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ADA News - 07/15/2002

American Dental Association, Publishing Division

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AMERICAN DENTAL ASSOCIATION
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JULY 15, 2002 www.ada.org VOLUME 33, NO. 13

'Join us'

Association calls on Congress to prioritize children's oral health

By Craig Palmer

Washington—The Association called on Congress June 25 to "join us" in helping children smile.

"Our profession doesn't expect Congress to solve the nation's oral health crisis with the stroke of a pen," ADA President Gregory Chadwick told a Senate health subcommittee. "But we do expect you to join us in making this a priority. Let's start with our children, our common future, and build from there."

The U.S. Senate held an historic first hearing on children's oral health and improving access to care for the nation's poorest children, inviting testimony from the American Dental Association, former U.S. Surgeon General David Satcher, M.D., and other oral health care advocates.

■ Dentists' ADA disability network, page 21

"For these children, their personal suffering is real," said Sen. Jeff Bingaman (D-N.M.), hearing chair and sponsor of ADA-backed bipartisan legislation, the Children's Dental Health Improvement Act, one of several oral health measures pending in Congress.

"The severity of this problem is even greater among children in poverty," the senator said in opening the hearing.

Sens. Bingaman, Jeff Sessions (R-Ala.) and Tim Hutchinson (R-Ark.) joined in questioning the witnesses,

See ACCESS, page 12

Photo by Anna Ng Delort

Dr. Chadwick: "Let's start with our children, our common future, and build from there."

BRIEFS

New JADA feature: A new monthly feature centered on the everyday issues and concerns confronting today's practicing dentist will debut in the August edition of The Journal of the American Dental Association.

Entitled "Practical Science," the new feature is "meant to apply sound scientific principles and knowledge to the practical challenges of treating patients—and to help narrow the gap between dental research and dental practice," writes JADA Editor Marjorie K. Jeffcoat, in an August JADA preamble to the new feature.

Practical Science is being produced in cooperation with the ADA's Council on Scientific Affairs and Division of Science. The first column focuses on making the right choices among the new drugs available for pain control.

In the months ahead, Practical Science will explore such wide-ranging topics as the use of antibiotics and local anesthetics, dental restorative materials, cosmetic dental care and more.

JADA invites feedback on the new feature, which should be sent care of: The Journal of the American Dental Association, 211 E. Chicago Ave., Chicago 60611; the e-mail option is: "jada@ada.org". ■

■ 'Core precepts' spotlight staff dedication to serving ADA membership, encouraging personal responsibility and pride in a job well done.

'Members are purpose of our work'

By James Berry

It's a multifaceted effort centered on an essential truth: the ADA exists to serve its members, would have no reason for being without them, must earn their trust and respect every day, and must change with the times while anticipating the future.

ADA Executive Director James B. Bramson puts it more succinctly. "Members are the purpose of our work," he says. "We wouldn't be here if it weren't for them."

None of this is news, of course. It has been ever thus. But what is afoot at the ADA these days is a staff renewal and rededication like none before it.

■ Core precepts, page 16

It's a seismic cultural shift that shrinks divisional boundaries, promotes cooperation, ties in neatly with the interests of volunteer leaders and has captured attention at all levels of the tripartite—the profession's family of local, state and national organizations.

At the heart of this effort are the "core precepts," a set of five staff-generated guiding principles that apply to and influence the work of all employees. (To review a complete listing of the core precepts, see page 16.)

The precepts are not mere words on paper. They're words to live by for the roughly 450 employees who toil at the ADA's Chicago headquarters, in the Washington office, at the ADA Health Foundation and Paffenbarger Research Center, and at ADA Business Enterprises, Inc., the Association's for-profit subsidiary.

Developed by a staff team—nine employees appointed by Dr. Bramson from about 50 who volunteered—the core precepts define ADA employees

See PRECEPTS, page 16

Talking it over: Dr. Bramson (above) addresses an all-staff meeting in February.

2003 budget

Proposal weeds out 'weaker' programs

By Judy Jakush

With an eye on programs that enhance the value of membership, the ADA Board of Trustees in June approved a 2003 budget proposal that projects $73.7 million in revenue and $75.5 million in expenses.

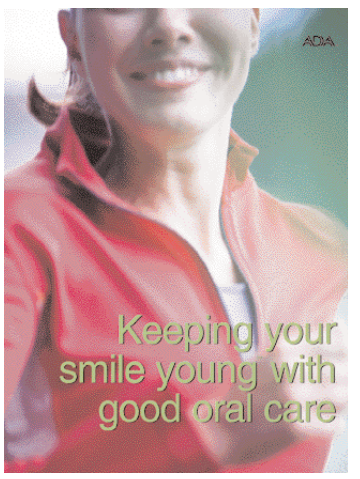
ADA Treasurer Mark Feldman explained that revenues are projected to increase by 5 percent over 2002, due in part to the strength of the ADA Membership Initiative. (For comparison purposes, these figures exclude the direct reimbursement campaign, he noted.)

See BUDGET, page 22

INSIDE

This second part of a series on retirement planning focuses on investing. **Story, page 18.**

Get ready: Materials set for Adult Oral Health Awareness



With the theme, "Keeping Your Smile Young with Good Oral Care," the ADA and its dental societies are preparing to launch this year's Adult Oral Health Awareness promotion.

Adult Oral Health Awareness targets adults of all ages, covering topics such as oral hygiene for older adults, tooth loss, dentures and dental implants, medication use, cosmetic dentistry and more.

National promotion for the event is planned for September. Those planning local activities can use the ADA's materials in September; however the materials are undated for use at any time.

As in years past, societies have the flexibility to conduct a local one-day, one-week or month-long promotion.

The Adult Oral Health Awareness kits—mailed to dental societies and dental schools last month—were redesigned for a new look for 2002.

Sample brochures are included, with an eight-by-10 inch tent card that reads, "Ask us about keeping your smile young with good oral care."

In addition, the Department of Salable Materials has several patient education resources designed for adults. Topics range from dry mouth to periodontal disease to bridges and crowns. For more information, call 1-800-947-4746.

Contact your local dental society if you're interested in conducting Adult Oral Health Awareness activities. ■

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StatesWatch

Michigan keeps Healthy Kids Dental program


Dr. Gist

Flint, Mich.—Despite the state's economic problems, a dental Medicaid program that administers care via Delta Dental Plan—and not government—will continue.

"We have maintained all 37 counties [currently participating in the program], with essentially a promise from state legislators that, as funds become available, the number of those counties will increase," says Dr. Raymond Gist, the new president-elect of the Michigan Dental Association.

Already, the program has shown success in increasing dentists' participation, "and this solves a great big problem," he says. Still, as head of the MDA, Dr. Gist's primary goal will be "to expand Healthy Kids Dental to all 83 counties in the state."

Dr. Gist also will be the first African-American president in the MDA's 145-year history.

Hygiene bill vetoed in Okla.

Oklahoma City—"While I support efforts to increase access to dental care for nursing home patients, this must be done in a manner that does not compromise the quality of care they receive."

So said Gov. Frank Keating to state legislators June 7 as he vetoed HB 1029. The bill would have allowed dental hygienists to provide care in nursing homes without a dentist's supervision.

"Today, I am directing the State Commissioner of Health to begin working with dental hygienists, dentists and those involved in the nursing home industry to reach a solution that increases access and guarantees quality care," he concluded.

Connecticut backs law on wastewater

Connecticut River, Conn.—At the governor's invitation, representatives of the Connecticut State Dental Association witnessed the signing June 13 of legislation for mercury waste reduction.

The new law reiterates the importance of dentists' continued compliance with manufacturer-provided material data safety sheets and mandates that dentists handle exposure to mercury in accordance with federal and state law, ADA guidelines or "best management practices" adopted by the state. The law also requires vocational dental education or training facilities to "provide for an education program for students regarding the hazards of mercury and best management practices."

The law does not require dentists to stop using amalgam or install mercury separator devices.

"The CSDA had previously established a strong working relationship with the state Department of Environmental Protection," noted CSDA President Michael Egan. "This law to protect Connecticut citizens—with appropriate language that our Association endorsed—was a culmination of the cooperating efforts of our legislative council and lobbying team, and the D.E.P."

—Reported by Mark Berthold

N.Y. launches 'MOO' pilot

Albany, N.Y.—A pilot program designed to help farmers in New York state to "moo-ve" more dairy products is giving students an "udder" choice when they buy vending machine beverages at school.

The New York State Assembly Agriculture Committee installed milk vending machines in three high schools chosen to test Project MOO, short for Milk Out in the Open.

"We started selling milk in test schools Feb. 14," says Scott Rapasadi, general manager of Aramatic Refreshment Services Inc., in Syracuse. "It's gone over very well." During the first few weeks, one test school principal reported selling about 800 bottles a week and admitted the school was having trouble keeping the machine stocked.

Mr. Rapasadi says that a half dozen other schools in his area have already requested milk vending machine installations.

Assemblyman Bill Magee, committee chair, said in a pre-project report prepared last November, "the ultimate goal and mission of Project MOO is to make sure that in addition to carbonated sodas, sports drinks and flavored beverages, the children of New York State also have an availability of milk and milk products. ... The corresponding result is healthier children and families as well as increasing milk consumption which is vital to the economic outlook of New York State's farmers."

Milk vending test programs are flowing at schools and workplaces nationwide, including Southern California, Florida, Massachusetts, Nebraska, Texas and Wisconsin, according to the Fluid Milk Strategic Thinking Initiative, a marketing think tank of the national "Got Milk?" Milk Mustache Campaign.

The National Fluid Milk Processor Promotion Board will conduct a more extensive study this summer.

—Reported by Stacie Crozier

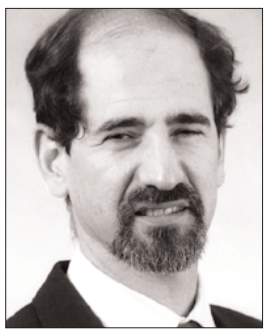
ViewPoint

MyView

Why can't I be paid for my time and expertise?

As a 50-plus-year-old male, I schedule a physical every two years. (My hospital requires it and also my wife will kick my butt if I don't.) When I go for my medical checkups, part of the process involves a doctor-patient interview. It is helpful for my internist to talk to me and ask questions in order to assess my general health.

How is work? How is the family? What do I usually eat and drink? Do I smoke and/or drink alcohol and if so how much? How much and what kind of exercise do I engage in?



Ronald Brown, D.D.S.

Along with blood and urine collection, electrocardiogram, pulse and blood pressure, my physician bills me for his time and expertise. It has never been an issue of contention. My medical insurance carrier even pays for most of it. I have never intimated to my physician that such billing was unfair or inappropriate.

As a dentist, I am often involved in providing services related to interviewing patients, counseling patients and utilizing my knowledge base and experience to positively influence my patients' oral and systemic health. So why as a dentist shouldn't I be compensated for my time and expertise?

I graduated from dental school in 1971. (It was an extremely difficult four years!) The working concept of dentistry at that time was defined within the phrase "drill, fill and bill." As a general dentist, I got paid for taking X-rays, for doing fillings, crowns, fixed bridges, root canals, partial and full dentures, periodontal scaling and for extracting teeth.

What I didn't get paid for, or at least what I got paid very little, was for diagnostic services, treatment planning, patient education and home care instruction.

I have gone to untold lectures and repeatedly I have been informed that the most important aspect of gaining success in dental treatment is the dental patient's attention to good oral hygiene procedures. I have read untold papers that documented the dental patient's practice of oral hygiene was the main factor in the success or failure of dental treatment (periodontal, restorative and both fixed and removable prosthodontic treatment).

Believe me. I am a believer. There appears to be no credible argument that denies the importance of oral hygiene within clinical dentistry. So why can't I be paid for teaching and reinforcing good oral hygiene patient behavior?

