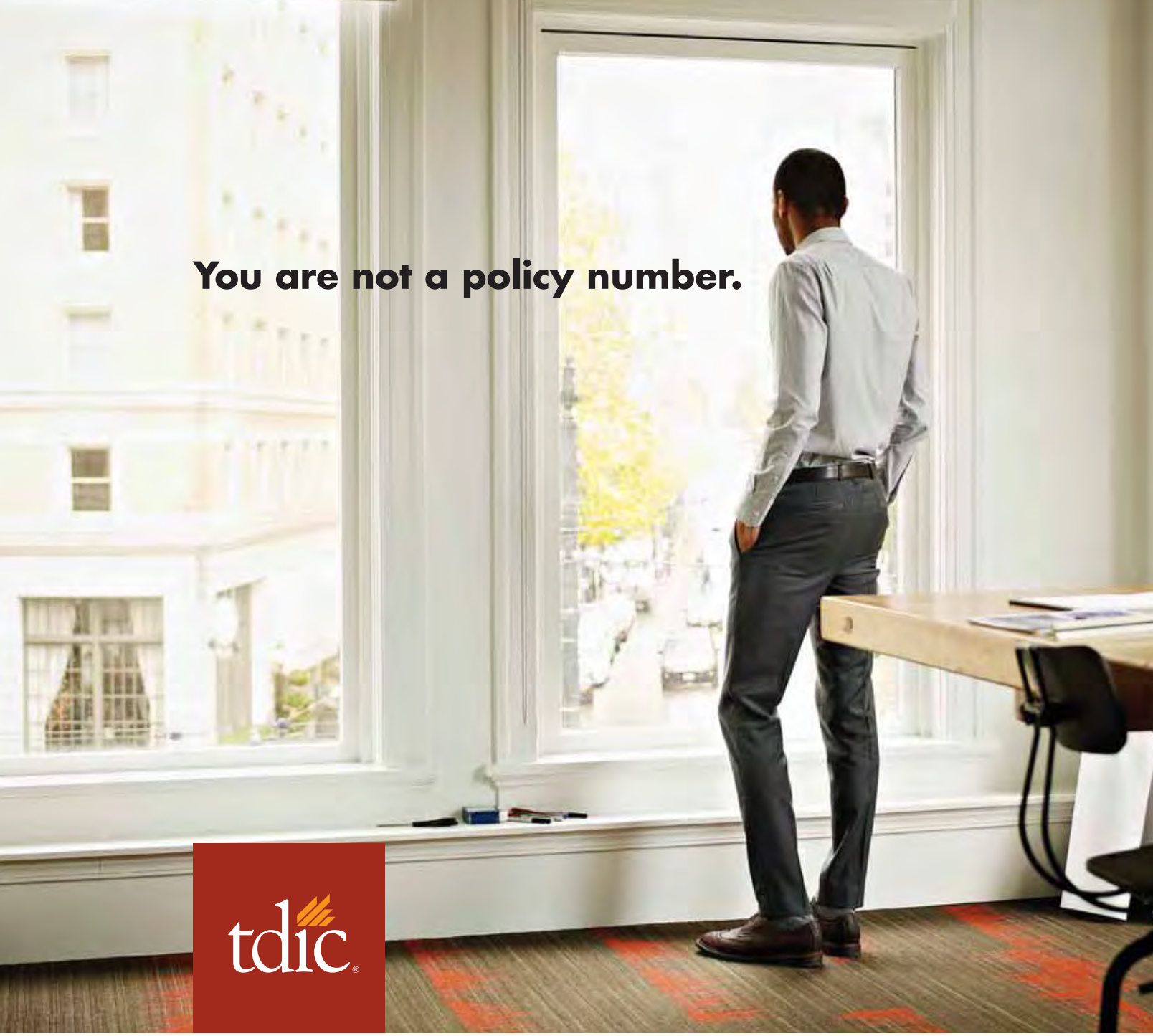
OF THE CALIFORNIA DENTAL ASSOCIATION

Journal

SEPTEMBER 2013

Americans with Disabilities Act: Understanding the Complexities and Dentistry's Role

Stanley R. Surabian, DDS, JD



And at The Dentists Insurance Company, we won't treat you like one because we are not like other insurance companies. We were started by, and only protect, dentists. A singular focus that leads to an unparalleled knowledge of your profession and how to best protect you. It also means that TDIC is in your corner, because with us, you're never a policy number. You are a dentist.

Protecting dentists. It's all we do.®

800.733.0633 | tdicsolutions.com | CA Insurance Lic. #0652783

DEPARTMENTS

657

FEATURES

Submitting a manuscript to the Journal? There's a site for that.

In fact, from letters to the editor to reviews, the new site is now the only way to submit anything to the *Journal of the California Dental Association*. Upload your content, receive automatic status updates, even track progress anytime day or night. See for yourself at editorialmanager.com/jcaldentassoc

OF THE CALIFORNIA DENTAL ASSOCIATION

Journal

CDA Journal
Volume 41, Number 9
cda.org/journal
SEPTEMBER 2013

Stay Connected
Visit cda.org

Journal of the California Dental Association

published by the California Dental Association
1201 K St., 14th Floor
Sacramento, CA 95814
800.232.7645
cda.org

Management/Editorial
Kerry K. Carney, DDS, CDE
EDITOR-IN-CHIEF
Kerry.Carney@cda.org

Ruchi K. Sahota, DDS, CDE
ASSOCIATE EDITOR

Brian K. Shue, DDS, CDE
ASSOCIATE EDITOR

Peter A. DuBois
EXECUTIVE DIRECTOR

Jennifer George
CHIEF MARKETING OFFICER

Cathy Mudge
VICE PRESIDENT, COMMUNITY AFFAIRS

Alicia Malaby
COMMUNICATIONS DIRECTOR

Andrea LaMattina
PUBLICATIONS SPECIALIST

Robert E. Horseman, DDS
CONTRIBUTING EDITOR

Stanley R. Surabian, DDS, JD
GUEST EDITOR

Blake Ellington
STAFF WRITER

Courtney Grant
COMMUNICATIONS SPECIALIST

Jack F. Conley, DDS
EDITOR EMERITUS

Advertising
Corey Gerhard
ADVERTISING MANAGER

Jenaé Gruchow
PROJECT/TRAFFIC ADMINISTRATOR

Erin Jernigan
ASSISTANT COORDINATOR

Production
Val B. Mina
SENIOR GRAPHIC DESIGNER

Randi Taylor
SENIOR GRAPHIC DESIGNER

Ann Davis
GRAPHIC DESIGNER/ PRODUCTION ARTIST

California Dental Association
Lindsey A. Robinson, DDS
PRESIDENT
president@cda.org

James D. Stephens, DDS
PRESIDENT-ELECT
presidentelect@cda.org

Walter G. Weber, DDS
VICE PRESIDENT
vicepresident@cda.org

Kenneth G. Wallis, DDS
SECRETARY
secretary@cda.org

Clelan G. Ehrler, DDS
TREASURER
treasurer@cda.org

Alan L. Felsenfeld, DDS
SPEAKER OF THE HOUSE
speaker@cda.org

Daniel G. Davidson, DMD
IMMEDIATE PAST PRESIDENT
pastpresident@cda.org

Reader Guide:

Upcoming Topics
OCTOBER: *General Topics*
NOVEMBER: *Student Issue*
DECEMBER: *Future of Dental Delivery Financing*

Classified Advertising
cda.org/classifieds

Display Advertising
Corey Gerhard
ADVERTISING MANAGER
Corey.Gerhard@cda.org
916.554.5304

Letters to the Editor
www.editorialmanager.com/jcaldentassoc

Permission and Reprints
Andrea LaMattina
PUBLICATIONS SPECIALIST
Andrea.LaMattina@cda.org
916.554.5950

Manuscript Submissions
www.editorialmanager.com/jcaldentassoc

Subscriptions
Subscriptions are available only to active members of the Association. The subscription rate is $18 and is included in membership dues. Nonmembers can view the publication online at cda.org/journal.

Change of Address
Manage your subscription online: go to cda.org, log in and update any changes to your mailing information. Email questions or other changes to membership@cda.org.

Journal of the California Dental Association (ISSN 1043-2256) is published monthly by the California Dental Association, 1201 K St., 16th Floor, Sacramento, CA 95814, 916-554-5950. Periodicals postage paid at Sacramento, Calif. Postmaster: Send address changes to *Journal of the California Dental Association*, P.O. Box 13749, Sacramento, CA 95853.

The Journal of the California Dental Association is published under the supervision of CDA's editorial staff. Neither the editorial staff, the editor, nor the association are responsible for any expression of opinion or statement of fact, all of which are published solely on the authority of the author whose name is indicated. The association reserves the right to illustrate, reduce, revise or reject any manuscript submitted. Articles are considered for publication on condition that they are contributed solely to the *Journal*.

Copyright 2013 by the California Dental Association.

CDA JOURNAL, VOL 41, Nº9

The Blogification of Science

KERRY K. CARNEY, DDS, CDE

In *Two Years Before the Mast* (Richard Henry Dana Jr., 1840), there is a passage in which the sailors come across a trunk they must unpack. The items being transported were of little interest to them compared to the packing material.

They became engrossed in reading the newspaper pages that were used to protect the items being shipped. They had been at sea a long time with little news from home and the newspaper pages provided a connection with their previous lives. They discussed the stories and speculated on the backstory of each classified ad.

I had the same kind of experience when I lived in Germany. I would become so starved for the English language that I would purchase an American weekly news magazine at the railway station and peruse every page. Even the calls for research subjects and the "positions available" were fascinating. That publication was my connection to another reality. It conveyed information that had relevance beyond my everyday existence.

There is a certain science magazine that I used to look forward to with the same relish every month. It was not a desire to communicate in English that fueled my anticipation. Instead, by revealing heretofore unknown facts and connections, it made my quotidian world more interesting.

But a sad thing happened. That magazine has undergone "blogification."

In an effort to remain relevant, it has adopted a blogger's style of communication: casual and personal. Instead of factual coverage, placing the story in context within history and or science, it presents facts as having the same weight as speculation. Hypotheses are indistinguishable from wishful thinking and the interviewer competes with the interviewee for primacy.

Trust in the peer review process is what gives the reader confidence in the reliability of the information provided.

Blogs began as Web logs in the 90s. Originally, they were journals or diaries. They gave a more personal level of communication. Blogging grew from the grass roots. It required no institutional affiliation. The authors had no need for degrees or credentials or impressive resumes. Blogs were immediate and unfiltered. They were unfettered by fact checking and quality control was unreliable or nonexistent. It was a more familiar, accessible, personal communication. That and the timeliness of the postings contributed to its appeal.

No stodgy, institutional, pedantic pedagogy. Blogs embody personal, contemporary, populist journalism. Like casual conversation with a friend over coffee, you can take it with a grain of salt, or a packet of Splenda.

When traditional scientific publications begin their blogification, they can lose the credibility they spent years earning. When entertainment value finally trumps scientific fact and relevance, then the blogification of science is complete. That is when science and junk science become confused and one loses faith and trust in the publication and in the institution behind it.

Daniel Patrick Moynihan is attributed with having said, "Everyone is entitled to his own opinion but not to his own facts." Facts are important. They ground us in truth.

Almost every publication carries a disclaimer similar to ours:
The Journal of the California Dental Association *is published under the supervision of CDA's editorial staff. Neither the editorial staff, the editor nor the association are responsible for any expression of opinion or statement of fact, all of which are published solely on the authority of the author whose name is indicated. The* Journal *reserves the right to illustrate, reduce, revise or reject any manuscript submitted. Articles are considered for publication on condition that they are contributed solely to the* Journal.

Some might think such a disclaimer means there is no need to fact check. After all, if it is the author's responsibility to be factual, why should anyone else have to fact check? However, one of the clearest reasons for the rejection of a submission is because its purported facts do not withstand peer review or simple fact checking. Trust in the peer review process is what gives the reader confidence in the reliability of the information provided. Reliable transmission of fact-based information is the foundation on which the reputation of a publication is based.

We are greatly indebted to our colleagues for their reviews of *Journal*

cda

Print, meet digital.

Delivered to your mobile device each month, the ePub *Journal* includes dynamic interactivity, such as embedded videos and one-click web and email links for more information, as well as the ability to "clip" an article or photo and share it through social media or email. Available for iPad, iPhone, Android and Amazon's Kindle Fire. Check it out at cda.org/mobile

submissions. Without the generous donation of their time and expertise, we could not continue to earn our readers' trust. Presenting inflammatory opinion or dubious research for the incendiary purpose of stoking controversy squanders that hard-won trust.

A forum is a place for a spectrum of ideas. However, in a scientific, peer-reviewed journal, that spectrum needs to be grounded in fact rather than emotion. The need to engage our readers should not lead to the sacrifice of science for entertainment.

For these reasons, the *Journal* strives to present reliable information and an array of responsible views. In our ongoing drive to stay relevant and current, we will incorporate technological advances to engage and inform our members and readers while continuing to eschew blogification. ■■■■

The *Journal of the California Dental Association* welcomes letters.

We reserve the right to edit all communications and require that all letters be signed. Letters should discuss an item published in the Journal *within the past two months or matters of general interest to our readership. Letters must be no more than 500 words and cite no more than five references. No illustrations will be accepted. Letters may be submitted at editorialmanager.com/jcaldentassoc. By sending the letter to the* Journal, *the author certifies that neither the letter nor one with substantially similar content under the writer's authorship has been published or is being considered for publication elsewhere, and the author acknowledges and agrees that the letter and all rights of the author with regard to the letter become the property of the California Dental Association.*

Continuing Education

Excellent learning experience ★ Useful and applicable clinical techniques ★ State-of-the-art facility

THE USC SIXTH INTERNATIONAL RESTORATIVE DENTISTRY SYMPOSIUM

Decision Making

Speakers: Dr. Alina Aalam, Dr. David S. Alleman, Dr. Paul Child, Jr., Dr. David Little, Dr. Baldwin W. Marchack, Dr. Ilan Rotstein, Dr. Frederick A. Rueggeberg, Dr. Alexander Waldman, Dr. John Weston, Dr. Homayoun H. Zadeh

Dates: Friday - Saturday, October 4 - 5, 2013

Location: USC Davidson Executive Conference Center, Los Angeles, CA

PEDIATRIC ORAL SEDATION CERTIFICATION PROGRAM

CA Board Approved Program
Lecture, Hands-On SIM-MAN Workshop, PALS

Faculty: Dr. Stanley Malamed, Dr. Ken Reed

Dates: Wednesday - Sunday, November 6 - 10, 2013

Location: Ostrow School of Dentistry of USC, Los Angeles, CA

ADA CERP® | Association for Continuing Dental Education

University of Southern California Ostrow School of Dentistry is an ADA CERP Recognized Provider.

ADA CERP is a service of the American Dental Association to assist dental professionals in identifying quality providers of continuing dental education. ADA CERP does not approve or endorse individual courses or instructors, nor does it imply acceptance of credit hours by boards of dentistry.

Ostrow School of Dentistry of USC
Office of Continuing Education
Phone: 213.821.2127
Fax: 213.740.3973
E-mail: cedental@usc.edu
Website: www.uscdentalce.org

THE USC 12TH INTERNATIONAL ENDODONTIC SYMPOSIUM

Honoring the life of Dr. James Simon

Speakers: Dr. Ken Hargreaves, Dr. Martin Trope, Dr. Parish Sedghizadeh, Dr. Michiel de Cleen, Dr. Louis Berman, Dr. Domenico Ricucci, Dr. Shane White, Dr. Khalid Al-Hezaimi, Dr. Rafael Roges, Dr. Ilan Rotstein

Dates: Friday - Saturday, November 22 - 23, 2013

Location: USC Davidson Executive Conference Center, Los Angeles, CA

CLINICAL INTRAVENOUS SEDATION 2014

Clinical Participation
Lecture, Clinical Participation, Live Patient Treatment

Faculty: Dr. Stanley Malamed, Dr. Ken Reed

Part I & II: Friday - Sunday, July 11 - 13, 18 - 20, 2014

Location: Ostrow School of Dentistry of USC, Los Angeles, CA

Clinical Intravenous Sedation requires completion of the following courses:

PHYSICAL EVALUATION

Date: Monday, May 5, 2014

EMERGENCY MEDICINE

Date: Tuesday, May 6, 2014

MONITORING AND SIM-MAN

Date: Wednesday, May 7, 2014

PHARMACOLOGY

Date: Thursday, May 8, 2014

USC University of Southern California

Ostrow School of Dentistry of USC

Dare to Compare on Innovation, Quality, Service and Value

Implant Direct
simply smarter.

Legacy™3 Implant

All-in-1 Packaging includes implant, abutment, transfer, cover screw & healing collar

$200 vs $633[1] from Zimmer Dental

✓ **Reality Check** Zimmer Customers
Save $433 with Legacy3

SwishPlant™ Implant

All-in-1 Packaging includes implant, abutment, transfer, cover screw, healing collar & comfort cap

$200 vs $737[2] from Straumann®

✓ **Reality Check** Straumann Customers
Save $537 with SwishPlant

ReActive™ Implant

All-in-1 Packaging includes implant, abutment, transfer & cover screw

$200 vs $718[3] from Nobel Biocare™

✓ **Reality Check** Nobel Customers
Save $518 with ReActive

Implant Product Page

NEW

All-in-1 Shopping

Visit our new online store, find the implant you want and the compatible components, abutments, instruments, biologics, literature are just a click away! There's no need to jump through different product categories or pages, you can find it all in one spot.

Implantology Basics and Beyond

24 CE CREDITS

Implant Dentistry 101
3 Day Introduction Course
December 12-14

12 CE CREDITS

Laser Surgery: A Quantum Leap Forward
2 Day Certification Course
November 1-2

View Dr. Niznick's 2-hour lecture & earn 2 CE credits FREE

Dr. Gerald Niznick discusses how the latest implant design innovations are shaping the future of implantology.

Introductory Offer: Make the switch & receive three FREE implants.[4]

www.implantdirect.com | 888-649-6425

Price comparisons based upon US list prices as of January 2013. All trademarks are property of their respective companies.
[1]US list price for Tapered Screw-Vent with micro grooves, healing collar & straight abutment
[2]US list price for SLActive Tapered Effect implant, closure screw, healing abutment, solid abutment, transfer and comfort cap.
[3]US list price for NobelActive with cover screw, impression coping & abutment
[4]Terms and conditions apply

Academy of General Dentistry PACE Program Approval for Continuing Education

Approved PACE Program Provider FAGD/MAGD Credit
Approval does not imply acceptance by a state or provincial board of dentistry or AGD endorsement
8/1/2012 to 7/31/2015
Provider ID# 316714

Others Do It

BY DAVID W. CHAMBERS, PHD

London streets come together haphazardly. And some of the intersections are truly Olympian in proportion, with no apparent logic to lights and lanes. One morning last May I competed in the "get across Piccadilly, if you can" event. I was huffing along smartly and noticed a fellow matching me stride for stride. As a gesture of good sportsmanship I asked how he knew it was okay to cross. "Don't rightly know," he said. "I was just going off you."

The most common reason people give for cheating is that "others do it." That is why insurance companies do not publish fee distributions — everyone would want to be at the top. The IRS tells us that the average American underpays income taxes by almost $4,000 each year. The number

CONTINUES ON 659

Antibiotic Therapy May Improve Effectiveness of Scaling and Root Planing

A new study in the *The Journal of the American Dental Association* has found preliminary evidence that suggests scaling and root planing (SRP) in combination with amoxicillin (AMX)/metronidazole (MET) therapy may be more effective in treating chronic and aggressive periodontitis than is SRP alone.

Authors of the study reviewed four randomized clinical trials, which included a total of 147 patients, for analysis. Patients in the SRP + AMX/MET therapy group demonstrated a greater gain in clinical attachment level compared with patients in the SRP only group and a greater reduction in probing depth, authors wrote.

"The reviewers found no significant differences between groups with regard to bleeding on probing or suppuration," the study noted.

Systemic AMX/MET may provide additional benefits to SRP in the treatment of chronic and aggressive periodontitis in terms of clinical attachment level gain and probing depth reduction, authors concluded, noting that results were based on a small number of studies and should be considered preliminary.

For more information, see the study in *The Journal of the American Dental Association,* 2013, vol. 144, no. 6, pp. 640-642.

Report: Billions Across the World Suffer From Major Tooth Decay

Worldwide, there are billions of people who suffer from major untreated dental problems, according to a new report published in the *Journal of Dental Research*.

Professor Wagner Marcenes, of the Institute of Dentistry at Queen Mary at the University of London, led an international research team investigating oral health as part of the Global Burden of Disease (GBD) 2010 study, according to a news release from the university.

The report shows that oral conditions affect as many as 3.9 billion people in the world — more than half of the total population. Authors found untreated tooth decay or cavities in permanent teeth was the most common of the nearly 300 major diseases and injuries measured by the GBD 2010 study, affecting 35 percent of the world's people.

"There are close to 4 billion people in the world who suffer from untreated oral health conditions that cause toothache and prevent them from eating and possibly sleeping properly, which is a disability," Marcenes said in the news release. "This total does not even include small cavities or mild gum diseases, so we are facing serious problems in the population's oral health."

The study also found that the global burden of oral conditions is shifting from severe tooth loss to severe periodontitis and untreated caries.

"Tooth loss is often the final result when preventive or conservative treatments for tooth decay or gum disease fail or are unavailable. It is likely that current dental services are coping better to prevent tooth loss than in the past but major efforts are needed to prevent the occurrence and development of gum diseases and tooth decay. Ironically the longer a person keeps their teeth, the greater the pressure on services to treat them," Marcenes said in the news release.

For more information, see the study in the *Journal of Dental Research* published online before print May 29, 2013.

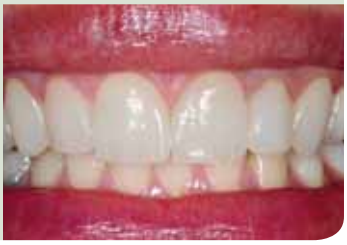
Study: Interproximal Fluoride Concentrations After Sealants

A randomized clinical trial performed in schoolchildren ages 6 and 7 evaluated fluoride concentrations in interproximal fluid after the placement of three different sealants. With 2,640 children who completed the trial, researchers of the study, which was published in the *Journal of Dental Research*, randomly divided their sample into three groups: a high-viscosity glass-ionomer cement group (GIC group), a fluoride resin-based group (fluoride-RB group) and a no-fluoride resin-based group (RB group).

Sealants were applied and interproximal fluid samples were collected at baseline and two, seven and 21 days after application of sealants, by insertion of a standardized paperpoint into the interproximal mesial space of the sealed tooth for 15 seconds, authors explained in the study.

Researchers found that at two days after sealant application, fluoride concentration was significantly higher in GIC and fluoride-RB groups compared with that in the RB group. After 21 days, fluoride concentration in the GIC group remained higher than that in the other two groups, leading authors to conclude that "high-viscosity GIC sealants increased the fluoride concentrations in interproximal fluid more than did a resin-based sealant containing fluoride."

For more information, see the study in the *Journal of Dental Research*, published online before print, May 20, 2013.



Study Evaluates Risk Factors and Frequency of Dental Visits

It is known that prevention reduces tooth loss, but little evidence supports twice-yearly dental preventive care visits for all adults, and frequency of patient visits should be based on personalized medicine that also accounts for genetics, according to a recent University of Michigan study.

Researchers used risk-based approaches to test tooth loss association with one versus two annual preventive visits in high-risk and low-risk patients and retrospectively evaluated insurance claims for 16 years for 5,117 adults for tooth extraction events, according to the study published in the *Journal of Dental Research*.

In this study, authors define high-risk patients as those with more than one risk factor including smoking, diabetes and the interleukin-1 genotype, and low-risk patients as those with no risk factors. According to a news story from the ADA, the authors found that increasing risk factors increased dental events and that for patients with no risk factors, no significant benefit was appreciated by undergoing two preventive dental visits compared to one visit annually.

"A personalized medicine approach combining gene biomarkers with conventional risk factors to stratify populations may be useful in resource allocation for preventive dentistry," authors concluded.

For more information, see the study "Patient Stratification for Preventive Care in Dentistry" published in the *Journal of Dental Research*, online ahead of print, June 10, 2013. See the ADA news story at ada.org/news/8702.aspx.

OTHERS DO IT, CONTINUED FROM 657

tends to drift upward with time because desire to conform with peers has stronger survival value.

According to ADA statistics (May 2012 issue of *JADA*), dentists' incomes began to drop (in real dollars) beginning in 2005. That is before the recession, and dental economists are saying the dip is self-inflicted. The profession is in a cycle where fewer patients are being charged higher fees for work that is not obviously necessary.

I received this email message from a colleague in the Washington, D.C., area this morning. "I have a young woman patient who I have seen all her life here and she has moved to S.F. I don't think she ever had any restorative treatment except a few sealants. In S.F. she went to her husband's 'high-tech' dentist and was told she needed six fillings. Her parents still see me and so when she was here for the holidays she came in. I saw no need for any treatment and maybe one small occlusal area to watch."

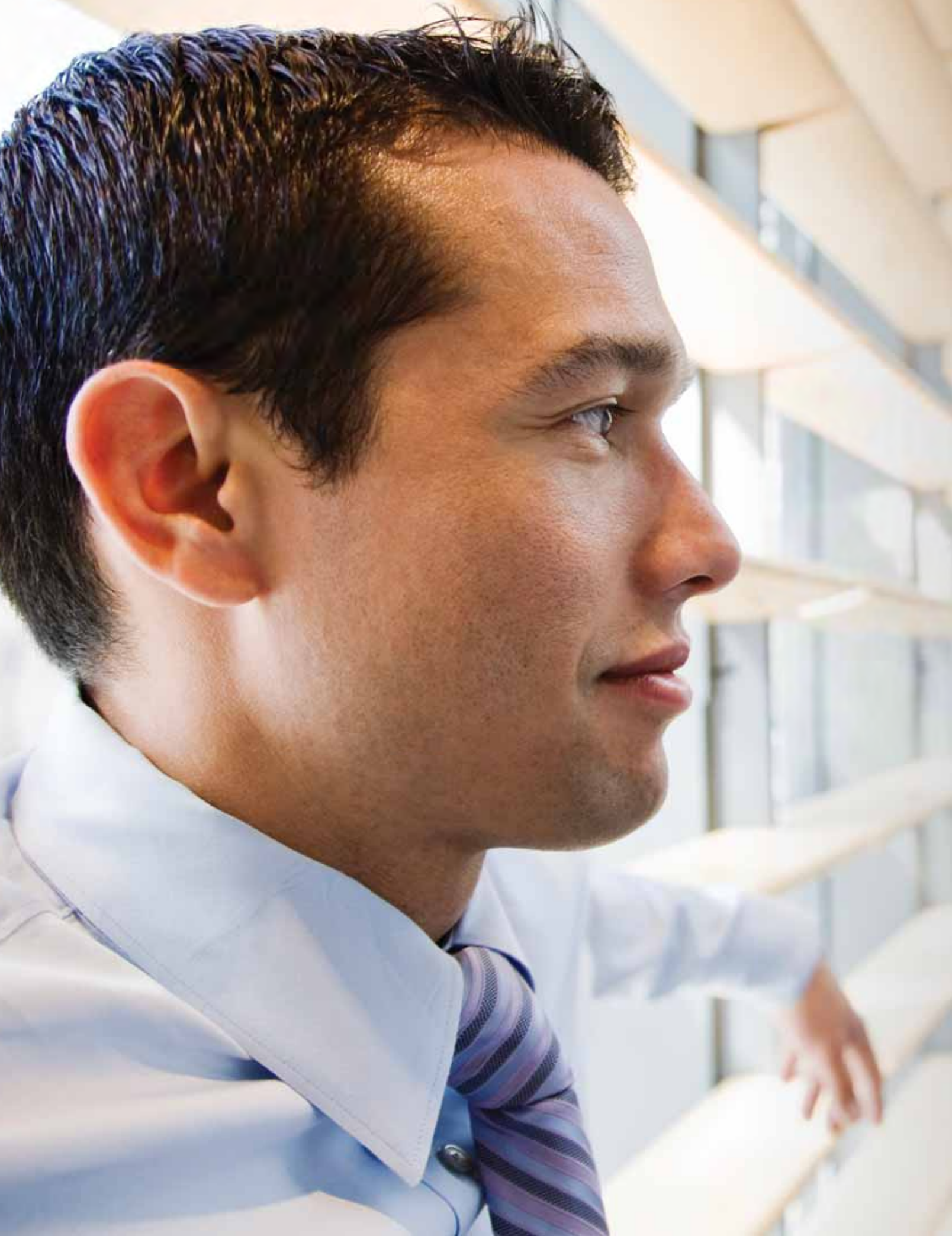
This is not the only such note I received this year. There are dentists pulling the rest of the profession in the wrong direction. How can one compete when "everybody else" is treating everything possible and target marketing those patients who can pay the most? What reward is there for the dentist who forgoes the advantages that others grasp? The regular listing of C.E. courses in this journal suggests there is very little envy among the high-end practitioners of their colleagues who take courses on patient medical conditions, safety or ethics.

