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The Organization for Safety, Asepsis and Prevention (OSAP) Symposium took place in Baltimore, Md., the last week of May. The attendance for this niche conference always astounds me, but also verifies its importance. Part of my interest comes from my experience in the field. Five years ago I was a field rep and witnessed many offices with little concern for infection control protocol. Some of the most vivid memories I had as a rep were of serious infection prevention protocol breaches. I have written about these in detail on our website, www.DentalSalesPro.com. Some of these breaches were both mind-boggling and downright frightening. In fact, the thread on www.DentalSalesPro.com is entitled “Dental Office Horror Stories.” Here is a brief sampling from that DSP post:

- An orthodontist using a toaster oven to sterilize his instruments.
- An assistant coming into the waiting room to pick up magazines for the patient with her gloves on.
- An oral surgery office, who had a contract with the county jail and refused to purchase an ultrasonic cleaner. The assistants had to hand scrub all instruments. Make sure you don’t poke a hole through your glove!
- An old dentist, without gloves, smoking a cigarette with two inches of ash dangling on the end, all while working on a patient. “Say ahhh.”

Despite this apparent disregard for infection control protocol, attendance at the OSAP meeting increases every year. You can read all about the OSAP Symposium on page 40.

There are several stories featured in this issue of First Impressions concerning infection control:

- “Sign of the Times” talks about the issues of instrument reprocessing.
- In “Infection Prevention in the Office,” we interview Kathy Eklund, RDH, MHP, director of occupational health and safety, patient safety advocate, The Forsyth Institute. Kathy talks about the role of a rep when it comes to training and educating staff on protocols.
- And, of course, the OSAP meeting article, which features the dedicated individuals who are trying to put the “control” back in infection control.

Keep the stories and lessons you’ve learned in this issue in mind the next time you call on an office. Maybe you can help your offices become a healthier and safer place, for both patients and staff.

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Bill Neumann
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**The camera does the work**

Today’s caries detection devices are designed to detect decay in its earliest stages, according to Sean Mitchell, imaging product specialist, ACTEON North America. “This tool can help the dental professional monitor the decay over a period of time, or show the patient the extent of the decay and recommend treatment,” he says. “Using the latest technology, cameras can be placed in the patient’s mouth and — at the push of a button — all of their caries appear as red areas on the screen. The need for messy caries detection dyes or calibrating detection devices is no longer needed.”

**Greater case acceptance**

When meeting with dentists and their hygienists, distributor sales reps should remind them that today’s caries detection devices make it easier to show patients problem areas in their mouth. Reps can open their discussion by asking customers, “Are you looking to increase case acceptance and patient recall?”

**Helping customers embrace new technology**

As with any new technology, some dentists and hygienists may be reluctant to try fluorescence products. Based on their experience with earlier caries detection technology, they may be concerned about false positives, Mitchell points out. However, newer cameras look at the breakdown of tooth structure, rather than the presence of bacteria, which limits — if not completely eliminates — false positives, he explains.

Some dentists may also be concerned that intraoral cameras can be difficult to use, which is why it’s important for sales reps to include a demonstration of the camera. “Sopro cameras are easy to use and work seamlessly in almost all imaging software,” says Mitchell. FI

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**Selling your customers on caries detection**

When discussing caries detection with your dental and hygienist customers, it can be helpful to point out that experts consider intraoral cameras to be very durable now and expect them to last for many years. In addition:

- The cost of caries detection devices has remained steady in the last five years — a trend that is expected to continue.
- The lifespan of a camera varies, depending on how well the office cares for the device.
- The only ancillary components required for a camera is a sheath, which is used for hygiene reasons.
- Some cameras, such as ACTEON North America’s SoproCARE and SoproLIFE cameras, offer four-year warranties.

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What has changed over the years in regards to how dentists buy, and how they work with reps?

What's always been true in sales is that people do business with those they like and trust, and that sales is about asking questions and solving problems. Simple, right? Therefore, let's leave those as a foundation, with the understanding that the sales process is actually a bit more involved now, and there have been some significant "shifts" in how to GET the account within the dental setting.

For example, how does a dentist define a problem? In the past, it was almost OK for the rep to go in and assume they knew the problem, state what it was, and provide a solution. It's not that that clear cut anymore. Also, many dentists may like and even trust you, but they still don't do business with you. While there are certainly many areas to consider, for the purpose of this article, let's focus on three things that have changed significantly over the years that affect the buying decision of the practice. Up front, it is important to note that, unfortunately, many reps are still using outdated techniques. It's not that your product isn't
good or that you aren’t “likeable or trustworthy,” it’s simply that the
dentist has a different way of deciding.

There is much more information available than ever before
Years ago, reps were the main information source. They were more “tellers” than listeners or consultants. Now, it has been shown that the dentist, if interested in what you are selling, often gets much of their product information, colleague opinions, and general insights, from online sources — the company website, social media forums, and/or YouTube videos as examples. The main objective of the rep today is to find out how their product or service fits the practice specifically. What is important to the dentist is how they practice and what improvement your product might give them. It’s not to immedi-
ately spew off a list of features and benefits. That can come later, and in fact, the dentist may know most or all of them
already. It’s about preparing beforehand to have a good idea of who they are first, showing them that you did your home-
work, and then asking questions that allow you to customize your “eventual” presentation and/or demo.

There are many more choices in every product/service category
There are only a handful of products that have no competitors. Meanwhile, there are dozens of composites, impression mate-
rials, burs, implants, etc., out there. Competition, for the most part, is good. What most companies teach, and the approach that most reps therefore take, is to either try to beat the competitor with pricing (thinking that the dentist will simply decide on that alone), or try to convince the dentist that their pitched product is the best on the market, using studies, presentations, etc.

Does that work? Sometimes. The problem with this ap-
proach is that with many choices, you can easily lose the
dentist within your presentation of all the stuff that makes you special, or you lose trust because everyone is telling him/her the same thing.

In a world overwhelmed with choices, once you find out what is important to the dentist, simplify your message and demo to that one area. It’s actually the opposite of what people have done, and are still doing. We feel that if customers have more choices, they need more information and more persuad-
ing, but that is not usually the case.

Dentists have to be cost-conscious, and sometimes the special or the bottom line pricing is the main variable, but for many products and for many types of dentists (especially those doing high end procedures — cosmetics, full mouth rehab, im-
plants), buying the cheapest cement or impression material doesn’t really feel right to them. My surveys show that pricing is often the second or third most important factor in buying decisions, not the main one.

In a world overwhelmed with choices, once you find out what is important to the dentist, simplify your message and demo to that one area. It’s actually the opposite of what people have done, and are still doing.

Get away from the negative sales approach
Many of us come from the “find the pain and then solve it” philosophy. It is still taught today and it doesn’t work well in dentistry. This is the “5 mistakes you are making in your hygiene department” or “What don’t you like about ______?” approach. The problem is that dentists are shrouded in negativity. Everyone scolds them and tells them what they are doing wrong. It also assumes that a dentist can’t, or shouldn’t, be using more than one product in a category.

Most dentists do, and should, use more than one product in each category. And, dentists want to talk about good things — what they do well, what they like to do, what is exciting and fun for them. When they do that, they will tell you what they would like more of or technically what their problems are. Anything that can be said in a negative way can be said in a positive way as well. For example, in-
stead of “Is your practice down from last year?” or “Is the economy hurting your practice”, say “What are your plans to beat last year’s numbers”? The conversation is different, and much more effective.

While this is only a partial list, the three areas discussed are important ones. The key is understanding that while you are still problem solvers, it is your job to have the dentist identify, define, and communicate the problem, and not for you to tell them their problem and then also immediately offer to solve it. Happy prospecting. FI
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The Art of Running a Business

Running a successful dental practice in an ever-evolving industry means engaging the appropriate professional team.

In many ways, your dental customers face the same challenges of running their practice as do many business owners. Yet, while some industries have remained more stable, dentistry is characterized by ever-changing technology and services.
First Impressions recently spoke with Allen M. Schiff, CPA, CFE Schiff & Associates, LLC; Schiff Wealth Advisors, LLC; Schiff Dental Brokerage about what it takes for dentists to build their practice in today’s evolving dental industry. Schiff, a founding member of the Academy of Dental CPAs, offers accounting, tax and consulting services exclusively to dental practices. He believes that with the right approach and qualified expertise, most dentists can run their practice successfully.

First Impressions Magazine: In your experience, is running a dental practice much different from running any other type of business?
Allen M. Schiff: Running a business is running a business, and [dentistry is no different from other businesses]. Every business depends on cash flow, the ability to produce (service one’s patients), the ability to collect for such services, and the ability to meet one’s overhead requirements as they become due. In the end, [the success of the business depends on its] ability to earn a profit after all services are collected and expenses are paid. Dentistry faces many of these challenges, whether it be increased competition from corporate dentistry, staffing issues, cash flow, marketing of oral healthcare services, keeping up with technology, reduction of student debt, and more. In order to face these challenges, dentists must engage the appropriate professional team to help guide them.

First Impressions Magazine: How do the challenges facing dental practices set them apart from other businesses?
Schiff: Dentistry is evolving as we speak. Change is here and we must be ready for it. Many businesses are stable, but dentistry is evolving [for a number of reasons]: Technology is evolving, the dental landscape is changing and student debt is at an all-time high. The challenges that dentistry places on [dentists] depends on where they are with regard to their professional career. For example, a recent dental school graduate is most concerned with landing a job, retiring student debt and making a living. A dentist out of school for five to 10 years may be looking into ways to market his or her services and fund a retirement plan, knowing very well that methodologies used in the past will not work in 2015 and beyond. And dentists [who have been practicing for] 20 to 25 years are thinking about why they should invest in the current technology, what the return on investment will be, and how to transition their dental practice.

First Impressions Magazine: What are the biggest mistakes dentists make that prevent them from reaching their full business potential and achieving the highest possible success for their practice?
Schiff: The biggest mistake dentists make is failing to organize a professional team to help guide them through the maze of business processes. The professional team should be made up of a dental CPA (www.adcpa.org), dental attorney, banker, practice management consultant, dental equipment specialists, personal and professional insurance advisor(s), and a retirement/financial planning consultant. In my opinion, the dental CPA should be the cheerleader, helping the dentist form their professional team.

First Impressions Magazine: As a CPA and member of the Academy of Dental CPAs (ADCPA), what role do you play in helping dental practices employ best practices to become successful businesses?
Schiff: Members of the ADCPA pride themselves on their proactive tax and practice management advice. Members of the ADCPA help their clients achieve financial success, as well as help them create a quality of life.
well as help them create a quality of life. The ADCPA is very progressive with year-round tax planning, financial planning and practice management advice, and it remains current with all factors that may impact our clients’ businesses. We partner with leaders in the dental industry through our national contacts and relationships. In addition, [with the aid of] its database of over 8,000 dental practices, ADCPA develops key performance indicators, along with various benchmarks, which allow ADCPA members to consult directly with their clients and guide them through the maze of overhead reduction techniques.

