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ADA News - 03/03/2008

American Dental Association, Publishing Division

Golden Apples call, page six ◆ Dr. Folse's work in spotlight, page 10

AMERICAN DENTAL ASSOCIATION WWW.ADA.ORG

ADANEWS®

MARCH 3, 2008 VOLUME 39 NO. 5

Workforce model set to pilot in fall

CDHC goal is outreach to underserved

BY KAREN FOX

The ADA is a step closer to demonstrating the efficacy of the Community Dental Health Coordinator workforce model.

Three sites have been selected to pilot the programs in rural, urban and Native American settings, beginning this fall. Members of the ADA Workforce Models National Coordinating and Development Committee welcomed the directors of the CDHC pilot programs to ADA Headquarters Feb. 21-22 to discuss, among other issues, progress to date, core competencies, program implementation, budgetary needs and online curriculum delivery.

■ Watch for more information about CDHCs on ADA.org

Defined as a new allied dental person with community health worker skills, the CDHC "has enormous

See CDHC, page 20

Dr. Brandjord: "Through this model, we are providing community health worker and dental skills to individuals who come from the communities they serve and work as a member of the dental team in underserved communities where residents have no or limited access to dental care."

BRIEFS

Volunteers needed: Health Volunteers Overseas is seeking dentists for programs in Nicaragua and Cambodia.

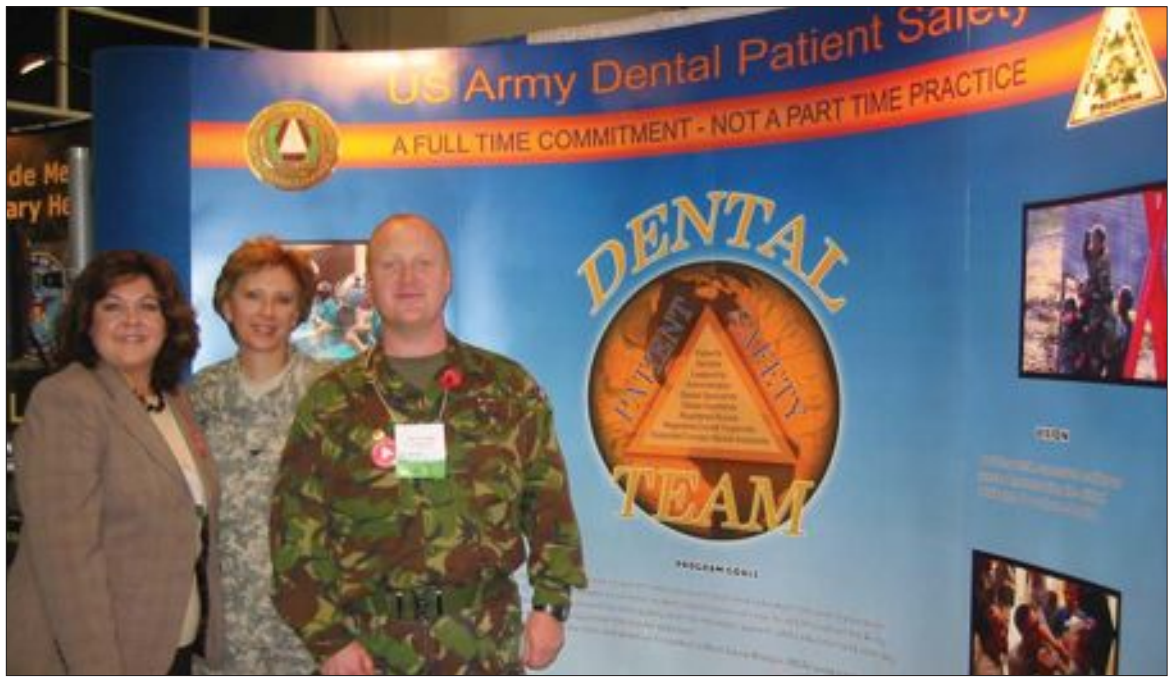
Dentists with an academic background or extensive clinical knowledge are needed to provide training at the Universidad Americana in Managua, Nicaragua. Assignments are for one week.

Dentists are also needed in Cambodia for two-week assignments during spring and fall 2008, particularly those with training in restorative dentistry, endodontics, prosthetics, orthodontics and implants.

HVO is a private nonprofit organization committed to improving health care in developing countries through training and education. By emphasizing teaching and training rather than direct patient care, HVO aims to create an indigenous group of trained health workers who can teach others in their communities.

The Dentistry Overseas programs of HVO are sponsored by the ADA and managed through the Center for International Development and Affairs. All volunteers must be ADA members. Currently HVO has dentistry programs in Cambodia, China, Laos, Nicaragua, St. Lucia, Tanzania and Vietnam.

Volunteers are responsible for all expenses incurred and housing is provided for volunteers at some program sites. For details, log on to "www.hvousa.org" or contact the CIDA at "international@ada.org" or 1-312-440-2726. ■



Safety first: Military personnel unveil a display that reflects a new patient safety system during the Association of Military Surgeons of the United States meeting in November 2007. From left are Robbie Sjelin, Department of Defense dental patient safety consultant and a dental hygienist and registered nurse; Col. Ann S. von Gonten, D.D.S., a dental consultant for the effort, and Maj. Tim Fildes, a British Royal Army exchange dental officer on assignment with the U.S. Army "to help with the patient safety movement." Story, page 10.

Lead in dental lab work?

ADA urges scrutiny

BY ARLENE FURLONG

When a TV station in Ohio Feb. 27 reported that a woman's partial bridge, as well as a dental crown manufactured in China and exported to the U.S. tested positive for lead, the ADA reaction was immediate.

"There is no appropriate use for lead in the manufacturing of dental prostheses," said ADA President Mark Feldman. "Our task now is to learn what the ADA can do to help prevent our members and our patients from ever hearing this kind of news again."

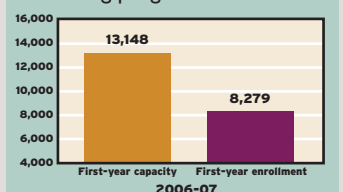
Product danger and contamination stories about imports are hot topics in the media these days. The real concern for dentists and patients related to this news isn't

See LEAD, page 22

JUST THE FACTS

Dental assisting

First-year enrollment was 63 percent of capacity in dental assisting programs in 2006-07.



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

Sealant use examined in JADA

March issue presents evidence-based clinical recommendations from experts

BY JENNIFER GARVIN

Pit-and-fissure sealants are an effective way of preventing caries in children and adults—even in early noncavitated (incipient) lesions, according to a new set of ADA evidence-based clinical recommendations.

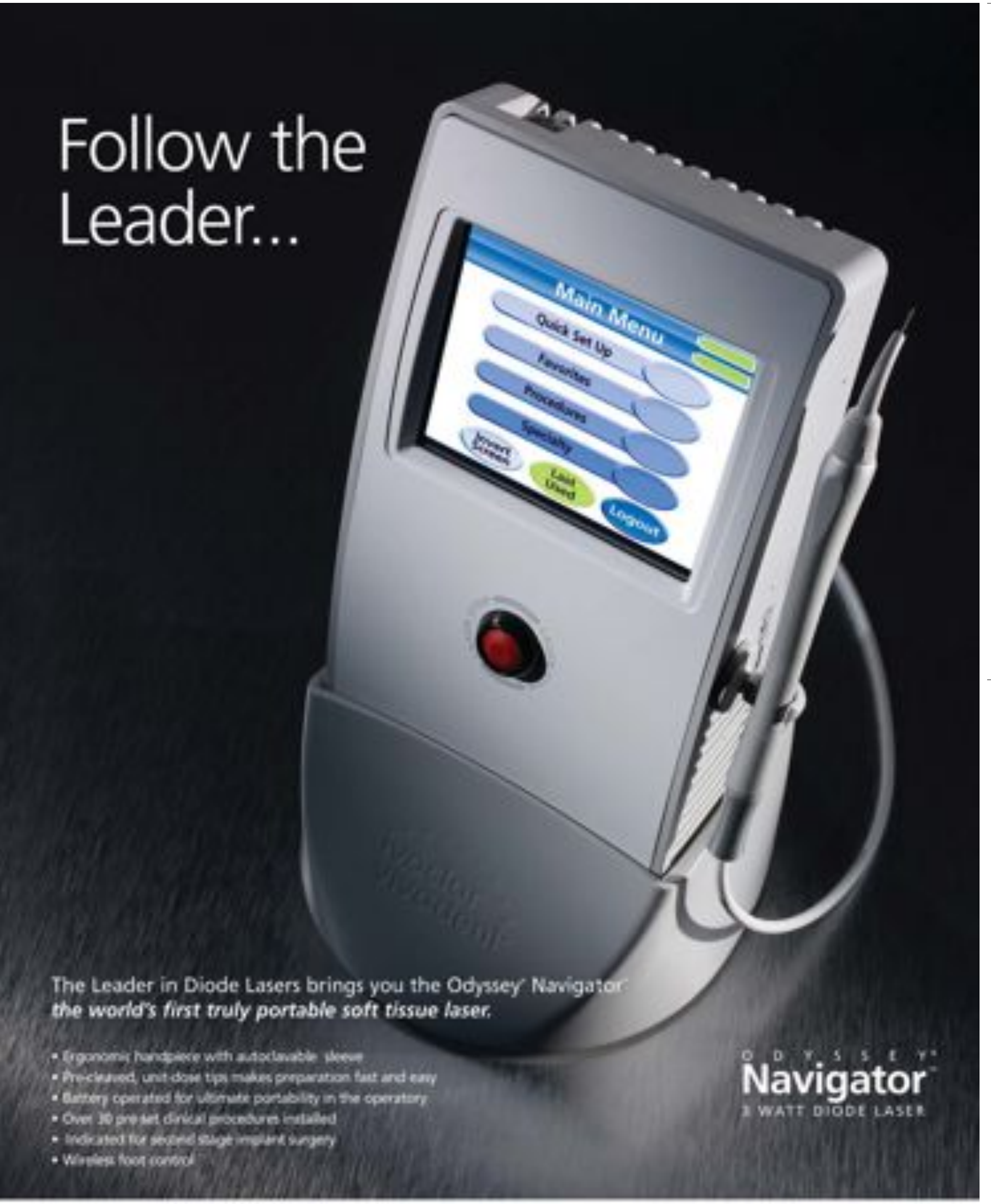
"Evidence-Based Clinical Recommendations for the Use of Pit-and-Fissure Sealants: A Report of the American Dental Association Council on Scientific Affairs," is published in the March issue of The Journal of the American Dental Association.

The council hopes practitioners will use the recommendations as a resource in their clinical decision-making process. In support of that goal, the ADA has developed a set of Questions and Answers (See Q&A, page 16.) to aid dentists in interpreting the new guidelines and discussing them with patients.

"This is the second in an ongoing series of evidence-based recommendations that will help our members

See SEALANTS, page 17

Follow the Leader...