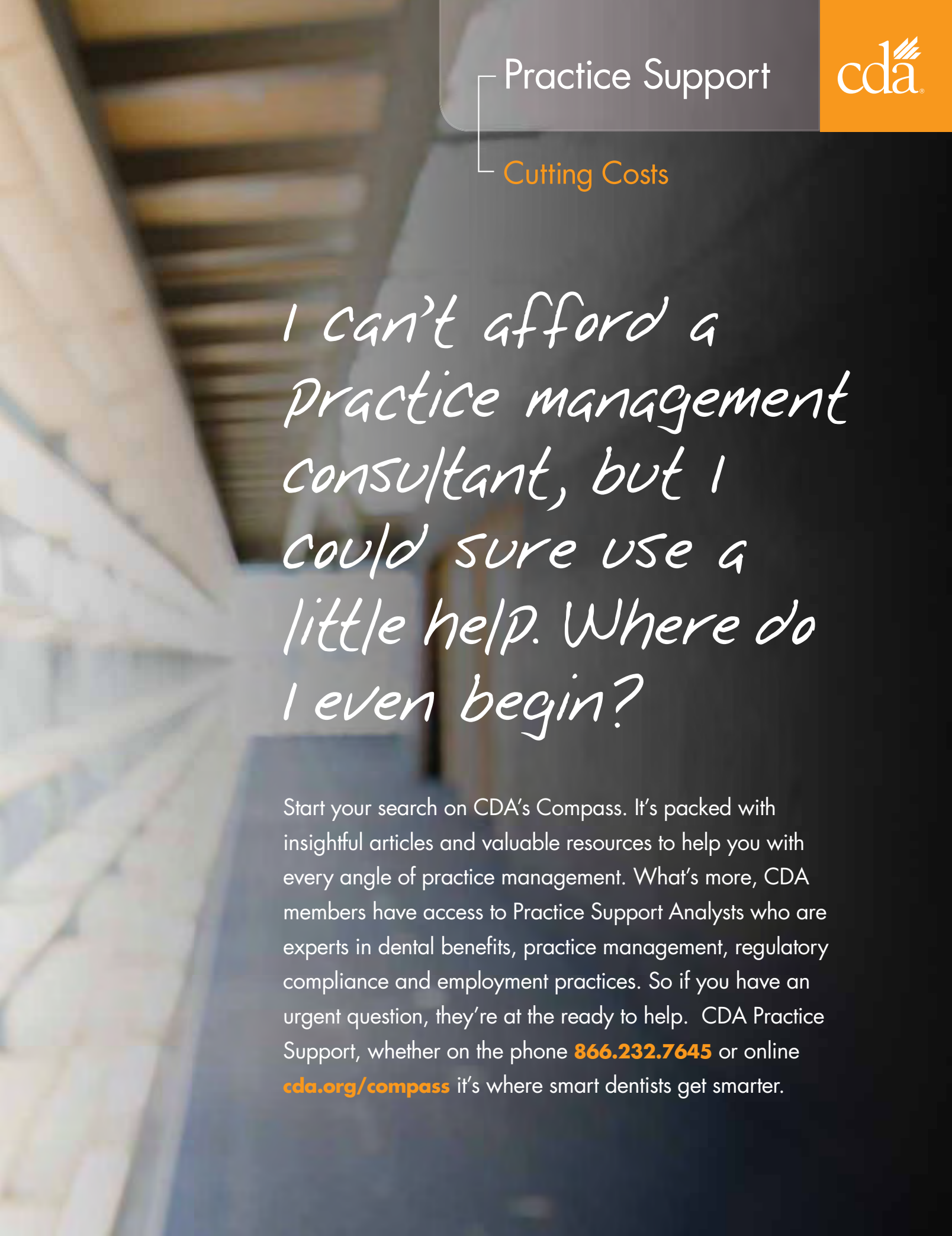
A student told me about the moral challenge he faced because he had access to pirated copies of National Boards that he could study from. He said his good grades would not be enough to get him into ortho school because he knew others were cheating. He felt he had to cheat to protect all the honest work he had invested in his career.

The nub:

1. There are some moral problems that are larger than what one individual can address — public disclosure is the only answer.
2. Some ethical problems are self-accelerating.
3. I have the greatest admiration for dentists who refuse to fudge because others are doing it. Thank you!

David W. Chambers, PhD, is professor of dental education, Arthur A. Dugoni School of Dentistry, San Francisco, and editor of the Journal of the American College of Dentists.



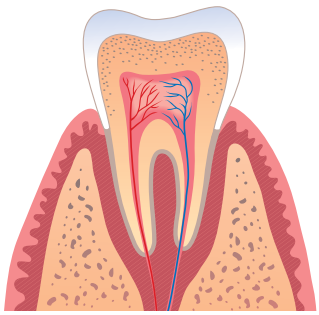


Practice Support

Cutting Costs

I can't afford a practice management consultant, but I could sure use a little help. Where do I even begin?

Start your search on CDA's Compass. It's packed with insightful articles and valuable resources to help you with every angle of practice management. What's more, CDA members have access to Practice Support Analysts who are experts in dental benefits, practice management, regulatory compliance and employment practices. So if you have an urgent question, they're at the ready to help. CDA Practice Support, whether on the phone **866.232.7645** or online **cda.org/compass** it's where smart dentists get smarter.



Study: Early Bisphenol A Exposure May Damage Tooth Enamel

According to a recent study published in *The American Journal of Pathology,* early bisphenol A (BPA) exposure may affect the enamel of teeth. Researchers, led by Ariane Berdal of the Université Paris-Diderot and Sylvie Babajko, research director at Inserm Unit 872 "Centre des Cordeliers," found that the teeth of rats were damaged when treated with low daily doses of BPA.

BPA is a chemical compound used in the composition of plastics and resins. It is used, for example, to manufacture food containers such as bottles or babies' bottles and is used in some dental sealants. Recent studies have shown that this industrial compound has adverse effects on the reproduction, development and metabolism of laboratory animals, a news release from Inserm stated, and it is strongly suspected of having the same effects on humans.

In this study, researchers found that incisors of rats exposed to 5 micrograms/kg/day of BPA shared multiple characteristics of the tooth enamel pathology known as molar incisor hypomineralisation (MIH), a recently identified pathology that affects roughly 18 percent of children between the ages of 6 and 8, according to the news release. Children affected by this pathology present with teeth that are hypersensitive to pain and liable to cavities.

After defining the characteristics of the BPA-treated rat incisors, authors compared these with the teeth of human MIH-sufferers and found similarities through macroscopic observation of marks on both series of teeth, in particular fragile and brittle enamel. Microscope observation of the enamel showed a significant reduction of the Ca/P and the Ca/C ratios in affected teeth, which leads to mineral depletion, making the teeth more fragile and more liable to cavities, according to the news release.

For more information, see the study in *The American Journal of Pathology,* vol. 183, issue 1, pp. 108-118, July 2013.

ADA Reports Rise in Dental-Related ER Visits

Record numbers of Americans are going to emergency rooms for dental treatment, which is straining the nation's health care system and increasing health care costs, according to new analysis released by the American Dental Association.

Research from the ADA Health Policy Resources Center (HPRC) found the number of dental ER visits in the U.S. rose from 1.1 million in 2000 to 2.1 million in 2010, according to a news release from the ADA. The study also cited an independent 2009 study by the National Emergency Department Sample (NEDS) showing that 41.8 percent of all ER visits for dental conditions were the result of dental caries.

While ERs can provide pain relief and treat infection, most hospitals don't have dentists on staff to provide comprehensive dental care, HPRC noted. In most cases, ER staff members prescribe medications for pain or antibiotics for infection, which eases short-term symptoms but won't solve the long-term underlying dental problem.

"Without further interventions from policymakers, dental ER visits are likely to increase in the future, putting additional strain on the health care system and increasing overall health care costs," said Thomas Wall, MA, MBA, a lead author of the briefs, in the news release. "Dental ER visits already cost the health care system up to $2 billion annually, money that is better spent on improving the dental safety net."

For more information, see ada.org/8793.aspx.

Bacteria that Causes Gum Disease also Triggers Bone-destroying Cells

Researchers have found that the newly discovered bacterium that causes gum disease, called NI1060, is also responsible for triggering normally protective proteins in the mouth to actually destroy more bone, a University of Michigan study found.

Scientists and oral health care providers have known for decades that bacteria are responsible for periodontitis, but until now, they hadn't identified the bacterium.

The study found that NI1060 also triggers a normally protective protein in the oral cavity, called Nod1, to turn traitorous and actually trigger bone-destroying cells, the news release said.

"Nod1 is a part of our protective mechanisms against bacterial infection. It helps us to fight infection by recruiting neutrophils, blood cells that act as bacterial killers," said Noahiro Inohara, one of the study's authors. "It also removes harmful bacteria during infection. However, in the case of periodontitis, accumulation of NI1060 stimulates Nod1 to trigger neutrophils and osteoclasts, which are cells that destroy bone in the oral cavity."

"The findings from this study underscore the connection between beneficial and harmful bacteria that normally reside in the oral cavity, how a harmful bacterium causes the disease, and how an at-risk patient might respond to such bacteria," said William Giannobile, professor of dentistry.

For more information, see the news release at ns.umich.edu/new/releases/21519-bacteria-that-causes-gum-disease-packs-a-one-two-punch-to-the-jaw or read the full study in the journal *Cell Host & Microbe,* 2013; vol. 13, issue 5, p. 595.

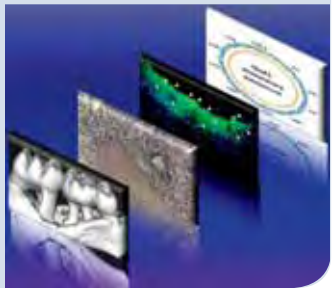


Photo: University of Michigan

Researchers Discover How Silver Can Disrupt Bacteria

A team of researchers led by James Collins, a biomedical engineer at Boston University in Massachusetts, recently described how silver can disrupt bacteria and showed that the ancient treatment could help to deal with the thoroughly modern plague of antibiotic resistance.

"We show that silver disrupts multiple bacterial cellular processes, including disulfide bond formation, metabolism and iron homeostasis," the authors wrote in the study, which was published in the journal *Science Translational Medicine*.

The study describes how dissolved silver ions make bacterial cell walls weaker and disrupts cell metabolism to create toxins. Collins and his team found that in the form of dissolved ions, silver attacks bacterial cells by making the cell membrane more permeable and interfering with the cell's metabolism, leading to the overproduction of reactive, and often toxic, oxygen compounds. Both mechanisms could potentially be harnessed to make today's antibiotics more effective against resistant bacteria, Collins said in a news article on nature.com.

The researchers showed that when boosted with a small amount of silver, antibiotics could kill between 10 and 1,000 times as many bacteria, the nature.com article reported.

"This work shows that silver can be used to enhance the action of existing antibiotics against Gram-negative bacteria, thus strengthening the antibiotic arsenal for fighting bacterial infections," authors concluded.

For more, see the full study in *Science Translational Medicine,* vol. 5, issue 190, p. 190ra81 or see the story at nature.com/news/silver-makes-antibiotics-thousands-of-times-more-effective-1.13232.

"We show that silver disrupts multiple bacterial cellular processes, including disulfide bond formation, metabolism and iron homeostasis."

Potential Dietary Supplement and Drug Interactions in Dentistry

Authors of a study recently published in *The Journal of the American Dental Association* delved into the potential interactions between dietary supplements and prescription drugs.

"Because nearly 70 percent of prescription drug users do not discuss their dietary supplement use with their health care providers, clinicians must be proactive in questioning patients about their use of these agents," authors wrote.

In this study, authors reviewed the literature regarding interactions between popular dietary supplements and medications used commonly in dentistry. They used clinical databases and decision support tools to classify interactions according to their level of risk for the patient, the study noted.

The authors found that recognition and avoidance of potential interactions between dietary supplements and medications prescribed or administered commonly in dentistry will help oral health care practitioners optimize treatment while emphasizing patients' safety.

"Provided that patients are not taking ginkgo, St. John's wort, evening primrose or valerian, clinicians can prescribe or administer any of the medications used commonly in dentistry without concern about possible dietary supplement drug interactions," authors wrote. They noted that "for a patient who is taking one of these four dietary supplements, the prudent practitioner may ask him or her to stop taking the supplement for at least four half-lives before a dental appointment involving administration of a drug," but added that "because the benefit of administering the appropriate emergency medication when required exceeds the risk to the patient of experiencing a dietary supplement drug interaction, clinicians always should administer the emergency medication."

For more information, see the study in *The Journal of the American Dental Association*, 2013, vol. 144, no. 7, pp. 787-794.

UPCOMING MEETINGS

2013	
Sept. 13–15	Fifth Annual Dental Motorcycle Ride, Windsor, sites.google.com/site/dentistrides
Oct. 18–21	The American Institute of Oral Biology 70th Annual Meeting, Palm Springs, theaiob.org
Oct. 31–Nov. 5	154th ADA Annual Session, New Orleans, ada.org/session
Nov. 3–9	U.S. Dental Tennis Association, Big Island, Hawaii, 800-445-2524 or dentaltennis.org
Nov. 10–13	National Primary Oral Health Conference, Denver, nnoha.org/conference/npohc.html
2014	
May 15–17	*CDA Presents The Art and Science of Dentistry*, Anaheim, 800-CDA-SMILE (232-7645) or cdapresents.com
Sept. 4–6	*CDA Presents The Art and Science of Dentistry*, San Francisco, 800-CDA-SMILE (232-7645) or cdapresents.com

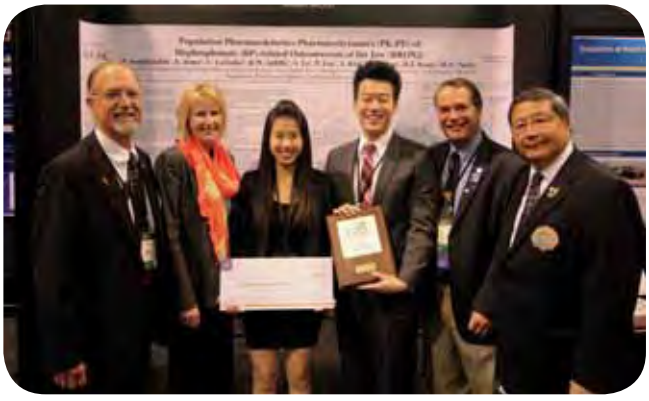
To have an event included on this list of nonprofit association continuing education meetings, please email Courtney Grant at courtney.grant@cda.org.

CDA JOURNAL, VOL 41, Nº9

Winners of the 2013 Table Clinic Competition

The California Dental Association encourages dental, dental hygiene, dental assisting students and military/residents from across the state to enter the annual Table Clinic Competition held during *CDA Presents* in Anaheim. Blue-ribbon winners from the April 12–13 contests were invited to submit an abstract of their work, which appear in this section. CDA entered into collaboration with the California Dental Hygienists' Association for the RDH portion of the table clinics.

CLINICAL DENTAL STUDENT WINNERS



Drs. Del Brunner, Lindsey Robinson, Donald Rollofson and Dennis Shinbori congratulate the clinical dental student category winners. The winners were Sophia Kang and Ronald Chung.

Population PK-PD Model of Bisphosphonate-related Osteonecrosis of the Jaw (BRONJ)

Sophia Kang and Ronald Chung, Ostrow School of Dentistry of USC

Osteonecrosis of the jaw (BRONJ) is a serious complication of bisphosphonate (BP) therapy. Our purpose was to create the first bisphosphonate pharmacokinetic-pharmacodynamic (PK-PD) model of skeletal drug accumulation predictive of BRONJ. Using the Non-Parametric Adaptive Grid algorithm within Pmetrics package for R, we designed a population PK model of bisphosphonate in plasma and bone using data from a published PK study. With duration of therapy and bone mineral content as model inputs, we estimated bone BP in 69 and 84 patients with and without BRONJ, respectively, who were treated with BP. Our data indicate that BRONJ is associated with toxic accumulation of BP in bone; this is a function of therapy duration and bone mineral content as predicted by our PK-PD model. With the toxic threshold bone BP at 0.2mM, the onset of BRONJ was predicted to occur with similar timing to that which is observed clinically.

THE CORRESPONDING AUTHOR, Ronald Chung, can be reached at chung.ronaldlee@gmail.com.

CDA JOURNAL, VOL 41, Nº9

COMMUNITY/EDUCATION DENTAL STUDENT WINNERS

Drs. Del Brunner, Lindsey Robinson, Donald Rollofson and Dennis Shinbori congratulate the community/education dental student category winners, Alex Goude, Zachary Mursic, Clint Walker, Amanda Zenthoefer and Caprice Hunter (not pictured).

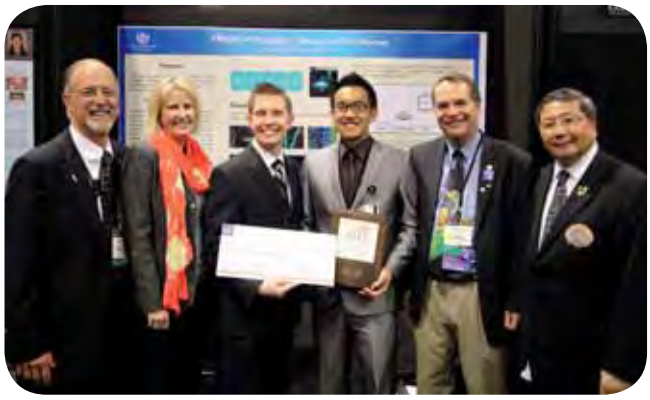
Comparing Variability Among Graders Using Traditional and Digital Grading Methods: A Pilot Study

Zachary Mursic, Amanda Zenthoefer, Alex Goude, Caprice Hunter and Clint Walker, Loma Linda University School of Dentistry

This pilot study was conducted to determine whether the addition of a digital scanning system to the traditional grading protocol could reduce variability among graders. Ten typodont teeth were prepared for full gold crowns. Five faculty members graded the preparations, each with a minimum of five years of experience, based on LLUSD's standard grading rubric. The preparations were then scanned with the Cadent iTero intraoral digital scanner and digitally graded by each student researcher using the 5-Axis CAD software and the same grading rubric. The traditional and digital methods were compared to determine correlation with regards to precision and variation. Initial data suggests that there is a significant difference ($\alpha < 0.05$) in consistency between the traditional and digital grading systems, with the digital system being more consistent. The results of the intraclass correlation coefficient (ICC) demonstrated a statistically significant increase of within group correlation for the digital grading method. The ICC for the traditional grading method is 0.251 with a 95 percent confidence level ranging from -0.541 to 0.764 ($p < 0.05$); while the ICC for the digital method is 0.910 with a 95 percent confidence level ranging from 0.776 - 0.975 ($p < 0.05$). Based on these results, this pilot study warrants future research into this topic because it suggests that there is greater consistency using a digital grading system in comparison to the traditional grading method.

THE CORRESPONDING AUTHOR, Zachary Mursic, can be reached at zachary.mursic@gmail.com.

SCIENTIFIC DENTAL STUDENT WINNERS



Matthew Enns, Eric Chen and Susan Choi (not pictured) were the winners in the scientific dental student category. They were presented their award by Drs. Del Brunner, Lindsey Robinson, Donald Rollofson and Dennis Shinbori.

Effects of Radiation Therapy on Oral Mucosa

Matthew Enns, Eric Chen and Susan Choi, Loma Linda University School of Dentistry

Effects of head and neck radiation exposure from conventional radiotherapy and proton therapy include oral conditions, such as oral mucositis. These oral conditions are mediated by varying degrees of cell death. Of particular interest is finding a method of diagnosis of early cell death in tissues that have received radiation therapy. Overexpression of BCL family apoptotic factors was chosen as the phenomenon that represents early cell death because it is a cellular response found in irradiated tissues. This study aims to use irradiated ferret gingival sections from a total of 18 ferrets as an animal model to measure early radiation damage. We found that BCL-2 was overexpressed in proton therapy groups as compared to conventional radiation and normal tissue. This study is a novel approach to a quantification model for early detection of radiation damage that can aid clinicians in the treatment of oral conditions like oral mucositis.

THE CORRESPONDING AUTHOR, Matt Enns, can be reached at menns38@gmail.com.

RDA STUDENT WINNERS

The RDA student category winners were Alicia Savage, Evelyn Hermosillo and Alyssa Snyder. They are congratulated here by Drs. Del Brunner, Lindsey Robinson, Donald Rollofson and Dennis Shinbori.

Is Your Toothbrush Safe From Bacteria?

Alyssa Snyder, Alicia Savage and Evelyn Hermosillo, Citrus College

Do bacteria grow on your toothbrush? Does where you store your toothbrush make a difference? We are going to place three toothbrushes in different places — one will be stored on the counter top, the other will be placed in a medicine cabinet and the last one will be placed in a drawer with a toothbrush cap on top. Then we will wet the toothbrushes two times a day just as they would normally be used. After about three weeks, we will swab each of the toothbrushes and then use petri dishes to determine which toothbrush has the least amount of bacteria growing on it.

THE CORRESPONDING AUTHOR, Alyssa Snyder, can be reached at alysnyder824@student.citruscollege.edu.

RDH INFORMATIONAL STUDENT WINNERS (CDA IN COLLABORATION WITH CDHA)

2013 CHDA President Susan Lopez, RDH, and Drs. Lindsey Robinson and Del Brunner congratulate the RDH informational student category winners, Nicole Pelc and David Whaley.

Rheumor Has It

David Whaley and Nicole Pelc, Cerritos College

BACKGROUND: Although rheumatoid arthritis occurs in the joints of the body, it has more in common with periodontal disease than previously thought. Both are characterized by chronic inflammation, which leads to the breakdown and deformation of their respective surrounding structures. Although the exact etiology of rheumatoid arthritis is unknown, research shows that periodontal disease may play a role in the development and severity of this often-debilitating disease.

METHODS: Current information and research from online academic journals and websites were reviewed.

RESULTS: Research showed that individuals who had both rheumatoid arthritis (RA) and periodontal disease had significantly worse RA development and symptoms than RA individuals without periodontal disease.

CONCLUSIONS: Treating periodontal disease may help to reduce the symptoms of RA, and may even prevent the development of the disease.

THE CORRESPONDING AUTHOR, David Whaley, can be reached at gnarlsome@hotmail.com.

RDH RESEARCH STUDENT WINNERS

RDH research student category winners Kimberly Swanson, Leah Regan, Nicole Black and Janelle Junn are congratulated by 2013 CHDA President Susan Lopez, RDH, and Drs. Lindsey Robinson and Del Brunner.

The Effects of Mineral Oil-based Products on Latex Gloves

Kimberly Swanson, Leah Regan, Janelle Junn and Nicole Black, Loma Linda University School of Dentistry

BACKGROUND: The purpose of this laboratory study was to determine whether mineral oil-based products degraded latex gloves.

METHODS: Four brands of powder-free, latex examination gloves were tested using petroleum jelly, lip balm and lip gloss. Gloves were measured and length was recorded at baseline. The Food and Drug Administration 1-liter water leak test was used to determine whether gloves would fail when exposed to mineral oil-based products. After 60 minutes, gloves were assessed for leakage and remeasured to see if there was any degradation of the latex.

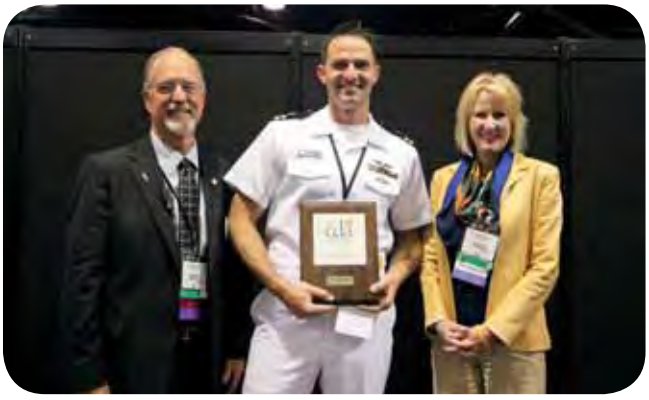
RESULTS: Mineral oil-based products did not cause leakage in latex gloves. A statistically significant change in glove length was seen [p value <.0001]. Although no leakage was recorded with any of the mineral oil-based products, lip gloss caused the greatest change in glove length, indicating degradation.

CONCLUSION: Lip gloss may negatively impact latex gloves more than other mineral oil-based products.

THE CORRESPONDING AUTHOR, Kimberly Swanson, can be reached at Kswanson@llu.edu.

MILITARY/RESIDENT WINNER

Drs. Del Brunner and Lindsey Robinson congratulate military/resident category winner Lt. Joshua Kats, United States Navy.



Beaming With Confidence — CBCT in Your Practice

Lt. Joshua Kats, United States Navy

Despite the advantages of cone beam computed tomography (CBCT) over traditional two-dimensional radiography, the 2012 advisory statement from the American Dental Association Council on Scientific Affairs states the use of CBCT imaging as a routine screening device should be avoided. Furthermore, CBCT imaging should only be used "after professional justification that the potential clinical benefits will outweigh the risks associated with exposure to ionizing radiation" and "only when he or she expects that the diagnostic yield will benefit patient care, enhance patient safety, significantly improve clinical outcomes or all of these." The author presents three clinical applications (orthodontics/implants, oral pathology and oral diagnosis) where CBCT imaging benefited patient care and improved clinical outcomes, thus providing the professional justification one needs to use CBCT in similar cases.

