Community Water Fluoridation: Protecting Public Oral Health for 60 Years

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In response to growing consumer demand, DDOK has developed DeltaPatient Direct™ - our new discount referral program that allows patients to access quality dental care and pay dentists directly - at the time of treatment.

Currently, there are an estimated 1.5 million Oklahomans without access to employeesponsored dental benefits. Delta Dental of Oklahoma has developed DeltaPatient Direct™ to benefit these Oklahomans who might not otherwise be able to access quality dental treatment. Additionally, we want to help bring additional patients to our valued participating dentists.

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Be sure to visit www.PatientDirect.NET. Should you need an enrollment package, or if you have additional questions about our new DeltaPatient Direct™ network, please contact Kim Montgomery, with our Professional Relations Department at: 405-607-2142 (OKC metro) or 800-522-0188, ext. 142 (outside the OKC metro).
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PRESIDENT’S MESSAGE

By: Sid Nicholson, DDS

Thanks in advance to the precious few of you out there who actually read this message. I hope it is of some value to you. This will be a smattering of things that are happening in and around the ODA.

First, I’d like to reiterate something I’ve said previously; that being, if you have a problem or a question regarding anything related to the ODA that you can’t get an answer for, let me know — if I can’t give you an answer, I’ll find someone who can. (email: oldnick@okda.org or 918.682.6452)

I can report that we have three task forces have been launched to deal with the perceived challenges identified at our strategic planning session in February of this year, which were 1) access to care, 2) technology, and 3) membership participation. Thanks to all those dedicated people who have agreed to serve on these task forces! I’m sure that all ODA members and the public we serve will benefit from their efforts. Much more will be reported in the ODA Journal as they begin to proffer ideas to make the ODA even better for us all.

Also, I’d like to take this opportunity to invite every dentist and staff member to be in Tulsa the last weekend in April for the ODA Annual Meeting. I can assure you quality educational experiences for dentists and the entire staff, as well as fun activities besides the continuing education for everyone to enjoy. This is the last meeting in Tulsa for two years due to remodeling of the convention center, so if you live in and around Tulsa, you won’t have another local state meeting until 2009! Believe me, every President wants the annual session during their term to be the best and most successful and I’m no different! I

Lastly, thanks to every single person who volunteers with organized dentistry in Oklahoma by giving their time to make the ODA the great and caring organization that it is. It couldn’t happen without each and every one of you (the ODA staff is also equally dedicated to the ODA and we couldn’t do it without them). Also, I’d request that those of you who haven’t yet taken an active role in organized dentistry to consider holding an office, serving on a Council, or volunteering in some other capacity.

If you’d like to help out, contact the ODA at 405.848.8873, ask for Kay Mosley and let her know how you’d like to participate. We will find something that you will really enjoy doing. Or, go to www.okda.org and fill out the membership participation form and we will put you on the list of those eager to help out.

Talk to you all again later! (and don’t forget to mark off those days in April for the ODA meeting that you simply can’t afford to miss!) •

Tulsa County Dental Society (TCDS)

By: Jeff Parker, DDS - Editor

A great time was had by all at our 4th Annual Molar Classic at Forest Ridge. Congratulations to the first-place team members Dr. Jim Yeats, Dr. Ted Marshall and two non-dentists who will have the honors of displaying the Josh Whitney Memorial Trophy at their offices this year! Special thanks to Patterson Dental Supply, Peoples Bank, 3M, and Kerr Dental Supply for sponsoring this fun event that just gets better each year!!

Our second annual “Back to School on a Full Stomach” canned food drive to benefit the underprivileged in the Tulsa area started in July! Our TCDS Dental Care Standing Committee is working hard to exceed last year’s spectacular participation!

Our Professional Development and Education Standing Committee has an awesome schedule of evening and all-day meetings confirmed that will be held at the Tulsa Renaissance Hotel: Tuesday, September 13th evening meeting will feature a local radio host Michael Deljou; Tuesday, October 18th evening meeting will feature Robert Dowd, JD, on “Improved Patient Care Through Malpractice Protection: Advanced Lawsuit Protection Strategies;” Tuesday, November 8th evening meeting will feature Dr. Angelo Cuzalina on “Extreme Dental Makeovers;” Friday, November 18th all-day meeting will feature Dr. Charles Blair on “Positioning Your Practice For Profit;” Thursday, December 8th Holiday Casino Party at the Renaissance Hotel; Friday, January 13th all-day meeting will feature Dr. Michael Koczarski on “The Bread, Butter and Caviar of Contempo-

Oklahoma County Dental Society (OCDS)

OCDS has announced the following new meeting dates for 2005/2006:

- Tuesday, September 13, 2005 - OCDS Board Meeting
- Monday, September 19, 2005 - OCDS Council on Administration
- Tuesday, October 18, 2005 - Golf Tournament - Gaillardia Golf Club
- Tuesday, October 25, 2005 - OCDS Board Meeting
- Thursday, November 17, 2005 - OCDS General Assembly Meeting
- Friday, November 18, 2005 - CE Course with Dr. John Kanka
- Friday, January 20, 2006 - Installation of Officers - Gaillardia County Club
- Friday, February 10, 2006 - CE Course with Dr. Gary Radz
- Tuesday, February 28, 2006 - OCDS Board Meeting
- Thursday, March 30, 2006 - OCDS General Assembly Meeting
- Friday, March 31, 2006 - CE Course with Dr. Scott Parker
- Tuesday, April 11, 2006 - OCDS Board Meeting
- Friday, November 3, 2006 - CE Course with Dr. Roger Levin contd. pg. 7
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Ready to enhance your practice? For more information, please contact Steve Baker at 877.867.6302 or steveb@televox.com

WE WANT YOUR BRIGHT IDEAS!

If you have a great idea for the Profile or Features section of the Journal, let us know!

Email your ideas to ideas@okda.org
### SEPTEMBER

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<td>SEPT 5</td>
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<td>SEPT 10</td>
<td>12th District Pre-Caucas, Dallas, TX</td>
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<td>SEPT 11</td>
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<td>SEPT 13</td>
<td>TCDS Dinner Featuring Local Radio Host, Michael Deljourno, Renaissance Hotel, 6:00 PM</td>
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<tr>
<td>SEPT 13</td>
<td>Okla. County Dental Society Board Meeting, 6:00 PM</td>
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<td>SEPT 14</td>
<td>Oklahoma Children’s Oral Health Coalition, ODA Headquarters, 10:00 AM</td>
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<td>SEPT 19</td>
<td>Retired Dentists Lunch, ODA Headquarters, 11:30 AM</td>
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<td>SEPT 23</td>
<td>ODF Annual Meeting, Tulsa, Holiday Inn</td>
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<td>SEPT 24</td>
<td>ODF Annual Meeting, Tulsa, Holiday Inn</td>
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<td>SEPT 30</td>
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<td>Okla. Academy of General Dentistry, Precision-Based Endodontics by Kenneth Koch, DMD, OU College of Dentistry</td>
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<td>OCT 6</td>
<td>ADA Annual Meeting, Philadelphia, PA</td>
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<td>OCT 10</td>
<td>ADA Annual Meeting, Philadelphia, PA</td>
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<td>OCT 10</td>
<td>ADA Success Program, OU College of Dentistry, 12:30 PM</td>
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<tr>
<td>OCT 11</td>
<td>ADA Annual Meeting, Philadelphia, PA</td>
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<td>OCT 12</td>
<td>Oklahoma Children’s Oral Health Coalition, ODA Headquarters, 10:00 AM</td>
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<tr>
<td>OCT 17</td>
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<tr>
<td>OCT 13</td>
<td>TCDS Dinner Meeting featuring Robert Dowd, JD, on “Improved Patient Care through Malpractice Protection: Advanced Lawsuit Protection Strategies”, Renaissance Hotel, Tulsa, 6:00 pm</td>
</tr>
<tr>
<td>OCT 18</td>
<td>Oklahoma County Dental Society Golf Tournament Gaillardia Golf &amp; Country Club</td>
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<tr>
<td>OCT 25</td>
<td>Oklahoma County Dental Society Board Meeting</td>
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Two of our ODA dentists are currently serving in the War on Terror providing dental (and medical) services to healthy troops, wounded coalition troops, and humanitarian aid to the Iraqi people. Currently the temperatures there can exceed 125 degrees during the day.

Lieutenant Colonel (Dr.) Jim Clark is currently on Air Force active duty in Iraq. His practice is in Ada and for several years he has been serving as Dental Group Commander of the 137th Medical Group at Will Rogers Air National Guard Base in Oklahoma City. Now activated, he is stationed with the 447th Expeditionary Group at Sather Air Base at Baghdad International Airport. They receive sporadic mortar and rocket attacks but are in a ‘relatively safe’ spot on the base, whatever that is...

