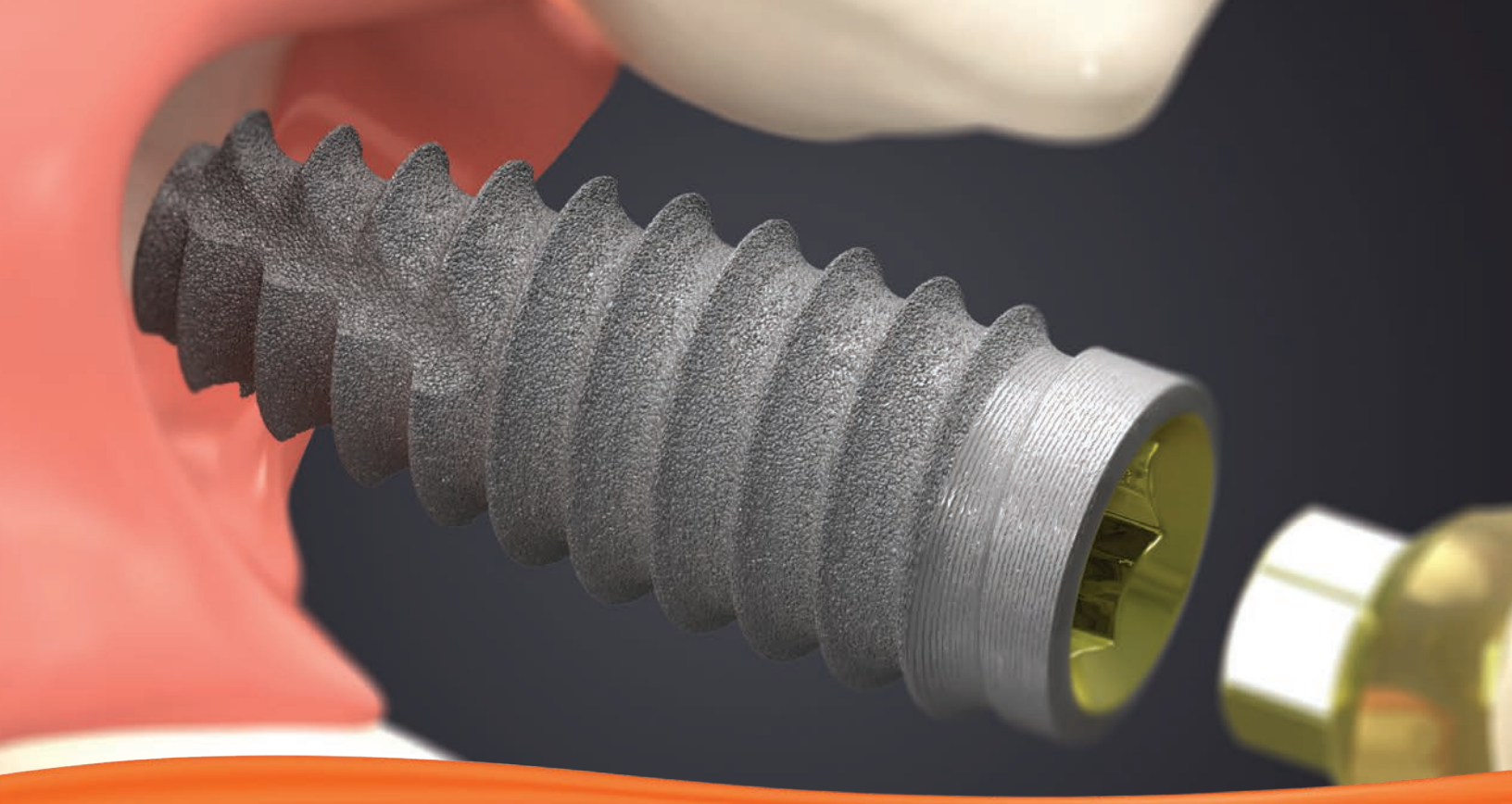
PUBLISHED BY THE AMERICAN ACADEMY OF IMPLANT DENTISTRY / 2020 ISSUE 2

AAID NEWS

TALES FROM THE TRENCHES

COVID-19 Stories from AAID Members

INSIDE



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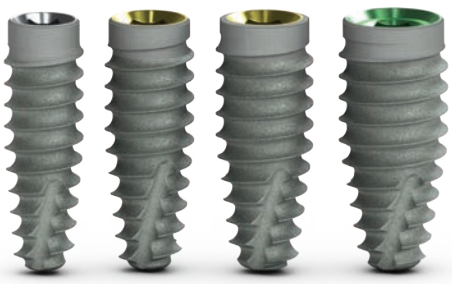

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Lead Stories

AAID News

Cover photo: Dr. Kelly Kaban with safety equipment for COVID-19 risk mitigation that she and her staff are utilizing in her office.

James E. Ference,
DMD, MBA, FAAID, DABOI/ID
Editor, *AAID News*

EDITOR'S NOTEBOOK

Clarity and Ethics in the Dental Insurance World

In 1906, one of the first consumer protection laws was passed. The Pure Food and Drug Act was essentially a "truth in labeling" law and was intended to raise the standards of those in the food and drug business. Apparently, the intent in that era was primarily to avoid fraud and deception about ingredients.

By 1973, nutrition labeling of some foods was required and has evolved now to the familiar "Nutrition Facts" on the back of most things in our grocery stores. It describes calories, total fats, saturated fats, carbohydrates, sugars, proteins, and a few other details.

These governmental intrusions into the marketplace are meant to allow consumers to make informed decisions so they can effectively and intelligently pursue what is in their best interest.

Similarly, pharmacy benefit managers who work for pharmaceutical companies previously prohibited information to the consumer disclosing that it sometimes was less expensive to buy certain drugs for cash than to use insurance and pay the copay. Pharmacists were prohibited from providing this information due to a clause included in the agreement required of the pharmacists to be permitted to be in the network. These "gag" rules have recently been largely made illegal due to legislation that recognizes the process as deceptive.

There are factors in the world of dentistry that also cause consumer confusion and misunderstanding.

Frequently third parties like insurance companies are involved and can skew the transaction in ways that may introduce a bias leading to decisions which are not obvious to the consumer. If patients know of the trade-offs and accept them, at least they will be making informed and voluntary choices. If, however, the options have been altered and they don't know about it, ethical issues arise. The patients may now be a subject to behind the scene arrangements of which they know nothing.

What biases result from insurance company policy that may lead to lower quality services? What services may not even be available to "insured" patients that others can access? Are patients able to access better options by paying "differences" or are they prohibited transactions? Are some reimbursements so low as to affect which options will be presented? What is the overhead of the insurance company that is not directed to patient care? What percent of revenue from subscribers is paid out for patient care? These and other revealing questions may be reasonable for an interested consumer to know before buying a product that may affect his or her health. Well thought-out and relevant questions and the answers—should be on the "label"— and in language that can be understood.

The *ADA News* recently described Louisiana Act 187, which limits an insurance company's freedom to "downcode," and keeps insurance companies from using "explanation of benefit" (EOB) notices to unjustly imply wrongdoing on the part of dentists. A second bill, Act 256, addresses how insurance companies deal with pre-existing conditions. The Louisiana Dental Association should be congratulated on pursuing these changes. It would be highly valuable to have an easy to understand summary of state-by-state legislation that is designed to combat inappropriate insurance company policies. Then practitioners as well as consumers in any state could pursue constructive change in their own area based on success achieved elsewhere. Consumers should be able to more easily understand the whole picture of how feasible and advantageous dental insurance policies really are—or aren't.

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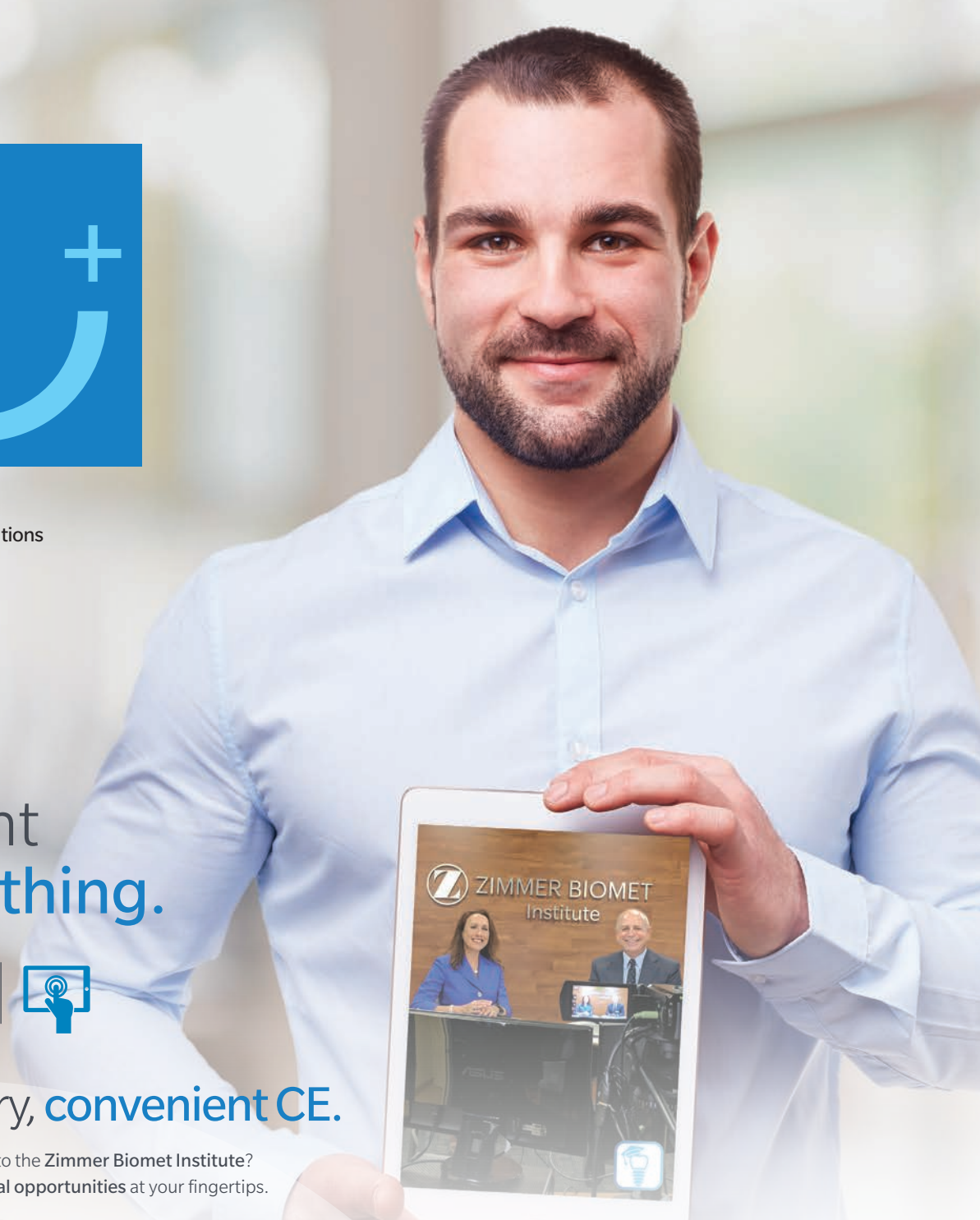

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Bernee Dunson,
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AAID President

PRESIDENT'S MESSAGE

Unprecedented Innovation

First and foremost, on behalf of the AAID, I hope you and your family are safe and healthy. During this time of COVID-19, safety is at the forefront of all of the decisions we are making as an organization. This is surely a challenging time for all of us, but I also see within this time an opportunity to innovate and elevate the way we live, treat patients, run our businesses, and interact and collaborate with colleagues.

