

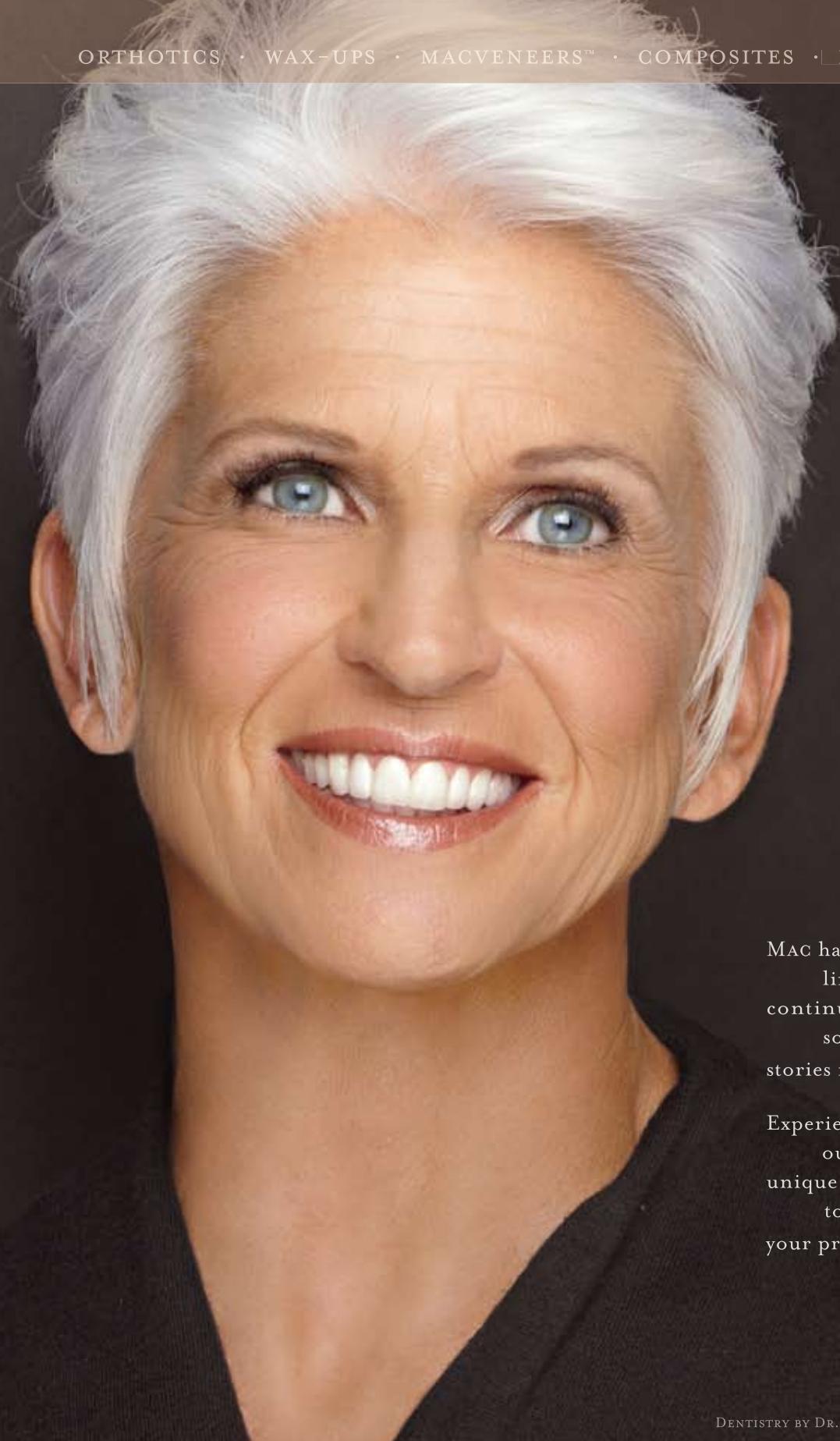
LVI Visions

Implant Dentistry:
What Are the Challenges,
What Are the Solutions?

Wake Up Call:
Soft Skills Drive
Business Performance

Another Bubble?

**The Keys to
Understanding NM, OSA
and PPM Philosophy**
Part I



Emily is an office administrator in Gulfport, Mississippi. She enjoys hiking, biking, water sports, writing poetry and creating beauty in her yard.

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CHANGING DENTISTRY. CHANGING LIVES.

EDITORIAL

SHAMSHUDIN "SAM" KHERANI, DDS, FAGD, LVIM



Is It Dental Care or Health Care That Should Guide Our Professional Care?



"The profession has come a long way from those days however should continue to evolve in order to become more and more relevant to the needs of the public."

As I observed snippets of the all-day televised Health Care Forum that took place live at Blair House across from the White House on Thursday, February 24, 2010, I could not help but begin a debate in my own mind. The debate in my mind was about the dental profession and exactly what its responsibilities are to the public. It was interesting to note that we also have the partisan issues albeit at the micro level compared to the macro partisan issues that were being debated at Blair House that day.

The dental profession, long before it was recognized as a health profession, began delivering necessary services to the public in barber shops. The profession has come a long way from those days however should con-

tinue to evolve in order to become more and more relevant to the needs of the public. Dentists today deliver an amazing plethora of services to the public that incorporate new technologies. So, what do I mean by the statement that the profession needs to evolve further?

What I mean when I refer to this evolution is exactly what the debate was in my mind and that is how much of an impact we can and do have on the entire health of the individual attached to the teeth that we restore. More specifically, I am referring to the following:

1. Balance within the stomatognathic system and its effect on overall body posture, on the health of the temporo-mandibular joint, on the cervical complex, on the

brainstem encased by the cervical complex and most importantly muscular health which can be compromised heavily if these physiologically-alive organs are forced to perform constant work.

2. The effect that poor periodontal health can have on many of the systemic aspects of the human being. I am now referring to the circulatory system, in particular, but it is well-known that there are many other systemic implications of poor periodontal health.
3. The effect that posture and the position of the structural elements along with the physiological responses of such realities have on both obstructive and central sleep apnea, which is prevalent in at least 20% of the American population.

The debate in my mind pointed to the fact that members of the dental profession need to first agree to be more holistic dental practitioners and after that make a concerted effort to learn the ever-changing and expanding body of knowledge that supports a holistic approach. Furthermore, in today's world, one cannot turn a blind eye to the ever-expanding world of technological advancements that help to peel off layers of the onion and look deeper into what is happening in the human body.

There was a time when I thought that knowing how to create great dental aesthetics and being able to create sound dentin and enamel bonding was a recipe for success in serving the patient. The whole arena of maintaining periodontal health was to make sure that the patient was able to maintain the dentition in the mouth for as long as he/she lived. Then came the need to change the habitual centric occlusion as it was the only way to create a much needed aesthetic change for drastically worn down teeth. This also helped with bringing balance within the stomatognathic system by aiding in the protection of the aesthetic porcelain not typically protected by metal (highly non-aesthetic) anymore.

While many dentists have evolved to be good at meeting the dental needs of patients the question still remains: *Are we, as the dental profession, meeting the patient's health needs?* Creating balance within the stomatognathic system, maintaining periodontal health and understanding the relationship between sleep breath-

ing disorders and dentistry is the next phase that dental practitioners must evolve to. And make no mistake that in this continuum, there will be other aspects that will come to surface as time goes on. This means that continuing education as well as contributing to the body of knowledge is going to be our responsibility forever.

The medical community has been helping patients with Sleep Breathing Disorders for a long time and the gold standard for care has been the use of the Continuous Positive Air Pressure units. The problem is that over 60% of the patients prescribed with such units do not use them. The alternative to this non-compliance is the use of a Mandibular Advancement Device which has to be fabricated and fitted by the licensed dentists in tandem with the treating physician. Therefore, this one example underscores the value of a professional relationship among the dentist and the physician. There are many such examples of synergies and unique attributes that are needed to bring our patients to a state of health which will reduce morbidity and mortality. And we, the dental community, play a critical role. We are not just professionals that restore teeth.

In the final analysis, the debate in my mind came to a final conclusion that we, as dental professionals, need to come to terms with the fact that we are "health practitioners" first and "tooth fixers" second. This will require us to avail ourselves the education that we did not get in dental school and one-day weekend courses.

We need to learn about the aspects beyond those that relate to fixing teeth and put into practice what we learn. That is our responsibility as the dental profession. At the Las Vegas Institute, there are courses on how to fix the teeth predictably however; there are also courses that support being the health practitioner first and then the tooth fixer. If you think about it globally, the fixing of the teeth comes at the end after all other aspects of diagnosis and treatment planning have been addressed.

Unlike the Health Care Forum debate at Blair House which ended in a stalemate between the Republicans and Democrats, you will agree that we have a consensus about where our profession, the dental profession, stands. We need to be providing "health" care before we provide "dental" care and that the two must be hand-in-hand.

**Dr. Shamshudin (Sam) Kherani DDS, FAGD, LVIM
Clinical Director**

Sam Kherani, DDS, FAGD, LVIM is a graduate of University of Western Ontario and has been in general practice since 1981 with a special interest in adhesive dentistry. Prior to joining LVI full-time, he served as a clinical instructor at the institute as well as a regional director. Awarded fellowship from the Academy of General Dentistry, and appointed Trustee of Public Colleges Foundation by the government of Alberta, Dr. Kherani is also one of handful of recipients of the coveted Mastership designation from LVI.

Additionally, he currently serves as the Immediate Past President of the International Association of Comprehensive Aesthetics (IACA). As a life long student, he has been exposed to many different philosophies in dental occlusion throughout his 25 year dental career. He teaches dentists from all over the world in the latest treatments for cosmetic dentistry, full mouth reconstruction, and neuromuscular occlusion.

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The Digital Advantage

Mark Duncan, DDS, FAGD, DICOI, LVIF

Patients often approach their dental health with conflicting emotions—they really don't want to go to the dentist, they usually can't recognize any of the reasons for treatment, and they don't have the time to schedule multiple visits. As professionals, we must focus on how to effectively illustrate the facts so patients truly comprehend our reasons for recommending certain procedures. Digital technology provides the opportunity to communicate with patients and colleagues and to improve other procedures around the office as well.

Digital technology provides the opportunity to communicate with patients and colleagues and to improve other procedures around the office as well.



Having used traditional film X-rays since my graduation from dental school in 1995, I was aware that this modality which is one of the most important aspects of the patient's visit, was filled with drawbacks. Diagnosing a case by looking at a 1 inch by 1-1/2 inch piece of acetate was inefficient and frustrating. The quality of the film X-ray was totally dependent on the exposure and processing, and patients had to accept the discomfort of "sharp" and uncomfortable film in their mouths. While a phosphor-plate system felt like a big improvement, when I arrived at LVI, I experienced imaging as it was meant to be. Digital X-rays give nearly instant feedback and almost perfect and consistent quality—something that was missing from my previous radiological experiences.

The information obtained by X-ray is not just for my edification. Patients must be able to understand the value of treatment so that they make the decision to move forward. With film on a light box, it was not unusual for a detail to be smaller than the finger that I was pointing with. Often, I was covering up the problem more than pointing it out. Digital images are displayed on a computer monitor and can be expanded without losing detail. I can also use the inverse function to highlight, circle or colorize areas of concern or put an area in "the

spotlight." Besides a benefit for the patient, I can easily share clear, crisp and clean digital images by email with referring colleagues.

With film, keeping patients comfortable was challenging. Patients dreaded X-ray film's sharp corners and thin edges and perceived them as "cutting." Also, too much time was wasted waiting for developing. Research and development of digital X-ray sensor technology has concentrated on improving these aspects. Our Clinical Affairs Manager, Minette Galura-Boquiren, RDA, notes that LVI's chosen system, DEXIS®, first utilized the Classic sensor and has upgraded to the Platinum. "It is more compact," she explains. "Even one of our patients who hated taking X-rays told me that the Platinum sensor was really comfortable. Patients definitely appreciate that."

The Platinum has beveled corners plus a slimmer case than its predecessor. The shape and positioning of the cable allows the assistant to move the digital sensor around the mouth more quickly and comfortably, shortening the time it takes for a full FMX to just a few minutes. The assistant does not have to disappear to develop the X-rays, and the dentist can allot more time to discuss the case. We have so little time to get patients up to speed on their dental condition; if we can increase the amount of high-quality and purposeful chairside time, that is important.

Here at LVI, we look to digital radiography, and to DEXIS, to gain the best diagnostic result for the patient. After all, this is the reason we clinicians take images at all—for diagnosis. Minette reports, "When the doctors who attend our courses view our Platinum X-rays, they can't believe how clear the images are." We understand that some of our doctors are experiencing live digital X-ray for the first time, and we want them to understand that this is the technology that will be most effective clinically and financially for their practices.

The DEXIS software program also facilitates the speed of X-ray capture. Minette also raves about how "the program navigates for us, helping us



Clinical Affairs Manager,
Minette Galura-Boquiren, RDA

They are durable and so small and portable that we keep them in a little tool box the size of a shoe box.



progress faster. During a course, we can take images on about 20 to 40 patients in one day. Whether the doctors want images for bone grafting, implants, endo, or in case they need to check the margin of a crown or check for the position of a post, taking images is so user-friendly.” She recalls that it took her just two hours

to become trained on the system. “Even if assistants are intimidated by a computer, after a few hours moving through the DEXIS software, they feel like experts.”

Besides the images themselves, assistants appreciate the Platinum sensors’ direct USB connection. “Direct USB makes taking X-rays so much

easier. There are no card readers or bulky boxes; just a simple plug-in to the computer,” says Minette. LVI’s 20 operators share two sensors.

She adds “They are durable and so small and portable that we keep them in a little tool box the size of a shoe box.”

Digital technology also reduces front-office paperwork and increases efficiency. Digital files can be shared with referring

dentists or insurance companies electronically. If someone requests a paper copy, we can send a narrative, digital photos, and an insurance claim form in one file with the touch of a button.

Digital technology has improved diagnosis and education; it offers understanding and acceptance, and makes taking and sharing X-rays easier and quicker. In every aspect of office life, film is yesterday’s technology in such a big way.



Mark Duncan, DDS, Clinical Director

A 1995 graduate of the University of Oklahoma, Dr. Duncan vigorously pursued continuing education to grow beyond what was taught in dental school; twice being recognized as the leader in Oklahoma for Continuing Education. He completed the surgical and prosthetic sections with the Misch Implant Institute earning a Fellowship with the Institute as well as holding Diplomate status with the International Congress of Oral Implantologists. He has also earned the Fellowship with the Academy of General Dentistry in the shortest time period allowed by the Academy. He considers his real advance in education to have started with his journey through the Las Vegas Institute where he earned a Fellowship and currently works full-time as Clinical Director. Dr. Duncan is a member of the International Association of Comprehensive Aesthetics (IACA) and holds a position on the Board of Directors.

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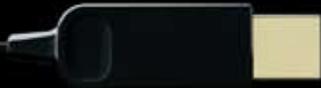


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The most successful businesses have the best ‘people skills.’

Michael Sernik, BDS

New evidence-based, distance training methods are transforming dental practices.

Background

The relative importance of hard skills (clinical skills) and soft skills (people skills) is one of the most studied phenomena in business literature and the evidence is very clear.

Soft skills, which require a high degree of emotional intelligence (EQ), are a greater predictor of business success than the technical skills.

EQ, unlike IQ, can be significantly improved with training.

Most people think of ‘people skills’ as somewhat ethereal and difficult to define or improve.

This is no longer true. Scientific method can now be applied to deliver significant improvements.

What's New.

Social psychology and neuroscience have defined laws of behavior that have added predictability to communications techniques. A whole new vocabulary has evolved with new concepts that make it easier to conceptualize and to teach communications.

Scientific method requires a hypothesis, testing and reproducible results. The PrimeSpeak™ communications system for dentists has unique communications tools that have been applied by several hundred practices and

the results have been monitored on a daily basis for 8 years. When the skills have been applied, the results have been predictably improved. The improvements are consistent in good and bad economic times and over a wide geographical range stretching from North America to Australasia.

The Problem with Benefit Statements, Recommendations, Giving Advice.

In the commercial world, soft skills are often taught by sales trainers using sales techniques. The problem with sales techniques in health care is that any perception of sales by the patient is damaging to the doctor-patient relationship.

Traditional sales techniques have been based on ‘benefit selling’: ‘talking-up’ the positive attributes of what we want someone to buy or do.

Following an examination of the mouth, it is conventional for the dentist to sit the patient up and give them advice.

Studies in social psychology have shown that there is a deep seated resistance to being controlled by anyone else. This resistance to any controlling force is most obvious in teenagers but is evident in all age groups. Teenagers are resistant to all controlling forces.

When a teacher or parent gives a teenager some advice, even good advice, it can trigger anger and resentment. Many neuroses can be ascribed to a resistance to all forms of controlling forces.

Not all patients are hypersensitive to being told what to do, but at a deep level it is always resisted to a degree. It's part of human programming. If we want to ensure we never trigger these types of feelings in our patients we can operate risk free if we learn to give out information in a way that gives the patient a feeling of full control.

We do need to give patients new information. But how can we do this without diminishing the patient's sense of control? Are we capable of informing without sounding paternalistic? How can we influence the patient without making recommendations?

Essentially, the PrimeSpeak exam goes through several broad stages of influence and none of these stages has any benefit selling.

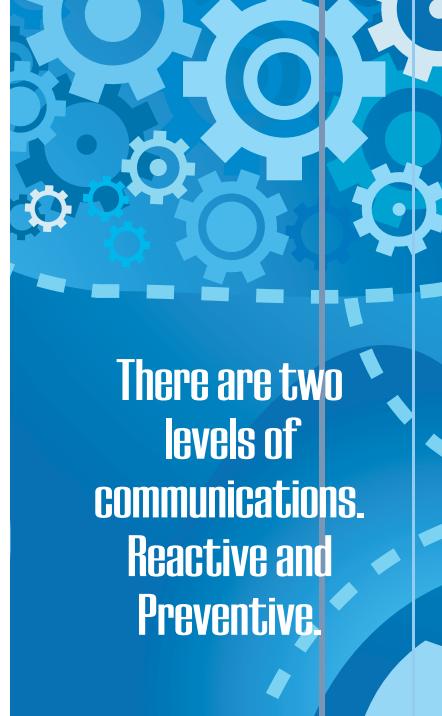
1. The first stage has the clinician gather information from the patient and building rapport. There is no danger of the patient perceiving a sales agenda provided no mention is made of any particular treatment solutions for the patient's condition.
2. The second stage requires the

transfer of information from the clinician to the patient. Patients usually need a degree of dental education in order for them to be able to make intelligent decisions. The focus should be on the damaging results of an existing condition rather than the solution to a problem. This information can be woven into a conversation that is not specifically about this patient, but a general comment about what can happen with this particular condition. We still have not done any benefit selling because we have not talked about solutions and we have not talked specifically about this patient

3. The third stage involves the patient overhearing some charting from clinician to DA. The language used is simple, descriptive and factual regarding what can be seen. No mention is made regarding treatment solutions. Then the patient will be able to see the images and will become involved in a conversation regarding what they can see. Still no mention of solutions and the visible facts are indisputable.

If we have created appropriate concern about the degenerative outcome of their particular condition, the patient is ready for treatment options.

The fourth stage involves going through the various options. The clinician needs a DOTO (Dentists Optimum Treatment Objective) to work towards and to guide the patient to. But the patient must not know the DOTO. We want the patient to feel like this is entirely their decision and we will sup-



port whatever they choose.

The PrimeSpeak clinician would guide the patient through the various options from the suboptimal treatment upwards. The undesirable options are progressively eliminated using a PrimeSpeak technique called 'guild and tarnish'. This leaves the optimum treatment as the natural default. The advantage of the system is we are not sounding like we are selling anything and the patient has been given no proposal to resist. The patient will have ownership of their condition and their solution and the dentist can never be rejected. The optimum treatment is reached by the patient's elimination of alternatives, not the clinician's promotion of benefits.

Challenges.

There are two levels of communications: Reactive and Preventive. It is relatively simple to learn how to deal with a problem that has arisen. Unfortunately, neuroscience tells us that once the patient (or team member) has negative feelings, the cognitive centers

of the brain will follow the emotional lead. In other words, it is very difficult to alter someone's negative feelings towards you. So the objection handling techniques taught at sales courses hardly ever work. The most they do is give you the comfort of having something to say...even though it makes no difference.

Where the big difference lies is knowing how to prevent negativity. Prevention requires a series of steps by the whole team. Seminars are useful for introducing concepts, but the development of skills come from repeated practice and monitoring. Like learning a language or playing a piano, these skills cannot be mastered at a seminar. They require daily practice.

Given that these skills require monitoring and supervised practice over a wide range of scenarios, the cost of daily professional facilitation puts this level of training out of reach for most practices. The dentist is not suited to facilitate the training because the dentist also needs training and is too busy doing clinical work.

Solutions.

PrimeSpeak, has developed a training system called PrimeSpeak Live. A trainer facilitates sessions in real time with several practices, via telephone conferencing and computer desktop sharing. The whole team can participate in 40 min sessions twice a month. Pre and post sessions are supported by a facilitator to ensure skills are implemented daily.

Clients can track results via a web-based reporting system so that the improvements can be validated.

Conclusion.

Soft skills are required for practices that want to prevent resistance and increase patient motivation for comprehensive solutions.

All perceptions by the patient of a

sales agenda can be damaging. Patients are sensitive at a deep level of being told what to do. Communication techniques have been developed that can deepen a patient's concern without taking away any control.

A dental team anywhere in the world can now be trained using PrimeSpeak

LIVE on all elements of practice management.

Daily monitoring and regular personal training can be achieved with real-time conference calls and desktop sharing technology (e-learning programs and off-site training are not required).

Synopsis of the PrimeSpeak LIVE™ training system

There are two plans: Basic and Premium

The Basic Plan:

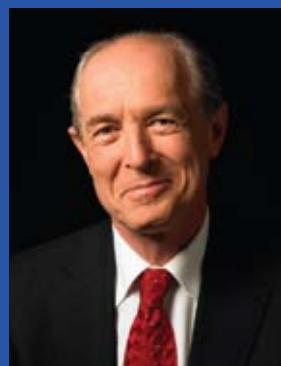
- Participants speak from their office in real time with a trainer via the telephone and using their computer screen they will be able to see the trainer's screen.
- Before and after each session, clear objectives are outlined and the dentist or the team member is given a TIP (Training Implementation Plan) to ensure learning is enjoyable and effective.
- Listen to segments of scenarios of dentist-patient interactions so you can hear how to Never Be Rejected. You will see photos and X rays of real cases and learn how to handle them.
- Each session is deliberately short. (30-45 mins) for minimum disruption to the schedule. Most dentists elect to participate in one session every two weeks but more sessions are optional without extra cost.
- All aspects of dental practice management are covered.
- Access to Dental Photobank™. This is an ever-growing collection of clinical photos depicting the outcomes of sub-optimal treatment.
- One monthly fee covers all of the above.
- Can quit at any time. No locked-in contract period.

The Premium Plan:

Includes everything in the Basic plan plus the following:

- Customized personal coaching. Each client is assigned a Business Coach who will track the practice figures and work closely with each client to ensure the implementation of a customized TIP (Training Implementation Plan).
- Clients receive a personalized annual plan in order to have daily goals and software will graphically highlight the progress of soft skills. This allows the practice to pre-empt problems.
- Staff questionnaire surveys are used to identify gaps. The coach can then assist in formulating solutions.
- Telephone skills audits. After the team has received telephone skills training, audit calls are made and recorded. Clients get a full report with suggestions for improvement. This is all achieved in a positive spirit and with the full support of the team for this training.
- The Prime Bonus system is unlike any other bonus system. It is managed in conjunction with the practice owner and is customized to the needs of the practice. Any practice weakness can be targeted selectively and corrected.
- Can quit at any time. No locked-in contract period.

