5-15-2006

ADA News - 05/15/2006

American Dental Association, Publishing Division

National provider ID, page seven ◆ Soda in schools, pages 14, 15

AMERICAN DENTAL ASSOCIATION WWW.ADA.ORG

ADA NEWS®

MAY 15, 2006 VOLUME 37 NO. 10

New dental team member proposed

Plan addresses access to care, needs of underserved

BY JAMES BERRY

A proposal calling for a new member of the dental team was presented in April to the Board of Trustees as "an innovative answer" from the ADA to the problem of access to care. The proposal will be included in a report to the House of Delegates this fall.

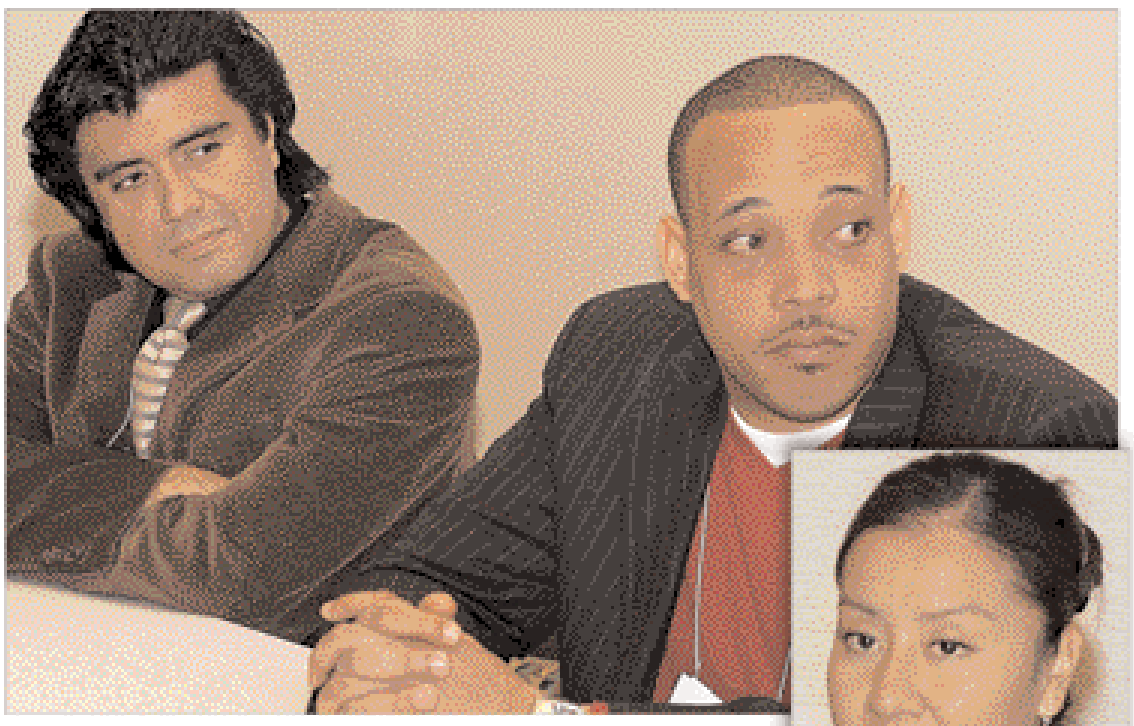
Developed in response to a resolution adopted by last year's House (96H-2005), the proposal details the duties, "core competencies" and training of a Community Dental Health Coordinator who would aid dentists and other dental team members in bringing care to the needy in remote and underserved areas.

■ ADA launches online CE program, page 22

"The Community Dental Health Coordinator would work under a dentist's supervision as an adjunct to the existing dental team," said ADA President Bob Brandjord, who appointed the six-member committee that developed the CDHC proposal.

He added, "The CDHC will connect with federally qualified health centers and community groups like senior citizen centers and school boards to promote dental health, particularly in remote areas or urban environments. This is an innovative answer from the ADA to the problems of underserved populations and underserved parts of our country."

See DENTAL TEAM, page 12



Perspective: DezBaa A. Damon (inset), president of the Society of American Indian Dentists' student chapter, offers insight into diversity in dental schools at the ADA's April 26 Outreach Forum: Increasing Diversity in the Dental Profession. Listening are Drs. Jose-Luis Ruiz (left) and George Jenkins, 2004 and 2006 Institutes for Diversity in Leadership, respectively. Full coverage of the meeting is on page nine.

Forum leader: Dr. Peter Robinson chairs the ADA Ad-Hoc Committee on Diversity to Attract Qualified Underrepresented Minorities Into Dentistry.

BRIEFS

Summer schedule:

The Association will close early three afternoons this summer before holidays:

• The ADA will close at 1 p.m. CDT on Friday, May 26, for Memorial Day weekend. The Association will open again for regular hours on Tuesday, May 30.

• The second early closing will be at 1 p.m. CDT on Friday, June 30, prior to the Independence Day holiday.

The ADA will open again for regular hours on Wednesday, July 5.

• The third and final early closing for the summer will be at 1 p.m. Friday, Sept. 1, for the Labor Day Holiday.

The Association will resume regular hours on Tuesday, Sept. 5.

The Association's official hours of operation are 8:30 a.m.-5 p.m. Central Time, Monday through Friday.

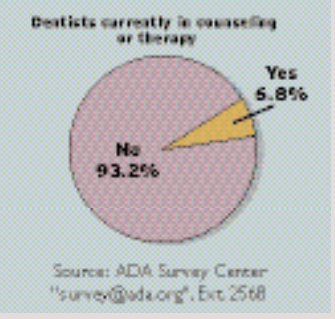
To minimize any inconvenience, the ADA encourages members to contact ADA staff in advance so requests can be accommodated prior to the early closing. Members can continue to access the Association through ADA.org.

And while the ADA Catalog sales team will also observe this first of three summer holidays, the e-catalog is available online 24 hours a day at "www.adacatalog.org". ■

JUST THE FACTS

Dentist Well-Being

Of dentists currently in therapy, 59.1 percent were in individual therapy and 35.2 percent were in marital/couples therapy.



Protecting the environment

ADA Best Management Practices brochure updated

BY JENNIFER GARVIN

Sultan SultanHealthcareInc.

Environmental awareness is a big topic for everyone these days—not just those in the dental profession—and by doing their part in reducing amalgam discharge, dentists can help contribute to a cleaner environment.

Inside this issue of the ADA News (between pages eight and nine) you'll find an updated brochure, Best Management Practices For Amalgam Waste. In addition to the brochure, a 10-minute DVD can be ordered online. Both the brochure and the DVD are being made available through an educational grant from Sultan Healthcare Inc. The video can be ordered on Sultan's Web site, "www.sultanhealthcare.com".

The ADA believes that reducing amalgam in wastewater discharge is one of the best ways to make dental offices environmentally friendly.

"It seemed very natural for an oral health organization like the ADA to work together on wastewater issues with other health care professionals who share similar ideas on voluntary initiatives to help improve the environment we

See BMP, page eight

■ Globalization series continues on page 18 with a look at offshore dental laboratory regulations

Special Care Dentistry meets in June

Special Care Dentistry Association will hold its 18th Annual Meeting of Special Care Dentistry June 7-11 at the Hyatt Regency Chicago.

This year's theme is "The Future of Special Care Dentistry—Confluence of Evidence-based Policy, Practice, Research and Education." Register today at "www.SCDonline.org".

Hear from dental experts, third party vendors and current residents about best practices for providing the care your patients deserve, and learn about the industry's most recent developments. The program will feature a keynote presentation entitled "The Role of Media in Special Care Dentistry," by Dr. Linda C. Niessen.

Come a day early and maximize your meeting experience—attend a pre-conference seminar June 8 from 8 a.m.-4 p.m. SCD is proud to announce a full-day seminar on mobile dentistry, among other options. The cost for the session is $199 per person for each full-day seminar and $99 per person for each half-day seminar.

Visit "www.SCDonline.org" for more program information. You can also register and make your hotel reservations online. ■

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Government

ADA urges legislators to abandon anti-amalgam bill

BY CRAIG PALMER

Washington—The American Dental Association urged cosponsors of anti-amalgam legislation pending in the U.S. Congress to withdraw their support on the basis of new findings from peer-reviewed research.

"The results of these studies support the American Dental Association's long-held position that dental amalgam is a safe and effective restorative option for patients and their dentists in treating dental decay," ADA President Robert M. Brandjord said in a "Dear Representative" letter to the 16 cosponsors of the bill. "It is my hope that based on the results of these very credible studies, you will consider removing your name as a cosponsor of HR 4011."

Dentist/Rep. Charlie Norwood (R-Ga.) said in a related "Dear Colleague" letter to all members of the House of Representatives, "Once again, science has demonstrated dental amalgam to be safe and effective." Citing the newly published research, he called on colleagues to dismiss the position of "certain outlier groups" who believe dental amalgam is dangerous. Dr. Norwood was a private practice dentist for 25 years before his 1994 election to Congress.

"My position has always been that criticism of a standard health care treatment option should be firmly based on sound science," Rep. Norwood said.

Two studies published in the April 19 Journal of the American Medical Association and supported by the National Institute of Dental and Craniofacial Research, one of the National Institutes of Health, measured whether children with dental amalgam fillings experienced any adverse effects related to neurobehavioral, neuropsychological (IQ) and kidney function.

"They found that there was no difference in neurological performance and kidney function in children who have amalgam fillings compared to a control group with composite (white) fillings," said the letter signed by Dr. Brandjord, the ADA president. "These two studies add to the substantial body of peer-reviewed scientific literature that already exists on this subject, supporting the continued use of dental amalgam as a restorative material. They also highlight that the minute amount of mercury released by amalgams, during such common activities as eating and drinking, does not affect one's health adversely. Most important, both studies support the continued use of dental amalgam as an important treatment option."

The ADA letter to HR 4011 cosponsors included attachments with additional information on the studies. The April 19 letter, an ADA press statement and a general news media report on the research are posted at "www.ada.org/goto/advocacy".

See the Library of Congress online legislative service ("thomas.loc.gov") for information on HR 4011 including the bill text. ■

HR 4011 sponsors listed

Washington—Rep. Diane Watson (D-Calif.) introduced legislation to prohibit after 2008 the introduction into interstate commerce of mercury intended for use in a dental filling. HR 4011 was referred to the House Energy and Commerce Committee. No hearings have been held.

The 14 Democrats and two Republicans listed as cosponsors May 1 were Reps. Tammy Baldwin (D-Wis.), Robert Brady (D-Pa.), Dan Burton (R-Ind.), Ben Chandler (D-Ky.), William Lacy Clay (D-Mo.), Elijah Cummings (D-Md.), Jo Ann Davis (R-Va.), Peter DeFazio (D-Ore.), Raul Grijalva (D-Ariz.), Michael Michaud (D-Me.), James Moran (D-Va.), Grace Napolitano (D-Calif.), Major Owens (D-N.Y.), Donald Payne (D-N.J.), Loretta Sanchez (D-Calif.) and Edolphus Towns (D-N.Y.). ■

ViewPoint

MyView

CE is good business

Marvin Greene, D.D.S.

In today's economy, we must use and incorporate new, sound business practices to succeed. Continuing education is a powerful and necessary tool to achieve this end. Enhanced profitability, better patient care, improved communication, scientific advances and increased marketability are just a few of the benefits we can attain through CE.

Traditionally, much of dental school tutelage focused on clinical techniques and expertise. In a volatile and changing marketplace, this is not enough. In addition to practicing our craft to the most professional level, we must excel on other fronts. We must also be a businessperson, psychologist, communicator and healer. CE can equip us with the needed tools to achieve these ends and more.

Like in other businesses, profitability doesn't occur by accident. Dentistry requires sound business acumen. Large corporations make large profits on small margins. CE courses can teach us essential business principles to increase profits.

Courses on newer techniques and materials enable the practitioner to offer his or her patients cutting-edge technology. I am always amazed by the huge variability in services and procedures from practice to practice. The most successful ones incorporate the latest proven advances.

At a recent dental meeting, I was greatly impressed by the current state-of-the-art in-office three-dimensional facial scanning. As a result, our practice has incorporated this technology. We have greatly improved diagnoses and treatment. Implant planning has risen to a new level. Anatomy we used to only guess at is now visible in the office. Sinus problems, facial pain, trauma, lesions and inferior alveolar nerve localizations are seen much more clearly. Accuracy is attainable to the nearest 0.01 mm.

