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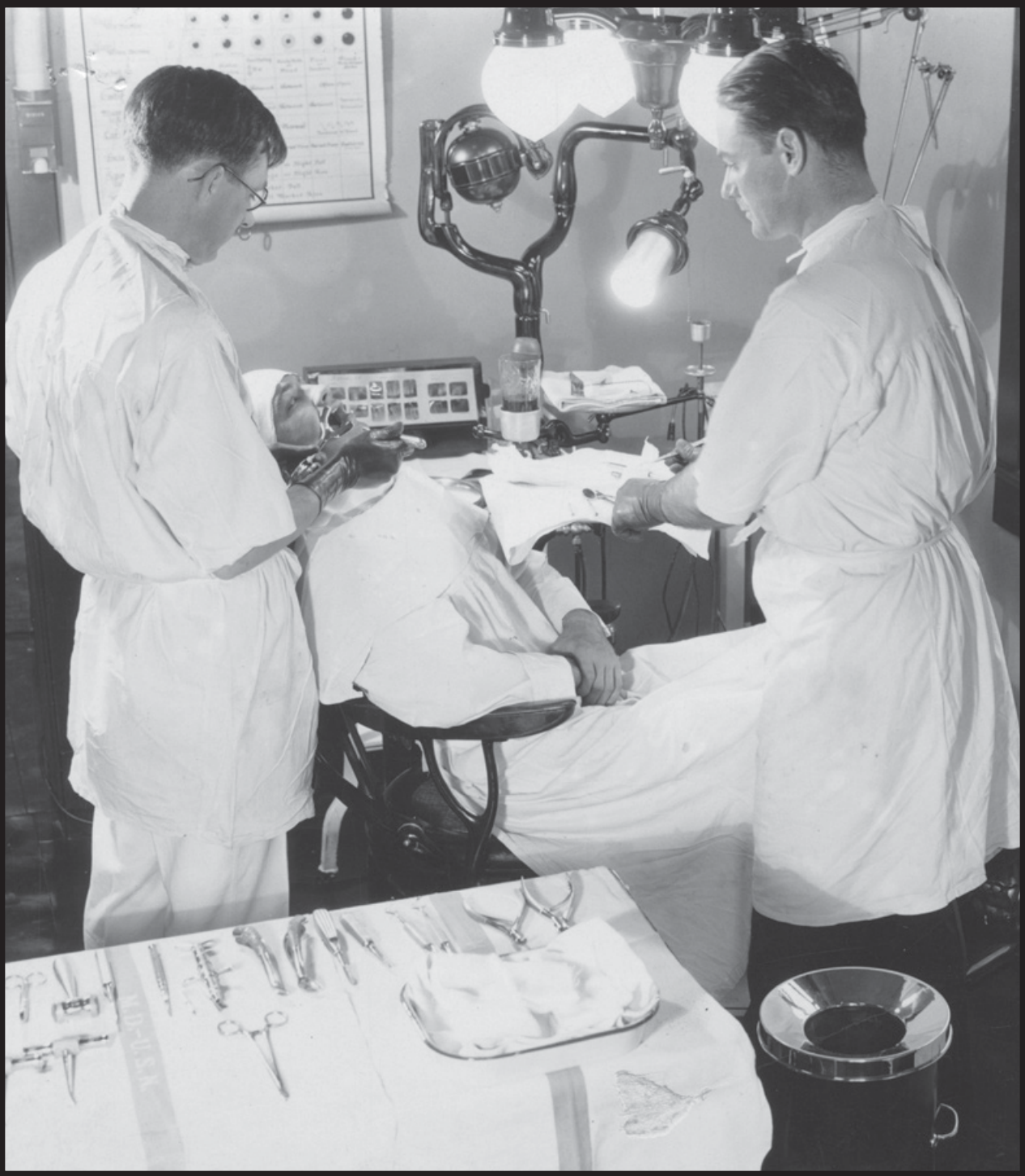

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NDA JOURNAL

FALL 24

On the Cover

U.S. Navy Dental School, Washington, D.C. (1931)

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NDAJ Exclusive

EHR 101

Someone, sans ID, walked into a Las Vegas hospital charting area this week and walked out with four hospital computers. Reportedly, the culprit was asked who he was and what he was doing. The ID-less perpetrator offered that he was from Information Technology (IT) and was directed to retrieve four computers. He was allowed to do just that; so much for protected information security. The feckless employees will now attend a retraining session about the loss of at least tens of thousands of protected records. Now, if someone walked into a dental office, picked up some computers with protected information on them, and disappeared, guess who would be in trouble, to the tune of potentially hundreds of thousands of dollars in fines in addition to administrative, civil, and even criminal prosecution? Yes, the dentist with the license.

A huge problem for doctors who use electronic health records (EHRs) is that they are generally the only ones held accountable for data breeches. National, state, and municipal governments, corporations and their employees, insurance companies, software manufacturers, and pretty much any other third-party that doesn't have a health professional's license generally is simply advised to be more careful.[1]

Nowadays, a significant consideration for such breeches is that records are often electronic. Thousands of patient files are much easier to steal if they're digital as opposed to on paper. This is but one disadvantage of an EHR.

Historically, many of us remember being taught how to develop a hard copy, handwritten document. What we actually wrote down is secondary to EHR issues discussed herein. What is important is the purpose of the record. Remember? The primary reason we created patient records was to optimize patient care. The records belonged to the doctor and were actually, as opposed to today, truly protected and confidential. Today, EHRs are neither protected nor confidential as seen with frequent huge data breeches of millions of citizens. And no individual is responsible for the breeches, except of course the gullible doctors.

EHRs are kept for vastly different reasons than our paper records were. Those of us who are coerced to used EHRs by third-parties know the new priorities have little to do with optimizing patient care. When EHR advocates speak in public, for decades they aways tout the too-good-to-be-true evanescent benefits of efficiency and safety, which is never the reality of the EHR. What is true is that the primary purpose, as iterated more privately, is to facilitate coding, ideally by vulnerable doctors, for more efficient billing. And boy, do some billers bill. I accepted a case recently for which a third molar was removed from a veteran who had undergone significant head-and-neck cancer therapy. He had vascular clips throughout his neck, had undergone a laryngectomy, and the standard radiotherapy. The tooth was removed in the OR because of the co-morbidities, not the difficulty of the 1–2 minute odontectomy. The office fee for this procedure would have been exponentially less than hospital bill of more than $18,000. But, don't worry, the vet didn't have to pay for it—the taxpayers did.

Another primary purpose of EHRs includes creating wealth for the conflicted software developers for endless programs that always, as in 100% of the time, do not perform as advertised.

Often, EHRs also relieve third-party billing entities of the burden of retaining coders, as doctors are now assigned to code procedures. UNLV

Dr. Orr practices Anesthesiology and OMS in Las Vegas, is an Adjunct Professor (Surgery) at UNLV SM and Touro University SM (Jurisprudence), Professor Emeritus at UNLV SDM, and a member of the CA Bar and Ninth Circuit Court of Appeals.

SDM invited Dr. Paul Bornstein, who wrote a book on coding, to get the faculty up to speed on correct coding. His talk included the opinion that all (100%, including himself) dentists have committed insurance fraud. That actually makes sense after the passage of Obamacare in 2010. Obama and the HHS adopted the unconstitutional burden of proof posture that accused doctor coders of being guilty until they can prove themselves innocent, just like the IRS does. The accusation often metastasizes to doctor bios and CVs (i.e., Have you been investigated in the last two years?—a common recredentialing query). Some states require that if one is accused, entities are required by law to report the alleged rascally health professionals to sister agencies. For instance, a civil court would be required to report the doctor to the AG for possible criminal prosecution and also to the State Board for an administrative evaluation.

A current case in another state involves administrative allegations and proposed penalties directly stemming from an EHR. A civil suit soon followed. The dentist's staff mistakenly checked an incorrect box on the EHR, for which the doctor is, of course, responsible. The doctor actually developed a contemporaneous paper record that is correct, but the state apparatchiks want to simply dismiss the correct document out-of-hand.

One bit of good news for dentists is that our CDTs are composed of only about 650 codes, while our medical colleagues must dance with 140,000 plus. It's almost as if someone wants our physician colleague to make coding errors—go figure.

That brings us to other not responsible for anything beneficiaries of EHRs, both plaintiff and defense attorneys. Depending on the way things fall out, they either view EHRs as scripture or as misinformation emitted from a vomitorium. EHRs are not true scripture, ever. They are in fact massive laundry lists that doctors must sort correctly, or face the consequences. Laundry lists never work either.[2,3]

A huge problem for doctors who use electronic health records (EHRs) is that they are generally the only ones held accountable for data breeches.

If one does a search for problems with EHRs, literally thousands of articles will be revealed. One thing all these submissions have in common is that the doctor whose name is on the EHR is virtually always the one left holding the bag, absent proven criminality of another.

Some of the problems often listed are:

1. **They Are a Waste of Valuable Time:** Perhaps this is a blessing if one works in time frames, rather than with patients. It took a couple of hours to complete the EHR for the two minute surgery mentioned above. Those hours happily represent less time to spend on other EHRs, but sadly, also less time left for actual patients.
2. **Data Entry (coding):** See 1. in part.
3. **Alerting is Absent:** Incorrect, or ambiguous, as in obscure allergies.
4. **Inoperability:** Routinely.
5. **Visual Display:** Chaotic.
6. **Availability of Information:** In reality, there is too much useless information to sort through. The doctor may be held responsible for everything in the chart, even the data of others.
7. **System Automation and Defaults:** There are always glitches.
8. **Improved Versions Never End and Always Contain New Errors.**
9. **Workflow Support:** Hospitals have assigned charting rooms with EHR computer babysitters for doctors attempting to use EHRs-surgery is much more straightforward.
10. **Patient Harm:** Generally, directly related to the EHR chaos.

