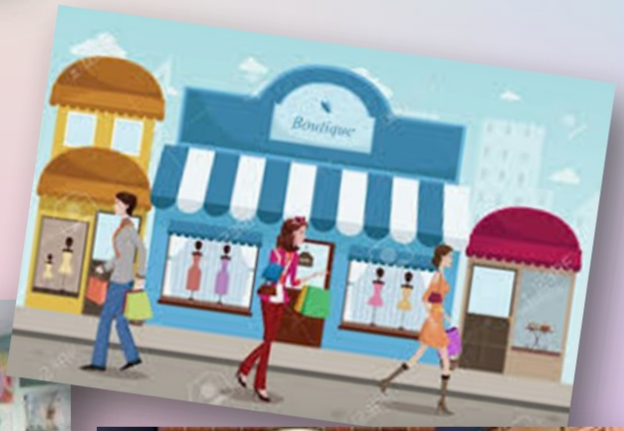
APEX

Publication of the Stanislaus Dental Society

Summer 2021



Content

Articles

Backyard

Published by the Stanislaus Dental Society

Mailing Address:
2401 E. Orangeburg Ave.
Ste. 675-319
Modesto, CA 95355
Physical address:
2339 St. Pauls Way
Modesto
Ph: (209) 522-1530
Fax: (209) 522-9448
Email: sdsdent@thevision.net
Website: stanislausdental.org

Questions or comments about the content of this publication may be directed to:

Editor: Charles Kim, DDS
Editorial Manager: Robin Brown

Your contributions in the form of articles, photos and/or ideas are greatly appreciated. The APEX editorial staff is interested in articles of general membership interest. This can include an accomplishment, interesting hobby, innovative idea, volunteer effort, etc. Please feel free to submit an article or call for an interview. All articles are subject to editorial review.

Presidential Pondering

Dr. Samer Hamza, SDS President

Dear friends and colleagues

The past year has been a true trial for all of us, and yet, our component continues to prosper with your efforts and relationships. It has been an honor to serve as a board member and a president in this last year, which presented several challenges to our communities.

The ADA and CDA, however, continues to support and advocate for us and our teams on multiple levels:

COVID19 vaccination is on top of the list of achievements; the great efforts that lead to our community of professionals receiving the vaccine early on would not have been possible without collaboration and advocacy, and for that type of involvement. Personally, I had been a passive member for thirteen years before I took that step and joined the SDS Board, but I'm so grateful for the opportunity to serve and to get involved in the efforts that take place behind the scenes. I'd like to recognize our ED, Robin, for her continuous support and daily emails and for keeping up with the changing demands this past year. I'd like to encourage every one of you to consider taking a seat as a board member; please contact Dr. Alexandra Hebert or Robin to be part of SDS Board.

Another is the support provided during the pandemic to explain the multiple changes in regulations, PPE requirements with their own set of changes, PPP, SBA loans and grants with the complications arising from the lack of clarity, and much more.

The end of this pandemic is approaching, and now we can sense the light at the end of this long tunnel, especially after the recently published marketing study referenced ADA email, projecting the dental expenditure, which was about 15.57 billion dollars in 2020, to rise to 30.59 billion in 2027. Let's take a moment to appreciate our professional community, our staff, our patients, and our families, and let this year be a lesson we walk out of with much reflection, wisdom, and faith that we will adapt, persevere, and prosper. Let us spread that optimism through our communities.

As we are preparing for a well-earned and deserved summer with a functional economy, I'm grateful for the involvement of all of our members and so happy to see so many new members join our component. Those of you new to Stanislaus Dental, I welcome every single one and hope that your journey is as enriching as mine has been, and to our valued Board members, thank you so much; your efforts are noticed and appreciated, and please continue to enrich this component and explore new ways to get involved in our professional community.

Respectfully,

Samer Hamza

2021SDS Officers

President
Samer Hamza, DDS

President-Elect
Eric Dixon, DDS

Treasurer
David Walls, DDS

Secretary
Alexandra Hebert, DDS

Editor
Charles Kim, DDS

Trustee
Matt Swatman, DDS

Immediate Past President
Victor Pak, DDS

2021 Committee Chairs

Bylaws / Ethics
Matt Swatman, DDS, MSD

Community Health
Gloria Fass, DDS

Continuing Education
Jeff Barton, DDS

Forensic Odontology
& State Emergency
Garry L. Found, DDS

Media Relations
Elizabeth Demichelis, DDS

Mediation
Kenneth Thompson, DDS

Membership
Alexandra Hebert, DDS

Program
Eric Dixon, DDS

Well-Being
Michael Shaw, MD, DDS

Quick Contacts

ADA. . . . (800) 621-8099
CDA. . . . (800) 232-7645
TDIC . . . (800) 733-0634
TDSC . . .(800) 253-1223
Denti-Cal Referral
…….(800) 322-6384

Nothing Has Changed

Author unknown

Take your mask off. Nothing has changed.

Welcome to our world. Nothing has changed.

Today. A woman asked if I would hold her hand during surgery.... "of course," I told her.

A few days ago. "I'm sorry I'm telling you more than you probably want to know." What did I tell her? "Thank you for letting me understand your anxiety."

Nothing has changed.

Excuse me while we dive headfirst into the one place every human being is telling you to mask up.

Why?

Because they're in pain. Because they have goals, wants, needs. Because they're self-conscious.... why?

Because his wife died of cancer two years ago after caring for her for so long and now he's ready to date.

Because her kids are out of braces that took 4 years for her to pay off. By herself. And now she wants a perfect smile.

Because his daughter is getting married this year.

Because her drug addiction destroyed her teeth. Now 2 years sober; she's ready for a whole new beginning.

Nothing has changed.

Every. Single. Day. We will not treat you like you have a plague. We will not judge you. We will ask you to remove your mask. We will ask to see inside of one of the biggest body insecurities people have. We will see your anxiety. We will see your fears. We will see your past. WE WILL SEE YOU.

And we're still here to help you. Nothing has changed.

We may not be the "Heroes" everyone is talking about. But we're here too. Diving headfirst into the one body part that is spreading this disease. We're changing lives too. We're saving lives too. We're risking our lives too.

This is what we went to school for. This is what we were born to do. Nothing has changed. ❤️

Is it safe to…?

Excerpt from UCSF School of Medicine Grand Rounds

by Charles C. Kim DDS, SDS Editor

Although it makes me feel like I am back in a classroom in college or a dental school, I've been periodically watching UCSF School of Medicine Grands Rounds throughout the pandemic. I preferred this over any news outlet only because of its evidence-based nature. This particular excerpt is from the latest one that I've watched. I thought it would be helpful to give you all the key takeaways from it. I have put an address to the video below in case you want to spend your time watching it from start to finish.

To summarize the main points, things are not going well at all in terms of the number of Covid-19 cases and mortality levels World Wide including surges in India where B.1.1.7, B.1.617, E484Q, L452R variants are prevalent. India shut down the export of vaccinations to use all manufactured vaccines for domestic usage which put many of the countries waiting for India to make vaccines in limbo.

The vaccines are helping in suppressing the Covid-19 which led to the US supporting Compulsory Licensing – waiver of intellectual property for public health emergencies. More transmission of Covid-19 directly means there will be more variants, so hopefully, the availability of vaccines happens throughout the world faster. Sometimes depending on the types of variants in a particular area of the world made them have to switch the type of vaccine they were deploying. For example, South Africa where B531 is the predominant variant at 90% has to seek other types of vaccine that are more effective compared to Astra Zeneca which doesn't work as well on the B531 variant.

Meanwhile, here in the US things are looking more positive especially in California. At this rate by June 15, all businesses with safety modifications will be open in California. The projections are leading us to reach what we call a regional/localized herd immunity is achievable around September 1, 2021.

We do have to understand the importance of B cell and/or T cell's role in immune responses. Many of the B cell and/or T cell depleting drug has a very negative effect on getting people to have immunity with vaccines (notably, Rituximab and glucocorticoids/prednisone 10mg or more). It would be best for people to receive vaccines before beginning treatment with immune-suppressing agents. Of course like all things, the risk/benefits of vaccine first vs risk/benefits of starting immune-suppressing agents before vaccines depend on each patient case and the overall risks of Covid-19 in the surrounding environment has to be determined between the health care professional and the patient.

I am excited that things are returning to the new normal. Hopefully, all countries throughout the world get to return to normal sooner than later.

