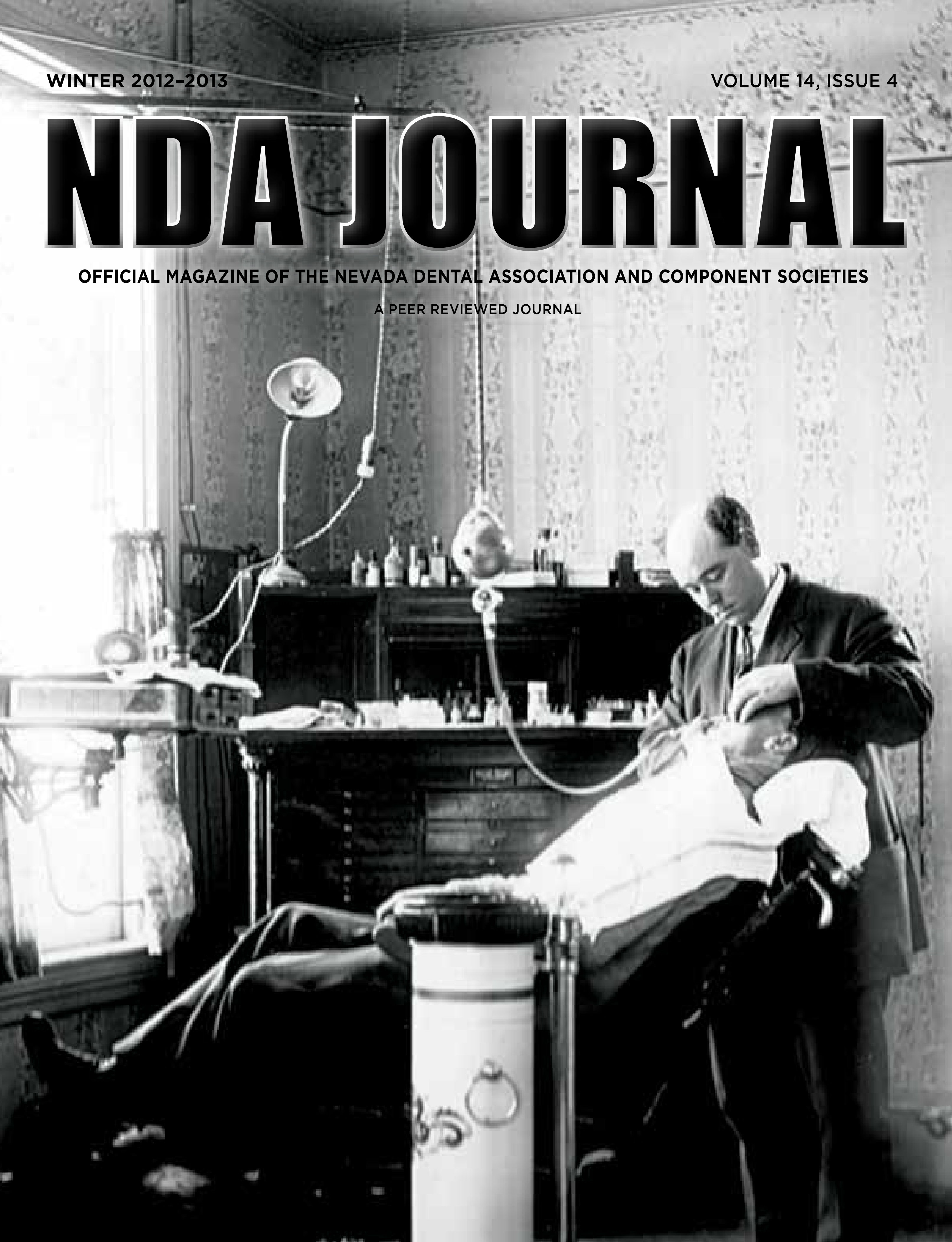

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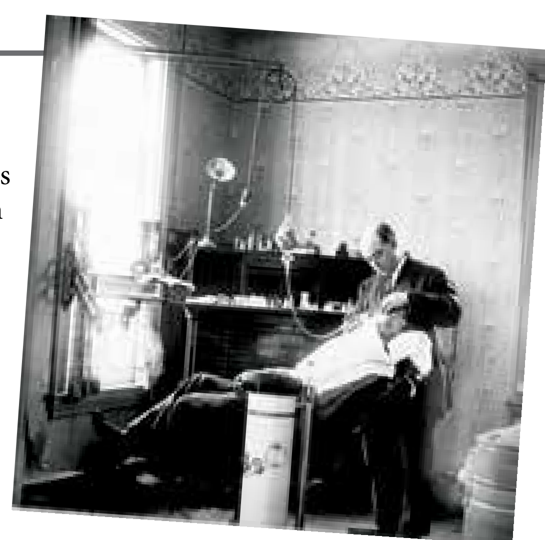

Dentist John Edward Burgan in his practice in Grantsburg, Wisconsin during the early 1900s.

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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 or 702-383-3711.

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.

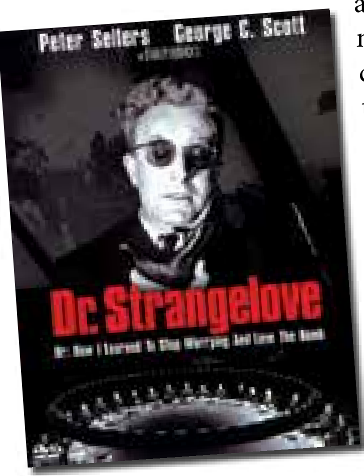
"Perhaps one of you gentlemen would mind telling me just what it is outside the window that you all find so attractive…?

Cartoon reprinted with permission

Continues ➲

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]

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.

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

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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Save the Date!

NDA Mid-Winter Meeting

Friday, Jan. 25, 2013

Gold Coast Hotel & Casino
Las Vegas

Visit www.nvda.org
or call 702-255-4211 for details

I hope your holiday season was happy and safe.

The 153rd annual convening of the ADA House of Delegates (HOD) completed its deliberations on October 23 at the 2012 ADA Annual Meeting in San Francisco, California. Attending the HOD meeting were Delegates Steve Rose, Gilbert Trujillo and Jade Miller; Alternate Delegates Mark Handelin, Brad Wilbur; and Executive Director Robert Talley.

The House of Delegates conducted four sessions including the election of Dr. Charles Norman of North Carolina as President-elect, Dr. Brian Scott of California as Second Vice-President, Dr. Ron Lemmo of Ohio as Treasurer and Dr. Glen Hall of Texas as Speaker of the House. The HOD installed Dr. Robert Faiella of Massachusetts as President and Dr. Ken Versman of Colorado (14th District) as First Vice-President. Over 180 primary and amended resolutions were considered during the sessions and some are of special interest:

- The House closely defeated a resolution to reduce the size of the House of Delegates from 473 to 300.
- A resolution to recognize Dental Anesthesiology as a dental specialty failed.
- The House approved a budget of about $117 million with an ADA dues increase of $10.
- Approved a resolution to increase active life member dues to 75% of regular dues, up from 50%.

These are only a few of the hotly contested resolutions and please call with any questions. Watch your ADA news for more on the annual meeting.

The NDA owes a debt of gratitude to Dr. Jade Miller for his 10 years service as Delegate from Northern Nevada. This was his last meeting as ADA Delegate. Good job, Jade!

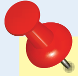
2013 events

The Annual NDA Mid-Winter meeting will be held January 25, starting at 9AM at the Gold Coast Hotel & Casino, 4000 W Flamingo Rd in Las Vegas. We are fortunate to have ADA Executive Director, Dr. Kathleen O'Loughlin, as our leadership speaker.

The 2013 Nevada Legislative Session begins on February 4. Your NDA team will be watching closely for anything that affects the interests of your profession, your practice or your patients. During the session you may receive e-mails that urge you to contact your legislators. We do not send these e-mails simply to clutter your inbox. As best we can, we limit our "calls to action" as we understand that too many e-mails will result in turning the member against the process. These calls to action are only sent at extremely critical junctures during the legislative process and only on issues of extreme importance. The value of a solid response by the membership to individual legislators is honestly "priceless." They do listen to their constituents and they prefer personalized communication instead of a "canned" or scripted e-mail. We will always provide talking points for you to use and then ask you to please personalize the communication.

Please save the date of Thursday, March 14 for the NDA "Oral Health Awareness Day at the Legislature" and spend the day with us in Carson City.

Save the date for the 2013 NDA Summer Meeting being held in Squaw Valley, California on July 4–6 at the PlumbJack Inn. A complete sign up and itinerary will be on the website soon and be included in the next journal. ◆



Note from the NDA Executive Director

I have included a letter from our law firm, Wilson Elser Moskowitz Edelman & Dicker, LLP, on employee breaks. This subject comes up from time to time and this is a reminder to our members that if they have more than one employee, they must provide their employees with breaks. The good news is the law allows for an agreement with the employee to be made to forego any rest or meal period, but that must be in writing and kept in the employee's file. Our attorney, Jorge Ramirez, suggests some type of "consideration" for this agreement.

Attention:

NDA new office hours

Mon–Thu, 8am–4pm

Friday, 8am–12pm

Requirements for dental office to provide breaks

By Jorge Ramirez, Wilson Elser Moskowitz Edelman & Dicker, LLP

Recently, the NDA office received an inquiry from a member seeking advice on whether they need to provide breaks to their employees and, if so, the frequency of said breaks. Nevada Revised Statute 608.019 requires that a 30 minute break for lunch be provided to each employee that works during an 8 hour period. The 30 minute lunch break does not have to be paid. NRS 608.019 also requires that a paid 10 minute break be given for each 4 hours worked. That equates to a break in the morning and afternoon for most employees. Unfortunately, dental offices are not exempt from these requirements.

