1-8-2007

ADA News - 01/08/2007

American Dental Association, Publishing Division

Dr. Michael Rainwater dies, page six ◆ Tobacco controversy, page 18

AMERICAN DENTAL ASSOCIATION WWW.ADA.ORG

ADA NEWS®

JANUARY 8, 2007 VOLUME 38 NO. 1

Anesthesia policy

CDEL proposes revisions to guidelines

BY KAREN FOX

Poised to make "significant" revisions to the ADA anesthesia guidelines documents and policy statement, the Association last month issued a call for comment regarding the revisions.

"The proposed revisions are significant," said Dr. Guy Shampaine of the ADA Council on Dental Education and Licensure.

■ Comments sought on revisions, page 12
■ Pediatric guidelines, page 12

Included among the changes, he said, are a reorganization of the documents by level of sedation vs. route of

See ANESTHESIA, page 12

Board consult: Dr. Shampaine discusses the revisions Dec. 10.

Photo by Bill Geiger

Getting ready for GKAS: Children at Harriet Tubman Elementary School in Washington, D.C., await dental screening by volunteers from the District of Columbia Dental Society and Howard University College of Dentistry Dec. 13. About 200 kids will receive treatment Feb. 2 at Give Kids A Smile.

BRIEFS

ADA gets personal:

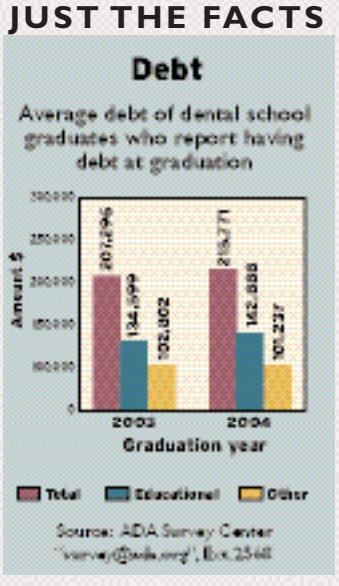
In February, the ADA will launch a new line of more than 200 personalized products to assist in practice development and recognition.

Personalized paper products will include recall and reminder cards, business and appointment cards, patient education brochures, coloring books and letterhead. Practice-building items will include full-color mugs, magnets and tote bags. All products will be shipped within 24 to 48 hours and personalized free of charge.

The ADA symbol will be included next to a practice's name on educational brochures and recall cards.

Personalized Products Catalogs will be mailed to ADA members and past customers in January. Others interested in the products can order catalogs by calling 1-800-947-4746. Orders will also be taken online at "www.adacatalog.org". ■

JUST THE FACTS



Dental claims confusion

Dentist deployed to Iraq thought he'd planned for every contingency but found out otherwise

BY ARLENE FURLONG

Lamar, Mo.—When Dr. Jeffery O. Moyer and his wife Jane learned Maj. Moyer would be deployed to Iraq in the National Guard, they immediately began preparing for his absence.

Substitute practitioners were scheduled and patients were informed about appointment changes. By the time Dr. Moyer departed on Aug. 31, 2006, six months after receiving notice, both were fairly confident that they'd done all they could do to ensure the practice would run smoothly until his return.

■ ADA, NADP share insights on claims denials, page 4

That confidence was shaken when Ms. Moyer learned that reimbursements for many of the claims sent to Delta Dental of Missouri from Dr. Moyer's office weren't arriving.

"We had a wonderful group of rotating dentists keeping the practice

See DEPLOYED, page 10

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ADANEWS
(ISSN 0895-2930)

JANUARY 8, 2007 VOLUME 38, NUMBER 1

Published semi-monthly except for monthly in July and December by the American Dental Association, at 211 E. Chicago Ave., Chicago, Ill. 60611, 1-312-440-2500, e-mail: "ADANews@ada.org" and distributed to members of the Association as a direct benefit of membership. Statements of opinion in the ADA NEWS are not necessarily endorsed by the American Dental Association, or any of its subsidiaries, councils, commissions or agencies. Printed in U.S.A. Periodical postage paid at Chicago and additional mailing office.
Postmaster: Send address changes to the American Dental Association, ADA NEWS, 211 E. Chicago Ave., Chicago, Ill. 60611.

American Dental Association
www.ada.org

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SUBSCRIPTIONS: Nonmember Subscription Department 1-312-440-7735. Rates—for members $8 (dues allocation); for nonmembers-United States, U.S. possessions and Mexico, individual $67; institution $100 per year. Foreign individual, $92; institution $125 per year. Canada individual, $81; institution $112 per year. Single copy U.S. $11, foreign U.S. $13. For all Japanese subscription orders, please contact Maruzen Co. Ltd. 3-10, Nihonbashi 2-Chome, Chuo-ku, Tokyo 103 Japan. ADDRESS OTHER COMMUNICATIONS AND MANUSCRIPTS TO: ADA NEWS Editor, 211 E. Chicago Ave., Chicago, Ill. 60611.

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ADA Foundation offers access grants

ADA. | FOUNDATION
American Dental Association Foundation

With a focus on access-to-care initiatives, the ADA Foundation will award up to $100,000 in grants to organizations for community water fluoridation infrastructure updates or collaborative statewide programs to address oral health awareness and access-to-care needs of vulnerable populations.

The deadline for submitting a grant proposal is Jan. 30.

The Foundation will award grants of up to $10,000 to not-for-profit or publicly funded programs in the U.S. and its territories for purchase of replacement water fluoridation equipment for acid-feed systems that serve 25,000-300,000 people. Applicants must demonstrate the ability to secure matching funds equal to 50 percent of the amount requested.

Grants of up to $25,000 are available to not-for-profit or publicly funded programs in the U.S. and its territories for state-level capacity building programs that have not received Centers for Disease Control and Prevention cooperative agreement funding. Applicants' programs can include developing coalitions, convening state oral health summits, developing state oral health plans, supporting volunteer and outreach efforts that involve dentists, developing public policies to expand oral health access and awareness, and incorporating public and interprofessional education efforts to expand oral health prevention and awareness. Applicants are encouraged to involve participation by the state dental society, allied dental professionals, state health officials and policymakers, community service organizations, consumers and other stakeholders, faith-based organizations, educators and other health professionals.

For more details or grant proposal summary forms, contact Lisa Barron, director of programs, by calling toll-free, Ext. 4639, or e-mailing "barronl@ada.org". Information is also posted online at ADA.org; click on the ADA Foundation link for details. ■

Dental Benefits

ADA, NADP share views on dentists' concerns

This is the second installment of a series of ADA News articles on dentists' "Top 10" concerns submitted to the ADA about their dental claims. These articles include perspectives from ADA members, National Association of Dental Plan members and the Council on Dental Benefit Programs.

Dental claims denials were among the most frequent concerns ADA members complained about to the ADA during 2005.

Two more topics under dental claims denials were featured in the Nov. 20, 2006 ADA News. Subsequent articles will cover the remaining nine of the "Top 10" concerns, which include claims processing delays, lost attachments, provider contract issues and others. ■

Benefits: From left, Drs. Jeffrey H. Rempell, Patricia I. Boyle, Robert G. Plage and John T. Mooney consider issues important to members at the Nov., 2006 CDBP meeting in Chicago.

Dental Claims Denials

D2950 core buildup, including any pins

Dentist perspective

Many complaints concerning the denial of core buildups were brought to the attention of the ADA Council on Dental Benefit Programs. Dentists perform this procedure when it is necessary prior to restoring a tooth with a crown. Complaints centered on the lack of a benefit for this procedure. Some dentists complained that this procedure is bundled with a crown procedure.

Position: Dr. Thomas J. Schripsema vice-chairs the Nov. 2006 CDBP meeting.

Bundling of separate procedures to limit a benefit is against ADA policy. If a plan chooses to bundle these procedures, the plan should allow the sum of the fees for the crown and the crown buildup as the total fee for the procedure and provide the appropriate benefit. Dentists do not always understand the parameters for payment by plan. Patients should be clearly informed as to benefit limitations and it should be made clear in the benefit booklet and explanation of benefits that plan limitations and not clinical necessity determine payments.

CDBP notes that many patients do not understand how their dental benefits really function. They do not understand that dentists who attempt to deliver ideal care may find that the constraints of a given policy do not align with the treatment plan. It is incumbent on us to give appropriate care notwithstanding a patient's insurance coverage. This is an example of just such a situation. We cannot interpret the meaning of any code beyond what it actually states.

The payers who choose not to fund for core buildups do so for many reasons. Having patients who understand the limitations of their plan prior to treatment can avoid problems.

Regarding explanation of benefit language, CDBP works very hard to help insurance companies find language which is not only succinct but which does not infer bad faith on the part of the dentist. We have had some success in this regard by direct correspondence with individual companies.

It is incumbent upon the dentist to help the patient understand the clinical basis for treatment, in spite of contractual limitations by the plan. In doing so, the rationale for the core buildup to improve retention form and improve the clinical outcome is clearly explained for the benefit of the patient. In cases of denial, it may be appropriate to submit an appeal outlining the reasons for the procedure, leading to improved prognosis.

Dental benefits industry perspective

Both this code and D6973 core buildup for retainer, including any pins, creates problems for payers. Some of the problems result from limitations in an employer's group policy and some result from lack of documentation to support use of this procedure in addition to a crown.

