Bulletin of the San Fernando Valley Dental Society

# Dental Dimensions

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Winter 2012


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DENTAL DIMENSIONS

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# In This Issue

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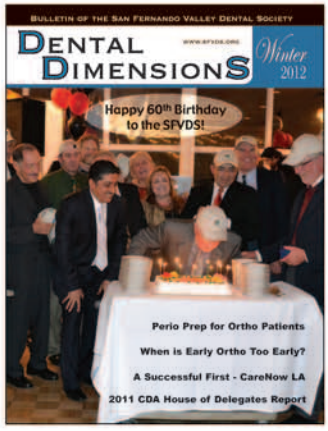
## On The Cover.....




SFVDS' 1961 President, Dr. Bill Holve, surrounded by other past presidents, works on blowing out the candles on the dental society's 60th anniversary cake at the 2011 annual holiday party.

# From the Desk of the Editor

## SFVDS Resolution becomes CDA Policy

Many of you who have been following the "mid-level provider" issue know that your SFVDS Board has been concerned and actively involved in this issue. The SFVDS Board believes that only dentists should be allowed to perform irreversible surgical procedures. Many states are either looking at or have adopted policies and training programs allowing high school graduates with one to two years of training to provide dental services such as fillings and "simple" extractions. The Board feels that this jeopardizes the safety of the public and potentially creates a two-tiered system of care in which the underserved and most vulnerable populations are placed at risk.

The SFVDS Board introduced a resolution to the CDA House Of Delegates (HOD) opposing non-dentists performing irreversible surgical procedures and promoting this position to parties of interest outside of dentistry. The reference committee heard testimony and proposed a substitute resolution which was again debated and modified on the House floor. It was an amazing process to observe and even more interesting to be a part of it. If you have an opportunity to attend a House of Delegates session, I would encourage you to do so. The final resolution passed by the HOD and adopted as CDA Policy is one that we can all be proud of. It maintained the intent and most of the wording of the original resolution and even improved upon it. CDA now has a policy opposing non-dentists doing irreversible surgical procedures, and that policy is to be promoted to legislators and other third parties where it will make the most significant impact. Dr. Maranon's guest editorial that follows will give insight and background and implications of this very significant step your CDA has taken in the right direction.

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

## Guest Editorial by George Maranon, DDS

In November of last year, CDA House of Delegates filed an Access to care report that clearly defined many of the barriers to dental care in California. The report outlined a phased approach to developing solutions to breaking down these barriers. The possible solutions included expansion of the oral health infrastructure in the State, Medicaid reform, expansion of school-based/linked oral health programs, expansion of dental residency programs, improved oral health literacy. The report also proposed studying the expansion of the dental delivery system and evaluating the economics of new workforce models and the impact of new workforce models on private practice dentists. By filing the report the House of Delegates did not establish the findings and recommendations of the report as CDA policy. Filing the report only formally ended the work of the committees that participated in its writing. After filing the Access report, the House of Delegates voted to reaffirm CDA policy opposing any scope of practice changes allowing non-dentist providers to perform irreversible/surgical procedures.

Recently, a report was published by the Children's Partnership titled "Expanding California's Dental Team to Care for Underserved Children – New Times – New Solutions". This document is not a scientific study and contains many misleading statements regarding access to dental care in California. This report is filled with anecdotal statements that argue for expanding the dental workforce utilizing non-dentist auxiliaries performing irreversible/surgical procedures. It is clear that the report was commissioned to show that there was a need to expand the dental workforce. Unfortunately, the Children's Partnership report serves as the basis for legislation submitted by Senator Alex Padilla in SB 694. In addition to calling for a state dental director, the Senator Padilla bill calls for a pilot study to train non-dentists to perform these irreversible/ surgical procedures on patients.

The rational for considering non-dentists performing irre-

versible/surgical procedures is assumption that dental practices in California do not have the capacity to see more patients. This assumption is based on a capacity study within the CDA Access report that suggests that California dental practice are already functioning at high efficiency. Unfortunately, the study fails to consider reimbursement with respect to capacity. The study tries to explain unfilled chair time in our offices with the argument that "The current economic recession and recent elimination of optional services for adults under Denti-Cal have likely created temporary excess capacity among private generalist dental practices that served adult Denti-Cal patients. However, a significant portion of this excess capacity should be eliminated relatively quickly as private practices that served large numbers of Denti-Cal patients cut staff and capital resources in order to maintain their profitability." If this is true, the converse should also be true. The capacity of dental practices should increase as compensation increases. The fact that dental practices are functioning efficiently is a testament to their efficient use of resources (e.g., dentists, operatories, dental hygienists, dental assistants, and office staff) based on reimbursement-good business practice. Another flaw in the Capacity study was that there was limited data available for safety net providers (e.g., Federally qualified health centers, school-based clinics, free standing dental clinics, mobile clinics, hospital based clinics, public hospitals, rural health clinics, medical/dental clinics, county health facilities, and free clinics). The limited data that was presented showed that these practices were the most technically inefficient and had the greatest potential to increase their capacity. The capacity study fails to note that California has the highest concentration of dentists than any other state. Shouldn't California dentists be able to expand their capacity and be more efficient so as to provide care to as many patients as dentists do in other states?

The issues responsible for access to care disparities are complex. Access disparities related to isolated geographic areas are easier to understand, but there are many others. In addition, utilization of dental care services needs to be considered. Of those 30% of Californian's that are considered to have limited access to dental care, how many would actually utilize those services if they were available. Reasons for lack of utilization include issues related dental health literacy and cultural factors. Then there are problems related to the economy and personal income, the inadequate oral health infrastructure, the disproportionate distribution of dentists and inadequate reimbursement for dental procedures. None of these factors would be solved by the introduction of a non-dentist provider performing irreversible/surgical procedures.

It must first be demonstrated that expansion of the dental workforce is an economically viable solution to access to care disparities in California. This must include an analysis of educational costs and the brick and mortar infrastructure costs associated with expanding the dental workforce with a new non-dentist provider. How would those costs compare with the costs associated with increased reimbursement and more efficient utilization of the existing workforce models? Would it be more effective to use resources to create incentives that encourage the existing workforce to underserved areas and increase the capacity of safety net providers?

The Children's Partnership report and Senator Padilla's bill do not consider the detrimental effect of this new provider on the dental care received by the majority of Californians. The law of unexpected consequences will need to be considered. With respect to the 70% of Californians who currently receive dental care, what would be the impact of expansion of the workforce? How would expansion of the workforce affect the number of current and future dentists? Would future recruitment of people to train to practice as primary care dentists be affected if the workforce is expanded? Would expansion of the workforce cause migration of dentists to other states? Lastly, and most importantly, would these non-dentist providers with less training be held to a different standard in their care of patients?

