11-5-2007

ADA News - 11/05/2007

American Dental Association, Publishing Division

YOUR DENTAL ADVOCATE

Your Dental Advocate, inside between pages 10-11

AMERICAN DENTAL ASSOCIATION

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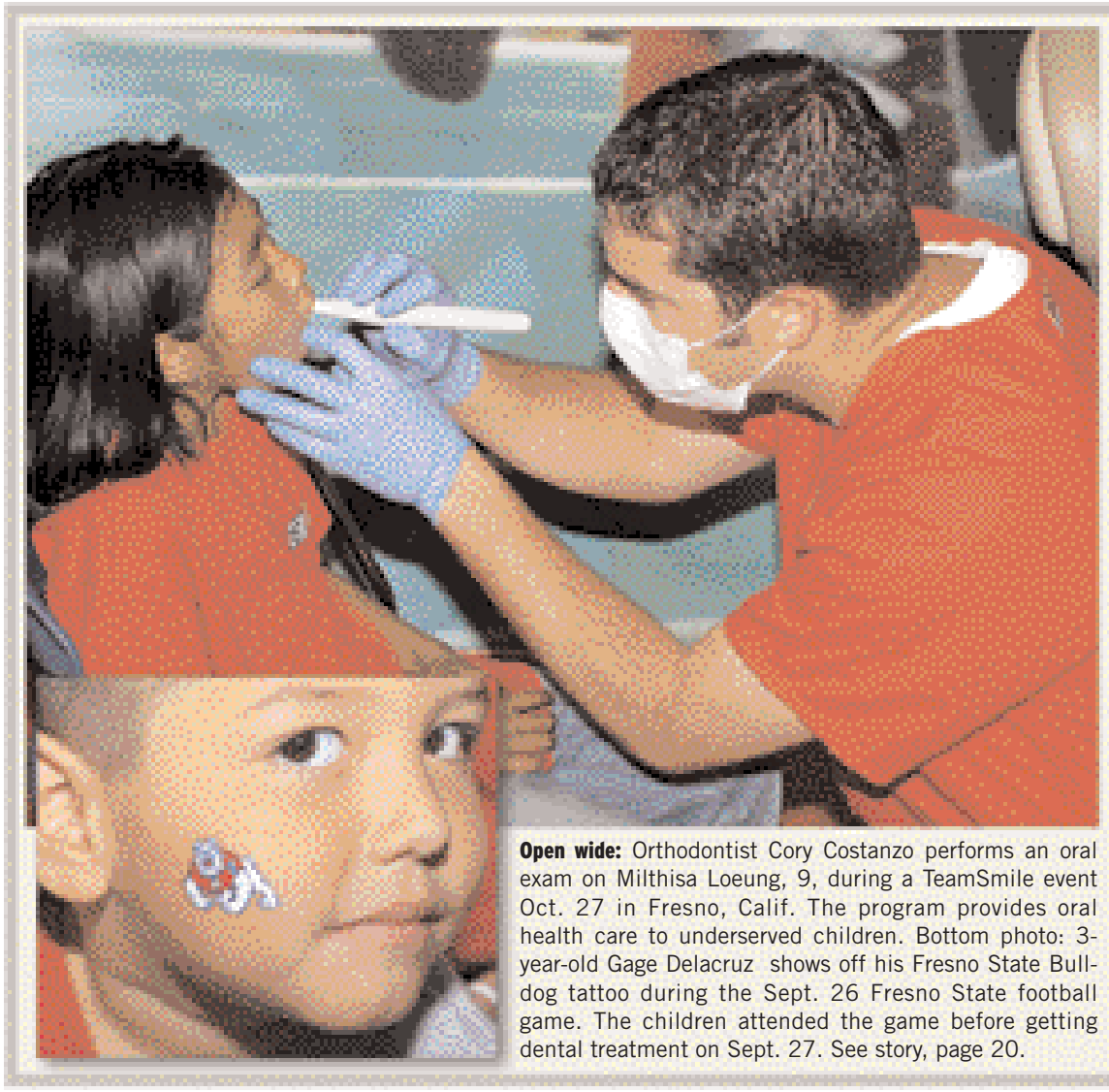
ADA NEWS®

NOVEMBER 5, 2007

VOLUME 38 NO. 20



Open wide: Orthodontist Cory Costanzo performs an oral exam on Milthisa Loeung, 9, during a TeamSmile event Oct. 27 in Fresno, Calif. The program provides oral health care to underserved children. Bottom photo: 3-year-old Gage Delacruz shows off his Fresno State Bulldog tattoo during the Sept. 26 Fresno State football game. The children attended the game before getting dental treatment on Sept. 27. See story, page 20.

Workforce efforts continue

Community Dental Health Coordinator development under way

BY KAREN FOX

San Francisco—Thanks to the House of Delegates, the ADA's workforce committee will continue its efforts to develop a new dental team member who will function as a community health worker with dental skills in an integrated dental care system.

The Community Dental Health Coordinator's duties will include oral health assessment, promotion of good oral health, preventive services, palliative care and patient navigation.

Vendor Showcase to launch in 2008, page eight

Resolution 54H-2007 provides funding for the Workforce Models National Coordinating and Development Committee to launch pilot programs for the CDHC.

The resolution was presented to the House with no opposition, leaving NCDC Chair Bob Brandjord "elated."

"The support from the House tells us we're on the right track for what is needed to help people in underserved areas get access to oral health care," said Dr. Brandjord, a past ADA president.

Community Dental Health Coordinators are seen as mid-level allied dental personnel who will work in underserved areas where residents have limited or no access to dental care. CDHCs will work as a member of a

See WORKFORCE, page 25

BRIEFS

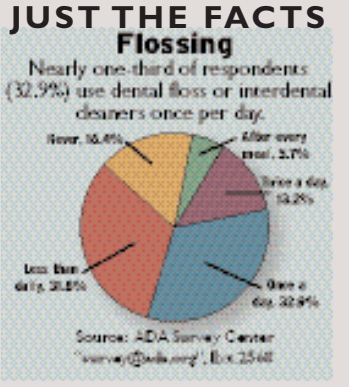
Dental residencies: At press time, the ADA News learned that a lawsuit has been filed (United States of America ex rel Allen Hindin v. UC San Francisco, UCLA, Univ. Fla., et al) under the Federal False Claims Act (the whistleblower law), alleging that 26 dental schools falsely applied for and received graduate medical education funding even though they didn't provide hospital-based dental programs, which Dr. Hindin contends the funding statute required.

The case was originally filed

under seal in 2000, but on May 4 the U.S. District Court for the Eastern District of New York unsealed the case so the amended complaint and other filed documents became public. Docket sheets indicate that summons were issued to defendants in September. The 105-count lawsuit—if the allegations are found to be true and if all of them were to be upheld—could potentially involve millions of dollars in returned payments, damages and fines.

The ADA News will provide further coverage in the Nov. 19 issue. ■

JUST THE FACTS



Anesthesia guidelines updated

Town hall meetings part of outreach to practitioners across the country

BY KAREN FOX

San Francisco—The 2007 House of Delegates last month overwhelmingly (92 percent) supported changes to the ADA anesthesia guidelines documents proposed by the Council on Dental Education and Licensure and its Committee on Anesthesiology.

"We began this process with a number of critical comments regarding the changes but in the end, the delegates recognized that the proposed changes would bring the ADA's anesthesia guidelines in line with other dental and medical organizations," said Dr. Frank Maggio, chair of the Council on Dental Education and Licensure.

Dr. Maggio attributed the approval of Resolutions 2H-2007 and 3H-2007 to improved communication with the communities of interest.

"The committee under the direction of Dr. Guy Shampaine held three different town hall meetings to explain the changes and address peoples' concerns, and I think that was quite beneficial to this process," Dr. Maggio said.

Prior to the 2007 House of Delegates meeting, committee members held a "Proposed Sedation and Anesthesia Guidelines: Q&A" at the ADA annual session and similar Q&A seminars at the annual meetings of the Academy of General Dentistry and American Association of Dental Examiners.

The House's actions officially revise the Association documents, "Guidelines for the Use of Sedation and General Anesthesia by Dentists," "Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students" and the "Policy Statement: The Use of Sedation and General Anesthesia by Dentists."

Changes had been in the works since 2005 when the House supported the Committee on Anesthesiology's comprehensive review of anesthesia guidelines documents and policies to bring them up to date and in line with other dental and medical organizations that had recently made significant changes to their documents.

The House made only two changes

See ANESTHESIA, page 25

House actions posted online

The ADA House of Delegates met Sept. 28-Oct. 2 during the annual session in San Francisco.

For a comprehensive listing of 2007 House of Delegates actions (unofficial), annual reports, Board reports and resolutions, visit ADA.org on the Internet at "www.ada.org/goto/hod" (members only section). ■

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ADANEWS
(ISSN 0895-2930)

NOVEMBER 5, 2007 VOLUME 38, NUMBER 20

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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Volunteers needed for Honduras mission trip

Eden Prairie, Minn.—International Health Service is seeking volunteers, including dentists, to join its annual two-week mission trip to Honduras in February 2008.

Dr. Richard Nelson, a retired general dentist in Rushford, Minn., serves as dental director for the program. He says an oral surgeon friend encouraged him to go on a trip 16 years ago, "and I've been doing it ever since. It sounded like something I wanted to do."

The father of three daughters, Dr. Nelson says he's also made the annual trips a family affair, as each of his daughters also have served on mission trips.

"I have been to Honduras for the past 16 years, Katy has gone with me three times, Trisha has gone once, and my daughter Suzy has also gone three times. They all agree that it has really changed their lives, as it has mine."

International Health Service is a nonprofit international relief organization that provides medical assistance to the people of Honduras. Founded 26 years ago, IHS now has approximately 120 medical, dental and support volunteers participate in the February mission.

"It's an extremely worthwhile experience," he adds. "We help genuinely needy people. So many times I hear fellow dentists say they want to help, but don't think they can take time away from their practice. A 16-day commitment is not the end of the world, that's for sure. And you get back so much more than you give."

For more information or to submit a volunteer application, contact Dr. Nelson at 1-507-864-2420 or "rlnelson@acegroup.cc". The Web site is "www.ihsofmn.org". ■

ViewPoint

MyView

What happened to direct reimbursement?

Michael D. Fisher, D.D.S.

A dentist recently asked me, "Why has the reported yearly number of direct reimbursement dental plan sales gone down?" Good question. Here are the reasons and some optimistic observations.

Direct reimbursement is a dental benefit plan that reimburses a patient's dental care expenses based on the dollar amount of these expenses, rather than the types of procedures performed by the dentist. DR provides a simple, easy-to-use dental benefit that permits patient choice while controlling dental benefit costs for the employer.

As of 2006, the ADA has noted 4,187 dollar-based dental plans, covering 1,430,100 employees and dependents. These DR participants spent an estimated $425 million on dental care and represent slightly less than 1 percent of the dental benefits marketplace.

