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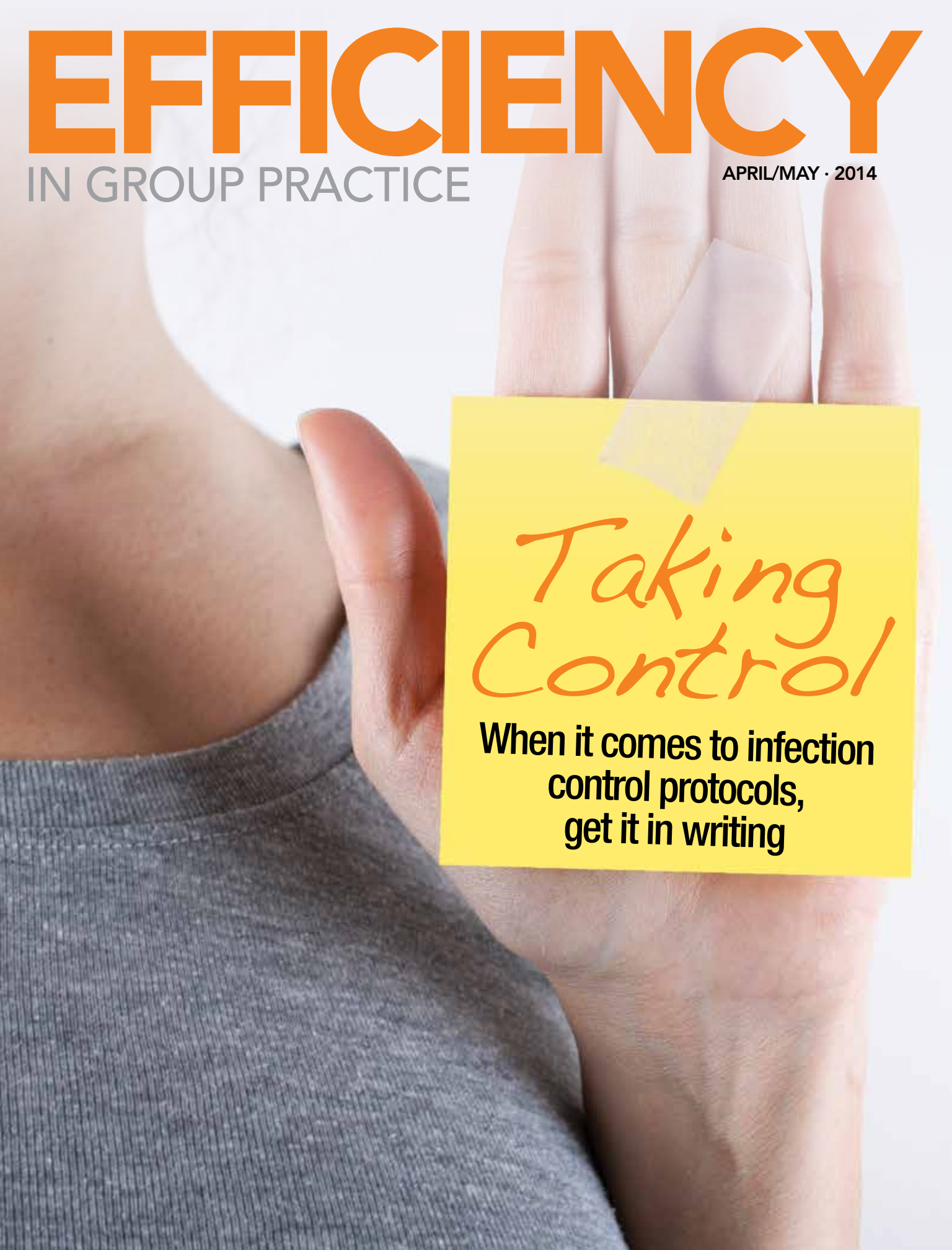
IN GROUP PRACTICE

APRIL/MAY · 2014



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Truth Scarier than Fiction

As a former dental manufacturer field sales rep, I can tell you from firsthand experience that infection control is not at the top of the list for many dental practices. When I was in the field, I called mostly on solo practitioners (So my DSO and GPO readers can now relax a bit). Some were in rural areas, some suburban and also many in urban settings. Many followed CDC guidelines, but many more did not. I bring this up, because our cover story is all about infection control. This is a must-read story with input from Hugh Norsted (Accreditation Association for Ambulatory Health Care), Heidi Arndt, RDH, BSDH, (president of Enhanced Hygiene), and infection control guru Nancy Andrews.

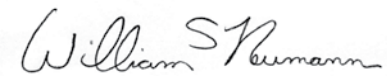
Infection control is a very serious matter and the media has highlighted this with the now infamous case that involved an Oklahoma oral surgeon. Although infection control should, and is taken seriously by most practitioners and most group practices, there are also many "horror stories." In our cover story there are some examples of these infection control breaches. This topic is also highlighted on our website, www.DentalSalesPro.com. It is well worth reading the dental office horror stories as written by the salespeople who called on these offices. The stories are almost unbelievable, except that I witnessed and wrote several of the "horror stories" myself.

One time a dental assistant came out to greet me and I did not see her gloves. I went to shake her hand and I pulled back when I saw she had her gloves on. She apologized that she couldn't shake my hand, and told me she didn't have any time to talk to me because she had a patient in the chair. She was simply coming out to get some magazines and newspapers for the patient, or maybe for the dentist to read. Yep, you can bet she picked up those magazines with the same gloved hands that were and will be again in the patient's mouth. Oh yeah, she also had time to pick up the phone to make a call.

Not glove related, but equally as disturbing. I ventured into a dental office in a small town to be greeted by the dentist. He invited me back into an operatory, where he proceeded to light a cigarette. Oh, yes there was a patient in the chair! So I start to tell him about my products as the ashes hang off of his cigarette and drop onto his pant leg. Fortunately, he didn't set himself or his patient on fire. I did get the sale!

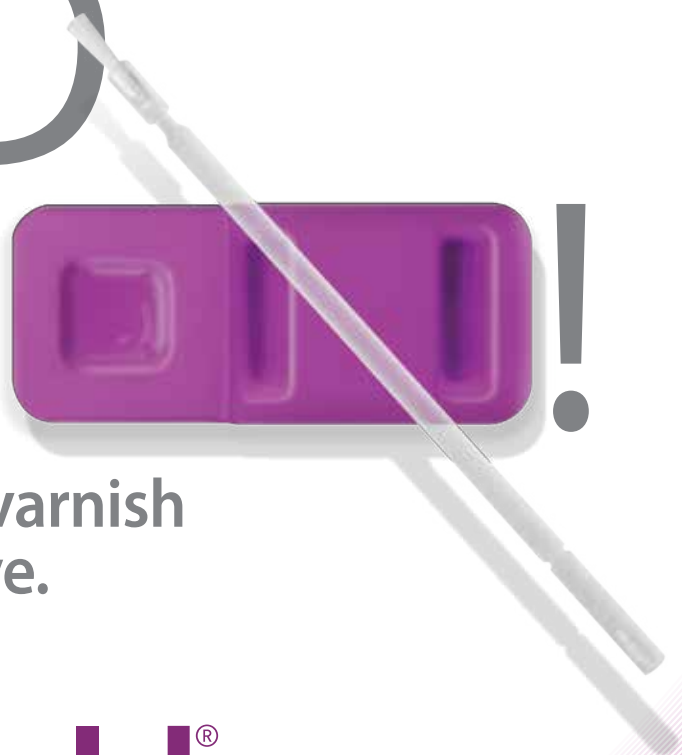
Yes, we are making light of this serious subject, but sometimes truth is stranger (and more dangerous) than fiction. For more horror stories follow this link - http://www.dentalsalespro.com/forum/topics/dental-office-horror-stories .

Happy sterilizing,



Bill Neumann
Publisher
EGP
wneumann@mdsi.org

WE HEAR YOU LOUD AND !



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'Lean' into Productivity

Symptoms that indicate you're wasting money

By Dr. Sami Bahri, DDS

Dr. Sami Bahri is the author of "Follow the Learner: The Role of a Leader in Creating a Lean Culture," and of the DVD "Single Patient Flow: Applying Aplying Lean Principles to Heathcare". The book won the 2010 Shingo Prize for Research and Professional Publication and the video won the same award for 2013. The Shingo Prize Conference also recognized Bahri as the "World's First Lean Dentist." He is a sought-after speaker and lecturer nationally and internationally on implementing Lean management in dentistry. Dr. Bahri can be reached at sami@baridental.com

Editor's note: *The following is part two in a series on how group practices can eliminate waste.*

The economy goes up and down, but for group practices, one goal doesn't change: the organization needs to stay profitable. In this article we present one way to take control of your profit that has proven effective for the last 70 years – the "Lean" way.

Production, volume and cost

Profit depends on three factors: Production, volume and cost. In a previous article we have submitted this formula:

Profit = (Fee – Cost) x Volume

As dentists, we are used to the term "Production." We can get to it if we expand the formula:

Profit = (Fee x Volume) – (Cost x Volume)

Where Fee x volume = **Production and Cost x Volume** = **Total Cost**

To increase profit, we can do any combination of increasing volume and fees or reducing costs. Among the many combinations, a single focus on reducing cost has proven most effective and sustainable, especially in low growth economic times.

