Aesthetic Dentistry

TECHNOLOGY AND TRENDS IN PRACTICE DEVELOPMENT & AESTHETICS • VOLUME 13 ISSUE 1 • SPRING 2014

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The Dental Insurance Conundrum

How Dentists Can Avoid the Trap of Compromised Care.

Recently the *ADA News* published an article with the headline: "Dentists remain cautious about economic conditions in their practices." I was baffled and dumbfounded by the inherent negativity of such a headline. It really does nothing but confirm to dentists that the economy is bad, when the economy is actually much better than it has been. According to an article published in the *Wall Street Journal* on January 1, 2014 titled, "Hopeful Signs for U.S. Economy in 2014," at least four main economic indicators point to economic growth in the United States: unemployment has dropped, home prices have risen, consumer spending is improving, and household wealth has increased. Economists believe that such indicators paint a brighter future for 2014 than for any of the previous five years.

Unfortunately, even though the economy is improving, many dentists still have a pessimistic economic outlook and are reacting likewise. Instead of offering the best treatment options to their patients, they are instead only offering what dental insurance will pay for, which in my opinion, is generally below the bare minimum of what people *really* need. Currently, many insurance companies pay a yearly maximum of one thousand dollars, which at the end of the year, only pays for very minimal treatment for many patients.

Consider, for example, if one of your patients needs 20 crowns in order to be restored to full oral health. With the current payout rate of insurance providers, it would take approximately 20 years for that patient to get the proper dental care that he or she needs (if insurance is solely used to pay for treatment). At that rate, both you and your patient will be lucky if you're around to see the process completed to fruition.

It's a scenario exactly like the previously mentioned one that inspired me to coin the phrase, "The Dental Insurance Conundrum." Since health insurance arrived in the dental profession more than 40 years ago, I've had a love-hate relationship with it. I've loved it because it brought new patients into my practice. I've hated it because the insurance companies tried to tell me what fees I should charge and the type of dentistry I should perform.

When insurance companies have the ability to dictate treatment (based on what they are *willing* to pay for and not on what is actually *needed*), some dentists find themselves slowly falling into a trap of compromised care. Compromised care is seeing and doing 'onesie-twosie' cases instead of the comprehensive care that patients really need. Unfortunately, once dentists accept insurance reimbursements as the primary way to get paid, we also start shopping around for cheaper materials and ways to cut costs.

The net result is a compromised level of care. The attitude of being "the best dentists we can be" changes. We are now the "the best dentists that the insurance companies will pay for." And who wants to be that type of dentist? I know I sure don't. At the end of the day, with this scenario the insurance company makes the profits while dentists struggle to be compensated at a level commensurate with our education. If dentists rely solely on reimbursements from insurance companies, then the insurance companies will dictate how dental practices operate.

Now is not the time to be cautious about the type of dentistry you offer in your practice.

Personally, I refuse to let insurance companies dictate the results of my hard work. Because of my mind-set, I have taken control of my relationship with dental insurance companies over the years. Instead of letting insurance companies benefit from my labors, I switched the focus and put myself in charge. When I did so, the insurance companies benefited me and my practice, instead of the other way around. I did this by presenting comprehensive treatment options to my patients, accepting what portion the insurance reimbursements would pay, and then helping patients to find other financial options for the remaining balance.

This method has worked successfully with many of my patients. But what about those patients who *only* want the treatments that the insurance companies will pay for? What should be done to help those patients and avoid the dental insurance conundrum? My approach in life has always been to only worry about the things that I can do something about. And I recommend the same for other dentists. Simply focus on the things that you can do to make a particular situation better. ***(continued on page 8)***

Aesthetic Dentistry

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"I Want That Smile"

Insights Gained From My Full Mouth Reconstruction.

My experience with full mouth reconstruction was amazing from the very start. When I made my decision to get my teeth done, I chose a dentist whose working style was very similar to my own professional style. After speaking with a close associate at Arrowhead Dental Lab, I chose Dr. Jason Lewis in Draper, Utah. Having a comprehensive dentist treat my dental needs confirmed the beliefs I had developed regarding comprehensive dentistry, based on my own clinical experience and presentation style. As I went through the procedure, I viewed the whole process through the eyes of a patient.

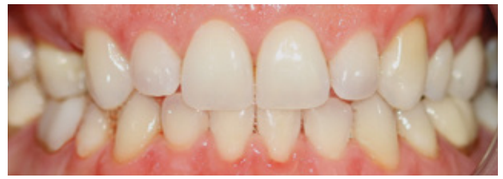
From the experience, I gained great insights—one of which concerned the length of time that such procedures take. I realized that in the grand scheme of things, even though the procedure doesn't last very long (considering how much work is being done), if you're the patient sitting in the chair with your mouth propped open, it feels like a long time.

I'm a very active individual and because of that, I got a little antsy. As I sat through my full mouth procedure, I made a clear decision. From then on, when I performed a full mouth reconstruction on patients in my practice, they wouldn't have an option of sedation. They would all be IV sedated. With IV sedation, patients can totally relax and wake up to a dazzling new smile.

As soon as my permanent Elite porcelain crowns were seated, I was in love. Honestly, these teeth are luxurious. When comparing my own teeth with the Elite crowns, I often use an automobile analogy. My original teeth seemed like 'driving a Chevy'—they worked well and they looked pretty good. Many people were shocked that I even thought about doing any dental work to my teeth. But I knew from clinical experience that there was room for improvement, and I felt I should be an ambassador for the possibilities that comprehensive dentistry can accomplish.

With my old teeth, the occlusion was good due to all of the orthodontic work I had done over the years. Yet, after one second with the Elite crowns, I realized that everything was completely different. I was no longer driving that Chevy, but I was now cruising down the highway in a Caddy! My own teeth, while good, were nothing compared to my new Elite smile.

A month after my full mouth reconstruction was completed, a patient saw me in a business meeting. I could tell out of the corner of my eye that he was staring at my smile from across the conference table. The next day, he phoned me and said, "Cress, I couldn't stop staring at your smile. I want that!" Of course, I told him I could do it. He immediately visited my office and we got the ball rolling—we did his impressions and his white wax-up that very day. He liked my teeth so much that we just recreated my smile for him; we did the same color formulation and everything.



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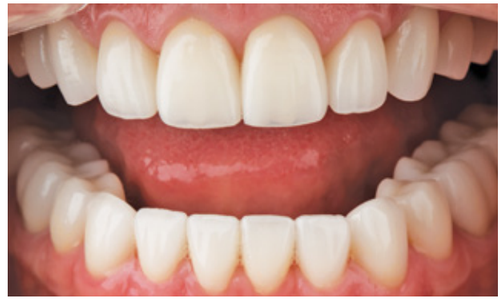

AFTER

Having strategized comprehensively about my own case has given me the confidence to present comprehensive dentistry to every patient who walks into my office. From simple fillings to tooth replacement, from treating patients with TMD to those with obstructive sleep apnea and those in need of full mouth rehabilitation, I am committed to treating comprehensively. I now look at the overall health of my patients. Treating comprehensively has given me great confidence and satisfaction in my chosen profession.

With each and every interaction, my new smile opens up doors of possibility for both the patient and me. Not all patients accept comprehensive treatment, and for those who don't I know the seeds of possibility have been planted. They now have a clearer vision of dentistry's potential to improve their lives. Many of these patients have left my consultation room with the realization, "Hey, if he did it and his teeth look that good, then I can do this too. I want a smile like that." Once a patient sees my Elite smile, they know what's possible and that I can deliver. My smile is my most effective case presentation tool.

I'm often asked if my full mouth reconstruction has benefited my practice in a financial way. My answer to that is simple: YES! Before I had my full mouth reconstruction, I was doing one or two cases a year. Currently, I'm doing one or two of these procedures every month. I kid you not. The numbers don't lie and I directly attribute that rise in productivity to the fact that I diagnose comprehensively and I'm a walking billboard for what is possible in cosmetic dentistry.

After I completed the Full Arch Course with Dr. Jim Downs in the beginning of 2013, I performed 16 full mouth reconstructions that year. Not full arch, mind you . . . *full mouth*. As of April 2014, I have already completed six full mouth cases for this calendar year.

When I am asked if I ever felt nervous about having this procedure done, I answer with an emphatic, "Absolutely not!" The dentist was someone whom I respected and trusted. The best dental lab made my crowns. I had absolutely no fears at all. I had one hundred percent confidence in the entire process and I knew that the aesthetic outcomes would be magnificent and the form and function would be perfect. There was no question in my mind that I would love the results and I absolutely do. The only regret is that I didn't do them sooner! ■

With each and every interaction, my new smile opens up doors of possibility for both the patient and me.

Now, not a day goes by without someone saying, "You have the most beautiful teeth. I love your smile." Such comments come from all kinds of people: my patients, business associates who see me in meetings or seminars, friends-of-friends and even, surprisingly enough, complete strangers (even when I am on the ski slopes!).

None of these people know that my teeth are Elite porcelain crowns—they just assume that these perfectly shaped, radiant teeth are my own. When I tell people they are crowns, they will often ask me more about my smile and if they might be a good candidate for the procedure. Once this conversation starts, it opens doors to a host of opportunities. Whenever I'm paid these compliments, I am reminded how important it is to think comprehensively as a dentist. I am so glad that I decided to do this!

Dr. Samuel E. Cress, D.D.S., director of The Center for Craniofacial & Dental Sleep Medicine in Sugar Land, Texas, specializes in dental sleep medicine, cosmetic and general dentistry. He is a clinical instructor with the Dr. Dick Barnes Group and is often a featured speaker at industry conferences and educational seminars. Dr. Cress pursues ongoing advanced education in the field of dental sleep medicine and full mouth rehabilitation.

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PUBLISHER: Tiffany Bloomquist

CUSTOM PUBLISHING: Arrowhead Dental Laboratory, Sandy, UT

PRINTING: Hudson Printing, Salt Lake City, UT

THESE COMPANIES HELPED MAKE THIS ISSUE POSSIBLE:
Arrowhead Dental Laboratory, Dentsply Implants (Atlantis), Dental Saver, Ivoclar and Revel TV

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The Dental Insurance Conundrum *(continued from page 3)*

For example, you *can* help people with insurance who *only* want to be treated for things that their insurance will cover. Invite them into your practice with open arms and show them what comprehensive dentistry is really about. Once patients see dentistry in terms of how it can enhance their lives, the question of what insurance will and will not cover becomes less of an issue.

When dentists learn to see and diagnose comprehensively, we will offer treatment options to our patents that will truly make their lives better and more comfortable for many years to come. Dentists should stop seeing insurance as an albatross around our necks, and instead view insurance as a vehicle that can help us introduce dentistry's true potential to new patients. For some patients, if they do not have dental insurance, then they believe that they can't afford dental care. So, for such patients, simply having insurance inspires them to call and make the appointment in the first place. Even though the one-thousand-dollar maximum per year

When dentists learn to see and diagnose comprehensively, we will offer treatment options to our patients that will truly make their lives better!

