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ADA News - 10/06/2008

American Dental Association, Publishing Division

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AMERICAN DENTAL ASSOCIATION WWW.ADA.ORG

ADA NEWS®

OCTOBER 6, 2008 VOLUME 39 NO. 18

ADA to mark sesquicentennial with year-long celebration

BY JAMES BERRY

In August 1859, 26 men representing several existing dental associations gathered at Niagara Falls, N.Y., and formed what would become the American Dental Association.

In 2009, 150 years later, the ADA, its constituent and component societies and its more than 156,000 members will commemorate that momentous occasion through a wide range of events and activities.

The ADA's sesquicentennial celebration actually will kick off at this year's annual session in San Antonio, build through the coming year and culminate in events surrounding the 150th annual session in Hawaii, October 2009.

Commemorative pin: Pictured here is a facsimile of the pin being given out at annual session in San Antonio. Story, page 22.

Those planning the celebration hope it will engender "a heightened sense of pride in our longevity and our record of improving the health of our patients over the years," said Dr. Walter F. Lamacki, a past ADA trustee from Illinois and chair of the sesquicentennial planning committee.

See CELEBRATION, page 22

Photo by Bill Geiger

Advocate: Dr. Grover speaks Sept. 23 to Congress.

Association seeks improvements for dental Medicaid at hearing

BY CRAIG PALMER

Washington—The Association urged Congress to shore up dental Medicaid for vulnerable low-income children by improving reimbursement rates, addressing administrative barriers and reaching out to the dental community.

"First, get many more dentists into the system, which is the primary focus of this hearing," Dr. Jane Grover, ADA first vice president, told the House Committee on Oversight and Government Reform's subcommittee on domestic policy. "Second, influence the geographic distribution of those dentists to make sure they can serve the Medicaid population in a timely fashion. Third, support other initiatives that strengthen the oral health delivery system."

The subcommittee chair, Rep. Dennis Kucinich (D-Ohio), cited the "positive impact" on dental Medicaid of increased dental reimbursement rates, disease management efforts and unified Medicaid management. "Today we seek to move beyond identifying problems with our pediatric dental program under Medicaid and start identifying the reforms necessary to fix a broken system."

Dr. Grover, the ADA witness at the Sept. 23 hearing, offered Michigan's "Healthy Kids Dental" program as one model of effectiveness in improving oral health access. "(This) is essentially the same as the private sector Delta Dental plan used by many people with coverage provided by their employers," she testified. "Dentists are paid at a PPO (preferred provider organization) rate, which might be less than the usual rate charged but is still widely accepted.

"The claims processing is identical to the private sector plan, except that beneficiaries have no copays and there

See MEDICAID, page 17

BRIEFS

Sign-up time: The seventh annual national Give Kids A Smile event is just four months away, and it's time for program coordinators and dentist participants to register their programs and request free products from GKAS program sponsors Colgate and Henry Schein Dental.

The 2009 GKAS day is set for Friday, Feb. 6.

"It's so important for dental professionals to register and be a part of Give Kids a Smile Day," said Molly Pereira, associate executive director, Colorado Dental Association, and a GKAS program coordinator. "This is the largest nationwide effort to not only help deserving kids on a designated day, but also draw attention to the fact that each of our states share the access-to-care problem and are committed to making a difference. While dental associations across the nation are working on the long-term solution, we can't ignore the immediate needs of these children, desperate for dental attention."

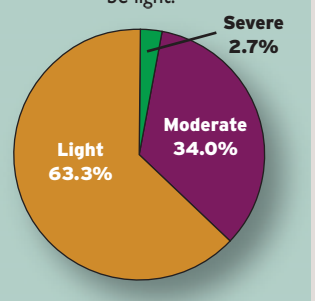
Participants can register their programs and request free products at "www.ada.org/goto/gkas".

See BRIEFS, page 17

JUST THE FACTS

Stress

The majority of dentists perceive their stress level at home to be light.



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ADA to study ways to collaborate with ADAA

Based on a request from the American Dental Assistants Association to explore additional ways to collaborate, the ADA Board of Trustees has directed the councils on Membership and Dental Practice to study ways the ADA can work with ADAA, the oldest and largest group representing professional dental assistants.

"For many years, the ADA and American Dental Assistants Association have collaborated on issues of mutual concern which has been a benefit to patients and the entire dental team. We value our past working relationship and look forward to exploring future collaborations," said ADA President Mark J. Feldman, who will also have an opportunity to address the ADAA membership during the organization's annual conference in San Antonio this month. The ADAA returned to holding its meeting in conjunction with the ADA annual session last year.

The ADA Council on Dental Practice and ADAA representatives already maintain liaison activities in order to discuss areas of mutual concern and identify potential collaborative projects. The council also collaborates with the ADAA, the Canadian Dental Assistants' Association and the Canadian Dental Association to promote the recognition of dental assistants during the annual Dental Assistants Recognition Week.

In addition, ADAA representatives have been a valuable resource to the ADA and its Council on Dental Practice and Department of Salable Materials in the development of three publications in the ADA Catalog: Fast Track Training: The Basics for Dental Staff; Basic Training II for New Clinical Personnel; and Basic Training III for Dental Administrative Personnel.

ADA and ADAA will begin discussions during upcoming meetings of the councils on Membership and Dental Practice. The councils will report back to the Board at a future date. ■

Ethics and integrity subcommittee outlines initiatives for House

BY KAREN FOX

With the ADA Board of Trustees' support, the Opening Session of the House of Delegates will now include a statement from the Speaker of the House on ethics and integrity in the dental profession.

The Speaker's address is just one of several recommendations made by the Joint Subcommittee on Ethics and Integrity in Dental Education, a workgroup appointed in 2007 when the Board charged two councils—Dental Education and Licensure, and Ethics, Bylaws and Judicial Affairs—to develop recommendations for advancing ethics in dental schools in an effort to curtail unethical and unprofessional conduct.

The dental profession has heightened its focus on ethics in education and the profession in recent years since several incidents of cheating on graduation requirements, National Board Dental Examinations and clinical licensure exams came to light.

At its meeting in August, the Board of Trustees approved the joint subcommittee's action plan, which proposes several comprehensive initiatives and activities already being implemented by stakeholder organizations working collaboratively with the subcommittee—including the American Dental Education Association, the American College of Dentists, American Student Dental Association, Commission on Dental Accreditation, American Association of Dental Examiners, American Society of Dental Ethics and the Joint Commission on National Dental Examinations.

"I am very pleased with the progress that the subcommittee has made this past year with issues as complex as ethics and professionalism," said Dr. Stephen K. Young, joint subcommittee co-chair. "The progress we have made is due in large part to the collaboration between CDEL and CEBJA with the American Dental Education Association and American College of Dentists and several other organizations. Each council and association brings its own expertise to the table and also reduces duplication of effort."

The joint subcommittee has already achieved several of its goals; others will take more time to complete. In August, the ADA Board approved the continuation of the subcommittee's work and authorized expansion of its scope to address ethics and integrity issues facing dental practitioners. In so doing, the Board directed that representation from the Council on Dental Practice be added to the subcommittee's membership.

"We are seeking to re-affirm a commitment to enhancing ethical standards and the conduct of all individuals in the dental profession," said Dr. W. Scott Waugh, co-chair of the joint subcommittee. "Unethical conduct impacts the entire profession, and the same expectations should be required in dental practices and dental organizations as they are in educational programs."

Some examples of the joint subcommittee's recommendations can be found in Board Report 14 in members-only content on ADA.org. (For a more complete list of the subcommittee's recommendations, see story, this page.)

An example of the initiatives considered by the subcommittee is the development of an ethics scenario library that could be used to further the understanding of ethical principles. However, the subcommittee learned that the American College of Dentists is in the process of developing a clearinghouse of ethical case studies that it intends to make available online. Some sample cases were published in a recent Texas Dental Journal and are posted at "www.dentalethics.org/ethicaldilemmas.shtml". Rather than duplicate ACD's effort, the joint subcommittee agreed that the ADA's support and assistance should be provided to ACD in developing its clearinghouse.

The subcommittee has also published the proceedings from the Symposium on Ethics and Integrity in Dental Education as a way to keep interested parties informed of the profession's efforts to curtail unethical or other inappropriate conduct.

In 2007, CDEL and CEBJA co-sponsored the Symposium on Integrity and Ethics in Dental Education to address the apparent increase in unethical and unprofessional behaviors by dental students. ADEA and ACD and 70 other stakeholders and national experts on ethics participated in the event.

Copies of the proceedings will be available for ADA delegates in the Information Resource Center in the Delegates Registration Area during annual session. An executive summary is available online at "www.ada.org/prof/ed/ethics_symposium.pdf".

The subcommittee continues with the full support of both CDEL and CEBJA.

"The council is highly supportive of this issue," said Dr. Frank Maggio, CDEL chair. "It started out as an idea within the council three years ago and has expanded to include all interested parties working diligently on solutions. I believe that having all of the profession's stakeholders involved has been and will be essential and beneficial as we move forward."

Continuing the work of the joint subcommittee is essential, added Dr. James F. Smith, CEBJA chair.

"We have been extremely pleased with the intercouncil cooperation with this subcommittee thus far, but these activities won't happen overnight," said Dr. Smith. "Continuing the joint subcommittee's work is fully supported by the council and is in the best interest of the profession." ■

—foxk@ada.org

Professional ethics: Dr. Stephen K. Young (right), shares an opinion during the Joint Subcommittee on Ethics and Integrity in Dental Education meeting at ADA Headquarters July 18. Looking on is Dr. W. Scott Waugh, who co-chairs the subcommittee with Dr. Young.

Student view: Dr. Shamik Vakil represents ASDA on the joint subcommittee.

Collaboration: Dr. Marsha Pyle, chair, Joint Commission on National Dental Examinations, speaks out at the July 18 meeting.

New Jersey dental students win first ethics video contest

San Antonio—Brett Druger and Aaron Brody of the University of Medicine and Dentistry of New Jersey/New Jersey Dental School are the winners of the Council on Ethics, Bylaws and Judicial Affairs' Student Ethics Video Contest.

Their video, "Dying For Fixed," will be unveiled during the ADA annual session in the prefunction space of Ballroom A near the Registration Area.

Additionally, CEBJA members may present the video during state caucuses at annual session, and plans are in the works to post the video on ADA.org in the near future.

Earlier this year, American Student Dental Association members were invited to submit video presentations on common ethical situations. The contest—which will be held again next year—is designed to encourage students to review and study the ADA Principles of Ethics and Code of Professional Conduct, said CEBJA Chair James F. Smith.

The video by Mr. Druger and Mr. Brody demonstrates Section 3 of the Code: "The dentist has a duty to promote the patient's welfare." They will share a $1,000 prize. ■

Range of activities addressing ethics comes into focus

San Antonio—In an informational report of the Board of Trustees to the 2008 ADA House of Delegates, the Joint Subcommittee on Ethics and Integrity in Dental Education describes key activities and recommendations. As outlined in the report, the subcommittee plans to:

- Present to ASDA and ADEA a model personal pledge of adherence to the student's dental school honor code. The pledge contains a commitment by the academic institution to uniformly enforce its honor or ethics code when it becomes aware of an alleged violation. Accompanying the pledge is a request that ASDA and ADEA urge schools to adopt the model, or modify it as appropriate, as a standard of dental education ethical conduct.
- Urge the 2008 House to adopt the amendment to the ADA Principles of Ethics and Code of Professional Conduct submitted by CEBJA which adds an aspirational statement on the ADA's expectations regarding student integrity. Resolution 7 calling for a revised Preamble to the Code will be considered by the House of Delegates this month.
- Urge the Council on ADA Sessions to continue to offer ethics and professionalism CE courses at every ADA annual session for members and student members, which includes offering the ACD's Ethics Facilitator Workshop at the 2010 annual session.
- Urge the ADA Office of Student Affairs to increase the ethics content and case studies for all four years of the ADA Success programming, so that about 25 percent of content is ethics-related; and encourage the OSA to interweave ethics content with other aspects of the programming so that it simulates the environment in which students will practice.
- Collaborate with the Office of Student Affairs on a Welcome Packet that could be sent to new dental students with materials on ethics and professionalism.
- Indicate the ADA's support for the ACD online ethics clearinghouse.
- Encourage ASDA to promote Student Professional Ethics Clubs to its chapters and urge its chapters to offer SPEC assistance.
- Work with ADEA to develop an educational "best practices" publication. The publication will inform dental school faculty of testing practices judged to be superior, suggested methods for teaching ethics, data revealing the techniques used to cheat on exams and security measures that guard against cheating.
- Recommend that ADEA urge dental schools to designate faculty members as ethics officers who would be trained in their school's honor or ethics codes, procedures by which alleged infractions are investigated and disciplinary processes.
- Request AADE to urge state boards of dentistry to revise licensure applications to inquire about applicants' dental school disciplinary history.
- Request that the mega issue discussion with the ADA House of Delegates in 2009 be focused on ethics and integrity within the profession. ■

Government

Red Flags Rules go into effect Nov. 1

ADA probes FTC on identity theft prevention compliance for dentists

BY ARLENE FURLONG

The ADA is continuing to make inquiries of the Federal Trade Commission to learn how new federal regulations, called the "Red Flags Rules," may affect dental practices.

