Happy Holidays from the Oklahoma Dental Association
THE LEGACY CONTINUES

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SNAPSHOTS

“Leadership and learning are indispensable to each other”.
- John F. Kennedy, from the speech prepared for delivery in Dallas the day of his assassination, November 22, 1963.

Leadership is a learned skill. And to become better leaders, we must dedicate ourselves to the continuation of learning about leadership. We must always be cognizant of the fact that we have “followers” who are looking to us to be their “leader” and that we can, and in fact do, lead in big and small ways each and every day. This issue of the ODA Journal is devoted to leadership – leadership in our practice, our Association, our community, our family, etc.

Happy Holidays and here’s wishing you a prosperous and happy 2008!

- Your Editorial Board & Staff

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The 2007 year of the Oklahoma Dental Association comes to a close. Remarkable? Without question. Amazing? Most definitely! Yes, I characterize our year with the word amazing. One hundred years and going strong!

The year is 1885 and Dr. J.E. Wright opens the first dental office just south of McAlester, Oklahoma. Five years later, governing laws of practice for dentistry begin to arrive in May of 1890. Dentistry, although in its infancy stages, was fast becoming mainstream in the state of Oklahoma. This, led to the Oklahoma Territorial Dental Association in 1891. A similar association was formed for the Indian Territory within the next several years. As the state began to grow, the populations of the Indian Territory and Oklahoma Territory were just about equal in 1900: 391,990 and 398,311, respectively. In 1893 there were a total of 52 dentists (on record), with that number increasing to 379 just ten years later. Oklahoma began to become a state with all the supporting health and human services and those needed services increased by 625% in less than ten years!

The two associations came together in June of 1907 (five months prior to statehood) to form the Oklahoma Dental Association. Since then, the association has grown to include over 1500 dentists serving over 2.5 million residents. The association consisted of eight district dental societies, as it still is today. Like our nation’s constitution, it proves that sound planning and strong judgment prevail. Even after 100 years, our association’s founding values still continue to work well.

In the late 1800’s and early 1900’s, “membership benefits” was a term that really was not even in the books. Doctors were members of an organization to help them support their profession and advance the delivery of care to their patients. The organization was their continuing education, so to speak. Today, our strength not only includes that initial goal, but also the numerous benefits from contract analysis (what was that in 1900?). And insurance services to discounted products and services from a multitude of merchants.

Yes, 1885 was a remarkable year to say the least, culminating in 1907 with the formation of our Association.

Much has happened in the last 100 years, and the next 100 years will be as great and enduring.

In closing, I hope that all of you have enjoyed your ODA Journal and what it has accomplished over the last several years. As always, from your Editorial Board and Staff, it has been a privilege and honor to serve you.

And from your 100 year-old Oklahoma Dental Association, we hope that you have a great holiday season and a wonderful year!
DECEMBER

DEC 4 – ODF Mobile Dental Unit - AEGD
DEC 5-6 – ODF Mobile Dental Unit - Riverside Indian School - Anadarko
DEC 7 – ODF Board of Trustees Meeting - 11:00 AM - ODA Building
DEC 7 – ODF Mobile Dental Unit - Major County Sooner Success - Fairview
DEC 12-13 – ODF Mobile Dental Unit - Riverside Indian School - Anadarko
DEC 12 – Childrens’ Oral Health Coalition - 10:00 AM - ODA Building
DEC 13 – TCDS Holiday Party - Meadowbrook Country Club
DEC 17 – Retired Dentist Lunch - 11:30AM - ODA Building
DEC 18 – ODF Mobile Dental Unit - AEGD
DEC 24-26 – ODA Office Closed
DEC 31 – ODA Office Closed

JANUARY

JAN 1 – ODA Office Closed
JAN 11 – OCDS Installation of Officers - Oklahoma History Museum
JAN 11 – TCDS All Day Continuing Education - Renaissance Hotel
JAN 11 – ODA Endorsement Committee Meeting - 10:00 AM - ODA Building
JAN 11 – ODA Council on Nominations & Elections Meeting - 12:00 PM - ODA Building
JAN 11 – ODA Annual Meeting Planning Committee Meeting - 1:00 PM - ODA Building
JAN 15 – ODF Mobile Dental Unit - Arkansas Verdigris Valley Health Clinic - Porter
JAN 17-19 – Southwest Dental Conference
JAN 18 – ODA Council on Dental Education & Public Info. Meeting - 9:00 AM - ODA Building
JAN 18 – ODA Council on Technology and Electronic Communication Meeting - 2:00 PM - ODA Building
JAN 21 – Retired Dentist Lunch - 11:30 AM - ODA Building
JAN 25 – ODA Journal Editorial Board Meeting - 8:00 AM - ODA Building
JAN 25 – ODF Mobile Dental Unit - Muskogee Head Start
JAN 29 – TCDS Evening Meeting - 5:30 PM - Renaissance Hotel
Starwood Hotels

As an ODA/ADA Member, you’re entitled to complimentary Starwood Preferred Guest Program (SPG) membership, at the Preferred Plus level, for special benefits at more than 850 hotels and resorts worldwide. You’ll earn rewards points and get great discounts on room rates, too.

► Save up to 50% at selected Starwood hotels and resorts including Westin, Sheraton, and W Hotels.

► When you book via phone, be sure to mention the ODA/ADA rate plan. Discounts are conditional on hotel availability so book early!

► The special ODA/ADA rate is also available to spouses and office staff.

Earn free nights and special status perks!

Call 1-866-500-0380 or visit www.starwood.com/dental to book your next trip!
Dental “Specialists” – A Quick Guide – what you should know...

Your general dentist may refer you to a dental specialist for additional treatment. There are several types of dentists that specialize in various dental treatments and the terms for these specialists can be confusing. Below, are the simple definitions of the various dental specialties:

**Endodontics**
Endodontists are dentists with at least two additional years of advanced specialty education in diagnosis and root canal treatment and use their special training and experience in treating difficult cases, such as teeth with narrow or blocked canals, or unusual anatomy. Endodontists may use advanced technology, such as operating microscopes, ultrasonics and digital imaging, to perform these special services.

**Oral and Maxillofacial Pathology**
This specialty deals with the nature, identification, and management of diseases affecting the oral and maxillofacial regions. It is a science that investigates the causes, processes, and effects of these diseases. The practice of oral pathology includes research and diagnosis of diseases using clinical, radiographic, microscopic, biochemical, or other examinations.

**Oral and Maxillofacial Radiology**
Oral and maxillofacial radiologists produce and interpret images of the jaws, teeth, bone and other structures of the head and neck region. Radiologists are involved in the diagnosis and management of diseases, disorders and conditions that affect this area of the body. The imaging modalities utilized by radiologists for diagnosis and evaluation may include traditional x-rays, digital imaging of structures both within the mouth and outside of the mouth, computed tomography (CT) scans of the head and neck, MRI (magnetic resonance imaging), as well as ultrasonography (ultrasound imaging).

**Oral and Maxillofacial Surgery**
Oral and maxillofacial surgeons are dental specialists who treat conditions, defects, injuries, and esthetic aspects of the mouth, teeth, jaws, and face. Their training includes a four-year graduate degree in dentistry and the completion of a minimum four-year hospital surgical residency program. Oral and maxillofacial surgeons care for patients who experience such conditions as problem wisdom teeth, facial pain, and misaligned jaws. They treat accident victims suffering facial injuries, offer reconstructive and dental implant surgery, and care for patients with tumors and cysts of the jaws, and functional and esthetic conditions of the maxillofacial areas.

**Orthodontics and Dentofacial Orthopedics**
By learning about tooth movement (orthodontics) and guidance of facial development (dentofacial orthopedics), orthodontists are the uniquely educated experts in dentistry to straighten teeth and align jaws. Orthodontists diagnose, prevent and treat dental and facial irregularities. Orthodontists treat a wide variety of malocclusions (misaligned teeth and/or jaws) of young children, teens and adults.

**Pediatric Dentistry**
Pediatric dentistry is the specialty of dentistry that focuses on the oral health and unique needs of young people. This specialized program of additional study and hands-on experience prepares pediatric dentists to meet the unique needs of infants, children and adolescents, including persons with special health care needs.

**Periodontics**
Periodontics is that specialty of dentistry which encompasses the prevention, diagnosis and treatment of the diseases of the gums and other structures surrounding the teeth, and the maintenance of the health, function and esthetics of these structures and tissues.

**Prosthodontics**
Prosthodontists diagnose and treat patients who need crowns, bridges, and partial or complete dentures. The practitioners provide diagnosis and restorative work for patients who have had dental implants placed by other surgical specialists. Some prosthodontists may place and maintain dental implants themselves.

**Dental Public Health**
Dental public health is the art and science of preventing and controlling dental diseases and promoting dental health through organized community efforts. It is concerned with the dental health education of the public, with applied dental research, and with the administration of group dental care programs, as well as the prevention and control of dental diseases on a community basis.

**PATIENT’S PAGE**

What is the difference between a DDS (Doctor of Dental Surgery) and a DMD (Doctor of Dental Medicine)?

The DDS and DMD are the same degrees. The difference is a matter of semantics. The majority of dental schools award the DDS degree; however, some award a DMD degree. The education and degrees are the same.

What is the difference between a DDS (Doctor of Dental Surgery) and a DMD (Doctor of Dental Medicine)?

