Dental Health Educator's Newsletter — *June Issue 2016*

CODA: Hearings/Comments on Standards Due

by Cindy Biron Leiseca

Comments on Dental Hygiene revisions to Standard 3-6 are due June 1, 2016.

In addition, there will be a hearing at the annual ADHA meeting in Pittsburg, PA on Saturday, June 11, from 3-4 PM. Here is the link to the information about the hearing http://www.ada.org/~/media/CODA/Files/CODA_2016_ADHA_Hearing_Agenda.pdf?la=en

Standard 3-6 includes the requirements for faculty to student ratios in clinical and laboratory learning environments. To view the proposed revision to the standard go this link: http://www.ada.org/~/media/CODA/Files/coda_dh_apx2_aug2015.pdf?la=en

At this time there are no proposed revisions or new standards for Dental Assisting programs.

However, every program should be reviewing current standards to make appropriate changes to their programs so that they remain compliant with the current standards. To help you find the standards and documents you need to view we have provided a list of links to those of importance to Dental Assisting and Dental Hygiene Education here: →

DA Accreditation Standards 2016: http://www.ada.org/~/media/CODA/Files/DA_Standards.pdf?la=en

DA Self Study Guide: http://www.ada.org/en/coda/site-visits/prep-for-allied-dental-site-visit/allied-dental-site-visit-documents

DH Accreditation Standards 2016: http://www.ada.org/~/media/CODA/Files/DH_Standards.pdf?la=en

DH Self Study Guide: http://www.ada.org/en/coda/site-visits/prep-for-allied-dental-site-visit/allied-dental-site-visit-documents

Unofficial Report of Major Actions: http://www.ada.org/~/media/CODA/Files/coda_actions_feb2016.pdf?la=en

Evaluation and Operational Policies and Procedures http://www.ada.org/~/media/CODA/Files/evaluation_policies_procedures.pdf?la=en

Program Changes http://www.ada.org/en/coda/policies-and-guidelines/program-changes/

Dental Therapy Standards http://www.ada.org/~/media/CODA/Files/dt.pdf?la=en

In this issue:

Can Oxygen Hurt Our Patients?

by Mike McEvoy, PhD, NRP, RN, CCRNEMS

EMS providers began giving oxygen not because it had medically or scientifically demonstrated benefits for patients, but because they could. Yet, inarguably, hypoxia is bad.

John Scott Haldane, who formulated much of our understanding of gas physiology, said in 1917, "Hypoxia not only stops the motor, it wrecks the engine."

Patients begin to suffer impaired mental function at oxygen saturations below 64 percent. People typically lose consciousness at saturations less than 56 percent, giving airplane passengers no more than 60 seconds to breathe supplemental oxygen when an airplane flying at 30,000 feet suddenly depressurizes[1-3].

More recent studies suggest that hyperoxia, or too much oxygen, can be equally dangerous. Hence the drug EMS providers administer most often may not be as safe as originally thought.

Studies on benefits and dangers of oxygen therapy are not new; intensive care practitioners have long recognized the adverse effects of using high concentration oxygen[4].

The Guidelines for Emergency Cardiac Care (ECC) in 2000 and 2005 recommended against supplemental oxygen for patients with saturations above 90 percent. The current 2010 ECC Guidelines call for supplemental oxygen only when saturations are less than 94 percent, perhaps in an effort to soften the impact of change[5].

Research

What is new are prehospital research studies comparing outcomes of patients treated without oxygen or with oxygen titrated to saturations versus patients routinely given high flow oxygen. These data are frightening; they invariably show impressive patient harm from even short periods of hyperoxia.

Continued on Page 3

A Message from the Editor:

Cindy Biron Leiseca, RDH, EMT, MA

A big "Thank You" to Mike McEvoy and the publishers from **EMS1** for allowing us to reprint this article "Can Oxygen Hurt Our Patients?" Please read the entire article as Mike has managed to simplify the complex in explaining the reason for cautionary measures with administering supplemental oxygen to patients in emergency distress.

During in-services and in our workshops at Summer Camp Amelia Island, we are astonished at the findings/comments indicating that many of our DA and DH programs are not equipped with low flow delivery systems for supplemental oxygen and are not routinely assessing patients blood oxygen saturation rates with Pulse Oximeters. If you provide supplemental oxygen you must comply with current guidelines as part of your management of medical emergencies in the dental clinical settings. Please share this article with all faculty members and colleagues. Thank you.

Oxygen—Continued from Page 2

We've known since 1999 that oxygen worsened survival in patients with minor to moderate strokes and made no difference for patients with severe stroke[6]. In fact, the American Heart Association recommended in 1994 against supplemental oxygen for non-hypoxemic stroke patients.

The dangers from giving oxygen to neonates have also been long appreciated[7]. The most compelling outcome studies of neonates published in 2004 and repeated in 2007 showed a significant increase in mortality of depressed newborns resuscitated with oxygen (13 percent) versus room air (8 percent)[9]. This led to the current neonatal resuscitation recommendations for use of room air positive pressure ventilation.

In 2002, a study of 5,549 trauma patients in Texas showed prehospital supplemental oxygen administration nearly doubled mortality[9]. A Tasmanian study of prehospital difficulty breathing patients published in 2010 compared patients treated with oxygen titrated to saturations of 88 to 92 percent to patients treated with non-rebreather oxygen masks.

It showed a reduction in deaths during subsequent hospitalization of 78 percent in COPD patients and 58 percent in all patients[10]. New studies are showing a troubling pattern of worse outcomes associated with hyperoxia post cardiac arrest[11].

Why would oxygen worsen patient outcomes?