**FI:** What “best practices” should dentists follow to maximize the success of their practice?

**Schiff:** The best of all best practices is [for dentists] to listen. [They should] listen to the members of their professional team, [who] have already experienced [the dentist’s] issues and can help solve them, in a relatively short period of time. Best practices impact all facets of the dental practice. It starts with [in-office] communication; the dental team members believing in the dentist’s philosophies and values of practicing; and the dentist showing a sincere level of gratitude on a daily basis. Systems and procedures must be in place to allow the dental practice to experience best practices.

**FI:** To what degree should dentists be involved in the business end of their dental practice, and how much responsibility/autonomy should they give to their office managers?

**Schiff:** Dentists should be involved in all aspects of the business – [in some respects], on the peripheral, and [to some degree, they should be] much more deeply involved. For example, the selection of a credit card processor could rest with the dental CPA and the office manager, whereas the selection of new technology should rest with the dentist, with help from the dental CPA and office manager. The more profitable dental practices tend to allow the office manager to make all of the major decisions, which allows the dentist to do what he or she does best: produce dentistry!

**FI:** Do some dental practices overpay in taxes? If so, why? What mistakes do they typically make?

**Schiff:** Yes, of course, some dental practices overpay their taxes. Many dental practices don’t know, what they don’t know. It is important [for them] to engage a dental CPA in whom they have confidence and trust, and allow him or her to help guide them through the maze of tax regulations. One of the largest mistakes dentists make is engaging the wrong CPA, who doesn’t ask the proper questions to determine whether they are leaving deductions on the table. For example, I was the first CPA in my state of practice to have the state grant an exemption of personal property taxes on both the CEREC and E4D, [because I understood the] technologies and how they impact state tax law, and [I had] the ability to communicate such to the state.

**FI:** On the flip side, do you find that many dentists underestimate their tax and insurance liabilities, and place their practice at risk?

One of the largest mistakes dentists make is engaging the wrong CPA, who doesn’t ask the proper questions to determine whether they are leaving deductions on the table. For example, I was the first CPA in my state of practice to have the state grant an exemption of personal property taxes on both the CEREC and E4D, [because I understood the] technologies and how they impact state tax law, and [I had] the ability to communicate such to the state.
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Schiff: Some dental practices understate their tax liabilities due to poor business practices. For example, recently I was engaged by a prospective client to perform a special audit of [his] patient accounts receivable. I discovered that the dentist was not depositing the cash within [his] practice from the patient payments. If the Internal Revenue Service was aware of this behavior, the practice would not have sustained an IRS audit, and chances are the dentist would have gone to jail, as well as had to pay all of the taxes, interest and penalties due. With respect to the insurance liabilities, the dentist must rely on the expertise of the insurance consultant, as well as the dental CPA, to make sure all coverages are in place and at their proper levels. To do otherwise could create unnecessary risk for the dentist and his dental practice.

FI: What can dental products distributor sales reps do to help their dental customers maximize the success of their business?

Schiff: In my opinion, dental products distributor sales reps should have the willingness to be educated by the best practice management consultants out there, including the Academy of Dental CPAs. This education could be in the form of a luncheon, sponsoring a study club, or attending the ADCPA members’ ongoing practice management seminars, which they conduct for their client base. Just as in the restaurant industry, success in the dental industry is about location, location, location. Dental sales reps need education, education and more education! If they obtain this education, they will set themselves apart from other sales reps working in the industry.

FI
The document underscores the importance of manufacturers designing reusable medical devices and instruments with reprocessing in mind, and providing crystal-clear instructions to providers on how to clean, disinfect and sterilize them. It also draws attention to the need for providers to place well-trained, well-qualified people in reprocessing areas. The FDA doesn’t have a direct role in monitoring how dental offices reprocess instruments, notes Susan Runner, DDS, MA, branch chief of dental devices, FDA, who spoke about the guideline at this spring’s OSAP 2015 Annual Symposium in Baltimore, Md. Rather, the agency’s regulations pertain directly to how manufacturers market their devices and the kind of labeling – including reprocessing instructions – they provide. That said, the FDA is working to develop partnerships with professional groups, such as OSAP, to emphasize the importance of proper reprocessing of reusable medical and dental devices, she said.
The guidelines were issued just one month after the FDA issued a highly publicized “Safety Communication” regarding a medical device called a duodenoscope, which is a flexible, lighted tube that is threaded through the mouth, throat and stomach into the small intestine. The scopes are used in more than 500,000 medical procedures, called endoscopic retrograde cholangiopancreatography, or ERCP, in the United States each year.

The communication warned healthcare providers and the public that even the most meticulous attention paid to cleaning and disinfecting the scopes may not be enough to protect patients from infection passed on by other users. One month later, on March 12, the Centers for Disease Control and Prevention issued an interim protocol for facilities that want to test their duodenoscopes for contamination with bacteria after cleaning and disinfection.

If an instrument or device is intended for single use, or if the manufacturer fails to give reprocessing instructions for a device, make sure the customer knows the device cannot be reprocessed.

If there is any message for distributor sales reps, it is this, says Runner: Be aware of the labeling on the devices you sell. If an instrument or device is intended for single-use, or if the manufacturer fails to give reprocessing instructions for a device, make sure the customer knows the device cannot be reprocessed.

Complexity of today’s devices
The complexity of medical instrumentation — and hence, the difficulty of ensuring its cleanliness and safety — was one of the primary reasons the FDA began work several years ago updating its 1996 guidance document titled “Labeling Reusable Medical Devices for Reprocessing in Healthcare Facilities,” noted Geetha Jayan, PhD, senior science health advisor, Office of the Center Director of the FDA, during a webinar following issuance of the guidelines.

The new document, “Reprocessing Medical Devices in Healthcare Settings: Validation Methods and Labeling,” does a few things, she said:

- Provides recommendations to medical device manufacturers for developing reprocessing instructions that can be easily understood and followed by users.
- Outlines the FDA’s current recommendations to manufacturers on how to conduct scientifically sound testing to validate reprocessing methods and instructions.
- Describes measures the FDA is taking to enhance its oversight of the reprocessing of reusable devices.

The document also emphasizes the importance of designing devices that are less challenging to reprocess than some on the market today. It also provides recommendations on the “human factors” that can affect device reprocessing, including the ability of healthcare workers to clean and sterilize devices in the everyday work environment.

“In recent years, there has been an evolution toward the development of more complex devices with designs that are more difficult to reprocess,” said Elaine Mayhall, PhD, scientific review, Infection Control Devices Branch, Division of Anesthesiology General Hospital Respiratory & Infectious Diseases, Office of Device Evaluation in the FDA, during the webinar. “However, there have also been significant advances in the knowledge and technology involved in reprocessing reusable medical devices.” The recommendations in the FDA guidance are intended to reflect these advances.

In the dental operatory, “instrument sets and devices have become more complex in terms of the composition of the metals used when the instruments were manufactured,” notes Ronda Lane, BS, CDA, RDA, FADAA, American Dental Assistants Association, 9th District Trustee. “Some instruments require specialized cleaning and care to maintain maximum efficiency.

“For example, I have worked with several implant sets that have very specialized instruments — implant drills with channels/lumens — which included titanium, brass, tungsten carbide and other alloys. Some composite instruments have a very special non-stick surface and require specialized handling, such as the Anodized Aluminum Goldstein and Felt instruments.
These instruments must be cleaned of composite within 5 minutes of use and never be placed in alkaline or iodophor solutions. They should also be separated from the setup before the cleaning process begins, because they could be scratched by other instruments during ultrasonic cleaning.

Challenges such as these are compounded by other factors in the typical dental practice, she says. “I believe that one of the challenges is that dental offices typically have a moderate amount of turnover of personnel, so the dental assistant who was in the practice when the instruments were purchased does not relay the information on how each instrument or set of instruments should be cleaned or reprocessed to the next assistant who takes over that duty. So the current chairside in charge of proper cleaning and reprocessing has no idea what directions the manufacturer recommended when the instruments were purchased.

“The second primary problem is time,” says Lane. “Most dental practices are so busy, that the time needed to properly care for instruments is not allowed, or perhaps the dental assistant is not aware of how important it is to thoroughly rinse or dry the instruments prior to re-sterilization.”

**Human factors**

The newly released guidance document differs from its 1996 predecessor in several ways, says Runner. First and foremost, it emphasizes the validation of reprocessing instructions, from point-of-use treatment, to cleaning, then to disinfection and/or sterilization. Second, it instructs manufacturers to consider the “human factors” in its reprocessing instructions, which, according to the FDA, “include, but are not limited to, actions...”

“Most dental practices are so busy, that the time needed to properly care for instruments is not allowed, or perhaps the dental assistant is not aware of how important it is to thoroughly rinse or dry the instruments prior to re-sterilization.”

- Ronda Lane
requiring substantial dexterity or strength, good visual acuity, or familiarity with uncommon practices."

The manufacturer’s validation study participants should be representative of healthcare workers in the field, state the guidelines: “If users would be wearing personal protective equipment (PPE), such as goggles, full-length face shields, heavy-duty utility gloves or liquid-resistant covering with sleeves, then the validation study participants should wear them as well.”

The guidance document includes six criteria manufacturers must meet to ensure that providers understand and correctly follow reprocessing instructions.

**Criterion 1:** The reprocessing instructions should reflect the intended use of the device. Appropriate instructions depend on the physical design of the device, the intended use of the device, and whether it has direct or indirect contact with the patient. They also should reflect the type and extent of soiling and contamination to which the device is likely to be exposed during clinical use. Reprocessing methods are also dependent on the use of disinfectants or other chemicals that might leave harmful residues or adversely affect device materials or performance if inadequately rinsed, and any risk to the patient or the user.

**Criterion 2:** Reprocessing instructions for reusable devices should advise users to thoroughly clean the device. Adequate sterilization or disinfection depends on the thoroughness of cleaning. If a device cannot be cleaned, it cannot be disinfected or sterilized.

**Criterion 3:** Reprocessing instructions should indicate the appropriate microbicidal process for the device. The microbicidal process recommended is dependent upon the intended use of the device and is described by the Spaulding Classification for critical, semi-critical, and noncritical medical devices. (Critical devices are those introduced directly into the bloodstream or that contact a normally sterile tissue or body space during use. Semi-critical devices contact intact mucous membranes or non-intact skin, but do not ordinarily penetrate tissues or otherwise enter normally sterile areas of the body. Noncritical devices contact only intact skin but do not penetrate it.)
**Criterion 4:** Reprocessing instructions should be technically feasible and include only devices and accessories that are legally marketed. The equipment and accessories needed to implement the instructions should be available for users to obtain. Also, the type of sterilizer, with manufacturer-validated sterilization cycle parameters and accessories, should be available to users.

