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**MEMBER PUBLICATION
AMERICAN ASSOCIATION OF
DENTAL EDITORS**

inside

Spring 2004

Volume 94

issue number 4

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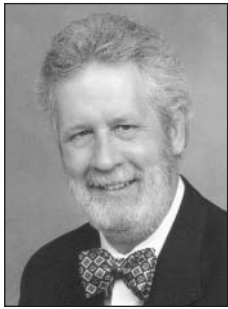
Yesterday, Today and Tomorrow. Yesterday's ODA – Oklahoma Territory. Today's ODA – Current Building. Tomorrow's ODA – Artist Rendering of ODA's Future Building.

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president's message



By Dr. Stephen Glenn

Approximately 89% of the dentists in Oklahoma are members of the Oklahoma Dental Association. This compares favorably to the national average, where the ADA is proud of its progress towards the 75 percent mark of partici-

pation. It dwarfs the membership percentage of the American Medical Association, which is far below the 50 percent mark.

Many observers attribute the dismal participation of physicians in their national organization as the inevitable result of accelerating specialization within the medical profession and the fact that many physicians prefer to contribute their dues dollars to organizations concerned with their practice and CE focus as opposed to those addressing global issues facing the medical profession. Indeed, in dentistry, the percentage of specialization is only about 20 percent and those who specialize have made an extraordinary effort to support the entire profession and all levels of organized dentistry. For that we can be thankful.

But I maintain the reason the AMA has experienced such a precipitous decline in membership has more to do with the public perception of that organization (and the resulting self-image of the organization held within the medical profession) than it does with specialization. The stature of the AMA has suffered because the public perceives the organization as being more concerned with the welfare of doctors than it is with issues of health. Whether or not the perception is accurate, there is a lesson to be learned.

Last fall, I reminded the House of Delegates that we run the risk of the same fate if we, as an Association, become too focused on selfish issues that impact our practices or become preoccupied with self-directed priorities. I do not deny the importance of these issues, but I urge you all to

give equal emphasis and consideration to the issues confronting public health and the welfare of all Oklahomans. I am proud to report that, true to our long tradition of emphasis on prevention and public service, your Association is indeed demonstrating its commitment to improving oral health.

At the urging of the Council on Governmental Affairs, chaired by Dr. Donna Sparks, we have introduced legislation, the Oklahoma Dental Loan Repayment Act (HB 2670), which addresses access and manpower issues by allowing for loan repayment for owner dentists who are willing to establish a practice in federally designated areas of need or who agree to accept at least 30 percent of their practice as Medicaid patients. The program will be administered by the Oklahoma State Department of Health.

Dr. Jim Murtaugh chairs the Sub-Council on OHCA and DHS. That group has been engaged in a collaborative effort with Delta Dental Plan of Oklahoma, analyzing a plan that has proved successful in improving access, participation and the utilization of benefits for Medicaid children in the state of Michigan. The ODA is willing to investigate any promising approach or model resulting in improved dental health or access and will work cooperatively with any qualified entity to attain that end.

We are a partner in the Fit Kids Coalition, which has introduced legislation addressing vending machines in schools (SB 1425) as well as other legislative initiatives impacting children's health. Dr. Tim Shannon, chairman of the Council on Dental Education, Dr. Andrew Guthrie, Chairman of the Sub-council on Public Information and Dr. Mike Steffen, Chairman of the Task Force on Pouring Rights have devoted many hours to the effort of making sure our children have healthier vending options at school and informing parents about the risks of unlimited access of toddlers to "sippy cups". The ODA plans to institute an educational program, direct-

editor's message



By Dr. David B. Shadid

As we go through life, we learn many lessons. This is especially true in the early years of life. Each day becomes a new adventure. Our minds and hearts are open to new ideas and concepts.

As we mature, we begin to realize that life is not always fun and games. We begin to decide what is important and what is a waste of time. We have to decipher between a barrage of options to best choose those that will benefit us throughout our lifetime.

Like all of you, I have been very blessed. I have a wonderful family. My practice is successful. I have food in my stomach and a roof over my head. Recently my beautiful and supportive wife brought a healthy boy into this world. People used to tell me, "Wait until you have a child, then you will know true love." I would politely agree, but doubted I could love someone more than my wife. They were right! It brought a whole new perspective to my life. Suddenly, I have two people who look forward to me coming home at the end of the day. I have two people who want me to be careful when I'm out on the road. I have two people who are depending on me. Most of all, being at the office, away from home, is not as important as it used to be.

You see it doesn't matter how many hours you work, or how much money you make if you don't have a bigger purpose in life. I realized that what really matters is not letting my son grow up without me. I want to be there when he takes those first steps. I want to be there to see him hit his first baseball. I want to be there to hear him say his one line in the school play. That's what matters. That's what life is all about. All the other things that go on around us only allow us to do what really matters. No one can fault you because you had to leave the office early to make it to your child's important event. I have heard the warnings too many times not to take them to heart. "They grow up fast. Don't look back in regret one day, wondering where the time went."

"Carpe diem", "Seize the day". You only get one chance at some things, so don't look back wishing you had done something different. It may be taking a trip to the Grand Canyon. It may be visiting your sister in Indiana. It may even be as simple as picking up the phone to tell your parents you love them. Think to yourself, can you recapture events that were put on the back burner so that you could spend more time at the office? As the old saying goes, "you can't take it with you". However, you can make sure that those around you know you love and support them and that they mean more to you than the world itself. ●

ed at students and their parents, about the health and nutritional issues of soda consumption.

The Council on Dental Care, chaired by Dr. Deboria Gill, and ODA Past President Glenn Mead, Chairman of the Task Force on Sr. Dent and CareDent, are re-examining these vital programs and developing recommendations to

increase dentist participation and extend dental care to the elderly and disadvantaged.

When you see these committed colleagues, thank them for keeping our Association focused on the issues of improved oral health, all the while making your membership more meaningful. Your participation makes a difference. ●

forum / viewpoint

Dental Extractions and Gum Surgery *on Anticoagulated Patients*

By W. H. Oehlert, MD, MMM

The conundrum of whether to hospitalize a Medicare patient on anticoagulants for dental extractions and gum surgery continues to be an enigma to many dentists and physicians. The general consensus from the literature and expert opinion is that dental extractions and gum surgeries can be performed with minimal risk in patients who have International Normalized Ratios (INRs) less than 4.1. Most bleeding episodes can be controlled with local measures and observation. They do not require hospitalization. Hospitalization would only be required for something occurring during the post-operative observation period that could not be controlled. There have been several documented cases of serious embolic complications in patients whose anticoagulation therapy was withdrawn.

Medicare does not pay for all of a beneficiary's health care costs. Non-covered Medicare benefits are the responsibility of the beneficiary. A reoccurring area of denied coverage involves hospital admission for dental extractions, even when

patients are on anticoagulation.

The Medicare program does not cover most routine dental services. The Medicare law clearly excludes coverage "for services in connection with the care, treatment, filling, removal or replacement of teeth or structures directly supporting teeth". This means that most routine dental care, such as fillings, cleaning, x-rays, and dentures, even if those services are performed in a hospital will not be paid by Medicare. Payment for most dental care is the beneficiary's responsibility.

A narrow exception permits coverage of certain dental services that are necessary to the provision of certain Medicare-covered medical services. For example, Medicare may cover the following services.

* Extraction of a tooth as part of a repair of a fractured jaw.

* Maxillofacial surgery for pathological or traumatic medical conditions (for example, in case of a serious injury).

* Prosthetic rehabilitation to replace or treat certain oral and/or facial structures related to covered medical and surgical interventions (for example, cancer surgery).

* Extraction of teeth prior to

radiation treatment of the jaw.

* Oral examination prior to kidney transplantation.

* Medicare may also cover certain medical procedures that dentists are licensed to perform (for example, a biopsy for oral cancer).

The above is not an all-inclusive list. These are examples for illustrative purposes. Additional questions concerning Medicare coverage for dental services can be obtained by calling Medicare at 1-800-MEDICARE (1-800-633-4227). [The coverage information is from a notice published by the American Dental Association (ADA) 211 East Chicago Avenue, Chicago, IL 60611. The Centers for Medicare & Medicaid Services reviewed this ADA notice about dental coverage and confirmed the accuracy of its content.]

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your health

Food Pyramids ... A better eating plan?

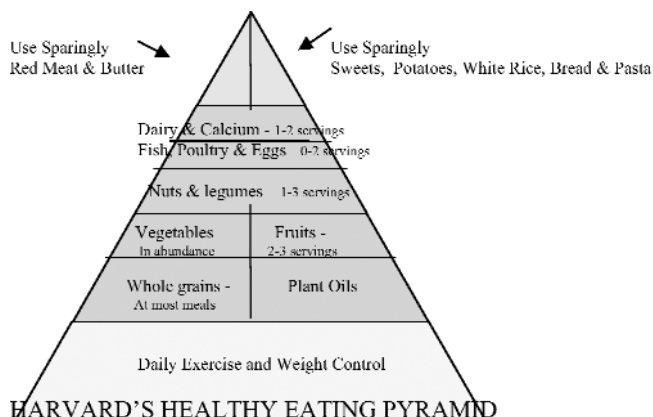
Some nutrition experts say the U.S. Department of Agriculture's good guide pyramid is behind the times - and as healthful as it could be.

And a new study seems to back that up.

When Harvard researchers looked at people's eating habits, women who followed a Harvard-devised diet pyramid reduced their heart disease by 28%. Men reduced their risk by 39%.

This compares to heart disease reductions of 14% (women) and 28% (men) for those who followed the traditional USDA pyramid.

Hope Health Editor's note: The USDA recognizes that its current food guide pyramid is out of date and plans to debut a revised eating guide in 2005. How closely it will resemble the Harvard pyramid remains to be seen.



Used with permission, Hope Health, Kalamazoo, Michigan, (269) 343-0770. ●

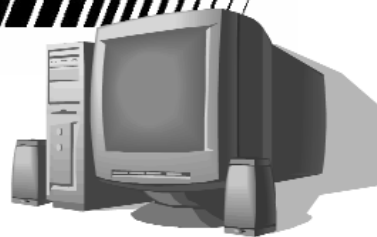
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Friday, April 30th

- Dr. Sam Strong - Taking Your Practice to the Next Level with Implant Prosthetics
- Dr. Henry Gremillion - TMD and Orofacial Pain: Making Sense of the Confusion
- Ms. Carol Tekavec - Update on Record Keeping and Insurance
- Ms. Kathleen O' Neill-Smith - Air Polishing: The Basics and Beyond (1/2 day) and Moving Forward with Ultrasonics (1/2 day)

Sunday, May 1

- QuickBooks - Mr. Johnny Curran and Ms. Audra Smith
- WebMD - Jackie Tasden

Saturday, May 1st

- Mr. Joe Dillon - Producing Peak Performance
- Dr. M. Leif Stromberg - Contemporary Issues in Treating Edentulous Patients
- Mr. G. Kent Mangelson - "The Latest Cutting Edge Strategies on Lawsuit Protection, Tax Reduction and Estate Planning"
- Dr. David Federick - Foundation and Aesthetic Restorations for Decimated Teeth
- Ms. Geneva Beach-Primer - "Dynamic Temporaries": Assistants Hands on Course
- Dr. Ray Beddoe - "Summary of Topics: New Disease Reclassification, New Antibiotics Regimen, Non-surgical Treatment Algorithms, Database Clinical Inferences"

Meeting Dates April 29-May 2, 2004
DoubleTree Hotel and Tulsa Convention Center

oda news

oda new employee

ODA Building update

On March 10th the new Mayor of Oklahoma City, Mick Cornett, was sworn into office and one of his first duties was to approve the zoning for the new ODA Building. We will close on the lots on March 30th and file for a building permit on the same day. The final plans are completed and the Journal cover shows the exterior of the building as viewed from the southwest. A groundbreaking ceremony was held April 2nd at 11:30 at 13th Street and Stiles

– Lee Beasley ●



Julie Noble joined the ODA in March 2004. Before joining the ODA, Julie resided in Denver, Colorado where she was an

administrative assistant at Wachovia Mortgage Corporation.

