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ADA News - 11/20/2006

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AMERICAN DENTAL ASSOCIATION WWW.ADA.ORG

ADA NEWS®

NOVEMBER 20, 2006 VOLUME 37 NO. 21

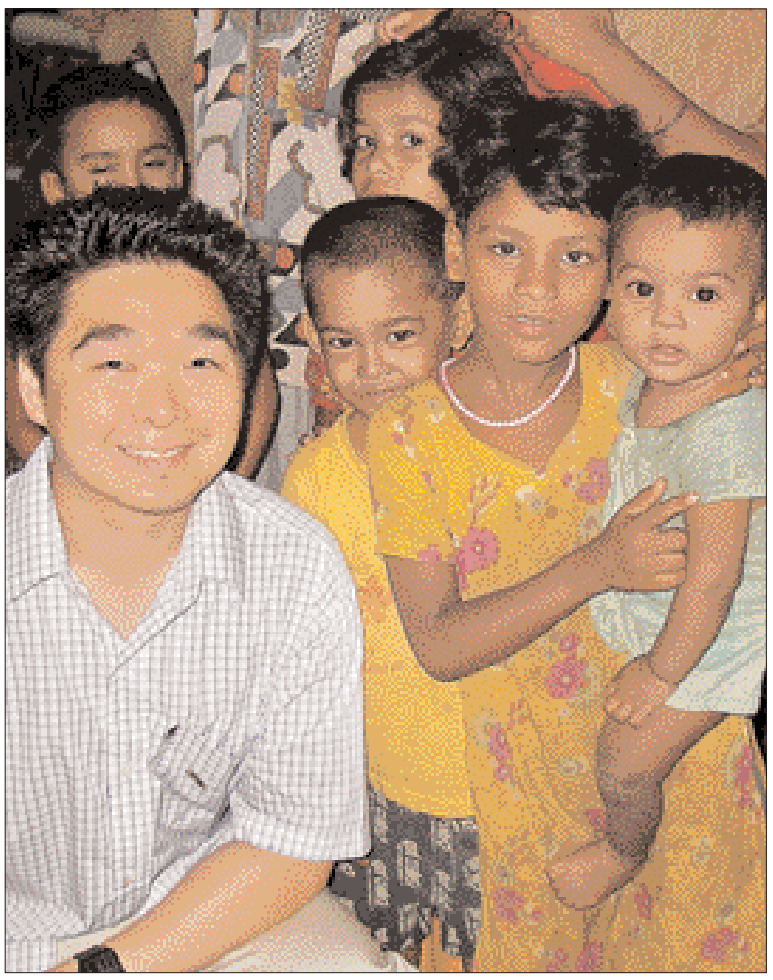


Photo by Dr. Irvin Silverstein

Long journey: University of California San Diego undergrad Erick Sato poses in Bangladesh with some of the people who came for dental and medical care offered by the USNS Mercy hospital ship. Mr. Sato was one of nine predental students who joined Dr. Irvin Silverstein as volunteers on the ship this past summer. See story, page eight.

Workforce progress

House creates new options for dental team

BY KAREN FOX

Las Vegas—Seeking meaningful solutions to dental workforce and oral health access issues, the 2006 ADA House of Delegates passed two resolutions that call for an expanded dental workforce team.

In accepting the Report of the Workforce Task Force, the House enacted Resolutions 3H-2006 and 25H-2006, which create two new dental team members and offer a guide that states can use to expand duties for allied dental personnel.

"Our profession certainly understands the responsibility we have to open doors to all those in need," said ADA President Kathleen Roth. "As we move forward creating the appropriate education and credentialing processes for these new positions, I am filled with pride that the House not only understood the issue but clearly set positive solutions in motion to address those concerns."

■ **Our Legacy—Our Future update, page 16**

The House action came after three years of work refining the model and working out the various strategies involved with training, supervision and duties, said ADA Executive Director James Bramson.

"At issue here was the House's desire to take a leadership position for the profession and support pilot studies of

See WORKFORCE, page 17

BRIEFS

Ortho complications: Lawsuits and counter complaints are flying between newly educated orthodontists and the Orthodontic Education Co. headed by Dr. Gasper Lazzara. At the same time, universities with OEC-backed orthodontic programs are ending their agreements with the company. Watch for a story that sorts through these complications in your next ADA News, Dec. 11.

Retiring: Dr. Dushanka Kleinman, deputy director at the National Institute of Dental and Craniofacial Research, will retire from government service Jan. 1, 2007, to assume a position at the University of Maryland-College Park's College of Health and Human Performance, which is transitioning to a School of Public Health.

Dr. Kleinman

Dr. Kleinman will be associate dean, Research and Academic Affairs, at UM-College Park, and have an appointment as professor in the Epidemiology and Biostatistics Department.

See BRIEFS, page seven

Periodontal treatment in pregnancy OK in study

Risk of adverse effects not reduced

BY JENNIFER GARVIN

Treatment for periodontal disease is safe for pregnant women, but such treatment does not reduce the risk of adverse outcomes, including preterm delivery, low birth weight, fetal growth restriction or preeclampsia.

Those findings are from a new study, "Treatment of Periodontal Disease and the Risk of Preterm Birth," published in the Nov. 2 issue of the New England Journal of Medicine.

Researchers based their findings on results from a four-site Obstetrics and Periodontal Therapy Trial that studied the effects of non surgical periodontal treatment on preterm birth.

The National Institute of Dental and Craniofacial Research, which funded the OPT study, described it as the largest clinical trial to evaluate whether treating periodontal disease during pregnancy reduces a woman's risk of early delivery.

■ **AAP statement, page seven**

The study enrolled 823 women from Hennepin County Medical Center in Minneapolis, the University of Kentucky in Lexington, the University of Mississippi/Jackson Medical Mall in Jackson, Miss., and Harlem Hospital/Columbia University in New York.

The study defines "preterm delivery" as a birth that occurs before 37 weeks of pregnancy.

The women studied were between 13 and 17 weeks pregnant on entering the study, and all suffered from periodontal disease. Researchers separated the women into two groups: those who received root planing and scaling during pregnancy (before their 21st week), and a control group that received periodontal treatment after delivery.

The OPT data showed that 12 percent (49 of 407) in the treatment group delivered earlier than 37 weeks, compared to 12.8 percent (52 of 405) for the control group.

"This research does not show a direct cause and effect relationship between periodontal disease and preterm birth," said Dr. Bryan Michalowicz, the study's lead author and associate professor, Division of Periodontology, University of Minnesota School of Dentistry.

"A common, nonsurgical treatment for periodontitis delivered between

See PERIO, page six

Give returning vets priority treatment time: delegates

BY CRAIG PALMER

Las Vegas—The 2006 ADA House of Delegates urged the nation's dentists to offer "priority treatment time" to combat veterans returning from active duty.

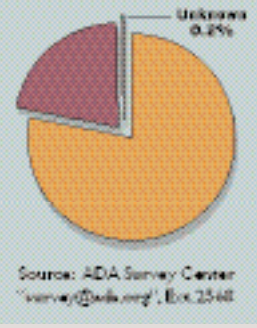
The ADA House at annual session adopted Resolution 70H-2006, "Resolved that the American Dental Association urges its members through ADA publications to give priority treatment time for veterans returning from

See VETERANS, page three

JUST THE FACTS

Peer review

Mediation decided 78.3 percent of the cases that were resolved in 2005. Full committee review settled 21.5 percent.



Source: ADA Survey Center

The future: University of Illinois at Chicago College of Dentistry students Jonathan Wong (left) and Chernara Baker listen to speakers talk about the future of dentistry Oct. 6 at ADA Headquarters. The Illinois State Dental Society sponsored "Field Trip to the Future" for 100 UIC and Southern Illinois University School of Dental Medicine students as a way to stimulate student involvement in organized dentistry. The event featured SUCCESS programs on ethics and practice management, a building tour, an exhibitors' fair and reception with ISDS members and trustees.

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Veterans

Continued from page one

deployment in a combat zone."

The House discussed the matter as new business in response to Department of Veterans Affairs appeals for private practice help in meeting service-related dental needs of combat veterans. Dr. Robert T. Frame addressed the House of Delegates Oct. 16. He is assistant undersecretary for health for dentistry for the VA and a decorated veteran of combat service in Afghanistan and Iraq.

"I am incredibly proud of our profession and of you, my peers, who represent the values of our great nation," he said. "I bring you two messages, one of appreciation and the other a call to service, a call for partnership. I want to thank the American Dental Association, particularly the leaders of this august body, those who serve on the Council on Government Affairs, and every dental professional represented here who provides outstanding care to our service men and women both during and after their active duty.

"The VA refers many of these great Americans to you, and we genuinely appreciate the superb care you and your staffs have provided to our veterans," Dr. Frame told the ADA House.

Photo by Lagniappe Studio

Dr. Frame

"I am requesting your assistance, not only on behalf of the Department of Veterans Affairs leadership but on behalf of the brave men and women who so nobly defend our country, to give priority to returning service members when scheduling appointments as they transition back into their communities."

Dr. Frame, ambushed in both theaters of war ("I don't learn too easily," he quipped in a telephone interview) and wounded in Iraq, said his reception by the ADA House "gave me the chills. We had two standing ovations." For his military service, he received a Bronze Star Medal with "V" (for valor) device for combat heroism and a Purple Heart. Dr. Frame is an ADA House delegate.

"I was shocked when Bob told me there was a problem and I urged him to address the House," said Dr. Murray D. Sykes, 4th District trustee. The House resolution adopted the day after Dr. Frame's speech, Priority Treatment for Combat Veterans, was offered by the 3rd Trustee District.

In a letter Oct. 9 to Dr. Robert Brandjord, ADA president at the time, another top VA official said the VA is falling behind on dental care for returning veterans. "Unfortunately, it may take months for new patients to receive dental appointments," said Gordon Mansfield, deputy secretary of veterans affairs. "I believe that with assistance from the American Dental Association we can provide dental care more expeditiously to veterans through VA's fee basis program. (See story, this page.)

"I am confident that members of the ADA are willing to assist us in meeting the needs of veterans, especially now with our returning Operation Enduring Freedom and Operation Iraqi Freedom service members. I am asking that you publicize this opportunity for dental professionals to care for these veterans by providing priority scheduling to them. Please consider an announcement at the ADA annual meeting in October ... In so doing, you will be assisting these men and women in their dental rehabilitation and also providing private sector dentists an opportunity to serve our nation's veterans."

The VA is asking that private practice dentists treat eligible veterans when VA dentists are unable to do so in a timely manner.

Dr. Frame was featured in the March 2005 special report, "Voices from the Front," in The Journal of the American Dental Association. ■

VA fee basis program details

BY CRAIG PALMER

Washington—Dentists with a current state license are eligible to participate in the VA fee basis program, says a Department of Veterans Affairs fact sheet. The VA appealed to private practice dentists to help meet the service-related dental needs of returning veterans.

Before a veteran is referred to a private sector dentist, the VA will first:

- evaluate the veteran and provide an initial evaluation;
- determine whether a fee basis referral is appropriate;
- provide the veteran with the appropriate paperwork to take to their dentist of choice;
- authorize the veteran to have an examination, prophylaxis and radiograph, as indicated, by a private practice dentist.

"The private dentist will determine dental needs and submit a treatment plan to the VA for authorization and approval of fees," the Department of Veterans Affairs said. "With approval, dental care is then provided by the private practitioner. Completed treatment forms are returned to the local VA facility for reimbursement once treatment is completed."

The VA approves fees when it authorizes the treatment plan.

