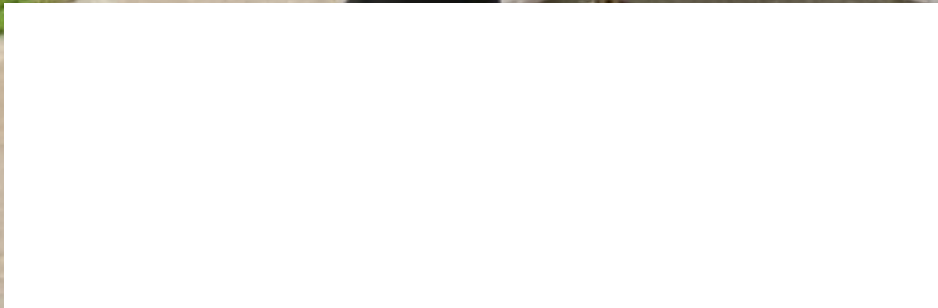


ODA JOURNAL

VOLUME 99/ISSUE 7 APRIL/MAY 2008





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INSIDE

SNAPSHOTS



**Don't miss the 2008
Annual Meeting!**
May 15 - 17
Oklahoma City
Cox Convention Center

ADVERTISER'S INDEX

Alexander & Strunk / pg. 23
Aurum Ceramics / BC
Core Vault / pg. 17
Delta Dental / pg. 13
Greater St. Louis Dental Society / pg. 21
Insurance Answers Plus / pg. 15
Kool Smiles / pg. 15
Melinda Lawrence Cons. / pg. 15
ODA Member Services / IBC
Paragon / pg. 29
Practice Transition Partners / pg. 21
Profess. Practice Assoc. / pgs. 17, 19
Stillwater National Bank / IFC

ON THE COVER:

ODA President,
Dr. Krista Jones, at the
Myriad Gardens in
Downtown OKC.
The gardens are located
across the street from
the Cox Convention
Center, the location
of the 2008 ODA
Annual Meeting.

ODA Today

President's Message / pg. 4
In Memoriam / pg. 5
Calendar of Events / pg. 5
ODA News You Can Use / pg. 6
Patient's Page / pg. 7
Letter to the Editor / pg. 8
2008 ADA Grassroots Training / pg. 8
Dr. Michael Hudson Memorial Fund / pg. 9
OUCOD Faculty Recognition Night / pg. 9
Adopt-a-Dentist Program Update / pg. 10
OUCOD Alumni Weekend / pg. 12

Who & What

2008 Annual Meeting CE Preview - Limoli, Jr. / pg. 14
Profile: Dr. Al Keenan / pg. 16

Features

Making Your Practice Visible / pg. 18
The Three Most Common Mistakes in Endodontics / pg. 20
Solving the Issue of Failed Appointments / pg. 22
2008 ODA Annual Meeting Preview / pg. 24

Clinical

Bisphosphonates... / pg. 28

Classifieds

General Listing / pg. 30



From the President

Krista Jones, DDS

Building Bridges

Don't miss the Oklahoma Dental Association's 101st Annual Meeting!

Dear Friends,

Starting our second 100 years in 2008, we have put together a phenomenal meeting that I know you'll enjoy. In keeping with the ODA Strategic Plan, we have brought in speakers to increase your knowledge and comfort level when working with pediatric patients (which will help increase our volunteer base for the ODF Mobile Dental Care Program), the aging population, and our special needs or medically compromised patients. Our Strategic Plan was visionary in identifying the need to increase our knowledge of each of these patient populations, and our 2008 meeting will provide invaluable educational opportunities to our members and all dentists in Oklahoma and beyond.

The whole dental team can find fascinating courses at this year's meeting. Topics such as periodontal therapy, stress management and tips for better insurance utilization will benefit all of the dental team members.

The popular "Twister" Series is back with a **BANG**, showcasing Oklahoma specialists presenting fast-paced, highly-focused CE during three sessions, broken down into three mini-sessions each.

We are hosting a blood drive, sponsored by the Oklahoma Blood Institute, to help replenish the Oklahoma blood reserve. Dentistry cares – and this is an opportunity for the dental family (dentists, hygienists, assistants, receptionists, business managers and spouses) to give back. With your donation, you will also benefit from a mini-health screening of your blood pressure, hepatitis antibody and cholesterol. Please stop by and donate – let's show everyone dentistry's incredible generosity!

There will be a special wine tasting, featuring only Oklahoma wineries, in the Exhibit Hall Friday night. Our exhibitors have everything your dental practice needs and more. They help make our meeting a big success, so please stop by their exhibits, check out new products and services, and get answers to questions about existing equipment, supplies, and services. Also in the Exhibit Hall, the ODA Digital Dental Office is back with new information and technologies. And the DENPAC Silent Auction, located in the center of the Exhibit Hall, promises to have just the right something that you didn't realize you even needed! Be sure to take some time to peruse those auction tables!

The President's Dinner/Dance will be a change from previous galas. It'll be an Island Party, complete with Caribbean dress and tropical food and drink. So come and relax, lay back and enjoy the rhythm of a steel drum band, and then dance the night away to Souled Out! You won't be disappointed!

The Annual Meeting Planning Committee has done a great job of putting together a meeting you'll enjoy and learn from, all while experiencing excellent camaraderie with your colleagues.

Don't miss it!

calendar of events

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may

MAY 12-13 – ADA Washington Leadership Conference - Washington D.C.

MAY 15-18 – ODA Annual Meeting - Cox Convention Center - Downtown Oklahoma City

MAY 19 – ODA Office Closed

MAY 26 – ODA Office Closed

MAY 30-31 – South Central States Leadership Conference - Oklahoma City



june

JUN 6 – ODA Strategic Planning - 9:00 AM - ODA Building

JUN 11 – Children's Oral Health Coalition Meeting - 10:00 AM - ODA Building

JUN 13 – Council on Government Affairs Meeting - 10:00 AM - ODA Building

JUN 16 – Retired Dentist Lunch - 11:30 AM - ODA Building

JUN 18-21 – ODF Mobile Unit - Migrant & Seasonal Head Start - Tahlequah

JUN 20 – ADPAC Grassroots Training Seminar - 10:00 AM - ODA Building

JUN 21 – ODF Mobile Unit - Bixby Community Center - Bixby

JUN 26-28 – ADA New Dentist Conference - New Orleans, LA

Frank Henry Dolf

March 18, 2008

Oklahoma City

William Wilkerson

February 29, 2008

Madill

In Memoriam

THE OKLAHOMA DENTAL ASSOCIATION JOURNAL (ISSN 0164-9442) is published ten times per year by the Oklahoma Dental Association, 317 NE 13th Street, Oklahoma City, OK 73104, (405)848-8873. Annual subscription rate of \$6 for ODA members is included in their annual membership dues. Rates for non-members are \$36. Single copy rate is \$6, payable in advance. Periodical postage paid at Oklahoma City, OK POSTMASTER: Send address changes to OKLAHOMA DENTAL ASSOCIATION JOURNAL, 317 NE 13th Street, Oklahoma City, OK 73104. Opinions and statements expressed in the OKLAHOMA DENTAL ASSOCIATION JOURNAL are those of the author and are not necessarily those of the Oklahoma Dental Association. Neither the Editors nor the Oklahoma Dental Association are in any way responsible for the articles or views published in the OKLAHOMA DENTAL ASSOCIATION JOURNAL.