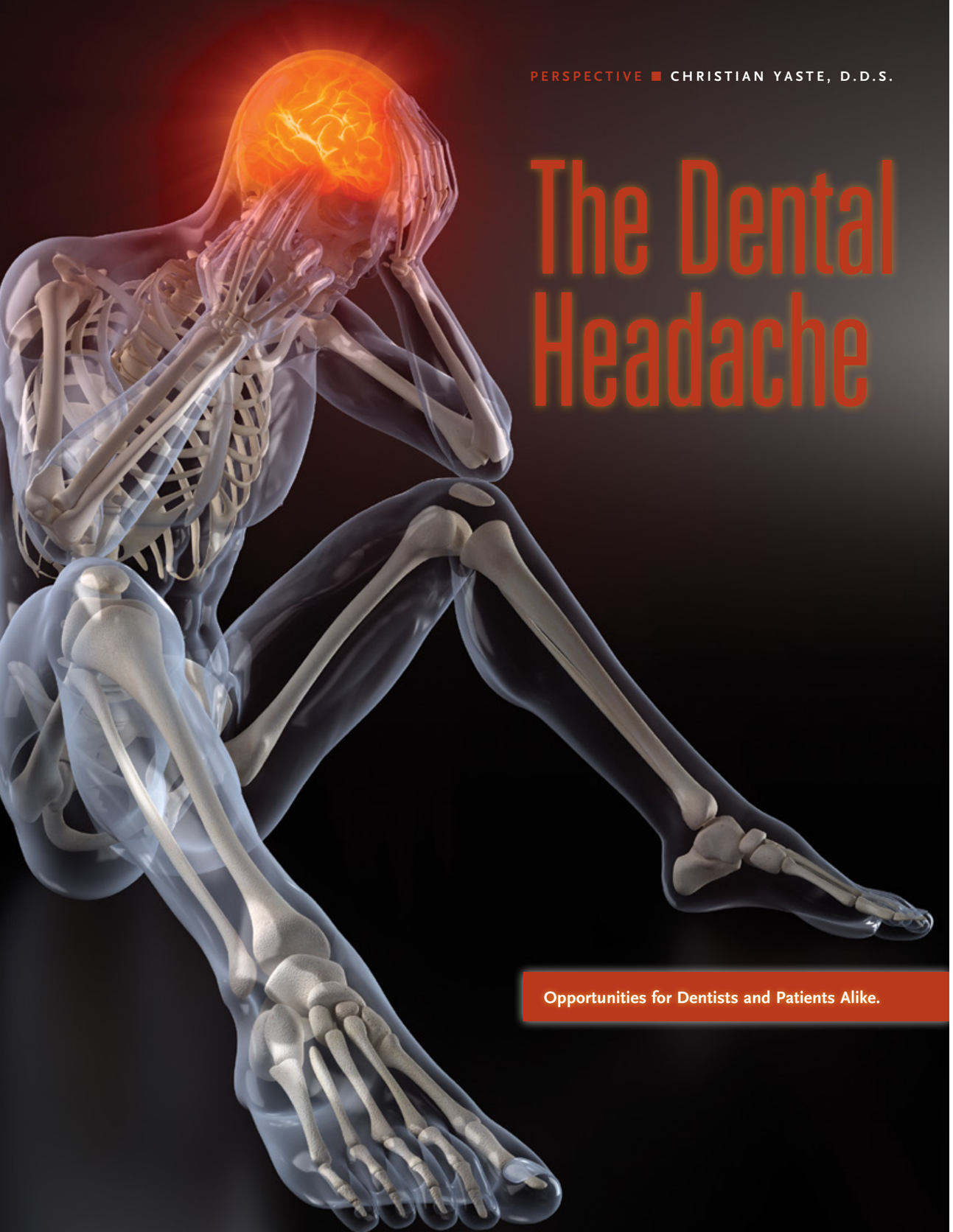
isn't much; for some patients, it is a starting point. It's something that helps patients take that first crucial step and make the call. Then, once they get into the office, it's our job to help guide them into taking the next steps towards the world of comprehensive dentistry.

I've always said that success is very easy: you simply just copy it. Success comes by doing the right thing and knowing that the benefits will follow. The structure that Tawana Coleman and the other members of the Dr. Dick Barnes Group teach is based upon the basic principle of value-based comprehensive dentistry. If you want to attain a new level of success in your practice, then start copying your peers who have already found it. Follow in the footsteps of the thousands of dentists who have used the Dr. Dick Barnes Group's structure and have discovered new levels of productivity.

Now is not the time to be *cautious* about the type of dentistry you offer in your practice. No, on the contrary. Now is the time for you to take back your practice and become more productive! By doing so, you'll become the dentist that you have always dreamed of becoming. Regardless of a good or bad economy or any financial restrictions that might be placed upon you by insurance companies, you *can* do something about your practice, your attitude, and your choice of offering comprehensive treatment to your patients. Remember, the only thing that can stand in the way of your success is you! ■

Hope Gordon, Elite Full Arch Reconstruction by Dr. Jim Downs, 2013.

The Dental Headache



Opportunities for Dentists and Patients Alike.

If you asked physicians to name one of the most common afflictions from which Americans suffer, chances are they will say "headaches." Chronic headaches are an overwhelming problem in the United States, with an average of 40 percent of Americans reporting chronic headache pain on a daily basis.[1,2] While many people (in the general public and among the healthcare community) have traditionally assigned headaches and their respective care to the purview of physicians and specialists, it is becoming increasingly clear that dentists have a greater part to play in providing comprehensive pain relief.

According to the National Headache Foundation, approximately 90 percent of the U.S. population has headaches, and more than 37 million people suffer from migraines.[3,4] Many of these patients have been suffering for years, seeking the advice of multiple healthcare professionals, trying any number of prescriptions or alternative medicines to find some relief, but often without success. Few, however, think to consult with their dentists.

Yet those in dentistry may have a good solution for many suffering Americans. An underlying condition causing many of these headaches and other pain symptoms is *dentomandibular sensorimotor dysfunction* (DMSMD), a condition involving imbalanced dental forces that dentists are uniquely positioned to treat.[5] By expanding the scope of care to include treatment of this type of chronic pain, dentists can improve the overall quality of life for their patients. Simultaneously, dental practitioners will differentiate themselves from other practitioners and establish themselves as effective providers of care, adding immeasurable value to their practices.

How DMSMD Affects Patients

DMSMD generally presents in the form of headaches or migraines, but patients may experience numerous other symptoms. Such symptoms include tinnitus, myofascial pain, TMJ disorders, and changes in the brain's neurotransmitter chemistry and balance. Additionally, many patients also present with multiple oral symptoms: bruxism, clenching, tooth wear, fracture or breakage, abfractions, and/or an unstable dental arch form. Other factors, such as malocclusion, may play a role, especially if clenching or bruxism is present.[6] Since DMSMD results from improperly functioning dental forces, muscles may become unbalanced or overloaded, causing or perpetuating localized and referred pain impulses throughout the trigeminal cervical nucleus.[7,8]

In recent years, assessment technologies and sports-derived rehabilitative devices have demonstrated a clearer picture of the relationship that exists among dental forces, disease and dysfunction—all involving the oral environment and surrounding muscle tissue and nerves.[9] Such advances have paved the way for an in-office system of care that is revolutionizing the way dentists are treating patients for a variety of DMSMD-related concerns.

An Effective System

The TruDenta® system incorporates several comprehensive assessments to determine how patients can best benefit from the customizable treatments available. The treatments include range of motion (ROM) and bite force analyses to understand the effects that DMSMD is currently having on the patient's well being. Additionally, patients are given a complete head health history form and comprehensive exam to establish parameters for treatment modalities. This detailed history gives patients an opportunity to clearly identify their pain and express any concerns they may have to the dentist. It also covers dental history and explores potential causes of their pain.

During the initial assessment, dentists use the TruDenta® system to provide patients with computerized measurements of the force balances in a patient's mouth, on a tooth-by-tooth basis. Patients can also see an exact measurement of the disability of their facial and jaw muscles to determine where the imbalances are occurring. They receive a computerized analysis of their mouth movements to determine any additional bite force imbalances.

It is becoming increasingly clear that dentists have a greater part to play in providing comprehensive pain relief for chronic headache pain.

Dentists can then prescribe one of four levels of care, depending on the severity of the case. Based on the assessment, treatment plans may last between one and 12 weeks. The system itself provides clinicians with objective information to present to patients, so patients can understand why the symptoms have manifested. The digital system provides a detailed visual aid that proves immensely helpful to dentists in garnering patient acceptance of proposed treatment plans. This, in turn, means a greater success rate for the practice, with loyal patients who return for the full course of treatment.

Upon completion of treatment, pain is no longer an issue for patients, which means that restorative or elective dental treatments may be completed more easily and at a pace that is more comfortable to patients and dental teams.[10] Thus, the system of care proves integral not only for eliminating the source of chronic pain for patients, but also for helping them on the path to better oral health.

Customized Treatment Modalities

Once patients have completed the necessary assessments to determine the appropriate level and length of care, dental teams provide a series of rehabilitation treatments designed to address the underlying causes of the patients' imbalanced force-related problems and resulting pain symptoms. The TruDenta® system is designed to be non-invasive—thus highly conservative—with no drugs or needles involved. Patients undergo a unique combination of multiple therapies, both in-office and at home. Each in-office treatment is approximately 50 minutes and can include any of the following:

Manual Muscle and Trigger Point Therapy. This treatment modality targets facial and jaw muscles, identifying any trigger points that may have developed as a result of unbalanced dental forces. Found within bands of muscles, trigger points are often a source of pain and inflammation for patients. This therapy breaks up any trigger points or muscle knots, thereby increasing blood flow to the area, which simultaneously decreases inflammation and pain while promoting faster healing. This therapy alone can reduce patients' need for pharmaceuticals and invasive dental procedures such as surgery. ›

Therapeutic Ultrasound. Designed to promote increased speed of healing, this method helps return circulation to muscles that have become sore or strained with improper use. It increases blood flow to the area, and the heat applied during the process reduces inflammation. Additionally, the sound waves work to break up scar tissue or deep adhesions that may have formed, perhaps as a result of injury or other trauma.

Transcutaneous Electrical Stimulation. This therapy is designed to reduce any muscle spasms and/or referred pain that patients may be experiencing. A low level electrical signal is used but its strength is sufficient to encourage nerve stimulation and decrease any lactic acid that may have accumulated over time. This therapy can also work to increase mouth opening in patients whose range has been decreased due to pain or inflammation.

Low Level Laser/Light Therapy. Like other treatments, this modality works to decrease pain and inflammation. However, it also reconnects the pathways of nerves to the brain stem, allowing muscle and joint tissue to heal faster as pain is inhibited. This therapy is especially useful for patients suffering from TMD symptoms, because the combination of the low-level laser therapy and electrical stimulation permits the patient's musculoskeletal system to heal naturally, albeit at a much quicker rate. For patients experiencing painful TMD symptoms, this therapy can increase stability of the TMJ and increase the mouth opening.

Depending on the needs of patients and the severity of their cases, they may also be provided with a homecare kit to use after in-office treatments for further rehabilitation. Patients may also be fitted for a rehabilitation splint (to be worn temporarily, as directed) to retrain and balance muscles.

Opportunities for Dentists

Patients experiencing frequent headaches and chronic pain often search for answers as to why they are experiencing this type of pain and how they can resolve their issues. The exceptional capabilities of the TruDenta® system serves as the solution many patients are seeking, and clinicians should take advantage of this opportunity to expand their offerings. By adding the TruDenta® system to their services, dentists can separately brand a part of their practice to cater specifically to such patients, increasing revenue from patients who require this type of treatment, as well as any subsequent restorative treatments that require a stable foundation. These services can also be marketed to current dental patients that team members believe will benefit from this type of customized therapy.

Dentists can position themselves as knowledgeable experts who can provide pain relief.

As patients continue to search for a solution to the problems of headaches and chronic pain, dentists can position themselves as knowledgeable experts who can provide pain relief. Doing so benefits clinicians and patients alike. Patients experience the conservative treatment results a system like TruDenta® can bring, and dentists secure themselves a unique position as the providers of care that such patients so desperately need. The result is an increasing patient base and additional, incalculable value to their practices. ■

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Full Arch Reconstruction: Simple When It's Systematic

Planning Ahead Makes Large Case Dentistry Predictable.

"Simple extraction? There is *no* such thing as a simple extraction!" I once overheard an oral surgeon in dental school utter those words to an unsuspecting dental student who had made that erroneous claim. Like that student, dentists often put procedures into categories and subsequently choose the ones they are comfortable with to perform. In other words, "difficult" cases get referred out. While this may be the model that many dentists were taught in dental school, I was blessed by mentors who taught me to embrace the challenges of complete dentistry. This fundamental difference has made a tremendous impact on my practice. A periodontist friend of mine labels general dentists who practice comprehensive dentistry as, "restorative specialists." This type of dentistry starts with one simple word—systems.

With appropriate systems in place, you have an entire world of dentistry to discover, enjoy and prosper from, while patients benefit from great care by a trusted dentist. Systems make procedures more predictable, less stressful and generally less time-consuming than procedures without such systems in place. Systems help build confidence in the skills dentists have and help your team have confidence in your leadership. Your staff will know you care about what you're doing and the patient will also sense the pride you take in your dentistry.

One procedure that demands a system (and that most dentists refer out) is full mouth reconstructions. The numbers don't lie. The vast majority of dentists have *never* completed a full mouth reconstruction. It sounds intimidating—daunting even. Thankfully, other dentists have already established systems that are . . . dare I say it . . . *simple*. Even full mouth reconstructions can be managed and tackled in an organized fashion.

One of the courses that helped me organize my approach and simplify the process was the Full Arch Reconstruction Course offered by the Dr. Dick Barnes Group. In this course, Dr. Jim Downs simplified the full mouth reconstruction process from treatment planning to finishing and photographs. Every case is different, but there are phases to each case that bring the doctor confidence and predictability. As I performed more full mouth and full arch cases, my systematic approach enabled me to visualize the entire case from start to finish and made it possible for me to enjoy the process rather than be intimidated by it.

Systems Case Study: Patient Mark

About four years ago, I met a patient named Mark. Mark was a hardworking gentleman who had a very difficult dental history and an equally difficult reconstruction to perform. Mark said that it took all his courage to walk through the door for his first appointment.

Mark came to my office in 2010 with pain on the lower left and it was determined that he needed a root canal, buildup and crown on number 20. We performed the procedure using IV sedation due to his extreme dental anxiety. Mark then had a complete exam, photos, FMX, and impressions and it was determined that he would be a candidate for a full mouth reconstruction. The important thing to note is that because I had already developed a systematic approach, I was able to see past Mark's chief complaint, understand the comprehensive needs and provide a solution for his whole mouth.