How will VA refer patients to my practice? Veterans are free to select their dentist of choice. In most cases, a direct referral from the VA will not occur.

What if additional treatment beyond the VA treatment plan is indicated? The VA is responsible for treating dental conditions incurred during the time of active military duty. Once the treatment plan approved by VA and agreed to by the private dentist is concluded, the veterans' case is closed by the VA. However, patients may seek additional elective care on their own. During the time of active VA care, only the VA-approved treatment plan should be carried out.

How long will I have to wait for reimbursement? The VA is making every effort to reimburse its fee basis providers in a timely fashion. In most cases, payment will be rendered within 30 to 60 days upon receipt of completed treatment forms. ■

ViewPoint

MyView

There is no single solution to access challenge

Richard Galeone, D.D.S.

Each time a patient with Down syndrome comes into our office it reminds me of my brother, Blaise, who passed away about 10 years ago. Blaise had Down syndrome. The name "Blaise" is the English derivation of Biagio, which was my grandfather's name.

Legend has it that St. Blaise, who was a third-century physician and the bishop of Sebaste in Armenia, was arrested for refusing to recant his faith. While in prison he saved a child who was choking on a fish bone. This led to the blessing of throats on Feb. 3, the feast of St. Blaise.

My brother was in the habit of walking around a circle in our living room. A path was worn into the pile of wool carpet. He waved a white handkerchief as he marched around and around, and would have made the world's most persistent striking Teamster. I can remember my dad and my other brothers and myself watching the Philadelphia Phillies or the Eagles while Blaise marched around cheering for the home team. I don't think he understood what we were watching. He was just happy to be one of the guys.

He was an interesting dental patient. He had an enlarged and creviced tongue that flared the upper and lower teeth. He was a mouth breather, which caused a mild and chronic gingivitis. He had bruxism both at night and during the day and of course refused to wear an appliance. There were a few congenitally missing teeth. He was terrified of the dental chair and I remember one occasion on which he sat on the floor in the corner of the operatory and refused to move.

Eventually I realized that it was not so much a fear of dental procedures as the fear of height in a moving chair that motivated his behavior. If I allowed Blaise to sit on the floor, he would allow me to provide his dental care. We scaled and polished and did fluoride treatments. The arm of our X-ray unit wouldn't reach down there but we were able, one time, to anesthetize and extract a tooth abscessed from his bruxing. He was a perfect gentleman.

Many times one hears from dental colleagues that they "don't feel qualified" to treat a handicapped patient. Yet these same people feel qualified to do implants, complicated prosthodontics, involved surgical procedures, and write and lecture about their expertise.

The truth of the matter is that 90 percent of mentally and/or physically challenged patients can be easily treated by the simple exercise of a little patience. When any fearful patient is referred to another office for treatment, there is only one advantage that the new dentist has that the referring dentist did not have. That is, they know that the patient is fearful.

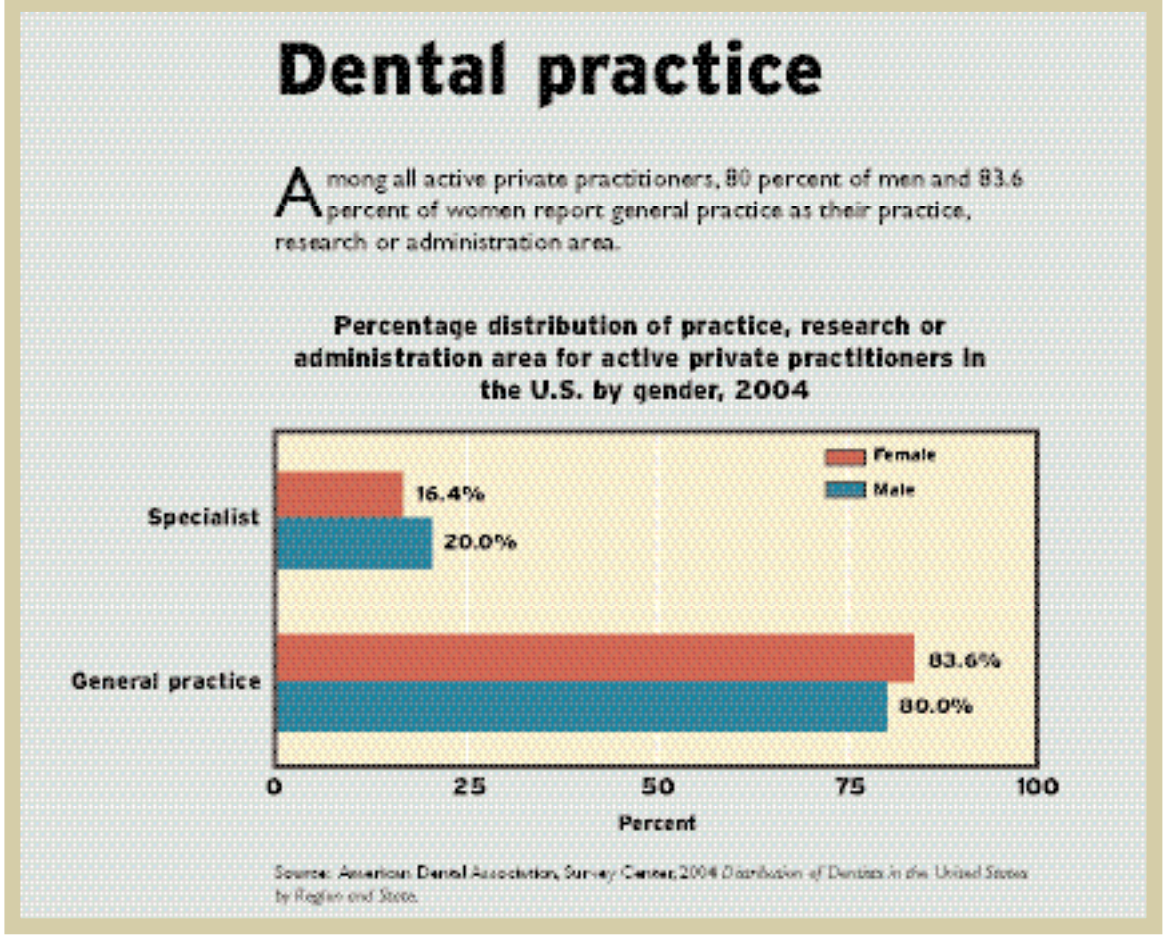
The new dentist will explain to the parent or caregiver that they will allow additional time in their schedule to deal with the fears of the patient. In most cases that additional time is necessary for only the first visit or two. Once the patient feels safe in the environment, procedures may be accomplished just as efficiently as with

See MY VIEW, page five

LettersPolicy

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

SNAPSHOTS OF AMERICAN DENTISTRY



Letters

Alaska

Why does Alaska matter? I am so thankful the ADA is opposing the formation of dental health aide therapists (DHATs) in Alaska. I have visited Alaska several times. It is extremely mineral rich. Its governor (and citizens) want to open more remote areas up to resource development. Our national legislation continues to bar this. The revenue from these areas could easily pay for real dentists doing treatment for Alaskans utilizing the same clinics built for DHATs.

Trust me, if you get the salary where it should be, dentists will be more than willing to live and practice in their beautiful state. This is good reason to not only back the ADA and ADPAC, but also encourage your legislators in the right direction. If it starts in Alaska, you can expect it in your own backyard next.

Virginia W. Crose, D.D.S.
Indianapolis

New Hill

I read with great interest the article about the fake invoices from New Hill ("Dentists Say They Were Misled," Oct. 16 ADA News).

We've been getting them, too, but realize that it is, at best, false and misleading; at worst, an outright scam. It ought to be reported to the Federal Trade Commission as well as the U.S. Postal Service.

I recently received a request from a colleague (the third this year) about a "child," Craig Shepard, who supposedly "has a brain tumor and very little time to live." Through the

Make-A-Wish Foundation, he has a desire to assemble enough business cards to make the Guinness World Records.

I received this very same request in 1980. Craig sure has outlived his "tumor." There is no Make-A-Wish Foundation office at the address listed, and the foundation knows nothing about "Craig Shepard." They don't like it either—phony campaigns like this give them a bad name and can affect their own efforts.

The whole thing is a scam (through my limited research) to build a list of businesses and professionals for direct marketing purposes—something we need like a hole in the head. I wonder if one of your crack staff could look into the matter, if for nothing else than warning every unsuspecting ADA member and saving us from endless mailings and telephone solicitations.

Alan H. Golden, D.D.S.
Quantico, Va.

Editor's note: According to the ADA Legal Division, the problem of misleading advertisements such as that noted by Dr. Golden is not unusual. He is correct that dentists victimized by such misleading advertisements should complain. Often, state attorneys general will entertain such complaints. The best protection, of course, is prevention. Dental offices should have procedures in place to review and approve any invoice received. Not only would this protect against the issue raised by Dr. Golden, it is a sound practice which may also protect against embezzlement and other financial problems.

Watch out

I want to commend author Arlene Furlong for exposing the company New Hill Services to our membership.

See LETTERS, page five

MyView

Continued from page four

any other patient. If most practitioners adopted this approach it would eliminate the access issue for the handicapped.

With the baby boomers knocking on the door of early old age, the problem of access to dental care for the elderly is going to worsen. Many of these patients will be nursing home residents. They may have medical or mental health problems that will affect how care is provided. They may complain and seem ungrateful for the care given. It may take much longer to accomplish a procedure than it does on the young and healthy.

The patient may have to be seen in the nursing home. They may even have to be seen in bed. Innovative approaches to care will be needed. It is difficult to see how our fee-for-service approach can fairly compensate a dentist for providing this kind of care. To me it seems the first step in addressing this problem is to encourage a system that would pay providers by the hour rather than by procedure. Just as dentists must be innovative in providing this type of care, we should develop innovative ways of attracting individuals to geriatric practice.

Patients on medical assistance and patients who are poor, but not poor enough to qualify for medical assistance, are the group usually thought of when we think of poor access to dental care. Although we may have difficulty in convincing some of our legislators, the truth of the matter is that the challenge of providing care to this segment of our population is primarily the responsibility of society, with the support of the dental profession, and not the other way around.

One possible approach to this problem might be the development of an additional member tier to the dental team; one trained and capable of performing simple dental procedures under the general supervision of a dentist. The ADA is studying this concept. A more immediate partial solution could be the elimination of some dental services now provided for by medical assistance so that treatment of more urgent problems would be more accessible. Still another advance would be the mandatory fluoridation of the state's water supply. This was the Pennsylvania Dental Association's primary legislative effort of the last year. The passage of the fluoridation bill of course would be the greatest victory in the access battle.

There is still another segment of our population suffering from lack of access. In many rural areas of Pennsylvania, people do not have access regardless of their ability to pay for dental care because dentists have not opened practices there. Programs of loan forgiveness have not been enough of an incentive over the years to convince dental graduates to locate in these communities.

Some providers of dental malpractice insurance support programs that provide for mobile dental facilities to visit remote areas on a regular basis. I have read about one such program in California. Perhaps this would be an appropriate project for a corporate sponsor in Pennsylvania. I can envision a program with several mobile dental units traversing our beautiful Pennsylvania countryside.

The point is that the access to care issue is not a single issue. It is a complex of interrelated challenges requiring multiple solutions.

The Pennsylvania Dental Association has established an access task force to study possible solutions to these difficult problems, and we invite everyone to submit ideas for consideration. The very future of the dental profession may depend upon our ability to address these challenges.

Dr. Galeone is the editor of the Pennsylvania Dental Journal. His comments, reprinted here with permission, originally appeared in the May/June issue of that publication.