So, what is a doctor to do? Well, it is difficult to refuse to use an EHR when one's employer requires it. As a courtesy to *Nevada Dental Association Journal* (NDAJ) readers, the following statement is something I try to attach to each EHR I am compelled to interact with. This is not legal advice nor an NDA-sanctioned treatment plan by any means, just a thought to consider:

"*The Electronic Record Developed by Dr. _____ for _____ is an Accommodation Only. Attestation Of Dr. _____'s Electronic Record Accuracy Is Perfected Via Dr. _____'s Notarized Physical Signature Only. Dr. _____'s Authorized Patient Record Will Be Maintained By Dr. _____.*"

Of course, dentists who unilaterally choose to use this or that software can't attempt to assign blame to another.

Good Luck! 🦷

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Electronic Medical Records, An Information Bubble?: EMR Claims vs. Reality

by: AAPS News, March 2013

We often hear about the phenomenal exponential growth of digital technology, with the implicit assumption that the doubling will continue—unlike exponential growth phases in nature, which are part of an S-shaped curve—and that it is an unmitigated blessing. The amount of paper in a print-out of a patient's chart and the amount of data one is required to gather also keeps doubling.

It reminds me of the 1797 poem Der Zauberlehrling by Johann Wolfgang von Goethe and the *Disney* animation ("*The Sorcerer's Apprentice*" in *Fantasia*). The apprentice calls up spirits to animate a broom to carry water to fill his bath, but forgets the magic word to stop it. Hacking the broom in half just doubles the deluge: "Die ich rief, die Geister, werd' ich nun nicht los!" ["The spirits I summoned will not let me go!"]

Claims vs. Reality

The electronic medical record (EMR) is touted as the key to containing costs, reducing errors, improving quality, and simplifying administration: an "elegant exercise in wishful thinking," in the words of Jerome Groopman and Pamela Hartzband.

The real motive appears to be control (*AAPS News*, April 2011). Indeed, to spur adoption, EMRs are becoming semi-compulsory. For example, the performance-in-practice (PIP) component of the Federation of State Medical Board's Maintenance of Licensure

> But what if the current HIT bubble bursts, and better HIT helps physicians and patients take back medicine?

template is EMR-dependent Also, physicians who are not "compliant" with various electronic requirements will have their Medicare fees cut.

The federal government has "invested" $20 billion over the last two years in promoting health information technology (HIT), based on expectations from a 2005 RAND study of $81 billion in annual savings. The study was paid for by a group of companies that profit from selling EMR systems to hospitals and physician practices. Cerner's revenue nearly tripled since the report was released, from $1 billion in 2005 to a projected $3 billion in 2013. The RAND study deliberately avoided looking at negative information. Double-blind, randomized studies have shown that EMRs with computerized decision-making tools did not result in a single improvement in any quality measure in the care of chronic diseases, and has not been shown to save money, writes Greg Scandlen.

Some think the growth of HIT is a bubble, which is very often the result of misallocation of funds derived from government subsidies (http://tinyurl.com/adwhj5r).

Costs have clearly increased. As an article in the *NY Times* pointed out, hospitals that received government incentives to adopt EMRs had a 47% rise in Medicare costs, compared to 32% in hospitals that did not.

Scot Silverstein, M.D., of Drexel University, describes the rapid changeover to EMR as a mania. "We know it causes harm, and we don't even know the level of magnitude." Poorly designed software can obscure clinical data and generate incorrect treatment orders. Errors voluntarily reported to the Food and Drug Administration (FDA) probably reflect a small percentage of events that actually occur.

There is a tacit admission by experts that EMRs by themselves don't improve quality of care. You have to have an army of technical consultants in your office, writes Lawrence Huntoon, M.D., Ph.D. One study reported that it took at least nine months of EMR use and eight or more technical assistance visits to show any statistically significant improvements in key quality measures. Even after two years, physician offices without such support showed no improvement (*Health IT News* 1/9/13).

Bad Engineering

In an article entitled "Escaping the EHR Trap," Kenneth Mandl, M.D., M.P.H, and Isaac Kohane, M.D.,

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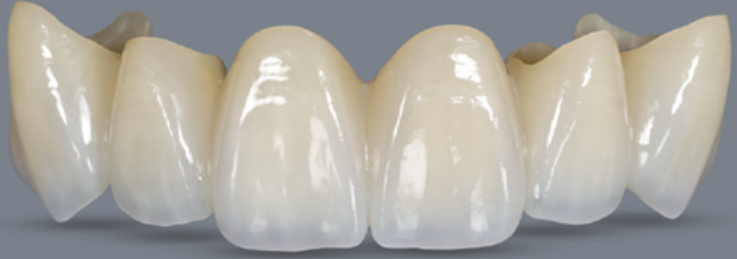

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Ph.D., write that commercial electronic health records evolved from practice-management (i.e. billing) systems, with various modules tacked on. Physicians are locked into pre-internet systems that are not designed to link with third-party applications and do not even embrace existing modular architectures. Complex software that was never properly engineered "must be reimagined, reinvented, and reimplemented constantly." Entrenched "legacy" approaches and other factors stifle innovation (NEJM 6/14/12).

In the same issue, Spencer Jones et al. describe the "IT productivity paradox." During the 1970s and 1980s, the computing capacity of the U.S. economy grew one hundredfold, while the rate of productivity growth fell to less than half that of the preceding 25 years. In the early 20th century, it took two decades to figure out how to realize the benefits of electricity, as factories initially replaced water-wheels and steam engines with large electric motors running the same central belt-and-pulley system. The breakthrough was to use small electric motors that provided power when and where it was needed.

Individual autonomy, self-directed work teams, "home-grown" IT systems relying on user-centered design practices are suggested. Does this spell "fragmentation" and "decentralization," instead of top-down central planning?

The federal government may be using HIT to drive more standardization and tighter regulation and monitoring of physicians—with the sacrifice of professional autonomy and independent clinical judgment. But what if the current HIT bubble bursts, and better HIT helps physicians and patients take back medicine?

HIT: The Bad and The Ugly

Template Bloat: Pre-programmed template notes are a workaround for time-consuming data entry. Word-for-word identical progress notes, even lengthy operative reports, are commonplace. The template includes what usually happens and what might happen, and notes may include pages of things that never happened (http://tinyurl.com/afgs23y).

Virus-Infected Medical Devices: Software-controlled medical devices are increasingly interconnected and internet-linked. Many run on older operating systems that are vulnerable to hackers and cannot be changed, even to add antivirus software, because of fear of violating FDA rules. Malware is rampant in many hospitals, from drug compounders to image-archiving systems (http://tinyurl.com/d6jcx8j).

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EHR Copy-and-Paste Can Get Physicians Into Trouble

by: Leigh Page, Medscape, April 11, 2024

Physicians who misuse the "copy-and-paste" feature in patients' electronic health records (EHRs) can face serious consequences, including lost hospital privileges, fines, and malpractice lawsuits.

In California, a locum tenens physician lost her hospital privileges after repeatedly violating the copy-and-paste policy developed at Santa Rosa Memorial Hospital, Santa Rosa, California.

"Her use of copy-and-paste impaired continuity of care," said Alvin Gore, MD, who was involved in the case as the hospital's director of utilization management.

Gore said the hospital warned the doctor, but she did not change her behavior. He did not identify the physician, citing confidentiality. The case occurred more than five years ago. Since then, several physicians have been called onto the carpet for violations of the policy, but no one else has lost privileges, Gore said.

Copy-paste practices can save doctors' time when dealing with cumbersome EHR systems, but they also can lead to redundant, outdated, or inconsistent information that can compromise patient care, experts said.

"EHRs are imperfect, time consuming, and somewhat rigid," said Robert A. Dowling, MD, a practice management consultant for large medical groups. "If physicians can't easily figure out a complex system, they're likely to use a workaround like copy-and-paste."

Copy-and-paste abuse has also led to fines. A six-member cardiology group in Somerville, New Jersey, paid a $422,000 fine to the federal government to settle copy-and-paste charges, following an investigation by the Office of the Inspector General of the Department of Health and Human Services, according to the Report on Medicare Compliance.

This big settlement, announced in 2016, is a rare case in which physicians were charged with copy-and-paste fraud—intentionally using it to enhance reimbursement.

More commonly, Medicare contractors identify physicians who unintentionally received overpayments through sloppy copy-and-paste practices, according to a coding and documentation auditor who worked for ten years at a Medicare contractor in Pennsylvania.

Such cases are frequent and are handled confidentially, said the auditor, who asked not to be identified. Practices must return

the overpayment, and the physicians involved are "contacted and educated," she said.

Copy-and-paste can also show up in malpractice lawsuits. In a 2012 survey, 53% of professional liability carriers said they had handled an EHR-related malpractice claim, and 71% of those claims included copy-and-paste use.

One such case, described by CRICO, a malpractice carrier based in Massachusetts, took place in 2012–2013. "A patient developed amiodarone toxicity because the patient's history and medications were copied from a previous note that did not document that the patient was already on the medication," CRICO stated.

"If you do face a malpractice claim, copying and pasting the same note repeatedly makes you look clinically inattentive, even if the copy/pasted material is unrelated to the adverse event," CRICO officials noted in a report.

Copy-and-paste is a great time-saver. One study linked its use to lower burnout rates. However, it can easily introduce errors into the medical record. "This can be a huge problem," Dowling said. "If, for example, you copy forward a previous note that said the patient had blood in their urine 'six days ago', it is immediately inaccurate."

Practices can control use of copy-and-paste through coding clerks who read the medical records and then educate doctors when problems crop up.

