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About the Cover: A montage of photos taken at the House of Delegates meeting, showing the spirit, diversity and solidarity of our CDHA members.
From the Editor’s Desk

A Conversation. . .

Our country, and her citizens, are known for venturing out on “grand adventures.” The home of the brave and the free has always welcomed those who were ready to tackle a challenge and see how they could make something better.

That’s what your representatives decided to do at the recent House of Delegates – to venture forward as an independent California Dental Hygienists’ Association. For details of the House of Delegates proceedings, check the messages from President Julie Coan and Speaker of the House Susan Lopez.

So what do we hope to achieve for you – our members and the dental hygiene community?

• To listen to you and your concerns as students, clinicians and members of the dental community
• To translate your concerns into action on your behalf
• To advocate for our profession and our patients
• To continue the conversation that helps us learn from each other so we can…
  o Encourage people to pursue a dental profession...
  o Support them toward success as both students and graduates…
  o Help those graduates “pay back” to their community as they apply their skills…
  o Encourage colleagues to pursue alternate paths in education, corporate, and public health venues…
  o And, most importantly, gather more of our colleagues into our CDHA family to… continue the conversation.

So, if you’ve already joined CDHA — we’re hoping you’ll be part of the discussion.

If you haven’t yet joined us, we hope you join our grand adventure. There’s a membership application in this issue, just for you — please tear it out and send it in. We’re saving you a seat at the table and hope you will join the conversation.

About the Editor

Liz Moore graduated from USC and embarked on a clinical 32 year clinical career. She transferred to the corporate world and has recently retired from DentsplySirona Implants as an Executive Territory Manager providing dental implants and bone regeneration materials as well as product training and educational programs to the dental community.

Liz has served as an elected School Board Trustee and on a County Commission of School District Organization. Her community activities included both local and state service in the American Association of University Women. She has served CDHA as Speaker of the House, Vice President of Administration & Public Relations and Editor of the CDHA Journal, a position to which she is now returning. She stresses the Journal relies on the efforts and talents of the entire Journal Advisory Board.
Cathy Draper, RDH, MS, has served dental hygiene in many ways over many years. Most recently she served as Editor of the CDHA Journal with excellence and style. Although she’s retired from that position, we want to thank her for all she brought us through the Journal.

In the whirlwind frenzy of summer traveling for business and pleasure, Cathy Draper graciously invited me to her San Jose home for this interview. Cathy had recently returned from the ADHA Annual Session in Pittsburgh, Pennsylvania and was preparing her presentation for the 2016 International Federation of Dental Hygienists (IFDH) in Switzerland.

Cathy is a graduate of Foothill College and has a Master’s of Dental Hygiene from the University of Michigan. After marrying her Canadian husband, the two moved to Munich, Germany, “just for the adventure.” After learning German, Cathy practiced clinically and taught advanced concepts to dental assistants.

On the move since she began her dental hygiene career over 40 years ago, Cathy continues to find more ways to contribute to the profession as educator, clinician, and author.

In addition to her service to CDHA and ADHA, Cathy is a frequent contributor to a variety of dental hygiene publications. She has also been a library reference associate at the Stanford Hospital Library since 1994, assisting patients and families to access health information. Cathy has been honored with the Stanford Health Library Volunteer of the Year Award.

Cathy’s dental hygiene education has taken her many places, providing numerous opportunities, including leading a delegation of dental hygienists to the People’s Republic of China in 2001. She continues to seek new avenues to collaborate with other healthcare professionals to integrate oral health with total health.

Q: What attracted you to dental hygiene as a career?
A: I initially wanted to be a teacher but there were few opportunities at the time. As I began exploring other avenues, my neighbor, a dentist, suggested dental hygiene. It seemed a good fit as I liked science, especially biology, and I could still be a teacher. I set my path and have been practicing since I graduated in 1975.

Q: How did you come to have such an expansive professional experience?
A: As a newly licensed RDH, I knew that I wanted more flexibility beyond clinical practice. After completing my AS Degree in Dental Hygiene, I was back in school completing my BA in Health Education. As a dental hygiene educator I would need advanced education to move beyond the operatory so I set my sights on completing my MS Degree in Dental Hygiene at the University of Michigan. At the time there was no masters degree program in California. I enjoyed private practice and direct patient care, but wanted to prepare myself for more options and other opportunities. I took a “detour” when I married and moved to Munich, Germany where I learned German and found a local dentist who was thrilled to hire an American dental hygienist. I was also asked to perform school screenings at the International School and gave several continuing education courses to dental assistants, “auf Deutsch,” of course!

By the time I returned to California, my family included two sons and a third on the way. I wasn’t sure if I would ever return to dental hygiene. While managing childcare was a major challenge, I was able to work two days a week after my fourth son was born. As the years passed I was able to take advantage of leadership opportunities at the local, state and national level.

I was also able to do more public speaking, initially to share my experiences working abroad and later to present continuing education. The courses included dental implants, new technologies, evidence-based practice, and caring for patients with cancer. Opportunities to write articles for dental hygiene publications followed, leading up to my appointment as editor of the Journal of the California Dental Hygienists’ Association. I have also been able

Thanks to Cathy Draper

Carol Lee, RDH, MS

Educator Stresses Importance of Performing Cancer Screening for Our Patients
to pursue my goal of teaching in a dental hygiene program at my alma mater, Foothill College in Los Altos Hills.

Q: What’s the most important thing YOU have learned while educating other dental hygienists?

A: As a lecturer/educator I always try to inspire my audience/students to consider themselves as being part of the healthcare team. Hygienists have an excellent education that often gets lost in the daily routine of hygiene recall patients. We need to think beyond “cleaning teeth” and consider ourselves as healthcare providers. Scaling and root planning are only a part of what we do. The health education we provide our patients is often far more important than the last speck of calculus on the distal of #15. Hygienists have the opportunity to influence positive change in the lives of the patients they care for on a daily basis.

Q: What do you feel is one of your favorite and most impactful topics?

A: The oral cancer exam is the most important 2 – 3 minutes of your dental hygiene care appointment. Hygienists play a key role in educating patients and the public about the increasing risks of oral cancer as well as the role we all play in screening and early detection. Every patient, no matter what their age, should have a head and neck exam each time we see them. The incidence of oral cancer is increasing in traditionally low risk populations due to the Human Papilloma virus #16. Lesions and swellings that do not resolve within 7 to 10 days require follow-up. While there are a number of screening devices available to dental practitioners, the only way to make a definitive diagnosis is with an incisional biopsy. An oral pathologist should interpret tissue biopsies from the oral cavity.

Committed to oral cancer awareness, as a faculty moderator for the Foothill College Dental Hygiene Program Student Chapter, I was able to work with my students to organize an Oral Cancer Awareness Walk on our campus. The students raised over $5,000 for the Oral Cancer Foundation in what is now an annual event. I also present a continuing education course, “Providing Compassionate and Comprehensive Care for Patients with Cancer,” focusing on the role the dental team plays in supporting patients through their cancer treatment and beyond.

Q: What trends do you see in dental hygiene care?

A: One of the trends in dental hygiene care I see is the tendency to think of dental hygiene as part of the dental “industry” and to look at our profession exclusively from the business side. Many CE presenters speak of the business of dental hygiene and production while losing sight of what it means to be a member of a health care profession.

Q: Please share your global perspectives of dental hygiene?

A: My dental hygiene career has taken me a number of places around the world yet it is a bit ironic that I ended up coming back to my Northern California home base and will finish out my clinical career in the same practice I started in back in 1975 and teach in the same community college I attended myself! People are often surprised when I tell them that I lived almost seven years in Germany and that I went to graduate school in Michigan. I think that it is very important to step outside of your backyard and look at the world, our profession and yourself from different perspectives. Having lived in a European culture, I became very sensitive to how Americans are perceived by others, rightly or wrongly. I learned from those experiences to be much more open to listen to other perspectives regardless of the problem or task at hand. In terms of the issues and challenges the dental hygiene profession faces on a global level, I have found that we share much in common, no matter what the country or culture. In my experience, overcoming issues related to the dental team, the hierarchical order of roles, and the responsibilities between staff (dentists, assistants, office

Continued on Page 20
Message from the President

Transitioning to a New Future

As summer shifts into fall, I’m pleased to say CDHA is moving forward as an independent professional organization. Our membership is growing daily, as more California hygienists join in support of CDHA. At our recent Leadership and Board of Trustees meeting in Sacramento, it was exciting to see our New Professionals actively participating in the decision-making process for CDHA’s future. The commitment to make our decision to break away from the national organization a successful one was evident. Fruitful and full discussions were shared among board members, and challenging decisions were made to invest in our future growth. One result was the addition of two new staff members at our Central Office; their tasks will be to ensure a more positive and robust future for CDHA. We welcome both Vickie Kimbrough RDH, MBA, PhD as our new CDHA Executive Administrator, and Bryan Sapp as Member Services Representative. They’re here to serve you.

