BULLETIN OF THE SAN FERNANDO VALLEY DENTAL SOCIETY

Dental DimensionS

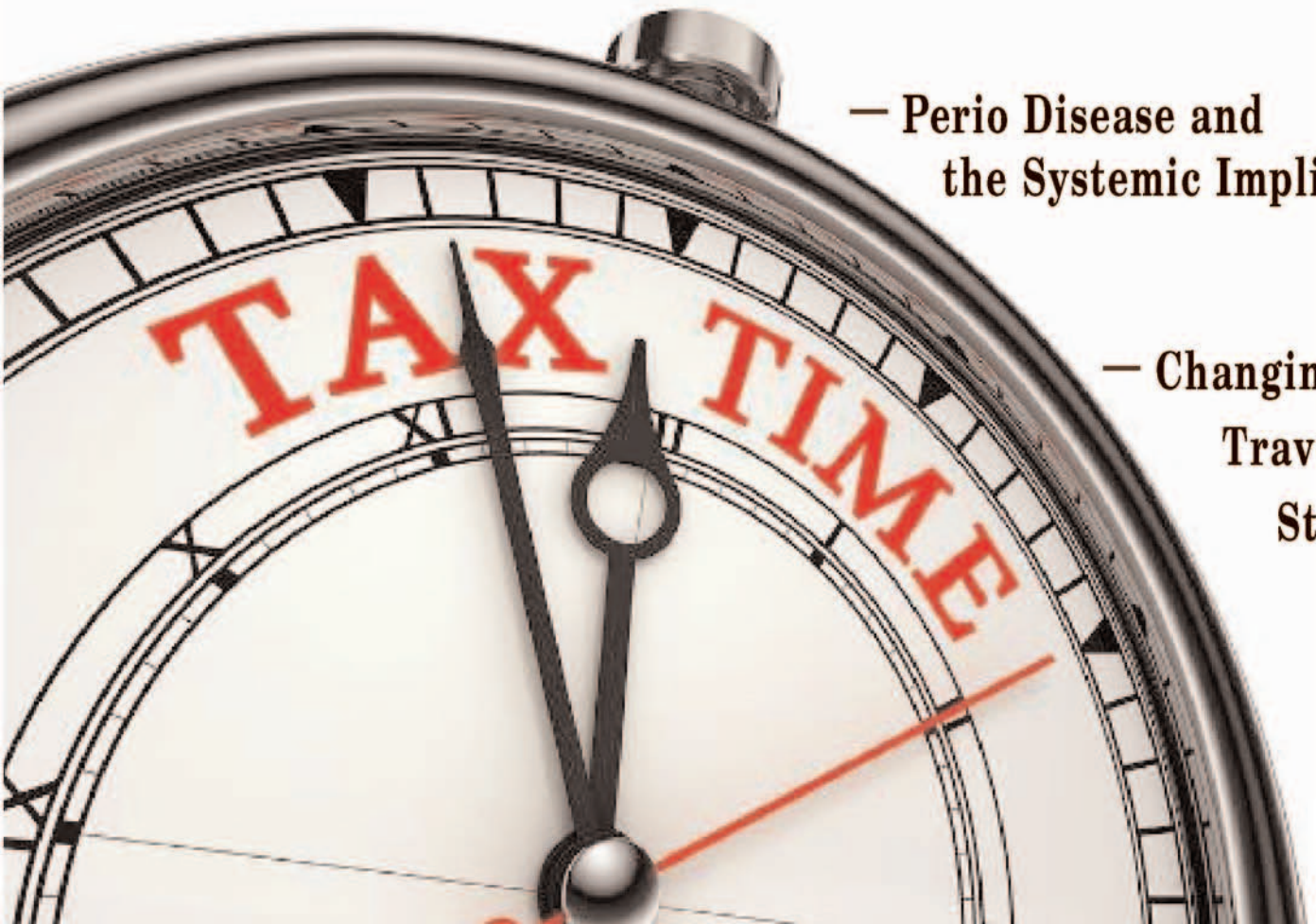
Fall 2017
WWW.SFVDS.ORG

Year-End Smart Tax Planning

— Update on Dentist Involvement in Sleep Disorders

— Perio Disease and the Systemic Implications

— Changing Travel Styles



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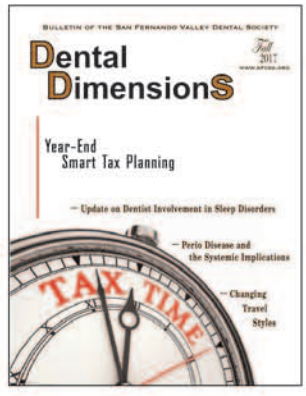
In this issue

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.....

Plain and Simple: It's time to start thinking abourt your 2017 taxes while you can still control some of the variables that will affect your tax liability. Read this informative article by a CPA, starting on page 18.

Trustees' Report

By: Martin Countney, DDS

ANNOUNCEMENTS!!

Save money on your dental supplies!! Go to www.TDSC.com and sign up your office. Can't find what you want call the phone number on the web page and TDSC will source it for you. This is the kind of service you expect from your CDA.

Actions of the Board of Trustees

Highlights of the July 27-29 Meetings

The executive committee, board of trustees and nominating committee met on July 27-29. The executive committee held discussions about the CDA strategic plan and achievement of the management objectives. They also previewed several items on the agenda for the board meeting. Highlights of the meetings include:

Nominations and Elections – The nominating committee, which is comprised of the trustee members of the board, selected Dr. Del Brunner (president-elect), Dr. Richard Nagy (vice president), Dr. Judee Tippett-Whyte (secretary) and Dr. Stephen Kend (treasurer) to be proposed for election by the House of Delegates in November. In addition, the board nominated Dr. James Stephens, as the candidate for thirteenth district trustee, to be proposed for selection by the House of Delegates in November and election by the 2018 ADA House of Delegates.

Strategic Plan – In May, the board began a thorough review of CDA's mission statement and strategic plan. At their July meeting, the board participated in another strategic planning session where they engaged in group discussions to review proposed language to the plan. The board will make final modifications in October, before approving the strategic plan that will be proposed to the House of Delegates in November. The revised draft of the CDA strategic plan is posted online at cda.org/board and cda.org/house.

Membership Category Simplification -- Over the last several years, CDA has made operational changes to support CDA's goal to make it easy for members to join and renew. The board approved recommending that the House of Delegates consider amendments to the CDA bylaws for the simplification of membership categories. The changes include removing licensure as an eligibility requirement for membership to comply with recent changes to the ADA bylaws and to consolidate membership categories into three -- dentist member, student member and general member.

Foundation Governance Task Force Recommendations – The board approved modifications to the foundation governance structure, which increase the size of the foundation board and lengthen terms, and call for the Foundation board to establish board subcommittees to oversee CDA Cares and the grants & scholarship programs. Changes to the committee structure will not take effect until late fall after CDA Cares in October, when the newly constituted foundation board holds its first meeting. The modifications also add outside and associate directors to the foundation board.

Volunteer Education Task Force Recommendations– The board approved the recommendations to implement volunteer role-specific or tailored education programs for volunteers serving as trustees, directors, officers and chairs, in place of the Leadership Education Conference and Regional Leadership Symposium.

Closed Session -

1. Legal Report: The board received a verbal update on matters related to the Delta Dental of California litigation. An action is recorded through separate closed session minutes. (Resolution #28-2017-B-Closed)
2. TDSC Update: The board received a verbal update on TDSC activities. An action is recorded through separate closed session minutes. (Resolution #29-2017-B-Closed)

My opinion

My CDA mentor, Dr. Gerry Gelfand, told me that words matter. He said choose them wisely so you communicate accurately with meaning. At a CDA Hosue of Delegates he spoke in opposition to changing CDA Scientific Sessions to CDA Presents because he felt a professional organization such as CDA should recognize that its foundation is built on science not showmanship. As I write this, there is a proposal to change the CDA membership categories and reduce them from eleven down to three (Dentist, Student and General.) Makes sense to get rid of the clutter and simplify things. However the proposal removes the 'Honorary Member' classification. Current CDA Bylaws provide for an honorary membership for an individual who has made outstanding contributions to the advancement of the art and science of dentistry, upon nomination by the board and election of the house.

Under the new classification an individual that earned and is recognized as an 'Honorary Member' will now be a 'General Member'. That just does not seem to carry as much significance as an 'Honorary' membership.