For 69 years, the AAID has been and is committed to that collaboration — especially during our annual conferences. While this year is unprecedented, it's no different than the others in terms of the dedication and commitment we have to gathering our implant community to learn from experts and each other and build lifelong relationships.

The AAID Virtual Experience, "Looking at Success: Moving to Consensus," will take place this year from November 11 to 14. Safety is our key concern, and planning decisions are being guided by science-based recommendations from health officials. As the COVID-19 pandemic changes how we engage with our patients and each other, and the AAID's commitment to the health and safety of all our members, the AAID is also innovating how we deliver education. As a result, this year's scientific session will be entirely virtual to enable our attendees, speakers, and exhibitors to participate and connect with the largest audience possible.

The conference will feature topics like digital dentistry, growth factors, bone growth, prosthodontics, materials, regenerative issues, and more. We will also once again offer an exciting lineup of team-focused workshops and programs for your dental teams to attend either virtually or real-time. We are also excited to present a robust experience to talk with vendors and sponsors.

Our keynote speaker is implant expert Dr. Joseph Massad, who will discuss the evolution of dentistry and start with the early principles our dental pioneers passed on to where we are now in our profession. And that's just a taste of what we have been planning. Visit the AAID website (aaid.com/annual_conference) for up-to-date information about all of these exciting offerings.

I hope you will consider joining us virtually this fall to innovate and elevate the way you work with your teams, collaborate with your colleagues, and how you approach and deliver care to your patients. The health and safety of the entire AAID community is of utmost importance to me and I look forward to seeing everyone at our Scientific Session happening this fall.

As the COVID-19 pandemic changes how we engage with our patients and each other, and the AAID's commitment to the health and safety of all our members, the AAID is also innovating how we deliver education.

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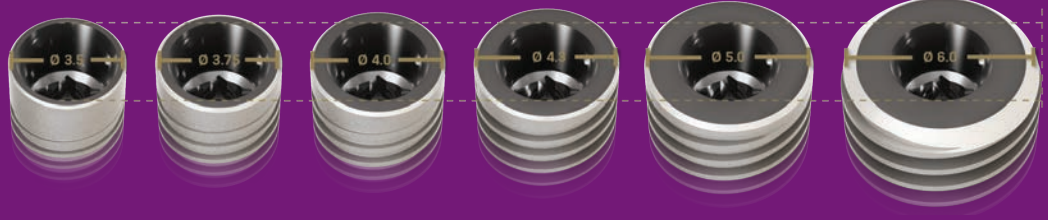

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TALES FROM THE TRENCHES

COVID-19 Stories

from AAID Members

In December 2019, an outbreak of the novel coronavirus in Wuhan, China, sparked what became a global pandemic. As the new year progressed in January and February, COVID-19 made its way through Asia and Europe like wildfire. Although we spent those early days glued to news shows, it still came as a surprise to many as the virus took hold in North America in March. Soon, cities across the continent shut down and people quarantined in an effort to stop the disease in its path. Today, we are still feeling the societal implications of COVID: emotionally, economically, and clinically. The effects of this virus have indelibly changed the world.

Dentistry, like many professions, had to pivot quickly to deal with the health and financial consequences of COVID. As practitioners with the mandate to heal, dentists have been particularly challenged by the quest to move forward during these difficult times. With their dual roles as clinicians and business owners, these individuals had to find a balance between treating patients while protecting themselves and their staff and keeping their practices afloat. Interviews with eight members of the American Academy of Impact Dentistry from across the country and Canada uncovered recurring themes on how they have endured COVID and how the pandemic may have permanently changed the way they will provide care.

THE SHUT DOWN

AS A PRACTITIONER AND A BUSINESS OWNER

"When COVID broke out in China in late 2019, I remember thinking that it wouldn't affect me," states Dr. James Miller from Hillsboro, Oregon. Many of his colleagues felt the same, making March's shutdowns even more unsettling. "It wasn't long before Oregon ordered dentists to stop seeing patients at the risk of a Class 3 misdemeanor," continues Dr. Miller. "We were healthcare professionals who were not allowed to treat patients except in the case of an emergency. And the definition of that term was not clear. We had to hold a CE course to discuss what was meant by the term 'emergency'."

Dr. James Miller

While practitioners understood that closing was important to slowing down the virus, these individuals were also business owners who could not ignore the impact this decision would have on their employees. Dr. Frank Caputo from Cudahy, Wisconsin, notes that his office could only support a skeleton crew to triage calls and handle urgent cases. "We had no choice other than to lay off the rest of the staff. We felt bad making that announcement, but what else was there to do? There was no income flowing into the office and the Paycheck Protection Program (PPP) wasn't quite clear at the beginning. Most applied for unemployment."

Dr. Frank Caputo

Dr. Lawrence Nalitt's office in Brooklyn, New York, is located in a low-income area that had high COVID numbers. He was very concerned about his staff. "I thought it was critical to reassure them during this stressful time. We talked about unemployment and furloughs, and that they would still have a job when the office reopened," states Dr. Nalitt. Ironically, he tested positive for COVID on the day the office officially shut down. "On that last day of work, I wasn't feeling well. Any other year, I might think that I had a little bug. Within a few days, my fever was 102 degrees and had a slight cough. Telemed said it might be COVID, but testing materials were scarce at that time, so I just quarantined at home for two weeks. Two months later, I tested positive for the anti-bodies."

Dr. Lawrence Nalitt

Luckily, he had a mild case and was able to help out patients via telemed and referrals. "New York was in bad shape at that time with overflowing emergency rooms. I did not want to send anyone to the ER for a

continued on page 10

Opposite page:
Dr. Lawrence Nalitt at his office in Brooklyn, New York

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Dr. Nalitt acquired necessary PPE including face mask and face shield.

toothache. I kept in constant contact with my staff, practiced telemedicine, and worked with colleagues to help patients."

Dr. Lion Berzin

Dr. Lion Berzin from Toronto, Canada, tells a similar story about shutting down his practice after receiving an email from the Royal College of Dental Surgeons of Ontario. The directive prohibited dentists from providing non-urgent services beginning the following day. "Staff-wise, we laid off 20 employees across our two offices, all of whom were eligible for wage subsidies from the Canadian government," he notes, appreciating those governmental supports.

Dr. Kelly Kaban, who practices with her father in Huntington Beach, California, made the joint decision to close the office completely and refer patients to other dentists during this global pandemic. "Our staff has been with us for many years and are like family. We did not want to put any of our employees in an unsafe position, even though this was not an easy business decision. They are on unemployment and we have stripped down our expenses to the bare bones," says Dr. Kaban. "We were outliers and did not see emergencies. We didn't want to open until we had more information on how to treat patients during this virus."

Dr. Kelly Kaban

REOPENING OFFICES

GETTING THE RIGHT INFORMATION AND PROTOCOLS

By May, most offices began to reopen, and they moved forward with a mix of excitement and trepidation. Each of the dentists interviewed expressed frustration with trying to obtain PPE, navigating access to the governmental safety nets, and deciphering the correct guidelines and protocols.

Dr. Grace Chung

"We reopened on May 12, following some intense training with the team," states Dr. Caputo. "The decision to reopen was filled with mixed emotions—some were excited to get back to the office to start treating patients, while others were filled with anxiety and fear. The weight of trying to navigate these tough decisions was not easy. We were trying to make sure our patients were being treated, trying to ensure our business could operate, and trying to get our team to feel comfortable with working in this environment again."

Dr. Grace Chung from Henderson, Nevada, notes that one of the biggest challenges was sifting through the mountains of information for best practices and guidelines. "Small offices like mine don't necessarily have the resources or people to call at their fingertips when we need advice," she notes. "State leadership did what it could do to help but they were preoccupied with the very conflicting data on how to move forward. In the end, we mostly relied on our dental colleagues for developing a roadmap for protocols – in terms of safety and to help keep our business above water."

Others experienced the same confusion, but were able to find protocols that made sense to them. "Soon, we started to see the American Dental Association (ADA), Occupational Safety and Health Administration (OSHA), and the Centers for Disease Control and Prevention (CDC) develop some type of guidelines as it applies to dentistry," explains Caputo. "The guidelines may not have been perfectly clear, but it gave some direction. Temperatures and screening questions have proved instrumental in lowering risks. Smaller protocols included hand hygiene, face coverings, and a change in PPE. The biggest change for us is that some of our team members decided that the risk was too great to return."

Dr. Nalitt took guidance from the CDC, AAID, ADA, and the New York Dental Society on how best to proceed. "Different

"In addition to expanded safety protocols such as COVID-19 patient screening and enhanced infection control, my staff and I are routinely wearing 3M™ Versaflo™ TR-300+ Powered Air Purifying Respirators."
— Dr. Kelly Kaban

Dr. Kaban utilizes a heavy-duty, hospital-grade air scrubber (Air Rover APS2000) that purifies the air in her office at a rate of 10,000 cubic feet of air in 23 minutes or 2,000 cubic feet per minute. The air is purified through HEPA filters and UV-C lights.

sources came out with different guidelines and suggested equipment for safety.