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How to reduce cost? By eliminating wasteful activities, and converting the time savings into value-creating work that patients are willing to pay for. Luckily, we have numerous opportunities for improvement. Even if we have established sound management systems, people who execute them spend only 20 percent of their time on value-creating work, and the remaining 80 percent on necessary but non-value creating activities. To help you detect those wasteful activities, we have listed seven categories of waste in a previous article and explored the first two, defects and waiting. (See "Working out the Waste," Issue 1, 2014)

In this article, we will explore the five remaining categories – overproduction, transport, motion, inventory, and excessive processing.

The more supplies you have at one time, the more time someone will spend managing them; and that is not value-creating work. The same goes for laboratory cases.

Overproduction

Overproduction focuses essentially on quantity, timing and speed. If those do not match patient demand, even if you're doing the right activity, you'd be wasting a lot of resources – and that happens most of the time.

Overproduction is the waste of making too much, too fast or too soon. It is the opposite of Just-In-Time (JIT,) a production system that seeks to spend the exact amount of resources and time necessary to perform a task at its highest quality levels.

Overproduction is the hardest waste to see because you'd be performing normal activities that are necessary for patient treatment, but in larger quantities than needed, too soon or too fast. To know the best timing you need planning and calculation; as you learn Just-In-Time practices, you would be able to reduce overproduction gradually.

In dentistry, the most relevant aspect of overproduction is timing. Interestingly, we generate more waste if we produce too early, than too late. When producing what's needed for tomorrow, we're not available to work on what's needed now; and that is considered to be the worst of all wastes.

To understand why timing can be wasteful, you can think of any situation where you need an assistant but she's busy preparing something that will be needed later:

- The insurance coordinator is not available to explain benefits to a patient because she's on the phone with the insurance company, verifying benefits for next week's patients.
- The assistant is not handing you the anesthetic syringe because she's placing a block in the CAD-CAM milling machine or ordering implant parts for a patient scheduled a week after the parts are expected to arrive or setting up the room for a patient coming in two hours – she's working many steps ahead thus not available for the present step.

To eliminate overproduction, you need to establish controls in your systems that prevent people from performing tasks too early.

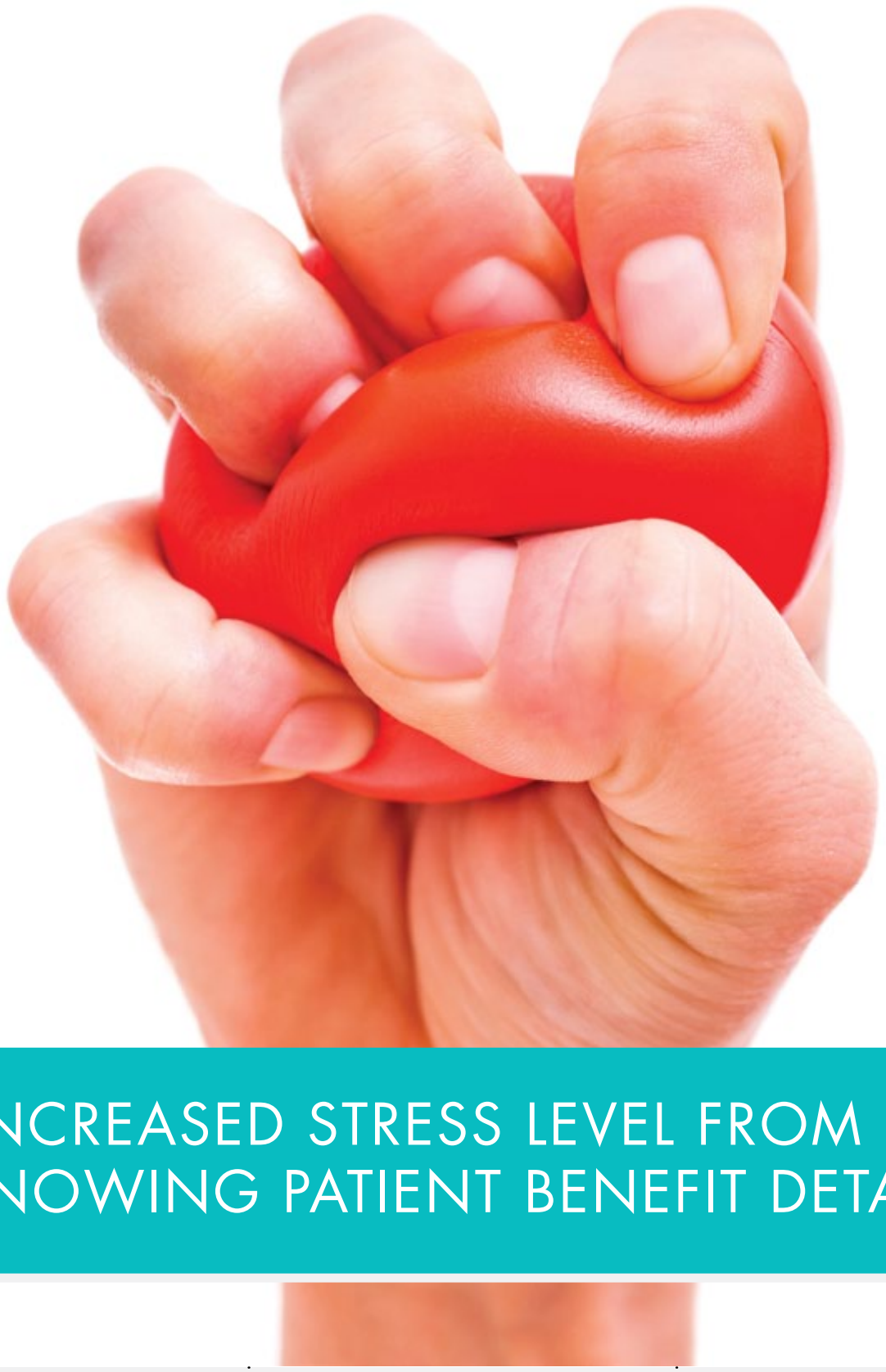
Transport

Transport refers to the waste of moving patients, equipment and materials.

Transport as a waste is a direct consequence of the division of labor pioneered by Adam Smith around 1770, a philosophy that led to improving productivity through the creation of specialties; but also generated the waste of transport.

The waste of transport is everywhere:

- Patients visit the hygiene room, the operative room, the consultation room, the front desk, and the waiting room. Moving patients is wasteful because it requires cleaning more rooms than necessary and because it takes longer to move patients than to move providers. We recommend that all team members – dentists, hygienists, insurance coordinator, treatment plan coordinator and others – come to the patient to provide services. In our office, patients would leave the room only for a panoramic radiograph.



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To reduce the effect of transport, lean gathers all the functions in one space, close to where the work is being done. The office layout and the location of supplies are crucial in reducing the waste arising from transport.

Motion

While transport refers to relocating patients, equipment and supplies, the waste of motion refers to movement by workers. Dentistry has skillfully used ergonomics to reduce excessive motion. In fact, our profession might well be the best organized of all healthcare professions.

Just like transport, motion is caused in part by the division of labor, the ensuing facility layout and the location of supplies.

One manager at Medtronic in Jacksonville, Fla., used pedometers and found that the plant's employees walked in a year an accumulated distance equal to a tour around the world. Needless to say that the waste of motion became the main target.

How far do people walk in your office? You could try to draw a "Spaghetti Diagram" – where you trace the movements of different employees on the office layout map. Chances are you will find opportunities to reduce walking.

Inventory

The first thing that comes to mind when we think about inventory is dental supplies. The more supplies you have at one time, the more time someone will spend managing them; and that is not value-creating work. The same goes for laboratory cases.

But we have an important lesson to learn from manufacturers; they consider excessive inventory any unfinished goods – "Work in Process" (WIP). WIP utilizes resources and ties up capital until it is finished and sold. The same reasoning applies to dentistry; our WIP is unfinished treatment plans.

As long as they have unfinished treatment, patients would utilize resources. They will call to ask about any kind of information, to report errors or even to compliment the staff on the quality of the service. They will come back for adjustments, fallen or broken temporary restorations. All of that prevents the staff from helping in value creating activities; the sooner the patient moves to the hygiene cycle, the less cost we will incur.

To reduce WIP, we treat as much as the patient allows in one visit; the whole treatment, if possible. You will not have to make new appointments, greet, prepare the room, anesthetize, collect, file insurance, sterilize instruments, etc. If you cut the number of appointments by even a small percentage, let's say 10 percent, you would still eliminate a considerable number of steps and free up staff time for productive work.

Overprocessing

The definition for overprocessing is simply processing beyond the customer's demand. The most common form we see is talking to the patient more than their treatment requires. Just as in any other waste, when you overprocess the large steps – as when you continue explaining a treatment after the patient has understood and agreed on it – you can certainly cause some waste, but you generate more waste when you do it in small, repetitive steps. As an example, rinsing and drying a tooth is an act that is repeated a large number of times over the professional career of an assistant. If she spends 10 seconds on it instead of five, the accumulated effect can be detrimental to the overall productivity.

We have explored the seven types of deadly wastes in any business. We hope that you spend more time learning how to eradicate them so you can increase profit. But as we said in the first article, those are symptoms of underlying diseases that you need to learn how to diagnose and cure. If you have any comments or questions please email me at sami@bahridental.com. ■

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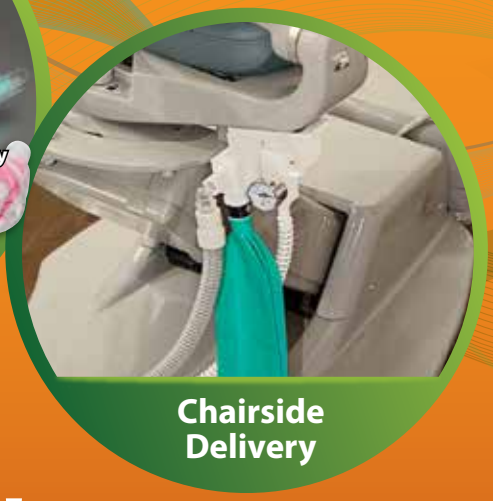

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Periodontal Therapy

How does your group practice measure up?