CDHA’s primary focus is to represent and serve its members by providing quality educational programs, affordable liability and disability insurance, employment services, labor issue support, purchasing discounts, legislative representation, professional coalitions to increase professional opportunities, and events that support networking and social interactions. Our goal is to be relevant, interactive, responsive, and inclusive as we invite all of our members to become a part of the CDHA conversation. We will achieve these goals through your support.

Membership is the lifeblood of our organization, and it is even more important as we transition into a new future. The decision to become independent required much thought and consideration, as well as vision and courage. The decision was made to protect and preserve CDHA’s ability to serve all of its’ members - students, new professionals, professional, retired, allied and future members. Your membership matters. It all makes a difference - from writing that check, attending a continuing education course, becoming involved with your component, participating at community service events, to serving on a council or running for an elected position. CDHA has something to offer every dental hygienist in California and each of you has something to offer to your profession. We want you to be successful!

As your president, I’m honored to serve this organization and to carry out the vision to make this historic decision a successful one. This success will require participation by both our current leaders and our future leaders. Be a part of that success, be a part of CDHA.

If you’re currently a professional member, I want to thank you for your commitment to your professional organization. If you haven’t taken that first step, I encourage you to do so today! I’m excited about what’s in store for CDHA! Be a part of the conversation, as we transition into a new future!

**CDHA strong, CDHA proud, CDHA now!**

Julie Coan, RDH, MPH
CDHA President 2016-2017

About the President

Julie received her certificate in dental hygiene from Diablo Valley College in 2002, and began practicing as an RDH in her hometown of Antioch. In 2009, she received a Bachelor’s degree in dental hygiene from Loma Linda University and began her teaching career as adjunct faculty for the Chabot College Dental Hygiene program. Having earned a Master’s in Public Health from Loma Linda, she recently became full-time second year lead faculty at Chabot.

Julie has been active in her professional organization since graduation, having served as President of Mt. Diablo Dental Hygiene Society. At CDHA she served as Student Relations Council Chair, Vice President of Administration and Public Relations, and is honored to currently serve as President of CDHA.
The 2016 House of Delegates (HOD) was an historic meeting that resulted in a momentous outcome for the future of CDHA. Fresno was the site of this year’s HOD that concluded and celebrated President Lygia Jolley’s unprecedented year of “Guiding Our Profession.” Her theme for the weekend was “Hitting One Out for CDHA.” With that spirit and guidance, the delegations, led by Speaker of the House, Susan Lopez, began the weekend.

Due to the complexity of issues to be addressed at the HOD, the 150 delegates came well prepared and well informed. Delegates and students gathered to decide CDHA’s future after months of consultation with CDHA members at component meetings, discussions at CE events, component town halls, and conference calls concerning the Proposed Resolutions, Bylaws, and our tripartite association with ADHA.

ADHA President Jill Rethman and Executive Director Ann Battrell addressed the House and took questions from delegates prior to the Opening Ceremonies. To provide guidance and information to this First Session of the House, the Executive Board was joined on the podium by CDHA Parliamentarian Gerry Olsen and lawyers representing CDHA from Knox Lemmon & Anapolsky. CDHA legislative advocates Aaron Read and Terry McHale from Aaron Read and Associates were also present.

The students recognized the importance of the decisions made at this HOD for their future and decided, rather than have their scheduled Student House of Representatives in a separate location, to remain on the House floor throughout the weekend for all discussions and voting. The Voting Student Delegates were Cayce Waipa from Carrington College Sacramento and Jonathan de la Cruz from Concorde College San Diego.

President Jolley led the Opening Ceremonies and received a Legislative Proclamation in recognition of her successful year guiding CDHA. Her “State of the Association” speech summarized the activities of CDHA’s hard working and effective councils and committees. Kristy Menage Bernie acknowledged the passing of Dr. Margaret Walsh and highlighted her many accomplishments that have advanced our profession.

Saturday began with the Candidates Forum followed by the Second Session of the House.

Reference Committee A – Chair: Vickie Kimbrough (Kern) and members Ashley Quezada (San Diego), Zoe Milke (Tri-County) and Colleen Beasley (Napa/Solano) presented their recommendations. Informative and vigorous floor discussions were followed by a votes on:

- **PR (Proposed Resolution) B** – Be it resolved that CDHA sign the Proposed American Dental Hygienists’ Association Constituent Charter Agreement dated October 30, 2015. PR-B was rejected with a ballot vote of Yes-14, No-140. This vote separated CDHA from ADHA.
- **PBY (Proposed Bylaw) 7** – Amend Article I Title, Section 1.01 Name to read: This Association is a California Mutual Benefits Corporation. PBY-7 was approved.
- **PBY-8** – This included 11 changes to CDHA Bylaws to remove references to ADHA and clarify finances, membership, components and supremacy as an independent association. PBY-8 was approved with a proviso which nullifies the changes if CDHA signs the ADHA Charter prior to the end of the October BOT.

Sunday’s Third Session of the House began with Student Speaker of the House Rachel Richards of West Los Angeles College calling...
the meeting to order. Speaker Richards remained at the podium as Co-Speaker of the House.

The Report of the Tellers informed the House of the election results:

Vice President of Administration and Public Relations:
Darla Dale, of Six Rivers Component

President Elect: Lory Laughter, of Mount Diablo Component

These newly elected officers joined the returning executive officers as well as the Trustees for the installation ceremonies presided over by Kristy Menage Bernie. The President’s gavel was passed to CDHA’s new president Julie Coan. Her daughters and husband shared their respect, love and admiration of President Coan with the House.

Reference Committee B – Chair: Rhonda McMorran (Orange Co.) with members PJ Attebury (Los Angeles), Mary Newton (Ventura), Gail Starling (Redwood), and Diane Okubo-Fong (San Francisco) reported out on bylaw changes that: clarified components HOD delegate count; stated who are the voting members of the HOD and BOT (to align CDHA Bylaws with non-profit tax laws); and Proposed Resolution A that stated CDHA opposes the marketing and sale of all tobacco products.

Reference Committee C – Chair: Diana Thompson (South Bay), supported by Carrie Sharp (Shasta), Kristy Menage Bernie (Mt Diablo), Stormy Li (Tri County) and Kristina Mankins (Central Coast) recommended approval on: the CDHA Budget; Professional dues at $210; Retired, Disabled and New Graduate dues at $105; Bylaw changes clarifying CDHA’s “Dissolution” protocols and financial policies. All Bylaw and Resolutions from Reference Committee B and C were adopted by the delegates.

The Sessions were masterfully supervised by the House’s Sergeant-at-Arms, Tricia Osuna and Credentials Chair, Mariann Fujimoto.

The complexity of the House business during the days gave way to the celebrations of CDHA in the evenings. Friday night’s President’s Reception began with baseball themed festivities with food, fun and dancing. Saturday night was “CDHA Night at the Ballpark.” Following a short walk to the Grizzlies Ball park, CDHA members were treated to a pre-game party as well as recognition on the scoreboard throughout the game. CDHA members provided oral cancer screenings during the game. Saturday’s President’s Luncheon acknowledged the support of CDHA’s many sponsors and honored Susan Lopez with the President’s Award. The 2016 House of Delegates was an extraordinary meeting. All members understood the magnitude and consequences of their votes. Personal partialities were set aside for the good of CDHA.

The members were resolute in their decision - they had moved CDHA forward in the best and only way to meet the needs of their association, their profession and the public.

**CDHA STANDS ALONE –**

**CDHA STANDS TOGETHER –**

**CDHA STANDS STRONG**
YOUR Employee Rights

Do you know your rights as an employee?
Are you doing all you can to protect your paycheck and your financial security?

As valued employees and team members, we should speak with our dentist employers openly and frankly about any concerns we have regarding office employment policies. Right! The reality is that some employers are more approachable than others. Hopefully you have a good relationship with your employer, but failing discussions with the “boss,” it is important to know and understand which labor laws apply to dental hygienists and where to go for help. A wealth of information is available on official government labor sites.