Mark had been dealing with his dental problems using a piecemeal approach and was not receiving regular preventative care. One of the significant factors in this case was Mark's heavy wear due to bruxism and the resulting collapsed bite. Mark was always uncomfortable and his masticatory muscles were extremely tender and caused him continual discomfort. Headaches were the norm and required him to take daily medications. In addition, Mark had a significant infection on number 14, number 29 and number 30. Although Mark understood my recommendations, he was nervous to proceed and finances were a concern.

With Mark, if I had merely looked at his chief complaints, he wouldn't have necessarily needed a full reconstruction. But when I systematically looked at his bite, looked at the wear and condition of the gums and the bone around the roots, this case was 'screaming' for a full mouth reconstruction. One of the key benefits of a systematic approach is that it causes dentists to slow down, go through the process and provide a comprehensive evaluation. The natural tendency is the opposite and focuses solely on the obvious problem.

Nonetheless, after his first visit, Mark disappeared, despite our follow-up calls. We simply told Mark, "When you're ready, we're ready." As part of my approach, I do not pressure patients for treatment, which is very important. Yet, I always make sure—as Dr. Dick Barnes says—"to figure out the patients' motivations."

Two years later, Mark returned to the office. By then, number 30 was so painful that he was ready for treatment. In our consultation, we talked about Mark's heart (he recently had a fifth heart stent placed), the infections in his mouth and how that can negatively impact other systems in the body. We talked about Mark being in pain every day. We talked about the desire to smile with confidence and look better. Every patient has internal motivations for moving forward and if dentists are in tune to what those reasons are, we can speak in ways that will resonate with patients. By understanding some of the underlying motivations, I was able to support Mark's decision to move forward.

Shortly after that visit, Mark returned to my office with another toothache—that was the "last straw." His finances were apparently in order and during the visit, his fiancé came with him for the consultation and encouraged him to move forward. "It's time," were the only words Mark needed from me.

As Mark's case showed, a systematic approach was important because it enables dentists to see and identify all the areas of concern and present them in a comprehensive fashion. With an established system, dentists don't have to convince the patient they need care. Establishing a thorough plan and an order in which to perform each step gives confidence to patients that they have selected the right dentist!

With appropriate systems in place, you have an entire world of dentistry to discover, enjoy and prosper from.

After Mark returned, the easy route would have been to simply say, "What would you like me to do for you?" Instead, we went through a defined process to create a vision for Mark for great dental health and great aesthetic results. We began with the necessary diagnostic records immediately. To complete the full mouth reconstruction, Mark's appointments included almost every level of dental reconstruction.

Below is a summary of some of the key elements in my process. Parts of the system merit a more in-depth analysis. I've included detailed explanations on selected parts of the system in the paragraphs that follow. ›

Summary of Key Steps in Mark's Case

- IV sedation for his anxiety.
- Full diagnostic white wax-up (Arrowhead).
- Diagnostic casts mounted on semi-adjustable articulator.
- Temporary stents (Arrowhead) for temporization based on the wax model.
- Scaling and root planing all four quadrants using local anesthetic.
- Extractions, bone grafting and barrier membranes.
- Root canals on number 14 and number 29.
- Build up/cores and preparation for IPS e.max press on all teeth.
- Opening vertical several millimeters using diagnostic temporaries.
- Crown lengthening/biologic shaping on numbers 2 to 5, numbers 12 to 15, numbers 19 to 20, and numbers 29 to 31.
- Grafting on upper right quadrant.
- T-Scan®/full occlusal equilibration following crown bonding.
- Occlusal guard for nocturnal bruxing events.

IV Sedation

When performing larger cases, patient comfort is a key component of my system. Starting with the first phone call, my staff is trained to evaluate the patient in terms of his or her need for sedation. Sedation isn't just for patients with dental anxiety, it's also utilized in my practice for cases involving surgery, long reconstruction appointments, sensitive gag reflexes and patients with TMD. Using sedation selectively allows me to be more productive in a single appointment, which benefits both the patient and the practice.

When Mark came into the office, he was so nervous, he could barely get through the door. Because the patient's comfort is part of my systematic approach, I knew from the outset that we needed to use IV sedation for Mark's extreme anxiety.

Full Diagnostic Wax-Up

The diagnostic wax-up is critical to identifying occlusal challenges and esthetic concerns prior to proceeding with treatment. It's almost like having the patient in the office when they're not! It's great to have X-rays, but they are two-dimensional images of a three-dimensional object. Models are a great way to bring about a total understanding of the relationship of the upper and lower teeth and the condition of the teeth. Having a complete white wax–up of the case is also a powerful communications tool. It keeps the patient, myself and the lab focused on the desired outcome. When Mark saw his white wax-up for the first time, he was able to see a physical representation of the vision we had previously established. I use white wax-ups on all of my large cases—it is a key part of creating predictability in these cases.

Diagnostic Casts Mounted on a Semi-Adjustable Articulator

In Mark's case, we were changing the occlusal landscape and increasing his vertical several millimeters. His attrition was significant and I wanted to know ahead of time if opening his bite would pose any challenges or create problems. Part of my system is starting with the end in mind.

Temporary Stents

When I have the white wax-ups fabricated, I also get a stent and a prep guide from Arrowhead. The stent makes the process of maintaining the bite simple and accurate. My dental assistants also use the stents to quickly make beautiful temporaries that mimic the wax-up model. At this stage, the patients are usually very excited because they begin to see what the end result will be. How many dentists would comfortably assign a fully prepped arch to their assistant to temporize? Many of my colleagues answered that they personally do this step themselves. With the white wax-up stent, it can be delegated with confidence!

Occasionally, I will use Arrowhead to fabricate another type of stent. It is a temporary occlusal stent designed to be worn by the patient during the temporary phase to help them adjust to their new vertical and to protect their temporaries from damage. Given his propensity for bruxing, Mark's case included temporary stents.

Temporary stents are especially useful if you are doing single arch dentistry and a patient will not be finishing the opposing arch for a while. During the intervening time, a patient simply wears a stent to help mitigate any bruxing that could otherwise complicate a case.

Scaling and Root Planing

One of my system's core beliefs is that the teeth we restore are only as good as the foundation supporting them. With Mark, the X-rays and probing depths at the very earliest appointments showed a significant amount of bone loss around different teeth on all four quadrants and some periodontal disease. So scaling and root planing go back to the foundation that I discussed earlier. Scaling and root planing not only remove plaque and calculus, which contribute to dental disease, they also smooth root surfaces, rendering them glassy and less likely for food and plaque to attach.

Bone Grafting and Barrier Membranes

Bone grafting is a way of both preventing bone loss and creating support areas for implants and soft tissue. Mark had areas that needed grafting. I wanted a strong platform of bone and soft tissue that was well adapted to the teeth and bone. The barrier membranes simply help hold the bone grafting products in place and keep the soft tissue from invading the surgical site while a patient heals following surgery.

Opening Vertical Using Diagnostic Temporaries

Opening Mark's vertical helped with the attrition loss and in reconstructing the youthful look of his teeth. This approach also helps with muscle function, as muscles tend to be in a more chronically strained position when the bite has collapsed from wear over time. We were able to help Mark achieve a more stable bite and more attractive smile by adding vertical dimension to his case. Shimbashi studies confirm the benefit of improving vertical dimension and I always establish the VDO (Vertical Dimension of Occlusion) prior to prepping teeth.

Biologic Shaping

Perhaps one of the least emphasized areas of comprehensive dentistry and full mouth reconstructions is biologic shaping. While many dentists define this simply as crown lengthening, that isn't accurate. The purpose of crown lengthening is to remove bone and lower soft tissue around a tooth in an attempt to "lengthen" the tooth. Biologic shaping involves the removal of old dentistry (including old crown margins), furcation issues, root irregularities and bony irregularities to create proper parabolic architecture of the bone and soft tissue around the tooth being restored. This means that often very little bone is removed at all!

Biologic shaping is a great way to create an ideal support structure around the teeth while simultaneously eliminating subgingival dentistry and making restorations easier to keep clean. We took this approach with Mark and as you can see, the results are just what we intended: healthy bone, healthy gums, healthy teeth!

Gingival Grafting

Another very important and often overlooked phase of full mouth reconstructions is the area of proper connective tissue around the teeth. Without connective tissue, teeth are highly susceptible to gingival breakdown and periodontal disease. Part of my system involves analyzing the health of the soft tissue around the teeth and identifying those areas that need connective tissue. Mark received grafting on the upper right quadrant. Failing to do this in Mark's case would have increased the likelihood of future problems. Because we systematically addressed this concern as part of our process, it was easy to see exactly where this needed to be done for Mark.

Occlusal Equilibration with T-Scan® and Bruxism Guards

In my system, I include some additional steps that go beyond placement of the restorations. This is the 'final piece to the puzzle,' and sadly, one phase that many dentists skip. It consists of two key elements: occlusal equilibration using T-Scan® and the fabrication of a bruxism guard. Those two steps are my insurance policy that ensures the dentistry will last.

Once the final restorations are bonded in place, I begin the equilibration process using the T-Scan®. It takes the guesswork out of getting that new bite just right! Then we fabricate an occlusal guard to help the patient protect their investment against nocturnal bruxing events.

Mark was a significant bruxer so this was a *must* in his case. For him, the result was a beautiful smile that looks as good today as the day it was seated. The last two steps saved me countless hours in chair time that I would otherwise have spent fixing fractured crowns due to occlusion problems.

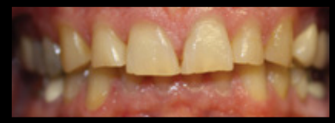
Overall Results

Since we completed his case last year, Mark is healthier, happier, and much more confident in his demeanor. He now says he loves to smile! What is that worth? For Mark, it is priceless.

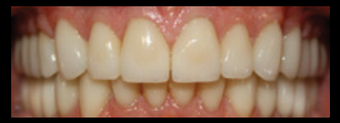
For me, having a systematic approach for evaluating and completing full arch reconstructions has taken my practice to a whole new level. I don't shy away from large cases and every complete reconstruction that I perform helps me gain more experience. I call each of these cases growing events. They are not always easy, but the challenges of such cases come with opportunities to grow in knowledge and skill; each one helps me refine my system so that the next case is that much easier. As a bonus, my confidence in single tooth dentistry has increased, too. Now, working on a single tooth area seems almost like a walk in the park!

This approach has also had a huge financial impact on my practice. Larger case dentistry has allowed me to attain higher levels of production and the referrals that these patients generate are a continual source of revenue. In other words, it is a win-win.

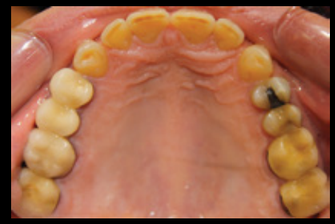
I encourage anyone who hasn't completed a full arch or full reconstruction case to make 2014 the year you begin! Start by creating a system for full mouth reconstruction that is repeatable and focuses on helping you attain more predictable outcomes. If you don't know where to start, I recommend attending the Full Arch Reconstruction Course taught by Dr. Jim Downs. Attending the Arrowhead courses will help you develop a system and make you a better clinical dentist. ■



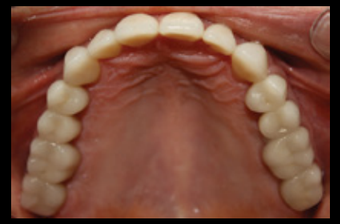
Mark's "before" smile.



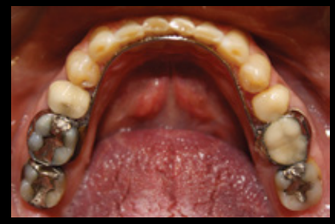
Mark's "after" smile.



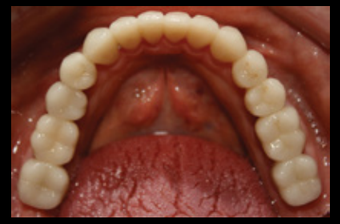
Mark's "before" upper arch.



Mark's "after" upper arch.



Mark's "before" lower arch.



Mark's "after" lower arch.

Mark LOVES his new smile!

To meet Mark and hear his story, check out a two-minute video by using this code or by visiting www.AdentMag.com/FullArchSystematic

Dr. Dan Hillis received his B.S. and D.M.D. from the University of Kentucky. At his Mason, Ohio practice, Hillis specializes in comprehensive dentistry (general, cosmetic, surgical, orthodontic and sedative care). He has received extensive training in full mouth reconstruction and surgical dentistry.

Obamacare and Dentistry

Are Pediatric, Orthodontic and TMD Services Covered?

Dental practices and the public alike are navigating the maze of the Affordable Care Act (ACA) (a.k.a.: "Obamacare"), and how its healthcare mandates relate to dentistry. As part of the ACA, dental care for children is cited as one of the "Ten Essential Health Benefits," but the reality is that pediatric dental plans may be optional. For children who have dental coverage, under Obamacare, pediatric dental plans allow for basic or expanded dental benefits and may also include orthodontic coverage.