Why only 1 percent? There are three general marketplace reasons:

1. Conventional, procedure-based dental plans were based on the medical indemnity benefit model. Dental is different than medical, but this inefficient benefit system persists. Why? Procedure-based dental plans have convinced employers that they need protection from dentists and employees. These plans are seen as the source of dental plan products, information and marketing. This dominance influences the dental benefits sales force:

• Brokers who sell dental benefits depend on dental plan providers for marketing, commissions, bonuses, overrides and "trips to Maui." Although DR offers competitive commissions, it does not provide this extra compensation and support. DR dental benefit dollars go toward dental care.

• Consultants who advise large employers on dental benefit choices are paid to manage complexity. Direct reimbursement has no complexity to manage; procedure-based plans do.

Dollar-based dental benefits are still the gold standard when it comes to simple, transparent, cost-effective dental plans.

• It is hard work to sell a unique dental plan like DR. Some benefit advisors are willing to do this, many are not.

2. Medical insurance is expensive in time and money. These demands on employers have made dental benefits the "maybe next year" topic, as in, "Maybe next year we will look at something different."

3. Everyone loves a deal. Can you really get one with professional services? The discounted-fee network dental plans have convinced employers there is no difference between full-fee and discounted-fee dental care. Discounts have become the expectation for employers.

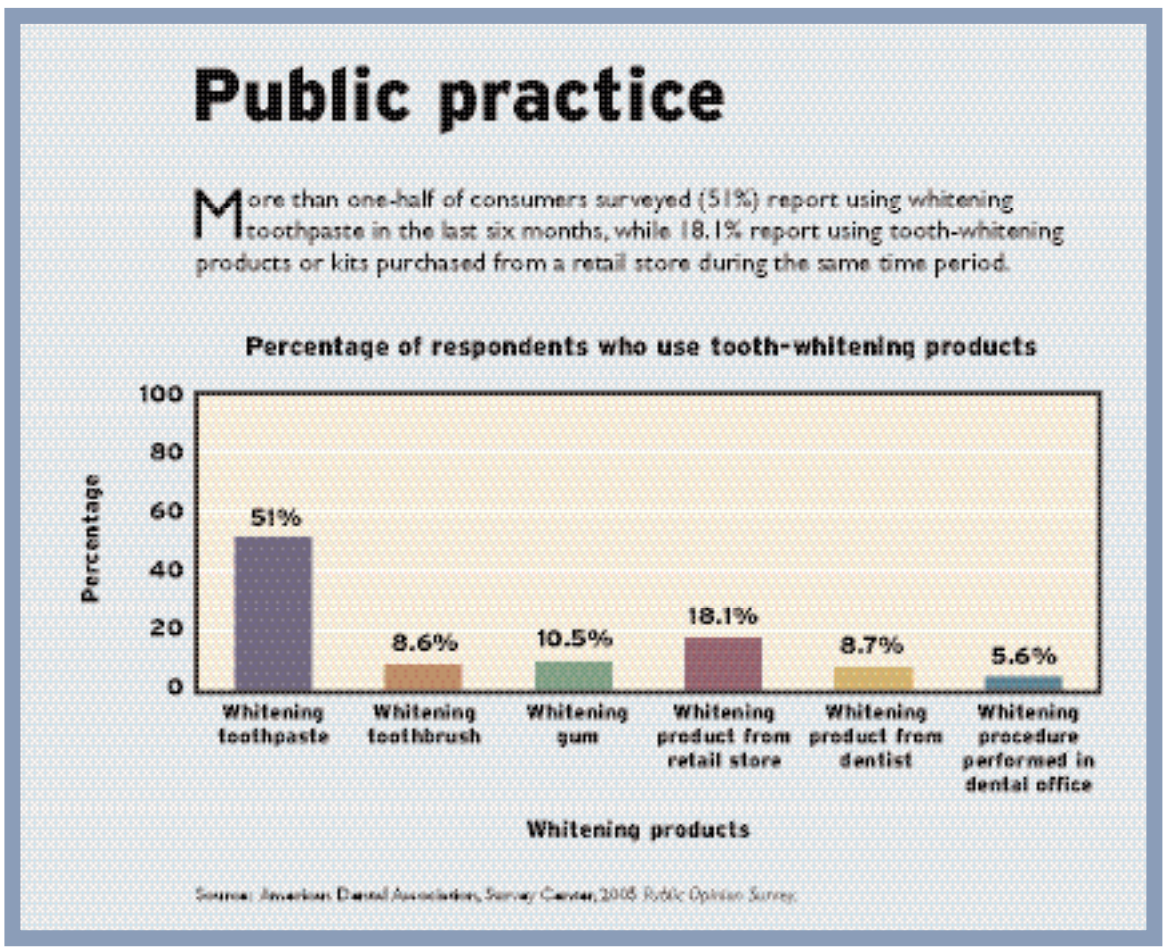
There are five DR-related reasons for the 1 percent market share:

See MY VIEW, page five

LettersPolicy

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

SNAPSHOTS OF AMERICAN DENTISTRY



Letters

LEAT clause

The Sept. 17 ADA News article "ADA/NADP Share Views on the Least Expensive Alternative Treatment Clause" states that if an alternate benefit is applied by the insurer, the dentist can then charge the copay on the LEAT plus the difference up to the negotiated fee.

This seems incorrect. If an alternate benefit is applied, the dentist should be allowed to charge their full fee.

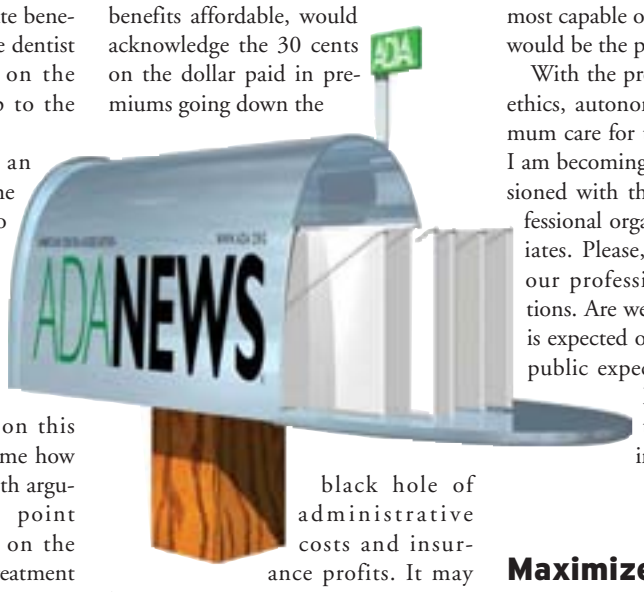
Paul H. Williams, D.D.S.
Mechanicsburg, Pa.

Optimum care

Reading the perspectives on this issue only serves to clarify for me how convoluted things get when both arguments miss a vital point ("ADA/NADP Share Views on the Least Expensive Alternative Treatment Clause").

Least expensive/most expensive are immaterial to the diagnosis. What are clinically the best alternatives for care can only be determined by the dentist (or "servicing provider" as the National Association of Dental Plans refers to us) and the responsible person or "patient" as we often call that person.

Why the ADA continues to give any legitimacy to third party entities (or "insurance companies" as we know them) by giving them space in any of our publications is confounding. They are not part of the profession, they are not licensed to practice dentistry, and if they were truly interested in keeping benefits affordable, would acknowledge the 30 cents on the dollar paid in premiums going down the



black hole of administrative costs and insurance profits. It may be more.

In truth, dental insurance is not indemnity insurance, but a tax-deferred benefit program, from which the insurance company takes their cut under the pretext that they know better than anyone else how to manage the dollars spent for dental care. When care is sought, the individual must seek the blessing from the carrier that does not know them, has no responsibility in the clinical outcome and is only concerned with their own bottom line. Direct reimbursement, medical savings accounts, cafeteria plans, etc. make total sense. The control of what is spent is in the hands of the individuals most capable of making choices, which would be the person receiving care.

With the profession's concern about ethics, autonomy and providing optimum care for the people that trust us, I am becoming more and more disillusioned with the direction of our professional organization and their affiliates. Please, let's look at ourselves, our profession and our organizations. Are we truly living up to what is expected of us? My fear is that the public expects and thinks less and less of us. I also fear that slowly we are earning that opinion.

James Craig, D.D.S.
Lenexa, Kansas

Maximize education

I would like to comment on the editorial written by Dr. Peter Rouff ("A Residency Made Me a Better Dentist," Sept. 17 ADA News) and the comments made by Dr. Jason M. Campbell ("Letters," Oct. 15 ADA News). I am in complete agreement to what Dr. Campbell has to say in his letter. Residencies are good for some students. Not all students need

See LETTERS, page five

MyView

Continued from page four

1. Three direct reimbursement plan administrators are no longer in business—reducing the sales outlets, but not capacity, for DR.

2. Dental association promotion of DR has seen reduced budgets and staffing.

3. Traditional marketing and advertising have become less effective.

4. A self-funded dental plan without "insurance" is still a labor-intensive sale.

5. Dollar-based dental plans have changed before our eyes. The increased use of flexible spending account, health reimbursement arrangement and health savings account plans means consumers have used DR-like benefits to pay health expenses, including dental. These benefits are in your practice today—you just do not know about them.

Is it time to quit on DR? No. Dollar-based dental benefits are still the gold standard when it comes to simple, transparent, cost-effective dental plans. Why be optimistic?

1. The growth of consumer-directed health plans tells us that dollar-based employee benefits are here to stay. There are new, creative methods to use pre-tax dollars for dental care expenses that offer savings and flexibility that the 50-year-old conventional dental plan cannot provide.

2. Focused marketing will get the message of dollar-based dental benefits out to brokers and employers. The Consumer Directed Benefits Association ("www.consumerdirectedbenefits.org") is a group of administrators, benefit brokers, consultants, dentists and others who promote dollar-based dental benefits. CDBA members can help bring the DR message to employers in your area.

3. The dental practice is vital to the dollar-based dental benefit sales process. Your expertise is disease prevention and quality restorative care. It is time to gain some expertise in the economic part of dental practice. We should no longer lose DR sales because of lack of understanding or support from dental practices.

Roger Schultz, Certified Life Underwriter, a pioneer in the development of direct reimbursement, reports that he sees no lack of interest in DR in his employee benefits practice. His new clients come to DR because of its simplicity and absence of networks. Dollar-based dental benefits are a great way for employers to introduce consumer-directed health benefits to employees.

The simplicity of the dollar-based dental benefit permits you, the dentist, to provide individualized dental care for your patients. Dentistry has an opportunity to be on the leading edge of the health care consumer movement. With your help, employers can learn about the original consumer-directed dental plan. Don't more people deserve the best of what direct reimbursement can offer?

Dr. Fisher is an Aurora, Colo., dentist, CEO of Dental Ingenuity, a member of the Consumer Directed Benefits Association and author of a book on direct reimbursement.

Editor's note: For information on direct reimbursement, visit "www.ada.org/goto/dr".

Letters

Continued from page four

to participate in a residency program.

I had the good fortune of attending the University of Pittsburgh School of Dental Medicine. At Pitt I had the opportunity to place and restore dental implants. Every Tuesday morning at 7 a.m. students had the opportunity to attend implant case presentations given by periodontal, prosthodontic and oral surgery residents. The case presentations were a great learning opportunity for undergraduate dental students. I also spent many hours in the oral surgery clinic learning from some of the best clinicians and residents.