Here, we focus on a key current issue for many hygienists: having your paycheck reduced due to openings in the patient schedule and the resulting lack of financial security. Under the law, employers can require you to clock-in, clock out. However, the labor laws determining whether or not your pay can be reduced for openings or changes in the patient schedule are less clear. There are many complex rules, exceptions and special circumstances which may come into play.

CDHA met with a legal representative from the Employment Development Department (EDD) in 2012. We were advised that if the understanding between the hygienist and the employer is that you are hired to work a certain period, whether that is a full day or partial day, you are entitled to pay for that full period. It does not matter if your salary was based on an hourly or daily rate, and it is not dependent upon the patient schedule. More recently in 2016, a hygienist following CDHA recommendations asked their local California Department of Industrial Relations (DIR) Labor Commissioner if their pay could be reduced for patient no shows or other openings in the patient schedule. The response was no and that hygienist reached an understanding with her employer. Bottom line, no pun intended, it is the understanding between employer and employee about the terms of employment that matter, whether verbal or written.

What should you do? Dental hygienists are not lawyers and CDHA does not provide legal advice nor can we interpret the laws. A good place to go for advice on employee rights and possibly free legal assistance is the National Labor Relations Board (NLRB). Provide as much detail about your particular work situation as possible including your understanding of the job required, work period you were hired for and the pay expected. You do not need to belong to a union for the NLRB to help you. To find their nearest office: www.nlrb.gov.

You should file an inquiry or a claim with the following state and federal agencies. Only they can make an official determination of the laws that apply in your situation. Do not wait too long to speak up, make inquiries or file a claim. It is easier to prove you are owed wages or benefits when events are close in time. Plus there is a statute of limitations. Generally, you have three years to bring a formal claim.

• Labor Commissioner, also known as the Division of Labor Standards Enforcement, Enforcement of the DIR, for questions about your employee rights or work arrangements, worker’s compensation or Cal/OSHA, or to file a claim for back wages. Go to www.dir.ca.gov/dlse/DistrictOffices.htm to find your local office;
• Employment Development Department (EDD) at www.edd.ca.gov for information on Unemployment Insurance benefits, State Disability Insurance benefits or if you are unable to work because of sickness, injury or pregnancy including while waiting to receive worker’s compensation benefits;
• The IRS can help you with employer matched Social Security and Medicare payments (www.irs.gov).

The law is the law. Employee/employer issues do need to be addressed. There are serious ramifications for both employees as well as employers if labor laws are not applied correctly. And if we wish legislators or the regulatory agencies to change or strengthen the enforcement of labor laws, they need to know that there are problems.

CDHA has developed a more detailed paper on labor laws and employee rights as they relate to dental hygienists. We’ll get into other aspects of labor law in future Journal issues.

About the Author

Lisa Okamoto, RDH, AS graduated with honors from the Foothill College Dental Hygiene Program in Los Altos Hills. Her 36 year career in dental hygiene includes general and periodontal private practice, as well as clinical teaching at Foothill College. A member since graduation, Lisa is a past president of the California Dental Hygienists’ Association. She became co-chair of the CDHA Government Relations Council in 2013, the same year she was honored for her leadership and service with the CDHA President’s Recognition Award.
Caring for Vulnerable and Compromised Patients

Call to Action: RDHAP and the care they provide for vulnerable patients are again under attack. Go to CDHA.org to learn how to contact your legislators and share this story with them.

On July 15, 2016, the Department of Health Care Services (DHCS) implemented new policies that make it extremely difficult, if not impossible, for many patients to receive the necessary oral health care provided to them by Registered Dental Hygienists in Alternative Practice (RDHAP). The patients affected are among our most vulnerable -- the elderly, developmentally disabled and medically challenged residents living in Skilled Nursing (SNF) and Intermediate Care (ICF) facilities, residential care homes or who are homebound.

DHCS is requiring pre-authorization for scaling and root planning (SRP) periodontal treatment, including supporting documentation and full-mouth radiographs or intra-oral photographs, which are not feasible or reasonable for these patients. CDHA is concerned that the pre-authorization requirements are being used by DHCS to deny care to patients in nursing homes or the homebound...just as DHCS has used them to deny care for patients who are able to visit dental offices.

To make matters worse, Denti-Cal reduced reimbursement rates by over 50% for follow-up and periodontal maintenance services, the standard of care for patients with periodontal disease. RDHAP are independent, small business owners and, like the private or portable dentist, run practices that involve extensive and often unseen business costs. At the lowered reimbursement rate, RDHAPs cannot sustain the cost of providing periodontal care to these patients in the settings where they reside. In effect, countless patients will no longer have access to the care they need.

It is far more cost effective, and less painful, to prevent disease than it is to treat it. The National Children’s Oral Health Foundation projected that $1 invested in prevention (dental hygiene services) saves as much as $50 in restorative care and emergency room visits. While DHCS added preventive procedures that apply to healthy mouths, it did not address the periodontal disease existing in the mouths of most SNF/ICF residents.

State funding is currently focused on health care for children, but we must not forget our elderly and disabled. They are at equal if not higher risk than children for dental disease due to systemic conditions and the side effects of numerous prescription medications. Over 60% of adults, 65 years of age and over, have periodontal disease. Under the new DHCS policies, periodontal disease for these vulnerable populations will advance, contributing to the deterioration of their overall health. Without the ongoing care provided by the RDHAP, the cases of aspirational pneumonia will once again be on the rise in nursing homes, as oral bacteria increase to levels that directly relate to this type of preventable pneumonia.

In April 2016, California’s Little Hover Commission issued a report supporting the RDHAP, noting that a majority of California dentists do not participate in Denti-Cal due to the low reimbursement rates and administrative obstructions. Few dentists are available to serve the ongoing needs of the 350,000 Californians who are cared for in Long Term Care facilities annually. For over 20 years, the RDHAP have filled this void, providing effective clinical preventive care, dental caries assessment and coordination of care for this neglected population. Now, as a result of the new DHCS policies, this population will once again suffer greater neglect.

DHCS and key legislators have committed to meet this fall to discuss the policy’s outcomes to that point. In the meantime, the oral health of countless elderly and developmentally disabled rapidly deteriorate!

About the Author

Karine Strickland, RDHAP, BS, is an actively practicing RDHAP providing care for elderly and developmentally disabled. Karine is the current CDHA Alternative Practice Council Chair, a past president of the California Dental Hygienists’ Association, and a 37 year member of CDHA. She is an advocate for prevention and the provision of quality care.
Learning Objectives

After completing this course, participants will:

- Understand the terms, literacy, numeracy, health literacy, and oral health literacy
- Appreciate the impact, including the costs and effects, of low health literacy
- Comprehend the breadth of skills needed to be health literate
- Know how to identify low health literate patients

Introduction

Literacy and health literacy are hot topics in modern healthcare, and for good reason. Compared with a non-literate person, a literate person is better able to find, evaluate, understand, and use health information to benefit themselves and their loved ones. Limited literacy can interfere with understanding and the ability to act on complex and unfamiliar health information, so it is an obstacle to improved health just as much as, or more than, the traditional obstacles such as finances and education.

This continuing education program will review the basic elements and consequences of low literacy, low health literacy, and low oral health literacy, and offer ideas for how to identify low literate people. The companion Practice Pointers article, Caring for and Communicating with Low Health Literate Patients, will offer strategies for working with this population.

Literacy

The term “literacy” to most people refers to the ability to read and write, but it is much more than that. The full definition of literacy includes three main areas of knowledge: print literacy, or reading and writing; numeracy, or a facility with numbers, mathematics, dates, and times; and oral literacy, the oral/aural exchange, or the ability to speak and make oneself understood, and also to listen, understand, and remember what others say.

Low literacy is a problem in the United States. The National Assessment of Adult Literacy (NAAL), published in 2003, found that approximately 93 million United States residents, roughly four out of every ten people, function at below basic or basic levels of prose literacy. In March of 2016, The Organization for Economic Co-operation and Development (OECD) released the preliminary findings from their Program for the International Assessment of Adult Competencies (PIAAC). This massive study built on the NAAL but added an international component, studying literacy, numeracy, and problem solving in technology-rich environments in adults aged 16-65 in 24 countries. Technological problem solving is a relatively new area of research that reflects the demands of the digital age.