UCSF School of Medicine. (2021, May 6). The State of the Pandemic, and COVID-19 and Immunosuppressed Patients [Video]. YouTube. https://www.youtube.com/watch?v=q7FY91kuBdM

The objective of the Stanislaus Dental Society shall be:

To encourage the improvement of the oral health of the public,
To promotive the art and science of dentistry,
To encourage the maintenance of high standards of professional competence and practice,
And to represent the interests of the members of the dental profession and the public which it serves.

Robin's Relevant Remarks

SDS Executive Director

Well...we're still here! We have adapted and persevered. Zoom meetings have allowed SDS to continue to bring you CE courses such as the January legally-required courses and the recent Symposium. Fortunately, technology worked in our favor, which isn't always the case, and the courses went off without a hitch and with great attendance. Being a party of one in the SDS office can be a little harrowing from time to time when you're hoping all your spinning plates won't all come crashing down to the ground at once! Thank you for your patience if you experienced any glitches. We are also grateful for the support of our vendors (listed on page 14) who support our virtual endeavors despite not being able to entertain the usual 'meet and greet' that in-person courses provide.

As with other dental components in California, the SDS board is looking to introduce in-person meetings and events. A survey recently sent out to SDS members asking their interest in attending a combination Staff Appreciation/Night at the Nuts event was answered with a YES by a majority of those who responded. A board decision was then made to hold an outdoor event with all the components of a regular Staff Appreciation event combined with the fun and fireworks of a Nuts game and include children! We are reserving both party decks so there will be plenty of room to spread out and this year we are including wine/beer in the decks as well as the raffle opportunity we always include in previous Staff Appreciation events. We are looking forward to an opportunity for some semblance of normality and the chance to meet up again with friends we haven't seen in awhile. We are hoping SDS members and their dental team, along with their children, will join us for a fun evening of fellowship!

As always, I'm grateful to be part of a profession where this is happening….

...SDS members (and team) preserving the dental health of the earth's population, one patient at a time!

Good to know…. Developmentally disabled patient care

Recently, the SDS office sent out a request for care for a 19-year-old developmentally disabled young man with autism. I received some compassionate responses from several SDS members who were at the least willing to screen this young man. The following SDS members may be local resources for you in the future. Several also advised UCSF for complicated cases.

Dr. Lance Bautista-pedo-523-5437 (children only)

Sami Smiles Pediatric Dentistry & Orthodontics-549-2400 (children only)

Dr. Gurneet Chahal—Oakdale Kids Dentist & Orthodontics-322-3174 (children only)

Hebert Family Dentistry-527-5455-limited care

Dr. Brian Hutto—oral surgery issues-522-5238

Salida Surgery Center—543-9299 (Children only. Takes Denti-Cal/has anesthesiologist)

The following was referred by one of our members. This is a corporate office but they are willing to treat developmentally disabled patients who age out and took care of this young man.

Children's Choice Dental, 2057 Tully Road, Modesto 353-3300 treats mostly children, but they provide sedation and hospital dentistry for handicapped patients of any age.

Thank you to those who responded with a generous heart.

ISSN: 2641-1962 DOI: 10.33552/OJDOH.2021.04.000594
Online Journal of Dentistry & Oral Health
Iris Publishers

Research Article

Use of A Novel Intraoral Device to Promote Nasal Breathing Reduces Risk of Tooth Decay in Children

Toshi Hart, DDS*

Toshi Hart DDS, Inc, 4213 Dale Rd B-6, Modesto, CA 95356, United States.

***Corresponding author:** Toshi Hart, DDS, Toshi Hart DDS, Inc, 4213 Dale Rd B-6, Modesto, CA 95356, United States.

Received Date: April 22, 2021

Published Date: May 18, 2021

Introduction

Introduction: Tooth decay is a major issue for children, particularly disadvantaging those from low socioeconomic backgrounds, and has both physical and psychological repercussions. Treatment is expensive and unavailable for many children, making prevention essential. Mouth-breathing dries the mouth, reduces saliva flow rate and increases the presence of cariogenic bacteria that cause tooth decay. It is hypothesized that use of an intraoral device to promote nasal breathing may reduce the presence of tooth decay in children.

Methods: In a retrospective chart analysis of 80 children aged 4-12, children who were using an intraoral device (Vivos Guide, Vivos Therapeutics, Inc.) to promote nasal breathing were compared against those who had not used the device (control group). The device was worn passively at night and children were also asked to complete 2-4 hours of 'active wear' during the day, doing functional exercises with the tongue to promote nasal breathing. The presence of tooth decay was evaluated at six and twelve months and compared between the two groups.

Results: The subjects who used the intraoral device averaged 0.3 instances of tooth decay at six months and 0.4 instances at twelve months. Those who did not averaged 1.28 instances at six months and 0.95 at twelve months.

Discussion: Use of an intraoral device to promote nasal breathing significantly reduced the risk of tooth decay by 76.4% after six months ($p = 0.0004$) and by 57.9% ($p = 0.05$) after twelve months. The device was well-tolerated by the subjects.

Conclusion: The study demonstrates use of an intraoral device to promote nasal breathing can reduce tooth decay and provides a novel method to supplement other means of prevention.

Keywords: Prevention of tooth decay; intraoral device; Vivos Guide; Nasal breathing

Introduction

Prevalence

Tooth decay in children is a painful, costly and widespread oral health problem. Overall, it is estimated that 3-6% of children in theUnited States have evidence of tooth decay [1], and the prevalenceis significantly higher in socially disadvantaged communities [2,3].

Consequences for children

Tooth decay has wide-ranging consequences for children. Cavities cause pain and discomfort within the mouth, influencing eating habits. In small children, tooth decay has been linked to reduced growth and weight gain [4]. Physically, poor oral health is associated with acute and chronic infections, abscesses, poor sleep, and gastrointestinal issues [5]. There is also a significant psychological component to oral health in children. Early tooth decay and cavities has been shown to impact self-esteem, feelings of well-being and socialization [6]. When causing tooth loss, decay has been linked to school absenteeism, inability to concentrate in school, failure to thrive, slowed speech development and lower self-esteem [7-9].

Contributing factors to childhood tooth decay

Research has identified the main contributing factors to childhood tooth decay, including the presence of cariogenic bacteria, diet, oral hygiene practices and the protective role of saliva. A primary culprit in the formation of tooth decay in children is the cariogenic bacteria Streptococcus mutans (SM). Within the mouth, this bacteria metabolizes sugars and produces acid which strips the enamel from teeth [10]. Research shows a clear link between SM and dental caries; in one study, children were five times more likelyto have caries if they had a high level of SM found in the mouth.

S. mutans metabolizes sugars to create acidic byproducts, meaning diet plays a major role in tooth decay among children. Studies have shown a link between consumption of fermentable carbohydrates and tooth decay [11] and research indicates that the prevalence of dental caries drops in communities with lower sugar consumption [12]. Links have also been found between bottle habits, particularly sleeping with a bottle, are associated with toothdecay, with the theory that

repeated, long-term exposure to sugars in the mouth promotes decay [13-15]. Proper oral hygiene can mitigate the effects of cariogenic bacteria and dietary influences. Unfortunately, not all children are educated in or have access to proper oral hygiene measures. Studies show that the socioeconomic status and education levels of caregivers has a substantial effect on the oral hygiene of children [16,17]. Consequently, research has shown children raised in low socioeconomic situations are twice as likely to have tooth decay as wealthier peers [18].

Saliva has a protective role to play in the mouth. It's the primary defense system against tooth decay. The saliva flow rate and properties of saliva are shown to prevent tooth decay [19]. Sugary foods at night, when the salivary flow rate is low, may be particularly dangerous in the formation of childhood tooth decay [20]. Mouth-breathing is associated with a dryer mouth, reducing the presence of saliva and its protective effects.

Treatment

Unfortunately, many children with pediatric tooth decay go untreated. Clinical management among children is often expensive because it necessitates the use of general anesthesia, with all the costs and associated risks [21]. In one study, researchers compared the effectiveness of three different treatment techniques among children. More than 1,000 children with tooth decay were randomized to either.

a) conservative care where they were given preventative recommendations about diet and oral hygiene,

b) standard 'drill and fill' techniques where the tooth decay is drilled out and replaced with a filling plus the same preventative recommendations, and

c) a less-invasive placement of a stainless-steel crown over the decayed area with the same preventative recommendations. The authors found no significant difference in outcomes between these three treatment methods [22].

