9-17-2018

ADA News - 09/17/2018

American Dental Association, Publishing Division

Budget
Board announces resolutions for next year

12

Reaching out
ADA visits Navajo Nation, honors work of health leaders

20

Unicorn of sea
ADA 2018 to feature narwhal presentation

22

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BPA WORLDWIDE

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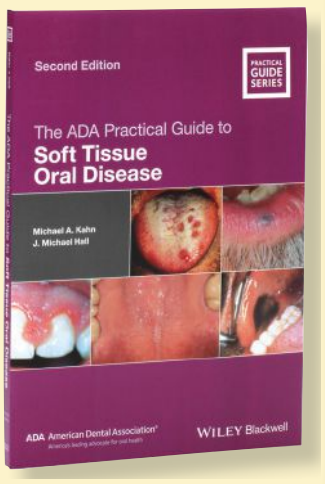
BRIEFS

Soft tissue lesion diagnosis made easier with revised ADA practical guide

What's even more useful than the best-selling ADA Practical Guide to Soft Tissue Oral Disease?

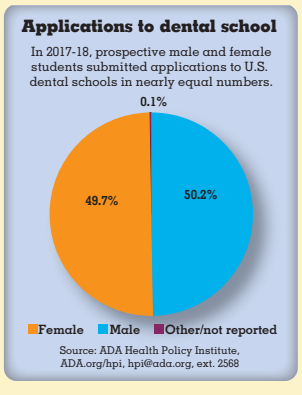
A new revision of the guide, in light of new diseases being discovered as well as a better understanding of some known diseases.



The second edition of The ADA Practical Guide to Soft Tissue Oral Disease is an updated new edition of the popular guide to oral and maxillofacial diseases that could be encountered in general or specialist dental practices. It is meant as an easy-to-use tool to aid in identifying, diagnosing and treating soft tissue disease in everyday practice with full-color examples and

See TISSUE, Page 25

JUST THE FACTS



United Concordia moves away from disallowing payment for services

BY DAVID BURGER

Editor's note: This is the 18th story in the Decoding Dental Benefits series featuring answers and solutions for dentists when it comes to the world of dental benefits and plans. The series is intended to help untangle many of the issues that can potentially befuddle dentists and their teams so that they can focus on patient care.

In what can be considered a win for the dentist-patient relationship, United Concordia Dental has just amended its policy on disallow clauses.

The third-party payer now allows dentists to charge patients for previously disallowed services if the dentist has explained to the patient that the service may not be paid for by the plan and the patient consents to the service.

The disallow clause had mandated that even after a treatment a dentist deemed necessary, not only will the third-party payer not pay for the procedure, but the dentist was also

See DISALLOW, Page 27

Prolific researcher, author receives 2018 Gold Medal Award

BY MICHELLE MANCHIR

Growing up in California's Bay Area, Dr. Kenneth Hargreaves liked to keep his hands busy. As a boy, he built rockets from kits and tinkered with electronics, such as radios, he said.

Now a prolific researcher, author, educator and endodontist, Dr. Hargreaves' work has reached a level far beyond his days with toy rockets. These days, he builds ideas that have led to treatments that have transformed dentistry.

"If we had to select an MVP in the profession of dentistry, I would say that Dr. Ken Hargreaves would be our man," said Dr. Clara Spatafore, chair of the department of endodontics at the Virginia Commonwealth University School of Dentistry.

Dr. Hargreaves in August was named the 2018 recipient of the ADA Gold Medal Award for Excellence in Dental Research. The award, sponsored by Church & Dwight, was established in 1985 and is presented once every three years to honor individuals who contribute to the advancement of the dental profession or who help improve the oral health of the community through basic or clinical research.

"We are delighted to honor Dr. Hargreaves for his outstanding career," said Jaime Shepler, professional marketing manager at Church & Dwight in a statement. "His industry-leading research, personal mentorships, community contributions, and his leadership really embody the values of the Gold Medal Award."

The Gold Medal honoree receives $25,000

See GOLD MEDAL, Page 18

Gold medalist: Dr. Kenneth Hargreaves will receive $25,000 and a gold medallion and serve a three-year term on the ADA Council on Scientific Affairs.

A conversation with the president-elect

'We can always do better'

Dr. Jeffrey M. Cole outlines goals for his year to come as ADA president

Childhood visits to the dentist were more than just check-ups or X-rays for Dr. Jeffrey M. Cole. His family dentist was a high school buddy of his father's, so when young Jeff went to a dental appointment, it was a gathering of friends and family. His mom or dad would take him, and the doctor would chat with them. "It was almost a social visit. I just loved that environment," he recalled.

No one in his family was in the health care field. His parents and sister all worked for the DuPont Company. But, he attributes the welcoming atmosphere of his childhood dental visits with leading him to decide by age 12 to become a dentist. That decision ultimately led him to open a practice in his hometown, Wilmington, Delaware, and to his ongoing involvement in local, state and national dental organizations. "Every decision I made

See CONVERSATION, Page 16

Dr. Cole: He will be installed Oct. 22 as the 155th ADA president.

Stan Brock, founder of Remote Area Medical, dies

BY DAVID BURGER

Stan Brock, the founder and president of Remote Area Medical, died from complications from a stroke Aug. 29 at the age of 82 in Knoxville, Tennessee.

Remote Area Medical is a Rockford, Tennessee-based nonprofit of mobile medical clinics with a mission of preventing and alleviating pain by providing free quality care to those in need, according to its website.

"Since he began Remote Area Medical in 1985, Mr. Brock as been a tireless advocate for those in need, and through his leadership, Remote Area Medical has provided free care to more than 740,000 individuals," said Jeffrey L. Eastman, CEO of Remote Area Medical, in a statement that announced Mr. Brock's passing.

"He put 740,000 people before himself," said Remote Area Medical spokesman Robert D. Lambert in an interview with ADA News. "He lived and breathed RAM."

According to its website, Remote Area Medical's Corps of more than 120,000 Humanitarian Volunteers — licensed dental, vision, medical and veterinary professionals — have delivered $120 million worth of free health care services in the 33 years of its life.

Mr. Brock was born in England and in 1952 moved to British Guiana (now Guyana) to become a vaquero, or cowboy. Through 1968, Mr. Brock managed the Dadanawa Ranch, the world's largest cattle ranch operation, according to his online biography on Remote Area Medical's website.

"It was during Brock's time in British Guiana that his vision for RAM was born," the biography said. "After being violently thrown off of the back of a horse, Brock found he was 26 days away on foot from the nearest medical care. Brock survived the accident, but went without any medical attention. He then vowed that he would one day bring medical care closer to the people who needed it."

Mr. Brock

On Remote Area Medical's website, Mr. Brock said, "RAM is the way I have kept a promise, not only to the Wapishana Indians, but to thousands around the world in similar health conditions. In other words, there are Wapishanas everywhere."

"Most people want to do good, but most don't have the impact Mr. Brock had," Mr. Lambert said.

In 1968, Mr. Brock arrived in the United States to begin a career in entertainment, cohosting NBC's Emmy-winning series, "Mutual of Omaha's Wild Kingdom," which, at its height, was one of the most watched television shows in the country, with more than 32 million weekly viewers, according to the biography.

Mr. Brock was instrumental in the passage of the Tennessee Volunteer Medical Services Act of 1995, which allows health professionals with out-of-state licenses to cross state lines and provide free care, the biography said.

A celebration of life will be held Sept. 27 at 6 p.m. at the Knoxville Civic Auditorium to celebrate Mr. Brock's life, Mr. Lambert said.

In lieu of flowers, Mr. Brock requested that donations be sent to Remote Area Medical in his memory. Donations can be made at ramusa.org/remembering-stan-brock.

Mr. Lambert was clear about the future. "RAM is going to continue his mission," he said of Mr. Brock. ■

—burgerd@ada.org

Association of Retiring Dentists to convene October annual meeting

Manchester, N.H. — The Association of Retiring Dentists' annual meeting is scheduled for Oct. 26 here at the Best Western Executive Court and Banquet Facility.

In addition to the morning session with New Jersey's Dr. Hugh Habas presenting "Retirement Money, Earning it, Managing it, Using it," teledentistry will be the focus of the afternoon session.

"Teledentistry has the potential to significantly change the landscape of dentistry, from diagnosis, to coordinated treatment for people in remote areas, to managing minor tooth movement, to education and perhaps unimagined services," said Dr. Neil Hiltunen, president of the Association of Retiring Dentists.

The founder and president of the American Teledentistry Association, Dr. Mark Ackerman, will lead off the afternoon with the presentation "Teledentistry, Applications and Pitfalls," followed by Dr. Maria Kunstadter presenting "The Teledentist."

Registration information can be found at retiringdentists.com. ■

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BPA WORLDWIDE

Institute for Diversity in Leadership dentists execute personal projects

Community projects: (Left photo) Dr. Estella Irelan, left, speaks with Dr. Tawana Ware about her Institute for Diversity in Leadership project on supporting first nations/Native American high school students in Milwaukee as they explore health care professions, including dentistry. (Right photo) Dr. Parampreet Chhina presents her Institute for Diversity in Leadership project Sept. 6 at ADA Headquarters. Dr. Chhina's project seeks to bridge the gap between ADA membership and licensed foreign trained dentists in the U.S. Dr. Chhina, of Philadelphia; Dr. Irelan, of Wauwatosa, Wisconsin; and Dr. Ware, of Indianapolis, are among the 20 members of the 2017-18 Institute for Diversity in Leadership. As part of the ADA Institute for Diversity in Leadership, participants are tasked with developing and executing a personal leadership project that addresses an issue or challenge in his or her community, organization or the profession.

VIEWPoint

MyView

Building practice through interprofessional collaboration

Melinda Clark, M.D.

Anita Glicken

Editor's note: The ADA Council on Advocacy for Access and Prevention asked Dr. Clark and Ms. Glicken to write this piece for the ADA News to provide readers with the medical perspective of the collaboration between physicians and dentists.

The U.S. Surgeon General Report in 2000 described oral disease as a "silent epidemic," preferentially affecting minority populations, low socioeconomic strata and the extremes of age. Much effort has been put forth in helping at-risk populations access dental care, but significant care gaps persist. Costs of dental services total over $100 billion annually, with the majority of the dollars spent on restorative care, while oral health disease remains pervasive among low-income, rural, minority and other underserved populations. The Surgeon General report envisioned a national partnership to integrate oral health into primary care, thereby increasing access to preventive services and bridging the gap between medical and dental care.

Medicine and dentistry have entrenched the separation of the mouth from the body through siloed training programs, care delivery systems and payment structures. Consequently, effective collaboration between medicine and dentistry remains rare. Consider that the teeth are the only organ where specialty care is the norm for those who are healthy. We continue to rely on specialists to provide primary prevention with the hope that the current system will expand to meet the massive population need. While we wait, preventable conditions like dental caries remain the most common chronic disease across the lifespan.