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Job well done: ADA President Mark J. Feldman and Executive Director James B. Bramson welcome the winners of the ADA/DENTSPLY Student Clinician Research Program to ADA Headquarters Feb. 22. From left are Dr. Feldman; Chi Tonglien Viet, University of California-San Francisco (Class of 2010), 1st place, Basic Science Research for "Promoter Hypermethylation Quantification in Oral Dysplasia and Cancer"; Abby J.T. Shannon, University of Iowa (Class of 2008), 1st place, Clinical Research/Public Health Research for "In-Vitro Vertical Marginal Gap Comparison of CAD/CAM Zirconium Copings"; and Dr. Bramson.

ViewPoint

MyView

A resolution for dentists

Bob Shaw, D.M.D.

Last week I was sorting through the mail and I came across something from the ADA. It was one of those envelopes with samples of brochures you can give your patients to help explain treatment options or use to provide informed consent. As I looked through the set, I wondered if many dentists knew where these came from.

For years, I hadn't given it much thought, at least not until I was selected to serve on the Council on Dental Practice, which is largely responsible for the development of these printed materials. When I joined the council, I was surprised to see the amount of material the council handled, both in volume and in breadth. Like all the other councils, the CDP has a broad spectrum of responsibilities that involve monitoring, evaluating and formulating plans that the Board of Trustees will consider while doing the work of the ADA.

A review of some of the topics of activity at the council's last meeting included disaster preparedness/bioterrorism, making recommendations concerning the Team Building Conference at the ADA annual session, approving nominations to and work submissions from the Standards Committee for Dental Informatics, approving work done at SCDI to be sent to the Board of Trustees for its action, reviewing options for moving ahead on our real-time claims adjudication project, discussing dentistry's involvement with the expected upcoming health care reform activity (sure to come along post-election regardless of who wins).

You might even give some thought to stepping up to the next level by volunteering to serve on a council.

In addition, we discussed the SUCCESS Program, the ADA CE Online program, the caries risk assessment forms that we have developed this year, and we participated in a scanner evaluation project, evaluating scanned and printed images from several scanners of various costs relative to their suitability for submission to insurance companies as attachments, instead of sending real radiographs.

We even spent a few hours discussing "going green" programs in the various parts of North America, with the hope we could find things that dentists across the country could apply to their offices, relatively easily, to reduce dental office contributions to the waste stream. Obviously, our plate is pretty full.

I think you find that same situation at every council in the ADA. Though you may not know who your representatives are or even what the councils do, each district has a representative on every council and they work tirelessly for you. Our Washington council appointees serve the 11th District (Alaska, Idaho, Montana, Oregon and Washington), just like our trustees, and our nominees for council members can come from any state in our district.

My council has 17 members, one from each trustee district, as well as five

See MY VIEW, page five

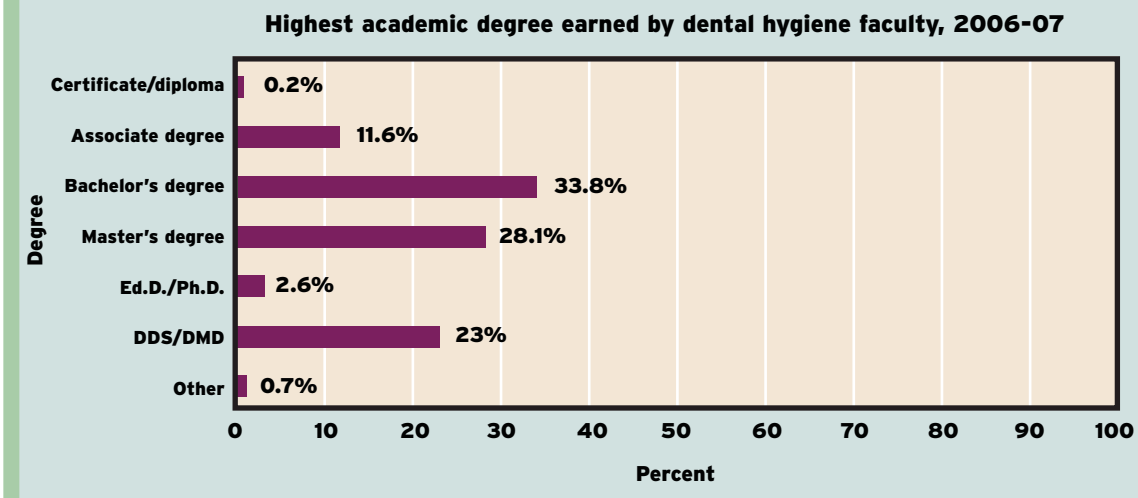
LettersPolicy

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

Dental hygiene education

Among all paid faculty members of dental hygiene programs, 61.9 percent hold either a bachelor's or master's as their highest degree, while nearly one-quarter are doctors of dental surgery or doctors of dental medicine.



Source: American Dental Association, Survey Center, 2006-07 *Survey of Allied Dental Education.*

Letters

Academic dentistry

This is more of a question rather than a response to Dr. Arthur Dugoni's editorial, "Dental Education Needs Our Help" (Feb. 4 ADA News).

Where are these 400 unfilled positions in the dental education community located? I have not been able to find them.

I have been in private practice since graduating from the University of Washington School of Dentistry in 1990. I decided that I wanted a career change (and change of location) and thought teaching would be something I would enjoy, as well as helping with this educational deficit we are constantly reminded of.

I contacted the American Dental Education Association before enrolling in graduate school. I received my Master's in June 2007. I submitted my curriculum vitae to ADEA's Academic Dental Careers Network. As of Feb. 19, the ADCN has six job openings posted.

The February 2008 issue of The Journal of the American Dental Association has three postings in the classified ad section.

I have investigated individual dental schools through their Web sites. A handful have a small number of listings, while most state that there are "no openings at this time." I have e-mailed the Academic Dental Careers Network twice with no response.

If there really are over 400 unfilled positions nationally, perhaps a well-maintained national job registry needs to be funded to help professionals like myself who want to make a change on the face of dental education.

Robin E. Reinke, D.D.S.
Federal Way, Wash.

Editor's note: Unfortunately, experiences like Dr. Reinke's are relatively common, according to the American Dental Education Association.

Academic vacancies may not always be posted in the same manner as traditional job listings. The positions that are advertised nationally tend to be high level or key positions requiring special expertise that merit recruitment at a national level while the more entry-level positions tend to be advertised at a local or institutional level. Most institutions have a job posting area on their Web sites, and dental school position openings are often included. Contacting individual dental schools appears to be one of the most efficient ways to find out about openings.

The 400 open positions noted by Dr. Arthur Dugoni in his My View editorial are based on the latest survey of open faculty positions in dental schools conducted by ADEA every two years, said Dr. Richard Valachovic, executive director of the American Dental Education Association.

"Many of these positions are ones that have been open for some time. We know that dental school administrators do a lot of personal recruiting not unlike a search firm that proactively seeks to fill a position. Faculty shortages come up time and time again as one of dental education's biggest challenge. I usually advise those in private practice who are interested in academic careers to contact the school of interest directly, beginning with the appropriate department chair," he said.

Academic dentistry is an enriching

See LETTERS, page five

Letters

Continued from page four

experience and rewarding career choice, and Dr. Reinke's difficulties in seeking employment led to this response from Dr. Dugoni, dean emeritus of the University of the Pacific Arthur A. Dugoni School of Dentistry:

"I decided 60 years ago that I wanted to be an educator, but I wanted to combine education and clinical practice. My career started as a part-time faculty member and over time I gradually increased the ratio of teaching to practice time, having started with a one-day-a-week position and ultimately to a half-time position.

"As time went on, I pursued graduate training and ultimately became a full professor and chair of the Department of Orthodontics. In 1978 and for the next 28 years, I served as dean of the University of the Pacific, now the Arthur A. Dugoni School of Dentistry.

"As challenges increase and our world continues to change, so has dental education. Dental schools continue to develop innovative ways to attract faculty, including clinical nontenure track, developing opportunities for senior experienced clinicians to come into education on a part-time basis, the development of faculty practice plans to enhance income and so on. The opportunities to become faculty members are there but require research and exploration and making contact with faculty members and especially chairs of departments.

"As dean for 28 years, professor and department chair who started as a part-time faculty member, I can re-echo over and over again the words of my son, Dr. Steven Dugoni, associate professor, one day a week, at the Pacific Dugoni School orthodontic graduate program: 'Dad, the best day of my life is the day I teach.'

"The best days of my life were the days that I spent working diligently with young minds to inspire them to be better than they ever thought they could be. It was the most satisfying and fulfilling experience of my life."

For more information about careers in academic dentistry, see "www.ada.org/prof/ed/careers/programs/academic.asp" and "www.adea.org".

Special needs

Dr. Kevin Norige's letter on special needs patients (Feb. 4 ADA News) in response to an earlier editorial by Dr. Burton Wasserman ("The Special Needs Patient: A Dental Dilemma," Oct. 15, 2007 ADA News) advocates a " … 'special needs' specialty" with specialized facilities for the delivery of care needs.

In a 2006 presentation in the Journal of Dental Education, "A Special Care Dentistry Specialty: Sounds Good, But … " (Volume 70, No. 11, pp. 1019-1022), we reviewed the demographics of increasing number of individuals with disabilities (currently, more than 51 million noninstitutionalized civilians). This number will grow as a consequence of (1) the anticipated dramatic growth in the geriatric population, and (2) the continuing abilities to maintain the lives of untold numbers of individuals with developmental and intellectual disabilities, most of whom now reside in our local communities (with dependence upon local health providers) rather than in isolated institutional settings.

While we agree with Dr. Norige in terms of the need to increase the knowledge, training and willingness that are needed, we took notice in the earlier presentation regarding the change in the Commission on Dental Accreditation's new standard for dental and dental hygiene schools which requires that, "Graduates *must* (CODA emphasis) be competent in assessing the treatment needs of patients with special needs" (CODA Accreditation Standard for Dental Education; June 30, 2004).

Advance training and abilities are essential in the schools of the profession. But in an effort to enhance the profession's ability to meet the needs of this burgeoning population, we must not lose sight of the reality that, as with other clinical dental specialties, the burden of providing the major component of care must fall upon the general practitioner.

It would be all but impossible to anticipate a few score or even hundreds of special care specialists to assume all the needed care for tens of millions of individuals (as defined by CODA) to include " … those patients with medical, physical, psychological, or social situations that make it necessary to modify normal dental treatment routines in order to provide dental treatment for that individual. These individuals include, but are not limited to, people with developmental

See LETTERS, page six

MyView

Continued from page four

liaisons from other councils, committees and the Board of Trustees. We also have several staff members who try to assemble and organize all our requests, as well as work on the projects the CDP has elected to take on, or that have been directed to us by the House of Delegates or the board.

The work at the ADA is done by a combination of staff and volunteers whose main guiding principle is to do their best for the ADA and their fellow dentists.

Your best chance to pass on your concerns to the ADA is through your delegates to the House, your representatives on the councils and through your trustee. Make it your New Year's Resolution to find out who these men and women are and to thank them for all they have done for dentistry and for you.

You might even give some thought to stepping up to the next level by volunteering to serve on a council. It's a challenging and rewarding experience and the ADA will take good care of you while you're visiting Chicago.