By Heidi Arndt

Heidi Arndt, RDH, BSDH has worked in the dental field for 18+ years. Her experience ranges from working as a treatment coordinator, dental assistant, and practice manager before graduating from the University of Minnesota with a bachelor's degree in Dental Hygiene. In 2011, Heidi founded Enhanced Hygiene. She is dedicated to helping dental practices realize their total hygiene profit potential through the development of their hygiene team, quality patient care, patient-centric service and by empowering the entire team.

One of the biggest hygiene opportunities within the dental group practice is the opportunity to improve on the diagnosis and treatment of periodontal disease. Having a tangible way in which to measure a team's effectiveness with treatment of periodontal disease lies within one important indicator – the periodontal percentage.

The periodontal percentage is the best Key Performance Indicator to review how well a team is addressing periodontal disease. The periodontal percentage provides a look at how many of the patients are treated for periodontal disease vs. receiving a prophy.

In 2012, the CDC released a report stating that half of American adults suffer from periodontal disease. (And remember, this number does not include "gingivitis," as many earlier statistics did.) The rate of periodontal disease went up to 70 percent with patients over the age of 65.[1]

Clearly, periodontal disease is prevalent in adult patients. It does not matter where we live, how much money we have, how well educated we are … periodontal disease is affecting a large amount of the patients in every practice.

There are several ways to calculate the periodontal percentage, but here is the best calculation:

SRP Quadrant (D4341) + SRP Localized (D4342) + Periodontal Maintenance (D4910) + Prophy (1110) = **A**

SRP Quadrant (D4341) + SRP Localized (D4342) + Periodontal Maintenance (D4910) = **B**

Periodontal Percentage = B/A

The periodontal percentage looks at the definitive non-surgical periodontal therapy codes measured against the number of adult prophy's performed in a practice.

There is one challenge with this calculation that should be addressed. While the adult prophy is a measure of one patient;

the 4341 or 4342 code will calculate up to four times for one patient. Thus, the periodontal percentage is the calculation of procedures only, not of actual patients.

Making sense of the percentages

So, what does the periodontal percentage mean?

Is the team's percentage above 60 percent?

If so, the team is delivering a very high level of non-surgical periodontal care to the patients. It is effective at assessing, educating and enrolling patients in necessary treatment.

Areas to focus on: Continue to focus on the periodontal therapy program and attend continuing education events to ensure the team is always providing the best of care.

Is the team's percentage between 40 to 60 percent?

This is better than average. However, there are several opportunities that still exist.

Areas to focus on: Review the periodontal therapy program and focus on effective and consistent communication with the patients, and between all providers. Ensure everyone is speaking the same language to increase treatment acceptance.

Is the team's periodontal percentage below 30 percent?

This periodontal program needs immediate attention. Most of the patients are receiving prophies and there is a good chance there is a high amount of untreated periodontal disease in the patient base. A low periodontal percentage is one indicator that it is time to evaluate the quality of the assessments and diagnostic care occurring in the hygiene chair. The **first step** to increase the periodontal program is assessing the patient and making a clear diagnosis. A strong and consistent assessment will guide you to a periodontal diagnosis for the patients.

Assessment

No matter what your periodontal percentage lands, the first place to focus on is the Periodontal Assessment. The dental hygiene team must complete a comprehensive periodontal assessment on every adult patient, with a full documentation in the patient record once yearly.

According to the Academy of Periodontology, the comprehensive periodontal assessment should include: A review of the patient's current healthy status, history of disease, and risk characteristics. The dental hygienists must then record the probing depths, recession, mobility, furcation, bleeding and exudate.[2]

Using the comprehensive periodontal assessment, the dental team can develop a logical plan of treatment to eliminate the signs and symptoms of periodontal disease.

Periodontal disease is affecting a large amount of the patients in every practice

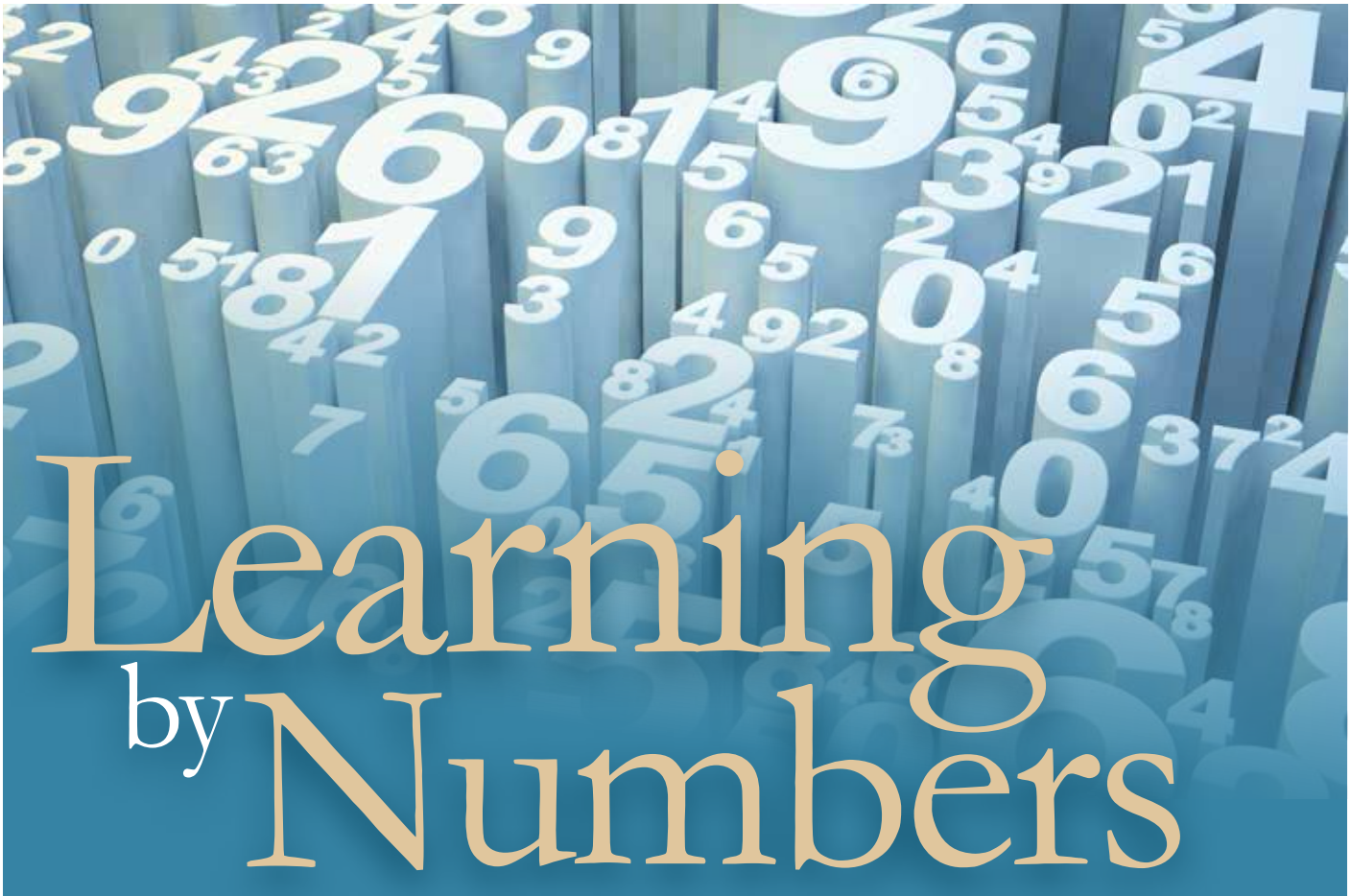
The Academy of Periodontology website www.perio.org, provides numerous resources to help support a strong periodontal therapy program.

In addition, the team should attend a continuing education course focused solely on the development and implementation of a non-surgical periodontal therapy program. Your periodontal therapy program does not need to be elaborate. In fact, the best and most effective plans are created for simplicity and easily implemented into any office. Enhanced Hygiene (www.enhancedhygiene.com) offers several courses throughout the year focused on periodontal therapy programs.

Placing a focus on your periodontal therapy program will improve the level of patient care and service you provide in your group practice; and, improve your hygiene revenue. ■

Sources:

1. P.I. Eke, B.A. Dye, L. Wei, G.O. Thornton-Evans, and R.J. Genco. Prevalence of Periodontitis in Adults in the United States: 2009 and 2010. J Dent. Res. 2012.
2. Comprehensive Periodontal Therapy: A Statement by the Academy of Periodontology. J Periodontal, July 2011.



Learning by Numbers

Great Expressions places a premium on sharing knowledge throughout its 215 practices

Can power be judged by numbers? Perhaps, if you're talking about purchasing power or marketing clout.

But for Great Expressions Dental Centers, the key to success could more accurately be characterized as "learning by numbers."

"Our multispecialty model gives us tremendous opportunity to share best practice modalities from one office to another," says Robert Brody, DMD, chief clinical officer. "We can do that individually or in a group setting. This gives everybody an opportunity to learn and understand what's happening. As a group, we provide more avenues – easy avenues – for our doctors to learn."