*Dr. Maranon practices Oral Maxillofacial Surgery in Encino, CA. He can be reached at (818) 344-0110.*

# From the Desk of the President

Dear Friends,

Honestly, I can't believe one year has already passed. Well, it was an honor and a privilege to have been the president of our dental society. With any member driven organization, the membership is the most important part of the organization. Thus, along with the ADA and CDA, the San Fernando Valley Dental Society has tried very hard to add value to your membership dues. On a local level this year we offered four dates for document shredding. Also, we started to offer live-scan services at reasonable rates for license renewal purpose at these sites. In addition we offered low cost tickets to Magic Mountain which included a very nice BBQ lunch, concert at The Hollywood Bowl and CPR courses at the central office.

Please use the central office as a resource for any questions you may have. Our wonderful staff will definitely point you in the right direction. Talking about the staff, I along with the entire board would like to extend our gratitude to Wendy, Bella and our Executive Director Andy Ozols for all that they do for the society.

Now on to a very important topic near and dear to all of us. As I promised in my last report, I would like to report about the CDA House of Delegates (HOD) meeting in November, 2011. Amongst all the resolutions on the floor, the ones that had everyone's attention were those related to the Access to Care report. In many delegates' minds, this report could have been used by some people to make a case for the need for mid-level providers in California. CDA leadership really wanted to have the HOD file the report arguing that it would benefit our position with some key people in the legislature.

Another important resolution on the access issue was resolution 24 (introduced by the SFVDS delegation) which essentially established a position for CDA that opposes non-dentist being able to diagnose and/or perform irreversible dental procedures. After a lot of one-on-one negotiations, and meetings with different components, our policy resolution was able to come to an acceptable conclusion. The report was filed, and our resolution 24, after a couple of modifications, became 24S1 and passed virtually unanimously. The most important thing about all of this was that we, as an association, now have a position opposing non-dentist being able to diagnose and/or perform irreversible dental procedures.

I will spare you the details, however, I am proud of our delegates to CDA's HOD because not all delegates at the House were on the same page at first. Our delegation was lucky to have some very knowledgeable members who were able to persuasively inform many of the other components' delegations who were not up to speed on some of the facts we had to deal with.

This year we started to look for a suitable building for our dental society, which is a very important endeavor in my opinion. Please, if anyone is aware of any property that may suit our needs, call the central office and talk to Andy. This will be a key piece of the puzzle for the plans the board has for the future of our society. Also this year we were able to finalize all the official documents to form our own non-profit foundation. These are all big steps in the right direction for our society.

With a sense of gratitude I will end my one year term as president of the dental society. I look forward to seeing more of you at the CE meetings and our social events. Until then please stay healthy and productive.

Yours truly,
Mehran

# THE LEGISLATIVE PROCESS SB 694 PADILLA

*By: Dr. Jim Mertzel*

I have the privilege of serving on the Government Affairs Council (GAC) of the California Dental Association in addition to having been a delegate to this year's CDA House of Delegate meeting.

A considerable amount of discussion occurred at the HOD regarding the position CDA should take about the bill submitted by State Senator Alex Padilla regarding access to care. It is the responsibility of the GAC to follow the recommendations voted for by the members of the HOD to assure that whatever legislation is submitted to the CA legislature concerning issues related to dentistry, that legislation is monitored by the GAC and staff to guide the legislation in a direction dictated by the membership of CDA.

The delegates at the 2011 HOD indicated that they were opposed to anyone, other than dentists, performing irreversible invasive surgical procedures. The Children's Partnership, the proponents of SB 694, contend that there is insufficient access to care for underserved children and are suggesting that mid-level providers are needed. CDA's own commissioned research has shown that there is insufficient evidence to establish the safety of non-dentists doing irreversible procedures. Therefore CDA is advocating that a safety study be completed that not only proves these mid-level providers are as safe as dentists, but also that they are more economical and that their utilization significantly reduces barriers to care.

Although I have served the SFV Dental Society for the past 10 years as legislative chairman I have not had the opportunity to have an inside look as to how a bill is molded to bring about the results lobbyists would prefer. Serving on the GAC has given me this opportunity.

As this article is written five weeks before it reaches the reader's eyes, there will be a number of additions, changes and deletions to the bill as it was initially proposed. The outcome of this legislation will affect not only us, as dentists, but it will also have an effect on our patients and students who are considering entering the dental profession. I suggest that you follow the progress of this bill. If you have an opinion, do not hesitate to express your concerns to your legislator, as well as to the members and staff of GAC.

In addition to the above-mentioned legislation, our component has been advocating for and working within our community to develop a comprehensive oral health literacy program for the underserved community. We believe that with education we can considerably reduce the amount of decayed, missing and filled teeth, and in the future, effectively eliminate the need for mid-level providers.

# *From the Desk of the Executive Director*

*By: Andy Ozols*
*Executive Director*

## *Well, welcome to 2012!*

Another year has passed and the dental society is looking forward to another great year of community service, member service, lots of socials and working within the world of organized dentistry to protect and enhance the practices of our members.

Our TV commercial will continue to run and with a little help (money-wise) from ADA, we'll be able to remake certain aspects of the commercial to make it specifically relevant to our members throughout our component jurisdiction. New versions will be created for the Santa Clarita and Antelope Valleys, as well as the East San Fernando Valley and the Glendale/Burbank area. Our primary target when selecting channels and airtime will continue to be women age 28-55, who as we all know, are the ones who make most of the dental appointments for their families.

We'll continue to coordinate events with the other LA County dental societies, create events for our new professionals, women dentists and help those older members who are readying to transition into retirement.

One way we will do this is to again hold a "Speed Pairing event in April and hopefully October as well. As you may recall, this is an event that draws both the younger and the older members to an event that aims to pair them up as they seek or offer associateships, partnerships and practice sales. Our goal is to 'keep it in the family', so that SFVDS members hire or sell to other SFVDS members.

For those of you who have volunteered to participate in our annual "Give Kids a Smile" program, please accept the warm and heartfelt thanks of not only the board of directors and me, but also from the children we serve in the program. 2012 marks a milestone for our new SFVDS Foundation, as it will assume the reigns of funding and managing this program.

Lastly, as we are well into the electronic age of communications, please watch your inbox for emails from the society's office and try to participate in the many great socials, programs and events we're planning for 2012! Having the opportunity to socialize, network and learn from your colleagues is one of the greatest membership benefits we can offer.

# General Meetings - Preview

## March 28, 2012

### The Christensen Bottom Line

Speaker: Dr. Gordon Christensen

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

**About the Program:** Dr. Gordon Christensen will present to our membership on his up-to-date "Bottom Line" series, which will include topical and timely information on the whole of dentistry, from new materials and methodology, to human resources in the office and the future of dentistry. You may have missed getting to a Beatles concert or selling your stocks before the economic downturn, but don't miss this icon of dentistry in one of his rare appearances in the San Fernando Valley.

