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Summer 2015

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Dental DimensionS

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In This Issue

Summer 2015

Volume XLIX Number 3

Call for Submissions

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

On The Cover.....

Cover photo courtesy of GIGAA Laser, Wuhan Gigaa Optronics Technology Co, LTD, showing a tabletop, diode laser, used in periodontal applications.

From the Desk of the Editor

Shukan Kanuga DDS, MSD.
Board Certified
Pediatric Dentist

Dear members,
I hope you are finding time to enjoy the summer with your families. Have you noticed the AADEJ logo on page 3? I am very excited to share with you that Dental Dimensions is now a publication member of the prestigious ADA endorsed, American Academy of Dental Editors and Journalists. AADEJ is an organization committed to the establishment and encouragement of responsible editorial policy. Our application was reviewed and successfully accepted earlier this year. I will strive to continue to improve our newsletter over the coming months and ask for your valuable support in contributing high quality articles. Remember, Dental Dimensions is the primary platform for communication amongst SFVDS member dentists.

With CA state government reverting the 10% Denti-cal rate cuts and CDA announcing the formation of TDSC (The Dentists Service Company), this certainly has been a quarter with positive news! I hope you enjoy reading our president's insightful article on corporate dentistry as a sequel to not only our last issue, but the recent formation of the TDSC. The articles on lasers are sure to pique interest of even the busiest of our members!

Please also make a note to attend the dental society's foundation gala on October 24, 2015 at the Mountaingate Country Club. Save the date as you will be receiving an invitation to attend during the summer.

Lastly, consider attending a very informative CE meeting exploring the field of 'Dental Sleep Medicine', the latest collaborative effort with the Western Los Angeles Dental Society and SFVDS on September 19 & 20, 2015. You can read more information about it on our website. Just click the link at the bottom of the home page (www.sfvds.org).

Happy reading and happy summer, you all!

Yours truly,
Shukan

"The Grey, The Green and The In-between"

From the Desk of the President

Michael S. Simmons, DMD

This tagline refers to the practice life of dentists or any lifetime job for that matter. The "Green" are the young, fresh new timers entering the dental job market trained and ready for action. They have typically accumulated a large debt, perhaps $300,000 or more[1, 2] and feel a strong pressure to reduce it. On top of this debt there are family and social pressures such as marriage, new families, a car and perhaps a new home on the horizon. They have specific needs to survive and an income requirement to make ends meet. What does the market offer them?

A new practice loan may be possible through aggressive bank lending but do the "Green" dentists have the business skills to make this work? Perhaps there is a pregnancy leave or two planned in the near future and this complicates practice purchase. A few may be lucky enough to have connections either through family or friends to jump right into an associateship. Every year about 1,500 choose to get additional advanced training in General Practice Residencies/Advanced General Dentistry and about the same amount start specialty programs[3]. This delays their entry into the market but with an even higher pressure to generate income because of their likely increased debt and late start in the job market. What options do they have to generate income to pay down their debt?

Enter corporate dentistry which offers: easy entry; relatively high starting income depending on the "Green" dentist's ability to produce dentistry; health and continuing educational benefits; some supervision and ability to learn on the job with reduced financial risk; no additional outlay for equipment or supplies for a dental practice; and no long term commitment. On the surface it sounds pretty good. After all, what other viable options are there for the >five-thousand U.S. dentists graduating every year[4]?

At the other end of the spectrum are the "Grey". These seasoned veterans, grey with experience, mostly owning their practices, are ready to spend a little more of their time enjoying the fruits of their labors, or are forced to slow down because of health issues, and certainly thinking in the future of cashing out their dental practice investment. Without a doubt market pressures are affecting them too. There are: market driven cost containment reducing their profits; increased governmental regulations and costs to do business; demands for newer high tech equipment or marketing; and a shrinking private pay new patient pool. Who do the "Grey" dentists sell their practices to, how do they find the right buyer and how do they transition? Enter corporate dentistry ready to buy up patients and practices much like the hospitals that have bought up more than 50% of medical internist and family practices[5]? Sounds like a quick and easy process and after all, the seller may be able to continue working in the same environment until he/she retires.

Of course the final group are "In-between" grey and green and my color chart would put them... well there is no easy to pick color in between... and there's the rub. They seem to be fading green or emerging into grey from a great many choices. In dental practice the "In-betweeners" have the same enormous spread with some owning or running multiple dental offices as administrators, working in a variety of dental environments, but mostly as owners of their single owner-dentist dental practices. They typically develop a loyal client base that grows over the years and have increased income based upon their honed clinical and business skills, life experience savvy and learning the systems. Does corporate dentistry appeal to them and if so, where is the fit?

Well let's take a quick peek at the opposite side of the coin and see if corporate dentistry is the panacea that it appears to be on the surface. Some of the issues we hear about with corporate dentistry include[6]: performance quota concerns – aka "are you meeting your daily quota of production to keep your job?"; time limit concerns on intake and performance of treatment – aka "are you risking your patient's health by deferring to company standardized time-saving maneuvers?"; precise payout concerns for your practice sale to corporate dentistry or for your corporate pension plan – "is selling to highly leveraged companies, with junk grade security putting your stock option, sale-based payments or corporate pension funding low on the list to be paid if the company goes belly up"; and of course legal concerns – "is there legal liability in selling to or working for non-dentists that potentially control clinical decisions which could compromise health care in a trade-off for profitability, or where corporate leveraging tax loopholes for profits are favored along with heavy lobbying investment for political influence to maintain structure? Finally, what is the overall associated risk to the individual employee dentist just for being part of this health care culture and is one willing to take it?

One recent outcome as an example of corporate dentistry taking legal risk was the publicized sanctioning of Aspen Dental by New York's Attorney General[7]. Also, there is past precedent of closure of corporate dental clinics along with patient abandonment as evidenced by the shutdown of AllCare Dental[8]. As an employee dentist what is your risk aversion quotient[9] and risk avoidance strategy in all this?

Continued on page 6

From the Desk of the President

One compelling reason corporate dentistry is so enticing, at all phases of a dentist's career, is the sense that someone is taking care of the business aspect. This frees up and allows the dentist to do what they love and are specifically trained for, namely the provision of dental care. Less worries about better and lower supply costs, less worries about the other human resources, the challenges imposed by government regulations, the ever morphing insurance reimbursement challenges and the myriad of other business related issues that come up daily. What if continuing education was also provided along with professional liability insurance, vacation and sick pay and even coverage for when vacation is taken? All this sounds too good to be true, but is it? And what are the other options available?

These are the challenges of the future of dentistry. We have heard about the strong foothold of corporate dentistry and that it is oncoming in a fast and furious way. Some states such as Florida are already strongly impacted with an approximate 40% of dentists working in a corporate dental environment[10]. Other states such as California have been lagging in part because of stricter governmental regulations. One might look to medicine and see the impact of corporate takeovers on that healing art, or look to see what corporate healthcare did to the pharmacy and optometry disciplines.

Sadly, it is a fact of life that when corporate profits drive the health care machinery, the health care professional loses autonomy and much of his or her control of the type of care they can render. The oft-seen result is that patients seem to suffer, having limited corporate driven treatment options, and the loss of much of the personal contact with and advocacy from their health care provider. So what is being done in dentistry and what can be done to provide good alternatives to "the Grey, the Green and the In-between"? Can organized dentistry make a difference?

Enter your very own California Dental Association (CDA). CDA is a model dental society and the biggest and probably best run of all the state dental associations. CDA actually has more assets than even the ADA[10] and California accounts for about 16% of all dentists in the U.S.[11].

Some 40 years ago CDA addressed a malpractice insurance crisis. Just watch the you-tube video of Dr. David Gaynor[12] to get a flavor for how the formation of The Dentists Insurance Company (TDIC) transpired and how it rescued CDA member dentists from profit driven insurance companies. Basically CDA saved the day by developing its own insurance company to compete with and beat out other dental malpractice insurance companies, and TDIC continues to this day as one of CDA's best member benefits.

Well, CDA is at it again and has now formed a new subsidiary called The Dentist's Service Company (TDSC)[13] whose underlying goal is to help all member dentists, "The Grey, the Green and the In-between", to not only survive but to thrive in this changing and challenging healthcare environment. Watch out for these changes as your component leaders, leaders from all of the other 31 CDA components, student representatives along with our CDA administration "Move Forward Together" into the future of dentistry (see page 21 for more information on TDSC).

