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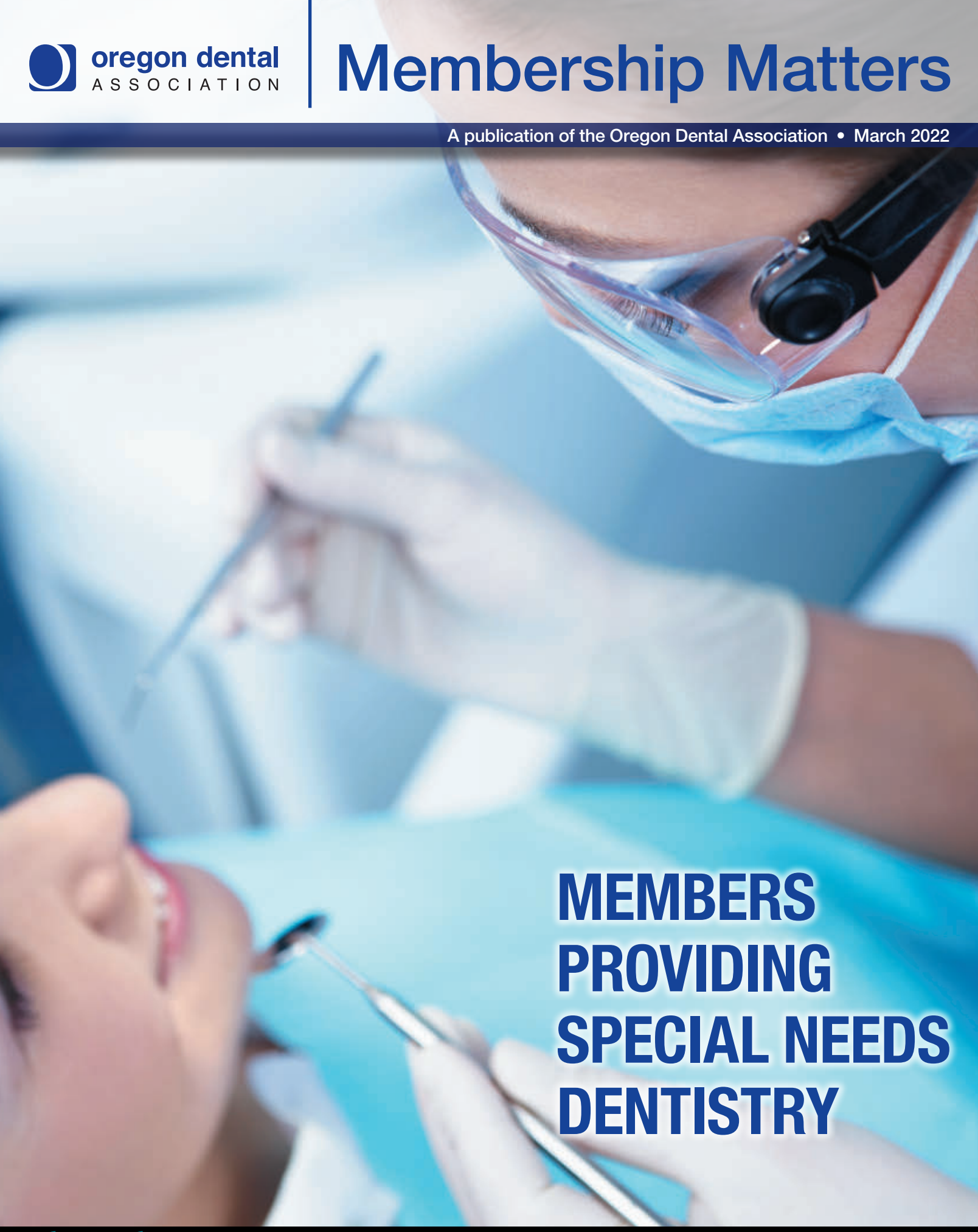
Membership Matters

A publication of the Oregon Dental Association • March 2022



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FROM THE EDITOR

What Will Our New Normal Be?

By Alayna Schoblaske

ON FEBRUARY 7TH, THE OREGON HEALTH AUTHORITY announced that they plan to lift the indoor mask mandate no later than March 31st. It is likely that a mask mandate will continue to apply in healthcare settings (just like it did last summer when the mandate was briefly lifted for the first time), and of course we dentists and our teams will continue to wear surgical masks while we treat our patients. Plus, the past two years have taught me that any attempt to predict the course of a global pandemic is entirely futile. I can't help but notice a part of me, though, that thinks that OHA's announcement may signal the start of our new post-pandemic version of normal.

Sonya Renee Taylor said in April 2020, "Our pre-corona existence was not normal other than we normalized greed, inequity, exhaustion, depletion, extraction, disconnection, confusion, rage, hoarding, hate and lack. We should not long to return, my friends. We are being given the opportunity to stitch a new garment." So what have we learned from COVID (so far) and what is important to acknowledge as we sculpt our new normal? Here are a few of my thoughts.

Oral health continues to be important, and dentistry can adapt and innovate to deliver care safely. During the initial shut downs in March 2020, I said to my colleagues on multiple occasions that this could be the end of dentistry. And yet, it wasn't. I say this not to minimize the hardships and setbacks that many—most—practices endured. Instead, I say it to highlight the flexibility that we showed as we integrated teledentistry, wore face shields and N95 masks, updated our waiting rooms, and even vaccinated community members against COVID-19. I also say it to demonstrate how the relationships we build with our patients and the education we do about the importance of oral health had an impact. By and large, patients continued seeking dental care and continued upholding their partnerships with us.

We must be involved in ensuring the sustainability of all parts of our dental workforce. Most of us have been impacted by a shortage of dental assistants, dental hygienists, and reception staff. These team members are critical to our success, and it will be important for us to increase our collaboration with their professional organizations and training facilities to ensure a sustainable influx of high-quality team members.

Technology increases our capacity for connection and reduces geographic barriers. We have effectively used technology to improve House of Delegates engagement, make Board of Trustees meetings easier to attend, lower barriers to Lobby Day participation, and include dentists outside of the Portland area in our mentorship pods. Zoom and other tools like it will continue to be a part of our life, and will hopefully continue to make member engagement easier.

And…technology will never replace in-person connection. One of my favorite memes last summer was from the comedienne Ali Barthwell (@wtflanksteak on Instagram). She posted, "Once people get vaccinated and we start mingling again, don't ask me 'how are you?' or 'what's new?' We're only going deep and weird conversation starters from now on. 'Hi! You look great! Drinks are on the patio. What's holding you back from being the person you want to be?'" Ali so poignantly—and hilariously—articulated how much we are craving "deep and weird conversation" with our community, and how important it is to gather with each other.

Finally, we have started to learn the importance of grief and tenderness. We have all had so much to grieve the past two years. Lost lives. Lost opportunities. Lost connection. Lost certainty. We have all had practice feeling into the tender experience of grief, and navigating the dark and twisty space of healing. As we move forward, there will still be plenty to grieve, so I hope we will be able to call on the lessons we learned from healing to care for ourselves and our loved ones.

We will, of course, all have our own unique lessons and reflections. And we will all create our own version of a new normal. What are you learning? What is going to be new about your normal? What new garment are you stitching?

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Dr. Bryan Baker

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Events & Education Component CE Calendar

Calendar provided by Mehdi Salari, DMD

This calendar is current as of February 10, 2022.

Due to the COVID-19 pandemic, events may be altered or postponed.
Please visit the host dental society website for the most up-to-date information.