## April 25, 2012

### CA DentalPractice Act and Infection Control

Speaker: Ms. Nancy Andrews, RDH, CDA

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

**About the Program:** Ms. Andrews will bring her lecture on these two required license renewal topics to our April meeting. Nancy has an uncanny ability for making this presentation interesting and at times funny… but certainly not boring. If your license is up for renewal and you have not yet taken this course, you won't want to miss this opportunity to kill two birds with one stone and satisfy both requirements in one sitting.

## General Meeting Review

While the September and October meetings were briefly reviewed in the last issue of Dental Dimensions, we neglected to inform the membership of a very special presentation that took place during the October 19, 2011 General Meeting. During the dinner break at the October 19, 2011 General Meeting at the Airtel Plaza Hotel, Dr. Karin Irani, Chair of the Membership Committee (L), presented Dr. Haleh Shaheedy of Woodland Hills, CA with ADA's Certificate of International Volunteer Service. Dr. Shaheedy was recognized for her exceptional ability to deliver dentistry to children in primitive settings in the jungles of Costa Rica, Nicaragua and Panama, and in supervising USC dental students through the AYUDA program that she brought along to contribute much needed care to these countries' poorest children.


# CARENOW! LA

Dear San Fernando Valley Dental Society,

On behalf of all of us at CareNow, I want to express our heartfelt thanks for making CareNow/LA an enormous success. We served close to 4,000 patients in four days and made a lasting impact in the lives of the most underserved in our community.

Without your support, the clinic would not have been possible. Your generous donation allowed us to deliver almost 6,700 procedures, including dental fillings, extractions and cleanings, eye exams and prescription glasses, pap smears, mammograms, and visits with family doctors, podiatrists, dermatologists, cardiologists and other specialists. We conducted 1,100 HIV tests, provided 1,780 immunizations and connected over 1,000 people needing follow-up care to medical homes in their community – 450 received appointments before leaving the building. We conducted screenings for diabetes, hypertension, and bone density. Our 37 exhibitors provided information and counseling on self-care and prevention, promoting healthier lifestyles among our most vulnerable population. Prevention and follow-up care will be important components of every CareNow event.

I also wanted you to know that cardiologist and Emmy-award winning talk show host Dr. Oz featured our CareNow/LA clinic on his Thanksgiving special which aired on Wednesday, November 23rd. on ABC in Los Angeles. Dr. Oz was also a volunteer at our clinic. I was at the taping of the show, and I can tell you that it is an emotional experience that will make us all proud of what we've accomplished together. I hope that you had an opportunity to view it.

You can view photos from the clinic at http://carenowusa.org/la/diary/index.html and get more details on The Dr. Oz Show at http://www.doctoroz.com/episode/dr-oz-gives-back-largest-free-health-clinic.

We know that you carefully consider how to spend your resources, and I am honored that you chose to be part of CareNow/LA. It is my hope that you will join us as we continue our work in California and beyond.

CareNow could not exist without the commitment and hard work of our sponsors, volunteers, and community partners. Your support makes it possible to provide free, quality care to those in desperate need of our help.

With deep appreciation,

Donald Manelli
President, CareNow

# HOUSE OF DELEGATES

November 11-13
2011

11 delegates, two alternates and your executive director represented the SFVDS at the recent CDA House of Delegates meeting in Sacramento.

Clearly, the biggest and most contentious issue at the House was the "Access to Care" issue, something that your SFVDS delegation has been alarmingly concerned about for more than three years… and three Houses. Because CDA had just completed its "Access to Care" report, the report and its three-phase implementation plan was submitted to the House for approval.

The SFVDS delegation noticed, however, that despite the report's not finding any evidence-based support that the so-called "mid-level" provider could help increase access to care, that conspicuous by its absence, was the lack of a CDA policy statement opposed to the performance of diagnosis and irreversible surgical procedures by non-dentists.

Knowing that an 'access to care' bill was in process in the California State Senate, and fearing for the public's safety, and wanting to maintain the integrity of the dental profession as a 'profession' and not a 'trade' with various tiers of dental care quality, your board and delegation submitted and were successful in marshalling the support of virtually all of the delegates from throughout the state, and passed an amended version of the SFVDS sponsored resolution establishing a very clear-cut CDA policy opposed to anyone other than a dentist performing diagnosis or irreversible surgical procedures! The exact wording of Resolution 24-S1 was:

RESOLVED, THAT QUALITY OF CARE AND PATIENT SAFETY SHALL BE FOREMOST IN ALL CDA EFFORTS RELATED TO THE REDUCTION OF ORAL HEALTH DISPARITIES IN CALIFORNIA, AND BE IT FURTHER

RESOLVED, THAT CDA CONTINUE ITS COMMITMENT TO USING AN EVIDENCE BASED PROCESS IN MAKING RECOMMENDATIONS TO REDUCE ORAL HEALTH DISPARITIES, AND BE IT FURTHER

RESOLVED, THAT AS COMPELLING DATA ON THE QUALITY, SAFETY AND COST EFFECTIVENESS OF IRREVERSIBLE / SURGICAL PROCEDURES (INCLUDING BUT NOT LIMITED TO EXTRATIONS, PULPOTOMIES, CAVITY PREPARATION) PERFORMED BY NON-DENTISTS DOES NOT NOW EXIST, UNTIL SUCH DATA ON WHICH TO BASE A RECOMMENDATION ARE AVAILABLE THAT INDICATE THAT THIS MODEL WILL REDUCE BARRIERS TO CARE, CDA OPPOSES ANY SCOPE OF PRACTICE CHANGES ALLOWING NON-DENTIST PROVIDERS TO PERFORM SUCH PROCEDURES, AND BE IT FURTHER

RESOLVED, THAT THE CALIFORNIA DENTAL ASSOCIATION USE ITS RESOURCES TO PROMOTE THIS POSITION TO ALL PUBLIC, PRIVATE AND GOVERNMENTAL STAKEHOLDERS AND DECISION MAKERS TO THE FULLEST EXTENT.

*(Resolution 24-S1 was substituted for Resolution 24, as submitted by the San Fernando Valley Dental Society, which was amended and subsequently adopted.)*

SFVDS delegates, (l-r) Mark Amundsen, DDS, Mehran Abbassian, DDS, & Virginia Hughson-Otte, DDS, pose for a photo with CA State Senator Bill Emmerson, DDS (with red tie), during the SFVDS Saturday morning caucus.

Former San Francisco Mayor, Art Agnos (standing) was chosen as the installing officer for CDA's 2012 Board of Directors. Mayor Agnos is a regular patient of new CDA President, Dan Davidson, DDS (seated).


SFVDS delegate, Dr. Gerald Gelfand, at one of his many trips to the microphone addressing the House.

You will see various images from the House on these two pages and please, take a moment when you see your board and delegate members to thank them for their relentless efforts to protect the public safety, and preserve the art and science of dentistry against the onslaught of non-dentists thinking they know what is best for the oral health of Californians.

