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Allcare offices close, page two ◆ Haiti Adopt-A-Practice, page 31

AMERICAN DENTAL ASSOCIATION WWW.ADA.ORG

ADA NEWS®

JANUARY 17, 2011 VOLUME 42 NO. 2

Photo by Peggy Cain, UNMC

Fun: Tooth fairy Whitney Heimann, right, a class of 2011 dental hygiene student, pauses for a photo with patient Veronica Ardon at the February 2010 University of Nebraska Medical Center Children's Dental Day clinic in Lincoln. This year's UNMC Dental Day will celebrate the program's 10th anniversary on GKAS Day Feb. 4. See story, page 18.

Dentists may see 'utility, benefit' in Tax Relief Act

BY CRAIG PALMER

Washington—Tax changes approved by Congress and signed into law by President Obama in December "are likely to have significant interest to dentists as individuals and small business operators in the form of utility and benefit," says Dr. Edward Leone Jr.

The Internal Revenue Service advises taxpayers impacted by changes in tax law to delay filing returns "to give the IRS time to reprogram its processing systems." (For details, visit the IRS online: "www.irs.gov/newsroom/article 0,,id=233910,00.html?portlet=7".)

"TRUIRJCA is complicated legislation in content and technical application," Dr. Leone says in describing the Tax Relief, Unemployment Insurance Reauthorization and Job Creation Act of 2010 known in short as the Tax Relief Act of 2010.

The ADA News asked Dr. Leone, treasurer of the American Dental Association, to summarize elements of the legislation that may be of interest to dentists and dental professionals. His bottom line, "Get your accountant's help on these issues."

■ Early childhood caries symposium, page 26

"My purpose in writing this is to highlight elements of the Tax Relief Act which are likely to have significant interest to dentists as individuals and small business operators in the form of utility and benefit," Dr. Leone replied. This is intended only as a summary of selected provisions in complex tax legislation and should not be read or viewed as advisory, he said.

The ADA News offers edited excerpts from Dr. Leone's summary of the Tax Relief Act, Public Law 111-312.

• Two year extension of current tax rates through 2012:

A. Marginal income tax rates remain

See TAX LAW, page 22

BRIEFS

GKAS Day: Grab your camera—GKAS is Feb. 4

With Give Kids A Smile Day just days away, a total of 1,962 GKAS events have been registered with estimates that nearly 319,000 children will be treated on or around Feb. 4.

Almost 12,700 dentists and 36,000 other dental team members and lay volunteers will be providing care to kids in need through GKAS programs.

Programs are encouraged to register if they haven't done so yet—either before or after their events, and all program coordinators/dentist participants are asked to report their actual program totals following their events. Log on to "www.givekidsasmile.ada.org".

GKAS corporate sponsors have generously supported the program. Henry Schein Dental provided professional dental

See BRIEFS, page 18

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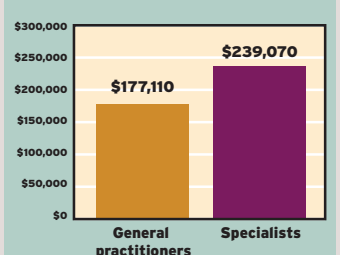
JUST THE FACTS

Nondentist employees

Average total salaries, wages, commissions and bonuses of nondentist employees of independent general practitioners and specialists.



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

Association commends new fluoride recommendations

BY CRAIG PALMER

Washington—The Association commended new government recommendations Jan. 7 on fluoride in drinking water and said the ADA will continue advocating for community water fluoridation at the proposed levels.

"This is a superb example of a government agency fulfilling its mission to protect and enhance the health of the American people," said Dr. Raymond F. Gist, president of the American Dental Association. "We have always looked to the federal health agencies to guide us on this and other public health matters, and we will continue to do so.

"We applaud the Department of Health and Human Services for reaffirming the safety and efficacy of optimal community water fluoridation, with science on their side," the Association president said.

■ Align settlement update, page 12

"Dentistry has succeeded in preventing disease better than any other area of health care," said Dr. Gist. "Water fluoridation is one of our most potent weapons in disease prevention, and we want as many people as possible to have the benefits of this simple, safe, inexpensive and proven health care measure.

"The ADA has long advocated for all Americans to have the best possible oral health. The recommended level has been set at the lower optimal limit, but the health benefits of fluoridation remain. The only real, known health risk is the dramatic increased levels of disease that are likely to afflict people without access to optimally fluoridated water." Learn more about the health benefits and safety of optimally fluoridated water from the ADA at "www.ada.org/fluoride.aspx".

Federal agencies in joint announcements proposed a change in the recommended level of fluoride in drinking water. The HHS department proposed setting the level at the lowest end of the current optimal range to prevent tooth decay. The Environmental Protection Agency is initiating review of the maximum amount of naturally occurring fluoride allowed in

See FLUORIDE, page 24

Allcare Dental & Dentures abruptly closes

BY KELLY SODERLUND

Buffalo, N.Y.—Allcare Dental & Dentures abruptly shut down its operations, according to news reports in late December.

The New York-based dental chain's home website was offline and phone numbers were disconnected. A different website, "www.allcareinfo.com", is providing updates and an explanation for the situation, but it's not clear whether that site is managed by Allcare or a separate entity. The accuracy of the website has also not been confirmed.

The American Dental Association in early January received calls from members reporting the closure. The ADA's call center has fielded calls from patients concerning Allcare's closing, and staff has directed them to contact their state board of dentistry and their state attorney general's office to see what their rights and options are, such as filing a complaint of abandonment. The ADA encourages members who have been affected by the closure to contact the Association.

The Allcare website says the company became "severely cash constrained and had no way to continue to operate going forward." The notice apologized to patients for not contacting them by phone but said the company's phone system and patient information computer network was abruptly shut down by their outside network provider.

"We are very sorry to inform you that Allcare Dental has closed down operations. There are no plans at this time to reopen the offices," the letter stated. "We want to assure you that this sudden closing situation was not our intent; it was due to circumstances beyond our control that arose very quickly. We understand that you must be very upset and frustrated about this situation, but please allow us to begin to explain the circumstances to some extent here on this site below."

The letter goes on to say the company had planned to "wind down underperforming offices" and raise capital from an equity group, but the closing date for the deal was not met and Allcare didn't have enough time to get to a closing with the capital group.

News outlets have reported that Allcare, a corporate dental practice, has 52 offices in 13 states.

According to the website, Allcare is working to transfer patient records to other dental offices near Allcare locations. It cited "positive developments" in Iowa, North Dakota, New Hampshire, several Ohio locations and two New York cities but did not provide specifics. Allcare also planned to notify state dental boards, according to the website.

Allcare was among 10 health care entities and four credit card companies cited by New York's attorney general in a state probe into patient credit financing programs last summer.

Patients interested in finding a new dentist can visit the ADA's website at "www.ada.org" and click the Find-a-Dentist feature. They can also contact their insurer for a referral to other dentists who accept their insurance plan. ■

—soderlundk@ada.org

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Registration opens April 6 for Oct. 10-13 ADA annual session

Las Vegas—The ADA's 152nd annual session will showcase "the future of dentistry" Oct. 10-13 at the Mandalay Bay Convention Center in Las Vegas. Registration opens April 6.

The meeting will offer more than 260 continuing education courses, and more than half of all lecture courses are free with registration. The World Marketplace Exhibition will feature the latest products, services and technologies available from more than 600 dental exhibitors—all conveniently located under one roof at the largest meeting facility on the Las Vegas Strip. Registered attendees receive free entry to ADA General Session and Distinguished Speaker Series.

Official ADA annual session hotels offer guests comfort and convenience. All six hotels—Mandalay Bay, THEhotel at Mandalay Bay, MGM Grand Hotel and Casino, Signature at MGM, Four Seasons Hotel Las Vegas and Luxor Las Vegas, are conveniently located on the South Strip.

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American Dental Association
ANNUAL SESSION
OCTOBER 10 – 13, 2011

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Starting April 6, registration for CE courses and housing will be open online at "www.ada.org/session". Request a preliminary program by calling 1-800-232-1432 or e-mailing "annualsession@ada.org". Preliminary programs will be mailed in early May. (Please type "Preliminary Program Request" in the subject line of your e-mail.) ■

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References: **1.** Xu T, Deshmukh M, Barnes VM, et al. *Acad of Gen Dent.* 2004;25(7, suppl 1):46-53. **2.** Panagakos FS, Volpe AR, Petrone ME, et al. *J Clin Dent.* 2005;16(suppl):S1-S20. **3.** Bolden TE, Zambon JJ, Sowinski J, et al. *J Clin Dent.* 1992;3(4):125-131. **4.** Cubells AB, Dalmau LB, Petrone ME, et al. *J Clin Dent.* 1991;2(3):63-69. **5.** Amornchat C, Kraivaphan P, Triratana T. *Mahidol Dent J.* 2004;24:103-111.

ViewPoint

MyView

What is poor, anyway?


Mary Jennings, D.D.S.

We have all been watching adult dental Medicaid die a lingering death for many years. In this tough economy it looks like it is a goner … again. As we have been discussing access it has amazed me how everyone has a different perception of what poor actually is. Even the poor people I know have a different definition of poor than I would think.

A long, long time ago when I was young and foolish I believed that poor people were just born tired and raised lazy. I figured that if we scrubbed them up and trained them that they would magically grow a fire in their bellies, get to work and not be poor anymore.

Well, that theory may hold for some but like the blind men and the elephant, I had my hand on just a tiny piece of a much larger animal.

I have learned that there are many ways to be poor. Poverty is personal and multifaceted. Being a dentist, I tend to think of poverty as I do pulpitis in a tooth. There is reversible and irreversible poverty. Sometimes it is chronic, sometimes acute.

We all know people who have been physically and financially devastated by disease or accident. We can see their disease and easily feel empathy for them.

I see quite a few young, healthy, hot-headed twentysomethings. Mostly men. They were working, living hand to mouth, perhaps did something stupid, lost their job and now have a toothache and no money. I hope most of them will mature out of poverty.

Anyone with children knows they are cash burners. Add a divorce and a few dicey life choices and poverty happens. I worry about young women with babies who float in and out of unstable relationships. Many have indentured themselves to at least 18 years of poverty. With methamphetamine addicts being almost 50 percent women, I see more men and grandparents raising children. Not everyone made plans for this.

Battered women may have money but no way to access it without risking their lives. Lack of stability will keep them out of the job market.

Newly released prisoners from Walla Walla get a bus ticket to the county where they offended, $40 and a new set of clothes. They are supposed to have a release plan, but I suspect there is no contingency for dentistry. The group that has impressed me the most is the absolutely HUGE population of people that have such horrible mental health problems that the rest of us simply would not tolerate working for any amount of time with them. Most of them are medicated with all kinds of psychotropic drugs, but I still would not like to spend the day with them. Because they can be unpleasant, in a wide and wild variety of ways and we cannot physically see their illness, it is not always easy to feel empathy for them. But we must. Until our mental health programs and medications improve, the vast majority of severe mental health patients will always need public funding—and that is just the way it is.

See MY VIEW, page five

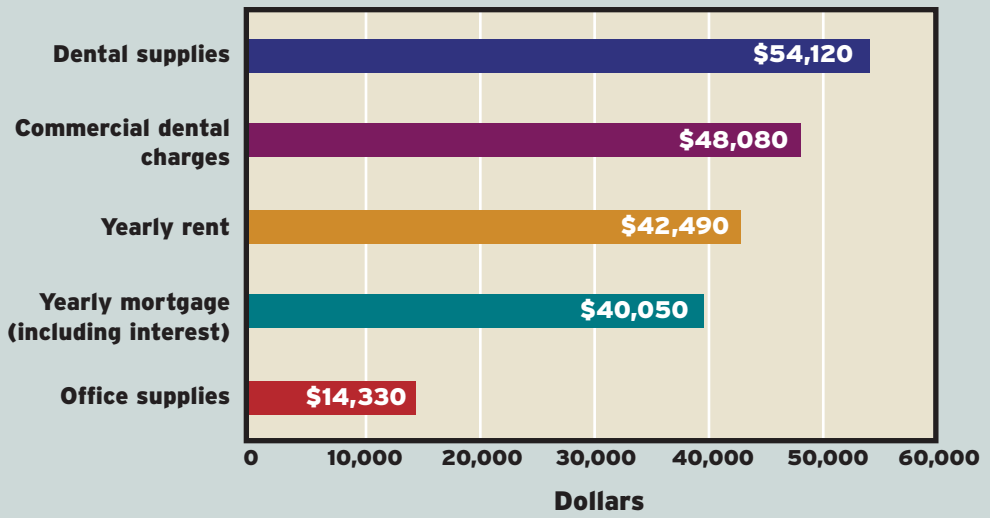
LettersPolicy

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

SNAPSHOTS OF AMERICAN DENTISTRY

Annual expenses

Independent dentists in 2008 spent more on dental supplies, an average of $54,120, than annual rent or mortgage.