For more information and to register visit www.primespeaklive.com



Dr. Michael Sernik is a dentist who, after 23 years of clinical dentistry in Australia moved into the world of corporate training and spent 10 years working throughout USA, Canada, UK, and Japan lecturing and training corporations in leadership, management, communications and sales.

As a partner in what is possibly the world's largest dental practice management company, Michael has accumulated a lot of experience in turning practices into successful businesses.

Michael has become recognized as the world authority in the field of dentist-patient communications. His ground-breaking PrimeSpeak Three-day seminars are run in Australasia and North America.

PrimeSpeak has a new delivery format called PrimeSpeak Live which enables dentists around the world to become masters of the PrimeSpeak techniques.

FOCUS ON HUMAN RESOURCES

Ginny Hegarty



Wake Up Call.

Soft Skills Drive Business Performance

The bar has been raised and it is now clear that when it comes to pleasing your patients, emotion trumps logic. Simply doing everything your patients expect of you is not enough to create breakthrough success.

It has been widely accepted that patients are rational people who judge their interactions with your practice analytically and therefore excellent delivery of care will result in satisfied, profitable, life-long patients. A Gallup Organization report published in the Harvard Business Review (HBR) turns that widely accepted premise on its head and reminds us “nothing human is ever that simple. People think that their behavior is purely rational, but it rarely is.”

The Gallup study of a large U.S. retail bank and an international credit card provider found that customers who scored themselves as “extremely

satisfied” actually broke into two sub-categories: those who had a strong, emotional connection to the company and those that did not. The “rationally” satisfied customers had virtually the same spending and attrition rates as “dissatisfied” customers. It was only the “emotionally” satisfied customers that represented growth and profitability to the company – even though both groups reported being “extremely” satisfied. HBR reported that emotional satisfaction mattered most in every study they examined.

The HBR article refers to emotionally satisfied customers as “fully-engaged” customers and reports “Fully Engaged Customers deliver a 23% premium over the average customer in terms of share of wallet, profitability, revenue and relationship growth.” Who do you count on to fully engage your patients – your employees of course. But first, your employees must be fully-engaged themselves.

Your team of employees plays an integral role in building a successful practice in terms of practice productivity and customer engagement leading to profitability. It then stands to reason that fully-engaged employees are the surest route to achieving fully-engaged patients. Any dentist who has been an employer for any length of time will confirm that developing a fully-engaged employee is not as simple as you might hope.

HBR reports “In the United States only 29% of employees are energized and committed at work, according to Gallup Poll Data. Perhaps more distressing is that 54% are effectively neutral – they show up and do what is expected, but nothing more. The re-

maining employees, almost two out of ten are disengaged.”

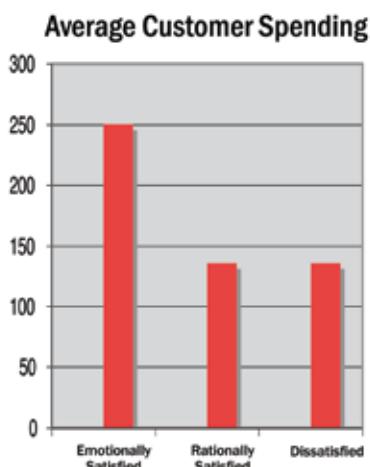
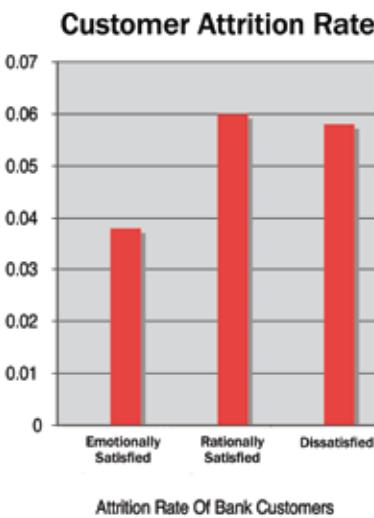
It is no wonder then that dentists, year after year, report that staff/team management is the hardest part of dentistry. It is also easy to understand why so many dental practices that are committed to excellence experience high turnover or are stuck at status quo and cannot break through to the next level of practice success.

The authors of the HBR article concluded “clearly, there is no single solution to pressing business challenges like customer and employee retention, authentic and sustainable growth, eroding margins, and cost efficiencies” but they “are confident that measuring and managing two simple factors – employee and customer engagement – can lead to breakthrough improvements in all aspects of your business.”

As an HR management consultant, I have received countless calls from dentists frustrated by office drama and related staff issues. The most compelling calls are from doctors who are discovering that either a new hire is not living up to their potential or a long-term team member seems to be self-destructing or distancing themselves from the practice philosophy and goals. Continue reading for tools and strategies that can help you breakthrough these roadblocks and enjoy healthy, productive relationships with your team.

Improving Hiring Success.

When choosing a new team member, most dentists pretty much go with their instincts and roll the dice. Hiring is tough; for most it is a crapshoot, a gamble, certainly a leap of faith at

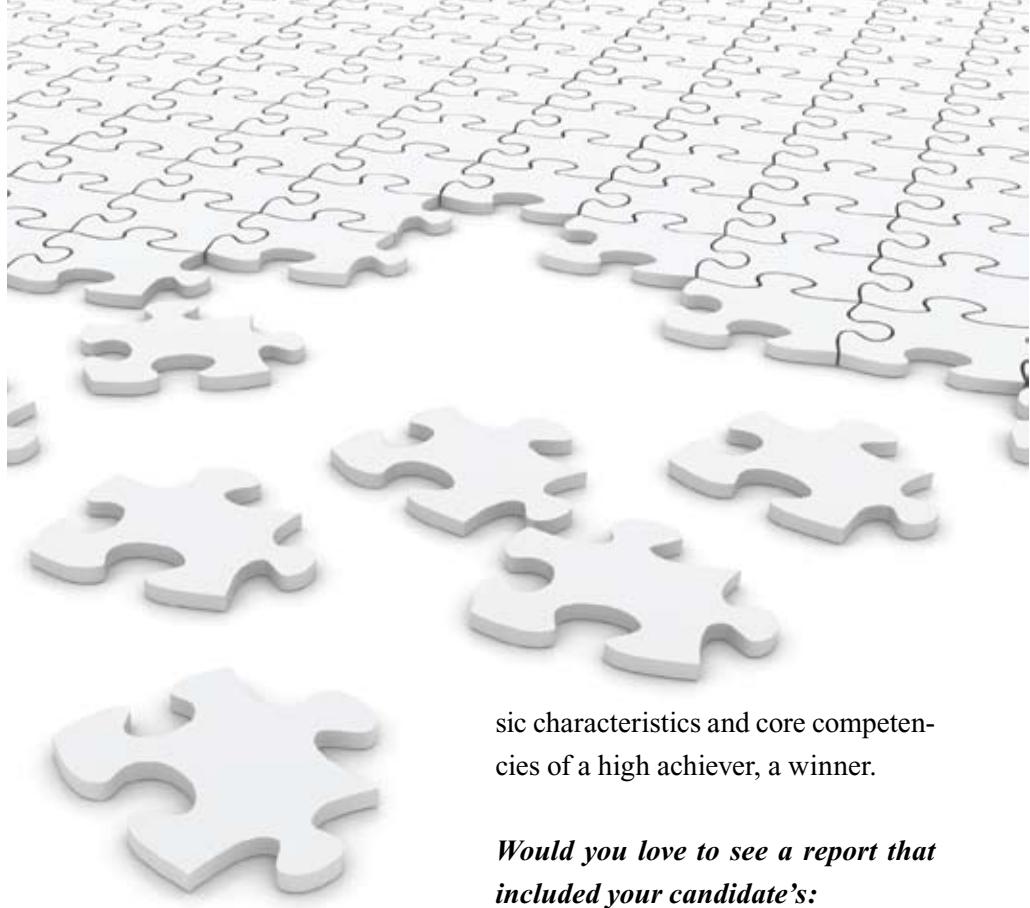


best. Who among us has not made a bad hiring decision? It is inevitable, almost expected, given that most employers and office managers have had little to no training in how to make a good hiring decision. Studies also show that most hiring decisions are made within ten minutes of meeting a candidate and the remainder of the interview process is spent justifying that decision. When the new hire does not meet expectations, many practices then spend years trying to make a round peg fit into a square hole. The result is stress, frustration and lost opportunity for everyone involved.

You cannot possibly know enough in ten minutes to determine if your candidate is the right person for your practice, or if they just know how to interview well. Will this potential hire have the desire, the drive, and the relationship skills to integrate well with the team as a lamplighter or will they be a distraction or worse yet, an energy drain causing serious damage to relationships as well as the bottom line? Will the candidate have the communication skills to serve your clients exceptionally well and continue to build your practice reputation?

In his groundbreaking book *Good To Great*, author Jim Collins lists five basic criteria for determining if someone is in the “right seat” and on the “right bus”:

1. Does this person share your core values? Collins explains you cannot give people new core values half way through life. You need to find people who have a predisposition to your core values.
2. Know when to make a change, and take action. The moment you



feel like you have to tightly manage someone, you have probably made a hiring mistake.

3. Do you believe that this person could potentially be one of the best in the industry in their position? They do not need to be the best now; just have the potential to be.
4. Does this person understand the difference between holding a job and holding a responsibility? Do they get the distinction?
5. If this were a hiring decision all over again, knowing what you do now, would you still hire them?

How incredible would it be if you could see into the future and have the benefit of knowing how well a potential new hire could work with your team and your practice? I am not talking about technical skills; that is the easy part. I am referring to the intrin-

sic characteristics and core competencies of a high achiever, a winner.

Would you love to see a report that included your candidate's:

- Job-specific core competency levels
- Primary personality attributes
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The great news is that this report does exist and also includes the capability to provide you with specific behavior-based interview question and answer guides to determine if the candidate's degree of adaptability will make him / her a good match for both the job and the practice.

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assessment that can be completed online in about ten minutes. Also available is a national database of compiled profiles of proven high achievers including dental administrative team members, clinical assistants and hygienists. Your candidate can be evaluated against this database of winners to see how well they score.

This Integrated Performance Management (IPM) assessment sheds light on the intangibles, on the information that would otherwise be impossible to predict during the interview process. When aptitude, personality and job-match assessments are combined with resumes, interviews and reference checking, the hiring success rate can increase to 75 percent.

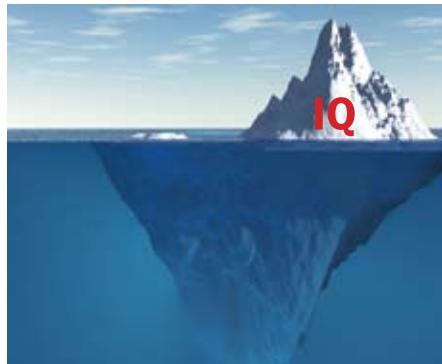
Improving Team Communication And Retention.

Many of you may be familiar with using the DiSC assessment to increase your understanding of your own behavior and the behavior of others, as well as how these behaviors impact your ability to connect and communicate well. I often refer to the Bent Erickson IPM assessment as "DiSC on steroids" since IPM builds on these very valuable behavioral tendencies to give us insight into core competencies, leadership style, decision-making style, energy & stress levels and the all-important emotional intelligence (EQ) levels.

Breakthrough research by Dr. Daniel Goleman revealed that the best predictor of success in life is not education, experience nor personality, but our level of emotional intelligence. While our cognitive intelligence level is stat-

ic and does not grow or develop, our emotional intelligence is fluid and can be developed throughout our lives.

While EQ is responsible for 60-80% of our success, only 1 in 3 of us is aware of our emotions as we experience them. It is no wonder that so many relationships are fraught with



miscommunication and talented teams find themselves incapable of realizing their potential. Most of us feel certain that we are the 1 out of the 3 who is fully aware of our emotions and actions in the moment. Yet, you have personally experienced this gap between emotion and awareness if you have ever, after an incident, found yourself saying things like: "I coulda, woulda, shouda said or done this; it would have been so helpful." "Why did I continue to fume and fuss in anger rather than take control?" "Why did I allow that to happen without taking any action at all?" It is probably safe to say that we have all found ourselves working against our best intentions.

The IPM assessment and team communication guides are an excellent resource and practical starting point to support team building, coaching and communication success. I have had the privilege of coaching both individuals and teams to help them identify and breakthrough their personal barriers to open, effective communication as they develop their emotional intelli-

gence and realize the power they gain when they are in control of their emotions and the power they give away when they are not. Improved practice productivity and profitability are the natural byproduct of this coaching.

Once you have the right people on the bus, remember that it continues to be the soft skills, the communication skills, which will drive performance and increase profitability. Any miscommunication left unsettled more than 24 hours will affect your practice productivity and profitability as it prevents your team from being fully-engaged with each other and with patients.

To break through your status quo and reach new levels of success, you and your team must have the skills to communicate clearly to successfully engage each other and your patients. This is your wake up call, it is a new day and the sky is the limit, so do not hit that snooze button. Make this a wake up call that inspires you to take action.



Ginny Hegarty is a Dental Practice Management Strategist, Speaker, Writer and Coach, passionate about helping dentists and their teams improve their practices and their lives. She is the owner of Dental Practice Development, Inc. and is a certified consultant for Bent Erickson & Associates.

Ms. Hegarty is a featured speaker at LVI as part of Core II & V. Her workshops as part of Dynamic Team Concepts will help your team to recognize and replace the behaviors that can be holding them back with strategies that will improve communication and create positive results for themselves and their practices.

For the past six years, Ginny has authored the Practically Speaking Column in Dental Practice / Products Report. She lectures at Temple University Dental School in Philadelphia as part of the Practice Management Program, and is a member of the Academy of Dental Management Consultants.

Ginny can be reached at 610-873-8404 or ginny@ginnyhegarty.com

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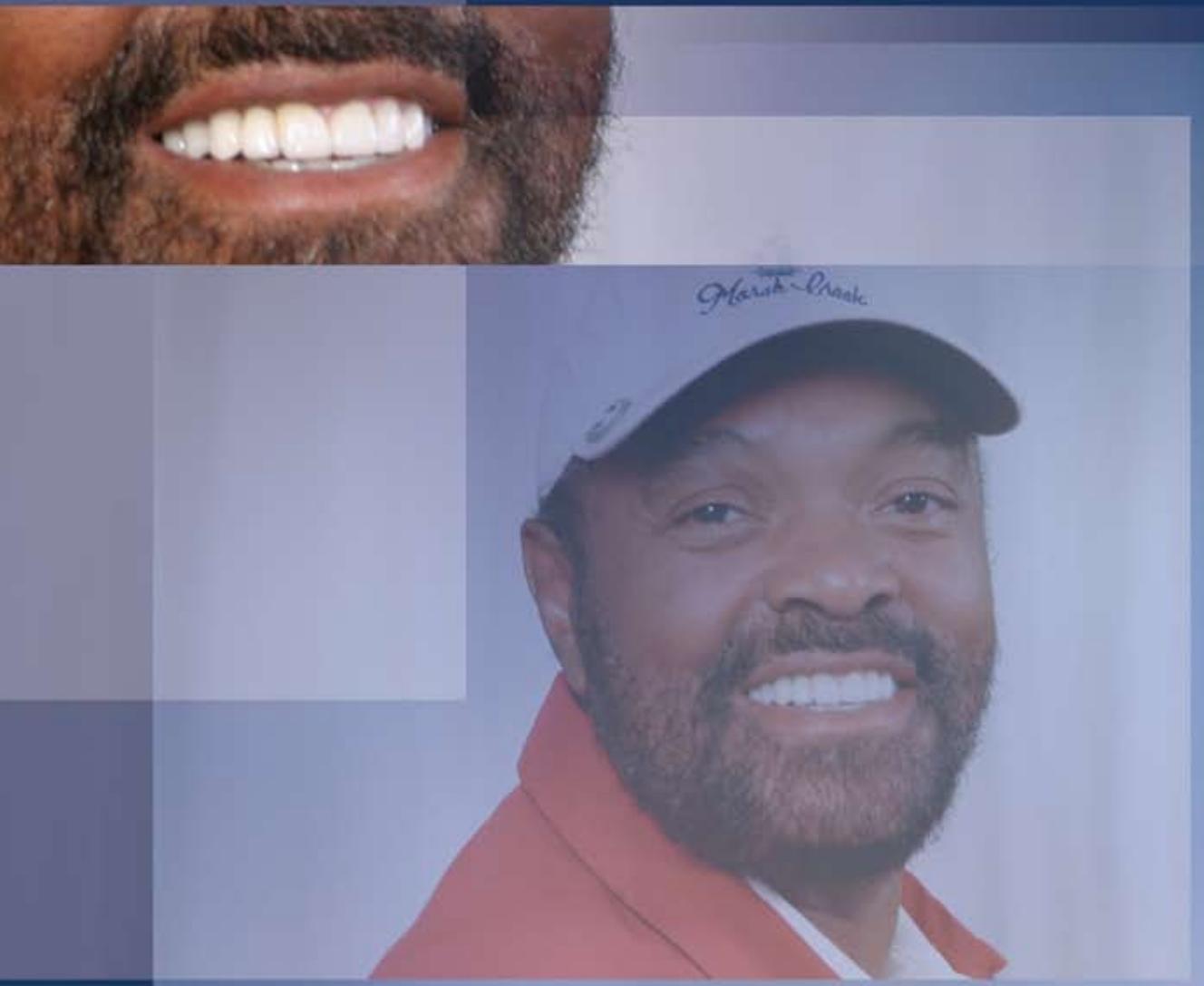
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Using A Lithium Disilicate Material To Restore Fractured Anterior Teeth

Joseph Barton, DMD, LVIM

The passion for dentistry that I feel continues to be fueled by the confidence and trust our patients—guests in our practice—have in my team and me. That trust is supported by the years of research and development that goes into the development of the materials we select when providing our patients with amazingly aesthetic restorations.

One such example is the lithium disilicate material (IPS e.max, Ivoclar Vivadent, Amherst, NY) highlighted in the following case study. The manufacturer of this material, Ivoclar Vivadent, has continued to provide materials that not only provide form and function, but which can be used to create masterful works of art. As demonstrated in this case, the diversity of IPS e.max becomes apparent in its natural tooth-supported and implant-supported restorations, as well as its ability to aesthetically match natural dentition.



Figure 1. Preoperative view of a 61-year-old male patient who presented with dental trauma after being knocked off balance on his scooter and landing face first on the throttle.

Clinical Presentation

A 61-year-old male presented after sustaining injuries from a fall while riding a Vespa scooter. He was knocked off balance by an automobile and landed face first onto the throttle of his scooter (Figure 1). The impact resulted in multiple soft tissue abrasions and three fractured anterior dentition (Figure 2). Tooth #7 had a previously treated root canal, a crown that appeared to be fractured below the gum line, and was deemed non-restorable. Tooth #8 had broken off at the gingival level, exposing the pulp but leaving sufficient ferrule for restoration. Tooth #9 had a clinical crown that was fractured in half without pulp exposure (Figure 3).



Figure 2. Preoperative retracted close-up view of the patient's trauma revealing multiple soft tissue abrasions and three fractured anterior dentition.

Initial Clinical Treatment

The patient was immediately referred for endodontic treatment on tooth #8, and preliminary impressions (Kromopan 100, Lascod) were made for a diagnostic wax-up. The patient also was referred for later extraction of tooth #7 and immediate implant placement at that site.

The models were used to fabricate provisional restorations for teeth #7, #8, and #9. Following endodontic treatment, the patient returned for temporization of teeth #8 and #9 using a bleach white shade of temporary



Figure 3. Radiographic view revealing the extent of the damage.

material (Integrity Temporary Crown and Bridge material, Dentsply).

The crown on tooth #7 was removed. A cantilever bridge was fabricated with an abutment on tooth #8 (e.g., a fibercore post was used as a temporary post in order to support the bridge), an abutment on tooth #9, and a pontic on tooth #7 over the temporarily retained root. The temporaries were seated using a temporary cement (Temp Bond NE, Kerr) (Figure 4).



Figure 4. View of the temporary restorations prior to extraction.



Figure 5. Close-up right lateral view of the patient's restorations.



Figure 6. Close-up left lateral view of the patient's restorations.

Periodontal/Implant Treatment

Prior to the extraction of the root of tooth #7, the provisional restoration was removed. A 4.0 x 15 mm implant (Astra) with a healing abutment was placed immediately (Figures 5 and 6). Allograft putty (RegnerOss) was placed adjacent to the implant. The temporary cantilever bridge was re-cemented (Temp Bond NE) to allow osseointegration of the implant.

Restoration

Once osseointegration of the implant had occurred, the temporary bridge was removed and a temporary abutment (Temp Design, Astra Tech) was customized and placed to simulate the tooth emergence and further support the papillae. New temporary restorations were fabricated to ensure proper papillae formation.

The final impressions were obtained using a fast-set, heavy body polyvinyl siloxane tray material (Aquasil Ultra Heavy Body, Dentsply) and fast-set wash material (Aquasil Ultra XLV wash material, Dentsply). Color mapping and a shade guide (Vitapan 3D-Master Shade Guide) were used for shade selection, which determined that shade 1M1/1M2 with incisal characterization would best match the existing teeth #6, #10, and #11. The die/stumpf selected was ND3 (IPS Natural die material guide, Ivoclar Vivadent).

Restoration Fabrication

A zirconia abutment was fabricated for the implant at the #7 site,

and a vectris post was fabricated for the endodontically treated tooth #8. IPS e.max full-coverage restorations were created for natural teeth #8 and #9, as well as the implant-supported zirconia abutment at #7.

Seating Appointment

A custom vectris post was placed in tooth #8. The post was treated with silanate (Monobond S, Ivoclar Vivadent) for two minutes and then evaporated. The tooth was then rinsed with an antimicrobial scrub (Consepsis, UltraDent Products, Inc.). A universal cement primer (Multilink a+b, Ivoclar Vivadent) was mixed and applied onto the tooth surface for 30 seconds, evaporated, and dried. The post was seated with the self-curing resin cement (Multilink Automix).

The custom zirconia abutment was placed at tooth #7 and torqued to 20Ncm. A direct composite (IPS Empress Direct, Ivoclar Vivadent) in a dentin shade BL-XL was applied over the screw hole and light-cured using an LED curing light (Bluephase, Ivoclar Vivadent).

The IPS e.max crown restorations for teeth #7, #8, and #9 were adhesively bonded into place. First, the teeth were rinsed with an antimicrobial scrub (Consepsis), and the inside of the crowns and zirconium abutment were silanated (Monobond S). A uni-



Figure 7. Close-up view showing tissue response.



Figure 8. Postoperative close-up view of the patient's full smile.



Figure 9. Postoperative portrait view of the patient's final restorative outcome.



Figure 10. Postoperative view of the patient showing off his new smile.



Figure 11. Postoperative radiograph showing the implant with the abutment and crown and the adjacent custom post and crown in place.

"After my motorcycle accident, I was a mess and thought I'd never look the same again. My wife said, 'I just want your beautiful smile back!' So we called Dr. Barton, and he really did give me my smile back!"

versal cement primer (Multilink a+b, Ivoclar Vivadent) was mixed and applied to the natural tooth structure. A self-curing resin cement for implants (Multilink Implant Automix) was then placed inside the crowns, which were seated using firm pressure.

Excess cement was removed using a rubber tip and then light-cured using an LED curing light. After receiving patient approval of the final esthetics, photographs of the definitive restorations were taken (Figures 7 and 8).

