8-8-2005

ADA News - 08/08/2005

American Dental Association, Publishing Division

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AMERICAN DENTAL ASSOCIATION WWW.ADA.ORG

ADA NEWS®

AUGUST 8, 2005 VOLUME 36 NO. 14

Alaska oral health needs

ADA offers Senate panel an alternate care model, rejecting 'second-class care' for Alaska Natives

BY JUDY JAKUSH

Washington—The ADA continued to urge support July 14 for innovative approaches to "help reduce the disproportionate burden of dental disease that many Alaska Natives suffer from today."

In a statement to a congressional committee, ADA President-Elect Robert M. Brandjord also presented the Association's "unequivocal opposition to experimenting on Alaska Natives by allowing nondentists to perform irreversible dental surgical procedures."

Dr. Brandjord addressed a joint hearing of the Senate Health, Education, Labor and Pensions (HELP) and Indian Affairs committees on S 1057, which offers amendments to the Indian Health Care Improvement Act.

He presented the Association's support for a four-point program that would provide preventive services by trained dental aides who live and work in the villages, fill dental vacancies within the Indian Health Service (currently at 25 percent of available positions), implement a community-based oral health providers (COHP) program to make the current delivery system more efficient, and eliminate the credentialing barriers to getting volunteer dentists to address the backlog.

"This is second-class care," Dr. Brandjord said in reference to the dental health aide therapists program currently under way in Alaska. "It is unsafe, unfair and unneeded. It is an admission that those who have been entrusted to care for these people have essentially given up on them. Instead

See TESTIMONY, page 11

Photo by Anna Ng Delort

Congressional address: Dr. Brandjord testifies before the Senate Health, Education, Labor and Pensions and Indian Affairs committees July 14. He stated the Association's "unequivocal opposition to experimenting on Alaska Natives by allowing nondentists to perform irreversible dental surgical procedures."

■ **Just the facts: Q&A explores Alaska issues, page 10**

Fluoridation: all smiles

Symposium spotlights past success, future goals

BY STACIE CROZIER

The National Fluoridation Symposium 2005 wasn't your run-of-the-mill dental conference.

There were ice sculptures, snow cones, trivia tests and private label bottled water—optimally fluoridated to 1 part per million.

There were new resource materials, panel discussions on history, science, policy and current status and the future of fluoridation.

There were enthusiastic speakers and audience members, closely examining the strategies and situations of a variety of local, state and international fluoridation campaigns and court cases, both victories and setbacks.

Celebrating fluoridation's impact over the past 60 years and sharing the tools to help launch fluoridation in unserved communities worldwide, the ADA in conjunction with the Centers

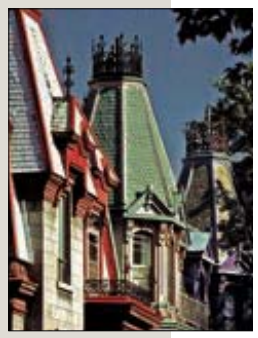
See SYMPOSIUM, page 13

Anniversary on ice: An ice sculpture represents one of many ways community water fluoridation was celebrated in July at the National Fluoridation Symposium 2005.

BRIEFS

Destination Montreal: There's still time to plan a trip to one of North America's most glittering international destinations, where the 2005 FDI Annual World Dental Congress meets Aug. 24-27.

The congress features more than 90 ADA-CERP recognized continuing education courses and more than 250 exhibitors—all included in your registration fee—making the FDI congress an affordable way to gain CE credit and experience dentistry on an international plane.



Montreal architecture

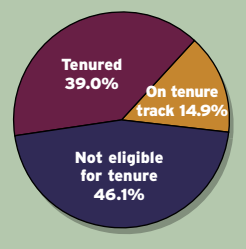
The congress also features a variety of social programs, including the traditional welcome ceremony, a Canadian night, a gala dinner at Chalet Mont-Royal and a golf tournament. Congress attendees will have the opportunity to discover Montreal's many world-class attractions.

On-site registration opens Aug. 22 and is quick and easy. For more information, contact the FDI U.S.A. Section by calling toll-free, Ext. 2727, e-mailing "hernj@ada.org" or logging on to "www.fdiworldental.org". ■

JUST THE FACTS

Dental faculty

Tenure status of full-time clinical science faculty, 2003-04



Source: ADA Survey Center "survey@ada.org", Ext. 2568

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ADANEWS

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Photo by Marlene Andrusz

Celebrating ADA history: From left, ADA Treasurer Mark Feldman, 4th District Trustee Bernard McDermott, 9th District Trustee Kathleen Roth, 2nd District Trustee G. Kirk Gleason and New York State Dental Association President Lawrence Volland display a plaque that commemorates the 1859 establishment of the American Dental Association. The plaque was rededicated at ceremonies June 9 in Niagara Falls, N.Y. The Association's founders—26 men from eight dental societies and two colleges—met Aug. 3, 1859, at Niagara Falls' International Hotel, giving rise to the modern-day ADA. "Our first leaders, a group of 26 forward-thinking dentists, gathered in Niagara Falls with the intent to create a professional association serving dentistry that promoted sound practice principles and scientific research," Dr. Volland told the ADA and NYSDA representatives gathered near the entrance to Niagara Falls State Park.

ViewPoint

MyView

Spotting meth mouth

Kenneth D. Jones Jr., D.D.S., J.D.

Well, it looks like I won't be treating Lori's decay or making Harry's dentures after all (not their real names).

Lori and her parents have been patients for a long time, but she hadn't been around for five or six years. She and Harry, her live-in boyfriend, made appointments for exams several months ago, when she and her three kids became Medicaid eligible. Harry worked for a local manufacturer and had dental insurance. His chief complaint was, "My teeth are sensitive and I don't like the way they look." He was right.

Harry was 28 years old. He had nothing more than root stumps topped with mushy mounds of decay. A few lower molars had enamel left, but the cratered, black, gingival decay extended almost all the way through what was left. His was an easy treatment plan: oral surgeon for full-mouth extractions and full upper and lower dentures. We didn't get into the reasons for his problems; we just diagnosed it and moved on.

Lori wasn't quite as bad. She, too, had black, gingival decay, especially on the lower molars. Even though she'd had some dental treatment since I saw her last, 18 teeth needed restorations. Chunks of calculus hid most of her lower anteriors. Pockets were everywhere. She was just 21.

"Meth mouth" is a growing dental problem nationwide. Its origins were primarily in the rural regions, but it's quickly spreading to the cities.

We talked a bit. Lori admitted she drank a 12-pack of Mountain Dew every day. She was fidgety in the chair, not relaxed like she used to be. Lori used to be slightly overweight, but now she looked like she was skin and bones; not quite anorexic, but way too thin. We talked about brushing, flossing, soda damage and what makes a good nutritious diet. She seemed to get the point, but looking back, I'm not really sure what got through to her—or to me.

We cleaned her up and made her an appointment to get started. That was the last I saw of Harry and Lori. Someone in the Ohio prison system will finish Harry's work, I guess, because Harry was indicted and arrested last week for selling (and using) methamphetamine. Lori is (or was) a "speed freak," aka, a "tweaker." Her acquaintance with crystal meth cost her a future. She drove her car into a light pole, either strung out or high and doing 85. She's dead. The kids, at least, were with her mother.

But long before this unhappy end, the consequences of their abuse were apparent to those who knew what to look for. I didn't. In fact, I didn't even suspect drug abuse until I read the police report.

"Meth mouth" is a growing dental problem nationwide. Its origins were primarily in the rural regions, but it's quickly spreading to the cities. It's estimated that 15

See MY VIEW, page five

LettersPolicy

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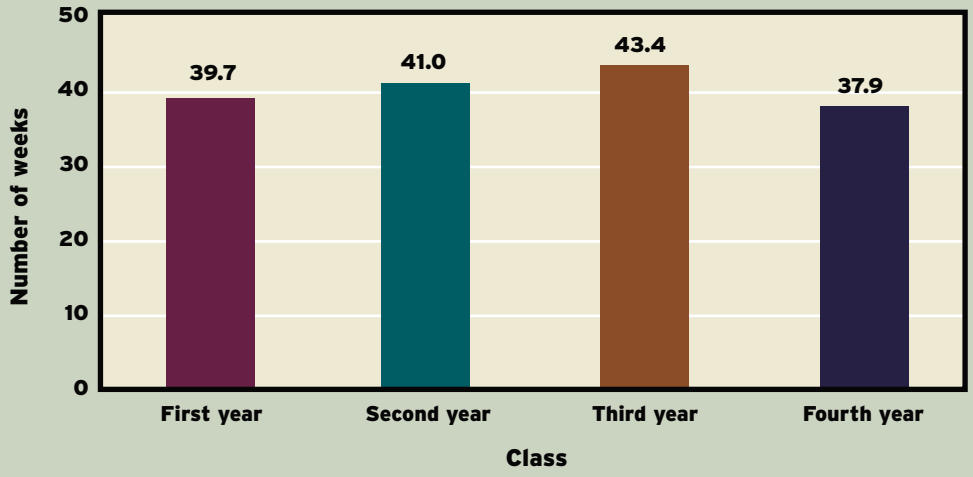
SNAPSHOTS OF AMERICAN DENTISTRY

Dental education

During the 2003-04 academic year, U.S. dental schools averaged 30.6 clock hours of curricular instruction per week.

