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DENTAL DIMENSIONS

Summer 2011

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In This Issue

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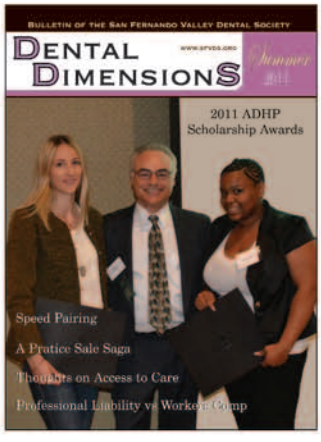
On The Cover.....



SFVDS President, Mehran Abbassian, DDS, with (l-r) Jeanette Kerestegian (hygienist student), and Rodnae Carter (dental assisting student), after the dinner time scholarship award at the June 22, 2011 CE Meeting. Two $500 Scholarships are awarded each year in a joint program with the CDA Foundation.

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From the Desk of the Editor

"Access to Care" Issue

The "Access to Care" issue has been at the forefront of much of the news and debate in California recently. The much awaited results of the two CDA task forces assigned to study this issue is now available for review on the CDA website. The CDA House of Delegates in November will have to decide what to do with this report and what policies we wish to form on this very prominent issue.

Earlier this year, the CDA Journal presented 3 issues dedicated to articles and opinions on this debatable issue. The July 2011 issue was very similar in its approach to the issue as the previous ones. Many, including your SFVDS Board, felt the viewpoints expressed were heavily weighted in favor of the mid-level provider as a viable solution for the 30% of our population that has a problem with access to care in California. We have been working diligently to stay on top of this issue and to keep you informed. In an effort to provide you with a different and balanced perspective,I have included guest editorials from our board and other dentists who feel that a new level of provider is not the answer to the existing problem.

We want to hear what you, the grassroots members think. If you did not have the opportunity to attend the CDA town hall meeting on July 18 at the LAX Marriott, you can still have input on this issue by contacting The San Fernando Valley Dental Society. We feel that CDA policy should be guided by and be congruent with what our members think and want.

Access to Care

Your Editor's View

In dental school, we were taught to look at research and published articles critically. Is the research well done, valid and relevant? Who is doing the research and what are their

motives? What previously published research is being used as a premise for the current paper and is that research valid and relevant? We must all put on our researcher hat and review the information available with that same critical thinking. You will find the CDA access to care report very thorough and well written. You may like much of what is written, but look at it closely with your critical thinking cap on. You may find a few things that you don't agree with.

Mid-level provider proponents base their proposals on studies that state the current dental workforce is at 90% capacity and cannot accommodate the 30% of the population in need of dental services. In essence this means that each of us can accommodate only 10% more patients in our practices. Is that true for your practice? What about your colleague down the street or in the next town?

Have you wondered why there is money for construction of a new building at a local school when teachers are being laid off? It is because the funding comes from different budgets and cannot be transferred. Given a choice, would you rather see that money go to keeping the teachers employed in the schools? Similarly, would you like to see adequate reimbursement for treating our underserved population or funding go towards developing a new non-dentist provider? Unfortunately, the funding for these solutions comes from different "budgets". The PEW, Kellogg and Macy Jr. foundations are mandated to direct their funding and efforts towards certain types of programs. The solutions they propose have to fit within those mandates regardless of how adequately or even inappropriately those solutions address the actual problem.

Using Mark Twain's phrase "Lies, damn lies, and statistics" can be used to manipulate anything. You can use logic to justify just about anything but facts are facts. What are the real facts? We all know. We live them every day.

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

From the Desk of the President

Dear Friends,

Well its midway through my term of president of the San Fernando Dental Society. I am so happy to communicate with you in this issue, for there has been a very important matter we have had to deal with. The matter I am speaking of is the mid- level provider issue in California. In my opinion the most important topic that pertains to our profession and the public in California at the present time.

As I mentioned in the last issue, we were waiting for the CDA's Task Force Committee's report on the mid-level issue in California. In April the SFVDS board formed an Ad-Hoc committee to decide on what our response would be, if it appeared that the report was not going to take a position on this issue in California. This was important because there are entities out there that are spending millions of dollars to make the mid-level program in California come into existence.

As it became clear to us after the report was released, CDA did not take a strong enough position on the issue of mid-level provider's place in California. The Board, based on the recommendation of the Ad-HOC committee decided to pursue this matter very aggressively with the CDA. Thanks a million to our Trustee Alan Stein, DDS, who recommended to the board that they propose a resolution to the CDA's Board of Trustees and see what type of response we would get from them on this matter.

After Alan Stein presented the resolution to the Board of Trustees, he contacted me with a very positive outcome. The Board of Trustees did not adopt the entire resolution. However, they definitely took a position on non-dentists being able to perform irreversible procedures on patients. This will be the CDA's position, until the House of Delegates meets later this year. In the House, the topic will be discussed in detail and voted on. I can assure you that The SFVDS will be well represented by your board and will do everything in its power to fight for the rights of the dentists and the public in California.

I could not be more proud to be a member of the Board of the SFVDS. So should you also be proud of this big change in CDA's position on this topic. We will keep you informed of the outcome as soon as it takes place.

On another note, the next Schlep and Shred event will be on Saturday August 13th from 9:00-11:00 AM, at Dr. Bart Conroy's office building located at 501 West Glenoaks Blvd Glendale, CA 9120. Also, for anyone who is in need of Live Scan fingerprint for license renewal, we will have that service available also. This is another way we try to add local value to your membership.

We are also working hard to find a building for our central office. If anyone knows of a suitable location or better yet, if anyone would like to donate a building to the dental society we would be grateful. Well, it does not hurt to ask!

Until the next issue stay well and productive, and let's see each other at the next general meeting, please stay connected to your dental society.

Yours truly,
Mehran

From the Desk of the Executive Director

By: Andy Ozols
Executive Director

I hope everyone is enjoying a good summer so far, as I know I am. Not because I have taken a vacation to a far flung tropical paradise, but because we have had some very successful meetings and socials, and I have had the pleasure and honor of working with your board of directors on crafting a successful response to the long-awaited CDA reports on Access to Care and the Dental Workforce. Three years in the making, CDA is to be lauded for its efforts at what appears to be a comprehensive assessment of California's 'Access to Care' situation, and its study of the 'dental workforce'.

