FLORIDA FOCUS

December, 2021

the publication exclusively for the general practitioner

AGD President Dr. Gerald Botko

Blatchford Block Booking

Dr. Lori Trost on "Making Sure It Sticks"

Dr. John Roberson on "The Medical Emergency UNprepared Dental Office"

Sue Boisvert on "Patient Safety in Dentistry"

FLORIDA
ACADEMY of
GENERAL DENTISTRY

FLORIDA FOCUS

How to Reach Us
Florida Academy of General Dentistry
5721 NW 84th Terr., Gainesville,
Florida, 32653
Phone: 866-620-0773
Email: Flagdinfo@gmail.com

President's Message

Dear All,

Finally, we have come to the end of the year.

We had our ups and downs, lefts and rights, rights and wrongs and what not!

With Thanksgiving around the corner and Christmas on the horizon, we should be in the spirit of being thankful to each and every one that has crossed our paths; thankful to the people who made us smile as well as thankful to the people who made us angry. I will take a step back and ponder and demystify this sentence. Other people do not have a switch in OUR brains that they can turn it on and make us smile or angry. It is WE, who decide to respond either with a smile or with anger. I want to bring a point here. It is not what life throws at us that is of significance. It is how we respond to what life throws at us is important. Our response mechanism makes our moods and makes our ultimate character. Why am I discussing this in a Dental Magazine? Because we come across the different people in our day to day lives; our patients, our staff and if we are working for someone, our colleagues and our bosses! So we have to be in full control of our response mechanism and be able to tame it. If you are interested and research deeper into the subject, you will get your answer and be able to take on the world of problems and handle with a smile!

I personally want to thank all of my Board Members who did all the hard work and made me look good. Many of them helped and or influenced me to conduct my Presidency, namely; Dr. Merlin Ohmer, the guy with a whip, but with good intentions; Dr. Andrew Martin, the cool leader; Dr. Harvey Gordon, the evergreen hero; Dr. Laurence Grayhills, ever ready to help behind the scenes; Dr. Millie Tannen, the Cheerleader; Dr. John Gammichia, the silent hero; Dr. Nicholas M. Kavouklis, who gifted me a book, *The Obstacle is the Way*, by Ryan Holiday, humbling me when I thought I knew everything about overcoming obstacles in our lives; and of course, our adorable Tri, who keeps us glued together with her smiles and hard work :)

Last, but not the least, I want to thank my son, Dr. Rajiv Kalra, for holding the fort during my absences from work, and I also want to thank my wife, Archana Kalra, for sacrificing my companionship, while I work for FLAGD!

Ever since I have been in a leadership role in AGD, whether at Component or State level, my focus has always been on increasing Membership Numbers. I am very happy to announce that our membership numbers finally went up for the first time since year 2015-2016, and I want to give credit to our Membership Chair Dr. Toni-Anne Gordon.

'Practice what you preach' was a phrase I often heard in my childhood. I am happy to share a 'crazy incident' in my life. My wife and I had been excitedly preparing for our younger son Dr. Roshan Kalra's wedding for more than a year, with meticulous details. The preparations included us practicing and mastering Bollywood Dance Moves past midnight, every night for the last 2 months, almost perfecting them!

I took a full 3 weeks off from work, 2 weeks before the wedding and 1 week after the wedding, to dedicate all my energies to preparing for one of the best and happiest events in my life, before resuming my dentistry. On my first day off, I was excited and climbed the ladder in my garage to fetch some decorations for the house. And WHOOOSHH! The ladder slid under me and I hard-crash landed onto a concrete floor, fracturing both of my heel bones. I mustered the strength, against my doctors' wishes, that I would walk into our son's wedding! But when five different doctors and specialists advised me not to walk, let alone dance or even put the slightest weight on either of my heel bones, I was disappointed and resigned to the fact that I would wheelchair into my son's wedding.

Guess what? I kept my spirits high and not only hosted the whole wedding but actually danced while being in the wheelchair, without putting weight on my heel bones!

When Life throws a curveball at you, you realize the Ultimate Truth of one simple sentence. This sentence is made of only four words: "Man Proposes, God Disposes!"

With these thoughts, I will be passing the gavel to my new incoming team led by Dr. Matthew Scarpitti in January, 2022. As I promised to all of you, I will be leaving the organization in a better condition and with a better leader! God bless everyone!!

Thank You Humbly,

Naresh A Kalra, BDS, DDS

Congratulations to our New Fellows, Masters, and LLSRs!

LLSR

Gerald J. Botko, DMD, MAGD

Andrew P. Martin, DMD, MAGD

MAGD

Paayal Bhakta, DMD, FAGD

James C. Lewis, DDS, FAGD

FAGD

Ahmad Sherriff F. Ali, DDS

Vladimir A. Avril, DDS

Lars Berk, DMD

Melissa B. Brim, DMD

Boris Bujila, DMD

Kevin M. Carbonell, DMD

Sabrina Garces, DMD

Troy A. Gessner, DDS

Dory A. Green, DMD

Ariel Westervelt Heisser, DDS

Eric L. Heisser, DDS

Alexander P. Hodge, DMD

Whitney Howard Haidet, DMD

Jobin Joseph, DDS

Nicholas E. Kizirian, DMD

Johanna Moorefield, DMD

Nadine B. Nicolas, DMD

Asha Patel, DMD

Samuel S. Wakim, DDS

Editor's Note

One of the advantages of serving on the FLAGD board has been the opportunity to meet so many extraordinary general dentists. During my first experience as a delegate to the AGD House of Delegates in November, I was impressed by the obvious love and dedication which so many members have for the AGD. This passion to improve our organization and the lives of other general dentists was evident in the speeches given by the candidates for the offices of Vice President and House Speaker, as well as in the many years in which they had served on AGD committees. Dedication to the AGD was expressed by the thousands of hours of work invested by members of the Governance Evaluation and Review Committee to discover ways in which to make the AGD more efficient, cost-effective, and "nimbler." Committment to the AGD was apparent in the 184 delegates who had traveled to Chicago in November for this meeting, and in the many resolutions and intense discussion of issues concerning the organization.

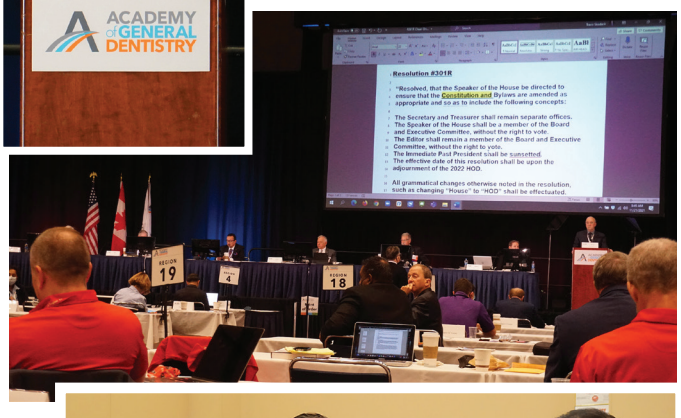
Congratulations to all the 2022 AGD officers, especially FLAGD members Dr. Gerald Botko, the AGD President-Elect, and Dr. Merlin Ohmer, our Region 20 Trustee who will be the AGD's Vice President next year! Past FLAGD President Dr. Andrew Martin will be serving as the 2022 Region 20 Trustee, and Dr. Linda Trotter will continue as the Region 20 Director, the liaison between the AGD and our members.

We hope you enjoy and profit from this issue of the *Florida Focus*, which includes articles about current adhesive technology, preparing for medical emergencies, patient communication and safety, and block scheduling. Please enjoy the benefit of our free CE program by completing the exercises on page 19.

Finally, a huge thank you to President Naresh Kalra, both for his leadership and for his constantly inspiring President's Messages. I wish all our members and your families and teams a very happy and healthy holiday season!

Millie Tannen, DDS, MAGD

Above: Drs. Linda Trotter and Merlin Ohmer with ADA President Dr. Cesar Sabates



Clockwise from top right: Installation of AGD 2022 Officers; the House of Delegates considers a resolution; President Botko's acceptance speech. Right: Region 20 delegates Drs. Aldo Miranda, Matthew Scarpitti, and Andrew Martin. Left: Dr. Bipin Sheth. Above, from left: Drs. Douglas Massingill, Herminia Rodriguez, Tara Fenn, and Nishita Patel

An Interview with AGD President

Dr. Gerald Botko

Florida Focus: Why did you choose dentistry as a career, Dr. Botko?

My goals were to go as far as I could in whatever I could do. I started at a prep school, which I paid for myself. Then, I got a scholarship to go to college and a fellowship to earn a mastership in microbiology at the University of Massachusetts.

I was still trying to go as far as I could go.

My roommate wanted me to take the MCAT and the DAT with him, and I said, "Well, I'd love to take the MCAT. I don't know about the DAT, but I'll take it, too."

We took both, and I did very well in the DAT, much better than I thought I would do. I was invited to Tufts for an interview and met the Dean. He said, "You know, your grades are great. We're interested in you."

I said, "The only problem is, I really don't have the money to go to school here. I really can't think of how I could pay for this. I'd love to go."

He said, "Why don't you apply for a military scholarship? They take top 10 percent, and you're in that top 10%."

I got some recommendations from different people that I knew were military, applied for the scholarship, and got it, so I went to Tufts. I owed them three years, and on my dream sheet, I put down that I wanted to go to Andrews Air Force Base in Washington DC. I did my GPR there at Malcolm Grow Medical Center.