The University of Pittsburgh also trained me in rotary endodontic instrumentation. This was a required course in order to graduate. Many of my classmates were able to use the rotary system to clean and shape canals.

I participated in the school's community outreach program where I was able to set up a weekly rotation at a rural dental clinic. At the clinic I was able to see up to 10 patients per visit. This was a great experience for me.

Like Dr. Campbell, I also had two beautiful daughters and a wife who gave birth to our third daughter two weeks before graduating from school. Because I was able to take advantage of the great opportunities that the University of Pittsburgh afforded me, I felt completely prepared to enter into the world of private practice.

It is imperative that students be aggressive in obtaining their education. Students should be actively involved in externship opportunities. Prospective students should carefully research the schools they are attending. Courses such as rotary endodontic instrumentation, dental implants, advanced surgical techniques, etc. should be offered. If they are not, the student is not receiving a comprehensive education.

Being in private practice has been refreshing. Working with an experienced doctor has been rewarding. Helping patients maintain their oral health has been gratifying. Being part of a cohesive dental team has been exciting.

I encourage all dental students to be aggressive in their education. Maximize your exposure to all aspects of dentistry. Seek out externships. Prepare yourself for private practice. Graduate from school, find a mentor and get on with life. Four years is more than enough time to gain the necessary skills if you work hard.

Daniel S. Malan, D.M.D.
Boise, Idaho
University of Pittsburgh School of Dental Medicine
Class of 2007

Third parties

It is pretty basic that dental plans have the contractual right to substitute a least expensive alternative treatment in lieu of the provider's recommended treatment ("ADA/NADP Share Views on

See LETTERS, page six

Dr. Frankl, longest serving dean, dies at 73

BY KAREN FOX

Boston—Dr. Spencer N. Frankl, dean of the Boston University Goldman School of Dental Medicine and the longest serving dean of any dental school in the country, died Oct. 20 after a battle with cancer.

Boston University is remembering Dr. Frankl as a leader who over the course of four decades expanded the school's degree programs and oversaw curriculum revisions to keep the school at the forefront of research, education and technology.

"He will truly be missed," said Dr. Jeffrey W. Hutter, BU senior associate dean and chair of the ADA Commission on Dental Accreditation. "He was an inspiration to us all and always brought out the best in each of us. I have told our students who have expressed their condolences to me that Dean Frankl will live on within each of them, and thus they should strive to do as well as they can in their studies and their chosen profession."

Dr. Frankl is credited with helping to sharpen the school's focus on experiential learning and community involvement through partnerships that offered care to the city's low-income, underserved populations. Grants received under his leadership funded national research on health disparities and helped train minority dentists.

Colleagues at BU remember Dr. Frankl as a leader always willing to face new challenges and embrace change, and whose vision became a model for dental education.

Dr. Frankl

President Emeritus John Silber, Ph.D., said Dr. Frankl "emphasized the pursuit of excellence in advanced medical research and in the compassionate care for patients."

"Spencer's deanship was notable for his unrelenting and highly successful efforts to build the research capabilities of the School of Dental Medicine and to integrate its program into Boston Medical Center," added Dr. Silber.

For the past 20 years, the dean spent one hour each day walking around the school talking to students, professors and patients, director of administration Kathleen Ferland told the BU Daily Free Press.

"It was part of his daily schedule as a dean," said Ms. Ferland. "He got to know people and learn about things to change in the dental school."

Dr. Frankl graduated from Temple University School of Dentistry in 1958 and completed his training in pediatric dentistry at Children's Hospital Medical Center in Washington, D.C., and a postdoctoral fellowship at Tufts University.

In 1964, he was recruited by founding dean Dr. Henry M. Goldman to develop Boston University's department of pediatric dentistry.

As associate dean at the dental school, Dr. Frankl initiated, planned and developed the DMD program, which began in 1972. He secured a $1.1 million federal construction grant to enlarge the school's physical plant to accommodate the program, and in 1977 became dean of the Goldman School of Dental Medicine and deputy director of Boston University Medical Center.

During his tenure as dean, the school's physical space more than doubled and there have been numerous facility upgrades, including the 2003 renovation of the predoctoral patient treatment center. The school's extramural programs now include more than 100 affiliates and partners.

In 2002, the Goldman School of Dental Medicine launched a $2 million campaign to establish the Spencer N. Frankl Chair in Dental Medicine to celebrate the 40th anniversary of the school and Dr. Frankl's 25 years as dean. The chair was fully endowed this year. The school has also established the Dean Spencer N. Frankl Scholarship to honor his more than 40 years of service and intends to raise $1 million for that fund.

Dr. Frankl, 73, is survived by his wife of 52 years, Rhoda, two daughters, two sons-in-law and three grandchildren.

Memorials in his name may be made to the Dean Spencer N. Frankl Scholarship, Boston University Goldman School of Dental Medicine, 100 East Newton, Boston, MA 02118; or the Brain Tumor Research Fund, c/o Dr. Patrick Wen, Dana Farber Cancer Institute, 44 Binney Street, Boston, MA 02115. ■

Letters

Continued from page five

the Least Expensive Alternative Treatment Clause," Sept. 17 ADA News).

To dentists offended because they must either abide by the plan's edict or convince the patient to pay the difference for "their" recommended treatment, the option remains to go non-par.

Years ago I would tell patients to go to another dentist when they wanted a denture rather than the fixed work I thought was best. I quickly learned that they actually went to the "other dentist," and the "other dentist" got to do the work I could have just as well done.

In my opinion, we have now become the very outgrowth of the environment we created by allowing third parties to compromise the dentistry we would think best. The only virtue we have left to defend is that of being honest about the work we do for our patients. If we ever begin to compromise honesty, we will truly become a second-rate profession.

Lloyd Wallin, D.D.S.
Burnsville, Minn.

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ADA Vendor Showcase to launch in January

Will offer product discounts, rewards, surveys

In January 2008, the Association will launch the ADA Vendor Showcase, a service for members and subscribers to receive special dental product offerings, discounts, rewards and survey requests, all provided via e-mail.

Those who opt into the ADA Vendor Showcase will receive three messages each month—36 in all in 2008, never more than one per week—with various offers in products and services, many of them exclusive to ADA Vendor Showcase participants.

The ADA assures participants that e-mail addresses will be kept in strictest confidence and never shared with a third party, in keeping with the Association's privacy policy.

"The ADA works with many companies offering products and services to help our members run their practices," said Dr. James B. Bramson, ADA executive director.

"Given the popularity of the annual session exhibits," he said, "we wanted to offer our members an opportunity to receive more information about products and services from our exhibitors as well as from companies that support ADA publications and other projects."

Each e-mail in the ADA Vendor Showcase will include special product offers, announcements, other special offers and surveys that link to a manufacturer.

A typical survey would ask dentists 10 to 20 questions about product usage and purchasing habits. Dentists who completed the survey might be eligible to win free products or gift cards.

To sign up for the ADA Vendor Product Showcase, even if you've already provided the ADA with your e-mail address, contact the Association at "www.ada.org/goto/vendorshowcase".

Also, each month, members who have supplied the ADA with their e-mail addresses will receive an update on ADA activities, including forthcoming features in The Journal of the American Dental Association.

This information, provided through the ADA Monthly Update, will include a link to information on the ADA Vendor Showcase and, in turn, links to the Web pages of participating manufacturers and suppliers. ■

Enter in New York to win trip to session

Visit the ADA booth at the Greater New York Dental Meeting Nov. 23-28 and enter to win a trip to ADA annual session in San Antonio Oct. 16-18, 2008.

The trip will include two roundtrip tickets from anywhere in the Continental U.S., four nights of hotel accommodations and two tickets to attend annual session. Winners will be notified by Dec. 4.

While there, check out new ADA products at discounted prices and member services. It's all at ADA Booth #315. ■

CORRECTION

Dr. Jeryl English, chair of the orthodontic department at the University of Texas Dental Branch at Houston, was pictured in a groundbreaking ceremony photograph taken at the University of Texas Health Science Center-Houston Aug. 30 and published in the Oct. 1 ADA News.

Dr. English participated in the ceremony as honorary representative of his friend, Dr. R.G. "Wick" Alexander, who donated $1 million for construction of the new dental school building.

In the caption, Dr. English was misidentified as the university's president. The ADA News regrets the error. ■

ADA and OralCDx

Oral cancer awareness messages are coming to newsstands nationwide

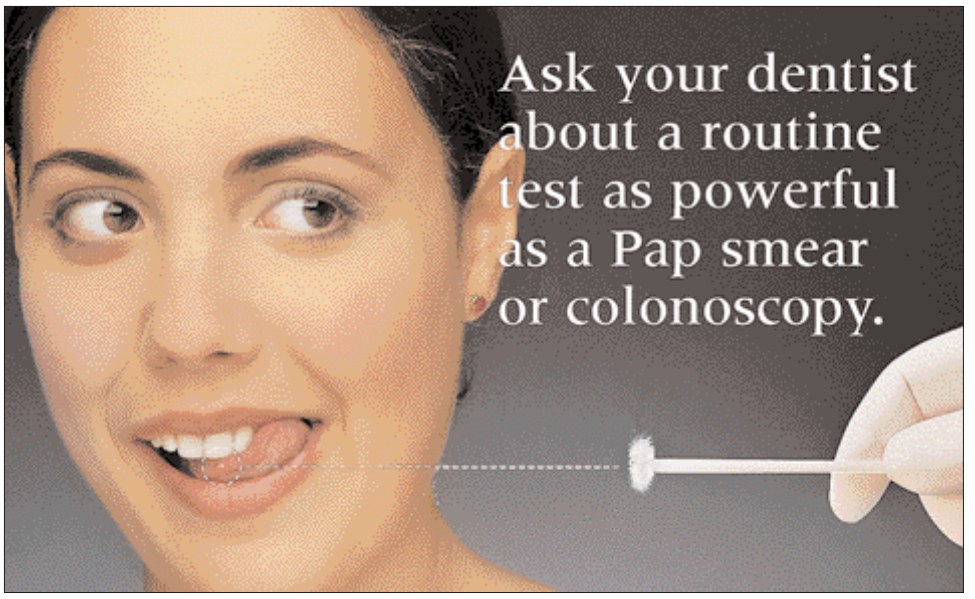
The ADA in collaboration with OralCDx Laboratories is embarking on a three-year nationwide public service campaign to boost public awareness of oral cancer and spotlight the dentist's role in the early detection of this often deadly disease.

Print public service announcements began appearing last month in Women's Day, More, People, Essence, Prevention and other nationwide monthly and weekly consumer news, lifestyle and health magazines. Over the course of the campaign, other media including newspapers, outdoor and electronic media will be added.

The ADA is involved in this campaign for two main reasons: oral cancer can be detected early and if so, it will save lives; and patients should see their dentist so appropriate treatment recommendations can be made.

See the Nov. 19 ADA News for more information on the campaign, or go to "www.ada.org/public/topics/cancer_oral.asp".

Resources will note that OralCDx Laboratories is underwriting the campaign, and will include a disclaimer stating that the ADA does not endorse any specific product in connection with the campaign and has no financial interest in the product featured here. ■



See your dentist: One of several images that began appearing in consumer, health and lifestyle magazines and other media last month.

