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EDITOR'S COMMENTARY ■ DR. DICK BARNES, D.D.S.



Taking the Lead

Ignite Your Passion Through Dentistry.

“Follow your passion” is a tidy cliché that for many has become a foundational ingredient for finding success and fulfillment. The phrase isn't just a harmless, bumper-sticker philosophy, however; it's actually really bad advice. Throughout my career, I have met struggling dentists who attribute dissatisfaction in their professional lives to their lack of passion for dentistry.

The problem is thinking that a passion for dentistry (or anything else) is something that comes naturally, and some people have it and some people don't. The extension of that philosophy is the notion that people just need to follow their passion to have happy and successful lives.

I firmly believe that passion is something that can be developed. As dentists work to build something unique and meaningful for themselves and their patients, they will correspondingly gain a greater passion for their work.

I firmly believe that passion is something that can be developed. As dentists work to build something unique and meaningful for themselves and their patients, they will correspondingly gain a greater passion for their work. Passion isn't the source of success, but rather the result of struggle and effort to move past the obstacles that hold people back from reaching their potential.

In the past, I logged many miles traveling around the country and met with dentists at their practices (see story on page 12, “Travels with Dr. Barnes” by Hernan Varas). When I met with a

dentist who was feeling unhappy or dissatisfied with his or her dentistry, my advice was always the same: get back to basics! By that I don't mean practicing basic dentistry, I mean relying on the three basic principles that govern success in any endeavor.

Any dentist seeking satisfaction and fulfillment should focus their efforts on the following three areas: move beyond your comfort zone, find a mentor, and practice dentistry as an art.

MOVE BEYOND YOUR COMFORT ZONE

A saying that I like much better is, “Life begins at the edge of your comfort zone.” I suggest that fulfillment in dentistry comes after venturing beyond one's comfort zone. Many of our colleagues spend their days just doing the standard “drill-and-fill” dentistry only to find that their happiness and satisfaction is constantly in decline.

Instead of venturing into the full range of treatment options available to patients, dentists often limit themselves and the outcomes they can achieve. Dentists should resist allowing themselves to be limited by what they are comfortable doing for their patients.

Dentists should resist allowing themselves to be limited by what they are comfortable doing for their patients.

Rather than remaining in their comfort zone, dentists should embrace the discomfort of pushing beyond the realm of basic dentistry. I've always said that dentistry can provide life-changing results for patients. But those results are rarely accomplished with standard dentistry. Life-changing dentistry is achieved from complex and comprehensive treatments such as implants, sleep dentistry, full arch or full mouth reconstructions, and appliance therapy, to name a few.

(continued on page 41)

To develop a passion for dentistry, dentists should focus on 3 areas:

- 1 Move beyond your comfort zone**
- 2 Find a mentor**
- 3 Practice dentistry as an art**

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Not a Moment Too Soon

A Young Mom Gets a Full Arch Reconstruction.

As I was growing up, I always liked my smile. I never thought I had any problems. My teeth were straight except for tooth number 10, which was a little crooked. It looked a little bit like a snaggletooth, but it had personality, so I was fine with it.

None of my dentists ever discussed putting me in braces or indicated that I had any problems with my bite. But when I was in junior high, I started getting headaches. Doctors said that I had migraines and they prescribed medications for me that made me either drowsy or sick to my stomach. Instead of taking the medication, I just learned to live with the daily pain.

None of my dentists ever discussed putting me in braces or indicated that I had any problems with my bite.

The headaches started getting worse in my mid-20s. I assumed that the cause for the headaches was just stress related, because I had newborn twins and I was working full time.

At the time, I worked for a dentist in Roosevelt, UT, which is a small town in northeastern Utah with about 6,000 people. The practice I worked for utilized lots of advanced technology.

The dentist did all kinds of tests and scans on me and he concluded that my grinding and clenching caused my headaches. As part of my treatment, I received a night guard, but I'd always pull it out in the middle of the night. I tried wearing the night guard during the day because I could feel myself clenching my teeth, but the headaches remained.

I then visited my primary care physician for advice, but he told me the same thing that I heard when I was

younger, and I still experienced unwanted side effects with the prescription medication.

About the same time, I began having dental problems. Constantly clenching my teeth caused stress to my bite and I started getting abfractions along the gumline. I needed several root canals, and one of them went awry, so I had to get an implant when I was just 24 years old.

While all of this was happening, I was juggling the responsibilities of my job and three small children. Sometimes the headaches were so bad that I had to tell my kids, "Mommy just needs to lie down for a minute. I just need some quiet time." Although they were young, the kids were great about trying to understand.

A NEW BEGINNING

Several years later, I divorced and moved to the Salt Lake City, UT, area. I focused on getting my kids settled in a new area

and finding a new job. I decided I was ready for a change and didn't want to be a dental assistant anymore. As a dental assistant in Roosevelt, I had worked with Arrowhead Dental Laboratory for about six years and I knew that Arrowhead was a great lab, so I applied for a job there and was hired.

Today, I am a sales representative for Arrowhead. I've been in this position since April 2016. However, I've worked for the company since December 2013. I started out in quality control, worked as a doctor relations rep, and eventually moved into sales. I love my current responsibilities and working with dentists.

During my first year at Arrowhead, Peggy Nelson (Director of Sales for Arrowhead) was looking for someone who had any TMD concerns to volunteer as a patient for a continuing education course, so I volunteered. During the course, the doctor said that I had hypertension in my jaw, and he gave me trigger-point injections to see if they would release the muscles. They ▶



(Above) Preoperative View, Closeup



(Above) Postoperative View, Closeup

Aesthetic Dentistry

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Warning: Reading about techniques, procedures, and materials in this publication does not necessarily qualify you to integrate the new techniques and/or procedures into your practice. Exercise caution as you are solely responsible for specific treatments and options for your patients.



(Above, left to right) Julie McClure, Chelsea Brock, Dr. Terra Pauly, and Jo Kennedy. The team worked with Chelsea to provide life-changing dentistry.

provided a short-term pain solution, but nothing permanent. After the treatments, my jaw wasn't as tight as usual but it still hurt.

We had no idea the problem was my bite. My jaw didn't lock or click (which are typical TMD symptoms), it was just tense and very tight. No one ever addressed the problems with my bite, not even an orthodontist I consulted.

One day, a Tekscan representative visited Arrowhead for training. I volunteered to do a T-scan® for a demonstration. During the demo, I couldn't bite the way the rep needed me to for the scan. I still remember the look on the Tekscan rep's face after she did the scan. She immediately asked if I was in pain. When I said that I hurt all the time, she responded that she could see why.

We had no idea the problem was my bite. My jaw didn't lock or click (which are typical TMD symptoms), it was just tense and tight.

The rep emailed me the scan, which I sent to Dr. Jim Downs from L&Downs Dentistry in Denver, CO. Dr. Downs looked at the scans and the lab took impressions and models of my teeth. He discovered several factors that could be causing my symptoms. Most significantly, my teeth were entrapped—when I bit down, my teeth would slide against each other. I couldn't slide my teeth from side to side, and that resulted in my clenching and explained why my jaw hurt.

HELP IS ON THE WAY

To address the problems with my bite, Dr. Downs initially recommended a temporary appliance. He suggested an Astron flat orthotic (also known as the L&Downs orthotic in his lectures). Dr. Downs customized my appliance because of the entrapment, and he wanted to open up my bite.

Dr. Downs wanted my bite at 16.5mm, so we opened it up to 17.5mm and then slowly dropped it down until I hit a "comfort zone." For the next six weeks, I wore the appliance day and night, except when

I removed it to eat or brush my teeth. I was extremely conscientious about my home care routine.

During that time, my three children all noticed the orthotic. They saw me taking it in and out of my mouth, and as curious as kids naturally are, they asked a lot of questions. My youngest daughter, Emilynn, who was five years old at the time, tried to understand why I had to use the appliance. After I explained a few things to her, I heard her tell her brother and sister, "Mommy is fixing her teeth for her headaches."

Within three days of wearing the appliance, I could feel physical relief in my jaw—my muscles were relaxing. I eventually got used to wearing the orthotic, and soon it felt strange to take it out. I wore the appliance day and night for about seven weeks, after which I had my full arch reconstructed during a Clinical Hands-On course with the Dr. Dick Barnes Group in October 2016.

During the course, Dr. Terra Pauly of Pauly Dental in Wichita, KS, did my dental work. She had registered for the course (which requires dentists to bring a patient), but her patient backed out at the last minute. I volunteered to fill in, which gave me the opportunity to discontinue wearing the appliance and to permanently fix my bite.

Dr. Pauly and I were able to work with the lab technicians at Arrowhead to create a smile that I really loved. It was important to me that my smile look natural—I wanted it to look like me. I really liked the look of my canines, which had a very feminine shape. Also, tooth number 10 (the one that I wanted corrected) still has just the slightest turn. No one else would notice it, but in my mouth I can feel it, and it feels normal to me.

Dr. Pauly and I were able to work with the lab technicians at Arrowhead to create a smile that I really loved.

On the first day of the course, I spent seven and a half hours in the dental chair, but it was surprisingly easy! I couldn't have asked for a better dental team to work on me (see photo on page 8). I was a bit nervous because I knew that it was a permanent change! But then I thought, "I'm wearing an appliance and I already feel better. If this is permanent and I don't have to wear the appliance, I can only imagine how much better I will feel!"

I knew that Dr. Pauly was a perfectionist and she was going to do everything just right—and she did! I was only in temporaries for about five weeks. The temporaries were great because they looked exactly like the White Wax-Up.

MY PERMANENT SMILE

I flew to Denver in November 2016 for the second part of the Hands-On course (where my permanent restorations were seated). The seating took about four hours, which is a bit longer than normal, because tooth number 2 (a gold crown) slipped at the last minute. The bonding was stuck and Dr. Pauly couldn't move it, so she had to cut the gold crown off and remake it. In October 2017, I got the new gold crown seated.

BEFORE



(Above) Preoperative View, Biting

BEFORE



(Above) Preoperative Retracted View. Chelsea has a Wonder Woman tattoo on a posterior tooth.

AFTER



(Above) Postoperative View

We decided to make tooth numbers 2 and 15 in gold because of my clenching and my bruxism, and to hold my bite stops. The remaining Elite restorations were made from IPS e.max. After the crown slipped, Dr. Pauly had to find a way to ensure that the rest of the restorations were seating correctly.

As a result, it took a little extra time to seat the rest of the crowns, but everyone felt that it was better to get it right, versus rushing and potentially replacing more than just one restoration. The next day, Dr. Pauly adjusted the Snowcaps, but didn't have to adjust anything on my new crowns.

In October 2017, I attended another Clinical Hands-On course and had the Snowcaps removed from my lowers, and the permanent restorations on my lowers completed (because >



(Above) Members of the Arrowhead Dental Laboratory Sales Team, including (left to right) Rob Patane, Chelsea Brock, and Hernan Varas at the 152nd Midwinter Meeting of the Chicago Dental Society in 2016.

the lower restorations were completed so recently, none of them are pictured in any of the photos accompanying this story).

THE FINAL RESULTS

I saw my parents, my friends, and my kids almost immediately after the seating. My kids noticed that something was new, but they didn't know exactly what I had done. My friends thought I had

bleached my teeth or had something minor done to them.

When I told them I had a full arch reconstruction done on them, everyone was completely surprised! My oldest daughter, Anna, was the first to comment. She said, "They look like princess teeth because they're so white!"

I am so happy with my new teeth! I love them because they are finally straight and even. I have a much fuller smile. The permanent teeth are better than the temporaries because they look even more like my natural teeth.

The best part of having a full arch reconstruction is that I haven't had a single headache since my seating. Not one! Therefore, I don't have to do twice-a-month massages to release any tension, and I'm not clenching or bruxing anymore.

My oldest daughter, Anna, was the first to comment. She said, "They look like princess teeth because they're so white!"

I'm not the only one who has noticed that the headaches are a thing of the past. My kids have all commented to me, "Mommy, you don't have to lie down for your headaches anymore." I hadn't realized that the kids noticed it until they pointed it out to me. And they're right!

Since my full arch reconstruction, I sleep better, I'm more energetic, I'm happier, and I feel like I can keep up with the kids more. I think it has made me a better mom because I'm not as tired and I have much more energy to put back into life.

I also feel that my experience has taught my kids the importance of taking good care of their teeth. At the very least, all three kids are more conscious of their teeth and their dental health, which is a great thing.