Editor's note: The ADA Council on Access, Prevention and Interprofessional Relations responds: Dr. Galeone's editorial raises a number of thought-provoking issues regarding access to care, including the need for multiple solutions to address the complex oral health problems in vulnerable populations across the country.

The PDA and several state dental associations are working hard to examine and address access challenges in their areas. The 2006 ADA House of Delegates adopted a number resolutions relating to access to care, workforce, elder care and public affairs. (Read more about the House actions on workforce, page one.)

Dr. Galeone invited readers to take time to write PDA with their suggestions for how to approach access to oral health care concerns. The ADA offers the same invitation. If there is an approach to enhancing access to oral health care that you believe the ADA has not considered, e-mail CAPIR at "access@ada.org".

Letters

Continued from page four

I found this information very valuable. For the last six months our office has received an invoice for a newsletter called Oral And Maxillofacial Coding And Billing Alert. I have saved all the invoices from Washington, D.C.; New York City; Hartford, Conn.; Denver; Naples, Fla.; Arlington, Texas; Albuquerque, N.M.; Chicago; and Baltimore. Fees for subscriptions range from $197-872.

The company states that it has over 300,000 satisfied customers since 1947. It has a very aggressive policy to send doctors what they call "subscription notices": offers to extend your trial subscription for one year, and that you have no obligation to pay for the issues you already received. I suspect office and account managers are paying many of these renewal notices because they look like legitimate invoices.

I see this article as another reason why I am proud to be a member of the American Dental Association. Participation in organized dentistry allows us to share our ideas and observations so that we feel like we are not practicing alone. I would like to advise all member dentists that if you do not want to subscribe to New Hill Services please alert your staff immediately.

Rory E. Mortman, D.D.S.
West Palm Beach, Fla.

Health&Science

Perio

Continued from page one

weeks 13 and 21 of pregnancy did not reduce the rate of preterm birth or low birth weight," added Dr. Michalowicz. "This could suggest that in the future, researchers [should] focus on testing other means to reduce rates of preterm birth."

For those dentists hesitant about treating pregnant patients, the study shows that treatment provided in the second or third trimester of pregnancy is safe. Women in the treatment group also received monthly prophylaxis.

"Dental care during pregnancy has long been an issue dominated by caution more than data," said Dr. Lawrence Tabak, NIDCR director, in the NIDCR press release. "The finding that periodontal treatment during pregnancy did not increase adverse events is important news for women, especially for those who will need to have their periodontal disease treated during pregnancy."

"As a dentist," Dr. Michalowicz said, "I am excited that our findings might be used to increase women's access to periodontal treatment, and that we confirmed the safety of periodontal care which should help eliminate any negative perceptions about treating pregnant women. By demonstrating that treatment is safe and efficacious we hope these results go a long way in debunking those myths."

"That's good for everyone to know: pregnant women, OB/GYNs, dentists," said Dr. Kenneth Krebs, immediate past president, American Academy of Periodontology, adding that he also still believes there is a link between periodontitis and adverse pregnancy outcomes.

"I honestly do because you often see changes in the oral tissues during pregnancy," he said.

While the OPT study does not support a causal relationship between periodontal disease and preterm birth, an accompanying editorial in the NEJM written by Robert L. Goldberg, M.D., and Jennifer F. Culhane, Ph.D., maintains that future studies may show that periodontal treatment can help reduce other adverse outcomes including "late miscarriage, early stillbirth, and spontaneous preterm birth before 32 weeks, rather than all preterm births before 37 weeks."

"For those who believed there was no connection between periodontal disease and preterm birth, they'll look at this and say 'I told you so,'" said Dr. M. John Novak, a periodontist and one of two researchers who participated in the study from the University of Kentucky. "But for those who do believe that periodontal disease and negative obstetrical outcomes are somehow linked, this study does not provide the answer on how they are linked."

He added, "There are potentially a lot of environmental and behavioral factors to consider such as the impact of socioeconomic status, lifestyles and smoking, all of which are known risk factors for both periodontitis and preterm birth."

Dr. Michalowicz: "As a dentist, I am excited that our findings might be used to increase women's access to periodontal treatment."

Dr. Daniel M. Meyer, associate executive director, ADA Division of Science, touched on pregnancy and periodontal disease in a recent special edition of Scientific American magazine. Genetic conditions and environmental issues, he said, must be weighed when considering systemic health outcomes.

"It is well-designed study that provides valuable insight into the complexity of these relationships," Dr. Meyer said of the new study. "A single study often raises more questions rather than merely provide precise answers to some of our clinical questions. Oral-systemic relationships obviously exist. We will need to continue to explore the extent of these associations in order to gain a far better understanding on the relative risks, along with the most effective methods to improve health.

The interactions of predisposing health conditions, whether oral or systemic, add to the complexities of determining the measurable health outcomes from a variety of current treatment options. We need to continue to evaluate these relationships and in the meantime, not overinterpret or misinterpret the significance of this study."

Another ongoing NIDCR-supported study,

See PERIO, page seven

Dr. Novak: Environmental and behavioral factors may also be involved in periodontal disease and negative obstetrical outcomes.

Perio

Continued from page six

"Maternal Oral Therapy to Reduce Obstetric Risk," includes 1,800 women from a broader range of socioeconomic classes, as well as women with less severe periodontal disease. Results from that study are expected within the next two years, NIDCR reports.

"This first study has opened up the box a bit more and provides more questions than answers," said the University of Kentucky's Dr. Novak. "However, at the present time we are not yet able to say that periodontal therapy before or during pregnancy will impact preterm delivery."

He continued, "There are multiple studies going on at the moment, and we can't close the book on this intriguing question. We believe that an association exists. We just don't know what it is."

For more information on the OPT study, visit "www.nidcr.nih.gov/NewsAndReports/NewsReleases/PeriodontalPretermBirthRisk.htm". To read more about ADA articles on the oral-systemic connection, visit "www.ada.org/goto/oralsystemic". ■

BRIEFS

Continued from page one

The former chief dental officer of the U.S. Public Health Service, Dr. Kleinman has served in the government for 28 years—26 of those years at NIDCR. Joining the agency in 1980, she conducted research on oral mucosal tissue diseases and conditions, directed planning and evaluation activities, and managed the Institute's epidemiology and oral disease prevention program. She was named deputy director in 1991 and since that time has also assumed the role of Institute acting director twice during transitions between directors.

A rear admiral in the Public Health Service Commissioned Corps, Dr. Kleinman spearheaded the first-ever U.S. Surgeon General's Report on Oral Health, which was published in 2000.

In 2001, she was named chief dental officer of the U.S. Public Health Service, the first woman to hold that position since its establishment in 1923. She stepped down from that position in April 2006. Most recently, Dr. Kleinman was on a detail to the Office of the Director at the National Institutes of Health.

Dr. Kleinman earned her dental degree from the University of Illinois at Chicago College of Dentistry and interned at the University of Chicago's Zoller Dental Clinic prior to studying at the Henry M. Goldman School of Graduate Dentistry at Boston University, where she received an M.Sc.D. in dental public health. ■

AAP calls for more research on perio, pregnancy

BY JENNIFER GARVIN

The American Academy of Periodontology said Nov. 7 that a new study showing periodontal treatment during pregnancy is safe is an "important message for the dental and medical communities and all patients."

The AAP emphasized "the need for additional research to clarify the potential effect of periodontal disease on adverse pregnancy outcomes" since the rate of preterm births continues to rise.

The AAP news release comes on the heels of the New England Journal of Medicine's Nov. 2 article, "Treatment of Periodontal Disease and the Risk of Preterm Birth," which documents the Obstetrics and Periodontal Therapy Trial that studied the effects of nonsurgical periodontal treatment on preterm birth on more than 800 pregnant women. While the study showed that treatment is safe, it did not show a link between periodontitis and pregnancy.

The AAP called the study results "intriguing" and said, "the outcome is at variance with findings of other studies, which have suggested that periodontal treatment positively affects birth outcomes.

"There may be several explanations for the differences in research findings to date including timing of the treatment intervention, as well as the pregnancy outcomes studied. For example, the research did not study the effect of periodontal treatment on early adverse outcomes, such as late miscarriage, stillbirth and early spontaneous preterm birth, which previous observational studies have linked with periodontal disease.

"Other trials are under way that should provide additional insight on this important topic," the AAP release concluded.

For more information about the AAP, visit "www.perio.org". ■

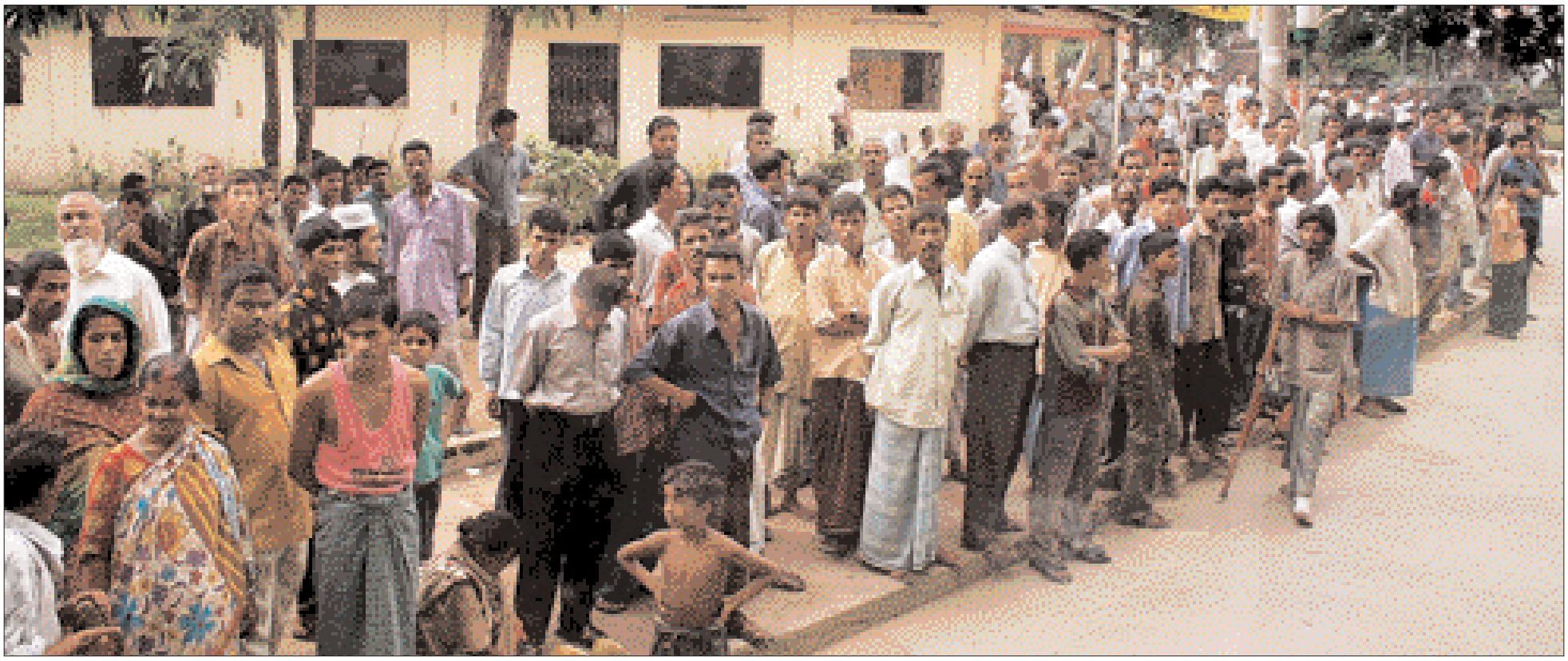


Photo by Dr. Irvin Silverstein

Waiting: Onlookers greet the U.S. Navy hospital ship USNS Mercy brigade bringing medical and dental aid to Chittagong, Bangladesh in June.