Why continue to be a CDA member and encourage others to be CDA members? My answer "There is just no better choice!"

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(9) http://pages.stern.nyu.edu/~adamodar/New_Home_Page/risk/riskaversion.htm
(10) Lecture to the SFVDS Board of Directors June 16, 2015 by Kevin Keating, DDS, MS, Treasurer CDA.
(11) Kaiser State Health Facts. Number of dentists: http://kff.org/other/state-indicator/total-dentists/ based on special data request for Dental Data, American Dental Association, September 2014
(12) https://www.youtube.com/watch?v=2ajncL63wrw
(13) http://www.cda.org/news-events/cda-establishes-the-dentists-service-company

Trustee's Report

By: Martin Countney, DDS

As I write this report there are many changes happening in the California Dental Association (CDA). How they will impact you, your practice, and your retirement may be significant. "How can changes at CDA make a difference in my life?" is a great question which needs some background. CDA was formed from two dental associations in California more than 40 years ago. When these associations joined, a great deal of thought went into how the organization would be formed and how members would have a say in the direction of their organization. As a California corporation, CDA needed a board of directors to run the business of the organization. As a member association, CDA must get direction from its members. To meet both of these needs CDA was structured to have a board of trustees (BOT) and a house of delegates (HOD). The BOT has about 40 members (1-2 from each component) and the HOD has 205 members (2-19 from each component depending upon their membership size). As a protection against a small number of dentists having too much influence on the direction of CDA the HOD was designated as the 'supreme authority'. Although the BOT was given the fiduciary tasks as required by California corporate law, all decisions and policies of the BOT are subject to approval by the HOD. Also standing committees (and councils) were created to address specific areas of need and importance, such as membership, peer review, legislation, judicial and policy development.

SO WHAT? Since all CDA functions and policy decisions are moved through a series of task forces, committees, councils, the CDA executive committee, the board of trustees and the house of delegates, input from all parts of the CDA family are considered. Urban, suburban and rural practices, solo and group practices, boutique and clinic practices, private and public health practices all get a chance to influence the policy created. The process is not quick, but very thorough. As day to day wet-gloved dentists we need to be sure there is someone that understands our needs, concerns and issues. The smaller the group that creates policies the greater the chance that your concerns will not be known and become part of the policy.

At the upcoming October 15-17, 2015 house of delegates, the CDA governance review committee will be recommending a variety of changes to the CDA governance structure (including those outlined above), for debate and approval by the house of delegates. Among the 17 areas of recommended change will be the elimination of the council on membership; elimination of the council on policy development and the elimination of the council on the new dentist. If passed by the HOD, all the duties of these eliminated councils/committees would be turned over to CDA staff (mostly non-dental people) and the board of trustees.

As a result, the 2015 HOD is sure to be filled with contentious debate as the forces aligned with the proposed change square off against those who are opposed to reducing member input and guidance of governance and policy development at CDA. During the months leading up to the HOD, the trustees will be having a final debate on which of the 17 governance changes will be recommended to the HOD and will formulate the exact wording of those recommendations. In addition, the state's 32 components will be holding individual and all-component caucuses to try to find common ground, and to develop a common front to either support or oppose the eventual recommendations that will reach the floor of the HOD.

As SFVDS trustees to the CDA, Dr. George Maranon and I would like to know how you feel about these proposed changes. Please take the time to review the governance committee's recommended changes on the CDA website under 'About CDA', 'Leadership', 'Board of Trustees', 'May 19 Meeting Materials', pages 79-171 - or type this link into your web browser to get directly to the document (you will likely have to enter your member access username and password):
http://www.cda.org/LinkClick.aspx?fileticket=GOElneMJWtw%3d&portalid=0

Exercise your right to provide input to your organization's governance structure and let us know what you think by sending an email to our executive director at exec.sfvds@sbcglobal.net, who will forward your input to us.

Thank you for being involved and have a great rest of the summer!

Legislative Committee Report

By: Jim Mertzel, DDS

THANK YOU WESTERN DENTAL!!!

Many of us have our own opinion of the service Western Dental offices provide to their patients. However, it seems that with all the lobbying and lawsuits filed by CDA to eliminate the 10% reduction imposed on Denti-Cal fees, and to actually increase the Denti-Cal fees paid to providers, it took a statement by some Western Dental offices that they would discontinue providing services to Denti-Cal eligible patients due to the fact that the Denti-Cal fee schedule was inadequate, to move the legislature to action.

CDA has one of the most respected and strongest legislative advocacy/lobbyist groups in California. Due to their efforts many effective laws have been passed to support the dental profession and to benefit our dental patients. However, through the years, CDA has been unable to move the legislature to increase the Denti-Cal fee schedule. The advocacy council spent many hours this year in an attempt to achieve an increase in Denti-Cal fees. However, I believe, that if it were not for Western Dental's announcement that they were cutting back on the number of offices that would serve Denti-Cal eligible patients, CDA's efforts this year may not have been effective in creating an increase in the fee schedule.

The Affordable Health Care Act has had the effect of making more individuals eligible for Denti-Cal benefits. However, due to the fee schedule which amounts to about 30% of many dentist's fees, very few providers have signed up to provide the services. One of the criticisms of the Affordable Care Act, from its inception, was that more people would be insured, but there would be insufficient providers to perform the required services.

The problem organized dentistry faces is that we, as dentists, are legally prohibited from organizing a union. Whereas public employees, school teachers and many trades can form unions and can go on strike to seek higher wages, the dental and medical professions cannot use that tool. Therefore the state legislature, when it comes to budget considerations, knowing that organized dentistry cannot go on strike, has no motivation to provide budget increases for medical and dental providers.

In addition, many dentists who accept PPO patients are also feeling the squeeze from some insurance companies that are reducing their fee schedules. As members of CDA we should be grateful that our state organization has been vigilant in monitoring some of the changes of policies of dental insurance companies and doing what CDA can do to hold dental insurance companies responsible.

General Meetings -Preview

SEPTEMBER 16, 2015

Reconstructive Surgery
Bob Hale, DDS

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

SFVDS' own past-president, Bob Hale, DDS will review the latest advances in reconstructive surgery based on his experiences as an oral surgeon in the U.S. Army during the Iraq and Afghanistan wars. This captivating lecture will give the attendee a greater understanding of what is possible and the successes that are now achievable.

OCTOBER 14, 2015

Technology and a Paperless Office
BJ Moorhead, DDS

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

You hear a lot about "going paperless," these days, and let's face it, "going green" is our future. But how do you completely make the transition from years of doing it the old way to paperless without losing your mind in the process? And how can you use your digital tools to run your practice more efficiently? Dr. Moorhead, past-president of the Kentucky Dental Association, will show you how he did it and he'll teach you how, step-by-step.

NOVEMBER 18, 2015

Dental Materials & Bonding
Raymond Bertolloti, DDS

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

Adhesive dentistry has not fully replaced traditional mechanically retained dentistry for many reasons. Lack of trust in adhesives, perceived difficulty, and "It wasn't what we were taught in dental school" are commonly heard. Now that we have proven methods to strongly adhere not only to enamel, but in fact to dentin and all restorative dental materials, there are many compelling reasons to stop doing "hack and pack" tooth destructive dentistry. Learn about the latest advances and methods at this lecture.

General Meeting Review

June 10
Oral Pathology and Medicine

Parish Sedgizadeh, DDS

This comprehensive course gave members a practical and logical approach to recognizing, diagnosing and treating various oral and maxillofacial diseases. The course reviewed principles of both soft and hard tissue lesion identification and management, and covered common odontogenic and periodontal infections, cysts and tumors, mucosal pathology, skin lesions of the face, salivary gland diseases, and diseases affecting the jawbones and temporomandibular joint (TMJ).

Sick leave law compliance

By: Michelle Corbo, CDA staff

The effective date for employers to begin providing mandatory sick leave to all employees was July 1, or on the first day of employment for new employees — whichever is later.

The new law requires nearly every employer in California to allow all of its employees at least three paid sick days each year. The law provides that employees receive no less than an hour of paid sick leave for every 30 hours worked. (Caring for themselves or family members can be reasons for taking the sick leave.)