Mouth breathing as a risk factor

Children who breath primarily through their mouth dry the mouth and reduce the presence of saliva. Mouth breathing is associated with higher levels of plaque and gingivitis. Studies have shown mouth breathing causes lower salivary flow rate and lower saliva pH. Perhaps most importantly, research indicates higher levels of SM bacteria in the mouth for mouth-breathers than for nose-breathers [23].

Study purpose and hypothesis

It is clear preventative measures are preferable to having to treat tooth decay among children. However, despite widespread teaching of oral hygiene techniques, fluoridation of water supplies and toothpastes and other preventative measures, childhood tooth decay continues to be a major problem. This study aims to evaluate the ability of an intraoral device designed to convert children from mouth-breathing to nose-breathing to reduce the risk of tooth decay. If the device is able to prevent mouth-breathing, it may be able to increase salivary factors, reduce the presence of cariogenic bacteria and, ultimately, reduce childhood tooth decay. The study will be conducted in an area with unfluoridated water supplies (indicating children at higher risk for tooth decay). Children who are in need of the intraoral positioner for jaw alignment, closed airways, snoring, bedwetting behaviors, or other reasons will also be monitored for tooth decay to determine whether an intraoral positioning device can reduce the risk of tooth decay.

Methods

This study is a retrospective chart analysis of 80 children, aged 4-12, who received treatment at a single dental clinic. Half of the patients (40) had been given an intraoral device to treat sleep- disordered breathing or other oral issues, while half (40) had not.

Preventative education

Both groups received the same information on measures to prevent tooth decay, including proper oral hygiene and dietary considerations.

Intraoral device

The intraoral device (Vivos Guide, Vivos Therapeutics, Inc.) is a flexible, mono-block, BPA-free polymer plastic device designed to reposition the jaw and seal the lips to convert mouth-breathing children to nose-breathing. The device is worn by the children throughout the night as they sleep for 8-10 hours of passive wear each day. There is also an active use component where the child actively conducts myofunctional exercises of the mouth with the device in for 2-4 hours during the day. The tongue is raised to the roof of the mouth, effectively closing the lips and retraining the body to breathe through the nose.

Study outcomes

Both children in the test group and the control group were evaluated for the formation of tooth decay. If tooth decay was found, it was treated. Then children were followed up at six and twelve months. If found at six months, tooth decay was again treated (so the check at twelve months measured new decay that formed between 6-12 months).

Results

Demographics

There was no significant difference between the control and test groups in either age or gender. The average age for both groups was 8.38 years of age (STD of 1.97 in the test group and 1.90 in the control group). The control group had 20 male and 20 female children, while the test group had 19 male and 21 female children

Table 1: Average Instances of Tooth Decay Per Child at 6 Months of Device Use.

	Test	Control
Average Instances of Tooth Decay	0.3 per child (SD 0.72)	1.28 per child (SD 1.61)
Risk Reduction	76.40%	

Table 2: Average Instances of Tooth Decay Per Child at 12 Months of Device Use.

	Test	Control
Average Instances of Tooth Decay	0.4 per child (SD 0.87)	1.28 per child (SD 1.90)
Risk Reduction	57.90%	

At six months, subjects in the test group averaged 0.3 instances of tooth decay on examination, ranging from 0 to a maximum of 3 areas of tooth decay found. The control group averaged 1.28 instances with a range from 0 to a maximum of 6 areas of tooth decay per child. At twelve months, subjects in the test group averaged 0.4 instances of tooth decay, ranging from 0 to 4 areas found. The control group averaged 0.95 instances of tooth decay, ranging from 0 to 9 per child (Table 1,2). The device was well- tolerated by children, with no reported complaints from children or their caregivers.

Discussion

The data indicate a statistically significant reduction in the risk of development of tooth decay at both six and twelve months when using an intraoral device to promote nasal breathing. At six months, risk of tooth decay was reduced by 76.4% ($p = 0.0004$) and at twelve months the risk reduction was 57.9% ($p = 0.05$).

An unpaired (independent) two-sample t-test was used for statistical analysis to compare the means of the control and treatment groups. The null hypothesis that there was no significant difference between the test groups was rejected and the difference in means was deemed statistically significant at a 95% confidence level.

While the mechanism of action was not investigated in this study, there are two possibilities that appear likely based on previous research and the results obtained in this study. The first is children were converted from mouth-breathing to nose-breathing. This increased the saliva levels in the mouth, increasing the pH of the mouth and decreasing the prevalence of cariogenic bacteria causing decay. It is also possible that converting patients to nose- breathing increased levels of nitric oxide in the nasal cavities and positively affected the oral environment to reduce cariogenic bacteria levels.

Conclusion

Use of an intraoral device promoting nasal breathing among children showed significant reductions in the risk of tooth decay among children aged 4-12 after six and twelve months of use.Additional research into the mechanism of action and whether these protective effects are maintained after use of the device is discontinued is warranted. This research demonstrates a novel technique for preventing tooth decay among children.

Acknowledgement

The author wishes to thank and acknowledge Aaron B. Stevens BSPE, PES.

Conflicts of Interest

The author declares no conflicts of interest.

References

1. Horowitz HS (1998) Research issues in early childhood caries. Community Dent Oral Epidemiol 26(1 Suppl): 67-81.
2. Ismail AI, Lim S, Sohn W, Willem JM (2008) Determinants of early childhood caries in low-income African American young children. Pediatr Dent 30(4): 289-296.
3. Vachirarojpisan T, Shinada K, Kawaguchi Y, Laungwechakan P, Somkote T, et al. (2004) Early childhood caries in children aged 6-19 months. Community Dent Oral Epidemiol 32 (2):133-142.
4. Petersen PE, Estupinan Day S, Ndiaye C (2005) WHO's action for continuous improvement in oral health. Bull World Health Organ 83: 642.
5. Nunn ME, Braunstein NS, Krall Kaye EA, Dietrich T, Garcia RI, et al. (2009) Healthy eating index is a predictor of early childhood caries. J Dent Res 88(4): 361-366
6. Locker D (1977) Concepts of oral health, disease and the quality of life. In: Slade GD, editor. Measuring oral health and quality of life. Chapel Hill: University of North Carolina, Dental Ecology pp: 11-23.
7. Acs G, Lodolini G, Kaminsky S, Cisneros GJ (1992) Effect of nursing caries on body weight in a pediatric population. Pediatr Dent 14: 302-305
8. Acs G, Shulman R, Ng MW, Chussid S (1999) The effect of dental rehabilitation on the body weight of children with early childhood caries. Pediatr Dent 21: 109-113.
9. Acs G, Lodolini G, Shulman R, Chussid S (1998) The effect of dental rehabilitation on the body weight of children with failure to thrive: Case reports. Compend Contin Educ Dent 19: 164-168.
10. Senesombath S, Nakornchai S, Banditsing P, Lexomboon D (2010) Early childhood caries and related factors in Vientiane, Lao PDR. Southeast Asian J Trop Med Public Health 41 (3): 717-725.

11.Paglia L, Scaglioni S, Torchia V, De Cosmi V, Moretti M, et al. (2016) Familial and dietary risk factors in early childhood caries. Eur J Paediatr Dent 17(2): 93-99.

12.(2003) Diet, nutrition and the prevention of chronic diseases. (1-149). World Health Organ Tech Rep Ser 916: i–vii. backcover.

13.Azevedo TD, Bezerra AC, de Toledo OA (2005) Feeding habits and severe early childhood caries in Brazilian preschool children. Pediatr Dent 27: 28-33.

14.Hallett KB, O'Rourke PK (2002) Early childhood caries and infant feeding practice. Community Dent Health 19: 237-242.

15.Oulis CJ, Berdouses ED, Vadiakas G, Lygidakis NA (1999) Feeding practices of Greek children with and without nursing caries. Pediatr Dent 21: 409-416.

16.Ramos Gomez FJ, Weintraub JA, Gansky SA, Hoover CI, Featherstone JD (2002) Bacterial, behavioral and environmental factors associated with early childhood caries. J Clin Pediatr Dent 26(2): 165-173.

17.Aida J, Ando Y, Aoyama H, Tango T, Morita M (2006) An ecological study on the association of public dental health activities and sociodemographic characteristics with caries prevalence in Japanese 3-year-old children. Caries Res 40(6): 466-472.

18.Gaur S, Nayak R (2011) Underweight in low socioeconomic status preschool children with severe early childhood caries. J Indian Soc Pedod Prev Dent 29(4): 305-309.