Nevada Administrative Code 608.145 provides even more guidance on the requirements each employer must adhere to for compliance with NRS 608.019. Any employee that works at least 3.5 continuous hours and less than 7 continuous hours is entitled to one 10-minute breaks. NAC 608.145(a). Any employee that works at least 7 continuous hours and less than 11 continuous hours is entitled to two 10-minute breaks. NAC 608.145(b). Any employee that works 11 continuous hours and less than 19 continuous hours is entitled to three 10-minute breaks. NAC 608.145(c). While these break requirements may seem daunting given the nature of the work and staffing needs of your members, the Nevada Administrative Code does provide a method that may be employed by your members' offices that have limited staff.

NAC 608.145(3) allows an employee to voluntarily forego any rest or meal period. After speaking with the Nevada Labor Commissioner, it is apparent that any agreement reached between the employer and employee to forego any rest or meal period **must** be in writing and kept in the employees human resources file. My recommendation is to also include some type of consideration for the employee foregoing the statutory required rest periods. The consideration can be an increase in hourly/yearly pay, a one-time payment or extra paid time off. Including some type of consideration makes the agreement a binding and valid contract that will then be viewed by the Labor Commissioner as an arms length negotiation with the employee.

I also discussed whether an exemption as whole is feasible for your members with the Labor Commissioner's investigator. According to the investigator, the only employers that are allowed exemptions are those that have only one employee working at the establishment. I explained to the investigator that a small dental office operates similar to a single employee establishment because not all of the employees are interchangeable and therefore cannot provide breaks to one another. The investigator said that because a technician can provide a break for the receptionist, an exemption will likely not be granted. We can plead your members' case to the Labor Commissioner, but given the opinions provided by the investigator, we may not prevail.

Please do not hesitate to contact me at **jorge.ramirez@wilsonelser.com** if you want to discuss this matter in greater detail. Thank you for your time, and the confidence that you have shown in my firm to handle this matter. ◆

Gilbert A. Trujillo, DDS
gtdds@charter.net

Well, it's the Holiday Season once again…seems like it goes by faster each year. I hope this finds you and your families healthy and happy.

Now that the elections are over, we have more clarity as to the makeup of our Nevada Legislature. Our lobbyist, Chris Ferrari, has provided us information that will enable us to continue to establish strong relationships with our legislators. He, along with Dr. Robert Talley and Dr. David White, met with most of our legislators over the past several months. Also, many of our dentists attended candidate fundraisers and events. These efforts have sown the seeds that we will need during the upcoming legislature session. (*Read a report from Chris Ferrari on page 12.*)

On the national level, it is apparent that Obamacare will continue. Although there is not a strong dental component to the bill, there will be implications down the road that will certainly affect us. There are estimates that tens of thousands of children in Nevada will join the Medicaid ranks. This influx will burden those dentists who take Medicaid, and it will certainly make it apparent that there are not enough providers or funding to handle such a large increase. The NDA is well aware to this impending issue and we will be monitoring the situation.

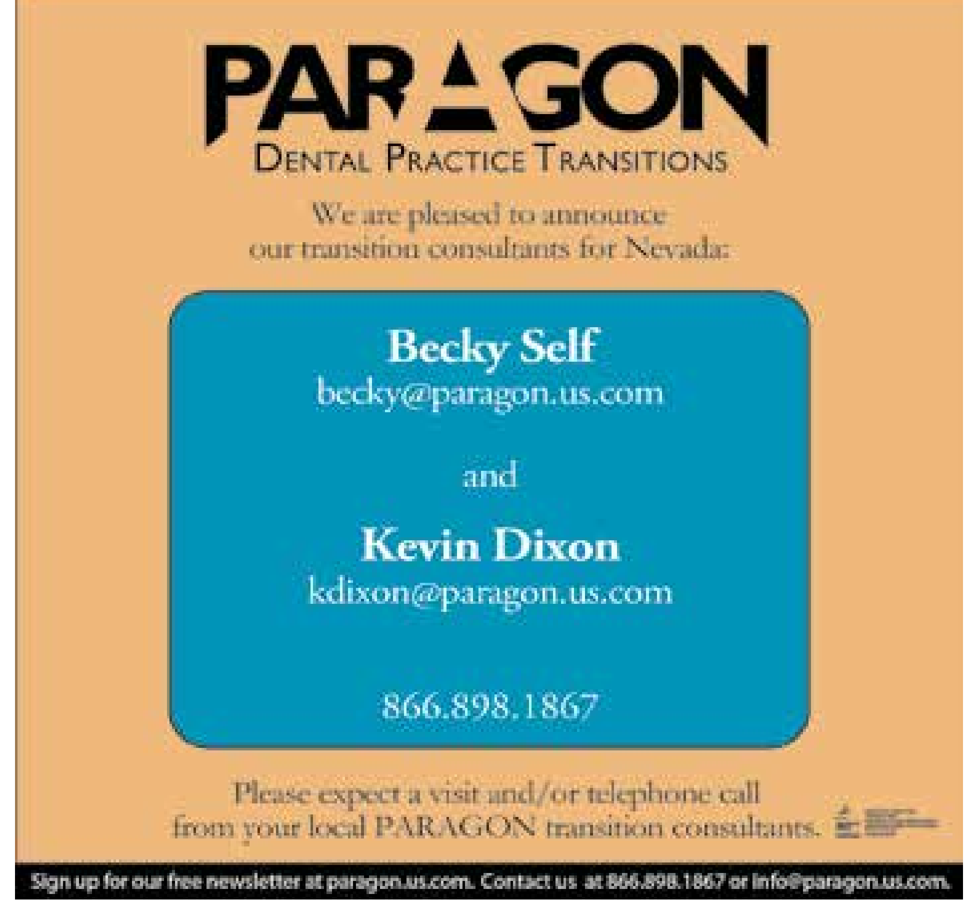
Mr. Ferrari and Dr. Talley are also monitoring any proposed legislation for dental implications. We feel that our number one job is to advocate for our members and patients. As of today, there is nothing proposed with a negative impact on dentistry, but it is still very early. On March 14, there will be a Legislative Day in Carson City that we hope to have a strong presence of dentists present. We will be providing information on this event later on as we develop our plans.

We are also pursuing our own legislative initiatives, such as Non-Covered Services. We have in place a task force of dentists working to ascertain if we should proceed with legislation. As this progresses, we will keep our membership informed.

Our Mid-Winter meeting will be held on January 25 at the Gold Coast in Las Vegas. This will be a working meeting and we will have Dr. Kathleen T. O'Laughlin, Executive Director of the ADA, as our guest speaker. Thank you to Dr. Talley for securing such a high profile speaker for us. We will use this meeting to further our leadership training to allow us to better handle our role as your advocate.

Our Summer Meeting will be held in Squaw Valley, California over the Fourth of July holiday. This is one of the most beautiful areas in the world and it provides a myriad of recreational opportunities for your families. I hope to see all of you there.

Again, I would like to thank all of the dentists who participate in the NDA, your commitment to dentistry is to be commended. I am blessed to be in such good company! ◆



Oral Health Program snapshot

June–November 2012

Staff changes

The Oral Health Program underwent major staffing changes beginning in June 2012. In June, Tim Streeper, MS, assumed the role of program manager, and Melanie Flores, MSW, became the new oral health program coordinator. In October 2012, Aisha Bowen joined the program as the Oral Health Educator/Fluoridation Coordinator. The new staff is eager to help propel the state Oral Health Program to continued success. For information about any statewide oral health matter, please contact Tim at 775-684-5985 or tstreeper@health.nv.gov.

Statewide dental director

Through an interlocal contract with the University of Nevada School of Dental Medicine, the Oral Health Program has obtained the services of Professor Christina Demopoulos, DDS, MPH, to serve as the Nevada State Dental Director. Dr. Demopoulos brings tremendous clinical knowledge, general oral health knowledge, and public health knowledge to this part-time role. She will serve as a liaison to the dental community, as well as providing guidance and advice to the Oral Health Program.

Sealant programs

The Oral Health Program continues to partner with Future Smiles, Seal Nevada South, and Health Access Washoe County (formerly St. Mary's) to provide dental sealants and oral health education to Nevada's school children. So far this year, the sealant partners have placed nearly 7,500 dental sealants on 1,750 school students, and have provided oral health education to over 3,000 students statewide.

The burden of oral disease in Nevada

In June 2012, the Oral Health Program published *The Burden of Oral Disease in Nevada*. The report summarizes the most current information available on the oral disease burden of people in Nevada. When available, comparisons are made with the most current national data, Healthy People 2020 goals, and in some instances where objectives have changed, Healthy People 2010 goals. The entire report can be found at: http://health.nv.gov/PDFs/OH/BurdenOfOralDisease2012.pdf.

Nevada Oral Health Initiative

http://health.nv.gov/CC_OralHealth.htm

Medicaid—Division of care financing and policy

Alexis Ulrich, has taken over the dental programs with social services of the state of Nevada, Division of Health Care Financing and Policy (DHCEP), Medicaid, Dental, School Based Services, Therapies, and Indian Health Programs opened lines of communication with Nevada's Advisory Committee on the state program for Oral Health (AC4OH) and Medicaid/CHIP for assistance in clarification, coding, billing issues, reimbursement delays and concerns of providers of Medicaid/SCHIP dental services. If you need assistance, please contact Alexis at 775-684-3613.

