PUBLISHED BY THE AMERICAN ACADEMY OF IMPLANT DENTISTRY / 2020 ISSUE 3

AADNEWS

Playing the Insurance Game

Understanding the business of running a dental practice

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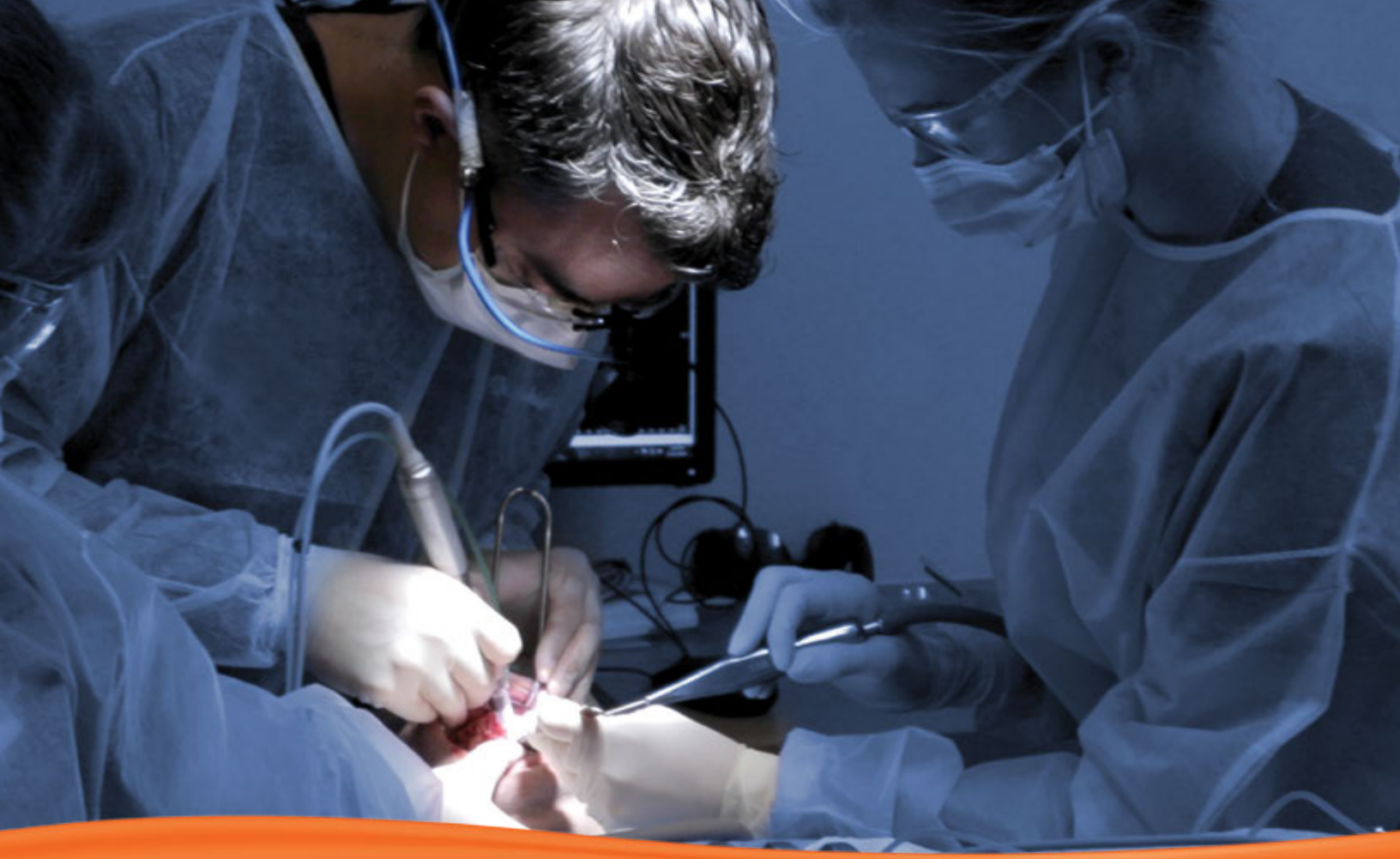

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Lead Stories

AAID News

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Editor, *AAID News*

EDITOR'S NOTEBOOK

Avoiding the Rear-View Mirror and Looking Forward

As we all know, the reactions to the COVID-19 issue has altered much of what we thought was a normal life. It will be interesting to see how we view this whole episode a decade or so from now. We will quite possibly look back and realize that some of the strategies were poorly thought out and should never have been pursued. Some will chalk that up to poor judgement by medical and political leaders, and no doubt some will believe many errors have been made. Other decisions hopefully will look like episodes of pure genius where we will marvel at well carried-out strategies when seen more clearly in retrospect. As we assess blame and credit, we could take a charitable view and call it a "fog-of-war" kind of circumstance where even the perceptions of "experts" are distorted by inadequate and rapidly changing information.

It is always easier to recognize errors when we are looking in a rear-view mirror. Looking forward is never quite so clear. As long as the intentions were honorable and not sullied by arrogance or self-interest, we should be tolerant of those on the firing line who have to make the tough decisions.

While it is hard to see the good side of the virus experience, it is possible that there is a positive side. One political leader I spoke to posed the possibility that this may be a "primer" for a more serious challenge that may lie ahead. While COVID-19 kills primarily the compromised and elderly part of the population, we should remember that some previous pandemics targeted the young and had much higher death rates.

As members of the AAID, many of us experienced an annual meeting like no other. It was of course a virtual event, but it still managed to offer great value to those who participated. Technologically, it was well planned and carried out. The continuing education offerings were outstanding, and there is much to be said about the option of viewing the material at your own best time from a comfortable location.

While the absence of hotel bills and travel expenses are a positive, the other side of the equation is the loss of interactions with our friends and colleagues. As usual, we frequently don't fully appreciate what we have until we lose it. Though continuing education credits play a role, much of what we learn comes not from the podium, but from the observations of our fellow clinicians at a luncheon or hallway conversation.

Attending a live event has a re-invigoration factor in its favor that "Zoom-type" events will never match. It is the best antidote for any tendency toward "burnout" and is a near essential part of professional life.

Barring a major setback, 2021 should bring with it the normal agenda of live meetings for which the AAID is so well appreciated.

As long as the intentions were honorable and not sullied by arrogance or self-interest, we should be tolerant of those on the firing line who have to make the tough decisions.

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Bernee Dunson,
DDS, FAAID, DABOI/ID
2020 AAID President

PRESIDENT'S MESSAGE

The Value of The AAID Credential . . . Priceless!

Obtaining a credential in the American Academy of Implant Dentistry is a significant accomplishment and it is not for the faint of heart. Those who embark on the credentialing journey must be dedicated individuals who are committed to putting in the effort and motivated to face the challenges of the process. This results in achieving the goal of competency and confidence.

As the Academy celebrates its 70th year, we reflect on our central mission: *Providing quality "implant education" and serving as the "credentialing standard" for the discipline of implant dentistry.* The profession of dentistry has well acknowledged that this unique discipline is restorative in nature but also has a surgical component. I have to compliment the visionaries of our Academy for creating a credentialing process that makes you a better implant dentist.

This credentialing program has two strategic parts.

Part 1 acclimates dentists to the basic sciences, which provides a foundation for success in implant dentistry. Through a written examination knowledge is assessed on the basic sciences and provides an understanding of implant dentistry principles and the ability to apply these principles in a clinical situation.

Part 2 challenges you to become a better diagnostician and combines case-based learning and problem-solving along with evaluation of cases that you submit. Completing this rigorous process, candidates challenge themselves to diagnose, create treatment plan solutions, and make decisions on the delivery and maintenance of care. These steps solve dental implant problems with greater predictable outcomes.

The AAID credentialing process reminds me of Stephen Covey's concepts in *7 Habits of Highly Effective People.* And while there are only two parts to the AAID credentialing process, it can set the tone for the long-term success of the implant dentist. The process of becoming credentialed creates the environment to become a highly effective dental implant clinician.

This leads to the final question: Do you really need to become credentialed? I submit that having a dental license to practice dentistry is a "must-have." If you desire to expand your knowledge in implant dentistry, obtaining the credential is a "should-have."

"We make a living by what we get, we make lives by what we give." The confidence that is obtained by becoming credentialed in the American Academy of Implant Dentistry is … *priceless!*

As the Academy celebrates its 70th year, we reflect on our central mission: *Providing quality "implant education" and serving as the "credentialing standard" for the discipline of implant dentistry.*

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Playing
the Insurance Game

Understanding the business of running a dental practice

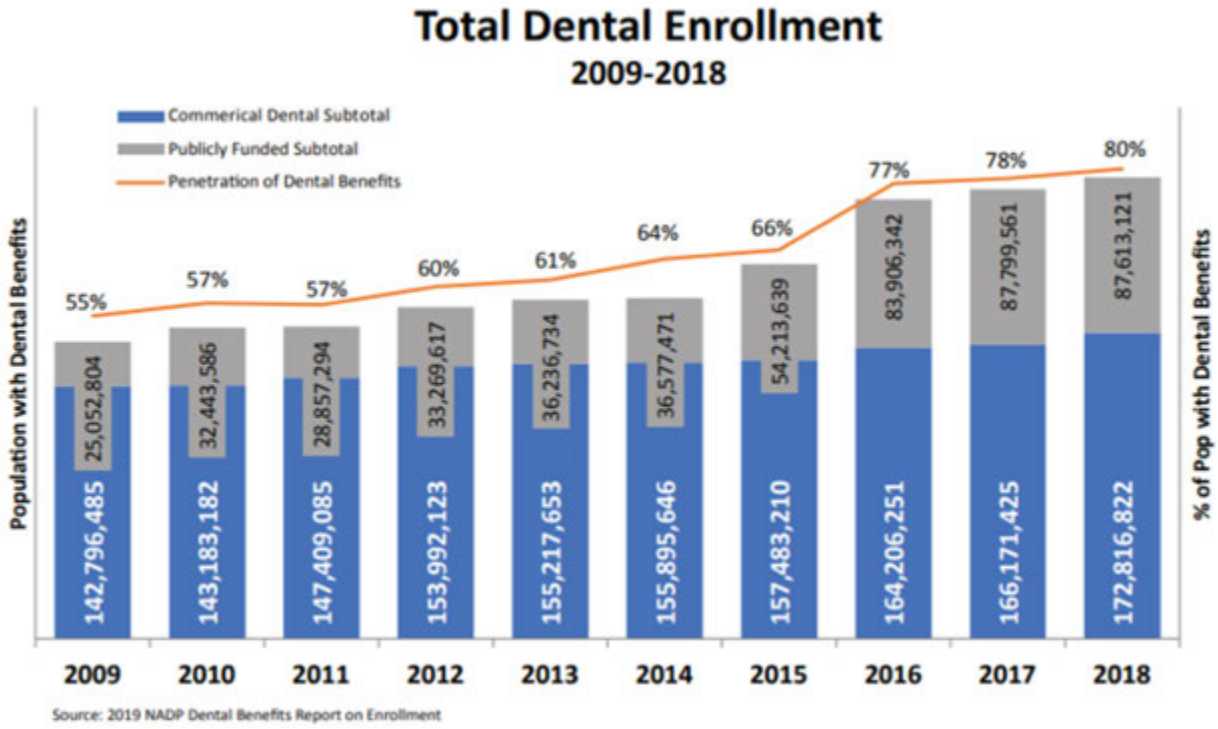
By Bonnie Litch

While dentists know they are in the business of helping patients achieve and maintain their best oral health, they should also be dedicated to the business of dentistry. It is critical to learn all business aspects, specifically the choices, impact, and intricacies of patient insurance.

When it comes to insurance, are you optimizing insurance revenues in your practice? According to the 2019 NAPD Dental Benefits Report, more than 80% of the U.S. population has dental benefits.