19. Jiang S, Gao X, Jin L, Lo EC (2016) Salivary microbiome diversity in caries-free and caries-affected children. Int J Mol Sci 17(12): 1978.

20. Silva PV, Troiano JA, Nakamune AC, Pessan JP, Antoniali C (2016) Increased activity of the antioxidants systems modulate the oxidative stress in saliva of toddlers with early childhood caries. Arch Oral Biol 70: 62-66.

21.Duangthip D, Jiang M, Chu CH, Lo EC (2016) Restorative approaches to treat dentin caries in preschool children: systematic review. Eur J Paediatr Dent 17(2): 113-121.

22.NP Innes, JE Clarkson, GVA Douglas, V Ryan, N Wilson, et al. (2019) Child Caries Management: A Randomized Controlled Trial in Dental Practice. J Dent Res 99(1): 36-43.

23.AlAwadi R, AlCasey M (2013) Oral health status, salivary physical properties and salivary Mutans Steptococci among a group of mouth breathing patients in comparison to nose breathing. J Bagh College Dentistry 25(1).

Citation: Toshi Hart. Use of A Novel Intraoral Device to Promote Nasal Breathing Reduces Risk of Tooth Decay in Children. On J Dent & Oral Health. 4(4): 2021. OJDOH.MS.ID.000594. DOI: 10.33552/OJDOH.2021.04.000594.

California Dental Association
1201 K Street, 14th Floor, Sacramento, CA 95814
800.232.7645 cda.org

CDA Board of Trustees Meeting Summary
June 11-12, 2021

Organizational Update: The board received an update from executive director Peter DuBois, including membership renewal trends; results from CDA Presents Spring; an overview of the new digital ad campaign (https://oralhealthequityforca.com), highlighting state budget funding priorities; the $1 million grant executed by the California Department of Public Health aimed at increasing vaccine confidence amongst dental team members and support and training for dental offices wishing to provide COVID vaccines; advocacy and political updates; and structural changes related to the membership, component relations, marketing and communications teams.

Additionally, the executive director updated the board on the state of the organization, including recent and upcoming innovations related to core member service areas such as replacement of the existing association management system (Aptify); new educational offerings; and enhancement of practice support resources. While an extraordinary amount of work on the initiatives outlined in the management objectives has taken place this year, some projected timelines may still need to be adjusted. As such, the 2021 management objectives will be discussed over the next couple of board meetings with necessary adjustments to be presented for the board's consideration in August.

Association Management Software Solution: Earlier this year, CDA began searching for a solution to replace the current association management system, Aptify, with an off-the-shelf solution that can effectively serve members, create efficiencies in CDA business process and maintenance costs, and replace CompPlus with an effective software solution for the 32 dental societies. The selection process has been completed and a company, Fonteva, was selected. Fonteva's product operates on the Salesforce platform, which will be more effective for membership data management needs and significantly less costly to operate.

The board approved funding to support the implementation of the new software for CDA and the components.

Education Update: The board received an update regarding the work of the education workgroup, which has meet twice. The scope of the workgroup is to reinforce education as a core service, increasing engagement opportunities, and to ensure dues value for all members. This is being accomplished by expanding current educational offerings in an effort to recognize the diverse membership and the way in which they learn, engage and connect with CDA and each other. The workgroup has begun assessing virtual programs that would appeal to a wide range of members and will be prioritizing those ideas and formulating a detailed plan to assess adoption, feasibility and engagement.

The board was informed that the new eLearning library, CDA Presents 360, went live on April 26. Understanding that new product lines take time to grow and mature, CDA will be tracking trends and utilization rates to help determine its success and will be sharing the results with the board.

Additionally, the dental office assisting program made significant strides recently – CDA partnered with two Bay Area cohorts to offer the program and will be launching two more in San Diego in the coming months. The goal is to help students secure full-time work at the completion of externships, by expanding cohorts across the state. CDA is also exploring ways to utilize the CDA Presents 360 platform to offer virtual training for rural areas.

CDA Presents Fall (San Francisco): The board approved holding an in-person CDA Presents Fall meeting, while making virtual options available for those who cannot attend in person. The meeting will be held September 9-11 at Moscone Center.

Practice Support Update: The board received an update regarding practice support initiatives, including the formation of the practice support workgroup. The workgroup has meet once, reviewing the scope of work which entails advising on development of additional practice support services to further support members with business acumen, practice services and compliance in the current environment. The workgroups next meeting is scheduled for June 16.

California Dental Association
1201 K Street, 14th Floor, Sacramento, CA 95814
800.232.7645 cda.org

Financial Update: The board received a financial update, which reviewed membership dues, non-dues revenue sources, total reserves and overall budget as of May 31, 2021.

Additionally, the board was presented with the 2020 consolidated audit results, which was conducted by Crowe LLP.

ADA House of Delegates: In 2020, the board approved a number of recommendations in response to COVID-19 and its financial impact on the organization. One of those recommendations was to attend the ADA House of Delegates virtually in 2020 and 2021. Being that ADA is not providing a virtual option, the board approved funding for the delegation to attend the meeting in person.

Referendum on Flavored Tobacco Ban: In August 2020, SB 793 was passed banning all flavors in tobacco and nicotine products such as cigars and electronic cigarettes. Following the signing of the bill, the tobacco industry successfully qualified a referendum measure against the legislation, putting it on hold until the November 2022 general election.

The board approved endorsing the opposition campaign, known as the Campaign to Protect California Kids. An endorsement will not include an obligation to contribute financially to the campaign. However, CDA will join other health care industry leaders such as the American Academy of Pediatrics California, American Heart Association, American Lung Association, American Cancer Society, Kaiser Permanente and the Tobacco Free Kids Action Fund.

Board of Component Representatives Discussion: The board participated in small group discussions focused on the proposed board of component representatives (BCR), including sharing of best practices at the component level – one of the many types of discussions that will be held by the BCR should the board composition recommendation be approved.

The board took additional actions of an operational nature, which are reflected on the meeting agenda and will be recorded in the official minutes.

Good to know.... Employment needs

Since the inclusion of several Facebook employment group sites, the SDS office has no longer received any resumes. Those seeking to fill employee positions or job seekers posting their availability have been utilizing the options below:

Facebook has several employment group sites where job needs can be posted:

- Dental Staff of Stanislaus County and Beyond
- Dental Staff of San Joaquin County
- Modesto Area Jobs Board

Other alternatives for those seeking prospective employees:

- Gurnick Academy
- Dental Assisting Institute
- CDA Career Center

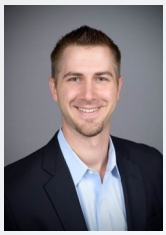
The following sponsors provide financial support to the Stanislaus Dental Society's continuing education course program which helps us bring quality speakers for your knowledge enrichment. Please support their generosity by asking them about what they can do to help your practice!

3M Science. Applied to Life.™ **Matt White** mwhite4@mmm.com	BencoDental™ We deliver success smile after smile® **Jose Virrueta** jvirrueta@benco.com	BIOCLEAR **David Cook** davidcook@bioclearmatrix.com
Carestream DENTAL **Emily Robb** Emily.Robb@csdental.com	Crest + Oral-B **Stephenie Gains** gans.si@pg.com	DMG AMERICA **Hillary Morris** hmorris@dmg-america.com
KETTENBACH DENTAL Simply intelligent **Kelly Meagan** k.meagan@kettenbachusa.com	Merrill Lynch Bank of America Corporation **Shaun Joseph** shaun.joseph@ml.com	NSK CREATE IT. **Katie Capalungan** k.Capalungan@nskdental.com
ORASCOPTIC™ SUPERIOR VISUALIZATION **Kayla Christensen** Kayla.Christensen@orascoptic.com	SHOFU Shofu Dental Corporation **Christina Diaz** cdiaz@shofu.com	straumann® simply doing more℠ **Julie Sutton** julie.sutton@straumann.com
ZD ZEST DENTAL SOLUTIONS® **Len Conner** len.conner@zestdent.com	cda®	tdic®

Stanislaus Dental Society

General Membership Meeting

October 21, 2021



6:00pm-Social / 6:45pm-Dinner & Speaker

Papapolloni's Bistro Ristorante
2501 McHenry Ave. Modesto

Advances in Digital Dentistry

Speaker: Hunter Dawson, DMD

Dr. Dawson is from the Piedmont Triad growing up east of Greensboro in Whitsett, NC. He attended NC State University where he earned his degree in B.S. in Biology. Dr. Dawson pursued his goal of becoming a dentist at the University of Louisville. After graduating in 2014, he continued his education by completing a Full Time Advanced Education Residency in Prosthodontics at the University of Louisville. Dr. Dawson has multiple publications in areas of complex implant rehabilitations using digital workflows and guided implant surgery. He is an adjunct associate professor at the University of North Carolina Chapel Hill and has lectured internationally on full mouth implant rehabilitation using digital workflows.

