

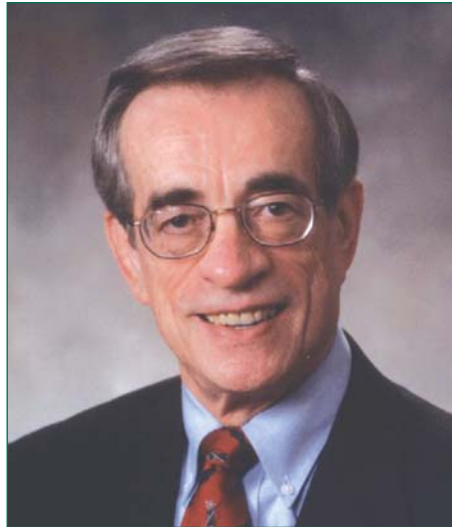
The Compliant Dental Office

Morris Robbins, Jr., D.D.S.

Chairman, TDA Committee on the Environment and Infection Control

If your office has a visit by TOSHA, would you be ready? It just happened to a Tennessee dentist. Your TDA Committee on the Environment and Infection Control is hoping to give each dental office a guide that enables them to reach compliance with several standards and/or rules so that it will create “the compliant dental office.” While it may seem that compliance is a harsh word, consider it to be one of conforming to a standard. As we all are aware, dentistry seems to have an increasing number of compliance issues it must deal with. Dentistry has been conforming to standards since its inception. For example: standards for education; standards of care; rules and regulations for the practice of dentistry; and, for the last twenty-five-or-so years, standards set by OSHA; recommendations by the Centers for Disease Control (CDC) for dentistry; and environmental issues dealing with amalgam, silver, lead and mercury.

In 1981, when the first cases of AIDS were reported in the United States, dentistry was already dealing with several clusters of Hepatitis B in dental practices that had produced morbidity and mortality among dental health care workers. At that time, there were few or no compliance standards the professions had to follow. The Federal Occupational Safety and Health Administration (OSHA) of the US Department of Labor had not previously been in the enforcement of health care workers safety and health. When asked by a hospital workers union to intervene in the hospital environment to provide standards for employee protection from the threat of the Human Immunodeficiency Virus (HIV), OSHA looked at all health care professions and began developing standards. On December 6, 1991, the first standards for Bloodborne Pathogens (29 CFR 1910.1030) were published and



Dr. Morris Robbins, Jr.

revised in 1992. Another revision occurred in 2000 when a law called the “Needlestick Safety and Prevention Act” was passed by Congress. Each of these had great impact on the practice of dentistry, as OSHA has powers of enforcement, something dentistry had not dealt with before. Also, OSHA enforces the (29 CFR 1910.1200) Hazard Communication Standard /The Hazardous Chemical Right to Know Law. The Centers for Disease Control and Prevention does not have powers of enforcement, but takes the lead in developing guidelines. It has developed the current “Guidelines for Infection Control in Dental Health-Care Settings – 2003.”¹ These guidelines are comprehensive and are an excellent source of information for all dental offices.



The dental team at work in the compliant dental office.

Environmental areas the practice of dentistry must deal with are amalgam, mercury, silver and lead. Issues of water quality, biofilm and dental unit water line contamination continue to become more important in dental practice. HIPAA has had a major impact on compliance for the dental profession and a full explanation of that impact is described later in this *Journal*.

Federal OSHA standards are enforced by a separate state agency in Tennessee and twenty-five (25) other states. Tennessee OSHA (TOSHA) is responsible to the Tennessee Department of Labor and must meet federal guidelines. TOSHA has developed a specific exposure control plan for dental offices that will serve as a complete guideline for Tennessee dentists to meet the Bloodborne Standards. This model Exposure Control Plan follows this introduction and should serve as an excellent guide for updating each dental office’s present exposure control plan. It is suggested that each dental office review their compliance needs and assess their present status.

Keeping up with reality is so important to understanding why we need these standards and recommendations. After twenty-five (25) years, the viral disease HIV/AIDS now exists in over one million people in the United States and more than one-half million have died from the disease. It is estimated that approximately 40,000 new HIV cases are now occurring annually and more than twenty-two million people world wide have died from HIV/AIDS.⁵ There have been successes in this time also. Perinatal transmission has decreased over tenfold following better education and therapies. Blood donor screening has reduced the risk of acquiring HIV to one per two million blood donations. A recent survey showed that fifty percent (50%) of

Sharps with Engineered Sharps Injury Protection

Below is a partial listing of products that may be evaluated by the dental office to assist in complying with the safer needle and sharps requirement.

Products Available

Needle Protective Devices

Safe-Mate Safety Needle
MedPro Safety Products
817 Winchester Road
Lexington, Ky. 40505
859-225-5347
www.safe-mate.com

Ultra Safety-Plus XL
Septodont Inc.
245 Quigley Boulevard – Suite C
New-Castle, Delaware 19720
800-872-8305 Ext.6660
www.novocol.com/septodont

Most of these products are available from your local dental dealer.

Scalpel Blade Protective Devices

BD Bard-Parker
1 Becton Drive
Franklin Lakes, NJ 07417
a) Protected Surgical Blade with Metal Handle
b) Protected Disposable Scalpel with Locking Retractable Shield
201-847-6800
www.bd.com

Qlicksmart Flask -
Quanta Technologies, LLC
7620 North Hartman Lane #184
Tucson, AZ. 85743
Removes surgical blade from metal handle (one hand technique)
800-529-7286
www.quantaweb.com



Front and side views of the Qlicksmart Flask. With this product,

surgical blades can be removed from metal handles with a one-hand technique.

adults, fifteen to forty-four (15-44) years of age, have reported having an HIV test.⁵

Some of the more difficult issues are that over 250,000 individuals in the US are unaware they have HIV/AIDS; also, this group is less likely to seek health-care. Males having sex with males (MSMs) account for forty-five percent (45%) of new HIV/AIDS cases in the US. One in four MSMs in their social venue are infected and fifty percent (50%) are unaware of their status.

Also in the first twenty-five years, fifty-one percent (51%) of cases were among the black population. Heterosexual contact has increased to eleven percent (11%) in men and fifty-four percent (54%) in women. All women account for approximately twenty-five percent (25%) of new diagnoses. In 2002, HIV/AIDS was the leading cause of death for black women ages twenty-five to thirty-four.⁵

The previous findings bear out the reason that dental health care workers should consider each patient to be infectious and meet the standards set by OSHA and recommendations by CDC.¹

Hepatitis B, C and D are the three primary infectious viral diseases of the liver that are of importance to dentistry because, like HIV/AIDS, they are blood-borne. From 1970 - 1987, there were nine clusters of Hepatitis B in patients through infected dental health care personnel. Since 1987 and the advent of immunization for Hepatitis B, there have

been no reported cases of dental transmission of the disease in dental practice.² Recently, one case of patient-to-patient transmission has been reported in an oral surgery office. Investigation has not been able to determine the mode of transmission as the office met the standard precautions necessary for bloodborne disease.⁷

While dentistry has a very good track record for Hepatitis B immunization, there are an estimated 1.25 million Americans who are chronically infected with the Hepatitis B virus.⁶ There are two specific antigens associated with Hepatitis B positive persons. Both are potentially dangerous as to bloodborne infection but (HBeAg) or the *e antigen* positive person is much more at risk for infection. This does not mean a person with Hepatitis B (HBsAg) or the surface antigen positive person is not infective because you must consider each patient potentially infective. Hepatitis D is a linked disease with Hepatitis B and cannot exist without the presence of Hepatitis B.