Average number of weeks of instruction by class: 2003-04



Source: American Dental Association, Survey Center, 2003-04 *Survey of Predoctoral Dental Education.*

Letters

Dr. Mascola

Much has been written about the passing of Dr. Richard Mascola. My recollections may be a little different than most, in that his presence changed my whole feeling about dentistry.

Yes indeed, his passion and enthusiasm for our profession flowed to all he taught. However when I first met him, over 30 years ago, I was one of a handful of American students studying at a dental school in Guadalajara, Mexico. The fact that he would give his time to come to our remote school made his presence so special to all of us.

When our paths crossed 20 years later, I realized that we not only shared a passion for dentistry, but also Italian ethnicity and a connection to Queens, N.Y. Thank you, Richie. You made us all proud.

Robert J. Oro, D.M.D.
Oro Valley, Ariz.

More memories

I served as 1st Vice President of the ADA in Dr. Richard Mascola's first year on the Board of Trustees and as a first-year trustee during his presidential year.

We became very close friends and I was saddened at his death. I want to thank the ADA News for a wonderful article regarding Richard. However, when you mention his "firebrand speech to the 1998 House of Delegates, delivered shortly after he was nominated as one of four candidates that year for president-elect," I really think you left out the most stunning part of that speech.

He opened with: "I believe in managed care."

There was complete disbelief and silence in the House following these words. After a long pause, he continued: "I believe in care managed by the dentist for the benefit of the patient." It was then that the "delegates responded with thunderous applause."

At that time, I was—and I continue to be—convinced that those few words won the election for Dr. Mascola.

Richard Mascola should always be remembered as the president who said that dentists and their patients had taken enough grief from the insurance companies and that it was time to do something about it. Following his presidency, the ADA filed its first lawsuit against Aetna Insurance Co. We all know how that turned out, and we also see that other insurers are now treading more lightly.

Dr. Mascola was an outstanding ADA president who deserves the thanks of all of America's dentists.

Edwin S. Mehlman, D.D.S.
Providence, R.I.

Embezzlement

I sympathize with Dr. Daniel Bade's recent predicament over employee embezzlement ("What Are Your Legal Rights?" May 16 ADA News).

I have had several colleagues over the years who have suffered through embezzlement—most of the time committed by trusted long-term employees.

The ADA guide will certainly help, but I will pass on something I learned at a seminar on the topic many years ago: open your own mail. I have never known a dentist or physician who opened and read their own mail to fall victim to embezzlement.

Dr. Bade may have found that his bills weren't being paid, along with other obvious red flags. I am sorry this happened, and it will happen to others

See LETTERS, page five

Letters

Continued from page four

in the future. Hopefully doctors can learn from this and other experiences.

Gary S. Barr, D.M.D.
New Braunfels, Texas

Office fraud

Thank you for writing about dental office fraud and embezzlement. These topics should be of interest to all our members, however most of us believe embezzlement and fraud only happen to others, and then rarely.

In my office, an "indispensable" employee of nine years was discovered to have been embezzling. The discovery was made when I hired a monthly bookkeeper to find out why I was getting poorer. Most of the embezzlement occurred through a fraudulent payroll—a place I did not think to examine.

It was discovered when the employee was forced to take a medical leave of absence. The typical profile of the embezzling employee, I believe, is one who is exceptionally dedicated to the job, refuses to take time off unless the doctor is away, and seems indispensable to the practice.

Fortunately, my employee fraud insurance through the California Dental Association covered a portion of the loss, but prosecution and recovery are difficult and add more stress to the office. I recommend purchasing the new ADA guide, and if you seem to be struggling financially and have a trusted employee who will not take time off, stand back and take a careful look at the business of your practice.

Robert Karl Jr., D.D.S.
Rancho Mirage, Calif.

Editor's note: Remember also that preventing embezzlement involves more than payroll and your mail system, says the ADA Council on Dental Practice. Thwarting embezzlement starts with smart hiring practices and background checks, and having a good system of checks and balances in place. The issue is complex, and precisely why the ADA developed the resource, "Protecting Your Office From Fraud and Embezzlement" ("www.adacatalog.org" or 1-800-947-4746).

Third molars

I read with great interest the advice regarding the extraction of third molars ("Third Molar Study Inconclusive," June 6 ADA News).

If one were to blame third molars for causing the movement of anterior teeth because coincidentally crowding or its appearance occurs at the same time as the intended eruption of third molars, then why not blame the eruption of second molars on the same effect? Or, why, if one were to believe this premise, don't impacted bicuspids just erupt into the arch as opposed to remaining buried?

Matthew Steiner, M.D., a pediatric endocrinologist, studied 100 of his patients for a period of 40 years. These select few returned to his office yearly for examination and measurement to study how the body grows even after the final growth spurt.

He noted that the maxilla and mandible in males (to age 28 on average) and in females (to age 26 on average) grows or modifies, thereby moving the embedded teeth and causing the anterior teeth to become malaligned way after orthodontic treatment was completed. He suggested that orthodontic patients wear their retainers well into their 30s.

Unfortunately, Dr. Steiner died before he could publish his results. In light of this discovery, and if one were to think of the non-effect of second molars and impacted cuspids and bicuspids, the concept of third molars moving dentition makes no sense.

Myles Sokolof, D.D.S.
Pleasantville, N.Y.

MyView

Continued from page four

to 40 percent of the nation's prison population has meth mouth. It's a growing problem in our young adults and teens.

Meth mouth is characterized by black, extensive decay focused initially around the gingival line. The enamel is brittle and decalcified. Eventually nothing but root stumps remain.

Crystal meth is a highly and quickly addictive, illegal street drug, ranking with crack cocaine in popularity. It causes reduction in saliva. Meth heads tend to drink lots of soda, both to relieve the dryness and to add to the high. Oral hygiene is generally lousy. Food and good nutrition become secondary to a new supply. Meth is said to reduce blood supply to the gingiva, causing perio problems.

When smoked, crystal meth gives off fumes of the lithium, muriatic and sulfuric acids, ether, red phosphorus and lye that are used in its manufacture. These highly toxic and highly corrosive vapors bathe the teeth, destroying enamel.

Paranoia, aggression, irritability and violence are all part of the meth user's personality profile. They may not have slept for several days. We need to learn the signs and symptoms—not only for our patients' good but for our safety.

Educate yourselves and your staffs. Do an Internet search for "meth mouth" and read the horror stories. It's an ethical obligation we have in today's complex and ever-changing society. ADA.org has several good references. One of the best sites I've seen is "www.mappsd.org", the home page of the Meth Awareness and Prevention Project of South Dakota. That's where much of this information came from. Straightforward information that is easy to understand.

When I saw them, Harry and Lori were probably too far gone for me to have done them much good. But had I, or some other dentist, been a little more aware, maybe—just maybe—her kids would still have a mom.

Dr. Jones is chair of the ADA Council on Ethics, Bylaws and Judicial Affairs and associate editor of the Ohio Dental Association.

Editor's note: For more information about meth mouth awareness, see page 15.

First-ever grants: Announcing the winners of the Access to Oral Health Care for Older Adults Initiative are, from left, Dr. James B. Bramson, ADA executive director; Dr. Arthur A. Dugoni, ADA Foundation president; Sydney R. Rollock, vice president, GlaxoSmithKline Oral Care, U.S.; Dr. Richard Haught, ADA president; and Dr. Ronald L. Rupp, senior manager, GSK Consumer Healthcare professional relations.

Grants help older adults

Association, industry work together to create initiative

BY STACIE CROZIER

Six grant recipients have been chosen for the first-ever Access to Oral Health Care for Older Adults Initiative, established in a cooperative effort between the ADA and the ADA Foundation and funded by a $250,000 grant from GlaxoSmithKline Consumer Healthcare.

"Dentistry has successfully helped millions of Americans keep their teeth as they age into their seventies and eighties," said ADA President Richard Haught.

"However, some older adults face barriers in accessing dental care. We look forward to working with GlaxoSmithKline and seeing the implementation of our grant winners' programs to help older adults get the dental care they need," continued Dr. Haught. "We also believe our grant winners' initiatives can provide examples of innovative, community-based programs for duplication in other parts of the country."

"It's simply unacceptable that so many Americans lack the access to oral health care that most of us enjoy," said Sydney R. Rollock, vice president of GlaxoSmithKline Oral Care, U.S. "While advances in oral care have benefited the majority of society, too many of us, especially the elderly, still suffer pain and other complications needlessly and at the expense of overall health and well-being. This is why we're so excited to partner with the ADA to help improve access to dental care for a segment of the population that truly needs our help."

An advisory committee selected the winning programs from a pool of 178 applications. The winners are:

• The American Red Cross—The American Red Cross will use its $50,000 grant to mount a one-year program to train 500 instructors in Red Cross chapters nationwide in an oral care program for older adults. The program—a part of the organization's nine-module Family Caregiving Program—will reach between 5,000 and 10,000 semidependent older adults and their caregivers. Red Cross chapters in up to 50 rural and urban areas with concentrations of elder caregivers will be included in the program to train instructors.

• National Foundation of Dentistry for the Handicapped—The NFDH will use its $23,760 grant to develop a pilot screening program and oral health education component of its Donated Dental Services program in up to 10 U. S. Department of Housing and Urban Development Section 202 Supportive Housing for the Elderly apartment buildings. The program will assess the impact for improving the screening and referral process and oral health behavior among residents.

