Bulletin of the San Fernando Valley Dental Society

Dental DimensionS

Spring 2019

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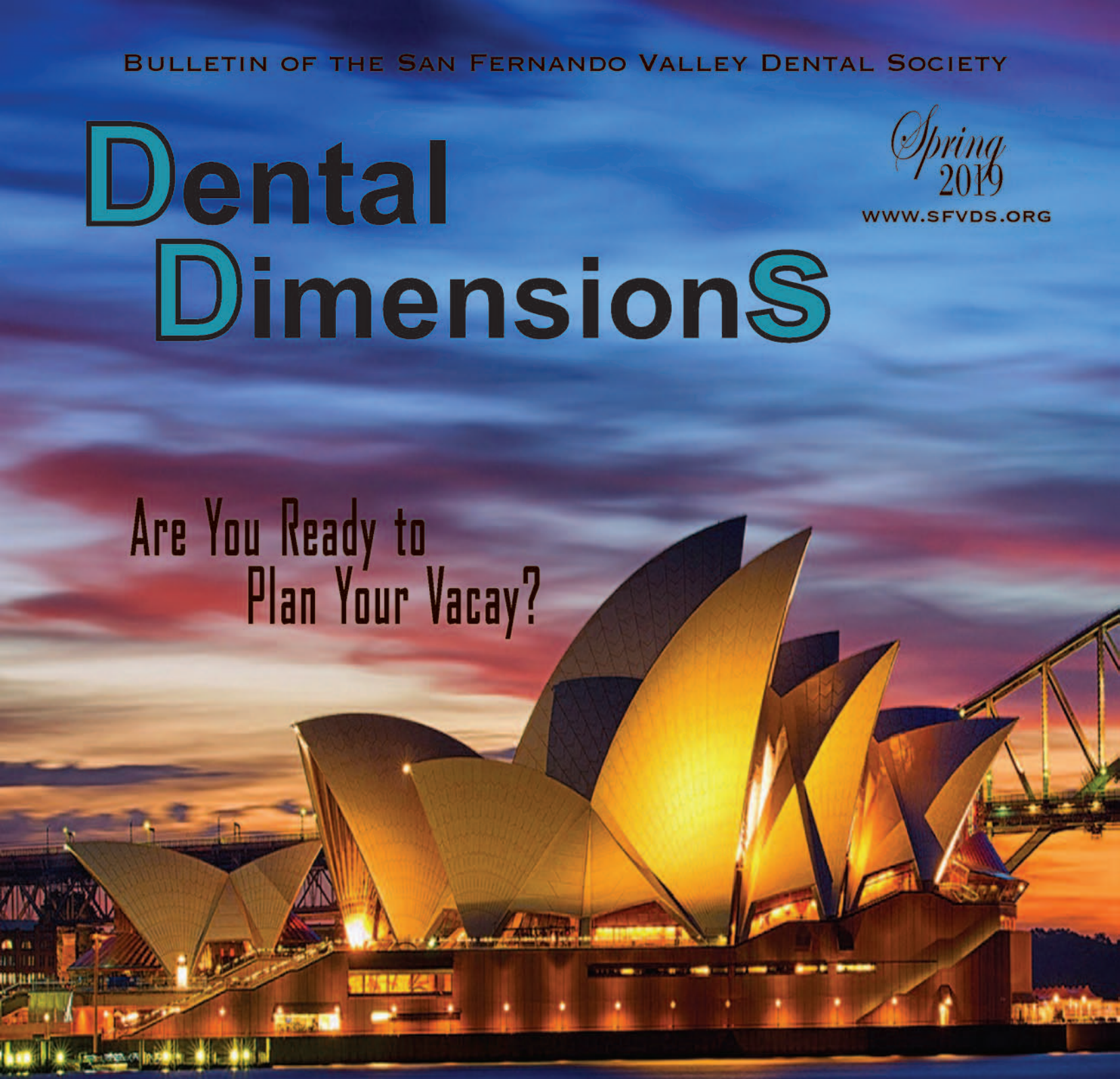

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Spring 2019
Volume LIII Number 2

Dental DimensionS

Published by the San Fernando Valley Dental Society
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Published quarterly by the San Fernando Valley Dental Society. The Society solicits essays, letters, opinions, abstracts and publishes reports of the various committees; however, all expressions of opinion and all statements of supposed fact are published on the authority of the writer over whose signature they appear, and are not regarded as expressing the view of the San Fernando Valley Dental Society unless such statement of opinions have been adopted by its representatives. Acceptance of advertising in no way constitutes professional approval or endorsement.

Graphics by: C. Stieger Designs

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Call for Submissions

Do you have an unusual case study or an interesting article you would like to have published? Dental Dimensions is looking for articles from our members so we can share our collective knowledge. Articles should be 500-1000 words with references where applicable and photos if possible. Send your submissions to:
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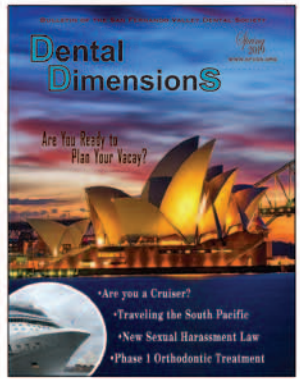

On The Cover.....

The Sydney Opera House and a Cruise Ship (insert) - vacations that are covered in this issue's non-clinical theme of leisure activities.

From the Desk of the President

Mahfouz Gereis, DDS

The continued success of an organization involves periodic review of its Mission and its Vision Statements. In the first week of March, I and thirteen members of the board along with our Trustee, and our Executive Director embarked on a 3-day cruise to Ensenada, Mexico to undertake this review of our strengths and weakness as well as our future goals as part of our biannual strategic planning process.

Wait, what?!? Did he day 3-day cruise? I know, you're probably thinking, what a fun way to "work", but I assure you that the majority of the cruise was spent in intense discussions by some of the most intelligent, dedicated and hardworking professionals in our dental society.

We devoted the first day of the cruise to analysis for the society and the second to work on our foundation. We used SWOT analysis which focuses on an organization's STRENGHES, WEAKNESSES, OPPORTUNITIES and THREATS.

The San Fernando Valley Dental Society's greatest STRENGTHES are its dedicated membership and board; the wide variety of services it provides; our responsiveness to you, our membership; and our advocacy on your behalf with organized dentistry.

For these reasons, our membership continues to grow year after year, which creates more OPPORTUNITIES to collaborate with other dental societies and dental support organizations, and to introduce programs to better serve our members and the underserved community.

We noted that our areas of WEAKNESS AND THREATS are diminished sources for fundraising, lack of engagement with non-dentists and new graduates, challenges with our market share, and abuse of programs. We brainstormed ideas to combat these problems.

It was a very productive and fun working weekend. The highlight of our fun events was Karaoke night. Although after listening to some performances, I see why none of us are pop stars!

In other news, we continue to receive numerous complaints from members about problems with third party insurance companies, including the high rate of denials of services and delays in solving problems.

In response, we conducted a survey of all SFVDS members with questions designed to establish whether a problem exists, how it has increased over time, and if our members are aware of the CDA's Practice Support Center (PSC), which deals with such complaints. The response to the survey was overwhelming, with 24% responding, which is very high compared to similar surveys. We certainly established that there is problem with this area that needs to be addressed.

As you may already know, in the 2017 CDA House Of Delegates the SFVDS introduced a resolution to form a task force to look into the stalling tactics used by third party insurance companies in handling claims. We shared our findings from this recent survey with CDA and are currently working closely with them on how to best utilize this valuable information as a tool for this task force.

