FALL 2013

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NDA JOURNAL

OFFICIAL MAGAZINE OF THE NEVADA DENTAL ASSOCIATION AND COMPONENT SOCIETIES

A PEER REVIEWED JOURNAL

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NDA JOURNAL

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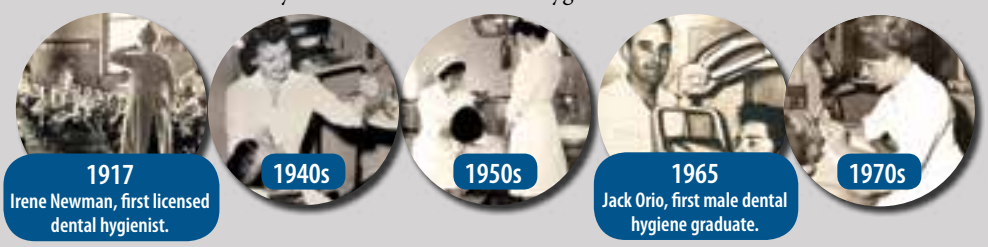

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Happy 100th, Dental Hygiene!

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Dr. Orr practices OMS in Las Vegas, is a Clinical Professor of Surgery and Anesthesiology for Dentistry at UNSOM, Professor and Director of OMS and Advanced Pain Control at UNLV SDM, a member of the CA Bar and the Ninth Circuit Court of Appeals. He can be reached at EditorNDA@lasvegas.net or 702-383-3711.

It took a couple of months to create a functional office space in 1979 after moving to Las Vegas from an OMS residency at Los Angeles County/USC/ Medical Center. Before welcoming our first patient (a Le Fort III fracture[1] secondary to cliff diving at Lake Mead), I had, gratefully, been employed at the new Clark County Community College Dental Hygiene Program, recently established by Dr. Ray Rawson and RDH Barbara Nelson.

My position at a dental hygiene school would have been newsworthy to RDH Anna Pattison, the USC School of Dentistry Dental Hygiene Chair. At USC, our first clinical experiences were hygiene-related and, interestingly, endodontics. Many people found hygiene so very mystifying that the 13 required root canals were often completed well before being signed out of hygiene, courtesy of charitable hygienists such as Ms. Pattison.

Hygienists have always been very kind—and extremely valuable—to dentists, both academically and within private practice. Many people in both professions can recall well the political controversy here in Nevada in the early 1980s about whether hygienists should be allowed to administer local anesthesia. There is no question now that typically superbly trained and conscientious hygienists are eminently qualified to help relieve the discomfort associated with dental procedures by means of local anesthesia.

Dentistry and its patients have been well-served in this area…but there still seems to be that provincial reticence to progress so often in dentistry. For instance, witness the current, frankly inexplicable discussions regarding dentists and their alleged inability to administer botulinum toxin.

Continues ➲

Hygienists have always been very kind—and extremely valuable—to dentists, both academically and within private practice.

Congratulations to Dental Hygiene on its 100th Anniversary and thank you for taking such outstanding care of our patients and dentistry.

In this case, the federal government appears very reasonable (anti-trust wise) by establishing that if one is reasonably trained to perform a procedure, one should be allowed to perform that procedure, regardless of professional degree. But, in this area, dentistry is once again dragging its feet; some would say shooting itself in one or the other, to its patients' detriment. No professional is more well-trained in facial anatomy and physiology. Medical assistants routinely administer Botox. Why the hesitance to allow dentists—or supervised dental hygienists, for that matter—to administer botulinum toxin, an agent with fewer complications than any local anesthetic? Botulinum toxin has dentally-related uses for cephalgia, pathology of salivary glands, and the TMJ in addition to the temporary paralysis of facial musculature that should be considered part and parcel of dentistry's treatment options. Some dentists use drugs such as succinylcholine or rocuronium which paralyze all skeletal muscles, including the diaphragm, not just levator labii superioris.

Hygiene in Nevada has continued to maintain an award-winning, cutting edge academic presence at both ends of the state. The Clark County Community College which morphed into the Community College of Southern Nevada (1991) and now the current College of Southern Nevada (2007) evolved from a two-year certificate to a four year bachelor's degree for hygiene. It took a little more time to establish the Truckee Meadows Community College hygiene program, which welcomed its first class in 2000, and is also nationally recognized for academic excellence.

The *Journal* is appreciative of the contributions of Dental Hygiene to Dentistry and its patients, including the articles in this issue. Congratulations to Dental Hygiene on its 100th Anniversary and thank you for taking such outstanding care of our patients and dentistry. ◆

Endnotes

1. Gartshore, L, A brief account of the life of Rene Le Fort, *Brit J Oral Maxillofac Surg*, 48:3, April 2010, 173-175, www.sciencedirect.com/science/article/pii/S0266435609005397, accessed 14 August 2013.

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As 2014 approaches and the implementation of the Affordable Care Act continues, many employers and consumers have questions about what health insurance options are available to them.

Employers and individuals should begin considering and investigating their options so that they are prepared on Jan. 1, 2014, when all individuals will be required to have health insurance.

Although the Obama administration recently announced that it has delayed the mandate requiring large employers to provide insurance for their employees, this change has no impact on other aspects of the law and does not affect businesses with fewer than 50 full-time employees. Individuals will still be required to purchase health insurance beginning Jan. 1, 2014, or face a penalty that will be one percent of their salary for the first year. Employers with more than 50 employees will be required to offer health insurance beginning in 2015.

Nevada is developing its own exchange, Silver State Health Insurance Exchange. The health insurance exchange, an online marketplace where consumers can compare and purchase health insurance plans, will be available Oct. 1, 2013. The website **www.nevadahealthlink.com** opens the Small Business Health Options Program (SHOP)—a marketplace for businesses with fewer than 50 full-time employees to search for and purchase health insurance for their employees, if they so choose.

Employers also can continue to purchase private health insurance, such as the health insurance plan offered by the NDA through TDIC Insurance Solutions.

On page 7 is a related article about Nevada Health Link written by KPS3, the marketing firm for Nevada's insurance exchange. ◆

What does Nevada Health Link mean for Nevada's dental care providers?

By Katie Coleman, KPS3

January 2014 is approaching and on its heels are the new online health insurance marketplaces that were created by the Patient Protection and Affordable Care Act (ACA). Nevada is among a group of 17 states and the District of Colombia that will operate state-based online marketplaces, whereas the remaining 33 states will have a one-size-fits-all marketplace set up by the federal government. Nevada Health Link (Nevada's online marketplace) will launch enrollment efforts in October of this year with the goal of enrolling 118,000 currently uninsured individuals in health insurance coverage by March 31, 2014.

Nevada Health Link will showcase Qualified Health Plans (QHPs) that meet the 10 Essential Health Benefits (EHBs) mandated by the ACA as well as all state-mandated benefit coverage. There are federal subsidies available for individuals and families with incomes below 400% of the Federal Poverty Level. Currently individuals who earn less than $45,960 and families of four that earn less than $94,200 will qualify for premium assistance in the form of an Advance Premium Tax Credit (APTC). The closer an individual or family's earnings are to the Federal Poverty Level, the greater the premium assistance will be. Nevada Health Link allows individuals, families and small businesses to shop for health insurance, compare available plans side by side and enroll in coverage from the comfort of their home or office.

Today, many Nevada dental offices are closed on Fridays. With the onset of the ACA, patients may see more offices open Fridays to meet the anticipated increased need for their services. This is especially true for pediatric dental providers. One of the mandated EHBs is pediatric dental coverage. This new mandate will allow more families to visit dental offices to ensure their children receive the appropriate preventive dental care they need.

All marketplaces nationwide were provided an opportunity to allow for standalone dental plans to create more plan variety and competition within the marketplace. Nevada Health Link chose to allow these plans, and as a result, there are 10 dental carriers offering plans throughout the state.

www.nevadahealthlink.com
855-7-NVLINK (855-768-5465)
contact@exchange.nv.gov

What is Nevada Health Link?

An organization created by the State of Nevada to help Nevada residents find a health insurance plan that fits their needs and budget.

The website is an online marketplace where individuals and businesses can shop for, compare and purchase health insurance plans.

Those 10 carriers offer 45 individual and 43 small group plans across Nevada. Additionally, where the federal government allows the pediatric dental EHB as an optional purchase for families purchasing plans on an Exchange, the Silver State Health Insurance Exchange Board that oversees Nevada Health Link voted to mandate that all children enrolling in plans through Nevada Health Link must purchase the pediatric dental EHB. In a Board meeting on May 16, 2013, Board Member and certified pediatric hematologist-oncologist and pediatric bone marrow transplant physician Dr. Ronald Kline addressed the Board with the issue of imposing additional regulations on ACA mandates: "As much as we hate to impose rules on anybody, our society imposes lots of rules on people. And maybe making sure that the kids get good dental coverage is one of them." Nevada Health Link is dedicated to providing the best plans with the best benefits to our consumers.

To ensure the greatest level of variety and competition, the Board also approved three ways for dental benefits to be offered on the Exchange: *embedded, bundled* and *standalone*. Today, a health plan can provide dental benefits by embedding them in the plan's overall structure. Similarly, in 2014, QHPs will be allowed to embed the pediatric dental EHB. This process will combine the dental costs with the medical costs to create a plan that meets the cost structure associated with the ACA metal tiers: Platinum, Gold, Silver and Bronze. Nevada Health Link is also allowing two additional offerings; *bundled* and *standalone*. Bundled plans are dental plans that could stand alone but are included as-is in a QHP. The rules for bundled plans follow two sets of cost structures: the metal tiers associated with QHPs and a selection between high and low actuarial values for the dental plans. Those two options are 70% and 85% respectively. That means that 70% or 85% of the costs of the dental care (not including preventive services) are covered by the plan, and the remainder is covered by the individual. Lastly, we have the standalone dental plan. This

Continues ➲

Nevada Health Link

continued from page 7

plan again is offered at a high and low-cost structure. It is interesting to note, that although Nevada Health Link allows for all three versions of dental plan offerings, no medical carrier opted to embed or bundle dental benefits with their QHPs. In 2014, Nevada Health Link will only have standalone dental plans to meet this need; however, with 45 individual plans and 43 small group plans, there will be more than adequate variety and competition.