Conclusion

During the follow-up appointment (Figures 9 and 10), the patient's occlusion was checked in centric and functional chewing movements, and radiographs were obtained to confirm cement removal (Figure 11). The patient approved of the final esthetics and recalled his pre-treatment condition: "After my motorcycle accident, I was a mess and thought I'd never look the same again. My wife said, 'I just want your beautiful smile back!' So we called Dr. Barton, and he really did give me my smile back!"

Joseph Barton, DMD, LVIM

Dr. Barton received his college and doctor of medical dentistry degree from the University of Florida in 1986. He is an LVI Instructor and has achieved the LVI Mastership award. He teaches dentists from all over the world in the latest treatments for aesthetic dentistry, full mouth reconstruction and neuromuscular occlusion. The past president of IACA, he is a frequent speaker to study groups and associations.



LVI VISIONS



LEO MALIN, DDS

Dr. Malin graduated from Marquette University in 1991, where he received his DDS. He maintains a private practice in La Crosse, WI where he has been utilizing occlusal based dental concepts since 1998.

Early in his career, he discovered that the implant placement techniques used could not deliver a standard, predictable result. Therefore, with the help of other experts in the fields of radiology and occlusion, Dr. Malin developed an implant placement technique which focused on occlusion (and cosmetics) for implant placement and crown restoration. This technique has led to four U.S. patents granted along with exceptional implant results.

Dr. Malin lectures throughout North America on full mouth reconstructions and implant placement. He is excited to share his experience and knowledge of implants with other dentists.

What do you consider your greatest accomplishment in dentistry?

If I had to pick one thing that I'm most proud of it is simply that I'm a much better dentist now than when I graduated from dental school, and I expect that to continue. That statement is not a criticism of my dental school experience. I just simply feel like I've continued to evolve as a clinician only because I've kept an open mind and had a thirst for knowledge and understanding. I am one of those proverbial C.E. junkies and I have learned so much from this profession and my mentors along the way. That educational experience has given me the opportunity to provide clinical dentistry at a progressively higher level from year to year. Certainly my journey required a significant amount of help from others and a personal responsibility; however, it was a journey worth taking.

I vividly remember my first day of practice following dental school graduation. I accepted a position as an associate dentist in a very busy dental practice. On my schedule that day was seven or eight patients, which in itself was a bit daunting. The owner of the practice was out of town leaving me responsible for the hygiene exams in addition to managing my scheduled patients. I recall one of the patients scheduled that day was coming in for a toothache. I was concerned that I may not be prepared or qualified to diagnose the cause of her problem, much less provide a solution for it without some assistance. I realized then that my journey had just begun; I certainly was not at the destination. In 1991, I received a dental degree and a license to practice but I was barely legal. Dentistry at the very least is an ongoing journey.

I have been extremely fortunate during my 19-year journey to come in contact with some fantastic mentors and teachers who helped clear up some of those initial confusions. They continually and effectively offered help and pushed and challenged my responsibility button. As my understanding of clinical and neuromuscular dentistry has evolved, my ability to treat patients at a higher level has grown exponentially. That is what I'm most proud of. Today, not only can I treat occlusal decay but have become a much better overall diagnostician, helping people with occlusal disease as well. A patient coming into the office with significant occlusal dysfunction, chronic pain or chronic temporomandibular

dysfunction is a patient that can be helped. Early in my career I could not offer this patient any help or resolution. This is a fantastic profession and I entered it not having any understanding at all of the impact dentists can have on people's lives. That reward is what continues to drive me in this profession. I know the learning will never stop and that is as it should be. Clinical dentistry will continue to evolve and it's our job as clinicians to evolve with it. Your original question was what I consider to be my greatest accomplishment in dentistry. In short it is simply that I have taken a personal responsibility to evolve and improve as a diagnostician and clinician. I have worked to improve my skill set so that I can provide better care for the patients that select me to be their dental provider. I have been pleasantly surprised at how willing and able my mentors are in assisting me in that mission. I am equally inspired and proud of so many doctors that I see coming through LVI programs on what appears to be a similar journey. There are many fantastic dentists out there continuing to learn, grow and evolve. I am very optimistic and hopeful for the profession that we're in.

*How did you get
into implants?*



Now that's a great question, and I have an interesting answer. I stated earlier that I graduated from dental school and worked as an associate in a private practice for the first year and a half. I then decided I was going to purchase my own practice from a dentist that was soon to retire. I purchased a practice that was full of active orthodontic and implant patients. Here's the kicker: I virtually knew nothing about either discipline. I was literally in trouble. It was a baptism by fire. Dr. Bentz, the previous owner of the practice, was a very progressive dentist and a bit ahead of his time. He was into functional orthodontics and implants when it wasn't very cool or accepted by this profession. Obviously he was criticized for it and survived, and I tried to follow his lead as best I could. I only followed that lead because it was obvious to me that he was right. His patients were genuinely loyal to him and his care because he was determined to treat them in the best way he could. His patients were very well served. It was obvious to him then, and me now, that to run a progressive general dental practice the dentist has to be proficient in implants, orthodontics, endodontics, periodontics, etc. Obviously to run a successful practice a general dentist doesn't have to provide all of those services in-house but certainly a good working knowledge of all the disciplines is important.

My decision to purchase that particular practice forced me into implants and orthodontics. It was one of the best decisions I ever made because it necessitated a response and plan of action. I spent the next few years traveling to many continuing education courses to learn everything I could about implants and orthodontics. Dr. Jay Gerber, who is currently the Director of Neuromuscular Orthodontics at LVI, remembers fondly the panicked phone call that I made to him late one evening in 1993. During that conversation I explained to him that I just purchased a practice with over 100 active orthodontic patients in mid-treatment. Some patients were in orthopedic and/or orthodontic appliances and

other patients were in fixed brackets. I communicated to him that it was my job to complete these cases and that I had no idea what these appliances did much less how to manage them. My question was simple, "Can you help me?" At that time, he and I were complete strangers. Fortunately, for me and my patients, he became a very valuable mentor and friend. All of us, including my patients, survived the experience. My introduction to implants was very similar. The more that I learned and understood about those two disciplines the more interested I became in providing those services. I fundamentally believe that patients in every dental practice deserve those treatment options. A responsible practice will either provide the services or make the appropriate referrals when indicated. I got into the implant side of dentistry in 1993 and stayed in the game because I found it very interesting and challenging at the same time. It was then a much underutilized service in our profession and continues to be today. In fact, one of the passions I have today is to encourage more clinicians to become involved in implant dentistry. I help them acquire the knowledge and the tools needed to succeed at a very high level.

How did you get into Neuromuscular Dentistry?



Honestly that was somewhat by accident. Around the same time that I purchased my original practice, a flyer came across my desk promoting a fixed and removable prosthetic course given by Dr. Bob Jacobson, Dr. Greg Bixby and Mr. Bill Wade. At that time, I had no idea who those guys were or what neuromuscular dentistry was. It was a two-day presentation on fixed and removable prosthetics. I signed up for the course and in two short days was convinced that neuromuscular dentistry had merit. Quite frankly, I was shocked that I hadn't heard about it before. It was very easy to see in that introductory course that these clinicians could do some things clinically with that equipment that I could not do without it. I don't understand how anyone with an open mind, once exposed to this technology, wouldn't come to the same conclusion. I purchased the K-6 I computer at the conclusion of that course and have never looked back. The K-6 I, now the K7, is an irreplaceable piece of equipment in my practice. I could not imagine practicing without it today. This technology in clinical practice is nothing more than a tool. However, that tool dramatically improves one's diagnostic capabilities. The educational opportunities to familiarize oneself with the technology were not what they are today. What took me four or five years to learn back in 1993, I now see being taught to doctors at LVI in 4 to 5 months. LVI's contribution to neuromuscular dentistry and the educational process is quite impressive to say the least. Countless numbers of patients are better served because of LVI's commitment. I personally am very proud to be part of LVI, both as a student and as an instructor. It is currently the pulse and cutting edge of neuromuscular dentistry. Its contribution to the science of neuromuscular dentistry is continually evolving and improving. How can that be a bad thing? It can't.

This leads into the next question; why is it that there seems to be some resistance to what you know is the truth about occlusion and the benefits Neuromuscular Dentistry offers to our profession?



To answer that question I'd like to make just a couple of points, and maybe I am too simplistic but it makes sense to me. First and foremost, I think anyone is entitled to their thoughts, beliefs and opinions. After all, it is their thinking process that constructs those conclusions. We should grant everyone that fundamental human right and freedom. Every individual should have the right to look, observe and evaluate a particular occlusal philosophy and draw a conclusion about its relevance. I expect that freedom for myself therefore I should grant that freedom to others. If someone honestly looks at neuromuscular dentistry and its principles and the science behind it and makes an honest attempt to understand it and at the end of the day rejects it, they're entitled to that opinion. I believe they're confused if that's their conclusion but they are certainly entitled to that conclusion. Here's the fundamental problem. Most of the people that I hear criticizing neuromuscular dentistry have very little or no knowledge of it. They are rejecting something that is a virtual unknown to them. The rejection motivator is likely a vested interest or just a lack of understanding. Criticizing something you don't understand is nothing more than a lack of personal responsibility. It is not unique to neuromuscular dentistry: it's prevalent in society as well. I personally don't pay much attention to the criticism because it's not real to me. My experience with neuromuscular dentistry in the past 15+ years has been tremendously beneficial for my patients. I have treated many patients with occlusal disharmony, chronic pain and temporomandibular dysfunction. I know it works because I've witnessed it in clinical practice over and over again. I can't imagine taking on some of the patients' issues without the diagnostic tools available to me. Neuromuscular dentistry in its most basic form is a way to measure, quantify and balance the teeth, joints and muscles of mastication to help ensure long-term clinical success. The computer and the T.E.N.S. unit are just tools that help us succeed in that mission. Certainly there is some criticism of the neuromuscular philosophy. In my opinion most of it is just a rationalization for the lack of understanding and responsibility on the subject. For me, criticizing the technology and these diagnostic tools makes about as much sense as criticizing an x-ray unit used to aid in the diagnosis of a patient. It is an uninformed argument. I suspect some of the criticism is to protect a vested interest, or possibly an old dental dogma or truism. Effective, successful, clinical treatment outcomes build a very strong argument for the use of this diagnostic equipment. Criticisms from the inexperienced or uninformed are not relevant or particularly useful to me.

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How important is occlusion with implants?

I don't think it's any more or less important than a proper occlusal philosophy involving natural teeth, ceramic restorations, implants or combination of all of these. Occlusion is everything. Long-term clinical success is always dependent on a good occlusal scheme. Certainly overloading an implant prior to complete integration can cause bone loss or complete implant failure. There is an ongoing debate about whether an implant should be restored back to full occlusion, light occlusion, protective occlusion or out of occlusion altogether. I believe that once an implant is integrated it should be treated as if it was a natural tooth and be part of the balanced support in that occlusal scheme. In my practice, when I'm replacing a single tooth or a couple of teeth back into centric occlusion, I generally allow for proper integration of the implant body and then build back into full centric occlusion. It is important, however, to minimize the lateral interferences in excursive movements.

On the other hand, when rebuilding an entire arch or both arches and changing the vertical dimension of occlusion or the AP position, neuromuscular implant dentistry changes the game completely. Using neuromuscular principles to construct the implant case will allow for less splinting of the implants and require fewer number of implants in the arch to ensure long-term clinical success. With this technology, one is able to measure occlusal function, reduce interferences and parafunction to better ensure balanced occlusal forces. Balancing the entire occlusal scheme in an implant reconstruction case significantly reduces the common problems that arise in the implant reconstruction. For example, common implant complications are porcelain fracture, loose abutment screws, implant body or abutment fractures and bone loss around overloaded implants. My experience has been that these complications are greatly reduced if the occlusal scheme is in neuromuscular balance. To answer your question more precisely, implant occlusion is critically important; however, it's also critically important in natural teeth. Proper occlusion is almost always the difference between success and failure, or pain and comfort.

What do you think will be some of the advances in implant dentistry in the future?

The future of implant dentistry is very bright for a whole host of reasons. In fact the future is here; unfortunately it's not well understood and utilized yet. Currently our profession is only serving about 5 to 6% of the patients qualified for implant treatment. In other words only 5 to 6% of people with a missing tooth or teeth are offered and provided implant dentistry. That is a very low number, but at the same time provides a tremendous opportunity to our profession.

To better answer your question let me describe what I think has been the two biggest historical challenges that implant dentistry has faced and in turn, has held it back. The first significant challenge has been placement control. It is very difficult to succeed in implant dentistry if you cannot guarantee proper

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placement of the implant body. Proper occlusion, function and aesthetics are virtually impossible if placement is not appropriate. The second historic challenge in implant dentistry is bone loss around the implant over time. Those two challenges have compromised implant dentistry and challenged its providers for a very long time. In fact those two challenges have kept the vast majority of the dental profession out of the game. The obstacle of placement control has virtually been eliminated with the introduction of CT technology and treatment planning software. That technology has given control to a process that was pretty much completely out of control. Used appropriately, this new technology can eliminate surgical surprise and placement compromise. When this technology was initially introduced it was difficult to access and almost unaffordable. That is changing quickly: the technology is becoming much more user-friendly, affordable and accessible.

The second historical challenge, bone loss around the implant over time, is being addressed as well. Implant abutment connections historically have been a bacterial trap and a major contributor to bone loss around the implant. Moreover, in those clinical cases where the placement of the implant did not allow the patient access to the connection for proper daily hygiene, bone loss was often dramatic. Those cases always resulted in significant crestal bone loss and compromise. There are better connections on the market today which address and solve the significant historic challenge.

The future is also bright in the restorative side of implant dentistry. In the very near future, stock implant abutments from the implant manufacturers will be replaced by laboratory-fabricated, custom, titanium and/or ceramic abutments designed specifically for each individual patient case. The implant abutments will be computer designed and milled with various CAD/CAM and other 3-D driven technologies in the dental laboratory. These technologies are quickly evolving and will certainly enhance the functional and aesthetic capabilities of implant restorations. Complete case-control is possible and improved implant aesthetics from this emerging technology in dental laboratories is just around the corner. All of these advancements will make implant dentistry much more attractive to the dental patient and provider. Laboratory involvement has always been a key component to implant clinical success. The enhanced capabilities on the horizon are exciting because it will solve many of the aesthetic challenges in implant dentistry that we still face. The future of implant dentistry is upon us and it is quite exciting.

What do you think is the biggest problem in dentistry today? What bothers you about our profession?

Now that's a loaded question and I'm going to try and answer it by not sugar coating a politically correct answer. We, as dentists, are by far our worst enemies. It is amazing to me how quickly we can create problems for each other and cannibalize a fellow college. In the 19 years that I've been in practice, I have observed many quality dentists going through a difficult time because





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someone had sued them for something they did clinically. Unfortunately, most of these suits arise from another dentist's criticism of their work. Now I am not naïve enough or delusional enough to think that some of these cases didn't have merit, but I do not understand the motivation to settle clinical difficulties in court. Just seems to me it would be more appropriate and noble to offer help when needed, rather than hitting someone with a big stick. There seems to be no shortage of expert witnesses out there who are very willing to testify against another colleague when it serves their disingenuous purpose. Criticism is cheap and easy. It takes a bit more responsibility to offer help when needed rather than throwing a fellow colleague under the bus. It's perfectly healthy for this profession to have differing viewpoints and spirited philosophical debates. It's not healthy to turn those philosophical differences into personal attacks and legal issues. But, it seems to be the current mindset and mode of operation that our profession is in. It is time for us to grow up.

While teaching the implant and bone grafting program at LVI, I have had the opportunity to work with many quality dentists across North America. Dentists that, with their skill set, should be heavily involved in implant dentistry but are not. The number one reason these dentists are not involved, and may never get involved in their entire career, is because of fear. If they make a mistake along the way, potentially, another colleague would become critical of their involvement and make life difficult for them. Certainly that is not the best way to treat their patient base, but that fear is a reality and most of their patients will not be offered or receive implant dentistry because of the clinician's fear. This is a significant issue within the dental profession which is holding a lot of clinicians back.

How can an average dentist apply the principles that you teach in their practice?

That's quite easy because the implant and grafting courses are designed for the average dentist. Its fundamental purpose is to demystify the implant process and give the clinician complete control of their implant cases whether they do the surgery themselves or refer the surgical phase out of the office. With today's technology, complete case-control is achievable. It requires that solid diagnostic protocols are followed, and if they are, the treatment phase of implant dentistry becomes a mechanical exercise. The average dentist finds it quite easy to apply the principles shared in the implant program. The implant program offers the help and control needed to succeed in implant dentistry at high-level. It is very satisfying to me to watch the doctors understanding and interest grow quickly in implant dentistry as they go through the implant and grafting programs. Most leave the programs very enthusiastic about implant dentistry and make appropriate changes within their practice to incorporate implant services.

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If you could give one piece of advice to all of the dentists out there, what would it be?

Define your personal and professional purpose and put an action plan together to achieve that purpose.

In other words: define what it is, both personally and professionally, that you want to obtain and go for it. Whatever barriers and hurdles you run into push them out of the way and persist through. Do not underestimate your God-given potential. Do not compromise your thinkingness, evaluate thoroughly what you are doing personally and professionally and make whatever changes are necessary for you to achieve those goals. Pay no attention to what someone else may think about it: it's not their game, it's yours. It's your life. It's your journey. You are entitled to your mission and your purpose. Certainly you don't need to ask for permission.

Your dental degree in itself offers you a whole lot of freedom and choice. Professionally, if you're going to provide clinical dentistry, fill your practice with team members that you want to be around and patients that you want to treat. Provide the services that you enjoy doing and refer out or disregard the rest. Moreover, do not resist change. Should your goals and purposes change in clinical practice from year to year, change with it. Remember, it is your game; play it freely and enjoy your accomplishments.

Who do you admire and why? Who are your mentors?

The people that I admire the most in life are the ones that take responsibility for themselves and their environment. Such a person generally injects a positive influence on themselves and everyone around them.

My parents were the first and most important mentors in my life. We are a product of our environment and if I have had any success in life it came from my experience, training and understanding that I was exposed to early in life. I was number 10 in a family of 12 children. I observed my parents raise 12 very successful children. It took a good partnership, a lot of work and significant personal sacrifice on their part to do it, but they were willing to do whatever it took to manage that responsibility. I very much respect their efforts, leadership and personal responsibility. I will be eternally grateful for their example. I hope to have that much success with my wife Lynn and our five children.

Professionally, I've had the opportunity to meet and learn a tremendous amount from several mentors. My true education started about two years out of dental school when I was introduced to neuromuscular dentistry. My mentors included Drs. Bob Jankelson, Jay Gerber, Jim Garry, Mike Mizzacco, Gary Wolford, Norman Thomas, Mr. Bill Wade and Mr. Dick Greenan. All of those gentlemen have had a tremendous influence on how I practice dentistry today. Each has had a significant impact in this profession and certainly has accepted a sphere of influence and responsibility.

You know it's fascinating and I did not realize this until just now; all of those mentors that I previously mentioned I met prior to my initial experience with LVI. Since that time, LVI has had all of those gentlemen on staff as part of the

*The revolution isn't over, it's just beginning.
It's not just implant dentistry that is changing quickly,
it's many aspects of dentistry.*

faculty. I must say that's impressive. No one should be surprised that my most recent mentors are Drs. Bill and Heidi Dickerson, Mark Duncan, Sam Kherani, Kit Weathers and Ron Jackson. All very gifted dentists with a passion for the profession and knowledge they are willing to share. I feel extremely lucky to have learned from all of the above.

*What do you think
the future of dentistry is
and why?*

I'm not sure I know what the future holds. It is not predetermined and will depend a lot on who emerges in leadership roles and how much individual personal responsibility each of us in the profession is willing to accept. It will also depend on how willing this profession is to accept change. Historically that's been a challenging and slow process. In my opinion, old dogmas are held onto way too long and vested interests are too influential. The cosmetic revolution is over and the occlusion revolution is finally coming. It will become increasingly difficult for the masses to ignore neuromuscular dentistry as the science becomes better understood and more accepted. Dentistry will need some more profoundly passionate and influential leaders to evolve. Leaders like Bob Jankelson and Bill Dickerson who were willing to take on the personal attacks to move forward a passion-driven purpose.

The potential future is very bright. Dentistry is full of very talented individuals. Technology is evolving rapidly both in the manufacture and laboratory side of clinical dentistry. The revolution isn't over, it's just beginning. It's not just implant dentistry that is changing quickly, it's many aspects of dentistry. It is honestly a bit challenging to keep up with all the emerging technologies, but it does indicate a healthy energy and future in dentistry.

*Do you have any final
thoughts you would like to
share with the readers?*

Simply this, if I have learned anything in life it is that I can only find happiness in the things that I take responsibility for. That seems to apply to both my personal and professional life. Being critical and irresponsible about something or somebody has exactly the opposite effect, and is a tremendous waste of time and energy. Attitude is everything and it's strictly an individual choice and responsibility.

I would encourage anyone reading this article to simply try and define their personal and professional purpose and take the steps necessary to achieve that goal. Provide and receive as much help as possible on that journey and happiness will be a natural byproduct.



LVI is a great example. It is an individual's creation manifested by taking great responsibility for our profession and its sphere of influence. Bill Dickerson and LVI have had a direct impact on the lives of thousands of dentists, technicians, team members, and the patients that they treat across the globe. It is an institution that provides significant help to dentists and their team members regardless of where they're at in their professional journey. If you have not been to LVI, I would encourage you to give it a try. This institution is unique in the sense that it comprises a fantastic team of full-time faculty, visiting faculty, and a large number of clinical instructors. All of these instructors have the sole purpose of enhancing your career. If you haven't had an opportunity to experience their passion you're cheating yourself of a fantastic opportunity to receive that help. It's simply a decision. Thanks Bill. I thank you for your significant contribution to this profession. I appreciate the opportunity to share some of my thoughts and ideas.

