3-6-2006

ADA News - 03/06/2006

American Dental Association, Publishing Division

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AMERICAN DENTAL ASSOCIATION WWW.ADA.ORG

ADA NEWS®

MARCH 6, 2006 VOLUME 37 NO. 5

Oral, systemic health

ADA,AMA talk to media about latest in research

BY JENNIFER GARVIN

New York—"Who benefits from medicine and dentistry working together? The patient."

That question, posed by ADA Executive Director James Bramson, kicked off the Feb. 23 joint media conference hosted by the ADA and American Medical Association, part of the ADA's national campaign to educate the public about the relationship between oral health and overall health.

"Oral health conditions and other health conditions are more closely related than many may once have thought," Dr. Bramson said, "and viewing them as separate matters no longer makes sense."

Dr. Bramson, along with AMA

See SYSTEMIC, page 13

Photo by Ted Grudzinski/Courtesy AMA

Working together: ADA Executive Director James Bramson (right) joins Samantha Cramoy, M.D., AMA trustee and JADA Editor Dr. Michael Glick at the start of the Feb. 23 media briefing in New York City.

Dental benefit trends and issues series starts

Inside, on page 17, is the first of an ADA News series on dental benefit trends and issues that will seek to explain changes in the industry, common problems faced by dentists and what's being done to eliminate those problems, wherever possible.

This first article looks at new marketplace developments, factors influencing those changes and efforts by the ADA and payers to forge mutually productive relationships. ■

Big decade

Feds predict dental spending to reach $167.3 billion in 2015

BY CRAIG PALMER

Washington—Dental and aggregate health spending are expected to outpace economic growth consistently over the next decade, government actuaries said in a report posing supply and demand questions for policy-makers.

The $81.5 billion dental expenditure in 2004 is projected to increase at an average annual rate of nearly 7 percent to $167.3 billion in 2015. Americans spent an estimated $87.4 billion for dental services in 2005 or 7.2 percent more than the year before.

Dental spending is expected to reach $94.3 billion this year and top $100 billion in 2007. Between 2010 and 2015, dental spending is expected to grow at a slower average rate of 6 percent a year.

Growth in total health spending over the decade is expected to average 7.2

See SPENDING, page seven

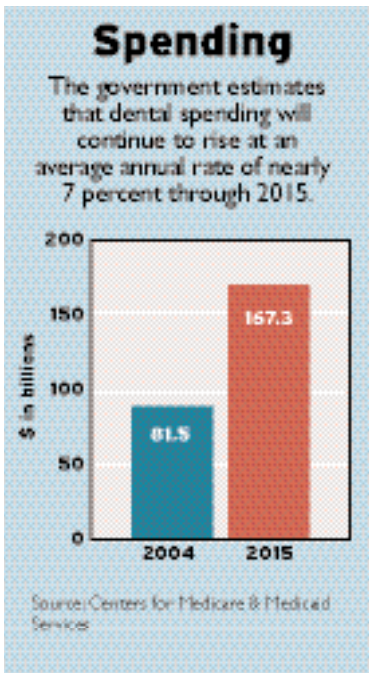


Photo by Dr. Ted Sherwin

Keeping warm: A mother and child use a blanket to fight off unseasonably chilly weather as they await treatment at the Misson of Mercy event in New Orleans last month. Dental volunteers helped provide nearly $2 million in care to nearly 4,000 people. Several of the 425 dental volunteers who participated and others relate their experiences, starting on page 14.

BRIEFS

Time to apply: Applications are now being accepted for the 2006 ADA Institute for Diversity in Leadership.

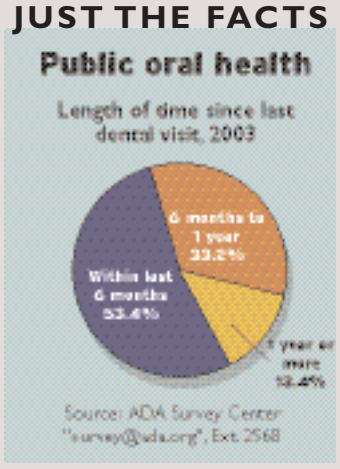
The ADA Institute is a three-part program designed to enhance the leadership skills of dentists who belong to racial, ethnic and/or gender backgrounds that have been traditionally underrepresented in leadership roles.

Courses take place in Chicago on Sept. 7-8; Dec. 11-12; and Sept. 6-7, 2007.

The registration deadline is May 1. Brochures, applications and evaluation forms are available for download at "www.ada.org/prof/events/featured/diversity.asp" or by contacting the ADA at "starsiaks@ada.org" or Ext. 4699.

The ADA Institute for Diversity in Leadership is made possible by the ADA Foundation through corporate contributions from Colgate-Palmolive Co., GlaxoSmithKline, Procter & Gamble and Sullivan-Schein. ■

JUST THE FACTS



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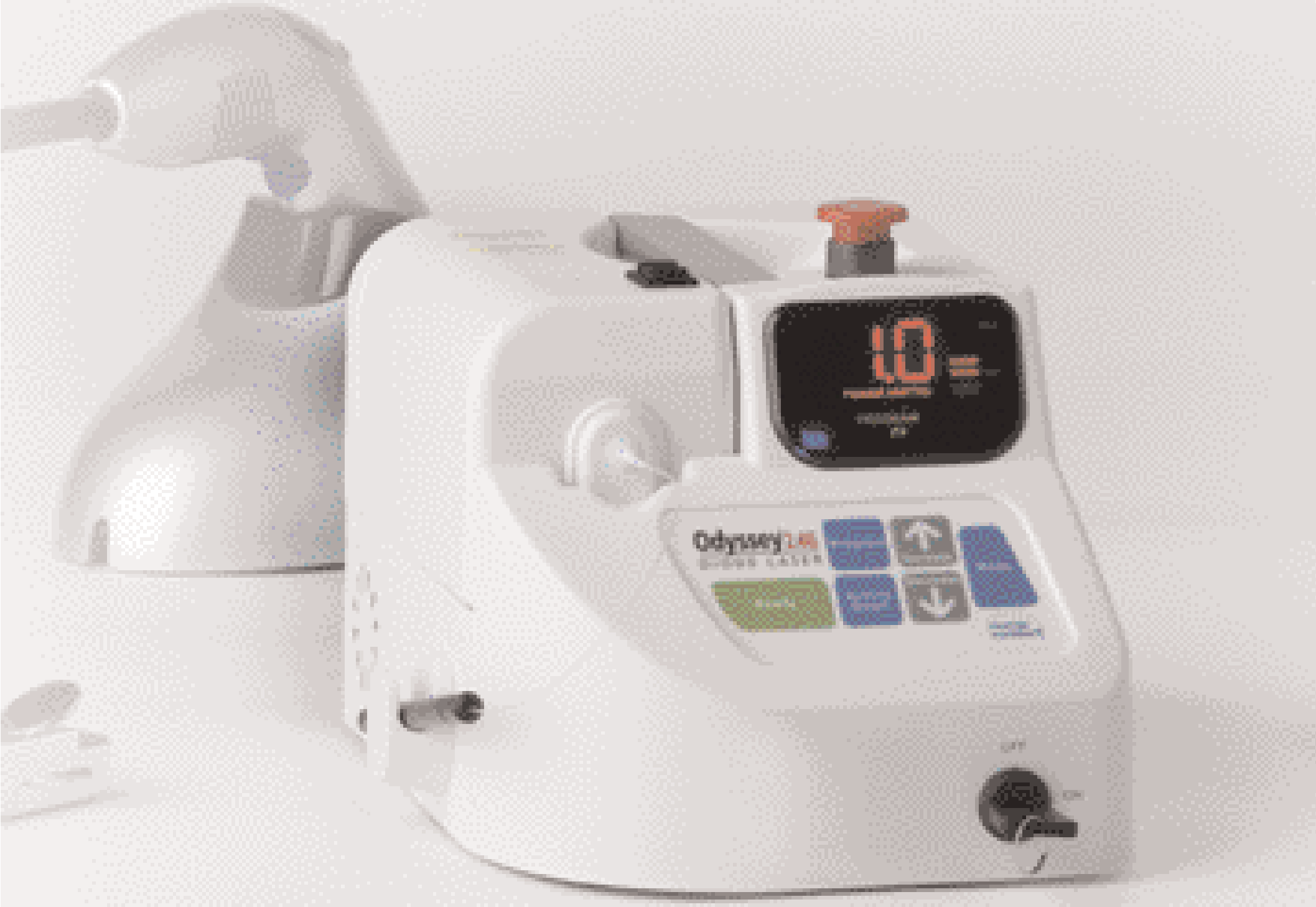

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NMD holds contest to update presidential smile

BY CRAIG PALMER

Baltimore—The National Museum of Dentistry invites the dental labs of America and Canada to give George Washington dentures fit for a 21st century smile, peer review and popular vote.

More than 900 dental laboratories are invited to replicate George Washington's maxillary and mandibular denture based on the hippopotamus ivory and gold set created in 1795 by New York dentist John Greenwood. Dr. Errol Reese, former dental school dean and former president of the University of Maryland, Baltimore, leads a judging committee of dental professionals across the country who will choose the winners.

Museum visitors will have an opportunity to select a "People's Choice" winner. All winners will be announced at a June 24 gala celebrating the museum's 10th birthday. Winning entries will be displayed at the museum and at ADA annual session Oct. 16-20 in Las Vegas and dental meetings in New York, Chicago and Anaheim, Calif.

Entries are due by May 1 and will be judged on the quality of materials and workmanship, accuracy to original specifications and resemblance to the original denture. The museum will offer photographic scans of the original mandibular denture, a maxillary replica created in 1976 and denture specifications. Rules and entry information are available from the museum by telephone at 1-410-706-8704. The museum exhibits the lower denture created by Dr. Greenwood and offers fantastic facts about the dental history of America's first president at "www.dentalmuseum.org". ■

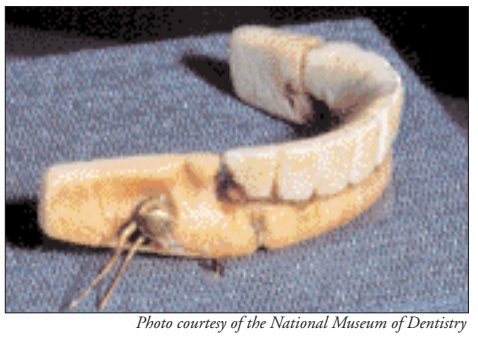


Photo courtesy of the National Museum of Dentistry

Presidential: The lower denture created for George Washington in 1795.

ViewPoint

MyView

What do we want to be?

Alan R. Gould, D.D.S.