• New York State Dental Foundation—The NYSDF received a $40,000 grant to develop an oral health resource manual for health and human service professionals and volunteers who work with older adults, covering topics from oral health needs to oral manifestations of systemic diseases or pharmacological effects in the oral cavity. The manuals will be produced in English, Spanish, Russian, Chinese, Korean and possibly Italian to better reach diverse older populations—up to 600,000 individuals in all. The

See GRANTS, page seven

JADA examines dentists' role in tobacco cessation

The August issue of The Journal of the American Dental Association explores the dentist's role in helping patients quit tobacco.

"Enhancing smoking-cessation activities as part of unabridged oral heath care no longer should be a choice" for dentists as health care providers, writes Dr. Michael Glick, JADA editor, in his August editorial. Dentists should improve their knowledge of smoking-cessation practices and play a more central role in helping tobacco-using patients kick the habit, he says, since cigarette smoking and second-hand smoke will be the cause of death of up to 450 million people worldwide over the next 50 years.

This issue of JADA includes two studies related to tobacco use.

A research team led by Deborah Hennrikus, Ph.D., from the University of Minnesota School of Public Health, found that adolescents routinely underreport tobacco use on health history forms that ask them simply whether they use tobacco. Researchers theorize that adolescents who smoke socially or experimentally may not consider themselves smokers and a revised question on a health history form asking if an individual has used tobacco within the past 30 days would result in more accurate reporting of smoking habits. Researchers also advise health care providers to have adolescents complete the behavioral section of a health history form in confidence, as a parent who completes a form may not be aware of the child's smoking.

In another study, researchers at Columbia University School of Dentistry and Oral Surgery, led by Carol Kunzel, Ph.D., found that dentists believe they lack the information and know-how to help patients stop smoking, that smoking cessation activities are peripheral to their role as caregivers and that colleagues and patients do not expect them to be involved in smoking cessation. Dentists getting more information on smoking cessation and changing their view on their role in treating patients who use tobacco will help them "provide better oral health care, enhance the outcome of therapeutic procedures and play an increasingly important role in promoting the general health of patients."

Dentists who are interested in learning more about tobacco cessation and early oral cancer detection can participate in the ADA's "Dentist Saves Patient's Life! Early Oral Cancer Detection and Tobacco Use Cessation," a five-hour continuing education course scheduled in locations nationwide this fall and continuing through November 2006. See related story, this page, for course dates and locations. ■

Oral cancer, tobacco courses set

The ADA's "Dentist Saves Patient's Life! Early Oral Cancer Detection and Tobacco Use Cessation" five-hour continuing education course will be held at the following locations through November:

Contact the individual course site for more information or to register:

• San Francisco, Sept. 11, California Dental Association, "www.cda.org";

• Los Angeles, Sept. 20, Los Angeles Dental Society, Sue Merrill, 1-213-380-7669, "lads@pacbell.com";

• Providence, R.I., Sept. 21, Rhode Island Dental Association, Valerie G. Donnelly, 1-401-732-6833, "www.info@ridental.com";

• Philadelphia, Oct. 7, ADA Annual Session, "www.ada.org";

• Pittsburgh, Nov. 9, University of Pittsburgh, 1-412-648-8370, "www.dental.pitt.edu\ce".

The ADA will schedule additional courses through November 2006. Watch the ADA News for future course listings or contact Mary Wheatley at the toll-free number, Ext. 2839, or e-mail "wheatleym@ada.org". ■

Grants

Continued from page six

NYSDF will also conduct a statewide conference with a variety of agencies on elder care oral health needs.

• Ohio Dental Association—The ODA will use its $23,000 grant first to train volunteer dentists from each component dental society, dental society personnel, and representatives from each of the state's 12 Area Agencies on Aging and 88 county health departments on oral health care and hygiene for older adults. Then, trained personnel will be able to train private and professional caregivers, reaching a minimum 5,000 older adults in one year.

• Medical College of Georgia School of Dentistry—The MCG School of Dentistry will utilize a $50,000 grant to increase the amount of didactic and clinical experience its students receive in geriatric dentistry; to establish a weekly presence at a local flea market that would offer dental education and screenings to older adults in the area with referrals for local dentists or the dental school clinic for follow-up care; and to provide dental care for 120-plus residents of a veteran's facility located near the dental school. The program will serve an estimated 1,500 seniors in total.

• Spokane Regional Health District—The SRHD's grant of $38,240 will help launch the Seniors … Be Wise program, a pilot program that uses public and consumer education to raise awareness of the importance of proper oral care for older adults, trains trainers to reach caregivers with the message and provides fluoride varnish for seniors. The program will reach more than 9,000 older adults. ■

StartingOut

New dentists speak their minds

BY KAREN FOX

A frequent question posed to new dentists during the ADA 19th New Dentist Conference June 23-25: What's keeping you up at night? Fortunately for the 359 in attendance, there were a multitude of opportunities to discuss the answers.

Funded by a grant from Mentadent, the sole corporate sponsor since the conference's inception, this year's New Dentist Conference drew more than 350 people to Chicago that included ADA members, dentists in practice fewer than 10 years and dental students.

"The general consensus regarding the programming was extremely positive," said Dr. Teri Barichello, vice-chair of the ADA Committee on the New Dentist, who also thanked dental society sponsors the Illinois State Dental Society, Chicago Dental Society, G.V. Black Dental Society, McHenry County Dental Society and the McLean County Dental Society for their support.

"Based on the feedback, next year we will allow for even more networking opportunities," said Dr. Barichello.

In opening remarks, Dr. Barichello said the conference "offers a balanced mix of personal leadership training, clinical education and networking" that included CE from Drs. Bill Blatchford, Gordon Christensen, Warren Jesek, William van Dyk and Ms. Mary Byers.

The conference offers new dentists an opportunity to express professional concerns to ADA leadership. Discussion at this year's Open Forum/Q-and-A with Officers and Members of the Board of Trustees included dental hygiene, licensure and the national exams for clinical licensure, disability insurance, the National Campaign for Dental Education and Alaska dental health aide therapists.

The profession needs input from new dentists to develop its priorities, ADA President-Elect Bob Brandjord told the crowd June 24.

"One of the greatest challenges you'll face is controlling your own professional destiny," said Dr. Brandjord. Joining forces with colleagues in the profession through volunteer activities will help affect positive change, he added.

Concrete examples of where new dentists can make a difference came in the keynote address by Mike Graham, ADA senior congressional lobbyist, who provided an overview of big picture issues. Included among those issues were Social Security reform, tax reform, rising costs of health care, Medicaid, student loan interest deduction, loan consolidation and dental amalgam.

In Congress, HR 1380 could provide a significant tax deduction to help dentists manage educational debt. "House Resolution 1380 could mean $2,500 back in your pocket," said Mr. Graham.

Conference CE: Recent University of Michigan dental graduates Drs. Ozzie Smith III and Jacqueline Coleman attend June 24.

"We need you to contact your elected officials in Congress to help gain support for this bill."

Dr. Melissa Primus, president-elect of the Kern County Dental Society (California), found the New Dentist Conference useful as she transitions from public health dentistry to private practice.

"Unless you have a family member as a dentist, you're kind of lost," Dr. Primus said. "There should be more opportunities like this, where young dentists can connect with others who are dealing with the same kind of practice and professional issues."

The 20th New Dentist Conference takes place June 22-24, 2006, at the Seaport Hotel in Boston. ■

Golden Apple times three

Mentoring, leadership recognized

Golden moment: From left, Drs. Stifter, Teri Barichello (ADA Committee on the New Dentist vice-chair), Katie DeFazio and Nava Fathi (California Dental Association Committee on the New Dentist) and Peralez display their Golden Apple Awards June 25 in Chicago.

BY KAREN FOX

The ADA Committee on the New Dentist presented its three annual Golden Apple Awards June 25.

Dr. Jose Peralez III of Edinburg, Texas, received the New Dentist Leadership award.

Dr. Peralez has been instrumental in elevating the public awareness of dental health through his service to organizations like Dentists Who Care and the Dental Hygiene Advisory Board for the Texas State Technical College. He is a past president of the Rio Grande Valley District Dental Society and member of the Texas Dental Foundation board of directors and the Texas Dental Association's Council on Legislative and Regulatory Affairs.

Leadership, Dr. Peralez told the new dentists, means a commitment to your profession and commitment to your patients.

"There's a simple philosophy," he said. "Every state legislator, every decision-maker has a dentist. If you establish trust with that individual, one day one of your patients will be a decision-maker and they'll trust you."

Dr. Ronald Stifter of Milwaukee received the Outstanding Leadership in Mentoring award.

For the past 10 years, Dr. Stifter has spent countless hours mentoring new dentists and students through job shadowing, personal and professional networking, and community service projects. He has been involved with the Marquette University School of Dentistry-Pierre Fauchard Academy mentoring program since its inception in 1995, and has mentored a minimum of two students a year and as many as four students at a time.

"Mentoring is an essential part of our profession," said Dr. Stifter. "If we don't mentor each other, we are going to fail."

