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American Dental Association, Publishing Division

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AMERICAN DENTAL ASSOCIATION
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The first ADA sponsored access-to-care initiative plans for take-off

By Karen Fox

On the morning of Feb. 21, thousands of children from low-income families will have scheduled appointments with dental offices and clinics around the country for free dental care and education.

The occasion is Give Kids a Smile, the first access-to-care initiative sponsored by the American Dental Association. With participation from state and local societies, dental schools, the armed forces, public health sector, allied professionals and the public, ADA officials hope to have a significant impact on access awareness and help thousands of people through various programs on Feb. 21.

But the ideals set forth by Give Kids a Smile run deeper.

"Our larger purpose is to deliver the message that we cannot solve this problem alone," said Dr. T. Howard Jones, ADA president. "For every child we care for on that day, hundreds and even thousands more will continue suffering until the nation gets serious about oral health."

Dr. James B. Bramson, ADA executive director, called Give Kids a Smile "one way to consolidate dentists' generosity and wake the nation up to a problem that too few people are aware of."

"Dentists aren't to blame for access problems, and we must not be afraid to acknowledge that problems exist and assume the leadership role in tackling them," he said.

Endorsed by the Board of Trustees in April 2002, the concept for a national access day was envisioned as a way to spotlight the dental care needs of indigent children and organized dentistry's role in helping to meet those needs.

"It's a true team volunteer effort on behalf of the profession," said Dr. Bramson.

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Full Coverage Inside

Policy changes improve access

Can new programs solve the problems?

By Mark Berthold

Gainesboro, Tenn.—Medicaid patients of Dr. Dillard Dycus probably aren't aware of the dental "carve out" from the TennCare program that occurred three months ago.

But the general dentist says the children of Tennessee's low-income families are nevertheless experiencing a change for the better.

"Before the carve out, a woman who lives almost 150 miles away made an appointment for her three children because no private-practice dentist near her took TennCare," he says.

"Another woman, 60 miles away, had appointments for her children but called my office to cancel. It was raining real hard, and the windshield wipers on her car were broken."

Since Oct. 1, 2002, when the dental carve out took effect, both mothers have left Dr. Dycus in favor of newly enrolled TennCare dentists, much closer to home, who will treat their children—and Dr. Dycus is glad.

"These people don't have money to travel," he says. "Fortunately, this is no longer an issue."

Under conditions of the carve out, dentists who join TennCare now have federal and state funding dedicated specifically for oral health care, and this "carved out" dental portion of Medicaid is administered by a single benefit manager, Doral Dental. The

See ACCESS, page 16

BRIEFS

GKAS donations: Want an alternative way to support Give Kids a Smile?

Consider making a tax-deductible donation to the ADA Foundation's Harris Fund for Children's Dental Health.

The Harris Fund provides grants to charitable organizations in support of preventive dental care for children.

For more information, call the ADA toll-free number at Ext. 2547 or go to "www.adahf.org".

Program resources: The ADA Council on Access, Prevention and Interprofessional Relations has available three resource monographs that can link dental access programs to helpful sources of information:

- Manual on Dental Care Access Programs;
- Obtaining Funding for Dental Access Programs: An Overview;
- Dental Access Program Marketing: How to Build Public Image and Participation.

Print copies are available to ADA members for $10. The cost is $15 for non-members, plus tax where applicable.

Contact CAPIR at 1-312-440-2673, calling toll free, Ext. 2673 or e-mailing "babcockj@ada.org". ■

INSIDE

In the heartland

Dentists make the most of limited resources, **Story, page 18.**

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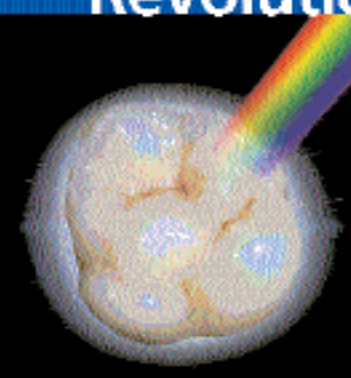

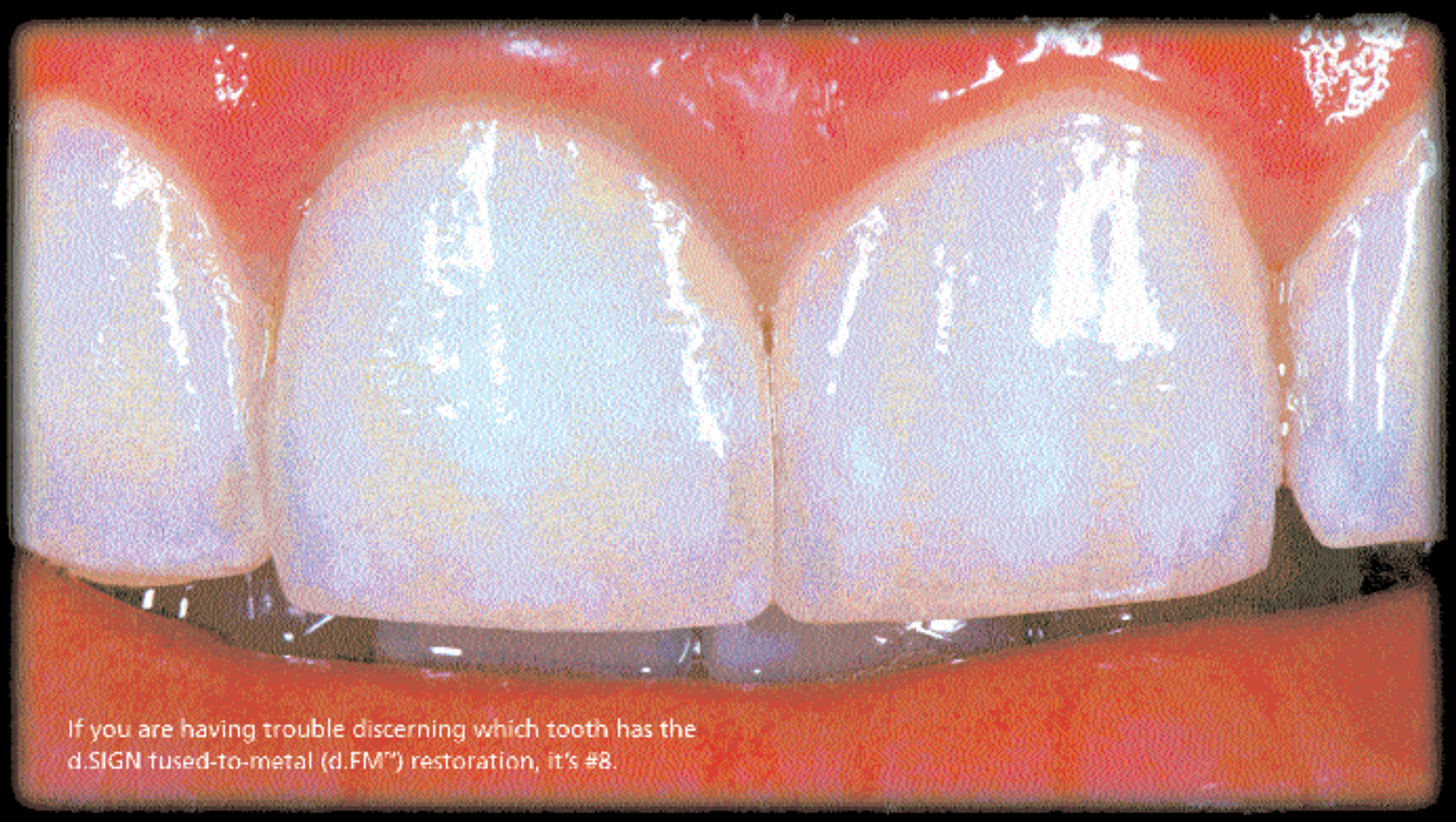

If you are having trouble discerning which tooth has the d.SIGN fused-to-metal (d.FM™) restoration, it's #8.

Photo courtesy of Olivier Tric and Dr. Bruce Adam's

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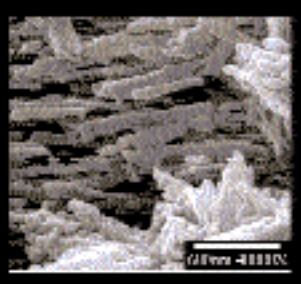
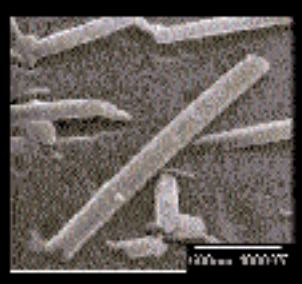


NATURAL TOOTH STRUCTURE



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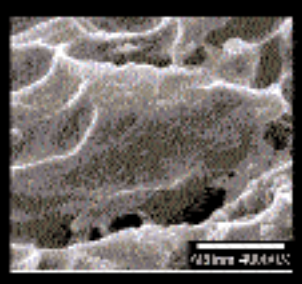

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These SEM photos show the similarity of crystals found in natural tooth structure and new IPS d.SIGN® fluorapatite-leucite material. This type of crystal is not found in feldspathic porcelain. University of Buffalo, Instrumentation Center, P. Rush. Data on file

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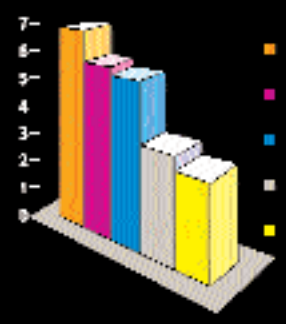

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Wear of enamel against Dental Ceramics. Sulzberger et al. J. Dent. Res. Vol 78, 1999 1909

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Holiday cheer: Three local organizations that treat underserved dental patients in Chicago receive donations during the ADA employee holiday gathering Dec. 13. ADA staff raised $11,775 in 2002 during their annual Smiles for Kids Charity Raffle. From left, R. Barkley Payne, ADA Foundation senior director; Dr. James Bramson, ADA executive director; and Mary Logan (in blue), ADA chief operating officer; present donations to Pat Ciebien (in red), director of dental services, DuPage Community Clinic; Dr. Ghassan Souri, dental director, Infant Welfare Society of Chicago; and Dr. Edward J. Schaaf, dental director, St. Basil's Free Dental Clinic.

When the icon at left appears with an ADA News article, turn to our counterpart on the World Wide Web—the ADA News Daily—for related news and information via ADA.org.

ViewPoint

Snapshots of American Dentistry

Laura A. Kosden, *Publisher* **Dr. Marjorie K. Jeffcoat,** *Editor*

James H. Berry, *Associate Publisher, Editorial* **Judy Jakush,** *ADA News Editor*

MyView

A better solution

The 2001 Future of Dentistry report documents the great unmet dental needs of people in the United States. Unfortunately, the 2001 report mirrors its predecessor. In 20 years, nothing has changed, even with the advent of myriad access programs.

As vice president of the American Dental Association Health Foundation, 300 grant requests cross my desk from small church-sponsored clinics and larger dental society-sponsored programs. All of them make a compelling case for partial or full funding.

Last year, the ADA Health Foundation granted $310,000 to access programs, mainly for children. Additionally, the ADA Health Foundation annually grants $75,000 to the Foundation of Dentistry for the Handicapped, a national organization that arranges dental treatment for handicapped people with little or no financial resources.

Walter Lamacki, D.D.S.

The Robert Wood Johnson Foundation and Oral Health America have funded an array of access programs. The Chicago Dental Society is granting money to the St. Basil's clinic and other small clinics that provide care on a free or sliding-scale basis. Recently, CDS joined with the University of Illinois at Chicago dental school to fund the McCormick Boy's and Girl's Club dental clinic. There, supervised UIC dental students provide care for needy youngsters. There are hundreds, if not thousands, of access programs across the country—yet nothing has changed. Why?

The reasons are many but distill down to one unavoidable fact: There isn't enough money to restore the teeth of the impoverished in the United States, even with hours of donated professional care. The existing programs are expensive and require annual funding. It is easy to point to a problem, but it is quite different to offer a solution.

Dr. Guillermo Vicuna, a Stockton, Calif., dentist, thinks he has just that.

Stockton, a city in the San Joaquin Valley, is surrounded by hundreds of farms. More than 700,000 individuals in this area are without medical insurance, much less dental insurance—190,000 of these are children. The city's population swells during harvest time when thousands of migrant workers and their families set up camp. The workers have some of the most acute dental needs in the nation. Exacerbating the problem is that the state of California is not totally fluoridated.

A year ago, I arrived in Stockton to present a check on behalf of the ADA Health Foundation to an organization called Su Salud (Your Health). Dr. Vicuna, one of three founders of Su Salud, explained that the mission of Su Salud is to prevent medical and dental disease through education.