One mechanism may be absorption atelectasis. Gas laws mandate that increases in the concentration of one gas will displace or lower the concentration of others. Room air normally contains 21 percent oxygen, 78 percent nitrogen, and less than 1 percent carbon dioxide and other gases.

Nitrogen, the most abundant room air gas, is responsible for secretion of surfactant, the chemical that prevents collapse of the alveoli at end expiration. Premature infants often are not developed sufficiently to produce surfactant and require endotracheal administration of animal surfactant.

"Washout" of nitrogen in adult lungs occurs when high concentration oxygen is administered. Lower concentrations of nitrogen can lead to decreased surfactant production with subsequent atelectasis and collapse of alveoli, significantly impeding oxygen exchange.

Oxygen is also a free radical, meaning that it is a highly reactive species owing to its two unpaired electrons. From a physics perspective, free radicals have potential to do harm in the body.

The sun, chemicals in the atmosphere, radiation, drugs, viruses and bacteria, dietary fats, and stress all produce free radicals. Cells in the body endure thousands of hits from free radicals daily.

Normally, the body fends off free radical attacks using antioxidants. With aging and in cases of trauma, stroke, heart attack or other tissue injury, the balance of free radicals to antioxidants shifts. Cell damage occurs when free radicals outnumber antioxidants, a condition called oxidative stress. Many disease processes including arthritis, cancer, diabetes, Alzheimer's and Parkinson's result from oxidative stress.

The concept of free radical damage suggests the old EMS notion that, "high flow oxygen won't hurt anyone in the initial period of resuscitation" may be dead wrong. Tissue damage is directly proportionate to the quantity of free radicals present at the site of injury. Supplemental oxygen administration during the initial moments of a stroke, myocardial infarct (MI) or major trauma may well increase tissue injury by flooding the injury site with free radicals.

Continued on Page 5

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Patient Appointment Tracking

Patient Classification Tracking
04/01/2008 - 12/01/2008
Clinic IIB

Student	CALCS 0	I	II	III	IV	Total	PERIO 0	I	II	III	IV	Total	MC	SN	PC	RC	Patient Ages 0-11	12-17	18-59	60+
ADAMS, MARSHA	0	8	7	13	0	28	0	11	13	3	1	28	7	4	15	11	0	0	22	6
BLACK, MIRANDA	2	8	3	4	6	23	3	6	9	4	1	23	1	7	9	2	1	0	20	2
CARSON, MARY	0	6	8	12	3	29	0	11	15	3	0	29	5	6	9	1	0	0	26	2
DAVIS, JOHN	1	7	6	6	4	24	1	9	8	2	4	24	2	7	5	4	1	0	16	7
ESTEP, ANGELA	2	5	8	7	2	24	3	7	11	3	0	24	4	5	11	1	0	3	16	5
FRANKLIN, ADAM	1	2	15	2	4	24	1	4	6	13	0	24	4	3	8	0	0	1	10	13
GOINGS, CINDY	0	6	8	10	0	24	1	10	6	7	0	24	8	12	11	8	0	0	14	10
HARPER, CONNIE	1	7	10	4	1	23	7	8	5	2	1	23	8	8	14	6	0	0	17	5
LEWIS, LOU	0	8	5	7	2	22	0	10	10	1	1	22	0	4	11	1	0	0	22	0
MASON, MARSHA	0	4	9	5	1	19	2	6	8	1	2	19	4	5	10	2	0	1	13	5
NEWSOME, PAT	1	8	7	3	2	21	4	7	9	1	0	21	5	6	13	3	0	1	14	6
	0	4	9	5	8	26	0	10	7	5	4	26	2	9	9	0	0	0	23	3
	1	2	12	7	1	23	2	12	4	5	0	23	6	7	9	4	0	0	16	7
	1	10	8	5	0	24	4	9	9	2	0	24	3	8	13	3	0	1	14	9
	0	10	7	1	3	21	2	8	11	0	0	21	0	2	14	1	0	0	19	2
	1	9	12	1																
	1	6	6	10																
	0	6	10	2																
	0	8	7	5																
	2	6	14	0																
	14	130	171	109																

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Date	Patient Name	Gender	Age	Med Comp	Calc	Perio	Quad	Phase	PC	RC	SN
08/03/2010	Abe, Sandy	M	22	No				Radiographs- BWX w initial appointment	No	No	
		F	57	No	I	I		Radiographs- CMX and Pan w initial appt	No	No	Wheelc
		F	45	No	II	II		Patient referred to physician	Yes	Yes	Walker
		M	23	No	I	II		Initial appointment with student	Yes	Yes	
		F	45	No	I	II		Radiographs- BWX w initial appointment	Yes	Yes	
		F	48	No	II	II		Radiographs- BWX and Pan w initial appt	No	No	IDDM
05/04/2010	Abberton, Al	M	23	No	I	I		Patient referred to physician	Yes	Yes	wheelc

Patient Care Report

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Oxygen—Continued from Page 3

Finally, consider this: five minutes of supplemental oxygen by non-rebreather decreases coronary blood flow by 30 percent, increases coronary resistance by 40 percent due to coronary artery constriction, and blunts the effect of vasodilator medications like nitroglycerine[12]. These effects were demonstrated dramatically in cath lab studies[13] published in 2005.

Wonder why the 2010 ECC Guidelines recommended against supplemental oxygen for chest pain patients without hypoxia? Now you know: supplemental oxygen reduces coronary blood flow and renders the vasodilators ALS providers use to treat chest pain ineffective.

Where do we go from here?

Knowing that both hypoxia and hyperoxia are bad, EMS providers must stop giving oxygen routinely. Oxygen saturations should be measured on every patient.

Protocols need to be aligned to reflect the 2010 ECC guidelines: administer oxygen to keep saturations between 94 and 96 percent. No patient needs oxygen saturations above 97 percent and in truth, there is little to no evidence suggesting any clinical benefit of oxygen saturations above 90 percent in any patient.