ON THE JOB

As a sales representative for Arrowhead Dental Lab, I've had the opportunity to go to trade shows with my work. At events for my job, I can now show doctors exactly what Arrowhead's restorations look like.

At events for my job, I can now show doctors exactly what Arrowhead's restorations look like.

A few months after my reconstruction, I was in Nashville, TN, representing Arrowhead Dental Lab for Crown Council, a prestigious alliance of leading-edge dentists from around the world. I was talking with a dentist about how lifelike and natural looking Arrowhead's Elite restorations are, and I showed the doctor the model. He responded, "They look great, but I wonder how they look in a patient's mouth." I then said, "Well what do you think? You're looking at them!" He was speechless! The doctor couldn't believe my smile had been reconstructed.

WHAT I LEARNED

My best advice for *doctors* doing these types of cases is to listen closely to your patients because they're investing a lot of time and hard-earned money into such a treatment. Your work is going to be in their mouths forever and they have to love the work! If your patients tell you something, take notes and listen to them.

My best advice for *patients* is to tell your doctor and his or her team members everything: mention any and all symptoms that

might be related to your teeth—anything that you have dental health concerns about.

Make sure to tell the clinician what you're feeling because the doctor needs to know as much information as possible. Communicate specific desires about the aesthetics with your doctor to make sure it gets done the way you envision.

I am so happy with my new teeth! I love them because they are finally straight and even. I have a much fuller smile. The permanent teeth are even better than the temporaries.

On my final Wax-Up, I was not perfectly happy with one minor thing, so I spoke up and asked Dr. Pauly to change it. And I'm so happy that I did! Good communication with your doctor is extremely important.

I also advise patients to take care of their dental problems sooner rather than later. I got my teeth done at just 29 years of age. It scared me a little—being so young and making such a permanent change. But I knew that my teeth would continue to get worse and that taking care of problems sooner rather than later would save me a lot of pain and trouble.

All the time, effort, and expense have been completely worth it! And the process itself is much easier than most people usually imagine. It wasn't until the pain was gone that I realized how much

pain I had been living with every single day. Thankfully, now everything is different.

I thought I smiled a lot before, but I smile even more often now! My coworkers, friends, and kids have commented on how much I am smiling. You wouldn't necessarily think that improving something like your smile could have such a huge ripple effect, but everything in my life just keeps getting better and better. ■



Diana M. Thompson graduated magna cum laude with a bachelor's degree in English from Utah State University in Logan, UT. For more than 10 years, she has worked as a copywriter and editor for the natural products industry. She has written for several newspapers and edited a variety of full-length books and booklets. She specializes in nonfiction literature, particularly for the healthcare industry. Diana can be contacted at dianamaxfield@gmail.com.

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(Above) Chelsea Brock with her kids (from left to right) Donovan, Emilynn, and Anna.

Travels with Dr. Barnes

A Comprehensive Guide to Treating Comprehensively.

For almost eleven years, I had the privilege of traveling around the country with Dr. Dick Barnes. We went on the road to fulfill the main goal of Arrowhead Dental Laboratory—to share tried-and-true strategies so that our clients could become better and more productive dentists. We visited every state in the Union except Alaska and Hawaii. We didn't just visit each place once—sometimes we went to locations multiple times.

During our travels, we went from dental office to dental office, sharing dental practice management tips and teaching dentists how to help their patients discover what is needed to maintain healthy teeth, or to restore teeth to good health.

Whenever we visited an office, the first question that Dr. Barnes always asked was, “How’s your practice going?” From that simple but comprehensive question, we learned many things. A dental practice is not just the procedures you do and the services you offer. A dental practice includes the relationships with patients, the organizational behavior of team members, the

“How’s your practice going?” From that simple but comprehensive question, we learned many things.

business practices, the interactions within the dental industry, the overall reputation of the dentist (including the digital and local community presence), and other outside forces. In other words, a dental practice is made up of many factors that combine to produce great dentistry.



In the past, dentists graduated from dental school, set up shop, and expected to almost effortlessly have patients. But it’s a totally different environment today. Dr. Barnes says, “Now, dentists have to co-discover with patients what is needed, so that they can produce great, life-changing dentistry.”

From traveling with Dr. Barnes, I learned three keys to a successful practice. First, dentists should learn to develop business relationships from the outset. Second, dentists should think and present comprehensively. It is important for dentists to know and believe in the value of their dentistry, mentor their teams about the value of dentistry, and teach all patients about the value of dentistry. Third, schedule for production and set clear, daily goals.

DEVELOP RELATIONSHIPS

Dr. Barnes always emphasized the importance of a new patient’s first visit. Whenever an office welcomes a new patient, *it is the single most important visit!* It’s important for the front desk team members, for the team members in the back of the office, for the dental assistants, the dental hygienists, and for the dentist.

The new patient visit should be conducted in such a way that the patient feels like there’s nobody else in the world but him or her. Dr. Barnes suggests imagining every new patient coming into the office carrying a big sign that says, “Make me feel important!” If dentists visualize that scenario, they will remember to make new patients a priority.

During the dentist’s initial meeting with a new patient, his or her job involves more than simply discussing why the patient is coming in. The job is also to establish a comfortable doctor-patient relationship. How can a dentist do this successfully?

It’s the simple but important things that matter: ask the patient about his or her family; ask about where they are from; ask about how they were referred to the office; and ask about why he or she chose to visit your practice.

It’s amazing how patients feel when you develop a relationship and talk about personal things. When doctors take the time to treat patients as individuals, patients develop a high trust/low fear relationship with the dentist. Such relationships are ideal and are key to having patients understand and accept the value of treatment. For some dentists, the activity of developing relationships can be uncomfortable. But from a business perspective, it is critical for business development.

It’s important to sit eye-to-eye and knee-to-knee with your patients. —Dr. Dick Barnes

During the initial meeting, details matter. If doctors are wearing scrubs and a surgical mask with loupes hanging down, patients will sense that he or she is in a hurry and doesn’t have time for them. Instead, get comfortable, relax, lose the mask and the loupes, and as Dr. Barnes says, “sit eye-to-eye and knee-to-knee with your patients.”

It doesn’t have to be a long conversation—you’ll be surprised that three minutes can go a long way. If you spend a little extra time with the patient, he or she will feel like you talked for hours. Dr. Barnes always says, “Talk about them and tell them about yourself. Discuss pleasantries.” Remember that dentists sit in front of a whole person, not just a mouth full of teeth. ▶

Ask questions, because everybody likes to talk about themselves. If you keep the conversation lively and light, people will remember you and like you—and more importantly, they will trust you. People like to do business with people they trust.

Dr. Barnes suggests relating to something that the patient tells you. Take notes after the conversation if it's helpful. That way, when the patient returns, you can ask, "How is your husband doing with the trees he was planting?" Or, "I remember that you were going on a great vacation to Florida. How did that go?"

You cannot have expectations of a dividend yield from an investment that you never made. That investment is an honest and ongoing conversation with your patients.

Always keep a positive outlook during the conversation. A positive mental attitude is a very powerful tool when you meet someone new. People can tell immediately whether you have a positive mental attitude or a negative one. The dentist sets the tone for the office with his or her mental attitude and approach towards patients.

TREATMENT ACCEPTANCE

Once you get past the pleasantries, you can learn more about each patient's particular personality and understand the best way to communicate with him or her. When it comes to case presentation, the way you approach each patient may be a little bit different.

In the Fall 2015 issue of *Aesthetic Dentistry*, Dr. Jim Downs wrote an article called, "I Object! Getting Patients to Say YES to Treatment." He said, "Some of your patients are going to want a lot of information to buy into the dentistry. Others will be overwhelmed by a lot of information." The only way you can know whether people want a lot of information or the bare minimum is to get to know them.

Dr. Barnes recognizes that this approach requires some time and effort. And for introverts, it's not something that necessarily

comes easy. Dr. Barnes had to work at it, too. He was an introvert and it wasn't natural for him to be outgoing and inquisitive with others—he had to develop those skills.

Therefore, read and study about ways to become more outgoing. There are several ways to do it. As you read about different techniques and practice them, you'll find a way that suits your personality and you'll improve your skills.

Most people don't want to go to the dentist, so try to make it as pleasant and as remarkable an experience as possible. Patients should feel that when they visit the practice, they are going to see someone they know and like—someone they trust and whose opinion they value. After developing a good relationship, patients will trust that their doctor is going to help them maintain their good teeth or restore them to good health.

Every doctor struggles with getting patients to accept treatment. But a good relationship with your patients helps improve case acceptance. A good relationship doesn't guarantee a "yes" every time, but when patients are comfortable and keep coming back to see you, it's more likely they will trust you and proceed with treatment.

Dr. Barnes said, "One of the constants in a dental practice is that many patients will tell you 'no' to treatment. You'll have to deal with that throughout your career. But a 'no' today doesn't mean a 'no' tomorrow."

Think of case presentation in terms of an investment—you cannot have expectations of a dividend yield from an investment that you never made. That investment is an honest and ongoing conversation with your patients. If you have that discussion, it establishes a foundation for case acceptance later on.

Some cases take time, but you'd be surprised at how many patients show up years after the original case presentation and say, "I'm ready to do what you told me to do." They may not remember in detail what you suggested, but they will remember that the work is important. But if you don't have that initial conversation, the investment will never yield a valuable result.

Occasionally, take time to evaluate and revisit the status of each patient relationship. If you have not seen a patient for a while, treat him or her like a new patient. Sometimes you can get to know that patient all over again.

THINK COMPREHENSIVELY

The second way to improve your practice is to take a comprehensive approach to your patients' health. A dentist's job is to share what is needed for patients to maintain or restore their teeth to good health. Whether a patient says "yes" or "no," or whether you perceive that a patient can or cannot afford the dentistry is immaterial. Every patient should be presented with comprehensive dentistry.

Some patients will say, "Please don't find anything," but they need to know what is going on with their teeth. Teaching patients about their teeth helps create value for the work.

Today, the life expectancy for men and women has been extended. Remind patients that teeth were originally expected to last for perhaps 50 years or so, and now people are living well beyond that, so it's important to protect their teeth. If you teach patients the value of keeping their teeth (value equals benefits minus cost), they will get the work done.

3 KEYS TO A SUCCESSFUL PRACTICE

- 1 Develop exceptional relationships with your patients and team members.**
- 2 Take a comprehensive approach to your patients' oral health.**
- 3 Plan your schedule according to production, and set daily goals.**

A SIMPLE EVALUATION

At every visit, Dr. Barnes was a true mentor to his peers on how to refine and rejuvenate their practices—which always began by thinking comprehensively. Dr. Barnes would often ask doctors to pretend that they had just bought their practice, and then ask them three questions to consider as the new owner.

The first question was, "How many adult prophys are in the practice?" This question is important because in general, half of all adult patients will need one crown. Some adult patients will need no work, others will need much more work, but that is an average amount.

The second question was, "How many new patients does the office have each month?" If dentists present comprehensively, the value of a new patient is between \$3,000 and \$5,000. Twenty-five new patients a month is a good goal for comprehensive dentists (or 30 patients a month for a drill-and-fill operation).

The third question was, "After presenting treatment, if patients tell you that they want to think it over, how do you respond?" How dentists respond to this question suggests whether or not they are closing on treatment.

Again, evaluate your practice as if you just bought it. Think about what you can do to improve the business. Ask yourself, "What specific areas could use improvement?" On his visits, Dr. Barnes offered a fresh, comprehensive, dentist-to-dentist perspective, and it helped doctors realize that there was always a lot more that they could share and communicate with their patients.

Always evaluate your practice as if you just bought it. Think about what you can do to improve the business.

During our travels, dentists often asked Dr. Barnes how to transition from drill-and-fill dentistry to more comprehensive work. Inevitably, his answer involved taking time to visit with patients and explaining the value of the treatments they need. Even if patients don't choose to have treatment done immediately, the dentist has set the stage for future (and likely more fruitful) conversations.

Once a good relationship is established, dentists can have a more direct conversation with patients. A dentist might say, "Mrs. Jones, I've been seeing you for the past five years and I've noticed a lot of wear and tear. I believe it's time for us to do something because my goal is to preserve your teeth for a lifetime. I would like to have you back for a diagnosis appointment and I will share with you exactly what I am going to do and how much it will cost before we do anything. I think you are going to be very happy with the results." There are many ways to start such a conversation.