There is one more aspect of Nevada Health Link that the professional dental community may find interesting, if not a bit exciting; employers with fewer than 25 full time employees can get a tax credit for providing health insurance to their employees. The Small Business Health Options Program, or SHOP Exchange, is a marketplace for small employers (50 or fewer full time employees) to find coverage options competitively priced with the large group market. The added bonus of receiving a tax credit of up to 50% of the employer's contribution may make looking at the SHOP Exchange worth the effort for the 2014 and 2015 plan years. Imagine offering your employees the choice of 10–15 different health insurance plans and receiving one easy-to-read and easy-to-pay bill from Nevada Health Link, not to mention a tax credit! Now that is business friendly.

Nevada Health Link's goal of increasing the number of insured individuals in the state will increase the number of individuals with the ability to pay for dental services, and increase the demand on dental service providers. In a time of prolonged recession and high unemployment in Nevada, an increase in customers with the ability to pay is a positive thing for any business. The only thing shining brighter than the smiles of Nevada Health Link's customers are the opportunities that lie ahead for Nevada's dental professionals. ◆

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As I write this message, we are in the dog days of summer—vacations are over, school is back in session, and there is work to be done. In the two months since our summer meeting we have been working very hard on your behalf.

First, thank you to Gilbert Trujillo for a great NDA summer meeting in Squaw Valley. This was a great venue and enjoyable for all who attended. The music provided by Gilbert's band was an absolute hit. Thanks to all who attended this meeting and participated in our association business.

Two representatives from the ADA attended the summer meeting to instruct us on membership strategies. We definitely have work to do in this area. I echo Gilbert's last message to the members of NDA. We need to invite the diverse groups in our state to join the ADA. The only way our voice can be heard is with strong membership. Please consider reaching out to those you know and ask them to join us.

In August, Mark Handelin and I attended the Western States President's Conference in Jackson Hole, WY. This was an opportunity to meet with the presidents and president-elects of the Western States in an open forum to discuss our common concerns. We learned about issues that others are dealing with and could be coming our way. We left the meeting with a lot of ideas to help us be prepared.

As you know, there are many questions about the ACA and how it will impact dentistry. We are closely monitoring the mid-level provider legislation in other states in order to position ourselves appropriately. Other areas of concern are Medicaid reimbursement, access to care, and many more. As you can see, we need to be united and increase our base membership. Organized dentistry is still the best option for us as dentists.

With the success of the most recent legislative session, we must take advantage of the opportunity to continue the momentum. Now is the time to prepare for the next session. Unfortunately, to be a strong player, we need money. During my term, I have a goal to increase our PAC money; and we will be working with our lobbyist, Chris Ferrari on this goal. Look for more information as the year progresses. We need to increase our membership and need everyone's help to strengthen the association. Please help your component society accomplish this goal.

In closing, let me say that I am honored and humbled to serve as your president this year. I will do my best to follow in the footsteps of the great individuals who have gone before me.

If you have any input, please email. Your thoughts are valuable and important. Your NDA officers serve the dentists of Nevada, first and foremost. Let's have a great year and continue to make the NDA great. ◆

Chris Ferrari

Protect your Practice:

Back the PAC

I want to commend you for being a part of the NDA. The NDA is committed to proactively helping create policy that benefits patients and dentists, and to protect you as a provider and a small business person. The NDA works continuously on these issues so you can focus on your patients and practice.

The 2013 Legislative Session ended in June. The NDA had many major proactive and defensive successes, some of which are highlighted below. It is important to note, that each of these, *individually*, would be a major accomplishment for one Legislative Session. The fact that all of these and many other efforts all happened in one Session, is truly a testament to the work NDA puts forward for its membership.

Bills that passed

1. Banning insurance companies from capping fees on services they don't cover within the insured's dental insurance policy;
2. Adding a formal definition of dentistry in statute; and
3. Ensuring that dental students are afforded the same protections as dentists if they are assaulted by a patient while performing a procedure.

Bills that failed

1. Mandated costly registration of dental assistants through the State Board of Dental Examiners; and
2. Limiting the ability for business (dental practices) to collect on non-payment for services rendered.

How you can help

Funding the Political Action Committee (PAC) is the way to foster continued success.

It is essential to allowing the NDA to support and educate candidates for political office, and to ensure your voice is heard. Believe it or not, this process has already begun in preparation for the 2015 Legislative Session.

Your NDA, its Executive Director and professional lobbying staff, spend literally thousands of hours preparing for the four-month Legislative Session to ensure your interests are met. Your support for the PAC is critical to continuing the momentum building for the dental profession.

It is a privilege to represent your interests in Carson City and we look forward to continued success. ◆

Implementing "Capping of Non-Covered Services" legislation into your practice

By J.B. White, DDS

The NDA was successful in passing Senate Bill 497 during the 2013 Session. SB 497 bans insurance companies from dictating fees on "non-covered services." Nevada was the 34th state to pass legislation banning this practice.

The term "capping of non-covered services" refers to insurance policies that set a cap on the amount a participating dentist can bill for services not covered by a dental insurance policy. Prior to passage of this law, this process was used by insurance companies as a client recruitment tool, allowing them to tell customers that while their policy does not cover a specific procedure, they have preferred rates with dental professionals.

Our goal as dentists is to provide the highest quality care and value to our patients. The practice of capping non-covered services did not allow us to do so. Allowing insurance companies to set costs for dental services which fall outside of policy benefits, leaves the dentist to absorb the cost. For the majority of dentists—small, independent practitioners—these costs add up.

The most frustrating of these scenarios is when a patient requests a particular treatment and has the means to pay for the service; but the patient's insurance policy covers preventative and basic treatment only. The policy caps the fee at a rate that doesn't even cover the dentist's hard cost for the service, thus leaving the dentist unable to render the service. While the patient doesn't care about cost, the dentist would be breaking their contractual agreement, which was an all or nothing policy, by allowing the patient to pay for the services. Thus, the dentist can not render the treatment.

Patients lose when they are not able to choose their course of treatment. Taking the decision process and eliminating advanced procedures and techniques puts a ceiling on the quality of care a patient can receive. The breakdown of this process starts with the contract the dentist signs with the insurance company, not necessarily the insurance the patient purchases.

In September 2012, the NDA Legislative Committee, along with Executive Director Bob Talley and our lobbying team, Ferrari Public Affairs, set out to educate lawmakers that passage of a bill banning the capping of non-covered services would benefit consumers. By passing language developed by the National Conference of Insurance Legislators (NCOIL), and following the lead of more than 30 states, the NDA demonstrated that passage of this law would benefit Nevada consumers.

The NDA team met with almost every post-primary legislative candidate, to educate them on this issue. This literally translates to hundreds of meetings. After countless hours, conference calls, meetings, dinners, lunches, emails, and texts, between NDA members, committees, and legislators, the legislative team was ready.

SB 497 was introduced to the Committee on Commerce, Labor and Energy on March 25, 2013. Being involved in the legislative process is an endless emotional rollercoaster that hits highs and lows around each corner. The Bill passed unanimously out of committee and the full Senate. It was then introduced to the Assembly in the Ways and Means Committee, which it passed and eventually passed the Assembly floor with a vote of 40–1.

SB 497 was signed into law by Governor Sandoval on May 29, 2013 and was effective immediately. The entire bill can be read at: www.leg.state.nv.us/Session/77th2013/Bills/SB/SB497_EN.pdf

The pertinent parts of SB 497 are: *Insurance carriers will not be allowed to cap fees on non-covered services.* You can charge your customary fee for services not covered in an insurance policy. However, dentists will have to extend the contracted fees on "covered services," even after a patient reaches their plan maximum.

The passage of SB 497 was a major victory in the preservation of the dental profession in the Silver State. The NDA team also successfully defeated several bills which would have negatively regulated and added cost to the business of dentistry.

SB 497 started out as a very divisive issue from our membership. I commend my colleagues for working diligently to make this effort happen. This was a great exercise to show how we can be successful when we work together.

The NDA Executive Committee has already set its sights on the 2015 Session and fundraising is in order. Political campaigns have kicked off and the NDA legislative team is taking action. Organized dentistry needs the support of all practicing dentists in Nevada. Please reach out to your local society component to help further our industry's success. ◆

Save the date: *The SNDS dinner meeting on October 8 at the Gold Coast Casino features a presentation on implementing the SB 497.*

HI-TECH is here, are we ready?