Modifications in prehospital equipment will be inherent in controlling oxygen doses administered to patients. In all likelihood, the venturi mask will make a comeback, allowing EMS providers to deliver varied concentrations of oxygen as needed to keep oxygen saturations between 94 and 96 percent.

Few patients will require non-rebreather masks which are prone to deliver too much oxygen (hyperoxia). CPAP (Continuous Positive Airway Pressure) devices will also need redesign as most conventional EMS CPAP delivers 100 percent oxygen. A study conducted by Bledsoe, et al in Las Vegas found that prehospital CPAP using low oxygen levels (28 to 30 percent) was highly effective and safe[14].

Bottom line: the drug we use most often can cause harm if we give it without good reason. In the absence of low saturations, oxygen will not help patients with shortness of breath and it may actually hurt them. The same holds true for neonates and virtually any patient with ongoing tissue injury from stroke, MI or trauma. Indeed, oxygen can be bad. Link to www.EMS1.com original article: http://www.ems1.com/columnists/mike-mcevoy/articles/1308955-Can-oxygen-hurt-our-patients/

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About the Author:

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Current Research on Instrument Sharpening

by Cindy Biron Leiseca

In recent years new equipment and products to aide in the process of sharpening instruments have become available, but none of the research conducted has dramatically changed the way instruments are sharpened by hand. Recent articles from scientific journals showed that there is a difference in the cutting edges of curettes when various sharpening techniques were used to resharpen dull curettes.

Drs. Andrade Acevedo RA, Sampaio JEC, Shibli JA described the results of many different methods of sharpening. In their study, the instrument sharpening was completed by experienced clinicians. The results of their study were published in an article titled "*Scanning Electron Microscope Assessment of Several Resharpening Techniques on the Cutting Edges of Gracey Curettes" in the Journal of Contemporary Dental Practice November; (8)7:070-077.*

The study included nine groups, each using different sharpening techniques. Each group was scored according to the Cutting Edge Index developed for this study:

- Score 1: A precise angle of the coronal and lateral faces without wire edges.
- Score 2: A slightly irregular cutting angle with or without wire edges.
- Score 3: A markedly irregular cutting angle with or without wire edges.
- Score 4: An extremely irregular cutting angle with a presence of a bevel or third surface.

The group whose technique produced the most precise cutting edge without wire edges and irregularities was Group 1: Stationary Stone, Moving Instrument (See Fig. 1).[1]

The most common technique taught in dental hygiene schools is, "Stationary Instrument, Moving Stone". It is the technique that was used by Group 3 of the study. Group 3 was not producing the perfect cutting edge; in fact, to quote the authors, ***"(Group 3 Moving Stone, stationary instrument) produced a high incidence of cutting angles with the formation of bevels or third surfaces"*** (See Fig. 2).

The other techniques in the study were ranked and scored as shown in Table 1. The results shown in Table 1 indicate that the "Stationary Stone, Moving Instrument" relationship produced the most precise cutting edges with scores of 1 to 2

Table 1 – Ranking of the Sharpening Techniques – Rank 1 is the best

(condensed from the content of the article)

Rank	Score	Group	Description of Sharpening Techniques	Relationship
1	1	1	Sliding the curette lateral surface of the blade against flat Arkansas SS6A (Hu-Friedy) stone toward operator with 100-110° angle	Stationary Stone Moving Instrument
2	2	2	Sliding stone from heel to cutting edge toe of coronal face, followed by the lateral face (as in Group 1)	Combination
3	2	6	Sliding the lateral face of the curette against the standardized Premier sharpening device (Premier Dental Products)	Stationary Stone Moving Instrument
4	2	5	Using pen-shaped Arkansas 299 stone (Hu-Friedy) slide against lateral face with up and down movements at 85° angle	Stationary Instrument Moving Stone
5	2	8	Sharpening coronal face with Neivert Wittler Blade device followed by movement of lateral face against an Arkansas SS6A stone	Combination
6	3	7	Sharpening coronal face with Neivert Wittler Blade device (Darby Dental Co, Rockville Center, NY, USA)	Stationary Instrument Moving Stone
7	3	9	Same as Group 7, followed by abrasive powder and spinning a felt wheel on the curette lateral face	Combination
8	3	4	Aluminium oxide cone (Shofu Dental Corp) in a handpiece at low speed against coronal face and then on the lateral face from heel to toe	Stationary Instrument Moving Stone
9	4 Worst	3	Sliding Arkansas SS6A stone against lateral face in upward and downward movements between stone and coronal face, finishing with downward movement	Stationary Instrument Moving Stone

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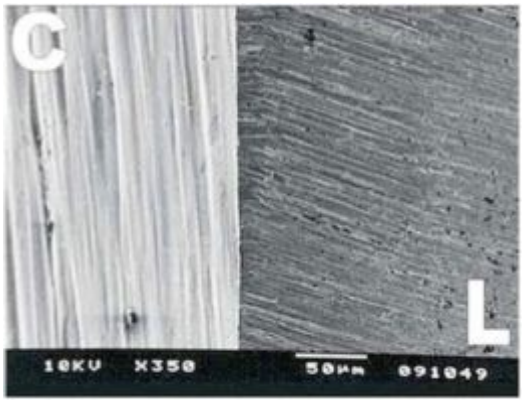