Under the rules, most dentists who extend credit to or arrange credit for their patients are supposed to have a written identity theft prevention program in place by Nov. 1.

The rules, mandated by a 2003 fair-credit law and issued in November 2007, go beyond financial institutions to include all types of creditors who maintain accounts for their customers (or patients). The rules require U.S. financial institutions and creditors, including many in the health care sector, to have written programs to detect and respond to activities that could indicate that an identity theft has taken place.

The FTC staff recently issued guidance expressly stating that the rules will apply to health care providers who provide or arrange for credit. They explain that by deferring payment—for example, sending a bill or establishing a post-treatment payment plan—a health care provider is considered a creditor under the rules.

"Health care providers can be the first to spot the red flags that signal the risk of identity theft, including suspicious activity indicating that identity thieves may be using stolen information like names, Social Security numbers, insurance information, account numbers and birth dates to open new accounts or get medical services," FTC staffers told the ADA in a statement of initial guidance on the rules.

The rules require a written identify theft detection program with policies and procedures to identify, detect and respond to "red flags" of identity theft. Instead of providing specific examples of what the program might entail, the FTC is allowing covered entities flexibility to implement a program that best suits their businesses or organizations, as long as the program meets the rules' requirements.

In addition to the general requirements, the program must also include, among other things, a reporting mechanism to allow periodic evaluations of the efficacy of the policies and procedures. Another section of the rules specifically requires persons who obtain reports from consumer reporting agencies to be alert for address discrepancies in those reports.

The ADA Legal Division is gathering additional information to clarify when dentists are covered by the rules and what dentists must do to comply with them and notes that many dental offices may already have policies and procedures in place to verify and protect the identity and privacy of patients and may have personal experience with an identity theft. Such existing policies, procedures and real life experience can be incorporated into the required program. The program, however, must be in writing. The rules also state that it must be administered by the "board of directors," or, if there is no board, by appropriate management. For a dental practice this means an appropriate staff member.

"Many dentists have longstanding relationships with their patients and their families," said ADA Chief Legal Counsel Tamra S. Kempf. "For those types of practices, a written program with policies and procedures may simply require a staff person to identify an existing patient by sight, obtain proper identification when a new or unrecognized patient comes to the practice, verify billing or other credit information in the patient's file, and take action where discrepancies are noted. These steps should go a long way toward complying with the rules."

As the ADA Legal Division continues to gather information, the ADA News will provide more details on who is covered and how dentists can best comply with the rules in a manner appropriate for dental offices.

Additional information and guidance may be found on the FTC's Web site at: "www.ftc.gov/bcp/edu/pubs/business/alerts/alt050.shtm." A copy of the final Rules can be found at "www.ftc.gov/os/fedreg/2007/november/071109redflags.pdf". ■

EPA backs voluntary approach on amalgam separators

ADA's best management practices inform decision to decline further regulation

Government

BY CRAIG PALMER

Washington—The ADA's best management practices for handling amalgam waste "will likely" encourage dentists' use of amalgam separators and deter federal regulation, the Environmental Protection Agency said in declining further regulation of the mercury discharge from dental offices.

"Most dental offices currently use some type of basic filtration system to reduce the amount of mercury solids passing into the sewer system," said the EPA notice published in the Sept. 15 Federal Register, a daily digest of government regulatory activity. "However, best management practices and the installation of amalgam separators, which generally have a removal efficiency of 95 percent, have been shown to reduce discharges even further."

The EPA signaled support for the Association's voluntary approach even as House subcommittee staff called for "a mandatory program wherein dental clinics are required to install amalgam separators and follow BMPs for management of amalgam waste." EPA's announcement disdains that approach as unnecessary.

"We agree with and applaud EPA's decision that mandatory measures are not needed in dental offices to protect the environment from dental amalgam waste," said ADA President Mark J. Feldman. "The ADA led the way with our voluntary best management practices, which provide dentists with step-by-step guidelines on how to capture and recycle dental amalgam waste.

"However, it is important for the dental profession to prove that our volunteer efforts will work," Dr. Feldman said. "I encourage our members to obtain a free copy of the ADA's Best Management Practices for Amalgam Waste by visiting our Web site at "www.ada.org/goto/amalgambmp" or by calling the ADA at 1-312-440-2878."

The EPA said it would continue to monitor dentists' use of amalgam separators.

"ADA's recently revised BMPs will likely help in convincing dentists to install amalgam separators and employ other BMPs to recover dental amalgam and prevent the discharge of mercury to POTWs (publicly owned treatment works). At this time, EPA is not identifying this sector for an effluent guidelines rulemaking.

"EPA will continue to examine the percentage of dentists using amalgam separators and their effectiveness at recovering dental amalgam and reducing mercury discharges to POTWs. EPA notes the Association's recent positive step in revising their BMPs to include the recommendation for dentists to use amalgam separators. In particular, EPA will examine whether a significant majority of dentists are utilizing amalgam separators. After such examination, EPA may re-evaluate its current view not to initiate an effluent guidelines rulemaking for this sector."

"The ADA led the way with our voluntary best management practices, which provide dentists with step-by-step guidelines on how to capture and recycle dental amalgam waste."

The EPA completed a dental amalgam management study before deciding against further regulation of dental offices, according to the FR notice. The entire document on EPA's planning processes and priorities for industries and health services potentially subject to new or further regulation is available online at "http://edocket.access.gpo.gov/2008/E8-21484.htm". ■

ADA, OSHA renew ergonomics alliance

BY CRAIG PALMER

Washington—The ADA and the Occupational Safety and Health Administration renewed an agreement focusing on ergonomic health issues.

"The ADA is pleased to renew the ADA/OSHA Alliance Agreement with OSHA," Dr. Mark J. Feldman, Association president, said in the Sept. 25 OSHA announcement. "By collaborating, both OSHA and organized dentistry are able to focus on important ergonomic health issues that advance the health and well-being of dentists and their staffs."

"OSHA looks forward to continuing its relationship with the ADA to develop and disseminate resources that advance a culture of safety and health in the workplace," said Edwin G. Foulke Jr., OSHA administrator.

The Association developed an Alliance-related Web page that offers additional ergonomic resources and links to OSHA's Web site ("www.ada.org/prof/resources/topics/osha"). Scroll to "Alliance News" for more information. ■

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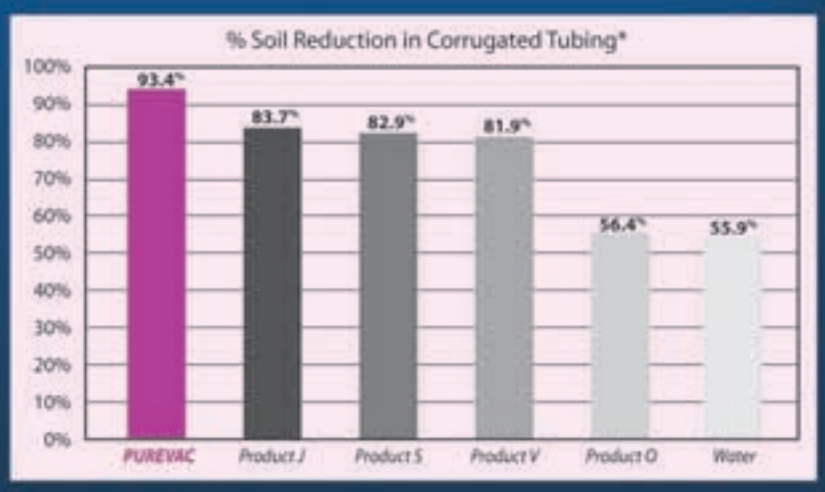

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Tobacco-related cancers decrease

CDC report stresses vigilance

BY CRAIG PALMER

Atlanta—The Centers for Disease Control and Prevention reports finding significant decreases over a recent five-year period in cancers that occur in the lung and bronchus, larynx, oral cavity and pharynx. These cancers "have the greatest average relative risks associated with tobacco use," the CDC said.

However, this rate of progress is unlikely to continue, said the CDC report, Surveillance for Cancers Associated with Tobacco Use—United States, 1999-2004 (Sept. 5 Morbidity and Mortality Weekly Report Surveillance Summaries, Vol. 57, SS-8, "www.cdc.gov/mmwr"). "Although advances have been made in knowledge of tobacco use and its health consequences, intervention strategies to reduce tobacco use must continue."

The tripartite dental profession is engaged in a nationwide campaign to increase public awareness of oral cancer. ADA President Mark J. Feldman joined dental volunteers at New York's Shea Stadium Sept. 9 inviting baseball fans to oral cancer screenings sponsored by the Queens County Dental Society. "We told the crowd that early detection is key to survival," he said.

William Bayer, QCDS executive director, thanked the New York State Dental Foundation and Major League Baseball's New York Mets for delivering the oral cancer screening message. The ADA offers oral cancer information for the public and the profession on ADA.org.

The tripartite dental profession is engaged in a nationwide campaign to increase public awareness of oral cancer.

Oral cavity and pharyngeal cancer is the eighth most common cancer in the United States among men but is less common among women, said the CDC analysis of state-level cancer incidence data. However, the highest rates of OCP cancer in men and women occur in the oral cavity as opposed to other anatomic subsites. This type of cancer includes tumors with origins in several anatomic organs of the head and neck.

"Strong evidence associates tobacco as the carcinogenic factor in squamous cell cancer of the head and neck, which the findings from this study indicate is the predominant histologic type of OCP cancers in the United States," the CDC said. "Smokeless tobacco use also is strongly associated with OCP cancer. Among women, OCP cancers were highest among whites, a finding that might partly be related to the higher prevalence of smokeless tobacco use among white men and women."

Dr. Scott L. Tomar, professor and chair of the department of community dentistry and behavioral science at the University of Florida College of Dentistry, is a consultant on tobacco issues for the ADA Council on Access, Prevention and Interprofessional Relations. "The good news is that the overall incidence of cancers of the oral cavity and pharynx had declined for black and white men and women during the past 20 years, which largely reflects the decline in the prevalence of smoking since the 1970s," he said.

"Unfortunately, we have made relatively little progress in detecting OCP at earlier stages. Overall, about two-thirds of cases are diagnosed at late stages that have a relatively poor prognosis, which is not appreciably different from the situation 20 years ago, even though most tumors arise at anatomical sites that can be visualized in a thorough, systematic examination." ■

—palmerc@ada.org

Photo by Dr. Alan Queen

Pre-game pitch: ADA President Mark J. Feldman joined dental volunteers inviting baseball fans to oral cancer screenings sponsored by the Queens County Dental Society at New York's Shea Stadium Sept. 9. From left are Dr. Ira Schwartz; Dr. Stuart Kesner, event chair; Dr. Chad Gehani; Dr. Feldman; and Dr. Viren Jhaveri, QCDS president. Spirit awards for community oral cancer screenings presented by New York Mets.