Source: American Dental Association, Survey Center, *2009 Survey of Dental Practice.*

Letters

Apology

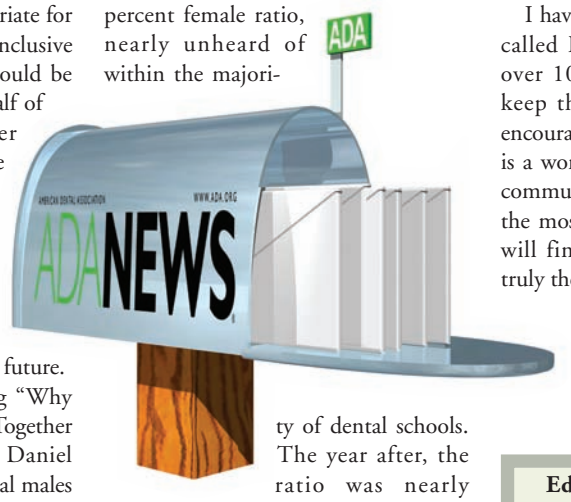
In response to Dr. Michael Lefkove's letter (Dec. 13 ADA News) asking if the ADA truly needed to apologize for its past racist ways, I would say, "yes."

Although the organization is moving on, I found the apology appropriate for the many, many years of noninclusive actions. My only suggestion would be for Dr. Raymond Gist, on behalf of the organization, to consider including an apology to the women that were blatantly kept from dentistry for many of the previous decades. The apology he did make is symbolic of growth and knowledge the organization has gained and is symbolic of its intentions in the future.

I would recommend reading "Why Are All the Black Kids Sitting Together in the Cafeteria?" by Beverly Daniel Tatum to help white heterosexual males understand discrimination and privilege they may have unknowingly had all of their lives. It enlightened me and may help shed light on why these apologies are so important.

And, to all of the pioneers in dentistry who endured the discrimination, inappropriate gestures, and subtle and not so subtle hurtful words … thank you. You have made my world as a female dentist much more enjoyable and much more attainable.

I would also like to thank the University of Michigan School of Dentistry for believing in underrepresented students and recognizing nothing will change unless we continue to think differently and act differently. It was my class of 1998 that amazed people with a 60 percent male to 40 percent female ratio, nearly unheard of within the majority of dental schools. The year after, the ratio was nearly 50:50—a more equal representation of college undergraduates.



The ADA is making a great start! Keep enlightening us! It will only make our profession stronger to have all voices heard and represented.

Lisa Knowles, D.D.S.
Charlotte, Mich.

Editor's note: The Diversity Committee of the ADA Board of Trustees will be considering issues related to diversity more broadly moving forward.

Lifeline

Dr. Larry Coffee's commentary on the Donated Dental Services organization is so true ("Celebrating 25 years of Donated Dental Services," Dec. 13 ADA News).

I have been a member of DDS (now called Dental Lifeline Network) for over 10 years. I applaud those who keep this work going. I would also encourage other dentists to volunteer. It is a wonderful way to give back to the community. These people are some of the most grateful and appreciative you will find anywhere. This program is truly the last option for so many.

My thanks to this organization. Keep up the good work!

Todd Chastain, D.M.D.
Killen, Ala.

Editor's note: Due to a high volume of letters received on workforce, they are grouped together here and continue on pages six and seven.

Hypocrisy?

A read of the recently released W. K. Kellogg Foundation report on a national "Dental Therapist Initiative" left me somewhat perplexed. Having

See LETTERS, page five

Letters

Continued from page four

finished the piece, I had the distinct impression that the Kellogg Foundation led by Sterling K. Speirn, CEO, envisions itself as the new-age champion in the fight against, as he calls it, "the silent epidemic" of the "deplorable state of oral health in America." I find the tenor of this report piously hypocritical.

While I realize the Foundation is separate from Kellogg Co., a long hard look in the mirror by Kellogg and its peer companies would reveal that these companies have spent the better part of the last 50 years and countless millions of dollars on slick advertising campaigns to seduce America's young mothers and children into consuming their high sugar content food products.

I quote from their own report, "As a result, millions of children and adults suffer unnecessarily, miss school or work and, in rare cases, face life-threatening infections from untreated dental decay." Consumption of their products (which 50-plus years of peer-reviewed unbiased research has proven causes dental caries) has caused countless people to suffer from this disease—a problem they helped to create in the first place.

The dental profession should not reverse its history of scientific progress and accomplishments and return to the trade status of yesteryear by allowing lesser-trained individuals to practice dentistry. Instead of trying to undermine the finest dental delivery model in the world by attempting to introduce an under-educated, lower-level provider to perform highly skilled and demanding irreversible surgical procedures that are best left in the hands of a Doctor of Dental Surgery or Doctor of Medical Dentistry, Kellogg could lead an altruistic effort by diverting some of the millions of dollars it is spending and partner with the ADA.

The preventively oriented Community Dental Health Coordinator that the ADA developed is an excellent beginning to address the need for expanded-function auxiliaries. The ADA, a long-acknowledged leader in the fields of education and prevention, working in concert with Kellogg and nonprofits like Community Catalyst, along with their dollars, could make a huge difference in the lives of the families and children with unmet dental needs.

Kellogg should lead the way by using some of its $16 million dollar campaign funds to begin serious research into developing nutritious sugar-free food products or at least label their box tops with a warning akin to the alcohol and tobacco industries' mandate. Something like "Cocoa Krispies Cause Cavities" would go a long way to mitigate the "silent crises" for which Kellogg and its peers, in large measure, are culpable.

Ron Collins, D.D.S.
Houston

Need evidence

In the Nov. 1 ADA News, you invited "open dialogue" with all ADA members ("Dr. Gist Invites 'Open Dialogue' with ADA Members, Leaders: New President Addresses House, Membership").

In that spirit, and aware that the ADA promotes the adoption of "evidenced-based dentistry," I ask the following question, which I have asked of numerous opponents of midlevel practitioners such as the dental therapist model promoted by the Kellogg Foundation and others, but have never received a coherent response focused on evidence.

I have seen the "over 50 years in numerous

See LETTERS, page six

MyView

Continued from page four

I see quite a few patients from other countries that are poor. They are mostly Mexican, Russians and Somalian patients. Some of them are on public assistance and some not. Many churches sponsor these emigres. I have no clear understanding of the politics behind this. They are here, low income, and need treatment.

Many Native American people live in abject poverty. Some do not. It doesn't matter. Their health care is not provided by welfare. It is part of an entitlement program based on treaty negotiations. These monies cannot and will not be voted away. We still need to recognize that this adds to our national dental debt.

In our current economy, we have the newly poor. People who were doing well but lost their jobs. The ones in reality shows from New Jersey should be ashamed of themselves. The rest will need help for a while.

This is just a tiny primer on poor. I don't have nearly enough space to cover the working poor, the developmentally disabled, senior citizens, hospice or other substance abusers—all who need support at different times and different levels.

I am so proud of my private practice friends. The vast majority of you have been racking your brains to help solve the access to care problem. A problem not of our making and one that all of the sudden we are charged with curing. God bless you for all your pro bono work. Don't stop! But realize that well-intentioned intermittent care is not historically sustainable and will not solve the access to care problem.

The U.S. Census Bureau says there are more than 43 million of us in poverty. What does that really mean in terms of national dental disease debt? Do we need to offer the reversible poor the same services as the irreversible poor? I don't know. Please consider this my little plea for our nation to determine who needs care, what level of care is indicated for various times of life and how we can best intervene to prevent and treat both poverty and oral disease. It is going to take more than just blind men and dentists to define this elephant.

Dr. Jennings is the editor of the WSDA News, the publication of the Washington State Dental Association. Her comments, reprinted here with permission, originally appeared in the October 2010 issue of that publication.

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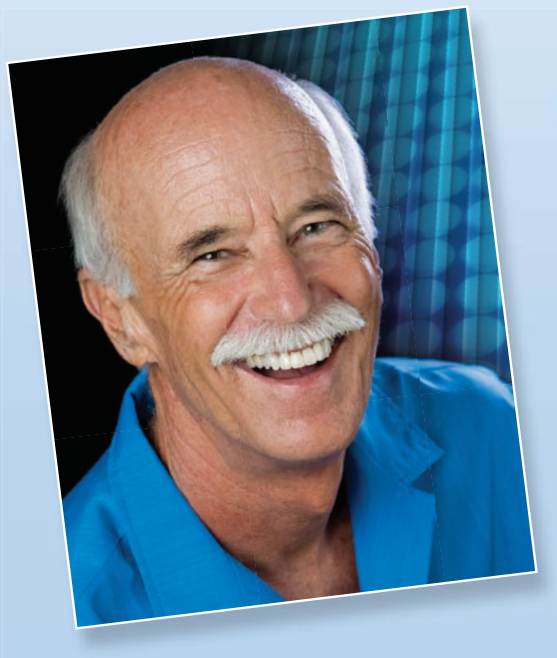

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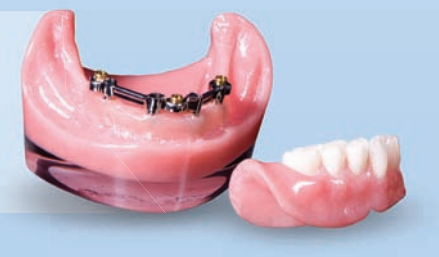

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Letters

Continued from page five

other countries" evidence in support of dental therapists, or at a minimum, in support of experimenting with this well-documented model. But I have never seen any evidence against use of dental therapists, except "feelings," "I know from my experience," or "here is the ADA model of the community health practitioner."

So, my question: Can you/anybody give me rational, documented evidence against the use of dental therapists? Can you, in a spirit of "open dialogue," also give me some evidence that supports the ADA fight against even reasonable experimentation with the model? Please, just some evidence—not lofty rhetoric.

Frank A. Catalanotto, D.M.D.
Professor and Chair
Department of Community Dentistry and Behavioral Science
University of Florida College of Dentistry
Gainesville, Fla.

Oral physicians

Dentists should take their heads out of the sand and recognize the inevitable. The public will ultimately succeed in obtaining more accessible and less costly dental care, and it will not be too long before they will not be able to distinguish between nondentist providers and the more medically- and surgically-qualified dentists. There is ample evidence from countries such as New Zealand[1], Canada[2] and the Forsyth experiment in the United States[3] that nondentists can and do provide quality oral health care.

Yet the negative arguments expressed recently in the "ADA Statement on the Kellogg Study of Alaska Dental Health Aide Therapist Program" are unconvincing and self-serving. For example, the statement that, "In many rural states for instance, residents are accustomed to driving hours to reach a shopping or entertainment destination and can be expected to travel similar distances to reach a dentist," ironically implies that dental care is a luxury rather than an essential health care service. Moreover, patients driving these long distances themselves who receive post-operative pain medications may be putting themselves and others at risk; or the converse, enduring suffering because of inadequate pain relief.

To avoid becoming irrelevant to overall health care[4], those among us who are willing and able to treat disorders of the orofacial area within the context of obtaining general health must reinforce our present roles and responsibilities as de facto oral physicians. By re-allocating oral health resources, dentists should be able to do what only they can do, thus leaving time to help alleviate the other major health care deficit: primary care. Thus, dentists should be able to provide preventive limited primary care in their offices; e.g., vital signs and screening for major diseases, certainly no less than is currently available in pharmacies and shopping malls.

Based on actual and projected changes in the health care system, now is the time to assert ourselves and assume the superordinate designation as oral physician in name and deed who will oversee all dental care, whether provided by dentists or nondentists, including physicians. Moreover, the term oral physician is a more accurate reflection of the actual and potential health care services which dentists can provide.

In summary, the ADA is leading us in the wrong direction. Dentists have to re-invent themselves as much as the other major paramedical health professions have done or are doing[5]; that is to say, pharmacists graduating as PharmDs, podiatrists as podiatric physicians, and chiropractors as chiropractic physicians, some of whom are receiving additional training as nurse practitioners to enable themselves to administer medication, perform physical exams, etc.

With impending health care reform, now is the time to act before the federal and state governments recognize the economic benefits now being enjoyed by dentists relative to increased access to care provided at lower cost and of comparable quality by nondental providers[2,6].

Let us take charge as oral physicians before it is too late.

Donald B. Giddon, D.M.D., Ph.D.
Clinical Professor
Harvard School of Dental Medicine
Brian J. Swann, D.D.S., M.P.H.
Clinical Instructor
Harvard School of Dental Medicine
Boston

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Lower standard?

The letter which Dr. Edwin Mehlman wrote in the Dec. 13 ADA News basically states that Pew and the Kellogg Foundation are going to force dental therapists on the American public whether dentists want them or not. Pew and Kellogg may find they face surprisingly uphill battle in offering the poor a much less trained alternative to a fully trained dentist.

Not only that, but they will have to convince state legislatures to accept a new, lower standard of care, provided by these not scientifically

trained tradesmen, not even trained as much as hygienists and certainly not to the level of the corresponding physician assistants in medicine.

I don't doubt that Dr. Mehlman, Pew and Kellogg believe they have that much power, but I think they are far from all powerful. Rich? Yes. Powerful? Yes. Able to make decisions for the American public? Don't bet on it.

Griffin T. Murphey, D.D.S.
Fort Worth, Texas

Other alternatives

I understand Dr. Edwin Mehlman's frustration with the House of Delegates' position on midlevel providers ("Letters," Dec. 13 ADA News). He certainly has had some experience with the House. It does seem to make a lot of sense to "go with the flow."