Lt Col Clark is in charge of all of the dental care for the Air Force contingent there and also treats many coalition force members. He is also the weapons officer, teaching and managing weapons safety and storage. In addition, he is the Executive Officer (XO) to the Medical Group Commander (MDG/CC) and acts as the MDG/CC in the absence of the Commander. He has seen all of the injuries you can imagine in this combat arena and his patient care for the wounded is rarely limited to dentistry only. His group also coordinates medical evacuation for injured troops needing transport to higher echelon facilities as soon as the patient is stable enough to travel. He is currently deployed for an unspecified length of time but hopes to return within the next few months.

Lieutenant Colonel (Dr.) Jeff Lunday is currently on active duty with...
D-DENT

By: Shirley Harris

The first Annual Croquet Social, held Sunday, June 26, 2005, was a great success! Two “Six-Wicket” croquet courts were set up on an empty lot next door with a large tent in the middle for a shade break. This four-ball game is the form of croquet played most often in the United States in tournaments and most croquet clubs. Most of the attendees really enjoyed their rousing games, which were surprisingly more competitive than imaginable.

Many thanks to Teri Stanek, one of our volunteers who acted as “referee” for “fault” calls, who encouraged and cheered on all the players in her sun hat and pearls.

In croquet it is actually legal for the referee to accept money from the players to sway the call their way; Teri was very good and made some extra money for the fundraiser. Always a cheerful help, Betty Carroll also volunteered, along with D-DENT’s own Phoebe Brown, who made a special appearance from her research project at school in Stillwater.

D-DENT is so grateful to Pat Hoge for hosting the event at her gorgeous home in Quail Creek that has “the perfect backyard setting” to accommodate any outdoor gathering. Of course the sparkling pool looked especially inviting as guests entered the large terraced backyard filled with beautiful blooming flowers. On one side of the pool under a trellis-covered bar area, the band provided pleasurable music throughout the afternoon.

A very profitable silent auction was held on the other side of the pool area, featuring many wonderful donated gifts which brought quite a competitive bidding. It seems no one left empty-handed.

Looking out from the pool on the top patio, huge abundant shade trees filled the rest of the yard where covered tables and chairs were set up for dining and visiting. Everyone enjoyed the charcoal-grilled “hamburgers ‘n fixin’s,” which the chef and his staff from The Centre in Oklahoma City continuously provided all afternoon under another large tent. Several choices of refreshing beverages were iced in large tubs all around the yard and croquet courts, with lemonade being a favorite along with beer and wine. Delicious fruit-topped cheesecake tarts provided a light and satisfying finale to satiate any sweet tooth. All in all it was a perfect way to spend a Sunday afternoon while helping a great cause.

Additionally, D-DENT was invited to participate in the “first in the nation” Medicare Part D Drug Benefit Sign-Up held at the Mayfair Center in Oklahoma City. Oklahoma senior citizens were the very first elderly group nationwide to be able to apply for this benefit, since federal legislation reorganized the government’s health care agencies into the Centers for Medicare and Medicaid Services earlier this year. About 100 clients were expected, but the affair drew over 1,000 applicants from around the state and was a huge accomplishment.

Daily Living Centers was chosen as the pilot site for this program, which provided information, help and support to seniors about this new Medicare Drug Benefit program.

Bill Weaver and Donna Bowers of the Daily Living Center also offered a free Health Fair, snack buffet, and transportation to better aid the elderly. Personnel from the Federal Centers for Medicare and Medicaid Services (CMS) and from Social Security Administration (SSA) in Baltimore, Denver and Dallas were on site to assist with the process, and were highly impressed at how smoothly the event ran, thanks to extra volunteers the Daily Living Center enlisted and all their hard work organizing this special day. The American Association of Homes and Services for Aging (AAHSA) and the National Adult Day Services Association (NADSA) were joint collaborators in the project.

D-DENT is so very lucky to have had Phoebe and Jessie Brown as volunteers for the last three years. As mentioned in the July/August Journal article, Phoebe was selected to participate in a dental research study at OSU, and was therefore unable to volunteer this summer. Being the kind, generous person she is, Phoebe enlisted one of her good college friends Ashley Turpin of Yukon, who also plans to become a dentist, to help D-DENT out. Her sister Jessie, who will be starting college this fall, is still volunteering, and now their mom Dorita Brown is volunteering also. What a great caring family; we really appreciate all their efforts!

Two exceptional D-DENT dentists need to be mentioned for each taking on a special case recently. Dr. Tim Hughes of Broken Arrow accepted a case referred by Congressman Ben Sheer to help a female client who had suffered a heart attack at the age of 48 and whose teeth had been severely affected by the stress, surgeries and medicine. Dr. Craig Wooten, Oklahoma City Oral Surgeon, agreed to assist another female client who was in the FBI’s Special Victim’s Program and needed urgent treatment while she was under FBI protection. D-DENT dentists are the greatest! Thank you Dr. Hughes and Dr. Wooten for the “extra” ordinary service.

Last year’s Jewel Box Theatre Benefit was such a huge success, the D-DENT Board again hosted its first benefit this past season at the Jewel Box Theatre on August 23rd, 2005. The benefit “A GRAND NIGHT FOR SINGING”, was directed by well-known Oklahoman Billie Thrash. The play was an “innovatively arranged” musical medley of a few of Rogers and Hammerstein’s greatest hits, such as Oklahoma!, The King and I, South Pacific, Carousel, and Flower Drum Song, to name just a few. This was a grand night of theatre!

The second Jewel Box Theatre Benefit Night will be held on April 10, 2006, and what better way to begin the State of Oklahoma’s “Centennial Celebration” than our very own favorite Rogers and Hammerstein production, “OKLAHOMA”. This rousing tribute to our state will have us all “bustin’ with pride” and gear us up for all the other State Centennial events scheduled next spring. You can support D-DENT and Oklahoma in one wonderful evening.

Jewel Box Theatre is located at 3700 N Walker, on the NW part of the “round-domed” First Christian Church at NW 36th and Walker. A special “themed” dinner will be served before each play at 6:00 PM, with the show starting promptly at 8:00 PM. No one is seated once the production has begun, and beverages will be available during intermission. Be sure to watch for your invitation to each of these exciting events! You can always call the D-DENT office for more information and reservations at 405-424-8092 or 800-522-9510.

September 2005  okda.org  7
EODDS
Steven O. Lusk, D.D.S.,
Chair; EODDS Board of Directors

EODDS is having a charity golf tournament on September 30th, 2005 (1:00 p.m. shotgun start). For more information please contact Pam or Margaret (918) 595-4151 or email eodds@hotmail.com for an entry form.

Also, EODDS is pleased to announce that the State Legislators allocated $70,000 for fiscal year 2005-2006 that will be used for laboratory services only.

EODDS volunteer dentists have already provided over $620,000 of free restorative dental care to the less fortunate in eastern Oklahoma. If you would like to join us in providing new smiles for the elderly or disabled, please call EODDS at (918) 595-4151.

Please join us in thanking Representative Ron Peters, Representative Thad Balkman, Senator Stratton Taylor, Senator Tom Adelson, Jack and Maxine Zarrow and Rob Johnson.

ODHA
Julie Gillispie, RDH, CMM

ODHA would like to announce its 49th Annual Session to be held October 21-22. The event will take place at the Renaissance Hotel/Convention Center in downtown Oklahoma City. For more information please contact Julie Gillispie, www.okdha.org.

In Memoriam

Dr. John Allen Bower
Birth: June, 1946
Death: May, 2005
Tulsa, Okla.

Dr. Bower was a member of the ADA and ODA. He was a 1968 graduate of OSU with a BS Degree in Pre-Dentistry and received his degree in dentistry from the Baylor College of Dentistry in 1971. Dr. Bower served as a dentist in the US Navy for three years before opening a private practice in Tulsa in 1974.

Dr. Jerry Stanley Anderson
Birth: April 15, 1934
Death: May 29, 2005
Holdenville, Okla.

Dr. Anderson, an ODA member, received his Doctorate in Dentistry from the Baylor College of Dentistry in 1960. He retired from dentistry in 1999 after practicing for 39 years.

Dr. Henry C. Easterling
Birth: June 24, 1920
Death: July 7, 2005
Norman, Okla.

Dr. Easterling received his degree from the Baylor College of Dentistry in 1945 after earning his degree in Pharmacy from the University of Oklahoma. Immediately after graduating from dental school Dr. Easterling went on active duty with the United States Navy. He was a veteran of World War II and the Korean Conflict. After serving his country Dr. Easterling returned to Norman, Okla. and established his dental practice in 1946.