Oral Health Summit

The statewide oral health summit, previously scheduled for June 2012, was rescheduled in conjunction with the Statewide Chronic Disease conference on Jan. 18–19, 2013 at the JW Marriott Hotel and Resort in Las Vegas. There will be an oral health summit on January 18 in the afternoon, with continued oral health interest areas woven throughout the conference, including a keynote presentation by William Bailey, DDS, MPH, RADM, United States Public Health Service, Chief Dental Officer, USPHS, Acting Director, Division of Oral Health, Centers for Disease Control and Prevention. For more information, please contact Tim Streeper at 775-684-5985 or tstreeper@health.nv.gov or visit www.nphf.org/events.asp.

Head Start Basic Screening Survey (BSS)

The 2011–2012 Head Start Basic Screening Survey (BSS) oral health, height, weight, and body mass percentile calculations has completed the data collection stage, and data analysis is currently underway. The Oral Health Program (OHP) invited 2,925 children, aged 3 to 5 to participate. Senior dental hygiene students from Truckee Meadows Community College (TMCC) assisted OHP in Reno and the College of Southern Nevada (CSN) partnered with OHP in Las Vegas.

Oral Health Program needs assessment completed

In October 2012, Lisa Maletsky, a MPH candidate from the University of Nevada Reno finished a 4-month internship with the Oral Health Program. Her primary project was the completion of a needs assessment, where she gathered data through personal interviews and surveys of oral health stakeholders from around the state of Nevada. She presented her findings at the quarterly meeting of the State Advisory Committee for Oral Health (AC4OH), on December 7, 2012. The meeting was in Las Vegas, and videoconferenced to Carson City. For more information about the meeting, contact Tim Streeper at 775-684-5985 or tstreeper@health.nv.gov. ◆

Chris Ferrari
chris@ferraripa.com

Nevada, the NDA, and the 2012 election

The 2012 election brought few surprises for those of us who live in the political world, but as always, there were a few zingers that kept us on our toes until the wee hours of election night, and overall—some very, very close races.

Your NDA interviewed every viable post primary state legislative candidate. To put that in perspective, there were 54 races in play—42 in the Assembly and 12 in the Senate, two candidates in each race, with each interview taking approximately 30 minutes. A special thanks to Drs. Talley and White for interviewing the candidates, and to the members of the Government Affairs and Executive Committees for their guidance in the process.

Federal races

On the national level, it's no surprise that Barack Obama swept the Silver State by more than six points. Democrats began a very significant voter registration drive early in 2012, and by June, monthly voter registration updates showed Democrats outpacing Republicans by nearly a 3–1 margin. That continued until election day, which made it impossible for Republicans to catch up, and President Obama won our "swing" state easily, which led some to ask if Nevada is still a swing state at all.

Congresswoman Shelley Berkley was defeated by Dean Heller in a nail-biter that lasted late into election night. Heller was the only Republican U.S. Senator to win his election over a Democratic challenger in the close "toss-up" races the national Republican party had bet they could win.

Republican Congressman Joe Heck easily defeated his challenger, Democrat State Assembly Speaker John Oceguera. State Senate Majority Leader Steven Horsford (D) easily beat Danny Tarkanian (R) to be the first to represent CD 4, while Dina Titus (D) and Mark Amodei (R) faced no real opposition and easily won their races.

Nevada has one Democrat and one Republican in the U.S. Senate, and two Democrats and two Republicans in Congress. Maybe we are still a swing state…

State races

On the state level, the battle for the state senate was the hot ticket. There were five key senate races that would ultimately determine control, and the Republicans had to win four of five to take it. Republicans won three of the five, giving them ten seats, and the Democrats held 11 seats, creating a one member advantage—the same as the 2011 session. Three of the five races were won by less than 1,000 votes.

In the state assembly, the shocker of the evening was the defeat of Democrat Majority Leader and Speaker-in-Waiting Marcus Conklin. Conklin was edged out by political newcomer Republican, Wesley Duncan, in a district in northwest Las Vegas that includes Sun City Summerlin.

New state leaders

In the state Senate, Mo Denis (D–North Las Vegas), will lead the Majority Caucus and Debbie Smith (R–Washoe) will be Assistant Leader. In the Minority, Michael Roberson (R–Las Vegas) will be leader and Ben Kieckhefer (R–Washoe) will be Assistant Leader.

Assemblywoman Marilyn Kirkpatrick (D–North Las Vegas) will be Speaker of the state assembly and she has appointed Assemblyman William Horne (D–Las Vegas) as Majority Leader. Kirkpatrick is the first Speaker from the private sector since Joe Dini (D–Yerington) nearly two decades ago. In the minority, Pat Hickey (R–Washoe) will be the leader.

At the time of this article being written, the Assembly had not chosen committee members yet, but Senate information is available at http://leg.state.nv.us/Session/77th2013/Committees/.

We need your help!

Thursday, March 14, 2012—Carson City

The foundation has been laid, the work has been done, and the relationships have been forged. On February 4, your NDA lobbying team will enter the 77th Nevada Legislative Session where we will be tackling issues—offensive and defensive—to help preserve the dentist-patient relationship.

The NDA has reserved Thursday, March 14, in the legislature for Oral Health Awareness Day and we need you there! We need to show legislators all of the positive services you provide, the pro bono work you do in your communities, and why it is so important to preserve the dentist-patient relationship. This is your chance to sit down with legislators, one on one, and tell them about who you are and what you do. Please book your plane tickets now! ◆

If you have any questions on legislative matters, please call me directly anytime. 702-574-8781 or chris@ferraripa.com

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Letters to the Editor

Caring for the future of our healthcare providers

Dear Dr. Orr:

Dentistry is fortunate to be not quite as far down the path as we in medicine are. Our country is in serious trouble, much more with us in healthcare in that we are being crushed so deeply from all angles, particularly regulation, by those who know next to nothing about what we are all about. At times I feel I might as well not practice. I have to always prove my practice to everyone besides my patients. I must submit to an audit monthly or bimonthly from different insurance companies in the midst of my busy primary care/ geriatric practice. I have 14 employees to care for. Credentialing and recredentialing left and right. Prior authorizations everywhere, even with generics, which is ridiculous. Practicing these days is not easy. I am always fighting for profit administrators for my patients' rights.

I sense our government and most lawyers are after us. Seldom have we found someone that is on our side. Our political adversaries already knew that attacking doctors is an easier way to justify their existence. I heard that we are government's priority at this time for healthcare fraud. We are such an easy prey. Our patient's lives are so precious we hardly find time to care for our own.

With so many doctors wrongly accused as murderers and drug pushers, it is sad that we remain so quiet as a community. A solo doctor will find it really hard to fight these injustices alone. When the government is on the offensive, who can you turn to for help? You find yourself all alone, except for a very few friends, loyal patients, and God.

We should all have a voice via a solid association so we can stand tall and combat anything that crosses delivery of care to the patients that we serve. With less than 15% of doctors nationwide as members, the AMA is a joke.

American healthcare, the finest in the world, is devolving because of non-doctor third parties and is not at a critical point. As much as I am interested in saving my profession, I am also very much interested in saving America. I want to save America's future. We cannot keep digging deeper fiscal and regulatory graves and expect to survive. In the current political clime, it will now be more difficult to save the patient-physician relationship and the medical profession. Practicing doctors are most qualified to determine the course of healthcare, and we aren't even invited to the table.

The use of free, early oral contraceptive pills (OCP) in our teenagers will precipitate a surge of earlier female cancer, also likely STDs. I cannot allow my two girls to get exposed. Optimal healthcare should be provided by and decided by doctors, not politicians or low level providers as dentistry is now facing.

We definitely need political reform. Doctors and our patients need protection. It is tragic that the best healthcare system in history is being attacked endlessly.

At this point, I don't know how long I can practice like this. Decisions used to be between just the patient and me… then the insurance company…and now even the government. At times, I must spend more time with the EMR than my patient. I have employees that do nothing but fill out forms, including the 75,000 now codes, hopefully correctly, so I'm not accused of a crime.

I often rise at 2:00 am during the week and spend most of my weekend finishing charts! How can we still provide traditional optimal care to sick and suffering patients? How long can I take this? I am still in love with my profession as a healer, but I hate the regulations, the oppression, and the criminalization of medicine. I didn't study medicine to become an unpaid charting expert for the government, with the threat of criminal accusations hanging over my head.

We need to care for the future of our healthcare providers and their patients. We need serious help…our charity can not survive at its historical levels in the current environment.

God Bless,
Cynthia Teh, MD ◆

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Supporting an anesthesia specialty

Dear Dr. Orr:

Thank you for this summer's editorial ("Dear 2012 ADA House of Delegates," *NDAJ* 2012). Unfortunately, these, and other logical and moral opinions arguing for optimizing the relief of pain and suffering in dentistry, fell on deaf HOD ears once again.

Oral and Maxillofacial Surgeons (OMS) will never support an anesthesia specialty unless operator-anesthetist form of deep sedation and general anesthesia is taken away from them due to medically-supported governmental or societal pressure.

By the time that AAOMS finally figures out that dentistry needs to have an anesthesia specialty in order for our dental profession to control how deep sedation and general anesthesia are provided in dentistry, it will only be after it is too late for the operator-anesthetist to continue to practice that way. Trying to close the barn door after the horse has run off doesn't make a hoot of a difference and neither will AAOMS's eventual plea to have dentistry support an anesthesia specialty so that the ADA can try to force the powerful and highly respected medical anesthesia community to bring back the operator-anesthetist practice of OMS. AAOMS can successfully politically lobby the ADA House of Delegates to get their way on most issues, but the HOD is small potatoes compared to the medical, and nursing, anesthesia communities.