Dr. Vicuna, by force of personality, has convinced dozens of health care professionals to volunteer their services. In 1987, six volunteer professionals diagnosed 80 impecunious people at a Su Salud Health Fair. Seven years later, the fair drew

See MY VIEW, page five

LettersPolicy

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".

Dental practice

Little fluctuation in the number of offices for individual dental practices has occurred over time. In 1999, 10.3 percent of independent dentists reported that their primary private practice had more than one office.

Letters

What harm?

I was very disappointed to read the ADA's new policy on oral sedative agents ("Anesthesia Guides Get Update," Nov. 4, 2002, ADA News).

What information was presented that shows the public is or has been harmed by general dentists using oral sedatives, such as Triazolam? I have used Triazolam in my practice hundreds of times without one emergency. It is a very safe and effective drug that is quickly reversible should an emergency occur.

I provide services to dental-phobic patients in rural Kentucky that are not available through oral surgeons and periodontists. The cost of having a dental anesthesiologist chairside would be cost prohibitive for many of my phobic patients.

Before I even considered starting the use of oral sedation dentistry, I spoke with a colleague and personal friend, Dr. Ted Raybould, who teaches IV sedation to general practice residents at the University of Kentucky School of Dentistry. I asked him if the training provided by the Dental Organization for Conscious Sedation (including their 20-hour advanced course) was appropriate to safely treat my patients, and specifically asked if he would recommend I receive training in IV sedation in order to perform oral sedation dentistry.

Dr. Raybould said to me (paraphrased) that just as a dentist providing IV sedation does not need to train to perform general anesthesia, a dentist providing oral sedation does not need to know IV techniques.

I fail to understand the logic behind this new revision and feel it is politically motivated. To discourage oral sedation among general dentists is a huge step backward—a step that will harm the public by restricting access.

The ADA News story contained some very inflammatory opinions from Dr. Robert M. Peskin, chair of the Council on Dental Education and Licensure's Committee on Anesthesiology. These comments can only hurt our profession and restrict care for dental-phobic patients. The Committee on Anesthesiology's actions are in serious error, and an immediate review is necessary before ADA member dentists are harmed by someone that has an unfair agenda.

William J. Moorhead, D.M.D.
Flemingsburg, Ky.

Editor's note: According to the Council on Dental Education and Licensure, the changes to the Association's anesthesia guidelines documents adopted by the 2002 ADA House of Delegates are not intended to discourage the use of oral sedatives.

Rather, they are intended to provide guidance to dentists who wish to use oral medications for sedation purposes. Additionally, the Association's guidelines require the provider to be responsible for the treatment of emergencies associated with the administration of enteral and/or combination enteral conscious sedation (combined conscious sedation), including immediate access to pharmacologic antagonists, if any, and appropriately sized equipment for establishing a patent airway and providing positive pressure ventilation with oxygen.

Providers must also document cur-

See LETTERS, page five

Letters

Continued from page four

rent successful completion of a Basic Life Support course. The Guidelines do not require training in IV sedation techniques for dentists who administer oral conscious sedation.

The ADA Guidelines for the Use of Conscious Sedation, Deep Sedation and General Anesthesia for Dentists and the Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry can be found online at "www.ada.org/prof/prac/issues/statements/index.html".

Implant dentistry

I was perusing the front page of the Sept. 2 ADA News when I came upon the brief on "Implant Course."

This course is a daylong implant surgical training course "designed to teach dentists the introductory skills needed for implant surgery."

As a board-certified oral and maxillofacial surgeon, this raises serious concerns I have for the public's welfare. In my professional opinion, implant surgery should be performed by oral and maxillofacial surgeons and periodontists alone.

These are the only two specialties of dentistry in which surgical skills are taught under supervision as well as dealing with any complications that may possibly arise. I find it insulting to think that through a weekend course, general dentists and prosthodontists, who have had no surgical experience other than the minimal tooth extraction qualifications in ADA-accredited dental schools, feel they can properly manage these surgical techniques.

There is a reason that dental implants have had such a high success rate when being placed. Up until this point, placing them have been surgeons trained in periodontics, which is a two- to three-year residency, or an oral and maxillofacial surgeon who has spent four to six years of surgical training. The reason that implant placement appears to be easy is that skilled surgeons have been providing these services.

I realize that the implant companies have been targeting the general practitioner by offering these courses. The representatives of these companies surely are not surgeons and their obligation is to increase the revenue of their companies by getting as many implants placed as possible.

Unfortunately, the conclusions that come to mind if unqualified doctors acting as surgeons are not good. In my opinion, the success rates will significantly decrease and with that, word of mouth will spread among the public and the acceptance for treatment will also decrease and finally, inevitably, a few people will get hurt in the process.

Let us not forget that when we perform certain procedures we are all held to a certain standard of care. Even the best-trained surgeons will have complications at times. Think about what you will say if you are sitting in a courtroom and the prosecuting attorney is asking what your qualifications are to perform this surgery. Will your answer be the weekend course, or can it be backed up by several years of surgical training under close supervision in a residency followed by board certification in your field?

As a side note, I can appreciate the desire to expand one's scope of practice. For me, as an extension of my facial trauma experience, I am interested in facial cosmetic surgery. Rather than taking numerous weekend courses that even may include cadaveric dissection, I have chosen to take the path of leaving my private practice after five years and returning for a year-long fellowship in this area.

Raymond J. Haigney II, D.D.S.
Diplomate, American Board of Oral and Maxillofacial Surgery
Lancaster, Pa.

Editor's note: According to the ADA Council on Dental Education and Licensure, implant dentistry may fall within the scope of practice of the appropriately trained general dentist. Additionally, in accordance with the ADA-approved definitions and the Commission on Dental Accreditation's advanced specialty education program standards, implant dentistry falls within the scope of practice of the following dental specialties: prosthodontics, periodontics and oral and maxillofacial surgery.

MyView

Continued from page four

18,000 participants. The need and the lack of resources to treat the poor overwhelmed the workers. They realized they needed a better way.

In 1997, Su Salud moved to a full-time Su Salud Disease Prevention Center in Stockton. When it became apparent that even this endeavor was inadequate, Su Salud entered into partnership with San Joaquin General Hospital, the largest hospital in the region. Now patients are able to access health education, as well as health care, in one location. The organization sponsors a call-in live radio program, a cable television program and has a weekly column in the local Spanish-language newspaper. Su Salud provides free dental screening for patients who qualify, but only after they participate in a free dental-education program. For those who need further care, a low-cost treatment is available.

Su Salud was the recipient of the 1,000 Points of Light Award from then President George H.W. Bush. Dr. Vicuna is a committed and tireless worker for the poor who believes "prevention is treatment." He and his volunteers found a better way!

At the turn of the 19th century, G.V. Black predicted that dentists would be preventing rather than restoring. Isn't it time to start?

Dr. Lamacki is the editor of CDS Review, the journal of the Chicago Dental Society. His comments, reprinted here with permission, originally appeared in the December 2002 issue of that publication.

Editor's note: As of Jan. 1, via action by the 2002 House of Delegates, the ADA Health Foundation was officially renamed the ADA Foundation. (See story, page 22.)

Access success stories

New ADA report to help states share program ideas

By Craig Palmer

Special Report

Washington—The ADA and state dental associations are putting the finishing touches on the first-ever state-by-state report and national compendium of initiatives to improve children's access to oral health care, a user-friendly snapshot expected by springtime.

"The Association recognizes that many states have been active in seeking solutions to access barriers the last several years, particularly for children enrolled in Medicaid and the State Children's Health Insurance Program," ADA Executive Director James B. Bramson told state professional and public dental leaders in a letter to state association executives announcing the project.

"The American Dental Association seeks through development and distribution of a compendium of states' access initiatives to disseminate each state's innovations to other states and stakeholders for their consideration and possible duplication. This project is just one of several ADA activities designed to find ways to improve access to oral health services and dental care in the nation."

Reports prepared by a Medicaid-experienced contractor and edited by the state dental associations before national distribution will offer a snapshot of oral health access activity since 1996.

The reports will include newly aggregated and state-specific data on the proportion of eligible children receiving public dental services, comparisons of Medicaid dental fees for 15 most common pediatric dental procedures with regional private sector fees reported by the ADA 2001 Survey of Dental Fees, annual EPSDT dental visits by children and other information on public programs. The Early and Periodic Screening, Diagnostic and Treatment service is Medicaid's comprehensive and preventive child health program for individuals under age 21.

Like the ADA Give Kids a Smile initiative and the dental access legislation passed by the 107th Congress and signed into law by President Bush (see related report below), the new assessment and documentation of state innovations is viewed by the Association as among the complementary state-friendly activities informing and supporting a growing national effort to improve access to oral health services and dental care.

In addition to state summaries, the compendium will include an executive summary and index categorizing state innovations and activities.

Dr. Don Schneider, former chief dental officer for the Centers for Medicare and Medicaid Services in the U.S. Department of Health and Human Services, is compiling the information and preparing the state-specific and final reports from publicly available materials under contract with the ADA. The reports will be issued without opinions or judgments on the success or failure of any state activity or innovation, although some may contain references by state officials to program results.

The ADA invited information from state dental associations, Medicaid and Child Health Insurance Program officials and state dental directors and is offering state dental societies a final editing opportunity. ■

'Safety net' law offers states flexibility for access programs

Washington—For now, Public Law 107-251 is on the books but unfunded, a promissory note of incentives for dentists and the states to find ways to increase access to care.

"The dental components in this bill take a common-sense approach," said ADA President T. Howard Jones. "Rather than imposing one solution to the states' unique problems, the safety net bill will provide grants to help states develop programs that address their specific dental workforce and access to care needs."

The new dental access legislation, "a small but significant step toward addressing these needs," was one of the few health policy measures approved by the 107th Congress. It is part of a larger bill reauthorizing community health center and National Health Service Corps programs.

PL 107-251 authorizes incentives in the form of grants and loans for the states and private practice dentists to "expand or establish oral health services" for underserved population groups. The legislation was passed with the strong backing and support of the American Dental Association and signed into law Oct. 26, 2002, by President Bush.

Funds authorized by the 107th Congress still have to be appropriated under separate legislation if the new dental access measures are to take effect. And that's a job for the incoming 108th Congress. ■

One child's pain, one mother's story

By Stacie Crozier

Special Report

The broad issue of access to dental care can be boiled down to the pain of one child and the frustration of a mother who just wants to find a dentist to treat her daughter.

But the solutions aren't as simple.

As executive director of the Virginia Dental Association, Dr. Terry Dickinson works with all sides of the issue. The state developed and implemented a plan for working families with low incomes that includes dental care—but never consulted a dentist or included a dentist on its advisory panel. The program has proved to be costly to the state, confusing for patients and frustrating for dentist participants.

Kim Seifert, a mother in Harrisonburg, Va., whose children were covered under the state health plan, shared her story with Dr. Dickinson via e-mail.

"Here in Harrisonburg/Rockingham County there are no dentists who will see my children other than the county health clinic, which has about a three- to four-month backlog to be seen," she wrote. "My daughter currently has two cavities which need to be fixed and she has to wait that long to have the work done. I am willing to drive to other cities/counties and obtained some names of [participating] dentists who will accept this insurance. When I call them, they tell me 'yes, we are accepting new patients' until they find out it's children on [the state plan] and then they say 'no, sorry, we can't see them as we have reached our limit of these types of patients.' Boy, does that make you feel second-rate!

■ "I have to tell my daughter to sit and wait as her teeth continue to get worse. … I ask to gain knowledge and insight, not to judge. …"

"I understand that there is probably a lot of paperwork/bureaucracy involved and lower payments," she continued, "but why don't dentists feel compelled to do the ethically responsible thing to see these patients? … I have to tell my daughter to sit and wait as her teeth continue to get worse. … I would like to know who I can complain to about this and would love to hear a dental professional's response/explanation. I ask to gain knowledge and insight, not to judge. …"

Dr. Dickinson found a local dentist who was willing to treat her daughter outside the program. He explained the problems faced by program administrators and providers and then he asked her to participate in a discussion group coalition that is trying to identify problems on a local level and find ways to address them.

Though Ms. Seifert's family recently moved from the area when her husband was transferred, stories like hers need to be heard by the profession, public policy makers and communities with people in need of dental care, Dr. Dickinson added.

The state dental association recently launched a new program that brought volunteer general dentists together with pediatric dentists to perform a one-day screening of more than 100 children in one community.

"The project was designed to help general dentists who don't normally treat children to get more comfortable working with younger patients," said Dr. Dickinson. "About half the children who received exams were called back in August for follow-up restorative care from the same dentist teams. It went great."