Dr. Shaw is a member of the Washington State Dental Association's editorial board and a past WSDA president (2003). His comments, reprinted here with permission, originally appeared in the January issue of WSDA News.

ADA calls for successful programs, activities worthy of annual Golden Apple recognition

Has your society developed an innovative program or activity that deserves national recognition?

The ADA is now seeking nominations for the 20th Golden Apple Awards, an annual occasion that provides component and constituent societies with an opportunity to celebrate the successes of their leaders, members and staff.

The program offers 10 categories, some with subcategories, for participation:

- Legislative Achievement;
- Excellence in Membership Recruitment and Retention;
- Excellence in Dental Health Promotion to the Public;
- Excellence in Member-Related Services/Benefits;
- Outstanding Achievement in the Promotion of Dental Ethics;
- Achievement in Dental School/Student Involvement in Organized Dentistry;
- Excellence in Science Fair Program Support and Promotion;
- Excellence in Dentist Well-Being Activities;
- Open Category—Offered for the first time last year, the Open Category is for an innovative, successful program that does not fit into any other existing category;
- Inspiring Careers in Dental Education—Now open to nominations from not only constituent and component dental societies but also other dental organizations and members at large.

Programs and activities must have been produced between June 1, 2007, and May 31, 2008. For "Excellence in Dental Health Promotion to the Public," the programs and activities must have been produced between June 1, 2007, and May 1, 2008.

There are two different deadlines for entries. Entries for "Excellence in Dental Health Promotion to the Public" must be postmarked or sent by e-mail by end of day on Thursday, May 1.

Entries in all the other categories must be postmarked or sent by e-mail by end of the day on Monday, June 2; or received by U.S. mail no later than June 9.

Nominations for the New Dentist Legislative Leadership Award, the New Dentist Leadership Award and Outstanding Leadership in Mentoring Award (judged by the ADA Committee on the New Dentist) were due Dec. 1 to enable these awards to be presented at the ADA New Dentist Conference in June. (See story, page eight.)

This year, Golden Apple Award entries can be submitted electronically. Entry forms may be found at "www.adadentalsociety.org". Electronic copies are encouraged, but hard copies will be accepted.

Once completed, forms and supporting materials can be sent to "ddss@ada.org".

If you have questions, contact Ron Polaniecki, Ext. 2599 or "polanieckir@ada.org". ■

Letters

Continued from page five

disabilities, complex medical problems, and significant physical limitations."

The dental profession has been rightfully reluctant to gerrymander components of services into an extended number of specialties. Essentially, as we wrote in the JDE, instead of "let someone else do it … let us all do it."

H. Barry Waldman, D.D.S.
Distinguished Teaching Professor
State University of New York at Stony Brook
School of Dental Medicine
Stony Brook, N.Y.

Steven S. Perlman, D.D.S.
Global Clinical Director
Special Olympics, Special Smiles
Associate Clinical Professor, Pediatric Dentistry
The Boston University School of Dental Medicine
Boston

Editor's note: The ADA Council on Access, Prevention and Interprofessional Relations appreciates Drs. Waldman and Perlman's well-stated response. Many with an interest in special needs patients have acknowledged that there are patients whose needs will exceed the expertise of the general practitioner. In some instances, the preparation of general practitioners falls short of what is necessary for them to comfortably treat special needs patients.

The treatment of special needs patients is a shared responsibility for the dental profession, however that does not preclude the critical need for a cadre of individuals with advanced training in special needs care—whether for the burgeoning geriatric population or those with developmental or acquired disabilities.

The need for general dentists who are better prepared to care for vulnerable populations as well as the need for dentists with advanced training is being addressed by the ADA through Resolution 5H-2006.

One initiative is collaboration with key stakeholders to enhance undergraduate dental education to better prepare dental and allied dental students in caring for the growing elderly population. A second initiative involves educating policymakers and seeking funding support for advanced training programs to improve the health of vulnerable elderly.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Full steam ahead

New dentists will head to New Orleans for annual conference June 26-28

BY KAREN FOX

New Orleans—With a vibrant mix of networking, continuing education, leadership training and social activities designed for dentists in practice fewer than 10 years, the ADA's 22nd New Dentist Conference is coming to the Big Easy June 26-28. Online registration is now open.

"I have never attended an ADA New Dentist Conference that wasn't invigorating and thought-provoking," said Dr. Jennifer Barrington, chair of the ADA Committee on the New Dentist.

Dr. Barrington

"This conference is special because its structure encourages you to make connections with colleagues," said Dr. Barrington. "The networking opportunities and social breaks enable us to not only come together for CE and practice management courses, but also find out how our colleagues are handling the pressures of being new dentists. You may even find support and acquire great ideas from someone you meet from another region of the country."

Dental students—undergraduates and residents—will also find the experience rewarding.

"Students often strike up friendships at this conference and gain information about dental practice in the early years, such as what it's like to start your practice, the decision between ownership and associateship and so on," she said.

CE courses are specially targeted to new dentists, recent graduates and dental students, with up to 11 hours of CE units in practice management and clinical topics offered in addition to leadership development workshops. This year's clinical courses include:

- "The Perfect Smile: The Power, the Passion and the Path to Success"—Dr. Corky Willhite.
- "Case Sequencing, ADA-Pankey Education Connection"—Drs. LeeAnn Brady, Gary DeWood, Steve Ratcliff.
- "Incorporation of Dental Implants, Esthetics and Advanced Prosthodontics in the Modern Practice of Dentistry"—Dr. Dean Morton.
- "Predictable Restorative Dentistry, ADA-Pankey Education Connection"—Drs. LeeAnn Brady, Gary DeWood, Steve Ratcliff.

Practice management courses include:

- "Why Dentists Fail: Uncommon Secrets of Success That Will Transform Your Practice"—Steve Anderson.
- "Preparing for Practice Ownership"—expert panelists Richard Armstrong, Joel Harris, Dr. Gregg Liberatore, Dr. Ashish Patel, William Prescott, Dr. Eric Solomon, Rick Willeford.

The conference's leadership development programs are also open to participants:

- "New Dentist Volunteers: How to Get Involved and Stay Involved."
- "Advanced Leadership Program: Strong Leadership through Persuasive Communication"—Robin Wright.
- "New Dentist Committee Network Idea Exchange" and "Hot Topics: Ask Your ADA Leaders."

"We consider the 'Ask Your ADA Leaders' segment one of the New Dentist Conference's most unique events," said Dr. Barrington. "ADA officers and members of the Board of Trustees are in attendance, which gives new dentists an opportunity to discuss professional issues directly with the leaders of organized dentistry."

Tourism is flourishing once again in New Orleans and the conference's host hotel, the Hilton New Orleans Riverside, is just three blocks from the famed French Quarter.

The conference offers an opening reception, a Saturday morning networking breakfast and a Friday night dinner cruise aboard the Steamboat Natchez sponsored by the American Dental Political Action Committee.

Registration fees are reduced for those who register by May 9. The $295 early registration fee for member dentists ($145 for member dental students) includes all preconference programming, two full days of CE, breakfasts and lunches for Friday and Saturday, the opening reception on Thursday night and the event aboard the Steamboat Natchez. Special rates also apply for spouses, guests, and office staff and dental society staff.

Those registering can also purchase a complete set of CE course recordings for only $99 (a $100 savings) which include audio and visual presentation and can be purchased on CD or as an MP3 file.

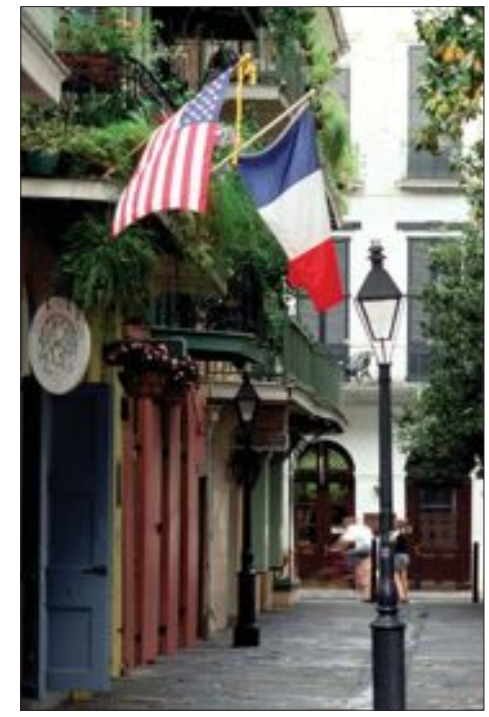
Sponsorship funding for the ADA's 22nd New Dentist Conference is provided by Matsco, Benco Dental Co., ADA Member Advantage, ADA Member Insurance Plans, ADPAC and the Oklahoma Dental Association.

Online conference materials, including registration, are available at "www.ada.org/goto/newdentconf".

If you have questions, contact the ADA Committee on the New Dentist at Ext. 2779 or "newdentist@ada.org".

The American Dental Association is an ADA CERP-recognized provider. ■

—foxk@ada.org



Scenes from the Big Easy: Bourbon Street, above, shines at night. At right, the French Quarter showcases New Orleans' unique architecture.

Photos by New Orleans Metropolitan Convention and Visitors Bureau Inc./Richard Nowitz

Members can save with ADA discounts on Chicago hotels, rental car rates

Terrific travel deals for ADA members—including discounts at Chicago hotels and Hertz #1 Gold membership—are available 24/7 online at ADA.org.

(ADA member number and password are needed to access this information. To obtain your password, contact the ADA at 1-312-440-2500, Ext. 3553.)

Discounted hotel rates in Chicago are available at the Ritz-Carlton, Four Seasons, Affinia, Hilton Suites, Homewood Suites, Whitehall and Wyndham hotels.

To check rates/availability and to make reservations, log on to ADA.org, click on the ADA Member Center, then Chicago Hotel Program. (If you're attending an ADA-sponsored meeting, please contact the ADA staff member organizing the meeting to determine if a special block has been arranged).

Discount car rentals are available to ADA members through Hertz utilizing the discount code: CDP#42371. Visit "hertz.com" or call Hertz reservations at 1-800-654-2200 to make your car rental reservations. ■

Government

Army Dental Corps sets high goals for patient safety

BY CRAIG PALMER

Fort Sam Houston, Texas—The Army Dental Corps has sights set on a "no blame" culture of patient safety in military clinics at home and abroad. "A Full Time Commitment, Not A Part Time Practice," says a promotional poster.

"With Fort Bragg DENTAC's commitment to TeamSTEPPS (a commercial training aspect of the patient safety effort) the vision is becoming a reality," said Col. Mary Jo Corbett, D.D.S. "This plan is not promoted as an initiative—this is the way that we do our mission every day to take care of soldiers." Dr. Corbett is the Fort Bragg, N.C., patient safety manager. DENTAC is one of 30 dental activities under the Army dental command (DENCOM).

"This plan is not promoted as an initiative—this is the way that we do our mission every day to take care of soldiers."