Legislative Committee Report

By: Rozeh Babaan, DDS

The committee had the pleasure of hosting Assemblyman Dante Acosta at the home of Dr. James Mertzel and his wife Marianne. Mr. Acosta was elected in 2016 to represent California's 38th Assembly District.

It was very informative and interesting spending time getting to know Mr. Acosta and some of the current issues facing Sacramento. Assemblyman Acosta was presented with documentation regarding issues concerning the dental society. They are:

Medi-Cal/Denti-Cal Funding-Proposition 56 Funding

Beginning for procedures done after July 1, 2017 providers will receive a supplemental check representing a 40% increase. In addition, all procedures that were previously deleted from the Denti-Cal program will be reinstated January 1, 2018 with the 40% increase. This represents a major accomplishment for the Government affairs committee and staff of CDA.

Health Care Reform. CDA is working to protect California's current Medi-Cal funding at both the federal and state levels, maintain state flexibility to provide coverage, prevent erosion of networks, and protect the overall dental safety net. Concerns about a roll back 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. SB 562 passed out of the Senate and is now in the Assembly, which will not take action this year since the bill does not have a funding mechanism specified.

Pediatric Dental Anesthesia. 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 under seven years-old. The bill is now under consideration in the Assembly. CDA opposed AB 224 (Thurmond), which sought to move forward with requiring a separate anesthesia provider in these cases, without the cost analysis called for by the Dental Board and without conclusive evidence that this would reduce adverse outcomes. The bill failed to pass this year and may be reconsidered in 2018.

Dental Plan Reporting & Accountability. 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. Recently, a dental loss ratio (DLR) standard for dental insurance plans has passed and been approved. CDA is exploring opportunities for establishing a suitable DLR (Dental Loss Ratio) standard for dental plans. 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 by 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. AB 1277 passed unanimously. It is expected that the Governor will sign the bill by the October 15 deadline.

Kindergarten Oral Health Assessment – SB 379 (Support). CDA is sponsoring SB 379 (Atkins) this year to: add "caries experience" (cavity history) to the reported data (this is currently collected in the existing 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 Dept. of Public Health. SB 379 passed unanimously with no opposition votes. The Governor is expected to sign the bill by the October 15 deadline.

State Office of Oral Health – Proposition 56 Funding. Dr. Kumar and the 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.

Dental board licensure fee increases anticipated in November

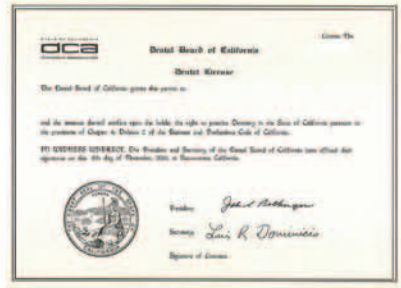
Reprinted with permission from California Dental Association

With the anticipated final approval from the state Office of Administrative Law, initial and biennial dental licensure fees will increase with an estimated effective date of November 2017. A group of ancillary fees that is linked by law to the biennial renewal fee will increase as well.

Dental licensure renewal fees were last raised in 2013, which was the first increase in 15 years. Although the Dental Board of California was facing an imminent budget shortfall and projected the need for a larger increase, it was limited by a statutory fee cap. The board subsequently sponsored legislation in 2015 to increase the cap, signaling it would return to reset fees in the near future. During this time, CDA urged the board to conduct an independent fee review to analyze expenditures and revenues, be more transparent with its budgeting process and develop a financial plan to provide a long-term, solid structural budget.

The audit, completed in December 2015, brought to light the substantial increase in expenditures the board was experiencing related primarily to the costs of the Department of Consumer Affairs' Consumer Protection Enforcement Initiative, expenses for the BreEZe licensing system, CURES development and the general increase in the cost of doing business over the years. Additionally, the audit analyzed the board's actual administrative cost for each fee category and made recommendations to bring each fee amount into closer alignment with its costs.

Upon completion of the audit, the board moved immediately forward with the rulemaking process to increase fees,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Dental Board of California

Dentist License

seeking to address the projected fund balance deficit in budget year 2017, as well as an ongoing fund balance deficit thereafter.

Key fee renewal increases are:

- Biennial licensure renewal — from $450 to $650
- Additional office permit renewal — from $100 to $250
- Fictitious name renewal — from $150 to $325
- Oral conscious sedation certificate renewal — from $75 to $136
- Oral and maxillofacial surgery permit renewal — $365 to $650
- General anesthesia or conscious sedation permit renewal — from $200 to $325
- General anesthesia or conscious sedation on-site inspection and evaluation fee — from $250 to $2,000

The complete list of proposed fee increases can be found on the dental board's website (www.dbc.ca.gov/formspubs/1021_1022_modified_text.pdf). The new fee schedule remains slightly above the midpoint of comparable California health professional licensing boards, currently ranging from $207-$820 for biennial renewal license fees.

CDA has advocated throughout this process for a full, fair and transparent approach to setting fees and encouraged ongoing financial analysis and budget planning so that fee increases occur incrementally over time. Additionally, CDA has consistently communicated that licensure fee increases should result in measurable improvements to the board's overall service to licensees and to patients.

- Visit BreEZe (www.breeze.ca.gov) the Department of Consumer Affairs' online licensing and enforcement system, to confirm your information is up to date.

General Meeting Review

Todd Snyder, DDS

September 20, 2017 - The Art of Aesthetics and Occlusion

The objective of this lecture was to present a predictable and systematic approach to occlusion and aesthetic restorations that would enable clinicians to achieve consistent quality results.
Attendees were taught how to: Diagnose a case and sequence the treatment in order to achieve the best aesthetic and occlusal outcome; Know when occlusal problems are present and how to address them so that the condition is not worsened; Understand what types of restorative material to use based on their material properties; Aesthetic crown and bridge techniques: Eliminate adjustments at cementation; Create fast and efficient temporaries every day; Use simplified impression techniques; and, How to use proper cementation of indirect restorations to eliminate any complications.

Ron Kaminer, DDS

October 25, 2017 - High Tech, Minimally Invasive Endo for the GP

This program covered current thoughts on a variety of topics related to Minimally Invasive Dentistry. Dr. Kaminer demystified posterior esthetic dentistry, utilizing both new, and tried and true materials. He instructed attendees on how tol create perfect contacts—guaranteed, and he provided concepts that could all be implemented immediately in the office.
Additionally, he reviewed: Cariology ; Therapeutic Fluoride; Esthetic posterior restorative dentistry without sensitivity; and, the myths and the truths of new restorative materials.

General Meetings -2017

Peter Jacobsen, DDS

November 15, 2017 - Fighting Dental Disease: Drugs, Bugs and Dental Products and Live Long and Prosper – Lifestyle Medicine in Dentistry

This course will update you with the latest information on a wide range of prescription drugs and over-the-counter dental products. It will also discuss the various "active ingredients", allowing you a better understanding of oral care products which will be useful for your patient. And, of course, Dr. Jacobsen will deliver the information in his unique, irreverent and entertaining way, while still focusing on the clinical realities of daily dental practice.

2018 Schedule at Glance *(remember to watch your emails for our discounted 'Season's Pass')*

January 24	Jeff Horowitz, DDS	The Science and Tech. Behind Treating Sleep Apnea
February 28	Nancy Dewhirst, RDA	CA Dental Practice Act and Infection Control
March 21	Tony Tomaro, DDS	Smile Design - How to Give Patients What They Desire
April 25	Sam Halabo, DDS	Achieving Superb Results with Everyday Bread and Butter, Direct and Indirect Procedures
June 20	Gordon Fraser, DDS	Soft Tissue Concepts for the General Dentist
Sept 26	Joyce Bassett, DDS	Cutting Edge Tech. with Digital Design and Real World Cosmetic Dentistry - Faults, Failures and Fixes
Oct 24	Susan McMahon, DDS	Conservative Cosmetic Dentistry for Teens and Young Adults
Nov 28	Gary Radz, DDS	Tips, Tricks and Techniques for the Esthetics Based General Dentist

Coming in 2018

(Working Titles)

Dental Success Summit

As a follow-up to 2017's successful, Dental MBA program, a series of seven CE lectures is being planned for 2018, starting in January and ending in the fall. Sign-ups will begin during December, 2017, so watch your emails for the registration forms. Each session will be held on a weeknight, include dinner and CE units for eligible courses. A series workbook will be provided.