DON'T FEEL GUILTY ABOUT FEES

Finally, dentists should stop feeling guilty about the amount of their fees. If dentists know the value of dentistry, they shouldn't worry about charging \$20,000, \$40,000, or even \$75,000. Yes, it is a lot of money, but if dentists know the impact it will have on their patients' lives, they can communicate that and patients will get the work done.

A certain number of patients will tell you 'no' to treatment. You'll have to deal with that throughout your career. But a 'no' today doesn't mean a 'no' tomorrow.
—Dr. Dick Barnes

Many doctors offer discounts because they feel like they are charging too much. Dr. Barnes has said, "Don't feel that way. I don't give discounts because I know the value of my dentistry. I know exactly how much I charge and why I charge it."

Every dentist should know the value of their dentistry—both from a clinical perspective and from a financial one. Believe in your dentistry, think comprehensively, and mentor your team to understand and convey the value of the treatment to all of your patients.

All successful practices have successful teams. The dentistry that you provide for your patients is absolutely remarkable, and it will change their lives. Your team should understand and believe in the value of your dentistry, too. It's important for all team members to communicate the same message. ►



SCHEDULE FOR PRODUCTION

On our trips, the final message that Dr. Barnes would share with his clients was about goal setting. In order to maximize production, dentists must set goals. Dr. Barnes recommended that all dentists start with a yearly goal and work backwards to set daily goals, so they know exactly how much to produce every day.

Here's how to do it: go to the yearly calendar and calculate how many days you are *not* going to work—take out weekends, vacations, holidays, etc. After you subtract those days from the calendar, the remaining days are how many days you will work.

For the sake of simplicity, let's say that number is equivalent to two hundred days. Next, set a goal for how much revenue your office will generate. Let's assume that your practice will produce a million dollars. If you divide your yearly production goal by the number of working days, you will get a daily production goal. If you are going to work two hundred days and produce a million dollars, your daily goal will be \$5,000.

The dentistry that you provide for your patients is absolutely remarkable, and it will change their lives.

Without a daily goal, the team members will get lost. Dr. Barnes and I once visited an office that set a monthly goal, but had no daily goals. Guess what happened? The first two weeks of the month, everything was relaxed and stress-free. But during the last two weeks of the month, the practice was in chaos as they tried to reach their goal. When your team members feel stress, your patients feel stress. It's important to have daily goals instead of monthly ones because they are much easier to digest.

Once you have your goals in place, schedule your day to be as productive as possible. Schedule all the production in the morning, and schedule the rest—crown seats and all the things that are non-productive—in the afternoon. Scheduling this way provides structure to the day.

When patients call, your team members can tell them that you schedule certain appointments in the morning, and other less-urgent procedures in the afternoon. Scheduling for production is a way of training your patients. Your patients are scheduled when it's convenient for you, and not the other way around.

COMING HOME

Being on the road with Dr. Barnes was always an adventure! Dr. Barnes always said, "If dentists invest in continuing education



to get better, if they read about sales, and how to become a provider and an advisor to their patients, then they can convey the value of what they're going to do."

Blake McKinley, Practice Coordinator for Ray McKinley, D.D.S. & Brittany McKinley-Holloway, D.D.S. in Shelby Township, MI, has implemented Dr. Barnes's advice for years. McKinley said, "The practice that is able to successfully implement all of these strategies will see an explosion of productivity, daily satisfaction with their work, and a patient base composed of elated fans."

From Dr. Barnes, I learned the importance of dental practices becoming better and more productive. Together, we saw countless dental practices transform before our eyes. The feeling of helping practices improve is a contagious one. Even though Dr. Barnes is enjoying staying grounded these days, like the old Willie Nelson song says, "I can't wait to get on the road again!" ■



Hernan Varas is in Clinical and Practice Development with Arrowhead Dental Laboratory in Sandy, UT. Hernan has been with the lab for more than 15 years and has worked in the dental industry for more than 30 years.

Originally from Chile, Hernan attended Westminster College in Salt Lake City, UT, for a bachelor's degree in marketing and communications. Afterward, he continued his studies at Westminster and received a Master of Business Administration degree, with an emphasis in international management.

Since working at Arrowhead, Hernan has been mentored by and visited thousands of dental practices with Dr. Dick Barnes—including every state in the contiguous United States. Hernan specializes in strategies and techniques for increasing productivity and case acceptance in dental practices.

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Restoration Success

Using Monolithic Zirconia Restorations for a Full Mouth Reconstruction.

With greater public awareness about cosmetic dental reconstructions, dentists are often challenged with greater demands from patients. This increased demand for aesthetic restorative treatment challenges dentists, laboratory technicians, and dental manufacturers to develop techniques and materials to satisfy such discerning patients.

Utilizing digital planning, modern materials, and effective techniques, restorative teams can succeed in restoring a smile to proper form, function, and health. Recently, I completed a case that demonstrates the feasibility and significance of utilizing the

latest techniques in planning, preparation, and material selection for a full mouth reconstruction of a patient's dentition.

CASE PRESENTATION

An adult woman in her early 40s was referred to my practice by her dental provider because she was dissatisfied with the appearance of her smile. The patient commented that her existing teeth and restorations were unattractive because of recurrent decay, wear, and color (see *Figure 1, below left*). Most notably, the patient mentioned that she was suffering from tension headaches, grinding, and a limited range of function.

Utilizing digital planning, modern materials, and effective techniques, restorative teams can succeed in restoring a smile to proper form, function, and health.

At the first appointment, the initial diagnostic evaluation consisted of digital images with study casts, a centric relation bite record, a facebow transfer, and a full mouth set of X-rays.

In the maxillary arch, the patient had several teeth with worn composite and veneer restorations, as well as abfractions with cervical decay (see *Figure 2, on page 19*). In the lower arch, several existing composite restorations had worn, and decay



Figure 1: Preoperative Retracted View



Figure 2: Preoperative Maxillary Occlusal View



Figure 3: Preoperative Mandibular View

was exhibited on the facial cervical areas. Although there were no restorations present in the anterior mandibular teeth, there was severe wear in the incisal edges due to possible grinding and parafunction (see *Figure 3, above right*).

PLANNING

After reviewing the clinical findings, as well as the mounted models, the patient was diagnosed with a restricted envelope of function and decreased vertical dimension from continuous and extensive wear.

To develop a treatment plan and determine if the vertical dimension could be increased, a diagnostic 3D White Wax-Up (from Arrowhead Dental Laboratory) was fabricated. In the White Wax-Up, the patient's vertical dimension was increased by 1.5mm.

Based on information gathered from the initial consult and digital images, we determined that the maxillary centrals could be lengthened by 1.3mm to improve the patient's overall aesthetics.

We determined that the canines would also be lengthened to restore canine guidance in lateral excursions. With regards to the patient's lower anterior teeth, the goal was to correct the length-to-width ratio, and create a less-worn appearance.

As a result of the information gathered from the diagnostic Wax-Up (see *Figure 4, below left*), I determined that aesthetics and function could be enhanced by restoring the patient's entire dentition. The final treatment plan consisted of crown restorations, placing composite cores where needed from tooth numbers 2 to 15 in the upper arch, and tooth numbers 18 to 30 in the lower arch.

The material of choice for the crown restorations was Zenostar® (Wieland, Ivoclar Vivadent). According to the manufacturer, this translucent zirconia material combines excellent flexural strength with the aesthetics of natural tooth shades.

With greater public awareness about cosmetic dental reconstructions, dentists are often challenged with greater demands from patients.

With full-contour Zenostar® restorations, there are two methods for achieving the desired shade: the Zenostar® brush infiltration technique, and the Zenostar® staining technique. Six pre-shaded zirconia blanks—pure, light, medium, intense, sun, and sun chroma—form the basis for reproducing the patient's natural dentition.

Due to their warm, reddish nuance, Zenostar® Zr Translucent sun and sun chroma are suitable for restorations with individual color characterization, and can therefore be used for patients whose own natural dentition deviates from the classic tooth shades. ➤



Figure 4: Digital View of Wax-Up



Figure 5: Bite Jig Relined Capturing Full Arch Bite



Figure 6: Fabricating Provisional Restoration

PREPARATION

After obtaining informed consent from the patient, treatment was initiated. First, we administered anesthetic to the patient and then removed any existing veneer and crown restorations. Then the teeth were cored with composite where there was any indication of recurrent decay remaining in the tooth. Adhese® Universal bonding agent (Ivoclar Vivadent) was applied following the manufacturer's protocol, and cured using the Bluephase® (Ivoclar Vivadent) LED curing light.

Using MultiCore® Flow Light (Ivoclar Vivadent), build-ups were accomplished on the teeth requiring cores. A Clear Reduction Guide (by Arrowhead Dental Laboratory) provided with the 3D White Wax-Up was used to ensure adequate reduction for the definitive restorations. We used a coarse grit chamfer diamond bur (Komet®) to prepare the entire dentition for the Zenostar crowns starting from tooth numbers 2 to 15, and then on tooth numbers 18 to 30.

We took a full arch impression using Instant Custom C&B Trays (Good Fit®). Made of a proprietary material PMMA—poly(methyl methacrylate)—that becomes adjustable when heated in boiling water, these trays provided a quick, efficient way of capturing a dimensionally accurate impression with

uniform thickness of the impression material. Once molded and customized to the patient's maxilla and mandible, full arch impressions were taken using a heavy and light polyvinyl siloxane (PVS) impression material (Panasil®, Kettenbach).

After the impressions were completed, a bite-relations jig was fabricated on the 3D White Wax-Up models (from Arrowhead Dental Lab) and tried in the patient's mouth. Medium body-impression material (Panasil®, Kettenbach) was placed into the relations jig and seated into the patient's mouth on the prepared teeth (see Figure 5, at left).

Most importantly, the patient said that she no longer experienced discomfort with her TMJ, and her bite had never felt better.

I asked the patient to bite into the relations jig until she reached the vertical stops and the material set. Instructions for the size, shape, and color of the final restorations were forwarded to the dental laboratory (Arrowhead Dental Lab), as well as the 3D White Wax-Up models.

Finally, a stump shade (Ivoclar Vivadent) was selected for shade-matching the preparations and to assist the laboratory technician in creating natural-looking restorations.

PROVISIONALIZATION

A provisional restoration, which aided in determining the best size, shape, color, and position for the definitive restorations, was made from a Sil-Tech (Ivoclar Vivadent) impression of the 3D White Wax-Up that was provided by the dental laboratory. Using a B1 shade of Visalys® (Kettenbach) temporary material, the Sil-Tech mold was quickly filled and placed on the patient's prepared dentition (see Figure 6, at left).

Within a few minutes, the provisionals were fabricated and effortlessly trimmed with trimming burs (Komet). Once the teeth were desensitized with Systemp® desensitizer (Ivoclar Vivadent) and then dried, the provisionals were temporarily cemented using Temp-Bond™ Clear (Kerr). The patient was given instructions regarding her home care routine with the provisional restorations, and regarding their use in eating, speaking, and biting.

A few weeks later, the patient returned for an evaluation of aesthetics, phonetics, and bite. She already exhibited excitement and confidence with her provisional restorations, commenting that all of her coworkers noticed that she looked younger and happier.

Most importantly, the patient said that she no longer experienced discomfort with her TMJ, and her bite had never felt better. Since no adjustment or modification of the temporaries were needed, the dental laboratory was instructed to replicate the 3D White Wax-Up when fabricating the definitive restorations.

LABORATORY CONSIDERATIONS

The 3D White Wax-Ups, color photographs, impressions, and bite relations were forwarded to Arrowhead Dental Lab. A scan of the 3D White Wax-Ups was used to select

an appropriate arch form, tooth size, and occlusion from the library of teeth available in the 3Shape Communicate™ software (see Figure 7, at right). Using 3Shape software, images of the proposed reconstruction were forwarded to my office via email. Any minor adjustments in tooth shape and contour were communicated to the laboratory's technical advisor to achieve the ideal aesthetics. Once approved, the milling process began (see Figure 8, at right).

CEMENTATION

Before try-in of the definitive restorations, the provisional restorations were removed using the Easy Pneumatic Crown and Bridge Remover (Dent Corp), and any remaining provisional cement was cleaned off the prepared teeth. The maxillary and mandibular zirconia restorations were tried to verify fit, form, and shade. After the patient was shown the retracted view for acceptance, we initiated the cementation process.