That's how I ended up in dentistry, but I've loved it ever since, and it's been a great ride. No matter what adverse conditions I had, dentistry always was there for me.

I started in multiple practices in Cape Cod but ended up getting deployed in the military, because I was still in the reserves. I had to sell them all at a loss and didn't know what I was going to do.

At Fort Jackson in South Carolina, I had worked on the chief of dentistry for the VA in Miami, and he said, "One of my practitioners has some medical problems, and he can't work any longer. I've got about 17 applicants already. Why don't you put an application in?"

I put in an application, and he called me that Friday.

"Can you start on Monday?"

I had to go to the colonel and ask him if I could leave. I flew down to Florida and started that Monday in an outpatient clinic.

I also stayed in the reserves because I figured, half my life is already in there. I got deployed another time to combat and came back again. I became coordinator of ACLS and BLS training for the whole hospital. I did that for about 10 years, and then I became the chief medical officer for the outpatient clinic and then Chief of Dentistry. I was there for about 17 years.

I retired in 2018 with the condition that I could select and train my replacement. I stayed on the staff as a WOC, which is "without compensation." That's where I am now.

So, I've had three careers, basically, but it worked out very well for me.

What originally motivated you to become active in the AGD, and why have you stayed involved?

In the GPR program at Andrews AFB, everyone was an AGD member. I came to realize that, in order to be the best I could be and keep abreast of all the latest technology, methodology, and techniques, I needed to belong to organized dentistry. I really loved the camaraderie, the networking, the interactions with colleagues, and the leadership.

When I started my journey to Fellowship, I became more involved in Region 17 and volunteered to do whatever they needed of me. Along this journey, I was elected a constituent president in Region 17. After my Fellowship, I started working on my Mastership, having developed a passion for learning. Knowledge is a gift that comes with responsibility and a duty to share it with your colleagues.

I was a delegate for several years, Region 17 Regional Director, Region 17 Trustee, a Division Coordinator for Advocacy, Division Coordinator for Public Relations and Communications, and an AGD spokesperson. I served on many Councils and Committees such as PACE and Communications. I love AGD and believe anyone who joins and takes advantage of all the organization has to offer will be a better, successful dentist.

AGD President Dr. Gerald Botko with Immediate Past President Dr. Bruce Cassis and President-Elect Dr. Hans Guter.

What are your goals for the AGD during your term as President?

A top goal is to increase our membership and retention, which is a primary goal for all nonprofit organizations. Membership has to be everyone's responsibility. AGD is unique. It is the only premier organization of general dentists for general dentists who care about the general dentist, defending the general dentist against all the threats to practice through advocacy and offering high quality continuing education for our members. We all joined AGD to become better dentists. These success stories must be shared with nonmembers so that they have the same opportunities. The Health Policy Institute stated that there are approximately 200,000 licensed dentists in the US and 20,000 in Canada. Approximately 160,000 are general dentists. We have approximately 40,000 members. We can do better. We need to achieve a larger share of the market.

Secondly, I want to continue the initiatives that have been started during my time on the Executive Committee. I plan to initiate succession development, which is lacking, and continue to have generative discussions and training, which is critical for a well-functioning learning organization. I want to continue the momentum achieved during the pandemic to increase our credibility and relevance to Congress, other government agencies, and other dental organizations., Our improved exposure, credibility, and relevance was proven recently when our AGD President, Dr. Bruce Cassis, was asked to testify before the Energy and Commerce Committee's subcommittee on health in support of the Oral Health Literacy and Awareness Act (H.R.4555).

Lastly, I believe, even with increased competition, AGD can achieve a larger share of the education market with high quality continuing education, because this organization is unique in the objective of keeping our members highly trained on the latest and greatest technology and methodology. The new Learning Management System (LMS) will respond faster to member requests and make AGD more efficient and user friendly. It replaces many outdated systems and is very adaptable. Work to improve this system will continue. A year-round app is being developed with great capability. The new two-alternative membership model (AMM) went live October 1, and more plans to have value-added benefits for our members are in the works. A new hands-on live virtual courses program is in progress. These are group benefits that our members want and need. We will continue to stay on the issues that threaten our profession through our advocacy and work to collaborate more with other organizations.

Has becoming a Lean Sigma Six Green Belt helped you in your dental career and with your involvement in the AGD? Is this a path you would recommend to dentists in private practice?

A Green Belt in Lean Six Sigma has contributed to eliminating waste and nonvalue-added parts of a process, especially in my practice. The areas that have been successful utilizing Lean Six Sigma have been safety, competence, acceptability, efficacy, and efficiency. Six Sigma is a methodology of process improvement. It is a course of study that has many levels such as yellow, green, and black belts. I cannot state that I would recommend it to all private practices, since it is a course of study. However, I believe most, if not all, dental practices that struggle with efficiency may want to hire a Lean Six Sigma consultant to help them become more effective and productive.

How has becoming a transformational integrated coach contributed to your career?

I became a transformational coach due to my positions as Chief of Dental Service and Chair of Medical Records. This requires a lengthy course of study and is similar to life coaching. This achievement was utilized to make our healthcare teams more efficient. The teams were to become recharged and energized by the coaches. They had to have clear goals and achieve as a cohesive team. The training also helped me in my position by recharging me, so that I became more positive and had a clear vision.

Could you please share some other memories of your AGD experiences?

Gaining my Fellowship was a feeling of accomplishment, and I felt better equipped to treat my patients. Gaining my Mastership and finally my LLSR were highlights of my careers and awards.

I have had the unique pleasure of getting to know many leaders, past presidents, editors, and many staff, some that are still with AGD and some that have moved on. I have never felt the love and the friendly warm feeling at any other organization as I have with AGD. It has been like a second family to me. The camaraderie, the networking, and the long-lasting friendships that I have made over the years can never be underestimated.

I cannot think of any particular memories or experiences, since there have been so many wonderful times in this organization. We all work for a common goal and become friends in the process. The people that I have had the pleasure to know over the years have all contributed to my love of education and advocacy. I owe the fact that I was so successful to AGD. I am sure that others will say the same.

While the proposal to expand Medicare to cover all seniors is no longer a current issue, I'm sure it will be reintroduced eventually. Would you like to comment on that?

I can comment a little bit about it. Obviously, Medicare for All or Part B or Part D or even part E, which they've already talked about, is not something that we want. It wouldn't be very good, especially for general dentists, because of all the different requirements that Medicare has, such as the coding and the training. We would probably end up not being able to make any money on most of the procedures that they would want us to do, because the way they've structured the cost factors is way below what it would cost us to do the procedures.

So, we're definitely against it. None of those plans seem to be very feasible. We've talked about alternatives, maybe put it in Medicaid or in Medicare Advantage, which is a private program. Medicare itself is not very solvent. It's not making money at all, at this point, and adding something else to it, it's just going to be a disaster.

We want to help and treat the elderly, no question there, but there's got to be another way to do it. Maybe we could have a DSO that specializes in geriatric dentistry. There's a lot of different ways to treat the elderly, but the way they're going to do it is probably not going to work so well. We need to have alternatives that we can put forward so that it will be a win-win for both the elderly and for our profession.

Is there anything else that you'd like to share with our members?

One of the topics I want to discuss is membership and our two-tier system of the alternate membership model, which has had a good response. If members select Premium Plus, they get free admission to the scientific meeting, a lot of free webinars, and discounts on a lot of our training programs for Fellowship and Mastership. It's a win-win, because you're only paying a little bit more than $100 to get the Premium Plus. If you're going the scientific meeting, it makes sense to be a Premium Plus member. You're getting in for free, instead of paying the $199 admission fee, and you're only paying for your courses.

The other topic is our relevance in the dental community. Something we wanted to do was make ourselves more relevant and have people understand that there is an Academy of General Dentistry. When I was running for office, people would say to me, "Oh, ADA." I'd say, "No, it's AGD," and people would ask, "What's AGD?" So now, a lot of people know what AGD is, thanks to the pandemic and our being out there with the private-public partnership. We were one of the first ones to join that. We got to converse with many, many dental organizations, Congress, Admiral Ricks from the Public Health Service, CDC, FEMA, and OSHA. We've got a very good collaboration now with ADA and a lot of the other organizations.

Our relevance was proven recently when Dr. Bruce Cassis was invited to speak to the Energy and Commerce Subcommittee on Health. That's a feather in our cap because we were the ones that were invited to talk on it, and that means that we've gained some respect in Congress, and we've gained some respect in a lot of other areas. I've talked to a lot of vendors, and they were saying, "We really respect AGD," which is great.

We've tried to make ourselves more lean and mean, using the Lean Six Sigma terminology. We used to use 19 different platforms to track CE and do a lot of other things. It wasn't a user-friendly system. We ended up getting Learning Management System from Top Class, and this system replaces 10 or 12 of those systems. That's going to make us more efficient and more member friendly. We're developing a year-round app which will work with the LMS, and you'll be able to put your CE in there with your mobile device. You'll be able to track it and print it with your mobile device.

