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P. Benjamin Meyer, DDS
David J. Dowsett, DMD, and staff
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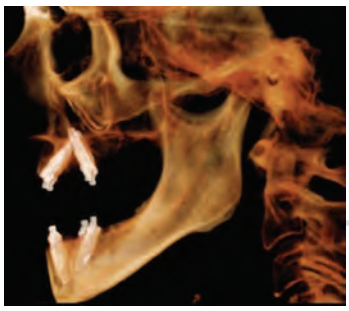

ALSO INSIDE...

CONTACT US

Letters to the Editor

Letters to the editor are welcomed. All letters and other submissions to this publication become the property of the Oregon Dental Association. Send submissions to:

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PO Box 3710
Wilsonville, OR 97070-3710
barrytaylor1016@gmail.com

Articles

Are you interested in contributing to Membership Matters?

For more information, please contact editor, Dr. Barry Taylor:
barrytaylor1016@gmail.com

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ODA CALENDAR
EVENTS & MEETINGS

APRIL 9–11	**Oregon Dental Conference** *(Portland)*
APRIL 12	**Board of Trustees meeting** *(Portland—Doubletree)*
MAY 14	**New Dentist Social** *(Portland—Lucky Labrador Beer Hall)*
MAY 30	**Board of Trustees meeting** *(Skamania)*
JULY 24	**Board of Trustees meeting** *(ODA)*
SEP 11–12	**House of Delegates** *(Bend—Riverhouse)*
SEP 25	**Board of Trustees meeting** *(ODA)*
OCT 30	**Board of Trustees meeting** *(ODA)*
NOV 23–24	**Oregon Mission of Mercy** *(Portland)*

For more information on these and other upcoming events, visit *www.oregondental.org*, and click 'Calendar' at the top of the page or call ODA at 503.218.2010.

DBIC RISK MANAGEMENT COURSES

Current reporting period: January 2014 to December 2016

2015

April 9
Oregon Dental Conference – Portland

October 16
Southern Willamette – Corvallis
Dr. Mark Swensen, 541.754.4017

November 10
Washington County – Beaverton
Dr. Kathy Reddicks, 503.848.5605

December 4
Marion & Polk – Salem
Sabrina Hance, 503.581.9353

2016

April 7
Oregon Dental Conference – Portland

December 2
Multnomah – Portland
Lora Mattsen, 503.513.5010

December 9
Central Oregon – Redmond
Dr. William Guy, 541.923.8678

COMPONENT CE CALENDAR

compiled by Mehdi Salari, DMD
Send your component's CE courses to *bendsalari@yahoo.com.*

FRI, MAR 13 Lane County **CE HRS: 6**
Oral Radiology, By Shawneen Gonzalez, DDS, MS
LOCATION: Eugene (Valley River Inn)
INFO: www.lanedentalsociety.org/programs

TUES, MAR 17 Clackamas County **CE HRS: 2**
Dental Materials, By Marmem Pfeifer
LOCATION: Oregon City (Willamette Falls Comm. Ctr.)
INFO: executivedirector@clackamasdental.com

WED, MAR 18 Multnomah **CE HRS: 1.5**
Tooth Resorption, Diagnosis and Treatment Strategies, By Salwan Adjaj, DMD
LOCATION: Milwaukie (Moda Plaza)
INFO: www.multnomahdental.org or lora@multnomahdental.org

TUES, APR 28 Clackamas County **CE HRS: 2**
Endo Update, By Dr. Aaron Welk
LOCATION: Oregon City (Willamette Falls Comm. Ctr.)
INFO: executivedirector@clackamasdental.com

FRI, MAY 8 Clackamas County **CE HRS: 6**
Clinical Records Prevent Criminal Records "Do Dentistry, Not Time", By Dr. Roy Shelburne
LOCATION: Oregon City (Willamette Falls Comm. Ctr.)
INFO: executivedirector@clackamasdental.com

TUES, MAY 12 Lane County **CE HRS: 2**
Oral Oncology, By Wayne Ormsby, MD, and Haidy Lee, MD
LOCATION: Eugene (Valley River Inn)
INFO: www.lanedentalsociety.org/programs

TUES, MAY 12 Marion & Polk **CE HRS: 2**
OSHA HIPAA, By Teresa Davis, Physician's Resource
LOCATION: West Salem (Roth's)
INFO: www.mpdentalce.com or mpdentalce@qwestoffice.net

TUES, MAY 12 Southwestern Oregon **CE HRS: 1.5**
Pediatric Dental Presentation
Heidi Pahls, DDS
LOCATION: Coos Bay (Red Lion)
INFO: Dr. Keith Kano

TUES, MAY 12 Washington County **CE HRS: 1.5**
Table Clinics
LOCATION: Beaverton (Stockpot Broiler)
INFO: www.wacountydental.org or wcdskathy@comcast.net

WED, MAY 20 Multnomah **CE HRS: 1**
Table Clinics
LOCATION: Portland (TBD)
INFO: www.multnomahdental.org or lora@multnomahdental.org

TUES, JUNE 9 Lane County **CE HRS: 2**
Managing Time and Productivity in the Dental Office, By Bethanne Kronick
LOCATION: Eugene (Valley River Inn)
INFO: www.lanedentalsociety.org/programs

WED, SEPT 16 Multnomah **CE HRS: 2**
Fluoride (Speaker & Location TBD)
INFO: www.multnomahdental.org or lora@multnomahdental.org

FRI, OCT 2 Lane County **CE HRS: 6**
Xylitol: The Oral and Systemic Benefits
Julie Seager, RDH, BS
LOCATION: Eugene (Valley River Inn)
INFO: www.lanedentalsociety.org/programs

TUES, OCT 20 Lane County **CE HRS: 2**
Infection Control in the Dental Office
Karla Kent, PhD
LOCATION: Eugene (Valley River Inn)
INFO: www.lanedentalsociety.org/programs

WED, OCT 21 Multnomah **CE HRS: 2**
Health Insurance Issues/Regulations/Rules and Options for Small Business & Individual Plans
Chris Wright
INFO: www.multnomahdental.org or lora@multnomahdental.org

WED, NOV 18 Multnomah **CE HRS: 2**
Employment Agreements, Buy-Ins, Transitions
Greg Englund, JD
INFO: www.multnomahdental.org or lora@multnomahdental.org

An *embellished* history of the ODA scarf

Barry J. Taylor, DMD, CDE

IT WOULD BE TOO BORING OF A STORY for me to tell you that the history of the Oregon Dental Association's "Fight Enamel Cruelty" blue and white scarf started when ODA members **David Dowsett, DMD**, and **Sean Benson, DDS**, showed up to an American Dental Association District XI caucus meeting wearing their Portland Timbers scarves, because it was a game day. I could also say that the idea was then further perpetuated in a New Dentist Committee meeting—at the time chaired by **Justin Gonzales, DMD**—but that would not add any color to the history of our scarf. Being as I was not present for any of those conversations, I did my own research to find out why, really, we now have a blue and white scarf, and what it means.

The history begins in ancient Egypt when Queen Nefertiti is reputedly the first woman to wear a scarf under her conical headdress, in 1350 BC. We know that the first dentist was Hesi-Re, "the greatest of the physicians who treat teeth," who lived during 2600 BC. So, it is safe to assume that, by 1350 BC, Queen Nefertiti had a dentist, and, likely, dental insurance—with a $1,200 maximum benefit. Thus, I have concluded that it was in 1350 BC that the scarf and dentistry first crossed each other in history.