Nicholas Partridge, founder and CEO of Five Lakes Dental Practice Solutions in Mayfield Heights, Ohio, believes when it comes to insurance, "you really can't avoid it."

"Most dental schools don't offer much in terms of a formal education around business," states Partridge, "yet dentists have to understand aspects of insurance, OSHA, accounting, and staff management. They are business owners without the business curriculum."



Conduct an in-house analysis of your current insurance relationships

"Before the decision to enter or exit a dental insurance plan or negotiate reimbursement fees, I advise clients to conduct an insurance analysis," states Roger P. Levin, DDS founder and CEO of the Levin Group in Owings Mills, Maryland.

Partridge emphasizes that, with the proliferation of PPO participation today, "you really need to look at your revenue cycle, how you are contracted, and at what rates." He believes that dentists should look at insurance issues with a focus like never before. He asks clients, how often are you reviewing your office fees and when are you scheduled to renegotiate with carriers? Or to evaluate network sharing agreements between insurance companies to maximize reimbursements.

Tom Limoli of Limoli & Associates in Atlanta, Georgia, asks his clients to calculate how much revenue they make per hour per chair, as well as their expenses. He says dentists must know how to determine the potential reimbursements per new patient when signing with a particular insurance company. He believes that "no one should ever participate with a plan that is going to reduce their full fee unless they need patients to fill empty, open, available chairs."

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In or Out of Network?

Should you participate in a plan? In Limoli's opinion, it depends on whether you can fill that chair at the price you want to charge for it. He says, "If your total unrestricted fee for a crown is $1,000 and you have patients willing to pay that amount and your patient capacity is at 110%, you can charge that amount and do not need to partner with an insurance company. However, if you cannot fill that chair, you may need the patients with benefits to maintain your practice. So, what does that look like? Beyond the negotiated Maximum Allowable Amount may be an emotional number—it doesn't exist if you don't have a patient willing to pay the full amount."

"The question you have to ask yourself is," states Partridge, "What are the benefits and drawbacks of being in-network? Going in-network means that I have to accept a reduced payment instead of my full fee. What am I getting for that discount? If I know that people with a dental benefit are 2.5 times more likely to visit the dentist and 85% of patients visit an in-network doc, practitioners have to address the insurance game more seriously."

This is the reason the Levin Group Data Center is seeing a decline in the percentage of practitioners that are solely "out-of-network" or fee-for-service (FFS), predicting that only 5 to 6% will be FFS by 2021.

Another strategy to eliminate the time a dentist has to navigate the insurance claim process is to create your own in-office plan for patients without any other form of coverage. The American Dental Association is promoting Bento, a program for practice owners to customize their own plans, simplifying the claims process, and decreasing administrative costs. Offerings two types of dental products—an in-office plan and a self-funded employer-sponsored group or individual plan—Bento is a modern alternative to traditional dental insurance. It enables employers, groups, and individuals access to comprehensive dental coverage through an advanced AI-based digital platform. The Bento kit includes marketing templates to help recruit patients and encourage them to use your plans. For more information, visit www.ada.org.

The patient-dentist relationship is important to patient satisfaction and regularity of care

Most patients (85%) visit an in-network dentist and nearly half see a dentist referred to them by a relative or friend. Either way, once they find a dentist they like and trust, many choose to stay with that practice. They will not switch dentists, which is one reason network size is so important.

Those who have been with their current dentist longest are most likely to receive regular care, report better oral health, and are more satisfied with the quality of care received.

Furthermore, patients who have long-standing relationships with their dentist rate the quality of their care higher than those who don't.

Length of patient-dentist relationship

	1–2 Years	3–9 Years	10+ Years
Visit dentist 2x/year	35%	49%	**57%**
Excellent/very good oral health	38%	50%	**60%**
Highly satisfied with quality of care	74%	86%	**92%**

Source: Dental Benefits 2020: Maintaining oral health during COVID-19 and beyond. The Guardian Life Insurance Company of America, New York (c) 2020.

Process and logistics: scheduling, financial arrangements, EOB, payment responsibilities

Dentists should consider the bottom line from the moment that an appointment is scheduled. Understanding the revenues/expenses per hour per patient in the chair will help determine how best to schedule caseloads. "If there is a booking imbalance toward reduced fee patients as well as lower revenue generating procedures such as teeth cleaning over higher revenue opportunities, the practice could suffer financially," says Limoli.

Limoli says sometimes there is a miscommunication surrounding the concept of insurance. "There is no such thing as an insurance portion versus patient portion. Patients are responsible for the agreed upon fees due (either in- or out-of-network); dental benefits are simply a device that individuals in the workforce use to help offset the cost of dental care." He thinks dentists should convey the full cost of care with details about how the benefits cover the treatments. This means giving patients a true picture of the costs that includes the Maximum Allowable Charge specified on the Explanation of Benefits (EOB) and the total cost.

Network partnerships: consider your competition and market your in-benefit practice

"Today, being in-network is no longer a novel competitive advantage. Most dentists are in-network and you have to do something else to differentiate your practice," states Partridge. "Dental benefits are more in-your-face now. As a result, dentists have been more open to going in-network. Plus, insurance companies have greatly expanded their reach through network leasing—partnering with other companies so you may be affiliated with more than the one with whom you negotiated. This may become complicated if you have negotiated different rates with different carriers. Even if you drop one of your plans, patients may still find you through a networking partnership they have with another company."

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Insurance Tips for New Dentists

Just starting out? Levin notes that many new practitioners, associate or partner with long-standing practices, learn the "tricks of the trade" from those already in the business. Partridge concurs, pointing out that this strategy can also help in terms of timing as newly minted dentists can quickly affiliate with insurance companies through the credentials of more experienced dentists.

For those who open their own practice, "the last thing you think about when creating a startup is insurance and getting credentialed," states Partridge. "Insurance companies aren't standing by to process you into the plan so that you can treat patients right away. Therefore, plan ahead of time for the weeks you will be out-of-network to minimize disruption." Farran advises hiring someone in the new office to serve as the benefits coordinator or bookkeeper and think about taking on business management classes.

"Before the decision to enter or exit a dental insurance plan or negotiate reimbursement fees, I advise clients to conduct an insurance analysis," states Roger P. Levin, DDS founder and CEO of the Levin Group in Owings Mills, Maryland.

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> "There is no such thing as an insurance portion versus the patient portion. Patients are responsible for the agreed upon fees due (either in- or out-of-network); dental benefits are simply a device which individuals in the workforce are using to help offset the cost of dental care."

Partridge advises his clients to collect relevant information when deciding on whether and what type of insurance plan to get involved with by asking:

1. Look at your existing patients, where do they work? What insurance is the most prevalent?
2. Look at the employers in your area, who is offering insurance and what kind is it? Are you in-network for those plans? Are your competitors?
3. What services do you offer and what is your current fee schedule?
4. How are you attracting and retaining patients?
5. What do you want to accomplish for the rest of your career? What are your short- and long-term goals?

"Answering these questions along with compiling valuable information is paramount," states Partridge. The next step is review all of your contracted rates and negotiate with other companies in the context of your practice goals.

In terms of marketing a practice, Howard Farran, DDS, a practicing dentist in Phoenix, Arizona and the founder and owner of Dentaltown.com and Dentaltown Magazine, recommends that dentists list their insurance partners as part of their online SEO information so that their practice comes up in a Google search for "Dentist near me who takes my insurance." Farran adds, "Try to keep as much carrier information as possible on your website. Make a video with your finance coordinator, connect to YouTube, add an FAQ—do everything on your website to get patients' attention."

Optimizing your bottom line

Analyzing and strategizing your partnerships with dental insurance carriers can make or break your financial success. Whether you conduct this investigation on your own, in conjunction with office staff who are dedicated to manage coding, billing, and financial considerations, or hire an outside consulting service, this exercise is critical to understanding your bottom line, setting goals, and building your patient base. Knowledge of your revenues/expenses per chair and how it connects to your negotiated fee schedules is a game changer as it allows you to make an informed decision. But remember, it is still your choice on whether to participate in these programs.

This article is in the first in a series on insurance issue. If you have a question that you would like answered, please email editor@aaid.com.

Bonnie Litch is a freelance writer in Northbrook, IL.

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By Frank R. Recker, DDS, JD
Legal Counsel, AAID

Commercial Free Speech and Empirical Evidence of Harm: A Cellphone Survey?

Recently an article was printed in the *Ohio Dental Association (ODA) News* which focused on advertising as a specialist and what the courts look at before allowing a state to impose restrictions on First Amendment–protected commercial free speech. The authors of the article included the results of a recent survey commissioned and paid for by several interested groups, including the ODA, American Dental Association (ADA), and several specialty groups. While it reads as if they hit a collective home run, I'm afraid they haven't walked in my shoes for the past 30 years—but then again, that's why their feet don't hurt.

Early in the 1990s, one of my earliest cases focused on whether or not a state could refuse to permit a dentist to advertise his/her earned credentials from a national dental organization, such as "MAGD" or "Master, Academy of General Dentistry." The case law recited by the Court went back to the mid 1970s, when the United States Supreme Court first decided that advertising for economic gain was a form of free speech, commercial free speech, and therefore should be accorded some level of protection via the First Amendment to the Constitution. What has evolved since then is a series of cases which became more definitive and descriptive relative to what a state needed to prove in order to sustain its burden of proof necessary to restrict such speech. And note that the burden is on the state, not the advertiser.

Where we stand today is that a state must demonstrate that the consumers would be harmed if they were exposed to such advertising. Just what "harm" a state needs to prove is how the law is evolving: Courts want more than conjecture or speculation. Several years ago, one Indiana Appellate Court heard the state argue that the "harm" to the consumer can be demonstrated if the consumer drives to a dental office and then finds out that the dentist is not a "specialist," as the ADA would define it, and turns around and goes home. Then, the Indiana Attorney General's office argued, the consumer has been "harmed" by the loss of time and the expenditure of gasoline. The Court readily dismissed that argument.

Many states have had surveys much like the kind written about in the *ODA News*. So far, no survey has passed judicial scrutiny. The last survey I personally encountered was in federal district court in Sacramento in 2010. Two highly regarded consumer survey companies were retained by organized dentistry, including the California Dental Association and the ADA.

Surveys to demonstrate harm to consumers are very easy to criticize. For example, the survey named in the *ODA News* article, which was designed by several dental school professors, overlooked the methodology used by the survey company: all were surveys conducted via cellphone.

This case took years to wind through the court system, only because the first district court judge read the surveys and decided they were meaningless, granting summary judgment to the American Academy of Implant Dentistry. The Appellate court reversed, stating that since there were two opinions that conflicted, the lower court should have held a trial on the surveys rather than just deciding that they were meaningless. After that, it took several more years to get to trial, as the original judge had moved on.

Surveys to demonstrate harm to consumers are very easy to criticize. For example, the survey named in the *ODA News* article, which was designed by several dental school professors, overlooked the methodology used by the survey company: all were surveys conducted via cellphone. One court opined that if a survey is introduced, for example, with "This survey is being conducted by the Ohio Department of Health, the Ohio State Dental Board, the Ohio Dental Association," instinctively the person on the other end of the line wants to agree with a credible entity affiliated with the state/government. And it isn't clear whether the term accredited was defined; it's likely that not only does the respondent not want to challenge or appear to be critical of such an entity, he or she likely does not have any idea of what an accredited postgraduate program might be.

In addition, I question how the number/caller ID appeared to compel so many people to even answer? Did it read "State of Ohio" or "Ohio Department of Health COVID Alert"? There are so many holes in such a survey, a Court will give little weight to it—certainly not enough for the state to carry its burden of showing harm to the public. And that means a representative cross-sectional sample of the public. And by the way, just because someone isn't familiar with something does not equate to harm.