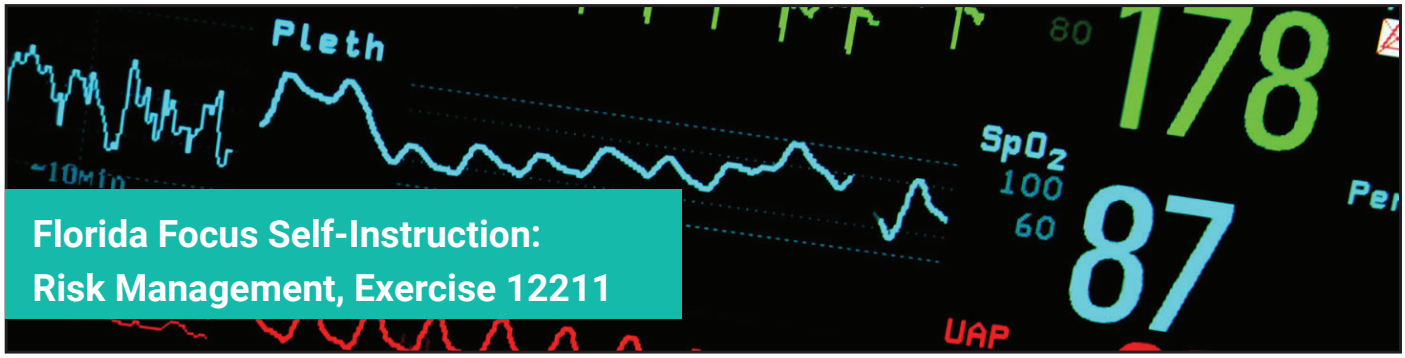
> "Knowledge is a gift that comes with responsibility and a duty to share it with your colleagues."

In membership, we're working on benefits that people really need and want, not just what we've decided that they want and need. We want to know what they want and need. We are looking for all kinds of input from any members that decide, hey, maybe this is something AGD should be doing.

We're going to continue thinking of ways to make AGD better, stronger, nimble, proactive, and flexible. We're in the black, and we want to continue in the black. If we have a threat to dentistry, we want to be able to work on that threat immediately, not wait until we have a meeting in a month or so. We're working on ways to do that, so we're very nimble.

We accomplished a lot during the pandemic. We wrote letters and talked to Congress. We were on Zoom calls six days a week. We just kept making sure that they knew our members were essential, that they needed the PPE, that we already had our experts in infection control. I think a lot of infection control became better, and I think dentistry

came out of it a little bit better, even though there was some negative impact. I think that our staff, our volunteers, and our councils and committees stepped up to the plate and worked hard to make sure that we're going to come out of this okay.



Florida Focus Self-Instruction:
Risk Management, Exercise 12211

The Medical Emergency UNprepared Dental Office

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

by Dr. John B. Roberson

Medical emergencies can happen anywhere at any time.

The Six Links of Survival

LINKS 1, 2 and 3 are the Educational Initiatives

Link 1 – Dentist Training

Link 2 – Staff Training

Link 3 – Mock Practice Drills

LINKS 4, 5, and 6 are the Physical Initiatives

Link 4 – Written Medical Emergency Plan

Link 5 – Emergency Medications

Link 6 – Emergency Equipment

The average response time for medical emergency services (EMS) to respond to a 911 call can be 11 minutes in an urban setting and 15 minutes in a rural setting. These are actual response times were based on the primary EMS unit being available and not already responding to another call, necessitating an alternate squad being dispatched. Consequently, dental offices should be prepared to manage a medical crisis for up to 30 minutes without outside assistance. The Six Links of Survival is a checklist of the educational needs and physical items necessary to fulfill the needs of a dental patient in that time period between the identification of a medical problem and the arrival of outside assistance.

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

About Dr. John Roberson

Dr. John B. Roberson received his dental doctorate from the University of Mississippi and his Oral & Maxillofacial surgery training from the University of Cincinnati Medical Center. While in dental school, he was elected President of the American Student Dental Association (13,000 members) during his third year. Then, in residency, he helped co-found the Resident Organization of the American Association of Oral & Maxillofacial Surgeons (ROAAMOS).

Dr. Roberson writes and lectures extensively on the subject of Medical/Sedation Emergencies and Emergency Drugs in the Dental Office. He has been selected as a CE Leader for *Dentistry Today* for over 10 years consecutively. He has authored a book on Medical Emergencies, has written almost 100 articles on the subject, has multiple Online CE courses, and co-developed the Emergency Response System for dental offices. He is currently lecturing around the country on advanced medical emergency preparedness.

eyes of your state dental board, your malpractice carrier, state and federal regulators, attorneys, judges, and juries.

CHAOS:

Critical Handling of Office Anesthesia Services

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

Now, let's look at the side of being unprepared. You opted not to thoroughly prepare your office; therefore, you and your staff are not ready. This means your office has breaches in patient safety now. That event occurred which you always said "this will never happen to me" in your office. Many failures at many different levels due to a lack of preparedness occurred on many fronts within your office. A patient dies in your office which eventually leads to a wrongful death suit brought against you. You go through the proper channels with your malpractice company. You will answer interrogatory questions followed by the Deposition.

At the Deposition, the Trial Attorney you face will be prepared with many questions such as but not limited to:

1. What is your staff training in medical or sedation emergency preparedness?
2. Do you have BLS? ACLS? PALS training? What about staff?
3. Have you attended a medical/sedation emergency course? If so, when?
4. Do you have all of the necessary emergency medications? Are they in date? May I see where you keep them?
5. May I see your AED? What kind of training do you and your staff have with the AED? NOTE: If you don't own an AED but did take Basic Life Support, you will not be able to say you didn't think an AED was important. 1,000 people die of Sudden Cardiac Arrest every day. The only treatment is an AED.
6. May I see copies of your documentation that you use during a medical or sedation emergency? What is your Medical Emergency Plan?
7. Do you know to call 911 during an emergency? Did you call 911 during this emergency and when did you decide to do so? How long did it take 911 to arrive? What were you and your staff doing during that time period?
8. May I see your training log outlining medical/sedation emergency practice drills? How often do you perform them?
9. Which medical/sedation emergencies are you ready for in this office? Please list them for me.
10. Which medications did you use for the medical emergency? Please explain each of these drugs to me.
11. Who inspected your office to ensure medical/sedation emergency preparedness was in place? May I see their credentials? May I see their report of your office? Did you have office inspected only once? When was that?

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

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

• **Prevention:** Complete a proper medical history on every patient who comes into the dental office as well as regular updates.

• **Personnel:** Your staff should be trained and prepared for medical & sedation emergencies. They are vital individuals when a crisis is unfolding in your office.

• **Products:** It can't be stressed enough about having proper equipment such as a glucometer, an automated external defibrillator, an emergency drug kit, and proper airway equipment. If you are administering any form of sedation or anesthesia, this equipment is imperative.

• **Protocols:** Develop a medical emergency plan that is consistently reviewed by ALL within the office on a monthly basis. Review all of the emergencies that have been previously stated in this article.

• **Practice:** You must stay current on all of the emergencies presented here so you can provide proper care. You can't accomplish successful results with training once a year. The members of your team need to practice monthly and take their roles very seriously. The time to practice is NOT when the actual emergency is occurring.

• **Pharmaceuticals:** Have current, in-date emergency medications within your office. There are specific medications that should be present in all dental offices unique to different emergencies. Know the emergency medications for all of the emergencies presented within this article. ALL should know

the location of these emergency medications. If you struggle with maintenance of your emergency medications, then activate an automatic renewal program.

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

Know planning = no CHAOS

No planning = know CHAOS

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

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

GET Prepared, STAY Prepared.

Never be the Unprepared!

Resources to help you get prepared:

-BLS for all in the office

-Advanced Life Support for Dentists (ALSD) at www.ALSDReady.com

-Advanced Life Support for Dental Assistants (ALSDA) at www.ALSDReady.com

-Advanced Life Support for Dental Hygienists (ALSDH) at www.ALSDReady.com

-Emergency Drug Kits and AEDs at www.ProtectItDental.com – use promo code of READYNOW for discount.

-Laminated Medical Emergency algorithm Checklists at www.goldmandental.org

-BASES checklist at sharden@aafdo.com (free)

-DOMES (dental office medical emergencies & simulation) video at www.goldmandental.org

-Medical Emergencies in Dental Office at www.quintpub.com

CE Questions are on page 19.

Patient Safety in Dentistry

Part 1: Communication

by Sue Boisvert, BSN, MHSA, DFASHRM
Patient Safety Risk Manager,
The Doctors Company Region III

This article is the first installment of a three-part series on patient safety in dentistry. The second article will examine the importance of clinical documentation, and the third will address safe management of adverse events.

Patient safety should be the underlying foundation of everything we do as healthcare professionals. It is a goal, a culture, and a destination. Unfortunately, achieving patient safety is ambiguous and hard to measure. How will an organization know that patient safety has been achieved? Questions like this lead safety experts to look outside healthcare to other industries. High-risk industries, such as airlines and aerospace, have made significant safety gains by pursuing high reliability. High reliability includes five premises: preoccupation with failure, sensitivity to operations, reluctance to simplify, commitment to resilience, and deference to expertise.[1] The first principle, preoccupation with failure, is the essence of patient safety. High reliability organizations employ teamwork, respect, and trust to ensure that everyone is situationally aware and free to speak up. Without effective communication, success is not possible.

Therapeutic Versus Nonprofessional Communication

Teamwork requires open communication. Therapeutic, or person-centered communication, embodies friendliness, genuine interest, empathy, and a desire to facilitate and support. The practice of therapeutic communication involves active listening, reflective statements, and open-ended questions to establish a patient-centered relationship. Therapeutic communication fosters trust, respect, and collaboration.