The primary care delivery system is in the midst of transforming to meet national health care priorities of reducing health care costs, improving the patient care experience and improving population health outcomes. Primary care teams are positioned to be active partners in oral health integration with their focus on whole human patient-centered care, skills in screening and risk assessment, behavior change counseling and support for patient navigation through the health care system. Arguably the greatest advantage of incorporating oral health prevention into primary care is expanded access, especially for children, as they visit their primary physician on average 13 times in the first 30 months of life. Many young children never see a dental health professional during this critical time, lost opportunities unless the primary care providers educate families about the importance of oral health and discuss nutrition, oral hygiene, fluoride and establishment of a dental home. In 2014, the U.S. Preventive Services Task Force "Dental Caries in Children from Birth Through Age 5 Years" moved oral health prevention from a pet project to a mandate for primary care, with a grade B recommendation for fluoride varnish application starting from tooth eruption through age 5 for all children in the medical home. This

See MY VIEW, Page 5

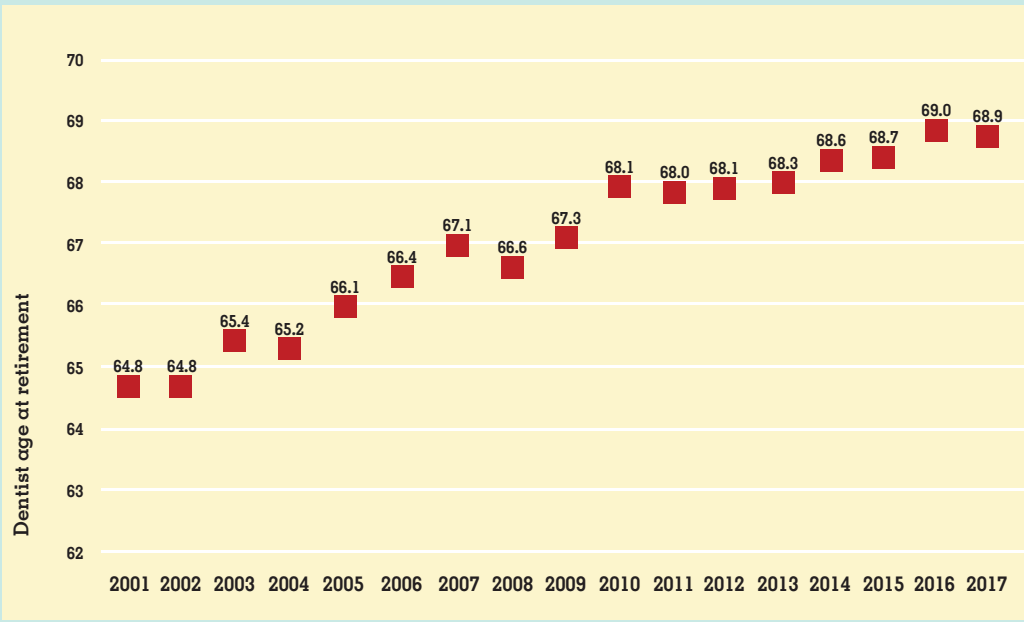
LETTERSPolicy

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

SNAPSHOTS OF AMERICAN DENTISTRY

Dentist retirement patterns

From 2001-17, the average retirement age among U.S. dentists increased by 4.1 years.



Source: ADA Health Policy Institute Infographic, "Dentist Retirement Patterns."
Available at: ADA.org/en/science-research/health-policy-institute/publications/infographics.

Letters

Student loans

Once again, student loans are in the forefront of the news. A few years ago, one of the lobbying efforts at the leadership conference was to promote some debt relief for student loans. Unfortunately, at that time, nothing happened in Congress.

Now, we have an effort by a dentist congressman for deferred interest for residency program students. Hope this succeeds.

A few years ago there was a great announcement by our leadership of a new arrangement with a bank to enable refinancing of student loans.

But there were initial problems with some trying to refinance.

In 2015, I made an unsuccessful attempt to be elected second vice president of the ADA.

As part of that experience, I had the privilege of not only addressing the House of Delegates but also addressing all 17 trustee districts and the American Student Dental Association.

In those presentations, I suggested the ADA start what I would call the American Dental Association Higher Assistance loan program using our own money, with terms that would be extremely favorable to our student borrowers.

This might include a cap of, say, 3 percent on interest rates; interest deferral and payment deferral for residency programs; interest deferral and some payment deferral for active duty military; or for some loan concessions for public heath assignments, just to name a few options.

Many of these features existed in the past but certainly can be consolidated if the ADA was acting as the bank. We can set the tone and take care of our own.

And, yes, I am familiar with the argument that many of the loans are "lifestyle" loans, but in today's world tuition alone ranges from $30,000 to $90,000 or more per year.

Then there is reasonable room and board and some lifestyle too. Maybe the American Dental Education Association could help here too.

Let's do for ourselves as a profession. Let's not have to rely on government to do what we can do for our own students. If we truly expect our new dentists to embrace the ADA, let's do something for them first.

Peter S. Trager, D.D.S.
Sandy Springs, Georgia

Editor's note: The ADA began an endorsed relationship with Laurel Road, previously known as DRB, in 2015. The program provides student loan refinancing and consolidation to members who qualify for refinancing an additional 0.25 percent rate reduction as long as they remain members. More than 2,200 ADA members have refinanced with Laurel Road, totaling more than $485 million in loan volume and saving the average member $33,000 over the life of the loan. The ADA foregoes all compensation for the endorsement and returns the savings to members. Information on Laurel Road and other debt resources can be found at ADA.org/mydebt.

MyView

Continued from Page 4

standard of care was reinforced with the addition of fluoride varnish to the Bright Futures Periodicity Schedule from tooth eruption through age 5. These recommendations, and others related to chronic disease management in older adults, communicate new expectations for primary care practice and a sense of urgency across health professions to manage patient oral health.

Since the Surgeon General's "call to action," many national organizations have endeavored to aid their constituents in oral health integration by educating, training and supporting the components of oral health delivery. These activities are illustrative of the movement to incorporate oral health into overall health care, rather than a discretionary addition to an over-burdened health system. The following are examples of how select health profession and support organizations are working to integrate oral health prevention into primary health care delivery and ultimately reduce the burden of oral disease in America.

In 2001, the American Academy of Pediatrics was among the first nondental health professions to identify oral health as a strategic priority and the AAP Oral Health initiative is responsible for education, training and advocacy for pediatricians, dentists, other health professionals and families. The AAP Section on Oral Health is a 500-member-strong voice of pediatricians and pediatric dentists who work to improve medical-dental collaboration, produce policy, practice guidelines, and curriculum training for pediatricians, and advocate for children's oral health. The AAP also trains and supports Chapter Oral Health Advocates who are pediatricians and pediatric dentists working across the United States and Canada to educate others on preventive oral health in the pediatrician's office, fluoride varnish application and the importance of establishing a dental home by age 1.

Smiles for Life is a curriculum developed by the Society of Teachers of Family Medicine that has evolved into an interprofessional training program. The mission of SFL is to produce educational resources to ensure the integration of oral health and primary care. The curriculum has been endorsed by over 20 health profession organizations, including the American Dental Association, and continuing education credit is available for physicians, nurses, physician assistants, pharmacists, midwives, medical assistants and dental health professionals through the ADA CERP program. The eight Smiles for Life modules can be completed online or downloaded for educator use in the classroom setting. Since the launch in 2010, the website has seen over 1.2 million discrete site visits, with over 80,000 registered users completing over 250,000 hours of online training for credit. These materials are being utilized by health professions of all types and at all levels of training, which speaks to the readiness and willingness of the primary care workforce to engage in oral heath prevention.

In 2009, the National Interprofessional Initiative in Oral Health was founded by a group of funders, medical and dental leaders and national organizations to promote the integration of oral health in primary care education and practice. As a systems change initiative, the National Interprofessional Initiative in Oral Health provides backbone support and facilitates interprofessional learning, agreement and alignment across health professions. Examples of the initiative's work include support for Smiles for Life and the commissioning of Qualis Health to create an implementation guide and tool kit to integrate oral health into whole person care.

The Physician Assistant Leadership Initiative in Oral Health (2009) and the Oral Health Nursing Education and Practice initiative (2011) were early efforts supported by the National Interprofessional Initiative in Oral Health and both remain at the forefront of innovation to integrate oral health across their professions. PAs engaged leadership across national regulatory and member organizations use a collective impact strategy to embed oral health competencies across the profession. A recent national survey of PA education program directors documented that these efforts are bearing fruit, with 96 percent of responding programs indicating they now include specific instruction on oral health and disease in their curriculum. The Oral Health Nursing Education and Practice Initiative works to integrate oral-systemic health into undergraduate and graduate nursing programs nationwide. The initiative's interprofessional oral health toolkit for primary care nurse practitioner and midwifery programs is widely used by nursing programs across the country and is a resource for other health professions seeking to develop similar tools.

Oral Health 2020 is a network of national, state, and community-based change agents dedicated to improving the oral health of all. The network engages partners who share the vision of eradicating dental disease in children, incorporating oral health into the primary education system, inclusion of an adult dental benefit in publicly funded health coverage, creating a comprehensive national oral health measurement system, integrating oral health into person-centered health care and improving the public perception of the value of oral health in overall health.

These are a few of many examples of national undertakings to expand oral health preventive services in the primary care setting. Additional efforts, including embedding a dental hygienist within the primary care team has proven successful at the local level, but has yet to be accepted as standard for practice in medicine or dentistry. The training of

See MY VIEW, Page 6

Stericycle settlement checks coming in mail

BY KELLY GANSKI

Dentists who were members of the Stericycle class action lawsuit should keep an eye on their mailbox for settlement checks.

A $295 million settlement was reached in October 2017 on behalf of a nationwide class of Stericycle customers, following a class-action lawsuit accusing the company of engaging in a price-increasing scheme that automatically inflated customers' bills up to 18 percent biannually.

Settlement checks were mailed to eligible class members on Aug. 28, according to stericycleclassaction.com, a website set up by the class action plaintiffs' lead law firm.

The class of Stericycle customers included any person or entities that between March 8, 2003, and Oct. 26, 2017, resided in the United States, except Washington and Alaska, were identified by Stericycle as a "small quantity" customer and were charged and paid more than their contractually agreed price for Stericycle's medical waste disposal goods and services, according to the website.

Hazardous waste pickup: A Stericycle truck parks in Chicago, not far from the company's headquarters in Lake Forest, Ill. Dentists have complained to the American Dental Association that Stericycle did not specifically outline escalating fees in their contracts.

Dentists can visit hbsslaw.com/cases/stericycle to view a sample check or stericycleclassaction.com/faq to view frequently asked questions about the litigation.

Dentists who believe they are eligible class members and did not receive their checks can contact the settlement administrator at: Stericycle Class Action, c/o GCG, P.O. Box 10515, Dublin, OH 43017-1515 or Questions@StericycleClassAction.com.

The ADA continues to receive calls from members regarding auto-renew provisions in service contracts, as in a typical Stericycle contract.

The ADA Center for Professional Success has guidance on auto renew contracts at ADA.org/autorenew. ■

—ganskik@ada.org

MyView

Continued from Page 5

community health workers, promatoras and other front line workers who meet individually with clients shows promise, as their contributions to chronic disease management is shown to be effective. We believe these lessons can be more robustly applied to the caries crisis.

We all want our patients to have healthy bodies and healthy mouths and to improve health outcomes while managing costs. We must continue to challenge the status quo that oral health is exclusive to the profession of dentistry. Certainly, dental health professionals should control the practice of dentistry, which is quite distinct from owning the oral health of the entire population. We hope to share the burden of prevention with dentistry as soldiers on the front lines of health care carrying oral health messages to the highest risk and most vulnerable every day. We must strive to embed oral health into all the health professions training at every level to empower them as a voice of advocacy for prevention. We must challenge the cultures of our professions to reform our training programs, payment structures, and system of care delivery to ensure preventive care services for all.

Dr. Clark is an associate professor of pediatrics at Albany Medical Center in Albany, New York. Ms. Glicken has a master's degree in social work and is the executive director of the National Interprofessional Initiative on Oral Health and the associate dean and professor emeritus at the University of Colorado School of Medicine.

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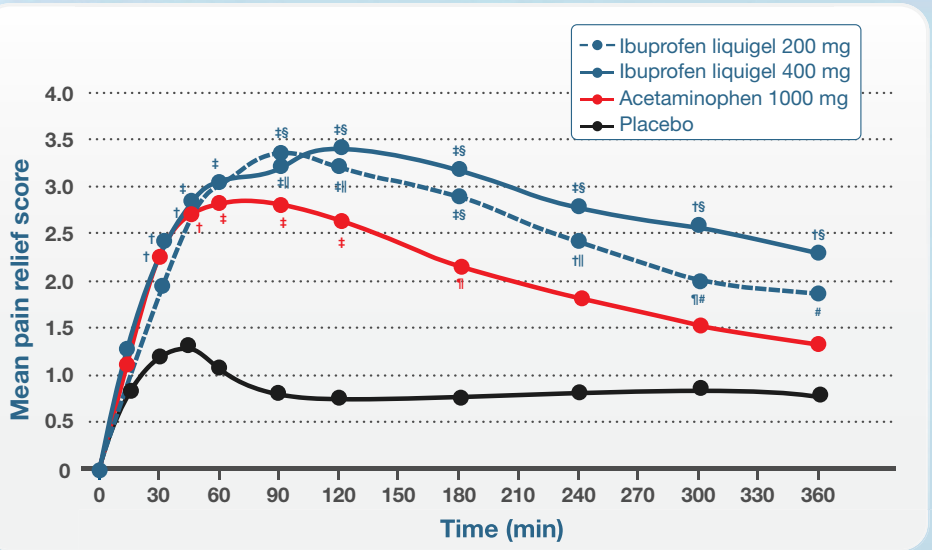

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‖$P<.01$ vs acetaminophen 1000 mg; ¶$P<.05$ vs placebo; #$P<.05$ vs acetaminophen 1000 mg.

