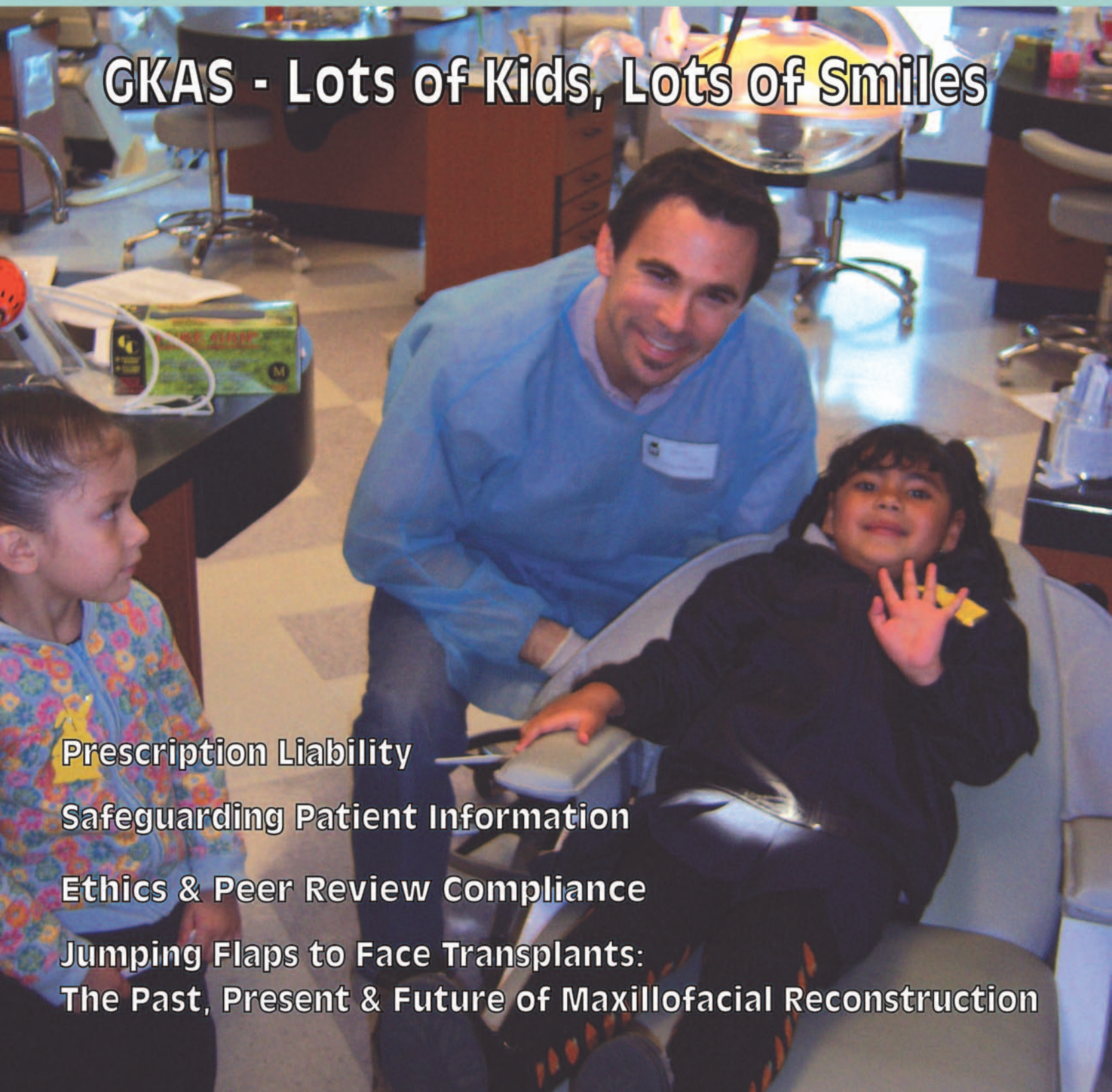
Bulletin of the San Fernando Valley Dental Society

Dental Dimensions

Spring 2010

www.sfvds.org



GKAS - Lots of Kids, Lots of Smiles

Prescription Liability

Safeguarding Patient Information

Ethics & Peer Review Compliance

Jumping Flaps to Face Transplants:
The Past, Present & Future of Maxillofacial Reconstruction

Six Flags MAGIC MOUNTAIN

Call SFVDS for reservations
818-884-7395

SAN FERNANDO VALLEY DENTAL SOCIETY

2ND ANNUAL

STAFF APPRECIATION DAY & FAMILY FUN PICNIC (10:30 A.M. - 9:00 P.M.)

SUNDAY, JUNE 6, 2010

MEAL SERVICE 1:00 P.M.- 2:30 P.M. **PICNIC HOURS** 1:00 P.M.- 3:30 P.M.
PARK HOURS 10:30 A.M.- 9:00 P.M.

PICNIC DETAILS

Member, Spouse & Dependent.....$35.00 ea.
Member's Office Staff.....$35.00 ea.
Non- Member Guest .....$70.00 ea.
Children age 2 and under are FREE

FREE PARKING ($15 VALUE) TO THE FIRST 100 MEMBERS TO SIGN UP and attend!*

PRICE INCLUDES

Full-Day Park Admission
All-You-Can-Eat Hamburger & Barbeque Chicken buffet
Free Hurricane Harbor Ticket valid any operating day in September 2010
6" x 8" Souvenir Photo
Picnic Games & Prizes • Discount Coupon Sheet
One Free Parking Pass to the first 100 members who sign up and attend

SPECIAL BONUS
FREE!
Hurricane Harbor Ticket
Valid Any Operating
Day in September 2010

Due to maintenance and other circumstances certain rides and attractions, including new rides, may not be open to the public.

MORE FLAGS. MORE FUN.

DENTAL DIMENSIONS

Published by the San Fernando Valley Dental Society
22110 Clarendon Street, Suite 101
Woodland Hills, CA 91367
Office: (818) 884-7395
Fax: (818) 884-2341
E-mail: sfvd@sbcglobal.net
Web Site: www.sfvds.org

Published quarterly by the San Fernando Valley Dental Society. The Society solicits essays, letters, opinions, abstracts and publishes reports of the various committees; however, all expressions of opinion and all statements of supposed fact are published on the authority of the writer over whose signature they appear, and are not regarded as expressing the view of the San Fernando Valley Dental Society unless such statement of opinions have been adopted by its representatives. Acceptance of advertising in no way constitutes professional approval or endorsement.

Graphics by: C. Stieger Designs

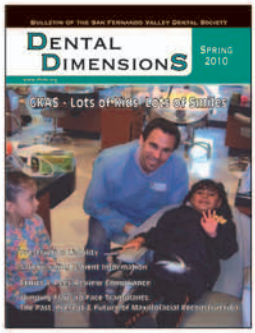
In This Issue

Spring 2010
Volume XXXXIV Number 2

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 editor.sfvds@sbcglobal.net or contact the dental society office at 818-884-7395

On The Cover.....



SFVDS past-president, Jason Pair, DDS, clearly made these two friends comfortable during their GKAS screening at MEND on Feb. 5, 2010, where a total of 280 children were seen by six SFVDS member doctors.

From the Desk of the Editor

The Mid-level Provider - a Solution or a Challenge?

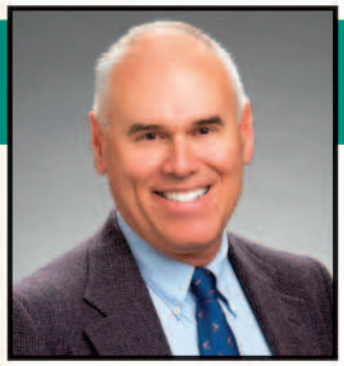
You have been hearing a great deal about mid-level providers lately. If you haven't, you will! There are numerous definitions of the mid-level provider. Some of these describe a mid-level provider as a non-professional provider that has been trained to perform irreversible dental procedures traditionally done only by licensed dentists. Variations of the mid-level provider exist today in different states across the country and in other countries around the world. The standard of care provided in other countries, however, is not consistent with that provided here in the U.S. The delivery care system, the educational costs, geography and climate are very different from ours.

During this time of economic uncertainty and escalating health care costs, the need to address access to affordable dental health care has become a priority. Workforce change agendas, being funded by the Kellogg and Pew foundations and studies by the Institute of Medicine and HRSA, propose reorganizing the dental delivery system. The American Dental Hygiene Association (ADHA) has been a strong force in advancing the mid-level provider. In 1992 they published a paper "The Dental Hygienist as Change Agent", in which they outlined a strategic plan which included increasing hygiene representation on boards, administration of local anesthesia, and independent dental hygiene practice so the hygienist can determine treatment plans and referrals. The ADHA has joined forces with many health care coalitions to advance this agenda.