The DDS and DMD are the same degrees. The difference is a matter of semantics. The majority of dental schools award the DDS degree; however, some award a DMD degree. The education and degrees are the same.

Patent’s Page

This message brought to you by your dentist - a proud member of the Oklahoma Dental Association

Also available online at www.okda.org
The American Dental Association House of Delegates Meets in San Francisco

By Raymond Cohlmia, DDS

The House of Delegates of the American Dental Association met in San Francisco, California, September 27 – October 2, 2007. Your ODA representatives were: Drs. Krista Jones, President; Jandra Mayer-Ward, President-elect and Ms. Dana Davis, Executive Director. Drs. Jim Torchia, Jerry Miller, Steve Hogg, and Raymond Cohlmia served as the ODA ADA Delegates. The ODA ADA Alternate Delegates in attendance were Drs. Allen Keenan, Scott Waugh, and Keith Keeter. Dr. Phil Abshere was not able to attend as he is currently stationed in Afghanistan, so Dr. Steve Glenn was selected as his replacement.

As usual, Oklahoma was well represented – five days of work is encompassed with multiple House of Delegates sessions, Reference Committee Meetings, and District Caucus meetings. There were two nominations from the floor for ADA President-elect: Dr. Joel Glover from District 14 and Dr. John Findley from District 15, with Dr. Findley winning election. The nominations for 2nd Vice-President were Dr. Andy Elliot from the 6th District, Dr. Rick Crinzi from the 11th District, and Dr. Debra Finney from the 13th District. After a runoff, Dr. Elliot was elected. Dr. Steve Schwartz, a close friend from our sister district to the south, Texas, has completed his term as First Vice President and Dr. Jane Grover was elevated to that position. Dr. Mark Feldman, previous ADA Treasurer, was elevated to the office of ADA President. Historically, the 12th District has only had two ADA: Drs. James Saddoris and Richard Haught, both from Oklahoma!

The House of Delegates opened on Friday with an inspiring presentation from Dr. Roth that marked all of the highlights from her year as president of the ADA. She mentioned on several occasions that Dr. Richard Haught served as inspiration during her term. We continue to be very proud of Dr. Haught and his continued presence in our profession. As a past president, he still has many leadership roles in many different sister organizations of the ADA.

During the opening session of the House of Delegates, the ADA had the honor to welcome Dr. Mike Simpson, an ADA member, as well as a member of the US House of Representatives. Representative Simpson was a strong presence during our introduction of several bills including access to care for children, and changes to medical reimbursement plans. He commented that one of our greatest challenges will be the continual support of the SCHIPS program and he requested that we all support the program. Most importantly, he continually reminded us that our voices do count.

The top considerations for the House included public relations, community dental programs, and membership bylaws changes. The House of Delegates divides its work into five specific categories of business; 1) Communications and Membership Services, 2) Dental Benefits, Practice, Science, and Health; 3) Dental Education and Related Matters; 4) Budget, Business, and Administrative; and 5) Legal and Legislative Matters. Below are items that were considered in each section.

• Communications and Membership: The ADA considered and approved a new membership category that includes non-practicing dentists. This change now allows members of the academic and research section who hold dental degrees from ADA-accredited institutions to become full members of the ADA. Over 7,500 dentists nationwide hold an accredited dental degree, but not an active license. Also under consideration was the diversification of membership categories to include allied personnel. The House believed this to be more a “states rights issue” and opted not to pursue allied team membership at this time.

• Dental Benefits, Practice, Science and Health Committees passed resolutions to address oral health literacy and continual monitoring of code misuse. The House supported the resolution to convene a national access to dental care summit and a Medicaid symposium. Other resolutions addressed included an emergency preparedness and disaster response program, refined guidelines of the ADA Seal of Acceptance program, and an extension of guidance on fluoride intake for infants and young children.

Among the heavily-debated topics regarding the safety of placement and disposal of dental restorative materials, two resolutions were passed. The first, the ADA will research and develop a new brochure on the safety and effectiveness of dental restorative materials, and secondly, policy was made to create “dental best management practices” specifically to address waste handling and disposal practices for dental offices.

• Dental Education and Related Matters passed a resolution that creates a process to provide dental candidates an opportunity to complete an independent, “third party”, clinical examination or assessment prior to graduation from an accredited program. Second, a resolution to strengthen the CERP guidelines was passed. Lastly, a workgroup was created to study a policy that would require one year of post-graduate studies for all dental school graduates, with a report due back the following year.

• The financial structure of the American Dental Association is strong, as shown by the Budget and Business Section. The House approved a $114,082,300 budget for the 2008 year and approved dues for the year at $498.00. Current reserves are at fifty percent of our annual operating budget, consistent with the ADA’s long-term financial strategy. There were concerns about the minimum level of reserves and the House decided to refer this concern to the Board of Trustees. A report is due back in 2008.

• Legal and Legislative Matters considered several key topics. Policy was enacted to assist, educate and recruit members in becoming candidates for elective public office at all levels of government. Also passed, was a resolution to develop a strategy to address advocacy efforts as they relate to potential universal health care proposals that could arise, and to create a proactive stance as needed. Third, reauthorization of the SCHIPS program was approved, as well as a program that would compile data and trends relating to funding, utilization and participation levels to be available to our constituent societies for evaluation.

Dr. Roth’s closing statement said it all: “We have many challenges facing us. Please consider this as you continue your endeavors for our profession: First, be good listeners; knowing all the facts is important to formulating good decisions. Second, keep the well-being of our patients and all that this encompasses as the basis of all your plans. And lastly, use science as your pillar of strength because it always gives credence and authority to any of our endeavors as a profession.”

As your representatives of the ODA, we thank you for the opportunity to represent you. Next year’s annual session will be held in San Antonio, Texas, October 16 – 21. For more information visit www.ada.org, or please feel free to contact any of your ODA representatives.

The Oklahoma Delegation continues to be recognized on a national basis as a very strong, organized, and prevailing small constituent in the American Dental Association.
The ODA Council on Technology and Electronic Communications understands how difficult it is to manage and keep up with all the daily tasks of running a practice. Recently, the Council discussed “electronic signatures” used by more and more dentists. The Council feels certain recommendations should be provided for your consideration when looking at a paperless office.

If you update your office to paperless and/or interactive dental forms to replace existing paper forms in an effort to streamline your dental practice, be sure the patient signs each form. Patients can digitally sign the documents. The patient is entitled to copies at any time during treatment. Ensure the forms are designed with the newest technology available and approved by the federal government for security standards. Our recommendation is that you look at software that allows for the provision that once the patient signs the form, the field pertaining to that signature is automatically locked, making it impossible to alter or change. This also should ensure that once the patient has signed, everything above that signature cannot be edited.

In the past, Council members have experienced cases of altered records. Locking the forms electronically should eliminate this issue. We appreciate you taking time to professionalize your practice.

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**NPI Deadline Extended**

**Dentists Should Still Apply Immediately**

The Center for Medicaid and Medicare Services (CMS) recently announced that covered entities have up to one year beyond the original May 23, 2007 deadline to comply with the National Provider Identifier (NPI) requirement.

During this 12-month extension covered entities, including insurance carriers, are expected to develop contingency plans that could include accepting legacy provider numbers to maintain operations until the new deadline. Legacy identifiers include dental plan specific identifiers, license numbers and social security numbers.

It is important to note that even with the deadline extension, all dentists should apply for and begin testing their NPI immediately. Dental plans have the option to require the NPI as the health provider identifier on paper claims even before the 12-month extension period ends. Once you receive your NPI, it is recommended you test it with business partners who will need them to pay benefits or facilitate delivery of health care.

The NPI is a government-issued identification number for individual health care providers and provider organizations. Federal law requires providers who use standard electronic transactions, such as electronic claims, eligibility verifications, claims status inquiries and claim attachments to have an NPI. The NPI will be a single-provider identifier on paper claims even before the 12-month extension period ends. Once you receive your NPI, it is recommended you test it with business partners who will need them to pay benefits or facilitate delivery of health care.

The Centers for Medicare and Medicaid Services (CMS) published three “features” of tamper-resistance. As of October 1, 2007, scripts for SoonerCare members must comply with at least one of the features. The Oklahoma Health Care Authority (OHCA) will accept any of the three features as compliance. Beginning October 1, 2008, scripts for SoonerCare members must comply with all three:

1. Prevent unauthorized copying of a completed or blank prescription form, such as a watermark on the reverse side.
2. Prevent erasure or modification of information written on the prescription by the prescriber, such as background ink that shows erasures or attempts to change the written information.
3. Prevent the use of counterfeit prescription forms, such as sequentially numbered blanks.

OHCA suggests that pharmacies may call the prescriber to verify the authenticity of a prescription if they receive a written prescription for a SoonerCare member that is not compliant with the tamper-resistant requirement. This call will bring the prescription into compliance with federal law as long as the medication is not a Schedule II controlled substance. CMS has announced that their interpretation of the law requires that prescriptions for Schedule II controlled substances must be written on tamper-resistant paper.

Please contact OHCA with questions or for more information, at (405) 522-7300.
GIVE KIDS A SMILE!®

Who: Many dentists across Oklahoma will take time from their practices to help underserved children who aren’t getting the oral health care they need. Will you join us?

What: Give Kids A Smile® is an annual one-day volunteer initiative to provide free educational, preventive and restorative services to children from low-income families.