As a member of the ODA staff, Julie is looking forward to being the welcoming face of the ODA. She is responsible for answering the phones, greeting visitors and taking care of the Senior and Care Dent programs.

Julie is joined in Oklahoma City by her husband, Bill. Julie has a 22 year old son, Aaron, who is a student at Plantation Junior College in Fort Lauderdale, Florida. She is excited about the future vision of the ODA and is grateful for the opportunity to contribute to the success of the new ODA. ●



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- *E-commerce payment solutions*
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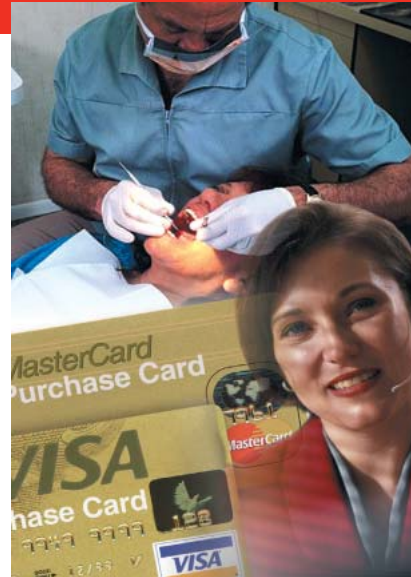
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QUARTERLY CE CALENDAR

Arizona

June 27 - 30
Flying Dentists Association
National Convention
Flagstaff

Canada

April 27 - May 2
American Academy of
Cosmetic Dentistry
Annual Scientific Session
American Academy of
Cosmetic Dentistry
Vancouver

California

May 5 - 9
American Association of
Endodontists
61st Annual Session
Anaheim

May 27 - June 1
American Academy of
Pediatric Dentistry
Annual Session
San Francisco

July 8 - 11
American Dental Assistants
Association
Annual Conference
Anaheim

July 8 - 11
American Association of
Women Dentists
83rd Annual Meeting
Anaheim

July 8 - 11
Academy of General
Dentistry
Annual Meeting
Anaheim

Colorado

June 11 - 13
Colorado Dental Association
118th Annual Session
Vail

Florida

April 18 - 20
American College of Oral
and Maxillofacial Surgeons
Annual Meeting
Hollywood

June 30 - July 4
Southern Academy of
Periodontology
Summer Meeting
Amelia Island Plantation

Hong Kong

May 28 - June 1
Hong Kong Dental
Association
26th Asia Pacific Dental
Congress 2004
Hong Kong

Massachusetts

June 10 - 13
American Academy of
Periodontology
8th International Symposium
of Periodontics and
Restorative Dentistry
Boston

Nebraska

April 23 - 25
Nebraska Dental Association
Annual Session
Lincoln

Nevada

June 24 - 27
International Congress of
Oral Implantologists
ICOI/TSOI World Congress
XXIII
Las Vegas

Ohio

June 24 - 26
International Academy for
Sports Dentistry
Annual Symposium
Cincinnati

Oklahoma

April 29 - May 2
Annual Meeting
Oklahoma Dental
Association
Tulsa

Oregon

July 18 - 24
College of Diplomates of the
American Board of
Orthodontics
Annual Meeting
Portland

QUARTERLY CE CALENDAR

South Carolina

May 8 - 12
American Academy of Oral &
Maxillofacial Pathology
Annual Meeting
Charleston

Texas

June 23 - 30
American Dental Hygienists Association
81st Annual Session
Dallas

May 13 - 16
Texas Dental Association
The Texas Meeting
San Antonio

letter to the editor

David,

I thought your "editor's message" in the winter ODA journal was well written and appropriate food for thought.

Over the years that I have been in practice, I've had many patients who have now become friends. We made the transition mostly by taking more time to listen to each other.

Regards,

Don Smith



c it establish.

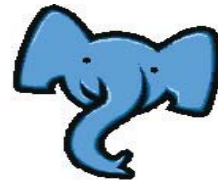
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2004



Dentist Day at the Capitol

February 11

Thank you to all of the dentists who participated in Dentist Day at the Capitol. It was a busy and effective day. Hopefully next year we can make it an even bigger success!

(From Left to Right): Dr. David Maddox, Rep. Fred Perry, and Dr. Robert Augsburger.



(From Left to Right): ODA Executive Director Dana Davis, Speaker of the House Larry Adair, ODA President Dr. Stephen Glenn, and ODA President-Elect Dr. Lee Beasley.

Oklahoma County dentists and elected officials enjoy lunch.

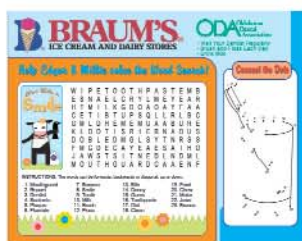


Tulsa County dentists assemble in the Hall of Governors during Dentists Day at the Capitol 2004.

We're all smiles when it comes to Braum's.



**The Oklahoma Dental Association proudly recognizes Braum's
as our Corporate Partner for Children's Dental Month.**



2004 is Braum's 4th year of sponsorship for National Children's Dental Health Month and the ODA would like to extend a big thank you!

In helping to promote the message of National Children's Dental Health Month, Braum's donates the printing of trayliners and posters which they display in their stores across the state, along with Braum's Kid Meals' prizes like toothbrushes and toothpaste. They also provide free ice cream to the statewide winners of the NCDHM annual poster contest.

With Braum's ongoing support and generosity, we've all got a lot to smile about. Thanks again.



HIPAA Security Regulations

Protecting patient's electronic health information

By **Peter M. Sfikas, J.D.**

Dentists who transmit certain patient health information electronically will have to comply with the recently released security regulations mandated by the Health Insurance Portability and Accountability Act of 1996, or HIPAA¹. Fortunately, compliance will not be mandatory until April 2005, so dentists will have plenty of time to adopt practices necessary for compliance.

There is a key difference between the security regulations and the HIPAA privacy regulations. Both sets of regulations apply only to dentists who are "covered entities." In order to be a covered entity, a dentist must transmit certain patient health information electronically, using a format established by the HIPAA transaction standards. However, the HIPAA privacy regulations apply to all communications - electronic, written or oral - of patients' protected health information. In contrast, the security regulations apply only to electronic protected health information, or PHI.

Under the HIPAA regulations, PHI is defined as information that identifies a patient and relates to that person's health, health care or payment for health care. Any dentist who is a covered entity will have to adopt the protections for electronic PHI contained in the security rule.

The final version of the security regulations was modified by the U.S. Department of Health and Human Services, or DHHS, to more closely reflect the requirements of the privacy regulations. Thus, a dentist who has implemented measures to comply with the privacy regulations already may have taken some of the steps needed to comply with the security regulations.

Similar to the privacy regulations, the security regulations allow covered entities flexibility to adopt implementing measures that are appropriate for that particular covered entity. That means that a small private dental practice will not need

to take the same measures to comply with the security regulations as will a hospital or an insurance company. In deciding what security measures to adopt, a covered entity must consider the following factors:

- * the size, complexity and capabilities of the covered entity;
- * the covered entity's technical infrastructure, hardware and software security capabilities;
- * the costs of security measures;
- * the probability of and degree of potential harm from potential risks to electronic PHI.

The security regulations contain standards with both "required" implementation specifications and "addressable" implementation specifications. While the required implementation specifications are mandatory, the addressable specifications may not be. In reviewing addressable implementation specifications, a dentist who is a covered entity must

- * assess whether the specification is a reasonable and appropriate safeguard for the dentist's office;
- * implement the specification if reasonable and appropriate;
- * if implementing the specification would not be reasonable and appropriate, document this fact and implement "an equivalent alternative measure" if reasonable and appropriate.

The DHHS commentary accompanying the regulations states that a covered entity also may decide that a particular implementation specification does not apply to its office and that the particular standard can be met without implementing an alternative measure in place of the addressable implementation specification.

The security regulations require covered entities to adopt administrative, physical and technical safeguards to protect electronic PHI. In addition,

See HIPAA, Page 18

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See you at the ODA
Friday April 30th and Saturday May 1st

HIPAA... Continued from Page 16

covered entities must adopt certain organizational requirements, such as business associate contracts, which are very similar to the business associate agreements required by the HIPAA privacy regulations.

Furthermore, a covered entity must adopt certain policies and procedures, including documentation requirements, to comply with the security regulations. Covered entities will have to retain documentation of their policies and procedures implemented to comply with the security regulations for six years after the date the documentation was created, or the date when it was last in effect, whichever is later.

Administrative Safeguards

The administrative safeguards contain several standards that must be followed. The first standard requires covered entities to implement a security management process. Covered entities will be required to conduct a risk analysis to determine potential risks to the confidentiality, integrity and availability of electronic PHI created, received, maintained or transmitted by the covered entity. The covered entity will then have to implement risk management practices to reduce the risks uncovered by this analysis.

Other required standards classified as administrative safeguards will include developing a policy for sanctioning staff members who violate the covered entity's security procedures, and implementing procedures to regularly review records of information system activity, such as audit logs, access reports and security incident tracking reports.

A key standard under the categories of administrative safeguards and organizational requirements will require covered entities to designate one person as the security official responsible for developing and implementing the entity's security policies. This mandate is similar to the requirement under the HIPAA privacy regulations for one person to be named as the entity's privacy officer. Dentists who are covered entities may want to designate the same person as the prac-

tice's security officer and privacy officer, since some responsibilities of these positions may overlap.

Another administrative standard will require covered entities to implement procedures to make sure that all work force members have appropriate access to electronic PHI - and to prevent any work force members who should not have access to certain electronic PHI from obtaining that access. Additional administrative standards will require covered entities to develop policies and procedures pertaining to information access management, and to establish a security awareness and training program for all work force members.

One of the "addressable" implementation specifications for this standard deals with the adoption of password protection for office computer systems. While dental offices that are covered entities will not be absolutely required to implement password protection for their computers, they will have to do this if it would be "reasonable and appropriate" to do so.

Furthermore, covered entities will have to implement an administrative standard for handling "security incidents". A security incident is defined as an "attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with system operations in an information system". Covered entities will be required to identify and respond to suspected or known security incidents; mitigate damages resulting from known security incidents, if possible; and document security incidents and their outcomes.

Another administrative standard will require covered entities to develop a contingency plan to deal with incidents - such as fires, vandalism, system failures or natural disasters - that could damage systems containing electronic PHI. Covered entities will be required to implement data backup, disaster recovery and emergency mode operation plans. Covered entities also will be required to conduct periodic evaluations to determine whether their offices remain in compliance with the security regulations.

Another similarity between the security regulations and the HIPAA privacy regulations is that

both sets of rules require covered entities to enter business associate agreements with certain outside parties who have access to PHI. As previously stated, the security regulations apply only to the use and disclosure of electronic PHI. Since covered entities who will be obligated to comply with the security regulations also will have been required to comply with the privacy regulations, covered entities should already have business associate agreements in place with applicable outside parties who have access to electronic PHI maintained by the dentist.

I explored the requirements for business associate agreements under the privacy regulations in my column in the January 2003 issue of JADA². The requirements for business associate agreements under the security regulations are very similar. The security regulations do contain an additional requirement for the contract to require the business associate to notify the covered entity if the business associate becomes aware of a "security incident". Also, the security regulations make it clear that business associates must implement "administrative, physical and technical safeguards" to protect electronic PHI, and must require subcontractors to implement "reasonable and appropriate" safeguards to protect electronic PHI.

Physical Safeguards

The HIPAA security regulations also require covered entities to adopt physical safeguards to protect electronic PHI. Covered entities will be required to implement a standard requiring policies to limit physical access to the entity's computer systems and the facility in which they are housed, while ensuring that properly authorized access is allowed. In addition, covered entities will be required to develop policies and procedures for workstation use and physical safeguards for workstation security.