Recently, the issue of access to care has gained greater national attention and the mid-level dental provider is being propagated as the answer to the problem. Unfortunately, legislators, third-party payers and bureaucrats do not understand the complexities of providing safe and cost-effective dental care. Our association is looking for and proposing innovative as well as proven solutions to access to affordable dental health care for the underserved. Increasing Medicaid or Denti-Cal (in California) reimbursement rates, increasing funding for training in primary care dentistry, as well as loan forgiveness programs for dentists practicing in underserved areas, are a few of the proven successful solutions to improving access to care. Our challenge has been to get legislators to commit the funding necessary to enact meaningful dental reform. Access to care is a multifactorial problem that requires multiple solutions. There is no single "silver bullet" answer.

We must not give up hope, or give in to the negativity, that these changes are inevitable. Our profession needs to stand and fight to prevent the encroachment by non-dentists performing irreversible dental treatment. We must not forget the importance of the educational disparity between dentists and mid-level providers. We cannot lose confidence in our ability as a profession to preserve high quality dental care equally, for our entire population, regardless of whether it is in a private fee-for-service, non-profit, or public-government funded setting. Some have likened the mid-level provider to a nurse practitioner. Would you want a nurse practitioner performing irreversible surgical procedures on you? Only the dentist has the knowledge, judgment and expertise to determine whether to treat or delegate to an appropriately supervised and trained dental auxiliary. Let's not let others underestimate the complexity of dental care. The oral cavity is intimately connected to the rest of the body and it is now more important than ever to have a properly educated doctor provide that dental care. Dentistry is a skill, an art and a science. It is not merely a trade. As one of our leaders in dentistry has said, let us not forget what we have endured and achieved as a profession to get where we are today.

Anita Rathee, D.D.S., MPH
Editor, SFVDS



From the Desk of the President

Mark A. Amundsen, DDS

Dental Mid-Level Care Providers

A Threat to Our Livelihood and the Public Well-Being

With many important healthcare changes on the horizon, our national and state legislators are listening to many interest groups who would like to make changes in our current dental care delivery models. Currently these new ideas are being proposed in hopes of solving access to care problems in many underserved areas throughout the United States. What is being proposed is the introduction of a new level of dental care provider who can do many of the same procedures a licensed dentist can do now, but with one half of the postgraduate education. This new level of caregiver is called a "mid-level provider", because these individuals will offer a level of care above what an extended function hygienist can provide, but below what a licensed dentist can manage. Once mid-level dental caregivers are trained and licensed, they will likely propagate out to all areas of the population, not just the underserved areas due to the low reimbursement levels currently offered.

Recently the Minnesota legislature created a new level of dental provider called the "Advanced Dental Therapist" to serve the needs of the state's underserved population. The training program for this new level of caregiver would provide a masters degree in dental therapy. It is an advanced degree, compared to the RDH, and requires two years of training past a bachelor's degree. The advanced degree in many states will allow this mid-level provider the ability to do irreversible dental procedures that only licensed dentists can do now. These include preparation and placement of permanent fillings, pre formed permanent crowns, cementing and re-cementing of permanent crowns, and simple extractions.

Recently CDA set up a taskforce to evaluate California's access to care issues, and to study alternate care delivery models. The CDA taskforce is looking at the Minnesota model, Washington's "Dental Therapist" model, Alaska's "Dental Health Aide Therapist", the American Dental Hygienist's Association's "oral health practitioner", as well as models from many other studies. CDA wants to take a proactive approach in dealing with this new special interest supported mid-level movement, while trying to understand how the needs of California's underserved population may differ from those of other states. Our state dental association wants to be able to deal with all the variables before they approach our legislators at the negotiation table to craft programs to help our state's underserved. A common popular phrase that was used at the House of Delegates meeting in Sacramento in November 2009 was that CDA wants to see "organized dentistry being at the table with the legislators and not on the plate". The leadership at CDA understands the importance of maintaining an influential relationship with the legislators, as well as their need to look out for the best interests of the members they serve. In these trying times, it can be like walking on a narrow tightrope on a windy day.

Early last fall many of the officers on the SFVDS board encountered a large number of local dentists who were either unemployed or under-employed. Many of these people were new members of CDA. It was clear to us, that the development of new categories of dental professionals were not in the best interest of our existing dentist members. In addition, test programs were being introduced in California that studied changes to our Dental Practice Act's direct supervision laws with assistants. This could create a second tier of care, and will serve as a foot in the door for the propagation of alternate care delivery systems. This became the genesis of the Access to Care Advocacy Resolution. At the California Dental Association's most recent House of Delegates meeting in Sacramento last November, our own San Fernando Valley Dental Society (SFVDS) introduced a resolution to suggest identifying and promoting alternative options to the mid-level provider using existing models.

In the San Fernando Valley's Access to Care Advocacy resolution introduced to the House of Delegates, it was displayed how several different models on reimbursement for care to underserved populations in various states had been studied. The results showed that the problem of distribution of dentists in these special needs areas would not be solved until there was adequate reimbursement for the services provided. A solution to this could be offering financial incentives to dentists and dental students to provide care in these underserved areas. One important positive thing that happened at the House of Delegate meeting was that the SFVDS resolution was referred to the CDA Workforce Work Group for study along with the many other proposed models. While CDA is studying models for new levels of providers as a solution to the access to care problem, there is no guarantee that once these practitioners are trained, that they too will be able to afford to work in these underserved areas - based on the current California reimbursement rates. Another important point that was raised is that this state does not have the climatologic and geographic problems that

Continued on page 6

will isolate populations for periods of time to prevent them from accessing licensed dentists for care like in Minnesota and Alaska.

The future of dentistry as we know it could be challenged. It is important for those of you who have an opinion about what you would like to see on the horizon for dentistry, to step up and voice your opinion to your local, state, and national leadership in organized dentistry as well as your legislators. In many models, the dentist will still be responsible for the work the alternate care provider does, and many irreversible dental procedures will be allowed. Worse yet, it could greatly increase the dentist's liability and it could create a new second-class level of dental care for the public. We all need to speak up and be the voices for the future of our profession!

Mark Amundsen, D.D.S.
2010 President
San Fernando Valley Dental Society

Correction/Addition

In the last issue of Dental Dimensions, we forgot to include the author information on Dr. Robert L. Merin, who took the time to write the informative article, 'Management of Periodontal Patients in the General Dental Office.'

Robert L. Merin, DDS

Dr. Merin graduated from the UCLA School of Dentistry, and he earned his MS in Periodontics at Loma Linda University School of Dentistry. He served as Chief of the Periodontal Department at Mather Air Force Hospital in Sacramento and then entered private practice in Woodland Hills in 1974. Bob is the first SFVDS member to become a Diplomate of the American Board of Periodontology. He was program chairman for the SFVDS in 1994, and is a past president of the California Society of Periodontists.

In 2000, he was honored as the UCLA Dental Alumnus of the Year. Bob has served on the California and ADA Anesthesia Committees, and is currently on the Board of Directors of the California Dental Society of Anesthesia, and a member of the American Academy of Periodontology Anesthesia Committee.

He has edited two CDA Journals dedicated to Periodontics, and authored or co-authored eight peer-reviewed articles. He has been writing chapters in Glickman's Clinical Periodontology since 1978, and he currently writes chapters in the 2010 edition of Carranza's Clinical Periodontology on the topics of Maintenance Therapy for implant and periodontal patients, Long-Term Results of Periodontal Treatment, and Sedation in Periodontal Therapy.

Bob would like to thank Dr. Donald Clem, President-elect of the American Academy of Periodontology, and Dr. Steven Schonfeld, current president of the California Society of Periodontists, for reviewing his article on *Management of Periodontal Patients in the General Dental Office*.

Dr. Merin can be reached at
6342 Fallbrook Avenue, #101
Woodland Hills, CA 91367
Phone (818) 887-7772 • Fax (818) 887-2231

Legislation Report

By: Jim Mertzel, D.D.S.
Chair, SFVDS Legislation Committee

In April I had the privilege of attending the ADA'sWashington, DC Leadership Conference. It is an annual affair to bring together ADA leaders from throughout the country to meet with their Senators and Congress people to advocate for issues of concern to our profession.