Mr. Edward L. Flud
Birth: August 29, 1928
Death: July 2, 2005
Tulsa, Okla.

Mr. Flud was the longtime owner/operator of Flud Dental Laboratory. Mr. Flud became a Certified Dental Technician in 1963 and was made an honorary member of the Oklahoma Dental Association in 1999.

Lt Col Lunday, an Army veteran, returned from a six-month tour. Until his deployment he had been a faculty member at the University of Oklahoma College of Dentistry. Although on an Army tour, Lt Col Lunday was a former Air National Guard member and frequent Dental Group Commander of the 137th Medical Group at Will Rogers Air National Guard Base. He is now assigned to the 155 Brigade at Forward Operating Base Kalsu in the Sunni Triangle. His is an ‘on the ground’ combat unit often sweeping the area and the Euphrates River for insurgents. He is seeing injuries essentially as they occur and is providing dental and often medical care for the wounded. When not on patrol, his brigade provides humanitarian relief to the Iraqis in the area. Lt Col Lunday and Lt Col Clark were able to spend part of an afternoon together in Baghdad as Dr. Lunday passed through with his Brigade.
Be a part of the headquarters for organized dentistry in Oklahoma by making a pledge to the ODA Centennial Membership Section.

Your contribution to the new ODA Headquarters is tax deductible as a business expense. Paying for the new ODA Headquarters now instead of later helps build the financial strength of the ODA by eliminating an annual interest payment of $25,000, decreasing the annual operating budget by $65,000, and creating a one million dollar asset for the Association.

The financial support your pledge provides will be recognized in the new ODA Headquarters.

Contact the ODA today to make your contribution to the new building
405-848-8873 / 800-876-8890
The 19th Annual ADA New Dentist Conference was held on June 23-24, in Chicago, Illinois. 

Oklahoma was represented by Dr. Steven Kendrick, New Dentist Chair; Dr. Jeff Danner; Dr. Raymond Cohlmia and ODA Membership Assistant Director Kay Mosley. Many of the ADA Board of Trustees members also attended the weekend events.

Dr. Steven Kendrick made a presentation regarding the ODA's activities and benefits during the idea exchange forum. Other issues challenging new dentists are legislative issues such as social security reform, healthcare costs, Medicaid participation, and student loan interest deduction.

Currently, 84% of all Oklahoma dentists are ODA members, compared with the national average of 74%.

The Oklahoma Dental Foundation Board of Trustees met on July 9, 2005 to conduct a Strategic Planning Session. The meeting was held at Jameson Management, Inc. in Oklahoma City. Dr. John Jameson served as the impartial meeting facilitator.

The ODF was founded in 1959 and is a benevolent 501(c)(3) charitable organization. It serves the general and dental public via charitable, scientific, and educational programs and services. It currently provides continuing education to dental professionals through its annual Fall Seminar and expanded duty certification courses. It assists with the Woody Cohlmia Golf tournament which provides funds for scholarships at the OU College of Dentistry. Finally, it educates the public about good oral hygiene through the “Mighty Mouth” exhibit at the Omniplex in Oklahoma City.

The strategic planning meeting began with a presentation from Ms. April Millaway, a consultant from the Center for Non-Profits. She presented on the make-up of successful non-profit foundations, and the evaluation and 12 actions needed to achieve success.

contd. on pg. 13
The Board approved the preliminary budget for 2006, which will be presented to the HOD in Board Report 2. The major change in the budget involves bringing the Washington real estate corporation (ADREC) back into the ADA. The net operating losses from previous years have been utilized, and there is now no advantage to maintaining a separate subsidiary. This move favorably impacts the budget by $545,250.

The Board is recommending a 2006 operating budget of $102,265,200 in anticipated revenues and $103,634,150 in expenses. You will note that this is the first time budgeted revenues and expenditures have ever been in excess of $100M. Further, the net deficit generated would be about $1,371,000. The Board recommended that this deficit be funded partially from reserves and partially by a $6.00 dues increase (well below the rate of inflation). If the HOD, in its wisdom, were to decide to fund this entire operating deficit from reserves, the reserve funds would remain over 40% of the operating budget with no dues increase. This budget also includes new or expanded programs that generate expenditures of $2.1M not in the 2005 budget. Because of the dues stabilization policy and our strong reserve position, this budget offers outstanding member services for the same member investment, while giving us the financial stability to respond quickly and efficiently to contingencies as they arise.

The Board passed three resolutions relative to the illegal practice of dentistry by Dental Health Aide Therapists (DHATs) in Alaska. A $150,000 advertising campaign was authorized to educate Alaska natives on the dangers inherent in allowing the poorly educated and unsupervised to perform surgical procedures on living tissues. The Board endorsed a pilot program to test the Integrated Dental Health Program for Alaska Natives (BAILIT, et. al.) as an alternative to DHATs. Finally, the Board authorized a confidential sum to consider support of the Alaska Dental Society’s proposed litigation against any possible illegal practice of dentistry in Alaska.

The Board heard an interim report from the Workforce Models Task Force (Zack Studstill, chairman). When this report is finalized it will present a series of options to the HOD, some of which may be considered radical, or even in conflict with current ADA policy. But you should remember that the task force does not accept the concept that any level of care is better than none, and is committed to a single standard of delivering the best care. The report of the task force will be found in Board Report 18.

The Board heard a presentation from Drs. Lorin Peterson and Paul Sims, President and President-Elect of the Western Regional Examining Board (WREB). The Board, as you probably know, has now heard from most, if not all, of the communities of interest related to a proposed uniform clinical licensure examination. It appears likely that we are heading initially toward two examinations at this point. The regional examinations which have generated the most support are ADEX and WREB. Both have offered liaison positions to ADA, and both seem capable of administering a national (or near national) examination. The BOT agreed to accept a liaison position with both ADEX and WREB in order to enhance collaboration and meaningful dialogue. Further, the Board urges individual state boards to evaluate and consider accepting the results of both exams. This is consistent with current ADA policy to facilitate greater freedom of movement of our members by recognizing the validity of multiple examinations.

The Board received a preliminary report from CAPIR (Council on Access, Prevention and Interprofessional Relations) on oral health literacy and resolved that this should be a high priority issue for this Council. The Board directed CAPIR to develop a comprehensive report with recommendations on strategic direction, policies, focus, projects, activities and programs, including budget implications, to be submitted to the June BOT for presentation to the 2006 HOD. It seems that our 2004 HOD seed resolution has begun to sprout and will soon produce fruit.

The Board had a mega-issue discussion on oral-systemic issues, and resolved that the Council on Communications (CC) and the Council on Scientific Affairs (CSA) should collaborate to create a quick reference guide for consumers and professionals that would provide a proper perspective concerning the relationship(s) between oral health and systemic disease.
On June 24, the ODA participated in an Oklahoma City Housing Authority (OCHA) Community Fair at the Oak Grove public housing center in Southwest Oklahoma City. The community fair was the first event in a partnership between the ODA and the OCHA that was formed for the purpose of increasing public housing resident access to and knowledge about oral health care.

The Oak Grove public housing center was an excellent location for this first fair as approximately 700 children. ODA dentists Michael Chandler and Andrew Guthrie attended the fair and provided free dental screenings to children. ODA staff members were also in attendance and handed-out oral health brochures, toothbrushes, t-shirts, and lists of facilities in which qualifying individuals could receive reduced-fee dental care. In addition to the ODA's role in providing oral health care information, ODA Executive Director Dana Davis took over cooking duties for the event, meaning that she spent the evening grilling 500 hot dogs for everyone involved in the fair.

In addition to the ODA's participation, several other community groups such as the Boy/Girl Scouts and the City Arts Center were present at the fair, making the event both fun and extremely informative. The ODA, Oklahoma Dental Foundation, and the Oklahoma Children’s Oral Health Coalition have submitted grant applications for funds to conduct additional community fairs both in Oklahoma City, Tulsa, and at public housing facilities across the state.
The Board also spent the morning discussing the Foundation’s current activities, and what each Board member would like it to become in order to craft a new vision statement. The new vision reads as follows: “The Oklahoma Dental Foundation will become the leading Foundation to address the need for quality dental care and public education/information as well as support professional dental education in the state of Oklahoma.” It was determined that the five foremost priorities needed to meet its new vision included: 1) professional dental education, 2) public information & education, 3) technology, 4) access to care, and 5) fundraising.