When: February 1, 2008

Why: To provide oral care to disadvantaged children and teach them how to take care of their teeth. It will also provide you an opportunity to educate the parents about the importance of regular visits to the dentist.

How: You can volunteer to participate in a number of ways:

1) Offer free educational, preventive and restorative services to children from low-income families in your practice on February 1, 2008.
2) Open your practice to allow other local dentists to provide services in your practice with you on February 1, 2008. We will direct volunteers to contact you.
3) Volunteer your services in another practice on February 1, 2008. We will put you together with dentists who are looking for help that day.
4) Make a donation to Give Kids A Smile® so other volunteer dentists will have help with the supplies they’ll need on February 1, 2008.

The ODA will have a limited number of toothbrushes and toothpaste, etc., available to help you and special Give Kids A Smile® t-shirts for the volunteers to wear that day. Return the form below by January 10, 2008 to have priority.

To volunteer please complete the short form below and return it to:
Give Kids A Smile®/Oklahoma Dental Association
317 NE 13th Street
Oklahoma City, OK 73104
Or fax to: 405.848.8875

To learn more please visit www.okda.org or call Lynn Means at the ODA at 848.8873 or 800.876.8890; or email lmeans@okda.org.

PLEASE TELL THE ODA WHAT YOU HAVE PLANNED!
Give Kids A Smile® Volunteer Form

List full names of all participating dentists: ____________________________

Name of your practice if different from above (for press release): ______________________

Address

Phone    Fax

City    Zip

E-mail address

Please mark all that apply:

☐ YES! I am planning to participate in GKAS! in my office. Here is what I have planned:

☐ Please send me some supplies. I realize the ODA’s inventory is limited.
☐ No, I do not need any supplies from the ODA.
☐ YES! I am planning to participate in GKAS! and would welcome a colleague from another office to participate in my office on February 1, 2008.
☐ YES! I want to participate in GKAS! and would like to volunteer in a colleague’s office.
☐ YES! I would like to make a donation to the ODA to assist in purchasing GKAS! supplies.
   My check is enclosed. Make check payable to the ODA and send with this form.

Even if you participate in GKAS! every year, and do not need supplies or t-shirts, the ODA still wants to know about it! The ODA will send a press release to the hometown newspaper of every participating dentist and will list the names of all participating members in a future issue of the ODA Journal. Please take pictures of the activities that day and send them to us! Thank you for volunteering for Give Kids A Smile®

CALL THE ODA TO PLACE YOUR ORDER TODAY!

Brochures available for your patients!
Delta Dental of Oklahoma is committed to providing affordable dental care to the 1.5 million Oklahomans who have no access to employer-sponsored benefits!

To do this, we’ve created Delta Dental Patient Direct™—Oklahoma’s discount referral program designed specifically with you in mind.

Delta Dental of Oklahoma invites you to participate in our Patient Direct™ network. There are no maximums, no deductibles, no waiting periods, no claim forms, and EVERYONE is eligible—regardless of preexisting conditions. Patients simply pay our participating dentist a discounted rate at the time of service according to the Patient Direct fee table.

With YOUR participation and OUR non-profit business model, we can join together to provide an affordable, insurance-free program that offers virtually every Oklahoman vital access to quality dental care.

Questions about enrolling in our Patient Direct™ network? Please contact Terri Green with our Professional Relations Department at 405-607-2142 (within the OKC metro) or 800-522-0188, ext 142 (toll free).

Patient Direct™ from Delta Dental of Oklahoma: It’s a whole new way to look at dental!
For Dr. Mike Morgan, 2007 has been a very exciting and eventful year. This year marks the 100th anniversary of both the state of Oklahoma and the Oklahoma Dental Association, the 80th anniversary of public health dentistry in Oklahoma, and a transition year for Dr. Morgan who decided to retire from the Oklahoma State Department of Health.

Dr. Morgan is a public health dentist and has provided a career of public service to help improve the oral health of Oklahomans. He has provided years of dental clinical care for low-income children, and additionally, has served as Chief of Dental Health Service at the Oklahoma State Department of Health, a position from which he recently retired after 32 years. That is a record for Oklahoma and the United States. During his tenure as Chief, he directed the statewide Public Health Dental Program which includes programs of dental health education, tobacco-use prevention, dental clinical care, community water fluoridation, consultation and research activities, and dental loan repayment. He has also served as a volunteer faculty member at the University of Oklahoma College of Dentistry since the mid 1970s.

He is a native of Shawnee and a Shawnee High School graduate. He graduated from Oklahoma Baptist University where he completed his pre-dental requirements. He then earned a doctor of dental surgery degree from the University of Missouri at Kansas City School of Dentistry, and later, a master of public administration degree from the University of Oklahoma.

Dr. Morgan has participated in many professional and community activities and has received numerous awards and recognition. These include serving as president of the National Association of State and Territorial Dental Directors, president of the Oklahoma Dental Foundation, and president of the Oklahoma Public Health Association. He received two Oklahoma Gubernatorial Appointments: (1) the Governor’s Task Force on Tobacco and Youth, and (2) the Tobacco Use Prevention and Cessation Advisory Committee, serving as vice-chair. Also, he served on the National Dental Tobacco-Free Steering Committee (an advisory committee to the National Cancer Institute), and is a founding member of the Oklahoma Alliance on Health. He is a fellow of both the International College of Dentists and the American College of Dentists.

Dr. Morgan has been a member of the Oklahoma Dental Association and the American Dental Association since he graduated from dental school, and believes that it is essential for dentists to have the support of their profession to achieve greater success in their chosen field of dentistry. He knows that support from the ODA has made it possible to have more effective programs to help improve the oral health of Oklahomans.

Dr. Morgan has lived in the Shawnee area all his life and enjoys many activities, especially music, model trains, and University of Oklahoma college football.

80th Anniversary of Public Health Dentistry

Celebrating 80 years of public health dentistry in Oklahoma (1927-2007) was also a very significant event this year. A luncheon celebrating this special event was held at the new Oklahoma History Center in Oklahoma City on June 29, 2007. This 80th anniversary was highlighted by a special “Proclamation” signed by Oklahoma Governor Brad Henry, a “Special Citation” plaque from the Oklahoma Dental Association, and a congratulatory letter from the Association of State and Territorial Dental Directors. Also, Dr. Mike Morgan was presented an Indian Headdress by Dr. Krista Jones, ODA president, assisted by Ms. Dana Davis, ODA Executive Director, and given the title of “Honorary Chief”, along with a Cherokee name meaning “man who served the public well.” This is an ODA tradition to recognize and honor outstanding dental leadership in the state.
The ODA recently spoke with Dr. Mike Morgan about his career in dentistry.

**ODA:** What is your opinion about the importance of good oral health?

**MM:** The importance of oral health in today’s society cannot be overemphasized for the individual, as well as the overall community. We should all work to prevent oral disease and always strive to maintain good oral health. The mouth is the portal for all bodily nourishment, without which we would cease to function. It serves as a vehicle for communication, therefore crucial for interpersonal relationships. It serves as an expression of love through the kiss bestowed upon loved ones. It provides each of us with improved self-esteem, for who can resist a beautiful smile or a healthy laugh? As former U.S. Surgeon General C. Everett Koop, MD, stated, “YOU’RE NOT HEALTHY WITHOUT GOOD ORAL HEALTH.”

**ODA:** What is the most fulfilling part of your dental career and what do you most like about dentistry?

**MM:** I really enjoy helping people on individual, community, and state levels. Kids are fun and we all can learn a lot from adults, especially senior citizens. The opportunity to help people is rewarding.

**ODA:** Who are your most important mentors and supporters?

**MM:** All of us receive help from many people throughout our lifetime. My parents, of course, provided the most help and assistance. Professionally, I receive good advice from both dentists and physicians in private practice, as well as valued friends and colleagues in the public health community.

**ODA:** Where do you see dentistry in the future?

**MM:** Dentistry will continue to rapidly advance in technology and materials and provide even better care for patients. Efforts to prevent dental disease will be increased. I’m confident that Oklahoma dentists will increasingly help to provide even greater access for the underserved population through opportunities such as the ODF Mobile Dental Care Program, and through public health dental programs. Also, the percentage of women dentists advancing to leadership positions in organized dentistry will continue to increase and we’re fortunate to have excellent examples here in Oklahoma.

**ODA:** Please list your favorite:

**MM:**
- Sport: College Football
  - College Team: O.U. Sooner Football Team
  - Professional Team: Dallas Cowboys
- Music: Country and Gospel
  - Musician: Elvis Presley
- Car: 1957 Chevy
- National Park: Yosemite
- Meal: Steak
- Ice Cream: Vanilla
- Dessert: Pecan Pie
- Color: Yellow
- Activities to Participate In: Music and Travel
**Who & What**

“Unmasking Your Mystery Patients: How to Gain & Retain Patients in Challenging Times”

Three (3) Hours of CE  
Saturday, May 17, 2008  
9:00 am – 12:00 pm  
A fun, highly interactive, and high-energy session!

This presentation is highly recommended for all members of the entire dental team.

The decision-making process of today’s patients is highly influenced by criteria unrelated to clinical issues. Feelings about accepting treatment begin before the clinical exam or the treatment plan is ever offered. In this seminar, a “professional patient” will introduce you to the societal trends that are presently influencing your patient’s decision-making process. You will learn what factors you can control in retaining your patients in challenging times and what it will take to build long-term patient loyalty. You’ll learn how patients “qualify” the practice and you’ll hear actual audios of patient phone calls to practices. Staff will learn the significance of patient loyalty.