A workstation may include a desktop or laptop computer, along with "electronic media" stored in the immediate vicinity of the computer. The definition of "electronic media" includes hard drives

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HIPAA... Continued from Page 19

and portable devices such as magnetic tape or disks, optical disks and digital memory cards. Electronic media also encompasses "transmission media" used to exchange information already in electronic storage media.

Transmission media can include the Internet, an extranet, leased lines, dial-up lines, private networks and the physical movement of removable or transportable electronic storage media. The regulations note that paper, facsimile and telephone transmissions are not considered transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission.

An additional physical safeguard will require covered entities to implement policies and procedures governing the receipt and removal of hardware and electronic media containing electronic PHI into and out of a facility, and the movement of those items within the facility. Specifically, covered entities will be required to adopt policies and procedures pertaining to the disposal of electronic PHI and the hardware or other media on which it is stored.

Covered entities also will be required to implement procedures for removing electronic PHI from electronic media before the media are made available for re-use. One of the "addressable" specifications for implementing this standard will be for covered entities to create a retrievable, exact copy of electronic PHI, when needed, before moving equipment.

Technical Safeguards

As previously noted, covered entities also will be required to implement technical safeguards under the HIPAA security regulations. Covered entities will have to implement an access control standard that permits only authorized people or software programs to access information systems that maintain electronic PHI.

Covered entities will be required to assign a unique name or number for identifying and tracking user identity. Covered entities also will be required to establish procedures for obtaining

necessary electronic PHI during an emergency. "Addressable" implementation specifications include establishing automatic logoffs after a certain time of inactivity on a system and adopting mechanisms to encrypt and decrypt electronic PHI.

In its commentary accompanying the security regulations, DHHS notes that since there is no generally accepted standard for encryption technology, covered entities might be unable to share encrypted emails with patients, and consequently this implementation specification was deemed "addressable." However, the commentary encourages covered entities to consider using encryption technology for transmitting electronic PHI, particularly over the Internet.

Other standards under the category of technical safeguards include implementing mechanisms to record and examine activity in information systems that contain or use electronic PHI, and implementing policies and procedures to protect electronic PHI from improper alteration or destruction.

Still other standards will require covered entities to implement procedures to verify the identity of a person or entity seeking access to electronic PHI, and to implement security measures to guard against unauthorized access to electronic PHI. Furthermore, covered entities will be required to implement measures to protect electronic PHI from unauthorized access during transmission.

Complying with the HIPAA Regulations

As noted, covered entities will not have to comply with the security regulations until April 2005. However, some have argued that the security regulations will have a more immediate impact. The HIPAA privacy regulations require covered entities to have in place "appropriate administrative, technical and physical safeguards to protect the privacy of protected health information".

It is possible that the standards in the security regulations could be used to determine the "appropriate safeguards" to be taken to protect PHI under the privacy regulations. In fact, the

See HIPAA, Page 22

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HIPAA... Continued from Page 20

DHHS commentary accompanying the security regulations notes that the implementation of appropriate security measures also will support compliance with the privacy standards, while the lack of adequate security also could increase the risk of violating the privacy standards.

In its commentary, DHHS acknowledged that there is no such thing as a totally secure system. While the HIPAA statute refers to "ensuring" protection for electronic PHI, DHHS noted that covered entities would not be required to provide protection regardless of the cost. Covered entities will be expected to balance the risks of inappropriate use or disclosure of electronic PHI against the cost of various protective measures. The size and capabilities of the covered entity also may be taken into account.

Furthermore, the commentary states that DHHS will be publishing guidance to help covered entities comply with the HIPAA security regulations.

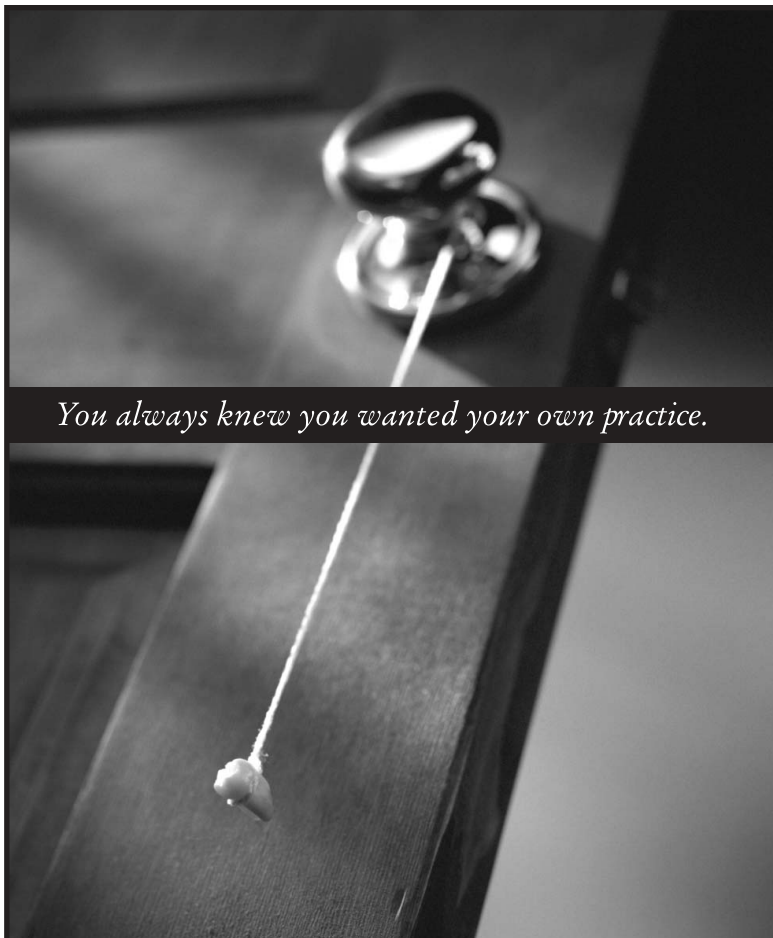
In addition, the American Dental Association will be developing materials specifically designed to assist dentists preparing to comply with the security regulations. ●

Mr. Sfikas is ADA chief counsel and an adjunct professor of law at Loyola University of Chicago School of Law. He has lectured and written on legal issues and is a fellow of the American College of Trial Lawyers. Address reprint requests to Mr. Sfikas at the ADA, 211 E. Chicago Ave., Chicago, IL 60611.

The author wishes to express his appreciation to Colleen Johnson, director, ADA Contract Analysis Service, for her assistance in preparing this article.

This article is informational only and does not constitute legal advice. Dentists must consult with their private attorneys for such advice.

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2. Sfikas PM. Business associate agreements. JADA 2003; 134:114-6.



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CURRENT INTRAORAL RADIOGRAPHIC FILMS AND REVIEW OF THE LITERATURE

By Farah Masood, BDS, MS and Dr. Patrick K. Hardman, DDS, MS

Radiography plays a vital role in dental diagnosis. Due to the potentially harmful effects of exposure to ionizing radiation, it is essential that the dental practitioner keeps the radiation dose as low as possible while still maintaining an image quality sufficient for accurate diagnosis. Constant efforts and improvements are being made to achieve this goal. Over a period of time a number of dental films have been made available to dentists, each with certain advantages and disadvantages.

Radiographic images are produced by exposing film emulsion to x-rays, which are differentially absorbed by the irradiated objects. This absorption varies depending upon the thickness, anatomical number, and density of the structures encountered. Conventional dental x-ray film consists of four elements: [1] base; [2] adhesive layer; [3] emulsion; and [4] protective coating. The film base is made transparent with a slight blue tint, for easier viewing. The adhesive layer attaches the emulsion to the film base. The emulsion (silver halide crystals suspended in gelatin) is coated on both sides of the base. The silver halide crystals are primarily silver bromide, with a small percentage of silver iodide

added to increase film sensitivity. During processing, the emulsion absorbs the processing solutions, allowing the chemicals to react with the silver halide grains. The protective layer is a thin transparent coating used to prevent damage to the emulsion surface during film handling and processing. The interaction of x-rays with silver halide crystals produces a latent image, which is converted into a visible image by the development process.(1)

Intraoral dental films are direct exposure films. Being more sensitive to exposure by x-rays, direct exposure film results in a higher image resolution. Film speed refers to the efficiency with which the sensitive grains in the film emulsion react to x-ray energy. Film speed is determined primarily by grain size; larger grain size results in a faster film speed and requires less radiation exposure. However, the downside of using larger grain film may be loss of some image resolution. The American National Standards Institute (ANSI) and the International Standards Organization (ISO) have developed a standard speed classification for intraoral dental x-ray film.(2,3) Film speeds are rated from A through F, with A being

the slowest and F the fastest. Ultraspeed (D-speed) film has been available since 1955, and is still in use. Ektaspeed (E-speed) was introduced in 1981, followed by Ektaspeed Plus in 1994. Both of these films required approximately 30-40% less radiation exposure. E-speed films are no longer available on the market. Insight, an F-speed film introduced in 2000 by Kodak (Rochester, NY), is the fastest film currently available, and requires 23% less radiation exposure than Ektaspeed Plus film.(4) Flow X-ray (West Hempstead, NY) has also introduced their F-speed film into the market. There is a dose reduction of as much as 60% when switching from D to F-speed film.(5) Kodak Insight film utilizes a patented T-grain emulsion containing flat or tabular-shaped emulsion grains, which collect the x-ray energy more efficiently because of their greater surface area. Thus, less radiation is required for image formation when compared to the rounded emulsion grains utilized in D-speed films. However, the round grain technology has the advantage of providing relatively higher image resolution. A typical skin exposure for D-speed film is about 300 mR (milliroentgens),

and for F-speed about 110-120 mR.

According to Kodak (and many independent researchers), F-speed film shows good contrast and uniformity. This film accommodates a wider range of processing conditions and is exceptionally tolerant of process variations. It maintains image quality as the processing chemistry ages. Exposure time is reduced while film characteristics remained unchanged. No major equipment adjustments are needed to accommodate the processing conditions. Film processing can be done using either manual or automated procedures, as needs require.

Darkrooms must be light tight, and safelight filters must be free from scratches. A Kodak GBX-2 ruby red safelight filter is required; and a frosted bulb of 15 watts or less should be used in the safelight, which should be at least 4 feet (1.2 meters) from the film being processed. An amber or orange safelight filter is not safe for F-speed films.

LITERATURE REVIEW

A number of studies have been performed comparing diagnostic accuracy of various films. Most studies reported no difference in image quality between F-speed and other older films (E and D), while some found D-speed better in certain aspects. Ludlow et al.(4) conducted a laboratory study comparing film speed, contrast, exposure latitude, resolution, and response to processing

solution depletion of three film types: Insight (F-speed), Ektaspeed Plus (E-speed), and Ultraspeed (D-speed). Eight observers were asked to assess resolution of radiographs taken with each film. An average gradient of 1.8 was found with all film types. Both Insight and Ektaspeed Plus were able to resolve at least 20 line-pairs per millimeter. Insight provided stable contrast in progressively depleted processing solutions. The study concluded that F-speed film shows stable contrast characteristics under a variety of processing conditions and reduced patient doses.

Nair and Nair(6) studied the diagnostic efficacy of Ektaspeed (E-speed) film, Insight (F-speed) film, and the Schick CMOS-APS digital sensor with respect to caries detection in 92 proximal surfaces of extracted unrestored teeth, of which 51 were carious. Eight observers interpreted the radiographs and used a five-point confidence rating scale when recording their diagnoses. The results suggested that none of the imaging methods evaluated differed in their ability to detect proximal decay. The authors concluded that the lower radiation exposure required with F-speed film, as compared with the other two sensors in the study, made F-speed film worthy of recommendation.

