6-18-2012

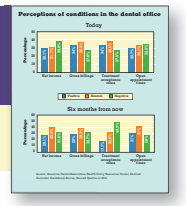
ADA News - 06/18/2012

American Dental Association, Publishing Division

Dental Student Research Conference 02
ADAF Paffenbarger Research Center hosts

Annual Session 12
Educating dentists and hygienists

Revamped survey 17
ADA releases new economic confidence figures



AMERICAN DENTAL ASSOCIATION WWW.ADA.ORG

ADA News

JUNE 18, 2012 VOLUME 43 NO.12

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BRIEFS

ADA CE Online course offers guidance for general dentists

Finding the canals in any specific tooth is the most important step in a root canal procedure.

"This is the base of the pyramid on which the success of this procedure rests," said Dr. Peter Zahi Tawil, author of a new ADA CE Online course, Advanced Endodontic Access: The Quest for the Extra Canal.

In his course, Dr. Tawil clarifies the steps necessary to finding all the canals in a tooth. The key, he said, lies in the ability to read and understand the internal anatomy and the map that each tooth provides.

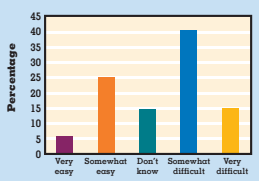
Dr. Tawil's course encompasses the landmarks inside a tooth, the internal anatomy, and the shape and color that guide dentists in finding the canals. From mesio-buccal canal 2 in the upper molars to the middle mesial canal in the lower, the course clarifies the steps

See CE ONLINE, Page 12

JUST THE FACTS

Perception

Among dentists who had not attempted to sell their practice in 2010, more estimated it would be difficult than easy if they were to try to do so.



Source: ADA Health Policy Resources Center, survey@ada.org, Ext. 2568

Oral health legislation introduced in Congress; ADA lauds effort

BY CRAIG PALMER

Washington—Sen. Bernie Sanders, I-Vt., and Rep. Elijah Cummings, D-Md., June 7 announced what they called "the most sweeping legislation ever to address the national crisis in dental care" at a Capitol Hill news conference.

Standing with several representatives of the 37 organizations listed as supporters of The Comprehensive Dental Reform Act of 2012, Sen. Sanders said, "We are breaking new ground. The struggle is not going to be easy."

INSIDE ADA pens letter of support to Sen. Sanders, Page 6

Asked about his plans for moving the legislation, S. 3272 in the Senate, and whether he would work with the American Dental Association, he replied, "We will work with anybody and everybody interested in making improvements. I'm pleased to see the statement the ADA recently made. I think they understand. It's not going to be passed tomorrow, but we're going to get support and this legislation will be passed."

The ADA is not listed as a supporting organization. The Association asked for clarification of some provisions, offered recommendations on others and said it could not support the bill's mid-level provider proposals and certain other provisions. ADA officials cited "many provisions in your bill that we enthusiastically support" and offered to work with the senator in crafting the legislation.

"We hope that our few areas of disagreement do not obscure our welcoming Sen. Sanders to this fight. His bill aims high, and that has long been needed," said Dr. William R. Calnon, ADA president. "We fully support his intent to help extend good oral health to all Americans and we applaud his leveraging his influence as a United States senator in pursuit of that goal."

Rep. Cummings offered a House

See LEGISLATION, Page 7

CAC given more responsibility

BY KELLY SODERLUND

"Do the right thing," said Mark Twain. "It will gratify some people and astonish the rest."

This is a concept the Council on Dental Benefit Programs takes seriously, enough so to create a Code Advisory Committee that's collegial, cooperative and a fair representation of all who are involved in adding, changing or deleting items from the CDT Code. Thanks to the care CDBP has taken to oversee the CAC, it's a maintenance process that's stronger and more responsive to the needs of dentists and the dental community.

Overseeing the Code maintenance process is just one way CDBP puts members first.

"The work of your American Dental Association, just in the area of Dental Benefit Programs, should alone make your ADA dues seem like a great value," said Dr. Jim Richeson, CDBP chair. "When you take into account the work of all the ADA councils, the return on your dues becomes a tremendous value."

Under the ADA Bylaws, CDBP has responsibility for CDT Code maintenance, as well as obligations under the Health Insurance

See CODE, Page 11

MouthHealthy.org launches June 25

BY KAREN FOX

Consumers may have a limited understanding of oral health care, but they possess a strong desire to find a dentist.

Those were the key findings the ADA captured in a consumer survey related to the launch of MouthHealthy.org, the new consumer website. Designed to gauge awareness of oral health care and oral hygiene, the survey found that when it comes to knowledge of their oral health, consumers' average score was only 60 percent correct—meaning

Americans scored a "D."

But help is on the way. The ADA unveils MouthHealthy.org June 25.

MouthHealthy.org is designed to provide patients with timely and credible oral health information on prevention, care and treatment in a highly engaging user experience.

ADA Find-a-Dentist, which is moving from ADA.org to MouthHealthy.org, provides access to information about members and their practices, including a photo that dentists can upload to the site. ADA Find-a-Dentist will appear on nearly every page of MouthHealthy.org.

See WEBSITE, Page 19

ADA Foundation and dental students confab on dynamics of research

BY JEAN WILLIAMS

Gaithersburgh, Md.—The ADA Foundation Paffenbarger Research Center hosted 41 dental students at PRC and at the National Institutes of Health April 15-17 for the 48th Annual Dental Student Research Conference.

Students are still reflecting on the value of the experience in their growth into dental clinicians.

Mingling: Students pose at the 48th Annual Dental Student Research Conference. The ADA Foundation Paffenbarger Research Center hosted 41 dental students at PRC and at the National Institutes of Health April 15-17.

"The message was clear: research is not simply something students should be involved in during their school years," said attendee Jessica Peinado, a dental student at University of Nebraska Medical Center College of Dentistry.

"But it should be an important part of every clinician's practice. It is not necessary to always be at a lab bench, but it is essential to be able to understand and apply the most current scientific findings. Staying up-to-date with dental research allows dentists to give patients the best care possible."

The annual gathering draws students from U.S. and Canadian dental schools for the chance to mingle with and hear from scientists about dental research careers and opportunities.

Students heard presentations from Dr. Gary Schumacher, associate director and chief research scientist of the PRC; Dr. Leo Rouse, dean of the Howard University School of Dentistry; Dr. Chris Fox, executive director of International Association for Dental Research/American Association for Dental Research; the ADA's Dr. Ronald Zentz, senior director of the Council on Scientific Affairs; and Dr. Eric Lin, chief of the Polymers Division of National Institute of Standards and Technology. They also toured the PRC and heard presentations by current researchers.

Additionally, 21 students made poster presentations to their fellow students, PRC researchers and NIST researchers. Later, they heard from Dr. Fotinos Panagakos, director, clinical research relations and strategy for Colgate Palmolive Company and a member of the ADA Foundation Board of Directors.

Ms. Peinado said the conference sparked her interest in dental research and made her aware of the opportunities available for her to pursue the field. "I have no intention of letting my curiosity die out anytime soon," she said.

"This event is a key component in the Foundation's mission," said Gene Wurth, ADAF executive director, who oversees PRC. "Ultimately, our goal is to improve patient care. In the medical and oral health arenas, better patient care results from the continuing education of the members of the profession.

"Better education results from better and innovative research and that research comes from the best and the brightest minds," Mr. Wurth added. "This is our effort to identify and encourage those innovative minds now and to support their development so that they can contribute to our knowledge base for years to come." ■

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ADA members can save $10 on membership plaques through July 30.

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Dentists can display the ADA membership plaque in their reception areas, consultation rooms or operatories as a reflection of professionalism, to inform patients and to inspire trust.

The 12-inch-by-9-inch plaques declare membership in the ADA and that the dentist subscribes to the Principles of Ethics and Code of Professional Conduct of the Association.

Mounted on polished hardwood, the plaques are available in two styles: bronze (N382) and stainless steel (N381).