Simple research shows that, about this time, trade began along the Silk Road, between Egypt and China. And, around 1000 BC, we know that scarves began to appear on sculptures of Chinese warriors. By 230 BC, the scarves were worn in China to show military rank. Additionally, in the second century AD, there is evidence that the Chinese were using arsenic to treat disease in teeth, so it is safe to assume that referrals were being made by dentists in Egypt for their patients to travel to China for dentistry.

But what of that jump between 1000 BC and second century AD? Well, in about 450 BC, the Romans were using gold to bind teeth together and practice dentistry. So I have reasonably deduced that the Romans, who at this time were using a sudarium, a linen cloth for wiping the body of sweat, and their friends—the Egyptians—were traveling to China for dental care. I won't bore you further with the details of history, but now you understand the good evidence that shows there is a long history bonding dentistry and the scarf together. During this time, dentistry is improving (Marco Polo reports in 1270 that "both men and women of this province have the custom of covering their teeth with thin pieces of gold"), and the scarf is being worn both as a show of military rank and, also, a sign of status.

We jump ahead to the 1700s, when the scarf and dentistry really start to come into their own. In England, soccer fans begin to wear scarves with their team colors, much as we see the green Portland Timbers scarves. Meanwhile, Dr. Pierre Fauchard is completing his epic work, *Le Chirurgien Dentist, Ou, Traite De Dents*, to be published in 1728. It is reasonable to assume that during the lecture circuit to promote his new text (but not to profit from it), while at a dental conference in England, he took in a good 'football' match. He saw the fans waving their scarves, and he returns to his home in Paris with a scarf as a souvenir for his trip to the 1730 England Dental Conference.

That is the history of why a blue and white scarf with the words "Fight Enamel Cruelty" is now held aloft by ODA members as a sign of support for their profession—a banner proclaiming our goal to improve our patients' health and to show solidarity for our profession. ●

Source for dental history is *Dentistry: An Illustrated History* by Malvin E. Ring, DDS.

Greek Statue of Apollo called Belvedere: This file comes from Wellcome Images, a website operated by Wellcome Trust, a global charitable foundation based in the United Kingdom.

Queen Nefertiti statue via Wikimedia Commons

The opinions expressed in this editorial are solely the author's own, and do not reflect the views of the Oregon Dental Association or its affiliated organizations.

Barry J. Taylor, DMD, CDE, is editor of *Membership Matters*. He can be reached via email at *barrytaylor1016@gmail.com*.

Did your component sponsor Give Kids A Smile! activities during the month of February?

If so, please send photos and a recap of the activity (time, place, population served, number of volunteers, number of patients seen, etc.) to ODA editor, Dr. Barry Taylor, at *barrytaylor1016@gmail.com*, so that we can publish them in *Membership Matters*.

The doctors and staff who volunteered deserve the recognition!

OREGON DENTAL ASSOCIATION

Don't miss it!
NEW DENTIST SOCIAL

6:30 – 10 PM, Thursday, May 14

Lucky Labrador Beer Hall
1945 NW Quimby, Portland

RSVP

BY: Fri., May 8

TO:
Anna Velasco

503.218.2010 x102
avelasco@oregondental.org

Dentists who have graduated within the last 10 years are invited to attend the New Dentist Social, sponsored by the ODA New Dentist Committee.

This is a casual event. Both ODA members and non-members are welcome to attend. Enjoy friendly, collegial conversation, along with pizza, salad, and perhaps a beer or two!

Volunteers NEEDED

The leadership positions detailed here are currently open for nominations. **All ODA members are encouraged to participate in the leadership of this organization.** The deadline to express interest is 45 days prior to election, unless otherwise noted below.

Interested applicants should submit a letter of interest and a one-page resume to:

Mail: ODA Leadership Development Committee
Jim Smith, DMD
Chair, Nominating Sub-Committee
PO Box 3710, Wilsonville, OR 97070

Email: *leadership@oregondental.org*

☑ Election held Sept. 12, 2015
Elected by ODA House of Delegates
★ ★ If interested, the deadline to submit materials is July 6, 2015. ★ ★

ODA Trustee
POSITIONS OPEN Three
TERM 4 years
INCUMBENTS Matthew C. Biermann, DMD, MS
Greggery E. Jones, DMD, MAGD
Steven E. Timm, DMD
DECLARED CANDIDATES

ADA Delegate at Large
POSITIONS OPEN One
TERM 3 years
INCUMBENTS Karley R. Bedford, DMD
DECLARED CANDIDATES

Leadership Development Committee
POSITIONS OPEN Three
TERM 3 years
INCUMBENTS Patrick M. Nearing, DMD
William F. Warren, Jr., DDS, MS
Kimberly R. Wright, DMD
DECLARED CANDIDATES

☑ Election held April 12, 2015
Elected by ODA Board of Trustees
★★ If interested, the deadline to submit materials is March 25, 2015. ★★

ADA Alternate Delegate at Large
POSITIONS OPEN Five
TERM 1 Year
DECLARED CANDIDATES Patrick V. Hagerty, DMD
Jill M. Price, DMD
Barry J. Taylor, DMD
Kimberly R. Wright, DMD

☑ Election held Oct. 30, 2015
Elected by ODA Board of Trustees

Dental Foundation of Oregon Board of Directors
POSITIONS OPEN Two non-independent (dental) directors
Two independent directors
TERM 4 Years
INCUMBENTS Janet P. Peterson, DMD, PhD
Thomas D. Pollard, DMD
DECLARED CANDIDATES

☑ Election held Oct. 30, 2015
Elected by ODA Board of Trustees

Moda, Inc. Board of Directors
★ ★ If interested, the deadline to submit materials is July 31, 2015. ★ ★
POSITIONS OPEN One dental directors
Two non-dental directors
TERM 4 Years
INCUMBENTS Mark E. Jensen, DMD
DECLARED CANDIDATES

April 30, 2015 | Beaverton

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SAYIJ MAKKATTIL, BDS, MDS, MSD
Salem
Marion & Polk Dental Society

THOMAS R. PETERS, DDS
Salem
Marion & Polk Dental Society

AMIT PUNJ, DMD
Portland
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JOSEPH P. SCHMIDT, DDS
Portland
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Bend
Central Oregon Dental Society

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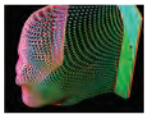
Lane County Dental Society presents



Wayne Ormsby, M.D. & Haidy Lee, M.D.
Willamette Valley Cancer Institute and Research Center
speaking on

Oral Oncology for the Dental Professional

Tuesday May 12, 2015 5:30 - 8:00 p.m. dinner included
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2. Familiarizing participants with the initial diagnostic and staging process.
3. Introducing treatment strategies including surgery, radiation therapy, chemotherapy, and targeted therapy.
4. Review outcomes and prognosis.

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complete program details and registration at
lanedentalsociety.org/programs

Do you want to be part of the Molar Movement?

#FightEnamelCruelty

Post your photos to Facebook or Twitter and tag the ODA, and you may be featured in a future *Membership Matters*!

