance for administrative costs. CDA had requested that the same 80% required for Medical Insurance plans apply to Dental Insurance plans. A compromise was reached with the conclusion that there was a lack of data to determine a MLR (medical loss ratio) for dental insurance plans. AB 1962 requires dental insurance plans to uniformly and publicly disclose the financial data necessary for the legislature to establish a dental insurance MLR effective January 1, 2018

Denti-Cal Benefits

Although the Governor approved some dental procedures for adult dental care effective in May of this year, the 10% cut for fees paid enacted in 2011 still remains in effect. While the cut back was being disputed, dentists who performed services between 2011 and 2013, will not be required to pay back 10% of the fees paid to them during that time. CDA is actively pursuing an attempt to eliminate the 10% cutback and to update the fee schedule, which would encourage more dentists to treat the thousands of patients who will be eligible for treatment under the ACA.

State Dental Director

The 2014-2015 budget provides funding for a State Dental Director to organize and execute essential dental public health functions. The director's role will include responsibility to establish dental health literacy and prevention programs. It is expected that a director and epidemiologist will be selected by the end of 2014.

CA Dental Licensure Fees

The biennial licensure fee has been raised from $365.00 to $450.00 effective July 1, 2014

AB 1174 – Virtual Dental Home

This bill, which was signed into law will allow RDHs and RDAs with extended training to work in community clinics, preschools and nursing homes to convey with the use of tele-health technology information to an offsite dentist and will allow these aides to scoop out dental decay and place ITR's (interim therapeutic restorations).

I hope that in this election year you have been actively involved in the political process to assure that the issues for which you advocate will become a reality. I welcome your active participation on the SFV Dental Society Legislative Committee.

Trustees' Report

By: George Maranon, DDS

At the August Board of Trustees meeting, Dr. Natasha Lee, was brought forward as the next Secretary of the California Dental Association. Dr. Lee practices general dentistry in San Francisco. Dr. Craig Yarborough was put forward for Speaker of the House. Dr. Yarborough is an Associate Professor of Administration at Arthur A. Dugoni School of Dentistry and will replace Dr. Alan Felsenfeld as speaker. Dr. Felsenfeld is completing his second three year term and has been an exceptional speaker and CDA leader. Dr. Lee and Dr. Yarborough's nominations must be approved by the House of Delegates in November.

The Board of Trustees is currently in a strategic planning process. Previously, three-year strategic plans had been developed. Strategic planning will now be an ongoing process with the plan continuously updated. A new mission statement has been put forward by the board-Helping Our Members Flourish. Goals are being developed as part of the strategic planning process and include financial goals to increase non-dues revenue and increased profits to help minimize the need for dues increases. A second goal is to increase member loyalty and retention of young dentists as they transition through different phases of their careers. Lastly, the Board wants to develop mechanisms to provide a consistent level of core services at each component dental society and create the same value for every member.

As of January 1, 2011, Assembly Bill 1524 allowed dental licensure in California through a dental school-based portfolio examination process. The portfolio examination process will replace the clinical examination administered by the dental board. The Dental Board of California, the California Dental Association and the six California dental schools all supported the measure. The Dental Board has completed the final regulations for licensure by portfolio which has been approved at the Department of Consumer Affairs and has been forwarded to the Department of Finance after which it will go to the Office of Administrative Law (OAL) for a final approval. Once regulations are adopted, students will have the option to take a school-based licensure examination that allows them to build a portfolio of completed clinical experiences and competency examinations in seven subject areas over the entire course of their final year of dental school. Approval of the regulations is anticipated by the end of the year.

The Medical Board of California and the Pharmacy Board of California made presentations to the Dental Board on the growing problem with deaths from prescription drug overdose. Dentists are the third leading prescriber of opioid medication and need to be aware of a problem that has reached epidemic proportions and appears to be increasing. The Dental Board appointed a prescription drug committee to look into this issue and provide guidance on the actions the board may take relative to dentistry's responsibility to protect the public.

In a related issue, drugs containing hydrocodone, such as Vicodin and Norco, have been reclassified as schedule II drugs. This change took effect on October 6, 2014. The following are the changes that have been made concerning prescribing of hydrocodone medications.

- Schedule II controlled substances require a written prescription that must be signed by the practitioner.

- Refilling a prescription for a schedule II controlled substance is prohibited.

- Prescribers may transmit a Schedule II prescription to the pharmacy by facsimile. The original Schedule II prescription must be presented to the pharmacist for review prior to the actual dispensing of the controlled substance.

- In an emergency, a practitioner may phone-in a prescription for a Schedule II controlled substance to the pharmacy, and the pharmacist may dispense the prescription provided that the quantity prescribed and dispensed is limited to the amount adequate to treat the patient during the emergency period. The prescribing practitioner must provide a signed, written prescription to the pharmacist within seven days.

- While some states and many insurance carriers limit the quantity of controlled substance dispensed to a 30-day supply, there are no specific federal limits to quantities of drugs dispensed via a prescription.

- As of December 19, 2007, an individual practitioner may issue multiple prescriptions authorizing the patient to receive a total of up to a 90-day supply of a schedule II controlled substance.

Legislatively, SB 1416(Block), sponsored by the Dental Board, has been signed by the governor and will mean an increase in licensing fees to $525 effective January 1, 2015. The Dental Board plans to complete a workload and fee analysis as part of their sunset review process as a basis for projecting an appropriate fee cap and licensure fees moving forward.

General Meetings- Preview

Schedule of 2015 CE Courses

Jan 14	Brian LeSage, DDS	Esthetics
Feb 11	Hessam Nowzari, DDS	Implant Failures and How to Avoid Them
March 11	Alan Felsenfeld, DDS	Oral surgery for the General Practitioner
April15	Nancy Dewhirst, RDH	CA Dental Practice Act and Infection Control
June 10	Parish Sedgizadeh, DDS	Oral Pathology and Medicine
Sept 16	Bob Hale, DDS	Reconstructive Surgery
Oct 14	BJ Moorhead, DDS	Technology and a paperless office

NOTE: *Hands-on courses for 2015 are being finalized as this publication went to print. Watch for notices of these courses in future issues.*

General Meeting Review

June 25, 2014
A Dental Materials Update
Todd Snyder, DDS

Dr. Snyder walked participating attendee through what has changed in dental materials during the past year, when to use those new materials, and what are the indications and contraindications of using various materials. Attendees learned about advances in direct adhesives, composites and nano-technology, as well as which materials provide strength and esthetics and when to use them.