AUTHOR, Lt. Joshua Kats, can be reached at Joshua.Kats@med.navy.mil.

Judges for the annual table clinics competition at *CDA Presents* in Anaheim

RDA JUDGES
Jennifer Broyles, RDA
Benson Dimaranan, RDA
Maleah Brooks, RDA
Jen Blake, FADAA
Maria Christina Ochoa, RDA
Shari Becker, RDA
Georgie Vargas-Burket, RDA
Karen Schroeder, RDA
Evangeline Enriquez, RDA
Jenna Redgate, DDS

RDH JUDGES
Arnold Valdez, DDS
Howard Richmond, DDS
Bruce Coye, DDS

DENTAL STUDENTS/ CLINICAL JUDGES
Zaw Thu, DDS
Jaymie Coria, DDS
Marileth Coria, DDS
Ramesh Gowda, DDS
Dale Johnstone, DDS
Judith Strutz, DDS
Al Ochoa, DDS
Pradip Patel, DDS
Dale Wagner, DDS

DENTAL STUDENTS/ COMMUNITY JUDGES
Leondard Raimonda, DDS
Tony Daher, DDS
Shi-Lin Niu, DMD

DENTAL STUDENTS/ SCIENTIFIC JUDGES
Peter Young, DDS
Donna Klauser, DDS
Mei Lu, DDS
Samuel Demirdji, DDS

MILITARY/RESIDENT JUDGES
Kenneth Yaros, DDS
Stephen Alfano, DDS
Robin Abari, DDS
Hemant Joshi, DDS
Arthur Gage, DDS
Stephen Sterlitz, DDS
Christina Lilli, DDS

cda

Where smart dentists get smarter.

The CDA Compass, where smart dentists get smarter, has gotten a bit smarter itself. Now, it's mobile friendly, easier to navigate, and the content has been reorganized so the path to resources is more intuitive. Plus, the new "Ask an Expert" feature allows you to ask our Practice Management Experts your own personal practice support question and read those asked by your peers. We think you're going to like what you see. Check it out at cda.org/compass

cda PRESENTS

The Art and Science of Dentistry

San Francisco C.E.

Looking for your C.E. certificate?

- Approximately three weeks after *CDA Presents* in San Francisco, licensed attendees will receive an email containing a link to their printable C.E. certificate.
- C.E. certificates can also be accessed at **cdapresents.com**
- Certificates can also be mailed by request — simply call 800.232.7645 approximately three weeks after the show. Have all three-digit course codes available, as they may be needed for verification.

Audio Recordings

Save $100 on course audio recordings!

For $149, you get your choice of Digitell's online library or CD-ROM of the *CDA Presents* courses from San Francisco.

Online Library

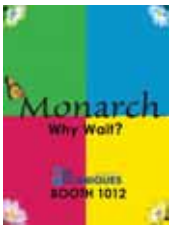
- All courses include downloadable audio MP3 format.
- Presentations are available in PDF format.
- Transfer audio to your MP3 player, iPad or smartphone.
- Stream the audio via an online media player.
- Search courses by speaker name, title and PowerPoint for easy reference and retrieval.
- A subscription includes three free co-users for easy sharing with staff, colleagues and friends.
- Access for additional users can be purchased at a discounted price.

Take advantage of this special at **prolibraries.com/cda** by using promo code CDASF13

Cool Products

The home for dental innovation.

If you're looking for the latest technology, products and services in dentistry, look no further than *CDA Presents.* The San Francisco tradeshow featured more than 100 new products. If you're looking for the next big idea in dentistry, it could be one of these Cool Products.

	Product Company Website	Product Description
	**Monarch™** **Air Techniques Inc.** **airtechniques.com**	Air Techniques proudly introduces The Monarch™ line of hygiene protection products for surfaces, instruments, skin and hands and equipment. • 60-second kill times or less for TB, viruses, bacteria and fungi • Packaging that reduces the amount of plastic waste • One-step cleaning and disinfecting method saves time and uses 50 percent less product • Clear color-coding by type of product
	**Gorilla® Crowns and Bridges** **Kainos Dental Technologies LLC** **kainosdental.com**	Kainos® proudly introduces the third generation of zirconia-based restorations. We call them Gorilla® crowns and bridges. Available in two designs that balance strength, beauty and versatility. Visit kainosdental.com to learn about a new breed of zirconia restorations. Built on a 20-year tradition of quality, integrity and solutions. • Gorilla® HY — first and only hybrid design to maximize esthetics and strength. • Gorilla® FZ — full contour design for strength and industry best esthetics. • Both options provide cementation choices, precise fit and much more!
	**GumChucks®** **GumChucks at OralWise Inc.** **gumchucks.com**	GumChucks® is an innovative new flossing tool for children that makes flossing fun, easy and effective. Resembling miniature nunchucks, the two-handle system allows kids to easily create the recommended "C" shape, reach posterior teeth and control floss tension, all without putting their fingers in their mouths. • Now available — GumChucks Pro, the new adult version and the new GumChucks Chairside Tools. • Coming soon — Orthogami, a specially designed flossing tip for use with the GumChucks handles, that makes flossing for orthodontic patients fast, incredibly easy and effective. • Brochures, displays, informational videos, commercials and a game app make marketing and merchandising easy.
	**ProSites Mobile Website Solution** **ProSites** **prosites.com**	Reach on-the-go patients with a new ProSites mobile website. With user-friendly navigation and prominent click-to-call and click-to-map icons, patients can find and contact your practice — instantly. Plus, add unlimited pages, showcase your services and play videos right from your mobile site. The mobile revolution is here — is your practice ready?

cda® PRESENTS

The Art and Science of Dentistry

Save the dates

CDA Presents. The premier dental convention in the U.S.

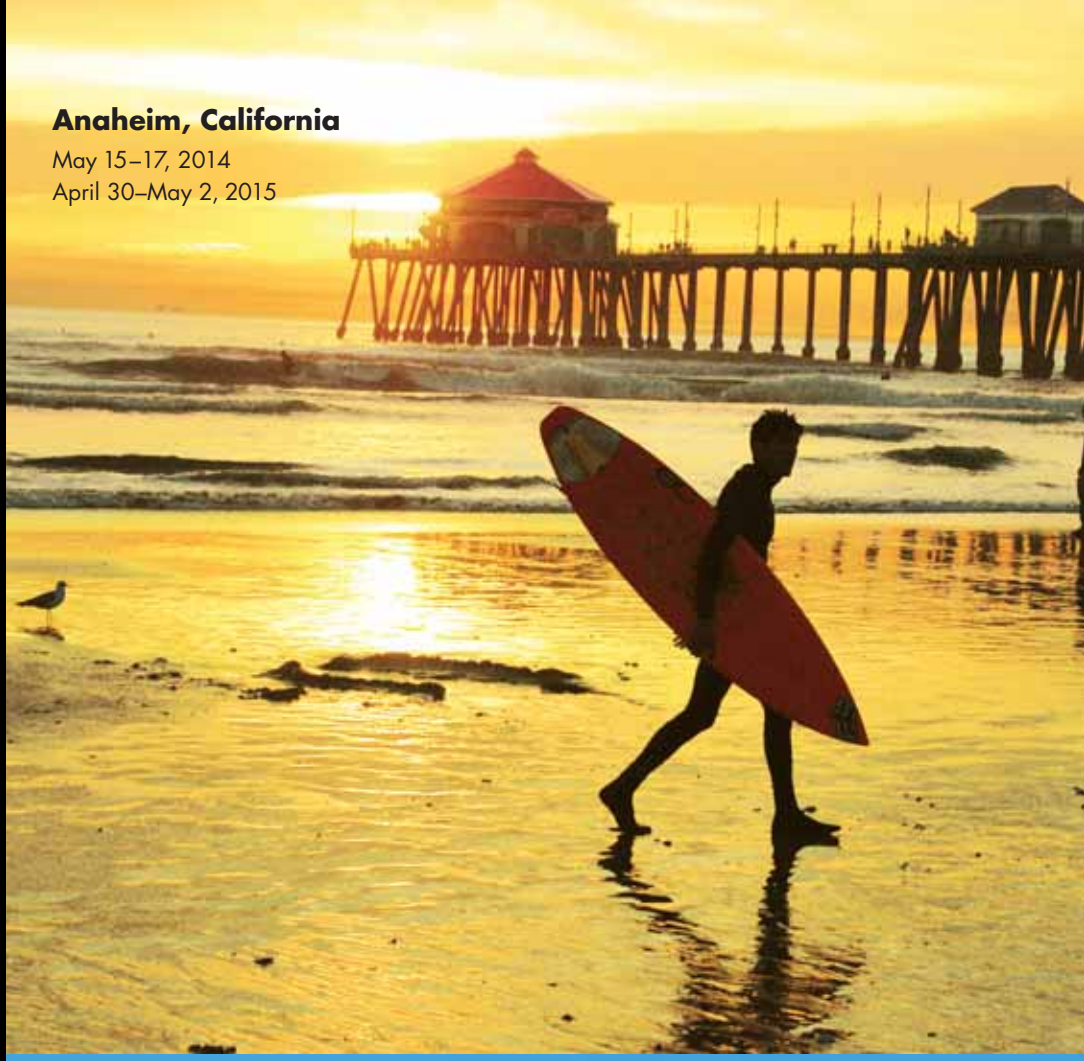
- Nearly 600 exhibiting companies
- More than 100 new product introductions
- Dynamic speakers
- Exciting attractions in Anaheim and San Francisco

▶ **cdapresents.com**

Like us
facebook.com/cdafan

#cdaANA
#cdaSF

Download the show app!



Anaheim, California
May 15–17, 2014
April 30–May 2, 2015

San Francisco, California
September 4–6, 2014
August 20–22, 2015

CDA JOURNAL, VOL 41, Nº9

Americans with Disabilities Act: Understanding the Complexities and Dentistry's Role

STANLEY R. SURABIAN, DDS, JD

GUEST EDITOR

Stanley R. Surabian, DDS, JD, is chief of Dental Services and program director of the General Practice Residency in Dentistry at Community Regional Medical Center's Surabian Dental Care Center in Fresno, Calif.
Conflict of Interest Disclosure: None reported.

This edition of the *Journal of the California Dental Association* focuses on the dentist's role and obligations to persons with disabilities under federal and state law. The five articles reveal the complexities dentists and others face to care for their patients. I am pleased to have participated as guest editor and as a contributing author to this edition.

California's history of civil rights and its nexus with persons with disabilities began, like other places in its time, as a story of bigotry. Bigotry was multifaceted and was used usually as a tool of oppression. Bill Boyarsky, a former city editor and columnist for the *Los Angeles Times* and author of the book *Big Daddy: Jesse Unruh and the Art of Power Politics,* relates that Jesse Unruh, a democrat, was elected to the California State Assembly in 1954 and was speaker of the assembly from 1961 to 1969. He later served as state treasurer, before losing the governor's election to Ronald Reagan. He represented a Los Angeles district like most other post-World War II areas of the city. Violence and segregation greeted African-Americans moving into Los Angeles. From his days growing up in Texas, the son of a sharecropper, Unruh despised bigotry. "Big Daddy" took on the bigots and racists in California. He sponsored a bill in the legislature, which was later referred to as the 1959 Unruh Civil Rights Act.[1] His immense political power and wit got the bill passed in the State Senate over severe opposition. The bill banned discrimination based on sex, race, color, religion, ancestry, national origin, disability, medical condition, marital status or sexual orientation. It's hard to believe that the Unruh Civil Rights Act was passed in California five years before Congress passed the Civil Rights Act of 1964 and the Americans with Disabilities Act of 1990.[2]

On Oct. 26, 2011, California Governor Jerry Brown signed into law a bill extending the Unruh Civil Rights Act to prohibit discrimination based on a person's genetic information.[3]

The articles in this edition are a small attempt to cover the field of federal and state laws preventing discrimination against persons with disabilities including the latest information from experts in the field based on their work with the Americans with Disabilities Act (AwDA) and the Fair Employment and Housing Act (FEHA) in California.

I authored an article entitled "Dentistry's Intrinsic Link to Provision of Services for Persons with Disabilities." This article provides dentists with a background on disabilities, education issues and provision of services related to statutory and regulatory requirements, particularly the AwDA and the FEHA.

In their article "Reducing the Risk of an AwDA Lawsuit," Kevin Franklin, JD, and Megan Oliver Thompson, JD, of Hanson Bridgett LLP, review basics of the AwDA, access to dental service, incentives to improve accessibility to your practice, reducing risks associated with lawsuits, violations, filing a complaint and legal processes.

Certified access specialist (CASp) Stephen J. Dolim, AIA, LEED AP, CASp, reviews a brief history of state legislation including legislation in 2008 regarding CASps and voluntary facility inspections to reduce accessibility claims in "Is Your Dental Office Accessible to People with Disabilities?" Mr. Dolim is a founding member of the Certified Access Specialist Institute.

Kimberley Stone, JD, president of the Civil Justice Association of California, reviews abusive and often unjustified litigation over the AwDA in "Disabled Access Claims: Issues and Liability." The history of legislation to correct earlier legislation is reviewed, especially SB 1186 (Steinberg, Dutton) signed by Governor Jerry Brown on Sept. 19, 2012, which is a serious attempt at reform in California.

Jan Katerkamp, CIPP, CHP, regulatory and privacy administrator at the California Dental Association, reviews CDA's resources for its members in "Disabled Access Resources at the California Dental Association." The CDA Compass and the CDA *Legal Reference Guide* both contain helpful information, as well as TDIC's Risk Management Advice Line. Other resources are available through the American Dental Association and federal and state websites.

Every dentist must understand the extent and parameters of providing professional care and how laws and recent amendments can alter our understanding of the term "disability." These articles should enlighten the dental community and increase the level of understanding of these current issues. I hope that the reader will be encouraged to explore the issues raised in this edition to practice successfully and manage the care of our patients, including those with disabilities. ■■■■

Voice your opinion.
We're listening.

Voice your views with CDA on everything from new products and services to policy decisions that will shape the profession. Simply download the free app, create a profile and prepare to speak your mind. Available for iPad, iPhone and Android.

cda.org/mobile

cda

REFERENCES

1. California Civil Code section 51-51.3. leginfo.ca.gov/cgi-bin/displaycode?section=civ&group=00001-01000&file=43-53.
2. Boyarsky B. Not pure, not simple. The *Los Angeles Times*. November 12, 2007. articles.latimes.com/2007/nov/12/opinion/oe-boyarsky12.
3. Governor Brown signs new antidiscrimination bill into law. The Armstrong Law Firm. Digital Journal. October 26, 2011. digitaljournal.com/pr/466210.

CDA JOURNAL, VOL 41, Nº9

Dentistry's Intrinsic Link to Provision of Services for Persons with Disabilities

STANLEY R. SURABIAN, DDS, JD

ABSTRACT This article provides the dentist with a background on disabilities, education, practice and provision of services related to statutory and regulatory requirements, particularly the Americans with Disabilities Act and the California Fair Employment and Housing Act.

AUTHOR

Stanley R. Surabian, DDS, JD, is chief of Dental Services and program director of the General Practice Residency in Dentistry at Community Regional Medical Center's Surabian Dental Care Center in Fresno, Calif.

Conflict of Interest Disclosure: None reported.

She didn't walk away with the crown, but Alexis Wineman knows she topped the American public's list for Miss America. Wineman, an 18-year-old from Cut Bank, Mont., made history as the first person with autism to compete in the 92-year-old beauty pageant. Though she did not become Miss America, Wineman was chosen as "America's Choice," beating out the other 50 contestants in an online vote that took place in the weeks leading up to the event.

Nearly 200,000 votes were cast, and the win — announced during the live telecast of the pageant — secured the reigning Miss Montana one of the 16 spots in the semifinals.

"I didn't know until they announced it to everyone," Wineman said, calling the popular vote win "unreal."

Not only did Wineman impress the public, but she made her mark in Las Vegas among a host of impressive ladies, according to Art McMaster, president and CEO of the Miss America Organization.

"It just seemed that anyone Alexis came into contact with just fell in love with her," he said. "She was the talk of Las Vegas and she really is a special young lady."

Bruce Boyajian/MAO

Miss Montana, Alexis Wineman, made history at the 2013 Miss America pageant, as the first woman with autism to compete.

The chance to be on television was a definite highlight, Wineman said, as was the opportunity to make so many new friends during the competition. But what brought the most joy to Wineman while competing for the Miss America crown was the chance to share her story, and through that, to open people's eyes to what is possible.

"I became an advocate for the special needs community," said Wineman, who was diagnosed with autism at age 11 and is using her position as Miss Montana to increase awareness of the developmental disorder. "I showed that you can become something great if you work hard to get there."[1]

More than a decade ago, *Oral Health in America: A Report of the Surgeon General* concluded that known barriers between people and oral health service should be removed:

> "Individuals whose health is physically, mentally and emotionally compromised need comprehensive integrated care. ... Given the wide variability among groups with disabilities ... more in-depth assessment and analysis of the determinants of oral health status, access to care and the role of oral health in the overall quality of life and life expectancy is needed."[2]

The term "disability" means different things to different people. As dentists, we may first think of some of our patients who have developmental disabilities. As business owners, we may think of all the hurdles our federal and state governments have strewn before us to make running a dental office seem overregulated. The stand-alone term "disability" is a conundrum. How can one word carry with it so many meanings? This article focuses on the Americans with Disabilities Act (AwDA), its California application,[3] a review of common diagnostic categories of developmental disabilities and educational and office issues for the dental team. In addition, the article will incorporate what else is regarded as a "disability," under our laws, all of which come under the penumbra of the AwDA.

The AwDA was enacted into law on July 26, 1990. On Jan. 26, 1992, dental offices were added to the AwDA as "places of public accommodation," requiring that the dentist serve persons qualifying as disabled under the AwDA.[4,5,6] Discrimination is prohibited in access to service and employment for those who qualify. The federal definition of an AwDA-qualified impairment has several components, as used in §12102 of the act:

> The term disability means, with respect to an individual,
> (A) a physical or mental impairment that substantially limits one or more of major life activities of an individual,
> (B) a record of such impairment; or
> (C) being regarded as having such impairment.[6]

While the federal AwDA definition "substantially limits," the California definition "limits." The California Code of Regulations states the following under §7293.5:

> (3) An impairment 'limits' a major life activity if it makes the achievement of a major life activity difficult.
> (C) 'Limits' shall be determined without regard to mitigating measures or reasonable accommodations, unless the mitigating measure itself limits a major life activity.[7]

The Fair Employment and Housing Commission in its statement of purpose states how the AwDA is to be interpreted in California under the Fair Employment and Housing Act (FEHA):

> (b) These regulations are to be broadly construed to protect applicants and employees from discrimination due to an actual or perceived physical or mental disability or medical condition that is disabling, potentially disabling or perceived to be disabling. The definition of 'disability' in these regulations shall be construed broadly in favor of expansive coverage by the maximum extent permitted by the terms of the FEHA.[7]

California has always provided a greater level of protection than federal law. The Prudence K. Poppink Act of 2000 made significant modifications to California's disability laws. The Poppink Act clarified that there only needs to be a "limitation" of a major life activity to determine mental and physical disabilities. A mitigating measure is not a factor unless the mitigation itself ends up limiting a major life activity. Under the federal AwDA the disability must "substantially limit" the major life activity and mitigation can be a factor for determination. Therefore, under California law, a broader consideration is afforded compared to the more narrowly defined AwDA.[8]

Americans with Disabilities Act

The federal definition for a developmental disability is found in the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. §6000 et seq.) and states the following:

> "The term developmental disability means a severe, chronic disability of an individual 5 years of age or older that –
> (A) is attributable to mental or physical impairment or a combination of mental and physical impairments;
> (B) is manifested before the individual attains age 22;
> (C) is likely to continue indefinitely; (D) results in substantial functional limitations in three or more of the following areas of major life activity
> (i) self care;
> (ii) receptive and expressed language;
> (iii) learning;
> (iv) mobility;
> (v) self-direction;
> (vi) capacity for independent living; and
> (vii) economic self-sufficiency.

(E) reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, supports, or other assistance that is of lifelong or extended duration and is individually planned and coordinated, except that such term, when applied to infants and young children, means individuals from birth to age 5, inclusive, who have substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in developmental disabilities if services are not provided."[6]

There is also a variation from the federal definition to the California definition. California Welfare and Institutions Code §4512 gives the state's definition of developmental disability as used in this division:

(a) "Developmental disability" means a disability that originates before an individual attains age 18 years, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. As defined by the director of developmental services, in consultation with the superintendent of public instruction, this term shall include mental retardation, cerebral palsy, epilepsy and autism. This term shall also include disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation, but shall not include other handicapping conditions that are solely physical in nature.[9]

Recently, government agencies and associations have together updated the term "mental retardation" to "intellectual disability."

The American Association on Mental Retardation (AAMR) is now the American Association on Intellectual and Developmental Disabilities (AAIDD).[10]

The federal government has also made the change. The American Psychiatric Association (APA), which publishes the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, is using the new term in its 5th edition published in 2013.[11] The term "mental retardation" is virtually obsolete. California legislation is seeking to change the term along with other states that have made the change or are considering the change in their legislatures.[10]

Developmental Disabilities

Intellectual Disability

"Intellectual disability" is a disability characterized by significant limitations both in intellectual functioning and in adaptive behavior, which covers many everyday social and practical skills. This disability originates before the age of 18.

Intellectual functioning — also called intelligence — refers to general mental capacity, such as learning, reasoning, problem solving and so on.

One criterion to measure intellectual functioning is an IQ test. Generally, an IQ test score of around 70 or as high as 75 indicates a limitation in intellectual functioning.

Standardized tests can also determine limitations in adaptive behavior, which comprises three skill types:

- Conceptual skills — language and literacy; money, time and number concepts; and self-direction.
- Social skills — interpersonal skills, social responsibility, self-esteem, gullibility, naïveté (i.e., wariness), social problem solving and the ability to follow rules/obey laws and to avoid being victimized.
- Practical skills — activities of daily living (personal care), occupational skills, health care, travel/transportation, schedules/routines, safety, use of money and use of the telephone.

TABLE 1

Levels of Intellectual Disabilities

Category	Number	Percent
None	49,557	25.6
Mild	72,865	37.7
Moderate	32,390	16.7
Severe	14,964	7.7
Profound	10,841	5.6
Unknown	12,885	6.7

Source: California Department of Developmental Services, 2007; client base of persons with developmental disabilities.

On the basis of such many-sided evaluations, professionals can determine whether an individual has an intellectual disability and can tailor a support plan for each individual.

But in defining and assessing intellectual disability, the AAIDD stresses that professionals must take additional factors into account, such as the community environment typical of the individual's peers and culture. Professionals should also consider linguistic diversity and cultural differences in the way people communicate, move and behave. Finally, assessments must also assume that limitations in individuals often coexist with strengths, and that a person's level of life functioning will improve if appropriate personalized supports are provided over a sustained period.[10] The California Department of Developmental Services (DDS) reported various levels of intellectual disabilities within its client base in its October 2008 *Fact Book*[15] (**TABLE 1**).

Waldman et al. discussed how stigma and stereotyped images of children with mental retardation is hard to change.[12] "History demonstrates examples of strongly believed characteristics. Identification of mental retardation

or the propensity toward mental retardation was based most often on whichever prejudice was at the forefront of thought. Ethnicity was often categorized as a factor. When classified by Caucasians in the mid-19th century, the 'Caucasian type was the highest functioning' in human abilities. Similarly, as reflected in a series of *New York Times* articles in the early 20th century, there was the concept of the 'feeblemindedness' and the dangers posed by 'weak minds.' The extrapolation was that the 'feebleminded' were a public menace and morally defective, including 'the insane, the socially deviant and the mentally deficient.'"[12,13]

Other developmental disabilities defined in the California codes include the following:[14]

Epilepsy. Epilepsy is the tendency to have seizures and a seizure is a transient episode of central nervous system dysfunction. "Epilepsy occurs when permanent changes in brain tissue cause the brain to be too excitable or jumpy. The brain sends out abnormal signals. This results in repeated, unpredictable seizures. (A single seizure that does not happen again is not epilepsy.)"[11] Epilepsy may be due to a medical condition or injury that affects the brain, or the cause may be idiopathic.[14]

Autism Spectrum Disorders (ASD). In DSM-IV, autistic disorder, Asperger's disorder, Rett syndrome and childhood disintegrative disorder are individually defined diagnostic categories.[16] In DSM-V, the diagnoses are collectively under the category of autism spectrum disorders. Asperger's disorder will now be referred to as "mild autism."[11] DSM-V now uses the following definition: "People with ASD tend to have communication deficits, such as responding inappropriately in conversations, misreading nonverbal interactions or having difficulty building friendships appropriate to their age. In addition, people with ASD may be overly dependent on routines, highly sensitive to changes in their environment or intensely focused on inappropriate items. Again, the symptoms of people with ASD will fall on a continuum, with some individuals showing mild symptoms and others having much more severe symptoms."[11]

TABLE 2

Major Categories of Developmental Disabilities

Category	Number	Percent
Intellectual disability	143,965	74.4
Epilepsy	37,887	19.6
Autism spectrum disorder	36,952	19.1*
Cerebral palsy	34,646	17.9
Developmental disabilities diagnostic categories	193,522	100

*Source: California Department of Developmental Services, 2007; *Autism spectrum disorder was 13.8 percent (23,502) in 2004.*

The story of Ms. Wineman's appearance in the 2013 Miss America pageant is a clear example of achievement based on hard work despite a clinical diagnosis of autism. Many people of accomplishment have a clinical diagnosis of a developmental disability or other limiting factor and function in the world with significant success and overcome obstacles in life that most people do not have to endure.[1] These legislative and regulatory actions on the federal and state levels help to place individuals who qualify under these acts on a level footing with most people in our society. DDS also reported on the prevalence of the four major categories of developmental disabilities. Autism spectrum disorder from 2004 to 2007 went from 13.0 percent to 18.1 percent of the diagnostic categories within DDS's client base, with cerebral palsy going from 22 percent to 17.9 percent[15] (**TABLE 2**).