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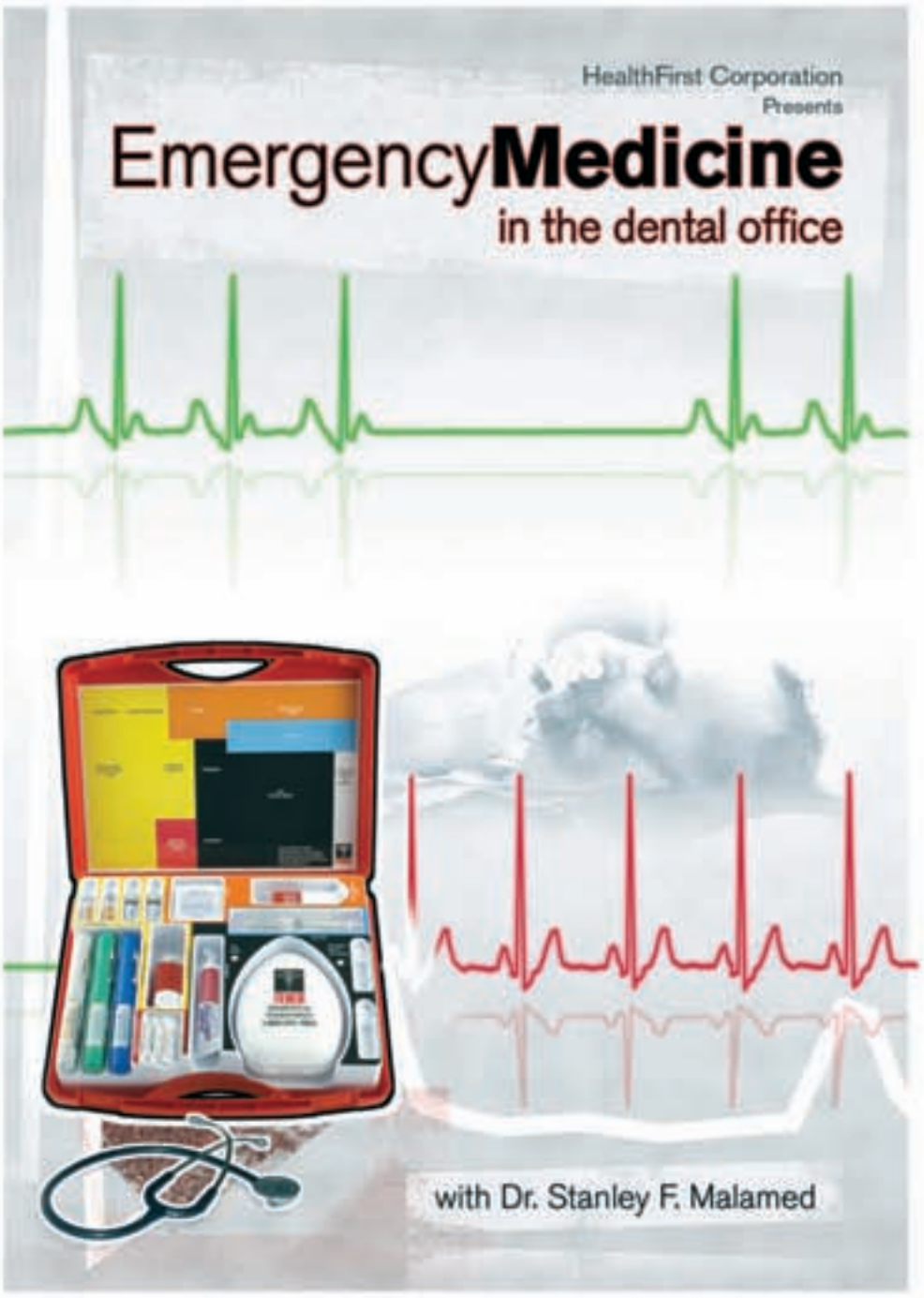

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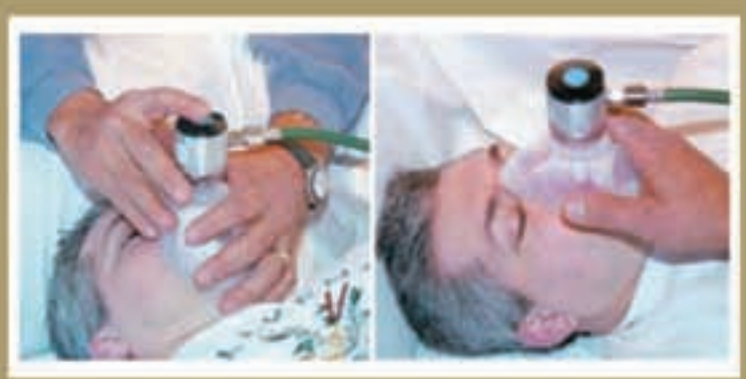

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Dr. Klein, ethics pioneer, former ADA trustee, dies

BY CRAIG PALMER

Jacksonville, Fla.—Dr. H. Raymond Klein, 71, who rose to professional leadership as "a servant leader," died unexpectedly Sept. 22. Faith, family and profession encouraged his success and completed his person, friends and colleagues said.

Dr. Klein served as president of numerous professional organizations including the American College of Dentists, American Academy of Pediatric Dentistry, Pierre Fauchard Academy, Florida Dental Association, Southeastern Society of Pediatric Dentistry, Jacksonville Dental Society and American College of Dentists Foundation. He was a trustee of the American Dental Association from 1993 to 1997.

Responses of colleagues and friends enunciate Dr. Klein's service and devotion to family, faith and profession.

• Dr. Larry J. Cook: "Ray is my model for being a servant leader."

• Dr. Lee Eggnatz: "I mourn the passing of a personal friend, a good husband and father, a great clinician, a willing educator, a man who worked tirelessly to advance the profession he loved."

• Dr. Clifford Marks: "We have lost one of dentistry's great leaders. His contribution to the dental health of this country was always predicated on doing what was best and right for the dental patient."

• Dr. Lew Walker: "Ray Klein served organized dentistry in every capacity he was called upon to serve (with) a calm demeanor, a quick intellect and a great sense of humor. His passion for dental ethics was ongoing."

• Dr. Barry Setzer: "Ray was my mentor. I am the pediatric dentist I am today due to Ray. I have tears in my eyes as I write this."

• Dr. Albert J. Bauknecht: "No thymus thumps (chest beatings) about all he accomplished. In fact, humility and acceptance prevailed."

• Dr. Ted Haeussner: "He practiced for children and he opened his heart for all who needed his touch."

• Dr. Robert T. Ferris: "While I was a vice president of ADA (2004-2006), I found his advice to be the most centered and the least political. Most of us knew the anatomy of the ADA, but Ray understood the physiology, the people, the passions, the issues and how they best worked together."

Family moments: Dr. Klein shares a moment with grandson Sean Yates, above left, at his dental office after Sean's dental checkup and pauses for a photo his wife Renée, right.

• Dr. Earl Williams: "Dentistry has lost a great advocate and a great champion. Those of us who were privileged to know him have lost a great friend."

• Dr. Jolene Paramore: "It was a privilege and a joy to be at his (ACD) president's dinner in San Francisco, standing on my chair in a formal gown to get a glimpse of his and (wife) Renée's walk through the crowd while the Florida section cheered wildly and the bagpipes played."

• Dr. Samuel O. Dorn: "Ray was one of my idols in dentistry, not only for his vast knowledge and personal integrity, but also for his wisdom in how to live a balanced life richly and joyfully. He was a loving husband to Renée and a devoted father and grandfather."

Dr. Klein pioneered ethics program development in Florida dental schools that "assisted the ethical understanding of 2,485 students," colleagues said. The Florida Section of the American College of Dentists honored him with a fund in his name to advance excellence, ethics, professionalism and leadership in dentistry.

Dr. Klein is survived by his mother, Esther Marlowe, his loving wife, Renée, their three children and six grandchildren: Raymond Klein, wife Sandra and children Sofia and Mila; Ronald Klein, wife Shannon and children Nora and Cavan; Robin Yates, husband Chris and children Sean and Leighton. Dr. Klein is also survived by his daughter, Pat Carnahan, husband Dennis and children Philip, John and Ben and son, Mike Klein, wife Tammy and their son, Zeb.

A native of Vincennes, Ind., he graduated from Indiana University's pediatric dentistry graduate program in 1964 and was the first board certified pediatric dentist in Jacksonville, starting his practice in 1965.

Memorials in Dr. Klein's name may be sent to the H. Raymond Klein-named fund c/o American College of Dentists Foundation, 839 J. Quince Orchard Blvd., Gaithersburg, MD 20878 or to St. John's Cathedral, 256 E. Church St., Jacksonville, FL 32202. Funeral services were held Sept. 27. ■

Hurricane damage still being tallied

ADA Foundation

BY JENNIFER GARVIN

More than three weeks have passed since Hurricane Ike pummeled the Texas and Louisiana coasts.

High tide: A street in Lake Charles, La., remains flooded after Hurricane Ike made landfall Sept. 13. The storm is responsible for at least 67 deaths.

The ADA estimates some 3,400 active member homes and offices were located in the hurricane's 12-county impact area, with approximately 200 of those located in devastated areas. Ike was the latest in a batch of powerful hurricanes and summer storms to batter the Gulf Coast in recent months, and dentists in Louisiana, Mississippi and Texas continue to struggle.

Among the hardest-hit areas were Galveston Island and Galveston, Texas. Other Texas counties severely affected were Seabrook, La Porte, Baytown and Texas City, all located in suburban Houston, as well as the Southwestern coast of Louisiana.

San Antonio, site of this year's ADA annual session, was not affected by the storm, and annual session will proceed Oct. 16-19 as scheduled. More than 30,000 people are projected to attend this year's meeting.

The ADA would like to remind dentists whose practices suffered damage that the ADA offers disaster relief and assistance.

As part of its Charitable Assistance Programs, the ADA Foundation has approved grants of up to $2,500 for dental professionals affected by disasters as well as grants for organizations that provide dental services to affected areas. Each dentist's situation will be considered individually by the ADA Foundation's Charitable Assistance Program Committee. Dentists applying for grants should fully explain what they have lost, including dental and other office/home supplies and goods. To apply for relief online, visit "www.adafoundation.org/ada/adaf/grants/index.asp#disaster".

Stay tuned to the ADA News and ADA.org for more details and personal stories from dentists who are recovering from storm damage. A longer story will appear in the Oct. 20 issue. ■

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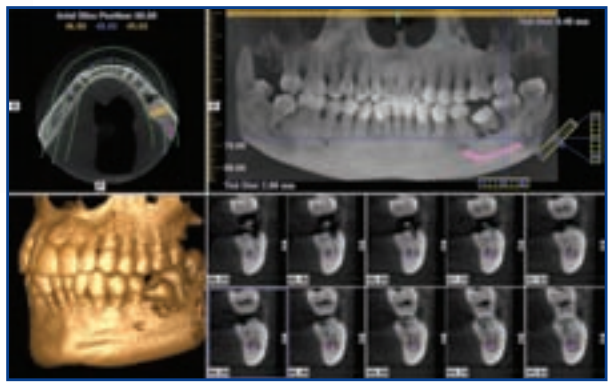

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Temple dental school names Dr. Ismail dean

BY JENNIFER GARVIN

Philadelphia—Dr. Amid Ismail, an expert in evidence-based dentistry and dental caries research, is the new dean at the Maurice H. Kornberg School of Dentistry at Temple University, the school announced on Sept. 10.

A "passionate advocate" for the underserved, Dr. Ismail said he plans to work with faculty and students to develop a new urban academic dental education model to improve dentists' clinical skills and knowledge of current health policy. He also hopes to foster relationships with the school's alumni.

"The challenges facing urban centers in the U.S. should receive the utmost attention from all policymakers, including universities," Dr. Ismail said. "I am pleased to join Temple University leadership who have taken this task as a major mission for the university."

Dr. Ismail, who is assisting Dr. Bob Brandjord in developing the ADA Community Dental Health Coordinator project (See story, page 26.), said he is committed to developing new models for dental education to improve access to dental care and to prepare dentists to meet the challenges of today and the future.

In a press release announcing the appointment, Temple President Ann Weaver Hart praised Dr. Ismail as a "highly-regarded educator, researcher and clinician who shares Temple's fundamental value of service to others.

"He will be an effective academic leader and a champion of improved oral health for our community," she said.

Dr. Ismail leaves behind the University of Michigan where he was a professor of health services research and cariology at the School of Dentistry and director of the dental public health program at the UM School of Public Health and a professor of epidemiology.

Dr. Ismail

He will assume his dean's duties Oct. 13.

While at Michigan, Dr. Ismail received the University of Michigan's Distinguished Public Service Award and led two collaborative research projects on underserved populations: the Detroit Oral Cancer Prevention Project and Detroit Center for Research on Oral Health Disparities. Both studies were funded by the National Institutes of Health, and he also was the principal investigator of a $6.9 million NIH grant to study evidence-based dentistry.

Previously, Dr. Ismail was the chair of the ADA Council on Scientific Affairs. Additionally, he has participated in ADA panels for developing clinical recommendations on fluoride supplements, sealants and professionally-applied topical fluoride.

According to Dr. Daniel Meyer, ADA senior vice president, science/professional relations, Dr. Ismail has the "unique combination of experience and skills" to integrate dental education with the needs of the students and faculty.

"He is more than qualified to prepare his students for the demands of patient care in private practice and public health communities. We wish him all the best," Dr. Meyer said.

Dr. Ismail received his dental degree from the University of Baghdad. He earned master's and doctorate degrees in public health and a master's in business administration from the University of Michigan. He also has served on the faculties of Dalhousie and McGill Universities in Canada. Dr. Ismail has published and presented more than 200 abstracts, many of which focus on oral and overall health issues facing the underserved. In 2001, he received the H. Trendly Dean Memorial Award from the International Association for Dental Research for distinguished achievements in behavioral science, epidemiology and public health.

The Kornberg School of Dentistry was founded in 1863 and is one of the oldest U.S. dental schools in continuous operation. ■

ADA personalized products available at session, online

San Antonio—The ADA carries an extensive line of personalized products, some of which will be on display at the annual session.

Take time out to visit the ADA Store and ADA Pavilion to pick up free samples of patient education brochures and select products. Dentists who order on-site can save 15 percent when placing an order of $150 or more.

These ADA brochures, tote bags, holiday cards, postcards and magnets are a great way to keep patients thinking about their oral health year-round. They also enable dentists to strengthen their connection with patients.