Questions about Hepatitis immunization continue to be asked. Booster doses are not recommended and neither is periodic antibody testing for the Hepatitis B surface antigen. While antibody levels in the bloodstream may decline over a period of time, it is recommended that due to an anamnestic (immune memory) response, persons with declining antibody levels remain protected against clinical illness and chronic disease. Post-

vaccination testing one to two months after the third vaccine dose is recommended for healthcare workers.⁴

Hepatitis C also is a viral disease and is spread as the other bloodborne diseases — through sharing needles or “works,” when “shooting” drugs, through needlesticks or sharps exposure on the job, or by an infected mother to her baby during birth. Eighty percent (80%) of persons have no signs or symptoms of Hepatitis C. When present in the bloodstream, it produces between fifty-five (55%) and eighty-five percent (85%) chronic infection. Chronic liver disease occurs in about seventy percent (70%) of those chronically infected, with a death rate of one to five percent (1-5%) of those infected. It continues to be the leading cause of liver transplant in the United States. There are about 4.1 million Americans infected with Hepatitis C and about 3.2 million with chronic infection. One important issue with Hepatitis C is that a co-infection rate with HIV exists.³

So, as we look at bloodborne infections, we must be aware that several common factors exist in transmission: a) sexual contact; b) intravenous drug use; c) needlesticks or spray/splash of an infectious organism; and d) maternal spread.

Infectious disease continues to be with us but specific measures to protect employees and the health care worker have taken a major focus in the health-care professions. OSHA has mandated

that certain steps be taken against blood-borne infections in order to minimize their spread. OSHA standard 29 CFR Part 1910.1030 requires that an exposure control plan be developed for the dental office to provide a safe working environment for employees. TOSHA, being one of twenty-six state-controlled OSHAs, has been generous and developed an Exposure Control Plan specifically for dental offices in Tennessee. This plan follows and is written in a clear and concise manner that will be a valuable asset for

every dental office to re-evaluate their existing plan and bring it up to date.

The Hazard Communication Standard, the Hazardous Chemical Right to Know Law, and MRSA will be featured in the next edition of the *Journal*, along with dental office infection control and environmental issues such as amalgam and mercury, silver, lead, latex sensitivity and dental unit water lines.

INTERNET RESOURCES

- American Dental Association: www.ada.org
- Centers for Disease Control and Prevention (CDC): www.cdc.gov

- CDC, Division of Oral Health: www.cdc.gov/dentalhealth/oralhealth
- CDC, Morbidity and Mortality Weekly Report: www.cdc.gov/mmwr
- OSHA, Dentistry/Bloodborne Pathogens: www.osha.gov/dentistry
- Organization for Safety and Asepsis Procedures: www.osap.org
- Tennessee OSHA (TOSHA): www.tennessee.gov/labor

REFERENCES

1. CDC. Guidelines for Infection Control in Dental Health-Care Settings – 2003. MMWR 2003;52 (No. RR-17)
2. CDC. Viral Hepatitis B. Fact Sheet. July 2007
3. CDC. Hepatitis C Fact Sheet. May 2005
4. CDC. Hepatitis B Vaccine: Fact Sheet. December 2006
5. CDC. MMWR Twenty-Five years of HIV/AIDS. United States 1981-2006
6. Miller and Palenik. "Infection Control and Management of Hazardous Materials for the Dental Team" Mosby, 1994
7. Redd et al. Patient to Patient Transmission of Hepatitis B Virus Associated with Oral Surgery, The Journal of Infectious Diseases 2007; 195: 1311-4



STATE OF TENNESSEE
DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
OCCUPATIONAL SAFETY AND HEALTH
220 FRENCH LANDING DRIVE
NASHVILLE, TENNESSEE 37243

Dear Tennessee Dental Association Member:

As part of the Department of Labor and Workforce Development, the Tennessee Occupational Safety and Health Administration (TOSHA) works with the dental healthcare community and other employers as a team to promote worker safety and improve working conditions across Tennessee.

There can be no better example of this than the cooperative effort shown between the Tennessee Dental Association and TOSHA's compliance, consultation and training sections who have worked together for a number of years to provide information on guidelines and standards that promote worker safety and health in dental offices. This has included providing speakers for dental study groups and dental society district regional meetings. Training programs on TOSHA standards have been developed and presented for students in dental and allied dental health programs throughout the state. On an ongoing basis, TOSHA has provided technical assistance and standards interpretation assistance.

This Model Exposure Control Plan for the Dental Office is part of that cooperative effort between the Tennessee Dental Association and TOSHA. It was written to serve as a guide to help the dental healthcare employer understand the requirements in the Bloodborne Pathogen Standard (29 CFR 1910.1030), a standard that strives to eliminate as far as possible the hazard of exposure to Hepatitis B, Hepatitis C, HIV and other bloodborne diseases to dental healthcare workers. We feel that providing technical assistance like this Model Exposure Control Plan enhances the quality of the relationship between the Tennessee Dental Association and TOSHA. We will continue to work together in the future and provide information to help the dental healthcare employer have "The Compliant Dental Office".

Sincerely,

A handwritten signature in black ink that reads "Jan Elovitz Cothron".

Jan Elovitz Cothron
Health Compliance Manager
TOSHA

Model Exposure Control Plan for the Dental Office

TOSHA believes the following information to be accurate. This was developed to help dental employers comply with requirements of 29 CFR Part 1910.1030 The Bloodborne Pathogens Standard as adopted by the Tennessee Department of Labor and Workforce Development and the Occupational Safety and Health Rules of the Tennessee Department of Labor and Workforce Development.