The California Dental Association's Committee on the New Dentist also received a Golden Apple Award during the New Dentist Conference. The committee was recognized for its CDA membership video and brochure that enhanced the CDA's annual orientation to organized dentistry for students at the state's five dental schools. ■

CORRECTION

In the July 11 ADA News story, "NCQA Revises Criteria for Annual Dental Visit," Dr. Charles L. Greenblatt Jr. was identified as chair of the Council on Dental Benefit Programs.

Dr. Greenblatt is vice-chair of the council, which is chaired by Dr. Glen D. Hall. The ADA News regrets the error. ■

Alaska Q & A: What is the ADA's role?

The ADA and the Alaska Dental Society want Alaskan Natives to get the dental care they desperately need, but both organizations believe that the care provided should be equal to treatment available elsewhere in the United States.

Both organizations support a four-point program designed to serve many more Alaska Natives in rural villages by making the current dental care delivery system more efficient.

ADA President-Elect Robert M. Brandjord described the ADA plan in a July 14 statement to a congressional committee. (See full story, starting on page one.)

Dr. Brandjord also noted that the ADA opposes allowing dental health aide therapists—nondentists with two years of training—to perform "irreversible dental surgical procedures."

The ADA's approach to circumstances in Alaska has fueled concerns and raised questions among many dentists across the country. Drawing on multiple sources from within and outside the Association, the ADA News attempts to address those concerns and questions in the following Q & A.

Q. I've heard that the ADA is opposed to a novel approach to getting badly needed dental treatment to Alaska Natives in the outermost reaches of Alaska. What's the story here?

A. In contrast to what you've heard, the ADA supports innovative approaches to getting Alaska Natives the care they need. The underlying goals of the ADA's approach are to make the current system more efficient and to find an Alaska-based solution to the state's unique access problem. What the Association strongly opposes is allowing nondentists to perform irreversible dental procedures—something that is not permitted anywhere else in the United States.

Q. How would the ADA make the current system more efficient?

A. The ADA asked a group of four independent dental experts to propose a delivery system designed to address the needs of the Alaska Natives in rural villages. One of those experts, Dr. Tom Kovaleski, is the dental director for the Alaska Native Medical Center in Anchorage. Dr. Kovaleski has been able to increase the productivity of dentists in his center by hiring more dental assistants and providing more operatories. The plan proposed by the experts builds on this model and adds a new support person, identified as a "community-based oral health provider," or COHP.

Q. What's the ADA doing to help get more dental care to the remote areas of Alaska?

A. In response to a 2003 House of Delegates resolution, the ADA established a task force to explore options to improve oral health care delivery to Alaska Natives in about 200 rural villages. The task force traveled to Alaska and has been attempting to work with the Indian Health Service, tribal leaders and the state dental society to find acceptable solutions to this problem. As noted earlier, the Association also asked an independent group of experts to study the situation and to make recommendations. Those recommendations included establishment of a newly designed support position—the COHP—who would be trained at the University of Alaska to coordinate care, provide preventive services and help with oral health education and nutrition. In addition, the ADA is lobbying Congress to increase funding for educational loan repayment as an incentive for dentists to fill IHS vacancies in Alaska and other states. The Association has established Operation Backlog to help bring dentists to remote areas and has introduced a new staff position (manager, American Indian/Alaska Native dental placement) to work with all parties involved to enhance outreach to the Native villages. The ADA is currently recruiting to fill this position.

Q. Why is the ADA opposed to dental health aide therapists, or DHATs? And where does the Alaska Dental Society stand on this issue?

A. Both the ADA and ADS oppose DHATs on the critical principle of patient safety. DHATs are being allowed to perform extractions and pulpotomies, and to diagnose and treat caries. Dentists generally receive eight years of post-secondary education and training in the health sciences. DHATs are high school graduates who've gone through a two-year training program at the University of Otago in New Zealand. The discrepancy in knowledge and skills is obvious and significant, and must raise questions of patient safety.

Q. How would COHPs help make the current delivery system more efficient?

A. Community-based oral health providers, who could be trained in Alaska in about 12 to 18 months, would help organize community health promotion and disease prevention programs, direct activities of dental health aides and increase the efficiency of visiting dental teams. They also would have an expanded clinical role, but would not perform irreversible dental procedures.

Q. Where do the Alaskan Native tribal leaders stand on this?

A. Some tribal leaders are willing to try DHATs, believing that their choices are between "some care and no care." The ADA contends that this is a false choice, a choice that no patient or community should be forced to make. With a more efficient delivery system, the ADA says, more care can be provided with relatively few additional resources. Alaska Natives would be afforded the same choices as patients in other states. They should expect nothing less.

Q. Is the ADA willing to compromise, to meet the tribes half way?

A. The ADA and the ADS have made compromises. These include, but are not limited to, accepting all but three procedures (extractions, pulpotomies, diagnosis/treatment of dental caries) from the original DHAT program, accepting the COHP program, Operation Backlog or combinations of the above. Leaders of the DHAT program indicate they would like to achieve some compromise, but they want any compromise to include the ADA and ADS accepting DHATs performing irreversible procedures. If that is half way, then the ADA and ADS cannot compromise further on that issue. Such a compromise would be in direct conflict with the Association's Principles of Ethics and Code of Professional Conduct. Such procedures involve the use of a high-speed handpiece and require the skills of a licensed dentist. All 50 states limit such procedures to licensed dentists, and the Alaska Board of Dental Examiners agrees with the dental community that DHATs are practicing dentistry illegally. If, on the other hand, half way means working to help relieve the backlog of disease and to establish a system that provides better and more appropriate oral health care, the ADA stands ready to help as an active partner with the tribes and the Indian Health Service.

Q. What about prevention? Is anyone teaching good oral hygiene to the children in remote villages?

A. That is the No. 1 priority. COHPs would work with dental health aides to support more prevention and education in the villages. The ADA believes very strongly that there should be a dental health aide who lives and works in every village to provide needed education and preventive services.

Q. Some natives in remote areas are resorting to self-treatment. Aren't dental health aide therapists better than that?

A. Again, "no care or DHAT care" is a false choice, one that no patient or community should be forced to make. The ADA and ADS, through Operation Backlog, have licensed dentists ready to resolve the immediate "no care" issue in remote areas. The key is to deliver quality oral health care in a much more efficient manner. The current system remains inefficient. With a targeted influx of resources that implements a community-based delivery system, self-treatment should not be necessary.

Q. How is the dental health aide therapist any different from an allied medical provider, such as a nurse or physician's assistant?

A. State laws govern the tasks that can be performed by registered nurses, who must graduate from an approved nursing program and pass a national licensing examination to receive a nursing license. All states also require periodic renewal of nursing licenses, which may involve continuing education. Most applicants to physician's assistant programs hold a bachelor's or master's degree. All states require that new PAs complete an accredited, formal education program, and all jurisdictions require physician's assistants to pass the Physician Assistants National Certifying Examination. Clinically practicing PAs always work under the supervision of a physician. (Source for this information: U.S. Department of Labor, Bureau of Labor Statistics.)

Q. How do ADA/ADS respond to those who suggest this is nothing more than a turf battle?

A. Absolutely untrue, if the question implies that it is a "turf battle" based on economic considerations. The only battle here is to provide proper oral health care and preventive services to people in dire need. That is central to the ADA's mission as a health care organization. The Association did not create this problem, but it does intend to be part of the solution.

Q. This is a local matter involving small populations of people in remote areas. Why not let the local authorities handle it?

A. Studies show that the 125,000 members of the Alaskan Native community have a significantly higher prevalence of untreated disease than other U.S. populations. What's more, more than half the Native population resides in villages not accessible by roads. For the ADA and the dental profession, the question is whether these patients should have access to professionals trained to provide optimal dental care or to others with very limited education and training. In the interest of all patients, the ADA cannot support a two-tiered dental care system, particularly when the opportunity exists to improve the current system.

Q. What are the administrative burdens that dentists have to go through to provide care in Alaskan Native villages?

A. There are credentialing and licensing impediments that could be simplified. For example, the ADA has been told that even moving from one village to another requires a practitioner to undergo a separate credentials review. The ADA is working with the Joint Commission on Accreditation of Healthcare Organizations, tribal leaders and the IHS to make this system less complex.

Q. Several Native corporations support the DHAT program for their own people. Why then does the ADA think it has the right to object?

A. Again, the ADA cannot stand by while patients potentially are put at risk as a result of a two-tiered dental care system. One of those who testified at the July 14 congressional committee hearing was Rachel Joseph, who co-chairs a steering committee for the reauthorization of the Indian Health Care Improvement Act of 1976. She noted that the act identified certain priorities, among them: "Equivalence. To end disparities, control diseases and environmental hazards, and to provide equivalent basic and specialized medical resources. Quality. To assure quality services and facilities … ." The ADA believes that the Native corporations and Native peoples should not settle for less-than-adequate care when equivalent care is attainable.

Q. If the ADA succeeds in defeating the therapist plan, will dentistry then actually deliver care to Alaskan Natives?

A. Yes, ADA and the ADS are committed to see that care is delivered to the Alaskan Natives. That is why the Association developed a new staff position within the ADA to work with the ADS, the tribes, the IHS, the Alaska Native Tribal Health Consortium and others to ensure that Alaska Natives get the care they need.