Another study(7) compared the properties of F-speed film with other established film types (D, E and E-plus), and evaluated the impact of six com-

mercially available processing solutions. All films were exposed under standardized conditions and processed in six different processing solutions. The choice of processing chemistry affected the radiographic characteristics. Film contrast was similar regardless of the film/solution combination. D-speed film had the lowest base plus fog density and the widest latitude. The new F-speed film reduced the patient exposure by one-half compared with D-speed film with no detriment to image quality.

Price(8) performed a sensitometric evaluation of F-speed (Insight), E-speed (Ektaspeed Plus), and D-speed (Ultraspeed) films. After exposure and processing under standardized conditions, film speed and contrast values were determined. Film resolution was also compared by a line-pair object. The results indicated that F-speed film was twice as fast as D-speed. Ultraspeed contrast was found to be marginally greater in the lower density range but was overtaken by both of the other emulsions at high density range. No evidence of deterioration in film contrast or resolution was reported with F-speed film.

A study by Sheaffer et al.(9) reported no significant differences in the ability of endodontic residents to determine working lengths when using D, E and F-speed films. The raters also demonstrated no significant preference when asked to

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rate the overall perceived image quality (desirable or undesirable) of the same images.

Rapid, manual processing solutions are concentrated versions of standard formulations, and have unique effects on film contrast, fog and speed. Bernstein et al.(10) evaluated the quality of radiographic images after rapid processing of D and F-speed direct exposure intraoral film. Five endodontic residents independently evaluated the images for density, speed and contrast. The study concluded that F-speed film can be used with rapid chemistry to ensure less radiation exposure to patients than is required with D-speed film.

In summary, research has shown that evaluators perceive no distinction between D and F speed images of similar contrast and density from the high density and high contrast groups. This is due to the fact that higher contrast exaggerates subtle differences in radiodensity, improving the distinction between objects on dental films. As an image receptor, radiographic film is versatile and serves both as the recording display and storage medium. Conventional x-ray film as an image receptor has remained the most widely used medium for intraoral radiography. Although all D and F-speed films are diagnostically acceptable, F-speed has the advantage of less radiation exposure to the patient and can be recommend-

ed for use in dental offices.

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HSAs carry generous annual contribution limits. The law allows annual tax write-offs equal to 100% of the annual deductible of the individual's high deductible health plan (HDHP). The maximum is \$2,600 for individuals or \$5,150

for families. The cap will rise in subsequent years, indexed to inflation.

People who are 55 to 64 years old can make additional "catch up" contributions, a way to maximize savings before they turn 65. In 2004, people in that age group can contribute an additional \$500. The amount increases by \$100 each year, to \$1,000 in 2009 and thereafter. At age 65, contributions are no longer allowed.

Withdrawals from the accounts are tax-free, as long as the money is used for "qualified medical expenses". The list of qualified medical expenses is very generous and includes vision, dental and other necessary medical expenses some of which are not insured by traditional medical insurance.

Anyone less than 65 who uses the account for anything other than qualified medical expenses will pay a 10% fine as well as tax on the amount spent. People 65 or older may withdraw money for other uses without penalty and pay tax on the withdrawals. However, at age 65 account holders may draw on their accounts tax-free to pay their share of Medicare premiums and co-pays as well as

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Early registration fees are available for attendees who register by May 14, 2004. Early registrants (dentists and dental students only) will be eligible for special prize drawings. Special rates also apply for spouses, guests, dental office staff and nonmembers.

Conference brochures were mailed to member new dentists in February and online conference materials, including registration, are available on ADA.org. Visit www.ada.org/goto/newdentconf for more information.

Contact the ADA Committee on the New Dentist on the ADA toll-free number, extension 2779, or call 312-440-2779 for more information. ●

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James Walter Martin, DDS
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Death: January 11, 2004
Muskegon

Charles C. Irhig, D.D.S.
Birth: March 12, 1931
Death: March 5, 2004
Oklahoma City

Thomas K. Robinson, D.D.S.
Birth: January 24, 1950
Death: March 7, 2004
Miami

William R. Bradford, D.D.S.
Birth: November 29, 1917
Death: February 24, 2004
Durant

Treatment RECORD KEEPING and Insurance

By Carol Tekavec, CDA, RDH

Problems with record keeping continue to be common with state dental boards. The most frequently seen problems of dentists facing board sanctions are quality of care, inadequate records, and financial/insurance disputes with patients. Malpractice carriers often caution their dentist subscribers to use detailed records to avoid malpractice lawsuits. When detailed records are presented at the outset of a case, plaintiff's attorneys may decline to pursue a lawsuit as "unwinnable". Records are also essential for documentation and support with third party payers. Insurance carriers are increasingly using aggressive and adverse utilization review of procedures when dealing with dentists in their networks. Detailed record keeping can protect a dentist against a poor outcome in a utilization dispute. How can a dentist prove that procedures were completed as submitted to a carrier? Only with detailed records.

Record keeping is an essential element of the professional dental office. Detailed records protect both dentists and patients. Patient care and treatment continuity are maintained through adequate charting and recording. This is because the patient record is the office blueprint for treatment, sequencing, scheduling, progress notes, insurance payment, and malpractice avoidance. Whether paper or computer, detailed patient records are the dentist's only documentation and defense for treatment and payment.

Many questions arise concerning what informa-

tion should be included in an adequate record. How records support insurance reimbursement may also be unclear. What follows are some common questions and answers.

- *What information should be included in the patient's medical history documentation?*

A general history should be obtained which includes the patient's ailments and disease history, allergies, reactions to anesthetics, if any, and current medications. A Yes/No format should be used which forces a response to each question. (The Yes/No format reduces the chance that a question will be missed by mistake.) The name and phone number of the patient's physician should be noted, as well as who should be contacted in an emergency. (The emergency contact may be included on the actual medical history form or on a separate patient information form.) Both the patient and the dentist must sign and date the initial medical history form.

If there are health issues with a patient, any consultation with his/her physician should be documented in the progress notes. Patient comments and/or the dentist's impressions should also be included.

An appropriate "medical alert" should be located in a consistent position in the chart. Patient privacy and HIPAA guidelines should always be taken into consideration.

A medical history should be updated periodically. Current thinking suggests this be done at least once a year. The updates should reflect

changes or no changes, and may be included on a form or in the progress notes.

• *I have read that a complete charting of all existing conditions in addition to pathology is required for a new patient. Is a dentist really required to write down all of that information?*

In a word-Yes. The documentation of the initial condition of the mouth and how the patient presents on a first visit are vital to patient treatment, insurance considerations, and malpractice avoidance. A patient's chief complaint or the reason they have sought dental care should be documented. Missing teeth, present restorations and their condition, evaluation of removable appliances as well as teeth replaced and number of clasps, and evidence of a TMJ exam and occlusal evaluation are needed.

Periodontal status should also be recorded. This should include a comprehensive evaluation of the gingival tissues, calculus, plaque, pocket depths, bleeding on probing, mobility and furcations. (Keep in mind that not all documentation must occur on the initial visit. Many offices perform a periodontal screening during the first appointment, with a subsequent appointment scheduled with a hygienist for detailed periodontal charting and documentation. This often works well for patient relations too. Many patients have a limited knowledge of periodontal disease, and may need to be gradually introduced to the specifics of the problem. A periodontal screening, in the format adapted from the Oral Health Unit of the World Health Organization (WHO) has been endorsed by the American Academy of Periodontology. The screening documents pocket depths in a "per sextant" format and focuses attention on conditions warranting a more comprehensive evaluation.)

Documentation of a patient's periodontal status and Case Type (I-V) is also recommended. While

the AAP has developed a different classification system for periodontal disease (Classification of Periodontal Diseases and Conditions-Dec. 1999, Annals of Periodontology, Volume 4, Number 1), many dentists and insurance carriers are still comfortable with the "Case Type" classification.

Documentation of an oral cancer screening is also essential.

• *What information must be included in progress notes?*

Progress notes are vital! They are the only record of what has transpired with the patient. They should include but may not be limited to:

1. Complete description of all treatment and extenuating circumstances written in ink.
2. Anesthetic type, number of carpules, conscious sedation, if used, and percentages. If no anesthetic used, note this as well.
3. Prescriptions and post-treatment instructions.
4. Medications dispensed in the office.
5. Lab prescriptions.
6. Phone discussions with the patient, specialists, or physicians.
7. Informed consent (either with detailed notes or with a treatment specific form).
8. Home care instructions and materials.
9. Documentation of a patient leaving the practice and reasons, if known.
10. Documentation of any records forwarded.
11. Entries signed, initialed and dated by the treating provider.
12. Corrections? No erasures or "white out". Single line through entry only, with reason for change.

• *Are there any guidelines for exposing and documenting radiographs?*

Radiographs are important diagnostic tools. An "adequate" number of radiographs to make an appropriate diagnosis and treatment plan is rec-

ommended. The FDA has published guidelines for prescribing dental radiographs. According to the guidelines, adults who are at "high risk" for caries should have posterior bitewings at 12-18 month intervals. Adults who are not at "high risk" should have bitewings at 24-36 month intervals. The guidelines may be viewed at several websites, among them the American Academy of Pediatric Dentistry site at www.aapd.org/pdf/radiographs.pdf. In general, radiograph exposure depends on complexity of treatment, caries susceptibility, and the amount and type of treatment and time since the last exposure.

Radiographs should be mounted, labeled and dated. ("Older" radiographs may be kept in labeled envelopes). Computerized/digitized radiographs must be appropriately identified.

- *A patient's insurance carrier denied reimbursement for BWS recently. Why?*

Four bitewings (BWS) are used primarily for patients with a full complement of teeth (12 years or older with erupted second molars). Any and all BWS taken with an Intraoral Complete Series (D0210) or Panoramic Film (D0330) are usually considered to be "all inclusive" by dental plans and are not separately reimbursable. BWS are typically reimbursed twice per year, or at six month intervals. A few plans pay only one time per year. With increased utilization review issues, taking radiographs (BWS and others) twice per year because the dental plan specifies that these will be paid, may be a problem. Many plans are requiring documentation in the patient's record of the need for each radiograph exposed, and the diagnosis of findings from the radiograph. Progress notes need to indicate why the radiograph was taken (for example, "suspected interproximal decay, maxillary right and mandibular left"). Then documentation of what the radi-

ographs revealed should be noted (for example, "Interproximal decay discovered maxillary right and mandibular left"). Detailed documentation of the pathology should also be listed in the progress notes or on another form. Future radiographic exposure, even when the reason for the radiograph is documented, without subsequent revealed pathology or "suspicious lesions", may not be paid, or worse, may be paid and then the payments demanded back. For example, if a patient had documented reasons for BWS in 2003 and then again six months later, but no decay or problem is revealed, the carrier may not automatically pay for BWS again in 2004. The patient chart is the best defense against this problem. Document the patient's specific problems, the radiographs taken, and what was revealed by those radiographs.

- *I think that it is outrageous that an insurance carrier can demand payment back for radiographs. What can be done?*

Many patients rely on dental plans to help them pay for treatment they need and want. Most plans are purchased by employers for their employees; your patients. The employer typically buys a plan based on the amount of benefit and how much the premium costs. Few plans cover more than just very basic treatment, and many specify how many of certain types of procedures will be considered during a year period. Plans limit the number of radiographs, cleanings, and perio maintenance procedures they will cover because these are the types of treatments that many people need to have frequently. They cost money.

Dentists who wish to provide treatment for patients covered by dental plans are obliged to furnish documentation that pathology has been diagnosed and treated. Detailed record keeping can accomplish this, and is the only method for

fighting a demand for repayment.

Dentists who do not wish to provide treatment for patients covered by dental plans may opt out of any direct involvement. They may furnish patients with statements and require them to apply for their benefits themselves, regardless of what treatment has been provided. Payments from carriers go directly to the patient – then the patient pays the dentist.

- *What is a treatment plan?*

A treatment plan for every tooth that requires a service is necessary for an adequate chart. The function of the treatment plan is primarily organizational and is considered an essential record element. A treatment plan can be mapped out on a form that provides for initial conditions including present restorations, initial diagnosis of pathology, treatment recommendations per tooth, and any appropriate alternatives. (I will show such a form during my course at the Oklahoma Dental Association meeting on April 30, 2004 or readers may call for a sample record at 1-800-548-2164.)