TABLE OF CONTENTS

| | PAGE |
|---|------|
| EXPOSURE CONTROL PLAN | 21 |
| DEFINITIONS | 21 |
| EXPOSURE DETERMINATION | 22 |
| SCHEDULE AND METHOD OF IMPLEMENTATION ... | 23 |
| Methods of Compliance | 23 |
| A) Universal/Standard Precautions | 23 |
| B) Engineering and Work Practice Controls | 23 |
| C) Personal Protective Equipment | 24 |
| D) Housekeeping | 24 |
| HEPATITIS B VACCINATION | 25 |
| POST-EXPOSURE EVALUATION AND FOLLOW-UP ... | 25 |
| EVALUATION OF EXPOSURE INCIDENTS | 26 |
| LABELING | 26 |
| EMPLOYEE TRAINING | 26 |
| RECORDKEEPING | 26 |

APPENDICES

- A. Hepatitis B vaccine declination form
- B. Healthcare Professional's Written Opinion Form – Hepatitis B Vaccination
- C. Healthcare Professional's Written Opinion Form – Post Exposure
- D. Bloodborne Pathogen Exposure Incident Form
- E. Annual Training Record
- F. Sharps Injury Log for type and brand of device
- G. Annual Documentation of Review of Program and Devices

EXPOSURE CONTROL PLAN

(Name of the dental practice)

This practice is committed to providing a safe and healthful work environment for the staff. In pursuit of this endeavor, the following exposure control plan is provided. This written exposure control program has been developed by (dental practice name) _____ on (date prepared) _____ to eliminate or minimize employee exposure to blood or other potentially infectious materials and is intended to comply with the requirements of OSHA standard 29 CFR 1910.1030, Occupational Exposure to Bloodborne Pathogens.

(Person designated) _____ has been designated as the exposure control program coordinator and will be responsible for enforcement, review (annually or more frequently when determined necessary — documented annually — Appendix G) and maintenance of this program.

Those employees who are determined to have occupational exposure to blood or other potentially infectious materials (OPIM) must comply with the procedures and work practices outlined in this exposure control plan.

(Person designated) _____ will maintain and provide all necessary personal protective equipment (PPE), labels, red bags and engineering controls (eg. sharps containers and sharps with engineered sharps injury protection). They will ensure that adequate supplies are available in the appropriate sizes.

(Person designated) _____ will be responsible for ensuring that all medical actions required are performed and that appropriate medical records are maintained.

(Person designated) _____ will be responsible for training, documentation of training and making the written exposure control plan available as required.

(NOTE — the name or job title of the program administrator should be used to ensure that authority and responsibility have been designated. In a small practice, the responsibilities for the program may be held by one individual.)

DEFINITIONS

The following are important definitions related to this written exposure control plan and 29 CFR 1910.1030 Occupational Exposure to Bloodborne Pathogens:

Blood means human blood, human blood components, and products made from human blood.

Bloodborne Pathogens means pathogenic microorganisms that are present in human blood and can cause disease in humans.

These pathogens include, but are not limited to, Hepatitis B virus (HBV) and human immunodeficiency virus (HIV).

Contaminated means the presence or the reasonably anticipated presence of blood or other potentially infectious materials on an item or surface.

Contaminated Laundry means laundry which has been soiled with blood or other potentially infectious materials or may contain sharps.

Contaminated Sharps means any contaminated object that can penetrate the skin including, but not limited to, needles, scalpels, broken glass, broken capillary tubes, and exposed ends of dental wires.

Decontamination means the use of physical or chemical means to remove, inactivate, or destroy bloodborne pathogens on a sur-

SCHEDULE AND METHOD OF IMPLEMENTATION

Methods of Compliance:

A) **Universal/Standard Precautions:** Effective immediately, universal precautions (or standard precautions) shall be observed to prevent contact with blood or other potentially infectious materials. Under circumstances in which differentiation between body fluid types is difficult or impossible, all body fluids shall be considered potentially infectious materials. All blood or OPIM will be considered infectious regardless of the perceived status of the source individual.

Exposure Control Plan:

Employees whose job titles are listed in the exposure determination section on page 22 will receive an explanation of this exposure control plan during their orientation. It will also be reviewed in their annual refresher training. All employees will have an opportunity to review this plan at any time during their work shifts by contacting the designated person listed on page 21. A copy of the plan will be made available free of charge and within 15 days of the request.

B) **Engineering and Work Practice Controls:**

Engineering and work practice controls will be utilized as a primary method for eliminating or controlling exposure to blood or other potentially infectious materials.

New technology for safer needles and sharps will be evaluated and implemented whenever possible to prevent needle-sticks and cuts. Non-managerial employees will be included in the evaluation of safer devices initially and at least annually during the program evaluation.

The following are a list of Sharps with Engineered Sharps Injury Protection that have been evaluated:

Devices Evaluated:

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

| | |
|--------------------------------------|-----------------|
| <i>Type of Safer Device Selected</i> | Location of use |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

| | |
|--------------------------------|---------------|
| <i>Non-safe devices in use</i> | Justification |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

This facility identifies the need for changes in engineering control and work practices through (Examples: Review of records, employee interviews, committee activities, etc.):

New procedures or new products will be evaluated by (describe the process): _____

Both front line workers and management are involved in this process (describe how employees will be involved):

Sharps containers will be located in each operatory and will be inspected and maintained or replaced by _____ whenever necessary to prevent overfilling (according to manufacturer's instructions).

The following work practice controls will be utilized and enforced by department supervisors:

- Employees MUST wash their hands and any other exposed skin with soap and water, or flush mucous membranes with water immediately or as soon as feasible following contact of such body areas with blood or other potentially infectious materials.
- Employees MUST wash their hands with soap and water immediately or as soon as possible after removal of gloves or other personal protective equipment.
- Contaminated needles and other sharps will not be sheared, bent, recapped, or removed unless no alternative is feasible or such action is required by a specific medical procedure. Such recapping, needle or blade removal will be accomplished through the use of a mechanical device (needle well, blade removal system) or a one-handed technique. Blades will not be removed using forceps, needle holders, or fingers.

List specific procedures and techniques where recapping or removal is done (by whom):

- Contaminated reusable sharps will be placed in appropriate containers immediately or as soon as possible after use for proper re-processing.
- Eating, drinking, smoking, applying cosmetics or lip balm, and handling contact lenses are prohibited in work areas where there is a reasonable likelihood of occupational exposure.
- Food and drink will not be kept in refrigerators, freezers, shelves, cabinets or on countertops or benchtops where blood or OPIM is present.
- All procedures involving blood or other potentially infectious materials will be performed in such a manner as to minimize splashing, spraying, spattering, and generation of droplets of these substances. The methods used to accomplish this include (for example: covers on centrifuges, usage of dental dams):

- Equipment that may become contaminated with blood or OPIM will be examined prior to servicing or shipping and decontaminated as necessary. If decontamination is not feasible, a readily observable biohazard label will be

attached to the equipment stating which portions remain contaminated.

- C) **Personal Protective Equipment:** Where occupational exposure remains after institution of engineering and work practice controls, appropriate personal protective equipment will be used. Personal protective equipment will be considered “appropriate” only if it does not permit blood or other potentially infectious materials to pass through to reach employee’s work clothes, street clothes, undergarments, skin, eyes, mouth, or other mucous membranes under normal conditions of use. Personal protective equipment is provided at no cost to the employee. (Person designated) _____ will be responsible for ensuring that employees wear appropriate personal protective equipment. The following job classifications and/or tasks or procedures require personal protective equipment (See Table 1):

according to federal, state and local regulations. Contact the Tennessee Department of Environment and Conservation, Division of Solid Waste Management, Biohazard Waste at 615-532-0796 with questions.