The program was an offshoot of Virginia Dental Health Foundation's Missions of Mercy Project, which has provided more than $1.5 million in free dental care to more than 4,500 patients of all ages, including the working poor, the elderly, the disabled and the uninsured.

MOM works with dental professional organizations, local foundations, insurance carriers, social services agencies, the health department, nearby dental and dental hygiene schools, dental products companies and philanthropic organizations to generate the resources needed to bring care to the underserved.

The Virginia Dental Association will also begin working with the state Medicaid department this year to try and recruit dentists to become traditional Medicaid providers, he added.

"We need to deal with the problem at a community-wide level," he added. "It's an immense challenge that will take lots of people working together to find long-term solutions." ■

Charter bus keeps costs down, reaches kids in remote areas

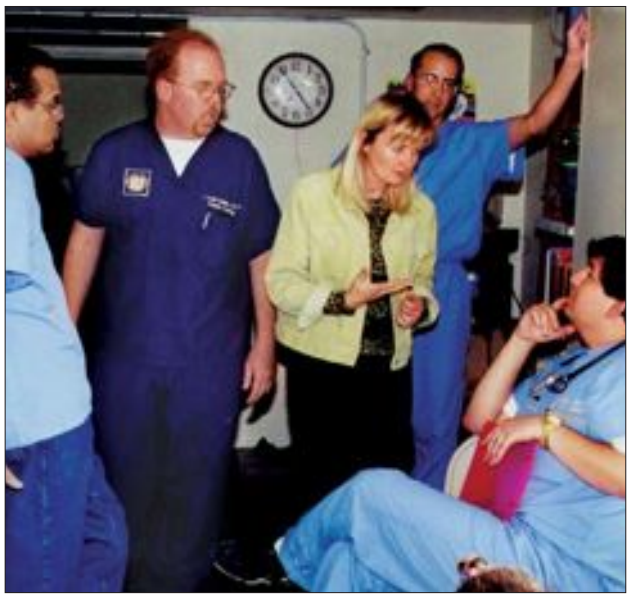
Special Report

By Stacie Crozier

Loma Linda, Calif.—Kids in remote areas of San Bernadino County had no way to travel to a dental clinic for much-needed care.

So Dr. Carla Lidner, a local dentist and professor at Loma Linda University School of Dentistry, came up with a simple solution: renting a bus.

Dr. Lidner nixed the idea of purchasing a dental van when she secured a tobacco tax (Proposition 10) grant to provide treatment to underserved young children in San Bernadino County. Instead, she chartered a bus and brought children and their caregivers from remote areas of the county to the dental school's pediatric clinic.



On schedule: Dr. Carla Lidner, third from left, reviews plans for the children's care with Drs. Ron Forde, Todd Milledge, Dan Pulsipher and David Rogers.

"We decided to try something new," says Dr. Lidner. "We picked up kids accompanied by their caregivers and brought them to the clinic on a bus that had air conditioning and restrooms. We fed them, entertained them and put them up for two nights, then we drove them back home."

The costs, she notes, were significantly lower than investing in a dental van, since the program didn't need its own liability insurance. Participants simply signed a release form with the charter bus company. A local business leader also helped keep costs down by donating the cost of the hotel rooms, she adds.

The first such program, conducted in April 2001, brought 60 children from Head Start programs and preschools in remote Needles and Big River, Calif. Dental school faculty, fourth-year dental students and community leaders participated in the volunteer effort. Children and their caregivers participated in dental health education sessions and were entertained by clowns, storytellers and firefighters as they waited for their turn. And children who needed extensive treatment under general anesthesia were able to have all their work done at one time.

Ready to roll: Dr. David Rogers screens a child at Big River Head Start preschool before her bus trip to the dental clinic.

"This was such an unbelievably rewarding experience," says Dr. Lidner. "These were very poor children, and a bus ride to the university was like going to Disneyland. Most had never stayed in a motel before, either, so it was a great opportunity for them to see a college campus and to take a little trip. The ride home was amazing, too. The kids were so happy and proud of their dental work and no one complained about pain or soreness. They were overjoyed."

Since the initial bus trip, the program has treated children in five other remote communities. The program also pays parents or neighbors 30 cents a mile if they live closer and are able to drive a child in for scheduled dental care.

"This is a neat model for getting not just screening, but also getting care," says Dr. Lidner. "And since we recently secured a $2.3 million grant, we will be able to offer fluoride and sealants to children under the age of 5 in 2003."

The program has also been able to set up three community dental clinics in the county where volunteer dentists are available to treat needy families every weekend.

Terrell Johnson, a family advocate in the preschool services department, County of San Bernardino Human Services System, shares one child's story:

"He was suffering and in pain for at least five days due to tooth decay. The child would not eat during breakfast, lunch or snack times; he cried and exhibited minimal interaction with classmates. This child, simply, could not function in class in this condition.

"Thanks to Proposition 10 funding and the helpful, courteous staff at Loma Linda University School of Dentistry, this child began treatment on July 16 and seems like a new person. He's participating in class more, eating and interacting with peers. You are making an awesome impact in the lives of children and their families."

A detailed story of the program is posted on LLU's Web site at: "www.llu.edu/news/scope/aut01/dentistry.html" and an article also appeared in the Sept. 16, 2002, issue of the California Dental Association Update. ■

International women's dental conference fosters leadership

Abstract submission deadline is Jan. 24

Göteborg, Sweden—A global conference this summer will promote the advancement of women and recognize their leadership value in the workforce and in the promotion of women's health and oral health.

Women in dentistry, their coworkers and mentors will gather here June 20-23 for the Second International Women's Leadership Conference, sponsored by the American Dental Education Association. The conference will precede the 81st general session of International Association for Dental Research, which begins here June 25.

This global professional conference for dental educators, practitioners and researchers who train, mentor and work with women is designed to foster global alliances and deliver leadership strategies that women can use to improve oral health and overall health in their communities throughout the world.

The conference format will include didactic lectures, interactive sessions, skills development workshops and oral and poster abstract presentations.

Individuals are encouraged to submit an abstract for oral or poster presentation following one of the following eight themes:

- women's health curriculum;
- workforce/research careers;
- model programs to promote women's health;
- women and family oral health;
- marketing women's oral health;
- leadership skills and development;
- change management;
- women's health research.

Deadline for submitting abstracts is Jan. 24. For information on how to submit an abstract or how to register for the conference, visit the ADEA Web site: "www.adea.org". ■

Get the right stuff

Order your GKAS supplies from corporate sponsors

Special Report

Let the countdown begin! Only 46 days until Give Kids a Smile.

Now is the time for dental societies and ADA members to order supplies for the ADA's first nationwide access-to-care initiative, which is set to take place Feb. 21.

Several corporate sponsors have stepped up and offered support for the event. Crest Healthy Smiles 2010, Sullivan-Schein Dental, DEXIS Digital X-ray Systems and Ivoclar Vivadent Inc. have all contributed significant amounts of dental products and supplies for use during Give Kids a Smile events.

How to find qualified kids to treat, page 20

Dentists and dental team members who plan to take part in Give Kids a Smile are encouraged to sign up at ADA.org "www.ada.org/prof/accessreg.asp". The event will be used as a platform to publicize the dire need for better access to oral health care programs, and it is essential that all participants sign up even if they are not ordering supplies.

Products available while supplies last include:

- Crest Healthy Smiles 2010 sample kits—Volunteers for Give Kids a Smile can now place online orders at "www.dentalcare.com/ hsmiles/ index.htm" for age-appropriate sample kits containing Crest brushes, paste and educational materials.

As the ADA's exclusive consumer product partner in the campaign, Crest Healthy Smiles 2010 will process requests for kits and mail them with sample bags and an ADA tent card for office display recognizing participants.

After you enter the Crest site, click on the "Order Now" icon under Give Kids a Smile. If you already have a user name and password for a Crest online account, you will be asked to enter them here. If you are not a registered user and would like to set up a free Crest account, you will be prompted to establish an account.

After completing the registration form and selecting a user name and password, you will be prompted to "Set Up Billing Account Now." Before submitting billing account information, enter GKAS03 in the "Pre-Approval Code" text box under "Optional Information."

By inserting GKAS03, your account will be immediately active and you may then access the Crest Healthy Smiles/Give Kids a Smile icon.

- Sullivan-Schein Dental—As the program's exclusive distributor, Sullivan-Schein will work with 40 access programs and Sullivan-Schein vendors to meet a full range of supplies for up to 200 children.
- DEXIS Digital X-ray Systems—DEXIS will supply X-ray units with a staff and equipment to large Give Kids a Smile programs.
- Ivoclar Vivadent Inc.—As the exclusive supplier of preventive and restorative materials, Ivoclar will provide 5,000 prevention and restoration kits containing fluoride varnish, sealant, amalgam and composite.

The supplies provided by ADA corporate sponsors may not meet all the Give Kids a Smile program needs. Program directors are encouraged to supplement supplies as necessary with other corporate contributions or from other sources.

All participants in Give Kids a Smile will be recognized in the ADA News. ■

GKAS

Continued from page one

"Many dental societies have existing access activities in place," he said. "Ideally, we'd like the national Give Kids a Smile program to deliver value to the state and local programs by getting them more attention."

Give Kids a Smile gained momentum in June 2002 when Dr. Greg Chadwick, ADA immediate past president, addressed a Senate subcommittee on children's dental health.

In lieu of effective public health financing programs, he said, many state and local dental societies sponsor voluntary programs delivering free or discount oral health care to underserved children.

Former Surgeon General David Satcher, M.D., who issued the nation's first report devoted exclusively to oral health issues, testified with Dr. Chadwick.

As societies and individual dentists volunteered for Give Kids a Smile, the Association saw an opportunity to solidify the event as part of the profession's dedication to underserved patients. In October 2002, the ADA House of Delegates passed Res. 29H-2002 making Give Kids a Smile a permanent annual event.

The ADA will continue its state and federal legislative efforts to increase funding for access activities and improve the Medicaid system, but Give Kids a Smile marks a turning point in the Association's commitment to improving access to care.

"Charity alone will never fix the problem because charity is not a health care system," said Dr. Bramson. "Give Kids a Smile taps into the volunteer spirit that all dentists have, and is a significant step toward making an impact in this area." ■

Dental industry shows it cares

Firms pitch in to Give Kids a Smile

By James Berry

In a year marked by so much unfavorable news out of Corporate America, the dental industry did itself proud in 2002.

Four companies in particular earned the profession's gratitude by stepping up to help make Give Kids a Smile, the ADA-sponsored access-to-care event, a reality.

Special Report

The four firms that have partnered with the Association on GKAS are Crest (Procter & Gamble) Healthy Smiles 2010, Sullivan-Schein Dental, DEXIS Digital X-Ray System and Ivoclar Vivadent Inc.

Crest Healthy Smiles 2010 was the first to lend support to GKAS. In September, the company pledged to provide toothpaste, toothbrushes and educational materials for participating dentists to dispense to the many underserved children who will be screened and treated through the Feb. 21 nationwide event. (See story, page nine.)

Crest also will fund two $5,000 dental school scholarships to be awarded to the constituent and component dental societies that organize the most successful GKAS programs.

Through its own Healthy Smiles 2010 campaign, Crest is pursuing "long-term solutions to the oral health crisis facing America's youth," Diane Dietz, North American marketing director for Crest, told the ADA News in September.

"Through partnerships with dental leaders like the ADA," she added, "we will improve the oral health of underserved communities, helping create smiles that will last a lifetime."

Through its national partnership with the Boys & Girls Clubs of America, Crest is encouraging the clubs to participate in GKAS. Also, United Way of America and the Head Start Association are helping to identify needy children.

In October, Sullivan-Schein agreed to come on board as the exclusive distributor of professional products for dentists participating in GKAS. The company will work with 38 GKAS programs around the country to fill their needs for supplies.

Sullivan-Schein also is providing discount certificates for its dental products to the first 10,000 dentist volunteers placing requests. What's more, the company is actively recruiting GKAS volunteers, distributing promotional literature through its sales force and publicizing the event in Sullivan-Schein promotional materials.

The dental product manufacturer and distributor "is committed to helping narrow the disparity of health care services and information in underserved communities," said Stanley M. Bergman, chairman, chief executive officer and president of Henry Schein Inc.

He added, "As the correlation between oral health and overall health becomes more widely recognized, we stand ready to help dental professionals provide the highest level of quality care for their patients."

DEXIS became the first professional product company to join the cause when it agreed in October to provide 50 staff and 50 portable digital X-ray systems for GKAS screening, prevention and treatment programs.

Nicholas Wilson, DEXIS president and CEO, noted that the company has long-supported a similar program in St. Louis and welcomed "the opportunity to extend our participation nationally."