On the other hand, nonprofessional communication projects attitudes such as anger or disinterest using sarcasm and self-aggrandizement. This type of negative behavior can lead to professional liability claims, cast doubt on a dentist's ethics, and create a hostile environment. Examples of nonprofessional communication include openly criticizing the treatment administered by another provider or berating staff in front of a patient. Nonprofessional communication is antithetical to patient care, camaraderie, and interprofessional relationships.

In clinical practice, it is helpful to examine communication from three perspectives: provider to provider, between providers and staff, and providers and staff to patients and families.

Provider-to-Provider Communication

Referrals are the dental version of a handoff. In clinical care, handoffs are subject to error and may contribute to patient harm when poorly done. A small study of referrals between general dentists and specialists showed a positive correlation between communication and quality of work.[2] One study found that timely referral reports significantly strengthened the relationship between the specialist and general dentist.[3] Managing referrals well is necessary to improve patient safety and reduce the risk for referring and receiving providers. Patient safety experts recommend a "closed-loop" process that tracks the referral from the initial treatment to the patient seeing the specialist to the report reaching the referring provider, who then reviews

Table 1. Improving Referral Communication

Referring Provider	Receiving Provider
Develop a standardized referral form.	Collaborate with the sending provider to ensure referral communication is effective.
Collaborate with receiving providers to ensure the information is complete and unambiguous.	Clarify patient care responsibilities with the referring provider.
Include appropriate diagnostic images.	Verify appropriate site (teeth) with the patient, images, and referral form diagram.
Send the information directly to the receiving provider.	Verify the images are for the correct patient, up to date, and appropriately marked (laterality).
Do not expect patients to carry the referral packet to the specialist.	Consult with the referring office if there are questions before proceeding with treatment.
Review the referral note promptly and update the treatment plan as necessary.	Complete the referral note and share it with the referring provider promptly.

the care, updates the treatment plan, and closes the loop by contacting the patient.[4] The referring provider must make sure that the specialist receives complete, accurate, and timely information. While limited dental data is available, the medical literature suggests that over 100 million referrals per year occur in the U.S.[5] Up to 50 percent of referrals are not completed.[6] A study of referral communication found that, while 70 percent of referring physicians said they sent patient histories, less than 35 percent of specialists reported receiving them.[7] Research indicates that breakdowns in the referral process contribute to 20 to 30 percent of diagnostic errors. See Table 1 for suggestions to improve referral communication.

Provider-to-Staff Communication

Consider the following elements from the Agency for Healthcare Research and Quality (AHRQ) Surveys on Patient Safety Culture® Medical Office Survey:[8]

- Providers and staff are willing to report mistakes they observe and do not feel like their mistakes are held against them,
- Providers and staff talk openly about office problems and how to prevent errors from happening,
- Providers in the office are open to staff ideas about how to improve office processes, and
- Staff are encouraged to express alternative viewpoints and do not find it difficult to voice disagreement.
- Safety culture requires teamwork, employee comfort in speaking up, and the ability by team members to report potential risks without fear of reprisal.

Improving teamwork and communication in healthcare has been well studied. AHRQ TeamSTEPPS® is one of the most studied and successful programs because it works well in outpatient settings. TeamSTEPPS® provides simple, easy-to-use tools, such as huddles, debriefs, and structured communication. A huddle is a brief planning meeting to ensure that the team understands the next steps. Huddles often occur at the end of the day to confirm that the necessary documents and equipment are ready for the next day's cases. Use a morning to evaluate staffing, make assignments, and discuss any pertinent patient safety issues, such as a patient who needs a translator. After an event or procedure, debrief to determine what worked well, what could have gone better, and what changes are necessary to decrease risk or improve a process.

Structured communication, which ensures complete information is shared in a meaningful way, often includes a mnemonic. SBAR stands for situation, background, assessment, and recommendation/response. SBAR was developed in hospital settings to improve telephone communication between nurses and providers. It can be very useful in a dental practice for electronic communication between staff and providers and for handoffs.

Finally, patient safety depends on team members having the courage to speak up. CUS is a simple tool to empower staff, using escalation to gain action: "I am concerned," followed by "I am uncomfortable," followed by "this is a safety issue." Using the phrase safety issue must trigger a pause to evaluate and discuss the situation before moving forward. The CUS tool's application in dentistry will require some finesse as the patient is present when these discussions are likely to occur. Consider identifying a CUS trigger word or phrase to signal the need for conversation out of patient earshot. Empower staff to CUS and thank them for their input.

For more information on TeamSTEPPS® in an office setting, visit ahrq.gov/teamstepps/officebasedcare/index.html.

Provider-to-Patient Communication

Poor communication between providers and patients is frequently identified as a contributing factor in professional liability claims. The Doctors Company is a large national professional liability carrier that provides insurance to physicians and dentists. Advice for managing dissatisfied patients is the most frequently asked question by dentists calling the helpline. Poor communication and patient dissatisfaction are common contributors to medical professional liability in medicine.[9] To determine if the same findings hold true in dentistry, we analyzed dental claims that closed with indemnity between 2016 and 2019 to determine if patient communication affected safety.

The findings in our study appear to support the conclusion. Of the 537 claims, approximately 50 percent (266) involved patients seeking care from another provider due to dissatisfaction with care. Transfers of care are inherently risky from a patient safety perspective and are at high risk of nonprofessional communication. Poor rapport, such as the provider making an unsympathetic response to the patient, contributed to just over 33 percent (178) of claims. Miscommunication between the provider and patient/family about expectations contributed to nearly 12 percent (63), and failure to inform the patient of an adverse event contributed to more than 3 percent (18).

An interesting 2018 study in dental communication found a difference between patient-reported experience with dentist communication and dental hygienist communication: Dentists were most frequently noted as disregarding patients' expressed feelings, while hygienists were noted as engaging in judgmental behaviors and language.[10(p1041)] The authors suggest that patients may misinterpret dental hygienists' education efforts as criticism rather than its intended purpose. Patient-reported negative communication experiences with dentists included disregarding concerns and feelings, discussing inappropriate topics, using a rude tone or sarcasm, and talking too much during the examination.[10] These findings confirm that nonprofessional communication is likely occurring between providers and patients, as also evidenced in the previously discussed closed claims data.

Dental care can be expensive, and coverage tends to be less common than medical care coverage. Unexpected out-of-pocket expenses can contribute to patient anxiety—which may contribute to unrealistic expectations. Dental providers should consider being transparent in their discussions of anticipated costs and expected outcomes. Consider explaining what is involved with an expected settling-in period and advising patients what to watch for and report.

Informed consent provides an additional opportunity to foster patient-centered care, promote collaboration, and establish expectations. The essential elements of informed consent include discussion of the intended procedure, its benefits, the patient-specific risks of the planned treatment, its likelihood of success, and the potential alternatives. When discussing the likelihood of success, be honest about the probable life expectancy of the work, the limits of the material(s) used, and the reasonably

expected cosmetic outcome. For multistep procedures, discuss the length of time between each step and the total expected time commitment for treatment and recovery.

Informed consent is not "informed" if the patient does not understand the discussion. It is important for dental providers to present treatment and consent discussions and forms in plain language. defines plain language as "communication your audience can understand the first time they read or hear it."[11] To achieve plain language, replace clinal terms with common usage, limit the use of multi-syllable words, and aim for a reading level between sixth and eighth grades. See Figure 1 for an example of dental plain language.

Figure 1. Example of Dental Plain Language

Before: **"A dental implant is a surgical component that interfaces with the bone of the jaw or skull to support a dental prosthesis such as a crown, bridge, denture, or facial prosthesis or to act as an orthodontic anchor." [Source: Wikipedia]**

After: "Dental implants are metal anchors put inside the jawbone underneath the gumline. Small posts are attached to the implants, and artificial teeth or dentures are fastened to the posts."

After essential communications, such as discussions involving consent or education, use teach-back to evaluate patient understanding. Advise patients that the information provided is important, and you want to make sure you did a good job explaining. Invite patients to share their understanding of the discussion in their own words. Gently clarify and correct any misunderstandings. Show me is the procedural version of teach-back; for example, asking patients to show you how they brush their teeth and floss. Document the process and result in the patient's dental record.

Patients with low English proficiency or hearing impairment may require the use of translators. Never use family, particularly children, to translate. Family members, who are there for support, may not have the linguistic capability to translate clinical information, and they may not be objective. Have commonly used documents translated from English into the most frequent languages spoken by patients. Use teach-back to assess patient understanding.

Sometimes patients need to be asked to leave a practice. The most common reasons for terminating the dentist-patient relationship are nonpayment of bills and aggressive or inappropriate behavior. Before dismissing a patient for nonadherent behavior, consider other options. Discharging a patient from the practice is not without risk; an improperly managed dismissal may be deemed patient abandonment by a professional review board. Meet with the patient to discuss the behavior and determine if there are any addressable barriers to compliance, such as lack of transportation, lack of childcare, or financial difficulties. Patients have the right to refuse care. Sometimes nonadherent behavior is a proxy for a patient's lack of comfort with directly refusing the treatment plan. Dentists are often concerned about professional risk when patients are nonadherent or refuse care. Under the circumstances, much like informed consent, the dentist's responsibility is to inform the patient of the purpose of the recommended treatment and the risks of refusing. The patient's responsibility is to agree or refuse. If the patient refuses, determine if there is an acceptable alternative. Memorialize the discussion using an informed refusal form, and include a summary of the discussion in a progress note in the patient's record.[12]

Good clinical communication improves teamwork and creates a safer environment for patients. Excellent communication engages and satisfies patients and reduces the risk of professional liability claims, even when things go wrong.