Finally, in addition to the biannual Strategic Planning meeting and our continued work with the CDA to address third party insurance company problems, the SFVDS conducted two general CE meetings and two zone meetings, both of which were well attended.

We strive to serve our members with whatever needs they have and we would love to hear from you with any remarks, concerns or complaints. Please contact our office if you need to get in touch with us.

Once again, we love to serve our members and community and we do it with integrity, honor and dedication because we are the SAN FERNANDO VALLEY DENTAL SOCIETY!

Mahfouz Gereis, DDS

Trustee Report

California Board of Trustees met on Feb 2019 and the following were discussed.

Medicare Task Force: At the 2018 CDA House of Delegates, the San Fernando Valley Dental Society submitted a resolution requesting the creation of a taskforce to explore the potential implications of including dental benefits within the Medicare program. The board approved the establishment of a 'Medicare Task Force' identifying the task force's scope and composition. The taskforce will take into account changing dental benefits, both in California and nationally. The report will include a summary of relevant CDA and ADA policies, current national advocacy efforts, proposed benefit designs, and potential economic factors for patients and dentists. The taskforce will be chaired by Dr. Gary Herman, who has previously served as a SFVDS president and trustee.

TDIC Update: The board was advised that TDIC successfully completed the merger of Dental Benefits Insurance Company (DBIC), Dentists Benefits Corporation (DBC) and Northwest Dentists Insurance Company (NORDIC), uniting all companies as one, and extending coverage to more than 5,000 additional policyholders in five states. The board also received an update regarding TDIC's current activities to position itself for future national growth. These activities include:

- Negotiations for continued endorsement in Oregon, Idaho and Washington.
- Consolidation of all policy administration systems for TDIC, TDIC Insurance Solutions, DBIC, DBC and NORDIC into Guidewire, which will take approximately three years.
- Implementation of a data warehouse.

Karin Irani, DDS

TDSC Update: TDSC was created to increase our members' buying power. The board received an update regarding the TDSC Marketplace's, out-of-state expansion, which has resulted in 21 affiliated states thus far. Make sure to check out the TDSC Marketplace. If you don't find items you are looking for, give them a call. Either they will find it on the site or they will try to order it for you.

Dental Licensure Portfolio Examination: Drs. Steven Friedrichsen, Dean, College of Dental Medicine, Western University of Health Sciences; Steven Morrow, Vice President, Dental Board of California; and, Sigmund Abelson, Associate Dean of Clinical Affairs, University of Pacific Arthur A. Dugoni School of Dentistry, provided background on the 'Dental Licensure Portfolio Examination'. The board received this presentation, in an

Continued on page 23

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Legislation Report

Jorge A. Alvarez, D.D.S.

On Thursday, February 21, 2019, the San Fernando Valley Dental Society's Legislative Committee, had the pleasure of inviting one of the candidates running in the special election for the City of Los Angeles' 12th Council District in June this year to replace council member Mitchell Englander, to the central office for a meet and greet.

The geographical areas that are part of 12th Council District are: Chatsworth, Northridge, North Hills, Granada Hills, Porter Ranch, Reseda, Sherwood Forest and West Hills. All of these communities fall within the San Fernando Valley Dental Society's component boundaries.

For almost two decades, Scott Abrams (fourth from the left) has served as a senior aide to U.S. Congressman Brad Sherman. As director of the San Fernando Valley constituent service office, he has attended hundreds of community events and helped Congressman Sherman host town hall meetings. He has lifelong roots in the San Fernando Valley, where he lives with his wife Dana and three children.

In the meeting with some of our Board members (see photo), he told us about himself and answered a variety of questions. His answers were very descriptive and revealed a good understanding of the complexities of governing in the City of Los Angeles, including some of the regulations that affect our dental practices.

Our Legislative Committee will be inviting other candidates to visit our dental society.

National Legislation:
Finally, on Feb. 28, 2019, the ADA has succeeded, after trying for more than 20 years, to get bipartisan legislation introduced in the U.S. House of Representatives to repeal the McCarran-Ferguson antitrust exemption for health insurance companies.

HR 1418, the Competitive Health Insurance Reform Act, was introduced in the 116th Congress by Rep. Peter DeFazio, D-Ore., and Dentist/Rep. Paul Gosar, R-Ariz., and included eight co-sponsors. The Senate version of the bill, S 350, was introduced on Feb. 6 by Sens. Steve Daines, R-Mont., and Patrick Leahy, D-Vt.

In an action alert to ADA grassroots members, Dr. Brad Barnes, grassroots chair of the American Dental Political Action Committee, urged dentists to contact their legislators to support the bill.

State Legislation
Proposition 56 Medi-Cal Funding: More than half of children and a third of adults — more than 13 million Californians — now rely on the state's Medi-Cal program for their medical and dental coverage. The passage of Prop. 56 in 2016 — a tobacco-tax increase co-sponsored by CDA — has led to significant Medi-Cal funding improvements. Prop. 56 funds have helped address this in a significant way, with $210 million going to rate increases for hundreds of dental procedures, and it is producing results. The number of enrolled dentists has increased 10 percent since 2017 and, in combination with additional provider incentives and administrative reforms, the state is finally seeing increases in the number of children and adults receiving necessary oral health services.

Universal Health Care: CDA is committed to building upon the existing health care delivery system to extend health coverage to all Californians. CDA will be working with lawmakers to achieve universal coverage that includes dental care and to protect the significant progress the state has made under the Affordable Care Act (ACA). CDA is urging the state to pursue universal health care in a way that is sustainable, that does not upend the progress made under the ACA and that maximizes funding from the federal government, which currently provides more than half of the state's health care dollars.

AB 954: Dental Plan Network Leasing – Sponsor: CDA is sponsoring AB 954 (Wood) to require 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. The growing trend of network leasing is causing confusion and difficulties for California dentists and their patients.

Sugar-Sweetened Beverages (SSBs): CDA and the California Medical Association are co-sponsoring three bills that would reduce the consumption of sugary beverages including soda, energy drinks, sugar-added juices and sports drinks:

- AB 764 (Bonta) will prohibit a soda company form offering a manufacturer's coupon to distributors, manufacturers or retailers.
- AB 765 (Wicks), the Healthy Checkout Aisles for Healthy Families Act, will prohibit placement of SSBs near the checkout counter at supermarkets, large grocery stores and warehouse clubs.
- AB 766 (Chiu) will ban the sale of unsealed beverages larger than 16 ounces at food service establishments.

CDA is also supporting AB 138 (Bloom) which creates a fee on the distribution of SSBs and SB 347 (Monning) which will require a warning label on sugary drinks to help educate consumers as they make their purchasing decisions.

Continued on page 11

You need a friend in the business.

The practice of dentistry is challenging…especially in California. Changing tax laws, redefinitions of Independent Contractors and discovery of errors, omissions and outright fraud related to dental practice acquisition (especially those offered by FSBOs) require experienced, expert handling. You need someone who has seen it all and knows what to look for…someone to protect your interests, your money and long-term profitability. I am that man.

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- **Risk Management**
- **Business Plan and Strategy**
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General Meeting Review

Nancy Dewhirst, RDH

February 20, 2019 - CA Dental Practice Act and Infection Control

The DPA topic areas that the Board of Dental Examiners considers important for all licensees to be aware of were reviewed and attendee questions were answered about all licensure and license renewal requirements, oversight of auxiliaries and independent practice laws, and application of standards of care provisions. The infection control portion of the class blended science with reality: reviewed CDC Guidelines and state regulations for Infection Control. Updates included challenges such as aerosol transmitted diseases (ATD's) and evolving / resistant pathogens.