After the treatment plan is devised, a treatment schedule mapping out the sequence of the treatment should be completed. This is one of the most underused and overlooked areas of dentistry and it should not be. The entire case should be sequenced and prioritized to reflect relief of pain, prevention and prophylaxis, perio and endo treatment, replacements and finally recall. Everyone in the office should be able to pick up a patient chart or access the patient's computer record and discern what treatment the patient has already received and what treatment will be accomplished at the next appointment.

- *What is Informed Consent?*

Informed Consent is actually a process, while we usually think of it as being a form. Informed consent may be obtained by explaining treatment

to a patient verbally, having them agree, and simply documenting the agreement and consent process in the progress notes. However, the legal importance of obtaining informed consent in a written format is becoming more evident. While patients may still argue that they did not understand their treatment, even after signing an informed consent form, it is harder for them to claim this after doing so. Informed consent is said to be required for any treatment that is "not commonly done or easily understood". While this might pertain to just about any dental treatment, it is usually thought to refer to procedures other than standard exams, cleanings and "fillings". With the confusion that can arise concerning the various types of "cleanings" and "fillings", informed consent may be recommended for these procedures too.

Informed consent forms should include recommended treatment for conditions, risks of these treatments, any alternatives and risks and the consequences of doing nothing. Fees should be explained and documented, and all questions the patient has should be noted as being asked and answered. If a patient refuses treatment, this should be documented as well.

- *You mention that fees need to be explained. What is the best way to do that?*

Patients often complain that they do not understand what treatment they will be receiving and how much it will cost. In fact, confusion about treatment and fees is the number one patient complaint with state dental boards. Fees and financial arrangements need to be addressed before treatment begins. Depending on time constraints, this can be accomplished at the end of the exam, at a separate appointment or at the patient's next appointment prior to beginning treatment for that day. A simple written Fee Estimate form can help explain details to patients.

It documents that fees have been covered and supports the informed consent process.

• *How do the HIPAA guidelines impact record keeping?*

Health care providers must comply with the Health Insurance Portability and Accountability Act of 1996. A few basics for dentists might be:

* A dental office needs to have a written privacy policy and provide a copy to patients. The patient's record should reflect this.

* A dental office needs to provide a copy of the privacy policy to staff and document that it has been distributed.

* A dental office needs to make a good faith effort to obtain a patient signature on an Acknowledgement of Receipt of Privacy Practices.

* Information contained in or on patient charts must be safeguarded using reasonable measures, according to 45 CFR 164.530 of the Privacy Rule. This may mean isolating file cabinets or records rooms where patient charts are kept or providing additional security such as passwords on computers maintaining personal information. Whether information is contained within the record or on the outside of a record, access to the record must be limited to those considered appropriate by the health care provider.

The Privacy Rule does not prohibit providers from maintaining patient charts in treatment rooms or outside of exam rooms in "chart boxes", or from displaying patient names on the outside of charts where reasonable precautions have been taken to protect an individual's privacy. Reasonable precautions might include limiting access to patient records to employees of the dental office, limiting access to record holding areas so that non-employees are not able to remove and look at patient records or using opaque boxes outside of treatment rooms.

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* A dental office needs to select a privacy and/or contact officer who will make decisions regarding implementing the office's privacy policy and receive any complaints.

Record keeping and insurance management are very "un-glamorous" aspects of dental office administration. They are often tedious and can seem unrewarding. Keep in mind, however, that accurate records reflect the only legal documentation that an office has for verifying patient treatment and insurance management helps patients pay for treatment they need and want.

Carol Tekavec, CDA, RDH is a well-known author and lecturer on practice management issues and is a presenter for the ADA Seminar Series on the topic of

Update on Record Keeping and Insurance as well as functioning as a consultant for the ADA Council on Dental Practice. She has developed a patient chart, two patient brochures; one on explaining the limited nature of dental insurance, and one on the differences among prophys, root planing, and perio maintenance. She is also the author of the Dental Insurance Coding Handbook-4th Edition which has been updated for CDT-4 codes and a booklet of Informed Consent forms. Still practicing clinically, she is the columnist on insurance for Dental Economics magazine. She may be reached at 1-800-548-2164 or through her company web site at www.stepsingstonesuccess.com.

Carol Tekavec will be a presenter April 30 at the 2004 Oklahoma Dental Meeting in Tulsa ●



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Executive Director Message

By Dana Davis

"Time does fly" when you are having fun! It is hard for me to believe that I have been the ODA Executive Director for over a year. While I am more inclined to focus on the present and plan for the future than to reminisce on the past, my first anniversary has provided me an opportunity to take stock of my first year in Oklahoma both personally and professionally. As I look back on my first year, it is easy to say that the year 2003 was truly about change.

The personal part was easy: golf game bad, golf game worse. Love my new home. I have a new doctor and dentist (You all know him well. Does Immediate Past President ring a bell?) Love the weather. Love the sports. Love the barbecue. Love the people. Love the pace of life. And thanks to so many of you, I am beginning to think like an Okie.

The cover of the Winter ODA Journal featured a Norman Rockwell classic "The Clock Repairman" with the words "A Time to Change for the ODA". That cover and those words summarize my impressions of my first year with the ODA. 2003 was the beginning of the New ODA. A year in which sev-

eral monumental decisions were made that will enrich the future of organized dentistry in Oklahoma.

On the administrative side, the accounting system has been changed to accrual, the annual budget is prepared for the dues (calendar) year, and the financial reporting system includes much more detail about ODA revenue and expenditures. Staff and the Council on Budget and Planning are in the process of developing a 3-5 year financial plan for the ODA. These changes will improve the stewardship of ODA finances and allow us to be more exact in our fiscal forecasts. Additionally, the ODA staff has just completed training to convert our records to the ADA Tripartite system. By 2005 we will be fully converted to the ADA membership system, which is a more efficient membership system that allows for more accurate records.

The ODA has a new contract lobbyist, Scott Adkins, who joined our government affairs team January 1. Scott's skills as a lobbyist will ensure that the ODA has a voice in the state legislature and that the knowledge and concerns of our mem-



bers will be heard when public policy decisions are made. The ODA also has a new legal counsel/advisor, Mr. James Holloman, who is an expert in nonprofit law and has been assisting the ODA Building Committee and Officers. With the addition of this legal expertise the ODA can now be certain that any decision made is legally and financially the best decision for the Association.

Speaking of new help, you have probably noticed the addition of new staff members. This was accomplished by collaborating with our Partners ODAS-CO, DENPAC, and the Oklahoma Dental Foundation to share staff expertise in the areas of membership service, website development, communications, and other administrative duties. Each organization contributes to staff expenses based on the percent of time allocated to each organization.

On the policy/governing side, during the fall 2003 ODA House of Delegates meeting, the House approved the purchase of land at 13th and Stiles and the construction of a new ODA Office building. We are in the process of finalizing the land purchase, rezoning the land, and obtaining a building permit. If all goes well, we should start construction in April. The new office location will enable the ODA to be closer to the Capitol, the Health Sciences Center, and the Board of Dentistry. Most importantly, it will improve our ability to conduct the business of the

Association in a more efficient manner and will be a beautiful new home for our members. In addition to the immediate benefits of the new building, this project also provides us the opportunity to create a concrete legacy for the members of the ODA who will come after us. Our commitment to dentistry in the state of Oklahoma will be unmistakable to the future dentists who will call the new building home for decades to come. We will keep you posted about the building progress through the Journal and the ODA website.

The ODA House also refocused the direction of the Public Relations Program. The new program is now entitled the Public Information Program and all projects were brought in-house. During the first year, resources will be used to enhance the ODA website (www.okda.org). The many new features of the website were highlighted in the Winter ODA Journal. If you have not visited the site, please do so.

We started a new tradition by welcoming home the retired dentists on the third Monday of the month for lunch and discus-

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sion at the ODA Office. The fellowship I have enjoyed with the retired dentists during these lunches has been one of the most rewarding aspects of my first year as Executive Director. The retired dentists of the ODA possess a wealth of information about dentistry in Oklahoma. They are a direct link to our past, and their knowledge and experience helps shape the future of our Association. I encourage any ODA retired dentist to come and join us for what is always a lively event.

Legislatively the ODA scored

a victory for both dentistry and access to care issues. The new statute enables dentists to better utilize their auxiliaries. Dental hygienists and dental assistants are now able to work outside the office in treatment facilities under the supervision of a dentist. Specific details of the new law can be found on the ODA website.

One of my favorite books is "Who Moved My Cheese" by Spencer Johnson, MD. He explains in a very creative story how we will become extinct if we do not change. He tells us

we must remember to "smell our cheese often so we know when it is getting old".

My first year here at the ODA has truly been one of the most exciting times of my career. I am proud of what we have accomplished and I am excited about the future. Thanks to each of you for all your advice, encouragement and support. I look forward to the many incredible goals we will accomplish together, both in my second year at the ODA and beyond. ●

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oral pathology: Target Lesions



Fig.1

Case History :

This 38-year-old white female was found to have a well-defined asymptomatic radiolucent/radiopaque lesion of the left mandible. The area has well defined but irregular margins with a thin radiolucent margin surrounding a radiopaque mass. There was no palpable buccal or lingual expansion of the bone in the area of the lesion. (Fig.1)

Questions:

1. An appropriate radiographic differential for this lesion of the left mandible might include (multiple answers):

- Central ossifying fibroma
- Osteoblastoma
- Idiopathic osteosclerosis
- Condensing osteitis

2. As a health care provider you should (multiple answers):

- Follow the patient with serial radiographs to establish continued enlargement
- Ignore the lesion
- Biopsy the lesion
- Palpate to establish the presence of buccal lingual expansion

3. Tissue was submitted for microscopic diagnosis. At surgery the lesion curetted out

Case provided by: Dr. David M. Lewis

Department of Oral and Maxillofacial Pathology, OUCD

easily in gritty pieces but did not separate cleanly from the adjacent normal tissue. The tissue was composed of fragments of fibrous connective tissue and woven bone. The correct diagnosis for this lesion considering the clinical presentation and histologic features would be:

- Osteoid osteoma
- Benign fibro-osseous process
- Focal cemento-osseous dysplasia
- Ossifying fibroma

Answers:

1. The correct answers would be (a and b) or any entity in the target lesion differential (Fig. 2). Target lesions are radiopaque lesions that are usually circular

Fig. 2

Target lesions:

Central ossifying fibroma
Osteoid osteoma/osteoblastoma

Periapical cemental dysplasia (cementoma)

Cementoblastoma

Some odontogenic tumors:

Odontoma, Ameloblastic fibro-odontoma, Adenomatoid odontogenic tumor, and Gorlin cyst

with a central nidus of opacity and an irregular peripheral radiolucent rim resembling an

archery target. Central ossifying fibroma (a) is an old term for a benign fibro-osseous process that may behave as a neoplasm (unlimited growth) or a reactive lesion (limited growth potential, not neoplastic). These lesions are now classified as ossifying fibroma (neoplastic) and focal cemento-ossifying dysplasia (reactive, see discussion).

Osteoid osteoma and osteoblastoma (b) are rare bone tumors (1% of all bone tumors) that are arbitrarily separated by size (lesions < 2cm are osteoid osteomas and lesions >2cm are osteoblastomas). The histology of both lesions is identical, but it has been shown that the tumor nidus in the osteoid osteoma contains a concentration of peripheral nerves not seen in other fibro-osseous neoplasms.

In addition, the tumor produces prostaglandins that result in significant pain that is relieved by prostaglandin inhibitors such as aspirin. Of those that develop in the jaw, there is a slight mandibular predilection with most occurring in the posterior region. Most occur before the age of 20 years and pain is a common presenting feature. Treatment is by local excision or curettage. The prognosis is good and some lesions will regress even after incomplete excision. A small number will recur and on rare occasions transform into an osteosarcoma. With the pre-

sent case, the lack of pain and expansion would eliminate this lesion from the differential. Answers (c and d) would be incorrect since they do not have a radiolucent rim surrounding a central opaque nidus. They are completely radiopaque lesions (fig.3).