**Criterion 5:** Reprocessing instructions should be comprehensive and include information about: special accessories and special protection needed during reprocessing; point of use processing or pre-cleaning instructions; disassembly and reassembly instructions, including step-by-step instructions with visual aids; the method of cleaning, including a list of parameters; the cleaning agent or the class of cleaning agent used in the manufacturer’s validation testing; instructions for rinsing the device following cleaning; the type and quality of water that should be used and the duration, volume, and temperature of the water; lubricating agent, if required; instructions for drying the device after processing and before storage; method of disinfection or sterilization, including the validated cycle parameters and accessories that should be used; instructions for reducing sterilant residuals following sterilization by ethylene oxide, hydrogen peroxide, or other processes that may leave sterilant residuals on the device; and more.

**Criterion 6:** Reprocessing instructions should be understandable. The instructions should be clear and legible. They should be presented in a logical, sequential order, from the initial processing step through the terminal processing step, and should be described using simple language. Charts, diagrams, and pictures that can be posted in a workstation are helpful.

**Manufacturers’ instructions are critical**

“Diagrams are probably the best way to educate somebody on how to properly clean something,” says Lane. “I think that portion of the guidelines is great.” She also commends the FDA for recommending that manufacturers include a telephone number, email address, and web page address for healthcare providers wishing to obtain additional information about reprocessing a device, including questions on infection control procedures for the device.

Having a resource to consult about reprocessing “is critical,” she says, adding that some implant manufacturers already have excellent web-based resources with information about cleaning and reprocessing their instruments.

The FDA guidance document recommends that manufacturers include instructions for visual inspection, which may include the use of magnification and adequate lighting. “Every dental office should have a lighted magnifier,” says Lane. “We work with instruments that are so very small,” such as burs. “The only way you can really tell if they’re clean or damaged is through lighted magnification.” Yet, only a small percentage of dental offices have magnifiers, even though they are inexpensive, she says.

Lane also applauds the FDA for recommending that manufacturers specify the number of times a device can be reused. In the typical dental practice, burs tend to be used over and over again, until the dentist says, “This isn’t cutting, get me another,” she says. Better to inspect the bur and follow the manufacturer’s instructions.

If the FDA document falls short, it is in the fact that it fails to specify what personal protective equipment the office staff should use when cleaning and disinfecting dental devices and instruments, she concludes.

**Editor’s Note:** “Reprocessing Medical Devices in Health Care Settings: Validation Methods and Labeling Final Guidance – March 24, 2015,” is available at www.fda.gov/downloads/MedicalDevices/DeviceRegulationandGuidance/GuidanceDocuments/UCM253010.pdf
Reprocessing instructions: Must-haves

Reprocessing instructions should include all of the elements below, and some additional ones, according to the U.S. Food and Drug Administration.

**Special accessories**
The instructions should describe any accessories needed for safe reprocessing. If the device requires any special protection during reprocessing (e.g., valves, plugs or stoppers to prevent ingress of harsh chemicals), they should be described in detail. The instructions should also identify any special tools, sizes and types of brushes (including custom brushes), flush port connectors and connector size specifications, trays, test kits, specific types of sterilization wraps or containers, and part numbers, if appropriate.

**Point-of-use processing**
As needed, labeling should include instructions for prompt, initial cleaning steps and/or measures to prevent the drying of soil on the device surface prior to cleaning, as this will facilitate subsequent cleaning steps. Delays may create conditions favorable to microbial growth, which may increase the challenge to subsequent steps, such as cleaning and disinfection/sterilization. Organic contamination may inactivate or prevent full penetration of a disinfectant or sterilant.

**Disassembly and reassembly**
If the device has removable parts, reprocessing instructions should include step-by-step instructions for disassembly and reassembly of the device to facilitate cleaning by the user. The equipment needed to perform these activities should be identified. Diagrams, photographs, illustrations and/or videos are recommended. In addition, the instructions should indicate the location where the user should perform the step (e.g., at the point of use, at the designated cleaning area). Additionally, disassembly and reassembly instructions should include information to visually inspect the device and components for wear and tear of components that cannot be assessed in the fully assembled configuration.

**Method of cleaning**
The labeling should provide a detailed, validated method of cleaning. The method may be manual or mechanical (e.g., washer, washer/disinfector, ultrasonic washer) or may combine the two. However, manufacturers should be aware that some small healthcare settings may not have automated cleaning equipment; therefore, validated manual cleaning instructions may be needed. Cleaning instructions should include a list of the appropriate parameters for each recommended method.

Whether the cleaning method is manual, automated, or a combination of the two, the labeling should contain comprehensive directions, including photographs and/or diagrams, if appropriate, for each cleaning, rinsing, and drying step so that users can accurately follow the steps or program them into the device washer or washer/disinfector. Recommendations for the use of detergents, enzymatic cleaners, and automated cleaning cycles should be consistent with the manufacturer’s directions for use for those products.

**Cleaning agents**
The instructions should recommend only cleaning agents or classes of agents (e.g., detergents such as quaternary ammonium...
compounds and enzymatic detergents) that were used during the cleaning validation studies, that have been demonstrated to be compatible with the device, and are effective in cleaning the device. Labeling should include instructions for the preparation and use of those agents. Labeling for use on specific medical devices should be consistent with the cleaning agent manufacturer’s instructions for use of the product.

Certain products (e.g., some quaternary ammonium compounds and alcohols) may be used for both cleaning (removal of soil) and disinfection (inactivation of microbes). Other products are capable of only performing one of these two functions. The instructions for use should address both cleaning and disinfection if both are intended, and should be clear regarding the difference between cleaning and disinfection, and the products used for each step.

**Rinsing**

The labeling should recommend specific directions for rinsing to remove chemical residues used during reprocessing; rinsing steps should be included after cleaning and after use of liquid chemical sterilants/high level disinfectants. Rinsing may be manual or mechanical. The rinsing instructions should include the type and quality of rinse water, duration of rinse (or, for flushes, the volume and number of repetitions), and temperature.

**Lubricating agents**

Lubricants may reduce the friction commonly associated with metal-on-metal movements and thereby reduce device wear and corrosion. If applicable, the reprocessing instructions should recommend lubricating agents, or a class of lubricating agents (e.g., water-soluble lubricants) that are compatible with the medical device, its intended use, and with any subsequent processing steps, such as sterilization.

Labeling should include any special warnings or precautions about the reprocessing procedure, when warranted. These may be related to user safety or emphasize conditions that could significantly alter the safety or effectiveness of reprocessing or the performance of the device.

Also, labeling for the reusable device should refer to the lubricating agent labeling for preparation and use instructions of those agents.

**Visual inspection**

All routine cleaning instructions should include instructions for visual inspection, which may include use of magnification and adequate lighting. The instructions should advise the user that if the device is determined not to be visually clean at the end of the cleaning step, the user should either repeat the relevant previous cleaning steps or safely dispose of the device. Additionally, the visual inspection instructions should identify acceptance or failure criteria related to device performance (e.g., unacceptable deterioration such as corrosion, discoloration, pitting, cracked seals), as well as instructions to properly dispose of devices that fail.

**Method of disinfection or sterilization**

For reusable devices intended to be disinfected or sterilized, reprocessing instructions should specify at least one validated microbicidal method for disinfection or sterilization. The type of microbicidal method would depend on the type of device to be reprocessed. Specifications for sterilization equipment and sterilization cycle parameters vary with manufacturers and models. Labeling for reprocessing should identify the particular sterilization method and type, and list the validated cycle parameters.

**Drying**

Labeling should recommend the procedures that should be used to thoroughly dry the device, after processing and before storage, to eliminate moisture that can support the survival of contaminating microorganisms. Labeling should also recommend a validated minimum drying time specification for terminal sterilization methods for wrapped/contained devices.
Cleaning:
All-important step

Cleaning is essential to reprocessing multiple-use devices and instruments. Manufacturers’ instructions must describe how their devices should be cleaned prior to disinfection and/or sterilization. Some points from the FDA guidance document:

- Details of the cleaning procedure will vary depending on the complexity of the device.

- Devices with features that may result in soil retention or that make them difficult to clean may need to be disassembled in order to be completely cleaned. For such devices, instructions/diagrams for adequate disassembly should be included in the cleaning instructions.

- Directions for use of the device may include the use of protective covers and sheaths to try to reduce the extent of cleaning needed before the device can be reused (e.g., bronchoscopes). The cleaning instructions should assume the worst-case where the device is used uncovered, because of the potential for loss of cover integrity during use.

- Flushable devices (e.g., endoscopes, laparoscopic instruments and other devices with flush ports) are prone to debris accumulation and should have instructions/diagrams to ensure proper flushing during cleaning. Flushing instructions/diagrams should include the specific accessories to be used, including proper size connectors for the flush ports, and the type and volume of flushing agent to be used.


Reuse life
The labeling should either 1) inform the user how many times the device can be reused, based on testing; or 2) provide the user with a mechanism or method to ascertain whether the device has exceeded its use life. In the latter case, the labeling should identify a method to establish that the device is still within performance specifications, as well as instructions for appropriate disposal of devices that fail. Whichever method is chosen, labeling should recommend how to evaluate deterioration in difficult-to-see areas of complex devices, especially those with lumens (e.g., leak testing).

Additional labeling recommendations
Devices that are initially supplied non-sterile to the user and require the user to sterilize the device before use should be prominently labeled “Non-sterile” directly on the individual device label (e.g., as opposed to only on the shipper carton) to ensure the non-sterile product is sterilized before use.

Labeling should include any special warnings or precautions about the reprocessing procedure, when warranted. These may be related to user safety or emphasize conditions that could significantly alter the safety or effectiveness of reprocessing or the performance of the device. For example, some devices may have unsealed seams/crevices through which excessive liquid disinfectant could reach the interior of the device and damage it.

Manufacturer’s contact information
The manufacturer of the reusable device is the appropriate contact for user questions about the reprocessing procedures. The instructions for reusable devices should include a telephone number, e-mail address, and web page address to obtain additional information about reprocessing the device. Customer service representatives of device manufacturers are often the initial point of contact when a device user has a question about device reprocessing. The training of these persons should include information on the reprocessing of devices for which they are responsible and the provision of information resources that they can access rapidly in order to provide assistance to device users.

The following are common terms that may be used in reprocessing instructions in device labeling, some of which are derived from referenced literature.

- **Biological Indicator (BI):** A test system containing viable microorganisms providing a defined resistance to a specified sterilization process.

- **Cleaning:** Physical removal of soil and contaminants from an item to the extent necessary for further processing or for the intended use.