Ali Nasseh, DDS

March 20, 2019 - Safety and Simplicity in Root Canal Instrumentation

Dr. Nasseh emphasized that recent improvements in metallurgy, enhanced designs and innovative rotary file motions, and that the need to understand how these changes affect clinical instrumentation is critical. He suggested that dentists must take advantage of these improvements to create an instrumentation protocol that combines safety with simplicity!

Ron Kaminer, DDS

April 6, 2019 - HANDS-ON Predictable Crown and Bridge (At the Burbank Dental Labs)

In the morning, Dr. Kaminer reviewed various prep styles, burs and today's materials used in crown and bridge work. He spoke about temporization of difficult cases, tissue retraction, an intro to diode lasers, impression tricks and cementation. In the afternoon, during the hands-on portion, he coached attendees on temporization, working with multiple scanners and cementation.

Jose Luis Ruiz, DDS

April 24, 2019 - Minimally Invasive Rehabilitation of the Worn Dentition

As affordability of large cases is frequently a problem for many patients, Dr. Ruiz taught a practical technique to treat these cases over time. He gave insights to the techniques used in full composite rehabilitation and how to implement occlusion into the overall treatment. He also reviewed the use of semi-adjustable articulators, CR bite and how to clearly and convincingly motivate patients for treatment acceptance.

General Meetings -2019

Sigal Jacobsen, DDS

June 19, 2019 - Create Butiful Composite Restorations in the Aesthetic Zone

Dr. Jacobson invented the patented UVENEER™, a unique template system for creating direct composite veneers and mock-ups. The Uveneer system is a unique way to create fast, predictable polished restorations and she will share practical techniques for minimally invasive dentistry and composites in the Aesthetic Zone.

Don Coluzzi, DDS

June 29, 2019 - Using Lasers in Your Practice HANDS ON

For those who are unfamiliar with using lasers in dentistry, this is the course for you. You will learn about the various lasers used and for what purpose, and you will have a chance to use lasers on both hard and soft tissue – on actual pig jaws with intact teeth and gums.

Anesthesiology recognized as the 10th dental specialty

By: Kimber Solana, CDA

Dental anesthesiology becomes the 10th dental specialty recognized by the National Commission on Recognition of Dental Specialties and Certifying Boards.

The recognition comes after the National Commission on March 11 adopted a resolution based on an application from the American Society of Dentist Anesthesiologists to recognize dental anesthesiology as a dental specialty.

The ADA House of Delegates in 2017 established the National Commission to oversee the decision-making process for recognizing dental specialties. Dental specialties are recognized "to protect the public, nurture the art and science of dentistry, and improve the quality of care," according to the National Commission website. The "Requirements for Recognition of Dental Specialties" is still managed by the ADA's Council on Education and Licensure and the ADA House of Delegates.

A sponsoring organization seeking specialty recognition for a discipline within dentistry must document that the discipline satisfies six requirements, as outlined in the "Requirements for Recognition of Dental Specialties." The sponsoring organization of the proposed specialty must provide documentation to show that it is a distinct and well-defined field that requires unique knowledge and skills beyond those commonly possessed by dental school graduates; that it requires advanced knowledge and skills; and that it scientifically contributes new knowledge, education and research in both the field, and the profession.

The American Society of Dentist Anesthesiologists submitted its application to the National Commission in September 2018. Following a review by the National Commission's Review Committee on Specialty Recognition in November 2018, the National Commission invited public comment for a 60-day period.

At its February 2019 meeting, the review committee considered all the comments received that directly related to whether the application met all the requirements for specialty recognition and made a recommendation to the National Commission to grant specialty status. At its March 11 meeting, the National Commission determined that the application did indeed meet the "Requirements for Recognition of Dental Specialties" and adopted a resolution recognizing dental anesthesiology as a dental specialty. A resolution needs a two-thirds majority vote to be approved.

Following approval by the National Commission, the sponsoring organization must establish a national board for certifying diplomats in accordance with the "Requirements for Recognition of Dental Certifying Boards."

Dental anesthesiology now joins the following dental specialties: dental public health; endodontics; oral and maxillofacial pathology; oral and maxillofacial radiology; oral and maxillofacial surgery; orthodontics and dentofacial orthopedics; pediatric dentistry; periodontics; and prosthodontics.

The National Commission on Recognition of Dental Specialties and Certifying Boards is comprised of nine general dentists, appointed by the ADA Board of Trustees and approved by the House of Delegates; one specialist from each of the nine recognized specialties, appointed by the sponsoring organization; and a public/consumer member appointed by the National Commission.

The recognition comes nearly 175 years after a Hartford, Connecticut, dentist extracted one of his third molars to test the analgesic properties of nitrous oxide. It was Dr. Horace Well's introduction of nitrous oxide, and the demonstration of anesthetic properties of ether by Dr. William Morton, a student of Dr. Wells', that gave the gift of anesthesia to medicine and dentistry.

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Employers must provide sexual harassment prevention training to all employees by Jan. 1, 2020

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Gov. Jerry Brown last September signed a bill requiring California employers of five or more employees to provide expanded training on sexual harassment prevention to all of their employees by Jan. 1, 2020. Practically speaking, this means employers will need to complete the mandatory one- or two-hour trainings for employees in 2019 to be compliant by the January 2020 deadline.

Crafted in response to renewed attention on sexual harassment in the workplace, brought on in part by the #MeToo movement that gained national traction in fall 2017, the new law is a dramatic shift from current requirements that have been in place for more than a decade. The Legislature concluded that millions of employees in the state may not be aware of their rights and responsibilities under California anti-harassment laws or trained on how to detect and report inappropriate behaviors. The new sexual harassment prevention training requirement impacts the majority of businesses in the state and all of their employees and managers.

Main points for employers

- Employers with at least five employees, in order to comply with the new requirements, must provide by Dec. 31, 2019: (1) at least two hours of sexual harassment prevention training to all managerial employees and (2) at least one hour of sexual harassment prevention training to all nonmanagerial employees.
- After the 2019 compliance requirements are met, employers must provide training every two years at minimum.
- Training must occur within six months of hire to a nonmanagerial position or promotion to a managerial position (including hiring) as applicable.
- Newly created businesses with five or more employees or contractors must provide training within six months of the business' establishment and then every two years thereafter.
- Part-time, temporary and independent contractors must be included toward the minimum count of five employees.
- The training may be conducted as a group presentation or on an individual basis and may be broken into shorter time segments as long as the two-hour requirement for managerial employees and one-hour requirement for nonmanagerial employees are met.
- Employees hired after Jan. I, 2020, who received training by a previous employer need only be required to read and acknowledge receipt of the employer's anti-harassment policy within six months of assuming the new position. The burden of establishing that the prior training was legally compliant with this section is on the current employer.

Training for seasonal and temporary employees

Also by the January 2020 deadline, employers must provide training to temporary and seasonal employees, as well as any employee who is hired to work for less than six months. The training must occur within 30 calendar days after the hire date or within 100 hours worked, whichever comes first. In the case of temporary employees employed by an agency (as defined by Lab. Code sec. 2810.3) to perform services for clients, the training must be provided by the agency, not the client.

Training formats

Employers can satisfy this training by offering classroom training, e-learning or webinars as described here.
Classroom training: In-person classroom training that features content created by a trainer. The employees receive the training from a trainer in a setting that is removed from the employees' daily duties. California law in CCR sec. 11024(a)(9) specifically defines the credentials that a qualified trainer must possess.