After the axe falls on the operator-anesthetist OMS practice, most dentist anesthesiologists (DA) will still continue to practice deep sedation and general anesthesia in either fixed or mobile venues because the vast majority of DAs practice in a similar manner as medical anesthesiologists, concentrating on only the anesthesia.

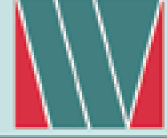
The American Society of Dentist Anesthesiologists (ASDA) has, for the past 30 years, and during all four unsuccessful specialty attempts, always supported both the solo mobile practicing DA as well as the OMS operator anesthetist model while the medical community has always been strongly against the operator-anesthetist OMS doing anything more than moderate sedation. The medical anesthesiologists will never change their opposition to the operator-anesthetist. But, the DA's view on OMS operator anesthetist practice will almost surely have to change in the near future.

DAs will undoubtedly drop their support of the OMS anesthesia model since obviously AAOMS does not support dental anesthesia other than in OMS practices. No organization on earth supports any group that totally works against them at every opportunity. Organized OMS continues to claim that mobile anesthesia practice might be dangerous, but in fact it is clear from their closed-claim morbidity/mortality record that just the opposite appears to be true. Mobile DA-administered anesthesia is much safer than the OMS operator anesthetist model.

In the meantime, the dental profession as a whole will continue to be taught by the teachers who teach the same minimal aspects of medical implications on dental practice that they were taught decades ago and the average dentist will continue to practice in the same mode as previous generations of dentists, like barnstorming in an antique airplane without being able to see another airplane through the clouds that might be on a collision course.

Sincerely,

Joel M. Weaver, DDS, PhD
Dentist Anesthesiologist
Emeritus Professor, College of Dentistry, The Ohio State University ◆



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Potential effects of the *Affordable Care Act* on dentistry

By Craig Palmer, ADA News staff • Reprinted with permission from the ADA

The Affordable Care Act has the potential to reshape health care in America. The expansion of medical insurance coverage, a move toward more integrated care delivery, and significant changes to how health care is financed are some of the main changes expected. Several aspects of the ACA have important implications for dentists as oral health care professionals and small business employers, as well as consumers of medical care. While much of the effect of the ACA on health care in general and on dentistry in particular remains uncertain at this stage, it is important to highlight some of the potential changes that are likely to occur.

Medicaid

The ACA provides for the expansion of Medicaid to cover people with incomes below 133 percent (138 percent, net of income disregards) of the federal poverty level (FPL). The federal government will pickup 100 percent of the cost of covering this additional population initially and 90 percent of the cost long term. The actual expansion of Medicaid coverage will vary significantly depending on how states respond to the Supreme Court ruling last June, which held that the federal government could not withhold all federal Medicaid funds from states that refuse to expand their programs. According to various policy experts, the number of children and non-elderly adults added to the Medicaid roles could be as high as 24 million or as low as 11 million, depending how many states accept the ACA money and expand their Medicaid program. Actual increases in monthly enrollment will likely be lower than these numbers because of the frequency with which beneficiaries enter and leave Medicaid as their financial circumstances change.

Health care delivery and financing

A major goal of the ACA is to better integrate and coordinate health care delivery and financing by expanding the level of health care provided under an Accountable Care Organizations (ACO) umbrella. ACOs are designed to align provider incentives with provision of quality and coordinated care and to shift reimbursement away from volume of services toward health outcomes and quality. ACOs are also meant to improve the infrastructure underlying care delivery. To date, the ACO models that have emerged have largely focused on health care services for the Medicare population. Expert analysis recently completed indicates that there are very few ACO type models of care that include any dental services. Looking forward, it is uncertain when and to what degree ACOs will integrate dental care delivery and reimbursement as part of the core health care services they provide.

The ADA has taken the lead in developing the Dental Quality Alliance to ensure that specific concerns of dentistry are adequately addressed. The Association is likewise engaged with federal health information technology officials to represent dentistry's interests.

Health insurance exchanges

Exchanges must be in place in time to begin enrolling beneficiaries by October, 2013. Initially, the exchange will be available to individuals and small businesses only allowing the purchasers to select from various private health care plans. Under the ACA, people with incomes between 100–400 percent of the FPL are eligible to receive federally subsidized coverage through the exchange.

A key aspect of the ACA is the individual mandate to obtain health insurance covering 'essential' health benefits. The law includes pediatric dental care in a list of essential health benefits to be provided by small and individual group health plans but dental care for adults is not included in that essential benefit package.

To ensure a consistent level of consumer protections, stand-alone dental plans must offer the pediatric oral essential health benefit without annual and lifetime limits. Stand-alone dental plans will also likely have to meet certain marketing requirements, ensure a sufficient choice of providers, and perhaps meet performance quality measures. Further, they may be required to use a single enrollment form and a standard format for presenting health benefits plan options.

It is estimated that 3 million children will gain dental benefits through the health insurance exchanges by 2018, or roughly a 5% increase over the current number of children with private dental benefits. A significant portion of children will also gain dental benefits outside of the health insurance exchanges through, for example, employer-sponsored dental benefits with dependent coverage, although the number is uncertain at this time. The effects for dentistry could be significant if, for example, the ACA-required essential pediatric dental benefit is

inadequate or too expensive or if plans with inadequate dental networks dominate the exchange marketplace.

The ADA offers advocacy materials and shares best practices with constituent dental societies to encourage maximum competition in the exchanges that gives consumers a real choice of benefit plans with robust dental networks. Case studies are shared with constituents on how a state society can ensure an adequate essential dental benefit for children (California), advocate for maximum competition within the exchange that includes stand-alone plans and plans with embedded dental benefits (Washington state and Colorado), and determine whether to include adults as an add-on to the essential benefit package (Vermont).

Dentist employers

The ACA does not require small businesses with 50 or fewer employees to provide health insurance. More than 99 percent of dental practices have 50 or fewer employees.

Small business employers who pay at least 50 percent of the premium for employee coverage may qualify for a small business tax credit. To qualify, the employer must have fewer than 25 full-time equivalent employees whose average annual wage does not exceed $50,000 per employee. The tax credits, which disappear after 2016, will be available on a sliding scale to assist the purchase of health insurance.

Taxes and limits on tax preferred accounts

Flexible spending accounts allow employees to set aside tax-free money to pay medical and dental bills. Starting in 2013, the FSA set-aside will be limited to $2,500 a year and increased annually by a cost-of-living adjustment.

The ADA continues to support repeal of ACA provisions that are inconsistent with Association policy. This includes the 2.3 percent medical device excise tax scheduled to take effect Jan. 1, 2013. The ADA and members of the Organized Dentistry Coalition have opposed implementation of the tax, and the U.S. House of Representatives has passed legislation, which is stalled in the Senate, to eliminate the tax. The coalition estimates that the tax will increase the cost of dental care by more than $160 million annually. The IRS has yet to issue final regulations.

In 2013, there is 0.9 percent payroll surtax on wage and salary income over $200,000 for single filers or $250,000 for joint filers. The 2012 Medicare Hospital Insurance (Part A) tax for the Medicare Hospital Insurance (HI) Trust Fund is 1.45 percent of all salary income, with an equal 1.45 percent paid by employers. Starting January 2013, the tax will be 2.35 percent on all earnings above $200,000 and $250,000 respectively. For the self-employed, the rate increases from 2.9 to 3.8 percent.

Continues ➲

ADA on Affordable Care Act, *continued*

There is also a 3.8 percent tax in 2013 on some investment income of taxpayers whose modified adjusted gross income exceeds $200,000 for single and $250,000 for joint filers. Investment income includes rents, dividends, interest, royalties and capital gains on property sales (with a partial exclusion for primary residence sales).

Dentists as health care coverage consumers

Plans in the individual and small group market could include prohibitions on refusal to cover pre-existing conditions, excessive waiting periods, copayments or deductibles for certain preventive services and on coverage rescissions, and comprehensive coverage, guaranteed issue and renewability, premium rating limits on rate increases based on age, gender or health condition and required coverage for dependents up to age 26.

Public health infrastructure

ACA provisions consistent with Association policy include:

- increased funding for public health infrastructure, including Centers for Disease Control and Prevention oral health programs and national oral health surveillance programs;
- additional funding for school-based health center facilities;
- increased grant opportunities for general, pediatric or public health dentists;
- funding for National Health Service Corps loan repayment programs;
- CDC initiation, in consultation with professional oral health organizations, of a five-year national public education campaign focused on oral health prevention and education.

Many of these new programs have not been funded. The ACA also authorizes federal spending to support a state alternative provider demonstration project, which is inconsistent with Association policy. Money has not been appropriated by Congress to support the demonstration. ◆

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"Non-covered services" a *paradigm shift* in dental insurance

By Steven A. Saxe, DMD

Dentists who choose to work with insurance providers need to be familiar with evolving insurance models.

The majority of states have adopted legislation related to dental benefits relating to non-covered services. Such statutes are necessary when detrimental non-covered service language is found in dental insurance contracts that undermine the conventional dental insurance benefit to our patients. **Non-covered services are benefits that the insurance carrier does not reimburse for. Dentists who sign such contracts are obligated to discount their fees for the non-covered services.**

As the affordable healthcare act regulations come into play, more dental insurance companies will transfer their structure to the more profitable non-covered services model. These so called "insurance" entities are not accountable to ERISA or the state insurance commissioners since they are **not technically providing insurance,** but are a means of providing employers with a cheap alternative to conventional insurance plans as they assemble a network of providers who discount their fees to the employees of the companies. Non-covered dental "insurance" entities do not need to conform to the federal Affordable Healthcare Act, which requires the insurance companies to have only a small percentage of the patient's premiums be expended on profits and administrative costs. Such "insurance" shifts costs to the patient to pay for non-covered services, thus leaving a larger profit margin for the "insurance" company.