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References: 1. Hersh EV, Levin LM, Cooper SA, et al. Ibuprofen liquigel for oral surgery pain. *Clin Ther.* 2000;22(11):1306-1318. **2.** Bjarnason I. Ibuprofen and gastrointestinal safety: a dose-duration-dependent phenomenon. *J R Soc Med.* 2007;100(suppl 48):11-14. **3.** Rainsford KD, Roberts SC, Brown S. Ibuprofen and paracetamol: relative safety in non-prescription dosages. *J Pharm Pharmacol.* 1997;49(4):345-376. **4.** Rainsford KD. Ibuprofen: pharmacology, efficacy and safety. *Inflammopharmacology.* 2009;17(6):275-342. **5.** McGettigan P, Henry D. Cardiovascular risk with non-steroidal anti-inflammatory drugs: systematic review of population-based controlled observational studies. *PLoS Med.* 2011;8(9):e1001098. doi:10.1371/journal.pmed.1001098.

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GOVERNMENT

Discussion abounds on adding dental benefit in Medicare

BY KELLY GANSKI

Adding a dental benefit within Medicare is a topic of conversation among agencies that advocate for seniors but also within the ADA.

The Council on Dental Benefit Programs, with support from the Council on Advocacy for Access and Prevention, is submitting Resolution 33 to the House of Delegates, which meets in October in Honolulu, which outlines what the council would want as an advocacy position if legislation to add a dental benefit to Medicare is introduced in Congress. This comes on the heels of the ADA's increasing awareness of Oral Health America's coalition of consumer advocacy groups that is beginning conversations with legislators and regulators on adding a dental benefit to Medicare.

"If the program were to be implemented, it must be designed to ensure dentists are willing to participate while taking the best care of our patients," said Dr. Brett Kessler, member of the ADA Council on Dental Benefit Programs, which had been charged by the Board of Trustees with exploring the implications of including dentistry in Medicare. "The big questions that we face are whether the ADA should advocate for a benefit? Should the ADA do everything in its power to prevent a benefit? Should the ADA develop a policy that we try to educate or guide any entity that is trying to develop a dental benefit in Medicare to include what we think are best practices?"

The ADA evaluated the benefit design developed by the coalition then began educating the group on the Association's perspective on benefit design, offering its own analysis on a Medicare benefit. The coalition July 20 released a white paper titled "An Oral Health Benefit in Medicare Part B, It's Time to Include Oral Health in Health Care," on the proposed benefit, examining need, cost and needed legislative changes.

The ADA contributed data to the white paper, but the Association's input "does not constitute endorsement of inclusion of a dental benefit under Medicare at this time," ADA President Joseph P. Crowley said in an email to members July 23.

"If we are not at the discussion table, no one will win. Not our patients, not our communities, not our practices," Dr. Kessler said.

The Council on Dental Benefit Programs' resolution states if legislation were introduced that would add a dental benefit to Medicare then the ADA should advocate for:

- Coverage for comprehensive services in an appropriate part within Medicare with adequate program funding.
- Reimbursement rates at or above median fees (50th percentile) as described in the current ADA Survey of Dental Fees to ensure adequate dentist participation.
- Funding for technical support for dental practice participation including adoption of health information technology standards.
- Minimal and reasonable administrative requirements for dental practice participation
- Medicare beneficiaries with the freedom to choose any dentist while continuing to receive the full Medicare benefit.

"No matter the outcome of this resolution, policymakers, legislators and members of the public look to the ADA for guidance and solutions on solving dental access issues for senior Americans," said Dr. Tim Fagan, chair of the Council on Advocacy for Access and Prevention. "Based on the ADA vision of 'achieving optimal health for all,' the ADA must take an active role in the ongoing discussions to help craft the best strategies for senior dental care."

Other ADA councils share a different perspective.

The Council on Dental Practice also believes that any benefit dependent solution for dental eldercare should be a needs-based program rather than the age-based program proposed by the Oral Health America consortium.

"CDP recognizes that the ADA is committed to empowering the profession of dentistry to advance the overall oral health of the public and there is no doubt that the ADA should continue to advocate for efforts that meet the dental care needs of the elderly who cannot otherwise obtain care," Dr. Craig Ratner, chair of the Council on Dental Practice, said. "Yet, we must be realistic and recognize that a needs-based program maximizes the ability of the program to provide care to those who need it and cannot afford it while preserving the Medicare program's limited funding and other resources."

In action in August, the Board of Trustees offered a comment to Resolution 33 that asks the House of Delegate to refer the resolution back to the appropriate ADA agencies so that a comprehensive strategy for addressing the needs of the growing elder care population can be addressed. In its comments, the Board noted that "as Americans live longer, growth in the number of older adults is unprecedented. In 2014, 14.5 percent (46.3 million) of

See MEDICARE, Page 9

ADA formally comments on proposed CMS changes

BY JENNIFER GARVIN

Washington — The ADA filed comments Sept. 6 on several parts of a proposed rule announcing changes to Medicare and Medicaid requirements as they relate to dentistry.

In a letter to the Centers for Medicare & Medicaid Services and U.S. Department of Health and Human Services, ADA President Joseph P. Crowley and Executive Director Kathleen T. O'Loughlin offered comments on the following areas:

The ADA's concern is based on the observation that none of the 33 dentistry-oriented products on the Office of the National Coordinator for Health Information Technology's Certified Health IT Products List are certified to 2015 Criteria.

- Requirements for Merit Based Incentive Payments System-eligible physicians to use electronic health records technology using 2015 criteria.
- Proposed measures to update the existing quality measure specifications for health care specialties, including dentistry.
- The Physician Self-Referral Law.

Regarding Certified Electronic Health Record Technology requirements, the ADA noted that in 2017 and 2018, eligible clinicians had the flexibility to use electronic health record technology that was certified by the 2014 or 2015 Edition certification criteria. In 2019, clinicians will be required to use the 2015 criteria exclusively, which is problematic for dentistry.

The ADA said it "appreciates CMS' and other stakeholders' concerns regarding the obsolescence of the 2014 Certification Criteria," but is concerned that dentists will not have access to 2015 Certified Electronic Health Record Technology products, and will not be able to participate in the Promoting Interoperability Programs in 2019, and possibly 2020 and beyond.

The ADA's concern is based on the observation that none of the 33 dentistry-oriented products on the Office of the National Coordinator for Health Information Technology's Certified Health IT Products List are certified to 2015 Criteria.

Because the Association is not aware of any "dentistry-specific, ambulatory-only" electronic health record vendors that plan to seek 2015 certification, Drs. Crowley and O'Loughlin suggested that the agency "examine the gaps" between existing dental electronic health record implementations and 2015 certified products and devise reporting criteria utilizing the existing 2014 Edition technologies.

In regards to proposed measures to update the existing quality measure specifications for health care specialties, including dentistry, the ADA commented on two oral health specific measures included in the specialty measure sets:

- Quality ID-378, which concerns children aged 1-20 who have dental decay or cavities.
- Quality ID- 379, which covers primary caries prevention intervention measures such as fluoride varnish for children as offered by primary care medical providers, including dentists.

See CMS, Page 15

Medicare

Continued from Page 8

the U.S. population was age 65 and older and is projected to reach 23.5 percent (98 million) by 2060. Currently, approximately one half of the U.S. population do not see a dentist for at least one visit a year."

"The Council on Government Affairs understands that this is a significant issue for dentistry and for seniors," said Dr. Craig Armstrong, vice chair of the Council on Government Affairs. "This is something that the council has discussed extensively over the last year and as a result, believes taking the time to develop a comprehensive strategy for older adults would put the ADA in a strong position as we continue to advocate for our members and the patients we serve."

The reaction from ADA members on the issue seems to be mixed, based on feedback the ADA Practice Institute has received via email. Some believe it would be a mistake for dentistry to get involved in Medicare while others believe it's dentists' duty to ensure seniors have access to financing support for dental care.

2018 Report 1 of the Council on Dental Benefits Program is posted in the members only board Reports and Resolutions page of ADA.org on Page 3018 of the document (3000-3999) Committee B - Dental Benefits, Practice and Related Matters - All Inclusive.

Members who want to share opinions on this issue can email the council at dentalbenefits @ada.org. Comments will also be shared with other ADA councils and the Board of Trustees for review. ■

FDA outlines plans for new guidance on developing pain drugs

BY JENNIFER GARVIN

Silver Spring, Md. — The Food and Drug Administration said Aug. 29 that it intends to withdraw its existing analgesic guidance for developing new pain drugs and will issue new guidance in 2019.

The decision, said FDA Commissioner Scott Gottlieb, M.D., is in response to the shifting nature of the nation's opioid epidemic. In prepared remarks, he noted that previously the crisis was "largely dominated" by prescription drug addiction but has now moved to one that "increasingly implicates the use of illicit drugs, including highly potent fentanyls. These drugs are obtained illegally, often through purchases made online, and in many cases shipped through the international mail."

In withdrawing the FDA's existing 2014 analgesic guidance, Dr. Gottlieb said the agency plans to issue no fewer than four documents, which will be released from February to August 2019. The new guidance documents will explore the following:

- Nonopioid alternatives. This guidance "will set forth the FDA's current thinking on how sponsors can demonstrate a clinically meaningful reduction in the use of opioid pain medications when used for acute pain," Dr. Gottlieb said.
- Charging drug makers with assessing the benefits and risks when new opioid pain drugs are put into development.
- Developing extended-release local anesthetics, which can serve as an alternative to the systemic use of oral opioid drugs. "This guidance will address the clinical pharmacology, the proper evaluation of safety and efficacy, and the types of studies that may support approval of these products."
- Assisting sponsors with the development of new nonopioid pain medications for chronic pain that can provide therapeutic alternatives to the use of opioids.

Dr. Gottlieb also detailed a recent FDA analysis that found declines in outpatient settings opioid dispensing. He shared that in the first half of 2018, the volume of opioid analgesics dispensed was down more than 16 percent — going from 88.8 metric tons of oral morphine equivalent to 74.1 metric tons. The volumes of opioid analgesics dispensed in the first halves of 2017 and 2016 were also down.

"These trends seem to suggest that the policy efforts that we've taken are working as providers, payers and patients are collectively reducing some of their use of prescription opioid analgesic drugs," he concluded.

Follow the ADA's opioids advocacy efforts at ADA.org/opioids. ■

Tricare retiree dental program to replace Delta Dental with federal plan

BY JENNIFER GARVIN

The Federal Employees Dental and Vision Insurance Program will replace the Tricare Retiree Dental Program later this year.

Participants may begin enrolling in the federal program Nov. 12 through Dec. 10 for coverage that starts Jan. 1, 2019.

Delta Dental previously administered the program. The move from Delta Dental to a federal plan resulted from the 2017 National Defense Authorization Act, which mandated giving military retirees access to a vision plan that was not previously available to them in Tricare.

Under the new plan, retired uniformed service members and their families who are eligible for the Tricare Retiree Dental Program will be eligible to enroll in dental coverage under the Federal Employees Dental and Vision Insurance Program.

The federal plan will give enrollees the option of choosing from six national plans: Aetna Dental, Delta Dental, FEP BlueDental, GEHA, MetLife and United Concordia Dental, and four regional plans: Dominion Dental, EmblemHealth, Humana and Triple-S Salud.

For dentists who receive questions from patients, Delta Dental is urging them to have patients select a FEDVIP dental plan in order to continue their dental benefits. The switch is not automatice: Patients must sign up during the open enrollment period.

Tricare is also encouraging patients to use its online comparison tool for figuring out which plan works best for them. The comparison tool can be found at tricare.benefits.com. By entering specific ZIP codes, patients will receive estimates on what to expect from coverage costs.