E-learning: Individualized, interactive and computer-based training that was created by a trainer and an instructional designer. Employees must have the opportunity to ask a trainer questions and receive a response within two business days.

Webinar: An internet-based seminar that features content created and taught by a trainer and that is transmitted over the internet in real time. Employers who use a webinar for training must document that each employee who is not physically present in the same room as the trainer attended the training. They must also document that the employee actively participated in the training's interactive content, discussion questions, hypothetical scenarios, polls, quizzes or tests and activities. Webinars must provide employees with the opportunity to ask questions and receive answers to those questions or otherwise seek guidance and assistance.

The regulations also authorize other effective, interactive training — including audio, video or other computer technology — but only if used along with, and as a supplement to, classroom, webinar or e-learning training.

Record-keeping requirements

To track compliance, employers must keep documentation for a minimum of two years and be able to provide copies upon request.

The training record must include all of the following minimum information:

- The name of the supervisor who received training
- The training type and date
- The attendance sign-in sheet
- A copy of all certificates of attendance or completion issued
- A copy of all written or recorded materials that comprise the training
- The training provider's name

In addition to the above, specific documentation requirements for both trainers and employers are mandated for e-learning and webinar training:

- E-learning: The trainer must maintain all written questions received and all written responses or guidance provided for a period of two years after the date of the response.
- Webinars: The employer must maintain a copy of the webinar, all written materials used by the trainer and all written questions submitted during the webinar. The employer must also document all written responses or guidance the trainer provided during the webinar.

Government obligations

The Department of Fair Employment and Housing must develop or obtain two online training courses on the prevention of sexual harassment in the workplace in accordance with the provisions of the law. Both courses must contain an interactive component that requires viewers to periodically answer questions in order for the course to continue to play. The DFEH published a new online resources webpage for California employers (www.dfeh.ca.gov/resources-for-employers) and expects to have such trainings available by late 2019.

Preparation and planning

Employers with five or more employees should check their calendars and determine when they can train their employees in 2019 in order to be compliant with the law by the Jan. 1, 2020, deadline.

Employers might begin by researching third-party companies that are qualified to conduct training under DFEH regulations for either in-person or online training. Before deciding to utilize a company, the employer should verify that its training meets the requirements outlined above.

Directing employees to online training courses hosted by DFEH is another way employers can satisfy their harassment prevention training obligations. Regardless, the unavailability of a specific training should not preclude employers from satisfying the requirement sooner rather than later.

Developing a written harassment, discrimination and retaliation prevention policy that reflects current law is a requirement under California law. A policy can be found in CDA Practice Support's "Sample Employee Manual" template.

- Find resources on employment practices at cda.org/practicesupport.

Continued from page 6

Legislation Report

CDA and CMA are also co-sponsoring a ballot measure for the November 2020 election to establish a statewide two-cent-per-ounce tax on the distribution of SSBs

SB 154: Silver Diamine Fluoride – Sponsor: CDA is sponsoring SB 154 (Pan) this year to add silver diamine fluoride (SDF) as a Medi-Cal benefit for treatment of dental decay when applied as part of a comprehensive treatment plan. SDF is an effective, noninvasive and low-cost option for slowing or stopping the growth of cavities and should be available when treating the Medi-Cal population.

State Office of Oral Health – Proposition 56 Funding: The state began providing ongoing funding for a dental director and the Office of Oral Health (based in the Department of Public Health) in the 2014-15 budget for the first time in decades. This effort received a strong boost from the passage of Prop. 56, which includes an annual $30 million for the state oral health program – a tenfold funding increase and the first time the program has ever had a dedicated revenue source.

Dental Unit Waterlines

Dental operative units are intended to supply power (electrical, air, water, etc.) and serve as a base for other dental devices, such as a dental handpiece and other dental accessories. The water supply of the dental operative unit is sourced from municipal water or a closed-bottle water system. The waterlines of a dental unit, typically constructed from a polymer (e.g. polyurethane, polyvinyl chloride) or silicone rubber tubing, provide water from its source for irrigation, cooling, and flushing of the patient's oral cavity during dental procedures. Dental operative units are Class I, FDA-regulated medical devices, and require premarket clearance (510(k)).

Importance of Infection Control

Municipal water contains microorganisms that may be considered safe for drinking water, but could potentially cause patient infections when used during dental procedures. Dental unit waterlines, including those connected to municipal water sources or closed-bottle systems, typically cannot be sterilized; however, they should be routinely cleaned and disinfected. Without proper cleaning and disinfection, waterborne microorganisms can collect in the dental unit waterline and form a biofilm, a layer of microorganisms or bacteria adhered to the surface of the dental unit waterline, that can become dislodged and enter the water stream. Contaminated dental unit waterlines pose a risk of infection to the patient, particularly during surgical procedures by direct exposure of waterborne pathogens and to dental professionals due to inhalation of aerosols.

The Centers for Disease Control and Prevention (CDC) Guidance Document, Guidelines for Infection Control in Dental Health-Care Settings — 2003, recommends treating the water used in dental units with commercial products such as chemical germicides to meet drinking water standards. Also, the American Dental Association (ADA) recommends routine monitoring of the water to demon strate bacteria count of less than or equal to 500 Colony Forming Units (CFU) per milliliter of heterotrophic bacteria.

Recommendations

Dental practitioners should adopt appropriate infection control procedures for dental unit waterlines based on the manufacturer's instructions for use. This should include infection control measures such as, but not limited to, monitoring water quality. The water management plan should include specific testing locations and frequencies, and actions to take (e.g., remediation, retesting at shorter intervals) based on test results.

Tips for Dental Practitioners

- Dental professionals should establish written standard operating procedures to guide dental personnel in performing infection control procedures for dental unit waterlines.
- Implement the use of equipment and procedures such as separate reservoirs, chemical treatment protocols, use of filtration systems, and sterile water delivery systems.
- For units using separate water reservoirs, purge the dental unit waterlines each night and whenever units are out of service to prevent stagnant water from settling within the waterlines.
- Discharge water and air lines for a minimum of 20–30 seconds after each patient to physically flush out patient material that might have entered the dental water system during treatment.
- Monitor waterlines for damage or visible contamination and replace if needed or as directed by the manufacturer.
- Be alert to signs that may indicate biofilm formation including musty odor, cloudiness or particulates in the water, and clogging of lines.

DO:

- For surgical procedures, use sterile irrigating solutions, such as sterile water or saline. Appropriate delivery devices (e.g., bulb syringe; sterile, single-use disposable products; or sterile water delivery systems that bypass the dental unit by using sterile single-use disposable or sterilizable tubing) should be used to deliver sterile irrigating solutions during surgery. This may include a dedicated surgical irrigation system with components including handpieces that are single-use disposable or compatible with heat sterilization methods used in outpatient dental settings.
- Adhere to the recommended service life and maintenance of the dental operative unit and its components and accessories.
- Follow the manufacturer's instructions to clean and

Prescribers can use existing controlled-substance Rx forms until January 2021

A bill to address problems implementing new requirements for controlled-substance prescription forms sailed through the California Legislature and received Gov. Gavin Newsom's signature in March.

AB 149 delays the requirement for prescription forms with uniquely serialized numbers until a date to be determined by DOJ but no later than January 1, 2020; and also declares that any prescription written on a form that was otherwise valid before January 1, 2019, or was written on a form approved by DOJ as of January 1, 2019, is valid and may be filled, compounded or dispensed until January 1, 2021.