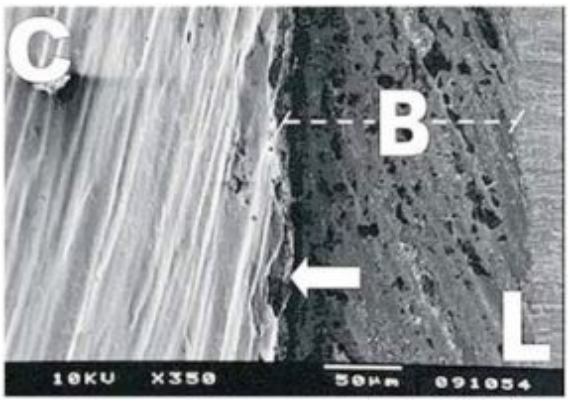

Fig. 1: Group 1 (Stationary Stone, Moving Instrument). By permission: Dr. Roberto Andrade Acevedo[5,6] Fig. 2: Group 3 (Stationary Instrument, Moving Stone). By permission: Dr. Roberto Andrade Acevedo[5,6]

Stationary Stone, Moving Instrument

This is the technique Group 1 used in the study (Fig. 1) Because the instrument is sharpened along the length of the blade, there are no wire edges such as those produced when moving the stone up and down against the cutting edge as Group 3 did with "Stationary Instrument, Moving Stone."

Understanding the design of the instrument's working end is crucial to proper instrument sharpening. Since Gracey curettes have an offset angle with a longer, lower cutting edge, the curvature of the blade is difficult to maintain when sharpening. Therefore, being able to see the blade against the stone will increase the chances of maintaining the original shape of the blade.[2]

There are numerous brands of sharpening guides to help with the "Stationary Stone, Moving Instrument" technique. These guides are excellent for those who can perform the technique by tactile sensitivity without visual assurance of seeing the blade against the stone.[2] None of the sharpening guides previously on the market position the stone so that the clinician can see the blade adapted to the stone when sharpening. A new product called the Sharpening Horse has been proven most effective among the three most common techniques of manual instrument sharpening.

In the Int J Dent Hyg. 2015 May;13(2):145-50. doi: 10.1111/idh.12109. Epub 2014 Nov 9. an article, ***Evaluation of three different manual techniques of sharpening curettes through a scanning electron microscope: a randomized controlled experimental study*** **by** Di Fiore A[1], Mazzoleni S, Fantin F, Favero L, De Francesco M, Stellini E showed the moving stone technique as the least effective in restoring the cutting edge of curettes to original contours of the blade producing defects, 3rd bevels and wire edges.

The experiment provided irrefutable evidence that the Sharpening Horse technique was the most effective in restoring the cutting edges to the original contour of the blade with clean, clear edges free of 3rd bevels, defects and wire edges.

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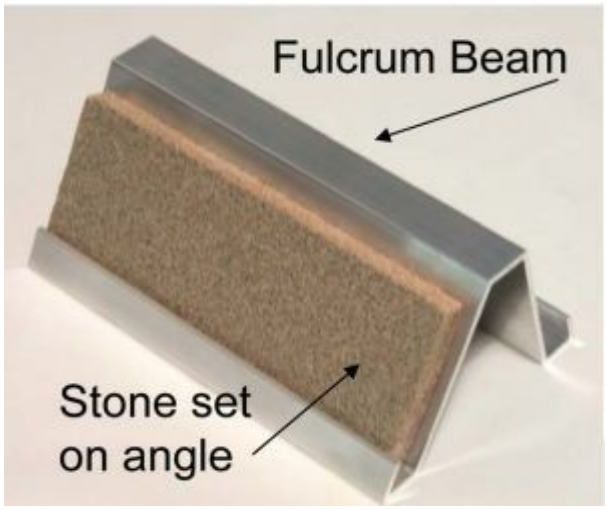
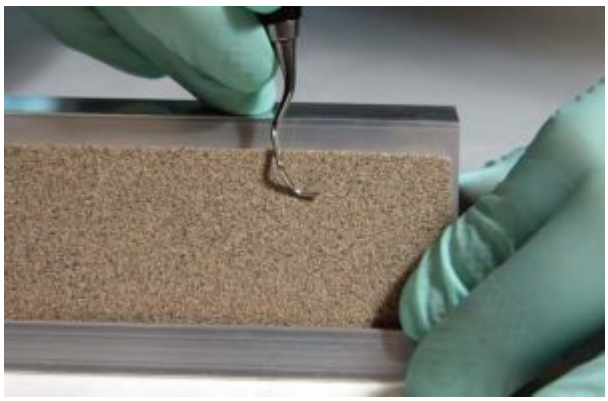




The Sharpening Horse – allows the clinician to perform Stationary Stone, Moving Instrument technique while using a fulcrum and seeing the blade against the stone.

Int J Dent Hyg. 2015 May;13(2):145-50. doi: 10.1111/idh.12109. Epub 2014 Nov 9.

Evaluation of three different manual techniques of sharpening curettes through a scanning electron microscope: a randomized controlled experimental study.

Di Fiore A[1], Mazzoleni S, Fantin F, Favero L, De Francesco M, Stellini E.

Abstract

OBJECTIVE:

The purpose of this study was to compare the effectiveness of three different techniques for manually sharpening of periodontal curettes (PCs) by examining the blades with the aid of scanning electron microscope (SEM).