Radiology meeting to convene this month

The American Academy of Oral and Maxillofacial Radiology will hold its 58th annual session in Chicago Nov. 28-Dec. 2.

"The recurring Chicago meeting is one of our academy's most popular," says Dr. Michael K. Shrout, executive director of the AAOMR.

The purpose of the academy is to promote and advance the art and science of radiology in dentistry, and to provide a forum for communication and professional advancement among its members. The meeting is an opportunity for knowledge exchange through continuing education, the presentation of papers and posters and other scientific seminars.

"The Saturday continuing education program, centered around discussions of cone-beam CTs, will be interesting to general dentists and specialists alike," said Dr. Shrout.

This year's annual session is scheduled to allow attendance at the Radiological Society of North America's annual session, also in Chicago, Nov. 25-30.

Courses will include two continuing education courses, one on molecular imaging and another on head and neck radiographic anatomy, and two scientific sessions on abstract presentations of leading-edge research in radiology.

In addition, the popular Clinico-Radiologic Conference will again be presented, a highly interactive discussion of diagnostically challenging cases. New this year will be a full-day CE course on 3-D dental imaging, with an emphasis on cone-beam CT (computed tomography) in diagnosis and image guidance of treatment.

For more information, contact Dr. Michael Shrout, executive director, AAOMR, P.O. Box 1010, Evans, Ga., 30809-1010 or visit the Web site at "www.aaomr.org". ■

Global EBD

ADA and JEBDP to host 3rd international conference in May

The Journal of Evidence-Based Dental Practice and the ADA will host the 3rd International Conference on Evidence-Based Dentistry: "Managing Dental Health in a Connected World," May 4 at ADA Headquarters. The conference is sponsored by an educational grant from Procter and Gamble.

The conference will explore the dissemination of evidence-based information with an emphasis on Clinical Decision Support and will be held following the first EBD Champion Conference May 2-3.

CDS provides clinicians, staff, patients or other individuals with knowledge and person-specific information filtered and presented at appropriate times to enhance health care.

"Clinical Decision Support tools and products are being developed and they will be widely used in the future," said Dr. Michael Newman, JEBDP editor. "CDS is an essential resource that will make it easier for dental practitioners to keep up to date."

Jonathan Tiech, co-author of the white paper "A Roadmap for National Action on Clinical Decision Support," and Mary Anne Hochadel, editor and chief, Gold Standard, will deliver the keynote addresses.

Other speakers are:

• Dr. Phillipe Hujoel, University of Washington and JEBDP, "Converting Science into Art: The Challenge of the Translationists";

• Dr. Janet Clarkson, The Cochrane Library, "Dissemination of Cochrane Resources Beyond the Library";

• Claudia Luciak-Donsberger, Ph.D., Vienna, Austria, "From Information to Action: Empowering Patients with Information to Improve Outcomes";

• Dr. George Merijohn, private practice dentist, "The Practicing Clinician's Perspective";

• Susan Griffin, Ph.D., and Dr. Barbara Gooch, Centers for Disease Control and Prevention, "Dissemination of Important Information in an EB World Example—Dental Sealants";

• Dr. Robert Ahlstrom, member, ADA National Health Information Infrastructure Task Force, "Practical Integration into the Health Care System by Dentistry";

• Anne Johnston, Gold Standard, "Increasing the Safety and Cost-Effectiveness of Medication Use Through Clinical Decision Support."

• Dr. Newman and Dr. Daniel M. Meyer, senior vice president, ADA Division of Science, will provide closing remarks.

"There is a gap between the most current evidence-based health knowledge and the information that is typically applied in making health care decisions," said Julie Frantsve-Hawley, Ph.D., director of the Research Institute and Center for Evidence-Based Dentistry. "Dissemination of evidence-based information through CDS is a necessary and crucial step to close the gap."

The program is open to dentists, educators, professional society leaders, administrators, researchers, dental hygienists and dental representatives of companies who develop and market new EBD and CDS products and technologies.

Attendance for the conference is limited so if you're interested, please fill out an online application form that can be found at "www.ada.org/goto/ebdconf". Applicants will be notified in February. Deadline for the applications is January 15.

For more information, call the toll-free number, Ext. 2519. ■

MRSA questions?

CDC fact sheet, ADA infection control guidelines available online

The ADA has received questions from dentists about what to tell patients concerned about methicillin-resistant *Staphylococcus aureus*, a bacterium that causes serious antibiotic resistant "staph" infections in different parts of the body.

MRSA has been in the spotlight since Oct. 15, when a Virginia high school senior died after the infection spread to his kidneys, liver, lungs and heart.

The Association urges dentists with questions about MRSA to consult the Centers for Disease Control and Prevention Web site at "www.cdc.gov/ncidod/dhqp/ar_mrsa.html".

There, doctors will find an updated MRSA fact sheet as well as information on MRSA in health care settings.

The ADA advocates the use of infection control procedures in dental practice and has provided dentists with resources to help them implement the procedures. The ADA worked with the CDC to develop the CDC's infection control recommendations for dentistry, which were updated in 2003.

To see the guidelines, visit "www.ada.org/prof/resources/topics/cdc/index.asp#guidelines". You can also call the ADA Division of Science at the toll-free number, Ext. 2878. ■

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Care on the U.S.S. Comfort

Dental team plays major role on Navy humanitarian mission

BY CRAIG PALMER

Washington—Dentistry "played a major role" in the U.S. Navy hospital ship Comfort's four-month humanitarian mission to Central America, South America and the Caribbean, say members of the dental team.

By one estimate, dental staff treated more than 25,000 patients during deployment, many lining up well in advance of the dental staff's arrival, a 5-year-old Peruvian waiting in line with his father for three days and an 8-year-old boy in Nicaragua, "badly in need of dental treatment" and his mother home sick, awaiting his turn in 110-degree heat. The mission departed Norfolk, Va., June 15, "on a new initiative to provide oral care to the region's poor" as described by President Bush in a March 5 Western Hemisphere policy speech.

A team of Air Force medics reporting from the Comfort in August said the staff had already performed 18,110 dental procedures.

Part of a comprehensive health care mission, dentistry participated with the support of military and public health general and specialty care dentists, American and international, dental auxiliaries, private sector and military dental supplies and equipment and local dentists in several countries. DENTSPLY, through the American Dental Association, donated 165 Delton sealant kits. "As a dental manufacturer, DENTSPLY was pleased to assist the U.S. Navy and the Public Health Service in their humanitarian efforts to improve the oral health of the children of Central America," said Bret Wise, chief executive officer.

Dr. Joseph Rusz, a Navy captain, commanded a dental department aboard the Comfort that included five general dentists, an oral and maxillofacial surgeon, four dental hygienists and 12 dental assistants supplemented by four consecutive teams of U.S. Public Health Service dentists and dental hygienists serving one month each and Canadian Forces Dental Service teams. Dr. Rusz is stationed at the Pentagon.

"Dental services played a major role in the care rendered during this operation and were delivered by a unique multiservice and international team," he told the ADA News. "Host nation dentists and assistants augmented our staff in some countries and provided a chance to exchange ideas and treatment philosophies. Dental disease activity varied greatly among and within countries. Services provided were comprehensive, including operative dentistry, routine and complex extractions, nonsurgical periodontal treatment and palliative care."

"When I heard that the mission was a humanitarian one, and that these countries specifically requested dental services, it was an easy decision to volunteer," said Dr. Sandra Shire, a PHS dentist. "One of the most interesting aspects to the

ADA names council chairs for 2007-08

The ADA Board of Trustees at its September meeting approved the new council chairs for 2007-08, as follows:

- Council on Access, Prevention and Interprofessional Relations, Dr. Lindsey A. Robinson;
- Council on ADA Sessions, Dr. Dennis A. Shinbori;
- Council on Communications, Dr. Larry D. Herwig;
- Commission on Dental Accreditation, Dr. Jeffrey W. Hutter;
- Council on Dental Benefit Programs, Dr. Stephen J. Jaworski;
- Council on Dental Education and Licensure, Dr. Frank A. Maggio;
- Council on Dental Practice, Dr. Robert R. Shaw;
- Council on Ethics, Bylaws and Judicial Affairs, Dr. James F. Smith;
- Council on Government Affairs, Dr. Keith W. Suchy;
- Council on Membership, Dr. Pamela Z. Baldassarre;
- Council on Members Insurance and Retirement Programs, Dr. Maxine Feinberg;
- Council on Scientific Affairs, Dr. Michael P. Rethman;
- Committee on the New Dentist, Dr. Jennifer J. Barrington;
- Joint Commission on National Dental Examinations; Dr. Marsha A. Pyle. ■

Screening: Cmdr. Bob Smith (center), an HHS Commissioned Corps dentist, and Dr. Rusz (right) screen patients at Delfinas Rivas Escuela near Hacienda Santa Emilia, El Salvador.

mission was learning how these countries compensate for the shortage of providers."

Dr. Rusz said the mission put special emphasis on care for children and adolescents and featured such preventive services as pit and fissure sealants, education and fluoride applications, oral hygiene products and home care instruction.

By one estimate, dental staff treated more than 25,000 patients during deployment, many lining up well in advance of the dental staff's arrival.

"A creative array of sites posed special challenges to dental providers," he said. "Empty classrooms and community centers quickly became dental offices when mobile units, field chairs, lights and small portable suction units were set up."

Dental sites were organized in 32 locations in 12 countries also including Belize, Colombia, Ecuador, El Salvador, Guatemala, Guyana, Haiti, Panama, Suriname and Trinidad. Most dental care was offered ashore although the oral surgeons would bring complex cases aboard.

When dental care arrived, patients showed their appreciation. In Morales, Guatemala, where the heat index was 110 degrees plus, "people who had been in line since the previous day stood and clapped as we marched in with our supplies and equipment," said Master Sgt. Faith Elmore, a Kansas Air National Guardsman. "Everyone we treated left happier and in better dental condition," said Dr. Richard Tate, a lieutenant colonel in the Arkansas Air National Guard. ■

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Honored: Dr. Vincent Filanova, past chair of the ADA Council on Access, Prevention and Interprofessional Relations (standing, in green shirt), accepts an award May 26 from Tom Shamshak of the National Center for Missing and Exploited Children for CAPIR's "unfaltering devotion and continuing labors to protecting children."

IRS announces inflation-related tax provision changes

BY CRAIG PALMER

Washington—Inflation adjustments will widen tax brackets and change some pension plan limitations in 2008, the Internal Revenue Service said. Dollar amounts for certain tax provisions must be revised annually to keep pace with inflation.

The IRS in related announcements posted Oct. 18 at "www.irs.gov" said tax bracket thresholds increase for each filing status and dollar limits on many pension plan benefits and contributions will change for the 2008 tax year, in both cases reflecting cost-of-living increases. Changes affecting most taxpayers filing returns in 2009 are detailed in the notices IR-2007-171 and IR-2007-172 and Revenue Procedure 2007-66. ■

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Surveys, symposium target oral health literacy

BY STACIE CROZIER

San Francisco—When you talk with your patients about their oral health, are you sure they understand their oral health status and your instructions?