The change in the descriptor in CDT-4 clarified the procedure, however all claims submissions are not consistent with the descriptor. In the description it states the procedure, "Refers to building up of anatomical crown when restorative crown will be placed, whether or not pins are used. A material is placed in the tooth preparation for a crown when there is insufficient tooth strength and retention for the crown procedure. This should not be reported when the procedure only involves a filler to eliminate any undercut, box form or concave irregularity in the preparation."

Some payers find that buildups are reported in addition to a crown procedure when there is a base placed only to restore undercuts and tooth structure that is removed during the crown preparation. This is contrary to the descriptor for this code. Under this definition, a dental consultant acting on behalf of the payer may decide, based on the documentation submitted, that the reported crown buildup did not meet the definition and is a part of the crown procedure. Thus, only the crown procedure will be reimbursed.

Benefit limitations are required, under state law or in the case of Taft-Hartley contracts under negotiated labor agreements, to be disclosed in plan documents that are provided to insured patients. These documents must meet readability standards which are most often at the grade school reading level and sometimes are required in foreign languages as well. While these plan documents are made available to insured patients, they may be lost or misplaced and thus not referenced by the patient when seeking treatment.

EOB* language is intended to be succinct yet descriptive of the payers' action relating to the patient's claim. Payers are often limited in the space provided for explanations and use shortened descriptions to convey information. When such language results in misunderstandings between the patient and the dentist, payers are open to suggestions for changes in language.

Tip to minimize claim denials for core buildup:

In the initial claim submission, documentation of the condition that resulted in the buildup should be provided, if applicable.

*The National Association of Dental Plans has recently distributed to its members the ADA Council on Dental Benefit Programs' summary, "ADA Position on Content of Explanation of Benefits (EOB) Statements."

Pre-authorizations

Dentist perspective

Although it is incumbent upon patients to understand their coverage, many times the policies are not easily understood by lay people. It can be time consuming for the dental office to first learn about and then explain the terms of any particular policy to a patient. Also, since policies can change at the beginning of a plan year, this can make it very difficult for any dentist to understand how they will be paid for any procedure. Dentists use the pre-authorization process to determine a patient's coverage.

Sometimes a treatment plan has been pre-authorized or pre-approved by the carrier and the treatment is performed by the dentist with the expectation that the claim will be paid, but it is denied. The reasons for denial vary, such as the patient is no longer eligible, the maximum allowable has been paid or time limitations have been exceeded. The pre-authorization should clearly indicate that the pre-authorization is not a guarantee of payment.

See DENTIST, page five

Dental benefits industry perspective

The complexity of dental benefits is market driven. However, employee benefits booklets and disclosure statements are required by state laws to be written at a grade school reading level and in some instances provided in languages other than English to facilitate patient understanding.

The involvement of the dentist in explaining benefits to patients varies by dental product.

In dental health maintenance organizations, network dentists are provided with a manual or Web site access that lists covered benefits and patient payment obligations. Since there is no routine claims process for DHMOs, there is an expectation that the dental office is explaining charges for covered services (co-payments) and non-covered services when they are completing treatment.

For dental preferred provider organizations (roughly half of the market today) and dental indemnity plans (about 26 percent of the market), payers do not expect dentists or their office staff to explain covered benefits to the patient. While dentists may elect to provide general information

See INDUSTRY, page five

Dentist

Continued from page four

The ADA Council on Dental Benefit Programs believes that if at all possible, patients should be empowered to get paper or Internet copies of benefit booklets and policy guidelines so they can make informed decisions.

When a preauthorization is received in one calendar year and is begun in the next, there is always the potential for a problem.

The slow turnaround on a preauthorization often creates frustration for patient and practitioner. The process can be used to uncover proposed treatment which is not covered or is disallowed.

Patients must understand the benefit outlined in the preauthorization is tempered by the allowable benefits at the time of service, not the time of preauthorization submission. ■

Industry

Continued from page four

about benefits based on their experience, payers make specific information available to patients through their Web sites, benefit booklets and customer service lines.

"Preauthorization" and "predetermination" are processes that payers make available to dentists to clearly determine the potential benefits for a specific patient. These are distinct and different terms and processes which are outlined in many state statutes. They are not interchangeable. ("Pre-approved" is not a term generally used by payers.)

Many DHMO plans require preauthorization prior to referral to a specialist so that the plan can review the treatment prescribed and authorize payment. However, even with a DHMO, eligibility must still be established at time of service for a benefit to be covered.

Most DPPO and dental indemnity plans do not require preauthorization but offer a voluntary predetermination of benefits process. This is a service to the dentist or patient to determine prior to treatment what their plan will cover and reimburse for the course of treatment presented if the patient does two things:

(1) remains eligible;

(2) has not exhausted the plan maximum at the time of service.

Most carriers do clearly note on these forms of advice about potential coverage that the estimated payments for services are not guaranteed. Whether it is a preauthorization or a predetermination (sometimes called pre-estimate), it is based on the eligibility and remaining benefits at the time it was issued. If a member loses coverage or other benefits are paid in the time between the preauthorization or predetermination and the submission of a claim, benefits would change.

Dental insurance is like other types of insurance, the actual coverage is determined on the date of occurrence. If any eligibility of coverage has changed, the benefits are adjusted accordingly.

Tips to minimize claim denials and promote patient understanding of benefits:

• Encourage patients to contact their payer directly through customer service lines to verify benefits for particular procedures.

• Submit predeterminations on complex, costly procedures as close to the date of proposed service as possible. ■

Compiled by Arlene Furlong

Research of the future: Dr. Lawrence Tabak (center), pauses with Carole Anderson, Ph.D. (left), vice provost and interim dean, Ohio State University College of Dentistry, and John Sheridan, Ph.D., OSU associate dean for research, during the Distinguished Lecture Series Oct. 26. Director of the National Institute of Dental and Craniofocial Research, Dr. Tabak kicked off the OSU College of Dentistry's Office of Research 2006-2007 program with an address about dentists' expanded role in diagnosing disease.

Dr. Michael T. Rainwater, ADA 5th District trustee, dies at 54

BY JAMES BERRY

In a tragic development over the holidays, Dr. Michael T. Rainwater, the ADA's 5th District trustee, died unexpectedly Dec. 22 at his family's vacation home in Big Canoe, Ga.

Dr. Rainwater was 54 years old. A family member said cause of death appeared to be heart failure.

"Mike loved organized dentistry, and he loved working with the ADA and serving as 5th District trustee," said Dr. Rainwater's widow, Susan. He also is survived by two daughters, Cason, 23, and Kathryn, 19.

A general dentist who received his dental degree from the Medical College of Georgia School of Dentistry, Dr. Rainwater made his home in the Atlanta suburb of Peachtree City, Ga., with his dental office in nearby Riverdale.

"Dr. Rainwater has been a strong voice of leadership for our profession, and his passing has come way too early for all of us who called him a friend and colleague," said Dr. Kathleen Roth, ADA president. "He will be sorely missed at the ADA Board as well as throughout the country. My heart is heavy as I express my sincere condolences to Susan and his family."

Dr. Rainwater

Dr. Roth and other dental leaders, including Executive Director James B. Bramson, attended Dr. Rainwater's Dec. 27 funeral service at the First Baptist Church of Peachtree City. In keeping with his wishes, Dr. Rainwater was buried near the family's vacation home in the mountains of Northern Georgia.

Dr. Bramson said the news of Dr. Rainwater's death came as a "huge shock" to all.

He added, "In only his second year on the Board, he was quickly becoming a seasoned veteran. As expected, he used his Southern charm and self-effacing wit to make his points. He will be sorely missed on our Board. Our hearts go out to Susan and their daughters. On behalf of the Board and all the ADA staff, we will honor and remember his legacy."

Dr. Rainwater was elected to the Board of Trustees in 2005 to represent the 5th Trustee District, which includes Georgia, Mississippi and Alabama. He also was one of four trustees on the Board of Directors, ADA Foundation.

He was a past president of the Georgia Dental Association and past editor of GDA's journal, GDA Action. He also was a past president of the South Metro (Atlanta) Dental Study Club, and a past trustee and member of the executive council of the Northern District Dental Society of Metro Atlanta.

On the national level, Dr. Rainwater was a past chair of the ADA Council on Dental Practice and a former member of the Editorial Board of The Journal of the American Dental Association. He was a fellow of the American and International Colleges of Dentists, as well as the Pierre Fauchard Academy.

When news of Dr. Rainwater's passing reached the Board of Trustees, Board members began e-mailing messages of shock and sadness.

Dr. J. Thomas Soliday, speaker of the House of Delegates, recalled deer hunting with Dr. Rainwater in the woods of South Carolina.

"It's comforting now to know that he always lived his life to the fullest, but what a terrible tragedy," wrote Dr. Soliday, adding, "Mike was a good friend to all of us and to dentistry. He will be missed but never forgotten."

Dr. William Calnon, 2nd District trustee, said he first met Dr. Rainwater nine years ago and counted him as one of his closest friends.

"His passion for life, family and our profession will continue to live," wrote Dr. Calnon in a message to his Board colleagues and staff. "We need to pray for Mike, Susan and their daughters, and how each of us might, in some way, continue Mike's attempts to make what we all do more meaningful in his memory."

Dr. T. Howard Jones, ADA president in 2002-03 and a fellow Georgian, knew Dr. Rainwater for 25 years.