Riva Luting Plus (SDI), a resin-modified, self-curing, glass ionomer luting cement, was used for the cementation of the zirconia restorations, because it can be used without requiring special preparation (cleaning agents), nor does it require any bonding agents (see Figure 9, below right).

According to the manufacturer, Riva Luting Plus utilizes proprietary ionglass™ filler. This material is a radiopaque, high-ion releasing, reactive glass used in SDI's range of dental cements. Riva Luting Plus releases substantially higher levels of fluoride to assist with remineralization of the natural dentition.

This higher level of fluoride has a proven antimicrobial activity against three cariogenic bacteria: *Streptococcus mutans*, *Streptococcus sobrinus*, and *Lactobacillus* (1). In addition, Riva Luting Plus has low solubility in the oral environment, increasing the material's ability to resist degradation and wear at the margins caused by oral acidity.

The preparations were washed and dried, so they were still slightly moist. Next, cement capsules were depressed consecutively to activate, and placed in the Ultramat 2 (SDI) amalgamator for only 10 seconds for trituration.

Using the applicator dispenser (SDI), the cement was loaded into the restorations starting from the midline and working distally. With a very low film thickness and a creamy consistency, the Riva Luting Plus cement was dispensed into the restorations with easy insertion and seating.

With Riva Luting Plus, it's easy to remove excess cement, it releases fluoride, and it has low solubility in an oral environment. Excess cement is easily removed.

From this experience, Riva Luting Plus offers several advantages. With no etching, priming, bonding, or conditioning, it saves time. Because it's hydrophilic, Riva Luting Plus works well in a moist environment. Additionally, the patient reported no post-operative sensitivity.

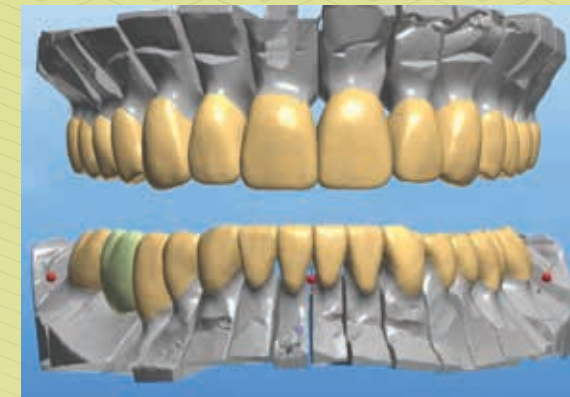


Figure 7: 3Shape Virtual Design Open Bite



Figure 8: Zenostar Monolithic Restorations on Model



Figure 9: Resin Modified Glass Ionomer Cement

With Riva Luting Plus, it's easy to remove excess cement, it releases fluoride, and it has low solubility in an oral environment. Excess cement was removed and cleaned up in about two minutes at the gel phase. After the cement was fully set (at five minutes), the occlusion was verified and adjusted. ▶



Figure 10: Postoperative Retracted View



Figure 11: Postoperative Maxillary Occlusal View



Figure 12: Postoperative Mandibular Occlusal View

The overall health and structure of the soft tissue and restorations was very good. The patient was extremely satisfied with the definitive results.

RESULTS

I checked the occlusion and verified it with the T-Scan® (Tekscan) to make sure that all the proper points of contact were in the ideal positions to ensure longevity of the reconstruction. The patient no longer experienced any pain and was very pleased with her new, enhanced smile (see Figures 10, 11, 12). In addition, she commented on how effectively and efficiently our staff worked together in delivering her treatment.

The patient no longer experienced any pain and was very pleased with her new, enhanced smile.

Having a systematic method in place for treatment planning, material selection, tooth preparation, and cementation enables the dental provider to address the needs of the patient more effectively and efficiently. Because of this, the final outcome is much more predictable aesthetically and functionally. ■

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Dr. Ara Nazarian maintains a private practice, Premier Dental Center, in Troy, MI, which has an emphasis on comprehensive and restorative care. He is a Diplomate in the International Congress of Oral Implantologists (ICOI).

His articles have been published in many of today's popular dental publications. Dr. Nazarian is the director of the Ascend Dental Academy. He has conducted lectures and hands-on workshops on aesthetic materials and dental implants throughout the United States, Europe, New Zealand, and Australia.

Dr. Nazarian teaches the Edentulous Implant Solutions Course with the Dr. Dick Barnes Group seminars. In addition, he is the creator of the DemoDent patient education model system. To reach Dr. Nazarian, please contact him at (248) 457-0500 or www.aranazariands.com.

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Q&A: New Options for Removable Partial Dentures

TECH TIPS ■ AESTHETIC DENTISTRY EDITORS, WITH ALBERT GARZA, MICHAEL LARSSON, AND LAMONT CARPENTER

A Discussion with the Team at Solvay Dental 360™ and LaMont Carpenter at Arrowhead Dental Laboratory about Ultaire™ AKP.

Aesthetic Dentistry recently spoke with Albert Garza, Head of Customer Engagement, and Michael Larsson, Business Development Manager, West Region, from Solvay Dental 360, and LaMont Carpenter, Arrowhead's Technical Consultant, to learn about a unique new material, and how it is transforming the options for patients interested in Removable Partial Dentures (RPDs). Here's a brief synopsis of that conversation:

AD: WHAT TYPES OF REMOVABLE PARTIAL DENTURE (RPD) OPTIONS ARE CURRENTLY AVAILABLE FROM ARROWHEAD DENTAL LABORATORY?

LC: For several years Arrowhead Dental Lab has offered two types of removable partial dentures—cast metal, and acrylic. Recently, Arrowhead has started offering the Ultaire™ AKP



(Above) Ultaire™ AKP RPD (left) and metal frame RPD (right).

RPD. We've been making RPDs with Ultaire™ for a few months now, and they're really increasing in popularity.

Arrowhead is excited to offer RPDs with Ultaire™ AKP because they provide several innovative advantages for patients and clinicians [see below]. If a clinician has any questions about RPDs, he or she can call Arrowhead or their dental laboratory to discuss the different options available for the particular needs of their patient.

AD: HOW MANY PATIENTS ARE PRESCRIBED RPDs EACH YEAR?

Solvay: According to our research, about 2 million patients are prescribed RPDs annually. Before Ultaire™AKP, the most popular option was a metal appliance. Metal RPDs don't offer a comfortable fit for the patient, and they typically require five to seven fitting sessions, which obviously takes up a lot of chair time and is an inconvenience for clinicians and patients alike. Being able to eliminate multiple fitting sessions frees up chair time for clinicians and can increase patient compliance, which can be a significant issue with metal RPDs.

For patients, RPDs with Ultaire™ are significantly more lightweight than chrome cobalt frames, and they don't have any kind of metallic taste, or the uncomfortable thermo transfers of heat and cold in the patient's mouth.

AD: WHAT IS ULTAIRE™ AKP?

Solvay: Ultaire™ AKP is a material made specifically for RPDs. The AKP stands for aryl ketone polymer. It's a class two, non-sterile medical device material. It can also be used for overdentures and implant-supported overdentures. We're really happy to offer it to dental labs and dentists.

AD: CAN YOU TELL US A LITTLE BIT ABOUT SOLVAY AND ITS BACKGROUND?

Solvay: Solvay was founded in 1853 in Belgium, and its mission is to encourage and support scientific advancement for solutions to the problems of everyday life. In 1911, founder Ernest Solvay created the first ever physics council, where he brought together some of the luminaries of the time—including Albert Einstein and Marie Curie. Today, the physics council still meets every three years in support of the same mission.

Solvay's mission is to encourage and support scientific advancement for solutions to the problems of everyday life.

Throughout its history, Solvay has created raw materials that are integrated into a lot of dental tools that clinicians use on a daily basis. Solvay offers an unrivaled portfolio of high-performance polymers, consisting of more than 35 brands and 1,500 formulations. Currently, Solvay supplies implantable and

PATIENT ADVANTAGES



non-implantable polymers to the orthopedic, cardiovascular, and renal markets.

Solvay Dental 360™ is backed by Solvay, a world leader in metal-replacing materials in healthcare and many other industries. We bring more than 150 years of expertise and innovation to the dental industry—which resulted in Ultaire™ AKP.

AD: WHY DID SOLVAY DECIDE TO ENTER THE DENTAL MARKET?

Solvay: Before Solvay Dental 360™ entered the dental industry, removable partial dentures (RPDs) hadn't seen significant innovation in well over 150 years. Chrome cobalt was typically the standard of care for RPDs, starting with the first metal frame in 1728.

Until recently, removable partial dentures were some of the only restorations in the dentistry industry that were still overwhelmingly fabricated using metal. Solvay saw a need in this market and was uniquely qualified to fill it. With numerous ▶



(Above) Ultaire™ AKP frame without teeth.



(Above) A patient wearing an Ultaire™ AKP RPD.

Ph.D. scientists focused on our specialty polymers group, we developed a product to serve a huge patient population that deserved something better.

AD: WHAT ARE THE ADVANTAGES OF USING RPDs WITH ULTAIRE™ VERSUS TRADITIONAL MATERIALS?

Solvay: Ultaire™ AKP RPDs are metal-free, comfortable, tooth-supported, bone-like, lightweight, biocompatible, and more aesthetically pleasing than traditional metal frames. All these benefits add up to increased patient compliance.

With chrome cobalt appliances, a lot of patients would only wear their RPDs when they needed to—when they were leaving the house to go out in public, or for family photos and the like. Metal RPDs can be uncomfortable and have visible, shiny clasps. Because patients aren't very compliant with consistent wear, they often get mesial drift, and teeth can move in different directions—which is very difficult for clinicians to correct.

In addition, a lot of patients with chrome cobalt RPDs have issues with tissue sensitivity and having a fulcrum or a point constantly under duress during mastication. With Ultaire™ AKP, lab technicians can create a more passive fit and get better retention because the material has a little bit of flex to it. The flex helps patients keep the prosthesis secure and in place.

It's worth noting, however, that Ultaire™ AKP is not a flexible appliance; it's a high-performance polymer. It's rigid, yet comfortable. And it offers a secure fit. While acrylic frames can

be attractive aesthetically, they tend to float around because they don't have built-in retention.

In contrast, Ultaire™ AKP RPDs are rigid enough to be tooth-supported, and the clasps are designed to engage undercuts more deeply, providing better retention. This, along with the fact that Ultaire™ AKP RPDs are lightweight and comfortable, can help increase patient compliance and make them something that patients will want to wear regularly.

LC: Sometimes flexible partial dentures with acrylic are almost too flexible. They don't rest on teeth, but instead rest on tissue. Therefore, every time a patient bites down, it moves and can push the tissue down. Ultaire™ is less flexible and is tooth-supported, which is nice because it doesn't damage the tissue.

Another advantage of Ultaire™ is that it is reline-able. Relineing is when, after years of wear, the gum tissue starts to shrink and the fit of the RPD is somewhat compromised. When that happens on an Ultaire™ AKP RPD, the dental laboratory technicians may be able to go back in and fill in the space between the tissue and the RPD.

Before Solvay entered the market, removable partial dentures hadn't changed in well over 150 years.

As noted earlier, another benefit with Ultaire™ is how lightweight the appliance is. Patients almost don't feel the RPD when they are wearing it because it is so comfortable.

In addition, Ultaire™ clasps are white, so people don't see the silver clasps around the teeth like they do with metal RPDs. Ultaire™ clasps "grab" the back of the tooth and stay there—it's an improved clasp design. Furthermore, the clasps don't bend or move if the RPD is accidentally dropped.

AD: WHO IS THE IDEAL PATIENT FOR AN ULTAIRE™ RPD, AND WHAT CHARACTERISTICS SHOULD CLINICIANS LOOK FOR?

LC: Ultaire™ RPDs are particularly suited for the following patients: someone who uses a metal RPD and complains or asks for options that don't involve a metal taste in the mouth, someone who thinks their RPD feels thick or bulky, someone who doesn't want to have metal clasps showing in their mouth, someone who is allergic to metal, and someone who wants a more lightweight, more comfortable RPD.

AD: CAN PATIENTS WITH ALLERGIES TO CERTAIN MATERIALS USE THIS PRODUCT?

Solvay: Ultaire™ AKP is not made from metal, but rather a high-performance polymer similar to those used in spine and hip implants. This biocompatible material is monomer free, and has a reduced occurrence of sensitivity issues, making Ultaire™ AKP an excellent choice for patients with metal sensitivities.



(Above) An unmilled Dentivera milling disc.