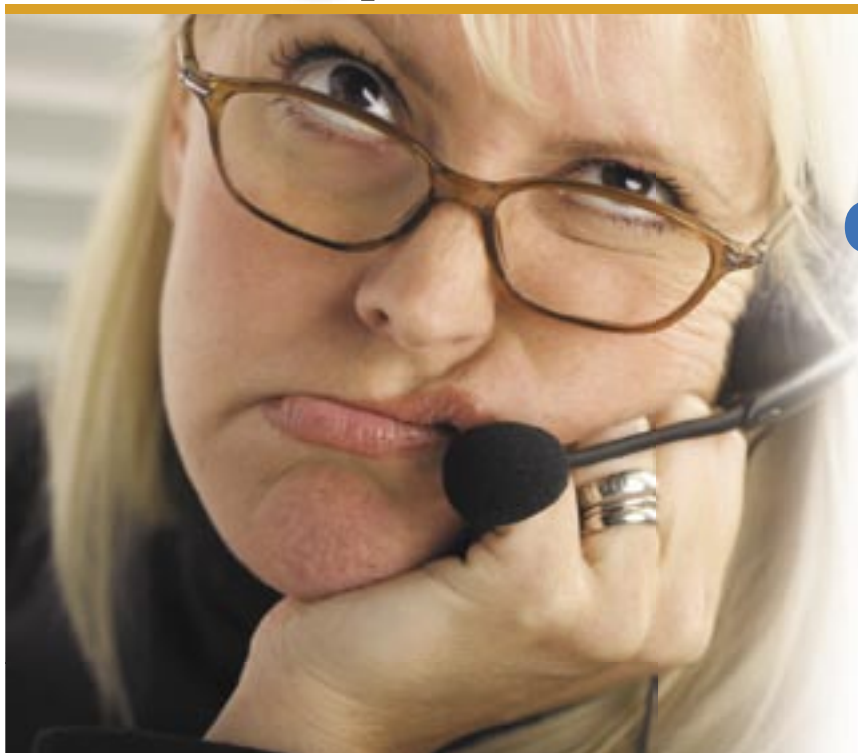
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ODA News You Can Use

This month's spotlight on an ODA endorsed company



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Flossing...the key to keeping your teeth!

Flossing removes bacteria, prevents gum disease and prevents the loss of teeth.

The purpose of flossing is to remove plaque, the colorless film of bacteria that forms on the surface of teeth. The bacteria in plaque produce toxins, and if you don't remove it the toxins will irritate the gums, create a painful inflammation, and eventually cause the loss of bone around the tooth. Flossing once at the end of the day is all it takes—before or after brushing doesn't matter. The primary reason for flossing is plaque removal.

If you're old enough to have teeth, floss them!

The point of flossing is to clean the tight space between teeth that grow closely together. Wherever two teeth are touching, you need to find a way to clean between them. Even baby teeth, though they will eventually fall out, should be flossed since bacteria can grow between closely spaced teeth and make gums tender. Children who do their own flossing may find that a floss holder makes the task easier.

Flossing only helps if you do it right.

While brushing cleans the sticky plaque off most of the tooth, floss reaches where bristles cannot. But the sticky stuff stays if you have poor flossing technique. The biggest mistake people make is that they just floss right down on their gums and back up. You want to wrap the floss around the tooth and then, in a sawing motion, rub the floss up and down the tooth to remove the bacteria.

Good oral health is a component of good overall health.

Gum disease is actually an infection in your mouth. No infection is good for the body, especially in people whose capability to fight infection may be compromised by an illness such as diabetes or an immune disease. Some research has associated chronic gum disease with conditions including stroke, heart disease, and low birth weight in newborns (when the mother had gingivitis).

Any floss is better than no floss.

The best floss is the one you're going to USE and flossing should be as routine as brushing. Find the floss you like, whether it's minty, flat, thick or covered in fluoride. Floss holders and disposable floss sticks have become popular and, many have found, easier to use. As long as you're getting in there and removing that plaque, you can prevent gum disease and preserve your teeth for a lifetime!

Did you know that without flossing, 40% of the surfaces of your teeth are NEVER clean?

Less than 50 years ago, elderly people went to sleep with their teeth in a jar next to the bed. But now your teeth can last a lifetime, provided you use good oral hygiene—which includes a daily regimen of flossing before bedtime.

Letter to the Editor

I am responding to recent articles around the world on the “safety” of formocresol in dentistry. Having started the debate in 1981, I have had the benefit of reviewing the literature as it has developed, without bias and with consistent regard for scientific principles and protocols. My concern is for your readership, well-meaning clinicians who might be confused by position papers that distort the overwhelming body of evidence that cite the genotoxicity, mutagenicity, carcinogenicity, and toxicity of formaldehyde. It is ludicrous to suggest that because other medicaments and prescribed medications in dentistry might also have deleterious effects it is therefore “safe” to use formocresol. It is a “tad” unscientific to further tell dentists that it is okay to add formaldehyde to their patients’ systems since its ingestion/inhalation is a part of life. Repeating the nearly hundred-year-old archaic notion of how to deliver a safe dose by squeezing a soaked cotton pellet is surprising in today’s sophisticated techno-based world. Hand-picking studies that have aberrant or inconclusive results when weighed against the accepted evidence becomes self-serving while simultaneously destructive to clinicians seeking the best for their patients. Much of the research about formaldehyde

was firmly established as far back as thirty years ago. Alternative medicaments have been proposed for many years with mixed results. Equal or better clinical outcomes have been demonstrated with some non-aldehyde compounds; ferric sulfate, white mineral trioxide aggregate, white Portland cement and beta-tricalcium phosphate. Systemic distribution after formocresol pulpotomy is irrefutable. Formocresol interferes with healing. As recently as March 2008 research has shown that formocresol causes genetic damage.

I urge dentists to rethink their use of formocresol. In 1981 (JADA) and again in 1998 (Journal of Clinical Pediatric Dentistry) I concluded, “If a medicament like formaldehyde is clearly not a necessary adjunct, then it may be wondered why it is used at all.”

Children should not be exposed to formocresol since there isn’t any conclusive evidence warranting its use.

Sincerely,
Bradley B. Lewis, D.D.S.