For more information, contact ODA Membership Specialist Kristen Andrews at 503.218.2010 x110 or kandrews@oregondental.org.

Top: **Dr. Kurt Ferré** in Maui
Above: The scarf takes a PDX carpet selfie!
Right: **Dr. Vanessa Browne** at Pilot Butte State Park.
Below: **Dr. Joni Young** in Newport.

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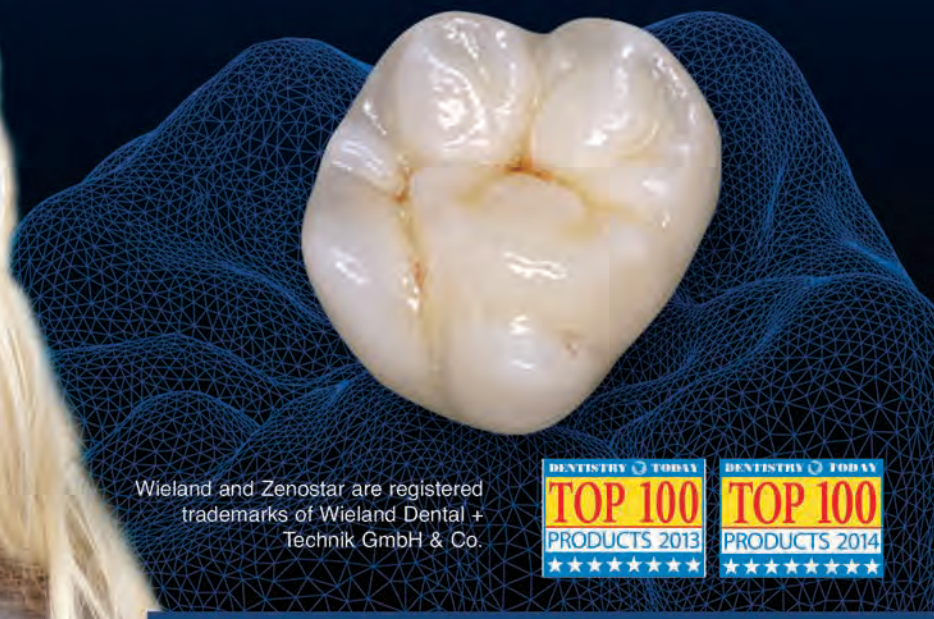

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ADA meets with CMS administrator on Medicare Part D opt-out, Medicaid

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ADA PRESIDENT, DR. KATHLEEN O'LOUGHLIN, and Washington office staff met with CMS Administrator Marilyn Tavenner [in early January] to discuss issues important to the dental community, including the Medicare Part D opt-out provision, Medicaid reform and RAC audits. They were joined by Dr. Terry Dickinson, executive director of the Virginia Dental Association.

The issues discussed included the final rule published early last year that requires dentists who prescribe Part D covered drugs to be enrolled in Medicare or opt out. The ADA is concerned about the rule because it would deny payment for a Medicare beneficiary's medication if the prescribing provider had not either enrolled or opted out of the program. The ADA has actively opposed this new Medicare provision as it applies to dentists and is currently seeking an exemption for the dental profession. CMS delayed the enforcement date; although the enrollment deadline remains June 1, 2015, the agency will not enforce the rule until December 1.

During the meeting Ms. Tavenner acknowledged that the approach CMS has taken on program integrity may not be universally applicable to both medicine and dentistry; this is what the ADA has said repeatedly in objecting to the opt-out provision as applied to dentists. Ms. Tavenner asked the ADA representatives to stay in touch with her staff as the process moves forward.

Also discussed was the ADA's Medicaid reform initiative, the objectives of which are to increase both the number of Medicaid beneficiaries receiving dental visits and the number of dentists participating in state Medicaid programs. The ADA would like to continue working with CMS and the state governments to help improve dental Medicaid. ADA staff cited the Association's Action for Dental Health initiative, which has identified 10 states in which the dental associations are addressing barriers to participation.

For information on whether to opt in or opt out of Medicare Part D, please select 'Overview' from this site: *med.noridianmedicare.com/web/jeb/enrollment/opt-out*

To opt out of Medicare Part D, download the affidavit form here: *www.noridianmedicare.com/je/partb/docs/optoutaffidavit.pdf*

Submit the filled out form, by mail, before June 1, 2015, to:
Noridian Health Care Solutions, Attn: Provider Enrollment
PO Box 6702, Fargo, ND 58108-6702

If you have further questions, please call
Provider Enrollment Medicare at 877.908.8431

Finally, the ADA raised the issue of RAC audits, a significant concern for its members, explaining that dentists would like additional guidance on how to avoid triggering the audits, which are intended to recover improper payments. Ms. Tavenner was open to continued discussions on this issue as well, asking that ADA staff follow up with representatives in her office.

It is critical for the ADA and CMS to work together, especially as the Association moves forward with its ADH Medicaid initiative. For its part, CMS is seeing good results with its Oral Health Initiative program and, as Ms. Tavenner said, collaboration with the dental community is a big part of the reason for that success.

Drs. O'Loughlin and Dickinson sent a letter to Ms. Tavenner [...], thanking her for taking the time to meet with them. ●

This article, with a link to the thank you letter sent to Ms. Tavenner, is available online at *www.ada.org/en/advocacy/advocacy-news/jan-13-ada-tavenner-meeting*

This new column is intended to help you to be better informed of the rules and regulations that are required of running a dental practice.

For additional information, please contact ODA Member Compliance Coordinator, Lori Lambright, at 503.218.2010, x104 or *llambright@oregondental.org*.

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A Different Intelligence

Steven A. Gold, DDS

WHY IS IT THAT SOME individuals, dentists included, are highly intelligent and highly skilled, yet struggle to attain success in their careers, while others with solid—but not extraordinary—intellectual ability and technical skills, soar in their professional achievements? What is this "stuff" that often translates to success for those who have it, and to mediocre performance for those who don't?

The answer, according to a growing body of evidence, is what has come to be known as emotional intelligence. The term "emotional intelligence" was popularized by Daniel Goleman in his 1995 book of that name, but he credits two psychologists, John Mayer and Peter Salovey, with coining the term five years earlier in an article published in a small academic journal. Emotional intelligence (EI) can be defined as the ability to manage ourselves and our relationships effectively.[1] To begin to get a handle on this rather broad and abstract concept, EI can be further broken down into five components: self-awareness, self-regulation, motivation, empathy, and social skill.

What is interesting about emotional intelligence is that it has been studied from an almost scientific perspective. This should make it of particular relevance to our profession, which is placing increasing emphasis on evidence-based decisions. In his research of nearly 200 large, global companies, Goleman found that truly effective leaders are distinguished by a high degree of emotional intelligence.[2] These leaders create a certain culture within their business that is conducive to employees being more productive and happier. Alice Isen, at Cornell in 1999, found that when immersed in an upbeat environment, people are better at taking in and processing information. And, of course, having employees who perform at a higher level has a direct impact on a company's profitability.