Jim Mertzel, DDS (L) with Congressman Duncan Hunter in Washington D.C.

Our component can be very proud and grateful for the service of several of our members, Myron Bromberg and Gerald Gelfand for the leadership they have provided on a national level for our profession. As I had the privilege of spending time with them on Capitol Hill during a reception for our government's legislative members and dentists attending the conference, I was impressed with the reception Mike and Jerry received from leaders of our profession throughout the country. Between the two of them they seemed to know everyone in attendance and their opinions were sought after and respected.

On the legislative side, the primary issues for which we were advocating were:

1. The House passed HR 4626 overwhelmingly by a vote of 406-19. This bill eliminates the exemption for insurance companies from the anti-trust laws under the McCarran-Ferguson Act. The ADA has been advocating for this issue for many years. However, there seems to be reluctance on the part of the Senate to bring this bill to the floor for consideration.

2. HR 3763. The bill would exempt employers with 20 or fewer employees from having to comply with the Red Flags Rule issued by the Federal Trade Commission. It passed the House by a vote of 400-0 and is presently in the Senate for consideration. Presently, as employers, we have had an exemption from complying with the "Rules" until June 1, 2010.

3. HR5000. The Dental Coverage Value and Transparency Act of 2010 The bill would require that all health plans that offer dental benefits, will among other provisions:

- Be prohibited from dictating fees for procedures that the plan does not cover.

- Provide uniform coordination of benefits. When a consumer is covered by more than one plan, the secondary payer should b responsible for paying the remainder of the claim (up to, but not exceeding, 100 percent of the amount of the claim).

- Permit consumers to designate dental benefits to a provider who is not participating in the network, so that the patient does not have to pay for covered services out-of-pocket and wait to be reimbursed by the plan.

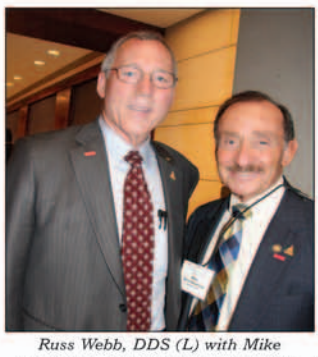
- Assure that consumers receive the full value of their coverage by requiring plans to provide the same dollar amount of coverage for a given procedure regardless of whether the provider of the procedure participates in the network.

- Be prohibited from systematically combining distinct dental procedure codes in a manner that results in a reduced benefit under the plan ("bundling procedures").

- Be prohibited from changing a benefit code to a lower cost procedure if such actions are inconsistent with the CDT or the terms of the network agreement.

Regarding the recently passed Federal Health Care Bill, any dental insurance will be stand-alone from the Health Care Bill. Adult Denticaid care was not included in the bill. However the ADA will be advocating to have the Denticaid services provided and requesting the federal government to provide more of the funding so as to relieve the states from already financially limited state budgets.

Thank you to all those who contributed to Dr Bill Emmerson's campaign for a seat in the CA State Senate. Bill won a large percentage of votes in the primary election and should win in the final election as a Republican in a predominantly Republican district. He will be the only Dentist in the CA State Legislature.

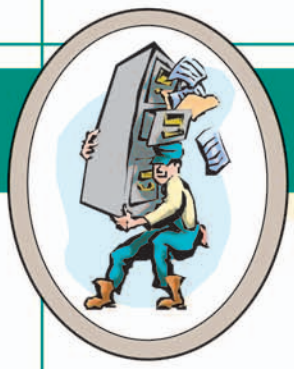


Russ Webb, DDS (L) with Mike Bromberg, DDS in Washington, D.C.

Russ Webb, a member of CDA, is a candidate for president-elect of the ADA. He could use your financial support in his campaign.

As I have in the past, I encourage every one of you to get involved in the political process. The outcome of this year's elections for congress, the US Senate, CA Governor, and state legislative offices will certainly have an effect on each of our lives.

DO NOT SIT BY THE SIDELINES AND THEN COMPLAIN ABOUT HOW OUR ELECTED OFFICIALS ARE EFFECTING YOUR PROFESSION AND YOUR TAXES.



Members Schlep 13,540 Pounds to Shredder!

By: Andy Ozols, Executive Director

Our Members schlepped 13,540 pounds of old patient charts, office records and e-waste to the parking lot behind the SFVDS central office in Woodland Hills on April 17, 2010 to have Paper Cuts, Inc. shred and recycle everything. Although this event was provided to the membership by the SFVDS membership committee at no charge to our members, a suggestion was made to make a donation of their choice, to the annual SFVDS Give Kids a Smile program. Some 35 members participated, not only with 13,540 pounds of shredded materials, but also with $920 in donations to the Give Kids a Smile program.

Watch your emails for announcements of additional "Schlep and Shred" events coming to the Santa Clarita and Antelope Valleys, as well as the Foothills area around Glendale and La Crescenta.

DATA BREACH – SAFEGUARDING THE CONFIDENTIALITY OF PATIENT INFORMATION

By: Taiba Solaiman - Risk Management Analyst, TDIC

Dentists have an ethical and legal responsibility to safeguard the confidentiality of patient information which includes name, date of birth, address, driver's license number, Social Security number, credit card numbers, in addition to health and other personal information. The practice owner is responsible to ensure the information is accessible to those authorized and is restricted from generalized use. Keeping current on privacy requirements under state and federal laws will help dentists and the dental team protect their patients. Compliance can also help protect the dental practice from claims of improper disclosure or use of a patient's information.

Any business that stores personal information can be the victim of a data breach. Networks can be hacked, a laptop computer stolen or personal information inadvertently revealed in an e-mail or on a Website. The thief can use a patient's Social Security number and birth date to create a false identity and utilize it to commit fraud. According to a 2006 survey by the Federal Trade Commission (FTC), three percent of identity thefts involve a person's healthcare information. A thief steals a patient's dental identity to get free dental services, prescriptions or to file false claims with insurance companies.

Establish the following protocols to protect from data breach:

- Develop a secure password system and train staff to understand why your security procedures are important.
- Encrypt sensitive data, such as Social Security numbers. Encryption provides better protection than passwords alone. It is the most effective way to achieve data security. To read an encrypted file, one must have access to a secret key or password that enables you to decrypt it. These protocols must be applied to all forms of data storage that contain patient information including computer hard drives, lap tops, thumb drives, CDs and back up tapes.
- Physically destroy or electronically remove data from hard drives before disposing of computers.
- All internet connections must have secure firewalls and anti spy/spam/virus programs.
- Disable computer jacks, such as USB ports, to make it difficult to copy information onto portable media.

Continued on page 23

General Meetings - Preview

MAY 26, 2010

Speaker: Homa Zadeh, DDS

2PM – 9PM Airtel Plaza Hotel, 7277 Valjean Ave., Van Nuys, CA 91406 818.997.7676

Immediate Tooth Replacements With Implants: Fact or Fiction

About the Speaker: Dr. Homa Zadeh is a Diplomate of the American Board of Periodontology and a tenured Associate Professor at the University of Southern California (USC) School of Dentistry. Dr. Zadeh is a graudate of the USC School of Dentistry and has completed the advanced clinical education in Periodontology, and earned his PhD in Immunology from the University of Connecticut. His clinical research interests involve studies on minimally invasive surgery and tissue engineering. Dr. Zadeh also maintains a part-time practice limited to Periodontology and Implant Surgery in Southern California.

About the Program: The lifestyle of people in the 21st century is fast-paced and many advances in the technology and service sector have enabled this lifestyle. Clinicians have attempted to accommodate patients' desires by developing protocols which shorten the duration of therapy. Some of these protocols include immediate placement of implants following tooth extraction, immediate provisionalization and loading of implants. While scientific evidence supports some of these protocols in specific clinical scenarios, some of these procedures have been utilized rather indiscriminately, leading to undesirable outcomes. In order to achieve predictable therapeutic outcomes, a prudent approach is necessary to consider individual patient risk assessment and select appropriate material and protocols. Decision trees will be presented to provide guidelines for treatment of patients with hopeless teeth to be replaced with implants. When delayed implant placement is indicated, appropriate management of extraction sockets will be necessary. All concepts will be illustrated with relevant clinical cases.

SEPTEMBER 23, 2010

Speaker: Ms. Sue Ann Van Dermyden, ESQ

5PM – 9PM Airtel Plaza Hotel, 7277 Valjean Ave., Van Nuys, CA 91406 818.997.7676

Coming Live to You: A Jam-Packed Evening of Employment Law – Tips for Your Practice.