Dr. Lewis is the former postdoctoral endodontic coordinator at St. Luke’s-Roosevelt Hospital Center, New York, attending at Columbia University, School of Dental and Oral Surgery, and associate at Cedars-Sinai Medical Center (Los Angeles).

DON'T MISS THE ADPAC GRASSROOTS TRAINING SEMINAR!

In an effort to revitalize the dental profession’s grassroots political efforts and get back to basics to rebuild dentistry’s activist network, ADPAC has rolled out a newly-designed grassroots/political education seminar. The seminar’s content will be individualized, combining both federal and state-specific issues, providing for maximum impact. Make plans now to attend this special seminar to learn more about politics and how to be effective advocates on behalf of dentistry!

Lunch provided by DENPAC

FREE and all ODA members are invited to attend!

Friday, June 20, 2008

10:00 a.m. – 3:00 p.m.
ODA Building
317 NE 13th Street
Oklahoma City, OK 73104

You're Invited!



Register TODAY by contacting Stephanie Trougakos at the ODA at 405.848.8873; or email strougakos@okda.org.

Dr. Michael Hudson Memorial Fund to benefit ODA's Give Kids A Smile!®

ODA member, Dr. Michael Ray Hudson, passed away suddenly on May 25, 2007, at the age of 44. After first graduating from Oklahoma City University, and then the University of Oklahoma College of Dentistry in 1995, he started his dental career, opening Stroud Family Dentistry. In 2005, he helped start the first Small Smiles Dental Clinic and served as Lead Dentist, helping to provide dental services to underprivileged children. Known by his staff and patients as kind, gentle and patient, "Dr. Mike" always believed that dentistry didn't have to hurt. He had recently again opened his own dental practice, Edmond Smiles, in Edmond.

Dr. Hudson graduated high school from Casady School in Oklahoma City. His friends wanted

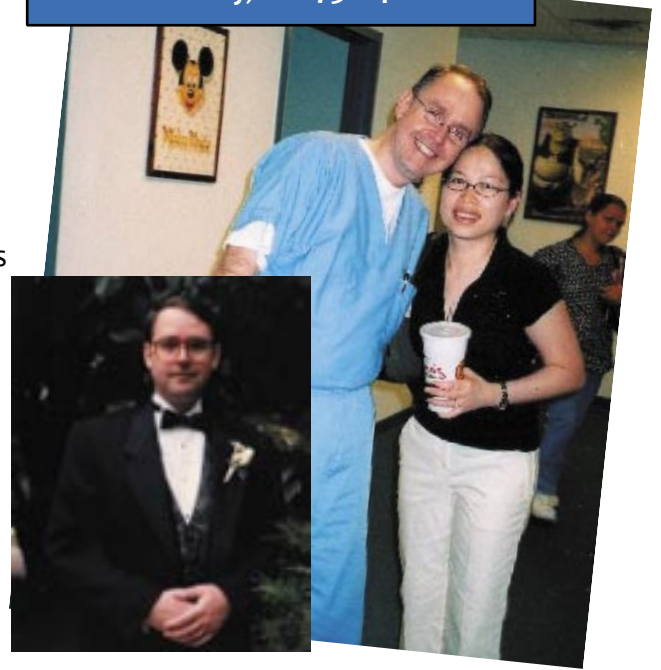
to remember him in a way that exemplified his passion – dentistry for children – and established the Dr. Michael Hudson Memorial Fund. The fund directly benefits the ODA's Give Kids A Smile!® program and is being used to purchase toothbrushes and toothpaste for underprivileged children all across Oklahoma.

THANK YOU!

to Dr. Hudson's Casady classmates who have already made contributions to the fund:

- Mr. Craig Alleman
- Mr. David Boggs
- Ms. Susan B. Donchin
- Mr. John C. Keitz
- Dr. Dana B. Price
- Mr. Lance M. Rothstein
- Mr. Kenneth K. Wert

Donations are still being accepted. Please send contributions to:
Dr. Michael Hudson Memorial
Oklahoma Dental Association
 317 NE 13th Street
 Oklahoma City, OK 73104



ODA Scrapbook

OUCOD Faculty Recognition Night
 April 19th, 2008
 Governor's Mansion - Phillips Pavilion





AN UPDATE! ODA / SCHOOLS FOR HEALTHY LIFESTYLES (SHL) "ADOPT-A-DENTIST" PROGRAM

The ODA, under the direction of the Council on Dental Education and Public Information, has recently partnered with Schools for Healthy Lifestyles (SHL), a non-profit program formed in 1997 in an effort to combat Oklahoma youth's declining health status. The organization's mission is to promote and maintain healthy lifestyles among students, families and educators. Elementary schools selected to enter the SHL program form a health advisory council to identify needs, establish goals, and implement plans to improve the well being of their entire school community. It's through this partnership with SHL that the ODA launched the "Adopt-A-Dentist" program.

Since the first call-for-volunteers in February, ODA members from all across the state have graciously volunteered to serve as "adopted dentists"! The ODA Council on Dental Education and Public Information will be matching those volunteers

with schools soon. **But we still have schools that are in need!**

Current SHL Schools Needing an Adopted Dentist

Bodine Elementary (OKC)
 Johnson Elementary (OKC)
 Buchanan Elementary (OKC)
 M.L. King Elementary (OKC)
 Columbus Elementary (OKC)
 East Side Elementary (Midwest City)
 Oklahoma School for the Blind (Muskogee)
 Fillmore Elementary (OKC)
 Southwest Elementary (Chickasha)
 Stand Watie Elementary (OKC)
 Heronville Elementary (OKC)
 Western Oaks Elementary (Bethany)
 Hillcrest Elementary (OKC)
 Willow Brook Elementary (OKC)
 Huston Center (Blackwell)
 Will Rogers Elementary (Shawnee)

What's Expected of an Adopted Dentist?

That's a fair question! Below is some background information on the program and an outline of basic expectations. The level of commitment is completely up to the Adopted Dentist and the school's SHL Coordinator to work out together, based upon the school's needs and the Adopted Dentist's schedule.

Program Information

- There are currently 40 participating schools in the SHL Program. There will be 50 for the 2008-2009 school year.
- Each school has an SHL Coordinator on staff – usually the physical education teacher.
- The ODA will develop and/or purchase the necessary oral health educational materials. The materials will focus on all four of SHL's key areas:
 - Nutrition Education and Awareness: "Sip All Day", the truth about bottled water/ fluoride use, how what you eat also affects your oral health, etc.
 - Tobacco Use Prevention: How tobacco use affects your oral health, the dangers of chewing tobacco, oral cancer, etc.
 - Promoting Physical Activity and Fitness AND Safety and Injury Prevention: Using mouthguards, what to do in the case of a dental emergency, etc.
- The ODA will recruit up to two volunteer dentists to serve as the "adopted" dentist(s) for each participating school.
- All participating dentists will be recognized with an SHL certificate and listed in the SHL newsletter, *Lifeline*, and are eligible for a new SHL award for the Outstanding Adopted Dentist, as nominated by the schools and chosen by the SHL Board of Directors and presented at the Annual SHL Awards Dinner.
- Timeline for implementation:
 - January-May, 2008 – the ODA will recruit the volunteer dentists and develop / purchase the educational materials.
 - May, 2008 – the ODA and SHL will send a joint letter notifying the schools of the name(s) of their adopted dentist(s).
 - August/September, 2008 – the dentist(s) will make initial contact with the SHL Coordinator to make introductions and schedule visits.