Date	Dental Society	Course Title	Speaker	CE	Location	More Information
03/15/22	Clackamas	Functional Occlusion for Full & Removable Partial Dentures	Jim Sagawa, DMD	2	TBD	executivedirector@clackamasdental.com
03/16/22	Multnomah	Cyber Crimes Safety, Social Media/Website Accessibility & Professional Insurance - What do I need?	Cory Roletto, Chris Verbiest & a Cyber Security Attorney	2	TBD	Register: www.multnomahdental.org
04/22/22	Lane	Endodontics Revisted	Dr. Anne L. Koch	6	Lane Community College	Register/Info: https://bit.ly/LCDSEVENTS
04/26/22	Clackamas	The Current State of Practice Valuations and Transitions	John Van Leeuwen	2	TBD	executivedirector@clackamasdental.com
05/18/22	Multnomah	Table Clinics	-	1	The Kennedy School	Register: www.multnomahdental.org
05/19/22	Central Oregon	Top 7 Reasons for Early Orthodontic Intervention	Shannon Woods, DMD	2	Bend (Riverhouse Convention Center)	drjessicahenderson@gmail.com
05/24/22	Clackamas	TBD	WEO Media	2	TBD	executivedirector@clackamasdental.com

Find this calendar online at **www.oregondental.org**. Click “Meetings & Events” > “Calendar of Events”.

Due to the COVID-19 pandemic, many component meetings were canceled or postponed. Looking for additional ways to get CE? The American Dental Association has a large collection of webinars and on-demand video learning opportunities available, many of which are free to members. Visit **adaceonline.org** to catch up on the latest offerings on your own schedule.

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Practitioners Discuss Challenges, Rewards of Special Needs Dentistry

By Melody Finnemore

IMAGINE BEING A DENTAL PATIENT who cannot, because of physical or mental disabilities, verbally communicate about oral pain or discomfort. For some people with these disabilities, hitting themselves in the face or head is one of just a few ways to convey what they are enduring.

A trio of ODA members who practice special needs dentistry described these and other experiences of treating people with disabilities that include cerebral palsy, Down syndrome, autism, and Tourette syndrome as well as psychiatric diagnoses such as schizophrenia, bipolar disorder, and other behavioral health conditions.

A common theme the dentists shared is that when they help to relieve oral pain and repair dental problems for special needs patients, the patients' and their families' expressions of gratitude come across loud and clear.

DR. BRIAN SUMMERS

Brian Summers, DMD, PhD, learned about special needs dentistry during his year-long residency after dental school about a decade ago. The residency program's hospital component provided an unexpected introduction to the practice area.

When patients with special needs cannot receive care in a traditional dental office because they are medically fragile, high risk, or other physical and mental health factors are involved, care under general anesthesia in a hospital setting is a more effective option.

"I didn't even know [special needs dentistry] was an area because you don't think about it sometimes. A lot of people with special needs aren't out in the public eye, so you don't think about how they get their care and where they get their care," he said.

"We never get taught about this stuff in dental school; at least I didn't," Dr. Summers added. "It floored me the amount of work that needs to be done and how many people need this kind of care."

Dr. Summers went on to join Patrick Hagerty, DMD, in his Albany practice, and noted that Dr. Hagerty had been providing special needs dental care in hospitals for decades before hiring him. "He's been a great mentor for me," he said.

Dr. Summers took over Calapooia Family Dental six years ago and, as the hospital-based practice grew in demand, Dr. Hagerty came back to help out so Dr. Summers can spend a couple of days a week providing care in hospitals in Albany, Lebanon, and Corvallis. He plans to add a third day each week to keep up with the demand.

"It's really rewarding to be the final stop and be able to say, 'You don't need to go anywhere else and we can help,'" he said.

Dental care is a "pretty intimate interaction" with patients, Dr. Summers pointed out, and especially so for people with special needs.

"For a lot of people, getting right in their personal space can be kind of confrontational almost, and there are some folks you can't even see inside their mouth until they are in the hospital," he said. "It's kind of like exploratory surgery where you don't really know what you've got until you're in there."

Hai Pham, DMD, began practicing special needs dentistry at Doernbecher Children's Hospital in 2007 through Oregon Health & Science University's residency program. He continues to practice pediatric special needs care there as well as at Randall Children's Hospital, St. Vincent, and Kaiser Interstate Day Surgery Center.

Dr. Pham, the owner of Hi5Dental in Beaverton and currently the Pediatric Section Chair at Randall Children's Hospital, said he often "piggybacks" with other doctors during procedures on patients to help reduce the amount of time they are in the hospital.

Access to care is a significant issue for many families who frequently face denied claims by private insurance companies, Dr. Pham explained. Medicaid often is a piece of the insurance puzzle as well.

"You're helping a patient who, a lot of the time, doesn't have anywhere else to go," he said.

Demand for Adult Care on the Rise

Access to care is even more pronounced for adults with special needs because they age out of pediatric care at 18, leaving them with limited options. Malin Friess, DMD, practices special needs dentistry exclusively and began serving adults nearly three years ago. He said OHSU is among the leading referral sources for the state.

"There are very few providers offering OR (operating room) care to special needs patients. There are more patients than we have the capability and the capacity to treat right now," said Dr. Friess, an assistant professor in OHSU's general practice residency and its acting program director.

OHSU receives referrals not only within Oregon but also from Alaska, Idaho, Montana, and California. In fact, OHSU is now closed to external referrals as it focuses on internal referrals from the School of Dentistry and the hospital.

"We're doing our best to increase capacity, and we're happy to say that, in the last six months, we've been able to add three new faculty," Dr. Friess said, adding OHSU also is exploring the establishment of a special needs dental clinic in its Center for Health & Healing.

From an educational perspective, OHSU included training for special needs dentistry when it restarted its general practice residency in 2016. Residents are encouraged to watch a video that introduces the program, they are invited to tour the clinics, and Dr. Friess connects them with other dentists who can answer questions and talk about their experiences.

"We wanted to fill the gap for patients who age out of the pediatric dental population and have nowhere to go. They are sort of the forgotten group," he said, adding the full range of treatment, from X-rays and cleanings to restorations and impressions for replacement teeth, is typically done in one visit.

In order to make patients more comfortable, they are welcomed to the hospital so they can become familiar with their surroundings and receive an exam to ensure general anesthesia is safe for them. OHSU accepts an array of insurance, and surgery schedulers work with those plans to get procedures approved.

"They may have gone to several other clinics before they come to us, and they are very appreciative," Dr. Friess said.

Rewards Include a Ripple Effect

In his own practice, which spans two decades, Dr. Friess has seen a broad spectrum of patients that includes people who need dental care before they can receive chemotherapy or have surgery for serious conditions. He also has encountered a range of personalities along the way, and has been on the receiving end of both stern frowns and bright smiles accompanied by hugs.

"The patients are very honest. They will tell you, 'I don't like your shirt or your mirror in my mouth,'" he said, adding the positive emotional responses create a ripple effect. "When you treat a special needs patient, you are treating their whole family, including their caregivers, their brothers and sisters, and their parents."

Dr. Pham, citing the need for more advocates for the special needs population, said he makes a point of talking to his patients even if they are non-responsive or non-communicative.

"Parents really appreciate that," he said. "You're not just making the patient feel better but the parents, too, because it's hard enough raising a child who has special needs and maybe can't communicate what they are feeling."

Dr. Summers said he finds it rewarding when patients who have difficulty communicating what they are feeling, sometimes injuring themselves or others, receive a diagnosis of an oral health problem that can be fixed and become calmer upon treatment.

"The other piece of it is knowing that you're contributing to keeping these folks healthy. So often with people with special needs, their dental care can be neglected or go by the wayside because they've got 10 other things going on in their life," he said.