The data from the PIAAC are still being analyzed, but both studies, and others, have found deficiencies in the literacy, numeracy, and technological problem-solving skills of American adults, and poor performance compared with other developed countries. The United States ranked eighth in literate skills and eleventh in numerate skills, and its technology problem-solving score was below the international average.
Demographics of Low Literacy

Who are low literate people? This is not always obvious. The majority are white, were born in the United States, and speak English with native fluency, mainly because this is the largest demographic group in the country. There are also high percentages of low literate people in the lower socioeconomic classes, certain ethnic and cultural groups, people with less than a high school education, those who did not learn English as they grew up, and elders over the age of 65, especially if they also belong to any of the other groups.3

Health Literacy

Health literacy is the ability to find, understand, evaluate, and use health information to achieve and maintain wellness.7 Literacy level and health literacy generally correlate with each other, so the terms are often used interchangeably,8 and the demographics are roughly the same as described for low literacy.9 In order to be health literate, people must be able to read, write, compute, speak, and listen, but at a more complex level than in familiar environments. They must understand treatments, medications, specialists, technology, a strange language, and be able to complete complex forms.10

Because of the unfamiliarity and the difficulties that can be encountered in health and healthcare, and because pain, fear, illness, uncertainty, and the effects of medications can be involved, even highly literate people often struggle with health literacy.8 Scholars estimate that approximately one in ten American adults are health literate.5,11 The following story illustrates one common misconception among low health literate people:

Former New York Mayor Rudy Giuliani had a test for prostate cancer. When the test came back positive he thought he was well. Then he learned that a positive test meant he had cancer. Even such a highly educated and literate person as Giuliani can misunderstand health information. He told a reporter, “I keep getting positive and negative mixed up….I kind of think of negative as bad and positive as good.”12

<table>
<thead>
<tr>
<th>Figure 1: Skills Needed to be Health Literate3,16,44,45,46,47</th>
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<tbody>
<tr>
<td><strong>Print Literacy</strong></td>
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<tr>
<td>Understand the fundamentals of personal health, including oral health, and the workings of the human body</td>
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<tr>
<td>Read, understand, &amp; follow instructions</td>
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<tr>
<td>Read appointment reminders</td>
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<tr>
<td>Complete forms: health history, consent, insurance, HIPAA, others</td>
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<tr>
<td>Read instructions regarding use, contraindications, side effects, and storage of prescription &amp; over-the-counter medications</td>
</tr>
<tr>
<td>Understand medical, dental, medication, &amp; insurance language</td>
</tr>
<tr>
<td>Read food &amp; nutrition labels</td>
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<tr>
<td>Read signs &amp; maps to navigate a hospital or office building</td>
</tr>
<tr>
<td>Understand patient’s rights &amp; responsibilities</td>
</tr>
<tr>
<td>Find reliable health information in print and electronic sources</td>
</tr>
<tr>
<td>Evaluate health literature &amp; websites for relevance, accuracy, and currency</td>
</tr>
<tr>
<td>Weigh dense, conflicting, complex, unfamiliar information &amp; make decisions</td>
</tr>
<tr>
<td>Understand safety precautions at work &amp; home</td>
</tr>
</tbody>
</table>

Please note: Skills are placed in their primary areas of literacy, but many skills can overlap.
Health literacy has been called the “currency” for negotiating complex modern healthcare systems, the “newest vital sign,” and the “sixth vital sign,” as important in assessing health as temperature, pulse, respiration, blood pressure, and pain level. The report, “Health Literacy: Implications for Australia,” which drew heavily on research conducted and published in the United States, concluded: “Low health literacy is a statistically independent risk factor for poor health. From an epidemiological perspective the risk of increased mortality stemming from limited health literacy is nearly the same as the impact of chronic disease — even after controlling for age, race, gender, income, education, health status, health behaviours (sic), health access and psychological status.”

Health professionals understand the issues, language, and reasoning used in healthcare. It is easy to take that knowledge for granted and to forget how much is known and what it was like before knowing it. Figure 1 outlines many of the skills needed to be health literate, dividing them into the three areas of literacy described above. This is not an exhaustive list, but it is representative of what patients are called upon to know as they try to navigate the complex and sometimes bewildering world of healthcare.

Health Numeracy

The concept of numeracy deserves mention on its own. It is formally defined as “the ability to access, use, interpret, and communicate mathematical information and ideas, to engage in and manage mathematical demands of a range of situations in adult life.” Numeracy requires attention because of its considerable impact in healthcare (see Figure 1). The concept has generated a few reports from government and private sources, most notably “Health Literacy and Numeracy,” published by the Institute of Medicine in 2014. Two areas of healthcare that call on numerate skill relate to properly dosing and taking medications and understanding and choosing insurance. Errors in either critical area can make huge differences in people’s health and finances.

The issue of low numeracy is complicated by the fact that it is much more socially acceptable than low literacy. It is not uncommon to hear a person declare, “I’m not good with numbers,” or, “I hate math,” and they are rarely judged because of it, but people are embarrassed to admit that they can’t read. There is much to learn about numeracy, so research continues.

Expanding the Definition of Health Literacy

Pioneer health literacy scholars and researchers, recognizing the complexities that have been revealed over time, challenge the field to create an expanded definition of the concept. The current definition focuses on the skills of an individual patient. The new definition would describe health literacy more holistically, as a “multidimensional concept” and a “heterogeneous phenomenon,” that should also include culture, language, and other contextual issues. This broader, more complex view recognizes the variety of higher-level skills needed to navigate healthcare. Besides a certain level of health knowledge and social skills, patients must be able to think critically, analyze situations, solve problems, and make decisions based on complex and unfamiliar information. These factors contribute to variations in an individual’s level of health literacy depending on the person’s physical and mental condition at a particular time and in a particular context.

Outcomes of Low Health Literacy

Higher literacy is related to better health within groups of otherwise demographically similar individuals. The researchers working on the PIACC stated, “our study elucidates the fact that higher literacy scores are associated with better health among people who otherwise have identical social, economic, and demographic traits.”

As early as 2003, Rudd found almost 100 studies that showed a relationship between adult reading ability and health outcomes. Low health literate individuals, compared with health literate people, are at greater risk of poor health, and, because they are less able to manage their illnesses, are more likely to be hospitalized or even die because of them. They have lower health knowledge, are less likely to practice prevention or participate in their own care, have trouble managing their chronic diseases, avoid necessary tests, often make mistakes with their medications and have higher pharmacy costs, make greater use of emergency and inpatient hospital services, and suffer greater health disparities.

Oral Health Literacy

Oral health literacy applies the concept of health literacy to the oral environment. Since the terms literacy and health literacy are used

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LifeLongLearning

interchangeably, it seems logical to conclude the same about the term, oral health literacy, which has earned some nicknames of its own. It has been called “a pathway to better oral health,” an “unrecognized patient risk factor,” and “the invisible barrier” to achieving oral health.

The vast majority of research on health literacy has been done in the medical field and can often be applied to oral health, but the research on oral health literacy has also been expanding. The American Dental Association published a Health Literacy in Dentistry Strategic Action Plan, 2010-2015 in 2009. In it they affirmed the role of low health literacy as a barrier to improving oral health, and asserted the role of effective communication, including the use of plain language (see Practice Pointers article), to overcome that barrier. They also called for more research and for the education of all oral healthcare professionals on health literacy.

Four publications seemed to answer or echo that call. First, Reardon, considering both the expanded definition of health literacy and oral health, wrote, “Outcomes cannot be optimum without simultaneous improvements in health and oral health literacy, cultural competence, and communication.” Second, Guo and his colleagues conducted one of the first research studies to show the negative effect of low health literacy on oral health status. They also emphasized the importance of improving communication between patients and oral healthcare providers as part of the remedy. Third, The Academy of General Dentistry issued a statement in 2014 that included a call to Congress “to make oral health literacy a priority public health concern.”

Finally, The Institute of Medicine conducted a workshop on oral health literacy and published a report in 2013. Scholars referred to four critical areas of information that are often unknown to healthcare consumers or to many medical personnel. Even some oral healthcare providers either do not know or neglect to share this foundational information with their patients. Perhaps it is assumed everyone knows that:

- Baby teeth are important.
- Oral diseases are infectious.
- Oral diseases are preventable, treatable, and in some cases reversible.
- Oral health is related to general health.

To improve oral health literacy, the report urged oral health professionals to emphasize these fundamentals. As the field of oral health literacy continues to expand, more will become known about its exact role in dentistry.