Recent months have seen a flurry of renewed interest in the linkages between oral and systemic health, and by extension, between dentistry and medicine. Attention is being directed at the potential influences of oral diseases such as chronic periodontitis on coronary vascular disease, babies born preterm and/or with low birth weight, pulmonary infection and diabetes mellitus.

The emergence of new technologies in saliva analysis may enable health care providers to accomplish early and efficient detection of oral cancer, cancers of the breast, pancreas and ovary, as well as diabetes mellitus and Sjogren's syndrome.

Recognizing the impending emergence of these therapeutic and diagnostic advances, the question is raised, as in the past, concerning the dentist's role in contributing to the general health of the patient.

It may be reasonably asked whether we will soon witness the evolution of a practice of dentistry in which, for example, diagnosis and control of periodontal disease will become a routine and necessary component of obstetric care. Should this come to pass, a major and largely artificial distinction—namely, the division of oral care into categories of "medically necessary" or otherwise—will lose a great deal of its purported validity.

This distinction has long been a favored strategy of medical insurers in limiting their liability for the provision of oral health care. As dentists become empowered with ever more sensitive diagnostic methodologies and are called upon to provide treatments intended to prevent and/or ameliorate diseases and conditions anatomically distant from the mouth, their participation in medical care and medical third-party reimbursements can be expected to increase.

Exciting as these prospects may be, these changes call to attention needed structural changes in the relationship between dentistry and medicine. Given the foregoing, one can envision a system of health care in which physicians and dentists will work together in an increasingly integrated and coordinated manner—providing diagnostic and therapeutic services to address a significant range of oral and systemic diseases.

Physicians will find greater recognition of the importance of early diagnosis and effective management of oral disease in the medical care of patients. Similarly, it will become incumbent upon dentists to grasp their expanding role in contributing to general health through timely use of diagnostic procedures and dental therapeutics.

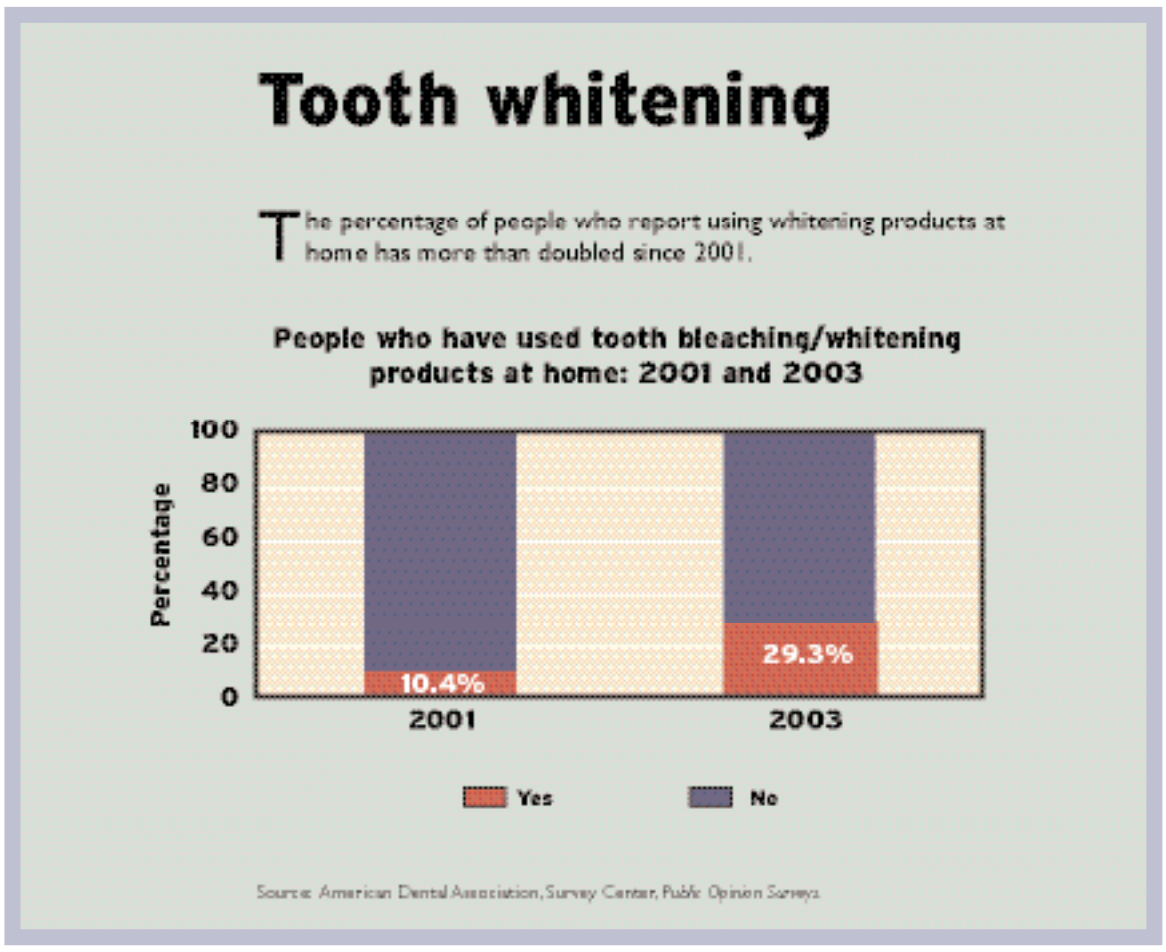
This emerging paradigm of patient care will require better-defined and more efficient systems of physician-dentist communication, with clearly articulated pathways for patient referral between the professions and respective specialists. These considerations may carry significant implications in: (1) the training of physicians and dentists; (2) the content of academic programs of medicine and dentistry as reflected in respective standards established by accreditation agencies; (3) the interactions of respective medical and dental educational institutions in academic health centers; (4) the content of medical and dental licensure examinations; and (5) the topic profiles found in clinical journals and health

See MY VIEW, page five

LettersPolicy

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

SNAPSHOTS OF AMERICAN DENTISTRY



Letters

Volunteerism

I read the article "Dental Volunteers for Israel" (Jan. 9 ADA News) with great interest since I just returned from spending two weeks volunteering at the Trudi Birger Dental Clinic.

I found my experience at the clinic to be very rewarding emotionally. The clinic is very professional and the quality of dentistry performed on these children is excellent.

I must express my admiration for dental companies such as Henry Schein and Premier for their generous donation of supplies for the clinic, as well as for the hundreds of dentists and individuals from many countries who have contributed their services and/or money to allow the clinic to provide its much-needed services.

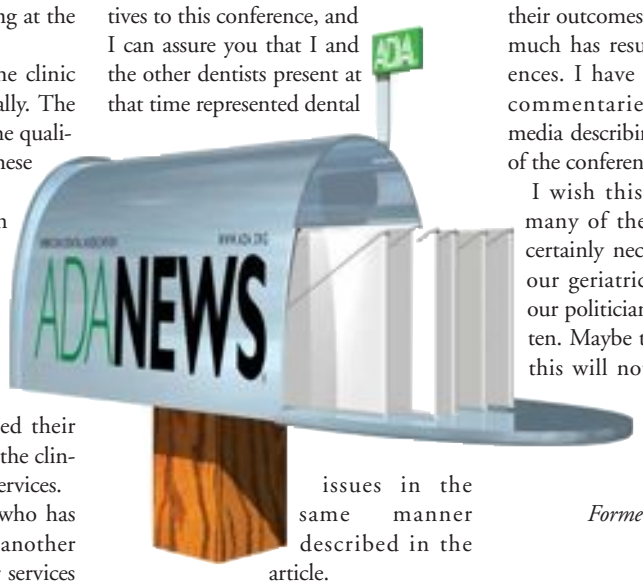
I would encourage anyone who has ever thought of traveling to another country to volunteer his or her services to contact DVI. I'm looking forward to returning this year.

Myron Kellner, D.D.S.
Baltimore

Not there yet

In the article about the White House Conference on Aging ("Delegates Make Impact at Conference on Aging," Jan. 9 ADA News), an ADA conference delegate stated that "dental interests were certainly represented to a greater degree than ever before."

As the ADA 1st Vice-President at the time of the last Conference on Aging in 1995, I was one of the ADA representatives to this conference, and I can assure you that I and the other dentists present at that time represented dental issues in the same manner described in the article.



That is, our issues were included in the implementation strategies of the key resolutions, and influential leaders of different health care organizations and aging advocates were educated as to the importance of oral health and the ability of dentistry to make a positive difference in millions of lives.

I want to forewarn the dentists who attended this conference that they should not expect many, if any, of the recommendations in the report being written for the benefit of the President and Congress to ever come to fruition.

This is probably the seventh White House Conference on Aging, and if you look at prior recommendations and their outcomes, you will realize that not much has resulted from these conferences. I have already read and heard commentaries in the various news media describing the recommendations of the conference as "pie in the sky."

I wish this were not the case, as many of the recommendations are certainly necessary for the benefit of our geriatric population. However, our politicians just do not wish to listen. Maybe the time will come when this will not be true, but I do not think that we have reached that time yet.

Edwin S. Mehlman, D.D.S.
Former ADA 1st District Trustee
Providence, R.I.

Editor's note: Dr. G. Kirk Gleason, 2nd District trustee and one of the ADA delegates at the 2005 Conference on Aging, responds: "The ADA News article was in no way intended to diminish the efforts of Dr. Mehlman and the delegates from 1995. I still believe the ADA has an important seat at the table at these conferences, and that the Association benefits from having ADA representatives educate dele-

See LETTERS, page five

MyView

Continued from page four

care continuing education programs.

Stated simply, dentists will be thinking about and will experience greater involvement in medical patient care, and physicians will be more mindful of oral disease in their patients.

The organizations that represent dentists, physicians and the specialists of these respective professions will find new incentives for cross-discipline and inter-profession interactions.

Given the foregoing, it can be predicted that physicians will develop an increased interest in oral health. It is probable that physicians will begin to provide more detailed and focused examinations of the oral cavity, based on a broadened array of diagnostic concerns. Such expanded examination will be accompanied by an increased frequency of physician detection of oral disease in all of its variety. These developments will inevitably lead to a rising demand for physician education on the nature of oral disease, its patterns of clinical presentation and respective diagnostic algorithms.

Dentistry, supported by a robust clinical scientific literature and numerous excellent texts, is well-prepared to share this information with our medical colleagues. However, a recent cursory survey of dental organization Web sites and organization responses to pertinent electronic inquiries suggests that little in the way of physician-targeted education in oral disease is being offered.

Opportunities for education in oral disease show little visibility in the continuing medical education sections of several physician organization Web sites. I believe that it is critically important for the dental profession to begin to develop and implement programs for the training of practicing physicians in the diagnosis of oral disease. We should seek to inform our medical colleagues of the many services in oral disease diagnosis and management which dentistry currently provides, and we must develop defined and efficient systems for patient referral between the respective professions. In a revealing and ironic sense, the headline of a recent ADA News—"What is our Role?"—characterizes the current circumstance very well.