Great Expressions is a Bloomfield Hills, Mich.-based dental services organization comprising 215 practices in nine states. Initially a single practice in Dearborn, Mich., founded in 1975, Great Expressions has grown primarily through affiliation ever since. In fact, the company opened its 50th location in 2002, and its 200th in 2012.

"We provide every service that the doctor would need," says CEO Richard Beckman. "We help them negotiate fees; and bill, collect, send claims – everything they need inside a dental office. And we can offer a career path for doctors. They start out as an associate, and can move into senior roles, such as clinical director. We want as many of our dentists as possible to be investors in the management company.

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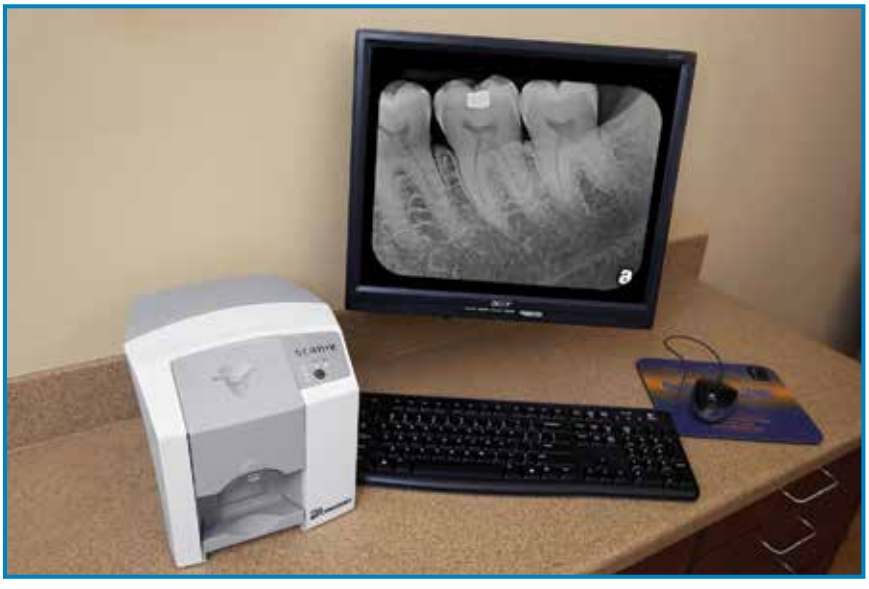

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Says Brody, "We take away all the business aspects of running a practice from our dentists, if that's what they want. They don't have to worry about the next payroll, or about putting an ad in the paper for a new staff member, and then training [him or her]." Great Expressions dentists can concentrate on what they want to do – provide high-quality dental care, he says. "And they have the resources of 215 offices to work with, as well as the ability to pursue CE [Continued Education] provided by Great Expressions, so they can enhance their skills."

National Doctor Panel

Great Expressions dentists maintain clinical control over treatment, but they are expected to follow a standard of care established by the National Doctor Panel. The eight-person panel – comprising dentists, orthodontists and other specialists – oversees and trains the DSO's dental professionals, and also assists with recruiting and hiring.

"As healthcare professionals and as dentists, we do provide a pathway to health function and aesthetics," says Brody, who owned a 36-office practice in Florida prior to affiliating with Great Expressions. "We don't reinvent pathways that already exist, but we do adopt existing pathways from other organizations." For example, Great Expressions has incorporated recommendations from the American Academy of Periodontology concerning the treatment of gum disease.

Richard Beckman

Robert Brody, DMD

In addition, the Panel has arrived at some standards for sequencing of treatment. "I don't know if you would call that a pathway, but it is an appropriate sequence for treatment that we teach all our doctors," he says.

The Panel is assisted by a network of regional clinical directors. Brody himself was a clinical director in Florida prior to becoming chief clinical officer two years ago. The clinical directors serve as resources to doctors by disseminating best practices. "Our doctors welcome their visits," says Brody, speaking of the clinical directors. "Everybody likes to share ideas and talk about treatment plans. And if I see something in an office that is really working well, I share it with everyone else, and I give them credit."

For example, Brody observed one Great Expressions dentist conducting morning staff meetings and afternoon meetings with the office manager, in an attempt to get everyone on the team using the same vocabulary with patients. "It earns the trust of the patient, and we want patients for life," he says. It's a practice he shared with other practices.

The National Doctor Panel has put together a quality assessment program, which is designed to help doctors understand the importance of documentation, diagnosis and treatment planning, he continues. Through that program and frequent in-office visits, Great Expressions has a better idea of what CE is needed. Examples include training on periodontal therapy and clear aligners, sponsored by industry partners.

The National Doctor Panel plays a role in product and equipment selection as well. "They review products, then

Standard charts

Great Expressions has yet to install a common electronic dental record in its 215 practices. However, the DSO has standardized its paper charts, so that they are easily readable by anyone in the organization, including those who have recently relocated from another office or region, or for practitioners treating patients who have relocated from another service area.

"We feel this is important," says Brody. "If we refer a patient from one office to another, we know exactly how the chart will be laid out and where the documentation will be. It eliminates mistakes."

Ultimately, Great Expressions intends to install a common electronic record system in all its offices, he says. "That's the best way to go. It makes communication easier, it makes the sharing of ideas easier, and it makes us better."

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Great Expressions: Inside and out

The public can tell a Great Expressions Dental Centers office by the distinctive smiley-face logo on the door. But the Great Expressions touch can be found inside its offices as well. With 215 practices spread across nine states, the DSO has learned a thing or two about efficient office layout.

"For the most part, we have grown by affiliation," says Chief Clinical Officer Robert Brody, DMD. "We have designed some offices, but not a lot." Even if the DSO can't reconfigure the offices it acquires, it can – and does – introduce some commonality to them, such as common color schemes and flooring. "Patients who move and trust us, can go into any of our offices and immediately recognize us," he says.

Great Expressions prefers a central sterilization and central supplies area. It's better for infection control, and it leaves rooms uncluttered, which is good not only for appearance's sake, but efficiency and easier disinfection.

Says CEO Richard Beckman, "The layout of the practice should maximize the patient experience, so the patient feels well-greeted, well-taken-care-of, and well-treated. Everything we do is geared to that.

"There's really not a lot of secret sauce in the layout," he says. "It can be important, but at the end of the day, it's important to make sure staff is trained to give patients the best experience possible."

try to select those that they believe are best suited to our practices," says Beckman. Doctors can go off formulary, but as much as 85 to 90 percent of products and supplies are purchased from the standard formulary, he says.

Great Expressions has a prime vendor relationship with Henry Schein, and a secondary relationship with Benco Dental. Sales reps who want to introduce new products to Great Expressions dentists are asked to take up their request with the National Doctor Panel, not individual Great Expressions offices.

Dentists for life

Just as Great Expressions wants patients for life, so too does it want dentists for life. And the DSO believes it can make a strong case for their doctors to stay.

"The independent solo dentist spends much more time on the business aspect of his or her practice than a Great Expressions dentist does," says Beckman. But that independent dentist will spend less time chairside. "Our dentists may spend zero time on administrative [duties], but more time treating patients." Consequently, Great Expressions dentists enjoy doing what they do best – taking care of patients – and, at the end of the day, leave the office without a lot of paperwork, he says. In addition, because the DSO actively works with insurers, Great Expressions doctors enjoy a consistent flow of new patients, he adds. "Doctors like that."

Doctors who want management or administrative responsibilities can embark on a different career path, perhaps by becoming a partner in the corporation, a clinical director, or quality control specialist. "We have all sorts of different paths for the dentist who doesn't want to spend all their time chairside," says Beckman.

Says Brody, Great Expressions offers great advancement and learning opportunities for the young dentist. He or she might spend a year or two as an associate, and then perhaps take responsibility for a practice of their own. They gain management and leadership skills and then, if they want, move into a larger practice.

The DSO offers flexibility for dentists – including the growing ranks of female dentists, who want to balance work and family demands, adds Beckman. Dentists who want to limit their hours are accommodated.

Great Expressions is an attractive option for recent graduates saddled with debt, because they begin practice with an immediate revenue stream, says Beckman. "There's a career path here. They can spend their entire career here, if they want, or they can spend a couple of years with us, then open their own practice. But we would prefer they didn't do that." ■

Group & Multi-Practice Summit 2014 Series

Dental Practice Strategist Rhonda Mullins has experienced a pattern in conversations with solo dental practitioners in the last 24 months. These dental entrepreneurs notice a shifting landscape in the dental industry – a trend of solo practices being consolidated (bought and merged) into existing large group practices that offer multi-disciplinary care teams, or MSO models, that remove the burden of business operations to free dentists up to function almost exclusively on the clinical side.

"What I see clients experiencing and/or inquiring about all over this country is, 'How can I help retain the integrity of dentistry as we know it? Where can I create an opportunity for this business industry that will serve the needs of not only the changing landscape of the business model in practicing dentistry, but get more without settling for less,'" says Mullins. "The need makes a loud roar in the industry today."

This need led to the creation of Group & Multi-Practice Summit 2014 series by Mullins and her guest experts. The objectives of the Summits are:

- To help dentists harness the fears of the shifting landscape of the industry.
- To educate dentists and investors on how to develop DSOs and MSOs. Culture is a key element in the successful formulation.
- To equip them with an architecture of a plan – not just the bricks – to build an efficient and significant entrepreneurial business for Scaling Excellence in a Care Driven® Culture.
- To create and support "Dentrepreneur℠" Study Groups for continued engagement with the "Dentrepreneur℠," with catalyst coaching and consulting strategies for greater significance and success throughout their journey.