Your board of directors saw and reviewed a copy of the report, but your board was disappointed with the lack of position on the dental workforce. What has long been seen by your board as an intuitive understanding of the workforce issue – that no one other than a licensed dentist should perform diagnosis and irreversible surgical procedures on a patient, evoked a response from CDA's leadership that we should await the results of the two CDA taskforces/workforces before attempting to craft a CDA-wide position on the issue.

Well, your board was polite and respectful for the past three years, and while making no secret of its position to CDA and the other 31 components in California, the board finally had enough of the non-commitment, no-policy position that CDA had chosen to adopt. Your board sensed a clear and present danger to the practice of dentistry as we know it, if for no other reason, than the reports made no recommendations whatsoever on the ominous prospect of a new dental team member coming into the fold – the so called, 'mid-level provider'.

Also, knowing that a 'spot bill' existed in the legislature, one that appeared to promote the expansion of the dental workforce, your board decided to move into action before those in favor of such an expansion seized on the lack of policy recommendations in the CDA reports as proof that dentists wouldn't object to such an expansion. In effect, your board believes this would endanger the safety and well being of the public. As a result, your board decided that a special meeting of the CDA House of Delegates was immediately necessary in order to adopt a policy of opposition before the November CDA House of Delegates meeting. Your board formed an ad hoc committee to study the issue, begin to assemble the needed votes to call for such a special house and begin to line up the votes necessary to pass a resolution mandating that CDA adopt (and begin to act on) a policy of opposition to the 'mid-level' provider in dentistry.

As you will read in the Trustees Report, one of our trustees, Dr. Alan Stein, suggested that we make one last effort to have the Trustees establish an interim policy of such opposition, before calling for a special meeting of the CDA House of Delegates, which of course would have been rather expensive. The ad hoc committee and the board agreed (after holding its own special meeting), and sent a resolution with Dr. Stein to be presented at the Board of Trustees on June 3, 2011.

Guess what, in essence, our resolution passed, though not before the trustees reworked the resolution into something a little softer and more palatable to CDA's current approach. To paraphrase, the trustees agreed to oppose mid-level providers being introduced to the dental workforce in CA until such time as evidence is presented that clearly shows that the quality of care and safety to the patient will not be compromised.

Accepting the interim policy adopted by the Board of Trustees, your board will now see if a more strongly worded opposition resolution should be presented to the CDA House in November, 2011. Stay tuned for updates on your board's leadership on this issue as they are not going to rest on their laurels hoping for the best.

Your board is taking an active position to protect your profession and the public health, and that is something you should all be very proud of. I too am proud to be working with your leadership and I hope you can see why working with such dedicated, informed and passionate leaders on your board has been a great start to summer for me!

Board of Trustees Report

By: Gary Herman, DDS,
SFVDS Trustee

The CDA Board of Trustees met on June 3rd and 4th in Sacramento. The main focus of the meeting was the Access to Care and Workforce report, which is in final draft stage and was discussed at the meeting. The Board received a panel presentation from a number of the researchers who contributed to the knowledge cited in the report. The presentation was videotaped and is available online at the CDA website.

This was followed by the introduction of a resolution by the SFVDS Board to establish a CDA policy against the delivery of surgical/irreversible procedures by non-dentists. Your Trustee, Alan Stein, did an excellent job helping craft a substitute resolution that maintained that position, but was more in line with CDA policy. I thank Alan for his well-honed wordsmithing skills.

CDA is spending a great deal of time and effort to help educate dentists about the access to care problem and the proposed solutions. I hope that you took the time to read the available information and attended one of the educational forums on this issue that CDA hosted in July. There is not a more important issue facing our profession right now.

Among other highlights, CDA authorized funding to provide relief to the Japan Dental Association and the Missouri Dental Association to help deal with the natural disasters both have recently faced.

CDA remains on a strong economic footing, but is always looking for ways to improve. Along those lines, we were briefed about the exploration into developing a dentist-focused financial institution to provide economic services to our members and strengthen our non-dues revenue. This process may take several years, but clearly shows that your organization never stands still in trying to deliver the best service to its members. Until next issue, stay healthy.

ADA DOES NOT ALWAYS REFER TO THE DENTAL ASSOCIATION

By: Jim Mertzel, DDS
Chair, Legislation Committee

For the most part we look forward to the communications we receive from the American Dental Association. The information we receive is usually beneficial to our practice.

However if you have had to deal with the information, rules and regulations issued by the other ADA, the Americans with Disability Act, you may be in for some discomforting moments.

Last year, at the CDA House of Delegates, some members reported that a number of Dental Offices in Northern California had been served legal papers, informing the dentist that their office building was not in compliance with the ADA (Americans with Disability Act) regulations. It seems that some individuals, together with their attorneys, were targeting vulnerable dental offices with the sole intention of extorting large sums of money from the owners of the vulnerable buildings or office premises.

Earlier this year, the owners of an entire street of small retail stores in a small community in Southern California, were each sued by the same individual for not being in compliance. The fact is that one of the proprietors was himself disabled, and confined to a wheel chair. It was obvious that the suits were merely an attempt to extort money from the owners.

Recently local dentists in our area have also been plagued by similar law suits.

Even though some buildings, built before the ADA laws were passed, may be grandfathered out of complying, it is still necessary for the owner to engage an attorney to dispute the charges. If the owner of the building tries to settle out of court with the individual who filed the action, it leaves the owner open for additional legal action.

In order to protect the owner of the building from further action it is advisable to contact an attorney who has expertise in this field. The owner must be able to prove that the building is exempt, and must prove that no major renovations have been made after the ADA laws were passed,

He must hire a compliance expert to evaluate the premises and list what will be necessary to bring the building up to ADA code. The owner must then hire a contractor to give an estimate as to what the costs will be to bring the building into compliance. The owner must then provide the information to a judge. He must show financial papers to the judge showing that the income provided from the business does not justify the expense to bring the building up to the ADA regulations. He may be required to do some renovations that do not present a financial hardship.
Ultimately, it is the judge who must make the decision to excuse the proprietor.

The costs, even assuming that the building is exempt, could be well over $4,000.00.

Attorneys familiar with the ADA regulations state that although legislators are well aware of the abuse by litigants attempting to extort funds from vulnerable building owners, no attempts have been made by state legislators to curb this practice.

One suggestion made regarding protective legislation was the state could grant an exemption certificate to buildings that were built prior to the ADA laws, after the building was surveyed by a state certified compliance expert stating that all efforts possible were made to bring the building into compliance. This would protect the owner from frivolous and expensive legal action.