By Wendy Woodall, DDS and Rick Thiriot, DDS, MS

Dentists need to be aware of the changes effecting privacy of patient health information. These changes may carry significant fines/penalties for non-compliance. The Health Information Technology for Economic and Clinical Health (HI-TECH) Final Rule was passed Jan. 25, 2013, and became effective March 26, 2013.[1] The compliance date was Sept. 23, 2013 (with a few exceptions). The federal Department of Health and Human Services (HSS) is the governing body, with enforcement allocated to the Office of Civil Rights (OCR) for protected patient health information security and access.[2] The OCR is directed to assure privacy, security and enforcement of HIPAA, as well as the new HI-TECH regulations.[3]

Dentistry has responded to the prior rules for Protected Health Information (PHI) security, through the use of consents for disclosure, and modifying practices. These modifications include removing 18 identifiers [4] from patient data prior to using such data for research, education, presentations or publications. These identifiers are:

- Name
- Social security number
- Postal address
- Email address
- Telephone number
- Fax number
- URL address
- IP address
- License number
- Account numbers
- Medical record number
- Health plan beneficiary number
- All elements of date except year
- Device identifiers and serial numbers
- Vehicle identifiers and serial numbers
- Full face photos and comparable images
- Biometric identifiers
- Any other unique ID number, code or characteristic

Major changes in the Final Rule

Any paper or device holding electronic PHI that is compromised or lost, requires the patient to be notified—whether or not that information is accessed or utilized. Dentists need to take that final step of shredding papers, removing identifiers from information, shrinking and/or locking computer monitors while not in use, utilizing passwords and encryption whenever possible, wiping or destroying retired hard drives, and encrypting email and devices (including mobile phones, if patient information is sent or accessed). An incident log will assure notification to the patient, as well as improve your work standards. Exemption from fines is allowed only through encryption.[5]

Another change is, put in place broad and strong Business Associate Agreements (BAAs). For every company a dental office engages, which might have access to PHI of your patients, a strong BAA is needed to specify the extended HI-TECH rules. This may encompass laboratories, janitorial services, maintenance contracts, accountants, electronic insurance processing companies, computer systems, etc. This agreement should also specify how those entities will assure reports of compromised data, if any, from themselves or any subcontractors. Items to include encompass performance standards (manner of notice, time of notice, etc.) If a current BAA exists, the compliance deadline extends to March, 2014 for implementation of contract addendums.[6]

Keep in mind that the HI-TECH Final Rule requires specific consent for certain additional items such as fundraising, research and grants, and marketing. Dental offices should review their Notice of PHI and add any additional statements or new consents to their workflow to assure compliance. For instance, be sure to have consent prior to mailing/emailing patient communications or leaving text or phone messages.[6]

Starting new systems in health care can be very successful or very frustrating. Some systems which help the former come with gaining information, envisioning the goal, conceptualizing the pathway, training, and moving forward with implementation, including professional legal review of these guidelines. The ADA has always served as an excellent resource through these changes, and we encourage you to consult their publication, "The ADA Practical Guide to HIPAA Compliance Privacy and Security Manual."[6]

We all want safe health protected information as we move toward health exchange networks. With careful planning, we will all succeed in this final HI-TECH process. ◆

Wendy Woodall, DDS and Rick Thiriot, DDS, MS, are the Associate Deans of Clinical Services at UNLV SDM.

Resources

1. www.hhs.gov
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Understand the rules

By Kathy Bassett, RDH, Med; Sean G. Boynes, DMD, MS; Art DiMarco, DMD

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Dental hygienists are well suited to administer local anesthesia to their patients, yet some state practice acts still limit or prohibit their provision of this important service.

Dental hygienists first began administering local anesthesia 40 years ago in the state of Washington, yet there are still six states that prohibit dental hygienists from administering local anesthesia. Dental hygienists are well-qualified to provide local anesthesia, which ensures patients can comfortably receive the level of care indicated without unnecessary pain.

The state regulations that govern the administration of local anesthesia can be confusing. A clear understanding of the types of local anesthetic injections used in dentistry is imperative to deciphering state practice acts.

Safety considerations

Some states limit dental hygienists to administrating infiltration injections only. The argument is that infiltration injections are easier to perform and provide a higher level of safety than nerve block anesthesia. A published argument against dental hygienists performing nerve block anesthesia stated that intraoral block injections, because they involve injection into main neurovascular bundles of larger areas of the mouth, are far more complicated procedures. Therefore, this type of injection has a greater potential for causing serious problems such as hematoma, permanent or partial paresthesia, stroke, cardiac arrhythmia, and syncope.[1] There are no comparative studies, however, that show infiltration injections are less likely to cause adverse outcomes than nerve block anesthesia. In fact, reports demonstrate that the adverse occurrences following nerve block anesthesia can also happen during infiltration injections.[3-5]

Safety relates more to the overall preparedness and performance of the administrator than the type of injection being used. Numerous studies have assessed the safety of dental hygienists administering infiltration and nerve block anesthesia. Anderson[5] and Lobene[6] reported nominal rates of complications resulting from the administration of local anesthesia by dental hygienists. Lobene reported that out of 19,849 administrations by dental hygienists, only three cases resulted in adverse consequences. Anderson's survey reported that 88% of dental hygienists did not describe any complications when administering local anesthesia. The safety of local anesthesia administration by dental hygienists also has been validated through the lack of disciplinary action. Analyses conducted in 1990 and in 2005 found no complaints reported to state boards or the American Dental Hygienists' Association (ADHA) against dental hygienists for local anesthesia administration.[7]

State practice acts

Forty-five states and the District of Columbia include local anesthesia in their dental hygiene practice acts. Alabama, Georgia, Mississippi, North Carolina, and Texas have practice acts prohibiting dental hygienists from administering local anesthesia.

Although local anesthesia is given worldwide to ensure comfortable patient care, there is a lack of standardized criteria regarding educational requirements, credentialing, and utilization by dental hygienists. Despite being educated and experienced in one state, dental hygienists may not be able to transport this training to other states due to varying state regulations.

Supervision of dental hygiene practice—direct (dentist must be onsite) or general (the dentist need not be onsite)—varies based on location. Furthermore, direct supervision generally means that not only is the dentist present, but also capable of responding should an emergency arise. Currently, 38 states require direct supervision of dental hygienists administering local anesthesia while five allow general supervision (Alaska, Colorado, Idaho, Minnesota, and Oregon). Nevada's state dental hygiene statutes do not make a distinction between direct and general supervision.[8]

Despite the overwhelming adoption of local anesthesia delivery by dental hygienists—and demonstrated safety of its use for more than 40 years—four states (Maryland, New York, South

Carolina, and Virginia) restrict the use of nerve block anesthesia by dental hygienists. Virginia allows nerve block administration by dental hygienists only on patients 18 years and older.

The biggest obstacle to the portability of local anesthesia skills, as well as general practice licenses, is individual state credentialing policy. Credentialing by examination is required by 27 states, although the basis of this exam varies across the 44 states and can include: successful completion of a written and clinical regional exam, a written-only regional exam, or documented completion of a course provided within a Committee on Dental Accreditation (CODA)-accredited dental hygiene program. Additionally, these courses must be approved by individual state licensing agencies. For example, in order for a dental hygienist to be credentialed for local anesthesia in Maryland, he/she must complete a course with no less than 20 hours of lecture and 8 hours of lab/clinical practice. In Minnesota, the course must include no less than 15 hours of lecture and 14 hours of lab/clinical practice, while in other states, such as Washington, the hours of the course are determined by the educational programs themselves.

Statute vs. rule

The nature of the authority governing dental hygiene practice is generally statute or regulation. Statutes and regulations are formally written legislation that have governance authority and are issued as legislative law. Statutes declare policy by commanding or prohibiting something. Dental hygiene practice may also be governed by state rules. Rules differ from statutes in that they can be adopted and drafted by a government agency in response to an Administrative Procedure Act or to exercise and delegate authority to a board. These rules have the force of law and impose new duties on the regulated parties but they are not incorporated into legislated definitions of the professional practice act and may be more easily modified by a supervisory agency.

Of the states authorizing the use of local anesthesia by dental hygienists, 27 have professional statutes and 17 have rules. There is no established relationship between the nature of practice authority and the requirement of examination. Portability of licensure is influenced most by hours of education, the range of injection techniques an individual is trained to administer, and previous examination. For state-specific information, see the Local Administration by Dental Hygienists State Chart at www.adha.org.[8]

Administration patterns

Regional and state variation is not limited to regulation, but also by how dental hygienists administer local anesthesia. Dental hygienists practicing in the Western U.S. report the most frequent use of local anesthesia injections and they are most likely to administer for the entire dental office.[9,10] Review of the data reveals a true West Coast to East Coast phenomenon—the regularity of dental hygienists administering local anesthesia decreases from west to east. In addition, dental hygienists practicing within the Western half of the country are more likely to administer nerve block injections than their colleagues in the East. This pattern is likely influenced by the fact that Western states have permitted local anesthesia injection by dental hygienists for the longest period of time; the oldest dates of introduction correspond to the highest utilizations.[9]

A recent study conducted at the University of Pittsburgh found that the type of practice in which a dental hygienist is employed dictates local anesthetic administration utilization.[10] The study showed that dental hygienists who worked in periodontal offices administered a greater number of injections than their colleagues in other types of practices. Those working in academic settings provided more field block injections than others surveyed. The study also determined that dental hygienists employed in pediatric dental practices were the least likely to administer local anesthetic injections.

Additional research also demonstrated the variation in anesthetic administration by practice type. In a survey of Minnesota dental hygienists, Anderson found that 47.6% of dental hygienists working in periodontal offices reported administering local anesthesia for three to six patients each week, while 63% of dental hygienists working in general practice administered local anesthesia for one to two patients each week.[5] These findings are not unexpected because the types of procedures performed, along with the severity of disease encountered by periodontal specialists, usually require more frequent pain control. It is interesting to note that dental hygienists working in the academic environment were the most likely to perform field block injections. This may be attributable either to the need for educators to provide students with a well-rounded injection portfolio or to help students better appreciate the differences between field block injections and infiltration injections.

Using data collected by investigators at the University of Pittsburgh, a new analysis was completed to determine differences in practice type and the administration of local anesthetic to patients being treated exclusively by the dentist.[9] In the original report, 58.4% of the respondents who reported administering injections delivered local anesthesia for the procedures in which the dentist was to perform total care.[11] The new evaluation revealed that dental hygienists working in a periodontal setting were the most likely to administer local anesthetic for the

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dentist's patients followed by public health, general dentistry, academia, and pediatric dentistry. These findings are similar to the frequency of injection type and most likely are a result of patient and practice need.