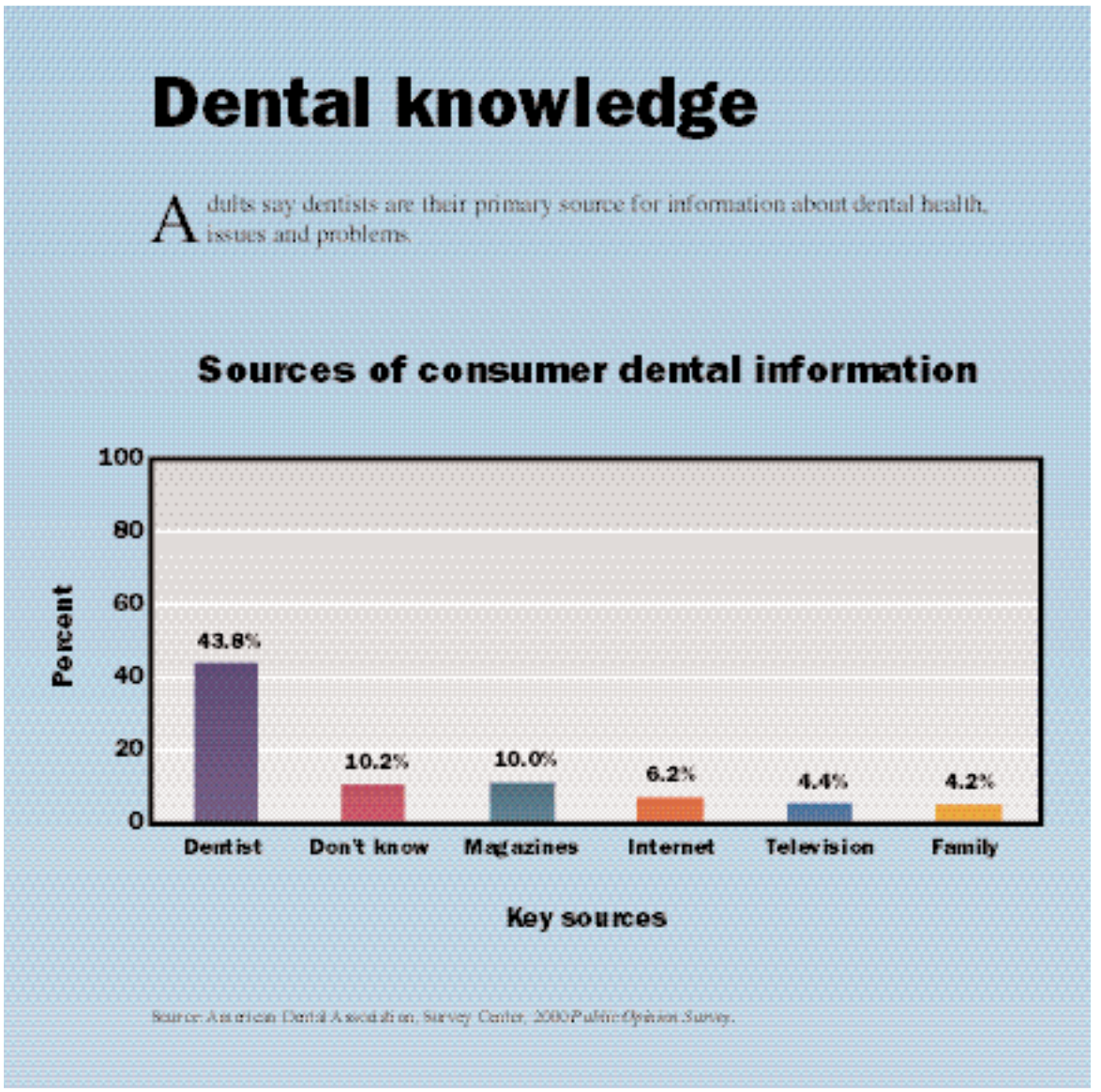
Several years ago, I was privileged to listen to a series of lectures by Drs. John Featherstone and Rory Hume. They demonstrated the scientific rationale,

See MY VIEW, page five

Letters Policy

ADA News reserves the right to edit all communications and requires that all letters be signed. The views expressed are those of the letter writer and do not necessarily reflect the opinions or official policies of the Association or its subsidiaries. ADA readers are invited to contribute their views on topics of interest in dentistry. Brevity is appreciated. For those wishing to fax their letters, the number is 1-312-440-3538; e-mail to "ADANews@ada.org".

Snapshots of American Dentistry



Letters

Gen. Patton needed?

The letters to the editor from Drs. Julius Hyatt and Richard Bravman (May 20 ADA News) point out some serious problems with board exams that are getting worse and worse.

The attitude of state board examiners that they are the only reliable judge of clinical competency to protect the public is a slap in the face to thousands of part-time and full-time dental school faculty.

Dental school graduates these days mostly expect to fail board exams. Rumors of the high failure rates seem to support that reality, and we all need some accurate information in order to fix a problem.

Any board examiner who defends the supreme decisions of their clinical exam needs to "sit on both sides" of the dental chair. I have taken and passed five individual state boards and two regional boards and have seen gross board examiner incompetency in all but one exam.

I took two boards upon dental school graduation, two while a periodontics graduate student and three while a full-time faculty member at the Virginia Commonwealth University/Medical College of Virginia School of Dentistry. All of the boards were given in dental schools where the rules were not the same in each separate clinic room.

I've seen all out-of-state candidates put in one clinic where examiners were rarely available to check each restorative step since they stayed with the in-state candidates.

I've seen examiners in one clinic stay an hour later than the other clinic to check off each candidate. I've seen oral pathology slides copied so many times before projection that you couldn't even identify anything on the screen.

I've seen the wrong written exams handed out to candidates. I've seen the wrong answer key used to grade exams. I've seen examiners out drinking heavily the night before the board exam.

I've only seen a couple of states try to formulate a fair exam for specialists.

Requiring specialists such as periodontists and oral surgeons to perform restorative treatment is ludicrous. If I could have graded the board examiners, many would have flunked.

We are graduating dentists with a very high amount of debt and then they can't even get past the board exams to make a living and pay off the school debts.

The problem couldn't be more obvious, and someone with some guts needs to bring together the educators and board examiners and some younger graduates who haven't forgotten what it's like to take clinical board exams.

Why aren't the success/failure statistics publicized once or twice a year? That fact alone makes me think some education administrators or board examiners don't want those figures to see the light of day.

We need a "Gen. Patton" or some similar determined group of people with strong personal values to work on fixing this problem.

R. Scott Ziegler, D.M.D.
Richmond, Va.

See LETTERS, page five

MyView

Continued from page four

the clinical procedures and successful clinical studies related to remineralization of early carious lesions. With proper hygiene and the correct oral environment, these early lesions can be reversed and offer the patient a better and longer lasting solution compared with fillings.

However, their procedures are not feasible in the current dental economic environment. Why would any dentist take the time and effort to correct a patient's carious lesion without doing a filling when the dentist could do a filling and be paid for his or her restorative services?

Personally, as an oral medicine clinician, I am paid for my time and expertise. I take an in-depth medical history and patient history. I can succeed in this manner because I bill under medical insurance, which allows clinicians to bill for time and expertise.

The medical insurance format requires a diagnosis code. (Dental diagnoses are generally not viable in this system.)

Also, the procedure codes are graded from one to four depending upon the amount of time necessary to carry out the procedure. However, each increasing procedure grade has increased clinical information requirements (social history, family history and so on).

As long as the primary diagnosis is related to a medical condition such as *lichen planus, candidiasis* or a neurologic entity, there is no problem with a dentist billing a medical insurance carrier.

Also, my patients accept this arrangement. However, organized dentistry and secondarily, the dental insurance industry and thirdly, dental patients do not currently support dentists billing for our time and expertise.

Is the dental profession perceived to be less trustworthy compared to our physician brethren? Does the insurance industry believe that dentists would pad insurance bills with billings for patient histories, oral hygiene modification and diagnostic processes that were unwarranted? I think the answer is—maybe!

But I believe the foremost reason that we dentists don't bill for our time and expertise is due more to a historical perspective related to our surgical-procedure economic model.

We only base our worth on what procedures we do rather than on what we influence, behaviorally modify, teach, deduce, diagnose or therapeutically manage.

The next logical question is which economic model is best for our patients? Presently physicians utilize a diagnostic-therapeutic model. Before the success of such medical specialties as internal medicine and cardiology, medicine too used a surgical-procedure economic model.

However, the diagnostic-therapeutic model is vastly more effective and economical compared to the surgical-procedure economic model.

Compare the cost of a hospital surgical procedure to preventive medicine. Trying to fix something after the fact requires great expertise, time and expense. Taking care of patients behaviorally and therapeutically is much more efficient and economic. But I shouldn't need to give away my hard earned expertise and my precious time for nothing.

Dr. Brown, associate professor at the Howard University College of Dentistry, is a contributor to the District of Columbia Dental Society Newsletter. His comments, reprinted here with permission, were originally published in the February/March issue of that publication.

Letters

Continued from page four

Failed exams

I am writing in response to Dr. Julius Hyatt's letter (May 20 ADA News) regarding licensure examinations.

I have one question to Dr. Hyatt and all of the other state board members, both past and present, and to all of the dental examiners who have administered these exams. How many times have you notified the patients that their candidate for licensure failed the exam and the restoration they placed needed to be redone to acceptable clinical standards?

In my 24 years in dentistry, I have never heard of such a recall. I have never heard of a testing board recalling the patient of a failed candidate and replacing the failed restoration.

So much for the well-being of the patients.

Bruce J. Trivellini, D.D.S
Contoocook, N.H.

Editor's note: The ADA Council on Dental Education and Licensure notes that many clinical testing agencies have a process for providing a temporary restoration or solution to the problem, and a requirement that the patient be notified in writing that additional treatment is required.

Details on how these situations are handled are available from the clinical testing agencies.

Accreditation criteria

The ADA Commission on Dental Accreditation will soon meet to consider their landmark document, "Criteria for the Initiation of an Accreditation Program in a New Dental Education Area."

These rigorous criteria will determine whether a non-specialty postdoctoral educational area for general dentists qualifies for accreditation. Narrowly focused or non-science-based areas would be easily denied accreditation based upon these masterfully written, legally defensible standards.

The obvious non-specialty area that begs for CODA accreditation is anesthesiology. We asked parents of the small children for whom we provide general anesthesia for full-mouth restoration whether our 27-month master's degree program should be accredited like the CODA-accredited program of the pediatric dentist who fixed their child's teeth, the CODA-

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Letters

Continued from page five

accredited program of the certified dental assistant who diligently mixed the cement and the CODA-accredited program of the certified laboratory technician who accurately fabricated their child's space maintainer.

Not surprisingly, every parent favored accreditation but were shocked that dentistry has no accreditation standards in such a critical, non-specialty area as anesthesiology training for general dentists.

The ADA House of Delegates has made their position on anesthesia training crystal-clear by approving "Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry, Part II," which provides a basic framework for two-year anesthesia residency programs. However, it is appalling that there are absolutely no didactic or clinical accreditation mandates for any of these programs.

Sensible people want accredited training for their anesthesiologist. However, a minority of dentists, but certainly no patients, oppose better education for general dentists.

Some blindly regurgitate their special interest group's feeble position that accreditation's higher quality of training would be bad for the public. Others tout the dreaded "snowball effect," claiming the CODA won't weed out marginal or fringe groups.

To the contrary, I have considerably more faith in the CODA's intellectual ability to use these rigorous criteria and have their decisions stand proudly against any legal challenge.

The criteria have been widely publicized to the dental communities of interest and thoroughly discussed at the 2002 American Dental Education Association. This is strictly an accreditation issue, certainly not a specialty issue, and is therefore outside the purview of the ADA House of Delegates.

In fact, in accordance with the U.S. Department of Education, which grants to the CODA its authority to accredit dental programs, the CODA is purposefully separated from the ADA to remove potential bias.

I strongly urge the CODA to demonstrate its commitment to the lofty goals in its own mission statement, "to serve the public by establishing, maintaining, and applying standards that ensure the quality and continuous improvement of dental and dental-related education and reflect the evolving practice of dentistry" by adopting the criteria.

The comfort and greatly enhanced margin of safety of our children, grandchildren and their children, among many other dental patients, depends on the CODA casting a timely, unbiased, informed affirmative vote.