Army patient safety representatives describe a system that is on the ground and running but still in infancy, created "to identify and mitigate error events" by communicating and sharing information and learning from those errors. Training is but one aspect. A Web-based monthly reporting system is already producing trend data, they told the ADA News.

"Through the leadership of the DENCOM commander, Col. Larry Hanson, the dental patient safety program has been elevated to a high level of visibility with an open and no blame culture," the patient safety representatives said. "This type of culture encourages subordinates to speak up without fear of punishment or blame when errors occur." Training emphasizes use of a two-challenge method applicable to any clinic procedure. But challenges in the operatory, they concede, may require a culture change whatever reporting tools are in place.

An average DENCOM day

An unclassified Jan. 21 dental command briefing reported 8,100 patients seated, 24,300 dental procedures performed and $2.4 million in dental care provided on "An Average DENCOM Day."

This includes 4,600 X-rays, 2,600 amalgam and resin restorations, 1,400 cleanings and fluoride treatments, 385 mouthguards, 106 root canals, 75 periodontal surgery procedures, 610 periodontal cleanings, 655 extractions, 70 gold crowns cemented, 25 porcelain crowns cemented, 13 complete and partial dentures inserted, and 350 nutrition and 200 tobacco counseling sessions.

There are 1,022 dentists in the "DENCOM family," including 722 active duty dental corps officers, 51 Army civilian dentists and 249 contract dentists. ■

"It's going to take 10 years to change a culture and reach maturity. As the program advances, we are learning from our errors and driving up the standard of excellence that we already enjoy," said Col. Ann S. von Gonten, D.D.S., a dental consultant for the effort. "We're not selling a product, we're selling a change of culture," added Maj. Tim Fildes, a British Royal Army exchange dental officer on assignment with the U.S. Army "to help with the patient safety movement."

Patient safety vignettes are in preparation to enhance clinical training, said Robbie Sjelin, Department of Defense dental patient safety consultant and a dental hygienist and registered nurse.

Under the system, clinics report near miss and actual safety events monthly to a patient safety center. Patient safety representatives claim to have 100 percent reporting from all 30 dental activities within the command but this may not necessarily include every one of the 155 dental clinics and the one dental laboratory.

The Web-based reporting system lists nearly 80 "administrative" through "wrong site" events with an option to "check here if this facility has no events to report." The reporting system is already producing results. "The more data we get the more we can see trends," said Dr. von Gonten. "For example, we're finding a lack of standardization of correct sterilization procedures." These findings are communicated up and throughout the dental command chain.

"The events are analyzed with the goal of improving systems and processes of care," the patient safety representatives said. "Dental activity sites recognize that when errors occur, individual occurrences have less impression and impact as when the data are collated with similar events from other facilities, tracked, trended and shared with all."

A "Time Out" initiative engages patients in the safety movement. "The whole time out process is intended to ensure that the right patient gets the right treatment at the right time with all the right equipment," said Lt. Col. Andrew J. Wargo, D.D.S., the Army dental officer who created the "Time Out!" posters on display in patient areas throughout the dental command. The posters advise patients: "To ensure that you are receiving the proper treatment, please make sure your doctor confirms who you are and why you are here."

Patients with similar names or identification numbers are at greater risk of receiving dental treatment that was scheduled for other patients, the patient safety representatives told the ADA News. "The Time Out verification is a fail-safe 'No-Go' model where all participating team members check and agree as a team that a set of essential safety elements are present prior to an invasive procedure or treatment." ■

—palmerc@ada.org

Back roads dentistry

One dentist's story spotlights needs of vulnerable populations

BY CRAIG PALMER

Lafayette, La.—Dr. Gregory Folse sees national media attention to his "back roads" dentistry as one more opportunity to focus policymakers on the desperate needs of patients like his and the public-private contract to help them.

"It was great to see the oral health of a vulnerable population make the front page of a national newspaper," he said of the Washington Post "Dentist of the Back Roads" report Feb. 23, also posted online at "www.washingtonpost.com". The Post report "used me to tell a story and I hope that's what people get from this."

Dr. Folse specifically cites national policymakers, who started calling the day the Post published the report on his mobile nursing home practice. "Right now I have 1,800 nursing home patients, 900 of whom have moderate to severe gum disease and/or chronically abscessed teeth. Medicaid does not cover treatment of those infections in Louisiana, and most other states fail to provide adequate coverage for the aged, blind and disabled." Most of his patients are on Medicaid.

Dr. Folse

Dr. Folse thinks there ought to be a law and he's working on several of them, as he has over the years, in collaboration with his professional organizations, the American Dental Association and Special Care Dentistry among them, members of Congress and federal and state Medicaid officials. The ADA News has reported as well on Dr. Folse's patient advocacy.

He donates more than he bills Medicaid, Dr. Folse estimates. "But I can't donate enough services to meet the needs of my patients. Nor can dentistry. Hopefully, our policymakers in the [District of Columbia] will finally understand the need for government to step up to the plate and help our profession assure access for this needy and vulnerable population."

Nor does Dr. Folse confine his definition to measures of age or disability. One legislative effort he's pushing would increase Medicaid funding for children's oral health. Another would "fix inherent problems" related to Medicaid administrative and reimbursement issues. And many of his patients "with no access to any oral health services unless they are donated" are 20-, 30,- 40-year-olds developmentally or intellectually disabled, he said.

The Washington Post report described "three and a half days in my world," said Dr. Folse, "and it's like this every day." ■

Medicaid changes 'long overdue,' ADA president tells Congress

BY CRAIG PALMER

Washington—The Association urged fundamental change to dental Medicaid as Congress convened hearings "one year later" on the government's response to a Maryland boy's death from complications of an untreated oral abscess.

"Fundamental changes to the Medicaid program are long overdue to ensure that low-income children have the same access to oral health care services that most Americans enjoy," said ADA President Mark Feldman. "It is time to help Medicaid meet its obligation to help vulnerable groups get necessary services."

The Association in a statement for the hearing record urged congressional action on two pending bills:

• The Essential Oral Health Care Act, HR 2472, co-sponsored by Reps. Albert Wynn, a Maryland Democrat, and Mike Simpson, a dentist and an Idaho Republican, would encourage greater private practice participation in dental Medicaid and State Children's Health Insurance Programs with increased federal matching funds for states.

• Deamonte's Law, HR 2371, named for Deamonte Driver and offered by Rep. Elijah Cummings (D-Md.) who participated in a Feb. 8 Give Kids A Smile event at Baltimore's National Museum of Dentistry, would address dental workforce needs by providing grants to dental schools and qualified hospitals to encourage careers in pediatric dentistry.

Several states have significantly improved dental Medicaid programs by using the approach called for in HR 2472, the Association told the domestic policy subcommittee of the House Committee on Oversight and Government Reform. The Healthy Kids dental program in Michigan and the South Carolina dental Medicaid program have been cited by the Centers for Medicare & Medicaid Services as "successful programs," the ADA said.

"Access to dental services continues to be problematic for low-income populations," said the Association statement for the hearing record. "In order to truly address this problem, practitioners, payers, parents and policymakers need to come together and make the system work for the most vulnerable among us."

The domestic policy subcommittee convened the Feb. 14 hearing, "One Year Later: Medicaid's Response to Systemic Problems Revealed by the Death of Deamonte Driver," to examine actions taken by the CMS Center for Medicaid and State Operations to reform the pediatric dental program for Medicaid eligible children since the 12-year-old boy's death Feb. 25, 2007. The Association submitted a statement but did not testify at the hearing. ■

FBI offers forensics courses for dentists

Clarksburg, W.Va.—The Federal Bureau of Investigation offers courses for dentists interested in learning how to code dental forensic information for the National Crime Information Center and National Dental Image Repository.

The next course is scheduled for April 12-13 in Atlanta.

The course is free, but attendees will have to pay for their own transportation and lodging. A block of rooms at a group rate of $159 a night at the Omni Hotel CNN Center have been reserved.

The course will present an overview of the NCIC missing, unidentified and wanted person files; NCIC supplemental dental record; NCIC dental comparison algorithms; coding of missing and unidentified person records; interpreting NCIC cross match reports; and NDIR overview and submission.

Attendance is limited to 40 persons (licensed dentists) and registration is accepted on a first-come, first-served basis. Due date for registration is March 11.

To obtain a form, contact Stacey C. Davis of the FBI's Criminal Justice Information Services at 1-304-635-2618 or by e-mail at "stdavis@leo.gov".

Participants will receive a certificate for 12 hours of training at the end of the course. (Continuing education credits issued for participation in the course may not apply toward license renewal.)

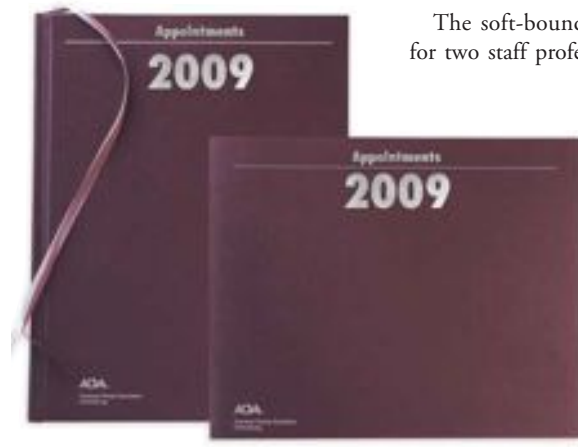
The ADA News will publish notices of future FBI dental coding workshops as information becomes available. ■

2009 appointment books available

Order now: get organized

ADA appointment books are a great way to make scheduling patients easier and stay organized in the process.

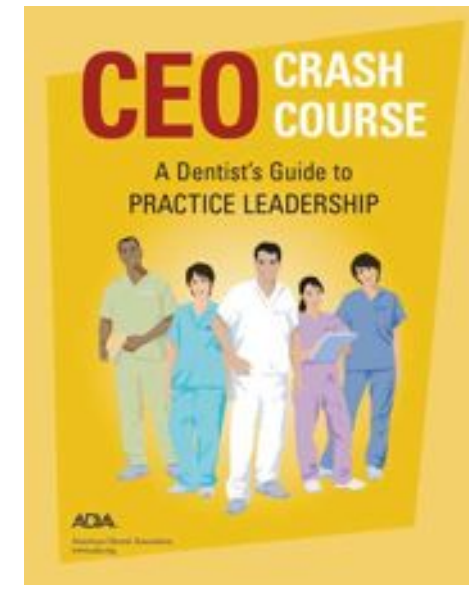
The 2009 books are maroon and each page spread is a week-at-a-glance. They also include your choice of bindings and layout. Holidays are clearly indicated, and ADA office phone numbers are listed along with annual session dates and locations.



The soft-bound book (E051) accommodates schedules for two staff professionals. The special binding ensures the book lays flat. Hours are divided into 15-minute increments (7 a.m.-5 p.m.) and space for evening hours.

Prices are $19.95 for members and $29.95 for nonmembers.

The hard-bound book (E050) is a single-column format and has two ribbons for marking pages. Hours are divided into 15-minute increments (7 a.m. - 9 p.m.) Prices are $24.95 for members and $37.45 for nonmembers.