2. Answer (a) follow the lesion



Fig. 3 Condensing osteitis and ideopathic osteosclerosis

radiographically is correct only if the lesion is asymptomatic and non-expansile; answer (b) biopsy the lesion particularly if there is expansion or symptoms, and (c) always palpate bony lesions to establish expansion are correct. Neoplastic processes will usually show some or marked expansion and should be biopsied. Choice (b) would be incorrect. All radiographic lesions need to be followed or biopsied to establish a diagnosis.

3. The correct answer is (c) focal cemento-osseous dysplasia (see discussion).

Discussion:

Since the 1990's the classification of benign fibro-osseous processes has changed and cri-

teria have been established to distinguish between neoplastic processes (ossifying fibroma) and reactive processes (cemento-osseous dysplasias). The current classification of fibro-osseous lesions of the jaw includes the following:

1. Fibrous dysplasia
2. Cemento-osseous dysplasias
 - a. Focal cemento-osseous dysplasia
 - b. Periapical cemento-osseous dysplasia
 - c. Florid cemento-osseous dysplasia
3. Ossifying fibroma

Fibrous dysplasia is a developmental tumor-like condition characterized by a poorly defined, ground glass bony proliferation that has poorly defined margins. This lesion does not have a target lesion appearance and therefore is not part of this differential. The two remaining lesions (cemento-osseous dysplasias and ossifying fibroma) can present with a target lesion appearance.

Florid Cemento-Osseous Dysplasia:

The cemento-osseous dysplasias are considered reactive lesions with limited growth potential, demonstrating minimal or no bony expansion and

once the diagnosis is established require no treatment. These lesions have been divided into three entities, the most common being the focal cemento-osseous dysplasia. Prior to 1990 these lesions would have been misdiagnosed as central ossifying fibroma.

Focal cemento-osseous dysplasia is usually found in a single site of involvement in dentulous or edentulous areas of the posterior mandible. The lesions rarely exceed 1.5 cm in diameter and do not show buccal lingual expansion. Approximately 90% will be in female patients with a mean age of 38 years and a predilection for the third to sixth decades. In contrast to florid and periapical cemento-osseous dysplasias, focal cemento-osseous dysplasia is most commonly found in white patients. When these lesions are found in black patients they may be an early manifestation of florid cemento-osseous dysplasia.

Periapical Cemento-Osseous Dysplasia:

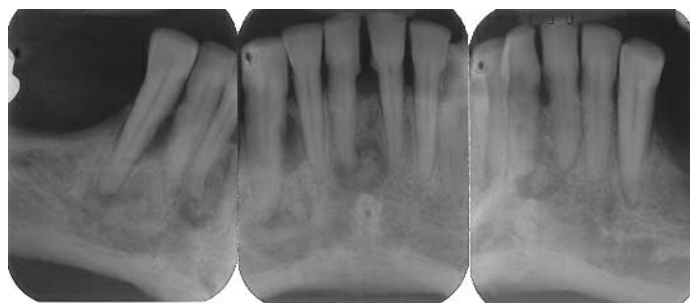


Fig. 4 Periapical cemento-osseous dysplasia

Periapical cemento-osseous dysplasia (fig.4) predominantly



Fig. 5 Florid cemento-osseous dysplasia

involves the periapical region of the anterior mandible with a marked predilection for black females (14:1 females, 70% blacks). The lesions may be solitary but more commonly are multiple. Most patients are diagnosed between the ages of 30-50. The teeth are vital and the radiographic appearance will start with a circumscribed radiolucency and mature to a mixed radiolucent/radiopaque appearance. In the final stages a target lesion is formed with a dense central calcification and a rim of radiolucency. The periodontal ligament is intact and the lesion is not attached to the tooth. Since these lesions are found only in the anterior mandible they can be eliminated from the differential in the current case.

Florid Cemento-Osseous Dysplasia:

Florid cemento-osseous dysplasia (fig. 5) appears with multifocal involvement in the posterior mandible but may include all posterior quadrants and the anterior mandible. The disease may be completely asymptomatic and found on routine

exam or may present with dull pain and alveolar sinus tracts secondary to infection. Rarely are these lesions expansile. These lesions occur predominantly in black females (90%). This lesion can be eliminated from the differential in the current case since the

lesion is an isolated lesion and the patient is white.

Ossifying Fibroma:

Ossifying fibroma is a true neoplasm that can resemble focal cemento-osseous dysplasia both radiographically and histologically. Prior to the refining of the concept of focal cemento-osseous dysplasia during the mid 1990's, ossifying fibroma was thought to be a common neoplasm. True ossifying fibromas are relatively rare with many previously reported examples being focal cemento-osseous dysplasia. Ossifying fibromas occur over a wide age range with most found in the third and fourth decades of life. There is a female predilection with the mandible involved far more often than the maxilla and a predilection for the molar/premolar area. Small lesions may be asymptomatic without expansion however large lesions will show buccal lingual expansion, and may cause facial asymmetry. Pain and paresthesia are rarely found.

Radiographically the lesion is

most often well defined and unilocular. Some show a sclerotic border and varying amounts of calcified material. True ossifying fibromas that are largely radiopaque with a thin radiolucent periphery (target lesions) are uncommon. Root divergence and resorption of associated teeth in the tumor has been noted. Large ossifying fibromas of the mandible often demonstrate downward bowing of the inferior cortex of the mandible.

Most important in the differentiation of ossifying fibroma from focal cemento-osseous fibroma is the findings at surgery. Ossifying fibroma generally permits enucleation of the tumor with relative ease. Focal cemento-osseous dysplasia consists of easily fragmented and gritty tissue that can be easily curetted from the defect but does not separate cleanly from the adjacent normal bone. Recurrence after tumor removal is rare and there is no evidence that ossifying fibromas undergo malignant transformation.

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district reports

Central District News

By Dr. Fred Benenati

A big vote of thanks to outgoing President **Dr. John Biggs** for all of his hard work this past year. Incoming President **Dr. Steve Powell** announced that the Spring meeting of the Central District will take place on April 22, 2004 at the Norman Holiday Inn. It will feature endodontist-oral pathologist **Dr. Steve Baker** from Washington state, and promises to be an exciting meeting. **Dr. Bobby Carmen** recently completed a nine-day esthetic dentistry compendium at Louisiana State University School of Dentistry. **Dr. Percy Bolen III** recently joined **Drs. Roane, Biggs** and **Benenati** in their endodontic practice in Norman. He is a 2000 graduate of OU, and completed his residency in San Antonio, TX. **Dr. Ed Braly** joined **Dr. Perry Brooks** part-time in his oral surgery practice in Norman. On a sadder note, we all mourn the recent loss of **Dr. Gary Livingston**, who passed away after a long battle with cancer. Our heart-felt sympathies go out to his wife and family.

Northwest District News

By Dr. Larry Kiner

The Northwest District Dental Society is pleased to congratulate **Dr. Trent Yadon** of Woodward as the recipient of the Woodward Chamber of Commerce's 2003 Citizen of the Year award. Dr. Yadon has been very active in the Woodward Chamber of Commerce and in a variety of Woodward civic activities. Dr. Yadon has been involved in the Woodward Education Foundation, Woodward Parks Board, United Fund, Lions Club, Leadership Woodward and Leadership Oklahoma. He is also an active member of the First Christian church and its Building Committee. He has also been a 20-year member of the Oklahoma Dental Association, and a 16-year member of the Academy of General Dentistry. He and his wife Krista are the proud parents of three children, LeAnn (11), Will (4) and Natalie (3). Congratulations to Trent on this honor. We are equally proud of his participation in our district and his many efforts on behalf of dentistry for the profession and the public.

In Ponca City, **Phillip Tyndall** has moved into his new office space. **Jim Highfill** reports

that the Kay County Dental group is meeting on a regular basis and have had some excellent programs. Last month, **Dr. Ogundipe**, an oncologist in Ponca City, gave a presentation on cancer therapy and the dental needs of the patient undergoing chemo therapy.

Kurt Gibson in Guymon will be attending the grassroots political action meeting sponsored by the ADA. The Washington Leadership Conference is held in March and gives dental representatives an opportunity to meet with their legislators and discuss pending legislation that affects dentistry.

Dr. Ronald Vaughn, of Guymon, has been elected president of the Northwest District. Dr. Vaughn has been a delegate to the ODA House of Delegates several times and has always been a strong supporter of organized dentistry. His many trips from Guymon to Oklahoma City or Tulsa for dental meetings should shame the rest of us if our attendance is poor.

Chicago will never be the same after a group of Northwest dentists attended the Implant Symposium held there by the American Association of Oral and Maxillofacial Surgeons. Dr. Braly hosted **Trent Yadon, Susan Davis, Kurt Grieshober, Erin Roberts, Lisa Grimes**, and **Larry Kiner**

to the Symposium. As always it was a tremendous learning experience, as was their visit with the Blue Man Group on a night on the town.

Oklahoma County News

By Dr. Tamara Berg

Oklahoma County Dental Society had a wonderful general assembly evening and continuing education course with **Bethany Valachi** in January. Our attendance was the highest of the year. Bethany Valachi speaks around the country on prevention and musculoskeletal disorders for the dental team. She is a physical therapist (her husband is a dentist) giving multiple chairside and home stretches to aid the dental team. Please visit their website at www.posturedontics.com.

February was our annual business meeting and election of new officers and delegates. The installation banquet will be held on Friday, April 16th, 2004 at Quail Creek Golf and Country Club.

President - **Jeff Cohlmi**

President Elect - **Myron Hilton**

Vice President - **Mark Hanstein**

Past President - **Tamara Berg**

New delegates serving a two-year term include: **Phil Abshere, David Birdwell, Jeff Danner, Thai An Doan, Robin Henderson, Grady Lembke,**

Eric Loper, Jeff McCormick, Frank Miranda, Ray Plant, Karen Reed, James Sparks, Jackson Sullivan, Scott Waugh, Pat Woods and Craig Wooten.

Congratulations to **David Shadid** and Lydia on the birth of their son Samuel Aidan on Dec. 16th, 2003 (7 lbs 3 oz and 19 3/4 inches).

Congratulations to **Carol Blossfeld** and Rob on the birth of their daughter Alexandra Caroline on Jan. 30th, 2004 (6 lbs 10oz and 19 1/4 inches).

Tulsa County News

By Dr. Jeff Parker

A great time was had by all at our Holiday Party at the Oklahoma Aquarium with live entertainment provided by the MidLife Crisis Band. Thank you to Angel Tree Volunteers **Drs. Conrad Casler, Mike Kincaid, Doug Kirkpatrick, John Landers, David Pedicord, Scott Wagner, Steve White** and **Ron Winder** who made the "holidays bright" for eight Tulsa area families in December!

We had an excellent Table Clinics program January 27th. Many thanks go out to the commercial exhibitors for their participation and donating some really nice door prizes! Congratulations to the door prize winners:

Dr. Howard Dunlap – 2 OSU Basketball Tickets donated by

Alexander & Strunk

Dr. Wade Sessom – Solution C&B Design System donated by Brasseler USA

Dr. David Wong – \$100 Burkhart Dental Supply Merchandise Gift Certificate donated by Burkhart Dental

Dr. Pam Low – \$50 Gift Certificate to Outback Steakhouse donated by Delta Dental Plan of Oklahoma

Dr. Kathy Beller – \$50 Gift Certificate to Bodean's donated by Dental Power of Oklahoma

Drs. Peggy Merrill, Laurence McElwaine and George E. Ballew each won one day temp service donated by Dental Power of Oklahoma

Dr. Bruce Horn – Free Practice Appraisal donated by Mid-America Dental Sales

Dr. David Marks – Desk Lamp donated by MetLife Financial Services

Drs. Richard Walker and Mike Kincaid each won an Oral B Professional Care Electric Toothbrush donated by Oral B

Dr. Jeff Parker – Patterson LED Curing Light donated by Patterson Dental Supply

Dr. Myron Katz – \$250 Office Depot Gift Certificate donated by POH Company

Dr. Jay Rad – \$25 Gift Certificate to Green Onion donated by Linda Stice-Gill

Dr. Marc Frazier – Two OSU Basketball Tickets donated by SS Wealth Management

Dr. Jerry Greer – \$100

Sullivan-Schein Dental Merchandise Gift Certificate donated by Sullivan-Schein Dental

Dr. Newton Simer – a Leather Binder donated by Terra Telecom

Dr. Stephen Glenn – a Certificate for \$100 off of 1st purchase at IMTEC Corp. donated by IMTEC Corp.