Basic Expectations

- The adopted dentist(s) will visit the school and make oral health educational presentations (# of times will depend on the school's size, specific needs, scheduling issues, etc.). The adopted dentist(s) and schools are encouraged to schedule the presentations during Children's Dental Health Month in February.
- The adopted dentist(s) will assist the school in making arrangements for emergency dental care for low-income students with no financial resources for treatment.
- The ODA will work with the Oklahoma Dental Foundation to try to schedule Mobile Dental Care Program visits to as many SHL schools as possible. The adopted dentist(s) and staff will serve as the volunteers in the mobile van that day, treating eligible students, as identified by the school.

THE SUCCESS OF THIS NEW PROGRAM IS 100% DEPENDENT UPON ODA VOLUNTEERS! PLEASE TAKE A MOMENT TO COMPLETE THE FORM BELOW AND VOLUNTEER A FEW QUALITY HOURS OF YOUR TIME TO IMPROVE THE ORAL HEALTH OF THE CHILDREN IN YOUR COMMUNITY.



ODA ADOPT-A-DENTIST VOLUNTEER FORM

- YES! I would like to volunteer as an Adopt-A-Dentist for 2008-2009!
- I would be willing to serve as the "Adopted Dentist" for more than one school.



Please pair me with the following school(s):

_____ FIRST CHOICE (from the enclosed list of schools)

_____ SECOND CHOICE

_____ THIRD CHOICE

NAME _____

PHONE _____ EMAIL _____

Please return to the ODA, 317 NE 13th Street, OKC, OK, 73104 or FAX 405.848.8875.

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Respectfully,

Terri Green

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Annual Meeting 2008

CE Preview



Tom Limoli, Jr.

Tom Limoli, Jr., is the prevailing expert on proper coding and administration of dental insurance benefit claims. He serves as president of Limoli and Associates / Atlanta Dental Consultants, Inc., a company that, over the past quarter century, has assisted dental offices in streamlining the insurance reimbursement process. Mr. Limoli's no-nonsense approach to the management of third-party reimbursement has been implemented in thousands of dental practices across the country. Mr. Limoli received his Bachelor of Science in Criminal Justice from Valdosta State University. Following his work with the U.S. Treasury Department's Federal Law Enforcement Training Center, Mr. Limoli has actively investigated fraudulent claims for the insurance industry, as well as numerous other third-party fiduciaries. He is a licensed private investigator and is a member of the American Association of Dental Consultants, and the National Speakers Association. Mr. Limoli is the editor of *Dental Insurance Today*, a monthly publication that addresses third-party reimbursement in the dental office. He is the author of *Dental Insurance and Reimbursement Coding and Claim Submission*, and co-author of *Fee-for-Service Dentistry With a Managed-Care Component*.

“Stop Telling Patients About Their Dental Insurance... It's the Patient's Plan – Not Yours!”

Six (6) Hours of CE Available

Saturday, May 17, 2008

9:00 am – 12:00 pm and 2:00 pm – 5:00 pm

Lecture format

Recommended for the ENTIRE dental team!

Patient dental benefit plans are continually changing. Are you and your team? This full-day workshop will provide you with a comprehensive overview of the skills and information needed to cope with, as well as profit from, market changes. Learn to work with and understand the patient's benefit plan restrictions and limitations. Tom's foolproof system to accurately document, code, bill and collect for completed procedures has been implemented in thousands of dental offices across the country. Even if your office doesn't accept the insurance assignment, you shouldn't ignore this critical component of “value added” customer service while you streamline and simplify the reimbursement process. Upon course completion, participants will be able to:

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If the answer to any of these questions is yes, please call me today. The solutions are easier than you think!

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Profile on Dr. Al Keenan Tulsa County District Trustee

Dr. Keenan always wanted to be a dentist. He remembers going to the dentist as a child and being quite impressed that the dentist could work on two patients at the same time while taking a puff of his cigarette as he passed from one operatory to the next. How times have changed!

He and his wife, Judy, lived in the same dorm during college and were married in dental school (between his junior and senior years), just as Judy had graduated from the UMKC dental hygiene program.

Dr. Keenan worked as the night manager at the student union during his senior year and Judy worked for two dentists in Leavenworth, Kansas.

After graduating in 1963, they had two wonderful tours in the Air Force; Tacoma, Washington, and Athens, Greece.

In 1970, they returned to Oklahoma to start a new practice in Tulsa with a three-month-old in tow. Dr. Keenan has two daughters who now live with their families in Zurich, Switzerland, and Poteau, Oklahoma.

Dr. Keenan became active in the Tulsa County Dental Society at the urging of Dr. Dan Brannin and worked through the chairs of leadership, becoming President in 1987-88.

In 1989, he filled a vacant ADA Alternate Delegate seat and was elected Vice President of the ODA in 1995. He was honored to serve as ODA President in 1997-98.

ODA: Why do you volunteer your time for organized dentistry?

AK: As a professional I feel that it is important to give back to my profession.

ODA: What do you most love about dentistry?

AK: I love helping others.

ODA: What goals do you have for your district in the next five years?

AK: Mentor others and show them the many benefits of ODA membership.

ODA: Who or what encouraged you to get involved in organized dentistry on the state level?

AK: Drs. Dan Brannin, Jim Sadoris, Jim Torchia and Richard Haught.

ODA: Tell us about your family. Is anyone else in the dental profession?

AK: I tried to interest my two daughters, Katie (the fine arts major) and Jennifer (the sociology major) to no avail. Other than my wife Judy, who is a hygienist, there are no other family members in the profession.

Dr. Keenan's Favorites

Movie – The Bucket List and Michael Clayton

Television Show – Boston Legal

Music – Most all classical and classic rock-n-roll

Oklahoma Golf Course – No golf

Sport (observe) – Tulsa University football and basketball & OU football

Professional Athlete – Roger Federer

Professional Team – New England Patriots

US Vacation Destination – Destin, Florida

International Vacation – Switzerland

National Park – Marron Bells, Colorado

Sports Car – Classic cars (I love my Porsche 911S)

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MAKING YOUR PRACTICE VISIBLE:

Practical Do's and Don'ts of Practice Marketing

By Steven Rasner, DMD, MAGD

For many dentists the idea of marketing their dental practice is met with hesitation because in their own minds, marketing = sales. Dentists often feel that they don't need to, or shouldn't have to, market (or sell). However, what we're talking about today is a new definition of marketing: letting your community know that your practice exists and informing your neighbors about the various services you provide.