METHODS:

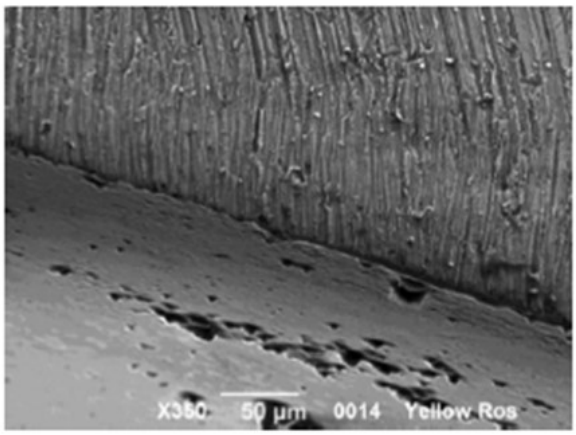
Three groups were considered based on three sharpening methods used: group A (moving a PC over a stationary stone); group B (moving a stone over a stationary PC) and group C (moving a PC over a stone fixed, placed on a 'sharpening horse'). After the sharpening, the blades were examined using SEM. The SEM images were assessed independently by five different independent observers. An evaluation board was used to assign a value to each image. A preliminary pilot study was conducted to establish the number of samples. Pearson's correlation test was used to assess the correlations between measurements. anova test with Bonferroni's post hoc test was used to compare the three groups.

RESULTS:

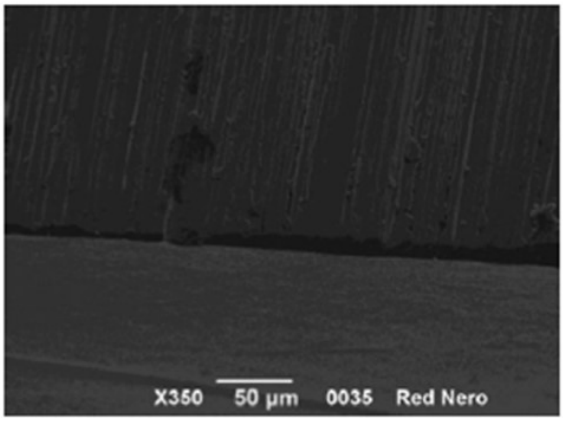
Sixty PCs (20 PCs per group) were used in this study. Statistically significant differences emerged between the three groups (P-value = 0.001). Bonferroni's test showed that the difference between groups A and B was not statistically significant (P-value = 0.80), while it was significant for the comparisons between groups A and C (P-value = 0.005) and between groups B and C (P-value = 0.001).

CONCLUSIONS:

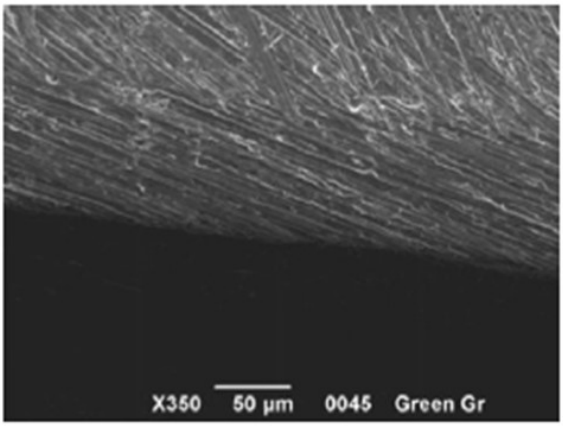
The sharpening technique used in group C, which involved the use of the **sharpening horse, proved the most effective.**



Group A : Moving Instrument—Stationary Stone without aide of Sharpening Horse



Group B: Moving Stone– Stationary Instrument



Group C: Moving Instrument-Stationary Stone with aide of Sharpening Horse fixture

Descriptive Statistical Analysis of scores in the measurements	Observer 1		Observer 2		Observer 3		Observer 4		Observer 5	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Group A (Moving Inst. Stationary Stone without Sharpening Horse)	2.3	0.44	2.5	0.97	2.5	0.51	2.2	0.70	2.5	0.51
Group B (Moving Stone – Stationary Inst.)	2.9	0.97	3.1	0.60	3.4	0.81	3.4	0.68	3.2	0.94
Group C (Moving Inst. Stationary Stone with Sharpening Horse fixture	1.5	0.51	1.6	0.51	1.6	0.60	1.6	0.50	1.6	0.51

Testimonials on the *Sharpening Horse*

"Now that the students use the Sharpening Horse, we can introduce sharpening earlier in the curriculum as it is so easy for them to master the technique. The instruments last longer. When they trade in their instruments before they take their boards the instruments are not over sharpened and worn like they use to be with the old techniques. With the Sharpening Horse technique there is more cutting edge left than before. It is much easier to get consistency with their sharpening with this technique. ***I have tried all the sharpening systems out there and this is the only thing that truly works****!" Marta Ferguson, RDH, PhD, Director of Dental Hygiene, Indian River State College, FL*

"The report from the second year instructors is that the students' instruments are not only sharp, but they are holding their shape and contour which ***is a vast improvement over the stationary instrument/moving stone method*** *which caused many curets to be turned into sickles from holding the stone at the wrong angle. The Sharpening Horse is easy to teach and use!" Janet Ogden, RDH, MS Columbia Basin College, WA.*

"We teach the students the stationary instrument/moving stone method first and then show them the Sharpening Horse. This year, the students wanted to know why we taught the other method when the Sharpening Horse is so much easier and exact. I like the Sharpening Horse because it makes sharpening so easy. "DIY Sharpening for Dummy's!" No need to spend so much time thinking about angles. ***The Sharpening Horse automatically "sets the perfect angle"*** *of the stone for the bevel of the blade." Susan Smith, RDH, MS Clinic Coordinator, Wake Technical College, Raleigh, NC. "*

"I discussed the Sharpening Horse technique with the full-time faculty and they said instrument sharpening has been much easier to teach and learn using the Sharpening Horse technique. By using it routinely students have positive experiences with their instrumentation. The Sharpening Horse helps to maintain the integrity of the instruments. " Susan Moss RDH, MS, Collin State College, McKinney, TX

"The Sharpening Horse design is a brilliant, user friendly approach to the critical maintenance of dental hygiene instruments. The concept and the technique is very adaptable for novice and experts in dental hygiene, and our ***program faculty made the Sharpening Horse its choice recommendation*** *for the dental hygiene student kits from this time forward!" Vicki L. Snell RDH, EdM Lewis & Clark Community College, IL*