The guidelines suggested here are not rules, do not constitute legal advice, and do not ensure a successful outcome. The ultimate decision regarding the appropriateness of any treatment must be made by each healthcare provider considering the circumstances of the individual situation and in accordance with the laws of the jurisdiction in which the care is rendered.

References

1. Wick KE, Sutcliffe KM. Managing the Unexpected: Assuring High Performance in an Age of Complexity. 2nd ed. John Wiley and Sons; 2007.
2. Yun TYH, Muntean SA, Michaud RA, Dinh TN. Investigation of dental implant referral patterns among general dentists and dental specialists: a survey approach. Compend Contin Educ Dent. 2018 January;39(1):e13-e16. Reviewed October 27, 2021. https://www.aegisdentalnetwork.com/cced/2018/01/investigation-of-dental-implant-referral-patterns-amongst-general-dentists-and-dental-specialists-a-survey-approach
3. Wolcott JF, Terlap HT. Follow-up survey of general dentists to identify characteristics associated with increased referrals to endodontists. J Endod. 2014;40(2):204-210. doi:10.1016/j.joen.2013.10.033
4. Institute for Healthcare Improvement / National Patient Safety Foundation. Closing the loop: a guide to safer ambulatory referrals in the EHR era. 2017. http://www.ihi.org/resources/Pages/Publications/Closing-the-Loop-A-Guide-to-Safer-Ambulatory-Referrals.aspx
5. Weiner M, Perkins AJ, Callahan CM. Errors in completion of referrals among older urban adults in ambulatory care. J Eval Clin Pract. 2010 February.16(1):76–81.
6. Singh H, Meyer AND, Thomas EJ. The frequency of diagnostic errors in outpatient care: estimations from three large observational studies involving US adult populations. BMJ Qual Saf. 2014 September.23(9):727–731.
7. O'Malley AS, Reschovsky JD. Referral and consultation communication between primary care and specialist physicians: finding common ground. Arch Intern Med. 2011.171(1):56–65.
8. Agency for Healthcare Research and Quality. Medical office survey on patient safety culture user's guide. Published July 2018. Page 4. https://www.ahrq.gov/sops/surveys/medical-office/index.html
9. Malpractice risks in communication failures 2015 annual benchmarking report. CRICO Strategies. https://www.rmf.harvard.edu/malpractice-data/annual-benchmark-reports
10. Fico AE, Lagoe C. Patients' perspectives of oral healthcare providers' communication: considering the impact of message source and content. Health Comm. 2018;33(28):1035–1044. https://doi.org/10.1080/10410236.2017.1331188
11. What is plain language? Plainlanguage.gov. https://www.plainlanguage.gov/about/definitions/
12. Cahill RF. Informed refusal. The Doctors Company. Published May 7, 2020. https://www.thedoctors.com/articles/informed-refusal/

Florida Focus Self-Instruction: Operative Dentistry, Exercise 12212

Making Sure It Sticks

by Lori Trost, DMD

Today's dentistry finds us removing decay, often prepping for a Class II restoration, placing a temporary crown or adhesively bonding an esthetic indirect restoration. No matter which composite, resin cement, bonding adhesive or etchant is utilized, as clinicians, we tend to have our personal preferences. Generally speaking, we select restorative materials that possess specific characteristics, such as ease of placement, esthetics, depth of cure, clean-up, cost, and viscosity. However, the true measure of restorative success is much deeper. It lies in the chemistry, compatibilities, and indications of use for each material and how they can be maximized.

Just as Albert Einstein describes insanity - "Doing the same thing over and over again and expecting different results", clinical dentistry is challenging. We must navigate instant decision making that includes isolation, occlusal forces, retention and resistance form, along with structural anatomy. Clinicians quickly come to learn that failures happen due to micro-leakage, inadequate polymerization, material manipulation, and even incomplete penetration of primers and resins.

Proper clinical technique is paramount, and short-cutting any aspect of a dental procedure can create instant doom. Through a review of tooth anatomy, understanding current curing science in combination with specific materials and their benefits, dentists can leverage these choices to create more predictable and durable outcomes. This article will discuss and offer practical solutions for making things stick.

Adhesion methodology

Bonding has evolved considerably since its introduction, and the discovery by Buonocore that by treating enamel first with phosphoric acid, acrylic-based materials could be more easily retained.[1] Decades later, the mechanisms by which adhesives work are multi fold and have gained widespread acceptance. Whether the surface is enamel or dentin, phosphoric acid demineralizes the surface to make it more receptive for bonding. Initially, hydrophilic monomers and solvents "prime" or wet the surface, followed by monomers that penetrate to create micro-tags of resin. Light curing formalizes the polymerization, producing a mechanical bond to seal the tooth anatomy, ultimately forming the restorative interface.[2, 3]

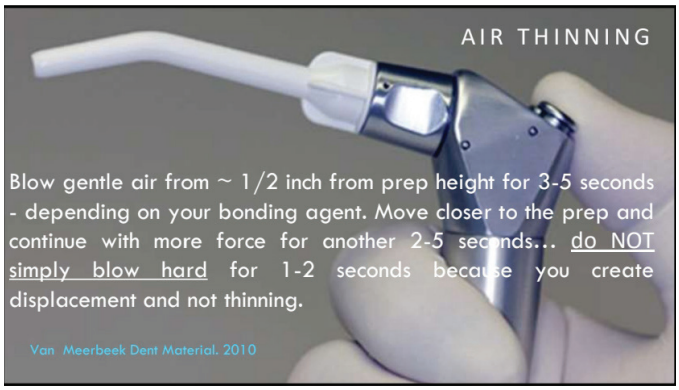
The latest generation of adhesives are termed "universal" in nature because they combine etch, primer, and an adhesive into one bottle. These bonding systems offer versatility in not only etching protocol and reduced inventory but also compatibility with various substrates from which they can bond to besides dentin and enamel. What separates this class of adhesives apart from others is the addition of 10-MDP, a monomer (methacryloyloxy decyl-dihydrogen-phosphate), which provides an extremely hydrophobic feature, bond durability, and chemical bond to calcium.[4, 5, 6]

Clinical takeaways using Universal Adhesives:

• Isolation of the tooth or surfaces to be restored is key. These bonding agents are not immune to blood, saliva, debris, or other contaminants. Rubber dams and quadrant isolation/evacuation devices should always be utilized.

• Select a high-viscosity, low flow phosphoric etch or gel. This will provide greater control and precise placement, especially when performing the selective etch method. For freshly cut enamel, etch should be placed for no more than 15-30 seconds and 10-15 seconds on dentin. The etchant should be copiously rinsed with a water stream and not a combination of syringed air and water, for 5-10 seconds. The tooth surfaces need to remain moist.[7]

• Refer to instructions how the adhesive should be stored. Some require refrigeration as advised by the manufacturer. Care should be taken to tightly seal the bottle as well as shaking the bottle prior to dispensing.



• Dispense a fresh drop of bonding agent to a clean micro-brush.

• Apply the bonding agent in a scrubbing fashion to the tooth surface for the recommended amount of time. Do NOT short-cut!

• Adhesives must be properly air-thinned. Clinicians should use a stream of oil-free syringe air held approximately one-half inch from the height of the preparation, using a cleared air line and gently blowing for 3-5 seconds in a zigzag movement across the tooth or surfaces. The goal is to properly thin and evaporate the adhesive, removing any ripples and not just displace the bonding agent.[8] Using a disposable air-water syringe tip is an easy solution to deliver dry air with no water contamination or biofilm build-up.

Light curing

Thorough light curing is another important factor to securing any restoration. Under curing is a common

reality leading to secondary decay, post-operative sensitivity, and restoration failure. Many curing lights lose the needed energy as they extend into the depth of the preparation, are not measured for their output, and may possess a limited wavelength.

Ideally, today's curing light emits a 1,000 milliwatts per squared cm, offers a collimated beam, and provides enough power to allow for a 4-5mm increment - such as a bulk-fill, to be cured within 20 seconds. Select a curing light that is wavelength compatible with all the materials that require curing in your practice. And also understand that ultimately operator control is imperative to properly photo-initiate all adhesive materials.

Clinical takeaways with Light Curing:

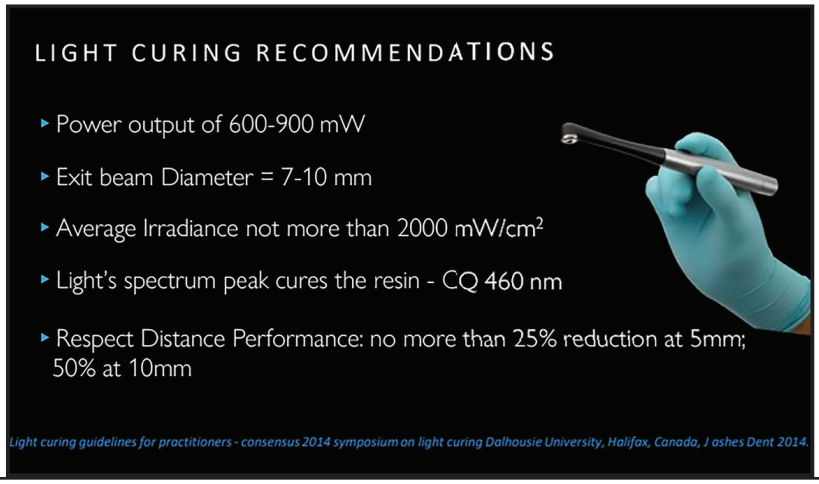
- Insure curing tips are clear and free of debris.
- Hold the light at right angles, as close to the preparation as possible, and stabilize with a finger rest.
- Properly time the curing and do NOT short-cut.
- Larger restorations may need longer curing and a rocking type motion of curing to reduce any shadows.
- Measure your light beam and overlap curing to insure complete polymerization.