Long field trip

UCSD dental volunteers on 'Mercy Adventure' to Asia

BY CRAIG PALMER

San Diego—Dr. Irvin Silverstein describes the deployment of nine pre-dental students on a humanitarian mission in Southeast Asia as "The Mercy Adventure." Students say it "renewed desire to continue on in the field of dentistry."

The University of California San Diego Student-Run Free Dental Clinic Project and Pre-Dental Society operates three community based clinics. Undergraduate pre-dental students from UCSD, local and community colleges see patients who are underserved and in need of dental care, said Dr. Silverstein. A private practice periodontist, he donates "many hours each week" as UCSD dental director and advisor of the clinic project and pre-dental society.

"My students learn at an early age the importance of outreach and how dentistry plays a

U.S. Navy photo by Chief Photographer's Mate Edward G. Martens

Teaching moment: Dr. Silverstein gives a presentation about periodontal surgery to the dental staff and students at the Chittagong Medical College Hospital in Bangladesh.

Photo courtesy Dr. Irvin Silverstein

Bangladesh Naval Academy: Members of the advance coordination team from the U.S. Navy hospital ship USNS Mercy stand in front of the dolphin statue that symbolizes the navy here.

Photo by Dr. Irvin Silverstein

Home again: The USNS Mercy returns to port in San Diego Sept. 29.

major role in one's health and overall well-being. It is amazing to see how much can be accomplished by pre-dental students who are not even associated with a dental school. We have provided more than $800,000 in patient care and more than 20,000 hours of educational experience for our future dentists.

"We now have approximately 60 dentist volunteers, and last year 79 of the UCSD students got into dental school," Dr. Silverstein told the ADA News.

The UCSD student-run clinic project, in partnership with the community, provides accessible, quality dental care for the underserved in a respectful environment in which students, health care professionals, patients and community members learn from each other, says the mission statement. The program's awards include the ADA Golden Apple.

This year Dr. Silverstein arranged "a field trip" for nine pre-dental students on the USNS Mercy hospital ship stationed in San Diego. "Surprisingly, we were able to establish a relationship between the U.S. Navy and UCSD Medical School that would allow students to take part in this humanitarian mission."

The students supported health care missions in the Philippines, Singapore, Bangladesh, Indonesia and East and West Timor, participating at four-week intervals at sometimes obscure sites where plastic patio furniture or wooden benches served for dental chairs.

Dr. Silverstein and one of his students joined a team in Chittagong, Bangladesh. "Elephants rampage through Bangladesh village, killing boy," said a headline on a recent (Nov. 2) news report from Chittagong.

"Nicole (Chung) and I became assistants and worked with the doctors and technicians," student Kristen Whetsell wrote in the Sept. 28 Pre-Dental Digest, a publication of the UCSD Student-Run Free Dental Clinic Project and UCSD Pre-Dental Society. "By far the highlight of the trip was when Nicole and I were able to go ashore and work with local populations. We made three stops in Indonesia: Simeulue Island, Nias Island and Banda Aceh."

Part of the Bangladesh mission worked with Operation Smile on cleft lip and palate repair for some 65 patients transported by helicopter to the Mercy stationed 30 miles offshore because of shallow waters. Other USNS Mercy participants included Project Hope, Aloha Medical Mission and doctors from Canada and several Southeast Asian countries.

Dr. Silverstein's students included Ujval Gummi, Brock Lorenz, Sheila Nguyen, Nick Marongiu, Erick Sato, Phillippe Sebrechts and Andrew Weeks.

"My students and I have learned much from this experience," Dr. Silverstein said. It was, he said, "one of our best field trips."

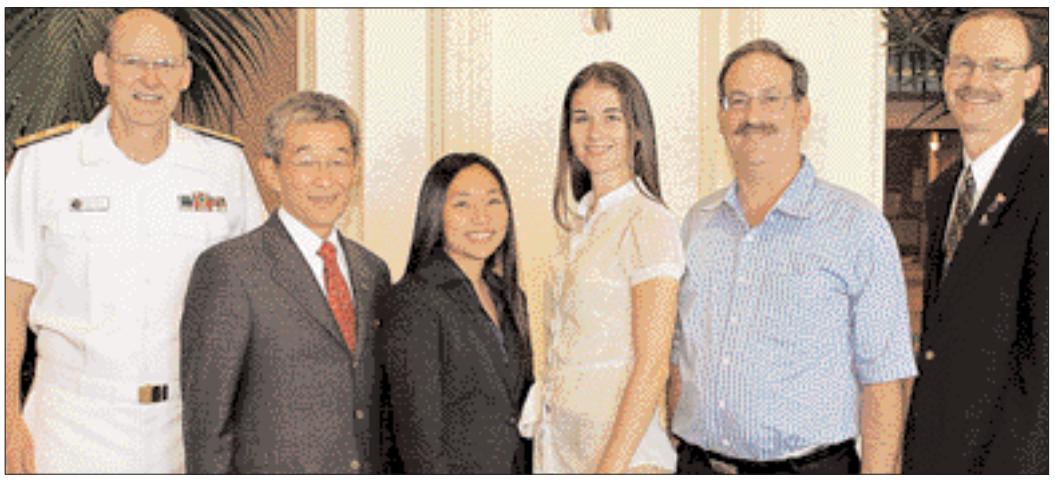
For more information about the USNS Mercy, go to "www.cpf.navy.mil/news_images/Mercy/index.htm". Photos of the 2006 deployment are located here: "www.cpf.navy.mil/news_images/Mercy/photos.htm".

For more information about the UCSD Student-Run Free Dental Clinic, contact Dr. Silverstein at 1-619-466-6666 or "dr. silverstein@sbcglobal.net". ■

Photo by Dr. Irvin Silverstein

Rush hour: Street traffic in Bangladesh, where Operation Smile volunteers provided cleft lip and palate repair for 65 patients.

Photo by Lagniappe Studio



Annual session: From left: Rear Adm. Edward Reidy, Naval Reserve Dental Corps; Dr. Eugene Sekiguchi, 2003-04 ADA president; students Nicole Chung and Kristen Whetsell; Dr. Silverstein; and Dr. Dennis W. Hobby, California Dental Association president, meet in Las Vegas in October.

E. Steven Smith, expert in forensic dentistry, dies

Cofounded new dental school at University of Nevada, Las Vegas

BY KAREN FOX

Las Vegas—Dr. E. Steven Smith, a dental educator known for his contributions to the field of forensic dentistry, died Oct. 16 after a three-year battle with interstitial fibrosis of the lungs.

Dr. Smith, 66, was the first dean of the University of Nevada, Las Vegas School of Dental Medicine, where he served as professor of professional studies until his death.

"I have worked with Dr. Smith in a variety of settings over the last 25 years," said Dr. William Harman, executive associate dean of the UNLV dental school. "It is very clear that his greatest joys came from facilitating the development of students and colleagues and following their accomplishments in their personal and professional lives. He will be missed by all of his colleagues throughout the country."

The Las Vegas Review-Journal reported that Dr. Smith began a career in forensic dentistry identifying victims of plane crashes through dental records when a British Royal Air Force bomber crashed during an air show in Chicago in 1978.

Dr. Smith was a 1970 graduate of the Northwestern University Dental School, where he taught for 27 years in oral diagnosis, oral medicine and restorative dentistry. He also founded a forensic dental program at Northwestern—the first of its kind in the nation—and developed a device and techniques for bite-mark identification and a computer program to aid in mass disaster ID.

Dr. E. Steven Smith

In 1999, he was appointed acting dean of the UNLV dental school and worked with university and state and federal officials to get the school built. The first class of students began school in 2002. Earlier this year, Dr. Smith watched proudly when this same class graduated from UNLV. Dr. Smith also continued his work in forensics in Nevada, serving as chief forensic odontologist for the Clark County coroner's office and on the county's domestic violence task force and fatality review team.

He also established the Southern Nevada Dental Identification Team and the Crackdown on Cancer Initiative for the state of Nevada, through which he and other dentists traveled to schools and warned about the effects of tobacco.

Dr. Smith is survived by his wife Kaye, five children, 14 grandchildren and his mother. Services were held last month in Las Vegas and Highland, Utah. ■

UNLV dental school names new dean

Las Vegas—The University of Nevada, Las Vegas Nov. 3 announced the appointment of Dr. Karen P. West as dean of the UNLV School of Dental Medicine, effective April 2007.

"I am honored to be selected as the new UNLV School of Dental Medicine dean," said Dr. West, currently associate dean for academic affairs at the University of Kentucky College of Dentistry.

"I'm excited to be part of its future and looking forward to working with such a fantastic group of highly qualified, innovative and collegial faculty, staff and students," she said.

Dr. Karen West

Dr. West earned a doctor of dental medicine degree from the University of Louisville, a master's of public health degree from the University of South Carolina, a certificate of medical management from the Gatton College of Business and Economics at the University of Kentucky and a fellowship with Executive Leadership in Academic Medicine. She also completed a GPR at the Medical College of Georgia where she went on to serve as a faculty member.

"I have great confidence that Dr. West's vision, enthusiasm and experience in academic dentistry will enhance our dental education programs and research activities,"said UNLV President David B. Ashley, Ph.D. ■

Fifteen dentists earn Kellogg certificates

Second Executive Management Program for Dentists wraps up

Strategy: Dr. Steven Reitan (left), Paradise Valley, Ariz., and Dr. Paul B. Sigfusson, Hinsdale, Ill., listen to a speaker during the July session at the Kellogg School of Management.

BY KAREN FOX

In addition to his 28-year-old dental practice, Dr. Bruce Stevens of Cedarburg, Wis., owns seven Dairy Queen franchises. Growing his business acumen in both areas led him to apply for the ADA/Kellogg Executive Management Program for Dentists.

"I wanted to be sure that I'm utilizing sound business principles when I'm making decisions," said Dr. Stevens, one of 15 class members who received their certificates Nov. 7. "Courses on leadership, marketing, finance and managerial accounting are very beneficial to someone like me. I've never had training like this, with the exception of 'Intro to Accounting' in college."

The Executive Management Program for Dentists offers management training to dentists seeking to hone their business skills. The curriculum draws from the core content area for Kellogg MBA students, with emphasis on business strategy, organizational leadership, marketing, finance, accounting, economics, quantitative methods and information systems.

As the second season of the program drew to a close, Kellogg faculty commended the dentists for their dedication.

"It is a wonderful experience to be in an educational setting around enthusiastic and positive dentists who applaud after each lecture in the ADA/Kellogg Executive Management Program for Dentists," said Thomas Prince, Ph.D., professor, Health Industry Management, and Accounting and Information Systems, Kellogg School of Management. "This environment stimulates the faculty member to reach a new plateau in each subsequent lecture."

Class members attended three sessions at the Kellogg School of Management in July, September and November.

The Executive Management Program will return in 2007. Watch upcoming issues of the ADA News for more information, or call the ADA at Ext. 3541. ■

AAO hosts interdisciplinary conference

St. Louis—The American Association of Orthodontists is inviting general dentists and specialists to attend its Interdisciplinary Conference, "Multiple Disciplines, One Focus," Feb. 9-11, 2007, in Indian Wells, Calif., near Palm Springs.

The meeting features experts in periodontics, oral and maxillofacial surgery, restorative dentistry and orthodontics who will share information regarding treatment of orthodontic patients with multidisciplinary problems.