Q. If I want to get involved to help, what can I do?

A. Dentists interested in volunteering their services should send their names, mailing addresses, phone numbers and e-mail addresses to ADA staff members Tom Spangler ("spanglert@ada.org") or Janice Babcock ("babcockj@ada.org"). Mr. Spangler and Ms. Babcock will forward the information to the new manager of American Indian/Alaska Native dental placement once he or she is hired. ■

Testimony

Continued from page one

of really focusing on preventing disease, their solution is to extract it."

The nonpreventive expanded duties that dental health aide therapists are being trained to perform include extraction of teeth, the diagnosis and treatment of caries, and pulpotomies. They undergo a two-year training program in New Zealand.

In Resolution 24H-2004, the ADA House of Delegates stated its opposition to nondentists performing irreversible procedures and directed the Association to develop ways to increase access to care for Alaska Natives.

While acknowledging that tribal leaders and others (who attended the hearing) see the DHATs as the only way to deliver much-needed care, Dr. Brandjord told the congressional panel that there is another way.

"Our written testimony includes an alternate model that builds on the current dental delivery system by making it more efficient," he said. This alternative model was developed by four dental experts, including the current dental director of the Alaska Native Medical Center in Anchorage, as an Alaska-based solution to an Alaska access problem.

In questioning Dr. Brandjord, panel member Sen. Lisa Murkowski (R-Alaska) was critical of the Association's terming the DHAT program as "experimenting" on Alaska Natives. However, after listening to Dr. Brandjord's response to her questions about the ADA's position, she urged all parties to work together to resolve the issues around credentialing and getting licensed dentists to provide care.

Photo by Anna Ng Delort

Hearing: Sen. Lisa Murkowski questions Dr. Brandjord July 14 about the ADA's position on the DHAT program in Alaska.

health care providers face, the ADA testimony notes, as each village requires a practitioner to undergo a separate credentials review.

"We need a more efficient system to provide the needed care safely and effectively," Dr. Brandjord told the panel. "And we need less red tape." ■

OnlineXtra
www. ada.org/goto/newsextra

For more information related to this story, visit the ADA's Web site, using the Web address above.

After the hearing, Dr. Brandjord said, "I hope we can keep the lines of communication open. If there is room for meaningful discussion, we can then pursue those opportunities."

The experts' proposal calls for more dental assistants and dental chairs for each dentist and the development of COHPs to train in Alaska and provide patient education and preventive services. The COHPs would do all the necessary preparation before a visiting dental team (dentist, dental hygienist and assistants) is scheduled to come and would also provide some needed expanded clinical functions, while leaving the provision of irreversible surgical procedures to dentists.

Regarding the credentialing obstacles, the ADA said it is a significant barrier to bringing dentists to Alaska villages. Some 140 ADA dentists volunteered as part of Operation Backlog in 2004. Only three dentists were requested by local tribal entities. The credentialing issue is one that other

CLARIFICATION

The July 11 ADA News included overviews of the two national examinations for dental licensure—the Western Regional Examining Board and the American Board of Dental Examiners (ADEX) exams.

The article stated that WREB's national exam is "is still several years from completion." However, WREB currently offers an exam that is presently utlilized in 30 states. WREB will continue to offer the current exam nationally while it explores and develops enhancements and alternative formats.

Innovations to the WREB exam will require some time before implementation. ■

Mississippi Dental Association elects its first woman president, Dr. Eleanor Gill

Jackson, Miss.—Dr. Eleanor Gill became the Mississippi Dental Association's first woman president in June.

The former member of the ADA Council on Ethics, Bylaws and Judicial Affairs and president of Mississippi's second district is a 1987 graduate of the University of Mississippi School of Dentistry.

Dr. Gill

Dr. Gill is now a member of the dental school alumni association's board of trustees and in 2000 served as its president. She holds membership in the American Association of Women Dentists, the American College of Dentists, the Academy of General Dentistry and the American Academy of Dental Practice Administration.

"My goal for the MDA is to advance the organization in the areas of communications, public awareness of optimal oral health care and dentist member involvement," said Dr. Gill. ■

Party in the park

ADA, CDC celebrate 60 years of community water fluoridation

BY ARLENE FURLONG

Got teeth? Get fluoride.

It's the slogan public health officials, dental professionals, researchers and community leaders rallied around at the 60th anniversary commemoration of community water fluoridation in the United States. Their approach was also unanimous: Can-do. Will-do.

Sponsored by the ADA in conjunction with the Centers for Disease Control and Prevention and with support from Delta Dental Plans Association, the July 13 reception at Millennium Park in Chicago kicked off the National Fluoridation Symposium 2005, July14-16 at ADA Headquarters.

Amid the surrounding skyline, participants' high spirits were even further buoyed by speakers' high expectations.

"What we're really celebrating today is the positive difference that water fluoridation makes in people's lives as a safe, effective and economical way to fight dental decay," said ADA Executive Director James Bramson, in welcoming participants. "Let's make this an occasion for rededicating ourselves to building toward the day when every community in our nation enjoys the benefits of water fluoridation."

Each distinguished speaker followed to reiterate the importance of dentistry's goal for the greater good of all people.

"What really stands out about fluoridation of drinking water and makes it so beneficial is that everybody in a fluoridated community has access to it, regardless of income, education, background, age or living circumstances," commented Dr. Richard Haught, ADA president. "Too many children are still missing out on the opportunity to get started on a lifetime of oral health."

"It's through partnerships like this one that the public gets the information it needs about fluoride to ensure that each successive generation's oral health continues to be better than the one before it," said Dr. William R. Maas, CDC director, Division of Oral Health.

Julius B. Richmond, M.D., former U.S. surgeon general 1977-1981, underscored that message and congratulated the ADA, saying the Association was doing exactly what a professional organization should be doing.

"This is a model for public-private partnership," he commented about the National Fluoridation Symposium 2005. "Fluoridation came out of science just as well-substantiated as the link between smoking and health."

Armed with scientific evidence, the 1950 ADA House of Delegates voted its support for the fluoridation of public water supplies. Fluoride is scientifically proven to be the single most effective public health measure to prevent tooth decay and improve oral health over a lifetime, in both children and adults. The CDC named fluoridation as one of 10 great public health achievements of the 20th century and estimates that every dollar spent on fluoridation saves $38 in treatment costs.

Fluoridation now reaches nearly 70 percent of people in the United States on public water systems. Not enough, according to M. Joycelyn Elders, M.D., former U.S. surgeon general, 1993-1994.

"Our work isn't finished until every community is fluoridated," she advised. "We always have more work to do."

Dr. Lawrence A. Tabak, director, National Institute of Dental and Craniofacial Research, said tooth decay remains a common childhood disease among low income and underserved populations.

"It is time to make this age-old condition a topic for the history books."

Thirty-four registrants from seven countries—Australia, Canada, England, Ireland, Korea, Japan and New Zealand—attended.

Dr. Hyun-Duck Kim, Department of Preventive and Public Health Dentistry, Seoul National University, said he came to learn how to spread the word about the benefits of fluoride beyond the 37 cities in South Korea that are currently fluoridated.

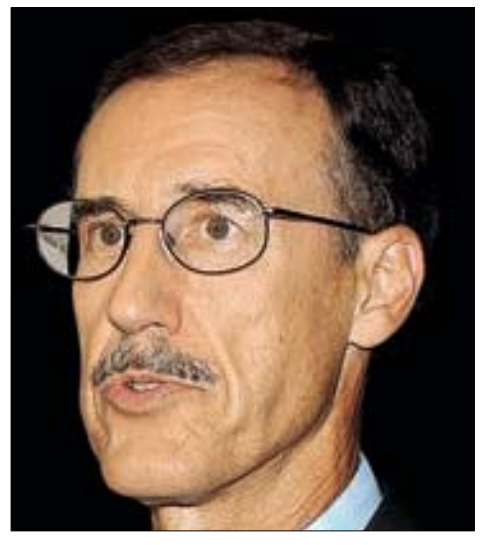
"Only 15 percent of people live in fluoridated communities in South Korea," explained Dr. Kim. "I'm here to learn how to change old attitudes there."

Also speaking at the symposium's reception July 13 were Dr. Dushanka V. Kleinman, U.S. Public Health Service chief dental officer and Lt. Gov. Pat Quinn, Illinois.

Making a video appearance were Julie L. Gerberding, M.D., director, CDC; Dr. Poul Erik Petersen, chief, Oral Health Programme World Health Organization and Richard Carmona, M.D., current U.S. surgeon general. ■

Warm reception: ADA President Richard Haught, left, chats with Dr. Michael L. Morgan, chief, Dental Health Services, Oklahoma State Department of Health and Dr. Scott Presson, chief, Program Services Branch, Centers for Disease Control and Prevention Division of Oral Health, during the celebration ceremony and reception July 13 in Chicago's Millennium Park.

M. Joycelyn Elders, M.D.: "Our work isn't finished until every community is fluoridated."



Dr. William R. Maas: "It's through partnerships like this one that the public gets the information it needs about fluoride to ensure that each successive generation's oral health continues to be better than the one before it."

ADA issues position statement, talking points on Harvard study

An article published in the July 22 Wall Street Journal might prompt questions from your patients on the safety of fluoridated water.

At the heart of the WSJ article is an unpublished thesis by a Harvard doctoral student researcher that reportedly suggests a link between fluoridated water and the development of osteosarcoma, a rare bone cancer. The Harvard University School of Dental Medicine has announced that it will conduct an inquiry into charges that a dental school professor misrepresented the student researcher's findings.