Those who complete all seven courses will be able to participate in a graduation-type ceremony, with a photographer available to provide 'year book' pictures for your social media and marketing applications.

Session 1: Nail it
The six drivers of business success. SWOT analysis

Session 2: Scale it
Creating a world class client experience & attracting a steady stream of new dentistry to your practice

Session 3: Organize it
Systematize your practice/business

Session 4: HR 4 Health : Systems for HR management

Session 5: Monetize it
Running your business at a profit and minimizing taxes

Session 5: Fund it & Grow it
Using debt to build your business value and why practice demographics matter

Session 6: Market it
Technology in Dental - how big data is changing how we approach dental marketing as a whole

Session 7: Keep it & Live it
5 key concerns of successful dentists - How to get to and enjoy a great quality of life.

Help Wanted

Volunteers needed to help provide dental services to:
Give Kids a Smile - Children
Smiles From the Heart - Uninsured adults
Veterans' Smile Day - Veterans

Please call the SFVDS central office to sign on.
818.576.0116

My Travels

By: Nita Dixit, DDS

While on my recent trip to Alaska, Past-President Jorge Alvarez, emailed me to ask if I was willing to write an article on my travels. I have shared pictures of my various trips with my Facebook friends (of which he is one) and he thought the article would be of interest to our dental community.

I did not want this article to be a travelogue so I decided to reflect on how my travel style had changed over the years and why I enjoy traveling so much.

The first overseas trip I took was to come to Los Angeles in June 1988. As my husband and I struggled to beg or borrow to pay for dental school every semester, there was no money for overseas travel. But we eventually had enough frequent flyer miles for two tickets to Europe and $400 in the bank, so off we went! It was an exciting trip where we visited France, Germany, Austria and Switzerland. I still remember waking up in a Zimmer (bed and breakfast) in Innsbruck, Austria to discover it had snowed at night and created a picture postcard vista. It was the first time I had seen snow!

I continued to accompany my husband to his various meetings in the US and abroad first by myself and then with my two sons. We stayed at the best of hotels and dined at the finest restaurants on those trips.

Interspersed between the meetings were trips to India with stopovers in Thailand, Malaysia, Japan, China and Taiwan. My husband, Vivek and I took every opportunity to travel although the travel style changed after we had children. We favored all-inclusive resorts and made sure the hotels had swimming pools the kids would enjoy.

Living in Los Angeles meant we had friends and colleagues from every part of the world and we visited some of them in England, Turkey, Trinidad and Tobago. I prioritized raising my boys over work so there were no luxury trips but we as a family continued to expand our knowledge of the world and discovered the commonality in people all over the world. We picked up phrases in the local language, figured out the vegetarian options in the local food, mimed our way when the locals did not speak English and swallowed lobster at the enormous feast put together in our honor at a fishing village in Taiwan!

There was a period of ten years when due to circumstances the only travel I could afford was to visit my parents in India. When their health started to fail, I visited them for a week every six months so that they did not feel dejected at the prospect of my departure.

When Vivek's work did not allow him to take longer trips, I started traveling with my younger son and siblings. My parents had passed away and we looked forward to exploring different countries together. We visited Bali in Indonesia, Greece, Norway and Denmark. I was determined to make up for lost time and visited a new country every year. I even traveled solo on an escorted trip to Italy when I could not coordinate travel with my family.

The other trips I have been making every year were to our neighboring country, Mexico. Vivek and I spent a week exploring Mexico City and Teotihuachan (land of the Aztecs). Another year we spent a week exploring the Yucatan peninsula and Guatemala (land of the Mayans). I look forward to visiting Peru next year (land of the Incas).

Continued on page 10

My Travels

By: Nita Dixit, DDS

By now, a pattern has started to emerge. Ideally, I like traveling for a week so that it does not inconvenience my patients too much and does not create too much work for me when I return. It also keeps me from getting bored! ADHD anyone? Advances in technology means that I can be more spontaneous in my travel and do not have to research and plan endlessly. All I need is an air ticket and a rental car! The time I spend visiting museums is proportional to the retention of information after my return. I do not much care about visiting another rich person's trophy home viz. palaces. All I want to do is get a feel for the place and the people and learn things that you would not know unless you visit the place.

A case in point is my recent trip to Alaska. Every person that I discussed my trip with asked me if I was going on a cruise. It is by far the most popular way to see Alaska. The thought of being stuck on a ship for 7 days was out of question for me so I looked at the map and decided to fly into Anchorage and rent a car. I took a red eye flight to maximize my time there and was in Denali by noon. The rain had cleared up by then and we took a tour of Denali National Park and visited the museum and visitor center. We saw some moose and caribou grazing in the wild. Next, a visit to the Husky Homestead gave us an insight into what it takes to prepare for and win the Iditarod.

The next day was sunny and we were overwhelmed by the grandeur of the Alaska Range. We took a flight over it from Talkeetna that was singularly the most beautiful and meditative experience I have ever had on a trip. Peaks like Moose's Tooth and Root Canal Glacier made me wonder if a dentist was involved in the naming of the landmarks! We stayed overnight in Wasilla and visited the Matanuska Glacier the following day. It is privately owned and you can walk on it at your own risk. The next day we set off for Seward, a commercial fishing hub and a port of call for cruise ships where we saw sea otters and salmon galore. We had to cancel our cruise to the Kenai Fjords the next day because of rain and returned a day early to Los Angeles. A visit to the Alaska Wildlife Conservation Center and Heritage Centre rounded off our trip. I look forward to flying into Juneau next year and continuing my adventure in Alaska!

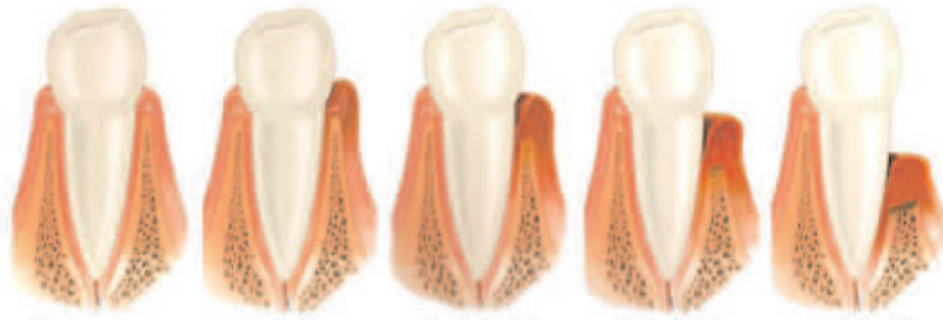
In today's world traveling is easy and does not have to be expensive. There are many modes and foci of travel and you can find one that appeals to you. I prefer the independent mode but have tried and enjoyed other modes of travel too. What you gain by traveling is a valuable insight into other cultures and a better understanding of the world. It rejuvenates you, reduces stress and gives your staff a break! You don't have to travel to far-off places. We are fortunate to live in a country that has abundant natural beauty.

I hope you have many safe travels that make you excited about coming back to work and planning your next trip!