"He excelled at every level of organized dentistry and was a terrific team player," Dr. Jones said.

See DR. RAINWATER, page seven

Dr. Gary Newman, former ADA trustee, dies

BY JENNIFER GARVIN

Topeka, Kan.—Dr. Gary J. Newman, 66, a former ADA trustee, past president of the Kansas Dental Association and a man friends remembered as "an all-around great guy," died Dec. 2, 2006.

Dr. Newman served the ADA as trustee of the 12th district from 1991-95. He was a graduate of the University of Missouri at Kansas City School of Dentistry and practiced dentistry in Topeka for more than 40 years.

His obituary in the Topeka Capital-Journal described him as a "selfless man of limitless compassion who gave of himself and expected nothing in return. Above all, he loved his family."

Friends recalled his "subtle sense of humor" and gentlemanly manners.

"He was just a wonderful man," said Dr. Michael Reed, dean at the UMKC School of Dentistry. "He was totally committed to everything he did. The dentists in Kansas and his district were well represented when he was their trustee. He's sorely missed already."

A friend of Dr. Newman's for more than 20 years, Dr. Reed said UMKC plans to honor Dr. Newman during its 2007 alumni meeting.

At the time of his death, Dr. Newman was president of the Rinehart Foundation, the charitable arm of UMKC's School of Dentistry. Dr. Barry Daneman, UMKC's director of advancement, said the Rinehart Foundation already had received 50 contributions in Dr. Newman's name as of Dec. 12.

Dr. Al Guay, ADA chief policy advisor who served with Dr. Newman as a trustee, spoke at the funeral. He said their friendship transcended dentistry.

"He was soft-spoken, but when he spoke, people listened," Dr. Guay said. "He was well-respected as a trustee. He did a lot of things for the community that you never heard about. He was a bringing-together-kind-of-guy, not a dividing-kind-of-guy, and you don't meet those kinds of people often."

Current 12th District Trustee Frank Grammer said he "was the kind of quietly competent man who never proffered unsolicited advice, but was always ready to help with thoughtful, intelligent and compassionate counsel when asked.

"Even though he was not a son of the South, he could well be described as a true Southern gentleman. My grandmother used to say, 'Quality people make everyone around them feel comfortable.' Dr. Newman managed to do that as well as anyone I have ever known. My grandmother would have loved him, as did all the members of the 12th district. He will be sorely missed."

Dr. Newman

Kevin Robertson, KDA executive director, knew Dr. Newman from organized dentistry and from being a long-time patient.

"He was a gentle dentist," he said. "He'd put the mirror in your mouth and you could hardly tell he was working. He will be missed."

Dr. Newman was a past president of Topeka Friends of the Zoo, where he provided dental work for zoo animals. He was a devoted member of St. David's Episcopal Church.

Among his credentials, he was a fellow of the American College of Dentists, the International College of Dentists and the Pierre Fauchard Academy of Dentists.

He is survived by his wife, Wanda, two sons, two daughters-in-law and three grandchildren. The funeral was Dec. 5 in Topeka.

Memorial gifts can be made to the Rinehart Foundation, UMKC School of Dentistry, 650 E. 25th Street, Kansas City, Mo., 64108.

Cards can be sent to the family at 4820 Southwest 45th Street, Topeka, Kan., 66610. ■

Western Regional Dental Convention planned for March

Scottsdale, Ariz.—The Arizona Dental Association will hold the 2007 Western Regional Dental Convention March 8-10 at the Phoenix Convention Center.

The three-day convention features some 100 lectures and workshops, and includes more than 300 exhibits and will be represented by 200 dental industry companies.

For more information, contact the Arizona Dental Association by phone at 1-800-866-2732, by fax at 1-480-344-1442 or visit "www.westernregional.org/index.asp". ■

Dr. Rainwater

Continued from page six

One day after the funeral, on Dec. 28, Dr. Rainwater was buried in a wooded plot near the family's cabin at Big Canoe, north of Atlanta.

Dr. Stephen F. Schwartz, ADA first vice president, and his wife, Sharon, were among about 50 mourners at graveside.

"It was a crisp, magnificent day in the mountains about two hours from Mike and Susan's [Peachtree City] home," Dr. Schwartz noted in an e-mail message. "The scenery looked like a landscape portrait and the cemetery was very small, without any headstones disturbing the natural landscape. There was no doubt that this is where Mike should have been buried."

In an earlier message of sorrow and hope, Dr. Schwartz offered a poignant reminder to all that life is a gift.

"Cherish every moment with those close to you," he wrote, "and share your blessings with all you touch." ■

Government

Kentucky boosts dental Medicaid services, fee coverage for kids

BY JENNIFER GARVIN

Frankfort, Ky.—More Kentucky children will receive dental benefits, thanks to recent changes in the state's Medicaid program.

The Department for Medicaid Services said Oct. 27 that it will increase the reimbursement fee for children's dental services by 30 percent, as well as add an additional oral health examination and a second prophy to its annual services.

The state also has added a debridement code for pregnant women to complete an oral health protocol in a disease management program.

The new benefits are the result of the U.S. Department of Health and Human Services' decision to make Kentucky one of the first states to receive new, enhanced benefits as a result of the Deficit Reduction Act. Other states include West Virginia and Idaho.

Kentucky's new rate increase became effective Aug. 1, 2006.

A 2005 study by the Kentucky Youth Advocates organization showed that half of the state's children ages 2-4 has untreated cavities. The Kentucky Dental Association hopes that the changes will attract more dentists to participate in the Medicaid program.

"We at the Kentucky Dental Association are excited about the changes based on improvements in access we hope they will allow," KDA President Andy Elliott said in a news release. "We recognize the problems we are having and we hope the changes will address that."

The state is also developing a "dental home"—where every patient will be assigned a specific dental practice—for Medicaid members and expects this to go into effect in Spring 2007. Dentists will receive a small management fee per month for each adult he or she serves, the release said.

For more information about Kentucky Medicaid, call 1-800-635-2570 or visit "www.chfs.ky.gov". ■

Dr. Slavkin to speak in Chicago

The University of Illinois at Chicago College of Dentistry will hold a clinic and research day at the school Feb. 7.

Dr. Harold Slavkin, dean at the School of Dentistry, University of Southern California, will provide the keynote address, "Emerging Opportunities for Dental Research and Education."

The program includes a mini-symposium and more than 80 oral and poster presentations by students and faculty in basic, translational and clinical research, exhibits by dental product vendors, wax carving stations and student research group activities.

For information about the event, contact Mary Ozanich, Office of the Associate Dean for Research, by phone at 1-312-413-1160 or by e-mail at "mozanich@uic.edu". ■

Missouri picks new executive

Jefferson City, Mo.—The Missouri Dental Association in November 2006 named Vicki Wilbers its new executive director.

Ms. Wilbers takes over for Dr. Jake Lippert. Dr. Lippert was the MDA executive director for nine years.

"I'm humbled and honored to continue to serve this association in the future as its executive director," said Ms. Wilbers, who has been with MDA for 14 years, most recently as assistant executive director. "My leadership style is that of a 'servant leader' who will be dedicated to meeting the needs of those whom I serve—the association members and MDA staff—but also the many related entities such as allied health groups, legislators and state agencies. We must all work together to improve prevention education within the public and the oral health of all Missourians." ■

Executive management

Business acumen, leadership among rewards of ADA/Kellogg program

BY KAREN FOX

These days, Dr. Patricia Meredith can be found wearing many hats.

Dr. Meredith is on staff at the University of Iowa Hospital and Clinics where she serves in three capacities: clinical associate professor at the University of Iowa College of Dentistry, director for general dentistry in the division of hospital dentistry and medical director for the department of hospital dentistry.

"I see patients three days a week and teach in a general practice residency program and I'm the administrator of our division, then have administrative responsibilities in our department," said the Coralville, Iowa, general dentist. "I'm increasingly active in hospital committees, too. It's a wonderful blend of hospital experience, teaching, administration and clinical practice."

In organized dentistry, Dr. Meredith is a second-year trustee for the Academy of General Dentistry and a member of AGD's budget and finance committee.

Last year, she found the time to complete the ADA/Kellogg Executive Management Program for Dentists—earning her certificate Nov. 7, 2006.

"I had found myself in a position within the hospital and College of Dentistry where I needed more business skills than what I had as a general dentist," said Dr. Meredith. "The ADA/Kellogg program offered a broader scope of training and more intensity for both business and leadership. It was a perfect fit for me."

Designed for dentists who want to learn more about business management, the ADA/Kellogg Executive Management Program for Dentists curriculum draws from the core content areas for Kellogg MBA students, including: business strategy, organizational leadership, marketing, finance, accounting, economics, quantitative methods and information systems. This is not a practice management course.

Classes will be held at Kellogg's Chicago campus, just down the street from the ADA. Participants will receive a Kellogg certificate and continuing education credit.

Class dates for 2007 are scheduled for July 20-25, Sept. 13-18 and Nov. 1-5.

Dr. Meredith was one of 15 certificate recipients in 2006. A class of 35 completed the program in 2005.

"You can immediately apply what you learn in the Executive Management Program because it's so practical," she said. "With the AGD, I looked at the budget in a different way and understood it more clearly.

"This level of training is something that will help to advance my career in both the hospital and organized dentistry," she continued. "It's hard work but it's very stimulating, and the rewards are much greater than you can imagine."