For more information about the membership plaques or to place an order, visit adacatalog.org or call 1-800-947-4746. ■

VIEWPoint

MyView

Headlines on dental radiographs

Matthew J. Messina, D.D.S.

I spent most of a week in April dealing with the media fallout from the release of the Yale University study on dental radiographs and brain tumors. As a result of the extensive media coverage, we all will be explaining things to our patients for quite a while. My task as an ADA spokesperson is to put a story like this in perspective.

How common are the brain tumors? (Six per 100,000.) How did the researchers find a link between dental X-rays and brain tumors? (They asked people with brain tumors to remember how many X-rays they had over their lifetime.) Is there a problem with this type of study? (Yes, it's called "recall bias.") Are dental X-rays now different than before? (Yes, the amount of radiation in current dental radiography is dramatically less than in years past.) What should patients do with this information? (Talk to their dentist about any concerns so that their dentist can give them accurate information and reassure them.)

The newspaper story as printed in the April 12 issue of the Cleveland Plain Dealer is about as good a result as we can get in a story like this. I spent 30 minutes with the reporter discussing the scientific study and its flaws. We also talked about the diagnostic value of radiographs and the risk to the patient of undiagnosed dental disease. I helped her to understand the ALARA (as low as reasonably achievable) principle in radiographic technique and how safe and low in radiation modern dental X-rays are.

The reporter listened to my arguments and used the information that I had provided. Her story included much of our message. Her article was balanced and accurate. It was not a press release, and certainly not a paid placement (infomercial), where we are able to control the entire message. As a spokesperson, I can only talk to the public through the filter of the reporter. We successfully got our message across. Unfortunately, it was on page A-4.

The story was above the fold on the front page of the Plain Dealer. The headline was "Dental X-rays Linked to Brain Tumors in Yale Study." Like a courtroom trial, the prosecution went first. Page 1 included the first six paragraphs of the article. Our defense was well presented, but after the "jump" to page A-4. It required that a person be committed enough to understanding the story to be willing to actually open the paper and read the article to the end. And that is one of the problems that we will always face as a profession.

Our answers to questions are rooted in the science. They are long and complex. Well-intentioned, but sterile and rather boring. Our opponent's answers are short, and often emotional. "Dental radiographs are safe and effective as a diagnostic tool to allow the dentist to truly see what is going on in your mouth. They are valuable to identify decay, periodontal disease, and other pathology, as well as to monitor proper growth and development." vs. "Dental X-rays cause

See MY VIEW, Page 5

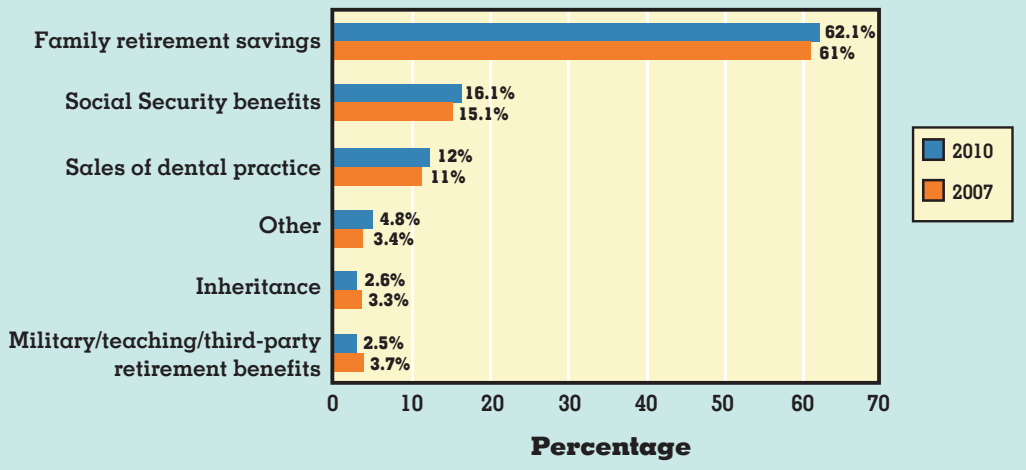
LETTERSPolicy

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

Retirement income sources

For ADA member dentists aged 55-65 in a 2007 survey, 87.2 percent of annual retirement income was expected to come from family retirement savings, Social Security benefits and the sale of their dental practice. In a 2010 survey, these sources were expected to provide 90.2% of annual retirement income.



Source: American Dental Association, Health Policy Resources Center, *2010 Survey on Retirement and Investment.*

Letters

'No evidence' of risk

Elizabeth B. Claus, M.D., et al., presented a case-control study in which they examined the association between dental X-rays and the risk of intracranial meningioma ("Dental X-rays and Risk of Meningioma," Cancer. 2012 DOI: 10.1002/cncr.26625).

While there is strong evidence that ionizing radiation may cause cancer, the question remains whether low doses lead to a detectable increase in risk. Regarding dental X-rays, the effective dose is far below the yearly exposure received from natural background radiation. In the present case, the cerebral region is not even within the primary radiation field. It is thus most disturbing that the authors do not consider doses.

The results suggest a twofold increase in risk if the subject had at least one bitewing in his entire life. However, Table 2 shows that both cases and controls report this case with nearly the same (high) relative frequencies: 95.8 percent and 92.2 percent, respectively. The authors seem to have missed the fact that the odds ratio may not simply be translated into relative risks if high probabilities are regarded (Davies H.T., et al. "When Can Odds Ratios Mislead?" British Medical Journal 316, 989-991m; 1998).

The article postulates a nearly fivefold increase in risk for subjects who got at least one panorex film at ages under 10 years, based on recalls by 22 out of 1,433 patients and five out of 1,350 controls (average age: 57.5). Recalls are fairly unreliable and prone to personal bias if events are affected that took place five decades ago.

Thus, these small numbers do not allow a reliable estimation of the risk.

Results for full-mouth films suggest smaller risks (not even statistically significant) than for the before mentioned cases. A full-mouth series consists of 16-20 single films and thus exposes the patient to a dose which is larger by one order of magnitude than with a single film and still considerably larger than that obtained with a panorex. In summary, the article suggests that relatively large doses do not lead to a significant increase in risk while much smaller doses do.

In conclusion, the study provides little to no evidence of an increased risk of meningioma for subjects exposed to low-dose dental X-ray diagnostics.

Dieter Dirksen, Ph.D.
Ludger Figgener, M.D., D.M.D., Ph.D.
University of Muenster
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Editor's note: The ADA News reported on the Cancer study in the April 23 issue, "Experts Question X-ray Study." The story is posted at ADA.org/news/6979.aspx.

Need more of ADA view

OK, when I read the April 23 ADA News article, "ADA's View of Access Solution Differs From Kellogg Report," I was looking for more of the ADA's view. Any dentist seeing "Kellogg report" at this point should have

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Letters

Continued from Page 4

some idea of what they will be seeing: access to care, and one of their solutions to it, dental therapists.

The creation of dental therapists, as currently proposed, will provide for a high school graduate, with 22 months training, to be able to do irreversible and surgical procedures without direct supervision. In other words, nondentists will be doing dentistry. This will be the creation of two-tiered system in dentistry. Is this the best we can do for the underserved in America?

The article stated that the ADA will submit a letter to the editor offering dentistry's dramatically different view, but it would be at ADA.org. Without a more complete ADA response, I felt the article became more of an advocacy piece for the Kellogg report. I read that former Health and Human Services Secretary Louis Sullivan, M.D., was in favor of dental therapists. The principal author of the report, Dr. David Nash, stated that of the 1,100 documents, there was no compromise to children's safety or quality of care. He wrote the report and was also in favor of dental therapists. Naturally, we were given his side of the controversy.

The ADA has already shown that there will be no shortage of dentists in the future. Dental workforce size is not a problem now, nor will it be in the predictable future. The problem is where the dentists are in relation to the underserved populations. There are solutions that exist and others are being tested. The National Health Service Corps, the Indian Health Service and the loose network of federally qualified health centers use various combinations of incentives to place dentists in underserved areas. The greater problem is that the states and federal government have reduced funding for Medicaid and other programs. They are also trying to provide care to more people, while reducing the money to pay for their treatment. Since they are reducing money for care, how will they fund new programs for schools, training and salaries for dental therapists?