September 17, 2014
Esthetics for the General Practitioner
Marc Geisberger, DDS

Dr. Geiberger lectured on treatment planning, designing and managing complex restorative, and esthetic cases. Dr. Geisberger taught that several universal design and treatment principles could be applied to the treatment of all complex cases. Particular emphasis was placed on specific techniques and design concepts to aid practi-

September 27, 2014
Periodontal Surgery for the General Dentist
Ziv Simon, DDS

This 3rd Hands-on course of the year was held at the Gelfand Educational Center at the dental society's office in Chatsworth. Dr. Simon provided a didactic lecture in the morning and attendees participated in practicing what they learned in the afternoon on pig jaws and sheep mandibles, using surgical kits by sponsoring company, Dowell Dental Products. Attendees also had the opportunity to try their hand at the Precision PiezoART Surgical Unit, an ultrasonic bone-cutting system.

October 22, 2014
Local Anesthesia: 30+ Years of Hits, Misses and Near Misses
Mel Hawkins, DDS, BScD(AN), FADSA, DADBA

Dr. Hawkins reviewed the local anesthesia pharmacology IS technique and the local anesthetic technique IS pharmacology. Attendees learned also how to enhance local anesthesia techniques. The Akinosi, Gow-Gates, Conventional Inferior Alveolar and Maxillary nerve block techniques including the V2 palatine canal block were reviewed. Product selection, what's new including the current status of articaine, reversal agents, buffering systems, inhalational local anesthetics, and what's upcoming were discussed

SFVDS LEADERSHIP CONFERENCE

By Anette Masters, DDS, SFVDS Membership Chair

Attendees of the first SFVDS leadership conference pose in the SFVDS board room. Keynote speaker, BJ Moorehead, DDS is 4th from the left, first row.

(below) Dr. BJ Moorhead, Immediate past-president of the Kentucky dental Association lectures on leadership.

In SFVDS' efforts to continue to find leaders amongst its members, we started a Leadership Conference Day where we provided a variety of speakers including, Dr's. Carol Summerhays, Mike Bromberg and Gary Dougan who shared with us their path to leadership positions. One of the biggest take-aways learned was that it takes discipline to be a leader. Our speakers, who have been involved in both state and national leadership, told remarkable stories on what it takes to be a leader and their journeys to get to their goals. A recurring theme emerged: It takes a vision, action and commitment to get to your goal, and, a dedication to put forth the efforts required to keep you on your journey's path. It takes courage to overcome the obstacles that get in your way so a determined leader does not give up but keeps moving forward.

Dr. Gary Dugan addresses the attendees

This year our main presenter, Dr. William Moorhead (former Kentucky Dental Association president), gave us tools and guidelines on how to become an effective leader. We learned that being organized will allow us to think better as leaders, because our ability to have organized systems in place will help us tackle our day-to-day activities with a lot less stress, thereby leaving more time and energy for leadership responsibilities. Implementing systems that are easy to follow makes our daily activities and tasks a lot smoother to deal with. Consistency and discipline allow us to accomplish tasks a lot quicker and easier. We also learned that learning about and accepting personality differences accounts for a successful working environment. As we learned about the different types of personalities we were then able to recognize how we can work with them and create much smoother communications within our working environments. Delegating specific tasks to each person ality category makes a team work harmoniously and efficiently.

Dr. Carol Summerhays, ADA President-elect & past CDA president addresses the attendees

As we cultivate a potential leader in each one of us, we need guidlines to follow and tools to use, to become better leaders. We can choose to become complacent or we can choose to become involved. We either believe we can do it or we give up on our potential. A leader is not always born because for many it takes practice and perseverance to become one. It takes faith not to give up and courage to keep on going. All these are pointers for us to remember that there is a leader in all of us, if we choose to pursue that path.

SFVDS in its quest to bring out the leadership potential in you will continue to provide ways and avenues to inspire you to become one. As the current SFVDS leadership has been inspired by great leaders around us, so too will we endeavor to inspire you. SFVDS will continue to have our accomplished leaders show us the path, lead us and inspire us to become leaders ourselves.

Attendees enjoy a wine and cheese social after the conference

SFVDS DIVERSITY FORUM

(left) Korean American Dental Society members pose with SFVDS Immediate Past-president, Nita Dixit, DDS and current SFVDS president, Mahrouz Cohen, DDS

By: Anette Masters, DDS
SFVDS Membership Chair

In an effort to continue emphasizing the value of diversity in organized dentistry, the SFVDS, for the second year in a row, once again reached out to all Los Angeles area ethnic dental societies and invited them to a forum to exchange ideas and interests to find how best to work with each other, and understand and respect each other. Based on the turnout and response of those attending, the SFVDS and its partner ethnic dental societies have been very successful in bridging any perceived gaps in understanding that may have existed.

(below) Women of the diversity forum pose together for a group shot.

Practicing dentistry in the State of California before the 70's was limited to local graduates. When the need for healthcare practitioners was at its high, the State of California allowed foreign trained dentists to take a separate 'Clinical Board Exam' (Part 3), allowing them to practice in this state. Our state was very fortunate to have accepted well trained and talented clinicians who became part of organized dentistry as well. When in 2007 the California Dental Board was 'sun-setted', organized dentistry kept moving forward toward accomplishing cultural inclusiveness within its membership.

(l-r) Dr. Raymond Gist, ADA Past-president and Dr. Ron Mito, UCLA Dental School Associate Dean

Dentistry and its diverse population have come a long way. Organized dentistry, as it continues to move forward and pursue its members' and non-members' needs, has found that cultural and ethnic inclusiveness is the path to a stronger organization. And, as a result of organized dentistry's efforts to include all ethnic groups in its membership, the first genera tion of diverse background dentists are now encouraging their children who followed into the dental profession, to become members and be active in organized dentistry.