Content will include:

- Pre-appointment impressions of the practice: how patients “qualify” a practice;
- Tele-talk: Power of a positive phone image;
- The significance of excellent interpersonal skills, body language of staff and doctor;
- The cohesive team: a crucial element from the patient’s perspective;
- How to recognize and address patient concerns;
- The power and responsibility of staff in patient perceptions; and
- Top Tips from patient focus groups.

You will leave with a fresh outlook and a “to-do” list that will help to gain treatment acceptance, earn patient loyalty, and build stronger team bonds.

**“Managing Maalox Moments ... Assertively and Confidently”**

Three (3) Hours of CE  
Saturday, May 17, 2008  
2:00 pm – 5:00 pm  
Lecture format: Audience will be involved in role-playing and/or group exercises

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Who & What

ODA: How do you think volunteer work differs between rural and city districts?
MF: As far as being involved and volunteering with the ODA, I think there are several differences when comparing rural and city districts. Two of the biggest differences are location and involvement. Up until recently, the inconvenience of location probably had a huge influence on those desiring to volunteer or not. For a meeting at the ODA building, I spend probably seven hours on the road. So even if it is only a two-hour meeting, that is a whole day away from my practice and/or my family. Now with the ODA offering the ability to teleconference and videoconference, I believe we will be able to attract more rural dentists to get involved. I think another difference for rural districts is the isolation from its members. I have no idea how many square miles the Northern District has, but it is tough to try and schedule a small function or gathering that everyone can conveniently attend. Without regular meetings and continual involvement, it’s hard to keep people motivated to volunteer. When you have 400-500 dentists within 30-45 minutes, it’s not as much of a challenge to have organized meetings and establish district leadership. The city districts have a great opportunity and do an outstanding job getting dentists involved early in their career and developing them, not only local leadership and service, but also for service at the ODA level. And organizations. The public still trusts dentists and I think we have a responsibility to give back to our communities.

ODA: What goals do you have for your district in the next five years?
MF: I believe for most rural districts, any goal is going to target getting more district members involved. Short-term goals include having a full representation of committee members, House delegates, etc. Another goal I have for our district is to have an annual district meeting. I think getting together, socializing, and talking dentistry with one another will help get more people involved. We need our members to believe and remember that it is not “THE ODA”, but it is “OUR ODA”, and they need to be a part of it.

ODA: Who or what encouraged you to get involved in organized dentistry on the state level?
MF: I don’t think there was one thing or person that twisted my arm to get involved. I have always felt that people need to be involved in their profession. Thinking back to what actually got me involved, I think it was just a simple phone call from Dr. Jandra Mayer-Ward asking me to serve in the House of Delegates. It was as easy as that.

Profile: Dr. Mark Folks – Northern District Trustee

After his graduation from the OU College of Dentistry in 2002, Dr. Mark Folks settled in Miami with his family. He and his wife Kim have been married for almost twelve years and have three boys, Christian (age 10), Caden (age 7), and Carson (age 4). Dr. Folks’ family has had a long history in farming and public education and his wife’s family comes from a fourth-generation farming and ranching family in Northeastern Oklahoma. When not doing dentistry, he and his family usually spend their time volunteering at their church, going from sport to sport, boating around on Grand Lake, hunting, fishing, or looking after their commercial Angus cattle operation. Dr. Folks puts it best himself: “Don’t let anybody fool you, there’s plenty to do in a small town!”
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Dr. Folks and family in the Cayman Islands

Dr. Folks and office staff

ODA: Please list your favorite:
MF: Movie – Tombstone
Television Show – Sportscenter
Music – Country
Oklahoma Golf Course – The one that lets you fish their ponds
Sport (participate) – Hunting
Sport (observe) – Whatever my kids are playing
Professional Athlete – Brett Favre
Professional Team – Dallas Cowboys
US Vacation Destination – Alaska when the King Salmon are running
International Vacation – Grand Cayman
National Park – Yellowstone
Sports Car – Hummer H2
Dream Ride – Sea Ray 60 Sundancer off the coast of Nassau
Meal – Beef “It’s What’s for Dinner”
Ice Cream – Braum’s (any kind)
Dessert – Peach Cobbler with a dip of vanilla
Current Reads – Bible and any Cabela’s catalog

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Dr. Douglas Auld graduated from the OU College of Dentistry with distinction in 1982. After his graduation, he returned to his hometown, McAlester, Oklahoma, to begin his career. He is married to his lovely wife Jane, who is an Executive Vice President and CFO of First National Bank of McAlester. Both his children, Emily and Elizabeth, attend the University of Oklahoma. Emily wants to be a Physician Assistant and Elizabeth is interested in Education. Dr. Auld says, “My family is, without a doubt, my greatest gift and motivator.”

Dr. Auld has served the Oklahoma Dental Association in various capacities since he began his membership. He is a long-standing member of the House of Delegates, representing the Eastern District. He has also chaired the Council on Bylaws and Policy, as well as the Membership Participation Task Force.

**ODA:** Are there any benefits or challenges that a dentist faces when choosing to practice in rural areas of the state?

**DA:** I don’t see there being any real challenges. A great benefit is that you know your patients outside the office, which makes the bond even closer.

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

**DA:** Dr. Bob Bartheld has been a great friend, colleague and mentor. He has always encouraged me to give back to our profession as much as possible.

**ODA:** Please list your favorite:

**DA:**
- Movie – *O Brother Where Art Thou*
- Television Show – *The Unit*
- Music – *All Kinds*
- Oklahoma Golf Course – *Southern Hills*
- Sport (participate) – *Golf*
- Sport (observe) – *OU Football*
- US Vacation Destination – *Destin, FL*
- International Vacation – *Scotland*
- Ice Cream – *Butter Pecan*
The Oklahoma Dental Association has joined ten other states in hosting the 4th Annual Ski ‘n Learn Seminar at Big Sky Resort in Big Sky, Montana, March 8-15, 2008.

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The Ski ‘n Learn Seminar offers 16 hours of continuing education held Monday, March 10, through Thursday, March 13. A morning session will be held from 7:30-9:30 a.m., with an afternoon session from 4:30-6:30 p.m.

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Do you consider yourself an effective leader in your office? Are you as respected by your dental team as you think you are? Although leadership may not always come naturally, it’s essential for success, and it takes work. Here are some resources to get you started.

We hear a lot about leadership these days. Seems everywhere you look there’s another self-help course, another management guru, or the latest set of motivational books or tapes. It gets overwhelming. Yes, we know that as the dentist in our office it’s our role to be the team leader. But if you’re like me, sometimes it all “gets old.” Sometimes you just want to be the doctor who treats the patient. You don’t want to be Napoleon crossing the Alps or Moses parting the Red Sea. You just want to be you. You know how it goes. Sometimes there are so many responsibilities. I have to confess that more than once, I’ve wanted to open up the window and shout, “I just want to be a dentist!”

But, there’s no escaping it. If we expect to be successful we’ve got to step up and assume our responsibility as the leader and team manager in our practices. And knowing how to properly lead and manage is a big part of that equation for success.

So, with that in mind, this article was written in order to achieve two primary goals. My first goal is to define what good leaders do in order to solicit loyal and supportive followers, and my second objective is to expose those personal leadership traits that can be strengthened in order to become an even better leader.

There have been hundreds of books written on the topics of “leadership development,” “human resource management,” and “team building,” but to me there are four works that have really appealed to me over the years. Through their writings, authors John Maxwell, Lance Secretan, Keith Harrell and Robert Greenleaf have brought to light many critically important leadership issues that could have significant influence in the way we operate our dental offices and manage our staffs on a day-to-day basis.

Let me begin with three self-evident truths that seem to contribute to what I term the “leadership dilemma” we’re experiencing today:

- There are few role models in our society today;
- Greed and power are the common denominators in the erosion of most businesses; and
- The worldwide leadership crisis is without precedent.

Defining Leadership

A commonly accepted definition of leadership comes from leadership professional Don Clark. He defines leadership as “the complex process by which a person influences others to accomplish a mission, task, or objective and directs people in a way that makes it more cohesive and coherent.”

There are as many leadership styles as there are leaders. Some leaders in corporate society tend to be geared to the “bottom line” issues, such as employee productivity and the number of products sold. In the case of our own dental practices, these would equate to the number of patients seen and the number of services performed. At the other end of the spectrum are those leaders whose ultimate concern is for people; in our particular case, our patients and staff. These leaders hold personal commitment and job satisfaction for employees in high esteem. In order for a leader/employer to be considered effective by his/her followers, I believe, there must be a balance between these two extremes.
Are Leaders Born or Made?

The burning leadership question that has been around as long as I can remember is, “Are leaders born or made?” John Maxwell, a highly respected and well-known expert on the topic of leadership believes that effective leadership styles are a combination of both innate and acquired characteristics. In his book, Developing the Leader Within You Maxwell categorizes leaders into four main groups. The grouping depends upon leaders’ exposure to other leaders in their life, in addition to their own proclivity, personal motivations and enthusiasm to become great leaders.

The Leading Leader. This type of leader is born with leadership qualities. He/she has seen leadership modeled throughout life and has learned leadership through training. This leader is self-disciplined to become a great leader. Of these four traits, three of them may be acquired.