So what I wanted from the ADA are facts as to whether dental therapists are the solution or not? Does it really work in the 54 countries cited? I have since seen the ADA response and it is good, but I would like it available for all to see. We must have evidenced-based data and the facts to refute the Kellogg report. In an Academy of General Dentistry webinar, Drs. Carter Brown and Mike Bromberg gave information on two programs. The following is an excerpt from the webinar that was published in the January AGD Transcript:

"New Zealand's oral health has seen an overall decline even though the dental therapist program has been in place for decades. According to Dr. Brown, the therapist model there has also not been shown to be an economic success either. 'There is significant evidence suggesting that there is a large amount of unmet dental care in New Zealand. In the dental health survey of 1988, it was found to be as high as 33 percent. The dental health survey results published in a December 2010 report, A Progressive Dental Health Policy 2011, the House of Representatives, New Zealand, show that this level has grown to 44 percent,' [said Dr. Brown.] These dental therapists are also utilized in Australia. According to Quarter of a Century of Change: Caries Experience in Australian Children, 1977-2002, a report in the Australian Dental Journal 2008 by School of Dentistry, Faculty of Health Sciences, the University of Adelaide, South Australia members JM Armfield and AJ Spencer, 'Since the mid to late 1990s, deciduous 6-year-old decayed, missing or filled teeth

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MyView

Continued from Page 4

brain tumors."

Our real challenge is not even in countering the statements of our opponents. We face stiff competition for the time and attention of the public. The Internet gives us access to unlimited information. But it also permits skimming the surface rather than deeper study of complex topics.

Most people will read the headlines on Yahoo News or Google search results, without clicking to look deeper into the story. Network television and cable news have conditioned us to expect answers in nine-second sound bites.

How can we have a meaningful discussion if no one is willing to ask questions? Is there a level of critical thinking still evident in the country?

While I have concerns that as a society we are too willing to skim the surface of the information available to us, I am encouraged that as individuals we are willing to ask questions when things relate to us. Patients will ask about X-rays when it directly involves their health. This will create teachable moments for us in our offices. We just need to be ready.

If we ask our patients to be willing to ask the questions; to turn to page A-4, then we owe it to them to have answers, and to be willing to take the time to care and to explain. Today's dental office is much more than a building where tooth dust is made. It needs to be a place of learning. Only then can we get past the headlines, and on to, as Paul Harvey would say ... the rest of the story!

Dr. Messina is the executive editor of ODA Today, the publication of the Ohio Dental Association and an ADA consumer adviser. His comments, reprinted here with permission, originally appeared in the May issue of that publication.

GOVERNMENT

ADA reviews draft Senate legislation

Sen. Sanders' 'ambitious' bill provides investment needed for decades

BY CRAIG PALMER

Washington—The Association cited "many provisions in your bill that we enthusiastically support" and offered to work with Sen. Bernard Sanders, I-Vt., in crafting his proposed Comprehensive Dental Reform Act of 2012.

The senator held a Feb. 29 Senate hearing on the "Dental Crisis in America: The Need to Expand Success" and shared with the Association a draft bill he expects to introduce. Speaking June 1 at the site of a dental clinic soon to open in Springfield, Vt., Sen. Sanders said that "more must be done in Vermont and the nation to address the national crisis" and that he would offer legislation to address access problems.

The ADA thanked the senator in a June 5 letter "for your efforts to break down the barriers that impede tens of millions of Americans from receiving regular dental care, many of whom suffer from chronic yet preventable dental diseases" and offered a section-by-section review of the draft bill.

"The ADA is committed to breaking down these barriers and there are many provisions in your bill that we enthusiastically support," said the letter signed by Dr. William R. Calnon, Association president, and Dr. Kathleen T. O'Loughlin, executive director.

The Association offered comments on these sections of the draft bill:

- coverage of dental services under the Medicaid program;
- case management grant program;
- oral health education of medical providers and other non-oral health professionals;

"The ADA is committed to breaking down these barriers and there are many provisions in your bill that we enthusiastically support."

- emergency funding for oral health services;
- dental clinics in schools;
- emergency room care coordination with respect to dental care;
- research funding;
- mobile dental services;
- dental education—dental residency programs and oral health professional student loans;
- cost-benefit analysis report;
- coverage of dental services under the Medicare program;
- National Health Service Corps;
- Department of Veterans Affairs, Department of Defense and the Federal Bureau of Prisons, and
- Indian Health Service.

The Association asked for clarification of some provisions, offered recommendations on others and said it could not support certain definitions and mid-level provider proposals.

"Clearly, this ambitious bill provides the degree of investment that has been needed for decades and it laudably acknowledges that oral health disparities represent a complex set of problems that call for multiple solutions," the Association told the senator.

"In the larger sense, the ADA believes firmly that the public health approach to ending untreated dental disease in America will require a fundamental philosophical shift from the current model of surgical intervention to one in which disease is prevented before it occurs. The nation will never drill, fill and extract its way out of what (former) Surgeon General David Satcher, M.D., famously called a 'silent epidemic' of oral disease.

"Again, thank you, Senator Sanders for your leadership, and we stand ready to work with you to achieve the best possible legislative outcomes in pursuing our mutual goal of a healthier, more productive nation." ■

—palmerc@ada.org

Mercury treaty negotiations conclude in 2013

BY CRAIG PALMER

Washington—A 10-organization dental coalition June 4 urged the U.S. government to oppose international mercury treaty curbs on dental amalgam.

The fourth session of the United Nations Environment Programme's Intergovernmental Negotiating Committee to prepare a global legally binding instrument on mercury will convene June 27-July 2 in Punta del Este, Uruguay. INC3 was held Oct. 31-Nov. 4 in Nairobi, Kenya.

INC5 will meet in Geneva, Switzerland in January 2013 to conclude treaty negotiations. The text will then be open for signature at a 2013 diplomatic conference in Japan.

"One small component of that draft binding instrument relates to dental amalgam, a dental restorative material needed to provide the most effective treatment for certain clinical situations and populations," said the coalition letter to the U.S. Department of State. "We urge the United States to oppose any effort in these negotiations to ban or limit the availability of dental amalgam."

The letter is signed by organizations "represent(ing) the preeminent authorities on and advocates for oral health," the Academy of General Dentistry, American Academy of Oral and Maxillofacial Pathology, American Academy of Pediatric Dentistry, American Academy of Periodontology, American Association of Endodontists, American Association of Orthodontists, American Association of Public Health Dentistry, American Dental Association, Association of State and Territorial Dental Directors and International Association for Dental Research.

The U.S. government should "use the ongoing negotiations…as an opportunity to promote public health here and throughout the world," the letter said.

"We further urge the United States to insist that the binding agreement (1) call for national efforts to prevent oral disease (thereby reducing the demand for amalgam and all other restorative materials), (2) promote research into alternative dental materials and (3) promote responsible handling of waste amalgam to mitigate an already small impact on the environment.

"By taking this approach, the United States will help to assure that optimal care is available to those who need it, while also promoting a worldwide campaign to eradicate oral disease." ■

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Legislation

Continued from Page 1

version of, "a bill to improve access to oral health care for vulnerable and underserved populations."

H.R. 5909 was referred to the Armed Services, Energy and Commerce, Judiciary, Natural Resources, Veterans' Affairs and Ways and Means Committees, "in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned."

"This bill represents a promise to the American people that dental health will no longer be a privilege," Rep. Cummings told a standing-room-only audience in a Senate-side room in the U.S. Capitol. "By making investments in our oral health workforce, additional dental professionals will be available to address the demand for oral health care in areas of need. Emergency funding will help expand the resources available to the National Health Service Corps to train a new generation of dental providers."

Dr. Paul Glassman, professor of dental practice and director of the Pacific Center for Special Care at the University of the Pacific Arthur A. Dugoni School of Dentistry, also spoke at the news conference.