Joel M. Weaver, D.D.S., Ph.D.
Director, Anesthesiology Residency Program
Section of Oral and Maxillofacial Surgery
The Ohio State University College of Dentistry
Columbus, Ohio

Learn composites

Dr. Richard Mielke ("My View," April 15 ADA News) has missed the boat completely on amalgams.

One more time for those still resisting learning composites: the G.V. Black tooth preps for amalgam absolutely destroy the tooth. Are we so afraid of giving up all those future crown preps, really?

Doesn't conservative treatment ring any kind of bell, even with the laziest of us? Put down the fissure bur, pick up the No. 2 and No. 4 round diamond and forget about wasting away good tooth, before you are forced into it by legislation.

There are plenty of teachers out there, thank goodness. Stop wasting time defending black metal fillings already.

James F. Aubrey Jr., D.D.S.
Elk Grove, Calif.

A simple concept

I have read with interest the letters and articles regarding the ongoing amalgam safety issue that, as I see it, is plaguing dentistry.

It seems so simple to me—the concept that once the mercury is mixed with the metal powder that little to no free mercury remains, yet amalgam opponents are convinced otherwise.

I liken this group to the Jim Jones followers: they are gullible hypochondriacs that need to find a reason for any illness they have, or believe they have. The silicone breast implant scare is very similar.

A patient of mine was in a few weeks ago for an exam. She spent many thousands of dollars having all of her metal fillings removed by a dentist in a major city three hours away because of the harm she believed was being caused by their presence.

Each time she comes in I just cannot shut up and let her go, so I invariably end up in a debate over the deleterious effects of amalgam.

The conversation ended with an agreement for her to bring in some of her literature about mercury and amalgam. One resource was a book put out by the U.S. Department of Health and Human Services—Toxicological Profile for Mercury (Update).

The last statement in the section on dental amalgam states, "However, it should be kept in mind that exposure to very small amounts of mercury, such as that from dental amalgam fillings, does not necessarily pose a health risk."

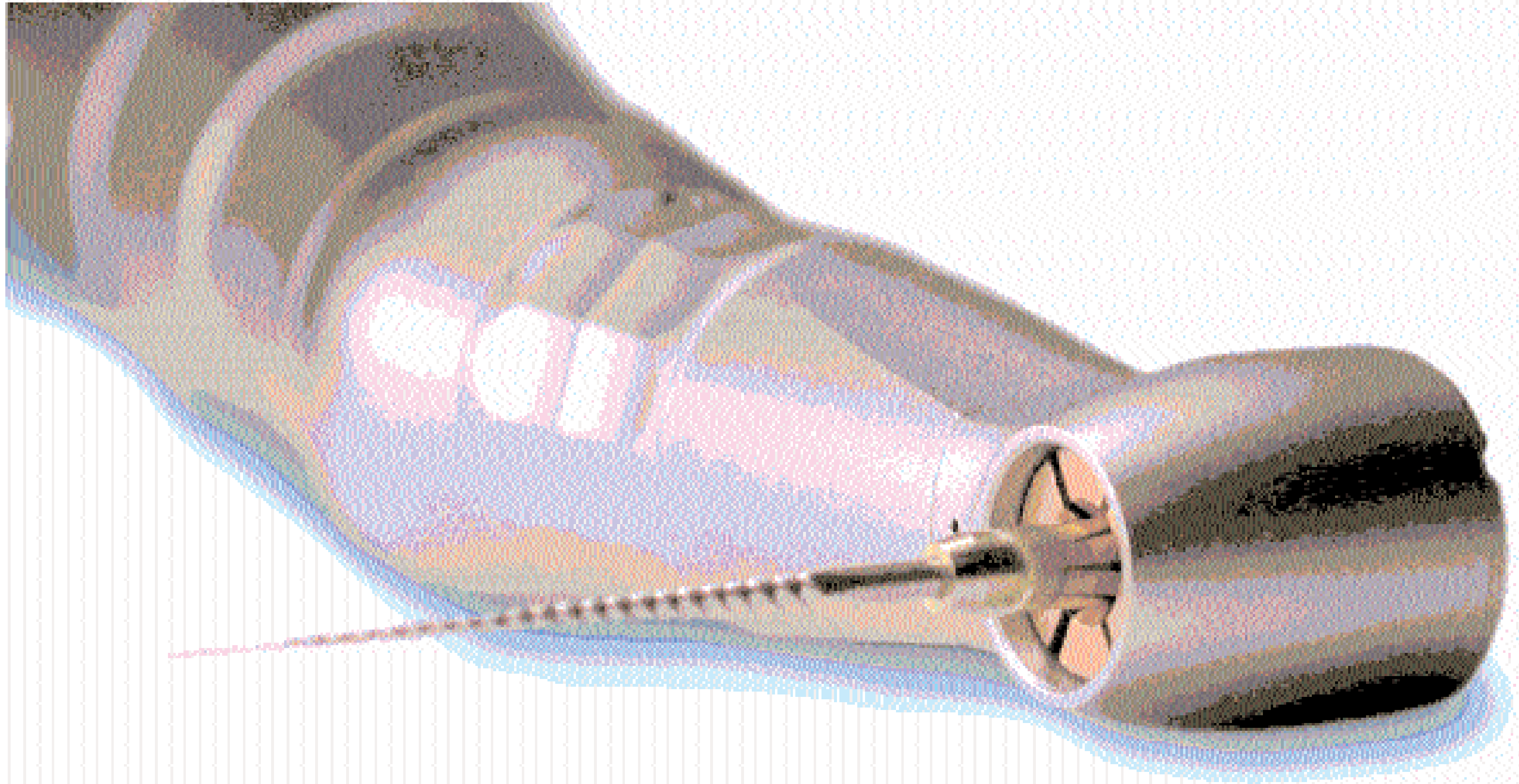
In spite of this statement, she found this book to be definitive proof of the evil of mercury amalgams.

How we can combat mental illness should be our focus, not more science; the science is already there.

By the way, are there any major companies on board with these lawsuits that just happen to market resin-based restorative materials, or any company for that matter, that stands to gain if amalgams are made illegal and must be removed and then replaced?

C. Nolan Carson III, D.D.S.
Yankton, S.D.

Editor's note: The Association is not aware of any manufacturers of dental products who are plaintiffs in the amalgam litigation against the ADA and others. Manufacturers of dental amalgam are themselves defendants in several pending lawsuits.



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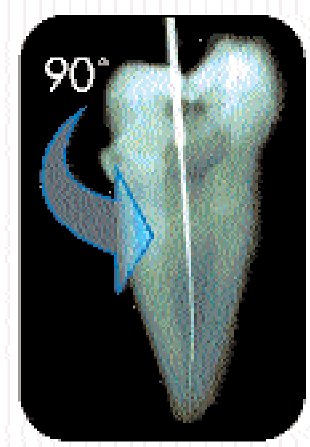
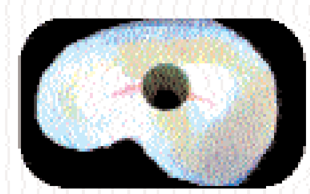
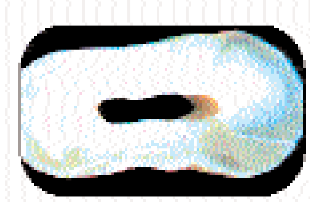
PERCEPTION



REALITY



CONVENTIONAL PREP



AET PREP

Perception

Canals viewed from the traditional radiographic perspective appear round in cross section.

Reality

These same canals rotated 90° and viewed from a new perspective, are rarely round but often ribbon shaped.

Rotary or Conventional Preparation Problems

- Complete cleaning is virtually impossible and would result in significant loss of tooth structure.
- Conventional instrumentation is tedious and time consuming.

AET Preparation Solutions

- Less aggressive milling files follow the natural anatomy of the canal.
- Prep is a minimally enlarged version of the original canal. The Endo-Eze oscillating handpiece and unique shaping files facilitate minimal invasive milling, cleaning and shaping of the "ribbon" shaped canal.

WHITEN
CONTROL
ETCH
BOND
RESTORE
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Volunteers honored

In June, the Council on ADA Sessions and International Programs awarded its Certificate of Recognition for Volunteer Service in a Foreign Country to dentists and dental students who spent at least 14 days performing dental services in a foreign country.

Recipients were nominated by their state or local dental society, federal dental service or dental school. A total of 93 dentists and dental students from 26 states were honored, including 27 participants in the Health Volunteers Overseas program, which is sponsored by the ADA.

For more information, award guidelines or an official nomination form, contact the Council on ADA Sessions and International Programs by calling the toll-free number, Ext. 2726, or visit "www.ada.org/ada/international/certificate.html".

Arkansas
Charles Alan Ainley
Thomas Stotts Isbell

California
Ronald Abaro (S)
Soonmyo Baek-Wheeler (S)
Jason Ballou (S)
J. Shea Bess (S)
Dean Brewer (S)
Bradley Briggs (S)
Nathan Carlson (S)
Melissa Chun (S)
Glenn DeLaRoca (S)
Byron Diehl (S)
Sherry Edwards (S)
Michael Giddings (S)
Stephen L. Gold (HVO)
Walter L. Griffin (HVO)
Michael Hummitzsch (S)
Sunil Ilapogu (S)
Amanda Jordan (S)
Roger Stephen Kingston
Jorge Larrondo (S)
Eduardo Lopez (S)
Nina Mirzayan (S)
Jared Nation (S)
Jacy Nelson (S)
Shannon Oh (S)
Jennifer Park (S)
Todd Schroeder (S)
Jeffrey Stonebraker (S)
Steven Streelman (S)
Jeremy Sweet (S)
Jeffrey Takahashi (S)
Steven Wernick (S)
Mary Yoo (S)

Colorado
Robert R. Faucett (HVO)
Mitchell N. Friedman

Florida
Howard Thomas Goodpaster, Jr.
Shaun D. Graser
David W. Heaton
Sandra Jean Lilo
Gail C. McDonald
Angella Tomlinson

Georgia
Robert T. Baird
Michael M. Kiyani (HVO)

Idaho
Bruce Morrison (HVO)

Illinois
Larry R. Abdullah (HVO)
Luciana E. Burca
Kenneth J. Evans (HVO)
C. Neil Kay (HVO)
David L. Krick
Jack L. Lieberman

Indiana
Norman Novak (HVO)

Iowa
David William Davidson

Maine
David L. Baker

Maryland
Robert P. Murphy (HVO)

Massachusetts
Dorothy Ellen Gurin
Rosalie A. Warpeha (HVO)

Michigan
Henry Louis Citron
Thomas W. Littlefield (HVO)

Montana
James C. Hanna

Nebraska
Terry Lee Malcom

New Jersey
Yede B. Dennis
Robert A. Leonetti

New York
Ruben Cohen (S)
Yael Freeman (S)
David C. Hoffman
Steven M. Roser
Laurence A. Wynn

North Carolina
Jeff Burkes (HVO)
Thomas E. Butler (HVO)
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Weston W. Heringer, Jr.
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Todd Michael Baumann (S)
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Haskell Gruber (HVO)
W. T. Parker (HVO)

Utah
Nicholas J. Weber (HVO)

Virginia
Gilbert De Biasi (HVO)
Earl Sanders (HVO)

Washington
Fred E. Ehrlich
Henry F. Evans (HVO)
Thomas R. Quickstad

Wisconsin
Timothy J. Brown (HVO)
Thomas J. Schuetz

S–Student
HVO–Health Volunteers Overseas

Denturists sue Montana

By Mark Berthold

Helena, Mont.—Denturists brought forth a lawsuit April 4 against state officials; the denturists are attempting to restore their own board of denturism that legislators terminated in 1987.

The bulk of the complaint is directed toward the Montana Board of Dentistry. The board is charged with acting "to advance the interests of dentistry by making examples of some denturists" and other "wrongdoings" and "offending actions and policies" that have resulted in "continuing harm to the profession of denturitry and the business of each denturist."

Jonathan Motl, lead counsel of the denturists, says there is a "need in Montana for more dental care, not less. The board of dentistry has lessened dental care by restricting what denturists can do, and that is socially wrong."