Conclusion

The practice of local anesthetic administration by dental hygienists is limited by statutes or rules that apply only to those practicing in that state. Included in these statutes and rules are supervisory authority and injection categories that often differ between states. Limitations on dental hygiene local anesthesia scope of practice may reflect fears of potential injury in the hands of dental hygienists; however, there is no published evidence of an increased incidence of adverse events, regardless of the varying scope of practice in the United States. ◆



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Hygiene, hygiene

By Heather Rogers, BSDH

When I became a hygienist in 1999, I remember being incredibly concerned that I was extraordinarily passionate about every aspect of dental hygiene—infection control was at or very near the top. My first memories of school focused on how to wash hands, properly set up a room, properly break down a room and how to keep it all clean in the process. We are called "hygienists" after all.

I was quite happy when I became a practitioner and realized that I would not be removing 8 pounds of plastic wrap after every patient. I was so happy! I may actually be able to treat patients and "keep it all clean in the process" in an hour. However, as we know, all is not perfect in dental land.

One of my first memories as a practitioner is forgetting to be a team player and telling a seasoned dental assistant not to put her bare hands in an ultrasonic to remove the newly washed surgical instruments. Needless to say, I've encountered other indiscretions, probably committed a few, and have wondered for years how to make this better.

Imagine my surprise when I was completing my bachelor of science in dental hygiene and discovered that the board of dental examiners would now require four continuing education credits to renew our licenses every other year. I had found the subject for my capstone project, and possibly the answer to my silent prayers.

I didn't expect to be speaking about this or even writing about it three years later. I truly expected to give a two-hour presentation and be done with it. The research and subject matter are dull. The effort to keep it interesting is tremendous. Why keep it up? Frankly, because of my colleagues and like I stated before; I may have been hoping for this all along.

I've had the opportunity to give classes for professional associations, study clubs, and in private offices. What I've discovered has been a bigger surprise than everything else to date. I've spent hours assuring my clients and students that all will be well and that their concerns though warranted, need not become obsessions. I've encountered many practitioners, front to back office, that are so worried that they are doing things correctly; I've completely changed my perception of infection control in dental settings.

Now, my biggest focus is teaching an efficient and safe way to observe CDC Guidelines without creating a lot of stress or expense for the office. Plus, I'm having a lot of fun in the process. This isn't quite the chore I'd expected, nor is it as overwhelming.

The board of dental examiners is interested in helping you with anything you may need in order to keep your office staff, practitioners, and patients safe. If you visit their website you can find the form used by the infection control inspectors when they visit dental offices. The simplest way to attack this list is to cross off everything you have in place and then begin to address the items that need attention.

One thing on the list which may come as a surprise is paperwork. Employee files, vaccination records, exposure protocols and reports, employee training, etc. These files can be digital, but they do need to exist and be up-to-date. This is an opportunity to get your MSDS Notebooks in order, too. Keep it alphabetized and make sure that if you have it in the office, you have a sheet for it. If it's not being used, this is a great time to dispose of it according to manufacturer's instructions.

The CDC recommends you have an infection control coordinator. I recommend the whole office be a member of the team. It's a good idea for everyone to be informed in case of an exposure or an inspection.

In the event of an exposure, don't panic; just go to the National HIV/AIDS Center Clinicians Consultation Center and look up the National Clinicians' Post Exposure Hotline. The website has a link to guidelines for exposures and a phone line with staff to help you from 9AM–2AM eastern standard time.

Clean up counters and implement a housekeeping protocol. Remember the front office area. Bacteria is airborne and can contaminate every surface. Keep single use items in one area separate from multiple dose products. Keep clean instruments stored in closed cabinets or drawers. If you don't need it for the treatment,

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Resources

www.nvdentalboard.nv.gov

National HIV/AIDS Center Clinicians Consultation Center:
www.nccc.ucsf.edu/home

National Clinicians' Post Exposure Hotline:
888-448-4911

Alfred Civilion Fones *Father of Dental Hygiene*

By Shari Peterson RDH, M.Ed.

Although dental hygiene practice dates further back than its cited inception in 1913, the preventive focus of this new profession was emphasized when Dr. Alfred Civilion Fones coined the term dental hygienists in the early 1900s. The change in title from dental nurse to dental hygienist focused on the preventive dental sciences. After research results on the preventive benefits of dental hygiene were published, the college discipline of dental hygiene was created.

Even though prevention was being discussed and even practiced in some offices, it was Fones who actually brought dental hygiene into existence. He saw it as a distinct profession and thought it should be positioned within dental public health as opposed to being offered only in private dental practices. In fact, Fones believed that the dental hygienist should provide education and treatment outside the dental office with particular focus on mass pediatric prevention. He emphasized the use of dental hygienists as outreach workers "outside" the dental practice to bring patients in need of restorative dental care to private dental practices while providing preventive services outside the dental practice, such as in a school setting.

Fones educated the first dental hygienist, Irene Newman, for one year before he permitted her to treat patients in his practice. In 1913, he started the Fones School of Dental Hygiene, which continues to educate dental hygienists today within the University of Bridgeport in Connecticut. Before he opened his school and working within the Bridgeport public school system, Fones initiated the dental hygienists' role in public health by developing curricula for dental hygienists.

Fones envisioned dental hygienists working collaboratively with health and social service workers to provide preventive health care to the public. He first introduced the profession to the public school system, hospitals administrators and professional health care organizations. The dental hygienist was widely accepted within the school system and public schools became the first employment setting for the first dental hygienists. As the interest in the profession progressed, Fones traveled the country to explain the new profession of dental hygiene to state dental associations, but most were opposed to it because preventive dental science was a new concept. When the profession was accepted, many state dental associations advocated for laws that prohibited dental hygienists from working in any setting other than a private dental practice with a dentist supervising all treatment.[1] ◆

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keep it stored. All unnecessary items should be safely out of sight.

Finally, a number 2 in a circle with a slash through it means you can only use it once. If it's a throw away item use it once and throw it away. Masks and gloves can be worn for about an hour and then they are no longer protecting you or your patients. Take a break during long procedures and replace your mask and gloves. Remember, when you take gloves out of the mouth and they have saliva on them you will need to wash your hands before donning another pair.

Like I said before, this can be an answer to a prayer. I believe that every one of us has wished for better education and awareness when it comes to more complete infection control practices. This is an opportunity to take advantage of a directive and make it work for us and our patient's. Why not be safer and happier in the process?

My favorite saying is, "Did we ever make someone sick from overdoing it?" The answer is no, and that includes ourselves. However, the simple observation of CDC Guidelines to provide the most comprehensive infection control in our offices is simple and easy to apply. We don't have to "overdo it." Also, if we keep the entire office in mind, we have an even better excuse to be more diligent in safe practices. Let's not forget, we're protecting ourselves *and* our patients. ◆

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Chronology of dental hygiene

By Shari Peterson RDH, M.Ed.

1913 Dr. Alfred Civilion Fones establishes the first Dental Hygiene Program in Bridgeport, Connecticut.

1914 First class of dental hygiene graduates was composed of 27 dental hygienists and immediately went to work in public schools.

1915 First dental hygienist employed outside of the public school system at New Haven Hospital.

Connecticut Dental Practice Act defines the practice of dental hygiene.

Irene Newman

1916 Columbia is the first school of dental hygiene to have definite educational requirements.

1917 Irene Newman, the first dental hygienist, becomes the first licensed dental hygienist.

1918 Forsyth School for Dental Hygienists opens. First school dedicated solely to the education of dental hygienists.

1919 Minnesota institutes a two-year Dental Hygiene Program.

1920 Six states have licensed dental hygienists.

1923 The American Dental Hygienists' Association (ADHA) is organized with 46 members.

1926 30 states have licensed dental hygienists.

1927 The *Journal of the ADHA* begins as a monthly publication.

1939 University of Michigan offers a baccalaureate degree in Dental Hygiene.

1945 New Jersey forms the New Jersey Dental Hygienists' Association although dental hygiene practice in not legal in the state.

Grand Rapids, Michigan becomes the first city in the world to fluoridate its drinking water.

1947 ADHA adopts the Minimal Standards for Dental Hygiene programs.

1948 ADHA adopts the Oath for the profession. The oath is still recited at dental hygiene pinning ceremonies today.

1949 ADHA adopts the term "registered dental hygienist" as the official credential of the profession.

1951 The American Dental Association Council on Dental Education sets the standards for the education of dental hygiene.

1952 All states license dental hygienists.

ADA begins accreditation of dental hygiene programs.

1958 Fully reclining dental chair invented.

Sigma Phi Alpha is founded by Esther Wilkens, Margaret Baily, Janet Burnham, and Evelyn Mass.

1960 Columbia University is first to offer a Master's degree in Dental Hygiene for teachers.

1961 ADHA establishes Nevada charter.

1963 Dental therapist education program is reintroduced in New Cross, England.

1965 Jack Orio becomes the first male dental hygiene graduate from University of New Mexico.

1968 First Regional Board Examination given (Northeast Regional Board Exam).

1971 Washington State is first to include administration of local anesthesia by dental hygienists.

1973 Iowa develops expanded functions program, including placement and carving of amalgam restorations.

1974 Dana Godbout Laake becomes first dental hygienist to serve on a dental board (Maryland).

1984 Washington State is the first with unsupervised practice for dental hygienists in hospitals and nursing homes.

1986 ADHA adopts a baccalaureate as the minimum degree for entry into the profession of dental hygiene.

1987 Colorado passes first law allowing unsupervised practice for all dental hygienists in all settings.

1994 New Mexico is the first state to have a self-regulatory dental hygiene committee.

1998 California creates the Registered Dental Hygienist in Alternative Practice license to practice unsupervised in alternative settings.