Dr. Summers offered to serve as a resource for other dentists who may have a traditional practice and feel unprepared to treat special needs patients. He and others who specialize in the practice can answer general questions, provide contact information for insurance matters, and offer referrals to other practitioners who can provide support.

"I'm always available to answer questions and help people out. Sometimes it's as simple as maybe the patient needs a medication to be more comfortable in the office, or maybe they are going to need general anesthesia," Dr. Summers said.

"I would just add that they should not freeze and be overwhelmed and default into inaction," he added. "There are several dentists in the state who do this work, and there are resources so these patients can have the same level of care as the rest of us."

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ODC SPEAKER HIGHLIGHT

Extraction with Immediate Implant for Mandibular Molars with a Diagnosis of Root Fracture: A Pilot Study of Eugene/Springfield Patients

By T. Matthew Jacks, DDS, FACS

THE PURPOSE OF THIS STUDY was to evaluate osseointegration of immediate implants after extraction of mandibular molars diagnosed with root fractures. From 2017 to 2021, results were obtained from 108 cases, of which 92 cases met the inclusion criteria and were treated with immediate implant placement. The remaining 16 cases were treated with site preservation for delayed implant placement. Ages ranged from 55 to 82, with 52% female and 48% male.

Criteria

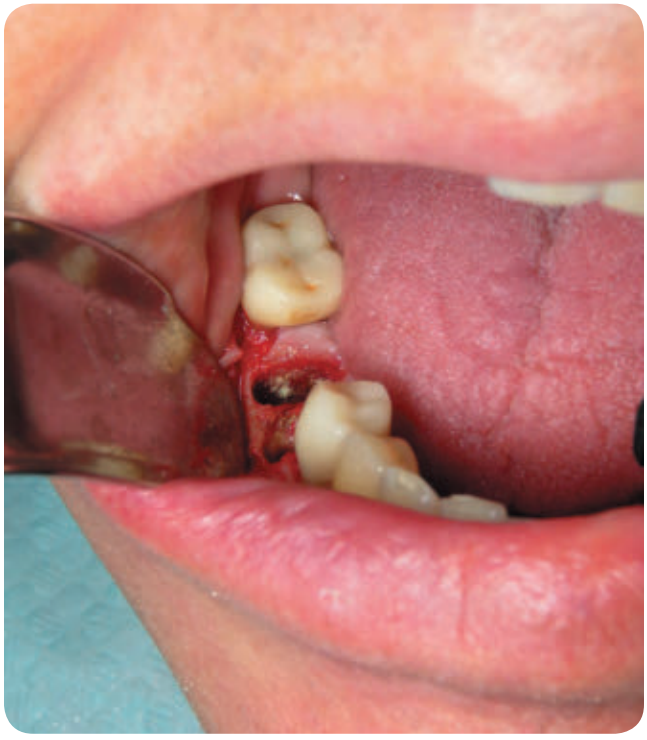
Patients were ASA I, II, and well controlled class III. The inclusion criteria included those cases where a buccal mucosal abscess or sinus tract was no greater than 2mm. Additionally, the buccal plate was intact or the existence of a vertical defect no greater than 3mm (associated with root fracture) measured from the implant platform. Finally, expansion of the socket volume from inflammation/granulation tissue could not exceed 25%.

Technique

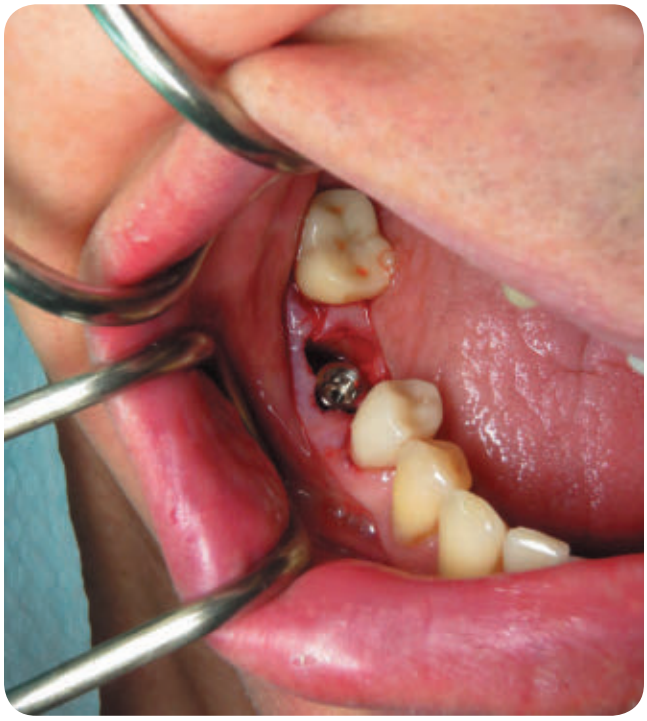
All patients received one perioperative dose of antibiotic.

- IV—Ancef 2G or Cleocin 600mg
- PO—Amoxicillin 2G or Cleocin 600mg

Mandibular molars were prepped with a periotome, and extractions were performed with a #23 forcep or surgically sectioned. All sockets were curetted of any/all granulation tissue. A two-minute application of doxycycline within the



Two-minute doxycycline application after extraction and curettage.



Immediate implant placement at insertional torque value of 45 N/cm².

ALL PHOTOS COURTESY OF T. MATTHEW JACKS

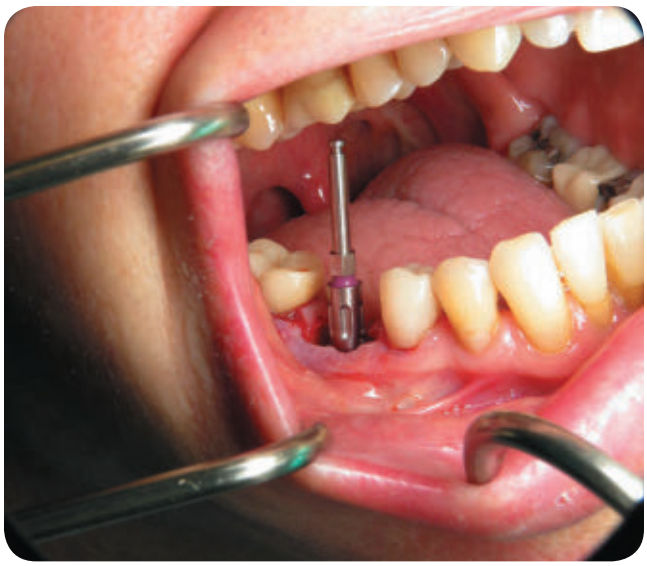
socket was utilized, then irrigated and suctioned. Implant placement consisted of a Keystone TilobeMaxx implant 7, 8, or 9mm width (7, 9, or 11mm length). Finally, 0.5-1ml of cortico-cancellous allograft was placed into socket voids. If a vertical facial defect of 2-3mm existed, a collagen extended membrane was placed over the bone defect with xenograft layered over allograft (under the membrane). If a facial plate width was less than 2mm in thickness, an onlay xenograft was layered under a collagen extended membrane. In this study, 90 of 92 implants had a healing abutment placed at the time of surgery, 86 of the 92 implants had a split collagen plug "tucked" into the coronal sulcus, and all 92 sites had two Gore-Tex (PTFE) sutures placed across both papilla in an interrupted fashion.

