# FACETS

San Diego County
DENTAL SOCIETY

**OCTOBER**
2020

**Oct 5**
Leadership Skills

**Oct 9**
DPA/Infection Control

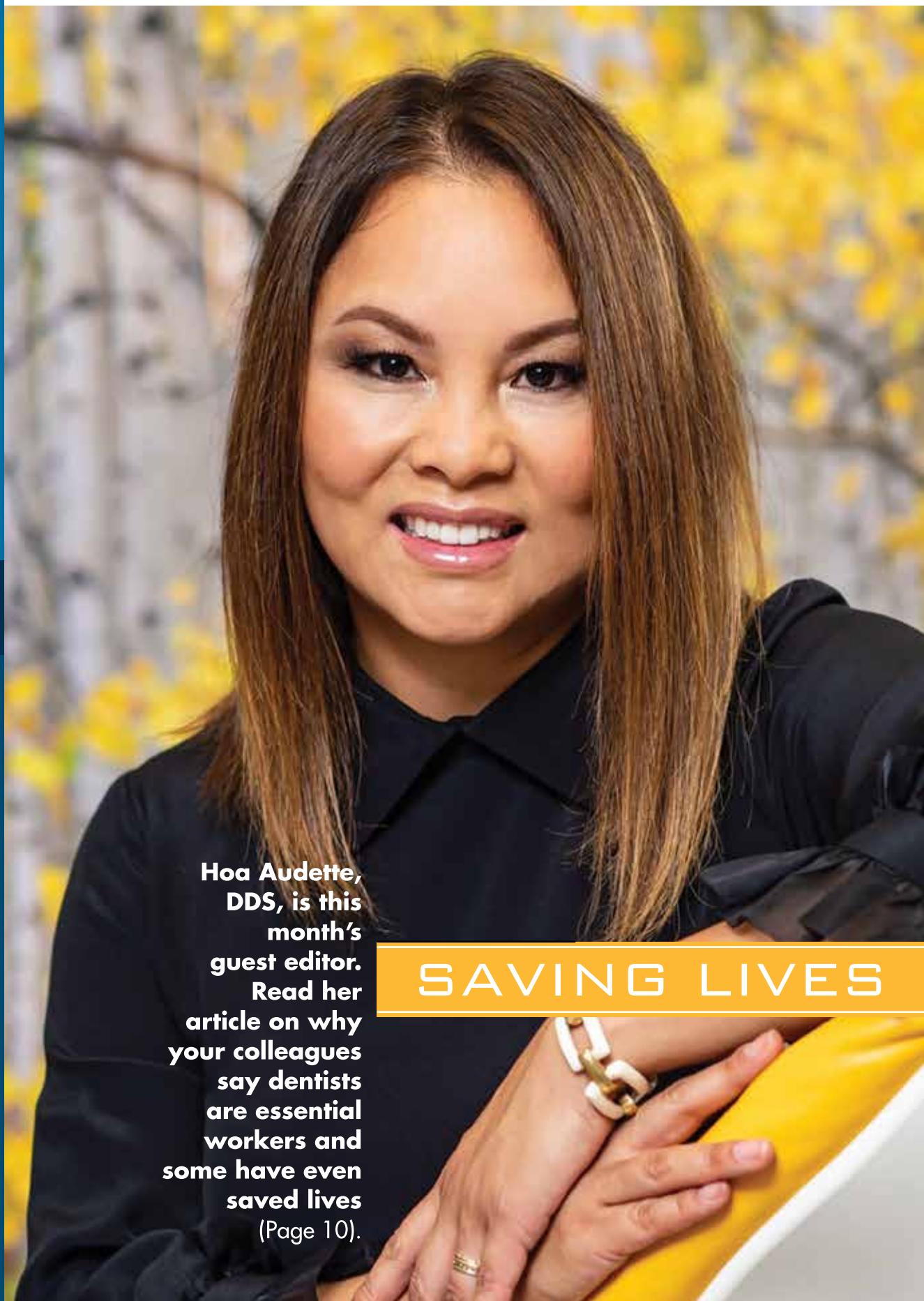
**Oct 22**
BLS Renewal

**Oct 27**
Treating with PRF

**POSTPONED EVENTS**

- Afternoon Tea
- Forensic Dentistry
- Gala Celebration

**ONLINE LEARNING**
see page 20



## SAVING LIVES

**Hoa Audette, DDS, is this month's guest editor. Read her article on why your colleagues say dentists are essential workers and some have even saved lives** (Page 10).

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OCTOBER 2020



### AWARD WINNING FACETS

The International College of Dentists — USA Section, awarded Facets these publication honors in Division 2:
2018 Newsletter Award
2017 Newsletter Award, Honorable Mention
2016 Outstanding Cover

ICD
INTERNATIONAL COLLEGE OF DENTISTS

## VOLUNTEERS NEEDED

**Community Events:**
Dentists, hygienists and assistants to volunteer as needed at community events.

**Adopt A Patient:**
Dentists willing to "adopt" patients (adults and children) for immediate or emergency needs in their office.

**Health Fairs and School Screenings:**
Dentists, hygienists and assistants to provide and assist with screenings and education.

**To Volunteer:**
support@sdcds.org

## FACETS NEWSLETTER


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1275-B West Morena Boulevard, San Diego, CA 92110
Phone: (619) 275-7188 Fax: (619) 275-0646

EDITOR/Managing Editor:
**Brian Shue, DDS, CDE**

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PRESIDENT'S PAGE

Brian Fabb, DDS

# Sweet

Every year it seems the ramp-up to the sugar-fest known as Halloween starts earlier and earlier. Along with Valentine's Day and Easter, Halloween is one of the peak days of the year for chocolate and candy consumption (and perhaps job security for dentists?). Americans spend almost $7 billion on Halloween each year, with over $2.6 billion on costumes, $333 million on pet costumes (my wife helps contribute to that annually), and over a whopping $2 billion on candy. My sweet tooth has mellowed significantly since childhood, but my favorite candy over the years is still Twizzlers, and my favorite chocolate is Toblerone. But what about other people and their favorites? How long have various candies been around? How much of these sweet treats do we eat? These curiosities led to a weekend of Google-based research and some interesting information I would like to share.

Chocolate has been around for ages, with experts estimating that human consumption began around 4,000 years ago in Latin America. The Olmec civilization was the first to turn the cacao plant into chocolate. Made from the fruit of the cacao tree, each tree yields about 20-30 pods a year, and the pods contain around 20-40 cacao beans. The cacao beans are dried and roasted to create cocoa beans. It takes about 400 cocoa beans to make a pound of chocolate. The Ivory Coast of Africa is the world's largest cacao producer, with over two million metric tons generated annually. Switzerland consumes the most chocolate at almost 8.8 kilos per person annually, while the United States consumes almost 20% of the world's chocolate overall.

Joseph Fry is credited with creating the world's first candy bar in 1866, known as the Chocolate Cream bar. His British company would become J.S. Fry and Sons, now owned by Cadbury. In 1875, Nestle would introduce their Milk Chocolate bar, followed shortly by Lindt's Chocolate bar in 1879, both in Switzerland. Hershey's Chocolate wouldn't make their U.S. debut until 1900. The largest candy company in the world is Mars, Inc., with over $18 billion in annual sales and 34,000 employees. Ferrero is second with $13 billion and over 35,000 employees.