In addition, here are other details of the law:

- The law applies to all employers, regardless of staff size.
- All part-time, full-time and temporary employees who work in California for 30 or more days in a year are eligible.
- No matter which method an employer chooses to provide leave, employers must provide at least one hour for every 30 hours worked, or three days per year.
- While the employee accrues this sick leave from the first date of hire, the employer can limit an employee from using that leave for the first 90 days of employment.
- The employer can limit employees to using no more than three days per year (24 hours).
- An employer who chooses to provide leave on an accrual basis, no less than one hour for every 30 hours worked, can limit the amount of paid sick leave to 24 hours/three days each year and can cap the total accrual banked by an employee to 48 hours/six days. Keep in mind that both regular and overtime hours are counted toward the employee's accrual rate.
- If the employer already has a policy in place that provides for paid sick leave equal to or greater than the state requirement, there is no requirement to provide additional paid sick days. CDA recommends adding additional language to a practice's employee manual that indicates that the policy adheres to the state requirements.
- The employer must provide the employee with a written notice indicating the amount of sick time available to the employee at each pay period. Records of an employee's hours should be kept for a minimum of three years.
- If an employee should leave the practice, sick leave does not need to be paid out unless the employer's policy combines the sick leave and vacation into a paid time off (PTO) policy.
- Noncompliance can result in fines and state penalties.
- An employee may determine when and how much paid sick leave he or she needs to use, but an employer can set a "reasonable minimum increment" of time not to exceed two hours. Dentists cannot require an employee to take sick leave in increments greater than two hours. For example, a dentist cannot tell an employee that he or she needs to take a half-day off for a brief morning appointment.

According to the CA Department of Industrial Relations, these are the six steps to successful compliance:

1. Display poster on paid sick leave where employees can read it easily. Document policy and share with staff.

2. Provide written notice to an individual employee at the time of hire with paid sick leave information. See a sample form through this link: http://www.dir.ca.gov/dlse/LC_2810.5_Notice.pdf

3. Provide for accrual of one hour of sick leave for 30 hours of work for each eligible employee to use.

4. Allow eligible employees to use accrued paid sick leave upon request or notification.

5. Show how many hours of sick leave an employee has available. This must be on a pay stub or a document issued the same day as a paycheck.

6. Keep records showing how many hours have been earned and used for three years.

CDA has included information on page 22 in its new 2015 Sample Employee Manual that dentists can use to notify their employees about the changes to the paid sick leave law in California.

Dentists should review their employee manual every year and make any necessary changes so that the practice remains in compliance with current state requirements.

For more information, contact Michelle Corbo at CDA at 916.554.4968.

CDA answers top mandatory sick leave questions

Q&A

By: CDA Staff

If I already provide my staff with sick time, do I have to pay an additional three days?

If you have an existing policy that meets or exceeds the three days or 24 hours and it can be used for any personal time off (PTO), you do not need to provide three additional days. Simply change the language in your current employee manual indicating that the time meets or exceeds the state requirements for the law. Be certain to place a notice for employees to review prior to implementation of the new policy (provide date it becomes effective), meet to discuss and have each employee sign an acknowledgement of the new policy.

I pay out unused sick time at the end of the year; can I continue to do so?

Yes, but are not obligated to do so.* With sick time, any unused front-loaded time provided in a lump sum at the beginning of the year is lost at the end of the benefit year. On the other hand, any time provided on an accrued basis (one hour for every 30 hours worked) is rolled over and can be capped at a maximum banked at 48 hours overall.

*Note: Sick and vacation time combined as PTO must be paid out when employment is terminated.

My current policy stipulates that employee provide a physician's note for time off due to illness, can I still require this?

Under the new law, you cannot require that employees provide a physician's note for extended leave, unless the need for time exceeds beyond your minimum policy limit for providing leave or three days. For example, if you provide staff beyond the minimum requirement of three days or 24 hours and pay five days sick leave, then your physician's release note policy must exceed five days.

Is this a required benefit for part-time employees as well?

The new sick leave law applies to all employees, full time, part time and temporary, as long as they have worked in California for 30 days.

I have a mix of full-time and part-time employees in my practice, how should I provide the leave?

Contined on page 12

CDA answers top mandatory sick leave questions

It is possible with the difference in office hours for you to provide the leave to employees you know will meet or exceed the minimum requirements (24 hours or three days) and "front load the time" in advance. In turn, you can provide the time to part-time staff on an accrued basis (minimum one hour for every 30 hours worked), as they will earn the time at different rates based on the days and hours worked in the practice.

My hygienist is paid as an independent contractor, is she eligible for sick leave under this new law?

We really have two issues at hand here. First, under almost all circumstances, hygienists by definition do not qualify for independent contractor status and therefore are considered W-2 employees. In its simplest form, an independent contractor relationship is a business-to-business relationship. With this, hygienists are considered employees and must be paid as such and qualify for the sick leave time.

Is the sick leave accrued or renewed and available immediately every new benefit year?

As the practice owner/employer, you can determine it the sick leave time is accrued or provided as front-loaded flat days. If the time provided is accrued (one hour for every 30 hours worked up to 24 hours), it does roll over into the following year, and you can "cap" this total time at 48 hours banked overall.

If you front-load the time, any unused time is lost at the end of the year and new days are provided the beginning of the next benefit year.

Will employees who have several employers, such as hygienists who work at several offices, be paid up to or more than 15 days of sick leave each year?

It is possible for an employee with several employers to earn different amounts of sick time depending on the provided days or accrued hours earned and determined by each employer's policy. The obligation to provide leave is tied to each individual employer.

Is there any burden on the employee to prove an actual illness is involved rather than personal or vacation time off? How can I keep my employee from abusing the sick leave time?

While you can't control an employee from abusing the time, we recommend that you add specific language to your employee manual regarding sick leave and its intended use.

See the Sample Employee Manual for assistance in adding this language to your policy: "Sick leave is a form of insurance that employees accumulate in order to provide a cushion for incapacitation due to illness. It is intended to be used only when actually required to recover from illness or injury; sick leave is not for 'personal' absences. Time off for medical and dental appointments will be treated as sick leave. The Practice will not tolerate abuse or misuse of your sick leave privilege."

Should the vacation benefit be different from sick leave?

This is up to you. If an employer provides PTO instead of separate benefits, your policy must indicate that the employee be allowed to use the time for sick leave under the new law.

Keep in mind that unlike vacation time, sick time is not paid out at the time of termination. From an administrative standpoint, separating the benefit might be beneficial.

Are hygienists and associate dentists (employees who are usually paid "by the day") eligible for paid sick leave as well? Do I need to start keeping track of their hours?

Yes, hygienists and associate dentists (unless otherwise contracted) are considered employees of your practice. Each of these positions, while paid by the day, should have an hourly salary related to the workday. This rate must be based on a normal workday (or alternative workweek schedule)

With this, yes, they are eligible for the paid sick leave and it is assumed you will continue to keep track of their hours. You will need to provide each employee with a written notice (pay stub) indicating the amount of sick time available to them at each pay period.

It is up to each individual practice how it would like to provide the leave — lump sum or accrual basis.

If my hygienist works only one day a week and I don't use the accrual method, does this mean she receives three full days of sick leave like my full-time employees? Or can we grant one and a half days upfront based upon the number of hours to be worked?

This scenario may work fine, but you should do the calculations based on the stipulation of the law — no less than one hour for every 30 hours worked. Make certain you don't under-estimate the time allotted for your employee.

According to the California Paid Sick Leave Law, does our office have a choice in providing leave on an accrual basis? If it does, what would be the minimum paid leave that we would need to provide in order to comply?

Yes, your office does have a choice. If you choose to provide the time on an accrual basis, you must provide no less than one hour for every 30 hours worked and can limit the amount of paid sick leave to 24 hours (three days) each year. Any unused time will roll over into the following year. An employer can cap the total accrual banked by an employee to 48 hours (six days) and can limit an employee who has accrued more than 24 hours to only use up to 24 hours in a year under the new law. Keep in mind that both regular and overtime hours are counted toward the employees accrual rate.

I have a 90-day probationary period for my new employees, when are they entitled to sick pay?

Accrual begins on the first day of employment (after July 1, 2015); however, your employee isn't eligible to use the time until after satisfying the 90-day probationary period.

Additional information
For more details on the new law, visit cda.org/sickleave or contact Michelle Corbo at 916.554.4968.