Do you feel equipped to communicate effectively with patients who might have oral health literacy challenges, like being elderly, having low income or educational levels, or having language barriers or special needs?Are dental schools addressing oral health literacy issues as part of their curricula and continuing education?

These are questions the ADA will seek to answer when it surveys dentists, dental team members and dental schools in 2008 to help identify the problems associated with oral health literacy.

AnnualSession

Building on the work it accomplished toward improving oral health literacy in 2006 and 2007, the ADA House of Delegates passed Resolution 16H-2007 last month. The resolution calls for the development, pilot testing, administration and analysis of a survey of dental team members about oral health literacy knowledge, attitudes and behaviors, as well as a survey of dental schools to determine how oral health literacy is addressed in their curricula and continuing education courses. Preliminary survey results will be reported to the 2008 House of Delegates.

Res. 16H is just one of the ADA's initiatives focusing on oral health literacy. During annual session, the ADA Council on Access, Prevention and Interprofessional Relations conducted a brief survey of dentists and dental team members on "Communicating with Patients." Results of the survey are expected in December.

This year the ADA also established its National Oral Health Literacy Advisory Committee, a diverse group of experts on health literacy from a variety of fields and disciplines. The NOHLAC, formed in response to Res. 17H-2006, is commissioned to assist CAPIR in all aspects of studying and promoting oral health literacy, serve as an informal conduit between the ADA and external organizations and institutions for oral health literacy activities, and advise the council and the ADA regarding oral health literacy policies, programs and research.

This month, the council will present "Oral Health Literacy: The Dental Profession's Response," at the American Public Health Association annual meeting. The interactive session will focus on what the oral health care team can do to reduce the information burden and more effectively communicate with dental patients and the general public.

The council is also planning a 1-1/2 day oral health literacy symposium at the 2008 ADA annual session in San Antonio.

"The ADA recognizes that health literacy touches the lives of everyone, from patient to health practitioner. That is why they have organized a cadre of experts for its National Oral Health Literacy Advisory Committee," said Alice Horowitz, Ph.D., advisor to the dean on health literacy at the School of Public Health, University of Maryland. Dr. Horowitz is a NOHLAC member. She recently endowed the Herschel S. Horowitz Center for Health Literacy and the Herschel S. Horowitz Endowed Chair for Health Literacy at UMD.

The health literacy endowments she has established honor her late husband. Dr. Herschel S. Horowitz, who died in 2003, was a pioneer in community-based health promotions like water fluoridation, topical fluorides and dental sealants. A public health specialist, educator and researcher, Dr. Horowitz served the ADA as a consultant and a fluoridation spokesperson.

"It's a logical fit with Hersh's professional commitments and it is a natural extension of his legacy," she said. "I am optimistic that with this endowment we can entice a gold standard person in health literacy and conduct world class research, education and training."

The Department of Community Dentistry at the University of Texas Health Science Center at San Antonio Dental School offers two behavioral science courses that integrate oral health literacy learning strategies, said Jane E. M. Steffensen, R.D.H., associate professor. Ms. Steffensen also has a Master of Public Health degree and is a certified health education specialist.

"The courses focus on patient-centered approaches that consider the social, cultural and behavioral dimensions of caring, including oral health literacy issues and applying strategies to meet the needs of patients with limited literacy," said Ms. Steffensen. "Students are taught about making dental offices patient friendly, using easy-to-read written material and improving interpersonal communications between clinicians and patients."

The dental school's preventive dentistry course, she adds, evaluates dental students' listening, interpersonal communication and counseling skills as a part of caries prevention and tobacco cessation in clinical practice.

"Increasingly, both educational institutions and professional organizations realize the need for students and professionals to be better prepared to provide oral health care to diverse individuals living in multicultural communities," she said.

Recent studies have shown that about one in 10 English speaking U.S. adults have proficient health literacy, leading to an estimated $2 billion in added health care costs each year.

The ADA defines oral health literacy as "the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate oral health decisions." ■

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Dental lab issues considered

BY ARLENE FURLONG

San Francisco—Many traditional products found in dental operatories in the U.S. are manufactured outside of its borders.

Resolution 6H-2007 seeks to find a way to notify dentists in advance when prostheses, components or materials indicated in the dentist's prescription are to be manufactured or provided, either partially or entirely, by a foreign dental laboratory or any ancillary domestic dental laboratory.

The resolution amends the Statement on Prosthetic Care and Dental Laboratories by adding the following new language before Glossary of Terms Related to Dental Laboratories in the Laboratory/Technician section:

"Notification of Prosthetic Cases Sent to Foreign or Ancillary Domestic Labs for Custom Manufacture: Constituent dental societies are urged to pursue legislation or voluntary agreements to require that a domestic dental laboratory which subcontracts the manufacture of dental prostheses notify the dentist in advance when such prostheses, components or materials indicated in the dentist's prescription are to be manufactured or provided, either partially or entirely, by a foreign dental laboratory or any domestic ancillary dental laboratory."

The state approach is consistent with current ADA policy on laboratory regulation and offers many advantages such as expediency and ability to create state-specific policy based on impact on members, including determining if the regulation should be voluntary or mandatory. One state, Missouri, offers its members a downloadable advance disclosure form on its Web site.

The National Association of Dental Laboratories believes that voluntary regulation will not be effective because there will be no means of enforcement. Rather, the NADL advocates that each state regulate dental labs through registration and/or certification of laboratories, laboratory technicians or both.

Dentists may not always be making the choice they think they're making when contracting dental laboratory services. Whereas the Food and Drug Administration has the legislative authority to regulate medical (including dental) devices through the Food, Drug and Cosmetic Act, the FDA does not require the registration of dentists or dental laboratories with respect to a dental prosthesis. Only the materials used are regulated and it is assumed by the FDA that only FDA materials will be used in the manufacture of prostheses. The FDA does regulate dental prostheses, by function, as follows:

• Registration. If a device is imported from overseas, the FDA requires the foreign exporter to register. The U.S. agent accepting the prosthesis is also required to register.

• Labeling. Current FDA regulations require that if a foreign dental laboratory fabricates a case, the laboratory must either label the case as "Manufactured for (name of lab contracting with dentist)" or "Distributed by (name of lab contracting with dentist)." This means that dentists do not know prior to delivery where a case will be fabricated or the origin of the materials. Upon delivery of the case, the dentist would need to note the "manufactured by" or "distributed by" label on the case and understand its significance. Some dentists may wish to have this information prior to selecting a dental laboratory.

• Materials. As part of importation, the manufacturer must certify that only FDA-approved materials are used. Actual enforcement of this requirement is done by the U.S. Customs and Border Protection in coordination with the FDA.

Although both the federal and state approaches were considered as means to address the advanced disclosure of subcontracting of dental prostheses to a foreign laboratory, the FDA does not believe it has the authority to regulate dental labs as suggested by Res. 69H-2006; therefore, pursuing a legislative change to the Food, Drug and Cosmetic Act would be required. The federal approach would require the support of the U.S. Congress to change federal law to give the FDA regulatory authority over dental laboratories that it does not currently have (nor want or support), would be a very long-term process and could impact both dentists and dental laboratories in unanticipated ways.

Additionally, the federal approach could be considered in conflict with ADA policy that says: "The Association opposes the creation of additional regulatory boards to oversee dental care and therefore, opposes any form of governmental regulation or licensure of dental laboratories not promulgated under the auspices of the state board of dentistry." ■

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House: ADA to study universal health care

San Francisco—Seeking a meaningful way to address the ambiguity associated with the phrase "universal health care," the 2007 House adopted Resolution 58H-2007 calling for:

• ADA lobbying efforts to emphasize that government dental programs prioritize resources for those most in need;

• a task force to be appointed by the ADA president to include but not be limited to the Council on Dental Benefit Programs; Council on Dental Practice; Council on Government Affairs; Council on Access, Prevention and Interprofessional Relations; Council on Communications and relevant consultants.

The task force will be charged with: defining the ADA role in development of future universal health care programs; developing goals and strategies to guide the Association's advocacy efforts as they relate to potential universal health care; and reporting to the 2008 House of Delegates with recommended action items. ■

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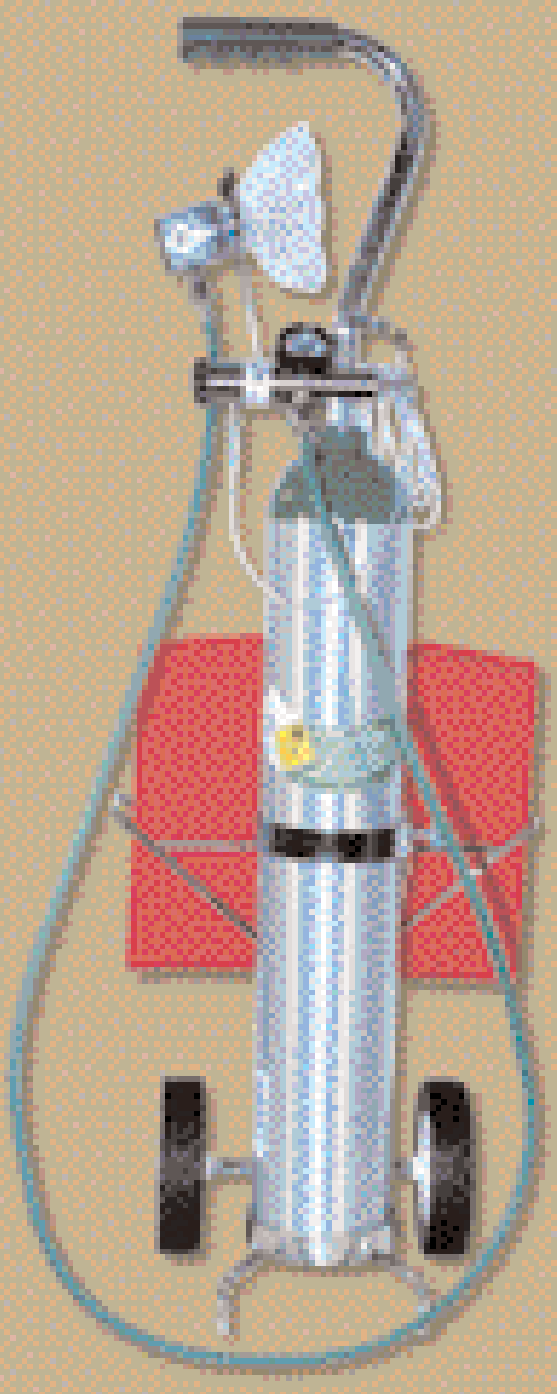

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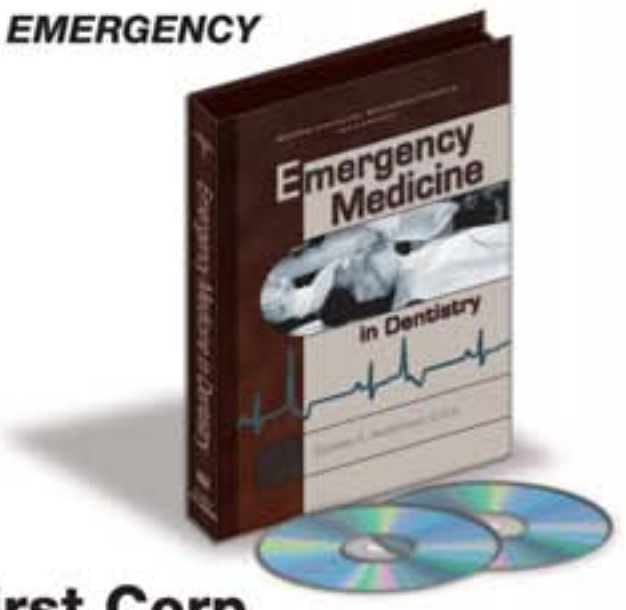

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TeamSmile program heads west

Volunteers offer Fresno kids in need dental care, football and fun

BY JENNIFER GARVIN

Fresno, Calif.—Jacob Johnson couldn't stop touching his left cheek.