- **Disinfectant:** An agent that destroys pathogenic and other kinds of microorganisms by chemical or physical means. A disinfectant destroys most recognized pathogenic microorganisms, but not necessarily all microbial forms, such as bacterial spores.

- **Disinfection:** A process that destroys pathogens and other microorganisms by physical or chemical means. Disinfection processes do not ensure the same margin of safety associated with sterilization processes. The lethality of the disinfection process may vary, depending on the nature of the disinfectant.

- **Germicide/microbicide:** An agent that destroys microorganisms, especially pathogenic organisms. Other terms with the suffix -cide (e.g., virucide, fungicide, bactericide, sporicide, tuberculocide) indicate an agent that destroys the microorganism identified by the prefix.

- **Physical/chemical sterilization process indicator:** A device intended for use by a healthcare provider to accompany products being sterilized through a sterilization procedure and to monitor one or more parameters of the sterilization process. The adequacy of the sterilization conditions as measured by these parameters is indicated by a visible change in the device.

- **Reprocessing:** Validated processes used to render a medical device, which has been previously used or contaminated, fit for a subsequent single use. These processes are designed to remove soil and contaminants by cleaning and to inactivate microorganisms by disinfection or sterilization.

- **Reusable medical service:** A device intended for repeated use either on the same or different patients, with appropriate cleaning and other reprocessing between uses.

- **Single-use device (SUD):** A device that is intended for one use or on a single patient during a single procedure.

- **Spore (or endospore):** The dormant state of a microorganism, typically a bacterium or fungus, which exhibits a lack of biosynthetic activity, reduced respiratory activity, and has resistance to heat, radiation, desiccation and various chemical agents.

- **Sterilant:** An agent that destroys all viable forms of microbial life.

- **Sterile:** State of being free from viable microorganisms.

- **Sterility Assurance Level (SAL):** The probability of a single viable microorganism occurring on an item after sterilization.

- **Sterilization:** A validated process used to render product free from viable microorganisms.

- **Sterilization wrap:** Pack, sterilization wrapper, bag, or accessories intended to be used to enclose another medical device that is to be sterilized by a healthcare provider. It is intended to allow sterilization of the enclosed medical device and also to maintain sterility of the enclosed device until used.

Dental staffs are accountable to patients. So are the distributors who bring products, instruments and equipment to the practice. “There is an expectation and a level of trust [among patients] that they will receive not only high-quality care, but safe care,” says Kathy Eklund, RDH, MHP, director of occupational health and safety, patient safety advocate, The Forsyth Institute, a non-profit dental research and treatment institution in Cambridge, Mass. The dental team earns that trust by putting into place infection-prevention-related policies and procedures. Distributor sales reps play their part by helping the staff understand how to use – and reprocess – instruments and equipment safely.

First Impressions spoke with Eklund following the 2015 OSAP Symposium in Baltimore, Md., at which she gave a presentation on the roles and responsibilities of the infection control coordinator in the dental practice.

“The end goal of an infection control program is to prevent healthcare-associated infections among patients, and injuries and illness among dental personnel,” she says.

In its 2003 “Guidelines for Infection Control in Dental Health-Care Settings,” the Centers for Disease Control and Prevention recommends that dental practices develop a written infection control program to prevent or reduce the risk of disease transmission. It also recommends that the practice appoint an infection control coordinator – either a dentist or other dental healthcare person – “knowledgeable or willing to be trained,” who carries responsibility for coordinating the program.

Leadership

“Leadership is extremely important,” says Eklund. In solo or small practices, it’s up to the dentist/owner to champion the cause of safety. “They may not write the policies, but they are supportive of the people who do, by providing time and resources to them.” In the corporate dentistry setting, the company must embrace the culture of patient safety and personnel safety, and then provide leadership at the individual practice setting, she adds.

Regardless of its size, the practice needs to identify an infection control coordinator. “Otherwise, how do these activities occur?” asks Eklund. Small practices may need to hire a consultant to put together policies and procedures, and set up SOPs, or standard operating procedures. That consultant may be asked to monitor the program on an ongoing basis, to ensure staff are adhering to it.

OSAP – the Organization for Safety, Asepsis and Prevention – provides ample continuing education for the coordinator and the dental team, notes Eklund. For example, the Boot Camp, held in January, offers three and a half days of training on infection prevention principles and programs. OSAP’s recently released Safest Dental Visit™
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“One reason OSAP has created the Safest Dental Visit program, with its focus on infection prevention, is to facilitate the dental practice setting and the infection control coordinator with credible and timely infection prevention resources and tools,” says Eklund.

One of the key challenges for the infection control coordinator is making sure that the entire dental team adheres to the standard operating procedures day after day, says Eklund. “You can have written policies and procedures in a manual, but that doesn’t ensure it’s actually happening.” The goal is to make safe dentistry second nature to the staff.

Role of the sales rep
Sales reps can help by demonstrating that the instruments or equipment they carry have been developed with infection prevention in mind, says Eklund. The rep can, for example, review the manufacturer’s instructions for use as well as the specific validated processing instructions for reuse of a piece of equipment or instrument.

It is the manufacturer’s instructions, after all, that guide the reprocessing procedure.

By doing these things, the rep helps ensure the safety of the patient and dental team, and in the process, enhances his or her standing in the practice as well, says Eklund. “I can have two products I like equally well,” she says, speaking from the practice perspective. “The make-or-break may be how knowledgeable the salesperson is about the product in the context of day-to-day dentistry, and whether he or she clearly understands the infection control considerations for the product or device.”

What the CDC says

In its 2003 “Guidelines for Infection Control in Dental Health Care Settings,” the Centers for Disease Control offers guidance on how dental practices should set up a program to reduce the risk of disease transmission.

Some key points:

- The program should include establishment and implementation of policies, procedures, and practices (in conjunction with selection and use of technologies and products) to prevent work-related injuries and illnesses among dental healthcare personnel, as well as health-care-associated infections among patients.
- The program should embody principles of infection control and occupational health, reflect current science, and adhere to relevant federal, state, and local regulations and statutes.
- An infection control coordinator (e.g., dentist or other healthcare personnel), knowledgeable or willing to be trained, should be assigned responsibility for coordinating the program.
- The effectiveness of the infection control program should be evaluated on a day-to-day basis and over time to help ensure that policies, procedures, and practices are useful, efficient, and successful.
- Although the infection control coordinator remains responsible for overall management of the program, creating and maintaining a safe work environment ultimately requires the commitment and accountability of all personnel.

Source: “Guidelines for Infection Control in Dental Health-Care Settings – 2003,” Centers for Disease Control and Prevention
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Taking precautions

We all know about standard precautions, but I’ve been hearing from offices that they want to be prepared for “special diseases,” and they are asking for different products. One office asked me to help them put together a special supply of PPE and disinfectants to use in case someone came in with a highly contagious disease. They want to be ready before flu season hits. I thought that the regular PPE and surface disinfectants were good enough, but they say there are other “transmission-based precautions” that require different products. What should I be selling them?

Transmission-based precautions are modifications to normal standard precautions. For contact and droplet diseases, standard precaution protocol changes, but very few changes are required in selection of products. You will find that most offices already buy what they need to respond to the rare and unexpected situation where patients with droplet or contact diseases must be treated.

However, modifications required to treat patients with aerosol-transmitted (airborne) diseases are major: building modifications include increased ventilation to provide 6 to 12 air exchanges per hour, as well as negative pressure rooms that isolate the contaminated air and treat it before it exits the building. Employees must be trained and fit-tested to wear N-95 or N-100 masks. Most dental offices can’t or won’t make such changes. Therefore, these highly infectious patients should be screened out and treatment should be postponed. If emergency care is necessary, they should be referred to a hospital-like setting where they can be treated in safe isolation. Dental workers should receive training on how to identify aerosol-transmitted diseases (ATDs), and should be routinely screening patients.

Transmission-based precautions are based on how infectious the disease is, the mode of transmission, and how to kill or inactivate the pathogen. Here are simple explanations of each type of transmission-based precaution:
What's lurking in your customer’s dental unit waterline?

Banish uninvited guests with DentaPure®
DentaPure iodinated resin bead cartridges, for municipal or bottle waterline systems, kill bacteria to provide safe water for an entire year.

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- Meets and exceeds microbiological standards including OSAP, ADA & CDC = Less than 500 CFU/mL.
- No hazardous silver. No special trash disposal requirements.

DentaPure is a simple point-of-source iodinated resin bead cartridge that retrofits your unit’s existing water bottle pickup tube (DP365B) or municipal waterline (DP365M).

Actual photo of handpiece biofilm.
Dental unit waterlines can exceed bacterial allowance standards by as much as 20,000% due to biofilm buildup.
Contact precautions
Contact diseases are transmitted by touching the patient directly or by indirect contact with contaminated surfaces or items. Body fluids are typically responsible for transmitting the pathogens, but even dried fluids can contain enough viable pathogens to infect others. Examples of contact diseases are Hepatitis A, Norovirus, Streptococcus or Staphylococcus skin infections, Clostridium difficile, influenza, Varicella virus (Shingles or Chicken Pox), Herpes zoster, rhinovirus, and conjunctivitis.

1. Isolate the patient to protect others.
2. Wear an ASTM Level 3 (high barrier) mask.
3. Gown before entering the patient room, remove the gown before leaving the room.
4. Isolate the used gown.
5. Glove when entering the room, remove gloves before leaving the room.
6. Perform immediate hand hygiene using an antimicrobial soap or alcohol agent.
7. Avoid bare-handed touching of the patient’s skin, clothing or personal items.
8. Barrier-protect non-critical items such as blood-pressure equipment or clean & disinfect such equipment if used.

Typical dental offices must avoid treating patients with ATDs by screening out symptomatic patients. Two key criteria are fever and respiratory symptoms. The best thing salespeople can do is to provide options for taking patient’s temperatures quickly and aseptically – such as digital thermometers, disposable thermometers or thermometer covers.

Droplet precautions
Droplet diseases are transmitted by the small droplets generated when people sneeze, cough, speak, or when dentistry is performed and spray and spatter is generated. Generally, droplets fall to the ground
The CDC strongly recommends single-use disposable instruments whenever possible.*

*Source: CDC MMWR Dec 19 2003.

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The CDC strongly recommends single-use disposable instruments whenever possible.*

*Source: CDC MMWR Dec 19 2003.
within about three feet. The concept of droplet precautions is to protect against droplets when moving within three feet of the patient. Examples of droplet diseases are meningitis, pneumonia, pertussis, pharyngitis, influenza, chicken pox and shingles (until lesions are crusted over), and infections with parainfluenza virus, rhinovirus and adenovirus. Many diseases, such as tuberculosis and influenza are transmitted by both airborne and droplet routes.