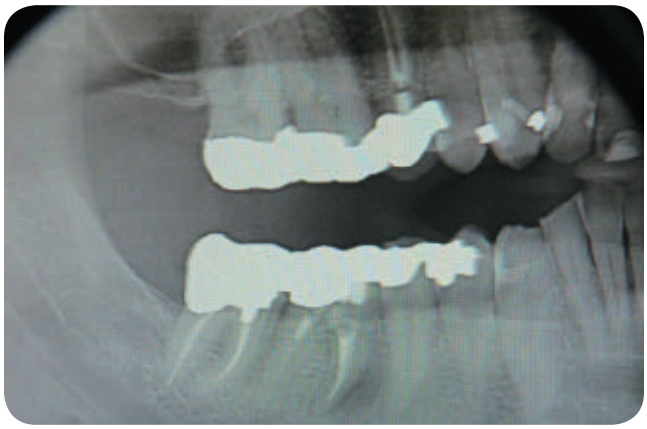
Discussion

In 1987, Gher et al. found that 71% of teeth with root fractures occurred on endodontically treated teeth. Gher defined root fractures as a fracture that exists or extends into the root to include dentin, cementum, and pulpal spaces. Root fractures can be further delineated as longitudinal, split, or vertical. Classic signs and symptoms of a vertical root fracture include biting pain, swelling, sinus tract, and abscess overlying the affected root. Extraction is indicated when propagation involves the periodontium or endodontium.

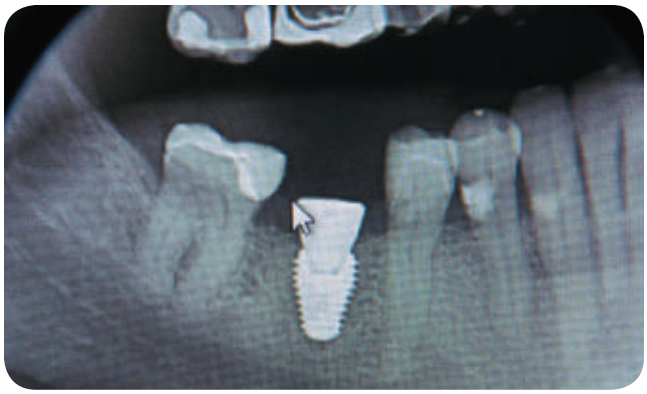
Regarding immediate implants after extraction of mandibular molars, Walker reported in 2008 a 95% success rate to osseointegration. He used a flapless design and did not graft the socket voids. He reported an average insertional torque value of 30 N/cm^2. In 2011, Block reported 29 of 30 implants had successfully integrated. All sites involved a conservative facial flap design. All sites had the socket voids filled with allogenic bone graft. Average insertional values via ISQ readings were 77.4 +/- 4.4. However, the presence of periapical pathology, any buccal bone defect and gingival inflammation were criteria for exclusion.

In this study, 90 of 92 implants successfully osseointegrated after four months from insertion (50 N/cm^2 forward and reverse torque testing). All sites involved root fracture with or without periapical pathology, facial bone defect 0-3mm from height of implant platform, and gingival abscess no greater

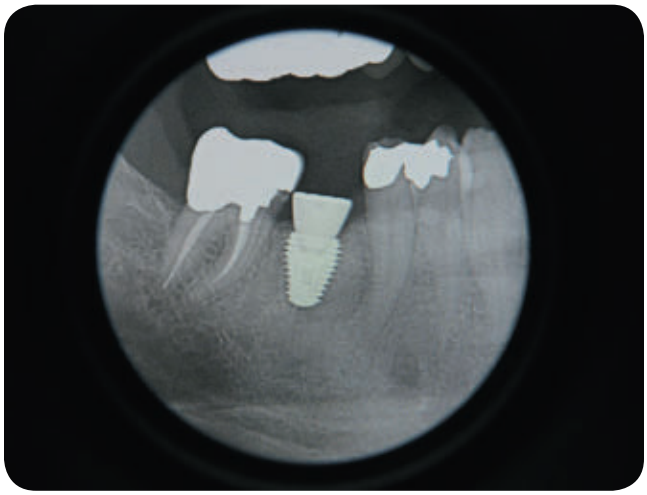




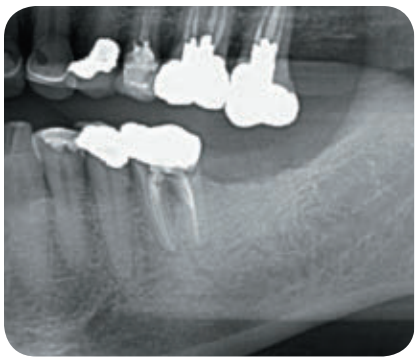
Expansion of socket from inflammation not to exceed 25%.



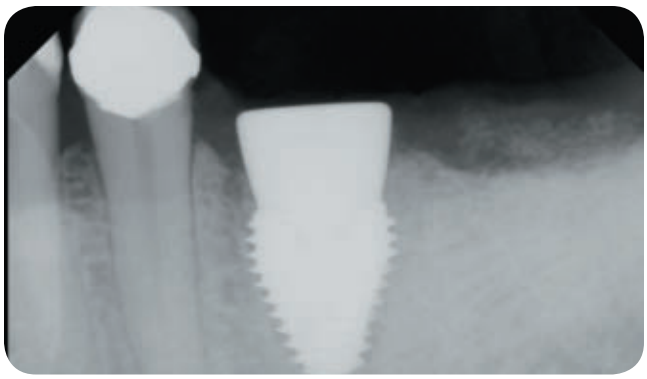
7mm x 9mm implant with insertional torque value of 45 N/cm^2.



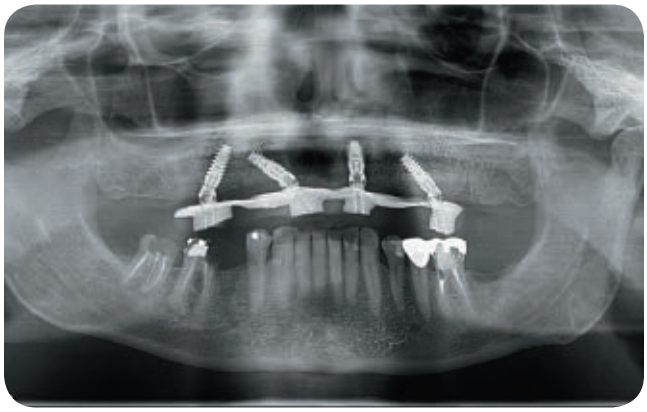
7mm x 9mm implant with insertional torque value of 45 N/cm^2. Note the allogenic bone grafting to fill the socket void. A buccal collagen barrier membrane was placed due to a 3mm defect on the buccal plate associated with the fractured mesial-buccal root.



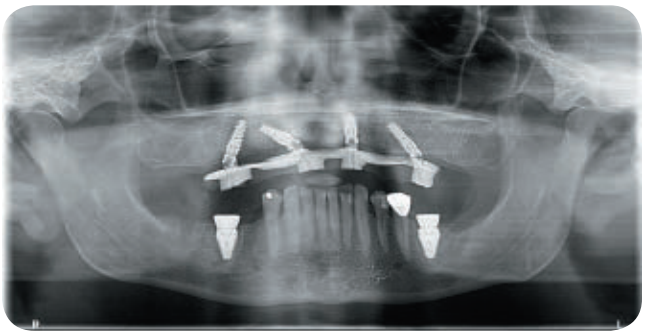
Root fracture with inflammation at the root furcation.



9mm width x 9mm height immediate implant with insertional torque value of 60 N/cm^2.



All mandibular molars sustained vertical root fractures from decay and/or occlusal forces.



Bilateral 8mm x 11mm implants with insertional torque values of 50 and 60 N/cm^2.

than 2mm. All sites involved a conservative facial flap. All sites involved curettage and removal of any granulation tissue and a two-minute doxycycline application followed by irrigation of the socket. All sites had the socket voids filled with allogeneic bone, and 20% involved a buccal barrier membrane. Average insertional torque values exceeded 45 N/cm^2.