The volunteer dentists had just finished restoring two cavities and his mouth felt "funny."

Still, it was his first visit to the dentist in five years and it felt good knowing he was back on track.

"I like going to the dentist," observed the 11-year-old, stretching his jaw as he spoke. "I don't like shots, but I like having my mouth taken care of."

Jacob was one of some 50 kids to benefit from Fresno's inaugural TeamSmile, held Oct. 26 and 27 at California State University, Fresno.

It marked the first time TeamSmile has traveled outside of Kansas City. The program, which strives to provide oral health care to underserved children, attracted 50 volunteers, including 14 dentists. Each child received about an hour of treatment, including an oral exam, X-rays and, when necessary, restorative work. They also received lessons in brushing and flossing from dental assistants.

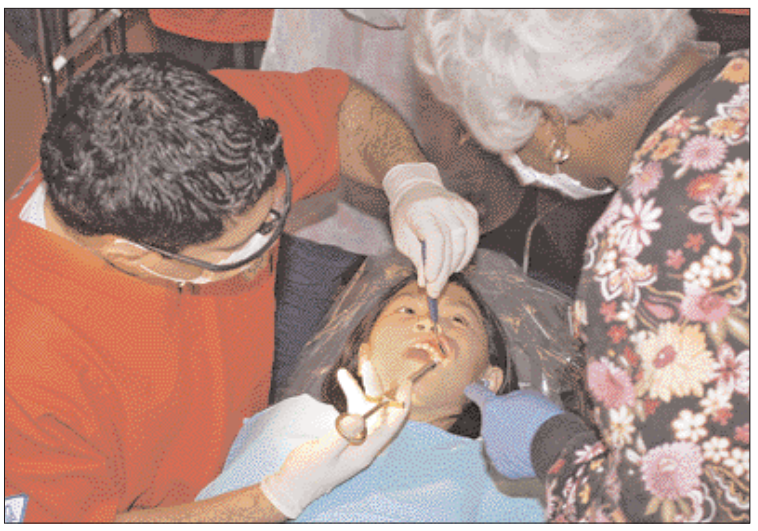
"It makes it all worth it, seeing dental professionals do what they love doing, for children who truly need their specialty," said Mike Stovall, a Sullivan-Schein field representative who coordinated the Fresno program. "I'm proud to say the Fresno team set the bar with how a collegiate program goes. The people who volunteered their time are as amazing as the kids we served."

TeamSmile hosted its first event, Kansas City Oral Healthcare Day, in September 2006 with the Kansas City Chiefs, a National Football League franchise. This year the city hosted its second annual Kansas City Oral Healthcare Day and assembled more than 100 dental volunteers and treated 300 kids.

Fresno's event was the first time the organization has worked with the National Collegiate Athletic Association. In addition to receiving free dental care, the kids were treated to Fresno State's home football game against Boise State and given T-shirts and dental products.

Mr. Stovall, a former Fresno State offensive lineman, contacted TeamSmile founder Dr. Bill Busch after reading about the Kansas City TeamSmile in the Sullivan-Schein company newsletter. He knew immediately that he wanted to do the same thing in Fresno and was confident he could get Fresno State to come on board. Not only did the university agree, TeamSmile was given full access to the football annex—similar to an auxiliary locker room, but bigger—where it set up four operatories and X-rays, screening and anesthesia stations. Fresno State cheerleaders, football and basketball players also stopped by the event. So did the mascot, Timeout, the bulldog. FSU's dentist, Dr. Xavier Gutierrez, who also practices in the community, coordinated the volunteers.

Here's how you do it: Theresa Nunez, 9, teaches the Fresno State mascot, Timeout the bulldog, how to brush his teeth.



Let me see: Dr. Jason Keledjian of Madera, Calif., examines 10-year-old Irene Keophongsavan's mouth before putting in two composites. He is assisted by Donna Lyons.

Dr. Busch

"Generally speaking, communities like Fresno don't have the 'safety nets' equipped to serve underprivileged children," Mr. Stovall said. "For the most part, larger cities have found ways to reach out to their respective communities. By building TeamSmile from the grassroots level, through college-level athletic programs, we are able to impact athletes who may go on to play professionally. That will allow us to continue TeamSmile at the professional level, through their personal involvement in the program."

Two hours into the event, people were already talking about ways to expand and improve for next year.

"I know we've done a good job when the doctors tell me, 'Next year we should … ' It feels good that they're already thinking about the next time," said Dr. Busch, who made the trip from Kansas City. "I really feel like volunteer dentistry is really stepping up to the plate."

All of the children invited to participate lived within walking distance of Bulldog Stadium, where Fresno State plays its home football games. The El Dorado Community Center of Fresno worked with Sullivan-Schein to find children in need of oral health care. The center serves as an after-school and summer shelter to keep kids out of trouble and away from gangs.

Jacob wasn't the only one in his family to receive treatment. His two brothers and nephew also were there.

His mother, Brenda Johnson, hopes the TeamSmile event will become a yearly staple. "This is such a good thing," she said. "Especially for our neighborhood."

Irene Keophongsavan's eyes got big when she was told the numbness in her mouth would probably last an hour. Irene, 10, received two composite restorations in her first trip to the dentist.

"I feel like Raven did when she went to the dentist," said Irene, referring to the popular kids' television show "That's So Raven."

Some of the children required follow-up care. Endodontist Chris Sabourin, who practices in Clovis, Calif., volunteered to perform a root canal pro bono for one young patient.

Said Steve Aaron, regional general manager for Sullivan-Schein: "Learning to give back to the community is an important thing. Those of us who work in health care have an obligation."

"I'm really happy," Mr. Stovall said. "The people's attitudes are just great. I asked a few doctors and team members if they would be interested in doing this again next year, but on a bigger scale, and all of them can't wait. Being the first event here, we had some hiccups and times when things got stressful, but everyone pitched in and gave their all to make it a successful event. You can plan and prepare for a year for an event like this, but if you don't have people with huge hearts willing to carry out the task, it's all for naught."

Future TeamSmile locations include Detroit, Houston and Chicago.

For more information about TeamSmile, visit "www.teamsmile.org". ■

—garvinj@ada.org

Delegates OK new nonpracticing ADA dentist-member category

BY KAREN FOX

San Francisco—The House of Delegates last month paved the way for nonpracticing dentists to become dentist members of the American Dental Association.

The House's adoption of Resolution 10H-2007 creates a new category of membership for individuals who hold a dental degree but not a U.S. license, do not provide patient care for remuneration and live in the U.S and/or its territories.

"The ADA as a membership organization can now say that not only do we represent all dentists in all practice settings, we represent all dentists," said Dr. Pamela Z. Baldassarre, chair of the ADA Council on Membership.

Some dentists who fit in this category include policymakers; government officials; dental industry representatives; dentists in the insurance industry; dentists in the corporate world; and researchers, educators and deans of dental schools previously eligible to join as associate members.

"The ADA is committed to being the umbrella organization for the dental profession, and we can now offer a place in our organization to dentists who are valuable to and involved in the profession who in the past were not able to be dentist members," said Dr. Baldassarre. "Many of these dentists have tremendous impact on our profession and the delivery of oral health care to the public. Input from a stronger more vibrant membership helps build capacity to anticipate future trends in the profession, and enables the organization to stay relevant and proactive, creating ongoing value for members."

The new membership category goes into effect in January 2008. The concept behind Res. 10H-2007 was approved in 2005, but the new category could not be implemented without a Bylaws change.

Res. 10H-2007 is one part of a comprehensive membership study that has taken place over a number of years. A resolution proposing dental team membership (Res. 15) was not passed by the 2007 House but Bylaws changes related to the membership category for nonpracticing dentists, among other items, did. (See additional Bylaws changes included in Res. 10H-2007, this page.)

U.S. Rep. Mike Simpson (R-Idaho) is an example of a nonpracticing dentist in the new category, said Dr. Baldassarre.

"Congressman Simpson is a dentist by training but left dentistry for Washington and no longer holds a license. Dentists like Mike Simpson are involved in careers where there is no need to hold a license, yet they are influencing the way we practice dentistry," she said. "Being able to offer this membership is a way to recognize the contributions that dentists who are not practicing are making to our profession. It is a way of telling them they are a part of the profession, we recognize that and we want to hear what they have to say."

Nonpracticing dentists will pay half the ADA dues of active members, and as direct members—not tripartite members—will enjoy such privileges as receiving The Journal of the American Dental Association, attendance at ADA annual session and election to councils, but they may not hold an ADA office.

The last time the House of Delegates approved a new membership category was in 1991, creating the active life membership category. ■

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House approves membership-related Bylaws changes

San Francisco—Bylaws changes made for Resolution 10H-2007 include these revisions in ADA membership:

- The ADA now allows international student membership. As with other student members, the American Student Dental Association will collect dues for the ADA.
- Changes will extend the number of years that graduate students are eligible for reduced dues and allow them to fully participate in the program for all four years, regardless of whether they start a new graduate program in the middle of the reduced dues schedule. The idea is to have recent graduates participate in the tripartite and enjoy membership benefits so they will want to join after completing their programs, and it helps to alleviate some of the financial pressures on new dentists holding a high level of educational debt.
- The ADA will no longer charge charitable dues. This is a dues waiver for dentists who do mission work or charitable work for little or subsistence pay.
- There is now just one approach to dues waivers: financial hardship. In the past, disability was also considered for dues waivers; however, some dentists have overcome disabilities and achieved success. Anyone who is currently on a disability waiver will continue to be on it.
- The Council on Membership can now offer strategic promotional incentives, which gives the council more marketing flexibility. Strategic promotional incentives create a mechanism for special marketing to target markets. However, the incentives can only be up to a 50 percent discount, and each person who receives the promotional incentive can receive it only one time. ■

Fire levels dentist's home

California family escapes, leaves behind 27 years of memories

BY CRAIG PALMER

San Diego—Dr. Cary Behle (retired), his wife and daughter had "about five minutes" from the sight of fire and a shouted warning, "You've got to get out; get out now," to leave the home of 27 years they would next see as rubble.