List of SFVDS Periodontist Dentist Members

Hanasab	Homan	DDS	7239 Van Nuys Blvd # 6	Van Nuys	CA	91405-5863	(818) 785-2424
Horowitz	Stephen	DDS	17777 Ventura Blvd Ste 214	Encino	CA	91316-3738	(818) 654-8310
Waki	Marc	DDS	3808 W Riverside Dr Ste 204	Burbank	CA	91505-4339	(818) 842-6162
Zussman	Kory	DDS	16311 Ventura Blvd Ste 625	Encino	CA	91436-4317	(818) 907-1318
Abelson	Michael	DDS	25880 Tournament Rd Ste 108	Valencia	CA	91355-2383	(661) 254-9640
Benarroch	Moshe	DMD	23838 Valencia Blvd Ste 230	Valencia	CA	91355-2190	(661) 222-7762
Benia	Todd	DDS	18250 Roscoe Blvd Ste 230	Northridge	CA	91325-4269	(323) 510-9708
Benveniste	Richard	DDS	19231 Victory Blvd Ste 256	Reseda	CA	91335-6347	(818) 881-7337
Exler	Steven	DDS	16311 Ventura Blvd Ste 1005	Encino	CA	91436-4344	(818) 907-1780
Fakheri	Pedram	DMD	1125 S Beverly Dr Ste 400	Los Angeles	CA	90035-1152	(818) 897-1234
Fingerman	Gordon	DMD	18740 Ventura Blvd Ste 103	Tarzana	CA	91356-6301	(818) 705-3232
Grasu	Rodica	DDS	16055 Ventura Blvd Ste 405	Encino	CA	91436-2608	(818) 990-5090
Green	Gary	DDS	16133 Ventura Blvd Ste 1040	Encino	CA	91436-2423	(818) 995-0294
Gross	Marc	DDS	5400 Balboa Blvd Ste 315	Encino	CA	91316-5229	(818) 990-5220
Hame	Homayoon	DDS	40414 California Oaks Rd, Ste A	Murrieta	CA	92562	(951) 304-7474
Hendry	Tyler	DDS	411 N Central Ave Ste 220	Glendale	CA	91203-2020	(818) 240-4555
Henick	Bertram	DDS	26560 Agoura Rd Ste 102	Calabasas	CA	91302-1949	(818) 871-9416
Hoang	Taylor	DDS	3808 W Riverside Dr Ste 204	Burbank	CA	91505-4339	(818) 842-6162
Hosn	Kalid	DDS	505 E Doran St Apt 105	Glendale	CA	91206-5320	(818) 813-3337
Imberman	Michael	DMD	18425 Burbank Blvd Ste 709	Tarzana	CA	91356-6669	(818) 345-5300
Isaacs	David	DDS	4350 Woodman Ave	Sherman Oaks	CA	91423-3031	(818) 981-4508
Khorsandi	S	DDS	4521 Sherman Oaks Ave Ste 201	Sherman Oaks	CA	91403-3807	(818) 981-4867
Kim	Clara	DDS	3971 Irvine Blvd Ste 102	Irvine	CA	92602-2476	
Lascoe	Ronald	DMD	3808 W Riverside Dr Ste 204	Burbank	CA	91505-4339	(818) 842-6162
Levine	David	DDS	3808 W Riverside Dr Ste 305	Burbank	CA	91505-4339	(818) 558-7454
Levy	Ori	DDS					(818) 427-4444
Matian	Fariborz	DDS	19900 Ventura Blvd Fl 200	Woodland Hills	CA	91364-2689	(818) 914-7484
Merin	Robert	DDS	6342 Fallbrook Ave Ste 101	Woodland Hills	CA	91367-1613	(818) 887-7772
Naim	Sam	DDS	16661 Ventura Blvd Ste 308	Encino	CA	91436-1919	(818) 336-1120
Niver	Franklin	DMD	16311 Ventura Blvd Ste 1110	Encino	CA	91436-4354	(818) 788-6600
Okui	Matthew	DDS	16055 Ventura Blvd Ste 820	Encino	CA	91436-2610	(818) 990-5222
Parham	Sohail	DDS	4955 Van Nuys Blvd	Sherman Oaks	CA	91403-1801	(818) 990-5795
Penhaskashi	Alfred	DDS	5363 Balboa Blvd Ste 226	Encino	CA	91316-2822	(818) 788-7091
Safarian	Andrioush	DDS	1000 N Central Ave Ste 250	Glendale	CA	91202-2912	(818) 241-6860
Saghizadeh	Mahasti	DDS	12423 Ventura Blvd	Studio City	CA	91604-2407	(818) 760-0333
Sakhai	Sean	DDS	6342 Fallbrook Ave Ste 101	Woodland Hills	CA	91367-1613	(818) 887-7772
Shahi	Rana	DDS	10244-1 Canoga Ave	Chatsworth	CA	91311	(818) 341-6655
Sin	Elisa	DDS	4455 Deanwood Dr	Woodland Hills	CA	91364-5620	(617) 620-0873
Singh	Shalini	DDS	44444 16th St W Ste 201	Lancaster	CA	93534-2840	(661) 723-9414
Tanavoli Sara	DDS		6325 Topanga Canyon Blvd Ste 202	Woodland Hills	CA	91367-2015	(818) 606-7871
Wasserstein	Jack	DDS	27450 Tourney Rd Ste 100	Valencia	CA	91355-1829	(661) 254-8484
Whang	Michael	DDS	16055 Ventura Blvd Suite 405	Encino	CA	91436	(818) 990-5090
Yashar-Matian	Aida	DDS	19900 Ventura Blvd Fl 200	Woodland Hills	CA	91364-2689	(818) 914-7484

PERIODONTAL DISESE AND THE SYSTEMIC IMPLICATIONS



Periodontal Disease is a condition in which an immuno-inflammatory response of the host results in the destruction of tooth-supporting periodontium. It is also caused by bacterial pathogens. The detrimental effects of periodontal disease are triggered by the presence of bacteria which leads to chronic inflammation around the periodontium, eventually resulting in the loss of periodontal ligament and the destruction of alveolar bone. As one of the most common oral conditions to affect the US population, recent studies on periodontal disease have shed light on possible implications and correlation between periodontal disease and systemic medical conditions. This review provides a brief overview of where the current literature stands in regards to the relationship between periodontal disease and systemic medical conditions.

Diabetes Mellitus

Literature indicates that the evidence is strong in the bi-directional relationship between poorly controlled diabetes and the progression of periodontal disease. Diabetes is a disease of metabolic dysregulation in which secretion or utilization of insulin is impaired, resulting in high blood glucose level. It is thought that high blood glucose results in defective neutrophils and phagocytes, thereby compromising the host's response to bacteria around the periodontium. In addition, diabetes upregulates inflammatory cytokines such as matrix metalloproteinases (MMPs) and prostaglandins which are essential in the breakdown of the periodontal ligament, the surrounding collagen fibers, and the alveolar bone.

Various studies have reported a statistically significant relationship between poorly controlled diabetic patients and periodontal disease, with odds ratios ranging from 2.8-3.4 (1, 2). This is corroborated by the US National Health and Nutrition Examination Survey (NHANES) III, which found that adults with elevated hemoglobin A1c (HbA1c) levels had significantly higher prevalence of severe periodontitis than those without diabetes. This was after controlling for age, ethnicity, education, sex and smoking (3)
It is important to note that the relationship is bi-directional, indicating that the presence of periodontal disease also has detrimental effects on the blood glycemic control in diabetic patients. It is relatively a recent finding that inflammatory mediators from periodontal infections such as tumor necrosis factor-alpha (TNF-_), interleukin-1-beta (IL-1 _), and interleukin-6 (IL-6) have shown to adversely affect the lipid and glucose metabolism as well as insulin action, resulting in development of diabetes (5). There are several systemic reviews and meta analyses which show that routine non-surgical periodontal treatment alone can reduce the HbA1c in diabetic patients (6-12). Thus, the recognition and intervention of periodontal disease in patients by dental health professionals can play an important role in establishing good glycemic control in those with diabetes, impacting patients' systemic health beyond the realm of oral health alone.

Cardiovascular Disease

Along with diabetes, cardiovascular disease is another condition that has been consistently correlated with periodontal disease through the literature. The underlying mechanism of cardiovascular disease involves the formation of atheroma, which is a build-up of plaque along the lumen of the vessels resulting in hardening of the arteries (atherosclerosis). This in turn may lead to partial or full blockage of the coronary arteries which reduces the blood flow to the heart (coronary heart disease). The end result can lead to hypertension and even heart failure.
Researchers today believe that inflammation plays a crucial role in pathogenesis and development of atherosclerosis; there is a growing body of evidence that inflammatory cytokines and chemokines, the same inflammatory mediators involved in chronic periodontitis, activate the endothelium and monocytes associated with developing atheroma (13). The link between inflammation and atherosclerosis suggests that chronic oral infections from periodontal disease can predispose one to a higher risk of cardiovascular disease (14).

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There are other direct lines of evidence that support this link. A number of studies have reported the presence of key periodontal pathogens including Porphyromonas gingivalis, Tannerella forsythensis, and Prevotella intermedia in the atherosclerotic plaque, suggesting possible direct invasion of these pathogens into the atheroma (15). In addition, P. gingivalis has been implicated with invading endothelium and facilitating platelet aggregation leading to the formation of atheroma along the lumen of the vessels (16).

Numerous epidemiological studies add support to link between cardiovascular disease and periodontal disease as well. The cross-sectional study from NHANES III examined 9,760 subjects and reported that the patients with severe clinical attachment loss were 3.4 times more likely to have myocardial infarction and had 25% increased risk of coronary heart disease compared with the subjects with healthy periodontium (17). Another study reported odds ratio of approximately 2.0 and concluded that periodontitis could be considered a risk factor for atherosclerosis and coronary heart disease (18).