(above) Paul Gosar, DDS, U.S. Congressman from Arizona, addresses SFVDS delegates during a surprise visit to the SFVDS caucus on Saturday.
(below) SFVDS delegates caucus over dinner, where planning the next day's strategy took place.

The SFVDS delegation, seated at the 2011 CDA House of Delegates.

SFVDS delegate, Dr. Virginia Hughson-Otte (center at microphone) addresses the House.

# 3rd Annual Holiday Party

*The SFVDS 3rd Annual Holiday party was again a smashing success. Members, their families and office staff, 217 strong, had a terrific time and all wished the night of December 8, 2011 would never end. As this year marked two significant events in our history: Our 60th anniversary as a free-standing dental society; and the formation of our own non-profit, charitable foundation, both were celebrated and recognized at the party.*

*23 of our society's past presidents attended the party and were recognized for their service with a token of our appreciation, a crystal diamond paperweight commemorating our 60th anniversary. Despite being the most senior past-president in attendance, Dr. William Holve, who was president of the SFVDS in 1961, had no trouble blowing out the candles of our anniversary cake.*

*In addition, to kick off the foundation's fundraising efforts, a silent and live auction took place which raised more than $2,000 for the foundation. This is money that will be used to support the Give Kids a Smile program's materials and supplies needs, as well as our supplies needs in community education and health fair participation.*

*As you can see from the images on these two pages, there was plenty of dancing, casino game playing, holiday photos, good eats and another drawing of gifts (including a flat screen TV, Kindle Fire and a $2000 mobile app to help a member manage their patient relations via smart phones) to mark the holiday season.*

*If you missed 2011's party, mark your calendars for December 6, 2012 to join us this year!*

# No quick fix for dealing with pain

*Written for TDIC by Lisa Fitzpatrick, President/CEO, Ergo Links*

Your colleague tells you about the best ergonomic stool in the dental market. You buy it, but find it does not cure the back pain. Did you just make a $700 investment for nothing?

More employers are looking for a quick fix for dealing with pain associated with work activities. Unfortunately, there is no quick fix. Purchasing products without understanding the root cause of the problem, how to fix the problem or how to properly use the product may only result in a decrease to your pocketbook instead of a decrease in pain.

In order to have a proper ergonomic setup in your office, it is critical to assess all components involved with the setup. The key to reducing an injury in the office or reducing pain is to reduce the risk of injury.

The Variance Reduction Model (see graft) is a standard often used by ergonomists, to provide a guideline for achieving an ergonomic setup in an office setting.
In the model shown, "RISK" sits on the outside of the circular diagram. Practice owners should address all areas collectively to reduce risk of injury for employees as well as themselves.

For example, if you purchase the stool (TASK/EQUIPMENT) but do not have proper training on how to use the stool, it may not work for you. Your ergonomic purchase may actually increase your risk of injury.

Proper position on the stool is dependent upon both proper patient positioning and proper positioning of the dental unit. If you do not have the involvement or support of your staff (PEOPLE) in the office to assist with this setup, the risk of injury increases.

Another area to address when considering purchase of an ergonomic stool is proper patient positioning. What is your policy (PROCEDURE) for positioning the patient? Do you have clear instruction or a diagram showing staff how you want a patient chair positioned for optimal patient positioning? Positioning a patient so both the dentist and staff can reduce risk of repetitive injury to the back and neck is a key function to allowing the ergonomic stool to work to its full potential.


Purchasing an ergonomic stool is what some could consider a fast and simple fix, however it is only a small component of obtaining a complete ergonomic setup in an operatory. If you truly want to invest the time in setting up your office so it is "ergonomically correct," address all components referred to in the Variance Reduction Model to reduce pain, risk of injury, and to reap the full benefit of your effort.

*Lisa Fitzpatrick OTR/CHT,CAE, CEAS is President/CEO of Ergo Links. Lisa provides ergonomic consulting services for dental professionals nationally. She also presents nationally at trade association meetings on injury prevention, biomechanics, and ergonomics in dentistry. For questions about information within this article, please contact Lisa at (877) 399-3746.*

# Dental Groupons & Incentives

## Possible state, federal legal issues as well as ethical ones

*By: Kelly Soderlund, ADA News staff*

They appear in millions of email inboxes every day. Half off Italian cuisine. Pay $10 and get $30 worth of spa services. Even discounted trips are available. Groupon, Living Social, Google Offers, Buy With Me: the number of companies offering discounted food, drinks and activities continues to grow.

The deals are typically pretty simple and self-explanatory. But when the offer is for dental services, it becomes a little trickier.

Some dental offices have signed up with companies like Groupon, a multimillion dollar corporation headquartered in Chicago that offers deals in 45 countries, to offer discounted teeth whitening, X-rays or teeth cleaning. But depending on the state in which the dental service is offered, it might raise legal issues, according to the American Dental Association's legal division.

"In today's economy, the consumer is always looking for, and sometimes even expecting, a good deal when it comes to purchasing products and services. It is no wonder then that many dentists have at least considered utilizing social coupons, such as Groupon, as a means of attracting new patients," said Amy Chase, ADA associate general counsel. "However, unlike other professions for which social coupons may be utilized without fear of violating legal or ethical rules and regulations, those in the dental profession must consider the application of professional conduct laws at both the state and federal level before proceeding."

The ADA legal department wrote a memorandum, which is posted on the Dental Practice Hub at www.ada.org/members/6502.aspx, detailing concerns about dentists offering referral gifts and Groupon-like discounts and providing examples from various state laws on the issue. Offering these types of incentives could violate state or federal laws, legal said.

Many states have regulations that prohibit or restrict the awarding of gifts as a means of soliciting patients or prohibit fee splitting between dentists and a third party. When a dentist offers a service through Groupon, the revenue generated from the promotion is split between the provider and the company.

The federal anti-kickback statute generally prohibits dentists from offering or paying money to encourage a person to refer a patient that may be eligible for services under a federal health care program, including Medicare or Medicaid, according to the memorandum.

## 2012 SFVDS Officers Installed

On December 6, 2011, SFVDS' CDA Trustee, Dr. Alan Stein, dutifully (and with a little humor) installed the 2012 SFVDS officers at Maggiano's Restaurant in Woodland Hills, CA. Witnessing this year's installation were both the outgoing 2011 board of directors and the incoming 2012 board of directors.