The benefits of marketing can be experienced on all levels of the practice. Although many dentists may find it easy to dismiss the notion of marketing for their practice, it's hard to dismiss the idea of a happy, thriving practice. Over time, fickle patients and changing lives will affect patient flow and new patients will be needed for even well-established practices. The best way to increase new patient flow is to make your practice visible to the community. Numerous opportunities to get in touch with your community are available, from patient "thank you" letters on your wall to sports dentistry for the local high school teams. Here's a list of some practical do's and don'ts for marketing your dental practice.

MUST DO'S

Do set goals. The goals you set need to be relevant to where your practice is and where you want it to be in terms of production and profitability. More than likely, you're not going to achieve your goals without increasing the number of new patients that come into the office, which requires marketing. So, set production goals that are tied to new patient consultations and make a plan to reach those goals.

Do make yourself visible. Marketing isn't about renting a billboard announcing you're here. It's about getting out there and being part of your community. Here are a few ideas: sponsor a family rollerskate night for charity. For about \$500 or less, you offer a couple hours of roller-skating and a slice of pizza for your pediatric patients and their parents. Their cost for admission is canned food, toys for tots or a donation to the Salvation Army. Your pediatric patients may even bring another family along who may not know you exist. Offer scholarships to high school students with the most improved grade point averages. Coordinate a dinner-dance for mentally disabled kids. And, become more than a dentist and a dental practice; become part of the community through on-going efforts.

Do encourage professional referrals from all related specialists. Contact your local Lasik centers, plastic surgeons, cardiologists, and other GP's, endodontists, oral surgeons, etc. Send a letter letting them know about you and your practice with an 8" x 11" of your best before-and-after case studies. (Make sure you have appropriate patient permissions.)

Do make your patient experience exceptional. A great marketing tool is word-of-mouth referrals. Giving your patients welcome gifts or end-of-treatment thank-you gifts are thoughtful ways to inspire your patients to give you referrals and to talk positively about their experience at your practice.

Do offer patient financing. You can leverage a patient financing program like CareCredit to bring

in new patients. It also increases recommended treatment acceptance because your current patients also need No Interest monthly payment plans. Plus, CareCredit can help you attract new patients with their online doctor locator site where patients go to find a practice that offers CareCredit in their neighborhood.

PRACTICAL DON'TS

Don't be afraid of the Web. Using the Web and creating a website is a great way to attract new patients. New patients you get from the Web tend to be high quality because if they're on the Web it tells you they've done their research.

Don't waste your money or energy. Results don't happen overnight. So, if you're not going to make a reasonable investment in time and money, it's better not to do anything at all. If you don't have patience or persistence, don't pursue marketing.


Don't wait. If you're a new dentist you should consider marketing for your practice as you would consider electricity or the office equipment as a necessary part of setting up shop. And for the established practice experiencing that period of non-growth, start now. It's much more difficult to fix a bad or declining situation than to be proactive.

Marketing is so much more than advertising; it's almost everything the practice says and does that is shared with the community. In addition to traditional and non-traditional methods, marketing is making your practice a positive part of the community through involvement and networking. Too many patients out there don't know you exist.

Be visible. Be creative. And be successful.

Dr. Steven Rasner is a noted author, lecturer and successful dentist. Practicing since his 1980 graduation from the University of Pennsylvania, Dr. Rasner has built a flourishing practice located in a low-income neighborhood. He often shares his philosophy and proven principles through his educational practice management program, *Realizing the Dream*. The course was developed to help new and veteran practitioners operate and manage healthcare services that can lead to professional and financial fulfillment. He holds Mastership status with the Academy of General Dentistry and has authored two books, *The Protocol Book* and *The Art of Getting Paid*, and his articles have been featured in the most prominent dental journals.

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The 3 Most Common Mistakes in Endodontics

By L. Stephen Buchanan,
DDS, FICD, FACD

The need and demand for endodontic procedures have never been greater. Radical new technologies have made it simpler and less time-consuming for the general practice to create better, more consistent results. Performing endodontic procedures can positively impact a practice's profitability, and General Dentists are very capable of performing these procedures with the right continuing education courses. Ironically, the level of impact on profitability will be higher when General Dentists choose only to do the more simple cases. When cases get complicated they can often become exponentially more difficult and set the stage for three of the most common mistakes. Understanding when and how these mistakes occur helps doctors make the right choice when it comes to performing Endodontic procedures.

Knowing When to Let Go

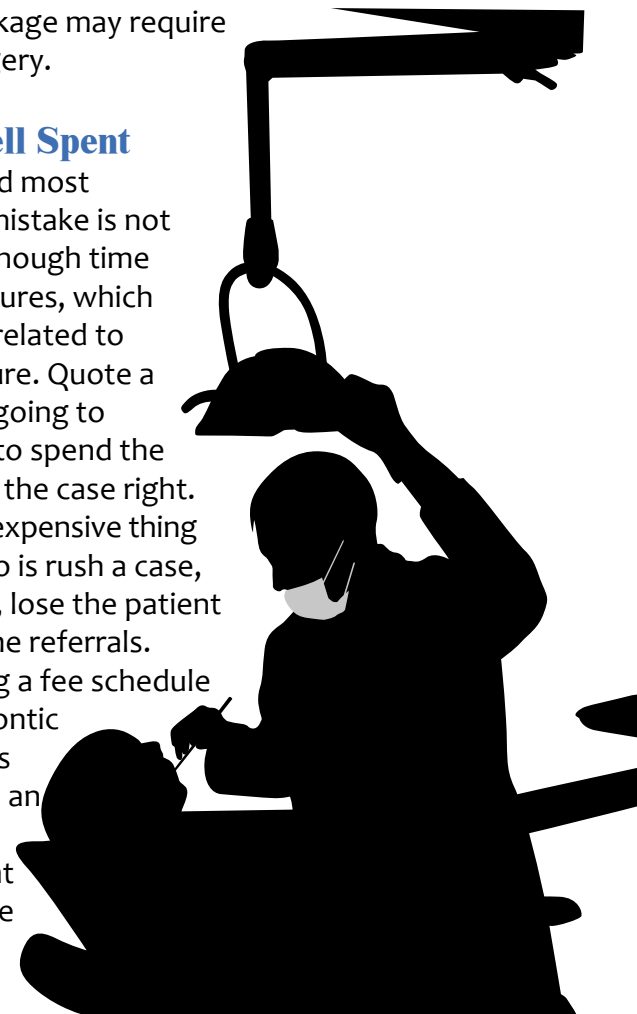
The first, and probably most critical, mistake is making a bad decision when choosing which cases to treat and which to refer. Dentists need to be honest with themselves about their skill level and training. It helps to have a humble attitude. Often, especially with newer dentists, it's hard to refer work out when you have openings in your schedule. So, it takes good judgment and an understanding that referring out a complex case will only have a short-term effect on your income. Choosing to do a case and having that case go wrong can have an enormous effect on your short-term and long-term income. It's not just the possibility of the cost associated with paying an Endodontist to fix the problem or the cost of being sued. The biggest cost is that you are going to lose that patient and everybody they know, are related to, are friends with – anybody they would have referred to you. Of course, nobody is going to get it right every time, but it's really unpleasant when a case goes wrong, regardless of what level of expertise the dentist has. Every one of us wants the case to work out and we have to be committed to looking at the long-term positives rather than the short-term negatives.