Costs of Low Health Literacy

Low health literacy is expensive. As any disease worsens it becomes more difficult and costly to treat. The cost is incurred to handle health problems not prevented or well-managed by low health literate people. Because of the effects of low health literacy mentioned above, we in the United States are paying either $50-78 billion or $106-236 billion extra each year. Either way, that is a lot of money. The cost to individuals is even greater. They are more likely to suffer poor health, to be hospitalized, and even to die compared with health literate people. Another, often hidden, cost of low literacy, is the shame that people feel because they can’t read, which adds another layer of difficulty for patients and clinicians.

Identifying Low Health Literate People

How can a clinician know that a person is struggling with low literacy? The chances are that the patient won’t reveal their limitations because they are ashamed and embarrassed by their lack of knowledge. One study found that many low literate people hide the information from people close to them, including their relatives, co-workers, supervisors, friends, children, spouses, and healthcare providers. (see Figure 2)

Scholars offer two main ways to identify low literate people, either test everyone or be observant and ask questions. Several screening instruments have been developed. Though these tests...
are used mostly for research, some scholars argue for using them in the clinical setting as well. One study found that low literate patients generally agreed to have their literacy tested in the office, and this did not decrease their satisfaction with the services.38 Heinrich also advocates for testing all patients, though adds that it should be done with sensitivity, and should take into consideration the possibility that patients may feel anxiety or shame due to being tested, and of course the results should be kept confidential.14 Others argue against office literacy screening for three main reasons. First, staff must be trained to administer the tests, to choose which patients to screen, explain the rationale to them, and to do the screening. Other considerations include how to account for confounding factors, how the results will be used and kept, and what the patient will be told about the results. Second, the tools measure only limited areas of health literacy, such as word recognition, reading ability, or numeracy. They do not necessarily account for other needed skills such as speaking, listening, facility with technology, navigation, or for contextual factors such as language and culture. Third, and most importantly, using such tests on patients in the office can stress, embarrass, or shame them.26,36,39,40 Archie Willard, who learned to read at age 54, wrote,

“People with other kinds of handicaps are not continually asked to expose their weaknesses to whatever degree they are handicapped....More written tests are seen as another step backward for us and it turns us away.”40

The last thing clinicians want to do is to turn people away. So, if low literacy is hidden, and office testing is unacceptable, how can practitioners know who needs help? Consider three strategies.

First, know that low health literate people are not stupid or of a particular race, ethnicity, age, or socioeconomic status, though they are often stigmatized and embarrassed.41 Most are of at least average intelligence and for whatever reason just never learned to read. So it is not possible to judge by just looking or speaking with someone.34,40

Second, ask questions such as, “How do you like to learn?” and “What kind of take-home information do you prefer?” Do they prefer literate sources such as brochures, websites, and books, or non-literate sources such as television, radio, videos, talking with friends, or viewing demonstrations?34,40 Finally, observe and note these clues.29,34,40,42,43

One incident is not conclusive, look for patterns and repetitions. Patients may:

- Frequently miss appointments
- Avoid care until illness is advanced
- Have trouble with forms: take a long time to complete them, fail to complete them, or make errors such as misspellings
- Want to take forms home so that a family member can help, or because “My eyes are tired,” “I have a headache,” or “I forgot my glasses.”
- Answer “no” to all health history questions to try to avoid follow-up questions
- Not focus on written materials
- Have trouble explaining their symptoms
- Ask few or no questions, or ask questions about topics covered in literature
- Not know about medications, such as the name, purpose, dose, or other details
- Fail to follow through with prescriptions, tests, referrals
- Get angry when asked to complete forms and/or walk out of the office to try to hide their embarrassment and frustration

Key Health Literacy Report Recommendations

The National Action Plan to Improve Health Literacy was issued in May 2010 by the United States Department of Health and Human Services.9 It offered many strategies for improving health literacy in this country; a few relate to healthcare providers. Among many other suggestions, all health professionals should:

- Be educated about health literacy during their training.
- Be tested on the topic to achieve licensure.
- Meet minimum continuing education requirements when in practice.

Continued on Page 16
Conclusion

Literacy, health literacy, and oral health literacy are complex and serious issues that can impact oral health and patient care. Health literate clinicians can take their skills for granted and find it difficult to comprehend the wide variety of everyday tasks that challenge people with low literacy. Oral healthcare providers must be aware of the impact of low oral health literacy and know how to recognize it.

The next step is to know how to care for, communicate with, and educate low literate people. For that, see the companion Practice Pointers article.

References on page 33

About the Author

Toni S. Adams, RDH, MA, combines 26 years of clinical dental hygiene experience with her baccalaureate and master degree education in Communication Studies to focus her writing and speaking on communication issues in healthcare. She has won awards for writing, speaking, scholarship, leadership, and mentorship, and is scheduled to teach “Health Communication and Cultural Issues” in the Foothill College Dental Hygiene Program BSDH completion program. She welcomes questions and comments at tonisadamsrdh@earthlink.net
1. Literacy involves three main categories or skill areas:
   a. Print, numeracy, and oral/aural
   b. Primary language, culture and print
   c. Level of education, primary language and numeracy
   d. Socioeconomic status, level of education and culture

2. The population demographics of low literacy in the United States include which of the following?
   a. The majority were born in the United States and speak English with native fluency
   b. Higher percentages are found in those who did not graduate from high school
   c. Higher percentages are found in those who are in the lower socioeconomic groups
   d. All of the above
   e. b and c

3. Low health literacy is considered an independent risk factor for poor health outcomes.
   a. True
   b. False

4. Which of the following describes the oral/aural aspects of health literacy?
   a. Explaining symptoms and history
   b. Reading and understanding instructions
   c. Listening and understanding instructions and advice
   d. All of the above
   e. a and c

5. Expanded definitions of health literacy recognize:
   a. A minimum level of reading, writing, and math competence
   b. A higher level of critical thinking, analysis, and decision making
   c. Deference to the language and culture of health care providers
   d. All of the above
   e. b and c

6. A deficiency in the __________ area of health literacy is considered more socially acceptable.
   a. Oral /aural
   b. Print
   c. Numeracy

7. Other terms associated with health literacy are:
   a. “Causative factors” and “Contributing barriers”
   b. “Newest vital sign” and “Sixth vital sign”
   c. “Primary literacy” and “Secondary literacy”

8. Which of the following is a critical piece of oral health information that is often not known by healthcare consumers and not shared by healthcare providers? (according to The Institute of Medicine)
   a. Oral health is related to general health
   b. Oral disease can be prevented by a vaccine
   c. Oral disease is caused by poor brushing
   d. Oral disease can be controlled by a healthy diet

9. Identifying low health literate people can be challenging because:
   a. Patients are reluctant to reveal their lack of knowledge due to shame and embarrassment
   b. Screening tools and literacy tests can have limitations in administration and content measured
   c. Individuals hide their lack of knowledge from people close to them
   d. All of the above

10. The National Action Plan to Improve Health Literacy recommends the following for healthcare providers?
    a. Mandatory second language skills
    b. Minimum continuing education requirements
    c. Health literacy education during training
    d. a and c
    e. b and c

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Introduction
The continuing education course, “Health Literacy: A Fundamental Ingredient of Oral Health,” appeared earlier in this journal. It defined relevant terms, described the costs and impact of low health literacy for society and individuals, and discussed how to identify low literate people. This article will outline strategies that can be used when caring for them. After introducing the concept of health literacy universal precautions, it will explain how to make a low health literate person comfortable in a dental office, outline several communication issues, and advocate for taking the time to teach patients how to search the internet.

Universal Precautions for Low Health Literacy
Because it can be difficult to identify people struggling with low health literacy, scholars recommend that healthcare providers employ a universal precautions approach, similar to that used for infection control. Use the same strategies with all patients because, just as it is not always possible to know whether or not a person has a transmissible infection, so it is not always possible to intuit a person’s literacy level or degree of understanding. The strategies that experts recommend for low health literate patients should be used for all patients. Some key elements are outlined here.

Create a Welcoming, Respectful, Non-Judgmental Environment
Patients who may already be embarrassed by low literacy will not open up unless they are in a comfortable place. A dental office, with its strange smells and scary sounds, is already intimidating, so making people comfortable can be a challenge. All staff members should greet patients with a warm smile and a helpful attitude, and be alert to possible needs, such as help with completing forms or reading signs. Prepare patients for office visits by being sure they know how to find the office, and that they are aware of the questions they might be asked, the procedures that are planned, any papers or information they might need, and other details. Ask whether or not they would like to be accompanied by a family member or friend or do they need interpretation services. Then, before they leave, give them a number to call if questions should arise. Excellent communication skills contribute to such an environment.