1. Isolate patient to protect others in a private room. Door may be open.
2. Maintain at least three feet between patient and others.
3. Don ASTM Level 3 (high barrier) mask to enter patient care area.
4. Wear complete coverage goggles or face shield with mask.
5. Only move patient out of private room if necessary (patient should wear a mask).

**Transmission-based precautions for droplet and contact diseases basically require a different sequence of donning and removing PPE and isolating and managing contagious patients.**

Airborne disease precautions

Airborne diseases, or aerosol-transmitted diseases (ATDs) are those capable of remaining viable and infectious when suspended in the air. The particles are typically 1 micron or smaller, and the particles remain suspended for long periods of time. Aerosol-transmitted diseases include tuberculosis, influenza, measles, chickenpox (until lesions are crusted over), and herpes zoster (until lesions are crusted over). It is important to remember that airborne pathogens enter the body various ways: absorption through mucosal tissues of the nose, mouth, throat, and through ocular tissue, as well as via inhalation. PPE includes fit-tested respirators and well-fitted ocular protection. If you call on a facility that is engineered to contain and purify the air within an isolated room, such as a hospital, special equipment and PPE will be appropriate. N-95 or N-100 fitted respirators or separate breathing apparatus and tight fitted goggles should be worn.

The bottom line is that typical dental offices must avoid treating patients with ATDs by screening out symptomatic patients. Two key criteria are fever and respiratory symptoms. The best thing salespeople can do is to provide options for taking patient’s temperatures quickly and aseptically—such as digital thermometers, disposable thermometers or thermometer covers.

Transmission-based precautions for droplet and contact diseases basically require a different sequence of donning and removing PPE and isolating and managing contagious patients. For maximum protection, high quality asepsis products should be used; for example, well-fitting ASTM Level 3 masks should be used. Intermediate-level disinfectants that clean and disinfect should be used on potentially contaminated surfaces. Surface barriers should be used correctly, and instruments must be sterilized and kept sterile until used.

Finally, aseptic technique should be used, and dental workers who are symptomatic should not expose co-workers or patients. Patients with ATDs should not be treated in standard dental offices, but should be referred to specially equipped and designed facilities such as hospitals if care is urgent.
Your endodontist customer can be much more than the outsourced “root canal guy.” Instead, he or she can be a thought leader to the local GP community as well as to patients. To do so, he or she must come from a place of generosity and abundance rather than scarcity. And sales reps can help.

“There’s often a sense of territorialism underlying the relationship between the GP and the endodontist – or any specialist,” says dental marketing consultant Naomi Cooper, president and founder, Minoa Marketing, and chief marketing consultant, Pride Institute. “And it doesn’t have to be that way.” Cooper gave a presentation at the American Association of Endodontists’ AAE15 conference on “Marketing the endodontic practice to GPs and patients.”

Just because a GP is doing a few simple endo procedures, for example, does not preclude that GP from continuing to be a good referral source, she says. By doing a few such procedures, the GP may gain a better understanding of his or her limitations, and a more keen sense of the circumstances under which it is better to call a specialist. “When the GP truly understands what the specialist does and why it is so unique, that serves to reinforce the referral rather than erode it.”

The successful endodontist – or, again, any specialist – chooses to act as

“When the GP truly understands what the specialist does and why it is so unique, that serves to reinforce the referral rather than erode it.”
A teacher, a mentor and a subject matter expert – rather than merely serving as the outsourced resource for especially tough cases, says Cooper.

It’s as true today as always, that “the more knowledge you share, the more people will respect the knowledge base you have,” says Cooper. The generalist will never know as much as the specialist about any given specialty, but the specialist can share enough knowledge for the generalist to feel, “Wow, I have really learned something from that person,” she says. In the process, the specialist not only earns that GP’s future referral business, but his or her respect as well. “It becomes a cycle of positive referral energy rather than a vicious cycle of scarcity.”

It’s a paradigm shift. Particularly among specialists, the sense of territoriality is strong. Orthodontists, for example, resisted Invisalign in the early years, she recalls. “But one could argue that Invisalign is one of the major trends that brought adult orthodontics into the forefront,” ultimately expanding the market for the orthodontist.

“It’s eye-opening for specialists to think of GPs as partners,” says Cooper. But today’s economy is no longer on the shaky ground of 2008, 2009 or 2010. “That scarcity mentality – the feeling that there’s not enough work to go around – isn’t [appropriate anymore]. And it was never the right mentality anyway.”

**Two customers**

Endodontists, like other specialists, have two sets of customers – GPs and patients. In order to market to both, the specialist must understand the mindset and needs of each. “But it’s important not to think of this just as marketing, but as better communication, and really fostering relationships,” says Cooper.

“When stepping into shoes of GPs, [the specialist] has to think about the fact that they are hungry for knowledge; they’re thirsty for it; they want to learn more,” says Cooper. “There’s a reason dentists do so much CE, and it’s not just because they have to. They love learning new techniques, ways to add revenue streams, ways to do more cool dentistry. And the more [the endodontist] can provide them in terms of knowledge, maybe by hosting a study club or meeting with them on a regular basis, the more value he or she offers them.”

In fact, specialists should ditch the Thanksgiving turkey or ham, and instead, offer their GPs something of real value – knowledge. And those specialists need to think beyond reaching the dentist. After all, many referrals are suggested at the GP’s front desk. “They might have a couple of endodontists’ cards for their patients, but it’s the front desk person who will say, ‘This is the guy or gal you really should call,’” says Cooper.

When dealing with patients, endodontists need to turn off their “dental brain” and instead turn on their “human brain,” says Cooper. “That’s difficult for GPs, and it’s almost impossible for specialists.” Specialists spend so much time talking to GPs and their peers, they almost forget how to communicate to patients.

Patients aren’t looking for in-depth information about endodontic technique, says Cooper. They know their limitations in judging the clinical expertise of the specialist. In fact, they assume competence on the part of the specialist to whom they have been referred.

Rather, patients are more concerned about, “Is she nice? Gentle? Is the staff friendly? Will I be treated like a human being?” Many patients today – particularly younger ones – consult Google prior to calling the specialist, to learn about the practice, read patients’ reviews, and get answers to some of those questions.

By also operating from a place of abundance, sales reps can help their endodontist customers thrive, says Cooper. For
At AAE15, Naomi Cooper, president and founder, Minoa Marketing, and chief marketing consultant, Pride Institute, offered endodontists three marketing upgrades. She shared them with First Impressions.

1. **Adopt a brand and logo.** Give your practice an identity. Many dentists and endodontists, particularly those who have been in practice 20 or 30 years or more, have a common name for their practice: First name, middle initial, last name, DDS or DMD. “Even if they have an associate or are planning to retire, or are thinking about running away to Europe to become a concert pianist, they still invest all of that affinity in their own names.” Sometimes, name does matter, such as a father/daughter or mother/daughter combo; a third-, fourth- or fifth-generation practice; a husband/wife team, etc. But in most cases, the doctor’s name isn’t necessarily the best route to go. Assuming the doctor does come up with a catchy or revealing name for the practice, he or she has to make sure that brand is consistent – on the website, business cards, signage, email communications, etc. “It’s a matter of making sure you’re not sending a mixed or confusing message,” says Cooper.

2. **Create a website, and keep it current.** A sharp, well-designed, well-maintained website demonstrates the practice is modern. More fundamentally, “it communicates you exist,” says Cooper. If the practice lacks a website or has failed to update it for months or even years, visitors will wonder if the doctor has retired or has simply refused to keep up with the times. Visitors want to see an up-to-date website; so does Google, which controls the lion’s share of web searches today. In fact, the company penalizes websites that haven’t been touched for awhile, by making them more difficult to find with its search engine.

   One more word about websites: Make sure the site has been optimized for mobile devices, says Cooper. “In today’s world, the majority of web traffic is on mobile devices, whether it’s a tablet or mobile phone.” When searching for information, people today are more likely to be in an elevator, at their kid’s baseball game or in line at the supermarket than they are sitting at their laptop. A mobile-optimized site is one with a responsive design, that is, one that transforms and changes shape based on the size of the browser used to access it.

3. **Solicit online reviews from satisfied patients.** Online reviews can validate a practice. Failure to ask patients to post good reviews is wasted opportunity.

**Editor’s note:** Reps can steer their customers to a Google site to help customers gauge the “mobile-friendliness” of their websites. The URL is www.google.com/webmasters/tools/mobile-friendly.

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**Marketing upgrades for the specialist**

At AAE15, Naomi Cooper, president and founder, Minoa Marketing, and chief marketing consultant, Pride Institute, offered endodontists three marketing upgrades. She shared them with First Impressions.

1. **Adopt a brand and logo.** Give your practice an identity. Many dentists and endodontists, particularly those who have been in practice 20 or 30 years or more, have a common name for their practice: First name, middle initial, last name, DDS or DMD. “Even if they have an associate or are planning to retire, or are thinking about running away to Europe to become a concert pianist, they still invest all of that affinity in their own names.” Sometimes, name does matter, such as a father/daughter or mother/daughter combo; a third-, fourth- or fifth-generation practice; a husband/wife team, etc. But in most cases, the doctor’s name isn’t necessarily the best route to go. Assuming the doctor does come up with a catchy or revealing name for the practice, he or she has to make sure that brand is consistent – on the website, business cards, signage, email communications, etc. “It’s a matter of making sure you’re not sending a mixed or confusing message,” says Cooper.

2. **Create a website, and keep it current.** A sharp, well-designed, well-maintained website demonstrates the practice is modern. More fundamentally, “it communicates you exist,” says Cooper. If the practice lacks a website or has failed to update it for months or even years, visitors will wonder if the doctor has retired or has simply refused to keep up with the times. Visitors want to see an up-to-date website; so does Google, which controls the lion’s share of web searches today. In fact, the company penalizes websites that haven’t been touched for awhile, by making them more difficult to find with its search engine.

   One more word about websites: Make sure the site has been optimized for mobile devices, says Cooper. “In today’s world, the majority of web traffic is on mobile devices, whether it’s a tablet or mobile phone.” When searching for information, people today are more likely to be in an elevator, at their kid’s baseball game or in line at the supermarket than they are sitting at their laptop. A mobile-optimized site is one with a responsive design, that is, one that transforms and changes shape based on the size of the browser used to access it.

3. **Solicit online reviews from satisfied patients.** Online reviews can validate a practice. Failure to ask patients to post good reviews is wasted opportunity.

**Editor’s note:** Reps can steer their customers to a Google site to help customers gauge the “mobile-friendliness” of their websites. The URL is www.google.com/webmasters/tools/mobile-friendly.
Cone beam and endodontics: Balance the risks and benefits.
New position statement advises against routine use of CBCT for endodontic diagnosis

**Cone beam-computed tomography should not** be used routinely for endodontic diagnosis or screening purposes in the absence of clinical signs and symptoms. That is the consensus of the American Association of Endodontists and the American Academy of Oral and Maxillofacial Radiology, which jointly issued a revised position statement on the use of CBCT use in endodontics.