Elements of the Dentrepreneur

The first Summit, held recently in Atlanta, covered four areas that are vital to the Dentrepreneuer℠ in these practice business models.

For "Healthcare Law," Stuart Oberman, Esq., discussed legal elements of how to incorporate or properly structure an LLC. He gave several accounts of his personal legal practice experience helping clients in the dental world, and offered a high-level overview of a legal structure needed for dentists who want to purchase practices.

For "Practice Transition," Pete Newcomb, CEO/Entrepreneur, of Southeast Transitions, shared industry trends, and how attendees could build their model of choice through acquisitions and mergers. Newcomb also offered insights into assessing the value of practices, the projected profitability of those candidates and terms of those acquisitions, including the provider agreements.

For "Excellence in Restorative Product and Services," Pinhas Adar, CEO/Entrepreneur of Adar Dental Network and Adar International, shared his insights on best practices for the sustainability of excellence in restorative dentistry materials, design and cost.

For "Scaling Excellence Operationally and Managerially," Mullins offered fundamentals to create ventures in business and life that allow for significance and success through key principals. She also discussed the Entrepreneur and Innovation, how they go hand in hand in an overview of the MSO Structure, with the right management partner to count on and the ability for them to transform any practice acquired through a mindset, not just footprint of scaling excellence.

Future Summits

Mullins says there are four more Summits planned for this year. Mullins will also facilitate monthly and quarterly engagement with each club and member to insure each "Dentrepreneur℠," Study Group succeeds in each city. ■

For more information, visit www.atl360group.com or email Rhonda@rhondamullins.com.

When it comes to infection control protocols, get it in writing

By Laura Thill

Ensuring that infection control protocols are followed consistently throughout a group dental practice can be a huge undertaking. But, by placing the right people in charge and providing written protocols for each facility to follow, it can be accomplished, say experts. In fact, anything less than this could place the practice – including the staff and patients – and the group at large at risk for life-threatening health issues and insurmountable financial liability.

Indeed, as large dental groups continue to emerge, having a comprehensive, written set of infection control protocols in place has become increasingly more important. "Dental groups tend to grow quickly and don't always have infection control protocols," says Heidi Arndt, RDH, BSDH, president of Enhanced Hygiene, a group dedicated to the support and development of dental hygiene teams. Or, if they do have protocols in place, they don't always assign and train staff to ensure that they are carried out, she notes.

Formerly, Arndt worked with American Dental Partners, which includes 23 dental groups and 250 dental practices. "At American Dental Partners, we believed that each practice should follow the Accreditation Association for Ambulatory Health Care (AAAHC) standards," she says. (AAAHC accreditation means that an organization participates in on-going self-evaluation, peer review and education to continuously improve its healthcare, including adhering to infection control guidelines.) This was "a driving force" in ensuring that each practice adhered to the group's infection control protocols, she points out. "At each practice, an operations person, as well as a dental hygienist or dental assistant, would be assigned to oversee quality assurance and infection control," she explains. "[He or she] would run through a checklist and report to a quality assurance director. The quality assurance director, [in turn], would address any concerns with the go-to person at the practice."

Hugh Norsted, DDS, an accreditation surveyor for AAAHC for over 25 years, agrees that having a written set of infection control protocols in place is essential to ensuring that each practice within a large dental group adheres to the group's policies. "Over time, there are changes in staff and leadership at each practice," says Norsted, who was a co-owner of Minneapolis-based Valley Dental Group before retiring in 2008. "In order to effectively train staff in infection control guidelines, you need written, easy-to-understand standards and policies – particularly when it comes to sterilization.

"The Centers for Disease Control and Prevention (CDC) has issued guidelines for infection control practices in dental offices," he continues. "In fact, its last edition was in 2003, and an update is anticipated soon. Many state boards look to these guidelines as a standard, and AAAHC relies on them as a reference." OSHA standards and guidelines also are designed to protect dental and medical staffs from infection, but patients benefit as well, he adds.

More than one person in charge

Maintaining a good infection control program calls for a team effort – and a well-trained team at that, note experts. "It's key for dental offices to designate a couple of people who can attend infection control programs and take continuing education classes, and then bring that back to the practice," says Norsted. "Many states mandate continuing education for dental staff in infection control. For example, New York has created its own program and Minnesota has core requirements for infection control course attendance that dentists must meet to retain their license." The problem, he adds, is that while dentists or hygienists might attend continuing education classes, they don't always share that information with the rest of the staff. "And, state boards typically do not inspect dental practices every three years," he says. "When they do, it is usually in regards to a complaint, or they focus primarily on sedation policies. So, often, dentists are left to their honor to understand and implement current infection prevention and control standards."

As group practices expand, they require cross-training programs to ensure consistency throughout the organization, notes Arndt. "We had cross training at ADP," she says. "We would educate new clinicians, including front office staff, on our standards and expectations." It's much more difficult to backtrack and repair a situation than to do it correctly from the start, she adds. "Years ago, I worked in hygiene for a group and oversaw 23 practices. [Protocols] can vary from one office to another, which is why cross-training is so important."

ADP schedules routine senior meetings to cover a gamut of points, from infection control to office productivity, quality assurance and more, she points out. "We wanted to know exactly what was going on at each practice.

"The biggest mistake is placing one person in charge," she continues. "You need a management team at each practice that is aware of the infection control standards and expectations."

Indeed, a dental group might have good policies in place, says Norsted, "but they need a certain level of observation and documentation. Surveillance is critical to ensuring compliance. [Dental offices] need to keep checklists, log books and have a good surveillance system, and they should retain their records for about three years for state inspections."

Key points

A good infection control program should cover a range of points, including the following:

- Hand hygiene and the use of gloves.
- Safe injection practices. Dentists should always use new, sterile needles and NEVER mix carpules.
- Barrier protection.
- Hard surface disinfection.
- Instrument sterilization.
- Management of sharps and needle/sharps disposal. (Are used needles and blades being properly transferred to tamper-resistant containers, and are the containers removed when they are filled?)

"It's hard to believe but some practices don't use new needles for each patient," says Norsted.

Arndt, too, has seen some hair-raising actions on the part of dental staff, although these were connected with solo practices – not ADP, she points out. "I have seen hygienists walk out of an operatory still wearing their gloves, and then touch things in the hallway," she says. "I saw one hygienist walk down the hall carrying an instrument after working on an HIV-positive patient! I have seen staff remove sterilized instruments with their bare hands!"

During the exam, dentists and staff should wear masks, safety glasses, lab jackets and gloves, she explains. At the end of the exam, they should remove their masks and

gloves, and appropriately dispose of needles and/or process instruments for sterilization. "These are safety precautions for both the patients and the staff." The potential transmission of hepatitis, influenza and airborne germs via instrument- and drill-spray are all real concerns, she adds, noting that sometimes solo and newly emerging practices "don't have the necessary awareness around infection control."

Liability huge

Accidents happen. Patients have been known to swallow crowns and it's not unheard of for a dentist or hygienist to be stuck with a needle. But, when an incident does occur, the liability can be monumental. "Once an incident gets into the press, it becomes a huge PR issue," with legal and malpractice implications, says Norsted. "If a dental office is treating a large number of patients, and it needs to send a letter out [asking] all of those patients to come in for hepatitis testing, it can mean a huge financial, PR and legal liability."

Again, it comes down to ensuring the right protocols are in place for the practice to follow. "The entire team must be aware of the infection control protocols," says Arndt. "This concerns non-clinical staff as well. They are often the eyes and ears of a practice. They see a lot of what goes on and need to know the proper protocols, standards and expectations. And when you are dealing with a large volume of people, it takes more than one person to oversee this."

"Communication, education and documentation are key to ensuring infection control," says Norsted. For a large group practice, one way to handle miscommunication and oversight is to "break the process down into components" so that a national team oversees regional teams, which in turn manage smaller groups and practices, he points out. Clinical and non-clinical staff at each practice must be responsible and accountable as well, he adds. "Lack of communications and [an inability] to oversee that infection control protocols are being followed is the greatest challenge." ■

A Culture of Safety

An educated staff is an empowered staff.

Get it in writing, says dental educator and consultant Nancy Andrews, RDH. When educating dentists and staff on infection control protocols, "everything must be in writing and people constantly need to be re-educated and re-assessed," she points out. This affects what types of products an office purchases, she adds. In the case of masks, the office must ensure they fit properly and accommodate potential staff allergies. "And, different masks are appropriate for different procedures," she adds. "An office needs enough masks, and everyone needs to know how to use them and what their limits are."

"Everyone needs to be on board when making decisions as to which masks or gloves to purchase," she continues. But this depends on "a culture of people wanting to comply with infection control protocols and standards." And, that's not always the case. "There are dental practices where the staff doesn't feel it has the power to change poor practices," she says. "The staff needs to be aware of why infection control is so important, and empowered to follow the correct protocols and speak out when those protocols are not being followed." If a practice has a program in place to prevent errors from occurring, as well as the ability to identify errors when they do occur, they are ahead of the game, she adds.

> "The staff at each office needs to show patients that it's taking steps to ensure infection control."
>
> **– Nancy Andrews**

The office needs to gain the trust of its patients as well, says Andrews. "If patients believe a dental office is clean and that the staff is trying hard [to follow infection control standards] but get a call that the sterilization equipment failed, they are less likely to sue the office," she says. "Patients notice when the staff doesn't wash their hands or wear gloves and masks. The staff needs to establish a culture of trust with the patients.