While these findings do not necessarily support the causal relationship between one another, it is evident that there is correlation between the two conditions as explained by the similar pathogenesis processes involving chronic inflammation. Therefore, the importance of the role of dental health professionals cannot be understated in recognizing periodontal disease. Controlling inflammation and establishing a healthy periodontium will not only affect the oral health, but it will also lead to decreased systemic inflammatory insult and may contribute to preventing cardiovascular disease.

Rheumatoid Arthritis

Two of the most common chronic inflammatory diseases affecting humans are periodontitis and rheumatoid arthritis (4). In both conditions, the inflammatory mediators have detrimental effects on the local soft and hard tissues. While the tissue destruction in periodontitis is well understood in that the presence of biofilm of bacteria elicits the inflammatory reaction, the autoimmune pathogenesis process in rheumatoid arthritis remains poorly understood in that the offending stimulus is still unknown (4).
There are a number of studies reporting that periodontal disease is more prevalent in rheumatoid arthritis patients and that the periodontal disease may even initiate the autoimmune response in rheumatoid arthritis (19). These individua ls seem to show higher prevalence of alveolar bone destruction and tooth loss (20). An animal study using rodents have also shown that P. gingivalis can induce a rheumatoid arthritis-like condition in susceptible rodents (21). Conversely, another study reports that citrullinated proteins, which are peptides detected in the blood in rheumatoid arthritis patients from converting of arginine residues to citrulline, are also detected in inflamed gingiva in patients with periodontitis (22). This may indicate the bidirectional relationship of the two conditions.

Despite these findings however, conflicting reports exist; several epidemiological studies including NHANES data found inconsistent association between the two conditions (23). While the possible correlation between the two seems plausible, further investigation is needed.

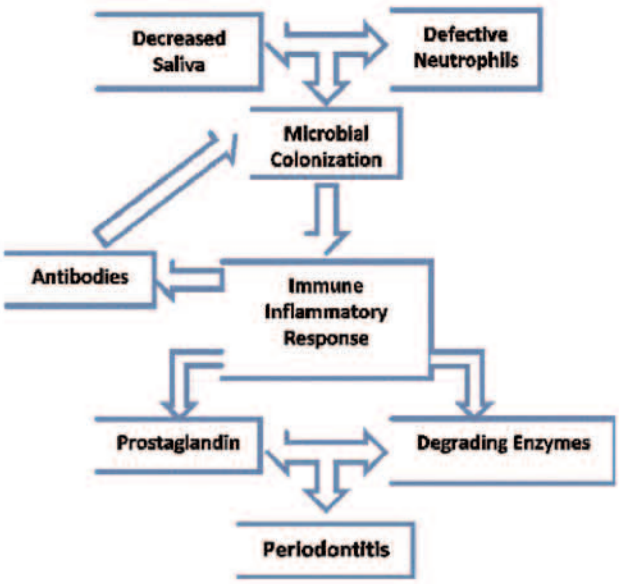
Cancer

Alcohol and smoking are two most well-known significant risk factors for oral/oropharyngeal cancer, but there have been some studies that propose possible link between oral/oropharyngeal cancer and poor oral hygiene/oral health (4). A study reported an increased risk for tongue cancer with odds ratio as large as 5.23 with each millimeter of alveolar bone loss (24). While some oral microbes have been known to cause malignant changes in the cells and tissues (23), the current existing evidence is not robust to support the association between periodontal disease and oral/oropharyngeal cancer and therefore further investigation and epidemiological study are needed.

Pregnancy

Periodontal disease has been associated with pre-term low birth weight in pregnant patient population. Pre-term birth is defined as birth before 37 weeks of gestation and low birth weight refers to less than 2500 grams. The current theory postulates that the gram negative bacteria that are prevalent in periodontitis elicit the response of inflammatory cytokines; these cytokines, especially prostaglandin E2, are thought to induce early contraction and preterm birth (25). A study with 1,020 subjects reported that the incidence of preterm birth was 11.2% in women with periodontal health compared with 28.6% in women with moderate to severe periodontitis (25).

Continued on page 14



Diseases of the Respiratory Tract

A number of researches have reported the association between dental biofilm and respiratory diseases such as chronic obstructive pulmonary disease (COPD) and nosocomial pneumonia. Although the mechanism is poorly understood, it is suspected that the pathogenic bacteria of the oral cavity can be aspirated into the respiratory tract to cause infection. Furthermore, some have suspected the cytokines induced from the periodontally inflamed tissues by the local biofilm may also be aspirated into the lungs, thereby stimulating the local inflammatory processes preceding colonization of pathogens and the actual infection (4). Although a few epidemiological studies are available that support this correlation (20, 26), further investigation would be valuable to strengthen the argument.

Chronic Kidney Disease

Statistically significant correlations have consistently been reported on several studies looking at the association between periodontitis and chronic kidney disease. Not only did a large epidemiological study of 11,955 subjects identify periodontitis as a risk factor for chronic kidney disease (27), but another systemic review also reported that treatment of periodontitis resulted in improved outcomes in patients with chronic kidney disease (28). It is unlikely however that periodontitis directly affects the kidneys. Rather, the association is thought to stem from other etiological factors such as blood pressure and diabetes which are delicately intertwined with the periodontal status and oral health (23).

Concluding Remarks

A plethora of literatures available today provide varying degrees of evidence in exploring the association between periodontal disease and various systemic medical conditions. The evidence is strong and robust in some conditions while others need further future investigation to shed light.

It should be noted that periodontal disease can be treated and prevented if screened and diagnosed at an early stage, resulting in reduction and even possible elimination of related systemic diseases and complications (29). Thus, healthcare providers (both dentists and physicians) should be able to recognize and diagnose oral and periodontal conditions in patients and help direct them to appropriate periodontal care, thereby improving the quality of life for patients in oral as well as systemic health. The importance of dentists and physicians working together cannot be overstated.

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Word Search

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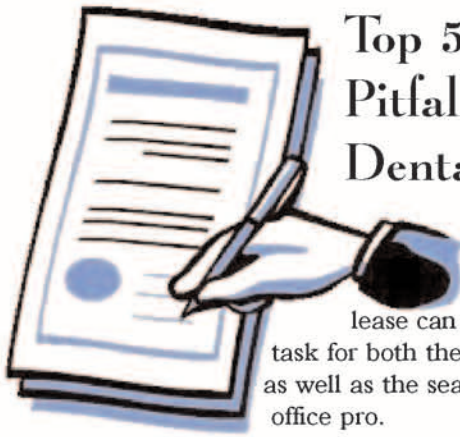

Top 5 Leasing Pitfalls for The Dental Tenant

Working through the fine print on a new dental lease can be a daunting task for both the first time tenant as well as the seasoned, multi-office pro.

The rental rate, lease term, Landlord's tenant improvement contribution and the renewal option are chief among the items that the dental professional will traditionally focus on. While all important deal points are worthy of your attention, there are many other terms and conditions contained in most leases that often go overlooked which can potentially cause serious financial implications down the line.

For the purposes of this article, we will focus on and bring to your attention five of those "hidden" deal points. Armed with the knowledge of them, the implications and rational for them in a lease, the savvy dental professional can often negotiate some, if not all, of them out of the lease.

We like to call these the Top 5 Dental Leasing Pitfalls:

#5. Base Year Reset: On a gross or full service gross lease (meaning that the landlord covers the cost of the real estate taxes, insurance, utilities and building maintenance within the rent) the "Base Year" is usually set as the first calendar year of your lease. The level of operating expenses that the landlord will continue to pay mirrors that of what is paid during the base year. Thereafter, any increase in the operating expenses is passed through to the tenant on a monthly estimate and reconciled at the end of the year. (ie. If it cost the landlord $1.00 per square foot in expenses in the first year, and $1.05 in the second year, the landlord continues to pay the $1.00 and passes the increase of $.05 on to the tenant.) The further that you get from the base year, the greater the increase in expenses over the Base Year that the tenant is required to pay. While this is normal in a full service gross type lease, it is critical, that in the exercising of your renewal option or any other extension to the lease term, that you have the base year reset to the then current year otherwise the expenses that the landlord is allowed to pass through to the tenant continue to build annually year after year. It is best to negotiate up front that upon the exercising of any lease option or extension, that the Base Year will automatically be reset.