Practice management seminars help us to increase the bottom line. Communication skills, staff maximization and phone techniques are just three of the many benefits gained from practice management courses and consultants. Better communication results in better care, which results in happier patients and increased profit. Communication is our biggest ally in averting problems and litigation. Disgruntled patients are those with whom we have not communicated, nor have we heard their concerns. They leave our practices and we never bother to ask why.

Our office instituted new phone answering techniques as a result of a practice management course. We are currently enrolled in an extensive, hands-on phone certification process. The phone is our lifeblood, the hub of our business. Patients must be communicated with in an honest, open, caring, accommodating and entrepreneurial way. Consistent office policies must be adhered to. We have to serve, but we also need to increase our business in order to survive. Practice management programs have been a great investment in our practice.

Increased marketability results from sound business principles, better care and communications-focused initiatives, as well as interacting with your peers. CE courses enable fellow practitioners—locally, nationally and internationally—to interact on similar business issues and dilemmas. Sales representatives who are

See MY VIEW, page five

LettersPolicy

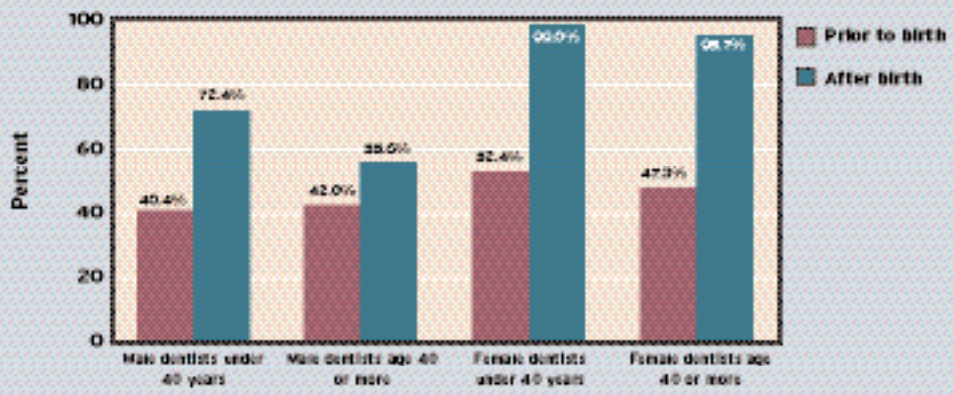
ADA News reserves the right to edit all communications and requires that all letters be signed. The views expressed are those of the letter writer and do not necessarily reflect the opinions or official policies of the Association or its subsidiaries. ADA readers are invited to contribute their views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

SNAPSHOTS OF AMERICAN DENTISTRY

Dental practice

Female dentists are more likely to take time off prior to and after the birth of a child than male dentists. More than half of female dentists under age 40 take some time off before the birth of a child (52 percent). Less than half (47.3 percent) of female dentists age 40 or older take time off.

Percentage of dentists who take time off for birth of child by gender within age group



Source: American Dental Association, Survey Center, 2003 Dentist Well-Being Survey

Letters

Under attack

Attacks on the dental profession occur with regularity. Now more than ever these brazen assertions are appearing at an increased rate, such as America Online's March 23 posting of "The 10 Things Your Dentist Doesn't Want You To Know" ("Article Under Fire From ADA," April 3 ADA News).

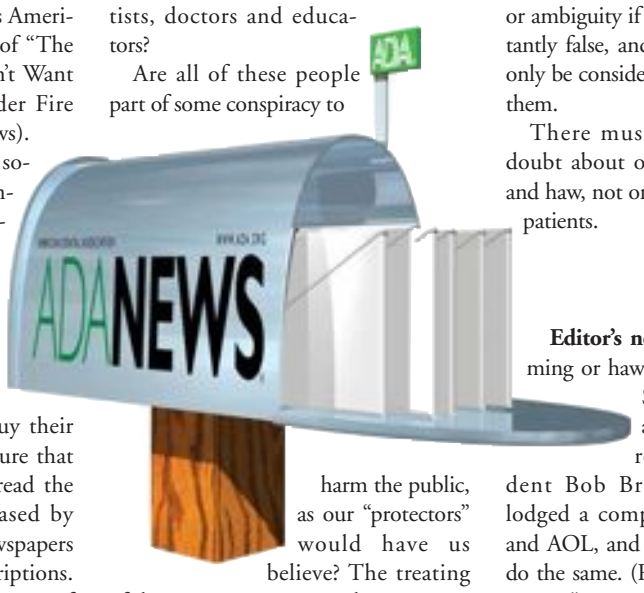
There is a proliferation of so-called experts who take advantage of fear, ignorance and cynicism to gain a hearing from an unsuspecting public, and their opinions are given validity by that same public. Who are these people?

Are they altruists who sincerely want to help? If you buy their books or products you can figure that one out. Or more insidious, read the "public service" articles released by periodicals, magazines and newspapers anxious to sell ever more subscriptions.

In creating an environment of doubt, these "benefactors" can easily exploit the situation to show that they are the benevolent guardians of our rights. It is absolutely correct to find out as much as possible about products and procedures that can affect us.

We must also learn as much as possible about the people who give us the information to help us with our decisions. We place an enormous trust in them, and so they must earn that trust. Why should we blindly take the word of someone who produces testimonials against years—maybe decades—of painstaking trials, studies and experience from established scientists, doctors and educators?

Are all of these people part of some conspiracy to harm the public, as our "protectors" would have us believe? The treating of their assertions as equivalent to scientific evidence is dangerous. The tragedy is that they are not exposed for what they are, and if there is something close to a conspiracy, then it is an ignorant media who supports them.



Where are we to go when we can't trust the very organizations that are supposed to enlighten us? Do we really believe everything we read in the Sunday papers? To say "we need more studies" begs the question. We have the studies. Let them produce their studies. Prove it!

Dentistry needs to present a consistent confident posture. Our responses need to be presented without question or ambiguity if what is being said is blatantly false, and that the assertions will only be considered when they can prove them.

There must not be the slightest doubt about our position. If we hem and haw, not only are we lost, so are our patients.

Lawrence Mogen, D.D.S.
Massapequa, N.Y.

Editor's note: There was no hemming or hawing when it came to the Smart Money magazine article that Dr. Mogen references. ADA President Bob Brandjord immediately lodged a complaint to Smart Money and AOL, and encouraged members to do the same. (Read Dr. Brandjord's letter at "www.ada.org/prof/resources/topics/amalgam_smartmoney_brandjord.pdf".) AOL has since agreed to post an ADA response to the article, which was being drafted as of press time.

The Association shares Dr. Mogen's concerns with the credibility of consumer health information. Because consumers are increasingly searching the Internet for health information, the

See LETTERS, page five

Letters

Continued from page four

May issue of The Journal of the American Dental Association included a patient page on "Evaluating Oral Health Information on the Internet," which also has links to Web sites of credible health information sources like the ADA, the Centers for Disease Control and Prevention and more. Members are encouraged to distribute this page to patients and share its content in communications with the public.

Smart Money

I read with interest Dr. Bob Brandjord's reply regarding the Smart Money article "The 10 Things Your Dentist Doesn't Want You to Know." Although I agree with the content of his reply, I disagree with the philosophy behind it. Dentists are forever defending themselves against third parties such as insurance companies and the press regarding errant information given to dental patients.

It is time for the philosophy among dentists to change. In contemplating all the health professions, only dentistry goes above the call of duty to educate patients about their oral health care needs, to the point of exterminating the need for our services. In return, patients question us and believe articles like Smart Money's and the replies of insurance companies which undermine the dentist-patient relationship.

Patients are trained to think only that which their insurance company covers is what they can have done—rather than seeing the insurance company as "assisting" them in obtaining total oral health care, which means they must invest in their own oral health care. Articles like that in Smart Money need a succinct reply and then it must be left for the patients to decide. Who are they going to believe? Their dental professional, some sensationalist journalist or their insurance carrier?

As dentists, we know the average cavity will result in need for endodontic therapy rather than a simple restoration, and that gingivitis we have been monitoring will result in their periodontal condition worsening resulting in more costly therapy or loss of teeth. We have as a profession long established the need for dental exams and prophylaxis twice per year. It would be the patient's responsibility both ethically and financially for following the advice of a nondentist.

It is time the consumer takes on the responsibility for their dental care regarding evaluating the information, regarding the truth.

When was the last time a patient let a journalist or insurance carrier decide for them what kind of car, boat or home they desired?

James A. Parenti, D.D.S.
Erie, Pa.

Politicians

Dr. Harriet Seldin's naivete is showing through in her editorial, "It's a Cautionary Tale" (March 20 ADA News). She attempts to make a comparison of ethical behavior between congresspeople, especially her congressman, and the dental profession. There's no comparison.

The dental profession has a relatively stringent code of ethics and a strong peer review process at the state and local levels. Most elected officials are generally characterized by moral ambivalence and self-serving ambition with very loose and broad ethical constraints.

Typically, politicians avoid all the tough problems requiring courage and basically take the politically safe approach. Holding public office gives one a sense of power, compounded by citizen adulation and idolatry.

Finally, what Dr. Seldin needs to know is that elected officials (especially her congressman) are not unethical because they accept gifts; they accept gifts because they are unethical.

Robert D. Helmholdt, D.D.S.
Fort Lauderdale, Fla.

Soda in schools

I am an ADA member and would appreciate your passing on my congratulations to Dr. Jonathan D. Shenkin, who appeared in an article by Craig Palmer ("Soda In Schools: IOM Panel Hears Dentist," March 20 ADA News).

Dr. Shenkin exhibited considerable courage in making his presentation before the school nutrition study panel and his arguments were lucid and compelling. I hope he will continue this good work.

Victor Bradford, D.M.D.
Colorado Springs, Colo.

Editor's note: Dr. Shenkin's testimony was provided on behalf of the state of Maine, notes the ADA Council on Access, Prevention and Interprofessional Relations, and now there's more good news to report. An agreement reached by beverage distributors and health advocates May 3 means that millions of students will no longer be able to buy non-diet sodas in public schools. See story, page 14.

Alaska

I support the ADA's lawsuit against the Alaska Native Tribal Health Consortium to halt the delivery of dental treatment to underserved Native Alaskans by dental health aide therapists.

While I concede that access to dental care issues pervade many areas (not just rural Alaska), attempts to fill these voids by allowing irreversible treatment to be performed by unsupervised and unlicensed nondentists is not only a direct threat to the patients being treated, but a threat to the legitimacy of an earned dental degree from an accredited institution.

I ask advocates of the DHAT program, would their support be as vociferous if suddenly medical health aide therapists were created, allowing for emergency medical care? If not, why not? Is it a perceived discrepancy in level of risk between medical and dental care? It is likely that these same patients have medical access issues as well as dental.

Nevertheless, much of the opposition to the ADA lawsuit is well-intentioned; that is, some care is better than no care. But is that necessarily true? One of the principles of the ADA Code of Ethics is nonmaleficence, do no harm. But irreversible dental care by nondentists will certainly lead at some point to significant harm.

Ask my seasoned oral surgeon about complications developing from an otherwise "easy extraction." Speaking as an endodontist, the mechanics of dentistry is oftentimes the simplest part of the job. Making an accurate diagnosis, distinguishing a suspicious lesion or managing a medical crisis is usually the greater challenge. Putting this authority in the hands of DHATs as they treat an unwitting populace is unconscionable. How will we justify, legally and ethically, a major physical deficit—possibly death (heaven forbid)—resulting from the mistreatment by a DHAT?

As a profession, for the ADA not to initiate a lawsuit would be an injustice to the Native Alaskans being treated. As individual dentists, we must express unified and robust opposition to the DHAT program. To not do so, we find ourselves culpable of maleficence by proxy.

Eric Weinstock, D.M.D., J.D.
Course Director
Ethics and Professionalism in Dentistry
Tufts University School of Dental Medicine
Canton, Mass.

DHATs

I've been an Alaska resident for 33 years, also a licensed practicing dentist. For years Alaska residents have watched the misrepresentations and lies concerning resource development in Alaska as reported by the lower 48 press. Now the incorrect information concerning dentistry in Alaska and the dental health aide therapist program is in the ADA News (April 17 issue).

I would like to give my opinions based on 33 years of dental practice and as past president and peer review member of the Alaska Dental Society.