Cerebral Palsy. Current research suggests the majority of cerebral palsy cases result from abnormal brain development or brain injury prior to birth or during labor and delivery. Accidents, abuse, medical malpractice, negligence, infections and injury are some known risk factors that may lead to cerebral palsy.[12] Diagnostically, of the four listed developmental disabilities, only intellectual disability has intellectual disability as a component. If an individual is diagnosed with epilepsy, autism spectrum disorder or cerebral palsy, that individual does not have an intellectual disability; however, it is always possible the individual may concurrently have a second or possibly third developmental disability.[14,15,17]

The Americans with Disabilities Act is important to us because dental offices are considered places of public accommodation.[18] Discrimination in access to services is prohibited against a person considered disabled under the AwDA.[19] There are three main categories of impairment under the act:

1. Physical or mental impairment that substantially limits one or more of the major life activities of that person.
    a. Persons with developmental disabilities.
    b. Persons with hearing or visual impairment.
    c. Persons with certain medical conditions
        i. Cancer
        ii. Diabetes
        iii. Heart disease
        iv. Human immunodeficiency virus (HIV)
2. A record of such impairment
    a. Alcohol or drug abuse
        i. If a person arrives at your office intoxicated and poses a direct threat to others, you can refuse service.

ii. Nonemergency treatment may be postponed if the patient is under the influence and it is in the patient's best interest to do so.

b. Mental illness

c. Cancer or heart disease, but not limited in major life activities

3. Impairment without actually being disabled.

a. Physical deformity where major life activities are not limited, but public reaction may be discriminatory.[6]

The Californians with Disability Act is substantially the same except the federal government uses the term "substantially limits," while California removes the term "substantially" and uses the term "limits."[20] For the dentist to provide dental services to clients of DDS age 21 and over, the dentist was required to obtain two vendor authorizations, one through DDS and one through Denti-Cal. Dentists already vendorized under Denti-Cal had to become separately vendorized through DDS, but this cumbersome process was changed. California Code of Regulations §54310 was recently amended to allow those dentists already enrolled in the Denti-Cal program not to have to be separately vendorized under DDS unless the regional centers are directly paying for services.[21]

Education of Dentists in Special Care Dentistry

Dental students need to be exposed to the management of patients with special needs or having trained dentists to provide necessary care in the future is going to diminish. When educated professionals are unavailable to provide care for patients with special needs, then this segment of our population will be unable to find practitioners to meet their oral health concerns. This situation decreases access to care for our most vulnerable population and creates an unnecessary burden on those dentists already providing crucial services to patients with special needs.[22,23]

A survey published in 1999 by Romer et al. reported 38 percent of the respondent dental schools had special patient care (SPC) clinics.[24] In a later dental school survey published in 2007, Schwenck et al. discovered that 40 percent of the respondents had SPC clinics. In these clinics, 94 percent used dental students to provide dental care.[25] During an eight-year period there was a net increase of 2 percent, which indicates that dental schools are not increasing their curriculum time to focus on SPC.

THE AMERICANS with Disabilities Act is important to us because dental offices are considered places of public accommodation.

A more recent survey indicated that "less than three quarters of U.S. dental schools have predoctoral students actively involved in treating patients with special needs."[26] Apparently, some dental schools regard Commission on Dental Accreditation Standard 2-24 as a guideline; however, a reading of the Standard shows "must" do wording:

"Graduates *must* be competent in assessing the treatment needs of patients with special needs."

The Standards define the term *must*: "Indicates an imperative or duty; an essential or indispensable item: mandatory."

Furthermore, the Standards define *patients with special needs* as: "Those patients whose medical, physical, psychological or social situations make it necessary to modify normal dental routines in order to provide dental treatment for that individual. These individuals include, but are not limited to, people with developmental disabilities, complex medical problems and significant physical limitations."[27]

A variety of conditions are defined as disabilities, particularly through the AwDA and through laws defining developmental disabilities. While the purpose of this article is not to redefine any terms or references, we have to consider how terms such as "disability" must be sorted into identifiable components. What are some factors influencing whether dental professionals will engage in the care of persons with disabilities? First, we will evaluate three types of predoctoral dental school programs. Second, we will evaluate two types of postdoctoral dental programs.

Predoctoral Dental Schools

Dental School No. 1

The first consideration is treatment provided by undergraduate dental students. At any particular institution, does the clinical director's office distribute case assignments for all patients seeking care? The second consideration is whether the institution also has within its structure a hospital-based general practice residency (GPR) program or an advanced education in general dentistry (AEGD) program, or possibly a pediatric dentistry residency program, offering hospital training and provision of services in an operating room under general anesthesia and whether dental students have access to participate

in hospital settings. Each institution would have to evaluate its abilities. If there is no undergraduate special needs accommodation within the school despite a "must" designation regarding predoctoral Standard 2-24, then it can be assumed that "disabled" patients will not receive care; furthermore, because there are no postdoctoral programs offering special care, in this scenario, patients will be screened to encourage those with disabilities away from this institution.

Dental School No. 2

If this institution offers care for persons with disabilities in the clinic, what about advanced care for those who require dental care under general anesthesia? If postdoctoral programs are not available to treat patients with special needs, a conclusion can be drawn that some of the persons within this identifiable group will receive care within the predoctoral dental school environment, but no one requiring sedative or operating room settings will be made available to patients with special needs.[22,23,26]

Dental School No. 3

The third type of institution would have a predoctoral special care clinic with appropriately trained faculty, who are able to manage patients in the operating room. The goal would be to train dentists either to go into postdoctoral general dentistry programs or adequately train predoctoral dental students to manage the care of patients with special needs.[22,23] Ideally, there would be an affiliation with a GPR postdoctoral program, an AEGD with an operating room component, or possibly a postdoctoral pediatric dentistry program with an operating room component for children and adults with special needs. Because a GPR is hospital based, an appropriate affiliation agreement would need to exist.

Postdoctoral Dental Residency Programs

Using postdoctoral GPR programs as our ideal source of care for patients with special needs, will the situation always achieve our goal?

GPR No. 1

Veterans Administration (VA) Medical Centers, also Health Care Systems:

In a VA GPR, the client base is identified as military service connected. Depending on a number of factors, military veterans may receive dental and medical services through qualification in the federal system.

Patients with special care needs would include geriatric patients and medically complex patients. Nonmilitary affiliated patients would not be part of the patient base at a VA institution. Similarly, postdoctoral GPR programs in VA institutions would not certify their residents in the management of children and those with developmental disabilities in hospital environments. The VA dental resident would not receive these experiences unless the residency had an affiliation and rotation to a non-VA site where operating room experiences with children and patients with developmental disabilities could be gained.

GPR No. 2

Institutions that are community or county based would have the ability to offer residents critical training in the full range of hospital-based activities: clinic, emergency department, operating room, consultative and comprehensive services for all patients seen by the institution.[28,29] Most patients will have third-party coverage, private pay, grant-related or Medicaid payment options. California law has always provided a greater level of protection through FEHA than federal AwDA law.[8] Therefore, qualifying under California law allows a much broader consideration compared to the more narrowly defined AwDA.[30] Emergency departments, because of federal Emergency Medical Treatment and Labor Act (EMTALA) provisions, may not discriminate against patients coming to the emergency department based on the individual's payment classification, particularly if the institution accepts federal money as payment for health care.[33]

Commission on Dental Accreditation-approved residency programs[34] with county or community sponsorship are often best suited to provide care to all persons coming for care than stand-alone VA residency programs.

The Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act, Section 1401, states that " ... pediatric dental benefits ... are included in the essential health benefits required to be provided ... "[31] The children's provision goes into effect in 2014; California will determine the range of benefits and has decided to allow stand-alone dental plans. Stand-alone plans do not have to be tied to the medical plan. There are more than 300,000 children with disabilities in California.[32] Major changes are coming to insurance coverage for health.

Office Concerns

Patients with Limitations

Because of a range of cognitive and physical impairments, examples of simple office demeanor changes can manifest into rewarding experiences in the dental office for the patient and the dental team.[35,36,37,38] One example is visual impairment.

Visual Impairment

Vision provides perspective to life functions. Once vision is lost, the other senses become heightened, especially hearing, smell and touch. The dental team approach to the visually impaired is critical. A member of the dental team who marches into the waiting room, grabs the patient by the hand and yanks the patient out of the chair saying "follow me" has forever negated this dental appointment. No matter how skilled the team is in providing dental services, the game is lost. Why? Because people do not like to be treated in an offensive manner. Are you dragged by the hand into your health care provider's exam room? Would you be offended?

So, if we do not grab people or pull and drag them, what should we do? With an adult, you offer your arm and speak calmly. You walk with the patient and tell the patient what is ahead — the door, the entrance into the office, the hallway, entrance into the operatory and the dental chair. The dental team member can describe where to sit, describe the room and equipment and ask the patient what they would like to touch as they are prepared in the operatory. Ask the patient whether they want to touch the doorframe, the back of the dental chair, etc. Team training is essential so no one grabs the hand of a patient who is then dragged to the operatory. Once the patient is seated, offer to let the patient touch the instruments, if he or she wants, steering him/her away from sharp edges. Personal protection standards apply here. Some patients with visual impairment may want to touch your arm as you retrieve instruments and go through the procedure. Once the patient is confident in you, he/she will be more comfortable in your care. Make sure you accommodate these patients.

Mea culpa — The alternative scenario might go wrong, very wrong. The patient is now in the dental chair and the assistant says, "Dr. Jim will be in shortly." Dr. Jim has silently followed the patient into the room. He comes by, shouts, "Hi Bill," and at the same time gives him a good, firm slap on the back. As the chair back is rapidly being positioned downward, Dr. Jim says, "Open wide so I can give you a shot." Bill finally says, "Wait a minute!"

Hearing Impairment

Similarly, the person with a hearing impairment uses a heightened visual sense in everyday encounters. If a dental dam is not placed properly, the upper edge of the dam could be at the level above the eyes making it difficult or impossible for the patient to visualize while receiving dental care. Often, it is the small things to us that are the big things to those with various disabilities. The use of the dental dam for many persons with disabilities helps make the dental experience satisfactory. Protecting the airway and isolating the operative site is for the patient's safety and enhances the dental team's efficiency.

Dental Dam Isolation

Why use a dental dam at all? Because your dental school made you use it. It is required in all regional board exams. And why would that be important? Dentists are able to achieve predictable isolation of the field. The dental dam makes our work as dentists easier and better. Using the dental dam in private practice is the standard of care, because it is protective and isolates the treatment area.[39,40,41] Persons with disabilities, such as individuals with epilepsy or cerebral palsy, greatly benefit from dental dam use and, when possible, stability is enhanced using a mouth prop.

A survey of general dentists revealed that the application of a rubber dam was not consistently used. Dentists have cited inconvenience (40 percent) and unnecessary (28 percent) as the main reasons. Only 18 percent always use a rubber dam to do posterior composites as compared to 17 percent with anterior composites.[42] Slawvinski and Wilson surveyed pediatric dentists and pediatric dentistry program directors. More than 80 percent of this group used the rubber dam, which they considered the standard of care in pediatric dentistry.[39]

The American Association of Endodontists in its position statement on dental dams makes the following statement:

> "Tooth isolation using the dental dam is the standard of care; it is integral and essential for any nonsurgical endodontic treatment. … The dental dam also offers other benefits, such as aiding in visualization by providing a clean operating field and preventing ingestion or aspiration of dental materials, irrigants and instruments."[43]

The use of the dental dam is the standard of care and one of the most effective procedures dentists can incorporate into clinical practice and in the care of persons with disabilities.

Transfer Considerations

The National Institutes of Health makes available several oral care pamphlets for dentists who treat special needs patients.[44-49] One publication is titled *Wheelchair Transfer: A Health Care Provider's Guide*. A safe wheelchair transfer requires six steps:[49]

> *Step 1.* Determine the patient's needs, which may require asking the patient or caregiver (**FIGURE 1**).
>
> *Step 2.* Prepare the dental operatory,

CONTINUES ON 686

Some folks didn't believe.

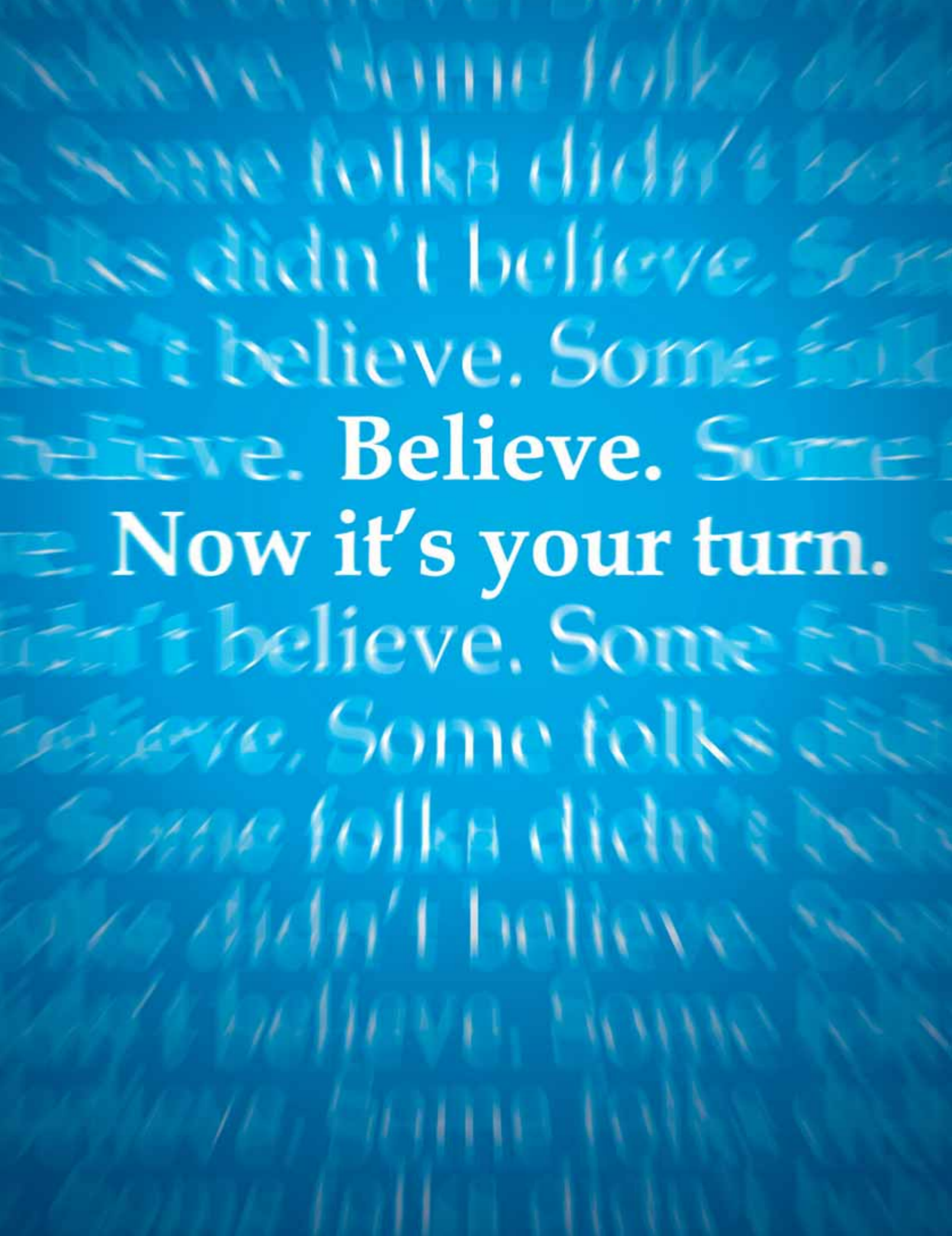
Apple would transform consumer electronics.
Google would transform the way we use computers.
Starbucks would transform the retail business model.
Nike would transform leisure time.

We want to team up with you to transform private dental practice management.

See how.

Visit | www.stratusdental.com/cda
Call | 888.708.8639
Email | info@stratusdental.com

Stratus DENTAL GROUP


Believe.
Now it's your turn.

CONTINUED FROM 683

FIGURE 1. Before attempting to transfer a patient, determine his or her needs. Ask the patient or caregiver about his/her preferred transfer method and the patient's ability to help.

FIGURE 2. Prepare the dental operatory, which may require removal, relocation or reposition of equipment. Position the dental chair to the same height as the wheelchair.

FIGURE 3. Position the wheelchair close to and parallel to the dental chair. Remove the footrests and armrest next to the dental chair and lock the wheels. Check for any special padding or equipment that needs to be moved.

FIGURE 4. Support the patient and transfer any special padding or equipment from the wheelchair to the dental chair. Perform a two-person transfer from the wheelchair to the dental chair, gently lifting the patient's torso and legs at the same time as you make the transfer.

FIGURE 5. Center the patient in the dental chair. Reposition any special padding and safety belt as needed for the patient's comfort.

FIGURE 6. Transfer the patient from the dental chair back to the wheelchair. Position the wheelchair close to and parallel to the dental chair, remove the armrest and lock the wheels. Raise the dental chair slightly higher than the wheelchair and transfer the patient using the two-person transfer described in **FIGURE 4.**

which may require removal, relocation or reposition of equipment in the room (**FIGURE 2**).

Step 3. Prepare the wheelchair, which may require removing footrests, moving the wheelchair close to and parallel to the dental chair (**FIGURE 3**).

Step 4. Perform a two-person transfer from the wheelchair to the dental chair (**FIGURE 4**).

Step 5. Position the patient after the transfer and complete care (**FIGURE 5**).

Step 6. Transfer from the dental chair to the wheelchair (**FIGURE 6**).

Wheelchair transfers may be easily accomplished in the office with a trained staff working in unison. Often, the caregiver or parent accompanying the patient provides input and assistance in the process.

Conclusion

A review of the Americans with Disabilities Act of 1990 and its California counterpart under the Fair Employment and Housing Act is necessary for our understanding of several aspects of the interface with the practice of dentistry. California law has a broader interpretation of who might be considered "disabled" than federal law, meaning more individuals are likely to meet qualifications under both state and federal interpretations, rather than meeting only the federal government's standard — the narrower path under a "substantial limitations" interpretation. Since 1992, dental offices are considered places of "public accommodation." Therefore, all the ramifications under federal and California regulations apply to dental offices as far as seeing patients with disabilities and making our offices and buildings compliant so we can accommodate our patients.

The word disability has several connotations. This article, in part, reviewed the factors in the determination of a disability, as well as the definitions of developmental disabilities. The American Association on Intellectual and Developmental Disabilities has replaced the outdated term mental retardation with the term intellectual disability. The federal government, several states and DSM-V use the new term. DSM-V has also changed other diagnostic terminology and now uses the term autism spectrum disorder for a wide variety of autistic diagnoses and has changed the term Asperger's disorder to mild autism.

The situation with special care clinics in our nation's dental schools shows that only 40 percent of the schools have SPCs. This situation is not encouraging when Commission on Dental Accreditation Standard 2-24 mandates compliance: "Graduates must be competent in assessing the treatment needs of patients with special needs." Predoctoral and postdoctoral scenarios were reviewed to help identify what our institutions are capable of providing in special needs education. The article focused on several office scenarios involving the dental team, the importance of dental dam use as the standard of care and safe wheelchair to dental chair transfer techniques.

Miss Montana, 18-year-old Alexis Wineman, despite being diagnosed with autism, came in 15th overall in the 2013 Miss America Pageant and was chosen "America's Choice" after beating out 50 other contestants in public online voting. A young woman determined to make a difference in how the public perceives persons with developmental disabilities has enhanced, in a positive way, how each of us regard her and her accomplishments. Alexis Wineman is a real example of success despite difficult odds. ■■■■

REFERENCES

1. Young L. Beauty queen with autism makes Miss America history. *Disab Scoop, LLC,* 2013. www.disabilityscoop.com/2013/01/15/beauty-queen-autism-history/17078/.
2. U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General.* U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.
3. Disability Under the Fair Employment and Housing Act: What you should know about the law. *DFEH-208DH,* 03/09.
4. American Dental Association Division of Legal Affairs. *Americans with disabilities act: questions & answers.* American Dental Association, 1992.
5. U.S. Department of Justice. A guide to disability rights laws, 2009. www.ada.gov/cguide.pdf.
6. AwDA enacted into law on July 26, 1990, P.L. 101-336; 42 U.S.C. 12102. AwDA Title III Regulations, 28 CFR Part 36; AwDA Amendments Act of 2008 (Pub. L. No. 110-325).
7.General prohibitions against discrimination on the basis of disability. *California Code of Regulations* Title 2, Div 4, Ch 1, Subch 9, §7293.5(a)(b), Dec 2012.
8. California Fair Employment and Housing Act. Government Code §§12926(i)(2) et seq.
9. Developmental Disability. California Welfare and Institutions Code §4512.
10. Definition of Intellectual Disability, *American Association on Intellectual and Developmental Disabilities (AAIDD).* www.aaidd.org/content_100.cfm?navID=21.
11. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders,* 5th ed. Washington, D.C., American Psychiatric Association, 2013.
12. Waldman HB, Swerdoff M, et al. Children with mental retardation stigma and stereotype images are hard to change. *J Dent Child* 66(5):343-7, 1999.
13. Surabian SR. Developmental disabilities and understanding the needs of patients with mental retardation and Down syndrome. *J Cal Dent Assoc* 29(6):415-23, 2001.
14. Surabian SR. Developmental disabilities: epilepsy, cerebral palsy and autism. *J Cal Dent Assoc* 29(6):424-32, 2001.
15. *Fact Book,* 11th ed. Department of Developmental Services, October 2008.
16. www.autism-society.org.
17. www.cerebralpalsy.org.
18. 42 USC §12181 et seq.
19. 42 USC §12182(a).
20. Developmental Disability. *California Welfare and Institutions Code* §4512.
21. Vendor application requirements, *California Code of Regulations* Title 17, Div 2, Ch 3, Subch 2, §54310(h).
22. Chavez EM, Subar PE, et al. Perceptions of predoctoral dental education and practice patterns in special care dentistry. *Spec Care Dent* 75(6):726-32, 2011.
23. Subar P, Chavez EM, et al. Pre- and postdoctoral dental education compared to practice patterns in special care dentistry. *J Dent Educ* 76(12):1623-8, 2012.
24. Romer M, Dougherty N, et al. Predoctoral education in special care dentistry: Paving the way to better access? *J Dent Child* 66(2):132-5, 1999.

25. Schwenk DM, Stoeckel DC, et al. Survey of special patient care programs at U.S. and Canadian dental schools. *J Dent Educ* 71(9):1153-9, 2007.
26. Clementson JC, Jones DL, et al. Preparing dental students to treat patients with special needs: Changes in predoctoral education after the revised accreditation standard. *Spec Care Dent* 76(11):1457-65, 2012.
27. Commission on Dental Accreditation. *Accreditation Standard for Dental Education Programs*. American Dental Association, 2013.
28. Haywood P, Karalliedde L. General anesthesia for disabled patients in dental practice. *Anesth Prog* 45:134-8, 1999.
29. Sani RJ, Spencer RO. Integrating hospital dentistry into the general dental practice. *J Cal Dent Assoc* 29:433-44, 2001.
30. American Dental Association Division of Legal Affairs. *Americans with Disabilities Act: Questions & Answers*. American Dental Association, 1992.
31. Refundable tax credit providing assistance for coverage under a qualified health plan. *The Patient Protection and Affordable Care Act*. §1401(E), HR 3590:97, 2010.
32. Waldman H, Perlman S. Almost 300,000 children (ages 5 to 15) with disabilities in California. *J Cal Dent Assoc* 32:651-5, 2004.
33. Surabian SR. EMTALA: impact on hospital dentistry emergency services. *Spec Care Dent* 20(1):7-11, 2000.
34. Commission on Dental Accreditation. Accreditation standards for advanced education programs in general practice residency. *American Dental Association*, 2013.
35. Yuen H, Wolf B, et al. Factors that limit access to dental care for adults with spinal cord injuries. *Spec Care Dent* 30:151-6, 2010.
36. Stiefel D. Dental care considerations for disabled adults. *Spec Care Dent* 22:26S-39S, 2002.
37. American Academy of Pediatric Dentistry. Guidelines on management of dental patients with special health care needs. Reference Manual *Pediatr Dent* 34:152-7, 2012.
38. Fisher K. Is there anything to smile about? A review of oral care for individuals with intellectual and developmental disabilities. *Nursing Research and Practice* 2012:1-6, 2012.
39. Slawinski D, Wilson S. Rubber dam use: a survey of pediatric dentistry training programs and private practitioners. *Pediatr Dent* 32(1):64-8, 2010.
40. The Dentist's Insurance Company Rubber dam it. *TDIC Summer Lifeline*. 1-3, 2004.
41. Anabtawi MF, Gregg GH, et al. Rubber dam use during root canal treatment: findings from the dental practice-based research network. *JADA* 144(2):179-86, 2013.
42. Hill EH, Rubel BS. Do dental educators need to improve their approach to teaching rubber dam use? *J Dent Educ* 72(10):1177-81, 2008.
43. AAE Clinical Practice Committee. Dental dams. *Dental Dam Position Statement*, 2010. aae.org/uploadedFiles/Publications_and_Research/Guidlines_and_Position_Statements/dentaldamsstatement.pdf.
44. Chin M, Fenton S, et al. Practical oral care for people with developmental disabilities. *National Institute of Dental and Craniofacial Research* NIH Publication No. 09-5196:1-7, 2009.
45. Chin M, Fenton S, et al. Practical oral care for people with intellectual disability. *National Institute of Dental and Craniofacial Research* NIH Publication No. 09-5194:1-7, 2009.
46. Chin M, Fenton S, et al. Practical oral care for people with Down syndrome. *National Institute of Dental and Craniofacial Research* NIH Publication No. 09-5193:1-7, 2009.
47. Chin M, Fenton S, et al. Practical oral care for people with cerebral palsy. *National Institute of Dental and Craniofacial Research* NIH Publication No. 09-5192:1-7, 2009.
48. Chin M, Fenton S, et al. Practical oral care for people with autism. *National Institute of Dental and Craniofacial Research* NIH Publication No. 09-5190:1-5, 2009.
49. Chin M, Fenton S, et al. Wheelchair transfer: a health care provider's guide. *National Institute of Dental and Craniofacial Research* NIH Publication No. 09-5195:1-3, 2009.

THE AUTHOR, Stanley R. Surabian, DDS, JD, can be reached at ssurabiandds@communitymedical.org.

PAYROLL COMPLETE UP TO 5 EMPLOYEES
$19.99 PER PAYROLL
FREE Set-Up - FREE First Month - FREE "Forever" Digital Archiving
All inclusive payroll includes Quarterly and Annual Reports and Taxes Paid!
Easy to Use: Log on √ Enter Hours √ Log off. We do the rest.
866-840-3400
*No recurring monthly, only pay for what you use
*We pay your workers comp thru the system
*Taxes paid using EFTPS for your protection
*Phones always answered by a live person
*No paper to store or have distroyed
*Direct Deposit Avaible
WWW.Green60.com
Payroll Processing green 60.com®

CDA JOURNAL, VOL 41, Nº9

Reducing the Risk of an AwDA Lawsuit

KURT A. FRANKLIN, JD, AND MEGAN OLIVER THOMPSON, JD

ABSTRACT Improving access to your dental office now is cheaper than waiting to be sued.

AUTHORS

Kurt A. Franklin, JD, has practiced labor and employment law for more than 15 years. He is well versed in the AwDA, the Unruh Act, the California Disabled Persons Act, Health & Safety Code sections 19955 et seq., the Americans with Disabilities Act Accessibility Guidelines and the California Access Compliance Building Regulations. He is a partner at the law firm Hanson Bridgett LLP in San Francisco. *Conflict of Interest Disclosure: None reported.*

Megan Oliver Thompson, JD, focuses on complex civil litigation, including business-related matters, civil rights defense and class actions. She is experienced in defending disability access claims under the Americans with Disabilities Act, the Unruh Act and the California Disabled Persons Act. She is a senior counsel at the law firm Hanson Bridgett LLP in San Francisco. *Conflict of Interest Disclosure: None reported.*

The Americans with Disabilities Act Title III and the Unruh Act (the state civil rights law counterpart) apply to dental offices and their landlords. Typically, businesses are sued because they have failed to remove a physical barrier when removing it would have been "easily accomplishable and able to be carried out without much difficulty or expense."