"Many dental offices may be treating patients who are retired from the military and using the Tricare dental plan," said Dr. Steven Snyder, chair, ADA Council on Dental Benefit Programs. "Following enrollment in the Federal Employee Dental and Vision Insurance Plan, their benefits may be significantly different. Offices should have a conversation about the patients' needs and their new benefits along with explaining the office's financial policies. Experiences that offices have with the national carriers already participating in the federal plan may give them a sense of what to expect in terms of processing policies and documentation requirements for claims for these patients." ■

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Search engine marketing, long-term stability all part of 2019 budget proposal

ADA Board submits resolutions for dues increase, special assessment

BY JUDY JAKUSH

In its 2019 budget proposal, the ADA Board of Trustees is investing in the Association's and members' digital and real-world future with a resolution seeking a $22 dues increase and, separately, a resolution seeking a one-time special assessment of $58 to fully fund the third year of the Find-a-Dentist campaign.

Said Dr. Joseph P. Crowley, ADA president, "One of the key actions in the new budget is funding, on an ongoing basis, the Association's ability to communicate in the digital world in a competitive manner. This requires best-of-class tools to help us organize and maximize what we do in reaching the widest possible audience with our oral health message through efforts such as search engine marketing."

Search engine marketing basically involves paying for ways to increase Internet traffic to specific content.

"Although the dues increase supports the addition of new member value through search engine marketing, this increase is not unreasonable given that the ADA had only one modest dues increase in the past five years," said Dr. Jeffrey M. Cole, ADA president-elect.

Dr. Crowley

Dr. Cole

Dr. Lemmo

"Due to the effects of inflation the Board is finding it difficult to maintain operations to support the advancement of the strategic plan," he said. "My personal feeling is that in the future we would best serve the members with small dues increases to keep up with inflation, rather than a sizable increase every few years. As a result, the Board will consider recommendations regarding smaller, incremental increases rather than larger infrequent dues adjustments from the Budget and Finance Committee."

Dr. Cole emphasized that the 2019 budget supports the goals and objectives of the Association. "It adequately funds the ADA so that it can fulfill Strategic Plan-Members First 2020 and its constitutional obligation of increasing the oral health of the public and advancing the art and science of dentistry.'"

Dr. Crowley noted that the budget proposal reaffirms the ADA's commitment to science and evidence-based research, the core of the profession. "The proposal also includes resources that help us continue to be the number one advocate for the oral health and wellness of the public. Our presence in Washington is in the highest priority category for the mission and vision of our ADA," the ADA president said.

Dr. Ronald P. Lemmo, ADA treasurer, said the dues proposal should be thought of separately from the special assessment, which is calculated to fund the third year of the Find-a-Dentist campaign. The campaign is focused on connecting prospective patients with dentists. The 2016 House of Delegates approved the effort in Res. 67H-2016: "Drive Utilization of Dental Services for ADA Members."

Find-a-Dentist is now on track to achieve 850,000 profile views in 2018 plus an additional 1,004,000 profile views in 2019, said Dr. Lemmo.

"So what does 1,004,000 profile views mean to each dentist?" the treasurer asked. "Profile views are not evenly distributed among all ADA members, but dividing the total number of profile views by the number

See BUDGET, Page 13

Study finds caries interventions effective for Australian aboriginal children

BY MICHELLE MANCHIR

A multifaceted intervention that included dental care for mothers during pregnancy, application of fluoride varnish to their children and anticipatory guidance in combination with motivational interviewing was seen to reduce prevalence of caries in Aboriginal Australian communities, according to a paper published online in July in EClinicalMedicine.

For the randomized controlled trial, researchers recruited 448 women pregnant with an Aboriginal child from health service providers across South Australia, resulting in 223 children in the treatment group and 225 in a control group.

Women in the intervention group received dental care during pregnancy and their children had fluoride varnish applied to their teeth at ages 6, 12 and 18 months. In conjunction, the women received anticipatory guidance and motivational interviewing.

Examining the children at 2 years of age, while no child in either group had missing or filled teeth, researchers found fewer decayed teeth on average in the intervention group (0.62) than in the control group (0.89).

"Our findings suggest that a highly structured, standardized, carefully implemented and culturally-sensitive multi-faceted early childhood caries intervention was effective in reducing carious lesions in this Aboriginal child population in an epidemiological sense, but the translation to dental public health settings (where there is usually not the same resources available or rigor applied) may not yield such results," the authors wrote, adding that "further consultation with Aboriginal communities is essential for understanding how to best sustain these oral health improvements."

To read the study, visit www.thelancet.com and search for "Dental Disease Outcomes Following a 2-Year Oral Health Promotion Program for Australian Aboriginal Children and Their Families: A 2-Arm Parallel, Single-blind, Randomised Controlled Trial." ■

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Budget

Continued from Page 12

of ADA regular and recent graduate members gives an average of roughly 10 profile views per member. This means that on average, each dentist gets 10 chances to recruit a new patient.

"The annual cost of the program is $6 million, which works out to about $6 per profile view," he continued. "Since $6 is a very small fraction of the average billings for any new patient, the average member can break even on the cost of Find-a-Dentist if even a very small percentage of profile views results in appointments."

In Board Report 2, which details anticipated revenue and expenses, the Board recommends a 2019 operating budget of $132,650,000 in revenues and more than $134,755,000 in expenses and income taxes, projecting a deficit of $2.3 million based on the current dues rate of $532. A $22 increase would bring the ADA 2019 dues rate to $554 and cover the deficit, the report explains.

Resolution 36 discusses the proposal for a $58 special assessment. Because of House notice requirements, a proposed assessment can only be amended to a lower dollar amount at the meeting. By forwarding a proposed $58 special assessment, the House retains the flexibility to adopt an assessment at any level from $0 to $58, Dr. Lemmo said.

"The average member can break even on the cost of Find-a-Dentist if even a very small percentage of profile views results in appointments."

"After paying for this program as an investment out of reserves for the first two years, the Board realized that if we want to continue this valuable program into the future it really needs to be transitioned into the operating budget. As a first step, the Board's proposed special assessment separates this funding question by moving this cost out of reserve expenditures and asks the House to consider having members pay for it. This is a decision for the House, and if the House agrees on the value of the program, then a long term funding plan will eventually be needed," he said.

The ADA House of Delegates will meet Oct. 19-22 in Honolulu. Board Report 2 and other reports and resolutions for the 2018 House are available to members only on ADA.org in the Member Center. Members First 2020 — Strategic Plan 2015-2019 is also available online in the Member Center. More information on Find-a-Dentist is found at ADA.org/findadentist. ■

ADA CDHC program helps Chicago nonprofit get kids access to care

BY MICHELLE MANCHIR

For almost a decade, Dr. Alejandra Valencia has been working to build a system that helps ensure underserved children in targeted Chicago ZIP codes have access to dental care and education.

"We analyze data and then develop programs to help address the disparities that we see," said Dr. Valencia, who has been director at the Oral Health Forum in Chicago's Pilsen neighborhood for four years.

For part of that time, the ADA-developed and trademarked Community Dental Health Coordinator, or CDHC, program has helped her do this. The Oral Health Forum is helping students in the program master essential case management skills that can help patients access dental care.

Dr. Valencia

Two years ago, the Oral Health Forum partnered with the CDHC programs at Prairie State College and Malcolm X College with funds from the Health Resources & Services Administration to the Illinois Department of Public Health. The CDHC program is a curriculum that emphasizes community-based prevention, care coordination and patient navigation to connect underserved patients with a dental home.

At the Oral Health Forum, CDHCs-in-training complete a required community internship as part of the program, while training and working as case managers, said Dr. Valencia. Meanwhile, CDHC students at two other Illinois colleges, Southern Illinois University and Parkland College, complete a webinar about the major tenets of case management from the Oral Health Forum as part of the Illinois health department grant.

The Oral Health Forum has used case management as a tool for five years, after a community assessment in two Chicago ZIP codes determined something needed to be done to help those underserved families find dental homes, said Dr. Valencia.

With funding from several local and national foundations, the Oral Health Forum case management model has been an "extremely successful" intervention, Dr. Valencia said.

"Case management is helping people express what type of health care their family needs as well as understand how they can access those services," said Dr. Valencia.

Oral Health Forum case managers and the CDHC students completing their internships spend time talking with families about what kind of care is needed to address their needs and how to make appointments and follow up with additional care or health questions. Case managers make outreach calls to families in documented areas of high oral health need, often following up with families of kids who have received preventive services and screenings from the Chicago Department of Public Health's School-Based Oral Health Program.

"It's about developing a personal relationship and building trust," said Dr. Valencia. "It is with this effort that children who have urgent dental needs can get connected with a dentist in an office within their community who can address those needs."

Connecting patients to care is one of the central tenets of the ADA CDHC program. Part of the ADA's Action for Dental Health Initiative, CDHCs arrange transportation programs between community centers and dental clinics, teach oral health education and help patients understand treatment plans and dental care needs. CDHCs are currently working in 21 states and educational programs to become a CDHC are available in every state.

"We have been able to document everything. We are clearly making progress."

"CDHCs empower patients to understand the care that they need and we help them feel confident to seek that care and be connected to that care," said Dr. Jane Grover, director of the ADA Council on Advocacy for Access and Prevention.

So far, more than 30 CDHCs-in-training have completed internships at the Oral Health Forum and many more have completed a course about case management, said Dr. Valencia.

Since the case management intervention began in 2015, the Oral Health Forum has found that urgent dental needs among children in three Chicago Public Schools in the program have fallen from 26 percent in 2014-15 school year to 14 percent in the 2016-17 school year, said Dr. Valencia. "We have been able to document everything," she said. "We are clearly making progress."

Furthermore, Dr. Valencia believes the case management model could be easily adapted into private dental offices and community clinics across the country "which is why the CDHC program is so beneficial to helping families remain connected to regular oral health care."

For more information about Oral Health Forum, visit HeartlandAlliance.org/OralHealth. For more information about the CDHC program and where it is offered, visit ADA.org/CDHC. ■

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Guide, webinar connect dentists with Medicaid resources

BY MICHELLE MANCHIR

Dentists who are considering becoming Medicaid providers, or those who already are and need some guidance on the topic, can reference an ADA-developed website and no-cost webinar.

The ADA Medicaid Provider Reference Guide and Advocacy Tool Kit, compiled and regularly updated by the ADA Council on Advocacy for Access and Prevention's Medicaid Provider Advisory Committee, contains information about Medicaid compliance, audits, the basics of recordkeeping, reducing barriers to Medicaid-eligible individuals seeking dental care and other topics relevant to current and prospective providers.

Earlier this year, the committee updated the webpage with an educational tab addressing use of silver diamine fluoride.

Visit ADA.org and search for "Medicaid Provider Reference Guide & Advocacy Toolkit."

"Dentists should consider treating Medicaid patients because today on average 20 percent of the population is covered by Medicaid."

"Dentists should consider treating Medicaid patients because today on average 20 percent of the population is covered by Medicaid," said Dr. Sid Whitman, chair of the Medicaid Provider Advisory Committee.

He added that, "Thirty-three percent of children are covered by Medicaid and at least 40 percent of the births last year were to Medicaid recipients. Therefore, for many dentists this is a potential source of business and revenue."

The webpage also includes a testimonial video featuring Dr. Howard Elson, a pediatric dentist in Pennsylvania, who describes his path to becoming a Medicaid dentist. When he started his career in western Pennsylvania, steel mills were thriving and most children had private insurance thanks to their working parents. But when the mills closed, many of them became welfare recipients, thus changing the patient demographics within his practices.

Shifting to a mostly Medicaid-providing practice, Dr. Elson said, "can be very rewarding emotionally, clinically and financially."

Those seeking more details can watch a no-cost webinar on the ADA website, co-authored by Dr. Whitman and colleagues. Maintaining Your Sanity and Practice Viability As A Medicaid Provider offers one hour of continuing education related to program integrity and provides insight on how to safeguard your practice while providing care to a growing population of Medicaid-eligible patients.

Additionally, the ADA has collected a number of resources designed to provide necessary evidence and technical assistance for dental Medicaid advocates.