First, there is not a dentist shortage in Alaska. According to the Institute of Social and Economic Research University of Alaska (March 2006), there are 58 dentists per 100,000 populations in the lower 48. Alaska has 126 dentists per 100,000 populations. Obviously, with more than twice the number of dentists per 100,000 populations in Alaska than the lower 48, there is no manpower shortage. Since the number of dentists in Alaska is not the problem; what is the problem?

The main culprit increasing the problem is the U.S. government, not dentistry. In the 1970s the U.S. Public Health Service had contracts with private dentists to go into villages and treat the dental needs. Then in the 1980s, the private sector dentists were told that they were no longer needed and Public Health Service would take care of the native needs as mandated by the U.S. Congress. We all know what has happened in the villages as far as dental care is concerned.

The reason the DHAT program was promoted in bush villages is money. The government was looking for a cheap way out and the Alaskan Natives, with their millions of dollars in profits in their native corporations, didn't want to spend the money on dental care. It was easy for the government to convince some native leaders that local kids could be trained to be junior dentists in New Zealand and it would be good for the native communities under native control.

Historically, the U.S. government has treated the aboriginal peoples of North America as second-class citizens. The DHAT program is an extension of that centuries-old policy. You can bet the government wouldn't open up a clinic in Kalamazoo, Mich., manned by DHATs to treat non-aboriginal Medicare and Medicaid patients.

It is true, that because of the proximity of the native villages, dental offices cannot exist, but neither can Wal-Marts or theater houses. It is just a matter of money and who's going to pay for proper dental care, or going to Wal-Mart and the theater in Anchorage.

The majority of dentists in Alaska believe Alaska Natives are residents of the state of Alaska, thus U.S. residents, and deserve the right to have access to the same standard of care that nonnatives have access to. The state of Alaska, with the ADA, should also be suing the U.S. government for denying our sovereign state right to control who provides dental treatment to our residents. Perhaps the other 49 state governments should join the suit against the U.S. government to help protect Alaska's sovereign state right from U.S. government infringement; they could be next.

The ADA is taking the high road and fighting for equal quality of care for all Americans.

Phillip L. Locker Jr., D.D.S.
Anchorage, Alaska

Editor's note: The ADA Legal Division adds that the Alaska Dental Society and the ADA filed suit against the Alaska Native Tribal Health Consortium asking for a determination that the state dental practice act is applicable to dental health aide therapists.

Fluoridation

I have been a practicing dentist for 43 years and, together with my senior colleagues, I am gladdened when I reflect on the thousands of people that I have professionally helped. Now, I must go public with an issue that may make me a pariah amongst my fellow members of organized dentistry.

The adage "You don't know what you don't know" applies to the ADA's applause to organized dentistry's victory in having the Vermont electorate reject an end to community fluoridation ("Vermont Victories," March 20 ADA News). All long-term studies on the potential deleterious effect of fluoride are flawed because we do not have, as yet, sufficiently sophisticated tools to distinguish and separate the insidious causes of long-term premature degeneration in an aged population. In our mobile and diverse society, the problem in defining the causes of human tissue degeneration are too complex and interwoven to even be able to establish sufficiently similar societal groups to which long-term (lifetime) research can be relied upon.

Lead and asbestos were part of our homes and environment for a very long time before statistical evidence incriminated them. The Red Cross contributed to the popularity of cigarettes by their free distribution to our Doughboys in World War I. Those and other substances that poisoned our bodies ultimately created epidemics of diseases for which individuals and society are paying a heavy price.

There can be little doubt that fluoride reduces the incidence of dental decay. Consequently, fluoridation of public water has been promoted by organized dentistry since I was a dental student. However, eliminating sugar would not only reduce, but probably eliminate, dental decay without the long-term negative potential of introducing a known toxin, fluorine, into our frail body chemistry systems.

It is possible to treat lead in our bodies through a high ingestion of vitamin C as an antidote, converting it into lead ascorbate for elimination. However, society has not taken such a repeated antidote route. So why do we keep promoting public water fluoridation if all we have to do is reduce sugar, as we did with lead?

How can you know if a life is shortened by 10 years, or if body resistance to cancer or cardiovascular diseases is curtailed by a chronic build-up of a toxin?

Why have we spent so many decades promoting a legal forced ingestion of a known toxin on communities while not using our organizational strength to legally challenge the use of the known cause of caries? As an ADA member, I would be

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MyView

Continued from page four

often present can be quite helpful. I've picked up many pearls from others attending CE seminars.

Keeping up with scientific advances is another benefit of CE. At a recent course, I learned much about tissue engineering or regenerative medicine. Huge advances are being made with adult stem cells, which are derived from bone marrow instead of embryonically.

Wounds have been closed, new tissues generated and surgical defects filled successfully in animal models. Adult stem cells can differentiate into bone, cartilage, muscle, fat and nerve tissue. This likely will lead to new cures and treatments that were never deemed possible.

CE is necessary for license renewal. The Illinois Department of Financial and Professional Regulation requires 32 hours every two years. If a dentist has an anesthesia permit, an additional four hours are needed. A dental hygienist requires 24 hours of continuing education as well as a CPR certification.

With the help of continuing education, we become better business people. We are more directed and discriminatory in how we practice. This in turn leads to increased personal satisfaction. Satisfaction at work makes it fun and profitable. CE is good business.

Dr. Greene is a regular columnist in CDS Review, the journal of the Chicago Dental Society. His comments, reprinted here with permission, originally appeared in the January/February issue of that publication.

Letters

Continued from page five

embarrassed to find that our hierarchy (the good guys) was intimidated by taking on the sugar industry.

For those who are not persuaded by my observation, there is always the route of prescription fluoride or fluoride added to bottled water. Government should not mandate the addition of any substance to public waters until medicine can run reliable lifetime double blind studies for certifiable similar large groups of people. Remember the Hippocratic oath: "Do no harm."

Robert Dubman, D.D.S.
Scotch Plains, N.J.

More on fluoride

I am a general dentist in Monroe, Washington. I prescribe, recommend and utilize an array of fluoride containing products for my patients. Fluoride use has been a great service to hundreds, if not thousands of individuals who have visited my practice over the past 29 years. Those who choose are able to utilize fluoride supplementation at home both topically and systemically.

I do not, however, support those in my profession who medicate without consent and that includes placing fluoride in public water that supplies individuals who may choose to benefit from fluoride in another manner. There are plenty of sources of fluoride in our society. Coercive use in public systems should not be one of them.

Richard L. Lowell, D.D.S.
Monroe, Wash.

Editor's note: The ADA's policies supporting community water fluoridation are based on the overwhelming weight of peer-reviewed, credible scientific evidence, which over the past 60 years has established that the fluoridation of community water supplies is safe and effective in preventing dental decay in both children and adults. In fact, the Centers for Disease Control and Prevention has proclaimed community water fluoridation as one of 10 great public health achievements of the 20th century along with other public health measures such as vaccinations and infectious disease control. In reviewing the legal aspects of fluoridation, the courts have ruled that fluoridation is not a medication and is a proper means of furthering public health and welfare. Water that has been fortified with fluoride is similar to fortifying salt with iodine, milk with vitamin D and orange juice with vitamin C. For additional information on community water fluoridation, including the ADA's responses to recent news coverage, visit "www.ada.org/goto/fluoride".

Media relations

What an honor it was to attend the American Medical Association's recent Media Communications Conference in Phoenix. I enjoyed nothing short of a first-class experience, interacting with a combination of nearly 200 of the finest ADA and AMA spokespersons as well as some of the most highly respected medical reporters and educators in the country.

I first learned about this conference just a couple of months ago when a short announcement appeared in our ADA News ("Medical Messages," Feb. 6 ADA News). I want to thank the ADA and the AMA for offering me the opportunity to attend. With research now available regarding the potential connection between periodontal disease and systemic disease, there has never been a more important time for our professions to join together in bringing responsible medical reporting to the American public. Because of this conference, I am more equipped than ever to do just that.

The passion, vision and integrity that we shared to "get the story right" and present our message effectively was refreshing and inspiring. I encourage any of our ADA members who have an interest in media relations to plan to attend the 2007 AMA Media Communications Conference in San Antonio, Texas.

Lisa Marie Samaha, D.D.S.
Newport News, Va.

Don't belong to the ADA? Try benefits of membership by attending ADA annual session at a reduced rate

Las Vegas—Are you a dentist who would like to test drive some of the benefits of ADA membership that 153,000 ADA members already enjoy?

Register for the 2006 ADA annual session and participate in continuing education programs, meet member dentists and see first hand how membership in the premier organization representing the dental profession can enhance your professional and personal life.

The ADA is offering dentists who are not yet members an opportunity to attend annual session at a reduced rate—the fee for dentists who do not belong to the ADA has been reduced from $750 to $75. (Dentists can only take advantage of this offer one time, so those who attended the 2005 annual session at the reduced rate are not eligible.)

In 2005, the first time the ADA made this opportunity available, more than 800 dentists took advantage of it—and 101 of those participants, nearly 13 percent, have joined.

For information or to register, go to ADA.org or call 1-312-440-2388 to receive an Annual Session Preview, including registration materials. ■

It's time to apply for a national provider identifier

BY ARLENE FURLONG

Dentists who want to avoid disruptions in claim payments next year can apply for a national provider identifier now.

The NPI is a unique, standard identification number for health care providers. Its use will be required on HIPAA standard transactions. The most common HIPAA standard electronic transactions used by dentists are electronic claims and eligibility inquiries.

This does not include stand-alone fax machines or voice communications via telephone.

The 10-digit NPI number will replace the current provider identification information used—usually called legacy identifiers. Legacy identifiers can be dental plan-specific identifiers, license numbers and Social Security numbers.

Like other regulations under the Health Insurance Portability and Accountability Act of 1996 (electronic transactions, privacy and security), the NPI applies to all health care providers and provider organizations that transmit HIPAA standard electronic transactions—either directly or through a vendor or clearinghouse.

Those required by federal law to include NPIs on electronic transactions must do so by no later than May 23, 2007. Enforcement will come under the supervision of the Department of Health and Human Service's Centers for Medicare & Medicaid Services.

Importantly, even dentists who do not use any HIPAA standard electronic transactions may encounter health plans that require an NPI on paper claims, according to the ADA Department of Dental Informatics. In addition, state laws could require dentists to obtain NPIs even if they are not HIPAA covered entities. Minnesota already does this. For these reasons, the ADA is encouraging all dentists to consider obtaining an NPI.

"Since the provider identifier is at the heart of the billing and claims payment process for every covered entity, successful implementation of the NPI and its use in internal systems and external transactions will be important for continued reimbursement," says Jean Narcisi, director of the ADA Department of Dental Informatics. "The NPI represents not only a new identifier, but may require practice management systems changes in many dental offices."

Dental informatics specialists believe the NPI has many advantages over identifiers now in use:

- Providers, including dentists, will not have to maintain multiple, arbitrary identifiers required by dental plans, nor remember which number to use with which plan;
- Electronic claims function more efficiently by introducing another element of standardization to processing;
- The NPI contains no vital intelligence about the provider's name, location, specialty, patients or qualifications.

The ADA Department of Dental Informatics suggests that dentists begin identifying key partners who will need their NPI information. This means any business that needs an NPI from a dentist or dental practice to facilitate payment of benefits and/or delivery of health care. These include, but are not limited to dental plans, clearinghouses, systems vendors, billing services and other health care providers. Laboratories and pharmacists should also be included in the health care provider category.

After identifying key partners, dentists can request their dental practice management system vendors to update their systems to include the NPI and conduct tests to ensure that each dental plan is receiving the necessary information to process claims efficiently. Dentists who submit electronic claims to a clearinghouse can ask if the clearinghouse is conducting NPI tests in preparation of the May 23, 2007, compliance deadline. In addition, the clearinghouse may need legacy identifier information in order to support the transition to the NPI. Look to future issues of ADA News for updates on NPI testing, implementation. ■

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

How to apply for your NPI

Applying for an NPI is free and easy to do, according to the ADA Department of Dental Informatics staff, which estimates the process typically takes 20-30 minutes. After receiving confirmation of receipt, dentists can expect to receive an NPI via e-mail in one to five business days. Processing of paper applications and NPI receipt from the U.S. Postal Service takes about 20 business days. NPI applicants' data is collected by the National Plan and Provider Enumeration System, which also distributes NPIs to applicants.