These lawsuits are common because more than 20 years after the AwDA was enacted,[1] businesses are still not accessible — even though many fixes are easy; often, business owners incorrectly believe their businesses are "grandfathered" so as to not require accessibility improvements; for the plaintiffs, proof is relatively easy, as the regulations are technical; and incentive to file a lawsuit is high — if a plaintiff can find any barrier, he or she will claim that they are entitled attorneys' fees. Moreover, in California, plaintiffs can obtain monetary damages, as well.

By developing a plan to remove barriers to access, dentists can significantly reduce these risks.

AwDA Basics

Title III of the AwDA prohibits discrimination by businesses that operate places of public accommodation.[2] Dental offices are places of public accommodation. Title III provides, "[n]o individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages or accommodations of any place of public accommodation by any person who owns, leases (or leases to) or operates a place of public accommodation."[3] Discrimination includes "a failure to remove architectural barriers in existing facilities where such removal is readily achievable."[4] Architectural barriers are those structural or design features that limit the access and mobility of disabled persons, e.g., ramps, counters and doorways. Readily achievable means "easily accomplishable and able to be carried out without much difficulty or expense."[5]

To prevail on a Title III discrimination claim, the plaintiff must show that he or she is disabled within the meaning of the AwDA; the defendant is a private entity that owns,

leases or operates a place of public accommodation and the plaintiff was denied public accommodations by the defendant because of his or her disability, i.e., because of a disability and its relationship to a barrier, the plaintiff was denied full-and-equal access to your dental office.[6]

In addition to AwDA Title III claims, plaintiffs virtually always file parallel California state law claims.[7] Federal courts have ancillary jurisdiction over these claims. Although the AwDA does not provide for any monetary damages awards, California's disability-access statutes permit a plaintiff to collect up to three times actual damages, or $4,000 per visit or deterred visit, if they can show the barrier also caused them "difficulty, discomfort or embarrassment."

Medical Providers

The U.S. government places extra importance on ensuring medical providers are accessible. However, AwDA civil rights activists see room for improvement in most businesses. AwDA Title III and related regulations are the law in the United States and California. Generally, judges consider the AwDA to be an important component of civil rights legislation. Further, as to dentists and other medical professionals, the government asserts that, because of physical barriers, individuals with disabilities are less likely to obtain routine preventive medical care than people without disabilities. The government has also stated that access to dental offices is important so that minor problems can be detected and treated before turning into major problems.

Understand that not every case is a "drive-by" lawsuit or shakedown. While some of the plaintiffs groups are motivated by financial recovery, many are motivated as civil rights advocates to take action to make the world more accessible to persons with disabilities. To these activists, their lawsuits are a form of protest to force compliance with the AwDA and, thus, they take umbrage to "shakedown" references. Among the disability-rights activists, there is a defined core of regular plaintiffs and lawyers who file the vast majority of these lawsuits. Indeed, a few dozen people are responsible for thousands of lawsuits.

ANECDOTALLY, barrier-related disability access lawsuits are the most common types of lawsuits initiated against businesses.

Financial Incentives to Improve Accessibility

Since January 2005, tens of thousands of AwDA lawsuits have been filed in federal courts across the country. Anecdotally, barrier-related disability access lawsuits are the most common types of lawsuits initiated against businesses. It's worse in California, where several lawsuits are filed each day. If this isn't enough, a sophisticated plaintiffs' firm recently filed AwDA Title III lawsuits on behalf of its clients as class actions — demanding (and achieving) settlements in the seven-figure ranges, i.e., $1 million per location.[8]

This means that failing to comply with the AwDA is expensive. An AwDA lawsuit can cost tens of thousands of dollars in defense-related costs and resolution efforts, plus attorneys' fees to the plaintiff if the plaintiff prevails. If a matter is complicated, or doesn't resolve early, the costs can be substantially more.

Steps to Reduce Lawsuit Risks

The first thing you can do to prevent lawsuits is listen extra attentively to your disabled patients and treat them with respect. This works because most of your disabled patients aren't AwDA activists. If a patient with a disability complains, be positive and see if you can successfully address the problem and solve it. Next, train your staff to think the same way. In addition, staff should know which examination and procedure rooms are accessible and where portable accessible equipment is stored. They should understand how to properly assist patients who need transfers and lifts. They should know that not all persons with disabilities are the same — each is unique. Of course, dentists and staff should first ask disabled patients if they need help before providing it because many people who use wheelchairs for mobility consider their wheelchair to be an extension of their body.

In addition to removing construction-related barriers, accessible medical equipment is required for dentists and other medical practitioners. The government asserts that examining a patient in his or her wheelchair usually is less thorough than on the exam table or exam chair and does not provide the patient "full and equal" medical services. Thus, availability of accessible medical equipment — specifically medical and dental examination tables and chairs — is an important part of providing accessible medical care, and dentists and other medical care providers must ensure that medical equipment is not a barrier to individuals with disabilities.[9]

Further, to prevent claims, consider conducting an AwDA facility audit — or "compliance implementation plan." Plans should include an AwDA survey, which notes each barrier/compliance issue, the costs to remediate each compliance issue and projected completion dates for items on the survey. In California, you can also hire a certified access specialist (CASp) to inspect your business. Working with a CASp provides added benefit if you are sued in state court by limiting damages and forcing early settlement discussion. Initially, plans to improve access should focus on getting patients into your office from the parking lot; providing "full and equal" dental care, with at least one fully accessible examination room; making sure public restrooms are accessible; and making sure waiting rooms and service desks are accessible. If a fix cannot be easily achieved, or achieving it would be an undue financial burden or would fundamentally alter your business, you'll want to note this in your plan. In addition, having a barrier-removal implementation plan well underway provides several potential defenses to AwDA claims, e.g., there are no barriers, and even if there are barriers that still need to be removed, an injunction would not be appropriate when the defendant is already taking action to comply with the AwDA.

Next, consider insurance. Many business insurance policies provide coverage for claims brought under Title III of the AwDA. Public accommodations lawsuits are civil rights claims in the same respect as employment-based lawsuits under the AwDA, or race claims under the Unruh Act. Thus, often the type of coverage that applies is a specialty insurance called employment practices liability insurance, or EPLI. Be savvy when it comes to claims. Most often, these policies are "claims-made" policies, meaning you must be insured during the time that a claim is made against you. If you receive any potential complaint about access, you'll want to report it to your insurer right away or risk having the insurer later deny it for being untimely. Finally, if your lease requires you to indemnify your landlord for AwDA claims (and most leases do), then you might evaluate whether the landlord can be named as an additional insured.

THE FIRST THING you can do to prevent lawsuits is listen extra attentively to your disabled patients and treat them with respect.

Typical Complaints

Most AwDA complaints are highly technical with respect to both the California Building Code and the federal AwDA Accessibility Guidelines (AwDAAG). Essentially, these regulations are encyclopedias of accessible design standards. Often based on technical violations, plaintiffs then allege that they were "denied full and equal access to defendants' facilities, goods and/or services in violation of both federal and state laws when they attempted to enter, use and/or exit defendants' facilities." Under recent Ninth Circuit case law, to obtain relief, plaintiffs now must allege how each specific barrier has denied him or her "full and equal access" to the office. Further, the alleged deficiency must be actually identified in the complaint.[10]

Violations frequently identified in an AwDA Title III complaint include the following:

- The tow away signage provided is incorrect, e.g., missing a telephone number to reclaim a towed car.
- The signage in the van-accessible stall is incorrect.
- There is no stop sign painted on the pavement where the accessible route crosses the vehicular way.
- The path of travel to the entrance has a cross slope that is greater than 2 percent.
- There are no detectable warnings where the accessible route crosses the vehicular way.
- The front door requires more than five pounds of force to open.
- The counter heights are too high.
- There is no directional signage leading to the accessible restroom.
- The signage at the restroom's entrance door is incorrect.
- The door into the restroom requires too much force to operate and does not completely close.
- The stall door is not self-closing.
- The handle and lock on the stall door require pinching and twisting to operate.
- The side grab bar is mounted more than 12 inches from the back wall.
- The side grab bar does not extend 24 inches beyond the toilet tissue dispenser.
- The toilet tissue dispenser protrudes into the clear floor space needed at the water closet.
- The toilet tissue dispenser is mounted so the dispensing point is less than 19 inches above the finished floor.
- The pipes underneath the sink are not wrapped to prevent burns and to cover sharp edges.

- The handles to operate the sink controls require twisting and grasping.
- The soap dispenser's operable part is mounted at more than 40 inches from the floor.
- The operable part of the hand dryer is mounted at more than 40 inches from the floor.

Should You Hire an Attorney?

An experienced AwDA defense lawyer understands the most common physical barriers in your business and how they can be remediated. In addition, they will know the plaintiffs, their lawyers and their experts — and the strengths and weaknesses of each. Indeed, each set of lawyers and plaintiffs is unique, requiring different strategic responses. Relationships and credibility matter. Equally important, an experienced AwDA defense lawyer will have a strong understanding of insurance coverage, a good relationship with insurance claim adjusters and an intimate familiarity with the insurance policies that have been sold and how they might pay for defense costs in defending AwDA lawsuits. In short, an experienced AwDA defense lawyer will know how to defend or settle your case to mitigate the risk of future claims and with the least amount of all-in costs, e.g., total defense-side attorneys' fees, remediation costs, damages to the plaintiffs and plaintiffs' attorneys' fees and costs.

Further, an experienced AwDA defense lawyer will help you evaluate your business goals in solving your AwDA problem. As a trusted advisor, experienced AwDA lawyers understand the typical emotional cycle of defendants in these types of cases, who are often experiencing their first formal interaction with the federal courts. You'll be advised on all available options, as well as the costs associated with each strategy. If an aggressive litigation strategy is ill advised with a particular plaintiffs' lawyer, the experienced AwDA defense lawyer will tell you that.

When to Settle

Aggressive litigation is expensive; does it make sense to settle? Cases should settle when it makes business sense. Understand the numbers — trials are unlikely and expensive. Unlike the many television shows about lawyers, in real-world civil litigation, few cases ever go to trial. Statistically, fewer than 2 percent of all cases filed in federal court go to trial. In the Northern District of California, it's less than 1 percent. And with AwDA Title III cases, the number is even smaller. The odds are your case will resolve before trial, too.

Moreover, AwDA Title III cases often settle early because the key facts are generally known or knowable. They settle at a high rate because taking any case to trial — even with a budget-minded lawyer and client — can easily be a six-figure proposition. If litigated vigorously, the defense side fees can be substantially more. Moreover, if the plaintiff prevails, he or she will be entitled to attorneys' fees. In a recent attorney fee application in an AwDA Title III case, a court awarded fees to a plaintiff's law firm based on rates ranging up to $825 per hour. On top of that, the court applied a 1.29 "success" multiplier. The takeaway is this: six- to seven-figure attorneys' fee awards can happen.

Going to Trial

If the case goes to trial, eight strangers will decide your fate. Both parties have the right to a jury trial. It's the plaintiff's burden to prove his or her case, and the defendant's burden to prove any affirmative defenses. Federal civil trials typically have eight jurors — strangers to you — impaneled to decide your dispute. In federal court, their decision must be unanimous. These eight jurors,from unemployed 18-year-olds to retired senior citizens, will decide the facts in your case. And while the court will instruct the jury to base its decisions solely on the evidence and the law, the truth is these eight jurors bring their experiences, personalities and perceptions into the courtroom and these things will help shape their decisions. In truth, it is very difficult to know how the unique facts of your case will be received by the jury.

Next, before the trial, no one knows for certain what evidence the jurors will hear. Before the trial, the judge will rule on pretrial motions in which the parties try to exclude whole segments of the other side's case and prevent any reference to them in front of the jury. For example, an AwDA activist's numerous prior lawsuits, feigned injuries, hidden video, photos of the activist's inaccessible home or workplace and criminal background may never come into evidence. In other words, the smoking gun you know will persuade the jury to rule in your favor may never be heard during trial.

What is certain about a trial is this — it's expensive. To get a case to trial takes at least a year in time, and likely more than six figures in attorneys' fees and costs. During trial, your lawyers will work 10 to 14 hour days. And for each lawyer in court, a lawyer or paralegal is working on the case back at the office. If you're paying your lawyers between $300 and $600 per hour, it adds up quickly.

Conclusion

Start planning your AwDA defense by working with an experienced AwDA lawyer and CASp on your AwDA compliance implementation plan. Improving access to your dental office now is cheaper than waiting until you are sued. If you're interested in aggressively defending lawsuits, pursue this strategy with a thorough understanding of the costs. ■■■■

REFERENCES

1. Congress enacted the AwDA in 1990, and President George H. W. Bush signed it that same year.
2. 42 USC §12181 et seq.
3. 42 USC §12182(a).
4. 42 USC §12182(b)(2)(A)(iv).
5. §12181(9).
6. 42 USC §§12182(a)-(b); see Parr v. L & L Drive-Inn Restaurant, 96 F.Supp.2d 1065, 1085 (D. Haw.2000); Dunlap v. Ass'n of Bay Area Gov'ts, 996 F.Supp. 962, 965 (N.D. Cal.1998).
7. Unruh Act, and the California Disabled Persons Act.
8. See Castaneda v. Burger King Corp., 3:08-cv-04262-WHA; Vallabhapurapu v. Burger King Corp., No. 11-0667 (N.D. Cal. Oct. 29, 2012) ($19 million settlement involving 77 locations, with an average payout of approximately $23,000 per class member).
9. www.ada.gov/medcare_mobility_ta/medcare_ta.htm#accessibleexamrm www.ada.gov/medcare_mobility_ta/medcare_ta.pdf www.ada.gov/anprm2010/equipment_anprm_2010.htm.
10. Oliver v. Ralphs Grocery Company, 654 F.3d 903 (9th Cir. 2011) ("[A] plaintiff must identify the barriers that constitute the grounds for a claim of discrimination under the AwDA in the complaint itself; a defendant is not deemed to have fair notice of barriers identified elsewhere," e.g., in an expert report.

THE CORRESPONDING AUTHOR, Kurt A. Franklin, JD, can be reached at kfranklin@hansonbridgett.com.

Get your CDA email precisely the way you want it.

We recently changed our email preferences to give you greater control. Now, you can opt in to the content you want to receive or opt out of the content you don't.

So if you only want to learn about advocacy, we can do that. Want more practice support or education? We can do that, too. It is really all about you. Customized content. We're hoping it makes you reconsider opting back in to emails from CDA.

Customize yours today at cda.org/emailpref

Dental caries is an epidemic.

See how your colleagues are treating patients differently.

Upcoming webinars with Dr. Kim Kutsch

- Private Practice CAMBRA Research Data
  August 20, 5:30 PM
- Private Practice ROI and CAMBRA
  September 17, 5:30 PM
- CAMBRA and Patient Treatment Expectations
  October 15, 5:30 PM

FREE CE WEBINARS

Register at **webinar.carifree.com.**

Treat People Better™

CariFree®

866.928.4445
www.carifree.com

Approved PACE Program Provider FAGD/MAGD Credit Approval does not imply acceptance by state or provincial board of dentistry or AGD endorsement 10/1/2011 to 9/30/2013

Academy of General Dentistry

PACE Program Approval for Continuing Education

CDA JOURNAL, VOL 41, Nº9

Is Your Dental Office Accessible to People with Disabilities?

STEPHEN J. DOLIM, AIA, LEED AP, CASP

ABSTRACT It has been estimated that more than 90 percent of the offices of health professionals in California have one or more accessibility issues, which commonly lead to lawsuits. Is your office among them?

AUTHOR

Stephen J. Dolim, AIA, LEED AP, CASp, is a licensed architect and certified access specialist. Mr. Dolim recently served on the California Building Standards Commission, the Accessibility Code Advisory Committee and on the California Commission for Disability Access CASp and Education subcommittee. He has served for three years as treasurer for the Certified Access Specialist Institute where he is a founding member.

Can you afford to lose 23 percent of your patients? Nearly 23 percent of the population requires some form of physical accommodation. Now think about it, is your dental office accessible? A quick Web search indicates 10 percent of the population has some form of documented mobility impairment based on disabled persons' license plates issued by the DMV, according to a *Los Angeles Times* article dated June 20, 2007. Some sources state as much as 15 percent of the general population has some form of mobility impairment, another 3 percent is vision impaired and 10 percent is hearing impaired. This is not counting those people with other protected classes of medical disabilities defined under the Americans with Disabilities Act (AwDA).

Each patient expects his or her dental office to have easy access from the sidewalk, to the parking lot and to the front door, especially if he or she is physically disabled. A dental practice may face exposure to lawsuits regarding accessibility compliance in common situations such as a patient parking his/her car in a large, level parking stall to exit the vehicle with ease, smoothly entering the office from the sidewalk or maneuvering around inside the office and into the dental chair without encountering obstructions. These "simple actions" may easily be overlooked by the dentist, staff and other patients. These kinds of physical accessibility issues led to the establishment of the AwDA in 1990, and recently were updated with the 2010 AwDA-Standards (AwDA-S) for accessible design, which became effective March 15, 2012 (ada.gov). Because California has a higher and often different standard for accessibility than the AwDA, it is imperative to reconcile the two often-inconsistent standards to avoid claims. Many properties, which

complied fully with the AwDA, have been subject to lawsuits.

The AwDA considers a dentist office as a health care provider, which is defined as a public accommodation under Title III (or Title II for a publicly funded entity). The Department of Justice (DOJ) is tasked with oversight and enforcement. The Access Board was set up by the DOJ to provide technical guidance on the AwDA-S. Any claims of accessibility deficiencies are generally brought forward in one of two ways:

- By the disabled party under a Civil Rights action in court, or
- By the DOJ in such overarching matters as HIV patient rights, as in the case of Woodlawn Family Dentistry in Alexandria, Va. (see ada.gov/woodlawn_fmly_dnst.htm).

The AwDA is evolving, as demonstrated when the 1994 ADAAG Design Standards were replaced with 2010 AwDA Standards, which modified some of the previous accessibility requirements and expanded into new areas, such as boat piers and golf tee boxes. The Access Board is currently working on new accessibility standards for medical diagnostic equipment to ensure that exam tables, chairs and other imaging equipment used by health care providers are accessible to and usable by individuals with disabilities (see access-board.gov/guidelines-and-standards/health-care/about-this-rulemaking). The Patient Protection and Affordable Care Act will be the mechanism to enforce this new regulation.

Considerable guidance is provided in *Access to Medical Care for Individuals with Mobility Disabilities* as published by the DOJ and the Department of Health and Human Services at ada.gov/medcare_mobility_ta/medcare_ta.htm. This guide discusses accessible exam room and medical equipment requirements, as well as staff training. The article outlines guidance on many commonly asked questions, a couple of which are noted below:

1. "If I lease my medical office space, am I responsible for making sure the examination room, waiting room and toilet rooms are accessible?" Answer: Most likely yes depending on the lease.
2. "Are there tax breaks available for making my office accessible?" Answer: Yes. There may be both tax credits and tax deductions, but be sure to get appropriate tax and legal advice from qualified advisors.

Many other relevant questions and brief, easy-to-read answers are covered in this excellent publication.

A Brief History

The California Unruh Civil Rights Act of 1959 and the Disabled Persons Act were the precursors to the federal AwDA. The Unruh Civil Rights Act recognized the potential for accessibility barriers in the built environment as a civil rights issue with the potential for damages in state accessibility lawsuits. Under the Unruh Civil Rights Act, $4,000 damages per issue plus attorney's fees may be available to successful claimants. When the AwDA was established in 1990, the Unruh Act was amended to provide that noncompliance with the AwDA could also trigger liability under the Unruh Act. Currently, this underlying legal structure allows many claims to be addressed while it also permits a few prolific claimants to find numerous ADA violations and serve "demand for money to early settle" letters for observed violations to large numbers of businesses.

Many business owners felt abused and complained vigorously to their legislative representatives. In response to these complaints, the California Legislature enacted and the governor signed into law SB 1608 in 2008, which established the California Commission on Disability Access (CCDA), as well as defined criteria for a highly trained accessibility expert called certified access specialist (CASp) to evaluate the accessibility of a facility pursuant to the Construction Related Accessibility Standards Compliance Act (CRASCA) requirements (applicable AwDA and CBC requirements). Under SB 1608, the following features were initiated:

- The CASp inspection program was developed to provide voluntary facility inspections and help business and property owners identify conditions that should be changed to improve accessibility for people with disabilities.
- Established a potential 90-day stay in court and an accelerated early evaluation conference for qualifying defendants.
- Limited claims for financial damages at certain properties to a single amount per visit, rather than the four-per-item calculations, which had been used by many claimants prior to that.
- Limited claims for financial damages based on conditions, which would actually deny full and equal access for the claimant's particular disabilities (rather than the "any noncompliance" standard asserted by many claimants prior to that).

New Legislation in 2012

The measures established under SB 1608 were not enough to adequately stem the complaints from California businesses, as numerous accessibility claims continued. In October 2012, SB 1186 was signed by Governor Brown to expand some of the benefits and protections offered by SB 1608 as follows:

- Provided a potential reduction of the $4,000 statutory damages to $2,000 or

less for qualifying defendants under certain defined circumstances.
- Banned attorneys from sending demand letters seeking financial payments for early resolution of the claim.
- Required the CCDA and State Bar Association to track the demand letters filed by any attorneys and that now must include the attorneys' state bar number.
- Starting after July 1, 2013, generally requiring all commercial property owners are required to disclose to new commercial tenants if a property has been inspected by a CASp or not.

The same complaints also reached the authors of the building code, the California Building Standards Commission and Division of the State Architect. Significant effort was expended over the last year to reformat the accessibility chapter of the 2013 issue of the building code to more closely follow the formatting and requirements of the AwDA-S. This is a significant improvement to previous issues of the building code that kept California's unique formatting system and created overlapping and occasionally conflicting code compliance requirements. This alignment will greatly assist the construction industry to build more accessible construction projects in the future.

Conclusion

Because of the unique interaction of federal and state accessibility standards in California, it is inadvisable to assume that any sort of exemption or safe harbor provision exists for improvements made before the AwDA, even if the improvements were completed with all the appropriate permits at that time. Additionally, there is an ongoing and iterative requirement for ongoing evaluation to determine if a particular barrier may be subject to the "removal barriers that are readily achievable without much difficulty or expense" requirements, noting changes in one's financial resources over time. Many defendants incorrectly believed that they were "grandfathered" or otherwise exempt from compliance with the AwDA because their structures predated it. California's higher accessibility standards compel prudent owners of businesses and properties open to the public to arrange a CASp inspection through an attorney and seek qualified advice to determine which changes may be required or appropriate for any business that is to remain open to the public. Accessibility has become a necessary area of specialization, and many architects and designers often seek advice from the CASp in unusual conditions. It makes sense to seek the expert's opinions when it comes to specialized procedures or situations, whether in the field of dentistry or in accessibility within the built environment.

IT IS INADVISABLE TO assume that any sort of exemption or safe harbor provision exists for improvements made before the AwDA.

You might ask how does one best protect the business from accessibility claims and associated damages? You should obtain a CASp inspection and associated report of the public side of your office in order to take advantage of the significant benefits, which may be available under SB 1186 and SB 1608. Those considering retaining a CASp inspector are strongly advised to do so through an attorney to reduce the risk that the findings will need to be provided to an opponent in current or future litigation. In order to prepare to speak with a CASp, you should know the answers to the following questions about your office:

- What is your office size, both in square feet and number of dental stations?
- Are you within a multitenant building or complex or a freestanding office by yourself?
- Are restrooms inside your space or out in a common area?
- When was your office built or most recently modified and do you have a copy of the plans?
- Did you perform any alterations or renovations with permits? If so, get the permits and plans.
- What floor are you located on and how many stories overall?
- Do you provide any patient parking and do you or the landlord control the parking area?
- Do you need to take an elevator to your office?

The Certified Access Specialist Institute (CASI), an organization dedicated to ensuring high standards for CASp practitioners, has a list of its members at casinstitute.org/directory. CASI was established as a not-for-profit professional association to advance the CASp profession by setting standards of practice for its members and to lead the recently created accessibility field. At last count, about 40 percent of all CASps were also CASI members, working to contribute and formulate their practice around the evolving standards established by CASI. You can also find a list of CASp professionals at dgs.ca.gov/dsa/programs/programcert/casp.aspx.

Based on the information listed above, a properly qualified CASp can provide invaluable information about improving accessibility for people with disabilities and reducing the risk of claims.

Experts often advise against assuming that removal of a particular barrier is not readily achievable. A party's financial resources, the size of the parent organization and the number of employees based at the site are a few of the relevant factors the court uses to determine what may or may not be "readily achievable" for removal of a particular barrier by a particular defendant at a specific property. Proper documentation that it is not "readily achievable" to remove a particular barrier may be a complex (and often expensive) process, involving accountants, lawyers, contractors, engineers, architects and CASp. However, in the end, there is no guarantee the court will share your opinion on this issue.

To reduce the risk of having to provide your CASp's findings to an opponent in any current or future litigation or discovery process, it is recommended to retain your CASp through an attorney from the onset.

It might be important to understand which professional background your CASp might have: architect, engineer, interior designer, contractor or building inspection. Some nonarchitect CASps may provide only a CASp Inspection Report, leaving you to find the appropriate design professional for any corrective work afterwards. However, an architect-CASp is licensed to provide not only the CASp Inspection Report, but can also prepare plans for appropriate improvements if necessary. Regardless of a CASp's background the potential legal benefits provided by the CASp Inspection and Report are all but identical. A written proposal and contract with your CASp inspector is important as it outlines each party's responsibility and obligation. To reduce the risk of having to provide your CASp's findings to an opponent in current or future litigation, or to have your CASp called as a witness in any claim against you, it is important to retain any CASp you are considering through an attorney before any documents are prepared. Many attorneys will arrange this at little or no cost for existing clients. You should discuss the report format and ask for an example in order to understand what you are buying. If you expect to use this CASp report in court, you will want to make sure it is of a quality product that will bear the scrutiny of the judge and plaintiff.

Obtaining a CASp inspection is an important first step in determining what changes need to be made to improve accessibility, and can provide important legal benefits. In addition to reducing the risk of litigation, making the changes identified in the CASp report could bring in potential patients who might have been deterred by even commonplace conditions that can limit accessibility. Barrier-free access enhances customer satisfaction and word spreads. ■■■■

THE AUTHOR, Stephen J. Dolim, AIA, LEED AP, CASp, can be reached at sjdolim@sbcglobal.net.

Online Master of Science in Geriatric Dentistry
Ostrow School of Dentistry of USC

The University of Southern California Ostrow School of Dentistry has launched an innovative 37-month hybrid online and face-to-face graduate training program in Geriatric Dentistry. The program is specifically designed for full-time practicing dentists from across the world to gain expertise in treating Geriatric patients using an evidence based medical model.

The graduates of the program will become competent in addressing the unique dental needs of geriatric patients within the context of their medical, psycho-social and physical conditions.

For more information please visit our website or contact us.

Ms. Dulce Acosta
Phone: (213) 821-5831
Fax: (213) 740-3573
Email: geriden@usc.edu
Website: http://geriden.usc.edu

CDA JOURNAL, VOL 41, Nº9

Disabled Access Claims: Issues and Liability

KIMBERLY STONE, JD

AUTHOR

Kimberly Stone, JD, is the president of the Civil Justice Association of California. A graduate of Stanford University and its School of Law, Ms. Stone previously served as a deputy district attorney for San Mateo County and as special assistant to the U.S. Attorney for the Southern District of California.
Conflict of Interest Disclosure: None reported.