Conclusion

For mandibular molars diagnosed with non-salvageable root fractures, most cases can be successfully treated with extraction and immediate placement of wide-bodied implants.

This technique enables the endodontist a viable option to give their patients after revealing the difficult fact that their fractured molar is not eligible for endodontic and restorative care. The healing time for an immediate molar extraction/immediate implant is *only four months* until a crown can be placed. This represents half the typical time (8-9 months) for conventional extraction, site preservation, implant healing, and crown placement.

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2. AAOMS Dental Implant Conference, Placement of implants into mandibular molar sites, 12/2008.
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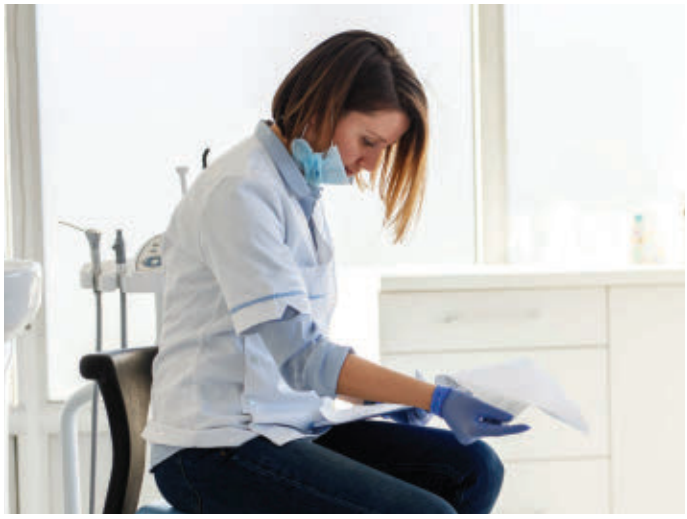

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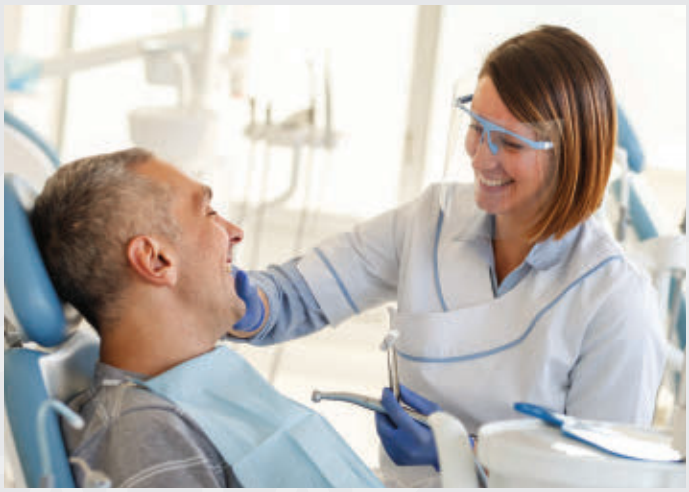

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SPECIAL CARE

Special Care Tips and Tricks

By Brooke MO Fukuoka, DMD, FSCD

Dr. Fukuoka discloses that she is sponsored by Elevate Oral Health and MouthWatch.

TREATING PATIENTS WHO HAVE SPECIAL HEALTHCARE NEEDS can be an asset to any practice. There are simple processes to help both providers and patients have more success working together.

Treating these patients is free marketing: Caregivers and families bring a loved one who has special healthcare needs because they hear you are willing to treat their loved one. They like your work, then they come see you and bring their family and friends. I have colleagues who say their largest practice builder is their willingness to treat patients of all abilities. This is even recommended as a growth strategy by marketing groups.[1,2]

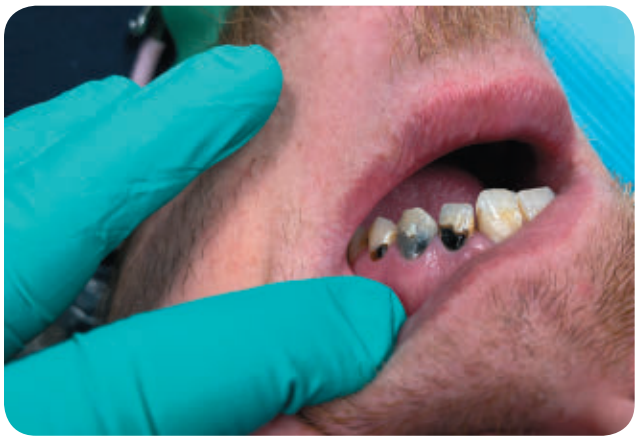
Treating these patients can improve staff retention: Let's say you have a new staff member. They have a challenging first few days. Frustration builds and they begin questioning their career. They could make equal money in a lower stress job. John, a patient with special health care needs, comes in. Something about your new hire makes John comfortable. John, generally uncooperative, lets your new hire brush his teeth. Everyone is surprised. As John leaves, he looks at your new hire and says, "you're my friend." Right then, that team member feels his/her/their value. With our patients, everyone has a chance to play the hero.

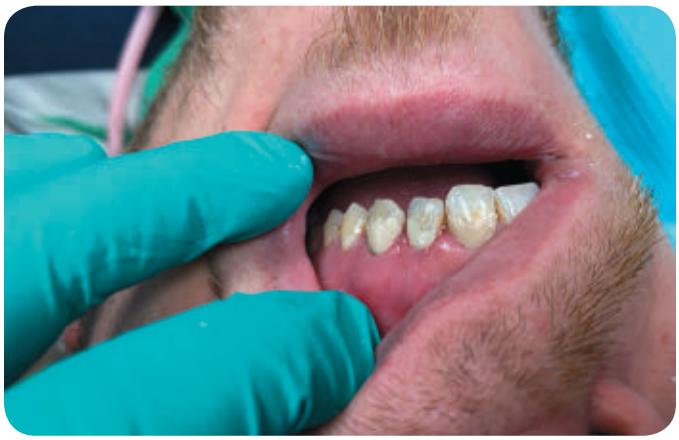
Being prepared improves success: The best way to address unique needs is to know and understand these needs before the patient comes into the office. I recommend contacting their physician and reviewing their most recent H&P and meds list. I also recommend asking the caregivers four important questions: 1) How do they communicate their needs? 2) What is something that makes them happy? 3) What are things that make them unhappy? 4) Who is responsible for making medical decisions?

Teledentistry: Some of our patients are more comfortable interacting with screens. Meeting for the first time on the screen allows them to get to know the team in their comfortable environment. Teledental office tours can also be beneficial to make the office a more familiar environment.

Positioning matters: If patients are not comfortable, they wiggle around, and everyone's job is more difficult. Wipeable pillows like the Stay N Place dental chair pillows can be used to help increase patient comfort. If a patient uses a wheelchair, treating them in their chair can be more comfortable than having them transfer. Some chairs adjust considerably. For those that do not adjust, there are wheelchair recliners. (I like the ones from Design Specific.)

Another consideration with positioning is aspiration risk. If a patient is at high risk for aspiration, it is recommended to position them favoring head flexion and no flatter than 30 degrees.[3] I try to keep them at 90 degrees with head flexion, and I approach from the front (I kneel). Two questions I use to assess aspiration risk are: 1) Do they cough a lot while reclined 2) Do they require thickening of liquids taken by mouth?





ALL PHOTOS COURTESY OF THE AUTHOR

First picture is of SDF treatment that was delivered at the College of Southern Idaho, then the patient was referred to Dr. Brooke. The SDF had arrested the caries, and Dr. Brooke was able to provide SMART restorations for this patient without any anesthetic.

Low-risk positioning and minimizing water can decrease aspiration risk.