If all of these foundations believe this is the way to solve our barriers to care issue, why not join them and help shape the program? We can all agree that you can train a person to do many of the tasks that dentists perform. But, can you teach diagnostic judgment without first giving a person a comprehensive scientific background?

My concern is not how to do the procedure but when and why. I am glad that the patients in Alaska are happy with the care they received from the five Dental Health Aide Therapists. I think I would want more data and I would want independent evaluators before I advocated for a change in our system.

I believe that Pennsylvania has found the right course of action. We use the person with the diagnostic judgment and scientific background—the dentist—to do all surgical procedures, including preparing teeth for restorations. We have trained expanded function dental auxiliaries who then place restorative materials under the direct supervision of the dentist. We don't think you can adequately supervise auxiliaries from miles away.

Your natural question might be: have we solved the barriers to care problem? No, because our legislature has not seen fit to reimburse dentists for Medicaid patients beyond 30 percent of usual, customary and reasonable reimbursement levels. I don't see how DHATs would solve that problem. Perhaps Kellogg would want to fund the Medicaid program or at least advocate for states to adequately fund it.

Bernie Dishler, D.D.S.
Elkins Park, Pa.

Cereal connection?

It is interesting to see that a foundation affiliated with a company based on infusing tons of sugar into their cereals and marketing to children is currently promoting alternate deliveries of dental care ("Kellogg Moves Ahead on Dental Therapist Project," Dec. 13 ADA News).

Perhaps a feeling of guilt exudes from the Kellogg Foundation's Board of Directors for contributing to the decay of millions of teeth!

Charles Schumacher, D.D.S.
Farmington, N.M.

Political solutions

I have a vision of what could happen or might still happen. I see highly educated and trained dentists in their offices sitting alone with no patients to treat. At the same time a few blocks away at a national chain drugstore, I see 10 Dental Health Aide Therapists busy treating scores of dental patients in a beautiful, fully equipped office.

DHATs are high school graduates who have been trained at a technical school in New Zealand for two years to do surgery and operative dentistry. They have been treating patients in the state of Alaska since 2006. In other words, DHATs are nondentists that have never been trained by the rigors of professional school, trying to do exactly what dentists do.

State and national political forces, and millions of dollars from ill-informed (but well meaning) foundations have set the table for the destruction of our great profession.

The following are two recent examples.

The American Association of Public Health Dentistry states (Fall 2010 Communiqué of AAPHD) that its members should be proponents for midlevel provider programs. They have received three grants by the W. K. Kellogg and Macy foundations that will provide background work for the AAPHD to be a proponent for midlevel provider programs.

A New York Times article in November reported on a two-year study funded by the Kellogg Foundation. It found that Alaska's DHATs provided "safe, competent, appropriate care." However, the article neglected to mention the small amount of procedures that were observed (nine sealants, 15 composites, 13 amalgams and one stainless steel crown were directly observed). While this is hardly a long-term comprehensive study, it gives the false impression that DHATs are the solution to the access problem.

If states would adequately fund the Medicaid programs for those who do not have access, the problem would be solved at the provider level. In every state where the reimbursement rates rise to the 75-80 percent level, a large majority of dentists join these programs. There is absolutely no need for under-trained nonprofessionals to be involved. The poor have very complex dental and health problems; they should be treated by dentists.

The final outcome for dentistry's future will be a political solution. The workforce issue will not be decided on the strength of the monumental advances that our profession has achieved in the last 150 years. It will not be solved by taking perfect impressions or by placing great implants. Most of these issues will be decided in general assemblies at the state level. We must educate, support and fund candidates who are willing to listen and act to preserve the best system of dental care in the world.

Our dental forbearers worked long and hard to bring us to this point. We must never compromise our professional principles. We must be strong and steadfast so that our children and grandchildren will be treated with the same excellent standards of care that we have inherited.

Thomas P. Conaty, D.D.S.
Wilmington, Del.

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Government

FTC staff comments on Georgia dental board supervision terms

BY CRAIG PALMER

Washington—Federal Trade Commission staff urged the Georgia Board of Dentistry by letter to reject proposed amendments to board rules governing the supervision of dental hygienists.

"We are particularly concerned about the possible negative effects of the proposed amendments on vulnerable populations," said the staff comment ("www.ftc.gov/opa/2011/01/dentists.shtm") signed by the directors of FTC's bureaus of competition and economics and office of health planning and issued with the 5-0 approval of FTC's commissioners.

The Georgia dental board scheduled a hearing Jan. 7 in Macon, Ga., "to provide the public an opportunity to comment upon and provide input into the proposed rule amendments," according to the notice that drew FTC attention and response ("www,sos.ga.gov/plb/dentistry/proposed_amendments.htm"). The amendments were scheduled to be considered for adoption by the Georgia Board of Dentistry on Jan. 7.

"Dental hygiene duties performed at approved dental facilities of the Department of Community Health, county boards of health or the Department of Corrections shall be allowed under indirect supervision," the board proposal says in part. "Indirect supervision as it pertains to procedures delegated to a dental hygienist shall mean that the licensed dentist is not on the premises but has given either written or oral instructions for the treatment of the patient."

Dr. Clyde Andrews, who chairs the board's rules committee, said that "the controversy lies with the facilities mentioned above not having the dentist resources to provide the level of supervision required for these dental hygiene procedures. This change in the level of supervision may limit care provided to those who only receive dental care from (the) Department of Community Health, county boards of health, or the Department of Corrections facilities.

"The legal mandate and charge of the Georgia Board of Dentistry is to assure the protection of the health, safety and welfare of Georgia's dental patients," Dr. Andrews said.

"The legal mandate and charge of the Georgia Board of Dentistry is to assure the protection of the health, safety and welfare of Georgia's dental patients," Dr. Andrews said in a statement responding to an ADA News request for comment.

"The FTC staff is especially concerned that the proposed changes to the rule, which could be interpreted to restrict hygienists from performing services such as sealant and fluoride treatments at approved facilities unless a dentist had previously examined the patient and ordered the treatment, would harm the state's most vulnerable consumers," said a press release posted Jan. 5 at "www.ftc.gov".

"We urge the board to reject the proposed amendments," FTC staff said in the letter.

"Restricting dental hygienists from performing services that they currently perform without either direct or indirect supervision in covered public health settings will likely raise the cost of these services and ultimately result in fewer persons receiving them," the letter concluded. "The possible negative effect of these amendments on vulnerable populations is of particular concern."

Other dental board proposals relate to examination for dental licensure. ■

ADA logs key dental victories in lame duck session of Congress

BY KELLY SODERLUND

Washington—The lame duck session of Congress was a busy one for the American Dental Association, which emerged victorious on a number of issues.

The ADA's successful lobbying yielded the passage of bills that will create better tax benefits for business owners—including dentists—exempt dental practices from the Red Flags Rule and reauthorize the National School Lunch Program, an initiative the ADA has long supported.

"The Association is proud of the legislation we were involved with in this session and want members to know what their Washington office is doing on behalf of dentistry and the public," said ADA President Dr. Raymond Gist.

What follows is a summary provided by the ADA Washington office of key legislation:

• **Tax Relief, Unemployment Insurance Reauthorization and Job Creation Act of 2010:** This measure institutes a two-year extension of the Bush-era tax cuts, which were scheduled to expire at the end of 2010. It continues the current 50 percent bonus depreciation for investments in new business equipment through Dec. 31, 2012; extends the new markets tax credit designed to encourage investment in businesses in low-income communities through 2011; extends the student loan interest deduction with phaseout at $70,000 of income for an individual and $145,000 for a couple filing joint returns; and for taxable years beginning after Dec. 31, 2011, extends the 2007 increase in the maximum amount and phaseout threshold that states up to $125,000 can be deducted and the phaseout threshold is $500,000, indexed for inflation, allowing businesses to continue a more rapid depreciation of costs.

• **Red Flags:** The ADA fought independently and with a broad-based coalition to get the Red Flag Program Clarification Act of 2010 signed into law on Dec. 18. The law exempts dental practices from the Federal Trade Commission's Red Flags Rule, which requires financial institutions and creditors to develop a written plan to prevent and detect identity theft. The FTC has said that dentists and other health professionals are creditors subject to the regulation depending on their credit arrangement with patients, an interpretation the ADA challenged.

• **America COMPETES:** The reauthorization of this act scored two victories for the ADA. The law reauthorized the National Institute of Standards and Technology with a provision that allows the agency to continue its 80-year-old cooperative research and development agreement with the ADA Foundation's Paffenbarger Research Center. It also contains a provision that requires federal agencies to work more closely with publishers in developing policies on access to digital data and scholarly publications.

• **Child Nutrition reauthorization:** The ADA secured passage of the Health, Hunger-Free Kids Act of 2010, which reauthorized two major child nutrition programs the ADA has long supported, the National School Lunch Program and the Special Supplemental Nutrition Program for Women, Infants and Children. New provisions include enhancing breastfeeding education, improving the nutritional quality of school foods and providing nutrition education and obesity prevention services to people participating in the Supplemental Nutrition Assistance Program (formerly known as the Food Stamp Program).

• **Healthy People 2020:** Oral health was retained as a separate and distinct topic in the latest version of the Department of Health and Human Services' 10-year health promotion and disease prevention agenda. Oral health was also featured in several other highly visible topics including access to health services, cancer, diabetes, educational and community-based programs, older adults and tobacco use. ■

New Medicare filing deadline reminder issued

Baltimore—The U.S. Centers for Medicare & Medicaid Services has issued a reminder to fee-for-service physicians and dentists, providers and suppliers regarding a change to the deadline for submitting Medicare claims.

Because of new federal health reform legislation, all claims for services furnished on or after Jan. 1, 2010, must be filed with the appropriate Medicare contractor no later than one calendar year from the date of service or Medicare will deny them. Dentists who provide covered services to Medicare beneficiaries should review their claims submission procedures in light of the new deadlines.

For more information about the new deadlines for Medicare claims submissions, contact your Medicare contractor or review articles on the CMS website at "www.cms.gov/MLNMattersArticles/downloads/MM6960.pdf" and "www.cms.gov/MLNMattersArticles/downloads/MM7080.pdf". The CMS website has a podcast on this subject at "www.cms.gov/CMSFeeds/02_listofpodcasts.asp". ■

New Dentist Conference marks 25th year

BY KAREN FOX

The ADA 25th New Dentist Conference, which takes place June 16-18 at the Westin, Chicago River North, offers unique programming for new dentists—those out of dental school less than 10 years.

Conference registration opens Jan. 18. Those registering by April 21 will have a chance to win early bird registration incentives.

"What stands out about this conference, first and foremost, is the programming," said Dr. Rob Leland, chair of the New Dentist Committee. "From the keynote speakers down to the clinical and practice management CE, everything is geared toward new dentists. All topics are germane to people who are right out of dental school.

"I've been attending this conference for the last 10 years, with my first one coming right after dental school," said Dr. Leland. "One aspect that I've appreciated is making connections with other new dentists and talking about the challenges of this career stage. It's such an intimate environment that you have an opportunity to get to know people and talk to others who are often in the same boat as you professionally."

The efforts of the ADA New Dentist Committee have helped countless new dentists realize their personal and professional goals. This year, the committee reflects on its past and looks toward the future as it celebrates the 25th conference, "Sweet Home Chicago, Silver Anniversary."

In 1986, a group of visionaries sought ways to encourage leadership and continuing education opportunities for dentists just starting their careers. That was the year the ADA created the one-year Special Committee on Young Dentists, which subsequently became a standing committee of the ADA Board of Trustees: the ADA New Dentist Committee.

The committee's first chair was Dr. William Ten Pas, who in 1995 went on to become president of the ADA. The 1988 first meeting of the Commission on the Young Professional, as it was known at the time, was called to order by its chair Dr. Patsy Fujimoto. In 2009, Dr. Fujimoto served as president of the Hawaii Dental Association.

Dr. Leland: Appreciates "making connections with other new dentists and talking about the challenges of this career stage" at the New Dentist Conference.

Through a variety of conference activities and events, the New Dentist Committee continues to cultivate leadership. The first day of this year's conference (June 16) is a full day of leadership programming which includes keynote speakers and workshops on social media marketing, involvement in organized dentistry, communication and public speaking, and the annual New Dentist Network Idea Exchange and Hot Topics with ADA Leaders—an open discussion with ADA officers and members of the Board of Trustees.

Up to 15 hours of CE are available this year. The following programs take place June 17-18:

• Dr. William Carpenter—The Oral Cavity: Gateway to Health or Disease;

The ADA 25th New Dentist Conference

Sweet Home Chicago, Silver Anniversary
The Westin, Chicago River North
June 16-18, 2011

• Dr. Gregg Liberatore, Judy Jennings, Dr. Michael Unthank, Geri True, Jim Boltz—Preparing for Practice Ownership;

• Dr. Joseph Massad—Spice Up Your Practice with Dentures and Implants: A Great Way to Ease the Economical Tensions in Your Practice Today;

• Dr. David Ahearn—Going Green: It's Not Just for the Environment;

• Dr. Mark Murphy—The Art, Science and Business of Dentistry: Growth and Planning Strategies for the New Dentist;

• Dr. Harold Crossley—Street Drugs Exposed: What Your Patients Are Not Telling You.