Starting Jan. 1, 2021, when prescribing controlled substances, prescribers will be required to use forms with unique serialized numbers compliant with National Council for Prescription Drug Program standards and that are linked to corresponding records in California's prescription-drug monitoring program known as CURES. These forms have not yet been developed and will be different from the forms the DOJ incorrectly approved in January 2019, as it was learned the serial number on those forms did not conform to national standards.

Until Jan. 1, 2021, pharmacists are authorized to fill, compound or dispense any prescriptions for controlled substances written on a form that was valid prior to Jan. 1, 2019, that doesn't include the unique serial number, or a form approved by the DOJ in January 2019 with an incorrectly formatted serial number. Neither of these forms, however, will be accepted beginning Jan. 1, 2021.

CDA actively supported AB 149 by Assemblymember Jim Cooper (D-Elk Grove) to resolve issues that began in early January when the previous bill, AB 1753, took effect and immediately required the availability and use of the new controlled-substance prescription forms. The absence of an expected transition period left prescribers and pharmacists scrambling to interpret and follow the law, and CDA Practice Support received numerous calls from dentists who reported having their prescriptions for controlled substances denied by pharmacists. CDA, other provider groups and the DOJ worked together to achieve a short-term resolution but issues with prescription fulfillment persisted.

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disinfect the dental unit at recommended intervals. Contact the manufacturer of the dental unit to obtain the most up-to-date instructions or with any questions regarding the reprocessing of the dental unit.

- Monitor the water quality and microbial contamination of the dental unit waterlines using standard culturing methods at appropriate intervals to keep bacterial counts lower than 500 CFU/mL of water as recommended by ADA.
- Always properly dispose of single use disposable items after they have been used.

DO NOT:

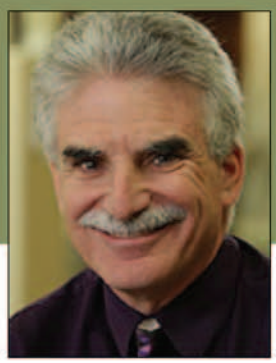
- Use the dental unit without following the cleaning and disinfection procedures in the manufacturer's reprocessing instructions.
- Attach dental handpieces or dental instruments to dental unit waterlines that have not been cleaned or disinfected per the manufacturer's instructions.
- Use cleaning and disinfection agents that are not recommended by the device manufacturer, as material incompatibility could result in structural damage that may increase the risk of biofilm formation or toxicity to patients.

Contact Information:
If you have questions, please contact CDRH's Division of Industry and Consumer Education (DICE) DICE@fda.hhs.gov, or via phone at 1-800-638-2041,
or 301-796-7100.

References:
Ricci ML, Fontana S, Pinci F, Fiumana E, Pedna MF, Farolfi P, et al. Pneumonia associated with a dental unit waterline. Lancet 2012;379:684.
Hatzenbuehler LA et, al. Pediatric dental clinic-associated outbreak of Mycobacterium abscessus infection. J Pediatr Infec Dis 2017; 6(3):e116-e112.
Peralta G, et al. Notes from the field: Mycobacterium abscessus infections among patients of a pediatric dentistry practice – Georgia, 2015. MMWR 2016; 65(13)355-6.
Orange County Health Care Agency. Dental Outbreak (Mycobacterium)

Additional Resources
- *Centers for Disease Control and Prevention. Guidelines for Infection Control in Dental Health-Care Settings - 2003. MMWR 2003:52(No.RR-17)-Accessed September 6, 2017*
- *Centers for Disease Control and Prevention. Questions & Answers: Dental Unit Water Quality*
- *American Dental Association: Oral Health Topics - Dental Unit Waterlines*
- *Organization for Safety, Asepsis and Prevention - Dental Unit Waterline Toolkitdisclaimer icon*

Phase 1
Orthodontic Treatment



By: Daniel Azani, DDS

Early orthodontic treatment or 'Phase I' treatment has been a controversial topic in the dental profession. Most people, including some dental professionals, feel that children should lose all their primary teeth before going to their local orthodontist for a consultation. However, most of the time that is not what should be happening. The American Association of Orthodontists recommends that children should have an orthodontic consultation by age seven.

But why, what are the advantages of doing this? In most cases, the patient will get orthodontic records started and the orthodontist will determine that treatment is not needed at that time, and the patient will be placed on a six-month recall. The advantage of doing this is that we will monitor dental eruption as well as growth and development, and we can then start treatment at the right time. Some children though, will need early orthodontic intervention due to dental and or skeletal problems.

Below are the possible reasons that make 'Phase I' treatment necessary.

1) Early or late loss of baby teeth
2) To create room for crowded or erupting teeth
3) To achieve facial symmetry by influencing jaw growth
4) To reduce the risk of trauma to protruding front teeth
5) Preserving space for unerupted teeth
6) To reduce the need for extractions by expanding and developing the arches
7) To correct mouth breathing
8) To correct speech impediments
9) To enable correct biting and chewing
10) Elimination of thumb sucking, or other oral habits
11) To correct facial asymmetries by correcting posterior and or anterior crossbites.
12) Early treatment may eliminate the need for surgery
13) Esthetics (large anterior spaces or crowding)
14) Reduces treatment time with braces
15) Stability (retention)

So then, what are the possible cons of 'Phase I' treatment?

1) Burn Out
2) Cost
3) Possible duplication of efforts

The goal for 'Phase I' is to reduce the amount of effort in 'Phase II' because we have already done the hard work in 'Phase I'. We like to use the analogy of a tree vs a twig. As a tree is growing and it's only a twig you can bend this twig and change the direction in which it is growing. Once the twig turns into a tree there is nothing you can do. Same principle applies to children. We can guide tooth eruption and alter facial growth during their growing years. Once the teeth erupt or the patient has ceased to grow the options for treatment are much more limited.

Traditionally we have used a combination of fixed and removable appliances during 'Phase I' orthodontic treatment. For the correction of posterior crossbite and to open more space for unerupted teeth, we either use an RPE (rapid palatal expander) or a W Spring. If the patient presents with a class III malocclusion, we will use a facemask also known as RPG (reverse pull headgear) for the correction of the anterior crossbite. This works really well in young children (6-8 year old). For the correction of class II malocclusions we will use the traditional Headgear or a Twin Block (removable appliance). We also typically bond fixed brackets on the upper and or lower incisors for alignment purposes. Other appliances that we commonly use are Tongue/Thumb appliances to help correct habits at an early age and the ALM (arch length maintainer) to help preserve the E space and for stability of the lower incisors. Studies have shown that the use of this appliance improves the stability of the lower incisors after orthodontic treatment.

Example of the use of 'First Phase Invisalign'

Can the digital world of Invisalign apply to the treatment of for 'Phase I'? The answer is yes.

Aligners can expand arches to regain space

Aligners can close spaces

Invisalign aligners have eruption compensation features that allow unerupted teeth to erupt into place

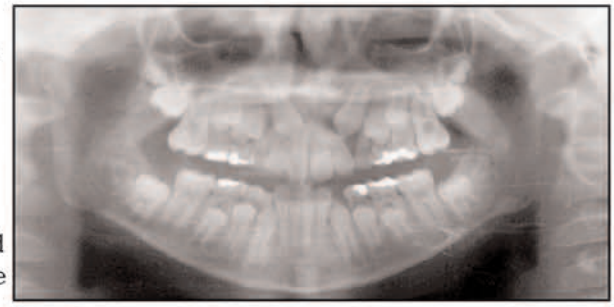
Elastics can be used with aligners to correct class II and class III malocclusions

Invisalign aligners now have an available mandibular advancement feature that allows for class II correction in growing children The biggest roadblock is that young kids like colors
We have been using an Invisalign product (Invisalign First) for the last year and one-half in our offices with great success. Cases are finishing faster than with traditional fixed appliances and more importantly, cooperation has not been an issue. In fact, most children are much better patients than most of our adult ones. Below are two cases treated with Invisalign First and both took only about six months to correct.