Intraoral cameras: When the patients see the problem, they may be more motivated to fix it. We have patients say "fix that hole" after showing them their video. We also use intraoral cameras to "push pause" on our patients. I capture video as the patient moves, and there are moments of clarity where I can pause to perform an exam on a still image. We utilize the MouthWatch intraoral camera.

Cheek retractors and handled bite blocks: Clear cheek retractors and ScanMate tongue retractors from Armor Dental are helpful for visualization. When patients need help staying open, always use bite blocks with a handle. The handle is important for control and to prevent choking. (I like the Open Wide wrap around mouth props from Specialized Care Co.) Frequent breaks from the block should be given.

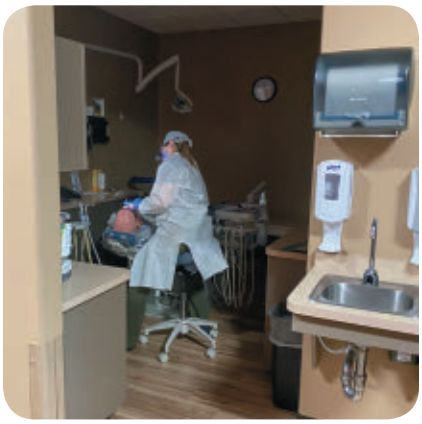
Improving home hygiene: No matter what we do, if there isn't prevention at home, even the best dental work fails. It is important to help the caregivers and the patients find oral hygiene tools and techniques that work for them. I recommend building a toothbrush petting zoo, toothpaste tasting station, and individualized OHI programs. (You can watch more at **http://youtu.be/CsPBvOMOQ4A**.) Assisted Oral Hygiene and Guided Oral Hygiene are processes developed to help improve home hygiene. (Learn more at **http://youtu.be/amvo5Stkm1Y**.) Finally, the YSS Oral Hygiene Ability Spectrum is a documentation system developed based on ability and cooperation. You can find it at **http://www.yourspecialsmiles.com/handouts-and-documents**.

Minimally invasive dentistry and topical treatments: We utilize povidone iodine, fluoride varnish, SDF, and chlorhexidine (or a combination of these) depending on the patient. We order these products from Elevate Oral Care (SDF, Povi-One, and Varnish) and Ultradent (Consepsis). If we can't control the caries chemically, we turn to minimally invasive restorative care. I have found success with the Silver Modified Atraumatic Restorative Technique (SMART) because of the lack of need for anesthetic. I prefer the two-visit SMART restoration. On the first day, I treat the patients with SDF. I have them return in 2-3 weeks. I use a spoon excavator and slow-speed handpiece to remove infected dentin and then restore with glass ionomer.

I hope these tips make it easier to help patients who have special healthcare needs improve their oral health. All dentists can, and should, help patients who have special healthcare needs. Even those of us who focus on this population cannot accomplish all the things we wish

Hygienist Alicia Miller RDH utilizes a wheelchair tilt to treat a patient in his wheelchair.

Customized Oral Hygiene Kit based on patient's unique needs. In long-term care facilities, it is important to label all things with the patient's name.



Hygienist Holly Jones RDH-EA treats patient who has light sensitivity in the dark. The TV helps distract the patient. He is wearing sunglasses to limit the TV light, and the room lights and the overhead lights are off to help him be more comfortable.

we could. The way I see it is, "If I can, I will. If I can't, I refer. If there is nobody to refer to, I at minimum topically manage disease and risk factors to prevent pain." Thank you for reading and your interest in this very important topic.

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3. Dyment, H.A. and Casas, M.J. (1999), Dental care for children fed by tube: a critical review. *Special Care in Dentistry*, 19: 220-224. **https://doi.org/10.1111/j.1754-4505.1999.tb01389.x**

If you would like further clinical studies regarding the topical treatment options mentioned, please contact Dr. Alayna Schoblaske (Editor) at **aschoblaske@gmail.com**.

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TOOTH TAXI

OVERALL STATS

(September 2008 to January 21, 2022)

Since September 2008, the Tooth Taxi has provided the following services:

Students screened - 25,186
Appointments on the TT - 14,998
Dental education in the classroom - 25,655
Value of services provided - $8,556,595

2021 TT STATS

(January 1 to December 31, 2021)

Students screened - 653
Appointments on the TT - 803
Dental education in the classroom - 100
Value of Services Provided - $395,359

TOOTH TAXI 2.0 UPDATE

The Winnebago factory has a chassis for our new Tooth Taxi 2.0, and the Taxi was tentatively scheduled to go on their production line at the end of January 2022. Global supply chain issues continue to have a negative impact upon production timelines.

PHOTO CREDIT: THE TOOTH TAXI TEAM & ERIN E. KANE

THE DENTAL FOUNDATION OF OREGON

CHIP! FOR TEETH GOLF TOURNAMENT

Friday, June 10, 2022
Langdon Farms Golf Club

Join us for the 17th Annual Chip! for Teeth Golf Tournament at Langdon Farms Golf Course in Aurora, Oregon. Registration officially opens on Tuesday, March 15, 2022 at SmileOnOregon.org!

For 17 years, Dental Foundation of Oregon supporters have traveled from all parts of Oregon for a delicious breakfast buffet, morning on the greens followed by a luncheon awards banquet. Your involvement this year will help us achieve our goal to raise $50,000 to help Oregon's children and vulnerable communities receive important dental and oral health care. The day begins at 6:30 a.m. with a hot breakfast buffet followed by a 7:45 a.m. scramble format, shotgun start. A delicious buffet lunch will be served soon after players come back from the course, and attendees are encouraged to purchase raffle tickets for a bevy of prizes.

ABOUT LANGDON FARMS GOLF CLUB

Langdon Farms is a premiere golf course and event venue located just 15 miles south of downtown Portland, Oregon. It's consistently rated highly among the best rated golf courses. **Visit them at** www.langdonfarms.com.

PHOTO CREDIT: ERIN E. KANE

NOTABLE 2021 END-OF-YEAR GIFTS

The Kelley Family Charitable Fund - $5,000 | The Piacentini Charitable Trust - $5,000
The Zera Foundation - $10,000 | Delta Dental (Moda) - $75,000
Willamette Week Give Guide - $19,567

PRESIDENT PROFILE

A Profile of ODA President
Calie Roa, DMD

By Barry Finnemore

CALIE ROA, DMD, ASSUMED THE YEARLONG PRESIDENCY of the Oregon Dental Association last September with the key goal of increasing engagement from a broader array of members.

Dr. Roa said she's been impressed with the level of involvement in organized dentistry from ODA's members, but noted that hearing a greater range of voices can be hugely beneficial to an organization dedicated to advancing the profession and promoting the highest care standards. It's also vital amid today's social and political divisiveness.

"We need to give people agency, listen to a range of ideas and opinions, and hear about the issues they are facing and the things we could be doing better for them," she said. "Sometimes we don't hear those voices enough."

To accomplish that, Dr. Roa said she's sought to reach out to the ODA's component dental societies, talk with respective leaders and sit in on component meetings, including those in geographic areas where membership isn't as great. She also noted that efforts are underway to place a greater focus on ODA social events in order to cultivate increased feedback and ideas.

Prior to becoming ODA president, Dr. Roa regularly attended the ADA Dentist and Student Lobby Day in the nation's capital and served in leadership positions on the ODA's New Dentist Council—the latter an experience she called invaluable because of the insight she gained about the struggles young dentists face, including job placement, student loans, and finding a balance in one's personal and professional life.

"I've listened to their struggles, and it was a good way for me to learn,"

DR. CALIE ROA

"We need to give people agency, listen to a range of ideas and opinions, and hear about the issues they are facing and the things we could be doing better for them," she said. "Sometimes we don't hear those voices enough."