Similar criticisms by a court were directed to a mall surveyor, asking similar questions of those people who agreed to participate in a mall survey regarding dental services. First of all, only a certain "type" of person would agree to stop in the middle of a mall and participate in a survey on anything. The survey is skewed from the beginning. The Court wanted to know why the surveyor arbitrarily limited the eligible participants to those living within a 25-mile radius of the mall, why a certain age group, why the last visit to the dentist was important, and so on. When the Court asked the witness how and why the radius from the mall was selected, the surveyor gave an answer relating to women and purses. At that point, counsel for the State of California, an Assistant Attorney General, instinctively jumped up and spouted, "Objection, your honor!" The federal judge calmly looked down at my opposing counsel, repeated the question he had just asked the witness, and calmly said, "I'll sustain your objection, counselor." He then went on to rephrase his question, with even more devastating results. That's when I was certain we had won the case, and in fact the judge went to his chambers and wrote his decision, eventually coming out of his chambers and reading it into the record.

Surveys are a touchy commodity. In today's COVID world, I think it is virtually impossible to obtain a survey that would hold judicial water. In any event, the only entity who really wins in surveys is the company who actually conducts the survey onsite.

By Bobbi Stanley, DDS

Restoring Your Dental Practice to Pre-COVID Status in a Post-COVID World

As 2020 rolled in, most dentists, as well as most business owners, were feeling great about the promising economy. People were spending money, the stock market was high, and tax breaks were helping to make small businesses more profitable. The new year was going to be a great year for dentistry.

However, by the middle of March, fear had set in. A world-wide pandemic was suddenly hitting home and decisions were being made whether to keep businesses open or shut them down. Most dentists decided to close their offices for one to two weeks to allow the United States to get control of the virus and to help "flatten the curve." No one thought that they would be forced to lay off their entire team and wait weeks—and then months—to reopen their businesses. The uncertainty and the fear during the shutdown seemed unbearable. How could one of the most secure jobs in America (dentistry) be facing uncertain reopening? What would the "new normal" look like when the world reopened? How could dentists possibly afford the personal protective equipment (PPE) that was now required but not available?

Although 98% of dental businesses have now reopened, not all are to full capacity. The American Dental Association Health Policy Institute has initiated a biweekly poll to report the economic conditions of dental practices during the pandemic. The COVID-19 Economic Impact on Dental Practices reports (effective September 7, 2020) that 48% of dental practices are open and business as usual, 50.5% are open but lower patient volume than usual, and the remaining 1.8% are closed or only seeing emergency patients. Fortunately, the report predicts that the dental economy could recover fully as soon as October 2020 through January 2021.

As dental offices have reopened and are starting to recover, dentists have been faced with a new dilemma: the rising cost of PPE and dental supplies. PPE has been in short supply since the beginning of the pandemic. Dentists are finding that dental supplies are now becoming harder to find. The shorter supply and higher demand have led to an increase in prices. How does a dentist pass these increased costs to his or her patients, as any smart small business owner should, and restore his or her practice in a world that is trying to recover itself?

Dentists must focus on their businesses now more than ever. Obviously, the dental professional's first, and most important, obligation is to the patients and their health. Now is the time to focus on restoring your dental practice and recovering fully from the COVID shutdown.

Dentists must focus on their businesses now more than ever. Obviously, the dental professional's first, and most important, obligation is to the patients and their health. However, if the dental practice does not recover, dental care cannot be provided to patients in need. Now is the time to focus on restoring your dental practice and recovering fully from the COVID shutdown. There are five simple ways to do that.

Five Ways to Restore Your Dental Practice:

1. **Inform your patients that your office is safe.** If you have not informed your patients of the precautions that you have placed for their safety, now is the time to do so. The World Health Organization just released a statement that encourages dental patients to postpone elective dental treatment, including routine hygiene visits, until after the COVID crisis. With news agencies broadcasting the announcement in all forms of media, patients are confused and afraid. It is important to assure patients that dentists have been practicing infection control for more than 30 years. In fact, dentists are experts at infection control: The dental office may be one of the safest public places to visit. It is important to reassure your patients regularly about your new procedures and protocols that have been put in place for their safety. Monthly email blasts or newsletters are a great way to send this message to your patients.

2. **Rescheduling past due (pre-COVID) patients.** The easiest patient to schedule is the most recent patient. Any patient who is active—meaning a patient who has been in the dental office within the last 18 months—should be invited to reschedule. The sooner you reach out to those patients to reschedule, the better. Dental patients have also experienced chaos in their personal lives from COVID. Many patients are now working for home and may have school-aged children taking virtual classes at home. It's not surprising that rescheduling their missed or postponed dental appointment may have slipped their mind. Team members should be reaching out to these patients to reiterate the importance their dental health and prevention of dental disease and emphasizing the safety measures in place at the office.

3. **Marketing your practice.** Many dentists feel that it is distasteful to advertise in these uncertain times. Dentists neglect to recognize that marketing is educating, not selling. When dental professionals market to their patients, the purpose is to inform the patient of ways to improve their smile and their health. Computer and television usage have increased tremendously during the pandemic. Why not take advantage of that increase to educate the public about how dentistry can benefit them? Patients who are interested in dental treatment want to research their options prior to searching for a dentist. If you are the dentist offering the information, that patient is most likely going to call your office when he or she is ready to move forward. Increasing the number of new patients will quickly restore your practice and possibly improve the pre-COVID status.

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Business Bite

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Dental patients have also experienced chaos in their personal lives from COVID. Many patients are now working for home and may have school-aged children taking virtual classes at home. It's not surprising that rescheduling their missed or postponed dental appointment may have slipped their mind.

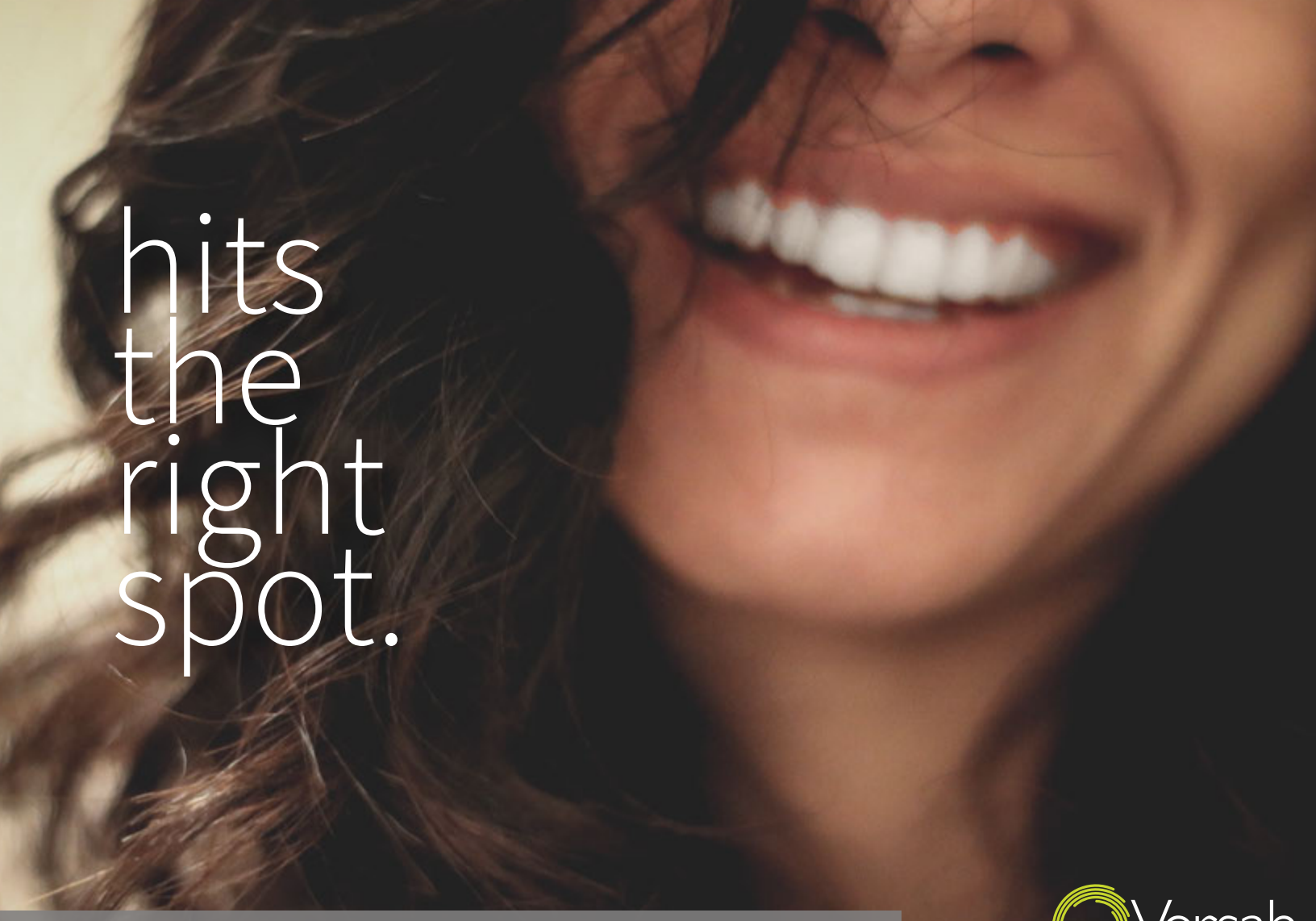
4. **Offering financial options.** Offering several financial options for patients will make it easier for your patients to accept treatment. The high cost of dental treatment could be the reason patients are not moving forward. Helping the patient fit the cost of treatment into his or her monthly budget not only helps the patient, it also helps the dental office. Americans are used to making purchases and paying over time. By providing options for your patients to finance their treatment, they are more likely to accept treatment. There are several finance companies that will finance dental care with low to no interest to the dentist. Find more than one company that fits your and your patient's financial needs.

5. **Expanding services.** Now is the time to look at the services that you are providing in your office versus the services that you are referring out. Offering a variety of services in your office will provide your patient the comfort and security of receiving treatment from a dentist that they know and trust. Patients do not want to go to other offices to receive dental services. Dentistry is already an uncomfortable experience for many patients, even more so with COVID. Sometimes it has taken years for patients to find the courage to visit the dentist. Once they find a dentist with whom they feel comfortable, they do not want to go to a stranger for additional services. Expanding your service menu in your office is a great way to help your patients. With many dental continuing education courses available virtually now, it is easy to gain new knowledge and expand your skill level to provide your patients better care without traveling. The addition of dental implants, orthodontics, endodontics, and sleep apnea therapy will make your practice more profitable while taking care of your patients in an office that they trust. Expand your skills so you can help your patients and restore your dental practice.

It is important to focus on your dental practice as well as your dental patients. Focusing on the five steps here will help your dental practice recover quicker and possibly more profitable. More profit means having the ability to help more patients and helping patients is what dentistry is all about.

If this pandemic has taught us anything, it is that dentistry is resilient. The dental profession will recover. Society is actually banking on it, as dentistry has become the model for the economic recovery of the world. Start your process to recovery today.

Dr. Bobbi Stanley has practiced dentistry for more than 25 years. She has established best practices for setting daily, monthly, and annual goals and the team incentives to encourage her staff to meet them. In her Dental Entrepreneur Summit, she details the methods she has used to build one of the oldest and largest comprehensive dental practices in the Southeast.