The Challenges of Rotary Instrumentation – Separation Anxiety

The benefits of using rotary instruments are pretty far-ranging. It is easier in terms of the amount of training required to become competent and it's radically different in the amount of time to actually do the procedure with more consistent results. The problem is, again, when your thinking is very short-sighted. When you look at the cost of the file and think you can add to your bottom line by re-using the instrument, you set the stage for separation and breakage. It's a really bad idea. When you use a rotary instrument on another case, it has accumulated a lot of cyclical fatigue, which is the primary cause of breakage, and it's duller and takes longer to cut the length. The consequence of the file breakage is different in every case. In a root canal system that's relatively or totally uninfected, there may be no consequence other than a little bit of heart muscle that's lost when you see the radiograph and the premature obturation that's occurred. In an infected case, breakage may require apical surgery.

Time Well Spent

The third most common mistake is not allowing enough time for procedures, which is directly related to fee structure. Quote a fee that's going to allow you to spend the time to do the case right. The most expensive thing you can do is rush a case, have it fail, lose the patient and lose the referrals. Developing a fee schedule for Endodontic procedures starts with an intelligent assessment of what the costs of



delivering the procedure are, including materials and time. You need to have a fee structure commensurate with the difficulty and quality of the case, and that's not always easy for the patient financially. That's why I recommend you partner with a patient financing company, such as CareCredit. With their wide range of payment options, patients get to receive the dental care they need and pay over a period of time that works for their existing economic situation. Having a payment program makes paying for care palatable and ensures our patients' dental wellbeing.

The bottom line is that performing Endodontics, especially simple cases, can positively impact your bottom line. The key to making Endodontics a positive experience – for you, your practice and patients – is to avoid these three most common mistakes and make sure you take as many CE and hands-on courses as you can. In Endodontics, technology and techniques are improving rapidly, providing opportunity for all dentists, including general dentists, who are trying to enhance their growth and profitability.

Author bio:

Known for his multimedia presentations, 3D anatomy research, technique articles, and instrument designs, Dr. Buchanan is a leading expert in the field of endodontics. He is a Diplomate of the American Board of Endodontics and a Fellow of the International and American Colleges of Dentistry. Dr. Buchanan lives in Santa Barbara, California where he maintains a private practice limited to endodontics and implant surgery and teaches hands-on laboratory courses through his business, Dental Education Laboratories. www.endobuchanan.com.

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Solving the Issue of Failed Appointments



Takes a Team Effort.

By Lois Banta, CEO Banta Consulting

Failed appointments can significantly impact a practice. On average, 15% of hygiene appointments are missed, which costs practices up to \$30,000 per hygienist per year in lost time and opportunity. And, if you factor in failed operative appointments, the loss can add up to \$100,000 per year. Wouldn't it be wonderful if you could reduce your cancellations and no-shows to under 5%? You can. When it comes to solving the issue of failed appointments, we're all in it together, because it starts with the leader of the practice – the doctor – and involves the entire dental team.

Follow the Leader

Most doctors know failed appointments are a huge problem, possibly even at epidemic proportions, but are perplexed on how to solve it. A lot of emphasis has been placed by consultants on how cancellations and no-shows cost the practice time, but the connection that time is money and how that translates financially has really not been made. When they understand the impact of the loss of literally tens of thousands of dollars doctors and their teams will understand they need to take specific steps to not only address when and why failed appointments happen, but also develop a program and train the team to prevent them from happening in the future.

The doctor's role in preventing cancellations and no-shows is leadership. One of the reasons doctors are puzzled on how to solve this issue is that they believe the cause and responsibility is primarily the patient's – which is not true. Unfortunately, when a doctor has this perspective, it de-emphasizes the need for the entire team to get involved to

resolve the underlying causes. But when the doctor expresses concern and wants to develop strategies to keep the schedule full, the team is motivated to take responsibility.

An Excuse is Not a Reason

It's easy to think patients are to blame for the majority of failed appointments. But often the failed appointment could have been avoided if the team had been given the tools and specific verbal skills they need. Sure, there are many reasons why patients cancel or don't show for their appointment that are legitimate, such as fear of pain, constraints on a patient's time, etc. But a significant number of cancellations and no-shows have to do with money and the fact that patients have not bought into wanting the dentistry. Unless patients understand their dental needs, the doctor and team have clearly communicated the benefits of treatment (and consequences of not moving forward with the dentistry), and tied those benefits emotionally to the patients' specific lifestyles and situations, they may schedule an appointment but have little intention of keeping it because they don't believe in the value of the dentistry.

A patient must hear something three times before they gain understanding. Therefore, when a doctor has a conversation with a patient, it's an opportunity to prepare the patient to want and accept needed dentistry, so that a proper hand-off can occur. Then the team must repeat the doctor's recommendations and the benefits of the treatment at least two more times during the case and fee presentations. They must also listen intently to patients to make sure they have bought into the treatments. If the patient hasn't, the team and the

doctor must be trained and prepared to answer questions and overcome barriers to treatment. For example, the patient may seem hesitant, so the team members ask, "You seem hesitant. What questions can I answer about the treatment the doctor has recommended or the cost that will make it easier for you to move forward with care?" This opens up communication with the patient. If the issue is cost, the team can address the patient's concern by discussing the practice's payment options, including No Interest and low-interest monthly payment plans through a program like CareCredit, which can give patients solutions that work within their budgets and lifestyles – helping them feel more comfortable and more inclined to keep their appointments. If the issue is last-minute cancellations by the patient, using appropriate techniques on the phone dramatically reduces failed appointments. For example, rather than calling to "confirm" or "remind" them of appointments, give patients "courtesy" calls to let them know you're on schedule and you're looking forward to seeing them tomorrow.

Measure Your Success

Once the doctor has taken the lead and has engaged the team to develop value and desire with the patient and the communications skills that discourage failed appointments, it's important to measure and monitor success. Constantly track failed appointments and make them part of your daily and monthly meetings. When the doctor and the team accept responsibility for cancellations and no-shows and proactively work together to solve the issue, achieving a failed appointment rate of less than 5% is very achievable. The doctor will have a full schedule, the team will have less stress, and practice profitability will be much healthier. Additional team training on how to minimize failed appointments can be found at www.bantaconsulting.com.