LC: The fact that Ultaire™ is a metal-free material is great for dental practices that are metal-free (meaning they are not using any metals as restoratives in the mouth). More and more patients are asking for alternatives to metal restoratives, and we're happy to offer a new option for them.

AD: HOW STRONG IS ULTAIRE™ AKP?

Solvay: Strength characteristics for Ultaire™ AKP surpass those of both acrylics and acetals that are on the market today. The flexural strength of any material used for RPDs needs to be high enough to withstand loading and not break.

At 148 MPa, Ultaire™ AKP has flexural properties that are well above the minimum requirements for denture base materials per ISO 20795 standards. Ultaire™ AKP is specifically designed to be supportive and have a long lifetime—well over 10 years with normal insertion and removal—but also to be comfortable enough to help improve patient compliance.

AD: WHAT SHADES OF THE MATERIAL ARE CURRENTLY AVAILABLE?

Solvay: At this time, only one color (white) is available. We are continually developing new options based on user feedback and plan on introducing additional shades, including pink, in the near future.

AD: CAN ULTAIRE™ AKP RPDs BE MODIFIED?

Solvay: Adjustments or tightening should not be necessary with an RPD made from Ultaire™ AKP after it has been designed and milled. To slightly relieve the fit, technicians may carefully remove material from the clasps of an Ultaire™ AKP using existing dental tools if necessary. It is recommended that minor alterations stay within design guidelines. Because Ultaire™ AKP is a high performance polymer, the shape of the RPD may not be changed.

AD: CAN TEETH BE ADDED TO AN ULTAIRE™ AKP RPD?

Solvay: Teeth may be added under specific circumstances.

To learn more about the possibilities, speak with a representative from Arrowhead or your dental laboratory for details and specifications.

AD: SHOULD DOCTORS USE CONVENTIONAL IMPRESSIONS WHEN REQUESTING AN RPD WITH ULTAIRE™?

Solvay: Ideally, we recommend that clinicians utilize a custom impression tray with border molding and a quality impression material. This provides more options when processing the acrylic, but as noted, digital impressions work just fine, too.

LC: Doctors can use conventional or digital impressions, whatever is easier for them. Either way, the impressions will be digitally scanned so we can work with them.

AD: WHAT IS THE TYPICAL LIFESPAN OF AN RPD WITH ULTAIRE™ AKP?

Solvay: Bench testing has shown that Ultaire™ AKP should maintain its original shape for up to 10 years.

Ultaire™ AKP RPDs are lightweight and comfortable, which increases patient compliance and makes them something that patients will want to wear regularly.

AD: WHAT IS THE RECOMMENDED MAINTENANCE FOR AN RPD WITH ULTAIRE™ AKP?

LC: Like any denture or removable partial denture, patients should remove Ultaire™ AKP RPDs at night and conscientiously clean them. Calculus will build up on any of these appliances pretty quickly if patients don't take care of them. If patients are diligent with a home care cleaning routine, including daily brushing, soaking the RPDs in a denture solution overnight, and handling the appliances properly, they will last a long time. ■



Maximize the Value of Your Practice

Considerations When Hiring an Associate Dentist.

According to the American Dental Association® (ADA), in 2016, more than 39 percent of dentists in active practice were aged 55 years and older. That statistic should be a reality check because after practicing dentistry for 20-plus years, many of us start feeling some aches and pains. A lot of experienced dentists feel pain in their backs and necks after repeat-

Some dentists, myself included, look forward to practicing dentistry well past the age of 50—in 2015, the average age of retirement (according to the ADA) was 68.8 years old. A lot of

ADVANTAGES OF HIRING AN ASSOCIATE

- 1 **The senior doctor can enjoy more flexibility in his or her schedule.**
- 2 **The practice hours can be extended to accommodate working patients.**
- 3 **Practice revenues can be increased with additional business.**
- 4 **The overall value of the business is maximized.**

Hiring an associate dentist can be a win-win proposition because the practice can expand and bring in more revenue, the senior dentist can enjoy more flexibility in the schedule, and the associate dentist is mentored and perfects his or her skill set.

edly practicing dental treatments. At the same time, the dental practice is usually especially busy during these years because the dentist and his or her team has worked hard to build up a thriving business.

dentists who are pushing towards 70 years old still enjoy making a significant contribution to their patients' well being, and want to keep their skills up to date.

Sometimes, though, older dentists fail to plan for a gradual easing of the workload, and mistakenly believe that maintaining a dental practice is an all-or-nothing commitment. When that happens, dentists often sell their practices quickly and may get less than the maximum potential value for the business. In addition, dentists miss out on an opportunity to mentor an associate dentist who can relieve some of the workload.

Having an associate dentist in the practice offers several advantages. One of the biggest advantages is having flexibility in the work schedule. As a senior dentist, it's great to have the ability to leave the office for a week or two and still keep it running smoothly.

Some senior dentists bring on an associate not to cut back on hours or explore other professional opportunities, but to make a shift in the business model and go from six treatment chairs to twelve. There are many reasons to consider bringing an associate dentist into a dental practice.

HOW TO BEGIN

Hiring an associate dentist can be a win-win proposition because the practice can expand and bring in more revenue, the senior dentist can enjoy more flexibility in the schedule, and the associate dentist is mentored and perfects his or her skill set.

Keep in mind that some dental practices hire associate dentists as independent contractors, but that is a completely different situation. For questions about hiring an associate dentist as an independent contractor, I recommend speaking with experienced legal counsel to determine the best direction for such an arrangement.

Every dental practice is unique, so it's important to do your research, consider hiring experts to help with the transition, and consult with legal counsel about all the requirements.

USEFUL METRICS

Some advisors suggest that dentists should consider bringing on an associate if the total practice revenues are over \$1 million. Other key metrics include having the number of active cases between 1,600 to 2,000, and consistently getting 30 new patients a month into the practice.

By actively increasing your business with an associate, your practice could have the potential to bring in another million dollars.

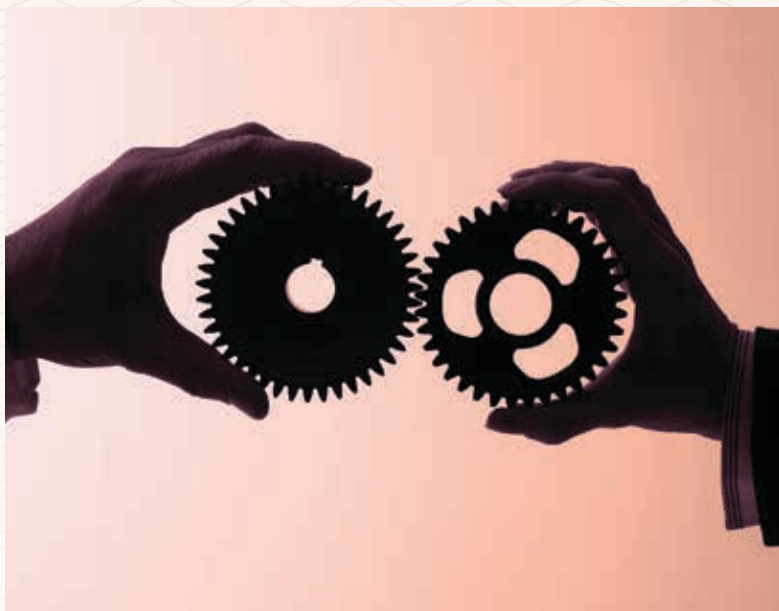
Another important consideration is if your practice has not been advertising and you want to advertise to increase new patient flow. In that scenario, a new associate may be needed to perform the additional work generated from the ads.

If your practice hasn't explored the possibility of expanding its practice hours and including weekend appointments, an associate dentist is a great way to increase business during those increasingly popular times. By actively growing your business with an associate, your practice could have the potential to bring in another million dollars.

MY EXPERIENCE

My wife, Dr. Nickie K. Lê, and I own a practice called LêDowns Dentistry, in Denver, CO. Our practice, like many typical dental





ONBOARDING TIPS

- 1 **Spend time mentoring the new associate.**
- 2 **Suggest books for the new associate to read.**
- 3 **Structure compensation for the associate based on the needs of your practice.**
- 4 **Consider creating the opportunity for the associate to have a contractual buy-in to the practice.**

practices, used to be open 32 hours a week. About a year and a half ago (in 2015), I noticed that many of our patients wanted to schedule appointments before or after their hours of employment, or on Saturdays. We weren't always able to accommodate the patients who wanted those appointments because of several other obligations that I already had.

Therefore, some patients were either leaving treatment undone or were not being retained because they couldn't get in for treatment. In general, patients delay or cancel treatment if they are not able to be seen within two weeks.

Our practice, like many typical dental practices, was open 32 hours a week. Therefore, some patients either left treatment undone or were not being retained because they couldn't get in.

I acknowledged that our practice needed to bring in another doctor. I realized that, in order to make the transition a smooth one, I needed to start helping that doctor learn how to run a practice, how to talk to patients, and how to learn the varied skill sets involved in dentistry.

Fortunately, many young dentists are trying to crack into the business and establish themselves in the dental industry. Being mentored as an associate dentist is a great opportunity for young doctors to learn advanced skills from their more experienced and established colleagues.

FIND THE RIGHT FIT

After making the decision to bring on an associate, we embarked on the process of interviewing and talking to candidates to find someone with a set of professional values that matched those of our practice. It's extremely important to find someone who is the right fit for your practice. We started

actively looking about a year or so before we brought the associate on board.

I reached out to colleagues who were in the teaching world at universities and general practice residency programs. Eventually the dentist running the University of Colorado School of Dental Medicine in Aurora, CO, called me and said that he thought he had found someone.

Our first directive for the new associate was to ask him to start reading some books. Dr. Dick Barnes suggests that all dentists should read (and re-read multiple times) a book by Dale Carnegie—*How to Win Friends and Influence People*. The book, published in 1936, has sold over 30 million copies worldwide, and still offers valuable insights. Instructing a new dentist to read the book sends a signal that he or she is not just going to do dentistry, but will also learn how to build relationships with people. Of course dental skills are important, but the associate should be willing to learn people skills, too.

Furthermore, we enrolled our associate in the New Dentist's Program with the Dr. Dick Barnes Group at Arrowhead Dental Laboratory so that he was committed to learning new skills. Investing in continuing education for associate dentists is a great way to keep them engaged and show them that you're making a tangible investment right away.

MAKE IT WORK

Taking on an associate dentist is a process that usually has its highs and lows. It requires a lot of work and mentoring. Working with another dentist is very different than working independently, and it typically requires a paradigm shift for the senior dentist. The senior dentist must be able to mentor and case plan with the new associate so that he or she learns the process. It isn't a matter of just hiring someone and turning them loose.

It's important to have a plan in mind when bringing on another dentist. It can take the new dentist as many as 10 years to get comfortable with the clinical aspects, and also with some of the management aspects. During that time, the associate dentist will need support from the senior dentist and the team.

With our new associate on board, I decided to work at the practice three days a week. So now I practice dentistry Monday through Wednesday, and our associate practices Tuesday through Saturday. When I started in dentistry, I was working six days a week.

Keep in mind that the senior dentist still has to show up and mentor the associate so that he or she doesn't get lost and deviate from the established structure. To manage our team and mentor the new associate, I also come into the practice on Thursdays. During this time, I do skill-set trainings with my associate and team members. These trainings can cover verbal skills, treatment planning, or learning how to prep properly.

BE A MENTOR

Being a senior dentist doesn't automatically give you the ability to mentor. I recommend reading *The One-Minute Manager*, by Ken Blanchard. This book is a great resource about how to mentor—how to direct and support someone, as well as how to let him or her discover their own potential.

My associate had completed two residency programs, so he was a senior resident during the second residency. As a senior resident, he taught junior dentists who were under his direction. When he started in my practice, he got "knocked down" a few times. Then I picked him up, told him what he did wrong, bailed him out, and showed him what to do.

The senior dentist must be able to mentor and case plan with the new associate so he or she learns the process. It isn't a matter of just hiring someone and turning them loose.

I reiterated, "I believe in you. You're in a different world now. This is the world of comprehensive dentistry, where you create relationships. You're going to have to think a bit differently than you did before."

After working with our associate for a year, he is really starting to catch on. Initially, there were some cases in which objections were raised that he didn't know how to overcome, or questions were asked that he didn't know how to answer, so he lost out on treatment.