Book offers management expertise

Does your practice need a boost? The ADA has a must-read management guide for dentists: "CEO Crash Course: A Dentist's Guide to Practice Leadership."

The book helps practice owners plan strategically, select trustworthy advisors, motivate staff and maximize practice efficiency.

CEO Crash Course is packed with expert tips from top practice management consultants, including Sally McKenzie, Dr. Roger Levin and Linda Miles.

The book is available in hard copy (item J712) and as a downloadable e-book (J712D). The cost is $39.95 for members and $59.95 for nonmembers.

Order your copy today and save 10 percent. Orders can be placed online at "www.adacatalog.org" or by calling 1-800-947-4746. To receive the 10 percent discount, reference priority code 20664N. ■

Consultants plan May conference

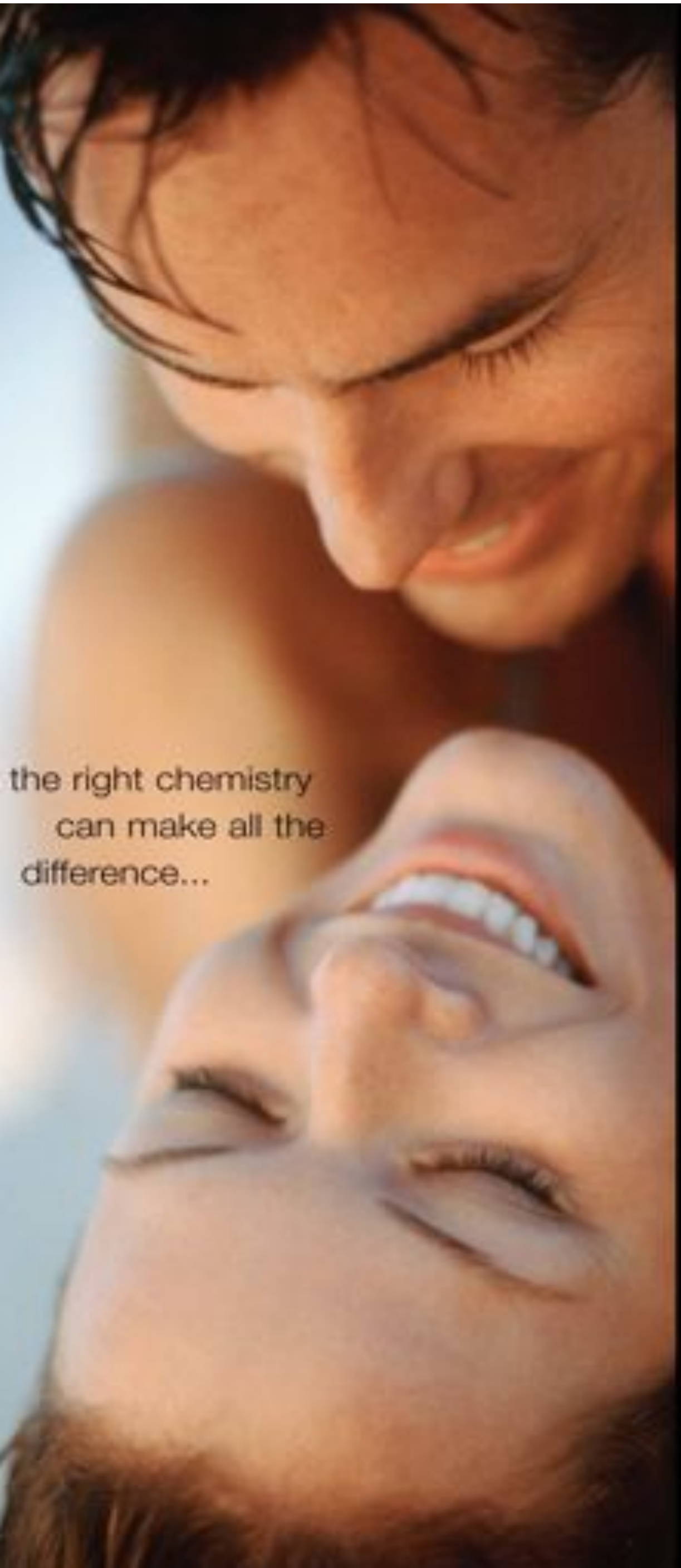
Scottsdale, Ariz.—The American Association of Dental Consultants will conduct its spring workshop here May 8-10.

Enhancing the Role and Relevance of the Dental Consultant is this year's meeting theme. Dentists, dental specialists and anyone else actively involved in the dental insurance business can attend the workshop for a potential 15 hours of continuing education credits.

Conference speakers include some of the industry's leading experts on clinical dentistry and dental claims management. They include:

- Dr. John Luther, senior vice president, dental practice/professional affairs, American Dental Association;
- Dr. Gordon J. Christensen, founder and director, Practical Clinical Courses and dean, Scottsdale Center for Dentistry;
- Dr. Warren A. Brill, trustee, American Academy of Pediatric Dentistry.

Prior to the workshop, on May 7, examinations for certified dental consultant candidates will be held. ■



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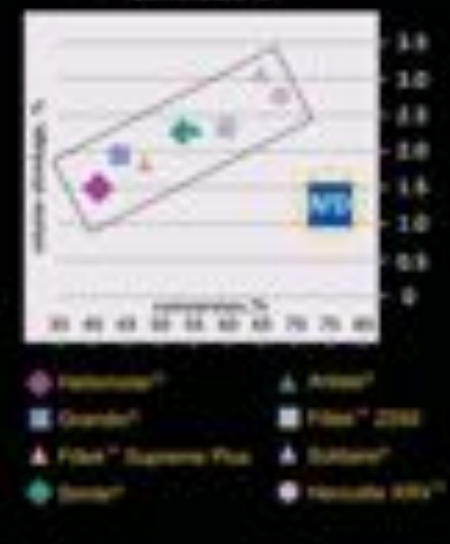

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Please visit us at the Hinman Meeting, March 13th-15th, Booth #1912

ADA Foundation grant to educate pediatricians in oral health care

BY STACIE CROZIER

A $300,000 grant from the ADA Foundation will help pediatricians collaborate with their dental colleagues to identify and refer young children with oral health problems.

The "Working Together for Oral Health" grant will arm pediatricians with the tools they need to assess the oral health of children, particularly those age 0-3, who can develop dental problems before they see a dentist for the first time. The grant will provide up to $100,000 annually for three years.

"The ADA Foundation is excited about this grant's potential to broaden the reach of oral health messages to parents," said Dr. Arthur A. Dugoni, president, ADA Foundation board of directors. "Our alliance with the American Academy of Pediatrics seeks to facilitate pediatrician and dentist collaboration at the national, state and local levels."

"Access to oral health care is critical for the early identification and prevention of childhood caries," said Dr. Lindsey Robinson, chair, ADA Council on Access, Prevention and Interprofessional Relations. "Unfortunately, many children in the 0-3 age group never see a dentist, especially economically disadvantaged children and those who live in areas without ready access to a dentist. Because pediatricians see children early and frequently, they can play a role in identifying high-risk children."

The AAP has recognized the rise of oral disease in young children and oral health as a key part of its strategic plan.

"We're grateful to the ADA Foundation for recognizing the importance of the role pediatricians can play in maintaining the oral health of young children," said Renee Jenkins, M.D., AAP president. "By arming pediatricians with the tools they need to assess oral health risk, we can begin to reduce the number of children who need but don't receive dental care and build a solid foundation for their oral health."

The collaborative effort will fund annual "train-the-trainer" oral health summits at which pediatricians will learn to conduct oral health risk assessments (including oral screening exams), teach families about oral health and prevention, and refer children to a dental home. Over three years, all 66 AAP chapters will have the opportunity to send representatives, who will return home to lead training in their home states.

The grant will also fund an oral health preceptorship program, which provides pediatricians in underserved areas with the support to promote oral health for the most vulnerable children. Ten awards will be given per year.

The grant will help address a variety of needs for young children. Recent statistics from the Centers for Disease Control and Prevention, the U.S. Surgeon General and the International Association for Dental Research show that:

- dental caries is the most prevalent infectious disease among U.S. children;
- while Americans of all ages continue to show improvements in oral health, tooth decay in primary teeth increased among 2- to 5-year-olds;
- more than 51 million hours of school are lost each year because of dental-related problems;
- caries in primary teeth increase the risk of caries in permanent teeth.

For more information on this or other ADA Foundation grants, log on to the Web site: "www.adafoundation.org". ■

FDI seeks executive director applicants

Ferney-Voltaire, France—The FDI World Dental Federation is seeking a new executive director.

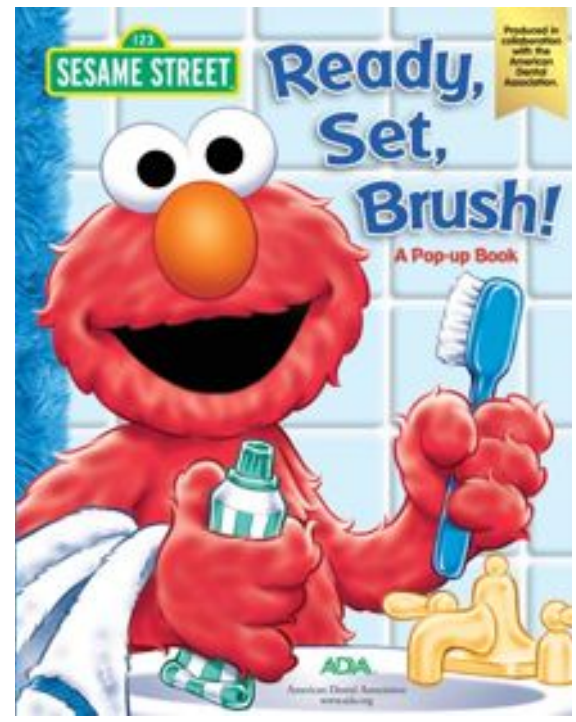
The successful executive director candidate will be responsible for the development and implementation of FDI strategy. He or she will lead and manage the Federation's office located near Geneva, and set up and run an efficient organization of all FDI activities, including its annual world dental congress.

A detailed job description and information on how to apply can be found at "www.ekornferry.com". (Click on the "Opportunities" link and then enter the Opportunity Code GQ382.)

The deadline for application submissions is March 24. ■

Brushing with Elmo

ADA teams up with Reader's Digest, Sesame Workshop on children's book



BY STACIE CROZIER

New York—A new pop-up book produced through a cooperative effort between Reader's Digest Children's Books, Sesame Workshop, the nonprofit educational organization behind Sesame Street, and the ADA will help young children across the U.S. learn how to take care of their teeth with help from Elmo, Cookie Monster and other Sesame Street characters.

"Ready, Set, Brush!" was released Feb. 5 and is available through retailers nationwide.

"We couldn't be more pleased to partner with Sesame Street on this book," said Dr. James Bramson, ADA executive director. "What a great way to get an oral health message out—it helps us live our vision of being America's leading advocate for oral health."

"What better way than to have Elmo remind another generation of children of the importance of good dental health?" said Harold Clarke, president and publisher, Reader's Digest Trade Publishing. "We are delighted to have the opportunity for Reader's Digest, Sesame Workshop and the ADA to combine resources on this project and hope that this book will be entertaining and educating kids for years to come."