Applications for the ADA/Kellogg Executive Management Program for Dentists are now being accepted. Go to "www.ada.org/prof/events/featured/kellogg/index.asp" for more information, or call Ext. 3541. ■

Photo by Connie Paslaski

Congratulations: Dr. Patricia Meredith receives her certificate for completion of the ADA/Kellogg Executive Management Program for Dentists on Nov. 7, 2006. From left are Tom Prince, Ph.D., Kellogg School of Management; Dr. James Bramson, ADA executive director; and Vennie Lyons, Ph.D., Kellogg School of Management.

ADA Library sends articles via e-mail

Did you know that ADA members can receive electronic copies of dental journal articles from the ADA Library through e-mail, saving you time and money?

Most requests are processed within two days and there's no wait for regular postal delivery. Articles are scanned from print at the member's request so there's no need for paper photocopies.

To request an article or for more information, call the ADA Library at Ext. 2653. ■

Deployed

Continued from page one

alive and everything was going smoothly until we ran into this glitch," explained Ms. Moyer. "I never could've predicted it."

Ms. Moyer assumed that claims electronically filed from the office where Dr. Moyer was a participating provider of Delta for some 23 years would be paid to the office. Instead, reimbursements on claims for treatment provided by substitute, nonparticipating providers went to patients. Payment for services provided by participating substitute dentists did go to Dr. Moyer's office.

"Our computers looked at the treating dentists who were nonparticipating providers and automatically issued reimbursements to the patients," said Al Martinez, DDM's vice president of government and dental affairs. "Participation is voluntary, but like in any other organization, certain benefits are reserved for the members."

Mr. Martinez told ADA News the problem would not have occurred if Delta had had advance notice that nonparticipating providers would be treating patients in Dr. Moyer's absence. "The providers could have been set up as participating only at Dr. Moyer's office without affecting their status at their own office," said Mr. Martinez, and added, "This is what occurred once the misunderstanding was cleared up."

Ms. Moyer said that with so many details to consider to prepare the practice prior to Dr. Moyer's departure, contacting Delta never occurred to them. "If we had a crystal ball we would've let Delta know substitute providers would be practicing here ahead of time," she said.

If the Moyers resided in a different state, it may not have mattered. Thirteen states have passed legislation forcing carriers to pay providers directly if the patient says to do so on the claim form.

A Council on Dental Practice publication, Dental Practice Management Guidelines, includes sections that may be helpful to practitioners, according to CDP staff, particularly Guidelines for the Development of Mutual Aid Agreements in Dentistry. Another avenue CDP staff recommend dentists explore is temporary placement services offered by local companies that advertise in members' constituent publications. Dentists can call the Council at Ext. 2895 for more information.

In Dr. Moyer's practice, communications were again tested when Ms. Moyer requested a special contract that would indicate temporary participation for substitute providers during Dr. Moyer's absence and the office was sent a standard contract instead.

"I'm treating patients at Dr. Moyer's office because this is how I get to serve my country, not because I want to become a participating provider with Delta," Dr. Michael Skahan said. From Dr. Skahan's perspective, the specifics of the contract and who signed what shouldn't be important. "If there is anything we can do to help dentists serving our country, it should be done," he commented.

"A special contract could be drawn up but it would have to be approved by the state department of insurance, which would take time," Mr. Martinez told ADA News. "The existing contract can easily accommodate similar situations by stipulating a termination date of the participating status."

After setting up the nonparticipating volunteer providers in Dr. Moyer's office as participating providers at that location, Delta agreed to help ameliorate Dr. Moyer's collections problems by sending letters to patients who had received reimbursements and requesting they refund Dr. Moyer.

Delta also agreed that payments for claims submitted from Dr. Moyer's office during his deployment will be sent directly to Dr. Moyer's office with a copy of the explanation of benefits. For the practice's accounting, Delta is sending Dr. Moyer's office copies of all of the EOBs sent while Dr. Moyer was away, so that the office can write off the difference between the billed amount and the amount patients received and didn't return to the practice.

En route: Dr. Moyer poses in Kuwait on his way to Iraq. "The one-on-one doctor-to-patient relationship was a gratifying aspect of my tour. Each encounter invariably included conversation about home in the U.S. and my patients' daily duties, which were sometimes interesting and sometimes heart-wrenching."

As of Jan. 2, Dr. Moyer's staff continued to call patients who received checks from Delta to ask them to mail their payments to the practice. "Recovering the income is crucial to us," Ms. Moyer said. Considering the situation overall, Ms. Moyers said, "Learning your husband is being deployed to war is hard enough, but managing your entire source of income with eight employees depending on you for their well-being makes the entire situation very intense. My hope is to be able to help someone else through my experiences."

Dr. Moyer returned home on Dec. 13, 2006. "I am especially grateful to the substitute doctors and my staff for providing care for my patients," Dr. Moyer said. "I'm also thankful to my patients for all of their support." In an e-mail from Balad, Iraq, Dr. Moyer said the colleagues covering his practice have really strengthened his opinion that dentistry is a great profession.

He said it was a challenge to provide a high standard of care to soldiers and coalition allies, describing the treating environment in Iraq as "less than ideal.

"Although I'm extremely happy to be home, my thoughts often go back to the troops and to those I served with who are still in Iraq and away from their families and loved ones." ■

House requests definition of exam format

BY KAREN FOX

Last year, the House of Delegates reaffirmed the ADA's support for the elimination of human subjects in the clinical licensure examination process while giving exception to a methodology known as the curriculum-integrated format.

But some are wondering whether "curriculum-integrated format" requires more clarity.

The American Student Dental Association thinks so. ASDA questions whether the format, as it is applied by some licensing agencies, is truly integrated into the curriculum of the final year of dental school.

At the 2006 House of Delegates in Las Vegas, ASDA advanced a resolution asking the ADA to define the curriculum-integrated format of an exam for initial clinical licensure as one that, at a minimum, is designed to test competency standards defined by the state board of dentistry that have been accepted by the dental school's curriculum committee and have been integrated into the pre-doctoral dental curriculum.

Education

Such an exam, says Resolution 34, should be offered more than once during the final year of the pre-doctoral curriculum and successful performance should be a requirement for graduation.

The House of Delegates referred Res. 34 to the Council on Dental Education and Licensure with a mandate to develop a definition and the necessary steps from the communities of interest and report to the 2007 House.

While supporting Res. 34's intent, the ADA Board of Trustees in August noted that at least two clinical testing agencies already have somewhat different definitions for the term. The Board concluded that the dental licensing, education and dental practice communities should collaborate on a definition that could be understood and supported by the entire profession.

The term "curriculum-integrated format" has generally been used to describe exams that evaluate dental students while they are in dental school during their clinical experiences. This format usually enables students to use their own patients—patients of record—and allows for remediation during the school year.

Dr. Young

Ms. Loftis

"ASDA took action to develop a definition since examining agencies could apply this terminology to their exam format although the live-patient portion of the exam remains unchanged," said Brooke Loftis, ASDA president.

"Unfortunately, this current format fails to address the initial concerns that led the ADA to support the elimination of human subjects from the process of examination for the purposes of initial clinical licensure," she said.

"Since ADA policy is that the only proper use of live patients on exams is the curriculum-integrated format, it is imperative that a common definition be developed so all parties are on the same page," said Dr. Stephen Young, chair, Council on Dental Education and Licensure.

In other licensure news, at its November meeting CDEL also took action to communicate with constituent dental societies and encourage them to work with state boards to undertake initiatives to implement all ADA policies related to licensure and freedom of movement. Correspondence is being developed.

"It is the responsibility of state boards to implement licensure policy," said Dr. Young. "It's our intent to let the states know about policies that promote freedom of movement and why the ADA supports these policies." ■

Licensure update

An Oct. 2, 2006, ADA News article detailed state clinical requirements for initial licensure. In that article, the Central Regional Dental Testing Services exam should have been included in Wisconsin's requirements.

Nan Kosydar Dreves, secretary of the Wisconsin Dentistry Examining Board, said Wisconsin accepts CRDTS and the North East Regional Board of Dental Examiners. The Western Regional Examining Board is also accepted if the American Board of Dental Examiners Parts I and III are completed.

Additional updates since the publication of that article include:

- Alaska accepts only WREB, not CRDTS and WREB.
- California now offers licensure applicants the option of completing a post-graduate residency of one year's duration in lieu of taking a clinical licensure examination.
- Puerto Rico accepts Council of Interstate Testing Agencies Inc. exam results.

These developments underscore the need for applicants to contact state boards of dentistry to find out current licensure requirements, and obtain them in writing. ■

Anesthesia

Continued from page one

sedation and elimination of teaching guidelines for deep sedation and general anesthesia from the Guidelines for Teaching.

The revisions include potential changes to the following documents:

• ADA Guidelines for the Use of Conscious Sedation, Deep Sedation and General Anesthesia for Dentists;

• ADA Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry;

• ADA Policy Statement: The Use of Conscious Sedation, Deep Sedation and General Anesthesia in Dentistry.

In 2005, the ADA House of Delegates called on the CDEL's Committee on Anesthesiology to host an invitational conference on anesthesia and conduct a comprehensive review and revision of the ADA's anesthesia documents and policies. The ADA Invitational Anesthesia Conference—held May 12-13, 2006—gathered information from the communities of interest and nationally recognized experts in the science and clinical practice of sedation and general anesthesia.