PROGRAM DESCRIPTION

Digital dentistry is changing the way general dentists, surgeons, and laboratory technicians interact with one another and plan treatment. Incorporation of CAD/CAM technology for restorative solutions can help deliver natural-looking, esthetic results for patients. Connectivity between current CAD/CAM scanners and intra-oral scanners allows the restorative doctor to take a digital impression, make any occlusal modifications chairside, and send the file to the laboratory to design the restoration. This program will review recent advances in digital technology; the increasing importance of the partnership between the dentist and the lab; the differences between various materials used for copings and abutments; surgical planning software for implant placement and restoration; and the many benefits available to the treatment team when using digital dentistry solutions.

Website Accessibility – Three Key Components

Cory Roletto, WEO Media co-founder and partner

American Disability Act (ADA) lawsuits have been on the rise for years. With the Department of Justice confirming websites fall under the law while refusing to define compliance standards, the environment is challenging for dental practices.

Dental offices can better serve the disabled people and greatly reduce the risk of an ADA lawsuit by implementing accessibility components on three areas of their websites: the code, patient forms, and videos.

Code: There are two ways to make the code of your website more accessible. Hire a firm that employs disabled people to evaluate your website, provide feedback, and review the website on a monthly basis. For small businesses this option is cost prohibitive. Typically, firms charge $10,000 or more for the initial evaluation by disabled people and $500 per month for the maintenance. The firms didn't actually update the website. The website owner needs to implement suggested fixes.

A less expensive and easier method is using artificial intelligence (AI) software to analyze the website and provide an overlay of modified code and accessibility features. This allows a disabled person to more easily navigate the website and customized feature just for them. This way, accessibility is improved dramatically at fraction of the cost, typically around $50 per month. You can see WEO Media's AI solution in action at www.weomedia.com. Click on the blue disability icon at the lower left.

Patient Forms: If you have new patient information, medical and dental history, HIPAA, and/or financial forms on your website, there are guidelines for ADA compliance. PDF scans of the office's paper forms do not have the necessary code for compliance. Forms need to be created with compliance in mind. If you are going to spend the time to rebuild forms that are HIPAA and ADA compliant, the best option is online fillable forms. There are several form systems that drive toward compliance, at WEO Media our coders are currently building patient forms in a system called Jot forms.

Videos: There are two video components for ADA compliance, caption and audio description.

Captions are translations for words set in the video to text so hearing-impaired people can read the text while watching the video. The easiest way to add caption to video is to host the videos on Youtube and ensure the video captioning feature is turned on. Youtube's software does a decent job at translating spoken words to text in creating the captioning.; however, if there are errors, captions can be manually added.

Audio Descriptions describe the imagery of the video to a visually-impaired person. Audio descriptions are more difficult to implement. Two versions of the video can be created. The normal version and a second version where the video is paused while someone narrates the visuals of the video. Another option is adding a link to a text file (txt) in the description area for the video on Youtube. The text file contains both the caption and audio descriptions in text format. Website reading software can then read the text file.

For more information on ADA compliance and dental marketing topics, watch our webinar series at https://weomedia.com/p/Dental-Marketing-Webinar-Collection-p22459.asp

Author: Cory Roletto, WEO Media co-founder and partner, info@weomedia.com, 888.246.6906

WEO is an endorsed provider with CDA

WEO MEDIA
DENTAL MARKETING

CDA Major Issues & Priorities

July 2021

1. SB 242/ AB 454: Health Care Provider Reimbursements - Support

The COVID-19 pandemic has highlighted the ability of medical and dental plans to make record profits during a public health emergency by collecting premiums while paying fewer claims as patients receive less care.

CDA is supporting SB 242 by Senator Josh Newman (D-Fullerton), which would require insurance plans to reimburse health care providers for costs related to the procurement of critical safety supplies, such as personal protective equipment (PPE). The costs of PPE vary throughout the state and have been exacerbated by product scarcity, supply chain disruptions and price gouging. Many providers are paying in the range of $10-$25 per patient, adding up to thousands of dollars of new costs every month. Although mask mandates and social distancing requirements are easing, these requirements will not be lifted in medical or dental offices any time soon. Federal and state financial assistance is not sufficient to cover the ongoing costs. With the increased economic burden of safely operating in the current circumstances, there is a risk of patients losing access to care and a constriction of the dental network in our state. SB 242 is needed to ensure that provider practices, which have endured over a year of sustained financial losses, are not also required to bear the cost of these new, medically necessary expenditures entirely on their own. SB 242 passed out of the Senate and is now moving through the Assembly.

While SB 242 focuses on near term relief for health care providers, CDA and the California Medical Association also co-sponsored AB 454 by Assemblymember Freddie Rodriguez (D-Pomona), which, in the event of a future catastrophic public health emergency, would give authority to the Department of Managed Health Care and California Department of Insurance to require plans to support providers through various means such as grants, increased rates or payments for increased costs of mandatory infection control measures. AB 454 was held in the Assembly Appropriations Committee and will not move forward this year.

2. 2021-2022 State Budget

The state's record revenues and federal stimulus funding provide an important opportunity to address oral health needs across the state. CDA advocated strongly for the following ongoing investments in oral health that are included in the 2021-2022 state budget:

- Provides long-term stability for Proposition 56 funded Medi-Cal provider reimbursement rates by making them permanent, removing the annual expiration date and providing much-needed stability for Medi-Cal providers.
- $230 million annually in new Medi-Cal Dental program benefits to continue, and expand upon, the most successful elements of the current Dental Transformation Initiative such as silver diamine fluoride, pay-for-performance incentives for children's prevention, and caries risk assessments.
- Fully funds the Office of Oral Health, as intended by Proposition 56, at $30 million annually, so that the State Dental Director can continue the community-based oral health improvement initiatives outlined in our state's 10-year Oral Health Plan.
- Allocates $75 million for the High Road Training Partnership initiative of the California Workforce Development Board, which will result in training for thousands of jobs, creating entry into careers such as dental assisting with competitive starting salaries and long-term growth potential. Programs such as CDA's SmileCrew will be eligible to apply for grants from this pool.

3. AB 526: Vaccine Administration and COVID-19 Testing - Sponsor

CDA is sponsoring AB 526 by Assemblymember Jim Wood, DDS, (D-Healdsburg), which amends the Dental Practice Act to allow dentists to administer COVID-19 and flu vaccines. This bill would codify the existing Department of Consumer Affairs waiver that allows dentists to administer COVID-19 vaccines during the current COVID-19 public health emergency. Specifically, it would allow a dentist to independently prescribe and administer influenza and COVID-19 vaccines approved by the FDA in compliance with federal vaccination schedule guidelines.

Additionally, AB 526 would align the California Department of Public Health regulations with federal lawso dentists can obtain the appropriate state licensure alongside their Clinical Laboratory Improvement Amendments certificate, which will allow them to conduct COVID-19 rapid tests to screen their patients and dental team members when such tests become widely available and appropriate for use in the dental office.

AB 526 passed out of the Assembly and is currently moving through the Senate.

4. MICRA Repeal Ballot Measure - Oppose

The Medical Injury Compensation Reform Act allows injured patients to receive unlimited economic damages for all past and future medical costs, lost wages and lifetime earning potential. MICRA also allows up to $250,000 in noneconomic damages and includes a limit on attorneys' fees, stabilizes liability costs and reduces incentives for frivolous lawsuits against health care providers. A group of trial lawyers have qualified a ballot measure for the November 2022 election that would essentially eliminate MICRA's protections. This measure would undeniably raise health care costs and reduce access to care for those who need it most, including people who use Medi-Cal, county health programs, safety-net providers and school- based health centers.

CDA is part of Californians to Protect Patients and Contain Health Care Costs, a broad coalition including physicians, nurses, hospitals, safety-net clinics and other health care providers committed to fighting this initiative.