Dentists can visit "https://nppes.cms.hhs.gov" to submit an application. For help with the process, go to "https://nppes.cms.hhs.gov/NPPES/Help.do" or e-mail "customerservice@npienumerator.com" or call 1-800-465-3203. Note: If you get to the NPPES Web site and it is down for updates and maintenance, do not be discouraged, as it is rarely down for more than two days. For more information from ADA.org, go to "www.ada.org/goto/npi". Questions, comments or concerns may be directed to "NPI@ada.org". Those without e-mail or members who would prefer to talk to a staff member may call the ADA directly and ask for Ext. 4608. ■

Grant winners will review EBD literature

With a goal of integrating and consolidating existing scientific research relating to evidence-based dentistry, the ADA Foundation has awarded $100,000 in grants to three proposals for review and consolidation of available dental literature.

Applicants were selected to complete systematic literature reviews that examine four specific clinical questions developed in cooperation with the ADA Council on Scientific Affairs. Grant winners include:

• Boston University Goldman School of Dental Medicine, which will cover the question: "At what frequency is dental prophylaxis effective in preventing periodontitis in individuals with and without known risk factors?"

• University of Washington School of Dentistry, Department of Orthodontics, which will address the question: "Does correcting malocclusion in children and adults reduce the risk of periodontal disease?"

• Loma Linda University School of Dentistry and the University of California Los Angeles School of Dentistry, which will examine the questions: "What are the clinical, biological, psychosocial and/or economic outcomes of treating a pulpally involved (periodontally sound) single tooth through: endodontic care, extraction and implant placement, fixed partial denture and/or extraction without implant placement?" and "What are the longitudinal beneficial and harmful effects of endodontic services compared to extraction and implant placement?"

ADA | FOUNDATION
American Dental Association Foundation

Evidence-based dentistry is defined by the ADA as 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 treatment needs and preferences. The ADA's 2004 EBD symposium identified the clinical questions that would benefit from a systematic review of the best available evidence. Representatives from 37 associations, specialty groups, research organizations, insurance carriers and government agencies participated. Before the symposium, the ADA also surveyed more than 5,000 general practitioners and specialists to learn which clinically relevant diagnostic and treatment procedures required systematic analyses to determine their levels of scientific support.

Grant recipients will complete their projects by April 2007. ■

BMP

Continued from page one

all work and live in," said Dr. Dan Meyer, associate executive director, ADA Division of Science.

Commented Carey Lyons, Sultan executive vice president, "As a dental company, we have long made the issue of amalgam waste a priority. We are gratified to collaborate with the ADA on this environmentally responsible effort to encourage the adoption of BMPs. This approach makes good sense for dentists as professionals, as citizens and as business owners."

Clay Mickel, associate executive director, ADA Division of Communications and Corporate Relations, said, "We're grateful to Sultan for their help in bringing this important message to our members. The dental industry and the profession have a long history of working together at every level to ensure that Americans get the best quality oral care. The support of BMPs is one way to show that we're also working together for a cleaner environment."

The BMPs for Amalgam Waste Management were first published by the ADA in 2004. The Association developed them as a tool for the dental community to voluntarily integrate environmentally conscious practices and procedures into their daily routine.

If dentists cannot achieve reduction in amalgam discharge, regulators may insist on mandatory controls such as requiring dentists by law to install amalgam separators or pay for the testing of their office wastewater discharge to see if the mercury levels are below a predetermined threshold and if they are achieving a certain level of mercury in the wastewater.

The ADA believes it is important for dentists to voluntarily follow the BMPs to demonstrate to regulators and legislators that they are willing to do their share to protect the environment.

The brochure includes a list of dos and don'ts for the dental practitioner on the handling of amalgam waste. For instance, dentists are advised to use precapsulated alloys, stock a variety of capsule sizes and avoid using bulk mercury. They also are advised to salvage, store and recycle scrap amalgam and not put used disposable amalgam in biohazard containers, infectious waste containers or regular garbage.

There also is a step-by-step list on how to recycle amalgam waste and a list of questions to ask a recycler. "The ADA recommends that you contact a recycler before recovering amalgam and ask directly about any specific handling instructions the recycler may have," the brochure reads.

For an online version of the BMPs for Amalgam Waste, visit "www.ada.org/goto/amalgambmp".

A limited number of BMP videos originally were produced in collaboration with the Naval Institute for Dental and Biomedical Research and funded by the ADA and Environmental Protection Agency. The new Sultan funding enables members to order their own individual copy. ■

Education

Getting results

Forum looks at ways to boost numbers of underrepresented minorities in dental profession

BY KAREN FOX

Change was the central focus of the ADA's April 26 Outreach Forum: Increasing Diversity in the Dental Profession.

Several promising models for recruiting underrepresented minorities into dental careers and helping them succeed were highlighted at the meeting.

"We're committed to changing the profile of practicing dentists to better reflect the overall population of the United States," said Dr. Peter Robinson, chair of the ADA Council on Dental Education and Licensure's Ad-Hoc Committee on Diversity to Attract Qualified Underrepresented Minorities Into Dentistry.

Cosponsored by the divisions of Membership and Education, the forum included representatives from 10 state and local dental societies seeking guidance on initiatives to increase recruitment of minority dental students. The program's focus was to stimulate practical programs that can be implemented by dental societies and individual dentists.

Presenters included experts from the Robert Wood Johnson Foundation, the American Dental Education Association, ADA Institute for Diversity in Leadership, Student Hispanic Dental Association, Student National Dental Association, the Student Society of American Indian Dentists and American Student Dental Association.

"As evidenced by the initiatives at the forum, we're finally getting some traction," said Dr. Robinson. "It won't happen overnight, but we have a lot of committed people involved and some excellent plans."

Data presented at the forum showed a high correlation between dentists' race/ethnicity and the race/ethnicity of the majority of their patients.

"We don't know all the reasons for this, but there is ample evidence that black dentists treat a much higher percentage of black patients and Hispanic dentists treat a much higher percentage of Hispanic patients," said Dr. Robinson. "Part of the answer is where practices are located, and that there is a tendency for black dentists and Hispanic dentists to open their practices in areas that are more accessible to people of color."

Currently, 61 percent of black dentists' patients are black and 76 percent of white dentists' patients are white, Dr. Jeanne Sinkford, director of ADEA's Center for Equity and Diversity, told the forum.

"We know that the percentage of the population that is white in the United States is declining while the percentages that are black and Hispanic are growing," said Dr. Sinkford. "This shift necessitates growth in minority dental school admissions."

Statistics confirm there is wide variability regarding the number of dentists per 100,000 population, both geographically and from the standpoint of racial/ethnic background. For example, data from the ADA Health Policy Resource Center and U.S. Census show a dentist-to-population ratio around 74 dentists per 100,000 population for states including New Jersey, Massachusetts, Hawaii and New York, while the ratio for states including Mississippi, Arkansas, North Carolina, Nevada and New Mexico is in the 35-40 dentists per 100,000 range.

When looking at how well dentistry mirrors the population as a whole, data reveals an overall ratio of 54.1 dentists per 100,000 population.

Dr. Sinkford: Demographics in this country are changing.

When looking just at white dentists and white population, the ratio is similar: 55.3 per 100,000. For dentists and populations of minority racial/ethnic background, the data shows 113 Asian dentists per 100,000 Asian people, 11.5 Hispanic dentists per 100,000 Hispanic people, 12 American Indian dentists per 100,000 American Indian people and 15.1 African-American dentists per 100,000 African-American people.

To equalize the dentist-to-population ratio for underrepresented minorities, it would require 13,830 more African-American dentists to enter the profession, 16,383 more Hispanic dentists and 925 more American Indian dentists.

What steps are needed to increase the number of minorities in the profession? Forum participants recognized it's a complicated issue but there were opportunities for many to contribute positively to the outcome. Speakers unveiled large- and small-scale initiatives, and considered ways to institutionalize these efforts for lasting effect. (See story, this page.)

"There are a lot of qualified underrepresented minority candidates," said Dr. Howard L. Bailit, a professor at the University of Connecticut Health Center and co-director of the Pipeline, Profession and Practice: Community-Based Dental Education Program. "But these students need to be identified early in their college careers, counseled on how to prepare for dental school and provided with enrichment opportunities."

In 2002, the Robert Wood Johnson Foundation and California Endowment began the five-year Pipeline initiative in which 15 dental schools received grant monies to establish clinical rotations for students and residents in community clinics that provide care to underserved populations and increase the number of underrepresented minority and low-income students.

To increase diversity, the Pipeline schools developed programs to educate college-based pre-professional health advisors about careers in dentistry, recruitment materials, and expanded summer enrichment and post-baccalaureate programs.

The efforts have proven successful—almost all participating schools have significantly increased minority student enrollment, and in four schools, minorities now comprise 20 percent or more of the first-year class. These four schools are perhaps the toughest academically, said Dr. Bailit.

"It shows what can be done if schools have the will and management capabilities to get the job done," he added.

One, the University of Connecticut School of Dental Medicine, went from a minority enrollment of 5 to 7 percent to well over 20 percent. Student rotations in community clinics are also influencing the career choices of students, said Dr. Robinson, who is also dean of the Connecticut dental school.

"Ninety percent of our students go into advanced programs when they graduate, and this year a full 10 percent are going to community clinics where the majority of patients are of color," said Dr. Robinson. "All of the students are white. They have such a sense of responsibility—it's phenomenal. If we didn't have the Pipeline program, they wouldn't even know about career opportunities in community clinics."

"We got into the Pipeline program as an access issue but became concerned about equality," said Judith Stavisky, senior program officer of the Robert Wood Johnson Foundation.

Through its early research of minority dental students, the RWJF found that "early and frequent exposure to dentists and dentistry is important to minority dental students," said Ms. Stavisky. Without mentors or outreach programs, minority college students often found themselves isolated from other pre-dental students.

"As a result, they didn't know about the application process, recommended undergraduate coursework, resources available, debt load," she said. "Few knew about funding opportunities and thought loans were the only possibility to finance education."

Added Ms. Stavisky: "We have to be more intentional about outreach and show young minority college students that dental careers are possible."

Last year the Robert Wood Johnson Foundation granted additional funding to nine dental schools for Summer Medical and Dental Education Programs. Administered by ADEA and the Association of American Medical Colleges, SMDEP enables dental and medical schools to provide six-week enrichment programs for freshman and sophomore college students in an effort to create a more diverse workforce.

"The number of students applying to dental schools has gone up 30 percent in recent years, along with higher grade point averages and dental admissions test scores," said Dr. David Brunson, associate director of the ADEA Center for Equity and Diversity. "Summer enrichment programs give schools ways to look at students outside the application process."

The program also provides help with the admissions process and study skills, and can often be a significant confidence boost.

The ADA pledged its support for the SMDEP program by sponsoring $25,000 in travel scholarships for scholars. Almost all the positions are filled for this summer. However, there are still some predental spaces at Case Western Reserve University, University of Louisville, University of Nebraska Medical Center and the University of Medicine and Dentistry of New Jersey. (Do you know a good candidate for one of these summer programs? Contact Dr. Brunson at "brunsond@adea.org".)

With the Pipeline program due to conclude in about a year, Ms. Stavisky is confident that changes implemented will be long lasting.

"We're trying to relieve access problems now and lay the groundwork for the future," she said. "It's important to get these program changes inculcated into the culture of dental schools."

The ADA Council on Dental Education and Licensure and Council on Membership cosponsored the Outreach Forum.

Next steps include developing a list of action items for the CDEL to consider pursuing with all stakeholders in 2006-07.

"We need to distribute materials and have a network and portfolio of best practices available," said Dr. Robinson. "So if a dental school or dental society wants to really commit itself to doing this they have something to use."

This year's annual session in Las Vegas will also feature a half-day program on developing minority outreach activities. Watch for more information on that program in upcoming issues of the ADA News. ■

Students, Institute grads, dental society rep talk about what works

BY KAREN FOX

Dental student leaders and members and graduates of the ADA Institute for Diversity in Leadership shared their unique experiences as underrepresented minorities and mentors at the April 26 Outreach Forum: Increasing Diversity in the Dental Profession.

As a child, Dr. George Jenkins had a dentist who encouraged his interest in dentistry. Growing up in the inner city of Newark, N.J., "I got cues early on that education was the way out." Now, as director of the office of multicultural affairs at the University of Medicine and Dentistry of New Jersey/New Jersey Dental School, Dr. Jenkins seeks ways to mentor youth in his hometown.