- **Equipment:** All equipment and environmental work surfaces shall be cleaned and decontaminated with an appropriate disinfectant after contact with blood or other potentially infectious materials.
- **Work Surfaces:** Contaminated work surfaces shall be decontaminated with an appropriate disinfectant after completion of procedures or as soon as feasible when surfaces are obviously contaminated, after any spill of blood or other potentially infectious material, and at the end of the work shift. The disinfectants listed below will be used according to label directions. (List EPA or FDA approved germicidal agents, bleach solutions, etc. See Table 2)

NOTE: Work surfaces include countertops, exam tables, mobile med-carts, etc.

Housekeeping Schedule
(See Table 2)

- **Protective Coverings:** Protective coverings such as plastic wrap, aluminum foil, or

| Table 1 — Personal Protective Equipment | | | | | | |
|---|--------------|--------|--|-------------------|--|-------------------------------------|
| Job &/or Task | Hand-washing | Gloves | Gown, Plastic Apron, Other Protective Clothing | Mask, Face Shield | Eye Protection (must have intact side shields) | Other Personal Protective Equipment |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

Legend: R = Routinely S = If soiling likely SP = If spattering likely

The following also applies to personal protective equipment:

- Personal protective equipment MUST be cleaned, laundered, repaired, and/or replaced as needed to maintain its effectiveness.
- If a garment is penetrated by blood or other potentially infectious material, this garment MUST be removed immediately or as soon as feasible.
- All personal protective equipment MUST be removed prior to leaving the work area (e.g. lunch and breaks). Location where it is stored during lunch/breaks _____ (label this storage area with a biohazard label).
- When personal protective equipment is removed, it MUST be placed in an appropriately designated container with a biohazard label until washing and decontamination, or disposal. (Location) _____

imperviously-backed absorbent paper used to cover equipment or environmental surfaces will be removed and replaced as soon as feasible when they become obviously contaminated and at the end of the work shift.

- **Trash Cans:** All bins, pails, cans, and similar receptacles which have a reasonable likelihood for becoming contaminated with blood or other potentially infectious materials will be inspected, cleaned, and decontaminated (frequency) _____ or as soon as feasible upon visible contamination.
 - **Sharps:** Contaminated sharps will be discarded immediately or as soon as feasible in approved containers. Sharps containers will be closed before they are moved.
- NOTE: Reusable sharps that are contaminated with blood or other potentially infectious materials will be stored or processed so that employees do not have to reach by hand into the containers where these sharps have been placed.

- D) **Housekeeping:** In keeping with the concept of Universal Precautions or Standard Precautions, this practice will ensure that the worksite is maintained in a clean and sanitary condition. Regulated waste will be disposed of

| Table 2 — Housekeeping Schedule | | | |
|--------------------------------------|------------------------------|-----------------------|--|
| Area or Surface to be Decontaminated | Frequency of Decontamination | Approved Disinfectant | Person Responsible for Decontamination |
| | | | |
| | | | |
| | | | |
| | | | |

- **Sharps Containers:** Sharps containers will be inspected (frequency) _____ to ensure they are not allowed to become overfilled. Sharps containers must be closable, puncture resistant, leakproof on sides and bottom, and contain a biohazard label or be colored red. Sharps containers will be located as close as feasible to the immediate area where sharps are used.
- The following is a list of locations requiring sharps containers, along with the individual responsible for ensuring that these containers are maintained:



- **Laundry:** Contaminated laundry will be bagged or containerized at the location where it was used in an approved bag or container. All personal protective equipment will be cleaned, laundered, and disposed of by the employer at no cost to the employee. Contaminated laundry must not be sorted or rinsed in the location of use. Laundry will be cleaned by: _____. The laundry has been notified of the potential for contamination by blood-borne pathogens and notified of the need to use universal precautions by: _____

HEPATITIS B VACCINATION

The Hepatitis B vaccine and vaccination series will be made available to all employees with occupational exposure (all employees with job titles listed in the exposure determination on page 22. (Person designated) _____ is responsible for ensuring that all employees who may be working in areas with occupational exposure are allowed the chance to receive the Hepatitis B vaccination after the employee has received the training required and within ten (10) working days of initial assignment. The vaccination will be administered according to the latest CDC Guidelines. A titer will be drawn to confirm immunity thirty to sixty (30 - 60) days following the completion of the third vaccination for those with ongoing contact with blood or OPIM.

The latest CDC Guidelines will be followed (these can be obtained by logging on to www.cdc.gov and searching for the latest guideline on administration of the Hepatitis vaccination series).

CDC guidelines currently followed for administration of the Hepatitis vaccination:

Employees who decline the Hepatitis B vaccination will be required to sign the statement given in Appendix A. If an employee initially declines the Hepatitis B vaccine but later decides to accept, it will be made available at that time, assuming the employee still has occupational exposure.

The employee will be medically evaluated before receiving the vaccination and a copy of the Healthcare Professional's Written

Opinion for Hepatitis B will be obtained from the Physician or Licensed Healthcare Professional (see Appendix B). A copy will be provided to the employee within fifteen (15) days. If the employee has previously received the Hepatitis B vaccination, testing showed immunity or the vaccine is medically contraindicated, the facility will have a copy of the documentation or have the employee sign the Declination Statement (Appendix A).

Documentation will be maintained (location of employee medical records) _____.

Any time an exposure incident occurs, employees must contact (person designated) _____ to ensure the proper evaluation and follow-up. The medical evaluation and follow-up will include the following elements:

1. Documentation of the route(s) of exposure and the circumstances under which the exposure incident occurred.
2. Identification and documentation of the source individual, unless infeasible or prohibited by state or local law. After consent is obtained (where required), the source individual's blood will be tested and the results documented.
3. Results of the source individual's testing shall be made available to the exposed employee, along with applicable laws and regulations concerning disclosure of the identity and infectious status of the source individual.
4. Exposed employee's blood will be tested as soon as feasible after consent obtained.
5. If the employee consents to baseline blood collection but does not give consent at that time for HIV serologic testing, the sample shall be preserved for ninety (90) days. If, within ninety (90) days of the exposure incident, the employee elects to have the baseline sample tested, such testing shall be done as soon as feasible.
6. When medically indicated, post-exposure prophylaxis will be provided, as recommended by the U.S. Public Health Service. The exposed employee will be sent to (physician, clinic, or hospital) _____ for counseling and follow-up.
7. Counseling and evaluation of reported illnesses will be made available to the employee.

POST-EXPOSURE EVALUATION AND FOLLOW UP

The latest CDC Guidelines will be followed for the post-exposure evaluation and follow-up for Hepatitis B and C and HIV (these can be obtained by logging on to www.cdc.gov).