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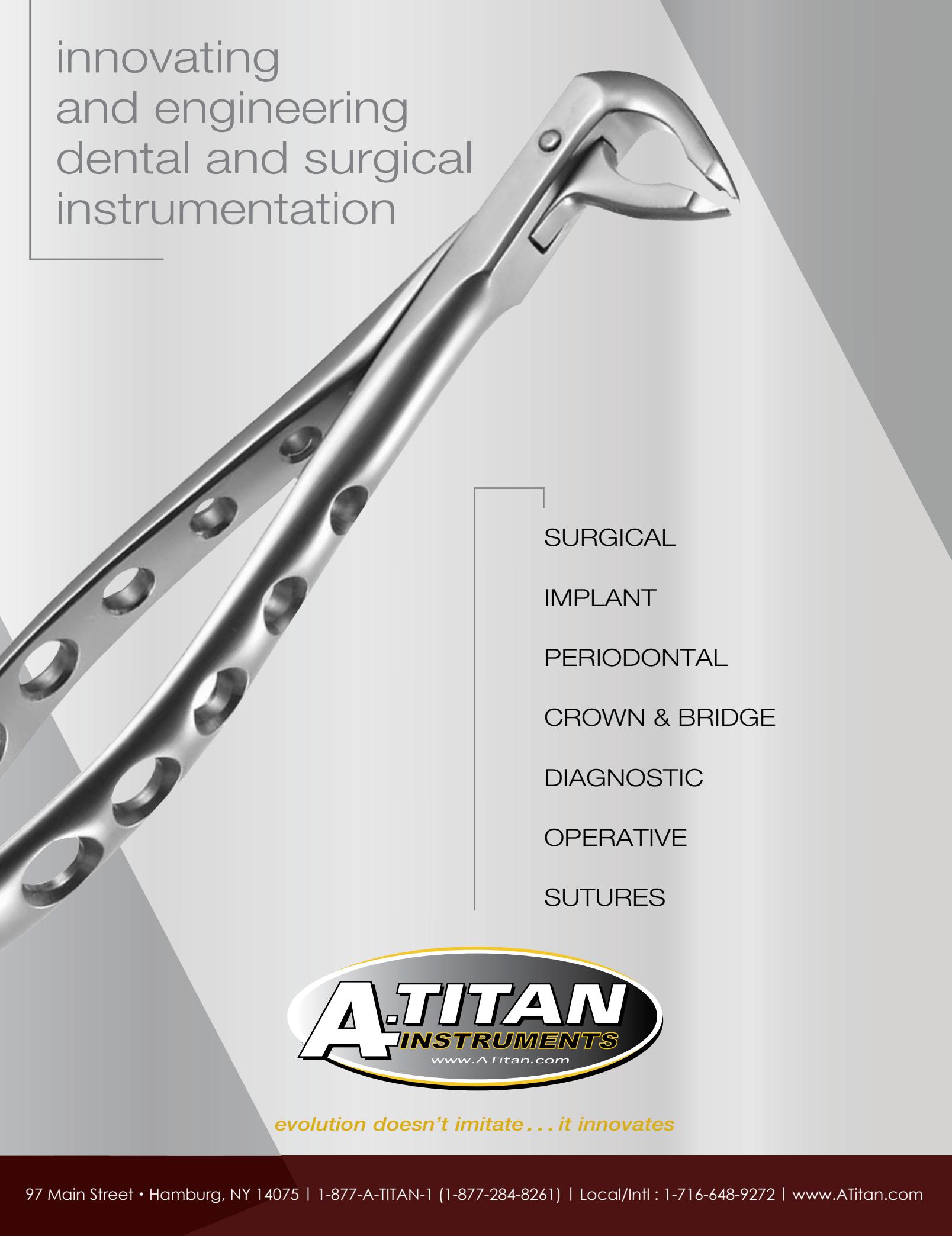
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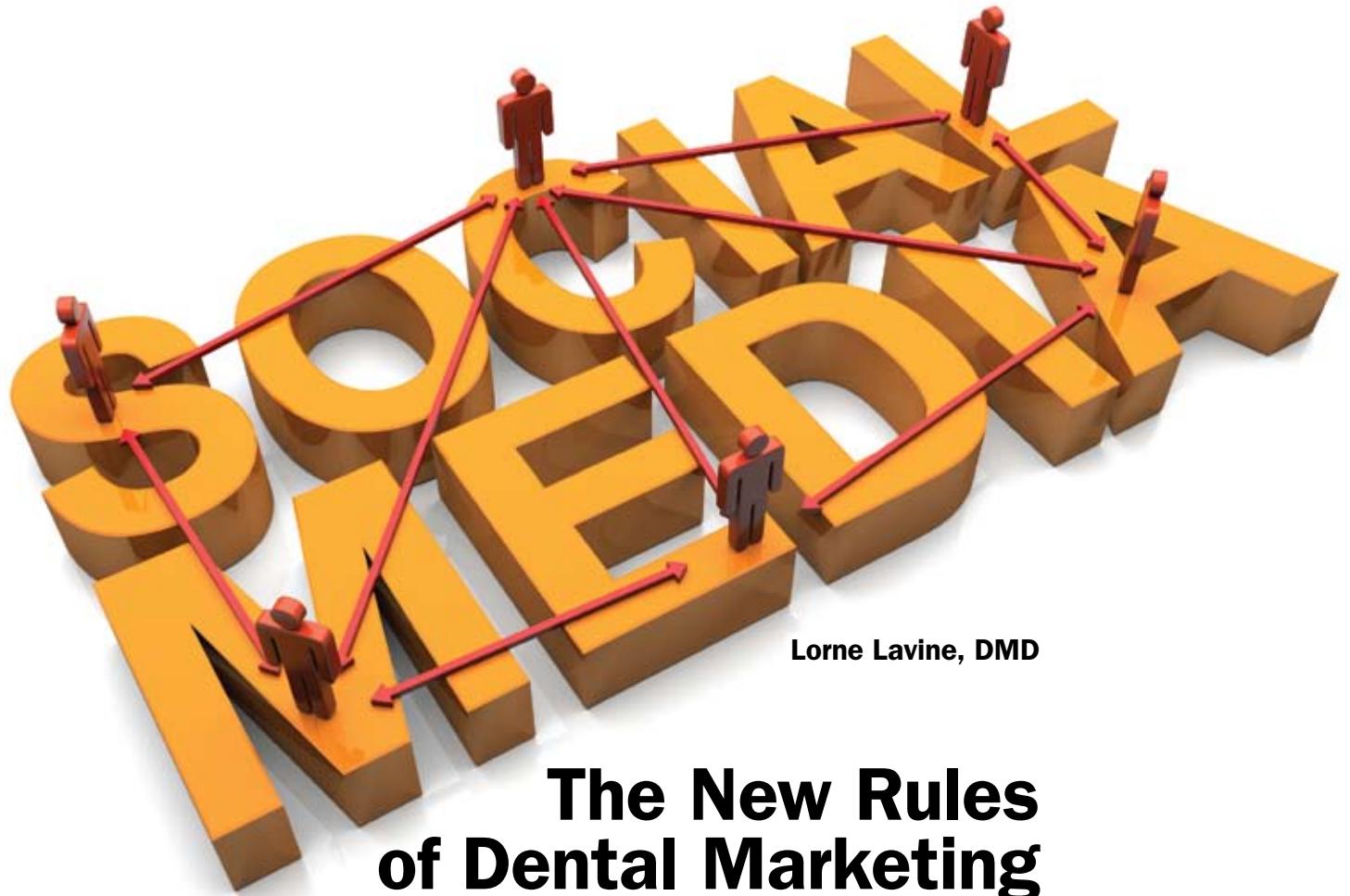
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Lorne Lavine, DMD

The New Rules of Dental Marketing

Many dentists have realized that, since the beginning of the century (21st, that is), the rules or how you market your practice and connect with your patients have changed dramatically. Yellow Page Ads? Postcards? Those are so last century...the name of the game today is social media. Facebook, Twitter, LinkedIn; the list goes on and on. However, it's not enough to just be on these services, you need to learn how to use them to connect with current and potential patients, without turning them off of you or the practice. There's little doubt that the site that gives you the best exposure is Facebook, so this article will focus on that service.

**Just because someone became a fan
does not mean you should send them a message
saying “Buy my stuff today!”**

So, you're the owner of a dental practice and you are trying to figure out the best steps to get on to Facebook to drive new patients. It can be a daunting task and with little extra time in the day, how can you be expected to spend time promoting your business on Facebook? I completely understand the challenges of running a small business as well as a dental practice. After speaking with many other small businesses, I've compiled the following list of strategies that should help ease the process.

1.

Contact Your Fans Directly

While digital media companies and large brands may have thousands upon thousands of fans, most dental practices don't end up with as many fans, especially if they are local. When you first start growing, it's a good idea to interact with each new fan on an individual basis. Send users a message after they've become a fan of your Facebook page. Build a relationship with each fan and they'll become a fan and a customer forever.

Once you build a connection there's a good chance the user will tell their friends. I'll be discussing that strategy further in an upcoming guide. The main point here is that each new fan can be considered a new lead for

a dental office. Selling on Facebook though is subtle and should not be done in an overly aggressive way. Just because someone became a fan does not mean you should send them a message saying “Buy my stuff today!”

Instead, reach out to each new fan individually to welcome them to your Facebook Page and begin a dialogue. Many times these initial conversations will lead to lasting business relationships.

2.

**Create A Facebook Page,
Not New Profiles**

A quick way to get banned from Facebook is to set up multiple accounts and multiple profiles. I have multiple friend requests in my inbox currently from people who've set up separate accounts to promote their business. Don't do this! You can go to <http://www.Facebook.com/advertising/?pages> to set up your own Facebook Page while keeping your existing profile. Under no circumstance should you be creating separate accounts. Not only is it against Facebook's terms, but it provides no additional value.

I could spend more time explaining why this is flat out a bad idea but I won't. It's much better to spend the time focused on the activities you should be doing!

3.

**Go Slow And Steady,
Don't Overdo It**

Any form of promotion is like compound interest. It takes time to build up the residual returns but if you stick with it, the pay off can be substantial. Many people hear that Facebook is a great way to promote their practices but after trying it out for a few days or even a couple weeks, they don't see significant results so they give up and decide to keep paying for Yellow Page advertisements. Who knows how well Yellow Page ads pay off but that monthly check must be going towards something, right?

The difference between Facebook and more traditional promotional channels is that the dentist or a dental team member needs to invest a little bit of time. The extra effort can go a long way and can even provide a rewarding experience as patients begin to provide feedback and communicate directly with you. So, how much time do you need to be spending? Not hours a day! While promoting via Facebook can become an addictive process, you can allocate little more than an hour a week to your promotional activities. While it's never bad to start off enthusiastically, you don't want to waste all of your efforts in the first few days.

**Rather than looking for an instantaneous return,
look at it as a long-term educational experience.**

Build up your fan base steadily and you will begin to see the benefits.

4. Don't Spam

I've written about this before and it never gets old: don't spam your users. As the owner of a blog, I get countless people who try to spam the comments and I've seen the same thing take place on Facebook. Spamming your users with too many links or trying "black hat" tactics to rapidly drive up your Facebook Page fan base is not worth it. Facebook is aggressive at stopping spam and there is a good chance that they'll stop you somewhere along the way, and it can potentially cost a lot.

5. Consider It An Educational Experience

Rather than looking for an instantaneous return, look at it as a long-term educational experience. As you improve your strategy, you'll attract more fans. It takes time to master Facebook promotion and time to reap the rewards but the payoff can be significant. The main point of this rule is clear: stick with it for the long haul. If you blow out your budget in the first few days and expect to have a massive

response, you will be seriously disappointed. Learn from the experience, take notes, and improve your strategy over time. It may sound like a lot of time but you can do much of this in as little as 15 minutes a day. One other benefit of considering it an educational experience is that the whole process is deductible in your taxes.

You can write off the expenditure as advertising or education (you need to speak to your accountant to determine the best way to file an entry for this).

6. Limit Your Advertising Budget

As I just mentioned, more dollars on advertising does not always mean more revenue. Start off with a few dollars a day to test out Facebook's advertising system. You can create a small ad to test out all of Facebook's targeting capabilities. Make sure that if you are spending money that you're investing in some long-term goal, otherwise you'll end up spending a lot of money aimlessly. Trust me, I know from experience! As your performance improves and you figure out which ads work most effectively you can begin to steadily increase your ad spending.

Figure that you'd spend a few hundred dollars on a Yellow Pages advertisement so be willing to test out

a similar budget on Facebook. If all goes well and your business starts to increase, you can always invest in more advertising as necessary. As I mentioned earlier, this is an educational process and with so many resources on the internet, learning has never been cheaper. Don't spend all your money when you don't have to! To most effectively manage your budget, start off with one Facebook advertising campaign which has a limited budget. For all of the initial ads use that same campaign rather than creating separate campaigns for each advertisement.

7. Use Coupons And Other Incentives

Now that you've got a Facebook Page, some ads running, and a few fans of your Facebook Page, what should you be doing? In addition to engaging users on Facebook, you also want to get them to become patients or get more services from the practice. Keep in mind that the incentives you use depend on the type of practice you are running. For example, some dentists may have price sensitive customers, and special deals may be an incentive to make a purchase.

There are plenty of other creative incentives to drive people back to

your page and to your business so test out different strategies and see which work best.

8.

Emphasize Mobile Subscriptions

One of the best components of Facebook Pages is the ability to receive updates via your mobile device. Once updates come to your phone you can also reply to the updates, making it possible for instant two-way communication. It's a model similar to Twitter except that on Facebook Pages you get more features for engaging users. The mobile component is an additional layer of interaction which can be used to build relationships with your new and existing customers.

Facebook is a relationship marketing platform, not a direct sales channel. That's why it's important to build your relationship with others through Facebook. Configure your Facebook Page to function with your current mobile device and communicate with users while on the go. This can make for some great, instantaneous dialogue.

Ultimately most internet based promotions are going the way of mobile, and it is in every business's best interest to take advantage of that trend; including on Facebook.

9.

Post Occasional Entertaining Statuses

Ask your patients this: When was the last time you saw an update from your dentist in your news feed? You probably never have and you may even find it strange to see one, un-

less of course it was a funny joke. For example if the dentist posted occasion updates about eating candy and junk food in general, you may get a quick smile and possibly even post a status update. Whatever the response, at least you are getting one, which is one additional level of interaction that you never previously had with your customers.

Keeping your fans engaged is an important component of any good Facebook strategy. How much time does it really take to come up with a clever status update? If you're like me, then catchy ideas occasionally pop into your head (or at least ones that you think are clever) when you are on the go. If you've properly configured your Facebook Page to work with your mobile device, you can in-

stantly update your status while on the go.

It takes very little extra effort to bring a smile to your fans and it's something that they'll remember.

Conclusion

Every dental practice can take advantage of the promotional opportunities that Facebook presents. By using some of the tips listed in this article, dentists can get a great start on promoting their practice on the site. While there are many other strategies to increase the number of fans you have on the site as well as drive new business, much of that can be learned through experimentation. The best thing to do is to get started and figure it out from there!



Dr. Lorne Lavine, founder and president of Dental Technology Consultants, has over 26 years invested in the dental and dental technology fields. A graduate of USC, he earned his D.M.D. from Boston University and completed his residency at the Eastman Dental Center in Rochester, NY. He received his specialty training at the University of Washington and went into private practice in Vermont until moving to California in 2002 to establish DTC, a company which focuses on the specialized technological needs of the dental community.

Dr. Lavine has vast experience with dental technology systems. He is a CompTia Certified A+ Computer Repair Technician, CompTia Network+ certified and will soon be a Microsoft Certified Systems Administrator. As a consultant and integrator, he has extensive hands-on experience with most practice management software, image management software, digital cameras, intraoral cameras, computers, networks, and digital radiography systems.

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Ask Heidi

Q

Dear Heidi,

Our doctor takes us to ONE dental meeting a year...do you have any recommendations for us? We've had a bad winter here in Wisconsin, and are ready to make some plans! Thanks for your advice.

C.Z.

Neenah, Wisconsin

A

Dear C.Z.,

The one dental meeting I cannot say enough about is the IACA. This year it is held in Boston, MA. The dates are July 22-24, 2010 at the Westin Boston Waterfront. Everyone that attends is fired up about learning. The environment is fun and the meetings are always jam packed with courses that will make a difference in your practice. You can check out their website at www.theiaca.com. You will not be disappointed.

Hope to see you there,

Heidi

Q

Dear Heidi,

I would really like to update my techniques when it comes to impression taking. We do many big cases in our practice from quadrants to full arch dentistry. Many colleagues have suggested digital impressions. Unfortunately, I don't know where to start with this. Can you explain how this works and a good system out there?

P.S. I am not very technical...so keep it simple if you can.

Thank you,

Dr. Cohen

Escondido, CA

A

Dear Dr. Cohen,

I applaud you for updating your techniques and procedures. As all of you know, I am a firm believer in education and in advancing our skills. I can only give you advice on what I truly think is the best system in my own hands and from my own experience.

Here at LVI we teach quadrant, full arch, and full mouth restorative procedures. These are only a few of the 35 different post graduate courses offered on our campus. I have had the opportunity to utilize digital impressions on many patients and have seen the amazing results. With that in mind, here it goes:

We all know the success of our restorations depends on an accurate impression. The more accurate, the better the fit...that is a given. However there are other things to consider when getting into a new technology...such as: how it works, ease of use, cost, and what can it really do?

My favorite digital impression system out there is Cadent's iTero. It takes digital impressions by confocal imaging and uses laser and optical scanning to do so. Basically, it digitally captures all images. Here's how it works: you take a digital scan of the teeth and the bite...this goes via a wireless internet connection to a Cadent-partnering lab for further processing. Then the digital file goes to Cadent and the model is milled, and this model then goes to the lab to be used for the final restorations.

It is easy to learn and to use. If I can ...YOU can! There are no powders involved and the training you receive is priceless. It saves time in your office as you do not have to take standard impressions. You can visualize your preps in a 360 degree image and correct any areas prior to imaging. The data files are sent out to the lab; therefore, no more lab slips and boxes to send out.

These digital impressions can be used to fabricate models for single units, inlays, onlays, veneers, crowns, bridges, implant abutments, and more.

I have used the iTero for single units, full arches, and yes...even in a full mouth case! The results were phenomenal and the units fit so accurately it blew me away!

I am an avid fan of the system. Not only are the marginal results excellent...it is fun to use and a great adjunct to my practice.

I hope this helps you. Try it for yourself and see what you think. It's worth looking into.

Heidi



Dear Heidi,

Our computer keyboards have a plastic key cover on them. We do this for infection control reasons and there have been episodes of “coffee spillage” as well. We decided in 2010 to take a look at the office and update things. As we walked around the office, I noticed how yellow and kind of gross these shields are looking! Is there anything better out there?

Barb

Savannah, Georgia

Dear Barb,

After a little investigating, I have a great solution. What would you say to a keyboard that is wipeable, waterproof, and aseptic? Sounds good, right? Look into the Cleankeys keyboard. It is a touch-sensitive keyboard with a flat surface that can be easily wiped down. What will they think of next? Personally, I think it has office and home applications...especially if you have kids.

Heidi



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A professional portrait of Dr. Brad Durham, a man with short, light-colored hair, wearing a white shirt and a striped tie. He is smiling and looking slightly to his right. In the bottom left corner of the photo, there is a handwritten signature that appears to read "R. Brad DMD".

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STRAIGHT

PEDIATRIC AIRWAY OBSTRUCTION

With all the recent interest in sleep dentistry, airway obstruction and apnea, I have decided to provide some invaluable information on "what-to-look-for" in your pediatric dental patients that present for treatment. It should be noted that what is discussed here is a basic guide for a cursory screening. A comprehensive examination and diagnosis would require more complete diagnostic records and tests than are to be discussed in this column. It is hoped that we will visit this topic in more detail in future installments.

As an added bonus for those of you that are parents and/or grandparents it is hoped that the following will give you personal insights into to the recognition of Upper Airway Obstruction (UAO).

UAO may be of varying degrees of severity and thus present differently from patient to patient. In pediatric patients that present with tonsillar or adenoidal hypertrophy we see that it is these tissues that block the normal function of the airway thus resulting in compensations by the body to allow for a more normal airway. As this condition becomes more chronic, changes to the structure and function of the body become more evident to the trained eye. Below are some examples:

Physical Posture (lateral) - First evaluate the AP position of the head as it relates to the shoulders. It should be positioned Front-Back just slightly in front of the shoulders. In UAO this head posture is noticeably forward of normal. Forward Head Posture (FHP) represents the compensatory position-

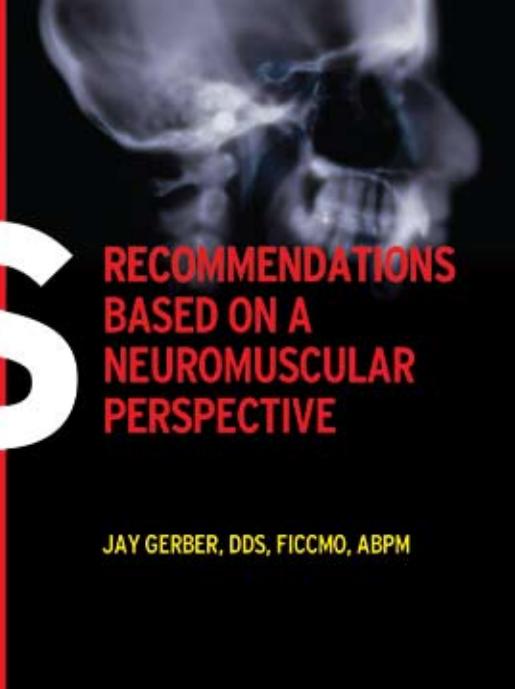
ing of the body to allow the airway to remain open.

Physical Posture (frontal) - Many patients suffering from UAO also exhibit side bending and tilting of the head to the horizontal plane.

In mouth breathers it is common to observe open lip posture in the relaxed frontal view. When asking the patient to close the lips it results in an obvious strain to the associated soft tissues including the Mentalis Muscle. When an obstruction is present, it will become progressively more difficult for the patient to breathe while holding their lips closed.

The clinician will observe a lack of development of the soft tissues of the nose. On observation the nose appears underdeveloped for the age of the patient. The shape will be more rectangular than triangular. There is

TRACKS



RECOMMENDATIONS
BASED ON A
NEUROMUSCULAR
PERSPECTIVE

JAY GERBER, DDS, FICCMO, ABPM

“I have decided to provide some invaluable information on “what-to-look-for” in your pediatric dental patients that present for treatment.”

often a ‘sunken-in’ look and underdevelopment of the mid-face. The resulting Leptoprosopic face is often more long, narrow and lacks transverse development. Lips are usually apart in the resting position and they are often chapped due to mouth breathing common in UAO of the child.

Intraoral/Dental - The oral cavity is a good place to look and observe the changes brought about due to imbalances of the facial and cervical musculature found in chronic airway obstruction. One would notice a more narrow palate, one without adequate lateral development and a very high ‘V’ shape extending to the nasal floor. Dentally, we will notice crowding of the maxillary dentition and often posterior cross-bites. Many patients present with a dental open bite and/or a Class II or Class III skeletal maloc-

clusion that is not consistent with the patient’s genetic tendencies. Tongue thrusting and/or a low tongue posture are often present due to the method of breathing. One commonly observes an anterior open bite dentally. On rare occasions the open bite extends to the posterior to reveal a lateral or complex tongue thrust.

Radiographic Observations - Doctors using lateral cephalometric and/or frontal PA images will gain additional insights into the examination. This includes the mandibular and maxillary position in the sagittal plane, the growth of each and their relation (Class II or Class III) to one another. Additionally both the mandibular plane angle and gonial angle are often increased. Observations of the size of the adenoids and other tissues including the nasal septum give us clues into

the severity of the imbalances brought on by the airway compensations.

Sleep and more – In numerous studies it has been found that snoring in children can be related to abnormal conditions including moderate to severe apnea, enlarged tonsils, obesity and asthma. Lack of sleep relates to the presence of interruptions in sleep, restlessness, inattentiveness, poor school performance, bruxism and excessive occlusal wear, head, neck and TMJ pain or discomfort.

In Summation - The above is only a brief review of the screening process used in the evaluation of airway obstruction in the pediatric dental patient. Airway obstruction is physically far-reaching for the young patient, not just in the present but to their over-all long-term growth and development. It behooves the dentist as a healthcare

"Airway obstruction is physically far-reaching for the young patient"

provider to recognize and refer these unfortunate children to the customary specialists including the Otolaryngologist for a more complete physical examination.



Dr. Gerber is the Director of Neuromuscular Orthodontics at LVI Global and serves as the Clinical and Educational Director of the Center for Occlusal Studies. Dr. Jay has clinically treated 1,000's of patients since the early 1980's using the principles of Neuromuscular Dentistry. Dr. Gerber is recognized as one of early innovators of neuromuscular functional orthodontics and for the applications of the 'EMG Guided' bite registrations.

Dr. Gerber has made a commitment to stable, pain free neuromuscular correction and long-term occlusal stability. He currently maintains a private practice in Parkersburg, West Virginia.