"We need to increase underrepresented minority students but face difficult challenges here," said Dr. Jenkins, including a high dropout rate among minority high school students. "All too often kids are not interested in pursuing college, then we come along and try to hit them with dentistry, and it's not always realistic."

For his personal leadership project for the ADA Institute for Diversity in Leadership, Dr. Jenkins is working with a new magnet high school in Newark to share information on dental careers and give students the tools and study habits needed to achieve their goals.

Dr. Jose-Luis Ruiz, a member of the inaugural class of the ADA Institute for Diversity in Leadership, credits the Institute with making one of his long-time goals a reality.

Through his faculty post at the University of Southern California School of Dentistry, Dr. Ruiz founded "USC Latinos for Dental Careers," aiming to increase the number of Hispanic dentists and hygienists in Southern California to better serve this growing population.

"I know now that anything is possible," said Dr. Ruiz. "Our next step is to secure funds for scholarships for some of these students."

Dr. Cedric Takeo Lewis of the 2005 ADA Institute for Diversity in Leadership began his career working in a community health center in Hawaii. "The kids who come to the center for care do not reflect dentists in Hawaii, so they have no one to look to as a mentor," said Dr. Lewis, who launched a career mentoring pro-

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What works

Continued from page nine

gram for high school students in a small community outside Honolulu for his Institute leadership project.

"We received 100 applications for the summer mentorship program," said Dr. Lewis. "We talked about careers, how to be a dentist, learned some dental terminology, dental anatomy, basic techniques, tooth preparations and talked about scholarship opportunities. Scholarships are often the biggest challenges."

His initiative was rewarding on many levels. "These kids are just so touched that professional people reach out to them and are truly interested in them," he said after the first year of the program.

Dr. Lewis: "The kids who come to the center for care do not reflect dentists in Hawaii, so they have no one to look to as a mentor."

Michelle Cunningham, director of communications for the Metro Denver Dental Society, shared information on the MDDS' successful Explorer Post program, forged through a partnership with the national Learning for Life Health Careers Exploring initiative. The program matches students with a particular career interest to local sponsoring organizations like MDDS, which then offers programs in dental offices and laboratories.

"We've grown to 37 this year, which is modest growth over time, but some of these students travel two hours to get there," said Ms. Cunningham. "These are not kids whose parents are dentists."

Passionate mentors are key, she added. "Our dentist leader grew up poor and eventually got a job working in a dental office, then pursued a career in dentistry and became an orthodontist," said Ms. Cunningham. "Her perspective shows kids there are ways to do this."

When he came to the University of North Carolina School of Dentistry, Dr. Damon Ross felt his classmates were perhaps better prepared for dental education.

"Histology came up, and everyone was talking about what they knew about histology, classes they had taken," said the 2006 UNC graduate and member of the ADA Council on Dental Education and Licensure's Ad-Hoc Committee on Diversity to Attract Qualified Underrepresented Minorities Into Dentistry. Dr. Ross earned his undergraduate degree at an historically black college and university. "I knew that I didn't have the opportunity to learn the same things my fellow classmates had learned."

As president of the Student National Dental Association, Dr. Ross sought ways to help students in the historically black colleges and universities system prepare for dental careers. He told advisors at HBCUs about recommended coursework and summer enrichment like the health careers opportunity program he completed in 2001.

The SNDA also offers a program called Impressions, where college and pre-dental students are invited to dental schools for guest speakers, financial aid lectures, typodont exercises and mock interview sessions.

Dr. Peter Robinson, chair of the ad-hoc committee, hailed Impressions for its peer mentoring.

"Interaction between dental students and college students is so much more meaningful than me going out there to talk to them about dental careers," said Dr. Robinson. "College students look at them and think, 'I could be like that person.' "

This summer, the Student National Dental Association is sponsoring a basketball fundraiser in Nashville where dental students from the North compete against those from the South. Proceeds go to a scholarship fund with half donated to the Boys and Girls Clubs.

Dr. Jessica Figueroa, a 2006 graduate of the New York University College of Dentistry, president of the Student Hispanic Dental Association and an ad-hoc committee member, coordinates programs that help Hispanic high school and college students pursue dental careers. Dr. Figueroa advised the forum attendees to provide financial aid counseling for minority students, as financing dental education "is very daunting."

"People wonder, 'What if I don't succeed? What if I don't graduate?' " she said. "They need people to support them. Their parents are often afraid of failure, too, and reluctant to consider the options available to them."

DezBaa Damon, a third-year dental student at the A.T. Still University, Arizona School of Dentistry and Oral Health, is president of the Society of American Indian Dentists-ASDOH chapter, and also a member of the ADA ad-hoc committee.

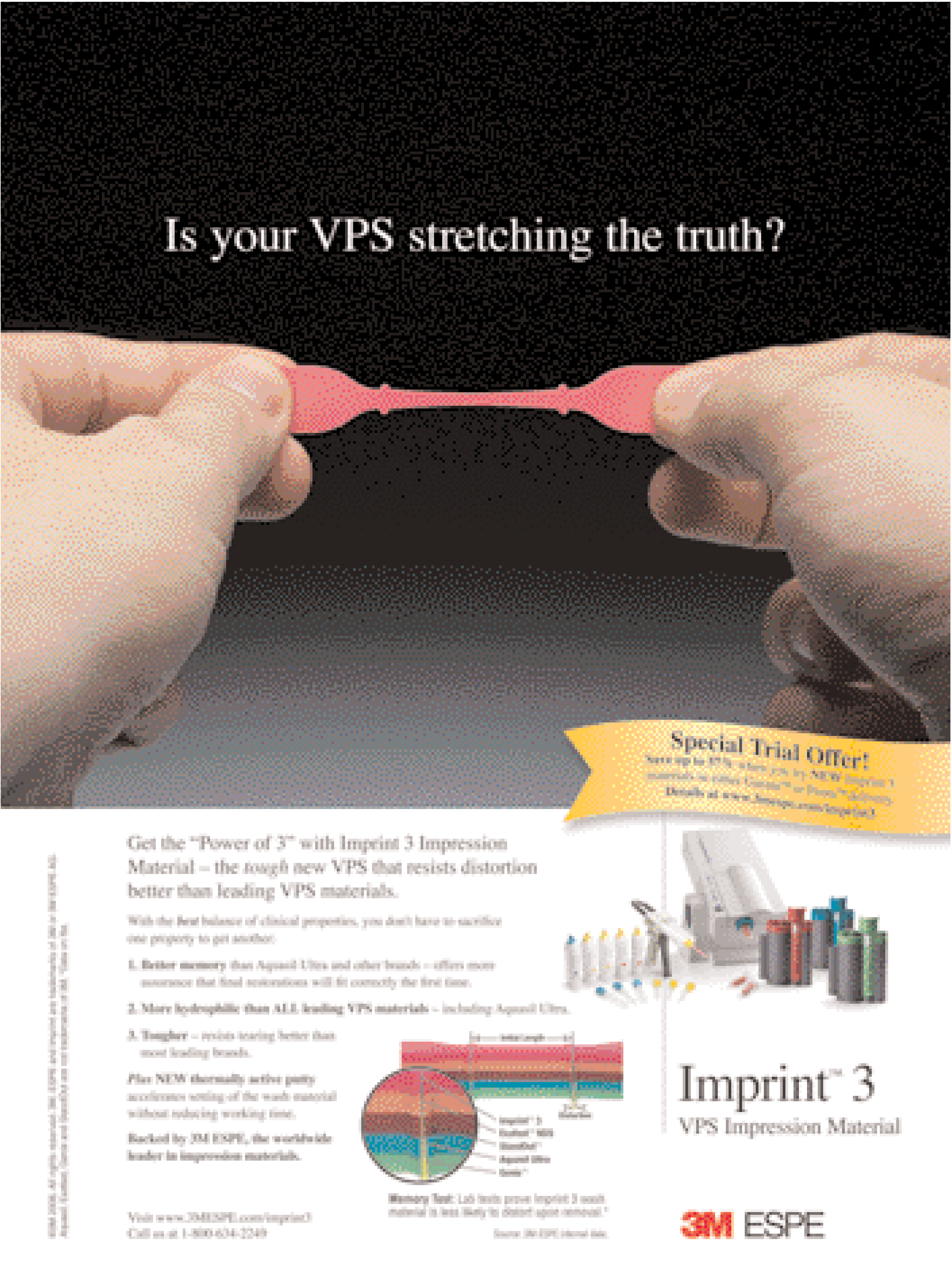
SAID-ASDOH has held tours of the dental school and lectures for interested pre-dental students and career fairs for high school and college students. "Currently we are developing a CD that would help American Indian students in preparing and applying to dental school," said Ms. Damon. "There are many ADA and ADEA resources available, and we are making this information much more focused on American Indians."

Ms. Damon is an active role model for youth thanks to people like Dr. George Blue Spruce, president of the Society of American Indian Dentists and a fellow ADA ad-hoc committee member.

"SAID has always been available as a resource for pre-dental and dental students, hygienists, assistants and dentists," she said. "Many pre-dental students are now contacting us for help in applying to dental school."

"This is only the beginning of what can be done," Dr. Marsha Butler, vice president of global and professional relations for Colgate-Palmolive Co., and ad-hoc committee member, said of the forum's presenters. "Obviously these young people are off to a good start and we have to catch up."

Noel Bishop, Connecticut State Dental Association executive director, added: "This is an excellent program. I only wish all the state executive directors could be here today to listen to this." ■



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Dental team

Continued from page one

Chaired by Dr. Perry K. Tuneberg, ADA 8th District trustee, the 96H committee is working in tandem with a larger Workforce Task Force charged to explore other staffing and dental care delivery issues. The task force will be sending a report to this year's House. More about that in the weeks ahead.

CDHCs most likely would be trained in dental schools, community colleges with existing dental hygiene and dental assisting programs, hospitals or community health centers.

Length of training may vary depending on how didactic and clinical instruction is delivered. Providing lectures through self-paced modules on the Internet will be encouraged.

Dr. Brandjord

Dr. Tuneberg

In addition to their work with community groups, CDHCs would "complement" the services provided by the current dental team by addressing "acute dental needs" and "freeing up the dentist, dental assistant and dental hygienist to concentrate on providing more definitive dental treatment," said Dr. Tuneberg.

The emphasis, he said, is on "guarding the public safety" while responding effectively to need.

In its report, endorsed by the Board of Trustees and the Workforce Task Force, the 96H committee notes that CDHCs would be "responsible for promoting oral health through organized and dental coordinated community-based promotion and prevention programs."

Working in underserved communities with a dentist's supervision, this new dental team member "will enable the existing dental workforce to expand its reach deep into underserved communities and influence local health and community organizations to adopt initiatives to promote oral health," the report says.

The committee identified seven core competencies of a CDHC, spelling them out in greater detail than limited space permits here:

1. The CDHC must be competent in the development and implementation of community-based oral health prevention (public water fluoridation, for example) and promotion programs.

2. The CDHC must be competent in the knowledge and skill required to collect diagnostic data, including health/medical histories, dental health screening/assessment, vital signs and dental charting.

3. The CDHC must be competent in the knowledge and skill required to perform a variety of clinical supportive treatments; examples include proper infection and hazard control protocols, tray set-ups, processing and storing radiographs, providing oral health instruction and much more.

4. The CDHC must be competent in the knowledge and skill required for administrative procedures, such as handling financial transactions, maintaining supply inventory and securing HIPAA [Health Insurance Portability and Accountability Act of 1996] clearances and informed consents.

5. The CDHC must be competent in the knowledge and skill required to triage patient groups; for example, identifying possible emergency dental care needs and communicating those findings to the supervising dentist.

6. The CDHC must be competent in the knowledge and skill required to provide individual preventive services, including fluoride and sealant applications, dietary and tobacco cessation counseling and more.

"The dental profession must respond to the needs of the underserved. The proposed CDHC is only part of that response but it is a vital part. ..."

7. The CDHC has the knowledge and skill required to temporize dental cavities in preparation for restorative care by a dentist; the committee stressed that temporization would be achieved using "hand instrumentation only," with no rotary instruments involved.

Dr. Tuneberg said recent developments in Alaska were not the sole catalyst for the CDHC proposal ("The ADA has focused on improving access to care for many years," he noted.), but he acknowledged that circumstances in Alaska had "accelerated the process."