If you own a building that may be in this category, you may want to hire a compliance expert to find out what you can reasonably do to conform to existing laws.

General Meetings - Preview

SEPTEMBER 14, 2011

Occlusal Disease

Speaker: J. Luis Ruiz, DDS

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

About the Program: In this very practical course the attendee will learn how to implement a methodic and incremental approach to diagnosis for every patient, understand the 7 signs and symptoms of occlusal disease, and how it impacts the longevity of restorations. The Occlusal Disease Diagnosis System is a methodic and practical "system" to diagnose and then treat occlusal disease, including equilibration. Practitioners will learn how to educate patients about occlusal disease, leading to excellent treatment acceptance, added profits and maintaining a highly ethical practice.

OCTOBER 19, 2011

Emerging Dental Materials

Speaker: Brian Novy, DDS

Sponsored by GCAmerica

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

About the Program: If the thought of sitting through a dental materials course makes you want to yawn, then this course is for you. Using a mini-lecture series format and the most current (and relevant) materials research, you'll get caught up on a myriad of current dental controversies such as: Dentin bonding agents, caries detecting dyes, pulp capping, bleaching, understanding the various types of fluoride (no, they aren't all the same), and Articaine. This course will be a great way to understand what has occurred in the research world, without ever having to read an abstract.

General Meeting Review

May 4, 2011

Speaker: Mark Exler, DDS, FACP

The Wonderful World of Prosthodontics

Dr. Exler took course participants through the various strategies of prosthodontic success, from the initial patient contact through the final completed treatment, including the potentialities of future rescues. Dr. Exler took a deeper look at implant technologies, procedures, esthetic restorations and properly understanding patients' needs and left plenty of time for audience questions.

June 22, 2011

Speaker: John Yagiela, DDS

Clear the Fears, Drug the Bugs: Pharmacologic Management of the Surgical Patient

Dr. Yagiela gave the attendees an update on the latest research and changes to a wide variety of drugs used by the dental office. The program reviewed cases in which dentists have experienced problems associated with drugs and included a review of local anesthetics, analgesics, antibiotics, sedatives, and other commonly used medical drugs

l-r, Dental hygiene student, Jeanette Kerestegian, a Glendale resident and student at West LA College, SFVDS President, Dr. Mehran Abbassian and Rodnae Carter, DA student at the Antelope Valley ROP program, pose for a picture after the award of $500 scholarships to each during the dinner hour of the June 22, 2011 CE meeting.

WHY I OPPOSE THE MID LEVEL PROVIDER

ONE MAN'S OPINION

By: Gerald Gelfand, D.M.D.

I graduated from dental school in 1971. Throw in those four years in school and that's forty four years that I've been in dentistry. I've been in leadership positions on the local, state and national levels for many years, both in organized dentistry as well as in my specialty organizations, and still continue as a delegate to the Houses of Delegates (HOD) of the American Dental Association, California Dental Association (CDA) and the American Association of Oral and Maxillofacial Surgeons, debating the vital issues of the day.

During these many years there have been numerous issues of significant importance to the profession of dentistry with which we have dealt successfully for the most part. There may even have been a crisis or two, though there are really few true crises. However, I believe we are facing one now. I believe that the contemporary concept of adding a new auxiliary to the dental team labeled, for lack of better term, the mid-level provider, licensed to perform irreversible/surgical procedures, including but not limited to extractions, pulpotomies, cavity preparation, etc., is just such a crisis and is the most important issue that dentistry has faced in my time and no doubt for many years to come.

It has placed dentistry at a crossroad and the decisions we make as organized dentistry will help determine our future as a respected and integral member of the health care professions. Will we remain such, our services being delivered by professionals at a post doctorate level, or will it deteriorate into a trade being delivered by lay people having served a short "apprenticeship" and trained to deliver a group of technical skills? While this contentious issue threatens to tear at the very fabric which makes this profession so great, it is our responsibility to stay informed and act vigilantly and responsibly on behalf of what is in the best interest of the dental profession and the patients it serves.

Until recently the CDA had not taken an official position on the mid level provider doing irreversible/surgical procedures. A direct result to the activism of your San Fernando Valley Dental Society, they have now taken such a position. While their now official position, recently adopted by the Board of Trustees as interim CDA policy until ratified by the HOD, does oppose non-dentist providers doing irreversible/surgical procedures, there is a caveat. That caveat is the condition that this position will sustain until such time as there are studies done to confirm the safety and cost effectiveness, etc. of mid-level providers performing these types of treatments. That's not good enough for me and here's why I oppose the mid-level provider regardless of the outcome of such studies.

I like to believe that I keep an open mind about the issues with which I'm involved. I listen to the debate and formulate calculated and thoughtful decisions. Yet on this one I'm intransigent. Let's assume that the prospective studies to which I referred above indicate that these minimally trained auxiliaries can, in fact, perform well and safely and yes, even less expensively than the dentist. There's no surprise that it may be less expensive treatment without the overhead burden facing the dentist. But you still get what you pay for. More importantly, a positive outcome merely means that you can take a young man or woman and train them to a minimal level of competence to do specific technical procedures. So what? Ours is not a profession of mechanics; it is a profession of scientists who do mechanical procedures. We refer to our profession as the art and SCIENCE of dentistry. You could perhaps teach a chimpanzee, with a little innate talent, the art, but you can't teach it the science. The CDA has always stood for supporting the highest level of education, training and continuing education for its members and has always been dedicated to the highest standards of care. Insuring the safest possible delivery of dental services has always been a priority for CDA. Don't let them stop now.

Dental services by their very nature may result in unpredictable intraoperative challenges and post treatment outcomes and complications even following what may have appeared pre-treatment to be the most routine of procedures. Early recognition of these challenges and complications and prompt and appropriate treatment is of paramount importance in averting negative outcomes. Achieving positive outcomes with the greatest frequency requires nothing less than a 4 year dental education. It is for these reasons that it is my opinion that all irreversible/surgical procedures delivered within the scope of the practice of dentistry should only be provided by practitioners having attained the degree of Doctor of Dental Surgery (D.D.S.) or Doctor of Dental Medicine (D.M.D.) or their equivalent (or by those with an M.D. where permitted by law).