Example of the use of 'First Phase Invisalign'

Example of the use of 'First Phase Invisalign'

As you can see, 'Phase I' orthodontic treatment is a very valuable tool that should be used when needed. Early detection of unfavorable eruption patterns of certain teeth, most often the maxillary canines, can be the difference between a tooth being impacted, and possibly causing resorption of the roots of the adjacent teeth and a tooth erupting normally into the arch.



At right is a very good example of a case that needs to be addressed in the mixed dentition phase rather than waiting for all permanent teeth to erupt. The roots of the upper incisors are already in jeopardy. Intervention is a dire necessity in this case.

In conclusion, even though 'Phase I' orthodontic treatment is not always indicated, a consultation with an orthodontist is recommended at age seven to detect potential orthodontic issues that may otherwise go undiagnosed until it's too late.

Dr. Azani is an Orthodontist at Snow Orthodontics in Palmdale, CA. He can be reached at 661-273-1750.

List of SFVDS Orthodontist Members

Melina	Adamian DDS	18250 Roscoe Blvd Ste 315	Northridge CA	91325-4276	(818) 885-8650
Nooshi	Akavan DDS	18919 Ventura Blvd Ste B	Tarzana CA	91356-3211	(818) 345-9601
Kati	Asgarifar DDS	5931 Kanan Rd	Agoura Hills CA	91301-1688	(818) 991-7522
Arleen	Azar-Mehr DDS	9535 Reseda Blvd Ste 206	Northridge CA	91324-6025	(818) 886-6666
Tamar	Babayan DDS	10727 White Oak Ave Ste 215	Granada Hills CA	91344-4662	(818) 832-4331
Avo	Babian DDS	1111 S Glendale Ave Ste 205	Glendale CA	91205-3268	(818) 676-0970
Cyrus	Bandary DDS	6325 Topanga Canyon Blvd #510	Woodland Hills CA	91367-2048	(818) 992-0756
Brian	Bergh DDS	1111 N Brand Blvd Ste 201	Glendale CA	91202-3023	(818) 242-1173
Peter	Brenn DDS	1400 W Olive Ave Ste 101	Burbank CA	91506-2411	(818) 563-3825
Timothy	Buckley DDS	41253 12th St W Ste A	Palmdale CA	93551-1413	(661) 267-1234
Anthony	Cha DDS	18909 Soledad Canyon Rd Ste G	Canyon Country CA	91351-3385	(661) 251-7107
Vivian	Chui DDS	1346 Foothill Blvd Ste 200	La Canada CA	91011-2136	(818) 790-6102
Sharon	Crowder DDS	5921 Kanan Rd	Agoura Hills CA	91301-1688	(818) 706-8081
Katherine	Curry DMD	11260 Wilbur Ave Ste 202	Northridge CA	91326-2450	(818) 366-8180
Harry	Dougherty, Jr DDS	4955 Van Nuys Blvd Ste 606	Sherman Oaks CA	91403-1836	(818) 986-6223
Mehdi	Fotovat DDS	5445 Laurel Canyon Blvd	Valley Village CA	91607-4661	(818) 980-5300
Kenneth	Gurstein DDS	6400 Canoga Ave Ste 180	Woodland Hills CA	91367-2463	(818) 592-0875
William	Hang DDS	30200 Agoura Rd Ste 220	Agoura Hills CA	91301-5436	(805) 374-9377
Stuart	Hoffman DMD	4764 Park Granada Ste 104	Calabasas CA	91302-3324	(818) 222-0090
Gowhar	Iravani DDS	405 N Maclay Ave Ste 101	San Fernando CA	91340-2454	(240) 938-6008
Elysa	Kahan DDS	18372 Clark St Ste 201	Tarzana CA	91356-3550	(818) 578-8782
Gary	Kevorkian DDS	418 E Glenoaks Blvd Ste 101	Glendale CA	91207-2093	(818) 244-8663
Brian	Kim DDS	10515 Balboa Blvd Ste 280	Granada Hills CA	91344-6377	(818) 363-7900
Thuan	Le DDS	7052 Owensmouth Ave	Canoga Park CA	91303-2005	(818) 713-8034
Megan	Lecornu DDS	23206 Lyons Ave Ste 206	Santa Clarita CA	91321-2672	(661) 588-2065
Alan	Licht DDS	18372 Clark St Ste 201	Tarzana CA	91356-3550	(818) 996-5100
Roger	Lim DDS	13320 Riverside Dr Ste 218	Sherman Oaks CA	91423-2512	(818) 783-4565
Jeffrey	Liu DDS	19950 Rinaldi St # 306	Porter Ranch CA	91326-4141	(818) 831-7600
Karmen	Massih DDS	1017 N Pacific Ave Ste A	Glendale CA	91202-2313	(818) 507-1515
Silva	Megerdichian DDS	2401 W Burbank Blvd	Burbank CA	91506-1237	(818) 846-6244
Miryam	Miyamoto DDS	23333 Cinema Dr Ste 200	Valencia CA	91355-5436	(661) 254-6464
Jimin	Oh DMD	11260 Wilbur Ave Ste 202	Northridge CA	91326-2450	(818) 366-8180
Jason	Pair DDS	18907 Nordhoff St Ste 42	Northridge CA	91324-3794	(818) 349-4956
Dongkeun	Park DDS	444 S Brand Blvd Ste 104	San Fernando CA	91340-3627	(818) 832-2828
Michael	Rabizadeh DDS	19409 Stagg St	Reseda CA	91335-2351	(818) 723-4337
Conrad	Sack DDS	20301 Ventura Blvd Ste 220	Woodland Hills CA	91364-0931	(818) 999-9559
Robert	Schacter DDS	6342 Fallbrook Ave Ste 201	Woodland Hills CA	91367-1613	(818) 348-0085
Warren	Schacter DDS	6342 Fallbrook Ave Ste 201	Woodland Hills CA	91367-1613	(818) 348-0085
Raphael	Separzadeh DDS	44407 Challenger Way	Lancaster CA	93535-3237	(661) 341-3111
Katayoon	Shafagh DDS	12932 Victory Blvd	N. Hollywood CA	91606-2924	(818) 761-9000
Gilbert	Snow DDS	868 Auto Center Dr Ste C	Palmdale CA	93551-4691	(661) 273-1750
Gary	Tang DDS	28212 Kelly Johnson Pkwy Ste 115	Valencia CA	91355-5085	(661) 222-9392
Alan	Taylor DDS	450 W Palmdale Blvd Ste D	Palmdale CA	93551-3104	(661) 265-7397
Michael	Theurer DDS	1629 W Avenue J Ste 108	Lancaster CA	93534-2851	(661) 949-2290
Rouzbeh	Vossoughi DDS	13910 Foothill Blvd Ste B	Sylmar CA	91342-3014	(818) 996-4480
Merilynn	Yamada DDS	2625 W Alameda Ave Ste 220	Burbank CA	91505-4823	(818) 846-3774
Farnaz	Zand DDS	212 E Providencia Ave	Burbank CA	91502-1432	(818) 845-7611
Kourosh	Zarrinnia DMD	22600 Ventura Blvd Ste 202	Woodland Hills CA	91364-1459	(818) 225-0530
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By: Mark Amundsen, DDS

Is Cruising for you?