PROFESSIONAL BACKGROUND:

Over 30 years ago, when Lois began her career as a dental receptionist, she discovered simple practical methods for streamlining scheduling, resolving outstanding insurance claims and decreasing accounts receivable. She later became financial manager of a large dental practice. Lois Banta is a member of and is co-executive director for "The Speaking and Consulting Network". Lois is founder, owner and CEO of Banta Consulting, a company designed to assist dental practices in managing their offices while at the same time de-stressing their environment. Lois is on the Board of Directors for the ADMC (Academy of Dental Management Consultants). She is also an affiliate member of The American Academy of Dental Practice Administration and a member of the American Dental Assistants Association.

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Please help celebrate the following members who have reached milestones of ODA membership. We congratulate and thank them for their continued commitment to organized dentistry!

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- Dr Richard E Bradley
- Dr Robert L Bartheld
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- Dr William W Castles
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- Dr Richard Hankins
- Dr Karen A Cox-Haymaker
- Dr Martin Hallren
- Dr John G Dyer

ODA CASINO NIGHT & Related Organizations' Reception

Join us Friday, May 16, 7:00-10:00 P.M., for a night of gamblin' ODA style! All meeting attendees are invited to play! We'll have 20+ tables of gaming and we'll be prizing, eating, drinking and spending time with our friends!

Joining us that evening will be the OU College of Dentistry, the Baylor College of Dentistry, Eastern Oklahoma Donated Dental Services (EODDS), and Dentists for the Disabled and Elderly (D-DENT), ODA's "related organizations" and co-sponsors of the event.

The party will be held at the ODA Building, 317 NE 13th Street, in OKC. A shuttle will be provided during the event, making frequent stops at the front entrance of the Renaissance Hotel.

A special thanks to our sponsors for this great event!



president's dinner

It's a Caribbean dinner party!
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2008 ODA President's Dinner Honoring Dr. Krista Jones

Saturday, 6:30 p.m.

Cox Convention Center Ballroom C

Krista invites you to join her at the Islands for an evening of turquoise blue water, white beaches, tropical food and drinks, and the laid-back beat of a steel drum band. The evening's attire is "Caribbean flair" and calls for your favorite grass skirt, tropical shirt, sunglasses and beach hat (you can leave your sunscreen at home)! After the dinner and 2008-2009 ODA officer installation, get ready to dance the night away to the fabulous sounds of Souled Out. Hope to see you there, 'mon!

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The Oklahoma Blood Institute (OBI) is sponsoring a blood drive and **FREE** health screening in the Exhibit Hall on Friday, May 16, 9:00 a.m. – 5:00 p.m.

Each donor will receive:

- Check on cholesterol levels (results mailed within 4 weeks)
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Prostate Specific Antigen is a protein that is made by the prostate and can be found in the blood in small amounts normally. However, men with prostate cancer can have elevated levels.

OBI is a non-profit, regional blood center serving 125 hospitals and medical facilities in the state. OBI provides blood products for 86% of the state's population thanks to its generous blood donors!



Save a life today – come by the OBI Blood Drive / Health Screening on Friday in the ODA Exhibit Hall!



The Oklahoma Dental Foundation Invites you to CELEBRATE!!

The ODF will be hosting a celebration party in honor of the many hours of contribution to the ODF and the Mobile Dental Care Program.

Enjoy a live band and light hors d'oeuvres at the Regatta Park Landing on the Chesapeake Boat House grounds. Also enjoy a moonlit boat ride on a River Cruiser - cruises will be on the half hour.

Thursday, May 15th
Come and Go from 7:00 - 9:00
Short program at 8:00

Cash bar available. Dress is casual, as it is an outdoor event.

Features

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BISPHOSPHONATES, OSTEONECROSIS OF THE JAW, AND DENTAL TREATMENT RECOMMENDATIONS

Dr. Lida Radfar* & Dr. Farah Masood**

*Assistant Professor of Oral Medicine, Department of Oral Diagnosis and Radiology, University of Oklahoma College of Dentistry, Oklahoma City, Oklahoma

**Associate Professor of Oral & Maxillofacial Radiology, Department of Oral Diagnosis and Radiology, University of Oklahoma College of Dentistry, Oklahoma City, Oklahoma



Figure 1: Maxillary edentulous arch with ONJ following extraction



Figure 2: Closer view of a lesion

Abstract

Millions of patients in the United States take bisphosphonates for management of malignant bone metastases, osteoporosis, osteitis deformans (Paget's disease), and osteogenesis imperfecta. Since 2003, over 200 cases of osteonecrosis of the jaws have been described, mostly in patients with multiple myeloma or breast cancer patients, and to a lesser extent in patients on oral medications.

Introduction

About 80 million people in the United States take bisphosphonate medications. Also called diphosphonates, bisphosphonates are synthetic analogues of pyrophosphate, a natural regulator of bone metabolism found abundantly in bone matrix.¹ They are effective in inhibiting bone resorption in the body.

Bisphosphonates can be either taken orally or administered intravenously. Oral bisphosphonates (such as alendronate sodium [Fosamax]), are used to help prevent or treat bone loss in various diseases including osteoporosis, osteogenesis imperfecta, and Paget's disease (osteitis deformans). Intravenous bisphosphonates (such as pamidronate, ibandronate, and zoledronic acid) are primarily used to treat bone erosion and hypercalcemia associated with cancer therapy, malignant bone metastatic disease, Paget's disease, and multiple myeloma.² They help reduce bone pain and hypercalcemia associated with metastatic breast cancer, prostate cancer, and multiple myeloma. Zoledronic acid is reportedly the most potent intravenous bisphosphonate³ and has demonstrated a broad clinical activity in patients with bone metastases, with a high affinity to bone.⁴ Its concentration in bone is greater than 100 fold of plasma and declines only slightly after six months.⁵

The true association of osteonecrosis of the jaw (ONJ) with bisphosphonate therapy is not clear. The risk of developing ONJ in patients treated with high doses of intravenous bisphosphonates is in the range of 1–10 per 100 patients, depending on the duration of the therapy. The risk of ONJ associated with oral bisphosphonate therapy is estimated at 0.7 cases per 100,000 person-years of exposure.⁶ Potential risk factors for ONJ include radiation therapy, dental extraction, infectious diseases, trauma, concomitant therapy with corticosteroids, and chemotherapy.^{7,8}

Bisphosphonates were synthesized for the first time in 1865 in Germany for industrial use to prevent calcium phosphate precipitation in irrigation systems.⁹ The first medication (Eidronate) in the bisphosphonate group was approved by the Food and Drug Administration in 1977 for treatment of Paget's disease.¹⁰ The initial rationale for human use was the potential of these medications to prevent the dissolution of hydroxylapatite, the principal bone mineral, thus stopping bone loss. It is reported that bisphosphonates inhibit the differentiation of osteoclastic precursors, induce apoptosis of osteoclasts, and stimulate the release of osteoclastic inhibitory factor from osteoblasts.¹¹

There are two classes of bisphosphonates: nitrogenous (N-containing) and non-nitrogenous (non-N-containing). Nitrogenous

bisphosphonates include pamidronate (Aredia; Novartis Pharmaceuticals Corp), neridronate, olpadronate, alendronate (Fosamax), ibandronate (Boniva, Bondronat®; Hoffmann-La Roche Inc.), risedronate (Actonel), and zoledronate (Zometa; Novartis Pharmaceuticals Corp.). These products act on bone metabolism by binding and blocking the enzyme farnesyl diphosphate synthase (FPPS) in the HMG-CoA reductase pathway.¹² Disruption of this pathway prevents the formation of metabolites essential for proper subcellular protein trafficking and binding proteins in osteoclasts.