2008 California establishes the first self-regulating Dental Hygiene Committee separate from the dental board of California.

14,000 dental therapists in 53 countries around the world.

2009 Minnesota passes law to educate the Advanced Dental Hygiene Practitioner which is a combination of dental hygiene and dental therapy.

2011 First advanced dental therapists graduate in Minnesota.

2012 California law states that the Dental Hygiene Committee of California *may* approve a CODA-accredited program instead of *must* approve, allowing the regulatory board control over dental hygiene education.

2013 100 years of dental hygiene practice is celebrated.

For a more detailed timeline and photos, visit the American Dental Hygienists' Association, "Celebrating 100 Year of Dental Hygiene" timeline at www.adha.org

History of dental hygiene at the College of Southern Nevada

By Shari Peterson, RDH, M.Ed.

The profession of dental hygiene has progressed significantly in the state of Nevada and has kept pace with most other states in regards to the duties delegable to dental hygienists, supervisory requirements and places of practice. Although the first dental hygienist Irene Newman was granted a license to practice in 1917 it wasn't until 1947 that Nevada granted the first dental hygiene license.

According to Barbara Nelson RDH, M.Ed., "There were only three dental hygienists that I knew of when I obtained my Nevada license in 1959." At that time there was no National Dental Hygiene Board Exam or State Clinical Licensing examination. Instead, Barbara met the Dental Board at Nellis Air Force Base dental clinic to have them evaluate her skills. When she arrived, a board member instructed one of the sergeants to be her patient. The board members directly watched her provide the prophylaxis to an advanced perio case. After two hours, Barbara indicated that there was no more she could do and she was finished. The examiners checked the patient briefly and said "okay." She then participated in an oral examination given by board members regarding her knowledge of dental materials and preference of instruments. She also recalls that the first dental hygiene meetings were held in the homes of the dental hygienists. The Nevada Dental Hygienists' Association first became an established charter in 1961.

In response to the growing profession, the Clark County Community College dental hygiene program was established in 1977. This occurred at the request of, and in cooperation with, progressive members of the dental profession in Nevada. The original program and clinic was located at the Cheyenne Campus on the second floor of the science labs above the planetarium and child care facility.

Barbara Nelson, RDH, MS, was recruited as the first program director. She and three additional faculty members developed the curriculum for the first accepted class of 12 students. Dr. Raymond Rawson was employed part-time the first year to teach Head & Neck Anatomy and by the second year was hired full-time as the program supervising dentist.

Five program directors have led the program over the span of 36 years:

Barbara Nelson
Adele Koot
Theresa Raglin
Doreen Craig
Shari Peterson

Since 1979, the program has graduated 648 dental hygienists with Associate degrees and an additional 94 dental hygienists have been awarded a Bachelor of Science in Dental Hygiene. ◆

1977 Clark County Community College dental hygiene program established.

1979 The program graduated their first class of 12 dental hygienists.

1984 Nevada State Board of Dental Examiners approved the administration of local anesthesia for dental hygienists. Local anesthesia added into the curriculum.

1988 The program moved to the West Charleston Campus and class size increased to 14 students. Lily Fong donated the land and Claude I. Howard provided funding for a health sciences building which housed the new 14-chair clinic.

1990 The Board of Regents approved the addition of a Dental Faculty Practice so that all dental hygiene students could observe the activities of the dental office.

1991 The institution changed its name to the Community College of Southern Nevada.

1994 A second 20-chair clinic was built on the West Charleston Campus and class size was increased, first to 24 students and later to 30 students.

2007 The institution changed its name to the College of Southern Nevada after establishing the Bachelor of Science Dental Hygiene degree.

Dental hygiene celebrates 100 years,

TMCC dental hygiene program celebrates 13 years

By Patti Sanford, RDH, MA and Julie Stage, RDH, MPH

Dental hygiene, as a profession, began 100 years ago in Bridgeport, Conn. Alfred C. Fones, DDS, considered the "father of dental hygiene," became convinced of the importance of the prevention of oral diseases. Much of his dental practice involved the extraction of diseased teeth and through dental education, he learned that bacteria caused tooth decay. This prompted him to focus on the control of bacteria in order to save people from the pain and loss associated with tooth decay. He trained his dental assistant, Irene Newman, to remove bacteria from their patients' tooth surface and perform the duties of what he would later call the "dental hygienist".[3]

In 1913, with the help of Irene Newman, Fones opened the first school of dental hygiene. Their first class graduated in 1914. In 1915, the state of Connecticut approved licensing dental hygienists. Irene Newman received the first dental hygiene license in 1917.

Dental hygiene licensure grew from three states in 1917 to all 50 states by 1951. In 1934, there were 16 dental hygiene education programs in the U.S. This grew to 34 by 1935, and today there are 334 entry level programs.[1]

In his focus on prevention, Fones believed that the role of the dental hygienist should include preventative education in good oral hygiene practices for all individuals. He encouraged dental hygienists to provide classroom education for school children in the proper toothbrush usage, hand hygiene, and nutritional counseling.[4] This focus on prevention continues in our educational programs today. Students in dental hygiene programs participate in community service and outreach by visiting schools, senior centers, nursing homes, health fairs, and Head Start programs providing preventative oral hygiene education.

> The dental hygienist must regard herself as the channel through which the knowledge of prevention that the dental profession has acquired is to be disseminated. The greatest service she can perform is the slow and painstaking education of the public in mouth hygiene and allied branches of general hygiene. It must always be borne in mind that the aim of the dental hygienist is to secure extreme cleanliness of the mouth in an effort to starve bacteria and render them inert.[2]
>
> —From the textbook, *Mouth Hygiene*, by Alfred C. Fones, DDS

Other dentists involved in the early days of preventive dentistry include Thaddeus P. Hyatt, DDS, considered the "father of preventive dentistry" due to his strong advocacy for preventive oral health concepts. David Smith, DDS, was called the "father of dental prophylaxis" for developing a system of hand polishing followed by scaling of the teeth and G.A. Mills, DDS, wrote a paper entitled, "How to Keep the Teeth Clean and Healthy."[1]

The history of dental hygiene would not be complete without including Esther M. Wilkins, BS, RDH, DMD, professor emerita at the Tufts School of Dental Medicine in Boston. She is the author of the textbook, *Clinical Practice of the Dental Hygienist,* now in the 11th edition. As a dental hygienist and periodontist, Dr. Wilkins was a very influential educator and mentor to dental hygienists throughout the world from the 1950s until today.[1]

Dental hygiene program at Truckee Meadows Community College

The dental hygiene program at Truckee Meadows Community College (TMCC) evolved in 1995 as a result of two problems that were a common topic of discussion among the members of the Northern Nevada Dental Society (NNDS). The first, being a shortage of licensed dental hygienists in the area, the other being the large number of students who were academically prepared, but not able to get into the only dental hygiene program in the state at Community College of Southern Nevada (CCSN).

With encouragement by Dr. David Dinner, then-president of the NNDS, Dr. Gene Pascucci contacted the Nevada State Senator and Dental Hygiene Program Director for CCSN, Dr. Ray Rawson, about the problem in the north. When asked about the number of Northern Nevada students CCSN program had accepted within the last five years, Dr. Rawson admitted that the number was zero. At the time, Las Vegas was experiencing a dental hygiene shortage of its own. Even with the expansion of their program,

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CCSN was having trouble meeting the needs of their community. During this time Dr. Rawson was also creating the new dental school in Las Vegas.

Meanwhile, Dr. Pascucci recruited Dr. Bill Wager, and Kathy Champagne, then-secretary of NNDS, to meet with him, Dr. Rawson and administration at TMCC to determine if there was an interest in developing a dental hygiene program. TMCC had the physical space, but developing an academic program would require a significant budget, Board of Regents approval, curriculum development, equipment, clinic construction, and faculty.

While Dr. Rawson was instrumental in ear-marking legislative monies, the school needed to raise about $225,000 in addition to the $225,000 the Board of Regents committed. Through the donations and efforts of the NNDS members, the money was raised. As a result of their successes, TMCC won an award from a national watch group in Washington, D.C., based on the creative partnership between the community dental society, the Nevada legislature and the community college.

In the summer of 1996, an ad hoc committee of the TMCC Dental Assisting Advisory Board explored the feasibility of creating a dental hygiene program. In 1997, the school conducted a needs assessment survey validating the need for more licensed dental hygienists in Northern Nevada.

In March 1998, Laura Webb, RDH, was hired as a consultant to develop a skeleton curriculum and write dental hygiene course learning outcomes. After a national search, she was hired in September 1998 as the first director of the TMCC Dental Hygiene Program, where she served until 2005.

In 1999, under Webb's guidance, and in collaboration with Julie Muhle, CDA, the TMCC Dental Assisting Program Coordinator, the dental assisting clinic was remodeled and expanded

to accommodate both the dental assisting and dental hygiene program needs with state of the art equipment that included ten dental units.

By July 1999, Julie Stage, RDH, was hired as the first full time dental hygiene faculty member. Together, Stage and Webb continued developing curriculum, clinical policies and procedures, working on accreditation and preparing the clinic for its first class of 12 dental hygiene students who began their two-year program in January 2000. Dr. Mario Gildone was hired as the first clinical supervising dentist. The first class graduated in May 2001, and the program received full CODA accreditation in July 2001.

Based on their National Dental Hygiene Board scores, TMCC's first graduating class ranked #3 in the U.S. among approximately 200 associate and bachelor degree programs that were in existence at the time. TMCC Dental Hygiene Program students continue to score very high on their National Board exam, but as of 2007, programs are no longer ranked. TMCC students also have excellent passing rates on state and regional clinical exams.