How good are your sea legs? How will you manage in a hotel on the water? Ocean and river cruising can be a great escape from the stresses of dentistry. If you are fine following an itinerary in a traveling hotel with lots of other people and you are not bothered by the motion of the sea, there are lots of cruising options for you!

There are ocean cruises and river cruises to destinations worldwide. Cruise market categories include mass market, premium and luxury cruise lines. The ship sizes range from under 100 passengers to more than 6,500 passengers. One can go on a cruise for a loud weekend bachelor party to Ensenada or on a luxury educational exploration of the Galapagos islands.

When one evaluates the pricing of a cruise compared to a land-based resort, once you factor in hotel, meals, drinks, entertainment and other activities, cruising is a great value for budget minded individuals.

The price you pay for the cruise is based on the category of cabin you select. The basic categories are inside cabin (cheapest category with no window in your room), outside window cabin, window cabin with a balcony, mini suite with a window and a balcony, and full suite with amenities galore (most expensive).

The food on a cruise is generally very good, and for longer cruises they will serve meals that include items like lobster on the formal nights. The drinks included in the basic pricing are juices, milk, tea and coffee. Alcohol, soft drinks and specialty coffees generally are not covered in the price you pay for the cruise, (but the cost on the ship is comparable to beverage pricing here on land). Most cruise lines have drink packages that include most alcohol, soft drinks and specialty coffees for between $60 to $80 per day per passenger. There are also options to order items like the "lobster dinner" in a dining room or a specialty restaurant for a cost that is significantly less than it would here in Los Angeles. The main dining room food and desserts are comparable to what you will get in an upscale restaurant here in town.

There is no shortage of food on a cruise ship. Food is generally available on 24/7 basis. Between the great food and desserts, the trick is to lose your cruise ship appetite once the vacation ends. The ships have free dining rooms, free buffet areas, free café / fast food/pizza/dessert areas, free room service, free pop up extra buffets, extra cost premium specialty restaurants, extra cost balcony dining and extra cost pop up specialty dining.

On sea days many cruise lines offer food related activities like "British Pub Lunch," "Seafood Sushi Buffet," "Afternoon Tea," "Midnight Dessert Buffet" and wine tasting. There are also different ethnic food nights in the dining rooms and buffet areas.

There are many destination specific lectures offered about things like the wildlife in specific Alaska ecosystems while you are traveling through the state's fjords. There are also lectures about the history and cultures of the areas the ship is going to visit. At any given time, there are lots of interesting activities happening on a cruise ship!

The larger ships have gyms, exercise programs, walking and running tracks so you can burn the calories off while you are on board. There are fitness training and yoga classes also. Some of the classes may have an extra cost associated with them. There are spas and serenity areas on the ships you can visit for an extra cost. You can get a private cabana in a serenity area on the ship to escape the crowds if you wish. The major cruise lines have a variety of entertainment options on the ship included in the pricing. There are original song and dance production shows, comedians, magicians, game shows, karaoke, trivia challenges, dancing instruction classes, night clubs, and special themed activities like "country music night" or '80's night. There are venues on the larger ships that have special parties to cater to all ages with music and dancing.

Most cruise ships have full casinos with all types of gaming activities including electronic machines, table gaming and poker tournaments. Most ships also have bingo games, dance contests, trivia contests and singing competitions for prizes

ranging from a bottle of champagne to several thousand dollars in cash.

When your ship visits a port, you can either book an excursion through the cruise line at an extra expense or you can visit the destination at your own pace and on your own budget. When you book an excursion through the cruise line, the ship will not leave until you are back on if complications arise. If you visit the destination on your own and you are not back on the ship by the departure time, the ship will not wait for you! You are on your own to get back to the ship or to get back home.

Going on a mass market or premium cruise line is like going to a resort where your room, most of the food and simple entertainment are covered in the price you pay to get on. They are more affordable at an entry level. If you don't want the higher end luxury items, you can get on board much cheaper and then pay extra for the more luxury items you desire.

Carnival, Norwegian and Royal Caribbean are examples of mass market cruise lines. Mass market ships are the largest and cater the most to younger families. They have huge water slides, surfing pools, bumper cars, laser tag areas, rock climbing walls, ice skating rinks and malls on board. Because of the younger demographic, be prepared for a louder more party-like atmosphere.

The premium cruise lines generally serve an older demographic. They also have lots of activities for kids and families, and these ships have nicer luxurious textures and designs, like more upscale hotels. The premium ships have lots of great activities, shows, night clubs and entertainment. Princess, Holland America and Celebrity are examples of premium cruise lines. Premium cruise line ships can be large like the mass market ships or small like the luxury cruise line ships. The smaller premium cruise ships can visit ports where the larger ships cannot go. That is why most luxury cruise ships are smaller.

Luxury cruise lines like Seaborn, Cunard, Azamara, Regent, Oceana, Viking and Crystal visit more exotic places and tend to be more all-inclusive. On these lines, most alcohol and specialty drinks, higher end meals and excursions are included in the price you pay to get on. Many of the shore excursions are also included in the basic pricing of a luxury cruise. With the exception of Cunard, most of the luxury ships tend to be smaller and more intimate. River cruise ships travel along famous rivers and visit towns along the river, giving the passenger a taste of each town's culture. River cruises are popular along famous rivers like the Mississippi, Rhine, Amazon and Nile. Smaller luxury ships can visit areas in the South Pacific, Asia and Alaska where the larger ships cannot go.

The cruise market has grown tremendously in Los Angeles over the last 20 years. There are several cruises leaving from

here to destinations as close as Santa Barbara, Catalina, San Diego and Ensenada Mexico, and as far as an around the world round trip from Los Angeles

There are many cruising options out of California with the ports of Los Angeles, Long Beach, San Diego and San Francisco being within several hours driving distance. When flying to a cruise destination, cruise lines organize transfers from the airports to the ships. If you are not retired already, time becomes a huge limitation to taking longer, more exotic cruises. If you are not wealthy, money is also an important factor.

Unlike a hotel, a cruise ship is a movable asset. The cruise lines will move their ships to different areas of the world where the cruise lines can maximize their profits seasonally. This makes summer and the holiday seasons the most expensive times to travel. Since Alaska and Europe are more favorable and exotic cruise destinations during the peak summer period, you will find more premium and luxury cruise lines in Alaska and Europe. In addition to the cruises themselves, the cruise lines also offer more extensive tours and excursions to enhance the cruise and land-based experience.

The mass market lines will offer more cruises out of Los Angeles and to the Caribbean during the summer season. For those who are more budget minded and don't have time to fly to get on a ship, the 3 to 7- day itineraries are very popular.

Cruising is not for everyone. It is not for those who want to do things on their own schedule and time. It is not for those who want to be in a specific location for a long time. If you have problems with crowds and don't like being in a hotel-like facility without being able to leave, don't get on a ship. Don't plan a cruise if you are very sensitive to motion sickness.

If you want to see if you may be all right to do a larger cruise, do a shorter cruise to a close by location during a time of the year when the oceans are calm! Some examples of these are the local 3 to 5-day getaways out of LA or Long Beach between April and October.
For those who plan to do a cruise:

Happy Cruising!

Traveling to the South Pacific

By: Emad Bassali, DDS

Australia

Travel is the movement of people between distant geographical locations. Motives for travel include pleasure, relaxation, discovery and getting to know other cultures. Let's fly to Australia!