Attendees may continue their education at the annual session Oct. 10-13 in Las Vegas with Dr. Crossley's course, A Potpourri of Practical Dental Pharmacology. The course is free to new dentists and is part of the New Dentist Track offered at annual session.

New Dentist Conference attendees will also have an opportunity to attend a private social event June 17 at the House of Blues Chicago.

For registration forms, go to "www.ada.org/newdentistconf". If you have questions about the conference, contact the New Dentist Committee at the ADA toll-free number, Ext. 2779, or "newdentist@ada.org". ■

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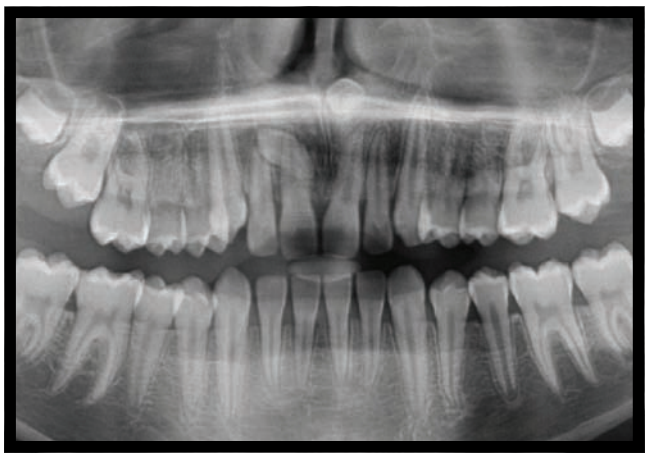

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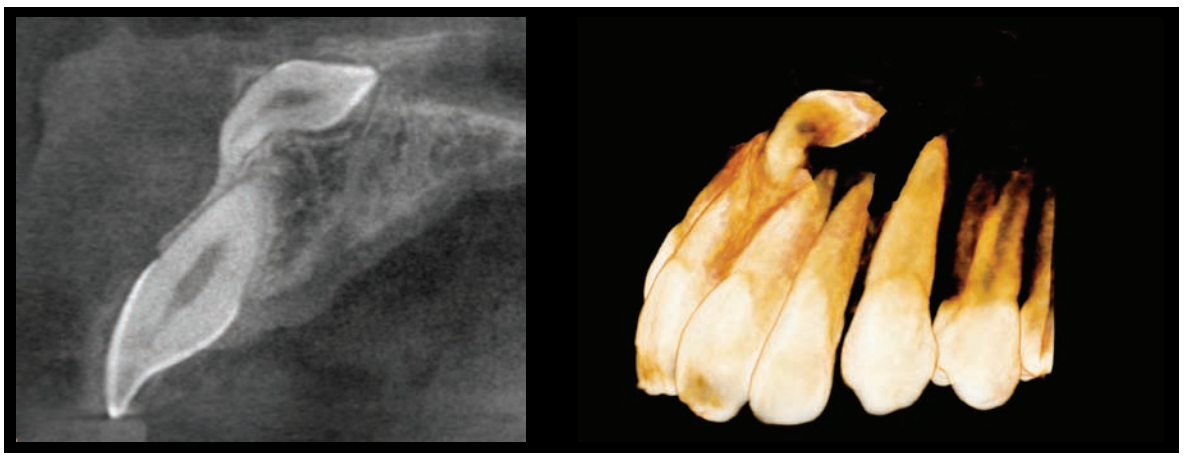

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Law

Align agrees to preliminary settlement

BY KELLY SODERLUND

San Francisco—Align Technology Inc. agreed to make nearly $8 million available and reinstate dentists as Invisalign providers as part of a settlement with doctors involved in a class action suit against the company.

The settlement was granted preliminary approval Dec. 23 by a California federal court. Letters notifying doctors in the class were mailed out last week, said Jason Hartley, attorney with Stueve Siegel Hanson LLP, the Kansas City law firm representing the class. Nearly 23,000 dentists and orthodontists nationally and internationally are represented in the class.

The lawsuit claimed Align, which manufactures and sells Invisalign, violated California public policy by requiring doctors to prescribe at least 10 new cases each year in order to maintain active status as an Invisalign prescriber. The lawsuit alleges Align was not concerned about patient welfare but about its own bottom line. It alleged that Align's practices were unfair and fraudulent.

The settlement agrees to reinstate doctors to prescribe Invisalign at no additional cost once they complete a free online recertification training course. Any doctor who, prior to approval of the settlement, paid the nearly $2,000 to retake Align's training courses after he or she was decertified will be mailed a check for $2,000, less court approved attorney's fees and costs.

Some doctors who do not wish to be reinstated may be eligible to receive a cash payment. The proposed court settlement includes a payment schedule for three different scenarios: dentists who had started at least one case after June 1, 2008, and had taken an Invisalign continuing education course in 2009; dentists who had started at least one case before June 1, 2008 and had taken an Invisalign CE course between June 1, 2008, and Jan. 1, 2009; and any dentist who had never started at least one case.

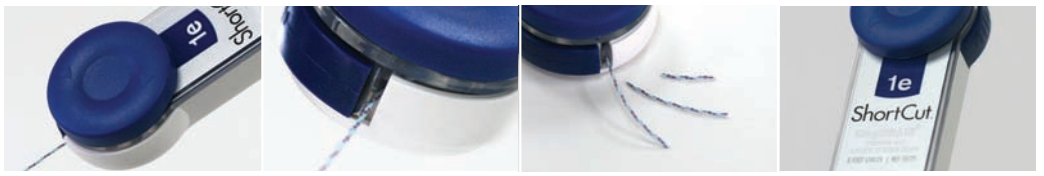
Eligible class members have until March 4 to submit a form either electing a cash payment or opt out of the settlement. The court has scheduled a final fairness hearing on April 8 for final approval of the settlement, Mr. Hartley said.

A website dedicated to the settlement has been established at "www.leiszlersettlement.com". Doctors can view the court documents and eligible class members can complete an online form electing their cash remedy.

Stueve Siegel Hanson also has a page on its website devoted to the lawsuit and settlement at "www.stuevesiegel.com/invisalign". Dentists who have questions or believe they were improperly excluded from the class can contact Stueve Siegel Hanson's dedicated Align settlement phone number at 1-888-816-1761. ■

—soderlundk@ada.org

Cool, yes.



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Registration open for 2011 ADEA annual session March 12-16

San Diego—The American Dental Education Association is holding the ADEA Annual Session and Exhibition here March 12-16.

The event's focus is one of the most important issues facing not only dental education but health care as a whole: interprofessionalism. Members of the health professions are encouraged to attend.

"Interdisciplinary education is the basis for the interprofessional health care teams that our graduates will be a part of in the future," said Sandra C. Andrieu, Ph.D., ADEA president. "By bringing together educators and students from across the nation, we can create mutual understanding and respect that will lead to a more integrated approach to health professions education and, ultimately, improved patient care."

Registration information is available at "www.adea.org". ■

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ADA says dental lab technician education misrepresented by Labor Department classification

BY KELLY SODERLUND

The American Dental Association, in a letter to the U.S. Department of Labor, offered its critique for the education and training classification system that defines occupational worker status, including dental laboratory technicians.

The ADA Council on Dental Practice responded via letter on Nov. 30, 2010, to a Federal Register's request for comment on the system. CDP supports the National Association of Dental Laboratories' position on the issue.

"The NADL is extremely appreciative to the quick action of the ADA's CDP to respond to the U.S. Department of Labor regarding the classification of dental laboratory technicians," said Bennett Napier, NADL executive director. "The ADA's support of dental laboratory technology in this effort underlines the true collaboration that is evident between dentistry and the laboratory profession."

CDP's comments focus on the clarity of the system of assigning education, previous work experience, state licensing and on-the-job training to each occupation. Their main concern is the misrepresentation of dental lab technician education, which currently describes the category as "some preparation needed." The ADA believes the proper classification would better be defined as "considerable preparation needed."

Currently, to be a DLT, an individual needs a high school diploma, although statistics from the profession show that DLTs hold and need formal education. The most recent National Board of Certification for Dental Laboratory Technology's survey findings showed that 29 percent of DLTs had some college training, 31 percent held at least a two-year degree in dental technology, 7 percent have other associate degrees, 14 percent have bachelor's degrees and 6 percent have a master's degree or higher.

"This current classification program diminishes the value of the DLT," said Dr. Bill D'Aiuto, chair of the CDP Subcommittee on the Future of Dental Laboratory Technology and council member. "We really are digging down deep because if we are without qualified dental laboratory technicians, a high percentage of dentists in this country will be without a formally trained component of our dental team that is irreplaceable."

The integration of computer-aided design and milling techniques and the use of digital imaging and the electronic transfer of such information between the dental operatory and dental lab may also require a higher level of skill and knowledge as it relates to record-keeping and patient privacy protocols. Dental labs are now hiring technicians with computer science and engineering backgrounds.

Dr. D'Aiuto

If the current classification remains, Dr. D'Aiuto is worried that dental laboratories will have a hard time recruiting people into the occupation. High school guidance counselors using occupational handbooks may not promote an "unskilled" profession even though it's a vital component in the health care arena.

Additionally, the number of Commission on Dental Accreditation accredited dental lab technology programs has decreased from 58 in the mid 1980s to 20 today. It may become more difficult for program directors to advocate to their deans to maintain funding for an "unskilled" profession.

"I'm extremely concerned about the retention of the remaining 20 laboratory schools let alone increasing the amount of dental lab tech preparatory schools, which is our goal," Dr. D'Aiuto said.

Some labs are eligible to apply for workforce training grants with state economic development incentives because of their Food and Drug Administration classification as a medical device manufacturer. An "unskilled" label may also affect this process.

"The comment letter the ADA provided was incredibly supportive of dental technicians in recognizing and advocating for the advanced level of skill, training and education," said Elizabeth Curran, assistant professor and director of laboratory services at A.T. Still University, Arizona School of Dentistry and Oral Health, certified dental technician and owner of Ahwatukee Dental Laboratory in Tempe, Ariz. "The impact of the downgraded occupational status is staggering and will continue to be harmful to the profession if left unchanged. High school career counselors don't recommend 'unskilled labor' career choices to students and won't recommend dental technology because of the unskilled status downgrade. That downgraded occupational status will harm dental technology educational programs. It is difficult to fund DLT programs now let alone develop new programs to educate students for a career that is now classified as an unskilled occupation." ■

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Practice changes on the horizon?

Small Business Jobs and Credit Act of 2010 offers opportunities for eligible customers

ADA members who are considering a practice expansion, purchase or acquisition and require a small business loan should take note of the many changes that are taking place due to new federal legislation.

President Obama recently signed the Small Business Jobs and Credit Act of 2010, which contains provisions that enhance the U.S. Small Business Administration loan programs. Wells Fargo, the nation's largest SBA 7(a) lender (in dollars), is positioned to meet customers' lending needs through its Practice Finance group, the only practice lender endorsed by ADA Business Resources.

WELLS FARGO

The following new SBA program provisions are currently in effect, according to Wells Fargo:

• Increased maximum loan amounts on core SBA products—The new maximum SBA 7(a) and 504 limits have increased from $2 million to $5 million. For manufacturers and certain energy-related projects seeking 504 loans, the new maximum is up to $5.5 million. Wells Fargo offers these larger loan amounts on transactions that include commercial real estate.

• Expanded SBA eligibility business size standards—The act establishes new size standards for both 7(a) and 504 SBA-backed loans. Businesses that have a tangible net worth of no more than $15 million and a two-year average net income of $5 million after federal income tax are now eligible to participate. More businesses can qualify for SBA financing than ever before.

• Temporary increase in maximum loan amounts for SBA Express—The new maximum for SBA Express loans has been temporarily increased from $350,000 to $1 million until Sept. 27. The SBA Express program has a 50 percent SBA guarantee and is primarily used for working capital needs.

ADA members can discuss SBA financing solutions for owner-occupied commercial real estate, business acquisition, equipment and business expansion loans with Wells Fargo Practice Finance representatives at 1-888-937-2321, or visit "www.wellsfargo.com/dentist". ■

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ADEA names 2011 Gies Foundation award winners

Washington—The philanthropic arm of the American Dental Education Association announced the winners of the 2011 William J. Gies Awards last month.

Named for education pioneer William J. Gies, Ph.D., the ADEAGies Foundation awards honor individuals and organizations exemplifying dedication to the highest standards of vision, innovation and achievement in dental education, research and leadership.

The Gies Awards will be presented March 14 in conjunction with the 2011 ADEA Annual Session and Exhibition (March 12-16, Manchester Grand Hyatt, San Diego).

The 2011 honorees were selected by a distinguished panel of judges from the ADEA-Gies Foundation Board of Trustees. Winners are:

• American College of Dentists—Gies Award for Achievement-Public or Private Partner;

• California Dental Association—Vision-Private or Public Partner;

• Center for Women's Health at Trover Health Systems—Innovation-Private Partner;

• Dr. Caswell A. Evans Jr.—Achievement-Dental Educator;

• Dr. Michelle M. Henshaw—Innovation-Dental Educator;

• Dr. J. Bernard Machen—Vision-Dental Educator;

• Dr. Diarmuid B. Shanley— Achievement-Dental Educator;

• Tufts University School of Dental Medicine—Achievement-Academic Dental Institution;

• University of the Pacific Arthur A. Dugoni School of Dentistry—Vision-Academic Dental Institution.