#4. Non-Disturbance Agreement: A Non-Disturbance agreement is an agreement where in the building's lender, in the case of a foreclosure on the building, will recognize your lease as being in full force and effect. Without such an agreement in place, were the landlord to foreclose on your building, they would have the option to either recognize your lease or consider it invalid. For the dentist, who often times spends hundreds of thousands of dollars to build out their dental office, proper assurances that their lease will be recognized is an important issue. That being said, one must understand that the landlord cannot compel their lender to provide such an agreement, and the best that a landlord can usually provide is to use "commercially reasonable efforts" to request such an agreement from their lender. One must also keep the size of your leased space in relation to the overall size of the building in perspective. If you occupy 50% of the building, your tenancy offers much more importance to the stability of the building and gives you more clout in requesting concessions from both the landlord and their lender. If unable to achieve such an agreement, the dentist needs to use reasonable judgment in assessing the financial stability of the building prior to entering into any lease where they will be required to provide a substantial portion of their improvement costs.

#3. ADA Code Compliance "Path of Travel": Current ADA building codes dictate accessibility standards for all new dental office locations. Not only does this include accessibility within the dental suite but also the entire path of travel from the suite to the entry point of the building (front door and parking area). While some standards are mandatory to be implemented in all buildings, in some cases the current building condition is "grandfathered" in, meaning no changes or updates are required, until or unless a new building permit is pulled for a use in the building.

Many dental leases will contain the clause that the tenant is responsible for any building changes triggered by their use of the building. If this clause is left unaltered in the lease, potentially the tenant could be held accountable for the entire path of travel from their suite throughout the building to the entrance, which could include the responsibility to upgrade common area corridors, common area rest rooms, elevators, the building lobby and access ramps. Depending on the size of the building, these cost can range from the tens of thousands to literally hundreds of thousands of dollars in improvement to the landlord's building. The best way to address this situation is negotiate to modify the lease language to state that the tenant shall be responsible for ADA compliance within the suite only and the landlord shall bear the responsibility for and compliance issues for the common areas.

#2. Option Rights – Are they Transferable? In covering the basic lease business terms, most doctors understand that an option gives them control of the space and the right to extend the lease term. Options tie the landlord's hands and give the control of the space to the tenant without having to make a longer commitment up front. As a counter to this, most leases make the Option rights "personal" to the original doctor signing the lease, meaning that if you plan to sell your practice, the rights to the renewal option do not transfer to the incoming dentist. This can put a big roadblock in the sale of a practice as dental lenders with not lend on the purchase of a practice unless there are at minimum of 5 years of lease term remaining. They will count options as part of the remaining term but only if they are transferable to the doctor taking over the lease. Most non-dental businesses that lease office space do not have the same retirement/exit strategy of selling the business, so making the option rights personal to the original tenant isn't a big issue for many. For the doctor nearing retirement age or thinking about selling their practice, this can be critical. Once properly explained to the landlord as to the particular rational

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of the need for the option transfer ability, most will grant the transfer right if it is association with the sale of the dental practice.

#1. Recapture Clause: This one can be the "sleeping giant" in the lease and it is very often overlooked. After practicing for 30 years and building up a lucrative practice with a great patient base and a lot's of good will associated with your office location, you decide that its time to spend more time enjoying life, sell your practice and retire.

Your practice sale brokers lines up a great dentist to purchase the practice who is financially qualified. You approach your landlord to let them know that you are retiring and that a new doctor will be taking over the practice. The landlord wishes you well but then informs you that he intends to take the space back from you which torpedoes your practice sale and the value of your practice plummets. There goes your retirement!

Buried within the Assignment and Sublease section of most leases is something known as the "Recapture Clause" which gives the landlord the right to cancel your lease and take back your space if you request an assignment of your lease or sub-lease of your space. Similar to the Option Rights issue, most non-dental tenants that lease space do not have the same plan of selling the business, so if the landlord takes back the space it isn't a big issue. For the selling doctor, this can spell disaster! The value of the your dental practice is highly dependent upon the improvements within the space and the assignability of the lease as well as the "good will" associated with that particular location that you have built up over the years. Without the ability to transfer the lease, all you really have to sell is your patient records.

Similar to the options transferability discussed above, provided that you explain the need for this change and negotiate this up front before signing the lease, most landlord's will agree to waive the recapture clause when it is association with the sale of the dental practice.

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Practice Transitions

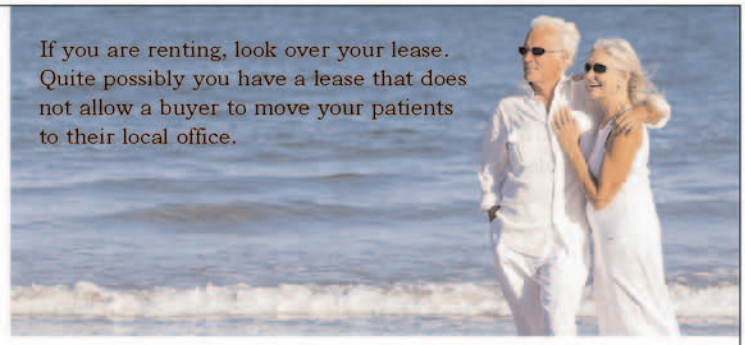
Step 5

Pull out your current lease and review it ! The things you will look for are benefits within your lease, for a new buyer. How will your lease increase the value of your practice?

For the buyer who wants to stay in your office with some modifications, it is necessary to have a lease that assures them that no major increases are just around the corner. For that same buyer, it is important to have a couple of 5 year options that continue at the same rate of annual increases..

For the Buyer who is looking to move your patients to their local office, it is important that you are currently on a month to month lease.

Let's face it, the fewer obstacles you have in your lease the better your chances are of having a buyer that can purchase without a lease full of drawbacks. The lease will have a definite impact on your sale and the purchase price.



A more favorable lease is one that is a full service gross.

That means that the lease does not have any NNN fees or those fees have already been calculated into the price per square feet.. The price per square foot that you pay is your only expense for rent.

Do you have a buy out clause in your lease? This is valuable because of two issues. The first is in the event you become unable to practice, your estate can purchase out of the lease by a single payment. In most cases it is 5 to 6 months of the lease. The second is that the buyer may not want to stay in the space your office is occupying. They may want to buy the practice and move the patients to an office nearby.

For information on, NNN fees, CAMS charges, rentable square feet v/s usable square feet call me: 626.583.8484 I will be happy to share this information.

Year-End Smart Tax Planning Moves for Dentists

If you find yourself asking your CPA for tax planning ideas in March and April when your corporate and personal tax returns are due you will have most likely missed the bus when it comes to the most beneficial tax moves. True tax planning happens before year-end when action can be taken to implement strategies to save you money. Here are some tax saving moves to consider as we near the fourth quarter of 2017.

Home Office: Set up a home office to be used regularly and exclusively to perform the administrative functions of your practice. This will allow you to deduct a proportional amount of otherwise non-deductible personal expenses such as property insurance, utilities, repairs or rent. By doing this your home office may qualify as your main place of business which will allow a deduction for travel back and forth to your practice which otherwise would be considered a non-deductible commuting cost. Have your practice reimburse you for the calculated costs of your home office.

Auto: Have your practice reimburse you for the business use portion of your auto expenses. In order to take a deduction for your auto expenses you must track your business and personal use of your auto. However, if your business travel can be shown to be consistent throughout the year you may track your miles for a certain period (we recommend three months) and apply the business percentage to the rest of the year. There are some great smart phone apps that will make this task much less painful than it used to be. You can be reimbursed by using the standard mileage rate (53.5 cents/mile in 2017) or the business portion of actual expenses.

If you purchase a new auto in 2017 you may be able to take advantage of accelerated depreciation of up to $11,160 in the first year. The amount increases to $11,560 for a new truck. If you purchase a truck or SUV that weighs greater than $6,000 lbs you may be able to take a first-year deduction of $25,000 plus bonus depreciation of 50% on the remaining cost. Both deductions are limited to your business use percentage which must be greater than 50%. Be sure to talk to your CPA about the possible pitfalls of "depreciation recapture" if your business use falls below 50%. By correctly implementing a home office you will increase your chances of meeting this 50% requirement since the miles to your practice each day will be business miles.

Section 199 Deduction: If you utilize a CAD/CAM machine to create in house crowns for your patients you may qualify for a special manufacturing deduction worth up to 9% of net income generated from the production and placement of the crowns. This represents an additional deduction for costs you have already incurred. Be sure to ask your CPA if you use a CAD/CAM machine in your office.