In response to that question, I would paraphrase the Cheshire Cat and offer a query to the dental profession: "Well, what do we want to be?"

Dentistry has the opportunity today to take an initiative, to define its diagnostic and treatment responsibilities in this new and emerging health care context, and to improve the sharing of information regarding oral disease diagnosis and treatment with our medical colleagues. In so doing, we will assure the dental profession a meaningful and rewarding future as a partner with the medical profession in serving the health needs of the public.

However, should the dental profession respond in a manner that is neither proactive nor focused—one that fails to inform and guide our medical colleagues—the outcome will not be favorable. Our best research findings will enhance the quality of health care, but the larger body of knowledge of oral disease detection and diagnosis will remain separated from the enterprise of general patient care. Our emerging health care system will continue to be less than "all it could be."

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For more information related to this story visit the ADA's Web site, using the Web address above.

Dr. Gould is in the private practice of oral and maxillofacial pathology in Crestwood, Ky., and is the Oral and Maxillofacial Pathology Section Editor for the journal Oral Surgery, Oral Medicine, Oral Pathology, Oral Radiology, and Endodontology. His comments, reprinted here with permission, were originally published in the September 2005 issue of that publication (V100(3):261-262, Gould AR, © 2005 Elsevier Inc.).

Editor's note: Recognizing the growing body of evidence linking oral health with general health, the ADA and Colgate Palmolive Co. recently launched an Oral-Systemic Education Campaign that kicked off Feb. 23 with "Oral and Systemic Health: Exploring the Connection," a national media briefing in which the American Medical Association also participated. The remaining components of the campaign are set to roll out in the upcoming weeks and months and include: an announcement letter to ADA members, a resource kit for dentists and hygienists that contains patient education materials and a tube of Colgate Total, a symposium at the 2006 ADA annual session and a JADA supplement on the oral-systemic connection. For information on the national media briefing, see story, page one.

Letters

Continued from page four

gates on the importance of good oral health care for the aging population. My network of influential New Yorkers that I can now contact and who will listen to me discuss oral health care issues is greatly expanded, and for that alone the conference was worthwhile."

Chewing gum

I enjoyed the My View editorial by Dr. Eric Curtis ("Chew On This," Jan. 9 ADA News). Facts and lore of chewing gum were interesting, but I wonder why Dr. Curtis failed to mention that chewing gum was first patented by a colleague, Dr. William Semple of Mount Vernon, Ohio?

Dr. Semple received a patent for chewing gum in December 1869—U.S. Patent No. 98304. Dr. Semple "invented" a chewing gum made from rubber combined with unnamed "other articles." Despite the patent, there is no record of his product ever entering the marketplace.

And one minor personal note: I mind the chewing of gum less than I mind finding the wrappers wedged deeply in every crevice of my car.

William Hartel, D.M.D.
St. Louis

Dental leader, mentor

Dr. Abraham Kobren dies at age 88

BY JENNIFER GARVIN

Bridgeport, Conn.—By becoming ADA president, he reached the pinnacle of his professional career, but it was his mentoring ability that left a lasting impression on those touched by the life of Dr. Abraham Kobren.

"He encouraged you," said Dr. Stuart H. Coleton. "He had a lot of confidence in me and I was in awe of him."

Dr. Kobren, who served as ADA president in 1985-86 and ADA treasurer in 1984-85, died Feb. 16 after a long illness. He was 88. Services were Feb. 19 in Fairfield, Conn.

"My father was passionate about clinical dentistry and relating with patients. He brought enthusiasm and excitement into every phase of his professional life. His office was always warm and open," said his son, Dr. Leonard Kobren, who followed in his father's footsteps and is a prosthodontist.

In addition to his ADA offices held, Dr. Kobren represented the ADA 2nd District as a trustee from 1978-1984 and also was a past president of the 9th District Dental Society, component of the Dental Society of the State of New York, and the New York State Society of Dentistry for Children. He was a longtime delegate to the ADA House of Delegates and a consultant for the ADA Council on Hospital and Institutional Dental Services.

"The funeral service was very moving," said Dr. Coleton, who credited Dr. Kobren with encouraging him to become involved in organized dentistry. Dr. Coleton is a former member of the Board of Governors for the New York State Dental Society.

ADA president 1985-86: Dr. Abraham Kobren "was recognized as an innovator, mentor and friend who loved his family and profession," said his son, Dr. Leonard Kobren.

His granddaughter, Jennifer Kanfer, and son, Dr. Leonard Kobren, gave eulogies that captured the essence of Dr. Abraham Kobren, who they said possessed integrity, passion and commitment to friends, family and his profession.

Born to Ukrainian immigrants who spoke little English, Dr. Kobren was indebted to the opportunities provided to him in the United States. He served with pride as lieutenant senior grade in the U.S. Army during World War II.

"He was forever in need of giving back to his community and profession," Dr. Kobren said.

He was proud of his Jewish heritage. He loved golf and the Mets and was involved in community affairs such as Cub Scouts, youth groups and virtually every aspect of organized dentistry.

"He really believed in youth," said Dr. Kobren. "The kids he most admired were those most like him, youngsters from modest backgrounds who really had to extend themselves. He felt that his wealth was measured by what he could give back."

During his career, Dr. Kobren also served as assistant dean of admissions, financial aid and housing for the New York University College of Dentistry. He was a professor and chair of the department of pediatric dentistry at the New Jersey College of Medicine and Dentistry when it was the Seton Hall College of Medicine and Dentistry. He also taught at the dental schools at NYU and Columbia University. A graduate of Wagner College, he received his dental degree from Georgetown University, where he also was honored with the school's distinguished service award and an honorary doctor of science degree. He also earned an M.S. from Massachusetts State College.

"It was thrilling to watch him with his students," Dr. Kobren said. "He had an immediate connection that was obvious and he believed in the need for young professionals to be recognized."

During Dr. Kobren's tenure as ADA president, development began for the Commission for the Young Professional, which was established in 1987 and is now the Committee on the New Dentist.

Dr. Kobren is survived by Ruth Spevack Kobren, his wife of 63 years, son Leonard and daughters Susan Morrison and Roberta Simon. In lieu of flowers, memorial contributions may be made to the Alzheimer's Association. A donation on behalf of the ADA was made in Dr. Kobren's name.

"He was almost 89 and had a wonderful life," Dr. Kobren said. "He was recognized as an innovator, mentor and friend who loved his family and profession." ■

Presidents-elect learn from each other at conference

BY KAREN FOX

Elected leaders from 52 constituent societies shared their experiences as they gathered at ADA headquarters Jan. 23-24 for the annual President-Elect's Conference.

ADA President-Elect Kathleen Roth presided over the event, at which key tripartite issues were brought to the forefront for discussion in advance of the state leaders' presidential years.

"This conference allows constituent society officials early in their year of leadership to spend time with their counterparts from other states," said Dr. Roth. "The presidents-elect take this opportunity to network and build friendships all around the country and get to know many of their colleagues with whom they share concerns."

The conference featured interactive sessions probing membership, dental education and dental practice; a leadership development session; a discussion of how the ADA strategic plan connects to the tripartite; and an update on the National Campaign for Dental Education.

Also highlighted were successful paths several dental societies are following in leadership development.

Dr. Anita Elliott came to the ADA conference for the first time as a constituent society representa-

See CONFERENCE, page eight

On point: Dr. Stephen Ura, New Hampshire president-elect, talks to Dr. Kathleen Roth, ADA president-elect.

Spending

Continued from page one

percent a year to more than $4 trillion, a rate of growth that is 2.1 percentage points faster than the projected average annual growth in Gross Domestic Product over the same period, the report said.

"Economic projections for the health care industry are certainly of great interest to dentistry," said Dr. Al Guay, ADA chief policy advisor. "Caution should be exercised when interpreting the projections, however. Whenever comparisons are made of health care spending and general economic growth, it is important to remember that variations in either factor influence the comparison. The behavior of the general economy has as much influence on this comparison as the behavior of the health care sector.

"Projections for the next decade duplicate the actual performance of the health care sector, including dentistry, compared to the Consumer Price Index and the GDP for the last two decades," said Dr. Guay. "What is seen as an economic anomaly by some may, in fact, be the norm."

"Each year we revise our econometric models," the authors said, citing "substantive revisions" to historical data and use of a new model for private personal health care spending. Still, the new projection differs little from last year's, they said.

"Noteworthy changes for both payers and purchasers may lie within the coming decade as our health care system responds to building pressure from such forces as the onset of Medicare Part D (prescription drugs), the aging of our society, and the expensive and unpredictable nature of new technologies," said the report prepared by the Centers for Medicare & Medicaid Services and published online by the journal Health Affairs ("www.healthaffairs.org").

"With national health spending growth in excess of GDP growth each year over the next decade, these changes could force payers and providers to reexamine fundamental questions regarding the delivery and financing of health care services." The authors are with the national health statistics group in the CMS office of the actuary, which annually produces 10-year projections of health care spending within the National Health Expenditure Accounts. The accounts track spending by source of funds and type of service.

By one measure, dental services weighed 5.2 as an indexed share of personal health care expenditures, including hospitals, physicians, nursing homes, prescription drugs and other health services and products.

A CMS press release ("www.cms.hhs.gov") highlights the slowing rate of total health care spending in 2005 and 2006. The full report concludes that costs and demand for health care are expected to increase over the longer period. "We anticipate that society will again need to confront the underlying questions about the supply of and demand for health care services, as we anticipate that one in every five dollars will be devoted to this sector by 2015." ■

HHS finalizes HIPAA enforcement approach

BY ARLENE FURLONG

Government

Washington—The Department of Health and Human Services Feb. 16 published the final rule on HIPAA administrative simplification enforcement.

The rule lays out a consistent series of guidelines for HHS to follow if complaints are filed against those who must comply with the Health Insurance Portability and Accountability Act of 1996. It also supplies detailed information about what a violation is, as well as appeal rights for covered entities. HIPAA regulations only apply to dental practices that submit or receive electronic transactions, for which HHS has established a standard, either directly or through a vendor or clearinghouse. (Electronic claims are the standard transactions most commonly used by dentists.) Three regulations are already in effect: electronic transactions and code sets, privacy and security.

Included in the enforcement rule is that HHS will "to the extent practicable" seek cooperation from covered entities in reaching compliance.

"HHS's first goal with respect to enforcement is to encourage and promote voluntary compliance with the HIPAA rules, by making various guidance and technical assistance materials available to all covered entities," said Winston A. Wilkinson, director of the HHS's Office for Civil Rights.