The personalized products available include:

- Thanksgiving cards. These are a wonderful way to show appreciation to patients and colleagues.
- Holiday cards. The cards are available as folded greeting cards with envelopes or as postcards.
- Tote bags. Patients love these stylish and sturdy take-home tote bags.
- Personalized calendar magnets. Give a gift that lasts all year.
- Postcards. The cards recall, remind and re-activate patients.
- Personalized ADA brochures. Give a practice visibility and teach oral health at the same time with these personalized brochures.

Can't attend annual session? View the 2009 ADA Annual Catalog to see all products and then place an order online by visiting "www.adacatalog.org" or by calling 1-800-947-4746. ■

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AnnualSession

San Antonio ready for ADA

San Antonio: Awaits the arrival of ADA annual session attendees.

The ADA's 149th annual session Oct. 16-19 will give attendees hundreds of opportunities to learn, network, shop for the latest dental products and services and enjoy ADA-exclusive special events.

"The 2008 annual session marks the kickoff of the ADA's year-long 150th anniversary celebration," said Dr. Mark J. Feldman, ADA president. "This is a time to not only look back with pride at the road we've traveled, but especially to look forward to the next 150 years—and beyond."

The annual session will convene at the Henry B. Gonzalez Convention Center in the heart of downtown San Antonio.

And, beyond the convention center, this historic city's unique attractions, shopping, cuisine and nightlife offer a fiesta for dental teams and families.

ADA pre-session activities begin Oct. 15, continuing education will be held Oct. 16-19, the World Marketplace Exhibition will be open Oct.16-18 and the House of Delegates meets Oct. 17-21.

Awake to eye-opening entertainment Oct. 17 and 18 at the ADA General Sessions and Distinguished Speaker Series. On Oct. 17, award-winning broadcast journalist and author Tom Brokaw will take the podium for the DSS. On Oct. 18, ABC newsman and Iraqi roadside bomb victim Bob Woodruff and his wife Lee will share their story of inspiration. The Distinguished Speaker Series is sponsored by Johnson & Johnson Healthcare Products Division of McNEIL-PPC Inc.

Enjoy an evening of San Antonio fun Oct. 17 at the ADA's Rockin' Rodeo and Barbecue. This ADA-exclusive event features exciting rodeo attractions, all-you-can-eat rodeo fare, a post-

New dentists to meet up at annual session

San Antonio—If you're a dentist in practice for fewer than 10 years and planning to attend the ADA annual session, here's a great way to network with your peers.

Join your colleagues for refreshments Thursday, Oct. 16, from 4-6 p.m. in the First-Time Attendee Orientation Center located in the Registration Area (Ballroom A) of the Henry B. Gonzalez Convention Center. New dentists can take this opportunity to re-acquaint themselves with with old friends, make new ones and pick up 150th Anniversary commemorative lapel pins.

For more information, contact the Committee on the New Dentist at Ext. 2779 or "newdentist@ada.org".

If you missed the ADA 22nd New Dentist Conference in June, CD and mp3 audio recordings of clinical and leadership courses are still available online at "www.softconference.com/ada" or by calling 1-800-747-8069. ■


Mr. Brokaw


Bob and Lee Woodruff

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Enhance your clinical skills and learn the latest developments in dentistry by attending some of the 225 continuing education programs offered at the annual session.

New this year, earn up to 3.5 hours of CE at the ADA Live Operatory Center, a unique blend of product training and CE for dental lasers, 3-D imaging and CAD/CAM. Also returning will be the ADA's Education In The Round series, featuring live patient procedures conducted in a fully functional dental operatory and projected on 60-inch flat-screen monitors. Educational tracks for new dentists, team building, anesthesia and oral sedation, esthetic dentistry, oral longevity and healthy aging, federal dental services, dental assistants and dental hygienists allow participants to target their own CE needs and interests.

Make plans to visit the ADA World Marketplace Exhibition and test drive the latest products and equipment while finding money-saving specials. And don't miss the New Product Showcase featuring the latest product releases.

Visitors to the Fiesta City will want to take a stroll along the scenic River Walk; soak in some history at the Alamo; enjoy the panoramic view of the city from atop the Tower of the Americas; visit SeaWorld San Antonio, Six Flags Fiesta Texas or other family-friendly attractions; or book a spa retreat or schedule a golf outing on one of more than 40 golf courses local to San Antonio.

San Antonio is also a city of unique gastronomic delights. Visitors can sample its famed Tex-Mex cuisine, German fare, barbecue and family-friendly food. Choose fine dining, dining al fresco along the River Walk or even floating meals on a river barge dinner cruise.

Shop till you drop at venues including the largest Mexican market north of the Rio Grande, art galleries, and of course, the famous River Walk shops featuring everything from local crafts to upscale retail products. Just a short distance from San Antonio, outlet malls await.

For more information, log on to "www.ada.org/goto/session". ■

Learn about careers in dental education

BY KAREN FOX

San Antonio—With about 400 vacant, funded faculty positions in U.S. dental schools and a large percentage of current faculty nearing retirement age, the dental profession is taking steps to increase the number of dental and allied dental faculty.

A special seminar will be held at the ADA annual session to provide interested dentists and allied dental professionals with information on transitioning to academic careers. "How To Position Yourself to Apply for a Job as a Dental Educator" takes place Friday, Oct. 17, from 2:45 to 5:15 p.m. at the Grand Hyatt Hotel's Independence room (Course No. 6346). The Grand Hyatt is located next to the Henry B. Gonzalez Convention Center.


Dr. Reinhardt

Academic dental careers offer an opportunity to pursue new and exciting challenges that often combine teaching, research, community service and patient care, said course moderator Dr. John W. Reinhardt, dean of the University of Nebraska Medical Center College of Dentistry.

"The needs and opportunities for dental faculty are great," said Dr. Reinhardt. "The ADA's Council on Dental Education and Licensure developed and supports this program as part of the ADA's effort to strengthen and maintain the dental academic workforce in the U.S. The quality of the profession is a direct result of the faculty who develop the next generation of oral health care providers."

Anyone considering a part- or full-time faculty career in a dental school or an allied dental education program is encouraged to attend this course.

"The program is designed to give attendees a better understanding of whether they would enjoy and would be strong candidates for academic positions, and how they might strengthen their application if they choose to apply," said Dr. Reinhardt.

In its fourth consecutive year, the academic dentistry course has added information for allied dental professionals to the program.

"This year, in addition to our panelist presentations, we will have brief testimonials from four practitioners who have entered dental academics recently," said Dr. Reinhardt. "Two of those four attended one of our workshops in the past and then became dental faculty members."

Testimonial speakers will offer brief presentations on their experiences, including why they chose to teach, how they were able to become teachers, obstacles they've faced and lessons learned along the way.

Panelists for this workshop include Drs. Reinhardt, Brad Potter, Diane Hoelscher, Susan Swanson, Steve Reynolds, Dan Ketteman, Merlyn Vogt and Eugene Brooks.

Topics include preparing a curriculum vitae, searching for positions, interviewing, licensure and frequently asked questions about academic dentistry. ■

—foxk@ada.org

Resort vacation and cash winnings await at session

San Antonio—A luxury vacation and $4,000 cash await one lucky winner of the ADA Member Advantage "4 Grand Getaway" sweepstakes this year. Visit Booth 2234 in the ADA Pavilion during annual session to drop off an entry form, or return the postcard in the back of your 2009 ADA Member Advantage catalog.

Starwood Hotels and Resorts is sponsoring the sweepstakes with a four-night stay at the beautiful Westin Resort and Spa in Los Cabos, Mexico. The winner will travel in grand style with $4,000 cash thanks to sponsors Matsco, CareCredit, Chase Paymentech and Citibank. The Westin Resort and Spa, Los Cabos, is one of 175 Starwood Hotels and Resorts worldwide that offer up to a 50 percent discount to ADA members.

Those not familiar with ADA Member Advantage can let the staff at Booth 2234 acquaint them with the products and services that have been researched, proven and endorsed for members of the ADA. ADA Member Advantage provides many resources such as the ADA World MasterCard, health savings accounts through First Horizon Msaver and credit card processing systems through Chase Paymentech. ADA members and their staff are eligible for the program's values. Some annual session highlights include:

• **Citi offers a chance to win $10,000 and more, plus 15,000 bonus points for new credit card applicants.** Thousands of ADA members enjoy the benefits of the ADA World MasterCard, such as no annual fee and an excellent travel rewards program. Members who make purchases with their ADA cards between Sept. 15 and Dec. 15 will be automatically entered to win a cash credit. One grand prize winner will receive a $10,000 credit, while first and second prize winners will receive $7,500 and $5,000. Members will receive two automatic entries for purchases at gas stations, supermarkets, drug and convenience stores, and restaurants (all other purchases receive one automatic entry).

For new cardholders, Citi is giving away 15,000 bonus points upon application. Citi representatives at Booth 2035 have information on bonus points and it's also available online at "www.adacard.com".

• **Viewing Dental Office Design Competition entries earns participants one hour of CE credit.** The 9th annual Dental Office Design Competition, sponsored by Matsco and ADA Member Advantage, takes place during the ADA annual session on the convention center's second level, Tower View Foyer. Hours are Oct. 15, noon-5 p.m.; Oct. 16-18, 7:30 a.m.-6 p.m.; and Oct. 19, 7:30 a.m.-noon. Winners will be awarded Friday, Oct. 17 at 1 p.m.

• **CareCredit offers enrollment for $20 and an exclusive Dentist Bear from Build-A-Bear Workshop.** This year, CareCredit is celebrating its 20th anniversary and the 100,000th practice to begin offering patient financing. During ADA annual session, new practices can get started for only $20. Offer is limited to new enrollments only at the show at Booth 2432.

• **Chase Paymentech is offering a chance to win a Nintendo Wii and a $250 credit.** The industry leader in credit card payment solutions, Chase Paymentech wants dentists to pay less and play more. Chase Paymentech representatives at Booth 2841 will offer a free analysis of current processing services vs. Chase Paymentech. ADA members are eligible for free operating supplies, highly competitive rates and no monthly minimums.

• **Information on health savings accounts.** Thousands of dentists across the country are already enjoying significant tax savings and reduced health insurance premiums by combining HSAs with qualified high-deductible health plans. First Horizon Msaver, endorsed by ADA Member Advantage, is offering ADA members who enroll in a First Horizon HSA no set-up fees, no transaction fees and access to a variety of tools and resources like free banking online and bill pay online, instant online enrollment and investment options. First Horizon Msaver offers dedicated 24/7 support from HSA experts before, during and after the enrollment process. Visit Booth 2039 for more information and to enter to win a portable DVD player. ■

Matsco offers CE at annual session

San Antonio—Matsco, the only practice financing company endorsed by ADA Member Advantage, is offering continuing education courses at annual session.

• 2008 Dental Office Design Competition—Wednesday, Oct. 15 through Sunday, Oct. 18, at the Henry B. Gonzalez Convention Center. Visitors can view this year's Dental Office Design Competition entries before the announcement of winners on Friday, Oct. 17, at 1 p.m. Receive 1 CE unit.

• Preparing for Practice Ownership (Course 5113)—Thursday, Oct. 16, 9 a.m.-1 p.m. Receive 4 CE units.

• Building Your Dream Office in a Challenging Economy (Course 6106)—Friday, Oct. 17, 10 a.m.-6 p.m. Receive 6.5 CE units.

Attendees can also visit Matsco during annual session at Booth 2139 in the ADA Pavilion. ■

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Celebration

Continued from page one

"Implicit in our message is that the ADA will continue to serve the public and our members for generations to come," added Dr. Lamacki, editor of the Chicago Dental Society's journal "Review."

The planning committee is working in cooperation with the Board of Trustees and the Council on ADA Sessions. (For a complete listing of the committee members, see story, this page.)

"The ADA sesquicentennial is a critical milestone in the history of our profession and in the life of our Association," said Dr. Mark J. Feldman, ADA president. "We hope that all our members across the country will join us in celebrating 150 years of excellence in service to our profession and our patients. We can all take great pride in our accomplishments and in our contributions to the nation's health."

What follows are descriptions of materials being developed and events planned to commemorate the Association's 150th anniversary.

Logo and signage: The sesquicentennial logo, which appears above, will be used all through the coming year, starting at this year's annual session, Oct. 16-19, where it will be on display at the Henry B. Gonzalez Convention Center in San Antonio. Logos, signage and other materials also will be made available to state and local dental societies to help them join in the celebration.

Commemorative pin: The Council on ADA Sessions has developed a commemorative pin that will be distributed at both the 2008 and 2009 annual sessions. The pins will be offered free of charge at the ADA Pavilion in the convention center, both this year and next.

Coffee-table book: A professionally written and produced, hardcover coffee-table-type book exploring the history of the ADA and the dental profession is in the works. The book is expected to be completed and available for sale in limited quantity by June 2009, the price to be determined. More about this later.