For more information about conference topics or to register, go to the Web site "www.AAOmembers.org" and scroll down to "AAO Interdisciplinary Conference." Early registration ends Jan. 3, 2007.

Dentists who are not AAO members should select the "Dental Partner/Specialist" category to qualify for the discounted $750 registration fee (a $450 savings). ■

Warm welcome for Iraqi dentist

ADA, U.S. dentists, Henry Shein Inc. reach out to help Dr. Salih

Photo by Lagniappe Studio

Lending a hand: Dr. Maida Salih, center, chooses dental products with Dr. Sally Hewett, ADA/Health Volunteers Overseas Steering Committee Chair and member, ADA Committee on International Programs and Development, left, and Tracy M. Sunke, marketing manager, Sullivan-Schein Dental, on the exhibit floor at annual session in Las Vegas Oct. 18. Henry Schein Cares donated a variety of dental products for Dr. Salih to take back to her home and practice in Baghdad.

Las Vegas—Each day, Dr. Maida Salih doesn't know how long she'll have electricity to power her dental equipment.

"Two weeks ago, in 24 hours, we had one hour of electricity," the Baghdad, Iraq, dentist said Oct. 15 while attending the ADA annual session. "Sometimes we go six hours with, one hour without."

On that day, she was in the International Lounge in the registration area of the Mandalay Bay Convention Center, having completed a 20-hour journey from Amman, Jordan, to Chicago to Las Vegas. Her luggage, however, didn't make it, and Michael Barry, manager, international business and communications for the ADA Center for International Development and Affairs, was placing calls to help her find it.

Dr. Salih was the only Iraqi dentist at the ADA annual session—the only one that had succeeded in getting a visa from the U.S. Embassy in Amman in time to attend the meeting.

She was one of several hundred international dentists who requested a letter of invitation from CIDA in order to obtain a visa, said Mr. Barry. About 400-500 dentists contact the ADA each year for an invitation to attend the ADA's annual session, to meet with U.S. colleagues, to learn the latest through continuing education courses, to check out the ADA Marketplace exhibition and more.

"It was a very brave thing for Dr. Salih to come to annual session," said Mr. Barry. "Logistically and culturally, she didn't know what to expect, but she came anyway."

"Baghdad is very dangerous," Dr. Salih said. She had to close her dental clinic in Ameriya a year ago—after having practiced there for 20 years of her 27 years as a dentist.

Now she sees patients in her home in Baghdad, sometimes six a day, sometimes fewer. Her clinic in Ameriya became difficult to get to because of the violence in Iraq, and the building itself suffered severe damage.

Dental care, like medical care, is in short supply in Iraq and the dental school is open no more. Patients who go to a government hospital to have a tooth extracted won't receive any anesthesia, as none is to be had, she said.

She was looking forward to the scientific program and the exhibit hall, hoping to bring back knowledge and materials to Iraq. She said what is currently available in Iraq is of poor quality, low supply and expensive.

She read about the meeting through the Iraqi Dental Association, which received CIDA's invitation. Her determination to attend the ADA annual session meant she and several colleagues had to wait in Amman for 20 days before finding out if they could get a visa.

CIDA staff, Mr. Barry added, made sure that Dr. Salih felt comfortable during her visit, by helping her make affordable hotel arrangements, signing her up for CE courses, escorting her around the exhibit floor, inviting her to the international reception and helping her contact friends and family in Iraq to let them know she'd arrived safely.

Helen Cherrett, CIDA director, also interceded on Dr. Salih's behalf for a donation of much-needed dental supplies for her to use when she returned home to Iraq. Stanley M. Bergman, chair and CEO of Henry Schein Inc., was more than happy to help.

"We were very pleased to meet Dr. Salih at the ADA annual session in Las Vegas and to support her ongoing work to deliver quality dental care to the people of Iraq," said Mr. Bergman. "Dr. Salih told us of the unique challenges she faces on a daily basis as she treats her patients. She requested a variety of quality dental products that are necessary for her to perform everyday procedures but impossible to obtain in her country. We were happy to donate the items she requested through Henry Schein Cares, our global social responsibility program, which seeks to increase access to care among underserved populations around the world."

Dr. Sally Hewett, chair of the ADA/Health Volunteers Overseas Steering Committee and a member of the ADA Committee on International Programs and Development, also spent a great deal of time with Dr. Salih.

"It was my great pleasure and honor to meet and spend time with my new friend and colleague, Dr. Maida Salih," she said. "She came here against great odds, and I wanted to make her time here as enjoyable as possible. We attended a course together and spoke with exhibitors and enjoyed conversation about our dental practices and families. Her dental practice in Iraq is now at about a third of its former production level, but she is a very optimistic woman and is ready to keep her practice going in any condition. She has loyal patients and friends in Iraq, and will now be certain of having some lifelong dental friends in the U.S. as well."

Dr. Hewett also helped Dr. Salih make arrangements to visit family and friends in San Diego following the meeting.

"She is like all of us—she wants to take the best care and provide the best service for her patients," Dr. Hewett added. "And she does it with exceptional courage during war time." ■

Dr. Margaret Chan named new director general of World Health Organization

Geneva—Dr. Margaret Chan is the new Director General of the World Health Organization.

The Chinese physician was nominated by the WHO executive board on Nov. 8 and her appointment was confirmed by the World Health Assembly Nov. 9. She succeeds Dr. Lee Jong-wook, who died in May.

Dr. Chan, known for her leadership in the face of the avian flu and severe acute respiratory syndrome, joined WHO in 2003 and has served as Assistant Director-General for Communicable Diseases and Representative of the Director-General for Pandemic Influenza.

She joined the Hong Kong Department of Health in 1978 and became its director in 1994. As director, she launched new services focusing on disease prevention and promotion of health and introduced initiatives to improve communicable disease surveillance and response, enhance training for public health professionals and establish better local and international collaboration. She effectively managed outbreaks of avian influenza by ordering the slaughter of Hong Kong's entire poultry population—some 1.6 million birds—to stop the outbreak. She also managed the world's first outbreak of SARS.

"What matters most to me is people," she said in her acceptance speech. "And two specific groups of people in particular. I want us to be judged by the impact we have on the health of the people of Africa, and the health of women.

"All regions, all countries, all people are equally important," she added. "This is a health organization for the whole world. Our work must touch on the lives of everyone, everywhere. But we must focus our attention on the people in greatest need." ■

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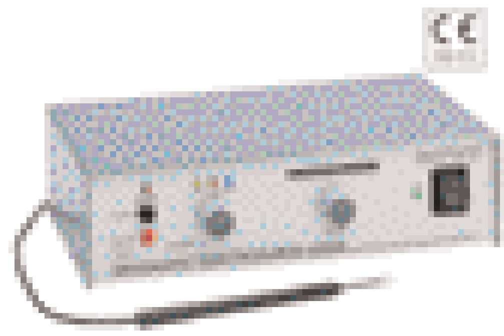

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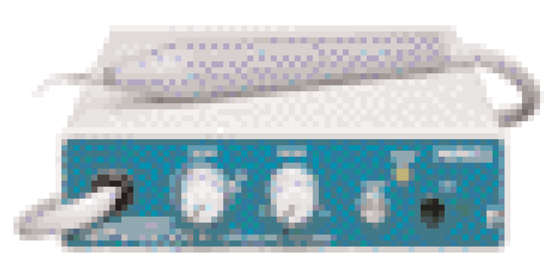

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SCALER	PRICE	RISK-FREE TRIAL	FREQUENCY	POWER UNIT WARRANTY
TurboSENSOR	[illegible]	[illegible]	[illegible]	[illegible]
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Visit Parkell at major dental meetings : Greater NY (Nov 24-29), Boston Yankee (Jan 25-27), Chicago Midwinter (Feb 23-25)

Dental Benefits

ADA, NADP share views on dentists' concerns

BY ARLENE FURLONG

Dental claims denials were among the most frequent concerns ADA members complained about to the ADA during 2005.

The topic kicks off a series of ADA News articles on dentists' "Top 10" concerns submitted to the ADA about their dental claims. These articles will include perspectives from ADA members, National Association of Dental Plan members and the Council on Dental Benefit Programs on specific issues.

"This series of ADA News articles grew out of CDBP discussions with NADP about our members' most frequent complaints," said Dr. Alan E. Friedel, chair of the council. "CDBP is working with NADP and the payer industry to facilitate communication to eliminate some of the problems our members and patients are experiencing. We want to clarify what information is necessary to adjudicate claims in a timely manner and consistent fashion."

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

Dr. Friedel: "CDBP is working with NADP and the payer industry to facilitate communication to eliminate some of the problems our members and patients are experiencing."

Ms. Ireland: "Responding to dentists' concerns required complex information collection, as well as broad circulation of the responses to dental plan members."

NADP member companies represent some 82 percent of the estimated 163 million Americans covered by dental benefit plans. Dr. Preddis Sullivan, of NADP's Professional Relations Commission, commented that while no one response can fully reflect the breadth of all plan designs and benefit adjudication requirements, the NADP developed a broad overview on claims denials overall.

"Responding to dentists' concerns required complex information collection, as well as broad circulation of the responses to dental plan members," said Evelyn F. Ireland about the topics to be covered in the series. The NADP executive director said, "We did this to assure the NADP perspective reflects, to the extent possible, the diversity of plans and products of its members and the dental benefits industry overall."

This installment features two topics falling under dental claims denials. An upcoming issue of ADA News will feature two more. Subsequent articles will cover the remaining "Top 10" concerns, which include bundling, processing delays, lost attachments, overpayment requests, post utilization review, provider contract issues and more. ■

Dental Claims Denials

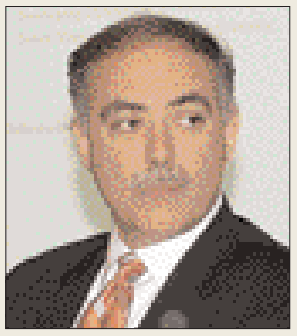
D4341, D4342 coding for periodontal scaling and root planing (SRP), per quadrant or partial quadrant

Dentist perspective

Many dentists don't understand why claims for SRP are denied when the patient has abnormal pocket depths. A claim may be paid on a patient with 4mm pockets while at other times the same payer may deny the same procedure for another patient who had the same or similar clinical presentation.

This is very confusing for dentists. When the claim is denied some patients may think that the dentist is performing unnecessary procedures.

When patients or members of the dental office staff contact a payer to determine whether a benefit is available under a specific plan, they are usually given a yes/no response. Specific payment guidelines may not be provided. If these were provided, the process would be much more transparent and many of these situations could be avoided. Until this is common practice, the carrier should make it clear to both patients and dentists that while SRP may be necessary, their plan will only provide a benefit when the plan's particular clinical indicators are present. If third-party payers disclosed the actual payment parameters, dentists could then tell the patient in advance what the plan might cover.



Dr. Robert A. Faiella: "Dentists should advise their patients that coverage is often based on employer funding of the policy purchased rather than the clinical need of the specific patient," says the CDBP member.

The ADA Council on Dental Benefit Programs notes that a single payer can reimburse various employee groups differently. In some cases payers act as insurers. In other cases they simply administer a policy on behalf of an employer. Purchasers of plans that cover many lives can often negotiate changes in reimbursement rates to meet economic targets. Dentists should advise their patients that coverage is often based on employer funding of the policy purchased rather than the clinical need of the specific patient.