The AAE and AAOMR said that their statement is consistent with principles of ALARA – keeping patient radiation doses “as low as reasonably achievable,” and noted that the patient’s history and clinical examination must justify the use of CBCT by demonstrating that the benefits to the patient outweigh the potential risks. The recently released statement updates a 2010 position on CBCT use in endodontics.

“Endodontists continue to have excellent results with two-dimensional radiography,” AAE President Dr. Terryl A. Propper was quoted as saying. “However, limited field of view CBCT does have a place in endodontics when dealing with more complex cases, which are reflected in the position statement.”

“Dental imaging is interlaced with endodontics not only for accurate diagnosis but for periodic evaluation of certain treatment outcomes,” said AAOMR President Dr. Christos Angelopoulos. “Complex cases may require the use of advanced imaging modalities such as CBCT for proper diagnoses, although advanced imaging may not be necessary as a routine diagnostic tool.”

The statement provides 12 recommendations and supporting evidence for when CBCT should be considered the imaging modality of choice.

### Diagnosis

**Recommendation 1:** Intraoral radiographs should be considered the imaging modality of choice in the evaluation of the endodontic patient.

**Recommendation 2:** Limited field-of-view (FOB) CBCT should be considered the imaging modality of choice for diagnosis in patients who present with contradictory or nonspecific clinical signs and symptoms associated with untreated or previously endodontically treated teeth.

### Initial treatment

**Recommendation 3 (preoperative):** Limited FOV CBCT should be considered the imaging modality of choice for initial treatment of teeth with the potential for extra canals and suspected complex morphology, such as mandibular anterior teeth, and maxillary and mandibular premolars and molars, and dental anomalies.

**Recommendation 4 (intraoperative):** If a preoperative CBCT has not been taken, limited FOV CBCT should be considered as the imaging modality of choice for intra-appointment identification and localization of calcified canals.

**Recommendation 5 (postoperative):** Intraoral radiographs should be considered the imaging modality of choice for immediate postoperative imaging.

### Nonsurgical retreatment

**Recommendation 6:** Limited FOV CBCT should be considered the imaging modality of choice if clinical examination and 2-D intraoral radiography are inconclusive in the detection of vertical root fracture.

**Recommendation 7:** Limited FOV CBCT should be the imaging modality of choice when evaluating the non-healing of previous endodontic treatment to help determine the need for further treatment, such as nonsurgical, surgical or extraction.
Recommendation 8: Limited FOV CBCT should be the imaging modality of choice for nonsurgical retreatment to assess endodontic treatment complications, such as overextended root canal obturation material, separated endodontic instruments, and localization of perforations.

Surgical retreatment
Recommendation 9: Limited FOV CBCT should be considered as the imaging modality of choice for presurgical treatment planning to localize root apex/apices and to evaluate the proximity to adjacent anatomical structures.

Special conditions
Recommendation 10 (implant placement): Limited FOV CBCT should be considered as the imaging modality of choice for surgical placement of implants.

Recommendation 11 (traumatic injuries): Limited FOV CBCT should be considered the imaging modality of choice for diagnosis and management of limited dento-alveolar trauma, root fractures, luxation, and/or displacement of teeth and localized alveolar fractures, in the absence of other maxillofacial or soft tissue injury that may require other advanced imaging modalities.

Recommendation 12 (resorptive defects): Limited FOV CBCT is the imaging modality of choice in the localization and differentiation of external and internal resorptive defects and the determination of appropriate treatment and prognosis.

OSAP intends to bring about patient-safety game changer

The dental profession is at a tipping point with regard to patient safety, says Therese Long, executive director, OSAP, following the 2015 OSAP Symposium in Baltimore, Md. And OSAP – the Organization for Safety, Asepsis and Prevention – intends to make sure that the tilt toward safety is permanent.

Approximately 300 people attended the Symposium, whose theme was “Gain the Edge on Infection Control.”

“We wanted to create and empower champions in the safe delivery of oral healthcare through didactic, interactive and networking sessions,” says Long. “The symposium addressed evolving guidance and emerging issues while delivering the most relevant science, policies and procedures for patient and provider safety and infection control and prevention.”

During the four-day event, speakers addressed a variety of topics, including the Dental Patient Safety Initiative, post-exposure management programs, infection control and handpieces, the roles and responsibilities of the infection control coordinator, eye safety, and the CDC’s One World Campaign. L. Clifford McDonald, MD, FACP, FSHEA, senior advisor for science and integrity in the Division of Healthcare Quality Promotion at the Centers for Disease Control and Prevention, delivered the 10th Annual Dr. John S. Zapp Memorial Lecture.

Twenty-two vendors exhibited their products and services, including OSAP “Super Sponsors” Air Techniques, Crosstex, Henry Schein, Hu-Friedy, Kerr TotalCare, Patterson Dental, SciCan and...
Sultan Healthcare/DENTSPLY. Other exhibitors were 3M, AquaSept, Biotrol, DentalEZ, Door to Door Dental, Halyard Health, Miele, Safe-Vac, SmartPractice, SolmeteX, Sterisil, Stoma Dental and Vistar Technologies.

At the Symposium, OSAP previewed its Safest Dental Visit™ campaign, set for a late summer launch. The campaign features courseware, conferences, speakers and publications designed to support an increased commitment to infection control and safety in dentistry. The program is intended to draw together clinicians, manufacturers, distributors and infection control specialists in a united effort for safety.

“Greater globalization, new and re-emerging threats, and increasingly complex policies and guidelines have transformed the role of infection control in dentistry,” says Long. “Patients are increasingly aware of and concerned about the potential risks of infection and disease from medical and dental procedures. OSAP thinks that a collaborative, profession-facing effort to support dental practitioners and help them communicate to patients the important role infection control in dentistry plays in preventing the spread of disease can be a game changer.”

Next up for OSAP: The Dental Infection Control Boot Camp in Atlanta, Ga., Jan. 11-13, 2016. “Some of the top infection control companies send their reps to boot camp to be trained as they move more into consultative selling,” says Long. “Distributor sales reps who want the leg-up on infection control product and equipment sales should attend. It’s worth the investment of three days.

“It’s a killer course, but people leave with the info they need — and more important, with key contacts to advance their careers and bottom lines.”

OSAP award winners

Therese M. Long, MBA, CAE, was awarded the 18th Annual Dr. James J. Crawford Award, which recognizes lifetime achievement in the field of dental infection control. Crawford is considered one of the founding fathers of dental infection control. Prior to joining OSAP as the organization’s first full-time executive director, Long worked for Johnson & Johnson Medical, where she became acquainted with OSAP, serving on its educational committee then as a board member.

Henry Schein Dental and Patterson Dental were co-recipients of the 14th Annual Dr. Milton Schaefer Award, which recognizes superior service to OSAP. Both companies have donated significant advertising support to OSAP in their publications over the years, and have supported key employees to serve on the OSAP board of directors. Henry Schein Dental initiated and funded OSAP’s pilot training initiative to China in 2014. The company’s vision sparked the newly developed campaign for the Safest Dental Visit™ and National Dental Infection Control Awareness month, and its creative team developed the new campaign materials. Meanwhile, Patterson has supported the printing and distribution of the “Infection Control in Practice” newsletter to the OSAP membership for the past several years, and in 2014, the company invested a significant amount of resources to print and distribute the inaugural issue of ICIP Team Huddle to over 100,000 dental practices.

Jessica Wilson, instrument management and infection prevention specialist for Hu-Friedy, received the 1st Emerging Infection Control Leader Award. Wilson is a national speaker, trainer and educator focused on infection prevention and compliance. Prior to joining Hu-Friedy, she served as a trainer and content specialist of infection prevention for five years in the dental industry. She has worked with hundreds of dental practices helping them understand compliance regulations for infection control, best practices for instrument processing and how to create standardized systems in sterilization.

Jill Hunt, wife of former OSAP board member John Hunt, received the 13th Annual Bette and Paul Schwarz Award, recognizing the spirit of volunteerism for OSAP. Through the years, Hunt has traveled from England to attend several symposia to offer her support to OSAP. She has been involved in making many of the international participants feel welcome through introductions to OSAP members and by organizing activities for them.
A Family Affair

For some, it’s hard to leave work at the office. For Henry Schein Dental’s Betty Jonson, it’s hard to leave family at home.

When Betty Jonson joined Henry Schein Dental in 1992 as part of a first wave of field sales consultants selected to help expand the company’s dental market, she was excited to be a part of its vision. What she herself could not foresee, however, was that over the next 21 years, her husband and two daughters would join her there as well.

Up for the challenge

Years before she joined Henry Schein Dental, Jonson worked with an orthodontic practice. The experience provided her with a strong clinical and practice management background, as well as an opportunity to explore the dental industry at large. “I loved marketing the practice to referring dentists and learned how to network with staff,” she recalls. “I also was very active in the dental societies.”

Soon afterward, Jonson made the transition to a career in dental sales. “I was young, driven, with no fear of failure when I ventured out to the world of dental sales,” she recalls. She joined Meer Dental, an independent dealer, looking to expand to the Midwest. At the time, dentistry and dental products sales were male-dominated fields, and her new employer made it clear that “females are a bad risk,” she says. “However, they said they would consider taking a chance on my abilities.”

Several successful years as a field sales rep put her on Henry Schein’s
radar. “I was approached in 1992 by Henry Schein,” she says. “The company had a clear vision of expanding into the dental market, and I was honored to have been selected among the first wave of field sales consultants to help execute that vision. Henry Schein changed the dental industry. By permitting the sales force to become the total solutions provider – and then training it to do so – the company created a new challenge and a new era of the dental industry.”

Indeed, the dental industry has changed immensely since Jonson began her sales career. “Technology advancement has been an amazing addition to the practice of dentistry,” she says. “From the beginning, I was one of the first sales consultants to offer an option for computer ordering and inventory. Technology has allowed dental practices to focus more on the clinical part of their practice, and it has allowed me the time to focus on educating staff and providing value-added services to my accounts.”

There were a couple of other changes in store for Jonson as well. It wasn’t long before she and her husband, John, had their first daughter, Aimee. Twelve years later, they welcomed daughter Alexa. There were more – and new – challenges, which the Jonsons embraced. Still, it wasn’t easy. Now, in addition to managing a busy sales career, she found herself juggling cheerleading and dance lessons as well. And, raising two daughters 12 years apart also called for some strategizing, she recalls. “Aimee started college when Alexa was in Kindergarten, so at times days were long,” she says. “However, I loved every moment.”