Special supplement to JADA: The Journal of the American Dental Association is preparing a special supplement commemorating the sesquicentennial, to be packaged and mailed with the June 2009 edition of JADA. Dr. David Chernin, editor of the Journal of the History of Dentistry, is serving as guest editor of the supplement, which will focus mainly on the historical advancement of dental science.

Gala event: Also in June 2009, a black-tie gala event marking the anniversary will be held in Chicago, coinciding with the June meeting of the Board of Trustees.

National Museum exhibit: MouthPower, a traveling exhibit developed by the Dr. Samuel D. Harris National Museum of Dentistry, is expected to be on display from June through August 2009 in the lobby of ADA Headquarters in Chicago.

Public outreach: A subcommittee has been tasked to identify ways to showcase dentistry's accomplishments by piggybacking with existing activities—Give Kids A Smile, for example, and National Children's Dental Health Month—and also through unique sesquicentennial events. More about that soon.

Media outreach: News releases, fact sheets, video footage, satellite feeds, newspaper inserts and more will be prepared and distributed to media outlets nationwide. These materials will stress dentistry's achievements over the years and the profession's contributions to good health.

Anniversary Web site: A special anniversary section of the ADA's Web site, ADA.org, will debut within the next several weeks to provide news updates and background information on the sesquicentennial. The Web address for the site will be made available as soon as the section goes live. Watch for it on ADA.org.

2009 Annual Session: The sesquicentennial celebration will culminate with a major event—still in the planning stages—at the 150th annual session in Hawaii next year.

Dr. John S. Findley, ADA president-elect, will be installed as president in San Antonio this month and preside over the 2009 annual session in Hawaii.

"Dentistry has come a long way, thanks to the efforts of the countless men and women who have contributed to our profession over the years," Dr. Findley said of the sesquicentennial.

"As we pause to reflect on our accomplishments," he added, "we must rededicate ourselves to an even better future. The past is prologue, but the future belongs to us and to the generations of dentists to come."

Planning for the sesquicentennial is still in progress, so keep an eye out for updates to this report on ADA.org and in the ADA News. ■

From San Antonio to Honolulu

Sesquicentennial celebrations planned for 2008, 2009 annual sessions

San Antonio—The American Dental Association is starting a yearlong celebration of its 150th anniversary during annual session here.

The Saturday, Oct. 18, General Session and Distinguished Speaker Series will include the kickoff for the 150th anniversary year.

The special events and projects during the year (detailed in story, page one) will culminate with the annual session in Hawaii in 2009.

Those attending the 2008 session can visit the 2009 Hawaii Booth, in the East Lobby of the Henry B. Gonzalez Convention Center Oct. 16-19, and receive a commemorative ADA 150th Anniversary lapel pin.

They can also find out about registration, travel and housing in Hawaii. The ADA offers many hotel options in Honolulu on the island of Oahu, along with the outer islands (Maui, Kauai and Hawaii) for pre- and post-annual session. The 2009 Committee on Local Arrangements and Hawaii Convention Center staff will be available to field questions about the Sep 30-Oct. 6 annual session. Experienced registration and housing staff will also be there to help.

Those who register in San Antonio will have the first choice of Hawaii hotels, in Honolulu and several outer Hawaiian islands. As an added boon for registering early, the booth will also give out tropic-inspired gifts like Hawaiian leis and enter registrants in a contest to win a Hawaiian-themed gift basket. Hawaiian dancers and music will be featured Saturday morning, Oct. 18, on the Entertainment Stage in the World Marketplace Exhibition.

Hawaiian-themed entertainment is also planned for San Antonio riverboats (known locally as barges). The barges will cruise the Rio San Antonio on Thursday, Oct. 16; Friday, Oct. 17; and Saturday, Oct. 18 from 5-8 p.m. to promote the 150th annual session and Hawaii.

The ADA Pavilion will also distribute the commemorative ADA 150th Anniversary lapel pin. ■

HAWAII
American Dental Association
150th Annual Session
September 30-October 4, 2009

A 'who's who' of the ADA sesquicentennial committee

Dr. Walter F. Lamacki, a past ADA trustee from Illinois and current editor of the Chicago Dental Society's publication "Review," is chair of the volunteer committee of dentists planning the ADA's 150th anniversary celebration.

Dr. Murray D. Sykes, the Association's 4th District trustee, is the Board of Trustee's liaison to the committee. A small cross-section of ADA staff is assisting the committee.

Committee members include:

- Dr. Jack Conley of Glendale, Calif., past editor of the Journal of the California Dental Association;
- Dr. Jack Gottschalk of Cincinnati, a renowned dental historian and past president of the Ohio Dental Association;
- Dr. Brandon Maddox of Springfield, Ill., the 2009 chair of the ADA Committee on the New Dentist;
- Martha Philips of Atlanta, executive director of the Georgia Dental Association;
- Dr. Jeanne C. Sinkford of Washington, D.C., associate executive director of the American Dental Education Association.

Helping out as consultants on the commemorative coffee-table book are Dr. Clifton Dummett of Los Angeles and Dr. Malvin Ring of Rochester, N.Y. ■

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OPA curriculum nears completion

Workforce model expands capabilities of dental team

BY KAREN FOX

The curriculum for the Oral Preventive Assistant workforce model will soon be ready for distribution.

At its meeting in August, the ADA Board of Trustees received a report on the Oral Preventive Assistant, reviewed the curriculum components and affirmed its support of the concept. In Resolution B-63-2008, the Board directed staff to develop operational mechanisms for making the OPA curriculum materials available to state dental associations and educational institutions.

A new member of the oral health team, the Oral Preventive Assistant will help to supplement the services of the dentist and/or dental hygienist—allowing them to deliver more advanced preventive services, said Dr. Carol Turner, a retired Navy Dental Corps Chief and chair of the OPA Curriculum Committee.

"The main focus of this new category of dental personnel is to provide the dentist and dental team an expanded preventive capability, thus allowing more flexibility to support increased access to care," said Dr. Turner. "The dental hygienist and the dentist can then concentrate on patients with more complicated needs."

The OPA will work primarily in private dental offices but will have expertise in patient oral health education, which will enable the OPA to work in schools, community health centers and other venues to raise oral health literacy. Depending on state regulations, the OPA may also be able to deliver preventive services in these settings, such as sealants and fluoride applications.

"This model is designed to create an assistant who has a solid background in providing patients with oral health education and information as well as the basic elements of preventive care, coronal polishing for all patients and scaling for periodontal Type I (gingivitis) patients," said Dr. Turner.

The OPA has been in development since 2006 when the House of Delegates approved new workforce positions to support the profession and expand the current workforce's scope of practice.

"The committee initially envisioned this new oral preventive capability set as requiring 12 months of training; however, after comparing the proposed OPA competencies to those competencies required for the Commission on Dental Accreditation-accredited dental assisting programs, which are nine months in length, they concluded that the OPA program would be developed by building on existing CODA-accredited assisting programs," said Dr. Turner. "This approach is consistent with the way the Navy and Army train dental assistants to be prophy technicians in three months."

Enrollees will have met one of four eligibility pathways for the three-month OPA program, she said:

1. Graduate of an accredited dental assisting program (accredited by CODA);
2. Certified Dental Assistant by the Dental Assisting National Board;
3. Graduate of a nonaccredited assisting program and Certified Dental Assistant by DANB;
4. On-the-job trained dental assistant who is a Certified Dental Assistant by DANB.

The ADA is in the process of developing ways to make the OPA curriculum available along with recommendations that state associations can use for its implementation. Individual state boards of dentistry or legislatures will determine specific duties to be delegated as well as education and credentialing requirements.

"States may choose to implement all or some of the OPA functions," said Dr. Turner. "There are several options for delivering the OPA training and assessing competencies."

Those options include:

- Full- or part-time online didactic and in-person clinical instruction and competency evaluations through a partnership between the ADA and an accredited dental assisting education program;
- Full- or part-time online didactic and in-person clinical instruction and competency evaluations through a partnership between a state dental association and an accredited dental assisting education program; or
- Online didactic and in-person clinical instruction offered via a continuing education program through the ADA, a state dental association or an accredited program.

"Ultimately, state dental boards will determine eligibility, training and certification and/or licensure requirements for their states," said Dr. Turner. "It is a state's prerogative to determine if and how to implement an OPA training program." ■

OPA curriculum at session

San Antonio—ADA delegates will have an opportunity to review the Oral Preventive Assistant curriculum during annual session in the Delegates Registration Area.

To read more about the Oral Preventive Assistant, including a list of Frequently Asked Questions, go to "www.ada.org/public/careers/team/opa.asp".

Board Report 8 is on ADA.org in members-only content at "www.ada.org/goto/hod". ■

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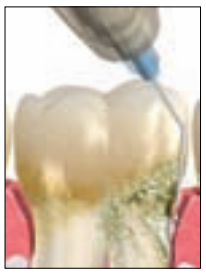

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WARNINGS
Prilocaine can cause elevated methemoglobin levels particularly in conjunction with methemoglobin-inducing agents. Methemoglobinemia has also been reported in a few cases in association with lidocaine treatment. Patients with glucose-6-phosphate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

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

Patients taking drugs associated with drug-induced methemoglobinemia such as sulfonamides, acetaminophen, acetanilide, aniline dyes, benzocaine, chloroquine, dapsone, naphthalene, nitrates and nitrites, nitrofurantoin, nitroglycerin, nitroprusside, pamaquine, para-aminosalicylic acid, phenacetin, phenobarbital, phenytoin, primaquine, and quinine are also at greater risk for developing methemoglobinemia. Treatment with Oraqix® should be avoided in patients with any of the above conditions or with a previous history of problems in connection with prilocaine treatment.

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

Allergic and anaphylactic reactions associated with lidocaine or prilocaine can occur. These reactions may be characterized by urticaria, angioedema, bronchospasm, and shock. If these reactions occur they should be managed by conventional means.

Oraqix® coming in contact with the eye should be avoided because animal studies have demonstrated severe eye irritation. A loss of protective reflexes may allow corneal irritation and potential abrasion. If eye contact occurs, immediately rinse the eye with water or saline and protect it until normal sensation returns. In addition, the patient should be evaluated by an ophthalmologist, as indicated.
Oraqix® should be used with caution in patients with a history of drug sensitivities, especially if the etiologic agent is uncertain.

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

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

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

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY:
Carcinogenesis - Long-term studies in animals have not been performed to evaluate the carcinogenic potential of either lidocaine or prilocaine. Chronic oral toxicity studies of o-toluidine, a metabolite of prilocaine, have shown that this compound is a carcinogen in both mice and rats. The tumors associated with o-toluidine included hepatocarcinomas/ adenomas in female mice, multiple occurrences of hemangiosarcomas/hemangiomas in both sexes of mice, sarcomas of multiple organs, transitional-cell carcinomas/papillomas of urinary bladder in both sexes of rats, subcutaneous fibromas/fibrosarcomas and mesotheliomas in male rats, and mammary gland fibroadenomas/adenomas in female rats. These findings were observed at the lowest tested dose of 150 mg/kg/day or greater over two years (estimated daily exposures in mice and rats were approximately 6 and 12 times, respectively, the estimated exposure to o-toluidine at the maximum recommended human dose of 8.5g of Oraqix® gel on a mg/m2 basis).

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

USE IN PREGNANCY:
Teratogenic Effects: Pregnancy Category B
Treatment of rabbits with 15 mg/kg (180 mg/m^2) produced evidence of maternal toxicity and evidence of delayed fetal development, including a non-significant decrease in fetal weight (7%) and an increase in minor skeletal anomalies (skull and sternebral defects, reduced ossification of the phalanges). The effects of lidocaine and prilocaine on post-natal development was examined in rats treated for 8 months with 10 or 30 mg/kg, s.c. lidocaine or prilocaine (60mg/m^2 and 180 mg/m^2 on a body surface area basis, respectively up to 1.4-fold the maximum recommended exposure for a single procedure). This time period encompassed 3 mating periods. Both doses of either drug significantly reduced the average number of pups per litter surviving until weaning of offspring from the first 2 mating periods. Because animal reproduction studies are not always predictive of human response, Oraqix® should be used during pregnancy only if the benefits outweigh the risks.

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

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

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

ADVERSE REACTIONS
Following SRP treatment with Oraqix® in 391 patients, the most frequent adverse events were local reactions in the oral cavity (see following table). These events, which occurred in approximately 15% of patients, included pain, soreness, irritation, numbness, vesicles, ulcerations, edema and/or redness in the treated area. Of the 391 patients treated with Oraqix®, five developed ulcerative lesions and two developed vesicles of mild to moderate severity near the site of SRP. In addition, ulcerative lesions in or near the treated area were also reported for three out of 168 patients who received placebo. Other symptoms reported in more than one patient were headache, taste perversion, nausea, fatigue, flu, respiratory infection, musculoskeletal pain and accident/injury.