The positive culture that is created in such an organization is directly related to the mood and behavior of the leader—manifestations of their emotional intelligence. There is science behind mood. Emotions are managed by the brain's limbic system, and positive moods have direct physiological effects, such as lowered blood pressure and heart rate, and improved immune function.[3] Furthermore, research by Bartel and Saavedra, along with others, found that mood is translated through the organization—like electricity through wires—by a process called mood contagion. And moods that start at the top tend to move fastest because everyone watches, and takes cues from, the boss. Knowing this, it would be surprising that a leader in any organization, including a dental practice, would not take careful measures to ensure that their own mood is anything other than positive.

Let's face it, raising one's emotionally intelligent is not a simple process. Becoming more self-aware, exhibiting a higher degree of empathy and improving communication skills—requires hard work dedicating many hours, if not years, to changing one's behavioral patterns. Yet if CEOs can create a culture of high emotional intelligence in companies with thousands of employees, why can't we do it in a dental practice with a half dozen or so employees, especially when the benefits are so tangible? The how-to of raising one's emotional intelligence is beyond the scope of this article, but there are ample publications and other resources available for those looking to achieve a higher "EIQ". A good place to start is *www.eiconsortium.org.*

Dr. Gold formerly maintained a private practice in Santa Monica, Calif. He is currently an assistant professor of restorative dentistry at the OHSU School of Dentistry. He can be reached at *goldst@ohsu.edu*.

Notes

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If we extrapolate from the research, dentists who raise their emotional intelligence can expect to have better communication and relationships with their staff. In becoming a great leader, the dentist may find his or her team more energized, happier, and more likely to buy into and support the dentist's mission. Improved social skills and empathy may extend beyond the staff to relationships with patients and colleagues, which may lead to increased referrals to the practice. In the end, this will likely have a direct positive impact on the practice performance and profitability. The bottom line benefit of elevating one's emotional intelligence may, literally, be the bottom line.

But perhaps emotionally intelligent dentists can have an even greater impact—one that extends beyond their practices to our profession as a whole. Imagine dentistry as a profession full of emotionally intelligent individuals who collectively demonstrate a high degree of empathy and are, thus, better tuned in to the needs and concerns of the public. Just as mood can be transmitted through an organization, envision transmitting a positive view of oral health care, and the dental profession, throughout society. We may gain an improved image with the public. We may realize a greater level of communication with other health care providers, resulting in reciprocated trust and respect. And we may elevate our relationships and influence with legislators and other policy makers. These outcomes may have a far reaching positive impact on our one and only true professional purpose: to provide the highest level of care to the public which we serve—our patients. ●

Frances A. Sunseri, DMD, MAGD

Kurt L. Ferré, DDS

Ngoc Pham; Jennifer Nguyen

Uniting Oregon dentists

One sc

MOLA Moveme

By Melody Finnemore

In a nice complement to the green and white Portland Timbers scarves that proliferate Soccer City USA, a splash of blue and white scarves are becoming increasingly visible in a movement to unite Oregon's dental professionals and raise public awareness about the importance of oral healthcare.

arf at a time.

R

nt

Joni D. Young, DMD; Conor P. McNulty, CAE

As part of its **Molar Movement**, the Oregon Dental Association has introduced the blue and white scarves, which feature a signature white **"molar bear."** The scarves were created for dental professionals to wear in their communities or to display in their offices to support the profession and increase public awareness of oral health. The scarves are available for $20, with proceeds going to support Oregon Mission of Mercy and the Dental Foundation of Oregon.

Olesya Salathe, DMD, of Northwest Dental of Molalla, recently saw the scarves and was excited to purchase them for her team. She says her office does a lot of community outreach, mostly within the rural setting of Molalla, and the scarves add to those efforts.

"When people ask questions that is an opportunity to get the conversation started about oral healthcare, and it raises money for some good causes. Plus it's catchy," Dr. Salathe says. "Anything that can catch someone's attention and raise awareness is always a good thing."

Colin Graser, DMD, a graduate resident of periodontology at the OHSU School of Dentistry, saw one of the scarves on campus and immediately knew he wanted to purchase one.

"I think it's a good idea of how to get dentists (or at least residents) excited about dentistry, and getting people not in the profession talking about it," he says.

Portland practitioner **David Dowsett, DMD**, and dental student **Margie Campbell** were involved in the concept and design of the scarves. Dowsett, a devoted Portland Timbers fan, ended his service on the Oregon Dental Association Board of Trustees before the scarves came to fruition. He says he was immensely pleased when one arrived in the mail for him.

MOLAR Movement

Jeffrey A. Kobernik, DMD; Steven E. Timm, DMD

"I smiled tremendously," he says. "I think it really hits a chord in the Portland area, especially because of the popularity of the Timbers and the Thorns."

Campbell says she enjoys the scarf's bright colors and playful pun. As the committee talked about designs for the scarf, the idea of the "molar bear" initially started as a silly suggestion. Now it has become a highly sought-after article that symbolizes professionalism, membership, and oral health awareness, she says.

"To me, the Molar Movement is a way to visually distinguish those individuals in our field who decide to devote their time and resources to becoming involved in the many aspects of organized dentistry," Campbell says. "So many dentists, specialists and students are passionate about legislative issues, community service, leadership and making changes for the better, and the scarves signify the wearer's dedication to our profession.

"The scarf's design invites colleagues and the public to approach its wearer and learn more about policies facing our profession, public outreach, and oral health in general," she adds. "In addition, the scarf is also a way to visualize just how many people are becoming involved in this movement, and I can already see it gaining momentum at the School of Dentistry."

Kristen Andrews, the ODA's Membership Specialist, says the association distributed the scarves to participants during Dental Day at the Capitol in February and will do so again on Signing Day. The ODA plans to make the scarves available for purchase during the Oregon Dental Conference in April and through the association's website. ●

Melody Finnemore is a freelance writer for ODA and a partner in Precision Communications. She can be reached at *precisionpdx@comcast.net*.

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Contemporary management of the edentulous maxilla

By Carlos M. Ugalde, DDS, MS

Co-Author, David R. Halmos, DMD

Dr. Ugalde is a Diplomate of the American Board of Oral and Maxillofacial Surgery. He is an oral surgeon at Sunset Oral and Maxillofacial Surgery, in Portland. He can be contacted at *cugalde@sunsetoms.com*.

IMPLANTOLOGY HAS BECOME one of the main focuses of modern dentistry. The high success rate and longevity of dental implants, documented over the past 50 years, has increased awareness in both the public and professional community. Implant supported restorations provide the best alternative for the rehabilitation of the partial or completely edentulous patient. The patient satisfaction is higher than any other restorative option providing advantageous psychological outcomes. Currently, our profession has a high demand for dental implants due to an increase in the aging population and to all the benefits that this restorative option provides.

Multiple problems have been associated with edentulism and its traditional management. Edentulous patients treated with complete dentures may suffer from a 75% reduction in the normal bite force when compared to a natural dentition.[1] In consequence, their food selection is very limited, with less intake of vegetables, carotenes, and fiber, and a high tendency to consume high cholesterol and saturated fat foods. Recently, a literature review confirms that completely edentulous patients have a higher risk to develop multiple systemic disorders.[2] The combination of poor oral intake, compromised dental function, and malnutrition, leads to a reduction in the patient's quality of life and may lead to debilitation, illness, and potential decreased life span.