All in the family
Dedicated as she was to her dental customers, for Jonson, family always came first. “I have always tried to be a positive role model for my daughters,” she says. “I’ve always encouraged them to follow their dreams and do something they love to do. They are strong, independent, driven women.”

As it turned out, work and family time often overlapped, which may have played a factor in Jonson’s daughters’ decision to join Henry Schein when they grew up. “I have been blessed to create personal relationships with my clients,” she says. “Most are my friends. My daughters were exposed to dentistry from the moment they were born. Aimee played with a briefcase as a toddler and, when asked what she was doing, she replied, ‘I’m playing dental sales.’” Today, Aimee (Jonson) McNeal is a digital technology specialist for Henry Schein Dental. Alexa, too, chose to follow in her mother’s footsteps. “In 2013, Alexa was an intern at Henry Schein’s global headquarters in New York, at which time she saw first-hand the unique family that Henry Schein truly is,” says Jonson. “She graduated from college last year and has spent the last six months in the field. I find it very motivating watching her develop her confidence, skills and expertise. And, seeing her enjoying her new career is so rewarding.

“I have always tried to be a positive role model for my daughters. I’ve always encouraged them to follow their dreams and do something they love to do. They are strong, independent, driven women.”

– Betty Jonson

“Henry Schein is an amazing company,” Jonson continues, adding that it came as no surprise that her daughters recognized “the opportunities the company provides for personal and professional growth.”

In fact, Jonson’s husband, John, recognized the same opportunity and, in 2003, joined Henry Schein’s Professional Practice Transitions team. “John facilitates the placement of associates and assists dentists who are looking for a succession plan for retirement,” Jonson explains. “His business and finance background has made him a perfect fit for that division. [Together], we have worked successfully on many dental transitions.”

Value-added solutions
A 30-year career in the dental industry has left Jonson smarter and wiser on more than one count. But perhaps one of the most important strategies she has developed has been her ability to
stay connected to her customers. “My reputation is my most valuable asset,” she points out. “My clients know I’m always available. Staying connected via email and text has made communication more effective.”

Particularly as concerns about insurance reimbursement and the need to balance patient fees keep her customers awake at night, Jonson has learned that “you have to build confidence with the clinician, [in order that] that they can overcome their fear of a new procedure. We provide cost-effective solutions for their inventory management system, as well as answer concerns and listen – always with a smile.

“The technology has made it easier to do business with more efficiency,” she continues. “Today, there is definitely a greater focus on value-added solutions for operating efficient practices, so knowing what will allow them to attain that goal is extremely important. Dentists have greater options when it comes to major purchases, and being knowledgeable about these options is very high on my priority list.”

Having a family of four involved in various aspects of dental sales makes it challenging to switch gears come weekends and holidays. “At times it is difficult to turn off the day,” Jonson admits. “We try very hard to turn business off and enjoy family time, but when it’s such a major part of our lives, it makes it very difficult to not engage in shop talk.”

Betty Jonson, Henry Schein field sales consultant, along with her husband John and daughters Aimee and Alexa.

First Impressions Magazine spoke with Aimee and Alexa Jonson about their decision to follow their mother to Henry Schein Dental.

**First Impressions Magazine:** Please share the impact your mother made on you growing up. How did this influence you to join her at Henry Schein Dental?

**Aimee (Jonson) McNeal:** Growing up, my mother taught me that anything is possible with hard work and dedication. I watched her work countless hours making sure she provided her customers with exceptional service. Each year, I watched her grow in her career, even when growth seemed impossible with her success. I remember being five years old playing Meer Dental with her business cards and catalogs. From a young age, I admired my mother so much that I wanted to follow in her footsteps and be a successful, independent woman just like her.

**Alexa Jonson:** Growing up, I watched my mother work very hard at her job, putting in countless hours along with

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**Anything is possible**

It’s not every day that one’s child decides to follow in his or her footsteps. When the whole family follows, that’s a rare thing. Henry Schein Dental field sales consultant Betty Jonson feels fortunate to have her husband, John, and daughters Aimee and Alexa, working close beside her. Her family, in turn, feels the same.

*First Impressions Magazine* spoke with Aimee and Alexa Jonson about their decision to follow their mother to Henry Schein Dental.

**First Impressions Magazine:** Please share the impact your mother made on you growing up. How did this influence you to join her at Henry Schein Dental?
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her constant dedication to Henry Schein. She always had a strong drive to be the best that she could be, and as I watched her grow her dental sales territory each year, she motivated me to work hard in school and everything else. I would watch her wake up at 5 a.m. to put in orders to ensure her accounts were always taken care of. No matter what else was going on in her life, my mom always made sure she took care of business. She has always gone the extra mile for dentists that she works for. Along with my mother’s hard work and dedication to her career, I’ve always known she loves going to work every day, and this has given her a sense of empowerment. I’ve always dreamed of being like my mother and being a strong, powerful, businesswoman. After I graduated college, my ultimate career goal was to work for Henry Schein and follow in her footsteps.

**FI:** How has your mother mentored you at Henry Schein?

**Aimee:** I could not have survived the first few years of my career without my mother! I was so fortunate to have a mentor that I could call with the most random questions. I would always get a good answer. She has been my role model throughout my career. In sales, it is inevitable that there will be bad days. I can always call her on those days to pick me back up. She has always taught me to be persistent and to never give up.

**Alexa:** My mother has mentored me a lot throughout my career. I co-traveled with her for one of my business classes in college, which led to my strong interest in sales and desire to be a part of the company she loves working for. I notice how much of an influence she has in the offices that she works for; her clients fully trust in her expertise and they look to her for advice on all of their practice needs. My mother works as a full-business solutions provider for her doctors and they have grown to love working with her. She has built strong business and friendly relationships that have lasted for over 20 years. I aspire to be just like my mom and to work closely with the dentists that I am working with now. I know it takes time to build these relationships, but she has taught me a lot about communicating with offices and how to take steps to ensure that they are satisfied with the services that they receive from Henry Schein.

**FI:** What is the best part about working closely with family?

**Aimee:** The best part about working so closely with my family is learning from each other. We all have different strengths, and being able to help one another in our individual areas of expertise helps each of us grow and learn every day. It is great to have someone you can go to at any time, who understands and encounters the same challenges. Family dinners can be quite interesting. Dental is always a subject of conversation!

**Alexa:** The best part about working so closely with my family is that they are always there for me if I have any questions or concerns about my work. My mom has a lot of experience and she has taught me many things that I wouldn’t have known otherwise. If I need her help, she is always just a phone call away. It is also nice to attend sales meetings together and spend time with one another while working and doing what we love. I am proud to be a part of the Henry Schein team, as well as a part of my family, who have worked very hard to accomplish all of their goals. My mom, dad and sister all work for Schein and we are very happy with our careers. We all work together to be successful, and that is what makes our bond as a family so strong. I am very blessed to have such incredible role models in my life and I always look to them for advice. I admire my family’s work ethic and I hope to be as successful as my mom is one day. I will always remember the lessons and advice she has taught me in order to achieve my dreams. **FI**
Dennis Borer knows how to repair equipment. He’s been doing mechanical repairs of one sort or another since he was a kid. But for Borer, senior service technician with Goetze Dental, it’s not just about the equipment. “My real passion is helping others improve and grow,” he says.

“I get great satisfaction by helping others improve their skills or making their lives easier by sharing my knowledge and experience with them. This includes my co-workers and those in the offices I serve.”

Perhaps at no time was Borer’s desire to help others tested more than in the aftermath of a deadly tornado that struck Joplin, Mo., on May 22, 2011. Growing up on a small farm south of Kansas City near Pleasant Hill, Mo., Borer had experienced tornadoes before. But none had approached the destructiveness of the Joplin tornado.

“The reports on the news didn’t do the destruction justice,” Borer wrote in an article for the Missouri Dental Association shortly after the tornado. “Had I not had my GPS, I wouldn’t have found the first office. As I looked around, I was surrounded by piles of debris that once were dozens of dental and medical offices. Nothing could prepare one for this. Items of every shape and size were strewn and intermingled as if processed in a blender. Then the human element crept into my mind. How did anyone survive this?”

Borer stayed in Joplin several days, helping his dental customers and others work through the shock of losing their offices, and – for some – their homes and even loved ones. Traveling home, to Independence, Mo., he reflected on what he had experienced.

“I, like most, wanted to make it all go away in one visit, but that’s not real,” he wrote. “We just need to continue to help in our own special way, so their deep wounds will heal and their lives will return to some normalcy.”

Five years in sales
During his high school years and after graduation, Borer worked in a family-owned hardware/auto parts store. “Being a small town, we did everything from roof repairs, plumbing and electrical,” he says. “I was exposed to just about anything that related to a home or automobile. The
He began his career in dentistry in 1975 with Healthco, the now-defunct dental (and medical) distributor, for whom his wife, Vicki, worked as a branch secretary. The company needed part-time help with equipment installations. “I helped them a couple of weeks and was hired full time,” he says.

For five years, he was a field rep for the company, selling both equipment and merchandise. “I enjoyed equipment sales the most, and was probably the most successful at that,” he recalls. As much as he enjoyed sales, however, he found it difficult to be away from his young, growing family. So he went back to equipment installation and repair. In 1993, he joined Goetze Dental.

“I like the diversity of what I do,” he says. “Every day is different and offers different challenges. I thrive on this challenge. We are involved in so many different technologies, and it falls to us to keep them all working in concert.”

Success as a service tech
Over the course of 35 years as a service tech, Borer has learned that success in the field depends on a number of things: creative problem-solving skills, continual education, solid relationships with the equipment salespeople, and, perhaps most important, excellent communication skills.

Creative problem-solving. “Some problems have obvious solutions, while others do not,” he says. “Unlike our dentist customers, our ‘patients’ – dental equipment – don’t tell us where it hurts. Sometimes the equipment just doesn’t want to malfunction while we are there, so we have to get creative to simulate conditions that caused the failure, to get to the core of the problem.” Sometimes the solution calls for Borer to return later with a necessary part. But many times, he can perform a temporary repair to keep the equipment working, then perform the permanent repair at a later time that’s convenient for the dental practice. “You need to respect their time,” he says.

Continual education. “You need to constantly be learning, or you fall behind,” he says. Borer attends as many manufacturer training sessions as he can, but finds help in many other ways as well. “When I need to confirm my thought process while performing a repair, I call the manufacturer for help. Also, with smartphones, it is easy to get technical information online.” The successful tech makes an effort to understand not only how a piece of equipment works, but how it is used in the office. “I try to learn something new on every call,” he adds. “If I see something new or different in an office, I ask questions about it. Who knows? That new item or technique may help someone else or myself in the future.”