Additionally, since 1960, a majority of "insurance" companies have allowed each patient a yearly maximum of $2,000 or less. Over the past 50 years historically pay out far less than $2,000 per patient per year, and as the premiums companies charge employers increase, and the fees they allow for reimbursement for services decrease, the companies reap greater profits from the scheme than ever.

Dentistry's technology and overhead expenses have increased greatly over the past 50 years. The non-covered services model transfers costs to patients to pay with their own after tax cash to the dentist directly. With non-covered services insurance models, dentists are expected to reduce fees for services that the insurances do not underwrite, imposing a "discount plan" the dentist absorbs fiscally.

As insurers may offer several different plans to the employer, the dentist is expected to accept the same allowances across the board, even for some plans offered by the insurer that exclude basic dental needs. This leaves patient employees and dentists bearing the burden of accepting lower reimbursement rates, which the dentist usually is forced to explaining in detail to unsuspecting patients.

Our patients' quality and availability of care will decrease if the non-covered services model is forced upon our patients. These types of plans have increased across the country as employers seek new methods to save money to deliver healthcare to their employees. A non-covered dental services contract has mandates imposed on dentists, which are a perceived cost savings to the employer compared to conventional dental insurance policies.

Advantages for corporate dental model for non-covered services

- The corporate model focuses on expenditure of the entire yearly insurance benefit per patient encounter.
- The corporate model can hire nameless dental providers whom have no reputation to uphold in the community, demand daily quotas which may lead to unnecessary treatment plans in which the sole purpose to expend the maximum of the patients benefit as soon as possible, and all services above their benefits would be available to the patient at a cash out of pocket discount per their insurance pre-negotiated discount on non-covered services.
- The new corporate dental model present in our communities will utilize, for cost cutting effectiveness, sub standard dental products perhaps purchased by bargain basement clearing houses with short shelf lives or expired materials that are set out on the dental trays for the unsuspecting dental practitioners to use without question. Or even worse, using gray market products produced in China, as counterfeit materials at

Continues ➲

deep discounted prices to be used in unsuspecting patients by these corporations in order to cut their costs to accommodate their agreements for low reimbursement levels.

- The cost savings additionally extend to the products manufactured by dental technicians off shore to produce crowns, bridges, implants, and dentures at very low costs while utilizing unknown materials including lead alloys.

Non-covered services are an ideal model for corporate entities to make large sums of money while taking advantage of innocent patients who have their health compromised when they expect to see a doctor whom they think they can trust. Patients' health is compromised by having unnecessary and poor quality services performed in order to conform to fiscal constraints. Profits are promoted before patient health.

Advantages to patients with conventional dental insurance providers in private practice

- The dentist addresses the patients' health needs one-on-one regardless of insurance benefits.
- Dentists in private practice display their name on the door and are accountable to patients to provide services in the patients' best interest. These dentists provide quality care and uphold their name in the community.
- The private practitioner dental model utilizes quality dental labs and suppliers, including the use of the highest quality products that are manufactured by FDA approved sources.
- Patients should have confidence that their dentists have their health and welfare as the priority. Non-covered services plans will compromise patient quality of care. A majority of dentists will either not make certain treatments available due to cost constraints or not accept insurance that a majority of patients have, which will leave patients to fend for themselves.

Conclusion

This legislative session, the NDA has the opportunity to defend our patients by introducing legislation to protect them from non-covered services. The NDA bill is crafted after American Dental Association guidelines. Thirty other states already have such laws in place. Encourage Nevada's legislators, colleagues, and patients to encourage the successful enrollment of this legislation in Nevada to protect our patients and our profession. ◆

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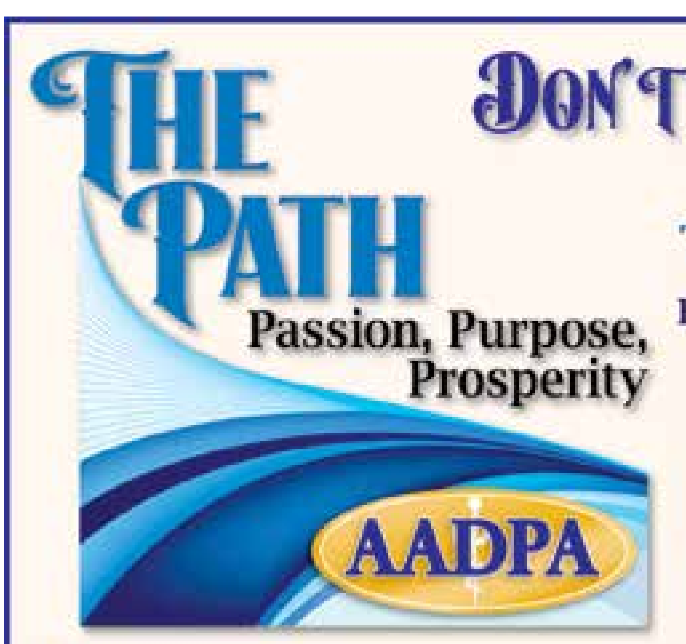

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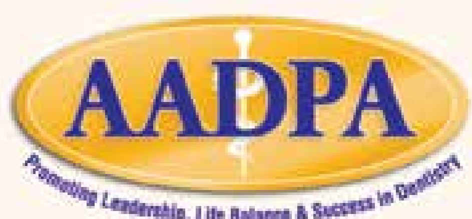

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A gingival lesion arising in pregnancy

By George Bitar, DS IV, UNLV SDM; Dr. Victoria Woo, DDS; Dr. Lauri Staretz, DDS

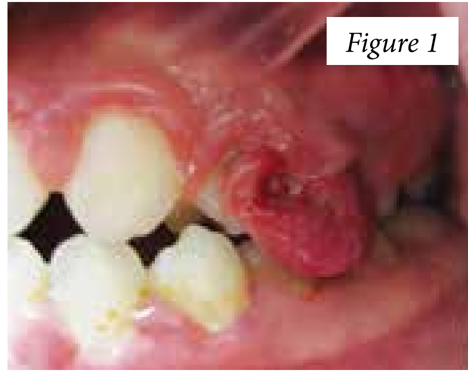


Figure 1

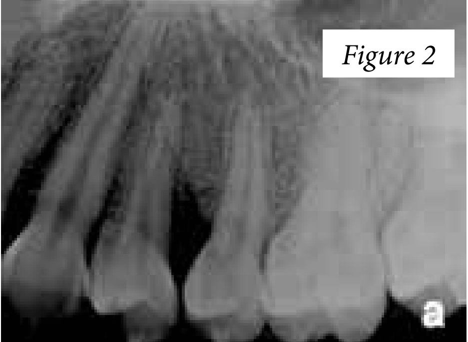


Figure 2

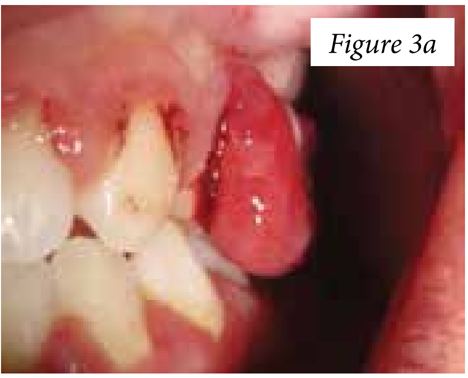


Figure 3a

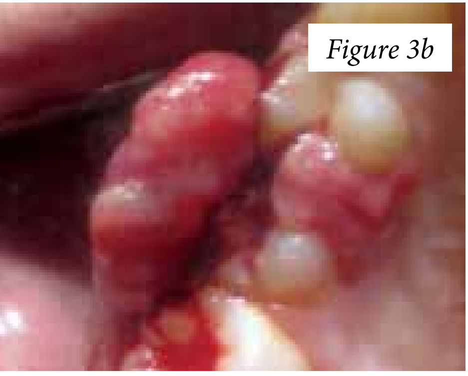


Figure 3b

Figure 4

Case report

An 18 year old half-Caucasian and half-Hispanic female presented to the Emergency Department at the UNLV School of Dental Medicine for evaluation of an exophytic mass involving her left maxillary gingiva. The patient first noted the lesion approximately four months prior to presentation and that it had demonstrated rapid growth in the last month. The patient stated that the lesion often bled on brushing, causing her to avoid the area during her daily hygiene routine. She had been referred to the UNLV SDM for evaluation following consultation with a general dentist. Her medical history was significant for pregnancy (37 weeks gestation) and she reported taking no medications except vitamin supplements. Her review of systems was otherwise unremarkable for cardiopulmonary conditions, endocrine dysfunction, hematologic abnormalities, nutritional deficiencies and disorders of other systems.

Intraoral examination showed a firm, red, lobulated mass measuring approx. 1.0 x 1.0 x 0.5 cm, located primarily on the buccal keratinized gingiva between teeth 12, 13 and 14 (*Figure 1*). Minimal involvement of the palatal gingiva was noted between teeth 12 and 13 and slight extension below the occlusal plane was observed. Focal areas of hyperkeratinization and ulceration, presumably secondary to trauma, were also seen. The patient's overall oral hygiene was poor, as evidenced by moderate-to-severe plaque accumulation and generalized inflammation of the marginal gingival tissues. Radiographic findings post-partum show vertical bone loss along the distal surface of tooth 12 (*Figure 2*).