Yes, errors can occur, which is why group practices need liability insurance, she says. At the same time, however, "the staff at each office needs to show patients that it's taking steps to ensure infection control."

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Check and double-check in-office sterilization

Best practices for sterility call for proper instrument processing and monitoring.

Now more than ever, the commitment to infection prevention is key to every practice's success. Patients trust and expect delivery of dental care to be safe. Instrument processing, treatment room cleaning and disinfection usually occur out of the sight of patients. It is in these moments, however, that clinicians must remain diligent in ensuring adherence to sterility assurance protocol.

Best practices for sterility assurance include a combination of physical, chemical and biological monitoring:

- Physical monitoring refers to the information provided on the gauges, printout or LED of a sterilizer and identifies sterilization parameters throughout the duration of a cycle.
- Chemical monitoring requires the utilization of chemical indicators designed to monitor specific parameters occurring during the sterilization cycle.
- Biological monitoring is the gold standard for sterilizer performance testing as it contains viable, highly resistant spores.

Chemical monitoring

The most basic external chemical indicator is a Class 1 single-parameter process indicator, such as indicator tape or specialized ink markings printed on pouches or labels. These external indicators are temperature-sensitive only and provide a definitive color change when exposed to heat. They are designed to enable staff to separate processed instruments from unprocessed by the color of the indicator. External indicators do not indicate or assure sterility.

The guidelines issued by the Centers for Disease Control and Prevention (CDC) recommend internal chemical indicators should be used inside each package to ensure the sterilizing agent has penetrated the packaging material and actually reached the instruments inside. A Class 3 single-parameter internal indicator produces a definitive color change when exposed to only one sterilization parameter (e.g. time or temperature). Multi-parameter internal indicators are designed to react to two or more parameters (e.g. time and temperature; or time, temperature and the presence of steam) and can provide a more reliable indication that sterilization conditions have been met. Pouches usually come with a printed external indicator, but not all pouches offer built-in internal indicators, requiring an additional step and cost to physically add an internal indicator strip.

Class 5 integrating indicators as classified by the Association for the Advancement of Medical Instrumentation (AAMI) and the International Standards Organization (ISO) contain a steam-sensitive material that sequentially moves across the strip into a safe zone indicating all parameters of steam sterilization (time, temperature, steam) have been met. The benefit of using Class 5 indicators is the ability to provide a distinct pass/fail result offering the confidence of sterility while awaiting biological testing results. Class 5 indicators closely mimic biological monitoring but do not replace the need for weekly biological testing.

Biological monitoring

A passing result on a biological monitoring test assures that all sterilization parameters have been met. In the United States, at least weekly biological monitoring is recommended by the CDC. Biological testing products are available as either mail-in services (that provide 3rd party testing verification) or in-office testing.

Dental offices should review their infection prevention protocol and all associated procedures to ensure they are compliant with guidelines in order to ensure safety for their practice, patients and their staff. ■

Editor's note: *Efficiency in Group Practice* would like to thank Crosstex for its contribution.

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New CDC guidelines will address unresolved issues

Agency preparing to update its 2003 infection control guidelines

The Centers for Disease Control and Prevention is updating its 2003 "Guidelines for Infection Control in Dental Health-Care Settings," and hopes to publish proposed recommendations in 2015, according to speakers at the OSAP 2013 Symposium. (OSAP is the Organization for Safety, Asepsis and Prevention.)

CDC researchers and others have been reviewing – and will continue to review – scientific evidence and literature concerning the risk of transmission in dental settings, focusing on unresolved and emerging issues not covered in the 2003 document. Those issues include the following.

- **Surgical smoke.** This issue was discussed in the 2003 guidelines, which noted that some viruses and bacteria had been detected in laser plume. But no recommendations were made.
- **Burs and endodontic files.** The overarching issue is single-use vs. repeated-use burs and files. The 2003 guidelines noted the difficulty of cleaning, but made no recommendation.
- **Prions Creutzfeldt-Jakob Disease**, and the risk of transmission via pulpal tissue, contaminated instruments, etc. The CDC's 2003 guidelines noted the resistance of the disease to standard sterilization procedures, but no recommendations were made.
- **Methicillin-resistant Staphylococcus Aureus.** MRSA was not covered in 2003, though the CDC did publish a review in 2008 advising strict adherence to standard precautions.
- **Clostridium difficile.** Like MRSA, C. difficile was not covered in the 2003 guidelines. The agency intends to review guidelines and literature, and to tackle the subject in the upcoming guidelines.
- **Double-gloving and its effectiveness in preventing disease.** In 2003, perforation studies suggested that double-gloving could provide additional protection from blood contact, but studies failed to demonstrate its effectiveness in preventing disease transmission. Hence, no recommendations were made 10 years ago.
- **Dental unit water lines**, specifically, frequency of monitoring. In 2003, the CDC noted that clinical monitoring of water quality can ensure that procedures are correctly performed and that devices are working in accordance with manufacturer's previously validated protocol. At the same time, the agency noted the lack of information to determine optimal frequency for each type of water maintenance system. The recommendation was to consult with the manufacturer to determine the best method for maintaining acceptable water quality (< 500 CFU/mL) and recommended frequency of monitoring. For the upcoming recommendations, the agency intends to review the literature, and discuss the issue with the Food and Drug Administration and the Environmental Protection Agency.
- **Sterilizers.** Ten years ago, the CDC recommended at-least-weekly monitoring using biological indicators, and monitoring of each load with mechanical and chemical indicators. Since 2003, a number of sterilizer-related recommendations have been issued, such as daily monitoring when processing multiple loads. In addition, new classes of chemical indicators have appeared since 2003. As it works on updating the 2003 guidelines, CDC intends to search the literature for new evidence, review the 2008 CDC guidelines, review American National Standards Institute/Association for the Advancement of Medical Instrumentation (ANSI/AAMI) standards, and consult with the FDA. ■

Since 2003, a number of sterilizer-related recommendations have been issued, such as daily monitoring when processing multiple loads.

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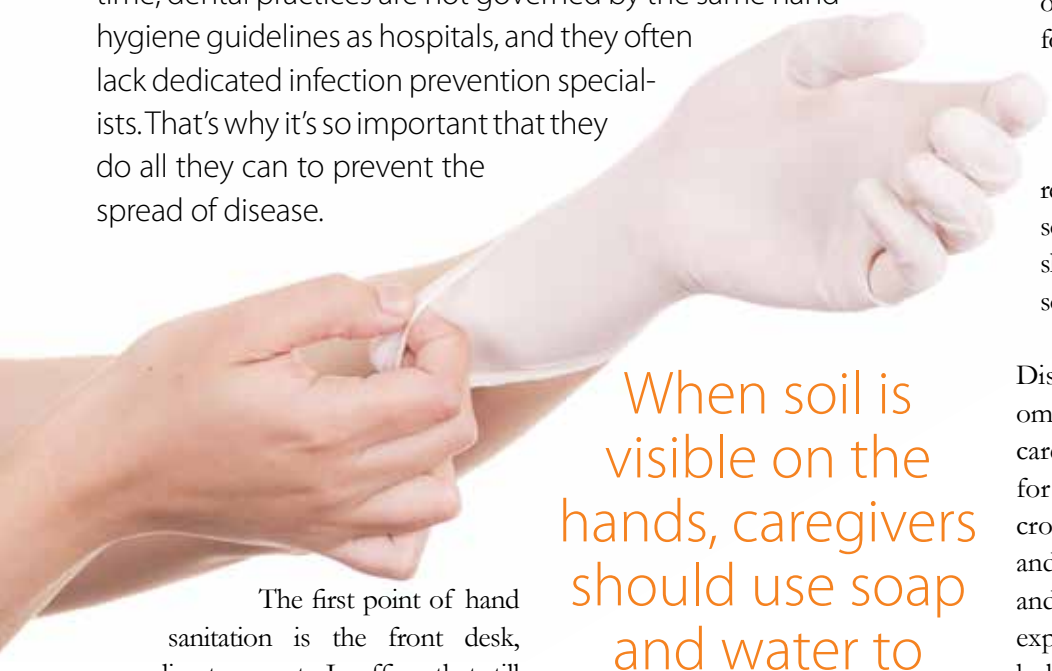
Hand Hygiene

Hand hygiene should be a priority across the group practice.

Are dentists and their staff doing enough to protect themselves and their patients from infection? With increased awareness of seasonal flu, Methicillin-Resistant Staphylococcus aureus (MRSA) and other infectious diseases, the demand for hand hygiene products has been on the rise in recent years, according to experts. At the same time, dental practices are not governed by the same hand hygiene guidelines as hospitals, and they often lack dedicated infection prevention specialists. That's why it's so important that they do all they can to prevent the spread of disease.



When soil is visible on the hands, caregivers should use soap and water to remove soil and organic matter.

The first point of hand sanitation is the front desk, according to experts. In offices that still rely on paper files, patients sign in and update their patient history before the dental assistant takes their file to the operatory. Infectious diseases, such as common cold, flu and several gastrointestinal disorders are commonly spread through hand-to-hand contact, according to the Mayo Foundation for Medical Education and Research.