The remainder of the meeting was spent brainstorming about goals that the Foundation has for each of its priorities, and devising methods to develop these goals. Before the meeting concluded, Board members volunteered for task forces that were created for each priority. The task forces will meet to create individual vision statements and outline the steps needed to accomplish their goals. Reports will be submitted to the ODF office by September 1, 2005 and presented to the entire Board during the ODF Fall Seminar, which takes place September 23-25.

For further information on the Foundation you can visit their website at www.okdf.org or call them at (405) 848-8873.

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Oklahoma’s premiere dental golf tournament completed yet another successful outing. The 11th Annual Woody Cohlmia Golf Tournament was held on April 27, 2005 in Oklahoma City. The tournament has been a beacon of community involvement, professional camaraderie, and benevolent giving.

The first tournament was held in conjunction with the 1995 ODA Annual Session at the Shangri-La Resort and Convention Center. Each year for the past eleven years, the Woody Cohlmia Memorial Golf Tournament has preceded the ODA Annual Session. Even though the golf tournament is not officially part of the ODA meeting, it has provided a tremendous amount of fun and excitement for all participants. The golf tournament was the idea of Dr. Bill Goodman. Dr. Ray Cohlmia began organizing the tournament in 1994 in preparation for the first event in the Spring of 1995. Numerous individuals helped promote and organize the fundraising and the format for the tournament.

Dr. Jeff Cohlmia is currently the main tournament organizer and is the son of the late Dr. Woody Cohlmia, for whom the tournament was named. Since the first tournament of 64 players, the event has steadily grown to as many as 124 participants.

The purpose of the tournament is to increase the fellowship of dentists in Oklahoma and to raise funds to support a need-based scholarship at the OU College of Dentistry. To date, the tournament has raised well over $120,000 to help dental students achieve their educational goals by offsetting costs of unforeseen circumstances while in dental school. In its third year, the tournament was expanded to also benefit the Oklahoma Dental Foundation programs and services.

Player entry fees as well as state & national corporate sponsorships support the tournament. Many of the corporate sponsors have been loyal supporters for each of the past eleven tournaments. Some of the top sponsors include: Stillwater National Bank; Alexander and Strunk Insurance; D & A Dental Lab; Dental Sply Professional; Patterson Dental – OKC; Oral and Maxillofacial Associates; Endodontic Associates and Mr. Jimmy North. A complete list of this year’s sponsors is outlined on pg. 15. Sponsorships have also come in the form of donated gifts and prizes to the tournament.

This year’s winning team included Dr. David Simon, Mr. John Kemp, and Mr. Todd Naifeh. Congratulations to the winning team on their victory!
11th Annual Woody Cohlmia Memorial Golf Tournament

Sponsors

Stillwater National Bank
Alexander and Strunk Insurance
D & A Dental Lab
Mr. Jimmy North

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Join over 1,000 dental offices who have instant answers on their patient’s dental plans. We go beyond the surface providing details on local, statewide, and national employers. Insurance Answers Plus is easy to learn and simple to operate. In just seconds, the benefit details are at your fingertips! Doing it the old fashioned way or even using some of the more so-called “sophisticated” technologies involve unnecessary time wasting steps that take away staff’s productivity and increase office overhead.

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<th>Traditional Method</th>
<th>Optional Methods</th>
<th>Best Method</th>
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<td>• File and wait for Pre-treatments</td>
<td>• Subscribe to Insurance Answers Plus</td>
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<td>• Input patient information &amp; Dr.’s Tax I.D.#</td>
<td>• Try to obtain a dental handbook from the patient (good luck!)</td>
<td>• Choose either Weekly or Monthly updates</td>
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<td>• Wait and hope to talk to a “real person”</td>
<td>• Navigate through the carriers’ automated phone system to request faxbacks</td>
<td>• Provide accurate and detailed information to your patients on the spot!</td>
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<td>• Cross your fingers that they gave you the right information!</td>
<td>• Research information via website (if available)</td>
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Thanks to the focused and intensive efforts of DENPAC, the Oklahoma Dental Association’s Dental Political Action Committee, dentistry in Oklahoma has numerous friends and advocates at the Oklahoma State Capitol these days. However, there is no Legislator that is more knowledgeable about public oral health or more understanding of the issues surrounding the practice of dentistry than Representative Bill Nations. This is because before Nations began crafting state public policy, he spent 28 years practicing general dentistry in Norman, Oklahoma.

Representative Bill Nations serves House District 44, a District in Norman, Oklahoma (Cleveland County) that is anchored by the University of Oklahoma campus. Nations has held this office since 1998. Before serving at the state level, Rep. Nations served six years on the Norman City Council and was also Mayor of Norman.

Nations was born in Greenville, Texas, on June 28, 1942. Nations and his wife Teena have one daughter, Tara Jaramillo, who is an architect in Denver. Nations graduated from the University of Oklahoma in 1964 and then went on to Baylor College of Dentistry, where he graduated in 1968. In addition to his current service to state government and his previous terms of government service at the local level, Nations also served in the U.S. Navy from 1968-1970.

The ODA Journal recently sat down with Representative Nations to talk about dentistry, the process of creating legislation, and, surprisingly, the Olympic sailing trials.

ODA: Your term as a State Representative coincided almost exactly with your retirement from practicing dentistry. Did you always plan on a life in politics once you were finished with your dental practice?

Nations: Not really. Other than dentistry, my love had always been sailing. I sailed for 25 years, actually my wife and I sailed. We are both romantics of the worst kind, and sailing is a romantic sport. And I actually got quite serious with sailing.

We competed in the 1996 Olympic sailing trials, but by the time that was over — the Olympic Trials were a three-year qualifying effort — I was totally burned out. I just couldn’t do it anymore.

ODA: So then you turned to politics?

Nations: Well, I was already involved in Norman politics. I had been on the City Council for six years and then was Mayor of Norman for another six years. So, I was already politically involved and I guess the idea of continuing at the state level was appealing.

ODA: How do City Council politics compare to the politics practiced at the state level?

Nations: For one thing, there were only nine members of the Norman City Council and there are 149 members here at the State Legislature, so there are a lot more opinions and egos at the state level. But beyond the obvious size difference, the other biggest change is the level of partisanship at the state level. The Norman City Council was almost non-partisan, but here at the state level every single decision and action is partisan. It seems like all that matters around here sometimes is what party gets credit for every little thing that gets done.

ODA: Is the level of partisanship at the state level detrimental to the process of creating public policy?

Nations: I think so. I mean, there is definitely a place for partisanship, and I am certainly proud of my party. But the environment at the Capitol now is partisanship carried to the extreme. Every vote is so close, and every issue seems to be an election issue, and this environment makes compromise less likely. Ultimately, extreme partisanship skews

PROFILE:
Bill Nations, DDS,
State Representative
the debate, and it keeps us from coming up with the best answer. When everyone is worried about who gets credit they are usually less worried about getting the best solution. What you have to do in this type of environment is just stay focused on what is the right thing to do for Oklahomans.

ODA: It sounds like creating good public policy can be a difficult proposition.

Nations: Democracy is an incredibly frustrating process, and if you want to take part in creating policy you must enjoy the process, because, again, it is so hard. Democracy will wear you out, and to be involved you must have thick skin and a sense of humor.

But even though it can be hard, I really enjoy it. I like the challenges; making public policy is difficult, but good. I really like the public life for two reasons: one, I enjoy solving social problems, it makes me feel good to be involved in an effort that really accomplished “something,” and second, I enjoy interacting with people about their problems and about their ideas.

ODA: What legislation or achievement during your time as Legislator are you most proud of?

Nations: There are a lot of things we have done that I think are really good. But what I think I am most proud of is the work we’ve done during the really difficult times. During the three years that the state, and the entire nation, had significant revenue shortfalls, Oklahoma survived in the top third of all states, and we did so without a tax increase. I’m really proud of that. Now, to accomplish this we really had to make some tough cuts, but we made the decisions we had to make. And true leadership is leadership during hard times, when the state doesn’t have any money. It’s real easy to spend money, to figure out how to distribute surplus funds, but when you show up at work and have to walk through picket lines, that’s tough.

ODA: And through all of the work and effort of politics, do you still have a heart and mind for dentistry?

Nations: Absolutely. Before I sailed or was a politician I was a dentist. I’m happy to be the first legislative line of contact for the ODA or for any concerned Oklahoma dentist. No one other Representative knows as much about dentistry as I do, and I hope that I have served the profession of dentistry in Oklahoma well. I’ve worked with Dean Stephen Young on appropriations issues for the OUCOD in the past, and I’ll continue to work with the College of Dentistry and the ODA as I’m needed in the future.