Communication Strategies
Communication competence is essential to modern healthcare, and especially so with low health literate people. “Effective communication is a major element in improving health literacy.”

Plain Language: Plain language makes communication understandable and should be used in both speaking and writing. Key elements include:6,7,8

- Use “living-room language,” terms everyone can understand. Say “mouth” instead of “oral,” “tarter” instead of “calculus,” and “medicine” or “pill” instead of “medication.” If there is no alternative for a technical term, then use it and explain it.9
- Slow down. Give people time to absorb the information. This doesn’t need to take a lot of time. Wait a few seconds (count to three slowly in your head) before moving on when confirming understanding or asking for questions.
- Keep it simple. Plain language creates clear and accurate messages that are easier to understand so more likely to be followed. Even highly literate readers prefer simplicity.10 On the importance of simplicity, Albert Einstein said, “If you can’t explain it to a six-year-old, you don’t understand it yourself.”
- Limit the number of points. Omit unnecessary information. Focus on what the patient needs most at that time, place the most important point first, and repeat each point in different ways.
- Dispense readable literature and forms. See Side Bar 1 for “A Way with Words” and “Simply Put,” which can be used to write readable literature, or to evaluate existing documents.
- Use Ask Me 3. This is a strategy for patients in which they seek the answers to three important questions: “What is my main problem?” “What do I need to do about it?” and “Why?” Clinicians can turn this around and assure that this critical information is given, with an emphasis on the “why.” People are much more likely to follow advice that resonates with them.11

Use Multiple Media: Repetition helps people recall information. Repetition in different forms can make that information even more memorable. Reinforce points by referring to appropriate literature. Underline or highlight key phrases, add personalized notes, or draw pictures or diagrams. Add videos, models, demonstrations, pictures, tables, graphs, and charts to your repertoire. The more variety, the better the chance that the patient will recall the information.12

Teach-Back: Patients immediately forget 40–80% of what clinicians tell them. The more they are told, the less they remember, and almost half of what they do remember is incorrect. Stress, pain, illness, fear, and other emotions common in dentistry can further interfere with memory.13 The teach-back method is one way to confirm that a patient understands and recalls the clinician’s message. Teach back is not meant to be critical of the patient, it confirms whether or not the clinician’s communication was clear. Ask the
patient, in a non-judgmental way, to teach back what was just explained. Here are a few questions that clinicians can use to start with; others will come to mind with practice:  
- Just so that I know I was clear, please tell me what you heard me say.
- We covered a lot today, so just to be sure, explain what you will do when you get home.
- When your husband asks you what you learned today, what will you tell him?

Begin slowly with one or two patients, perhaps at the end of the day. Plan the most appropriate phrases ahead of time. If the patient cannot teach back the information at first, be prepared with a second non-judgmental request. Keep trying; success can require several efforts. As clinicians gain experience with teach-back, they will learn which phrases are most effective.

Teach back works! A resident physician in a pediatric office offered this testimonial:

I decided to do teach-back on five patients. With one mother and her child, I concluded the visit by saying, ‘So tell me what you are going to do when you get home.’ The mother just looked at me without a reply. She could not tell me what instructions I had just given her. I explained the instructions again and then she was able to teach them back to me. The most amazing thing about this ‘ah ha’ moment was that I had no idea she did not understand until I asked her to teach it back to me. I was so wrapped up in delivering the message that I did not realize that it wasn’t being received.

Teach back can be an excellent strategy to prevent misunderstandings, but, as with any strategy, it is not necessary or appropriate to use with every patient at every appointment.

Refer to Quality Websites & Teach Patients How to Evaluate Sites

People use the internet for many tasks. They shop, find recipes, watch demonstrations, and, of course, search for health information. Unfortunately, there are many unreliable websites that can mislead and misinform. Patients with higher literacy and more education tend to search for health information on higher quality non-commercial sites, while those with lower literacy and education tend to favor advertising-based sites. Hana and colleagues evaluated health websites for usability, accessibility, trust, readability, and scientific information quality (SIQ). They concluded that government sites offered the highest SIQ, even though commercial and treatment provider sites can also offer quality information. Clinicians can steer people toward more reliable sites by teaching them what to look for. The following tips were adapted from a tutorial from the National Library of Medicine (see Side Bar for links).

A reliable health website:
- Is run by experts who are clearly identified.
- Has a clearly stated purpose.
- Labels advertising.
- Uses experts to review information before posting it on the site.

Links

- “Evaluating Internet Health Information: A Tutorial from the National Library of Medicine.” This brief (16 minute) tutorial can be invaluable for patients. Find it at: https://medlineplus.gov/webeval/webeval.html
- Medicines in My Home (MIMH), “multimedia educational program to teach consumers from adolescence through adulthood how to choose over-the-counter medicines and use them safely,” from the U.S. Department of Health and Human Services Food and Drug Administration at: www.plainlanguage.gov/populartopics/health_literacy/index.cfm
- Ohio State University College of Medicine Area Health Education Center on creating a shame-free and patient-centered environment at: http://medicine.osu.edu/orgs/ahec/chcp/modulecontent/pages/creatingenvironment.aspx
- Plain Language Thesaurus for Health Communications, from the Centers for Disease Control and Prevention’s National Center for Health Marketing, download Word document at: www.plainlanguage.gov/populartopics/health_literacy/index.cfm

- Explains the sources of information posted on the site.
- Is up-to-date and posts the last time the site was updated.
- Will not share readers’ personal information.

Conclusion

Health literacy is essential to patient participation in their own care, and to achieving higher levels of health. Healthcare providers are tasked with raising the level of health literacy among their patients. This job is facilitated when they employ a universal precautions approach; create a welcoming and shame-free environment; use plain language, multimedia, and the teach-back method; and guide patients toward quality information on the internet.

References on page 34
managers and hygienists) exists around the world. Learning how to work as a team focused on meeting the oral health needs of the patients and the public and increasing access to oral care for all are really universal themes no matter where you live and work.

**Q: What are your plans for the future?**

**A:** Our profession is constantly evolving and I’ve always tried to be engaged in order to grow with it. I plan to continue to teach while still staying “grounded” in clinical practice. One of my personal mottos is “never stop learning”. I am looking forward to teaching a new class in the fall, “Contemporary Health Concerns,” a general health education class along with “Orientation to Health Careers,” an overview of current issues in health care delivery and medical terminology for students entering allied health programs. Both classes are great teaching opportunities as they focus on broad issues in health and health care. I have the opportunity to utilize all that we learn in dental hygiene about total health with my students. I really enjoy working with community college students who have an interest in the heath care professions. Community college students today have many challenges balancing work, family and their education. I find it really rewarding to be part of their education and the support system to help them achieve their goals. I continue my work in the health library at Stanford and am busy giving presentations on supporting patients undergoing cancer therapy as well as a number of continuing education programs and workshops for dental hygienists.
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</tbody>
</table>

**Membership Dues Totals and Method of Payment**

- Enclosed is my payment of $_______ by check made payable to CDHA for the amount of my annual dues. Check # ______

- Please charge my annual dues to my credit card listed below (CDHA accepts VISA, MasterCard and cards). My signature is authorization to charge the $_______ annual CDHA membership dues to the card number provided.

  Card Number: ___________________

  Billing address (if different from address above): ___________________

  Expiration Date: ___________________ / ___________________  

  CVV Code: ___________________  

  City, State, Zip: ___________________

  Signature: ___________________

Dues are not deductible as a charitable contribution for federal income tax purposes. They may be deducted as a business expense. The portion of your dues that is allocable to lobbying for 2016 is 16%. That portion of your dues is not tax deductible.

**California Dental Hygienists’ Association – 1900 Point West Way, Suite 222 – Sacramento, CA 95815-4706 – 916-993-9102
Fax: 916-487-7105 – Email: memberservices@cdha.org – www.cdha.org**
Membership

CDHA Working TOGETHER
Our Interim Therapeutic Restoration (ITR) and Radiographic Decision-Making program is a 30-unit continuing education program for dental hygienists and RDHAPs. This blended course incorporates online, home study and in-person clinical training and is the sole educational program that satisfies the Dental Hygiene Committee of California requirement.

The goal of this program is to provide information, techniques and clinical training to prepare registered dental hygienists to perform the ITR procedure and to prepare dentists on treatment planning and evaluation of ITRs. In addition, dental hygienists will learn to determine which radiographs to perform on a patient for the purpose of facilitating an initial examination by a dentist.