"The Invitational Anesthesia Conference was invaluable in assisting the committee with a comprehensive review of the documents," said Dr. Shampaine, chair of the Committee on Anesthesiology. "What has resulted is a year-long study of the anesthesia documents that includes input from experts in the current practice and delivery of outpatient sedation and anesthesia and deep sedation and general anesthesia."

Discussion: Members of CDEL's Committee on Anesthesiology meet at ADA Headquarters Sept. 15 to consider proposed revisions to ADA anesthesia documents. From left are Drs. Mort Rosenberg, American Dental Society of Anesthesiology; David Rothman, American Academy of Pediatric Dentistry; and Robert Merin, American Academy of Periodontology.

The most significant change to the documents takes into account that sedation and anesthesia are a continuum, said Dr. Shampaine. Reorganizing the documents by the intended levels of sedation and anesthesia—rather than route of administration—indicates that different levels present unique management challenges for patients.

"When the original documents were promulgated, they were organized by route of administration," Dr. Shampaine said. "At that time, route was associated with the intended depth of sedation and anesthesia. To achieve that goal, you would use a particular route of administration.

"As the practice of sedation and anesthesia has evolved and therapeutic uses have become more complex, we are organized around a therapeutic endpoint," said Dr. Shampaine.

The revisions also propose to eliminate information pertaining to deep sedation and general anesthesia from the Guidelines for Teaching.

"We believe that instruction on this level of sedation should take place at the advanced education level in a program with standards set forth by the Commission on Dental Accreditation," said Dr. Shampaine. "We don't think that dentists can be adequately trained or receive the clinical management experience currently needed for this level of sedation outside of a CODA-accredited residency program."

Another result of the revision of the guidelines is the development of a continuing education course that is an alternative to advanced cardiac life support and pediatric advanced life support training.

It became evident at the anesthesia conference that certification in either ACLS or PALS was required because it was the only available certified course, said Dr. Shampaine. "However, in my opinion, neither is focused on the main issue of management of patients in outpatient sedation and anesthesia, such as the management of the patient airway—the primary dental concern," he said.

CDEL is now in the process of requesting funding from the ADA Foundation to proceed with development of an emergency management course specifically for handling outpatient sedation and anesthesia.

"This will put the ADA in a patient safety leadership role among all health care professions," said Dr. Shampaine.

Other proposed revisions to the anesthesia documents include:

• amended titles to reflect changes in terminology used in the documents;

• updated definitions to be consistent with definitions used by other organizations such as the Academy of General Dentistry, American Academy of Pediatric Dentistry, American Academy of Periodontology, American Association of Oral and Maxillofacial Surgeons, American Academy of Pediatrics and the American Society of Anesthesiologists;

• elimination of Parts I, II and III of the "Teaching Guidelines" and reorganizing by level of sedation vs. level of education because the Council on Dental Education and Licensure believed that education should be required for each level of sedation, whether the dentist is at the pre-doctoral, advanced or CE level.

"The council was very pleased with the report from the Committee on Anesthesiology," added Dr. Stephen K. Young, chair of CDEL.

"The committee produced a document that not only updated the definitions and concepts in sedation and anxiety control, but was able to tie the guidelines for use of various levels of sedation with the educational requirements," stated Dr. Young. "I think the Board of Trustees, House of Delegates and membership will view this report as a significant step forward." ■

How to submit your comments on revisions

The ADA issued a broadcast e-mail on the proposed anesthesia revisions last month to executive directors of constituent and component societies, dental-related professional organizations, state boards of dentistry, recognized specialty organizations and certifying boards, dental school deans, advanced education program directors and select ADA councils.

Members and dental organizations now have the opportunity to review the revisions and make written comment to CDEL by Friday, Feb. 23.

The proposed revisions can be viewed on ADA.org at "www.ada.org/goto/statements". Click on "Anesthesia and Pain Control."

CDEL anticipates submitting final proposed documents to the 2007 House of Delegates.

Anyone wishing to provide comment may submit them to: Dr. Stephen K. Young, CDEL chair, ADA, 211 E. Chicago Avenue, Chicago, 60611; fax 1-312-440-2915; or e-mail "haglundl@ada.org". If you have questions, call Ext. 2694. ■

AAPD/AAP offer standardized approach to pediatric sedation

BY KAREN FOX

The American Academy of Pediatric Dentistry and American Academy of Pediatrics last month announced joint guidelines for all medical and dental practitioners for monitoring and management of pediatric patients during and after sedation.

"This partnership with the AAP to provide extensive, updated sedation guidelines is a monumental step toward ensuring that all children who undergo a medical or dental procedure receive the safest, most effective treatment," said Dr. Phil Hunke, AAPD president.

"Sedation of children is different from sedation of adults," the announcement reads. "Children often require deeper levels of sedation to control their behavior for safe completion of a procedure, and they are particularly vulnerable to the physiological effects of sedating medications. The close monitoring of a child during and following procedures that require sedation medications is critical for patient safety."

To view the new guidelines, go to "www.aapd.org". ■

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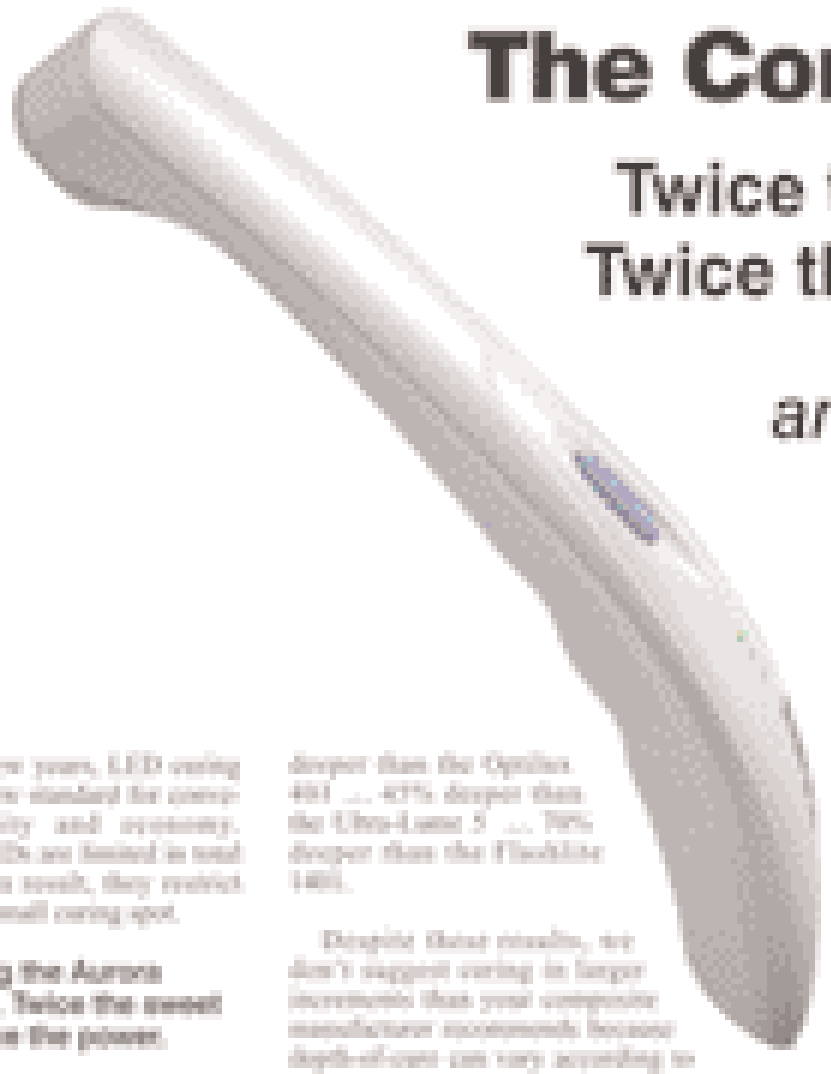

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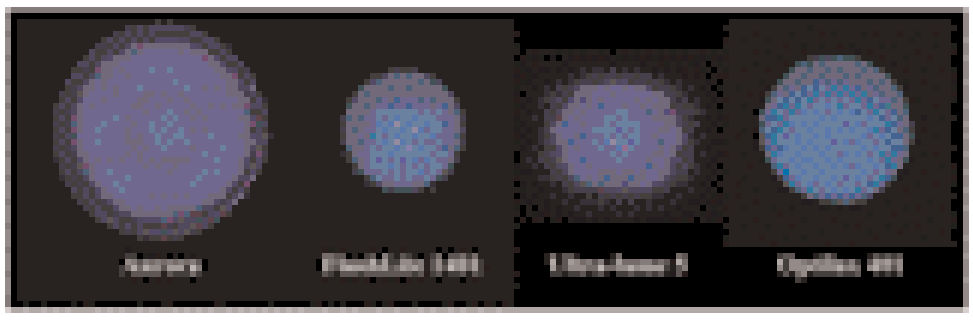

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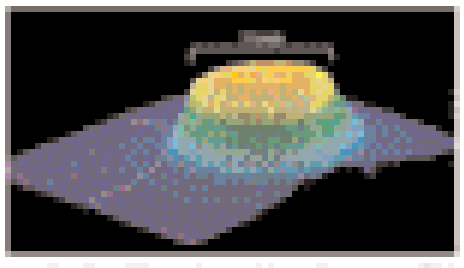

Predictable curing without hotspots. This spatial profile of beam-intensity demonstrates how evenly the Aurora distributes light across the curing spot. (Analysis generated using the Optilux Spectrum beam analyzer.)