Registration information about the ADEA annual session is at "www.adea.org". Tickets for the Gies Award celebration are available through Trish Smith at 1-703-506-3272. ■

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A decade of smiles in Nebraska

Children's dental program marks 10th anniversary on GKAS Day

Lincoln, Neb.—A children's charity dental care program will celebrate its 10th anniversary in conjunction with Give Kids A Smile Day Feb. 4 at the University of Nebraska Medical Center College of Dentistry.

UNMC's Children's Dental Day, launched in 2001, has provided more than $2 million in care to 4,375 children and now serves as a full dental clinic that provides sealants, extractions, restorations, pulpectomies on primary teeth, root canals, crowns, cleanings and dental health education. On Feb. 4, its 19th clinic will be held at the dental school in Lincoln and on May 20-21, a clinic will serve communities in Nebraska's western panhandle.

"Many children who are dental day patients have no other access to care," said Dr. John Reinhardt, dental school dean. "It's estimated that 25 percent of the children in Nebraska experience 80 percent of the dental disease reported in the state."

But many of the children in need were too far from Lincoln to participate in the clinic, so in 2002 the program expanded to include a spring clinic in the panhandle, about 500 miles from Lincoln.

"For many of the children, we are their dentist and this is their annual checkup," said David Brown, Ph.D., executive associate dean. ■

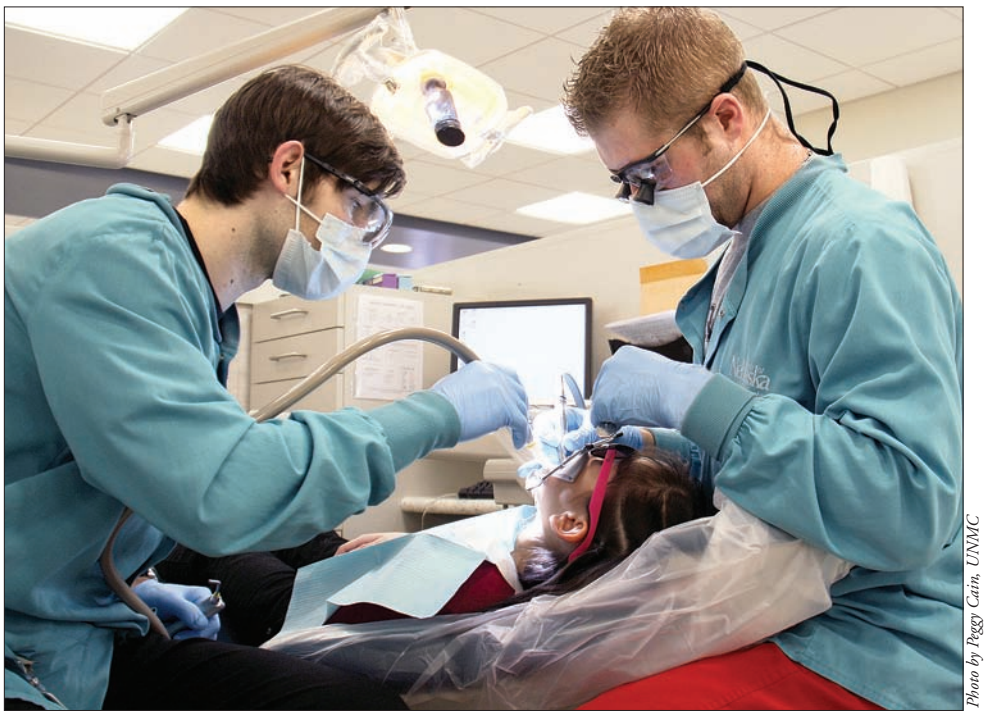

Photo by Peggy Cain, UNMC

Cleaning: UNMC dental students Jack Huebner, left, class of 2012, and Michael Eickman, class of 2011, volunteer at the 2010 Dental Day clinic in Lincoln.

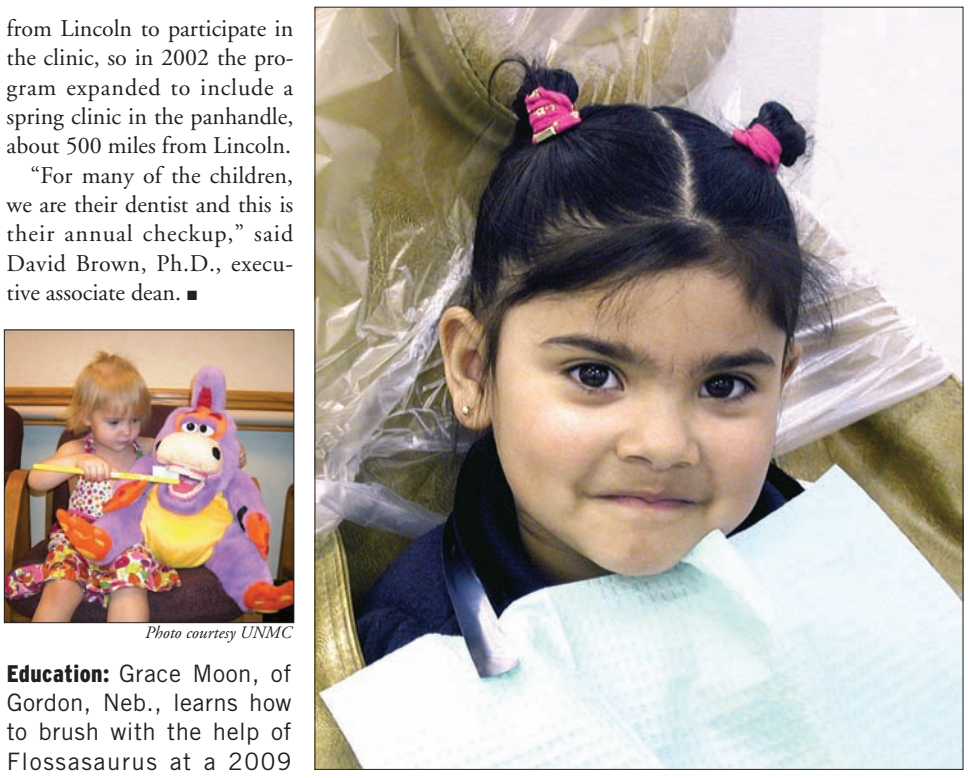

Photo by Peggy Cain, UNMC

Smiles: A young patient shares a smile at the 2001 inaugural UNMC Children's Dental Day clinic in Lincoln.

Photo courtesy UNMC

Education: Grace Moon, of Gordon, Neb., learns how to brush with the help of Flossasaurus at a 2009 UNMC Dental Day program.

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BRIEFS

Continued from page one

kits containing gloves, masks, patient bibs, dental floss, prophy paste and fluoride products. Colgate-Palmolive Co. donated toothbrushes and tubes of toothpaste. DEXIS Digital X-ray Systems donated use of their X-ray units and the expertise of their staff to U.S. dental schools requesting help during GKAS.

Each year on the first Friday in February, thousands of dentists and their dental team members provide free oral health care services to children from low-income families across the country. (While the first Friday of February is the recommended event date, GKAS programs can be successfully conducted during any month of the year.)

The ADA News welcomes digital photo submissions from GKAS program participants—including candid pictures of children, dentists and team members interacting and clinical photos (patients in the chair, dental team in gloves, masks and protective eyewear).

Be sure to include identification of those pictured and facts about your event.Send high-resolution photos for consideration for use in the ADA News and on ADA News Today (on ADA.org) to "adanews@ada.org" as soon as possible following your event. ■

Resource kits available for NCDHM celebrations

February is National Children's Dental Health Month and a great time to teach kids healthy habits.

This year's NCDHM themes are "A Healthy Smile? It's Easy to Find! Remember to Brush & Floss Everyday!" and "A Healthy Smile Looks Good Up Close." To celebrate, the ADA Catalog is featuring two specially-priced NCDHM resource kits:

The Dudley DVD Kit 2011 (W745) includes a Dudley Goes to Camp Brush and Floss DVD and teaching guide, a two-sided NCDHM poster (one side for teens, one side for children) with matching plastic supply bags, plus packs of Sealant Quick Reference Cards and Dudley Visits the Dentist Coloring Books.

The Healthy Friends NCDHM Kit 2011 (W744) comes with a Ready, Set, Brush! Book with Elmo and a two-sided NCDHM poster, plus packs of matching plastic supply bags, Snack and Sip All Day brochures and Dental Fun Books.

Other popular ADA materials for parents and young patients include:

- Dental Fun Books (W430) (a personalized version is available, DAC007);
- Your Child's Teeth (W177), Spanish (W230);
- Happiness is a Healthy Smile: A Message for Parents (W290), Spanish (W206);
- Seal Out Decay, a mini-brochure (W191).

From now until Feb. 28, use priority code 11152 to receive a 15 percent discount on all patient education and personalized products with a purchase of more than $75.

For more information visit "www.adacatalog.org" or call 1-800-947-4746. Please note that personalized products cannot be shipped outside the contiguous U.S. 48 states. ■

Helping children: The Dental Society of Greater Orlando raised $20,000 for the pediatric craniomaxillofacial surgery department at Arnold Palmer Hospital for Children. Pictured from left are Ashley Comstock, DSGO; Dr. Ramon Ruiz, medical director, pediatric oral and maxillofacial surgery at Arnold Palmer Hospital for Children; Dr. Pete Lemieux, DSGO president; and Wes Bishop, Arnold Palmer Medical Center Foundation. The charity event was held Dec. 10, 2010, at the Winter Park Farmers' Market.

MOM fundraiser: The Alliance of the Georgia Dental Association held a silent auction Nov. 13, 2010, at the home of Dr. Kent and Mary Percy (past presidents of the Georgia Dental Association and the Alliance to the GDA) to benefit the state's first Mission of Mercy Project. The MOM event is set for August 11-13 in Woodstock, Ga. The fundraising committee, pictured from left, includes Jean Harrington, president-elect; Fran Brown; Debbie Torbush; Pam Pafford, event co-chair; Helaine Sugarman, vice president and event co-chair; Mary Percy; Molly Bickford, president; Dawn Hutchinson; Cindy Jernigan; and Janelle Kauffman. The dental association expects some 900 volunteers, including dentists, dental hygienists, dental assistants, lab technicians, Alliance members and lay volunteers from statewide to donate their time and skills to provide $1 million in charitable care to some 2,000 patients.

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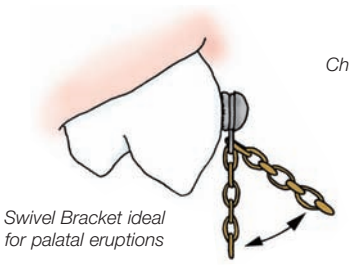
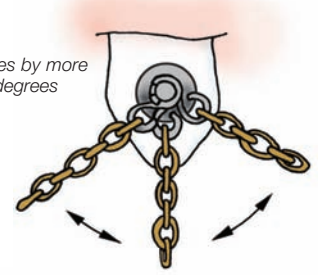

Swivel Bracket ideal for palatal eruptions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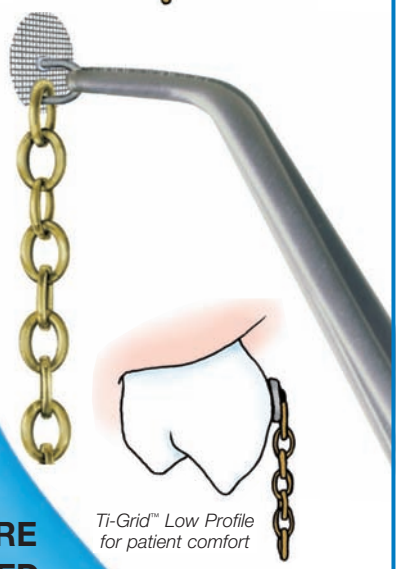
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ADA House defines noncovered services

BY KELLY SODERLUND

Orlando, Fla.—The House of Delegates passed a resolution that provides definitions for covered and noncovered services as a means of providing clear guidance for the ADA to pursue state and federal legislation prohibiting insurance companies from controlling what dentists may charge for services the insurers don't cover.

Resolution 79H-2010 defines "covered service" as any service for which reimbursement is actually provided on a given claim. A "noncovered service" is defined as any service for which the third party provides no reimbursement.

"The ADA refined its definition of noncovered services to aid in explaining these issues to the public and legislators when lobbying for legislative relief from these restrictive practices," said Dr. Christopher Smiley, chair of the Council on Dental Benefit Programs, which proposed the resolution. "The ADA needs to seek relief through legislation because federal and state laws prevent dentists from working collectively to resolve these issues with the carriers."

Sixteen states passed laws during the 2010 legislative session prohibiting insurance companies from controlling what a dentist may charge for services that an insurance plan doesn't cover: Alaska, Arizona, California, Idaho, Iowa, Kansas, Louisiana, Mississippi, Nebraska, North Carolina, Oklahoma, Oregon, Rhode Island South Dakota, Virginia and Washington.