The Learned Leader. This type of leader has also seen leadership modeled throughout life, and has also learned leadership through training. In addition, this type of leader, like the Leading Leader, has the self-discipline to be a great leader. All three of these traits may be acquired.

The Latent Leader. Unlike both the Leading Leader and the Learned Leader, this type of leader has just recently seen leadership modeled. This person is learning to be a leader through training, and has the self-discipline to be a good, not great leader. As with the Learned Leader, all three of these traits may be acquired.

The Limited Leader. This person has little or no exposure to leaders, and has little if any exposure to leadership training. However, this person does have the desire to become a leader. All three of these traits may also be acquired.

Leadership, in my opinion, is an assimilation of a number of important characteristics necessary for a person to possess if he/she aspires to be that great leader. Leadership embodies influence, honesty, competence, vision, inspiration, and the right attitude.

Personality and Leadership Traits

There are a number of assessment protocols that are used to determine individual personality traits and leadership styles. Some of you may have heard of the well-known Meyers-Briggs Assessment Instrument or the Blake-Mouton Grid.

Meyers-Briggs. A Harvard University study indicated that for every dismissal in the workplace based on “failure to perform,” there were two dismissals due to “personality and communication” problems. The Meyers-Briggs Assessment has been widely used to determine individual personality traits that are categorized as either introverted or extroverted; sensing or intuitive; thinking or feeling; and judging or perceiving. For employers seeking to hire appropriate staff, this is a very important tool that determines whether or not a prospective employee will fit into the overall culture of your office. The actual questionnaire for this assessment may be downloaded from the Internet for personal as well as dental team evaluations at www.careermetropolis.com.

Blake-Mouton Grid. This is a similar assessment protocol widely used in corporate America today to evaluate leadership style. This method is named after its developers, Robert Blake and Jane Mouton. Their grid plots “concern for production” on a horizontal axis against “concern for people” on a vertical axis. It fairly accurately evaluates management styles in terms of attitudes, values and beliefs. In the process of determining personal leadership styles through this particular method, the grid exposes five major characteristics of leaders. These include:

- respect for authority
- team management
- country club management
- impoverished management
- organizational management.

This is an excellent tool in determining where we stand as employers in the dental office. The questionnaire for this evaluation tool may also be downloaded from the Internet for personal as well as team assessment. Visit www.nwlink.com/~donclark/leader/bm_model.htm

Enhancing Leadership Skills

The Greek philosopher Aristotle believed that humans acquire traits by modeling their behavior after moral as well as not-so-moral people. He theorized that people could become either good or bad based on the role models with whom they surrounded themselves. However, Aristotle believed, one can’t choose to be or not to be someone else’s role model. Other people make that decision.

Keith Harrell, in his book, Attitude is Everything brings to light a number of basic facts. One is that the attitude of a leader is the first thing followers notice. The best thing about one’s attitude is that if it is bad, it can be made better, and if it’s good, it can be made even greater. Harrell says that each and every one of us has the power to choose a positive or negative attitude. No one forces us to have either. Our attitude determines whether we are “on our way” or “in the way.” And dealing with negative attitudes due to stress in the workplace is one of the biggest challenges facing both employers as well as employees.

You might ask, “If we have a bad attitude, can we actually change it?” The answer is a resounding “yes!” Negative attitudes generally are initiated by undue stress. As employers, if we have a negative attitude, then our employees tend to have negative attitudes. If this is what’s happening in your office, you need to focus on handling that stress in a positive manner. Then and only then will we be successful team managers.

How can we manage stress in the workplace? It can be done in a number of ways. First, we have to identify our negative and pessimistic thoughts in order to control them.
That’s the first step. Secondly, and most importantly, after we’ve identified the root cause of our negativism, we need to work quickly and diligently to rid ourselves of it. Once we’ve put our negativism behind us, then and only then can we inspire our followers to follow.

In his book, *Inspire! What Great Leaders Do*, Lance Secretan philosophizes that “We need a deeper sense of who we are, to be fully present as conscious beings, before we can presume to inspire.” Direct your daily stress into positive and productive pathways.

A new buzzword in corporate human resource circles today is “emotional intelligence.” It’s a philosophy that we must incorporate into our routine management activities in the dental office if we are to be great leaders. The critical components of emotional intelligence are self-awareness, self-regulation, motivation, empathy, and social skill.

**Self Awareness** is the ability to assess and understand one’s moods, emotions, and drives, as well as what effects our mood has on others. A person who is aware of himself or herself is not only self-confident, but has a realistic self-assessment, and has a self-deprecating sense of humor.

**Self Regulation** is the ability to control or redirect disruptive impulses and moods. In other words, think first, then act. A person who is clearly self-regulated is trustworthy and has integrity. The self-regulated person is comfortable with ambiguity and possesses an openness to change.

**Motivation** is a quality in leaders who have a passion to work beyond money and status. The motivated person has a propensity to pursue goals with energy and persistence. The hallmarks of a motivated person are a strong drive to achieve; optimism, even in the face of failure; and an organizational commitment.

**Empathy** is the ability to understand people’s emotional makeup and the skill to treat people according to their emotional reactions. People who display an empathetic attitude have an expertise in building and retaining talent. They also possess a cross-cultural sensitivity while serving their patients.

**Social Skill** refers to a proficiency in managing relationships and building networks as well as an ability to find common ground and build rapport. A person who is adept at social skills is effective in leading change, is persuasive, and tends to be an expert in building and leading teams.

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*Solving the Leadership Crisis*

In addition to incorporating the principles of emotional intelligence, proper role modeling, and having the right attitude in the workplace, I believe there is really only one other approach to solving what I call the “leadership dilemma” in our society and in our own offices.

The solution was actually the brainchild of Robert Greenleaf when he published his national bestseller, *The Power of Servant Leadership* less than a decade ago. His philosophy for successfully leading organizations begins with the duty of a leader to develop a mission. Without a mission, he theorized, there is really no reason for an organization or even businesses like the dental offices we run, to exist. He believed that once a mission is determined, the role of persuasion -- one person persuading others to pursue the mission -- is the next vital step in fulfilling the essence of a company, organization, or in our case, a dental office.

This process is obviously more of a “team” approach to leadership than other leadership methods we’ve been exposed to through the years. Once the mission is developed, Greenleaf goes on to state in his book, we as the team leaders must actively encourage all team members to embrace it.

Throughout his professional life Greenleaf was relentless in his belief that servant leadership results from people whose main motivation is a deep desire to help other people. Greenleaf was also a firm believer in the fact that businesses should strive to make a positive impact on employees as well as in the community, not just exist to make money.

**Isn’t that what life is all about, when you come to think of it?**

A servant leader, in Greenleaf’s vision, asks what he can do for others. The servant leader is someone who goes ahead of his or her followers to show them the way. Servant leaders take a stand against power and competition. Servant leaders, Greenleaf says, set themselves apart from other leaders whose primary motivations are power, greed, and deception.

**Some final thoughts**

Even though the corporate debacles of Enron, WorldCom and Global Crossing, Ltd. are behind us, the American public is still very skeptical about placing unconditional trust in our leaders. In my opinion, Greenleaf’s concept of “servant leadership” has never been more necessary than it is today, especially in our own dental practices. This leadership style is one that’s on the rise. It can replace the traditional types of leadership styles and help businesses thrive and survive in this very competitive marketplace of ours.
When incorporated into our own dental management skills, I believe servant leadership can nurture and build trust and loyalty in our employees. In addition, patients will undoubtedly sense this new form of leadership through our own actions as well as those of our loyal and respecting staff.

So, after reading this article are you ready to be the leader you’ve always dreamed of becoming? Probably not! But I hope that this brief review of leadership styles and resources will be a stepping stone for you to become, truly, a leader in your own dental office.


About the Author
Dr. William Chase received his D.D.S. from the University of Detroit School of Dentistry in 1972. After over 30 years in private practice he received a master’s degree in organizational management from Spring Arbor University in 2001. He lectures nationally on the topics of dental team management, leadership development, and international health volunteerism.

He is a past editor and past president of the Michigan Dental Association and currently lives in Palm Desert, Calif. Contact him at frndshp97@aol.com.

Resources to Get You Started

*Developing the Leader Within You*, by John C. Maxwell. Published by Thomas Nelson, Inc.

*Attitude Is Everything*, by Keith Harrell. Published by HarperBusiness.

*Inspire! What Great Leaders Do*, by Lance Secretan. Published by John Wiley and Sons, Inc.


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However, your dental association is more than a mere special interest group. It is your best hope for making the practice of dentistry better not only for yourself, but for your patients as well. The association was originally created for this sole purpose. Conscientious practitioners started the ADA in 1859 to eradicate the rampant quackery that plagued the public for centuries and gave Dentistry a bad name. They obtained protective legislation and raised the average level of practice through education. Association members maintain higher standards by agreeing to live by a code of ethics. As a member, you demonstrate that you are more than an opportunistic merchant of dental services. You are a doctor who cares--first and foremost--about the welfare of human beings.

Your professional organization cannot succeed without grassroots participation. Thwarting of imposed government regulations and ambitious public relations efforts do not happen by chance. Your dental association is the source of the miracles and it is run entirely by volunteers—your colleagues. They determine through the democratic process what Dentistry’s unified policies will be, what approach the profession will take to solve complex issues, what the dues will be, how benefits and services will be funded, and what actions the staff will take. To be maximally effective, your volunteer colleagues must have access to a steady supply of dynamic ideas and new talent. They need what you have to offer.