Networking in the lobby before the forum started.

As part of our pursuit to achieve cultural inclusiveness, this year we wanted to hear from different ethnic dental groups on how we can work together for the common good in dentistry.

As we set out to celebrate diversity this year, our goal was to bridge the perceived gap between a variety of ethnic dental groups and the ADA/CDA/SFVDS tripartite. We had Dr's Raymond Gist (past ADA president), Dr. Ron Mito (associate dean of UCLA's dental school) and Dr. Walt Weber (president-elect of CDA), give us pointers on how we can all work together. They talked about their own experiences on how they got involved in organized dentistry, and the values that inspired them to give back and achieve a leadership position.

(below) Panelists from various ethnic dental societies answer audience questions.

Following their presentations, the SFVDS put a panel of seven ethnic dental society leaders (Dr. Barbosa, Hispanic DS; Dr. Trivedi, Indian DS; Dr. Kim, Korean DS; Dr. Gereis, Arab American DS; Dr. Namazikah, Iranian DS; Dr. Eagilen, Angel City DS; Dr. Lozada, Filipino DS) to hear their perspectives on how we can all move forward together, and reach out to both members and non members to inspire and work together to expand the network of organized dentistry. As leaders of their own dental groups, they were able to tell us their needs and expectations from our local to state and national organizations. They talked about the progress being made with their members slowly seeing the value and benefit of being a part of organized dentistry.

As we continue every year to reach out to our peers, we continue to learn that we can all come together and come up with great solutions that benefit all of dentistry. With continued collaborative efforts, we will accomplish our goal of CULTURAL INCLUSIVENESS and create even more member value in organized dentistry.

SFVDS *Afternoon Tea*

By: Anette Masters, DDS, SFVDS Membership Chair

As we see the rise of female dentists in the profession, we understand that there are unique challenges in being a female dentist. The SFVDS continues to think about meeting these unique needs, in part by recognizing that those needs exist and helping to solve the challenges our female members encounter as the minority gender.

Now in its third year of addressing the needs of the female membership through the 'Afternoon Tea' event, SFVDS has shown how bonds and support systems between colleagues work most effectively when we continue to address those issues out in the open. This consistent reaching out to our female membership has been positively received and recognized by all three levels of the tripartite. This is a program that was inspired by one of our own female dental leaders, past-membership chair and current board secretary, Dr. Karin Irani, and has now become a trend inspiring local, state and even national dental organizations.

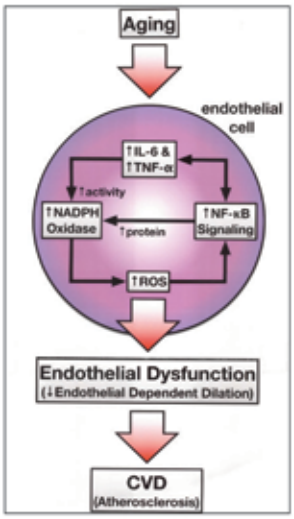
ADA's market research shows that the number of female dentists has increased from 15% to 27% during the past decade or so, so organized dentistry understands that it is critical to address the needs of this growing segment of female members. As part of the tripartite, SFVDS is now in its third year of getting our interested female dentists to come together and create a network of colleagues that is willing to help each other with the challenges female dentists face in their profession. Our goal is to create a support system among their peers and to be able to mentor a colleague who needs guidance as they move forward with their careers. Our efforts to build friendships and camaraderie among their colleagues is something that membership in organized dentistry can help with, thus giving us a sense of belonging as well.

This year, we had wonderful keynote speakers from ADA: Drs Kathy O'Loughlin and Maxine Feinberg; from CDA, Drs Lindsey Robinson and Carliza Marcos, who shared with us their journey to their leadership positions, as well as the challenges and rewards they have encountered to get there. In addition, SFVDS president, Dr. Mahrouz Cohen and membership chair, Dr. Anette Masters, shared powerful stories in their struggles as leaders and working moms. Received well by the members, the bond among female colleagues is now more evident.

These brief presentations were coupled with a life coach this year, who gave us tools on "boundaries" within yourself and your office. We have shown the value of belonging to organized dentistry where you can have a voice and be understood. Members from different components and non-members as well, were very receptive on how we can come together, develop a support system and mentor each other as we move forward in our personal lives and careers as female dentists.

Speakers at this year's Afternoon Tea Party included, from l-r: Drs Mahrouz Cohen, SFVDS President; Kathy O'Loughlin, ADA Executive Director; Lindsey Robinson, CDA Immediate Past-president; Carliza Marcos, CDA Leadership Development Committee Chair; and Maxine Feinberg, ADA President (2015).

As dentists, we thrive on interaction with our colleagues, for support not only in our profession, but also for ideas on how to create a balance between our families and our professional lives. Belonging to organized dentistry affords an opportunity to open avenues to improve yourself and your profession. It is a path and support system to guide you as you move forward with your career, and it will always be a part of your network of colleagues who are always willing to reach out to guide and mentor you with your personal and professional needs.



BY: Dr. Michael Simmons, DMD, FAGD, Diplomate ABDSM & ABOP

INTRODUCTION

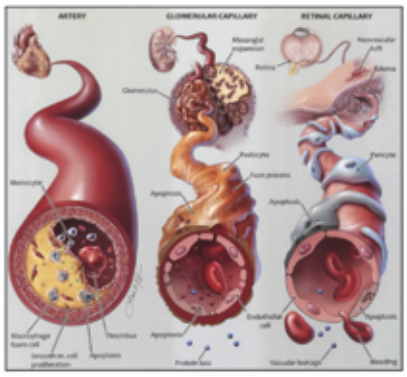
It is clear with the aging of America and the additional medical issues associated with an older population, that dentistry is increasingly required to co-ordinate care with medical colleagues. This is becoming more apparent with respect to vascular issues that may not only impact general systemic health, but also periodontal health. This brief overview specifically addresses endothelium (En), the innermost unicellular lining of blood vessels. En is present in all blood vessels ranging from smaller veins to the largest of arteries. Interestingly, this inner lining has an extensive series of functions that can be negatively impacted by inflammation caused by Chronic Periodontitis (CP) or Sleep Disordered Breathing (SDB). Addressing both CP and SDB is therefore, an important charge for dentists to improve the well being and survival of their patients. This year 3 CDA journals were dedicated to Interprofessional Education and Practice which speaks to the importance of evolving collaboration with our physician colleagues.