Within fifteen (15) days of completion, a copy of the evaluating healthcare professional's written opinion shall be obtained (see Appendix C) by (person designated) _____ and provided to the employee. This written opinion will be limited to the following information:

- That the employee has been informed of the results of the evaluation.
- That the employee has been told about any medical conditions resulting from exposure to blood or other potentially infec-

tious materials which require further evaluation or treatment (**other findings or diagnoses shall remain confidential and not be included in the written report**).

(Person designated) _____ is responsible for providing the following information to the healthcare professional following an exposure incident and prior to medical evaluation:

- A copy of 29 CFR 1910.1030, the Bloodborne Pathogens Standard.
- A description of the exposed employee's duties as they relate to the exposure incident.
- Documentation of the route(s) of exposure and circumstances under which exposure occurred.
- Results of the source individual's blood testing, if available.
- All medical records relevant to the appropriate treatment of the employee including vaccination status.

EVALUATION OF EXPOSURE INCIDENTS

(Person's name) _____ will be responsible for immediately conducting an investigation into the circumstances of exposure incidents.

Procedure for Evaluating the Circumstances Surrounding an Exposure Incident:

- A. _____ will review the circumstances of all exposure incidents to determine:
- why the exposure incident occurred;
 - if procedures were being followed;
 - if procedures, protocols, and/or training need to be revised.
- B. If it is determined that revisions need to be made, _____ will ensure that appropriate changes are made. (Changes may include an evaluation of sharps with engineered sharps injury protection, more frequent changes for sharps containers, etc.)
- C. Documentation of this evaluation should accompany the exposure report.

Sharps Injury Log: According to the Tennessee Safer Needle Law 0800-1-10, a log will be kept of all sharps injuries that will include the type and brand of device involved in the incident. See Appendix F.

Labeling: Warning labels shall be affixed to containers of regulated waste, refrigerators and freezers containing blood or other potentially infectious materials, and other containers used to store, transport, or ship blood or other potentially infectious materials. These labels shall include the biohazard legend shown to the right.



EMPLOYEE TRAINING

All employees with occupational exposure will be expected to participate in a training session that will be provided at the time of initial assignment to tasks where occupational exposure takes place, every year thereafter, and whenever changes such as modifications of tasks or procedures or institution of new tasks or procedures affect the employee's exposure. (Employee's name) _____ will be responsible for coordinating training sessions, which will consist of the following:

- A. An explanation of the bloodborne pathogens standard (29 CFR 1910.1030) and the fact that a copy of the text of this standard will be accessible to employees at all times.
- B. A general explanation of the epidemiology and symptoms of bloodborne diseases.
- C. An explanation of the modes of transmission of bloodborne pathogens.
- D. An explanation of (practice name) _____ exposure control plan and the means by which employees can obtain a copy of the written plan.
- E. An explanation of the appropriate methods for recognizing tasks and other activities that may involve exposure to blood and other potentially infectious materials.
- F. An explanation of the use and limitations of methods that will prevent or reduce exposure including engineering controls, work practice, and personal protective equipment.
- G. Information on the types, proper use, location, removal, handling, decontamination, and disposal of personal protective equipment.
- H. An explanation of the basis for selection of personal protective equipment.
- I. Information on the Hepatitis B vaccine and a statement that the vaccine will be offered free of charge.
- J. Information on the appropriate actions to take and persons to contact in an emergency involving blood or other potentially infectious materials.
- K. An explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident and the medical follow-up that will be made available.
- L. Information on the post-exposure evaluation and follow-up that the employer is required to provide for the employee following an exposure incident.
- M. An explanation of the signs and labels and/or color coding that is used in the facility.
- N. An opportunity for interactive questions and answers with the person conducting the training session.

The training coordinator will keep a record on file concerning all training sessions. A sample copy of the training record form is included in Appendix E.

RECORDKEEPING

_____ is responsible for maintaining records regarding the exposure control plan and for ensuring that all medical records are kept confidential. The following

records will be kept on file:

- A. A file for each employee with occupational exposure to blood or other potentially infectious materials including the name and social security number of the employee, a copy of the employee's Hepatitis B vaccination status, including dates of all Hepatitis B vaccinations, any medical records relative to the employee's ability to receive vaccination (previously vaccinated, testing showed immunity, medically contraindicated).
- B. A copy of all results of examinations, medical testing, and follow-up procedures following an exposure incident.
- C. The employer's copy of the healthcare professional's written opinion regarding the employee's ability to receive the Hepatitis B vaccination (See Appendix B).
- D. The employer's copy of the healthcare professional's written opinion regarding post-exposure evaluation and follow-up (See Appendix C).
- E. A copy of the information provided to the healthcare professional regarding post-exposure evaluation and follow-up.

The above records will not be disclosed or reported without the employee's express written consent to any person within or outside the workplace except as required by the bloodborne pathogens standard or by law. Additionally, these records will be maintained for at least the duration of employment plus thirty (30) years.

Training records: (See Appendix E) Will be maintained for three (3) years from the date on which the training occurred.

Transfer of records: Must comply with 29 CFR 1910.1020 Access to Employee Medical and Exposure Records (h) Transfer of Records.

APPENDICES

Appendix A

HEPATITIS B VACCINE - DECLINATION STATEMENT

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Signature

Date

Appendix B

HEALTHCARE PROFESSIONAL'S WRITTEN OPINION FOR HEPATITIS B VACCINATION

Employee Name: _____

Date of Office Visit: _____

Healthcare Facility Address: _____

Health Care Facility Telephone: _____

As required by the bloodborne pathogen standard:
Hepatitis B vaccination is _____ is not _____ recommended for the employee named above.

The employee named above is scheduled to receive the Hepatitis B vaccination on the following dates:

First of three: _____

Second of three: _____

Third of three: _____

(Signature of Health Care Provider)

(Printed or typed name of Health Care Provider)

This form is to be returned to the employer, and a copy provided to the employee, within fifteen (15) days.

Employer Name: _____

Title: _____

Address: _____

Appendix C

HEALTHCARE PROFESSIONAL'S WRITTEN OPINION FOR POST-EXPOSURE EVALUATION

Employee Name: _____

Date of Incident: _____

Date of Office Visit: _____

Healthcare Facility Address: _____

Health Care Facility Telephone: _____

As required by the bloodborne pathogen standard:

- The employee named above has been informed of the results of the post-exposure health evaluation.
- The employee named above has been told about any health conditions resulting from exposure to blood or other potentially infectious materials which require further evaluation or treatment.
- Hepatitis B vaccination is is not indicated.

(Printed or typed name of Health Care Provider)

(Signature of Health Care Provider) (Date)

This form is to be returned to the employer and a copy provided to the employee within fifteen (15) days. Please label the outside of the envelope "Confidential."

Employer Name: _____
 Title: _____
 Address: _____

Appendix D

**BLOODBORNE PATHOGEN EXPOSURE INCIDENT FORM
— CONFIDENTIAL —**

(Send with employee at the time of an exposure incident along with relevant medical records for employee including Hepatitis B vaccination status and a copy of Appendix C - Healthcare Professional's Written Opinion Form - Post Exposure and a copy of the Bloodborne Standard 29 CFR 1910.1030.)