Dental benefits industry perspective

Payers' standard clinical policies relating to coverage of specific procedures are developed based on a review of the scientific literature, the experience of their dental professionals, dental advisory councils and claims histories. A payer's standard practice in an area such as SRP may be modified for a particular employer based on that employer's preferred or negotiated benefit design, analysis of the employer's claims history, or recommendations of their benefits consultant. Thus, two claims to the same payer with a similar patient profile may be treated differently based on the employers' group dental policy under which each patient is covered.

While a pocket depth of 4mm or greater is the most commonly recognized indicator in the literature for SRP, there are differences within dentistry and dental literature about the specifics of pocket depths as benchmarks. Thus, payers establish their own criteria based on all these factors which can differ from payer to payer and potentially, from one customer to another within a single payer's book of business.

Just as payers' clinical policies differ, claims for periodontal procedures and treatments are frequently subject to coding variations when submitted by dentists. The addition of code D4342 has been helpful in determining appropriate benefit reimbursements. In the past, when code D4341 (full quadrant) was the only SRP code, it was more difficult to determine coverage where diagnostics supported SRP for a small number of teeth in a quadrant.

The use of D4341 or D4342 in reporting more than 2 quadrants within a single dental visit will usually trigger a request for additional information such as a full-mouth periodontal charting, full-mouth X-ray, periodontal diagnosis and the treatment plan.

Many payers now post their guidelines to their Web sites (usually in a member protected area due to the inclusion of CDT codes which are copyright protected), include them in the provider office reference guide or make them available to dentists on request.

Tips for minimizing claim denials or delays for SRP:

• Before submitting a claim for SRP, check the company's guidelines on their Web site or in the provider office reference guide.

• When submitting SRP for more than 2 quadrants within a single visit, include documentation—full-mouth periodontal charting, FMX, periodontal diagnosis and the treatment plan.

D4910 coding for periodontal maintenance

Dentist perspective

According to the Code on Dental Procedures and Nomenclature, this procedure is performed following periodontal therapy and continues for the life of the dentition. Periodontal maintenance is often denied, however, because many carriers have limited benefits for this procedure. Reports received from our member dentists indicate that some payers have limited this procedure to being paid as a benefit only within 2 to 12 months of SRP. No mention of a time period following periodontal treatment is provided in the Code. Some payers have qualified periodontal maintenance by

See DENTIST, page 15

Dental benefits industry perspective

Quite frankly, this code is a challenge for benefits administrators as well. In order to appropriately determine the benefit for procedure code D4910, it is necessary to have knowledge of the patients' prior periodontal history. Often, this information is not available during claims processing. If the patient has no prior claim history with the payer, or previous periodontal services were not paid by the current payer, it is difficult to properly assess the benefits level available to the patient.

If you are aware that the current payer does not have previous periodontal history on a patient, sub-

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Dentist

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denying benefits for this procedure unless two or more quadrants have received prior therapy.

It seems that each carrier has different policies/limitations for this procedure. This is very confusing for both dentists and patients. While the dentist is performing and reporting the correct procedure, benefits are denied solely because of the plan's limitations. However, absent a full explanation that accompanies the denial, the patient may think that the dentist is incorrectly reporting or performing dental procedures. Disclosure of the processing policies in the employee benefit booklet and in an Explanation of Benefits would be very helpful to avoid inadvertent negative implications with respect to the doctor-patient treatment. Allowance of an alternate benefit for a lesser procedure should also be disclosed in the benefit booklet and the EOB.

The ADA Council on Dental Benefits believes it is incumbent upon dentists to deliver appropriate care to patients based upon clinical need, not by third party reimbursement that may be forthcoming. After periodontal therapy has been completed, newly exposed root structure and altered architecture often make debridement of plaque and calculus more difficult. This does not change with time.

Patients should be told in advance that plan provisions may not provide for reimbursement of D4910 for extended periods. We must code for what we do, and educate our patients that all procedures are not covered by all plans. ■

Industry

Continued from page 14

mitting periodontal charting with the claim will assist in the determination of benefits. Since most payers electronically store claim forms, submitted diagnostics and electronic attachments, an existing record will reside with the payer should there be any question as to the handling of the benefits reimbursement. Thus, resubmission of diagnostic materials would not be necessary on a patient whose periodontal therapy was covered by the payer.

Many payers require an examination, targeted periodontal probing, and a periodontal diagnosis for reimbursement of code D4910. As stated in the Code on Dental Procedures and Nomenclature, this procedure is instituted after periodontal therapy.

Although no time frame is outlined in the CDT, most payers require a waiting period of 8 to 12 weeks. If there are unusual circumstances that would require a different interval of treatment, documentation by the dentist with the original claim submission should forestall requests for additional information to determine the patient's benefits.

At times, payers are limited by specific guidelines from employer group and dental group contract language. When plan limitations exist, and continued D4910 are reported, many payers will allow payment for an adult prophylaxis, which is an integral component of the more global D4910, to provide some level of coverage for the insured patient.

Tips for minimizing claim denials for periodontal maintenance:

• If there are unusual circumstances that require a different interval of treatment than the one specified in the patient's plan documents, the dentist should provide documentation with the original claim submission.

• If a patient is covered under a new group policy, submission of the patient's history of treatment with the initial claim for D4910 will assist in the determination of benefits for the patient. ■

Thinking of changing payroll providers?

Try SurePayroll, a worry-free online provider

On average in 2006, small businesses that ran payroll in-house and filed and paid quarterly taxes manually spent more than 250 hours away from customers and patients doing these tasks.

Those who outsourced weekly payroll to traditional phone or fax services received two to three late payrolls or payroll mistakes, according to customer testimonials and surveys.

Why not avoid the unnecessary headaches in 2007 by switching to a worry-free online payroll service?

SurePayroll, the only payroll service endorsed by ADA Member Advantage, offers full-service online payroll that allows you to enter data when and where you want. In addition to special discount pricing for ADA members, SurePayroll:

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To learn more, contact SurePayroll at "www.surepayroll.com" or call 1-866-535-3592. ■

Past president urges support for dental education initiative

Need is great, urgent, Dr. Haught tells ADA House

BY JAMES BERRY

Las Vegas—Dentistry's educational system, the backbone of the profession, could soon be in crisis unless dentists themselves pitch in to help.

That call to action was at the heart of Dr. Richard Haught's remarks to the ADA House of Delegates Oct. 20. A past president of the ADA (2004-05), Dr. Haught is co-chair of "Dental Education: Our Legacy—Our Future," a nationwide initiative to boost awareness of the challenges facing the profession's educational system.

Faculty shortages, rising costs, outdated facilities and equipment, and limited resources to embrace diversity are chief among the "serious and complex challenges" confronting dental schools, Dr. Haught told the delegates.

"If we don't address these issues, we'll encounter a crisis in the next 10 years that will jeopardize the future of our profession and adversely impact the health of our communities," he added.

Dr. Haught's co-chair in the initiative is Dr. Cecile Feldman, dean, University of Medicine and Dentistry New Jersey, New Jersey Dental School. The honorary chair is Dr. Arthur A. Dugoni, president of the ADA Foundation, which is spearheading the initiative.

The effort currently involves 71 partner organizations—and counting—including dental schools, specialty groups and others. The long-term objective: partners collectively raising more than $1 billion by the year 2029.

"Our goal moving forward is that every dentist in America, as well as organizations that understand the importance of oral health, will join in this effort," said Dr. Haught, urging the delegates to support the initiative and to encourage others to do the same.

Photo by Lagniappe Studio

Call to action: Dr. Haught addresses the ADA House of Delegates Oct. 20 in Las Vegas.

"The time has come for us to financially support dental education, because it is our legacy and it must be our future," he said. "It is time for us to give back to the profession that has served us so very well."

To learn more about this collaborative project or to make a donation to one or more of the partners involved, visit the Web site: "www.ourlegacyourfuture.org" or call 1-312-587-4716. ■

Stakeholders: Strong dental education system protects oral health of public

BY STACIE CROZIER

DENTAL EDUCATION
OUR LEGACY OUR FUTURE

Protecting the integrity of dental education will also protect the oral health of the public, said Dr. Richard Haught, co-chair of "Dental Education: Our Legacy—Our Future."

"The tremendous strides we've made in oral health status and dental care in the United States are a direct result of our dental education system," said Dr. Haught. "From private practitioners, to dental educators and administrators, to public health dentists to researchers—every one of those groups would not be where they are today without a strong dental education system."

Our Legacy—Our Future, a nationwide collaborative initiative to boost awareness of the challenges facing dental education, will help dental schools and stakeholders continue to make strides in improving the oral health of the public through quality dental education for dentists and dental team members and continued emphasis on research and access to care, he said.

"The dental profession's continuing service to society is safeguarded by academic dental institutions that recruit, educate and develop the future members of the profession: practitioners, educators, researchers, administrators and the organized dentistry's leaders," said Dr. Richard W. Valachovic, executive director, American Dental Education Association.

"Through teaching, academic dental institutions have ensured a competent workforce. Through research, academic dental institutions translate science into practice. Patient care is a distinct mission of academic dental institutions. Community-based dental education has become a major focus of dental schools, energized by funding initiatives such as the Robert Wood Johnson Pipeline Project. Dental schools have and continue to play the primary role as the nation's safety net for underserved populations."

Change and innovation in dental education must be responsive to evolving societal needs, practice patterns, scientific developments and economic conditions, added Dr. Valachovic.

"Academic dental institutions must prepare students to enter the practice of dentistry as professionals, informed citizens and enlightened leaders in a changing health care system," he said.

"Academic dentistry is strong, a critical partner in supplying health care professionals for the nation's workforce and a real value to parent institutions," said Dr. Valachovic. "Yet, academic dental institutions face a number of significant challenges."

Those challenges, he said include financing of dental education and growing levels of student debt as well as the approximately 400 vacant budgeted faculty positions in U.S. dental schools.

"Student debt has a significant impact on students' career choices and practice locations. Without faculty, there simply is no dental education and therefore no dentists. These challenges are occurring at a time during which higher education in general is being forced to pursue new and innovative ways of funding to remain vital."

The most serious issue facing health care today, including oral health care, is providing care for an increasing population of unserved, underserved and uninsured patients who lack access to oral health care and as health care costs rise, Dr. Valachovic said.

"Not only do our dental students continue to serve a growing percentage of the underserved, their experience in access to care immerses them in a culture that teaches them how to be charitable," said Dr. Haught. "Dentistry and dental education have always risen to the occasion to help the underserved in our public and will continue to do so in the future."

Log on to "www.ourlegacyourfuture.org" for more details. ■

HRSA awards $9.1 million for HIV/AIDS dental care

BY CRAIG PALMER

Washington—The federal Health Resources and Services Administration awarded $9.1 million to hospitals and dental schools providing oral health care to HIV-positive patients.

"These awards help reinforce the importance of good oral health and treatment, especially for people living with HIV/AIDS who often have no other source of dental care," said HRSA Administrator Elizabeth Duke.

The awards are funded under the HIV/AIDS Dental Reimbursement Program of the Ryan White CARE Act. In 2006, dental reimbursement programs reported caring for more than 34,000 patients living with HIV, and dental and dental hygiene students and post-doctoral residents provided more than 408,000 hours of direct clinical oral health services to these patients.

The 68 grants under HRSA's dental reimbursement program are listed at "http://newsroom.hrsa.gov/releases/2006/dental-reimbursement-grants.htm". ■

Workforce

Continued from page one

some new types of auxiliaries," he said.

The House action creates two new members of the dental workforce:

• Oral preventive assistant: OPAs may be utilized to provide preventive services for relatively uncomplicated patients, permitting dental hygienists to focus on more complicated patients. OPAs can also fill a role in public facilities such as community health centers and schools. The OPA model is designed to create an assistant who has solid background in providing patients with oral health education and information as well as the basic elements of preventive care.