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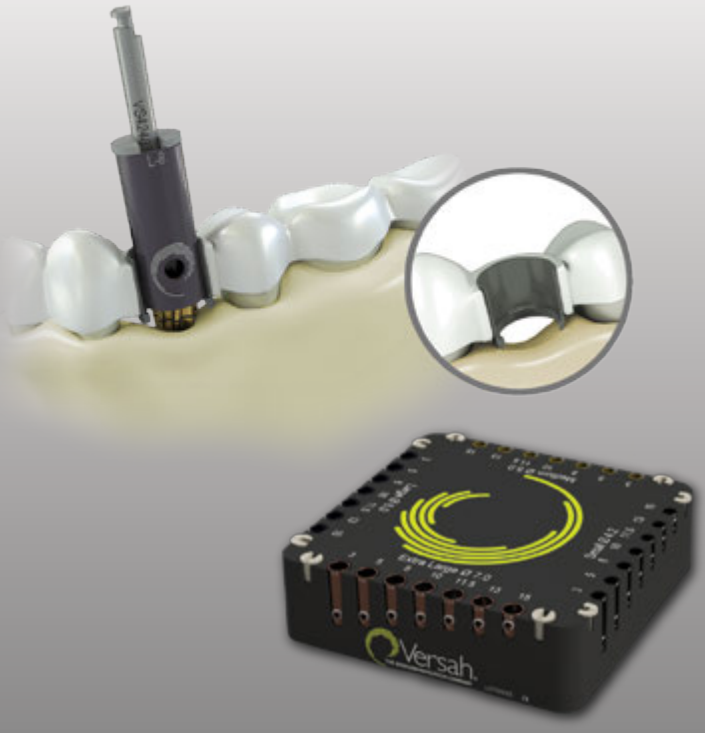

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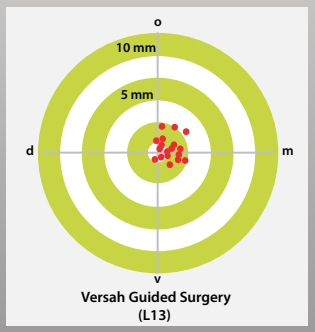

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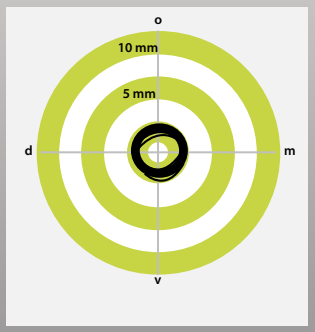

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Accuracy of the Versah Guided Surgery System, Arndt Guentsch. Pending Publication

By James Rutkowski, DMD, PhD, FAAID, DABOI/ID

Dental Office–Based SARS-CoV-2 Testing

The World Health Organization has suggested that testing is crucial to controlling the spread of SARS-CoV-2 and its clinical manifestation, COVID-19.[1] Patients and dental healthcare providers (DHCPs) have been cautioned that the SARS-CoV-2 virus can be transferred from infected patients to DHCPs or other patients by aerosol-generating dental procedures. Patients and DHCPs are rightfully concerned about how to best receive and provide dental care in a safe and responsible manner.[2] Concern is justified, but historically, just as other infectious diseases have been of concern to DHCPs and patients, the profession has always adopted guidelines to mitigate the threat of infectious disease spread.

In September 2020, the *Journal of Oral Implantology (JOI)* published the "AAID White Paper: Management of the Dental Implant Patient During the Coronavirus Pandemic and Beyond."[3] This white paper discusses what COVID-19 is, how it impacts dental treatments, and presents guidelines specifically for dental implant–related treatments.[3] The suggested methods will allow implant practices to function at a near-normal level, while at the same time protecting DHCPs and patients from SARS-CoV-2.

SARS-CoV-2 molecular or antibody testing of DHCPs and pre-operative patients would help minimize concerns surrounding dental treatment and possibly mitigate the community spread of COVID-19.[2] Testing is not only important for minimizing the spread of COVID-19, but is also vital to the return of implant practices in a timely manner. Testing does not change the cardinal rule that must be followed when patients present with: (i) COVID-19 symptoms, (ii) a positive COVID-19 test or (iii) a social history of exposure to individuals with COVID-19. The rule is that patients presenting with any of those three should only receive dental treatment if postponing treatment would have a significant life-altering effect on the patient.[3] Notwithstanding the treatment for those "positive" or "suspected positive" patients, testing would allow for implant dentists to return to providing implant related treatments sooner and with greater confidence.

In-office testing would be beneficial for patients and DHCPs. It would be helpful if implant dentists could provide a quick and reliable in-office COVID-19 test for the DHCPs every 2-3 days and patients immediately before scheduled appointments. If the test results were negative, DHCPs could perform implant treatments and patients could receive care with greater confidence. Knowing the COVID-19 status of all individuals in the operatory will decrease concern and possibly allow for the use of less cumbersome personal protective equipment (PPE).

There are two types of tests that could be used for in-office testing to identify positive individuals: antibody-based and amplified polymerase chain reaction (PCR)–based. Antibody-based test results have quick turn-around result times; however, they are the less accurate of the two. PCR–based tests have greater accuracy, but take longer to obtain results.[3]

Antibody-based "rapid" SARS-CoV-19 identifying tests provide results in 2 to 30 minutes. Antibody tests measure the patients developed immune response when exposed to the SARS-CoV-2 virus. The test detects the presence of 3 antibodies (IgG, IgM, and IgA). These three antibodies are produced in response to infection. These tests are often referred to as immune response tests. Immune response tests are less able to detect the presence of an infection when the patient is early on in the disease course. This is because the body needs time to respond to the antigenic viral invasion. Antibody tests are serological (blood) tests and confirm the presence of the antibodies (IgG, IgM, or IgA) produced by the immune system in response to a SARS-CoV-2 infection. Normally, these tests require a blood draw; however, newer systems entail a less invasive finger prick blood sample.[2] The antibody test is usually contained in a "cassette" and is interpreted as a binary outcome (presence/absence) through a color change.[2]

PCR testing determines the presence of the SARS-CoV-2 virus's genetic material (RNA) by swabbing the nasal passages, throat, or—more recently—from a salivary sample. These tests are frequently referred to as "molecular tests." Molecular tests can determine if an individual has an active, current COVID-19 infection. This test does not quantify the viral load, because it amplifies the presence of any found viral material in the effort to determine the presence of the virus in the sample.[2] A PCR test utilizes a molecular biology technique that multiplies (amplifies) a single fragment of the SARS-CoV-2 virus DNA (or gene) that can then be easily detected and quantified.[4] As a result, PCR tests can detect very low titers of the virus. The virus just needs to be captured in the sample.

This testing method is thought to be the most dependable method for diagnosing an active case of COVID-19, especially when a patient is early in the disease course. It is also the most reliable method of determining if a patient is actively contagious. These tests detect the presence of viral genetic material in the nasal, oral, and respiratory tracts. If the virus is present in these areas or saliva, the patient can be actively shedding the virus and therefore spreading it to others.[2] PCR tests can confirm viral presence up to 2 days prior to the onset of clinical symptoms. The antibodies examined in the "rapid" antibody tests may not be detectable until 6 to 7 days after the onset of symptoms; therefore, molecular tests may fast-track the diagnostic timeframe by up to 9 days.[2] Viral shedding normally becomes undetectable 21 to 35 days after the onset of symptoms or 3 to 5 days after a patient becomes asymptomatic. The viral load ultimately becomes undetectable once the disease has run its course. Thus, a PCR (molecular) test will not detect even a recently ended infection. All currently available PCR tests require the use of a sophisticated laboratory analyzer platform for anlaysis.[2] The test sample can be taken in the office, but normally must be sent to an outside laboratory for analysis.

continued on page 22

Clinical Bite

continued from page 21

Salivary diagnostics is an emerging field that is gaining credibility in disease diagnosis. Dentists and the analysis of saliva may become key methods for the early detection of SARS-CoV-2.

Testing has two purposes: identify positive COVID-19 individuals and facilitate public health screening. Generally, antibody tests could possibly be self-administered by all individuals every 2 to 3 days. This test frequency would: identify positive and previously exposed individuals; assist in public health screening; and augment contact tracing efforts. Patients with symptoms and/or possible COVID-19 exposure with a negative antibody-based test could be retested with the more accurate molecular (PCR–based) test. Frequent testing with contact tracing will help not only the community, but also benefit every patient's ability to confidently and comfortably seek dental or medical care. Frequent testing and tracing will help assure clinicians that the asymptomatic patient and DHCPs providing treatment are **most likely COVID-19 negative** and therefore this could **diminish—but not entirely eliminate—**concerns regarding aerosol-generating dental implant procedures.[5]

The future may provide for a "rapid" SARS-CoV-19 salivary diagnostic test. When at higher titer levels, coronaviruses have been detected in the saliva of patients, even when they are without pyrexia or respiratory symptoms. Salivary diagnostics is an emerging field that is gaining credibility in disease diagnosis. Dentists and the analysis of saliva may become key methods for the early detection of SARS-CoV-2. Additional research and development of salivary COVID-19 testing is needed to assure the accuracy of a rapid chairside test. Such a test in conjunction with successful strategies for disease spreading prevention would help reduce the COVID-19 based concerns associated with dental implant procedures.[6]

Roe Dental Labs, in partnership with Core Bio Labs, is offering Implant Dentists kits that enable in-office COVID-19 testing.[7]

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3. Rutkowski J, Camm DP, El Chaar E. AAID White Paper: Management of the Dental Implant Patient During the Coronavirus Pandemic and Beyond. *J Oral Implantol*. 2020.
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5. Gurzawska-Comis K, Becker K, Brunello G, Gurzawska A, Schwarz F. Recommendations for Dental Care during COVID-19 Pandemic. *Journal of Clinical Medicine.* 2020;9(6):1833.
6. Sri Santosh T, Parmar R, Anand H, Srikanth K, Saritha M. A Review of Salivary Diagnostics and Its Potential Implication in Detection of COVID-19. *Cureus*. 2020;12(4):e7708.
7. Lab CRD. COVID-19 Testing Kits https://covid.roedentallab.com. Published 2020. Accessed 09/21/2020.

Dr. James Rutkowski just retired from his private practice. He earned his Bachelor of Pharmacy from Duquesne University School of Pharmacy, his dental degree from the University of Pittsburgh School of Dentistry, and his PhD in Pharmacology/Toxicology from Duquesne University. Dr. Rutkowski currently serves as the editor of the AAID Journal of Oral Implantology.

JOISAMPLER

Editor's Note: Because of busy schedules, you may not have time to read the dozen or so articles in each issue of the *Journal of Oral Implantology*. In this section of AAID News, we selected a few articles that have broad applicability to the daily practice and provide a brief summary of key points so you can decide if you wish to read the complete article. The following articles are from Volume 46, Issue 4 (2020).

CLINICAL RESEARCH

A Study to Evaluate Efficacy of 810nm Diode Laser in Maintenance of Dental Implants: A Peri-Implant Sulcular Fluid (PISF) Analysis

Biological Implant failures are primarily related to biofilm which can lead to peri-mucositis and further on, peri implantitis. 810nm diode laser has an affinity for pigmented chromophores, so its use in the peri-implant sulcus has a significant bactericidal effect on the black pigmented anaerobes such as P.gingivalis; therefore, it can be used to eliminate or reduce the bacterial count in the peri-implant sulcular fluid (PISF), thus increasing the life of the implants and reducing the chances of failure. The aim of this study was to evaluate the efficacy of 810nm Diode laser for the maintenance of dental implants using the diode laser as a regular in-office tool for limiting the microbiological count in the PISF and thus increasing the implant life. The authors randomly studied 20 patients undergoing implant treatment, collecting PISF before and after the sulcus was lased with 810nm diode laser and sent for quantitative microbiological analysis using universal bacterial count and quantity of P.gingivalis using real time PCR. The authors concluded that the two main outcomes of the study after 810nm diode laser was used around the implant were a drastic reduction in the total bacterial count and a significant reduction in the P. gingivalis count as evaluated by real-time PCR.

Prerna Sanjay Ghodke, BDS, Rashmi Hegde, MDS, Waqas Ansari, BDS, Sangeeta Muglikar, MDS, Alia S. Dholkawala, MSc, *Journal of Oral Implantology*. 2020 August; 46(4): 381-88.