Pediatric Orthodontics

September 28-30, 2010

December 1-3, 2010 (West Virginia)

Neuromuscular Functional Orthodontics I

June 13-15, 2010

October 17-19, 2010 (West Virginia)

January 20-22, 2011

Neuromuscular Functional Orthodontics II

June 17-19, 2010

January 24-26, 2011

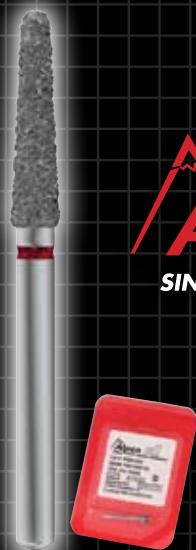
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Implant Dentistry: What Are the Challenges, What Are the Solutions?

Leo Malin, DDS

Implant dentistry today serves only about 5% of the patients that are eligible for implant services. That statistic alone would indicate that the dental profession is not doing an adequate job of providing dental implant services to the patient population. Implant dentistry was introduced into the market in the 1930s, but has obviously struggled to effectively capture its audience, both from a provider and patient standpoint. Unfortunately, many dental providers and patients alike are not terribly interested in this service. An argument could certainly be made that at a 5% market penetration, improvements are indicated and needed to make implant dentistry more successful and attractive. For implant dentistry to have struggled for that length of time would also indicate that it has some significant challenges. In order to effectively make a change, it is important to first identify what the challenges are and determine whether there are realistic solutions available. If not, implant dentistry will likely continue to do what it's always done; underachieve in the marketplace.

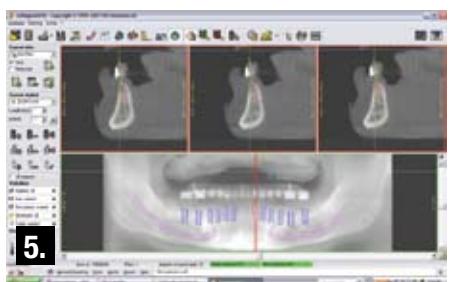
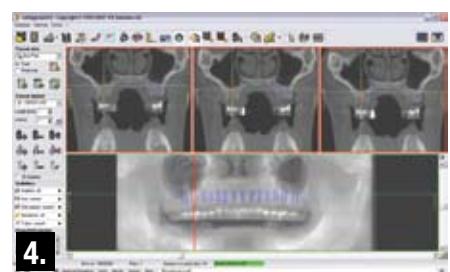
The intent of this article is to discuss the historic challenges and offer some solutions. The implant challenges are real and have been effective in holding implant dentistry back for much too long. Solutions have arrived. The technological implant revolution is upon us. It's exciting, it's effective and it has a broad sweep. This revolution is significantly changing all phases of implant dentistry, including diagnostic processes, surgical protocols, and restorative approaches. The technology is quickly evolving in the dental laboratory industry with CAD technologies and fabrication of computer-generated custom titanium and ceramic abutments. This evolution is enhancing the functional and aesthetic results of clinical implant dentistry. The revolution is here but it's not well understood. This article will also clear up some of the misunderstandings and provide help for the implant clinician to address some of those significant historic and persistent challenges.

I have addressed in prior issues of LVI Visions what I felt to be the two biggest historical challenges that implant dentistry has faced and provided workable solutions to those challenges. In summary, the two challenges were first, predictable implant placement control and second, bone loss around dental implants over time. Implant placement control challenges are completely handled by simply incorporating cone beam computerized technology (CBCT) and treatment planning software into the diagnostic and surgical protocols. In short, a CAT scan x-ray produces a three dimensional view of the area of surgical interest and the treatment planning

software is used to turn that diagnostic data into a usable surgical stent. Incorporating those two tools or technologies into the diagnostic and surgical phase eliminates surgical surprise and placement position compromise. Anatomical patient limitations are discovered prior to the implant surgical event and surgical plans are modified accordingly to ensure optimum implant placement. Proper implant position or placement control with this technology is understood and achieved in the treatment phase and successfully carried over into the surgical phase.

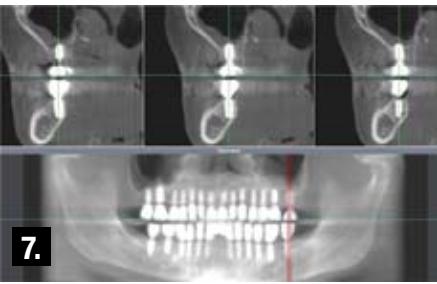
A clinical example of poor placement control is displayed in the first two photographs. Unfortunately, in implant dentistry, this is and has been an all too common occurrence and threatens the interest and very existence of implant dentistry. With today's technologies, clinical results like this should never happen. As a comparison let's look at a different case with a different approach.

The second clinical example is an edentulous patient with a treatment objective to place 26 dental implants. The restorative plan was to have all individual crown restorations, except for a fixed implant bridge from tooth number 24 to 26. This implant case was planned using CBCT technology and treatment planning software. The photographs would certainly indicate that this case was done with significantly more control than the first case displayed. Placement control is not only predictable but absolutely achievable using this technology. Observe photographs three through eight. The historic challenge of implant place-





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ment control with this technology is eliminated. This control is real and it is repeatable. There are several options in treatment planning software on the market today that provide this kind of control. Another challenge is certainly controlling the costs associated with these emerging technologies. I will discuss that in more detail later.

The second historic challenge is sustained tissue and bone health around the implant over time. Significant bone loss around dental implants over time has been a considerable challenge in implant dentistry. With today's improved implant abutment connections and sub crestal placement protocols, bone loss around implants can be significantly reduced or eliminated with proper implant surgical and restorative protocols. Photograph nine is a clinical example of that considerable bone loss around the implant body following abutment and restoration placement. The implant abutment connection in this case is a hexed connection and the connection was not adequately accessible to the patient. In those clinical circumstances bone loss is always inevitable.

Photograph number 10 is a very similar case in terms of implant placement position. The implant abutment junction is also not reachable for the patient to maintain daily oral hygiene because of the implant placement depth, however the long-term bone health is remarkably better than the first case. The implant abutment junction in this case, is a tapered connection which is tighter and affords a much smaller micro gap between the abutment and the implant. This micro

gap is so small that bacteria cannot be harbored in the connection therefore bone health is sustainable over time in the sub crestal or significantly sub gingival placement protocol. A one piece implant would have some of the same clinical advantages in these cases simply because it is one piece implant abutment combination. There is no micro gap or micro movement between the implant and the abutment obviously because it is machined as a single unit. These technological advances have significantly improved bone health and bone stability around dental implants in those challenging implant cases.

Another area in implant dentistry that is quickly emerging is the dental laboratory equipment and technology. Until recently, most of the implant abutments utilized were purchased by the implant manufacturers. These manufacturers produce standard or stock implant abutments or attachments for their particular implant systems. Many of these abutments once purchased were being modified or customized in the laboratory to enhance or improve functional and aesthetic characteristics of each particular implant restoration. Certainly the degree of modification is limited once the abutment is manufactured and can be self-limiting. Today, in some dental laboratories, the emerging technology is capable of designing and creating custom implant abutments in-house. These abutments are designed and manufactured specifically for each individual implant or clinical case that the laboratory restores. This technology provides much more flexibility in the restorative process. Better case

control with enhanced aesthetic and functional capabilities.

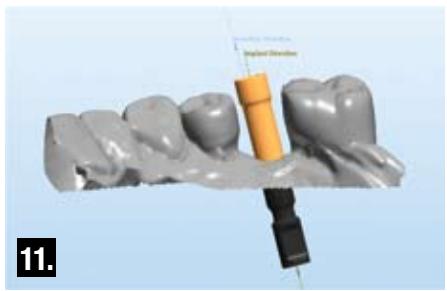
For example, Dental Crafters in Marshfield Wisconsin is a laboratory that is heavily engaged in the implant technology revolution. Dental Crafters uses the 3Shape dental scanner and associated Dental Design CAD software package to design custom implant abutments. This software is one of several CAD design products on the market today. The process begins by scanning a standard model from either the dentist office or from another laboratory that is outsourcing the implant abutment design and fabrication process to Dental Crafters. Ultimately this process culminates in creation of customized implant abutment milled from either titanium or zirconium. The design process is broken down into several scanning steps as well as the actual designing of the abutment. The major steps are summarized below.

The CAD technician scans the model with the scanning abutment pin in place. The scanning abutment pin is a metal or plastic alignment pin that when scanned represents the placement of the implant in the mouth. Because each implant system is different, a proprietary scanning abutment pin is specifically designed for each implant system. The laboratory purchases these alignment pins from the implant manufacturers. The orange cylinder in the photograph represents the proprietary scan abutment pin for this case, which gives the software the proper orientation of the implant and its connection to the abutment. This scan also allows the scanner to capture the interproximal areas between

the teeth as well as the tissue around the abutment site.

Photograph 13 is a representation of a scanning abutment prior to any custom design of the implant abutment. Photograph 14 is a proposed abutment that could be milled out of the titanium or zirconium scanning abutment. Photograph 15 is a custom abutment design in relation to the surrounding teeth. The CAD technician can utilize many design and measurement tools to fully design, customize and mill a titanium or zirconium abutment. An additional scan is taken by the CAD technician of the antagonist arch which will be used to determine the clearance for the restoration between the upper and lower arches.

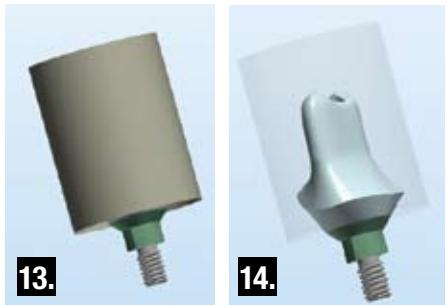
This technology is a game changer in the laboratory. The laboratory can design a custom abutment to maximize proper orientation, build a proper abutment profile coming out of the tissue, and place finish lines for the crown margin at the appropriate tissue heights. Each of those characteristics alone is of significant importance in restorative implant aesthetics. Having the ability to control all of those characteristics in the design process for each case is a dramatic improvement from where the laboratory capabilities were a very short time ago. I suspect the whole restorative implant market will change quickly with this technology. Fully customizable laboratory fabricated implant abutments will soon be the standard and stock implant abutments will be a thing of the past. Why wouldn't the implant and laboratory industry embrace this technology? The answer is that they will simply because it is profoundly



11.



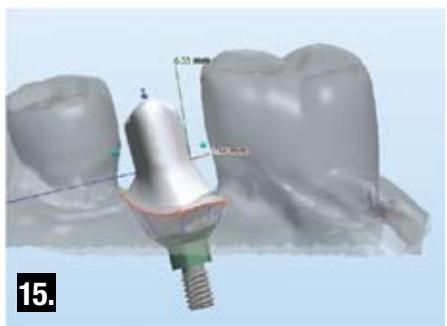
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better than what they're accustomed to. This technology provides a much simpler solution for the challenging cases that dental laboratories often receive from their doctor's offices.

A similar technique being used in laboratories today is purchasing only the titanium connection to the implant from the manufacturing source and then using CAD software to construct a zirconium core which is looted to the titanium abutment connection. A zirconium crown then is fabricated and looted to the zirconium core. The distinct clinical advantage in this approach is that the implant abutment connection is titanium and has the strength of titanium. However, the remaining portion of the abutment is zirconium and has the cosmetic advantage of a zirconium abutment coming through the tissue to support the restoration. In other words, these cases have a strong titanium connection that is much less likely to fracture than a ceramic abutment while retaining the aesthetic advantages of a ceramic abutment. It's really the best of both worlds in the restorative process which makes it one of my favorite implant abutment choices.

I would suspect at this point in the article you are intrigued by the technological advances and certainly understand their usefulness in solving some of implant dentistry's significant challenges. The 800 pound gorilla that remains in the room is: what is the cost of this technology, and is it realistic and affordable? I have incorporated all of these technologies into my implant practice and find them very useful and affordable. To help you better understand the economic consider-

ations in the use of this technology I will share my implant fee schedule as well as the real costs associated with those implant services and the technology utilized. In order to make the numbers realistic I will assume most doctors will rent the CT images needed to do a proper diagnosis. I own a CT machine in the office so my numbers would be slightly different on the revenue side versus expense side but for the sake of this exercise I will assume the images are rented from an outside source.

Granted these are my expenses and my revenues from my office and they may vary dramatically in your particular office environment. Your revenues may be significantly higher or lower based on your practice model. I did not include in this comparison additional cost such as practice overhead, initial equipment investment or fixed practice costs. I also did not include other revenue potential that implant dentistry provides to the practice. It is strictly meant as a guideline to the fixed costs associated with guided implant surgery and custom implant abutments and the restoration process.

It is also understood, based on the analysis, that this technology is affordable even in the worst-case financial scenario, which is a single implant placement and restoration case. The cost of the technology becomes negligible and considerably more favorable in implant cases involving multiple implants.

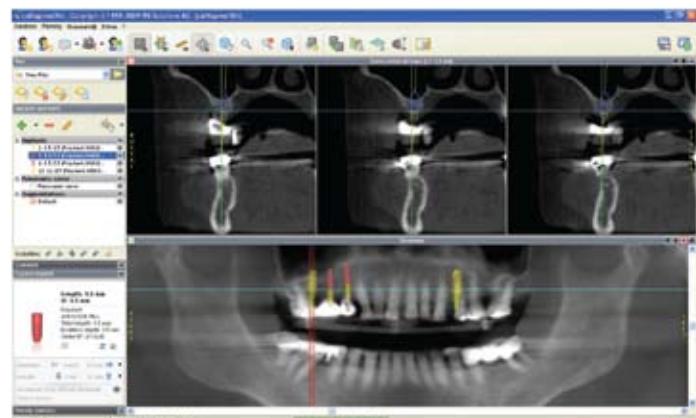
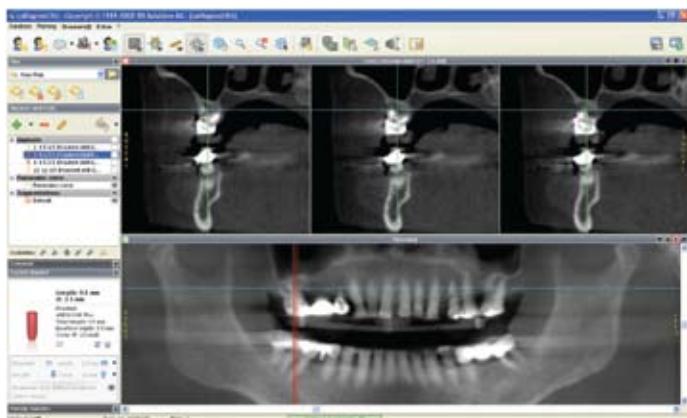
Photographs 20 through 26 are a clinical example of a four tooth implant case using all the latest technologies. This clinical example is a patient

Fixed costs for this technology in my office.

| | Single Site Implant Case | Four Site Implant Case |
|--------------------------------------------------------------------------|--------------------------|------------------------|
| Patient's Scanning Appliance for CAT scan X-Ray | \$175 | \$175 |
| CAT Scan X-Ray with Scanning Appliance in Place | \$250 | \$250 |
| Fully Guided Surgical Stent (\$40 per site) | \$40 | \$160 |
| Dental Implant (\$205 each) | \$205 | \$820 |
| Laboratory Fabricated Custom Titanium or Ceramic Abutment (230 to \$270) | \$250 | \$1000 |
| Lava Implant Crown | \$233 | \$932 |
| Implant Analog and Miscellaneous Laboratory Fees. | \$45 | \$180 |
| | ----- | ----- |
| Total Cost for a Single Implant Case versus Four Implant Case. | \$1198 | \$3317 |

Implant Revenue

| Procedure | CDT code | Medical Code | Fees Single Implant Case | Fees Four Implant Case |
|---------------------------------------|-------------|--------------|--------------------------|------------------------|
| CT scan | D0360 | 70486 | \$350 | \$350 |
| Scanning Appliance and Surgical Stent | D6190 | 21085 | \$400 | \$600 |
| Implant Placement | D6010 | 21248 | \$1600 | \$6400 |
| Custom Abutment | D6057 | | \$500 | \$2000 |
| Implant Crown | D6065/D6058 | | \$1200 | \$4800 |
| | | | ----- | ----- |
| Total Revenue | | | \$4050 | \$14,150 |



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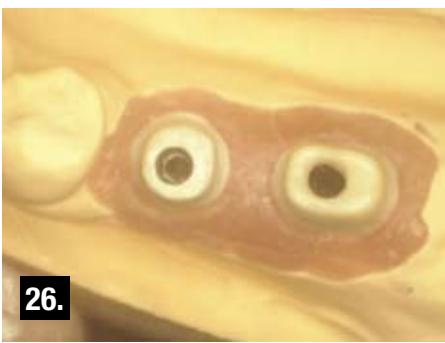
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26.

85 years of age with some medical compromise. Treatment plan is to extract tooth numbers 3, 5 and 12. Both three and five have apical abscesses and a poor prognosis. Tooth number 12 has a root fracture and a hopeless prognosis. CT technology and treatment planning software were used to plan and place four dental implants in the most ideal position. Immediate extraction and sub crestal placement of the implants were done to expedite the treatment process as well as maintain adequate crestal bone health. Tissue and bone health are apparent on the clinical photographs shown. After four months of healing, impressions were taken and Dental Crafters used its CAD design software to make custom abutments. These abutments had a titanium implant abutment connection or junction with a zirconium abutment core and crown. All of these technologies combined guarantee proper implant placement position and enhanced function and aesthetics of the restorations. 21st century implant dentistry guarantees better control, better function and aesthetics.

In summary, implant dentistry and its processes are changing quickly. These technological advancements are improving diagnostic, surgical, and restorative protocols. These improvements provide better control of implant cases and guarantee a more functional and aesthetic outcome for our patients. These improvements solve many of our historic implant challenges and make implant dentistry more attractive to our profession and to the patients that we serve. The technology is effective and fortu-

nately for all of us, providers and patients alike, it is here to stay. I would encourage every dental practitioner to get involved in implant dentistry.



Dr. Malin graduated from Marquette University in 1991, where he received his DDS. He maintains a private practice in La Crosse, WI where he has been utilizing occlusal based dental concepts since 1998.

Early in his career, he discovered that the implant placement techniques used could not deliver a standard, predictable result. Therefore, with the help of other experts in the fields of radiology and occlusion, Dr. Malin developed an implant placement technique which focused on occlusion (and cosmetics) for implant placement and crown restoration. This technique has led to four U.S. patents granted along with exceptional implant results.

Dr. Malin lectures throughout North America on full mouth reconstructions and implant placement. He is excited to share his experience and knowledge of implants with other dentists.

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Are Your Patients AND Your Practice Protected



Brian Sachs



"I had no idea that storing my patient's credit card numbers on my business computer would jeopardize everything I have worked for."

Dr. Harvey thought he was doing the right thing by storing his patients' credit card data in his computer system. "I thought I was providing an incredible convenience for my patients. This way, if they ordered products or wanted to pay for their visits, they didn't have to keep taking out their credit cards." However, everything soon changed for Dr. Harvey. One evening when someone from the office cleaning crew found a computer printout of his credit card list, a two-year nightmare began that almost ended Dr. Harvey's successful dental practice. "When my credit card processor called me and asked if I was PCI (Payment Card Industry) Certified, I had no idea what they were talking about," he explains. Dr. Harvey faced more than \$400,000 in fines for fraudulent credit card charges and for accepting credit cards without proper PCI Certification. "I spent tens of thousands of dollars over the next few years defending my dental practice. I was worried that I would have nothing left from all my years of hard work." Dr. Harvey quickly realized that PCI and HIPAA (Health Insurance Portability and Accountability Act of 1996) compliance was a critical business process that he, and the majority of his peers, had overlooked.

River Cohen, Chief Executive Officer of Compliance Services, Inc., states, "Quality care for your patients extends beyond the dental chair. As more and more patients are paying for their services via credit cards and their crucial private health information is stored on your computers, it is imperative that security becomes a top priority to you and to your dental practice." Mr. Cohen consults hundreds of dentists on the importance of patient data protection. "The cost of compliance is minuscule compared to the ramifications of non-compliance." Dental practitioners are responsible for ensuring that patient data is protected. Mr. Cohen cannot emphasize enough how crucial creating 'End-to-End Risk Management Procedures' and 'Offsite Data Back-up' is for dentists in this electronic age. Cohen adds, "I use the term 'mandatory' with my clients. Our dentists cannot take the risk of losing everything." Failure to protect patients' information makes one susceptible to annual fines of up to \$1,500,000 and can cause the practitioner to lose valuable patients as well as their practice's reputation. In this tenuous economy, the fines and losses can be devastating.

Is your patient data really safe? Do you have proper passwords on your computer network? Are you adhering

to all of the compliance rules defined by PCI and HIPAA Regulations? Dr. Harvey believed that his back office procedures were secure, until he received that dreaded call from his credit card processor...

"A failure to protect your patient's information with a secure risk management and data back-up system can severely jeopardize your dental practice."

The Payment Card Industry Security Standard (PCI DSS) is a global security standard designed to protect you and your patients from identity theft. There are several benefits to becoming PCI compliant. If you are PCI compliant and a violation in security does occur, you will not be fined as long as you were compliant at the time of breach. By becoming PCI compliant and securing your patient's data offsite, your systems will be less prone to a successful breach and there will be continual security checks to make sure compliancy is preserved at all times.

PCI compliance is required for any business that accepts credit cards – even if only a few credit card transactions are accepted. To achieve PCI DSS Compliance, there are 180 re-

quirements in 12 different categories – all of which must be met. The categories are as follows:

1. Install and maintain a firewall configuration to protect cardholder data.
 2. Prohibit vendor-supplied defaults for system passwords and other security parameters.
 3. Protect stored cardholder data
 4. Encrypt transmission of cardholder data across open, public networks.
 5. Use and regularly update antivirus software or programs.
 6. Develop and maintain secure systems and applications.
 7. Limit access to system components and cardholder data to only those individuals whose job requires such access.
 8. Assign a unique ID to each person with computer access.
 9. Restrict physical access to cardholder data.
 10. Track and monitor all access to network resources and cardholder data.
 11. Regularly test security systems and processes.
 12. Maintain a policy that addresses information security for employees and contractors.
- 7,176 HIPAA complaints were received by HSS with more than 90% resulting in investigation and action!
 - Over 90% of data breaches were in digital form!
 - Only 23% of healthcare institutions use data loss prevention (DLP) solutions!



In addition to PCI Compliance, HIPAA sets specific guidelines for any site that stores or transmits Personal Health Information (PHI). This can be in one location or divided between many different locations - whether it is internal or external it still requires the same protection. Regardless, you are obligated to secure your patients' critical data including, but not limited to, health records, demographics, insurance, credit, and financial information. Whether the infringement of this information is accidental or intentional you are liable. Don't let your patients, your practice and your livelihood be exposed.

So, what's so different now than before? The American Recovery and Reinvestment Act of 2009 changed how the healthcare industry manages health data. When necessary, you are required to share patient data, erase copies of that data, expire access privileges when the need passes, and audit this entire process for fraudulent activity. This increase in the electronic traf-

fic of health records will no doubt lead to a rise in security breaches. Whether it's a patient record that erroneously gets sent through an email to large-scale patient databases or whether it's being copied to a USB flash drive on an unattended computer, a breach is just waiting to happen. Unless you are compliant, you are liable.

“Don’t let your patients, your practice, and your livelihood be exposed.”

There are many products and services available to help meet the requirements for Risk Management and Data Storage. Mr. Cohen explains, “We established Compliance Services, Inc., and launched www.dentalpracticecompliance.com to help dentists learn about PCI and HIPPA Regulations. We believed it necessary to provide End-to-End Risk Management and Data Back-Up solutions tailored to the Dental industry.” He continues,



An even bigger risk would be a PCI or Data Breach.