Vickie Kimbrough-Walls, RDH, replaced Laura Webb as Program Director from 2005–2011. Through Kimbrough-Walls' efforts, a grant was obtained to purchase computers for each of the ten dental units—moving the TMCC Dental Clinic into the technology age! Grants were also obtained to purchase digital x-ray equipment and dental software.

In 2013, a $300,000 Pennington Foundation Grant was acquired for major expansion of the dental clinic— adding two dental units, a digital panoramic x-ray machine, a renovated dental lab, additional storage, and distance education capabilities. The renovations will be completed by fall 2013. Many thanks go to Julie Muhle, Patti Sanford and the TMCC Institutional Advancement Division for their efforts in writing the grant and coordinating these efforts!

In 2008, the economic downturn hit Nevada very hard, and for the first time since its inception, TMCC graduates started having a difficult time finding employment. As the economy slowed, state funding to higher education was effected. In 2011, TMCC's budget was negatively impacted and the Nevada System of Higher Education had to make major cuts. To reduce the overall expenses for TMCC, the dental hygiene program had to let go the majority of their part-time faculty. As a result, they would not be able to meet the CODA faculty-to-student ratios in clinical courses (one instructor to every five students), so it was decided that no new class would be accepted for the fall 2011 semester. There would be no dental hygiene graduating class in 2013.

Rumors flew in the Reno dental community that the TMCC dental hygiene program was closed. *Not true!* The class of 12 students who started the program in 2010 graduated in May 2012. A class of 12 began in Fall 2012 (graduating in 2014), and the program is alive and well! In fact, a class was just accepted for fall 2013 (graduating in 2015). Once again, there is a first- and second-year cohort!

When Kimbrough-Walls left at the end of the 2011 academic year,

Julie Stage, RDH and Patti Sanford, RDH, agreed to serve as interim co-directors during the transition. They served in this capacity through June 2013. As of July 2013, Lori McDonald, RDH, is the director. She will serve the program well, as she worked as both a part- and full-time instructor in the program for seven years.

Since the early years of the TMCC dental hygiene program many local dentists (and hygienists) have shared their academic and clinical expertise with the students. Dentists who have worked the most hours include, Drs. Greg Eissmann, Jim Davis, Gerald Jackson, Dayton McDonald, Rosalyn Wright, William Downey, and David Lund. Drs. Eissmann and Lund remain involved in both clinical and didactic courses. Other dentists have served as members of the TMCC DH Program Advisory Board, including Drs. William Rohel, Ken Lang, Bill Wager, Gene Pascucci, Mary Papez-Berg, and the late-Dr. Joel Glover.

Without the support of the local dental community, the TMCC Dental Hygiene Program would not exist. As they say, "if you build it, they will come." To date, TMCC has graduated a total of 144 dental hygienists, the majority of whom have remained in Nevada, with some even moving to the rural areas where the need is always the greatest. Through the inspiration and efforts of a few devoted individuals, a great dental hygiene program has evolved—one that serves the needs of our community and state, and is a flagship program for the college. ◆

Note: We acknowledge and thank Gene Pascucci, DDS and Laura Webb, CDA, RDH, MS, for their help with recalling the historical events that led to the start of the TMCC Dental Hygiene Program.

Patti Sanford, RDH, MA is an instructor at the Truckee Meadows Community College Dental Hygiene Program.

Julie Stage, RDH, MPH is an instructor at the Truckee Meadows Community College Dental Hygiene Program.

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As great as summer is, there's something nice about settling back into our usual, productive routine. Of course, at the SNDS, our busiest time of the year is the summer, as we get ready to launch our program year in September.

As I write this, our Community Night in September hasn't taken place yet, but it will be history as you read this. If you attended, you know it was perhaps the most significant member meeting we've had in some time—we launched new member benefits, programs, and revitalized our society. Even if you weren't able to attend, the ripple effect of Community Night should still be rolling out, and I hope you are now aware of our new way of doing business. Essentially, we are re-affirming the priority of putting our members first, and being the best value we can be—while giving the best service possible.

One of the new benefits you may want to look into is our connection with AMS Insurance. They work with over 30 different insurance programs, and can provide our members with insurance ranging from professional liability to homeowners insurance, car insurance, and health and life insurance. Of most interest, though, is that SNDS member dentists get their insurance at a significant discount. This can mean a significant savings. In some cases, our members have seen savings that put a major dent in their membership dues! For AMS contact information, call the SNDS office, we'll be happy to pass it along.

Look forward to spring cleaning next April, when we hold our first annual Shredding Day! We'll have a truck on hand at the SNDS office to shred all of your old records and papers, *free*, for members. Watch for details, but we're planning on making it into a party, with food, refreshment, and, of course, free shredding.

Another benefit many members don't realize is our range of CE programs. We have our Premier Series, which is a set of four all-day lectures. See our lineup for the new season in Dr. Blasco's report (page 25). These seminars provide a great value, with world-class speakers right at your door, for as little as $187.50 per seminar!

We record many of these lectures, and have them on-hand at our office for our "CE On Demand" program. You can set up a time and come in and watch a seminar you missed, or make up your CE hours, if need be.

Perhaps you'd like a more informal, social experience. Then you'll like our CE Café series. This is a series of six, two-hour seminars held during the week, after work. Come early, have a sandwich and soda, and then enjoy a very engaging seminar. Each of the six seminars in the CE Café series provides two CEUs, or a total of 12 CEUs for the series, and they are *free* to SNDS members!

Also free for members are our SNDS Member dinner meetings. We now hold eight of these meetings each year, and, along with dinner and conversation, we have a variety of speakers and topics. Each dinner meeting provides one CEU, too!

So, just by paying your dues, you can attend the CE Café series and pick up 12 CEUs, plus attend our dinner meetings and pick up another 8 CEUs, for a total of 20 CEUs. That's your annual requirement for licensure! You can meet that requirement simply by joining the SNDS and participating!

There is much more, of course, so I hope you'll stop by our next member dinner meeting, or CE event, and find out about all the things going on with your SNDS! ◆

As I write this report, I must begin by thanking my friend, colleague, and predecessor Brendan Johnson for passing along to me an organization that is functioning well. I look forward to contributing to the continuous elevation of the SNDS.

We've just completed our program year, including our dinner meetings and CE seminar series. We had the opportunity to host a great slate of speakers, which will continue in the upcoming year. Our planning extends to our very popular CE Café series, which is a set of six, two-hour after work seminars (free to members). The CE Café format allows us to present niche topics in an atmosphere that encourages active participation with the speaker and with other colleagues in attendance. Watch for details on the 2013–2014 schedule!

We are also expanding our "CE On Demand" library. This has proven to be a *great* member benefit in which we professionally record our seminars, put them on DVDs, and make them available for members to watch at our SNDS office. This allows members the flexibility to obtain CEUs, or to watch a seminar they may have missed. Viewing is available during our regular office hours.

Then, we offer our mainline CE Series—four seminars with the best presenters and topics we can bring to Las Vegas.

SNDS Board of Directors

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IMMEDIATE PAST PRESIDENT Brendan Johnson, DDS

Our upcoming CE schedule includes:

2013–2014

Dr. Larry Emmot October 1, 2013
Dr. Larry Rosenthal November 5, 2013
Dr. David Hornbrook March 7, 2014
Dr. John Jameson April 4, 2014

2014–2015

Dr. Charles Blair September 26, 2014
Dr. John Kois November 7, 2014
Dr. LeeAnn Brady March 6, 2015
Dr. Gerard Kugel April 24, 2015

The SNDS offers a broad range of member benefits and opportunities for continuing education. For example, members can earn up to 20 credits free with their membership! 8 CE credits by attending our eight dinner meetings, and an additional 12 CE credits by attending the CE Café series. With enrollment in our mainline CE series of four lectures, members also are entitled to a great discount as well as earning an additional 24 CE credits.

We are striving to educate all dentists as to the many opportunities and benefits offered through membership in the SNDS. For a complete list of the multitude of benefits, please contact the SNDS office. It is our desire to provide benefits which our members will utilize and which will allow them to prosper.

The SNDS continues to strive to raise the bar for continuing education and expanding member benefits. In these challenging economic times, it is a bonus that we anticipate this will be the ninth straight year with no dues or fee increases for SNDS members.

We are excited to keep you informed through our improved website, our Facebook page, and our new generation of Prezfax (soon to be renamed.) I encourage you to be involved, participate, and stay in touch with your SNDS. "Like" us on our Facebook page and visit our website at www.sndsonline.org.

Byron M. Blasco, DMD
drbyronblasco@gmail.com

I, along with all those on the SNDS executive board and staff, wish you a safe and happy fall and look forward to seeing you soon.

Some time has passed since I wrote this report, and I regret that it wasn't in the summer issue of the *Journal*. But the information, the excitement, the commitment are all still valid. I want to express to all of our members how different this year will be; how important it will be to stay in touch with our society to learn about new member benefits, new programs, and new opportunities. If there is one operative word that sums up my report over the summer, and now still some months later, it is just that…"*NEW*."

Since we consider the SNDS an association of leaders, the previously known Prezfax will now be known as "*The Leader*."

Watch for information on meetings, seminars and events, and get involved, watch your fax and email, and catch the energy that our Society has in store for you! ◆

Lori Benvin
nnds@nndental.org

This past June, the Northern Nevada Dental Health Program (NNDHP) assimilated the Adopt A Vet Dental Program (AAVD). AAVD (www.adoptavetdental.com) began in mid-2010 as a non-profit dental care program in northern Nevada that assists low-income veterans who do not qualify at the VA. The program was started by a WWII vet's daughter, Linda Haigh, and her husband, Wayne, as a way to give back to our community and help our veterans.