"Recently I had the opportunity to sharpen many instrument kits for a hands on scaling technique presentation. Each kit contained 10 various curettes and scalers. ***I was amazed at how easy it was to sharpen these instruments quickly and precisely with the Sharpening Horse****. I recommend the Sharpening Horse to all my students, faculty and fellow hygienists at every given opportunity. When I am in clinic and instruments need sharpening I have the students take their instruments for a quick ride on the Sharpening Horse and they are truly amazed at how accurate and easy this technique is to return their blades back to a sharp and effective working edge." Cathleen Korondi, CDA, RDH, EdM, Director of Dental Hygiene Illinois Central College*

The sharpening horse has proven to be the best method of sharpening instruments for our students. The technique is easy to learn for beginning clinicians, producing a sharp cutting edge and maintaining the original design of the blade. The instruments are lasting longer, since the ***students can consistently control the angle, pressure and movement of the blade against the stone****. They love it and sharpening has never been so easy. Michele Edwards, CDA, RDH, MS Tallahassee Community College Dental Programs, FL.*

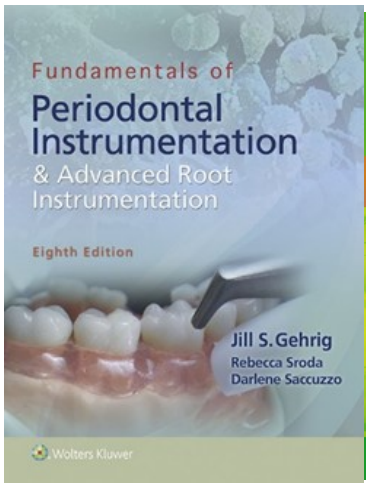
Instrument sharpening is one of the most important, yet challenging, skills for hygiene students to master. The Sharpening Horse makes this skill easy to learn and students can quickly produce a perfectly sharp cutting edge restoring the blade in its original design. ***Confidence in their ability to produce a sharp cutting edge motivates students to employ instrument sharpening as a routine daily task****. Jill S. Nield-Gehrig, RDH, MS Dean Emeritus Asheville-Buncombe Technical College, NC*

The Sharpening Horse is great to use chairside as it is easy to use and to autoclave. It has given the students the confidence to sharpen their instruments without asking, "Am I doing this right?" Our instructors say that the Sharpening Horse makes it so easy for students to sharpen instruments ***they actually use it in clinic!"*** *Catherine Dunn, RDH, MS Director of Dental Hygiene Mississippi Delta College*

Sharpening Horse Kits include the fixture, ceramic stone, directions and test sticks.
Bulk orders of 10 or more for students is $63.00 per kit

Complete instructions on how to use the Sharpening Horse can also be found on Pages 616-623 of this textbook →

Bulk Order Online: http://www.dhmethed.com/PP1/SSHK.html



Winter 2016 Review Committee Meeting Reports

The Dental Assisting Review Committee Report

There were no matters related solely to Dental Assisting Education.

The Dental Hygiene Review Committee Report

At its Winter 2016 meeting, the DH RC reviewed the subcommittee's findings. The DH RC determined the findings are preliminary and warrant further consideration at the regularly scheduled review of the Annual Survey curriculum section in Winter 2017. The DH RC noted that because standards and terminology are routinely modified, the identified inconsistencies may require additional modification and revision in 2017.

Summary: The DH RC considered the subcommittees findings and determined the proposed changes to the Annual Survey curriculum section are preliminary and should be re-considered for implementation at the time of the regularly scheduled Annual Survey curriculum section review scheduled for Winter 2017 (**Appendix 1, Policy Report p. 400)**.

Recommendation: It is recommended that the Commission direct the proposed revisions to the Dental Hygiene Education Annual Survey Curriculum Section be reviewed at the Winter 2017 meeting for possible implementation in 2017.

NEW BUSINESS

Consideration of an Interprofessional Education Standard: The DH RC considered the need for a standard to provide oversight for the increased focus in dental hygiene programs on collaboration of the dental hygienist within interprofessional healthcare teams. The DH RC discussed a variety of topics surrounding the issue and determined more information and data would be beneficial in determining how a new standard should be structured. The DH RC determined that a subcommittee of six (6) RC members would be beneficial in narrowing the focus of development for the new standard. Additionally, subcommittee members would conduct independent research relevant to dental hygiene education focused on interprofessional healthcare, for presentation at one (1) conference call meeting to be scheduled prior to April 30, 2016. The DH RC noted a possible second conference call may be required prior to the Summer 2016 DH RC meeting after Frequency of Citings data is available. The subcommittees findings would be reviewed at the Summer DH RC and Commission meetings. The conference calls would have minimal financial impact on the Commission. **Recommendation:** It is recommended that the Commission direct the formation of a six (6) member subcommittee of the DH RC to develop a new potential standard on interprofessional education for consideration by the DH RC and Commission in Summer 2016. http://www.ada.org/en/coda/accreditation/coda-meeting-materials/

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Community Dentistry Educator's Workshop

Summer Camp Amelia Island 2016

August 4-5, 2016

Course Description:

This 12 hour workshop provides the attendees with an understanding of the components necessary for developing competency-based community dental health courses and community partnerships and service opportunities for dental hygiene students. Presenters will demonstrate methods of measuring student competency in assessing needs, planning, implementing and evaluating community programs; demonstrating communication skills in diverse populations; application of self-assessment in problem solving and critical thinking. It also includes examples of how the program can best demonstrate compliance with accreditation standards regarding community dental health in the curriculum and during the preparation of the self-study report and conduct of the site visit.