Only if HHS's attempts to informally resolve a covered entity's noncompliance are unsuccessful will HHS pursue imposition of civil monetary penalties for violations, according to Mr. Wilkinson, who added, "The enforcement rule sets out the procedures that would be used in such a case." HHS has not imposed civil monetary penalties on any covered entities to date.

The enforcement rule says HHS has the right to conduct compliance reviews to determine whether covered entities are meeting the requirements of the HIPAA regulations. Although compliance reviews have been complaint-driven until now, it is possible that HHS might on its own initiative endeavor to determine if a covered entity is in compliance, according to HHS. Compliance reviews are applicable to all HIPAA regulations, under the enforcement rule.

The enforcement regulations reinforce that covered entities must keep records to document their compliance with the HIPAA regulations. It also holds them liable and subject to civil fines for the actions of staff members acting within the scope of their responsibilities. ■

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For more information related to this story, visit the ADA's Web site, using the Web address above.

HIPAA resources

The ADA offers resources to help members comply with the Health Insurance Portability and Accountability Act of 1996. They are:

- HIPAA Security Kit;
- HIPAA Security Kit e-Book;
- HIPAA Security Seminar DVD;
- HIPAA Security Seminar Video;
- HIPAA Security Update CD.

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Conference

Continued from page seven

tive, having served in the past as a member of the Committee on the New Dentist and currently as a speaker at ADA SUCCESS seminars. The Arizona Dental Association president-elect gave a presentation at the President-Elect's Conference on AzDA's two-year-old Leadership Institute.

"The institute is one way we're fostering leadership in Arizona, by bringing together our component leaders with state council and board members and providing training on aspects of leadership such as facilitating a meeting and motivating volunteers," said Dr. Elliott. "A lot of people in dentistry know how to volunteer but often are unfamiliar with how to work with volunteers, so this has become a valuable tool for our association."

Inviting the presidents-elect to ADA headquarters also gives the ADA an opportunity to familiarize state leaders with national resources and staff members who are here to assist them.

"You should know who to contact when you have a question or a problem," said Dr. Roth. "The presidents-elect need to be in touch with us here, and it is much easier to do that when you can match a name with a face."

"There is so much that goes on at the ADA," added Dr. Sean Benson, president-elect of the Oregon Dental Association. "The conference was an outstanding review of the many services that we as members don't use often enough." ■

Cigarette smokers, root canal association made

BY CRAIG PALMER

New York—A 30-year study finds smokers at greater risk of root canal treatment than nonsmokers, the ADA and American Medical Association reported Feb. 23 at a joint news conference on the relationship of oral and general health.

"We found that cigarette smokers are 70 percent more likely to need root canal treatment than nonsmokers," said Elizabeth Krall Kaye, Ph.D., the study's lead author, an epidemiologist and professor in health policy and health services research at Boston University's Goldman School of Dental Medicine. "No matter what your age, you may need a root canal and as our research shows, smoking increases your risk."

The media conference put a public face on the professional ADA/Colgate "Oral-Systemic Education Campaign" announced in October with coorganization letters offering ADA member dentists and registered dental hygienists resource kits for patient education on the oral-systemic link. The ADA and the AMA partnered in the news conference on "Oral and Systemic Health: Exploring the Connection." Representatives of all three organizations offered opening remarks.

Preterm births and perio, page 12

Dr. Michael Glick, editor of The Journal of the American Dental Association, moderated the event featuring presentations on:

- Periodontal Inflammation and Your Health by Dr. Robert J. Genco, editor, Journal of Periodontology, and distinguished professor, department of oral biology, School of Dental Medicine, State University of New York at Buffalo;
- Periodontal Inflammation: the Sixth Complication of Diabetes Mellitus by Dr. Louis F. Rose, clinical professor of periodontics, University of Pennsylvania School of Dental Medicine, and professor of surgery, Drexel University College of Medicine;
- Oral Infections and Cardiovascular Disease: where do we stand? by Moise Desvarieux, M.D., Ph.D., assistant professor, department of epidemiology, Mailman School of Public Health, Columbia University, and chair of excellence, Institut National de la Sante et de la Recherche Medicale (INSERM), Paris, France;
- Pregnancy Risks Associated with Periodontal Disease by Dr. Steven Offenbacher, OraPharma distinguished professor of periodontal medicine, University of North Carolina, and director, Center for Oral and Systemic Diseases, UNC Chapel Hill School of Dentistry.

Dr. Kaye's "breaking news" reported findings based on data collected in Veterans Affairs Normative Aging and Dental Longitudinal studies at the VA Boston Healthcare System in Boston. With the help of endodontic residents who re-examined dental X-rays taken over a 30-year period in a study of 18,893 teeth, Dr. Kaye identified 998 teeth that had received root canal treatment and related the data to each man's smoking habits.

The research also showed the positive effects of quitting. "The total amount of time smoked and total time they remained smoke-free was directly related to their risk," she said. Since fewer men in the study smoked cigars and pipes, researchers "cannot be absolutely positive" of increased risk of root canal therapy for these smokers.

Further research is necessary to explain why the risk increases for cigarette smokers.

The study will appear in the April issue of the Journal of Dental Research. ■

GKAS resolution OK'd in U.S. Senate

BY CRAIG PALMER

Washington—The U.S. Senate approved with unanimous consent a resolution declaring access to dental care for children "a vital element of overall health care and development."

Dental caries is the most common chronic childhood disease and untreated tooth decay results in thousands of children experiencing poor eating and sleeping patterns, suffering decreased attention spans at school and being unable to smile, the Senate-passed resolution says.

Sen. Stabenow

Offered Feb. 3 by Sen. Debbie Stabenow (D-Mich.) with bipartisan support, the measure congratulates the ADA for sponsoring the fourth annual Give Kids A Smile. Some 500,000 children received dental care from more than 12,000 dentists and 27,000 dental team members at GKAS events. Sens. Norm Coleman (R-Minn.), Thad Cochran (R-Miss.) and Russ Feingold (D-Wis.) cosponsored the resolution.

Sen. Stabenow noted that children from low-income families are three to five times more likely than other children to suffer from untreated dental problems.

Senate Majority Leader Bill Frist (R-Tenn.) asked for unanimous consent and the Senate Feb. 7 agreed to S. Res. 369, which congratulates the American Dental Association for establishing and continuing its sponsorship of the Give Kids A Smile program; emphasizes the need to improve access to dental care for children; and thanks the thousands of dentists, dental hygienists, dental assistants and others who volunteered their time to bring a smile to the faces of hundreds of thousands of children on Feb. 3.

A preamble cites "the generous support of numerous corporations, such as Crest Healthy Smiles, Sullivan-Schein and DEXIS Digital X-ray Systems" for contributing to GKAS success. ■

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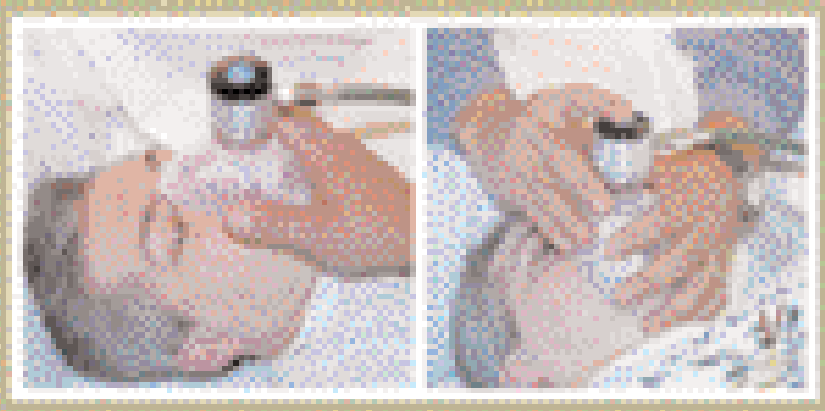

DEMAND VALVE (LEFT): Patient activated valve with breathing RESUSCITATION (↓): The non-rebreathing valve permits it to be used as a resuscitator in conjunction with a manually operated suction bulb/s located on top of the valve.

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Preterm births, perio linked in UNC study

Taking a moment: Drs. Steven Offenbacher (left) and Louis Rose, both presenters at the Feb. 23 media briefing on oral and systemic health, relax during a break. The event marked the first time the ADA and AMA have held a joint media conference.

BY JENNIFER GARVIN

New York—Some adverse pregnancy results can now be directly linked to periodontal disease.

A new study shows that 28.6 percent of women with moderate-to-severe periodontal disease had preterm births (less than 37 weeks) compared to only 11.2 percent of women with healthy gums.

"Our findings indicate that periodontal disease progression during pregnancy contributes to preterm deliveries and especially very preterm deliveries (less than 32 weeks) which places the baby at high risk for neonatal problems and disability," said Dr. Steven Offenbacher, a distinguished professor at the University of North Carolina School of Dentistry who also directs the UNC Center for Oral and Systemic Diseases.

Dr. Offenbacher was a featured speaker at the ADA and American Medical Association's media briefing, "Oral and Systemic Health: Exploring the Connection," held Feb. 23.