It is inconsistent with current standards to subject patients to two levels of care when requiring irreversible/surgical procedures. There are better ways to deal with whatever access issues we perceive and those perceptions run the gamut from a severe issue to no real access to care issue at all. While the dental profession has been exemplary in providing pro bono care and care for the

Continued on page 10

ONE MAN'S OPINION

Continued from page 9

disadvantaged, the government just wants to throw the entire problem in our laps and have us solve it but, by the way, there's no money for any support of any program. I don't believe that's a fair burden for us to bear. There's better ways to deal with whatever access issues exist than mid-level providers, which I guarantee you will not be the answer. Several months ago we had a meeting of new dental graduates at the Society headquarters. There were about 8-10 young dentists there and lo and behold, not one had a job. NOT ONE. They were all looking. There's your pool of people to deal with access and I've got some pretty good cost effective ways of using them, but that's for another editorial. Of course it can't be done for free and the state and federal governments will have to decide how serious they are when it comes to dealing with the oral health of the American people.

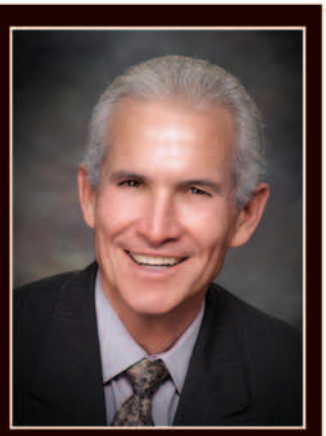
Policy makers must appropriate adequate funding to allow dentists to better serve patients in underserved areas rather than settling on mid-level providers to treat this population, a program that is destined to fail as an answer to the so-called "access to care" problem. There is only one way to insure the protection of patients seeking dental services. Providing these services by anyone without the requisite education, training and experience places the patient at risk and constitutes an unacceptable compromise to the welfare of the public.

The American Way

I clearly recall the initial presentation from Dr John Ingle, Dean of USC Dental School, proposing that the State of California place in our schools the New Zealand School Nurse Program. The proposition would be that school nurses would restore teeth in public schools.

The reaction was immediate and decisive. There was a huge uproar. Dr Ingle was dismissed as Dean. After that time (late 1960's to early 1970's) I had occasion to meet people from New Zealand. The common thread to my inquiries were that in New Zealand it is not uncommon to be in your twenties or thirties and not have any teeth. It then became even more clear to me that the principles of freedom and free enterprise are the principles that have distinguished America from all other countries in the history of mankind.

When money is taken from the producer and given to the non producer we will always see shortages and waiting lines. In this case we see less dentistry along with a shortage of quality care. It is interesting to note that those that propose this system are generally (not always) those that live from the fruits (taxes and donations) of the labors of the producer, most notably the Public Health Dentist. These ideas generally do not come from those in dentistry that are taking a risk of being in business for themselves. It turns out that those that are in business for themselves are providing the greatest service to the public (at their own risk).



Gib Snow, DDS
Snow Orthodontics

Without placing a burden upon the public treasury, the San Fernando Valley Dental Society recently formed a foundation to further improve the dental health of our community. This action comes from those that are committed to the American way. It is the compassionate capitalist that gives strength to our way of life.

It gives strength to the citizen not to enslave him but to allow him to retain his wealth and then to share in a way far more effective than the inefficient bureaucrat.

The question now arises that since Denti-Cal has stopped providing dental care for adults, the word is getting out that one needs to prepare himself for dental care at all times including periods of unemployment.

Children are a different story. Children are at the mercy of their environment. Adults can prepare. Maybe the word is out that if one prefers good health he has to prepare both with insurance and a savings account.

Dear Mr. Kellogg

By: Ken Jones, DDS, JD
Guest Columnist to the Ohio Dental Association Today

To those who run the Kellogg Foundation:

OK, let's talk. Maybe we can find some middle ground. Or maybe we can't. Maybe we can figure out a way to do what you think you want to do – provide dental care for everyone – and also to do what I think needs to be done to do just that – and do it the right way.

Do we need Alaska-style DHATs as mid-level providers in Ohio and the few other target states where you're pushing the legislatures to do the dirty work? Maybe. Maybe not. Will they solve all the dental care and access woes in Ohio? Not in my lifetime. Will they provide care – whether good, bad or indifferent – out in the areas that actually need more dentists and dental care? Don't make me laugh.

Here's what I said in August 2005 ("Mea culpa – not," ODA Today, August 2005). Sometimes you have to say it a number of times before the message sinks in. So let me say it again in January 2011 and tell you that it's even truer and more relevant today than it was five and a half years ago.

"I've been a member of organized dentistry for over three decades, and I'm tired of wearing sack cloth. My fault? I don't think so.

"Dentistry has worked its collective butt off for years to "solve" the problem of access to dental care. We've worked at prevention and education and charity since dentistry evolved from bloodletting and barbershops. It hasn't worked to date, and, unless fundamental changes are made in our society's attitudes, access will remain a bone of contention and controversy forever."

The view that isn't often publicly espoused is one with which I agree — specifically, that there is a segment of the population that must change its psychological and sociological perspectives in order to improve its own fortune. I'll help, but I can't [and won't] try to do it alone. They need to accept some of the grass-roots views of us grass-roots dentists as valid. Like these, that show how priorities are getting out of whack:

1. At least three-fourths of my Medicaid patients use only cell phones. I stood behind a patient at Verizon while she discussed her $235 monthly phone bill.
2. Money spent for tongue studs, body piercing, tattoos, smokes, soda and bottled water should instead be used to support the family.
3. Ortho, implants, bleaching and crowns for esthetics are a privilege, not a right. And if Medicaid patients offer to pay for them out of their pockets, why am I doing their discounted dentistry that they get for nothing?
4. Fluoride is still the best preventive tool we've found. It needs to be in every water supply, and it's not.
5. Learn to think beyond the next half hour. Show up for appointments with those who are trying to help you. I'm told that a lot of Medicaid recipients don't even bother to pick up their monthly benefit cards.
6. Pain meds are not definitive dental care. Don't ask for (or demand) them from me. Ibuprofen works wonders.
7. Parents need to teach their kids it's not OK to be 15 (or any age, for that matter), never married, and have multiple kids that society pays for. And parents need to accept more responsibility for their kids' actions."

So what else can make the difference? How about putting everyone on the same fee schedule? Some of us get our whole fee by qualifying for federal funds to supplement state funds. Others can't get that special, preferential treatment. Maybe some of that $16 million that you're holding out to grease the legislative wheels could convince me to do more if it actually would end up in my pocket, hmmmmm?