Date: _____

Employee name: _____

Date of the Incident: _____

How exposure occurred: _____

Route of exposure: _____

Description of exposed employee's duties relating to the incident:

Source individual: _____

Results of source individual blood test results: _____

Results of the source individual's blood test results have been given to the exposed employee and they have been counseled on confidentiality: _____

Evaluation of circumstances surrounding the incident has been completed by the employer as stated on Page 26 of the Exposure Control Plan _____.

- Action for healthcare provider:
- Copy of healthcare professional's written opinion for post-exposure completed and sent to employer (date) _____.
 - Copy of healthcare professional's written opinion for post-exposure provided to the exposed employee (date) _____.

Appendix E

ANNUAL TRAINING RECORD

Date of Training: _____

Trainer Name and Qualifications: _____

Employee Names and Job Titles who attended:

- Summary of Training:
- A) An explanation of the standard (29 CFR 1910.1030).
 - B) A general explanation of the epidemiology and symptoms of bloodborne diseases.
 - C) An explanation of the modes of transmission of bloodborne pathogens.
 - D) An explanation of the employer's exposure control plan and the means by which employees can obtain a copy of the written plan.
 - E) An explanation of the appropriate methods for recognizing tasks and other activities that may involve exposure to blood and other potentially infectious materials.
 - F) An explanation of the use and limitations of methods that will prevent or reduce exposure including engineering controls, work practice, and protective equipment.
 - G) Information on the types, proper use, location, removal, handling, decontamination, and disposal of personal protective equipment.
 - H) An explanation of the basis for selection of personal protective equipment.
 - I) Information on the Hepatitis B vaccine and a statement that the vaccine will be offered free of charge.
 - J) Information on the appropriate actions to take and persons to contact in an emergency involving blood or other potentially infectious materials.
 - K) An explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident and the medical follow-up that will be made available.
 - L) Information on the post-exposure evaluation and follow-up that the employer is required to provide for the employee following an exposure incident.
 - M) An explanation of the signs and labels and/or color coding that is used in the facility
 - N) An opportunity for interactive questions and answers with the person conducting the training session.

Appendix F

SHARPS INJURY LOG - TYPE AND BRAND OF DEVICE

(0800-1-10 Tennessee Safer Medical Device Law)
(Refer to completed form from Appendix D)

Exposure Incident Date: _____

Type and Brand of Device: _____

Changes made:

Date: _____ 200__

Signature: _____

Devices reviewed: _____

Appendix G

ANNUAL BLOODBORNE PATHOGEN PROGRAM REVIEW

(List devices evaluated during the annual review)

Date: _____ 200__

Signature: _____

Devices reviewed: _____

Changes made:

Date: _____ 200__

Signature: _____

Devices reviewed: _____

Date: _____ 200__

Signature: _____

Devices reviewed: _____

Changes made:

Date: _____ 200__

Signature: _____

Devices reviewed: _____

Changes made:

Date: _____ 200__

Signature: _____

Devices reviewed: _____

Changes made:

For questions about compliance with the Bloodborne Pathogens Standard or other TOSHA standards, feel free to give TOSHA Consultation a call at 1-800-325-9901 or log on to the OSHA website at www.osha.gov and left click on "D" in the index, then left click on "Dentistry."

The Updated 2007 Exposure Control Plan (ECP)

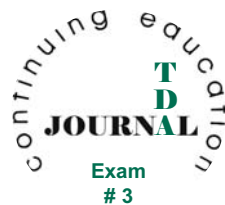
IN BRIEF

This section is designed to answer some common questions about the ECP and not to be comprehensive. Specific questions should be directed either directly to TOSHA or to the Committee on the Environment and Infection Control of the Tennessee Dental Association.

1. **Classify by job and not by name.**
2. **Standard Precautions** – All body fluids shall be considered potentially infectious. Includes saliva, even without blood in it.
3. **Engineering and Work Practice Controls — Sharps with Engineered Sharps Injury Protection (SESIP).**
What does it mean? That each office must evaluate annually and document products that provide protection from sharps. This is to be done in concert with employees who work with sharps to choose the best approach for the practice. For example, retractable needles, protective sheath needles, retractable blade scalpels etc. (Available through dental suppliers and manufacturers.)
4. **Sharps containers in each operatory.**
5. **Handwashing** – Use techniques as described in the CDC Infection Control Guidelines 2003.
6. **Recapping needles by one hand technique** or a mechanical device are to be used and scalpel blades are not to be removed by forceps, needle holders or fingers. Products are now available that mechanically remove the blade from the handle.
7. **Personal Protective Equipment (PPE)** – Does not permit blood or OPIM to pass through. Provided at no cost to the employee. All PPE is to be removed when leaving the work area (e.g. for lunch or breaks) and kept in a designated area. Shoes must not have open toes or openings on the top of shoes (Crocs-type).
8. **Housekeeping** – Read the definition of regulated waste (ECP page 24) carefully and clearly know what classifies

as regulated waste. Disposal must meet federal, state and local regulations. Call the telephone number listed in section D (ECP) if you have any questions about local or state issues.

9. **Sharps Containers** – Know where the fill line is on each container and do not overfill.
10. **Exposure Incident** – (See definition ECP page 22.) Remember “needle sticks” can be by hollow bore needles, solid wire or sharp solids (scalpel blades) used in dentistry or any contaminated object that breaks the skin or mucosal barrier. Be sure all employees understand clearly that they are to report the incident as soon as possible and, if the source individual is known, that they are also informed. Each office should have a relationship with a medical provider who will provide the proper screening for HIV and Hepatitis for the involved individuals at no cost to them. This to be done with permission of employee and source individual. A Bloodborne Pathogen Exposure Incident Form is to be recorded for each incident and filed in the employee’s medical record.
11. **Labeling** – If a refrigerator, freezer or other container has infectious or potentially infectious materials in them, a proper warning label must be affixed.
12. **Employee Training** – Training must be accomplished prior to initial assignment to a position that presents an occupational exposure hazard. Then, training for all employees classified must have annual training. If tasks are modified, additional training must occur and be documented.
13. **Recordkeeping** – All records mandated by the Exposure Control Plan must be kept for the term of employment of that individual and then for 30 years.
14. **Disinfection** — Disinfectants used to clean equipment and environmental work surfaces must be used according to the label instructions for the required contact time.



**See Page 34 for the CE Questions for this Exam # 3.
Follow all instructions on the Answer Form
on Page 35 regarding
submission of Exam # 3 for CE credit.**

HIPAA — Where are We Now?

Stephen C. Alsobrook, D.D.S.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that required the Department of Health and Human Services (HHS) to establish certain national standards for electronic health care transactions. This included standards for the security and privacy of healthcare data. In addition it requires the standardization of the nomenclature of all medical and dental transactions. It also requires them to provide national identifiers for health care providers, health plans, and employers.