Installed were: Dr. Anita Rathee, Editor; Dr. Nita Dixit, President-elect; Dr. Mahrouz Cohen, Treasurer; Dr. Michael Simmons, Secretary; and of course, Dr. Afshin Mazdeyasnan, President

# Periodontal Preparation of the Orthodontic Patient
## A Consideration for the Primary Care Provider

As dentists, we all know the importance of a coordinated, multidiscipline approach to the care of dental patients. Ideally, the general dentist should be the primary care provider who then coordinates the involvement of other dental specialists. Unfortunately, in reality there is frequently a disconnect between the various aspects of a patient's treatment and the dental professionals involved in this care. One of the areas for which this is true is the periodontal preparation of the orthodontic patient. Orthodontics has much to offer in the esthetic improvement of smiles as well as an indispensable adjunctive tool in restorative treatment and other aspects of dental care. When performed on patients who are free of inflammation and active periodontal disease, orthodontics can be accomplished without significant periodontal risk. However, in the presence of inflammation (poor oral hygiene) and other periodontal disorders, orthodontic treatment can pose a significant threat to the health of the periodontium. Therefore, for the safety of our patients, a periodontal evaluation and necessary treatment must be completed prior to engaging in any orthodontic tooth movement and good communication between the patient's dental providers is essential in this process.

During orthodontic treatment, both the orthodontist and the general dentist are responsible to ensure that the optimal care is provided to their patients. If a general dentist does not feel comfortable making the initial periodontal evaluation, diagnosis, and prognosis, then the patient should be referred to the periodontal specialist. It can be a delicate issue between orthodontist, periodontist, and general dentist as to who provides the periodontal evaluation, any needed preparatory periodontal care, and maintenance and monitoring during orthodontic treatment. This should be determined based on the difficulty of the periodontal situation and the expertise of the general dentist. Out of professional courtesy, a discussion of these issues should occur between the general dentist and the orthodontist. However, if the general dentist fails to provide the required preliminary periodontal diagnosis and documentation, the orthodontist may elect to refer the patient directly to a periodontist.

Adult orthodontics is one of the most important applications of this multidisciplinary approach. Adequate periodontal care is usually even more critical for the adult patient undergoing orthodontic treatment. As more and more adults engage in orthodontic treatment, this becomes a more prevalent issue in the practices of the dental professionals involved. Prior to undergoing orthodontic treatment, each adult patient must have a periodontal evaluation. This includes a complete hard and soft tissue evaluation, full periodontal probing, and a periodontal diagnosis and prognosis. In order to safely begin orthodontic movement, the patient (of any age) must be:

- Free of active periodontal disease
- Free of calculus
- Free of inflammation: This is the most significant factor contributing to periodontal tissue destruction with or without orthodontic movement

In addition they must have:

- Adequate bone support, including the resolution of vertical defects when not caused by malalignment of the teeth.
- Adequate soft tissue support: Thin, friable tissue may need reinforcement; however, there is debate regarding the importance of a band of attached tissue (Sanders); The need for (or benefit of) gingival grafts in these circumstances depends also on the direction of tooth movement and should be considered on an individual basis with treatment goals in mind (Wennström).

The presence of these problems during active orthodontic movement will very likely result in an accelerated deterioration of the periodontium. Therefore, orthodontic treatment should be postponed until these problems are resolved. Further consideration should be given to the patient's medical history looking for factors that contribute to periodontal problems. These include smoking habits, diet, bisphosphonate drugs, anti-seizure medications, stress levels, immune deficiencies, diabetes, osteoporosis, certain blood dyscrasias, and polymorphonuclear leukocyte disorders, as well as other diseases and medications. These periodontal and health history findings are then put together with the findings and objectives of the orthodontist and general dentist to make the best and most well-informed decisions about the patient's treatment.

Whereas the decision to treat with orthodontics is much easier in the absence of periodontal problems, the practitioner is often faced with the decision whether or not orthodontics should be performed in the presence of a compromised peri-

By: Dr. Eileen Zierhut

odontal condition such as significant bone loss. The good news is that the presence of bone loss alone is not a reason to exclude a patient from orthodontic treatment. Most studies demonstrate that in the absence of inflammation, orthodontic movement can be accomplished with minimal to no further bone loss or tissue destruction (Eliasson, et al). In fact, in some studies, improvement in the periodontal condition was seen using both traditional braces (Corrente, et al.) and clear aligner therapy (Lee, et al). If there is no active periodontal disease and no inflammation present, a patient can undergo comprehensive orthodontic treatment without any further significant loss of bone. However, tissue thickness and attachment levels need to be addressed and treated as necessary prior to orthodontic treatment to prevent fenestration and dehiscence. Each case should be considered individually and the periodontist brought in to consult as to whether a patient has an adequate level of bone and soft tissue support for this treatment.

Adults are not the only ones who should have periodontal evaluations and treatment prior to orthodontics. Frequently, children have periodontal issues that should be addressed before placing braces or other orthodontic appliances. One of the most prevalent of these is the presence of thin, friable tissue or minimal or absent attached tissue. It is not uncommon for these children or adolescents to require pre-orthodontic grafting, although the pre-orthodontic grafting purely for improving tissue attachment is controversial. If retrusion or reclination of the tooth is planned, gingival grafting may have no benefit (Ngan, et al). However, if any potential for protrusion (or further labial movement) exists, then grafting may be advisable (Wennström, Sanders). Even if no grafting surgery is recommended, it is still recommended that these areas be carefully monitored throughout orthodontic treatment

Once a patient has had a comprehensive periodontal evaluation, communication should occur between the periodontist or general dentist and the orthodontist. This communication should consist of a written periodontal diagnosis, prognosis and treatment plan, as well as provide any radiographs made. If there is not any indication for any preparatory periodontal treatment, a clearance should be provided in writing to the orthodontist stating that it is okay to proceed with orthodontic treatment. Any maintenance recommendations should be included in that letter. If periodontal treatment is recommended, a written statement of that plan should be provided to the orthodontist. Both the orthodontist and the general dentist should follow up to ensure that this treatment has been completed. When periodontal treatment is completed, the orthodontist should be provided (in writing) a summary of treatment completed, the prognosis, a clearance to start orthodontic treatment and when to start, and maintenance recommendations (including frequency of scaling, root planing, and periodontal evaluations for adults or periodontally-compromised adolescent patients). This communication and follow-up should continue throughout active orthodontic treatment and retention to ensure the excellent oral hygiene of the patient, the absence of inflammation, and no exacerbation of any periodontal condition. Prevention of periodontal disease during and after orthodontic treatment is an equally important consideration and is facilitated through this communication.

As seen, good initial and continued communication between dental professionals is critical for excellent orthodontic care. This is especially true for the periodontal preparation and follow-up care of orthodontic patients. When we work together as professionals, we provide a level of service that is deserved by our patients and maximizes our combined abilities and knowledge.

This article is in no way designed to be a comprehensive review of the literature or the periodontal problems or issues that arise with orthodontic care. A very comprehensive review of the literature on this subject by Dr. Norman Sanders can be found in the Journal of the American Dental Association ("Evidence-based Care in Orthodontics and Periodontics: A Review of the Literature").