Having studied the sections of Obamacare that pertain to dental care, I've found that much of the text is concerned with the definitions of "medical necessity." Therefore, it is important for dentists to be familiar with this term. Keep in mind that the definition of medical necessity varies from state to state, so for more information, please check with the U.S. Department of Health and Human Services (HHS).

In talking with dentists around the country, the top ten questions I hear about the ACA are:

1. *Q. How many people are expected to gain dental benefits as a result of the ACA?*

A. The American Dental Association (ADA) estimates that as many as 8.7 million children will gain some form of dental benefits by 2018 as a result of the ACA. Roughly one-third of those children will be covered by their parents' employer-sponsored insurance; another third will gain coverage through Medicaid. The remaining third is expected to be covered by new policies purchased from the health insurance exchanges. Since pediatric dental coverage is not mandatory when policies are purchased from the health insurance exchanges, many people suggest that this estimate is on the high side of what will likely occur.

A total of 17.7 million adults are also projected to gain dental benefits as a result of the ACA. The ADA projects that 5.3 million adults will gain extensive dental benefits, 85 percent of which are linked directly to Medicaid expansion in states that currently provide extensive adult dental benefits (AK, CT, IA, NC, ND, NM, NY, OH, OR, RI and WI). An additional 12.4 million adults are expected to gain emergency or limited dental benefits.

State-by-state projected changes as a result of the expansion of dental benefits due to the ACA are available for download online (http://www.ada.org/sections/professionalResources/docs/HPRCBrief_0413_3x.xlsx).

2. *Q. What impact will the ACA have on dental spending and the number of dental visits?*

A. It is estimated that the ACA will increase U.S. dental spending by an estimated four billion dollars, including an increase of 2.4 billion dollars in Medicaid dental spending plus an additional 1.6 billion dollars in expenditures by adults and children gaining private dental benefits through exchanges and employer-sponsored coverage.

The ACA is also expected to add 11 million pediatric private dental visits through expansion of dental benefits through the exchanges and employer-sponsored insurance plus 1.7 million adult private dental visits through expansion of dental benefits in the health insurance exchange.

3. *Q. Why is pediatric dental coverage part of the ACA?*

A. As noted earlier, pediatric dental care is cited as one of the "Ten Essential Health Benefits" under the ACA. Its inclusion was prompted (in part) by the 2007 death of an uninsured, 12-year-old Maryland boy named Deamonte Driver. Deamonte was killed by a bacterial infection that spread to his brain from an abscessed tooth. His story was widely reported as an example of limited access to dental care.

Although it is an "essential health benefit," last year, states were informed by the HHS that pediatric dental coverage is optional. The change was the result of a court ruling, which held that while pediatric dental coverage must be offered on the health exchange, consumers cannot be required to purchase it. As a result, fewer children may actually gain dental benefits under the ACA than originally estimated.

4. *Q. Does the ACA mandate coverage of specific pediatric and orthodontic dental services?*

A. No. Under the ACA, each state is responsible for setting its own package of "essential health benefits" within HHS's guidance. With the exception of Utah (where pediatric dental coverage purchased on the exchange is limited to coverage of semi-annual dental cleanings and sealants), most people will find that dental procedures covered as a result of implementation of the ACA are similar to their state's Children's Health Insurance Program (CHIP). Additionally, it should be noted that some states specifically include coverage of what they have defined as "medically necessary" orthodontics; others do not.

5. *Q. Is our practice required to provide pediatric care at fees designated by the ACA?*

A. No—not unless you are a contracted provider for Medicaid or a specific plan. In that case, you must provide pediatric dental services at rates designated by Medicaid or the specific insurance plan. Dentists may sign up as providers in the various HMO or EPO plans, such as Delta Dental Plans Association, which are offered on the Health Insurance Exchange or through brokers.

6. *Q. What is the pediatric age limit? Does the ACA allow children to remain on their parents' dental insurance plans through age 26?*

A. The ACA is designed to provide pediatric dental insurance for patients under the age of 19; however, states have the flexibility to extend coverage. In addition, some dental insurers are voluntarily opting to extend the dependent age limit for their plans beyond age 19. Unlike medical insurance, however, there is no provision in the ACA that allows dependent children to remain on their parents' dental insurance through age 26. Since states and plans vary, patients should be advised to check their current dental plan (or any dental plans they may be considering) carefully to confirm eligibility.

7. *Q. Will dental coverage be part of medical insurance plans?*

A. Since pediatric dental care is required under the ACA, basic dental coverage will be included in some health plans. In most cases, however, separate, stand-alone dental plans will be offered for basic dental services and preventive care. In fact, 99 percent of dental benefits are sold under a policy that is separate from medical coverage and this is not expected to change significantly.

Stand-alone dental plans are likely to have much lower deductibles than medical plans that also include child dental care, or possibly no deductibles, according to Delta Dental. They are also likely to have lower limits on out-of-pocket expenses than plans that combine medical and pediatric dental care. This may benefit families of children with acute dental care needs as well as those who want paid preventive care without having to wait until they have spent enough money to meet a higher deductible.

8. *Q. Are adults required to obtain dental coverage under the ACA? Will medical insurance reimburse adults for TMJ splints and sleep apnea appliances?*

A. First, no, the ACA does not require adults to obtain dental coverage. While some people believe that insurers may offer more stand-alone dental policy choices for adults and families as a consequence of the ACA, such stand-alone plans will not be subsidized.

Second, adults in some states may gain benefits for TMJ splints as well as Durable Medical Equipment (DME) for oral appliances for obstructive sleep apnea. One example is in West Virginia, where the state insurance commissioner has adopted guidelines for coverage of diagnosis and treatment of TMD and craniomandibular disorders (CMD) in medical policies as part of the ACA; other states have followed. It is important to note that this coverage is under medical (not dental) insurance.

9. *Q. Are there any loopholes or technicalities we should be aware of with regards to pediatric dental coverage?*

A. If the patient purchases insurance within Health Insurance Marketplace, the patient is not required to purchase pediatric dental insurance. In other words, although the health exchanges are required under the ACA to offer pediatric dental benefits, consumers are not mandated to purchase them.

When healthcare coverage is purchased outside of the Health Insurance Marketplace, however, the patient is required to purchase pediatric dental insurance. ***(continued on page 24)***

Making the Jump into Dental Implants

Get Out Of Your Comfort Zone and Improve Your Practice.

Sixty-nine percent of adults ages 35 to 44 in the United States have lost at least one permanent tooth…by age 74, 26 percent of adults have lost all of their permanent teeth.

Since the 1980s, dental implants have been a reliable method of replacing missing teeth. However, during the last few years, this specialized dental procedure has grown dramatically in popularity. Why? The answer is simple: advertisements. Today, dental implant ads are everywhere—on television commercials, billboards, magazine ads and articles and, of course, the Internet. A quick Google search of dental implants generates more than 3.5 million pages. The average person is likely familiar with dental implants and knows about some of the benefits. As a result, many patients request dental implants before their dentist even has a chance to suggest the procedure as a viable option. I have personally spoken to many general practitioners who are experiencing this phenomenon on a regular basis.

So how does a sudden increase in consumer awareness impact the practices of a general dentist? After all, in the past, such cases were typically referred to oral surgeons, endodontists, prosthodontists, periodontists or other specialists. While such specialists still perform these procedures regularly, many general practitioners are now taking on some of the less complex cases. This might seem like a revolutionary idea to some dentists and specialists who believe in following traditional methodology; they might even question whether or not a general dentist has the expertise to perform such advanced cases. I agree that some of these concerns are valid. If general dentists do not have the desire or confidence to perform basic surgical procedures, then getting involved in dental implants is probably not the best choice.

However, if general practitioners have a desire to improve their practices and get out of their comfort zones by learning new procedures (providing they have some basic surgical skills), then there is absolutely no reason why that dentist cannot be trained to offer dental implants. The desire is the first key ingredient. Once a general practitioner has that desire, he/she needs to gain the proper training in dental implant procedures. Then, the dentist needs to be educated on suitable case selection; some cases general practitioners should accept and other cases should be referred to a specialist.

Believe in the Product

Attaining a desire to perform dental implants is easy for a dentist who really believes in the superiority of the procedure and knows the tremendous benefits it can offer to patients. Dental implants are superior to fixed bridges and removable dentures for several reasons:

First, there's the "smile factor." People with dental implants generally have a better, more natural, and more youthful smile than people with dentures or fixed bridges.

Second, there's the "health factor." People with fixed bridges and removable dentures are limited in the types of food they can comfortably eat. People with dental implants, however, do not have the same restrictions, thus enjoying better overall health and a better quality of life. People with dentures and bridges can eventually develop problems associated with missing teeth such as gum loss, gum disease and bone loss. The healthy teeth surrounding the bridgework are also often affected. These types of health problems are generally mitigated with dental implants.

Third, there's the "social factor." People with removable dentures often admit that they avoid eating in public or speaking in public for fear that their dentures will slip and make embarrassing clicking sounds. This is not a fear that people with dental implants have to worry about.

Knowing the benefits of dental implants allows the general practitioner to stop seeing dental implants as *luxury* treatments for their patients but instead to start viewing them as *necessary* and *natural* treatments. This paradigm shift is extremely valuable for dentists, especially considering the current national statistics.

According to the American Association of Oral and Maxillofacial Surgeons (AAOMS), "Sixty-nine percent of adults ages 35 to 44 in the United States have lost at least one permanent tooth to an accident, gum disease, a failed root canal or tooth decay… by age 74, 26 percent of adults have lost all of their permanent teeth." Such numbers portend an inevitable future—a very large percentage of your patients are going to eventually need tooth replacement at some point in their lives. If the trends continue, this tooth replacement will most likely be in the form of dental implants. Both you and your patients will benefit tremendously if you can start offering this type of treatment at your own office.

Advanced Training is Key

Gaining a desire to perform dental implants is only the first step. Once that desire has been 'implanted,' a dentist (and any attendant staff members) must then attain the training he/she needs in order to properly perform the procedures. Many great training options are available for dental implants. Continuing education courses (like those offered by Arrowhead Dental Lab) are some of the best avenues. For example, Arrowhead's Implant EZ II course is particularly helpful because students observe dental implants over the shoulder of an expert and are then given the opportunity to perform the procedures on state-of-the-art mannequins that closely simulate live patient placements. During the procedures, an expert dentist guides the novice dentist's every move. This type of hands-on training is invaluable when learning advanced procedures like dental implants.

Prior to taking these advanced courses, though, I highly recommend that dentists 'brush up' on basic surgical suturing skills. Personally, I have found that most general dentists who attempt dental implants do not end up with major difficulties installing the implant. What they may have an issue with, however, is suturing up the wound after the procedure is completed. Many general dentists often avoid doing procedures that require them to suture. This lack of confidence in suturing can absolutely affect a dentist's ability to perform dental implants.

Suturing is a basic skill required for any oral surgery. So if you find that you're lacking skills in this area, take a refresher course on oral surgery and suturing techniques. Afterwards, start increasing the number of surgical extractions, suturing, and socket grafting that your office schedules. You're only going to get better if you practice, and these types of procedures will allow you to do so. By perfecting these procedures, your initial experience with dental implants will be much more positive.

As noted earlier, not only does a dentist need advanced training in surgical procedures, so do the staff members. The most important skill that dental assistants in general practitioners' offices need to attain is proper surgical asepsis. Without proper training, dental assistants may have a tendency to cross-contaminate during a surgery by inadvertently touching too many objects and tools. While this might not be an issue in other dental treatments, in a surgical setting, it can lead to major health problems for the patient, including possible infections.

After the assistants receive specialized training, dentists need to make sure that the assistants understand and apply the new techniques. With any oral surgery procedure, the goal is to have the highest level of predictability so that success can be achieved. ›

This outcome is only possible by starting with the basics, which includes your aseptic technique. A general practitioner should ensure that the office space has an aseptic environment for surgical procedures. A separate room should be dedicated specifically for oral surgery. This room and its tools should be used for no other purpose. By designating such a space, the proper aseptic environment can be created.

Case Selection 101

It doesn't matter how great your knowledge and skills are, if you work beyond your skill set, your chance of success will be significantly decreased—particularly with dental implant procedures. If a dentist accepts a case that is far beyond his/her skill set, the procedure likely won't succeed. So, careful attention to case selection is crucial and perhaps should be considered the *most* important aspect of the dental implant procedure. Only accept cases that you know you can handle and refer the more difficult ones to specialists.

This piece of advice naturally leads to a fundamental question that many general practitioners ask: how can dentists know which cases are within their scope of expertise and which cases to refer to specialists? The first and most important method of determining proper case selection is by conducting a thorough and detailed medical history on your patients. The medical history is a window that allows you to assess the predictability of the patient's likelihood for healing. The medical histories that I conduct in my office are *extremely* detailed. I find out everything about a patient's health, habits, medications, etc. Once you know this information, you can assess the situation and determine whether or not they are a good candidate for a dental implant in your office or if you'll need to refer them to a specialist.