• Community dental health coordinator: New team member that will be specifically trained to help organize community programs and function in remote locations and other underserved areas. CDHCs will be of particular value to public programs, but could be useful in larger private practices, too. CDHCs will enable the existing workforce to expand its reach deep into underserved communities and influence local health and community organizations to adopt initiatives to promote oral health. CDHCs working in facilities without the continuous presence of a dentist could perform palliative temporization of conditions (limited to hand instrumentation only) for later diagnosis and treatment by a dentist.

Res. 3H also creates guidelines that states can use to expand duties of dental assistants, if they so choose.

Since 2004, the House of Delegates has directed three work groups to study dental workforce issues as part of a much broader Association effort to evaluate workforce and oral health access.

Res. 85H-2005 created a 19-member workforce task force with membership from each trustee district, two trustees, and representatives of the councils on Dental Practice and Access, Prevention and Interprofessional Relations. The task force's charge was to analyze data and information regarding the adequacy of the current workforce to meet the access needs of the underserved and make recommendations.

"This past year's task force included representatives of every district so we received very broad input and had great discussion," said Dr. Bramson. "Most importantly, the task force listened to the House last year and made adjustments to the model. Our next steps are to first develop the curriculum for these two new types of auxiliaries and then start our pilot training programs."

The Board of Trustees understood that "solutions need to be multiple, flexible and much more creative than our current system of the dental team and traditional private practice dental settings," said Dr. Roth.

"The creation of the workforce task force brought together many volunteers from different specialties and practice settings to comprehensively study the issue of access and put forward recommendations for expanding our dental team members as well as the skill sets and scope for those on the team," she said. "All members of our team can gain further education and expand their value and expertise while bringing about a more efficient, productive model with the goal of seeing more patients in a variety of dental settings."

The Report of the Dental Workforce Task Force 2006 indicates that oral health has significantly improved in the last 20 years, a large majority of the U.S. population has excellent access to dental care, and overall, there is an adequate supply of dentists to meet demand for care. But not all oral health needs are being met.

Last year, the House approved the task force's proposal for the development of the community dental health coordinator model in Res. 96H-2005. Dr. Perry Tuneberg, then trustee of the ADA 8th District, was named chair of the Res. 96H committee.

"Our studies showed that if you can make rural dentists more productive in their office, you can significantly reduce access to care issues," said Dr. Tuneberg in describing how the committee arrived at its recommendation for the CDHC. "In many underserved areas, there are dentists to address needs but those dentists are having a difficult time finding additional staff. If we can help dentists operate more efficiently, then they can treat more patients."

The workforce task force's report emphasizes that access problems can't be solved by focusing only on the supply of dentists or expanding or creating new types of dental personnel. Even so, "the ADA workforce proposal can help improve access for these populations," said Dr. Roth.

"All of us understand that funding of government-provided programs remains critical to success, but expanding the skills and services of all those providing dental care is a major step

See WORKFORCE, page 19

Photo by Lagniappe Studio

Speaking their minds: Attendees at the Reference Committee on Dental Education and Related Matters wait to provide testimony during annual session in Las Vegas Oct. 17.

House passes resolutions on oral health literacy

BY STACIE CROZIER

Las Vegas—Armed with data showing that nearly half of all Americans lack adequate oral health literacy skills that account for billions of dollars in added health care costs each year, the 2006 ADA House of Delegates adopted several resolutions addressing this need.

In March, the Council on Access, Prevention and Interprofessional Relations held a mega issue discussion on oral health literacy. Council members learned that people with low oral health literacy are often less likely to seek preventive care, comply with prescribed treatment and maintain self-care regimens. They can also be embarrassed or ashamed to admit they have difficulty understanding health information and instruction and hide the problem.

Data show that limited literacy skills are a stronger predictor of an individual's health status than age, income, employment status, education level and racial or ethnic group and that low health literacy costs the health care system as much as $58 billion each year.

Dr. Vincent Filanova, council chair, said most of his patients are elderly or have special needs, so it's important for him to work with caregivers to make sure they have good oral health literacy skills.

"I talk to family members, advocates, residential managers, nurses and other caregivers every day about what my patients need," he says. "It's not only important to educate patients, but also caregivers, parents and other health professionals."

Increasing oral health literacy in the general population, Dr. Filanova added, can help reduce health disparities and increase access to care by spurring public desire for dental care and public interest in the connection between oral and overall health.

Photo by Lagniappe Studio

Literacy: Dr. Vincent Filanova speaks to the House Reference Committee on Dental Benefits, Practice, Science and Health regarding oral health literacy Oct. 17 at annual session in Las Vegas.

"Low oral health literacy doesn't have boundaries," he said. "It can affect people regardless of their educational level and economic status."

Resolution 13H-2006 modified the Association's definition of oral health literacy. It now reads "that it is the ADA's position that oral health literacy is the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate oral health decisions."

Res. 14H-2006, "Limited Oral Health Literacy Skills and Understanding in Adults," notes that "limited oral health literacy is a potential barrier to effective prevention, diagnosis and treatment of oral disease" and directs the ADA Council on Access, Prevention and Interprofessional Relations and other appropriate agencies to work with state and local dental societies, other dental and non-dental organizations, the health care community and governmental agencies "to increase awareness that many adults have limited oral health literacy skills and difficulty understanding oral health information and available services."

Res. 17H-2006 directs the ADA president to appoint a three-year oral health literacy ad hoc advisory committee to help CAPIR develop policy recommendations, targeted educational strategies and other health promotion programs to address oral health literacy issues.

Res. 18H-2006 directs CAPIR to develop a funding proposal for implementation in 2008 and seek external funding to support the design and execution of a comprehensive oral health literacy awareness and education strategy targeting the entire dental team and Res. 19H-2006 encourages the development of oral health literacy continuing education program to train dentists and allied dental team members to communicate effectively with patients with limited literacy skills. ■

Science resolutions address use of human subjects, laboratory animals

BY JENNIFER GARVIN

Las Vegas—The ADA House of Delegates adopted two resolutions on scientific issues in October:

Resolution 33H-2006 adopts the World Medical Association Declaration of Helsinki, Ethical Principles for Medical Research Involving Human Subjects (2004) and updates ADA policy entitled Declaration of Helsinki. It also resolves that Guidelines for the Use of Human Subjects in Dental Research (Trans.1978:62, 536), be rescinded.

Res. 43H-2006 amends ADA policy, Use of Laboratory Animals in Research, by including the following statement to reflect that the ADA favors all reasonable efforts that would ensure the humane treatment of laboratory animals but opposes the enactment of restrictive legislation that would hamper investigation or impede the progress of research.

In the background information, the 14th District pointed out current alternative technologies to aid in testing required an amendment. The statement noted that the ADA is responsible for the ethical foundation of the dental profession and must provide leadership and guidance for the testing of the products used.

The amended policy now states:

"The American Dental Association encourages researchers and dental material manufacturers to find non-animal testing modalities for dental materials and techniques whenever alternative testing modalities would accomplish the same purpose." ■

2006 Delegates focus on dental tourism

BY ARLENE FURLONG

Las Vegas—The 2006 ADA House of Delegates addressed dental tourism for the first time in Association history last month.

Recognizing that an increasing number of U.S. citizens are seeking dental treatment in other countries, Resolution 44H-2006 directs the ADA to determine how the Association can best support the dental community, patients and the public.

In its comments, the Board observed that patients crossing the border for dental care may see value in reducing the initial cost of treatment, but be unaware of differences in other areas related to treatment, such as dental education, credentialing standards and quality issues. That patients may not understand the importance of an established doctor/patient relationship or that there may be no legal recourse or malpractice coverage in the event of a serious adverse outcome were other issues noted by the Board.

Although there are Association policies on dental benefits, insurance plans, quality dental care and freedom of choice for patients that relate to the topic, the House decided dental tourism should be addressed directly and called for development of a public affairs approach to show the overall value of good dental care.

It directs the appropriate ADA agency to:

• research the issues surrounding the practice of dental tourism including service levels, quality, reimbursement, ethics and other related concerns;

• initiate dialogue with benefits administrators and representatives of the dental insurance industry, including payers, purchasers and regulators to address treatment, payment and claim-related issues related to dental tourism;

• report its findings to the 2007 House of Delegates, including any recommendations for new or revised policies addressing the concerns related to dental tourism. ■

Washington dentist shares his thoughts over coffee

BY JENNIFER GARVIN

Yakima, Wash.—Endodontist Scott Williams received some unexpected—yet welcome—notoriety when his opinion was featured on the side of a Starbucks coffee cup as part of the company's "The Way I See It" program.

Dr. Williams submitted his saying early in 2006, and in June, the Seattle-based Starbucks notified him that his quote was selected as No. 156. He first saw it on a cup in August.

"I'm having my Andy Warhol moment," said Dr. Williams. "I've had a lot of fun doing this."

Perhaps the most entertaining aspect has been seeing the outreach beyond Yakima, Wash., where he lives and owns an endodontics practice.

Dr. Williams' daughter, Shelly, a student in Minneapolis, spotted it there and reacted by saying, "Hey, this is my dad," he said.

Shelly's former roommate reported seeing it at a Starbucks in Princeton, N.J., and other friends and family across the country have seen it as well.

"It's just one of the many ways this personable endodontist has served our community with his skills and wisdom," wrote Dr. Roman W. Rossmeisl, Dr. William's associate at the Yakima practice, in a letter to ADA News.

Full disclosure: At the time Dr. Williams submitted his quote to the contest, he was a "grande"-sized, two-to-three-shots-of-espresso drinker at his local venue. However, he recently switched to decaf, nonfat lattes after having two stents placed in his heart.

The quote reads: "We don't need less partisanship in our political system. We need passionate partisanship thoroughly seasoned with civility, respect and responsibility. It would be a refreshing and welcome change."

Photo courtesy of Dr. Scott Williams

Coffee break: Dr. Scott Williams loads up on Starbucks for his endodontics practice in Yakima, Wash. A Starbucks devotee, Dr. Williams is responsible for Quote No. 156 in the company's "The Way I See It Campaign."

Of some 200 quotes currently in circulation, only about 35 according to Dr. Williams, were non-celebrities. He's found himself in good company, with notables including Roger Ebert (Saying No. 10), Steve Martin (No. 112) and Tom Brokaw (No. 130). Dr. Williams' quote, No. 156, is wedged between Seattle Mariners All-Star Ichiro and Dyson vacuum inventor James Dyson. ■

Users: CE Online a 'win-win'

Dentists, members of the dental team are logging on

BY ARLENE FURLONG

"This is something I'll never stop using."

That's Dr. Richard K. Schock of Bend, Ore., on ADA CE Online.

"I used to read up to 16 journals a month and never got any credit for it," Dr. Schock explained. "The topics and materials I've found on ADA CE Online are good ones."

Since its July launch, general dentists, specialists, dental hygienists, assistants, dental students, dental laboratory technicians, administrative personnel, treatment coordinators and dental team members are earning continuing education credits 24 hours each day, seven days a week, 365 days a year at "www.ada.org/goto/ceonline".

The cost is $28 per credit hour for members and $42 per credit hour for nonmembers. Newly reduced pricing for dental team members is $15 per credit hour.

"For me, it's a win-win all the way around," Dr. Schock told ADA News. "ADA CE Online is easy to use, very convenient."

Registrants have access to a course for one year from the date of purchase and can bookmark courses to return to and complete at a later time.