Non-nitrogenous bisphosphonates include etidronate (Didronel), clodronate (Bonafos, Loron), and tiludronate (Skelid). This class of bisphosphonates is metabolized in the cell to compounds that compete with adenosine triphosphate (ATP) in cellular energy metabolism. Almost half of the absorbed oral or intravenous bisphosphonate is excreted unchanged by the kidneys. The remainder has a very high affinity for bone tissue, and is rapidly absorbed into the bone surface. Bisphosphonates, when attached to bone tissue, are ingested by osteoclasts which initiates apoptosis and the death of osteoclasts, leading to an overall decrease in the breakdown of bone.¹³

Bisphosphonate-related osteonecrosis of the jaw

Since 2003, over 200 cases of osteonecrosis of the jaws have been described, mostly in multiple myeloma or breast cancer patients. ONJ is a site-specific pathological condition. It can occur spontaneously or after a simple tooth extraction with the mandible twice as frequently affected as the maxilla. Figure 1 shows post-extraction ONJ in a patient with breast cancer who received intravenous bisphosphonate therapy. Most ONJ cases occur following high-dose intravenous administration of the medication. Side effects of bisphosphonates include upset stomach, electrolyte disturbances, osteonecrosis of the jaws, musculoskeletal pain, nephrotic syndrome, and renal failure. Upset stomach and esophageal inflammation and erosion may occur with oral N-containing bisphosphonates.^{14,15} Patients are advised to sit in an upright position for 30 to 60 minutes after taking these medications to decrease such possible complications. Some patients may remain asymptomatic for a few weeks or months, and the problem becomes apparent only upon oral examination. In other cases, the problem may mimic dental or periodontal disease. However, dental or periodontal treatment does not resolve the patient's symptoms.¹⁶ Radiographic findings of ONJ have been reported by several investigators and include osseous sclerosis and poorly defined lytic lesions.^{16,17}

Type I collagen is primarily synthesized in bone and accounts for about 90% of the organic matrix of bone. During bone turnover, type I collagen is degraded and small peptide fragments are excreted into the blood stream. These fragments can be measured by serum CrossLaps ELISA,^{18,19} an immunological test to measure carboxy-terminal collagen crosslinks (C-Terminal [CTx] Telopeptide) in human serum and plasma. This test is more specific for bone resorption than other tests such as aminoterminal cross-linking telopeptide (NTx).²⁰ Marx et al.²¹ recommended it as a tool to assess the risks and help treatment decisions. The CTx level recommendations are: <100 pg/ml (high risk), 100-150 pg/ml (moderate risk), and >151 pg/ml (minimum or no risk).²¹

Practical guidelines for dental treatment

Patients generally fall into one of three groups with regard to bisphosphonate therapy: those about to start bisphosphonate therapy; those already on such therapy; and those who have ONJ. Treatment recommendations differ as follows:

Recommendations for patients about to start bisphosphonate therapy

Patients should be educated on minimizing the risk of occurrence of ONJ and optimizing their oral health care. Hopeless teeth should be extracted and the healing process completed if time permits.²¹ It is important to inform the treating oncologist that these patients should be managed as though they were

going to have radiation therapy to the head and neck area.²¹ Dental prophylaxis, caries control, and conservative restorative dentistry should be performed.

Recommendations for dental treatment of patients on bisphosphonates

Maintaining good oral hygiene is crucial to reduce the risk of dental and periodontal infections. Good oral care should be reviewed and reinforced. Routine dental cleaning should be performed with an emphasis on avoiding soft tissue injuries. Removable dentures should be examined for their potential to induce soft tissue trauma. If possible, endodontic therapy is preferred to extraction. Implants should be avoided on patients undergoing IV bisphosphonate therapy.^{22, 23}

After a study of 30 consecutive patients on oral bisphosphonate therapy²¹, the following guidelines for dental treatment of such patients have been proposed:

1. If oral bisphosphonates are used for <3 years, no precautions is necessary;
2. If oral bisphosphonate has been used for <3 years and the patient is taking prednisone concomitantly, or if the patient has been using oral bisphosphonate for >3 years with or without concomitant prednisone use, discontinue bisphosphonate use for three months prior to the planned procedure and test the fasting CTX level. Patients should resume bisphosphonate therapy only after complete healing following the procedure.

It is believed that the ONJ is not preventable but it is controllable. The patient can minimize the risk of developing ONJ by maintaining good oral hygiene and regular dental care. Although complications of bisphosphonate therapy are rare, patients should be informed of the possibility and of the necessity of routine dental care and good oral hygiene. Previous reports have indicated that ONJ usually happens within two months of the extraction. Therefore, the clinician should wait for a two-month disease-free period before treating multiple sextants.²³

Recommendations for dental treatment of patients with post-bisphosphonate ONJ:

Based on the diagnosis and management of the ONJ, patients can be stratified into three stages:

- Stage 1: Asymptomatic exposed bone with no significant regional soft tissue swelling or infection. Patients may have pain prior to development of radiographic bone changes.
- Stage 2: Symptomatic exposed bone with regional soft tissue inflammatory swelling or secondary infection.
- Stage 3: Symptomatic exposed bone with regional soft tissue inflammatory swelling or secondary infection that is difficult to manage with oral or intravenous antibiotic therapy. Pathological fracture or an extraoral cutaneous fistula may be present. Patients may need surgical debridement due to necrotic bone.²¹

A complete history and clinical examination should be performed, and imaging taken to evaluate the bone lesion. Biopsy is indicated if a metastatic lesion is suspected in multiple myeloma or breast cancer patients. Culture and sensitivity studies will aid in selecting a more specific antibiotic.


Benefits of bisphosphonate therapy specifically in breast cancer and multiple myeloma patients outweigh the risk of developing ONJ. However, it is strongly recommended that physicians request a complete dental examination and treatment prior to initiating the bisphosphonate therapy.

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