Accelerated depreciation on equipment: Equipment purchased in 2017 is eligible for a first-year section 179 deduction of up to $500,000. Bonus depreciation of 50% is also available. This can allow you to recover all (or a large portion) of the cost of new equipment in the first year of purchase. Be aware that if your practice is set up as an S-Corporation there may be basis limitations that can affect the amount of deduction you can pass through to your personal return and the amount of tax free distributions you can take. Hire your spouse or children: If your practice has a 401(k) or another qualified retirement plan hire your spouse through the practice and pay a salary that will enable them to contribute $18,000 to a 401K plan ($24,000 if over 50 years of age). Even greater benefits can be received if your practice operates a profit sharing plan. Speak with your CPA to determine the most beneficial salary amount for both doctor and spouse.

If your children are of an age that they can help with certain tasks hire them through the practice. If their pay is less than $6,300 they will have no federal filing requirement (state filing thresholds may vary). If you have children in college it may be beneficial to hire them through the practice and have them pay for a portion of their schooling from their wages. If you can earn at least 50% of their total support they can claim themselves and offset all or most of their tax liability by taking advantage of the American Opportunity Tax Credit which will most likely be phased out and of no value on your own return.

Retirement plans: If you don't currently have a retirement plan speak to your CPA now to determine which type of plan offers to the best options for your unique situation. By setting up the plan before year-end you will have access to more plan options to allow you to make tax deductible contributions for 2017.

Health Savings Account contributions: If you utilize a High Deductible Health Plan set up and fund a Health Savings Account. Tax deductible contributions for 2017 can be made of $6,750 for a family and $3,400 for an individual. The contributions are made pre-tax and can be withdrawn

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tax free if used for qualified medical expenses. Catch up contributions of $1,000 can be made for an individual over 55.

Meals and Entertainment: Expenses paid for meals and entertainment are generally only 50% deductible for tax purposes. This is because the IRS assumes there is an inherent personal enjoyment being received by taking part in the meal or the entertainment activity. However, there are some meals that are 100% deductible. We recommend setting up two "meal" accounts. Label one account "meals and entertainment" and include meals with customers, referral sources, or one on one meetings with employees. Label the other account "100% meals" and include expenses for in-house staff meals or company parties which are 100% deductible. Separating the accounts will enable your CPA to identify the correct treatment of each group of expenses.

Rent your home to your practice: If you facilitate company parties or staff meetings at your personal residence have your practice rent your home for the day and reimburse you for the expense. Your personal residence can be rented for up to 14 days per year without you having to report the income on your personal tax return. The expense will be fully deductible to your practice. Likewise, if you use your home to store client records or other files related to your business have your practice reimburse you for the use of the storage space.

Child Tax Credit: If you pay for childcare expenses for children under 13 in order to allow you or your spouse to work you may be eligible to take a credit for a portion of up to $6,000 in childcare expenses. This credit, unlike most, does not fully phase out as income increases. No matter the amount of your income you can always take a credit of at least 20% of $3,000 in expenses for one child or $6,000 in expenses for two or more. Expenses eligible for the credit are limited to the amount earned by either spouse.

Health Insurance: In order to deduct your health insurance payments fully have you practice pay the premiums. Otherwise the deduction may be limited or lost altogether if it is reported as an itemized deduction where your total deductible medical expenses will be limited to the amount in excess of 10% of your adjusted gross income.

Prepay expenses: To accelerate deductions into the current year prepay your January mortgage payment in December or pay the first installment of your 2018 property taxes in 2017. This is especially effective if you expect your income to be greater this year than next. Beware that AMT (Alternative Minimum Tax) may limit your ability to benefit from prepaying taxes. It may be worth asking your CPA to do a tax projection to determine if you will be in AMT. You can also prepay certain practice expenses, such as office supplies, in December rather than January in order to move the deduction into the current year rather than the next.

Get reimbursed for expenses paid personally: Be sure to have your practice reimburse you for any company expenses that you may paid out of pocket or with a personal check or personal credit card. Often times expenses are paid personally for the sake of convenience and then forgotten about and never reimbursed.

Update on Dentists involvement in sleep disorders at the organized dentistry level.

On Saturday October 21, 2017 the ADA house of delegates reference committee will have discussed resolution AB 17 - "Proposed Policy Statement on the Role of Dentistry in the Treatment of Sleep-Related Breathing Disorders". (As the press deadline for Dental Dimensions precedes the outcome of the ADA House discussion, I will provide an update of any ADA actions in the Winter issue, 2018.) Sleep related breathing disorders (SRBD) range from benign snoring conditions to severe obstructive sleep apnea and worse. Many dentists are starting to learn about sleep disorders and provide care for some of these breathing conditions as well as sleep bruxism. Sleep bruxism is also a sleep disorder but under a different category called "sleep related movement disorders". These categories are defined primarily by a publication through the American Academy of Sleep Medicine now in its 3rd edition called the International Classification of Sleep Disorders.
The arrival of the ADA on the scene of sleep disorders started as a resolution before the ADA house in 2015 written by Dr. Keith Thornton of TAP oral appliance fame, myself and expertly shepherded by Dr. Bill Gerlach, a Texas delegate to the ADA house. The resolution passed unanimously on November 9, 2015 and asked for the ADA to weigh in on what dentists should be doing for this epidemic SRBD problem.

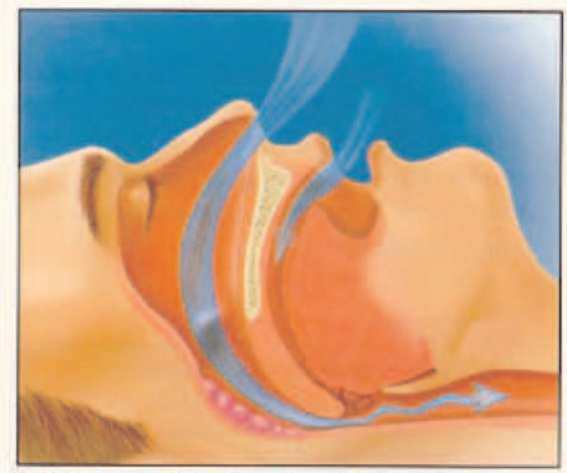
Funding independent of the ADA was required to develop the Proposed Policy Statement on the Role of Dentistry in the Treatment of Sleep-Related Breathing Disorders and was provided by outside sources.

The ADA counsel on scientific affairs (CSA) worked diligently for over a year to come up with the current version. They consulted with experts in the field to develop a policy and asked for input from the community on two occasions as modifications were made on each version. The final version as presented by the CSA will receive any fine tuning at the ADA house and then be voted on as the ADA policy. The actual

By: Michael Simmons, DMD

voting for Resolution AB 17 by the ADA house occurs on Sunday October 22 and I am proud to have two of CDA delegates, Dr. Jorge Alvarez and Dr. Mahfouz Gereis present District 13's (California) viewpoint, as they are members and leaders in your very own SFVDS.

The ADA is not the only dental association working on dentist's involvement in sleep disorders care. CDA has long been discussing sleep disordered breathing conditions at the CDA house starting around 2008. All of the proposed sleep related resolutions have been generated by your component dental socicety (SFVDS) and much has been achieved on your behalf over the past decade. The most recent commentary by the CDA House on sleep related breathing disorders was Resolution 28 accepted on 3/5/16 by the CDA House of Delegates and unanimously approved by the CDA trustees at its April 24-25 meeting. Resolution 28 stated:
Resolved, that the Report of Sleep Disordered Breathing be filed, and be if further Resolved, that CDA reaffirms existing policy related to sleep disorder breathing (Resolution 25RC-2011-H), and be it further Resolved, that CDA recognizes the unique role dentists can continue to play in the screening, referral for diagnosis and treatment of sleep disordered breathing, and be it further Resolved, that CDA continues to seek opportunities to educate its members and the public about the importance of proper diagnosis and treatment of sleep disordered breathing. With the ADA coming to the table with a policy statement, this is an exciting time for dentistry and sleep medicine. Now dentists can turn to the ADA for independent and impartial guidance on what is expected of dentists practicing dental sleep medicine and not just be impacted by sleep society guilds that may have self-serving and self-survival interests at heart. Let's see what ADA comes up with and if they can help dentistry evolve into full partnership with other health care providers in identifying and treating sleep disorders.