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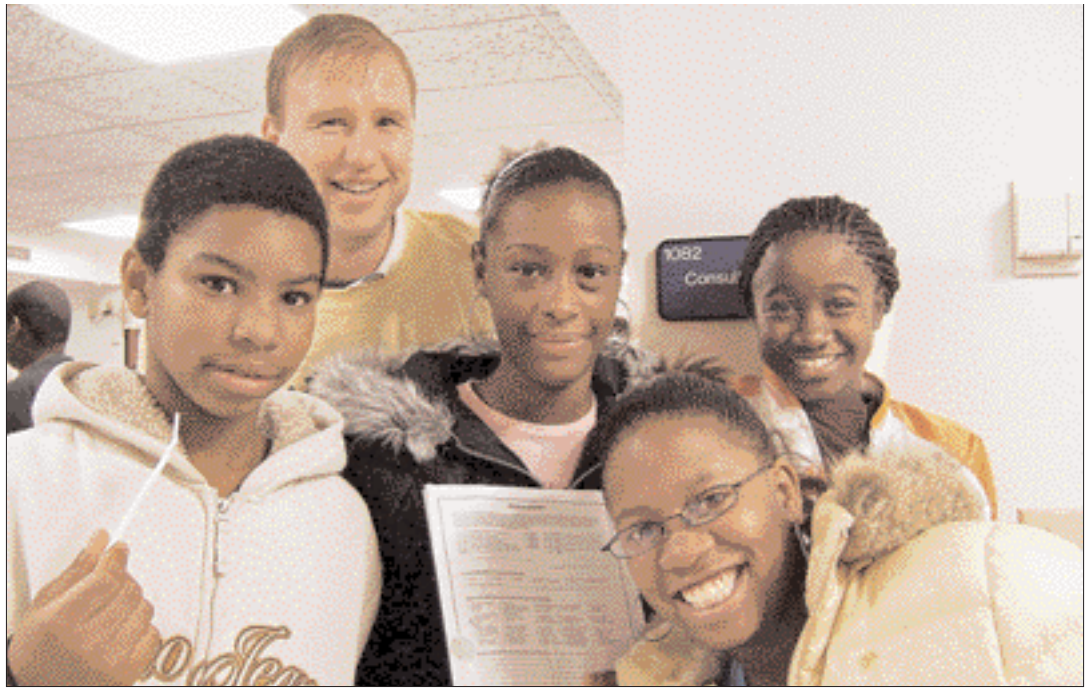

Camaraderie: Bob Seals of Young Dental joins a group of patients who received care Oct. 27, 2006, at one of the Greater St. Louis Dental Society's twice yearly GKAS events. More than 600 kids were treated.

GKAS

Details, details as Feb. 2 nears; please send photos to ADA News

There are only four weeks until the 5th anniversary Give Kids A Smile—and it looks like the 2007 event will be a record breaker.

More than 50,000 volunteers, including 14,000 dentists, have registered 2,100 programs for the Feb. 2 event. Some 735,000 children will receive care at an estimated value of $71.5 million dollars.

Give Kids A Smile volunteers can register their programs on ADA.org ("www.ada.org/goto/gkas") up to and after Feb. 2.

Those who return to the Web site to update their statistics after Give Kids A Smile are eligible to win $500 toward their next GKAS program. (Two $500 prizes will be awarded.)

Products that were requested from the GKAS corporate sponsors—Colgate Palmolive Co., Sullivan-Schein and DEXIS Digital X-ray Systems—are being distributed this month.

GKAS program participants from across the country are invited to send event photos to the ADA.

The News encourages submission of candid pictures of children and dentists and team members interacting as well as clinical photos (patients in the chair, dental team in gloves, masks and protective eyewear). Be sure to include identification of those pictured and facts about the event, too.

High-resolution digital photos will be considered for use in the ADA News and on ADA News Today (on ADA.org). Send high-resolution photos to "adanews@ada.org" as soon as possible following events. ■

Photo by Bill Geiger

Paperwork: Dr. Donna Grant-Mills of Howard University prepares a student for pre-GKAS screening Dec. 13 in Washington, D.C.

Save the date

Plan to attend annual session in San Francisco Sept. 27-30

San Francisco—Make a New Year's resolution to attend the 148th Annual Session of the American Dental Association at the Moscone Center in San Francisco, Sept. 27-30.

Mark your calendar. Registration for ADA07 San Francisco opens March 28. Be sure to register early so you can sign up for your first choice of continuing education programs and your favorite San Francisco hotel.

ADA07 San Francisco will offer dentists, dental team members, families and guests golden opportunities for:

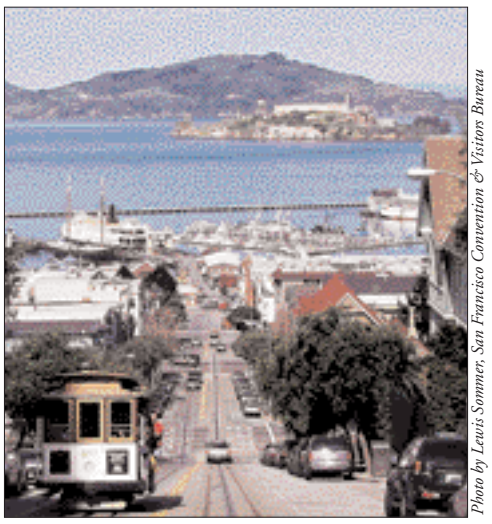

Photo by Lewis Sommer, San Francisco Convention & Visitors Bureau

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Request an annual session preliminary program by calling toll-free, 1-800-232-1432 or e-mailing "annualsession@ada.org". Preliminary programs will be mailed in March 2007. An electronic (PDF) version of the Preliminary Program will be available on ADA.org when registration opens on March 28. ■

DENTAL EDUCATION
OUR LEGACY-OUR FUTURE

Four new partners join Our Legacy—Our Future initiative

Four new facilitating partners have joined the Dental Education: Our Legacy—Our Future initiative.

The newest partners include the Academy of General Dentistry, the American Association for Dental Research, the Colorado Dental Association and the New York State Dental Foundation.

The initiative, a collaborative effort involving the input and participation of hundreds of dental stakeholders and 75 partners to date, has three goals:

• to raise awareness of the challenges facing dental education in the United States—faculty shortages, lack of diversity, aging physical and clinical facilities, lagging local and state government support, as well as escalating costs;

• to promote a culture of philanthropy within dentistry to address these issues;

• to deliver a call to action—starting within the dental community—to support dental education.

The purpose of the initiative is not to create a new fundraising entity. Our Legacy—Our Future will not collect a single dollar of its own, but will serve as a support tool for the fundraising efforts of its partner organizations.

Partners can be one of three types:

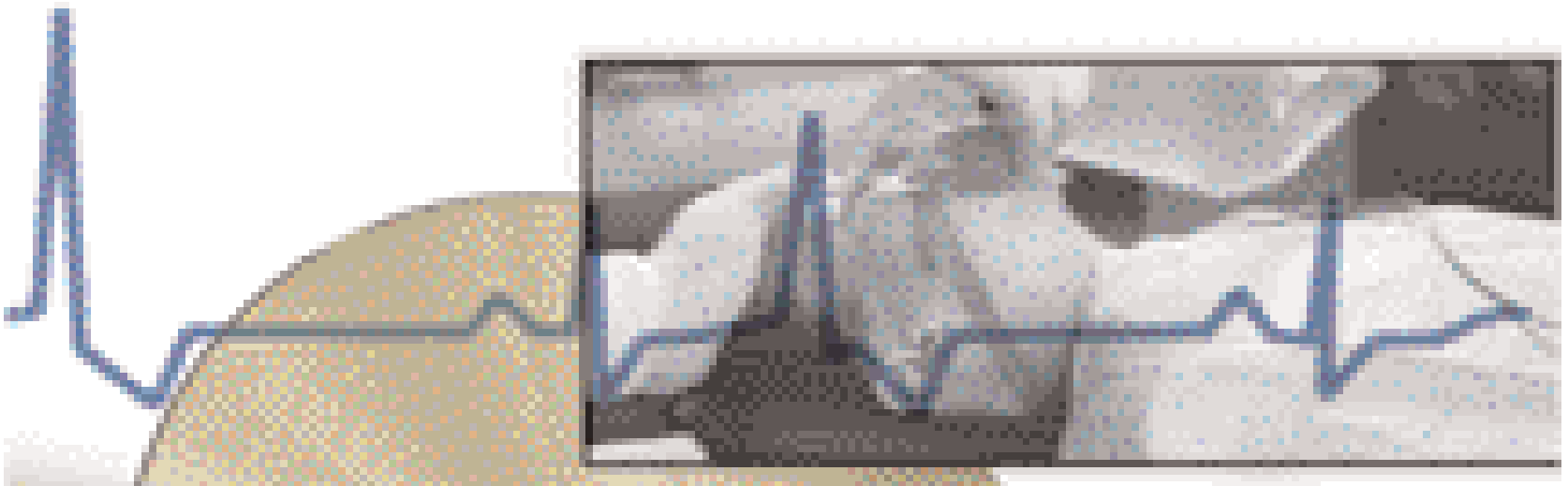
• recipient partners—institutions that maintain dental educational programs accredited by the ADA Commission on Dental Accreditation, including dental schools, graduate dental education programs, hospital-based dental residency programs and allied dental health programs;

• facilitating partners—organizations that solicit, hold and redistribute funds for dental education;

• donor partners—both for-profit corporations and non-profit or philanthropic organizations that financially support dental education.