Implant therapy to address the shortcomings of traditional dentures have mostly focused on the mandibular denture as this has been the most problematic for patients. Over the last five decades, our profession has addressed the mandible in several very successful ways including the mandibular, fixed, implant supported restoration. The maxillary prosthesis, on the other hand, has proven to be more challenging for dental implant restoration. The anatomic structures, such as the nasal floor and maxillary sinuses, limit the ability to place implants in a vertical position. Many situations required the use of sinus augmentation, increasing the morbidity, time, and cost of the treatment. Therefore, many providers do not offer, and many patients do not pursue, a fixed arch restoration of the edentulous maxilla.

Treatment options for the edentulous maxilla

Historically, the most traditional option for the edentulous maxilla has been the complete denture. It is usually the most popular due to the low cost and wide accessibility of this treatment option. Most dentists would agree that a removable denture is a poor substitute for a natural dentition but makes for an acceptable substitute compared to living without teeth. Nevertheless, few patients would opt for this type of removable prosthesis when given the choice for a fixed solution. In some cases, however, this is the best treatment option, and the patient is comfortable with the modality of treatment.

Implant-retained overdentures, using the Locator Abutment System for example, have been a good alternative for the edentulous patient. However, these prostheses are most often tissue-born and, thus, have the usual problems that come with a tissue born prosthesis. Maintenance issues increase (wear of the nylon components or the abutments themselves) when compared to a traditional denture, especially when the overdentures are incorrectly constructed to support, rather than retain, the overdenture. Treatment options typically include two to four implants, which also increase the expense of this treatment option. While overdentures have been a wonderful alternative to traditional dentures, they still are considered removable prostheses and do not compare to the patient satisfaction associated with fixed prosthetics.

Porcelain fused to metal restorations, typically in the form of fixed partial dentures supported by implants, have been used very successfully as an alternative to the traditional denture or overdentures mentioned above, with the benefit of being a fixed solution. The prostheses usually require six to eight

dental implants for the completely edentulous arch and face the usual anatomic limitations that are inherent in the maxilla. The need for posterior support of the prosthesis typically requires attention to be paid to the maxillary sinuses, and while the literature has documented the success rate of maxillary sinus augmentation in systematic reviews to be around 90–93%,[3,4,5] the success rate is lower when compared to implants in native bone. The fixed prosthesis is an inherently expensive prosthesis due to the number of implants and components involved and the time required by the surgeon, restorative dentist, and dental laboratory. Other limitations include an increased treatment time for the restoration because of the two stage protocol that is often followed and the inability to immediately load the prosthesis due to the lack of immediate cross arch

stabilization. Due to these limitations, we are faced with decreased patient acceptance of the treatment modality.

What do patients want?

Most practitioners involved in treating the edentulous patient with traditional complete dentures have heard the common complaints of denture sores, a lack of stability and retention of the prosthesis, and an inability to masticate effectively. For patients contemplating implant therapy to treat their edentulism, the complaints typically revolve around treatment time, comfort during the healing phase, the number of surgical procedures, and the expense associated with it.

The tilted implants concept

Tilted implants were described shortly after the concept of osseointegration was introduced to North America in 1982. Some of the first implants to be placed with non-axial loading were the Pterygoid/Tuberosity Dental Implants that were first described in 1985.[6] The positioning of the dental implant was used to overcome anatomic obstacles, such as the maxillary sinus, in the posterior maxilla when bone was available in the maxillary tuberosity *(see Photo 1)*. This type of implant has been used for 30 years with success well documented in the literature.[7,8]

Photo 1.

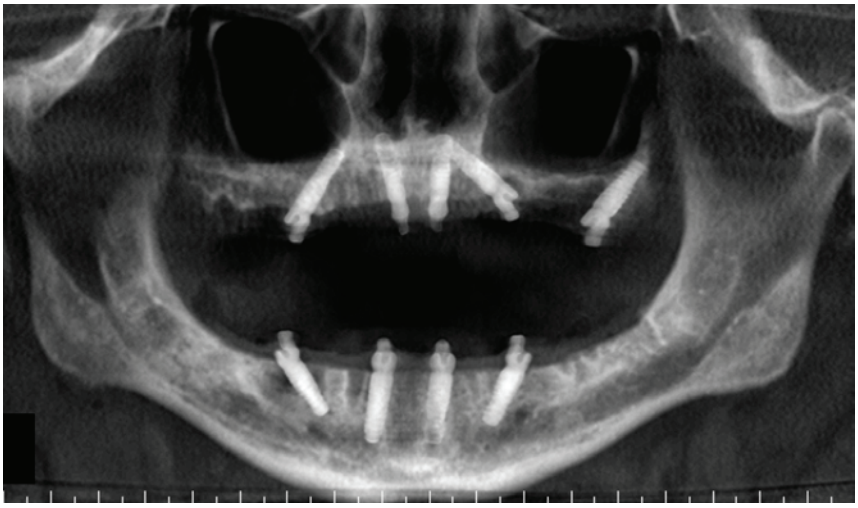


Photo 2.

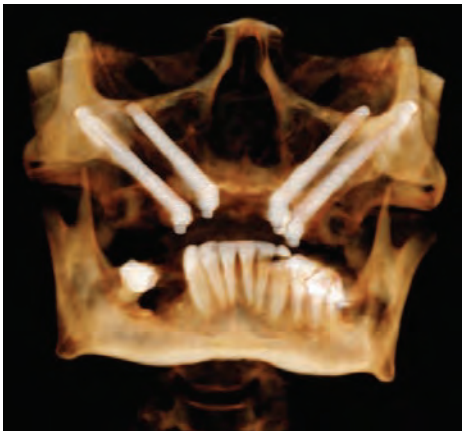
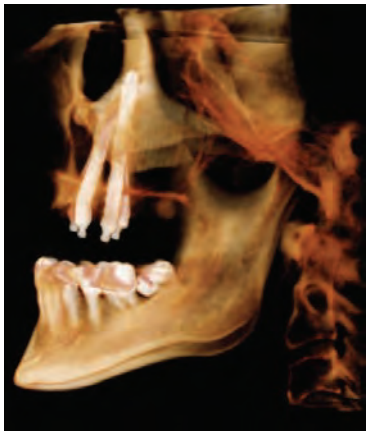


Photo 3.



The Zygomaticus Implant, another non-axially loaded implant, was created by the late Professor P.I. Branemark and has been commercially available for the last 25 years.[9] This type of implant also allows implant rehabilitation of the posterior maxilla without the need for sinus augmentation *(see Photos 2 and 3)*. The approach is recommended for the severely atrophic posterior maxilla, with anterior extension of the maxillary sinuses up to the bicuspid area. Zygomaticus Implants where introduced in 1998 by Branemark and carry a high success rate reported between 94%–100%.[10,11]

In the last decade, the concept of using tilted implants to avoid anatomic structures has eliminated the need for bone grafting procedures, while simultaneously obtaining adequate primary stability to permit immediate function and immediate fixed restoration. The concept, commonly referred to as "all-on-four," incorporates tilted implants similar to the Zygomaticus protocol and the Pterygomaxillary implant protocol. Use of the all-on-four protocol has addressed many of the disadvantages, mentioned above, of more traditional methods used to treat the edentulous patient.