*SFVDS member, Dr. Eileen Zierhut, is a native of the San Fernando Valley and has practiced in the San Fernando and Santa Clarita Valley communities for 26 years. She has specialized in the field of orthodontics for more than 18 years. Presently, she maintains two private practices in orthodontics.*

*Her bachelor's and dental degrees were earned from UCLA, and her Master of Science degree in Dentistry and Orthodontics specialty were earned from the University of Washington in Seattle. Dr. Zierhut has taught at the UCLA School of Dentistry in both the Fixed Prosthodontics Department and in the Orthodontic Department, as well as at the University of Washington Department of Orthodontics.*

*Dr. Zierhut can be reached at: (818) 703-0162*

# SFVDS Editor is the CAGD "Spirit of Leadership" Awardee


*By: Andy Ozols, Executive Director*

Dr. Anita Rathee is the recipient of the California Academy of General Dentistry (CAGD) Spirit of Leadership Award. This award goes to a member who has consistently contributed time, effort and talent for the betterment of the CAGD, well beyond the terms of office. Aside from serving as CAGD president in 2006, Dr. Rathee has served in all officer capacities for CAGD and continues to remain active in various leadership roles in organized dentistry at the local, state and national levels.

Dr. Rathee has been elected and served as a delegate to the California Dental Association's (CDA) House of Delegates (HOD) three times and will continue to represent the San Fernando Valley Dental Society (SFVDS) for 2012. Prior to officially attending as a delegate, she attended the CDA HOD as a member to learn about the process, as any CDA member is entitled to do. Since becoming editor at the San Fernando Valley Dental Society in 2008, Dr. Rathee has brought a new look and feel to Dental Dimensions, and has provided its readers with informative articles and thought provoking editorials which keep the SFVDS membership well informed on the most current and relevant issues. Dr. Rathee has completed two three-year terms on the AGD national Membership Council and is serving her second three-year term on AGD's national Dental Practice Council. This council deals with many issues that are important to the practice of dentistry, including representing patients' and dentists' interests with insurance carriers, and other third parties. Dr. Rathee has lobbied in Washington D.C. for patients' rights, safety of the public, and many legislative issues affecting the practice of dentistry. She has represented California as a delegate to the AGD HOD for more than 10 years and has chaired three different reference committees.

After graduating from Dalhousie University School of Dentistry in Halifax, Nova Scotia, Canada, Dr. Rathee completed a General Practice Residency at the University of British Columbia in Vancouver and a Master's degree in Public Health Policy and Administration at UCLA. Dr. Rathee continues to pursue post graduate continuing education as she believes this is essential in providing the best patient care. She is a strong proponent of private practice dentistry, the model upon which the United States enjoys the highest standard of dentistry in the world. She feels strongly that only fully trained and licensed dentists can safely perform irreversible surgical procedures. Together with the SFVDS Board of Directors, she has fought to ensure that CDA policy reflect this premise to protect the safety of the public.

The SFVDS is proud to have such an active leader on its board of directors and congratulates her on this well-deserved award.

## Mission Accomplished: ADA's 2011 Annual Session

The 2011 Annual Session in Las Vegas was a great success. Approximately 48,400 continuing education seats were occupied during the four days of the meeting, which equates to 3.07 continuing education courses per dental professional. The unofficial registration numbers from the meeting are as follows: Dentists: 8,767 • Dental Team (Professional Staff): 7,004 • Exhibitors: 6,123 • Friends and Family/Guests: 3,552 • Dental Students: 749 • Others: 859 • Total attendees: 27,05 - To all attendees: thank you for your participation. If you couldn't make it, we hope to see you next year in San Francisco.

### ADPAC Sets New Record

This year, as in years past, ADPAC set up its booth directly across from the ADA House of Delegates main entrance. 2011 set a new threshold, as giving to ADPAC at the Annual Session in Las Vegas eclipsed the $300,000 mark for the first time-reaching a total of $326,426. The prior high giving mark was $299,000 in 2010.

Through the financial contributions of member dentists, ADPAC works to elect congressional candidates who understand the importance of dentistry and the link between oral health and overall health. Regardless of party affiliation, ADPAC supports candidates who will be strong advocates for dentists and the patients they serve.

ADPAC also provides educational opportunities for dentists who are interested in running for public office at local, state and national levels.

### House Balances 2012 Budget

The 2011 ADA House of Delegates approved a 2012 operating budget of $120,139,667 in expenses and $120,512,074 in anticipated revenue and called for a $7 increase in membership dues. National dues, as of Jan. 1, 2012, will be $512. For more details and other Annual Session coverage, please see the ADA News.

### NY dentist Installed as new ADA president

William R. Calnon, D.D.S., who practices general dentistry in Rochester, N.Y., was installed as the 2011-2012 president of the American Dental Association (ADA).

# When is Early Too Early?

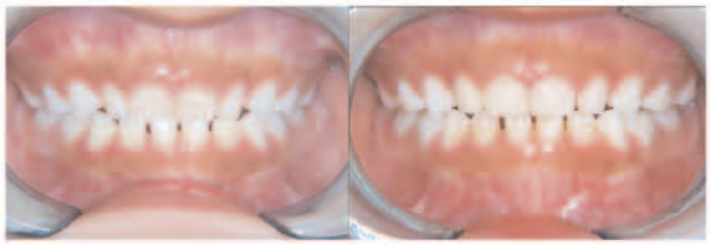
*By: Brian J. Kim, DDS, MSD*

When is early too early to start orthodontic treatment? This is a question that is not only asked by parents, but by my general dental colleagues as well. Many times, the question is framed by this observation – " Every time I refer a patient to Dr._____ (orthodontist), I see "Johnny" at their next appointment with braces or appliances on their teeth, and it doesn't matter if he's 7 or 8 and still in their mixed dentition." Translation: why are orthodontists treating patients this early and is it just to keep the patient in their practice, commit them to treatment, and make money regardless of the patient's true needs?

Early orthodontic treatment has many names – limited treatment, phase I treatment, interceptive orthodontics – but one common thread is that it is a confusing and controversial topic. The most common questions associated with early treatment are 1) is it necessary? 2) At what age is treatment appropriate? 3) When should I, as a dentist, refer a patient to an orthodontist? 4) Does it make the patient undergo unnecessary and more costly treatment?

Let's address the first question – is Phase I treatment necessary? According to published studies, certain types of malocclusions warrant early treatment and certain types do not. The most common type of malocclusion is a Class II bite (a bite with an excessive overjet, overbite or a combination of the two). It was widely believed that starting early treatment to "grow or lengthen" the mandible was a legitimate reason to begin early therapy. However, it is known that the body of the lower jaw cannot be lengthened with orthodontic appliances – only jaw surgery or a surgical distraction procedure can lengthen the jaw beyond its genetically pre-determined size. Studies by the University of North Carolina and the University of Florida determined that 1) patients undergoing Phase I and Phase II treatment for correction of Class II's did not improve the quality of occlusion compared to patients who underwent single treatment only, 2) that two-phases of treatment almost always took significantly longer than single-phase treatment, and 3) early treatment did not reduce the number of patients who needed premolar extractions (Tulloch et al., 2004, Dolce et al., 2007). In short, there is no significant benefit from early treatment of patients with Class II malocclusions. However, things can be complicated if there is a Class II malocclusion with severely protrusive incisors that are prone to trauma and can benefit from Phase I therapy (Wieslander, 1975) and for patients who are undergoing psychological distress from their malocclusion (Jacobson, 1979). Most dentists would agree that these exceptions would warrant early treatment.