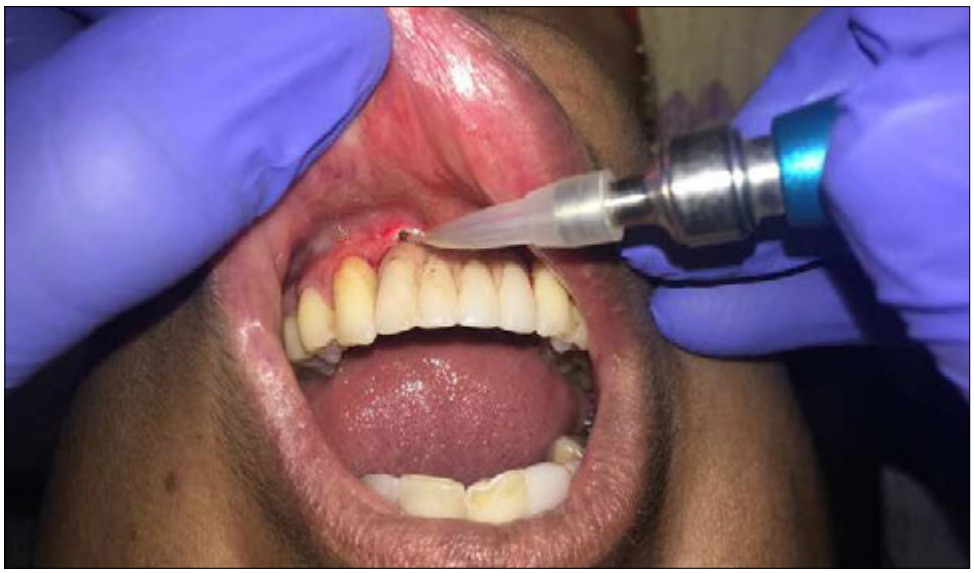

FIGURE 3. 810nm Diode laser used at 3 intervals for 20 seconds each and settings at 1.5W, CW. 434 fibre tip of 200 micron diameter.

FIGURE 4. Colonies of implant number 42 [before (250 CFU/ml) and after (60CFU/ml) the use 436 of 810nm diode laser]

FIGURE 7. Micropipettes in use for transferring the samples

continued on page 26

JOI Sampler

continued from page 25

RESEARCH ARTICLE

Axial Triangle of the Maxillary Sinus, and its Surgical Implication With the Position of Maxillary Sinus Septa During Sinus Floor Elevation: A CBCT Analysis

The aim of this study was to measure the convexity of the lateral wall of the maxillary (Mx) sinus and identify the locational distribution of antral septa in relation to the zygomaticomaxillary buttress (ZMB), in order to suggest another anatomical consideration and surgical modification of sinus floor elevation procedures. This study was designed as a cross-sectional study, and a total of 134 patients and 161 sinuses containing edentulous alveolar ridges were analyzed. The angle between the anterior and lateral walls of the Mx sinus (lateral sinus angle [LSA]), and the angle between the midpalatal line and the anterior sinus wall (anterior sinus angle [ASA]) were measured. The prevalence of septa was 37.3%, and it was most frequently noted in the second molar region (32.8%), followed by the first molar (20.9%), retromolar (16.4%), and second premolar regions (14.9%). Septa were most frequently located posterior to the ZMB (49.2%), while ZMB was mostly located in the first molar region (66.4%). Narrow LSAs may complicate the surgical approach to the posterior maxilla, especially when sinus elevation should be used in the second molar region. Considering the occasional presence of antral septa, membrane elevation may be complicated when a septum is encountered during the procedure. These results suggest that 3-dimensional examination of the convexity of the Mx sinus should be performed preoperatively to choose proper surgical techniques and minimize surgical complications.

Junho Jung, DMD, MSD, Jung Soo Park, DMD, MSD, Seoung-Jin Hong, DMD, MSD, PhD, Gyu-Tae Kim, DMD, MSD, PhD, Yong-Dae Kwon, DMD, MSD, PhD, *Journal of Oral Implantology*. 2020 August; 46(4): 415-22.

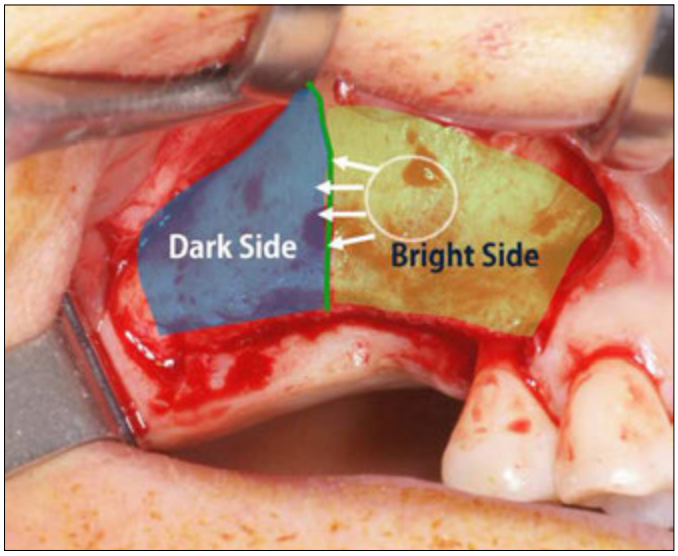

FIGURE 1. The lateral wall for sinus floor elevation (SFE) can be divided into two surfaces, bordered by the zygomaticomaxillary buttress (ZMB). The anterior part is easily accessible, whereas the posterior part can occasionally present limited access. The easily accessible anterior part is so called the "bright side," and the less visible posterior part is also called the 380 "dark side." It is easy to make a window on the 'bright side,' which can be extended to the posterior part, if necessary.

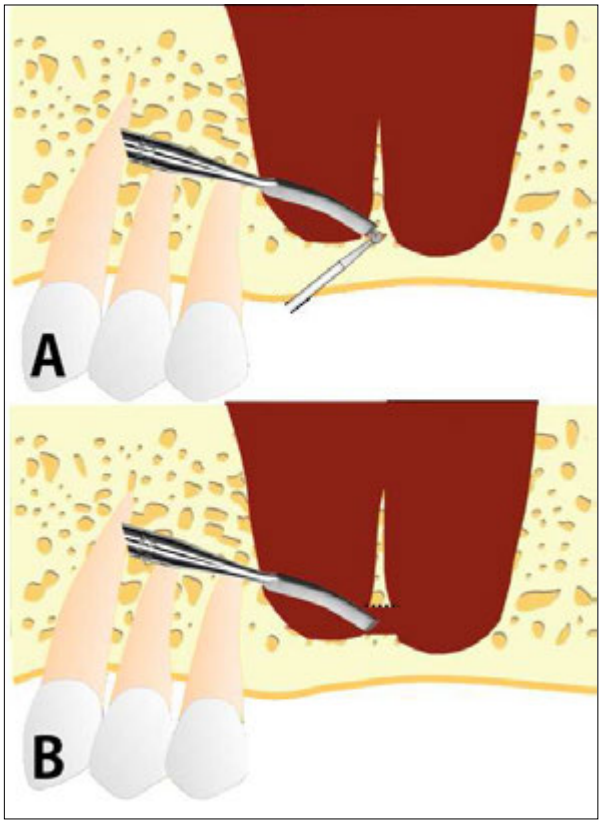

FIGURE 7. A schematic drawing of the septum resection to facilitate the grafting procedure. After revealing the septum, a small gutter can be formed to securely place an osteotome. A. The osteotome can be gently tapped on the back. B. The concave side of the osteotome should be inferiorly directed.

CLINICAL RESEARCH

AAID White Paper: Management of the Dental Implant Patient During the Coronavirus Pandemic and Beyond

In this white paper, *JOI* Editor Dr. Jim Rutkowski and Drs. Daniel Camm and Edgard El Chaar address the current climate in implant dentistry amidst COVID-19. The scientific community's understanding of how the SARS-CoV-2 virus is transmitted and how to best mitigate its spread is improving daily. To help protect patients from acquiring COVID-19 from a dental office nosocomial infection, many state or local governments have classified dental treatments as "non-essential" and put routine dental care on a "pause." Dentists have been instructed to only perform "emergency" procedures. Unfortunately, there is not a good understanding of what a "dental emergency" is amongst governmental leaders. What a government agency may perceive as an "elective procedure" may be seen as "essential" by the dental clinician responsible for maintaining the oral health of the patient. Each dental specialty understands the effects delayed care has on a patient's oral and systemic health. Dentistry has made extensive progress in improving oral health through prevention of the "dental emergency." Today the dental profession must work together to prevent the reversal of the progress dentistry and patients have made to this point.

Jim Rutkowski, DMD, PhD, Daniel P. Camm, DDS, Edgard El Chaar, DDS, MS, *Journal of Oral Implantology*. 2020.

CASE REPORT

Oral Rehabilitation With Dental Implants and the Importance of a Preventive Evaluation for Osteonecrosis of the Jaws Associated With Medications

Osteonecrosis of the jaw is a possible oral complication resulting from antiresorptive therapies, such as bisphosphonates (Bfs). Although the etiology is not entirely clear, it has been shown to be dependent on several factors, with the traumatic stimulation caused by the placement of teeth implants indicated as one of the predisposing factors to this pathology. The indications and preventive methods for performing these procedures have been questioned, making it essential to determine the proper protocols. Thus, the present study aims to discuss the risks of the development of osteonecrosis in patients undergoing dental implant surgery who use Bfs as well as to discuss related local and systemic factors and possible methods for preventing this side effect. The study also aims to present a clinical case of an osteopenic patient who used Bfs and underwent rehabilitation through implants according to specific protocols, which resulted in successful treatment. The authors conclude that Bfs promote a clear risk of osteonecrosis development in the jaw. The duration of therapy and type and administration method of the Bfs are factors directly related to the onset of this pathology. Bone trauma through the installation of osseointegratable implants is a predisposing factor of the disease. Therefore, its indication must be carefully evaluated, and if this treatment is chosen, preventive measures should be taken, such as the interruption of the use of Bfs, antibiotic prophylaxis use prior to surgery, and adequate prosthetic rehabilitation.

Gustavo Zanna Ferreira, DDS, MS, Amanda Bolognesi Bachesk, DDS, Andressa Bolognesi Bachesk, DDS, Gustavo Jacobucci Farah, DDS, PhD, Liogi Iwaki Filho, DDS, PhD, Rafael dos Santos Silva, DDS, PhD, Rodrigo Lorenzi Poluha, DDS, MS, Carolina Ferrairo Danieletto-Zanna, DDS, MS, Eduardo Sanches Gonçales, DDS, PhD, *Journal of Oral Implantology*. 2020 August; 46(4): 431-7.

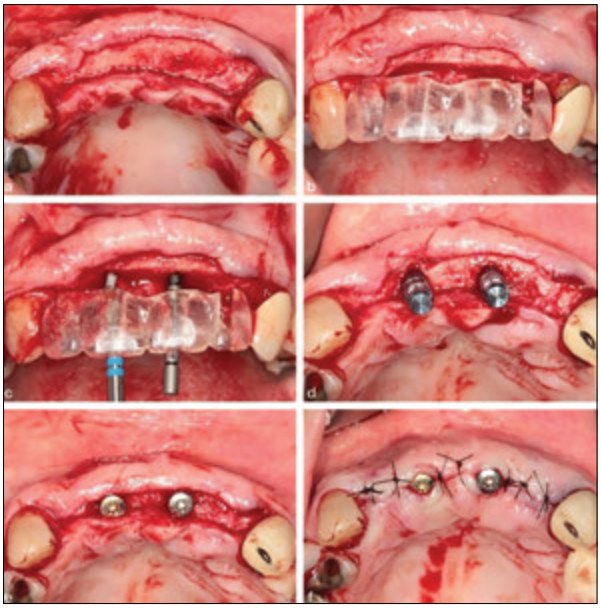

FIGURE 2. Installation of the implants in region of elements 11 and 21. (a) Incision and syndesmotomy. (b) Surgical guide test. (c) Installed implants observing parallelism. (d) Occlusal view of installed implants. (e) Installation of the cicatrizadores. (f) Suture.

academynews

2020 AAID Award Winners

Aaron Gershkoff/Norman Goldberg Memorial Award

The Aaron Gershkoff/Norman Goldberg Memorial Award was established by the American Academy of Implant Dentistry to honor one individual who exemplifies his or her commitment to implant dentistry and honors both Dr. Gershkoff and Dr. Goldberg who not only founded the organization but wrote the first textbook on dental implants in the United States. This award was established in 1973 and upon the passing of Dr. Goldberg was changed in 2013 to the Gershkoff-Goldberg Memorial Award. This award is selected by the past president's council.