Dr. Glassman cited recommendations from an Institute of Medicine committee on which he served.

The 2011 IOM report, Improving Access to Oral Health Care for Vulnerable and Underserved Populations, called for expansion of the oral health workforce, integration of oral health into general health activities and use of 21st century telehealth technologies to foster collaboration and communication between distributed sectors of the health care system.

"It is time to develop new and innovative solutions to these problems," Dr. Glassman said.

Representatives of the Children's Dental Health Project, the Community Catalyst dental access project and the National Committee to Preserve Social Security & Medicare and a self-described "parent" also spoke at the news conference.

To read the ADA's letter to Sen. Sanders, view a draft of the bill and a summary of it, visit the Association's Advocacy website, www.ada.org/advocacy.aspx ■

—palmerc@ada.org

Dental spending growth projected through 2021

BY CRAIG PALMER

Bethesda, Md.—Dental spending is projected to increase at an average annual rate of 5 percent through 2021, government analysts said in a June 12 report.

Total health spending is projected to grow at a slightly higher 5.7 percent annually or 0.9 percentage point faster than the expected growth in the gross domestic product. The growth rate accelerates in 2014 with expanded coverage under the 2010 Affordable Care Act. However, the ACA will add just 0.1 percentage point to overall and dental spending through 2020, aging baby boomers seen as a greater contributor to spending growth.

New estimates from the Centers for Medicare & Medicaid Services' National Health Expenditures team project an increase in expenditures for dental services from $104.8 billion in 2010 to $179.8 billion in 2021 under what the analysts said is "a 'current law' framework. These projections are subject to substantial uncertainty for many reasons."

The report's authors note the pending U.S. Supreme Court decisions regarding the Affordable Care Act expected by the June 30 end of the court's term.

"The supply-side effects of the Affordable Care Act, such as changes in providers' behavior in reaction to an influx of newly insured patients, also remain highly speculative and are not included in these estimates," they said.

But even "without the impacts of the Affordable Care Act," the NHE team projects steady gains in dental and aggregate health care spending through the decade. The dental share of total health expenditures is projected at 3.7 percent in 2011 and 2021 with or without the ACA expansions.

The NHE accounts project the first albeit minimal dental spending increase under the Affordable Care Act for 2011, from an estimated $107.6 billion not factoring in the ACA to $107.9 billion with the ACA. The differences increase throughout the decade, particularly in 2014 and beyond when Medicaid and other ACA expansions take effect and peak in 2021 when dental spending without the ACA is projected at $177.1 billion or $2.7 billion less than the "current law" projection of $179.8 billion.

The annual dental services growth rate throughout the decade is slightly higher when the projections include ACA impacts. Dental spending is projected to increase by 5.4 percent in 2015 over the previous year when the ACA is included and 4.4 percent without the ACA. The annual growth rate in dental spending accelerates after 2013 to as high as 6.6 percent in 2019 with the ACA and 6.4 percent without the ACA.

Major ACA coverage expansions take effect beginning in 2014. These expansions are expected to increase the number of persons with health insurance, the demand for health care and the share of total health spending sponsored by federal, state and local governments, the NHE team says in a Web First report published in the journal Health Affairs (www.healthaffairs.org).

Projected health spending over the decade reflects the impacts of economic, legislative and demographic factors, such as the aging population, on U.S. health care costs. Rising government spending on health care, projected to reach nearly 50 percent of total national health spending by 2021, is expected to be driven by faster growth in Medicare enrollment, expanded Medicaid coverage and the introduction of premium and cost-sharing subsidies for health insurance exchange plans.

The health spending projections were based on the National Health Expenditures released in January. ■

—palmerc@ada.org

Letters

Continued from Page 5

has increased by 24 percent and 12-year-old DMFT has increased by almost 15 percent. Reductions in caries experience of those children with the most disease have also ceased, and between 1999 and 2002 an increase in the Significant Caries Index occurred.' "

We need all the help we can get, as the foundations, the public health lobbies and many dental schools are supportive of midlevel providers. The Kellogg Foundation has pledged $16 million over three years to promote the expansion of midlevel providers in Kansas, New Mexico, Ohio, Vermont and Washington. This year legislation failed in these states, but they will be back!

Mel Kessler, D.D.S.
Miami

Editor's note: The ADA has two significant studies under way: one looking at the economics of new workforce models and a systematic review of the literature related to new workforce models and their impact on the oral and cost effectiveness on the health of the population.

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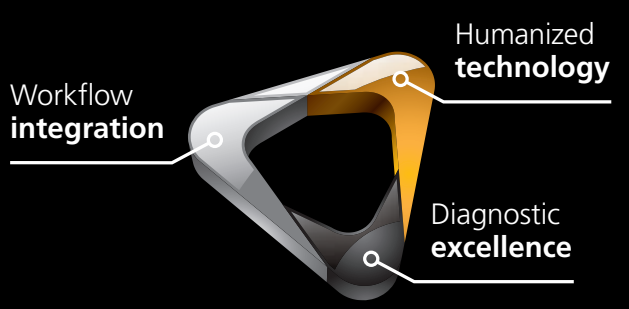

YOUR PRACTICE

Delta Dental cuts reimbursement fees for New Jersey and Connecticut dentists

BY KELLY SODERLUND

Parsippany, N.J.—Dentists in New Jersey and Connecticut are the latest to be affected by cuts in reimbursement fees by Delta Dental.

Delta Dental of New Jersey, a subsidiary of Delta Dental Plans Association that oversees plans in New Jersey and Connecticut, sent a letter to participating dentists May 14 announcing it was reducing fees for many of the procedures it covers.

All procedures were analyzed individually, with a goal of attaining a 4-5 percent claim savings, said Diane Belle, vice president of corporate communications for Delta Dental of New Jersey. Fees for some procedures were lowered, others remained the same and some increased, she said.

Reimbursement fees were reduced between 4 and 13 percent in Idaho last year and in Washington by an average of 15 percent for dentists participating in the premier network and 5 percent for those in the PPO network. The same reason was given for all of the cuts: Delta Dental wants to remain competitive.

"With the economy being the way it is, the employer groups that offer our benefits have a lot of challenges and they're always looking to lower their costs, including lowering employee benefits," Ms. Belle said. "We took this action to ensure our benefit plans remain competitive in the marketplace."

The changes in New Jersey and Connecticut will take effect Jan. 1, 2013.

"It is always unfortunate when reimbursements to dentists are reduced at the same time when the cost to dentists in providing services and patient premiums continue to rise," said Carol Dingeldey, executive director of the Connecticut State Dental Association.

"With the economy being the way it is, the employer groups that offer our benefits have a lot of challenges and they're always looking to lower their costs, including lowering employee benefits."

Arthur Meisel, executive director of the New Jersey Dental Association, echoed the comments made in Connecticut and is also concerned about the decreasing reimbursements paired with increasing costs.

"Based upon anecdotal information, not unexpectedly, dentists in New Jersey are very concerned about reductions in reimbursement levels by any third-party payers," Mr. Meisel said.

"Since dental practice operating costs and remuneration expectations are unique to each office, if plan reimbursement levels continue to fall and dental practice operating costs continue to escalate, dentists will have to decide on an individual basis whether and to what extent they continue to participate in particular third-party plans."

Delta Dental of New Jersey set up a phone line and email inbox for dentists to contact with concerns or questions.

There hasn't been an unusually high number of dentists reaching out but Ms. Belle believes that's because of the thorough letter the company sent outlining the changes. Beginning May 21, dentists could visit a secure area of Delta's website to see exactly how their fees would be affected.

The company's ultimate goal is to continue to provide dental insurance so that more people will visit the dentist, Ms. Belle said.

"We know that people go to the dentist if they have dental insurance so we want to see our groups keep our dental insurance," Ms. Belle said. "We know it's good for the dentist when people have dental insurance because people come to them." ■

—soderlundk@ada.org

Code

Continued from Page 1

Portability and Accountability Act to oversee an open and participatory process.