During snoring, air flow is partially blocked.

SFVDS *Foundation*

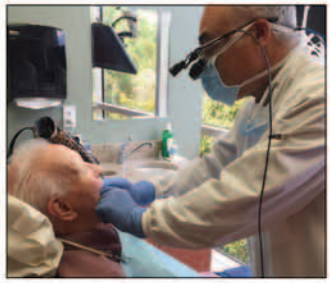
thank you to our volunteers

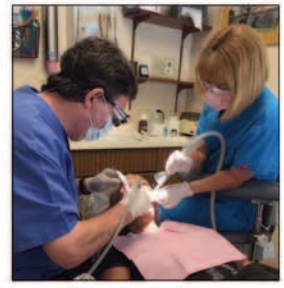
Veterans Smile Day

Karin Irani, DDS
Michael Simmons, DMD
Afshin Mazdey, DDS
Mehran Abbassian, DDS
Nita Dixit, DDS
Anita Rathee, DDS
Sean Naffas, DDS - Non-Member
Elham Partovi, DDS - SBVCDS Member
George Maranon, DDS
Jorge Alvarez, DDS
Mahrouz Cohen, DDS
Thomas Rennaker, DDS - Non-Member
Philomena Oboh, DDS
Gib Snow, DDS

Give Kids a Smile

Kahn Le, DDS
Anetter Masters, DDS
Roya Shoffet, DDS
Henide Arias, DDS
Kevin Gropp, DDS
Sarkis Aznavour, DDS
Randi Oyama, DDS
Hyungrim Oh, DDS
Basel Herbly, DDS – Non-Member
Ingrid Scoble, DDS





Smiles from the Heart

The San Fernando Valley Dental Society Foundation and the patients that have been served by its Smiles From the Heart program, wish to express their warm and heartfelt thanks to those members who have voluntarily worked to alleviate their pain and restore their dental functionality and smiles.

Mehran Abbassian, DDS - Valencia
Nooshi Akavian, DDS - Tarzana
Jorge Alvarez, DDS - Tarzana
Henide Arias, DDS - Reseda
Mark Amundsen, DDS - Woodland Hills
Sarkis Aznavour, DDS - Newhall
Emad Bassali, DDS - Sherman Oaks
Rex Baumgartner, DDS - Newhall
Mahrouz Cohen, DDS - Encino
Martin Courtney, DDS - Northridge
Nita Dixit, DDS - Studio City
Mahfouz Gereis, DDS - Panorama City
Gary Herman, DDS - Valley Village
Birva Joshi Jones, DDS - West Hills
Rambod Kamarava - Encino
Andre Kanarki, DDS - Palmdale
Joshua Kang, DDS - Valencia
Shukan Kanuga, DDS - West Hills
Kavian Kia, DDS - Encino
Bob Kogen, DDS - Newhall
Chi Leung, DDS - Glendale
Serge Lokot, DDS - Encino
Randy Lozada, DDS - Palmdale
George Maranon, DDS - Encino
Afshin Mazdey, DDS - Northridge
Jim Mertzel, DDS - Sunland
Jorge Montes, DDS - N. Hollywood
Philomena Oboh, DDS - Van Nuys
Sarah Phillips, DDS - Santa Clarita
Anita Rathee, DDS - West Hills
Teresa Romero, DDS - N. Hollywood
Phillip Sacks, DDS - Woodland Hills
Sean Sakhai, DDS - Woodland Hills
Michael Seastrom, DDS - Tarzana
Michael Simmons, DMD - Tarzana
Gib Snow, DDS - Palmdale
Mark Stein, DDS - Encino

Our programs are looking for additional volunteers to help those in need. The Foundation pays all required lab fees and volunteers provide the expertise in their own offices. Call Wendy at the central office, 818.576.0116, to sign up and help a patient who has no means to pay for desperately needed dental treatment.

Antelope Valley Report

By: Gib Snow, DDS

September 7, 2017 CE Seminar

Digital Smile Design: A Tool for the Team to Treatment-Plan Multidisciplinary Cases and to Communicate with the Patient

SPEAKER: Dr. Andrea Ricci

There were 30 Attendees, dinner was served and Dr. Ricci was well received on this topic.

We held a CE Seminar on 06/22/17 with speaker Dr. Gadzhy Dazhaev. Topic: The Prosthodontic Treatment Plan for Long-term Success of Dental Rehabilitation. There were 32 attendees and dinner was served.

UPCOMING C.E. SEMINARS

10/26/17
Christine Taxin
Dental-Medical Cross Coding

12/7/17
Dr. Jamison Spencer
Make NEXT YEAR Your BEST YEAR

For More Information on upcoming C.E. Seminars contact: Danielle @ 818.418.2234 or Vanessa @ 661.208.4749

We have completed 7 CPR Certification classes in the past 3 months. Please see information below if you would like to attend a class or schedule a class in your office.

CPR CERTIFICATION

Classes will be scheduled as needed. $35 per person Dental Discounted Price w/ $5 Donation to the SFVDS Foundation Minimum of 9 people per class (can be combined with other offices).

CONTACT: Eric Sarkissian @ 661.273.1750

Welcome New Members

Aram Sexenian, DDS
General
Roseman University of Health Sciences, 2017

Sepi Fatahi, DDS
18846 Stone Canyon Ln
Santa Clarita, CA 91351
General
University of Nevada, 2011

Melineh Dereghishian, DDS
Orthodontics
UCLA, 2012

Ariga Garagousian, DMD
General
Western University of Health Sciences, 2017

Ali Dabirian, DMD
General
New York College of Dentistry, 2016

Vahe Boghossian, DDS
332 E. Glenoaks Blvd. Ste. 200
Glendale, CA 91207
818-400-6229
General
Roseman University of Health Science, 2017

Jouliana Davoudi Chegani, DDS
General
USC, 2017

Niloo Farahani, DDS
Pediatrician
UCSF,

Azadeh Tavari, DDS
Periodontics
USC, 2014

Christie Park, DMD
303 S. Glenoaks Blvd.
Burbank, CA 91502
818-640-7781
General
University of Pennsylvania, 2016

Jeffrey Proniloff, DDS
General
UCSF, 2017

Patrick Kang, DDS
General
UOP, 2016

Danny Hadaya, DDS
221 W. Alameda Ave #101
Burbank, CA 91502
818-303-8379
General
UCLA, 2017

Emil Simanian, DDS
23107 Lyons Ave
Newhall, CA 91321
310-339-3026
General
USC, 2017

Jin Kim, DDS
23922 Summerhill Ln
Valencia, CA 91354
661-857-7662
General
SUNY, Buffalo, 2008

Zay Ya Kyaw, DDS
5807 N Figueroa Ave
Los Angeles, CA 90042
323-982-0999
General

Robert Luszczak, DDS
10718 White Oak, Ave Ste. 1
Granada Hills, CA 91344
818-363-7484
General
UCLA, 1990

Vadim Lebovich, DDS
16055 Ventura Blvd. Ste 1126
Encino, CA 91436
818-522-1745
General
USC, 2006

Pegah Khorram, DDS
Benjamin Garai Shayesteh , DDS
Andrea Ustarez, DDS

Word Search Answers

F	O	S	S	T	Z	E	H	U	H	T	U	O	M	V	A	T	G
E	L	R	T	H	T	E	E	T	M	O	D	S	I	W	R	U	U
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L	P	E	L	Y	A	M	D	I	S	I	P	Y	X	R	B	E	T
C	A	V	I	T	Y	O	L	S	S	L	S	H	I	W	R	H	O
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S	Y	L	R	Y	O	S	S	E	A	R	B	X	E	H	S	S	W
H	F	E	L	N	D	E	H	S	U	R	B	W	S	P	I	D	T

BICUSPID
BRACES
BRUSH
CAVITY
CHEW
DENTIST
FILLING
FLOSS
FLUORIDE
GUMS
HYGIENE
MOLARS
MOUTH
ORTHODONTIST
PLAQUE
RETAINER
RINSE
TEETH
TOOTH FAIRY
TOOTHPASTE
WISDOM TEETH
XRAY

Thank you to our 2017 program sponsors. Each of them has helped us offer better membership programs throughout the year. Please thank your local representatives for their generosity the next time you see them.

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San Fernando Valley Dental Society
9205 Alabama Ave., Suite B
Chatsworth, CA 91311

DATED MATERIAL