And we had a "full house" to hear **Dr. Bill Robbins'** very informative esthetic program January 30th!

Congratulations to our newly elected TCDS Officers and Executive Committee for 2004-2005:

President **Dr. Mike Kincaid**, President-Elect **Dr. Wade Sessom**, Secretary-Treasurer **Dr. Steve White**, Immediate Past President **Dr. Doug Kirkpatrick**, and executive committee members **Drs. Conrad Casler, Jim Hackler, Mike Hosier, Nick Hunter and David Maddox**. Also, congratulations go out to our newly elected House of Delegates 2004-2006: **Drs. John Landers, Richard Brown, Conrad Casler, Scott West, Jeffrey Johnson, Mike Hosier, Peggy Merrill, Scott Wagner, Jeff Parker, Laurie Southard, Kyle Shannon, Walter Davies, III, and Newton Simer**.

Many thanks to our NCDHM chairperson **Dr. Kimberly Cozort** for organizing activities for our Share-A-Smile program

and February 6th Give Kids A Smile Day.

We are looking forward to our March 9th Awards Banquet & Installation of Officers evening meeting and our March 26th all day C.E. program that will feature **Dr. John Burgess** on "Restorative Dentistry - 2004".

A fun night has been organized by our TCDS Activities Committee for April 29th: TCDS Dental Night - Bedlam Series OSU Cowboys vs OU Sooners at Driller Park in Tulsa. And another spring event that's been set is our June 11th TCDS Molar Open.

Mark your calendars now for three "dynamite speakers" our society has confirmed for our 2004-2005 all day C.E. Programs: Friday, November 12, 2004 **Newton Fahl, Jr., D.D.S., M.S.**

Friday, January 14, 2005 **Charles Wakefield, D.D.S.**

Friday, March 11, 2005 **Gordon Christensen, D.D.S., M.S.D., PhD**

We want to say "Welcome" to our new TCDS Members: **Drs. Richard Stephens, Blake Henry and Kathryn Henry**. Congratulations to Drs. Blake and Kathy on the birth of their 8 lb. 9 oz. baby boy - Hunter Charles - born October 20th. ●

dental organizations

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(405) 424-8092

Oklahoma Board of Dentistry

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Pierre Fauchard Academy

Dr. William Goodman
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Fairland, OK 74343

D-DENT

By Shirley Harris

As D-DENT continues in its mission to help provide free comprehensive dental care for low-income elderly and developmentally disabled, the waiting list for those in need becomes longer and longer, and the outcry for help grows louder and stronger. Therefore, both D-DENT offices stay constantly busy and we would be grateful for any volunteers out there and would appreciate any kind of assistance. The work would not be difficult and would be very rewarding. So if anyone would be interested in helping out in either Tulsa or OKC, please call the OKC office at 800-522-9501 or 405-424-8092.

FORE! It's that time of year again when planning D-DENT's Annual Charity Golf Tournament is in "full swing". Spring is just around the corner and we hope everyone is dusting off their clubs and hitting those links. This year's tournament will be held in early June. We will be mailing further information and registration forms in April.

We will still have the Charity Dinner & Silent Auction in OKC, but it will not be held in conjunction with the Golf Tournament this year. Instead, there will be a separate date to make this a more special affair by itself. In Tulsa, D-DENT plans to hold a "Wine Tasting and Silent Auction" later in the year.

Look for more details on these two upcoming events in the next Journal issue.

The Tulsa Preventive Dental Education Program has a very special presentation to give in March this year. D-DENT's Tulsa Hygienist, **Ren Reyes**, and participating dentist, **Dr. Charles Eiler**, will be volunteering at the 2nd Annual Hispanic Health Fair on March 13, 2004. It will be held from 9:00 am to 1:00 pm at Southwood Baptist Church in Tulsa. We sincerely appreciate Dr. Eiler donating his time to this big event.

D-DENT is always proud of all their participating dentists, but when they do something distinctive, we like to give them extra recognition. Of course the biggest news for the Oklahoma dental world is **Dr. Richard Haught's** election as ADA President. What an honor to have an ADA President from Oklahoma! D-DENT is especially proud since Dr. Haught has also been a participating dentist in our program since its inception.

Everyone probably knows by now that **Dr. Jim Lloyd** is the "official" OKC Zoo Dentist, but there was another wonderful article with some fabulous pictures recently in the Living section of the Sunday Oklahoman. It takes a really special dentist to work on those exotic animals with very special needs. D-DENT is so lucky to have Dr. Lloyd on their team!

"REALITY TV" seems to be

here to stay, and another one of D-DENT's dentists became involved in one of the popular series early this year. **Dr. Jim Spurgeon** of Norman was a SPONSOR for the TV hit "Extreme Makeover", based in California. When the program came to Oklahoma to select a contestant, all the Sponsors held an Open House at Quail Springs Mall the weekend of January 10-11, 2004. What an exciting opportunity!

Once again, D-DENT Board Member **John Gladden** and Delta Dental of Oklahoma stepped up to the plate for Oklahoma dental care by offering PATIENT DIRECT, an affordable fee-for service program that's specially designed to help people better afford dental treatment. This new discount referral program is designed for individuals or the entire family. For a low annual fee you can: access a network of participating PATIENT DIRECT dentists who have agreed to discounted fees, paid at the time of treatment, which can result in savings from 10% to 75%; enjoy no claim forms and no maximums or deductibles; access "Ask a Dentist" on-line to e-mail questions to a dental professional 24-7; receive complimentary vision care benefits from EyeMed; and maintain the choice to use a CareCredit dentist, who is enrolled in a treatment financing program that allows convenient, low monthly

payments, with no interest, low interest and extended payment plans available. This is a wonderful opportunity for so many struggling Oklahomans without any dental or vision insurance!

Alliance of Oklahoma Dental Association

By Judy Keenan

May Day will be the occasion for our State Luncheon at Southern Hills Country Club. Put May 1st on your calendar, register for the ODA annual session and come for lunch. A trolley will shuttle us from the DoubleTree Hotel. We'll have a fashion show and lots of fun and we want you there.

Dental Health Day at the



The Alliance works their magic at the capitol.

Capitol went well as you can see from the nice group in the photo. After meeting with LT. Governor **Mary Fallin**, we distributed dental health kits to each legislator and secretary, reminding them to always consult with the ODA on legislative

matters that concern dentistry. Later, our Board members met for lunch at the ODA Building and had a meeting where we had good reports from our secretary **Susie Taylor**, our treasurer **Melinda Danner** and especially from our Dental Health



Mella Glenn and Judy Keenan visiting the Lieutenant Governor's office.

Chairmen **Becky Baggett** and **Tina King** who had assembled dental health care packets for distribution to the City Rescue Mission in Oklahoma City. The packets included brush, floss, toothpaste and educational materials. In Tulsa, dental health packets were also assembled and were delivered to the Domestic Violence Intervention Service. DVIS was most appreciative. Other agencies will also receive packets.

The Tulsa County spouses have met twice this year. After a reunion Taste and Tell meeting

in November, we wanted to see each other again. In February, **Gretchen Landers** hosted a pot luck party at her home after which we made quick work of assembling dental health packets.

The get-togethers in Tulsa County have been such fun for all of us, old and new. We would wish the same good times for all of you and would challenge you to plan something in your district.

Baylor College of Dentistry

By Elizabeth J. Fulce

BCD FACULTY, STAFF TAPPED FOR LEADERSHIP

Dr. Stanton Cobb (BCD '83), assistant professor of restorative sciences at Baylor College of Dentistry, was appointed to be a peer reviewer for the *Journal of Contemporary Dental Practice* and will evaluate manuscripts for the electronic publication. **Dr. Joseph Chasteen**, editor, made the appointment Jan. 21. For more information, go to <http://www.thejcdp.com>.

Cobb also was appointed to the National Advisory Committee for the medical and dental teaching track at the National Faculty Leadership Conference set for June 2004 in Washington, D.C. This marks the first year the conference will have a track devoted to medical and dental academics.

Ann McCann, associate pro-

fessor and director of planning and assessment in academic services at BCD, was appointed to Procter & Gamble's Dental Advisory Board in October. Members serve on the editorial board of the electronic publication *The Journal of Contemporary Dental Practice* and to peer review its website, The Dental ResourceNet. For more information, go to <http://www.dentalcare.com/drn.htm>.

BCD ALUMNI ASSOCIATION PRESENTS AWARDS

The Baylor College of Dentistry Alumni Association recognized three alumni during the Homecoming Weekend Gala Jan. 10 in Dallas. More than 300 BCD alumni and friends attended the event.

Dr. Chris Cartwright (BCD '78) of Grand Prairie, Texas, and **Dr. David Hildebrand** (BCD '69) of Dallas received the Distinguished Alumnus Award, which honors distinguished service to BCD, the Alumni Association and/or the dental profession. It is the highest award presented by the association.

Dianna Prachyl (BCD'94, '00-DHyg) of Plano, Texas, received the Outstanding Young Alumnus Award, which honors young alumni (less than 10 years post-graduation) who have exhibited outstanding contributions to their profession, community and BCD. Presented for the first

time this year, the award reflects the association's commitment to reach out and include young alumni in the organization's activities.

The Distinguished Alumni Award Committee included: **Dr. Bill Brown** (BCD '53) of Dallas; **Dr. Bob Cederberg** (BCD '79), associate professor of diagnostic sciences at BCD; **Dr. James Cole** (BCD '75), BCD dean; **Dr. O.E. Dickinson** (BCD '54) of Dallas; **Dr. Vernon Nesmith** (BCD '78) of Wichita Falls, Texas; and committee chair **Dr. Ron Trowbridge** (BCD '73) of San Antonio.

The Outstanding Young Alumnus Award Committee included: **Dr. Ernie Brooks** (BCD '94, '96), director of student development at BCD; Cole; and committee chair **Dr. Pam Moore** (BCD '96) of Richardson, Texas.

Oklahoma Academy of General Dentistry

By Dr. Mark Duncan

The Oklahoma AGD has started another year off with excellent clinical education! **Dr. Terry Tanaka** was in town in February for an incredible program on Treatment Planning: Restorative and Prosthodontic Problems. Dr. Tanaka, long recognized as a leader in dentistry, has given an outstanding program on complex treatment issues. The Academy is also hosting a fantastic participation program in

the fall that is a 'must-see' for both the doctor and the hygienist!

We are reluctantly giving **Dr. Karen Rattan** up (we hope temporarily) so that she can dedicate herself to her role as secretary of the ODA. She has been a pillar for the OAGD and will be dearly missed, but share her excitement for her new role with the ODA.

On a lighter note, we are very excited about the newest members of the Board. **Drs. Donna Galier, Rob Muller** and **Randall Haskins** have stepped up to help guide the OAGD toward a brighter future. The OAGD has been recognized at the national level as a constituent that is on the move and the new board members are a key part of that growth. Although the Board is strong, we welcome the input and assistance of all our members and could seat an additional board position. (You're all invited!)

The National meeting is looking to be an exceptionally good meeting with educational opportunities that span the entire breadth of dentistry and a chance to see the original Mickey Mouse! Join us in Anaheim, CA for the meeting July 8th-11th.