Dr. Roa said. "And I've experienced it myself—being a woman, having kids, school debt. More grads are choosing to go into corporate positions and public health early in their careers. It's very different now than it was 30 years ago."

Her professional experience in Medford exposed her, in part, to the challenges many people face in accessing care. Dr. Roa served in public health for four years, working to pay off school debt as a National Health Service Corps scholar. She then bought into a Southern Oregon private dental practice, East Main Dental Center, serving as a partner for some seven years.

In October of 2020, she opened her own practice, Mint Dental in Medford. Dr. Roa called the opportunity to establish her own general dentistry practice in a region she first visited as an 18-year-old high schooler a "blessing." Her loyal base of patients has grown, and she continues to give back through pro bono dentistry, in large measure serving older people without insurance coverage.

Dr. Roa was born and raised in the small farm town of Eshowe, South Africa. Her dad, who is South African, and her mom, who is British, met in Zimbabwe, married and moved to South Africa. Her dad, who today lives near Durban, South Africa, worked in malaria vector control, and her mom, who now lives in Boise, ran a computer training school.

South Africa is wholly unique, Dr. Roa said, noting its culture, climate and people. "I try to go back as often as I can," she said. It was

Dr. Calie Roa and her sons, Elliot (back) and Digby, enjoy a backpacking trip in Southern Oregon.

there that she also was first exposed to people living in poverty.

In 1997, Dr. Roa boarded an airplane for the first time and came to the United States as an exchange student through Rotary International. She attended South Medford High School for a year, and planned to return to South Africa afterward and pursue medicine, but her experience in Southern Oregon was so positive that she decided to stay and attend college. That experience included shadowing for a day a dentist who performed a root canal on Dr. Roa.

America was an adjustment, however. Dr. Roa recalls the shock of not having to wear a school uniform at South Medford High, and not having to stand silently when a teacher entered a classroom. Both were requirements in South Africa.

Many of the personal connections she made then still exist. Her best friend today was her host sister during her exchange, and together they've watched their children grow up.

After her student exchange, Dr. Roa attended Southern Oregon University

and Oregon Health & Science University School of Dentistry, then returned to Southern Oregon. Today, Dr. Roa and her family live in Jacksonville. Their passion is travel, including backpacking. A favorite outing is around Southern Oregon's Fish Lake, where the rhododendrons, she noted, are "amazing."

Dr. Roa said she's proud of the inclusiveness of ODA's board, noting that the American Dental Association has recognized it for its diversity. "The board is not one-shaded, and that's intentional," she said. "I want people to know that ODA is open to change, that it's not running the way it's always been run."

Though the dental profession's collective No. 1 job is keeping staff and patients safe and healthy, particularly amid COVID-19 and its accompanying protocols, ODA can help cultivate understanding among providers and practices across the state by ensuring differing points of view are heard, Dr. Roa said.

"I want us to help people understand that we need to listen and then make the best decisions," she said.

ODC SPEAKER HIGHLIGHT

The Medical Emergency *UN*prepared Dental Office

Prepare Your Office Today, Save Patient Lives Tomorrow (and Your Practice)

Medical emergencies can happen anywhere at any time.

By John Roberson, DMD, FACD, FICD, FICOI

Background

Dental offices should be prepared to manage a medical crisis for up to 30 minutes without outside assistance. The Six Links of Survival is a checklist of the educational needs and physical items necessary to fulfill the needs of a dental patient in that time period between the identification of a medical problem and the arrival of outside assistance.

LINKS 1, 2 and 3 are the Educational Initiatives

Link 1—Dentist Training

Link 2—Staff Training

Link 3—Mock Practice Drills

LINKS 4, 5, and 6 are the Physical Initiatives

Link 4—Written Medical Emergency Plan

Link 5—Emergency Medications

Link 6—Emergency Equipment

As you read this article, you will know exactly where you stand as far as a state of readiness in your dental office. You are either a Medical Emergency Prepared OR Medical Emergency Unprepared dental office. There is NO in between. When the highly pressurized emergency occurs in your office (and it will), you will sink to the level of training that you have or have not done. if you don't have the knowledge to respond to an emergency, and you haven't done the office emergency drills to perfection, then you are going to sink to the level of your training—meaning that you could lose a patient's life. Are you ready to accept something like this? You need to make yourself as defensible as possible to your defense team in the event something catastrophic goes wrong in your office! If the standard of care is having the proper knowledge, having done the emergency drills, then failing to do these things is failing to meet the standard of care. That will be indefensible in the eyes of your state dental board, your malpractice carrier, state and federal regulators, attorneys, judges, and juries.

CHAOS:

Critical

Handling of

Office

Anesthesia

Services

It all starts with a properly prepared dental office. If the office is ready, the dentist and staff are ready. Any compromise will lead to disastrous results when an unpredictable medical emergency occurs. Inadequate medical emergency planning, lack of protocols, and an ill-prepared office will lead to CHAOS.

Now, let's look at the side of being unprepared. You opted not to thoroughly prepare your office; therefore, you and your staff are not ready. This means your office has breaches in patient safety now. That event occurred which you always said would "never happen to me" in your office. Many failures at many different levels due to a lack of preparedness occurred on many fronts within your office. A patient dies in your office, which eventually leads to a wrongful death

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suit brought against you. You will go through the proper channels with your malpractice company. You will answer a plethora of interrogatory questions followed by the deposition. Then it could be jury trial after that!

How do you think you would fare under these questions plus so many more? Treat this matter serious to prevent failures at many levels by preparing yourself and your team and reducing the potential for a catastrophic event, which can affect your livelihood at so many levels. Remember, your patients already expect that you and your facility are fully prepared when they arrive there for their office visit.

Integrate the six P's of preparation for medical & sedation emergencies:

- **Prevention:** Complete a proper medical history on every patient who comes into the dental office as well as regular updates.
- **Personnel:** Your staff should be trained and prepared for medical and sedation emergencies. They are vital individuals when a crisis is unfolding in your office.
- **Products:** It can't be stressed enough about having proper equipment such as a glucometer, an automated external defibrillator, an emergency drug kit, and proper airway equipment. If you are administering any form of sedation or anesthesia, this equipment is imperative.
- **Protocols:** Develop a medical emergency plan that is consistently reviewed by ALL within the office on a monthly basis. Review all of the emergencies that have been previously stated in this article.
- **Practice:** You must stay current on all of the emergencies presented here so you can provide proper care. You can't accomplish successful results with training once a year. The members of your team need to practice monthly and take their roles very seriously. The time to practice is NOT when the actual emergency is occurring.
- **Pharmaceuticals:** Have current, in-date emergency medications within your office. There are specific medications that should be present in all dental offices unique to different emergencies. Know the emergency medications for all of the emergencies presented within this article. ALL should know the location of these emergency medications. If you struggle with maintenance of your emergency medications, then activate an automatic renewal program.

Take the six P's of preparation seriously, so your team can prevent the seventh P from happening, which is panic. Panic doesn't do any good during a medical emergency; it just introduces CHAOS. When you panic, you're going to forget simple life-saving skills on what to do. When you forget, you risk your patient's life. Or to put it another way:

Know planning = no CHAOS

No planning = know CHAOS

In conclusion, no dental healthcare practitioner is able to determine when he or she will be faced with a medical emergency that will require the use of the six links. It is for that reason alone that dental healthcare practitioners should stay up to date on medical emergencies as well as the drugs and equipment used to treat them and maintain a professionally inspected dental office on a regular basis. Develop a regular protocol with your staff every month to rehearse various emergencies using your emergency drugs and equipment.

if you don't have the knowledge to respond to an emergency, and you haven't done the office emergency drills to perfection, then when the pressurized emergency happens for real (and it is not a question of if, but when), you are going to sink to the level of your training—meaning that you could lose a patient's life. Are you ready to accept something like this? Treat this matter seriously to prevent failures at many levels by preparing yourself and your team and reducing the potential for a catastrophic event which can affect your livelihood at so many levels.