Causes of Endothelial Dysfunction

- High LDL
- Low HDL
- High triglycerides
- Smoking
- High blood pressure
- Diabetes
- High fat diet
- Metabolic syndrome
- Obesity
- High CRP
- High insulin levels
- Low nitric oxide
- Low vitamin D
- Lack of exercise

ENDOTHELIUM

The En is considered an autocrine (hormonal action on the same cell type as that producing the hormone) and paracrine (hormonal action on nearby different cell type) organ that functions on many levels. En plays a key role in normal vascular health and En dysfunction (EnD) is believed to be an early event in atherogenesis. Although the healthy endothelium is a single layer of cells that was initially regarded as a semipermeable barrier lining the vasculature, it is positioned and acts to affect important homeostatic functions. For example En cells can respond to a variety of blood-borne signals and intravascular stressors such as shear stresses by secretion or modification of factors that include regulation of vascular tone, thrombo-resistance, and cellular adhesion (Celermajer 2008). En cells, in addition to being actively responsive, function as a protective biocompatible barrier between all tissues and the circulating blood. Their dysfunction predisposes the vessel wall to vasoconstriction, leukocyte adherence, platelet activation, mitogenesis, pro-oxidation, thrombosis, impaired coagulation, vascular inflammation, and atherosclerosis (Verma 2003).



In health, En functions in response to local tissue demand. Walking several flights of stairs demands increased vascular response in order to serve the metabolic requirements of the heart and muscles. In order to accommodate this need the heart has increased output and the blood vessels serving the respective muscles dilate. Athletes would likely manage this demand easier than matched sedentary individuals as there is more perfusion ability of the circulatory system, especially the arterial blood vessels to accommodate the increased demand. This may be viewed from the perspective of an artery, as a continuum from healthy elasticity, that accommodates increased demand, to less healthy stiffness that expands minimally to allow more flow. While too much elasticity may be interpreted to result in aneurysm, this is not the case as aneurysms signify weakness in much more than the thin endothelial layer of the inner lining of the blood vessels. Aneurysms result more from weakness of the surrounding media and to a lesser extent, adventitia layers and may also be seen in connective tissue disorders such as Marfans and Ehlers-Danlos syndrome. The current perspective is that aneurysms result from stiffness with overall weakness of arteries associated with advanced atherosclerosis. Each year, about 15,000 people in the United States die of a ruptured abdominal aneurysm. This makes it the 13th leading cause of death in this country. Brain aneurysms are also a common occurrence, and at autopsy with incidental testing, asymptomatic aneurysms are found in more than 1% of people, ranging by study between 0.2% - 8.9% (Tomasello 1998 Wardlaw 2000). Most brain aneurysms remain small and never become an issue and are never diagnosed.

ENDOTHELIAL DYSFUNCTION

EnD primarily reflects decreased availability of local nitric oxide (NO), a vasoactive molecule released by endothelial cells in response to surrounding demand for vasodilation. NO also has anti-atherosclerotic properties and increasing its production through use of statin type drugs is thought to both inhibit blood vessel wall inflammatory response

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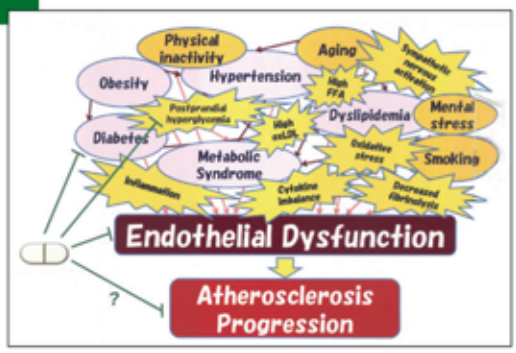
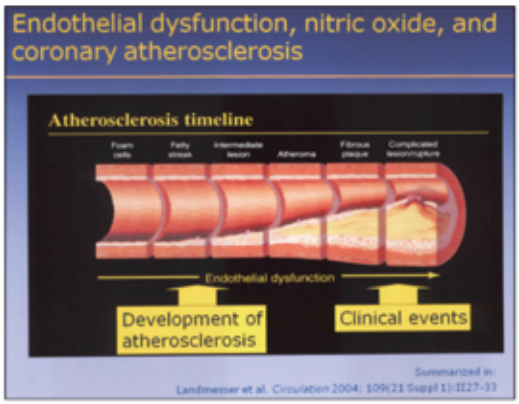


believed to contribute to atherosclerosis and also to promote re-endothelialization after arterial injury. (Ii 2007). The impact of EnD in humans include increased metabolic disorders such as diabetes, cardiovascular and cerebrovascular damage as well as damage to other organ systems like the kidney, affecting renal function. Specifically treatment of cardiovascular disorders both with and without hypercholesteremia utilizing statin type drugs has been shown to reduce EnD (Dilaveris 2007). Impact on dentistry can also be quite profound since EnD has increased prevalence in patients with moderate to advanced periodontal disease and if treated with periodontal therapy, shows favorable outcomes of improved EnD. Sleep disordered breathing (SDB) is particularly prevalent and significantly under-diagnosed and is associated with intermittent hypoxia resulting in En cell damage and dysfunction. Treatment of SDB has been shown to improve EnD. (Itshaki 2008).