About the Speaker: Sue Ann Van Dermyden is the founding partner of Van Dermyden Block, Attorneys At Law, and a licensed California attorney. Sue Ann has specialized in employment law since 1993. After spending several years litigating employment matters in state and federal courts, Sue Ann's practice now focuses on conducting workplace investigations; advice and counseling on employment matters; and, employment-related training seminars. Sue Ann has handled hundreds of workplace investigations on all types of employment matters over the last several years, including claims of discrimination, harassment, retaliation, whistle blowing, substance abuse, threats of violence, assault, theft, embezzlement, violations of company policies, wage and hour violations, and other forms of alleged misconduct.

About the Program: As the title suggests, this lecture promises to help you in your understanding of how employment law affects your practice and your relationships with your employees. You will learn about the latest employment laws to be enacted and how to deal with the most common employment related problems in your office. While Ms. Van Dermyden's lectures are always chock full of information, she also has a knack for making an otherwise dry subject matter quite entertaining. Attendees will also have the opportunity to ask specific questions relevant to their particular practices.

General Meetings Review

By: Andy Ozols

The first quarter of 2010 offered three excellent CE courses forour membership. Attendance of both member doctors and supporting vendors was a little weaker than usual, most likely because of the effects of the recession. The courses were held at the Airtel Plaza Hotel, which everyone seems to agree is a very comfortable venue with good food as well. Below is a brief summary of each of those three courses.

Dr. Hewlett, DDS

January 27, 2010, "Maximize the Power of Minimally Invasive Techniques and Making it Stick: An Update on Adhesion in Dentistry."

Starting from the premise that advances in understanding that the pathogenic and risk factors for dental caries has produced new protocols for effective management of this infectious disease, Dr. Hewlett lectured that the paradigm has shifted from a reparative model to detection, risk assessment, and healing of early lesions. He provided information and procedures for incorporating this important treatment concept into everyday practice. In addition, his lecture reviewed the complexity of today's materials and the clinical variables that affect their performance. Dr. Hewlett's presentation provided attendees with practical tips for maximizing restorative predictability. Attendees learned how to select materials according to specific patient factors, how to place posterior composites more efficiently while eliminating post-op sensitivity, and more!

Dr. Sedghizadeh, DDS

February 19, 2010, "Bisphosphonates and Oral Lesions"

At this lecture, attendees were given an understanding of the following concepts related to Jaw Osteonecrosis: Definition of Jaw Osteonecrosis. Risk factors and risk assessment. The role of bisphosphonates and anti-resorptives in disease pathogenesis. Identification of clinical and radiographic lesions of Jaw Osteonecrosis. Staging of patients with Jaw Osteonecrosis. Prevalence of the disease nationally. The importance of imaging studies for disease evaluation and follow-up. The role of microbial biofilms in disease pathogenesis. Current research trends in the field. Management and treatment strategies for all stages of the disease. Prevention protocols and the importance of dental care. Medico-legal considerations and case histories.

Ms. Marcella Oster, RDA

March 10, 2010, "California Dental Practice Act and Infection Control"

Ms. Oster lectured on the California Dental Practice Act, including the following topis in her presentation: Highlights and updates of the Dental Practice Act; Scope of practice for dentists and allied dental health professionals; License renewal requirements, continuing education, laws governing citations and fines; Laws pertaining to prescriptions; Dental record keeping; Acts in violation of the Dental Practice Act including unprofessional conduct. Ms. Oster also provided up to date information on Infection Control, the Dental Board of California required Infection Control lecture for license renewal for all dental employees.

Welcome New Members

Welcome New Members

Smitha Reddy, DMD
11050 Vare Ct
Moorpark, CA 93021
General
Temple University, 2009

Michelle Han To, DDS
13320 Riverside Dr., #202
Sherman Oaks, CA 91423
818-789-3844
Pediatric
U of Toronto, 1998, USC-Pediatric, 2000

Joo Bin Lim, DDS
10178 Reseda Blvd
Northridge, CA 91324
714-522-1291
General
Dan-Kuk University, Korea, 1987

Deepa Pandian, DDS
411 E. Palm Ave
Burbank, CA 91501
818-846-7008
General
Nova Southeastern University, 2005

Tiffany H. Hsu, DDS
368 Kanan Rd
Oak Park, CA 91377
818-889-5440
Pediatric
USCF, 2009

Raphael Separzadeh, DDS
5543 Aura Ave.
Tarzana, CA 91356
Orthodontic
St. Louis University, 2009

Sohrab Imani, DDS
10727 White Oak Ave # 213
Granada Hills, CA 91344
General
UCLA, 2004

Emineh Khachian, DDS
12125 Vanowen St. # 1
North Hollywood, CA 91605
General
USC, 2004

Lourdes S. Aquino, DMD
14435 Sherman Way Unit 107
Van Nuys, CA 91405
818-785-7498
General
University of the East, Philippines, 1989

Ethical Implications of Noncompliance with Peer Review

By: Brooke Vanderlinde, CDA

In keeping with its obligation of service to the public, the California Dental Association (CDA) has established a statewide peer review system to resolve disputes that may arise in the delivery of dental services to the public by CDA member dentists. The peer review process is in place as a membership benefit to assist members in resolving disputes with their patients in a fair and equitable manner outside of the legal system. The procedures used in the peer review process for the management of disputes between dentists, patients, and carriers are designed to be consistent to assure that all parties concerned are treated fairly.

When a peer review decision is made in favor of the patient, it is understandable that the member dentist may feel frustrated and betrayed by his or her peers. But membership in CDA requires agreement by the dentist to comply with the association's Code of Ethics, which obligates the dentist to cooperate with the peer review committee and abide by their findings. So what happens if you decide to just disregard the committee's decision and the instructions provided in the resolution letter?

Failure to cooperate with any component committee or council could result in charges being brought forth against a member for violating Section 3 of the CDA Code of Ethics. Approximately half a dozen member dentists are referred to the Judicial Council each year for failing to comply with a peer review committee's decision. The Judicial Council has ultimate authority to take disciplinary action against a member for any Code of Ethics violation.

Disciplinary action can range from probation or censure to expulsion from the organization. Disciplinary action against your membership due to non-compliance with peer review may also result in an adverse action report filing with the National Practitioner Data Bank and the Dental Board of California. But rather than considering your options from a disciplinary standpoint, as a CDA member it's more important to consider the ethical implications of non-compliance with a peer review decision.

Please remember that your peers volunteer a significant amount of their time to participate on the peer review committee with the goal of helping you prevent incurring the substantial emotional and financial costs that are associated with litigation. To disregard their decision, and refuse to comply with the resolution, is not only unethical, but disrespectful of the efforts of your peers.

For additional information on this or any other ethical issue, or for a hard copy of the CDA Code of Ethics, please contact Brooke Vanderlinde at (916) 554-5948.

Emelio T. Calderon, DDS
9036 Reseda Blvd. Ste 102
Northridge, CA 91324
818-701-5210
General
Unciano Paramedical College,
Philippines, 1989

Victoria Nisman-Bacquet, DDS
17214 Saticoy St
Van Nuys, CA 91406
818-708-9889
General
Moscow Stomatological, USSR, 1984

Charles R. Bacque, DDS
1305 N. San Fernando Blvd.
Burbank, CA91504
818-841-5654
General - UCLA, 1978

Emelito T. Calderon, DDS
9036 Reseda Blvd., Ste 102
Northridge, CA 91324
818-701-5210
General
Unciano Paramedical College,
Philippines, 1989

Did You Know?

DENTAL BOARD OF CALIFORNIA

Effective February 1, 2010, the Dental Board of California (Board) will be uniformly citing and fining licensees who fail or refuse to comply with the Board's request for dental records.

Business and Professions Code Section 1684.1. (a) (1) states:
A licensee who fails or refuses to comply with a request for the dental records of a patient, that is accompanied by that patient's written authorization for release of record to the board, within 15 days of receiving the request and authorization, shall pay to the board a civil penalty of two hundred fifty dollars ($250) per day for each day that the documents have not been produced after the 15th day, up to a maximum of five thousand dollars ($5,000) unless the licensee is unable to provide the documents within this time period for good cause.

ALSO:
Effective July 1, 2009, the Dental Board of California (Board) became the regulatory board for licensed Dentists (DDS), Registered Dental Assistants (RDAs) and Registered Dental Assistants in Extended Functions (RDAEFs) health care professionals.