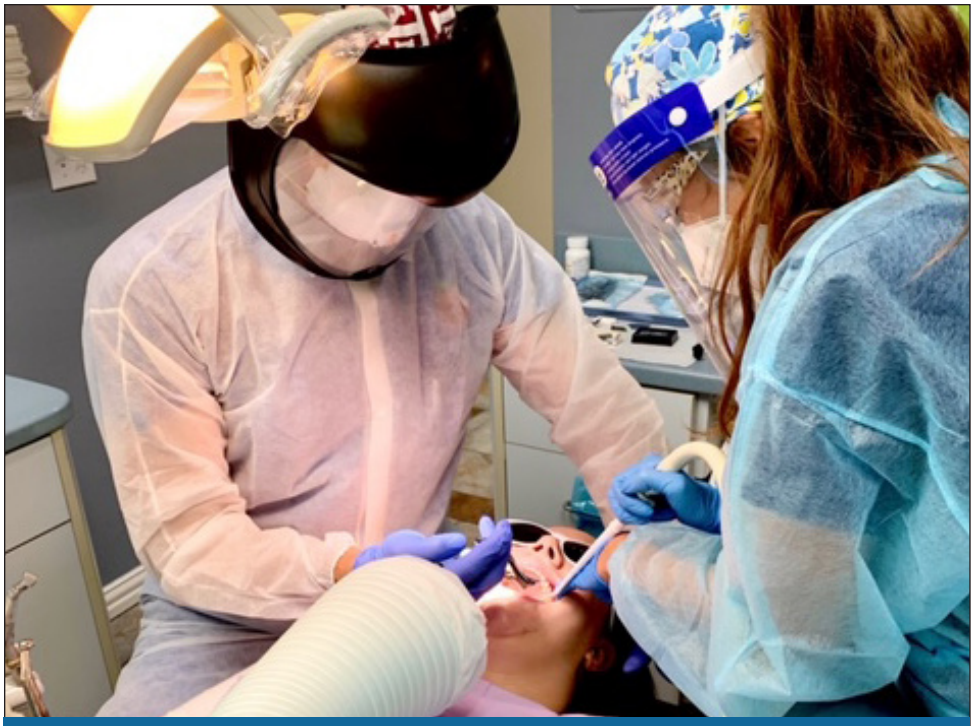
However, I talked regularly with peers to figure out how to navigate during this difficult time – in particular, the district 'happy hours' on Zoom organized by the AAID were great opportunities to strategize and learn more about protocols."

Dr. Miller also relied on other credentialed dentists in his state to develop a plan when he felt that he didn't get any official guidance. "We met on Zoom and asked ourselves questions like: Should we revamp HVAC systems to filter and clean the air? What about using pre-filters, carbon filters, HEPA filters, and UVC light systems to kill viruses?"

Dr. Berzin in Canada also tried to stay abreast of the new information that was being released. "Many practices bought new products and technologies to meet the ever-changing protocols, only to be told that they were no longer being required," he notes. "In fact, I almost 'pulled the trigger' several times to purchase new equipment that quickly was pulled from the revised guidelines. In the end, it turned out that we already followed many of these practices and did not need to change much in our office."

Obtaining PPE was a challenge and working in the equipment has not been easy. According to Dr. Nalitt, dentists were asked to donate their PPE to front-line workers in hospitals at the beginning of the pandemic. Therefore, many practices found themselves without the protective equipment for their own safety when dental offices eventually reopened. States Miller, "We had difficulty in getting PPE – including getting fitted for N95 masks. People don't realize that each N95 mask manufacturer required its own fitting. Eventually, I found KN95 masks, but it turned out that they were fake."

Another frustrating issue has been accessing governmental benefits such as PPP and unemployment benefits: forms were confusing and phone calls for clarity went unanswered. Dr. Miller shared that one member of his staff that didn't receive his unemployment benefits for more than two and a half months. And Dr. Nalitt still feels the stress experienced with the collapse of the economy while his practice was closed, thus hindering his ability to earn money.



Dr. Jay Elliott's staff wearing PPE while caring for a patient.

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NEW PRACTICES

Dr. William Liang from British Columbia states, "Here are some of the things we learned: Coronavirus is not a hardy pathogen. It can be easily destroyed outside the body. The trick is to manage the workspace, focusing guidelines on sanitizing surfaces and the air quality. Our current aseptic protocols in dentistry far surpass the requirements to kill SARS-COV-2 virus. Dental practices should address the air quality. We are researching and revising air filtration systems for small particles and aerosols. One possibility is a Hypochlorous Acid fogger (HOCL) which fogs the air in the room and destroys the virus on contact. This can be done between patients. It is important to be cautious and willing to adapt when we don't know the pathology of the disease. We cannot easily test for the presence of the virus after thorough disinfection, but we could use devises such as the ATP meter adopted by the food industry do the job. While it is not an exact process, it does show what we are doing is working." [See box for other new equipment and protocols.]

Dr. William Liang

LESSONS LEARNED: THE GOOD, THE BAD AND THE UGLY

Dr. Kaban and her father have reopened their practice. "Ultimately, reopening is about our own risk tolerance and we wanted to have more protections in place before coming back. Some dentists went in as soon as the state allowed. Others were nervous about how quickly offices were opening without new information about risks and protocols. For us, it was about the health of our staff and ourselves. In particular, our dental hygienist was concerned. You can screen patients, but what if they are asymptomatic? If I am not willing to put myself in that position, I won't have my staff or patients in it either. I felt that we needed more information from the CDC, ADA and other sources/journals with evidence to further understand the virus to inform the decision process."

Dr. Jay Elliott

Dr. Jay Elliott from Houston, Texas, feels that this time is reminiscent of the AIDS crisis in the 1980s. "I am the oldest in my office – and was around for the uncertainty that came along with the HIV/AIDS crisis in the 1980s. I was able to impress upon the staff that a lot of people would be afraid and we needed to reassure them. These new protocols will become regular tools in our kit as gloves did following the AIDS crisis."

Dr. Miller concurs, "I think the biggest lesson learned is one I learned from the 1980s AIDS crisis: you cannot let fear take over. I didn't become a dentist to treat well people; I became a dentist to treat the sick. We need to make educated decisions on where to proceed safely."

Others see a silver lining from this difficult situation. Dr. Chung notes that "being away from dentistry made me remember how much I love the profession. Our staff as a team is stronger. And I have brought in my teenage children to help out at the practice – a side benefit I did not expect!"

Dr. Liang, who is also the director of the AAID MaxiCourse® in British Columbia states that this pause in time has allowed him an opportunity to better reflect on matters and to figure out priorities. "I have had several ideas for restructuring and improving the course over the years. But time has always been at a premium and getting the other organizers together to work on the program has been an impossible task. During the quarantine, we were all able to gather via Zoom and enhance the quality of the series. We are ready to move forward with enhanced materials and a wider variety of speakers."

Dr. Elliott also moved the Houston MaxiCourse online beginning in March and went through May. It has been a real challenge for both the course and participants.

"I'm looking to make the experience better for myself, my assistant, and my back office. We realize that the upfront costs may be higher, we believe these strategies will save us money in the long run," Dr. Kelly Kaban says.

Here are some of the protocols / equipment that the group has started to incorporate.

Respiratory and air circulation in operatories and in common space

- Engineering changes to the air controls in the operatories
- Retrofitting the office with an air scrubber to allow for negative pressure
- HEPA filtration units
- Aerosol protection for every operator in the practice
- ULPA filtration -- leave them running all day, whether or not there is a patient in the room
- Ozone generator when leave room that kills everything
- Air purifying respirators (PAPRs)

Infection control

- Spread out time between patients to allow for disinfecting and air decontamination in operatory
- Wrist-to-knee, full-length overgowns and pharmaceutical wipes
- Removing furniture and decorations from office
- Remove clutter like magazines
- Heavily sanitize high touch areas several times a day

Patient logistics

- Pre-screen patients/take temperatures.
- No waiting inside – wait outside until appointment
- Online forms
- Preform all needed work in one appointment vs. spreading out over several
- Meet with whole family/bubble to take care of patients with less downtime

Hygienists

- Use hand tools
- High volume evacuation
- Schedule these appointments for the end of the day so the rooms can be left overnight for decontamination
- Having patients pre-rinse with hydrogen peroxide to minimize risk of germs in their mouths
- Oral suction units

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

Defending AAID Members' Rights: Updates From Around the U.S.

Despite court victories in Florida, California, Texas, the Fifth Circuit Court of Appeals covering Texas, Louisiana, and Mississippi, the Michigan Board of Dentistry chose to file disciplinary charges over advertising against Dr. Pierre Tedders, a Diplomate of the American Board of Oral Implantology/Implant Dentistry (ABOI/ID) and Fellow of the American Academy of Implant Dentistry (AAID). The AAID Board of Trustees reviewed the facts and the advertising at issue (Fellow of the AAID and Diplomate of the ABOI/ID, Certified Dental Implantologist) and in response, the AAID launched a federal lawsuit challenging the constitutionality of the Michigan regulations, which prohibit non-American Dental Association (ADA)-recognized specialty advertising and mandate disclaimers of "general dentist," which was the basis of the Sixth Circuit reversing the lower court in Ohio, and leading to Resolution 65 in the ADA House in 2017.

In past court rulings, such regulations were struck down as violations of commercial free speech. And, based upon the 2015 Supreme Court Decision *NC Board v FTC*, the Supreme Court held that dental board members who constituted a majority of the board that regulated the dental profession in any state could be personally liable for a violation of the antitrust laws if his or her conduct was found to be anticompetitive; as a result, the individual members of the Board were also sued on the basis of antitrust activities. When the AAID sees boards acting contrary to established case law, it will act to protect its credentials and the integrity of its credentialing processes.

When the AAID sees boards acting contrary to established case law, it will act to protect its credentials and the integrity of its credentialing processes.

Clearly, dental advertising has its supporters and detractors.
The detractors are usually from the old school of dentistry who believe it is unprofessional, and the supporters are typically business-oriented professionals who understand the value of marketing. And until the United States Supreme Court resolves the dental advertising conflicts, various state challenges will continue.

In another more recent case, the Mississippi Board was recently sued in federal court (although the AAID is not a party in that suit). A federal suit was filed in Jackson several weeks ago alleging multiple constitutional violations. One is a board regulation that gives the board investigators or agents the alleged authority to walk into a dental office and seize any record they wish to take. They disregard the protections afforded by a subpoena, search warrant, or court order, and rely on a regulation that purports to give themselves the right to take whatever they want without any statutory or judicial authority, forcing the dentist to waive his or her rights under the fourth, fifth and fourteenth Amendments. It also tramples on the rights that patients have under state laws involving patient privilege and other protections. I am unaware of any other state with such an egregious regulation, and it has never been challenged on a constitutional basis before.

The typical Mississippi pattern is to seize records, charge a dentist, and negotiate with the dentist for a suspension of licensure, repayment to the board of investigatory costs, a fine, and probation. Most dentists would rather "eat" such a sanction than pay to exonerate themselves and fight the state. If a board fundamentally dislikes advertising, it can target a dentist, especially one who advertises on billboards or television. One past case in Texas illustrated this principle. It brought every complaint it had on file involving advertising. When the complainant was investigated, it was found that a dental assistant or hygienist wrote a complaint on behalf of the employer dentist—but that wasn't disclosed until he or she was deposed. The individual board members were also sued in their personal capacities for $10 million.