Unfortunately, that means lost revenue, but the senior dentist should help the associate understand what happened and say something like, "Let's talk about what you did that we can improve upon for the next case." Eventually the associate will get some big cases and gain acceptance. The associate learns what works and what doesn't work, and that builds confidence.

Another important consideration is facilitating the team's acceptance of another practitioner. Helping the team learn to value and trust the associate dentist is important for any office.

COMPENSATION FOR YOUR ASSOCIATE

With regards to compensating an associate, a lot of doctors use a model where they pay on collection. It's often structured



one of two ways: either the senior dentist pays the associate 30 percent on collections, or the senior dentist pays 35 percent on collections, and then requires the associate to pay his or her own lab bill.

We discovered that if you pay the associate on collections, it takes almost three months to build up the collections, so we needed some sort of base pay for the first three months of the associate's work—otherwise, he (or she) wouldn't have any money coming in. If your practice is not consistent at collections, it might take even longer for money to roll in from insurance company checks.

I've noticed that sometimes when dentists offer 35 percent of collections and the associates pay their own lab bills, an associate can be tempted to use a cheap dental lab. If you're the senior doctor and you use a high-quality lab, then you might want to consider the 30-percent model, so that all patients receive the best quality dentistry, regardless of which practitioner they visit.

As with any new product or program, it's important to invest some time and energy in marketing the plan to patients.

A third option is to devise a compensation method that is unique for your practice. In our practice, we use a tiered system based on production, and the business always pays the lab bill. A tiered system calculates payment based on the amount of production completed each day, and increases the payment percentage for the associate based on the overall level of production.

This system is simply a way to incentivize the associate. We want the associate to become increasingly proficient and to start doing comprehensive dentistry, and we also want him or her to use the best quality materials. This is why we structure our compensation in such a manner. *(continued on page 40)*

It's Never Too Late

Making the Dream of Dental School a Reality.

My exposure to dentistry began when I extracted one of my younger sister's loose primary teeth when I was about 10 or 11 years old. I literally tied a string around her tooth, tied the other end to the doorknob, and slammed the door. It worked! The tooth came out and I thought that was pretty cool.

In the late 1960s, when I was just out of high school and going to junior college, I started having a more serious interest in dentistry. Whenever I visited my dentist I asked questions, and eventually the doctor invited me to come back and observe. I accepted the invitation, and after that day I was hooked—dentistry was what I wanted to do.

When I finally started dental school, many of my classmates were in their early 20s. I was 56 years old and the only dental student in the program who had grandchildren.

Around that same time, I married my wife, Beverlee, who was a dental hygiene student. She graduated from dental hygiene school at about the time I applied to dental school. I wasn't accepted into a program immediately, so I decided to look into dental technology. I then spent some time studying crown and bridge work, and laboratory work.



After learning skills in dental technology, I started working for a group of five dentists who had a dental laboratory in the basement of their practice. At the time, there was only one technician who was doing gold and porcelain work for them, and there was a backlog of work to do. When I joined him at the lab, we caught up in a couple of months. Eventually the other technician and I decided to start a dental lab, which we operated for about two years.

During those early days, I learned that although I liked dental laboratory work, I did not enjoy working in a basement and only seeing one other person every day. I went back to school, started taking the dental prerequisites again, and doing lab work at home to support my family.

When I completed the basic prerequisite classes and started applying to dental schools, the response I got from everyone was that everything looked good, but they wanted me to complete a bachelor's degree. My family was growing, and by this time, my wife and I had four children. I couldn't complete another two years of school and support my family at the same time so I put aside my plans for dentistry, and I became a landscape contractor in the Portland, OR, area for about 15 years.

A SECOND CHANCE

My dreams of dentistry remained on the back burner while my wife and I raised our five children. Then my oldest son got accepted to dental school at Oregon Health & Science University (OHSU) in Portland, OR. During his first year, I asked if I could visit the dental laboratory at the school.

I went on a Saturday and met with my son and one of his classmates. They were busy waxing gold crowns. They had been working at it for over an hour and asked me if I wanted to try. Although several years had passed since I'd done any sort of laboratory work, it came back like riding a bike. I was able to wax a decent crown in about 20 minutes.

I showed my son and his friend some tricks for getting things done just right. My son said to me, "Dad, maybe it's not too late. Maybe you should think about going back to school."

The next week, I made an appointment with the admissions office at OHSU. A counselor who was helping me said, "You're not too old, but you ought to get with it!" At the time, I was 52 years old. I decided to follow her advice and get started.

Then my son said to me, "Dad, maybe it's not too late. Maybe you should think about going back to school."

After learning that Portland State University (PSU), which is near OHSU, did not offer the general chemistry or biology classes that I needed, I stopped by the community college and signed up for an inorganic chemistry class that was starting at night. Then I went home and told my wife what I had done. "You did what?" she said.

We agreed that I would try it, and if I did well in chemistry, then I would go back to school. I went to school during the

YOU'RE NOT
TOO OLD

spring and summer semesters and did well, so I signed up for additional classes at PSU in the fall. Thankfully, my wife returned to the workforce at a dental practice so I could stop working and concentrate on my schooling.

After two years at PSU, I was still about 20 hours short of a bachelor's degree, but I had finished up the dental prerequisites, so I started applying to dental schools. I got a couple of interviews with schools, but did not get accepted into a program. When I followed up with the schools, they told me that they wanted candidates with degrees; all their other applicants had bachelor's degrees, and some students had master's degrees.

My advice to anyone with a lifelong dream is: Don't procrastinate. If there is something that you really want to do, don't be afraid.

I spoke to my PSU counselor and she was able to work her magic for me. She looked at the classes that I had taken in the 1970s, and she was able to petition some of the credits to count towards a general science degree. Because of her help, I had enough credits to graduate with a bachelor's degree.

Even with a college degree, it was difficult to find a school that would consider someone my age as a candidate. I called several private dental schools directly, and when I asked what my chances were, they said that I would be better off applying somewhere else because of my age. State schools, however, have to follow equal opportunity laws and couldn't outright reject me just because of my age. So I focused primarily on applying to state schools.

Eventually, I was accepted into the Indiana University School of Dentistry in Indianapolis, IN, which was great because it was near my family. It was an exciting time for my whole family.

My son, Doug, who had been in dental school at OHSU, was accepted for an oral surgery program at the University of Kentucky (UK) College of Dentistry. My youngest son, Jeff, also got accepted to UK into a general dentistry program a couple years later. For a period of two years, three of us were in either dental school or an oral surgery M.D. program. ▶



(Above, left to right) Dr. Randy Bird, Dr. Jeff Bird, and Dr. Doug Bird at the University of Kentucky School of Dentistry graduation.

CHALLENGES AND REWARDS

When I finally started dental school, many of my classmates were in their early 20s. I was 56 years old. On the first day of class, I discovered that there was a woman (a former dental hygienist) who was 52 years old. Some of the other students were in their early 30s, but I was the only dental student in the program who had grandchildren.

The younger students would show up to class and talk about all the fun they had the previous evening. But I had to study hard throughout dental school. At times, my wife and I wondered what we had gotten ourselves into.

Life has challenges, and from those challenges we gain experience—we grow and become different.

Fortunately, part of the curriculum included laboratory work, which was easier for me since I had done it before. I grasped a lot of the concepts and was able to do well with the hands-on work.

Another challenge, which is not any different for any other student, was student loans. I started dental school about a month after my youngest child was married. I ended up with student loans, but that is a challenge with most professional programs.

Being an older dental student did have some benefits. Many of the volunteer patients I had in clinic appreciated an older student rather than somebody who was in their early 20s, because I was someone they could relate to.

SETTING UP PRACTICE

Completing all of the requirements and boards and finally graduating from dental school was a dream come true. But with any ending, there's a new beginning. I then took steps toward becoming a practicing dentist and owning a dental practice.

When I graduated in 2010, I was lucky enough to work as an associate at an amazing dental practice in Northern California. I worked for a dentist who had graduated from dental school in the 1970s. His practice was well developed. I worked with him for two years before my wife and I decided to move to the Pacific Northwest to be closer to our family members.

I then went to work for a corporate dental group in that area for about three or four years. Finally, in September 2016, my wife and I moved to the Tri-Cities area in Washington State (a region in Southeastern Washington that includes the cities of Richland, Kennewick, and Pasco) and opened up a brand new practice. From the beginning, that was not something we had planned to do, but it just felt right. Besides, I thought that nothing could be harder than graduating from dental school.

We've since learned that opening a new practice is a difficult challenge, especially because there are many great dentists in the Tri-Cities area. Those first few weeks of business, my stomach was churning!

After years of planning and working towards this goal, I was ready to work, and I wanted to see patients and have a full schedule. But that did not happen right away. It took some discipline and trust to believe that the practice would grow and patients would find us. I kept telling myself to relax and the patients would come.

We've since learned that opening a new practice is a difficult challenge. Those first few weeks of business, my stomach was churning!

The advantage of a slow start is that it gives you time to build and develop your reputation and office systems. Over the past year, my team and I have met with great patients, and we are grateful that they have given us wonderful reviews. I've learned not to get uptight when the schedule is not full, because it gives us more time to spend with patients.

Several patients have commented that they've never had a dental team spend that much time with them before. It feels great to provide conscientious, personalized care for all of our patients. By taking time with each patient, we've been able to develop good relationships. In our practice, we want patients to feel like they are coming to an office where somebody really cares about them.

A DIFFERENT PERSPECTIVE

I didn't go into dentistry for the lifestyle and the financial rewards. I wanted to practice dentistry because it's something that I love, and because I enjoy being around people. My philosophy is that I'm doing dentistry to help my patients, if they want the help. I tell them what I diagnose, what the benefits and drawbacks are with each of the available treatments, and then my team and I try to help guide them towards a decision that will benefit them in the long run.

I probably have a different approach than I would have if I were 28 years old and just graduating from dental school. I've learned the value of paying for something that will last a lifetime. Overall, I try to seek out more value in life.

That means I don't necessarily seek out the least expensive options. It means that I try to seek the most efficient, most cost-effective, and highest-quality options—and this philosophy extends to our practice. Experience has taught me that there are few solutions to problems that are quick and easy.

Some of our patients have had beautiful work done on their teeth prior to coming to my practice. We've got a few patients who have lots of crowns, and the last time they had a new crown was about 15 years ago. These patients come in regularly and take care of anything that starts to pop up periodontally. Their dental foundation stays healthy and the work that they've had done will last them the rest of their lives.

My team and I work hard to diagnose and practice comprehensive dentistry. When we put together a treatment plan, we first talk to the patient about what they'd like to accomplish. The objectives may be improved function, better aesthetics, or longer-lasting restorations.

Dentistry gives you an opportunity to engage both the heart and the brain.

We confirm what the patients want, and then we put together some options that will meet the objectives. One of these options will meet all the objectives, the rest of the options will not satisfy all the objectives but the cost will be lower. We try to be clear with the patients up front.

Another thing we try to do for our patients is to break down and then prioritize the treatment plan—what needs to be treated immediately, and what will need to be treated in the next one to two years, two to five years, and so on. Having a long-term, comprehensive plan has helped us with treatment planning. As Dr. Jim Downs of L&Downs Dentistry in Denver, CO, says, a good philosophy is to “help patients keep their teeth for a lifetime.”

With that in mind, we try to plan treatments that reach the desired goal instead of just fixing problems as they arise. When patients know their options, they can make educated choices for their own care.

LESSONS LEARNED

If I had to do it over again the only thing that I would change would have been to start 10 or 15 years earlier because I'd like to be able to practice dentistry longer. I love it! My advice to anyone with a lifelong dream is: Don't think you have missed your opportunity. And don't procrastinate. If there is something that you really want to do, don't be afraid. If you're willing to work for it, then jump in and go for it!

Believe in yourself and rely on the support of your family members. Whether it's going to dental school, or learning advanced dentistry, things can get extremely difficult, but be prepared for the hard times and stick with it. It helped



tremendously to have my family supporting me. My wife told me, “You can do hard things.”

As noted earlier, there were times my wife and I wondered, “What did we get ourselves into?” But I really never wanted to quit for a couple of reasons. One, I had already invested too much, and two, I truly wanted to do it. I had already given up the dream of dentistry once, in the 70s, and I didn't want to do that again. We don't always get second chances in life, but opportunities are out there if we look for them and take them.

I have a different approach than I would have if I were 28 and just graduating from dental school. I've learned the value of paying for something that will last a lifetime.