Gerald A. Niznick, DMD, MSD, FAAID, 2020 Gershkoff/Goldberg Award Recipient

The 2020 recipient of the Gershkoff/Goldberg Award is Gerald A. Niznick, DMD, MSD, FAAID, of Las Vegas, NV. He was the founder and President of Core-Vent Dental Implant Company from 1982 to 2001 when it was sold to what is now known as Zimmer Biomet. Dr. Niznick returned to the implant industry in 2004, as the developer and president of Implant Direct. Barron's Magazine Article on Dental Implant Industry Feb. 15, 2005, referred to Dr. Niznick as "a prosthodontist and entrepreneur who is considered by many as the godfather of American implant dentistry.

From 1982-2017, a 35-year span, Dr. Niznick was issued 33 U.S. patents on dental implant-related products, including his invention of the internal conical connection in 1986 which has become the cornerstone of modern implant design. In 1991 Dr. Niznick was the fifth recipient of the American Academy of Implant Dentistry's Isiah Lew Research award. After almost a half century of membership in the AAID, Dr. Niznick is receiving the 2020 Gershkoff-Goldberg Award for his exceptional contributions to the field of implant dentistry in product development and his distinguished career in dental implant research and education.

Terry Reynolds Trailblazer Award

The Terry Reynolds Trailblazer Award was introduced in 2018 to honor the contributions Dr. Reynolds made to the profession of implant dentistry. Dr. Reynolds conceptualized, developed, and founded the American Academy of Implant Dentistry MaxiCourse, which has become the gold standard for implant education. In 1998 he was the first African American to serve as AAID president. The award recognizes an AAID Member who personifies the spirit of Dr. Reynolds' work as a leader in implant dentistry and education.

N. Cory Glenn, DDS, AFAAID, 2020 Terry Reynolds Trailblazer Award recipient

The 2020 recipient of the Terry Reynolds Trailblazer Award is N. Cory Glenn, DDS, AFAAID, of Winchester, TN. Dr. N. Cory Glenn graduated from Arkansas State

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Terry Reynolds Trailblazer Award *continued from page 28*

University in 2004 and from University of Tennessee College of Dentistry in 2008. Following graduation, he went on to complete the Lutheran Medical Center's advanced education in general dentistry residency at UT Memphis. He is a continuing education (CE) "junkie" and a graduate of the Georgia MaxiCourse® in Implant Dentistry, the American Orthodontic Society's Comprehensive Ortho Program, and is an Associate Fellow in the American Academy of Implant Dentistry. He served as the CE director for the Tennessee AGD and as president and CE director of the Middle Tennessee Dental Study Club.

For several years, Dr. Glenn ran a private practice in Winchester, TN, where he performed all disciplines of dentistry with a focus on utilizing technology and innovative techniques to make comprehensive treatment more accessible to his patients.

In late 2015, he was diagnosed with APL leukemia and spent 8 months doing chemotherapy achieving complete remission. However, due to ongoing back problems following treatment, he has since retired from clinical practice and now focuses entirely on dental technology and teaching. He is the Vice President of Technology for Blue Sky Bio where he works in product and software development as well as clinical customer support.

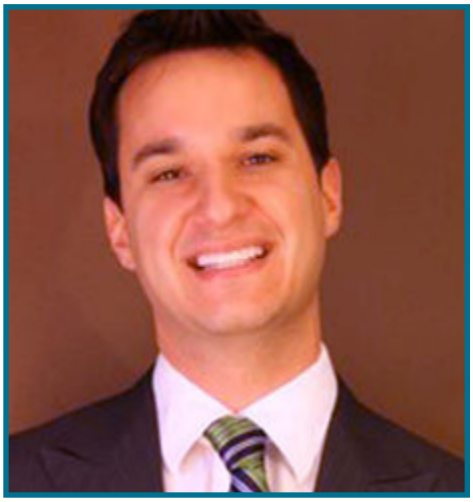
Paul Johnson Service Award

The Paul Johnson Service Award recognizes a volunteer of the American Academy of Implant Dentistry who has gone "over and above" in their service to the organization. The award, named for Dr. Paul Johnson…a past president…highlights the importance of volunteers in the success of the AAID. The recipient of this award consistently participates at the committee and district levels; contributes to task forces, districts, and meetings with thoughtful discussions; and sets an example for the rest of the AAID volunteers, just as Dr. Johnson did during his tenure.

The 2020 recipient of the Paul Johnson Service Award is Daniel Domingue, DDS, FAAID, DABOI/ID, of Lafayette, LA.

Dr. Domingue received his Bachelor of Science in 2003, his DDS from Louisiana State University in 2007, and attend Brookdale University Hospital and Medical Center in 2010. Among his many accomplishments, Dr. Domingue became an AAID Fellow in 2011 and a Diplomate of American Board of Oral Implantology/ Implant Dentistry in 2012. He also is a Diplomate with the International Congress of Oral Implantologists in 2012.

Dr. Domingue is the Founder and President of Acadiana Southern Society. He also serves as chair of AAID's Membership Committee and is one of the hosts for AAID's Podcast.



Daniel Domingue, DDS, FAAID, DABOI/ID, 2020 Paul Johnson Service Award recipient

International Dentist of the Year Award

The International Dentist of the Year Award is given to a member of the American Academy of Implant Dentistry who has demonstrated a significant contribution to the organization by way of educational and training programs and helping to grow AAID Membership internationally.

The 2020 recipient of the International Dentist of the Year Award is Yasunori Hotta, DDS, PhD, FAAID, DABOI/ID of Japan. Dr. Yasunori Hotta graduated from Al Aichi Gakuin University, School of Dentistry, Japan in 1976, where he would later become a part-time lecturer in 2009. In 1990, he received his PhD in oral anatomy from Aichi Gakuin University. In 1994, Dr. Hotta became a Fellow of the AAID.

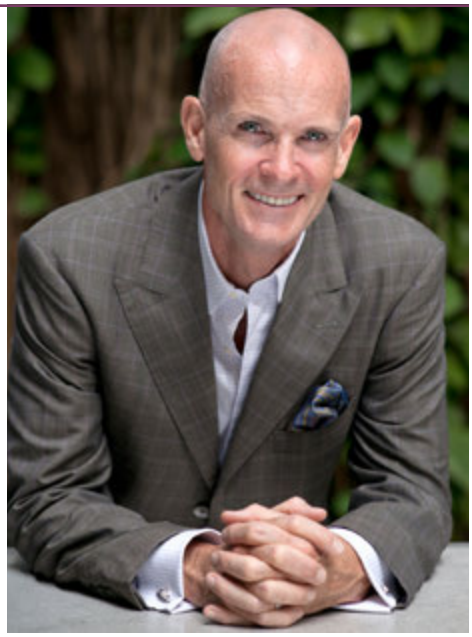
Yasunori Hotta, DDS, PhD, FAAID, DABOI/ID, 2020 International Dentist of the Year Award recipient

Much of Dr. Hotta's professional career took place in Japan. He is an active member within the Japanese Society of Oral Implantology, holding six positions from 2005 to the present. In 2009, he was a part-time lecturer for the Division of Oral Implants. From 2013 to March 2019, he was the visiting professor of Asahi University, School of Dentistry, Department of Oral and Maxillofacial Implantology.

In 2015, Dr. Hotta was the Director of the AAID Nagoya Japan MaxiCourse®. In 2017, he became an ABOI/ID Diplomate. Two of his case reports have been featured in the Journal of Oral Implantology. His dedication to educating implant dentists worldwide makes him the AAID's International dentist of the year.

GUEST COLUMN

AAID or ABOI Credentialing During a Pandemic? *Absolutely!!*



Dr. James McAnally practiced dentistry for 19 years before starting Big Case Marketing. He has been a long-time supporter of AAID. He believes strongly in the AAID Credentials and here's why.

I'm here to provide good news related to dental implants, as well as to encourage members who are on the path to advance their implant education toward their goal of Associate Fellow, Fellow, or becoming a Diplomate in implant dentistry through the American Board of Oral Implantology. I encourage anyone with a deep passion for the life-changing treatments offered by dental implants to embark on this professional journey to use the skills developed to help more patients benefit from life-changing treatments.

Running a specialized dental advertising agency that focuses on sending full-arch implant case patients to member clients every month puts me in touch with a wide variety of implant-oriented clinicians in the United States, Canada, United Kingdom, and Australia. It allows me to place a "finger on the pulse" of how, when, and why patients opt in to implant treatment discussions and choose some clinicians over others.

While we continue to be in the midst the COVID-19 pandemic, waiting for the vaccine to arrive, a predictable treatment for patients, or a future 'burn-out' general immunity has spread (yes, meaning more of us are infected and recover), I can tell you that assuredly all of this will pass. I'm likely the only practitioner and consultant with a direct connection to the Spanish Flu of 1918 as my grandfather Dr. William Monday McAnally was practicing during that pandemic in the newly minted state of Oklahoma. I can relay that in my family's oral history, WWII was discussed more than WWI and the Spanish Flu was never a topic amongst any family. So, what was likely seen as the "end of the world!!" in its time passed, and dentists continued helping patients. We are doing the same right now.

As of early December, a rolling 30-day call average tracked from our advertising campaigns across the U.S., with 15% fewer active campaigns reporting than in 2010, shows a 48% higher call volume from full-arch implant ad patient inquiries compared to the same 30-day period in 2019. When we look at total call volumes for these cases for 2020 compared to 2019, full-arch patient inquiries are up 11%. Consider that in the beginning of March there was a three- to four-month period of serious economic disruption, during which most advertising campaigns were halted and call volumes dropped. Increases in volume for the year are simply amazing and of course great news for implant-focused practices.

On the clinician's side, member practices have reported record months and a record Q3 as cases have flooded their practices upon re-opening. If I were Rip van Winkle awakening and looking at these three reports, I would have little inclination that a disruption had occurred—much less a 5 billion person global "lockdown." In fact, the musing would be "Cool, we are up 11% over last year and up on average 40% or more since July...looks great…good work gang…carry on clinicians!"

So moving past the discussion of COVID-19, let's talk about the commonalities of implant-focused practices that treat "mind-boggling" numbers of full-arch implant cases on a monthly and annual basis. Are there commonalities that are worth exploring? Is there a tie-in to how credentials can impact cases?

Of course!

I can state emphatically that with 15 years of observation helping our clients find implant cases, the "trifecta" client who treats mind-boggling numbers of cases (up to one to two per week year after year) share the following commonalities:

No. 1: A serious focus on clinical skills – often with credentials, such as Associate Fellow, Fellow, or Board Certified by the ABOI that credential plus ongoing practice means being confident in the ability to not only arrive at good options for a patient but also in delivering on treatment promises made.

continued on page 33

AAID
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Dr. Andy Burton
Dr. Frank Caputo
Dr. Danny Domingue
Dr. James Gibney
Dr. Cory Glenn
Dr. Shankar Iyer
Dr. Bassam Kinaia
Dr. Andrew McConnell
Dr. Tommy McGee

*Speakers are subject to change

For registration information, go to
http://bit.ly/aaidcentral20

newmembers

The AAID is pleased to welcome the following new members who joined between May 8, 2020, and August 12, 2020. The list is organized by state, with the new member's city included. International members are listed by country, province (if applicable), and city. If you joined the AAID recently and your name does not appear below, it will be listed in the next issue of AAID News.