The resolution is the first time the American Dental Association has provided specific definitions for covered and noncovered services. Res. 79H-2010 also reaffirms a previous directive for the ADA to pursue the passage of federal legislation to prohibit federally regulated plans from applying such provisions and to encourage state dental societies to pass state legislation that does the same.

It also stresses the ADA's opposition to any third party contract provisions that establish fee limits for noncovered services. ■

—soderlundk@ada.org

Panel: From left, Dr. David S. Samuels, Dr. Joseph Crowley and Dr. Rob Roda listen during the reference committee hearing where the noncovered services resolution was discussed.

Photo by EZ Event Photography

Fact sheet, resource guide on sealants now available

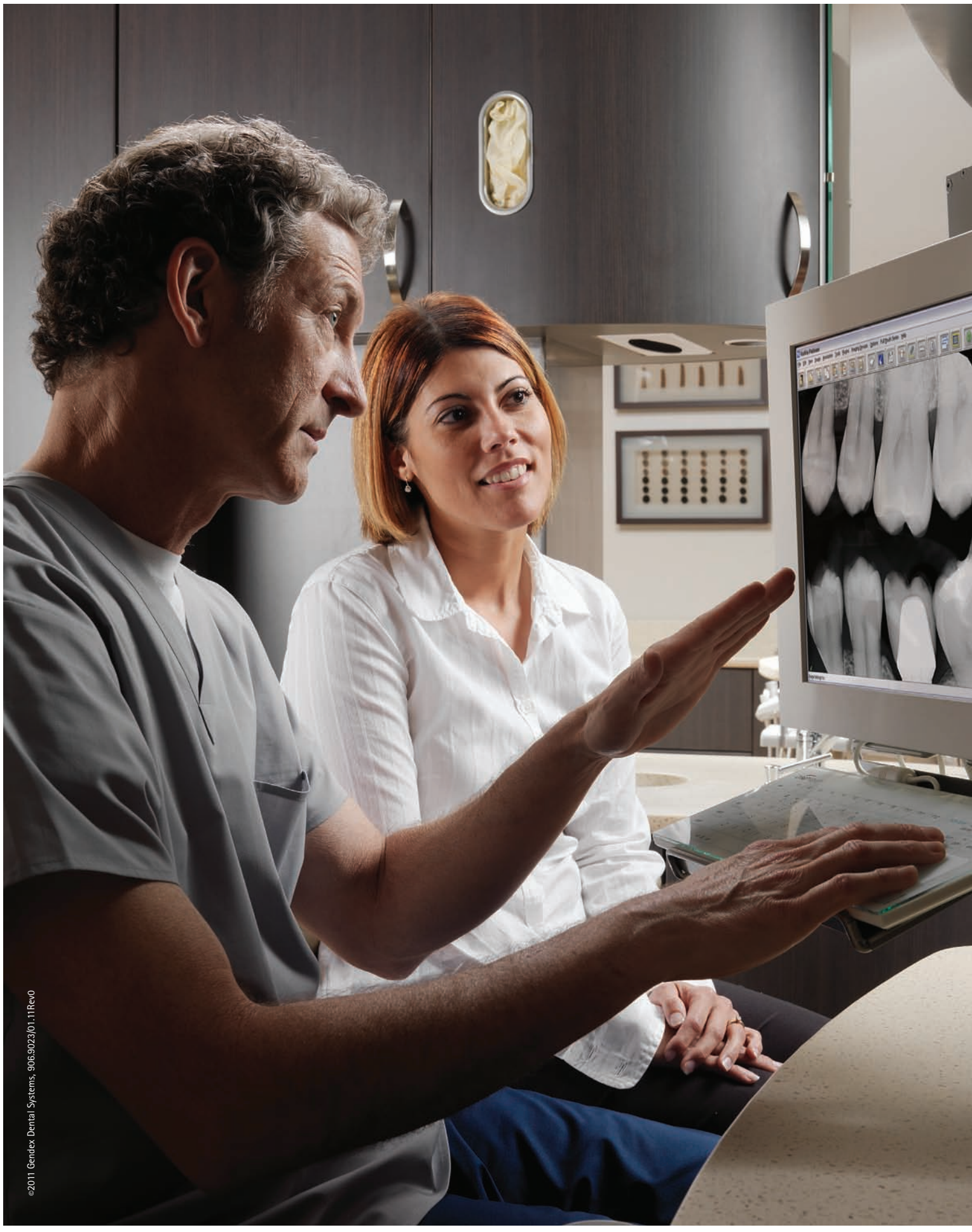
Washington—Two new resources on dental sealants are available from the National Maternal and Child Oral Health Resource Center.

Dental Sealants: A Resource Guide, 3rd Edition, provides information about the use and application of dental sealants. The guide includes an annotated list of journal articles, materials and organizations. Download a PDF version at "www.mchoralhealth.org/PDFs/DentalSealantGuide.pdf".

Preventing Tooth Decay and Saving Teeth with Dental Sealants is a four-page fact sheet with information about dental sealants and their use, effectiveness, service delivery, disparities, public awareness and programs. A PDF version is available at "www.mchoralhealth.org/PDFs/OHDentSealantFactsheet.pdf".

Single or multiple print copies of both resources are available at no charge. Order online at "www.mchoralhealth.org/publications.html". Allow two weeks for order processing.

These resources were produced with support from the Maternal and Child Health Bureau, Health Resources Services Administration and U.S. Department of Health and Human Services. ■



Dental consultant policy amended; fees defined during ADA House meeting

AnnualSession

BY KELLY SODERLUND

Orlando, Fla.—The House of Delegates amended policy on dental consultants and the definitions for usual and customary fees, approving two resolutions forwarded from the Council on Dental Benefit Programs.

• Resolution 5H-2010, Statement on Dental Consultants, strengthens the recommendations regarding qualifications of dental consultants who review claims in the United States. Under the amended policy, dentists must be licensed in the U.S., preferably within the jurisdiction of the dentist treating the patient, in accordance with applicable state law and competent with regard to current clinical procedures and practice.

• Res. 8H-2010, Definitions of "Usual" and "Customary" Fees, instructs the American Dental Association to communicate the definitions to insurance regulators, consumer advocacy groups and dental benefits administrators to encourage the proper use of the terms. The resolution defines "usual fee" as the fee that an individual dentist most frequently charges for a specific dental procedure independent of any contractual agreement. It's always appropriate to modify the fee based on the nature and severity of the condition being treated and by any medical or dental complications or unusual circumstances, according to the resolution.

The resolution states the use of the terms "customary" or "UCR" to justify denial of a claim or communicate with patients or dental benefit plan purchasers is inappropriate because of the arbitrary and prejudicial manner in which it can be designated. ■

—soderlundk@ada.org

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Delegates form well-being task force at session

BY KELLY SODERLUND

Orlando, Fla.—Four members of the Council on Dental Practice will serve on a well-being task force being formed at the direction of the House of Delegates to consider addiction issues and develop a national well-being action plan.

Resolution 110H-2010, which the House of Delegates adopted in October, directs CDP, through its Well-Being Advisory Committee, to develop strategies to communicate the value and importance of confidential treatment and monitoring for dental team members suffering from addiction.

CDP nominated Drs. H. Lee Gardner Jr., Christopher Larsen, Roger Newman and Judee Tippett-Whyte to the new task force at its November meeting and will begin searching for four additional members from constituent committees in well-being. The resolution directs the council to submit a report and action plan with recommendations to the 2011 House of Delegates.

The action plan should include promoting the availability of intervention programs in all constituent jurisdictions; developing materials and protocols to support state and constituent-sponsored programs; building connections with the broader medical community; advocacy communication with national and state policy decision-makers; communicating the availability of services within the profession; and an ongoing evaluation of the action plan, according to the resolution. ■

Government

Tax law

Continued from page one

at 10, 15, 25, 28, 33 and 35 percent: without action by Congress, marginal income tax rates would have reverted to pre-2001 levels of 15, 28, 31, 36 and 39.6 percent. This action is clearly helpful to dentists and many other individual taxpayers by leaving revenue earned in the hands of taxpayers to a greater extent than would otherwise be the case.

B. Extension of the 0 to 15 percent tax rate on capital gains and qualified dividends: without this action, rates would revert to 20 and 39.6 percent respectively. Depending on the ownership form of the dental practice and the retirement savings strategy, it may be possible and sensible to take a part of compensation in the form of a dividend. The 15 percent rate will likely be lower than the marginal tax rate.

Dr. Leone: "The law reunifies the estate tax and the gift tax creating a single graduated rate schedule."

C. Continued repeal of the Personal Exemption Phaseout and itemized deduction limitation: without this action, individuals with income over $83,400 and couples with income over $166,800 filing a joint return would see a reduction in their personal exemption ($3,650). Itemized deductions other than for medical expenses and theft loss would have been reduced by up to 80 percent when income earned is exceeding the phaseout thresholds. This may be a significant issue for taxpayers who plan to make substantial gifts or donations in 2011 or 2012.

D. The law reunifies the estate tax and the gift tax creating a single graduated rate schedule (and a single exemption for gifts during life and/or at death). The estate tax exemption is $5 million per individual with an estate tax rate of 35 percent for assets exceeding the exemption. The new law also allows a surviving spouse to utilize the unused portion of the deceased spouse's estate tax exclusion amount, providing the surviving spouse with a larger exemption from the estate tax. This will ease the estate tax burden on the transfer upon death of business interests, real estate and other assets to the decedent's heirs. The exemption amount is indexed to inflation. It will be interesting to see what happens with the estate and gift tax after 2012. The history of adjustments and changes in this tax area is long and complicated.

E. A 100 percent first-year depreciation allowance for property acquired and placed in service after Sept. 8, 2010 and before Jan. 1, 2012 is permitted. A 50 percent first-year depreciation is permitted for property placed in service after Dec. 31, 2011 and before Jan. 1, 2013. There is also an extension to December of 2012 of the election to accelerate the AMT credit instead of claiming additional first-year depreciation. Get your accountant's help on these issues.

F. IRC Section 179 allows the expensing of investment in machinery and equipment at a phaseout of $500,000/$2,000,000 for 2010 and 2011. The new law sets phaseout at $125,000/$500,000 for tax years after 2011. The opportunity for dentists to make capital investments in equipment for their practices and expense them instead of submitting to a depreciation schedule is still available but at a reduced level. A dentist engaged in an investment that may fall under Section 179 should work closely with an accountant to maximize the benefit potential.

• Temporary modifications will occur as follows:

A. An alternative minimum tax fix for 2011 is instituted by raising exemption amounts to $47,450 for individuals and $72,450 for couples filing a joint return. Congress addresses this issue annually lest many more Americans be subject to the AMT. Your accountant calculates your regular tax burden then separately calculates your AMT under a different set of IRS rules. You pay the higher of the two.

B. The law provides for a 2 percent payroll tax holiday for 2011 on the employee's Social Security tax rate. This will put $2,136 in the pockets of those who earn the $106,800 maximum income on which the tax is levied for 2011, $1,000 for those earning $50,000 and $500 for those earning $25,000. The lost revenue to the Social Security trust fund will be made up from the general fund. This means a tax increase in the future or the borrowing or printing of money to cover the cost eventually. It is expected that the money in the hands of individuals as a result of this tax reduction will stimulate spending and consumption. The employer share of Social Security tax paid on employee wages up to $106,800 will continue to be 6.2 percent.

The law provides for a 2 percent payroll tax holiday for 2011 on the employee's Social Security tax rate. ... The lost revenue to the Social Security trust fund will be made up from the general fund.

There are a variety of other tax incentives that are included as continuing in the Tax Relief Act. A selected few follow:

• Tax-free distributions of up to $100,000 from individual retirement plans for charitable purposes under certain conditions;

• Expanded Coverdell Accounts for education savings;

• Student loan interest deduction with phaseout at $70,000 of income for an individual and $145,000 for a couple filing joint returns;

• 15-year straight-line cost recovery for qualified leasehold improvements. ■

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Photocopiers may store data: FTC

Your copier may have a hard drive that stores data about documents, which could be used for fraud and identity theft if it falls into the wrong hands.

The Federal Trade Commission has issued a guide for businesses on how to protect sensitive data stored on the hard drives of digital copiers.

The FTC's new publication, "Copier Data Security: A Guide for Businesses," provides a number of suggestions for business owners. Among them:

• Include your copier in your information security policies.

• When buying or leasing a copier, evaluate your options for securing the data on its hard drive. Consider how you will dispose of the data that accumulates as the copier is used.

• Take advantage of all of the copier's security features.

• Securely overwrite the entire hard drive at least once a month.

• Before returning or disposing of a copier, check with the manufacturer, dealer or serving company for options to secure the hard drive. If the hard drive must be removed, it's generally advisable to work with a skilled technician, rather than attempting to remove it on your own.

To read more about the publication, or to download a copy of it, visit "http://business.ftc.gov/documents/bus43-copier-data-security". ■

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New technical standards available

The ADA has published two new technical reports and three revised specifications.

ADA Technical Report No. 1057 for Guidelines for Imaging Systems and Interoperability in Today's Dental Practice discusses the issues involving interoperability that arise when digital radiography and photography are integrated into a dental practice. This report highlights the features of the Digital Imaging and Communications in Medicine standard that facilitate resolution of these issues.