Ivoclar Vivadent Inc. signed on in December to provide 5,000 "prevention and restorative" kits for GKAS. Each kit contains fluoride varnish, sealant, amalgam and composite, and will treat about 10 children.

"This initiative will bring many smiles to less fortunate children and their families," said Ivoclar President Robert A. Ganley, adding that the company was "proud" to be a GKAS supporter.

Dr. T. Howard Jones, ADA president, expressed the Association's gratitude to the corporate sponsors. As a one-day event, he noted, Give Kids a Smile will spotlight dentistry's sense of public responsibility—and also send a message to government.

"Dentists can be proud that they routinely provide free and discounted care to people who otherwise couldn't afford it," said Dr. Jones. "But with Give Kids a Smile, in addition to helping a lot of kids, we're letting policymakers know that too many children are not getting the oral health care they need."

ADA leaders and industry supporters agree that GKAS is an important milestone on the road to better oral health for all. ■

The Perfect Handpiece.

Now For The Truth: despite many claims that constantly compete for your attention, there's no such thing as the "perfect" handpiece. Every handpiece has its strengths. And every handpiece has its compromises. That's why it's so important to ask the question: "Which handpiece is perfect for me?" Certainly we believe A-dec/W&H handpieces are the finest handpieces made today. They're powerful, quiet, lightweight, and feature smaller heads for an exceptional view of the treatment area. Yet to be certain, contact your colleagues, do some research. And by all means, contact your authorized A-dec dealer. That way, you can see, touch, and hear the difference for yourself. Then, and only then, will you truly know which handpiece is perfect for you.

a-dec | W&H

To find out more about A-dec/W&H handpieces, contact your authorized A-dec dealer, or call 1 800 547 1883.

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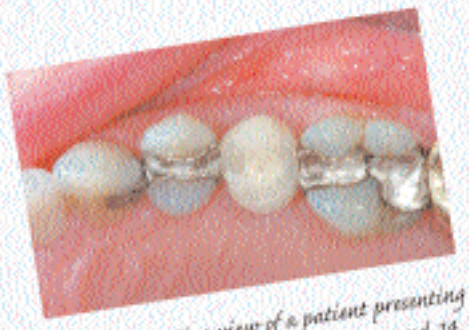
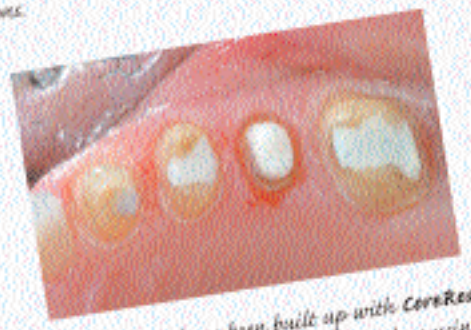
YOUR BEST IMPRESSIONS

Every so often, a product is introduced that has a significant impact on the way we practice dentistry. When that product provides quick, predictable soft-tissue management for crown and bridge procedures, it's a certain success. Expa-syl has proven to be a valuable adjunct for taking accurate impressions. One significant advantage of Expa-syl versus conventional retraction methods is its time savings. Also, the control of soft-tissue deflection combined with hemostasis means the quality of final impressions and the fit of laboratory restorations are significantly improved. Expa-syl also creates the ideal environment for bonding of final restorations. It's just one of the fine Kerr products that help make crown and bridge work exceptional.

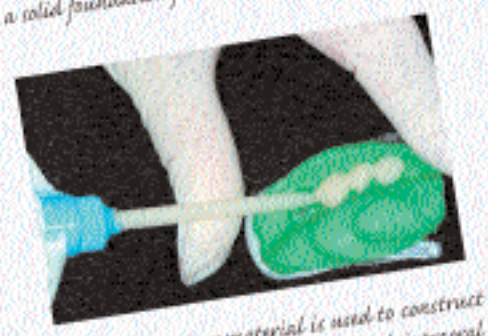
Robert A. Lowe, DDS



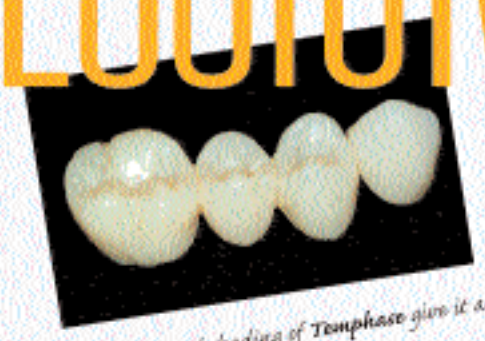
1. An occlucal preoperative view of a patient presenting with defective amalgam restorations on teeth 11, 12 and 14. Tooth number 13 has a porcelain-fused-to-metal crown with recurrent decay. It has also had previous root canal therapy requiring a post and core buildup. Due to the functional and esthetic needs of the patient, it was decided to place bonded esthetic restorations.



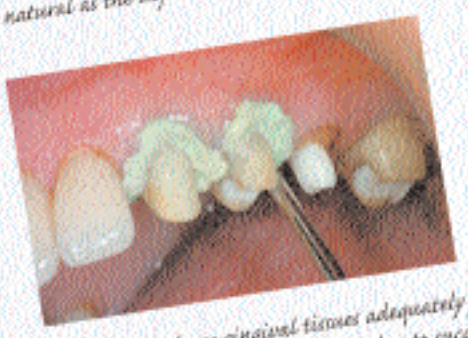
2. Teeth 11, 12 and 14 have been built up with **CoreRestore2**. Tooth number 13 had a fiber post bonded in place using **Nexus2 Universal Luting Cement**. A maxillary premolar core form was selected and a hole placed into the top of the form to allow complete seating over the fiber post. The strength of **CoreRestore2** provides a solid foundation for a long-term esthetic result.



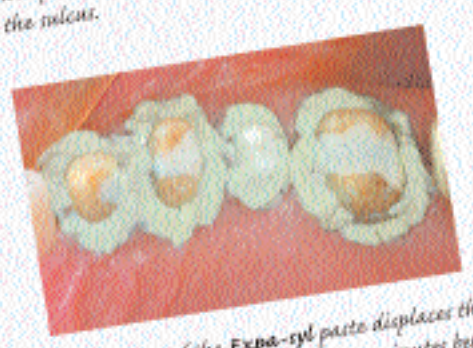
3. **Take 1 Super Fast Tray** material is used to construct a provisional matrix. The firm viscosity and quick intraoral set time of 1:30 are ideal. **Temphase** is extruded into the matrix and the unit placed over the preparations. The patient is instructed to close into the matrix and hold it in centric occlusion for 2 minutes.



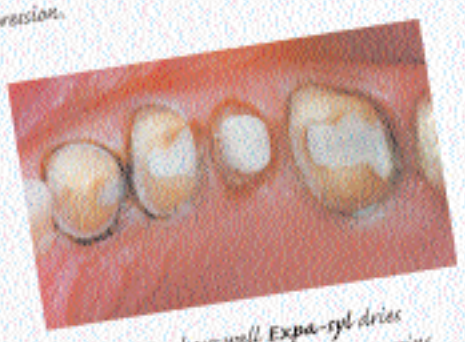
4. The polishability and shading of **Temphase** give it a look almost as natural as the definitive restoration.



5. **Expa-syl** alone displaces gingival tissues adequately for final impressions in many clinical situations. The key to successful **Expa-syl** placement is keeping the dispensing tip parallel to the long axis of the tooth. Correctly displaced tissue will have a blanched appearance. In this case, the restorative margins are located about one millimeter subgingival, therefore a 00 retraction cord was placed initially so **Expa-syl** could penetrate further into the sulcus.



6. The thick viscosity of the **Expa-syl** paste displaces the soft tissue. **Expa-syl** remains in place for 1 to 2 minutes before rinsing. The excellent hemostatic effect eliminates sulcular bleeding, which may lead to voids in critical areas of the final impression.



7. After rinsing, notice how well **Expa-syl** dries the sulcular environment and exposes the margins. A precise impression is virtually assured, which in turn leads to superior-fitting restorations.

CORERESTORE2

TEMPHASE

EXPA-SYL

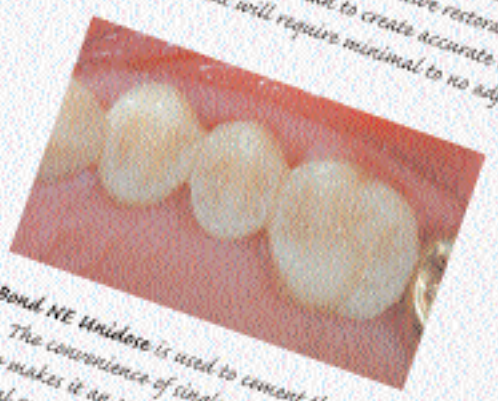
TAKE 1
SUPER FAST

sds Kerr
SYBRON DENTAL SPECIALTIES

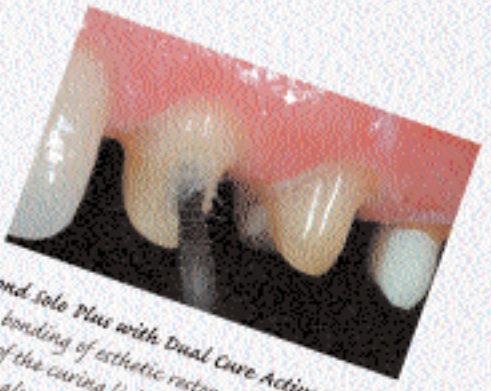
8. Using **Take 1 Super Fast Wash** material (top left), the intraoral tip is placed between the retracted tissue and the restorative margin. The material is expressed in front of the tip and moved circumferentially twice around each preparation. The wash viscosity is thixotropic, flowing under pressure to provide excellent detail without dripping. One minute of working time is plenty, even for this four-crown case.

9. Take 1 Super Fast Medium (middle left) was used in the impression tray. **Super Fast's** color combinations make impressions easy to read and patients appreciate the peppermint scent. The final impression is free of voids and the subgingival margins are captured in perfect detail.

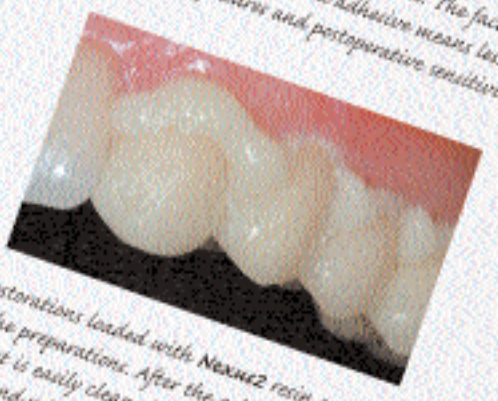
10. Take 1 Bite (bottom left) creates a precise centric registration record to accurately position the opposing cast in the laboratory with its quick set time and no resistance to closure. When set, its rigidity allows for accurate placement of the working casts for fabrication of the definitive restorations. This allows the dental technician to create accurate occlusion in the restorations that will require minimal to no adjustments.



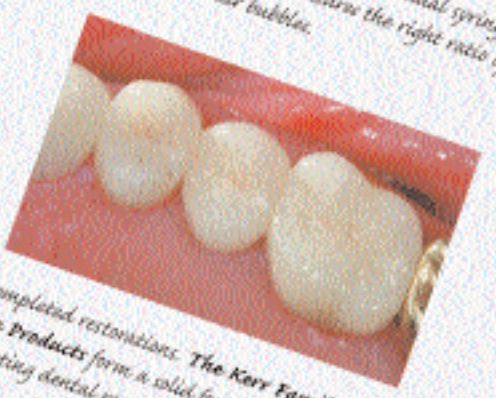
11. TempBond NE Unidose is used to cement the provisional restoration. The convenience of single-dose dispensing plus the easy cleanup makes it an excellent choice. Properly contoured, the provisional restorations will provide a healthy environment that will nurture the tissues. The control of the subcular environment is paramount to the success of bonded restorations.



12. OptiBond Solo Plus with Dual Cure Activator allow for predictable bonding of esthetic restorations even if thorough penetration of the curing light is prevented. The fact that OptiBond has always been a filled adhesive means less chance for adhesive failures and postoperative sensitivity.



13. The restorations loaded with **Nexus2** resin cement are seated on the preparations. After the gel sets, about 2 minutes, excess cement is easily cleaned. The new dual syringe eliminates hand mixing and ensures the right ratio of base and catalyst with no air bubbles.



14. The completed restorations. **The Kerr Family of Crown and Bridge Products** form a solid foundation for successful and long-lasting dental reconstructions.