This Advocacy Toolkit provides a variety of approaches that serve as a foundation to launch dental Medicaid improvements.

For more information about being a Medicaid provider, contact Dr. Steve Geiermann, ADA senior manager for Community Oral Health Infrastructure and Capacity for the Council on Advocacy for Access and Prevention by email at geiermanns@ada.org.

To view the Medicaid resource guide and advocacy tool kit, visit ADA.org and search for "Medicaid Provider Reference Guide & Advocacy Toolkit." ■

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CMS

Continued from Page 9

The ADA pointed out that the first measure, No. 378, has not been risk adjusted and said that the value sets included in the measure are not valid.

"There is a large body of evidence that various socio-demographic factors influence outcomes, and thus influence results on outcome performance measures," wrote Drs. Crowley and O'Loughlin.

For measure No. 379 they noted that it only tracks a single fluoride varnish applied during the measurement period which goes against evidence-based clinical recommendations that suggest topical fluoride should be applied at least every three to six months in children with an elevated risk for caries.

The ADA "strongly urged" CMS to consider incorporating additional measures — including sealants — into the dentistry specialty set which have been developed by the Dental Quality Alliance through support from the Office of National Coordinator for Health Information Technology and tested using the Measure Authoring Tool based on the Quality Data Model and value sets.

Regarding the Physician Self-Referral Law (Stark Law), the ADA supports CMS' efforts to make the regulations more consistent with the Bipartisan Budget Act of 2018 and to help relieve some of the burden of the law's compliance, Drs. Crowley and O'Loughlin concluded. ■

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Conversation

Continued from Page 1

starting with choosing what high school to go to, and what classes to take, was all in support of my goal to be a dentist," he said.

It worked out so well that not only does he still have his own general practice, which he opened in 1993, Dr. Cole is also about to become the 155th president of the American Dental Association on Oct. 22 in ceremonies at the 2018 ADA House of Delegates in Honolulu.

He attended Villanova University in Philadelphia for his undergraduate degree, choosing it because he thought it would be a good preparation for dental school. Dr. Cole said the Villanova faculty had a great relationship with Georgetown University School of Dentistry, which was a major factor in his choosing Georgetown over the other dental schools to which he had been accepted. He graduated from Georgetown in 1986. While he concentrated in science and math as an undergrad, he also took some business courses at Villanova as well as Georgetown. After six years as an associate, he opened his own practice. He also returned to school at Temple University Fox School of Business, where he received his MBA in 1996.

The closing of Georgetown was one of the reasons Dr. Cole became an adamant advocate of student issues such as debt relief. "Georgetown wasn't the first dental school to close. People always ask me, 'Why are you so passionate about things like student debt?' It's because I've seen the devastation that occurs when people outside of our profession make decisions that affect our profession. Georgetown closing was the result of a federal government take-back of incentives for dental schools. Schools like Fairleigh Dickinson and Emory closed for the same reason."

Office: Dr. Cole poses at ADA Headquarters in Chicago this summer.

During dental school one of his jobs was in the admissions office, taking care of registrations for continuing education courses. His experience there remains a reminder to him of how vulnerable students can be.

"The dean of admissions came over to my desk, pushed all my work to the side, and put down a list of applications, and said, 'I want you to call all of these undergraduate students,'" he recalled. "'They've all been accepted to Emory. Emory just announced they are closing. I want you to call them and talk them into coming to Georgetown instead.' So I did that. I continue to be passionate about issues that affect students like student debt in part because some of those people came to Georgetown because I called them. And they were students at Georgetown when the school announced it was closing. I thought I was doing them a favor only to find out Georgetown fell victim to the same outside influences."

Dr. Cole and his wife, Linda, met at Villanova as undergraduates, where she was a business major. This summer they celebrated their 34-year anniversary, having married while he was in dental school. When he was ready to start as an associate, his wife, after having a career in a different city, took the job of business manager at the same practice. When Dr. Cole started his own practice, six years later, she became his business manager and has been managing his office ever since. They both feel very blessed to be an active part of an amazing profession, one that has become a second family to them.

During his general practice residency in Delaware at the Christiana Care Health System, Dr. Cole met Dr. Nick Russo, who volunteered in the residency clinic. The group in his GPR wanted to start a study club after they finished their residency and contacted the Academy of General Dentistry, to see how they could be approved for CE credit. The AGD directed them to Dr. Russo. He came to their meetings, and eventually encouraged Dr. Cole to get more involved.

"He told me, 'Well, you've been approved for your continuing education credit, but I also have something else in mind for you.' And so with his encouragement I got more involved and eventually became the president of the Academy of General Dentistry for the state of Delaware at the age of 29."

Always motivated to get involved, Dr. Cole also headed local arrangements after his first year of membership in the Delaware State Dental Society. "That meant I was in charge of working the front door at the general membership dinner meetings. It was a great opportunity to get to know my colleagues."

Because of Dr. Russo's example, Dr. Cole sees himself encouraging students and new dentists to get involved. "If I see students who seem to be good leaders, and I see there are opportunities to get them involved, I try to make connections."

In addition to his presidency of the Delaware AGD, Dr. Cole served as Delaware

State Dental Society president and as national AGD president. He was the ADA 4th District trustee prior to his role as ADA president-elect. He is a former chair of the ADA Budget and Finance Committee, the ADA Strategic Planning Committee and the ADA Business Model Project Oversight group. Dr. Cole is a member of the American College of Dentists, Delta Sigma Delta International Dental Fraternity and the International College of Dentists. He served in numerous leadership roles in both the state and national AGD and ADA.

Dr. Cole was interviewed by Judy Jakush, ADA News editor, during the summer. Part 1 of the Q&A follows here.

ADA News: How do you describe your leadership style?

Dr. Cole: My leadership style is one of being very collaborative. I want to hear everybody's ideas. I want to vet whoever's in the room. We've done that, for instance, with the business model project. We were making some innovative, and I want to say scary, decisions that were really out of the norm of business as usual. And we had a great group in there, including the Board's Budget and Finance Committee, leadership, senior management, finance staff and support staff. We went around the room, seeking input from everyone there. And one of the individuals said, "Oh, I'm staff." I said, "Are you sitting in this room?" He said, "Yeah." I said, "Do you have an opinion?" And I knew he did. He said, "Oh, yeah." I said, "Then I want to hear it." And it's gathering all those ideas, being collaborative and inclusive that moves us forward.

The other thing is that we can always do better. I'm not a type of person that celebrates mediocrity. I'm somebody that celebrates success, but the celebration is very short lived. Let's do a high five, let's feel good about ourselves, and let the conversation immediately go to, how can we get even better? We are in a climate that is much different, say since 2008, whether it's the practice of dentistry, whether it's the world of business, things have changed dramatically for a whole lot of reasons. And because of that, I think the only way we stay ahead is to constantly try to make ourselves better.

My leadership style is one of being very collaborative. I want to hear everybody's ideas. I want to vet whoever's in the room.

Sometimes I get feedback that I'm kind of hard on people, or hard on myself. I find that people are much happier when they start realizing accomplishments that they never knew were possible. I've seen it here in the ADA and in other organizations. I like to bring people to their highest potential.

ADA News: What do you see as the biggest issues facing the profession right now? What are the biggest issues facing the Association? And do you equate the profession with the Association, or are these going to be the same or different things?

Dr. Cole: With the profession, one of the things really affecting us is student debt. The challenge is how we can help new dentists succeed financially, but also support them in delivering what's best for patients.

Another major challenge for the profession is that there are people who are not in good oral health. We have done a lot; we work diligently to help improve oral health, but as long as there are people who are not in good oral health, that challenge remains.

There are factors beyond economics changing the profession, such as technology, advances in science, professional uncertainty and outside influences. Some of these things may be disrupters to our profession, but I think that we can move the profession forward in a very positive way as long as we make sure that we remain true to the foundation of what makes us professionals. That means that the business and practice of dentistry must remain true to the trust that's been placed in us by our patients.

That's on the profession side. The ADA's challenge is also the fact that there are people who aren't in good oral health, and we need to change that.

The ADA as an organization has to be financially sustainable into the future. We have a 150-year history, and we have to make sure that we can continue into the future.

The ADA has to remain relevant, and not only with the general public, but within our profession, and with our members. That's an issue that ties the profession and the organization together. We have to offer a solution to help our members be more efficient, to deliver better oral health care. If we offer that through good business methods on the ADA side, we can take care of all those challenges. It's a really big lift, but I'm confident that we can do it.

ADA News: Here's another basic question, why are you a member of the Association? Why should a nonmember join?

Dr. Cole: The reason that I'm a member is because I think that it's extremely important that we support what basically powers our profession, the ADA. It does that so that all of our members can succeed in delivering good oral health. We do that through science, through standards, through advocacy and more. Some people look at what benefits them individually, and we have to show them how the ADA is relevant to them.

If the profession can be more efficient in how we deliver care, if we could make member dentists who are in this husband-and-wife, mom-and-pop and small group office settings successful, then we achieve all those goals of oral health and everything else. I think that it's incumbent upon us to do that.

If we do it in the right way, we not only achieve that relevance, but we connect with those individuals who say I need a little bit more for my membership — those who ask, "What's in it for me?" We are working towards that, and

See CONVERSATION, Page 23

Gold Medal

Continued from Page 1

and a gold medallion. Additionally, he will serve a three-year term on the ADA Council on Scientific Affairs.

Dr. Hargreaves will be recognized with the honor on Oct. 18, during a ceremony at ADA 2018 – America's Dental Meeting in Honolulu.

Dr. Hargreaves' research in pain management and regenerative endodontics introduced "cutting-edge treatment options and improved the patient experience," according to a letter to Dr. Hargreaves announcing the win from ADA President Joseph P. Crowley, who also lauded Dr. Hargreaves' dedication to mentoring students and his "tireless efforts in publishing and lecturing."

"On behalf of your colleagues, please accept our deepest gratitude for your lifetime of work," Dr. Crowley wrote.

Among his most noteworthy achievements, Dr. Hargreaves helped discover a family of "endo-capsaicins" that contribute to many pain disorders, including pain due to symptomatic irreversible pulpitis, cancer, post-burn pain, neuropathic pain and other inflammatory pain conditions.

"We have applied this knowledge to the development of new classes of nonopioid and nonaddictive analgesics," Dr. Hargreaves said.

American Association of Endodontists

Engaging endodontist: Dr. Kenneth Hargreaves, the 2018 Gold Medal award recipient, speaks at the American Association of Endodontists' annual meeting in April in Denver. He is professor and chair of the department of endodontics at UT Health San Antonio.

His efforts on this issue have changed the way dental professionals manage patients' pre- and post-treatment pain and is influencing pain management in other areas of medicine, said Dr. Patrick Taylor, president of the American Association of Endodontists, in a letter nominating Dr. Hargreaves for the award.

Furthermore, "in an era of overprescribing of opioids and opioid addiction, Ken's evidence-based advocacy for nonopioid pain control undoubtedly has led to changes in prescribing patterns and improved patient care," said Dr. Alan Law, a dentist with a Ph.D., and president of The Dental Specialists, in another letter of nomination.

Colleagues of Dr. Hargreaves recognize him as an outstanding author and editor, having been editor-in-chief since 2003 of the Journal of Endodontics and the author of five books, 33 textbook chapters and hundreds of published papers.

"He is one of the most prolific and influential authors and researchers in the history of endodontics," said Dr. Taylor, crediting Dr. Hargreaves with more than 13,000 citations of his papers in Scopus, a database of scientific peer-reviewed literature.

Dr. Hargreaves is also known for his lectures around the globe and for his generosity and thoughtfulness as a mentor and educator. He has served in nine academic appointments since 1985, most recently and currently as professor and chair of the department of endodontics at The University of Texas Health and Science Center at San Antonio. He has supervised more than 30 post-doctoral fellows and been advisor to almost three dozen Ph.D. and masters degree students.

"He has dedicated his career to training the next generation of dental scientists, with (the) leadership, scientific, clinic and organization skills required to make a significant contribution to our profession," said Dr. Anibal Diogenes, a dentist with a Ph.D. who had Dr. Hargreaves as Ph.D. mentor. "I am a living example of the profound effect that he has had in many of us." Dr. Diogenes is currently a diplomate to the American board of endodontics and associate professor and vice-chair in the department of endodontics at UT Health at San Antonio.