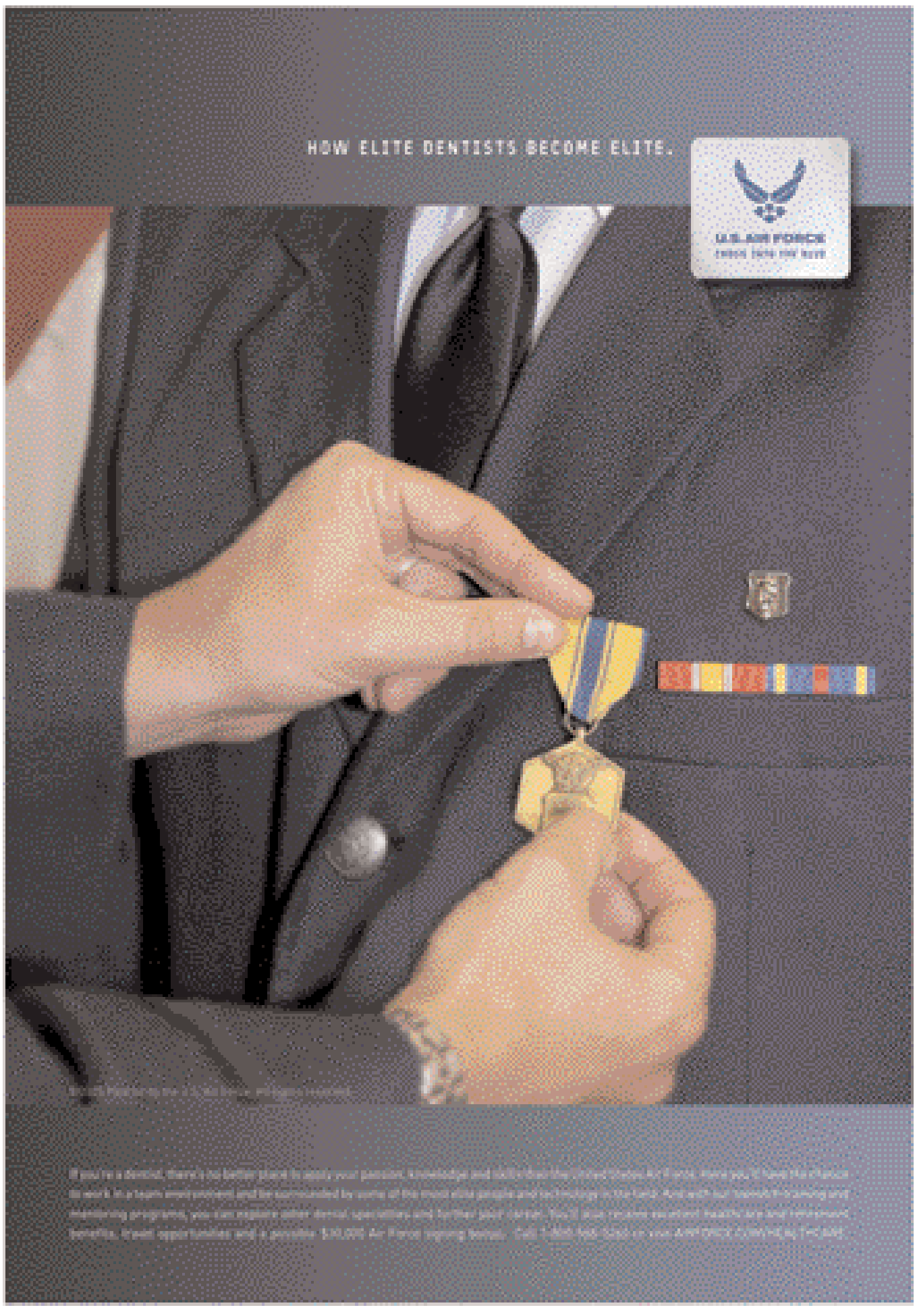
Working with a grant from the National Institute of Dental and Craniofacial Research, Dr. Offenbacher is currently conducting multicentered trials to see if intervention by maternal gum treatment during pregnancy reduces the risk for prematurity and other periodontal disease-related complications.

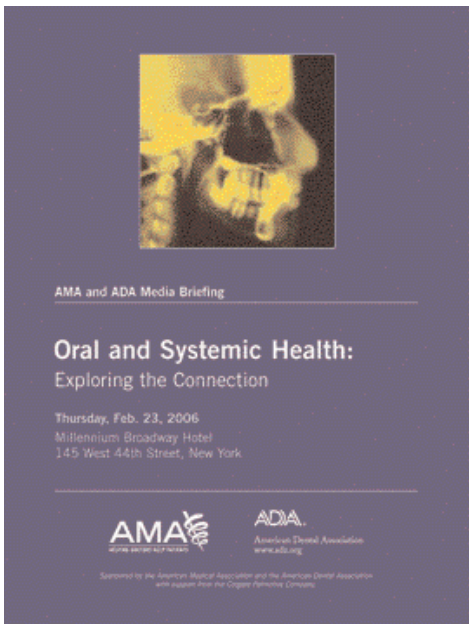
Dr. Offenbacher and his team of researchers recently monitored the dental health of 1,020 pregnant women, who over the course of their pregnancy and after delivery were given comprehensive periodontal exams. The first exams were performed at about 15 weeks, where 58 percent had mild gum problems and 14 percent had moderate-to-severe periodontal disease, he said. Of the women with moderate-to-severe disease, more than a quarter (28.6 percent) had a preterm birth.

"Furthermore, women who had progressing periodontal infection over the course of their pregnancy were nearly 2.5 times more likely to have a very preterm birth compared with women whose infection did not change," Dr. Offenbacher said. "Periodontal progression was a significant risk factor for very preterm deliveries, even after controlling for many traditional risk factors such as race, smoking, other infections and social domain factors.

"Good oral hygiene and regular dental office visits can help in treatment and prevention of periodontal disease," he said. "These results are exciting because periodontal disease represents a new risk factor we may be able to control. If periodontal care is included in the prenatal care of women planning to get pregnant and those who are already pregnant, we know we can safely treat and improve oral health. Studies are now under way to determine whether treating gum disease can also reduce the number of preterm low birth weight deliveries each year and avoid the associated complications."

"This research has some significant implications for dentistry," said Dr. Daniel M. Meyer, associate executive director, ADA Division of Science. "This adds to the growing body of knowledge and evidence that oral health and general health are closely related. The key to this in the future will be new studies to assess how and when dentists should treat patients afflicted with periodontal diseases to minimize the risks associated with bacterial infections and inflammation. Ultimately, dentists in the future may have more prominent roles in general health care teams to help improve not only the health of the mother but her newborn child as well." ■





Systemic

Continued from page one

Trustee Samantha Cramoy, M.D., and Dr. Foti Panagakos, public relations director for Colgate-Palmolive, provided the opening remarks for the historic event, which marked the first time the ADA and AMA have worked together on a media briefing.

The conference, "Oral and Systemic Health: Exploring the Connection," addressed periodontal inflammation, diabetes and periodontal disease, oral infections and cardiovascular risk factors, and pregnancy risks and periodontal disease. Additionally, a new report linking smoking and root canals was discussed.

Dr. Michael Glick, editor of The Journal of the American Dental Association, moderated the conference. About 25 journalists—from media outlets as diverse as abcnews.com, Self magazine, Dentistry Today and Scientific American—attended.

"The biggest question is whether there is a casual relationship or a causal relationship and we don't know," Dr. Glick said. "The closest thing we have is the research from Dr. [Steven] Offenbacher and the evidence suggests that some women may benefit from periodontal intervention in order to minimize adverse pregnancy outcomes."

"This kind of research is life and death," said Dr. Louis F. Rose, a periodontist and physician. "We can't overstate it, but we must inform the public."

Dr. Robert J. Genco, editor of the Journal of Periodontology, began the conference with a presentation on "Periodontal Inflammation and Your Health" and estimated that 80 percent of adult Americans have some form of periodontal disease. He stressed the need for enhanced communication between dentists and physicians to keep patients' risks for heart disease and stroke, premature births, worsening diabetic control and lung infections low.

"The fact that the mouth is connected to the rest of the body is often overlooked," said Dr. Genco, who is a professor of oral biology and microbiology at the State University of New York at Buffalo.

Dr. Rose spoke about the relationship between diabetes and oral health.

"Many of my patients know that their diabetes puts them at a greater risk of heart disease, kidney failure and nerve damage, but they know very little about their risk for periodontal disease and infection," said Dr. Rose, a surgery professor at the Drexel University School of Medicine and a clinical professor of periodontics at the University of Pennsylvania School of Dental Medicine.

Dr. Rose said that although periodontal disease and diabetes differ in their manifestations, both are chronic and appear to have a genetic component.

"The research is astounding," he said, "and points to the same conclusion: the relationship is cyclical. Periodontal disease, if left untreated, will adversely affect a patient's diabetes and vice versa."

Good oral health isn't the only way to combat a risk for heart disease, said Moise Desvarieux, M.D., an epidemiologist and professor at Columbia University's Mailman School of Public Health. Patients must also manage other risk factors for the disease.

"It appears a relationship exists, but we don't know exactly what it is and if it's a causal relationship," Dr. Desvarieux said. "therefore, we can't make recommendations for people with periodontal disease in respect to cardiovascular disease."

Photo by Ted Grudzinski/Courtesy AMA

Dr. Genco: "The fact that the mouth is connected to the rest of the body is often overlooked."

The event was part of the "Oral-Systemic Education Campaign," the ADA's campaign with Colgate announced in October 2005. Other facets of the campaign are set to roll out in the upcoming weeks and months and include an announcement letter to ADA members, a resource kit for dentists and hygienists that contains patient education materials and a tube of Colgate Total, a symposium at the 2006 ADA annual session and a JADA supplement on the oral-systemic connection.

Other speakers included Elizabeth Krall Kaye, Ph.D., director, epidemiology division, department of health policy and health services research, Boston University (See story, page nine.), and Dr. Offenbacher, director, Center for Oral and Systemic Diseases, University of North Carolina School of Dentistry. (See story, page 12.) ■

Association offers resources on oral, systemic health

For information on subject of oral and systemic health, visit "www.ada.org"or call the toll-free number at Ext. 2878.

Additionally online at ADA.org is Science in the News, a feature that the ADA Division of Science prepares on scientific topics in the popular press of concern to the dental profession.

The Web address is "ada.org/prof/resources/topics/science.asp".

Also available are articles from The Journal of the American Dental Association, which can be accessed by going to "www.ada.org/goto/nexextra". ■

OnlineXtra
www.ada.org/goto/newsextra
For more information related to this story, visit the ADA's Web site, using the Web address above.

New Orleans Mission of Mercy

Dental volunteers from 38 states open their hearts, donate care

BY STACIE CROZIER

New Orleans—By the weekend of Feb. 4-5, everything was coming together at New Orleans' Audubon Zoo—hundreds of volunteers, pallets of supplies and truckloads of equipment—in preparation for a six-and-a-half day medical and dental clinic to serve victims of last fall's devastating hurricanes.

On Feb. 4, like many volunteers, Dr. Bob Plage headed to New Orleans for the Remote Area Medical/Mission Of Mercy medical/dental clinic from his home in Wilmington, N.C. He flew with colleague Dr. Keith Taylor of Chapel Hill, N.C., in Dr. Taylor's Cessna.

"We took off in some foul weather and fought a headwind all day trying to get there," Dr. Plage says. "Some 12 hours after leaving my home we arrived in New Orleans. I was not a happy camper at that point. I was glad to have a bed and slept like a log."

Dr. Plage woke on Sunday and started the set-up process. "The heavy work of unloading trucks began by about 8 a.m. and lasted all day, setting up the chairs, lights, tables and supplies. Three of us set up a 10-chair hygiene clinic and that afternoon I became a diesel mechanic."

Dr. Plage says the diesel compressor that would power the dental clinic's equipment had run out of fuel and wouldn't start again. With the help of a zoo mechanic, he says, they bled air out of the line and got the dental clinic's power working again. The clinic had 73 chairs, and dedicated areas for triage, radiography, sterilization, endodontics, oral surgery, restorative work and hygiene.

"As I left the site Sunday night, I still wondered if anyone would show up the next day—you never really know until that day comes," he says.

"When I arrived on Monday morning, the patients were lined up by the hundreds if not thousands," Dr. Plage continues. "After two days of work and bouncing around in an airplane I was having my own pity party."