The Pennsylvania auditor, who now works for a large group practice, said the group has very few copy-and-paste problems because of her role. "Not charting responsibly rarely happens because I work very closely with the doctors," she said.

Dowling, however, reports that many physicians continue to overuse copy-and-paste. He points to a 2022 study which found that, on average, half the clinical note at one health system had been copied and pasted.

One solution might be to sanction physicians for overusing copy-and-paste, just as they're sometimes penalized for not completing their notes on time with a reduction in income or possible termination.

Practices could periodically audit medical records for excessive copy-paste use. EHR systems like Epic's can indicate how much of a doctor's note has been copied. But Dowling doesn't know of any practices that do this.

"There is little appetite to introduce a new enforcement activity for physicians," he said. "Physicians would see it just as a way to make their lives more difficult than they already are."

Some hospitals and health systems have gone as far as disabling copy-and-paste function in their EHR systems. However, enterprising physicians have found ways around these blocks.

Some institutions have also introduced formal policies, directing doctors on how they can copy-and-paste, including Banner Health in Arizona, Northwell Health in New York, UConn Health in Connecticut, University of Maryland Medical System, and University of Toledo in Ohio.

Definitions of what is not acceptable vary, but most of these policies oppose copying someone else's notes and direct physicians to indicate the origin of pasted material.

Santa Rosa Memorial's policy is quite specific. It still allows some copy-and-paste but stipulates that it cannot be used for the chief complaint, the review of systems, the physical examination, and the assessment and plan in the medical record, except when the information can't be obtained directly from the patient. Also, physicians must summarize test results and provide references to other providers' notes.

Gore said he and a physician educator who works with physicians on clinical documentation proposed the policy about a decade ago. When physicians on staff were asked to comment, some said they would be opposed to a complete ban, but they generally agreed that copy-and-paste was a serious problem that needed to be addressed, he said.

The hospital could have simply adopted guidelines, as opposed to rules with consequences, but "we wanted our policy to have teeth," Gore said.

When violators are identified, Gore says he meets with them confidentially and educates them on proper use of copy-and-paste. Sometimes, the department head is brought in. Some physicians go on to violate the policy again and have to attend another meeting, he said, but aside from the one case, no one else has been disciplined.

It's unclear how many physicians have faced consequences for misusing copy-paste features—such data aren't tracked, and sanctions are likely to be handled confidentially, as a personnel matter.

Geisinger Health in Pennsylvania regularly monitors copy-and-paste usage and makes it part of physicians' professional evaluations, according to a 2022 presentation by a Geisinger official.

Meanwhile, even when systems don't have specific policies, they may still discipline physicians when copy-and-paste leads to errors.

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Scott MacDonald, MD, chief medical information officer at UC Davis Health in Sacramento, California, told *Medscape Medical News* that copy-and-paste abuse has come up a few times over the years in investigations of clinical errors.

Physicians can be held accountable for copy-and-paste by Medicare contractors and in malpractice lawsuits, but the most obvious way is at their place of work: A practice, hospital, or health system.

One physician has lost staff privileges, but more typically, coding clerks or colleagues talk to offending physicians and try to educate them on proper use of copy-and-paste.

Educational outreach, however, is often ineffective, said Robert Hirschtick, MD, a retired teaching physician at Northwestern University Feinberg School of Medicine, Chicago, Illinois. "The physician may be directed to take an online course," he said. "When they take the course, the goal is to get it done with, rather than to learn something new."

> Definitions of what is not acceptable vary, but most of these policies oppose copying someone else's notes and direct physicians to indicate the origin of pasted material.

Hirschtick's articles on copy-and-paste, including one titled, "Sloppy and Paste," have put him at the front lines of the debate. "This is an ethical issue," he told Medscape Medical News. He agrees that some forms of copy-and-paste are permissible, but in many cases, "it is intellectually dishonest and potentially even plagiarism," he said.

Hirschtick argues that copy-and-paste policies need more teeth. "Tying violations to compensation would be quite effective," he said. "Even if physicians were rarely penalized, just knowing that it could happen to you might be enough. But I haven't heard of anyone doing this."

In the Tiger's Mouth: A History of Veterinary Medicine, Part 1 of 4

by: Tina Brandon Abbatangelo, DDS MPH

Tina Brandon Abbatangelo, DDS

The development of human dentistry is comparable to that of veterinary dentistry in that both are vibrant and progressive disciplines. Each field has a unique story to tell.

Abstract

The discipline of dentistry includes most animals that have a masticatory system and have experienced contact and interaction with humans. This article provides an illuminating account of the historical development of animal dentistry, as well as outlining the future direction of the specialty. Animal dentistry has undergone a complex evolution, with pioneers in the field guiding the way for both dentists and veterinarians. It has transitioned from being a source of financial dependence through equine dentistry to include the dental care of household pets. Through the examination of several animal dentistry cases, we will uncover both the commonalities and distinctions. Animal dentistry is an essential specialty in veterinary medicine that is experiencing growth both economically and in its integrative approach to treating the entire body and its systems.

Part 1

History of Veterinary Dentistry

The history of teeth among all species mirrors the evolution of the world.[1] The narrative shares a ripening story that encompasses science, research, animal welfare, prevention, and technology. The development of human dentistry is comparable to that of veterinary dentistry in that both are vibrant and progressive disciplines. Each field has a unique story to tell. Veterinary dentistry did not come with ease and acceptance due to evidence-based science, modalities in treatment and in organization.[2] As a veterinary specialty it has a unique two-part history. This article will focus on the progress made within this specialty of veterinary medicine over time, along with a display of common animal dentistry cases. The first slice of history begins with equine dentistry. The second part brings domestic animals into the story and places us where we are today. It is not surprising to begin with the fact that horses have been considered indispensable and have played a vital role in numerous aspects of human survival.

Early veterinary dentistry was primarily concerned with the dental care of equines, but as knowledge of oral pathology, aging characteristics, and other relevant factors in other animals accumulated, the scope of dental care provided by veterinarians expanded to include all animal patients. This expanded knowledge has benefited humans and animals alike. Through confirmation with animal dental experimentation, we have been able to scientifically examine issues such as the development of oral neoplasms, the cause of caries and periodontal disease, and numerous other topics associated with dentistry. Similar

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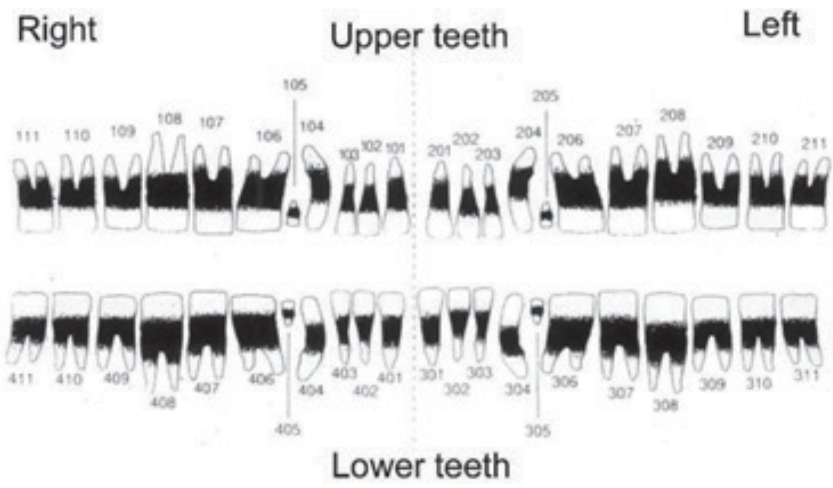
She has earned an MS in public health and is continuing studies in Dental Public Health at UNLV School of Dental Medicine. She is a volunteer secretary for the Peter Emily International Veterinary Dental Foundation (PEIVDF) and the author of the children's book *Animal Dentistry Adventures with Dr. Tabby, Animal Dentist Extraordinaire*.

complications can be observed in the oral cavities of other animals and pets, as our understanding of the pathological processes affecting the human mouth has progressed.

The horse has exerted the most evident influence of any domestic animal throughout human history.[3] The earliest evidence of equine dentistry was discovered in 1150 BCE in the Mongolian Steppe. Equine veterinary care, specifically concerning oral health, played a crucial role in ensuring the continuation of a strong human-horse relationship because of the limitations imposed by horse biology and available riding apparatus. The preservation of equine health through dental procedures strengthened the critical role of horses throughout economies and cultures across the globe.[3]

Horses have historically been necessary for transportation, sports, mechanical power, and military use. Strong jaws and teeth were essential to fit their mouths securely, with bits to control and manipulate the horse's direction and speed.[4] To manage occlusal abnormalities, their teeth were intentionally modified (floating) to help accommodate mechanical gags in the horse's mouth.[3] Horse teeth floating, a dental procedure that eliminates the sharp edges that develop on horses' teeth, is essential to proper bit comfort. Moreover, it creates a uniform grinding pattern for the horse's chewing, promoting better digestion. There are at least forty teeth in the mouth of an average adult male horse: twenty teeth positioned in the maxillary and twenty in the mandible. Occasionally, the absence of canines in females results in up to four fewer teeth. "Wolf teeth" are present in both sexes. Based on position and structure, horse teeth are classified like human dentition with incisors, canines, premolars, and molars.[5] The Triadan system of dental nomenclature for a horse is shown in figure above.