AAVD provides free dental care to northern Nevada's low-income veterans who are in critical need. Although most of these veterans fought bravely for this country, they do not qualify for treatment at the VA Dental Clinic. What's more, they do not have dental insurance, and average a humble income of $900 a month. VA policies are very specific as to who can receive dental treatment at their facility; only about 5% of our local veterans qualify for care. This leaves a large majority of our veterans without access to dental care. Many veterans face poor overall health, self-esteem issues, or cannot secure work because they can't smile or eat. Additionally, most of these veterans do not have a family or support system, which forces them to rely on help from their community and now this program.

NNDHP Board members met with Linda & Wayne Haigh to see how they could help. AAVD was also invited to the NNDS general membership dinner meeting to inform our members on their need for additional providers and for financial assistance. NNDHP knew how important this program was, not only to our veterans, but to the community and unanimously decided to 'adopt' AAVD with our existing low-income children's program. It just made sense since many of our existing providers for NNDHP were also on board as pro-bono providers for AAVD.

Currently AAVD has 97 dental providers including specialists and 14 dental labs. To date, dentists have donated over $850,000 in dental treatment to over 230 veterans. Just this week, we hired a new Dental Case Coordinator and Linda will continue to advocate for the program by writing grants and fundraising.

Additionally, the 11th Annual NNDHP/Joel F. Glover DDS Charity Golf Tournament chose AAVD as its sole beneficiary. Dr. Arnie Pitts was our Chair and we thank all of you who came out to LakeRidge Golf Club on September 27 to help us raise funds for this amazing program and for our veterans.

Watch for upcoming eNewsletters for information about the NNDS 2013–14 Calendar of Events. We will again be offering all dinner meetings at a cost of $35 for members, as well as reduced rates for continuing education courses. Our Executive Board wants to thank our members who support NNDS events by offering lower costs to our valued members; we hope you will take advantage. ◆

NNDS Board of Directors

On June 1, my year as president of NNDS began. This date coincides with the start of the NNDS business year. I would like to thank our Immediate Past President, Jason Ferguson, for his service and for the successful year NNDS had while under his leadership.

The NNDS ended the fiscal year in good financial standing. Our revenue comes from two main sources, membership dues and profit from CE courses. Dues revenue is strong because of the high percentage of dentists who are NNDS members (80%). The other big contributing factor to our financial success is profit from the all-day CE courses and OSHA certification class provided by NNDS. Attendance at these venues can make or break our fiscal year. So, thank you to all who attended a CE function last year and please continue to attend this year.

Your NNDS leaders feel these courses are a good value and enable members to earn all their CE requirements without the added cost and hassle of traveling for CE. We strive to fill the calendar with quality classes that will keep members informed on the current trends in the practice of dentistry.

Another accomplishment for the year was lowering the price for attending dinner meetings to $35. The leadership was hopeful that this would bring more members to dinner meetings, and it worked. The price reduction was also intended as a give-back, or thanks, to our loyal members. It is important to note, the actual cost per person at NNDS dinner meetings is almost $60. The difference is underwritten by NNDS from profit made on CE and OSHA courses. So please attend our CE courses and help keep the price of dinner meetings low. We have filled the coming year with an entertaining calendar of dinner meetings, social events and CE courses.

In August, the annual summer BBQ at Bartley Ranch was another success. Special thanks to Nick Benvin for the delicious barbecued tri-tip, chicken, and all the fixings. If you did not attend, plan to make it next year.

In late August, our Spouses Night at the Reno Aces game was a fun night of baseball and fellowship for all who attended. Also, thanks to NDA President Steve Rose for making the trip from Las Vegas to attend the game.

Frank Beglin DDS, MS
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I look forward to the coming year and the opportunities to interact with our membership at various functions. It is an honor to serve in the leadership of NNDS and I will do everything I can to help us have another successful year. ◆

Welcome New NNDS MEMBERS

Alan Larkin, DMD – Orthodontist
Jeremy Louk, DMD – General Dentistry
M. Wayne Martin, DDS – General
Ben Syndergaard, DMD – Periodontist

UNLV
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School of Dental Medicine

Continuing Education Calendar

November 19
UNLV/Nobel Implant Study Club:
Restoring the Edentulous Mandible w/Locator Abutments
Dr. Brendan Johnson and Dr. John Holtzen

October 12–13
Medical Emergencies in the Dental Office/Monitoring & Sim Man
Dr. Stanley Malamed, Dr. Amanda Okundaye, Dr. Ken Reed

October 18
Real World Endo® Seminar
Dr. Lynne Brock

October 26
AAID Live Surgical Broadcast
Istvan Urban, DDS, MD

October 26
Ridge Preservation: Rationale, Indications and Techniques
Dr. Mauricio Araujo

November 1
Botox and Dermal Fillers
Dr. Jeannie Khavkin, Dr. James Mah, Dr. John Y.H. Ismail

November 21
Implant Dentistry Preceptorship
This program consists of five weekend sessions and assembles faculty from UNLV, Loma Linda University, UCLA, USC, and Midwestern University. The course is designed for both generalists and specialists who seek concentrated curriculum which is evidence-based and clinically relevant. The faculty is comprised of all of the clinical specialties (Radiology, Prosthodontics, Periodontics, Oral Maxillofacial Surgery and Endodontics) of Implant Dentistry and foundational basic sciences. Upon completion of this program, registrants will be eligible for Fellowship Status in the International Congress of Oral Implantologists.

To register for these courses or for information on continuing education at UNLV SDM, visit sdm.unlv.edu/ce.

The "Dental Spa"

By Robert E. Horseman, DDS

We know readers will find this difficult to believe, but prior to 1950 A.D., providers of that era (referred to as "dentists"), did their work while standing upright. Or as nearly upright as they could manage, because after years of attempting to negotiate procedures in the darkened recesses of the mouth, their right shoulders typically were four inches lower than their left. (Unless, of course, they were left-handed or, worse yet, ambidextrous.) Tired of being called "Quasimodo," many turned to barbering, a proud profession whose members still operate standing today, acknowledging that the cutting of hair is less arduous than the cutting of teeth.

In March 1951, brothers Wilber and Orville Wong of San Francisco deferred to their varicosities and tried to operate in a sitting position. Even though the patient's head was a good 10 inches higher than the brothers' heads in this position, the comfort factor was not to be denied. Several months later, smiting their foreheads in unison, they came up with the idea of lowering the chair and tilting it back as far it would go. "Wow! This changes everything!" they cried.

Thus was born the concept of Four-Handed Dentistry. It was also the birth of the high-speed vacuum and the demise of the saliva ejector except as an obligatory prop in comical cinematic portrayals of dental offices.

In the halcyon years following the introduction of four-handed dentistry, many enthusiastic practitioners experimented with six and even eight-handed dentistry until the operatories resembled Grand Central Station during peak hours. This was the result of dentists watching too many emergency room scenes on television where multiple surgeons and their auxiliaries stood four deep around the patient in tense moments of high drama. Eventually the dentists' accountants pointed out that the revenue from an MOD restoration did not support an assisting staff of ten, particularly those who insisted on being paid on a regular basis. The innovative "preventive nurse" whose job it was to teach people for a fee how to brush their teeth, the "nutrition nurse" giving detailed advice on proper diets and the "rover nurse," who filled in when one of the others was busy or indisposed, all quietly faded away.

Thus it has been for the last 35 years—the dentist and an assistant, a hygienist and the front office people doing what they had to do, coping with insurance companies and governmental intrusions. This included experimental forays into providing soothing music via earphones, ceiling-mounted televisions and a tsunami of marketing ploys designed to lull the patient into forgetting that she was a captive audience at her most vulnerable, flat on her back with her mouth wide open.

Exit polls indicated patients, although appreciative of all this programmed TLC, still had one overriding emotion expressed as "hurry up and get this over with and let me get the hell out!"

According to a story in the *Los Angeles Times*, the status quo is in for another crack at patient pacification. A California dentist predicts it will become the cutting edge of this new century. It has been named *"The Dental Spa."*

"This business joins a handful of practices in New York and Texas that have begun serving up paraffin baths and reflexology—even Botox injections," reports the *Times*. Reflexology, for the uninitiated, is the study and interpretation of behavior in terms of simple and complex reflexes. Reflexologists are in short supply as confirmed by the *Yellow Pages*. High school counselors, take note.

The *Holistic Dental Association*, based in Durango, Colorado was founded in 1978 by a handful of dentists wishing to explore and effectively utilize the mind-body connection they perceived to be an important and little understood or used modality in dental treatment. They believed that the patient should be provided with choices that will enhance personal health and wellness while feeling loved, accepted and understood, similar to the feeling you get from flashing an American Express Platinum card.

With that credo, the *dental spa* was born and conventional dentists are observing it carefully to see if full-body massages ought to be combined with tooth whitening at an introductory fee of $350. If so, it is not too early to place a help wanted ad in the paper for a qualified "aesthetician massage therapist." Forward-looking dentists who believe the future lies ahead are saying, "Forget the 60s, that was then, this is *now*!"

Continues ➲

The "Dental Spa"

continued from page 29

When entering the *dental spa*, patients are aware of a new kind of dental office. Strains of "spa music"—normally heard in salons catering to the pampered and plucked—waft gently through air perfumed by delicate scents of tangerine and lavender. Mesmerized patients are invited to forego the old "exam and prophy" routine momentarily and while sipping glasses of pure water with lime and lemon slices, they peruse a menu that includes massage therapy, aromatherapy, facials, cosmetology services, chair-side massages (hands or feet). It dawns on them they are not in Kansas anymore.