For candy overall, tastes have changed over the decades with the addition of newer candy types in addition to chocolate. The 1920's most popular candy was a Baby Ruth bar. In the 30's, it was 3 Musketeers. M&Ms was the favorite of the 1940's, and the intense cinnamon candy Atomic Fireballs dominated the 50's. The 1960's saw tangy Pixy Stix and Lik-M-Aid beat out by SweeTarts, and the 70's saw the rise of Laffy Taffy. Capitalizing on the success and popularity of Cabbage Patch Kids, Sour Patch Kids was the favorite of the 1980's, and Airheads was king of the 1990's. Nerds was a marketing ploy from Willy Wonka and the Chocolate Factory movie that ruled the 2000's, and most recently, Skittles has been the most popular the past decade. A 2019 USA Today poll asked people what their current favorite candy was, and the top five included candy corn (which are awful; I can't understand how people eat them), Hershey's chocolate, M&Ms, Snickers, and the overall winner, Reese's Peanut Butter Cups.

The most recent top-selling candy bar across the globe is Snickers. Worldwide chocolate consumption is estimated to be over seven million metric tons. Candystore.com, which delivers tasty treats in bulk to distributors, listed their top 10 candies delivered here in North America as #10 Hershey's, #9 Sour Patch Kids, #8 Tootsie Pops, #7 Hot Tamales, #6 Candy Corn (again, yuck!!!), #5 Starburst, #4 Snickers, #3 M&Ms, #2 Reese's Peanut Butter Cups and #1 Skittles. Walmart is the most common store to purchase Halloween candy.

On a final note, the average Trick-or-Treater consumes about three cups of sugar, or around 220 packets of sugar, and 3.4 pounds of candy over Halloween. "It's the Great Pumpkin, Charlie Brown," was released as a prime time animated special on October 27, 1966, and Tim Burton's "The Nightmare Before Christmas" debuted in 1993. If any of this information helps you win a trivia contest someday, you can always thank me with a Toblerone!

EDITOR

Brian Shue, DDS, CDE

# Medicare and dental benefits, part seven: Do Americans support this? Hello!

### Getting up to speed

There is significant nationwide interest in adding dental benefits to the Medicare program, which is the federal health insurance program for 60 million American seniors (defined by Medicare and this article as those aged 65 and older). Over 70% of Americans aged 65+ do not have dental insurance. In 2019, the U.S. House of Representatives passed H.R. 3: Elijah E. Cummings Lower Drug Costs Now Act, which would have added vision, hearing, and dental benefits to Medicare, except it arrived DOA at the U.S. Senate.

### CDA Medicare Task Force

The 2019 CDA House of Delegates did not endorse adding a dental benefit to Medicare, let's be clear. The CDA Board of Trustees established the Medicare Task Force after the CDA 2018 House of Delegates passed Resolution 19-2018-H. "The Task Force was charged with providing a summary of relevant CDA and ADA policies, current national advocacy efforts, proposed benefit designs and potential economic factors for patients and dentists, including policy or other recommendations".

Gary Herman, DDS, Task Force Chair and Marko Vujicic, PhD, Chief Economist and Vice President of the ADA Health Policy Institute gave presentations at the CDA House and their PowerPoints are available for download at CDA.org – enter your login, go to bottom of page and enter "leadership" then "House of Delegates." Note that the actual CDA Medicare Task Force report is not currently available. The CDA House voted to file the report and requested a "report be provided to the house in 2020 (November 13-14) on the status of national discussions regarding dental benefits in Medicare."

Vujicic presented on the topic "Seniors Oral Health and Medicare." He stated: "A dental benefit within Medicare is at the top of the 'wish list' of items Americans would like added to Medicare." And further research is needed.

### Vujicic: A quick overview of access issues for seniors

A survey in 2016 asked: Who had a general dentist visit during the year? 61.3% of high income seniors had a visit to a dentist (this percentage was 54% in 2000 and each year, this percentage has been steadily increasing up to 2016), but only 24.4% of low income seniors did (this percentage has been fairly stable since 2000). Additionally, 47% of high income adults (ages 19-64) had a visit, while only 21.7% of low income adults did (both categories have been fairly stable since 2000). And 58.3% of high income children had a visit (stable since 2000), while 38.4% of low income children had a visit (a significantly large increase since 2000, when it was about 26%). High or low income thresholds of this survey were not defined.

Is it too expensive to see the dentist? From national NHANES 2013-2016 data, 8.8% of seniors stated yes, financial barriers kept them from seeing a dentist, while 3.2% stated non-financials barriers prevented a visit.

### Vujicic: A summary of research related to Medicare dental benefit

A 2017 survey conducted in Chicago and Tampa with participants of all group types ages 50 and older found: "Americans ages 50+ want dental coverage included in Medicare", which was the highest scoring benefit above all other possible health benefits not currently provided by Medicare. 93% said "Definitely Yes" or "Probably Yes" to wanting a dental benefit, as compared to vision coverage (90% affirmative), hearing (80%), long-term care (75%) and foot (only 50% affirmative).

### Vujicic: What do older voting Americans think?

A 2017 Families USA survey of 1,000 likely voters in all categories were asked:

> *"Currently, seniors receive healthcare coverage through Medicare, but it does not include dental insurance. Would you support or oppose including dental insurance as part of their Medicare coverage, as well?"*

A whopping 86% support a Medicare dental benefit and 12% oppose (note: HPI does not use the word "whopping"). Here's where it gets even more interesting. Vujicic showed Americans overwhelmingly support this dental benefit no matter how those surveyed were categorized. Data from the survey show **support** for a Medicare dental benefit by:

- **Ideology:** Liberal (95% supported), Moderate (89% supported), Conservative (78% supported)
- **Political affiliation:** Democrat (96% supported), Independent (82%), Republican (81%)
- **Age, in 3 groups:** under 40, 40-64, 65+ (ranged 84%-88% support)
- **Race:** White (86%), Black (90%), Hispanic (89%)
- Gender: male (82%) female (90%)
- **Household income:** low income (91%), middle income (88%), high income (81%)
- **Residence:** rural, suburban, urban (range 84-88%)
- **By current dental coverage:** government-funded (90%), private-funded (90%), not funded at all (80%).

**Vujicic concluded:** "There is strong support among the public for a dental benefit within Medicare." And do dentists support this? What do you think? That is an entirely new topic, we'll examine next month. Warning: I'm just the messenger.

Mike Koonce, MA, CAE

## Workforce for Dentistry

In our COVID-19 survey of our members, we asked how you are doing now that you're back at work. Staffing issues rose to the top of your greatest concerns. Finding good staff was not easy before the virus hit. Unemployment was extremely low and finding talented and loyal staff was like finding a member of the gold foil club! Then with the complications around COVID, it was difficult to get staff back to work even when the state and county offices of public health gave the green light.

In the survey, a quarter of you said that about 22% or more of your staff were not coming back to work. The three main reasons were:

1. Fear around contracting the virus.
2. Lack of child care.
3. Staff were happy with the unemployment check they received.

At the time, 33% of you needed additional staff. By now, some of those employees have returned to work, however the workforce issue is still a significant problem.