The ADA, in a position statement on water fluoridation and bone cancer, "cautions the dental profession, public health officials and the public against drawing conclusions based on a lone researcher's unpublished study. Indeed, the student notes in her thesis that there are several limitations to her study and recommends that the findings be confirmed using data from other studies. … ADA policies on community water fluoridation are based on the overwhelming weight of credible scientific evidence. That evidence stems from extensive scientific research and has been published in refereed (peer-reviewed) professional journals that are widely circulated. The research concludes that there is no association between cancer rates in humans and optimal levels of fluoride in drinking water.

"The ADA encourages, supports and welcomes scientific investigations into matters pertaining to oral health. It will continue to monitor this development closely and if necessary will advise the public and the dental profession of any steps that we believe are needed to ensure the public's safety."

The full text of this position statement is posted on ADA.org. The ADA has also developed nine talking points on water fluoridation found in the ADA.org "members only" content section to assist ADA member dentists in answering questions from patients.

For more information on the statement and talking points, contact Fred Peterson, manager, Media Relations, Ext. 2855.

Find more information on fluoridation or an electronic press kit that contains a variety of informational materials on community water fluoridation on ADA.org or contact Nicole Stoufflet, coordinator, Fluoridation and Preventive Health, Ext. 2858. ■

Shaved ice: Thomas A. Kochheiser of the Michigan Dental Association, above left, takes a snow cone break between sessions July 14.

Optimally fluoridated refreshment: Specially bottled for the event, National Fluoridation Symposium 2005 private label water was served throughout the four-day event.

International gathering: The symposium attracted participants from seven nations, including a delegation of 15 from Japan.

Shared thoughts: Participants, including Eleanor Nadler, RDH, executive director of the San Diego Fluoridation Coalition, were able to ask questions and share strategies.

Symposium

Continued from page one

for Disease Control and Prevention hosted the symposium in Chicago July 13-16.

The intensive four-day program set sail July 13 with an anniversary celebration of fluoridation in Chicago's hottest new venue, Millennium Park. (See story, page 12.)

And during the next three days, participants and speakers boarded a philosophical ship in the harbor of ADA Headquarters. ADA Chief Operating Officer Mary Logan welcomed them and shared an anonymous quote, " 'A ship in the harbor is safe,' " she said, " 'but that's not what ships are for.' Remember this quote, because we will talk about it again before you leave."

The symposium attracted some 250 participants from 39 states and the District of Columbia, as well as nearly three-dozen from Australia, Canada, Ireland, Japan, Korea, New Zealand and the United Kingdom. Dentists and team members; dental society members and staff; local, county and state government and public health representatives; legal and legislative experts; water system personnel; and other advocates heard from more than 50 speakers during the event.

Experts at the podium included former U.S. Surgeon General M. Joycelyn Elders, M.D.; Dr. William R. Maas, director of the CDC Division of Oral Health; George Heartwell, mayor of Grand Rapids, Mich.—the city where it all started Jan. 25, 1945; and many other notable experts in fluoridation science, engineering, policy and surveillance.

The symposium's curriculum immersed participants in fluoridation's 60-year history and examined ongoing scientific study of fluoridation's benefits, safety and cost-effectiveness.

Courses also focused on policy issues, legal and legislative challenges and developments, and opportunities for the future. Participants earned up to 15.75 hours of ADA CERP-recognized continuing education credit for attending all the sessions, including a four-hour fluoridation spokesperson training seminar July 16.

Dr. Scott Presson, chief, Program Services Branch, CDC/Division of Oral Health, noted that although 67 percent of U.S. citizens currently have access to optimally fluoridated water, nearly 100 million are still without access to fluoridation.

"Healthy People 2010 includes a national objective to reach 75 percent of the U.S. population with optimally fluoridated water," he said. "Currently 24 states meet this goal, but we have to continue making progress to reach this objective."

The final panel discussion, led by Ms. Logan, gave panelists and participants a chance to step up to the microphone and discuss the strengths, weaknesses, threats and opportunities covered during the symposium. "Now we hope you take what you've learned and set sail toward your fluoridation goals," she concluded. "And remember that the ADA and CDC are always available to help you after you've left the harbor." ■

ADA, CDC offer fluoridation resources

Even if you weren't able to attend the National Fluoridation Symposium 2005 last month, you can still get the latest scientific and policy information and materials on community water fluoridation through new resources launched in conjunction with the meeting.

• The ADA's brand-new 2005 edition of Fluoridation Facts is a 72-page resource with more than 350 scientific references designed to assist policymakers and the general public in making informed decisions about community water fluoridation. Fluoridation Facts can be viewed by professionals and the public on ADA.org. Printed copies are available from the ADA Catalog; price is $11.95 for ADA members; 17.95 for nonmembers. To order, log on to "ADAcatalog.org" or call toll-free, 1-800-947-4746 (ask for item #J120).

• The ADA and the Centers for Disease Control and Prevention have issued an updated joint pamphlet, Nature's Way to Prevent Tooth Decay—Water Fluoridation, now available for the first time in Spanish as well as English. The pamphlet can be customized and reproduced with local contact information and logos. Copies are available at no charge by contacting Nicole Stoufflet, Ext. 2858, e-mail "stoufletn@ada.org" or by contacting the CDC, 1-770-488-6054 or e-mail "OralHealth@cdc.gov".

• The ADA's new electronic media press kit on community water fluoridation is available on ADA.org, and includes an overview, reports from the national symposium, press releases, articles and position statements, downloadable videos and photographs. ■

DentalPractice

FAQs: ADA HIPAA helper

The ADA Division of Dental Practice is stepping up its efforts to help members comply with regulations under the Health Insurance Portability and Accountability Act of 1996.

Look to future issues of the ADA News for further clarification on the various regulations under HIPAA and compliance guides specifically tailored for dental practices.

In this issue, ADA members' most frequently asked questions about the HIPAA security rule are listed below and posted at ADA.org.

(1) What is this security rule? Isn't it the same thing as privacy? Isn't privacy what HIPAA is all about?

The Health Insurance Portability and Accountability Act of 1996 is a large piece of federal legislation. There are several unique sections of this legislation and security is one of those sections. Privacy is another section that is separate and distinct and has its own requirements. The enforcement deadline for the HIPAA security rule was April 20, 2005.

(2) Do I have to comply with the security rule? Does my office need the ADA's HIPAA Security Kit?

All of the HIPAA rules—for privacy, security, transactions, and identifiers—apply to a dentist if he or she electronically transmits or receives a patient's protected health information using one of the standard transactions established by the U.S. Department of Health and Human Services.

HIPAA standard transactions are:

- claims or equivalent encounter;
- claim attachments;
- claim status inquiry;
- eligibility inquiry;
- payment advice or remittance advice;
- coordination of benefits, explanation of benefits;
- first report of injury for workers' compensation;
- enrollment in or withdrawal from a health plan;
- notice of premium payment.

For assistance in determining whether you are a covered entity, you may wish to consult the "Covered Entity Decision Tool" posted at "www.cms.hhs.gov/hipaa/hipaa2".

Dentists should note that they will be required to comply with HIPAA even if they indirectly transmit or receive patients' protected health information using one of the standard electronic transactions.

For example, if a dentist sends paper claims to a clearinghouse, which then converts the paper claims to electronic claims and transmits them to a health plan, the dentist is a covered entity.

Keep in mind that faxes are not considered to be electronic transactions because they exist on paper before transmission.

Finally, remember that dentists who are subject to HIPAA must comply with the security rule in addition to the privacy rule.

(3) Who will enforce the security rule?

The Centers for Medicare & Medicaid Services' Office of HIPAA Standards.

(3a) We don't see Medicare patients. Why is CMS involved?

CMS is part of HHS and was named by the secretary of Health and Human Services to enforce HIPAA rules for electronic transactions and code sets, security and national provider identifiers.

(4) It's already past the April 20, 2005, deadline for security compliance. I just found out that the security rule existed. Am I in trouble?

If you are a covered entity and you have not implemented the security rule in your office, it would be very wise to implement the security rule as soon as possible. At this time, the Office for HIPAA Standards has no plans to perform random audits and is relying on complaints to drive HIPAA security enforcement. No one knows if this will always be the case, of course.

(5) What software do I need to comply with the security rule?

The security rule does not prescribe specific software or technologies. Each covered provider can use the hardware and software that meets the needs of the practice, as long as the technology used in the office provides the appropriate level of security for all electronic public health information, also referred to as ePHI.

(6) What are some of the main differences between the privacy and security rules?

Unlike the privacy rule, the security rule does not establish any new patient rights. It does not require providers to ask patients to read or sign any forms.

The privacy rule establishes protections for health information in oral, written and electronic form. The security rule establishes highly detailed standards for the protection of electronic health information, but does not apply to written or oral communications.

The security rule requires covered providers to protect the integrity and availability of electronic health information as well as its confidentiality. This means:

- Only authorized individuals may access electronic health information (confidentiality).
- The information does not change except when changed by an authorized person (integrity).
- Authorized persons can always retrieve electronic health information regardless of circumstances (availability).

The security rule is composed of administrative, physical and technical standards. These standards are designed to help protect the confidentiality, integrity and availability of electronic health information. Covered providers meet these very flexible standards by assessing risks, deciding how to manage risks in a reasonable manner and documenting their decisions.