In-Person Dates:  
Saturday, November 19, 2016 8:00 am – 5:00 pm  
Sunday, November 20, 2016 9:00 am – 12:00 pm

Course Director:  
Paul Glassman, DDS, MA, MBA

Tuition:  
$2,995 for a team (1 dentist and 1 dental hygienist must register as a team)

Location:  
Dugoni School of Dentistry, 155 Fifth Street, San Francisco

Credits:  
This activity is designated for 30 units of continuing education credit.

* Program is limited to 20 teams and includes lunch and coffee/tea service in the morning. Teams are responsible for the recruitment of their own patients for the clinical portion of the training.

Register at dental.pacific.edu/ce1

For questions, contact CDE at cedental@pacific.edu
Cora Ueland Scholarship Winners Share their Goals

Rebecca Zwingman

In five years, I envision my dental hygiene career leading me to being involved in the community in which I reside. I hope whichever office I start and continue my career with will be open to the idea of doing a day of free dental care for the less fortunate in our community. I started the event while working for an office prior to being accepted into dental hygiene school. We were able to help over 125 individuals and donate over $75,000 worth of dental treatment to those who were otherwise unable to attain the treatment. I think it is a wonderful thing to do for your community, allows your office as well as other dental professionals to come together and provide a great service to others. I would also like to stay involved in my community by volunteering not only for dental events, but also health fairs to help educate the community regarding how dental health correlates to an individuals’ overall health.

Continuing with the theme of giving back to communities, I would also love to volunteer my time at least once and experience Flying Dentists, Dentists without Borders or Dental Abroad. I believe it is a once in a lifetime opportunity and not everyone can say they’ve done it. Seeing the faces of those you’ve helped and the gratitude they exude is a remarkable feeling that warms your heart.

Another career goal of mine is to become established in a Periodontist office. I feel being a part of a team at a Periodontist office will help me refine my skills, help me grow, learn, increase my knowledge and excel in the dental hygiene profession. The procedures done there are ones you aren’t able to see in a general dentist office.

I will engage myself in the CDHA by keeping up with current topics within our profession as well as the supporting professions i.e. Dentistry. I will be involved in the government and litigations regarding passing or denying certain laws that can make an impact in the dental field. Be active in voting, an active member having a voice, as well as paying my dues to the organizations because that is what helps keep our profession secured, keeps it going, and protects it. I also plan on attending local CDHA conferences where I will also take continuing education courses to broaden my knowledge in the field, as well as be able to network with my fellow professionals. I will push myself to go above and beyond the required amount of continuing education requirements that way I can push myself to keep learning, keep my brain active and be able to implement new procedures into my daily practice. I believe you never stop learning, and the more you learn the more well-rounded person and clinician you will become.

Emi Hoshino

My aspiration to become a dental hygienist stems from my desire to be of service to others. This influences my goal to become a hygienist that works with the population that cannot afford dental care. In five years from now, I envision myself as a successful clinician in this industry, as well as being heavily involved in the community through volunteer work and by working as an RDHAP.

I plan to start my career as a clinician to develop my clinical skills, then further expand my horizons by continuing my education to become an RDHAP. Obtaining an RDHAP license would allow me to step outside of the traditional office setting and reach patients in remote areas or in situations that may prevent them from receiving care easily. I believe that everyone should receive quality care and do not want a physical limitation or socio-economic situation to prevent a person from receiving the work that they need. My solution to these challenges that a person may face is by becoming an RDHAP.

My success in the dental hygiene program relies so much on the active involvement and participation from myself, my peers, the educators at my school, and professionals in the dental hygiene community. This serves as an example that involvement in my profession once I graduate is vital and necessary to my success and growth in this industry. By continuing to be a member of CDHA, I will have access to resources and opportunities that will help me grow professionally in a career that I hope to retire from. It is even more important to me that I stay connected to my peers and to be aware of the policies that affect our profession.

As a student, I am already actively engaged in CDHA, having just attended the Student Regional Conference in Los Angeles this past March. I will also be attending the 2016 House of Delegates/Student House of Representatives, where I will witness and experience firsthand how I can make an impact in this industry, even as a student. CDHA serves as my voice that represents my interests and well-being as a future dental hygienist and by participating in local and national events, continuing education, and component meetings, my involvement and contributions to this profession can make an impact in an industry that I am proud to be a part of.
Student Table Clinic Award Winners

Informational Category

1st Place
Angela Sue Yeaton, Simon Weber
Cerritos College
Yoga Flow for the Dental Pro
Educates our colleagues on the prevalence of musculoskeletal disorders and how the practice of yoga aids in the prevention, maintenance, and relief of this disorder.

2nd Place
Julian Devac, Kathy Ho, Jason Uribe
Cypress College
Del-1 Protein: A New Hope
To inform the public on Del-1 Protein potential to disrupt the progression of periodontitis.

3rd Place
Tammy Blancher, Tatyana Altukhov, Yunen Aguirre
West LA College
Arginine: A New Alternative to Caries Prevention
Provides information on an alternative option to caries prevention.
Original Category

1st Place
Jason Abellera, Remy Grace Ramos
Cerritos College
Vaping and Oral Health
To observe the effects electronic cigarette vapors have on saliva to determine if they are a risk factor for dental caries.

2nd Place
Robyn Wirth, Natalie Swall, Connie Suh, Ashley Dela Resma
West Coast University
The Efficacy of Activated Charcoal Versus Over-the-Counter Dentifrices
Compares the efficacy of activated charcoal to a dentifrice containing triclosan, a natural dentifrice containing xylitol without fluoride as an antimicrobial agent.

3rd Place
Dieu-Mi Dao, Kristine Ina, Carlene Mauk
Chabot College
Antibiotic Prophylaxis for Breast Implant Patients - Trust or Bust?
To identify the attitudes and recommendations of cosmetic surgeons regarding antibiotic premed for breast implant patients prior to dental care.
Cayce Waipa, a senior dental hygiene student at Sacramento’s Carrington College, was a CDHA sponsored student to the 2016 House of Delegates (HOD). With passions riding high and voices shouting to be heard, Cayce’s exceptional leadership qualities came through and his fellow delegates elected him to speak for the students on the floor of the HOD.

A Rising Star and Future Dental Hygienist

Cayce refers to himself as a “true Hawaiian.” He takes his Hawaiian heritage seriously as a “product of the Hawaiian people” with, he states, a “culture that has been built on the premise of Aloha and stewardship to the land and all of its inhabitants. I am charged with the task of upholding the state of my community’s health so as to maintain the very fabric in which the vibrant Hawaiian culture has been woven.”

Cayce received the Native Hawaiian Health Scholarship, a merit-based scholarship awarded to recruit, nurture and train primary health care professionals to deliver quality, culturally competent health services to Native Hawaiians. After graduation, Cayce will return to Hawaii to address the access to health care disparities unique to Hawaiian communities.

Other Health Care Careers in the Path to a Registered Dental Hygienist

When Cayce was 16, his brother suffered a serious surfing accident, which caused a 7% curvature of his spine. In order to ease his brother’s pain, Cayce and his mother sought massage classes that specifically dealt with scoliosis dysfunction. He discovered the power of healing and realized his calling to help improve the quality of peoples’ lives through public service. He became a Certified Massage Therapist with his own practice. When the economic climate made it difficult to sustain the practice, he went back to school to become a dental assistant. While working at the West Hawaii Health Center Keiki Clinic, he was shocked to see the neglect and lack of basic services and access to care. Cayce’s compassion motivated him to further his education in dental hygiene to expand his ability to help. “We as Hawaiians deserve certain human dignities and basic privileges, including the ability to live a healthful life.”

One of Two Voting Student Delegates

During the proceeding of this year’s momentous CDHA House of Delegates, Cayce was able to testify on behalf of all the students present. Along with the attending California delegates, he voted to support the decision of the CDHA Board of Trustees to terminate all existing charter agreements with the American Dental Hygienists’ Association. This vote meant separating from ADHA to become a new and independent CDHA. This separation then allowed a vote that created a special membership category for newly graduated dental hygienists - The “New Professional.” These members will pay reduced dues, while enjoying all the benefits of CDHA membership and the support of their professional association.

Final Comment at HOD

On the last day, and after the final vote, Cayce spoke to the delegation once more. In a rallying call to action, this future dental hygienist spoke from his heart:

“On behalf of the student body I would like to extend a warm thank you and a deep sense of gratitude for allowing the students to have an active voice in this year’s House of Delegates. It has been an illuminating experience of unprecedented measure.