Table 1. Number (percent) of patients with adverse events occurring in more than one patient in any of the treatment groups. Each patient is counted only once per adverse event. The occurrence in a single patient is included in this table if the same symptom has been seen in at least one patient in another group.

System Organ Class Preferred Team	Oraqix® gel* (N = 391) n (%)	Placebo gel (N = 168) n (%)	Lidocaine injection* (N = 170) n (%)
Muscular-Skeletal System Disorders			
Myalgia	1(0)	2(1)	
Arthralgia and/or Arthropathy	1(0)	1(1)	
Central & Peripheral Nervous System Disorders			
Headache	8(2)	3(2)	5(3)
Dizziness	1(0)	1(1)	1(1)
Special Senses Other, Disorders			
Taste Perversion[1]	8(2)	1(1)	
Gastro-Intestinal System Disorders			
Nausea	3(1)		1(1)
Respiratory System Disorders			
Respiratory Infection	2(1)		1(1)
Rhinitis		2(1)	
Body as a whole-General Disorders			
Accident and/or Injury	2(1)	2(1)	
Fatigue	3(1)		2(1)
Flu-Like Disorder	2(1)		
Pain (remote from application site)	1(0)	1(1)	1(1)
Application Site Disorders**			
Anesthesia Local	2(1)		
Application Site Reaction***	52(13)	20(12)	

[1] includes complaints of bad or bitter taste lasting for up to 4 hours after administration of Oraqix®
* in a cross-over study, 170 subjects received either Oraqix® or lidocaine injection 2% in each test period
** i.e., symptoms in the oral cavity
*** includes pain, soreness, irritation, numbness, ulcerations, vesicles, edema, abscess and/or redness in the treated area

Allergic Reactions: Allergic and anaphylactic reactions associated with lidocaine or prilocaine can occur. They may be characterized by urticaria, angioedema, bronchospasm, and shock. If they occur, they should be managed by conventional means.

OVERDOSAGE
Local anesthetic toxicity emergency: Oraqix® used at the recommended doses is not likely to cause toxic plasma levels of lidocaine or prilocaine. However, if other local anesthetics are administered at the same time, e.g. topically or by injection, the toxic effects are thought to be additive and could result in an overdose with systemic toxic reactions. There is generally an increase in severity of symptoms with increasing plasma concentrations of lidocaine and/or prilocaine. Systemic CNS toxicity may occur over a range of plasma concentrations of local anesthetics. CNS toxicity may typically be found around 5000 ng/mL of lidocaine, however a small number of patients reportedly may show signs of toxicity at approximately 1000 ng/mL. Pharmacological thresholds for prilocaine are poorly defined. Central nervous system (CNS) symptoms usually precede cardiovascular manifestations. The plasma level of lidocaine observed after the maximum recommended dose (5 cartridges) of Oraqix® in 11 patients exposed over 3 hours ranged from 157-552 ng/mL with a mean of 284 ng/mL ± 122 SD. The corresponding figure for prilocaine was 53-181 ng/mL with a mean of 106 ± 45 SD. (see CLINICAL PHARMACOLOGY, Absorption).

Systemic adverse effects of lidocaine and/or prilocaine are manifested by central nervous system and/or cardiovascular symptoms.

Clinical symptoms of systemic toxicity include CNS excitation and/or depression (light-headedness, hyperacusis, visual disturbances, muscular tremors, and general convulsions). Lidocaine and/or prilocaine may cause decreases in cardiac output, total peripheral resistance and mean arterial pressure. These changes may be attributable to direct depressant effects of these local anesthetic agents on the cardiovascular system. Cardiovascular manifestations may include hypotension, bradycardia, arrhythmia, and cardiovascular collapse.

Management of Local Anesthetic Emergencies: Should severe CNS or cardiovascular symptoms occur, these may be treated symptomatically by, for example, the administration of anticonvulsive drugs, respiratory support and/or cardiovascular resuscitation as necessary.

See warnings on methemoglobinemia on Oraqix® full prescribing information at www.oraqix.com.

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

DOSAGE AND ADMINISTRATION
The maximum recommended dose of Oraqix® at one treatment session is 5 cartridges, i.e., 8.5g gel.

When administered, Oraqix® should be a liquid. If it has formed a gel, it should be placed in a refrigerator (do not freeze) until it becomes a liquid again. When in the liquid state, the air bubble visible in the cartridge will move if the cartridge is tilted.

DO NOT FREEZE. Some components of Oraqix® may precipitate if cartridges are frozen. Cartridges should not be used if they contain a precipitate.
Do not use dental cartridge warmers with Oraqix®. The heat will cause the product to gel.

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House to consider CDHC resolution

Long-term commitment sought for piloting, evaluating of training programs

BY KAREN FOX

The development of the Community Dental Health Coordinator has been in the works since 2006, with pilot training programs set to start early next year. Later this month, the House of Delegates will consider a resolution to provide long-term financial support for the program.

"The Community Dental Health Coordinator is designed to assist dentists in improving dental care for patients with limited and no care," said Dr. Bob Brandjord, chair of the ADA Workforce Models National Coordinating and Development Committee. "Working with other dental team members under the remote supervision of a dentist, CDHCs will increase access for underserved people by coordinating their dental needs, triaging care based on emergent or urgent needs, and organizing transportation and other logistical or social support as needed."

After providing an update on the CDHC to the Board of Trustees Aug. 12, Dr. Brandjord took the opportunity to address some misconceptions regarding the workforce model. He emphasized that the CDHC:

- is not intended to substitute for dentists in providing clinical care;
- performs no irreversible procedures;
- does not diagnose;
- is part of the dental team;
- screens patients for emergent, urgent or routine dental care;
- places temporary restorations after consulting with the supervising dentist.

"The development of the CDHC has been in keeping with the ADA's commitment to the public's oral health," said Dr. Brandjord, also an ADA past president (2005-06).

"CDHCs will be recruited from distinct communities to work and build trust at the grassroots level and play an important role in bridging the gap between local cultures and dental health care systems," he said. "They will navigate community members through the health care delivery system, helping diverse populations overcome barriers that prevent them from accessing and benefiting from dental health services. Their overall goal will be empowering community members, communities and the dental health care systems to achieve positive outcomes and to reach the optimal level of wellness for everyone.

"This is not the only solution to dental access problems, nor is it the only solution proposed by the ADA," he added, citing improvements in funding and organization of Medicaid, promotion of the expansion of the State Children's Health Insurance Program and support for Federally Qualified Health Centers as a few examples.

"This is different than any other new, proposed workforce model in that the CDHC's focus is on the prevention of dental disease," said Dr. Brandjord.

CDHCs will 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 people similar to their own ethnic and cultural background. CDHCs will be trained to promote oral health and provide preventive services including screenings, fluoride treatments, placement of sealants, placement of temporary fillings and simple teeth cleanings (selective scaling for plaque-induced gingivitis, i.e., removing gross debris, stains and calculus using anterior and posterior sickle hand scalers) until the patient can receive comprehensive preventive services from a dentist or dental hygienist.

CDHCs will not excavate caries, but temporary restorations in caries will be placed (as well as sealant and fluoride application) by the CDHC after approval from a supervising dentist after the dentist has made a diagnosis.

"Temporization will stop the caries from progressing, increase secondary dentin formation and in some cases cause remineralization," said Dr. Brandjord. "Temporary restorations will eventually be replaced by the supervising dentist when he or she completes the patient's care. In cases like these, the CDHC will be instrumental in ensuring that the patient follows up in a timely manner with definitive care by the dentist."

Aside from working in health and community settings, the CDHC will collect information to assist the dentist in patient triage and address the social, environmental and health literacy issues facing the community. Linking patients to oral health care will also be an important role for the CDHC in working with underserved populations going through the maze of the health and dental care systems.

Dr. Brandjord has delivered presentations on the CDHC at 27 dental organization meetings in the last two years and to key staff of U.S. Senate and House of Representatives committees associated with health care. The ADA Board of Trustees in August reiterated its strong support for the CDHC program and adopted resolutions approving next steps for program implementation and evaluation. The Board reviewed the program's current funding, as well as anticipated additional financial implications for the ongoing operations and evaluation of the pilot sites, and recommended that the ADA commit to the program's long-term financial support.

The Board also directed that a similar presentation be made available to ADA members during annual session. "Presentation on the CDHC Pilot" takes place Friday, Oct. 17, from 11 a.m. to noon at the Henry B. Gonzalez Convention Center (Ballroom C).

Dr. Brandjord will also be available for state caucuses during annual session, and the CDHC curriculum will be on display in the Delegates Registration Area.

The 2008 House of Delegates will consider Resolution 39, recommended by the Board, which calls for the ADA to commit to up to $5 million to support the CDHC model. The funding would include the three pilot sites, management of the online curriculum, evaluation of the program, project support, and equipment and supplies. Board Report 10 states: "Because the program evaluation will be a multi-year endeavor with a formal agreement, the Board believed that the ADA should formally commit to long-term support for the program while continuing aggressive efforts to seek external funding."

"The ADA Foundation has helped us to identify potential funding sources that may be interested in providing financial support for the CDHC and we are aggressively pursuing those options," said Dr. Brandjord. More than 100 foundations and federal grant-making agencies have been contacted, and local funding support for the CDHC pilot programs has also been encouraged.

"Potential support from funding sources is more likely if there is clear support—including a financial commitment—from the ADA," said Dr. Brandjord.

Information sharing: Dr. Bob Brandjord gives an update on the CDHC program at the Aug. 18 Meeting of the ADA Recognized Dental Specialty Certifying Boards and Organizations, the annual event sponsored by the Council on Dental Education and Licensure.

The Community Dental Health Coordinator workforce model has been in development for several years. Dating back to 2004, the House of Delegates has directed three different workgroups to study workforce issues as part of a broad Association effort to evaluate workforce and oral health access. In 2006, the House of Delegates passed two resolutions calling for an expanded dental workforce team, as proposed by the ADA Workforce Task Force.

The 2007 House passed Resolution 54H-2007, which, among other things, encouraged the National Coordinating and Development Committee to complete the CDHC curriculum, begin piloting and evaluating the model training program at three sites, and allocated up to $2 million from reserves to fund pilot programs over a three-year period. That $2 million has been allocated to support the overall management of the online curriculum, initiate the training program and develop the comprehensive evaluation component in 2008-09. By early 2010, those funds will be fully allocated.

Each of the three pilot sites will cost a minimum of $1.5 million to operate for three years. The evaluation component, including a clinical care data management system, will be about $1 million. To date, approximately $170,000 in project administrative costs have been paid from the $2 million granted by the ADA to run the project. That figure is expected to increase to $250,000 by the end of the year.

Total funding for the CDHC pilot program will be almost $8 million, including project support costs for temporary staff, volunteer meetings, and promotion and evaluation of the pilot programs' overall success. Financial support of $5 million over the next five years is requested if external funding cannot be achieved.

"Report 10 of the Board of Trustees to the House of Delegates: Update on the Community Dental Health Coordinator Pilot Programs" is on ADA.org in members-only content.

To view the report and the "CDHC Curriculum: Community Health Worker and Health Promotion Skills and Dental Skills," visit "www.ada.org/goto/hod" and click on "2008 Reports and Resolutions." ■

—foxk@ada.org

CDHC training program includes supervision by licensed dentists

Phase 1 of the Community Dental Health Coordinator has been completed and Phase 2 begins in early 2009.

In Phase 1, the Workforce Models National Coordinating and Development Committee completed the development of a model CDHC training program. The 18-month program has been designed to prepare individuals to work under a dentist's supervision in health and community settings promoting oral health and providing preventive services until the patient can receive comprehensive care from a dentist or dental hygienist.

With a grant from the ADA Foundation, the CDHC curriculum was developed including objectives, outlines, teaching resources, learning activities and evaluation mechanisms, with modules designed primarily for online delivery. A sample copy of the CDHC curriculum will be on display in the Delegates Registration Area during annual session.

Three sites have been selected for Phase 2—the pilot training component—in which CDHCs will work under the supervision of a licensed dentist, said Dr. Bob Brandjord, chair of the National Coordinating and Development Committee.

"During the demonstration projects, the CDHCs will be supervised by a committee that includes a representative of the host state's board of dentistry," he said. "If the demonstration projects prove effective, CDHCs could be recognized by a state board of dentistry."