The medical history is the *only* way to determine which cases to accept. A patient might look and act completely healthy, but they could have medically-compromising conditions that could make the case extremely difficult. Here are two examples of medically-compromising conditions:

1. Certain medications can lead to problems with healing and increased bleeding. Dentists can only determine if someone is taking such particular medications after conducting a thorough medical history.
2. Smoking is another medically-compromising factor. This habit can cause tremendous problems for the success of any oral surgery procedure, especially dental implants. If a patient smokes, I immediately tell the patient that smoking will absolutely cause a problem in the procedure's outcome and I am thereby unable to guarantee the procedure's success.

Patients in these two types of scenarios should *always* be referred by a general practitioner to a specialist who can properly assess the situation and decide if the case will be successful.

An ideal dental implant case for a newly-trained general practitioner would be a healthy 30-year-old with a broken bicuspid who is not taking any medications and is a nonsmoker. On the other hand, a poor candidate would be just the opposite—a polypharmacy patient who takes a medicine-cabinet full of pills and is a smoker. Do yourself and polypharmacy patient a favor—send the patient to a specialist. Don't accept the case no matter how easy the procedure might appear. Save yourself the headache and heartache and let someone with more expertise take on the case.

In addition to carefully considering medical history, the best types of cases for dentists who are new to dental implants are generally those that involve a single tooth in the non-aesthetic zone (bicuspids and molars). Start with cases that involve these teeth first. Then move on to more advanced cases once you have these teeth mastered. The next step is accepting cases that involve multiple implants in the non-aesthetic zone—or multiple bicuspids or molars next to each other. Once you've perfected that technique, you will have the skills and confidence necessary to perform the most difficult cases, which are implants in the aesthetic zone—the cuspids and incisors.

Working With Your Patients

Prior to performing a dental implant, all dentists must conduct a formal consultation with their patients and discuss the pros and cons of the procedure. Dentists should also get the patient's written, signed consent. I use a two-page patient consent form from the AAOMS. The American Dental Association (ADA) and most insurance companies also offer similar forms.

How can dentists know which cases are within their scope of expertise and which cases to refer to specialists?

In the initial consultations, I prepare the patient for the worst possible scenario. That way, if the worst does happen, the patient will not be surprised or concerned because we will have already discussed it. The patient will know exactly how I plan to handle the situation and will feel comfortable with my methods of treatment. The same can be true for your dental implant patients if you take the time to discuss both the good and the bad possibilities. Because you've prepared the patient for the worst, when everything goes perfectly—which it usually does—they'll be absolutely delighted and think you're the greatest dentist ever.

Proper scheduling is also another key component for the success of dental implant procedures. If dental implants are a new procedure for you, don't schedule the patient in the middle of your workday when you are busiest. Instead, schedule the dental implant patient as your last appointment for the day. That way, you'll have plenty of time to methodically work through the procedure and you won't be stressed with time restraints. If you need to spend extra time suturing, you'll have it. If something arises that you didn't expect, you'll have time to work through it. Whether the procedure takes 10 minutes or two hours, it won't matter. No one will be pressuring you to move faster than you're comfortable.

For your first few dental implant procedures, I recommend finding a friend or relative as your volunteer patient. Since you have a personal relationship with this person, he or she will understand if you move a little slower, seem a little more meticulous, or even sweat a little more than usual—there will be no unnecessary alarm. These are the best kinds of cases to get you started. I speak from experience, as the very first dental implant I performed was on my mother-in-law. ›

Diving In

The biggest problem for general dentists who want to perform dental implants is a lack of preparation. Performing dental implant procedures requires a lot of advanced planning. Remember the following: hone your professional skills and the skills of your staff. Set up an appropriate space in your office for the procedures. Find out a detailed medical history of your patients. Properly consult with and schedule your patients for their procedures.

In addition to these tips, know your limits and stay well within those boundaries. If you do so, dental implants will be a profitable, enjoyable, and productive procedure for you to include in your general dentistry practice. It will also be something that will greatly benefit the lives of your patients. Considering the national statistical data, the number of your patients who have lost or will lose teeth during their lifetime is significant. Knowing the vast benefits that dental implants can (and do) offer over other treatment methods, general practitioners should have the desire and skill to provide such options in their offices. Get the training you need and jump on in! Your patients deserve it. ■

Dr. Bill Black received his degree from the University of Tennessee (Memphis) in 1984 and completed his residency in Oral and Maxillofacial Surgery at the University of Tennessee (Knoxville) in 1989. There he participated in some of the original research involving osseo-integrating, root form and implants. Since that time, he has been in private practice as an oral and maxillofacial surgeon in Scottsbluff, Nebraska as well as an educator for dentists who are looking to develop their skills in the area of implantology.

Check out Dr. Bill Black's webinar, "Implant S.O.S." by using this code or visit www.ArrowheadDental.com/implant-sos

Sources for statistical and other data:

http://www.aaoms.org/conditions-and-treatments/dental-implants

Obamacare and Dentistry *(continued from page 19)*

10. Q. Will patients still have out-of-pocket dental expenses under the ACA?

A. Yes. If purchased from a federally-run exchange as a stand-alone policy, pediatric dental coverage can include annual out-of-pocket expenses as high as 700 dollars per child or 1,400 dollars per family, according to Colin Reusch, a senior policy analyst with the Children's Dental Health Project, a nonprofit based in Washington, D.C. And the cost of stand-alone coverage cannot be counted toward the medical out-of-pocket limits built into the health care insurance policy. In addition, while some people may qualify for tax credits to help pay medical premiums, there are no tax credits for stand-alone pediatric dental plans.

As these questions and answers suggest, navigating through the ins and outs of the ACA may be challenging—particularly for dental practices that accept large numbers of Medicaid patients. We will undoubtedly learn more as the law is implemented. In the meantime, with 26 percent of preschool age children, 44 percent of kindergarteners, and more than half of adolescents experiencing preventable tooth decay, the intent of the ACA to expand dental coverage to millions of children is one we can all rally around. ■

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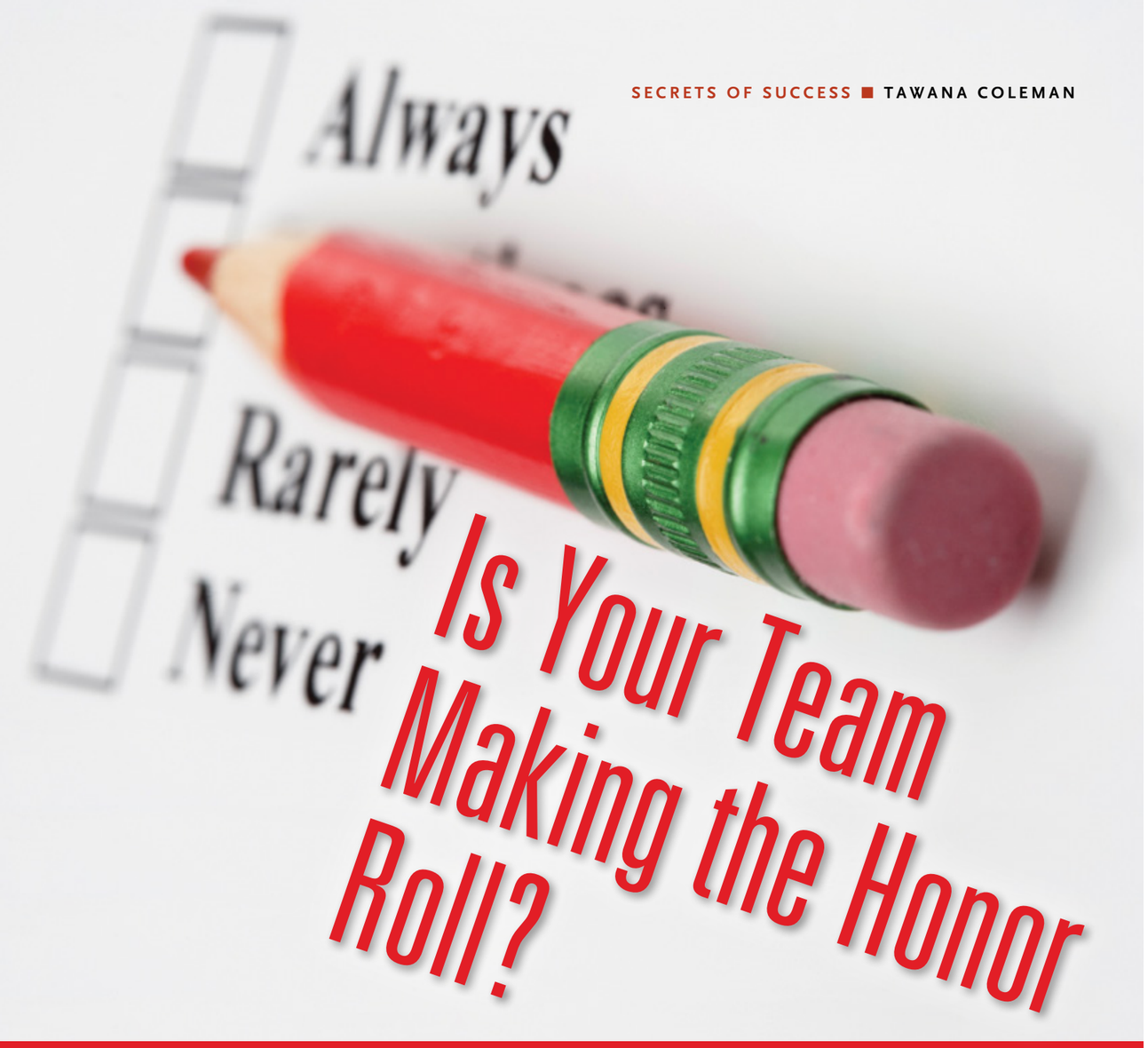

Is Your Team Making the Honor Roll?

How Evaluations Improve Overall Performance.

When I meet with a new dental team, one of the first steps that I take is to conduct an in-office evaluation. I run through a systematic list of questions to get an idea of what specific remediation is necessary for a particular group. The questions help me to understand the strengths and weaknesses of the team, and believe me, every team has a combination of both. My main objective in conducting evaluations and offering suggestions for improvement is to help practices improve their overall production and evolve from being a good or average practice to a great or exceptional practice. Why would anyone want to be a C student if they can be an A+ student? This mind-set holds true in the business and dental worlds, just as it does in an academic environment.

From my 30-plus years of experience in the dental business, I can attest to the fact that all dental practices—big and small, old and new—can benefit from regular evaluations. Without proper and steady assessments, practices have absolutely no way of knowing how they're *really* performing. Dental offices need to know the answers to the following types of questions:

- *Are patients happy with the services provided by the dentist and hygienist?*
- *Is the schedule organized in such a way as to provide maximum productivity?*
- *What kind of first impressions do new patients receive when they call to schedule an appointment?*

To address the need for dental offices to regularly assess their performance (and the lack of anything readily available to help them to do so), I have devised a simple in-office evaluation plan that dental teams can use to discover how they're performing—both internally (among the office staff) and externally (among their patients). This evaluation is meant to be a springboard—a system by which dental offices can get a basic idea of their performance, so they can obtain the training and consultation necessary to make any improvements, if desired.

The in-office evaluation is two-fold: The first part *(see page 29)* is intended for staff members, while the second part is intended for a selection of patients, who have both short- and long-term relationships with the practice and who have been treated for a variety of dental issues. *(Note: Both evaluations are available for download at www.AdentMag.com/HonorRoll or use the QR code at the end of the article.)*

A Chance to Build the Team

I am a proponent of teambuilding exercises in a dental office environment. And that's exactly what the evaluation should be used for—a way to help the entire team learn, grow and improve together. I do not recommend completing this evaluation during a morning huddle. The first hoorah for the day needs to be positive and upbeat so that the rest of the day can run smoothly. If you insert the word "evaluation" into the morning dialogue, the whole tone of the day may change.

The most appropriate time to complete the evaluation is during a special staff meeting. Set the stage so the team knows that their efforts are appreciated; order lunch from a favorite local restaurant and have it delivered to your office. Make sure that the team isn't anxious about the evaluation. Each person needs to understand that the purpose of the evaluation is not to nitpick at any one individual and point out his or her shortcomings. Instead, the objective of the evaluation is to find out the great things that everyone is doing and what ways that each person can help the team grow and improve together. An emphasis on the word "team" will help accomplish this goal.

Team members may also feel more comfortable answering the questions anonymously. Tell the team members not to put their names on the evaluations and provide the same type of writing instruments (same color of pen, pencils or whatever you choose) for them to use. That way, no one will feel singled out and they will be able to provide more honest feedback.