TAKE 1 BITE

TEMPBOND NE UNIDOSE

OPTIBOND SOLO PLUS WITH
DUAL CURE ACTIVATOR

NEXUS2
DUAL-SYRINGE

Dentists make a difference

Access programs meet children's critical needs

By Arlene Furlong

Special Report

There was no way Adriana could keep up with oral hygiene habits. Twelve-years-old and moving from shelter to shelter, she couldn't even keep track of a toothbrush. What would become of her dental health?

Chris' problems dwarfed the teenage growing pains of most of his peers. Struggling to clean up his act, he endured an excruciating toothache just 30 days into sobriety. With no money and no dental insurance, where would he turn?

Chocolate and soda are the staples of 4-year-old Miguelito's diet. His teenage parents, both migrant farm workers, give it to him "because that's what he likes to eat." Every tooth in his mouth is decayed. What will become of his permanent teeth, his oral health, his overall health?

These stories have unlikely endings. Dental services provided by volunteers changed the fates of these children—and thousands more like them.

Government statistics from the U.S. Bureau of the Census prove what volunteers see firsthand: Target populations for access programs are increasing in both number and need.

Contributing factors include a 20 percent poverty rate for children under 18 and an increasing percentage of foreign-born children. Children in both these groups are at increased risk for dental disease.

Unable to take advantage of the health care benefits many take for granted, poor, uninsured and disabled children depend on access programs. And although many programs provide services to children who would probably otherwise not receive care, the number of potential candidates for such services escalates.

"The need for volunteers is increasing," observes Dr. Edward J. Schaaf, director of St. Basil's Free Dental Clinic. Operating in the basement of a church rectory in Chicago's Englewood neighborhood since 1987, the clinic provides badly needed dental services to those who can't afford care.

"When I began I thought we could knock out this problem," says Dr. Schaaf. "But now I know the problem of access won't be solved in the foreseeable future."

Fortunately, once providers begin volunteering they're hooked, says Dr. Schaaf.

"I've seen very few people unchanged by the experience," he notes. "There's that immediate gratification when you get people out of pain or get them a set of good-looking functioning teeth and then the pleasure in knowing how many patients say 'Thank you.'"

He recalls Ann, a pre-teen, who walked into the basement of the church rectory without a front tooth, without self-esteem. She left with a new front tooth and an ear-to-ear smile.

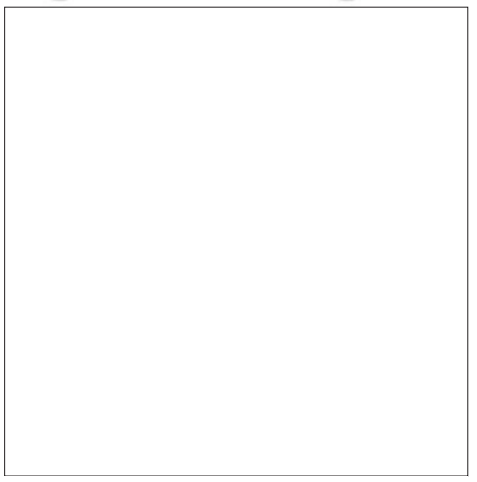
"What can I say?" he comments. "To see that just warms the cockles of your heart."

Beyond dental benefits, Dr. Schaaf says about half of St. Basil's nine general practitioners are African-American and serve as role-models for the mostly African-American patient group. (Fourteen volunteer specialists take referrals from the clinic.)

"The volunteers help kids see what's possible for them," explains Dr. Schaaf. "Dentistry may be a career they never thought of."

Many children of migrant farm workers get disease prevention education, dental screenings and care through Su Salud (Your Health), co-founded by Dr. Guillermo C. Vicuna.

The Stockton, Calif. agency began as a touring health fair more than 20 years ago. From those humble beginnings it grew into the Su Salud (Your Health) Disease Prevention Center. The center now provides free disease prevention education, dental and health screenings, referrals and other services for the poor and uninsured.



Hopeless? Dental disease plagues every tooth in 4-year-old Miguelito's mouth.

Team spirit: Dentist volunteers get together at the San Joaquin Dental Society at Su Salud's last health education fair at San Joaquin County fair grounds. Former ADA President Dr. William S. Ten Pas, (front row, center) joined the volunteer efforts there.

In collaboration with the University of Pacific School of Dentistry and San Joaquin County Hospital, Dr. Vicuna and some 14 volunteer dentists treat patients in the lobby of the San Joaquin County Hospital.

Dr. Vicuna is a longtime advocate of preventive services, not only to maintain the health of patients, but to avoid the high costs of care down the road.

"The children of farm workers are one of our biggest health problems in the U.S.," explains Dr. Vicuna. "Without insurance or education, these children of the working poor are often treated like the lepers of Calcutta."

Drs. Schaaf and Vicuna aren't alone in their efforts. Across the country, many dentists are developing different types of programs and expanding existing ones to extend care to needy children.

This small sampling of such programs shows models of varying design:

- USC Mobile Dental Health Clinic, Los Angeles

The University of Southern California School of Dentistry program began in 1965 when Dr. John Ronnau, his family and a few dental students visited a remote site in Mexico to provide emergency dental care and information on prevention of dental disease. In 1968, students identified an underserved population closer to home, among the migrant workers' children in central and southern California.

Faculty, staff and students from USC, as well as other schools in southern California, participate.

"We're a pretty versatile group of free labor," says former director Dr. Randall Niederkohr, who often was among the students and faculty driving the 48-foot trailers that served as mobile clinics. "It's a lot of work, but we saw many children who wouldn't have anywhere else to go."

During its 33-year history, the clinic has treated some 70,000 children from low-income families. During the past five years, the USC Mobile Clinic provided sealants and fluoride treatments to an additional 3,000 children attending inner-city schools.

Dr. Niederkohr, who stepped down from his position in June after 12 years, says he noticed through the years how the benefits of treating older children trickled down to their younger siblings.

"I'd ask why they didn't have cavities and the young ones would tell me how they watch their older brothers and sisters brush," he says.

Where clinics are sponsored by Denti-Cal, the state dental plan, the USC Mobile Clinic accepts Denti-Cal fees for services provided. Funding is also provided by contracts and grants from government agencies, private foundations and service clubs, as well as individual gifts. USC students and faculty design most of the portable equipment used.

One of the clinic's former patients is now among them, a student in the dental school's pediatric program.

- Homeless Not Toothless, Los Angeles

Providing free dental care for homeless persons since 1993, this project operates anywhere there are homeless people, volunteer dentists and a medical clinic to perform pre-screening.

Patients are initially referred to volunteer dentists, on a rotation basis, by the Venice Family Clinic of California. Dentists see patients in their private offices.

"I was concerned about the hours it would take for dentists to trek over to another location," says program developer Dr. Jay S. Grossman. "This way volunteers can incorporate patients into their practice without additional expense."

Some 36 general practitioners and specialists actively participate in the program and volunteer one hour a month plus supplies. Dental laboratories donate one procedure per month.

Because dentists and dental labs donate their services, there is virtually no expense incurred by the program other than the time and supplies provided by program volunteers.

Local radio and television stations, as well as articles in professional journals and local newspapers, publicize the program.

- Kids in Need of Dentistry (KIND), Denver

The nonprofit organization was founded in 1912 by members of the Denver Dental Society to help impoverished children receive essential care.

KIND's mission is to provide quality, comprehensive dental care to children from parents with marginal incomes who don't receive public assistance and are not covered by dental insurance.

"These are kids who would otherwise fall through the cracks between public assistance and the ability to afford private dentistry," say program administrators.

In addition, KIND offers a portable school-based sealant program for second-graders in low-income neighborhoods.

Some 300 dentists serve as volunteers. The program combines private and public sector resources, academic and seasoned practitioners and paid and volunteer professionals.

For example, the University of Colorado School of Dentistry provides such services as emergency after-hours care and placement of dental students in KIND clinics as part of a clinical rotation.

KIND receives donations from public and private sources, individuals, special events, foundations, corporations, dental vendors and the United Way.

- St. Raphael's Dental Clinic, Stockton, Calif.

The program has snowballed since its 1987 beginnings in a one-room dental clinic, according to founder Dr. Bruce Toy.

"We see more and more children," he says of the clinic that originally provided treatment for the patrons of St. Mary's Interfaith Dining Hall, a non-denominational organization for the indigent.

"It seemed like I worked alone forever, but actually it was only about one year before more dentists became involved," he says.

Housed in a building made possible by funding from the Dominican Sisters of San Rafael, the dental clinic has three operatories and is open several days each week. Preventive screenings, restorative dentistry, oral cancer screenings, extractions and basic periodontal services are performed by 22 dentist volunteers.

"Sometimes I see children years after treatment who remember me," says Dr. Toy. "They're still grateful."

- Washtenaw Children's Dental Clinic, Ann Arbor, Mich.

The Washtenaw District Dental Society and its Women's Auxiliary started the Children's Dental Health Clinic in October 1992. Their goal was to provide dental care for children from needy families in Washtenaw County.

Some 6,000 children are currently eligible for the clinic's services. Although nearly all dental procedures are performed in the clinic, volunteer dentists also provide treatment in their private offices.

The Ann Arbor Board of Education provides

space for the clinic at Mack Elementary School.

Volunteers include 33 dentists, 16 dental hygienists, nine dental assistants and 45 dental hygiene students.

Some patients pay modest fees for services to help offset overhead expenses. However, no child is denied treatment.

Professional associations, service clubs, dental supply firms, local businesses and interested individuals support the clinic.

Patients are sought through school nurses and social service agencies.

Although less than one in 10 people under age 21 is disabled, the risk of dental problems in children with special needs is great. For example, almost all developmentally disabled people are likely to have moderate to severe periodontal disease.

- The National Foundation of Dentistry for the Handicapped is one organization that develops and implements dental care programs for the disabled.

Through its Donated Dental Services program, some 44,000 special needs patients have received comprehensive care since 1986—many of them children.

Through DDS, more than 10,000 dentist volunteers are signed up to provide treatment to patients across 33 states. Volunteers work in their own offices at the level of involvement they choose, treating a few patients each year to several per month. Some 2,500 dental laboratories, materials and supply companies also donate their time, services and products. ■

Practical advice about publicity, funding

Many volunteer programs advertise in professional journals and general media, as well as at dental meetings and conventions.

In return, such programs often serve as public relations vehicles for organized dentistry by assisting with their public education objectives and enhancing the public's perspective of dentists and dentistry in general.

Word of mouth helps a lot. "It's faster than the Internet," says Dr. Edward J. Schaaf, dental director of St. Basil's Free Dental Clinic in Chicago.

The ADA Council on Access, Prevention and Interprofessional Relations recommends program facilitators contact ADA members, the community and caretakers of the patients the program will serve.

In its Manual on Dental Care Access Programs the Council suggests direct mail campaigns, brief speeches at society meetings, articles in dental society publications and announcements on society Web sites to inform members.

Like many other access programs, St. Basil's Free Dental Clinic receives donations from organized dentistry, foundations and dental manufacturers and suppliers.

"Getting financial support isn't rocket science," says Dr. Schaaf. "You have to tell your story as honestly as possible. Let people know what your needs are."

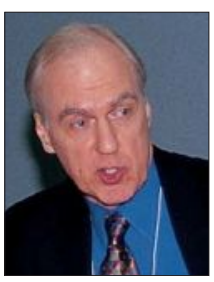
He says talking about funding with his colleagues made it easier.

"For the longest time, I would haul my handpieces from my practice to the clinic," he says. "It wasn't until a friend suggested that I ask for a donation that it occurred to me." ■

JCAHO elects ADA past president

The Joint Commission on Accreditation of Healthcare Organizations Board of Commissioners has elected ADA past president and Virginia oral and maxillofacial surgeon David A. Whiston secretary of the organization for 2003.

Dr. Whiston also serves as a liaison to the American Medical Association representing the ADA.



Dr. Whiston

"The interface with the Joint Commission and the AMA is important for the ADA as it continuously works to enhance its interprofessional relations with other health care organizations," says Dr. Whiston. "Dentistry is directly affected by many issues that face all health care professions, and I am happy to be able to represent dentistry's interests and input through the work of the Joint Commission."

Dr. Whiston joined the Joint Commission's governing body in 2000, and has served on the board's executive, finance and audit, nominating and human resources and compensation committees. Beginning next month, he will chair the accreditation committee.

Founded in 1951, the Joint Commission evaluates and accredits nearly 17,000 health care organizations and programs in the United States, including some 9,000 hospitals and home care organizations, and 8,000 other health care organizations that provide long-term care, assisted living, behavioral health care, laboratory and ambulatory care services.

The Joint Commission also accredits health plans, integrated delivery networks and other managed care entities. ■

Access

Continued from page one

reimbursement fee schedules are up to the 75th percentile. And other financial and organizational incentives are helping attract dentists back to a Medicaid program they once left in droves.