Treatment of Severe Maxillofacial Battle Injuries: The Past, the Present and the Future

By: COL Robert G. Hale, DDS, US Army Dental Corps

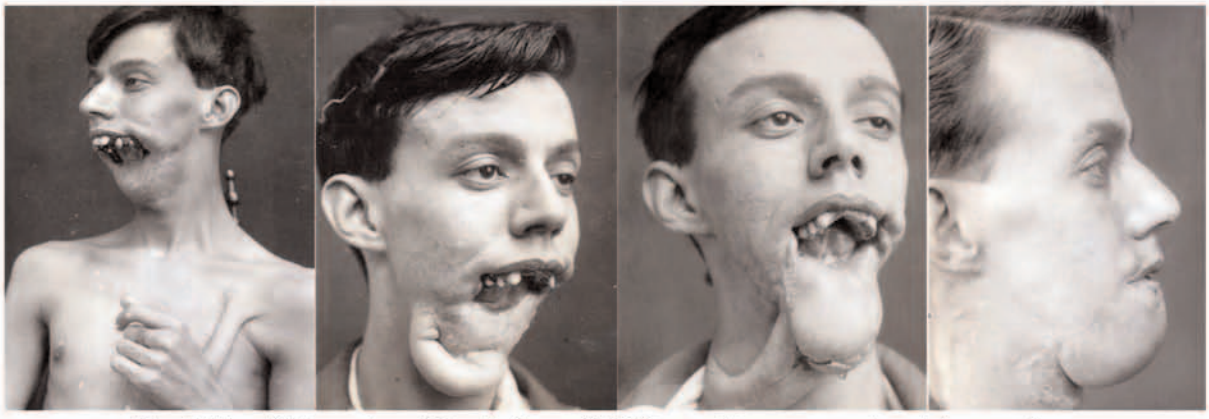
Director, Craniomaxillofacial Research, US Army Institute of Surgical Research, San Antonio, TX, Past President, San Fernando Valley Dental Society

(The opinions or assertions contained herein are the private views of the author and should not be construed as official or reflecting the views of the Department of Defense or the US Government; the authors are employees of the US government)

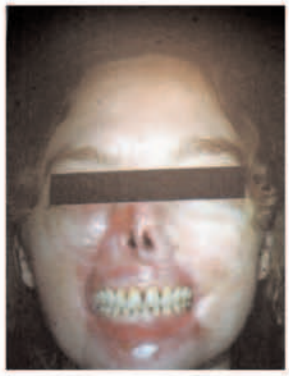
Maxillofacial battle injuries created the need for maxillofacial reconstructive surgery during the World War I (WW I). Devastating maxillofacial injuries challenged the surgical professions to provide form and function of defects inflicted by penetrating trauma on the battlefield. Local, regional and distant flap transfers were developed to treat maxillofacial battle injuries in WW I and while still valued procedures, multiple surgical steps, donor site morbidity and limited esthetic-functional outcomes are often the result. These staged procedures endured until the 1980's when microvascular techniques provided options to transfer distant composite tissues in one step to close wounds and provide support. Although microvascular transfer of distant tissues was an improvement, the bar has been raised by face allotransplantation. Now, severe facial defects can be repaired with "like" tissue through allotransplantation with favorable prospects of achieving exquisite facial form and function, but at cost of lifetime immunosuppression. This article will describe past and present treatment of maxillofacial battle injuries, and extrapolate into the foreseeable future with recent developments in reconstructive allotransplantation and regenerative medicine.

Techniques based on procedures developed in WW I have been used with some degree of success for the past 90 years. WW I was the first conflict major industrial powers used explosive devices on a large and destructive scale. To avoid certain death on the battlefield, the opposing armies dug trenches and fought with grenades, machine guns and artillery, exposing only their faces and hands momentarily to engage the opposing side. In essence, the trench served as the soldiers' body armor. Over 10 million allied soldiers were injured in WW I and while injury statistics were crude, it is estimated the allies treated over 20,000 maxillofacial injuries in specialized units at France and Britain.[1] Sir Harold Gilles, a significant pioneer of plastic and maxillofacial surgery, lead the most famous maxillofacial unit of WW I in Britain.

To treat the devastating maxillofacial battle injuries Gilles utilized local and regional flaps from the cheeks, forehead, neck and scalp to replace missing facial features, especially the central features of the nose and lips. Giles also used autogenous transfers of distant skin by attaching a tube of chest skin to the hand and then subsequently transferring the skin flap to the face via the so-called "jumping flap".[2] Large chest flaps were also elevated and advanced to resurface scarred faces. These skin flaps were not necessarily based on vessels; therefore, healing characteristics were unpredictable. Giles also devised many local and regional flaps to reconstruct facial features that are still used today.[3]



Dr Gilles' "Jumping Flap" from WWI used to reconstruct lower face. No bone reconstruction was performed in that pre-antibiotic era.


World's first face transplant pre-injury, 6 months after injury and 3 years post face transplant.

Autogenous flap techniques developed during WW I remain the workhorse of facial reconstruction for mild to moderate face soft tissue defects caused by injury or cancer resection. These flaps necessarily cause donor site deformity, preferably to a lesser extent than the untreated primary defect. Reconstruction of central facial features are especially challenging due to subtle changes in skin thickness, delicate contours, and varying projections that define the facial subunits. Adding to the complexity of the face is the lips; not only are lips anatomically distinctive in shape, tissue type and projection, reconstruction must provide anatomically correct muscle function in order to achieve an adequate result.

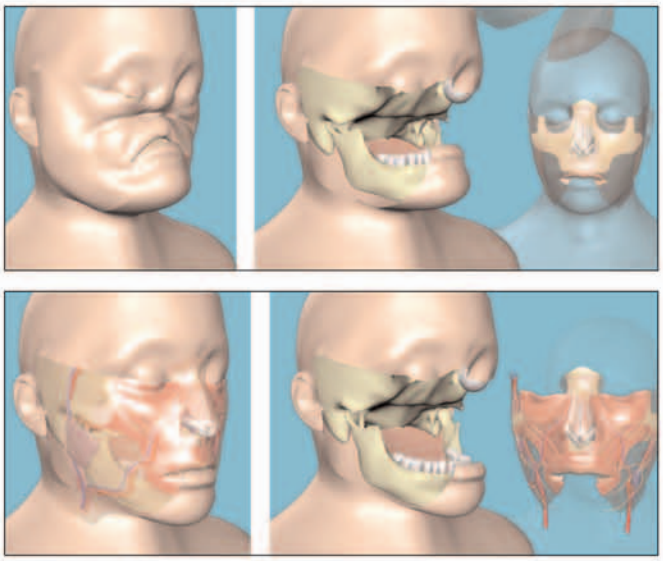
Large facial defects were inadequately treated until microvascular tissue transfers became available in the 1980's. These microvascular flaps could close large composite defects in one operation with radial, scapular and fibular flaps. These flaps, however, are limited to restoring basic anatomy for support. The transferred skin bears little resemblance to facial skin; the results often have color, texture, and hair mismatch, with loss of sensory and motor activity. These limitations are perhaps acceptable to an elderly cancer survivor but not necessarily to youthful service members severely deformed by battle injuries.

Battlefield survivors of facial avulsions are often characterized by loss of central facial features, notably portions of the jaws, lips and nose. If the penetrating trauma is from a nearby blast, 2nd and 3rd degree burns complicate the injury by scarring skin adjacent to the area of tissue loss, making local flaps and tissue transfers difficult or impossible. Facial burns lead to lid ectropion, microstomia, extra-articular ankylosis, and involve the destruction of the cartilaginous portions of ears and noses. This combination of burns, avulsions and compound fractures, conditions seldom seen with civilian trauma, create a challenge for military face surgeons.