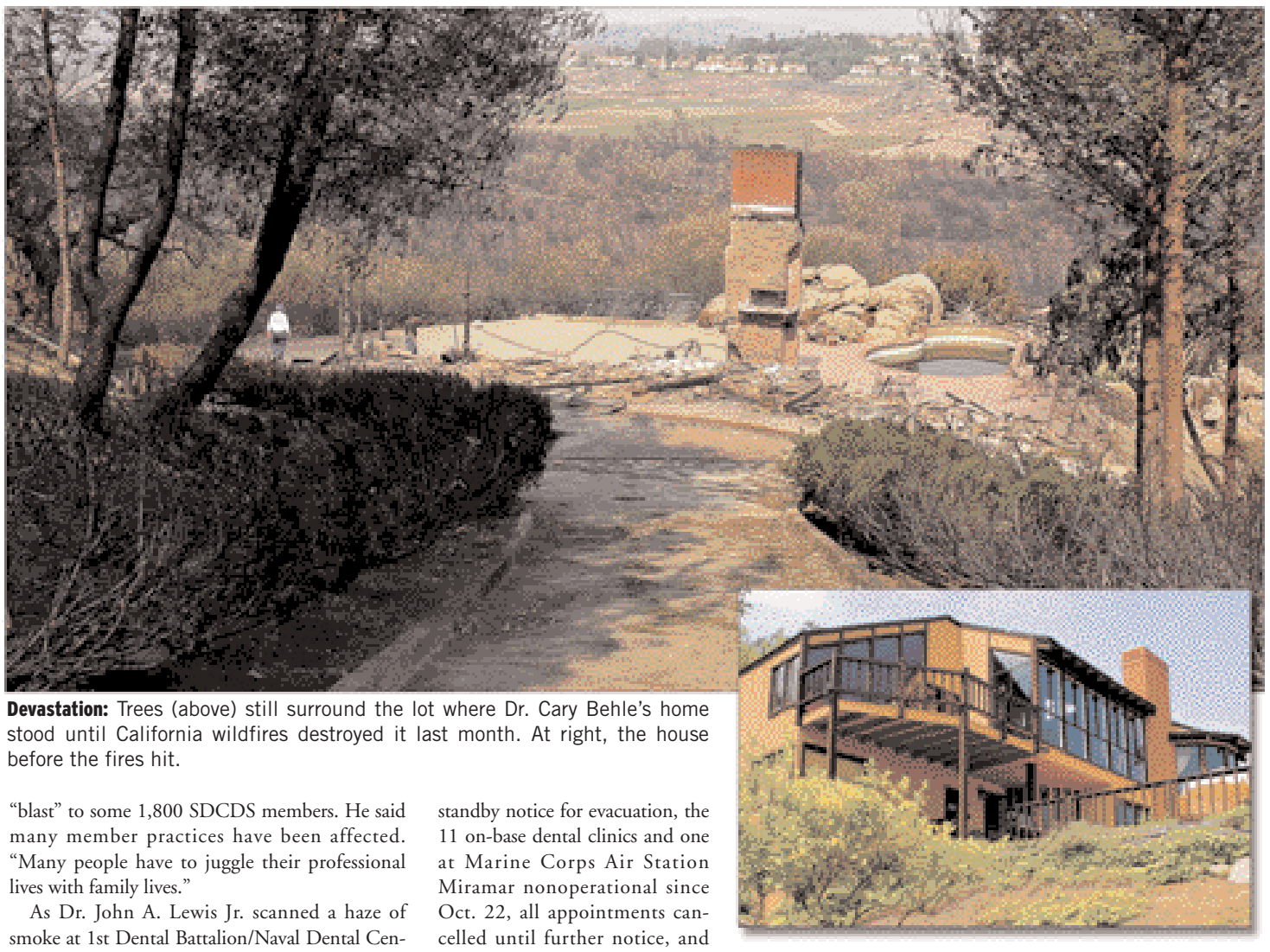
"We were probably one of the first houses hit in San Diego city," Meg Behle said in a telephone interview.

It was four in the morning Oct. 22. Meg Behle awakened her husband, who retired from general practice a year ago, and the three of them left with what they could manage, hastily clothed with a laptop, an accounting book, a small bag, their dog. "It's heartbreaking," she said. "Our children were born and raised there. We haven't decided whether to rebuild or relocate. We appreciate all the thoughts and calls from friends. It's been very comforting."

Dentists and tripartite officials report curtailment of some private practice and military dentistry and unknown numbers of dentists evacuated from homes in the Southern California fire zone.

The ADA Health Policy Resources Center on Oct. 26 said three of the fires potentially affected 51 dentists on 51 properties. A "potential impact" was defined to include homes and/or offices of dentists within two burn zones indicated by the Southern California Fire (Report at "www.calfires.com".) The figure includes active and retired dentists. An ADA staff command team was assembled to assess damages from the wildfires.

"The enormity of this disaster is unknown at this point as is the number of CDA (California Dental Association) member dentists and component staff directly affected by this catastrophe," David I. Baron, executive director of the San Diego County Dental Society, said in an e-mail "blast" to some 1,800 SDCDS members. He said many member practices have been affected. "Many people have to juggle their professional lives with family lives."



Devastation: Trees (above) still surround the lot where Dr. Cary Behle's home stood until California wildfires destroyed it last month. At right, the house before the fires hit.

As Dr. John A. Lewis Jr. scanned a haze of smoke at 1st Dental Battalion/Naval Dental Center headquarters here, facilities nearby were on standby notice for evacuation, the 11 on-base dental clinics and one at Marine Corps Air Station Miramar nonoperational since Oct. 22, all appointments cancelled until further notice, and many of the dental officers and staff evacuated from homes on and off-base. Dental emergencies were being handled at two sites, one here and one at Miramar.

"We're trying to minimize the blazes on base," he told the ADA News in a telephone conversation as the Web site reported, "Camp Pendleton is currently fighting two separate fires aboard the base, the largest covering approximately 6,000 acres."

Dr. Lewis, a Navy Dental Corps captain and ADA member, is the executive officer for a dental command responsible for the care of some 55,000 Marines and sailors. "We've got 46 of our staff members displaced," he said. "Right now we're not hearing any reports of building damage."

The ADA potential impact and the military displacement figures are unrelated and do not cover the same wildfire areas, the former referring only to dentists and the latter to dental officers and dental staff. Also the snapshots were taken at different times as officials continue to assess the damages while firefighters battle scattered fires.

Dr. Barbara Kabes, president, and Mr. Baron of the San Diego County Dental Society distributed toothbrushes Oct. 22 to evacuees at San Diego's Qualcomm Stadium but quickly ran out of the limited supply on hand in search of more. "We donated everything we had," he said. Officials Oct. 26 began moving evacuees from the stadium, which housed some 10,000 evacuees and volunteers at peak. ■

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IRS extends deadlines for wildfire victims

Washington—The Internal Revenue Service is extending tax filing and payment deadlines for victims of California wildfires. Affected taxpayers in Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara and Ventura counties will have until Jan. 31, 2008, to file returns, pay taxes and perform other time-sensitive acts.

The extended deadline applies to tax actions due on or after Oct. 21, when the fires began, and on or before Jan. 31, 2008, including the federal withholding tax return normally due Oct. 31 and the estimated fourth quarter tax payment normally due Jan. 15. See notice IR-2007-178 and related disaster relief information posted at "www.irs.gov " under "Help for California Wildfire Victims." ■

Resources available for dentists affected by fires in California

BY STACIE CROZIER

Sacramento, Calif.—The California Dental Association and the CDA Foundation are ready to help dentists affected by the Southern California wildfires with a variety of assistance, resources and information.

"CDA is very concerned about our members, their staff and component staff who have been affected by the tragic firestorms in Southern California," said Dr. Ronald Mead, CDA president. "We are in the process of developing an action plan, and the entire organization is ready to assist the dental community. The CDA Foundation is accepting applications for relief assistance; The Dentists Insurance Company has representatives on call 24 hours a day for property loss claims; and the CDA Resource Center is available to answer any questions."

Log on to the CDA Web site, "www.CDA.org", to view and print an advisory with tips to help dentists affected by the disaster. (CDA also sent the advisory in a CDA Executive Bulletin to each of the state's 32 component dental societies.) The advisory emphasizes personal safety of dentists, staff members and patients as the first priority. Dentists are also encouraged to secure pertinent business and financial information. Phone numbers for affected component societies, the CDA Foundation and TDIC are also listed.

TDIC policyholders can make a property loss claim by calling 1-800-733-0634 or completing an online claim form. TDIC representatives are on call 24 hours a day.

Disaster assistance from the CDA Foundation and the ADA Foundation is available to those affected by the wildfires. Please contact Jolene Murray at Ext. 4929 or "Jolene.Murray @cda.org" with the CDA Foundation to submit relief applications for both grants.

The CDA Resource Center, at 1-800-CDA-SMILE (1-800-232-7645), is also ready to take calls from dentists affected by the fire. Phone lines are open Monday through Friday, 8 a.m. to 5 p.m. Pacific Daylight Time. You can also e-mail the CDA Resource Center at "contactcda@cda.org".

The November issue of the CDA Update news magazine will provide its members the most current news possible.

"CDA has been in communication with key members of ADA staff and the ADA Foundation to share information and learn from the ADA's activities following the Katrina disaster," said Dr. Russell I. Webb, ADA 13th District trustee.

The CDA is also on the front lines to help citizens affected by the wildfires and is working with the Red Cross to distribute emergency supplies—toothbrushes and toothpaste—donated by the Colgate-Palmolive Co. ■

FDA urges awareness of potential for acute pancreatitis complications for exenatide patients

Rockville, Md.—The Food and Drug Administration is advising health care professionals to be aware of the signs and symptoms of acute pancreatitis after reviewing 30 post-marketing reports of patients taking Byetta and linking it to pancreatitis.

Byetta (exenatide), a drug used to treat adults with type 2 diabetes, is manufactured by Amylin Pharmaceuticals Inc. The company has agreed to include information about acute pancreatitis in the precautions section of the product label.

Health care professionals are advised to instruct patients taking Byetta to seek prompt medical care if they experience unexplained, persistent, severe abdominal pain which may or may not be accompanied by vomiting.

For more information, visit the FDA MedWatch at "www.fda.gov/medwatch/safety/2007/safety07.htm#Byetta". ■

X-ray attachment guidelines updated

AnnualSession

BY ARLENE FURLONG

San Francisco—Recognizing that many dental insurance carriers don't return radiographs or photos (some not unless a stamped, self-addressed envelope is provided and others not at all), the Council on Dental Benefit Programs sought a policy change in guidelines on the use of images in dental benefit programs.

Resolution 35H-2007, amending current Guidelines on the Use of Images in Dental Benefit Programs, comes on the heels of joint Council on Dental Benefit Programs and National Association of Dental Plans' efforts to address issues of unsolicited radiographs and return polices.

CDBP recommended that NADP develop a set of common criteria NADP member companies would use to determine when radiographs are required for claims adjudication, with a view toward industry standardization. The goals were to reduce the number of unsolicited submissions, which create administrative burdens on payers, as well as to give providers direction as to when image submission is necessary.

At the November 2005 meeting of the joint ADA/NADP workgroup, NADP proposed that the following be submitted to NADP members for standards or guidelines.

X-rays that have been requested or required by a dental plan will be returned by the plan to the dentist and X-rays not requested by a dental plan for adjudication of a claim will be returned only when requested by the dentist.