Dr. Lidahl

Mr. Motl also notes that Montana is a Western state with a strong emphasis on individual rights and individual property rights.

"That affects this lawsuit because the board of dentistry is run by dentists who view themselves as a competing profession with denturists," he says. "Regulation of a profession, by another competing profession, violates Montana's statutory and constitutional law."

Jack Atkins, the board's prosecuting attorney, says the board "takes the lawsuit very seriously, but it would be inappropriate to comment on the merits of the case at this time."

The lawsuit also names the Montana Dental Association as a co-defendant for its "practice and a pattern of obstruction, interference and restriction of all or any aspects of the profession of denturitry."

Lead plaintiff Lee Wiser, a denturist, claims the MDA has filed complaints against him that are unlawful and "designed to restrict the scope of Wiser's business practice … and generally damaging the ability of his business to fairly compete" with dentists.

Dr. Tom Lidahl, MDA president, says he is "disturbed" by the lawsuit, calling it "time-consuming and upsetting."

He adds, however, that MDA members are "extremely confident in our legal counsel and we look forward to a conclusion to this issue," a conclusion that will be "a very favorable one for our members."

ADA policy supports a single state board of dentistry in each state which serves as the sole licensing and regulatory authority for all dental personnel. ■

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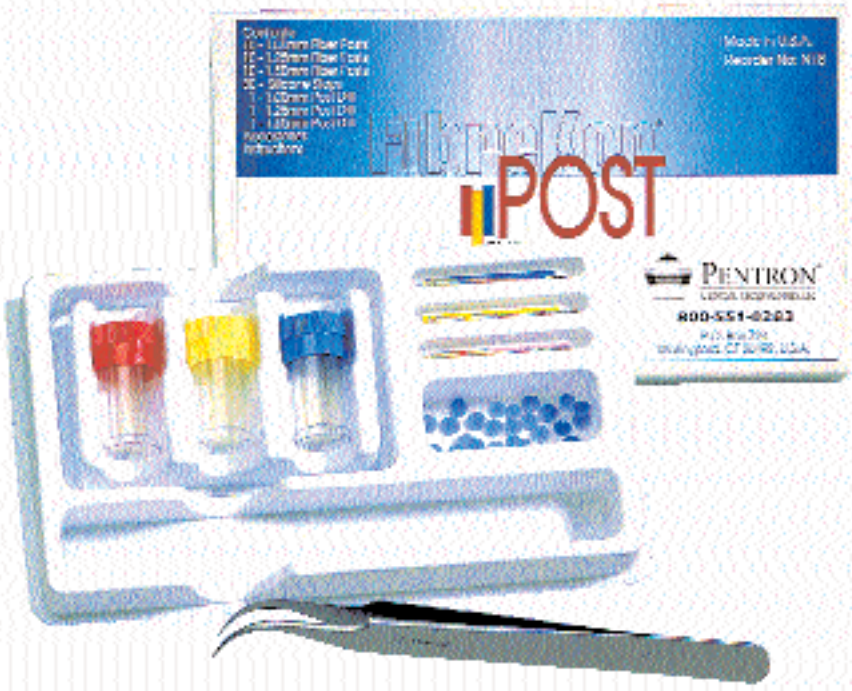

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Government

Amalgam 'safe and appropriate'

Idaho congressman speaks in support of dental amalgam use

By Craig Palmer

Washington—Rep. C.L. "Butch" Otter (R-Idaho) stood on the floor of the U.S. House of Representatives June 20 to deliver a statement on dental amalgam safety.

Rep. Otter is a member of the Committee on Government Reform, which held a hearing June 19 on research into vaccine safety at which there were several references to the safety of dental fillings.

Rep. Otter said in a "floor statement" the day after the hearing:

"Today I rise to support the continued recognition of amalgam as a safe and appropriate material to be used in dental fillings. Numerous studies conducted by a diverse assortment of health research organizations including the National Institutes of Health, the World Health Organization, the U.S. Public Health Service, the Food and Drug Administration and the Centers for Disease Control and Prevention all confirm that the use of amalgam in dental fillings is safe.

Rep. Otter

"With the costs of health care already soaring it is important to protect those treatments that have a proven track record of reliability and are cost effective for patients. Dentists have come to rely on the use of amalgam as a harmless, dependable and cost-effective material with which to treat their patients, and I believe the use of amalgam should remain a viable option for dentists and their patients." ■

Program seeks access scholars

Alexandria, Va.—The American Dental Trade Association and The Santa Fe Group, a nonprofit organization that focuses on enhancing dental public health through policy research and analysis, leadership development and information dissemination, will collaborate to address oral health care access issues by funding up to 10 "oral care access scholars" through a special program.

According to the ADTA, scholars chosen for the program will work with mentors from both organizations to develop practical programs that could be used as policy recommendations to government agencies, educational institutions and dental health care providers, agencies and organizations.

The cooperative program will focus on five topic areas:

- assessing potential roles for para-professional practitioners;
- developing culturally and linguistically targeted dental awareness aids;
- designing a multidisciplinary public awareness program to alert the public to the links between oral and systemic health;
- identifying the best management practices in dentistry;
- improving curricula and instructional materials for dental students and practitioners.

Scholars chosen for the program will receive grants of $5,000-$8,000, participate in two special workshops and have about nine months to complete their projects and submit reports. For more information or application guidelines, contact David O. Born, Ph.D., Executive Director, The Santa Fe Group, 223 North Guadalupe Street, Suite 459, Santa Fe, N.M. 87501, 1-505-603-0804 or e-mail "dborn@umn.edu". ■

Access

Continued from page one

and other senators offered statements on "the crisis in children's dental health," including Sens. Christopher Bond (R-Mo.), Susan Collins (R-Maine) and Bill Frist, M.D. (R-Tenn.).

Dentists take pride in the excellent oral health enjoyed by most Americans, said Dr. Chadwick.

"But we also believe it is a national disgrace that in America today, thousands of children can't sleep or eat properly, can't pay attention in school, and don't smile because of untreated dental disease, which is so easily preventable." He announced an Association access initiative (see story below) and illustrated the testimony with posters of children who fell through the safety net.

One Association poster child for the Senate hearing, a boy, 4, was hospitalized five days with what Dr. Chadwick described as a preventable infection "costing taxpayers over $20,000 (when) routine dental care would have prevented the pain, emotional trauma and vast expense.

"Dentists are fighting to bring these children into the system, but we can't do it alone," he said. "Until we as a nation find the political will to make oral health a priority, our children will continue to suffer." (The ADA's prepared testimony, which was submitted for the hearing record, is available online at "www.ada.org/prof/govt/dentistryworks/testimony/020625access.html").

Photo by Anna Ng Delort

United focus: ADA President Greg Chadwick (at left), Special Olympics President and CEO Timothy Shriver and former U.S. Surgeon General David Satcher brought their concerns about children's oral health and access to care to Congress.

Some children, like the Arkansas boy who came through a recent dental screening program, suffer with pride in what they have, however meager, Dr. Lynn Mouden, state dental director, said in separate testimony. The boy was asked if he had a toothbrush. "He responded, yes, but it doesn't have any hairs on it anymore. The toothbrush was so worn it no longer had even one bristle, but he was proud to have a toothbrush."

Timothy Shriver, Ph.D., president and chief executive officer of Special Olympics, said it was the first time the organization had been called to a hearing in Washington to speak to the health concerns of persons with mental retardation. He urged Congress to increase training funds for dentists and other health professionals treating people with mental and physical disabilities. "Actual teaching hours in dealing with these types of patients has declined in dental schools over the last decade," he testified.

Congress is an important but not a singular partner in establishing the leadership to address these and other barriers to care, with no single piece of legislation likely to solve the problems or reduce barriers to care, the ADA testified.

"Our biggest challenge remains convincing legislators that oral health care is just as important as medical care and not simply a throw-away benefit or the easiest program to be cut from a tight budget," Dr. Chadwick said. "The missing element is committed leadership at the national and state levels."

Dr. Satcher and several of the U.S. senators referred to "a shortage of dentists" to address the problems. Dr. Chadwick in response cited need for continued government commitment and funding for dental education and training, encouragement of racial and ethnic diversity in the dental class, incentives for dentists to practice in underserved areas and Medicaid enhancements as being among the answers to access problems.

"Another barrier to access is a lack of dentists, particularly pediatric dentists, in underserved areas," he testified. "Congress can help states establish programs to attract dentists to underserved areas, through tax credits and student loan forgiveness. This committee can also support dental training programs that have been targeted for severe cutbacks and elimination.

"I wish I could tell you that if Congress did a few simple things, the problem would be solved, but I can't," Dr. Chadwick said. The full ADA statement submitted for the hearing record goes into greater detail on training and workforce issues and other congressional and government responses that might address the access problems.

Dr. Satcher, director-designee of the National Center for Primary Care, Morehouse School of Medicine, served as the 16th surgeon general of the United States from Feb. 1998 to Feb. 2002 and issued the first Surgeon General's report devoted exclusively to oral health in May 2000. ■

'Give Kids a Smile' targets improved access for needy kids

By Craig Palmer

Washington—ADA President Greg Chadwick June 25 announced a nationwide campaign to improve access to dental care for needy children. An Association news release on "Give Kids a Smile" is posted on ADA.org.

"The dental community is committed to working with Congress, the federal agencies and the states to address and remedy this fixable problem," Dr. Chadwick told a Senate subcommittee at an historic hearing on children's dental health. (See story, beginning on page one and continuing above.)

In the absence of effective public health financing programs, many state dental societies sponsor voluntary programs delivering free or discount oral health care to underserved children, the Association testified. Dr. Chadwick cited the Smile Alabama program as an exemplary private sector response to access problems. Some states like Michigan have improved their Medicaid and State Children's Health Insurance Programs to increase access to care for children, he said.

Many dentists provide free care in their communities, added David Satcher, M.D., the former U.S. surgeon general who issued the nation's first report devoted exclusively to oral health issues. Dr. Satcher also testified at the Senate public health subcommittee hearing on "the crisis in children's dental health: a silent epidemic."

Building on these efforts, the ADA will join state and local dental societies across the country in a one-day campaign Feb. 21, 2003, to deliver free services to children who would not otherwise receive dental care, Dr. Chadwick testified.

"Although the 'Give Kids A Smile' project will help thousands of children, our larger purpose will be to deliver the message that we can't solve this problem alone and that for every child we care for on that day, hundreds, even thousands more will continue suffering until the nation gets serious about oral health," the ADA president said. "Charity alone will never fix the problem because charity is not a health care system.

"The real irony is that preventive programs could effectively eliminate dental disease, and they do not cost a lot of money," Dr. Chadwick testified, citing community water fluoridation and dental sealant programs as "equal access" preventive measures. ■

JADA series to focus on the future of dentistry

The Future of Dentistry report, received by the ADA House of Delegates last year, will be the subject of a series of articles in The Journal of the American Dental Association, starting in August.

Panels of experts will explore various elements of the report in a question-and-answer format. The installment in August JADA reviews dental practice issues. Future installments will explore what the FOD report has to say on access to dental care, the dental workforce and dental education.

Those who wish to obtain an executive summary of the Future of Dentistry report should contact the ADA Health Policy Resources Center at Association headquarters, Ext. 2568. ■

Precepts

Continued from page one

as "dedicated partners" contributing their experience and expertise "to support the dental profession and the people it serves."

The precepts underscore service as key to the ADA's success—service to members, to elected and appointed officials, to coworkers and to the public at large.

The precepts encourage staff to take "personal responsibility" and pride in their work, to keep a positive attitude and to "thrive in a supportive organization" by tapping opportunities to "learn and grow."

Unveiled in February at an all-staff meeting hosted by Dr. Bramson, the precepts have been inscribed on colorful posters found everywhere in ADA buildings. The precepts appear side by side with a second poster heralding the ADA's overall vision and mission statements, as well as its "guiding principles, values and beliefs."

Dr. Bramson says the two posters, with their complementary messages, bring together staff and volunteer leaders in a cohesive effort.