The amount of contributions received by the partners from July 1, 2004-Dec. 31, 2014, will be counted toward the objective of generating an estimated $500 million for dental education.

For the latest news on OLOF, its partners, a "donor spotlight" feature or to view a special video on the initiative, log on to "www.ourlegacyourfuture.org". ■



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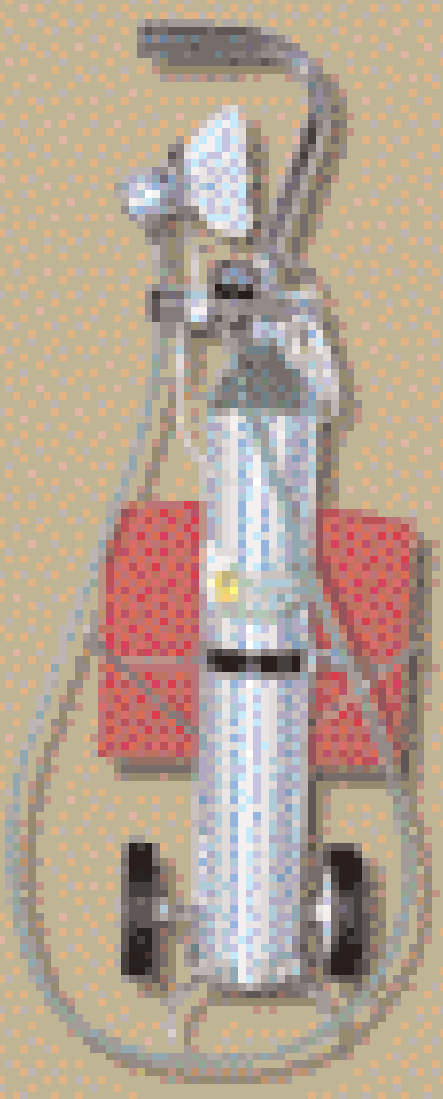

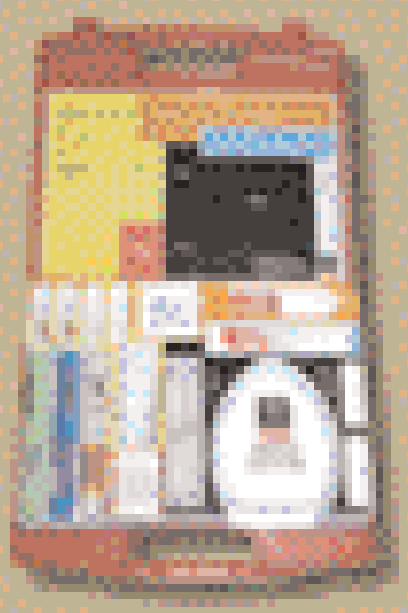

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‘Is it a trusted source?’

Tobacco control resources cause debate in health care community

BY STACIE CROZIER

Are all tobacco control materials and resources created equal?

That’s a question that researchers, public health officials, health care professionals and even The New York Times are raising as tobacco companies produce and distribute tobacco prevention and smoking cessation materials to the health care community and the public.

“It seems incongruent with the mission of a dental office to display or use materials provided by companies who produce a product that when used as intended can kill you,” says Cathy Backinger, Ph.D., acting chief, Tobacco Control Research Branch, National Cancer Institute.

She cautions dentists to carefully evaluate the entities that produce tobacco control resources and materials. “Is it a trusted source?”

Materials available from the National Cancer Institute, she adds, have been shown through scientific research to be effective tools in helping smokers quit.

Smokers who want to quit and parents who want to prevent their children from smoking have a variety of resources at their disposal proven to be effective tools, she says.

“There are some 45 million smokers and we need to have a variety of ways to help them quit,” Dr. Backinger says. “Brochures are helpful for some; interactive phone quitlines and online resources provide support; physicians and dentists can provide counsel and, consistent with applicable state law, prescription medications to help. Not every individual responds to one method, but there are a variety of choices out there, and we hope they choose materials from a trusted source.”

In November 2006, when Dr. Backinger heard reports of dental offices displaying and distributing QuitAssist materials produced by Philip Morris USA, she sent a letter to ADA President Kathleen Roth.

“Dental offices are a prime location to promote the health importance of both tobacco prevention and cessation. The implied endorsement of the Philip Morris QuitAssist materials is incompatible with the aims of dental offices that are concerned with patients’ oral health,” she wrote. “The tobacco industry markets a product that is both highly addictive and lethal under normal conditions of use. Thus, dental professionals’ goal of oral health and those of the tobacco industry are fundamentally different and irreconcilable.”

Philip Morris USA spokesman David Sutton says health care providers and consumers can request free QuitAssist materials from the company or obtain them on the PMUSA Web site.

The company in 2006 also distributed 2.4 million guides to U.S. dental offices through a third-party vendor. Since the QuitAssist program was launched in 2003, its Web site has logged more than 1.5 million visits and it has been promoted through “onserts” on more than 750 million packs of the company’s cigarettes.

“We want to make health care professionals and the public aware of the resources we offer and the opportunity for them to obtain more,” says Mr. Sutton. “We are trying to raise awareness of our smoking cessation efforts.”

In her letter to Dr. Roth, Dr. Backinger said tobacco products are responsible for more than 440,000 American deaths each year.

“Because tobacco use is responsible for about 30 percent of all cancer deaths, efforts to prevent and control tobacco use are a very high priority for the National Cancer Institute. Recently, some tobacco companies have sought to portray themselves as interested in helping to prevent youth smoking, or in helping adults to quit. … Some individuals may benefit from cessation information provided by Philip Morris. However, many more will suffer, so long as the company’s aggressive marketing efforts continue.”

According to the Campaign for Tobacco-Free Kids, the tobacco industry spent $15.1 billion to market and promote tobacco products in 2003—a 21.5 percent increase from the 2002 figure of $12.47 billion and a 125 percent increase since tobacco companies and states reached tobacco settlement agreements in November 1998 that placed restrictions on tobacco industry marketing.

(The 1998 Master Settlement Agreement was signed with 46 states, five U.S. territories and the District of Columbia. Florida, Minnesota, Mississippi and Texas had previously signed settlement agreements. All the agreements combined are known as the state Tobacco Settlement Agreements.)

The Centers for Disease Control and Prevention has set recommended levels that states should spend on tobacco control activities—about 8 percent of approximately $20 billion in settlement funds received each year. According to CDC data, only three states currently fund tobacco prevention programs at recommended levels. Less than half (22 states) fund programs at less than 25 percent of recommended levels—with five states spending none of their settlement funds on such programs.

“State legislatures decide how to use tobacco settlement funds,” says Dr. Backinger. “They can and do use them for a variety of things not related to tobacco control.”

A study published in the December 2006 issue of the American Journal of Public Health showed “little relation” between exposure to tobacco company-sponsored, youth-targeted ads and youth smoking outcomes. But ads targeted to parents but viewed by older teens may actually increase teen smoking and reduce their perceptions of danger about smoking, researchers concluded.

The study focused on parent-directed ads from Philip Morris USA and youth-directed ads from Phillip Morris and Lorillard Tobacco Co.

“Adolescents need accurate information about the serious health consequences of smoking, and they should be wary of tobacco marketing that portrays smoking as cool and glamorous,” says Melanie Wakefield, Ph.D., lead researcher and author of the study. “An important thing that parents can do to prevent their kids from smoking is to set a good example and quit smoking themselves. Or, if they don’t smoke, make their homes and cars smoke-free.”

Dr. Wakefield, a behavioral scientist, is director of the Centre for Behavioural Research in Cancer for the Cancer Council Victoria, in Melbourne, Australia. The study was supported by grants from the National Cancer Institute State and Community Tobacco Control Initiative, the National Institute on Drug Abuse and the Robert Wood Johnson Foundation.

“Parents can also support smoke-free laws, tobacco tax increases, tobacco advertising bans and funding for real tobacco prevention and quitting programs sponsored by state and federal governments,” Dr. Wakefield adds.

A statement on PMUSA’s Web site regarding the AJPH study and its television ad campaign, “Talk. They’ll Listen,” says, “Based on June 2006 research, 61 percent of parents of kids 10 to 17 years old reported being aware of at least one ad from the campaign. Of those aware, 61 percent reported having talked to their child about not smoking as a result of seeing the ad.”

Philip Morris USA established its Youth Smoking Prevention Program in April 1998—about seven months before tobacco companies signed the Master Settlement Agreement.

Since the YSP program’s inception, PMUSA has pumped about $1 billion into the program, over and above the $30 billion it has sent to the states during the last eight years through Tobacco Settlement Agreements, says Mr. Sutton.

“We believe that kids should not smoke,” says Mr. Sutton. ”This is a product intended for adults only, and we put our money where our mouth is.”

YSP encompasses a variety of activities, including research and research reviews on youth behavior and smoking rates, parent communications, grant programs, and a variety of strategies designed to prevent youth from gaining access to tobacco products, Mr. Sutton says.