Working with the equipment rep. The service tech can be a valuable resource for the equipment rep, says Borer. “I need to provide the information needed to assure success in replacing equipment,” he says. That involves sizing correctly and helping identify equipment that will fit the customer’s current and future needs. “I need to determine if new equipment will physically fit
in an existing space, and provide information for structural and utility changes required for the new equipment. Last, I provide a timeline for each phase of the installation."

**Communication skills.** “To exceed customers’ expectations, you need to have good communication skills,” he says. “Without these skills, important clues are sometimes lost in translation.” The successful tech listens closely to the customer’s description of the problem, and then asks specific questions to pin down exactly what they are experiencing. “Experience has taught me that by not doing this, you waste time chasing assumed symptoms that do not exist.” The successful tech keeps the customer updated on the progress of the repair. “You also need to help the customer feel good about their repair and assert that you have their best interest at heart. By taking this extra step, it builds customer confidence in my company and me.”

**Off-hours**

When he’s not working, Borer enjoys spending time with his wife, Vicki (“who has put up with me for 40 years”), their two children – David and Kristy, and their five grandchildren – Ashley, Emma, Haley, Maddie, and Michael. “I am fortunate that most of my family live close by, so we are together often,” he says.

He has a variety of hobbies. For example, he has built some high-quality furniture, such as tables, cabinets and other things. He owns a welder and does some metalworking as well. And he is a proponent of repurposing, or, as he says, “creating things out of junk.” His repurposing projects include a rod wrapper (for fishing poles), constructed from a discarded dental processor motor; and a rope twister, which he built for his father, made from an old dental chair motor.

And though he doesn’t get into Joplin that often, he is heartened by what he sees there today.

“‘They are definitely on their way back. I do know some offices opted not to rebuild for whatever reasons; maybe [the practice owners were] closer to retirement age. And new businesses rose after this, too.’ The city has improved its infrastructure, and many businesses and homeowners have chosen to establish roots there.

“‘There is one thing that amazed me,’” he says. “‘After the tornado, there was desolation and no leaves. Just a few months after that, it was amazing to see greenery coming back. I just did not expect that?’

Today, the people in the area seem to be more caring, more concerned with their fellow man, he says. “It definitely changed people.”

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“If I see something new or different in an office, I ask questions about it. Who knows? That new item or technique may help someone else or myself in the future.”

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Borer family

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Making a Good Impression

Dentists utilize impression materials for some of the most complex procedures during their day. Inaccuracies will result in longer chair time, increased amounts of work, and perhaps even remakes. None of these situations are ideal in terms of patient care, and can cause frustration to a dentist (and patients).

Understanding the properties of Impression Materials — the techniques and troubleshooting — will assist in a good final result. Critical features are: accuracy, detail, clarity of margins, good color contrast between viscosities, and a final product fabrication that requires little or no adjustment.

Although each situation is unique, there are certain ideal properties that an impression material should possess:

**Wettability (hydrophilicity)**
Impression material should be able to displace moisture and form intimate contact with the tooth and soft tissues. It should not form bubbles or voids.

**Flexibility**
Flexible impressions are easier to remove from the mouth when set.

**Elastic recovery**
The set impression should return to its original dimensions upon removal from undercut areas in the mouth without distortion.

**Tear strength**
The impression must resist tearing upon removal from the mouth, especially in interproximal areas, and when separating the model from the impression.

**Detail reproduction**
Impression material must reproduce the finest details of the oral tissues and be able to transfer these details accurately to gypsum dies.

Desirable features:
- Auto-mixed, easy to use
- Acceptable odor and taste
- Non-toxic and non-irritating
- 1.0-1.5 minutes working time
- 3.0-3.5 minutes setting time
- Distinctive color contrast between viscosities
- Ability to be disinfected
- Compatible with die materials
- Adequate shelf life
- Cost effective

With the addition of CAD/CAM and Digital Impressions, many readers have asked us about the future of impression material. Even in the age of Digital Dentistry, Impression Materials will never disappear. Impression materials are beginning to become scannable, as many processes at laboratories change. Dental laboratories are often scanning impressions, and many chairside impression scanners are being introduced to dental practices. Even the practices that are milling in office will tell you that they have impression material on hand for difficult to scan cases, or patients who cannot tolerate powders or intraoral scanning.

How can a dental representative be most helpful to a practice in regard to impressions? First, know the different techniques used in dentistry, and the products that solve a particular clinical challenge faced when taking impressions. Second, keep a close watch on dental practices that hop between brands or return impression materials. It’s likely something is not working in their impression taking process. Remember that the impression supports one of the more profitable procedures in the practice, so retakes and redos are not only irritating, they are costly. Finally, ask your offices if they are happy with their seat times. Although impression materials are only one part of a successful preparation, asking if crowns and appliances fit is a key indicator and could lead to other product discussions. FI
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Candace Myers  Michael Ongay  Angela Paulsell  Garrett Pizzaloto  Will Rodriguez

Katie Shaughnessy  Jamie SingletonBooth  Jamyang Tashi  Corrin Wolf  Mallory Zivney
Benco Dental Appointee Announcements

David Bedford, Territory Representative
The Benco Dental team welcomes David Bedford in the Trailblazer region. Bedford, a Pepperdine University graduate, brings 16 years of dental and sales experience to the Benco Dental family. He will call on customers in Sacramento, California.

Kara Brown, Territory Representative
Benco Dental is pleased to welcome Kara Brown to its Gateway region. Brown brings more than five years of dental and medical experience to the Benco family.

Jill Davies-White, Territory Representative
The Benco Dental team in the Trailblazer region welcomes Jill Davies-White. She will call on customers in the Sacramento area, Yuba City and Davis, California. The Sierra College attendee brings four years of dental experience to the position.

Steve Dutson, Territory Representative
The Benco Dental team in the Desert region welcomes Steve Dutson. Along with an MBA from Thunderbird AGSIM and a B.A. from University of Utah, Dutson brings five years of dental experience to the position.

Bob Frein, Territory Representative
Bob Frein is part of Benco’s SoCal region. Frein, who brings 23 years of dental industry expertise to the position, will call on customers in Southern California.

Angie Hines, Territory Representative
Angie Hines joins Benco Dental’s team in the Ohio Valley region. Hines will call on customers in Pittsburgh, Pennsylvania.

Darla Jones, Territory Representative
Darla Jones joins Benco Dental in the Midsouth region. A University of Arkansas Little Rock graduate, Jones brings seven years of dental experience to the position.

Nikona Jones, Territory Representative
Benco Dental is pleased to welcome Nikona Jones to its Trailblazer region. The Registered Dental Assistant will call on customers in Turlock, Modesto, Merced, Manteca, and Stockton, California. Jones brings more than 14 years of dental experience to the Benco family.

Nancy Regalbuto, Territory Representative
Nancy Regalbuto joins Benco Dental in the Ohio Valley region. The West Virginia University graduate will call on customers in Morgantown, West Virginia.

Mike Warner, Territory Representative
Mike Warner joins Benco Dental in the Blue Ridge region. A North Carolina State University graduate, Warner brings nine years of dental and sales experience to the position.

Henry Schein Appointee Announcements

Lacie Knowles, CAD CAM Specialist
Knowles will represent Henry Schein Dental in the Arkansas/Oklahoma area. She has 15 years of experience in the dental industry and was previously employed as an account executive. Knowles received her B.S. from University of Arkansas at Monticello in Monticello, AR.

Ryan Schlosser, CAD CAM Specialist
Schlosser will represent Henry Schein Dental at its center in Pittsburgh, PA. He has 13 years of experience in the dental industry and was previously employed as an exclusive products specialist. Schlosser received his B.S. from University of Pittsburgh in Pittsburgh, PA.

Robert Martiny, CAD CAM Specialist
Martiny will represent Henry Schein Dental at its center in New Orleans, LA and Jackson, MS. He has 38 years of experience in the dental industry and was previously employed as a digital technology specialist.
Charles Picou, Field Sales Consultant
Picou will represent Henry Schein Dental at its center in Fresno, CA. He has nine years of experience in the dental industry and was previously employed as a territory representative. Picou received his B.S. from California State University, Fresno in Fresno, CA.

Frank Spanish, Field Sales Consultant
Spanish will represent Henry Schein Dental in the Minnesota area. He has 41 years of experience in the dental industry and was previously employed as a field sales consultant. Spanish received his B.S. from University of Minnesota Duluth in Duluth, MN.

Annika Swenson, Digital Technology Specialist
Swenson will represent Henry Schein Dental in Dallas, TX. She has 13 years of experience in the dental industry and was previously employed as a sales representative. Swenson received her B.S. from University of Colorado in Boulder, CO.

Danny Calabrese, CAD CAM Specialist
Calabrese will represent Henry Schein Dental in the NYC/Westchester, NY area. He has 10 years of experience in the dental industry.

Adrienne Deranian, CAD CAM Specialist
Darianian will represent Henry Schein Dental at its center in Waltham, MA. She has two years of experience in the dental industry and was previously employed as an exclusive products specialist. Deranian received her B.S. from University of Vermont in Burlington, VT.

Marc Kohli, CAD CAM Specialist
Kohli will represent Henry Schein Dental at its center in Syracuse, NY. He has seven years of experience in the dental industry and was previously employed as a territory manager. Kohli received his B.S. from Barry University in Miami, FL.

Jocelyn Franco, Field Sales Consultant
Franco will represent Henry Schein Dental at its center in Albuquerque, N.M. She has 37 years of experience in the dental industry and was previously employed as a territory manager. Franco received her B.S. from University of New Mexico in Albuquerque, NM.

Kelly Krinkie, Field Sales Consultant
Krinkie will represent Henry Schein Dental in the Minnesota area. She has 14 years of experience in the dental industry and was previously employed in outside sales. Krinkie received her B.A. from University of Minnesota Duluth in Duluth, MN.

Lisa Enneking, Field Sales Consultant
Enneking will represent Henry Schein Dental at its center in Columbus, OH. She has 14 years of experience in the dental industry and was previously employed as a field sales consultant.

Erica Clark, CAD CAM Specialist
Clark will represent Henry Schein Dental at its center in Birmingham, AL. She has five years of experience in the dental industry and was previously employed as a treatment coordinator. Clark received her B.A. from University of Alabama at Birmingham in Birmingham, AL.

Dave Schellenberger, Field Sales Consultant
Schellenberger will represent Henry Schein Dental at its center in Louisville, KY. He has two years of experience in the dental industry and was previously employed as an exclusive products specialist. Schellenberger received his B.A. from The Ball State University in Muncie, Indiana.

Chris Stromdahl, Field Sales Consultant
Stromdahl will represent Henry Schein Dental at its center in Auburn, WA. He has two years of experience in the dental industry and was previously employed as an exclusive products specialist. Stromdahl received his B.A. from University of Washington in Seattle, WA.
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