But a patient named Ella transformed his mood, a women from Baton Rouge who'd lost her home and most of her possessions during Hurricane Katrina.

"She asked me several questions about my family and where I was from. She asked me their names. She said, 'Dr. Bob, I am going to pray for you and each of your children and your wife this week while you are away from home helping us here. God has sent you here to help us and that is the least I can do for you.' She brought tears to my eyes. She set me straight.

Photo by Dr. Ted Sherwin

Bright smiles: Dr. Vince Dougherty, Alexandria, Va., and his patient enjoy a little sunshine on a chilly day.

"You may have watched a lot of television coverage from the Gulf Coast, but when you get tired of seeing it, you can turn it off," he adds. "When you're actually there, you can't tune it out anymore. It becomes a part of you."

By Wednesday, the weather turned unseasonably chilly, and patients waited and received treatment wrapped in blankets while dentists and other volunteers donned parkas, scarves, hats and other cold-weather outerwear in an attempt to fight off the cold, sticking their hands in their pockets to warm them when they weren't gripping chilly dental instruments. During the week, volunteers and patients battled rain and winds that scattered patient napkins and other paper goods and collapsed supply tents. But patients' gratitude and volunteers' enthusiasm remained high throughout the grueling program.

Between Feb. 6 and Feb. 12, some 425 volunteers from 38 states—including 239 dentists—helped provide nearly $2 million worth of dental care to nearly 4,000 individuals. The entire medical and dental health outreach drew about 10,000 patients, making it the largest event of its kind held in the United States.

MOM dental care organizers were able to purchase dental supplies thanks to a $50,000 grant from the ADA Foundation and Ron and Pam Lamb of World Dental Relief donated three pallets

of supplies to the cause. The Salvation Army provided hot chocolate and food for patients and volunteers and the American Red Cross donated some 4,000 blankets to help keep patients in line warm during the chilly days. Henry Schein, a partner with Virginia's MOM Project, took daily orders from organizers and shipped needed supplies overnight every night and preshipped 2,000 pounds of donated supplies via the "Schein Cares" program.

Other partners in the dental program included Virginia Commonwealth University School of Dentistry, the Louisiana State University School of Dentistry, the Virginia Department of Health's Dental Division, which donated 3,000 brushes, floss and toothpaste, and many individuals who helped organize and run the dental clinic event.

"The wonderful feeling of teamwork and accomplishment set in every night when we left and yes, we did feel like we made a difference," says Dr. Plage. "I now have faces to remember when I think of Katrina. It is now very real for me. I will go back again if we have another MOM planned. They sure need us and, as I found out, we need them."

Dr. Plage's story is one of many that volunteers shared with the ADA News. What follows are some accounts by a variety of volunteers who offered to share their experiences and impressions.

Family affair

Dr. Stuart Feintuch of Great Neck, N.Y., remembers the day he learned about the New Orleans MOM. At home with his five children, ages 16-25, he read an article calling for volunteers.

"I told my kids, 'You know, I think I'll go to New Orleans,' and they said, 'Why don't we all go?' "

The Feintuch family, including Benjamin, a junior at State University of New York at Stony Brook School of Dental Medicine; Rachel, a senior at New York University; Michelle, a freshman at NYU; and twin sons Jeremy and Joshua, high school sophomores; spent three days volunteering, from assisting dentists to registering patients to setting up instruments, carrying supplies and escorting patients to treatment areas. They also recorded their experiences with a digital camera and wrote a short summary describing their mission trip. Four of the five aspire to become dentists; the fifth is studying psychology.

"It was an unbelievable experience," Dr. Feintuch says. "The kids are still talking about it all the time and they say it was one of the most rewarding experiences of their lives."

More student stories

Janice Chou, a student in the University of California San Diego Pre-Dental Society, said she chose to participate in the MOM "for a selfish reason: to be able to find something from this experience to use in a personal statement in my application to dental school. However, as soon as I got there, I began to understand that this event was much more than something I can use for an essay—it helped me grow as a person and learn to appreciate everything in life."

Added Ms. Chou, "Every single doctor that I met at the MOM project is such an inspiration to me. I would definitely volunteer my time again, and this event is definitely one of the most rewarding experiences I have ever had in my entire life."

A second-year endodontics resident at the University of Pennsylvania School of Dental Medicine, Dr. Kevin Axx got home from New Orleans just before 18 inches of snow closed the Philadelphia airport.

"I wondered a few times while I was there who was actually getting more out of the experience—me or the patients," Dr. Axx said. "You'd never expect to meet so many dentists, egos checked at the door, and develop a bond over a short period of time."

Planting the seed

Dr. Robert Monsen of Seattle had signed on for the MOM and was telling a friend about his upcoming trip.

"This friend, Phyllis Lichenstein from Eugene, Ore., was very interested in the project. A few years ago she joined the Peace Corps and went to Lithuania but now she is 79. She said she would like to help in some way. She had no dental training but I assured her that there was surely some way she could help out. I gave her the contact information. She arranged her schedule, got her own plane ticket and hotel reservation and went to New Orleans not knowing exactly what she would be doing," he said.

Photos courtesy of the Feintuch family

Family time: Far left, Dr. Stuart Feintuch's children Jeremy, Michelle, Benjamin, Rachel and Joshua pause for a photo after arriving in New Orleans. Left, Rachel Feintuch assists her father with a patient.

Ms. Lichenstein, who helped with sterilization, organized X-ray paperwork and more, "worked the long, stand-up, 10-hour days like all of us, never complaining once about the work or conditions. I think she is to be commended for the work she did and the flexibility she showed to help the group treat so many patients in such an excellent manner."

Every patient has a story

Dr. L. Michael Gouveia, New Bedford, Mass., met many unforgettable patients as a MOM volunteer and got quite a few dinner invitations from grateful patients.

"My first patient claimed that she was the first one in line for registration—arriving at 4 a.m. on

See NEW ORLEANS, page 16

New Orleans

Continued from page 15

day one," he says. "She was a single mother and a state police officer who worked the hurricane. She was forced to place her 6-year-old child with someone headed to the Superdome while she worked the day Katrina hit and it took her 6 weeks to find him again."

Dr. Gouveia says he was moved by a man who asked him to re-cement his bridge. "I found it held tightly in his closed hand—a 4-unit cantilever off of tooth No. 10 replacing Nos. 7, 8 and 9. When I pointed out that it was inadequately supported and would fail again, he said, 'That's OK, Doc, I'll just put it back with Crazy Glue again. You know, sometimes you just have to be creative and I just won't go around snaggle-toothed.'

"I managed to bond it back using composite through the facial window on No. 10 and then fabricated a composite facing for the one missing on tooth No. 7."

Dr. Gouveia's dental assistant hunted down a mirror so the patient could see the final result.

"His wide smile and his most heartfelt thanks were enough to make the entire trip worthwhile."

Photo by Dr. Ted Sherwin

Ready to work: Dr. Charles Johnson, Richmond, Va., and his dental assistant Ignacia Turner pause for a photo while treating a patient.

Local thanks

Still reeling from the effects of hurricane destruction, a local dentist and a state public health official offered praise to MOM volunteers.

"Being from New Orleans, I was very touched that people cared enough to come from all over the country to help my neighbors," said Dr. Wallace Serpas, who also volunteered for the event. "I felt that I needed to go, even if just for one day, to do something, too, and show my appreciation to all of these fine people."

"We here in Louisiana are deeply grateful for the enormous contribution all of you and your colleagues made to the health of our citizens last week in New Orleans," said Erin Brewer, M.D., director, Center for Community Health and medical director, Office of Public Health, for the Louisiana Department of Health and Hospitals. "Thank you for treating our fellow Louisianans with your skills, expertise and compassion. Seeing your tireless support of strangers has been moving and heartwarming to me."

Brrrr

"It was so cold at the end of the week that I wore my Kanuk parka—bought in Montreal to ward off the harsh Canadian winters," says Dr. Reginald Moncrieff, New York City. "It barely kept out the damp of the Mississippi River. The patients had been given colorful blankets to keep them warm in the long lines and during procedures, but as they opened their mouths for us, their breath turned to fog in the chilly air."

"The wind was blowing outside," wrote Dr. Usa Bunnag, of Kensington, Md., after her volunteer experience. "The side of the tent flapped up and down with each gust. The ground was soggy from last night's rain. The roof of the tent was sagging from rainwater. With small holes, water dripped inside the tent and wet everything in its path. We were afraid to touch the roof with fear of causing a downpour. My feet and hands were numb. My body shivered. It was cold to the bones. Not what I had expected.

"No, I was not camping," Dr. Bunnag wrote. "I was down in New Orleans providing dental care for Katrina victims. I was honored to be part of this team."

From tsunami to hurricane

Dr. Bunnag is no stranger to disaster response. She has also made several dental mission trips to Thailand, both before and after the deadly tsunami in 2004, through Smile On Wings, a humanitarian mission organization she founded.

"My experience working in two different disasters in two most opposite countries taught me valuable lessons," she said. "I learned that disaster spares no one: races, classes, genders, countries. I learned that there are so many willing to help and so many needing help."

Photo by Dr. Knox McMillan

Unfazed: A white Bengal tiger at New Orleans' Audubon Zoo loses no sleep while thousands visit for medical and dental care.

No stress

Dr. Ken Davis, Bernardsville, N.J., shares a story about his most memorable patient:

"A 60-something woman, who had lost her home and all her possessions, and who—on top of everything else—buried her husband on the previous Saturday, said that she was happy. I asked why or how she could be happy in view of the fact that her entire life had been turned upside down.

"She looked straight at me and told me that she never knew how much stress was in her life until everything she owned was gone. Now she told me, for the first time she felt free of worry. She said that she realized how much time and energy, not to mention worry, it required to maintain her life. Now she said, Katrina had freed her.

"She looked around and pointed out how all these people were helping her and how the new clothes she was wearing were given to her and how the family she worked for for many years took her in and gave her a place to live. She was free from the things that stressed her and was surrounded by generosity. Her life, she said, finally had meaning.

"When I finished treating her, she gave me a hug and said that she was really, finally happy. I heard in her voice and felt from her arms that she meant it. She, in this case, benefited me more than I her."

For more volunteers' impressions of the New Orleans MOM, log on to the ADA News Today Web site, "www.ada.org/goto/adanews". ■

LSU students say thanks

BY KAREN FOX

Baton Rouge, La.—After extracting teeth from patients at New Orleans' Mission of Mercy program last month, Nick Rauber reflected on the upheaval of his last year in dental school.

The junior class president of the Louisiana State University School of Dentistry is now practicing with fellow students at the school's temporary clinic in Baton Rouge, moved here after flooding from Hurricane Katrina damaged the New Orleans dental school.