Dr. Hargreaves explained to ADA News the personal satisfaction of being a mentor, calling it "being part of a tapestry. You have mentors that proceed you and in turn you are a mentor to your own students. I have two biological children but more than 30 intellectual children, many of whom have now trained their own students."

Dr. Hargreaves said he was drawn to dentistry as a child in part because he had a dentist growing up who was willing to let him shadow in his practice. After earning his D.D.S. from Georgetown University in 1983, Dr. Hargreaves went on to earn a Ph.D. in physiology from the Uniformed Services University of the Health Sciences in Bethesda, Maryland, in 1986.

He said he spent summers during dental school doing research in the neurobiology and anesthesiology branch of the National Institute of Dental and Craniofacial Research, which is just a few miles from Georgetown University. "I won the International Association for Dental Research's Hatton award as a dental student and it was an easy transition to consider doing a Ph.D. after dental school," he said.

Dr. Hargreaves went on to earn his certificate in endodontics from the University Minnesota in 1993.

Following years of research and teaching, he has gone on to receive many awards and honors for his labor, including two IADR distinguished scientist awards, the IADR/AADR William J. Gies Award for Best Paper of the Year in Biomaterials/Bioengineering, and honorary membership in the American Academy of oral medicine.

On top of his professional achievements, Dr. Hargreaves is a hard-working athlete, having completed four Ironman races and currently in training for a fifth, he said. For those in the dark, the grueling Ironman Triathlon consists of a 2.4-mile swim, 112-mile bicycle ride and a marathon 26.2 mile run — done in that order without breaks.

"My goal is to finish without a cardiac event. So far, so good," Dr. Hargreaves said.

"This recognition is humbling and represents the efforts of teams of colleagues, students and patients."

Married to Holly Dybdal-Hargreaves, his high school sweetheart of 42 years, Dr. Hargreaves has a son, Nick, in his last year of a D.D.S./Ph.D. Program, studying oral cancer for his thesis. A second son, Michael, is in medical school.

For all of his achievements, Dr. Hargreaves said the most rewarding part of his career is "seeing the success of colleagues and their students."

"We work in a team science environment, in which five faculty members share the same suite of labs," he explained, adding that his research on pain mechanisms from the perspective of developing new nonopioid, nonaddictive analgesics is ongoing.

"We now have our first test drug in a clinical trial in pain patients. I am incredibly excited about the prospect of making a difference in the lives of pain patients," he said. "Another focus of our research is on stem cell therapy in regenerative endodontics. We are about two-thirds completed in one of the first multi-center clinical trials on regenerative endodontics."

When asked what he wants ADA members to know about him, Dr. Hargreaves broadened the spotlight to include those around him.

"This recognition is humbling and represents the efforts of teams of colleagues, students and patients," he said. "They are the ones who truly allow us to make lives better." ■

Dental CE provider Spear Education announces purchase of Pride Institute

Scottsdale, Ariz. — Dental continuing education provider Spear Education acquired the Pride Institute, a California-based industry authority, according to a Sept. 4 news release.

"Pride Institute is one of the most respected names in practice management," said Spear President Rezwan Manji in the release. "Their approach to dental consulting aligns perfectly with Spear's philosophy and Practice Solutions consulting model. We are excited to incorporate Pride Institute's decades of knowledge and expertise to help our clients and their teams achieve their practice goals."

Dr. Jim Pride, a longtime advocate for increased education to help dentists balance the clinical and business demands of their practices, founded the Pride Institute in 1974 to deliver information and counsel in every aspect of practice management.

"When Dr. Pride passed away in 2004, we made a promise that we would carry on his legacy, utilizing new models and new methods to create success. It has been 14 years and all of us at Pride Institute continue to pursue that vision," said Amy Morgan, Pride's CEO, in the release. "We are excited to join Spear Education and take Dr. Pride's vision to the next level."

With its campus and headquarters in Scottsdale, Arizona, Spear was founded in 2007 and is a provider of multiplatform continuing education and practice growth resources for dental professionals.

For more information on Spear Education, visit speareducation.com. ■

ADA visits Navajo Nation, honors work of local oral health leaders

BY MICHELLE MANCHIR

Window Rock, Ariz. — ADA President Joseph P. Crowley and a contingent of ADA and New Mexico Dental Association staff visited the capital seat of the Navajo Nation Aug. 20 to pay tribute to the positive impact that Community Health Representatives trained as Community Dental Health Coordinators have made in serving as oral health resources for the serving Navajo people.

The Navajo Community Health Representatives are community health workers who work with residents by serving as interpreters, offering health screenings, providing home visits, encouraging preventive activities and more. They represent one resource that the Navajo Nation has been using to improve the oral health and overall health of the Navajo people.

ADA at Window Rock: A delegation from the ADA visited the capital of the Navajo Nation in August. From left, Dr. Jane Grover, director of the ADA Council on Advocacy for Access and Prevention; (back) Chad Olson, ADA director of state government affairs; (front) Dr. Jennifer Thompson, New Mexico Dental Association president; Dr. Tom Schripsema, executive director of the New Mexico Dental Association; Jonathan Nez, vice president of the Navajo Nation; Dr. Joseph P. Crowley, ADA president; Dr. Luciana Sweis, ADA CDHC project manager consultant; Mae-Gilene Begay, director of the Navajo Community Health Representative and Outreach Program; and Dr. Steve Geiermann, ADA senior manager on access and community oral health.

As early as 2014, organized dentistry and the Navajo Nation began collaborating to help improve the community's oral health care, in part by educating Community Health Representatives about the importance of oral health across the lifespan, as well as by recruiting them to become certified as Community Dental Health Coordinators. The CDHC cohort at Central New Mexico Community College that started in January of 2017 included four Community Health Representatives from the Navajo Nation.

During his visit, Dr. Crowley was able to find out firsthand how these CDHC-certified Community Health Representatives have had a positive effect on oral health in the Navajo Nation, where challenges remain prevalent. Tooth decay is four times more prevalent among Native American children than white children, according to the Indian Health Service.

"Having CDHCs with the cultural knowledge and understanding of the Navajo community helps build strong connections, and trust, with patients here," said Dr. Crowley. "The focus is on community-based education and pushing for prevention."

During the visit, Dr. Crowley met with Jonathan Nez, vice president of the Navajo Nation, who oversees the health and wellness of the tribe.

Mr. Nez shared his support for the Navajo Community Health Representative and Outreach Program and their efforts to incorporate oral health into the overall health practices of Navajo people across the lifespan, from pregnant women to esteemed elders, according to Dr. Crowley.

Mr. Nez spoke of the challenges of residing in a food desert, where fresh, affordable fruits and vegetables are not always readily available. He noted progress in promoting less processed foods and drinking more water, while moving junk food away from the checkout lines within reservation grocery stores. He cited the recent restoration of funding for the Community Health Representative program that had previously proposed to be cut from the federal budget.

Mr. Nez thanked the ADA for its efforts to increase Indian Health Service funding to attract more providers and offer additional loan repayment incentives, as well as encouraging a more efficient credentialing system for providers willing to serve on the reservation, Dr. Crowley said.

During the visit, Dr. Crowley presented four ADA presidential citations during a luncheon, acknowledging the success of the CDHC program on the Navajo Nation. Mae-Gilene Begay, the director of the Navajo Community Health Representative and Outreach Program, was honored for her efforts to improve the oral health of all Native Americans. Dr. Sandra Aretino, chief executive officer, and Dr. Jason Price, dental director, both of Tsehootsooi Medical Center, were honored for their willingness to support the four CHRs in their CDHC internships. Dr. Tom Schripsema, executive director, New Mexico Dental Association, was honored for his long-standing support of improving the oral health of Native Americans in New Mexico.

Honored: Mae-Gilene Begay receives a ADA Presidential Citation from ADA President Joseph P. Crowley during the Association's visit to Navajo Nation. At left is Jonathan Nez, vice president of the Navajo Nation.

For more information about the CDHC program, visit ADA.org/CDHC. ■

Dental companies reach agreement in antitrust suit

BY JENNIFER GARVIN

Three dental companies have reached a tentative agreement to pay $80 million as part of a class action lawsuit alleging they violated federal antitrust laws by fixing prices on dental equipment and supplies.

The dental companies, Benco Dental, Henry Schein Inc. and Patterson Companies Inc., are alleged to have conspired to suppress price competition so that "they each could charge artificially inflated prices for dental supplies and equipment," according to the lawsuit, which was filed in March 2016 in the Eastern District of New York. The plaintiffs filed on behalf of some 142,000 U.S. dental offices and laboratories.

According to Eric Cramer, an attorney with Berger Montague, one of the firms leading the class action litigation, the entire settlement is expected to total $80 million. Henry Schein said Aug. 30 that it expects to pay approximately $38.5 million to settle the class action lawsuit. In a press release announcing first-quarter results to investors, Patterson said it has established a pre-tax reserve of $28.3 million to pay for the settlement. Benco — a privately-held company — did not announce its expected payment.

"We categorically and emphatically deny any wrongdoing, and we have made a business decision in the best interests of the company to engage in settlement discussions to avoid long, distracting litigation and the additional use of resources," said Stanley M. Bergman, chief executive officer, Henry Schein, in a news release. "We have a long history of serving customers with integrity and honesty, and we have earned our reputation for doing business ethically in a competitive business environment."

"The lawsuit ran contrary to our nine-decade history of bringing choice and innovation to dentists across the United States. In agreeing to the settlement, we're able to dedicate all efforts to our customer-focused mission," said Chuck Cohen, managing director, Benco Dental, in a press statement.

The class action suit is not the first legal action alleging Benco Dental, Henry Schein Inc. and Patterson Companies Inc. violated antitrust laws.

In February, the Federal Trade Commission filed a complaint against the three companies, alleging that they "deprived independent dentists of the benefits of participating in buying groups that purchase dental supplies from national, full-service distributors." The complaint also estimated that "collectively, the big three are alleged to control more than 85 percent of all distributor sales of dental products and services nationwide, a total market estimated at approximately $10 billion." The complaint also alleged that Benco invited Burkhart Dental Supply to "refuse to provide discounts to buying groups" and separately charged Benco with a Section 5 invitation to collude. The trial is scheduled to begin Oct. 16.

There also have been multiple shareholder class action lawsuits filed against Henry Schein and Patterson Inc. on behalf of purchasers of the company's securities following news of the FTC complaint.

Once the class action settlement is final, customers whose names and addresses are included in the defendants' databases will be notified of the next steps. The class attorneys will also contact organizations such as the ADA so it can provide information, and the law firms will also set up a website to explain the terms of the settlement and process for making a claim.

The ADA News will provide updates as this story unfolds. ■

NYU, Columbia researchers receive grant to study chronic pain

New York City — A researcher at the New York University College of Dentistry will receive a $2.4 million, three-year grant from the U.S. Department of Defense to study painful medical conditions prevalent in military personnel and veterans.

Dr. Brian Schmidt, director of NYU's Bluestone Center for Clinical Research, will work with Nigel Bunnett, Ph.D., professor in Columbia University's departments of surgery and pharmacology, to study how receptors inside nerve cells generate chronic pain, including headache, nerve injury and infectious colitis.

The study's findings have broad implications beyond the military and may be used to develop new treatments for chronic pain, according to NYU.

Drs. Schmidt and Bunnett will investigate receptors on and within nerve cells. Theses receptors can detect many substances that are produced by injured tissues and some types of cancer.

"The knowledge derived from our work might be useful for modification of existing drugs used to treat a wide variety of diseases including heart disease and cancer," said Dr. Bunnett. ■

San Fernando Valley Dental Society, LAPD team up to provide oral care for at-risk youth

BY KIMBER SOLANA

Chatsworth, Calif. — In an effort to help underserved children receive basic oral health care in their community, the San Fernando Valley Dental Society and its foundation found an unlikely partner — the Los Angeles Police Department.

"With their help, we're screening and seeing kids who are homeless and undocumented and many at-risk youths," said T. Andris Ozols, San Fernando Valley Dental Society executive director.