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Party in the park
ADA, CDC celebrate 60 years of community water fluoridation

BY ARLENE FURLONG

Got teeth? Get fluoride. It’s the slogan public health officials, dental professionals, researchers and community leaders rallied around at the 60th anniversary commemoration of community water fluoridation in the United States. Their approach was also unanimous: Can-do. Will-do.

Sponsored by the ADA in conjunction with the Centers for Disease Control and Prevention and with support from Delta Dental Plans Association, the July 13 reception at Millennium Park in Chicago kicked off the National Fluoridation Symposium 2005, July 14-16 at ADA Headquarters.

Amid the surrounding skyline, participants’ high spirits were even further buoyed by speakers’ high expectations.

“What we’re really celebrating today is the positive difference that water fluoridation makes in people’s lives as a safe, effective and economical way to fight dental decay,” said ADA Executive Director James Bramson, in welcoming participants. “Let’s make this an occasion for rededicating ourselves to building toward the day when every community in our nation enjoys the benefits of water fluoridation.”

Each distinguished speaker followed to reiterate the importance of dentistry’s goal for the greater good of all people.

“What really stands out about fluoridation of drinking water and makes it so beneficial is that everybody in a fluoridated community has access to it, regardless of income, education, background, age or living circumstances,” commented Dr. Richard Haught, ADA president.

“Too many children are still missing out on the opportunity to get started on a lifetime of oral health.”

“It’s through partnerships like this one that the public gets the information it needs about fluoride to ensure that each successive generation’s oral health continues to be better than the one before it,” said Dr. William R. Maas, CDC director, Division of Oral Health.

Julius B. Richmond, M.D., former U.S. Surgeon General 1977-1981, underscored that message and congratulated the ADA, saying the Association was doing exactly what a professional organization should be doing.

“This is a model for public-private partnership,” he commented about the National Fluoridation Symposium 2005. “Fluoridation came out of science just as well-substantiated as the link between smoking and health.”

Armed with scientific evidence, the 1950 ADA House of Delegates voted its support for the fluoridation of public water supplies. Fluoride is scientifically proven to be the single most effective public health measure to prevent tooth decay and improve oral health over a lifetime, in both children and adults. The CDC named fluoridation as one of 10 great public health achievements of the 20th century and estimates that every dollar spent on fluoridation saves $38 in treatment costs.


“Our work isn’t finished until every community is fluoridated,” she advised. “We always have more work to do.”

Dr. Lawrence A. Tabak, director, National Institute of Dental and Craniofacial Research, said tooth decay remains a common childhood disease among low income and underserved populations.

“It is time to make this age-old...
the ADA in conjunction with the Centers for Disease Control and Prevention hosted the symposium in Chicago July 13-16. The intensive four-day program set sail July 13 with an anniversary celebration of fluoridation in Chicago’s hottest new venue, Millennium Park.

And during the next three days, participants and speakers boarded a philosophical ship in the harbor of ADA Headquarters. ADA Chief Operating Officer Mary Logan welcomed them and shared an anonymous quote, “A ship in the harbor is safe;” she said, “but that’s not what ships are for.” Remember this quote, because we will talk about it again before you leave.”

The symposium attracted some 250 participants from 39 states and the District of Columbia, as well as nearly three-dozen from Australia, Canada, Ireland, Japan, Korea, New Zealand and the United Kingdom. Dentists and team members; dental society members and staff; local, county and state government and public health representatives; legal and legislative experts; water system personnel; and other advocates heard from more than 50 speakers during the event.

Experts at the podium included former U.S. Surgeon General M. Joycelyn Elders, M.D.; Dr. William R. Maas, director of the CDC Division of Oral Health; George Heartwell, mayor of Grand Rapids, Mich. — the city where it all started Jan. 25, 1945; and many other notable experts in fluoridation science, engineering, policy and surveillance.

The intensive four-day program hosted the symposium. “Now we hope you take what you’ve learned and set sail toward your fluoridation goals,” she concluded. “And remember that the ADA and CDC are always available to help you after you’ve left the harbor.”

COMMUNITY WATER FLUORIDATION: 60 YEARS OF FIGHTING TOOTH DECAY

**ADA Statement Commemorating the 60th Anniversary of Community Water Fluoridation**

Sixty years ago, Grand Rapids, Michigan became the world’s first city to adjust the level of fluoride in its water supply. Since that time, fluoridation has dramatically improved the oral health of tens of millions of Americans. Community water fluoridation is the single most effective public health measure to prevent tooth decay. Additionally, the Centers for Disease Control and Prevention proclaimed community water fluoridation as one of the 10 great public health achievements of the 20th century.

Fluoridation of community water supplies is simply the precise adjustment of the existing naturally occurring fluoride levels in drinking water to an optimal fluoride level recommended by the U.S. Public Health Service (0.7 – 1.2 parts per million) for the prevention of dental decay. Based on data from 2002, approximately 170 million people (or over two-thirds of the population) in the United States are served by public water systems that are fluoridated.

Studies conducted throughout the past 60 years have consistently indicated that fluoridation of community water supplies is safe and effective in preventing dental decay in both children and adults. It is the most efficient way to prevent one of the most common childhood diseases — tooth decay (5 times as common a asthma and 7 times as common as hay fever in 5-17-year-olds).

Early studies, such as those conducted in Grand Rapids, showed that water fluoridation reduced the amount of cavities children get in their baby teeth by as much as 60% and reduced tooth decay in permanent adult teeth by nearly 35%. Today, studies prove water fluoridation continues to be effective in reducing tooth decay by 20-40%, even in an era with widespread availability of fluoride from other sources, such as fluoride toothpaste.

The average cost for a community to fluoridate its water is estimated to range from approximately $0.50 a year per person in large communities to approximately $3.00 a year per person in small communities. For most cities, every $1 invested in water fluoridation saves $38 in dental treatment costs.

The American Dental Association continues to endorse fluoridation of community water supplies as safe and effective for preventing tooth decay. This support has been the Association’s position since policy was first adopted in 1950. The ADA’s policies regarding community water fluoridation are based on the overwhelming weight of peer-reviewed, credible scientific evidence. The ADA, along with the state and local dental societies, continues to work with federal, state, local agencies and community coalitions to increase the number of communities benefiting from water fluoridation.

**Fluoridation Facts**

- Fluoridation of community water supplies is the single most effective public health measure to prevent dental decay.
- Through more than 60 years of research and practical experience, the overwhelming weight of credible scientific evidence has consistently indicated that fluoridation of community water supplies is safe.
- The Centers for Disease Control and Prevention has proclaimed community water fluoridation (along with vaccinations and infectious disease control) as one of the ten great public health achievements of the 20th century.
- More than 100 national and international health, service and professional organizations recognize the public health of community water fluoridation for preventing tooth decay.
- Water that has been fortified with fluoride is similar to fortifying salt with iodine, milk with Vitamin D or juice with Vitamin C.
- Simply by drinking water, people can benefit from fluoridation’s cavity protection whether they are at home, work or school.
- More than two-thirds of the population in the United States are served by public water systems that are optimally fluoridated.
- In the past five years (2000 through 2004), more than 125 U.S. communities in 36 states have voted to adopt fluoridation.
- Fluoridation has been thoroughly tested in the United States’ court system, and found to be a proper means of furthering public health and welfare. No court of last resort has ever determined fluoridation to be unlawful.
- Be aware of misinformation on the Internet and other junk science related to water fluoridation.
- One of the most widely respected sources for information regarding fluoridation and fluorides is the American Dental Association. The ADA maintains Fluoride and Fluoridation Web Pages at http://www.ada.org/goto/fluoride.
HIPAA Security Rule FAQs

HIPAA Security Rule Frequently Asked Questions
The Health Insurance Portability and Accountability Act (HIPAA) requires all health plans, including ERISA, health care clearinghouses and any dentist who transmits health information in an electronic transaction, to use a standard format. Those plans and providers that choose not to use the electronic standards can use a clearinghouse to comply with the requirement. Providers’ paper transactions are not subject to this requirement.

The HIPAA Security Rule was published in 2003 and the enforcement date for this rule was April 20, 2005. What follows are frequently asked questions about the HIPAA Security Rule and how it applies to dental practices.

What is this “Security Rule”? Isn’t it the same thing as Privacy? Wasn’t Privacy all of HIPAA?
The HIPAA Security Rule is a separate, distinct regulation which was required by the original 1996 HIPAA legislation. The final version of the Security Rule was published in February 2003 after a lengthy development. The enforcement deadline for the HIPAA Security Rule was April 20, 2005.