Clearly, dental advertising has its supporters and detractors. The detractors are usually from the old school of dentistry who believe it is unprofessional, and the supporters are typically business-oriented professionals who understand the value of marketing. And until the United States Supreme Court resolves the dental advertising conflicts, various state challenges will continue.

I am hopeful that, in our ongoing parade of state-by-state challenges, we will eventually get a final conclusion that solidifies and ends the debate, solidly on our side, in Washington, D.C.

By Roger P. Levin, DDS

The Director of Production

Just imagine this fantasy: Your practice has a Director of Production. The job description is simple—hit the production goal set by the practice. This means that every day the Director of Production must make sure that the most important factors in achieving the daily production goal, and ultimately the annual production goal, are happening. This person helps the dental team improve performance, ensures that everything is being done properly, makes course corrections as needed, and measures results. If the measurements aren't acceptable, then the Director of Production will work with the necessary team members to revamp their duties and ensure that the annual production goal is achieved within 12 months.

The Director of Production would be a wonderful position to have in every dental practice, especially in this COVID-19 era. That person would spend his or her day with a solitary focus: making sure everything is being done to maximize revenue. He or she would help everyone understand that production is the number one factor in the business turnaround and that the business turnaround is the number one focus in the practice.

The Focus of the Director of Production

In this COVID-19 environment, your Director of Production would understand that his or her main job is to make sure that the practice survives and returns to profitability. The Director of Production's mantra would be, "Production leads to revenue, revenue leads to cash, and cash leads to income."

So, in this fantasy scenario on which areas of the practice would the Director of Production focus most?

1. **Reactivate patients.** The first and biggest opportunity to increase production is through the reactivation of patients. The Director of Production would use a nine-step, nine-week process starting with phone calls to achieve this goal. During this crisis, patients will be afraid for their health *and* their wallets. Therefore, the Director of Production would instruct the team to call first, using scripting to create comfort about safety, expanded financial options, and interest-free financing. This would give many patients the confidence to schedule appointments.

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Business Bite

continued from page 16

The Director of Production would be a wonderful position to have in every dental practice, *especially* in this COVID-19 era. That person would spend his or her day with a solitary focus: making sure everything is being done to maximize revenue.

2. **Revamp the schedule.** There is an old expression that says, "Do the most productive things first." This always made sense in business but was not necessarily urgent in dentistry. Now it is and your Director of Production will "live it." They will realign the schedule to handle the most productive procedures first, training the team to schedule new patients, large cases, implant cases, and emergencies as soon as possible because they all represent a higher average production per patient and average production per hour. He or she would also create a schedule with expanded hours, which allows patients more convenience to return to the practice. More hours mean more production, and in a business turnaround you want to accumulate as much production as possible as quickly as you can.

3. **Educate patients about dental hygiene.** For many patients, dental hygiene is simply cosmetic and discretionary, especially during this time. The Director of Production would want patients to start thinking about their hygiene appointments as essential. Remembering that in the 2008/2009 recession practices lost 8 to 9% of their patients especially in dental hygiene, the Director of Production would email all patients with information about gingival and periodontal disease. Further, he or she would train every dental hygienist to probe every patient at least once a year. If periodontal disease is identified, it can then be presented to the patient with a treatment plan. This could increase dental hygiene production by 20% or more.

4. **Institute new financial options.** The Director of Production will be focused on increasing the use of patient financing by 200 to 300% per year with the understanding that practices that don't do this will end up losing a great deal of cases and production. They would also institute payment plans, even though traditionally they have an approximately 8% rate of default. To help ensure some level of profit, the Director of Production would insist on a 50% upfront payment with the understanding that the collections from these patients will contribute to covering overhead. Even if they end up not finishing their payments, some profit is better than none during this time. The Director of Production will also focus on collecting a target of 92% of payment plans in full, providing staff an excellent scripting and follow-up system to pursue collections, maintaining continuity with patients, and, when necessary, renegotiating the payment plan. The Director of Production would allow discounts for patients who otherwise would be unable to take advantage of full treatment. A 10 or 15% discount on a large implant case still allows for a 25 or 30% profit margin. It is not the fees of any single patient on which you should focus; rather, it is about the mix of all fees, and if that mix allows the practice to achieve the production goal, the Director of Production is doing a great job.

5. **Create best practices for operating on an accelerated schedule.** Many dentists think that they are on accelerated schedule, but they didn't truly understand the concept and aren't fully leveraging the idea. A true accelerated schedule has a dentist working two (or three) rooms with one assistant per room. This ends up creating a 30% higher overall production than the way a dentist would normally work. If a third room is incorporated into the accelerated scheduling model, it would produce at least 50% of rooms 1 and 2.

6. **Analyze all insurance plans and participation.** The Director of Production would look at the number of patients per plan, total numbers of patients in all plans, total revenue per plan, total revenue for all plans, discounts against standard fees, referrals per plan, and

What if your practice could implement all the actions that would be taken each day by a Director of Production? Production would certainly go up by as much as 5 to 25%—maybe even more.

referrals for all plans. Once the Director of Production has completed this insurance analysis he or she would then determine which plans should be exited and if any new plans should be joined. This can have an impact of 10 to 15% production up or down.

7. **Manage and monitor staff.** The Director of Production will continually ensure that the phone is answered within two rings, new patients are scheduled within seven days, filling the next open appointment is a major focus of the front desk, and daily operations are built for production. The Director of Production would also make sure that that patients pay balances at the time of their visits, that the staff is alerting patients when their family members are overdue for appointments, staff members are asking for positive reviews, and coupons are provided to patients for referrals.

There's no need to post a job ad or call a recruitment agency: The Director of Production is not a real position and I am not recommending that it should be. It would simply add too much overhead for most practices. Still, it's something to think about conceptually. What if your practice could implement all the actions that would be taken each day by a Director of Production? Production would certainly go up by as much as 5 to 25%—maybe even more. Use the recommendations outlined above to ensure that your practice stays focused on everything needed to boost your production during the recovery.

Roger P. Levin, DDS is the CEO and Founder of Levin Group, a leading practice management consulting firm that has worked with over 30,000 practices to increase production. A recognized expert on dental practice management and marketing, he has written 67 books and over 4,000 articles and regularly presents seminars in the U.S. and around the world.

To contact Dr. Levin or to join the 40,000 dental professionals who receive his Practice Production Tip of the Day, *visit* www.levingroup.com *or email* rlevin@levingroup.com.

By Dennis Flanagan DDS, MSc, DABOI/ID, FAAID

Mini Implants: They Cannot Be Placed in Every Site, But They Can Be Effective Treatment

Mini implant dental implants can save a compromised edentulous site and improve a patient's quality of life. (See Figures 1-4 on page 21) However, they cannot be placed in every site with the expectation of long-term success.[1] Nonetheless, mini implants may be as successful as standard diameter (>3.0mm) implants when placed appropriately.[1] Indications for mini implant treatment include, atrophic bone, decreased site width and length but not height, patient fear of surgery or tissue grafting, medically compromised, and financial inabilities.[1] Nonetheless, an appropriate referral may be necessary for appropriate treatment. There are no high-level credible studies on mini implants supporting fixed prostheses, but they may used to support fixed prostheses using mechanical physiologic knowns. Mini implant treatment may require clinical experience and training.

There are no high-level credible studies on mini implants supporting fixed prostheses, but they may used to support fixed prostheses using mechanical physiologic knowns. Mini implant treatment may require clinical experience and training.

After an extraction, the bone atrophies and volume shrinks. The facial wall moves to the lingual and the lingual wall generally does not change much.[2] The facial and lingual cortices become close in proximity.[3] The 2 cortices may approach contact and dense bone for mini implant support. These sites may not require grafting or ridge splitting for mini implant placement.

Mini implants can be placed flaplessly.[2] The clinician needs to know the underling osseous contour for appropriate placement.[4] This may require a preoperative cone beam computerized tomogram (CBCT) or ridge mapping.[2,4,5]

The small physical displacement mini implants may be less of an obstruction for angiogenesis and osteogenesis.

There may be heat produced to bone during seating of mini implants in the anterior mandible.[6] The thermal conductivity of titanium is about 70 times that of bone. Thus, irrigation may be appropriate during mini implant seating.

Percutaneous exposure is much smaller with mini implants compared to standard diameter implants and may be less susceptible to peri-implantitis.

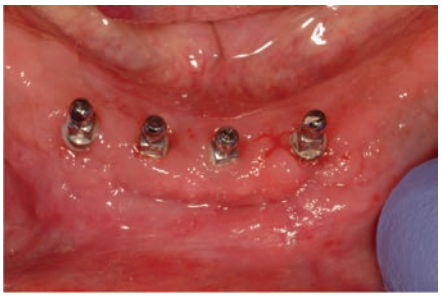

Figure 1

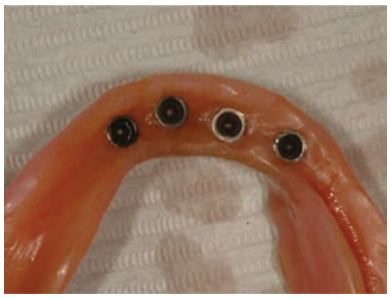

Figure 2

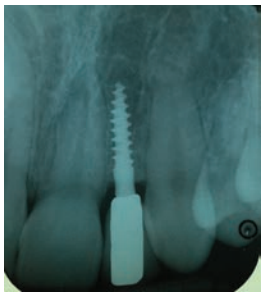

Figure 3

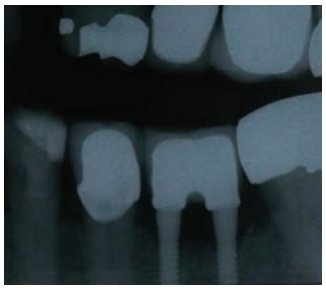

Figure 4

Just as with any implant, adequate attached tissue or immovable mucosa should be present.[7] Since mini implants have a small diameter and loading is delivered to the implant cervical, there will be a larger per-square millimeter of force delivered to the cervical embedding bone.[1] This will be about twice the load of larger implants.

So, occlusal loads must be controlled. A narrow flat occlusal table with rounded cusps is indicated. Anterior guided occlusal schemes for fixed restorations and lingualized occlusion for removable dentures are best. Protection from off-axial loads is very important.

Testing the patient for maximum bite force capability may be in order.[8,9] There are 3 companies that sell oral bite load capacity devices: KUBE, Montreal, Canada; FUTEK, Irvine, California; and Tekscan, South Boston, Mass. Occlusal relief up to 100 microns may be indicated to ensure a long-term favorable outcome. The bite load capability of complete denture patients is much lower than dentate patients and may be the most appropriate patient for mini implants.[8-10] Nonetheless, mini implants will not "save" a case with an ill-fitting denture or inappropriate occlusal scheme.[8,9]

Mini implants retaining removable dentures can be immediately loaded so the seating torque should be a minimum of 32ncm.[11] If the anatomy allows, more may be placed for improved retention.