If you haven't renewed your membership yet, it isn't too late! Among the many benefits is the journal *General Dentistry*. Each issue is fresh with solutions to issues we all face daily.

Hope to see you in Anaheim!

University of Oklahoma College of Dentistry

By Dr. Frank J. Miranda,
Senior Associate Dean

KIDS' DAY 2004

Our 7th annual Kids' Day was held on Saturday, February 21, at OUCOD. A great deal of planning and effort went into this year's program, which coincided with Children's Dental Health Month. Thanks to the leadership of senior dental students **Jeff Broermann, Michael Baird, Sarah Fox,** and **Gayla Winters** (and others), the day was a resounding success!

Approximately 140 children, including many that did not speak English, received treatment ranging from oral examinations and prophylaxes to restorative care and pulp therapy. Dental students and faculty provided the treatment. At the end of the day, everyone was tired but very satisfied with what had been accomplished.

While everyone contributed greatly to the day's success, a special note of thanks is extended to the College's staff in Central Sterilization and the various clinics who gave up their Saturday to provide necessary assistance. The day would not have been a success without their unselfish hard work! As important as the services provided to the kids were the

smiles and words of thanks from the parents. Kids' Day 2004 was a positive experience not only for the children and their families but also for the College and the entire dental community. A full report on this special day will be included in the next issue of the Journal.

NATIONAL BOARDS - PART II

We are very proud to report that the Class of 2004 had a 100% pass rate on Part II of the National Dental Boards. This is our first perfect score on Part II since 2001 and only the third in the last 10 years. Congratulations to our outstanding seniors!

OMICRON KAPPA UPSILON

At the annual membership meeting of the College's Omicron Pi Chapter of Omicron Kappa Upsilon (national dental honor society) held on January 14, the following five members of the Class of 2004 were elected to membership: **Sarah Fox, Jacob Hager, Kelly Joice, Greg Seagraves** and **Brian Ward**. Elected to faculty membership were **Luis Blanco** (Chair, Fixed Prosthodontics) and **Theresa White** (Co-Chair, Pediatric Dentistry). These seven individuals will be formally inducted during OKU's Convocation and Banquet scheduled for March 27 at the Petroleum Club. The 2004 Dr. William S. Kramer Award of Excellence, given to a rising junior student for out-

standing scholarship and personal character will be presented to **Aaron Bulleigh** (DS-3) during the convocation ceremonies.

ODA/OUCOD LUNCHEON

On Monday, February 23, the Oklahoma Dental Association sponsored its 2nd Annual Faculty Appreciation Luncheon at the College of Dentistry to thank OUCOD faculty for their efforts on behalf of Oklahoma dentistry and education. Well over 50 faculty members attended the catered luncheon. Representing the ODA were **Larson Keso** (ODA Speaker of the House), **Jerome Miller** (President, ODASCO), **Dana Davis** (Executive Director), **Kay Mosley** (Membership Services Staff), and **Brian Houston** (Director of Communications). On behalf of the faculty, **Stephen Young** (Dean) thanked the ODA for its continuing support of OUCOD and once again touted the strong relationship between the school and organized dentistry in Oklahoma.

SCIENTIFIC DAY

OUCOD's 23rd annual Scientific Day will be held on April 27 at the Meridian Convention Center in the Clarion Hotel, south Oklahoma City. Last year, we had 33 table clinics, five oral presentations for the Ishmael Essay competition, and over 300 attendees including students, residents,

faculty, alumni, and dentists and dental hygienists from the community. We invite all dentists and dental hygienists in the community to attend this year's Scientific Day and see some of the excellent research projects our students and residents have been working on, as well as listen to what promises to be excellent and informative oral presentations. A full report on Scientific Day 2004 will be included in the next issue of the journal.

STUDENT/FACULTY RECOGNITIONS

Joseph Cain (Removable Prosthodontics) was inducted as a Fellow of the American College of Dentists during the ACD convocation ceremony held in conjunction with the Annual ADA meeting last October in San Francisco.

The American Dental Education Association selected **Jane Wilson** (Dental Hygiene) as one of the winners of the 2004 ADEA/Procter & Gamble Company Crest Dental Hygiene Teaching Excellence Awards. The award was presented on March 6 during the ADEA Annual Session in Seattle, Washington.

Leon Bragg (Operative Dentistry) has assumed a position as Dental Director at the Oklahoma Health Care Authority effective as of mid-February. Dr. Bragg had served the last six months as the College's

Assistant Director of Clinics.

At the February business meeting of the Oklahoma County Dental Society, **Frank Miranda** (Senior Associate Dean) was elected to the OCDS Board of Directors for the 2004-06 term. Also elected to two-year terms on the Board were **Eric Loper** and **James Sparks**, part-time faculty with the Department of Oral Diagnosis/Radiology.

FALL 2003 HONOR ROLL

We have two honor roll categories for academic achievement: College of Dentistry Honor Roll (GPA 3.00 to 3.49) and Dean's Honor Roll (GPA 3.50 and above). For the Fall 2003 semester, 152 students from the four dental classes earned honor roll status. Space prohibits a full listing, but we do want to recognize our Dean's Honor Roll members: (Class of 2007) **Ashley Adams, Ryan Arnold, Hanh Dang, Amanda Hendrickson, Drew Holloman, Kyle McNatt, Tevi Meek, Grant Pitt, Spencer Sautter, Jared Smith, Byron Tucker, Kyle Vroome, Amanda Ward, and George Zakhary**; (Class of 2006) **Jamie Ariana, Felipe Avery-Miranda, Lauren Avery-Miranda, Neil Ayers, Chase Dighton, Seth Evetts, Cord Fitzgerald, Kimberly Greenlee, Brad Hall, Erin Heathcock, Colin Holman, Doug Huber, Mark Kelly, Jason Knapp, Jennifer Matousek-Ronck, Shane Ragan, Miranda**

Ruleford, Amanda Sengel, Kyle Serfoss, and Jayson Voto; (Class of 2005) **Brooke Bottom, Aaron Bulleigh, Carrie Chastain, Lori Holden, Brandon James, Jake Mendenhall, Jamie Potts, Darek Ridpath, Tommy Rogers, and Eric Tuggle**; (Class of 2004) **Scott Bedichek, Shawn Benso, Deanna Berry, Sarah Fox, Jacob Hager, Kelly Joice, Hugh McDougall, Chris McKinney, Abbey Onan, Elis Papparisto, Nathan Parrish, Adam Pitts, Brant Rouse, Nathan Shapard, and Brian Ward**.

Retired Dentists

By Dr. Sunshine Sullivan-Myers

The December meeting of the Retired Dentists was held in the ODA Building on December 15.

Following lunch, **Wm. Lee Beasley**, President-elect of the ODA, presented details of the proposed new building for housing the staff that will be located at N.W. 13th and Stiles. Plans are to erect the structure in 2004 and take occupancy in early 2005.

Following a discussion and question and answer period, **Dr. John Carmichael** gave an interesting talk about a motor trip he made to several historical sites in Oklahoma. The sites were well-known by events occurring during the last half of the 19th Century, including the "Battle of the Washita" and others.

The February meeting of the Retired Dentists was held at the ODA building, February 16, 11:30 a.m. There were twenty-two members and guests present.



Ms. Dana Davis speaks to the Retired Dentists after lunch.

After lunch, the group was entertained by Executive Director, **Ms. Dana Davis**, who gave us a superb synopsis of her life which began in Ohio where she obtained her college education.



Dr. Sunshine Sullivan-Myers and Dr. Beasley join for a photograph.

Following college, Dana taught Junior High students for three years and graduated with an M.S. in Education. Then she went to Chicago and the ADA headquarters for 5 years. She then moved on to the American School Health Association for 11 years as Executive Director. Later, she was at the American Radiological Society. In 2003, she became the Executive Director of the Oklahoma Dental Association.

Oklahoma State Department of Health

By Dr. Michael L. Morgan
Dental Health Service

Special "Rose Rock Paperweights" were presented to **Tom Reeves** and **Dave**

Apanian during a recent CDC fluoridation training program in Murfreesboro, Tennessee. Tom and Dave have worked as fluoridation engineers at the Centers for Disease Control and Prevention in Atlanta, Georgia for many years and have provided significant help to state fluoridation programs. In fact, the paperweights were presented to them in appreciation of their dedication to fluoridation and for the outstanding service they have given to Oklahoma. Tom retired December 31, 2003 and Dave left CDC and transferred to the U.S. Environmental Protection Agency.

The last few months have been busy with activities in the areas of education, prevention, and care. We had a great deal of activity during National Children's Dental Health Month. Many unique and very effective program presentations were



L to R: Tom Reeves, Mike Morgan, Dave Apanian

made using videos, puppet shows, posters, etc., and toothbrushes and dental floss were given to participating children. Our staff provided dental educa-

tional programs for several thousand children during this month. As in previous years, we included information about the hazards of tobacco use as a part of our dental educational program. I want to thank our staff and the many teachers, dentists, hygienists and assistants who worked with us during this special month as well as those who work with us on projects throughout the year.

The Oklahoma State Department of Health 2004 reportable disease statistics for the reporting period ending January 31, 2004 are published for your information.

AIDS	0
Gonorrhea	209
Hepatitis A	3
Hepatitis B	0
Hepatitis C	0
Syphilis	3
TB	4

American College of Dentists

By Dr. Krista Jones

The American College of Dentists will have their annual breakfast meeting on Saturday, May 1st at the Downtown Doubletree in Tulsa at 7:30am in conjunction with the Oklahoma Dental Association meeting. **Dr. Vann Greer** is getting our speaker for us. Our section voted unanimously last spring to nominate **Scott Waugh** for the ACD Regency V opening. Chairman **Ron Winder** is on the

nominating committee and has made the nomination. We look forward to determining the outcome. Please come enjoy each other, Saturday, May 1st.

Oklahoma Dental Assistants Association

By Linda Bilby, CDA

Spring finds the ODAA very busy planning for our annual meeting, Dental Assistants Recognition Week and board meetings. Dental Assistant Recognition Week was held in March and many plans were made to host receptions and hand out tokens of appreciation to dental assistants through out Oklahoma. Thank you to all of you who took the time to recognize your dental assistant in your office. We appreciate your efforts.

The Executive Board of the ODAA held a board meeting January 17 at the office of **Drs. John and Andrew Carletti** in Sapulpa. Plans were being confirmed and finalized for our Annual Meeting to be held in conjunction with the ODA April 29-31 Meeting in Tulsa at the Downtown DoubleTree Hotel and Convention Center. We have set up some wonderful CE for dental assistants. Please encourage your staff to attend one of our eat and learn breakfasts. Our speakers for the breakfasts are **Dr. J. Butler** and **Sharon Dickinson CDA** from El Paso, Texas. Dr. Butler's title for

his presentation is, "From Integration to Restoration". Please join us for a great meeting and a great time of fellowship. Also, please stop by our hospitality suite to rest your feet and enjoy a cold drink and a bite to eat. See you at the ODA.

Pierre Fauchard Academy Press Release...

Dr. Carl Lundgren, president of the Pierre Fauchard Academy Foundation, is pleased to announce the awarding of almost \$3,000,000 in grants and scholarships since 1996.

Over 720 scholarships have been awarded to dental students who possess leadership qualities. Each of the 54 dental schools within the continental United States is eligible for a \$1,500 scholarship. Outside the U.S. some 28-30 countries have been awarded scholarships, and, in light of a favorable exchange rate, some of these countries have been able to share the money between two (or more) dental schools.

240 to 250 grants have been awarded to dental programs serving the needy. One such program in Massachusetts helps to identify lost or abused children through a dental print program.

Over \$350,000 is available for grants and scholarships in 2004. Grant applications must be submitted by June 1, 2004 (late

submissions will not be considered for 2004).

For further information, please utilize the PFA website, www.fauchard.org or contact:

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