Then, how about requiring Medicaid recipients to get dental treatment (at least for the kids) in order to get their monthly check? That might solve a lot of the "chronic need" problem. Acknowledge the fact that I will NOT take the blame for others' poor choices in life. Require changes in those poor choices or remove the state's support system.

Support a return to the ability of the US Public Health Service to provide care for those who can't afford the basics. Maybe we could use those facilities to actually do some dental service instead of allowing the leadership and care providers to drop to a level that puts us to shame.

Then, maybe we can solve that "access" problem. Maybe we could even solve it and stay a profession that I'd be proud of.

And then, Mr. Kellogg, maybe I'd eat a bowl of Corn Flakes again.

* * * * * *

Dr. Jones earned his DDS degree from Ohio State University College of Dentistry in 1970 and was in the US Army Dental Corps from 1970-72. He has been a member of the Ohio Dental association since 1972 and a delegate and/or alternate to the ADA House of Delegates from 1984-1992. He has also served in various capacities on the ADA Council on ethics, Council on Bylaws, and Judicial Affairs from 2001 – present. Dr. Jones may be reached at jonesddsjd@aol.com.

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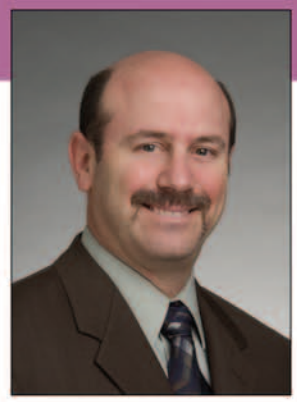
The Myth of Mid-Level Providers as a Solution to Access to Care



By: Martin Courtney, DDS

According to The PEW Center on the States "Access to oral health care is becoming an increasingly serious problem for many people in the Unites States, particularly for children."[1] Access to oral health care is limited by geographic, economic, convenience, and cultural factors as well as the number of providers willing and able to treat the affected population. It makes sense that the closer a patient is to the location where care is available, the more likely the patient will seek and obtain care. Similarly, the more funds available to the patient for care and the more convenient it is, the more likely the patient will seek and obtain care. Cultural factors are not as simple to overcome. Assuming that there is a real and growing problem, what can be done to get oral health care to the affected populations? One solution, proposed as a cost effective model, is the addition of another dental provider (the Mid-Level Provider) since other countries have had these providers for many years. The scope of duties allowed to this provider include diagnosis, extractions, basic restorative and hygiene services under general supervision of an offsite dentist.

There are many reasons to conclude that the addition of the Mid-Level provider will not improve access to oral health care to the underserved in California. One reason is that it has already been tried and it failed to dent the problem. The Registered Dental Hygienist in Alternative Practice (RDHAP) was proposed and tested in 1980 to work in underserved communities. In 1997 legislation was passed to create the RDHAP. As of 2009 less than 250 RDHAPs were licensed to practice in California. Quite to the contrary of expectations, in the 13 years since the inception of the RDHAP the underserved population in the alternative practice locations has grown. No clear studies indicate why there are not more RDHAPs but anecdotally it is believed that the practice is not generally economically viable particularly at Denti-Cal reimbursement rates.

A new provider who is limited in scope of practice cannot meet the needs of the very young, disabled or the elderly. These most vulnerable groups require additional education and training often beyond that of a general dentist's school training. The younger the child the more likely sedation will be needed to perform extractions and restorative care. The more elderly in our aging society have considerably more complex medical issues. Pedodontic and Prosthodontic specialties exist for this very reason.

The New Zealand model of dental therapist is school based and was fully funded. Overcrowded California public schools simply do not have the physical space for a dental clinic. The limited funds will go to hiring and maintaining teachers. No matter how many mid-level providers are licensed, if there is no place to treat patients and no funds to provide care there will not be any change in the access to care problem. Some of the savings of the New Zealand model is based on only needing a 2 year training program. Currently New Zealand is expanding to 3 years to add additional training in dental hygiene. Furthermore, the oral health level of New Zealand's late teenagers is no better than those in California. For the very young any school based program will be ineffective simply because they are too young to attend.

The only time that more Denti-Cal patients were treated and more of their needs were met was in 1992 when, by court order, reimbursement rates were brought to a reasonable level and administrative restrictions eased. No additional provider types were created nor was there an increase in the number of dentists. More dentists agreed to treat Denti-Cal patients. The number of patient treated was doubled and the amount of treatment per patient was increased. Unfortunately this was not viewed as a success since the cost quadrupled.

The mid-level provider as a solution to the access to care is a myth because it is woefully inadequate in addressing a very small facet of a multi-faceted problem. It is also irresponsible and dangerous to allow the most vulnerable populations to be treated by anyone other than a fully trained and licensed dentist.The very same models that promote the mid-level provider are the ones that prove it is a failure. Enough information exists for us find viable solutions to the access to care problem. The mid-level provider is not one of them.

[1] S. Gehshan, M. Takach, C. Hanlon, C. Cantrell "Help Wanted: A Policy Makers Guide to New Dental Providers" May 2009

FLIPPIN' OUT OVER CARDBOARD

By: Ken Ross, D.D.S. (U.C.L.A. '74)

It was so long ago that I attended something called Byrd Junior High School (no MiddleSchools in the '60s). Instead of video games and texting, my passion was FLIPPING BASEBALL CARDS. Shockingly, many of my guy friends didn't give a thought to flipping a "Hammerin'" Hank Aaron as opposed to a "Suitcase" Harry Simpson against the porch wall.

Back then, almost no one (but a few O.C.D. future dentist-types like me) even noticed that the superstar cards were now actually dented forever! Since a Topps baseball wax pack each contained a lot of shinny trading cards (with a yummy stick of card-sized Double Bubble) and it cost no more than a dime, kids were understandably not thinking about the "future value" of the cards they flipped about… we were just being kids…at innocent play.

No one bought a star player card from anyone else; you either traded with your buds or tried to steal it away during a game of "Leaners", "War", "Odds Or Evens", or "Closest To The Wall". My favorite game was "Tops" (also called "Toppers"). We alternated tossing a card a ways away and the first one to land one on top of any other tossed card joyfully won the whole bleepin' pile.

Sometimes, there would be so many cards just lying there tantalizingly that it would seem to be impossible to not top one of them…even accidentally! Of course, I'd be almost out of my mind because I'd spent multiple hours practicing a novel wrist flip that (to me) often seemed as consistent as a Jerry West free throw.