Mr. Ozols is referring to participants of the LAPD's Police Activities League and the LAPD Cadet program. Both are youth crime prevention programs that help form a bond between police officers and the youth in their community through education, athletic and recreational activities, including preparatory activities for those who aspire to become police officers.

Since June, member dentists have visited three of the 17 LAPD divisions in the San Fernando Valley Dental Society jurisdiction, providing oral screening and dental education to program participants.

The plan is to visit all seven divisions.

Many of the children, ages 8-21, fall through the cracks and are not eligible for Denti-Cal, the dental program within the state's Medicaid (Medi-Cal) program, said Mr. Ozols. Others have difficulty receiving dental care due to affordability, accessibility, and cultural and language barriers.

"There are pockets in the valley that are considered 'dental deserts,'" Mr. Ozols said.

The collaboration with the LAPD began when Mr. Ozols was introduced to an LAPD Cmdr. Jorge Rodriguez at a separate nonprofit event. When Mr. Ozols had suggested a collaboration where volunteer dentists screen and provide dental education to PAL and LAPD Cadet participants, the commander agreed.

Screen: Dr. Karin Irani, right, conducts an oral screening on a junior cadet at the Los Angeles Police Department's Mission division in Mission Hills, Calif. The San Fernando Valley Dental Society and its foundation are collaborating with the LAPD in providing oral screenings to participants of the LAPD's Police Activities League and LAPD Cadet programs.

The dental society provides the volunteers, the San Fernando Dental Society Foundation provides the funding and the LAPD provides the locations because they have access to community centers and available rooms in various city hall branches.

The first event was held in the Pacoima division where about 36 children were screened. One of the children, Mr. Ozols said, brought his grandmother who had a 30-year-old denture. It had broken about 20 years ago. A member dentist volunteer asked the grandmother to come in to her office to take care of the issue.

Mr. Ozols said the dentists are screening the children and then make recommendations to their parents. These recommendations include getting X-rays, cleanings, caries restorations, extractions and orthodontic evaluations. Mr. Ozols said the volunteers emphasize the need to establish a dental home to ensure continuous oral care.

In addition, the program involves an education component, which includes teaching proper brushing and flossing techniques and providing information on the impact of sugary drinks and diet on teeth.

"Our members are very keen to giving back to the community," Mr. Ozols aid. "They've been successful and lead a good life but they see a lot of folks who can't afford dental care. They want to give back. As a local dental society, we believe in making sure this community has access to dental care." ■

Annual meeting course spotlights 'unicorn of the sea'

BY DAVID BURGER

Honolulu — The ADA annual meeting doesn't usually include presentations on unicorns, much less than those in the sea.

This year is different.

ADA 2018 – America's Dental Meeting will feature a presentation called "Narwhal, Arctic Legend and its Extraordinary Tusk" (5318) on Oct. 18 from 7-9 a.m.

Dr. Martin T. Nweeia, lecturer in the department of restorative dentistry and biomaterials sciences at the Harvard School of Dental Medicine and arguably the world's leading expert on narwhals, will present the continuing education course. It's worth two hours of credit and offered without a fee.

The narwhal is often called the unicorn of the sea, a pale-colored porpoise in the whale family found in Arctic coastal waters and rivers. It is known for possessing a large, long, straight tusk from a protruding canine tooth.

Dr. Nweeia was invited to speak at the annual meeting for his work that includes how narwhal tusk function relates to the function of human teeth and why the origins of tooth function are important to consider.

"Narwhals are important today because we underestimate how awesome a tooth can be," Dr. Nweeia said in an interview with the ADA News. "And there is no better example in nature than a narwhal tusk to remind us of that. Unquestionably, this is the coolest tooth on the planet."

He continued: "This tusk also forces us to look at the evolution of teeth, which were originally derived from Ordovician fish scales and sensory to their environment. The narwhal tooth as a sensory organ reminds us of our own sensory organ teeth, and that they are not passive organs for merely chewing and biting, but are capable of detecting many other variables like particle gradients, temperature and pressure. So we can ask in a fresh context, how did teeth evolve and what can the narwhal tusk tells us about that evolution?"

Photo by Gretchen Freund

Unicorn: Dr. Martin T. Nweeia, left, with Inuit hunter Adrian Amauyumayuq, working on a captive narwhal in Qaqqiat Point in the Admiralty Inlet in Canada. The image is taken from the Eyes On The Arctic exhibit hosted by the U.S. Embassy under a Fulbright grant to Dr. Nweeia and honoring the 150th anniversary of Canada.

The narwhals are unique in nature, Dr. Nweeia said. "The narwhal has a tooth like no other. It is not only extraordinary but defies about every principal and property of teeth imaginable, and thus forces us to question the very definition of a tooth. It is nature's only straight tusk, only spiraled tusk and the most extreme example of dental asymmetry and sexual dimorphism in nature."

The narwhal is even more strange when you consider that other than the tusk, it is toothless. "Though it relates in many of the biomaterials that constitute teeth, narwhal have no teeth in their mouths despite a diet of fish," Dr. Nweeia said. "More strange is that in their embryonic development they have the potential for 12 erupted teeth and most are genetically silenced at birth."

Dr. Nweeia's research has been so groundbreaking that much of his work, along with that of his colleagues, is featured in a current exhibit at the Smithsonian National Museum of Natural History. The museum in Washington, D.C., opened "Narwhal: Revealing and Arctic Legend" in 2017 and it runs through 2019.

To read a previous ADA News story on Dr. Nweeia's research and career, along with that of his colleagues, visit ADA.org and search for "narwhal" and the dentist's name. ■

— burgerd@ada.org

No need to face third-party payers on your own

ADA Third Party Concierge provides help on dental benefit issues

BY KIMBER SOLANA

When Dr. Ron Riggins received a notice via mail earlier this year from a third-party payer that it was only going to send electronic funds transfer payments and no longer sending paper checks, he knew something was off.

"I had remembered from a previous article in the ADA News that this was not standard practice," said Dr. Riggins, a general dentist from Moline, Illinois.

Dr. Riggins said he immediately contacted the ADA Third Party Payer Concierge, an exclusive member perk that connects dentists with ADA staff from the Center for Dental Benefits, Coding and Quality to help resolve dental benefit issues.

"The Third Party Payer Concierge gathered all the information from my staff and began to solve the problem," Dr. Riggins said. "Within a few weeks the ADA had reached out to the third-party payer and clarified the situation. The ADA then used its resources to inform members of the issue."

Provider issues remain among the top concerns for dentists, according to ADA surveys. Members have expressed frustration and confusion when it comes to denied claims, low reimbursements and dealing with third-party payer portals and processing policies.

"Issues with third-party payers, whether it is intrusive processing policies, medical necessity rules or explanation of benefits language, affect most dentists every single day," said Dr. Steven Snyder, Council on Dental Benefit Programs chair. "For members, the ADA offers this concierge service with experts a phone call away to support and help you in navigating this environment."

Recently, the ADA staff has helped members with third-party payer issues in:

- Providing guidance in the appeals process when a claim has been denied.
- Contacting dental plans to revise explanation of benefits language that impugned on the dentist-patient relationship.
- Connecting individual dentists with a dental plan's consulting dentist.
- Clarifying requirements on electronic fund transfer payments.

"The ADA staff is always extremely helpful when calling with questions or concerns," Dr. Riggins said. "The Third Party Payer Concierge is a real person who picks up the phone. Since third-party issues are one of the top concerns of dentists and dental offices, the service is a huge member benefit that hopefully more dentists will utilize."

The ADA can help dentists with dental benefits-related and coding problems, questions and concerns. Call the ADA's Third Party Payer Concierge at 1-800-621-8099 or email dentalbenefits@ada.org. Additional dental benefit resources can be found at ADA.org/dentalbenefits.

Members can also fill out an online third-party complaint form at Success.ADA.org/en/dental-benefits/online-third-party-form. ■

—solanak@ada.org

Conversation

Continued from Page 17

we should never lose sight of the big picture. That means imagining what would happen if we weren't here. Try envisioning the world if the ADA wasn't here. Not just today, but for the last 150 years. Ask yourself, where would the profession be? As a professional, maybe you'll see the answer is to be part of the Association.

ADA News: Do you have priorities for your year as president?

Dr. Cole: I know I'm here for a short period of time. I want to make the biggest difference I can, but to set priorities that aren't in step with the strategic direction of the Board and that aren't in step with the strategic plan of the organization and the operational goals would be counterproductive. When leadership changes in some groups, the new leader will take everybody in a different direction. I think that's very disruptive.

My goals are very broad and overarching: to become more relevant to members who particularly need some individual attention and to make sure that we keep the organization financially sound by doing that. We achieve this by helping members be very successful in delivering care to their patients, which brings us again to the other big goal, to increase oral health and overall health.

Part 2 of the interview will appear in the next issue of the ADA News. ■

Connecting students with the latest in dental technologies

BY KIMBER SOLANA

Dr. Edward Rossomando thinks about the way technology has changed the dental profession.

"Imagine what happened when electricity was introduced into the dental practice," he said. "That changed the way decay was removed."

In this day and age, technological changes continue.

"But at a much faster pace," said Dr. Rossomando, president of the Center for Research & Education in Technology, or CRET. "Things can be done in a dental office in minutes. Before, making crowns or prosthetics appliances took weeks."

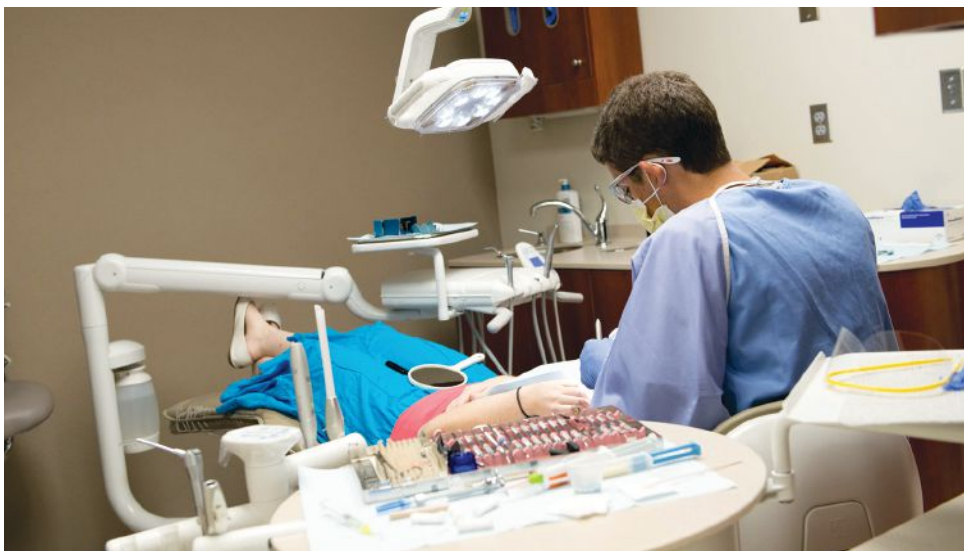
For him, the evolution in the practice of dentistry begs two questions: What will dentistry do? What will dental education do?

Dr. Rossomando is answering those questions through CRET, which was founded in 2004 by a group of dental industry leaders with a goal to expose dental students and faculty to the latest advancements in technologies available to dentists.

So far CRET, which is based in Westerly, Rhode Island, has partnered with three dental schools at Loma Linda University, University of Missouri – Kansas City and West Virginia University in creating innovation centers. Another innovation center is scheduled to open at the University of Mississippi this winter.

These centers are modeled on a private practice setting. CRET equips and continually updates these clinics with the latest in technology and products.

"What makes CRET so unique is that it brings together the manufacturers and distributors into a cohesive unit working together…[with] the school and students," said Don Hobbs, CRET chair of the board and CEO. "The focus is not on any one company or distributor, rather it is all about exposing [the students and faculty] to the most up-to-date, innovative technologies available."



Innovation: A fourth-year dental student examines a patient at the Dr. Charles Dunlap Innovation Center for Research and Education in Technology, which is in the University of Missouri – Kansas City dental school. The seven-chair clinic opened in 2012 in collaboration between the dental school and the Center for Research & Education in Technology.