ADA Technical Report No. 1059 for Guidelines for the Application of the DICOM Standard to Radiographic Cephalometric Data provides imaging equipment vendors with a standardized means of storing cephalograms, along with their clinically relevant data, in an interoperable manner.

Revised ANSI/ADA Specification No. 1000 for Standard Clinical Data Architecture presents the logical data model structure, modeling method, metadata and nomenclature comprising the electronic health record.

Revised ANSI/ADA Specification No. 1047 for Standard Content of an Electronic Periodontal Attachment provides uniform content requirements for documentation to be included in a periodontal attachment.

Revised ISO/ANSI/ADA Specification No. 3950 for Designation System for Teeth and Areas of the Oral Cavity provides a standardized system for designating teeth and areas of the oral cavity.

ADA specifications and technical reports assist ADA members in choosing safe and effective materials, instruments, equipment and information systems and are available for download, purchase or print from the ADA Catalog at "www.adacatalog.org"; phone, 1-800-947-4746. International callers may dial 1-312-440-2500.

Copies of draft technical reports are available via the ADA toll-free number, Ext. 2506, or e-mail: "standards@ada.org". ■

Standards Committee seeks volunteers, comments

The ADA Standards Committee on Dental Products is seeking volunteers for two new work projects.

Proposed ANSI/ADA Technical Report No.142 Dental Implant CAD/CAM Surgical Guides will provide information that may lead to performance standards for dental implant CAD/CAM surgical guides. The SCDP hopes that through the standardization of the accuracy and precision of dental implant CAD/CAM Surgical Guides, patient safety and efficacious treatment will be enhanced.

Proposed ANSI/ADA Technical Report No. 143 for CAD/CAM Bonding Cements will provide information that may lead to performance standards for bonding materials for dental computer-aided design and computer-aided manufacturing.

The SCDP has also approved for circulation for review and comment Proposed Addendum to ANSI/ADA 108-2009 Amalgam Separators. This addendum will help testing labs clarify an inconsistency in the wording of the testing and provide guidance in a test procedure for minimum flow rate so that more accurate and consistent results will be obtained.

Copies of the draft addendum are available by calling the ADA toll-free number, Ext. 2506, or e-mailing "standards@ada.org". For more information or to volunteer to work on the new projects, contact Kathy Medic at the ADA toll-free number, Ext. 2533, or by e-mail at "medick@ada.org". ■

ADA/Kellogg

Learn business management from the experts

Applications are available for this year's ADA/Kellogg Executive Management Program. The three-week intensive business education program at Northwestern University's Kellogg School of Management is designed for dentists interested in the core principles of an MBA program. The program dates for 2011 are Sept. 15-20, Nov. 10-15 and Dec. 1-6.

Attendance is limited to facilitate smaller class sizes, which enable dentists to share ideas and practical applications of business principles with other dentists.

Previous ADAKEMP graduates say they have been able to apply what they learned throughout all parts of their professional life, for example in growing and managing their dental practices, leadership pursuits and other business ventures. Dentists in the program have come from diverse backgrounds with varied interests in practice, management of business interests outside practice, and leadership in nonprofit or government organizations, and share a common interest in expanding business and management expertise. More than 87 percent of those completing the program called it a valuable financial investment.

All classes are taught at Northwestern University's Chicago campus near the ADA Headquarters.

The application deadline is July 1. Information about the program and applications are available at "www.ada.org/3774.aspx". ■

Hispanic Dental Association celebrates 20th year

ADA, NDA, SAID receive Presidential Awards

BY KAREN FOX

The ADA was one of three associations receiving the Hispanic Dental Association's Presidential Award in 2010 during the HDA's annual meeting in Chicago.

ADA President Raymond F. Gist accepted the Association's award from Dr. Victor Rodriguez, 2010 HDA president, for "contributions to the improvement of oral health in majority and minority communities." The National Dental Association and Society of American Indian Dentists also received HDA Presidential Awards.

"The growth of the Hispanic patient demographics and increased communication among colleague associations focusing on underserved minorities has created a heretofore strength in the dental professional community," said Dr. C. Yolanda Bonta, HDA executive director.

The HDA's 18th meeting drew members, students, supporters, exhibitors and corporate sponsors. HDA celebrated its 20th anniversary in 2010.

In keeping with milestones celebrated, HDA presented Ian Cook, president and CEO of Colgate-Palmolive, with the organization's Lifetime Achievement Award, celebrating the partnership between HDA and Colgate-Palmolive, the HDA's founding sponsor.

The annual meeting began with a symposium, Improving Oral Health Matters, Oral Health Disparities, and Oral Health Access for Hispanics, and ended with a Gala and Award Dinner, which included recognition of the winner of the Scientific Abstract Competition, Alejandra Valencia of the University of Iowa; HDA student chapter winners in the Orgullo Competition (1st place, University of Iowa College of Dentistry; 2nd place, University of Maryland Dental School; and 3rd place, University of Connecticut School of Dental Medicine); and two additional Presidential Award winners (Dr. Aidee Nieto-Herman, Tufts University, and Dr. Elena Rios, National Hispanic Health Foundation).

For more information on the Hispanic Dental Association, visit "www.hdassoc.org". ■

Distinction: ADA President Raymond F. Gist accepts an HDA Presidential Award from Dr. Victor Rodriguez, 2010 HDA president, on Oct. 28 in Chicago.

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ADANEWS 11/10

Fluoride

Continued from page one

drinking water under current regulations.

"Today's announcement is part of our ongoing support of appropriate fluoridation for community water systems and its effectiveness in preventing tooth decay throughout one's lifetime," HHS Assistant Secretary for Health Howard Koh, M.D., said in a statement posted at "www.hhs.gov".

These are science-based decisions, Dr. Koh told Association volunteer leaders and senior staff in a briefing before the public announcement.

"We view this as a continued affirmation of fluoridation as a public health advance, and we view this as a way of updating recommendations based on the best available science provided in this case by the EPA and other top scientists in the federal family," the HHS health official said.

"So we want to continue to send a message that fluoridation is critical for oral health. It is a major public health achievement, and community water fluoridation should proceed according to the best science possible, and that's going to be our message."

The proposal to recalibrate the ratio of fluoride to drinking water to a specific point at the lower end of the current recommended range is based on an increase in dental fluorosis over the last 20 years, said Dr. William G. Kohn, director of the division of oral health at the HHS Centers for Disease Control and Prevention.

"This is not about safety within a narrow range at all," said Dr. Kohn. "In this whole documentation you see that. Even at our current range, we don't feel that there is a safety issue here. It's just that based on the current science we don't need a range anymore." More information is available at "www.cdc.gov/fluoridation".

The federal government is not recommending that communities stop adding fluoride to drinking water, the ADA told state and local dental leaders: "Rather, it has recalibrated its recommendation for what it considers an effective level of fluoride to reduce the incidence of tooth decay while minimizing the rate of fluorosis in the general population, which has been slowly increasing." ■

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Experts eye early childhood caries

ECC symposium participants see hope for reducing disease burden in American Indian, Alaska Native children

BY STACIE CROZIER

Rapid City, S.D.—Receiving both a close-up look at the microbiology of early childhood caries and a panoramic view of its effects on affected communities, some 50 researchers, clinicians, tribal health and dental public health representatives gathered in the City of Presidents Oct. 20-22, 2010, for the second Symposium on Early Childhood Caries in American Indian and Alaska Native Children.

Meeting in Rapid City's historic downtown, where life-sized bronze statues of the United States' chief executives grace the street corners and local events, shops and galleries feature traditional Sioux and Lakota art, craftwork and culture, stakeholders with a variety of viewpoints came together for the conference with a long-range goal "to eliminate the burden of disease from severe caries among American Indian and Alaska Native children."

The symposium was co-hosted by the ADA and its Council on Access, Prevention and Interprofessional Relations and the American Academy of Pediatrics. Oral Health America co-sponsored the meeting with support from the DentaQuest Foundation.

The meeting featured two full days of scientific presentations, workgroup activities and goal setting, followed by an optional field trip for participants that wound through the Badlands to meet with a variety of American Indian health and education officials on Pine Ridge Indian Reservation, about 70 miles from Rapid City.

Participants evaluated the latest research in the epidemiology and microbiology of ECC; a variety of traditional and newly developing interventions, cultural and anthropological influences and barriers and more to determine how best to work collaboratively in the future to reduce or eliminate the disease in population groups that have a disproportionately higher risk.

L.D. "Dee" Robertson, M.D., a retired pediatrician who spent 20 years working at an Indian Health Service clinic, served as a conference coordinator. Though little progress has been made in alleviating disease burden in AI/AN children over the past three decades, he said the symposium gave him renewed hope and energy for future success.

"From the information presented by researchers and tribal and public health representatives, we are acknowledging that the situation is obviously far more complex than we'd thought in the past, and more effective products and strategies may be available in the near future," said Dr. Robertson. "What we need now is exactly what we have lacked for the last 30 years—a sustained commitment to first understand all the factors in development of very severe early childhood caries and second to develop and implement more effective interventions than are currently available."

According to statistics presented at the symposium, ECC prevalence is about 400 percent higher in AI/AN children than for all U.S. races. In addition, ECC is often much more aggressive and destructive in AI/AN children. In some communities, up to 50 percent of the children have such severe caries that they require full mouth restoration under general anesthesia—a rate about 50-100 times that in all other U.S. races. Severe ECC often leads to a lifetime of oral health problems.

Participant Dr. David R. Drake, a microbiologist and professor at the University of Iowa College of Dentistry and Dows Institute for Dental Research, has dedicated his career to learning more about the transmission of early childhood caries in this population group. He was the first investigator to establish a formal research contract from a National Institutes of Health grant directly with an American Indian tribe (Oglala Sioux). "When I became aware of the magnitude of this horrible disease in such young children, and after all of the things we have done over the years to deal with it with only very limited success, I realized that we needed to see if there were things about this disease that were different than other forms of caries," said Dr. Drake. "I am committed to working toward understanding the microbiological components of this devastating and unbelievably rapid disease in American Indian children. I am indeed passionate about this."

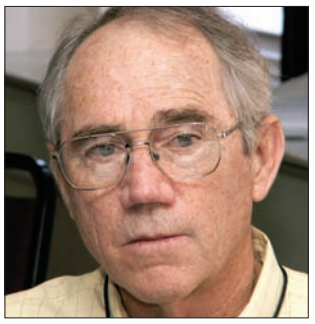
Also participating in the symposium was Dr. Robert Schroth of the University of Manitoba Faculty of Dentistry, whose research is investigating whether prenatal and environmental factors predispose Aboriginal Canadian children to early childhood caries.

"It is interesting that the life challenges faced by families on either side of the border are similar and undoubtedly contribute to their children's poor oral health," said Dr. Schroth. "Many live in poverty, have limited access to running water in the home, face food security issues and have limited access to early preventive dental care. Researchers and the dental profession, in both the U.S. and Canada,

Crazy Horse Memorial: The world's largest sculpture-in-progress is just minutes away from Rapid City, where experts gathered for the second Symposium on Early Childhood Caries in AI/AN Children.

Ideas sharing: Sara Jumping Eagle, M.D., from the AAP's Committee on Native American Child Health, and Dr. Joel Berg, University of Washington School of Dentistry, compare notes during a workgroup discussion.

Dr. Schroth



Dr. Robertson

Dr. Hebl

Workgroup discussion: Dr. Rosamund Harrison, University of British Columbia Division of Pediatric Dentistry, and Dr. David R. Drake, University of Iowa College of Dentistry, discuss microbiology issues at the symposium.

should partner with communities to develop, implement and evaluate culturally appropriate prevention strategies. We can share and learn from our own experiences in our respective countries."

Sara Jumping Eagle, M.D., a representative of the AAP's Committee on Native American Child Health, said her organization was excited to co-host an event to address the oral health disparities facing AI/AN children and adolescents.

"The AAP wants to be part of national and community-based efforts to solve the enormous problem of poor oral health among American Indian/Alaska Native children," said Dr. Jumping Eagle. "Not only has poor oral health been shown to contribute to worsening health in general, it also affects quality of life and self-esteem. High rates of early childhood caries are an additional stressor to the community members and health care providers that are already working hard to address the many health disparities American Indian/Alaska Native people face."

Dr. Jumping Eagle said she was impressed by the dedication of scientists and health care providers to creating new technology and medicines to address poor oral health and looks forward to the next steps in working to solve the problem of early childhood caries.

"As pediatricians and dentists, we have to reach out to American Indian/Alaska Native communities in new ways that help us to be accessible and trusted members of the communities we serve and work to increase the number of American Indian and Alaska Native dentists and oral health care providers," Dr. Jumping Eagle said.

Helping AI/AN families, she added, will include addressing not only the physical aspects of oral health, such as brushing and flossing and applying fluoride or other varnishes, but also addressing the community and family's view of oral health, teaching others to be health educators, working to improve child and family nutrition and empowering community members to develop culturally relevant community-based programs to more fully address these significant oral health disparities.