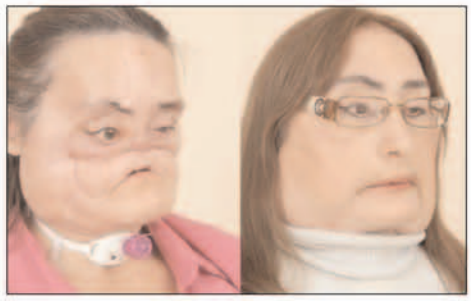
Complex maxillofacial injuries caused by explosions are addressed by stabilizing the facial skeleton in the same fashion as blunt trauma patients, unless the overlying skin is burned or avulsed. In cases of severe soft tissue compromise, external fixation and IMF is necessary until serial debridement, flaps and grafts can close the integument. Re-establishment of gross facial dimensions, occlusion and facial projection guide treatment at this phase. Comminuted fractures deemed non-repairable are debrided and bone replaced with primary grafts in the upper face, midface and condylar areas, provided soft tissue coverage is possible; primary bone grafts to repair continuity defects of the mandibular body are avoided until the zone of soft tissue injury is demarcated, debrided and reconstructed with robust flaps.[4]

Once the existing facial skeleton is reconstructed and wounds closed, re-evaluation of avulsed and damaged facial features is performed. Treatment options to replace avulsed and damaged features are basically the same options used by reconstructive surgeons for decades: autogenous flaps with attendant donor site morbidity and acceptance of treatment limitations in cases of severe tissue loss or burns. Significant loss of lip structure creates a difficult deformity to reconstruct, especially if lip loss of greater than 75% occurs or there is significant involvement of the opposing lip. To avoid severe microstomia, regional or distant tissue transfers to close the wound are performed but these reconstructions seldom provide acceptable appearance or function.[5]

In November of 2005, a team of surgeons in Amiens, France led by Drs. Dubernard and Devauchelle performed the first face allotransplantation to reconstruct a young woman's entire lower face, to include the nasal tip, lips and chin. The case was deemed successful from a reconstructive view but controversial due to patient selection criteria and lifetime use of immunosuppressants to prevent graft rejection. The face transplant successfully replaced the missing tissues with "like" tissue from a brain-dead, beating heart donor. ABO blood type and major histocompatibility antigens were matched, as well as skin color, gender and age. During the first 18 months after surgery, the patient had 2 acute rejection episodes requiring hospitalization and high doses of corticosteroids. Post-transplant cytomegalovirus (CMV) and fungal infections also required interventions. Three years later, the patient is stable with no signs of rejection, the replaced tissue appears normal and well-integrated, and partial sensory/motor function has returned to the lips.



Recent Cleveland Clinic case: Young woman with near avulsion of entire midface after shotgun blast wound.



Allotransplanted graft includes lower eyelids, orbital floors, nose, zygomas, anterior maxilla (incl. 8 teeth), cheeks and upper lip.

Application of allotransplantation to reconstruct facial defects currently appears suitable for only the most severe cases of facial defects. As researchers develop predictable protocols to modulate the immune system, allotransplantation to repair composite facial defects or resurface facial burns will undoubtedly become more acceptable. The recent Cleveland Clinic face allotransplant case was a young woman with a near total midface avulsion, dependent on a tracheotomy and feeding tube. This patient underwent multiple conventional surgeries, all predictably futile, before finally becoming a transplant candidate. Although not fully researched and appreciated, the burden of disease in patients with severe face defects must be significant, which is the most compelling argument in favor of face allotransplantation.[5,6,7] Dr. Maria Siemionow, head surgeon of Cleveland Clinic's face transplant team, said it well: "You need a face, to face the world".

A limited pool of brain dead, beating heart donors, issues with immunosuppression and a lifetime expense of approximately $1,000,000 for each patient receiving an allotransplant will spur science to develop the regenerated face. As "constructs" of composite tissue are developed, scientists will focus on the face, a highly vascularized, accessible body part of high value, as their target for reconstruction. Indeed, it is well within the realm of possibilities to develop a vascularized soft tissue composite tissue autograft in the next 10 to 15 years using growth factors and mesenchymal stem cells to re-vitalize and re-populate an extracellular matrix from a donated face, a face depleted of antigenic proteins. Tissue engineered bone and cartilaginous ear and nose constructs can be added to this regenerated soft tissue autograft. Regeneration of nerves and muscles would be the last challenge to achieve the fully regenerated face.

War, once again, has greased the wheels of innovation. The maxillofacial area is vulnerable in today's battlefield predominated by explosive devices. Maxillofacial battle injuries characterized by lacerations and avulsions, open and comminuted fractures, and occasionally complicated by burns, occur at a rate of approximately 10%. Conventional treatments with autogenous flaps are inadequate in the most severe cases. Dozens of service members are candidates for face composite tissue allotransplantation but the associated risks of lifetime immunosuppression dampens enthusiasm for that technology. Regenerative medicine, ultimately, will provide "like" subunits of functional autogenous tissue to not only reconstruct maxillofacial battle defects but facial defects from all causes. Dentistry, a profession steeped in scientific discovery, has the opportunity now to step up and define specific regenerative medicine research initiatives, leading the future of face reconstruction.

References

1. Beebe GW, DeBakey ME. Location of hits and wounds. In: Battle Casualties. Springfield, IL: Charles C. Thomas; 1952:165-205

2. Santoni-Ruigi P, Sykes PJ. History of Plastic Surgery. Heidelberg, Germany. Springer; 2007

3. Sikes JW, Ghali GE. Lip Cancer. In: Miloro, editor. Peterson's Principles of Oral and Maxillofacial Surgery. Vol 1, Chapter 34. Hamilton, Ontario. BC Decker; 2004.

4. Peleg K, et al: Gunshot and explosion injuries: Characteristics, outcomes, and implications for care of terror-related injuries in Israel. Ann Surg 239:311, 2004

5. Shakur M, et al: Maxillofacial Blast Injuries. J Cranio-Maxillofacial Surgery, 23:2, 1995

6. Rumsey, N. Psychological aspects of face transplantation: read the small print carefully. Am J.Bioethics 4:22, 2004

7. Morris, P.J., and Monaco A.P. Facial transplantation, is the time right? Transplantation 77: 329, 2004

The Los Angeles Dodgers &
The 5 Los Angeles County Dental
Societies Invite You, Your Staff, Families and Friends to Join
us on July 23, 2010

All Component Baseball Caucus
at Dodger Stadium

vs.

Friday, July 23rd, 2010, at 7:10 PM
Bleacher Beach Section with an All You
Can Eat Barbecue Buffet
Sections 55 & 59 (3rd Base to Left field)
TICKETS ARE ONLY $37

BLEACHER BEACH
AT DODGER STADIUM

Participating Dental Societies:
Harbor, Los Angeles, San Fernando Valley,
San Gabriel Valley, West Los Angeles

Reserve your tickets today by calling the SFVDS
central office at 818.884.7395

Prescription Liability

By: Carla Christensen
Risk Management Analyst, TDIC

Many dentists treat their dental teams like an extension of their families; so when an office manager has a sinus infection or a hygienist has trouble sleeping, the dentist may feel compelled to help them. Unfortunately, attempts to assist staff, relatives or friends with non-dental ailments may result in discipline with the dental licensing board and may even cost the dentist his or her dental license, as well as, place the person taking the medication at risk. Practicing medicine without a license is a presumption of negligent care.

For example, a dental assistant's husband strains his back while repairing his car. The assistant asks the dentist to prescribe her husband a few prescription painkiller tablets until he can see his physician. This is a valued employee so the dentist decides to write the prescription. Two days later, her husband is involved in a work-related accident. Drug testing by his employer reveals the presence of the painkiller, which is in violation of the company's vehicle operation policy. He admits he failed to contact his doctor after he obtained the medication from his wife's employer. The dentist is charged with practicing medicine without a license and the dental board and Drug Enforcement Agency (DEA) initiate investigations. State licensing boards give particular scrutiny to prescribing narcotic pain medications such as VICODIN® because of the potential for misuse.

Even if the treatment involves a condition of dental origin, a dentist is at risk if he or she writes a prescription without first performing a dental exam, obtaining a health history and documenting indications for prescribing the medication. Asking if the employee, relative or friend has any known allergies prior to prescribing is not sufficient. The individual may be taking another medication that could result in a serious drug interaction.

Be aware of staff that have access to your DEA number. It is illegal for an employee to use your DEA number to call in a prescription or to order additional medication through an established vendor without your authorization. Access to your DEA number does not entitle a member of your staff to prescribe or obtain prescription medications without your knowledge and approval.

To avoid potential exposure for prescription liability follow these guidelines:

- Do not write a prescription for anyone who is not a patient of record.
- Do not provide medication or prescriptions for non-dental issues.
- Examine the patient, obtain a health history and document the diagnosis related to treatment recommendations and prescriptions.
- Keep all narcotics in a locked location; you should maintain possession of the only key.
- Perform frequent, random stock checks and audits.
- Secure prescription pads and closely monitor quantity.
- When possible do not delegate pharmacy prescription calls to staff.

Prescribing medication for an employee, friend or family member who is not a patient of record places a dentist's reputation and license at risk. The best of intentions may result in the worst outcome for you. The best practice is to treat family members and friends the same as all other patients, without exception. Avoid liability exposure by refusing to write prescriptions for non-patients and for non-dental reasons. If you have any questions regarding the information presented in this article or you need to discuss another risk management issue affecting your practice, please call the TDIC Risk Management Advice Line at 800.733.0634.