If your dental practice is not PCI and HIPAA compliant your practice is at risk! A PCI breach is both a HIPAA violation and a violation of Visa / MasterCard Acceptance Standards. Fines of up to \$50,000 per incident are not uncommon.

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ABOUT THE AUTHOR

Mr. Brian Sachs is President of Albion Inc. Albion provides merchant processing and regulatory compliance services to over seven thousand businesses nationwide. Mr. Sachs has over 20 years of experience consulting small businesses on payment processing, regulatory compliance and data privacy. Mr. Sachs speaks regularly on PCI and HIPAA regulatory compliance and specializes in risk management consulting focused on the medical and professional service industries.

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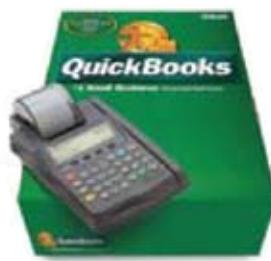
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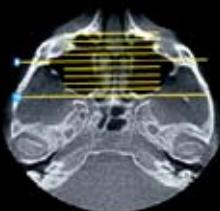
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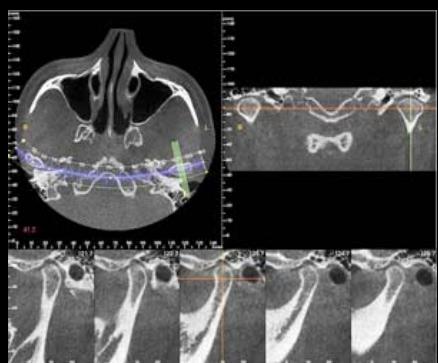
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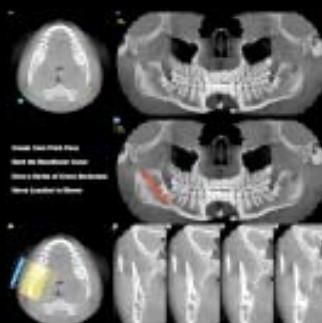
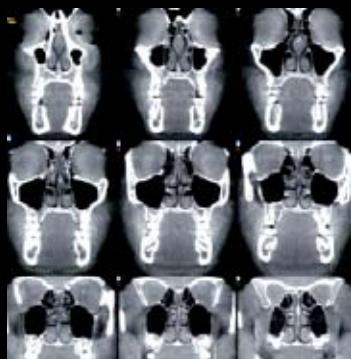
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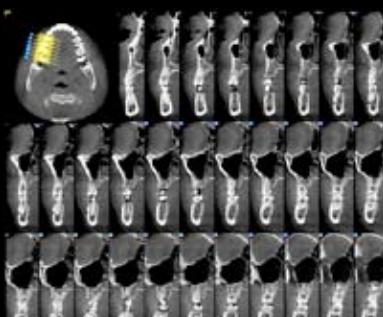
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Another Bubble?

Sheila Keator

There is an old adage; “Those who ignore history are destined to repeat it”. So let’s journey through a couple of the major milestones in the market since 1982. I’ve chosen 1982 because that was the time the market became the subject of daily media chatter. Paul Volcker was the Chairman of the Federal Reserve at that time and in August of 1982 he lowered interest rates. This caused the stock market to take-off. From that point onward the market was a hot topic.

One of the first “derivatives” that emerged after that time was in the form of Portfolio Insurance. The idea was attractive. Essentially it was a program sold to institutions and large investors that “sold” their securities if the market hit certain levels. The large investors and institutions loved the idea. This “product” became so lucrative to Wall Street that it was repackaged and sold to smaller investors. Everyone started buying-in to this protection mechanism. In hindsight, this idea failed to recognize that it could become self-fulfilling. If the market started to fall then the “insurance” would be triggered which would in turn signal program selling. This would cause the market to fall as more and more program selling would ensue. This period in the market has been labeled The Crash of ‘87. Let’s call this automatic pilot approach “complacency”.

Starting in 1995 new technology burst onto the scene and the Over the Counter Market (NASDAQ – all those 4 letter stocks) became the “new” hot investment. It was the subject of every analyst, commentator and/or neighbor with a computer. Sometimes the value of a stock would double in a day. It looked like there was no end to the money that could be made. It looked easy and complacency took hold again. “How could you lose? The internet isn’t going away. Technology has changed our lives”.

That bubble burst in March of 2000 and the subsequent recovery was interrupted by the attacks on September 11, 2001. This economic road-bump would keep further growth in the stock market at bay until March of 2003 when stocks began to rally again.

Who would have guessed the next bubble would be Real Estate. There is another Wall Street axiom; “Trees

don’t grow to the sky”. Housing prices soared; people were refinancing their mortgages and spending their equity as if going to an ATM machine. That bubble has now burst and real estate values have plummeted from stratospheric highs. This has caused many consumers a tremendous amount of pain and panic. Many feeling helpless have walked away from their homes to the detriment of their credit scores and overall financial well-being.

We believe that this real estate adjustment is going to have long-term effects on our economy as it will take time to work through the excess real estate inventory. Until that happens prices probably won’t rise. Although there are pockets of the country that have already seen some stabilization, it could be years before there is substantial growth in the real estate market.

We see the new bubble being In-

terest Rates. Remember that current yields are a function of income divided by price. If bond yields are low then bond prices are high. Everyone is looking for someplace to invest their money for a better return. The U. S. Treasury is borrowing money for two years at a rate of less than 1%. Money Market rates are less than 1/4 of 1% (0.25%).

So if you want to help reduce risk, you may need to endure some pain by accepting low current yields. If inflation stays low then real return is okay. Unfortunately if inflation starts to rise then the net return on low yielding investments could be zero or worse. Looking for more income in the market is like walking through a minefield. If you exclusively hunt for yield without paying attention to quality then your perceived "safe" investment might not perform to your satisfaction. It reminds me of another adage; "Buyer Beware". I can't predict when, but interest rates will rise. They cycle just as all other asset classes and markets do.

OK so what do I DO?

1. Keep a good cushion (we call it a bunker) of available cash for emergency purposes. This could include money markets, certificates of deposit or short term government bonds. No, the yields aren't attractive now but it will allow you to access funds if needed without forcing the sale of something at an inopportune time.
2. Keep your portfolio liquid. Stay clear of investments that tie-up your funds and have large charges or limited liquidation rights.
3. Have a diversified investment

plan. By identifying future goals you can back into the risk that you should be taking. If that is excessive then you know you need to modify your goals and expectations.

4. Think globally when determining your asset allocation. There may be investment opportunities in the international markets which could potentially enhance a portfolio's return.
5. Look for transparency in your investments. What do you own? What does it cost? These are all appropriate questions to be asking your advisors.
6. Stay disciplined. Keep your consumer debt low and continue to actively save for your future.

Keeping these points in mind will help you avoid some of the pitfalls that investors have suffered over the last decade. It is through planning and discipline that we believe you will have the best chance of reaching the financial future of your dreams.



This article was written by Sheila Keator, a financial advisor with Keator Group, LLC at 218 Main Street, Lenox, MA 01240 (413) 637-2118; www.keatorgroup.com

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As the Founder of Keator Group, LLC, Sheila devotes her time working with clients to help them define and achieve business and investment objectives. For clients seeking less volatility in their investments Sheila's strength in fixed-income management can help provide a stream of income while also helping to buffer them from the daily turbulence of the equity markets. With over 25 years of experience, her knowledge of the investment industry is invaluable. Prior to the First Albany Corporation — First Union Securities merger, Sheila was a member of First Albany's President's Club and First Albany's Directors Advisory Council. Currently, Sheila sits on a number of advisory committees. She was named to the 2004 Research Magazine's Women's Winner's Circle of top-ranked Women's Advisors in America¹, Barron's Top 100 Financial Women in 2006, 2007, & 2008², and ranked in Barron's Top Advisors in Massachusetts in 2009.²

A graduate of The College of Our Lady of the Elms, Chicopee, Massachusetts, Sheila went on to receive her certificate of finance and accounting from the Wharton School of Business. She holds her 7, 63 and 65 securities registrations.

Sheila and her husband George reside in Lenox and Becket, MA. They have eight children.

¹Criteria was based on more than 7,000 filtered nominations from over 80 investment, insurance, banking and other related firms, which were narrowed down by quantitative and qualitative criteria as well as by examining regulatory records and talking with peers, supervisors, clients and the advisors themselves. Portfolio performance is not a criterion because most advisors do not have audited track records.

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DENTISTRY NEWS

Making Headlines:

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You may have heard the old adage that any publicity is good publicity. That's perhaps the case for certain industries and celebrities, but that's not the way it is for dentistry. As dentists we have a responsibility to ourselves, our colleagues, and our profession to cultivate and maintain a positive image in the public's eye. We are doctors and, as such, we are healers, helpers, and trusted advisors. How we are perceived by our patients and communities impacts how, when, where, why—and if—people seek treatment. No profession wants a bad rap, and certainly not one in the medical industry.

"When being interviewed the instinct is to want to promote your practice. Try to avoid that. Presenting yourself as a dental expert indirectly promotes your practice without sounding salesy."

In my last article I discussed ways to generate favorable publicity for your practice with press releases. As promised for this edition, I will discuss methods for effectively participating in an interview, conducting a background check on a journalist, and how to handle a visit from a local TV station.

If you utilize some of the press release techniques I mentioned before, there is a distinct possibility that you will be contacted by one of your local news professionals for an interview. Being prepared to speak to and present your office to that person is critically important. Remember—when you're in the public eye, you are a direct representative of the dental community.

All dentists participate in at least eight years (often more) of higher education, not to mention countless hours of post-graduate CE. In all of those years each of us has experienced the vital lesson of being prepared. Learn all that you can, whenever you can, from the best you can, and use that knowledge to your advantage. Participating in an interview is really no different. The key to giving an effective interview is to be prepared.

Prior to participating in your interview, ask the journalist general

questions about their interest in speaking with you. "How did you hear about me/my practice?" "What type of story are you writing?" "What type of information are you interested in?" "Where and when will that story be featured or published?" "Are you interviewing any other dentists or offices on this same topic?" These basic questions will give you insight into the intentions and goals of the journalist and ensure that they are interested in giving you positive not negative, press.

How to Research a Journalist

Doing your homework on the involved journalist is part of being prepared. Knowing who you're talking to, the types of stories that journalist has covered in the past, and their reputation is essential. A little due diligence in the beginning can save you a lot of embarrassment or surprise down the road.

We live in an age of technology. Conducting background research on people in the public eye has never been easier.

Start with a basic Google™ search, beginning with the journalist's name. You can expand that search by adding words like "article," "beat," "story," "news," and so on. This should turn

up many of the journalist's articles accessible via the Web. Look to see what types of stories they've previously written, whether they took a positive or negative angle on their pieces, and how they've portrayed the people involved. If their stories are negative or take on a vigilante approach to their subjects, you want to steer clear.

If the journalist writes for a particular newspaper, magazine, or TV station, visit their website(s). Most sites contain archives of past stories. Run a search for the journalist's name or particular beat. See if there's a trend in the types of stories they write.

Use a reputable resource like NewsBios.com to do a background check. NewsBios.com tracks professional journalists and compiles detailed biographies on them that are accessible to anyone. The service costs a small fee, but will give you valuable information on the stories, trends, and reputation of a particular journalist.

Your research can also give you an "in" with the journalist. Say you discover that the journalist has written multiple stories on oral cancer. You can find a way to incorporate that subject into your interview. Make sure your waiting room is stocked with oral cancer screening and

“Giving an interview can be easy when you’re prepared. Make sure to do background research on the journalist prior to sitting down with them, set up your office as appropriate, and always be professional.”

education brochures. Perhaps even reference a particularly impactful case that you had. It will serve as a relationship builder between you and your interviewer.

Preparing Your Office

Preparing your office is perhaps the easiest part of the interview process. Cleanliness, sterilization, safety, protection of both patients and practitioners, and orderliness are all cornerstones of the dental profession. That being said, here are some tips to remember for preparing your office for a visit from a news professional:

Make sure your office is clean. Not just tidy, but thoroughly clean. All tools, trays, and instruments should be in their proper places.

If patients are being seen at the time of your interview, make sure proper procedures are followed.

Make sure your team’s scrubs, uniforms and/or lab coats are clean, crisp, and freshly pressed.

Consider adding welcoming touches like fresh flowers in your waiting room and reception area.

Last but Not Least: The Interview

In preparation be sure to write down notes for yourself. Journalists are looking for sound bites (those



“That’s an excellent question. Here’s what I’ve found is even more important...”

punch-out quotes that appear extra large on the page of a newspaper or that brief video clip that highlights the focus of the interview). Write down bullet points for yourself on the topic and think proactively about additional questions the journalist may ask. It’s much easier to read from your notes if you’re giving a phone interview, but your conversation should not sound scripted. It’s ok to use notes during in-person interviews as well, but be sure you’re not looking down at them more than you’re looking up at the interviewer.

If you’re asked a question that you’re not comfortable answering, find a subtle way to redirect the question into something that you are ok with answering. For example, you can say “That’s an excellent question.

Here’s what I’ve found is even more important...”

When being interviewed the instinct is to want to promote your practice. Try to avoid that. Presenting yourself as a dental expert indirectly promotes your practice without sounding salesy. Speak about dentistry and the profession as a whole and discuss questions that patients can ask their dentists.

Important Points to Remember:

- Write down notes for yourself prior to the interview.
- Think about things that would make great punch-out quotes or sound bites.
- ALWAYS wear a lab coat and look professional for an interview. Do not

wear scrubs.

- Women should revert from wearing excessive jewelry—keep it simple.
- Men should wear a nice watch if possible.
- NEVER go “off record.” There’s no guarantee that what you say won’t be used.
- NEVER make a disparaging or negative comment about the profession.
- Keep the focus of the interview on patient education and care.
- If participating in a video interview, make sure that neither you nor your team wear any small-patterned clothing. Fine-detailed patterns can have a moiréing effect on screen, creating dizzying lines and making your image hard to focus on.

Conclusion

Positive publicity for the dental profession benefits us all. Utilizing PR techniques to promote your practice can help you attract new patients, establish yourself as an expert in the field, and create a favorable image of dentistry in your community. Sometimes that PR will result in an interview request from a local journalist or news professional. Giving an interview can be easy when you’re prepared. Make sure to do background research on the journalist prior to sitting down with them, set up your office as appropriate, and always be professional. With a little due diligence, you can ensure your interview goes off without a hitch.



Michael D. Silverman, DMD, DDOCS, DICOI, is an internationally-recognized dental educator, business leader, marketing expert, entrepreneur, speaker, and author. He is the President of b2d Marketing (b2dmarketing.com), a dental and medical business marketing company. Always at the forefront innovation, Dr. Silverman and b2d Marketing have helped launch and maintain the success of some of the most premier dental and medical products and services on the market today. Dr. Silverman also serves as the President of RAMP (rampresults.com), the largest dental practice marketing agency in the U.S. Additionally, he is the Co-founder and President of DOCS Education (DOCSeducation.org), an organization that provides continuing education training, products, and membership to dentists and team on sedation dentistry and emergency preparedness. Dr. Silverman can be reached at (206) 812-7729 or Michael.Silverman@b2dMarketing.com.

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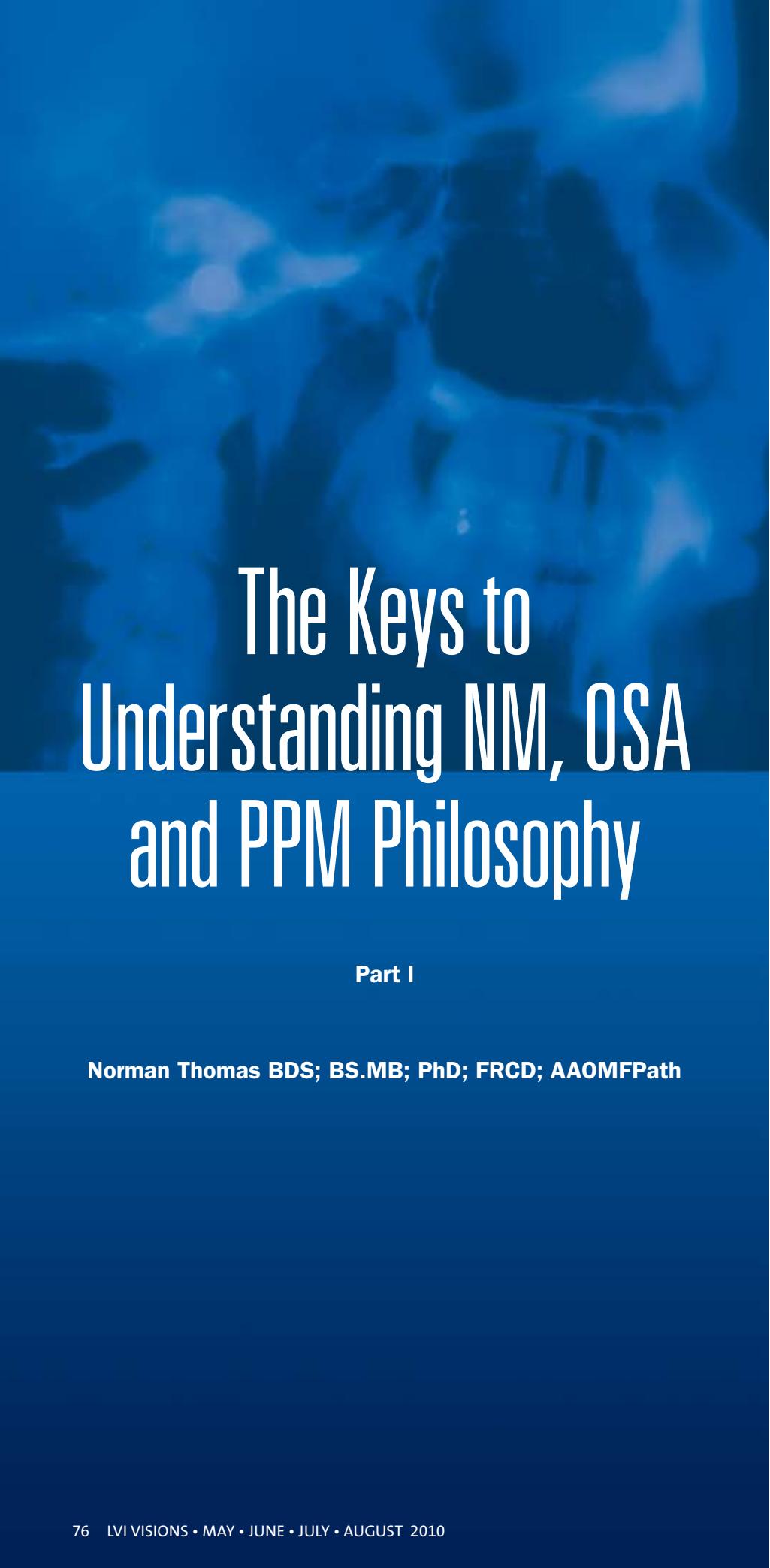
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1. Please see Laser-Lok Clinical Overview (BioHorizons document ML0606).

2. Human Histologic Evidence of a Connective Tissue Attachment to a Dental Implant. M Nevins, ML Nevins, M Camelo, JL Boyesen, DM Kim. The International Journal of Periodontics & Restorative Dentistry. Vol. 28, No. 2, 2008. SPMP10130 REV A FEB 2010



The Keys to Understanding NM, OSA and PPM Philosophy

Part I

Norman Thomas BDS; BS.MB; PhD; FRCD; AAOMFPath

Two papers define the relationship between muscular strength, flexibility, endurance, body posture and electromyographic(EMG) voltage(v) and frequency(f). In 1990 and again in 1996 these correlations based on the Nobel Prize studies of Sherrington (1932) were demonstrated (Thomas NR: Frontier of Physiology vol 7:162-170 Thomas NR and (1996) Anthology of ICCMO 159-170). Eble OS Jonas IE and Kapper HF (2000) confirmed a significant finding of these studies that TENS (transcutaneous electroneural stimulation) of cranial nerves V and VII produced muscle relaxation by means of spectral analysis of the masticatory muscles. Here is presented in caption form the salient features of the above researches.

In the healthy posture, the head, shoulder and pelvic planes are parallel to the earth's horizontal planes. Figure 1 defines the two postural anomaly types characterizing descending and ascending temporomandibular disorder (TMD). The ascending disorder originates in a nociceptive reflex below the thoracic outlet (from the foot plane to lower cervical plane). It does not normally produce the collapse of the upper airway because the accompanying scoliosis involves a unidirectional rotation of the skull and neck. It should be understood that inflammation of the airway typically arising from adenoidal and tonsillar hypertrophy may give rise to increased airway resistance. This then becomes a descending disorder due to compensatory postural changes such as forward head posture (FHP). The descending postural form originates in nocice-

ptive reflex in the structures above the thoracic outlet principally in the stomatognathic structures whereas the ascending involves all structures below the cervical complex C3 to C7. The accompanying scoliosis in the descending form involves a bidirectional/antiparallel rotation of the head and upper cervical complex. The descending posture therefore directly causes antispiralling of the airway leading to concentrated, intermittent hypoxia of OSA and FHP.

Two metabolic graphs provide the rational of the philosophy expounded in the above mentioned studies. Figure 2 is a graph of muscle force vis-à-vis muscle sarcomere length. There is an optimal force development at the physiological resting length of the muscle where the muscle is neither contracted nor lengthened. This physiological resting length is responsible for the strengthening effect of the Pure Power mouthpiece which is constructed at the physiological resting length of the skeletal muscles with no antispiralling of the airway that would reduce air intake leading to oxygen debt. The patient under such conditions not only shows increased muscular strength but also a prolonged duration of breath holding because the oxygen supply to the respiratory substrates and center is maximal. The shortened muscle at one end of the abscissa and the lengthened muscle at the other end are associated with collapsed blood vessels with resulting metabolic oxygen debt but due to the higher oxygen intake and physiological conditions the oxygen debt is at a lower level than when air intake is restricted as in apnea.