CDA has created a "Dental Office Staffing Work Group" and I am serving as a component level representative. The fact that there is a shortage of good staff across all of California is well established. The group will spend its time focusing on solutions and supporting members. One goal is to provide dentists with a set of online materials to train dental assistants that would be combined with in-office hands-on training. The result would be a professional program to use to develop eager but "raw" talent. Given the closures in restaurants and other sectors that require good customer service, our hope is that some of those unemployed workers will transition to the oral health profession.

Until CDA rolls out the educational program, be sure to check out SDCDS and CDA websites for the on-line jobs board. CDA Practice Support has also created an HR toolkit that offers resources in recruiting, hiring, and on-boarding. I happen to know it's good – I've used it myself. •

## Welcome New Members

Hayat Fahliogullari-Smith, DDS, NYU 2020
Patrick Hachee, DDS, LLU 2011
Raoul Santos, DDS, Univ. of Washington 1998
Maryam Ghorbani, DDS, NYU 2020
Akbar Khorshidi, DDS, NYU 2020
John Lupfer, DDS, SUNY Stony Brook 2020
Piper Dankworth, DDS, Utah College of Medicine 2020
Ryan Bramhall, DDS, Baylor College of Dentistry 2020
Mark Sidransky, DDS, Univ. of Colorado 2020
Nicole Elia, DMD, Nova Southeastern Univ. 2020
Regina Dowdy, DDS, USC 2017
Ryan Dull, DDS, Ohio State Univ. 2020
Sarah Borghei, DDS, USC 2016, Orthodontics at Roseman 2020
Emmanuel Delagrammaticas, DDS, Georgetown Univ. 1983
Jennifer Schlesinger, DDS, Temple 2013, Endodontics at Albert Einstein Med 2020

# SAVING LIVES

GUEST EDITOR

By Hoa Audette, DDS

Our stories are not isolated. Our stories are not unique. Extraoral and intraoral exams are what we do on every visit while we are doing prophylaxes, restorations, crowns, and other dental work. The dental community is the first line of defense in early detection for a variety of diseases. These stories are examples of how oral health plays an integral role to a patient's general health. We are a critical part of patients' essential health care team. According to the Oral Cancer Foundation, "there are over 100,000 dentists and dental specialists in the US, each one seeing between 8 and 15 patients per day." If we include hygienists, the number of patient visits is significantly higher. In addition, the American Dental Association states that "60% of the US population sees a dentist every year and just doing 'opportunistic cancer screenings of the existing patient population which visits a dental office every day, would yield tens of thousands of opportunities to catch not only oral cancer in its early stages but other systemic related diseases that manifest in the oral cavity." The goal of these stories is to inspire others to tell their stories, and to embrace our professions during these challenging and unprecedented times. It is intended to raise awareness that oral health has always, and will always, be integral to the general health. Dentists do more than just "fillings", we save lives.

I could tell you stories of patients' lives I have saved. I could tell you about my 45-year-old patient, father of two, who I diagnosed with oropharyngeal cancer and who has just recently reached his 5-year cancer remission milestone. I could tell you about how grateful his, now college aged, children are. I could tell you how every time I see a patient in my chair, I think of not only the one life I can save but also of the many lives that are connected. Yes, I could tell you about my 51-year-old, female patient that was just diagnosed with metastatic colon cancer from an off-and-on burning mouth syndrome complaint that she presented during a routine recall visit. I could tell you about the bittersweet feeling I get when I receive a phone call from a patient thanking me for saving their life. I am happy for them that it was an early diagnosis, but sad because they will have a long road ahead. I could tell you how many letters I have written and sent out to medical providers asking them to re-evaluate the patients' oral health because I suspect it's more than just teeth-related. I could tell you stories, and I could tell you the statistics to prove that my stories are not unique, but that's why I feel they must be told, because it is a story of so many dentists, like me. We fix teeth, and sometimes, we save lives. These are our stories…

I had a very dental phobic patient come in saying his tooth was hurting his tongue. His tongue looked suspicious of squamous cell. I extracted the tooth and had the patient return two weeks later to check if the tongue was improving. I talked to him and his wife and told them what I thought. I gave them an oral surgeon referral and called every week to see if they went. After two weeks of not going, I told his wife to see if he would be more comfortable with his medical doctor instead. Two years later he returned to the office to tell me I saved his life. They removed half his tongue and lymph nodes down his neck, grafted from his arm. He had radiation therapy as well. It was a long recovery, but he was thankful I pushed him until he went.

Sophia Kalawi, DDS
La Mesa, CA

A few years ago, a 14-year-old walk-in patient came into our clinic for recurrent tooth pain. After doing a complete examination, we referred her for a consultation with a periodontist for atypical findings related to her clinical findings. Due to financial constraints, mom took the 14-year old to Mexico for treatment and was not seen for a year. The patient returned later for her exam complaining of swelling and pain. After seeing her atypical presentation with swelling and ulceration of the oral mucosa, I referred her immediately back to the same periodontist on the same day. The periodontist performed biopsy which led to his finding of osteosarcoma. The patient was able to get fast tracked to the Oncology department where she was able to get scans and biopsies to develop a course of treatment.

Anonymous Pediatric dentist, DDS
Vista, CA



## ADA statement on dentistry as essential health care

ADA

A new interim policy from the American Dental Association (ADA) states dentistry is an "essential health care service," reafrming that oral health has long been recognized as an integral part of overall health.

"Whether it's the current pandemic, a future epidemic or a natural disaster in a particular area, this policy recognizes the need for people to be able to continue to access the full range of dental services," said ADA President Chad P. Gehani, D.D.S. "Oral health is integral to overall health — staying well depends on having access to health care, which includes dental treatment."

Dr. Gehani added that regular dental visits are important because treatment, as well as prevention of dental disease, helps keep people healthy. "Beyond teeth and gums, the mouth also serves as a window to the rest of the body and can show signs of infection, nutritional deciencies and systemic diseases," he said.

– excerpted from ADA News, 8-10-20

About five years ago, I had a patient come in for a second opinion. He had been to several dentists for continual pain on the left side. He could not localize the pain to a single tooth but complained of generalized pain. I took radiographs and got a good medical and dental history. I asked him when the pain started, the pain scale, if anything triggered it. When I looked at his radiographs, he had had all his posterior teeth from the bicuspids to molars, endodontically treated and crowned. All within the last 5 years; however, he was still having the pain. I palpated his left lymph node under his mandible and the side of his neck was swollen and just a bit hard. I referred him to an ENT because it was obvious that his pain was not emanating from his teeth. He was diagnosed with throat cancer, treated with radiation therapy and is cancer-free to this day. I especially appreciate that his oncologist called me and asked if I had any suggestions prior to radiation. I advised that it would probably be a good idea to remove his posterior teeth as I knew his salivary glands would be affected by the radiation and increase the chance of rampant caries in those teeth. I told him that any extractions after radiating his mandible would be unwise. I still see him today, and he is a great patient!

Misako Hirota, DMD
National City CA

We were reviewing my patient's panoramic x-ray and saw what looked like plaque or build up in her carotid artery. I recommended she consult with her MD. Her MD's findings supported she had 80% blockage and they were able to move forward with necessary treatment. My patient was grateful and said "little did I know a routine check-up with my dentist could save my life".