The clinical differential diagnosis included pyogenic granuloma, peripheral giant cell granuloma, inflamed peripheral ossifying fibroma, and hemangioma.

A mutual decision to delay excision was made and the patient was advised to return for re-evaluation within one month post-partum. Two weeks following the delivery of her baby, the patient contacted UNLV SDM requesting that the excision be performed as soon as possible. She stated that the continued growth of the lesion had led to constant hemorrhaging and difficulty with eating. The patient returned the following week and intraoral examination revealed noticeable enlargement of the lesion and progressive involvement of the palatal gingiva (*Figures 3a* and *3b*).

Following informed consent and administration of local anesthesia, both the buccal and lingual portions of the lesion were completely excised and the gingiva was recontoured to achieve esthetic results (*Figure 4*). The tissue was preserved in 10% formalin was sent to the Department of Oral Pathology, Medical University of South Carolina for microscopic evaluation. The adjacent teeth were scaled to remove any local irritants that could promote recurrence of the lesion.[2,5]

Fig. 1 Clinical appearance of lesion on presentation (buccal view).

Fig. 2 Radiographic appearance of involved site on presentation. Note the vertical bone loss distal to tooth 12.

Fig. 3 Clinical appearance of lesion one month following initial presentation. Note the marked enlargement and progressive involvement of the palatal gingiva (A. buccal view, B. occlusal view).

Fig. 4 Clinical appearance of gingival tissues immediately following excision of the lesion.

Re-evaluation at one and three weeks showed good healing and no evidence of recurrence.

Histopathologic examination of the submitted specimen showed lobulated masses of tissue covered by focally ulcerated and parakaratinized stratified squamous epithelium (*Figure 5*). Beneath the surface was a proliferation of granulation tissue characterized by numerous blood vessels surrounded by fibrous connective tissue and mixed inflammation (*Figure 6*). The histologic features were pathognomonic for pyogenic granuloma.

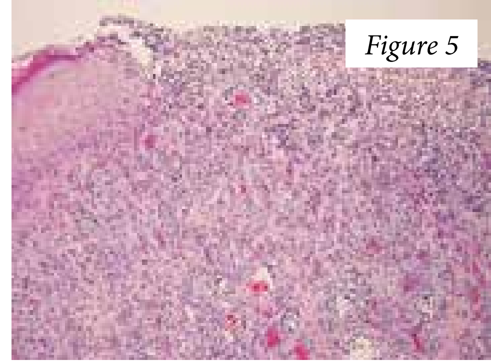
Discussion

Pyogenic granulomas (PGs) have been variably classified as reactive or vascular tumor-like lesions. Most authorities believe they represent a proliferative tissue response to local trauma, irritation and/or hormonal changes.[2] The name "pyogenic granuloma" has long been criticized for its inaccuracy from both an etiologic and histopathologic standpoint, as these lesions are neither granulomatous in nature nor associated with pyogenic bacteria. Despite this, the term so entrenched in history and clinical practice that it continues to be used routinely today. The majority of PGs are found on the gingiva but they may involve any oral mucosal site [1,6,7] A strong predilection for females has been observed, which has been attributed to the hormonal fluctuations experienced in puberty and pregnancy.[1] Pregnancy-related cases comprise approximately 1% of PGs and generally present in the first trimester, although they can continue to develop throughout the perinatal period.[1,3] Multifocal PGs have been described and are most commonly seen in the setting of pregnancy.[2] Historically, PGs arising pregnancy were referred to as "tumors of pregnancy" or "granuloma gravidarum." These designations have since been discouraged because of the unnecessary distress it can cause in pregnant patients.

PGs present clinically as nodular or lobular proliferations that bleed easily with mild trauma, owing to their highly vascular nature. The tendency for PGs to grow rapidly may be worrisome for the patient as well as the practitioner, often raising concerns for malignancy or other tumors.[1] In contrast to true neoplasms, however, PGs will typically resolve with time or undergo fibrous maturation to a fibroma. The size of the lesion may determine whether regression or progression will occur, with smaller lesions more likely to resolve with time. Reported recurrence rates range from 5.8%[8] to 23.3%[9] and tend to be higher in lesions excised during pregnancy.[1] Factors that contribute to recurrence include incomplete removal, persistence of promoting sources of irritation such as calculus, and removal during pregnancy.[1] If surgical removal is indicated, excision of the lesion should extend to the periosteum or periodontal membrane.[2] For pregnancy-related PGs, it is generally advised that excision be delayed until the post-partum period with the hope that it may regress with stabilization of hormone levels.[1,2,4,5] Furthermore, higher recurrence rates have been noted in PGs excised during pregnancy.[1]

Summary

The clinical presentation of PGs is non-specific and can mimic a variety of other reactive proliferations and soft tissue neoplasms. Moreover, the rapid growth rate of many PGs may raise fears of cancer in both the patient and practitioner. As such, excisional biopsy and histopathologic examination of the removed tissue is indicated for diagnostic and curative purposes. Complete resolution of PGs is generally observed following excision, although recurrences have been noted, particularly if local irritants such as plaque and calculus are still present or if removal is performed during pregnancy. As such, clinical follow-up is indicated to assess for healing and relapse in patients affected with PGs. ◆



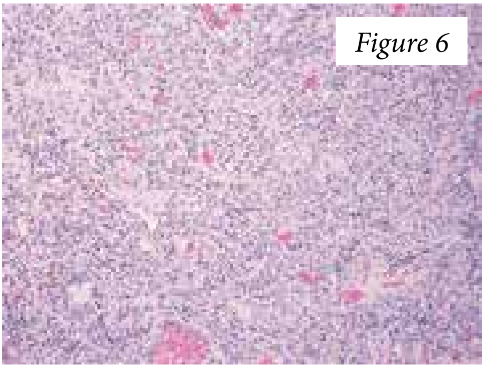


Fig. 5 Histopathologic examination of the biopsy showed a lobular proliferation of granulation tissue covered by ulcerated stratified squamous epithelium (hematoxylin and eosin, original magnification X100).

Fig. 6 High-power view of the underlying granulation tissue, which was composed of well-vascularized fibrous connective tissue with mixed inflammation (hematoxylin and eosin, original magnification X100).

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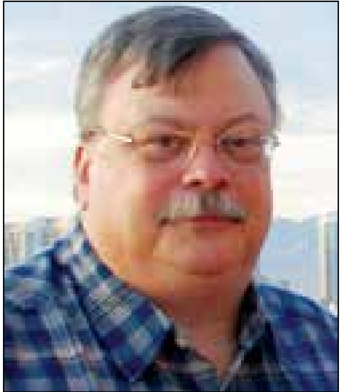
Happy holidays from the SNDS!



Robert Anderson
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We have so much to be thankful for, and so many things going on, even in this supposedly sleepy time of the year.

We have worked with our partners at Henry Schein, Burkhart, and Benco to make the holidays (and the smiles) a bit brighter for 5,000 children at Opportunity Village, and with Darby Dental to provide toothpaste, brushes, and floss for 500 school children in cooperation with United Way!

We also had our fourth year of Operation Dental Elf, a truly unique project. Our members, their team members, families, and even patients, gathered toys and gifts, which were turned over to our colleagues at the 99th Dental Squadron at Nellis Air Force for distribution to the families of deployed Airmen. Every year, we've been able to increase our giving, and last year, we more than doubled what had been donated or collected from all other sources. Judging by the mound of presents at our office, we may have exceeded even that!

We are also preparing for our 11th annual Give Kids A Smile (GKAS). We are blessed with partnerships with the UNLV School of Dental Medicine, for hosting the event and recruiting faculty and students to help out, and with Henry Schein for their gracious sponsorship, Roseman University, the hygienists' school at CSN, the Nevada Dental Hygienist's Association, and many more. Together, we are able to treat hundreds of kids whose families have no insurance, no Medicaid and no ability to pay. While many programs give exams to many more children, of those that give hygiene and restorative care, we're told that ours is among the largest in the country.

As successful as GKAS is, it's still just one day a year. So to augment that, we have started the KIND program, (Kids in Need of Dentists). While there are many school-based programs out there, this is the only one that offers emergency treatment. We can always use more help, so if you'd like to volunteer, contact the SNDS office for information. Basically, you'll be put on a rotating calendar, and if a child needs care on your day, the school nurse reporting the problem will be given your name to set up an appointment. Later, we'll contact your team to record the work that was done, along with the value of that work. This way, we'll be able to let our legislators in Carson City know exactly how much the dentists here in southern Nevada give back to the community. We are also looking at fun ways to provide proper recognition for our volunteers.

Of course, that's not all that's going on. We are preparing for a new slate of programs at our dinner meetings, including the February meeting at Nellis AFB. The CE Café is up and running, along with our mainline CE series. We've also provided updated training for our new and seasoned Peer Review Committee members. We never forget that you are not customers of some company, but rather, you are members of a society!

We do hope that once the holidays have settled down, you'll remember to send in your membership renewal. All the things that we're doing to increase favorable visibility for dentists won't matter a bit in Carson City if we don't have numbers behind us when we talk to the legislators. Elsewhere in this issue you'll see the dynamic legislative agenda the NDA is pursuing, and you'll find why it's so important, now more than ever, to work together.

Together, we're putting a smile on southern Nevada! ◆

Save the Date!

Brendan Johnson, DDS

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Let me wish everyone a happy and prosperous new year! It is a time for celebration and planning, and I'm happy to say that the SNDS has a bit of both to report.