The discipline of animal dentistry appeared in Ancient Egypt; nevertheless, its progress has been obstructed due to the Library of Alexandria fire of 48 BC, which destroyed over 700,000 ancient historical manuscripts.[6] The ancient Greeks contributed to veterinary dentistry with Simons of Athens writings of *The Veterinary Art of the Inspection of Horses* in 480 BCE. Aristotle's *History of Animals* was written in 333 BCE, where he wrote about horses' aging teeth and periodontal disease.[7,8,9] The Romans also contributed to veterinary dentistry through Chiron, a veterinarian, who wrote a series of animal books with material including equine oral pathology and fractured jaw management.[9] The fascination with horses continued into the Byzantine Empire. The interest continued throughout Europe as horse riding and ownership became more progressive among the elite making veterinary medicine an even more essential discipline.[10]

The origins of small-animal dentistry were independent and gradual. Unfortunately, it began with barbaric procedures that were performed only due to superstitions.[4] One example is the excision of the lyssa (the fibro-muscular tube that supports the rostral end of the tongue). The belief that rabies was transmitted by a small "worm!" located at the base of the tongue was widespread. Grattius Falistcus, a poet, (1st century BC), was aware of the legend surrounding the origin of the sublingual 'lyssa' of rabid dogs. They held the belief that the dog could be wholly cured by extracting the worms.[13] Furthermore, it was suggested that this worm, when injected, possessed miraculous curative abilities capable of averting the disease in the bitten individual; however, this was only the case after the individual had been carried three times around a fire.[11]

There was even evidence of the fabrication of dog dentures.[12] The progressive shift into smaller animal dentistry came when there was an increase in companion animals. Their oral health needs became a priority, and owners paid more attention to the animals' diets, especially when these animals were no longer hunting for their food. Refined diets brought on more periodontal and oral disease due to reduced masticatory function.

The first-ever veterinary dental school was established in 1762 in Lyon, France.[13] (photo on page 13) It marked an initial milestone for a shift in veterinary dental teachings. Following this breakthrough in 1889, the first veterinary dental written material was published. Many books followed. These publications expanded the scope of veterinary

dental techniques beyond equine dentistry to encompass small animal dentistry. Veterinary dentistry originated as an independent discipline within veterinary surgery after the release of "*Outlines of Veterinary Medicine and Carnivore Pathology*" by Delabere Blain in 1832.[14]

Although nitrous oxide (N_2O) was utilized in human anesthesia since the 1840's, its prominence in veterinary anesthesia was limited. In 1799, Sir Humphry Davy introduced the notion of implementing nitrous oxide in veterinary medical procedures.[16] Despite a limited application period in dentistry, it ultimately proved ineffective in veterinary medicine due to its lack of potency. William Morton, an oral surgeon at Boston Hospital was advised to undertake the anesthesia endeavor. This was followed with the utilization of ether in a tooth extraction in 1846. This became a remarkable advance in the field of veterinary surgery during the 19th century with the introduction of anesthesia. The advancements in human medicine have resulted in favorable developments in the fields of veterinary medicine and veterinary dentistry.[15] In current times, nitrous oxide can be used in conjunction with other medications including isoflurane, halothane, and sevoflurane to increase its effectiveness.[16]

Joseph Bodingbauer, Arthur Mellenby, Louis A. Merillat, Hobday, and Garbutt were among the initial pioneers. During the 1930s, Bodingbauer shed light on the field of small animal dentistry in Vienna. As opposed to horses, dogs, cats, and other small animals gained importance. Arthur Mellenby published a collection of comprehensive papers in 1929 that examined the impact of dietary modifications on the dental health of animals and the progression of dental diseases.[17] In the United States, these teachings did not arise until much later. *Animal Dentistry and Oral Diseases* was published by Merillat in 1905 (Arslan, 2021). Hobday published *Surgical Diseases of Dogs and Cats* in 1925. Furthermore, dental prevention and prophylaxis were first proposed by Garbutt in 1938.[17]

There was a significant gap in history until the 1970s. A small but dedicated group of veterinarians created the Veterinary Dental Association (VDA) in 1976. Advances in animal dentistry treatment were initiated by the group. Greater emphasis was placed on the animal masticatory system following the establishment of the organization. The VDA understood the importance of proper oral hygiene and function for an animal's overall health. By 1987, the VDA recognized dentistry as a specialty in veterinary medicine. These pioneers began consulting zoos for help on veterinary dentistry issues. Their combined knowledge and efforts have contributed to its trajectory today. The specialty has amazingly advanced from a few colleagues conversing over coffee to the founding of a Veterinary Dental College that is widely regarded and forward-thinking. In 2017, The American Veterinary Dental College also introduced a certification program targeted at zoo and wildlife veterinarians.

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August 19, 2024

American Legislative Exchange Council
Board of Directors
Alexandria, VA

RE: ALEC Model Policy on Dental Therapy

Dear Members of the ALEC Board of Directors,

As America's leading advocate for oral health, the American Dental Association is committed to advancing access to quality oral health care for all. This includes workforce innovations that allow for dentists to delegate procedures to appropriately educated and trained practitioners, thereby increasing access to care. However, central to this belief is the conviction that in the best interests of the public, only dentists, equipped with comprehensive education and training, are the qualified professionals to diagnose dental disease, identify oral pathology such as oral cancer, perform surgical and irreversible procedures and supervise procedures by allied dental team members.

On July 26, 2024, the ALEC Health and Human Services Task force approved, by a vote of 10-9, a model legislation on dental therapy that falls short of meaningfully increasing access to care in an appropriate, timely, and economically feasible way. Therefore, the ADA opposes adoption of this model and asks that you not support its final approval.

The dentist is ultimately responsible, ethically and legally, for patient care as acknowledged by the proposed model legislation -- "*A supervising dentist shall accept responsibility for all services performed by a dental therapist pursuant to a collaborative management agreement*." The weight of this responsibility requires that the dentist be the healthcare provider that performs examinations/evaluations; diagnoses; treatment planning; and surgical/ irreversible procedures; prescribes work authorizations; prescribes drugs and other medications; and administers enteral, parenteral or inhalational sedation, or general anesthesia.

Although the model proposed by the taskforce places the "responsibility of all services performed by a dental therapist" on the dentist, it allows the therapist to:

- Conduct an oral evaluation and assessment of dental disease and formulation of an individualized treatment plan.
- Evaluate radiographic images.
- Administer nitrous oxide.
- Perform services such as suture placement, pulpotomy on primary teeth, tooth reimplantation and stabilization, etc.
- Perform a nonsurgical extraction of periodontally diseased permanent teeth with tooth mobility.
- Directly supervise a dental hygienist and authorize them to perform procedures as well as supervise unlicensed individuals who are allowed to perform "remediable" procedures in accordance with a treatment plan approved by the therapist.

We note that "oral evaluation" as defined by the Code on Dental Procedures and Nomenclature (CDT Code) includes a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues including an evaluation for oral cancer, the evaluation and recording of the patient's dental and medical history and a general health assessment. It may require interpretation of information acquired through additional diagnostic procedures. The purpose of these activities is to reach a fully informed diagnosis and individualized treatment plan for each patient. Given this definition, this model allows a dental

therapist to diagnose dental disease. The training and education required to perform services as a dental therapist does not prepare individuals to diagnose dental disease, identify oral pathology such as oral cancer and determine an individualized treatment plan.

The primary purpose of dentists delegating functions to allied dental personnel is to increase the capacity of the profession to provide patient care while retaining full responsibility for the quality of care. When delegating, the degree of supervision required to assure that treatment is appropriate and does not jeopardize the systemic or oral health of the patient varies with the nature of the procedure and the medical and dental history of the patient, as determined with evaluation and examination. In this context, the proposed model allows a dental therapist to perform services under "general supervision" defined as "the *dentist is not present in the dental office or other practice setting or on the premises at the time tasks or procedures are being performed by the dental therapist, but that the tasks or procedures performed by the dental therapist are being performed with the prior knowledge and consent of the dentist*". "Prior knowledge and consent" alone, in our view, is insufficient to support diagnosis, treatment and supervision of other allied personnel. The dentist is the qualified professional to diagnose dental disease, and written standing orders are not a substitute for obtaining a diagnosis.

The ADA believes that the development of any new member of the dental team be based upon determination of need, a CODA-accredited dental school or advanced dental education program, and a scope of practice that ensures the protection of the public's oral health. Failure to specify that dental therapists must graduate from a program accredited by the Commission on Dental Accreditation (CODA), the only body in the United States tasked with evaluating dental education programs, which includes dental therapy; and failure to assure that the patient first become a patient of record examined by the dentist raise significant concerns for the ADA. The ADA believes that any patient to be treated by a dental therapist as authorized by this model legislation must first become a patient of record of a dentist. A patient of record is defined as one who:

a. has been examined by the dentist;
b. has had a medical and dental history completed and evaluated by the dentist; and
c. has had his/her oral condition diagnosed and a treatment plan developed by the dentist.

Furthermore, the stipulation around informed consent within this model states the following: "*Any dentist or dental therapist who treats a patient shall inform the patient about the availability of reasonable alternate modes of treatment and about the benefits and risks of these treatments. The reasonable dentist standard is the standard for informing a patient under this section. The reasonable dentist standard requires disclosure only of information that a reasonable dentist would know and disclose under the circumstances."* This inappropriately places the burden on the dental therapist to be able to explain treatment plans and alternatives to patients to the same level as a dentist who has much more expansive education and qualifications, all while the dentist takes full responsibility for the actions of the dental therapist.

In addition to our concerns expressed above, we maintain that there appears to be little appetite for dental therapy in states that have adopted authorizing legislation. Advocates have long asserted that dental therapy would address dental workforce shortages, particularly in rural areas and other areas with underserved populations. This has not come to fruition. Despite fourteen states having passed some form of dental therapy legislation, most of these states do not have a single therapist practicing or even licensed years after passage of their legislation.