Joy Bonifacio-Lockwood, DDS
San Diego, CA

I restored multiple carious lesions on a 50-year-old male patient. To my surprise, on his 6-month recall appointment, multiple new carious lesions were detected. The patient claimed to have a "regular diet". Upon questioning him further about his habits, he did state that he uses lozenges all day long for a persistent cough. He has been under medical care for the cough with no results. I suggested he gets checked for acid reflux. At his next 6-month recall visit, the patient came in bearing a gift. It was a yellow Christmas ornament that had a smiley face with teeth and braces. He thanked me for my suggestion to get checked for acid reflux which resulted in the discovery of a large hiatal hernia. The hernia was causing the acid reflux which triggered his persistent coughing. He said, "if it weren't for you, I would have never known I had that. Thank you." Till this day, this beautiful ornament hangs on my Christmas tree every year. It is a reminder of what an impact we have on our patients' lives. We don't just "fix teeth", we listen, pay attention, and we save and change lives.

Mayce M. Kachi-George DDS
Farmington Hills, Michigan

# SAVING LIVES

A 43-year-old male patient came in for an Invisalign consult and full exam. CBCT was taken and it showed that all four of his sinuses (Max sinus, ethmoid sinus, sphenoid sinus and frontal sinus) were full of mucus secretions. The lateral walls of his maxillary sinus were destroyed. I asked the patient if he had difficulty breathing. Patient said he suffered from constant congestion, headaches, lack of smell, snoring, difficulty breathing, and postnasal drip. He used a saline nasal rinse daily. He had a previous nasal surgery more than 15 years ago, but complained that "it feels worse than before." I informed the patient that he needed to see an Ear Nose and Throat Doctor immediately and told him what we saw in his CBCT. He went to ENT doctor and was informed that he had large nasal polyps and mucus that needed to be removed. Patient underwent surgery and it changed his life. He can now breathe for the first time, his heavy congestion is gone, his headaches are gone, he can now smell, he no longer snores at night, and he feels so much better. Patient was very thankful and grateful that a dentist was the one who figured out his problem and pointed him the right direction.

Uyen Thompson, DDS
Chula Vista, CA

Once I had a lesion scheduled for biopsy which had gotten considerable larger in just a week so I referred the patient to an oral surgeon. Turned out to be Squamous cell carcinoma.

George Crow, DMD, MS
San Diego, CA

I had a new patient examination scheduled for a 65-year-old female. She was accompanied by her husband, a retired State Department employee who had spent years serving our country around the world. The husband was present for the exam and answered several questions asked of the patient. Smoking was a part of their history, and she exhibited obvious signs of staining and gingival recession. The examination began normally, with a look around the mouth and check of oral soft tissues: lips, buccal mucosa, tongue and sublingual areas, hard palate, soft palate… The soft palate stopped me cold. I had never seen anything like it other than in pathology books. My description to my business partner was, "It looks like someone put a cigar out on her soft palate distal-lingually to tooth #2!" I could actually see through an opening in the lesion into the nasopharyngeal cavity. I finished the exam, measured the lesion and its indurated border, and referred them to an ENT. The biopsy report came back with "no evidence of malignancy"! I called the ENT's office and the Coronado hospital where the tissue sample was analyzed. I spoke to both the Physician and the Pathologist and told them something was wrong with the results, then called the patient's husband and let him know I thought there was a problem with the biopsy's conclusion. Fortunately, a new biopsy was not needed, but just a reevaluation of the original tissue sample. I insisted on a second reading of the tissue and it came back with the correct diagnosis, squamous cell carcinoma. We did follow up work on the patient prior to her cancer treatment, including replacing some lost restorations and in-office periodontal work. I became a very diligent reader of pathology reports after that scare, and always signed and dated each report I read. I never trusted that a physician or dental specialist knew more than what I saw with my own eyes.

Bruce Goldman, DDS
Chula Vista, CA

Six years ago, while performing a periodic exam on a recall patient I noticed a 4x3 mm lesion around the left pharyngeal. Since the 52 year-old patient had decades of smoking history, I immediately referred the patient to an ENT. As it turned out, the patient had stage II Squamous Cell Carcinoma. The patient returned to my practice a couple of weeks later to thank me. The patient's ENT believed that it was caught early and the patient would respond well to treatment. Dentists are in a unique position to monitor a patient's vital statistics and alert them, and their medical doctor, to any changes that may indicate a more serious underlying condition before it is too late. I cannot count how many times per year that I have done medical consultations since I suspect uncontrolled Type II DM, Coronary Heart Disease, Osteoporosis and various cancers. Dentists are definitely part of the essential health care team!

Susan Nguyen, DDS, MSD
Chula Vista, CA





Zeynep Barakat, DMD, FAGD

## First impressions

Before the days of the pandemic, like a lot of us, I used to shake my patients' hands and smile. Now, my patients don't receive a handshake and definitely can't see my smile. What does that do to my coveted initial interaction between doctor and patient?

That went through my mind after welcoming a new patient to our office last week. How odd it felt to not be able to give that comforting handshake and a warm smile to greet her. Conversely, I couldn't see her smile behind her mask, either. This is hard. After all, as dentists, we take pride in our smiles and naturally want to see our patient's smile in return, relating their facial expression in a dynamic way. Sadly, modifications due to our pandemic has changed many things, including the nature of the first impression. It had me thinking about how the minor details of a first introduction matter so much, now that we have them altered.

The business management world tells us it takes just seconds to make a first impression. Mere seconds and opinions are already formed between two people or between a person and a business. That's clearly not long, but apparently it's long enough. Life doesn't give us much time in that first impression to go into detail about who we are and what we have accomplished, but smiling does have an impact.

Patients or customers can always look at websites and biographies to gather factual data about our achievements. Ultimately however, it all boils down to the human interaction and their own experiences when they walk in the door and finally meet us.

Friends in finance tell me about the well-known "elevator pitch", which is telling an investor or executive about you or your business in the span of time an elevator ride would take. That would have been interesting in the cranky old elevator of my college days in Boston — which would get stuck several times a week. But let's assume most modern elevators are fast.

In the practice of dentistry, we too have very little time to make a good first impression. I think it comes down to the most basic element of human dialogue—the greeting. Cultural norms aside, I find that the greeting between a provider and new patient carries with it a fundamental need to bestow comfort and trust to someone who may be anxious at that moment. Usually, no one is excited to see the dentist, so I should recognize that first and foremost. The smile and the handshake are a perfect way to help do that while also being approachable to the patient. Take away those forms of communication, as I have these days, and we can only use our eyes and speech to gain our patients' trust, while still hoping to make that same good first impression.

The greeting package seems to be disassembled. So after welcoming them with words, I happily add that I am smiling, only behind my mask. Thankfully, most say they are too as we both acknowledge this new form of safe communication. Clearly, a few words in a few seconds at a safe distance can make this first impression a favorable one, albeit with a hidden smile.

Dr. Barakat graduated from Boston University School of Dental Medicine, completed an AEGD residency in Detroit and practiced in New England before moving to San Diego. She is currently in private practice and is the President of the San Diego AGD component. She is a regular contributor to the AGD's Daily Grind blog.