In January, the ADA and the Alaska Dental Society filed a lawsuit asking that non-dentists be barred from performing irreversible dental surgery. The suit culminated two years of negotiations with Alaska tribal health authorities over allowing dental health aide therapists to use high-speed handpieces and perform irreversible procedures requiring the skills of a licensed dentist.

"Our goal here," said Dr. Tuneberg, "is to ensure the safety of the public and to check the development of a two-tiered dental care system."

The CDHC, he said, represents a "proactive response" from organized dentistry to the plight of underserved populations everywhere, "not solely those in Alaska."

Some fine-tuning will be done to the 96H committee report before it reaches the House of Delegates in Las Vegas this fall. This summer, the committee will meet again to review feedback on the report from the Board of Trustees and the Workforce Task Force.

Also in summer, the committee will prepare a request for proposal, an RFP, to seek funding for two or three pilot tests of the CDHC concept.

"The dental profession must respond to the needs of the underserved," said ADA President Brandjord. "The proposed CDHC is only part of that response, but it is a vital part that will help us live up to our mission of providing care for those who need it, while doing all we can to guard the public safety." ■

Soda sales in schools curbed

Major beverage distributors, health alliance sign agreement

BY STACIE CROZIER

New York—The nation's soft drink heavy hitters—Cadbury Schweppes, Coca-Cola, PepsiCo and the American Beverage Association—have agreed to stop nearly all sales of sodas in schools by the 2009-10 school year in a deal brokered by the Alliance for a Healthier Generation.

This is the first industry agreement for the alliance, a joint initiative of the William J. Clinton Foundation and the American Heart Association, and will affect nearly 35 million students nationwide. The organization's overall strategy is to help kids live healthier lives by decreasing excess calories consumed while increasing calories burned.

Former President Bill Clinton and Arkansas Gov. Mike Huckabee, leaders in the alliance, announced the agreement at a press conference May 3.

"We enthusiastically support the agreement that Alliance for a Healthier Generation has reached with the major beverage distributors to help improve the oral and overall health of our nation's children," said ADA Executive Director James B. Bramson.

"The ADA has actively worked to educate parents and school administrators about the risks of soft drinks to oral health, and their link to poor nutrition and obesity," Dr. Bramson added, "and we will continue to work to ensure that parents and children understand the risks."

Under the new guidelines, elementary and middle schools will only sell water, calorie-capped servings of juices and fat-free and low-fat milks in age-appropriate serving sizes. High schools will also be allowed to sell no-calorie and low-calorie drinks like diet and unsweetened teas, diet sodas, fitness water, low calorie sports drinks, flavored waters, seltzers, light juices and sports drinks.

Beginning in 2007, the beverage industry will compile data on the percentage of schools under contract that are in compliance with the new guidelines and will work to have 75 percent of schools meet the standards by the beginning of the 2008-09 school year and hope to fully implement the guidelines prior to the 2009-10 school year.

"This appears to be a big step in the right direction for providing healthy choices in schools," said Dr. Bob Brandjord, ADA president. "Many states have already been working on legislation and public relations campaigns about school nutrition and healthy choices. This should give support to those efforts."

A number of state dental associations, including the Minnesota Dental Association with its "Sip All Day Get Decay" project (online at "www.mndental.org"), have conducted public relations campaigns to educate patients about the dangers of soda to oral and overall health. Several states have recently considered legislation on school nutrition and Connecticut passed such a sweeping school nutrition bill April 27. (See story, page 15.)

School districts nationwide have also been replacing soda and high-calorie, high-fat and sugary snacks in school vending machines with healthier choices.

While hailing the agreement, the Pennsylvania Dental Association issued a press release May 4 stressing that it's a first step, and the PDA remains concerned that children and teenagers are vulnerable to "substitute beverages" that contain massive quantities of sugar and that the agreement's relationship to children's oral health is ignored.

"While we view this agreement as a huge step forward, it is crucial to understand that curtailing obesity and maintaining good oral health are two entirely different concerns," said PDA President Linda Himmelberger. "We wholeheartedly support the agreement, and are greatly encouraged that this dialogue is taking place, but there remains much work to be done in educating parents and school administrators about the oral health risks posed by sugary sports drinks and juices."

"This is an important announcement and a bold step forward in the struggle to help America's kids live healthier lives," said President Clinton. "These industry leaders recognize that childhood obesity is a problem and have stepped up to help solve it. I commend them for being here today and for taking this important step. There is a lot of work to be done to turn this problem around but this is a big step in the right direction and it will help improve the diet of millions of students across the country."

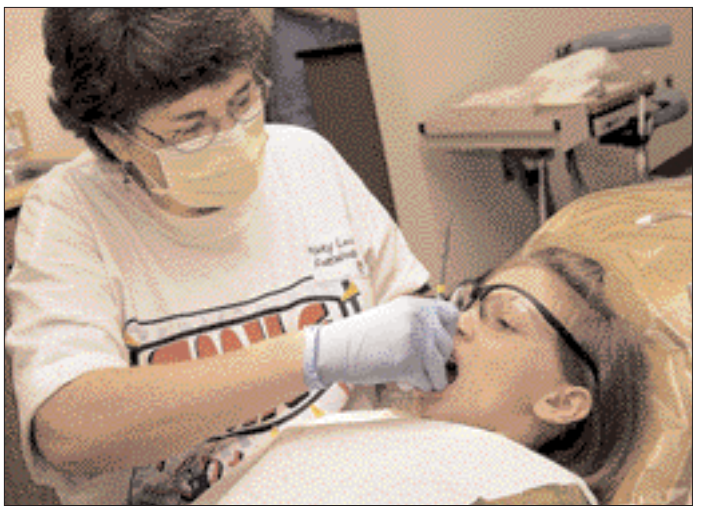
For more information on diet and oral health or ADA resources on soda, visit "www.ada.org/public/topics/diet.asp".

The ADA also offers a poster with soft drink and oral health information. The poster, in English on one side and Spanish on the other, is available through the ADA Catalog. The poster is $15.95 and the item number is W358.

Order by calling 1-800-947-4746 or going to "www.adacatalog.org". ■

Making a difference

Harris grants help children nationwide



Cleaning time: Hygienist Mary Lou Finewood cleans a child's teeth during the Smile Kentucky! treatment day.

BY STACIE CROZIER

Statewide public service announcements, dental exams and education at a baby's 12-month well visit at a community health center and screenings and care for underserved schoolchildren were among the 47 programs that received grants from the ADA Foundation's Harris Fund for Children's Dental Health grants program for 2006.

The Foundation announced the names of grant winning programs from 26 states last month and awarded $195,000. More than 200,000 children nationwide in 2006 will receive oral health education or access to care through programs receiving grants from the Harris Fund.

Parents and grandparents of young children and health care professionals throughout the state of Utah are the target audience for the public service announcement campaign "Mind Your Mouth," says Peggy Bowman of the Maternal Child and Health Bureau Oral Health Program. "Our 30-second spot features a dancing baby and an announcer who tells viewers about the importance of a dental visit by a child's first birthday to prevent early childhood caries," she says. "We have found that at-risk children who don't see a dentist until they are 2 or 3 have a much greater chance of having decay."

See HARRIS, page 16

Connecticut legislators pass school nutrition bill April 27

BY STACIE CROZIER

Hartford, Conn.—Is the second time the charm for schoolchildren in Connecticut?

On April 27 state legislators passed Senate Bill 373, a school nutrition bill that will restrict the sale of soda and junk food in Connecticut schools, and Gov. M. Jodi Rell has indicated she intends to sign the bill into law.

A similar bill passed the Connecticut General Assembly in May 2005, but the governor vetoed the measure.

The Connecticut State Dental Association lobbied strongly for passage of the bill, as it did with the failed measure last year.

More than 40 coalition groups representing the health care community lobbied for passage of the bill, said CSDA President Dean Cloutier of Hartford.

"As a dentist and president of the CSDA, I see the damage done to teeth by the sugar in regular sodas and sports drinks and the acids in regular and diet soft drinks, as well as sports drinks," said Dr. Cloutier in a letter to the editor of the Hartford Courant. "This bill is about preventing obesity and dental decay, but most important, it's aimed at promoting overall health. We believe this legislation represents an historic decision. It takes a responsible stand on an issue that has begged to be addressed."

The CSDA distributed a sheet of talking points encouraging state legislators to pass the bill in its entirety (which they did), hoping to educate them about the relationship of soft drinks and oral health. Coalition members also encouraged lawmakers to choose good health over the interests of a powerful lobbying effort by the beverage industry, said Noel Bishop, executive director of the CSDA.

"This is a 'David and Goliath' kind of victory and a role model for others in establishing good public policy," added Mr. Bishop. "The way the CSDA and others in the coalition advocated made a real difference in showing that this should not be an economic decision, but a decision to protect the public interest."

Efforts ongoing in other communities and states, plus the recent agreement by beverage distributors to stop selling soda in schools, he added, show that a "domino" effect is bringing the issue of nutrition in schools to the forefront. ■

Harris

Continued from page 15

The oral health PSA is an extension of the successful and award-winning "Baby Your Baby" media campaign, a two-year outreach campaign initiative by the Utah Department of Health that worked hand in hand with the state's expanding prenatal care services delivered through local health departments, community health centers and other clinics.

Production for the PSA was funded through a Health Resources and Services Administration grant, and the $5,000 Harris grant enabled the bureau to secure a matching grant and secure airtime for the spots.

Hilltop Community Health Center in Valparaiso, Ind., used its $2,200 Harris grant to purchase supplies and educational materials for a program to educate parents of 1-year-olds about the importance of oral health and preventive care for their children.

First visit: A young patient and his mom at Hilltop Community Health Center in Valparaiso, Ind., receive dental health education from hygienist Rose Kusmiz during a 12-month well visit.

"We primarily serve Medicaid patients and most of our parents don't go to the dentist because it isn't covered for them and it's financially out of their reach," said Beth Wrobel, executive director. "But Medicaid covers all dental care for children in Indiana, and we wanted a program that would help these children receive dental care and education and help show their parents the value of good dental health."

Hilltop is fortunate to have both medical and dental clinics on-site, allowing a dentist and/or a dental hygienist to be present at a client's 12-month well visit, she added. "We're trying to make it seamless with overall health care."

With its grant, Hilltop was able to purchase children's toothbrushes and toothpaste, a book about visiting the dentist that each family receives, other educational materials and a dental health education puppet—Al E. Gator, who, Ms. Wrobel added, is a big hit with the kids.

"The kids love the puppet and it takes the fear away from a dental visit. We are fortunate to have the ADA Foundation here to help us with this. I'm really excited about it. If we can save just one child from mouth pain by introducing them to the dentist at 1 year, then we're doing something worthwhile," Ms. Wrobel said.

The community health center also mandates that expectant mothers receive a prenatal dental exam and cleaning, and help patients find funding to cover the cost. This is a step, she explained, toward showing families that dental care is a necessity and not an option.

"It's critical for young children and expectant mothers to take care of their oral health and prevent serious health problems later on," she added.

Four years after a school-based access to care program was born, some 17,000 children are smiling in Kentucky. The Smile Kentucky! program screens about 4,000 children in grades 3-6 at 30 schools each year, and then provides free dental care to children in need at the University of Louisville School of Dentistry.

The program has now provided free care to more than 1,000 children and has smoothed out all the bumps in the road they experienced in the first year, says Susan Broughman Lewis, executive secretary of the Louisville Dental Society.

This year, after screening some 4,000 children, the program invited more than 900 children to receive free treatment at the dental school and about 350 accepted.

Smile Kentucky! used part of its $5,000 Harris grant to purchase portable dental lights that volunteers can take to schools for initial screenings instead of borrowing them for each school visit.

The funding also helped purchase displays and education materials that are used at the dental school and can be taken to the elementary schools for oral health education and purchased dental health books for participating schools' libraries.

The grant also invests in a research project by two pre-dental students to evaluate the records of every Smile Kentucky! screening and treatment since it began, enabling program organizers to track the type and frequency of services provided and plan for the future.

Nearly 700 volunteers participated this year, adds Mr. Lewis, including all junior and senior students from the dental school.

"We plan to do this forever and invest in things that will help us provide screening and care in the future," she says. ■

2007 Harris grant applications due to ADAF by July 10

Are you involved in a program that is geared to prevent childhood caries or provide access to oral health care for underserved children?

If so, you may qualify for a grant of up to $5,000 from the ADA Foundation Harris Fund for Children's Dental Health. A total of $210,000 will be awarded. Grant proposals for the 2007 program year must be received by July 10.