While pilot projects exist on tribal lands in Oregon, Washington, and Idaho, the vast majority of dental therapists continue to practice in Minnesota. A report from 2019 indicated that about 73 percent of dental therapists in Minnesota work in a metropolitan area[i], and 139 total dental therapists had active licenses in Minnesota as of April 2024[ii]. The state of Minnesota provides detailed healthcare workforce data[iii], including work status, average hours worked, time spent providing patient care, and other metrics, for dentists, dental hygienists, and dental assistants. However, it does not track such data for dental therapists. This lack of transparency makes it virtually impossible for policymakers to determine whether dental therapists are making a measurable impact in improving access in rural and underserved areas as intended.

Furthermore, dental therapy education programs exist only in three states – Minnesota, Alaska, and Washington – while dental schools and dental hygiene and dental assisting programs operate in virtually every state in the nation. Earlier this year a dental therapy education program at Metropolitan State University was suspended.

We find, as well, that state investment in these programs tends to have a poor return. In Vermont, over $2.6 million in private, state, and federal funds have been spent on a still non-existent program intended for Vermont Technical College (VTC). A 2023 state audit[iv] identified several critical issues, including the potential misuse of funds as well as an inability of VTC to satisfy the conditions necessary for CODA accreditation. At best, VTC will be unable to enroll any students until 2027, even if all underlying concerns were fixed immediately.

We acknowledge that the long-running debate over dental therapy has resulted in good faith efforts by the model's author to improve upon initial proposals and address concerns in the dental community. However, underlying policy issues lead us to conclude that dental therapy is not a viable dental workforce innovation for state policymakers to pursue.

The ADA believes a better and faster approach to address dental workforce shortages is to create state legislation and funding initiatives for existing dental education programs to address the current shortage of hygienists, dental assistants, and expanded function dental assistants who function efficiently in the current dental team model. The ADA encourages states to adopt policies incentivizing dentists and dental hygienists to work in rural and health provider shortage areas serving publicly insured patients by reducing their student loan burden as a quick, cost-effective pathway to help reduce the numbers of underserved populations while simultaneously delivering high-quality care. Community Dental Health Coordinators (CDHCs) who work closely with families to find appropriate care should also be supported within state health policies.

We appreciate both your commitment to improving oral health and your diligent review of model legislation before you determine your final position this December. We would welcome the opportunity to meet with you to discuss and develop innovative approaches and best practices we have identified that achieve the goal of improving access to care that are economically viable, expedient, and provide adequate protection of the public's health.

As such, we respectfully request that you do not support the dental therapy model legislation recently passed by the Health and Human Services Task Force.

On behalf of the 159,000 members of the American Dental Association, thank you for considering our request. Please contact Jim Schulz, Senior Vice President of Government Affairs, for more information at schulzJ@ada.org.

Sincerely,

Linda J. Edgar, D.D.S., M.Ed.
President

Raymond A. Cohlmia, D.D.S.
Executive Director

LJE:RAC:js

[i] https://www.health.state.mn.us/data/workforce/oral/docs/2019dt.pdf

[ii] https://mn.gov/boards/dentistry/consumers/active-licenses/index.jsp

[iii] https://www.health.state.mn.us/data/workforce/hcwdash/index.html?url_var=workstatuspatientcare#NaN

[iv] https://auditor.vermont.gov/sites/auditor/files/documents/Dental%20Therapy%20Final%209-22-23.pdf

Editor's Note: The ADA's analysis and advisement with regard to the ALEC report is correct 85736 vdin the opinion of the Editor. If ALEC is implemented by organized dentistry, it is a recipe for the loss of one's license. When one is responsible for others' conduct (respondiat superior theory legally), one should be able to define the boundaries of that conduct. If another entity wants to define those parameters, that entity needs to assume responsibility for any adverse results.

Talking Points

ADA American Dental Association®
America's leading advocate for oral health

National Toxicology Program (NTP) Review of Fluoride Exposure, Neurodevelopmental, Cognitive Health Effects 2024

ADA Assessment:

- The American Dental Association (ADA) has reviewed the NTP report and continues to support community water fluoridation to help prevent tooth decay.
- As a science-based organization, the ADA welcomes reviews and additional research that adds to the body of knowledge on the safety and the effectiveness of water fluoridation.
- The ADA agrees with NTP's conclusion that there is no evidence of a causal relationship or biological mechanism to explain how fluoride affects cognitive development.
- What is important to keep in mind is that the threshold level of possible harm (1.5ppm) is ***more than double*** the amount of fluoride typically found in fluoridated U.S. public water systems (0.7 ppm).

What this Monograph Does Not Explain:

- This Monograph and Addendum do not address whether the exposure to fluoride added to drinking water in some countries (i.e., fluoridation, at 0.7 mg/L in the United States and Canada) is associated with a measurable effect on IQ.
- This Monograph does not provide a quantitative estimate of the number of IQ points lost for a given increase in fluoride exposure measures.
- Another thing to keep in mind is that the review states that it does not weigh the ***benefits*** of water fluoridation. Adding a tiny amount of fluoride to drinking water helps prevent tooth decay, save on treatment costs and improve oral health of the community.

Review of the Monograph's Findings:

- The report reviews scientific studies related to fluoride in high doses and its potential effect on brain development and function and was unable to provide any new or conclusive evidence about community water fluoridation practices for public health policy consideration.
- The latest version of the NTP monograph does not find harm associated with the 0.7 parts fluoride per million parts water (the current recommended levels for optimally fluoridated water levels per the U.S. Public Health Service recommendations.)
- The NTP acknowledges the weakness of the evidence when they cannot establish fluoride as the cause of affecting IQ.
- A major failing is the omission of the meta-analysis, which undermines the report's robustness. Many of the concerns previously raised by the National Academies of Sciences, Engineering, and Medicine (NASEM) panel—such as inconsistent application of risk of bias criteria, inadequate statistical rigor, and selective reporting of non-significant study results—persist in this version.

Other Information:

- Public health recommendations are based on a collective weight of scientific evidence. Studies prove water fluoridation continues to be effective in reducing tooth decay by more than twenty five percent in children and adults, even in an era with widespread availability of fluoride from other sources, such as fluoride toothpaste.
- For nearly 80 years, people in the United States have benefitted from drinking water with fluoride, leading to better dental health.
- The U.S. Public Health Services' recommendation is that the amount of fluoride needed in water to help prevent tooth decay is 0.7 parts per million is supported by the Centers for Disease Control and Prevention (CDC) and many other public health authorities.
- The American Dental Association will continue to monitor scientific research regarding the safety and effectiveness of water fluoridation.

Editor's Note: Fluoridation controversies are never ending gifts to dentistry, so far. In the Editor's opinion, there is nothing new with regard to the report linking fluoride to potential cognitive compromise in humans. After all, everything is toxic, even lethal, in the right wrong dose, such as oxygen or water, which both can kill humans. Whereas in the right dose, oxygen and water sustain life as fluoride helps mitigate the ravages, including death, of the most common disease in the modern world, dental decay. The overriding question is whether or not our patients/citizens have given their consent for the Rx in question. The attached 2012 NDAJ 14:4 Editorial "Trust Me, It's Good For You" addresses the responsibility for dentists to obtain reasonable consent before recommending fluoridation. In 2012, citizens who had not approved fluoridation in Clark County had it poured down their throats anyway, in part secondary to support of the forced fluoridation by some politically placed dentists. The same philosophy regarding consent holds for the Editor no matter what the Rx is, including the recent now proven unsafe and ineffective experimental Covid formulations. 🦷

Trust me… It's good for you.

Editor's Message

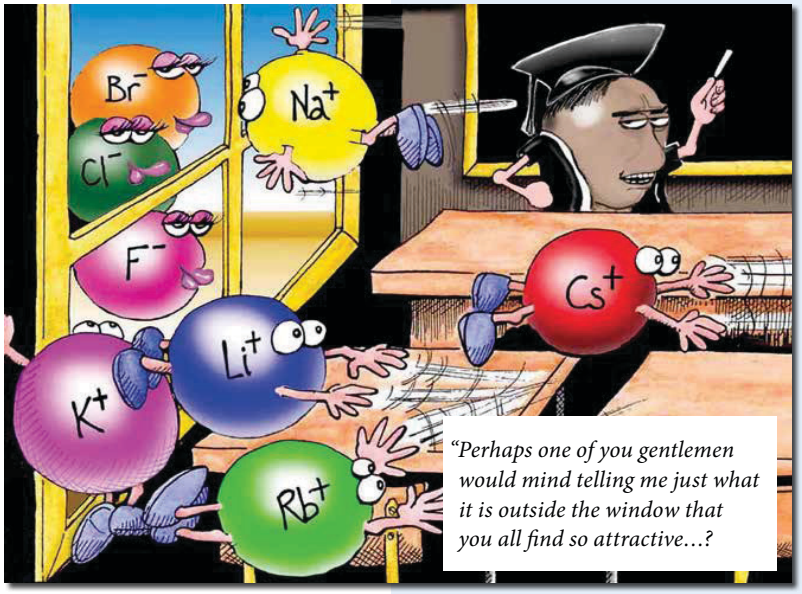
Daniel L. Orr II, *DDS, MS (anesth), PhD, JD, MD*
editornda@nvda.org

Dr. Orr practices Oral & Maxillofacial Surgery in Las Vegas, is a Clinical Professor of Surgery & Anesthesiology for Dentistry at UNSOM, Professor and Director of OMS at UNLV SDM, and is a member of the California Bar. He can be reached at editornda@nvda.org

There is no question that if my community's water supply had been fluoridated, Dr. Stratico would have had much less opportunity to treat carious lesions in my own A, B, G, H, I, J, S and T. He restored as necessary, with functional mercury alloy amalgam, every deciduous molar that had the temerity to erupt into my mouth, where frosted flakes regularly competed with chocolate bars for nutritional supremacy. If given the option of drinking fluoridated water with the promise that fewer cavities would be filled, I would have voted "yes" as a child.