Australia, or how the locals say it, 'Streya', is a country and continent surrounded by the Indian and Pacific Oceans. The capital, Canberra, is inland. The major cities are Sydney, Brisbane, Melbourne, Perth and Adelaide – all of which are coastal. The country is known for its Sydney Opera House, the Great Barrier Reef and a vast interior desert wilderness known as the Outback.

Sydney

The capital of New South Wales and one of Australia's largest cities, is best known for its harbor-front, Sydney Opera House, with a distinctive sail-like design. The massive Darling Harbor and the smaller Circular Quay ports are hubs of waterside life, with the arched Harbor Bridge and esteemed Royal Botanic Garden nearby.

The Sydney Opera House is "A building that changed the image of an entire country. It is one of the most recognizable buildings of the twentieth century. Australian culture reached a remarkable milestone on October 20, 1973. The completion of one of the greatest buildings of the 20th century, the birth of an icon and the beginning of an incredible performance history at Sydney's new opera house.

The Sydney Harbor Bridge, nicknamed "The coat hanger" and dating back to 1932, is one of Australia's grandest engineering feats. Visitors are free to walk or cycle across this vast structure, but book a 'bridge climb' for the opportunity to scale to the summit and enjoy unbeatable panoramic views.

Bondi Beach is a world famous beach with something for everyone: surf or lay in the sand; visit the shops and the boutiques; or take a scenic walk on the trail! It's one of Sydney's busiest beaches and the setting for more postcards and travel snaps than perhaps any other destination in Australia.

The Blue Mountains are famous for their rock formations known as the three sisters, along with quaint hotels and charming townships. The Blue Mountains National Park is less than a two hour drive from Sydney. Here you can discover 2.5 million acres of tall forests, sandstone cliffs, waterfalls and bushland, either mountain biking, or on foot. For a unique perspective, head to 'Scenic World Blue Mountains', a private, family owned tourist attraction located in Katoomba in the Blue Mountains, home to a cable-

way, a walkway over the rainforest canopy and a glass bottom skyway.

Get up close and personal to the animals at the zoo. We were able to see koalas and kangaroos. After spending five days in Sydney, we flew up north to Queensland to visit the famous Great Barrier Reef, the largest living thing on Earth and even visible from outer space! The 2,300 Km- long ecosystem compromised thousands of reefs and hundreds of islands made of more than 600 types of hard and soft coral. It's home to countless species of colorful fish, mollusks and starfish, plus turtles and dolphins.

Bula! Welcome to Fiji!

Scattered across 518,000 square kilometers of South Pacific Ocean, the 333 islands of Fiji can be foound. This beautiful, diverse country is world renowned as the ultimate Pacific holiday destination with warm sunshine, sandy beaches and hospitable, friendly people. There is so much to experience in Fiji! Make sure you take the time to look around and enjoy all that this wonderful country has to offer.

Finally, we had to experience the unforgettable. We went on an underwater adventure exploring the reef with friendly bull sharks. It was definitely a memorable experience, the experience of a lifetime.

Where will you next adventure take you?

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Buy - Sell - Lease **DRE:01993607**

Glendale-Foothills Report

By: Chi Leung, DDS

The Glendale/Foothills area held another successful zone meeting on March 7, 2019. The meeting was held on the El Grillo Bar and Grill. Dr. Jean Creasey gave an enlightening lecture on caries management by risk assessment (CAMBRA). Dr. Creasey lectures internationally on CAMBRA and was kind enough to come down from Nevada City, California to share her knowledge.

The member dentists who attended this course highly appreciated the learning experience, giving them a better understanding of how to analyze the principles and value of caries risk assessment with their patients. The course informed dental professionals about improved caries prevention strategies based on scientific evidence for Caries Management by Risk Assessment. The attendees also gained knowledge about the dental products most useful in CAMBRA.

This zone meeting, which included a great dinner, was free to our members as part of SFVDS' local member benefits.

Watch your emails as we will schedule a CPR class in our area in the coming month or so.

Document Retention Guide

Business Documents	Retention Timeframe
Annual Audited Financial Statements	Indefinitely
Annual Plans and Budgets	2 Years
Charitable Contributions	7 Years
Financing Documents/Agreements	10 Years after Payoff/Termination
Monthly Financial Statements	7 Years
General Correspondence	1 year

Compliance Documents	Retention Timeframe
CE Certificates	6 Years (3 license renewal periods)
Hazardous Waste treatment/disposal/recycling records	5 Years
Medical Waste treatment/disposal records	3 Years
Controlled Substance purchase records/inventory log/ Dispensing log	3 Years
Employee Cal/OSHA training records	3 Years

Employee Documents	Retention Timeframe
Main employee files (License, signed handbook, wage Records, evaluations)	4 Years after termination date (or the duration of any claim or litigations involving the hiring practices)
CE certificates	6 Years (3 license renewal periods. Note: Employee Is responsible for maintaining his/her own Certificates)
Background checks, drug tests, driving records, references, Interview notes & employment testing	5 Years
Non-hired applications & resumes	3 Years for applications (or the duration of any claim or litigations involving the hiring practices)

Patient Documents	Retention Timeframe
Explanation of Benefits (EOBs)	7 Years
Patient payment records	3 Years after full payment
Patient records	*Active patients* – Indefinitely; Inactive (patients not seen in two years): Adult patients – 10 years from the date the patient was last seen; Minors – 7 years from the patient's last treatment or 11 year past the patient's 18th birthday (age 19), whichever is longer. *Closed practice* – 7 years (mandatory) *Death of patient* – 2 years after patient's death

Welcome New Members

Arnulfo Molina, DDS
General
International, 1992

Luis Sosa-Turcios, DDS
20434 Sherman Way
Canoga Park, CA 91306
818-888-7962
General
Univ. Evangelica de San Salvador, 1993

Telal Elmaki, DDS
General
USC, 2009

David Chang, DDS
20439 Sherman Way
Winnetka, CA 91306
818-883-3922
General
UCLA, 2014

Tania Shanazari, DDS
General
UCLA, 2005

Raffie Garabedian, DDS
General
Univ. of Pennsylvania, 2017

Kanika Sharma, DDS
4910 Van Nuys Blvd. Ste. 100
Sherman Oaks, CA 91403
818-783-5234
General
Tufts University, 2016

Melissa Guzman, DDS
General
Univ. de la Salle, 2017

Amanda Jenney, DDS
151 E Avenue J Ste. A
Lancaster, CA 83535
661-942-1179
General
Case Western Reserve Univ., 1998

Jade Ong, DDS
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Van Nuys, CA 91405
818-908-1175
General
Univ. of the East, 1993

George Apelian, DDS
30300 Agoura Rd. Ste. 230
Agoura Hills, CA 91301
818-865-8651
General
Loyola Univ of Chicago, 1981

Justin Berman, DDS
23838 Valencia Blvd. Ste. 300
Valencia, CA 91355
661-259-2690
General
UCLA, 2017

Trustee Report

Continued from page 5

effort to provide background and pertinent information regarding portfolio examination, as CDA anticipates that potential legislation may be introduced to update California's portfolio examination during the 2019-2020 legislative session. The board also discussed the continued and growing interest in licensure examinations that are recognized nationally.

Portfolio dental licensure examination was authorized in 2010 through AB 1524 and first implemented in California in 2014. Since its implementation, a total of 55 California licenses have been issued through the portfolio examination pathway. National and California-based exam activities and discussions will continue in 2019, so that CDA, dental schools and the Dental Board of California will be prepared to understand and support examination improvements.

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