Started in a closet

And to think that CRET started in a closet, Dr. Rossomando said.

"More accurately, it started because of equipment collecting dust in a closet," he said.

In an effort to get their new technologies and equipment to students and faculty, dental manufacturers, in 2001, approached some dental schools and offered to donate their equipment.

"Without exposure to products and services that CRET represents, dental students have to learn and use the innovative products after graduation as opposed to it being central to the educational experience," said Mr. Hobbs.

Dr. Cain

Dr. Rossomando

Mr. Hobbs

When the industry reached out to the schools a year later to see what the faculty and students thought of the donated items, Dr. Rossomando said, no one knew where the equipment was located.

"They turned to the janitor who tells them that they're in the closet," he said. "No one knew how to use them."

In 2004, a group of about 10 dental manufacturers and dental industry leaders approached Dr. Rossomando to help them figure out how to go about working with dental schools. And CRET was created.

The group's mission is "to develop a technology educational program for dental students, dental residents and dental faculty that will promote knowledge and competency in 21st century technology."

Working with dental schools

The first school to build and open an innovation center with the help of CRET was Loma Linda. However, CRET had actually began working and communicating with the University of Missouri – Kansas City dental school first.

Dr. Marsha Pyle, UMKC dental school dean, recalls seeing an email from CRET around 2009 about their mission and goal on getting new technology in dental schools.

"At that same time, I had already wanted to create a setting, supported by curriculum, that brought together practice skills, technology and evidence-based decision making," Dr. Pyle said. "I wanted the students to see the pros and cons of new technology coming into dental practices."

After about three years of discussions and agreements, the 2,026-square-foot Dr. Charles Dunlap Innovation Center for Research and Education in Technology opened in 2012. The school provided the space for the seven-chair clinic, while the dental manufacturers equipped the operatories. The equipment, provided by CRET members, include dental chairs, cone beam X-ray, CAD/CAM, sterilization equipment, impression materials and electronic practice management systems.

"The most recent innovation center [at West Virginia University dental school] received about $800,000 in donated equipment and materials," said Mia Cassell, CRET executive director. Today, CRET represents more than 25 dental manufacturers.

At UMKC, each room contains different equipment, allowing faculty, fourth-year dental students and dental hygienist students to rotate and use new technologies and products. Patients are brought in to the clinic for faculty-supervised assessments and treatment.

"The students can see these equipment side-by-side, and they can think about what will be best for them when they're ready to be on their own in a practice setting," Dr. Pyle said.

Discovering what works best

With dental technology and innovation advancing so fast, Dr. Andrea Cain said it's important for her to stay in-the-know of the latest equipment and products available for her — even back when she was still a dental student.

Fortunately, she said, she attended West Virginia University School of Dentistry, which had the W. Robert Biddington Center for Dental Innovation — the latest innovation center CRET helped built.

As a fourth-year dental student, Dr. Cain had spent a two-week rotation in the 2,239-square-foot center, treating patients in one of the five state-of-the-art operatories.

"The innovation center is every dentist's dream," said Dr. Cain, a general practice resident at WVU dental school. "I was in a position where I had the ability to combine patient comfort, convenience and learn leading-edge technology to provide quality reliable oral health. A truly one-of-a-kind opportunity that I am incredibly grateful and fortunate to experience."

It was at the innovation center where Dr. Cain said she found a true appreciation for restorative materials.

"As a student, we are limited to what is available in our main clinic," she said. "As a comparison … at the innovation center, we are given the whole alphabet of restorative material options. This has greatly opened my eyes to what is available in the market, while I am allotted the chance to figure out what works best in my hands."

After a full orientation of the center, Dr. Cain said, each student was assigned to a different operatory every day of their rotation. This allowed students to fully operate and learn each unit, use different dental products and equipment. These materials include intraoral light, suction, and automatic impression material mixer and dispenser.

"I discovered I enjoyed treating patients in units that are different than what I was previously trained to use in our main dental clinic, and surprisingly, this has greatly impacted my decision on what I plan to use in private practice."

For more information and for dental schools interested in the CRET program, visit cretdental.org or contact the program at info@cretdental.org. ■

Tissue

Continued from Page 1

case studies.

"The revision was necessary and warranted because of new reference publications — journals and textbooks — that updated information in the first edition or to include new information since the first edition," said co-author Dr. Michael Kahn, diplomate of the American Board of Oral and Maxillofacial Pathology and professor emeritus in the department of oral and maxillofacial pathology, oral medicine and craniofacial pain at the Tufts University School of Dental Medicine. "Better photographic examples were obtained of some of the diseases illustrated. Lastly, the drug formulary was updated to add new medications and drugs marketed since the first edition and, likewise, remove drugs no longer marketed in the United States."

In addition to updates to knowledge, references and images throughout, this edition covers new diagnostic methods, narrowband imaging devices and saliva testing. And, unlike the first edition, the second edition includes multiple-choice self-assessment questions at the end of each chapter.

The 280-page guide's co-author is Dr. J. Michael Hall, a retired associate professor in the department of oral and maxillofacial pathology, oral medicine and craniofacial pain at the Tufts University School of Dental Medicine.

Emphasizing foundational information on the most common oral diseases, the book provides summaries of essential information for diagnosing and treating soft tissue oral pathology, according to Dr. Kahn. With a focus on clinical decision-making, the book includes important information for diagnosing disease and determining the best course of action.

"General dentists or specialists should have a copy of this book in the dental office to aid the clinician in the evaluation, differential diagnosis formulation, establishment of a provisional and final diagnosis and/or management of their patient's diagnosed oral mucosal disease," Dr. Kahn said. "Chapters three and four arrange the lesions' clinical photographs based on their morphology and color to aid the clinician's chairside comparison with the lesion in question."

The guide is also essential for correct diagnoses, and knowing when to refer to another specialist, Dr. Kahn said. "The challenges of accurately diagnosing soft tissue oral disease included a sufficient knowledge base of the patient's medical and dental histories, an efficient method of performing an extraoral and intraoral soft tissue head and neck examination, the pertinent questions to ask the patient about their lesion's symptoms as well as recognition of its signs, combined with the clinician's knowledge of the most common sites, morphology and color(s) of the oral soft tissue lesions.

"Furthermore, the clinician must know and understand the available diagnostic procedures and adjunctive devices that are currently available to aid in the formulation of a suitable differential diagnosis, provisional diagnosis and final diagnosis. The clinician must decide if they are going to perform these procedures or appropriately refer the patient."

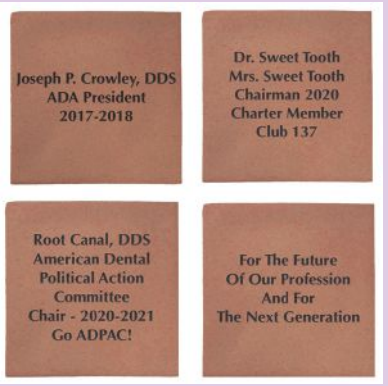
Readers can save 15 percent on the guide and all ADA Catalog products with promo code 18138 until Nov. 23, by visiting ADAcatalog.org or calling 1-800-947-4746. ■

Purchase a personalized brick for the ADA House

Washington — The ADA is inviting members to leave their mark at the ADA House on Capitol Hill by purchasing personalized bricks for the front or back patio. See the graphic at right for examples.

The double paver bricks feature personalized engravings of up to six lines of text, with 20 characters per line (including spaces and punctuation.) Back patio bricks cost $500, and front patio bricks are $1,000.

Money raised from this campaign will be reinvested into the ADA House for future renovations and upkeep.



To see more brick inscription examples or to place a brick order, visit fundraisingbrick.com/online-orders/ada/.

In May, the Board of Trustees approved the purchase of the building at 400 C St., NE, on historic Stanton Park, about 2.5 blocks from the Hart Senate Office Building.

For questions regarding the engraved brick campaign, email Sarah Krejci, senior project assistant, American Dental Political Action Committee and political affairs, at krejcis@ada.org. ■

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Disallow

Continued from Page 1

prohibited from charging the patient for the procedure.

The decision to change its policy, said Dr. Quinn Dufurrena, United Concordia Dental chief dental officer, was inspired partly by an article written by Dr. Dave Preble, senior vice president of the Practice Institute at the American Dental Association, titled "Ethical Considerations in Dental Plan Claims Adjudication," which appeared in the June 2017 edition of The Journal of the American Dental Association.

"Our goal is to not interfere with the doctor/patient relationship," said Dr. Dufurrena. "We recognize the need for patients to be involved in dental treatment decisions. We encourage dentists and patients to have detailed discussions about proposed treatments, as well as reasonable alternatives. If the information available to United Concordia suggests that the claim be denied for lack of dental necessity, we support the dentist discussing treatment options with the patient. If the patient signs a consent form agreeing to proceed with the treatment and acknowledging the lack of insurance reimbursement for the treatment, a participating dentist can bill the patient. The key is that the provided treatment has been agreed upon by both the patient and dentist."

Dr. Preble's article leads off with a question the ADA Council on Dental Benefit Programs received from a dentist who said that part of his contractual agreement as a participating provider allows dental plans to 'disallow' treatment. "This means the plan can prevent him from billing the patient in addition to denying benefits, which essentially precludes him from performing the service even though, in his professional judgment, the treatment is necessary and the patient has been appropriately involved in the decision. Are there ethical issues for the third-party payer, the dental consultant and me? asked the member."

Dr. Preble was clear in his answer. "A system that results in unilateral interference in the dentist-patient relationship, denying patients their right to involvement in treatment decisions and making those decisions without the necessary information best evaluated by the patient's dentist, is not an acceptable way to protect patients," he wrote in the article. "The policy of disallowing claims should be discontinued as inappropriate and potentially unethical. It does not serve patients well, and it requires dentist consultants, the licensed dentists who evaluate claims for third-party payers, to engage in the questionable practice of making treatment decisions without an adequate informational basis or the necessary dentist-patient interaction. They should limit their decisions to approval or denial of benefits to minimize their risk."

This is not the first time a third-party payer has rescinded a policy based on input from the ADA. This summer, the Guardian Life Insurance Company of America reversed its position on third molars and associated sedation and anesthesia, now assuring dentists that claims will no longer be reviewed for medical necessity.

"This is just another example of the ADA advocating on behalf of all dentists nationwide," said Dr. Steve Snyder, chair of the Council on Dental Benefit Programs.

"Dr. Preble's article supports the ADA contention that third-party payers are not in a position to determine which services need to be performed and we appreciate United Concordia Dental's recognition of this fact," said Dr. Christopher Bulnes, vice chair of the ADA Council on Dental Benefit Programs. "Patient care and treatment decisions should be made in an informed partnership between patients and qualified and duly licensed dental professionals. The ADA has been very active in its opposition to these types of contractual clauses. United Concordia Dental's decision, in light of Dr. Preble's advocacy in JADA, proves once again that the ADA believes in the integrity of the dentist-patient relationship and will fight for it.

The House of Delegates adopted a policy in 2016 that opposes practices by third-party payers that permit disallowed claims and other practices the Association believes are inappropriate or intrusive. Resolution 12H-2016, Comprehensive ADA Policy Statement on Inappropriate or Intrusive Provisions and Practices by Third-Party Payers states: "The American Dental Association opposes interference in treatment decisions made between the doctor and patient," the policy states. "Plans which contain inappropriate and intrusive provisions substitute business decisions for treatment decisions made through a patient-doctor dialogue. Such provisions and practices deny patients their purchased benefits and robs them of their rights as informed consumers of health care."

The ADA has drafted an informed consent form that dentists can use if faced with a similar situation. The sample consent form can be found at ADA.org/dbfaq and may be customized to meet a dentist's particular needs.

The ADA has also created an online landing page for dental benefits information that can help dentists address and resolve even their most vexing questions. Go to ADA.org/dentalbenefits, part of the ADA Center for Professional Success.

Staff from the Center for Dental Benefits, Coding and Quality can help dentists with dental benefits-related and coding problems, questions and concerns. Call the ADA's Third Party Payer Concierge at 1-800-621-8099 or email dentalbenefits@ada.org.

Previous installments in the Decoding Dental Benefits series are available at ADA.org/decoding. ■

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