Bulk-fill composites

Along with the composite evolution is the foundational element of bulk-fill resins. Dentists can leverage the benefits of these materials because of their larger incremental placement, adaptation, reduced volumetric shrinkage, and depth of cure. Bulk-fill composites offer efficiency, less contamination, and reduced post-operative sensitivity due to lower polymerization stresses.[9] The unique chemistry of bulk-fill resins offers clinicians a 4-5mm incremental placement, various viscosities, and often a release fluoride.

Clinical takeaways when using Bulk-fill Resins:

- Follow the manufacturer's directions regarding placement depth and do NOT exceed or over fill, violating a depth of cure and creating under-cured material.[10]
- Use a periodontal probe to measure the specific depth that is to be restored.
- Allow the material to flow and adapt to the cavity preparation, usually 5 seconds.
- Avoid any manipulation of the material that could potentially introduce contamination, bubbles, or voids.



About Dr. Trost

Dr. Lori Trost graduated from Southern Illinois University, School of Dental Medicine and created a comprehensive restorative and preventive-based practice in the Greater St. Louis area. She offers post-graduate courses to dentists and their teams that focus on solid restorative dentistry principles, digital workflow solutions, and exceptional team building. She is a recognized author, clinical evaluator, and editorial board member. Dr. Trost has also been honored by the ADA with a Shils Foundation Award, named a "Top 25" Woman in Dentistry and a Leader in Continuing Education by *Dentistry Today*.

Temporaries

Temporary fabrication and retention needs to be a cornerstone of your practice, but often it becomes a dreaded time-consuming and schedule interrupting process. Dual cure resin materials are readily available that offer unique benefits that can expedite the fabrication process, come in a variety of shades, can be "added to", and easily trimmed and polished.

A good temporary starts with a good prep. Once created, the temporary then must be placed for a "temporary" amount of time. Temporary cement choice is critical, especially today with the resin-based chemistries and adhesion qualities. Care should be taken to select a temporary cement that does not include eugenol because studies show it can interfere with the final resin cementation and lessen the bond strengths.[11]

Clinical takeaways with Temporary Fabrication:

- Make a model of the tooth to be restored using a PVS hybrid material that can be stored for up to 2 weeks, is stable and reproducible.
- Select a dual-cure temporary material for efficiency and any "add-ons".
- Use a temporary cement that is easy to clean up, seals the margins, retentive, but also easy to retrieve.

Surface treatment and definitive placement

The first step to obtaining a lasting result for the final indirect restoration placement is to treat the substrate surface. Decontaminating and applying an appropriate primer to the restoration will insure a stronger bond and reduce bond failure. After try-in, it is important to decontaminate the restoration due to phosphates in saliva that weaken bond strengths of the adhesive cement. Furthermore, the correct priming of the substrate - whether it is zirconia or lithium disilicate - is essential because longterm retention and durability are dependent upon it.

When choosing a cement, the decision process begins with, where are the margins? Are they supra or sub-gingival? What about margin isolation or is saliva an issue? How accessible is this prep? And finally how retentive is the prep form? Will the restoration need to be adhesively bonded?

How Block Booking Was Discovered 35+ Years Ago...

and Why It's Still the Most Efficient Way to Schedule Patients.

By Drs. Bill and Christina Blatchford

HISTORICAL BACKGROUND: In 1985, Dr. Bill Blatchford was a solo G.P. practicing in Corvallis, Oregon. His annual collections were $1.1M ($2.8M adjusted for inflation). His production was great, but when you took a closer look inside the numbers, his scheduling system was wildly inefficient. His team would put patients anywhere and everywhere on the schedule. As you can imagine, it was unbelievably stressful.

Then the lightbulb went off! Together with his business coach, he invented what he coined "block booking," a simple, but practice-changing scheduling system that was designed out of total frustration.

His daughter, Dr. Christina Blatchford, purchased a practice in 2009 in Milwaukie, Oregon, while in her final semester of dental school. She had the luxury of having her father, by now a world renown business coach for dentists, as her practice consultant. After running through a few chaotic hygiene cycles that she inherited from the previous owner, she installed the Blatchford Block Booking System™ and life became a lot easier.

This interview has been condensed and edited. It was conducted at a recent live seminar in Washington, where Dr. Bill Blatchford, and his daughter, Dr. Christina Blatchford, trained 35 doctors and more than 245 team members on the core principles of block booking. Both Dr. Bill and Dr. Christina are retired dentists who have combined to coach more than 4,000 dentists over the past 41 years.

DR. CHRISTINA: Why do you think scheduling is such an under-appreciated aspect of running a dental office?

DR. BILL: Primarily, I think it boils down to the myth of getting as many patients as you can in order to be successful. The idea that more-more-more will make your practice better.

The patient calls in for an appointment and the team

"Making Sure It Sticks," continued from page 15.

All of these factors are taken into consideration when selecting a cement. For retentive preparations, a traditional cementation process can be utilized. Many of these traditional cement chemistries now offer a tack curing to expedite clean-up. If the preparation is non-retentive and can be isolated, the restoration must be adhesively bonded to the preparation to satisfy retention. Adhesive protocols then apply. For preparations that are both non-retentive and be isolated, bioactive or glass ionomer-based chemistries are relied upon.

Clinical takeaways for Final Placement:

- For zirconia restorations, scrub Ivoclean or ZirClean for 20 seconds, then rinse and air thoroughly.
- For lithium disilicate, cleanse the substrate with Ivoclean for 20 seconds, then rinse and air thoroughly.
- Choose a primer wisely. Many of the universal adhesives already contain a primer - 10-MDP.
- Apply silane to lithium disilicate substrates for 1 minute and vacuum dry. Do not introduce water. Silane improves the wettability of the porcelain AND enhances the bond between the ceramic and the resin cement.
- Tack cure the margins to remove initial cement, followed by a thorough light curing of the restoration once all the cement has been removed.

CE Questions are on page 19.

Conclusion

Dental materials and techniques have evolved, and with that in mind, our restorative choices should shift to capitalize on each material's properties. In doing so, we are able to offer not only the best clinical outcome for patients, but also provide procedural efficiency and effectiveness. Essentially, we are making sure it sticks!

References

1. Buonocore MG. A simple method of increasing the adhesion of acrylic filling to enamelsurfaces. J Dent Res. 1955;34(6):849-853.

2. Latta M. Recent advances in dental adhesives - part 1. Dent Adhesives 2010;1-6.

3. Rusun O, Blatz M. Clinical applications of self-etch and etch-and-rinse adhesive systems.Inside Dent 2013; 6:64-74.

4. Margeas R. Universal adhesives: new realm of possibility. Comp Vol 37; (10); 720-721.

5. Fukegawa D, Hayakawa S, Yoshida Y et al. Chemical interaction of phosphoric acid esterwith hydryosapatite.J Dent Res. 2006; 85(10): 941-944.

6. Van Landuyt KL, Yoshida Y, Hirata I, et al. Influence of the chemical structure of functionalmonomers on their adhesive performance. J Dent Res. 2008;87(8):757-761.

7. Strassler HE. Contemporary resin adhesives. Inside Dent. 2014; 10:47-54.

8. Van Meerbeek B, Yoshida Y, Mine A, Van Landuyt K.L. State of the art of self-etch adhesives. Dent Mater. 2011; 27(1):17-28.

9. Sarrett DC, ed. Flowable composites. In: ADA Professional Product Review: A Publication ofthe Council on Scientific Affairs. 2009;4(2):2-13.

10. Ganesh N, Strassler HE. Posterior Composite Resin Restorations: Keys to Long-term Survivability. Comp. 2019;40(2)120-121.

11. Carvalho C, Bauer J, Loguercio A. Effect of zoe temporary restoration on resin-dentin bond strength using different adhesive strategies. JERD. 2007;19:144-1

member at the front automatically asks them when they can come in and then places that patient on the date and time that's convenient for the patient—not for the doctor. It's really a chaotic way to schedule.

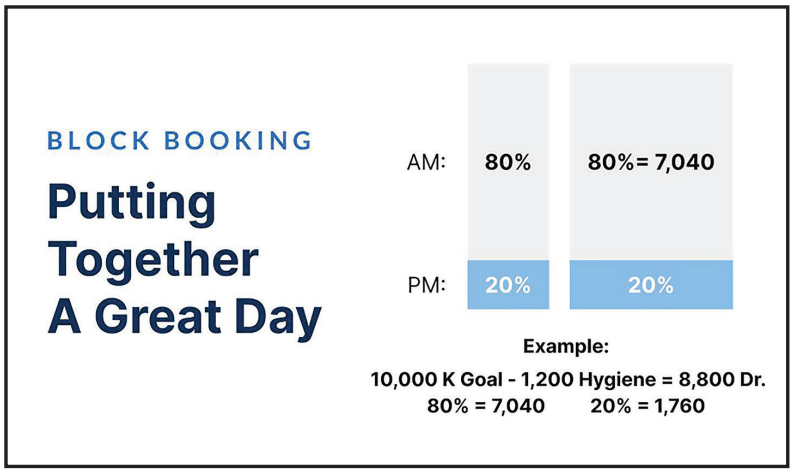
DR. CHRISTINA: Well, there's definitely no script that the person answering the phone is following. It's like she's taking down dinner reservations at a restaurant. Just fill-in the spaces.