Suzanne Newkirk, RDH* Lynne Slim, RDH, MS† Charles M Cobb, DDS, PhD‡

Laser assisted new attachment procedure (LANAP™): strength of evidence

Treatment of chronic periodontitis (chP) and aggressive periodontitis (agP) can generally be classified as either surgical or nonsurgical, with surgical therapy frequently divided into either resective or regenerative procedures. SRP is the most common and conservative form of treatment for periodontal disease (PD) and has been recognized as the gold standard of nonsurgical periodontal therapy. Existing evidence from numerous clinical trials and systematic reviews provide conclusive support for the beneficial effects and efficacy of mechanical nonsurgical pocket therapy.[1,2] The goal of SRP is to remove plaque and calculus deposits on contaminated root surfaces and thereby provide a biocompatible surface for reattachment.[3]

Surgical debridement of periodontal pockets basically consists of the reflection of a full-thickness mucoperiosteal flap (a.k.a. access flap), followed by thorough debridement of the root surface. The most commonly practiced technique is based upon the modified Widman flap (MWF), which involves minimal flap reflection. Healing studies indicate that the MWF procedure results in a long junctional epithelium that, in turn, results in a gain in CAL and reductions in PD.[4] In 1974, Ramfjord and Nissle[5] introduced the MWF technique, which has been used over the subsequent 40 yr as a successful treatment for many patients exhibiting moderate levels of chP.

Examining the LANAP evidence

When faced with new clinical protocols or procedures, clinicians should weigh the strength of scientific evidence prior to application in patient therapy. In 1994, Millennium Dental Technologies, Inc. (MDT) was formed to market the PerioLase® dental laser, a 6 watt FR (free running) Nd:YAG (neodymium:yttrium aluminum garnet) laser specifically designed for the LANAP (laser assisted new attachment procedure) protocol. The LANAP protocol is promoted as a surgical therapy for the treatment of periodontitis through regeneration, rather than resection, and incorporates a comprehensive multistep protocol that involves the PerioLase laser, a piezoelectric scaler for SRP and crestal bone manipulation, occlusal adjustment, and systemic antibiotics.

The evidence supporting use of the LANAP protocol in the treatment of periodontitis has been slow to evolve. Twenty-four papers have been published since 1994, 9 (38%) in peer-reviewed journals and the remaining 15 (63%) published in marginally or nonpeer-reviewed journals. Of further interest is that 11 (46%) articles can be classified as opinion articles; 8 (33%) can be classified as research articles; 5 (21%) are uncontrolled case reports; 14 (58%) are authored or coauthored by officers of MDT; and 10 (42%) of the articles have been published in *Dentistry Today* which has an officer of MDT on the editorial board (see table).

Six of the aforementioned articles are considered to be research, either clinical trials or private practice based, and have been published in a peer-reviewed journal. Of these, Harris et al.[6] (2004) was the first of the peer-reviewed research articles. This retrospective multicenter study consisted of 4 clinical treatment sites. Three of the 4 sites were conducted in private practice settings. One of the sites belonged to a proprietor of MDT.

The 3 private practice sites had no controls, meaning no blinded clinicians, no blinded examiners, and no examiner calibration was provided. The fourth site was conducted at a university and used a randomized, blinded, split-mouth design. However, the university site used a slightly different, albeit similar Nd:YAG laser, with the treatment protocol similar but not exactly the same as that used in the private practice settings. The retrospective data from the 3 private practice sites were compared to the university site data. Interestingly, the 3 private practice sites had similar results and collectively reported a greater mean improvement in PD reduction than did the university site.

Periodontal pocket sites of 4–6 mm and ≥7 mm showed average posttreatment reductions of 1.55 mm and 3.44 mm, respectively. However, a comparison of the LANAP protocol to previously reported studies

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Table. Evidence base for the LANAP™ protocol in the treatment of periodontitis

Reference	Type of article	Examiner blind	Examiner calibrated
Gregg RH, McCarthy D. Laser ENAP for periodontal bone regeneration. *Dent Today* 1998;17(5):88–91	Single case report	No	No
Gregg RH, McCarthy D. Laser ENAP for periodontal (PDL) regeneration. *Dent Today* 1998;17(11):86–88	Single case report	No	No
Gregg RH, McCarthy DK. Laser vs. laser. *Dent Today* 2001;20(5):8,10	Opinion	n.a.	n.a.
McCarthy DK, Gregg RH. Making waves. *Dent Today* 2001;20(9):8,10,11	Opinion	n.a.	n.a.
Gregg RH, McCarthy D. Laser periodontal therapy: case reports. *Dent Today* 2001;20(10):74–81	Uncontrolled case reports	No	No
Gregg RH, McCarthy D. Laser periodontal therapy for bone regeneration. *Dent Today* 2002;21(5):54–59	Opinion	n.a.	n.a.
Gregg RH, McCarthy D. Lasers do have a place in periodontology. *RDH* 2002;22(8):12,14	Opinion	n.a.	n.a.
Gregg RH. Will periodontists ever be satisfied? *RDH* 2002;22(7):8,10	Opinion	n.a.	n.a.
Harris DM, Gregg RH, McCarthy DK, Colby LE, Tilt LV. Sulcular debridement with pulsed Nd:YAG. *Proc SPIE* 2002;4610:49–58	Clinical research	No	No
Gregg RH, McCarthy DK. Eight-year retrospective review of laser periodontal therapy in private practice. *Dent Today* 2003;22(2):74–79	Private practice research	No	No
Harris DM, Gregg RH, McCarthy DK, Colby LE, Tilt LV. Laser-assisted new attachment procedure in private practice. *Gen Dent* 2004;52:396–403	Private practice research	No	No
Gregg RH. It's not your dad's dental laser. *Dent Econ* 2004;94(8):44–50	Opinion	n.a.	n.a.
Yukna RA, Carr RL, Evans GH. Histologic evaluation of an Nd:YAG laser-assisted new attachment procedure in humans. *Int J Periodont Restorative Dent* 2007;27(6):577–587	Clinical research	Yes	No
Long CA. New attachment procedure: using the pulsed Nd:YAG laser. *Dent Today* 2008;27(2):166–171	Uncontrolled case reports	No	No
Nevins ML, Camelo M, Schupbach P, Kim SW, et al. Human clinical and histologic evaluation of laser-assisted new attachment procedure. *Int J Periodont Restorative Dent* 2012;32:497–507	Clinical research	No	No
Tilt LV. Effectiveness of LANAP as measured by tooth loss. *J Gen Dent* 2012;60:143–146	Private practice research	No	No
Gregg RH. The LANAP protocol: laser-assisted new attachment procedure. *Dentaltown Magazine* 2012; Feb:108–112	Opinion	n.a.	n.a.
Gregg RH. Lasers. *Dent Today* 2013;32(10):16	Opinion	n.a.	n.a.
Brown IS. Current advances in the use of lasers in periodontal therapy: a laser-assisted new attachment procedure case series. *Clin Adv Periodontol* 2013;3(2):96–104	Uncontrolled case reports	No	No
Mangot D. The LANAP protocol: the legend continues. *Dent Today* 2013;32(11):130,132	Opinion	n.a.	n.a.
Nevins ML, Kim SW, Camelo M, et al. Prospective 9-month human clinical evaluation of laser assisted new attachment procedure (LANAP) therapy. *Int J Periodontics Restorative Dent* 2014;34(1):21–28	Clinical research	No	Yes
Harris DM, Nicholson DM, McCarthy D, et al. Change in clinical indices following laser or scalpel treatment for perio: a split-mouth, randomized, multi-center trial. *Proc SPIE* 2014;8929:89290G-1-9	Clinical research	Yes	Yes
Khadtare Y, Chaudhari A, Waghmare P, et al. The LANAP protocol (laser-assisted new attachment procedure): a minimally invasive bladeless procedure. *J Periodontol Med Clin Pract* 2014;1(3):264-271	Opinion	n.a.	n.a.
Suzuki JB. Millennium dental's minimally invasive PerioLase MVP-7 laser: not just for periodontitis. *Compendium* 2015;36(1):76	Opinion	n.a.	n.a.

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that used SRP+osseous surgery, SRP+MWF, SRP+systemic antibiotics, and SRP alone revealed no significant differences, primarily due to the large range and overlapping values of standard deviations.