How many of us have everything going rosy for us every day of the year? It doesn't happen. Life has challenges, and from those challenges, we gain experience and develop new skills. In so doing, people become more developed as human beings. I think that's part of the value of the experience. For some of us, it's never going to be the ideal time to pursue a lifelong goal, so why not just start now?

WHAT'S NEXT?

Looking back on the past few years, I'm happy to report that it's all been worth it. As many dentists can attest, the best part of dentistry is meeting people, diagnosing their dental issues, and helping them improve their health.

It's great to help patients out of pain and help them develop better function with their teeth. Or to perform cosmetic work so that patients look better and feel better about themselves. It's very satisfying work. It's the heart and science of dentistry combined. Our profession gives dentists an opportunity to engage both the heart and the brain. *(continued on page 42)*

Dental Sleep Medicine 101

An Introduction and Guide to Dental Sleep Medicine.

Nearly everyone has experienced nights when they don't get good sleep or don't sleep much, and they wake up feeling "fuzzy" the next day. When we sleep, we go through several sleep cycles, including light sleep, deep sleep, and REM sleep (dreaming). Ideally, a sleep cycle takes about 90 minutes. Adults should have four to five 90-minute cycles of sleep each night.

However, if someone wakes up mid-cycle, the cycle starts over. A person with a sleep breathing disorder might restart the sleep cycle more than 18 times per hour, which reduces how much deep sleep (which is restful sleep) and REM sleep (which is active sleep) that person gets.

A person with a sleep disorder might restart the sleep cycle more than 18 times per hour, which reduces how much deep sleep and REM sleep that person gets.

Deep sleep and REM sleep are extremely important, and scientists are learning more and more about what happens to the brain during sleep. A 2013 study funded by the National Institutes of Health (NIH) suggests that sleep is important in "cleaning" the brain.

Maiken Nedergaard, M.D., D.M.Sc., co-director of the Center for Translational Neuromedicine at the University of Rochester Medical Center in New York, led a study about what happens to the brain during sleep. For the study, researchers injected

dye into the brain cells of mice while monitoring their electrical brain activity. The researchers observed the brain cells while the mice were in deep sleep. According to an NIH press release, the "space inside the [mice] brains increased by 60 percent when the mice were asleep or anesthetized." This space allowed cerebral spinal fluid and blood to flow through the brain and remove the plaque that had built up on the brain throughout the day.

The study suggests that sleep clears the brain of "damaging molecules associated with neurodegeneration." Although this was not a human trial, the theory suggested by the study is that the less deep sleep one gets, the less time the brain has to be cleaned. Thus, the research appears to support all the adages about "getting a good night's sleep" or "sleeping on it" when approaching an important decision. The NIH press release said, "A good night's rest may literally clear the mind."

BACKGROUND

With it becoming increasingly clear that sleep is critical to overall health, all dental professionals should be educated about the risks of sleep breathing disorders and know the benefits of treatment. Dental professionals and medical doctors are on the frontline for patients who have questions and concerns about sleep problems.

Medical doctors and dental teams typically work together to help their patients with sleep breathing disorders. Patients often ask questions about whether insurance will cover sleep treatments, and how much it will cost. Dental professionals should be able to educate patients on the benefits of reducing the number of sleep disruptions through oral appliance therapy,



if appropriate, or possibly opening up the nasal passage so that patients don't have as many arousals an hour.

I began my career as a dental assistant in a "Barnesified" practice in Colorado. When I joined the team, our practice had already attended several Dr. Dick Barnes Group seminars, and we were implementing many principles of their philosophy. Because of this, our team dove into dentistry a bit deeper than most general dental practices.

We became involved in full mouth reconstruction cases and rebuilding patients' occlusion and function. We also became interested in what dental practices could do to evaluate and improve patients' airways.

In 2008, I took a job with software company called Dental Writer. While working for them, I attended several dental sleep medicine (DSM) courses around the country, listened to a number of speakers, and learned how they integrated DSM into their practices. With my background as a dental assistant, I was naturally interested in figuring out how to make this happen.

SLEEP BREATHING DISORDERS

Sleep breathing disorders happen when an airway collapses during sleep. Chronic, loud snoring is a common symptom. To be diagnosed with obstructive sleep apnea (OSA) as an adult, patients must meet the following criteria: stop breathing for 10 seconds or longer during sleep, have the oxygen saturation in their blood drop anywhere from 3 to 4 percent, and have it all happen five times or more an hour.

Another sleep disorder that can affect breathing at night is upper airway resistance syndrome (UARS). UARS is a common sleep disorder that is most often characterized by the narrowing of the upper airway, which causes sleep disruptions called

respiratory effort-related arousals (RERAs). These arousals are a constant irritant that can be very taxing on the body.

According to the American Sleep Apnea Association (ASAA), OSA affects an estimated 22 million Americans. Sadly, 80 percent of moderate to severe cases of OSA have not been diagnosed. And it's not just the patient's physical health that is suffering—it's costing billions of dollars and taking a toll on emotional health because of crabby days and irritable living.

Research shows that sleep disorders may also be linked to a variety of other diseases, including high blood pressure, diabetes, and even some types of cancer.

Last year, the American Academy of Sleep Medicine™ (AASM) released an analysis called "Hidden health crisis costing America billions." The analysis summarized the financial implications of undiagnosed OSA. On its website, the AASM notes that the consulting firm of Frost & Sullivan estimates that an "annual economic burden of undiagnosed sleep apnea among U.S. adults is approximately \$149.6 billion. The estimated costs include [among other costs] \$86.9 billion in lost productivity, \$26.2 billion in motor vehicle accidents, and \$6.5 billion in workplace accidents."

Research shows that sleep disorders may also be linked to a variety of other diseases, including high blood pressure, diabetes, and even some types of cancer. Once I learned about the many implications of undiagnosed sleep disorders, I urged all my family members to get tested. Sure enough, we learned that nearly >

everyone in my family has a sleep breathing issue. I even learned that I have UARS.

Since sleep disorders affected so many family members, I started thinking about how many patients might benefit if more dentists integrated DSM into their practices. As dental professionals, it's our job to ask patients whether they have had their sleep evaluated if we see any of the following health problems: high blood pressure, a history of heart attack or stroke, diabetes, cancer, acid reflux, depression, or daytime sleepiness.

In addition, we should be vigilant in looking for dental signs that could be linked to OSA like worn teeth from clenching and bruxing, a retruded mandible, a scalloped tongue, a high palatal vault, or a red soft palate.

MEDICAL TREATMENTS

Dental professionals should always keep in mind that sleep-disordered breathing is a medical condition. A dentist cannot diagnose it and proceed with treatment without working with a physician. Fortunately, there are several treatment methods, depending on the severity of the diagnosis and patient preference.

For UARS, treatment usually focuses on opening up the nasal passages. Sometimes that means that an ear, nose, and throat (ENT) doctor will have to perform surgery to open up that passageway.

For less severe diagnoses, non-surgical methods may be sufficient. Nasal strips can be an option, or nose cones that go up the nose to keep the nasal airway open may be helpful. Oral appliance therapy (OAT) may be another great option.

For OSA, most physicians prescribe a continuous positive airway pressure (CPAP) machine. This machine supplies constant air pressure through a mask or nosepiece that patients wear while sleeping. However, patient compliance is an issue with CPAP therapy. Many patients either remove the mask in the middle of the night or do not use it at all because it is uncomfortable, or they can't tolerate having a machine blowing air into their airway all night.

A dental oral appliance may be used in conjunction with CPAP therapy through combination treatment or as an alternative to CPAP therapy if a patient is unable to wear or tolerate the CPAP machine.

For severe cases, physicians may recommend surgery to remove soft tissues in the back of the throat to keep the airway open. But some statistics show that this surgery may only last



(Above) The EMA is an oral appliance for noninvasive treatment of snoring and OSA.

about a year before relapse. A local ENT doctor once told me that his surgeries are typically about 40 percent successful.

Another option may be a surgery called a maxillary mandibular advancement surgery, which involves pulling the upper and lower jaw forward, which works well to open up the airway. This surgery has a high success rate, but it is a major surgery.

THE ROLE OF DENTISTRY

Maintaining an open airway during sleep is essential. Therefore, in my opinion, oral appliance therapy may be necessary. Dentists can help patients keep their airway open with OAT or with other treatments, like expansion of the maxillary or mandibular jaw (this is performed mostly in pediatrics, but I've witnessed many adult cases, too), or possibly comprehensive dentistry.

Look for dental signs that are linked to OSA like worn teeth from clenching and bruxing, a retruded mandible, a scalloped tongue, a high palatal vault, or a red soft palate.

Oral appliances are popular in dentistry right now. They are considered durable medical equipment, so they need to go through U.S. Food and Drug Administration (FDA) clearance to ensure that they can open and maintain a person's airway.

Making oral appliances for sleep-disordered breathing is not new. The first oral appliances were made in the 1970s. In 1995, the AASM published its first ever parameters regarding OAT. Still, OAT didn't become a hot topic until as recently as 2011—when Medicare announced that custom-made oral appliances for OSA would be a covered benefit.

Medicare's policy is that only a dentist can offer oral appliances, and in many cases Medicare sets the standard that many private insurance companies follow. However, not all private insurance companies follow the same guidelines. I advise dentists to use a manufacturer that is making FDA-cleared oral devices,



(Above) The Herbst is an adjustable orthodontic appliance for the aid of snoring and mild to moderate OSA.

which means that they've undergone a vetting process by the FDA with regards to the manufacturer and lab. To use benefits from medical insurance for your patients, you have to follow their rules.

Arrowhead Dental Laboratory offers two oral appliances, the EMA appliance and the Herbst appliance (see *photo above and on page 38*). There are many more appliances available that are also FDA-cleared.

COMPREHENSIVE DENTISTRY

To find patients who are undiagnosed with dental sleep issues, consider including the following questions on the dental medical history questionnaire: "Have you ever had a sleep test? Has anyone ever told you that you have obstructive sleep apnea? Do you snore?"

If you conduct a brief new patient interview in conjunction with a health history questionnaire, it's easy to start talking to patients and educating them about sleep issues. Dental team members can follow up with patients by asking, "Did you know that snoring can indicate an obstruction in your airway? We know now that when you have an obstruction, it can impact your overall health and wellness. We should have you evaluated and see what we can do."

If patients are not yet diagnosed with a sleep breathing disorder, the dental team can arrange an appointment with a physician to get an evaluation. If the patient is already diagnosed, establish a protocol with your dental team to learn what therapies he or she is using, and offer additional support. Evaluating a patient's airway should be part of a comprehensive dental exam.

GETTING STARTED

Any practice looking at implementing dental sleep medicine should consider taking an airway course that will allow dental teams to evaluate the patient prior to diagnosis. Once some initial education is obtained, dentists can decide if they want to implement DSM treatments slowly or more aggressively.

Some practices may just want to do an appliance or two a month and help their existing patients. But other dentists realize there is a bigger potential and may decide to stop doing general

dentistry altogether to specialize in DSM. For the last two and a half years, I have worked with offices to help them analyze what to implement in terms of DSM, and strategize about how to make it happen. Typically, an exclusive DSM practice usually has relationships with physicians in the community who refer patients to the dentist for oral appliance therapy.

A specialty DSM practice might not do any general dentistry at all, but they likely offer ancillary treatments like position therapy—this focuses on different sleeping positions patients can use to keep them off their backs (typically airways collapse most often when patients sleep on their backs).

If you conduct a brief new patient interview in conjunction with a health history questionnaire, it's easy to start talking to patients and educating them about sleep issues.

Practices that opt for the exclusive route typically have to develop relationships with physicians and get referrals coming in quickly. Once they are well known in the community, the practice can start to see results.

BILLING

With general dentistry, dentists and their teams have learned to overcome the "insurance barrier." Even though insurance only pays a certain amount for some procedures, and may not offer benefit for others at all, it hasn't stopped dental teams from educating patients about what they need so that they can make the decision to move forward.

Dental sleep medicine is similar. Dental practices have the power to help patients keep their airways open while they sleep. It's about informing the patient, so the patient can make an educated decision to act.

Only patients who are diagnosed with OSA can use traditional medical insurance for reimbursement. With something like UARS, patients are usually unable to draw upon medical insurance benefits.

Insurance benefits depend on the severity of a patient's condition. If the patient has mild OSA, a doctor typically needs to prove that the patient truly needs treatment. Most insurance companies will require one of seven medical conditions to be present in the patient in order to qualify for the benefit.