"During its April meeting, the council listened to feedback from members of its Code Advisory Committee and felt comfortable expanding the committee's responsibilities," Dr. Richeson said. "The CAC provides an invaluable service by bringing a spectrum of views to discussion of CDT Code change requests. It is a logical next step to have the CAC vote on whether a change should be accepted or declined."

ADA and payer representation is balanced, as it was with the Code Revision Committee, which preceded the CAC. There are also 11 additional voting members from independent dental professional organizations who now have a direct voice in CDT Code maintenance.

Changing the CAC to a voting body was one of several CDBP actions. Other process changes include:

- Adopting of a new pair of simplified and focused CDT Code change request forms.
- Setting Nov. 1 as the closing date for submissions to provide more time for interested parties to prepare and submit their requests.
- Moving up the date for distributing and posting requests submitted on ADA.org to Dec. 15 so CAC members and other stakeholders will have more time to review and prepare their comments for discussion at the annual CAC meeting.
- Pushing back the annual CAC meeting to late February/early March to provide more time for change request review.
- Extending the CAC meeting to three days, with the first dedicated to public discussion and comment on the CDT Code change requests.

The second and third days, open to observers, are for the committee to discuss and vote to accept or decline each change request.

- Moving up the completion date for work on the next version of the CDT Code to June 1 to provide timely publication for members and third-party payers and more time for practice management system vendors to update their software.

The current CDT Code maintenance process incorporates best practices of other entities that maintain HIPAA medical code sets, such as CPT and ICD-9-CM. Information on the process, including reports of the latest activity, the change request forms, and timeline for the next version can be found online at www.ada.org/3827.aspx.

"The ADA believes it is imperative to keep members updated on this process. The CDT Code is something that affects every dentist, and it is also important for everyone in the community to understand how certain codes come to be and the rationales behind them," Dr. Richeson said.

"We're building an open and participatory environment where dentists, dental benefit companies and other invested agencies can learn what goes into creating the CDT Code."

Questions and requests for additional information may be directed to CDBP staff via email at dentalcode@ada.org or via telephone to the ADA at 1-312-440-2500. CDBP staff are also available to answer questions on other areas of interest.

As the premier professional association of dentists, the ADA and its councils strive to provide the best member services and benefits.

"There's no question about the value of being an ADA member." Dr. Richeson said. "Pick any area and we are here to help. The legal department provides a free Contract Analysis Service to members with questions on agreements. The ADA is charged with maintaining and updating the CDT Code, the only government-designated terminology to document what we do in dentistry. CDBP is regularly interacting on members' behalf with dental benefit companies. And the council helps ADA constituents provide Peer Review, an alternative to costly legal proceedings. Whatever you need, we are here to help." ■

—soderlundk@ada.org

A seat at the table: Dr. Jim Richeson, left, chair of the Council on Dental Benefit Programs, and Dr. Stephen Ura, chair of the Subcommittee on the Code, participate in a discussion at the Code Advisory Committee meeting in February.

Dental teamwork

Dentists, hygienists sponsor Annual Session course

BY KELLY SODERLUND

San Francisco—They work side by side every day but are dentists and hygienists working together as effectively as they can?

The relationship between the two team members is pertinent to a practice's success and one that will be explored during a new course at Annual Session this year.

Building Optimum Oral Health Care Teams will be presented from 8-11 a.m., Oct. 20. There is no fee for the course, and participants are eligible to receive three hours of continuing education credit.

It's a collaborative course between the American Dental Association and the American Dental Hygienists' Association. It's being presented at both the ADA's Annual Session in San Francisco and at the ADHA's 2013 Annual Session in Boston.

All ears: Ann Battrell, executive director of the American Dental Hygienists' Association, left, and Pamela Quinones, president of the ADHA, listen to questions from the Council on Dental Practice after their presentation May 31.

"My daughter, Dr. Danielle Riordan, and I would be lost in our practice without our hygienists. As dentists, we depend on our hygienists and they equally depend on us," said Dr. Mark Zust, chair of the ADA Council on Dental Practice. "It's important for us to be able to work together in a positive environment and have the same goal of providing the best patient care."

The course will be presented by Dr. Robert Gottlieb, Suzanne Newkirk, a registered dental hygienist, Dr. James Rozanski, and Lisa Shaw, also an RDH. The purpose of the course is to help dentists and hygienists learn how to work together effectively in an environment that has become much busier for everyone involved in a dental practice.

The course will teach participants what it means to have the ideal dental team and the impact on quality oral care; how to develop interdependent relationships within a dental practice to improve care and advance learning; and how to revive the dental hygiene department in a private practice during challenging economic times.

"This program is a wonderful opportunity to address an issue that has been around for many years. Dentists and dental hygienists are educated in isolation of one another and are then expected to inherently know how to work together in a private practice," said ADHA President Pamela Quinones, a registered dental hygienist. ■

—soderlundk@ada.org

CE Online

Continued from Page 1

needed to find extra canals.

Any dentist who performs root canal therapy will find the course useful. Two continuing education credits are available on successful completion, and the course's registration fee is only $76 for members.

Dr. Tawil is a diplomate of the American Board of Endodontics and a fellow of the Royal College of Dentists in Canada. He is in private practice and serves as a clinical assistant professor at the University of North Carolina at Chapel Hill.

ADA CE Online is designed for general dentists, specialists and dental team members. To review the library of available courses, including special pricing for ADA members, visit adaceonline.org. ■

Dr. Christensen set for Education in the Round course

BY STACIE CROZIER

San Francisco—Dr. Gordon Christensen, one of dentistry's most popular clinical lecturers, will demonstrate use of class II resins during the Education in the Round course, Class II Resins Can Be Simple and Fast, Oct. 18, 10 a.m.-1 p.m. (course 5401) at the ADA Annual Session.

"Would you like your class II resins to be faster, easier, better and less expensive to place? Let me show you how to do just that in a live clinical demonstration," said Dr. Christensen.

Dr. Christensen, director, Practical Clinical Courses, and CEO and co-founder of the CR Foundation in Provo, Utah, will show participants how to identify and discuss the best materials for class II resin-based composites, the best techniques for class II resin-based composites and reasons for post-operative tooth sensitivity and premature restoration failure.

"This live demonstration includes proven and new concepts for class II resin restorations," said Dr. Christensen, "including identification of minimal class II carious lesions, minimal tooth preparations, tooth desensitization, liners, the best matrices, comparison of composite brands, finishing for optimum longevity, fees and third party payment."

Dr. Christensen

The ADA's Education in the Round courses allow Annual Session attendees to experience live-patient procedures in a fully functional dental operatory, right in the Moscone Center. The cost for these courses is $69 each.

Other courses set for the 2012 EIR lineup include:

- Live-Patient Demonstration of Immediate Lower Denture Stabilization Using Mini Dental Implants, by Dr. Raymond Choi (course 5402);
- Soft-Tissue Surgery for Augmentation of Keratinized Gingiva, by Dr. Jon B. Suzuki (course 6401);
- User-Friendly Techniques for Automatic Atraumatic Extraction of Teeth and Socket Grafting, by Dr. Lee H. Silverstein (course 6402);
- Examination, Diagnosis and Treatment of the Restorative-TMD Patient, by Dr. James McKee (course 7401);
- Lasers in the Dental Practice—A Live-Patient Demonstration, by Drs. Charles Hoopingarner, David Roshkind and Donald Coluzzi (course 7402).

For more details, course descriptions or to register, visit ADA.org/session. ■

SNODENT goes global

The ADA's Systemized Nomenclature of Dentistry will be incorporated into the International Health Terminology Standards Development Organization's SNOMED CT medical code set, thanks to a licensing agreement between the two groups.

The IHTSDO is the leading provider of standardized clinical terminology. By incorporating SNODENT—the ADA's dental diagnostic codes—within the SNOMED CT International Release, it will be available for dental professionals around the world to use. SNODENT is a vocabulary designed for use in the electronic health records environment.