# Returning to work: a compassionate approach to staff well-being

By TDIC Risk Management Staff

Practice owners wear many hats. Not only must they be experts in clinical care but also in countless aspects of regulatory compliance, marketing, operations and employment practices. And one of their most essential hats to wear is team leader. From the hygienist to the receptionist, employees often look to practice owners for leadership and to help them navigate emotional, social and financial challenges in the workplace.

Today, staff need strong direction and guidance more than ever before. The COVID-19 pandemic has instilled feelings of stress, anxiety and fear in many dental professionals. Staff may be returning to work with significant anxiety over their own health and safety, not to mention financial worries, child care concerns and general unease about the current environment.

The Dentists Insurance Company has reported an increase in calls to its Risk Management Advice Line from dentists seeking guidance on how to address employee stress. Some dental practice staff are expressing concerns and hesitation about returning to work for fear of contracting COVID-19. Some are concerned because they live with a medically compromised or elderly family member. Still others are unable to report to work because of a lack of child care.

As team leaders, practice owners are being called upon to provide their staff with support in their time of need. While distraction, stress and fear are normal and expected during this time, a compassionate approach can give your staff the sense of well-being they need to return to the workplace with more confidence.

To address these fears, dentists are advised to approach their staff with care, compassion and understanding. Having open conversations and truly listening to the concerns expressed can go a long way in calming nerves on both sides. These are unprecedented times and employees need reassurance, so it's important to provide a sympathetic ear no matter what the issue or fear may be. Some practices have even implemented a system for submitting anonymous comments or questions so employees can feel empowered to speak up.

## Use a Facts-Based Approach

With so much misinformation circulating, separating fact from fiction can be difficult. As the team leader, it is up to you to educate your employees and reassure them that you are committed to providing a safe working environment. If you haven't already, consider holding a training focusing exclusively on COVID-19 best practices with ample time to answer questions and address specific concerns. Additional training in infection control, treatment-area disinfection and donning/ doffing personal protective equipment (PPE) may also help put staff at ease.

Spend time studying guidance from the Centers for Disease Control and Prevention (CDC), OSHA and other state and federal agencies to familiarize yourself with the latest guidelines and provide updates regularly. These guidelines have been fluid in response to the ever-changing pandemic environment. Keeping employees informed and involved on the current protocols can help alleviate feelings of helplessness. It also demonstrates that you take the safety of your staff seriously and are adding informed steps to minimize risk.

CDA members also have access to a back-to-practice staff training program, which can help you and your team navigate best practices and protocols for mitigating COVID-19 in the workplace. The training covers patient and staff infection control and patient scheduling, including a patient appointment dress rehearsal.

## Provide Flexibility

If job responsibilities allow, consider providing employees with a bit of flexibility in their schedule. Some duties can be performed remotely, allowing staff to stay home if needed. Others may be struggling to balance work life and home life, so allowing them to come in later or leave earlier may help ease their frustration. Some practices have implemented alternative workweeks and staggered shifts to reduce the number of employees in the office at one time.

These are unprecedented times and employees need reassurance, so it's important to provide a sympathetic ear no matter what the issue or fear may be.

## High-Risk Employees

In some situations, employees have been hesitant to return to work because either they or someone in their household is at high risk of contracting the virus. While this caution is certainly understandable, employers must do all they can to reassure them that all recommended safety precautions are in place.

Some employees are considered high risk because of conditions protected under the federal Americans with Disabilities Act and the Fair Housing and Employment Act. For example, diabetes is a protected group under both acts, meaning employers are required to make reasonable accommodations for diabetic workers, such as moving workspaces 6 feet apart and installing Plexiglas barriers.

Although accommodations are expected, and in some cases required, making assumptive health and safety decisions on behalf of your employees is ill advised. For example, limiting assigned work hours without employees' approval because of their age or medical status can be grounds for a discrimination claim. Instead, provide the employee with reassurance, but ultimately allow them to make the decision.

## Lack of Child Care

Many parents are struggling to return to work due to a lack of child care. Some child care centers remain closed, and those that have reopened have reduced capacity. Due to lost wages during shelter-in-place orders or practice interruption, some parents may simply not have the means to pay for child care. Practice owners are advised to have open conversations with employees to discuss the possibility of flexible hours or telework, if possible. Employers should also be prepared to provide resources to parents, such as links to state and local agencies that can provide assistance. You can access state-by-state COVID19-related child care resources via the federal Office of Child Care.

## Employee Protections

Peter Finn, an attorney with Bradley, Curley, Barrabee & Kowalski PC in Larkspur, Calif., notes that there are typically no legal protections for employees of dental offices or health care facilities who refuse to return to work due to COVID-19-related reasons. Although Congress passed the Families First Coronavirus Response Act to provide additional leave to those impacted by the pandemic, the act does not typically apply to employees of health care facilities — including dental practices. The act provides the ability for businesses with fewer than 50 employees, under certain circumstances, to self-exclude from the extended leave for child care purposes when an extended leave would jeopardize the viability of the business. Employers have the ability to seek 100% reimbursement for wages paid under this act through IRS tax deductions. However, some protections exist with regard to OSHA, Finn said. If an employee raises concerns that the office is not following proper health and safety protocols by providing PPE or implementing social distancing guidelines, the employee may be protected.

"In addition, federal OSHA law permits an employee to refuse work if the employee believes in good faith that doing the work would place them in 'imminent danger' and the employer has failed to eliminate the danger," Finn said.

Even when employees may not have specific protections under law, it is recommended that the practice owner attempt to work with the employee to find a solution that meets the needs of both parties. Keeping staff safe is of the utmost importance, and taking a collaborative, compassionate approach goes a long way in reassuring staff and keeping morale high. Should an employee still refuse to report to work, consult with an attorney prior to considering terminating their employment.

## Care and Compassion

Although dental practices are cautiously resuming care, fears over health and safety and financial security remain. As leaders of the dental team, practice owners are encouraged to take a gentle, flexible and compassionate approach when addressing employee concerns during this time. A dental team is a close-knit group, one that's often considered family, and a little empathy can go a long way in assuaging fears and getting back to business.

TDIC's Risk Management Advice Line is a benefit of CDA membership. If you need to schedule a no-cost consultation with an experienced Risk Management analyst, visit tdicinsurance. com/RMconsult or call 800.733.0633. Reprinted with permission from CDA.

# Prepare Your Office for the Big One

By Brian Shue, DDS, CDE

The end came suddenly and violently for many in the dark, early morning of April 18, 1906, when the earthquake's epicenter struck just 2 miles off of San Francisco's western shoreline. The magnitude **7.9 earthquake** on the San Andreas fault crumpled homes and buildings to the ground, trapped sleeping occupants, and crushed the very last breath out of the unsuspecting. When the dust and soot finally settled, the earthquake and subsequent fires had claimed the lives of 3,000 to 5,000 people, damaging property all the way from Humboldt County in the north to Hollister in the south.

If the 1906 earthquake were to repeat in the Bay Area today, it would cause 5,800 deaths and destroy 150,000 residences.[1] A magnitude 7.8 earthquake in Southern California's section of the San Andreas fault would cause 1,800 deaths, 53,000 injuries, the collapse of thousands of older buildings, 45,000 other buildings would be complete losses, and would total $213 billion in damages.[2] Compare those statistics to the scale of Hurricane Katrina that killed more than 1,500 and caused $81 billion in losses.