What’s in it for you? As a volunteer, you will have a unique opportunity to personally shape your own future, to steer the profession on the right path, and to have a say about what is happening. What’s more, the leadership skills involved in running a committee—delegating, budgeting, communication, public speaking, writing, working with computers—are the very same ones you need to make the most of your dental practice! There is no question that whatever you give to your profession returns to you ten-fold. But there is more. Volunteers beyond the isolated sphere of a dental office, and who you would otherwise never meet. Volunteers develop a unique camaraderie because they know that collectively their efforts—however small—really do make a difference in solving problems and helping others. In fact, they make all the difference!
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As Chair for the Mobile Dental Care Program, I have been privileged to witness the generosity and caring of the dental profession at a statewide level. The amount of donated dental services by the dentists in Oklahoma is inspirational. I am also aware that many dentists across our State donate their dental services in their own dental offices on a routine basis.

The Council on Dental Care has been asked by the House of Delegates to track the Charitable Care donated by Oklahoma dentists every two years. It is important for our Association to be able to collect data from individual dental practices on the amount of dental services donated for many reasons, such as support for legislation and to help aide the Foundation in acquiring grants. We will begin this tracking project in 2008, and are relying on all Oklahoma dentists to help support this initiative by providing information regarding their charitable dental services.

Tracking charitable dental services on a statewide basis seems like it should be a fairly easy process. However, trying to determine our collective amount of donated dental services across the state is somewhat more complicated by the mere fact that each office may track their charitable services differently—or may not track them at all.

While trying to discover the easiest way to collect this data, I spoke to several dental offices to find out how they tracked their donated services. I have found that there is a great disparity in this effort. Surprisingly, many offices were not sure how to code donated services. With that in mind, and in an effort to create some continuity among dentists, here is a suggested method to track donated services which will also enable you to run a scan at anytime to see how much dental treatment you have donated throughout the year.

This method is assuming that most dental offices are computerized and are using dental practice software applications (i.e. Dentrix, SoftDent, EagleSoft, etc.). The first step is deciding how you would like to break down your donated services. Common categories include “Courtesy Discounts”, “Complimentary Dental Services”, and, hopefully “Charitable Care.” The charitable category should only be used to identify those services that you provide to patients that could not afford the care—patients that you have decided to “give” your services to as a charitable donation.

Once you have decided on the categories, you then create a “fictional” ADA-type of code to be assigned to that category. For instance, the category for “Courtesy Discounts” can then be assigned the code of “D33”, the “Complimentary Dental Services” category can be assigned a code of “D55”, and the category of “Charitable Care” can be assigned a code of “D77.” I know that in Dentrix a code can consist of only letters if that is easier to remember when charging out the specific treatment at the time of services.

The next step is to assign an amount to be charged-out for each visit under that code. Every dental software company is a little bit different, but the main companies (Sofident, EagleSoft, Dentrix, etc.) should have the capability of creating this type of fictional code system without difficulty.

By codifying these unique categories, it is a lot less cumbersome to run scans and reports on different types of services. I hope that by encouraging dentists to use a system to track the amount of donated dental services in their practice, they will be able to realize exactly how generous they really are, as well as have a tool that will enable them to report accurate data to the ODA.

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**What is DENPAC?**

By Dr. W. Lee Beasley, Chair, ODA Council on Governmental Affairs

**DENPAC** is the Dental Political Action Committee for the Oklahoma Dental Association. It was established for the purpose of electing candidates who understand and support the views of the dentists of Oklahoma. Dentistry must be represented when dental policy is being discussed and new laws are being formulated. Issues such as amalgam, anesthesia, access to care, fluoride, licensure, tort reform, scope of practice and third party coverage are all important to our profession and we need to be a part of the policy making process. If we are not involved, then others will make the decisions for us. So we need representatives who are favorable to dentistry and our profession. DENPAC has been selected as one of the top ten PACs in Oklahoma.

**Why should I belong to DENPAC?**

Individually, dentists have limited time and ability to devote to the legislative process, but together we have extensive political power. The PAC establishes dentists as an important constituency for politicians and gives each member a bipartisan voice of hundreds of dentists who care deeply about their patients and their profession. DENPAC’s sole purpose is to elect candidates who understand the importance of dentistry and are committed to the state’s oral health. In fact, DENPAC is a critical component in organized dentistry’s advocacy strategy at our Capitol as one of the top PACs in the state. In today’s political environment, campaigns are expensive, and for our voice to be heard we must support the election of our candidates. The more funds DENPAC has to support our candidates, the better the chances they will be elected. The dues for DENPAC are $150 per year – a small price to pay for the amount of representation you receive.

**Where do the dollars go?**

There are two types of funds available depending on how the funds are contributed.

- **Hard funds** - money personally given by an individual dentist. The funds are used for campaign expenses and are given to candidates for their campaigns.

- **Soft funds** - money given by corporations. This money is not given to candidates. These funds are used for the expenses of the PAC such as receptions for legislators, but not for their campaigns.

**How do I join?**

When you receive your 2008 dues statement, there is a line item for DENPAC and you can join DENPAC when you pay your annual dues. I would recommend you pay it with a personal check so it can be used as hard funds.

**ADPAC**

This is the ADA's PAC and $40 of DENPAC’s $150 membership fee goes to ADPAC to support national, dentistry-friendly candidates.

Please support your PAC, It is working for you!

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By Dr. Krista Jones, ODA President

Many, many ODA members join DENPAC, but also make personal contributions to candidates’ campaigns over and above their DENPAC contributions. When I first heard about various members of our ODA House of Delegates writing personal checks to political campaigns totaling more than $500 or $1,000, I suspected that my contributions probably added up as well, but I had never kept a record of my contributions or tracked the checks I’d written. Then I found out how important it is for our Association and our lobbying efforts to have an accurate account of who we support with our personal political contributions. By tracking this information and reporting every contribution to the ODA, when the time comes, we know who we can call about certain issues important to dentistry. In other words, this knowledge gives us the clout we need to ask dentistry-friendly legislators to support pro-dentistry legislation, or to vote against legislation that is potentially harmful to our practices, our profession and our patients.

Most political contributions are from my personal checkbook instead of my corporation, so a way of tracking that I’ve found works for me is, at the end of the year when I am going through my personal checkbook for my charitable contributions for tax purposes, I have another column that I have created for political contributions. This includes the name of the candidate and the amount contributed to that particular campaign for the past twelve months. These, of course, are not tax-deductible contributions. I then send that list to the ODA and they keep a detailed record of those campaigns to which I’ve contributed. We all know Legislators are much more inclined to listen to you if you live in their district; but chances are they actually recognize your name if you’ve given them a check!

This is just an easy way for our Association to know to whom our members are giving in legislative, congressional, mayoral, governor, city council and presidential races. Our Association members are active in government and that is a great thing, but it is also a great thing to know how much and to whom we are making political contributions. Our strength is in our numbers, and our numbers are bigger and stronger when armed with accurate information!

Please first join DENPAC in 2008, and second, please track your personal political contributions and report every contribution to the ODA. Help YOUR ODA be an even stronger political voice in 2008 – thanks!

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DENPAC/ADPAC/ADPAC/DENPAC is a federal state and federal political committees that makes contributions to state and federal candidates and committees. Contributions to ADPAC are voluntary and any member has a right to refuse to contribute without reprisal. The contribution guidelines are merely suggestions and a member may contribute more or less or not at all without concern of favor or disadvantages by the association. $40 of each contribution is transferred to ADPAC Federal to support Federal candidates and committees, while the balance remains in the state to support state candidates and committees. Corporate donations will be used exclusively to pay for the administrative and operating expenses of ADPAC. Contributions are not deductible as charitable contributions for federal tax purposes. Federal law requires ADPAC to request the name, address, occupation, and employer for each person whose contributions exceed two hundred dollars ($200.00) or more in a calendar year.
This year, we are celebrating and recognizing the accomplishments that have taken place during Oklahoma’s first 100 years. But our state’s centennial is also the perfect time to look ahead and consider how our state will be defined during its second century.

At this unique juncture in the story of our state, we can once again make Oklahoma the beacon of hope, growth and opportunity that it was 100 years ago.

The future that I envision for Oklahoma includes healthy and prospering families; a world-class education system; safe communities; a strong and diverse economy that encourages and rewards innovation and creativity; and, the type of quality of life that attracts and retains the best and the brightest.

I know that vision can become a reality. We are already seeing a new energy at the State Capitol as we discuss initiatives and reforms that take a long-term approach to the state’s needs. Oklahomans are finally being offered real solutions to real problems. If we want to see dramatic improvements in Oklahoma, we need bold ideas and strong leadership. This is a time for the citizens of our state to be hopeful, optimistic and confident. This is our time for change.

I believe in Oklahoma and the unlimited potential of its citizens. Our state was built by people like the land run pioneers who loaded up in their covered wagons and risked everything they had to pursue their dreams. We can build a stronger future with that same spirit.

Many of you may ask what else should the ODA be expected to do? In early 2007, at the urging of the Children’s Oral Health Coalition, the ODA sent a letter to Governor Brad Henry requesting that he form a Task Force on Children and Oral Health. Because of our relationships with other organizations and state agencies, we had thirteen organizations sign on to the letter. I know we did not think he would do it, but it was worth a try. Be careful what you wish for! On August 22, he issued and Executive Order creating the Task Force. To me, this is ODA’s single most important accomplishment in regard to access to care.