"The staff is saying that they're partners in this process," notes the executive director. "They're saying that, although most of them don't have the dental skills, they bring other knowledge, experience and expertise to the table. If you combine that with the knowledge, experience and expertise of dentists and dental leaders, you've got something pretty powerful."

And the end products, he says, will be greater membership satisfaction and improved member retention.

Values: Sabrina Collins of the Council on Dental Benefit Programs highlights a core precept: "We take personal responsibility."

"If we work better as a team, if we understand each other better, we're going to be more productive," says Dr. Bramson. "The more productive we are, the more the members see it and feel it, and the less likely they will be to question why they're members. They will see why they're members."

The core precepts also mesh well with the Tripartite Grassroots Membership Initiative introduced last year by ADA President Gregory Chadwick. The initiative's goal: to boost ADA's membership market share from its current level of 70.4 percent of active practitioners to 75 percent by 2005.

To help drive the initiative, ADA senior managers, directors and most rank-and-file staff—about 350 employees in all—will participate in a customer-service training program in September.

Since the all-staff meeting in February, the core precepts development committee has given way to a larger, broad-based Employee Advisory Community, or EAC. Among other duties, the EAC is empowered to make recommendations on "policies, programs and work-related issues affecting ADA employees" and to serve as liaison between staff and executive management.

Believing that "executive management buy-in" is critical to the success of core precepts, Dr. Bramson participated in the EAC's first meeting in April. He or Chief Operating Officer Mary K. Logan (or both) will attend all subsequent meetings—including one that took place July 9, after press time.

"I'm not there to steer them my way," says Dr. Bramson of EAC meetings. "I'm there to show them that what they're doing is important to me and to senior staff."

One of the core precepts (No. 5) touches on the value of innovation and "reasonable risk-taking"—a phrase that raised a few skeptical eyebrows when first heard.

Dr. Albert H. Guay, ADA chief policy advisor, understands that reaction but insists the skepticism is outdated.

"We have the reputation of being a completely risk-averse organization, but there's nothing in life that's risk-free," he says.

The core precepts, he adds, are meant to assure employees "that we're willing to take a reasonable risk if the benefit of taking that risk is demonstrable and substantial—if it means improved service to the membership, and innova-

'Core precepts' at a glance

The staff-generated core precepts include a brief mission statement and a set of values meant to guide ADA employees in their daily work.

Inscribed on colorful posters, the precepts are displayed throughout ADA buildings—the Chicago headquarters, the Washington office and the Paffenbarger Research Center. The precepts appear alongside a second poster that carries the ADA's overall vision and mission statements, as well as its "guiding principles, values and beliefs."

The core precepts are as follows:

Mission

ADA staff are dedicated partners, contributing their knowledge, experience and expertise to support the dental profession and the people it serves.

Values

1. Members are the purpose of our work.

The same is true of communities of interest and coworkers seeking assistance from us in serving our membership. We are all part of the same team, working for the same goals.

- Membership is everybody's business.
- Diversity adds value to our community and work.
- Support the improvement of oral health worldwide.
- Take pride in dentistry.

2. We take personal responsibility.

to ensure that all members, potential members, coworkers and others we serve receive a timely, accurate and courteous response to their needs.

- Listen with intent to understand rather than merely intent to reply.
- Freely share our knowledge.
- Meet and exceed expectations.
- Communicate clearly.

3. We take pride in our work.

- Do the little things and the big things well.
- Demonstrate zeal for finding solutions.
- Work diligently, creatively and effectively.
- Demonstrate personal dignity, integrity and dedication.

4. Attitudes are contagious.

- Extend courtesy and compassion.
- Be committed and professional.
- Give praise, recognition and appreciation often.
- Lead by example.
- Have fun: enjoy our professional life.

5. We thrive in a supportive organization that ...

... is based upon trust and mutual respect;
... facilitates opportunities to learn and grow;
... provides the necessary tools and information to do our job;
... treats people fairly;
... helps us feel that we make a difference and rewards contributions;
... applauds innovation and reasonable risk-taking.

tion in response to changes in the world where we do business."

Adds Ms. Logan, "We ask ourselves whether there is a benefit to the members. And we ask ourselves, what are the risks? If the benefits to the members outweigh the risks, then we do it. We go forward."

When it comes to embracing reasonable risk, Association leaders have led by example. Two that come to mind: the class action civil suits filed over the past year against a pair of major health insurers—Aetna Inc. and Wellpoint Health Networks Inc.

The ADA says the two companies have undercut dental fees without justification, shortchanging dentists and patients alike. Both complaints are pending in federal court.

To underscore the premium placed on service and innovation, the ADA has introduced the "I Made a Difference" staff award for outstanding performance in support of the core precepts. Recipients get their photos and a brief profile splashed for all to see on the ADA Intranet, the intramural component of the Association's Web site.

All smiles: Heather Burns (center), director of the Department of Salable Materials, shares a laugh with colleagues during a presentation on membership relations at the February all-staff meeting. Flanking Ms. Burns are Bob Owens, associate executive director for Information Technology and Standards, and Mary Logan, chief operating officer.

■ The core precepts define ADA employees as "dedicated partners" contributing their experience and expertise "to support the dental profession and the people it serves."

Another new staff incentive is the "spot" award, a quick-hit honor for individuals or groups of employees who show initiative beyond the call. Recent recipients include a cross-divisional staff team that pulled together to help the tripartite respond to a media report alleging a link between environmental waste and the dental office.

Dr. Bramson, who completes his first year as the ADA's chief executive officer this month, acknowledges that the core precepts concept is borrowed from corporate America.

He introduced it at the Massachusetts Dental Society during his tenure as MDS executive director. Employees there valued the concept enough to bring it to fruition on their own, after Dr. Bramson had left for the ADA.

Judging by ADA staff reaction, core precepts are having the desired effect on the national organization and its affiliates.

"The atmosphere here is totally different in a very positive way," says Delanor M. Tucker, senior manager for administrative services in the Division of Dental Practice, and a member of the EAC.

"People feel that what they say matters, that we're all part of a new ADA," adds Ms. Tucker, a 32-year staff veteran.

After the EAC's first meeting in April, the ADA News' own Judy Jakush penned a memo to her colleagues in publishing.

"I have to state that the EAC meeting was one of the most productive and informative meetings I have ever attended at the ADA, and I have attended way more meetings than I can even begin to count," gushed Ms. Jakush, not one for whom such praise comes easily.

The renewed dedication to membership service also is a top priority at the local and state levels of organized dentistry.

"We're very interested in the membership initiative," says Michelle M. Quade, executive director of the Minneapolis District Dental Society. "We're working every day with our members to provide whatever they may need."

See PRECEPTS, page 23

A wealthy retirement

This second installment of a continuing series on retirement issues affecting dentists examines how to retire wealthy.

By Richard Collier, M.S., J.D.

Richard Collier

There are only three ways to get wealthy beyond what can be produced by your own personal labor:

- by having people work for you;
- by having machinery work for you;
- by having money work for you.

While traditional businesspeople can use all three, we, as professionals, can only use the first and third methods. I see many dentists retire wealthy using a simple three-step process of letting their money and the magic of compounding work for them.

The rest of this article explains how they do it. It's so elementary, everyone can do it. Here are the steps:

Save something every year

Savings come first since we can't invest unless we have some money. I don't care how small the monthly savings are at the beginning. The crucial thing is to get in the saving habit. If we are students or starting in practice, it might be just $10 or $20 per month.

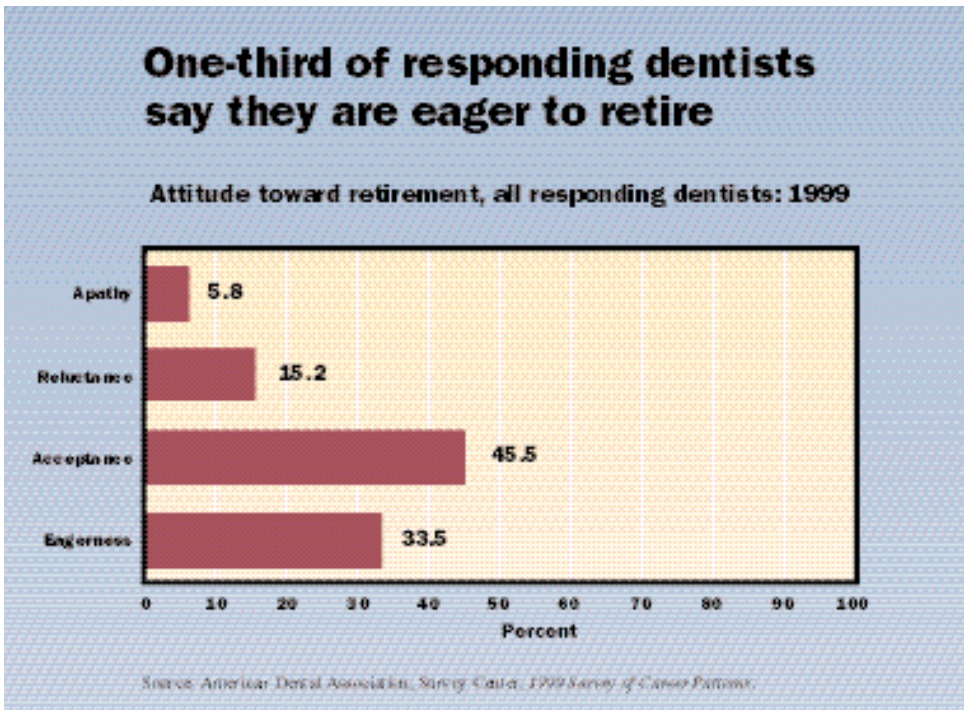
If we dismiss that as meaningless it means we are waiting until the amount we can afford to save is "meaningful," (whatever that means). People who do that end up spending everything they make and don't get started saving until desperation sets in when they reach their 50s.

Unfortunately, this first step means we must have the discipline to live within our means. I can ask a young doctor two questions and predict his or her financial future:

- How much do you make a year?
- How much do you spend a year?

I can predict a bleak financial future for the person who spends $65,000 a year when he is making $65,000. I can predict a bright financial future for the person who spends $60,000 when she is making $65,000, and waits til the next year, when she is making $70,000 to spend $65,000.

It's nothing more complicated than setting spending a year or so behind our income!



Invest simply and sanely

Note that I wrote "sanely," not "safely." All investments carry some risk.

It's each investor's job to set goals, to understand one's personal profile (how much volatility and risk you can tolerate), and then determine the potential risks and the potential rewards from each investment considered. Only then can we make an intelligent decision as to whether an investment matches our goals and personality and is worth buying.

Investing does not have to be complicated. I have observed time and again that the more complicated we make investing, the less likely we will be satisfied with the results.

To make a living, many investment salespeople try to convince us that investing is too complicated for us to do on our own. That gives them a conflict of interest that some people handle better than others. Saddling a long-term investment portfolio with even an unnecessary 1 percent takes a terrible toll, particularly when investing in stocks can be as simple as adding money to a broad-based stock index fund.

For example, investing $1,000 per month over a 35-year career means we will have invested a total of $420,000. If that grows at 7.5 percent per annum (compounded monthly), the ending balance is $2,030,762. Cut the growth rate by just 1 percent to 6.5 percent, and the end result is $1,600,316 (a loss of $430,446—an amount exceeding our entire savings over the 35 years).

The doctors I see retiring wealthy usually tried giving their money to others to invest for them. Most grew dissatisfied. They finally realized that no one cared about their money more than they and their spouses did. They took back the money and spent some time learning how to invest it. They started with the basics. Based on their time and desires, some worked up from there.

Avoid big blunders

They're always out there waiting for us. Usually they are the too-good-to-be-true ideas brought to us by a salesperson or a con artist. For example, the tax shelter "investments" of the 1970s and 1980s were recommended by salespeople and even tax professionals (who, lamentably, sometimes shifted to being salespeople if they were getting a fee from the shelter promoters).