"In the first few months of actively recruiting dentists into the new TennCare program administered by Doral, we've seen an increase of nearly 75 percent in the number of unique providers," says Brett Bostrack of Doral. "We're encouraged by the very positive response from the dental community and expect that number to continue to grow."

Adds Dr. Dycus, "The dental carve out is the best thing to happen to oral health care in Tennessee. [Doral] is approving work that needs to be done so we can help these children, and momma and daddy are not losing as much sleep taking care of them."

In Ithaca, Mich., where the Healthy Kids Dental experiment is underway, Dr. Dale Nester is happy he gave the Medicaid program another chance.

"Shalie had four occlusal areas of decay, but this 4-year-old girl couldn't get emergency dental treatment because, at the time, the decay wasn't deep enough to cause her acute pain," he says.

"After we treated her, her mother was really grateful, the way she thanked me, and you could see it in her eyes."

Dr. Nester is all praise for Healthy Kids Dental, a program in which 37 counties in the state use Delta Dental of Michigan to administer dental Medicaid.

"It takes the roadblocks out of reimbursement, red tape, frustrations, bureaucracy," he says. "This allows me to focus on kids, to reach a child who has never seen a dentist and educate parents about what they can do to maintain a healthy mouth."

Dr. Nester reasons that when parents themselves are in a Medicaid system that only allows for emergency care, they may have fears and apprehensions about their child going to the dentist. This perception and behavioral pattern

"The neatest thing is, kids don't just visit for emergencies. The Healthy Kids Dental program gets children into regular, preventive dental care."

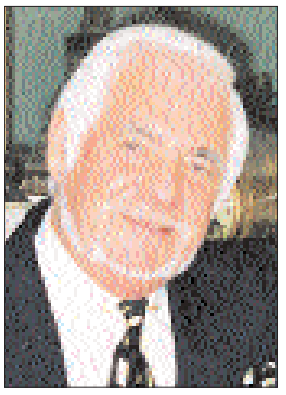
is what Dr. Nester hopes is changing under HKD.

"The neatest thing," he notes, "is kids don't just visit for emergencies. The Healthy Kids Dental program gets children into regular, preventive dental care."

Children in several other states aren't so lucky. The advances in access to oral health services for Medicaid-enrolled children "do not mean, by any stretch of the imagination, that access is equal and there is no room for improvement," says Tryfon Beazoglu, Ph.D., of the University of Connecticut dental school.

Parents who have difficulty paying for dental services usually have other demands on their financial resources. Culturally, they may have low expectations of oral health for their children. Geography can compromise access to dental services for children in both rural areas and inner-city neighborhoods.

Personal aspects, such as level of education and type of occupation, also can affect a parent's utilization of dental care and overall dental health. And children with disabilities, limited physical mobility or special medical conditions often have the added difficulty of finding an appropriate provider.



Dr. Dycus

Dr. Nester

"There are far too many individuals—with limited resources and difficulties in navigating the dental care system—unable to receive even basic dental care," says Dr. Richard Manski of the University of Maryland dental school.

The American Dental Association, together with constituent and component dental societies, considers access to dental services for all children to be a major issue. Access for underserved, indigent and special-needs children continues to be addressed by the tripartite. Some examples:

- The ADA supports federal legislation on access to oral health care and state legislative models for resolving access issues.
- The Association urges constituent societies to push for Medicaid reform, lobby their state governments and encourage members to respond favorably to reimbursement increases.
- The ADA Future of Dentistry Project has a panel on the Financing of and Access to Dental Services.
- The ADA Council on Access, Prevention and Interprofessional Relations offers resources on improving dental access, such as the Manual on Dental Care Access Programs, to state and local dental societies by calling Jan Babcock at Ext. 2673.
- CAPIR also offers technical consultation for dental societies, members and others in the implementation of dental access programs; call Jane Jasek at Ext. 2673.
- The Association supports community water fluoridation and provides resources on dental sealant programs as being "equal access" preventive measures.
- The Give Kids a Smile campaign will deliver donated dental services Feb. 21 from ADA, state and local dental societies to needy children, with the larger message to policymakers that dentistry alone cannot solve the access problem.
- The Association offers suggested language for financial incentive laws to encourage dentists to practice in underserved areas.
- The Association has a "Sample Exclusive School Vending Contract Bill" for lobbying against public school contracts for beverage sales, seen as detrimental to overall health. The ADA also has called for an in-depth study on the soft-drink issue.
- The ADA Department of State Government Affairs, through its State Legislative Report and other communication vehicles, shares success stories, ideas and concepts on access with all constituent societies, allowing the states to learn from each other.
- SGA also offers a resource packet, exclusively for state dental societies, on Medicaid concerns, including an overview of activities and suggested advocacies for improving access through a better Medicaid program.
- The Association supports dental licensure laws meant to bolster access to care. For example, most such laws enacted provide temporary licensure for out-of-state dentists who agree to provide charitable care for the indigent. The Association also supports laws that provide liability benefits to dentists who provide charitable care.
- The Association was a key participant in the passage of the Dental Health Improvement Act providing $50 million in grants to states to support a myriad of access programs, such as loan forgiveness and fluoridation.
- The Association actively participated in the National Governors Association's Policy Academies, "Breaking Barriers: Access to Oral Care," designed to help stakeholders work with state governors to formulate and implement policies and programs to address the oral health care of children.
- The Association worked to establish a full-time dental officer position at the Department of Health and Human Services to represent its programs and policies on access to oral health care for children in Medicaid and the State Children's Health Insurance Program.
- The Association in 2002 testified before the U.S. Senate on children's access to dental services during the first-ever hearing specific to children's oral health, and is working toward a similar hearing in the U.S. House in the new Congress.
- The Association is preparing a report of state innovative models on Medicaid financing, workforce concerns and patient education to improve access to oral health care.
- The Association is working with the Surgeon General on a "National Call to Action" report in a follow-up to the Surgeon General's report, "Oral Health in America." The ADA also is participating in a Surgeon General conference and report on improving care for individuals with mental retardation.

These are but examples of the work being done by the American Dental Association and state and local dental societies to improve access to dental services for children.

Still, to reach those pockets of the population for whom access remains elusive, our nation's policymakers must find the political will to provide adequate financial resources to address the issue of access to dental care for the disadvantaged.

"Although many dentists provide philanthropic care to underprivileged children, most dentists cannot assume the financial responsibility of large-scale care of patients, for whom fees are heavily discounted, as substitutes for those patients who are willing and able to pay full fees," says Dr. L. Jackson Brown, associate executive director of ADA Health Policy Resources Center.

"The issue of access to care for the disadvantaged is a wider social responsibility." ■

Cindy's smile takes a detour through the TennCare system

Red Boiling Springs, Tenn.—"One of my prized possessions has always been my smile, but I didn't want to smile because my teeth were so awful looking," says 18-year-old Cynthia Fox.

"And they were breaking. I actually woke up at night with pieces of my top front teeth sitting on my tongue."

Cindy, as she goes by, knew that she needed to visit a dentist.

Unfortunately, "most dentists listed in the TennCare book [of participating providers] are in Nashville, which is 2½ hours from Red Boiling Springs," she says.

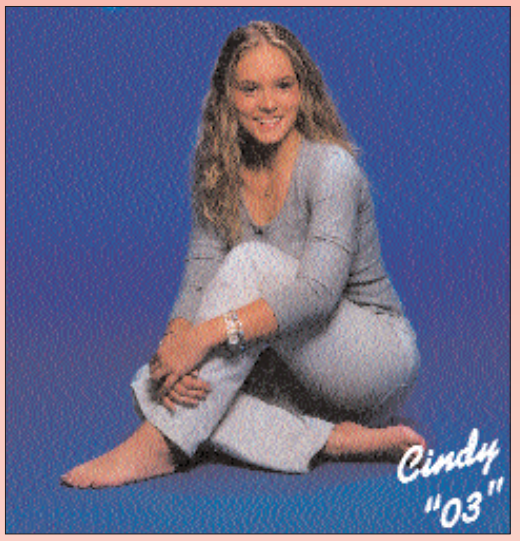
So Cindy and her mother, Peggy, began to cold-call dentists. "We would open up the phone book and just call and ask," she remembers.

"No one would take TennCare. It took about three or four weeks of calling around before we could find a dentist who took TennCare.

"We got a very large long-distance phone bill that month."

When Cindy first visited the office of Dr. Dillard Dycus, "her teeth were pretty bad," he recalls.

"When I put in the crowns, she cried in the dental chair and hugged me and thanked me.



Class of 2003: Hermitage Springs High School senior Cynthia "Cindy" Fox greets the future with a winning smile.

"Her mother said to us, 'We had never been treated as nice in the doctor's office as you have, and you have reestablished my confidence in doctors helping people.'"

But Dr. Dycus won't accept kudos.

"I just did the work," he says flatly.

"Credit belongs to the state government's dental 'carve out' and Doral Dental for getting this child's teeth fixed.

"I took a cut in fees, of course," he adds, "but I was rewarded personally and we got a nice card from her with high school pictures."

Cindy still has to travel 30-40 minutes each way for each dental visit, "but I know Dr. Dycus will wait for us, even if he doesn't have another patient in between," she says.

"He will work around my school and work schedules," the graduating senior adds.

"My last appointment took three hours, lasted until seven in the evening, but he didn't rush through it."

And as Cindy prepares for life after high school, she carries a new attitude.

"I feel wonderful," she says.

"All I ever do now is smile at people because my teeth look perfect." ■

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Stretched to the limits

Underserved patients' daily concerns reach far beyond dental health

By Karen Fox

Hastings, Neb.—Jennifer Klatt has six children—four 4-year-olds, a 7-year-old and a 15-year-old—all adopted through the state's foster care program.

At one time, the Klatts were raising nine foster children, all in dire need of dental care.

"They are the ones who really need the most care and attention," Mrs. Klatt said. "With foster kids, they haven't been to a dentist in years, and their mouths are a mess."

Children in the foster child program are eligible for Medicaid health coverage in Nebraska. But for the Klatts and thousands of other Medicaid beneficiaries, finding a dentist who participates in the program is nearly impossible.

Fortunately for her, Mrs. Klatt lives in Hastings, home to the practice of Drs. Jessica Meeske and Ed Lockwood—who together comprise two-thirds of the state's pediatric dentists outside Lincoln and Omaha.

With a practice composed of about half Medicaid patients and a number of who drive up to four hours for dental care, Dr. Meeske is keenly aware of the obstacles faced by the Klatts and too many rural and impoverished Nebraskans.

"My heart goes out to a family when they have taken on difficult children in the foster care system and the state is not helping her find good medical or dental care," said Dr. Meeske. "Mrs. Klatt has already taken the biggest plunge of all."

Dr. Meeske has always had a strong commitment to the needs of underserved patients, but the shortcomings of Nebraska's Medicaid system are a daily frustration.

"Some days I admit that I feel like I'm just putting out fires by getting kids out of pain," she said. "But instead of saying no and turning your back on the system, you hopefully try to figure out ways to work with it."

Even with the many challenges, she is quick to point out the benefits of working within a network of health and social services professionals to provide needed care.

"You just set policies to work with the limitations," she said. "I don't have the same expectations of kids from tough backgrounds that I do for families where both parents are educated and there are plenty of resources to pay for dental care."

The reality of treating low-income patients is that the best isn't always an option.

"It is not my goal to end up with the perfect patient who never has any dental disease," Dr. Meeske said. "For some of these families, they have to figure out where their next meal is coming from, or how they are going to pay for their child care."

Photo courtesy Hastings Tribune (Hastings, Neb.)

Dr. Meeske: "I don't have the same expectations of kids from tough backgrounds that I do for families where both parents are educated and there are plenty of resources to pay for dental care."

Special Report

One advantage of establishing a relationship with Nebraska's Medicaid system is working with public health nurses to improve the rate of no-shows in her practice. If a patient misses an appointment, the nurse contacts the family.

To educate patients and improve compliance, Dr. Meeske and her staff find success in keeping the message short and simple.

"You don't start talking to a single mother with four children on Medicaid, and all the kids with severe decay, about flossing when a child is still sleeping with a bottle or sippy cup," she said. "It's like telling someone whose house is on fire that they need to redecorate their living room."

In spite of the best efforts of dentists like Dr. Meeske, the already tenuous situation for patients in Nebraska appears to be worsening. There are simply not enough new dentists to replace those who are considering retirement in the near future.

Tom Bassett, the Nebraska Dental Association's executive director, said the state has seen a population increase of 6 percent since 1990 while the number of dental licensees has dropped 5 percent.

"For pediatric dentists, it's much worse," Mr. Bassett said. "There are only 25 in the state and some are retired, so it's more like 22. A number of those are within six to eight years of retirement."