Biomechanics of tilted versus axial implants

To address the biomechanics of dental implants in human bone, the Skalak model was created in 1983 and establishes that a given number of implants distributed within a defined anterior posterior spread will follow a mathematical equation.[12] Biomechanical studies using this model involving the number of implants and their angulation were performed by Brunski.[13] The results showed that the load on a fixed prosthesis involving

four versus six implants was not dramatically different when the most posterior implants were placed in the same position.

Interestingly, when this model is applied to tilted implants, the stress on tilted implants is as great as with vertically placed implants. A 30 degree distal implant tilt appreciably decreases the force on the dental implants by redistributing the load. Brunski also suggested that a lower force on the tilted implant and components could reduce stresses and strains associated with the tilted position of the implant.

A study by Lambert, et. al.[14] determined that it is not the number of implants but the anterior-posterior spread of the implants that is important in the distribution of stress to the implants. Other studies have shown no difference between tilted versus axial implant success.[15,16,17]

Immediate loading

The concept of immediate loading was introduced in 1990, and the initial research pointed to suboptimal success rates compared to delayed loading protocols. In the last 15 years, however, the success has been well documented in the literature, with results showing high survival rates and a low incidence of complications in the maxilla between 94–98%.[18,19,20,21,22] The introduction of Cone Bean Computed Tomography (CBCT) has facilitated a practitioner's ability to examine a patient's anatomy and allow a surgeon to better predict the bone density and volume when attempting implant placement and immediate loading. The advancements in imaging and the related software have allowed better planning and estimation of the results of surgery.[23,24,25,26,27,28]

Evolution to the all-on-four concept

The benefits demonstrated with the use of tilted dental implants and in conjunction with the evidence of immediate loading evolved to the all-on-four (AO4) concept introduced by Maló, et. al.[29] The AO4 concept consists of rehabilitating the edentulous arch through a fixed prosthesis supported by four tilted implants. The posterior implants, placed at an angle, are used with axially placed anterior implants providing appropriate anterior-posterior spread and allowing for immediate loading under most circumstances *(see Photos 4 and 5)*.

This concept, first popularized in 2003, was a considerable departure from the traditional concepts put forth by P.I. Branemark four decades prior. Due to the radical differences, questions about implant survival, bone resorption, prosthesis survival, and the ideal number of implants have emerged. The first studies documenting this technique had few patients and were not statistically significant. Since then, there have been more additions to the literature supporting success rates in the mandible at 97.5–99.0% and in the maxilla at 93.0–99.0%.[30,31,32,33,34,35]

Photo 4.

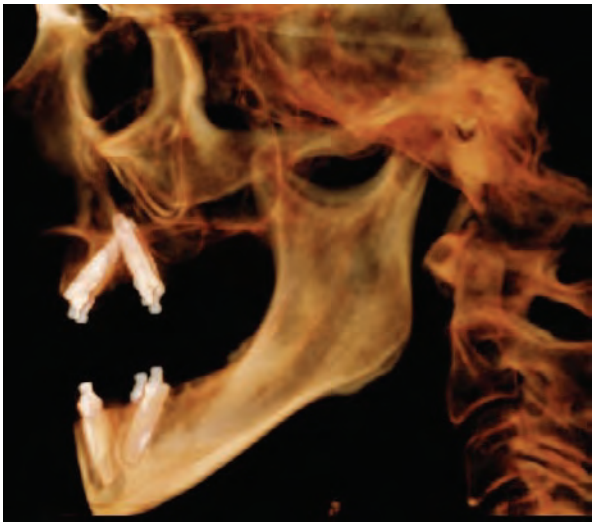
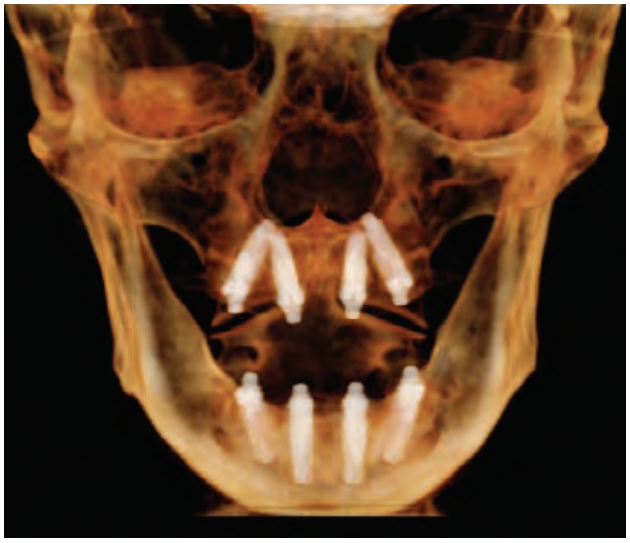


Photo 5.



Advantages of tilted implants

There are multiple benefits of tilted implants when compared to our more traditional methods of axially loaded implants. Tilted implants avoid various anatomic structures and allow us to use fewer implants to support the same prosthesis. The elimination of bone grafting procedures provides a shorter total treatment time, less patient morbidity, decreased cost, and possible immediate restoration. Tilted implants also provide an increase in the anterior-posterior spread, resulting in a stronger prosthesis by eliminating or shortening distal cantilevers that are common with non-tilted implants used to supported fixed prostheses.

Risks and failures

In a recent study, Parel et.al.[36] described risk factors that must be considered when contemplating the use of tilted implants. The primary factors identified included a natural opposing dentition, poor bone density, bruxism, and male gender. Secondary factors, such as smoking and poor bone volume may increase the failure rate and consideration should be given to these risks by the placement of additional implants or delayed loading.

Conclusion

The fundamental idea in today's use of titanium root forms to support prosthetic appliances is relatively unchanged when compared to the original concepts put forth by P.I. Branemark decades ago. However, use of modern implant surfaces, improved materials, different implant designs, and expansion of our knowledge and literature base have caused a change in the protocols that were used decades ago. Part of this change has led to the more common use of tilted implants and their use has allowed for a radical expansion of the surgical and prosthetic possibilities that our profession can offer our patients. The dental profession is now able to treat the edentulous maxilla with a larger arsenal of tools which now includes a fixed, implant-supported prosthesis that can be done in less time, with less cost, and with reduced surgical intervention than options we have had in the past. ●

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Protecting your practice from fraud

By Christopher Kane

BEING A DENTIST TODAY IS much different than it was just a few years ago. Gone are the days of paper records, manual tools, and "analog" records. Technology has fundamentally changed everything from our home life and personal time, to certainly the way dentists operate their practice. Today's dentists and administrators are living the revolution of electronic records, with all its convenience and access. But that convenience and access comes at a price. Fraud and electronic theft are real threats to every practice, and every dentist needs to be keenly aware of the tools and steps needed to protect your most precious investment.

In fact, the National Health Care Anti-Fraud Association (NHCAA) estimates that the financial losses due to health care fraud are in the tens of billions of dollars each year.

So how can technology help reverse this trend in losses each year?

The first step is to strongly consider switching to an online business banking platform. Online banking is a powerful way to maximize your productivity by completing a number of transactions with the bank, securely through the internet, and at your convenience. But just as importantly, it provides a strong firewall to fraud.

Online banking

- Allows you to view balances and activity including images of checks written and deposited paper items.
- Allows you to stop payments immediately on an account.
- Provides a messaging vehicle to communicate securely with the bank.
- Provides online balance alerts to indicate a potential problem.