While there still remains a long road ahead to forge a new definition of what CDHA’s future identity may be, it is akin to the development of a diamond in geologic terms. The development of
terrestrial objects requires three major precipitating factors - time, pressure, and temperature, the last two being particularly relevant to this year’s House of Delegates. A piece of coal starts with all the constituents for clarity. It just awaits actualization through the forces of nature. With consistency it does eventually emerge from millennia as a precious stone with luminous clarity.

CDHA’s road may not be clear at this point. However, from what we have observed it has all the constituents to be a grand, autonomous entity. The time has come to effect change, to bring about the greatest definition of a clear path for California’s dental hygienists future. Thank you for being the change that you want to see in the great state of California.”

The Voice Behind the Call
Cayce is truly committed to giving back to his professional association. Did you receive a call from CDHA after the HOD? Over 1,200 hygienists have been contacted. Cayce, while still a student, eagerly spent countless hours during the summer making calls to recruit and retain members for the new CDHA. In this time of transition, he is continuing the effort, updating expired members and processing payments. Cayce explained that he was inspired by his role as a voting student delegate and was deeply moved by what transpired at the HOD. He was compelled to invest further in the success of the California Dental Hygienists’ Association and the future of California dental hygienists.
TIME TO FIND A JOB YOU LOVE?

Join DentalPost, the premier online and mobile job board and community.

BUILD  SEARCH  APPLY

Special CDHA member offer*

*Receive a free 90-day dental professionals premium account upgrade. Email CDHA@dentalpost.net to redeem.

VISIT WWW.DENTALPOST.NET TO LEARN MORE.
DentalPost Named Official Job Board of the California Dental Hygienists’ Association

ATLANTA, GA (June 30, 2016) – DentalPost, the dental industry’s premier job board and community, announced today its selection as the official job board provider of the California Dental Hygienists’ Association (CDHA). The partnership will help association members find a job or hire staff via a targeted online job feed. Together, DentalPost and CDHA will help California-based dental professionals connect and use data to make better hiring decisions.

“This opportunity to partner with the CDHA is extremely exciting for us,” said Tonya Lanthier, RDH, CEO and founder of DentalPost. “We look forward to working together to make the lives of California dental professionals easier as we continue leading the future of hiring.”

CDHA President Julie Coan, RDH MPH shares, “CDHA is excited to partner with DentalPost to provide RDH job opportunities to our CDHA members. By connecting dental professionals and practices, DentalPost has become a reputable source for building high-performance teams. This venture will allow our members access to current job postings available near their home.”

As an added benefit, all CDHA members will receive a complimentary 90-day premium dental professional account. Premium accounts include an account badge, top applicant placement in searches, access to anonymous resume profile feedback and a 10% discount on resume services.

For more information or to create your free account, visit www.dentalpost.net.

About California Dental Hygienists’ Association

The California Dental Hygienists’ Association (CDHA) is the authoritative voice of the state’s dental hygiene profession. The organization was established over 30 years ago when two regional associations merged to form a unified professional group. CDHA represents thousands of dental hygienists of California. For more information visit http://cdha.org.

About DentalPost

Based in Atlanta, DentalPost is the dental industry’s premier online and mobile job board. With more than 700,000 job seekers in the U.S. and Canada, DentalPost connects dental professionals with dental offices to help create dental teams that excel. Founded in 2005 by Tonya Lanthier, a Registered Dental Hygienist, DentalPost leads the industry in metric-based career matching including personality tests as well as values, skills and work culture assessments to assist in selecting the best match for each position. For further information on DentalPost visit www.dentalpost.net, download the app on Android and iOS or contact us at 678-805-7820.

Teaming Together for You.
CDHA Members in the News

CDHA Oral Health Awareness Night At Grizzly Stadium

The puzzle question: where do dental hygiene and baseball meet? At the Grizzly Stadium in Fresno to celebrate “Oral Health Awareness Night” with a tailgate party and Baseball game! “Get your popcorn, get your soda — then brush and floss!!”

CDHA sponsored a public relations event “Oral Health Awareness Night” at Grizzly Stadium at Chuckansi Park in Fresno, CA. The evening was a welcome break for the delegates, who were joined by some fellow CDHA members from the area who braved the hot weather to enjoy the baseball game and tailgate party before the game. CDHA President Lygia Jolley and President Elect Julie Coan participated in the opening pitch ceremony and Lygia threw out the first pitch. Attendees received free baseball caps.

A full page CDHA advertisement was in the game program, and three public address announcements urged attendees to see their dental hygienists for regular checkups, and to ask for oral cancer screenings at all future visits. The last announcement reminded game attendees to brush and floss because oral health is part of total health.

In between innings, activity breaks featured a relay race for two child teams, and four CDHA members who participated in a Lip Sync Contest. The winners all received Sonicare toothbrushes donated by Phillips. CDHA members Trisha Thomas and Ashley Quezada from San Diego Component won the lip sync contest.

We hope this unique type of public relations event can be held in other areas where we can reach the public with our special message.

Sunstar/RDH honors JoAnn Galliano

California’s own JoAnn Galliano, MEd, RDH, was among four dental hygienists recently honored at the RDH Under One Roof conference. As one of the 2016 Sunstar Americas Award of Distinction honorees, JoAnn was recognized for her legislative advocacy work on behalf of dental hygiene in California.

JoAnn was pivotal in the formation of the Dental Hygiene Committee of California (DHCC), which regulates dental hygienists in our state. She has given years of energy, effort, and talent as our representative to both legislators and dental consumers. Working with Aaron Reed & Associates, she has become well known and respected at the state capitol as an advocate for our profession and the patients we serve.

Besides serving as CDHA’s current Legislative Consultant, JoAnn is also an educational consultant for the DHCC and has served CDHA as President.

Congratulations to JoAnn for this well-deserved honor.
LifeLongLearning (Pg 11) – Health Literacy: A Fundamental Ingredient of Oral Health


FALL SYMPOSIUM
REGISTRATION FORM

Registration & Payment Information:

Name:_________________________________________ Telephone:__________________________

E-Mail Address:

☐ Master Card  ☐ VISA  ☐ Check payable to CDHA

Credit Card no.:__________________________ Expiration:__________________________

Name on Card:__________________________ CVV:__________________________

Billing Address:

Signature:________________________________ Amount Paid:__________________________

Mail Registration Form & Payment Information to:
California Dental Hygienists’ Association
1900 Point West Way, Suite 212
Sacramento, CA 95815-4706
(916) 993-9102 | (916) 487-7105 Fax
memberservices@cdha.org

FRIDAY, OCTOBER 28 AND SATURDAY, OCTOBER 29 PROGRAMS
Select the session you are attending:

Tuition Fee: $40.00 $80.00

Member: ☐ Friday Session only ☐ Saturday Session only ☐ Both Friday and Saturday

Potential Member: ☐ Friday Session only ☐ Saturday Session only ☐ Both Friday and Saturday

POST MARKED AFTER OCTOBER 15, 2016 AND ON-SITE

Tuition Fee: $65.00 $110.00

Member: ☐ Friday Session only ☐ Saturday Session only ☐ Both Friday and Saturday

Potential Member: ☐ Friday Session only ☐ Saturday Session only ☐ Both Friday and Saturday

STUDENT BOARD REVIEW

Tuition Fee: $80.00

Member: ☐ $80.00

Non-Member: ☐ Not available

STUDENT BOARD REVIEW

Tuition Fee: $185.00 $200.00

Member: ☐ $185.00 ☐ $200.00

STUDENT BOARD REVIEW

Tuition Fee: $280.00 $325.00

Member: ☐ $280.00 ☐ $325.00

Student registrations will not be accepted after Saturday, October 15th

TOTALS

Total: ____________________________ Late Registration Total: ____________________________

You will receive an email confirmation of your registration

Registration Deadline: Oct. 15, 2016
Presented by the California Dental Hygienists’ Association
Friday October 28 and Saturday, October 29, 2016
Hilton San Francisco – Bayfront, 600 Airport Blvd., Burlingame

Friday, October 28
Providing Care in a Marijuana Legal World
Speaker: Heather M. Rogers, BSDH

Saturday, October 29
Aging and Oral Systemic Diseases
Geriatric Diseases and Dementia
Speaker: Eric Shapira, DDS, MAGD, MA, MHA
Student National Board Review
Applying Critical Thinking to Case Studies
Speaker: Pam Hughes, RDH, MS

Register online at CDHA.ORG