Class III malocclusions are a different animal altogether. Studies show that early treatment will promote skeletal changes that can benefit the patients later in life(Ngan et al, 1997, Ngan, 2005, Toffol et al, 2008, and Ngan et al, 2004). Removable appliances even when a patient is in their primary dentition (see Picture 1) can correct an anterior crossbite. More advanced treatment in the mixed dentition with protraction facemask can benefit the patient with changes in maxillary size and length and also direction of growth.



Picture 1: Correction of anterior crossbite in primary dentition with removable appliance

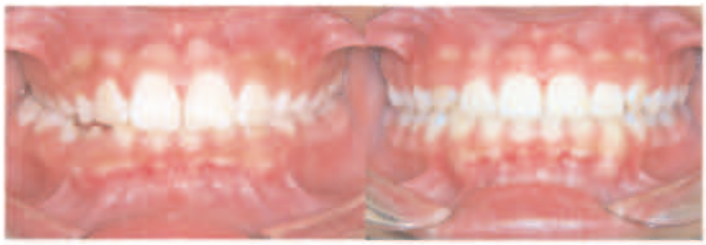
Patients with transverse discrepancies, namely posterior crossbites, have been shown to benefit by early correction (see Pictures 2 and 3). Studies show that a child with a posterior crossbite with a lateral functional shift (a shift that occurs because the mandible is trying to compensate for a constricted maxilla to achieve intercuspation, however pre-

*Continued on page 20*

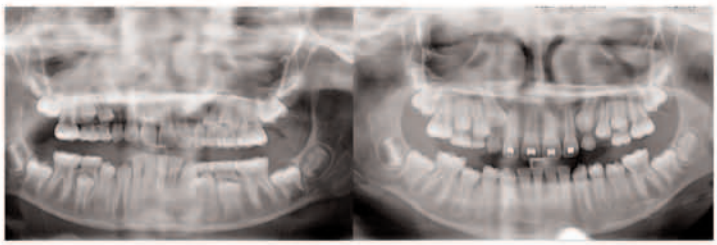
# When is Early Too Early?

*Continued from page 19*

mature contact occurs and the mandible shifts to one side) can develop skeletal and facial asymmetry. This can lead to permanent facial asymmetry even if the maxillary arch is expanded when the patient is older (Pirttiniemi et al, 1990). Also expanding the maxillary arch has been shown to relieve nasal obstruction in children with respiratory problems when they are treated before the age of 12 (Monini et al, 2009).

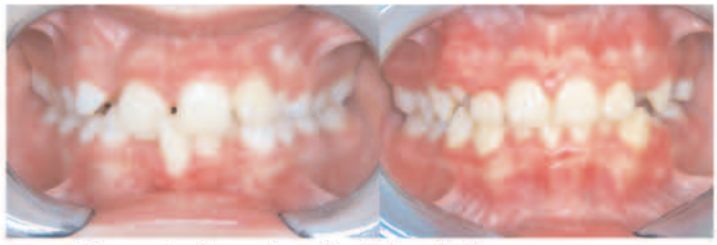


Picture 2: Correction of posterior crossbite



Picture 3: Note impacted maxillary cuspids and improvement after maxillary expansion.

Severe crowding (arch-length discrepancies) will call for early treatment protocols (see Picture 4). Most studies show that moderate dental crowding will resolve with utilization of the "leeway" space, while more severe crowding will necessitate fixed appliances and/or serial extraction (Gianelly, 1994, Foley et al, 1996, Ngan et al, 1999).



Picture 4: Correction of arch-length discrepancy, note the improved position of the lower right incisor and the improved gingival architecture

The second and third questions are obviously related– At what age is treatment appropriate and when should children be referred to an orthodontist ? The American Association of Orthodontists recommends that children have an initial evaluation "no later than age 7." This age is recommended because this is usually when the permanent 1st molars and incisors are erupting. This is considered a good time for an orthodontist to evaluate the eruption process and make sure that no serious issues are arising. It is important to understand that this is a recommendation for an evaluation only, NOT treatment. Chronologic age differs from a child's dental age in many cases.

With that in mind, it is important to understand that the more appropriate time to either refer for an evaluation and/or treat a malocclusion relates directly to the type of malocclusion, as discussed above. Class II malocclusions can wait until the patient has erupted their permanent dentition, usually age 12. The exceptions are if the child is suffering from psycho-social issues because of their overbite or if the protrusion of incisors makes them more prone to trauma. For Class III malocclusions, the earlier the patient is seen, the better. Even in a complete primary dentition, removable appliances can be used to aid in the appropriate development of the usually small, under-developed maxilla. For transverse discrepancies and arch-length discrepancies, early orthodontic treatment can prevent more serious skeletal asymmetries or teeth impactions from occurring.

The fourth question – Does the patient undergo unnecessary and more costly treatment? Hopefully, the discussion of malocclusions and the appropriate treatment response and timing helps answer if the treatment is unnecessary. The cost is more difficult to answer since there are more variables to consider. Almost all orthodontists charge a discounted fee for a second phase of treatment that is significantly less than a single-phase of treatment. The thinking is that a significant portion of the malocclusion has been corrected in Phase I, so Phase II is shorter and "easier" to complete. In total, the Phase I + Phase II fee may be the same or slightly more than the fee charged for single-phase treatment. More complex single-phase treatments (made more complex because early treatment was not done) can

cost more than a moderate malocclusion to correct. An interesting study published in the Journal of Clinical Orthodontics studied the profitability of Phase I/Phase II treatment vs. Single-phase treatment in 93 practices (Haeger et al, 2008). The surprising result was that single-phase treatment was significantly more profitable that two-phase treatment. Haeger states "These findings disprove the conventional wisdom that two-phase treatment is more profitable than single-stage comprehensive treatment. The decision of whether to undertake Phase I treatment should be based not on the financial return to the orthodontic office, but rather on the patient's needs and the parents' wishes. Persuading parents of young children to delay orthodontic treatment and return later for single-stage comprehensive treatment results in a "win-win" situation for both patients and doctors. It shows parents that we are less interested in making money than in timing treatment to maximize the orthodontic benefits and limit the number of appointments and expense. That, in turn, increases the chances that they will select us for future care."