Dr. Ed Lockwood, Dr. Meeske's practice partner, is about 10 years from retirement.

"I am scared to death," Dr. Meeske said. "How am I going to get a pediatric dentist to come to rural, central Nebraska when I was just the third one in the last 30 years?"

One way is to begin recruiting now. As a part-time educator for pre-dental students at Hastings College and the University of Nebraska Medical Center College of Dentistry, Dr. Meeske has students rotating through her practice in the hope that one of them might have an interest in practicing with her some day.

Successful recruiting is a high priority for the NDA and state public health officials.

There are currently 18 counties in the state without a dentist, and 30 counties have only one or two.

But Nebraska has two dental schools: the UNMC dental school and the Creighton University School of Dentistry. The UNMC dental school has a limited class size, and Creighton is a private school that draws students from all over the country. Few stay in Nebraska after graduation. To help retain some graduates, state officials are turning to financial incentives.

One is the Rural Health Opportunities Program, which guarantees students at state colleges a slot in the UNMC dental school if academic requirements are met. The students agree to practice in underserved areas after graduation and can then apply to the student loan repayment program for up to $20,000 a year for four years. Another way to recruit dentists is the state's loan forgiveness program that provides licensed dentists with loan repayment monies of up to $20,000 a year for three years for practicing in health professional shortage areas.

It remains to be seen how oral health services in Nebraska will fare in 2003, with the state facing budget shortfalls and an almost certain elimination of Medicaid dental services for adults.

Mr. Bassett said the Nebraska Dental Association is in the process of working with the state hospital, medical, pharmacy and nursing home associations to develop a strategy to help the state reduce costs and retain health services for those who need them most.

When the foster children first came to her home, Mrs. Klatt and her husband took them to Dr. Meeske every three months.

"We knew the genetic history of the kids," she said. "The parents had no teeth, so we had them treated every three months to make sure we were doing everything OK."

The priority they placed on prevention panned out, and Dr. Meeske has reduced their visits to once every six months. It was a tremendous relief to Mrs. Klatt, who works 30 hours a week while her husband works full time.

Thanks to dentists like Dr. Meeske who dedicate themselves to working with the system, theirs may be a success story. ■

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Want to find GKAS participants?

These groups can help you identify qualified kids to treat

Looking for qualified children to screen or treat for Give Kids a Smile?

If you plan to participate in activities on Feb. 21 either in your practice or as part of a larger program, the ADA suggests the following options:

Special Report

Boys & Girls Clubs

Many of the 3,300 Boys & Girls Clubs nationwide will be involved with Give Kids a Smile. Through a partnership with Crest Healthy Smiles 2010, more than 1,000 clubs already conduct some level of oral health education, screening or treatment. Some even have on-site dental clinics.

Because Boys & Girls Club members tend to fit the demographic targeted by Give Kids a Smile, those members and the program are a natural fit.

To locate a Boys & Girls Club in your area to discuss joint activities on Feb. 21, visit: "www.bgca.org".

- select "Find A Club";
- type in your city.

A list of clubs and contact information will appear for the city requested.

Tips for contacting a Boys & Girls Club:

- When calling, the best time to reach the programming staff is late morning or early afternoon before school ends. Staff become very busy after 3 p.m. and may not be able to take your call.
- Ask to speak with the Health & Life Skills program director, or if this individual is not available, ask to speak with the individual in charge of educational programming.
- Explain your event to the programming director. Ask if they are interested in bringing their members to your event or practice or holding an event at their club.

United Way of America

The United Way system has offered its support to Give Kids A Smile in several ways, and while the level and type of support may vary from United Way to United Way, its resources will play an important role in the campaign's success.

Each United Way has a network of relationships with social and health service agencies, local government and business. Through that network, children with unmet oral health needs can be identified and connected with local access programs or individual dentists. United Ways may play a role in transporting children to points of treatment or assisting with other volunteer capacities.

To contact your local United Way, visit "national.unitedway.org/myuw" and enter your zip code. If you need assistance in contacting your local United Way, call Caroll Vasquez at 1-800-892-2757, Ext. 522.

National Head Start Association

Head Start is a federally funded and administered early childhood development program serving children from low-income families (from birth to age 5), pregnant women and their families.

There are currently more than 2,400 Head Start grantee agencies across the nation that strive to provide comprehensive child development services, including early childhood education, health, dental health and nutrition services with a focus on family support and parent involvement.

Head Start programs can be administered by local public agencies, private organizations, Indian tribes or school systems. Head Start programs partner with a wide variety of community-based organizations to meet the federal Head Start Program Performance Standards, ensure program quality and promote the Head Start philosophy of comprehensive services for young children.

You can find a Head Start program in your area by using the Head Start Bureau's Web site at "www2.acf.dhhs.gov/programs/hsb/hsweb/index.jsp".

For more information on Head Start, look at "www.nhsa.org", the Web site for the National Head Start Association, the membership organization representing Head Start directors, staff, parents, children and friends. ■

A sampling of activities scheduled for Feb. 21

Coast to coast, the profession of dentistry is teaming up to provide free dental care for underserved children on Feb. 21. Here's a glimpse of what some are contributing to Give Kids a Smile:

- The University of Florida College of Dentistry is conducting two programs involving 10,000 children: one will educate children kindergarten through fifth grade at 25 disadvantaged public and charter schools, and the other will provide care for the state's foster children.
- The Zuni Public Health Service Indian Hospital of New Mexico will reach out to 500 children for Give Kids a Smile activities throughout February.
- The South Carolina Dental Association is working with its dental school and two hygiene schools to treat 600 to 800 children. Partners include local charities and community organizations that will identify children in need and transport them to Give Kids a Smile sites.
- At Greenwood Elementary School (Texas), a team of dentists and hygienists will screen and deliver preventive and restorative care to 1,100 children.
- Many U.S. Armed Forces bases in Germany and Japan and stateside have signed up to deliver care to thousands of military children who have limited access to care. At Ft. Campbell, Ky., 1,200 children whose parents are on active duty in the Middle East will be treated. ■

Jerusalem-based dental clinic continues its mission to treat underserved children

Jerusalem—Dental Volunteers For Israel continues to provide dental care at its children's clinic despite the death of its founder, Trudi Birger, last July 18.

To honor her memory, the clinic now bears its founder's name: The Trudi Birger Dental Clinic.

Ms. Birger, a Holocaust survivor and microbiologist, founded the non-profit clinic in 1980 to provide free dental care to underprivileged children of all religions who couldn't otherwise afford it.

Since its inception, dentists from 13 countries have volunteered. The clinic, which offers state-of-the-art dental treatment, focuses on teaching patients ages 5 to 18 and their parents preventive oral hygiene techniques and nutrition information. The clinic sees about 200 patients each day.

"I have been coming to the clinic annually since 1992," says Dr. Alan Wender of Mount Holly, N.J. "The DVI board of directors intends to keep the clinic open and functioning as they know that this would be Trudi's wish. We are asking dentists to help us by volunteering or making monetary donations."

Volunteers are asked to work in the clinic for a minimum of one to four weeks and pay for their transportation and food. DVI provides living quarters for volunteers. For more information, visit the Dental Volunteers for Israel Web site, "www.dental-dvi.co.il", or contact a United States DVI representative:

- Dr. Don Simkin, (N.Y.) 1-845-439-4100, "d.simkin@worldnet.att.net";
- Dr. Alan Wender, (N.J.) 1-856-751-0386, "imdocw@nothinbut.net";
- Dr. Allen Helfer, (Conn.) coordinator for North America, 1-203-348-4413, "bemcrm@aol.com";
- Dr. Samuel Millstone, (Mich.) 1-248-855-1726, "shmillstone@earthlink.net".

To make a contribution to DVI, contact Friends of DVI, c/o Lila Seiler, 11 Sage Circle, Scarsdale, N.Y. 10583, 1-914-725-2485. ■

January JADA explores the 'well-equipped' dental office

More than 85 percent of U.S. dental offices have a computer, and the volume of clinical uses for those computers is on the rise, Dr. Titus K.L. Schleyer and colleagues note in a report on dental office technology in January's Journal of the American Dental Association.

The article, appearing as JADA's January cover story, explores the state of the art of several technologies for the "well-equipped" dental office and provides suggested guidelines for making technology purchase decisions.

Dr. Schleyer is director of the Center for Dental Informatics, School of Dental Medicine, University of Pittsburgh. He is also JADA's associate editor for Informatics and Technology. ■

Dental schools ease burden

By Karen Fox

The nation's dental schools often serve as safety net providers for children with limited access to care.

"In some states, dental schools are the primary providers of dental care to Medicaid-eligible children," said Dr. David C. Johnsen, American Dental Education Association president and dean of the University of Iowa College of Dentistry.

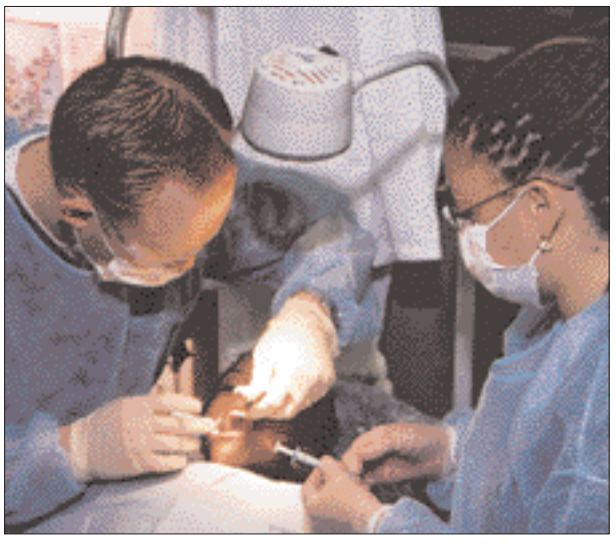
"More importantly, dental schools are more actively engaged than ever before with their local communities, providing outreach and helping find solutions to the access to care challenges."

Some of the dental schools' contributions to needy children include:

● University of the Pacific School of Dentistry—The UOP dental school recently established the "UOP Dental Care for Children Fund" to cover the cost of dental care for patients with no financial means to pay for care. Corporate and private donors and individuals such as alumni, faculty and staff members contribute to the fund. Monies are used to cover the balance of services after patients pay a reduced fee based on what they can afford.

● Case Western Reserve University School of Dentistry—"Healthy Smiles, Bright Futures" is the dental school's prevention program that provided 15,000 students in the Cleveland Municipal School District with free screenings and sealants last year.

● University of Mississippi School of Dentistry-Medical Center—The dental school created "Seal Mississippi," a sealant program with participation from the Mississippi State Department of Health, private practitioners, public schools and school districts. Dentists apply sealants to referred children at either their office or at the elementary school utilizing portable equipment purchased specifically for the project.



Donating: Case Western Reserve University dental school students provide sealants to second and sixth graders in Cleveland public schools. The program will continue this year.

● Marquette University School of Dentistry—Through state grants, the dental school dispatches students right into the community to provide care. One such program enables dental students to treat the oral health needs of children in Milwaukee's Hispanic community, and another is a sealant program at 15 elementary schools. Last year, the program screened close to 2,000 children.

● University of Nebraska Medical Center College of Dentistry—In one day last fall, the dental school hosted "Children's Day," providing free dental care and education to 123 underserved children. In the end, 1,072 procedures were performed at no cost to the patients or families.

● New York University College of Dentistry—The school's "Smiling Faces, Going Places" mobile dental care program travels throughout New York City and beyond to treat children living in areas with limited access to oral health care. Each day the van travels to a Head Start Program, public school, community health center or facility for the developmentally disabled.

The "No More Cavities/Smile Team Guarantee" promotes cavity prevention for children ages 2 to 11. Children are treated at regular clinic rates for existing dental problems and once cavity free, the "Smile Team" provides a complete preventive plan. Cavities that occur in "Smile Team" participants are treated free of charge.

● University of Colorado School of Dentistry—The school is proud of its 13-chair Healthy Smiles 2010 Clinic, a former U.S. Army facility saved from demolition to become a pediatric clinic for the poor. The dental school and the Children's Hospital operate the clinic, and officials expect to have 10,000 patient visits a year.

● University of Medicine & Dentistry of New Jersey-New Jersey Dental School—Last year the school's pediatric dental department had 8,541 patient visits by children with the New Jersey Medicaid/Kid Care Programs and contracts with the Newark school system. The statewide network attracts 6,936 children yearly.

● University of Kentucky College of Dentistry—The dental school's pediatric dental department provides dental care through a "dental bus" program for underprivileged children.