After three-plus decades of watching people do things well and do things badly, here are some lessons that can help avoid blunders:

- Recognize that every investment being promoted will always look like a sure-fire, can't-miss winner. If not, the promoter will not present it to you. He will keep tinkering with the assumptions until it looks perfect.
- Recognize that greed usually trumps common sense. So listen if your common sense is trying to be heard over the sales pitch. If your common sense tells you there's something wrong, take its advice and, without remorse, pass up whatever the person is trying to sell.
- Be skeptical. Here is one question that can save you a fortune: "If it's such a good deal, why do they need my money?" After all, if the promised return is so high, why does the promoter want my money? Why doesn't he borrow from a bank, invest himself, and keep all the sky-high profits? To do otherwise defies business common sense and is likely a sign of either a con job or a salesperson just trying to earn a commission without regard to the true merits of what's being promoted.

Why isn't everyone wealthy if the steps are so simple and obvious?

Maybe there are more, but I see two reasons. First, this approach can seem so simple, some dismiss it as too simplistic and even boring. They assume building wealth needs to be complicated or they approach it with a speculator's casino mentality.

Second, this approach requires some self-discipline—a commodity that's in short supply. Those who have followed this approach tend to get wealthy over time. It does not have to get more complicated than that! Thousands of dentists have done it. Of course it takes time for the incredible power of compounding to work for you.

What if you are getting a late start? It's not hopeless. You'll just have to work longer (and keep your life and disability insurance). Consider this analogy: The best time to plant an oak tree is 20 years ago; the second best time is now! ■

Richard Collier is a lawyer who also has two business degrees from the University of Pennsylvania's Wharton School of Business. His practice is limited to representing doctors (primarily dentists) in the business aspects of their affairs. He conducts his own seminars and is a frequent lecturer on investing, reducing taxes, practice management and practice transitions.

He also publishes the twice-monthly Collier, Sarner & Assocs. Doctor's Newsletter covering those subjects.

A sample Newsletter for information about his seminars can be obtained by calling toll-free, 1-888-888-4840.

HIPAA Privacy Checklist

The HIPAA privacy compliance date is April 14, 2003. It's time to assess your readiness. Get started with the ADA HIPAA Privacy Checklist, part of the ADA Privacy Kit. The complete kit, which will be available by August, tells dentists more specifically what they need to know to comply with the HIPAA Privacy Rule, as presently proposed.

To make your dental office compliant by April 14, 2003:

Task	Planned Completion Date	Completed by 4/14/03
■ Develop a compliance timeline, using this checklist as a starting point.		❑
■ Learn what HIPAA requires and do a gap analysis to assess where your current practices may be lacking.		❑
■ Develop privacy policies, procedures and documentation practices.		❑
■ Develop necessary forms to implement your policies and practices (for example, Acknowledgement of Receipt of Notice of Privacy Practices).		❑
■ Develop a Notice of Privacy Practices to post and give to patients, and a method to document your good faith attempt to secure patients' acknowledgment of receipt of the Notice.		❑
■ Designate a privacy officer and a contact person to receive complaints.		❑
■ Train employees in privacy. Document all training efforts.		❑
■ Develop an employee discipline process for privacy violations.		❑
■ Evaluate which of your relationships requires a Business Associate (BA) Agreement and enter into the required written contracts, using BA agreement language satisfying HIPAA's specific requirements. (Compliance date is April 14, 2004 for amending existing written BA agreements, but those that are renewed or modified before then must be amended at the time of that renewal or modification.)		❑
■ Your dental office should have appropriate administrative (for example, policies, procedures and staff training), technical (for example, secure software and passwords), and physical (for example, doors and locks) safeguards in place to make sure health information is private and secure.		❑
To remain compliant during the operation of your practice:		**Completed by 4/14/03**
■ Implement procedures to verify identity and authority to access, receive or use what is protected health information (PHI) under HIPAA. Keep in mind that PHI includes oral communications (for example, verbal communications among staff members, patients and/or other providers).		❑
■ Secure the right to use or disclose PHI. For purposes of treatment, payment and healthcare operations (TPO), your good faith attempt to secure an Acknowledgement of Receipt of your Notice of Privacy Practices will suffice. Otherwise, secure a written authorization as required by HIPAA.		❑
■ Plan to use PHI information by applying the minimum necessary standard, which will often require that you make reasonable efforts to use or disclose only the information that is needed to accomplish the intended purpose.		❑
■ Know what patients' federal rights are established by HIPAA, and develop processes to ensure you will honor those rights (for example, the rights to access and copy protected healthcare information; the right to amend a patient record; the right to an accounting of disclosures, the right to confidential communication and so on).		❑
■ Implement complaint systems.		❑
■ Know the HIPAA marketing rules and follow them.		❑
■ Limit the consequences if there is a breach of confidentiality by you and/or your business associate.		❑
■ Develop and implement a HIPAA privacy self-audit program to make sure your compliance efforts are working.		❑
■ Document, document, document!		❑
* The Checklist does not assure compliance with HIPAA or constitute professional advice. Dentists must consult with their professional advisors for such advice.		

Just for you

ADA's HIPAA privacy kit geared to meet dentists' needs

By Arlene Furlong

Made by the American Dental Association. Made for practicing dentists.

It's the ADA HIPAA Privacy Kit—the easy favorite for dentists betting on the best source to help them meet the April 14, 2003, HIPAA Privacy Rule deadline.

"ADA staff have the expertise to point out in a dentist-friendly manner what's important for us to know," said ADA President Greg Chadwick. "These are people who understand a dental office."

Members report receiving offers for HIPAA compliance products at prices as high as $1,000 since the Health Insurance Portability and Accountability Act of 1996 proposed changes in the management of patient information. Many of the vendors are from outside the profession—potentially making compliance for dentists more difficult than it should be.

In contrast, the ADA is uniquely positioned as a source of HIPAA information through its consistent review and evaluation of HIPAA standards. Association activities, including consulting with the Secretary of Health and Human Services on HIPAA legislation, providing comments to the proposed rule and answering members' questions about HIPAA preparedness, are routine.

■ "HIPAA requires dental offices that transmit health information electronically to comply with all aspects of HIPAA. Electronic transmissions may be directly with a payer or through a practice management vendor or clearinghouse."

The ADA is also reaching out to dental societies with straight talk about the HIPAA Privacy Rule. More than 60 dental societies participated in last month's conference call.

The ADA Privacy Kit specifically addresses dental office issues by summarizing more than 300 pages of regulatory requirements. Because HIPAA Privacy Rules are still evolving at the federal level, the ADA Privacy Kit will provide an update when the rule is finalized. No source knows the final compliance rules at this time.

"Dentists should be ready before the April 14, 2003, deadline with privacy policies and forms, employee training and business associate agreements," noted Dr. Chadwick. "Between the ADA Privacy Kit, the ADA HIPAA Privacy Seminars and ADA staff, our members have the edge."

The ADA will ship the HIPAA Privacy Kit by August. If you can't go to an ADA HIPAA Privacy Seminar—which includes the kit—you can purchase the kit (and an update when the rule is finalized) for $125. Call 1-800-947-4746 to reserve your copy.

More information is posted on online at "www.ADA.org/goto/HIPAA". ■

ADA Reports

Disability network gets green light

By Arlene Furlong

How can dentists help each other through temporary or permanent disability?

The ADA Council on Dental Practice wants to know and is calling on all interested dentists to join a new physical disability support network to share their ideas.

"We're all so proficient in helping our patients," says Dr. Michael T. Rainwater, Council on Dental Practice chair. "Now, here's an opportunity to help each other."

Establishing a venue where disabled dentists can share information that may help them rehabilitate and even re-enter dentistry will be the network's first step, according to Dr. William Calnon, Ergonomics and Disability Support Advisory Committee chair.

"Dentists often come up with unique approaches to their disabilities," he said. "The network will allow them to share what they've learned."

Dentists who retain the professional title but lose their ability to practice say facing the future alone can be daunting.

"You can easily go from a prestigious position in life where people look up to you—to having difficulty finding a part-time job," says Dr. Norman Schreiber. "Sometimes dentists just think, 'That's it. I'm done.' "

Transitioning out: These days, Dr. Norman Schreiber has time to pursue new interests.

He was in his early 50s when complications arose from one leg being slightly longer than the other and scoliosis. One impairment led to another until he says his pain was "too distracting."

After a 1995 hip surgery, Dr. Schreiber scaled way back, selling his practice to an associate and setting up a home office for about 100 patients.

But the fix was short term. After two years of practicing at his own pace with new equipment that he had modified for his home and physical predicament, he quit dentistry.

"The unusual positions that dentistry demands, as well as the prolonged sitting and standing, stopped me from going on," he says.

Resources that he found on transitioning out of dentistry helped but weren't enough, he says. "Current technology can facilitate a discussion forum to provide information and documents, yet still be secure and private."

Dr. Mervyn Dixon says he could've benefited from talking to other dentists last year, after suffering a heart attack and undergoing a quadruple bypass at the age of 64.

"First there's the initial shock. Then you spend your recuperation time wondering what you're going to do with the rest of your life," he recalls. "It would have been helpful to get some perspective from other dentists who went through the same thing."

Dr. Dixon says he was shocked by his health predicament because he thought he had the world by the reins—exercising at least twice each week, taking cholesterol medication and watching his diet.

William Sullivan, M.D., a physician who also serves on the committee, says, "Sometimes when people are treated early enough they can get appropriate treatment and stay in their profession or reduce further disability." Dr. Sullivan treats a variety patients with neurological and orthopedic conditions at the Rehabilitation Institute of Chicago.

For Dr. Dixon, a gradual approach back to practice did the trick.

And is he still living that healthy lifestyle?

"Now I drink a glass of red wine each day instead of white," he jokes.

If you or a dentist you know has experienced a disabling condition and is interested in joining the support network, contact Dr. Donald Collins at Ext. 7463 or e-mail "collinsd@ada.org". ■

SurePayroll saves time, lets you control payrolls

SUREPAYROLL

By Karen Fox

Would you like to save time processing your employee payroll?

Try SurePayroll, an online service that enables users to process their payroll at any time.

ADA members who use SurePayroll cite its flexibility as what they value most.

"Our research indicates that time is a precious commodity for ADA members," says SurePayroll's Michael Alter. "Innovations that free up extra time and put dentists in control of their schedules are a welcome relief."

Through an agreement with ADA Business Enterprises, Inc., SurePayroll offers discounted service for ADA members.

Here's how it works: payroll is entered online at your convenience, so you control the process. All that's needed is a connection to the Internet. You don't even need to be in the office on payday.

Additional benefits include:

- SurePayroll costs about half that of traditional payroll services.
- SurePayroll keeps up with any changes in payroll regulations and withholding tables.
- Payroll accuracy is improved with real-time feedback on payroll entries.
- SurePayroll helps calculate all federal, state and local taxes, deposits them into government accounts and files all the necessary forms.
- ADA members receive free W-2 forms for the first year, free payroll processing for the first 30 days and free setup when they enroll.
- There is a risk-free, six-month money-back guarantee.

SurePayroll wants to know more about your practice's payroll needs. Go to "www.surepayroll.com/adasurvey" to take a short survey, and you'll be entered into a drawing to win a free Palm Pilot m100 series.

For more information, contact SurePayroll at 1-877-954-7873. ■

Correction

Three of the ADA Health Insurance Portability and Accountability Act Privacy Seminars listed in the story, "HIPAA: ADA ready to help," from the June 17 issue of ADA News contained incorrect information.

Please note that the location for the Oct. 28 and Nov. 5 seminars is the Pennsylvania Dental Association.

Also, note that a firm time has not yet been established for the seminar listed for Nov. 12 at the Connecticut Dental Association. For more information on this seminar, contact Noel Bishop at 1-860-278-5550.

The ADA News regrets the errors. ■

Budget

Continued from page one

Expenses are expected to increase by 6.1 percent over 2002. The growth in expenses is driven principally by the cost to the ADA for new programs and products that will generate greater revenue.

Staff presented the board's budget team and then the full Board with a balanced budget (with a small surplus) prior to consideration of new programs and activities.

"One of the driving forces in the budget process this year was to find revenue enhancements wherever possible," noted Dr. Feldman.