OK, so I was a bit delusional about my skills. More often than not some idiot (note: in my mind, any kid was an idiot who ever beat me) living outside the neighborhood would aim his card at nothing in particular. Then, he would errantly bounce it 10 feet away from anything and ridiculously have it roll around in circles until it barely covered the corner of a Harry Chiti (pronounced how?)…to unimaginably win the whole danged pile! I'd be left drooling over my favorite pitcher Whitey Ford's likeness a mere couple of feet away as the blithering idiot scooped up what should have been my booty. How much madder would I have been knowing that today that Hall-Of-Famer Yankee card is worth over $60….alright maybe half that since a corner was pretty bent. Lots of life lessons happened on my stoop. And I learned a lot about salesmanship in trying to keep that kid from going home early before I had a chance again to win that '59 Topps Whitey Ford. However, if it didn't happen then, well perhaps we might meet on another glorious day on my porch… where hope might again spring eternal.

It's probably been over 40 years since neighborhoods of kids flipped baseball cards in the San Fernando Valley. So, I decided to conduct a "Sports Card Flipping Clinic". Maybe some dentist baby boomers will read this, remember the "good ole' days" and challenge their colleagues, relatives, friends and neighbors to a good old card flippin' contest at my event. If their kids and grandkids see them reveling in sport, then maybe we can teach the kids this lost art also…and find a part time alternative to the impersonal world of electronics.

Apparently, there hasn't been a "SPORTS CARD SHOW" in the Valley for more than 5 years! If interested in attending one soon that includes CARD FLIPPING DEMONSTRATIONS & CONTESTS, please e-mail me (with Subject: CARD SHOW) to get details and the date/time

e-mail address: kenrossdds@aol.com.

Policyholder Expectations:
Professional Liability v. Workers' Compensation

By: Taiba Solaiman
TDIC Risk Management Analyst

Professional Liability policyholders should expect excellent claims service from their carrier. For example, once a TDIC policy holder opens a claim under a professional liability line of coverage, an assigned claim representative acts as the policyholder's advocate by keeping him or her informed and engaged throughout the claim process. On the other hand, Workers' Compensation insurance provides protection for injured employees. The carrier designates a claims examiner to investigate the claim made by the injured worker. The examiner must remain impartial throughout the investigation to determine the extent of the injury and provide benefits to the injured employee in accordance with state regulations.

"Workers' compensation laws provide money and medical benefits to an employee who has an injury as a result of an accident, injury or occupational disease on-the-job. Workers' compensation is designed to protect workers and their dependents against the hardships from injury or death arising out of the work environment. It is intended to benefit the employee and employer alike. The employee receives money (usually on a weekly or bi-weekly basis) and medical benefits in exchange for forfeiting the common law right to sue the employer. The employer benefits by receiving immunity from court actions against them by the employee in exchange for accepting liability that is limited and determined." --- www.workerscompensation.com

All states require employers to promptly report work related injuries. It is not at the discretion of the employer to determine whether or not an employee should receive a medical evaluation following an incident. Failure to report an injury is a violation of the workers' compensation regulations and can result in substantial penalties to the employer.

Most dental office workplace injuries result in medical treatment only and do not result in the employee taking time off from work. If the injury does require the employee to remain off the job, the workers' compensation claims examiner will request a copy of the employee's payroll information to calculate disability payments that may be due. The examiner also coordinates the employees' return to work. Be prepared to give the claims examiner a copy of the injured employee's job description. The treating physician advises the examiner about which regular job tasks the employee can perform and which tasks need modification. Check with your workers' compensation carrier for state-specific information.

While the professional liability policyholder participates in the decision making process on how a claim is handled, workers' compensation gives employers (policyholders) limited rights. They can obtain general information regarding the status of a claim such as the employee's anticipated return to work date and any necessary job modifications. Privacy laws do not allow specific medical information about the employee to be disclosed to the employer.

For more information or advice on workplace injuries, call TDIC Insurance Solutions at 800.733.0633 option 1.

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Kids' Community Dental Clinic's *Dale Morimizu Gorman* named NONPROFIT EXECUTIVE DIRECTOR OF THE YEAR

By: Suzy Jacobs

Dale Morimizu Gorman

Kids' Community Dental Clinic Executive Director, Dale Morimizu Gorman, was honored as Nonprofit Executive Director of the Year by Senator Carol Liu, Assemblymen Anthony Portantino and Mike Gatto at the 12th Annual Women in Business Legislative Update and Awards Ceremony. The Women in Business Awards honor local women whose exceptional abilities have contributed to the economic vitality and diversity of the 21st Senate District and/or 43rd and 44th Assembly Districts. This year's award was presented on July 15th at the Castaway Restaurant in Burbank.

Ms. Gorman's recognition is well-deserved. She accepted the position of Executive Director in 2009 and in just two years has revamped the Kids' Community Dental Clinic (KCDC) operations, solidifying its continued viability and future growth. Dale sought out efficiencies that trimmed expenses while enhancing the clinic's services and support network. She developed community partnerships in Burbank and beyond (including the SFVDS), enabling the clinic to screen thousands of children and identify those in need of urgent and ongoing care, as well as providing much-needed preventive education to both children and parents.

Dale has increased the clinic's patient base by more than 50%, and has recruited a record number of volunteer dentists and dental specialists, many of whom are SFVDS members. The clinic's operating hours have also been expanded to include after school, evenings and Saturdays, which has been a huge advantage to the low-income working families the clinic serves. Dale leads a staff that includes a part-time hygienist, dental assistant and several office volunteers. The clinic also works with dental hygiene students from local community colleges, providing training and hands-on experience to the students while caring for the oral hygiene needs of the clinics patients.

Dale is a perfect example of a big-picture planner with a hands-on approach. Visit the clinic and you will likely find her in scrubs, pitching in to clean up after each appointment and preparing tools for the next. Dale's endeavors with her staff, volunteers, patients, community and board of directors are always undertaken with vision and grace, undoubtedly contributing to the bestowal of the Women in Business award.

The Kids' Community Dental Clinic, located in Burbank, CA, is the only clinic of its kind in the San Fernando Valley. Its mission is to provide affordable, quality dental care and preventative education for children of low-income families without access to dental insurance, in an environment conducive to promoting good health. The clinic believes in treating patients and their families with integrity and respect, scheduling appointments, and nurturing families through education and follow-up care. Because dental decay is a silent epidemic, many of the clinic's patients do not seek out services until their mouths are completely decayed. Many need eight appointments to get healthy. Services include check-ups, cleanings, x-rays, fluoride treatments, sealants, fillings, maintenance care, and preventative education. Other treatments are performed as needed, including crowns, extractions and extreme cases of required orthodontia. KCDC is located in a bungalow on the grounds of McKinley Elementary School in Burbank and the staff is both kid-friendly and professional. Prizes are awarded after each visit and a lack of cavities is celebrated!