In addition, presenters will outline the methods of assembling the components of a community-based program through the formation of committees and establishing networks for finding stakeholders and partners. Institutional reviews, legal considerations and affiliation agreements will be presented and discusses. A tour of a community health center which ranks in the top 1% of the most successful community health centers in the country, the Barnabas Center, will take place on the second day of the course. At the Barnabas Center a class will be presented on grant writing. The logistics of setting up a Community Dental Health Programs will be detailed in the final segment of the workshop. The course is limited to 30 attendees to allow for discussions and information sharing.

Thursday, August 4th 8AM-/Noon Gwen Welling, RDH, MS (Former DH Manager at CODA)

Competency-Based Education in Community Dental Health Courses

This course includes information on how to measure and verify student competency in assessing needs, planning, implementing and evaluating community programs (DH Standard 2-20); competent in communication skills and interacting with diverse populations (DH Standard 2-19); application of self-assessment and preparation for life-long learning (DH Standard 2-24); and competent in problem-solving skills and critical thinking (DH Standard 2-26). It also includes examples of how the program can best demonstrate compliance with standards regarding community dental health, during the preparation of the self-study report and conduct of the site visit. This course provides an overview of service learning, its connection to course requirements and course/graduation competencies and how to measure stated goals and objectives for projects and student learning to ensure they have been met.

Upon completion of this session, the participant will:

- Understand methods for compliance with CODA Standards that relate to community dental health projects: assessment of community needs, program development, program implementation and outcomes evaluation.
- Describe how students' problem-solving abilities, independent learning capabilities and appreciation of diverse populations are expanded by participating in community projects and service learning activities.
- Determine how to match course competencies and specific course objectives with stated graduation/program competencies.
- Identify how students are deemed competent in relation to CODA DH Standards 2-19, 2-20, 2-24 and 2-26 after completion of a required community course(s).
- Use service learning as an effective teaching method for bridging classroom learning and real world experience. Better facilitate the student in applying classroom knowledge to community activities.
- Objectively measure students' ability to self-evaluate and peer evaluate when working on team projects.
- Develop metrics and rubrics for measurement of community projects such as educational presentations to a variety of populations.
- Recognize what learning and values clarification changes take place during service learning activities and know how to assist the students in incorporating them into their community practice.
- Acknowledge and describe possible negative outcomes and roadblocks when incorporating service learning into a community health course

Continued on Page 13

Thursday August 4th 1-5PM Bobbie Brown, CDA, RDH, MS and Cathleen Korondi, CDA, RDH, EdD

Community-Based Programs: Assembling the Components

This session covers many basic components necessary for creating public health opportunities for dental hygiene students. Following a brief review of the types of programs which students can plan and/or participate in the presenters will provide information on how to locate stakeholders and partners, remain compliant with the institutional review policies of the institution, create and utilize articulation agreements to partner with stakeholders, and the legal considerations that come into play when collaborating with diverse stakeholders. In addition, this presentation will discuss how to position students for new practice models as well as covering evidence for the potential increase in opportunities for employment in public health settings. Various resources for employment in public health settings will also be discussed.

Upon completion of this session, the participant will:

- Discuss various types of public health programs in which students may plan and/or participate Locate interested partners and stakeholders to provide physical and/or financial support for a community event
- Describe the legal considerations inherent in forming public health partnerships in which students will provide care
- Discuss the evolution of new practice models in the profession and how best to position students to take advantage of changing opportunities
- Describe the employment potential in public health and guide students to resources available for such employment

Friday, August 5th 8:00-9:30 AM Barnabus Center – Tour of entire facility at the community center (15 mins). Presentation on grant writing (50 minutes)

Upon completion of this session, the participant will:

- Discuss services provided at the Amelia Island Community Center
- Discuss important terminology and concepts to be included in effective grant writing

10-Noon Cathleen Korondi, CDA, RDH, EdD –

Logistics of Setting-Up Community Dental Health Programs **(Advertise for those who have never set up an event)**

This session is a nuts-and-bolts overview of the logistics necessary when creating community dental health programs. The strategies covered will include planning for the event with outside stakeholders, recognizing the importance of relationships with vendors, securing media coverage and creating talking points, assessment of volunteers, assigning duties for volunteers, designing treatment areas for maximum flow of supplies, and reflection post-event; pros and cons.

Upon completion of this session, the participant will:

- Identify interested stakeholders
- Plan, implement, and evaluate a community dental health program
- Recognize the role of media in event-planning
- Assess the volunteer workforce and assign duties appropriately
- Design treatment areas for maximum flow of supplies
- Conduct both formative and summative evaluations of the event
- Complete a post-event reflection covering pros and cons