Dr. Robert J. Weyant, professor and chair for the Department of Dental Public Health and Information Management at the University of Pittsburgh School of Dental Medicine, said the conference was not only interesting but also relevant to him personally as he is currently conducting a five-year study to examine oral health disparities in rural Appalachia.

"Our research right now looks at pregnant women and follows them through their child's birth and first two years to see how early childhood caries affects them," Dr. Weyant said. "It seems like it's similar between the population groups in that it is defined by living in environmental adversity."

The highlight of the symposium for Dr. Monica Hebl, a Milwaukee general dentist and CAPIR member, was the visit to Pine Ridge Reservation.

"The generosity of the people we met on the Pine Ridge Reservation was inspiring. Knowing how much they appreciated our hard work made our efforts even more worthwhile," said Dr. Hebl.

She said she also appreciated meeting symposium participants, leaders in their fields who came to help alleviate suffering caused by ECC. "The severity of early childhood caries in these kids created a sense of urgency among the attendees. I am proud to be a part of the ADA efforts to gather the best and brightest minds from so many different groups together with the long-range goal to form a research agenda. The conference fostered enthusiasm and collaboration between the groups and individuals that are interested in trying to help these children. Hopefully we can build on the enthusiasm and collaboration generated at the conference so we can begin to translate the efforts into an improved quality of life for the kids."

A report detailing the scientific presentations of the symposium and results of the workgroup collaborations will be available on ADA.org later this year. ■

—croziers@ada.org

Dental clinic touches hearts

Special Olympics Special Smiles, MOM team up at Nebraska event

BY STACIE CROZIER

Lincoln, Neb.—Nebraska Dental Association members brought their best game to the 2010 Special Olympics U.S.A. National Games in Lincoln last July and demonstrated how a Mission of Mercy dental care clinic can make an amazing difference for patients with special needs.

NDA volunteers—many who had participated in five state MOM events since 2005—took the national Special Olympics Special Smiles screening and education program to a new level, not only offering oral health screening and dental education to nearly 1,000 athletes with intellectual disabilities, but providing more than 1,600 dental procedures on-site to 416 athletes in need of care during a weeklong dental clinic. The clinic provided nearly $105,000 in free dental services.

Heading up the treatment clinic at downtown Lincoln's historic Pershing Center was past NDA president Dr. James Jenkins. Volunteer dentists, dental students from both University of Nebraska Medical Center College of Dentistry and Creighton University School of Dentistry, hygienists, assistants and hygiene and assisting students manned about 30 dental operatory stations on the Pershing Center stage to provide treatment and pain relief for athletes with dental problems.

"I loved volunteering on the stage where I had seen Lynyrd Skynyrd and Charlie Daniels perform in the past," said Dr. Jenkins, assistant professor, Department of Adult Restorative Dentistry, University of Nebraska Medical Center College of Dentistry and practicing dentist at the dental school clinic. "Even Elvis played that stage. Lincoln was really jazzed to host the national event and our dental professionals were ready to volunteer. It was really a team effort."

Photos courtesy of Special Olympics Healthy Athletes

Education: A Special Olympics athlete practices brushing techniques on a stuffed animal dental aid. Education such as the proper way to brush is a critical part of the Special Smiles mission.

Volunteers worked from 2-8 p.m. July19-22, 2010 and from 10 a.m.-2 p.m. July 23, 2010 providing extractions, cleanings, restorations, fluoride treatments, sealants and more. "We were busy all the time," Dr. Jenkins said. "Frankly, I was surprised at the amount of need in this group. A lot of them had lost adult Medicaid dental coverage in their home states. A lot of them have jobs that don't offer dental coverage. I've had experience treating patients with special needs in my practice and in a hospital setting, but it was exciting to see our volunteers learn that it's wonderful taking care of patients with special needs. Their concerns just melted away. There were lots of hugs."

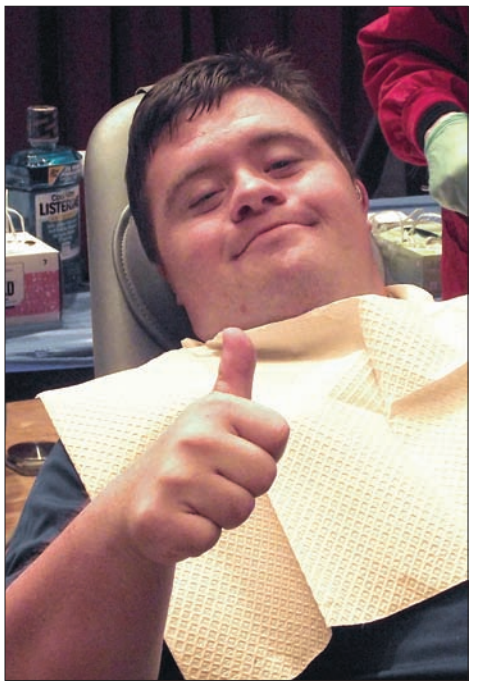
Dr. Jenkins said the NDA also set up a critical care clinic at the dental school in case athletes needed injury care or treatment for problems too serious for the temporary clinic to address.

"We did have a few major cases that went to UNMC, and when the volunteers there didn't have patients, they headed to the Pershing Center clinic to help out. It worked out really well."

Other important components to the clinic included dental education for athletes, coaches and caregivers and counseling on how each patient could establish a dental home after the national event.

"Our priority was to take care of immediate pain issues and counsel patients on how they could get follow-up care," Dr. Jenkins said. "Everyone—volunteers and athletes—had a wonderful time. It was cool to meet Tim Shriver (Special Olympics chairman and CEO) and Steve Perlman (senior global clinical advisor and founder, Special Olympics Special Smiles). They were extremely cordial and very appreciative. I was honored to be a part of something that helped so many people."

Bruce Bergstrom, CEO of America's Dentists Care Foundation, the organization that conducts Missions of Mercy events, said his organization was honoring a request by NDA members to help with the SO clinic.



Smiles: A Special Olympics athlete gives two thumbs up after receiving free dental care that the Special Smiles/Mission of Mercy clinic in Lincoln, Neb.

"We currently hold annual events in 15 states, including Nebraska, and continue to grow," said Mr. Bergstrom. "Our events are generally about 100 chairs, so this one was small for us. Dr. Jenkins planned it, and we provided him with the equipment he requested. I think our staff went to the event with some preconceived notions about these patients that were very wrong. Once we saw how many challenges these athletes overcome and yet they still find ways to excel, we were so inspired. I assumed because of their medical needs they would have access to terrific dental care, but that was not the case."

One athlete told Mr. Bergstrom that he had stopped brushing his teeth because his gums started bleeding when he brushed. "He thought he was doing something wrong, so he just

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Aliso Viejo, CA March 26
Miami, FL March 26

Care: A Special Olympics volunteer provides dental care for an athlete in the Special Smiles/Mission of Mercy clinic in July.

stopped brushing. It brought tears to my eyes."

Mr. Bergstrom described the Lincoln dental clinic as "one-quarter the size and quadruple the emotion" of a typical MOM event.

"It had a different feel. We got together with the Special Olympics people, and I thought, we've got a marriage here. It's going to be a great relationship going forward. They've worked hard to bring screening to these people, but in our world screening isn't a verb; treating is. We are definitely going to be involved with Special Olympics going forward. It's an amazing organization that serves people who really need our help."

"It was a fabulous, fabulous event," said SOSS's Dr. Steven P. Perlman, who is also a professor of pediatric dentistry at Boston University School of Dental Medicine. "The Nebraska Dental Association, the University of Nebraska and Creighton dental schools, dental hygienists and hygiene students, and dental assistants and assisting students all came together for this. NDA brought its experience as a MOM group and insisted on doing this. It was amazing."

Of the 977 athletes screened in Lincoln, more than 21 percent had untreated caries; almost 40 percent had periodontal disease; 28 percent had missing teeth; and more than 11 percent had oral pain.

"Sometimes we wonder how these athletes can even compete with the pain and problems they present when they come to a Special Olympics event," said Dr. Perlman, who is also a pediatric dentist with a large Medicaid patient population in Lynn, Mass. "The Special Olympics people were so moved because dental volunteers actually delivered care to people with serious needs. We have some 3.5 million athletes worldwide now. And this clinic gave hope to families whose lives were forever changed when their child was born with special needs. Special Olympics is not only about sports, it's about changing people's lives."

For more information on SOSS, including a training manual, handbook and many additional oral health resources for athletes, caregivers and oral health professionals, log on to "www.specialolympics.org/healthy_athletes_resources.aspx".

For more information on America's Dentists Care Foundation and upcoming Missions of Mercy events, visit "www.adcfmom.org". ■

—croziers@ada.org

UW dental school creates fact sheets on treating special needs children

Seattle—The University of Washington School of Dentistry has created a free online resource to support dentists as they treat children with mild to moderate special needs.

The series of fact sheets covering 14 special needs conditions is designed to help dental and medical professionals, parents and caregivers better understand these conditions and their effects on oral health.

"We recognize that most dentists are already treating many patients with special needs, such as diabetes, asthma and anxiety," said Kimberly Hanson Huggins, a department of oral medicine affiliate instructor and clinical research manager who directed the compilation of the materials. "However, we also believe that with this information, many more private practice dentists are fully capable of delivering care to patients at the more moderate end of the special needs spectrum, and we hope to broaden these patients' access to care by providing these materials."

Conditions include: ADD/ADHD; anxiety/depression; asthma and allergies; autism spectrum disorders; cerebral palsy; cleft lip/palate; congenital cardiac disorders; diabetes; Down syndrome; eating disorders; epilepsy; hearing impairment; HIV; and traumatic brain injury.

Fact sheets and guidance on special needs conditions are available at "www.dental.washington.edu/departments/omed/decod/special_needs_facts.php".

For more than 30 years, the UW School of Dentistry's nationally recognized Dental Education in Care of Persons with Disabilities program has trained dental providers and allowed thousands of special needs patients to receive oral health care. ■

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Haiti dentists still devastated by 2010 earthquake

Donors can help colleagues rebuild through ADA/HVO Adopt-a-Practice

BY STACIE CROZIER

Although a year has passed since a catastrophic earthquake devastated Haiti, many Port-au-Prince dentists are still struggling to rebuild their offices and serve their patients.

The ADA and Health Volunteers Overseas continue to raise funds to help Haitian dentists rebuild.

Through Adopt-a-Practice: Rebuilding Dental Offices in Haiti, the two organizations have a goal to raise $350,000 to rebuild or re-equip about 35 dental practices—nearly a third of the city's dental offices—that were damaged or destroyed by the earthquake in January 2010.

"After a slow start, the joint ADA/HVO Adopt-a-Practice project is reaching its cruising altitude," said Dr. Samuel Prophete, Haiti Dental Association president. "This project will allow selected Haitian dentists to plan their future as professionals with hope and serenity as well as allow the patients to receive the quality oral care they need from their trusted caregivers."

"On Jan. 12, 2010, a regular day at our clinic, Dr. Louise Marie Fene and I would not imagine that our world would be torn apart in just a few seconds," said Dr. Vadna Georges. "The 7.0 magnitude earthquake hit us very hard."

Dr. Fene was with a patient when he felt the building collapsing around them. They managed to escape through a window to find chaos in the streets. "I don't know how we survived," he said. "It was a miracle."

Dr. Georges' Hope Dental Clinic collapsed in the earthquake, leaving a pile of dental equipment and debris.

For weeks following the earthquake, patients came to them with dental emergencies, but the dentists didn't have a building to practice in and patients were leery of entering any buildings in the city, as many were structurally damaged and dangerous to enter. "It was a very difficult situation," said Dr. Georges.

By February 2010, they were able to begin to offer limited services to patients thanks to colleagues who shared space in their undamaged offices with dentists who lost their offices in the earthquake.

Disaster: Many buildings in Port-au-Prince were reduced to rubble in the earthquake, including some three dozen dental offices.

Dr. Fene

Dr. Georges

"We would be forever grateful to the ADA and HVO for their help through Adopt-a-Practice," they said. "This will allow us to stay in our country and to do what we've been doing for the past 10 years—provide basic oral services to our patients. Thanks for giving us hope that in the near future we will be able to start practicing again."

ADA members are encouraged to help their Haitian colleagues by donating to the Adopt-a-Practice fund. Donors can visit the International Activities page on ADA.org ("www.ada.org/goto/international") for information and a link to the HVO website. HVO will also accept donations by phone at 1-202-296-0928 and by mail to Health Volunteers Overseas, 1900 L Street, NW #310, Washington, D.C. 20036. Donation checks must be made out to Health Volunteers Overseas, and the memo line should read: ADA/HVO Haiti.

The ADA can also help dental societies, specialty organizations and other groups who want to conduct a fundraising campaign for Adopt-a-Practice with a variety of support materials. More information about fundraising materials is available from the ADA Department of Marketing and Brand Management. Call toll-free, Ext. 2802, or e-mail "eitels@ada.org". ■

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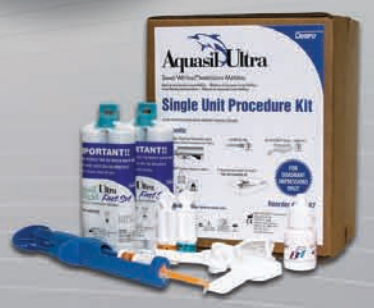

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