SNOMED-CT is a required terminology for use in certified Electronic Health Records Systems for the Medicaid and Medicare meaningful use incentive reimbursement program. This means that SNODENT will likely be named as the clinical terminology required for certification of electronic dental systems and for meaningful use attestation. Any dentist who uses electronic health records or who plans to in the future will want to be familiar with SNODENT as it is used within those records.

"The agreement will make SNODENT content more widely available for the ultimate benefit of patients and global health," said Dr. William Calnon, ADA president. "Both parties have also committed to identify if there are ways of working more closely together to deliver further benefits."

The agreement also calls for the establishment of an International Dentistry Specialty Interest Group to provide new and updated content to SNOMED CT Core; offer proposals of project groups to the IHTSDO's Content Committee, which will oversee the Dentistry SIG, in development of the annual work plan; and work on opportunities to improve organizational efficiencies.

Dr. Calnon appointed Dr. Mark Jurkovich, member of the ADA Council on Dental Benefit Programs, to the Dentistry SIG.

"I'm delighted with this cooperation agreement," said John van Beek, chair of the IHTSDO management board.

For more information, visit www.ihtsdo.org. ■

YOUR HEALTH

Medicines, grapefruit juice don't always mix

Grapefruit juice can be part of a healthful diet—most of the time. It has vitamin C and potassium, substances your body needs to work properly.

But it isn't good for you when it affects the way your medicines work. Grapefruit juice and fresh grapefruit can interfere with the action of some prescription drugs, as well as a few nonprescription drugs.

This interaction can be dangerous, says Shiew Mei Huang, Ph.D., acting director of the Food and Drug Administration's Office of Clinical Pharmacology. With most drugs that interact with grapefruit juice, "the juice increases the absorption of the drug into the bloodstream," she said. "When there is a higher concentration of a drug, you tend to have more adverse events."

For example, if you drink a lot of grapefruit juice while taking certain statin drugs to lower cholesterol, too much of the drug may stay in your body, increasing your risk for liver damage and muscle breakdown that can lead to kidney failure.

Drinking grapefruit juice several hours before or several hours after you take your medicine may still be dangerous, said Dr. Huang, so it's best to avoid or limit consuming grapefruit juice or fresh grapefruit when taking certain drugs.

Examples of some types of drugs that grapefruit juice can interact with are:

- some statin drugs to lower cholesterol, such as Zocor (simvastatin), Lipitor (atorvastatin) and Pravachol (pravastatin);
- some blood pressure-lowering drugs, such as Nifediac and Afeditab (both nifedipine);
- some organ transplant rejection drugs, such as Sandimmune and Neoral (both cyclosporine);
- some anti-anxiety drugs, such as BuSpar (buspirone);
- some anti-arrhythmia drugs, such as Cordarone and Nexterone (both amiodarone);
- some antihistamines, such as Allegra (fexofenadine).

Grapefruit juice does not affect all the drugs in the categories above. Ask your pharmacist or other health care professional to find out if your specific drug is affected.

The FDA has required some prescription drugs to carry labels that warn against consuming grapefruit juice or fresh grapefruit while using the drug, says Dr. Huang. And the agency's current research into drug and grapefruit juice interaction may result in label changes for other drugs as well. ■

Source: Food and Drug Administration

Tips for avoiding drug/grapefruit juice interactions

- Ask your pharmacist or other health care professional if you can have fresh grapefruit or grapefruit juice while using your medication.
- Read the medication guide or patient information sheet that comes with your prescription medicine to find out if it could interact with grapefruit juice.
- Read the drug facts label on your nonprescription medicine, which will let you know if you shouldn't have grapefruit or other fruit juices with it.
- If you must avoid grapefruit juice with your medicine, check the label of bottles of fruit juice or drinks flavored with fruit juice to make sure they don't contain grapefruit juice.
- Seville oranges (often used to make orange marmalade) and tangelos (a cross between tangerines and grapefruit) affect the same enzyme as grapefruit juice, so avoid these fruits as well if your medicine interacts with grapefruit juice. ■

Grant to NYU dental school will support perio research

BY JEAN WILLIAMS

New York—New York University College of Dentistry received a subcontract of $1.8 million from the Forsyth Institute to help investigate new ways to diagnose and prevent periodontal disease.

The Forsyth Institute, which is affiliated with Harvard University, was founded more than a century ago to provide charitable dental care to children in Boston. Today it is dedicated to promoting oral health through research and education.

The National Institute of Dental and Craniofacial Research granted Forsyth Institute $20.7 million in September 2010 to explore microbiological, genetic and immunological aspects of periodontal disease.

"The knowledge generated by this project will start a new era in risk assessment and diagnostic tests for periodontal patients, bringing us one step closer to the goal of personalized therapies," said Dr. Ricardo P. Teles, director of the Center for Clinical and Translational Research Department of Periodontology at Forsyth Institute.

The four-year grant supports three major subprojects: Biomarkers of Periodontal Disease Progression, Oral Microbial Biomarkers in Periodontal Disease Progression and Metatranscriptome of the Oral Microbiome during Periodontal Disease Progression.

Aside from NYU College of Dentistry, other clinical research partners include the Michigan Center for Oral Health Research, the University of Florida College of Dentistry and The State University of New York at Buffalo School of Dental Medicine.

Dr. Teles

For its part, NYU College of Dentistry will screen research subjects and collect biological samples for the project Biomarkers of Periodontal Disease Progression. NYU dental school researchers will seek to expand the use of biomarkers in clarifying why people develop periodontal disease, what circumstances lead to progression of periodontal disease and how treatment affects biomarkers.

"Biomarkers are factors in people's blood, dental plaque, saliva or tissue that might indicate that they are more susceptible than others to developing periodontal disease," said Dr. Patricia Corby, principal investigator on the NYU College of Dentistry grant. "By identifying these factors, we will be able to design more specific treatments for this condition; thus we're changing the paradigm of how we diagnose and treat periodontal disease."

Dr. Corby is an assistant professor of periodontology and implant dentistry and associate director of the NYU Bluestone Center for Clinical Research.

Aside from identifying and exploring biomarkers, researchers are also investigating novel approaches to treating periodontal disease. ■

—williamsj@ada.org

Dental Office Design Competition entries due July 31

Wells Fargo Practice Finance is accepting entries for the 2012 Dental Office Design Competition.

A panel of dental industry and design experts will judge the entries, and winners will be announced in October at the ADA Annual Session in San Francisco. All newly built offices and offices with leasehold improvements or renovations completed between Jan. 1, 2009, and Dec. 31, 2011, are eligible to enter. All practice types and sizes are welcome.

A grand prize "Dental Office Design of the Year" winner will be selected from Small Practice and Group Practice categories. Grand prize winners will receive a $2,500 bonus marketing fund, media exposure, an engraved plaque and more.

Awards and media coverage will also be presented to Outstanding Achievement award winners in the following categories:

- Outstanding New Dentist Practice recognizes the best new, remodeled or expanded facility for the first practice owned by a doctor or group of doctors who have graduated from dental school since 2002.
- Outstanding Specialty Practice recognizes the best new, remodeled or expanded facility for a specialty practice.
- Outstanding Design Efficiency recognizes the most effective space planning and use of square footage to meet practice needs and objectives.