If a patient has severe OSA, which means that they stop breathing 30 times or more an hour, most insurance policies consider the therapy medically necessary when the patient is CPAP or PAP intolerant or contraindicated.

EDUCATION AND CERTIFICATION

There are several ways to get education and certifications for DSM. One organization that I recommend is the American Academy of Dental Sleep Medicine (AADSM). The AADSM is very research-based. They have educated dentists who have been helping patients and making *(continued on page 42)*

CHILDHOOD OSA

Obstructive sleep apnea can affect people of all ages—including children. According to the American Sleep Apnea Association (ASAA), an estimated 1 to 4 percent of children suffer from OSA. With children, the criteria for diagnosis are less strict than with adults.

With a tiered system, the dental practice must have a good method for tracking each day's total production. We use an Excel spreadsheet to calculate the incentive each day—one day the associate might get 28 percent, and 33 percent the next. There are some stipulations to the process. For example, if the dental practice is billing insurance, an adjustment has to be factored in.

Additionally, to get the associate going in the beginning, we double-booked hygiene appointments on a Friday or a Saturday, and the associate only checked hygiene visits that day. We paid him a standard amount (flat rate) on that day to show up and check hygiene.

That strategy gave the associate the opportunity to start building a client base. All the patients who showed up were basically new patients. And if the associate found work to do, then he (or she) could start building business for the next week. Now that the associate has been with us a year, he's seen some patients two or three times. The hygiene checks were a big part of building his patient base.

MAKE IT A WIN-WIN

Something else to consider when taking on an associate is a contractual agreement for the transition and the eventual buy-in of the practice. Senior dentists with high-value practices should consider bringing on an associate who can be trained to eventually take over the practice. This strategy is designed to maximize the value of the practice.

I decided to invest my time and effort into such an arrangement because I want to capture the full value of my business, versus a doctor who has to sell his practice because he has health problems and needs to liquidate quickly. That doctor likely won't capture the full value of his practice.

When you bring in an associate, the production of the practice increases. And when the production of the practice increases, so does the overall value of the practice.

When you bring on an associate, the production of the practice increases. And when the production of the practice increases, so does the overall value of the practice.

Typically, a broker will use 60 or 65 percent of a dental practice's collections to determine the value of that practice. Onboarding an associate with the intent of eventually having him or her buy the practice is a great way to maximize the value of your business.

Chrisad, a dental marketing agency, has been a great resource in helping us figure out how to structure this part of the agreement. It's much easier for a new associate graduating from dental school with some associated debt to buy into a practice gradually, rather than try to buy it out completely.

By starting early, the associate's equity grows as the practice grows in business. The associate can start putting money into the transaction at a very low level. The goal is for the senior dentist to eventually become the associate dentist and vice versa.

When the senior dentist is ready to stop practicing altogether, the associate dentist (now the senior dentist) can bring another associate in. By so doing, dentists can realize the maximum value for their dental practices.

Having an associate is beneficial for many reasons. It can add value to the business and give doctors some flexibility to decide how much and how long they want to work.

With professional legal help, dental practices can structure arrangements that are beneficial for both senior and associate dentists. Of course, it requires official paperwork to draw up the details, but the paperwork also sets a framework for the level of commitment for the associate dentist. The agreement should include defined goals (and the consequences for achieving or missing those goals) for year five, year ten, etc.

SO FAR, SO GOOD

Having an associate dentist in the practice is beneficial for many reasons. He or she can add value to the business and give senior doctors some flexibility to decide how much and how long they want to work.

Some doctors get short-sighted and don't want to deal with the process of finding and training an associate. But if a practice is so busy that patients can't get in for treatment for three to four weeks, those are missed opportunities. Don't sell yourself short or miss out on getting the maximum value for your practice. The payoff is worth the investment. ■



Dr. Jim Downs received a D.M.D. degree at Tufts University School of Dental Medicine in Boston, MA. He is an expert in comprehensive restorative treatment and has completed numerous full mouth reconstruction cases. He maintains an aesthetic, family-oriented practice in Denver, CO. Dr. Downs is an instructor for several dental continuing education (CE) courses for the Dr. Dick Barnes Group, including Implant EZ, Full Arch Reconstruction, and more.

To master complex treatments, dentists must seek out opportunities and experiences beyond what is taught in dental school. Learning a new skill is scary, but satisfaction almost always results after accomplishing something that you thought you couldn't do.

Another way to achieve satisfaction is to provide quality-of-life improvements for another human being. As healthcare providers, dentists are in the unique position of being able to offer treatments that improve the everyday functionality and aesthetics of their patients. Improving the quality of life for another person is inherently satisfying and fulfilling.

The possibilities for dentists are broad and exciting. If you want to feel passion for dentistry again, do a case that pushes you beyond your comfort zone and offers transformative changes for a patient.

FIND A MENTOR

Obstacles and setbacks are a natural part of any meaningful learning process. Too many people think that obstacles represent the boundaries of our abilities, rather than the beginning of new opportunities. Often, people let those obstacles stop them from making progress, and they languish in professional dissatisfaction, mediocrity, and safety.

At such times, a mentor can be a powerful agent for change. Having someone who can help you identify obstacles and can show you how to move past them is critical to overcoming challenges and ultimately finding success.

Mentors can be found in various places. A mentor could be a continuing education (CE) instructor, a trusted colleague with skills that you want to attain, or a former associate from dental school. Regardless of where you find a mentor, it's critical to seek them out and foster that relationship.

Having someone who can help you identify obstacles and show you how to move past them is critical to overcoming challenges and ultimately finding success.

In the previous issue of *Aesthetic Dentistry* magazine (*Aesthetic Dentistry*, Volume 16, Issue 2, Summer 2017), Dr. Jason P. White from Lubbock, TX, discussed the importance of mentors in "Cheering You On: Why Mentors Are Critical to Success." Dr. White suggests that the power of mentorship completely transformed his dental practice, and subsequently his love for the profession.

Mentorship is an active, two-way relationship—it isn't enough to watch mentors from afar. Younger or less-experienced dentists must humble themselves as students, and share their honest experiences with their expert mentors. Only then can mentors truly help and offer advice that the less-experienced dentists must be bold enough to try.

PRACTICE DENTISTRY AS AN ART

A third way to develop a passion for the profession is to treat your dentistry as a work of art. In my experience, all dentists are doing one of two things—they are either practicing the business of dentistry, or they are practicing the art of dentistry. The difference between the two has to do with what I call the *artisan mindset*. Art has the ability to elevate one's perspective and lead to an understanding of the beauty and value of things that for many go unrecognized.

The phrase "follow your passion" is for followers. As a dentist, you are the leader of your practice and not a follower.

Dentists who are stuck practicing the business of dentistry often view dentistry as a series of treatments that insurance is likely to cover, or only those treatments that they think their patients can afford. For such dentists, case presentations are trapped in the uninspired world of everyday price-point dentistry.

Conversely, those who practice the art of dentistry seek to increase the value that their patients see in dentistry by showing patients the full range of possibilities. Presenting comprehensive dentistry to every patient, regardless of their perceived ability to pay, is one of the only ways to practice the art of dentistry.

True artists are always seeking to refine their skills in a new and different creative endeavor. Artists are not content to repeat the same work over and over. Instead, they seek to repeatedly improve by seeking new and different challenges. For dentists with an artisan mindset, each case presents a different challenge because no two patients are exactly alike.

The artisan mindset is also obsessed with craftsmanship—using the highest-quality materials and taking time with their work—in order to deliver the best dentistry. The artisan usually does work by hand and is concerned with the highest-quality result. In contrast, a traditional mindset is generally concerned with mass quantities rather than great quality.

If you have grown comfortable with the cases you are doing every day, take a step back and seek the skills and cases that will push you beyond your comfort zone. If you welcome the cases that challenge your skills, you can rekindle your love of and excitement for dentistry.

The phrase "follow your passion" is for followers. As a dentist, you are the leader of your practice and not a follower. Instead of "follow your passion," make your motto "dentistry is my passion!" If that phrase becomes your mantra, you will constantly seek to improve dentistry to a level that delivers the beautiful and functional dentistry that will enhance the lives of your patients.

Start today and take a chance! I have walked along this very path and it wasn't always easy. But it made all the difference to me and I know it will for you. ■

It's Never Too Late (continued from page 35)

It's fun for me to have sons who are involved in dentistry as well. We aren't in practice together, but I talk to my son, Doug, who is the oral surgeon, about implant cases and extraction techniques. If I've got a problem with some pathology, I email him an X-ray or photo and he'll reply back and tell me what he thinks.

I have also taken some continuing education (CE) courses with my other son, Jeff, who is a general dentist. In fact, Jeff and I are currently in the New Dentist Program together at Arrowhead Dental Lab. It's been great to work with family members and share our mutual love of dentistry together.

THE FUTURE IS BRIGHT

People ask me all the time how long I am going to practice dentistry, and the answer is until I am too old to take care of my patients! When I told my mother that I was going to go back to school with the ultimate goal of dentistry, she was very supportive. She had a classmate from high school who was living in Southern California, practicing endodontics, and he was 86 years old. I don't know if I'll practice dentistry that long. But I've learned that doing something you love isn't much of a chore.

I've come to believe that if you're happy with what you're doing every day, you're doing well in life. I don't pretend to have

all the answers to making one's dreams come true. I feel like I've had my share of bumps along the road. But I am grateful for my second chance at dentistry and to be working in the profession of my dreams. I truly believe that if you have the drive, the desire, and the determination, you can make dreams happen. It's never too late. ■



James R. Bird received a D.D.S. degree from Indiana University School of Dentistry in Indianapolis, IN. Earlier in his career, he worked in a dental laboratory, gaining valuable skills that help him provide the highest-quality dentistry. After practicing dentistry in California, Dr. Bird opened Paradise Family Dental in West Richland, WA, where he works with his wife, Beverlee, as the practice manager.

Dr. Bird specializes in family dentistry and takes seriously the responsibility of helping patients improve or maintain their dental health.

Dental Sleep Medicine 101 (continued from page 39)

oral appliances for about 26 years. If a dental office is interested in getting involved in DSM, they can go through the AADSM to apply for facility accreditation. Dentists can work towards "diplomate" status, which means that dentists have to take an exam and submit cases to qualify. I consider diplomate status through the AADSM to be the "gold standard." Because DSM education has blossomed in popularity recently, the academy sets standards to ensure that dentists are getting qualified education.

good introduction to DSM. It's a great way to learn if you are interested in gaining certification through the accredited agencies.

Once you become knowledgeable about dental sleep medicine, turn to your inner circle to look for cases. Reach out to your family, dental team, and friends to discover who you can help and to gain valuable practice while learning the intricacies of dental sleep medicine. It's a great way to become comfortable with the specialty. From there, the sky's the limit! ■



Glennine Varga is a Business Development Coach for Arrowhead Dental Lab. She has been a TMD/OSA trainer and speaker with an emphasis on medical billing and documentation for over 15 years, and has trained doctors and teams in the use of electro-diagnostic equipment. Glennine is an expanded duties dental assistant, certified in TMD with the American Academy of Craniofacial Pain. She is a visiting faculty member of The Pankey Institute, the American Dental Association, the Academy of General Dentistry, and Spear Education's Dental Sleep Medicine courses. Glennine currently teaches Total Team Training and co-teaches Airway Management and Dentistry for the Dr. Dick Barnes Group seminars.

It's about informing the patient, so the patient can make an educated decision to act.

Alternatively, in the past five years, several other academies and teaching institutes have started their own certifications. Another great institution is the American Thoracic Society (ATS). It is a medical group, but they include dentists in a lot of their education.

The AADSM recently released a "qualified dentist designation" that provides a way for dentists to receive qualified education through a university-based setting, or through a not-for-profit organization. They require 25 continuing education credits to earn the designation. Courses are available at places like the Pankey Institute (where I am on faculty), through a university, or through the AADSM.

I also co-teach a course for the Dr. Dick Barnes Group seminars called Airway Management and Dentistry, which is a

"My practice is more successful than I could have imagined!"

Dr. Valerie Holleman, Broken Arrow, OK

Arrowhead Dental Lab and the Dr. Dick Barnes Group offer a CE plan specifically designed to make new dentists more successful. Dr. Valerie Holleman was in practice for about eight years before starting the New Dentist Program with Arrowhead. Dr. Holleman said, "My advice? Do it now! It's the best decision I ever made and the courses are life changing."

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