Give Kids a Smile

By: Andy Ozols

2010 saw a dramatic increase in the number of children served in our annual Give Kids a Smile program. 41 member doctors volunteered in 24 locations throughout our component's boundaries, to serve 1,748 children. This bests last year's 238 children served in one location by a long shot (a 734% increase)!

In addition, five vendors stepped up to the plate and provided the necessary supplies to serve the children, and 31 additional non-dentist volunteers pitched in to make this our most successful effort ever.

While our core focus during the event was to provide oral health education, visual oral health screenings, entering kindergartener assessments and fluoride varnish application, we discovered that 15.4% of the kids, or 269, needed some form of follow-up care. One of our volunteers, Dr. Jim Mertzel, suggested that in the future, we make an additional effort outside of the scope of Give Kids a Smile, to educate young parents (especially parents to be) on matters of oral health, as a preemptive strike against early childhood carries. Members who would like to sign up with the central office to provide the follow-up restorative services to these children are encouraged to call and register their willingness to help. Better yet, of course, would be your willingness to provide these low-income kids with a 'dental home' so that they have a dentist to go to for routine cleanings and ongoing evaluations during their formative years.

While Give Kids a Smile had been a one day event for the SFVDS in years past, this year we scheduled and provided services to children throughout the month of February, 2010. Through our relationship with the Valley Care Community Consortium, we worked closely with new partners to reach a larger number of underprivileged children than ever before.

Mahvash Shayan, DDS, at the Maude Booth Head Start Program in N. Hollywood.

Our new partners included 20 of the Volunteers of America's Head Start programs in Tujunga, Sun Valley, Pacoima, San Fernando, Sylmar, N. Hollywood, Valencia, Newhall, Val Verde, and, MEND (which we served twice during the month) in Pacoima, the UCLA Dental Clinic at Mission Community Hospital in San Fernando and the Kids Community Dental Clinic in Burbank.

Jim Mertzel, DDS, at the El Cariso Head Start Program in Sylmar

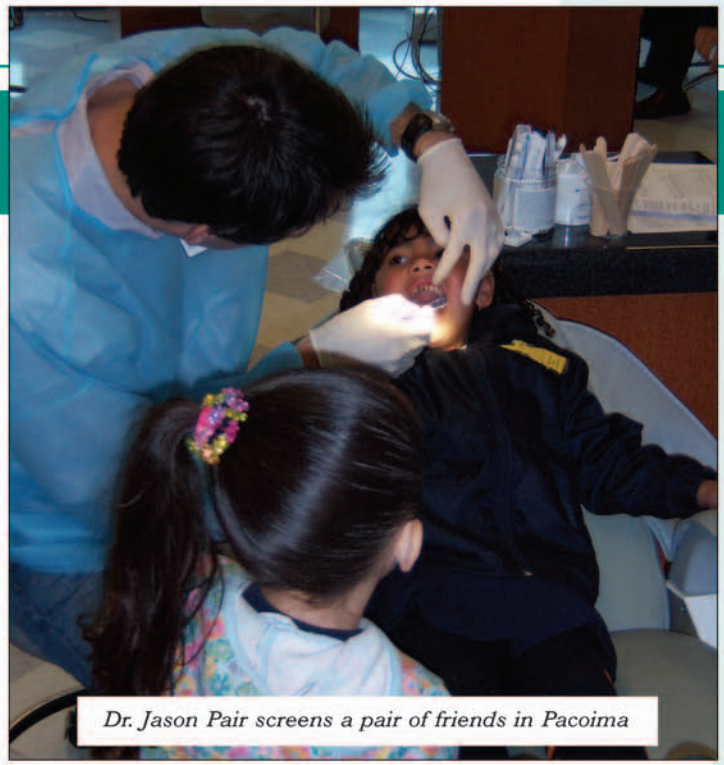
Our program also screened nearly 1500 children in the Antelope Valley, through the able coordination of our Antelope Valley Liaison, Dr. Gib Snow. Dr. Snow and his team coordinated SFVDS members in the Antelope Valley in providing visual oral health screenings, kindergarten assessments, fluoride varnish application and oral health education to children at 15 school sites, including many Head start programs in the High Desert. Sadly, their efforts discovered that some 10% of children had never been to a dentist, 20% had not been to a dentist in more than a year, and too high a percentage need immediate follow-up care. In addition, Dr. Snow's efforts reached out to 26 girl scout troops with an essay contest designed to raise awareness of oral health issues.

Continued on page 20 & 21

Large groups of 4&5 year old children received oral hygiene instruction and goodie bags, while waiting their turns for GKAS screenings & fluoride varnish applications.

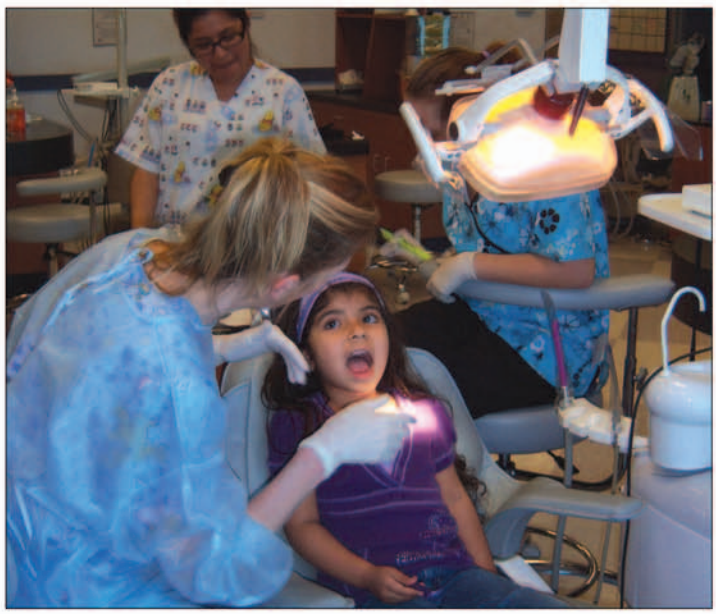
On these three pages, you'll find a listing of your colleagues who volunteered, as well as the vendors and some of the non-dentist volunteers who stepped up to the plate and hit a home run in the name of the San Fernando Valley Dental Society. You will see a collection of photos illustrating the work we did and the smiles we helped to give the children. Seeing these photos, will hopefully inspire those of you who could not help this year, to volunteer in 2011, when we hope to expand the program even more. The need to help parents of young disadvantaged children identify their oral health needs just keeps growing – and so, therefore, should our willingness to help.

As members of the SFVDS, you should all be very proud of the work we did with this year's Give Kids a Smile program. We really did 'give lots of kids, lots of smiles." Thank you to everyone who participated.



Dr. Jason Pair screens a pair of friends in Pacoima

Dr. Art Davoodian screens a youngster at the El Cariso Head Start program in Sylmar



Dr. Eileen Zierhut readies a fluoride varnish application at M.E.N.D.

Dr. Punita Oswal, with one of many new friends she made at M.E.N.D.

Give Kids a Smile

Volunteer Doctors

Sam Ganji , DDS
David Ganji, DMD
Marc Gross, DDS
Karin Irani, DDS
Mahvash Shayan, DDS
Nita Dixit, DDS
Marvin Sagerman, DDS
Valentina Goren, DDS
Viken Toutounjian, DDS
Paul Applefield, DDS
Sarah Phillips, DDS
Susan Jarakian, DDS
Sarah Phillips, DDS
Jorge Montes, DDS
Mehran Abbasian, DDS
Artin Davoodian, DDS
Gib Snow, DDS
Jorge Alvarez, DDS
Mark Amundsen, DDS
Alexis Gutierrez, DDS
Jason Pair, DDS
David Pair, DDS
James Mertzel, DDS
Gina Muir, DDS
Mahrouz Cohen, DDS
Emad Bassali, DDS
Gordon Fingerman, DMD
Moris Ayenechi, DMD
Mahrouz Cohen, DDS
Behnaz Sepehipour, DDS
Carolina Pablo, DMD
Armina Gharpetian, DDS
Punita Oswal, DDS
R. Craig Ford, DDS
Bill Weisman, DDS
Anette Masters, DDS
Khanh Le, DDS
Joel Miller, DMD
Elaine Wattar, DDS
Andy Tran, DDS
Eileen Zierhut, DDS

Volunteers Of America

Jennifer Ordinario
Patricia Rigney
Aleta Bryant

Vendors

Chris Mayberry, Patterson
Maritza Alford, Henry Schein
Michelle Lohman, P&G
Shaneese Nunnaly, Colgate
Charlotte Smith, Sultan Healthcare

Other Volunteers

Dale Gorman, Kids Community Dental Clinic • Wendy Abrams, SFVDS Staff
Bella Penate, SFVDS Staff • Andy Ozols, SFVDS Executive Director, Audrey Simons,
UCLA Dental Clinic at Mission Community Hospital

Antelope Valley Report

By: Char Brash

The Vision of the San Fernando Valley Dental Society is to provide services to its members. The society also strives to increase the oral health awareness in our community with special contests and events.