Abusive and often unjustified litigation over the Americans with Disabilities Act (AwDA) has been an ongoing problem for dentists and other health care professionals for more than two decades. Thankfully, our public officials in Sacramento recently started to take AwDA abuses more seriously.

Bipartisan legislation passed in 2012 by the California Legislature and signed by Governor Jerry Brown — SB 1186 — goes further than any previous legislation in our state to curb abusive AwDA lawsuits. This article will help you understand how you can use SB 1186 to your advantage if you are faced with a disabled access claim.

Before getting into the details of the bill, let's review some of the history around the AwDA and California's disabled access laws in order to understand how we got to where we are today.

The AwDA was passed by Congress and signed by President George Bush in 1990. The law prohibits discrimination on the basis of disability in employment, state and local government services, public accommodations, transportation and telecommunications. Notably, it also provides that federal laws shall not supersede state laws with more stringent accessibility provisions.

California was one step ahead of the federal government and in 1987 added those with disabilities as a protected class under the Unruh Civil Rights Act (Civil Code Section 51), California's antidiscrimination law. This made individuals with disabilities entitled to full and equal access to public accommodations (Civil Code Section 54 et seq.; Government Code commencing with Section 12900) as well as any governmental program (Government Code Section 11135 et seq.).

However, after the federal AwDA went into effect, California took further action and made any violation of the AwDA a violation of the state's Unruh Act as well. This was significant because the penalties for a violation of the Unruh Act are far greater than the penalties under federal law for an AwDA violation.

Under federal law, the Department of Justice may sue for damages when a person has been denied access to a public facility, but in a private lawsuit only injunctive relief (fixing the violation) is permitted and attorney fee awards

are discretionary. In contrast, under California's Unruh Act, plaintiffs may recover up to three times the actual damages but in no event less than $4,000 per violation, plus attorney fees, regardless of the significance of the violation. A victim is eligible for the same amount regardless of whether the alleged physical barrier is the lack of a wheelchair-accessible parking space or a coat hanger on a door that is too high.

So it appeared that California lawmakers had decided that any minor technical violation of federal or state disabled access law, intentional or not, was to be treated in the same way as a civil rights violation.

It is important to realize that federal and state disabled access rules are incredibly lengthy, complex and are even in conflict in certain instances. Both set out technical regulations for everything from the height of a bathroom mirror or angles of striping on parking to the shade of blue used for signage or the maximum height of carpet pile. Additionally, both federal and state law change over time through the regulatory process, making it difficult for dentists and other business owners to keep up with what exactly is required of them in order to make their offices or facilities accessible.

Moreover, a claim could be filed for each time a disabled individual came into contact with a violation. In one case in Los Angeles, a plaintiff visited a restaurant 27 times over a three month period where the bathroom mirror was two inches too high, knowing he could file claims for each and every visit.

Thus, in California we've had a perfect storm of confusing rules that were easy to abuse coupled with major financial incentives for those who wanted to sue over any violation, no matter how small. Quick settlements seemingly were the best option for the accused. The result has been a cottage industry of AwDA litigation in California. Forty percent of all AwDA lawsuits in the nation have been filed in our state, according to Lawyers Against Lawsuit Abuse.

In 2008, the California Legislature recognized that AwDA litigation was getting out of hand and passed SB 1608, which at the time was considered a major breakthrough. Most notably, the bill created a system of state certified access specialists (CASp) who would inspect business properties and certify those that were in compliance. Business properties that had been inspected by a CASp would also have the opportunity to take advantage of a new court procedure if they were sued that would allow them to request a 90-day stay of the action so a court could evaluate the claim and the CASp certification that had been issued, and to request an early evaluation conference with the court to resolve the lawsuit before litigation ensued.

A VICTIM IS ELIGIBLE for the same amount regardless of whether the alleged physical barrier is the lack of a wheelchair-accessible parking space or a coat hanger on a door that is too high.

Unfortunately, SB 1608 did not go far enough and the problem continued.

More far-reaching attempts at reform continued but repeatedly died in the Legislature's Judiciary Committees. Altogether, there were 14 bills introduced over a 10-year period that would have provided an opportunity to cure after being notified of an alleged violation — in other words, a certain number of days for a property to be fixed before a lawsuit could be filed.

So going into 2012 there wasn't much reason for optimism that meaningful reform was anywhere in sight.

Then, in April 2012, a reason arrived. U.S. Senator Dianne Feinstein, who had continued to hear from Californians about the abuse that was happening, sent a letter to California Senate President pro Tempore Darrell Steinberg stating that a fix was still needed and that she would "consider introducing legislation in the U.S. Senate if this problem cannot be solved by the California State Legislature."

Steinberg initially pushed back and sent a response letter arguing the problem was being addressed by SB 1608, but he apparently had a change of heart soon thereafter, and teamed up with Republican State Senator Bob Dutton to joint-author SB 1186.

The bill was very much a work in progress throughout last year's session and took a number of different forms, at times looking so watered-down that it would provide essentially no help.

But to Steinberg's credit, he remained diligent about keeping all the stakeholders at the negotiating table and in the final days of session, a comprehensive bill was put forward. It passed through both houses of the Legislature with very little opposition and went into effect as an urgency measure when Governor Brown signed it on Sept. 19, 2012.

So what exactly does SB 1186 do?

First, it bans prelitigation, monetary demand letters, in which an attorney alleges an AwDA violation and seeks a specific amount of money from the property owner without actually filing a lawsuit. These demand letters are often

What can dentists do to reduce their chances of being sued for an AwDA violation?

1. Complete an annual accessibility audit performed by a state certified access specialist (CASp). To find a CASp in your area, go to https://www.apps.dgs.ca.gov/casp/casp_certified_list.aspx.

2. Sign up at cjac.org to receive the latest updates on disabled access issues, as well as other civil liability legislation.

sent with attorneys offering to "go away" for a mere $7,500 or so, and in some cases, they demand only money and do not even request that the property become compliant. Out of fear, many businesses comply with the demand and pay in order to avoid a lawsuit, even though they are unsure of whether a violation actually occurred. These types of extortionist letters harmed businesses and enriched unscrupulous plaintiffs' attorneys without improving access for the disabled.

Second, SB 1186 increases the pleading requirements for claims alleging a violation. Specifically, the bill requires a plaintiff to verify the complaint under penalty of perjury. Letters sent in conjunction with a lawsuit now have to include sufficient facts notifying the business of the alleged barriers, how the alleged barrier denied the individual access and the dates on which this denial occurred. A copy must be sent to the State Bar as well. This should make attorneys more careful about the claims they choose to pursue, encourage them to ensure their cases are legitimate and deter those who file frivolous claims only to make a quick buck.

Third, the bill allows for a reduction in statutory damages for those who are making good faith efforts to comply. Statutory damages will be reduced from $4,000 per violation to $1,000 for those who had their properties inspected by a CASp or had construction approved by local building officials as long as the property is brought into full compliance within 60 days. Also, specified small businesses would have damages reduced to $2,000 if the necessary fixes were made within 30 days.

As mentioned above, California is unique in providing a minimum $4,000 in statutory damages that can be recovered in addition to any actual damages suffered. In addition to incentivizing litigation and quick settlements, this minimum amount also fails to take into consideration the actions taken by the defendant to address the alleged access issue. SB 1186 mitigates this. It should be noted that victims are still entitled to actual damages suffered as well as attorney's fees.

Fourth, the bill allows for judicial scrutiny of stacked claims. SB 1186 will require courts to consider the reasonableness of plaintiffs' conduct when they intentionally visit the same property repeatedly knowing they can file multiple claims for the same violation.

Finally, the bill should increase the supply of certified access specialists by adding a dollar to business license fees to strengthen and expand the state's CASp program.

SB 1186 is certainly a compromise measure. Nobody got everything they wanted. The Civil Justice Association of California, which works to reduce excessive and unwarranted litigation, and many other business groups have long supported providing notice and opportunity to cure. But sadly, given the number of times bills with that provision have failed, there simply isn't adequate support in the Legislature for that idea.

There are issues that remain that could limit the bill's impact. Financial incentives for AwDA lawyers have been reduced, but not eliminated. They could target more businesses to make up the difference. Prohibiting prelitigation demand letters could result in more lawsuits actually being filed, and with the harsh reductions in court, funding costs and stress for defendants could increase as their cases are prolonged.

Additionally, bringing a property into compliance can often take longer than 30-60 days, so the changes in statutory damages may not help some businesses.

That all being said, SB 1186 is the most serious attempt at reform to come out of the California Legislature since the AwDA was enacted.

There was some additional positive news this past January when, in a regulatory effort that complemented SB 1186, the California Building Standards Commission adopted a new regulatory package that uses the federal AwDA regulations as the basis for California's regulations while maintaining the state's provisions that are more stringent. The new standards will go into effect in January 2014, and for the first time, local building departments will be required to inspect for compliance with both federal and state provisions.

This should be very helpful in reducing confusion for business owners.

So, after more than two decades of chaos, there is finally a reason for at least cautious optimism. Only time will tell if these changes will work. The jury is still out, but it is certainly encouraging.

In the meantime, remember that the best way to avoid a lawsuit continues to be having a CASp inspect your facilities. However, if you find yourself accused of a violation, SB 1186 is now the law of the land so remember to use it to your advantage. ■■■■

THE AUTHOR, Kimberly Stone, JD, can be reached at kstone@cjac.org.

Will work for smiles.

You didn't enter this profession to become a pro on the nuances of benefit plans and employment law. You became a dentist to help people. We get that at CDA. That's why we provide practice support resources and offer peer review to help resolve patient disputes. Giving you more time to do what you love — care for your patients.

CDA Membership
cda.org

cda®

CDA JOURNAL, VOL 41, Nº9

Disabled Access Resources at the California Dental Association

JAN KATERKAMP, CIPP, CHP

AUTHOR

Jan Katerkamp, CIPP, CHP, is the regulatory and privacy compliance administrator at the California Dental Association.
Conflict of Interest Disclosure: None reported.

California dental practices continue to be popular targets for claims of disabled access violations. While there have been many legislative attempts to level the playing field for businesses, plaintiffs are still able to sue for damages under state law and the federal Americans with Disabilities Act (AwDA). Receiving a monetary demand letter or lawsuit for an access violation can be very stressful — and expensive — for small business owners. The only way to avoid a lawsuit or monetary demand is full compliance with the access requirements. Disabled access laws are broad, and even a bit vague in certain areas. To help members wade through the muddy waters of the AwDA and California-specific disabled access requirements, the California Dental Association offers several resources to help members understand the applicability and scope of the laws and address some common misconceptions.

A good starting point is the CDA Compass at cda.org/compass. The resource *"Best Defense Against Disability Lawsuits: Compliance"* is available in the regulatory compliance section of the website. This article answers frequently asked questions about disabled access issues. It debunks the common misconception that facilities constructed prior to the effective date of the AwDA are "grandfathered" and thus exempt from modification requirements. The article discusses accessibility obligations for existing structures versus newly built or remodeled facilities, as well as whether the responsibility to modify existing structures sits with the building owner or a tenant leasing the space. It also touches upon California's Certified Access Specialist (CASp) program and the legal protections available for businesses that avail themselves of an access inspection.

The article also contains links to helpful external resources for small businesses, such as the *ADA Update: A Primer for Small Businesses* from the U.S. Department of Justice at ada.gov/regs2010/smallbusiness/smallbusprimer2010.htm and an online course "Reaching Out to Customers with Disabilities" at ada.gov/reachingout/intro1.htm. Both of these resources offer practical advice for effectively, responsibly and of course legally, interacting and communicating with disabled individuals.

Members can also find the *2010 Standards for Accessible Design* document at ada.gov/2010ADAstandards_index.htm, which contains the highly detailed specifications that places of public accommodation — including dental offices — must implement in order to achieve full compliance with the law. Keep in mind, it is always advisable to rely on a reputable expert in the field of disabled access rather than attempting to make alterations or modifications alone. Another helpful link is to the FAQ page on the California Division of the State Architect website at dgs.ca.gov/dsa/Home.aspx. The Division of the State Architect's website is also where businesses can find more information on California's CASp program and a complete list of Certified Access Specialists in the state of California.

Also available in the regulatory compliance section of The Compass is an article entitled "Americans with Disabilities Act and Disability Rights Laws." This article provides some general information on accessibility standards, but also discusses other disability rights laws under the AwDA and state law. There is practical guidance on communicating with hearing impaired individuals, employment discrimination based on disability and disabled individuals' rights regarding service animals. Links to the U.S. Department of Justice AwDA homepage and the California Department of Rehabilitation are also provided. Both of these sites have helpful background and guidance for businesses seeking more information regarding their obligations to disabled individuals.

The Compass is also the place to find the CDA *Legal Reference Guide*, which contains helpful information regarding disability rights laws. Chapter 2 of the *Guide* has information regarding office design requirements under the AwDA. Chapter 5 goes into a bit more detail on patient care, specifically the requirements for the use of interpreters for hearing impaired patients.

CDA's practice analysts are available through the Practice Support Center to field member questions regarding disabled access or treating patients with disabilities. They can be reached at 800.232.7645 or via email at compass@cda.org. For those insured through The Dentists Insurance Company, TDIC's risk management analysts are also available to answer questions about disabled access and providing dental care to disabled individuals. They can be reached via the Risk Management Advice Line at 800.733.0634 or via email at risk.management@cda.org.

The resources CDA provides can be used to gain a better understanding of a business's obligations under the AwDA and California-specific disabled access laws. When the time comes to make modifications or alterations to a facility or structure, it is always best to consult an expert in the field to ensure that everything is done to the letter of the law and nothing is missed. Disabled access compliance can be very complex and should not be taken lightly. Any violations, however minor they may seem, leaves the business owner and/or tenant open to frustrating and expensive claims of accessibility violations. ■■■■

THE AUTHOR Jan Katerkamp, CIPP, CHP, can be reached at jan.katerkamp@cda.org

cda.org/jobs →

The new cda.org classifieds work harder than ever. From job listings to practice or equipment sales, it's all **free** to CDA members. Check it out at cda.org/classifieds.

Specializing in the Selling and Appraising of Dental Practices

CALIFORNIA PRACTICE SALES INC.

Serving California Since 1974

"Your local Southern California Broker"

Phone: (714) 639-2775
(800) 697-5656
Fax: (714) 771-1346
Email: jknipf@aol.com
rpalumbo@calpracticesales.com
WWW.CALPRACTICESALES.COM

John Knipf & Robert Palumbo

LOS ANGELES COUNTY

BEVERLY HILLS - GP/Perio Prosth emphasis on Perio Surgery & Implants in 4 story med bldg w/ 3ops. Grossed 1M in 2012. ID#4035
BURBANK (Ortho) - 45 yrs gdwll. Consists of 2 chairs in open bay w/ Pano/Ceph in 1,221 sqft ste. Grossed ~$292K in 2012. **SOLD**
COVINA - Leasehold & Equip Only! 3 eq op office located in 1 story med building. Reasonable rent with excellent terms. ID #4355.
CULVER CITY - Leasehold & Equip Only! 10 eq op office in a single story bld. In residential area. Heavy traffic flow. ID #4261.
HUNTINGTON PARK (GP) Established in 2008. In a 2 story free stranding bldg near residential area. Has 4 eq ops. ID#4295.
LOS ANGELES (GP) - Well designed practice w/ 5 eq op in a strip shopping center. 20 years of goodwill. Some Denti-cal. ID#2771.
LOS ANGELES (GP) - Three operatory office located on a 13 story prof bldg. Fee for service. 14 yrs of goodwill. Net $209K. ID#2831.
LOS ANGELES (GP) - Turn-Key office located in busy small shopping center. 3 operatories. Some Ortho. Near residential area. ID#4367.
MOORPARK - Leasehold & Equip Only! Modern office w/ 4 eq ops, 1 plmbd not eq in a 1,346 sqft ste. Reasonable rent. ID # 4343.
PACOIMA - Leasehold &Equipment Only! Two eq op w/ 1 plmbd not eq office in small strip mall. Charts included. ID #4361.
RESEDA - GP located on a single story bldg w/ heavy traffic flow. 18 year of gdwll. 5 eq operatories. Some Ortho. Net $235K. ID#4333.
TARZANA (GP) - Fee for service practice w/ over 28 yrs of goodwill. Consists of 8 eq ops and 2 plmbd not eq. ID #4313.
TORRANCE (GP) - Modern designed office w/ 44 yrs of gdwll. Has 3 eq ops, 1 plmbd not eq w/ digital x-ray & Eaglesoft soft. ID#4375.
TORRANCE - GP w/ over 30 yrs of gdwll in 2 story prof med bldg. Consists of 8 eq ops, 1 plmbd not eq in 2,208 sq ft suite. ID #4377.
VALENCIA - Leasehold Improvements Only! Beautiful office w/ 6 plmbd not eq ops in 2,400 sqft. suite. Busy shopping center. ID#4321.

ORANGE COUNTY

ANAHEIM HILLS - Leasehold &Equipment Only! Beautiful office in busy shopping center w/ 3 eq ops, 1 plmbd not eq. ID #4379.
COSTA MESA - Three (3) eq ops office w/ over 19 yrs of gdwll in busy strip mall. Fee for service. Revenues of $38K/mo. ID#4365.
LAKE FOREST (GP) - Turn key practice w/ 3 spacious eq ops, 1 plmbd not eq in a 1,200 sq ft ste. Busy shopping center. ID #4123. **SOLD**
MISSION VIEGO (GP) - Well designed turn-key practice w/ 3 eq op & 3 plmbd is located in a prestigious shopping center. ID #4303.
ORANGE - Turn-key office w/ 42 yrs of goodwill. Has 2 eq ops, 1 plmbd not eq in 1,200 sq ft office. Not computerized. ID #4353
SAN CLEMENTE (GP) - Modern designed turn-key office in 2 story med bldg w/ 4 eq ops, 2 plmbd not eq for expansion. ID 4359.

RIVERSIDE / SAN BERNARDINO COUNTIES

APPLE VALLEY (GP) - Well established practice w/ 5 eq op, 3 plmbd not eq, Dentrix software and digital x-ray. Net $214K. ID #4349.
BARSTOW(GP) - Long established office w/ 4 eq ops in a single story bldg. Easy freeway access. Fee for service. ID #4241
MURRIETA (GP) - Beautiful office w/ 3 eq ops surrounded by major anchor tenants. Some Capitation. 4 day/wk office. ID #4247. **SOLD**
PALM DESERT (GP) - Well established practice w/ 5 eq ops in 1 story bldg w/ ample parking & excellent signage. Net $119K. ID#4331.
RIVERSIDE - Fee for service practice w/ over 50 yrs of gdwll. Modern office w/ 4 eq ops in corner single prof. blfg. ID #4351.
UPLAND - Leasehold & Equip Only! All active pt charts included. Located in 2 story med bldg (ground level) w/ 3 ops. ID #4323. **SOLD**

SAN DIEGO C OUNTY

CHULA VISTA (GP) - Located in downtown. Store front. Consists of 4 eq ops 1 plmbd not eq. Some Cap. Net $152K. # 4279.
ENCINITAS (GP) - Corner location w/ excellent signage and street visibility. Consists of 2 eq ops. Fee for service. ID # 4315. **SOLD**
RAMONA (GP) - Established in 1979 and located in single strip mall. Busy area. Fee for service. Consists of 3 eq op. ID #4305.
SAN DIEGO (GP) - In free standing bldg w/ private prkng. Consists of 5 ops w/ Dentrix software. Monthly revenues of ~$40K. ID #4279.
SAN DIEGO (GP) - Beautiful Turn-Key practice with 8 eq ops in a modern designed shopping center. Absentee owner. ID #4335.

VENTURA & SANTA BARBARA COUNTY

SANTA BARBARA (GP) - Well established practice in busy shopping center w/ 3 eq ops in a 1,220 sq ft suite. ID #4311. **SOLD**

http://www.calpracticesales.com/blog

Call us about Debt Consolidation & Retirement Planning
VISIT OUR WEBSITE WWW.CALPRACTICESALES.COM
CA DRE#00491323

John Knipf
President
John W Knipf (Neff)

Also serving you: Robert Palumbo, Executive V. P. /Partner, Alice C. King, V.P., Greg Beamer, V.P., Tina Ochoa, V.P., & Maria Silva, V.P.

How to Place a Free Classified Ad

The *Journal* has changed its classified advertising policy for CDA members to place free classified ads online and publish in the *Journal*. CDA members can place any classified ad. Non-CDA members can post employment classifieds or place display ads in the *Journal*.

All classified ads must submitted through cda.org/classifieds. Fill out the blank fields provided, including whether the ad is to appear online only or online and in the *Journal*. Click "post" to submit your ad in its final form. The ad will post immediately on cda.org and will remain for 90 days. Space permitting, your ad will run one time in the next issue of the Journal following the posting of your online ad. After 90 days, you will need to repost your ad if you wish to continue running it online. Note that CDA reserves the right to modify your classified ad for CDA style and to correct typographical errors.

Classified ads for publication in the *Journal* must be submitted by the fifth of every month, prior to the month of publication. Example: Jan. 5 at 9 a.m. is the deadline for the February issue of the *Journal*. If the fifth falls on a weekend or holiday, then the deadline will be 9 a.m. the following workday. After the deadline closes, classified ads for the *Journal* will not be accepted, altered or canceled. Deadlines are firm.

Classified advertisements categories are: Equipment for Sale, Offices for Sale, Offices for Rent or Lease, Available Positions, Opportunities Wanted and Practices for Sale.

How to Place a Display Ad

Nonmembers are welcome to place display ads. For information on display advertising, please contact Corey Gerhard at 916-554-5304 or corey.gerhard@cda.org.

CDA reserves the right to edit copy and does not assume liability for contents of classified advertising.

AVAILABLE POSITIONS

DENTAL ASSISTANT — Endodontic office in Vallejo is seeking an experienced, caring, enthusiastic, dependable Dental Assistant with excellent communication skills, organizational skills, great rapport with patients, high level of professionalism and collaborative attitude. Must have CPR and X-ray licenses. Previous endodontic experience, digital radiograph experience and Spanish language experience preferred. Position to start in late July or early August. Currently Mon-Wed, with room for growth. Please submit your resume with cover letter and references by email to bwm.dds@gmail.com.

DENTAL ASSISTANT — General dental office is looking for a DA/RDA who is friendly, responsible, professional and a team player to work in the back. Prefer at least one year of experience. The position requires some aspects of administrative work, so the successful candidate should be willing to learn the administrative work at the front. Competitive compensation. Email resumes to foothilldental4@aol.com.

DENTAL ASSISTANT — Position summary: Performs a variety of dental assisting duties to promote dental care for patients. Assists the doctor, communicates effectively with patients, maintains equipment and inventory and follows

CONTINUES ON 710

When Looking to Invest in Professional Dental Space Dental Professionals Choose

Linda Brown

30 Years of Experience
Serving the Dental Community
Proven Record of Performance

- Dental Office Leasing and Sales
- Investment Properties
- Owner/User Properties
- Locations Throughout Southern California

For your next move,
Contact Linda Brown:
Direct Line: (818) 466-0221
Fax: (818) 593-3850
E-mail: LindaB@TOLD.com
website: www.TOLD.com
CA DRE #: 01465757

TOLD partners INC.
INDUSTRIAL/COMMERCIAL REAL ESTATE
CA DRE #: 01132455

WESTERN PRACTICE

800.641.4179
WPS@SUCCEED.NET
WESTERNPRACTICESALES.COM

BAY AREA

AC-187 SAN FRANCISCO: Near Union Square in the heart of the City! 950 sf w/4 ops **$225k**

BC-162 PLEASANT HILL Facility: Updated office, large windows & views of the outdoors. Open floor plan. 1,852 sf w/6 ops **Reduced! $150k**

BC-174 DOWNTOWN HAYWARD: Large & Stable. Off major thoroughfare. 1,500 sf w/4 ops **$200k**

BC-175 EAST CONTRA COSTA: Vast employment, shopping & activities! 1,995 sf w/5ops **$300k**

BN-183 HAYWARD: ***Kick it up a notch by increasing the current very relaxed work schedule!*** 1,300 sf w/ 3 ops **$150k**

CC-077 BENICIA: Highly visible. Within walking distance of downtown. 820 sf w/2 ops **$100k**

CC-133 SANTA ROSA: Stable patient base. Well-respected. Location = new patient traffic. 1,291 sf w/3 ops + 1 add'l **$480k**

CC-151 SANTA ROSA: Stable patient base, well-respected, close to Memorial Hospital. 2,262 sf w/ 6 ops **$875k** *Real Estate avail.*

CC-170 SOLANO COUNTY: Minutes from nearby wine country! 950 sf w/3 ops **$225k**

CN-158 PETALUMA: Predominantly Capitation practice. 1,000 sf w/ 4 ops **Reduced! $395k**

CN-184 SOLANO COUNTY: Well established, premier practice. 2,180 sf w/ 5 ops. State of the art equipment **$775k**

CN-189 ANTIOCH VICINTY: In the heart of the beautiful California Delta! 3 ops **$275k**

D-9091 ATHERTON: Turnkey operation 969 sf & 3 ops ***Call for Details!***

DC-113 MILPITAS: Seller retiring! Great location 1,009 sf w/ 3 ops. Plumbed for 1 add'l **$110k**

DC-164 WATSONVILLE: Shopping complex/main thoroughfare. Modern & Attractive. 2,365 sf w/ 6 ops **$395k**

DG-116 SALINAS AREA: Large, loyal & stable. Popular Retail Center. 1,400 sf w/5 ops. State-of-the-art Equipment **Reduced! $205k**

DG-124 MILPITAS: Highly visible. Desirable area. 960 sf w/ 2 ops + 1 add'l **$130k**

DG-156 SAN JOSE: Hardwood Floors & plenty of windows! 1,160 sf w/ 3 ops (+2 add'l) **$145k**

BAY AREA CONTINUED

DG-161 FREMONT: Beautiful office generating 40+ new pts/mo. 1,440 sf w/ 4 ops **$215k**

DG-202 SARATOGA Facility: Attractive, well-maintained, 2-story Medical/Dental/Professional building. Desirable upscale, affluent area. 1,568 sf w/ 4 ops **$185k**

DC-191 MOUNTAIN VIEW: Rare opportunity! High quality, potentially large-scale practice. Heart of Silicon Valley. 2,000 sf w/7 ops (+1) **$950k**

NORTHERN CALIFORNIA

EG-198 SACRAMENTO: Tucked in well established "Pocket Area" in highly desirable corridor. 1,112 sf w/3 ops **$155k**

EN-145 ROCKLIN Facility: Very desirable community! 1,400 sf w/3 ops +1 add'l **$150k**

EN-167 SACRAMENTO: One of the most desirable, affluent areas. 2,400 sf w/5 ops. **$450k**

FN-181 NORTH COAST: Well respected FFS GP. Stable patient base. 1,000 sf w/3 ops **SELLER MOTIVATED! $150k (25% int. in bldg. avail.)**

FN-087 LAKE COUNTY: Quality practice, friendly staff & Cerec 2,400 sf w/3+ ops **$699k**

FN-148 MENDOCINO CO: "Gateway to the Redwoods!" Quality care in 4 ops **$325k**

FN-185 UKIAH: Street-level office/desirable area. 900 sf w/ 3 ops **$275k**

GG-140 CHICO VICINITY: **Selling for less than 50% of gross!** 1,200 sf w/4ops. **Reduced! $195k**

GN-058 YUBA CITY: Known for quality dental care. 1,704 sf w/ 4 ops Reduced! **$359k**

GN-134 REDDING: Stellar reputation, quality care and location! 2,264 sf w/4 ops. **$500k**

GN-149 YREKA: Quality FFS, Warm & Caring. 900 sf w/ 3 ops. Now Only:**$180k/Real Estate $110k**

GN-166 CHICO: Well Respected w/loyal patient base. 1,800 sf w/4 ops. **$395k (or $450k w/Cerec)**

GN-177 CHICO/OROVILLE: Spacious and spectacular! 2,500 sf w/6 ops **$399k**

What separates *us* from other brokerage firms?