Alcohol-based hand sanitizers

Two major types of microorganisms reside on the skin: resident, or everyday flora, which is located in the dermis; and transient flora, or contaminants, which are located in the epidermis of the skin. Hand hygiene is a general term that refers to the removal of transient flora through handwashing, as well as the use of alcohol-based sanitizers (e.g., rubs and wipes) and antiseptic handwashes. Dental practices generally need both soap/water solutions and FDA-approved waterless, alcohol-based sanitizers (e.g., wipes, gels or foams). Although alcohol-based foams and gels remove germs, they can leave soil behind; however, alcohol-based wipes have demonstrated in studies their ability to physically remove soil from the hands. When soil is visible on the hands, caregivers should use soap and water to remove soil and organic matter.

Therefore, the Centers for Disease Control and Prevention recommends that, whenever possible, caregivers should wash their hands for 30 or 40 seconds with an antimicrobial soap. However, when dentists and hygienists are between patients, and their hands are not visibly soiled, experts recommend they use alcohol-based hand rubs, which are considered very effective.

When it is not possible for dentists and their staff to properly wash their hands, experts recommend they use an alcohol-based hand sanitizer with an alcohol content ranging from 60 to 95 percent. (Sixty-two to 65 percent alcohol content is required to keep the hands moist enough for 12 to 15 seconds, which is necessary for the product to be effective.) The CDC has identified ethanol as the preferred alcohol formulation due to its superior efficacy against viruses on the hands.

Investing in efficacious and healthcare-grade hand hygiene products is a small price for group dental practices to pay to protect the health of their staff and patients. ■

Infection control tools

OSAP, the Organization for Safety, Asepsis and Prevention, has developed a number of tools to educate patients and dental staff about patient safety in dentistry. They can be found and downloaded at http://www.osap.org/?page=IC_in_the_news.

Patient resources

The website includes the following tools designed for patients:

- **Questions for your dentist:** Five questions patients should ask about infection control. (Examples: How do you know that the sterilizer is working properly? Do you disinfect the surfaces in the operatory between patients?)
- **Travel resources:** a traveler's guide to safe dentistry.
- **Overview of dental office infection control practices:** a variety of infection control resources – including online videos – from the American Dental Association.
- **Five things to do in the dentist's office:** an article for patients from CNN Health. (Here are the five: Watch the gloves, check out the office, ask for autoclave validation, check the instruments, speak up.)

Dental team resources

The OSAP toolkit includes the following resources for the dental team:

- **Reassuring patients:** Seven key talking points. How to discuss infection prevention with your patients.
- **OSAP infection control workbook. "CDC Guidelines: From Policy to Practice by OSAP,"** a 170-page workbook with practical information to help healthcare professionals put recommendations into practice.
- OSAP interactive guide to the Centers for Disease Control and Prevention guidelines. Complimentary interactive guide, also available in Spanish.
- OSAP checklist for incorporating CDC guidelines. OSAP converted the Centers for Disease Control and Prevention "Guidelines for Infection Control in Dental Health-Care Settings – 2003" into a checklist for dental practices.
- **CDC Guidelines and Recommendations:** Oral health resources, including information on safe injection practices from the nation's leading public health agency.
- CDC "Recommended Infection Control Practices for Dentistry." Infection control resources, including fact sheets, FAQs, glossary and publications.
- American Dental Association "Statement on Infection Control in Dentistry," issued March 29, 2013.
- ADA "Policy Statement on Bloodborne Pathogens, Infection Control and the Practice of Dentistry."
- Strategies to reassure patients. Tips on reassuring patients of the dental practice's safety procedures. ■

To visit the OSAP toolkit, go to http://www.osap.org/?page=IC_in_the_news.

Overcoming Challenges with Compliance

Investing in every team member, including the dental assistants, can minimize the risk of incidents, reduce turnover, improve patient care, increase patient retention and generate overall greater efficiencies.

Adhering to oral healthcare regulations, including federal and state infection control standards and guidelines, is an ongoing effort, and there's no room for complacency with patient safety at stake. When you operate a multi-site group dental practice, reputation management becomes even more important. An infection control breach in one location can have widespread consequences for your practice and your patients. However, there are many steps you can take to minimize your risk.

When it comes to infection control, dental assistants fill a critical role. They often are tasked with preparing and sterilizing instruments and equipment, and may even serve as infection control coordinators. Dental assistants are frequently the closest eyes and ears to the day-to-day operations – which means they have the opportunity to stop a potential hazard before it happens.

The DALE Foundation's DANB ICE Review course is a great resource to brush up on infection control guidelines.

One of the biggest challenges with hiring, educating and training this group is that dental assisting requirements and delegable duties vary from state to state. When operating dental practices in multiple states, this challenge is amplified – making it tough to standardize the education, experience and training requirements for dental assistants.

Taking a state-specific approach may serve your practice and your employees best in the long run. Yet, there are some practices you can follow to streamline your protocol.

1. Understand dental assisting requirements

Become familiar with the dental assisting requirements across locations by visiting the Dental Assisting National Board, Inc.'s (DANB's) free search-by-state map, which includes dental assisting job titles, requirements, and allowable and prohibited duties. Make sure to check this resource along with the state dental board websites regularly, as rules and regulations frequently change.

2. Encourage national certification by DANB

Since each state has different dental assisting requirements, encouraging or requiring all dental assistants to also earn national certification can help multistate practices streamline their office protocol and create a national baseline for hiring decisions. DANB is recognized by the American Dental Association as the national certification board for dental assistants. Currently, 38 states, the District of Columbia, the Department of Veterans Affairs and the U.S. Air Force recognize or require DANB exams, and there are more than 35,000 DANB certificants nationwide, with over 73,000 dental assistants passing DANB's Infection Control (ICE) exam since 1997.

Beyond proven knowledge in infection control, radiation safety and chairside assisting, DANB Certified Dental Assistants (CDAs) can benefit your practice in numerous other ways, including lower turnover, increased patient trust and greater efficiency.

3. Keep infection control a top priority

As part of earning DANB's CDA certification, dental assistants must pass DANB's ICE exam, which measures knowledge of important Occupational Safety and Health Administration (OSHA) standards and Centers for

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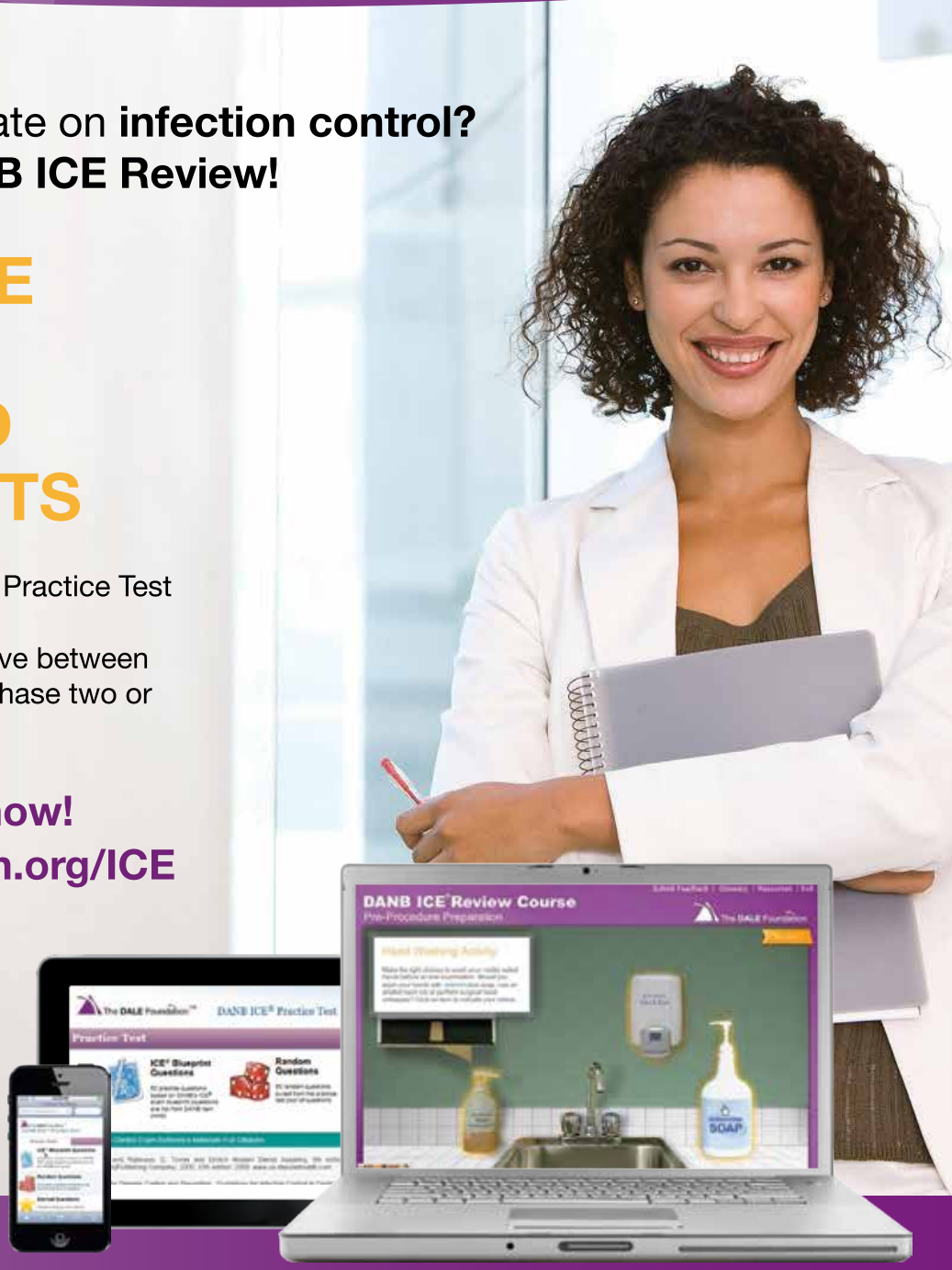

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The DALE Foundation is an ADA CERP Recognized Provider. ADA CERP Is a service of the American Dental Association to assist dental professionals in identifying quality providers of continuing dental education. ADA CERP does not approve or endorse individual courses or instructors, nor does it imply acceptance of credit hours by boards of dentistry. Concerns or complaints about a CE provider may be directed to the provider or to ADA CERP at ada.org/cerp

Disease Control and Prevention (CDC) guidelines. Dental assistants who pass DANB's ICE exam also receive a certificate of knowledge-based competency, which can be displayed in the office in an area visible to patients. Check DANB's free online verification tool to verify whether new hires or currently employed dental auxiliaries have passed any national exams or hold DANB certification.