The overall expectation for the team is that a truly great practice would be doing ALL of these things ALL of the time, or at least striving towards that goal. Be sure not to dismiss any of the questions with an offhand attitude like, "Oh, this one doesn't apply to us, so we don't need to worry about it." All of the questions are important and impact dental practices in measurable ways. *(The Total Team Evaluation is available on page 29)*

Getting Feedback From Your Patients

The second part of the evaluation, the part completed by selected patients, is incredibly crucial. The data obtained from the patients allows you to compare and contrast how you think you're doing with how you're actually doing. It is the "acid test" that lets you know if your team's perceptions of the practice are accurate. After all, it really doesn't matter how great your team thinks they are if the patients do not agree. Ultimately, the patients' opinions are of utmost importance.

What methods are recommended for conducting patient surveys? First, each day for a couple of weeks, ask one or two patients to complete the survey. The best-case scenario is to choose a variety of patients. Choose some patients who are visiting for a cleaning. Choose other patients who are coming in for fillings. Choose still other patients who are scheduled for more advanced dental procedures, such as crowns, bridges, and implants. Finally, choose some patients who are longtime, loyal customers and others who are totally new to the practice. By choosing to survey a wide array of patients, the results will better represent a true evaluation.

Second, just like it's necessary to make this evaluation a desirable activity for your team members, do the same for your patients. Keep in mind that the patients are using their personal time to complete the survey and may feel more inclined to do so with some kind of incentive. A suggestion is to hold a random drawing as an incentive. The drawing could be for a free dental procedure (like teeth whitening), a free product (like a water flosser or electric toothbrush), or a gift card.

Another idea is to offer an automatic incentive for completing the survey. An automatic incentive may include a pair of free movie tickets, passes to a local museum, or a discount coupon for a local restaurant. Whatever incentive you offer, make sure it is something attractive to the patients and affordable for your office. Another way to encourage patient involvement is to help them feel that their input is needed and of value.

All dental practices—big and small, old and new—can benefit from regular evaluations. Without proper and steady assessments, practices have absolutely no way of knowing how they're *really* performing.

One patient whom I spoke to recently said that his dentist personally phoned him and asked him to complete a survey about a recent visit, asking him to be as frank as possible with his answers. During the call, the dentist explained that patient input was crucial for the practice to improve its overall treatments. The patient was very motivated to complete this survey for a variety of reasons. Most importantly, he was shocked and impressed that the dentist would actually take the time to call him. He remembers thinking, "Wow! My dentist just personally called me to ask me to do this! How cool!" If another member of the office team had made the call, it wouldn't have left such a lasting impression. But the fact that the dentist was interested enough to take the time to solicit the patient's opinion was impressive. Because of this action, the patient was eager to answer the questions. The patient felt that the dentist really wanted to improve the practice and he was making a real contribution to the way his dental care would be handled in the future.

The list of patient questions for my Dental Practice Evaluation can be found on the *Aesthetic Dentistry* website (www.AdentMag.com/HonorRoll) or by using the QR code at the end of the article. The questions can be distributed to patients in a variety of formats ›

Simply print out the survey and ask patients to complete them before leaving the office. Or, if preferred, patients can send completed surveys by email. Alternatively, a dentist may choose to personally call a selection of patients and ask specific individuals to complete the survey.

Another way to distribute these surveys, according to some of my colleagues at *Aesthetic Dentistry*, is through an online survey-generating website. I personally have not used these platforms, so I cannot give any recommendations for specific websites. However, colleagues suggest you could easily find some by doing a quick Google search using the phrase, "free online survey" for some options. Once you find a survey website to your liking, you can then copy and paste the questions and answer options into the site and an electronic survey will be generated for you. Then, the link (or a QR code) can be given to your patients and they can complete it on their computers, tablets or smartphones. Some survey websites will also send you the results once the survey period has ended.

Why would anyone want to be a C student if they can be an A+ student?

Tallying Up the Results

Once both the dental team and the patients have completed the evaluations, the results should be tallied and evaluated. Since the team evaluations were likely completed in a pencil/paper format, a staff member can simply tally the answers by hand. For each question, mark the total number of responses ("always," "sometimes," "rarely," "never," and "unsure").

When I recently surveyed a dental team on the first question of the Total Team Evaluation (Does the dentist diagnose every patient comprehensively?), the five members of the dental staff team reported the following: one member-always, two members-sometimes, one member-rarely, no members-never and one member-unsure. Remember, for a dental practice to be exceptional, ALL of the answers to the questions should be ALWAYS! Because this dental team only answered "always" once, there is room for improvement!

Once the staff evaluations are tallied, compare the results with the patient evaluations. Some of the staff questions are not applicable for patients, so only compare and contrast the questions that are asked to both groups. Does your team feel like they are doing better or worse than they are, or are the numbers about the same? A big discrepancy is a red flag, especially if your team members have more positive responses ("always" and "sometimes") than the patients do. If the team thinks they are doing better than they actually are, then the results are a reality check. Also, pay particular attention to the amount of "rarely" and "never" responses from the patients. Such responses are crucial, since such answers provide specific opportunities for the team to learn and grow.

When discussing the survey's results, make sure that no team member feels singled out. Remind the team that their answers are anonymous. Also, make sure that everyone knows that if changes are needed, all members of the team need to do their part for the improvement overall.

Taking It to the Next Level

As noted previously, this two-part questionnaire is just a basic way to get an initial idea of how your practice is doing and the ways that it can be improved; it is not a comprehensive evaluation and treatment plan. To obtain a thorough understanding of team-building methodology, I recommend taking some office management educational courses—such as my Total Team Training seminar offered by the Dr. Dick Barnes Group. Another option is to schedule a one-on-one consultation with a team-training professional (like myself) who will come to your office and establish an improvement plan for you. Remember, you wouldn't trust a mechanic to do your taxes or an accountant to do your root canal. Therefore, recognize your special skills and rely on team-training professionals to provide you with the expertise necessary for your practice to be the best it can be.

Don't settle for average. Don't settle for a C grade on your office-management report card. Make the changes necessary to move your practice to the top of the honor roll! Start with this in-office evaluation and use the results to move forward. If additional training and consultation are required, resources are available. Keep climbing this office management ladder of success. ■

Tawana Coleman has been a practice development trainer with the Dr. Dick Barnes Group for more than 20 years. She has worked with thousands of dental practices. The structure that she teaches has empowered dental practices across the country to dramatically increase production. Contact Tawana toll free at 866-364-8657 or email rtcoleman@cox.net

To download .pdf versions of the "Total Team Evaluation" and "Dental Practice Evaluation," use this code or visit www.AdentMag.com/HonorRoll

To view recent webinars from Tawana on "Finding The Money" and "Ending Appointment Cancellations," use this code or visit www.ArrowheadDental.com/Education/Webinars

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Total Team Evaluation

In-office evaluations are a great way to understand the strengths of a dental practice and find ways to improve. In this evaluation, you will be asked to evaluate your own work as well as the work of your colleagues. Below is a series of questions for staff members regarding the following areas: treatment, financing, operations, patient relations, hygiene and scheduling. Please answer each question.

	always	sometimes	rarely	never	unsure
Treatment					
1. Does the dentist diagnose every patient comprehensively?					
2. When the dentist discusses treatment recommendations with the patients, does he/she create a desire for treatment?					
3. Does the dentist complete the procedures quickly and comfortably?					
4. Does the dentist try to understand the patients and their possible fears of dentistry?					
5. Does the dental assistant anticipate the requirements of the procedure and stay ahead of the dentist while he/she treats the patient? (*For example, having all instruments, supplies and equipment ready chair-side before the procedure begins*)					
6. Does the dental assistant work to develop a synergistic and seamless working relationship with the dentist? (*For example, do the dental assistant and dentist have common goals, such as making sure the patient is as comfortable as possible and is receiving the most comprehensive treatment possible?*)					
7. Does the dental assistant coordinate as much of the lab work as possible? (*For example: monitor cases leaving and returning*)					
8. Does the dental assistant make the patient's visit more comfortable and less frightening? (*For example, does the dental assistant offer reassuring words; touch the shoulder or arm of patients to let them know they're not alone; offer encouraging and reassuring words to patients like "You're doing great!" or "You're almost done" and let patients know when to breathe or swallow, etc.*)					
9. Does the dental assistant pay close attention to the physical state of the patient during the procedure and then do something about it? (*For example, noticing signs of anxiety—rapid breathing, chair clenching, dry mouth, trembling, elevated blood pressure and heart rate, unresponsiveness to questions, and wide fearful eyes—and then asking patient if he/she is okay*)					
10. Does the dental assistant direct the dentist throughout the day? Specifically, does the dental assistant plan the traffic flow for the day and direct the dentist from treatment room to treatment room and hygiene exam to hygiene exam?					
11. Does the dental assistant make sure he/she attends required CE courses for the year to maintain the license required by the state?					
12. Does the dental assistant ask the dentist for coaching and feedback so he/she can improve skills?					
13. Does the dental assistant properly manage the ordering of clinical supplies? Specifically, does he/she know the office budget and watch the supply inventory so supplies can be ordered before they run out?					
Financing					
14. Does the financial coordinator counsel with the patients and help them find a way to pay for treatment?					
15. Does the financial coordinator regularly research lending institutions to discover financing options available to patients?					
16. Does the financial coordinator spend the time asking the "right" questions to patients about financing and really listen to their answers? (*For example, does he/she say, "Help me understand what fits in your budget?"*)					
17. Are those patients who did not secure financial arrangements during their visit contacted and followed up with?					
Subtotal:					

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Total Team Evaluation (*continued*)

	always	sometimes	rarely	never	unsure
Operations					
18. Are insurance claims processed daily? Do they include appropriate attachments? (*For example, X-rays, photographs and narratives*)					
19. Are insurance claims and payments monitored to make sure they correspond?					
20. Does the office set and regularly achieve a goal to have a specific number of new patients per month? (*Twenty-five new patients per month is recommended*)					
21. Does the dentist have a constant awareness of the accounts payable and receivable?					
22. Does the dentist seem cognizant of the costs associated with running the practice?					
Patient Relations *Note: This section contains questions about tasks fulfilled by multiple staff members.*					
23. Do I answer the telephone calls by the third ring at the latest?					
24. Do I smile before answering the phone and during the call?					
25. Do I show genuine concern and empathy for each patient's situation?					
26. Am I positive and enthusiastic about the dental practice? (*For example, do I make sure the patients know that they have called the right office to schedule an appointment?*)					
27. When I answer the phone, do I identify the office name and my personal name? (*For example, "Good morning, this is XYZ Dentistry, Tawana speaking."*)					
28. Do I say such phrases as, "How may I help you" (*which shows an attitude of helpfulness to the patient*)?					
Hygiene					
29. Does the hygienist oversee the periodontal health of the patients by educating them on the benefits of periodontal care?					
30. Does the hygienist talk to the patient about the things he/she specifically notices during the cleaning, so the patient is able to talk to the dentist about those issues during the exam?					
31. Does the dental hygienist act as a scout for the dentist? In other words, does he/she review charts daily to find potential dentistry waiting to be done?					
32. Is the dental hygienist a technical expert? Specifically, does he/she stay current on the latest technology and treatment of periodontal disease?					
33. Does the dental hygienist attend continuing education classes?					
34. Does the dental hygienist monitor the success of the treatment that he/she has recommended for the patients?					
Scheduling					
35. Does the office staff schedule patients in a productive way, so the office can meet daily goals? (*For example, does the office staff direct patients to schedule during the time available for their particular procedure*)					
36. Does the office staff create an "ideal day" in the schedule that allows the office to meet that goal? *(Note: An ideal day uses block scheduling because dentists can't be in two places at the same time. Each block represents a certain dollar amount, thus meeting the production goal. For detailed information, see my scheduling webinar at www.ArrowheadDental.com/scheduling-for-production)*					
37. Does the office staff monitor the schedule throughout the day to ensure it is flowing smoothly and fill "holes" (cancellations), if there are any?					
38. Does the office staff engage in recall activities on a daily basis?					
TOTAL: Always:_____ Sometimes:_____ Rarely:_____ Never:_____ Unsure:_____ **Subtotal:**					

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The Real Cost of In-Office Milling

Making Sure Advanced Technology Really Benefits Your Practice.

Computer aided manufacturing (CAD/CAM) is all the rage these days and with it people can create everything from the simple to the complex: jewelry, tools, machine parts and toys. Considering the widespread utilization of this type of technology, it's no surprise that CAD/CAM machines are in widespread use throughout the dental industry. In-office milling machines—which are used to create dental crowns—are the most common examples of this type of technology.

The principle of these computer aided manufacturing machines is pretty simple: First, a dentist takes a digital impression of a patient's mouth. Then, that image is sent to the machine's computer. The dentist then uses the machine's software to design the dental restoration. Once the design is complete, a small porcelain block is placed in the machine and the milling process begins. After the base crown has been milled, the dentist must hand-polish the crown. To give the tooth's surface a more natural appearance, a natural coloring is then applied. Next, the crown is placed inside a porcelain oven for firing or curing. Finally, the dentist polishes the tooth again and seats the crown in the patient's mouth.