As dentists and business professionals, we understand the unique aspects of dental practice sales and offer more practical knowledge than any other brokerage firm. We bring a critical inside perspective to the table when dealing with buyers and sellers by understanding the different complexities, personalities, strengths and weaknesses of one practice over another.

Our extensive buyer database and unsurpassed exposure allows us to offer you…

A Better Candidate A Better Fit and A Better Price!

SALES

CENTRAL VALLEY

HN-059 LASSEN CO: Quality, well-established, family-oriented. 1,600 sf w/3 ops **$120k**

HN-169 SONORA AREA: Nestled in Pines East of Sonora. 1,800 sf w/3 ops + 1 Add'l **$250k**

I-9721 STOCKTON: Prof. complex. 1,450 sf w/ 3 ops & plumbed for 1 add'l **$75k**

IG-067 STOCKTON: Fully computerized, paperless, digitalized. 5,000 sf w/10 ops **Now $425k**

IG-165 TURLOCK: Well established Shared/Solo Group Practice. 10 ops (shared) **$428k**

IN-176 TURLOCK: Mother Lode, SF Bay & Sierras nearby! 2,500 sf w/3 ops **$120k**

IN-193 Modesto Facility: Recently remodeled! High foot traffic! Can be purchased with or without new equipment. 2,300 sf w/6 ops **$349k**

JG-137 FRESNO: Own the Building too! 3,500 sf w/ 5 ops **Now Only $395k/ Real Estate $350k**

JG-188 FRESNO: Loved, respected, Established! Net Profit over $350k! 1,452 sf w/4 ops **$390k**

JN-157 FRESNO: Comprehensive care and comfort . 1,470 sf w/3 ops **$200k**

JC-178 SAN JOAQUIN VALLEY: Historical Building in thriving area! 2,206 sf w/6 ops **$495k**

SPECIALTY PRACTICES

AC-119 MILL VALLEY Prostho: State-of-the-art equipment including: digital charting and x-ray. 1,100 sf w/ 3 ops. Plumbed for 4th **$450k**

EG-131 ROSEVILLE/AUBURN Ortho: 2 practices within ½ hour of each other! **$175k**

I-7861 CENTRAL VALLEY Ortho: 2,000 sf, open bay w/ 8 chairs. Fee-for-Service. **$370k**

I-9461 CENTRAL VALLEY Ortho: 1,650 sf w/5 chairs/bays & plumbed for 2 add'l **$180k**

IC-163 CENTRAL VALLEY Perio: Well-respected FFS. 2,300 sf w/5 ops **$175k (Bldg: $250k)**

We are a proud member of:

ADS DENTAL TRANSITIONS™

VALUATIONS | SALES | CONSULTING

ASK THE BROKER

I have enjoyed your articles from "Ask the Broker". Where can I find all the topics you have covered?

Thank you for the compliment. I have been writing that article for almost five years now!!! Even I did not realize how long I had been trying to address the various issues that come up during a transition!!! All of the articles published by any of our brokers can be found on our web page at **www.westernpracticesales.com**. Recently I compiled all of the "Ask the Broker" articles into a nice "mini book" that I gave out at the CDA convention in San Francisco. Most of the topics are actual questions posed by either buyers or sellers in the midst of a transition or acquisition of a dental practice. We have tried to categorize the topics without regard to the chronology of the articles. Generally the questions or topics are timeless concerns except for minor specifics such as current interest rates or local economic factors as the supply and demand for dental practices.

One topic of interest that is changing rapidly is how we as a profession should deal with the existing PPO plans and our affiliation with such plans. I especially encourage your reading of my essay on the "Patient's freedom of choice" proposal in this area. The way some insurance companies are dealing with new buyers of existing dental practices is affecting the value of future dental practices.

Unfortunately each article has space limitations of about 400 words. Many of these topics require more attention and explanation. I certainly encourage everyone to contact our office for further opinions on any of these topics. We at Western Practice Sales are proud to boast that every one of our brokers have some type of post graduate degree, (CPA, JD, MBA or DDS) and our company has been in business for 30 years. We also have a network of attorneys, accountants or consultants that we work with to help us stay informed on the many aspects of dental transitions. If you would like a copy of the "mini book" , please email us or call us and we will be happy to provide you one!!!

Timothy G. Giroux, DDS is currently the Owner & Broker at **Western Practice Sales** and a member of the nationally recognized dental organization, ADS Transitions. You may contact ***Dr Giroux at*:** **wps@succeed.net or 800.641.4179**

We have been handling dentists' practices **with care** since 1997.

It's what we do!

Dental Practice: Sales - Acquisitions - Mergers - Valuations

FEATURED LISTINGS

New! **MISSION VALLEY, CA** Seven op prosthodontic practice

MISSION VALLEY EAST AREA, CA Five op general practice

RENO, NV Four op (3 equipped) general practice

UPCOMING LISTING

LOS ANGELES, CA Busy general practice. Building will also be for sale.

PRACTICE TRANSITION PARTNERS
realizing the possibilities


Russell Okihara, D.M.D.
CA Representative


Robert Stanbery
Owner

Visit our website to view our current listings.

888.789.1085

www.practicetransitions.com

CLASSIFIEDS, CONTINUED FROM 707

universal precautions and all OSHA requirements. Knowledge of Eaglesoft software a plus. Duties: Take digital X-rays when needed; assist doctor during diagnosis and treatment; perform postoperative patient care; perform instrument sterilization and infection control in the office; clean and stock operatories; control inventory of clinical supplies. Requirement: High school graduate, dental experience preferred; X-ray certified; exceptional human relation skills; ability to work with people of all ages; ability to maintain outgoing, friendly attitude with patients and staff; ability to speak, understand and write grammatically correct English; ability to accept and follow instructions from supervisor. For more information, call 805.494.3377.

DENTAL ASSISTANT — We are a general dentistry office in Pleasanton looking for a Dental Assistant (DA) with current X-ray license. The right person has good communication skills, excellent chair-side manners, drive to learn and is energetic. You will be expected to take digital X-rays, sterilize instruments, prepare treatment rooms and assist in all procedures. You will also be expected to answer phone calls as needed. Applicants should be available to work flexible hours and be available to work on Saturdays. References must be available upon request. New graduates are welcome to apply. Please email your resume to stevenroy12345@gmail.com.

DENTIST — BC/BE Oral Surgeon sought by UC Davis-affiliated public hospital system in Contra Costa County. Located 30 miles east of San Francisco, with excellent weather and close to outstanding cultural, recreational and natural attractions. One hour to the Napa

Valley wine country or beach. 2.5 hours to skiing. Martinez sits on the San Francisco Bay, at the gateway to the Sacramento River Delta, known for its superb boating and fishing. New hospital and surgical facilities serve needs of ethnically and culturally diverse population who have a fascinating variety of clinical problems. Excellent compensation package includes health care, vacation and sick leave, disability insurance, paid CME, defined benefit pension and more. Malpractice insurance provided. Position available immediately. California license required. Contact Nick Cavallaro, DDS, at 510.918.2159 or at nickcav@comcast.net.

DENTIST — Looking for a General Dentist: We are a state-of-the-art general dental practice, looking for excellent GP clinicians with minimum requirements as follow: 1. U.S. dental school graduate. 2. Three years of real-life dentistry or two years of real-life plus AEGD or GPR certificate 3. Have worked with HMO/ PPO/ insurance 4. Available 2-3 days/ week (M, Th, F or Sat). One to two Saturdays per month 5. OK with root canal therapy 6. Speaking some Spanish is a plus. Looking for Perio, Endo or Prosthodontist. We are looking for a 1 or 2 days per month specialist who can come to our office and provide specialty service. 50/50 compensation. If you wish to use our space and get referral from other local dentists, you can establish a permanent office at our office. Discussion with open-minded owner. Please send email to lochuynh@yahoo.com.

ORTHODONTIST — Orthodontist needed for busy office. Great patients, friendly team, wonderful pay. One day a week in the Modesto area. Please send email to happybraces@gmail.com.

DENTIST — Established practice in Chico, Calif., is looking for that special Dentist to grow and care for our patients. Very supporting staff and dentist to work with. Must have good rapport with patients, treatment plan well and be willing to learn. We have our own Endodontist and Periodontist. Please email resume to gilbertlim@msn.com. Can also call or text 916.838.1090.

DENTIST — We are a state-of-the-art general practice, looking for a good General Dentist with the following requirements: Understand and be able to work with PPO. No HMO. Good communication skills. Able to handle most situations by yourself with help from another dentist. Team work. Send email to vunvhuy@yahoo.com.

DENTIST — Associate Dentist opportunity available in a growing, established practice with a comfortable, modern design. State-of-the-art equipment, digital panoramic, CAD/CAM, laser and much more. Doctor must be ethical, have a positive, outgoing chairside demeanor and be a participating team player with our fantastic supportive staff. Ability to perform full dental services including extractions, molar endo and takes an interest in cosmetic dentistry. This

CONTINUES ON 712

First in Proactive Dental Care

Willamette Dental Group

Willamette Dental Group has been providing high quality dentistry for more than 40 years. We are the **largest multi-specialty group dental practice** in the Pacific Northwest with more than 50 dental offices throughout Washington, Oregon and Idaho. Serving more than 350,000 patients, our unique model delivers proactive, preventive dental care focused on **promoting long term health** through a partnership with our patients.

Featured opportunity this month: General Dentist - Tillamook, OR and Twin Falls, ID. To view current General Dentist and Specialist practice opportunities, visit www.WillametteDental.com/careers

Please visit our exhibitor booth at the **American Student Dental Association District 11 Vendor Fair** in Irvine, CA, **October 12**, and the **American Dental Association Annual Session** in New Orleans, LA, **October 31-November 3**, to learn more about group practice opportunities and to enter our free raffle!

Connect with us on:

Tiffany Brown
tbrown@willamettedental.com or Direct: 503-952-2171

CLASSIFIEDS, CONTINUED FROM 711

is a wonderful opportunity for the right candidate. Benefits include assistant, medical, 401k, vacation and a stable patient base. Contact Dr. Denise Riemer at denise_riemer@yahoo.com to learn more. Can also email Practice Administrator Tiffany at tiffany@lemooredentalcare.com.

ENDODONTIST — A general practice in Pleasanton is in need of an Endodontist on part-time basis. Please send your resume to stevenroy12345@gmail.com.

ORAL SURGEON — A general practice in Pleasanton is in need of an Oral Surgeon on part-time basis. Flexible schedule available. Please send your resume to stevenroy12345@gmail.com.

ORTHODONTIST — A general practice in Pleasanton is in need of an Orthodontist on part-time basis. Flexible schedule available. Please send your resume to stevenroy12345@gmail.com.

DENTIST — Great opportunity for a Pediatric Dentist to join our multispecialty group. Since 1979, we have proudly served the community of Manteca, Calif., often referred to as the "family city." We are looking for someone compatible who is enthusiastic, caring, skilled and who loves what he/she does. Currently, we are seeking someone on a part-time basis; however, this could lead to a full-time position or partnership in the near future. Outstanding earning potential. For more info please call 209.823.9341, please email your CV to admin@valleyoakdentalgroup.com.

DENTIST — Located 30 miles east of San Francisco, with excellent weather and close to outstanding cultural, recreational and natural attractions. One hour to the Napa Valley wine country or beach. 2.5 hours to skiing. Martinez sits on the San Francisco Bay at the gateway to the Sacramento River Delta, known for superb boating and fishing. The new hospital and surgical facilities serve the needs of an ethnically and culturally diverse population who have a fascinating variety of clinical problems. Position available immediately. California license required. Position requires above-average oral surgery skills. Contact Domenic Cavallaro, DDS at 510.918.2159 or at nickcav@comcast.net.

PERIODONTIST — Dear Doctor : We are looking for a board-certified or eligible Periodontist to join our group. Must be able to commit to five or six days per month. Excellent opportunity to grow the program to six to 10 days per month. Please email your resume/CV if interested to bayareadentist2009@gmail.com.

DENTIST — Kids Dental Kare is in a growth phase and seeking a Dentist with experience treating children. We prefer doctors who have limited their practice to children's dentistry long enough to have skills, confidence and experience to handle working in high-volume practice. This is truly an opportunity to get in on the Affordable Care Act before California adds 2 million kids to Medicaid enrollment. We have systems, which allow you to become very productive, and for those seeking to become an entrepreneur Dentist there is a pathway to ownership. If a fast-track career is in your future, send your resume to hr@kidsdentalkare.com or call 323.240.7313.

OFFICE MANAGER/FRONT OFFICE — Endodontic office in Vallejo is seeking a full-time, bilingual Spanish speaking Front Desk and Office Manager with back-office experience. Candidate must have excellent communication skills, organization and time management skills, a strong work ethic, reliability and professionalism. Candidate must have dental front office and management experience, scheduling experience, billing experience and experience with various dental insurances (PPO/HMO) and collection procedures. 2-3 years previous endodontic office and back office experience preferred. Position to start in late July or early August. Currently Mon-Thurs, with room for growth. Please submit your resume with cover letter and references by email to bwm.dds@gmail.com.

EQUIPMENT FOR SALE

EQUIPMENT FOR SALE — Periopro available for purchase for $250. As Is. Pick up only. Bay Area Peninsula area. Send email to hjhong@hotmail.com or call 650.349.2343.

EQUIPMENT FOR SALE — Disability requires me to discontinue clinical practice. Had just established a mobile Endodontic practice. Most supplies and equipment are one year old and gently used. Please check out my inventory at www.BarbaraKabesDDS.com.

OFFICES FOR RENT/LEASE

OFFICE FOR LEASE — Great opportunity in Chico, Calif., to lease a fully equipped dental office. Clean and modern, 1,900 sq. ft. building with close proximity to Enloe Hospital. Three operatories, large waiting room and reception area. Full basement for storage or staff lounge. Set up and ready to go.

CONTINUES ON 714

HENRY SCHEIN®
PROFESSIONAL PRACTICE TRANSITIONS

A. Lee Maddox, DDS, Esq.
Western Regional Director
(949) 566-1866
CA Broker Lic. #01801165

SOUTHERN CALIFORNIA

Kerri McCullough
Transitions Consultant
(949) 566-3056
CA R.E. Lic. #01382259

NORTHERN CALIFORNIA

Dr. Dennis Hoover
Transitions Consultant
(209) 605-9039
CA R.E. Lic. #01233804 • NV R.E. Lic. #0053890 • NV B.O. Lic. #0000301

NORTHERN CALIFORNIA

Dr. Tom Wagner
Transitions Consultant
(916) 812-3255
CA R.E. Lic. #01418359

NORTHERN CALIFORNIA

Jim Engel
Transitions Consultant
(925) 330-2207
CA R.E. Lic. #01898522

SOUTHERN CALIFORNIA

Thinh Tran
Transitions Consultant
(949) 533-8308
CA R.E. Lic. #01863784

SOUTHERN CALIFORNIA

Mario Molina
Transitions Consultant
(323) 974-4592
CA R.E. Lic. #01423762

SOUTHERN CALIFORNIA

Jaci Hardison
Transitions Consultant
(714) 318-4911
CA R.E. Lic. #01927713

DENTAL PRACTICE BROKERAGE

Making Your Transition a Reality

• **BAKERSFIELD and SMALL FARM COMMUNITY:** Two practices 30 minutes apart from each other, staff and doctor work both locations. Strong patient base in both practices, room for growth, communities are underserved. This is a rare opportunity to own two practices. $588k gross with $278k combined adjusted net. #CAM557

• **BAKERSFIELD:** General Dentistry Practice: 8 ops, 7 fully equipped, 1 plumbed, in a 3,650 sq. ft. suite with digital x-rays and intra-oral camera in a growing area of Bakersfield.$453,000 adjusted net income on $1.2M of Collections. #CAM554

• **BISHOP:** General Dentistry Practice & Building. Collections were $1,000,243 in 2011 with $387,000 Adj. Net Income. 5 op., 1,800 sq. ft. building. #14390

• **CENTRAL COAST:** Pedodontic Practice. 4 operatories. Gross Receipts of over $775,000. #CAM546

• **CENTRAL COAST:** Prosthodontic Practice. 4 operatories, full in-house lab. $1.1M in Gross Receipts in 2011. #CAM535

• **CHICO:** General Dentistry Practice. 2012 Collections of $1,385,222. Free-standing building with 2,464 sq. ft. Buyer can purchase or lease building. #14392

• **COASTAL ORANGE COUNTY:** General Dentistry Practice/Implant Practice. 2011 Gross Receipts were $1.2M 1,800 sq. ft., 4 op office with implant systems in every op. #CA520

• **COASTAL ORANGE COUNTY:** Perio Practice. 5 Operatories, retiring doctor works 3 days with 4 days of hygiene. 2011 Gross Receipts were $400,000. #CAM533

• **COASTAL ORANGE COUNTY:** General Dentistry Practice. 4 Operatories with modern, new equipment and high-end finishes. 2012 Gross Receipts of over $690,000 #CAM529

• **DANVILLE:** FACILITY ONLY. Office has 5 fully equipped & furnished ops. Digital X-ray, Digital Panoramic X-ray, and central Nitrous Oxide/Oxygen. Seller relocating after 27 years of practice. #CA548

• **FREMONT:** General Dentistry Practice: 10 treatment rooms, Digital X-ray, Digital Pan in 3,050 sq. ft.. 4,000+ active patients, PPO/HMO with 2012 GR of $1.2 million with Adj. Net of over $300,000. #CA553

• **FRESNO:** General Dentistry Practice: $935K in collections in 2011, w/Adj. Net Income of $337K. Office is 2,300 sq. ft. with 6 equipped operatories. #CA502

• **GRASS VALLEY:** General Dentistry Practice. Collections of $491K with an Adj. Net Income of $130K. Office is 1,555 sq. ft., 4 equip. ops, 5 available. #14379

• **GRASS VALLEY:** General Dentistry Practice. 2012 Gross receipts of $442,736. 1,950 sq. ft. office with 6 operatories. Office condominium available to purchase. #14372

• **GREATER SACRAMENTO:** General Dentistry Practice. 2012 Gross Receipts of $879,000 and Adj. Net Income of $446,218. 1,400 sq. ft. office with 5 operatories. #CA525

• **GREATER SACRAMENTO:** Orthodontic Practice: Like-new, 2,300 sq. ft. office w/extensive improvements and 6 chairs. 220 active patients in Phase I, 135 waiting for Phase II, 60 patients in recall. #CA551

• **HAWAII (MAUI):** General Dentistry Practice: GR of $572K, 4 ops in 1,198 sq. ft., 4 days hyg., Laser, Surgical Implant System, Digital X-ray & Pano. Low A/R, approx. 1,000 active patients. 33 years in practice, owner retiring. #20101

• **INDIAN WELLS:** General Dentistry/TMJ Practice. 4,000 sq. ft. suite, 6 ops. 2011 Gross Receipts over $350,000 on just one doctor day/week. #CAM530

• **LANCASTER:** General Dentistry Practice. This 4 operatory office is located in 2,360 sq. ft. Gross Receipts were $676,000 with $174K Adj. net income. #14376

• **MERCED:** General Dentistry Practice. 2011 gross of $878K with Adj. Net Income of $294K. 4 treatment rooms in 1,550 sq. ft. office. #CA512

• **MURRIETA:** General Dentistry Practice. 4 operatories in 1,300 sq. ft. 2012 Gross Receipts were over $530,000 with $213,000 Adj. Net Income. #CAM544

• **NEWPORT BEACH:** General Dentistry Practice.3 operatories, newer, high-end equipment. 2012 Gross Receipts of $350,000 on 3 1/2 days per week. #CAM534

• **NORTH OF SACRAMENTO:** General Dentistry Practice. 2012 Gross Receipt of $521K with low overhead of only 52%. 1,650 sq. ft. with 4 operatories. #CA528

• **N. SAN DIEGO COUNTY:** General Dentistry Practice: Lg legacy practice with 12 equipped ops. in a free-standing building in a desirable area of N. San Diego County. 35 years of goodwill with established CAP and PPO contracts. $1.2M in collections with $405k adjusted net. #CAM555

• **ORANGE:** General Dentistry Practice. 5 operatories. 2012 Gross Receipts of over $830,000. #CAM543

• **ORANGE COUNTY:** Periodontal Practice. 6 operatories available, 5 fully equipped. 2012 Gross Receipts of over $450,000 on a 4 day week. #CAM536

• **PALM SPRINGS:** General Dentistry Practice. 4 operatories. PPO/Fee For Service, no HMO with 2012 Gross Receipts of $348,000 #CAM538

• **RIDGECREST:** General Dentistry Practice and Dental Building. 4 operatories in 1,536 sq. ft. office building. This small practice grossed about $175K in 2012. #CA523

• **SACRAMENTO:** General Dentistry Practice. Owner retiring. 2012 Gross Receipts of $642,507 with low 54.2% overhead. 8 available ops with 7 equipped in 2,400 sq. ft. office/building. #CA549

• **SALINAS:** General Dentistry Practice: Office with 4 ops. in approx. 1,275 sq. ft. GR in 2012 were $226,000 on a reduced schedule. Refers out all Endo, Perio, OS, and Ortho, provides great upside potential. Owner is retiring after 34 years in this location. #CA552

• **SAN GABRIEL VALLEY:** General Dentistry Practice. 4 operatories. 2011 Gross Receipts of over $590,000 on a 3 1/2 day week. #CAM541

• **SAN JUAN CAPISTRANO:** General Dentistry Practice. 4 fully-equipped operatories. Gross Receipts of $650,000 in 2012. #CAM539

• **SAN RAMON:** FACILITY ONLY. Great location, equipment, leaseholds & furnishings only. 1,400 sq. ft. with 4 equipped treatment rooms (2 additional plumbed) #CA511

• **S. ORANGE COUNTY:** General Dentistry Practice with 5 ops, 4 fully equipped. EagleSoft, laser, digital x-rays, and an intra-oral camera. Most specialty work is referred out. 2012 Adjusted net of $324k on $793k Collections. #CAM556

• **SOQUEL:** General Dentistry Practice: Professional building with 3 ops. in approx. 1,100 sq. ft. GR of $338,000 on 2 days per week. Average 10 new patients per month. Schick Digital X-ray and Dentrix. #CA550

• **TURLOCK:** General Dentistry Practice. Doctor's gross receipts in 2012 were over $950,000 with $443,777 Adj. Net Income. #CA506

• **WALNUT CREEK:** Prosthodontic Practice. Three fully-equipped operatories and lab. 2012 Gross Receipts of $530,000. #CAM540

• **WESTWOOD:** Amalgam-free General Dentistry Practice. Five operatories, near UCLA. $672,000 in Gross Receipts in 2012. #CAM542

• **YORBA LINDA:** General Dentistry Practice. Five well-appointed operatories in a central location in this family community. #CAM531

Practice Sales ~ Mergers ~ Partnerships ~ Appraisals ~ Patient Record Sales

MPG MADDOX PRACTICE GROUP
A DIVISION OF HENRY SCHEIN®

Southern California Office
www.henryschein.com/mpg
(888) 685-8100
414 31st Street, Suite C
Newport Beach, CA 92663

Northern California Office
www.henryschein.com/mpg
(800) 519-3458 ~ (209) 545-2491
5831 Stoddard Road, Suite 804
Modesto, CA 95356

Nationwide Practice Listings:
www.henryschein.com/ppt
More information is available on our website regarding practices listed in other states, articles, upcoming seminars and more.

CLASSIFIEDS, CONTINUED FROM 712

This is a must see! Available for lease on or about December 1, 2013. Please call 530.342.0716 for more information.

OFFICES FOR RENT/LEASE — Turnkey dental office in Modesto available for lease September 2013. Includes 8 operatories, 2 bathrooms, 2 doctor offices, and one break room with kitchen facilities. Modern building in great location within a couple of miles of two hospitals. Cabinets and sinks in operatories in good shape. Two chart cabinets remaining and in good shape. Dry vacuum in basement plumbed into all operatories. Compressor to be supplied by new tenant. 4 operatories are wired for X-ray. An additional 10' x 10' space is wired for Pano. Two operatories are plumbed for N2o. Suite includes large improved basement for storage; no rent is charged for this space. Cat 5 cabling to all operatories. Parking immediately adjacent to suite meets medical/dental office requirements. Includes one covered parking space for tenant. Tenant name to be placed on 2 illuminated monument signs on corners of lot, and 2 nonilluminated signs in parking lot. HVAC unit is 2 years old. Location has housed a number of thriving dental practices for more then 30 years. Please call 209.526.3000 or send email to gtesluk@sbcglobal.net.

OFFICES FOR RENT/LEASE — Long-established Bakersfield pediatric dental office. Directly across from local community college. Four plumbed operatories. Newly remodeled. Quiet space. 1,000 sq. ft. office. Tremendous amount of under serviced young families in the area. $1,250 a month. Please call 661.871.0780.

OFFICES FOR RENT/LEASE — Excellent opportunity for a specialist in Chino, Calif., with numerous referring dentists nearby — 3 GPs and an Oral Surgeon in a long-standing dental professional complex. 1,450 sq. ft., 3 ops. Features include consultation room, private office and staff room. Great location and access. Call 909.628.4287 or email lovemydentist@gmail.com.

DENTAL OFFICES FOR SALE

OFFICE FOR SALE — A dental office on University Ave. in Berkeley, Calif., is for sale. Office consists of 4 chairs, a lab and patients. Price is negotiable. For more information, please call Dr. Hala at 209.676.1362.

DENTAL PRACTICES FOR SALE

PRACTICE FOR SALE — General Practice dental office with 30-plus year history of goodwill in the Davis, Calif., area looking to find a wonderful, kind

CONTINUES ON 716

PARAGON
Dental Practice Transitions

THE PARAGON DIFFERENCE

After handling thousands of transactions over the past two decades, PARAGON consultants know that no two clients and no two transactions are the same.

A practice transition is a very personal event that requires very special attention. Nothing is taken for granted. We customize every single transaction to satisfy the needs and goals of our clients. We handle each transaction as if we are the client. This is just one of the many reasons why PARAGON is so unique.

Judge for yourself! Call us for a complimentary consultation. No obligation…just a very worthwhile education!