The hands-on book is designed to help children and parents learn and discuss important oral health behaviors while they are having fun. Readers can spin a wheel to see how much toothpaste they need to put on Elmo's toothbrush (a pea-sized amount instead of a large dollop), use a cutout brush to clean Marvin Monster's teeth and more.

"We couldn't be more pleased to partner with Sesame Street on this book. What a great way to get an oral health message out—it helps us live our vision of being America's leading advocate for oral health."

"Sesame Workshop is pleased to have worked with the ADA for this newly released Sesame Street children's book," said Jeanette Betancourt, Ed.D., vice president, Outreach and Educational Practices, Sesame Workshop.

"It is just the start of an expected long-term collaboration in assuring that all young children, their families and caregivers have information that offers the need for preventive oral health practices that will last for a lifetime of well-being."

The book's back cover tells readers, "Even monsters need to brush their teeth to keep them healthy and strong. … Flaps to open, wheels to turn and fun pop-ups help illustrate elements of oral hygiene. … Learning to brush has never been so much fun!"

Sesame Street "monster" friends featured in the 12-page sturdy cardboard book include Elmo, Zoe, Cookie Monster and The Count.

"As part of our effort to reach out to nontraditional partners, the ADA Council on Access, Prevention and Interprofessional Relations has collaborated with Sesame Workshop and Reader's Digest to disseminate key prevention messages in an easily understood way using the power of media and global reach of their brands," said Dr. Lindsey Robinson, council chair.

"CAPIR is continuing to explore other collaborative opportunities which fall outside of the box to improve the oral health of the public," Dr. Robinson added.

The book is priced at $12.99 and is available through a variety of retailers, including Amazon.com, Barnes and Noble, Borders, Target, Costco and Sam's Club. ■

Health&Science

Q&A on evidence-based clinical recommendations for sealants

To assist dentists in using the new Evidence-Based Clinical Recommendations for the Use of Pit-and-Fissure Sealants, the ADA has developed a set of questions and answers to help in interpreting the new guidelines and discussing them with patients.

I've heard of evidence-based dentistry, but what is EBD really?

Evidence-based dentistry is based on three equally important pillars: a dentist's clinical skill and judgment, each individual patient's needs and desires, and high quality evidence. Only when all three are given due consideration in individual patient care is EBD actually being implemented. The third pillar, high quality evidence, is there to inform dentists and patients, but never to mandate a specific course of treatment.

What are evidence-based clinical recommendations?

They are a set of recommendations derived from the current scientific evidence that serve as a tool for dentists to use in addressing specific clinical situations.

Who actually develops these recommendations?

A panel of researchers and practitioners developed the recommendations after conducting an extensive critical assessment of the scientific literature. The results are reviewed by the ADA Council on Scientific Affairs and other ADA agencies. See "www.ada.org/goto/ebd" for more information about evidence-based dentistry.

How could the sealant clinical recommendations change the way I practice dentistry?

The clinical recommendations reach a number of conclusions that support things that dentists have known all along, including:

• Dental sealants are effective at preventing dental decay (primary prevention);

• Both children and adults can benefit from the use of sealants.

Other conclusions may be less familiar to dentists including:

• Sealants can stop noncavitated (incipient) lesions from progressing (secondary prevention);

• In most cases, removing tooth structure before placing a sealant is not recommended.

To be effective, sealants must be applied properly, monitored and replaced when needed. The evidence shows that retention of sealants is significantly enhanced when a four-handed placement technique is used.

What is the difference between primary and secondary prevention?

Primary prevention is intended to prevent the onset of disease—in this case, using sealants to prevent caries. Secondary prevention is intended to treat a patient who presents early (preclinical) signs of a disease to stop the disease from progressing. As a secondary preventive measure, a sealant is placed on an early, noncavitated lesion to stop it from progressing to a cavitated lesion.

Do the recommendations say anything about using X-rays?

A footnote to the sealant recommendations states that dentists should use recent radiographs, if available, in decision-making but should not take radiographs for the sole purpose of placing sealants. The ADA/Food and Drug Administration radiographic guidelines include recommendations on prescribing and patient selection.

What is the difference between a "noncavitated" lesion and an "incipient" lesion?

The recommendations use the term "noncavitated," defined as pits and fissures in fully erupted teeth that may display discoloration not due to extrinsic staining, developmental opacities or fluorosis, but that exhibit no shadow indicating dental caries. Some dentists use the term "incipient lesion" to describe the same condition.

How can I best explain to my patients that sealing over incipient decay is the most appropriate treatment?

How you communicate with an individual patient depends on that patient's understanding of dental caries. The ADA has published a patient education page, "Dental Sealants: Protecting Teeth, Preventing and Halting Decay," in the March JADA, which you can remove and use to talk with your patients.

I'm uncomfortable sealing over incipient lesions. Is it wrong to remove the incipient decay prior to sealing the tooth?

Patients rely on their dentists—as members of a science-based profession—to use the best available science to inform their treatment decisions. Your professional judgment, which is based on your experience and high quality evidence such

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Sealants

Continued from page one

apply the results of scientific studies to the unique clinical conditions presented by their patients," said ADA President Mark J. Feldman. "We feel certain that dentists and their patients will benefit from these reports."

The recommendations, developed by a CSA expert panel, reinforce the evidence that dental sealants are effective at preventing dental decay (primary prevention) and that both children and adults can benefit from the use of sealants. They also observe that sealants can stop noncavitated (incipient) lesions from progressing (secondary prevention) and, in most cases, removing tooth structure before placing a sealant is not recommended.

"These recommendations not only show how essential evidence-based reviews are, but also how effective sealants are in preventing and managing incipient lesions in children and adults," said Dr. Daniel Meyer, senior vice president, ADA Science/Professional Affairs.

The recommendations stress that in order to be effective, sealants must be applied properly, monitored and replaced when needed and the evidence shows that retention of sealants is significantly enhanced when a four-handed placement technique is used.

"The recommendations are applicable not only in private practice but also in public health settings because of their ability to help prevent the progression of disease in all age groups," Dr. Meyer said.

JADA contains a pull-out executive summary of the recommendations that explains the systems used for grading the evidence used and how the evidence is classified as to the strength of the recommendations. There also is a patient education page, "Dental Sealants: Protecting Teeth, Preventing and Halting Decay," which dentists can remove and use to talk with their patients.

Additionally, the March JADA includes two studies by the Centers for Disease Control and Prevention: "The Effect of Dental Sealants on Bacteria Levels in Caries Lesions," and "Four-Handed Delivery of Sealants: Exploring Four-handed Delivery and Retention of Resin-Based Sealants."

The panel began with the following clinical questions:

• Under what circumstances should sealants be placed to prevent caries?

• Does placing sealants over noncavitated lesions prevent progression of the lesion?

• Are there conditions that favor the placement of resin-based vs. glass ionomer cement sealants in retention or caries prevention?

• Are there any techniques that could improve sealants' retention and effectiveness in caries prevention?

The panel worked with ADA Center for Evidence-Based Dentistry staff and reviewed systematic reviews and clinical studies to develop recommendations for each of those clinical questions concluding, "sealants are effective in caries prevention and that sealants can prevent the progression of early noncavitated carious lesions."

In the summary of clinical implications, the authors note that they present the recommendations as a resource to be considered in the clinical decision-making process.

"As part of the evidence-based approach to care, these clinical recommendations should be integrated with the practitioner's professional judgment and the patient's needs and preferences. The evidence indicates that the sealants can be used effectively to prevent the initiation and progression of dental caries."

The Association also has EBD recommendations on professionally applied topical fluoride applications. Both sets of EBD recommendations represent a new approach to developing recommendations for the ADA. The EBD process involves analyzing and weighing the scientific data to support each

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Q&A

Continued from page 16

as the clinical recommendations, together with the patient's needs and desires, determine the appropriate course of action.

I routinely use sealants for children. Should I consider using sealants more frequently on adults?

Yes, the recommendations are clear: sealants are not just for children; adults can benefit too. The evidence supports placing sealants on pits and fissures of an adult's permanent tooth when it is determined that the tooth or the patient is at risk of developing caries. It also supports placing sealants on early (noncavitated) lesions in adults to reduce the percentage of lesions that progress to the dentin.

Will dental benefit plans cover sealants placed on adults?

The dental benefit industry will make decisions about coverage based typically on financial considerations. Additionally, the coverage may vary between benefit plans.

Will benefits be paid for replacement of sealants?

Specific details on coverage, such as replacements, are contained in the benefit plan documents. Since the clinical recommendations point out that sealants are effective in reducing the need for subsequent restorations, the ADA hopes that dental benefit plans may begin to include or increase coverage for sealant replacements.

Where can I go for more information about clinical recommendations on use of pit and fissure sealants or evidence-based dentistry in general?

Members are encouraged to call the ADA at the toll-free number, Ext. 2878, visit ADA.org or e-mail "science@ada.org". ■

AADA offers Senior Smiles kits

BY STACIE CROZIER

Applications for the 2008 Senior Smiles grant program are now available from the Alliance of the American Dental Association's Web site, "www.allianceada.org".

May 15 is the deadline for receipt of applications.

AADA conducts the Senior Smiles national oral health awareness campaign in partnership with Henry Schein Dental and GlaxoSmithKline Consumer Healthcare.

Health&Science

Grant recipients will receive a number of kits containing oral health products. Applicants must request a minimum of 100 kits. There are no limits to the maximum number of kits that can be requested. Recipients will also receive materials to help publicize their Senior Smiles programs as well as educational materials from the ADA's OralLongevity program.

These grants are open to all dentists and other dental team professionals who conduct educational programs in their communities. Grant applications that clearly demonstrate collaboration between an AADA member and a dental health professional will be given priority.

The mission of the Senior Smiles campaign is to educate seniors on the importance of good oral health and to raise awareness within the community of the oral health needs of seniors. This is the third year of the program.

AADA, developer of the Senior Smiles program, represents more than 6,000 American Dental Association member spouses committed to supporting the ADA through public oral health education, legislative advocacy and the well-being of the dental family.

Henry Schein Dental and GlaxoSmithKline Consumer Healthcare are the sponsors of Senior Smiles and exclusive providers of the oral health care products and educational materials. ■

FDA reports on denture cleansers

Rockville, Md.—The U.S. Food and Drug Administration has posted a Public Health Notification for health professionals on its Web site regarding possible allergic reactions from denture cleansers. The FDA says it has received at least 73 reports of adverse events related to proper and improper use of denture cleansers, including at least one death resulting from misuse of a product.

The PHN says the reactions, which include irritation, tissue pain, gum tenderness and respiratory conditions, can occur soon after the patient begins using the product or after years of use. All FDA safety alerts relevant to dentistry are posted on ADA.org. To access the one on denture cleansers and an accompanying Advice for Patients document from the FDA, go to "www.ada.org/public/topics/safety.asp". ■

Sealants

Continued from page 17

specific recommendation and is designed to assist dentists in making informed decisions about patient treatments.