4. Centralize continuing education and staff training

Providing quality patient care requires an ongoing commitment to staff training and education – especially when it comes to infection control. Assign a staff member to oversee compliance with company-wide mandatory continuing education and keep records in an accessible place for easy review and retrieval.

Incorporate engaging and convenient training tools for your staff, such as the DALE Foundation's online review courses and study aids. The DALE Foundation, an approved ADA CERP and AGD PACE provider, offers e-learning products on a variety of topics, including infection control.

The DALE Foundation's DANB ICE Review is an interactive, self-paced course that provides an overview of important infection control topics, including how to adhere to standards set by OSHA and guidelines established by the CDC and the Organization for Safety, Asepsis and Prevention (OSAP). This course is worth 12 CDE credits upon successful completion.

For group practices, one of the benefits of incorporating these products into your training approach includes being able to manage the courses for the entire team through one account. The courses can either be purchased by each individual or by the practice manager. If courses are purchased by the practice manager, they can be assigned and progress can be tracked across employees, from one central account.

5. Engage and incentivize dental assistants

As part of the commitment to staff training and education, engage dental assistants by providing meaningful goals that make them feel successful while benefiting the bottom line. If you are encouraging all assistants across dental practices or practice sites to take the DANB ICE exam or earn certification, provide incentives that make the exam and certification process easier. For example, offer study materials or sign up for group testing so the dental assistants can take their exams at the same time – which can foster a sense of camaraderie and support.

On the dental team, every member plays a critical role. When it comes to the dental assistant's position, investing in resources and standardizing practices for this essential team member will serve your business long into the future. ■

Additional Resources

At DANB and the DALE Foundation, public protection is at the heart of what we do – and the resources we provide can help you make it a core part of your practice, too. Take advantage of our resources and underscore your office's commitment to patient safety.

To learn more, visit www.danb.org and www.dalefoundation.org.

The DALE Foundation Course Catalog:
http://www.dalefoundation.org/Courses-And-Study-Aids/Product-Catalog-Search

The DALE Foundation CDE Requirements by State:
http://www.dalefoundation.org/Resources-And-State-Requirements/CDE-Requirements-By-State

DANB State Requirements Map:
http://www.danb.org/Meet-State-Requirements/State-Specific-Information.aspx

DANB Dentist/Employer Resources:
http://www.danb.org/The-Dental-Community/Dentist-Employers.aspx

DANB-Issued Credential Verification
https://www.danb.org/The-Dental-Community/Credential-Verification.aspx

Heartland Dental's DeAnn McClain to serve on *Efficiency in Group Practice* advisory board

DeAnn McClain, vice president of operations for Heartland Dental, has agreed to serve as an editorial advisory board member for *Efficiency in Group Practice*. Born and raised in Hidalgo, Ill., McClain graduated from Eastern Illinois University and joined Heartland's accounting department in 1996. Heartland Dental is an Effingham, Ill.-based dental service organization with more than 550 dental practices in 26 states.

DGPA announces new executive director

The Dental Group Practice Association (DGPA), has announced the appointment of Quinn Dufurrena, D.D.S., J.D., as its new executive director, following a nationwide search. Dr. Dufurrena comes to DGPA with more than 30 years of dental experience in government, private practice and nonprofits. He received his D.D.S. from the University of the Pacific in 1983 and his J.D. from Concord Law School in 2008. Most recently, he served as the executive director of the Colorado Dental Association. He also previously served as executive director of the Idaho Dental Association. Prior to those roles, he provided dental care to patients in a private practice and as part of the U.S. Navy Dental Corps. Beyond his chair-side duties, Dr. Dufurrena served an associate professor at the University of Colorado School of Dental Medicine and worked at the ADA as a Hillenbrand Fellow.

More dental hygienist jobs on the way

According to the U.S. Bureau of Labor Statistics (Washington, DC) and its *Occupational Outlook Handbook*, the in-demand job paying more than $70,000 per year is dental hygiene. According to the report, dental hygiene is expected to add 33 percent more jobs over the next 10 years, which is three times more than the estimated 11 percent job growth in the U.S. The anticipated job openings are a result of greater focus on dental health, an aging population, and Federal health legislation. More than 114,000 jobs will be added from 2012 to 2022, and 64,000 of those will be new jobs and not simply filling existing jobs of people retiring or leaving the workforce.

Heartland Dental opens new offices and affiliates

Heartland Dental announced the opening of several new full-service, state-of-the-art family dental offices, including:

- Complete Dental Care of Richmond – Richmond, Va.
- Dental Care of Manassas – Manassas, Va.
- Oak Hills Family Dental – Kansas City, Mo.
- St. Lucie Family Dental – Port St. Lucie, Fla.
- Family Dentistry of Ellisville – Ellisville, Mo.
- Prairie Ridge Dental Care – Pleasant Prairie, Wis.
- Milton Family Dental Care – Milton, Ga.
- Woodland Family Dental Care – Gurnee, Ill.

Also, Heartland Dental recently affiliated with Robert Wootton, DDS and his team members at Midtown Dental Associates in Austin, Texas. Heartland Dental also announced its affiliation with Dr. Denise Flynn and her team members at Flynn Orthodontics located in Peoria, Ill., and Pekin, Ill. Additionally, Heartland Dental affiliated with Michael Price, DDS and his team at Family Dentistry of Poplar Bluff in Poplar Bluff, Mo.

Smile Source adds 24 new locations in March 2014

Smile Source® (Kingwood, Texas), a large dental group made up of independently owned dental offices across the nation, announced the addition of 24 new locations in the month of March 2014. These like-minded professionals offer preventive, general, restorative, orthodontic, periodontal, and cosmetic dentistry, as well as lifelike replacement teeth and state-of-the-art technology. Many of its dentists also treat other conditions, like sleep apnea, TMJ dysfunction, and special needs patients. The expansion brings the company's total number of offices to over 120.

Crosstex/SPSmedical launches High-Level Disinfectant Website: OPA28.com

Crosstex/SPS medical has developed an informational website for healthcare professionals dedicated to the High-Level Disinfectant: Rapicide® OPA/28. Rapicide® OPA/28 High-Level Disinfectant from Crosstex/SPSmedical is a fast-acting, long lasting, highly compatible high-level disinfectant that ensures a safe and healthy environment for patients and staff. This reusable ortho-phthalaldehyde disinfectant is designed for use on heat-sensitive, semi-critical devices that are unsuitable for sterilization. Recognized as a leader in sterilization & infection prevention training, with award winning speakers and a commitment to best practices, Crosstex/SPSmedical is proud to offer this new educational website, which includes a web-based seminar approved for 1.0 FREE accredited CEU by IAHCSMM, CBSPD, and CBRN. For more information visit www.Crosstex.com or www.SPSmedical.com.

ADA: Chairside screenings for chronic disease could save millions

According to an American Dental Association (ADA) (Chicago, IL) Health Policy Resources Center (HPRC) survey, chairside screenings by dentists for the most common chronic medical diseases could save the American health care system as much as $102.6 million annually. The findings were published February 13, 2014 in the *American Journal of Public Health*. According to the Centers for Disease Control and Prevention (CDC) (Atlanta, GA), 7.8 percent of the U.S. population has undiagnosed hypertension, 2.7 percent has undiagnosed diabetes, and 8.2 percent has undiagnosed high cholesterol. There is potential for additional savings over the long term through prevention, health promotion, and early interventions that the study did not model.

Ivoclar Vivadent hosts "Experience Innovation" event at the 2014 Mid-Winter Meeting in Chicago

Ivoclar Vivadent brought together dental leaders, influencers and innovators during the Chicago Mid-Winter Meeting when they hosted "Experience Innovation." The exciting and entertaining event celebrated the advancements in dentistry and the innovations that are shaping the future direction of the laboratory industry. Highlighting the event was the unveiling of the new Wieland Zenotec select platform of milling systems, designed specifically for the dental laboratory industry. "The dental industry is rapidly changing," says Robert Ganley, CEO of Ivoclar Vivadent. "We believe that these changes will point the dental industry in a more digital direction with an emphasis on consistent high-quality materials, processes, and results. With collaborative partnership and strong leadership, we can connect to the heartbeat of innovation and see improved efficiencies and growth throughout our profession."

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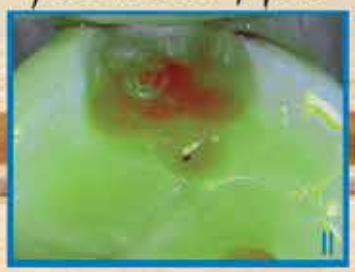

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