It isn't a question of "if" a major earthquake strikes California, but "when." A major study reports there is a 37% probability that a magnitude 7.5 or greater earthquake will strike the southern San Andreas and a 15% chance in the north in the next 30 years.[3] However, the study also shows there is an 82% chance a smaller magnitude 7.0 will strike Southern California and a 68% chance of one in Northern California in the 30-year span.

Are you ready for the Big One? If not (and surveys show most of us are not), it's time to get prepared. We live and work in earthquake country, whether we like it or not. An Easter Sunday magnitude 7.2 earthquake that hit just across the international border a few dozen miles away from El Centro in 2010 was another reminder that life in our Golden State's land of dreams also has the potential to become a place of nightmares.

It is not enough just to make earthquake preparations at home. Earthquakes can strike during working hours, so we need to protect not only our patients and staff, but our businesses as well. As health professionals who are the head of our dental teams, it is our responsibility to provide leadership with well-planned emergency systems in place at work, and that includes earthquake preparedness.

There are many steps that can be taken to prepare for a devastating earthquake that may occur while at the dental office.4 See the accompanying graphic for a summary. Thorough details can be found at: https://www.earthquakecountry.org/sevensteps/. The basics include preparing your office and staff with fire and evacuation plans, including scheduled drills and reviewing earthquake safety techniques.

Know **"Drop, cover, and hold on."** Understand the "triangle of life" is bogus. Know where each patient in the office can seek cover, such as along a wall in the operatory. Identify unsafe areas: near windows, doorways (unless it is a load-bearing doorway), outside doors and walls, masonry veneers, heavy furniture, glass, or lighting fixtures. Train staff on their responsibility to direct the patients where to go for safety in the office. Make sure your staff has family emergency communication plans: how they will communicate and find their family members after a major earthquake.

Identify potential hazards. Bolt heavy equipment and office furniture like file cabinets to wall studs. Place heavy objects closer to the ground, secure cabinet doors with latches to prevent contents from falling out. Fix potential problems around the office and building. Strengthening your office will allow you to be open sooner and will protect staff and patients. Work with landlord and property manager to address concerns.

The key is to be self-sufficient for a minimum of three days at your dental office since first responders may be overwhelmed in the aftermath of a large quake. You may not be able to get to your home immediately. Overpasses can collapse, roads can be damaged, or you can possibly be trapped in your building. Have an easily accessible disaster supply kit. Staff should monitor items for expiration. Staff should also have a 3-day supply of personal medications.

It is important to have a written Fire and Emergency Action plan. Access a "Fire and emergency action plan" that you need to customize for your office under "Regulatory compliance manual" at the "Resource library" found at cda.org.

The 1906 San Francisco earthquake mortally wounded its fire chief when the building next door collapsed through his roof. Despite his emergency plans, subsequent failure to follow through and poor decision-making resulted in San Francisco's further collapse.

When a major earthquake strikes, your staff and patients may be dependent on you for solid leadership. Now is the time to take responsibility and the proper steps necessary to get your office and building ready for the Big One.

GENERALLY RECOMMENDED

## BASIC SUPPLIES

**FIRST AID KITS/MEDICAL SUPPLIES**
*cuts are most likely injury so have bandages, pads, wraps*

**FOOD**
*canned, packaged, ready to eat*

**WATER**
*enough for one gallon/per person/ per day*

**LIGHTING**
*flashlight & extra batteries, lanterns, light sticks*

**COMMUNICATIONS**
*portable AM/FM radio and extra batteries, portable TV*

**TOOLS**
*basic hand tools: hammers, screwdrivers, wrenches, etc.*

**TARPS/PLASTIC SHEETING**

**PERSONAL PROTECTIVE EQUIPMENT**
*hard hats, gloves, dust masks*

**EXTRA GLASSES/CONTACTS**
*Burgess Meredith?*

**FOOD PREPARATION**
*portable stoves/grills for outdoor use, can openers, mess supplies*

**HYGIENE AND SANITATION SUPPLIES**

**ADDITIONAL SUPPLIES**
*to meet the training level of your employees*

**BACK-UP POWER**
*generator & extra fuel, batteries, uninterruptable power supply (UPS), and consider other sources: e.g. solar, hand-cranked.*

**"On October 15, millions of people worldwide will practice how to "Drop, Cover, and Hold on" during the ShakeOut earthquake drills. Last year 918,966 San Diegans participated. As of August 27, 3.4 million Californians are registered to participate, including 125,442 in San Diego County and 22,592 from Imperial County. Participating is a great way for your family or organization to be prepared to survive and recover quickly from big earthquakes – wherever you live, work, or travel." — shakeout.org**

Reprinted and updated from CDA Journal November 2010

**REFERENCES**
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2. Recovering from a big one. Southern California Earthquake Center. https://www.earthquakecountry.org/roots/recovering/
3. U.S. Geological Survey report: forecasting California's earthquakes — what can we expect in the next 30 years? pubs.usgs.gov/fs/2008/3027
4. 7 steps to a disaster resilient workplace. 2nd edition, Earthquake Country Alliance. https://www.earthquakecountry.org/booklets/
5. UC Berkeley. The Bancroft Library presents: The 1906 earthquake and fire. Requires Adobe flash.

## FOR SALE/LEASE

### Attention Dental Practice Buyers!

We've sold over 350 San Diego dental practices since 2004. Most of our listings are sold in less than 30 days. Get added to our Buyer Notification List so you can find out about our newest listings before they appear in ads. Ken Rubin Practice Sales, Inc. call 619.299.6161, krpracticesales.com

### For Sale, Boutique Office Suite

La Jolla Professional Center now accepting CA licensed Real Estate Borkers, Attorneys, CPA's, Architects, Engineers, Investment Advisors, Physicians and Dentists. 612 SQ. FT. OFFICE SUITE, $495K. CALL: Ken Gott, 575. 613.6619, kengott77@gmail.com

### Practices for Sale directly by Owner

Sqft & 2019 Collections - Kearny Mesa: 4,000; $622K, North County: 3,500; $246K, El Cajon: 4,500; $970K, Chula Vista: 2,500; $450K. Contact: sdcadentist@gmail.com

### Practices for sale in North County 4 Ops

Fully Equipped Laser, Air Vac, Pulse Oximeter, Ozone Machine 24 Yrs Goodwill AND in South Bay in a rapidly growing area 5 Ops New Building 35+ Goodwill Low Overhead DrSamHeals@gmail.com

### Built-out Dental Suites Available throughout San Diego County

La Mesa - Solana Beach - Escondido - Carmel Valley We also have equipment and Dental Practices for sale. 858.395.6438 csanders@cesandcompany.com

### Pacific Beach Dental Office For Rent

For Lease PB Dental Office. 3 ops, 900sf, vaulted ceiling. Excellent location Behind Trader Joes. Windows on all 4 sides, Security gates, ample parking. Available Dec.1, 2020. Call or text Dr. Fallon 619.379.3771

### General Dental Practice For Sale in Bonita, CA

Approx. 1,100 SQ FT. 3 Plumbed operatories, reception area, private bathroom, sterilization area and office. Practice collected approx. 350k in 2019. Send CV to edental@aol.com

### Dentist/Associate

Newly remodeled (6) op Dental Office One dentist, one hygienist, digital, paperless environment. Space available for established dentist with patient base or start up practice. Hours: M-F flexible hours. No start up expense. E-mail jberrydds@yahoo.com or contact Marian at 858.571.3534. Cost will be established on percentage of collection determined by type of expense sharing, if any that you want to do.