For an application form and more information on eligibility criteria, submission guidelines and the program timetable, log on to "www.adafoundation.org" or contact the ADA Foundation by calling 1-312-440-2547 or e-mailing "adaf@ada.org".

You can find more information on the programs of past grant winners at "www.communityoralhealthstation.org". ■

Does your lab outsource offshore?

BY ARLENE FURLONG

Made in China. Made in Mexico. Made in India.

Labels indicating foreign manufacture are on Americans' clothes, furniture, even souvenirs from a Florida vacation.

Some don't care where a product is manufactured, as long as quality isn't sacrificed and the price is right. Still others will choose a product with the "Made in America" label over competing products every time, regardless of price.

Many of the traditional products found in dental operatories in the United States are manufactured outside of its borders, such as cements, handpieces, curing lights, amalgam and gloves. Dentists know this when they select these products because the information is included on the box. But dentists may not always be making the choice they think they're making when contracting dental laboratory services. The Association is seeking to change that.

The ADA House of Delegates in Resolution 83H-2005 called for the Association to urge the U.S. Food and Drug Administration to require that a subcontracting dental laboratory notify the dentist in advance when prostheses, components or materials indicated in the dentist's prescription are to be manufactured or provided either partially or entirely by a foreign dental laboratory or any domestic ancillary dental laboratory.

FDA labeling regulations require that a finished dental prosthesis be labeled with the foreign dental laboratory's name and address. Disclosure by a domestic dental laboratory would only be a result of providing the dentist with the finished dental prosthesis in the package received from the foreign dental laboratory. This is the package labeled with the foreign laboratory's name and address.

Ask: "Labeling requirements are anything but crystal clear," says Dr. Gordon Isbell III, chair of the Council on Dental Practice.

Questions: NADL's Ricki Braswell (left) speaks at the May 5 Council on Dental Practice meeting about offshore lab practices. Drs. Richard Hunt (center) and Jeanne Nicolette, ADA 7th District trustee, ask questions about FDA labeling and registration requirements.

The regulations require that if a foreign dental laboratory fabricates a case, the foreign laboratory must either label the case as "Manufactured for [name of lab contracting with dentist]"or "Distributed by [name of lab contracting with dentist]."

The Council on Dental Practice believes it's important for dentists to know where a case will be fabricated and where the materials are coming from prior to its delivery so dentists can use that information in selecting a dental laboratory.

"Labeling requirements are anything but crystal clear," said Dr. Gordon Isbell III, chair of the ADA Council on Dental Practice. "Dentists who want to know if their labs are outsourcing offshore should do one thing: Ask."

His recommendation has roots in ADA policy, which states: The dentist carries the ultimate responsibility for all aspects of the patient's dental care, including prosthetic treatment. In a free market society, dentists select dental laboratories that provide the best quality services and prostheses.

"It's absolutely critical for a dentist to know not only the skills and qualifications of their own staff, but also those they assign work to outside of their office," says Dr. Isbell. "Since every treating dentist has responsibility for every aspect of the care their patients receive, it's imperative that when a dentist provides a prescription for a prosthetic device the dentist knows that the quality and materials are exactly what was expected. That means knowing both who will make a device as well as where it will be made."

Though offshore outsourcing began in the mid-1980s, it has become increasingly common in the current price-competitive, technician-short dental laboratory industry. The National Association of Dental Laboratories estimates that between 10 and 15 percent of the total number of U.S. restorations (mostly crowns, according to FDA field agents) are currently produced offshore. Outsourcing dental labs either ship to a U.S.-based broker laboratory that sends the work offshore, or ship directly to an overseas lab.

"We support advance disclosure," said Bennett Napier, coexecutive director of the National Association of Dental Laboratories. "FDA labeling requirements may not make it immediately apparent to most dentists that a lab is outsourcing to either a domestic or foreign lab. But any 'distributed by' language on the labeling should serve as a trigger for dentists to question their lab about where a case was manufactured."

According to Mr. Napier, the NADL is working to get the message out to all of its 1,400 member labs. According to NADL estimates reportedly based on U.S. Census Bureau data, there are some 12,000 dental laboratories, 5,000 of which are one-person operations in the United States.

NADL's Mr. Napier says that based on dental manufacturer data, there are some five million restorations being produced by offshore labs right now. Industry predictions show that by 2007 this figure will reach 7.1 million units of a total U.S. market of 45 million units.

While it's only a small number of labs that are outsourcing overseas, for those that do, it's often their sole business model, according to Mr. Napier.

"It's the combination of a shrinking qualified technician population and lower costs that are luring more laboratories to consider overseas production," said Mr. Napier. "It's all driven by price, not just for profit reasons, but also demand from dental clients. And some of that is driven by insurance."

GLOBALIZATION

The distinguishing difference between what the FDA requires and what the ADA is seeking with regard to disclosure in the 2005 HOD resolution is advance notice, rather than post-fabrication notification through labeling.

All dental laboratories (foreign and domestic) are required to comply with the FDA Quality System/Good Manufacturing Practices. Not all dental laboratories are required to register with the FDA. Only those that operate overseas, serve as the initial importer for a foreign laboratory, conduct repackaging services or manufacture sleep apnea/snoring and other certain orthodontic appliances are required to register.

The FDA has authority to inspect any dental laboratory manufacturing for the United States—registered or unregistered—in the United States or abroad.

"Legal authority allows us to inspect any entity (foreign or domestic) who makes a medical device, [including dental prostheses, such as crowns]," says Bryan Benesch, special assistant to the director, FDA office of compliance. "The only difference is that registration triggers periodic inspections."

However, Mr. Benesch acknowledges that despite FDA labeling requirements, it is possible that an unregistered dental laboratory wouldn't be subject to FDA inspection, simply because the FDA can't find them. "We want to know where they are," says Mr. Benesch. "That's the whole point of registration."

Every box that comes into the United States is required to say where it's from and where it's going.

Mr. Benesch points out that with hundreds of thousands of packages coming in every day, this system, like any other, isn't 100 percent foolproof. If the FDA is denied access to an inspection in a foreign lab, it can prevent the products from entering the country, but there is really no scientific methodology available to identify the materials.

"If that information is missing, the product can be detained in customs until that information is provided," said Mr. Benesch. "If it can't be provided that product will be exported or destroyed."

U.S. Customs Border and Patrol and the FDA work together to ensure that devices entering the United States comply with applicable federal regulations. All device import entries are referred to FDA for review. If nothing on the package indicates a product is a medical device (dental product) or triggers suspicion about its contents, it is possible that the FDA will not be notified by U. S. Customs that a device is entering the United States.

Some say this possible loophole makes it that much more difficult for the FDA to trace a material if a product failure occurs.

Dental prosthesis are among products marketed in the United States that require FDA clearance before they can be sold. Such products require the submission of a pre-market notification application, called a 510(k). Any manufacturer marketing a product requiring a 510(k) in the United States has to have shown the product is the equivalent to a product that the FDA has already cleared for marketing domestically.

The difference between dental prostheses and many other items is that in the 1970s the FDA decided to regulate the materials rather than the finished restoration itself for determining class and marketing authorization in the United States. As a result, foreign dental laboratories list the 510(k) application numbers of the dental materials they use to fabricate the case on the invoice that they provide with each shipment. This information can then be reviewed by the FDA.

In the June 2005 issue of The Journal of the American Dental Association, Dr. Gordon J. Christensen (and co-author Dr. William Yancey) outline some of the potential solutions to the challenges facing the dental lab industry, including verification of materials, and emphasize that the use of 510(k) materials should be ensured:

- Only materials for which manufacturers have completed a premarket notification 510(k) of the FDA should be used in prostheses.
- The NADL should encourage laboratories using prostheses made offshore to require materials to be specified and identified.

"The dental profession and the dental laboratory industry should encourage and support the FDA to carry out their requirements," said Dr. Christensen. "The ADA and state dental societies should lobby for legislative support in enforcing requirements and regulations for products made offshore."

See OFFSHORE, page 20

Background for action on Res. 83H-2005

The rationale posed by the Council on Dental Practice in its background statement for "Prosthetic Cases Sent to Foreign Labs for Custom Manufacture," says that laboratories outside the United States are obviously not subject to the same standards of laws as dental laboratories within. It concludes that remedies for inferior products or those that may result in potential harm to the patient do not fall under the authority of the U.S. court system.

"Considering that there are clear and definite limits as to what can be established in terms of monitoring mechanisms, and also offer a realistic expectation for implementation, the resolution may serve as a template for ADA initiatives toward ultimate legislative actions." ■

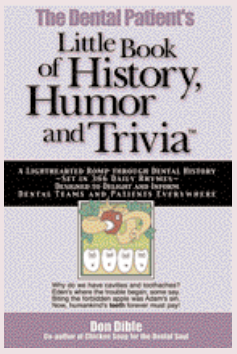
Dental book of humor ties into ADAF Harris Fund

Murrieta, Calif.—"In the animal tooth department, cats—

Like humans—have canines, count 'em: four;
So why don't dogs have felines?
It's enough to make any pussycat roar!"

So says the entry for July 14 in a new book of dental history, humor and trivia.

The light-hearted new book, "The Dental Patient's Little Book of History, Humor and Trivia" by Don Dible is now available, and readers who buy it will also be helping children receive access to dental care and education through the ADA Foundation's Samuel D. Harris Fund for Children's Dental Health.



Mr. Dible, co-author of Chicken Soup for the Dental Soul, describes dentistry's development from its beginnings in ancient Egypt to today in 366 quatrains that the author hopes his readers will find "informative and amusing.

"This thoroughly researched 228-page trade paperback features 36 illustrations, an index and a bibliography with online references for readers who want to learn more about dentistry's history," he says. "Reviewers say this is an ideal book for every practice reception area."

A portion of the sales of each copy will be donated to the ADAF's Harris Fund, which supports access and education programs for children throughout the United States.

To purchase a copy, talk to your dental supply distributor or contact the publisher, DMD House, by calling 1-800-BOOK-LOG or online at "www.dmdhousebooks.com". Cost of the book is $14.95 plus tax and shipping. ■

Offshore

Continued from page 19

The FDA's Mr. Benesch says Congress would have to amend the Food and Drug Cosmetic Act to give the FDA the kind of authority it would require for both advance disclosure and materials verifications.

"The burden of proof is on the foreign company to give us the correct information," says Mr. Benesch. "If they say they're using 510(k) materials, we're going to assume they are unless we find out otherwise or they've lied to us before. If a foreign lab provides the FDA with false information regarding what they were using, the FDA will take action."

Mr. Benesch thinks it's currently a matter of due diligence on the part of the domestic lab working with the foreign supplier to either check the materials or go to the foreign lab to inspect it.

"There's nothing preventing a dentist from asking their contracted dental laboratory to give them something that certifies that the lab is giving them the materials they say they are," says Mr. Benesch.

The Missouri Dental Association intends to do just that.

The MDA developed a form, approved by the Missouri Dental Board, that members can send to labs that asks where the case will be fabricated before it is made and affirms the materials used afterward.

"The Missouri form is a step in the right direction, " says Ricki Braswell, coexecutive director, National Association of Dental Laboratories. "But I would take it a step further and ask for the [FDA] registration number of the foreign lab."

"There's nothing preventing a dentist from asking their contracted dental laboratory to give them something that certifies that the lab is giving them the materials they say they are."

Foreign laboratories are required under the law to register. Domestic dental laboratories that don't manufacture materials restorations that fall into the Class II Medical Device Category—such as sleep apnea devices—and don't serve as an initial importer are not required to register.

Ms. Braswell believes there's no reason for the vast majority of U.S. dental labs to be registered, as all U.S. manufacturers are required to meet U.S. Good Manufacturing Practices.

Elizabeth Curran, owner of Ahwatukee Dental Laboratory in Tempe, Ariz., believes all dental labs—domestic and foreign—should be registered with the FDA.

"It's appropriate for dentists to not only ask where a prosthesis is made but to be able to confirm that the materials used in making it are FDA approved through labeling requirements—whether the prosthesis is made in the United States or a foreign lab," says the certified dental technician and assistant professor and director of laboratory services, Arizona School of Dentistry and Oral Health. "At the end of the day, dentists are responsible for making sure that there's no way a non-FDA approved material is part of a crown in a patient's mouth. And it ultimately boils down to the integrity of the dental laboratory to tell them that."