NADP adopted the voluntary policy for its member companies, but CDBP did not endorse the policy because it is voluntary, allowing continued variance in submission policies from plan to plan. Also, it does not address what should be initially submitted, providing insufficient direction to dentists.

NADP since proposed an interim solution to the problem of radiograph return policies of its member companies by entering into a joint agreement with an organization that provides an on-line portal to access dental payer claim attachment requirements by payer name and CDT code. However, this subscription service has an associated cost to the members and does not address the issue of lack of standardization.

According to Res. 35H-2007, ADA recommendations on selection criteria for images states:

• Diagnostic imaging should be used only after clinical evaluation, review of the patient's history and consideration of the dental and general health needs of the patient.

• Type, frequency and extent of diagnostic images necessary for each individual patient will be provided in accordance with the dentist's professional judgment. Federal and state laws regarding patient privacy are subject to change and may supersede these guidelines.

The Association believes the following guidelines should be applied for using images in dental care plans:

1. Images should be generated only for clinical reasons as determined by the patient's dentist. Clinical images may be used as part of a system for determining benefits the patient is entitled under the terms of a contract. Third-party payers should not request that images be generated solely for administrative purposes. If a third party requests an image that was not generated as part of the dentist's clinical treatment, dentists should consider the clinical necessity of the image in connection with the request.

2. When a dentist determines that it is appropriate to comply with a third-party payer's request for images, it is recommended that a duplicate set be submitted and the originals retained by the dentist. All images, including duplicates, except those submitted in digital or other electronic form, and whether or not they have been requested, should be returned to the dentist.

3. There are many instances in which a determination of care cannot be made solely on the basis of images and it is improper for third-party payers to deny authorization for payment or make determinations about treatment based solely on images.

4. Third-party payers should not use images to infringe upon the professional judgment of the treating dentist or to interfere in any way with the dentist-patient relationship. All questions of interpretation of images must be reviewed by a dentist consultant.

5. Clinical images should only be requested when they will be reviewed by a dentist to make a determination regarding the patient's entitlement to benefits. Dentists reviewing images for this purpose should be licensed in the U.S., preferably within the jurisdiction of the dentist providing the images in accordance with applicable state law.

CDBP recommended that NADP develop a set of common criteria NADP member companies would use to determine when radiographs are required for claims adjudication, with a view toward industry standardization.

6. Patients should be exposed to radiation only when clinically necessary, as determined by the treating dentist. Postoperative images should be required only as part of dental treatment.

7. It is important that images be correctly identified and be of diagnostic quality.

8. Third-party payers should protect the confidentiality of all records, including images, which are submitted to them by dental offices. All images submitted to third-party payers, except those in digital or other electronic form, should be returned to the treating dentist within 15 working days. Images received in an electronic form should be permanently deleted within 30 days of the completion of claims adjudication.

9. Images held by parties other than the treating dentist should not be transmitted to any agency or entity without written consent of the dentist or patient.

10. When a claim or predetermination request indicates that images are provided, the third-party payer should immediately notify the submitting dentist's office if the images are missing.

11. A patient's predetermination request or claim should not be prejudiced by the third-party payer's loss or misplacement of images.

12. Images are an integral part of the dentist's clinical records and, as such, should be considered the property of the dentist where consistent with state law. Because it is necessary for a dentist to maintain accurate and complete records, third-party payers should accept copies of images in lieu of originals.

13. Any additional costs incurred by the dentist in copying images and clinical records for claims determination should be reimbursed by the third-party payer or the patient. ■

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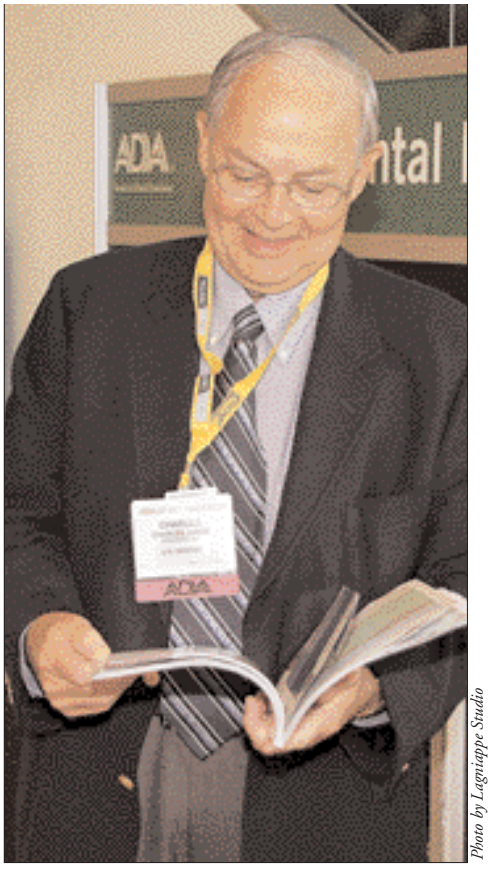

Photo by Lagniappe Studio

Session planning: Dr. Charles Judge of Cincinnati explores his annual session options in the Official Guide while in San Francisco in September.

Dental benefits, practice focus of resolutions

Actions on dental benefits and practice issues are summarized here.

The 2007 ADA House of Delegates addressed dental tourism for the second time in Association history last month.

Supporting the ADA Strategic Plan Goal: Create and Transfer Knowledge, the House referred Resolution 34-2007 to appropriate ADA agencies for additional research and development of a more definitive definition of dental tourism and to report its findings to the 2008 House.

The Board's February mega issue discussion on dental tourism, feedback from the April 2007 Board meeting and discussions by the Council on Dental Benefit Programs continued 2006 HOD dialogue by identifying new ADA strategies to address dental tourism.

The 2007 House gave the councils on Dental Practice and Dental Benefit Programs the go-ahead to develop a proposal for policy on public workers' compensation and no-fault insurance programs for consideration by the 2008 House.

Recognizing the expansion of publicly regulated and funded benefit programs, Res. 36H-2007 calls for the proposal to include recommendations for time frames for reimbursement, standardization of claim forms and code sets, appeals procedures and recommendations on the following concepts:

• that the doctor-patient relationship remain sacrosanct in such programs;

• that programs allow patients to be treated by their own dentists of record for injuries sustained that fall within the purview of such programs;

• that the objective of such programs should be to restore to health patients requiring treatment as the result of a workplace or motor vehicle injury at no cost to the patient.

Res: 33H-2007 calls for the ADA to educate members on the appropriate use of the Code on Dental Procedures and Nomenclature and encourage them to report misuse by third-party payers. It also directs the ADA to actively pursue violations of the third-party licensing agreement for use of the Code. ■

Anesthesia

Continued from page one

to the proposed guidelines. One change was the addition of text under Clinical Guidelines for Moderate Sedation, stating:

"When active treatment concludes and the patient recovers to a minimally sedated level a qualified auxiliary may be directed by the dentist to remain with the patient and continue to monitor them as explained in the guidelines until they are discharged from the facility."

The House also changed the definition of supplemental dosing, where the phrase "on the day of treatment" was added to the end of the last sentence in the definition.

"The revised anesthesia guidelines will provide practicing dentists with safe parameters for patient care at different levels of sedation," said Dr. Maggio.

The new guidelines are posted on the ADA's home page at "www.ada.org".

The ADA is in the process of transmitting the guidelines to state boards of dentistry and other communities of interest. The guidelines are available immediately for use by the profession.

The new sedation and anesthesia guidelines are posted online on the ADA home page at "www.ada.org".

In addition, during its review of the guidelines the Committee on Anesthesiology found that certifying courses in emergency management in dental sedation and anesthesia are limited to Advanced Cardiac Life Support courses, which involve interventions concentrating on cardiac arrhythmias that are not the early presentation of the emergencies most commonly faced by dentists administering sedation.

The ADA Foundation has announced a request for proposals for 2008 regarding development of a new course curriculum to train dentists to recognize, treat and prevent complications and emergencies related to sedation and general anesthesia with special emphasis on airway management. (For more information, go to "www.adafoundation.org".) The deadline for proposals is Feb. 26, 2008. ■

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Comments sought on root canal spec

The ADA Standards Committee on Dental Products has approved for circulation and comment the proposed ANSI (American National Standards Institute)/ADA Specification No. 71 for Root Canal Filling Condensers (pluggers and spreaders).

This specification is for root canal instruments for finger, hand, or mechanical operation used to compact root canal filling materials. A copy of the draft specification is available by calling the ADA toll-free, Ext. 2533, or sending an e-mail to "standards@ada.org". ■

Workforce

Continued from page one

team led by a dentist, promoting good oral health through community based promotion and prevention programs. CDHCs are from the communities in which they will be working, and therefore have the cultural competency to understand the community, the knowledge of the local health care system and the ability to bring the patients in need into proper agencies for care.

The model for the CDHC is based on that of a community health worker. Studies have shown that CHWs are cost-effective in managing care for chronic disease, said Dr. Brandjord.

"The further along we proceed with this model, the more evidence we see of a need for exactly what we're creating," said Dr. Brandjord. The Health Resources and Services Administration (the U.S. Department of Health and Human Services agency for improving access to health care services for people who are uninsured, isolated or medically vulnerable), legislative advocacy groups and third party carriers have all expressed interest in community health workers with dental skills.

"We believe this workforce model has a greater chance for success than you believe," Dr. Brandjord told the ADA Board in September. Pilot sites for the CDHCs will be selected by end of the year.

Adoption of Res. 54H-2007 provides a maximum of $2 million from reserves to fund selected pilot programs in at least three sites with at least six students per year per site over a three-year period. A key stipulation of the House's support requires the Workforce Models National Coordinating and Development Committee to seek matching funds from other foundations and agencies to develop the CDHC model.

"As we move forward, we will be seeking additional funding from government agencies, foundations, the dental industry and the health industry," said Dr. Brandjord. "Having funds from the ADA shows that the profession supports these ideas by putting some money behind the program.

"ADA funding is also more likely to help us garner financial support on the local level, and having this type of funding to support the needs of the community is our best chance for long-term success," he said.

Dr. Brandjord also lauded the NCDC's curriculum committee for their work—Dr. Amid Ismail (chair), Dr. Paul Glassman, Dr. Marshall Kreuter, Dr. Joan Nyquist, Dr. Judy Skelton, Dr. Bob Weyant, Adm. Carol Turner, Carl Rush, Anne Willaert and Laura Webb. The curriculum is modular, which offers CHWs and members of the dental team expedited education without being repetitive. Modules cover three areas: community health worker and health promotion skills, dental skills and an internship program.

Members of the NCDC have visited potential pilot sites and are now in the process of coordinating several sites that will work together for Native American communities. ■

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* Tunkel J, Heinecke A, Flemmig TF. A systematic review of the efficacy of machine-driven and manual subgingival debridement in the treatment of chronic periodontitis. *J Clin Periodontol*. 2002; 29 (Suppl 3):72-81.
**Ryan DL et al. Effects of ultrasonic scaling and hand-activated scaling on tactile sensitivity in dental hygiene students. J Dent Hyg 2005; 79(1):9.

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