The second peer-reviewed study was published by Yukna et al.[7] in 2007. This was a proof-of-principle study showing the possibility of regeneration of alveolar bone proper, PDL, and cementum with the absence of a long-junctional epithelium following LANAP treatment of intrabony defects. The study compared LANAP (6 teeth) to SRP alone (6 teeth) with both treatment groups being comprised of single-rooted teeth. The primary purpose of the study was to gain human histologic evidence supportive of regeneration. The study was of short duration (3 mo) and there was no mention of randomized or blind allocation of treatment sites. Study results reported histologic evidence of regeneration of bone, PDL, and cementum in 66% of the specimens (LANAP group).

Numerous clinical trials have demonstrated that manual probing without the benefit of a customized stint results in a standard error (SE) of measurement for PD and CAL of ±1.0 mm. The Yukna et al.[7] study used manual probing without a stint. Thus, when allowing for the SE for PD measurements, the results were no better than SRP alone.

The histology derived from the Yukna et al.[7] study was based on serial sections of block specimens. The study did not indicate what percent of the serial sections were examined. Calculations of data offered in the materials and methods, depending upon interpretation, show that either 4.5% or 43% of the total number of sections were examined. This does not allow a conclusion regarding consistency of any observation.

The third study in the series of 6 was authored by LV Tilt,[8] a devoted proponent of the LANAP protocol. Tilt reported a retrospective study of 107 patients treated by LANAP who were followed for an average of 6.2 yr. Thirty-two percent of the patients were classified as Periodontal Case Type III and 68% were considered Case Type IV. The measurement outcome was the percent of teeth lost following treatment over 6.2 yr in maintenance therapy. In this regard, Tilt reported a loss of 0.07 teeth/patient/year; extrapolated to a 10 yr period, this equals 0.7 teeth.

From a comparative standpoint, it was reported by Cobb[9] in the 1996 World Workshop in Periodontics that patients receiving periodontal treatment experienced a tooth loss rate of 0.08 teeth/patient/year or 0.8 teeth over a decade – a result nearly equal to that reported by Tilt.[8] A major difference, however, is that calculations in the latter case (Cobb) were based on 13 studies that collectively followed 3373 patients over extended periods of time, ranging from 3.7 yr to 22 yr, with the average for all 13 studies being 13.6 yr. One could safely conclude that tooth loss outcome as reported by Tilt was no better than that achieved by traditional periodontal therapy.

Studies 4 and 5 in the LANAP series were authored by ML and M Nevins et al.[10,11] Similar to the Yukna et al.[7] study, the first Nevins et al.[10] study was designed to procure human histology to show the healing response following treatment of intrabony defects with the LANAP protocol. The study included 8 patients with 930 sites. A quick calculation reveals an average of 19.38 teeth per patient (assuming 6 sites per tooth). This would imply that most of the treated sites involved single-rooted teeth and, therefore, the results cannot be extrapolated to include multirooted teeth.

Both of the Nevins et al.[10,11] studies were based on the same group of patients. Neither of the studies had control sites. The first paper[10] reported results showing that 60% of the sites selected for histologic examination exhibited some degree of periodontal regeneration. The second study[11] reported an overall decrease in PD of 1.48 mm and a gain in CAL of 0.92 mm. Posttreatment gingival recession was reported to be 0.66 mm. It should be noted that in periodontal literature where SRP is used as a control or as a primary therapy, an average of 1.0 mm PD reduction and 0.5 mm gain in CAL can be expected following treatment of pockets with an initial 4–6 mm depth. Thus, the difference between traditional therapy and the Nevins et al.[11] study is about 0.5 mm. One could easily make a convincing argument that 0.5 mm is of marginal clinical significance.

Over the last 2 yr, MDT sponsored a multicenter, prospective, longitudinal, clinical trial at 5 domestic performance sites: 3 university-based dental schools and 2 private practices.[12] The protocol was reviewed and approved by the IRB, having jurisdiction over each site, and the trial was registered with ClinicalTrials, gov (NCT01282229). Liza Burns Associates, an independent CRO, monitored the trial. In this clinical trial, each treatment was randomized to a different quadrant of 51 subjects with advanced chP and a minimum of 4 sites per quadrant with PD ≥5 mm and 2 sites with PD ≥7 mm. Operators and examiners at each center were trained and calibrated. The investigator administering the treatments did not conduct clinical

Continued on page 16

measurements. A blinded examiner conducted all clinical measurements.

At baseline, each patient received a limited occlusal adjustment in all quadrants, and full-mouth coronal debridement was provided using an ultrasonic scaler and hand instruments. Following coronal debridement, 3 quadrants were randomly assigned to receive treatment by LANAP, SRP, or MWF. The remaining quadrant, serving as a control, was left untreated except for the coronal debridement procedure. At 12 mo posttreatment there were no statistically significant differences in PD or BoP among the SRP, MWF, and LANAP results. The one significant finding in this trial was that patients found the LANAP procedure to result in less discomfort than the MWF.[12]

Controversies

LANAP is promoted as a minimally invasive procedure that involves surgical removal of the sulcular epithelium using an Nd:YAG dental laser, with modification of bone consisting of perforation of the bony surface and exposure of the PDL using piezoelectric bone cutting tips. Wound closure avoids the use of sutures and relies on a gelled or polymerized fibrin clot created from the thermogenic effects of the PerioLase laser.

According to MDT, their laser (the PerioLase) selectively removes "only diseased epithelium" from the periodontal pocket with no damage to connective tissue or the root surface. However, there are no studies showing that the LANAP protocol is capable of differentiating between diseased epithelium and the subjacent diseased connective tissues of the lamina propria.

Marketing claims often cite as a benefit the fact that the wavelengths of diode (810–980 nm) and Nd:YAG (1064 nm) lasers exhibit an absorbance coefficient for dark-colored biologic tissues containing melanin, hemoglobin, and oxyhemoglobin. This has been extrapolated to state that these wavelengths will, therefore, destroy periodontopathic bacteria within the periodontal pocket that accumulate iron protoporphyrin pigment, which ranges in color from brown to brownish-black. However, there is no evidence that BPB (black/brown pigmented bacteria), such as *Porphyromonas* spp., *Prevotella* spp., and *Bacteroides* spp., produce dark pigments in the periodontal pocket. These bacteria have only been shown to produce a black/brown pigment when grown on blood agar plates.[13] Consequently "selective black pigmented bacterial kill" with the PerioLase may have no bearing on the outcome in patients treated with the LANAP protocol. Any benefit derived is more likely the result of a generalized reduction in subgingival bacterial loads rather than a reduction of specific target microbes.

LANAP is marketed as a no-cut, no-sew procedure that uses the PerioLase laser instead of a scalpel to remove sulcular epithelium and open the pocket. The treated pocket is sealed with a thermogenic stable fibrin gel clot, thereby avoiding use of sutures. Due to a controversy over insurance coding that resulted, in part, from the LANAP protocol being promoted as a type of osseous surgery, the CDT Code Maintenance Committee redefined the D4260 descriptor to include "elevation of a full thickness flap."

Interestingly, prior to May 2014, the LANAP protocol did not involve surgical reflection of a gingival flap. However, after the announcement of the impending change to the D4260 descriptor, MDT issued a handbill at the May 2014 meeting of the American Association of Dental Consultants indicating a new "LANAP Flap Ostectomy/Osteoplasty procedure," in which "a flap is created with blunt dissection and the bone recontoured to establish parabolic architecture with a diamond piezo electric bone cutter." This change in protocol calls into question the motivation for the change; is this simply a ploy to justify insurance benefit reimbursement – or is the change necessary to achieve better clinical results? Further, does this apparent change in protocol negate the findings of the 5 treatment site clinical trial,[12] specifically the finding of patients reporting less discomfort?

Conclusions

Evidence-based dentistry integrates the oral health care professional's clinical expertise, the patient's needs and preferences, and the most current, clinically relevant scientific evidence. All 3 components are part of the decision-making process for patient care.[14]

A critical review of the existing peer-reviewed evidence shows LANAP to provide an alternative treatment modality for chronic and aggressive periodontitis. However, when one compares the 6 peer-reviewed studies of LANAP, the quality of the research studies is poor with a high risk of bias and the strength of the limited bodies of scientific evidence is weak.