"We have much to be thankful for, namely cash donations from the ADA, the Louisiana Dental Association, American Student Dental Association and Delta Dental," said Mr. Rauber. "All the equipment in our new temporary dental clinic here was donated, too."

The ADA Foundation donated $60,000 to the LSU School of Dentistry for disaster recovery in the wake of Hurricane Katrina. Funds helped provide meals for students living in a makeshift dormitory on a cruise ship and gave support to those who lost books and living essentials in the flooding.

Members of the dental industry stepped up, too. Patterson Dental Co. stocked supplies in the mobile dental unit being used by LSU in Monroe, La., Sunstar Butler donated oral care products, and Henry Schein Inc., helped the school establish the clinic in Baton Rouge and donated equipment and supplies.

Gratitude: "Your donation meant so much to us and we wanted to show you our appreciation," wrote David E. Donald, LSU senior class vice president, to the ADA in a card signed by all members of the senior class.

Dr. Eric Hovland, LSU dean, added that significant donations came from the American Dental Education Association, Adec Corp. and Axium, which provided the clinic with electronic record capability.

The dental school will begin to move some of its activities back to New Orleans this fall, said Dr. Hovland. A complete return is expected in the spring of 2007.

For now, students like Mr. Rauber will continue to lend a helping hand where it's needed.

"If there is one thing I've learned this year," he said, "it's how generous people can be." ■

Dental Benefit Trends & Issues

ADA and payers convey concerns, ideas

BY ARLENE FURLONG

Gaps of understanding between the dental profession and the payer industry are nothing new. But Association efforts to bridge those gaps are intensifying.

Dr. Mercer

Dr. Bramson

Dr. Levicki

Mr. Seltenheim

Last month, Dr. James Mercer, chair, Council on Dental Benefit Programs and Dr. James Bramson, ADA executive director, hosted a meeting with leaders of Delta Dental Plans Association at ADA Headquarters in Chicago.

In January, the ADA met with leaders of the National Association of Dental Plans. NADP member companies represent some 67 percent of the estimated 159 million Americans covered by dental insurance plans. DDPA is the coordinating organization for Delta Dental Plans throughout the country.

"As the voice of the dental profession, the ADA is making positive strides in the relationship between dentistry and the dental benefits industry," Dr. Bramson said after the meetings. "Improved communications will lead us to a better understanding of the issues we share in common."

Evidence of relationship building in 2005 included cooperative efforts between the Association and the payer community on Hurricane Katrina relief efforts, industry support for the National Fluoridation Symposium 2005 and participation in the Give Kids A Smile initiative. Additionally, in 2004, the ADA negotiated a unique licensing program with NADP for the use of the Code on Dental Procedures and Nomenclature, assuring that third-party carriers are using the most current and correct version of the code.

Opportunities for two-way communications have resulted in third-party carriers being more receptive to the ADA in areas that concern grassroots members. Helping the industry gain a keener understanding of issues from the perspective of the ADA member is a major focus of the meetings, according to Dr. Mercer.

"It makes sense if we can reach mutually satisfactory resolutions to our problems by working directly with national carrier organizations," Dr. Mercer explained at the meeting. "There's a lot to be gained by working together."

The ADA Council on Dental Benefit Programs maintains a close watch on industry trends, tracks complaints from members and, when appropriate, works with individual companies to seek solutions.

After the February meeting, Dr. George Levicki,

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Benefits

Continued from page 17

DDPA board chair, said, "In-person meetings are always valuable because they allow people sitting on different sides of the table to express their concerns and consider areas of interest for potential collaboration."

The Association discussed with both NADP and DDPA some of the problems and market trends associated with administration of dental benefit claims. Problems encountered by members who report them to the ADA include improper bundling and downcoding, claims delays and denials, X-ray return policies and payment explanations given to patients (explanation of benefit language).

"We're changing a lot of the language so it does not inadvertently impugn the dentist. The language will show benefits are contractual and the dentist is treating under a contract, not doing something wrong if benefits are denied."

Eradication of problematic EOB language that can be confusing to patients by not indicating that benefit limitations are based on patients' dental plan contracts, rather than dental treatment or fees, is moving forward, DDPA's Dr. Max Anderson, dental affairs advisor, said after last month's meeting with ADA leadership.

"We're changing a lot of the language so it does not inadvertently impugn the dentist," Dr. Anderson said. "The language will show benefits are contractual and the dentist is treating under a contract, not doing something wrong if benefits are denied."

The council and NADP are currently working together on a project toward a more standardized process to determine which claims require radiographs—and which ones do not—that the entire industry could agree on.

"This project, if successful, would be a win-win for industry and for every dentist in the United States," said Dr. Mercer. "Right now, because radiograph policies vary so much across the third party industry, radiographs are typically submitted with more frequency than necessary, simply because it is so difficult for dentists to determine which claims for which carriers require them. The ADA applauds NADP for its willingness to work on this project with the ADA."

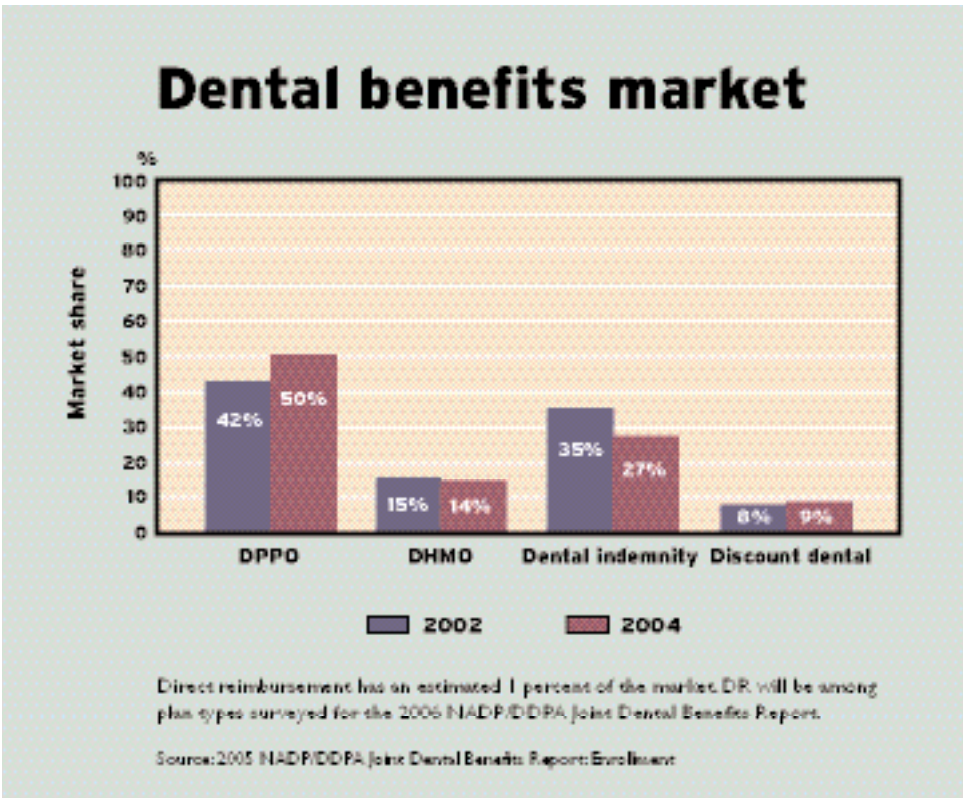
Another area under discussion at the meetings is the definition and use of evidence based dentistry in plan design and claims payment. According to Dr. Daniel M. Meyer, associate executive director, ADA Division of Science, the ADA definition is that EBD is designed to be an approach to oral health care that requires the judicious integration of systematic assessments of clinically relevant scientific evidence, relating to the patient's oral and medical condition and history, with the dentist's clinical expertise and the patient's needs and preferences.

Dr. Anderson said DDPA interests are to formulate policies and practices based on entire populations.

On another front, Jon Seltenheim, chair, NADP board of directors, reported to ADA representatives in January that actual growth in the number of new dental plans being sold has flattened in recent years due to the pressure on employers to deal with the escalating costs of their medical plans.

"Most employers are looking for ways to shift premium costs to employees in order to avoid reducing dental benefits," Mr. Seltenheim told ADA leaders. "They are also seeking managed care plan designs that offer a discount based on a PPO or HMO design."

Dental preferred provider organizations now dominate the market with an estimated 50 percent market share in 2004, up from 42 percent in 2002, according to a 2005 NADP/DDPA joint dental benefits report on enrollment.



"Right now, because radiograph policies vary so much across the third party industry, radiographs are typically submitted with more frequency than necessary, simply because it is so difficult for dentists to determine which claims for which carriers require them."

The survey reveals a continuing trend toward dental PPO plans at the expense of dental health maintenance organizations and dental indemnity plans. Traditional fee-for-service indemnity plans now represent an estimated 27 percent of the market, down from an estimated 35 percent in 2002.

Dental HMOs have 14 percent of the market compared to 15 percent in 2002. Straight discount dental plans, similar to buyers' clubs, are growing and now claim 9 percent of the market. Direct reimbursement has an estimated 1 percent of the market. DR will be among plan types surveyed for the 2006 NADP/DDPA Joint Dental Benefits Report. (See chart, this page.)

Rising medical premiums are also responsible for more consumer-driven health plans, as employers look for ways to curb their medical costs. Higher deductibles are a common characteristic of consumer health plans.

"Consumers will have to make harder choices about where their out-of-pocket dollars go," explained Mr. Seltenheim. "If they have a $1,000 deductible, those dollars could be competing with medical expenditures. They'll be looking at dental as part of their overall out-of-pocket dollars, rather than separate from their medical expenses, and employers' support will go toward benefit choices overall, with dental being just one of them."

He said that what this means in terms of business realities for the dental benefits market are changes in plan design more than changes in the claims adjudication process. And while high deductible plans might discourage consumers from procuring preventive services, newer plan designs won't.

"Patients are going to have to understand the value of regular exams and prevention vs. the possibility of higher expenditures down the road," said Mr. Seltenheim. ■

Dental benefit plan types

• An indemnity plan is a fully insured or self-insured plan where an assigned payment is provided for specific services, regardless of the actual charges made by the provider. Payment may be made to enrollees or, by assignment, directly to dentists.