● University of North Carolina School of Dentistry—The school's two-year-old "Dentistry in Service to Communities" program provides practical experiences for second- and third-year dental and dental hygiene students. In one semester last year, the students treated more than 1,000 children in rural and underserved communities.

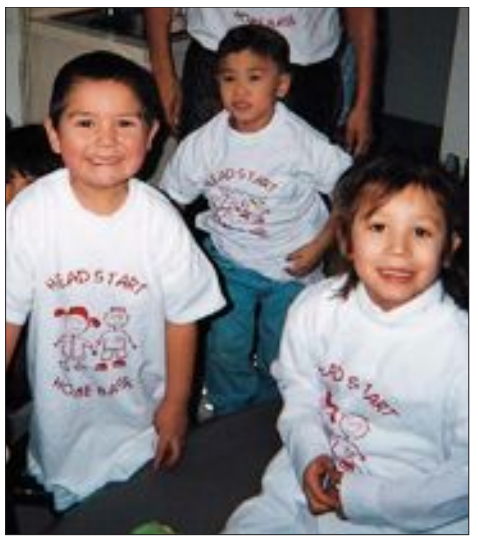
Students also participate in the "Seal Orange County Kids" program, where over 100 disadvantaged children received sealants at no charge. Dental students at UNC are also required to complete a pediatric dentistry rotation in a public health dental clinic before graduation. ■

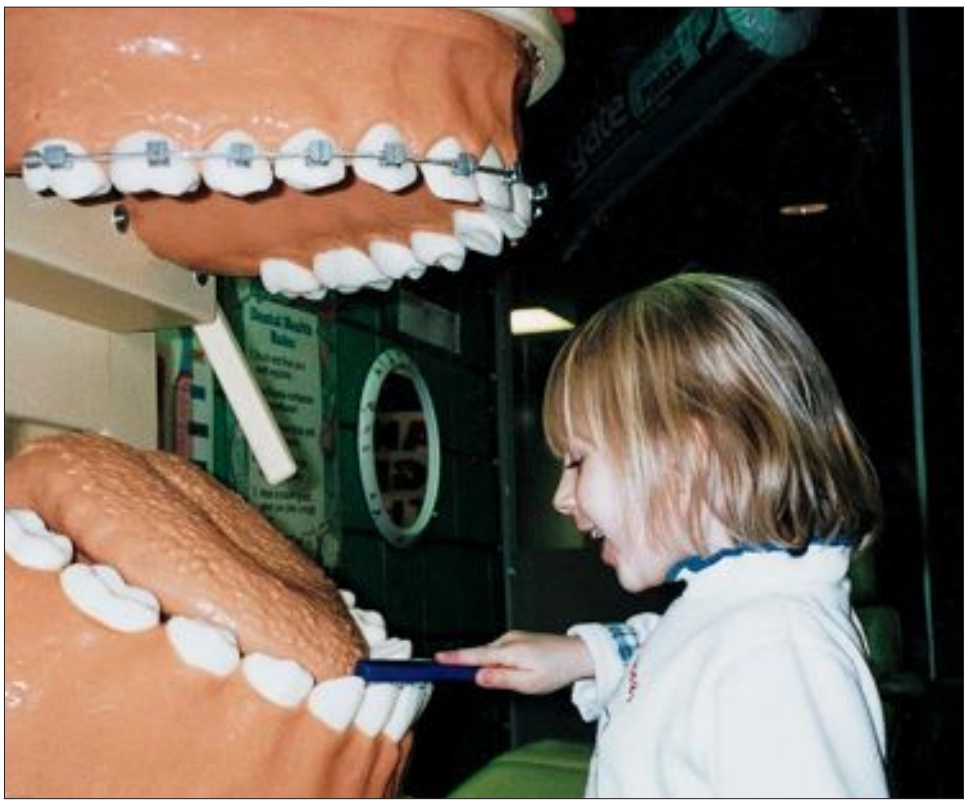
Why give to dental charity?

Contributions to ADA Foundation help make 'clinical dentistry better'

By Stacie Crozier

Special Report





Reaching out: Donations to ADA Foundation programs like the Harris Fund for Children's Dental Health Grants Program helps fund access programs like those pictured above.

The ADA Foundation embraces a mission that spans a broad range of initiatives: bringing access to care to children in need of dental services, supporting and enhancing dental education, introducing new innovations into clinical practice, providing assistance to dentists in need.

And it all starts with the support of individuals who contribute to the cause.

In 2002, the Foundation awarded more than $639,000 to some 50 different philanthropic programs. The ADA's charitable arm gathers funding from grants and government agencies to help support access, research and education programs, but it relies greatly on the contributions of private donors to support its endeavors in access to care, research, education, and now relief programs and emergency grants.

As both a contributor and an advocate for access to care for children, Dr. John Bogert knows that every donation, large or small, can make a difference in the life of a child.

"Access to care, especially for children, has been a real problem for a long time," he says, "but I am seeing increasing awareness."

A retired pediatric dentist, former executive director of the American Academy of Pediatric Dentistry and chair of the ADA Foundation's Harris Fund for Children's Dental Health Grants Program, Dr. Bogert says that in just four years, the number of applications the Harris Fund received for children's access programs has increased sevenfold because of the Surgeon General's report on oral health, the legislative efforts of the ADA and grassroots-based activities that work on behalf of children.

Contributions to the ADA Foundation also help the ADA "get the message out about the true crisis affecting dental education," says Dr. Jeanne P. Altieri, a member of the ADA Strategic Planning Committee. "The Foundation's initiative to establish a national endowment for dental education and its support of dental education for patients and continuing education for dentists shows a terrific dedication to lifelong learning."

Dr. Altieri says she also gives to the Foundation because she knows where her money goes.

"You can specify the programs you want to support, and there aren't many charities that enable their donors to do that."

Dr. Jeffrey Hutter says, "The main reason I give is to support the ADA Foundation's commitment to clinical research and the patients we treat." Dr. Hutter, who serves on the ADA's evidence based dentistry advisory committee, says programs the Foundation supports—like the annual Health Screening Program at annual session, continuing work at Paffenbarger Research Center and symposiums on emerging clinical discoveries like the relationship of overall health to oral health—help tie things together for the profession.

The reasons for donating are more personal for dentists like Dr. Robert Armstrong in Cheboygan, Mich. Dr. Armstrong has made an annual donation to the Foundation's Relief Fund for nearly a decade as a way to express his thanks.

"I had cancer in 1992, I didn't have health insurance and I had to cut back to working half time," he explains. "A dentist in my local dental society contacted the Relief Fund and got the ball rolling. I received a $40,000 grant.

"It was a life-changing experience for me," adds Dr. Armstrong, who has returned to good health. "I tell other dentists about it every chance I get and they are amazed that the ADA has such a powerful tool to lend help to dentists in need. My goal is to pay them back every penny, one gift at a time."

Dental industry leaders, like Carl Bretko, president of DentalEz, view donating to the Foundation as part of being a good citizen in the profession.

"By donating to the ADA Foundation, we can strengthen the dental industry that we rely on for security and success and reach out to those in need," says Mr. Bretko. "The Foundation's work all leads to a stronger profession and better oral health for people, and that gives you a good feeling."

For more information on ADA Foundation programs or how to make a donation, call toll free, Ext. 2547 or go online to "www.adahf.org". ■

Expert explains charity catalysts

What motivates people to make charitable contributions and how do they select a cause from countless options?

An expert in philanthropy, Timothy Siler, Ph.D., says choosing a charity is a personal decision for a contributor.

"Some givers choose a charity that reflects their own personal values," says Dr. Seiler, assistant professor of philanthropic studies for the Center on Philanthropy at Indiana University. "They often choose an organization from which they've had a direct or indirect benefit. Others give to a cause to help spare others from having a painful experience or loss that they've lived through themselves.

"But, often," he adds, "people give because they were asked. Usually, the motivator is an unpaid volunteer who says 'this is an important cause that I support and I think you should, too.' " ■

ADA charities begin 2003 with new name, structure

The ADA's charitable activities enter 2003 with a new name and structure called the ADA Foundation.

At press time, the ADA Foundation, comprised of the former ADA Health Foundation, the ADA Relief Fund, The ADA Endowment and Assistance Fund, Inc. and The ADA Emergency Fund, Inc., was anticipated to launch on Jan. 1.

The ADA House of Delegates approved the merger at annual session in October 2002.

"Combining our charitable efforts will give the ADA a more streamlined approach for marketing and carrying out its charitable activities," said Dr. Anthony Volpe, president of the Foundation board of directors. "This merger will help us enhance our strategic ties with the ADA and help bring attention to the Foundation's mission."

Relief efforts for dentists in need will continue to follow the same process under the Foundation's new Charitable Assistance Program arm, said Dr. Charles Procini, CAP committee chair.

"We will still be here to respond in times of catastrophe or to help a dentist through a personal crisis," said Dr. Procini. "Dentists who need assistance will still apply at the local level and their state and the ADA will combine their efforts to offer financial aid.

"We also continue to offer scholarships for aspiring dentists, dental assistants, dental hygienists, and dental laboratory technicians and minority scholarships as well," he added.

"This merger is patterned after a similar situation in California at the CDA," said Dr. James Bramson, ADA executive director. "It should help us greatly to consolidate our solicitation efforts, develop consistent and clear messages to donors about our overall charitable activities and allow the Foundation to broaden its mission and purpose.

"This year will be an important one for the Foundation: the merger will take place and we will begin to focus in earnest on a national endowment to support dental education." ■

Remember the dates!

Annual session convenes in San Francisco Oct. 23-26

San Francisco—Even if you end up leaving your heart here when you attend the 144th Annual Session of the American Dental Association Oct. 23-26 in San Francisco, you'll return home with a wealth of new ideas for enhancing your practice and terrific memories of a long weekend trip to one of the world's most beautiful cities.

ADA's 2003 annual session has a new schedule, developed to minimize your time away from the office. Scientific sessions will be held for four days—from Thursday, Oct. 23, through Sunday, Oct. 26. One of the most comprehensive dental education experiences available, the ADA annual session will include more than 180 scientific programs for dentists, hygienists, dental assistants, business managers and assistants and dental laboratory technicians; more than two dozen hands-on participation workshops; and special seminars on women's health and leadership, esthetics, technology and team building.

More than 625 companies will showcase their newest technologies and products during the annual session's three-day technical exhibition Friday, Oct. 24, through Sunday, Oct. 26.

The ADA will also reprise its highly acclaimed Distinguished Speaker Series, bringing some of the world's most notable personalities to the annual session dais. (Keep your eyes on the ADA News for more details as they become available.)

There's even more—you'll have the opportunity to attend an array of ADA-sponsored special events in San Francisco and post-session seminars in California's Napa Valley.

Known as "Everybody's Favorite City," San Francisco also offers visitors an amazing variety of cultural, sightseeing, entertainment and dining opportunities. Enjoy the wide variety of tours offered as you take time to explore the city's architecture, bridges, cable cars and parks and fuel your sightseeing energy by sampling the array of cuisines available from its 3,300 restaurants—in the city with more restaurants per capita than any other in the nation.

For more information or to receive a 2003 Preview to the annual session, call the toll-free number, 1-800-232-1432, e-mail "annualsession@ada.org" or watch for updated session information on line at"www.ada.org/goto/session". ■

SFCVB photo by Phillip H. Colbentz

Moving history: About 13 million people travel on the cable car's 17 miles of tracks a year. This unusual mode of transportation is popular with tourists and is also used by locals to get around San Francisco.

SFCVB photo by Crystal Cruises

Scenic shoreline: The Crystal Symphony glides gracefully through San Francisco Bay.

This dental professional helps deliver healthy babies. You can too…

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HEALTHY GUMS. HEALTHY LIFE.™
HEALTHY BABIES

March of Dimes WalkAmerica
Saving babies, together

Help promote prenatal and oral care. Join the 2002 WalkAmerica T.A.G. Team.

The Butler GUM® brand is proud to be a leading resource for dental professionals in the effort to promote the potential links between oral health and overall health. Some research indicates that pregnant women with advanced periodontal disease may have a several-fold increased risk of delivering a preterm low birthweight infant.* John O. Butler Company, a Sunstar Company, has partnered with the March of Dimes to increase awareness of this link, as well as to financially support lifesaving research and community programs that help promote healthy babies.

The Butler GUM® brand invites you to join the T.A.G. (Teeth and Gums) Team of Dental Professionals and participate in March of Dimes WalkAmerica 2002, held in more than 1,400 locations across the USA. In most communities, WalkAmerica is held at the end of April. It's a great way to celebrate the work you do so well and to get together with your colleagues for a great walk, for a great cause. To join the T.A.G. team, please visit www.jbutler.com/mod.

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*Offenbacher, S. et al. J Periodontol 1996;67(10S):1103-1113