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Gordon J. Christensen
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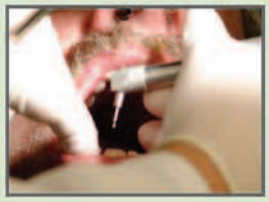
Do lasers added to scaling/root planing improve periodontal outcomes?

Gordon's Clinical Bottom Line: Lasers have established firm niches in medicine over many years. Dental applications have been slower to develop and are often controversial. Dental uses tried so far include resin polymerization; tooth bleaching; endodontic canal disinfection; cutting of enamel and dentin; soft tissue surgeries; and treating periodontitis after scaling and root planing. Some of these applications have disappeared, others remain—but none has flourished to the point of replacing conventional methods. The current question is: Do lasers used after scaling and root planing improve the outcome? *This question received extensive effort from CR's human studies team (TRAC Research). You will be interested in their findings.*

TRAC RESEARCH

These studies were initiated at the request of many clinicians nationwide to verify reports from laser companies and clinicians claiming superior clinical outcomes when lasers were used after scaling and root planing *(SRP)* in the treatment of periodontitis. These studies were designed to compare ***SRP Alone to SRP+Laser***. They do not compare the different laser wavelengths. The studies address 4–6mm pockets only because this was the range laser companies promoted for use of their instruments by general dental practices. Specific laser ***claims*** of interest to TRAC Research were:

Claim 1. Laser use results in pocket depth improvements substantially better than SRP Alone.
Claim 2. Laser use after SRP sterilizes the pockets.
Claim 3. Laser use resolves bleeding and suppuration on probing better than SRP Alone.
Claim 4. Laser treated patients often do not require anesthetic and experience less post-op pain.
Claim 5. Post-op laser biostimulation speeds healing and increases bone regeneration.



CO_2 laser being used in treatment of periodontitis. Is it helpful?

The goal was to collect *actual clinical data* from laser-company-trained general dentistry practitioners who used lasers routinely in periodontal treatment. TRAC researchers documented the clinical proceedings and outcomes and performed the microbiology. The clinicians selected the patients per the study inclusion/exclusion criteria and treated them according to their laser company's protocol, using the techniques and accessory instruments specified by each laser company. **Results showed none of the five claims could be confirmed regardless of the laser, the clinician, or the patient in the test. Important information follows on pages 2 and 3.**

1. Methods: Two separate studies were performed

- **Study #1** *(Oct 2008–Feb 2010)*
  - 30 patients; 8 clinicians; 4 laser wavelengths *(**CO_2**=Deka PerioPulse; **Diode**=Ivoclar Vivadent Navigator; **Er-Nd:YAG**=Lares [now Technologies4Medicine] PowerLase AT; **Nd:YAG**=Millennium PerioLase MVP-7)*
  - 5 microbiology labs *(Accugenix, DE; Forsyth Institute, MA; Hain Diagnostics, Nehren Germany; Oral DNA Labs, TN; TRAC Research, UT)*
  - First 4 patients were treated with SRP+Laser only. When no dramatic results were observed, the remaining 26 patients received split mouth treatment using SRP+Laser on one quadrant and SRP Alone on the opposite quadrant
  - Both quadrants were treated the same day and follow-up data collected at 3 and 6 months
- **Study #2** *(Mar 2010–Sept 2012)*
  - 10 patients; 4 clinicians; 2 laser wavelengths *(**CO_2**=Deka PerioPulse and **Er-Nd:YAG**=Lares PowerLase AT)*
  - This smaller study was designed to increase the amount of data collected by:
    (1) Collecting all data monthly instead of quarterly, except pocket depths which were collected before treatment, 6 and 12-months post op
    (2) Microbe samples collected on treatment day after each step as well as before treatment, 1, 2, 3, 6, and 12 months
    (3) Both paper point and saliva DNA collection kits used
    (4) Periodontal susceptibility testing performed
    (5) All four quadrants treated the same day with one SRP Alone quadrant as the control
    (6) Perio-pathogen specific antibiotic(s) administered per Hain DNA report suggestions

See full methods: www.CliniciansReport.org Home Page under Complimentary Information.

2. Critical problems that call into question results of past and present clinical studies on lasers in perio

- **Energy output at laser working tip varies during clinical use.** Laser design, operator technique, and lack of proper maintenance cause this. Energy can cease altogether intermittently with some laser/operator combinations. Yet no way is provided by any laser company to indicate real time output at the working tip ***during use.*** *How can effects of laser energy be studied if it ceases during treatment?*
- **Clinical techniques ignore basic tenets of microbial transmission.** The same probe, scaler, and laser tip are used throughout the oral cavity deep within both infected and non-infected pockets, thereby causing these instruments to become ***inoculating instruments.*** Yet bacteria are recognized universally as an important factor in the etiology of periodontitis. *(NOTE: Our tests showed the laser tips did not self-sterilize as claimed, but after contamination required operation in excess of 16 seconds outside the oral cavity for organism kill on metal or sapphire tips or clipping off the used portion of fiber tips—and none of this was done between pockets by any clinician in this study.) How can status of microbes in a pocket be monitored after treatment when new organisms are added repeatedly by clinicians?*
- **Identification of organisms in periodontal pockets is imprecise.** Despite perceptions that DNA testing gives ultimate data, there are significant problems such as: (1) DNA identifies both live and dead organisms, thus confounding organism kill counts; (2) The different labs we used did not agree even though portions of the same samples were sent to each; (3) Results from the saliva and paper point DNA kits often did not agree, and when we tested their accuracy by sending known organisms, they reported organisms not sent and/or failed to report those that were sent. *We concluded that the current DNA kit tests for perio-pathogens need further refinement.* However, use of culturing also has serious problems such as inability to grow some organisms with current methods and human handling error. *How can the contribution of specific microbes be determined without precise identification of **viable** organisms involved?*

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Do lasers added to scaling/root planing improve periodontal outcomes?

3. Results below are from Study 2 only comparing SRP Alone vs. SRP+CO_2 or Er-Nd:YAG lasers

- **Claim 1: Pocket Depth Resolution**

(This study looked specifically at 4–6mm pockets because this is the range promoted by laser companies for treatment by general practitioners.)

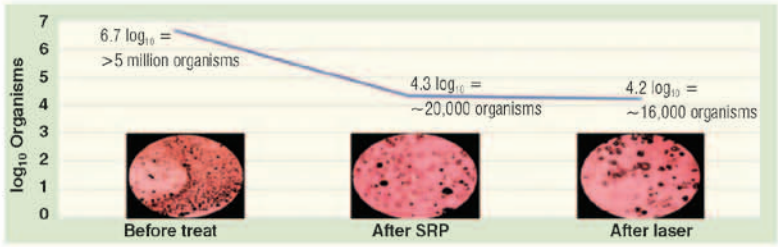
– **6mm pockets** showed ***statistically better pocket improvement at 1 year when treated with the CO_2 laser after SRP (p=0.020),*** with an average improvement of 1.045mm more than with SRP Alone. However, this point needs confirmation in studies that include more patients and more 6mm and deeper pockets *(total 6mm pockets in this study = 63).* ***There was no difference in 6mm pocket depth resolution when comparing the Er-Nd:YAG laser to SRP Alone.***

– **4mm and 5mm pockets** showed ***no difference between SRP Alone and SRP+Laser using either laser,*** regardless of how pockets were analyzed, using many different statistical approaches and combinations of data.