Ultimately, while the security rule at first may seem narrower than privacy because it covers only electronic communications, it can cut across even more operational lines, involve more business decisions and take more time to comply with than did privacy.

(7) I use X billing software with Y clearinghouse. They say they're HIPAA compliant. Does that mean I'm in compliance?

Maybe. It is possible that your existing policies, procedures and safeguards, in combination with your vendors' efforts, could meet HIPAA security standards without modification. However, there is no way of knowing this for certain without doing a risk analysis. The risk analysis process helps a practice identify and correct its weaknesses.

(8) What is a security officer?

Covered practices must appoint a security official to carry out a risk analysis in order to identify vulnerabilities to the security of electronic public health information. After identifying these vulnerabilities, the security official will write policy or update existing policy and implement safeguards to manage risks associated with these vulnerabilities. All of the new and existing policies and implementation procedures form the practice's security documentation. In the unlikely event a practice was audited by CMS for security reasons, this security documentation will help the practice avoid or reduce fines.

(9) Who should be my office's security official? Can the responsibilities be delegated to an office manager, hygienist or other staffer?

The security rule's standards cut across many practice operations in such a manner that dentists may not feel comfortable with leaving some of the decisions in the hands of an employee.

In many cases, the best individual for the job of security official may well be the dentist. The job may be delegated, in which case the dentist should keep in mind that as the covered entity he or she is ultimately responsible for HIPAA compliance.

(10) How does the security official do the risk analysis? How is it documented?

The risk analysis is a careful assessment of the areas of the practice to identify vulnerabilities to the security of ePHI.

The use of this particular checklist is not required; the office must, however, carefully analyze all of the risks in the areas specified by HIPAA. There is no prescribed method to complete the risk analysis, but the risk analysis must be completed and documented. It could be as simple as a log sheet that records the dates of periodic risk assessments.

The ADA HIPAA Security Kit comes with a detailed risk analysis tool (pages 26-34). This tool is a checklist of potential threats and vulnerabilities. Answering the questions contained in the tool helps to provide a clearer image of the practice's weaknesses and helps to prioritize implementation activities.

(11) How does one obtain a HIPAA Security Kit?

The ADA HIPAA Security Kit is a useful tool designed to help dentists comply with the HIPAA security rule. If you are subject to HIPAA and have not yet implemented the security rule, call the ADA Catalog at 1-800-947-4746, or visit the ADA Catalog online at "www.adacatalog.org" to order your HIPAA Security Kit today. The cost is $99.95 for members. ■

OnlineXtra
www. ada.org/goto/newsextra

For more information related to this story, visit the ADA's Web site, using the Web address above.

HIPAA: The Current Issues

Take the mystery out of regulations under the Health Insurance Portability and Accountability Act of 1996 and learn about the benefits that can be achieved through compliance from Dr. Daniel W. Croley, ADA director of dental informatics.

By attending the ADA Seminar Series Course, "HIPAA: The Current Issues," participants can gain understanding about:

- what's happening with HIPAA;
- what covered dentists must do;
- the difference between privacy and security;
- why there is so much incorrect information about HIPAA;
- who is responsible for enforcing the various HIPAA regulations;
- consequences of noncompliance;
- how to identify reliable and valid HIPAA sources.

Dr. Croley

Upon request, the seminar will focus on the HIPAA security regulations using the ADA HIPAA Security Kit as a resource. State societies can purchase the kits at a discount for the HIPAA seminars and kits must be ordered at least two weeks prior to the seminar from "www.adacatalog.org" or by calling 1-800-947-4746. ■

Health&Science

‘Meth mouth’ resources

ADA posts information for dentists, public

BY CRAIG PALMER

Dental professionals and patients should be aware that use of an addictive and toxic drug called methamphetamine is associated with severe oral effects described as “meth mouth,” the ADA said in communications launched online at ADA.org and extended to professional and public media.

“The American Dental Association wants more dentists and patients to understand the devastating effects the illegal drug methamphetamine has on oral health,” the ADA said in a media statement. “In addition to numerous threats to overall health, methamphetamine users risk rampant tooth decay in a distinctive pattern on the smooth front surface of the teeth and the spaces between the front teeth.”

Statements posted at ADA.org provide an overview of methamphetamine use and oral health with the makings of a “meth mouth” bibliography in the form of professional, research and drug abuse endnotes.

“The oral effects of methamphetamine use can be devastating,” says a Dental Topics statement on methamphetamine use posted Aug. 1. “Reports have described rampant caries that resembles early childhood caries and is being referred to as ‘meth mouth.’ A distinctive caries pattern can often be seen on the buccal smooth surface of the teeth and the interproximal surfaces of the anterior teeth.

“The rampant caries associated with methamphetamine use is attributed to the following: the acidic nature of the drug, the drug’s xerostomic (dry mouth) effect, its propensity to cause cravings for high calorie carbonated beverages, tooth grinding and clenching and its long duration of action leading to extended periods of poor oral hygiene.”

The ADA media advisory puts it this way: “Methamphetamine users’ teeth have been described as ‘blackened, stained, rotting, crumbling or falling apart.’ Often, the teeth cannot be saved and must be extracted.”

Other ADA and professional communication efforts are under way to share the growing meth mouth information base with dentists and patients. The ADA Update and Community Brief publications will offer further information, and the ADA library offers a package library on the topic.

ADA News coverage includes a first-person “My View” (page four) and an upcoming story in the Aug. 22 issue.

Dentists may access information by telephone through the ADA toll-free number, Ext. 2878, and by e-mail to “science@ada.org”.

“The topic has been the subject of media interest recently, and we anticipate that more and more dentists and their patients will want information about it,” said ADA Executive Director James B. Bramson. “We synthesized practical information for members with a very short turnaround time in a document that can continue to be refined and updated as our knowledge base on this topic grows.” ■

OnlineXtra
www. ada.org/goto/newsextra
For more information related to this story, visit the ADA’s Web site, using the Web address above.

■ **Dentist’s perspective, page four**
■ **More meth coverage in Aug. 22 ADA News**

Fly fishing, CE in Montana setting

Dillon, Mont.—If you’re angling to learn the latest developments in restorative dentistry, plus a chance to brush up on your fly fishing skills, the Montana Fly Fishing Dental Conference meets Sept. 8-10 in Dillon.

Dr. Terry Donovan will present “Update in Esthetic Restorative Dentistry.”

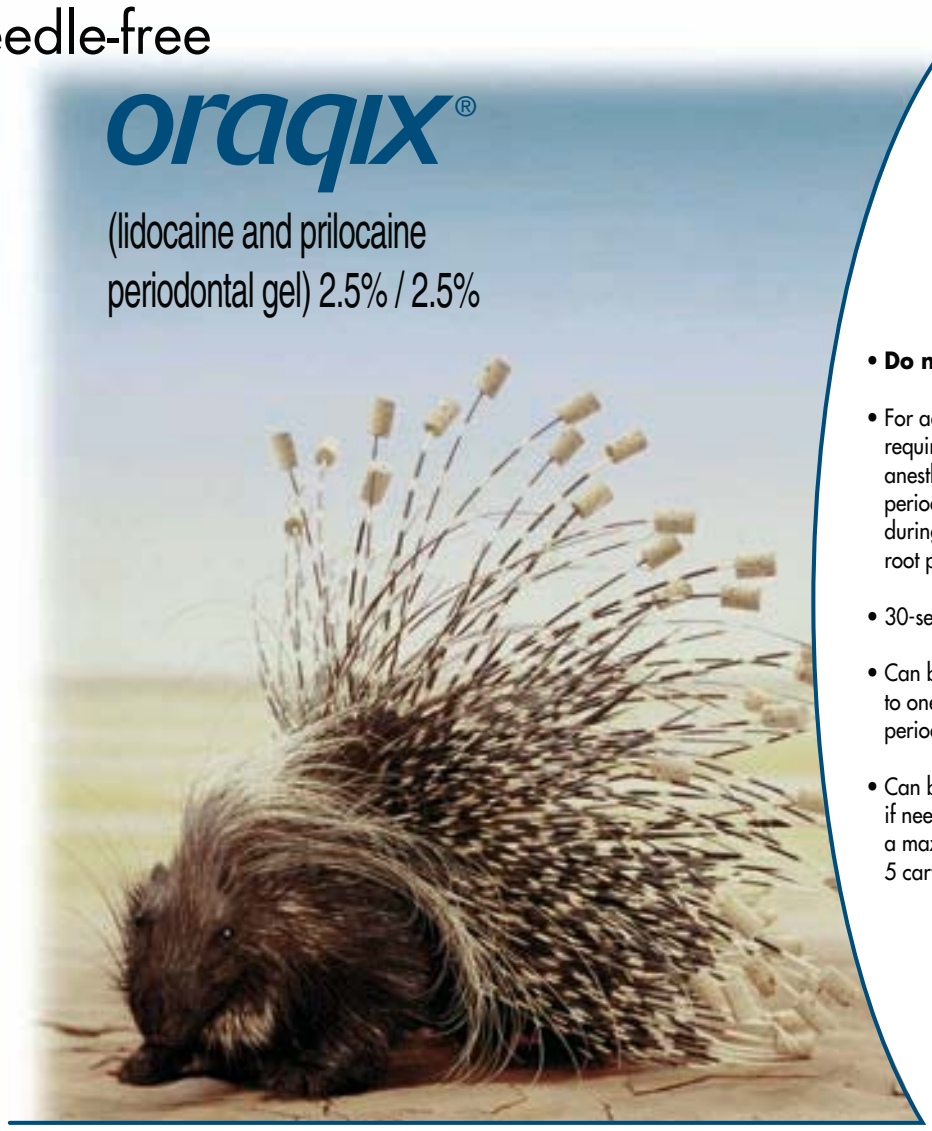
Participants will also have the chance to fly fish for rainbow and brown trout on the Beaverhead, Big Hole, Madison and Ruby rivers. Dr. John B. McCollum, conference organizer, hosts a barbecue dinner on Sept. 9. For more information on the event, contact Dr. McCollum by calling 1-406-683-5125. ■

Introducing Needle-free, Patient Friendly Anesthesia for Scaling & Root Planing

Needle-free

oraqix®

(lidocaine and prilocaine periodontal gel) 2.5% / 2.5%



- **Do not Inject**
- For adults who require localized anesthesia in periodontal pockets during scaling and/or root planing
- 30-second onset
- Can be applied to one or several periodontal pockets
- Can be reapplied if needed up to a maximum of 5 cartridges

Don't Get Stuck Without It!