In dental school, the knowledge about the benefits of fluoridated community water supplies are, like fluoride into teeth, dutifully absorbed into student cerebra. The degree of altruism involved in organized dentistry's support for the elimination of so many profitable restorations via fluoridation has likely prompted even St. Apollonia to smile perfectly resurrected teeth from her saintly sphere, even if debt ridden dental students get just a bit concerned about lost MOD revenue.

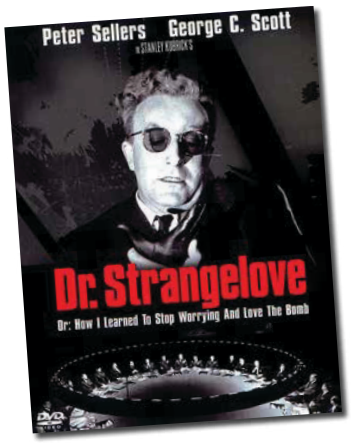
Who couldn't help but wonder though, if fluoridation is such a great idea, why have so many voters been opposed to it over the years and even during the recent presidential election?[1] After reviewing the dental school dogma (fluoride is naturally occurring, will be carefully monitored, etc.), those dentists in the know often opine that anyone who doesn't agree with fluoridation has to be irrational to some degree. A problem is that some of the opposition, a few dentists included, who warn of fluoride-related cancer, CNS, orthopedic, or renal pathology, don't sound that illogical. Parents probably notice that dentists now advise that children drinking fluoridated water need to be careful with the use of fluoride toothpaste, prescriptions, trays (don't swallow!) and other sources of the second most attractive (chlorine is first) oxidizer.



Cartoon reprinted with permission

Some may recall an inhalational anesthetic, penthrane. Kids liked penthrane because it smelled like Juicy Fruit gum. But anesthesiology residents were warned to be judicious when administering methoxyflurane, as penthrane is generically known, because its metabolites include fluoride, which was particularly troublesome in patients who possessed kidneys and livers. Dental anesthesiology residents couldn't help wondering what would happen metabolically in our pediatric renal patients who might also metabolize fluoride from other sources in addition to that mandated by the government in the community water. Methoxyflurane use was largely discontinued in the mid-1970s, in large part because of fluoride issues.

In spite of views expressed in popular media such as the 1964 movie *Dr. Strangelove*, fluoridated water is not likely a Communist plot to exert mind control. However, many creators of film, literature, television, music, etc. have suggested, theoretically tongue in cheek (humorous, not masticatory), a potential use for government prescribed psychogenic medication administration by means of community water supplies.



Interestingly, we now have a very real, very scientific, suggestion that we should consider medicating water with another naturally occurring element, lithium. Studies, initially reporting about communities in Japan and Austria, found up to a 15% decrease in suicide in areas with naturally occurring lithium in the water.[2] Further, lithium has been found helpful in Alzheimer disease. Anecdotal stories about towns with lithium laced "happy water" are abundant.

Dental anesthesiology residents were also warned about psychiatric patients who had been prescribed lithium and were prone to complications of electrolyte imbalance and of the cardiovascular system secondary to concomitant anesthesia administration.[3]

The University of Arizona's *Arizona Water Resource* newsletter reported on pharmaceuticals in the water supply, with particular emphasis on the ramification for the West, in July 2000.[4] This article has been followed by many more commenting on the phenomena of things in our H_2O in addition to hydrogen and oxygen molecules.[5,6]

> "...we as health professionals need to keep an objective professional and ethical eye on things."

The concern is all these additional additives in our water can have significant effects. As tempting as it might be to now pour lithium into the water supply to achieve what is generally seen as a public health benefit, we as health professionals need to keep an objective professional and ethical eye on things. As dentists, we can't be concerned only about the teeth.

To many of the lay public, fluoride is just another government mandated drug—safe and dentally effective though it appears to be.

Dentists promoting fluoridation need to be sensitive to the concerns of our fellow citizens (patient autonomy). Many in Clark County were very agitated when fluoride was placed into the storage tanks in March 2000 after voters had been told that would only happen after a public vote. However, the Water District unilaterally decided the legislature actually meant the voters could vote the fluoride *back out of the water*.[7] No one at the water district in Washoe County has turned on the fluoride yet.

Nearly everyone understands the fact that fluoride helps prevent caries. It is the ancillary issues—real or imagined—associated with fluoridation that dentists are called on to explain logically. This risk benefit analysis not only includes the concerns about adverse effects of fluoridation, but also the political freedom and self-determination of others, which may even be more important. If artificial fluoride in the water is good, why isn't lithium, or something else?

Dental professionals must be prepared to discuss fluoridation in public fora with the same expertise and sensitivity they use in their offices in face-to-face communication.

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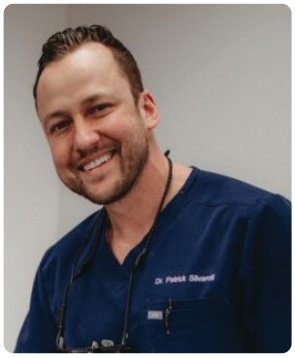


Patrick R. Silvaroli,
DMD

NDA President's Fall 2024 Message

GREETINGS NDA MEMBERSHIP,

I hope you're all doing great and surviving this scorching Nevada summer! It's definitely been a hot one for all of us!

As I get ready to step into the role of NDA president, I've been reflecting on the path that's led me here. And if there's one word that keeps coming to mind, it's mentor. While individually, we ultimately have to do the heavy lifting and put in the hard work, it's mentorship that helps us figure out the way forward. From my days at UNLV (which still feels like just yesterday!) to now, mentorship has been a huge factor in both my professional and personal life.

One of my big focuses this year, along with advocacy, membership growth, and boosting value for our members, is mentorship. I truly believe that while our profession starts in dental school, the guidance we receive shouldn't stop there. We're working on a pilot program within the NDA to connect mentors and mentees throughout the state in various areas of dentistry. This is about more than just clinical mentorship; it's about advice on practice transitions, ownership, retirement, and even physical, mental health and wellness. How great would it be to have someone to turn to, not just as a mentor, but as a friend, when you need some guidance? What better way to unite us as a profession across the state than by building a strong dental community where we can support and help each other?

I'm really excited to see this program grow into something that includes support for all aspects of our lives, from legal and financial advice to overall wellness. We have such a wealth of experience within our community, and I think this network can be a game changer for bringing us closer together.

In other exciting news, we are thrilled to welcome Ms. Marianna Kacyra as our new Executive Director! She's already hit the ground running, and I'm confident she's going to do an amazing job for the NDA and we're so lucky to have her on board!

Now, switching gears to legislative news—2025 is shaping up to be another exciting legislative year. After a successful 2023 session alongside our lobbying partners TriStrategies, we were able to make some gains with the DLR (Dental Loss Ratio) bill and teledentistry regulations addressing DIY dentistry (e.g., Smile Direct Club). We look forward to tackling new initiatives in 2025.

Here's a quick rundown of what's coming up:

External Review Process for Dental Insurance Claims

We want to establish a third-party review system for claims disputes. No more insurance companies having the final say, let's make it fair!

Temporary Licensure for Dental Hygienists

We're looking at ways to get out-of-state hygienists working in Nevada faster with temporary licenses. This will help fill those staffing gaps in the interim while we continue to work on avenues available for increasing the dental workforce.

Same-Day Denial Prohibition

We're pushing for legislation that stops insurance companies from denying claims when multiple procedures are done in one day. It's about time dentists' judgment takes priority!

Medicaid Rate Review and Adjustment

Raising Medicaid reimbursement rates could make a big difference in access to care. We're working on this one too, either through legislation or by teaming up with state agencies.

And don't forget to mark your calendars for Oral Health Day at the state Legislature on April 15, 2024! This is a chance for us to meet with our lawmakers in Carson City, tell our stories, and make sure they understand what's important to us in the dental community.

As always, if you have any questions, ideas, or just want to chat, please reach out to your component leadership (NNDS, SNDS, NENDS) or to me directly. I'm so grateful for all of our amazing volunteer leaders, committee members, and of course, the fantastic support we get from Lori Benvin NNDS/NEDS, Esther Johnson SNDS, and Marianna Kacyra. We couldn't do any of this without you!

We've got a lot to do, but I'm feeling energized and ready to take on the challenge. We'll keep you posted on all the latest updates throughout the year. Please remember to check your emails and attend your local component society meetings to stay up to date.

Hope you all enjoy the rest of your summer! 🦷

All the best,

Patrick R. Silvaroli, DMD
NDA President

Marianna Kacyra

NDA Executive Director's Fall 2024 Message

HELLO NDA MEMBERS,

I am thrilled to share the exciting news that the NDA's Executive Committee has appointed me as the new Executive Director. I am deeply honored to take on this role and look forward to leading our association to new heights. While I understand that the journey ahead may present challenges, I am fully committed to facing them with determination and resilience.

During my tenure as the Membership Director at NDA, I was fortunate to build meaningful and valuable relationships with our members and directors. These relationships have been the cornerstone of my work, and I firmly believe that together, we can accomplish great things. As a relationship-focused person, I am dedicated to fostering these connections to support our shared goals and advance organized dentistry.

I recognize that there will be a learning curve, but I am prepared to navigate it with the same dedication I have always shown. My primary goal is to enhance the NDA and to provide unwavering support to all of you. I am here to assist in any way I can, and I am committed to serving our community with everything I have.

Each one of you plays a vital role in our collective journey, and together, we can achieve remarkable success. Let's move forward, hand in hand, united in purpose and vision.