Course Tuition $450 Register online www.DHmethEd.com

The Best Textbooks for DA & DH Students

Summer Camp Amelia Island 2016
Schedule of Courses

Mon. 8/1		Tues. 8/2		Wed. 8/3			Thurs. 8/4			Fri. 8/5			Sat. 8/6	Sun. 8/7	
Days Inn Jasmine & Magnolia	Amelia Room	Days Inn Jasmine & Magnolia	Amelia Room	Amelia Room	Days Inn Magnolia	Days Inn Jasmine	Days Inn Jasmine	Days Inn Magnolia	Amelia Room	Amelia Room	Days Inn Jasmine	Days Inn Magnolia	Days Inn Jasmine & Magnolia	Days Inn Jasmine	Days Inn Magnolia
8-Noon	8-5	8-5	8-5	8-Noon	8-5	8-Noon	8-5	8-5	8-Noon	8-Noon	8-Noon	8-Noon	8-5	8-Noon	8-Noon
#1 How to Teach DH Preclinic	#3 Radiology Educator's Workshop	DH Clinical Teaching Method. Continue	Radiology Educator's Workshop Continue	Radiology Educator's Workshop Continue	#4 DH Accred Workshop	#5 How to Teach Oral Anatomy	#8 Community Dentistry Educator's Workshop	#9 DA Accred Workshop	#10 How to Teach Ethics	#12 How to Teach DHNB Review	#8 Com Den Continue	#13 How to Teach Nutrition	#16 Allied Dental Educators Teaching Methodol.	#17 How to Teach Pharm Emerg	#18 How to Teach Dental Mater
End				End		End			End	End	End	End			
Lunch at LaMancha Restaurant														END	
1-5	Continue	Continue	Continue	1-5	Continue	1-5	Continue	Continue	1-5		1-5	1-5	Continue		
#2 DH Clinical Teaching Method.				#6 Histology & Embryol		#7 How to Teach Preventive Dentistry			#11 How to Teach Perio		#14 How to Teach Oral Path	#15 How to Teach Community Dentistry			
		End		End	End			End	End		End	End	End		
5:30 Reception Sea Breeze Lounge				5:30 Reception Sea Breeze Lounge						5:30 Reception Sea Breeze Lounge					

Rates at Amelia Hotel at the Beach:
Standard Room: $94 per night
Deluxe Room: $109 per night
Ocean View: $119 per night
Deluxe Room with Balcony $129 per night

Rates at Days Inn at Amelia Beach:
All Rooms: $89 per night

Rates at Hampton Inn Ameila Island at Fernandina Beach:
Mon. –Thurs.: $99 per night
Fri-Sat.: $119 per night

All Classes held in Amelia Hotel and Days Inn.

Call the hotels directly and tell them you are with the "DENTAL CAMP"

DH Methods of Education, Inc.

Summer Camp Amelia Island, FL August 1-7, 2016

PRINT Name:_____ **Courses in color coded text to help you avoid registering for classes offered at the same time**

(This is how your name will appear verifying your continuing education credits)

Address:_____

City, State, Zip_____

Phone:_____Fax _____ E-mail: _____

College/ Univ. Where Teaching:_____Circle your discipline: CDA, DDS, DMD, RDH

Requests for cancellations must be received at least 2 weeks prior to the camp date. However, for cancellations received after this deadline, 75% of the tuition may be applied toward future camps. Tuitions for no-shows will be forfeited NO EXCEPTIONS. DH Methods of Education, Inc. is not responsible for reimbursement of non-refundable airline tickets and any other travel expenses if the course is cancelled. **Final Registration**

		Final Registration Payment by: July 11, 2016
Mon. Aug. 1, 8a-Noon	**1.** *How to Teach DH Preclinic* (4 ceu's)	$525 _____
Mon. Aug. 1, 1-5p & Tues. Aug. 2, 8a-5p	**2.** *DH Clinical Teaching Methodology* (12 ceu's)	$650 _____
Mon. Aug. 1 & Tues. Aug. 2 8a – 5p & Wed. Aug. 3, 8a-Noon	**3.** *Radiology Educator's Workshop* (20 ceu's)	$950 _____
Wed. Aug. 3, 8a-5p	**4.** *DH Accreditation Workshop* (8 ceu's)	$525 _____
Wed. Aug. 3, 8a-Noon	**5.** *How to Teach Oral Anatomy* (4 ceu's)	$525 _____
Wed. Aug. 3, 1-5p	**6.** *How to Teach Histology & Embryology* (4 ceu's)	$525 _____
Wed. Aug. 3, 1-5p	**7.** *How to Teach Preventive Dentistry* (4 ceu's)	$525 _____
Thurs. Aug. 4, 8a-5p	**8.** *DA Accreditation Workshop* (8 ceu's)	$525 _____
Thurs. Aug. 4, 8a-5p & Fri. Aug. 5, 8a-Noon	**9.** *Community Dentistry Educator's Workshop* (12 ceu's) (Accreditation and public health update)	$450 _____
Thurs. Aug. 4, 8a-Noon	**10.** *How to Teach Ethics* (4 ceu's)	$525 _____
Thurs. Aug. 4, 1-5p	**11.** *How to Teach Periodontology* (4 ceu's)	$525 _____
Fri. Aug. 4, 8a-Noon	**12.** *How to Teach National Board Reviews* (4 ceu's)	$450 _____
Fri. Aug. 4, 8a-Noon	**13.** *How to Teach Nutrition* (4 ceu's)	$525 _____
Fri. Aug. 4, 1-5p	**14.** *How to Teach Oral Pathology* (4ceu's)	$525 _____
Fri. Aug. 4, 1-5p	**15.** *How to Teach Community Dentistry* (4 ceu's)	$525 _____
Sat. Aug. 6, 8-5p	**16.** *Allied Dental Educator's Teaching Methodology* (8 ceu's)	$325 _____
Sun. Aug. 7, 8a-Noon	**17.** *How to Teach Pharmacology/Emergencies* (4 ceu's)	$525 _____
Sun. Aug. 7, 8a-Noon	**18.** *How to Teach Dental Materials* (4 ceu's)	$525 _____

View Course Descriptions and Register Online: http://www.dhmethed.com/category/EC5.html

To register by mail: ***Make checks payable to:*** DH Methods of Education, Inc. and mail with this completed form to:

DH Methods of Education, Inc. P.O Box # 17197 Fernandina Beach, FL 32035

Please: Do NOT mail or FAX credit card or P.O. numbers

Please do not ask us to reserve your place in a class without making registration payment . We do NOT accept P.O. # for registration. Requesting an invoice does not reserved place in a class. Only payment reserves your place.

Travel to: Jacksonville, FL airport (JAX). 22 miles to hotels. Shuttle service http://ameliaislandtransportation.com/