Alabama
Andrew Henninger, Madison
Samuel McLemore, Birmingham

Arkansas
Evgeny Titov, Fort Smith

Arizona
Nashid Ahmed, Phoenix
Jeannie Ju, Tucson

California
Joseph Larsen, Oro Valley
Saad AlResayes, Loma Linda
Sungio Justin Choi, Redlands
Priscilla Cury Rose, Anaheim
Hiral Desai, Irvine
Madhavi Durvasula, Fairfield
Bashar Fargo, Redlands
Bassam Fargo, Riverside
Trent Gillard, Redlands
Nada Hanna, Loma Linda
Diary Hoshiyar, Corona
Samer Itani, San Francisco
Eunice Jong, San Ramon
Ryan Kearbey, Oroville
Enrique Lewin, Rancho Cucamonga
Cecilia Miranda-Oglesby, Banning
Jenny Najjar, Loma Linda
Tuan Nguyen, Placentia
Brian Olvera, Los Angeles
Deborah Owen, Laguna Hills
Alexander Philips, Covina
Sharoung Sahawneh, Costa Mesa
Dhwani Shah, Chino
Vinni Singh, San Jose
Yara Soto Solis, San Diego
Jeanette Thai, Lake Forest
Leanna Ursales, Gonzales
Elaine Vong, Loma Linda
Hila Yacoub-Fokas, Yucaipa
Parnell Yao, Chino
Lavth Yaseen, Brea

Florida
Edward Abreu, Brandon
Orlando Diaz Valle, Miami
Anna Krizan Fano, Ft Myers
Rafael Martinez, Davie
Rishit Patel, Lady Lakes
Arturo Perez, Lutz
Charles Poblenz, Jacksonville
Luis Rodriguez, Gainesville

Georgia
Joseph Weber, Gainesville

Illinois
Matthew Nye, Chicago
Colleen Scheive, Glen Ellyn

Kentucky
Mackenzie Brindley, Florence

Louisiana
Vincent Williams, Sulphur

Massachusetts
Mohamed Butt, Somerville

Maine
Lucas Homicz, Cape Elizabeth

Michigan
Jason Baker, Okemos
Daryl Moseley, Southfield

Minnesota
Steven Sarles, Prior Lake

North Carolina
Mandy Ghaffarpour, Chappel Hill

North Dakota
Joshua Grenier, Minot Air Force Base

Nevada
Thanh Njo, Las Vegas

New York
Rush Hejazi, Rush
Shu Ping Rong, New York

Ohio
Scott Schumann, Grove City

Pennsylvania
John Gililand, Long Pond

South Carolina
Mark Burns, West Columbia
Eberechukwu Njoku, Greenville
Sheryl Voulgaropoulos, Clover

Tennessee
Bostros Aivad, Nashville
Kevin Shepherd, Knoxville

Texas
Maged Shokralla, Houston
Christopher Stevenson, Dallas

Virginia
Anthony Castellano, Richmond

Washington
Susannah Bohannon, Olympia
Rusell Rogers, Lacey

Wisconsin
Casey Messer, DePere
Muhammad Omari, Milwaukee
Aarathi Rao, Wausau

CANADA

Alberta
Kirsten Hooper, Calgary

British Columbia
Yi Xing, New Westminster

Ontario
Manoj Kumar Sundar, Scarborough

Quebec
Virginie Bordreau-Larouche, Dolheau-Mistassini

INTERNATIONAL

Australia
Azher Al-Abedi, Smithfield

Brazil
Luis Carlos Magno Filho, Sao Paulo

Egypt
Ahmed Abdelkreem, Ad delingat
Haythem El-Khouly, Obour City
Tarmim Mahmoud, Cairo

Republic of Korea
Jae Hak Choi, Pocheon-si

South Korea
Young Lik Jung, Cheongju-si
Sung Jin Kim, Seo-gu Gwangju
Kangnam Park, Seongnam-si Gyeonggi-do
Sangho Park, Gimbae-si
Jaeyong Yang, Incheon

STUDENTS

Omar Alzein
James Amir
Jessica Arland
Rajdeep Singh Badwalz
Virginie Boudreau-Larouche
Aaron Compton
Gerard Guimond
Kristen Hooper
Ryan Jin
Madiha Khan
Jane LaPorte
Elizabeth Lucas
Olga Malukova
Robyna Marmoor
Umair Niazi
Kangnam Park
Stephen Patterson
Maria Paz
Bryce Richardson
Sonya Shafique
John Sinclair
McKenzie Taylor
Aaron Wilson
Shannon Young

AAID or ABOI Credentialing During a Pandemic?

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To patients, this confidence comes through in language, body posture (yes, it matters!), and projection of authority in their treatment proposals, which leads to patient trust and cases entering treatment.

Your credential with the AAID or ABOI means it takes you less time to diagnose, sequence treatment steps, and to treat your cases. This translates to less stress on you, your team, and patients, and it means more profitable cases.

This competency opens up additional mental energy stores to devote to the "business of implantology." Ultimately, they are at a higher level in their knowledge base as it relates to how to best treat patients with implant modalities.

No. 2: A serious focus on how to consistently create phone calls from new perspective dental implant patients, usually by using direct-to-consumer advertising (e.g., Google, TV, newsprint). The typical investment starts at $3,000 per month to create two to three full-arch implant cases per month. It's also typical that full-arch implant advertising creates a "rising tide" that lifts the overall practice production besides just implant cases.

No. 3: A serious focus on the process that impacts the total number of cases which go to treatment. This administrative process is considered sales, conversions, or case acceptance. No matter which name you apply, it's the last third in the "trifecta" requirement to routinely treat full-arch implant cases.

There is a high value for the sake of professionalism in pursuing credentials. Ultimately patients look to you for guidance and expect the best services from you. COVID-19 will pass and fade from memory, while the AAID credential and the benefit to your professional growth and the patients you restore to function and improved living will live on for decades.

Dr. James McAnally runs Big Case Marketing, a specialty advertising agency that puts full-arch implant cases in practices every month. You can schedule a time to talk with Dr. McAnally at www.meetme.so/jamesmcanally *or go to* www.BigCaseMarketing.com.

AAID MaxiCourse®
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Abu Dhabi, UAE AAID MaxiCourse®
Abu Dhabi, UAE
Director: Shankar Iyer, DDS, MDS, FAAID, DABOI/ID
Assistant Director: Ninette Banday, BDS, MPH
Email: drsiyer@aol.com
Phone: 908-527-8880
Website: www.maxicourseasia.com

Augusta University AAID MaxiCourse®
Augusta, GA
Director: Douglas Clepper, DMD, FAAID, DABOI/ID
Assistant Director: Michael E. Pruett, DMD
Contact: Lynn Thigpen
Email: lbthigpen@augusta.edu
Phone: 706-721-1447
Website: www.georgiamaxicourse.com

Bangalore, India AAID MaxiCourse®
Bangalore, India
Director: Shankar Iyer, DDS, MDS, FAAID, DABOI/ID
Assistant Director: Dr. Vadivel Kumar, DDS
Contact: Syed Khalid, DDS
Email: drsiyer@aol.com
Phone: 908-527-8880
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Boston, MA AAID MaxiCourse®
Boston, MA
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Phone: 315-922-2176
Location: Harvard Club of Boston
Website: www.bostonmaxicourse.com
Instagram: bostonmaxicourse_bic
Facebook: Boston MaxiCourse

Las Vegas AAID MaxiCourse®
Las Vegas, NV
Director: John Minichetti, DMD, FAAID, DABOI/ID
Assistant Director: Shankar Iyer, DDS, MDS, FAAID, DABOI/ID
Contact: Sarah Rock
Email: sarah.englewooddental@gmail.com
Phone: 201-871-3555
Website: www.dentalimplantlearningcenter.com

Nagoya, Japan MaxiCourse®
Nagoya, Japan
Director: Yasunori Hotta, DDS, PhD, FAAID, DABOI/ID
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Hiroshi Murakami, DDS, PhD, FAAID
Koji Ito, DDS, PhD, FAAID
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Director: John Minichetti, DMD, FAAID, DABOI/ID
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Email: sarah.englewooddental@gmail.com
Phone: 201-871-3555
Website: www.dentalimplantlearningcenter.com

Nova Southeastern University College of Dental Medicine Implant AAID MaxiCourse®
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Assistant Director: Thomas J. Balshi, DDS, PhD
Contact: Linnette Dobbs-Fuller
Email: dentalce@nova.edu
Phone: 609-314-1649
Website: dental.nova.edu/ce/courses/2018-2019/aaid-maxi-course.html

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Assistant Director: Shankar Iyer, DDS, MDS, FAAID, DABOI/ID
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Email: vdrent@roseman.edu
Phone: 801-878-1257

Rutgers School of Dental Medicine AAID MaxiCourse®
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Assistant Director: Shankar Iyer, DDS, MDS FAAID, DABOI/ID
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Email: gibbs@sdm.rutgers.edu
Phone: 973-972-6561
Website: sdm.rutgers.edu/cde/maxi-course

San Juan, Puerto Rico AAID MaxiCourse®
San Juan, PR
Director: O. Hilt Tatum, DDS, FAAID DABOI/ID
Assistant Director: Jose Pedroza, DMD, MSC
Contact: Miriam Montes
Email: prmaxicourse@gmail.com
Phone: 787-642-2708
Website: www.theadii.com

Vancouver AAID MaxiCourse®
Vancouver, BC
Director: William Liang, DMD, FAAID, DABOI/ID
Contact: Andrew Gillies
Email: andrew@implant.ca
Phone: 604-330-9933
Website: www.vancouvermaxicourse.com

Waterloo, Ontario AAID Maxicourse®
Waterloo, Ontario
Director: Rod Stewart, DDS, FAAID, DABOI/ID
Assistant Director: George Arvanitis, DDS, FAAID, DABOI/ID
Contact: Chantel Furlong
Email: info@timaxinstitute.com
Phone: 905-235-1006
Website: www.timaxinstitute.com

AAID CONSUMER OUTREACH

Leverage our monthly website traffic to help promote your practice

Total sessions on consumer-facing website since launch

1,400,913

Join your AAID colleagues and be featured here:
AAID-implant.org/blog

Top blog posts:

- Teeth in a Day—Myth or Reality? How the Dental Implant Process Works
- Considering Dental Implants? Here are 5 Things You Should Know
- Caring for Your Teeth During COVID-19
- The 4 Characteristics of a Candidate for Dental Implants
- What to Expect Going to the Dentist After the Stay-at-Home Order is Lifted

Total page views on the LifeSmiles Blog since launch

10,615

Total sessions from LifeSmiles Blog, offers, and brochures

18,218

Total questions and referrals requested by patients

1,518

Total searches for AAID dentists on the Dr. Finder

8.7M

6 Benefits of Guest Blogging:

1. Improve your website's visibility
2. Increase exposure to your target audience
3. Produce more referral traffic
4. Generate more trust and credibility
5. Gain new patients
6. Measurable results

Become a Featured Guest Blogger:

Help educate patients and drive traffic to your website

Did you know that AAID's consumer-facing website has received **over 8.5 million searches for implant dentists?** They look for AAID dentists in their area as well as for implant advice and guidance. Share your expertise and build credibility for your practice by guest blogging for us!

Email us at **editor@aaid.com** to secure your guest spot! Even if you only have a little time or feel uncertain about a topic to cover, we can do the legwork.