Please join us in congratulating Dale Gorman on this befitting award. If you are interested in volunteering, contributing, attending the clinic's upcoming Casino Night fundraiser on September 24th, or just learning more about the Kids' Community Dental Clinic, please contact Dale Gorman at (818) 841-8010 or visit www.kidsclinic.org

Pictured is Dale with Dental Assistant students & hygienists at a local health fair.

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February 11, 2013	November 15, 2012

Visalia	
Start Date	**App Deadline**
February 6, 2012	November 15, 2011
October 1, 2012	June 15, 2012

**Statistics as of May 2011. Visit www.sjvc.edu for the most updated information.*

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or call **866-314-4523**.

Bad Review Equals Good News?

By: Carla Christensen,
TDIC Risk Management

Even the best dentist may receive an unfavorable review online; however, there can be positive aspects to receiving a negative posting. Websites like doctoroogle.com, healthgrades.com, and localsearch.com are examples of online venues that encourage users to rate or review dentists. Unfavorable postings demonstrate the reality that despite your best efforts, you may not please all your patients, all the time.

A bad review can provide:

- *A learning opportunity:* Determine if there is any truth to the review. A negative complaint can serve as a teaching point from which you and your staff can improve upon your patient care or communication skills. Anonymous reviews typically more candid due to no fear of retaliation.
- *A dose of reality:* If every online assess ment offers flattering comments promoting a dental practice, then the validity of the reviews may be suspect. The public may infer family, friends, staff or even the dentists themselves attempted to bolster ratings by providing positive feedback.
- *An opportunity to give a negative rating a positive spin:* How you respond the posting can tell prospective patients everything they may need to know about how you do business. Many review sites allow the service provider to post a response. Do not attempt to refute damaging claims online. Instead, consider using a generic posting. For example, "I am sorry you feel that the treatment/service you received was less than satisfactory. Please contact me directly to discuss your concerns." If applicable, have your response be a link to your practice website that details your office financial policies, treatment philosophy or complaint resolution process.
- *A method of patient selection:* The people you choose to include in your patient base should be those with whom you can form a productive, healthy doctor/patient relationship. You may lose a potential patient if he or she reads a negative review; however, do you really want a patient who bases dental decisions on an unsubstantiated post?

If you receive a negative review, consider the following:

1. Perhaps the website is a "troll" site where users post inflammatory messages to bait others into responding; or,

2. The tone of the posting is a rant, i.e., sarcastic or extremely angry and argumentative; or,

3. The poster appears to be misguided; e.g., the complaint relates to medical and not dental treatment.

Individuals researching clinicians online will see these reviews as petty comments from mean-spirited people not worthy of a response.

For 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.

Speed Pairing
A Pay it Forward event

By: Andy Ozols, Executive Director

Dr. Bette Robin, JD presented in detail on the ins and outs of partnerships, practice sales and the absolute need for representation on both sides of the equation.

On June 9, in the multi-purpose room of the Balboa Biltmore Condominiums, 32 dentists met to hear a presentation from a practice sales broker, Bette Robin, DDS, JD, and to network with each other in an effort to identify available partnerships and practices for sale.

Billed as an opportunity for our older members to 'keep it in the family' by taking on a partner or selling their practices to a younger member - a 'Pay it Forward' type gesture, 19 older members and 13 younger members attended.

After an hour long presentation by Dr. Robin, with plenty of Q&A time, those offering partnerships or looking to sell their practices were asked to stay seated on the outside of a U-shaped seating arrangement, and those seeking such opportunities were asked to move around the inside of the 'U' until each had a chance to meet with all the others.

Dr. Robin answers a question from the audience, during the presentation when all participants were sitting on the outside of the 'U' to listen.

Younger members and older members on opposite sides of the 'U' exchanged information during the 'Speed pairing' portion of the event – where much was reported learned on both sides.

Like a 'speed dating' scenario, participants were encouraged to spend no more than 5-7 minutes with each other, just long enough to exchange contact information and to get to know one another and a little about their practices. After that, it was left up to each attendee to follow-up and work out their mutual needs and interests privately and with the legal and accounting advice promulgated by the speaker, Dr. Bette Robin.

While the event ended promptly at 9PM, the after event networking lasted past 10PM – which gave the membership chair, Dr. Karin Irani, and me some company during the cleanup!

An Ugly Practice Sale Saga

By: Bette Robin, DDS, JD

A Los Angeles area physician thought he was easing towards retirement when he sold his urology practice to an eager young buyer. In fact, buyer and seller were social acquaintances and both thought the transition would be easy. However, nothing could have been further from the truth.

The sale closed, but as time went on, the deal turned ugly. Buyer claimed seller breached the covenant not to compete, stole patients, defamed him and unfairly competed in the practice of urology. The buyer further claimed that the seller made a 'promise to retire' from the practice of medicine in the Los Angeles area as part of the sales agreement. However, the written contract did not state or make any reference to these points. The parties ended up in Los Angeles Superior Court.

The terms of these doctors' written agreement were silent on many important issues. There was a covenant not to compete, but the language was vague and unclear. There was no covenant not to derive income, no covenant not to solicit, no covenant not to treat, no covenant not to accept referrals, and no covenant not to hire employees. Seller honored the written terms and conditions of the agreement, at least as to what was actually written down. He certainly did not honor the "spirit" of the sale. However, the spirit remained ethereal and was never memorialized in writing. The court came down with a defense verdict in favor of the seller, and buyer had to pay seller's attorneys' fees. A very different verdict than buyer anticipated. The court found that a 'deal is a deal', especially between doctors with like bargaining power, education and access to professionals for advice. The court did not even consider any of the "promises" made by the parties to each other that were not written down the agreement.

Remember: For both buyers and sellers, the sales contract is very important. It is the only document that defines your sale.

1. If it's 'no big deal', a 'gentleman's agreement' and you completely trust your buying or selling doctor, then put it in writing. That should be no big deal either!

2. Each party must have their own attorney if they want to protect their interests. Buyers and sellers do have conflicting interests in a sale and individual concerns that need to be met. This cannot be appropriately handled by one attorney.