Dr. Vincent Rapini, a Webster Groves, Mo., general dentist, originally brought the disclosure issue to the attention of the Missouri Dental Association. He says it had never crossed his mind to ask where his cases were fabricated until friends of his, dental laboratory technicians, told him offshore production was becoming prevalent in the industry.

He says, "The importance of having a good relationship with your dental laboratory is more important now than ever." ■

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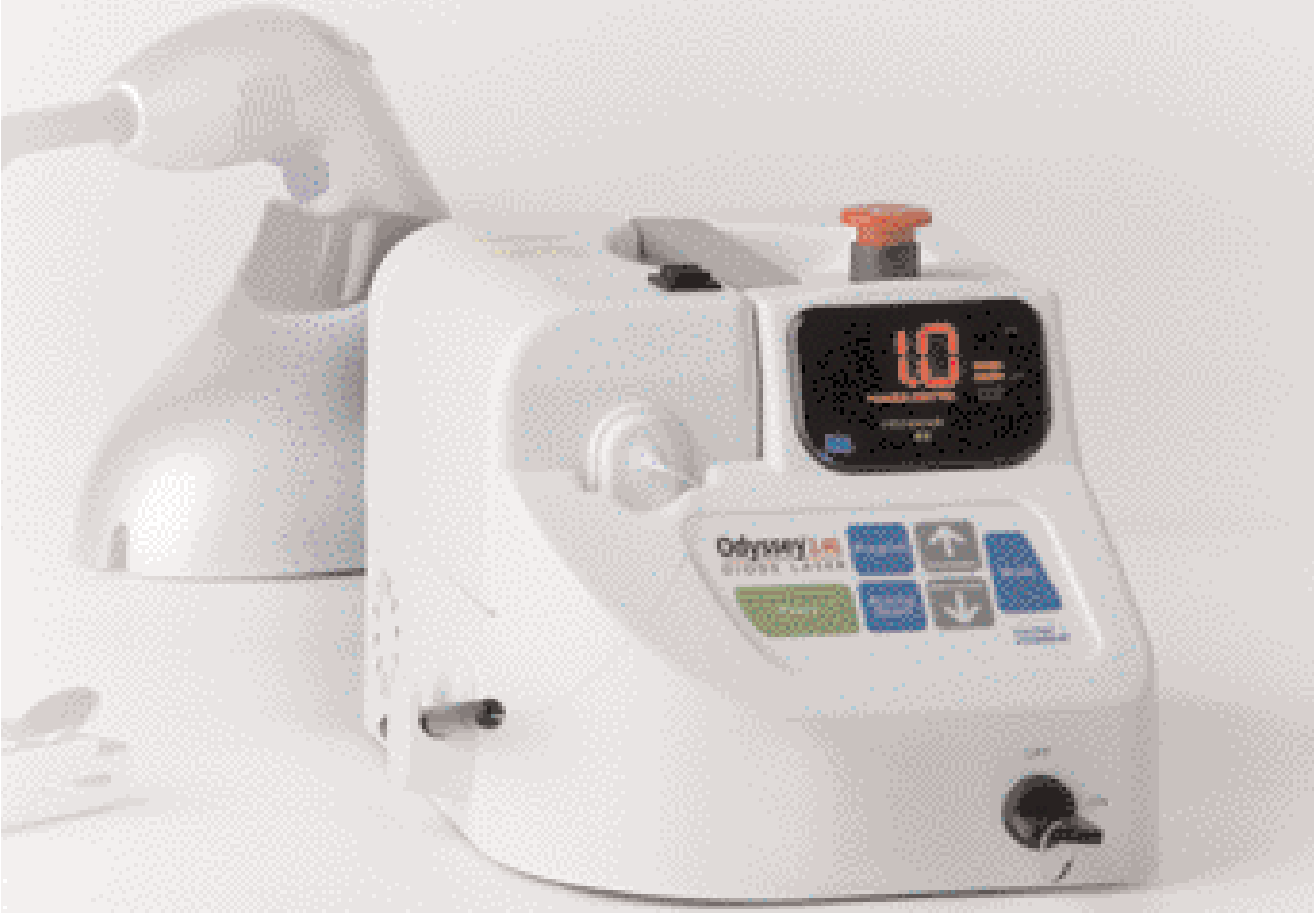

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ivoclar vivadent:

ADA CE Online launches May 22

BY KAREN FOX

It's an e-learning world, and now the ADA lives in it.

On May 22, the Association unveils ADA CE Online, a new comprehensive e-learning system for dental professionals at "www.ada.org/goto/ceonline". Offering an array of peer-reviewed courses for dentists and allied personnel, ADA CE Online is available to registrants any time of day, any day of the year.

The ADA is launching this distance learning opportunity in response to members' needs and to provide broad-based educational programming that highlights CE across the tripartite, said ADA Executive Director James B. Bramson.

"This is a comprehensive e-learning system for dental professionals," said Dr. Bramson. "And the program is being developed in a collaborative model to involve our state societies."

State dental societies and others will be able to collaborate with the ADA by including their own programs on ADA CE Online, enabling the tripartite to share a single platform and expand the visibility of CE to national and international audiences.

"Each and every program is evaluated to ensure it has value to you, our members," said Dr. Gordon Isbell III, chair, ADA Council on Dental Practice.

"This is a wonderful opportunity for dentists to access quality education, real-time, and specific to the area of their interest," said Dr. Billie Sue Kyger, a CDP member who has analyzed content. "It will be advantageous to members especially during busy times of their lives, and also beneficial to dentists located in more rural settings where an abundance of CE is not readily available."

"Having ADA CE Online available any time is conducive to busy dentists, especially new dentists who often have young families and new practice obligations that make traveling for CE courses difficult," added Dr. Shiva Shanker, a member of the Committee on the New Dentist.

Dr. Shanker joins CDP members and ADA staff on an advisory committee that will provide general oversight of ADA CE Online and its editorial board, which includes dental professionals, scientists and specialists who review scientific content.

Using an ADA CERP-approved provider is yet another way to ensure quality continuing education, said Dr. Stephen McDonnell, chair of CERP, the ADA agency that evaluates and recognizes institutions and organizations that provide CE through an application and review process.

"All online courses offered by the ADA, an ADA CERP provider, have broad acceptance as quality CE," said Dr. McDonnell. "It is the responsibility of each participant to verify the CE requirements of his or her licensing or regulatory agency."

ADA CE Online courses are priced at $28 per credit hour for member dentists and $42 for nonmembers. Once registered for a particular course, registrants will have access to course material for a 12-month period. ADA CE Online will generate non-dues revenue for the ADA and state societies; however, revenue is expected to be fairly small.

Users experiencing difficulty ordering a CE course may contact ADA CE Online Customer Service by clicking on the "Contact Us" icon on any of the Web site pages, sending inquiries to "info@adaceonline.org" or by calling the toll-free number at 1-877-4ADACE1 (423-2231).

Demonstrations of ADA CE Online will take place at the ADA New Dentist Conference in Boston June 22-24 and at ADA annual session in Las Vegas this fall. Watch for more information on dates and times in upcoming issues of the ADA News.

ADA CE Online is managed by the ADA Center for Continuing Education and Lifelong Learning. For more information and to discuss ways to market the system to members in your state, call the ADA toll-free, Ext. 2830. ■

Log on to ADA.org for CE opportunities

BY KAREN FOX

With the new ADA CE Online, the Association now offers a variety of continuing education opportunities for dental professionals, with a few highlighted here. For more information, visit "www.ada.org/goto/ce".

• JADA CE—Licensed U.S. dentists can earn up to two CE credits a month through the JADA Online Continuing Education program. Developed in association with the University of Colorado School of Dentistry, the program provides complete online testing and submission grading. For more, see "www.ada.org/goto/jadace".

• ADA-Pankey Education Connection—The collaborative initiative with the L.D. Pankey Dental Foundation offers new CE content for members (with a focus on new dentists) at venues like the New Dentist Conference and ADA annual session, and may expand to include regional workshops, online CE, podcasts and more. Programming will be inclusive in nature, featuring information relevant to dentists in private practice and non-private practice occupations. For information, go to "www.ada.org/goto/ce". ■

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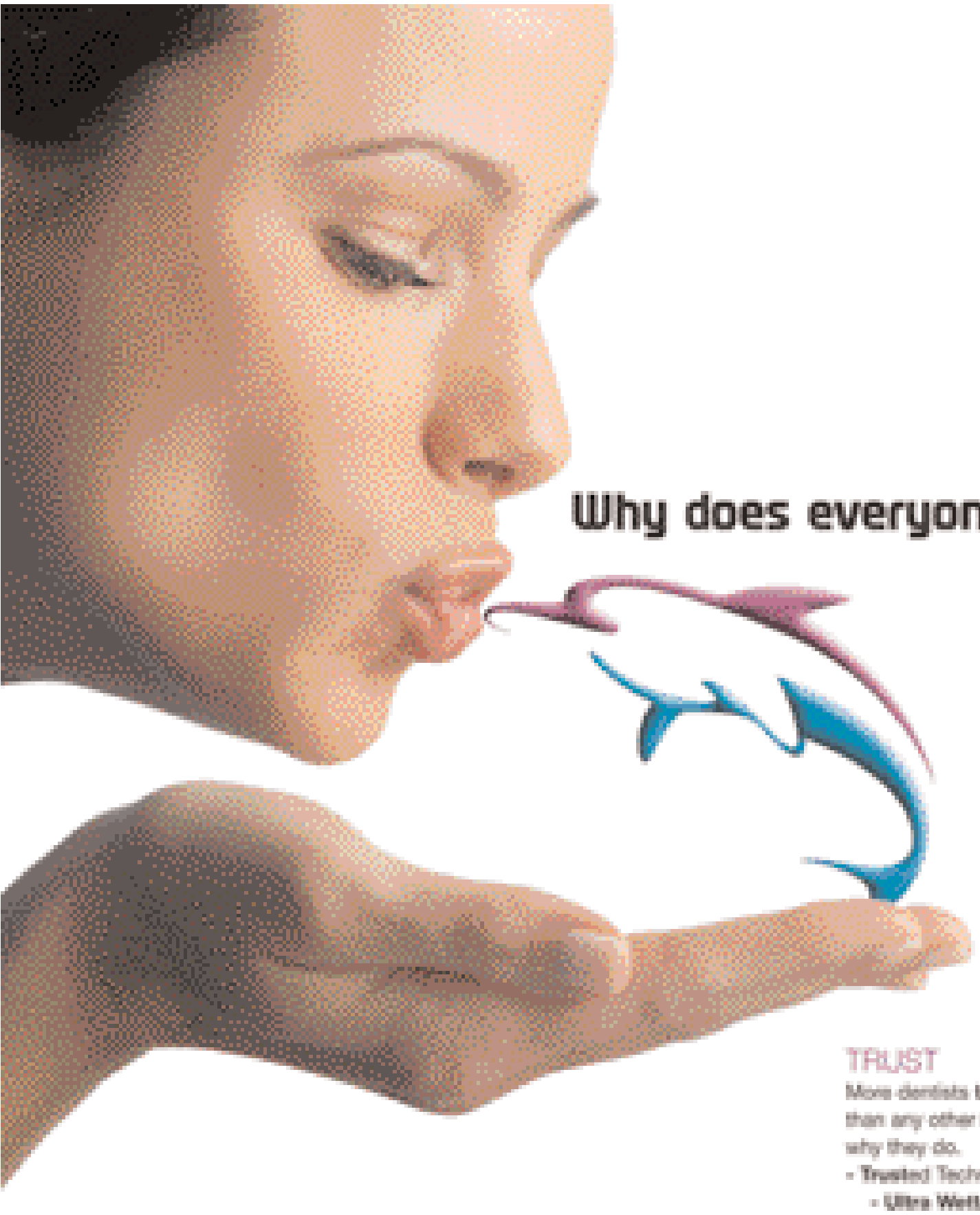

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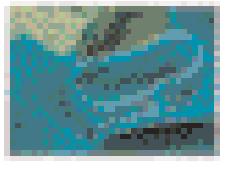

Outstanding detail reproduction, minimizing impression flaws

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more than just a material

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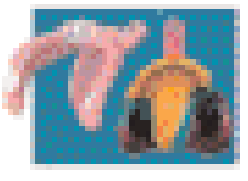

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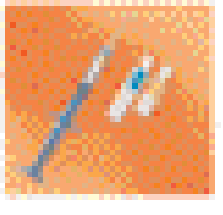

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