## SUPPORT SERVICES

### Anesthesia Associates

I.V. sedation & general anesthesia in your office. Board certified Drs. Marco Savittieri and Carl (Chip) Miller. Providing 26 years of anesthesia services to San Diego County Dental Society members. Call Brigitte at 760.451.0582 or 760.419.4187. *We thank you for your continued support!*

### Dental Equipment Repairs

All makes and models, 35 years' experience. U.S. Navy retired dental equipment repairman. San Diego Dental Equipment Service and Sales. Steve at 619.200.2023

### Office Based Dental Anesthesia

Board-certified, licensed, insured. Anesthesiologist available to provide general anesthesia (or IV sedation) to patients in your office, pediatric or adult. Please contact me for more information or questions. 40winksanes@gmail.com or 206.948.2468

## AVAILABLE FOR HIRE

### In-house Implant Surgeon/Prosthodontist

Misch Implant Institute Faculty; available 1-4 days/mo, including evenings and Saturdays. Implant placement; grafting; extractions. 25+ years of private practice and in-house surgical experience. See website, www.inhouseimplantdentistry.com for additional details and dentist testimonials. 818.359.2076

## HELP WANTED

### Dentist and Pediatric Dentist

Private Group seeks: 1) GP & 2) Pediatric Dentist / GP + enjoys kids. PT to FT Send CV to dentalSDteam@gmail.com. And please state desired position you're applying for in subj:

### Manager

Looking for a Dental Assistant to work Monday, Wednesday and Thursdays. Eaglesoft experience is a plus. 3 years of experience a must. Please call 858.268.8112 or send your resume to murphycanyon122@gmail.com







Yvette Carrillo, DDS, MS

Yvette Carrillo DDS, MS graduated from Loma Linda Univ. School of Dentistry 2015 & 2018 respectively. She is a diplomate of the American Academy of Periodontics. In addition to private practice, she is an adjunct faculty member at various teaching institutions. Dr. Carrillo enjoys blogging, working out, cooking, and spending time with her fiancé, Dr. Riley Garrett, a medical anesthesiologist practicing in San Diego.

# WHO's wrong

On August 13, 2020, WHO Chief Dental Officer Benoit Varenne, Ph.D., expressed concerns about media coverage of the interim guidance:

*"Unfortunately, a number of media headlines intentionally or not — when they are referring to the WHO guidance, did not mention that the recommendation to delay routine oral health care is only suggested in an intense uncontrolled community transmission scenario. A scenario that [does] not fit with the current situation of [most countries] around the world," Dr. Varenne said. "So please be aware of the missing information sometimes disseminated by the media that could increase fear and concern of patients seeking oral health care. I think we have all to play a part in sharing with the public, national dental associations and health authorities the full story provided in the guidance document."*

Dentistry has been greatly affected by the COVID-19 pandemic. Initially, the ADA and CDC recommended that we halt all elective dental procedures and treat only emergency patients out of concern that rapid spread of the COVID-19 SARS virus was caused by respiratory droplets, aerosols, and close proximity to those that are actively infected. Dental professionals working in such close proximity to the mouth were deemed high risk for cross contamination and spread of the virus.

Even though we have been doing our part in postponing care, we as dentists knew that we could only delay dental procedures, therapies, and surgeries for so long before so called "elective" procedures went from having a good outcome to a poor or hopeless prognosis. Many dentists were forced to grapple with the clinical judgement of what dental problems could wait, and what could send a patient to urgent care.

Dental professionals quickly came up with solutions and guidelines for continuing safe dental treatment. Shorter dental appointments, telephone screenings and triage, additional PPE, patients wearing cloth face masks to appointments, additional air filtration systems, and practicing hand hygiene were all part of the "new normal."

It seemed that as soon as we found a balance between safety and providing essential services, another roadblock came in August when the WHO put out a statement or "guidance" that dental procedures should be delayed until after the pandemic.

The ADA, CDA, AAP, and numerous other organized dental bodies quickly made position statements disagreeing with the WHO guidance. Dentists were quick to point out that there is limited evidence showing that dental offices have been vectors for spreading the COVID-19 virus.

Dental settings which include clinics, surgical centers, dental schools, supply centers, and laboratory facilities should all continue to balance the need to provide the necessary services in order to ensure that our patients and support staff remain healthy. The link between systemic diseases and oral health is clear, and the only way to establish good oral health is by early prevention and intervention.

Ultimately, we must continue to use our clinical skills, better judgment, and fulfill our moral obligations in order to find balance and do what is right by our patients. By utilizing our words and voices in a productive and constructive matter, we can continue to prevent fear mongering, and the spread of misinformation.

In order to stay informed with the latest COVID-19 updates, please go to the following: California Department of Public Health: cdph.ca.gov, and your local health departments: San Diego County: https://www.sandiegocounty.gov/coronavirus.html or Imperial County: http://www.icphd.org/

## A MESSAGE FROM CDA

CDA and ADA strongly disagree with the WHO's August 3 guidance advising non-essential oral health care, including oral health check-ups, dental cleanings and preventive care, be delayed.

The WHO provides guidance worldwide, and its recent document "Considerations for the provision of essential oral health services in the context of COVID-19" is not specific to CA.

*"The American Dental Association (ADA) respectfully yet strongly disagrees with the World Health Organization's (WHO) recommendation to delay "routine" dental care in certain situations due to COVID-19".*
*– ADA*

CDA Practice Support provides resources and tools to help dental teams practice safely during the pandemic using guidance from the CDC, and CA Dept. of Public Health.

References: ADA.org, CDA.org, PERIO.org, CDC.gov
"Oral health is integral to overall health. Dentistry is essential health care," states ADA President Chad P. Gehani, D.D.S.
"Dentistry is essential health care because of its role in evaluating, diagnosing, preventing or treating oral diseases, which can affect systemic health."
CDA will inform members of the latest updates regarding WHO's recommendation as they become available. –Cda.org (8-12-20).

Garrett Guess, DDS

Dr. Guess (pictured here with his family) is a Diplomate of the American Board of Endodontics, with a private endodontic practice in the La Jolla/UTC area. He developed EndoTrak, an endodontic practice management software program. Email: endo@drguess.com

# Dental Practice Cybersecurity Readiness

As dentists there is no question we are living and working in a "cyber" age: one where information technology and computerization affects and runs many aspects of our lives. In this age, it may seem overwhelming to keep up with the the technologies that exist, as well as the risks that are present. Fortunately, our government's Department of Homeland Security has an agency that is trying to help us keep afloat, called the Cybersecurity and Infrastructure Security Agency (CISA). Recently the CISA published the first couple chapters of their six-part "Cyber Essentials Toolkit" which are informational pamphlets or guides that help business owners like dentists navigate safely in this cyber age we practice in, by recognizing and then building an action plan to be better prepared to face the risks and continue to function in this challenging age.