Additional details are at www.wellsfargo/practicefinance.com. For more information, contact chris.greenhalgh@wellsfargo.com. Entries must be postmarked by July 31. ■

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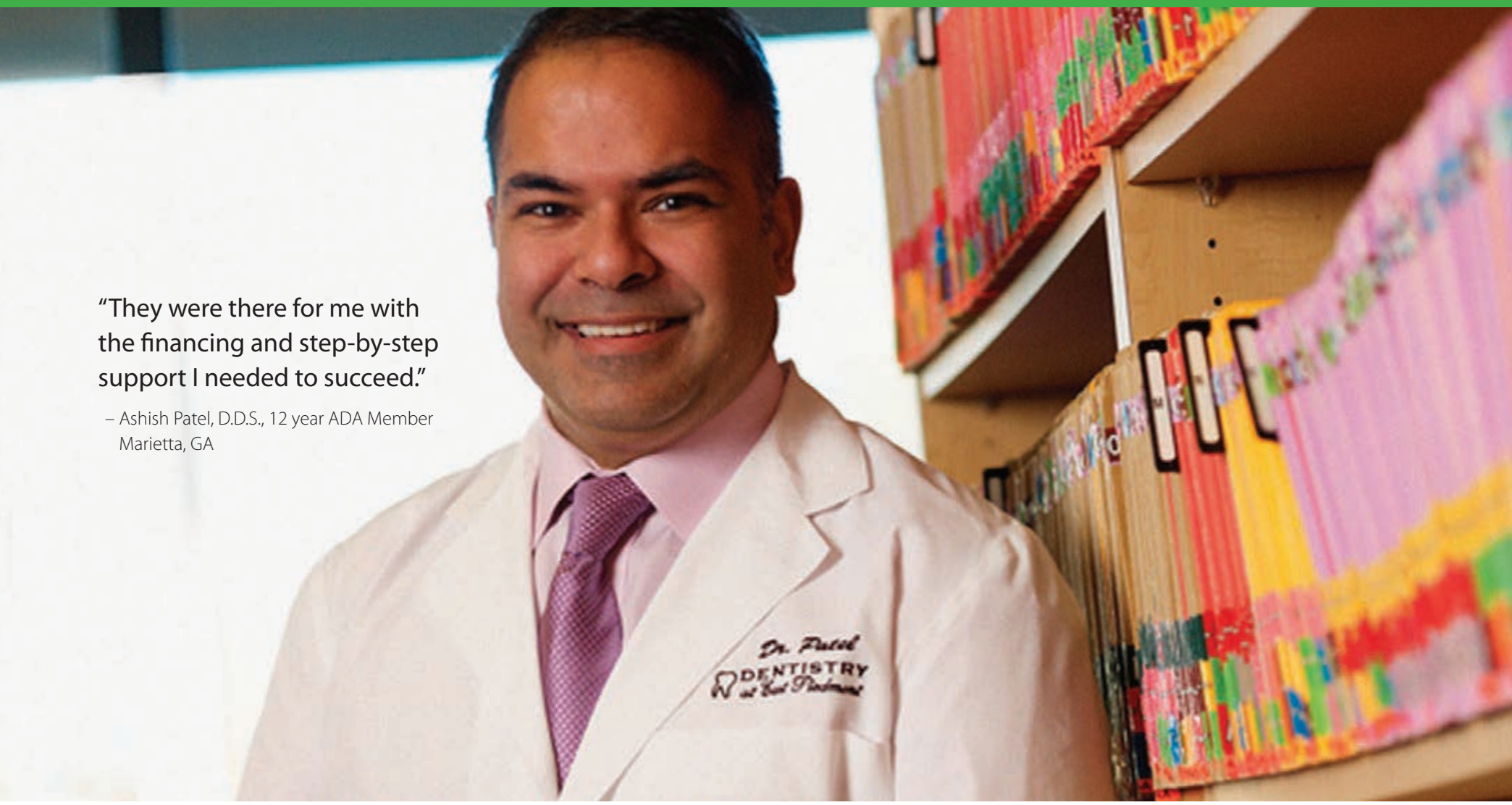

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– Ashish Patel, D.D.S., 12 year ADA Member
Marietta, GA

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What do you think of the economy?

Revamped ADA survey asks dentists about their confidence in the market today and in the future

BY KELLY SODERLUND

The ADA Health Policy Resources Center changed the way it surveys dentists about the economy and says the new format creates a more accurate picture of dentists' confidence now and in the future.

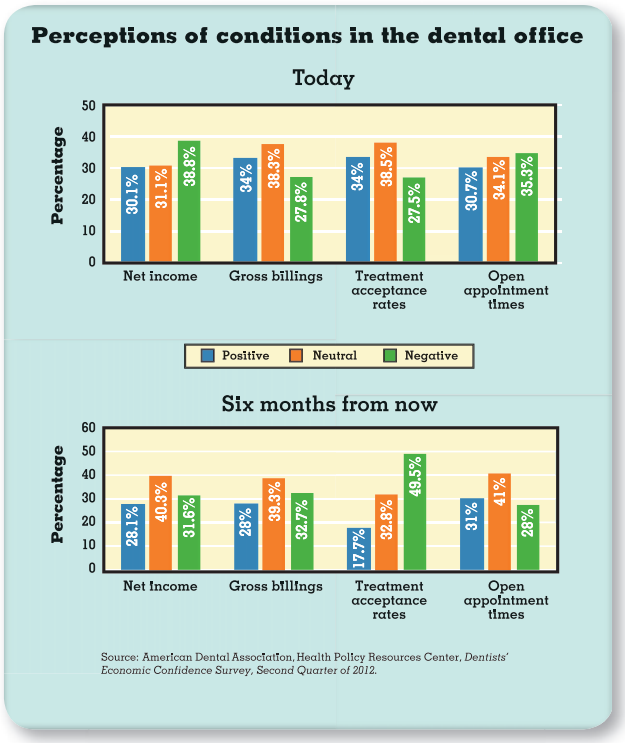
The first results from the revamped Dentists' Economic Confidence Survey, which are from the second quarter of this year, were released in May. Nearly 1,700 dentists completed the survey between April 6-19.

"The new format is in the survey style that is used in most studies of consumer or manufacturer confidence," said Dr. Jeffrey Cole, member of the Council on Dental Practice's Subcommittee on Economic Issues. "Before, our study asked members to comment on their experience compared to last quarter. This made it more difficult to see what changes were a result of the economy or economic trends and what changes were due to the cyclic nature of our business. Now the respondents are asked how they feel today and how they feel about the near future, as opposed to focusing on the past."

Based on survey results, the HPRC created two indices of economic confidence on a scale from -100 to 100. The index scores reflected an overall picture of dentists' confidence in net income, gross billings, open appointment times and treatment acceptance rates, both today and six months from now. A score of 100 would be achieved if no negative responses were received, while a score of -100 would be the result of no positive responses.

In the second quarter, the index score for April was 0, meaning dentists' confidence is around neutral. The index score for six months from now was -14.

Dentists were the most pessimistic about their net income today than other areas measured by the survey, with nearly 39 percent reporting a negative feeling. When asked to look out six months, dentists were the most negative about treatment acceptance rates. Nearly half of those who responded had negative feelings about treatment acceptance rates.



Source: American Dental Association, Health Policy Resources Center, *Dentists' Economic Confidence Survey, Second Quarter of 2012.*

The majority of dentists surveyed don't have any plans to hire additional dentists or other staff for their practice in the next year.

CDP has made economic issues one of its main focuses this year. CDP is presenting a forum at Annual Session in San Francisco titled Has the Economic Downturn Changed Dentistry Forever? It's scheduled for 10:30 a.m.-1 p.m. Oct. 18. There is no fee for the course and it is worth 2.5 hours of continuing education credit. Marko Vujicic, Ph.D., managing vice president of the HPRC, will be among the panel members, and the course will be moderated by a CDP member.

The council continues to look at the economy in a broad manner. Efficiencies in practice, tips and advice on running the business side of dental practices can be found on the council's Dental Practice Hub, www.ada.org/245.aspx. Emerging models of practice, such as the increasing trend toward group practice, is also being studied by the council.

"CDP's focus is more on how economics are affecting dental practice in an effort to provide the membership with more information on how to make their practices more efficient and successful," Dr. Cole said. "This will allow the council to focus on what the membership is telling us at the ADA is most important to them. We are building the value of membership by helping members build the success of their practices." ■

—soderlundk@ada.org

QuickTakes

Summaries of ADA News stories published online

Dr. Reeves takes reins at University of Mississippi School of Dentistry

Dr. Reeves

After more than two years as interim dean, Dr. Gary Reeves has been appointed dean of the University of Mississippi Medical Center School of Dentistry in Jackson, Miss.