In order to meet the cost of the new initiatives included in the proposed budget, the Board adopted a resolution calling for a $403 dues rate in 2003. Dr. Feldman cautions, however, that this figure is likely to change.

"We did not include any provision for the direct reimbursement campaign, the funding for which is scheduled to end this year. The Board felt this was a decision for the House of Delegates to make, as delegates have done twice before in the past six years."

The House in 1996 and 1999 approved resolutions calling for three-year DR campaigns, at $2.5 million dollars per year for each three-year period. The 2003 budget proposal does not include any DR expenditures.

The proposed $403 dues figure represents $17 less than the current $420 dues level. As they have for the past two years, members in 2003 also will pay $30 each for the third year of a six-year special assessment to continue the renovation and asbestos abatement of the ADA Headquarters in Chicago. Dr. Feldman wants members to understand that they will likely have to pay at least $433 (current dues proposal plus special assessment) in 2003.

"I don't want members to anticipate that their dues bill will be $403," he explained. New programs, in addition to the direct reimbursement campaign proposal, are likely to come before the House this fall in New Orleans." Before a final vote, the dues proposal will be adjusted at the House meeting to cover the cost of any new programs that are adopted above and beyond what is already in the Board's budget proposal.

ADA President Gregory Chadwick emphasized that more programs are in the 2003 budget that will help members in their practices. "This is due to increased projected revenues from the membership initiative," he said, as well as some tough decisions to cut other programs deemed of lesser value.

Even before the initiative was officially launched, the ADA had already shown a gain in the number of active licensed dentists: in 2000, there were 116,593 and at the end of 2001, 117,278.

Dr. Feldman heads the Board's Administrative Review Committee, which oversees budget development. Serving with him and Dr. Chadwick on the committee are President-elect T. Howard Jones; 2nd District Trustee Howard B. Fine; 3rd District Trustee Ronald B. Gross; 6th District Trustee William D. Powell; and 14th District Trustee Edward Leone Jr.

The budget was handled differently this year, noted Drs. Feldman, Chadwick and Jones. The ADA divisions for the first time re-allocated money from the same overall pool, rather than just from within a department or division. The 2000 and 2001 actual expenditures were compared to the benchmarks given to each department as a guideline for developing a base budget for 2003. Division chiefs were given the authority to reduce a benchmark number in order to increase available monies for other departments.

"There has been concern in the House of Delegates in the past over the entire budget process," recalls Dr. Jones. "The process we have now resulted in part from action by the House, including the change in the way we elect the treasurer. We now have continuity on the Administrative Review Committee that we didn't have in the past.

"Besides those positive changes, we had a tremendous amount of work accomplished under the leadership of Dr. Jim Bramson, ADA executive director, and Mary Logan, chief operating officer," Dr. Jones continued. "I was extremely pleased with their preparation. It was also obvious the directors in each division worked hard on this process. Administrative review went through in record time, but I believe the members will be very comfortable because it's easy to see this budget has been thoroughly examined. It is a very lean budget, but it also includes new programs that we need for our members."

Using the ADA's Strategic Plan helped all involved in the budget process to prioritize

See BUDGET, page 24

Access issues: First District Trustee Edwin S. Mehlman (right) discusses access to dental care with 9th District Trustee Kathleen Roth and Dr. Burton L. Edelstein, director of the Washington-based Children's Dental Health Project, at the June Board of Trustees meeting.

Precepts

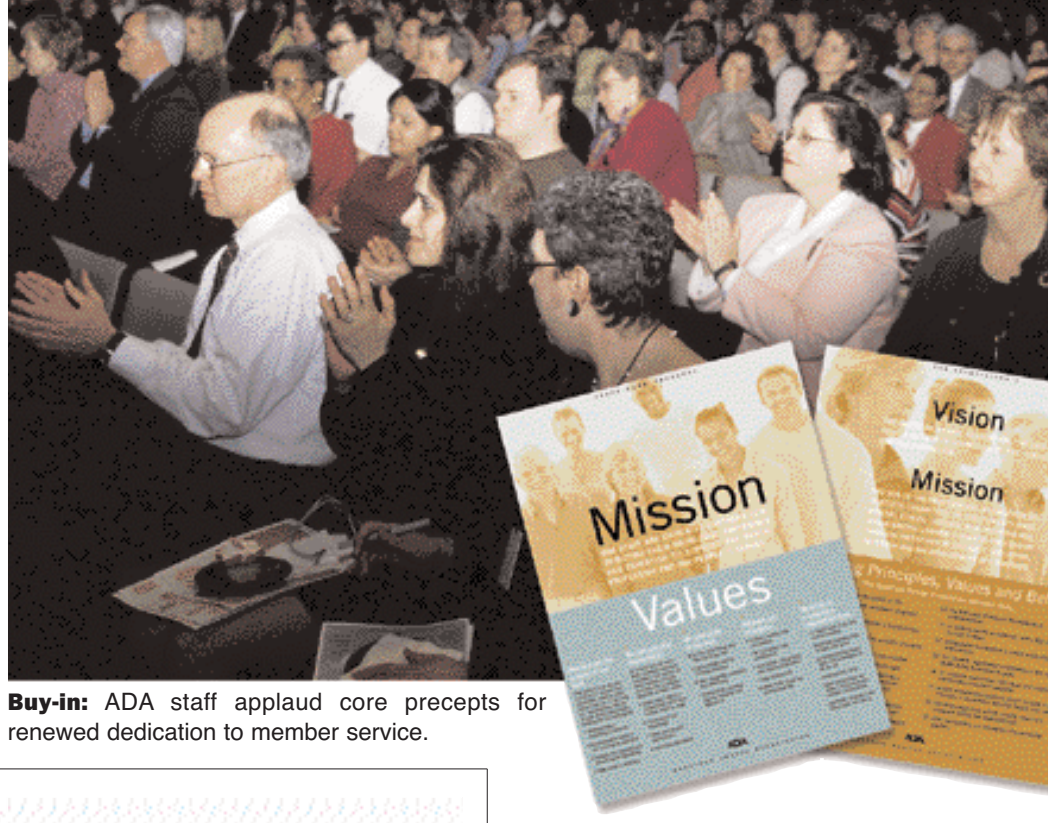
Continued from page 17

Robert Rechner, executive director of the Illinois State Dental Society, says he's noticed a difference in the general demeanor of ADA staff.

"Out in the field, I've heard nothing but good remarks about the changes that have taken place since [Dr. Bramson] took over," Mr. Rechner reports. "Attitudes have improved dramatically. That's been very obvious on an everyday basis to those of us who work regularly with the ADA staff."

Mr. Rechner is one of a number of state and local executives who say they've shared the core precepts concept with their own staff, proving once again that all good ideas have legs. ■

Teamwork: Dr. Bramson discusses how the precepts bring together staff and volunteer leaders in a cohesive effort.



Buy-in: ADA staff applaud core precepts for renewed dedication to member service.

New benefits from Paymentech

Paymentech, a company offering the dental community equipment and services for in-office credit card transactions, has gone high-tech.

With a tool called "MyMerchantView," ADA members using Paymentech now have a secure, easy-to-use Internet-based service that provides timely access to credit card account and transactions.

MyMerchantView includes an array of account management tools and direct access to bankcard account information—combining the reconciliation, reporting, research, auditing and trend analyses you want with the financial control that you need for your business.

A unique feature is MyMerchantView's ability to respond to unusual situations. Accounts outstanding, reversed or expired can be quickly retrieved, and data can be pulled up for up to 18 months.

As an ADA Member Advantage program partner, Paymentech offers ADA members low rates on MasterCard and Visa transactions. There are no additional fees for operating supplies, and ADA members are eligible for a free analysis of their current processing system.

For more information, contact Paymentech at 1-800-618-1666. ■

New brochure on xerostomia

Give your patients the facts on dry mouth with a new full-color, patient-education brochure, available from ADA Salable Materials.

Created by the Association in response to House resolution 87H-2000 and approved by the Council on Scientific Affairs, the brochure covers causes and problems of xerostomia—estimated to affect about one of every 10 patients—possible solutions and how dentists can help patients be more comfortable with the condition.

To order the Dry Mouth brochure in packs of 50, call 1-800-947-4746 or visit the ADA Online Catalog at "www.adacatalog.org". ■

Past ADA president dies

By James Berry

Dr. Truono

Dr. Eugene J. Truono, ADA president in 1990-91 and a staunch advocate of "mentoring" as a way to help new dentists get started in practice, died July 6 at his home in Greenville, Del., after a long illness. Dr. Truono was 77 years old.

A 1953 graduate of Philadelphia's Temple University School of Dentistry, Dr. Truono had been a member of the Delaware State Dental Society since 1954, serving as its president in 1963-64.

Dr. Truono was instrumental in passage of a 1965 state law on fluoridation, making Delaware just the fourth state to adopt such legislation.

In 1967, he was appointed to the state's Comprehensive Health Planning Council and served on the Advisory Board to the governor. He also spent seven years with the state Department of Health and Social Services from 1967-74.

A general practitioner in Wilmington for 44 years, Dr. Truono was a delegate to the ADA House from 1966-83, and 4th District trustee from 1984-89.

He was elected president-elect in 1989. A year later, Dr. Truono ascended to the ADA presidency, the first Delawarean to hold the Association's highest office. He also was a long-time member of the Academy of General Dentistry.

In a series of ADA News interviews in late 1990, Dr. Truono talked about his life and work, emphasizing a mentor-protégé plan he advocated as a way to promote unity among dentists.

"To help promote professional unity," he said, "I think older dentists who have been successful are obliged to reach out and help the young dentists until they reach a point in their careers when they are able to move along on their own. This is the bond that will help keep us together."

Later in the interview, he observed, "All dentists have to recognize that the one organization that will help them succeed and improve as a profession is the American Dental Association."

Dr. Truono was born Feb. 10, 1925. During World War II, he served in the U.S. Army Signal Corp, with the 303rd Battalion. He and his wife, Dolores, were married for 52 years and had seven children who gave them 12 grandchildren.

Dr. R. Alan Stewart met Dr. Truono in dental school, and the two became fast friends. In 1952, Dr. Truono was an usher in Dr. Stewart's wedding. Some 38 years later, Dr. Stewart more than returned the favor when he co-chaired Dr. Truono's campaign for ADA president.

"He was a great guy—jovial, good-natured, hardworking, a staunch supporter of organized dentistry," Dr. Stewart said of his friend. "He will be missed."

In lieu of flowers, the Truono family has asked that donations be made in Dr. Eugene J. Truono's name to Delaware Hospice, 3315 Silverside Road, Wilmington, Del., 19810; or to St. Francis Healthcare Services, 7th and Clayton Streets, Wilmington, Del., 19805. ■

Budget

Continued from page 22

where dollars would be spent, Dr. Jones added.

Dr. Chadwick agreed the overall process has improved during the past six years. "But this year was a giant leap forward. It's Mark Feldman's second year as treasurer and the staff preparation of the budget was the key piece," Dr. Chadwick said, also thanking Dr. Bramson and Ms. Logan for their efforts.

Dr. Feldman said the budget format is easier to read and understand. Last year, the budget report to the delegates was 180 pages long, down from 300 pages the year before. "Ultimately, I'd like to make it even shorter to increase our effectiveness as leaders. It's difficult to absorb 200 pages. We need to develop an executive format that efficiently and precisely communicates the budget. I think we will be able to do that as we continue refining the budget process."

The 2003 budget includes funding for a new member service center, the membership initiative, improvements to the Seal program to make it more clinically relevant to members and other new programs to enhance member value. There were some tough decisions to cut other programs deemed of lesser value.

"Dr. Bramson and the Board are making the Association more user friendly. One example is their creation of a new Membership Service Center," said Dr. Feldman. "Members will be able to call the ADA and have their membership questions answered more easily and quickly based on technology and personnel enhancements. We are presenting a budget that funds a broad base of programs that support the things the Association does: advocacy, science, education, access—all the issues of importance to the profession."

"I believe members will be pleased with the outcome of this budget," said Dr. Chadwick. "It's a responsible proposal; it weeds out weaker programs and allows us to put in new programs. It really is an improved budget and budget process." ■

Annual Session

Looking to build or renovate?