Maxillary bone may not provide adequate support for kin implants due to less dense bone. Nonetheless, it is possible when there is dense bone, the occlusal loads are controlled, and the measured bite force is low.[1]

After placement, the mini implant should be very stable with a solid feeling when tapped.1 Coping abutments can be used for telescoping crown fabrication. Systemic factors can influence the clinical longevity due to the disease itself or the systemic treatments.[12]

Cementing of mini implant supported crowns and dentures should be done with cemented with resin cements. Soluble cements should be avoided.

Any implant placed in the anterior mandible can severe the sublingual artery that can subsequently retract into the floor of the mouth creating a significant hematoma.[13,14]

A 2010 directive from the Food and Drug Administration (FDA) classified mini dental implants acceptable for "long term use."[15] Any "off-label" use has a guarded prognosis.

Most research in dental implants has been on standard sized implants. There is a very small knowledge base on mini implants. Mini implants are similar to standard diameter implants, indeed, but the physio-mechanics are very different and this needs difference needs exploration.

Mini implants cannot be placed in just any anatomical site. The clinician needs to be aware of the osseous and soft tissue features of a prospective site, the patient's bite force capability, esthetic expectations, appropriate occlusal schemes, and treatment of complications. Complications can occur and should be addressed early.

Indications for mini implant treatment include inadequate site length or width, atrophic bone, medical issues, fragility, financial hardship, patient declination of grafting, and patient fear of surgery.[1,16] Maxillary lateral incisor and mandibular incisor sites may be most amenable for mini implant restoration due space limitations, favorable bone density and decreased occlusal force impartment.[17]

continued on page 22

continued from page 21

Mini implants cannot be placed in just any anatomical site. The clinician needs to be aware of the osseous and soft tissue features of a prospective site, the patient's bite force capability, esthetic expectations, appropriate occlusal schemes, and treatment of complications. Complications can occur and should be addressed early.

Guidelines for Mini Implant Treatment

- Know the osseous contour before placement.
- Type 1 and 2 bone sites are the most appropriate bone types.
- Adequate attached tissue is necessary.
- Off-axial loading must be controlled.
- Maintenance is important.
- Resolve complications expediently.

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AAID CONSUMER OUTREACH DURING COVID-19

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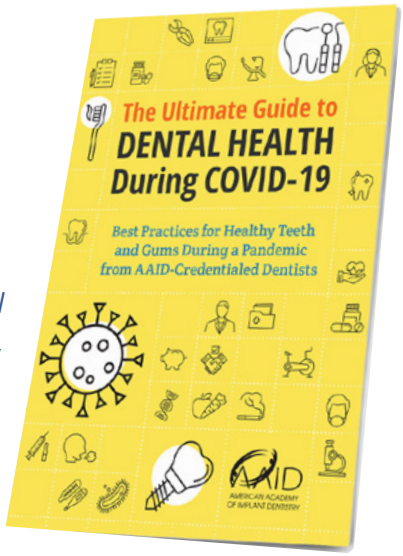

2 Patient Checklist About New Office Safety Measures

The checklist illustrates the new safety measures and protocol patients can expect at the dentist office.
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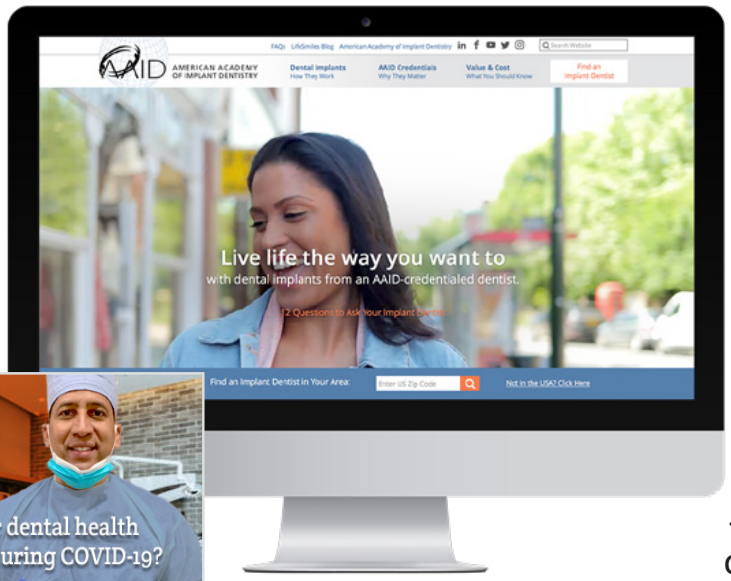

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JOISAMPLER

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 2 (2020).

CLINICAL

Effects of Ultraviolet Photoactivation on Osseointegration of Commercial Pure Titanium Dental Implant After 8 Weeks in a Rabbit Model

This study investigated whether a 6-Watt ultraviolet C-lamp was capable of producing photofunctionalization on commercial implants during a medium observation term of 8 weeks. A total of 20 implants were inserted in 5 New Zealand rabbits, with each animal receiving 2 implants per tibia (one photofunctionalized and one untreated), according to a previously established randomization sequence. All implants were inserted by a single surgeon following the manufacturer's instructions. Histological analysis was performed by an evaluator who was blinded to the treatment condition. After 8 weeks of healing, the 2 groups showed no statistically significant differences in terms of bone-to-implant contact. Compared to control implants, the photofunctionalized implants showed improved wettability and more homogenous results. Within the limits of the present study, the use of this 6-W ultraviolet C-lamp, for an irradiation time of 15 minutes at a distance of 15 cm, did not improve the percentages of bone-to-implant contact in rabbits at an osseointegration time of 8 weeks. Although there were no significant differences between photofunctionalized and non-treated implants, the photofunctionalized implants showed more homogenous BIC values. Future studies should be performed using higher irradiation power, longer irradiation times, or a combination of both to determine the best photofunctionalization protocol.

Arturo Sanchez-Perez, MD, PhD, Carlos Cachazo-Jiménez, DDS, Carmen Sánchez-Matás, MD3, Jose Javier Martín-de-Llano, BDS, PhD, Scott Davis, MDSc, Carmen Carda-Batalla, MD, PhD, *Journal of Oral Implantology*. 2020 February; 46(2):101-6.

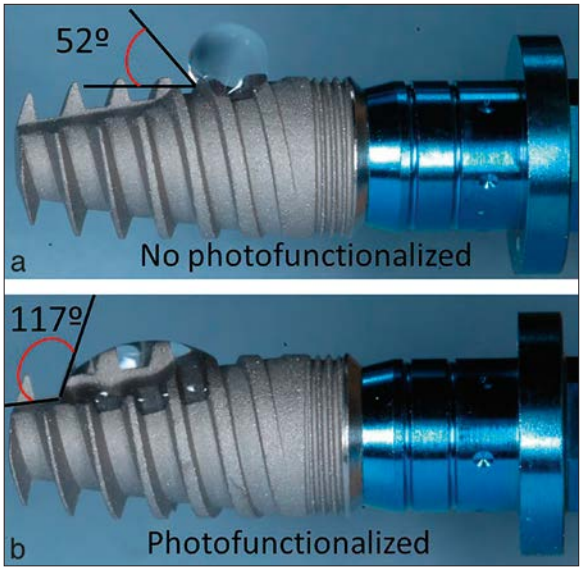

FIGURE 1. A micro-pipette was used to place 10-lL drops of bidistilled water on untreated and photofunctionalized implants. (a) Poor wettability (,908) on the untreated implant. (b) Good wettability (.908) on the photofunctionalized implant.

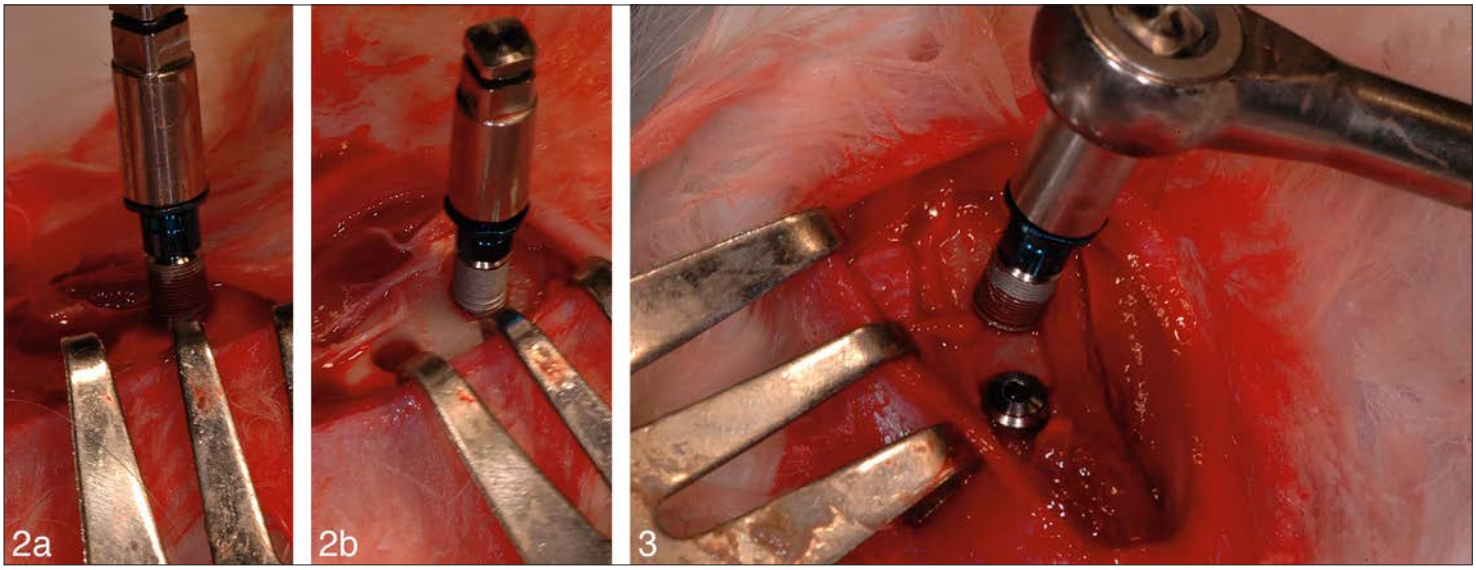

FIGURE 2 AND 3. (a) Upon insertion of a photofunctionalized implant, blood rapidly reached the coronal zone. (b) Upon insertion of an untreated implant, blood only moisturized the area in contact with the cortical bone. FIGURE 3. Insertion of a photofunctionalized implant, along with a non-photofunctionalized implant. The hydrophilicity of the photofunctionalized implant can be observed.