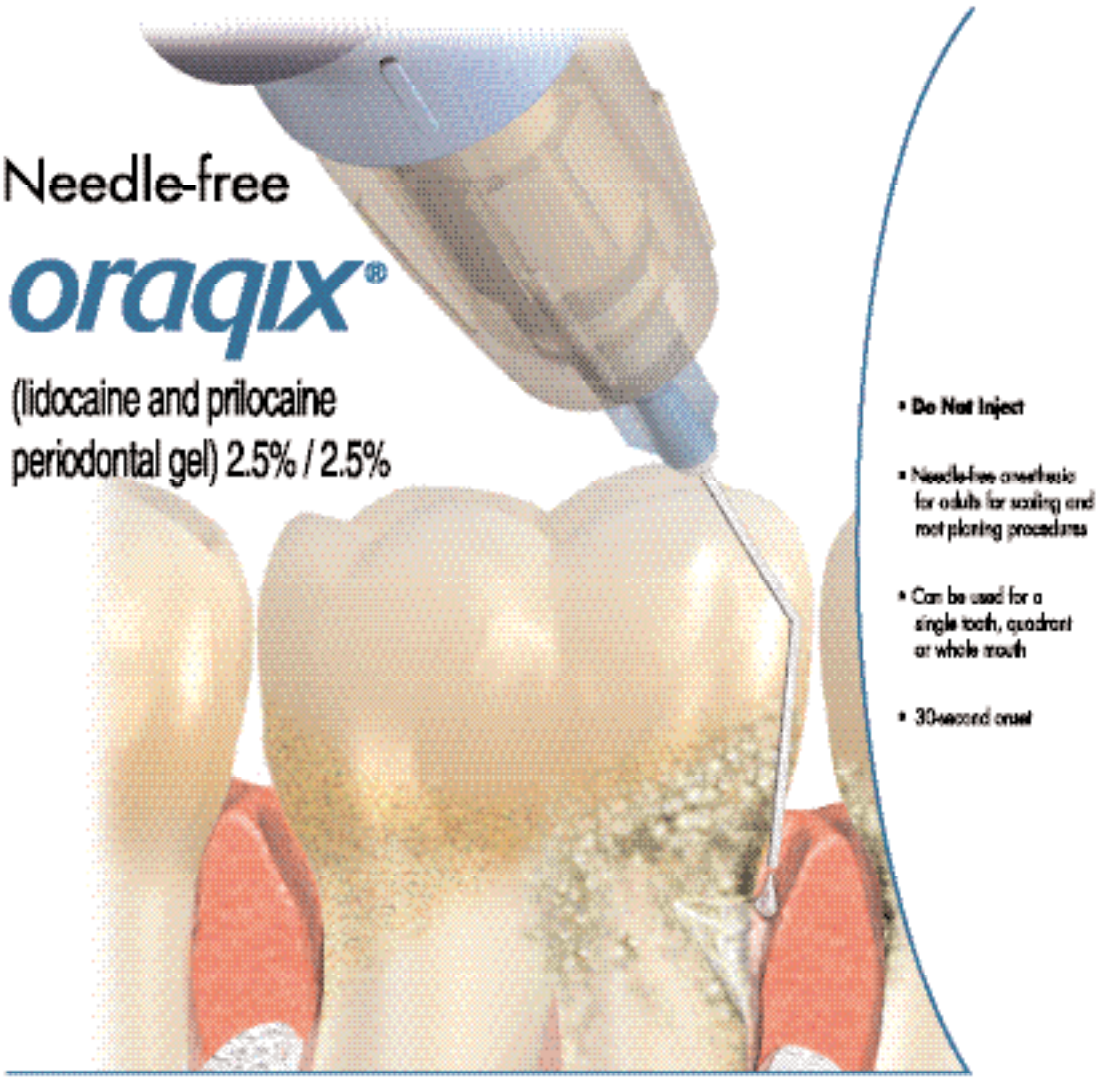
• Preferred provider organization programs are managed care plans under which patients select a dentist from a network or list of providers who have agreed, by contract, to discount their fees.

• Dental health maintenance organization or capitation plans pay contracted dentists a fixed amount (usually on a monthly basis) per enrolled family or individual, regardless of utilization. In return, the dentists agree to provide specific types of treatment to the patient.

• Discount/referral plans are arrangements in which employers direct employees to a limited number of providers who have agreed to discount their normal fees in exchange for the expectation of a larger patient pool. There is no reimbursement to the patient or to the provider.

• Direct reimbursement is a self-funded program in which the individual is reimbursed based on a percentage of dollars spent for dental care provided, and which allows beneficiaries to seek treatment from the dentist of their choice. ■

Needle-free, Patient Friendly Anesthesia for Scaling & Root Planing



Don't Get Stuck Without It!

- Oraqix is a novel formulation of lidocaine and prilocaine that dispenses as a liquid, then sets as a gel at body temperature.
- Oraqix should not be used in those patients with congenital or idiopathic methemoglobinemia.
- Indicated for adults who require localized anesthesia in periodontal pockets during SRP procedures.
- Contraindicated in patients with hypersensitivity to amide type local anesthetics or any other product component.
- Oraqix is applied first to the gingival margin, then periodontal pocket with the use of an Oraqix™ Dispenser and a blunt-tip applicator.
- Most common adverse reactions in clinical studies were application site reactions, headache and taste perversion.

Please see the accompanying brief summary of the prescribing information.

To order or for more information on Oraqix, contact OraPharma at 1.866.273.7846 or visit our website at www.oraqix.com

Manufactured for:

DENTSPLY PHARMACEUTICAL

Distributed by:

ORAPHARMA, INC.

PM-Oraqix-003482 1/06

Local anesthetic for periodontal administration
Not for injection

oraqix®

(lidocaine and prilocaine periodontal gel) 2.5% / 2.5%

Brief Summary of Prescribing Information

INDICATIONS AND USAGE
Oraqix® (lidocaine and prilocaine periodontal gel) 2.5%/2.5% is indicated for adults who require localized anesthesia in periodontal pockets during scaling and/or root planing.

CONTRAINDICATIONS
Oraqix® is contraindicated in patients with hypersensitivity to amide type local anesthetics or to any other product component.

WARNINGS
Prilocaine can cause elevated methemoglobin levels particularly in conjunction with methemoglobin-inducing agents. Methemoglobinemia has been reported in a few cases in association with lidocaine treatment. Patients with glucose-6-phosphate dehydrogenase deficiency or congenital or idiopathic methemoglobinemia are more susceptible to drug-induced methemoglobinemia. Oraqix® should not be used in these patients with congenital or idiopathic methemoglobinemia and in infants under the age of twelve months who are receiving treatment with methemoglobin-inducing agents. Signs and symptoms of methemoglobinemia may be delayed some hours after exposure. Initial signs and symptoms of methemoglobinemia are characterized by a slate-gray cyanosis seen in, e.g., buccal mucosa membranes, lips and nail beds. In severe cases symptoms may include central cyanosis, headache, lethargy, dizziness, fatigue, syncope, dyspnea, CNS depression, seizures, dysrhythmia and shock. Methemoglobinemia should be considered if central cyanosis unresponsive to oxygen therapy occurs, especially if methb-inducing agents have been used. Calculated oxygen saturation and pulse oximetry are inaccurate in the setting of methemoglobinemia. The diagnosis can be confirmed by an elevated methemoglobin level measured with co-oximetry. Normally methb levels are <1%, and cyanosis may not be evident until a level of at least 10% is present. The development of methemoglobinemia is generally dose related. The individual maximum level of methb in blood ranged from 0.8% to 1.7% following administration of the maximum dose of 8.6 g Oraqix®.

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

Patients taking drugs associated with drug-induced methemoglobinemia such as sulfonamides, acetaminophen, acetanilide, aniline dyes, benzocaine, chloroquine, dapsone, naphthalene, nitrates and nitrites, nitrofurantoin, nitroglycerin, nitroprusside, para-aminosalicylic acid, phenacetin, phenobarbital, phenytoin, primaquine, and quinine are also at greater risk for developing methemoglobinemia.

Treatment with Oraqix® should be avoided in patients with any of the above conditions or with a previous history of problems in connection with prilocaine treatment.

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

Allergic and anaphylactic reactions associated with lidocaine or prilocaine can occur. These reactions may be characterized by urticaria, angioedema, bronchospasm, and shock.

Eye contact with Oraqix® should be avoided. Animal studies have demonstrated severe eye irritation. Corneal irritation and potential abrasion may occur. If eye contact occurs, immediately rinse the eye with ster or saline and protect it until normal sensation turns. In addition, the patient should be evaluated r an ophthalmologist.

raqix® should be used with caution in patients with history of drug sensitivities, especially if the etiologic pes is uncertain.

atients with severe hepatic disease, because of their ability to metabolize local anesthetics normally, are t greater risk of developing toxic plasma oncentrations of lidocaine and prilocaine.

formation for Patients: Patients are cautioned to avoid injury to the treated area, or exposure to extreme hot or cold temperatures, until complete ensation has returned.

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

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY
Carcinogenesis - Chronic oral toxicity studies of o-toluidine, a metabolite of prilocaine, have shown that this compound is a carcinogen in both mice and rats. The tumors associated with o-toluidine included hepatocellular adenoma/carcinoma in female mice, multiple occurrences of hemangiosarcoma/hemangioma in both sexes of mice, carcinoma of multiple organs, transitional-cell carcinomas/papillomas of urinary bladder in both sexes of rats, subcutaneous fibromas/fibrosarcomas and mesotheliomas in male rats, and mammary gland fibroadenomas/ adenomas in female rats. These findings were observed at the lowest tested dose of 150 mg/kg/day or greater over two years (estimated daily exposures in mice and rats were approximately 8 and 12 times, respectively, the estimated exposure to o-toluidine at the maximum recommended human dose of 8.6g of Oraqix® gel on a mg/m2 basis).

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

USE IN PREGNANCY
Teratogenic Effects: Pregnancy Category B
Treatment of rabbits with 15 mg/kg (180 mg/m2) produced evidence of maternal toxicity and evidence of delayed fetal development, including a non-significant decrease in fetal weight (7%) and an increase in minor skeletal anomalies (skull and sternebral defects, reduced ossification of the phalanges). The effects of lidocaine and prilocaine on post-natal development was examined in rats treated for 8 months with 10 or 30 mg/kg, s.c. lidocaine or prilocaine (60 mg/m2 and 180 mg/m2 on a body surface area basis, respectively) up to 1.4-fold the maximum recommended exposure for a single procedure). The dose period encompassed 3 mating periods. Both doses of either drug significantly reduced the average number of pups per litter surviving until weaning of offspring from the first 2 mating periods. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, Oraqix® should be used during pregnancy only if the benefits outweigh the risks.

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

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

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

ADVERSE REACTIONS
In clinical studies, the most common adverse reactions are application site reaction (including pain, soreness, irritation, numbness, ulcerations, vesicles, edema, abscess and/or redness), headache and taste perversion.

Rx only
For more detailed information, consult your DENTSPLY Pharmaceutical representative and read the full Prescribing Information.

Manufactured by Recip AS for DENTSPLY Pharmaceutical, York, PA 17404

Form No. PM-Oraqix-PI-0501 Rev 11/04

DENTSPLY PHARMACEUTICAL