Do I have to comply with it/does my office need the HIPAA Security Kit?
All of the HIPAA Rules for Privacy, Security, Transactions, and Identifiers apply to a dentist if the dentist electronically transmits or receives a patient’s protected health information using one of the standard transactions established by the U.S. Department of Health and Human Services. HIPAA standard transactions are:
- Claims or Equivalent Encounter
- Claim Attachments
- Claim Status Inquiry
- Eligibility Inquiry
- Payment Advice or Remittance Advice
- Coordination of Benefits/Explanation of Benefits
- First Report of Injury for Workman’s Compensation
- Enrollment or Disenrollment in a Health Plan
- Notice of Premium Payment

For assistance in determining whether you are a covered entity, you may wish to consult the “Covered Entity Decision Tool” posted at http://www.cms.hhs.gov/hipaa/hipaa2. Dentists should note that they will be required to comply with HIPAA even if they indirectly transmit or receive patients’ protected health information using one of the standard electronic transactions. For example, if a dentist sends paper claims to a clearinghouse, which then converts the paper claims to electronic claims and transmits them to a health plan, the dentist is a covered entity. Keep in mind that faxes are not considered to be electronic transactions because they exist on paper before transmission.

Finally, remember that Dentists who are subject to HIPAA must comply with the Security Rule in addition to the Privacy Rule.

Who will enforce this rule?
The Centers for Medicare and Medicaid Services’ Office of HIPAA Standards.

We don’t see Medicare patients, why are they involved?
CMS is part of the U.S. Department of Health and Human Services, and was named by the Secretary of Health and Human Services to enforce HIPAA rules for Transactions, Security, and Identifiers.

It’s already past the April 20, 2005 deadline for Security Compliance. I just found out that this new rule existed. Am I in trouble?
If you are a covered entity, it would be very wise to implement the Security Rule as soon as possible. However, there is probably no need to panic. At this time, the Office for HIPAA Standards has no plans to perform random audits and is relying on complaints to drive HIPAA security enforcement.
We cannot say that this will always be the case.

**What software do I need to comply with this Security Rule?**
The Security Rule does not prescribe specific software or technologies; instead, covered providers are given the flexibility to determine whether new security software or devices are needed, based on the practice’s actual risks, size, complexity, technical capabilities, and resources.

**What are some of the main differences between Privacy and Security?**
Unlike the Privacy Rule, the Security Rule does not establish any new patient rights. It does not require providers to ask patients to read or sign any forms. The Privacy Rule establishes protections for health information in oral, written, and electronic form. The Security Rule establishes highly detailed standards for the protection of electronic health information, but does not apply to written or oral communications.

The Security Rule requires covered providers to protect the integrity and availability of electronic health information as well as its confidentiality. This means that a) only authorized individuals may access electronic health information (confidentiality), b) the information does not change except when changed by an authorized person (integrity), and c) authorized persons can always retrieve electronic health information regardless of circumstances (availability). The Security Rule is composed of Administrative, Physical, and Technical standards. These standards are designed to help protect the confidentiality, integrity, and availability of electronic health information. Covered providers meet these very flexible standards by assessing risks, deciding how to manage risks in a reasonable manner, and documenting their decisions. Ultimately, while the Security rule at first may seem narrower than privacy because it covers only electronic communications, it can cut across even more operational lines, involve more business decisions, and take more time to comply with than did Privacy.

**I use X billing software with Y clearinghouse. They say they’re HIPAA-compliant, does that mean I’m OK?**
Maybe. It is possible that your existing policies, procedures, and safeguards, in combination with your vendors’ efforts, could meet HIPAA Security standards without modification. However, there is no way of knowing this for certain without doing a risk analysis. The risk analysis process helps a practice identify and correct its weaknesses.

**What is a Security Officer?**
Covered dentists must appoint a Security Officer to carry out a risk analysis in order to identify vulnerabilities. After assessing vulnerabilities, the Security Official will write policy or implement safeguards to manage the risks associated with the vulnerabilities. The Security Official will also document existing policy or safeguards that appear to meet Security Rule standards. The combination of existing and new policy or safeguards forms the practice’s Security documentation. In the unlikely event a practice were audited by CMS for Security reasons, this security documentation will help the practice avoid or reduce fines.

**Who should be my office’s Security Official? Can the responsibilities be delegated to an office manager, hygienist, or other staffer?**
The Security Rule’s standards cut across many practice operations in such a manner that dentists may not feel comfortable with leaving some of the decisions in the hands of an employee. In many cases, the best individual for the job of Security Official may well be the dentist. The job may be delegated, in which case the dentist should keep in mind s/he, as the covered entity, is ultimately responsible for HIPAA compliance.

**How does the Security Official do the risk analysis? How is it documented?**
The ADA HIPAA Security Kit comes with a detailed risk analysis tool (pages 26-34). This tool is a checklist of potential threats and vulnerabilities; answering the questions contained in the tool helps to provide a clearer image of the practice’s weaknesses and helps to prioritize implementation activities. The use of this particular checklist is not required; the office must, however, carefully analyze all of the risks in the areas specified by HIPAA. Documentation of the risk analysis is up to the covered entity, there is no prescribed method. It could be as simple as a log sheet that records the dates of periodic risk assessments.

**How does one obtain a HIPAA Security Kit?**
The ADA HIPAA Security Kit is a useful tool designed to help dentists comply with the HIPAA Security Rule. If you are subject to HIPAA and have not implemented the Security Rule yet, contact the ADA catalog at 800 947-4746, or visit the ADA catalog online at www.adacatalog.org, to order your HIPAA Security Kit today. Cost is $99.95 for members.
Editor’s Note: Recently, the Oklahoma Dental Association has sent several Legislative Alert e-mails asking ODA members to contact their Senator regarding the Community Health Aide Program (CHAP) in Alaska. Several ODA members have responded to these legislative alerts with question about the CHAPs. The following ADA Question & Answer article is intended to provide background and additional details about this issue.

The ADA and the Alaska Dental Society want Alaskan Natives to get the dental care they desperately need, but both organizations believe that the care provided should be equal to treatment available elsewhere in the United States.

Both organizations support a four-point program designed to serve many more Alaska Natives in rural villages by making the current dental care delivery system more efficient.

ADA President-elect Robert M. Brandjord described the ADA plan in a July 14 statement to a congressional committee. Dr. Brandjord also noted that the ADA opposes allowing dental health aide therapists — non-dentists with two years of training — to perform “irreversible dental surgical procedures.”

Q. I've heard that the ADA is opposed to a novel approach to getting badly needed dental treatment to Alaska Natives in the outermost reaches of Alaska. What’s the story here?

A. In contrast to what you've heard, the ADA supports innovative approaches to getting Alaska Natives the care they need. The underlying goals of the ADA's approach are to make the current system more efficient and to find an Alaska-based solution to the state's unique access problem. What the Association strongly opposes is allowing non-dentists to perform irreversible dental procedures — something that is not permitted anywhere else in the United States.

Q. How would the ADA make the current system more efficient?

A. The ADA asked a group of four independent dental experts to propose a delivery system designed to address the needs of the Alaska Natives in rural villages. One of those experts, Dr. Tom Kovaleski, is the dental director for the Alaska Native Medical Center in Anchorage. Dr. Kovaleski has been able to increase the productivity of dentists in his center by hiring more dental assistants and providing more operatories. The plan proposed by the experts builds on this model and adds a new support person, identified as a “community-based oral health provider,” or COHP.

Q. What’s the ADA doing to help get more dental care to the remote areas of Alaska?

A. In response to a 2003 House of Delegates resolution, the ADA established a task force to explore options to improve oral health care delivery to Alaska Natives in about 200 rural villages. The task force traveled to Alaska and has been attempting to work with the Indian Health Service, tribal leaders and the state dental society to find acceptable solutions to this problem. As noted earlier, the Association also asked an independent group of experts to study the situation and to make recommendations. Those recommendations included establishment of a newly designed support position — the COHP — who would be trained at the University of Alaska to coordinate care, provide preventive services and help with oral health education and nutrition. In addition, the ADA is lobbying Congress to increase funding for educational loan repayment as an incentive for dentists to fill IHS vacancies in Alaska and other states. The Association has established Operation Backlog to help bring dentists to remote areas and has introduced a new staff position (manager, American Indian/Alaska Native dental placement) to work with all parties involved to enhance outreach to the Native villages. The ADA is currently recruiting to fill this position.

Q. Why is the ADA opposed to dental health aide therapists, or DHATs? And where does the Alaska Dental Society stand on this issue?

A. Both the ADA and ADS oppose DHATs on the critical principle of patient safety. DHATs are being allowed to perform extractions and pulpotomies, and to diagnose and treat caries. Dentists generally receive eight years of post-secondary education and training in the health sciences. DHATs are high school graduates who've gone through a two-year training program at the University of Otago in New Zealand. The discrepancy in knowledge and skills is obvious and significant, and must raise questions of patient safety.