Just as it's a new year, it's also time to renew your annual membership. We work hard to make this a good value for our members. In my time as an officer, I've been impressed with the committee members and leaders who work behind the scenes to make our Society hum. Thanks to them, our members enjoy the benefits of Peer Review (a benefit that's hard to put a price tag on, when it's needed), the Dentist Health and Wellness Committee, and our outstanding continuing education program, to say nothing of our monthly dinner meetings. These gatherings provide more than just continuing education, the fellowship enjoyed each month is worth a great deal in a profession such as ours. Whether renewing and maintaining friendships, or sharing clinical experiences, the value is priceless.

Membership is also important when the NDA goes to Carson City to speak with our legislators. There's strength in numbers, and it's imperative that we have that strength when we advocate for our profession and our patients. You can read elsewhere in this edition of the *NDA Journal* about the legislative issues important to dentistry in Nevada, but the money we pay in dues works hard at every level, and I can't stress enough the importance of renewing now. Help us to send a strong message from a strong organization to our legislators in Carson City!

We are also doing good things here in Las Vegas. The SNDS was joined by three dental suppliers in providing toothbrushes and toothpaste for 5,000 children with physical, economic and developmental challenges through Opportunity Village. Around the same time, we launched our fourth annual Operation Dental Elf project. This is a unique program that enlists our member dentists, their team members, families, and even patients, in gathering toys and gifts. These are brought to our SNDS office, where members of the 99th Dental Squadron pick them up and distribute them to families of deployed airmen at Nellis Air Force Base. Each year, the response has grown and this year was no exception. Both of these efforts are examples of how the SNDS, bringing others together, can make a difference here in our community.

Of course, the most visible example is our upcoming Give Kids A Smile event—now in its 11th year! Organizations from around the valley join us. Most notably our host, the UNLV School of Dental Medicine, Roseman University, and Henry Schein Dental, along with a host of others, from the Nevada Dental Hygienist's Association to Pizza Hut! Last year, we treated 220 kids within five hours! If you haven't volunteered to participate in Give Kids A Smile, you owe it to yourself to get involved. It's a rare opportunity to work with dental students, as well as other dentists, in a community setting. You can check out the GKAS video on our website and call the SNDS office to ask questions or sign up.

Of course, the one problem with Give Kids A Smile is that it's a one-day annual event. We're looking at ways of developing new partnerships and expanding that impact, to really make a difference in southern Nevada. In that light, we're launching the KIND program, which is all about Kids In Need of Dentists. All we ask of our members is to volunteer to take one day on a rotating basis, and be available if a child needs immediate care on that day. The public will not have access to the program, and initially, only school nurses will be able to contact us. We'll follow the same criteria as GKAS, that the children's families have no insurance, no Medicaid, no access to oral health care. We want to make sure that the care goes where it's needed, and also that you are not taken advantage of. The SNDS will follow up to record the time and value of the care you deliver, so that we can let the legislators in Carson City know what southern Nevada dentists give back to the community! Please contact Bob Anderson, our Executive Director, if you have questions or if you'd like to volunteer. There are a number of school-based oral health programs, but KIND will be the only one helping kids needing emergency care.

Closer to home, I'm happy to report that our CE series, and the CE Café series, along with our dinner meetings, are planned out for the new year. Expect a slate of clinical and practice management topics, presented by excellent speakers. We're adding a special dinner meeting in May, where we'll include more members in our installation of officers, as well as recognize those who give their time to make organized dentistry what it is.

So please step up to help us continue to make a difference, get involved, check out our new website and Facebook page. There's a lot happening at the SNDS, and plenty of ways to keep up! ◆

Lori Benvin
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As the autumn leaves let go of the trees and winter comes again to northern Nevada, I brace myself for 2013. Much uncertainty faces us in this economic climate, but I have to be positive and hope that we will all persevere.

I've decided to outline our 2013 NNDS event calendar, but not before I welcome our newest members to the NNDS. We introduced 17 new dentist members to our Society at our October membership dinner meeting. It was very exciting to welcome these young talented professionals. I hope many of you get to introduce yourselves to them and encourage one or two to join you at a 2013 event.

Now more than ever, our newly graduated dentists need encouragement from the more seasoned and experienced professionals. They need to understand your compassion to your profession, including the work ethic you bring to your patients, your willingness to give back to our community, and your ability to be a successful business owner. We recognize that they are the future of dentistry and hope to see our newest members return to our events and be a part of the continued camaraderie of NNDS.

Our Executive Board is giving thanks to our members for supporting NNDS by passing along some great savings. For 2013, the cost for all dinner meetings, as well as continuing education courses, has ***lowered***. Members can attend our dinner meetings for $35.

January

January 15: Northern Nevada Dental Health Program (NNDHP) Advisory Board Meeting. NNDHP will review proposals to expand our 30+ year NNDHP program to include more outreach to underserved children, and to consider collaborating with the Adopt a Veteran Dental Program.

January 17: Local periodontists will be our guest hosts for a Perio Symposium Dinner Meeting. Come to The Grove Event Center in Reno for some great information and a case study symposium.

January 25: The NDA Mid-Winter Meeting and House of Delegates in Las Vegas. If you are a delegate, or would like more information about becoming a delegate, please give me a call or email nnds@nndental.org. I will be happy to tell you how you can get *more* involved with leadership and with the decisions that affect dentistry.

February

February 21: NNDS General Membership Dinner Meeting with guest presenter Dr. Matti Vazeen on "Advances in Cataract and Refractive Surgery." All of our dinner meetings are worth at least 2 CEUs.

March

March 14: NNDS General Membership Dinner Meeting with Randy Kuckenmiester, CPA, on "Taxation in 2013 and Beyond: Adapting to changes and planning for the future."

March 15: Jose Luis Ruiz, DDS, presents a full-day continuing education course on "Excellence with Anterior and Posterior Composite Restorations." Don't miss either of these excellent course opportunities.

April

April 25: The 10th Annual Mario Gildone Lifetime Achievement Award Night. We are delighted to recognize Dr. Bruce Pendleton for his outstanding achievements to dentistry. We are equally delighted to celebrate Dr. Pete DiGrazia for his accomplishments and leadership. Please join our MGLAA Chair, Dr. Tom Pitts, and your colleagues as we celebrate these great individuals.

Bruce and Pete are truly worthy to be in the company of our past recipients: Drs. Mario Gildone 2003, Carl Herrera 2004, Harry Massoth 2004, Gerald Jackson 2005, Stephen Vaughn 2006, Lloyd Diedrichsen 2007, Dave Melarkey 2008, Morris F. Gallagher 2009, Joel F. Glover 2010, Jim Davis 2011, and Walter R. Bell 2011.

May

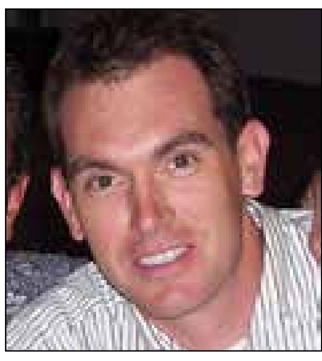
May 10: The NNDS hosts its annual OSHA Update Continuing Education Course along with the licensing requirement of CDC Infection Control at the Atlantis Hotel Casino in Reno.

July

July 4–6: Bring the whole family to the NDA Annual Summer Meeting at the PlumpJack Resort in Squaw Valley. This includes our House of Delegates, but there will also be fun for the whole family. Watch for more information to come!

September

September 27: An early save the date for the 11th Annual Northern Nevada Dental Health Program/Joel F. Glover Charity Golf Tournament at LakeRidge Golf Club. We are changing it up this year with a morning tee-time, including breakfast and a BBQ lunch at the conclusion of our event. We also plan to earmark all proceeds for this tournament to benefit our local veterans for all they have done to serve our country. Mark your calendars and come out to support our veterans. ◆



Jason Ferguson, DDS
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The end of every year seems to go out with a bang. When January comes, we can look back at the last year and sigh with relief; then turn around and plan for the unknown in the coming year. That is exactly where we are during this time of year in the Northern Nevada Dental Society (NNDS) office. The budget is set, our continuing education courses and dinner meetings are booked, and now it is time to search for the next batch of volunteers to recruit.

Every spring, NNDS members are nominated and then elected to fill the vacated seats of the NNDS Executive Committee (EC). The EC consists of the NNDS immediate past president, president, vice president, secretary-treasurer and two members at-large. All of these chairs have voting power to set policy and to provide direction as to best serve the membership. EC meetings take place once a month at the NNDS office in South Reno and last about an hour.

The EC members sit at each position for one year, with the possible exception of the members at-large. The first member at-large acts as the continuing education chair who organizes, schedules, and books speakers. The second member at-large plays a supporting role for the board. He or she fills the voids of the EC and may be asked to oversee special assignments. Any member at-large may be elected to advance through the chairs.

The incoming NNDS Executive Committee secretary-treasurer will propose a budget that will be voted upon and followed during the year. The secretary-treasurer will monitor and advise the EC regarding the monies earned and spent. The secretary-treasurer is typically nominated as vice president and if elected will assume that position.

The vice president has few obligations, but will shoulder the duties of the president in his or her absence. The EC, at times, will assign duties or will allow the vice president

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to volunteer for duties, such as this year, the administration of the Temporary Dentist Network.

The presidential chair comes with more responsibility. The president acts as chair of the EC, presides over all meetings of the society, and provides representation for the NNDS while attending meetings of other organizations, such as the Nevada Dental Association (NDA).

NNDS has various committees such as the New Dentist Committee and Membership Recruitment/Retention. These committees are comprised of EC members as well as general members of the society. The EC typically has first-hand knowledge of current events in the dental community. I encourage anyone interested in becoming more involved to contact any of the EC members or the NNDS Executive Director, Lori Benvin.