– **1–3mm sulcus depths** were treated to determine the response of shallow pockets to SRP Alone and SRP+Laser. ***1–3 mm pockets treated with the Er-Nd:YAG laser did not recover as well as those treated with SRP Alone (p=0.015). However, the CO_2 laser used on 1–3mm pockets showed no difference between SRP Alone and SRP+Laser.***

- **Claim 2: Pocket Sterilization**

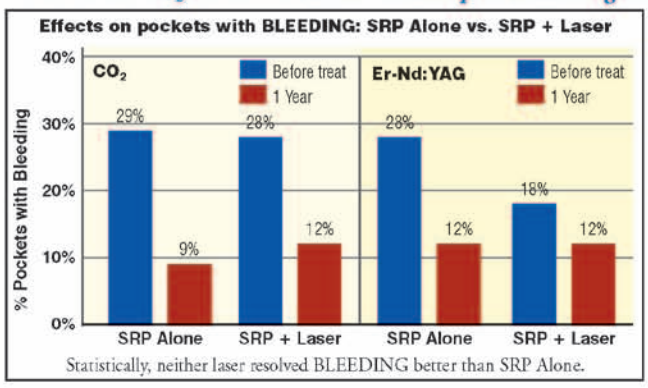
– ***Neither SRP Alone nor SRP+Laser sterilized any pocket, on any patient, at any time regardless of laser wavelength used.*** However, use of ultrasonic scalers *(Cavitron or PiezonMaster)* set on ***high water*** eliminated a substantial number of organisms *(2.5 log_{10})*. Follow-up with the lasers after SRP reduced microbes further by only a small amount *(0.1 log_{10})*. ***See graph below.*** The actual clinical pocket shown below contained more than 5 million organisms before treatment. The ultrasonic scaler on high water reduced the organisms to about 20,000. Er-Nd:YAG follow-up further reduced the organisms to about 16,000. However, this quantity of remaining organisms are able to ***re-populate rapidly*** by cell division which proceeds logarithmically to produce enormous numbers in just 24 hours. The ***Petri dish images*** show the appearance of the microbial colonies on anaerobically cultured blood agar plates. Note the presence of the characteristic black pigmented colonies typical of some perio-pathogens.



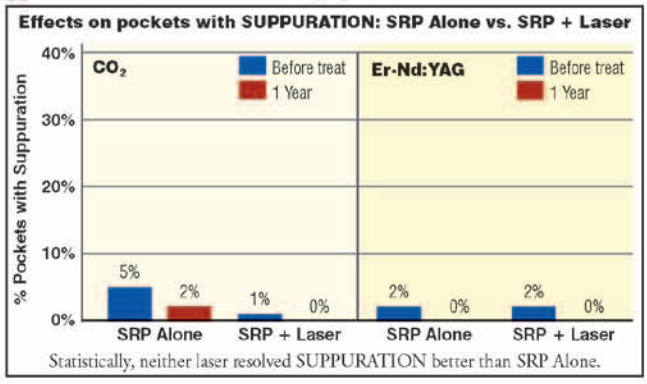
– ***Microbe reductions did not correlate with pocket depth improvement.*** Others have reported similar findings *(Ximenez-Fyvie, et al; J Clin Periodontal 2000, 27:637, page 640).* This contradicts clinical perceptions that decreasing the microorganisms will result in pocket depth resolution. Our data may support current thought that while the bacteria are important in initiating inflammation, it is the inflammation that drives the disease. *(No steps were attempted in this study to measure or control inflammation.)* In Study 2, antibiotic type, dosage, and duration suggested by the Hain Diagnostics DNA test was initiated immediately following treatment to assist in lowering microbe numbers. Although microbe numbers ***were*** lowered, there was only very low correlation with pocket depth improvement *(0.1–0.4)*.

- **Claim 3: Bleeding and Suppuration Resolution**

– ***Neither the CO_2 nor the Er-Nd:YAG laser improved bleeding or suppuration over SRP Alone.*** See graphs below.



Statistically, neither laser resolved BLEEDING better than SRP Alone.



Statistically, neither laser resolved SUPPURATION better than SRP Alone.

- **Claim 4: Pain During and After Treatment**

– Patients rated pain *(escalating scale of 1–10)* immediately after treatment, at one month, and 6-months post-op. ***Pain ratings did not differ for SRP Alone and SRP+Laser,*** and none of the patients correctly identified the SRP Alone quadrant on treatment day or at any time based on pain. ***All patients required anesthetic for treatment.*** Without anesthetic, only very cursory treatment could be tolerated.

- **Claim 5: Post-op Biostimulation**

– ***No effect, either good or bad, could be identified for biostimulation.*** *(NOTE: Biostimulation used the Nd:YAG laser to emit laser energy to interact with tissue to stimulate circulation, healing, and bone growth. This was done for some patients, while others served as controls.)*

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Do lasers added to scaling/root planing improve periodontal outcomes?

4. Important Observations

- **Laser advantages in soft tissue surgery.** Benefits of lasers for *soft tissue surgery* in both dentistry and medicine are well accepted. Their simultaneous cut and coagulate capabilities can be useful in removing sulcular tissue to gain ultrasonic scaler access and contouring papillas. They also can cut next to metal and uncover implants without harming bone or damaging implants. *It is the claims related to periodontitis that need validation.*
- **Critical importance of homecare.** We concluded that we could treat 4–6mm pockets with or without a laser, but we could not achieve optimal results without patient cooperation. Overall patient homecare compliance in this study was rated fair. *Neither SRP Alone nor SRP+Laser treatments were substantial enough to overcome effects of casual homecare.*
- **Clinician and patient perception of laser efficacy:** We noted that both clinicians and patients were motivated by the laser use. However, SRP Alone with the ultrasonic scaler on high water setting resulted in the same or better outcome than when a laser was added. Interestingly, not all clinical studies of lasers in periodontitis include an SRP control. However, it is notable that ***all*** *laser companies use their laser in periodontitis treatment* ***after SRP.***
- **Laser stimulation of bone growth and healing not seen:** Clinically, we did not observe a systemic boost of healing sometimes claimed as a laser energy/soft tissue interaction, but we refer readers to Section 2, Bullet 1, on page two noting inconsistent laser energy output at working tips and no way for clinicians to monitor the tip output during use. ***We concluded that laser use in periodontitis treatment is in an early crude stage and needs significant refinement of both the lasers and the clinical techniques.***
- **Unique clot produced by laser use.** Treatment with all the lasers studied produced a seeping, sticky, lymph-rich clot typical of burn wounds, and noticeably different from the RBC-rich clots produced by scalpel surgery and SRP with hand instruments. However, the difference in the clots did not result in differences in clinical outcomes.
- **Fees for SRP Alone *vs.* SRP+Laser.** We noted substantially higher fees for SRP+Laser vs periodontal SRP Alone *(3 to 5 times higher). In light of results from these two studies, and others in the literature, showing little to no significant differences in clinical outcomes in SRP Alone vs SRP+Laser, substantially higher fees cannot be justified at this time.*

TRAC Conclusions:

These studies did not confirm 5 frequent claims of superiority for lasers used after scaling and root planing in treatment of periodontitis. SRP Alone was either the same or superior to SRP+Laser EXCEPT the CO_2 laser in 6mm pockets showed pocket depth improvement at one year that was *statistically* better than SRP Alone. This result is intriguing, but requires confirmation in additional studies. For now, it appears lasers are not the "magic bullet" claimed for periodontitis treatment—and definitely cannot be justified for "pocket sterilization" after SRP.

Sincere thanks to the many people who worked with us in these studies, including the clinicians, report reviewers, and the Brigham Young University statistical team.

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LASER ASSISTED NEW ATTACHMENT PROCEDURE (LANAP)

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SFVDS conducts an Affordable Care Act (ACA) Symposium for Members

Dr, Anette Nasters (L) moderated a Q&A session with (L-R) Nicette Short, Dr. Gary Dugan, Dr. Paul Manos, Taylor Priestly and Doris Ford

Attendees listen attentively during the presentation

Another view of the Q&A session in the dental society's Gelfand Educational Center

One of the most neglected parts in the clinical practice of dentistry is keeping up to date with legal issues and regulations on the dental profession. SFVDS keeps its members in the loop by providing short and all-day presentations on current events, techniques and legislation.

The ACA Symposium held on May 16th in the Gelfand Educational Center at the SFVDS central office was one of those events. With all available seats occupied, the ACA Symposium was a success, especially in keeping its members informed on the Affordable Care Act and how dental practices are and will continue to be affected.

By: Anette Masters, DDS, SFVDS Membership Chair

Nicette Short of the California Dental Association talked on the regulations that affect offices that provide dental care to pediatric patients in the State of California.

Covered California Representative, ,Taylor Priestley, also spoke to the members in detail on different agencies that provides coverage under the umbrella of the current ACA legislation.

Covered California representative, Doris Ford, touched on the different Insurance plans that are available for the dentist as employers under the Affordable Care Act.