Features include a link allowing users to check with their licensing states regarding exact requirements for continuing education. Students receive an electronic letter of completion showing the hour(s) of CE earned.

Compatible for PC and/or Mac users with the connection speed of a dial-up modem (56 kilobits), ADA CE Online also offers toll-free technical support: 1-877-4ADACE1 (1-877-423-2231).

The ADA is a CERP-recognized provider.

The American Dental Association Continuing Education Recognition Program is administrated by a standing committee of the Council on Dental Education that includes representatives of the American Dental Association, the American Association of Dental Examiners, the American Dental Education Association, the Canadian Dental Association and the organizations representing the recognized dental specialties. ■

CE Online seeks reviewers, courses

Do you have additional education or interest in a specific area of dentistry?

The Center for Continuing Education and Lifelong Learning is seeking volunteers for ADA CE Online's editorial review board.

Requirements include the ability to review a CE course within two weeks and provide comments on its accuracy and relevance to dentistry. Three reviewers review each course before it can be approved.

Please submit brief biographical information, including practice type, education and areas of interest to the ADA CELL office, 211 E. Chicago Ave., Chicago 60611 or e-mail "mckinneym@ada.org".

In addition, ADA CE Online is seeking courses. A shared royalty program is available to organizations and authors for accepted manuscripts.

Guidelines can also be accessed at "www.ada.org/goto/ceonline"—click on "Submitting Course Content." If you have questions, call Ext. 2662. ■

Workforce resolutions summarized

Res. 3H-2006 calls for the ADA to support the model for expanded duties for allied dental personnel as presented in the Report of the Workforce Task Force but changes "formal education" and "Certification Required" to "additional education and a certificate of completion as determined by each state board of dentistry."

Res. 3H also urges constituent dental societies in consultation with state boards of dentistry to review the model and determine its possible applicability in their states. Further, the ADA president in consultation with the 2005-06 task force chair should appoint a work group of five task force members to design and develop pilot projects that can be carried out to test the oral preventive assistant model in selected states or locales.

Relevant constituent dental societies and licensing boards should be urged to collaborate on the pilot projects, and short- and long-term data collection and evaluation should be developed to support documentation of the progress that the pilot projects and other models outlined by the task force have made in private practice, community clinics and underserved areas.

Res. 3H directs the Board of Trustees to provide a progress report to the 2007 House on the status of the pilot projects and other aspects of the Workforce Task Force Report, and emphasizes that the Report of the Workforce Task Force 2006 is a guide for states to develop programs.

Res. 25H-2006 calls for the ADA to establish a National Coordinating and Development Committee—appointed by the president in consultation with the Res. 96H-2005 committee—to create a community dental health coordinator model training program, including a complete curriculum with implementation and evaluation guidelines consistent with the Report of the Dental Workforce Task Force 2006.

Res. 25H directs the committee to issue the request for proposals this month and oversee the implementation of at least three pilot CDHC training programs in 2007-2008.

The same committee should also evaluate the overall success and impact of the pilot programs in training individuals to function in the role of a CDHC and establish an ongoing process for assessment of the impact of this provider on improving access to dental care and reducing disparities of dental care in their communities, and report progress on this activity to the 2007 House of Delegates. ■

Workforce

Continued from page 17

toward improvement in delivering care to those in need," she said.

"This workforce model is meant to reach across America where states determine there is a piece of this comprehensive model that might help their own state and they will need to implement that change to scope and dental practice," Dr. Roth continued. "This model has been built on flexibility and what one state needs, others may have no desire to implement. The ADA is the appropriate body to build the model but all states must remain responsible for determining solutions and practice models to fit their needs."

The ADA Foundation has funded Phase 1 of the project to develop a model CDHC training program, including a curriculum and evaluation guidelines. Phase 2 calls for the model to be piloted in urban, rural and Native American community settings. Funding for the Phase 2 pilots is being sought from foundations, state dental associations, and state and federal agencies.

The overall success and impact of the pilot programs on improving access to dental care and reducing disparities in the pilot communities will be carefully studied, said Dr. Tuneberg.

In its deliberations, Dr. Tuneberg said the task force relied heavily on the expertise of Dr. Albert Guay, ADA chief policy advisor, and Dr. Jackson Brown, associate executive director, ADA Health Policy Resources Center, for policy and past workforce issues; the total number and geographic distribution of dentists, hygienists and assistants; and workforce projections.

In the end, he commended task force members for remaining committed to their primary objective: creating a workable solution that offers access to dental care while maintaining patient health and safety. ■

House-revised CE policy gives dentists, state boards more options

BY KAREN FOX

Las Vegas—Seeking guidance on what constitutes continuing dental education?

The 2006 House of Delegates last month adopted revisions to the ADA Policy Statement on Continuing Dental Education.

"Newer state board laws and policies are allowing a greater variety of activities to qualify as continuing education, and the ADA implemented changes to its policy statement to address those CE programs," said Dr. Denis "Chip" Simon, chair of the ADA Continuing Education Recognition Program, the committee that evaluates and recognizes institutions and organizations that provide continuing education.

The Council on Dental Education and Licensure sought the changes to broaden the current definition of CE, understanding that state boards ultimately may set specific guidelines or limit the amount of credit accepted in certain CE categories. The council also believed that ADA policy on CE should be broadened beyond dental and medical sciences and embrace the variety of members' choices for CE, including practice management, and support members' quests for lifelong learning.

Examples of CE added to the ADA policy statement through Resolution 1H-2006 include volunteering pro bono dental services and authorship of publications.

"This makes it easier for us at the ADA to be at the forefront of CE," said Dr. Simon. "The policy reflects our philosophy that CE should embrace the needs and wants of the members while respecting the differences in individual state continuing education requirements."

Acceptable forms of CE might now include:

• attendance at and/or delivery of a formal CE course (didactic and/or participatory presentation to review or update knowledge of new or existing concepts and techniques);

• general attendance at a multiday convention type meeting (held at the national, state or regional level which involves a variety of concurrent educational experiences);

• authorship of publications (book, chapter of a book or article or paper published in a professional journal);

• completion of individualized CE instruction (course of study that is structured and organized, but available on an unscheduled/unsupervised basis; a method of providing feedback to the learner on performance or comprehension must be incorporated in the self-study activity);


Dr. Denis "Chip" Simon

• enrollment in a preceptor program (an independent course of study with a formally structured, preplanned and prescheduled curriculum where the participant observes and provides patient treatment using criteria and guidelines provided by the instructors; this type of study does not lead to an academic degree);

• academic service (instruction, administration or research related to undergraduate, postgraduate or graduate dental/allied dental training programs);

• presenting posters or table clinics;

• participation on a state dental board, a board complaint investigation, peer review or quality care review procedures;

• successful completion of Part II of the National Board Dental Exam, a recognized dental specialty examination or the National Board Dental Hygiene Exam if taken after initial licensure;

• test development for written and clinical dental, dental hygiene and dental specialty exams;

• volunteering pro bono dental services or community oral health instruction at a public health facility;

• participation in dental research as a principal investigator or research assistant. ■

DENTSPLY
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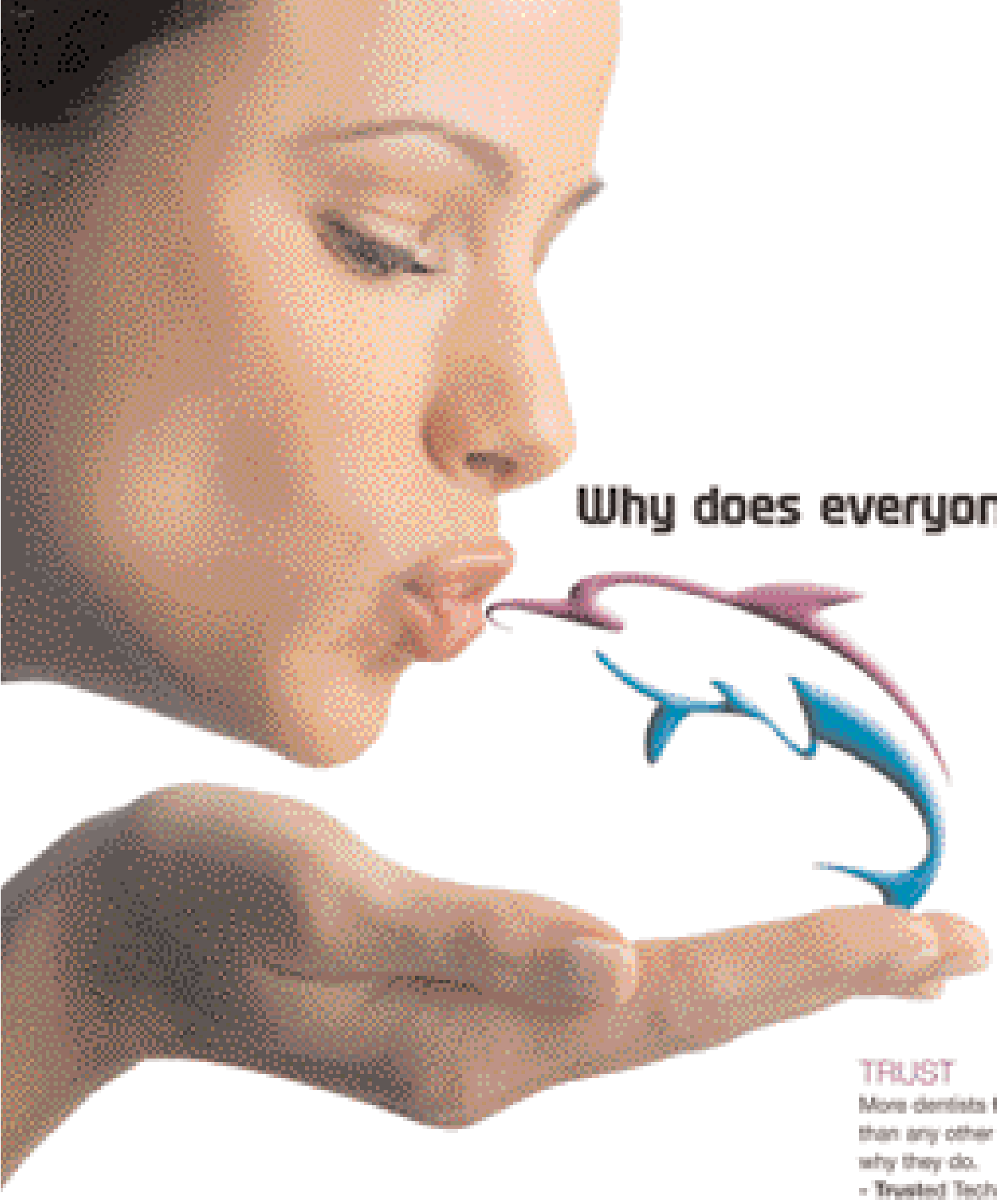

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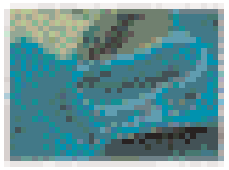

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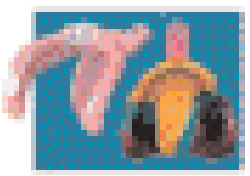
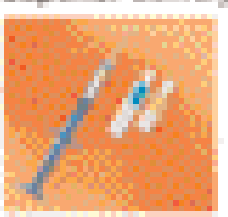


The Massad™ System for predictable fitting dentures
- A custom tray impression in one visit

- **Superior** delivery:



digit™ targeted delivery system
- Precise and convenient delivery of wash material

- **Superior** versatility:
  More viscosity, set time, and delivery choices to meet all of your clinical needs

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