"I have been at Mississippi since I started dental school in 1980, and my whole professional career is associated with the school," said Dr. Reeves. "I'm very honored to accept this position."

Dr. Reeves took over as the school's leader in February 2010. "Since that time, he has provided effective leadership and earned the confidence and trust of the school's faculty, staff and students," said James E. Keeton, M.D., vice chancellor for health affairs at UMMC.

Dr. Reeves said he looks forward to continuing the work he began as interim dean as well as new challenges. To read more, visit ADA.org/news/7122.aspx. ■

Dr. Assael named dean of University of Minnesota School of Dentistry

Dr. Assael

The University of Minnesota May 29 announced the appointment of Dr. Leon A. Assael, a past chair of the ADA Council on Dental Education and Licensure, as dean of its School of Dentistry.

Dr. Assael's appointment is effective Aug. 1 pending approval by the university's Board of Regents. He succeeds Dr. Judith Buchanan, interim dean.

Dr. Assael is a past dean of the University of Kentucky College of Dentistry. He comes to the University of Minnesota from Oregon Health and Science University School of Dentistry, where he was professor and chair of oral and maxillofacial surgery since 2003.

A past editor-in-chief of the Journal of Oral and Maxillofacial Surgery, Dr. Assael's primary clinical interest is in the area of facial injuries, facial pain and maxillofacial nerve injuries. To read the full story, go to ADA.org/news/7170.aspx. ■

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Consumers score a 'D' for knowledge of oral health

'Nice smile' tops eyes, hair as most important attribute

BY KAREN FOX

In a national online survey of nearly 1,500 consumers across the U.S., the ADA inquired about consumers' knowledge of oral health and hygiene.

No one aced the test.

Scores ranged from a high of 85 percent correct to a low of 29 percent. The average score overall was 60 percent correct. If the results are any guide, there's much room for improvement when it comes to educating patients about their oral health.

Included among select findings, the survey concluded that:

• Those consumers who are caregivers with children in the home scored slightly higher.

• Women scored higher than men by 4 percentage points.

If the results are any guide, there's much room for improvement when it comes to educating patients about their oral health.

• Higher formal education equated to a higher score. Those with a college degree scored 62 percent and those without a high school diploma scored 55 percent. The range of scores increased progressively with more education.

• Higher incomes also scored higher, except among Hispanics where income made no difference.

• When it came to the following topics, consumer knowledge was actually pretty good: what is gingivitis? (95 percent were correct); your mouth changes as you get older (93 percent correct); pregnant women should pay extra attention to their dental health (92 percent); and denture wearers still need to visit the dentist (92 percent).

• On the other hand, consumer knowledge was not so good on when children should be able to brush their teeth (only 6 percent were correct); whether one should brush after every meal (10 percent correct); whether sugar causes cavities (19 percent); and at what age a child should have their first visit to a dentist (25 percent).

The survey also asked consumers for their opinion on a number of oral health topics, which yielded the following results:

• Eighty-three percent of households still participate in tooth fairy rewards.

• Eighty-five percent of respondents indicated that a good smile is extremely or very important for finding a job.

• One in five have shied away from a social event because of problems with their teeth.

• Regarding physical attractiveness, a nice smile outweighed skin, eyes, hair, and build or figure as the most important attribute.

An abbreviated and interactive version of the survey will be available on MouthHealthy.org so consumers can "Test Your Dental IQ"—allowing them to compare their scores with the national average. ■

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Website

Continued from Page 1

ADA Find-a-Dentist is undergoing a few changes for the new site, too. For example, there's an enhanced view of member credentials and contact information that includes social media tools. Consumers can now search for dentists who have posted photos.

Making ADA Find-a-Dentist so readily accessible is giving consumers just what they want. In the recent survey, consumers indicated that finding a dentist was one of the top three most requested features of the new website. Having a current profile on ADA Find-a-Dentist is a great opportunity to help build practice visibility, so members are encouraged to update their profiles soon. To update profiles on ADA Find-a-Dentist, members should visit ADA.org/memberprofile.

In the weeks to come, the ADA will distribute a promotions toolkit with ads, articles and flyers so that constituent and component dental societies can help promote MouthHealthy.org and the enhanced ADA Find-a-Dentist feature.

Once MouthHealthy.org is up and running, dentists are encouraged to go online and enjoy interactive tools on patient education and share its many resources with their patients. ■

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Dr. Christensen set for Education in the Round course

BY STACIE CROZIER

San Francisco—Dr. Gordon Christensen, one of dentistry's most popular clinical lecturers, will demonstrate use of class II resins during the Education in the Round course, Class II Resins Can Be Simple and Fast, Oct. 18, 10 a.m.-1 p.m. (course 5401) at the ADA Annual Session.

"Would you like your class II resins to be faster, easier, better and less expensive to place? Let me show you how to do just that in a live clinical demonstration," said Dr. Christensen.

Dr. Christensen, director, Practical Clinical Courses, and CEO and co-founder of the CR Foundation in Provo, Utah, will show participants how to identify and discuss the best materials for class II resin-based composites, the best techniques for class II resin-based composites and reasons for post-operative tooth sensitivity and premature restoration failure.

"This live demonstration includes proven and new concepts for class II resin restorations," said Dr. Christensen, "including identification of minimal class II carious lesions, minimal tooth preparations, tooth desensitization, liners, the best matrices, comparison of composite brands, finishing for optimum longevity, fees and third party payment."

Dr. Christensen

The ADA's Education in the Round courses allow Annual Session attendees to experience live-patient procedures in a fully functional dental operatory, right in the Moscone Center. The cost for these courses is $69 each.

Other courses set for the 2012 EIR lineup include:

- Live-Patient Demonstration of Immediate Lower Denture Stabilization Using Mini Dental Implants, by Dr. Raymond Choi (course 5402);
- Soft-Tissue Surgery for Augmentation of Keratinized Gingiva, by Dr. Jon B. Suzuki (course 6401);
- User-Friendly Techniques for Automatic Atraumatic Extraction of Teeth and Socket Grafting, by Dr. Lee H. Silverstein (course 6402);
- Examination, Diagnosis and Treatment of the Restorative-TMD Patient, by Dr. James McKee (course 7401);
- Lasers in the Dental Practice—A Live-Patient Demonstration, by Drs. Charles Hoopingarner, David Roshkind and Donald Coluzzi (course 7402).

For more details, course descriptions or to register, visit ADA.org/session. ■

SNODENT goes global

The ADA's Systemized Nomenclature of Dentistry will be incorporated into the International Health Terminology Standards Development Organization's SNOMED CT medical code set, thanks to a licensing agreement between the two groups.

The IHTSDO is the leading provider of standardized clinical terminology. By incorporating SNODENT—the ADA's dental diagnostic codes—within the SNOMED CT International Release, it will be available for dental professionals around the world to use. SNODENT is a vocabulary designed for use in the electronic health records environment.

SNOMED-CT is a required terminology for use in certified Electronic Health Records Systems for the Medicaid and Medicare meaningful use incentive reimbursement program. This means that SNODENT will likely be named as the clinical terminology required for certification of electronic dental systems and for meaningful use attestation. Any dentist who uses electronic health records or who plans to in the future will want to be familiar with SNODENT as it is used within those records.

"The agreement will make SNODENT content more widely available for the ultimate benefit of patients and global health," said Dr. William Calnon, ADA president. "Both parties have also committed to identify if there are ways of working more closely together to deliver further benefits."

The agreement also calls for the establishment of an International Dentistry Specialty Interest Group to provide new and updated content to SNOMED CT Core; offer proposals of project groups to the IHTSDO's Content Committee, which will oversee the Dentistry SIG, in development of the annual work plan; and work on opportunities to improve organizational efficiencies.

Dr. Calnon appointed Dr. Mark Jurkovich, member of the ADA Council on Dental Benefit Programs, to the Dentistry SIG.

"I'm delighted with this cooperation agreement," said John van Beek, chair of the IHTSDO management board.

For more information, visit www.ihtsdo.org. ■