DR. BILL: Exactly. And I'm glad you mentioned scripting. The words that we use matter. You can't just wing it. That schedule has to have a lot of planning built into it. And a lot of intention on the predictability of how our days go. This is where block booking is a total game-changer!

A great schedule is planned with certain procedures at specific times. Times that make the most sense for the profitability—and I'd even say the sanity—of a practice.

But block booking isn't really a consideration for most dentists. And that's understandable, because dentists can spend a lot of money on marketing to get more patients. Just get me more new patients.

So to them, having a full schedule gives them the false belief that their business is successful. We call this: The New Patient Myth.



And many of these offices are high volume, high stress and highly inefficient.

DR. CHRISTINA: When I started my own practice I made that same mistake. The previous owner's mentality was to just fill the schedule. And the team just kept that same train rolling. We'd run behind schedule, and would sometimes call patients and ask them to come in 15-to-30 minutes later than their scheduled appointments. It was amateur hour. And I went to you for help, and your block booking system really changed everything.

I know your practice had a chaotic scheduling system prior to changing that, but in 50 words or fewer…what was it that inspired you come up with the concept of block booking?

DR. BILL: Well, first of all you could hardly call it a system. It was just…a schedule. We were all running around like hamsters on a treadmill. Especially me! Back in the 1980s, aerobic exercising had become popular. And I would joke that I was doing Aerobic Dentistry!

DR. CHRISTINA: Constantly running from room to room.

DR. BILL: That's right. I know I'm over 50 words now (laughs), but I really want to emphasize that what we were doing was not the ideal way to schedule and it was becoming clear to me that this way of scheduling was unsustainable. For myself. For my team. And for my patients. I mean… it got to the point where dentistry wasn't fun anymore.

DR. CHRISTINA: I know that there's this misguided belief in dentistry that many dentists don't know—that dentists who out-produce other dentists—who are more profitable than other dentists—do not necessarily see tons of patients or spend long days at the office.

DR. BILL: That's right. It's part of the New Patient Myth I mentioned earlier. I subscribed to it for a while myself, and it doesn't work well for the longevity of the dentist—and the team.

DR. CHRISTINA: And so you created block booking because having a chaotic, stressful, and unproductive schedule was becoming unsustainable.

DR. BILL: Correct. So I discussed this with my business coach and thought, what if we could schedule only perfect days? What if we could schedule days where we saw less patients and gave those patients V.I.P. service? What if we could schedule certain procedures in the morning, so that by noon, 80% of the daily collections goal was achieved? And what if we could keep some blocks of time open for the higher ticketed cases, instead of turning them away because we were overbooked? And so, I presented this idea to my team.

DR. CHRISTINA: And how'd they react?

DR. BILL: Well, at first they gave me all the reasons why it wouldn't work. "Patients are in charge of their own schedule." And "We can't keep blocks of time open! What if no-one books it? We'll lose money?"

DR. CHRISTINA: We all have a pesky little naysayer inside us, because it's often hard to make changes.

DR. BILL: It sure can be. But I was ready for a change and as the leader of my practice, I told my team we were going to try it out for one day. Baby steps. Let's just see if we can schedule the perfect day. So we went back to the old schedule and found a few perfect days and used those days as a template.

And lo and behold, it worked great! Now of course, there were some glitches, and there were things that needed to be ironed out, but for the most part, it really worked!

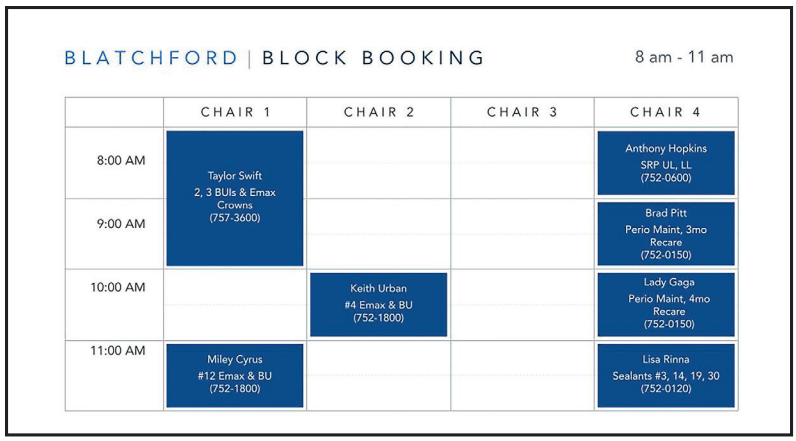
DR. CHRISTINA: And that was the first time you scheduled intentionally.

DR. BILL: Yes. And I thought, if it could work for one day, why not the whole week? And because that worked so well, we were able to cut back days. We now have hundreds of practices that we've coached that are now working 3-day weeks—and every day they are block booking.

DR. CHRISTINA: We do. And I'm glad you mentioned it…the goal is to consistently have super productive and profitable days…this is really only possible when the team is totally on-board with block booking.

I remember when I was still practicing, going to the attic of my old practice, and seeing my old schedules and thinking wow, how crazy my schedules were before I installed block booking. There was no rhyme or reason… fillings here…crown and bridge here… hygiene recall here, and so on. It was a space puzzle, as I called it. We'd see an empty space on the schedule and we'd fill it, and if we filled all the spaces for the day, we felt good, like we accomplished something. But with block booking, it's a space puzzle with math. That's the key.

DR. BILL: Precisely. Without the math part, it's a free for all.



BLATCHFORD | BLOCK BOOKING 8 am - 11 am

	CHAIR 1	CHAIR 2	CHAIR 3	CHAIR 4
8:00 AM	Taylor Swift 2, 3 BUls & Emax Crowns (757-3600)			Anthony Hopkins SRP UL, LL (752-0600)
9:00 AM				Brad Pitt Perio Maint, 3mo Recare (752-0150)
10:00 AM		Keith Urban #4 Emax & BU (752-1800)		Lady Gaga Perio Maint, 4mo Recare (752-0150)
11:00 AM	Miley Cyrus #12 Emax & BU (752-1800)			Lisa Rinna Sealants #3, 14, 19, 30 (752-0120)

This is where having a daily production goal becomes important. Typically, with block booking, you want to schedule 80% of your daily goal in the morning, before lunch. Let's say a daily goal is $10,000. So, you'd want to schedule $8,000 worth of treatment in the morning. And roughly, 20% of that $8,000 comes from hygiene, the other 80% of that comes from the doctor's side.

DR. CHRISTINA: So to doctors and teams out there, think of what type of mix of treatment in your office that you can fit in the morning that will help you attain your daily goal. What are the higher ticket items that you can schedule there, such as root canals, crown and bridge, implants, and so forth?

DR. BILL: Say from 8AM to 10AM you have a $3,800 procedure. Then from 10AM to 11AM you have a $1,200 procedure. So you already have $5,000 before lunch, but you still need $3000 to hit the 80% of the daily goal of $10,000, and this also includes hygiene, I might add. So, if someone wants to come in with a $500 filling in the 11AM to NOON slot, that's not the best use of that block.

DR. CHRISTINA: Right. You want to keep that block open with a higher ticket procedure to fulfill the daily goal, so you'd want to schedule that $500 filling in the afternoon.

DR. BILL: And this is where scripting comes in. We help train your whole team—because everyone will need to learn block booking. We train them to offer times in the morning or afternoon which best suits you—the doctor—to achieving your daily goal.

DR. CHRISTINA: Exactly. And if there's a doctor hearing this who is saying to themselves this will never work because I'm not a morning person—the answer to that is we will customize it to when the doctor feels he or she has the most energy. In those instances, we will simply flip the schedule to make the afternoons be your biggest production hours. The bottom line is that it's a proven system and it works!

DR. BILL: And I'm glad you mentioned getting the team on the same page…because with our bonus system, the whole team gets involved with block booking, because when they reach their daily goal number consistently, their bonuses get bigger.

DR. CHRISTINA: Right. So another big aspect of block booking is holding some blocks open. This is hard for some doctors to understand, but an open spot is actually an opportunity. For example, if a patient broke a tooth and needed to come in, but if your schedule was filled, you just missed an opportunity because you were over-scheduled, and they'll go to someone else.

DR. BILL: And it's not just emergencies, it's also about utilizing those open blocks for patients who may need more than one procedure, so why not give that patient the opportunity to get as much done in one appointment, or two appointments, rather than having them come in on multiple days.

This where effective case presentation comes in. We also train the doctor and team with great questions for the patient to see if they want to go ahead with treatment. Nothing pushy or salesy. Never-ever. Always 100% authentic.

DR. CHRISTINA: I'm really glad you mentioned that. And we never offer treatment that we wouldn't do on our own family members. That's a Blatchford Rule.

DR. BILL: That's correct.

DR. CHRISTINA: One last thought about those blocks. Since the blocks have been held open, you can offer the ideal treatment that same day, which many patients like. Because let's face it, they don't want to spend more time at the dentist than they'd have to. Another important feature about block booking is that the doctor sees one patient at a time. There's no rushing from chair to chair. It's start. Finish. Stop.

DR. BILL: This allows the doctor to give patients the VIP treatment they deserve, and leaves a lasting impression on them. This is a key that should not be overlooked.