The CISA Cyber Essentials Toolkit Chapter 1 is titled "Yourself, The Leader" and is a worthy two-page PDF document I recommend every dentist, especially those who define their office policies, to read. These are the main points this document brings to light:

**1. Approach computerization and information technology as a business risk.** It is important to realize that there are significant risks that technology brings to our practice of dentistry, in addition to its benefits. Often many dentists focus on benefit utilization but do not take a step back and ponder the risks. Identifying the risks so you can reduce your vulnerability, and then also plan for contingencies, is essential for a dentist who defines their office policy to perform. Everyone's utilization of technology is different, so everyone should assess their risks and plan individually. That means just downloading a generic risk assessment document and adopting it as your practice's risk management plan isn't very helpful.

**2. Determine how much of your organization's operations are dependent on IT.** If you take the time to write out all of the operations that a dental practice performs that are based on information technology and the storage and transmission of data, it will help you recognize what it would take to restore normal operations should a failure or loss of services occur.

**3. Invest in basic cybersecurity.** Spend the time to train your staff and consult with your software and hardware vendors and IT support people to ensure your practices are appropriate for managing risks, and you have plans in place to recover and get back to normal operation when a security breakdown occurs.

**4. Build a network of trusted relationships for timely/updated cyber threat information.** Reviewing the ADA and CDA websites with their practice management resource library sections can be helpful. Staying up on the current trends in cybersecurity issues via various websites like the www.CISA.gov can also be helpful.

**5. Develop cybersecurity policies based on input from your trusted relationships.** Even if you have the knowledge and experience to manage your own practice's systems, one must continually adapt and update policies to stay on top of the latest risks.


If you are interested in reading the first Chapter of the *Essentials Toolkit* which provides numerous direct resource links to take action on the above 5 main points, the PDF can be accessed from the Department of Homeland Security's CISA website here: https://www.cisa.gov/publication/cyber-essentials-toolkits. •

MONDAY

**OCT 05**

1 CE unit

## How to Make your Staff a High Performance Team in Times of Uncertainty

SDCDS

**Speaker:**
Jonathan Miller

**Summary:** This course offers 'real world' solutions to specific team challenges that practices struggle with daily. You will learn valuable techniques that will help you improve leadership skills, communication, build teamwork, and increase your staff's commitment to practice excellence.
**Time:** 6pm-7pm
Registration: sdcds.org, 619.275.7188 or admin@sdcds.org Meeting ID and password will emailed on Sept. 30th.
**Pricing:** Free
**Sponsors:** Fortune Managment

FRIDAY

**OCT 09**

## Dental Practice Act and Infection Control

*FREE CE**

SDCDS

**Speaker:**
Diane Arns, BS

**Summary:** This course reviews the DPA topics and regulations that are required for re-licensure. Then review CDC guidelines and State regulations for Infection Control.
**Time:** 8am-12:30pm
**Location:** SDCDS Office
**Register:** sdcds.org, 619.275.7188 or admin@sdcds.org Meeting ID, password and handouts will be emailed on October 6th.
**Pricing:** member/staff $25 (or use your * 1 FREE member benefit CE for 2020). nonmember: $50
**Sponsor:** Bank of America, Bank of California, Fortune Management, GlaxoSmithKline
**Co-Hosted by:** San Diego County Dental Hygienists' Society

THURSDAY

**OCT 22**

4 CE units

## BLS Renewal for Healthcare Providers

*FREE CE**

SDCDS

**Summary:** Register early if your CPR card is expiring; limited spaces available.
**Time:** 5:30-9:30pm (5pm check-in)
**Location:** SDCDS Office
**Register:** sdcds.org 619.275.7188 or admin@sdcds.org
**Pricing:** member $40... (or use your * 1 FREE member benefit CE for 2020). nonmember $60, member staff $50

TUESDAY

**OCT 27**

1 CE unit

## Oxidative stress: The mechanism that destroys bone around implants. Can we prevent or treat with PRF?

SDCDS

**Speaker:** Dr. Joseph Choukroun, Inventor of the PRF® technique

**Summary:** Oxidative Stress: The mechanism that destroys bone around implants. Can we prevent or treat with PRF?
**Time:** 8pm-9pm
**Register:** sdcds.org 619.275.7188 or admin@sdcds.org. Meeting ID and password will emailed on October 23rd.
**Pricing:** Member: FREE Non-members: $50

FRIDAY

**NOV 06**

3.5 CE units

## TMD and Non-dental Tooth Pain

*PART 1 Webinar*

SDCDS

**Speaker:**
Dr. Joseph R. Cohen

*Course credit approved by AGD for your Fellowship/Mastership

**Summary:** Avoid Restorative and Orthodontic Failures Due to Undiagnosed TMD and Orofacial Pain. Learn how to screen for TMD (TMJ) as part of the complete dental examination. Review how to treat uncomplicated cases and which cases to refer to an orofacial pain dentist with specialty training.
**Time:** 8:30am-12:30pm
**Register:** sdcds.org, 619.275.7188 or admin@sdcds.org Meeting ID, password and handouts will be emailed on Nov. 3rd.
**Pricing:** member/staff $15 | nonmember: $30 or TWO-DAY BUNDLE price member/staff $25 | nonmember: $50
**Sponsor:** Bank of America, Bank of California, Fortune Management, Ken Rubin Practice Sales, Integrity Practice Sales

SATURDAY

**NOV 07**

3.5 CE units

## TMD and Non-dental Tooth Pain

*PART 2 Webinar*

SDCDS

**Speaker:**
Dr. Joseph R. Cohen

*Course credit approved by AGD for your Fellowship/Mastership

**Summary:** 40% of patients presenting to the dental office with tooth pain do not have pain related to teeth. This presentation will help dental practitioners identify these patients to avoid unnecessary dental procedures that often cause more pain and loss of healthy teeth.
**Time:** 8:30am-12:30pm
**Register:** sdcds.org, 619.275.7188 or admin@sdcds.org Meeting ID, password and handouts will be emailed on Nov. 3rd.
**Pricing:** member/staff $15 | nonmember: $30 or TWO-DAY BUNDLE price member/staff $25 | nonmember: $50
**Sponsor:** Bank of America, Bank of California, Fortune Management, Ken Rubin Practice Sales, Integrity Practice Sales

**COVID-19 UPDATE:** Because of the lead time required for printing and shipping, and the changing landscape of the Coronavirus, subsequent event cancellations may be necessary. Please check our website for the latest information sdcds.org/events

# 2020 POSTPONED EVENTS NEW DATES PENDING, STAY SAFE.

**Sep 19**

6 CE units

## Contemporary Forensic Dentistry

**Summary:** Topics will include forensic dental identification of decedents of varying postmortem states including: skeletal, fragmented, decomposed, burned remains and pattern injuries as they relate to bite mark investigation not only in human bites but animal bites as well.
**Location:** Handlery Hotel
**Sponsors:** Banc of California, Fortune Management, Garfield Refining, Integrity Practice Sales, Ken Rubin Practice Sales

**Sep 26**

## Gala Celebration

**Summary:**
Red Carpet fundraiser, 'Old Hollywood'. Last years event was attended by over 300 guests.
**Time:** Evening
**Location:** Del Mar Hilton
**Includes:** Dinner, Silent Auction, Live Auction
**Pricing:** Member $175

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