Ideally, when these types of machines are used, patients can have a crown completed in a day because the dental office has become the lab. This idea of same-day dentistry has caught the attention of many dentists throughout the country as a way to stay marketable in an ever-changing industry.

But are such machines really helpful or necessary? Are they the most productive way for dentists to run a practice? Will in-office milling machines truly allow dentists to do the type of dentistry that will differentiate his/her practice and stay competitive?

'Ideal' versus 'Real'

As noted earlier, some people claim that in-office milling machines will make dentistry more efficient, productive and profitable. The companies that produce these machines often claim that by eliminating the middleman (i.e., a dental lab), dentists who invest in this technology *should* be able to significantly cut their expenses, attract more customers, and reap greater financial benefits for their overall practice.

But does this technology truly perform as the companies claim? Are such machines really the 'genie in the bottle' that will make all your dreams of profitability come true? While such claims may be true for some dentists, they definitely are not true for a *majority* of dentists. Before a dentist decides to invest in *any* kind of advanced technology, it's best to conduct a thorough examination of their business model and make sure that the decision to buy the product is based on what's best for the business and not on hyped-up claims.

So how do dentists effectively evaluate whether or not these particular devices will benefit their practice? I advise using the following strategies, which I teach in my "Know Your Numbers" course. ›

Don't Get Wowed By the Latest and Greatest

First, don't let new technology *wow* you too much with it's flashiness, impressiveness and promises of profitability. Just because a particular machine is the most advanced gadget on the market doesn't mean that you *need* to have it. It might be great, it might do great things, but the real question is, will it *really* benefit your practice or will it just end up becoming a very expensive dust collector in the corner of your office?

The real question is, will it *really* benefit your practice or will it just end up becoming a very expensive dust collector in the corner of your office?

When I am evaluating a piece of equipment or device for my office, I ask myself a series of key questions. These questions help me determine whether or not the technology that I am considering will be a good fit for my office. I would recommend that other dentists consider asking themselves these questions—or something similar—as they contemplate making major purchases for their businesses:

- *How long will it take for the equipment to pay for itself?*
- *Is the equipment easy to learn?*
- *Can it be implemented into my practice immediately or are additional investments in training and resources required?*
- *Will my staff be willing and able to operate the equipment or will I need to use my time to operate it?*
- *If my staff can operate it, will I need to hire another full-time person to manage its operation?*
- *If I have to operate it, how much of my time will be spent each day actually using the equipment and how much is that ultimately going to cost in chair-side production?*
- *Will I get a chance to use the equipment before I buy it? (Will my staff get a chance to use it as well?)*
- *Is my staff enthusiastic for the new equipment to be added to the office?*
- *Will the equipment enhance the type of dentistry I want to do or does it dictate the type of dentistry I have to do?*
- *Hypothetically, if I bought this tool and then had to give it up, would my dental practice's productivity be negatively impacted, positively impacted, or would there be no measurable impact?*

Essentially, the questions are meant to provide a quick evaluation as to what an overall return on investment (ROI) might be. Such questions help me to understand the real cost of equipment ownership and not the ideal cost of ownership that is presented to me via flowery sales pitches.

Evaluating the Real Cost

My second piece of advice is that you understand the finances of your specific business before making any major purchases. Do you really know how much money it costs to open your office every day? If not, then you should find out and you should know this figure before you write a check for an expensive gadget. In-office milling machines, for example, are extremely expensive, ranging between one-hundred-thousand to one-hundred-thirty thousand dollars. Of course, the sales teams will convince you that you will make this money back in no time because you will no longer be sending cases to an outside lab.

However, you must evaluate whether this machine is something you can afford and estimate how long it will take for the machine to pay for itself. You certainly don't want to get in over your head financially because that affects the type of dentistry you can perform. You should be in charge of the type of dentistry you offer in your practice. You don't want a machine—which you just shelled out six figures for—to determine what you can offer to your patients. For example, if you have a case that really would benefit from an outside lab making the crown, you don't want to make the crown in-house just because you want to utilize a costly machine.

A basic idea in economics is opportunity cost. Everything has a cost. If you choose to do one thing, the opportunity cost is losing out on being able to do something else. From a financial standpoint, it is best to choose things that have the lowest opportunity cost. For example, if you decide to buy an in-office milling machine, what is its real opportunity cost? You can determine this by using several different variables. First, consider that if you pay six figures for the machine, you will not be able to use that money to buy something else. Maybe there is another piece of equipment that would have reaped greater rewards for your office and now that you've tied up your money, you won't be able to purchase it. Also, if all your capital is tied up in expensive equipment, you may no longer have the ability to retain key talent, which could result in a high turnover rate among your staff.

You must also consider the opportunity cost in your overall level of productivity. If you purchase one of these machines, what role will you be playing in its operation? If you have to actually make the crown yourself, you have now taken yourself out of the role of dentist and instead have become a dental lab technician. How many patients are you unable to treat because you are fulfilling a role that was once filled by someone else? If you decide to hire a full-time employee to run the machine and make the crowns, that too has a cost. How much will their salary cost you? How much will it cost you to train that person to run the machine? Training—whether internal or external—costs both money and time.

In addition, think about the physical logistics of where the patients (for whom you are milling the crowns) will wait for their crowns to be completed. Will you ask them to just 'hang out' in the chair for an hour or so waiting for the machine to finish? Probably not. Therefore, you will likely need to determine where patients can sit while they wait for a finished crown. You might end up having an additional cost of extra waiting rooms or furniture.

Along with such costs, dentists who consider purchasing in-office milling equipment must also evaluate the operation costs for the equipment itself. The six figures you initially paid isn't all the money you'll need to invest and run the machine. All machines require regular maintenance and repairs, software updates, etc., which definitely lengthens the ROI on the device. Oftentimes, the most expensive machines require the most expensive repairs and maintenance-related issues. Moreover, just like a photocopy machine needs paper and toner to run, a milling machine also needs similar supplies. One of the main ancillary supplies is the porcelain milling blocks, which (while not extremely costly) are an expense that will accrue over time.

Dentists should also consider the question of redundancy. What happens if the milling machine breaks down for a period of time? Either you will need a backup machine for the office, or you will need to send all of the cases out to a lab. The first solution of having an additional backup machine doubles an already large investment. The second solution also has its own set of problems. If you've been making all of your crowns in-house on a milling machine, you may no longer have a relationship with a lab and therefore no lifeline to call when you need someone who knows you and is readily familiar with the way you like your cases handled.

Here's a specific example of *ideal* cost versus *real* cost. A recent advertisement for an in-office milling machine claims that it only takes "9 crowns a month" to recoup an investment on the equipment. However, by completing a simple mathematics calculation with the numbers presented in the advertisement, I quickly deduced that according to their price point, it would cost 180 dollars per crown for the machine. That figure doesn't include the other costs associated with milling machine ownership, such as time, materials, staff compensation, updates, repairs, training and retraining. After taking the time to crunch the numbers, this particular sales pitch did not add up. That is why I evaluate equipment purchases carefully and from all angles before making an investment.

Unforeseen Problems

Dentists considering expensive purchases (such as milling machines) must also understand that sometimes unforeseen problems arise with the technology. For example, there is a learning curve in creating the perfect crown on a milling machine. During the learning period, mistakes are possible—even likely. Such mistakes cost money, time and can impact your reputation. Here's a possible scenario: you spend the time to make a crown on the machine, yet for some reason the machine wasn't exactly set just right or your prep wasn't exactly perfect and the resulting crown doesn't fit the patient. The incorrectly created crown has cost you both time and money.

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Patient Expectations

The big argument for in-office milling machines is a competitive advantage: "You must buy one because if you don't, patients will go to another office where they can get the same-day dentistry they want and expect." I totally disagree with this idea. Most patients don't care about same-day dentistry. Most have never even heard about this option or the technology of in-office milling.

Patients generally care about the following considerations when choosing a dentist:

- *Is the dentist close to where I live or work? Is it convenient to get to his/her office?*
- *Does the dentist accept my insurance?*
- *Is the office clean?*
- *Is the staff nice and efficient?*
- *Is the dentist proficient enough not to hurt me while he or she completes a procedure?*

Rarely do patients care about whether or not an office has the latest and greatest technology. Patients look to build a long-term relationship with a dentist—they want to find someone whom they can trust and who has their best interests in mind. They aren't looking to build a relationship with a roomful of expensive machines. Sometimes those machines can actually be a detriment to attracting patients. Patients may look around a room with expensive gadgets and think, "Wow, this is why the dentist charges me so much—this equipment must cost a fortune!"

Make a Wise Plan

I'm certainly not suggesting that dentists should never consider purchasing equipment to make their practices better. That is not a practical mind-set in the world we live and work in today. However, dentists must be smart with their purchases. I write from personal experience on this matter. There are some pieces of equipment that have made a tremendous impact on my practice and there's no way that I can imagine doing business without them. On the other hand, there are other items that literally have become proverbial "white elephants." They never reaped financial benefits and they have now become very expensive dust collectors.

When you decide to make your purchases, keep the aforementioned tips in mind. Analyze the financial state of your practice and evaluate how this equipment may benefit you as a dentist and business owner. Don't let pressurized sales pitches influence your decision. You are the leader of your own practice. Find out the facts, know and understand your practice and finances, and make an educated decision that is based on real knowledge rather than emotions. If you do, you won't cringe every time you see that six-figure, dust-collecting-white elephant sitting in a much-avoided corner of your office. Instead, you'll make wise equipment purchases that will benefit your practice in profitable and effective ways. ■

Jim Downs received his D.M.D. degree from Tufts University School of Dental Medicine. 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.

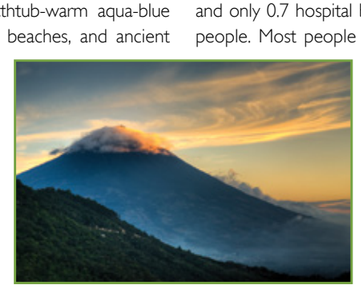
Humanitarian Dentistry in Guatemala

Opening Hearts and Brightening Smiles.

Guatemala is a land of wonder: a strikingly beautiful country both in geographical features and cultural landmarks. In this Central American nation (about the geographical size of Ohio), there are lush green rainforests, cone-shaped active volcanoes enveloped in misty clouds, bathtub-warm aqua-blue water bordered by sparkling white sand beaches, and ancient stone pyramids constructed many centuries ago by a once-prosperous and advanced civilization. Yet even though Guatemala is overflowing with a vast richness of physical beauty, it is a land of dichotomy. Guatemala is one of the poorest countries on the globe and is greatly struggling to meet the basic needs of its people.

As of April 2014, the United Nations World Food Programme listed on its website that 53 percent of Guatemalans live below the poverty line, with 13 percent of the people living in extreme poverty. In addition, according to statistics found on the Central Intelligence Agency (CIA) World Factbook website in the same month, Guatemala has the largest population of any Latin American country and almost half of the population is under the age of 19. Naturally, along with this very young population comes a host of problems—child labor, poverty and malnutrition are chief among them.

Twenty-one percent of Guatemalan children ages 5 to 17 years (a total reaching nearly one million) are engaged in some type of child labor: be it out in the fields planting and harvesting crops, working long hours in manufacturing, or hunting through garbage at the city dump in an attempt to find any type of usable scrap that can be traded or bartered for money. In addition to the sometimes horrid living and working conditions, this country has the fourth-highest malnutrition rate in the world for children under the age of five years.



As expected with Guatemala's extreme poverty, the health-care system is also severely lacking. The website for the CIA World Factbook in April 2014 estimates that there is less than one physician available for every 1,000 people in Guatemala and only 0.7 hospital beds are available for the same number of people. Most people are so poor that even if medical facilities and physicians were readily available, they wouldn't have the funds to pay for the services and would still likely go untreated. Because of the inadequate services and the lack of funds, many Guatemalans suffer from pain, infection and various other maladies that could easily be alleviated with access to basic medical care.

Making a Difference

Guatemala's dire circumstances are a magnet for medical professionals from around the world. Every year, hundreds of professional medical teams and pre-professional medical students travel to the emerald-green rainforests of this Central American country to offer their services as part of a global humanitarian effort. Medical teams do basic examinations and provide necessary treatments. Surgical teams repair birth defects like cleft lips and palates. And dental teams perform a variety of procedures in critical, emergency, and preventative care.

Tooth decay is a huge problem in Guatemala and is attributed to several factors, including no basic personal dental hygiene, lack of access to fluoridation, poor diet, and easy access to foods and drinks with high-sugar content. Therefore, dental teams that embark on service trips to the country often perform hundreds of extractions, root canals, fillings and cleanings on each visit.

Dentists generally go for at least a week, pay for travel expenses, bring portable equipment and supplies, and often traverse all kinds of terrain as they move from place to place within the country. ›

Some visitors prefer to stay in well-known American chain hotels in tourist areas while others choose to rough it in less-frills motels and even portable tents. Some dentists work in medical clinics constructed by international humanitarian groups and nonprofit organizations. Other dentists set up shop in churches and community centers. Dentists who travel to the mountain villages or the inner rainforest generally find conditions so primitive that they often perform procedures in tents, lean-tos or even the great outdoors.