One of the aspects I am particularly grateful for is the opportunity to network with Executive Directors across the nation. Learning from what other states do to achieve success and enhance their membership has been incredibly valuable, and I am excited to bring some of these insights to the NDA.

We have many exciting initiatives on the horizon. NDA President Dr. Silvaroli is launching a new benefit program with a Mentorship initiative designed to support our dentists. Our Membership Council Chair and the entire Council are enthusiastic about taking this program to new heights and providing invaluable assistance to all our members.

In addition, I am pleased to announce that the NDA will launch new Wellness Sessions, which I hope all of you will participate in. We all face numerous challenges in our daily lives, and wellness is something we all need to prioritize. These sessions are designed to support your well-being, and I believe they will be a valuable resource for all our members.

My ultimate goal is to see Nevada united as one state. We are powerful when we work together; when we do, there are no limits to what we can achieve. This is my motto, and nothing is going to stop us.

Thank you once again for your confidence and support. Your trust in me is the fuel that drives my commitment to this association. I am excited to embark on this journey with you, and I can't wait to see what we will achieve together.

NNDS President's Fall Message

K.C. Gilbert,
DMD, MS

GREETINGS FROM THE NORTHERN NEVADA DENTAL SOCIETY,

It has been a great year so far in Northern Nevada! We have been successful in offering events that bring great value to our members. I am so appreciative of the strong relationships and bonds that have been and continue to be created between NNDS members. The outstanding tradition of collaboration and support that has been established in our community of dentists is alive and well! I would be remised if I did not thank our Executive Director, Lori Benvin, as well as our newly appointed NDA executive director, Marianna Kacyra, for their dedication and work to help maintain that tradition.

This past January we hosted a great dinner meeting on Forensic Accounting and Embezzlement. I would like to thank Keith Dunnagan from BPE Law Group for his professional insight on the topic. Our dental society also hosted a successful Vendor Night this past February as well as a great course on local anesthesia by the renowned Dr. Stanley Malamed in April.

We are excited to kick off our fall events and offerings for members which started with our annual NNDS Picnic on August 15. The annual picnic has become one of my favorite yearly events as it not only brings members together but their families as well. This upcoming fall we are excited to host more wonderful CE events including a lecture by Dr. Aora on "Perimplantitis" as well as a hands-on course on 3D scanner digital workflow. We will also continue to host great social events for our members such as our annual Mystery Bus Trip, which was a tremendous success last fall.

I am encouraged by the NDA's advocacy efforts for our profession in collaboration with our lobbying team, Tri-Strategies. Current legislative efforts include establishing third-party adjudication for dental insurance disputes, temporary and immediate licensure for dental hygienists to address workforce shortages, adjustment of Medicaid dental reimbursements, and prohibition of insurance companies denying multiple medically necessary services provided on the same day. The NNDS executive board is working hard to support advocacy efforts to help protect and grow our great profession. Many of our NNDS executive members are contributing significantly to the NDA's Council on Government affairs and I would like to sincerely thank them for donating their time and efforts.

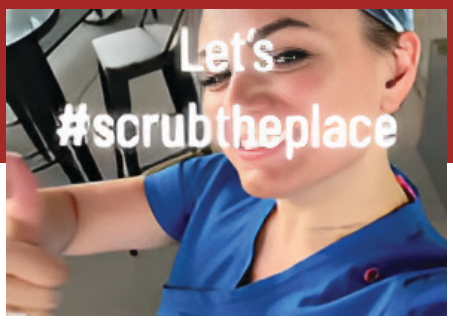
In closing, I'd like to thank all our dedicated NNDS members for your continued support and active participation in our events and advocacy initiatives. It is through your engagement that we can strive for positive change and progress. As we look forward to the upcoming events and educational opportunities, let us continue to enjoy the connections and friendships that make our society truly unique. Thank you for being a part of the NNDS community! 🦷

Thank you

Sincerely,

Dr. K.C. Gilbert
NNDS President

SNDS



SNDS is embracing a new way to build community! On July 30th, 2024, SNDS members, non-members, and students gathered to "Scrub" (fill it with Dentists wearing scrubs) the Taps & Barrels!

WANT TO GET INVOLVED???

Join SNDS for another chill Happy Hour shindig on September 5th, 2024 from 6-9 Pm (or whenever) at Taps & Barrells on S Buffalo! We're encouraging New Dentists (10 yrs of practice or less) to come out and get to know each other!

WE WANT TO KNOW YOU!!! - DR. CHRISTINE LEMON, SNDS PRESIDENT

ON FIRE!

Mark your calendars on October 10th, 2024 at 6PM for an incredible evening celebrating Southern Nevadan Dentists and supporting the Oral Cancer Foundation!

SNDS GALA & AWARDS NIGHT

Experience Old Hollywood with the incredible view of the Hard Rock Cafe! Wear your finest Black, White, or "Oscar Gold" formals as you get your picture taken on the red carpet! Enjoy delicious food and find your way to the dance floor before the big presentation. Could you take home an award?!

NOMINATIONS ARE OPEN! JOIN US!
- ESTHER JOHNSON, SNDS ED

Lori Benvin
nnds@nndental.org

News from the Northern Nevada Dental Society

This year, behind the scenes, Nevada was initially chosen, along with five other states, to be part of the ADA's membership Pilot Program launching in September and impacting your membership dues for 2025. Unfortunately, just last week the ADA announced Nevada is being paused from this program until 2026.

For many of you this announcement may be unclear as most members weren't even aware of what the pilot program entailed and what benefits it would bring. As much as there were staff at the component level, the state level, and national who put many hours into developing and preparing for this launch we are confident that giving Nevada more time to polish these exciting benefits for all dentists in Nevada for 2026; making them worth waiting for. Watch for more news on this to come.

Looking ahead and knowing Nevada has a bright and successful future is the announcement of Nevada Dental Association's new Executive Director Marianna Kacyra! You all know her already as the former Director of Member Services, she started her new role as E.D. on August 1 and we welcome the change and know Marianna will move Nevada in a positive and united direction. Congratulations Marianna!

The NNDS is moving into its continuing education and special event year for 2024–25. With this new event year, we welcome your 2024/25 Executive Board members; Drs. K.C. Gilbert, *President*, Garrett Swanson, *Vice President*, Whitney Bryant, *Secretary/Treasurer*, Chris Galea, *Past President,* and our three *Members at Large* Drs. Megan Utter, Trisha Hansen, and Debra Peterson. We know under their leadership, NNDS will continue to bring value to the NNDS. Watch our email communication for all of our upcoming events and continuing education opportunities tailored to enrich the professional development of our members. **See Page 33** for a list of our events and speakers.

In conclusion, the Northern Nevada Dental Society remains firm in its mission to promote excellence in dentistry through education, community service, and member involvement. Our appreciation to all our members, the dental community, and volunteers for their steadfast support with NNDHP or whatever charity you choose to give back, and we eagerly anticipate the opportunities and challenges that lie ahead as we strive toward continued growth of the NNDS!

Please be patient with our website as with the big change at the ADA with a new software, Fonteva Salesforce, With anything new comes bumps in the road and our website will be experiencing some glitches, but we will work to get them ironed out and convenient for all registrations and information on line at www.nndental.org/events.

Welcome Newest NNDS Members

Andrew Korcek, DDS — *General*

Michael Aglietti, DDS — *Dental Pathologist*

Jessica Miskavage, DDS — *General*

Hannah Swift, DMD — *General*

Cole VanderWel, DDS — *General*


Northern Nevada
DENTAL HEALTH PROGRAMS
/ Joel F. Glover DDS Charity
22ND
ANNUAL GOLF
TOURNAMENT
providing dental care to the underserved in our community
20 SEPT 2024 || 7:45 AM AT RED HAWK GOLF-
HILLS COURSE
REGISTER NOW

David Mahon, DDS

Fall Article

The Nevada Dental Foundation (NDF) opened the Tonopah Dental Center (TDC) November 3, 2023, in rural Central Nevada. The practice has been well received by the residents of this underserved, frontier region.

Currently, the staff is comprised of volunteer tripartite members, hygienists, dental assistants, and support staff.

Our goal is to recruit a qualified full-time dentist, eligible for one of the available student loan repayment programs.

This enterprise has been a rewarding experience for our volunteers, building camaraderie amongst colleagues, while facilitating team building with staff.

We value our partnership with the Nevada Dental Association; your support has made the NDA's Council on Advocacy for Access and Prevention concept of rural dental care a reality, showcasing organized dentistry's ability to solve access issues in our state. For decades, no progress was made, or dental programs established.

Please contact the NDF if you would like to volunteer and improve rural residents' access to oral health care.

NevadaDentalFoundation@gmail.com or call TDC (775) 477-3033.