Oraqix provides pain relief and its needle-free application avoids patient concern(s) regarding needles and injections.

- Oraqix should not be used in those patients with congenital or idiopathic methemoglobinemia.
- Novel formulation allows Oraqix to change from a liquid to a gel at body temperature.
- Oraqix is contraindicated in patients with hypersensitivity to amide type local anesthetics or any other product component.
- The most common adverse reactions in clinical studies were application site reactions, headaches and taste perversion.

Please see the accompanying brief summary of the prescribing information.

To order or for more information on Oraqix, contact OraPharma at 1.866.273.7846 or visit our website at www.oraqix.com

Manufactured for:
DENTSPLY PHARMACEUTICAL

Distributed by:
ORAPHARMA, INC.

PM-Oraqix-0036 11/04

Local anesthetic for periodontal administration
Not for Injection

oraqix®

(lidocaine and prilocaine periodontal gel) 2.5% / 2.5%

Brief Summary of Prescribing Information

INDICATIONS AND USAGE
Oraqix® (lidocaine and prilocaine periodontal gel) 2.5%/2.5% is indicated for adults who require localized anesthesia in periodontal pockets during scaling and/or root planing.

CONTRAINDICATIONS
Oraqix® is contraindicated in patients with hypersensitivity to amide type local anesthetics or to any other product component.

WARNINGS
Prilocaine can cause elevated methemoglobin levels particularly in conjunction with methemoglobin-inducing agents. Methemoglobinemia has been reported in a few cases in association with lidocaine treatment. Patients with glucose-6-phosphate dehydrogenase deficiency or congenital or idiopathic methemoglobinemia are more susceptible to drug-induced methemoglobinemia. Oraqix® should not be used in those patients with congenital or idiopathic methemoglobinemia and in infants under the age of twelve months who are receiving treatment with methemoglobin-inducing agents. Signs and symptoms of methemoglobinemia may be delayed some hours after exposure. Initial signs and symptoms of methemoglobinemia are characterized by a slate grey cyanosis seen in, e.g., buccal mucous membranes, lips and nail beds. In severe cases symptoms may include central cyanosis, headache, lethargy, dizziness, fatigue, syncope, dyspnea, CNS depression, seizures, dysrhythmia and shock. Methemoglobinemia should be considered if central cyanosis unresponsive to oxygen therapy occurs, especially if metHb-inducing agents have been used. Calculated oxygen saturation and pulse oximetry are inaccurate in the setting of methemoglobinemia. The diagnosis can be confirmed by an elevated methemoglobin level measured with co-oximetry. Normally, metHb levels are <1%, and cyanosis may not be evident until a level of at least 10% is present. The development of methemoglobinemia is generally dose related. The individual maximum level of metHb in blood ranged from 0.8% to 1.7% following administration of the maximum dose of 8.5 g Oraqix®.

Management of Methemoglobinemia: Clinically significant symptoms of methemoglobinemia should be treated with a standard clinical regimen such as a slow intravenous injection of methylene blue at a dosage of 1-2 mg/kg given over a five minute period.

Patients taking drugs associated with drug-induced methemoglobinemia such as sulfonamides, acetaminophen, acetanilide, aniline dyes, benzocaine, chloroquine, dapsone, naphthalene, nitrates and nitrites, nitrofurantoin, nitroglycerin, nitroprusside, pamaquine, para-aminosalicylic acid, phenacetin, phenobarbital, phenytoin, primaquine, and quinine are also at greater risk for developing methemoglobinemia.

Treatment with Oraqix® should be avoided in patients with any of the above conditions or with a previous history of problems in connection with prilocaine treatment.

PRECAUTIONS
General:
DO NOT INJECT
Oraqix® should not be used with standard dental syringes. Only use this product with the Oraqix™ Dispenser, available from DENTSPLY Pharmaceutical.

Allergic and anaphylactic reactions associated with lidocaine or prilocaine can occur. These reactions may be characterized by urticaria, angioedema, bronchospasm, and shock.

Eye contact with Oraqix® should be avoided. Animal studies have demonstrated severe eye irritation. Corneal irritation and potential abrasion may occur. If eye contact occurs, immediately rinse the eye with water or saline and protect it until normal sensation returns. In addition, the patient should be evaluated by an ophthalmologist.

Oraqix® should be used with caution in patients with a history of drug sensitivities, especially if the etiologic agent is uncertain.

Patients with severe hepatic disease, because of their inability to metabolize local anesthetics normally, are at greater risk of developing toxic plasma concentrations of lidocaine and prilocaine.

Information for Patients: Patients are cautioned to avoid injury to the treated area, or exposure to extreme hot or cold temperatures, until complete sensation has returned.

Drug Interactions: Oraqix® should be used with caution in combination with dental injection anesthesia, other local anesthetics, or agents structurally related to local anesthetics, e.g., Class 1 antiarrhythmics such as tocainide and mexiletine, as the toxic effects of these drugs are likely to be additive and potentially synergistic.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY:
Carcinogenesis - Chronic oral toxicity studies of o-toluidine, a metabolite of prilocaine, have shown that this compound is a carcinogen in both mice and rats. The tumors associated with o-toluidine included hepatocarcinomas/adenomas in female mice, multiple occurrences of hemangiosarcomas/hemangiomas in both sexes of mice, sarcomas of multiple organs, transitional-cell carcinomas/papillomas of urinary bladder in both sexes of rats, subcutaneous fibromas/fibrosarcomas and mesotheliomas in male rats, and mammary gland fibroadenomas/ adenomas in female rats. These findings were observed at the lowest tested dose of 150 mg/kg/day or greater over two years (estimated daily exposures in mice and rats were approximately 6 and 12 times, respectively, the estimated exposure to o-toluidine at the maximum recommended human dose of 8.5g of Oraqix® gel on a mg/m2 basis).

o-Toluidine, a metabolite of prilocaine, was positive in Escherichia coli DNA repair and phage-induction assays. Urine concentrates from rats treated orally with 300 mg/kg o-toluidine were mutagenic to Salmonella typhimurium in the presence of metabolic activation.

USE IN PREGNANCY:
Teratogenic Effects: Pregnancy Category B
Treatment of rabbits with 15 mg/kg (180 mg/m2) produced evidence of maternal toxicity and evidence of delayed fetal development, including a non-significant decrease in fetal weight (7%) and an increase in minor skeletal anomalies (skull and sternebral defects, reduced ossification of the phalanges). The effects of lidocaine and prilocaine on post-natal development was examined in rats treated for 8 months with 10 or 30 mg/kg, s.c. lidocaine or prilocaine (60 mg/m2 and 180 mg/m2 on a body surface area basis, respectively up to 1.4-fold the maximum recommended exposure for a single procedure). This time period encompassed 3 mating periods. Both doses of either drug significantly reduced the average number of pups per litter surviving until weaning of offspring from the first 2 mating periods. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, Oraqix® should be used during pregnancy only if the benefits outweigh the risks.

Nursing Mothers: Lidocaine and, possibly, prilocaine are excreted in breast milk. Caution should be exercised when Oraqix® is administered to nursing women.

Pediatric Use: Safety and effectiveness in pediatric patients have not been established. Very young children are more susceptible to methemoglobinemia. There have been reports of clinically significant methemoglobinemia in infants and children following excessive applications of lidocaine 2.5% and prilocaine 2.5% topical cream (See WARNINGS).

Geriatric Use: In general, dose selection for an elderly patient should be cautious, usually starting at the low end of the dosing range, reflecting the greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other drug therapy.

ADVERSE REACTIONS
In clinical studies, the most common adverse reactions are application site reaction (including pain, soreness, irritation, numbness, ulcerations, vesicles, edema, abscess and/or redness), headache and taste perversion.

Rx only.
For more detailed information, consult your DENTSPLY Pharmaceutical representative and read the full Prescribing Information.

Manufactured by Recip AB for DENTSPLY Pharmaceutical, York, PA 17404

Form No. PM-Oraqix-PI-0024 Rev 11/04

DENTSPLY PHARMACEUTICAL