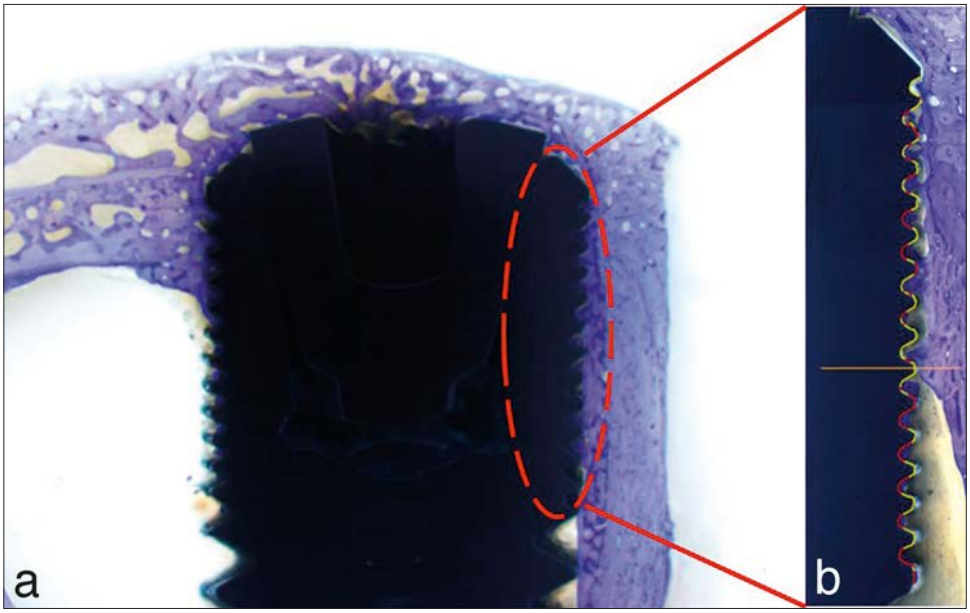

FIGURE 4. (a) Sagittal section of the implant. (b) 310 magnification image. Red lines indicate bone-implant contact, yellow line indicates the area without contact, and orange horizontal line indicates the separation between the cortical and medullar bone.

continued on page 26

JOI Sampler

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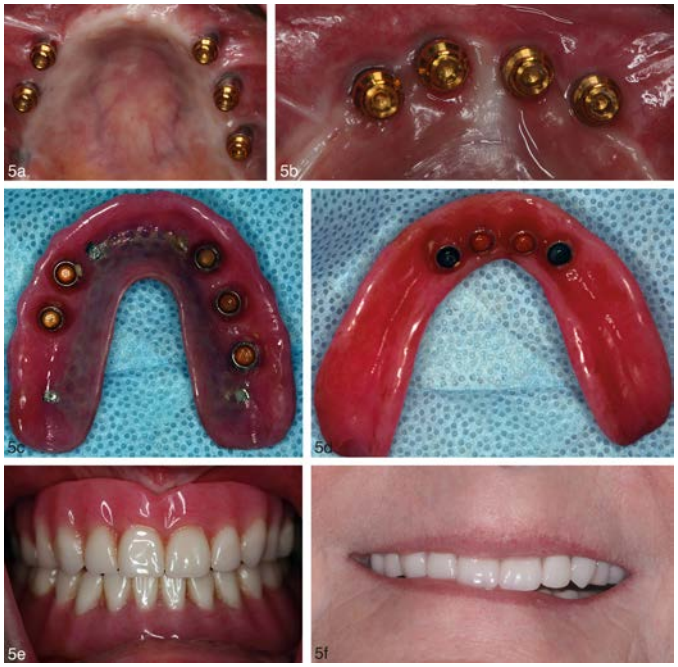
CASE REPORT

Full-Mouth Rehabilitation With Implant-Prosthesis in Marfan Syndrome Patient: Clinical Report and Literature Review

To the authors' knowledge, implant-retained full-arch prostheses have not been reported in a patient with Marfan syndrome. Interestingly, defective collagen metabolism has been associated with decreased bone volumes and lower bone to implant contact. While other collagen disorders have similar presentations (lathyrism and multiple sclerosis), there is no evidence regarding the effect of Marfan syndrome on the osseointegration of dental implants. The purpose of this case report is to present implant-retained maxillary and mandibular complete overdentures in a patient with Marfan syndrome. The patient initially presented with generalized periodontitis (stage IV, grade C). Due to the progressive nature of periodontal disease, the patient elected to have implant-retained maxillary and mandibular complete dentures. Bilateral maxillary sinus augmentation was performed 6 months before full-mouth extraction, alveoloplasty, and immediate implant placement. Maxillary and mandibular immediate overdentures were delivered. After 4 months of healing, the final overdenture was fabricated. The patient was seen regularly throughout the healing process for peri-implant maintenance. Soft-tissue grafts were completed to increase the thickness of the mucosa around the implants. The patient has been followed for 2 years and is functioning well without major complications. For patients with Marfan syndrome, implant-retained prostheses are a viable treatment option in the presence of a failing dentition.

Ahmad Kutkut, DDS, MS, Rasha Abu-Eid, BDS, PhD, Lina Sharab, DDS, MS, MSc, Mohanad Al-Sabbagh, DDS, MS, *Journal of Oral Implantology*. 2020 February; 46(2):115-21.



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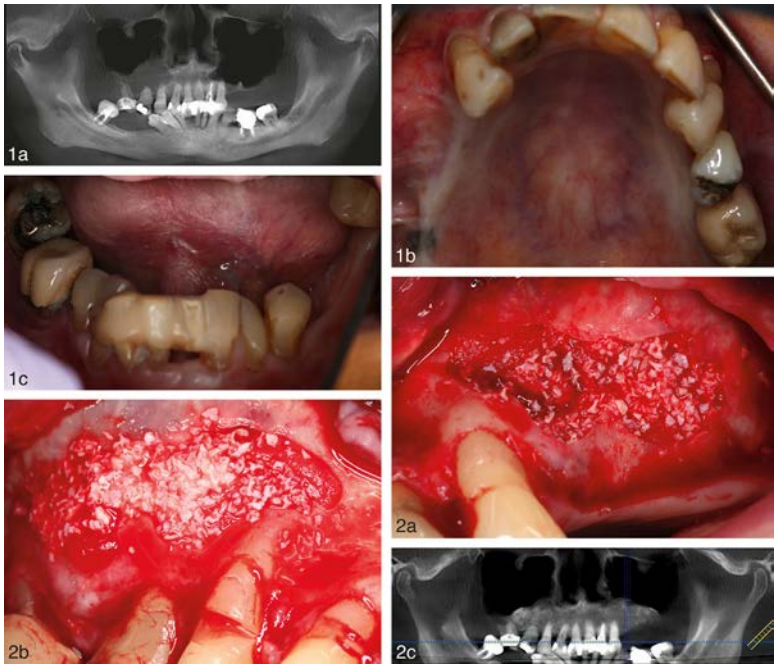

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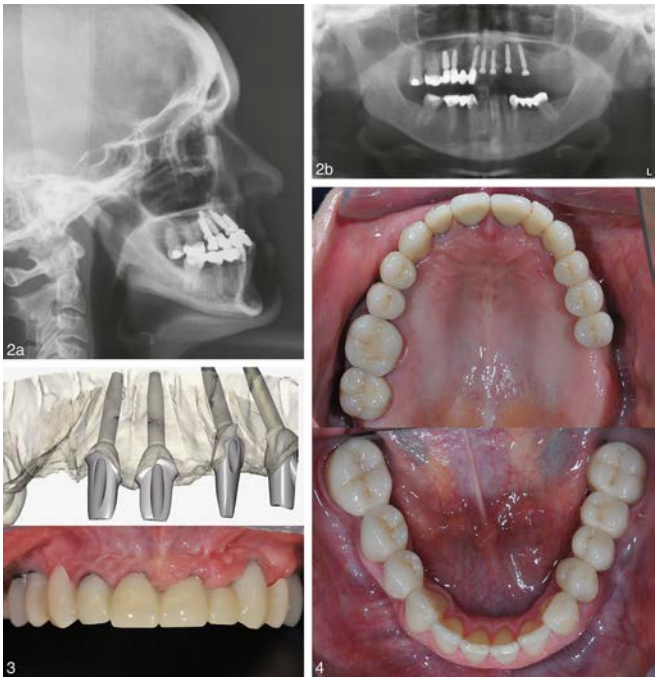
CASE LETTER

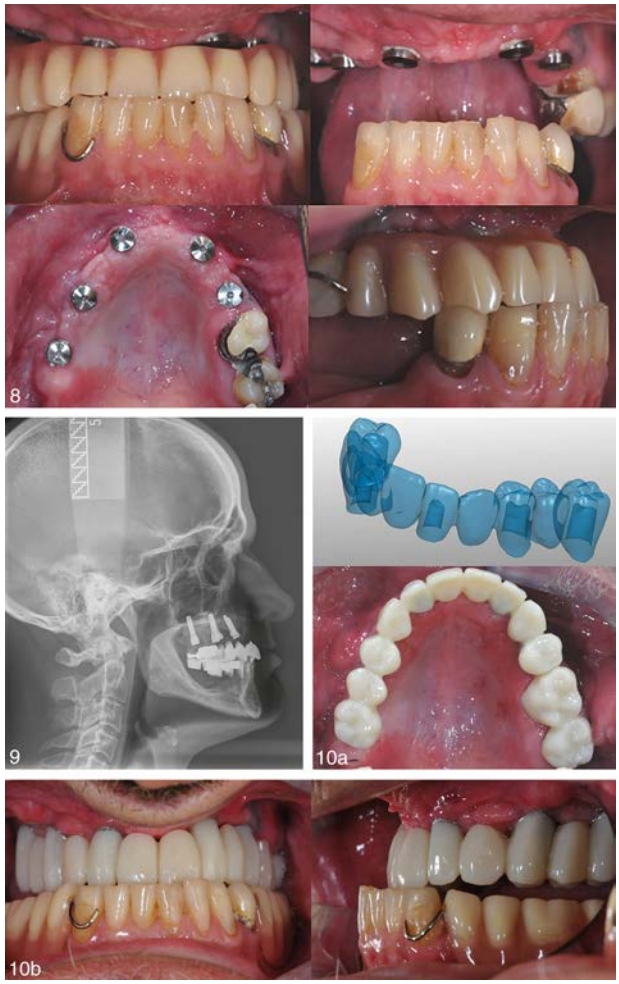
Orthognathic Surgery for Correction of Skeletal Class III Malocclusion Using Osseointegrated Dental Implants: A Clinical Case Letter

An idealized alveolar bone positioned in class I relation axially aligned to the opposing arch is the concept for optimal dental restoration, even if there are frequent discrepancies between the jaws, such as skeletal class III malocclusion with an increase of older patients seeking correction of their jaw deformities. Usually, in such a case, dental implants are inserted after orthognathic treatment as it is difficult to plan the postsurgical occlusion before surgery. In this clinical letter, the authors describe a technique for correction of class III malocclusion using several osseointegrated implants and computer-aided design/computer-aided manufacturing (CAD/CAM) milled, pre-planned fixed dentures in the maxilla by means of Le Fort I osteotomy. The authors present a case series of correction of skeletal class III malocclusion using implant-supported restorations as splints and fixation for Le Fort I osteotomy. The technique described allows renewal of the interalveolar relationship together with predictable results, and creates a fitting environment for dental restoration in a comparable short treatment time without the need for intermaxillary fixation.