It seems clear that the bottom line is not two-phase vs. single-phase treatment, but what treatment is the best for the individual patient. Armed with evidence-based research, there are now some clearer guidelines that can help us determine that.

**Brian J. Kim, DDS, MSD, graduated from UCLA School of Dentistry in 1999 and completed his orthodontic program at Saint Louis University in 2001. Dr. Kim is currently practicing in Granada Hills, CA as a private practitioner since 2005. He may be reached at: (818) 363-7900, email: info@kimorthodontics.com**

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# Antelope Valley Report

## TEAMWORKS OFFERS HR SERVICES TO THE ANTELOPE VALLEY

*By: Char Brash*

Mat Pentalute of Teamworks shared valuable human resource strategies with dental professionals at a December seminar in the Antelope Valley. With a direct focus on patient service he provided ideas and scenarios on how to exceed the expectations of patients. He stressed that to maintain and grow your practice you must provide your patients with optimal care that insures that you will hold their loyalty in these tough economic times. In addition, it is how you made them feel … not just the perfect filling that keeps them as your biggest fans.

Another area covered in the seminar explained how Teamworks claims they can contain the cost of overhead without decreasing staff. Teamworks puts into place a time system that cuts down on hidden overtime and misused timekeeping. Also, offering extra benefits that cost little or nothing, but mean a lot to staff, such a flex spending for medical and childcare costs will help keep morale high.

The presentation was very interesting, informative and well received by our dental professionals.

**SEMINAR EXIT SURVEY RESULTS**
**Very Informative: 84%**
**Informative: 12%**

## DENTAL BOARD AMENDS INFECTION CONTROL REGULATIONS

By Teresa Pichay, cdacompass.com

The Dental Board has amended the regulations to conform to 2008 CDA guidelines on sterilization and disinfection and with Cal/OSHA regulations. The amended regulations were effective August 20, 2011. The definition of several terms has been broadened and made to conform to CDC's use of the terms. Definitions of new terms, "germicide," "cleaning," and "dental healthcare personnel" (DHCP) have been added. The definition of DHCP include non-paid personnel, contractual personnel, and other persons not directly involved in patient care but potentially exposed to infectious agents.

*Some of the amendments include:*

- Requirement to update periodically the written protocol for proper instrument processing, operatory cleanliness, and management of injuries.
- Requirement to wear personal protective equipment for disinfection, sterilization, and housekeeping procedures involving the use of germicides or handling contaminated items. Eliminating the condition "if contaminated" from the requirement to change and dispose of masks and to clean and disinfect face shield and protective eyewear after each patient treatment.
- Requirement to wear heavy-duty utility gloves when processing contaminated instrument, needles and devices.
- Requirement all germicides be used in accordance with intended use and label.
- Requirement to clean items and surfaces before disinfecting or sterilizing them.
- Requirement for heat-sensitive items to be packaged or wrapped upon completion of the disinfection process.
- Requirement to label package of sterilized items with date of sterilization and sterilizer used if more than one sterilizer is utilized in the practice.

The new regulations must be posted in a dental practice. You can download a copy of the regulation at cdacompass.com.

# Welcome New Members

## CLASSIFIED

Golden opportunity to share space in a stunning, state of the art Tarzana dental office. High visibility, lone standing single story Ventura Blvd. address with ample parking. Lease or buy-in options available. Great for new or retiring general or specialist dentist. Email your interest to view the space and meet the leasehold dentist to: tarzanadental@gmail.com

Rare opportunity to share space in a gorgeous office in the highly sought after West Hills Medical complex (adjacent to West Hills Hospital). Must see! 4 ops can be expanded to 5. Great opportunity for dentist with a nucleus of patients or any Dr. looking to reduce overhead while upgrading to a high end office, fully equipped including digital X-rays. Call 818-348-8898 or email: twila@ratheedds.com.

Benjamin Aaron Freed, DDS
General
20173 Saticoy St.
Canoga Park, CA 91306
818-717-9066
UCLA, 2010

Dean Wright
General
UCLA, 1998

Lena Bedrossian, DDS
4308 W. Magnolia Blvd
Burbank, CA 91505
General
UCLA, 1998

Payam Sanjideh, DDS
Orthodontics
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Northridge, CA 91324
323-938-6137
USC, 2005

Rambod Kamrava, DDS
Endodontics
University of Penn, 2004
USC, 2011

Maria Cecilia F. Guerra, DDS
Oral Surgeon
Centro Escolar University, Philippines

## UPCOMING EVENTS

2012

FEBRUARY: GIVE KIDS A SMILE, ANNUAL COMMUNITY SERVICE PROGRAM SPONSORED BY ADA. SERVING DISADVANTAGED CHILDREN IN LOCATIONS THROUGHOUT THE SAN FERNANDO, SANTA CLARITA AND ANTELOPE VALLEYS DURING THE ENTIRE MONTH. VOLUNTEERS MAY CONTACT THE CENTRAL OFFICE FOR ASSIGNMENTS (818.884.7395)

FEBRUARY 25: SCHLEP AND SHRED. OFFICES OF MEMBER DR. ANDRE KANARKI IN PALMDALE, 9AM-12PM

FEBRUARY 29: DR. SHAHRIAR PARVIZPOUR, 7 CE UNITS ON 'CREATING PREDICTABILITY IN ANTERIOR TOOTH REPLACEMENT & MANAGEMENT OF ESTHETIC COMPLICATIONS' – AIRTEL PLAZA HOTEL, 2PM

MARCH 3: 1) LA KINGS HOCKEY GAME SOCIAL AT STAPLES CENTER
2) BERNADETTE PETERS IN CONCERT (WITH DINNER) AT THE CSUN PERFORMING ARTS CENTER, 6:15 PM

MARCH 7: CPR RECERTIFICATION AT THE CENTRAL OFFICE, 6PM

MARCH 28: GORDON CHRISTENSEN, 7 CE UNITS ON "THE CHRISTENSEN BOTTOM LINE" – AIRTEL PLAZA HOTEL, 2PM

APRIL 19: SOCAL COMPONENTS' NEW PROFESSIONALS MEETING AND NETWORKING OPPORTUNITY. LOCATION TBA

MAY 17: SFVDS NEW PROFESSIONALS SOCIAL. BJS, WOODLAND HILLS

JUNE 7: SPEED PAIRING EVENT THAT MATCHES SFVDS MEMBERS SEEKING ASSOCIATESHIPS, PARTNERSHIPS AND PRACTICES WITH THOSE MEMBERS OFFERING ASSOCIATESHIPS, PARTNERSHIPS AND/OR TO SELL THEIR PRACTICES. BALBOA BILTMORE MULTI-PURPOSE ROOM, ENCINO, 6-9PM

JUNE 9: SFVDS MAGIC MOUNTAIN PICNIC

JUNE, 2012: SCHLEP AND SHRED IN CHATSWORTH. DATE AND TIME TBA

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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