Sign up for our free newsletter at paragon.us.com

Your local PARAGON practice transition consultant is Trish Farrell
Contact her at 866-898-1867 or info@paragon.us.com

CARROLL & COMPANY

"MATCHING THE RIGHT DENTIST TO THE RIGHT PRACTICE"

Complete Evaluation of Dental Practices & All Aspects of Buying and Selling Transactions

Serving you: Mike Carroll & Pamela Carroll-Gardiner

4009 WOODLAND GP

Woodland GP and building available w/4 fully-equipped ops in approx. 1,500 sq. ft. office in gorgeous garden setting. Well est. prevention oriented family practice w/ seasoned & loyal staff. 2012 GR $232K+ w/just 3 doctor days. Only those interested in both the building and practice need respond. Practice asking price $138K, building asking price $315K.

4004 LOS GATOS GP

Seller retiring from a high quality cosmetic general practice in upscale neighborhood w/well-educated and loyal patient base & long term dedicated staff. Currently working equivalent of 2+ doctor-days with hygienist working 3 days per week. Seeks to transition practice to an experienced buyer with a passion for dentistry. Modern 1,200 sq. ft. office w/4 fully-equipped ops., digital x-ray & 7 fully networked computers running Dentrix. 5 year avg. GR $408K. 2013 GR on target for $360K.

SOLD

3092 SF FACILITY

1,600 sq. ft. street-level dental facility in Marina/ Cow Hollow neighborhood across from Presidio with excellent visibility and signage for foot traffic plus easy diagonal parking in front of building. Move in ready with 4 ops., 2 labs, kitchenette, reception and 2 desk areas plus 2 pvt. offices, 2 bathrooms, 1/2 basement & backyard with deck.

3096 NORTH BAY PERIO

Step into quality practice with established referral base. 2,200 sq. ft. office w/6 fully-equipped ops. Modern facility kept updated with recently purchased chairs, lights, Pano & lasers. Seller will grant a fair market lease and would consider selling the office space. 5 year avg. GR $1.2M+

3099 LOS GATOS GP

Well-est. general, restorative & cosmetic practice available in very desirable neighborhood. Gorgeous 1,530 sq. ft. office in single story dental complex w/4 ops. Asking $580K.

SOLD

3098 SALINAS GP

Well-known GP specializing in restorative dentistry retiring from 28 year practice located in highly visible downtown office. 4 fully-equipped ops., Panorex, digital x-ray & recent equipment upgrades. 2 year avg. GR $331K+ w/approx. 152 doctor days/yr. Asking $210K.

3095 SAN CARLOS

Seller well-known for quality patient care retiring from established practice with loyal patient base, in highly desirable neighborhood. Asking $515K.

SOLD

3085 MODESTO GP

State-of-the-art practice in approx. 2,800 sq. ft. facility w/7 fully-equipped ops. This practice is for an established dentist or 2 dentists w/experience & who will appreciate a high quality practice. Asking $745K.

4002 SANTA CRUZ AREA GP & BLDG

Well-est. practice in modern 1,250 sq. ft. office w/ 4 ops. 5 year avg. GR $630K+ w/ just 4 doctor days. Selling building & practice together. Practice asking price $430K, building to be determined.

4001 NORTHERN SONOMA COUNTY GP

Approx. 1,059 sq. ft. facility w/3 fully-equipped ops and dedicated parking in downtown area. Practice & building for sale. Great opportunity. Practice Asking $311K, building to be determined.

PENDING

3094 NORTH BAY PERIO

North Bay Perio now available. Seller retiring from well-est. practice with seasoned staff and active referral base. 1,300 sq. ft. very nice office with 4 fully- equipped operatories. 2012 GR $450K+ with just 3 1/2 doctor days and 5 days of hygiene per week. Great upside potential since owner does few implants. Asking $271K.

Contact Us:
Carroll & Company
2055 Woodside Road, Ste 160
Redwood City, CA 94061

Phone:
650.403.1010

Email:
dental@carrollandco.info

Website:
www.carrollandco.info

CA DRE #00777682

CLASSIFIEDS, CONTINUED FROM 714

practitioner to purchase practice. Offering many transition options. The office is conveniently located in a highly visible, easily accessible professional building. The office occupies approximately 2,000 sq. ft. and consists of 6 fully equipped ops, a private office, a reception area, a sterilization area, a staff lounge (which can be converted to a 7th op), a lab and 2 restrooms. The practice functions with state-of-the-art technology. It has a 3 year-old Planmeca Pano/3D/Ceph, a Cerec 3 with milling unit and a Biolase laser. The office is fully computerized with 14 workstations and operates Dentrix practice management software and Dexis digital X-rays. This FFS practices grosses approximately $1.5 million per year and generates approximately 30 new patients per month. The doctor will work back in the practice or mentor (if desired) to help the new doctor with a successful transition. This is only at the request of the purchasing dentist. The practice is located in a great community in which to live and practice dentistry. Please send your CV to Davisgpdds@gmail.com.

PRACTICE FOR SALE — General practice dentist in Visalia looking to find a wonderful, kind practitioner to purchase practice. The office is conveniently located in a highly visible, easily accessible professional building. The office occupies approximately 1,200 sq. ft. and consists of 4 fully equipped ops, a private office, a reception area, a sterilization area, a lab and 2 restrooms. The office is fully computerized and digital and operates with the Dentrix practice management software. This primarily FFS practice grosses approximately $650k and generates approximately nine new patients per month. The practice is located in a great community in which to live and practice dentistry. Please send your CV to centralvalleydds@gmail.com.

PRACTICE FOR SALE — Beautiful North Orange county office for sale. 26 years at this location, cash and PPO practice, doctor retiring, grossed more than $610,000 last year. On track to gross $700,000 this year. Working only 3 days a week. 5 ops, digital X-ray and computer in every op. Asking $560,000. Email pc3436@gmail.com for information.

PRACTICE FOR SALE — GP-private dental practice for sale within a group practice environment in Roseville, Calif. Large office with 15 equipped operatories but not a clinic-like feel. Personal patient attention. Not a managed office. Friendly and knowledgeable staff with low turnover rate. Practice is computerized with digital X-ray system and intraoral digital integrated cameras. Buy 100 percent of solo dental practice and 25 percent of shared group practice. Must associate with group for a minimum of 12 months before buy-in. Practice serving loyal and stable patient base for nearly 40 years. Current office building is only 10 years old. Gross production for 2012 is $937K. Office is located in Placer County, still one of the best communities in which to practice dentistry and raise a family. Please call Stuart Wakeman, DDS, at 916.797.4040 or email to stuartwakeman@surewest.net.

PRACTICE FOR SALE — Beautifully decorated, almost-new dental office located in the heart of Pleasanton, Calif. The 1,600 sq. ft. office is fully equipped with five operatories. Equipment includes digital X-ray accessible from every chair and a panoramic X-ray machine. Must sell quickly. Please call cell: 925.918.0920, office: 510.481.8566 or send email to tunhla@sbcglobal.net.

OPPORTUNITIES WANTED

GENERAL DENTIST SEEKING TO PURCHASE PRACTICE — General Dentist seeking to purchase a practice located in southern Marin, San Francisco, northern San Mateo or western Alameda. I am looking for a high-quality, PPO/fee for service modern family dental practice. I would prefer the practice to have the following amenities: paperless office, 3-4 fully equipped operatories with computers in each, Dentrix or Eaglesoft software, digital radiographs, digital panoramic unit, intraoral camera. If you are looking to sell your practice, this is a great time, and I would look forward to speaking with you confidentially. Please email me if you are interested at californiadmd@gmail.com.

GENERAL DENTIST SEEKING ASSOCIATE POSITION — I am a California licensed dentist seeking an associate position in the Bay Area. I graduated from University of the Pacific in San Francisco and completed an AEGD residency. My experience includes all aspects of general dentistry including

CONTINUES ON 718

Specialists in the Sale and Appraisal of Dental Practices
Serving California Dentists since 1966
How much is your practice worth??
Selling or Buying, Call PPS today!

Practices Wanted

NORTHERN CALIFORNIA
(415) 899-8580 – (800) 422-2818
Raymond and Edna Irving
Ray@PPSsellsDDS.com
www.PPSsellsDDS.com
California DRE License 1422122

SOUTHERN CALIFORNIA
(714) 832-0230 – (800) 695-2732
Thomas Fitterer and Dean George
PPSincnet@aol.com
www.PPSDental.com
California DRE License 324962

RARE OPPORTUNITY - SAN FRANCISCO'S EAST BAY

2012 collected $1.9 Million. Available Profits topped $1 Million. Collections thru 6/30/13 were $1.2 Million.

Performance realized by One Dentist. After you get past "Wow!" factor, there is nothing special. As well as this practice is performing, it is not close to realizing its potential. With right Successor who tweaks the practice where it needs to be tweaked, then this shall be something special. Paperless and digital. Ambitious SoCal Dentist who is not averse to commuting should consider this opportunity. Phenomenal opportunity for Periodontist. Great two Dentist purchase. Make this a "One Stop" Shop. Little competition with phenomenal upside.

Full price $1.2 Million. Contact Ray Irving at 415-899-8580 or Ray@PPSsellsDDS.com.

6051 FRESNO'S FIG GARDEN VILLAGE AREA Not a Delta Premiere Practice. Collections through 6/30/13 totaled $225,000 with $85,000 in profits. 3.5-days of Hygiene.

6050 MERCED 2013 trending $360,000. Very profitable. Refers Endo, OS & Perio. Not a Delta Premiere Practice. Great foundation to build upon. Full Price $150,000.

6048 SALINAS Great opportunity for ambitious. Ideal for two Dentists. 9.5 days of Hygiene per week. 6-Ops. 2012 collected $1.1 Million.

6047 STOCKTON Best location outside Brookside Community on West March Lane. Annualized revenues of $500,000. 2013 trending $535,000. Attractive 3-Op Office.

6046 PINOLE Collected $500,000 in 2012. 4-days of Hygiene produced $178,600. Beautiful office. Refers Endo, OS. Lots of Goodwill here.

6045 MANTECA / MODESTO AREA - RIPON Great location. 3 Ops, 2 more wired & plumbed. $180,000 invested here. Practice did more when Owner worked harder. 2012 collected $327,000 on 3-day week with 5-weeks off.

6044 MODESTO Best location. New development occurring nearby. Collects $380,000. Digital with computers in Ops. Very attractive office.

6043 EL SOBRANTE 3-day practice collected $170,000 in 2012. 3-Ops. Building optional purchase.

6041 PLEASANT HILL Collected $365,000 with Profits of $142,000 in 2012. Owner slowing down. Previous 3-years averaged collections of $415,000 and Profits of $180,000.

6040 SANTA ROSA Beautiful 4-Op office. Paperless and digital. Collected $480,000 in 2012. Should have done more! Prior year did $625,000. Package includes Condo.

6039 CALIFORNIA'S SOUTH LAKE TAHOE Long established. 2012 collected $515,000 with 2-months off. Realized Profits of $230,000+. Attractive 3-Op office. SOLD

6038 FREMONT On part-time schedule due to other responsibilities, collects $300,000 per year. 2-days of Hygiene. Digital radiography.

6008 MENDOCINO COAST'S FORT BRAGG Cultural haven offers attractive lifestyle. 2012 collected $750,000. 4-days of Hygiene. Digital radiography. Computers in Ops. Full Price $235,000.

TEMECULA - MURIETTA VALLEY Hi identity, Classic GP! Gorgeous 6 Op office. Grosses apprx $800K. Right Buyer can gross to $2 Million in 5-years. Valuable Dental/Professional Building also available.

ALISO VIEJO Best Shopping Ctr location. Grosses almost $1 Million. 5-Ops. "State-of-the-art". PT Owner. Wants "hands-on" Owner. Work here, live at beach! Over 70 New Patients per month. Full Price $945,000.

CUCAMONGA 50 NPs/mth. Located off freeway exit. 5-Ops. Beautiful. Grossed $850K in 2012. Should do $1.2 Million 2013. FP $850,000.

RIVERSIDE Hi Identity building 4 Sale. Elegant 5-ops. CT digital Pan & x-rays. PT Conservative Female Owner Grossed $550,000. One PPO. Full-time Successor shall do better.

RIVERSIDE Grosses $1.3 Million. $6-to-$7K/mth from HMO. Does ortho. 10-Ops in 3,000 sq.ft. with low rent. Hi identity Shopping Center near Wal-Mart. Full Price $1 Million.

IRVINE Grossed $1.2 Million in 2012. 2013 should do $1.3+ Million. 5-Ops. Absentee Owner. Unique transition assistance can be made available. 50 New Patients per month. Full Price $1 Million.

SAN FERNANDO VALLEY Best location. Grosses $1.2 Million. Lots of work referred. This is $2 Million location. 8-Ops. 30 Hygiene patients per day. Full Price $1.2 Million.

SAN FERNANDO VALLEY – BEST HISPANIC LOCATION 7 state-of-art Ops, room to expand. 70 New Patients per month. Building part of sale. Another $2 Million location.

TORRANCE – GARDENA Very conservative Chinese DDS. Lots of work referred. Young Chinese/AM Successor will do $600K. FP $185,000.

LANCASTER Established location. Equipped. Seller needed more room. Many walk-ins each day. Seller did $900,000 here. FP $125,000.

BALDWIN PARK 80% Hispanic. High identity building. 3-Ops. Grosses $250,000. Full Price $150,000.

BAKERSFIELD Grosses $750,000. Established 50-years. 5-Ops. Successor should do $1 Million. Full Price $500,000.

SMALL TOWN NEAR BAKERSFIELD Practice & RE. Gross $400,000 with Full Time DDS. Practice & Building $350,000.

ORANGE Female DDS doing $30-to-$40K/month part-time. Seller will work-back for smooth transfer. Full Price $295,000.

FONTANA 100,000 autos daily. PT Owner grosses $250,000. FT Successor should Gross $500K+. Remodeled 3-yrs ago. Firm Price $275,000.

REDLANDS Low overhead, 5-Ops, digital. Gross $30,000+/mth. FP $350,000.

NEVADA Small resort city near Las Vegas. 5 "state-of-the-art" Ops. Grosses $600,000 3-days. Will do more by adding additional days. Full Price $600,000.

DENTURE CENTER 30+ denture patients/day. Grosses $1.3 Million. Patients ask "Will you do Implants?" Answer is always "We just do just dentures." Specialist will take to $2 Million. Full Price $1 Million.

FOUNDERS OF PRACTICE SALES
120+ years of combined expertise and experience!
3,000+ Sales - - 10,000+ Appraisals
CONFIDENTIAL
PPS Representatives do not give our business name when returning your calls.

D&M

PRACTICE SALES AND LEASING

Paul Maimone
Broker/Owner

It's Time to Sell! Inventory & Rates are Low! Buyer Demand is High!

BAKERSFIELD #21 – (10) op comput. G.P. & Bldg. on main St. (3) ops fully eqt'd, (3) ops part eqt'd, and (4) add. plumbed. Annual Gross Collect ~ $500K. Cash/Ins/PPO. **SOLD**

BAKERSFIELD #25 – 4 op comput. G.P. & free stand. duplex bldg. for sale. Located on a main thoroughfare. Cash/Ins/PPO pts. (3) days/wk of hygiene. Gross Collections $400K/yr.

BAKERSFIELD #26 – 3,500 sq ft free stand. duplex bldg. w a (5) op fully equipped turnkey dental office. Located on a main thoroughfare w monument signage. Move in condition.

BAKERSFIELD #27 – (4) op comput G.P. starter pract. 2 ops of new eqt. (2) add. plmbd ops. Opened June 2012. (12) mos Gross Collect $75K p.t. & growing. Mixed pts. Seller moving. **NEW**

BEVERLY HILLS – Great startup or second office. (2) op Turnkey Office. Leaseholds & eqt'd. No charts. Located in a smaller two story prof. bldg. on a main thoroughfare. Low rent. **NEW**

CENTRAL VALLEY/So. FRESNO COUNTY – (3) op comput. G.P. in smaller town w ltd. competition. Newer eqt. Networked & digital. Dentrix & Dexis. Gross Collect $40K+/mos.

CORONA – Dental Spa & Free Stand. Bldg. for sale. (5) op comput. G.P. w (2) spa rooms; one for facials & one for massage. Drop dead gorgeous facility w all the special touches. New eqt. Digital x-rays. Pano eqt'd. Production of $1.0M+ on a (4) day week. **NEW**

EAST VENTURA COUNTY – (3) op compt. G.P. Fee for Service. Located in a smaller prof. bldg. w some exposure & visibility. Pano eqt'd. 2013 Proj. Gross Collect $500K. **NEW**

OXNARD #7 – (5) op turnkey G.P. No pts. In a free stand bldg. on a main thoroughfare.

SAN JOAQUIN VALLEY – G.P. & Bldg. in small town w ltd. competition. (4) op comput. office. Cash/Ins/PPO. Annual Gross Collect $500K+. Low overhead. Seller retiring. **REDUCED**

SANTA CLARITA VALLEY – Cash/Ins/PPO bread and butter practice. (4) ops eqt'd. Located in a medical/dental/professional bldg. complex. 40+ yrs of Goodwill. Seller retiring. **NEW**

TOLUCA LAKE – Starter Pract. (4) op comput. G.P. (2) ops eqt'd w new eqt./(2) plmbd. Digital x-rays. In free stand. bldg. Main thoroughfare. Collect ~ $10k/mos on (1) day/wk **PENDING**

WEST SAN FERNANDO VALLEY PEDO/ORTHO OFFICE – Comput. Pedo/Ortho office. (3) op open bay & (1) op quiet room. Pano eqt'd. Digital X-rays. Cash/Ins/PPO small % Denti-Cal. 30+ years of Goodwill. Annual Gross Collect $600K+. Seller retiring but will assist with transition and/or stay to do Ortho.

WOODLAND HILLS #4 – Beautiful state of the art (9) op comput G.P. in a Shop Ctr. on a main thoroughfare. Excellent exposure/visibility/signage! (6) ops eqt'd w newer eqt. (3) add. plumbed. 2013 Projected Gross Collect $370K on a 3-3.5 day wk. Cash/Ins/PPO/HMO pts. **PENDING**

UPCOMING PRACTICES: Agoura, Alhambra, Beverly Hills, Camarillo, Covina, Glendora, Montebello, Monrovia, Pasadena, SFV, Torrance, Ventura, West Covina, & Westchester.

D & M SERVICES:

- Practice Sales & Appraisals
- Practice & Equipment Financing
- Expert Witness Court Testimony
- Pre - Death and Disability Planning
- Practice Search & Matching Services
- Locate & Negotiate Dental Lease Space
- Medical/Dental Bldg. Sales & Leasing
- Pre - Sale Planning

P.O. Box #6681, WOODLAND HILLS, CA. 91365
Toll Free 866.425.1877 Outside So. CA or 818.591.1401 Fax: 818.591.1998
www.dmpractice.com CA DRE Broker License # 01172430

CA Representative for the National Associaton of Practice Brokers (NAPB)

CLASSIFIEDS, CONTINUED FROM 716

endodontics, fixed and removable prosthodontics, pediatrics, cosmetic dentistry and oral surgery. I have immediate availability, can work weekends, and am proficient in Spanish. I would be delighted to send my resume, cover letter and references to you upon request. I sincerely thank you for your time and interest. Vinni Singh, DDS 650.450.9887 vinnikaur1@gmail.com.

GENERAL DENTIST SEEKING TO PURCHASE A PRACTICE — General Dentist seeking to purchase a practice located in southern Marin, San Francisco, northern San Mateo or western Alameda. I am looking for a high-quality, PPO/fee for service modern family dental practice. I would prefer the practice to have the following amenities: paperless office, 3-4 fully equipped operatories with computers in each, Dentrix or Eaglesoft software, digital radiographs, digital panoramic unit, intraoral camera. If you are looking to sell your practice, this is a great time, and I would look forward to speaking with you confidentially. Please email me if you are interested at californiadmd@gmail.com.

ORTHODONTIST AVAILABLE— Need a vacation? Want to make some money and vacation, too? Experienced Northern California Orthodontist will allow you to leave your practice in competent, experienced, skilled hands at a nominal cost, which continues the office income stream while you relax. Recently retired orthodontist with 30-plus years owning and running a solo practice is available to cover your office in your absence. Call 530.272.2142 to discuss.

QUESTIONS MOST OFTEN ASKED BY SELLERS:

1. Can I get all cash for the sale of my practice?
2. If I decide to assist the Buyer with financing, how can I be guaranteed payment of the balance of the sales price?
3. Can I sell my practice and continue to work on a part time basis?
4. How can I most successfully transfer my patients to the new dentist?
5. What if I have some reservation about a prospective Buyer of my practice?
6. How can I be certain my Broker will demonstrate absolute discretion in handling the transaction in all aspects, including dealing with personnel and patients?
7. What are the tax and legal ramifications when a dental practice is sold?

QUESTIONS MOST OFTEN ASKED BY BUYERS:

1. Can I afford to buy a dental practice?
2. Can I afford not to buy a dental practice?
3. What are ALL of the benefits of owning a practice?
4. What kinds of assets will help me qualify for financing the purchase of a practice?
5. Is it possible to purchase a practice without a personal cash investment?
6. What kinds of things should a Buyer consider when evaluating a practice?
7. What are the tax consequences for the Buyer when purchasing a practice?

Lee Skarin & Associates have been successfully assisting Sellers and Buyers of Dental Practices for nearly 30 years in providing the answers to these and other questions that have been of concern to Dentists.

Call at anytime for a no obligation response to any or all of your questions
Visit our website for current listings: www.LeeSkarinandAssociates.com

LEE SKARIN & ASSOCIATES INC.

Offices:
805.777.7707
818.991.6552
800.752.7461
CA DRE #00863149

ADVERTISER INDEX

FOR ADVERTISING INFORMATION, PLEASE CONTACT COREY GERHARD AT 916.554.5304.

CONTINUED FROM 722

interpretations of Stupid. Whoa! No wonder children are confused about who and what they are. I thought I was just Me. Turns out you get to choose your name only if you're a celebrity clever enough to come up with something like Ke$ha or 50-Cent. Hesitate and other people will rush in to choose it for you.

One day not long after I became Adult, I was Doctor, Lieutenant and IRS ... 7147 for short. A few months later a young lady I met called me Fiancé, and before I could look up the difference between that and finance, a minister referred to me as Husband and a nice lady told her friends I was Son-in-Law; right back where I started, only more lawyerly.

It's unclear to me how this happened, but a medical doctor I dimly recognized as the one who had called me Fetus, smacked me on the bottom and categorized me as Boy, has now returned, whacking me on the back with, "Congratulations, Father!" What happened to Son, Brother and Grandson?

And who is Girl?

About the time Halley's Comet reappeared, I decided to don a backpack and thumb my way across the Serengeti in search of the real me. I was advised to eschew personal hygiene, grow a beard and practice introspection on $5 per diem until the real me revealed himself. I needed to get away, someplace where everybody knows my name. "Bum" was the consensus when I returned. Oddly enough, during an era when "identity theft" is of international concern, not once has any of my generous numbers ever been heisted.

A young woman, who only yesterday knew me as Dada, suggested I give her five bucks. "For lunch, Pop," she explained, adding, "Daddy-o, meet my father-in-law and my brother-in-law."

"Pleased to meetcha, Bob," the kid beams. *Bob*? Where'd that come from?

The following month — or maybe it was a year or two — I notice the television is bigger, but the room has shrunk. A restaurant I frequent calls me Early Bird on the way in and Senior on the way out and a hearing aid company charms me with colorful literature personally addressed to Occupant.

A couple I believe to be relatives, drops by accompanied by two small persons who have evidently been schooled to label me Grandpa. They engage in random acts of gymnastics on my bed until I cry *UNCLE!* I am now Uncle Grandpa. There is a playpen in the corner containing a two-toothed occupant who has not called me anything yet. If I can get down to his level, I think I can get him to eventually call me ... ah ...

well ... something I can remember before he can get his tongue around Great-Grandpa.

Even allowing for duplicates, the search for who I am now appears large enough to abort. From Fetus to Great-Grandpa in only 1,116 short months!

In the meanwhile, there's still that girl to whom I was Sweetie Pie back in the day. Me — real or otherwise — can live with that. ■■■■

We're taking your requests

If you have a favorite Dr. Bob column you want to see again, email Publications Specialist Andrea LaMattina at Andrea.LaMattina@cda.org. We will oblige by reprinting those requested favorites interspersed with any new Dr. Bob submissions.

Bring in a new member, get $200.

Refer a new member to CDA and receive double the reward, a $100 check from CDA and a $100 American Express gift card from the ADA for every referral. Simply share with your peers why you love being part of the 25,000 dentists who are working to make the profession stronger.

For details visit **cda.org/mgm**

Dr. Rockwell referred a new CDA member.

ADA campaign ends September 30. The total awards possible per calendar year are: $500 from CDA, and $500 in gift cards from the ADA. Members may decline the gift card and the ADA will contribute $100 to the ADA Foundation.

ADA®

cda®

CDA JOURNAL, VOL 41, Nº9

Who Am I?

Troubling as this is, the real you remains in a state of flux throughout your entire life.

Robert E. Horseman, DDS

ILLUSTRATION BY VAL B. MINA

Did you ever wonder who you are? Neither did I, but I understand there are many young persons who embark on lengthy journeys trying to discover the identity of the "real" them. Listen carefully and you may hear a recurring theme from the old *Cheers* sitcom as the searchers thread their way through the Sturm und Drang of today's world:

Making your way in the world today takes everything you've got,

Taking a break from all your worries sure would help a lot.

Wouldn't you like to get away?

Sometimes you want to go where everybody knows your name …

On the other end of the age spectrum are some elderly persons who used to know who you are, but are now experiencing a bit of bother remembering either of you by name. Troubling as this is, the real you remains in a state of flux throughout your entire life.

My mother's obstetrician recognized me immediately as "Fetus." Before long, I was the Baby. In the course of just 3 hours and 20 minutes and nine months later, the Baby merited an upgrade to the maternity ward and an instant promotion to Son, Brother, Grandson, Great-grandson, Nephew and Cousin. Birth registrations insisted I was Male. That's nine identities prior to soiling my first diaper!

Before I could sort out a few uncles and aunts-in-law, I became Friend. Friend to classmates who fancied my lunch to theirs. In the next few years, I was Kid Next Door, Kid Who Cried When He Fell off the Monkey Bars and a few innovative

CONTINUES ON 721

© 2013 Keller Laboratories

AMAZINGLY POWERFUL FOR SOMETHING SO SMALL.

NTI-tss Plus.™ Clearly a big relief.

It's no small wonder the compact NTI-tss Plus is such a huge success. Unlike full coverage bite guards, it discludes posteriors and canines, suppressing nearly 70% of parafunctional muscle contraction. So it conquers migraine and jaw pain while protecting teeth, muscles and joints—all with less chair time and more comfort. NTI-tss Plus. Clearly better.

keller

Call (800) 325-3056
Visit kellerlab.com

Opalescence® go

Be Bright

Powerful, professional whitening. To go!

Introducing Opalescence Go. For a more adaptable, more comfortable whitening experience. Opalescence Go offers complete molar-to-molar coverage. And its new UltraFit tray easily conforms to any patient's individual smile, ensuring the maximum amount of gel stays in contact with the teeth during whitening.

With UltraFit Tray

10-day treatment

PROUD USA MANUFACTURER Ultradent is a proud USA manufacturer. To learn more visit ultradent.com/USA

800.552.5512 | ultradent.com

© 2013 Ultradent Products, Inc. All Rights Reserved.

WHITEN

ULTRADENT PRODUCTS, INC.
Improving Oral Health Globally