New clinic offers blueprint for designing the ideal dental office

New Orleans—If you're planning to build a new office or renovate your existing facility, you won't want to miss "Building Blocks for Success: Construct Your Ideal Dental Practice."

A new registered clinic, Building Blocks for Success will convene at the 143rd Annual Session of the American Dental Association at the Morial Convention Center in New Orleans Oct. 19, from 10 a.m.-5 p.m.

"You want to build your practice on a firm foundation—not just the building itself, but also the work environment that makes your practice a strong and unified entity," says Dr. Joseph Schachner, program director for this year's annual session and member of the Council on ADA Sessions and International Programs. "This brand-new registered clinic will cover all the building blocks you'll need to build your ideal practice from the ground up."

This detailed session will explain how to maximize the significant investment that you're making in your practice and optimize your returns. The program covers everything from planning and design to building and financing your project. You'll learn about the benefits of creating an attractive and comfortable, ergonomically efficient practice—productivity levels will increase, and team stress levels will decrease.

Presenters for this special program include dentists, consultants and industry experts in architecture, design, construction and finance: Dr. Nate Booth, Dr. Michael Unthank, Patricia Carter, John Devine, Mike Talley, Allison Farey and Richard Armstrong. The seminar is underwritten by The Matsco Companies and presented in cooperation with the ADA Committee on the New Dentist.

Whether you're a new dentist just starting out or you're a seasoned practitioner ready to expand or maximize an established practice, this all-day seminar will help dentists learn to set goals, create a vision and translate that vision into greater practice success.

Register early to reserve your spot and to save money. New dentists can attend at the reduced rate of $90 in advance or $100 on site (Course code: C8). Cost for all others is $125 in advance; $150 on site (Course code: C8A). Course fee includes lunch.

For more information or to register, consult your annual session Preview, call toll free 1-800-974-2925 or visit the annual session Web site: "www.ada.org/goto/session". ■

Correction

The toll-free number for ADA annual session information and registration that appeared in an article on the Esthetics Forum in the June 17, 2002, issue of the ADA News, page 17, was incorrect. The ADA News regrets the error.

For information on the scientific program, special events and hotels, call 1-800-974-2925. ■

Plan your trip online

Visit 'ADA.org' for 'Big Easy' details, registration

By Stacie Crozier

By taking a virtual visit to New Orleans now, you can make your trip to the ADA's annual session a more convenient and enjoyable reality when the scientific sessions convene in October.

"The ADA is doing everything possible to make your experience fun and relaxed in the 'Big Easy,' " says Dr. Joseph Schachner, annual session program director. "By logging on to ADA.org, you can plan your daily and evening activities, choose your courses, and pick your time slots and days with the touch of a mouse."

By pre-registering now, you can ensure you can attend what matters most to you—tickets are limited. You'll also save money on registration and ticket prices, avoid on-site registration lines and spend more time enhancing your clinical and management skills, checking out the latest products and services, networking with colleagues and enjoying the sights, sounds and tastes of New Orleans, Dr. Schachner adds.

Learn everything you want to know about the scientific program lineup by following special links found at "www.ada.org/prof/events/session/index.html".

Get the scoops on all of the 190 or so scientific programs by clicking on the "scientific and general interest programs" link and searching by topic, program type, date or speaker. Courses are available in more than 30 topics, from cosmetic dentistry to temporomandibular joint disorders. Listings include all registered clinics, conferences, non-ticketed open sessions, panel discussions and participation workshops.

This year's program features more than 200 speakers—some of the most respected experts in their fields. You can view biographies, credentials and courses taught by clicking on the "speaker information" link and entering a speaker's last name.

If you want to do a little pre-session window-shopping, click on the "search for exhibitor information" link to search 123 product categories or to search by exhibitor name or booth number.

"While you're online, you can plan your stay in New Orleans well in advance of arriving," says Dr. Schachner. "You can make hotel reservations, order clinic and workshop tickets, link to discounted flight information, plan tours and evening activities—all without leaving the comfort of your office or home. So when you arrive for annual session, everything's in place—hassle-free—ensuring you a memorable ADA meeting in the memorable city of New Orleans."

Hear a sneak preview of the ADA Health Foundation's special event, Linda Eder…In Concert, by clicking on a special link. The Web site also includes details on the ADA Health Foundation health screening program, free child-care, related meetings, special events and much more. Visit today for comprehensive information about annual session. Registration and hotel reservations may be completed on one easy online form. ■

Photo by Carl Purcell©New Orleans CVB

Moving landmark: The oldest continuously operating street railway system in existence, the St. Charles Avenue Streetcar is an official historic landmark that has transported visitors from downtown New Orleans to Uptown and back for more than 150 years.

Team Building Conference VII designed to build team spirit

New Orleans—You can help your office team work together with ease by attending annual session's Team Building Conference VII: "Making It Easy In the Big Easy," Oct. 18 and 19 at the Morial Convention Center.

"Excellence in dentistry is truly a team effort," says Dr. Joseph Schachner, 2002 program director for annual session and member of the Council on ADA Sessions and International Programs. "Be sure to bring all the players of your team to attend this important and exciting conference that can enhance every aspect of your dental practice."

This two-day registered clinic gathers your office's entire staff: dentists, assistants, hygienists and business assistants for a motivational conference that includes lectures, interactive activities and team discussions that can make your practice run more smoothly and effectively.

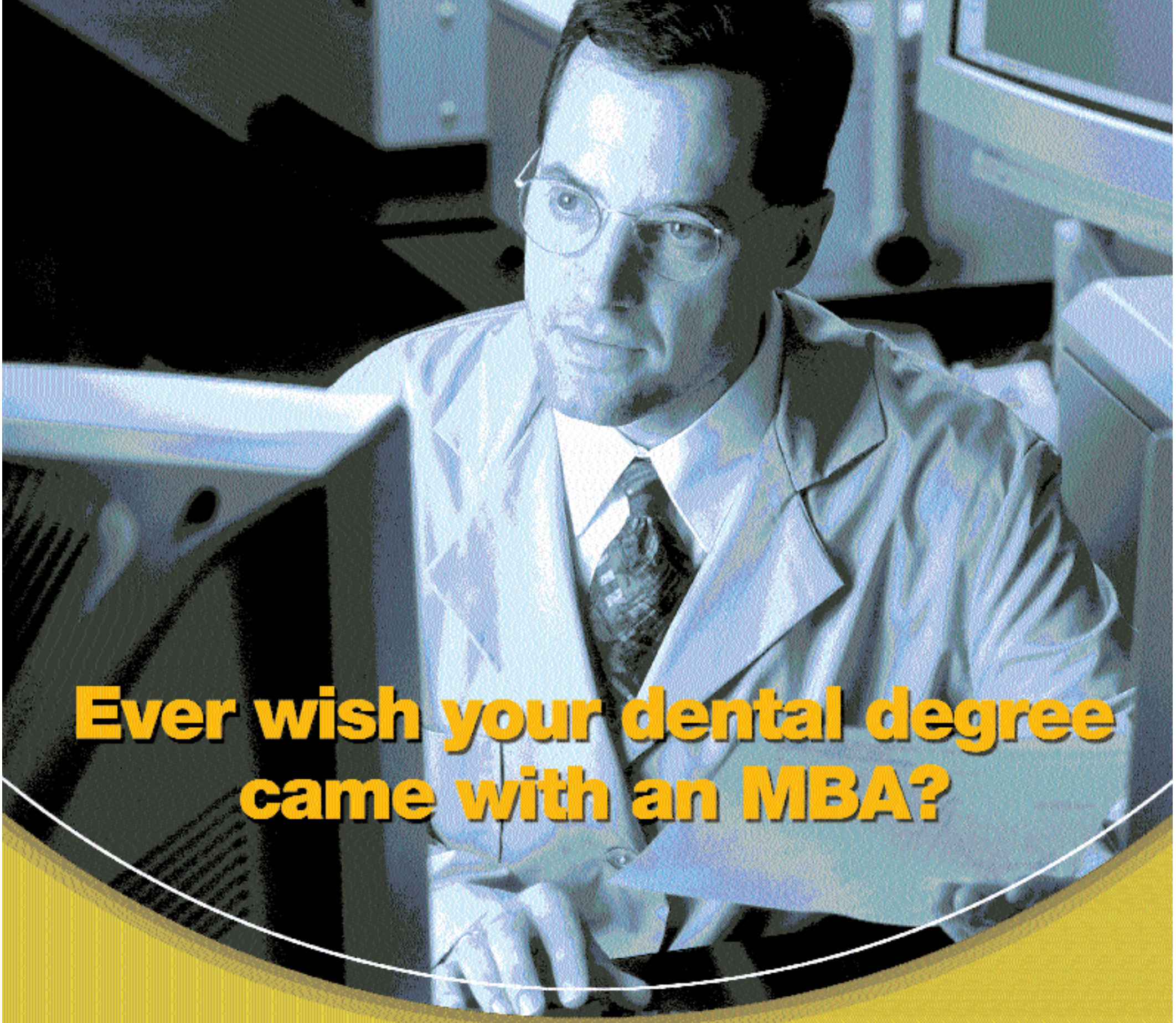
Learn methods to effect change to take your practice to new levels of success and how to develop your team's full potential during this Team Building Conference.

And, in a city known for its easy-going atmosphere, fabulous food and fun, your team will have a chance to relax from the stresses of the office and discuss important issues in a stimulating, fast-paced and entertaining environment.

Dr. Mark Hyman, Dr. Roger Levin, Alyce Cornyn-Selby, Cathy Jameson, Robert Gray and Naomi Rhode will help your team deal with conflict resolution issues, improve problem solving abilities, promote individual initiative and take home a guide to strategies for building a strong and effective dental team.

The clinic will meet Oct. 18 from 8:30 a.m.-4:30 p.m. and Oct. 19 from 10 a.m.-5 p.m. Cost is $260 for dentists (Course code: C3); $175 for staff members (Course code: C3A).

For more information or to register, consult your annual session Preview, call toll free 1-800-974-2925 or visit the annual session Web site: "www.ada.org/goto/session". ■



Business tools from ADA Member Advantage℠ help you stay focused on what you do best.

Don't let a tangle of office work get in the way of patient care. ADA Member Advantage's complete selection of competitively priced business services, offered exclusively for ADA members, can help you create a more organized and effective dental practice.

- Practice Financing
- Credit Card Processing
- Fee Recovery/Collections
- Payroll Services
- Office Supplies and Furniture
- Postage Meters
- Shipping
- Patient Financing
- And Much More

For information on our products, call 1.800.ADA.2308 or visit adamemberadvantage.com

ADA MEMBER ADVANTAGE℠
Business & Lifestyle Solutions

Two years after her whitening,

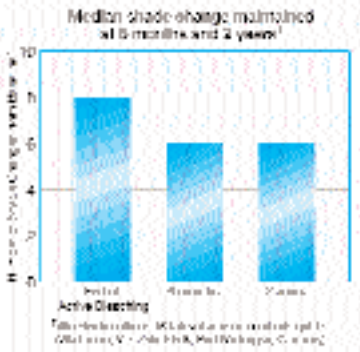
Beth's friends and family still look at her differently

NUPRO WHITE GOLD

NUPRO White Gold™ is the take-home tooth whitener clinically proven to maintain results for at least 2 years

NUPRO White Gold. Fresh new look. Same proven long-lasting results.

- In a clinical study, more than 80% of patients treated with NUPRO White Gold (10% carbamide peroxide) maintained their whitening results* for at least 2 years ($P<.0001$)[1]



- Each complete treatment comes in a convenient, new, 2-part packaging system
  - Lab materials for you
  - A take home kit for the patient
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*According to American Dental Association guidelines, a bleaching material is judged to be efficacious if its use results in at least 2 shade changes according to a value-oriented Vita shade guide.[1]

Reference: 1. Swift EJ, May KN, Wilder AD, Heymann HO, Bayne SC. Two year clinical evaluation of tooth whitening using an at home bleaching system. *J Esthet Dent.* 1999;11(1):36-42.

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