Figure 3 shows a composite graph of

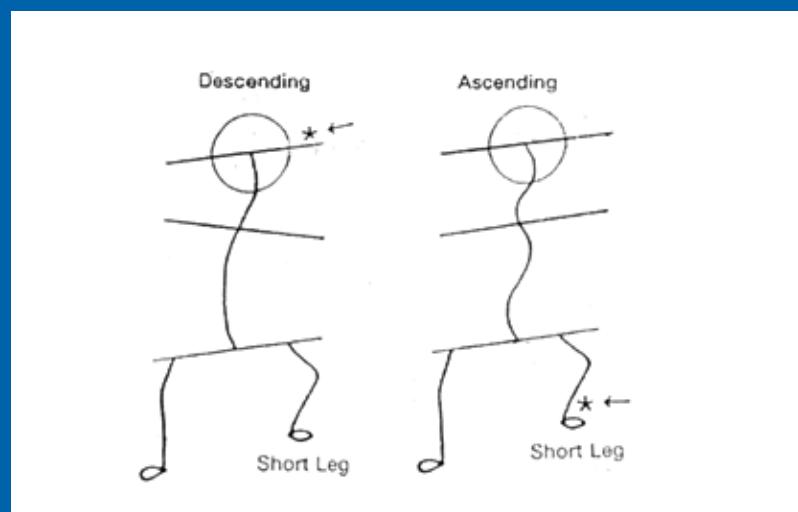


Figure 1

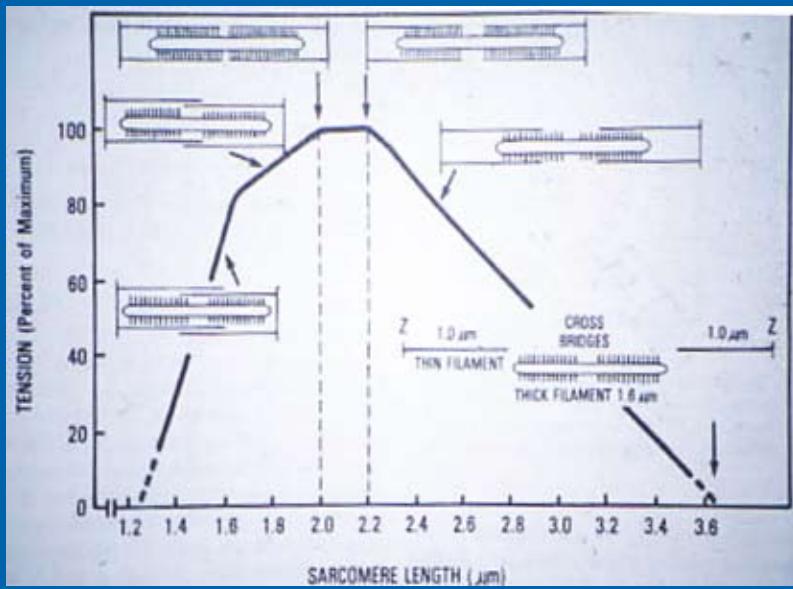


Figure 2

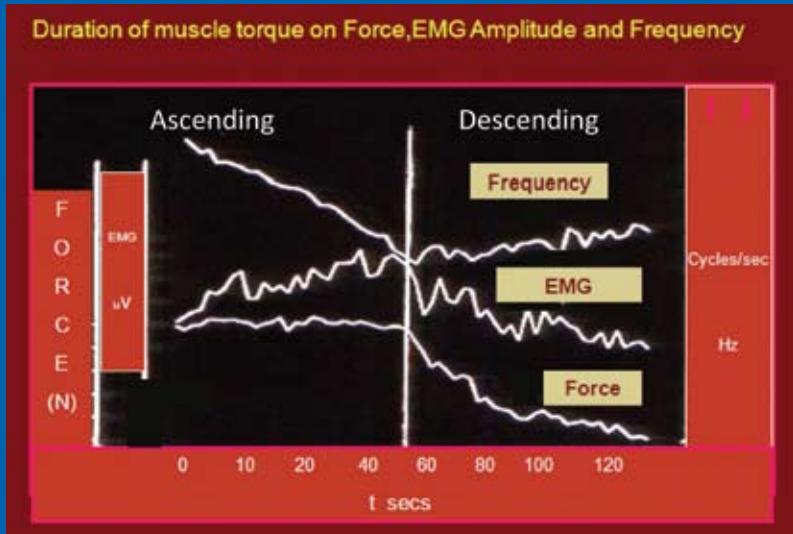


Figure 3

Healthy Patient Scan 18 No Postural Fatigue

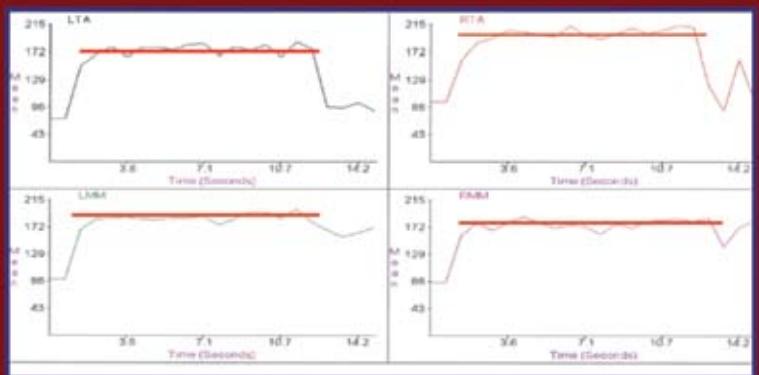


Figure 4

Scan 18 in Ascending TMD

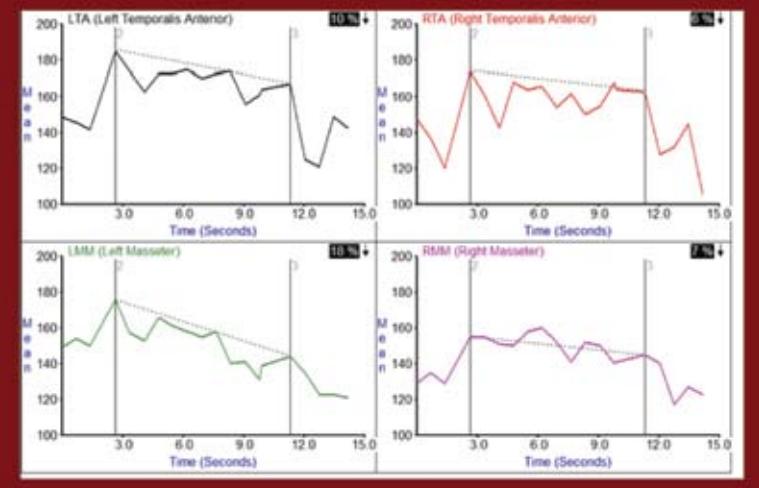


Figure 5

Scan 18 in Descending TMD

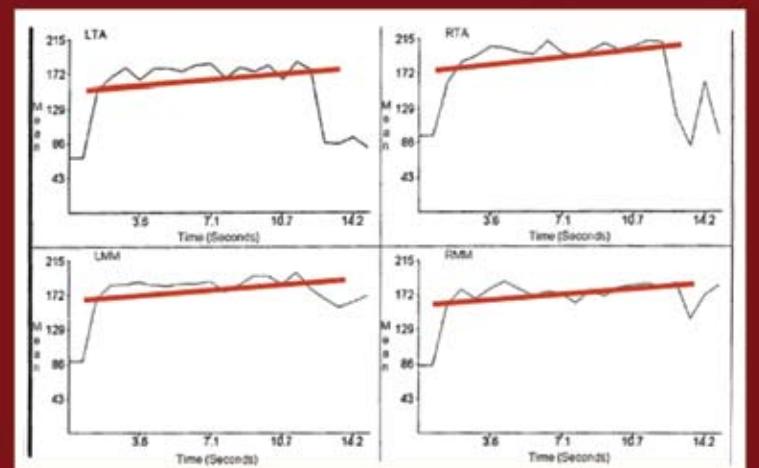


Figure 6

muscle force, electromyographic voltage and frequency under the ascending and descending postural anomalies. The muscle tension (EMG v), muscle frequency changes (mean or median EMG f) show dramatic differences between the ascending and descending form. The force line shows two phases: an early recruitment phase of muscle tension in which the frequency decreases to a minimum while the EMG v increases and a later phase of frank fatigue in which the frequency increases while the muscle tension decreases. Thus in the ascending patient the mean frequency progressively decreases while in the descending form due to upregulation of hi frequency power muscles to resist collapse of the contribution of masticatory muscles to the airway restricted intermittent hypoxia. These two phases define the frequency characteristics of the ascending posture to the left where oxygen supply is adequate to maintain muscle metabolism and the descending posture to the right of the graph where oxygen debt from airway hypoxia becomes predominant.

Thus, we see an understanding of Scan 18 as designed by Myotronics in Figures 4, 5 and 6 of the pre TENS condition. It should be noted from Figure 4 that the healthy subject shows neither decreasing nor increasing frequency from a ten second clench. In Figure 5 of the ascending posture TMD subject there is decreasing frequency as the clench tension progresses as seen from the composite Figure 3. The descending posture TMD frequency of scan 18 in Figure 6 is accompanied by increasing frequency. TENS, as proven in

the research publications mentioned previously, is known to reverse the frequencies so that the slope of the frequency changes decrease post TENS, becoming closer to the flat frequency recording of the healthy patient in Figure 4. It is important to recognize that if the muscles and supporting tissues of the teeth are the source of inflammation then the anticipated improvement with TENS does not occur. It can be seen from

the various graphs that with TENS it is possible to convert a descending TMD subject into an ascending posture type. It is essential for all doctors to be trained in understanding Obstructive Sleep Apnea because in an airway compromised subject where the FHP posture acts as a compensation for the airway restriction, our improved postural treatment may result in less than desirable results. I strongly recommend that all doctors

undertake the Dental Sleep Medicine foundation training at LVI to better understand how we as dentists can save our patients lives and not do any harm by what we believe is helpful treatment.

In part two of this article (next issue), consideration will be given to how oxygen dept is a chronic condition and why the related pathophysiology requires TENS of specific cranial nerves such as XI.



Norman Thomas graduated as a Doctor of Dental Surgery with honors and double Gold Medals in 1957. Dr. Thomas was awarded a Nuffield Fellowship (Oxford) to complete an honors degree in medical sciences in 1960. Between 1960 and 1974, he pursued residency and research programs at the Bristol Royal Infirmary, The Royal College of Surgeons of England, the Medical College of Virginia, and the University of Alberta, where he is now Professor Emeritus. From 1970 to 2002, Dr. Thomas served on the Medical Research Council of Canada, the National Institute of Health, USA, and the Canadian Dental Association, gaining a Certificate of Merit from the latter and several Fellowships in medical sciences and dentistry. He is a Life Member of the Alberta Dental Association and retired from dental practice in 2002. In 1998, he was appointed Chancellor of the International College of Head and Neck Orthopedics and, in that capacity, has lectured in the U.S., Europe, Australia, and Asia. He was awarded a Ph.D. degree in Oral Medicine for research on the process and mechanism of tooth eruption.

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PRODUCT

REVIEWS

Mark Duncan, DDS, LVIF

J. Morita's TwinPower Turbine

The process of removing decay and preparing a tooth for a restoration is convoluted and involved, but something that dentists have been well trained in completing. For years the dental industry had made do with technology that didn't exactly get in the way, but also didn't really help the process along, and in many cases actually created new issues to deal with. Fortunately, the high speed hand piece has allowed dentists to take a big step forward and now many are hard pressed to think of operating without that kind of technology. However, what is not done often enough is re-evaluating the technology to discover potential advances in the processes. For many practices, the advent of electric motor high speed hand pieces was a blessing and offered a much

improved level of control and accuracy. Electric motor hand pieces are a big advantage over conventional air driven hand pieces because they offer almost unlimited torque and allow the doctor to bull doze through the process using more intent when prepping to create a more refined final preparation and work. Torque is only half of the equation and it turns out that there is a balance between the two sides. Both torque and speed, the two cutting tools, are necessary and each offer certain advantages. While the electric hand piece offers a dramatic increase in torque, they also force a dramatic decrease in speed.

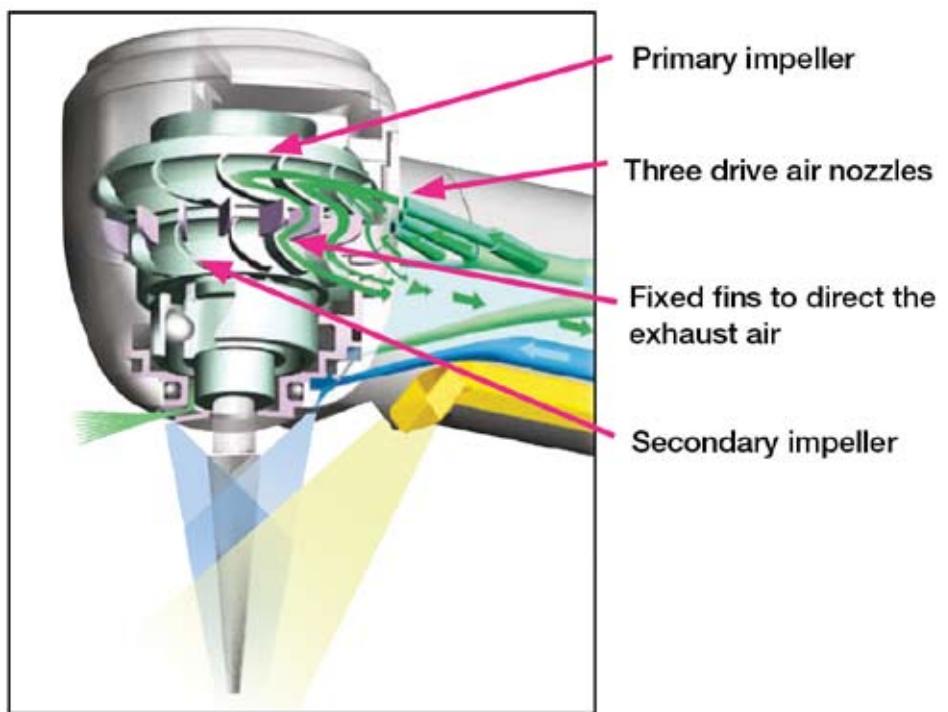
Conventional air driven hand pieces come at the other end of the spectrum. They cut with speed, but you have to convince the tooth to allow itself to be prepared. Light feather touch while

gently painting the preparation onto the tooth is required. Although there is a much better speed to work with, under load, you lose the torque and from time to time the bur literally stops spinning! The ideal solution would be to find a way to strike a balance between the grunt of high torque and the finesse of high speed. That is exactly what J. Morita has done!

The TwinPower Turbine offers big advantages and is built on several technological upgrades. As with everything dentists do, the key is in having the right tool. The ingenious development of the TwinPower Turbine is the right tool based on a couple of things. The bearings are ceramic, resulting in a lighter, stronger and better running system. However, this is not where the real advance lies. There is also a unique zero-suck back tech-

nology which eliminates the intake of particulates and aerosols when the hand piece is stopped. Again, that is not the major step forward. The exhaust is diverted away from the patient, which is also nice, but again it is simply icing on the cake. The great advance lies in the turbines themselves. To begin with, the turbines are built with a double-impeller technology which essentially utilizes exhaust air and drives a second impeller. There is also advancement in the delivery of the air stream within the hand piece and it provides a more direct and productive drive system.

The TwinPower Turbines are actually at a fantastic balance of the best in speed of the air driven hand piece along with exceptional and otherwise unheard of torque power of 22W. While this isn't the almost unlimited torque you may be accustomed to with an electric hand piece, it is dramatically more powerful than any air hand piece in your office! If you are staying away from electric hand pieces because of the weight or cost, but would like to have additional power, precision, and control; then this is the hand piece for you. J. Morita has put together a perfect balance of ergonomics, power and speed to create a package that can be fit in any office. As an option to your electrics, or as the go-to workhorse in your office, this TwinPower Turbine should be the engine that drives your burs!



Compliance Services

One of the great things about the business of a dental practice is that there aren't many threats to our viability and those that do exist are within our means to control and avoid, until now. While most of us have been in practice, we have seen things legislated that have the potential to destroy the practice. In the name of the 'greater good', leaders have created safeguards designed to protect the little guy from the negligence or carelessness of the big corporation. Unfortunately, in this day of picking the pockets and minds of the owners to feed and protect the masses we have seen a number of things created that put the dental practice at extreme, though probably unintended risk.

The first of these was OSHA and along with it came the potential threat of someone completing a site inspection and catching the dental practice grossly out of compliance with a guideline that rivals the tax code. Each of infraction carries the potential of a \$70,000 fine and the cumulative effect can cause a practice to implode. Obviously the point of the OSHA guidelines is reasonable and would largely be common sense, but it was written for large corporations and small businesses are often unintended targets. Fortunately, there are a number of processes and services available to help protect the office, and in the end, a \$70,000 hit would be a very

bad thing for the office but likely not catastrophic.

Then HIPAA was created. HIPAA is also a blanket answer to a common sense issue. It would be important to not share with the world an individual's private information, both health-related and personal. The scary thing about HIPAA is that it is designed to be policed by attorneys and at some point an attorney may figure out how to make money by targeting dental practices. While it is vital to maintain security on a patient's personal information, it is highly unlikely that someone would be bothered if it were exposed that they needed a buccal pit or had a 4mm pocket at the mesial of the lower right first molar. Again, the intention is good and there are some real benefits to having this information guarded. However, it also carries the potential for huge fines if found in violation and these can exceed the annual income of the dentist and practice!

While these are potential issues, at least they are something that we are

all aware of and they are relatively appropriate and answered by common sense solutions in the practice. Currently, the issue that is most frightening is PCI (Payment Card Industry) Certification. I know; what the heck is that? PCI Certification is designed to ensure that personal financial information is secure. Of course dentists want patients to be comfortable paying for their treatment with a credit card and knowing that information is safe. PCI Certification is an answer to something that should be pretty well common sense, but every practice is at risk for violating the protocols. Not just the practices that offer the courtesy of VIP processing and keep a card on file for the convenience of the patient, but any practice that accepts credit card payments is supposed to be PCI Certified.

The problem is that being out of compliance can carry fines adding up to more than a million dollars! Again, intended for the large scale processing companies, but the small businesses get caught in the fray and the poten-

*The problem is that being out of compliance
can carry fines that add up to more
than a million dollars!*

tial liability is monumental! There are exceedingly few practices that can easily take a hit for fines that are in the hundreds of thousands to over a million without changing the owner's life! Fortunately there is a very simple and inexpensive solution to this and that is utilizing a service that ensures both HIPAA and PCI compliance.

Compliance Services, Inc. has pioneered the comprehensive protection approach to avoiding the headache and the hassle of managing compliance with a changing set of rules. This isn't a watered down or slightly modified copy of something that already existed at nine times the cost. This is a purpose built and dental protection specific insurance against what would be a catastrophic problem if it were to happen. As the age of digital finances develops, these safeguards are necessary. The old adage of build a better mouse trap and you built a smarter mouse applies. People will find a way to sneak around the corners to steal money and steal identities so securities must be put in place. As the unfortunate byproduct of these rules, the dentist will need to be adept and familiar with the laws governing the management of this data.

In most cases dentists or practice managers don't have the perspective or expertise to be able to determine the right course of action to take to ensure that the practice and patients are protected. For a monthly fee that is less than the water bill, a practice can move forward knowing they are protected and in compliance with both. Through Compliance Services, there

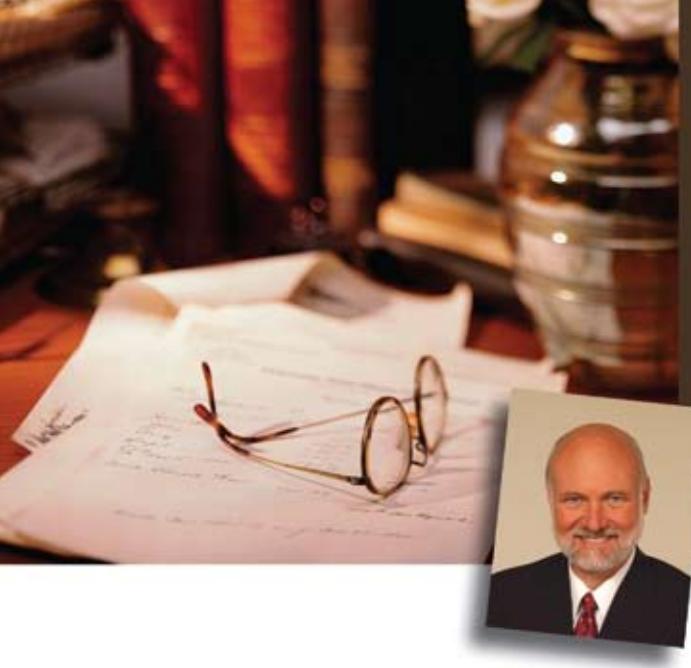
In this time of changing rules and financial dangers lurking, it is nice to know that you are protected by Compliance Services!

is a whole host of benefits available to the dentist and the package provides a number of safeguards and solutions. The most important issue to ensure is that you are not at risk of being fined on the order of tens of thousands of dollars PER INSTANCE. In a single day a practice could be fined the same amount of money it produces in 3-6 months! For less than \$50.00 a month the doctor can be comfortable knowing the practice is protected. Along with that also comes a data backup package that will provide off site data backup of up to 2 gigs. For LVI alumni or IACA members, the company has agreed to provide that same service for just under \$30.00 a month! In the more technologically integrated practices, they can provide up to 20

gigs of data backup as well as training and other benefits for less than \$90.00 a month (\$69.95 per month for LVI alumni or IACA members). This kind of risk management and security protocol is vital to the future and success of the practice as it allows the focus to stay on the growth and development of the dentist and team. In this time of changing rules and financial dangers lurking, it is nice to know that you are protected by Compliance Services! For more information visit Compliances Services at www.dentalpracticecompliance.com. Every practice in the country should take advantage of their security protocols. This is one of the easiest and cheapest bits of protection that can be found, and like gloves, no practice should operate without it!



A 1995 graduate of the University of Oklahoma, Dr. Duncan vigorously pursued continuing education to grow beyond what was taught in dental school; twice being recognized as the leader in Oklahoma for Continuing Education. He completed the surgical and prosthetic sections with the Misch Implant Institute earning a Fellowship with the Institute as well as holding Diplomate status with the International Congress of Oral Implantologists. He has also earned the Fellowship with the Academy of General Dentistry in the shortest time period allowed by the Academy. He considers his real advance in education to have started with his journey through the Las Vegas Institute where he earned a Fellowship and currently works full-time as Clinical Director. Dr. Duncan is a member of the International Association of Comprehensive Aesthetics (IACA) and holds a position on the Board of Directors.



THE WEATHERS' REPORT



Arthur "Kit" Weathers, Jr., DDS

Endodontic Access for the 21st Century **(Size Matters)**

A few years ago I had back surgery to deal with a displaced disk and the surgical access was less than one inch wide. The tiny incision was closed with a bandage glued in place with cyanoacrylate and I was able to go home from the hospital the very next day. When I was six years old, however, my appendix was removed and the scar was huge by today's standards.

When it comes to surgery, smaller is definitely better. So, why should we continue cutting away large amounts of sound tooth structure looking for canals when we can locate them scientifically with a much smaller access?

My goal for creating an ideal access opening is to remove only enough tooth structure to obtain straight-line access to all canals. On posterior teeth, this usually means removing less tooth

structure than what I was taught in dental school. On anterior teeth it usually means removing slightly more tooth structure to obtain the required straight-line access.

Broken cusps and large areas of decay will dictate larger than ideal access openings, but I prefer to keep the access as conservative as possible to improve the long-term prognosis of the final restoration.

Compare the size of the access preparations in Figures 1 and 2 and ask yourself which one would be easiest to restore and which one would have the best long-term prognosis.

Why is straight-line access so important?

The leading cause of rotary file breakage is not obtaining straight-line



Figure 1 – This is not a particularly bad access, but it could definitely be smaller and therefore easier to restore. The occlusal reduction may or may not have been necessary.



Figure 2 – This new conservative access is not only easy to restore, it becomes easy to obtain straight-line access by following a few simple rules.

access, which places rotating files in a bent and strained alignment. It is much like bending a coat hanger back and forth. When files rotate in a bent position, they will eventually weaken and separate.

A bad file path leads to accelerated cyclic metal fatigue, and competing forces on the same portion of the file accelerates the aging of the metal.

At 300 rpm, the file is cyclically stressed around its circumference 5 times per second and it may come apart after only 50-100 revolutions. Studies show almost zero file breakage if you obtain straight-line access and use new files in every case.

The purpose of this article is to present a new system for accessing teeth for endodontic treatment that minimizes the amount of tooth structure being removed, making restoration of the tooth easy and predictable.

Four steps to conservative and predictable endodontic access preparation.

The secret to this new system is simple. On all molars and premolars, the working cusp is directly over the canal orifice. The working cusps on lower teeth are buccal, and on upper teeth the working cusps are on the lingual. It may help to remember that “Buccal equals Bottom.”

There are four simple steps for creating an ideal access preparation on all posterior teeth.