EVALUATING ENDOTHELIAL DYSFUNCTION

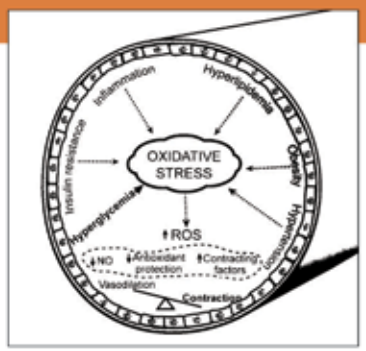


Evaluation of healthy En addresses the relationship of arterial elasticity and endothelial function. En health has been assessed through pulse wave analysis which provides measures of pulse wave velocity, arterial compliance and wave reflection. In the past EnD has been tested with invasive procedures involving cardiac catheterization and focused on large vessels such as the aorta. More recently, however, less invasive approaches are validated although a non invasive approach was first described in 1992. (Celermajer 1992). Several devices have measured endothelial function of smaller vessels, such as in the brachial artery utlilizing ultrasound (Kuvin 2001) or even the finger utilizing pulse wave amplitude in peripheral arteries of the finger (Kuvin 2003) and have been validated to reflect the general health of the larger vessels and the whole cardiovascular system. While in the past measurement included pulse wave velocity, change in diameter or area of an artery to distending pressure using ultrasound, and analysis of arterial waveforms obtained by applanation tonometry and sizeable equipment, there are now validated techniques using peripheral arterial tone of the finger and small portable equipment (Oliver 2003).

The additional "non cholesterol reducing" effects of statins are termed pleitrophic affects and may have dramatic impact on reducing EnD (Wang 2008 Zhou 2009). For example, clinical trials on patients with heart failure compared a lipid-lowering agent, Ezetimibe, which decreases blood cholesterol by reduced intestinal absorption of cholesterol, to Simvastatin and also to both drugs in conjunction and showed interesting differences (Sudhop 2002 Bruckert 2003). For example, despite a single drug therapy, comparable reduction in serum cholesterol levels after 4 weeks of Simvastatin, but not Ezetimibe treatment improved endothelial function and reduced oxidative stress (Landmesser 2005). Additionally, patients receiving combination therapy of Ezetimibe and statin were compared to patients receiving a higher dose of the statin, to achieve equal reduction of cholesterol resulting in greater improvement in endothelial function (Fichtlscherer 2006), lower platelet activation and Chemokine levels (Piorkowski 2007).

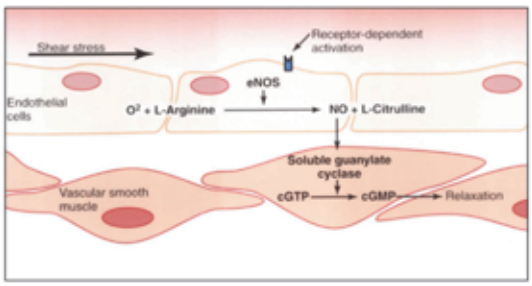
SDB and EnD

SDB is highly prevalent and depending on the inclusion criteria may involve > 1/3 of the U.S. population. SDB ranges from more benign socially disruptive snoring to severe sleep apnea. Obstructive sleep apnea (OSA) is a chronic medical condition characterized by repeated episodes of apnea/hypopnea during sleep. Each episode characteristically lasts about 20 seconds and is terminated by an abrupt arousal and restoration of ventilation. Obstructive sleep apnea prevalence is much higher in specific high-risk patient groups, such as those with congestive heart failure (40%), end-stage kidney disease (50%), and stroke (60%). In the majority of patients, the pathogenesis of OSA involves both a structural and a functional abnormality of the pharynx. Each cycle of apnea/hyopnea and resumption of ventilation is accompanied by arterial oxyhemoglobin desaturation and re-saturation. Since most individuals with OSA typically re-saturate their hemoglobin into the normal range, this exposes them to intermittent hypoxia throughout the night. The development of the physiological response to intermittent hypoxia is believed to be responsible for the subsequent vascular disease



(Lavie, 2005). Strong epidemiological associations between OSA and vascular disease have led to the consensus that OSA is a risk factor for the development of hypertension, myocardial infarction, and stroke. Data from the Wisconsin Sleep Cohort Study, which investigated the association between OSA and hypertension in a community-based population over many years, showed a dose–response relationship between OSA at baseline and the prevalence of hypertension four years later. This result was independent of confounding factors such as weight, age, gender, and the consumption of alcohol and nicotine. OSA is also associated with an increased risk for myocardial infarction. In a cross-sectional analysis of the Sleep Heart Health Study with 6424 individuals from the general population, the relative odds for heart failure, adjusted for confounding factors, were significantly elevated in patients with OSA (2.38), indicating an elevated risk for myocardial infarction. In a 3rd study, a cross-sectional analysis of 1475 subjects from the general population showed increased odds for stroke in those with an Apnea Hypopnea Index (AHI)>20 compared to no OSA. Observational cohort studies indicate that untreated patients with OSA have an increased risk of fatal and non-fatal cardiovascular events and during the sleeping hours, increased sudden cardiac death. Effective treatment of OSA with continuous positive airway pressure (CPAP) or Oral Appliance Therapy (OAT) may reduce this risk of cardiovascular disease. OSA is quantified by the most common index called the Apnea Hypopnea Index (AHI) which averages the number of restricted breathing "events" per hour during sleep. Each event is typically an arousal from sleep associated with a ≥ 4% desaturation. While it is considered normal for adults to have up to 5 events per hour, over 30 events per hour is considered severe OSA. It is also important to determine how low the desaturation dips and how long it extends. Loosely speaking, it is generally considered significant if the desaturations fall below 90% for more than 1% of the night. However it should be understood that it is the re-saturation, that occurs when the patient arouses/wakes to breathe, that is the damaging event. Re-saturation is associated with release of free oxygen radicals that damage the endothelium by creating macrophage invasion and a cascade of events resulting in atheromas. Drager and colleagues (2007) reported significant improvement in carotid intima-media thickness and arterial stiffness after 4 months of CPAP therapy when compared to a group of untreated severe OSA patients.