5. AB 733: Increasing Oral Health Care Through Medical-Dental Integration - Co-Sponsor

CDA and the California Dental Hygienists Association are co-sponsoring a collaborative effort to help improve access to care for Medi-Cal dental beneficiaries without a dental home. AB 733 by Assemblymember David Chiu (D-San Francisco) seeks to expand access to oral health care for Medi-Cal-enrolled children and pregnant people by allowing RDHAPs to partner with physicians in medical settingsto provide fluoride treatments and oral health education and to coordinate care with dental providers and the dental care system. CDA and CDHA are working with stakeholders including the California Society of Pediatric Dentists, CMA, Children Now and the American Academy of Pediatrics-California on thiscollaborative effort to expand access to care and improve medical-dental integration. AB 733 is a two-year bill as CDA continues to work with stakeholders.

6. AB 1400: Single-Payer Health Care - Oppose

CDA is committed to improving the state's health care delivery system and to extending health coverage to all Californians. We are eager to work with lawmakers on solutions the state is capable of implementing to achieve universal coverage and protect the significant progress made under the Affordable Care Act (ACA), which allowed California to achieve a larger reduction in its uninsured rate than any other state. Introduced by Assemblymembers Kalra, Lee and Santiago, AB 1400 would replace Medicare, Medi-Cal, all private insurance and the Covered California exchange with one state health care program. CDA has numerous concerns with such a proposal including the lack of any funding details and the great difficulty the state has meeting its existing obligations to underserved patients in the Medi-Cal program. Creating the single-payer health care system proposed in AB 1400 would also require passage of a ballot measure by voters and approval from the federal government and could require hundreds of billions of dollars in new tax revenues. The bill did not receive a hearing this year and will not move forward.

7. AB 1163: Sugar-Sweetened Beverage Local Tax Preemption - Co-Sponsor

Sugar-sweetened beverages are the single largest source of added sugar in the American diet. They are also a significant driver of various health conditions including tooth decay, which affects more than two- thirds of California children (making dental caries the most common chronic childhood disease). CDA and a coalition of more than a dozen leading health care organizations are pursuing legislation, AB 1163 by Assemblymember Adrin Nazarian (D-North Hollywood), to return power to local cities and counties, allowing them to pass local sugary drink excise taxes if they are appropriate for their communities. When the legislature passed a statewide preemption on these local taxes in 2018, the state eliminated a popular and helpful tool that municipalities could use to raise additional revenue and improve public health - dual policy objectives especially important in the wake of the COVID-19 pandemic. AB 1163 did not receive a hearing this year and may be reconsidered next year.

8. Direct-to-Consumer Orthodontic Consumer Protections

Providing dental care that involves the movement of teeth without a proper evaluation, including X-rays, can lead to serious patient harm, such as loose or cracked teeth, bleeding tongue and gums, gum recession or a misaligned bite. With the emergence of new direct-to-consumer (DTC) business models offering various dental services that are ordered without an in-person clinical examination, it is imperative that dental treatment continues to meet a uniform standard of care regardless of whether a dentist provides treatment through telehealth or in person. CDA continues to advocate for consumer protections that ensure that DTC orthodontic business models have the same level of dentist oversight and patient safety as the virtual dental home model and in-person dental care. CDA will continue to work with the appropriate enforcement entities, including the dental board, to push for increased patient safety while pursuing improved statutory and regulatory enforcement.

9. Dental Plan Transparency

Over the past several years, CDA has worked to improve transparency of dental benefit plans for dentists and consumers. AB 1962 (2014) required commercial dental plans to annually disclose to the state how much premium revenue they spend on patient care versus administrative costs, known as a dental loss ratio (DLR). The reported data show a wide range of premium revenue spent on patient care, with a quarter of all California dental plans spending less than 50% of premiums on care and some plans even falling below 10%. SB 1008 (2018) built upon this by requiring all dental plans to use a uniform matrix to disclose their benefits directly to consumers, similar to the one used by medical plans. This provides plan beneficiaries with a uniform summary of plan details, including covered services, reimbursement levels, estimated enrollee cost share, limitations and exceptions. In 2019, CDA successfully sponsored AB 954 (Wood, D-Santa Rosa), which requires dental benefit plans to be more transparent about the common practice of "leasing" access to a network of contracted dentists from another dental benefit plan to provide clarity for patients and providers, reduce confusion and help preserve trust in the dentist-patient relationship. These transparency measures help level the playing field for consumers and providers, are consistent with standards that apply to medical plans and help hold dental plans accountable for how they spend premium dollars.

California Dental Association
1201 K Street, Sacramento, CA 95814
800 CDA.SMILE cda.org

Stanislaus Dental Society

Staff Appreciation Family Ballgame!

(Show up in your favorite baseball gear or wear pink for Sutter Gould's Breast Cancer Awareness event!)

Friday, September 10
6pm-10pm

Modesto Nuts vs. Fresno Grizzlies

John Thurman Field
601 Neece Dr.—Modesto

SDS has booked both sky party decks for an evening of food, fun, raffle prizes, baseball, and fireworks for SDS members/dental team and are including spouses and your children!

Includes:

- All-you-can-eat BBQ ribs, tri-tip, pulled chicken, hot dogs, sides, dessert, sodas, water
- Wine/beer will also be available in the party deck areas (c/c only, no cash)
- Unlimited play wristbands to the children's play area for children ages 2-12
- Drawing to throw 1st ball (drawing at party deck by 6:30pm, sharp!)
- Fireworks post-game!

BBQ from 6:00-7:30pm

Considerations when billing for an associate in the dental practice

By Cindy Hartwell, dental benefits analyst at CDA Practice Support

May 10, 2021

Reprinted with permission from California Dental Association

At least once a day I take a call from a member who is hiring an associate dentist for the first time. Their question is always the same: ”How do I bill plans when my associate/employee dentist performs the treatment?”

As we look at the proper way to bill for the treating dentist, remember that a dental claim is a legal binding document and, as such, all elements documented on the claim form must be accurate.

Today, many dental plans have adopted contracting based on the contract and compensation of the treating dentist, not just the billing (owner) dentist.

When billing a dental benefit plan, the information documented in the billing dentist or billing entity, treating dentist and treatment location sections of the claim must be accurate. If the treating dentist documented on the claim differs from the treating dentist noted in the patient’s chart, the dental-benefits industry considers this billing practice to be fraudulent billing because the treating dentist is misrepresented on the claim.

Bill properly by registering all treating dentists

Let’s review how a practice can bill properly by registering all treating dentists in the practice with a dental plan.

When adding a new treating dentist to the practice, the billing dentist should try to contact the dental plans well in advance of the associate’s start date to learn how to add the treating dentist to the plan’s system of records. This is done by either contracting them with the plan or listing them as an out-of-network dentist.

If the treating dentist will contract with plans, remember that in most cases the plan will consider the dentist as out of network until the plan completes the credentialing and contracting process. This means that many plans will treat the dentist applying to their network as out of network while the plan works to complete the application for that dentist.

Different plans, different contracting protocols

Keep in mind that the plans have different contracting protocols, including compensation. Determining a plan’s contract protocol well in advance, including how long it will take the plan to process the contract, is critical for a smooth transition when adding a treating dentist into the practice.

Also, not all PPO policies allow assignment of benefits when an uncontracted dentist performs the treatment, and this means the patient, rather than the practice, will receive payment for services provided. What's more, many plans will decrease a patient’s benefits when they see an out-of-network dentist. So, if the goal of the practice is to have the treating dentist in network with plans due to the previously mentioned factors, it is important to try to align their start date with the time frame the plan provides to contract them.

Considerations when adding a treating dentist to the practice

If your practice plans to add a treating dentist, here are some things to remember:

- The dentist who performs the treatment must be documented as such on the claim in the treating dentist section.
- If the treating dentist will be contracting with the dental benefit plan, the billing dentist should learn the plan’s contracting requirements and time frames.
- If improper billing is done, the billing dentist may be found in breach of contract with the dental plan and would be penalized for the improper billing i.e. misrepresenting the treating provider on the claim form.
- The billing dentist should follow the plan’s stated contractual obligations for reporting any treating dentist working in their practice.
- Some dental benefit plan contracts are portable, while others are not. If a contract is not portable, the dentist will be required to sign a new contract with the plan if they want to be an in-network dentist at a new location — even if the dentist is currently contracted with a plan at another practice location.