3. Management companies, supply companies, professional organizations are not attorneys and rarely create adequate legal documents. Such professionals often provide a valuable service by negotiating terms of a transaction, but when it comes to memorializing those terms in a legal contract, that should be handled by an attorney.

Selling and buying a dental practice is an exciting time for both parties, and represents a considerable life change and new directions. Having an appropriate sales contract is the first step to ensuring it will happen in the way you want.

Bette Robin, D.D.S., J.D. can be reached at 714.421.4407 or by email at: Betrobin@aol.com or www.betterobin.com

3rd Annual Magic Mountain Family Fun and Staff Appreciation Picnic

SFVDS President, Dr. Mehran Abbassian (right) gets in a competitive spirit at the tricycle race. Behind him is team member (and executive director), Andy Ozols

By: Andy Ozols, Executive Director

On Sunday, June 5, 2011, 147 SFVDS members, their families and office staff converged on Magic Mountain to enjoy a fun-filled day at the park, enjoy an all-you-can-eat buffet and engage in a coordinated group of activities for adults and children alike. For the third year in a row, this SFVDS social event proved to be a big success, where a great time was had by all.

Luckily, this year's picnic was blessed with a partly cloudy sky, which kept the temperatures down and the fun way up! Starting at 10:30 AM, attendees arrived at the park to begin their day of roller coaster rides, carnival midway games and periodic stage and street performances. At 2:30 PM, everyone met at the private picnic area reserved just for the SFVDS and ate hamburgers, salad, barbecue chicken, unlimited drinks and ice cream to their hearts content. About an hour into the picnic, the magic Mountain supplied activities coordinator got attendees to their feet in a wide variety of picnic games, including water balloon, hula hoop, sack race and trivia contests.

At 5PM, the picnic portion of the day came to an end and attendees went back into the park to catch the crazy roller coaster rides they missed in the morning. Many attendees turned out to be die-hards who stayed until the park's closing time of 9PM, happy, tired and looking forward to next year's 4th annual Magic Mountain Picnic.

Antelope Valley Report

By: Char Brash

HI -DESERT CHILDREN'S DENTAL CLINIC BENEFITS FROM THE 17th ANNUAL THUNDER ON THE LOT EVENT.

Saturday, June 11-12, 2011

Location: AV Fairgrounds, 2551 West Avenue H, Lancaster, CA

The volunteers for the Hi Desert Children's Dental Clinic participated for the sixth consecutive year at the 'Thunder on the Lot' event. Each year 'Thunder on the Lot' focuses on assisting hundreds, if not thousands, of children in the Antelope Valley. As the event has grown, so have the donations. Since 1994, the 'Thunder on the Lot' event has raised more than three million dollars and all of the proceeds have gone to charity groups that assist needy children in the Antelope Valley. This is a genuine grass-roots event that is fully organized and operated without paid staff - only hundreds of enthusiastic volunteers. We are proud to be one of the charities supported by this event and we hope to see even more dental professionals in future years. For more information: www.thunderonthelot.com

Schlep and Shred...

On Saturday – April 16th the SFVDS hosted a Schelp & Shred event at the offices of their Antelope Valley Liaison, Dr. Gilbert Snow in Palmdale. The dental society contracted with an industrial shredding company to shred and dispose of all old patient records, office/business records, and e-waste. Many local member dental professionals participated, and while there was no charge for this service, there were several donations made to the SFVDS "Give Kids A Smile" program.

(l-r) Mehran Abbassian, DDS, President, SFVDS
Gib Snow, DDS, A/V Liaison
& Ed Baker, DDS prepare to shred as they help Dr. Baker unload his old files.

Welcome New Members

Robert Lytle, DDS
500 N. Central Ave Ste. 710
Glendale, CA 91203-3386
818-240-1805
Oral Surgeon
USC, 1998

Ariel Julian Rodriguez, DDS
428 Arden Ave Ste 201
Glendale, CA 91203-4013
818-243-4287
General Dentistry
UCSF, 2002

Jovita Barcena, DMD
8217 Woodman Ave
Panorama City, CA 91402-5426
818-988-3916
General Dentistry
University of the East, Philippines, 1983

Vivien Matibag Maghiranm, DDS
9506 Sepulveda Blvd.
North Hills, CA 91343
818-891-1136
General Dentistry
Centro Escolar University, Philippines, 1990

Todd Nicol, DDS
5736 N. Las Virgenes Rd. #208
Calabasas, CA 91302
General Dentistry
Ohio State, 1988

Norberto Brave Lupisan, DDS
3415 Montrose Ave
La Crescenta, CA 91214
818-248-7126
General Dentistry
De La Salle University, Mexico, 2010

Paul Anthony Thompson, DDS
5055 Indiana Way
La Canada, CA 91011
818-790-5220
General Dentistry
UCLA, 1990

Enrique A. Araujo, DDS
1024 N. Maclay Ave #3
San Fernando, CA 91340
818-365-8653
General Dentistry
Universidad Federal De Santa Maria, Brazil, 1976

Khoi D. Tran, DMD
9545 Reseda Blvd. #1
Northridge, CA 91324
818-886-6660
General Dentistry
University of Pittsburgh, 2010

Angela B. Guiao, DDS
Canyon Country
General Dentistry
UCSF,2009

Aqeela Syeda Shah, DDS
Glendale
General Dentistry
Univ. of Karachi, Pakistan, 1984

Benjamin Cole Karabell, DDS
Los Angeles
General Dentistry
Tufts University, 2008

Upcoming Events

2011

August 13: Schlep and Shred - Glendale
August 20: Fantasia & Fireworks at the Hollywood Bowl
August 27: Head to Toes event at MEND (Help prepare kids for back-to-school)

September 07: CPR Recertification (central office)
September 29: Zone Meeting – Glendale (Employment Law)

October 01: Schlep and Shred – Sherman Oaks
October 13: Zone Meeting – Palmdale (Employment Law)

November 2: CPR Recertification (central office)

December 03: Glendale Theatre (Charles Dickens, A Christmas Carol)
December 08: Annual Holiday Party (Knollwood Country Club)

2012

January 18: The Madow Brothers CE Course (Two brothers, both dentists, present a rip-roaring, comedy presentation on Practice Management)

March 28: GORDON CHRISTENSEN – The Christensen Bottom Line CE Lecture

Please watch for future announcement, particularly in your snail-mail and email boxes, or call the central office for more information.

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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