One study (Itzhaki 2007) investigated the impact of oral appliance therapy using a mandibular advancement device on patients with OSA and EnD and showed remarkable improvement in the EnD even when the AHI did not improve fully into the normal range. The hypothesis of a causal relationship between sleep apnea and EnD is pathophysiologically plausible and could explain in part the etiopathogenic role of sleep apnea in hypertension and cardiovascular disease. The fact that flow-mediated changes in brachial diameter was more strongly related to sleep apnea among those with hypertension is consistent with results from a previous study. It is reasonable to speculate that the stronger association between sleep apnea measures and EnD in subjects with hypertension may be evidence that susceptibility to sleep apnea–mediated high blood pressure may vary in the population; those individuals who have both hypertension and elevated AHI levels may be those in whom sleep apnea induces EnD. The putative association between sleep apnea and EnD could be explained by sleep-associated intermittent hypoxemia and re-oxygenation associated with enhanced generation of superoxide free radicals, sympathetic nervous system stimulation, augmented systemic inflammation, or enhanced expression of adhesion molecules. These effects may reduce the availability of endothelial Nitric Oxide, a potent vasodilator, as well as enhance vascular shear stress and/or alter vascular tone and structure.



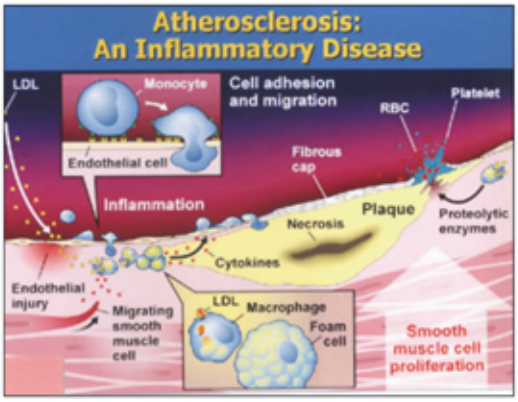
PERIODONTAL DISEASE / CHRONIC PERIODONTITIS and EnD

Epidemiological research provides strong evidence that severe periodontitis is a risk factor for cardiovascular disease. Higashi et al. (2008) found periodontal infection is associated with endothelial dysfunction in healthy subjects and hypertensive patients. A number of other studies have demonstrated an association between periodontal disease and the risk of myocardial infarction and stroke (Mattila 1995, Beck 1995, Joshipura 1996). However, the identified relationships between periodontal disease and cardiovascular disease by no means indicate a causal association. The CDA journal April 2010 was devoted to the Perio Systemic Link but no mention of EnD was present in the 5 articles. In this journal Rethman (2010) mentioned parallels between inflammatory mediators and mechanisms common to both oral and systemic diseases. Furthermore,

Continued on page 16

Continued from page 15

he describes immune cytokines such as Interleukin 6 and TNF in periodontal breakdown which are the same cytokines produced by OSA. Korman, in the same 2010 journal reported results from meta-analysis that concluded that periodontitis is a significant and independent risk factor for artheroslerotic cardiovascular disease. The most reasonable explanation given for this association was the role of systemic inflammatory mediators. Kao in the same journal described a new paradigm of periodontal disease having a relationship to various systemic inflammatory conditions and Schonfeld, in another 2010 CDA journal manuscript attributed most of the tissue destruction in periodontal disease to be caused by the patient's inflammatory response. However, he summarized that current NSAID's probably do not have much of a role in reducing this periodontal inflammation.



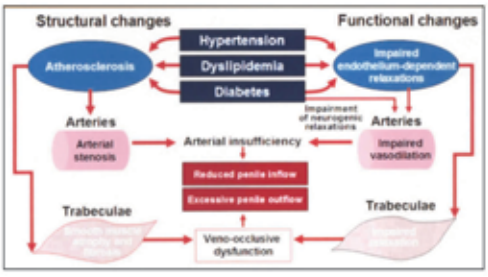
Seinost et al tested EnD in 30 patients (25-50 y.o.) with severe periodontitis and 31 control subjects, matched for age, sex, and cardiovascular risk, using flow-mediated dilation (FMD) of the brachial artery and C-Reactive Protein (CRP) as a marker of systemic inflammation. Subjects were excluded if they had a history of cardiovascular disease, diabetes mellitus, hypertension, or hypercholesterolemia. Subjects were tested to both endothelium dependent vasodilation via a 5 minute forearm cuff occlusion and En independent vasodilation 4 minutes after administration of sublingual Nitroglycerin. Three months after periodontal treatment which included root planing, oral hygiene instructions and pharmacological therapy (Chlorhexidine Gluconate (0.1%) mouth washes for 14 days and systemic antimicrobial therapy of Amoxicillin plus Clavulanic acid and Metronidazole for 7 days), EnD was reassessed. Markers of systemic inflammation were measured at baseline and at follow up. Testing one week post initial therapy, FMD was significantly lower and C-Reactive Protein significantly higher in patients with periodontitis than in control subjects. Retesting at 3 months after therapy, the successful periodontal treatment resulted in a significant improvement in both of these parameters. En-independent nitro-induced vasodilation did not differ between the study groups at baseline or after periodontal therapy. These results support the hypothesis that treatment of severe periodontitis reverses EnD and while effects are not immediate, they are present at 3 months. Whether improved EnD will translate into a beneficial effect on atherogenesis and cardiovascular events needs further investigation.