Q. How would COHPs help make the current delivery system more efficient?
A. Community-based oral health providers, who could be trained in Alaska in about 12 to 18 months, would help organize community health promotion and disease prevention programs, direct activities of dental health aides and increase the efficiency of visiting dental teams. They also would have an expanded clinical role, but would not perform irreversible dental procedures.

Q. Where do the Alaskan Native tribal leaders stand on this?
A. Some tribal leaders are willing to try DHATs, believing that their choices are between “some care and no care.” The ADA contends that this is a false choice, a choice that no patient or community should be forced to make. With a more efficient delivery system, the ADA says, more care can be provided with relatively few additional resources. Alaska Natives would be afforded the same choices as patients in other states. They should expect nothing less.

Q. Is the ADA willing to compromise, to meet the tribes half way?
A. The ADA and the ADS have made compromises. These include, but are not limited to, accepting all but three procedures (extractions, pulpotomies, diagnosis/treatment of dental caries) from the original DHAT program, accepting the COHP program, Operation Backlog or combinations of the above. Leaders of the DHAT program indicate they would like to achieve some compromise, but they want any compromise to include the ADA and ADS accepting DHATs per forming irreversible procedures. If that is half way, then the ADA and ADS cannot compromise further on that issue. Such a compromise would be in direct conflict with the Association’s Principles of Ethics and Code of Professional Conduct. Such procedures involve the use of a high-speed handpiece and require the skills of a licensed dentist. All 50 states limit such procedures to licensed dentists, and the Alaska Board of Dental Examiners agrees with the dental community that DHATs are practicing dentistry illegally. If, on the other hand, half way means working to help relieve the backlog of disease and to establish a system that provides better and more appropriate oral health care, the ADA stands ready to help as an active partner with the tribes and the Indian Health Service.

Q. What about prevention? Is anyone teaching good oral hygiene to the children in remote villages?
A. That is the No. 1 priority. COHPs would work with dental health aides to support more prevention and education in the villages. The ADA believes very strongly that there should be a dental health aide who lives and works in every village to organize community health promotion and disease prevention programs, direct activities of dental health aides and increase the efficiency of visiting dental teams. They also would have an expanded clinical role, but would not perform irreversible dental procedures.

Q. Some natives in remote areas are resorting to self-treatment. Aren’t dental health aide therapists better than that?
A. Again, “no care or DHAT care” is a false choice, one that no patient or community should be forced to make. The ADA and ADS, through Operation Backlog, have licensed dentists ready to resolve the immediate “no care” issue in remote areas. The key is to deliver quality oral health care in a much more efficient manner. The current system remains inefficient. With a targeted influx of resources that implements a community-based delivery system, self-treatment should not be necessary.

Q. How is the dental health aide therapist any different from an allied medical provider, such as a nurse or physician’s assistant?
A. State laws govern the tasks that can be performed by registered nurses, who must graduate from an approved nursing program and pass a national licensing examination to receive a nursing license. All states also require periodic renewal of nursing licenses, which may involve continuing education. Most applicants to physician’s assistant programs hold a bachelor’s or master’s degree. All states require that new PAs complete an accredited, formal education program, and all jurisdictions require physician’s assistants to pass the Physician Assistants National Certifying Examination. Clinically practicing PAs always work under the supervision of a physician. (Source for this information: U.S. Department of Labor, Bureau of Labor Statistics.)

Q. How do ADA/ADS respond to those who suggest this is nothing more than a turf battle?
A. Absolutely untrue, if the question implies that it is a “turf battle” based on economic considerations. The only battle here is to provide proper oral health care and preventive services to people in dire need. That is central to the ADA’s mission as a health care organization. The Association did not create this problem, but it does intend to be part of the solution.

Q. This is a local matter involving small populations of people in remote areas. Why not let the local authorities handle it?
A. Studies show that the 125,000 members of the Alaskan Native community have a significantly higher prevalence of untreated disease than other U.S. populations. What’s more, more than half the Native population resides in villages not accessible by roads. For the ADA and the dental profession, the question is whether these patients should have access to professionals trained to provide optimal dental care or to others with very limited education and training. In the interest of all patients, the ADA cannot support a two-tiered dental care system, particularly when the opportunity exists to improve the current system.

Q. What are the administrative burdens that dentists have to go through to provide care in Alaskan Native villages?
A. There are credentialing and licensing impediments that could be simplified. For example, the ADA has been told that even moving from one village to another requires a practitioner to undergo a separate credentials review. The ADA is working with the Joint Commission on Accreditation of Healthcare Organizations, tribal leaders and the IHS to make this system less complex.

Several Native corporations support the DHAT program for their own people. Why then does the ADA think it has the right to object?
A. Again, the ADA cannot stand by while patients potentially are put at risk as a result of a two-tiered dental care system. One of those who testified at the July 14 congressional committee hearing was Rachel Joseph, who co-chairs a steering committee for the reauthorization of the Indian Health Care Improvement Act of 1976. She noted that the
Oral Health and Learning

*When Children’s Oral Health Suffers, So Does Their Ability to Learn*

“What amounts to a silent epidemic of dental and oral diseases is affecting some population groups. This burden of disease restricts activities in schools, work, and home, and often significantly diminishes the quality of life.”

Surgeon General David Satcher, Ph.D., M.D.¹

**Lost School Time and Restricted-Activity Days**

An estimated 51 million school hours per year are lost because of dental-related illness.²

Students ages 5 to 17 years missed 1,611,000 school days in 1996 due to acute dental problems—an average of 3.1 days per 100 students.³

Children from families with low incomes had nearly 12 times as many restricted-activity days (e.g., days of missed school) because of dental problems as did children from families with higher incomes.⁴

Over one third of Navajo children living on the Navajo reservation in New Mexico and Arizona missed school because of dental-related pain or discomfort.⁵

Early tooth loss caused by dental decay can result in failure to thrive, impaired speech development, absence from and inability to concentrate in school, and reduced self-esteem.⁶

Students with preventable or untreated health and development problems may have trouble concentrating and learning, have frequent absences from school, or develop permanent disabilities that affect their ability to learn and grow.⁷

Children who take a test while they have a toothache are unlikely to score as well as children who are undistracted by pain.⁸

Poor oral health has been related to decreased school performance, poor social relationships, and less success later in life. Children experiencing pain are distracted and unable to concentrate on schoolwork.⁹

Children are often unable to verbalize their dental pain. Teachers may notice a child who is having difficulty attending to tasks or who is demonstrating the effects of pain—anxiety, fatigue, irritability, depression, and withdrawal from normal activities. However, teachers cannot understand these behaviors if they are not aware that a child has a dental problem.¹⁰

Children with chronic dental pain are unable to focus, are easily distracted, and may have problems with schoolwork completion. They may also experience deterioration of school performance, which negatively impacts their self-esteem.¹¹
Left untreated, the pain and infection caused by tooth decay can lead to problems in eating, speaking, and learning.\textsuperscript{9}

If a child is suffering pain from a dental problem, it may affect the child's school attendance, and mental and social well-being while at school.\textsuperscript{12}

School nurses report a range of oral health problems such as dental caries, gingival disease, malocclusion (poor bite), loose teeth, and oral trauma in children.\textsuperscript{12}

When children's acute dental problems are treated and they are not experiencing pain, their learning and school-attendance records improve.\textsuperscript{13}

People who are missing teeth have to limit their food choices because of chewing problems, which may result in nutritionally inadequate diets.\textsuperscript{14}

The daily nourishment that children receive affects their readiness for school.\textsuperscript{15}

Inadequate nutrition during childhood can have detrimental effects on children's cognitive development and on productivity in adulthood. Nutritional deficiencies also negatively affect children's school performance, their ability to concentrate and perform complex tasks, and their behavior.\textsuperscript{16}

Oral health care is a critical component of health care and must be included in the design of community programs.\textsuperscript{17}

Head Start and Early Head Start are examples of programs that provide medical, dental, and nutritional screening, assessment, and referral, and seek to provide every child with the learning experiences necessary to succeed in school.

School-based oral health services can help make preventive services such as fluoride and dental sealants accessible to children from families with low incomes. Services should include screening, referral, and case management to ensure the timely receipt of dental care from community practitioners.\textsuperscript{5}

The federal government, through Title V of the Social Security Act, provided the genesis for most state dental public health programs in the country. It is estimated that 90 percent of states' dental programs are funded through Maternal and Child Health Services Block Grants to states.\textsuperscript{18}

References
18. Personal communication with Mark Nehring, Maternal and Child Health Bureau, Health Resources and Services Administration, 7/12/01.
CASE STUDY OF BENZOCAINE-INDUCED METHEMOGLOBINEMIA

PROVIDED BY ALISON CARROLL, R.PH., G. PAUL SESIN, PHARM.D., R.PH.