Lastly, dental plans’ contracting and compensation rates change from time to time. Because of this, do not assume that the dentist being added to the practice will be offered the same contract or compensation of the billing dentist who contracted with the plan in the past.

To learn more about billing for an associate, see the related CDA Practice Support resource.

California Dental Association
1201 K Street, Sacramento, CA 95814
800.232.7645 cda.org

CDA Practice Support Experts

While our resources at cda.org/practicesupport resolve many of your questions, we know there are times you'd prefer to speak directly with a human being. So we've made it easy for you to ask an expert. The same team of dedicated professionals that develops our online content is available to share the perspective and information you need to make smart decisions.

Ann Milar

Director, Practice Support
ann.milar@cda.org
916.554.7324

Ann provides strategic direction for Practice Support's resources and initiatives while leading the team of expert analysts. She is also responsible for identifying and analyzing emerging issues for policy development and implementation on behalf of CDA's 27,000 member dentists. Ann has worked with CDA for more than 13 years and her health care experience spans 20 years of working with associations, health plans and advocacy organizations.

Teresa Pichay, CHPC

Regulatory Compliance Analyst
teresa.pichay@cda.org
916.554.5990

Teresa specializes in regulatory compliance, including information verification, documentation strategies and referral to legal references. For more than 20 years, she's worked with CDA members in the areas of occupational and environmental safety and health, HIPAA, California Dental Practice Act and other business regulations.

Michelle Corbo, PHR, PHRca

Employment Practices Analyst
michelle.corbo@cda.org
916.554.4968

Michelle specializes in employment practices, including employee management, policy development and wage and hour compliance. She began her dentistry career as an assistant, quickly becoming an office manager, and now brings 18 years of private practice management experience, plus another 13 years supporting CDA members.

Katie Fornelli

Senior Practice Management Analyst
katie.fornelli@cda.org
916.554.5308

Katie specializes in dental practice management and marketing. For more than 18 years, she's worked with dentists and their teams in areas such as scheduling, collections, front office systems, case presentation, patient management, practice transitions, and dental practice marketing.

Cindy Hartwell

Dental Benefits Analyst
cindy.hartwell@cda.org
916.554.5941

Cindy specializes in consulting with practices on dental benefit plans, navigating the benefits system and advocating for providers. She brings more than 20 years of experience, including RDA and office manager roles in private practice before working in a large dental benefit organization's commercial and state government divisions.

Lisa Greer

Practice Support Analyst
lisa.greer@cda.org
916.554.5953

Lisa specializes in several aspects of dentistry, including working with dental benefit plans, dental billing, accounts receivable, community marketing, human resources, practice management and regulatory compliance. As a Practice Analyst, she brings more than 20 years of dental industry experience to CDA, including having served as a regional collections specialist for a dental support organization that supported 70-plus California offices.

Regulatory Compliance Tips for New Dentists

CDA Practice Support Staff

Reprinted with permission from California Dental Association

Once a dental license is obtained, a new dentist should complete at least one more step before starting work, complete other steps soon after starting work and be aware of certain regulatory compliance matters of interest to new dentists.

Obtain National Provider Identification Number

Every licensed dentist should have an individual (Type 1) NPI number. The Type 1 number is used to identify a prescriber on prescriptions and also the treating provider on treatment claim submissions. A new dentist need not obtain a Type 2 NPI number until they form a business entity, such as a sole proprietorship or dental corporation, which will bill third-party payers for treatment. A dentist may have several Type 2 NPI numbers in the course of their professional career but only one Type 1 number. Apply for an NPI number through the National Plan and Provider Enumeration System at nppes.cms.hhs.gov.

Register Places of Practice

A licensed dentist is required to register their place or places of practice. If they have no place of practice, they should register with the Dental Board of California within 30 days of obtaining their license. A dentist also must notify the board within 30 days of starting at a new place of practice or leaving a practice. Written notification of place of practice must be done on the board-approved form "DDS Change of Address" found on dbc.ca.gov or through the state at breeze.ca.gov.

Register With DEA and CURES

A dentist who prescribes, administers or dispenses controlled substances must register with the U.S. Drug Enforcement Agency at deadiversion.usdoj.gov. Separate registration in California is not required. The DEA registration is location specific. Additional DEA registration is required if a dentist stores and dispenses or administers controlled substances at more than one facility or practice. If a dentist only prescribes controlled substances at another facility or other dental practices, then only one DEA registration is necessary.

Every prescriber with a DEA registration must register to access the Controlled Substance Utilization Review and Evaluation System (CURES), California's prescription drug monitoring database, at oag.ca.gov/cures. Access credentials must be updated regularly, and the Department of Justice audits for appropriate use of the database. A prescriber is required to check CURES for a patient's controlled substances prescription history before prescribing a Schedule II–IV drug. More information on CURES is available at cda.org/ practicesupport in the resource titled "Prescribing and Dispensing."

If a dentist does not prescribe, administer or dispense controlled substances, registration with the DEA or CURES is not required. However, know that some dental benefit plans require a dentist to have a DEA registration as part of the credentialing process. A dentist who intends not to prescribe controlled substances should contact the plans with which they are contracted to confirm the plans' requirements on DEA registration.

A dentist who does not have a DEA registration must still pay the CURES fee that is included as part of the biennial dental license renewal fee.

Prescriptions

In 2021, both paper and electronic prescriptions are accepted at pharmacies. Starting Jan. 1, 2022, all prescriptions must be submitted electronically with few exceptions. A new dentist may be required to register to use an employer's prescribing software or can choose to subscribe to prescribing software that can be used at more than one location. Find more information on prescription forms and e-prescribing in "Prescribing and Dispensing" at cda.org/ practicesupport.

Comply With Practice Name and Ownership Requirements

A practice owner should know that the name of a dental practice or dental corporation may only utilize the name of the licensed dentist owner or owners, unless the owner or owners obtain a fictitious name permit from the dental board at dbc.ca.gov.

A dental practice may be owned only by a licensed dentist or dentists. Majority ownership of a dental corporation must be a licensed dentist or dentists except in one limited circumstance. Shareholders in a dental corporation may include non-dentists in limited circumstances. Legal counsel should be consulted when considering non-dentist ownership in a dental corporation.

Understand C.E. Rules for Postgrad, First License Renewal

Continuing education units earned toward license renewal must be delivered by continuing education providers registered by the Dental Board of California, American Dental Association CERP providers or Academy of General Dentistry PACE providers. The board will consider granting continuing education credit for courses offered by non-approved, out-of-state providers if the dentist submits an application before license renewal. Continuing education units also may be earned through completed curriculum in the license renewal period in a residency program or postdoctoral specialty program approved by the board or the ADA Commission on Dental Accreditation. If audited, a dentist must be able to provide school transcripts to the board.

A dentist renewing their license for the first time is exempt from the continuing education requirement. For additional information on C.E. requirements, see the board website at dbc.ca.gov.

Understand Scope of Practice and Supervision

Primary care clinics or clinics owned or operated by a hospital or nonprofit corporation may employ dental professionals but these entities may not interfere with, or otherwise direct, the professional judgment of a dentist or licensed dental auxiliary acting within their scope of practice. The supervising licensed dentist is responsible for determining the competency of the dental assistant to perform basic supportive dental procedures.

Stanislaus Dental Society
invites you to attend:

Digital Implant Planning for Full Arch Dental Implant Treatment - Surgical and Restorative Options

Speaker: Hunter Dawson, DMD

Friday, October 22, 2021

Papapolloni's Bistro (formerly named Famiglia Bistro)
2501 McHenry Ave. Modesto

8:00am Full breakfast and registration

8:00am – 1:30pm (5 Hours Core CEU's)

Sponsored by: straumann® simply doing more℠

Dr. Dawson is from the Piedmont Triad growing up east of Greensboro in Whitsett, NC. He attended NC State University where he earned his degree in B.S. in Biology. He is a passionate Wolfpack fan and played on the Club Baseball team while in college.

He pursued his goal of becoming a dentist at the University of Louisville. After graduating in 2014, he continued his education by completing a Full Time Advanced Education Residency in Prosthodontics at the University of Louisville. Dr. Dawson has multiple publications in areas of complex implant rehabilitations using digital workflows and guided implant surgery. He is an adjunct associate professor at the University of North Carolina Chapel Hill and has lectured internationally on full mouth implant rehabilitation using digital workflows.