Automated Clearing House (ACH)

The second step could be to utilize Automated Clearing House (ACH), which is an electronic network for financial transactions in the United States providing users the ability to utilize direct deposit payroll and vendor payments.

Christopher Kane is vice president and commercial banking manager at Pacific Continental Bank. He can be reached at *christopher.kane@therightbank.com*.

> ***...financial losses due to health care fraud are in the tens of billions of dollars each year.***

ACH offers practices the power to electronically disburse or collect funds to employees, vendors, and other partners. This is an obvious convenience, but it can also help protect your practice.

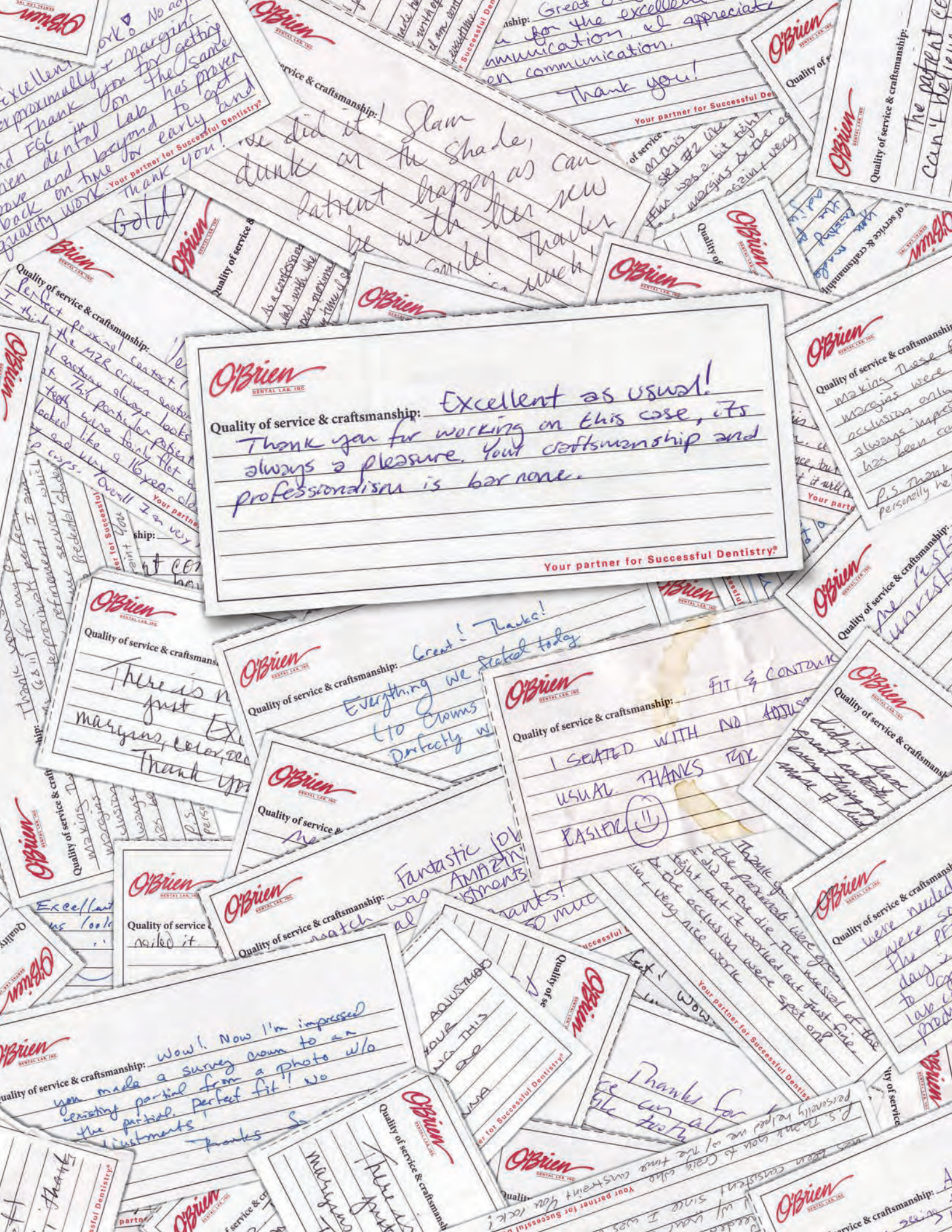
- ACH reduces the chance of check fraud, as lost and stolen checks are eliminated and there is less potential for the introduction of counterfeit checks, stolen checks, washed checks, altered amounts, or forged signatures.
- According to *www.directdeposit.org*, the likelihood of having a problem with a paper check is 20 times greater than with ACH direct deposits.

Remote Deposit

Finally, there is the option of remote deposit. This capability allows users to scan checks from their desktop and present an electronic version to their bank for deposit at their convenience. One of the biggest advantages of this tool is keeping deposit information safe. Managing deposits in-house allows you to keep your practice's financial information secure because it never leaves the office. All information is protected with encryption technology, for the best security over the Internet.

Conclusion

Indeed, as dentists and health care providers know, better than anyone, technology has revolutionized the way care is delivered. And just as you work to keep your skills sharp by learning and implementing the latest innovations in patient care, your back office operations should also keep pace with modern improvements. By using technology to protect your practice, you virtually guarantee your ability to continue to provide that care into the future. ●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Dental practice employment law update

After Measure 91, is marijuana just another legal drug?

By Randall Sutton

RELIABLE AND PRODUCTIVE STAFF is the backbone of every dental practice. It is well known that substance abuse problems can interfere with work. Unreliable attendance, lack of focus, and poor decisionmaking are common outcomes of staff substance abuse. For these reasons, many dental practices find it critical to maintain a drug-free workplace.

With that in mind, it should come as no surprise that the legalization of marijuana for recreational use poses new challenges for dental employers. If the experiences of Colorado and Washington are any indication, Oregon is likely to see a significant increase in the number of employees testing positive for marijuana. In the year following legalization in both states, positive tests increased by over 20% according to a recent study by a national testing lab. Moreover, the decriminalization of marijuana and resulting drop in prices, combined with tightened controls on prescription drugs, has led to a surge in the manufacturing and importation of heroin into the United States from Mexico. Given the level of dependability, skill, and professionalism required of dental staff, these developments make an enforceable drug and alcohol policy and testing program more important than ever.

> ***Given the level of dependability, skill, and professionalism required of dental staff...an enforceable drug and alcohol policy and testing program [are] more important than ever.***

The recent change in the law has also brought changes to perceptions and expectations about marijuana use, particularly on the question of whether the drug should be subject to looser regulation by Oregon employers. As of July 1 of this year, marijuana will join alcohol as the only legal intoxicants that can be used recreationally. Given the significant change, your staff may erroneously anticipate that marijuana use will be treated the same as alcohol use. Under Oregon law, a dental practice cannot test for alcohol use unless a trained individual determines that the staff member is presently (and visibly) under the influence. Similarly, staff may believe that after July 1, 2015, they may use recreational marijuana away from work so long as they do not appear to be under its influence while at work.