Dentists should be aware of the relationship between methemoglobinemia and benzocaine therapy, as well as its associated factors and the proper treatment.

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Benzocaine spray is a topical anesthetic that is commonly used to prevent the gag reflex in many procedures, including transesophageal echocardiograms. Methemoglobinemia is a rare complication that seems to have an idiosyncratic presentation correlating with the administration of the drug. The reaction can give rise to complications that include cyanosis and hypoxia, and has the potential to result in death. The following is a case report that illustrates a highly suspected case of benzocaine-induced methemoglobinemia.

Presentation and Resolution

A 59-year-old Asian female was admitted to the hospital as an out-patient to undergo a transesophageal echocardiogram in an effort to evaluate for a possible cardiac embolic source of neurologic events. Immediately prior to the procedure, the patient was treated with benzocaine spray (20%); she then received 750 mcg of midazolam (Versed) intravenously. The echocardiogram was performed and proved to be uneventful. The patient tolerated the procedure well.

Approximately 90 minutes later, medical attention was called to recovery as the patient appeared cyanotic and was exhibiting signs of hypoxia. The patient’s oxygen saturation was at 80%, and her blood pressure was 155/70 mmHg with a heart rate of 90. Because the patient had a recent history of transient ischemic attacks, the possibility of a pulmonary embolism was considered. However, that possibility seemed unlikely, since she was hemodynamically stable and denied pain of any kind. All other labs were within normal limits. An emergent blood gas was requested, and it was noted that the patient’s blood appeared chocolate brown in color. The echocardiogram was performed and proved to be uneventful. The patient tolerated the procedure well.

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An emergent blood gas was performed and was shown to be clear. Although the patient was placed on 100% oxygen, she continued to be hypoxic. At that time, methylene blue 1 mg/kg was administered intravenously over five minutes. One hour later there seemed to be an improvement in the patient’s overall appearance, though subsequent measurements showed her oxygen saturation to be 76%. A second dose of methylene blue, 2 mg/kg, was administered in a similar fashion. The patient responded well and her oxygen saturation began to show an improvement, increasing to 86%.

Blood samples were sent out for analysis, as methemoglobin levels were unable to be obtained on site. Results ultimately proved a methemoglobin concentration of 55%. The patient had no known personal or familial history of enzyme deficiency and was not taking any other medications known to cause this reaction.

Discussion

Methemoglobinemia may be either inherited or acquired. As an inherited disorder, patients lack the enzyme NADH cytochrome b5 reductase (methemoglobin reductase). Methemoglobin is therefore unable to be converted back to hemoglobin, rendering the blood less capable of carrying oxygen. Exposure to specific drugs or toxins that precipitate an idiosyncratic reaction may be responsible for acquired methemoglobinemia. Nitrates, nitrites, nitroprusside, sulfonamides, metoclopramide, topical anesthetics (benzocaine, lidocaine, cetacaine, and prilocaine), chlorates, and pyridium are all examples of irritants that may predispose a patient to methemoglobinemia. Of particular interest are the topical anesthetics. Though usually safe since they are not systemically absorbed, predisposing factors such as an increased dose, damaged oral mucosa, co-administration with another causative agent, or enzyme deficiency may render a patient more susceptible to methemoglobinemia. The patient was exposed to both the topical lidocaine and benzocaine, but there were no additional predisposing factors for this type of reaction. The patient had also received lidocaine in the past without any reactions. Signs and symptoms develop in stages and become progressively more evident as the levels of methemoglobin increase. As concentrations exceed 50%-60%, arrhythmias, seizures, and acidosis may result. Complica-
tions progress to coma, vascular collapse, and possibly death once levels exceed 70%. This profile is of particular interest and concern since the patient’s methemoglobin concentration was 55% and she was exhibiting a decrease in oxygen saturation levels, both of which correlate with the diagnosis of methemoglobinemia.

A diagnosis of methemoglobinemia is based on the clinical presentation of the patient. Cyanosis is initially the most significant sign and should prompt the analysis of arterial blood gas. The sample of blood may appear dark brown, blue, or black. (In this case, the patient’s primary symptom was cyanosis and her blood had a chocolate brown color.) Cooximetry can establish the relative concentrations of both oxyhemoglobin and methemoglobin. Therefore, it is only when based on cooximetry measurements that a definite diagnosis of methemoglobinemia can be made.

Treatment should begin with discontinuation of the offending agent and concurrent administration of oxygen. The antidote for methemoglobinemia is methylene blue. It acts as a reducing agent in the NADPH methemoglobin reductase pathway, which ultimately enables hemoglobin to carry oxygen to tissues. Intravenous methylene blue should be administered to patients who exhibit signs of hypoxia and/or have methemoglobin levels above 30%. The standard dose of methylene blue in instances of methemoglobinemia is 1 to 2 mg/kg, given as a 1% solution administered over 5 minutes. Administration may be repeated in 1 hour if symptoms do not resolve. The total dose should not exceed 7 mg/kg, as amounts greater than this may be toxic. The patient was treated in accordance with the above-mentioned treatment recommendations.

Conclusion

Upon evaluation of the clinical presentation and the laboratory data, it is believed that this patient experienced an idiosyncratic reaction to the 20% benzocaine spray that resulted in her episode of methemoglobinemia. Use of the Naranjo ADR Probability Scale indicated a probable relationship between the methemoglobinemia and benzocaine therapy in this patient.

Proper measures should be taken to educate healthcare professionals on the presentation of methemoglobinemia, its associated factors, and the proper treatment.

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REFERENCES

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THE BUCCAL PIT STUDY CLUB #2

“I don’t care whose dog that is, get him out of here or the health inspector will shut us down!” Unusually polite words from Wanda, considering her normal tone used on the assembled members of the Buccal Pit Study Club. Ever since Dr. Ed Lebiew’s disappearance (see previous Journal report), the study club had wrestled with several issues and made little progress. Another matter was Dr. Ed’s dog, who fortunately possessed a rather laid-back attitude toward life and was very little trouble. “K-Flex” was of questionable ancestry, slack-jawed, bent-tailed, and couldn’t tell a squirrel from a sewing machine, but had become the study club’s unofficial mascot. Standing rules at the Longbranch Saloon frowned on livestock in the non-smoking section, resulting in his temporary banishment to the back porch. The dog’s role in finding his missing owner, however, was soon to become apparent.

Wanda returned, orders were taken, and the weekly meeting called to order by the acting president. A scientific paper was presented by one of the younger members describing the use of a surplus colonoscopic endoscope found on eBay as an intraoral camera. Although somewhat bulky, the scope did produce remarkable pictures, but it was suggested that the operator might want to reference the instruction manual as to which end the instrument was designed to be used on most efficiently. There being no other technique flaws found, the manuscript was submitted for hopeful publication in Dental Abstracts.

Under old business was the dilemma of finding Dr. Ed. Not only was his practice suffering from lack of attention, but also the other members were rapidly tiring of dealing with emergencies from Dr. Ed’s unusual collection of patients. One late night call to a semi-retired club member whose memory is not what it once was resulted in confusion at the pharmacy in the back of the local Piggly Wiggly when an antibiotic scripts for Zithromax was misread as Zippo-Lax, with the imagined results creating a stir on aisle three. It was becoming apparent that either Dr. Ed was to be located soon or the Study Club would be saddled with both dog and extra patients for some time.

By now, K-Flex had had enough of his back porch exile and began the laborious process of working the screen door latch with both front paws until the old door swung open. Knowing his fate if discovered, he assumed his low-to-the ground slinking position, learned from years of sleeping under Dr. Ed’s third operatory chair, and made his escape across the back alley. He had a pretty good idea where his owner could be found and headed south out of town at flank speed towards the lake. He would soon be proven correct.

Club members were getting restless as Wanda looked at her watch. Only thirty minutes to closing time and she could run this bunch out of the Longbranch and get home in time for Wheel of Fortune. As a last-ditch effort, once-sterile cotton swabs found behind the bar were used to extract a saliva sample from Dr. Ed’s favorite beer mug on the shelf above the mirror. Placed in an empty Pabst Blue Ribbon can for safekeeping, the sample was taken to Gator Crossing law enforcement for DNA sampling and hopefully some leads. It was an unspoken fact among the whole study club that times were getting desperate, and time was running out. (Next: K-Flex makes a discovery)
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