GET Prepared, STAY Prepared. Never be the Unprepared!

NEW DENTIST CORNER

New Dentist Spotlight: Dr. Britta Martinez

WE'RE HIGHLIGHTING A FEW ODA NEW DENTIST MEMBERS—starting with Dr. Britta Martinez, the chair of ODA's New Dentist Council.

The New Dentist Council is a group of mostly newer dentists whose goal is to promote and help engage newer dentists—those who finished dental school within the past 10 years—in the Oregon Dental Association, providing resources and showing them what organized dentistry has to offer. The council also recently revamped the ODA's mentorship program.

Dr. Martinez grew up in Arizona and came to Oregon for dental school. She graduated from OHSU School of Dentistry in 2017, completed a residency in Minnesota, and now works at a public health dental clinic in East Portland near Gresham.

"When I first came into dentistry, it was a very new world for me, and I had a lot of questions, but the people I knew in the field were in the same boat because they were also new dentists," she said. "There's a lot of space for dentists who have been practicing to connect with those newer dentists and help them along in that early journey."

Dr. Martinez said it's important to connect with other dentists early, and for everyone to have a voice.

"Health care is something that's constantly progressing and changing, and I think it's important that everybody has a place in that. And I think that it's a place where I can give back and help others through the things I've gone through myself," she said.

"There's such a wealth of information we can tap into, and that can make us as individuals a lot better. That's one of the big benefits of the ODA and organized dentistry: People are super willing and happy to share. Sometimes you just have to be in the space in order to know it's there."

Follow us on Facebook and Instagram to see additional member spotlights.

DR. BRITTA MARTINEZ; IMAGE DESIGN: KARA HANSEN

RISK MANAGEMENT

Romantic Relationships with Patients: Your Obligation as the Employer

By TDIC Risk Management

In any workplace, navigating relationships is complicated. But the potential for unforeseen and possibly high-risk issues increases when a dentist—or anyone else on the practice team—chooses to date a patient. Be aware of potential risks, impacts, and your role in mitigation.

IS IT EVER OKAY TO DATE PATIENTS? *The unqualified answer is simply no.*

The ethical considerations of personal relationships with patients are addressed in the ADA Principles of Ethics and Code of Professional Conduct. Under the Principle of Nonmaleficence ("do no harm"), the ADA states, "Dentists should avoid interpersonal relationships that could impair their professional judgment or risk the possibility of exploiting the confidence placed in them by a patient."

When it comes to matters of the heart, however, objectivity can be compromised. Romantic chemistry happens, and there are risks beyond the ethics that can have profound impacts on your practice, whether or not the relationship works out. If an attraction develops, emotions and stakes are heightened. Consider beforehand how personal relationships could evolve (or devolve) into troublesome situations in the future. If you or any member of your dental team intends to pursue a personal relationship with a patient, the patient must be referred to another practice for care before the relationship begins.

The Dentist Insurance Company provides a no-cost Risk Management Advice Line to help ODA members and TDIC policyholders navigate challenging situations. As calls to the Advice Line illustrate, romances that

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evolve in business and health care settings often have an imbalance-of-power aspect that creates even more tension and risk—even when the relationship is between a staff member and a patient.

A case study in dating a patient

In a recent Advice Line call, a dentist shared how the complications of a romantic relationship between a staff member and patient were fueling drama and discontent in his practice. The office's receptionist, who was married, had been dating an elderly patient who was professionally successful. The patient sent gifts to her and took her on lavish dates. The receptionist shared the details of her dating life with other staff members and admitted that flowers sent to her at the practice were from the patient.

The receptionist's husband discovered the relationship and "lost control"—getting into an argument with her in the office parking lot, which escalated into him throwing an item at his wife. The police had to be called to put an end to this disruptive and embarrassing scene.

In this case, the dentist did not wish to dismiss the patient due to the patient's high standing in the community. To complicate the issue, while the dentist's employee manual did include a policy that specifically referenced not dating patients, not everyone on his staff had provided a signed acknowledgment that they had received the manual.

The analyst urged the dentist to meet with the employee and remind her of the office policy and clearly communicate their expectation that she adhere to these guidelines. In addition, given the disruption that occurred when the patient's husband confronted his wife at the practice, the dentist may consider obtaining a restraining order against the husband to prevent further occurrences. While employee termination may also be an option, the dentist was advised to consult an employment attorney prior to taking any definitive action.

Regardless of whether the potential relationship with a patient is to be with the dentist or a staff member, the patient must seek dental care from another office. This can prevent potential financial and privacy concerns. What if the patient's balance was forgiven or an unauthorized credit was placed on their account? If the relationship doesn't work out, the patient could voice concerns about unauthorized access to private health information.

Patients should be able to trust their health care providers and have the expectation that any confidential information revealed will be used only in their best interest. This dynamic must not be exploited, regardless of the relationship status. If a romance ends, hurt feelings can even lead to retaliatory action taken by a patient, such as a complaint to the dental board or filing a malpractice claim.

What can you do?

- **Lead by example.**

  As practice owners and employers, dentists must model the behavior they want to see in others. They should neither initiate relationships with patients nor encourage romantic interest. If staff members observe a practice leader setting clear boundaries with a patient and referring a patient to another dental practice when needed, they are more likely to make prudent decisions about their own behavior.
- **Proceed with caution.**

  If you have weighed the potential consequences of dating a patient and are serious about pursuing a relationship, you must refer the patient to another provider. Include staff in your reasoning about these types of decisions, as it will demonstrate accountability and encourage discussions around similar situations among the team.
- **Put your policy in writing.**

  The Dentists Insurance Company recommends a written office policy that is applied universally, regardless of the staff role. In addition to having a policy in place, you should also communicate what behavior is unacceptable in the workplace, such as certain displays of affection and discussing relationship issues. For any employment policy, the consequences of violation should be equitable and clear. It can be helpful to establish an anonymous reporting process to allow employees to feel more comfortable to share when they've witnessed violations or concerning situations.
- **Add a layer of protection.**

  If you haven't already done so, consider adding employment practices liability (EPLI) coverage as an endorsement to your professional liability policy. EPLI can provide protection if you or one of your employees is sued for harassment, discrimination, wrongful termination, failure to promote, or other employment-related issues. Talk to your trusted insurance advisor about the right coverage for your practice's needs.

In any workplace, navigating relationships is complicated. But the potential for unforeseen and possibly high-risk issues increases when a dentist—or anyone else on the practice team—chooses to date a patient. Protect yourself, your staff, and your practice by keeping relationships professional.

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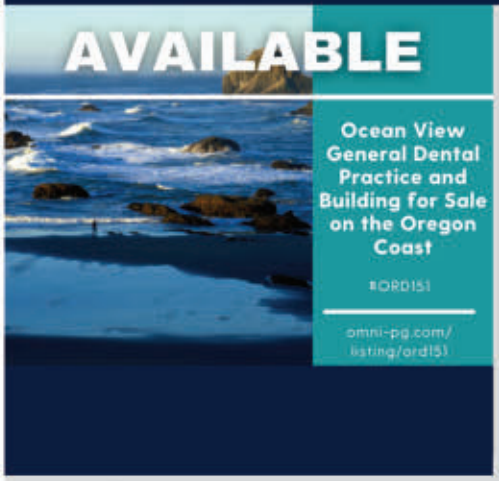

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