Step one – Use a #4 round bur to prepare a slot preparation from the working cusp to within 2mm of the non-working cusp.

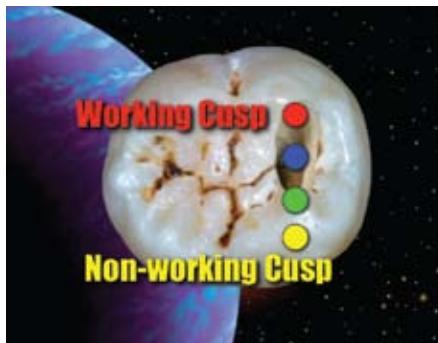


Figure 3 – The red dot is directly over the working cusp tip, which is directly over the canal below. The yellow dot is over the non-working cusp, while the green dot is over the mesio-lingual root. The blue dot is half way between the red and yellow dots, and is in the center of the tooth.



Figure 6 – Because the distal root is at an angle, the files will not have to bend to go straight into the distal canal.



Figure 4 – This is the initial slot created by connecting the green and yellow dots as shown in Figure 3.

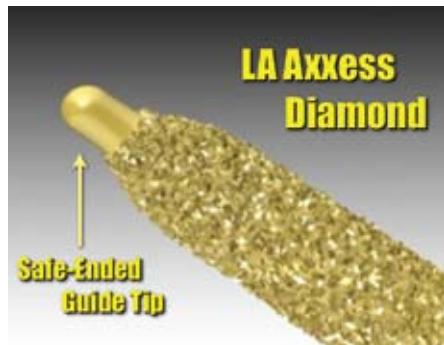


Figure 7 – The safe-ended LA Axxess Diamond is used to finish the preparation and create a series of grooves that guide the files and gutta-percha cones directly into the canals.

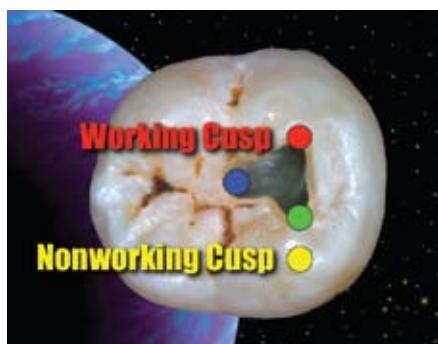


Figure 5 – Show the final position of the blue dot indicating the extension of the preparation toward the distal.



Figure 8 – The LA Axxess Diamond is inserted slightly into the canal while the safe-ended guide tip insures straight alignment into the canal. The resulting grooves in the walls of the access cavity serve to guide the files into the canals.

**Step 4 – Use hand files to verify
that there is a straight path
into each canal.**



Figure 9 – Slide a file into the canal to verify proper positioning in relation to the long axis of the root. In this particular photo, the file is not parallel to the root, because the LA Axxess Diamond hasn't been inserted into the canal.



Figure 10 – Straight-line access into anterior teeth will usually result in a small groove, which extends almost to the incisal edge.

The same rules apply for upper molars and all premolars.



Figure 11 – An ideal access preparation is created by following the same four steps used to create the prep on the lower. Note that the groove for the disto-buccal canal is almost directly in the center of the tooth and the preparation does not cross the transverse ridge.



Figure 12 – The same four steps created the preparation in this bicuspid. The lingual cusp on this upper bicuspid is directly over the main canal, and if there is a second canal it will be 2mm away from the non-working cusp. (On lower bicuspids the technique is the same, remembering that the buccal cusp is the working cusp.)

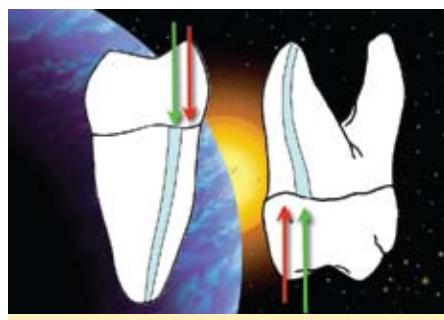


Figure 14 – The non-working cusp is not directly over the corresponding canal, and for this reason, the initial slot stops 2mm from the cusp tip



Figure 15 & 16 – In the past, endodontic access openings have been larger than necessary, and the techniques described in this article will help conserve valuable tooth structure leaving teeth stronger and easier to restore.

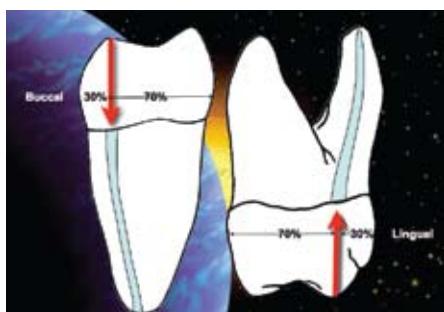


Figure 13 – The working cusp is directly over the canal in the working root, so the slot prep extends to the tip of the cusp.

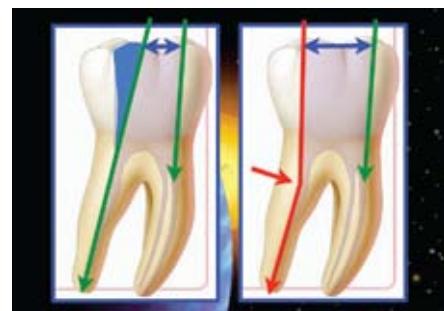


Figure 17 – Shows why we do not extend the access preparation much beyond the central groove, which results in the removal of significantly less sound tooth structure. The tooth on the left demonstrates ideal straight-line access into the distal canal, and the resulting minimal access opening.



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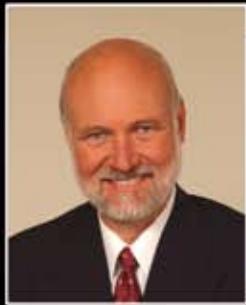
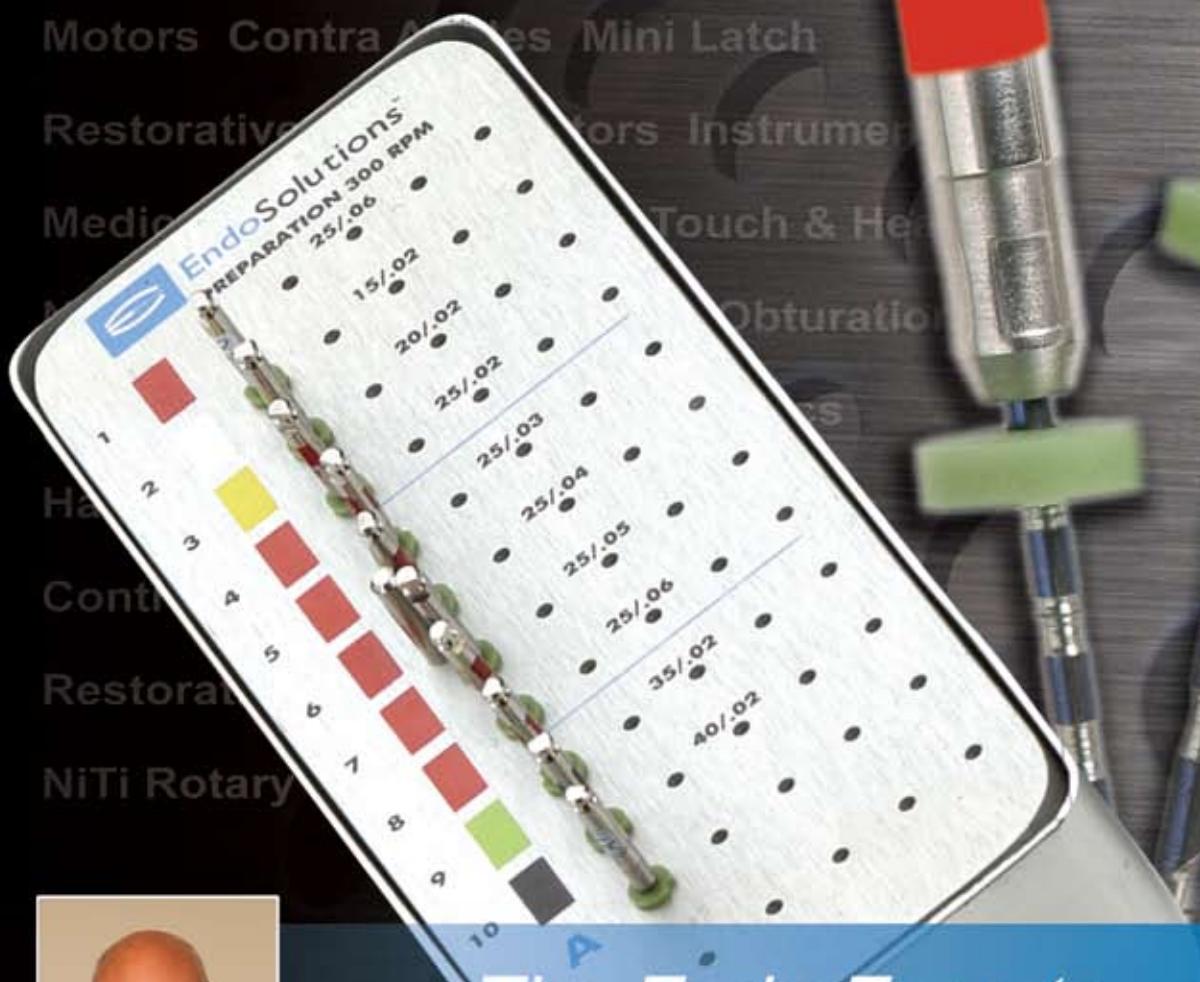
Microfiles Obturation

Hand

Contra

Restorative

NiTi Rotary



The Endo Experts
As Designed by Dr. Kit Weathers





Figure 18 – Don't forget that lower anterior teeth have two canals roughly 50 percent of the time, making parallel access even more important. The good news is the two canals usually join, so we have been getting away with only finding and filling the buccal canal. If the canals do not join, however, and we miss the lingual canal, the case will fail.

A few more pearls for obtaining ideal endodontic access.

It is always best to remove crowns prior to endo whenever possible. The crown is placed where it looks and feels best, not where the roots are, and with the crown out of the way, you will have easier access to the canals. In addition, your files will have easier access and will not be impeded by the crown walls. Another good reason for removing crowns prior to endodontic access is there is often decay that doesn't show up on the x-ray.



Figure 19 – If this tooth had been treated with the crown in place, the decay might have gone unnoticed, resulting in failure of the case.

Always make your initial access penetration in the pulp chamber prior to placing the rubber dam. This allows you to visualize the position of the roots and if the tooth is not completely numb,



Figure 20 – The root canal did not fail in this case, but the crown failed from undiagnosed decay.

you do not have to remove the dam to administer additional anesthetic.

If the distal canal of a lower molar is not in the center of the tooth (remember that nature loves symmetry), or if the distal canal is not twice the diameter of the mesial canals, look for a fourth canal.

Accessing the MB2 canal and dealing with calcified canals is a whole other story, and will be discussed in a future article.

Finally, the initial penetration into the pulp chamber should be made with a round bur to a maximum depth of seven millimeters. If you do not feel the bur drop into the pulp chamber, the pulp chamber may be calcified and this might be a good case to refer to the endodontist.

Incidentally, making a small access opening doesn't mean that you should not clean out all residual pulp tissue. Most of the tissue can be dissolved and removed by flushing the pulp chamber with sodium hypochlorite and activating the solution for at least two minutes with a file in a sonic or ultrasonic hand-piece with the water turned off.

**If you are having trouble with the access, stop and take another x-ray to see where you are.
Yogi Berra once said,
"If you don't know where you're going, you might wind up someplace else."**



Figure 21 – Beware of calcified pulp chambers and do not go deeper than 7 millimeters or you risk perforating into the furcation.

For more than thirty years, Dr. Arthur "Kit" Weathers has lectured worldwide on technologies, products and processes designed to simplify the practice of endodontics by the general dentist. The developer of a range of dental products, Dr. Weathers pioneered the EndoMagic! Nickel-titanium file system for general dentists seeking to improve both the quality of care and the economics of the endodontic services they offer. As the clinical technique developer of the X-tip Intraosseous Anesthesia System, he has assisted practitioners in need of patient-friendly anesthetic application methods.

Dr. Weathers is the author of numerous articles on innovations in endodontic treatment products and processes as well as intraosseous anesthesia delivery systems. His most recent four part series of articles entitled, "Endodontics, From Access to Success," appeared in Dentistry Today. Dr. Weathers has also introduced the well-reviewed C.E. Magic "edutainment" interactive learning system, entitled "Antibiotics in Dentistry" to the field of dental continuing education.

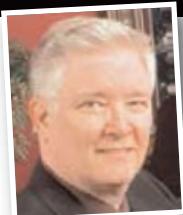
Dr. Weathers serves as the Director of Endodontics at the Las Vegas Institute for Advanced Dental Studies (LVI). Lecturing extensively to dental organizations, Dr. Weathers integrates an academically grounded approach to his subject with humor, magic, and mnemonics to enable his audience to recall his well-accepted techniques. As the founder of the Practical Endodontics "Root Camp," Dr. Weathers offers numerous two day, hands-on training sessions at the Las Vegas Institute and his facility in Griffin, GA.

Dr. Kit Weathers is the creator and featured speaker at the LVI Endo Root Camp®

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Patient Management as the Core of Your Dental Practice Management Strategy

Part 2



Brad Durham, DMD, LVIM

When I decided that I could no longer be everything to everybody I began to make choices as to who would be in my practice.

In part one of this article, I mentioned that for years I tried to be everything to everybody and that choice created a lot of headaches. Most of the management headaches I had then were created by developing a practice full of patients of differing goals and values. It looked to me that I was trying to ‘herd cats’ as I attempted to manage my practice.

I discovered that practice management in this environment was pretty frustrating and even impossible. When I decided that I could no longer be everything to everybody I began to make choices as to who would be in my practice. I quickly discovered that if I did not allow anyone and everyone in the practice, practice management was a non-issue.

Please understand that there is a perfect dentist for every patient. If I am not the ideal dentist for a particular patient, another dentist surely will be. Why should I change my idea of who I consider an ideal fit for me in order to keep a patient in the practice who probably does not want to be there anyway? Am I being selfish in this approach? I don’t think so! I learned when I gave up my approval addiction (of trying to be everybody’s dentist), I could be a much better dentist to a smaller group of patients who actually needed my services more and would really appreciate them.

What I am talking about here is specializing your general practice. Your specialty choices are many: cosmetic, restorative, TMD, sedation, implants and any combination of these areas. You could even specialize in economy dentures, Medicaid, or even in PPO services. The choices are endless. Let’s choose for the purpose of this article the choice of cosmetic-restorative-TMD as the desired type of practice.

Once I have my end goal in mind I can easily make decisions as to which patients to enroll based on their particular values. Values are the drivers of decisions and observed behavior. If I were to look at dental values, I would focus primarily on the values of health, prevention and cosmetics.

It is fairly easy to determine a perspective new patient’s values by simply asking them how they feel on the subject. It goes like this:

“Bill, since you are thinking about joining our practice would it be OK if I ask you a few questions about what is important to you?”

“How healthy do you want us to help you get your mouth?”

“How preventive do you want to be?”

“How important are dental and facial cosmetics to you?”

Once you begin asking patients these questions, you will need to decide what answers you are looking for in the patients you are willing to accept into your practice. It is your choice.

Another major consideration is watching the behavior of the patient already in your practice. You will need to consider changing their status based on how they keep their appointments, handle their charges, and possibly even accept treatment. A lot of patients will say they have high dental values, but their actions will prove otherwise!

Patients who miss appointments or do not properly pay their bills create a lot of problems in the office. Why have all those headaches in your practice? These patients are fairly easy to recognize. Another type of headache is the patient who does not follow your treatment recommendations. This could simply be non-compliance on exams, cleanings, or failure to not follow through on treatment recommendations. I don’t know about you, but I do not favor having my schedule interrupted by an “emergency” that could have been prevented if the original recommendations had been followed. My experience is that you can observe the behavior of a patient for a year or so and have a good idea of what the future will look like.

A/B/C VALUES – BEHAVIOR – RELATIONSHIPS

| BY VALUE | A | B | C |
|------------------------------------------------|--------------------|--------------------|----------------------|
| How healthy do you want your mouth to be? | Ideal | Average | Don't Care |
| How prevention oriented would you like to be? | Highly | Average | Wait until it hurts! |
| How important are dental and facial cosmetics? | High | Average | Low |
| BY BEHAVIOR | A | B | C |
| Follows Treatment Recommendations | Yes | Somewhat | Never |
| Appointments | Missed less than 3 | Missed less than 3 | Missed more than 3 |
| Account History | Pays | Pays | Doesn't Pay |

Just so you don't think I am espousing some elitist philosophy of practice development, let me assure you I am not. I just simply like to run an efficient practice and focus on a smaller group of patients. Again, every patient has his ideal dentist, and if I am not that one, I will refer them to one who is. I also believe that it is the dentist's responsibility to help those who are truly in need. I enjoy helping others and donating my time and resources...just in a different environment or on a different day than I am seeing my other patients.

Let's revisit stated dental values and observed behavior. Once you begin to develop a "profile" for a new or perspective patient you can easily begin to rate them. It is easy to use an ABC system to do so. You can create a grid

that helps determine the proper rating. For example, if the patient scores high on the values questions, you can rate them an "A". If they are fairly neutral on the concept of health, prevention, and cosmetics, you can rate them a "B". If they are not interested in any of the values, you can rate them a "C". You can also rate them based on their appointment record, history of payment or decisions about treatment acceptance.

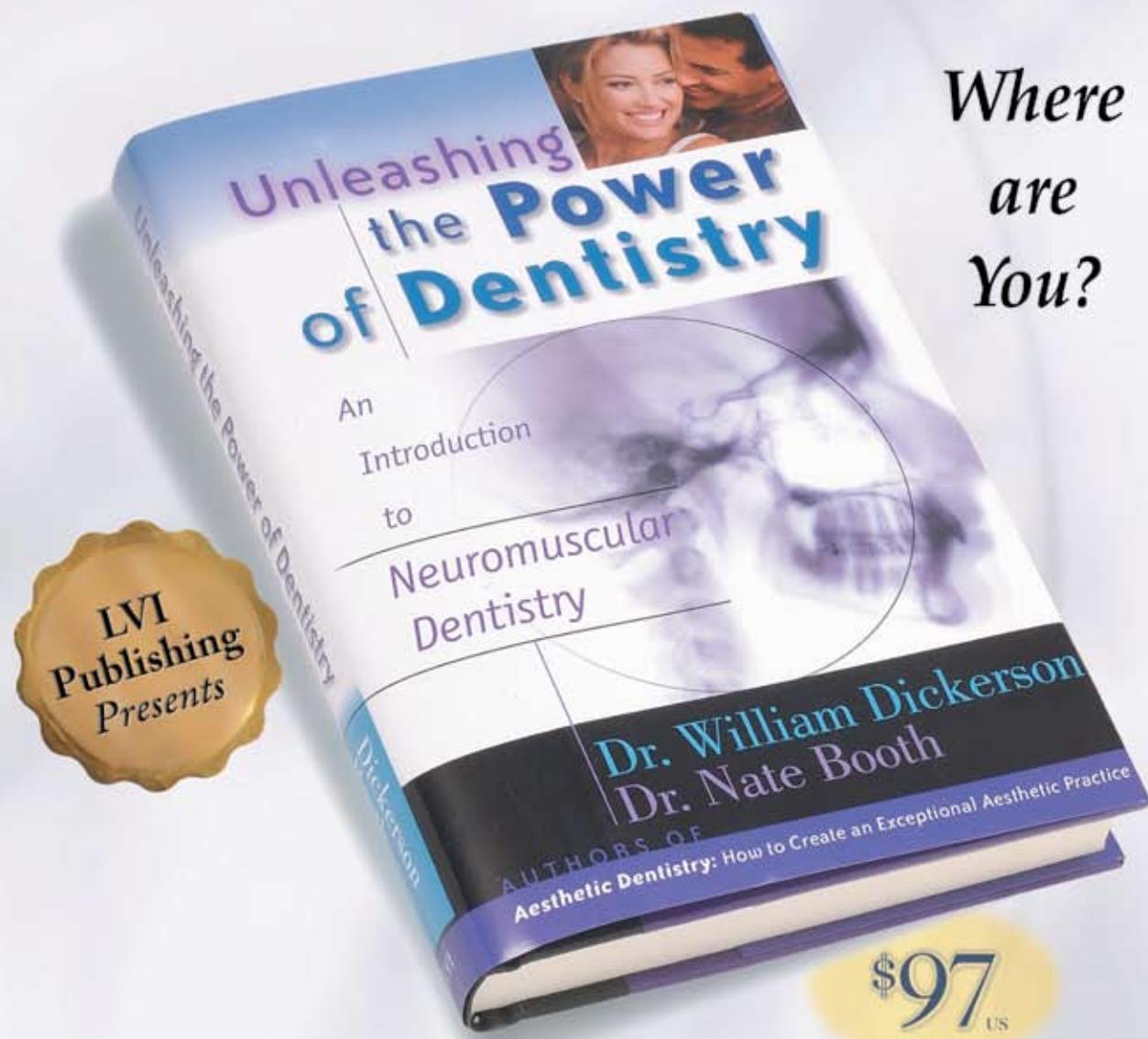
The last and final step is to determine how to treat each particular rating. You may or may not want to keep the "B" and "C" patients depending on your particular situation or "busyness". Dentists have always been reluctant to refer anyone out of their practice because of the concept of "busyness". That is especially true

in the present economic recession.

I can absolutely promise you that the more "C" patients you choose to work with the busier you will be. It is a real shame that you can't write checks on or deposit "busyness" in to your retirement account. Busyness has no real value at all, except to distract and confuse the dentist. You have an obligation to yourself, your family, your staff and your patients to be able to offer your best at all times and to remain as a viable practice for the future. Busyness does not support this obligation.

Dentistry has always been confused with this concept of busyness. In fact, if you pay attention, the first thing another dentist will ask you as you walk in to the local dental meeting is "Been busy?" Don't get caught in this trap!

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*Every patient has the perfect dentist
and every dentist the perfect patient.
I am all about the perfect match...are you?*

Busyness numbs your brain and the drive to be your best because after all if you are busy why would you want any more? The busy dentist also has a hard time transitioning his practice. It is the perfect “Catch 22”. What I mean by that is, he is too busy to have time to go to CE and learn new skills, too busy to apply them, and because he is too busy the image his practice projects is probably fairly average so the practice does not attract anyone with high expectations that demand anything more than basic services.

I personally instruct the full mouth

course at LVI (Core 7). As I talk with the dentists during the course, I ask them how much of this type of dentistry they are doing. Almost all respond that they would like to do more. What is standing in their way? Typically it is the fact that they have no real plans in place to develop that type of practice. They are “busy”, so they don’t have the time or notion to do anything else. Some are so busy that they literally are stuck. They don’t have the spare time to spend with the right patients to develop the trust and relationship in order for the

patient to feel good about enrolling in the more complex treatment.

Being busy is an expensive mistake if you are trying to be the best you can be. Whatever practice you choose for yourself is your choice, and that choice is perfect. I am just trying to give you the ability to choose. The solution starts with the realization that you can’t be everything to everyone and then acting on it. Every patient has the perfect dentist and every dentist the perfect patient. I am all about the perfect match...are you?



Dr. Durham practices neuromuscular, cosmetic, and TMJ related dentistry in Savannah Georgia. He was the first in the world to receive the LVI mastership. He teaches Niche oriented management and technical courses at LVI and lectures frequently on the topic. For more information on this course contact LVI at www.lviglobal.com or 888.584.3237.

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