Members of the ADA expert panel for sealants were:

- Dr. Jean Beauchamp, former member, ADA Council on Access, Prevention and Interprofessional Relations;
- Dr. Page W. Caufield, professor, cariology and comprehensive care, New York University College of Dentistry;
- Dr. James J. Crall, chair, pediatric dentistry, University of California, Los Angeles, School of Dentistry;
- Dr. Kevin Donly, chair, pediatric dentistry, University of Texas Health Sciences Center San Antonio Dental School;
- Dr. Robert Feigal, professor, pediatric dentistry, University of Minnesota School of Dentistry;
- Dr. Barbara Gooch, dental officer, Division of Oral Health, National Center for Health Promotion and Disease Prevention, Centers for Disease Control and Prevention;
- Dr. Amid Ismail, professor, University of Michigan School of Dentistry;
- Dr. William Kohn, associate director for science, Division of Oral Health, Centers for Disease Control and Prevention;
- Dr. Mark Siegal, chief, Bureau of Oral Health Services, Ohio Department of Health;
- Dr. Richard Simonsen. dean, Midwestern University College of Dental Medicine.

For more information, contact the ADA by phone at 1-312-440-2878 or by e-mail at "science@ada.org". Information on what to tell your patients is in the Q&A on page 16. For more on sealants, visit "www.ada.org/goto/sealants". ■

Capital treatment

D.C. dentists, Howard combine Give Kids A Smile efforts

Photo by Justin Knight

In training: Two unidentified dental students look for decay in a young GKAS patient at Howard University while Dr. John Bailey (right), director of clinical operations, observes.

Washington—Following a prescreening event for students at Powell and Truesdell Elementary Schools in the nation's capital, volunteers from the District of Columbia Dental Society and Howard University College of Dentistry provided free dental treatment for the children Feb. 1 for Give Kids A Smile Day.

School nurses identified children in need of care, said Dr. Eugene Giannini, GKAS chair for the D.C. Dental Society. On Feb. 1, more than 130 children received comprehensive treatment and preventive instruction at Howard University dental school.

Volunteers included Howard junior and senior dental students, faculty and private practice dentists. Additional support was provided by the District of Columbia's Public School System and Department of Health. Two members of the D.C. city council, Muriel Bowser and David Catania, observed the event.

"The oral health care needs of the underserved are not someone else's problems but rather they are our collective problem and concern," said Dr. Leo E. Rouse, dean of the Howard University College of Dentistry. "The dental school through Give Kids A Smile clearly demonstrates that as part of its mission, dental professionals have a responsibility to contribute to the elimination of oral health disparities, especially in children." ■

More GKAS coverage in March 17 issue

Happy result: Dr. Patrick Grogan and young patient who had chipped teeth. She is one of two triplets treated by Dr. Grogan on GKAS Day.

Workforce

Three pilot programs

Rural, urban and Native American sites prepare for launch this fall

Team work: The five individuals who will direct the CDHC pilot testing programs came to the ADA Feb. 21-22 to meet with the Workforce Models National Coordinating and Development Committee. From left are Donna Kotyk, Salish Kootenai College, Montana; Dr. Nancy Reifel, University of California-Los Angeles; Dr. Amid Ismail, Michigan Coalition for Development and Implementation of the CDHCs; and Dr. Dunn Cumby and Rosita Long, Ph.D., University of Oklahoma College of Dentistry.

BY KAREN FOX

ADA Workforce Models National Coordinating and Development Committee Chair Bob Brandjord looks at the three sites selected to pilot the Community Dental Health Coordinator training and knows the program is in good hands.

"I am really excited to be moving ahead with this demonstration of the CDHC, especially when I look at the directors of the pilot programs and their credentials," said Dr. Brandjord.

"Every director has a master's degree in public health. Dr. Dunn Cumby has a master's in theology, Dr. Amid Ismail has a doctorate in public health and master's in business administration, Dr. Nancy Reifel served her entire career in the Indian Health Service," he said. "The ADA couldn't have asked for better people to direct this program."

The ADA selected three sites—rural, urban and Native American settings—at which the CDHC workforce model will be piloted this fall.

The rural site will be directed by Dr. Dunn Cumby, chair, and Rosita Long, Ph.D., assistant professor of research, of the University of Oklahoma College of Dentistry's Division of Community Dentistry. Participating in the pilot program presents a great opportunity for the college to bridge the gap between dentistry and the people who have oral health disparities, they said.

"Access to care is such an ingrained problem in the rural communities," said Dr. Long. "Most people in rural areas have low expectations for health care, and unfortunately many don't even care anymore. They tend to think that no one wants to help them. This has become a real deep hole that we as health practitioners have got to dig our way out of.

"Dr. Cumby and I both grew up in rural Oklahoma," she continued. "Those are our relatives. We know what they've been through, what they've had to do without. What happens is their overall health declines because of behavior related to their oral health."

Drs. Long and Cumby will recruit potential CDHCs for the rural program by seeking out people who are involved in the community, said Dr. Cumby.

"We're looking for people who have a history of community involvement, and we're going to federally qualified health centers and Native American health centers to ask them to help us identify individuals who would function well in this new role," said Dr. Cumby. "We see them as valuable resources for navigating the health system and identifying people within a community who for many reasons don't utilize services of dentists."

The pilot program for the Native American site is a partnership between the University of California-Los Angeles and Salish Kootenai College of Pablo, Montana, a tribal college on the Flathead Indian Reservation with a CODA-accredited dental assisting program. Dr. Nancy Reifel, a public health dentist retired from the Indian Health Service, and Donna Kotyk, director of dental assisting at SKC, are directing the program.

Many graduates of Salish Kootenai are ideally suited for the Community Dental Health Coordinator program, they said. Some are already working in Indian Health Service facilities where they coordinate health screenings and sealant programs for organizations like Head Start and WIC. "We depend on our local dental assistants to help with community integration of dental services," said Dr. Reifel, an assistant researcher at UCLA. Training CDHCs would build on the skills that these individuals already have.

The potential for success of this workforce model comes from "ease of access, ability to triage patients and communicate effectively with doctors," added Dr. Reifel. "Not only do they have an understanding of the community, but also can communicate with dentists in a manner that facilitates treatment and referrals."

Dr. Reifel and Ms. Kotyk will promote the CDHC program in all IHS regions and offer a nationwide application process.

The potential for success of this workforce model comes from "ease of access, ability to triage patients and communicate effectively with doctors," added Dr. Reifel. "Not only do they have an understanding of the community and have access to these populations, but also can communicate with dentists in a manner that facilitates treatment and referrals."

"At Salish Kootenai we feel it's a great honor to be part of this pilot program," said Ms. Kotyk.

"I see this as one of many changes that are happening in the dental profession," added Dr. Reifel. "We are recognizing a need that's not being met. It's a monumental change and it's good to keep moving forward. The pilot project will tell us what community needs the CDHC has the ability to address."

Dr. Amid Ismail is directing the urban site in Detroit through the Michigan Coalition for Development and Implementation of the Community Dental Health Coordinators. The coalition will collaborate with the Wayne County Community College District and include representation from the Michigan Dental Association, the state dental board, the state dental hygienists' association and the state dental assistants' association, federally qualified health centers and the two dental schools in the state.

"What we're doing here is providing necessary care with the idea to test the model, continue it or stop it," said Dr. Ismail, a member of the NCDC and past chair of the ADA Council on Scientific Affairs. He cites data from 2002 that underscores the need for oral health care for Detroit's underserved populations.

With a population of 920,000, Detroit has about 318,600 children age 0 to 21 who are eligible for Medicaid. Of those children, 29,932 are age 0-1. The percentage of children in the 0 to 1 age group who had a dental visit in 2002 was 0.2 percent.

"We ask ourselves, how can we assist with change?," said Dr. Ismail. "Our focus will be on families. By age 2, about 20 percent of children in Detroit have cavities. We are starting with very young children (infants to age 1), and educating caregivers and mothers.

"The CDHC will be the extension of the clinic in the community," he continued.

"The CDHC identifies urgent needs and follows up with the family and caregivers with preventive care. If there is a problem such as a child with a lot of caries, the CDHC will go into the home and assist the caregivers to develop and implement a prevention plan. The CDHC will be trained in motivational interviewing and have knowledge of all resources in the community."

Dr. Cumby of Oklahoma said the CDHC proposal is one that "gives the profession an opportunity to make changes and also dream a little bit."

"I applaud the ADA for taking the initiative to do something here," said Dr. Cumby. "There is so much resistance to change. Change is challenging. If we don't do something as a profession to address these people we're called to serve, the government will.

"It's pretty neat to be part of this new initiative," he continued. "Any time you can still be innovative and look for different solutions to old problems, that needs to be commended." ■

CDHC

Continued from page one

potential to deliver oral health care to underserved populations," said NCDC Chair Bob Brandjord.

"Through this model, we are providing community health worker and dental skills to individuals who come from the communities they serve and work as a member of the dental team in underserved communities where residents have no or limited access to dental care," said Dr. Brandjord.

The ADA is committed to exploring new allied personnel categories to help the profession address access needs, he added.

The CDHC, which has been in the works for several years, is one part of the ADA's response to the oral health needs of the underserved.

"Community Dental Health Coordinators are the navigators who get patients in need into the system, and connect them with providers of care and those who work with services such as Medicaid and other public assistance type programs," said Dr. Brandjord.

The proposal calls for CDHCs to:

- work under a dentist's supervision in health and community settings such as schools, churches, senior citizen centers, Head Start programs and other public health settings with residents who have ethnic and cultural backgrounds similar to the CDHC.
- collect information to assist the dentist in the triage of patients.
- address the social, environmental and health literacy issues facing the community population.
- assist community members in developing goals to promote their own personal oral health.
- manage the care and navigate patients through the maze of the health and dental care systems.
- provide preventive services including screenings, fluoride treatments, placement of sealants, placement of temporary fillings and simple teeth cleanings (selective scaling for periodontal type I [gingivitis] such as removing gross debris, stains and calculus using anterior and posterior sickle hand scalers until the patient can receive treatment from a dentist or hygienist). Type 1 periodontal disease is defined as inflammation of the gingival tissue in the absence of clinical attachment loss.

The CDHC program does not propose to eliminate any current category of dental personnel, Dr. Brandjord emphasized, nor deliver a substandard level of care to any patient.

"CDHCs will enhance and complement the services delivered by dental hygienists, dentists and community health workers," he said.

"They will function in an integrated system with a dentist and other dental team members, whatever the clinic may be—Indian Health Service, Native American community, federally qualified health center," said Dr. Brandjord. "They are part of a dental team. CDHCs are the ones who go out into the field and help bring patients into this environment to be treated, while delivering some care and evaluation."

The ADA has estimated that CDHCs will cover their cost of operation through the recruitment of Medicaid recipients. To accomplish that, they must be salaried employees of a dental clinic and work remotely and directly with a dentist. A

See CDHC, page 23

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Lead

Continued from page one

where dental lab work is done, but rather how dentists and their patients can be assured of the quality and safety of materials.