Peer W. Kämmerer, MA, Jens M. Wolf, DMD, Michael Dau, MD, DMD, Henning Staedt, DMD, MSc, Bilal Al-Nawas, MD, DMD, PhD, Bernhard Frerich, MD, DMD, PhD, Peter Ottl, MD, PhD, *Journal of Oral Implantology*. 2020 February; 46(2):146-52.



FIGURES 2–4. FIGURE 2. Patient 1: Initial radiograph: cephalometric X ray (a) and orthopantomography (b). FIGURE 3. Patient 1: Individual abutments and implant-supported maxillary temporary restoration as surgical splint. FIGURE 4. Patient 1: Implant-supported maxillary restoration.



FIGURES 8–10. FIGURE 8. Patient 2: Initial clinical position with and without removable, mucosa-supported restoration. FIGURE 9. Patient 2: Initial cephalometric X ray. FIGURE 10. Patient 2: Computer-aided design/computer-aided manufacturing design and implant-supported maxillary temporary restoration as surgical splint (a) and the clinical situation with temporary restoration before surgery (b).

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2021 Slate of Officers

The AAID Nominating Committee, chaired by Dr. Natalie Wong, presents the following slate of officers for consideration at the AAID 2020 Annual Business meeting during the Scientific Session, November 11-14, 2020.

In accordance with Article IX, Section 7 of AAID's Bylaws, members not nominated by the Nominating Committee may be nominated by petition as follows: "3) Nothing herein contained shall prevent voting members from nominating a candidate provided that the nomination petition is submitted to the chairman of the Nominating Committee or that person's designee at least 30 days in advance of the election at the Annual Meeting for distribution to the voting membership at least 21 days in advance of the election. "4) A nominee not announced by the Nominating Committee must include the signatures of at least 5 percent of the voting membership on the petition. "5) The Committee shall obtain a disclosure statement from each candidate nominated by the Committee or by petition and make this information available to the voting members."

President Duke Heller, DDS, FAAID, DABOI/ID
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Matthew Young,
DDS, FAAID, DABOI/ID

Meet Matthew Young, DDS, FAAID, DABOI/ID

Dr. Young graduated with honors from dental school in 1999 from the State University of New York at Buffalo. He completed a surgically based General Practice Residency program in 2000 at the Albert Einstein Medical Center in Philadelphia earning the Resident of the Year Award. Upon graduation, he became a member of the AAID and now has been an active member for over 20 years.

He became an AAID Fellow 2012, an Honored Fellow in 2016, and earned his ABOI/ID Diplomate in 2011. Dr. Young has been very involved in the leadership of the AAID, serving in the following capacity: AAID Board as Trustee from the Western District, Western District Officer including President, Director of the Bay Area Implant Synergy Study Group an AAID Affiliated Study Group, and District Planning Committee. He also served on the following committees: Education, Finance, Admissions & Credentials and Annual Meeting Education.

Dr. Young has taught multiple implant programs during the AAID Annual Conference and District Meetings. He served as Past President of the San Francisco Dental Society and was a Delegate of the California Dental Association. He has been active with Operation Smile and is honored to be a Fellow of the International College of Dentists Humanitarian Society.

Dr. Young operates a successful group practice in San Francisco where he focuses on implant surgery and implant prosthodontics. Outside of his practice, he spends time with his wife and two children. He is proud to coach his son's youth baseball team to a championship last fall and his daughter's youth soccer team.

AAID Foundation Update

Smile, Veteran™ Program Moves Forward

The AAID Foundation continues progress with the *Smile*, Veteran!™ program.

As the leader in implant dentistry, the AAID Foundation recognizes the extraordinary sacrifices veterans and their families have made for our nation. They often face considerable challenges as they transition back to civilian life. Most veterans do not qualify for dental care through the Department of Veteran Affairs and have difficulties accessing some much-needed dental services. Good dental health provides a foundation for overall well-being and our veterans deserve to have a better quality of life. This program helps veterans who have served our country with the opportunity to access and receive a dental implant services from our membership.

This work cannot be done without the support of the AAID membership and our corporate partners.

Making a donation to the AAID Foundation is critical to the success to our programs and will have a tremendous impact on the veterans and patients the membership serves. To make a donation, go to *aaid.com/foundation*. To volunteer to be a participating dentist, contact *foundation@aaid.com*.

The AAID Foundation was founded in 1982 with a mission to further the science of oral implantology through research and charitable programs. For nearly forty years, your support has moved the AAIDF moved in its mission.

Obituaries

Sir Lionel W. Richards, DDS, the first president of the Western District, passed away on Wednesday, June 10, 2020, at the age of 81.

Dr. Richards was proud member of the AAID and his contributions to implant dentistry. He was an Fellow (1985), an Honored Fellow (2002) and Life Member (2016) and a Diplomate of American Board of Oral Implantology/Implant Dentistry (1992), where he served on the panel developing the first credentialing exam for this organization. He was knighted by the Knights of Malta for his demonstration of nurturing, witnessing, and protecting the faith and serving the poor and the sick worldwide.

Upon completion of Stanford University in 1960, and St. Louis Dental School in 1964, Dr. Richards was a dentist for the Veteran's Administration in Palo Alto, where he completed a V.A. Fellowship before opening dental practices in Sacramento and Sutter Creek, California.

Dr. Victor Sendax, a past president of the AAID, died December 26, 2019, at the age of 64.

Dr. Sendax was the first director and adjunct associate professor of Implant Prosthodontics at Columbia University School of Dental and Oral Surgery and Columbia-Presbyterian Hospital from 1975 to 1989. He patented the Sendax Mini-Dental Implant System. He was a President in 1981, Fellow (1985), and a ABOI/ID Diplomate (1990). In 1996, he won the Gershkoff/Goldberg Award in 2011, he received the Isiah Lew Memorial Research Award in recognition of his important contributions to research in Dental Implantology.

Dr. Sendax received a DDS from NYU College of Dentistry in 1955. He joined the Air Force in 1955, with the rank of Captain and served as the Base Dental Surgeon at Schroi Air Force Base in Japan. Upon his return to New York City in 1958, he opened his private practice and treated patients for 52 years, retiring in 2010.

AAID Bylaws update

At its August meeting, the AAID Board of Trustees approved circulation to the membership of 10 Bylaws changes, which will be voted on at the 2020 Business Meeting. The proposed amendments are below with deletions noted with ~~strikethrough~~ and additions with underline.

Electronic meetings

The Bylaws Committee agreed to add an amendment to allow the Board of Trustees and Committees to officially hold meetings electronically, ultimately improving efficiency, especially in the case where an in-person meeting is not able to occur. Even though the AAID Bylaws do not prohibit electronic meetings, this amendment designates the minimum level of interface required.

No. 1: Addition of Article XII, Electronic Meetings, with remaining articles to be renumbered.

Meetings of the Board of Trustees and of the membership may be held utilizing a technology that permits all members to participate through synchronous aural and oral communication.

Membership Status

The Committee felt that the bylaws needed the basic outline of a due process policy.

No. 2: Amendment Article III, Membership, Section 12, Suspension or Expulsion

Any member found to be in substantiated violation of the AAID Bylaws, Code of Ethics *or other due cause may, by majority vote of the Board of Trustees, be suspended or expelled with due process as follows:*

The matter will be forwarded to the Ethics Committee within 30 days,

The Ethics Committee shall be members not currently serving on the Board of Trustees,

The Board of Trustees shall vote on the Ethics Committee recommendation within 60 days from when the Ethics Committee received the violation allegation.

Board of Trustees Alternates

Should a Trustee not be able to make a Board Meeting, a substitution can be made in the person's place according to the Bylaws. This change provides a clarification that allows the alternate attendee to exercise voting rights of that office.

No. 3: Amend Article V, Organization of the Academy, Section 4, Regional Districts, C) Trustees for Regional Districts

*C) **Trustees for the Regional Districts**. Regional District Trustees shall serve two-year staggered terms and shall be eligible for election to a second two-year term. Thereafter, a Trustee shall not be eligible for election for a period of at least one year. In the event of the inability of either to attend an upcoming Board of Trustees meeting, the President of the Regional District may appoint an alternate Trustee with voting rights for that meeting only. The duties of the Trustee shall include:*

Past President's Council

The Bylaws Committee believes that the participation of the past presidents is important for the decision-making body of the Board. The addition accommodates those past presidents who have difficulty traveling to the in-person event and protects their right to participate in the selection process for their representative.

No. 4: Amend Article V, Organization of the Academy, Section 5, Past President' Council, B)

B) At the Annual Meeting, those Past Presidents in attendance or real-time virtual attendance select a representative from among them who shall be eligible to attend, participate and vote at Board of Trustees meetings for one year.

Board of Trustees Roles

The addition to the Bylaws clarifies that it is the duty of the Executive Committee to manage the process in which candidates are evaluated during the selection process. Final approval remains with the Board of Trustees.

No. 5: Amend Article VI, Board of Trustees, Section 1, Authority and Responsibilities, H)

H) To employ an Executive Director and appoint agents to conduct the Academy's business upon the recommendation of the Executive Committee nomination process;

Board of Trustee Meetings

The addition to the Bylaws gives the Board of Trustees final approve for the location of its meetings.

No. 6: Amend Article VI, Board of Trustees, Section 3, Meetings, A) Regular Meetings

*A) **Regular Meetings**. The Board of Trustees shall meet at least once during each official membership meeting of the Academy, and at such additional times, during membership meetings, as may be requested by two or more members of the Board of Trustees or the President. The Board of Trustees shall ~~further~~ meet at least two times, ~~in the course of a year~~. per year at a location to be approved by the Board of Trustees.*

Board Vacancies

The AAID Bylaws do not address vacancies in the officer positions, only President. The edits expand the process to vacancies in any officer position. The Executive

Committee would serve as the Nominating Committee to seek candidates to fill the vacancy unless two vacancies occur at the same time.