The NDF would like to thank the following volunteers for their service providing patient care:

Kalpana Bhatt, Dental Assistant
Adaven Children's Dentistry & Orthodontics, Henderson

Phyllis Boucher, RDA
Wineman Dental, Henderson

Dr. Trina Chau
Radiant Smiles, Las Vegas

Dr. Grace Chung & Kaylee Chung
Smile Shop Dental, Henderson

Ronda Farnsworth, Dental Assistant
Round Mountain

Libby Griego, RDH
Siena Dental, Henderson

Jennifer Krantz, Dental Assistant
Dr. Robin Lobato & Associates, Las Vegas

Dr. Robin Lobato
Dr. Robin Lobato & Associates, Las Vegas

Brea Mahon, RDH
Siena Dental, Henderson

Dr. Dave Mahon
Siena Dental, Henderson

Lourdes Mcintire, Dental Assistant
Siena Dental, Henderson

Dr. Nina Mirzayan
Adaven Children's Dentistry & Orthodontics, Henderson

Kiana Oda, Dental Assistant
Siena Dental, Henderson

Linda Pilster, Sterilization Technician
Wineman Dental, Henderson

Shawna Rivera
Dr. Robin Lobato & Associates, Las Vegas

Dr. Mark Rosenberg
Captain, United States Public Health Service (retired), Sparks

Julie Stage-Rosenberg, RDH, MPH Professor, Truckee Meadows
Community College (retired), Sparks

Tiffany Schultz, Treatment Coordinator
Dr. Robin Lobato & Associates, Las Vegas

Dr. Mary Tabrizi
Associate Professor, UNLV School of Dental Medicine, Las Vegas

Dr. Sean Truong
Dr. Robin Lobato & Associates, Las Vegas

Dr. Joseph Wineman
Wineman Dental, Henderson

TONOPAH DENTAL CENTER

Dr. Mark Rosenberg and assistant Ronda Farnsworth, patient Donald K

Dr. Rosenberg, and patients

Dr. Trina Chau and Dr. Valeria Romero

Dr. Rosenberg, assistant Lisa Gillard, patients Rebeca and Normar Martin

Dr. Mark Rosenberg and RDH Julie Stage-Rosenberg

Dr. Robin Lobato and his team, Jennifer K and Tiffany S

Assistant Kaylee Chung

Dr. Trina Chau and assistant Norma R

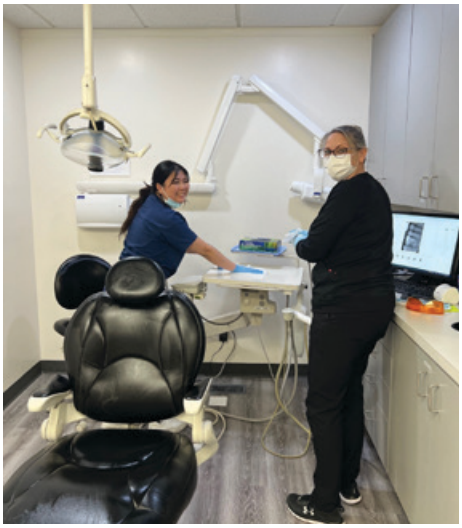
Dr. Rosenberg and patient Alex Guzman

Dr. David Mahon

Dr. Valeria Romero

Dr. Grace Chung and assistant Kaylee Chung

Assistant Lourdes McInquire and patient Laura N



Assistant Kiana Oda and Ronda Farnsworth

RDH Elizabeth Griego and patient Terry Owers

Patient Laura N

NDA Calendar of Events

Northern Nevada
DENTAL SOCIETY

2024			
September			
9/10	**NNDS Executive Committee Meeting**	*5605 Riggins Court, #101A, Reno*	*5:30pm*
9/20	**NNDHP/Joel F. Glover 22nd Annual Charity Golf Tournament**	*Red Hawk Golf Club, Hills course*	*7:30am*
9/27	**NNDS Mystery Bus Trip**	*Location: it's a secret!!*	*5:00pm*
October			
10/8	**NNDS Executive Committee Meeting**	*5605 Riggins Court, #101A, Reno*	*5:30pm*
10/10	**NNDS General Membership Dinner Meeting "Periimplantitis"**	*Atlantis Casino Resort Spa, Reno*	*6:00pm*
10/11	**3D scanner digital workflow hands-on CE/Nobel Biocare Sponsored**	*Atlantis Casino Resort Spa, Reno*	*8:00pm*
November			
11/12	**NNDS Executive Committee Meeting**	*5605 Riggins Court, #101A, Reno*	*5:30pm*
11/14	**NNDS General Membership Dinner Meeting with Dr. Nathaniel Lawson**	*Atlantis Casino Resort Spa, Reno*	*6:00pm*
11/15	**All-day CE Course w/ Dr. Lawson/3M Sponsored**	*Atlantis Casino Resort Spa, Reno*	*8:00am*

Check our website for the latest updates to calendar at www.nndental.org.

Administrative Offices

NDA Executive Offices

Marianna Kacyra, Executive Director
600 E William St, Ste 202
Carson City, NV 89701
Office 775-558-9404 • Cell 775-772-6744
mkacyra@nvda.org • www.nvda.org

PRESIDENT	Patrick Silvaroli, DMD
PRESIDENT-ELECT	Sheronda Strider-Barraza, DMD
VICE PRESIDENT	Aimee Abittan, DMD
SECRETARY	Perry Francis, DDS
TREASURER	Tina Brandon-Abbatangelo, DDS
PAST PRESIDENT	Ed De Andrade, DDS

Nevada State Board of Dental Examiners

Christopher Bateman, MBA, Executive Director
Chelsea Lucas and Parker Arecchi, Licensing & Credentialing
2651 N Green Valley Pkwy, Ste 104
Henderson, NV 89014
702-486-7044 • 800-DDS-EXAM
FAX 702-486-7046
nsbde@nsbde.nv.gov
www.nvdentalboard.nv.gov

Northern Nevada Dental Society

Lori Benvin, Executive Director
5605 Riggins Ct, Ste 101A
Reno, NV 89502
775-337-0296 • FAX 775-337-0298
nnds@nndental.org • www.nndental.org

PRESIDENT	K.C. Gilbert, DMD, MS
VICE PRESIDENT	Garrett Swanson, DMD
SEC./TREASURER	Whitney Bryant, DDS
PAST PRESIDENT	Christopher Galea, DDS, MD
MEMBERS AT LARGE	Megan Utter, DDS, MS
	Debra Peterson, DDS
	Trisha Hansen, DMD

Northeastern Nevada Dental Society

Marianna Kacyra, Executive Director
600 E William St, Ste 202
Carson City, NV 89701
Office 775-558-9404 • Cell 775-772-6744
mkacyra@nvda.org • www.nvda.org

PRESIDENT	Jeremy Keener, DDS
VICE PRESIDENT	Scott Forvilly, DDS
SEC./TREASURER	Todd Thompson, DMD

Southern Nevada Dental Society

Esther Johnson, Executive Director
9205 W Russell Rd, Ste 240
Las Vegas, NV 89148
702-793-4455 • FAX 702-733-6062
www.sndsonline.org

PRESIDENT	Christine Lemon, DDS
PRES-ELECT	Sonal Shah, DDS
PAST PRESIDENT	Richard Shoen, DDS
SECRETARY	TBD
TREASURER	Moni Ahmadian, DMD

American Dental Association

211 E Chicago Ave
Chicago, IL 60611-2678
312-440-2500 • 800-621-8099
www.ada.org

ADA DELEGATES	TBD
	Tina B. Abbatangelo, DDS
	David M. White, DDS

NDA Committees

Council on Communications

Dr. Erin Anderson, *Chair*
Dr. Daniel Orr
Dr. Garrett Swanson
Dr. Tina Brandon-Abbatangelo
Ms. Marianna Kacyra (NDA Staff)

Council on Ethics, Bylaws and Judicial Affairs

Dr. Tina Brandon-Abbatangelo, *Chair*
Dr. Brady Neugebauer
Dr. Michael Banks
Dr. Todd Wilkin
Ms. Marianna Kacyra (NDA Staff)

Council on Government Affairs

Dr. David White, *Chair*
Dr. Whitney Bryant, *Vice Chair*
Dr. John Griffiths
Dr. Steve Saxe
Dr. Christian Peralta
Dr. Rick Dragon
Dr. Daniel Orr
Dr. John Nerwinski
Dr. Michael Britting
Dr. Marc Cirelli
Ms. Marianna Kacyra (NDA Staff)

Council on Membership

Dr. Scott Sutter, *Chair*
Dr. Deaudre LeCato
Dr. Christine Lemon
Dr. Steve Saxe
Mr. Tyler Divis
Ms. Autumn Wolfer (ADA Staff)
Ms. Lori Benvin (NNDS Staff)
Ms. Esther Johnson (SNDS Staff)
Ms. Marianna Kacyra (NDA Staff)

ADA Business Resources affliated

We are pleased to announce that the NDA and ADA have combined the purchasing power of dentists to gain discounts on a large variety of products and services. Call the company or the NDA to learn more.

CareCredit
Patient Financing
800-300-3046 x4519 www.carecredit.com

InTouch Practice Communications
877-493-9003
www.intouchdental.com/ada

NDA-Affiliated Products

These companies and their products have been evaluated by the NDA and are recommended for use in running your practice. Let us know if you have any feedback or would like to recommend a product or service for affiliation. For a weblink to each company, go to www.nvda.org/affiliatedproducts.shtml.

Best Card, LLC
Credit card processing
877-739-3952 www.bestcardteam.com

The Dental Record
Digital record keeping
800-243-4675 www.dentalrecord.com

TDIC
The Dentists Insurance Company
800-733-0633
www.tdicinsurance.com

TDSC Supplies
The Dentists Supply Company
dentalsupplies.tdsc.com/nevada

IC System
Collection service
800-279-3511 www.icsystem.com/nda.htm

Lands' End Business Outfitters
Uniforms
800-490-6402 www.ada.landsend.com

Lenovo
800-426-7235 ext. 4886
www.adabusinessresources.com/en/endorsed-programs/computers

Mercedes-Benz
Mercedes-Benz leasing
866-628-7232 http://ebusiness.ada.org/adabei/luxury-vehicles.aspx

Office Max
Office supplies
702-647-8662 www.officemax.com

SurePayroll
Payroll processing
866-535-3592 www.surepayroll.com/ada

Compliancy Group
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You wouldn't want a coach who hadn't been a player, so why would you want a lawyer who hasn't practiced dentistry? Contact Tom Brooksbank, DDS, Esq. at 702-337-6772 or dr.tom@runbox.com.

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