"When we learned of these findings we immediately pooled our resources to determine what we should do first to guide our members and our patients," said Dr. James Bramson, ADA executive director. "The first thing our members should do is start talking to their dental laboratories to be sure they know what methods and materials those labs are using."

How do you write a lab prescription?

How can you be sure the prosthesis you ordered is what you receive ?

The Council on Dental Practice says the more detailed your request is in terms of what materials you expect the dental laboratory to use (or not use), the more assurance you will have about what they are providing and the more assured you can be about receiving a prosthesis that will best meet patient needs. ■

The first resource the ADA is providing to members is a tip sheet (on this page and ADA.org) listing what dentists should know now and be able to learn from their dental laboratories to gain reassurance that the products made there are lead free. ADA.org is also providing talking points to help members answer patients' potential questions about dental work.

While the TV investigation sounded alarms, it failed to put its discoveries into any meaningful context, specifically, how did the lead in the dental prostheses occur? Furthermore, what does it mean? What should the existence of lead in the proportions provided in the report—160 parts per million for a bridge, 210 ppm for a crown—mean to dentists and their patients?

The ADA is devoting its resources to find out by working closely with the Food and Drug Administration and other state and federal regulatory agencies. The objective: To learn what can be done to help protect the public from potential hazards stemming from raw materials or manufacturing of dental prostheses.

The Feb. 27 TV program didn't have enough information to report where in the dental prostheses the lead was found. Materials experts say the stain is a likely culprit because lead helps with shading certain colors.

The ADA Standards Committee on Dental Products intends to address specific requirements that test for the concentration or composition of the pigments used by dental laboratories to pigment and glaze porcelain materials.

The ADA Department of Standards works with the American National Standards Institute and the International Standards Organization to create international standards for the profession. (The ADA tip sheet recommends dentists request verification of dental laboratory compliance with ANSI and ISO standards.) Theoretically, it's possible that lead could have come through a soldering process or as a contaminant from the lab environment. Standards are already in place that dental laboratories should comply with to address the safety and quality of the metal ceramic dental restorative system (ANSI/ADA Specification No. 38) that include requirements to test for the metal alloy composition and concentrations of the materials. ANSI/ADA Specification 41 requires that all materials used in the final porcelain/ceramic materials meet the Standard Practices for Biological Evaluation of Dental Materials.

According to stain suppliers and manufacturers contacted by ADA News both here and abroad, the surface material for a dental prosthetic device should never contain lead. That's what the FDA requires.

The ADA strongly supports state legislation in the dental practice act that requires all dental laboratories to disclose to dentists where a product was manufactured (all or part of it) and what materials were used, through documentation to the dentist. Dentists can then place documentation received from the lab about sources and materials in the patient's chart, so that patients can request the information and it can be tracked and traced later on, if needed. The best thing for a dentist to do is to ask the lab what stains it is using and to ask the lab to provide the material safety data sheets on those stains, according to materials managers. The dental laboratory gets the MSDS from the raw materials vendor and should provide it to the dentist.

Every U.S. stain supplier and manufacturer ADA News interviewed here and abroad reported the ability to provide the MSDS for all of their products.

"We develop the MSDS as part of the product development process long before we're ready to market a product," said Julie Noriega, manager, quality assurance and regulatory affairs for DENTSPLY Ceramco Manufacturing, Puerto Rico.

All dental laboratories (foreign and domestic) are required to comply with the FDA Quality System/Good Manufacturing Practices for products distributed in the U.S. Dental laboratories that operate overseas, serve as the initial importer for a foreign laboratory, conduct repackaging services or manufacture sleep apnea/snoring and other certain orthodontic appliances are required to register.

The FDA told the ADA News it has the authority to inspect any dental laboratory manufacturing for the U.S.—registered or unregistered—in the United States or abroad. Registration triggers periodic inspections.

Dental prostheses are among products marketed in the U.S. that require FDA clearance before they can be sold. Such products require the submission of a pre-market notification application, called a 510(k). Any manufacturer marketing a product requiring a 510(k) in the U.S. has to have shown the product is the equivalent to a product that the FDA has already cleared for marketing domestically. Only materials for which manufacturers have completed an FDA pre-market notification 510(k) should be used in dental prostheses.

Dental laboratory experts say there are many excellent dental laboratories overseas. For them, the savings isn't incurred through raw materials, but lower labor costs.

DENTSPLY opened an FDA registered dental laboratory—Prident—in China in 2006. The dental laboratory materials used there are the same materials cleared by the FDA, supplied by DENTSPLY and sold to its U.S. laboratory customers, according to Arlo King, director of technical education for DENTSPLY Prosthetics, and Charles Pigott, vice-president quality assurance and regulatory affairs.

"We can trace any raw materials we use through the lot and case number," said Mr. King. "Dentists should know their lab partners well enough to know if they ask for this kind of information the lab can provide it."

Prident sells only to U.S. dental laboratories, not directly to dentists.

Upcoming ADA News issues will feature more detailed coverage on this topic and guidance from ADA leaders, as information and news develop. ■

eGRAM update

The ADA believes news like this shows how important it is to have members' current e-mail address. Please share this information with your colleagues and ask them to let the ADA know ("dpdfeedback@ada.org") their e-mail addresses if they did not receive this eGRAM directly from the ADA. ■

Tip sheet for dentists concerned about lead

I am a general dentist and have just seen a television news story about a dental crown manufactured in China that was contaminated with lead. I am concerned about lead contamination. I am also concerned for the safety of my patients. What can I do?

First and foremost, call the dental laboratory that you use in your practice and ask:

- Do you outsource any part of my work to other labs?
- If yes, specifically what work of mine is outsourced?
- Do you outsource any part of my work to a foreign lab?
- If yes, will you provide me with the FDA registration number of foreign lab doing my work?
- Will you also provide me with your registration number with the FDA as an "initial importer," "re-packager" or "re-labeler?"
- Have you actually visited the foreign lab to which you are outsourcing my work?
- Will you provide me with documentation that the materials used in the work you outsource are FDA approved and compliant with all ANSI and ISO standards?
- Will you fill my detailed lab prescription as written, regardless of where my work is fabricated?
- Do any of the materials you use to fabricate my work contain lead?
- Will you provide me with a document detailing the materials used in my work?
- Do you have products liability insurance or other insurance that will protect me against claims for injuries allegedly caused by dental restorations coming from your lab?

Your dental laboratory should be able to answer each question to your complete satisfaction. ■

Reasoning behind the questions

- Some labs outsource domestically, as well as internationally.
- Most of the outsourcing to foreign labs is crown and bridge.
- Foreign outsourcing is still a relatively small share of the market, estimated to be approximately 15-20 percent.
- A foreign lab importing to the U.S. must be registered with the FDA.
- Domestic labs that import, re-package or re-label must also register with the FDA.
- A site visit may imply a higher level of "due diligence" by the domestic partner.
- Labs should stand behind the material content of the outsourced work.
- Dentists should be as specific as possible, designating components and brands in their prescriptions. Labs should fill dental prescriptions exactly as written and inform dentists in advance of any substituted materials.
- There is no justifiable reason to use lead in dental materials.
- Labs should be able to provide you with detailed written statements of assurance. ■

Dentist named to heritage commission

Commissioner: Dr. Michael A. Menis (center) is sworn in as a member of the U.S. Commission for the Preservation of America's Heritage Abroad in June 2007 at the U.S. Supreme Court Building by Justice Samuel A. Alito Jr. (left). Commission chair Warren Miller is also present.

Washington—President George W. Bush in May 2007 appointed oral and maxillofacial surgeon Dr. Michael A. Menis of Crystal Lake, Ill., to serve on the U.S. Commission for the Preservation of America's Heritage Abroad ("www.heritageabroad.gov").

"I am deeply honored to have been appointed to serve on this commission," said Dr. Menis, a 2007 graduate of the ADA/Kellogg Executive Management Program for Dentists.

"Current and past commission members have dedicated themselves to preserve and restore sites of America's heritage throughout Central and Eastern Europe," he said. "I look forward to the opportunity to work with the commission in continuing to carry out to its vital mission."

Established by an act of Congress in 1985, the 21-member commission is charged with preserving, protecting and restoring sites of religious and cultural heritage of Americans in Central and Eastern Europe that have been neglected due to the destruction of the local communities during the Holocaust. In addition, the Commission identifies sites of mass murder and erects monuments to memorialize the victims.

Commission members work with Warren Miller, chair, in identifying projects that are in keeping with the commission's purpose. Projects are implemented through the support of the U.S. Department of State and respective European governments. The projects are all privately funded. ■

CDHC

Continued from page 20

financial analysis conducted by an expert in evaluating community health centers concluded that recruiting around 540 new Medicaid recipients would cover the cost of operation and the extra care provided by the clinic.

Phase 1 of the CDHC proposal (development of the comprehensive curriculum materials) has been completed. The ADA Foundation funded Phase 1 with a $334,000 grant.

Phase 2, with $2 million in funding from the ADA, calls for the curriculum to be piloted and evaluated independently at three different settings (urban, rural and Native American) over a three-year period. The sites selected are:

• Urban: The Michigan Coalition for Development and Implementation of the Community Dental Health Coordinators in collaboration with the Wayne County Community College District. Plans are in the works for training to take place in federally qualified health centers.

• Rural: University of Oklahoma College of Dentistry. Plans are in the works for hands-on clinical training to occur in Native American health facilities and federally qualified health centers.

• Native American: This site involves several locations directed by the University of California-Los Angeles and Salish Kootenai College of Montana. Hands-on clinical training will occur in Native American health facilities in several different sites.

(For more about the pilot programs, see story, page 20.)

Rio Salado College, a Tempe, Ariz. community college with an accredited online dental assisting program, will deliver the online components of the CDHC curriculum for pilot programs in the rural sites and Native American sites.

Longer term assessment of the CDHC program is also in place, said Dr. Brandjord.

"The outcomes will provide objective evidence regarding the future viability of this new personnel category," he said. "This is a demonstration project and we want to be sure that this is the right solution for part of the oral health access problem." ■

—foxk@ada.org

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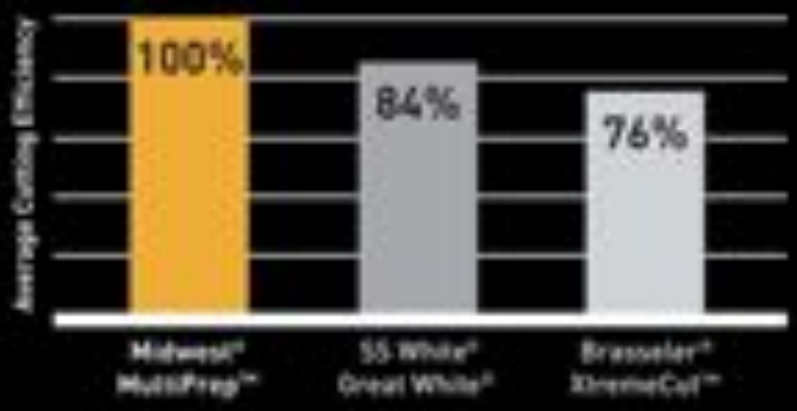

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