LEARNING OBJECTIVES

- Identify the need and opportunity to treat full arch patients with fixed detachable prostheses
- Recognize how to incorporate recent technological advances as part of the treatment plan
- Identify cases where guided surgery planning would be helpful for implant placement
- Understand surgical treatment options based on a restorative-driven team approach
- Review restorative materials and processes available to meet your patient's expectations

Fair Thee Well, Good Sirs!

Carey Penrod, DDS
10/24/63—4/06/21
Member 1990-2000

Walsh Conmy, DDS
08/22/32—04/17/21
Member 1968-2021

Anthony Nagy, DDS
02/06/41—04/23/21
Member 1969-2021

Dentists receive confidential support for alcohol, chemical dependency through CDA's Well-Being Program

In conversation with Matthew Korn, DDS, Well-Being Committee chair
April 7, 2021

"There are people in my community who will tell you that the Well-Being Program is probably the most important benefit they've received as a CDA member," said Matthew Korn, DDS.

Last May, Dr. Korn co-presented the confidential webinar "Coping with Chemical Dependency During COVID-19." CDA hosted the webinar, and it was open to all CDA members. Near the start of the webinar, he offered a statistic: In the first month of the pandemic, sales of alcohol increased 50%. Alcohol and drug-related hospitalizations are now up 30%. A research letter published in JAMA Network Open last September looked at the recent change in alcohol use and its consequences.

"There can't be a reduction in the disease expression when there's an increase in consumption of the thing that causes it," Korn said, noting that while Alcoholics Anonymous and other recovery support meetings weren't operating, access to alcohol was unrestricted.

The fear and isolation of the pandemic, Korn says, creates the perfect breeding ground for the disease of addiction to take hold, while shame and fear of professional repercussions, particularly among health care providers, discourage individuals from seeking help.

"We're treated differently in the recovery world by our peers because we have health care licenses and we are expected to not get the diseases that other people get because of that," Korn said.

As chair of the CDA Well-Being Program, which assists dental community members who suffer from alcohol or chemical dependency or both, Korn said dentists have additional stressors to contend with during the pandemic: Have they become unemployed or laid off staff? Are they able to pay their employees? How has social isolation contributed to disease or impacted providers' overall sense of well-ness?

For these reasons, the Well-Being Program is evolving to become a referral source for dentists who are trying to cope with stress and burnout.

"These are the human elements that we're fighting against, and it's never been more difficult than right now for dentists who need help or for our committee to offer that help," Korn said.

Three practicing dentists share their stories

Korn himself battled alcohol dependency from his college years and into his early years practicing dentistry, although by his own words he was "born an alcoholic." He later developed prescription-opioid dependency.

"It got worse and worse over the course of 15 to 20 years, so it wasn't a single event — it wasn't a one-time light bulb that came on where I realized I needed help," he said. "And for years I remember thinking I was too smart to succumb to this disease. Obviously, I was proven wrong."

Eventually, enforcement officers with the Dental Board of California's Diversion Program showed up at his dental practice with badges and guns.

"I thought my life was over," Korn said.

He and his webinar co-presenters, all practicing dentists, shared their unique but similar stories — similar most appreciably in that all three dentists' stories "end" positively, with each maintaining their license, never ceasing practice and emerging from their different recovery programs and treatment centers with insight, new tools and confidence.

Korn participated in the dental board's program, but CDA members today can participate in CDA's Well-Being Program as an alternative.

“Every single dentist who has successfully completed a recovery contract with CDA Well-Being reports that their lives are not only better than before, but better than they thought possible,” Korn said. “We are here to serve patients and to help dentists recover their lives and livelihoods with proven, effective support.”

He said recovery doesn’t happen by simply going to AA meetings. “It happens by going deep inside ourselves and looking at the things that make us want to drink or abuse other substances. And that’s what the treatment is about as well as what the support systems afterward are about.”

Intervention and support; local components are also a referral resource

The two primary purposes of the CDA Well-Being Program are to perform interventions and provide support following successful treatment.

Typically, the committee chair in one of the program’s five California regions receives a call from a concerned spouse or significant other or the dental office manager. Executive directors of component dental societies also receive calls. Most of the calls Korn receives are from executive directors who have spoken to a struggling dentist or a dentist’s loved one.

The call launches an investigative process wherein the Well-Being Committee seeks confidential firsthand knowledge of the dentist’s behavior. If they have enough valid information to perform an intervention, the intervention follows.

“The only goal of an intervention is to open something up in a person,” Korn said. “But we then make a recommendation, which is simply to accept referral to a medical professional who does an assessment.”

Each regional Well-Being Committee has an established relationship with a team of medical professionals who perform the assessment. That assessment would indicate abuse, dependence or missing coping mechanisms. The Well-Being Program always follows the recommendation of the medical assessment team and implements after-care programs to help dentists continue their journey to healthy living. For health care professionals, 90 days of treatment is typical.

‘I want dentists to know they’re going to get confidential support’

“For years, I could hear a little voice within me that told me I was slowly killing myself,” Korn said. “But every morning when I woke up that voice was gone, and by noon I was already thinking about what I was going to consume to make that voice go away again. Most likely there are dentists out there in this beautiful state of ours who have a quiet voice within them that knows they have a problem.”

Korn hopes that other dentists who hear that quiet voice will listen to that voice, pick up the phone and contact the chair of their regional Well-Being Committee knowing there’s an experienced and compassionate soul on the other end.

“I want dentists to know that they’re going to get confidential support and be allowed to stay in their practices and they’re going to get the help they need. Dependence is treatable.”

If you believe someone has an alcohol or chemical dependency problem, contact CDA or a regional Well-Being Committee near you for confidential assistance.

SDS Calendar - 2021

July	5	Monday	Independence Day Observed (office closed)
	13	Tuesday	SDS Board meeting
	20	Tuesday	Stanislaus Dental Foundation board meeting
September	6	Monday	Labor Day - (office closed)
	7	Tuesday	SDS Board meeting
	10	Friday	Staff Appreciation/Night at the Nuts!
	9,10,11	Thur-Sat	CDA Presents-San Francisco
October	21	Thursday	SDS General Membership Meeting—in person!
	22	Friday	CE course-Dr. Hunter Dawson—in person!
November	9	Tuesday	SDS Board meeting
	11	Thursday	Veteran's Day (office closed)
	12	Fri-Sat	HOD - Virtual
	25-26	Thurs-Fri	Thanksgiving holiday - (office closed)
December	2	Thursday	SDS Member/Spouse Holiday Mixer-tbd
	Dec 24-Jan 2	Wed-Wed	Winter Holiday - (office closed)

SDS Members of the Number
Total: 270
Market Share: 85%
(Total # of Dentists in Stanislaus County who are Members of the Tripartite (ADA, CDA, SDS)
Active – 178
(Recent graduate-Reduced dues members)
RD0 – 1 / RD1 – 11 / RD2 – 5 / RD3 - 8 / RD4 – 2
Life Active – 20 / Life Retired – 43 / Retired – 1
Permanently disabled – 1
Non-members in county – 68

Welcome New Members!

Gaston Arata, DDS
General Dentist
Primary
101 S El Circulo Ave Patterson
Secondary
803 Coffee Rd Suite # 3 Modesto
Univ Peruana Cayetano Heredia, '97

Bhupinder Bahia, DDS
General Dentist
700 Crane Ave Turlock
IL- Midwestern University, '20

Sugandha Gupta, DDS
General Dentist
2801 Coffee Rd Bldg B Modesto
Herman Ostrow School of Dentistry of USC, '20

Alan Hernandez Lara, DDS
General Dentist
333 San Carlos Way Stockton
Mexico-Universidad De La Salle, '18

Jashandeep Kaur, DDS
General Dentist
3309 Sierra St Riverbank
CA-UCSF School of Dentistry, '20

Ignacio Esaul Mendoza Ham, DDS
General Dentist
No known practice address
Mexico-Universidad De La Salle, '15

Puneet Pandher, DDS
General Dentist
No known practice address
Herman Ostrow School of Dentistry of USC, '20

Muhammed Randhawa, DDS
General Dentist
7206 Hughson Ave Hughson
Mexico-Universidad De La Salle, '13

Ranjan Abhishek, DDS
General Dentist
4925 Sisk Rd Salida
Herman Ostrow School of Dentistry of USC, '20

Saad Tarar, DDS
General Dentist
No known practice address
Mexico-Universidad De La Salle, '20

Berta Tarverdi, DDS
General Dentist
No known practice address
CA-UCLA School of Dentistry, '21