This brief overview is intended to familiarize you with the basics of HIPAA and the various sections of the law that apply to dentistry. This paper will offer some suggestions as to how to comply, or continue to comply, with these provisions of the law. The regulation itself is nearly 100 pages long.¹ For a detailed look at two important parts of the law, the American Dental Association has put together two kits, each containing a three-ring binder and CD-ROM.² The kits contain sample forms and specific information on the Privacy and Security aspects of HIPAA. (See Photo 1)

Due to the large amount of material, this paper will not be able to give you all the details you might need to form your own program. I highly recommend that you go through one or both of the ADA manuals if you need to generate a compliance program from scratch.

The first thing a health care provider should determine is whether or not the law applies to them as a “covered entity.” It applies only to “a health care provider who transmits any health information in electronic form.” Electronic form includes storing health information in electronic storage media such as hard



Dr. Stephen C. Alsobrook

drives or removable media such as magnetic disks, optical disks and memory cards. It also covers any data moved by the Internet, leased lines, private networks, and dial-up lines. It does not include the use of fax machines, if the data did not exist in digital form before it was sent.

See Table 1 on the following page for the major provisions of the law and their associated compliance dates.

Transaction Standards and Code Sets

In order to facilitate the efficient transmission of information, HIPAA mandates that healthcare procedures and transactions be standardized. Under this provision, the American Dental Association is given sole responsibility for publishing descriptions of dental procedures and their associated codes, which they do under the Code on Dental Procedures and Nomenclature. This work is updated and published by the ADA as part of the Current Dental Terminology (CDT) book, the national standard for reporting dental services.

HIPAA Privacy Standard

This provision is probably the most familiar to most practitioners. You most likely have experienced this provision if you have been a patient for any reason in almost any medical office in the past few years. The intent of this provision is to ensure that Protected Health Information (PHI) gathered in the normal course of dental/medical treatments is used solely by the treating practitioner and others who need to know that information.

The Privacy Rule establishes a requirement that health care providers obtain a written consent before using the patient’s PHI to carry out treatment, payment, or healthcare operations (TPO).

The dental practitioner is required by HIPAA to have a written “Notice of Privacy Practices” posted in the office and distributed to patients. What should be contained in this notice is too lengthy to be presented here, but the ADA Privacy Kit has an excellent sample form printed in the manual and on an accompanying CD that can be customized for your practice.

The other requirement of HIPAA privacy is that each patient receive a form of “Acknowledgement of Receipt of Notice of Privacy Practices” with a copy of the Notice of Privacy Practices. This form should be signed and placed in the patient’s record.

A Privacy Officer should be designated and a Contact Person to receive complaints. Both of these people could be the dentist. There should be a training program for employees and that training should be documented. There should be an employee discipline process for any privacy violations that are uncovered.

The practice should evaluate



Photo 1

Photo courtesy of Patrick Alsobrook

whether there should be a Business Associate Agreement with those companies or individuals that have access to PHI but are not themselves covered entities. Referring dentists, specialists, healthcare insurers, etc. are covered entities and do not need Business Associate Agreements. Those that may require agreements, if they have regular access to PHI, are: accountants, lawyers, collection agencies, etc.

Patients have the right to look at, copy and amend their healthcare information. They also have the right to request restrictions on disclosures and have the right to offer complaints regarding the disclosure of their healthcare information.³

A good rule to follow is the minimum necessary standard. This means you will use reasonable efforts to disclose only the information needed to accomplish a given purpose to as limited number of people as possible.

Privacy policies should be updated and modified as needed based on periodic audits of the policies and their effectiveness.

HIPAA Security Rule

If you follow the national news, you have probably heard numerous stories of electronic information such as names, addresses, birthdays and social security numbers being lost or stolen from various companies. The HIPAA security rule is designed to help prevent the loss of

Protected Health Information (PHI) through security breaches in the dental office.

There are three principles that provide the foundation for security:

1. Integrity — PHI should not be changed or destroyed without proper authorization;
2. Confidentiality — PHI should be available only to those authorized to receive it; and
3. Availability — PHI should be accessible by authorized persons when needed.

These principles lead to three categories of security safeguards that must be addressed by the dental practitioner: administrative, technical and physical. Each will be discussed briefly here, but again, the ADA Security Kit provides an excellent detailed outline with a companion CD. The security kit, for example, provides an extensive checklist of security risk management items that should be considered when implementing the security rule.

Administrative Safeguards

The first step in administrative safeguards is to perform a risk analysis of the

office. From this analysis, a list of items to be addressed and who is responsible for these items is generated.

An example of items that may be addressed may be the location of electronic PHI. It should be decided whether PHI

should be stored on fixed office computers only, or will the information also possibly be stored on portable computers, handheld devices or memory cards. If so, it should be decided if these data should be encrypted.

It should be specified who is authorized to change the content of dental records. A Security Official should be appointed. This official is responsible for coordination of these safeguards within the office. This individual could also be the dentist.

In addressing administrative safeguards, the use of anti-virus software, firewalls, and encryption should be considered. Should someone suspect security has been compromised, any necessary corrective procedures should be outlined.

Another administrative aspect which should be addressed is the formulation of a contingency plan in the event of the destruction of office data, or the loss of the office itself. This is a good business practice, regardless of HIPAA requirements. The ADA has an excellent disaster preparedness manual available online, the reference for which is listed at the end of this article.⁴

There should be a priority list of what needs to be restored, how to

| Table 1 | |
|--------------------------------------|--|
| HIPAA Effective Dates Summary | |
| Effective Date | Standard |
| April 14, 2003 | Privacy |
| October 16, 2003 | Electronic Health Care Transactions and Code Sets |
| July 30, 2004 | Employer Identifier Standard |
| April 20, 2005 | Security Standards |
| May 23, 2007 | National Provider Identifier |
| May 23, 2008 | National Provider Identifier Contingency Extension |

restore it, and who will do the restoration. Backup plans should be practiced. There should also be a list designating critical hardware, software and contact information for essential workforce members. This list should be kept off site.

Technical Safeguards

Each member of the team should be assigned a unique user identification and password. There should be a sanction policy in place for employees that share passwords. The software vendor should provide you with a method to monitor and audit which team member is accessing PHI, as each user should be using only their unique identification when logged into the system.

Physical Safeguards

This aspect involves access to the physical location of the PHI. You should address who has physical access to your facility in the event of a disaster. There should be a documented plan about how various workstations are to be used in the practice. Another consideration is whether wireless connections can be used in the office and how the connection is secured. The log-off policies for the office computer system should be delineated. Practice data should be regularly backed up and the backups should be maintained off site.

Employer Identifier Standard

HIPAA requires that all employers have a standard number to identify themselves on healthcare transactions. The Employer Identification Number (EIN), issued by the Internal Revenue Service, was selected as the identifier for employ-

ers. This became effective July 30, 2002.