For a second year, the Girl Scout troops of greater Los Angeles participated in an essay contest throughout the month of February to enhance the ADA "Give Kids a Smile" program. Participants were given the opportunity to enter the contest with the winner, as well as their troop, being given an award. In 2009, ten (10) Girl Scout troops participated. This year, the number increased to 26 troops! The goal of the contest was to focus on untreated oral disease and why it is important to practice good oral hygiene.

Providing service to the local Head start program has elevated the GKAS program to a higher level. The need for dental services became apparent when local dentists visited Antelope Valley schools and discovered that more than 10% of the children examined had never seen a dentist; 20% hadn't seen a dentist in more than a year, and even a higher percentage of the children seen needed some immediate dental treatment. Children miss more school due to oral disease than any other disease, even Asthma or allergies. The Head Start program consists of 15 school sites in the Antelope Valley. The number of children seen this year was approximately 1,500. Volunteers provided kindergarten assessments, visual exams, and oral health education.

Palmdale's Head Start Program Director presents a certificate of appreciation to Amanda of Dr. Sadet's office.

A great deal of pride comes from being part of the Give Kids a Smile program. We all look forward to added successes in the future.

Foothills Report

By: Bart Conroy, DDS

SFVDS ZONE LUNCHEON

The program for the first 2010 Zone Meeting of the SFVDS was focused on current events in the legislature that affect all of us. Michelle Rivas gave a presentation about insurance legislation as well as Mid-Level Provider issues, which attendees were able to discuss with their colleagues and patients. We served a Round Table Pizza lunch at the La Crescenta Branch of the LA County Public Library, located at the intersection of Foothill Blvd. and La Crescenta Ave. in La Crescenta, on Wednesday, May 19th, from 12:00 – 2:00 p.m. One-hour of continuing education credit was provided. The cost was FREE and we hope to organize another meeting in the Foothills later this year.

ORAL SURGEON, DR. LARRY LYTLE SPEAKS AT OAKMONT

The Glendale Academy of Dentistry continued their tradition of quality continuing education programs and camaraderie at the Oakmont Country Club on May 6, 2010 with a presentation by Dr. Larry Lytle about *'Le Fort Osteotomies and Esthetic Immediate Implant Technique'.*

Continuing education credit was provided and non-members and guests of the Academy were in attendance. The Oakmont Country club is located at 3100 Country Club Drive, Glendale, CA, 91208.

Other recent presentations have included Dr. Mark Urata, *'From MOD onlay to the Separation of Craniophagus Twins: Dentistry as the Constant'*; Dr.Avishai Sadan, *'Comprehensive Esthetic Dentistry—An Update'*; and Dr. James Paternak, *'The Magic of Lumineers'.*

CONTINUED FROM PAGE 9

DATA BREACH - SAFEGUARDING THE CONFIDENTIALITY OF PATIENT INFORMATION

In the event your office sustains a data breach, follow your state laws to find out how to respond. Reporting identity theft to local law enforcement will enable a more effective response.

The Health Insurance Portability and Accountability Act (HIPAA) has provisions regarding data security breach notifications. The provisions were amended by the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH). As of September 23, 2009, patients must be notified any time their unsecured personal health information (PHI) may have been compromised through unauthorized acquisitions, access, use or disclosure. HITECH's security breach notification requirements apply to covered entities.

TDIC developed a sample letter for dentists to send to patients as notification of a data breach. This letter can be accessed at thedentists.com in the recordkeeping and forms section of the Risk Management link.

The impact of losing electronic data is expensive, time consuming, and can be damaging to the operations and reputation of a dental practice. Often, office property insurance provides coverage for physical loss or damage to electronic data processing hardware, software and media. This does not usually cover costs associated with data being lost, stolen or damaged. TDIC offers Data Compromise Coverage to help dentists respond to loss or theft of patient information as an optional piece of the office property policy. Contact your TDIC broker to inquire about Data Compromise Coverage. If you don't have TDIC, contact your existing carrier to determine coverage and limits in the event of a data breach.

Dr. David Podsadecki

As many of you may already be aware, our father, and SFVDS member, Dr. David Podsadecki, was critically injured in an automobile accident on February 23rd and we nearly lost him. Due to his great stamina, his wonderful team of physicians, and his incomparable oral and maxillofacial surgeon, Dr. John Scaramella, he is doing amazingly well. However, he still has a long way to go to complete recovery.

Unfortunately, his medical bills are piling up quickly and we need your help. To help our dad with his overwhelming medical bills, we have set up a fund.

If anyone would like to donate, please contact Travis Podsadecki by e-mail at TravisPods@aol.com, by phone at (818) 314-9286, or you may go to any Wells Fargo bank and directly deposit into the David Podsadecki Donation Fund, Account #8022616208. Donations will go solely to our father's medical bills.

Thank you, The Podsadecki Kids

CLASSIFIED ADS

Board Certified Anesthesiologist
Providing mobile anesthesia services for all dental procedures: from general anesthesia to IV sedation. BLS, ACLS, PALS Certified
Please call 206.948.2468 or email 40winksanes@gmail.com for info.

Beverly Hills family Dental Practice for Sale.
Four operatories, 1100 square feet, ground floor corner,
no HMO, all PPO's. dentist@dslextreme.com

West Hills Office for Lease: Beautiful fully equipped 4 operatory office for lease, part or full office/time. Competitive rate. Call for details: 818.348.8882 or 818.631.6735

In Memoriam

Gray Berg, D.D.S.
Sep. 20, 1926 – Feb. 4, 2010

Gray Berg, D.D.S., SFVDS member since 1960 and past editor of Dental Dimensions, passed away on February 4, 2010 in the early morning hours.

Dr. Berg was always happy and cheerful and was dedicated to enjoying life to its fullest. He loved the profession of dentistry, his home, his family, his wonderful dog and all the people he had come to know throughout his life in Southern California.

Dr. Berg was an avid skier (both on snow and water), volunteered at his local sheriff's station, visited patients at a local hospital with his dog, read to second graders at a local elementary school, and of course edited Dental Dimensions for many years, both while in active practice and after retiring.

As an avid animal lover and veteran of the U.S. Air Force, his request of those wishing to remember him, was to have them donate to either, the Best Friends Animal Sanctuary (www.bestfriends.org), the USO (www.uso.org) or the Wounded Warrior Project (www.woundedwarriorproject.org) in his memory.

San Fernando Valley Dental Society
22110 Clarendon Street, Suite 101
Woodland Hills, CA 91367

DATED MATERIAL

Trigeminal Neuralgia Treatment with GAMMA KNIFE RADIOSURGERY

TRIGEMINAL NEURALGIA Facts:

- Characterized by brief attacks of severe electric shock-like pain (with rapid onset and abrupt end) on the face
- Pain is usually on one side of the face, about 10 percent of patients have pain on both sides
- Stimuli may trigger an attack (touch, cold, eating, brushing hair, etc.)
- More frequent in women and people over 50
- If medications are unable to control the pain or if they cause intolerable side effects, interventional treatment may be indicated
- Such intervention may include microvascular decompression, rhizotomy, or Gamma Knife Radiosurgery
- Gamma Knife Radiosurgery is the least invasive method for treating this condition and results in comparable outcomes

GAMMA KNIFE Facts:

- Northridge Hospital has the only Gamma Knife in the San Fernando Valley
- Our physicians have treated more than 550 patients
- Radiation conforms to the shape of the lesion or tumor while sparing the surrounding tissue

Trigeminal Neuralgia Support Group at Northridge Hospital
In partnership with the Trigeminal Neuralgia Association

Patients can obtain information, encouragement and treatment options by calling **(818) 885-8500, ext. 2565**

Gamma Knife Center
(818) 885-5432

Northridge Hospital Medical Center
A member of CHW
www.NorthridgeHospital.org