Each medical team has its own reasons for serving in Guatemala. Some go as a way to "give back" and make the global community a better place. Others go to make a difference in the lives of others and help people who are in dire need. Still others go to have a life-changing experience and use their talents in a meaningful way. Regardless of the reasons that individuals go, rarely does anyone depart from a Guatemalan medical service trip without having their expectations abundantly fulfilled.

Of course, the best way to find out what it's really like to participate in a dental service trip is to read the stories of the people who have already experienced it. To give you an idea of what dental humanitarian trips are like in the country of Guatemala, the editorial team at *Aesthetic Dentistry* sought out and interviewed three different dentists or dental teams. These individuals have all been on numerous trips to Guatemala, some—in fact—have more than a decade of humanitarian work experience in this country. Here are their stories.

Decades of Service

Dr. James McHenry, of Dental Arts in Plymouth, Michigan, has been on 20 dental service trips since 1988. In addition to visiting Guatemala a total of 15 times, McHenry has traveled to such places as the Amazon Jungle in southern Columbia, El Salvador, the Dominican Republic, Moldova in Eastern Europe, and the Andes of Peru. Some of these places were so remote and primitive that he felt like they were "straight out of *National Geographic*."

McHenry explained why he has visited Guatemala numerous times: "I was drawn to this particular location because there was a missionary family from my church who had dedicated their lives to living among the Mayan people in the mountainous region of this country." McHenry said, "When the missionaries first arrived there, the people of this particular tribe were on the verge of extinction. They were living in stick huts with dirt floors. They had no electricity, so they cooked over an open fire inside their huts. They essentially had no protein in their diets and subsisted off a little corn and wild roots. They had no access

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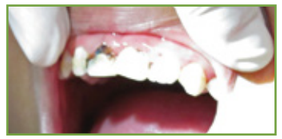
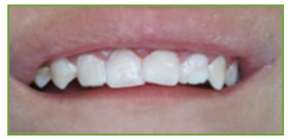
to clean water. The only water they had was run-off water, and because of that, many were dying from diseases like diphtheria and cholera. The missionaries were committed to improving the people's lives in every way that they could." McHenry added, "And I wanted to do my part to help them out. I have come back year after year to do that."

At the beginning of his travels, McHenry worked directly in the villages—performing most of his procedures outside with portable equipment. But about 10 years ago, a Rotary International club provided the funds to build a small cinder block clinic in the area. Now, on each visit to Guatemala, McHenry performs most dental procedures at the clinic, including extractions, fillings, and bondings—particularly on the front teeth.





Dr. McHenry (top, right) after working on a girl's front teeth.

In the villages, the missionaries would encourage the young women, who were near the age of marriage, to receive dental treatment. Many of the young women had black or discolored teeth. "We would get the decay out and then bond the teeth to make them look the best we could for our limited time and conditions," McHenry explained. "It was so rewarding to see the joy on the young ladies' faces when they looked in a mirror and realized that their teeth were no longer discolored and decayed. Many would start crying or laughing when they saw their improved, white smiles. They actually showed their teeth instead of hiding them with their hands or their lips. The procedures literally saved these young women's chances of getting married, which meant everything to them and their future in the villages."

In addition to his clinic work, McHenry typically travels to two or three outlying villages to perform dental procedures. To access the villages near Belize (about three hours to the east

Tiffany Beene Bridge offers access to remote areas.

of the missionaries' clinic), he would cross a "nasty, snake-filled swamp." McHenry explained, "We'd be up to our hips sometimes in mud carrying all of our supplies and equipment. It was just so hard getting to people sometimes, until fortunately, at one point an outreach group from our church built a 300-yard bridge across the swamp. This made transport so much easier and with the improved access we have been able to help even more people there."

Usually, McHenry goes on a 10-day trip to Guatemala once a year. After accounting for travel days, he's able to put in five full days of dental work. In Guatemala, a typical work day for McHenry starts at eight or nine in the morning and lasts until ten at night. "I honestly don't count the number of people I see every day," McHenry explained, "but it's probably around 30 or so, depending upon the procedures I need to perform. I usually try to work as quickly as possible to see as many people as I can before I have to leave for the next village." By the end, he's both exhausted and energized and ready to come back another year.

One Trip Was All It Took

The husband-and-wife team of John and Terri Bauer and their son, Cody, of Mansfield Family Dentistry in Mansfield, Texas have collectively been in the dental industry for 40 years. John and Cody are dentists and Terri is a dental hygienist. In 2013, the Bauers had an opportunity with their church to participate in a mission trip to Guatemala. They planned on putting their 40 years of experience to good use in this country by helping out with the people's dental needs.

One of the Bauers' favorite experiences involved a young child who came in for dental work on that first trip. The child was around eight or nine years old. He was blind, unable to speak and had almost completely lost his hearing. "The mother begged us to help him. His teeth were in awful condition. One was totally infected and the child was clearly in pain," Terri explained. "Just imagine how frightening this must have been for a child in this condition to be treated by a dentist for the very first time. I closed my eyes and imagined what it must have been like for this child sitting there in his dark and quiet world and I felt so bad for him," Terri said.

Dr. John knew that he couldn't perform the extraction on the child unless the team could get the child to remain still. "We tried everything we could," Terri explained further. "There simply was no holding this child down. Dr. John told us later that it was at that point that he said a quick prayer in his mind. Then, immediately, for just a moment, the child—while holding on to the hand of his younger brother—was able to hold still long enough for Dr. John to extract the tooth. To this day, Dr. John still says that he has never pulled a tooth so fast in his entire career. He felt the hand of God guiding him as he performed the procedure," Terri said. "We all cried when we were done. This experience was so rewarding for us. Just helping this one child made our entire trip worth it."

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One trip was all it took for the Bauers to be hooked on dental humanitarian work. "We were so moved by our experience in Guatemala," Terri explained, "that we just had to go back. When you're there, you almost feel like never leaving. The people are just so grateful for anything that you do for them. Many of the teens and adults have never had their teeth cleaned in their entire lives. Afterwards, they look at their teeth in the mirror and it changes the way they view themselves."

Dr. John Bauer (above and top, right) with children. Terri Bauer (bottom, right) works hard to clean teeth.

Upon their return home, the Bauers immediately planned another trip, and then another. In 2013, they went on a total of three trips to Guatemala and in 2014, they are planning the fourth and fifth trips. The Bauers even started a nonprofit organization called Professional Response, which will help other dentists get involved with service work for the Guatemalan people.

After the first trip, the Bauers knew that this type of experience would be the best team building opportunity they could offer to their staff. So while some of their team stays in Texas and maintains the office, the others go on the trip and then the roles are reversed for the next trip. They also bring along other dentists and their teams, too, so they can combine forces, make the trips more productive and also learn from each other. "We stay in a variety of locations when we visit Guatemala," ›

Each day, a line of patients waited outside a local church building for treatment. The line seemed to stretch on forever.

Terri explained. "Sometimes we stay in the villages or orphanages and other times we stay in hotels and travel back and forth in vans to the locations where we help our patients. After working hard all day, we enjoy spending time together in the evenings. This time is a critical component of our trip. It's an opportunity for everyone to get to know each other better and also reflect on some of the day's experiences. These humanitarian missions have really helped to unify our team. They have also helped each staff member know that they are part of an organization that truly changes lives through dentistry."

Being involved in humanitarian dental work has been life-changing for the Bauers. "These experiences have helped us grow closer together as a family and as a dental practice. The people in Guatemala do not have any sense of entitlement whatsoever. They are just so grateful for anything and everything they have and that attitude has helped transform the way we look at life, too. It helps us be more grateful for what we have in our lives as well," Terri explained.

Changing the World, One Smile at a Time

Dr. David Prince of Prince Dental Group in Midway, Utah was a third-year dental student when his father approached him with the idea of going on a humanitarian dental trip with the Hirsche Smiles Foundation. The Hirsche Smiles Foundation (HSF) is a nonprofit organization that brings plastic surgery and dental teams to underprivileged areas in Guatemala. HSF has three components: one focuses on surgical procedures (like cleft lips and palates), one focuses on construction projects (like building clinics and digging wells), and one focuses on dentistry. All three parts of this foundation are like cogs in a wheel and help the entire organization run smoothly.

Prince accepted the offer to go on that trip and afterwards he found that getting involved with humanitarian service while in dental school was extremely helpful in many ways. First, it helped him gain a tremendous sense of compassion and empathy for his patients. Second, it helped him attain some practical clinical skills. Prince explained, "On one trip alone, we performed more than 200 extractions and most dental students are only required to do 20 to 25 extractions in order to graduate."

During Prince's fourth year in dental school, he encouraged fellow dental student Nate Lester (who is now Dr. Nathan Lester of Bear River Dental in Evanston, Wyoming), to sign up for the service trip, too. "We did all sorts of odd jobs to raise the money," Prince explained. "We participated in various university research studies that paid us money for our involvement. We also mowed lawns. In addition, I received a scholarship at the eleventh hour that equaled what I needed in order to go on the trip," added Lester.

Since that first trip together in 2005, Prince and Lester have become a team. They travel to Guatemala once a year, often with their wives, to help out the HSF. They have now been on a total of nine service trips together. On the most recent trip in early March 2014, Prince and Lester scheduled eight days away from their practices in order to spend five "very long days" performing dental procedures.

In Guatemala, Prince and Lester treated patients in a local church building. Each day, the line of patients outside the church just seemed to stretch on forever. They worked as quickly and efficiently as they could. After five full days, the four dentists on the team cared for a total of 930 patients, performed 1,769 extractions, and completed 179 fillings. This was their best trip ever, in terms of performance. "We worked our guts out," Prince said. "By the end, our hands were killing us and we had blisters across our fingers. We worked as hard and as fast as we could, so we had to turn away as few people as possible."

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One of their favorite memories involved an elderly lady who came in with serious oral health issues. "Her mouth was so infected that we had to extract all 25 teeth that were left in her mouth," Lester explained. It might sound like a horrifying experience to have all of the teeth in your mouth extracted, but this woman was so grateful not to be in pain anymore that she was glad to have them gone. Lester said, "After the procedure, she returned later in the day. She had a basket on her arm and inside was one chicken egg. It was probably all she had, and she wanted me to have it. She presented it to me like it was the greatest treasure on earth, kissed me on the cheek, and went on her way (*see photo, bottom left*). That memory will stay with me forever."

Along with Drs. Prince and Lester, Kathy Ross volunteers with HSF. She is the Director of the Dental Service Team and often volunteers as a dental assistant when she travels with teams to Guatemala. Ross became involved as a dental assistant with HSF long before the dental portion of the foundation existed. Ross's son Tyler was born with a cleft palate and Dr. Blayne Hirsche was the surgeon who performed his reconstructive surgery. Every time Ross brought Tyler in for an appointment, Dr. Hirsche would talk about Guatemala and the number of cleft palate cases that he would see in that region. She asked Dr. Hirsche more about the foundation and decided to get involved. Ross explained, "I had so many resources at my fingertips when Tyler was born, but it was still very difficult and stressful for me to handle everything associated with his situation. I couldn't even imagine how difficult it must be for a mother to deal with these same issues in a place without any medical care. I knew I had to go and help however I could."

Ross has been going on service trips to Guatemala for 17 years. "I was even there in the village when the conversation happened about starting the dental team," she stated. "I just love serving the people of Guatemala. Every time I go, I feel like I'm going home to my people." Ross's advice to dental teams who have had humanitarian experiences is simple: "Share your experiences with others so they can feel inspired and want to get involved, too. I would likely have never gotten involved with service work like this if I hadn't been introduced to it by Dr. Hirsche years ago. I'm so glad he shared that with me. The experiences I've had in Guatemala have truly changed my life."

Deciding to Make a Difference

There's a world of work still to be done in Guatemala—millions of people are waiting for even the most meager amount of help. While one person certainly can't help everyone, the adage of "many hands make light work" definitely rings true. Every little bit of help that someone can offer definitely makes a difference. If dentists are unable to go on these trips themselves, they can alternatively donate funds, supplies, and humanitarian kits to worthwhile organizations.

Because of all of their rewarding experiences, the dentists interviewed in this article unanimously agreed that they would whole-heartedly recommend humanitarian service experiences to their fellow dentists. Dr. James McHenry summed it up best: "Find the right venue for you. There are many opportunities locally, on the other side of the world, and everywhere in between. All you have to do is open your eyes and look. I don't think you'll ever be disappointed or think you shouldn't have done it. You'll be glad you did. In most cases, I think dentists have an awful lot to be thankful for. You have to realize that it could have been you born out there in the types of conditions these people are living in. If this was your life, you would want someone to come and help you." ■

Dr. Nathan Lester (top of group, in black) and Dr. David Prince (seated in front) with children. Elderly patient who "paid" with an egg. Kathy Ross (above, center) often travels with her children (above).

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