A satisfied *dental spa* patient is quoted as saying she was pleasantly distracted from the real business of having her teeth cleaned when a heated cushion filled with flax seeds was placed under her neck. As she surrendered her shoes, she was further pampered with a lotion-enhanced foot massage and a hand massage with a salt scrub, followed by a steaming towel.

Dental students who feel their education at $40,000 per year is sadly lacking in the essentials necessary to make it in today's "feel good" environment, are well-advised to address their concerns to the curriculum committee before it's too late and they discover they are ill-prepared to do anything but basic dental services upon graduation.

As for the rest of us, if we are interested in joining the 21st century, we should keep our eyes open for franchise opportunities. The *Medical Spa Association* is a newly formed subgroup of the 8 year-old *Day Spa Association.* The way things are going, this could be bigger than anything Painless Parker could have imagined on his best day. ◆

Originally published in the Journal of the California Dental Association, 08/02.

Robert E. Horseman, DDS, graduated from USC SD in 1943, was a USN marine pilot in WWII. He has practiced dentistry from California to Australia and back and is a long-time contributing editor for the Journal of the California Dental Association.

NDA Calendar of Events

OCTOBER – DECEMBER 2013

OCTOBER

Thu 3	NDA Executive Committee meeting	6 PM	Video Conference
Tue 8	SNDS Member Dinner meeting	5:30 PM	Gold Coast Hotel & Casino, Las Vegas
Tue 8	NNDS Executive Committee meeting	5:30 PM	161 Country Estates Cir, #1B, Reno
Thu 10	NNDS General Membership Dinner meeting "State Board of Pharmacy"	6 PM	The Grove Event Center at SouthCreek, Reno
Fri 11	*SNDS presents:* CE Seminar—Dr. Larry Emmot "Maximizing technology in the Dental Office: From paperless records to Google"	9 AM – 4 PM	Gold Coast Hotel & Casino, Las Vegas
Wed 16	SNDS CE Café	6 PM	Nevada State Bank Warm Springs & Stephanie
Thu 17	SNDS Peer Review Committee meeting	6 PM	Location: to be determined
Thu 17	AGD General Membership Dinner & Case Study	6 PM	Location: to be determined
Tue 22	SNDS Executive Committee meeting	6 PM	SNDS Office, 8863 W Flamingo Rd
Fri 25	NEVADA DAY—NDA, NNDS and SNDS OFFICES CLOSED		
Thu 31	ADA Annual Session, New Orleans, LA		

NOVEMBER

Operation Dental Health Commences

Fri 1– Sun 3	ADA Annual Session, New Orleans, LA		
Tue 5	NNDS Executive Committee meeting	5:30 PM	161 Country Estates Cir, #1B, Reno
Thu 7	NNDS General Membership Dinner meeting—Dr. Winston Chee "Occlusion as it Relates to Implant Supported Structures"	6 PM	Atlantis Hotel Casino Spa, Reno
Fri 8	*NNDS presents:* All Day CE Course—Dr. Winston Chee "Decisions For Extensively Damaged Dentitions"	8 AM	Atlantis Hotel Casino Spa, Reno
Tue 12	SNDS Member Dinner meeting	5:30 PM	Gold Coast Hotel & Casino, Las Vegas
Wed 13	SNDS CE Café	6 PM	Nevada State Bank Twain & Jones
Thu 14	AGD General Membership Dinner & Case Study	6 PM	Location: to be determined
Fri 15	*SNDS presents:* CE Seminar— Dr. Larry Rosenthal "Aesthetic Dentistry Update"	9 AM – 4 PM	Gold Coast Hotel & Casino, Las Vegas
Thu 21	NDA Executive Committee meeting	6 PM	Video Conference
Thu 21	SNDS Peer Review Committee meeting	6 PM	Location: to be determined
Thu 28– Fri 29	THANKSGIVING HOLIDAY—NDA, NNDS and SNDS OFFICES CLOSED		

DECEMBER

Sat 14	NNDS Christmas Gala "Winter Wonderland"	6:30 PM	Atlantis Hotel Casino Spa, Reno
Wed 25	CHRISTMAS HOLIDAY—NDA, NNDS and SNDS OFFICES CLOSED		

SAVE THE DATE!

January 24, 2014—NDA Mid-Winter Meeting, 9 am, Gold Coast Hotel & Casino, Las Vegas

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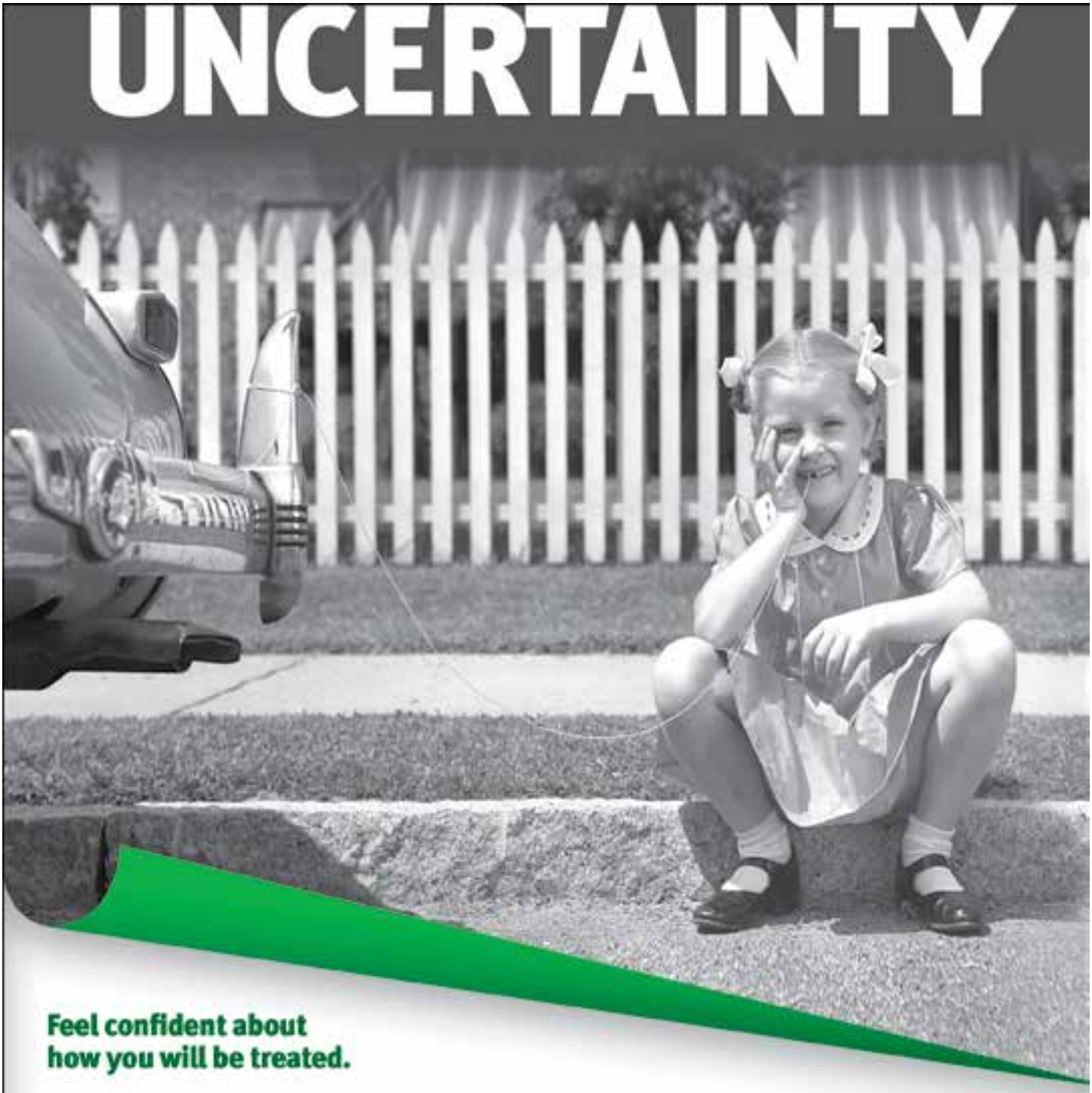

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1930 William H. Cavell
1931 Harold E. Cafferata
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1937 Alexander A. Cozzalio
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1940 & '41 George A. Steinmiller
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1964 Morris F. Gallagher
1965 Wayne L. Zeiger
1966 Mario E. Gildone
1967 William D. Berry
1968 James F. Archer
1969 Philip J. Youngblood
1970 Carl M. Hererra
1971 George P. Rasqui
1972 William H. Schaefer
1973 Robert L. Morrison
1974 John S. McCulloch
1975 James M. Jones
1976 Harry P. Massoth
1977 Leeland M. Lovaas
1978 Blaine R. Dunn
1979 Louis J. Hendrickson
1980 Duane E. Christian
1981 Dwight Meierhenry
1982 Clair F. Earl
1983 R. D. Hargrave
1984 James L. Davis
1985 N. Richard Frei
1986 Lloyd Diedrichsen
1987 Gerald Hanson
1988 Gerald C. Jackson
1989 James C. Evans
1990 Whit B. Hackstaff
1991 William E. Ursick
1992 Dennis J. Arch
1993 A. Ted Twesme
1994 Bruce Pendelton
1995 J. Gordon Kinard
1996 Joel F. Glover
1997 Rick Thiriot
1998 Jade Miller
1999 Patricia Craddock
2000 William C. McCalla
2001 Robert H. Talley
2002 Susan Jancar
2003 Dwyte Brooks
2004 Peter DiGrazia
2005 Robert Thalgott
2006 Arnie Pitts
2007 George Rosenbaum
2008 Joel T. Glover
2009 Peter Balle
2010 John C. DiGrazia
2011 Michael Banks
2012 Gilbert A. Trujillo