No.7: Amend Article VII, Officers, Section 2, Eligibility for Office, C) Vacancies

1) In the event of a vacancy in the office of President, the President-Elect shall become the President and shall complete the remaining unexpired term and shall also serve as President for the next immediate term. In the event of a vacancy in the ~~office of President-Elect~~ Executive Committee, the Board of Trustees may fill the position for the remainder of the unexpired term from the recommendation of the Executive Committee. Such person named to fill a vacancy in the office of President-Elect shall not automatically succeed to the office of President, except to fill the unexpired term in the office of President, should a vacancy occur while this appointed person is serving as the appointed President-Elect. Should vacancies in the offices of President and President-Elect occur at the same time, the ~~Board of Trustees~~ Nominating Committee shall slate at least one candidate for each office and the Board of Trustees shall elect the individuals to fill the unexpired terms.

Committees

The Bylaws Committee believes there is value in adding a Minutes Approval Committee so that the time taken to approve minutes is completed more quickly. This change dictates how the committee will be appointed.

No. 8: Amend Article IX, Committees

*C) **Appointment**. The President will nominate and the Board of Trustees shall elect all committee members except the Minutes Approval Committee, which the President may appoint three members (the Secretary and two Trustees not within the same district) in attendance of that meeting to review the minutes. Approved minutes are then made available to those members in attendance.*

Appointment of Special Committees

The Board of Trustees has the fiduciary responsibilities of the actions of the organization and is the highest governing authority, so oversight of committees should be outlined in the Bylaws.

No. 9: Amend Article IX, Committees, Section 8, Special Committees

***Special Committees**. ~~The President, or the Board of Trustees~~, The Board of Trustees, or the President upon ratification by the Board of Trustees, may appoint such other committees, sub-committees or task forces as are necessary and which are not in conflict with other provisions of these Bylaws, and the duties of such committees shall be prescribed by the Board of Trustees upon their appointment.*

Voting rights

The Committee recommends removing facsimile transmission as new technologies have replaced this method of communication.

No. 10: Amend Article X, Committee Operations, Section 3, Voting, C) Voting by Mail

*C) **Voting By Mail**. Written proposals may be submitted to a committee for a vote by mail, ~~facsimile transmission~~, or other electronic medium. Within ten days of such submission, each committee member shall forward a vote on the proposal to the Headquarters Office.*

Elections

The Committee added clear instructions on how to proceed in the event of a tie during the annual election.

No. 11: Amend Article XI, Meetings and Sessions, Section 3, C) Elections

***Elections**. The annual election of officers will be conducted at the membership business meeting.*

1) Candidates receiving the highest number of votes for each office shall be declared elected.

~~2) If no nominations are made by petition as prescribed by these Bylaws, the Secretary shall cast a single ballot for the candidates of the Nominating Committee.~~

2) If there is a tie, then balloting continues of the tied candidates until a candidate receives a majority.

3) In the event candidates are unopposed, they can be voted by acclamation.

4) The meeting cannot be adjourned until election results have been completed.

Parliamentary Authority

The Committee added a second source for when the *American Institute of Parliamentarians Standard Code of Parliamentary Procedure* does not address an issue.

No. 12: Amend Article XI, Meetings and Sessions, Section 3, D) Parliamentary Authority

*D) **Parliamentary Authority**. In all matters not covered by its Bylaws and standing rules, this organization shall be governed by the current edition of the American Institute of Parliamentarians Standard Code of Parliamentary Procedure. The parliamentary authority may be suspended only on a three-fourths affirmative vote of the voting members present at any meeting. If the American Institute of Parliamentarians Standard Code of Parliamentary Procedure is silent on a topic, the current edition of Robert's Rules of Order Newly Revised should be consulted.*

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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.

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Contact: Jackie Martinez
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Phone: 281-703-9468
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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

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Assistant Directors:
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Assistant Director: Joseph C. D'Amore, DDS, AFAAID, DABOI/ID
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Contact: Linnette Dobbs-Fuller
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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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Phone: 801-878-1257

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Assistant Director: Shankar Iyer, DDS, MDS FAAID, DABOI/ID
Contact: Janice Gibbs-Reed, MA
Email: gibbs@sdm.rutgers.edu
Phone: 973-972-6561
Website: sdm.rutgers.edu/cde/maxi-course

San Juan, Puerto Rico AAID MaxiCourse®
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Assistant Director: Jose Pedroza, DMD, MSC
Contact: Miriam Montes
Email: prmaxicourse@gmail.com
Phone: 787-642-2708
Website: www.theadii.com

Shanghai, China AAID MaxiCourse®
Shanghai, China
Director: Jaime Lozada, DMD, FAAID, DABOI/ID
Contact: Joey Chen, DDS, MS, AFAAID
Email: anshindental@gmail.com
Phone: 886-988272033
Website: http://weixin.meiweigroup.com/zt/tuopu

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September is Dental Implant Awareness Month!

Reinforce your value as an AAID Dental Implant Specialist

Make it Fun

Download crossword puzzles and games for patient goody bags, wear pins and t-shirts!

AAID *Healthy Mouth Healthy YOU!*

SEPTEMBER IS DENTAL IMPLANT AWARENESS MONTH

Make it Social

Download ready-to-use social media kits

Promote to your Community

Download ready-to-go ads, website badges, and email signatures

Decorate and Celebrate

Order posters to hang in your waiting room to promote your credential and brochures for patient goody bags

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aaid-implant.org/diam

AAID MaxiCourse®
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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 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

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Dr. Ihab Hanna
Phone: 650-701-1111
Email: info@bayareaimplantinstitute.com
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Dr. John C. Minichetti
Contact: Sarah Rock
Phone: 201-871-3555
Email: sarah.englewooddental@gmail.com
Website:courses.htmhttps://www.dentalimplantlearningcenter.com/ce-courses/

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

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United States

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: 01-800-757-1202
Website: https://cancunimplantinstitute.org/

Implant Complications:
A 25 Year Retrospective Review
Dr. Brian J. Jackson
Contact: Jana Selimovic
Program Coordinator - Boston MaxiCourse
Email: education@bostonmaxicourse.com
Phone: 315-922-2176
Cell. 315-790-7890315-922-2176
Website:http://eastcoastimplantinst.com/upcoming-courses/

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/

Midwest Implant Institute
Drs. Duke & Robert Heller
Advanced Courses:
(305) Implant Prosthetics
(411) The All Inclusive Live Surgical Course
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Contact: 614-505-6647
Email: samantha@mii1980.com
Website: www.midwestimplantinstitute.com

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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/

Canada

WESTERN IMPLANT TRAINING:
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Dr. Robert E. Leigh, Director
Contact: Corie Zeise
Email: coriemanager@gmail.com
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Toronto Implant Institute
Dr. Natalie Wong
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Executive Director - Toronto Implant Institute Inc.
Phone: 416.566.9855
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Website: http://torontoimplantinstitute.com/

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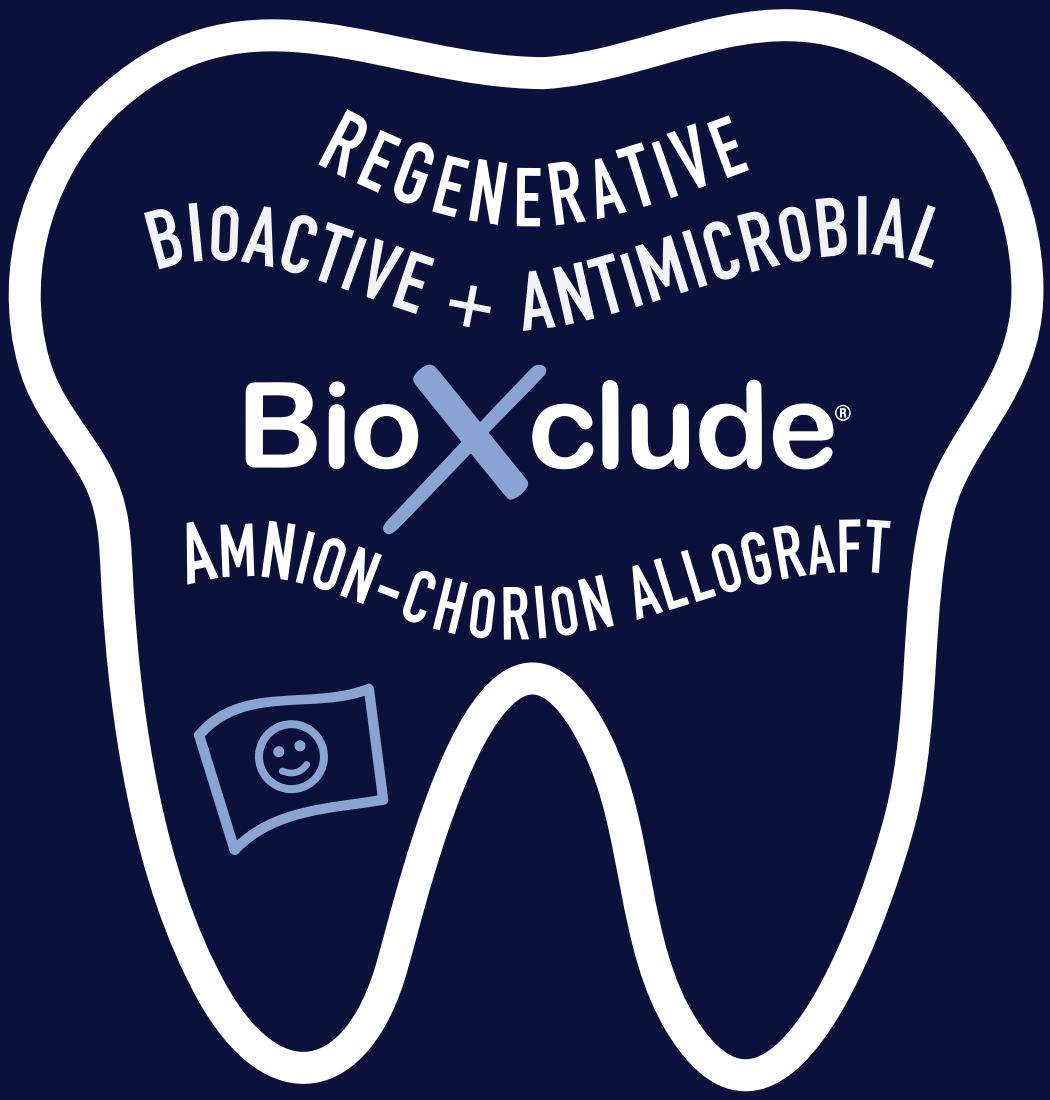

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