I am now learning the “ins and outs” and “dos and don’ts” of working with the State to get the Task Force up and running. ODA did submit a list of 25 to 30 people for the Governor to consider for the Task Force. And yes, it is working. ODA did submit a list of 25 to 30 people for the Governor to consider for the Task Force. And yes, it was a bipartisan list. As of this writing, I am only aware of three people that have been officially appointed, and these are from state agencies. I will keep on pushing.

I want so much for the Task Force to have the right people and to be able to develop a state plan that is comprehensive and lays out the ultimate solutions to Oklahoma’s dental care issues. Many people call me naïve (most of the time they call me a bull in a china shop), but I see this as ODA’s one chance to ensure that all Oklahomans receive the same quality dental care across the State. I often say to our members in discussions about government programs, if we do not create the solutions, someone else will. And we won’t like them! I know many of us are looking at the candidates for the next Presidential election. To me it is a bit scary. Will we have national health insurance? Where will dental care be? Can we solve the problems before they do? Inquiring minds want to know.

The Governor’s Executive Order can be found on pgs. 33 - 34

A Message from Lance Cargill

ODA Executive Director

By Dana A. Davis, ODA Executive Director

The ODA is perceived as the go-to organization for all things dental in Oklahoma. We have an excellent working relationship with the Board of Dentistry, the University Of Oklahoma College Of Dentistry, the Oklahoma Health Care Authority, the Oklahoma Department of Health Services, and the Oklahoma Legislature. ODA is also a vital member of the Oklahoma Children’s Oral Health Coalition which meets monthly at the ODA office.

There are many reasons that we are the go-to organization, but the most important is the image of the ODA as it relates to access to dental care. In this area, we are known for our collaboration, dedication to serving the public, and willingness to help when help is needed. ODA has been the leader in numerous initiatives to address the myriad of problems associated with access to dental care. ODA sponsored legislation that created the Oklahoma Dental Loan Repayment Program and obtained $100,000 per year to support the Oklahoma Dental Foundation’s Mobile Dental Care Program. We supported legislation that made the Office of Oral Health a permanent entity within the Department of Health Services and required that a licensed dentist serve as the director. ODA members participate in Give Kids a Smile! Day and National Children’s Dental Health Month annually. Our Council on Dental Care is providing oral hygiene kits to thousands of children taken from their homes for a variety of reasons. And our Council on Dental Education and Public Information has made the ODA a partner in the Schools for Healthy Lifestyles program. The ODA and the ODF participated in 10 block parties held at public housing projects in Tulsa and Oklahoma City, where oral hygiene kits and oral health education materials were distributed, as well as free dental care provided for the children. These are but a few highlights of ODA’s activities to provide quality dental care to all.
I, Brad Henry, Governor of the State of Oklahoma, by the authority vested in me pursuant to Sections 1 and 2 of Article VI of the Oklahoma Constitution, hereby establish the Governor’s Task Force on Children and Oral Health.

The purpose of the Task Force shall be to study the existing state, federal, and private sector funded programs that address the health of children, youth, and families to avoid duplication of effort and resources. Additionally, the Task Force shall determine ways to infuse oral health education, dental care, and dental disease prevention into these existing programs. The Task Force shall also make recommendations regarding the need for new programs and develop a State Oral Health Plan. Finally, the Task Force shall specifically address programs for children and youth as well as those with special health care needs.

The Task Force shall consist of twenty-one (21) members to be selected as follows:

1. The Secretary for Human Services or a designee;
2. The State Commissioner of Health or a designee;
3. The Executive Director of the Oklahoma Department of Environmental Quality or a designee;
4. Two members of the House of Representatives, appointed by the Speaker;
5. Two members of the Senate, appointed by the President Pro Tempore and the Co-President Pro Tempore;
6. Four members who shall represent entities associated with the dental industry;
7. A representative from the Oklahoma Commission on Children and Youth;
8. A person with special knowledge on children with special needs;
9. A representative from the Oklahoma Health Care Authority specializing in dentistry;
10. Two pediatric dentists;
11. A public health dentist;
12. A private dental practice hygienist;
13. A public health dental hygienist;
14. A representative from one of the Federally recognized Native American Tribes; and

15. A pediatrician representing an entity in the medical community.

The Task Force shall meet at such times and places as it deems appropriate. Members shall serve without compensation. Task Force members employed by a state agency shall be reimbursed travel expenses related to their service on the Task Force as authorized by state law by their respective state agency. Legislative members of the Task Force shall be reimbursed as authorized by state law by their respective houses for necessary travel expenses incurred in the performance of their duties. Remaining Task Force members shall be reimbursed travel expenses related to their service on the Task Force by the Oklahoma Board of Dentistry.

Administrative support for the Task Force, including, but not limited to, personnel necessary to ensure the proper performance of the duties and responsibilities of the Task Force, shall be provided by the Oklahoma Board of Dentistry.

The Task Force shall elect a chair and vice chair from its membership. The Task Force shall complete a final report within two (2) years of the date of this Order. The Task Force shall provide a copy of the final report to the Governor, the President Pro Tempore and the Co-President Pro Tempore of the Oklahoma State Senate and the Speaker of the Oklahoma House of Representatives.

This Executive Order shall be forwarded to the Executive Director of the Oklahoma Board of Dentistry who shall cause the provisions of this order to be implemented.

IN WITNESS WHEREOF, I have hereunto set my hand and caused the Great Seal of the State of Oklahoma to be affixed at Oklahoma City, Oklahoma, this 22 day of August, 2007.

BY THE GOVERNOR OF THE STATE OF OKLAHOMA

BRAD HENRY

ATTEST:

SECRETARY OF STATE
The ADPAC Board along with District 12 Board Member Dr. Kim Keisner and past board member Dr. James Torchia wish to recognize and thank the 283 members of the Oklahoma Dental Association for their significant 2007 contributions to ADPAC.

Thank You

We wish you a prosperous 2008 and we encourage you to be informed and involved in this important political year.
“Can you hear me now?...How about now?” This is probably today’s most widely known colloquialism, from our television sets to our cell phones (which themselves are as common as bottled water). However, at the ODA it’s slightly different. It’s “Can you see me now?” As many of you may know, we recently installed our new Internet videoconferencing system. This article is intended to explain what a videoconferencing system is, how it works, and how you can take full advantage of it.

Several years ago, the Council on Membership and Membership Services, the Council on Dental Education, and our Strategic Planning Group on Governance, began researching ways to increase attendance and interest in our council activities. The number and makeup of the various councils had been changed, but attendance and meeting quorums continued to be a problem. Using such tools as the ADA Environmental Scan, we learned several key items about our members of tomorrow. For example, their level of involvement with associations is based rather strictly on the amount of personal time they are willing to invest. Their value system is not based on dollars, but on time away from families, personal business, etc. When you consider that council members from outlying areas of the state must often invest several hours of driving to attend a two-hour meeting, their willingness to participate can diminish rapidly. Secondly, our new members are coming from a generation that thrives on person-to-person contact. Those wanting to become involved in their association will not be attracted to meetings that don’t include a visual component (for example, conference calls). This is why such interactive methods as “YouTube” and the I-phone are so popular. Third, today’s potential members don’t mind working hard, but they prefer short-term involvement and don’t wish to waste their time and expertise on projects that cannot demonstrate quick positive results. In summary, time and a sense of belonging are critical elements in making the new member an interested and involved part of the association’s activities. This is where Internet videoconferencing enters the picture.

Last year, the Council on Technology, with input from the Council on Dental Education, supported the installation of an Internet videoconferencing system to be housed at the ODA. All constituent societies and the Oklahoma Dental Foundation participated in the fundraising effort for the project, and the equipment was installed in the first quarter, becoming operational in the second quarter. Since then, the system has allowed numerous council members from outlying regions to participate in their meetings without being physically present.

To understand how videoconferencing works, let’s start with its audio component. The clarity of audio exchange using cell phones, for example, is dependent on such factors as strength of signal and bandwidth. Lack of sufficient bandwidth is probably the most common reason for dropped or poor-quality phone calls. If you are far away from the closest cell phone tower, your signal would be low and the voice data would have a difficult time getting through. The same is true if the person with whom you are talking is far from a phone tower. The old adage “You’re only as strong as your weakest link” holds true here; you both must have a strong signal for an effective conversation. Bandwidth determines the number of individual conversations a particular tower can handle at a given time. On one tower you can literally have thousands of callers wanting their piece of the tower to maintain their conversations. Once the maximum number of calls that can be processed through one tower is reached (determined by bandwidth), the result is an upswing in dropped or poor-quality calls. Videoconferencing involves simply adding video to the mix. A good video conversation, like a cell phone conversation, must have three important elements: [1] a good connection on both ends; [2] enough speed to allow the transfer of both voice and video data; and [3] sufficient bandwidth.
The ODA’s videoconferencing system is both dependable and consistent. When it was installed, the connection to the Internet was upgraded to two “T-1” lines. In layman’s terms, if the computers in our homes and businesses were connected to the Internet with a cable the size of a garden hose, each of the ODA’s T-1 lines would be comparable to a three-foot diameter water main pipe. In addition, the system in the ODA building has enough capacity to handle 16 internet videoconferences, while allowing Internet access through all computers (about 12) and phone lines -- with plenty of capacity to go!