DR. CHRISTINA: Right. Dentists often wonder why they don't retain patients or wonder why those patients don't refer their friends and family. Well, mostly it's because you are not giving them VIP treatment. Patients notice these small things.

DR. BILL: And since block booking affords you the time to treat each patient like a VIP, your referrals will explode.

DR. CHRISTINA: So, as dentists, you have to ask yourself. Do you want your schedule to control you? Or do you want to control your schedule? With block booking, you can control your schedule.

DR. BILL: Of all of our coaching systems, many Blatchford clients say that block booking has been the single most important game-changer in their practice, as many have dramatically reduced their number of clinical days and at the same time increased their profits. And patients love it too!

DR. CHRISTINA: They sure do. Block booking also helps with the doctor's overall…well, what most people call work-life balance.

DR. BILL: Or, as we at Blatchford like to say, "Life-work balance." Because your life outside the office is just as important as your life at the office. And with block booking, you'll be able to spend more time with your family and have the time to do the things you always dreamed of doing.

DR. CHRISTINA: Right. It certainly has changed the lives of thousands of dentists and their teams and their families. Well, thanks, Dad. And thanks for coming up with this revolutionary way to schedule.

DR. BILL: You're quite welcome, Christina. I'm just glad to share this system with other dentists.

"Since we applied the Blatchford block booking principles to our scheduling, our practice has thrived. And our patients are thriving, too - experiencing the benefits of world-class dentistry every day."

- Dr. Xhoana Gjelaj, Trinity, FL
DMD, MAGD, DICOI, DABOI

Florida Focus Self-Instruction:
Exercise 12211, 1 CEU
Risk Management, Subject 565

Florida Focus Self-Instruction:
Exercise 12212, 1 CEU
Operative Dentistry, Subject 250

Please email your answers with your name and AGD number to flagdeditor@gmail.com. 80% of the answers must be correct to received credit. Answers for this exercise must be received by March 31, 2022.

1. The average EMS response time to a 911 call can be ___ minutes in a rural setting and ___ minutes in an urban setting.

A. 30, 11 B. 11, 15 C. 15, 30 D. 15, 11

2. Dental offices should be prepared to manage a medical crisis for up to ____ minutes without assistance.

A. 20 B. 30 C. 40 D. 60

3. In the Six Links of Survival, the educational initiatives include all except _____.

A. a written emergency plan B. practice drills
C. dentist training D. team training

4. The standard of care for medical emergency preparation includes proper medical knowledge and annual emergency drills. Physical preparation includes a written medical emergency plan, emergency medications, and emergency equipment.

A. Both statements are true.
B. The first statement is true; the second one is false.
C. The first statement is false; the second one is true.
D. Both statements are false.

5. If a medical catastrophe occurs, questions at the deposition may include _____.

A. Does your staff have BLS training?
B. What is your medical emergency plan?
C. Can you explain each of your emergency medications?
D. All of the above.

6. Sudden cardiac arrest kills ____ individuals daily.

A. 300 B. 600 C. 800 D. 1000

7. The 6 P's of Medical Emergency Preparation include _____.

A. protocols, products, participation
B. personnel, protocols, practice
C. prevention, personnel, pace
D. prevention, patency, palliation

8. Necessary emergency equipment includes all except _____.

A. pulse oximeter
B. automated external defibrillator
C. glucometer
D. airway equipment

9. Emergency medical drills should be performed _____.

A. monthly B. quarterly C. semi-annually D. annually

10. Practice drills should include _____.

A. the use of emergency medications
B. the flexibility to compromise treatment as needed
C. the use of emergency equipment
D. outside professional evaluation of office preparedness

1. Causes of restoration failures include _____.

A. inadequate polymerization
B. material manipulation
C. microleakage
D. all of the above.

2. Etching of enamel with phosphoric acid was introduced by Buonocore in ____.

A. 1945 B. 1950 C. 1955 D. 1960

3. "Universal" adhesives include all except _____.

A. decontaminant B. primer C. 10-MDP D. etch

4. 10-MDP is a hydrophilic monomer. It is characterized by its bond durability and chemical bond to calcium.

A. Both statements are true.
B. The first statement is true; the second one is false.
C. The first statement is false; the second one is true.
D. Both statements are false.

5. In the selective etch technique, a high-viscosity phosphoric gel is applied no more than _____ seconds to enamel and _____ seconds to dentin.

A. 10-15, 5-10 B. 15-30, 5-10
C. 30-60, 10-15 D. 15-30, 10-15

6. Proper air thinning of adhesives includes using a cleared air line and gently blowing for 3-5 seconds in a zigzag movement. Using a disposable air-water syringe tip delivers dry air without contamination.

A. Both statements are true.
B. The first statement is true; the second one is false.
C. The first statement is false; the second one is true.
D. Both statements are false.

7. Today's curing lights should _____.

A. emit 1000 mW/cm^2
B. have sufficient power to cure a 6-7 mm increment
C. have a dispersed beam
D. cure within 10 seconds

8. Bulk-fill resins offer dentists all the following advantages except _____.

A. reduced volumetric shrinkage
B. reduced post-op sensitivity
C. increased manipulation time
D. larger incremental placement

9. Temporary cements should not contain _____, as it can reduce the bond strength of the final resin cement.

A. 10-MDP
B. calcium
C. fluoride
D. eugenol

10. Prior to final placement, lithium disilicate and zirconia should be scrubbed for _____ seconds with an appropriate decontaminant.

A. 10 B. 20 C. 30 D. 40

FLORIDA ACADEMY of GENERAL DENTISTRY

Venipuncture Technique for L-PRF Grafting - Hands on Workshop
Speaker: Dr. Stephen Lockwood

DATE: January 15, 2022
TIME: 9:00 AM - 4:30 PM
LOCATION: Courtyard Marriott - Amelia Island
COST: $365 AGD Members ---- $550 Non-Members **SUBJECT CODE:** 690
RSVP: flagdinfo@gmail.com

COURSE DESCRIPTION:

The art and science of autologous socket grafting is becoming more popular in dentistry as dentists become better educated and trained in this procedure. The simplicity of using readily available blood derivatives of centrifuged venous blood has enhanced the clinical outcomes of regenerating tissues, while reducing the need for costly biologics such as allograft and membrane materials. In this course, we will review the science, clinical applications and handling techniques/preparation of the Leukocyte-Platelet Rich Fibrin (L-PRF) towards various clinical uses, primarily socket regeneration. Venipuncture technique will be presented and demonstrated during the lecture in preparation for the hands-on portion, where attendees (FL licensed dentists) will volunteer to perform venipuncture on attendees and volunteer to allow venipuncture on themselves. A Licensed RN and experienced licensed FL dentists will assist with such procedures. The samples of blood will be collected in vials for use with centrifugation followed by handling techniques to simulate the clinical preparation just prior to a clinical use. We will discuss best practices for disposal of biological waste as well. Audience: Dentist, Staff ; Materials required: Eye protection and masks

LEARNING OBJECTIVES:

- Understand the science of blood derivatives involved with clinical applications in dentistry
- Understand the process of venipuncture and centrifugation of blood
- Understand patient management of related procedures
- Experience and demonstrate venipuncture
- Learn the techniques in handling blood samples and the fibrin manipulation
- Learn the safe handling of biological waste

ABOUT THE SPEAKER:

Dr. Stephen Lockwood has been practicing dentistry in La Jolla since 1985. He is currently a partner with Dr. Stephen Eskeland at Regents Dental Group where he performs implant and restorative dentistry as well as orthodontics. He is a part-time faculty member of UCSD School of Medicine- Department of Family and Preventive Medicine, where he serves as a dentist volunteer at the UCSD Free Dental Clinics at Veterans Village of San Diego.

Dr. Lockwood graduated from the University Of California, Irvine in 1980. He received his D.M.D. (Doctor of Medical Dentistry) Degree from Oral Roberts University, School of Dentistry, in Tulsa, OK in 1984. After graduating from dental school, Dr. Lockwood completed a General Practice Residency at Loma Linda University Veterans Hospital, in Loma Linda, CA. During his residency he received extensive training in surgical procedures as well as training in treating medically compromised individuals. Dr. Lockwood has had additional training in Implant Dentistry completing LLU Implant Dentistry Maxi-Course and has earned Associate-Fellow status with the American Academy of Implant Dentistry (AAID). He is an involved life-long learner with AGD having earned his Mastership through the AGD. In his spare time Dr. Lockwood is the principal trumpeter for the Coronado Concert Band and is also the trumpeter at Our Mother of Confidence Catholic Church in San Diego. He has three adult children who have all graduated from college.

Dr. Lockwood is a member of the following Professional Organizations:

American Dental Association, California Dental Association, San Diego County Dental Society, Academy of General Dentistry - Master American Academy of Implant Dentistry- Assoc. Fellow American College of Dentists- Fellow

CANCELLATION POLICY:

In the event that a registrant needs to cancel, please email flagdinfo@gmail at least 30 days prior to the course date to receive a full refund. Cancellations received less than 30 days, but more than 15 days prior to the course date will receive a 50% refund. No refunds are provided after this date. Failure to attend the meeting without written notification will not qualify for a refund.

PACE ACADEMY of GENERAL DENTISTRY PROGRAM APPROVAL FOR CONTINUING EDUCATION

AGD-Florida Nationally Approved PACE Program Provider for FAGD/MAGD credit. Approval does not imply acceptance byany regulatory authority or AGD endorsement. 1/1/2021 to

12/31/2023. Provider ID# 219295