National Provider Identifier

National Provider Identifier (NPI) is a new ten-digit number to replace the legacy identifiers such as license numbers, Social Security numbers, etc. which were previously used to identify health-care providers.⁵ They are required on all HIPAA standard transactions. The deadline to obtain the number was May 23, 2007; however, it is not too late to register and receive a number, because the Centers for Medicare and Medicaid (CMS) have allowed a one-year contingency period before it will enforce actions against covered entities. This contingency period will expire May 23, 2008. Your NPI can be obtained by following the information at the following web link: <https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.npistart>. Paper applications are also accepted.

The numbers are assigned based on two different groups: Type 1 numbers are assigned to individual health care providers; Type 2 numbers are given to organizations that render health care such as clinics, group practices, corporations, etc. Incorporated/group practices can be Type 2 while individual providers are Type 1. This new number will not replace tax identification numbers and social security numbers for tax purposes.

Also please note that some dental insurance companies will accept only Type 1 numbers for claims processing. Most insurance companies have stated they will reject all electronic transactions that do not have NPIs after the end of the

contingency period.

The Future

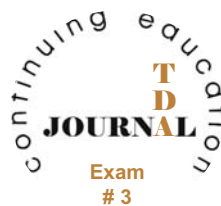
Fortunately, all the major provisions of the HIPAA law have now been implemented. There are a few issues that may, or may not, be added to existing HIPAA requirements. These may be published in future implementation regulations. Possible future issues include: the use of electronic signatures; formats for electronic health records including the transmission of claims attachments; and possibly, unique patient individual identifying numbers (other than the Social Security number).

Conclusion

The HIPAA law has changed procedures in many offices throughout the country. Many of the provisions seem to be burdensome, but the principles involved — such as keeping patient information private, having a unique code for each procedure, keeping the practice computer network safe from attack, etc. — make good business sense. It is hoped that such “simplification” and standardization will lead to a secure healthcare record that provides benefits for the patient, healthcare providers, and the healthcare system.

REFERENCES

1. A full text version of all the HIPAA regulations can be found at the below link: <http://www.hhs.gov/ocr/AdminSimpRegText.pdf>
2. HIPAA Privacy Kit and the HIPAA Security Kit from the American Dental Association members only catalog: <http://www.adacatalog.org>
3. Department of Health and Human Services HIPAA information for consumers and many other links to the regulations and standards: <http://www.hhs.gov/ocr/hipaa/>
4. American Dental Association Disaster Preparedness Manual Online: <http://www.ada.org/goto/disaster>
5. An overview of the law from the Centers for Medicare and Medicaid: <http://www.cms.hhs.gov/HIPAAGenInfo>



**See Page 34 for the CE Questions for this Exam # 3.
Follow all instructions on the Answer Form
on Page 35 regarding
submission of Exam # 3 for CE credit.**

QUESTIONS FOR CONTINUING EDUCATION ARTICLE - CE EXAM # 3

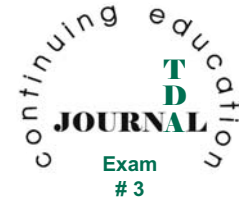
1. The first cases of AIDS were reported in the United States in:
 - a. 1966
 - b. 1991
 - c. 1981
 - d. 2001
2. Your new employee has worked as a dental assistant in another office. OSHA training in your office:
 - a. is not necessary due to prior employment
 - b. can be given within 10 days of employment
 - c. is to be given before patient contact
 - d. does not include hazardous chemicals
3. After twenty-five (25) years of HIV/AIDS in the United States, approximately how many cases exist?
 - a. Five hundred thousand
 - b. One million
 - c. Two million
 - d. Two hundred thousand
4. A patient tells you they are Hepatitis B, *e antigen*, positive, this means:
 - a. The patient is quite infectious
 - b. Has a protective antigen and is not infective
 - c. *e antigen* means they have a protective antibody
 - d. They should not be classed as infectious.
5. The term "Personal Protective Equipment" (PPE) includes all but one of the following:
 - a. Eye protection for the employee
 - b. Gloves and mask for the employee
 - c. Protective clothing for the employee
 - d. Plastic covering for the dental chair
6. How should a 2 x 2 gauze with a small amount of saliva and blood be disposed of in the dental office?
 - a. Placed in the Sharps Container
 - b. Placed in the regular garbage
 - c. Placed in a red bag
 - d. Sterilized
7. Hepatitis B Immunization for the dental office employee that qualifies:
 - a. Must be available within the first 15 days
 - b. Is done at the cost of the employee
 - c. Must have a titer drawn 30-60 days after the last shot
 - d. May be declined by the employee
8. Under the HIPAA law, who is a "covered entity"?
 - a. All health care providers
 - b. All licensed professionals
 - c. A health care provider that transmits any health information in electronic form
 - d. A health care provider that uses electronic records
9. Under the Privacy Standard, practitioners are required to post the:
 - a. Privacy Policies and Procedures
 - b. Notice of Privacy Practices
 - c. Business Associates Agreement
 - d. Consent to Privacy Practices
10. What is the first step to begin compliance with the Security Rule Administrative Safeguards?
 - a. Appoint a Security Official
 - b. Install a firewall on the network
 - c. Formulate a disaster contingency plan
 - d. Perform a risk analysis

**See the Answer Form on the next page
and follow all instructions regarding
submission of TDA Continuing Education Exam # 3 for credit.**

Answer Form for TDA CE Credit Exam # 3— One Sheet Per Person Please

**Circle Correct
Letter Answer
for Each CE
Exam
Question**

| | |
|------------|-------------|
| 1. a b c d | 6. a b c d |
| 2. a b c d | 7. a b c d |
| 3. a b c d | 8. a b c d |
| 4. a b c d | 9. a b c d |
| 5. a b c d | 10. a b c d |



PLEASE PRINT OR TYPE: ADA ID Number (*Dentist Only*) _____

**Cost per exam per person is
\$15.00 for one (1) continuing
education credit.**

License Number if RDH _____

Registration Number if RDA _____

**Deadline for exam submission is
twelve (12) months from date of
exam publication.**

Last Name First Middle

Office Address

City State Zip

**This page may be duplicated for
multiple use.**

(_____) _____
Daytime Phone Number

Component Society (*TDA Member Only*)

(*Auxiliary Staff: Please provide name of Employer Dentist*)

Dr. _____

**All checks should be made payable to the Tennessee Dental Association.
Return the Exam Form & your check or credit card information to the
Tennessee Dental Association • 660 Bakers Bridge Avenue, Suite 300 • Franklin, TN 37067.
The Form may be faxed to 615/628-0214 if using a credit card.**

Credit Card - Use your TDA/Bank of America Card - MasterCard or Visa ONLY:

Signature: _____

Card # _____ Exp. Date: _____

Three Digit CVV2 Code (*on back of card following card #*) _____

Name as it appears on card: _____

Do Not Write In This Space — For TDA Administrative Purposes Only

Check # _____

CC Paid w/doctor's cc