CDHC pilot projects will take place in three sites:

- Native American site—Partnership between University of California-Los Angeles and Salish Kootenai College of Pablo, Mont., a tribal college on the Flathead Indian Reservation with a CODA-accredited dental assisting program. The curriculum's online components will be provided by Rio Salado College (Arizona) and hands-on clinical training will occur in Native American facilities in several different states.
- Urban site—Michigan Coalition for Development and Implementation of the Community Dental Health Coordinators in collaboration with the Wayne County Community College District. Pending state approval, hands-on training will occur in Federally Qualified Health Centers. In June, a bill was introduced in the Michigan legislature proposing to establish a four-year demonstration program authorizing the practice of CDHCs who would work in designated underserved areas and provide limited dental care, including tooth scaling and placing temporary restorations—all under dentists' supervision.
- Rural site—University of Oklahoma. The curriculum's online components will be provided by Rio Salado College and hands-on clinical training will occur in Indian Health Service facilities and Federally Qualified Health Centers. The pilot program has been approved by the Oklahoma Board of Dentistry. ■

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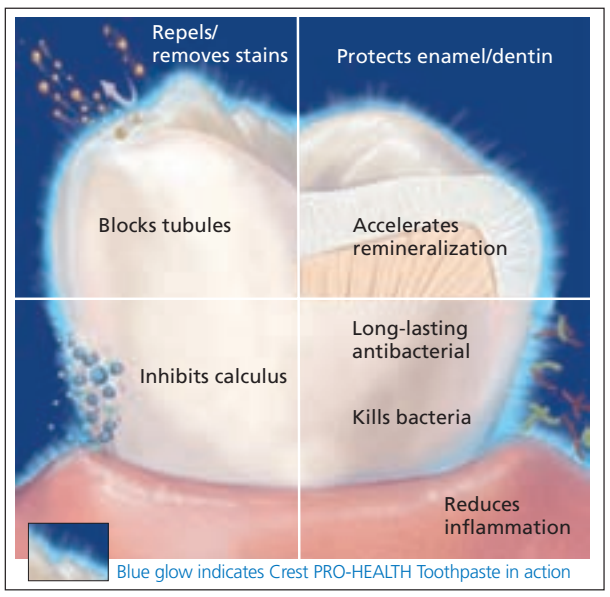

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Reference: 1. Baig A et al. *Compend Contin Educ Dent*. 2005;26(suppl 1):4-11.

P&G Professional Oral Health

President-Elect's Interview

Workforce, advocacy, electronic health record

Dr. Findley focuses attention on these issues and more

Editor's note: This is the second and final installment of an interview with Dr. John S. Findley, ADA president-elect. Dr. Findley will take office as Association president before the House of Delegates Oct. 21 in San Antonio. The first part of this interview appeared in the Sept. 15 ADA News. Dr. Findley was interviewed by ADA News Editor Judy Jakush during the summer.

ADA News: The ADA's Workforce Models National Coordinating and Development Committee has been working on two models—the CDHC (Community Dental Health Coordinators) and OPA (Oral Preventive Assistant). As a member of the dental health team, and under a dentist's supervision, the CDHC will work in communities where residents have limited or no access to dental care. The concept of the CDHC in reaching the underserved communities is that the CDHC will come from the community in which they will serve. Because they come from this community, the CDHC understands the culture, language and barriers to care. The ADA's vision for the Oral Preventive Assistant program proposes an additional capability set for the dental assistant that is focused on the basics of preventive care—including oral hygiene education, the application of fluorides, placement of sealants and coronal polishing for all patients—along with the ability to perform scaling procedures for plaque-induced gingivitis patients.

What is your view of these two new workforce models and why are these workforce issues important for the profession?

Dr. Findley: These proposed two models were supported by the ADA House of Delegates in 2006 and 2007. From the standpoint of protecting our patients and keeping their care paramount, we have consistently stressed that both new positions are a part of the dental team—by definition the dentist is the leader of that team. We also continue to stress the dental home concept, believing that everyone should have a dental home. That's the best way for dental care to be provided and the best way we can guarantee success in areas where there is lack of care today.

The CDHC and OPA concepts recognize the position of dentist as leader of the team. They help provide an answer to questions about providing health care in areas where there is great unmet need. The alternative to making change is just saying no. One of my favorite quotes from Dr. Richard Haught, past ADA president (2004-05), is when he said, "It's time to just quit saying 'no' and come up with positive answers." This resonates with me, just as when I realized that I first had to get involved in organized dentistry and try to help solve the problem before complaining. So the models described as the OPA and the CDHC are the ADA's positive workforce answers to issues of access. Those models describe workforce issues consistent with what we believe to be appropriate procedures for dental team members. We'll be evaluating the pilot programs we are establishing right now—determining whether those answer the needs as we think they will do or not.

I would hope that dental boards would be amenable to the CDHC and the OPA, but there is still a lot of discussion ongoing and I would emphasize that we welcome input from anybody. We're inviting people to come in and talk—if you've a proposal you think might work better, let's look at it. Meanwhile, what we have proposed we have backed up with curriculum and recommended pilot programs. Just as Dr. Haught advised, we'll help more people by providing positive answers, not complaints.

Provision of care to underserved communities carries a cost, and the answer to that lies in some sort of economic package or stimulus, loan forgiveness or tax credit. There has to be some sort of provision that allows dentists and dental team members to go to smaller or remote communities and practice. The independent practice of dental hygiene model does not work well economically—or it would be more prevalent in the states in which it is legal. The traditional dental model may be strained at various times. We feel that increasing auxiliary efficiency of the members of the dental team, perhaps by 15 percent or 20 percent, is one aspect of making things better and reaching a different level of care. These models are intended and designed to be self-sustaining. A lot of money and time has gone into these proposals, including money contributed by the ADA Foundation to fund the CDHC curriculum development. We believe the solid research and development effort that has gone into the CDHC and OPA models is a sound investment that will translate into workable models. These workable models will have the dentist as the head of a team; they are completely within parameters that we believe provide good patient care. They are our solutions—not solutions that will be provided by others if we fail to move this concept forward.

"The dental home is a concept that provides continuing care, care not on a one-shot basis—care in dentistry that is necessary and appropriate. The concept of the dental home is one that is based on a doctor-patient relationship, and we need to emphasize that. You just don't fly somewhere one time to receive dental care and then it's over."

ADA News: The Board of Trustees has had some discussions of dental tourism. The ADA News also has addressed this topic within the context of globalization. Is dental tourism a realistic concern for our members? Is it chiefly an issue for the border states, such as your home state of Texas?

Dr. Findley: I think dental tourism is tied to many factors. Yes, along the border, it's always been an issue. It's not new. It may not be dental tourism per se on the border, because in some instances going across the border is no more than going to your local grocery store for some. There has always been an issue of cross-border care with Mexico in my state, Texas, because the border is so close.

Keynote: Dr. Findley speaks at the 2007 Baylor College of Dentistry commencement.

And yet, though it's always been there, there is great concern on the part of ADA members and justly so. Speaking from a local standpoint—and I am the first to tell you that you should not assume that all cross-border dentistry may be bad, because it's not—but when we do see problems from cross-border dentistry, they are significant and many times retreatment is no longer an option. It's a situation we've been aware of but we need to get documentation of the problem before advocating any course of action.

True dental tourism is increasingly a problem, and that doesn't affect border areas so much. Any city in this country can be affected by dental tourism because of the ease of travel. There are significant questions about that, and people need to be aware of what it entails. As I have said many times before, you don't find the dental home at the end of a tour bus stop. The dental home is a concept that provides continuing care, care not on a one-shot basis—care in dentistry that is necessary and appropriate. The concept of the dental home is one that is based on a doctor-patient relationship, and we need to emphasize that. You just don't fly somewhere one time to receive dental care and then it's over. Dental care is continuing involvement and care, and this concept is something each of us as dentists can talk about with our patients.

ADA News: Since its launch last year by the ADA, ADA Foundation and GlaxoSmithKline, the OralLongevity initiative has resonated with dentists. Did you and the Board have any idea that the OralLongevity and other outreach to older adults would generate so much response? And what kinds of expansion do you see for the future?

Dr. Findley: It's interesting how both the profession and the public have embraced this effort, saying, "Wow, we really need this." There is a lot of opportunity to accomplish so much here. It is an area that has traditionally been in the background, but with people living longer, the need to provide preventive care and restorative care for people over 60 is getting more attention. I am particularly pleased that the profession and the business sector could join together in such a worthwhile venture for patients. The response to it indicates that this is a type of activity that we need to do more of in the future.

The program got off to a great start last year with a supplement to The Journal of the American Dental Association on oral health and the aging population. Also included were an OralLongevity—A Healthy Smile for Life patient brochure and an Oral Health Awareness educational DVD program, which was followed up by distribution at annual session and continuing education courses at session—and we've got more this year in San Antonio.

We've gotten tremendous feedback from dentists who are putting these OralLongevity tools into practice. Some of their stories are online at "http://orallongevity.ada.org." This Web page includes an overview of the OralLongevity initiative and links visitors to resources for dental professionals, resources for consumers and a link to the OralLongevity's brochure and DVD.

ADA News: The Association and its partners have chosen to expand Give Kids A Smile from its once-a-year observance to include other year-round activities. What do you think of this change?

Dr. Findley: When I first heard of the year-round effort, I saw it as an opportunity to take something we know works and works well and broaden its scope. GKAS observance has certainly brought needed attention to the access to care problem and shows that the profession is willing to step up and answer the need.

Expanding it should bring an even greater impact. Participating in GKAS—providing care to those who otherwise don't receive it—is extremely gratifying. Whether a dentist participates in the one-day event or in an expansion activity, you are likely to see some things and provide a type of dental care you may not otherwise see. I'm delighted efforts are going year-round and I'm certainly expecting to continue to see very, very positive things from GKAS. It's one of the greatest things we do.

ADA News: The Public Affairs Initiative is about two years old now and was launched by the House in 2006 as part of the ADA's renewed emphasis on advocacy. Is it doing what it was intended to do?

Dr. Findley: I think dentists are becoming more aware the Association is representing their interests on regulatory issues. We deal with so many issues across the country and we know that if some issue is not in your particular area of the country right now, it will be soon. I think the tripartite and the members are much more aware of how much the Association provides in the area of legislative and regulatory services. There is not a day that goes by that we don't get some sort of inquiry from a state or local area that hasn't already been handled in another area of the country. The ADA does quite well in coordinating and sharing that information and providing advice. The people behind our Public Affairs Initiative in our governmental affairs area are always equipped to handle questions. They are well experienced and able to give some pretty good advice. I think the advocacy aspect of what the Association does is

recognized by members and the tripartite as very important.

ADA News: The electronic health record is the focus of ever-increasing discussion. What does it mean to the profession? What is the Association doing to help dentists deal with EHR and its implications for dental practice?

Dr. Findley: This again is an area in which the ADA is working hard and we have a long way to go. The electronic health record may not be the result of changes of our choice. They are going to be mandated. No one is going to ask, "Do you want to do this?" No, it's going to be, "You have to do this." That's why we absolutely need the profession to be represented in the discussions about EHR to make sure our ideas are enacted to the greatest extent possible.

If we don't participate, then who knows what will happen regarding the dental part of the EHR? EHR is on the way. Hospital administrators and physicians are already dealing with it. We have a slight advantage in that we are working on the issue and providing input.

The aspect of paramount concern is privacy. That's always an important issue for the health care system. Cost is also an issue—the increased cost of compliance has to be borne by somebody. For the average practitioner, this will mean an investment in certain types of technology and maintenance of those resources. This aspect has to be examined very closely.

I feel comfortable about the effort the ADA is making here. In addition to the Council on Dental Benefit Programs, the ADA has two committees, the EHR Workgroup and the SNODENT (Systemized Nomenclature of Dentistry) Editorial Panel. These workgroups include representatives from ADA councils, committees, volunteers, staff and dental specialty groups. We need to position dentistry correctly for the future, working to maintain as much control for dentists as government will allow.

All these systems that exist now will need to be able to talk—to interface—in a common way. All the while, the ADA must protect the profession's interests and our members' interests while moving into this new area. The end result will be the simplicity and efficiency of having all your medical information at hand instantly. The hard work is getting to that point.

ADA News: At its June meeting, the Board reviewed a 2009 proposed operating budget of $115.9 million in revenues and $117.4 million in expenses, income taxes and cash flow items, generating a net deficit of $1,499,350. The Board voted to fund the deficit with a $14 dues increase, which would bring dues to $512 next year. What are you telling members who are asking you about the 2009 budget?

Dr. Findley: The Association has a long-term financial strategy of dues stabilization, seeking to limit any annual dues increase to inflationary levels or less. We are recommending less than the inflation rate. The proposed dues increase is 7 percent less than the $15 increase which current inflation levels would equate to.

In the process of examining the financial picture of the Association, I am most satisfied with the dues stabilization policy. We have achieved that through judicious budgeting, an adequate reserve and good business strategy practices. The addition in 2009 of over $1.5 million in new programs for our members and the fact that 53 percent of our total revenue is nondues income speaks to the success of our efforts.

It's a challenge to balance the needs of the members with the knowledge that expenses are ever increasing and that reducing costs usually means cutting programs. On one hand, we are challenged to be good stewards of our members' money and on the other, to produce the quality of services and programs that make being a member of the ADA a good value for every dentist. I think we perform exceptionally well in looking at existing and proposed programs to see that we get appropriate returns. In hard economic times, however, the challenge is to do more and to do it better. Nothing is getting cheaper, certainly not gas, not food and neither is technology. So for us to remain at the top, I am not surprised that a small increase in dues is recommended by the Board.