What would cause a poor videoconference hookup to the ODA? Quite simply, some remote users may have slower Internet connections. High-speed broadband connections are required for smooth “glitch-free” video. Many remote connections are the old “dial up” kind, lacking sufficient “throughput” (data that can be carried through the phone line). Connection is possible, but consistent quality connection is unlikely. We recently conducted a council meeting utilizing two video connections, one high-speed and one dial-up modem. The high-speed connection was excellent with all video and audio working as if the person were in the room. The dial-up connection’s audio was good but the video “froze” frequently. Because audio is considered the most important element of a conferenced meeting, business was conducted satisfactorily. However, the importance of video to the new members of today and their reliance on video as part of the “whole” experience underscores the obvious value of error-free videoconferencing.

Another reason that video may experience problems even with a high-speed connection is “piggy backing”, where the Internet provider combines a user’s signal with several other users on the same connection line. The provider claims that the line is high-speed, but fails to inform you that there are multiple users on that same line. If there are seven users and they are all “online” at the same time, your speed just went down by a factor of at least seven – at which point video quality would drop off dramatically. This is becoming the most common problem with today’s Internet connections. You’ll hear claims of fast connection “with speeds up to ……”. This actually translates to “We can get you to that speed, but most of the time, it’ll be much less.”

Should you consider a video system for yourself? The answer is an emphatic “yes.” Internet systems are becoming more and more stable over time. Almost all local and national vendors are now changing their lines to fiberoptic to support the ever-increasing demand for high-speed connections. In addition, video system software is improving all the time to meet the increasing demand for high-speed connections. Many remote users are now changing their lines to fiberoptic to support the ever-increasing demand for high-speed connections. In addition, video system software is improving all the time to meet the increasing demand for high-speed connections.

The ODA’s video system works on “known addresses” for connection to the ODA conference unit. All computers that contact the ODA conference unit have identifiable addresses. If an unknown videoconference caller tries to connect into an ODA council meeting, access would be blocked because the system would not recognize the address as one approved to have access to the system. Therefore, when you connect from a consistent location, there is no no problem. When you connect from a location not in the system, you will have to call to the ODA and add your new address into the system so that it will be granted future access.

**To establish a video link with the ODA you will need the following:**

1. *A fairly new computer.* Most machines manufactured in the last few years can handle this process.
2. *A high-speed Internet connection* (preferable); a very stable modem connection should suffice. Remember that when in conference, you will be on the line constantly; if you have to connect via a phone line and it is long distance, cost may be consideration.
3. *The software from Polycom.* You can learn more about it through the ODA or Diverse CTI if you wish. It is available through direct-order.
4. *A camera for your computer* designed for video, not still pictures.
5. *Installation assistance* via the ODA or Diverse CTI. The ODA staff is ready to help you configure your machine and environment to get you connected to our system.

When you install the software, remember to contact the ODA to establish your address as an “approved” participant! Otherwise, you will not be allowed hook-up access. When the initial set-up is completed, linking with the ODA is merely a desktop icon click away!

As you begin to use the system, you will find that it is somewhat “universal” in its application, meaning that you will be able to hook up to many other systems. You can then perform a two-way link to another system without having to go through a main hub like the ODA -- just like making a regular phone call, except with video!

If you are a new member and have to have that “visual” interaction, we have it! If you’re an old member who wants to learn what’s new with the ODA, we have it! There is no longer an excuse not to get involved. Now you can join a council or committee, and when it’s time for a meeting, stay at home or in the office and just “video in”!
CASE HISTORY: A 43-year-old male presents for an oral prophylaxis appointment. At this appointment, you are asked by the dental hygienist to evaluate an area involving the lower lip. During your examination, an umbilicated lesion involving the right lower lip is noted. The patient states that the area has been present “for a few days and is painful to the touch.”

QUESTION 1:
An appropriate differential diagnosis for this presentation might include (multiple answers):
   a. Keratoacanthoma
   b. Squamous cell carcinoma
   c. Basal cell carcinoma
   d. Ulcerated fibroma
   e. Erythema multiforme

ANSWER:
An appropriate differential diagnosis should include:
(a) Keratoacanthoma
(b) Squamous cell carcinoma
(c) Basal cell carcinoma
All three (3) of these entities may present as an umbilicated lesion with a raised, rolled border involving the lower lip.

The keratoacanthoma (a) is typically observed on sun-damaged skin, particularly the face, as well as the lower lip. This benign lesion has a clinical presentation, rapid growth, and histologic characteristics similar to squamous cell carcinoma. This entity is typically observed in adult males.

Squamous cell carcinoma (b) of the lower lip typically presents as an oozing, crusty, nontender, indurated, ulcerated area. Eventually, this non-healing ulcer develops a raised, rolled border that is quite indurated. This lesion is much more common on the lower lip than the upper and is usually observed in adult males. Most squamous cell carcinomas arising on the lower lip are associated with a lengthy history of sun exposure.

Basal cell carcinoma (c) is also typically observed on sun-damaged skin, particularly the upper face, with over 85% of the cases found in the head and neck region. The basal cell carcinoma represents the most common form of skin cancer and is more common in males than females. This neoplasm usually presents as a firm, painless papule that slowly enlarges and gradually develops a central depression with an umbilicated appearance.

The fibroma (d) is the most common “tumor” of the oral cavity. Although it can appear anywhere in and around the oral cavity, the buccal mucosa is the most common anatomic site. It would not be included in the differential diagnosis here because it typically presents as a smooth-surfaced, firm nodule, with a broad, sessile base that is asymptomatic and not ulcerated.

Although erythema multiforme (e) may present with a wide spectrum of clinical disease, oral lesions typically begin as multiple, erythematous patches that undergo epithelial necrosis and evolve into large, shallow erosions and ulcerations with irregular borders. Patients are usually young males in their 20’s or 30’s. This condition is not considered in the present clinical differential diagnosis.

QUESTION 2:
Which of the following procedures should be accomplished? (multiple answers):
   a. No surgical intervention, follow closely for 3-4 months
   b. Consultation with a specialist
   c. Biopsy
   d. Exfoliative cytology

ANSWER:
The following procedures are indicated in this case:
(b) Consultation with a specialist
(c) Biopsy
Consultation with a specialist (b) in order to determine optimal treatment and management of the patient is necessary. Additionally, biopsy of the lesion (c) in order to establish a definitive treatment format is essential.

The choices no surgical intervention, follow closely for 3-4 months (a) and exfoliative cytology (d) would be of no benefit in the management of the umbilicated lesion.

QUESTION 3:
The following microscopic features are noted for this lesion:
a flask-shaped, central zone of keratin; the surrounding surface epithelium forms a “lip” or “buttress” over the sides of the central zone producing a raised rolled border; at the deep, leading edge of the lesion, islands of squamous cells are noted; and cytologic atypia of the squamous cells is not prominent. The correct diagnosis is:
a. Squamous cell carcinoma
b. Keratoacanthoma
c. Basal cell carcinoma
d. Necrotizing sialometaplasia

ANSWER:
The correct answer is keratoacanthoma (b). See “Discussion” section. The other possibilities are not considered here. Squamous cell carcinoma (a) arises from dysplastic surface epithelium and is characterized by invasive islands and cords of malignant epithelial cells. Varying degrees of cellular and nuclear pleomorphism will be observed. Basal cell carcinoma (c) is composed of cells that are arranged into well demarcated islands and strands which arise from the basal cell layer of the overlying surface epithelium and invade into the underlying connective tissue. Epithelial islands typically demonstrate palisading of the peripheral cells with a
zone of “retraction” between the epithelial islands and the adjacent connective tissue. Necrotizing sialometaplasia (d) is a salivary gland lesion characterized by necrosis of salivary gland acini with an associated squamous metaplasia of the salivary gland ducts. These histologic features are not observed in the present case.

DISCUSSION:
Only since 1950, subsequent to the publication by Rook and Whimster and by Musso and Gordon, has this fairly common lesion been accepted as a distinct clinical entity. The keratoacanthoma is a benign tumor that occurs on sun-exposed skin. The etiology is unknown, although both genetic and viral factors have been considered.

From a clinical standpoint, the keratoacanthoma is most frequently observed in men between the ages of 50 and 70 years of age. Approximately 90% of the tumors, as noted above, have occurred on sun-exposed skin with the cheeks, nose, and dorsum of the hands being most often involved. The lesion occurs on the lips in roughly 10% of the cases. The keratoacanthoma presents as an elevated, umbilicated or crateriform area with a depressed central plug or core. Because of this clinical presentation, the keratoacanthoma may resemble both squamous cell as well as basal cell carcinoma; however, the microscopic features are characteristic and, if untreated, the lesion will spontaneously regress within 6-24 months.

Microscopic features of the keratoacanthoma are characterized by an abrupt marginal change with marked hyperkeratosis. The lesion has a flask-shaped crateriform configuration with superficial collarette and a bulbous, expanded base composed of surface epithelium. Well-formed keratin islands are observed “dropping off” into the underlying connective tissue. Cytologic atypia of the squamous cells in these islands is not prominent.

Surgical excision is the treatment of choice. Waiting for spontaneous involution is not advisable for two reasons: (1) one cannot be assured clinically that the lesion does indeed represent keratoacanthoma rather than cancer, and (2) the scar created from surgery is often more cosmetic than that which develops from spontaneous regression.

REFERENCES:


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