Dr. Paul Manos, National Dental Director of United Concordia's dental plans, talked about how health care reform is primarily focused on medical coverage, for now. He also spoke about how employer sponsored group coverage will be affected on a limited basis. The only dental mandate that is currently in play is pediatric dental coverage. On another note, he mentioned that pediatric dental benefits can be purchased through the California Health Insurance Exchange which is also called "Covered California". Limited dental plans are available through Covered California and federal subsidy assistance is also available based on income thru the exchange. Meanwhile, Covered California's dental benefit offer is based on the former Healthy Families dental benefit. As of 1/1/15 Pediatric dental coverage has been included as part of the medical health benefit under the ACA. And in 2016, plans are underway to include an adult dental benefit as well.

Dr. Gary Dougan, National Dental Director for Liberty Mutual's dental plans, talked about the aim of health care reform, which is to get the uninsured covered, decrease the waste and abuse of the health care system, as well as improve the transparency and quality of health care delivery. He went over the history of the ACA starting in 2012, including that children on parents' policies can now be covered until 26 years of age, the elimination of pre-existing conditions and changes made to prescription drug coverage. In 2013, health exchanges and marketplaces were created on all levels, federal, state, private and individual. In 2014, a mandatory inclusion of pediatric dental benefits, in and out of the exchanges as well as bundled, embedded and stand alone dental policy coverage became available. In 2015, the emphasis is on using the federal exchange and "Small Business Health Options Program" (SHOP). In

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Cruisin' With Dental Students

By: Birva Joshi Jones, DDS
SFVDS New Dentist Chair

Students gathered on the top deck of the Tiki Mermaid Yacht

One of the more difficult tasks we've faced in the dental tripartite has been that of recruiting new graduates for our membership. Obviously, if we aren't successful in recruiting new grads, we'll simply dwindle as an organization over time and lose much of the intrinsic value that comes from the breadth of membership we currently enjoy.

In 2014, SFVDS applied and received ADA grants to fund events geared toward outreach to and mentoring dental students on the benefits of organized dentistry, spreading knowledge about the tripartite (ADA, CDA, SFVDS) and to increase participation in local component events.

A UCLA student takes her turn driving the yacht in Marina del Rey

We were pleased to put these funds to use in our first recruiting event in April. We charted a private, three-hour cruise along the Marina Del Rey waterfront with 47 3rd and 4th year dental students. Hors D'oeuvres and cocktails were served and the atmosphere was generally light and jovial. We observed great student / member interaction and the students asked many good questions.

SFVDS member teamwork put the generous funding supplied by the ADA to good use on this adventurous and fun-filled cruise. The message that our society, CDA and ADA can assist through all stages of a dental career was well received by the students. The relaxed environment allowed open discussion and a forum for the students to express their concerns and expectations regarding the various services and benefits available at all three levels of the tripartite. We received great feedback from the students and each expressed how glad they were to attend the event. They indicated that they would have a high degree of interest in future events and gained a new perspective on the value of joining organized dentistry after graduation.
On this page are a few pictures that captured the essence of our interaction with the students.

Drs. Anette Masters and Mahfouz Gereis pose with three attending dental sutdents

Continued from page 20

addition, there is more emphasis on creating embedded plans especially pediatric dental essential benefits and medically necessary Ortho plan design. Luckily, quality metrics are being discussed as well.

Attendees enjoyed a scrumptious salad and sandwich bar during lunch

Among the predictions from the speakers were that there will likely be experimentation with reimbursement designs to include payment by visit, payment by group types, as well as all types of other reimbursement models namely capitation, capitation by supplemental fee schedules and fee for service.

And for the future, the effect on general practices include:

There will be millions of children receiving dental coverage within the system;
There will be more patients in the dental offices;
Family dental plans will be offered, not just for children;
There will be more government subsidies and various plan designs including pediatric coverage.

Finally, Dr. Dougan's advice for general practitioners is to gear up for children in your dental practice. Try to learn behavioral management as well as sedation techniques, and certification for pediatric patients. Efficiency and practice systems is a must in your dental office and make sure to shadow your pediatric dentist friend or colleague, or even have your staff do so to learn the ins and outs on how to treat pediatric patients more effectively and efficiently.

With all this information and a lengthy Q&A session after the presentations, attendees were better equipped and ready to tackle the changes that the Affordable Care Act brings on!

Antelope Valley Report

By: Kathy McKay

2015-2016 SCHOOL SCREENINGS

Goal: 40 Schools
Schools Visited: 16
4th Graders Screened: 1,920
Kinder Assessments: 700
Awaiting schools to re-start in August

CPR Certification

$35 per person dental discounted price w/ $5 donation to the SFVDS Foundation. Classes need to consist of 9 persons or more per class.

In order to schedule for a class, please call Bella at SFVDS or to Eric at Snow Orthodontics @ 661-273-1750.

2015 C.E. SEMINARS

6-8-15 California Dental Practice Act
Attendees: 50
7-13-15 Infection Control

HI DESERT CHILDRENS DENTAL CLINIC

- *2015: Received 13 Applications, Treated 6 Children so far.*
- *Thunder on the Lot Fundraiser For more information go to: http://www.thunderonthelot.com/index.php*
- *Working with the Antelope Valley Press on a feature article on the clinic.*

Smiles From The Heart

Thank you to the following members who have volunteered to provide dental care to low income, uninsured people within our component. 22 members have signed on and have already treated 20 patients in dire need.

Name	City	Specialist
Anita Rathee, DDS	West Hills	
Chi Leung, DDS	Glendale	
Gary Herman, DDS	Valley Village	
George Maranon, DDS	Encino	Oral Surgeon
Jorge Alvarez, DDS	Tarzana	
Martin Courtney, DDS	Northridge	
Nita Dixit, DDS	Studio City	
Phillip Sacks, DDS	Woodland Hills	
Rex Baumgartner, DDS	Santa Clarita	Prothodontist
Shukan Kanuga, DDS	West Hills	Pediatric
Mafouz Gereis, DDS	Van Nuys	
Randy Lozada, DDS	Santa Clarita &	Lancaster
Roya Shoffet, DDS	West Hills	
Charles Maseredjian, DDS	Burbank	
Michael Seastrom, DDS	Tarzana	
Henide Arias, DDS	Reseda	
Bob Kogen, DDS	Newhall	
Jim Mertzel, DDS	Sunland	
Afshin Mazdy, DDS	Northridge	Endo
Michael Simmons, DDS	Tarzana & Palmdale	
Gib Snow, DDS	Lancaster	Ortho
Birva Jones, DDS	West Hills	

The Smiles From the Heart needs additional member volunteers to provide donated care to an already large number of patients who have completed applications and are awaiting to be assigned to a member for much needed treatment. The program needs general dentists and specialists to help. If you would like to volunteer, please contact Wendy at: 818.576.0116 or wendy.sfvds@sbcglobal.net

CLASSIFIED ADS

"P/T DENTAL HYGIENE POSITION available for Monday & Wednesday or Tuesday & Friday in our private office in Burbank. Please email resume to Nguyendds2009@yahoo.com"

"Small Claims Court Collections. Pay 1/3 when we collect" Michael Marcus please call at 408.410.8922

General Dentists Needed: Family Smiles desires motivated, quality oriented general dentists to work in our busy New Mexico practices. At Family Smiles, we focus on providing the entire family superior quality general dentistry in a modern technologically advanced setting with experienced support staff. Because we understand the tremendous value of our associate dentists, we make sure that their compensation package is amongst the best. Our competitive compensation package includes: minimum guaranteed salary starting at $120,000 with potential to earn up to $300,000, visa sponsorship, and health and malpractice insurance. To apply, please email CV to jboyce@kosservices.com or call 312.274.4520.

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Lan Su, DMD, PhD, Diplomate, American Board of Oral & Maxillofacial Pathology
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Welcome New Members

Peter Huu Dang, DDS
General
NYU, 2012

Peter Suh, DDS
General
Tufts University, 1991

Badri Jureidini, DDS
11550 Mission Hills Road. Ste. 2
Mission Hills, CA 91345
424.288.6761
Endodontics
Univ. of Minnesota, 1995

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La Canada Flintridge, CA 91011
917.582.1707
Pediatrics
Univ. of Pennsylvania

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818.576.9990
General
Loma Linda, 2005

Amir Choroomi, DDS
30313 Canwood St. Ste. 36
Agoura Hills, CA 91301
General
UOP, 2005

Joseph Baha, DDS
1220 W. Glenoaks Bld. Ste. 203
Glendale, CA 91201
General
818.247.8132
NYU, 2007

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