Gunaratnam et al. reported in 2009 on the prevalence of periodontitis in a group of 66 (54 men and 12 women) treatment-naive patients diagnosed with OSA (AHI) >5/h (mean AHI 36.55 SD 25.77 indicating severe OSA). They surmised that both periodontitis and OSA are associated with systemic inflammation and cardiovascular disease and found that the prevalence of Chronic Periodontitis (CP) in patients with OSA was 77-79% or fourfold higher than the national CP average depending on the definition used. They opined that periodontal pathogens may directly affect the endothelium thereby initiating an atherosclerotic response, secondly there is a shared list of associated risk factors by both PD and CV diseases such as smoking, diabetes, old age, male gender and obesity and thirdly PD may cause a systemic inflammatory burden that affects CV diseases and vice versa. Keller et al reported in 2013 on 7673 subjects with OSA and randomly selected 21,963 control subjects without a history of OSA looking for an association between OSA and a prior diagnosis of CP. They found a smaller odds ratio of 1.75 for OSA and prior Chronic Periodontitis (CP). The disparity between 1.75 and the previously reported Odds Ratio (OR) of four times as controls was after adjusting for monthly income and geographical location, as well as hypertension, diabetes, coronary heart disease, hyperlipidemia, obesity, tobacco use, chronic obstructive pulmonary disease and alcohol abuse. Finally Seo et al in a 2013 cross-sectional study of 687 Korean participants (460 male), 47-77 years of age, who underwent both standard polysomnography and clinical periodontal examination with health-screening examinations. Periodontitis was defined as clinical attachment level loss (CAL) 6 mm and probing pocket depth 4 mm. OSA was determined using the (AHI) score of 5 as the cut-off to indicate the presence of OSA (AHI averaged 7.86 and SD 9.51.) Results showed 17.5% of the participants had periodontitis, 46.6% had OSA and 60.0% who were diagnosed with periodontitis also had OSA. Old age, male gender, current smoking status, mouth breathing during sleep and high AHI were all identified as risk factors for periodontitis. OSA was positively associated with a 95% confidence index for periodontitis [odds ratio (OR) = 1.84, probing pocket depth (OR = 2.22, and CAL (OR = 1.86,) in a dose-response manner. Additionally, OSA was

positively associated with periodontitis (OR = 2.51,) in subjects ≥ 55 years of age, but not in subjects < 55 years of age. They concluded a significant association between OSA and periodontal disease but were unable to clarify the causal relationship between the two conditions. Patients with OSA often presented with oral breathing and dryness of the oral cavity and the pharynx which can impair the self-cleaning ability of the oral cavity and lead to gingivitis and increased bacterial colonization potentially increasing susceptibility to periodontitis.

END and other medical conditions.

There are many other functions affected by EnD. Otomo-Corgel a local periodontist, overviewed in 2012 the current evidence linking periodontal diseases to diabetes, cardiovascular disease, osteoporosis, preterm low birth weight babies, respiratory diseases, and rheumatoid arthritis. One other condition or function that might motivate the male patient to pursue treatment is the associated erectile dysfunction (ED) aspect. Erectile dysfunction (ED) according to Laumann ED is generally attributed to psychologic, neurologic, endocrine, vascular, and local anatomic systems. Drainage of the venous sinuses occurs, resulting in penile flaccidity. ED risk is related to age, smoking, diabetes, heart disease, depression, hypertension and more (Johannes 2000). Amar (2003) showed periodontal disease is associated with brachial artery endothelial dysfunction and systemic inflammation. The periodontal disease induces local and systemic elevation of cytokines, such as Tumor Necrosis Factor-alpha (TNF-a), IL-1 and IL-6. In addition, levels of TNF-a are increased in the serum of patients with moderate to severe ED (Vlachopoulos et al. 2006, 2007, Karadag et al. 2007). Zou and colleagues showed penile erection is impaired by periodontitis in the rat model (2013). Zadik et al in 2009 reported on the association between ED and CP in 305 men (mean age 39.5 +/- 6.7) who filled the Sexual Health Inventory for Men (SHIM) and underwent a pair of standardized posterior dental bitewing radiographs in order to detect CP. SHIM questionnaire scores 21 or less represented ED. Alveolar bone loss of >or=6 mm represented CP. Results showed 22.9% had ED and 4.3% had CP. CP was significantly more prevalent among men with mild to severe ED in comparison to men without ED. The findings were consistent with theories that associate both conditions with systemic inflammation. Tsao et al found that dental extraction seems to attenuate damage to the penile endothelial beds caused by CP -related inflammation and overcame the process of ED in the middle-aged and older populations. Matsumoto et al in 2014 examined the relationship between CP and ED via interview sheet including the CP self-checklist and the five-item version of the International Index of Erectile Function (IIEF-5) in 300 adult men. Of these 88 received a comprehensive dental examination (response rate 29.3%, 50.9±16.6 years old). There was a statistically significant correlation between the CP score and the presence of ED (P=0.0415) and the author suggested that ED is related to the damage caused by endothelial dysfunction and the systematic inflammatory changes associated with CP.



CONCLUSION

This paper explores the relationships between EnD and two prevalent disorders in the U.S. that dentistry impacts. The paper also touches upon the relationship of EnD to ED. It is apparent that these disorders can be better managed, in a collaborative manner by both dentists and physicians. Increased awareness of non invasive testing of EnD may enable such testing, validate effects of treatment and improve health outcomes.

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Continued from page 17

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Tobacco Cessation Training for Dental Providers

A. BACKGROUND

Tobacco use has been linked to numerous periodontal diseases and is a leading cause of preventable and unnecessary deaths in the United States. Cigarette smoking and secondhand smoke exposure results in approximately 443,000 deaths each year. A portion of the excessive mortality is explained by low rates of tobacco cessation.[1-3]

To improve cessation efforts, the United States Public Health Service, American Dental Association, American Dental Hygienists Association, along with other leading agencies endorse the delivery of evidence-based tobacco cessation services by healthcare providers. Even brief office-based interventions in medical and dental office settings are helpful in motivating and assisting cessation attempts. [4-6]

Although there is growing scientific evidence that dental providers are effective in helping smokers quit, [7,8] the delivery of such services among dental providers is disappointing. In July 2014, the CDC published an article indicating that only 1 in 10 smokers who visited a dentist in 2010 reported receiving advice to quit. [9]

Concerns about inadequate training, along with lack of time, comfort and appropriate resources are commonly cited obstacles.[10-15]

Although referring tobacco users to quitlines help overcome time and resource constraints,[16-18] recent data reveal that utilization of free smoking cessation helpline services by dental patients in Los Angeles County is low.

To address this issue, the Los Angeles County Department of Public Health's Oral Health Program in collaboration with the Chronic Disease and Injury Prevention Division set a goal to assess the feasibility of engaging dental providers in tobacco control and prevention activities. The purpose of this project is to provide training of dental providers in the provision of brief clinical tobacco cessation to their patients. The overall aim is to increase utilization of evidence-based smoking cessation services provided by the California Smokers Helpline (1-800-NO-BUTTS). The Helpline provides free telephone counseling to all types of tobacco users, lists of community resources, and a two-week supply of nicotine replacement therapy to residents of Los Angeles County. This article describes the model employed to train dental providers.