Photo by PRD Photography

Dr. Findley: "We need to continue to build support and cooperation between the dental education and practice community. It's something that is not just nice to have, but is required for the future of the profession."

ADA News: Our Legacy—Our Future, an initiative spearheaded by the ADA Foundation and other partners, is designed to raise awareness of the importance of dental education and to promote a culture of philanthropy within the dental profession and solicit a call to action to address these issues. OLOF encourages interested donors to give directly to the partner institutions of their choice. The goal is to collectively raise more than $500 million by the end of 2014 to address the issues facing the future of dental education. There are more than 130 partners now. How do you view the progress of the campaign and its ultimate goal? What would you like to see happen with it during your year as president?

Dr. Findley: Education is critical to us as a profession and I have been impressed by the success we've had with the initiative. We are in a time that calls for the profession to fully join the program. I say that education is a critical issue because we are professionals because of our education. Dental education is costly. It's essential our schools operate in an environment that is free from any influence on how or what they teach. So I can see the need for the profession to step up and support dental education. Believe me, I think we've got an obligation. We need to continue to build support and cooperation between the dental education and practice community. It's something that is not just nice to have, but is required for the future of the profession. I'd like to see not only a commitment on the part of the profession in monetary form but also a commitment in terms of time, serving in whatever capacity can help.

See DR. FINDLEY, page 31

Dr. Sturdevant, renowned dental author, dies

BY JENNIFER GARVIN

Chapel Hill, N.C.—Dr. Clifford Max Sturdevant, author of The Art and Science of Operative Dentistry, died Sept. 9. He was 90.

A founding faculty member of the University of North Carolina at Chapel Hill School of Dentistry, "Dr. Cliff" joined UNC in 1950 and from 1959-79 served as chair of the department of operative dentistry. His father, Dr. Roger Sturdevant, was the first operative dentistry chair.

Dr. John Sturdevant, Dr. Cliff's son, also followed the family tradition and is an associate professor at UNC School of Dentistry. "Like my father, I enjoy being around students who are highly motivated and extremely talented. Dad enjoyed fixing things, and loved teaching others how to do so. Operative dentistry was a natural choice."

Dr. John recalled his father's dedication to the profession, noting that he was known for his compassion and skill. "He always found time to listen, understand and help with the problems of others. Dad will be remembered for his work in the church, his love of family, and for his commitment to excellence in operative dentistry."

Dr. Sturdevant

The Art and Science of Operative Dentistry, is now called Sturdevant's Art and Science of Operative Dentistry after current editor and former student, Dr. Ted Roberson, asked the publisher to change the name to honor its scholastic contribution to operative dentistry.

"He demanded excellence and that's what he always displayed himself," said Dr. Roberson in a UNC news release. "He loved this dental school and this university, and he loved operative dentistry."

Said Dr. Gregory Chadwick, a past ADA president (2001-02), "Our profession has lost a true giant and a gentleman. His passion for the smallest details in both the art and the science of operative dentistry made 'his' textbook the most widely used around the world. He loved his family, profession and his students, and will be long remembered for the difference he made in all our lives."

A past president of the Academy of Operative Dentistry, Dr. Sturdevant was affiliated with A Consortium on Restorative Dentistry Education, a project created in the 1970s to standardize operative dentistry teaching materials throughout all U.S. dental schools. He was known for his professional dedication and rumor had it among the dental school that he often worked until the early morning hours.

He received his dental degree in 1943 from the Atlanta-Southern Dental College, which later became the Emory University School of Dentistry.

Dr. Clifford Sturdevant is survived by three children, four grandchildren and three great-grandchildren. Funeral services were held Sept. 15. ■

Your Spitting Image is ready to travel

National Museum of Dentistry's newest exhibition will head to San Antonio

Education to go: Your Spitting Image, the National Museum of Dentistry's newest traveling exhibit, attracts local attention in Baltimore before going on tour to San Antonio.

San Antonio—The National Museum of Dentistry will preview the Healthy Mouth, Healthy Body portion of its newest traveling exhibition, Your Spitting Image, at the Henry B. Gonzalez Convention Center, Booth 2940. ADA President Mark Feldman is scheduled to help cut the ribbon at 9:45 a.m. on Thursday, Oct. 16.

Healthy Mouth, Healthy Body highlights the importance of oral hygiene and the mouth-body connection, featuring animated video and an exploration of the impact oral health can have on other conditions such as diabetes. Visitors can assume forensic investigator roles, take a closer look at that most remarkable fluid of the mouth, and see how scientists use bioengineering to grow replacement teeth. And while you're there, try the exhibit's "sensory element."

"Advances in dentistry are making a positive impact on our lives, and this new traveling exhibition shows some of the ways these advances affect us all," said Rosemary Fetter, executive director, NMD. "We are excited to bring a part of Your Spitting Image to the ADA annual session to show the impact this exhibition will have on helping to improve oral health across the country."

AnnualSession

Lead support for Your Spitting Image is provided by Patterson Dental Foundation with major support from Johnson & Johnson Consumer & Personal Products Worldwide, Planmeca Inc., Drs. Leslie W. Seldin and Constance P. Winslow, and Dr. Laurence E. Johns and Dr. Robert J. Wilson. Your Spitting Image highlights the convergence of genetics and dentistry with hands-on interactive and computer activities. The exhibit begins touring children's and science museums in 2009.

The museum in Baltimore, Md., at 31 S. Greene St. is open Wednesday-Saturday from 10 a.m.- 4 p.m. and Sunday 1-4 p.m. It's closed on Mondays, Tuesdays and major holidays. Call 1-410-706-0600 or visit "www.dentalmuseum.org". ■

Two reports from the Survey of Dental Education series available

Two reports from the 2006-07 Survey of Dental Education are available. They are Volume 2—Tuition, Admission and Attrition, and Volume 5—Finances.

Volume 2 of the Survey of Dental Education includes statistical information on annual resident and nonresident tuition, general fees and other fixed costs. It also provides information on admissions policies of dental schools in the U.S. and Canada; the number of applicants; academic qualifications of first-year students; criteria employed in the admissions process; advanced placement and number of international dental school graduates; distribution of first-year students according to citizenship; and information on students withdrawing from dental school.

Volume 5 of the same report series details the revenue and expenses for the operations of 56 U.S. dental schools during the fiscal year ending June 30, 2006.

To ensure confidentiality, randomly generated school codes are used in place of school names in all tables that provide financial data. Both surveys are published annually.

Volume 2—Tuition, Admission and Attrition—reports that trends in total costs for all four years of dental school show a consistent yearly increase for both residents and nonresidents.

Volume 5—Finances—reports total revenue per full-time enrollment decreased from $102,852 in the fiscal year ending 2005 to $102,146 in FYE 2006. Total expenditures per FTE, meanwhile, increased slightly between FYE 2005 and FYE 2006, from $96,671 to $96,714.

The cost of these reports (items SDE2 and SDE5-2006) is $90 for members, $135 for nonmember dentists and $270 for commercial organizations, plus shipping and handling. The reports are also available as downloadable files (code SDE2-2006D) at the same prices.

These and other ADA Survey Center publications can be ordered online at "www.adacatalog.org" (reports are listed under Survey and Economic Research on Dentistry) or by calling 1-800-947-4746. ■

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ADAF grants scholarships, seeks applicants

The ADAF is pleased to announce its 2008-2009 Dental and Allied Dental Scholarship recipients.

Each year, the Foundation awards over 80 scholarships totaling more than $150,000 to dental students ($2,500 each); minority dental students ($2,500 each); and dental assisting, dental hygiene and dental laboratory technology students ($1,000 each).

To view a complete list of this year's recipients, visit "www.adafoundation.org/ada/adaf/index.asp".

The Minority Dental Student Scholarship program is funded in part by Harry J. Bosworth, Procter & Gamble, Colgate-Palmolive Co. and Sunstar. The Dental Laboratory Technology Scholarship Program is funded in part by Handler Manufacturing Inc.

Those students interested in applying for a 2009-10 scholarship must first contact the associate dean for student affairs, program director or financial aid officer at their school to request a scholarship application form. Each school can submit two applications for consideration. Only schools accredited by the ADA Commission on Dental Accreditation are eligible to nominate students for the scholarship program.

Applicants must be U.S. citizens and enrolled as full-time students. Eligibility is determined by the applicant's demonstrated financial need, academic achievement, biographical sketch questionnaire and two completed reference forms.

School officials will be contacted directly by the ADA Foundation and provided with scholarship application forms in spring and summer of 2009. For more details, log on to "www.ada.org/ada/prod/adaf/prog_scholarship_prog.asp". ■

New ADA report on orthodontists and orthopedists details expenses and billings

For all owner orthodontists and dentofacial orthopedists, the average practice expenses as a percentage of gross billings decreased from 58.1 percent in 1998 to 56.9 percent in 2005, according to a new report published by the ADA Survey Center.

"Orthodontists and Dentofacial Orthopedists in Private Practice," the first of six specialty reports published from the ADA 2006 Survey of Dental Practice specialty series, also shows that gross billings per practice hour for all solo orthodontists and dentofacial orthopedists increased 138.9 percent from $222.70 in 1992 to $532.10 in 2005.

The cost of the publication (item ORT-2006) is $100 for members, $150 for nonmember dentists and $300 for commercial organizations, plus shipping and handling.

Order online at "www.adacatalog.org" or call 1-800-947-4746. ■

Dr. Findley

Continued from page 29

ADA News: Why is the Association putting so much effort into evidence-based dentistry? Why is this important for practicing dentists?

Dr. Findley: I think that all of us want to be better practitioners. It is one of those things we're obligated to do as professionals. Evidence-based dentistry has different meanings for many people, but the Association has spent a great deal of time and effort working with experts to develop consensus for the profession on what it is and how to apply the process.

Even though we have met the challenge of defining EBD as a profession, we need to enhance our efforts to make sure dentists have appropriate tools and information to use the evidence-based approach in practice.

It's also important for dentists to recognize misperceptions about EBD. For example, it is not a tool for policymakers to establish dental benefits coverage based on claims data. Every patient's needs are different and the EBD approach takes this into account to provide personalized care. EBD is a cornerstone of dental practice, based on a clearly defined methodology that is transparent to all. Members can find the ADA's definition of EBD, which recognizes the importance of integrating scientific evidence, the dentist's experience and patient needs and preferences in oral health care decisions, and a wealth of other information on the current EBD Web site ("www.ada.org/goto/ebd").

Our Center for Evidenced Based Dentistry is launching an enhanced EBD Web site with grant support form the National Library of Medicine and the National Institute for Dental and Craniofacial Research. We will be including critical summaries of systematic reviews. This will be a tremendous tool for the practitioner. This is a good example of our Association's relevance to the profession.

In a few clicks on the Web site, the practicing dentist will be able to quickly find a bottom-line analyses of systematic reviews on a multitude of clinical topics. Dentists will also have opportunity to investigate their question further by accessing links to supporting references and other databases if interested. The Web site will be an easy-to-use portal for dentists, and future upgrades will provide patient-friendly resources.

ADA News: Can you provide an update on what is happening with the ADA and licensure?

Dr. Findley: Licensure is always an issue for both new graduates and established practitioners wishing to relocate to a different state. It is an issue, that, as an Association, we have probably worked on to the extent that we can. We are still vitally interested and we are still working to find solutions that are broadly accepted. Are we there yet? No, not yet, but I feel we've made progress. We still have hope. Ultimately, a nationally accepted exam will come to be. What we've seen so far is that we've managed to promote acceptance by states of several clinical licensure exams as substantially equivalent. That is progress and we are moving in the right direction, even if we're not quite where we want to be yet.

Several states have moved to the PGY1 (post graduate year one) model. New York did so in 2004. I think it's an individual state's right to choose which method of licensure evaluation to use. It is not yet totally accepted across the country, but it appears to have worked well in the states that it is in, and each year will give us another chance to evaluate outcomes and see where we are.

ADA News: There is much going on to help new dentists in practice and dental students as they prepare to become dentists, help such as lobbying for student loan assistance, loan forgiveness programs in exchange for service, mobility in licensure process and streamlining the ADA SUCCESS Program to ensure dental schools have a program for every year of dental school. How do you assess this effort?

Dr. Findley: This is another area in which the Association has made tremendous progress. We have certainly benefited from dental student participation in several committees or as liaison to councils. I think the other side of this is that they have taken back to the American Student Dental Association words and thoughts that explain how dentists in practice feel about issues. It has been a mutually beneficial relationship and will become increasingly more important, with more opportunities developing for increased involvement. ■

At the office: Dr. Findley poses with his staff (from left) hygienist Maggie Davis, assistant Jill Griffin and receptionist Judy Devine during the 2005 Give Kids A Smile observance at his office in Plano, Texas.

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