The program’s parent resources were created in conjunction with an advisory board of psychologists, psychiatrists and public health professionals, chaired by Lawrence Kutner, Ph.D., clinical psychologist; lecturer, Harvard Medical School Department of Psychiatry; and president, Health Communications Consultants Inc. Dr. Kutner is a former columnist on child development and parent-child communication for The New York Times and Parents magazine, and author of five books on those topics.

“Our advisory board is an independent group that works to ensure the scientific accuracy and developmental appropriateness of the print and online materials for parents funded by the PMUSA Youth Smoking Prevention program,” says Dr. Kutner. “Our goal is to provide accurate, practical and effective resources that parents can use to help prevent kids from using tobacco in any of its forms.”

Dr. Kutner says that in addition to the health consequences of smoking he’s seen clinically, he works in youth smoking prevention and smoking cessation for a more personal reason.

“Both of my parents were smokers,” he notes. “Both died from smoking-related cancers by the time I was 18 years old. I know the health consequences of smoking. No child should have to deal with that.”

The advisory board, he says, has no involvement in television campaigns for PMUSA print and online materials.

“We’re providing our expertise to parents,” Dr. Kutner adds. “PMUSA is getting the same advice and counsel we would provide to any youth smoking prevention group. As independent consultants, each of us would walk away from the project if we ever feel that our advice is being either ignored or misused. I was initially concerned that this effort at youth smoking prevention might be a ruse, and that our advice would be ignored. Other members of the advisory board initially had the same concerns—indeed, I’d be suspicious of any health care professional who did not.”

PMUSA’s financial resources, he says, have served to “distribute approximately 70 million

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ADA resources help dentists, patients

The American Dental Association has long been active in promoting tobacco cessation and prevention, beginning with policy to inform the membership and the public of the health hazards of tobacco products that was first adopted in 1964.

“Many dentists may not be aware of all the information and materials available on tobacco control through the ADA,” said Dr. Vincent Filanova, chair, ADA Council on Access, Prevention and Interprofessional Relations. “Smoking can be a difficult subject to broach with patients, and ADA resources can help dentists break the ice with patients.”

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

Dr. Filanova, a dentist in Amsterdam, N.Y., says dentists should “not only ask patients ‘Do you smoke?’ but also ‘Would you like to quit?’ It’s a very easy thing to ask and there is lots of information and groups that you can access through the ADA that can help.”

The ADA offers dentists and the public a variety of resources, many of which are showcased in newly updated tobacco cessation pages on ADA.org.

Log on to “www.ada.org/goto/quitsmoking” to find the latest information on the effects of alcohol and tobacco, smoking cessation strategies to help your patients, tobacco FAQs, links to other recognized resources for professionals and patients and national health promotions that address tobacco cessation, such as Kick Butt’s Day and The Great American Smokeout.

The ADA Annual Catalog also offers a variety of brochures, posters, flip guide and video/DVD materials, including resources in Spanish, to help dentists’ tobacco cessation and prevention efforts in the dental office. Call toll-free, 1-800-947-4746 or log on to “www.adacatalog.org”.

In November 2006, the ADA concluded a four-year continuing education program, “Dentist Saves Patient’s Life: Early Detection of Oral Cancer and Tobacco Cessation.” The course, funded by a $1.2 million grant from the National Cancer Institute, was developed and presented 64 times in locations nationwide. Nearly 4,300 participants completed the course and a post-session survey.

Since 2004, the ADA has offered a variety of additional continuing education opportunities on tobacco control and/or oral cancer for dental professionals, including seven Journal of the American Dental Association Online CE courses. Since 2000, JADA has published almost three-dozen related articles and supplements and the ADA News has published more than 70 related articles. The ADA has also produced 12 video news releases, 14 news releases and eight e-publications featuring tobacco- and oral cancer-related topics.

JADA and ADA News articles, as well as many other articles on tobacco control are available from the ADA Library. Articles are available by mail or e-mail. Contact the ADA Library toll-free, Ext. 2653, for more information.

For more information

For a more in-depth look at the sources and materials cited in the ADA News story on tobacco control materials, log on to these Web sites:

- ADA News OnlineXtra: “www.ada.org/goto/newsextra”;
- National Cancer Institute: “www.cancer.gov”;
- Campaign for Tobacco-Free Kids: “www.tobaccofreekids.org”;
- Centers for Disease Control and Prevention: “www.cdc.gov”;
- Agency for Healthcare Research and Quality: “www.ahrq.gov/path/tobacco.htm”;
- American Journal of Public Health, “www.ajph.org”;
- The New York Times: “www.nytimes.com”;
- Philip Morris USA: “www.philipmorrisusa.com”. ■

Parents, online tools keep teens from smoking

BY ARLENE FURLONG

Although some studies show tobacco use among adolescents is decreasing, many smoking cessation experts still view tobacco use as a disorder of childhood and adolescence.

"If a child gets to 18 years of age and hasn't started, it's unlikely he or she will ever be tobacco dependent," says Dr. Theresa Madden, a faculty member at the School of Dentistry of the Oregon Health Sciences University. A Ph.D. in microbiology and immunology, she has conducted workshops and lectures widely on substance abuse and tobacco addiction. She says prevention programs that can delay tobacco use for as long as possible have a great effect.

Dr. Madden believes teenagers are very different from adults when it comes to the reasons they begin using tobacco and the ways they quit. "Marketing techniques that don't have an effect on adults may lure adolescents," she says.

She would like to see tobacco settlement money used to "reimburse dentists and other health professionals for engaging in tobacco-use cessation counseling; for health care and disease prevention, particularly of tobacco-related problems; and particularly for prevention programs that work." (Six tobacco companies, 46 states, five U.S. territories and the District of Columbia signed the 1998 Master Settlement Agreement. All the agreements combined are known as the state Tobacco Settlement Agreements.)

Quitlines, similar to traditional phone hotlines, can be very successful with adolescents, particularly if they include Web resources, Dr. Madden says. Currently, all but six states have tobacco cessation quitlines. The toll-free number 1-800-QUITNOW (1-800-784-8669) is a single access point to the National Network of Tobacco Cessation Quitlines. Callers are automatically routed to a state-run quitline, if one exists in their area. If there is no state-run quitline, callers are routed to the National Cancer Institute quitline.

"Teens are accustomed to getting their information from the Internet," Dr. Madden explains. "They might not want to tell their parents they're smoking so the Web is a good place for them to learn about quitting while retaining confidentiality."

Dr. Prashant Gagneja, chair of the pediatric department at OSHU School of Dentistry, says dentists are a tool, but parents still have the greatest impact on their kids' tobacco use. "It doesn't do any good for me to talk to a child about smoking prevention if a parent is smoking."

"Adolescents are the fastest-rising group of tobacco users," says Carol Southard, who leads the smoking cessation initiative for the American Dental Hygienists' Association.

The ADHA launched a Web site for dental professionals at "www.askadviserefer.org", which provides news and resources aimed at helping patients quit tobacco use. At the Web site, dental professionals can order free credit card-sized cards with quitline information that serve as convenient handouts to patients.

The ADA Division of Legal Affairs points out that applicable state law will govern permissible roles of dentists in tobacco-use cessation counseling. ■

Tobacco

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copies of our brochures through a variety of channels—numbers that most youth smoking prevention programs can only dream about."

Philip Morris has placed paid advertisement inserts promoting the free parent brochures and tip sheets in their "Raising Kids Who Don't Smoke" series in a variety of health trade publications, including the November 2006 Journal of the American Dental Association.

Dr. Scott L. Tomar raised an objection to the insert in a letter to JADA Editor Michael Glick.

"Philip Morris' advertising campaign focuses on peer influence, parental factors and commercial access being the primary influences on youth smoking initiation, rather than tobacco industry marketing, inaccurate risk appraisal, price and other factors known to influence youth smoking," wrote Dr. Tomar, professor and chair, Department of Community Dentistry and Behavioral Science, University of Florida College of Dentistry. He opined that, "The available evidence suggests that not only is this tobacco industry campaign not effective in reducing youth smoking, it was associated with lowering youths' perceived harm of smoking."

Even The New York Times has weighed in recently on the issue. An editorial in its Nov. 27, 2006, issue, states, "Philip Morris says it has spent more than $1 billion on its youth smoking prevention programs since 1998 and that it devised its current advertising campaign on the advice of experts who deem parental influence extremely important. But the company has done only the skimpiest research on how the campaign is working. …

"Philip Morris, the industry's biggest and most influential company, is renowned for its marketing savvy," the Times editorial adds. "If it really wanted to prevent youth smoking—and cut off new recruits to its death-dealing products—it could surely mount a more effective campaign to do so."

In a published response to the editorial, Jennifer Hunter, vice president, Youth Prevention and Corporate Responsibility Programs for Philip Morris USA, said, "We understand the skepticism regarding how a tobacco company can be serious about preventing youth from smoking, but our business is grounded in competing for the largest share of the adult tobacco market. As a business and as parents, we don't want kids to smoke, and when society feels that we behave otherwise, it actually harms our business. … While we have serious concerns about the design and conclusions of the study cited in your editorial, the study does highlight the need for continued understanding of how parent-directed youth smoking prevention advertising affects youth. We intend to pursue this issue and to engage with relevant experts to identify opportunities to improve all youth smoking prevention efforts, especially our own." ■