I know that the outlook for this upcoming year is cloudy and full of unanswered questions, but as members of our Nevada dental organizations, we have an advantage to overcome when supporting one another. We hope to see you soon. ◆

Welcome New NNDS MEMBERS

Dan Barrett, DDS – General

Benjamin Brooks, DDS – General

Eric L. Gregg, DMD – General

Steve Huang, DDS – Oral Surgery

Kyung M. Kim, DDS – Pediatric

Benita Ng, DDS – General

Lindsey M. Nelson, DMD – General

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By Karen P. West, Dean, UNLV SDM

In our tenth anniversary year, we are proud to welcome the Class of 2016 to our family! From an applicant pool of 2,182 students, 81 began orientation on August 27. The class is composed of 28 female and 53 male students. Forty-four students are Nevada residents while 37 hail from Alaska, Arizona, California, Georgia, North Carolina, North Dakota, New Jersey, Utah, Virginia, Washington and Canada. Twenty-four are graduates of UNLV, and nine are graduates of UNR. The average age of the group is 26.2 with a range of 20–40 years old.

Dean's Symposium and Research Day

The Dean's Symposium and Research Day will be held on March 4. Dr. Leon Assael, dean at University of Minnesota School of Dentistry and oral surgeon will be our speaker as well as one of our student poster judges. He will present an hour lecture on "Nerve Injury" for the faculty, 3rd and 4th year dental students, and residents. The practicing community is invited to attend. One hour of CE will be awarded.

Dr. Brownstein to retire

Dr. Marshall P. Brownstein will retire from the school on January 31. He held the position of Associate Dean of Admissions and Student Affairs for eight years and had an impressive 40-year career in dental academia. He has promised to volunteer at the school and continue to write great letters of recommendation for our students applying to graduate programs.

On January 25, we will hold a Farewell Dinner and Roast for Dr. Brownstein. Contact the Office of Student Affairs & Admissions at 702-774-2524 to purchase tickets.

Las Vegas, Nevada/Tianjin, China dental school exchange

In January 2013, eight faculty members from the Stomatological Hospital of Nankai University in China will begin as visiting faculty at the UNLV SDM on a rotational basis. Their goal is to learn more about the United States system of dental education and consider international accreditation of their dental school. Dr. Wenlian Zhou is the faculty coordinator of the exchange program. Two of the UNLV SDM faculty have been invited to provide instruction at the Nankai University in the summer of 2013.

Drs. Jones and McClain awarded $12,000

Dr. Frank Jones and **Dr. Mildred A. McClain**, UNLV SDM faculty, were awarded $12,000 by the American Dental Education Association and University of Pacific Arthur A. Dugoni School of Dentistry National Learning Institute (NLI) Dental Pipeline.

Funded by the Robert Wood Johnson Foundation, the NLI provides opportunities for dental educators and their community partners to address the problems of access and workforce disparities. Partnering with the UNLV Center for Academic Enrichment and Outreach Upward Bound program, UNLV SDM will provide minority and disadvantaged students opportunities in advising, mentoring and outreach experiences to facilitate a decision to pursue a career in medicine or dentistry.

2013 continuing education courses

January
- WREB Remediation Program
- Las Vegas AAID Maxicourse®

February
- Direct and Indirect Composite Restoration

March
- Tru Denta/Dental Resource Systems
- AvaDent™ Digital Dentures
- 2nd Annual UNLV Dean's Symposium/Student Research Day
- Real World Endo® Seminar—New Dimensions in Endodontics
- Las Vegas AAID Maxicourse®
- The ULTIMATE Surgical and Restorative Esthetic Implant
- Conquering the Esthetic Zone with Surgical Precision!

April
- Las Vegas Implant Immersion Program (Module 1)

May
- Las Vegas Implant Immersion Program (Module 2)

June
- TruDenta/Dental Resource Systems

July
- Surgical Cadaver Bone Grafting
- Las Vegas Implant Immersion Program (Module 3)

August
- Dental Resource Systems Occlusion
- TruDenta/Dental Resource Systems

September
- The ULTIMATE Surgical and Restorative Esthetic Implant
- Advanced Conquering the Esthetic Zone with Surgical Precision!

October
- TruDenta/Dental Resource Systems
- Real World Endo® seminar

November
- Advanced Orthodontic Concepts (Brazilian Orthodontists)

Dr. Michael David Scherer joins faculty

Dr. Michael David Scherer is our new full-time faculty member. Dr. Scherer received a BS in biology from the University of Miami in 2003. He earned his DMD from the Nova Southeastern University Dental School in 2007. After two years of private practice, he entered an MS specialty program in prosthodontics at the Ohio State University, and in 2011, he was awarded an MS and a specialty certificate in prosthodontics. His practice experience before his specialty program included a year working in community outreach for the underserved in Florida. He has presented at national meetings and participated in three professional publications. Dr. Scherer served as chief resident in his prosthodontic program and as the student government president in his predoctoral program. The UNLV SDM is happy to have him join our institution. ◆

We are looking for instructors and for volunteers at our outreach clinics. Contact Dr. Sanders or Dr. Thiriot for information.

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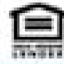

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1941 George A. Steinmiller
1942 Omar M. Seifert
1943 Stephen W. Comish
1944 Quannah S. McCall
1945 Oliver M. Wallace
1946 Gilbert Eklund
1947 Robert H. Gatewood
1948 E. Ross Whitehead
1949 Howard W. Woodbury
1950 Roy P. Rheuben
1951 Leonard G. Jacob
1952 Clifford A. Paice
1953 Walter R. Bell
1954 Raymond J. LaFond
1955 Jack E. Ahlstrom
1956 J. D. Smith
1957 Kern S. Karrash
1958 Vincent J. Sanner
1959 Wallaxe S. Calder
1960 John B. Hirsh
1961 David W. Melarkey
1962 David W. Melarkey
1963 Fae T. Ahlstrom
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

Calendar of Events

JANUARY 2013

Day	Event	Time	Location
Tue 8	NNDS Executive Committee Meeting & Delegate Pre-Meeting	5:30 pm	161 Country Estates Cir, #1B, Reno
Tue 8	SNDS Member Dinner Meeting	5:30 pm	Gold Coast Hotel & Casino, Las Vegas
Thu 10	AGD General Membership Dinner Meeting	6 pm	*Location: tbd*
Wed 16	SNDS Peer Review Committee Meeting		*Location: tbd*
Thu 17	NNDS General Membership Dinner Meeting, "Perio Symposium"	6 pm	The Grove at SouthCreek, Reno
Tue 22	SNDS Executive Committee Meeting	6 pm	SNDS Office 8863 W Flamingo Rd, Ste 101, Las Vegas
Fri 25	**NDA MID-WINTER MEETING/HOUSE OF DELEGATES**	8 am	Gold Coast Hotel & Casino, Las Vegas

FEBRUARY

Day	Event	Time	Location
Sat 2	**GIVE KIDS A SMILE**	All day	
Tue 12	NNDS Executive Committee Meeting	5:45 pm	161 Country Estates Cir, #1B, Reno
Tue 12	SNDS Annual Nellis Meeting	5:30 pm	Nellis AFB
Wed 20	*SNDS presents:* CE Café	6 pm	Nevada State Bank Stephanie and Warm Springs, Las Vegas
Wed 20	SNDS Peer Review Committee Meeting	6 pm	*Location: tbd*
Thu 21	NNDS General Membership Dinner Meeting	6 pm	The Grove at SouthCreek, Reno
Thu 28	AGD General Membership Dinner Meeting	6 pm	*Location: tbd*

MARCH

Day	Event	Time	Location
Tue 5	NNDS Executive Committee Meeting	5:45 pm	161 Country Estates Cir, #1B, Reno
Tue 12	SNDS Member Dinner Meeting	5:30 pm	Gold Coast Hotel & Casino, Las Vegas
Thu 14	NNDS General Membership Dinner Meeting	6 pm	The Grove at SouthCreek, Reno
Fri 15	*NNDS presents:* All Day CE Course – Dr. Jose Luis Ruiz	8 am	Atlantis Hotel Casino Spa, Reno
Fri 15	*SNDS presents:* Infection Control Seminar	9 am – 1 pm	Gold Coast Hotel & Casino, Las Vegas
Wed 20	*SNDS presents:* CE Café	6 pm	Nevada State Bank Jones and Twain, Las Vegas
Wed 20	SNDS Peer Review Committee Meeting	6 pm	*Location: tbd*
Thu 21	AGD General Membership Dinner Meeting	6 pm	*Location: tbd*
Tue 26	SNDS Executive Committee Meeting	6 pm	SNDS Office 8863 W Flamingo Rd, Ste 101, Las Vegas

APRIL

Day	Event	Time	Location
Tue 9	SNDS Member Dinner Meeting	5:30 pm	Gold Coast Hotel & Casino, Las Vegas
Tue 9	NNDS Executive Committee Meeting	5:45 pm	161 Country Estates Cir, #1B, Reno
Wed 17	*SNDS presents:* CE Café	6 pm	Nevada State Bank Stephanie and Warm Springs, Las Vegas
Wed 17	SNDS Peer Review Committee Meeting	8 am	Atlantis Hotel Casino Spa, Reno
Thu 25	*NNDS presents:* Mario Gildone Lifetime Achievement Award Dinner	6 pm	The Grove at SouthCreek, Reno
Fri 26	CE Seminar	9 am – 4 pm	Gold Coast Hotel & Casino, Las Vegas

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