B. METHODS

Sample Population. The sample population for this performance improvement project consisted of Healthy Way Los Angeles (HWLA) dental professionals. HWLA provides oral health coverage to low-income uninsured residents of Los Angeles County. Dental providers attended a 50-minute training session entitled, "Brief Tobacco Interventions for the Busy Dentist." Training. The overall objective of the training is to provide essential knowledge and skills that will enable dental providers to discuss cessation with their patients and to refer tobacco users to 1-800-NO-BUTTS. A key goal is to teach dentists how to deliver quality presentations to their patients using a pre-designed tobacco cessation strategy that is brief (less than 3 minutes), effective and low-cost.

The training presentations covered a variety of topics, including tobacco products, nicotine addiction, treatment, brief cessation interventions and how to refer patients to the 1-800-NO-BUTTS. Throughout the session, didactic presentations were supplemented with teaching activities designed to enhance retention of key concepts and to reinforce learning.

Upon completion of the presentation, 1-800-NO-BUTTS cards in English and Spanish were distributed and dental providers were asked to refer tobacco users to 1-800-NO-BUTTS by providing the cards.

Evaluation. To examine the effects of the training on performance (referrals to 1-800-NO-BUTTS) and perceptions (comfort level, ability and likeliness to delivery cessation messages), all trainees were asked to complete a post-training questionnaire. To help validate the impact on performance, data about referral rates from the California Smokers' Helpline was obtained.

C. RESULTS

From January 2013 to June 2013, two presentations were conducted. A total of 32 (50% of all HWLA) dental providers completed the training. Of the 32 trainees, 11 completed a post-training questionnaire.

Impact on Performance. Nine of eleven (81.2%) dental providers reported that upon completion of the training, they referred more patients to 1-800-NO-BUTTS. In addition, there was an increase in the number of referrals to 1-800-NO-BUTTS six months after the project was implemented.

Impact on Perceptions. Results from post-training questionnaires revealed increases in dental providers:

1. Comfort level advising smokers to quit.
2 Comfort level referring patients who smoke to 1-800-NO-BUTTS.
3. Overall ability to help patients quit smoking.
4. Likeliness to refer a smoker who wants to quit to 1-800-NO-BUTTS.

D. DISCUSSION

This article is one of the first to outline a low-cost model for training dental providers who service medically underserved population in Los Angeles County. Our findings suggest that with minimal investments in training, dental providers have the potential to expand their contribution to the field of public health. Although the small sample size in the training program limits the generalizability of our results, this instructional approach appears to be promising.

To schedule a training or request smoking cessation materials, please contact Susan Bradshaw, M.D., M.P.H., TTS at (213) 351-7312 or sbradshaw@ph.lacounty.gov. You may also contact the office of Maritza Cabezas, D.D.S, M.P.H at (213) 351-7804 or mcabezas@ph.lacounty.gov.

E. REFERENCES

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BIOGRAPHIES

Maritza Cabezas, D.D.S., M.P.H. is the Dental Director for the Los Angeles County, Department of Public Health - Oral Health Program. She obtained her dental degree from the University of Sao Paulo, Brazil. Dr. Cabezas completed a Dental Public Health residency at the University of California, San Francisco. She applied to the University of Michigan to obtain her Masters' degree in Dental Public Health (DPH). She is an Adjunct Faculty at the Arizona School of Dentistry and Oral Health. You may contact her at 213-351-7804 or mcabezas@ph.lacounty.gov. Susan Bradshaw, M.D., M.P.H. TTS is a physician specialist with the Los Angeles County Department of Public Health's Division of Chronic Disease & Injury Prevention. She earned her medical degree from the University of Pittsburgh and completed a residency in Preventive Medicine and Master's Degree in Public Health at Loma Linda University Medical Center in California. Dr. Bradshaw received her Tobacco Treatment Specialist training from Mayo Clinic in Rochester. She is board-certified in Preventive Medicine as well as Integrative and Holistic Medicine. You can contact her at (213) 351-7312 or sbradshaw@ph.lacounty.gov.

Antelope Valley Report

By: Kathy McKay

SCHOOL SCREENINGS

The statistics are alarming! 10% of the children screened have never seen a dentist; 20% have not seen a dentist in more than a year; and a large percentage need extensive dental treatment. Research shows that tooth decay is the MOST common disease amongst children in the United States, and that poor oral health is the number one reason for absence in our schools.

A school screening form for each student is given directly to the school health clerk, who in turn sends the information home to the parents and/or guardians. Students who need immediate dental care and cannot afford it, are referred by the school health clerks to the Hi Desert Childrens Dental Clinic. The clinic provides free dental care to children from low income families without insurance. The clinic's motto is that "no child should go without dental care" and is responsible for treating approximately 100 children each year.

CPR CERTIFICATION

CPR Certification is available for SFVDS Members at a cost of $35 per person. If you are interested in scheduling a class, contact Bella at the central office @ 818-576-0116

When your schedule a CPR Certification for your office, $5 of the fee per participant is donated to the SFVDS Foundation!

Glendale/Burbank/Foothills Report

By: Chi Leung, DDS

On September 20th, the San Fernando Valley Dental Society held its first ever e-waste collection and patient file shredding event in Glendale, at the 11 North Central parking lot.

This special service was provided as a benefit to all dentist members in the Foothill area, as a helpful method to dispose of old patient charts. More than 20 delighted dentists attended the event, with carts full of files and e-waste in tow. The event was such a success that it had to be cut short, because the truck quickly filled to the brim! We are planning to host more activities towards the end of the year and I hope all members will attend these upcoming events. Please keep a look out for emails – you definitely don't want to miss out on these exciting events!

Welcome New Members

Pedram Zarabian, DDS
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General
UCSF, 2012

Jared Weiss, DDS
General
UCLA, 2014

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