However, testing protocols and Oregon employment laws treat marijuana very differently than alcohol, and the new law allowing recreational use does nothing to change that. Marijuana is fairly unique among the drugs typically included in an employment-related test panel. Unlike other drugs, which leave one's system in a matter of hours or days, THC (the active ingredient in marijuana) is stored in fat cells in the body and tests may be positive weeks or even months after the staff member's last use. Second-hand smoke can also trigger positive results, but testing cutoff protocols are intended to screen out results that arise solely from spending time around pot-smoking friends or colleagues. In any event, marijuana is unlike alcohol because there is no recognized test to determine whether your staff member is presently impaired by marijuana.

Not only are testing protocols different for alcohol and marijuana, but Oregon laws treat them differently—even after legalization of recreational marijuana. Since Prohibition ended in the 1930s, alcohol has been legal at the federal level. In contrast, marijuana continues to be illegal under federal law. For employers, this distinction is critical. Given that federal law continues to identify marijuana as a Schedule I controlled substance with no accepted medical use, the Oregon Supreme Court held in a 2010 decision that Oregon employers can enforce zero tolerance policies, even against authorized medical marijuana users. Measure 91 does little to change that holding, as the new law specifically does not "amend or affect in any way any state or federal law pertaining to employment matters."

In other words, Measure 91 does not require that you abandon zero tolerance drug and alcohol policies or make significant changes to testing protocols. But, in light of changing perceptions about the drug, we recommend

Randall Sutton is the partner in charge of the employment law and litigation practice group at Saalfeld Griggs, PC. Visit *www.sglaw.com* for more information.

that dental offices update their policies to address the issue of recreational marijuana use and make it clear that the drug is still illegal under federal law and prohibited under the practice's drug and alcohol policy.

This is also a good time to ensure that your drug and alcohol policy strictly complies with the myriad of complex drug testing legal requirements. In Oregon, there are restrictive regulations governing whether or not a termination resulting from a positive drug test affects the staff member's ability to collect unemployment benefits, and it can be challenging to win unemployment appeals if the practice's policy is not sound and all regulations are not followed. For these reasons, dental practices should work with employment counsel to review and update their drug and alcohol policies before recreational marijuana is decriminalized on July 1. ●

Mary Daly shares tales from the road as she embarks on new adventure

By Melody Finnemore

AFTER TRAVELING THOUSANDS OF MILES around Oregon to ensure that scores of underserved children received high-quality dental care, Mary Daly, the Tooth Taxi's project manager, has ended what she called her most challenging and rewarding job.

Daly helped establish the mobile dental care program in 2008, and became a familiar, friendly face as she traveled with **Dr. Weston Heringer, Jr.,** to provide care for low-income children. Daly says she treasured the ability to connect with students, community members, dental professionals, and school personnel, while witnessing firsthand the state's changing population demographics and diverse landscape.

Education is a key component of the program, from teaching children how to care for their teeth (and how to share that knowledge with their parents) to educating the general public about the Tooth Taxi's mission through various forms of media.

"People often commented on their surprise at the realities of the road. Most of us middle-class folks are so accustomed to growing up with dental care, it is shocking to hear stories about kids who don't have a toothbrush, or that their dad borrowed it to clean machinery. About 10 percent of students we saw had never been to the dentist before. And the poverty level of families was alarming," Daly says.

The logistics of running a dental clinic out of an RV presented some problems along the way. Daly did troubleshooting on the roof and under the vehicle. The Tooth Taxi has been stranded roadside, was in an accident, and has been caught in a snowstorm, not to mention the wildlife encounters. Scout, Daly's English Springer Spaniel, occasionally joined the adventure as well.

Life in the Tooth Taxi brought many rewards, too. Daly recalls staying in a small coastal town and returning to her hotel room to find a handwritten note from a maid thanking her for the care her daughter received. Smiles, high-fives, and hugs from kids who were no longer in pain, and on the path to healthy teeth, also mark highlights of Daly's career.

Several colleagues lauded Daly's accomplishments and attributes, as she handed the reigns to new manager, Carrie Peterson.

"Mary was one of the key players in the development and launching of the Tooth Taxi back in 2008, and her contributions were critical to its success," says Charlie LaTourette, executive director of the Dental Foundation of Oregon.

"She had to juggle a hundred different things every day to make sure the Tooth Taxi operated smoothly," he says. "She helped thousands of vulnerable children get the dental care and oral health education they deserve, and those healthy kids are a wonderful legacy to her effort. We wish her the best in her future adventures."

Holly Spruance, executive director of OEA Choice Trust—which sponsors the Tooth Taxi along with the DFO and Moda Health—says she admires Daly's dedication, creativity, efficiency, and decisiveness.

"Mary started the weekly Tooth Taxi recaps, speaking to the incredible work the team does, and always sharing something unique about the community the Tooth Taxi had visited. I have always thought she should put a book

The Dental Foundation of Oregon is the charitable arm of the ODA.

For more information, visit *www.SmileOnOregon.org*.

together about the Tooth Taxi travels," she says.

Dr. Heringer, Dental Foundation of Oregon president, says Daly gave more than 100 percent to her work, which enhanced his experience as well.

"The Tooth Taxi was a highlight of my career, and Mary made that happen," he says. "I finally figured out at the end that she was the boss, but she was kind enough to let me think I was running things." ●

Melody Finnemore is a freelance writer for ODA and a partner in Precision Communications. She can be reached at *precisionpdx@comcast.net*.

Carrie Peterson

Tooth Taxi Program Manager

Welcome Carrie!

Carrie comes to the Tooth Taxi team with over 16 years experience in the dental field. She has volunteered for several years, including working on the Tooth Taxi, as well as serving at Oregon Mission of Mercy, working on the MTI dental van, and providing dental screenings at elementary schools in her community.

In her spare time, Carrie enjoys spending time with her husband and two sons, as well as reading, camping, and hiking. Carrie brings passion for children's oral health and extensive dental experience to the Tooth Taxi, and we are delighted to welcome her aboard!

Poker tournament raises $18,000 to help kids

Nearly 70 players put on their best poker faces for the DFO Texas Hold'em Poker Tournament, presented by Bnk Construction, on Saturday, January 31, at the Moda Plaza in Milwaukie, and helped raise over $18,000 for DFO and programs like the Tooth Taxi.

Thank you to the table sponsors, who included: BnK Construction, Columbia Bank, Advantage Dental, Gramor Development, Kaiser Permanente, Paltzer Wealth Management, Deadwood Mechanix, and Moda Health.

Jim Jenkins was the last man standing, finishing with the largest pile of chips.

Runners up, in order, were: Naomi Simon, **Dr. Brad Sievert**, Eric Lingo, **Dr. Jason Bajuscak** (previous tournament winner), Sam Slaughter, Robbie McEachern, and Jim Fogel. Congratulations to all!

Poker tournament winner, Jim Jenkins (right), with Rick Shandy of BnK Construction.

"It was another fantastic event thanks in great part to the folks from BnK Construction and our many sponsors and players," said Charlie LaTourette, DFO's Executive Director.

Read the full poker wrap-up on the DFO website at *www.SmileOnOregon.org*

Don't miss the DFO Motor Mouth car raffle at the ODC!

This is your chance to drive away with a new car, and support programs of the Dental Foundation of Oregon, like the Tooth Taxi!

$100 per ticket

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The winning ticket will be drawn at approximately 12:45 pm in the Exhibit Hall on Saturday, April 11, 2015. Participants need not be present to win. Only 1,000 tickets will be sold.

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