Follow AAID LifeSmiles on social media, too!

AAID Active Study Clubs*

United States

AAID Bergen County Dental Implant Study Group
Location: Englewood, NJ
Director: John Minichetti, DMD
Contact: Lisa McCabe
Phone: 201-926-0619
Email: lisapmccabe@gmail.com
Website: https://bit.ly/2rwf9hc

Acadiana Southern Society
Location: Lafayette, LA
Director: Danny Domingue, DDS
Phone: 337-243-0114
Email: danny@jeromesmithdds.com
Website: www.acadianasouthernsociety.com/upcoming-meetings.html

Alabama Implant Study Club
Location: Brentwood, TN
President: Michael Dagostino, DDS
Contact: Sonia Smithson, DDS
Phone: (615) 337-0008
Email: aisgadmin@comcast.net
Website: www.alabamaimplant.org

Bay Area Implant Synergy Study Group
Location: San Francisco, CA
Director: Matthew Young, DDS
Phone: 415-392-8611
Email: young.mattdds@gmail.com
Website: http://youngdentalsf.com

Calderon Institute Study Club
Location: Queens, NY /Oceanside, NY
Director: Mike E. Calderón, DDS
Contact: Andrianna Acosta
Phone: 631-328-5050
Email: calderoninstitute@gmail.com
Website: www.calderoninstitute.com

CNY Implant Study Club
Location: 2534 Genesee street. Utica, NY
Director: Brian J Jackson, DDS
Contact: Tatyana Lyubezhanina, Judy Hathaway
Phone: (315) 724-5141
Email: bjjddsimplant@aol.com
Website:wwwbrianjjacksondds.com

Hawaii Dental Implant Study Club
Location: Honolulu, HI
Director: Michael Nishime, DDS
Contact: Kendra Wong
Phone: 808-732-0291
Email: mnishimedds@gmail.com
Website: www.honoluludentaloffice.com

Hughes Dental Implant Institute and Study Club
Location: Sterling, VA
Director: Richard E. Hughes, DDS
Contact: Victoria Artola
Phone: 703-444-1152
Email: dentalimplant201@gmail.com
Website: http://www.erhughesdds.com/

Implant Study Club of North Carolina
Location: Clemmons, NC
Director: Andrew Kelly, DDS
Contact: Shirley Kelly
Phone: 336-414-3910
Email: shirley@dentalofficesolutions.com
Website: www.dentalofficsolutions.com

Mid-Florida Implant Study Group
Location: Orlando, FL
Director: Rajiv Patel, BDS, MDS
Contact: Director
Phone: 386-738-2006
Email: drpatel@delandimplants.com
Website: http://www.delandimplants.com/

SMILE USA® Center for Educational Excellence Study Club
Location: Elizabeth, NJ
Director: Shankar Iyer, DDS, MDS
Contact: Terri Baker
Phone: 908-527-8880
Email: dentalimplant201@gmail.com
Website: http://malosmileusaelizabeth.com

Canada

Vancouver Implant Continuum
Location: Surrey, BC, Canada
Director: William Liang, DMD
Contact: Andrew Gillies
Phone: 604-330-9933
Email: andrew@implant.ca
Website: www.implant.ca

International

Aichi Implant Center
Location: Nagoya, Aichi-Ken, Japan
Director: Yasunori Hotta, DDS, PhD
Phone: 052-794-8188
Email: hotta-dc@ff.iij4u.or.jp
Website: www.hotta-dc.com

Beirut AAID Study Club
Location: Beirut, Lebanon
Director: Joe Jihad Abdallah, BDS, MScD
Phone: 961-174-7650
Email: beirutidc@hotmail.com
Website: http://www.beirutidc.com

Courses presented by AAID credentialed members*

United States

2020 Bay Area Implant Institute Continuum
Dr. Ihab Hanna
Phone: 650-701-1111
Email: info@bayareaimplantinstitute.com
Website: https://www.bayareaimplant institute.com/page/course-schedule/

The Dental Implant Learning Center-Basic to Advanced Courses in Implant Dentistry
Dr. John C. Minichetti
Contact: Sarah Rock
Phone: 201-731-3239
Email: sarah.englewooddental@gmail.com
Website: https://www.dentalimplantlearningcenter.com/ce-courses/register-online/

California Implant Institute
Dr. Louie Al-Faraje, Academic Chairman
Phone:858-496-0574
Email: info@implanteducation.net
Website: http://www.implanteducation.net/

Cancun Implant Institute: Comprehensive Oral Surgery Training for Modern Dental and Implant Practice
Dr. Joseph Leonetti & Dr. Bart Silverman
Emails: Jal3658@aol.com
Bsilver293@aol.com
Phone: 1-800-757-1202
Website: https://cancunimplantinstitute.org/

Connecticut Dental Implant Institute Manchester, CT
Various Courses available
Dr. Joel L. Rosenlicht
Contact: Michelle Marcil
Email: michelle@jawfixers.com
Website: www.jawfixers.com

East Coast Implant Institute Implant Complications: A 25 Year Retrospective Review
Dr. Brian J. Jackson
Contact: Jana Selimovic
Phone: 315-922-2176
Email: education@bostonmaxicourse.com
Website:http://eastcoastimplantinst.com/upcoming-courses/

Courses presented by AAID credentialed members*

United States

Implants in Black and White
Dr. Daniel Domingue
Dr. Jerome Smith
Contact: Maggie Brouillette
Phone: 337-235-1523
Email: maggie@jeromesmithdds.com
Website: http://blackwhiteimplants.weebly.com

Introductory Implant Placement 6-Day Dental Implant Course: 48 CE in 6 Days
Advanced Courses:
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(601) Bone Grafting & Sinus Elevation
(602) Digging Out of Problems
Drs. Duke and Robert Heller
Phone: 614-505-6647
Email: dustin@implantdentist.org
Website: midwestimplantinstitute.com

Midwest Implant Institute
Drs. Duke & Robert Heller Advanced Courses:
(305) Implant Prosthetics
(411) The All Inclusive Live Surgical Course
(601) Bone Grafting & Sinus Elevation
(602) Digging Out of Problems
Phone: 614-505-6647
Email: samantha@mii1980.com
Website: www.midwestimplantinstitute.com

Mini-Residency in Implants in Sri Lanka and Malaysia
Course Director: Dr. Shankar Iyer
Contact: Dr. Prasad Amaratunga, Sri Lanka
Email: pgdasrilanka@gmail.com
Contact: Dr. Ahmed Shugey, Malaysia
Email: shugey64@gmail.com
Website www.smileusacourses.com

Pikos Implant Institute
Dr. Michael A. Pikos
Soft Tissue Grafting Sinus Grafting Alveolar Ridge Strategies: Single Tooth to Full-Arch Fully Guided Full-Arch Immediate Implant Reconstruction Contact: Alison Thiede
Phone: 727-781-0491
Email: learn@pikosInstitute.com
Website: www.pikosinstitute.com/programs-and-courses/coursecontinuum-overview/

Stanley Institute for Comprehensive Dentistry
Dr. Robert Stanley
Contact: Megan Carr, Interim Director of Continuing Education
Phone: 919-415-0061
Email: megan@stanleyinstitute.com
Website: https://stanleyinstitute.com/

Canada

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Pacific Implant and Digital Dentistry Institute
Dr. Ron Zokol
Contacts: Barbara Cox and Dr. FarajEdher
Emails: barbara.cox@ddidental.com
faraj.edher@ddidental.com
Website: www.ddidental.com

Toronto Implant Academy
Dr. Emil LA Svoboda
Taming The Old Dragons of Implant Prosthetics-3 Part Virtual Webinar Series
Contact: Christine Wade, Communications Officer
Phone: 416-432-9800
Email: www.reversemargin.com
Link for AAID Group: https://www.reversemargin.com/aaid_guest_ access/
Password: AAID20

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Director Dr. Robert E. Leigh,
Contact Corie Zeise
1-780-349-6700
coriemanager@gmail.com
http://www.westernimplanttraining.com/dentist.htm
http://www.westernimplanttraining.com/about.htm

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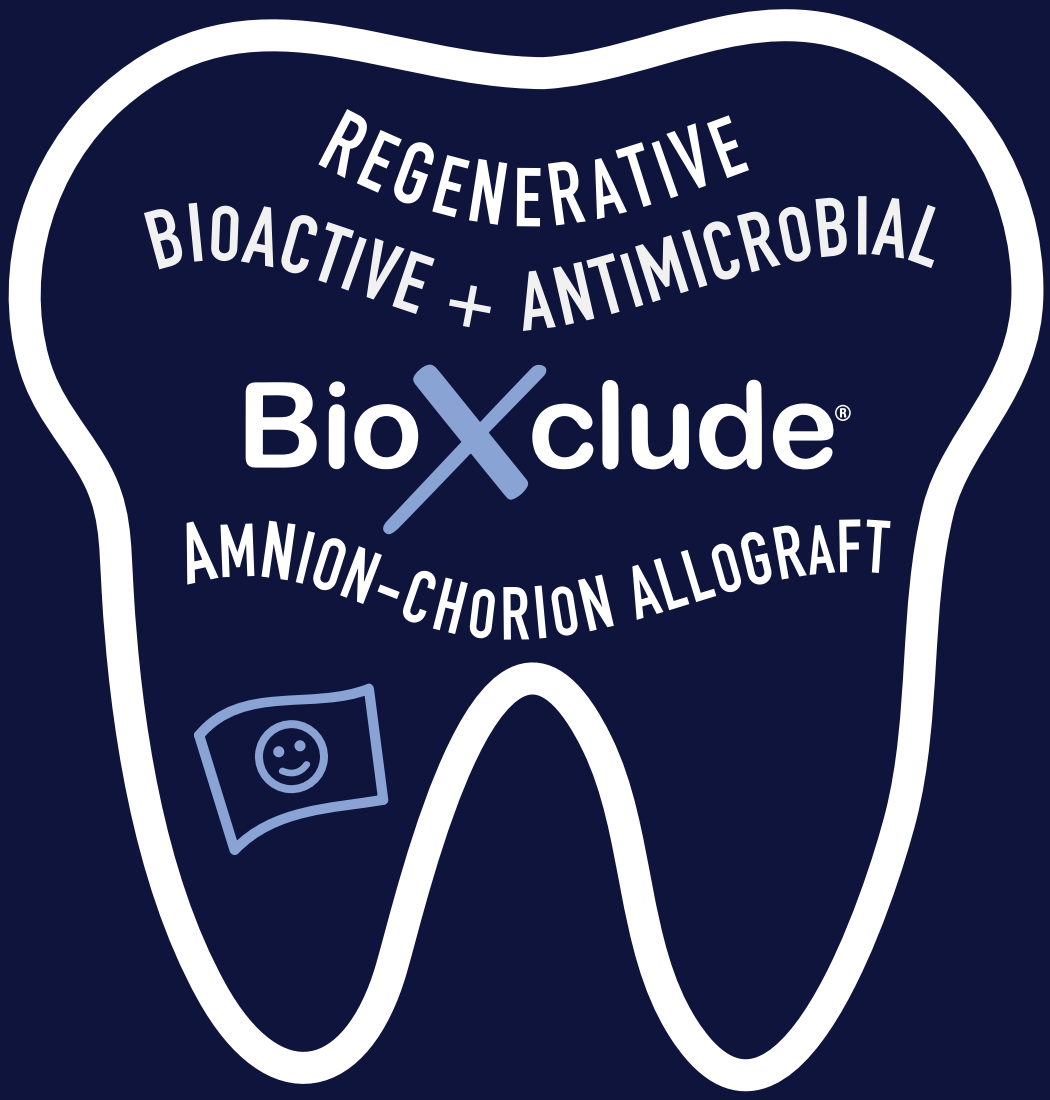
WHY HAVEN'T YOU SWITCHED?



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