american academy of gold foil operators

Gold Leaf

JULY 2015

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American Academy of Gold Foil Operators
Annual Meeting October 21 - 24, 2015

Pensacola Beach, Florida

Wednesday, October 21
- 1PM - 8PM Registration
- 2PM - 5PM Executive Council Meeting
- 6PM - 10PM Reception, Heavy hors d'oeuvre's

Thursday, October 22
- 6AM- 9:30AM Breakfast Buffet
- 8AM - 2PM Clinical Session
- 7AM & 8AM Trolley Leaves for the Clinic
- 3PM & 2PM Trolley Returns to Hilton Hotel
- 6PM "Dine Around" dinner on your own

Friday, October 23
- 6AM- 9:30AM Breakfast Buffet
- 8AM - 11AM Lecture "Tucker Technique", Dr. Barry Evans
- 11:15PM - 12:15PM Lecture "Future of Dentistry", Dr. Fred Eichmiller
- 1PM Trolley to Naval Air Station
- 1:30PM - 2:30PM Lunch, Naval Air Station Pub Cubi Bar Cafe
- 2:30PM - 4:30PM Naval Air Museum Tour
- 5PM - 9PM Tour and Dinner, AMBITION National Flight Academy. Speaker Ken Runkle. Flight Simulators
- 9:30PM Trolley returns to Hilton

Saturday, October 24
- 6AM - 9:30AM Breakfast Buffet
- 8AM - 10AM Lecture "Gold Foil Restorations", Dr. Wendell Foltz
- 10:15Am - 11:15AM Lecture "Goal Oriented Splint Therapy" , Dr. Matthew Henry
- 11:30AM - 12:30PM "Clinical Review", Dr. Bruce Small
- 6:30PM - 9PM Gala Dinner, Installation of Officers

Registration for the Annual Meeting is available on the AAGFO website. This year you will have the option of paying the meeting fees using PayPal. You do not need a PayPal account to complete the transaction. A credit card, bank account or PayPal account can be used. There will be an added fee of 2.99% for paying throught the PayPal site. The registration form should be self explanatory. Once completed and "Submitted", you will be re-directed to Paypal to pay your fee.

In addition to the PayPal option there are two different PDF registration forms you may use. These forms consist of an "online fillable" form and a manual form. Once completed you would then send with your check to Dr. Elaine Neal.

We encourage you to use the PayPal feature as it will simplify our record keeping.

FEATURED SPEAKERS

Dr. Barry Evans, "Tucker Technique"

Dr. Fred Eichmiller, "Future of Dentistry"

Mr. Ken Runkle. "Leadership"

Dr. Wendell Fo;tz, "Gold Foil Restorations"

Dr. Matthew Henry, "Goal Oriented Split Therapy"

Dr. Bruce Small, "Clinical Review"

This meeting will have plenty of time for exploring the beaches of Pensacola and surounding areas. You will be able to test your flying skills in the jet simulators on Friday night.

The Annual meeting is the perfect setting to renew friendships, earn continuing education credit, and experience the hospitality of a new city.

Register early and make your hotel reservation now. If you have any questions contact Dr. Elaine Neal, (email: elaine.neal1@gmail.com or phone, (603) 643-3509)

The Changing World of Dentistry: A View From The Dark Side

Dr. Fred Eichmiller

Like the title, my role in the world of dentistry has been ever changing. Eight years ago I moved from the world of materials science and therapeutics to the payer business side of dentistry. I would have never guessed what an interesting journey that would be. What I have to present is the result of analyzing a lot data. Much of the data comes from the ADA's Health Policy Institute, and in fact many of the charts will be copied directly out of the ADA's publications. A lot of the data comes from the company I work for, and our 1.7 million patient members. But a very wise statistician I had the privilege of working with at the National Institute of Standards and Technology always started a conversation related to data as "its only a bunch of numbers if it doesn't tell a story. Tell me the story and I'll tell you how well your story matches the data, or if it is the only story." What I hope you take away today is not the numbers, as they will be in a constant state of change, but rather the story that the numbers tell. Like I was advised, I will qualify my story in that it may not be the only story. But it's mine and I'm sticking to it.

There are two "must reads" I recommend for all of you. Both come from the American Dental Association's Health Policy Institute and the first is "Critical Trends Affecting the Future of Dentistry: Assessing the Shifting Landscape", published in May of 2013. The second is "A Profession in Transition: Key Factors Reshaping the Dental Landscape". Both present compelling analyses of economic and demographic factors that are driving change in the business of dentistry.

To start my story I want to go back to 2007 when leaders in business and healthcare were looking at the growth rates in overall healthcare costs as a doomsday scenario. Annual inflation trends were double digit and employers were contemplating the very real possibility that spiraling healthcare costs could exceed compensation costs in the foreseeable future. Overall healthcare costs were expected to exceed 20% of the gross national product by 2015 and there was a general awareness that healthcare economics simply failed to react to the generally accepted rules of supply and demand. But something much unexpected happened around 2008. Growth rates costs could exceed compensation costs in the foreseeable future. Overall healthcare costs were expected to exceed 20% of the gross national product by 2015 and there was a general awareness that healthcare economics simply failed to react to the generally accepted rules of supply and demand. But something much slowed dramatically and the growth curve flattened. Spending leveled off at about 17% of GDP and the last five years annual inflation slowed to just 3.6%. It still must be kept in perspective, however, that average annual healthcare costs per capita was still over $9,000 in 2013.

So what happened? There were many factors that came into play including a global economic slowdown, a local U.S. recession, high unemployment, and a greater political focus upon healthcare costs. These all played a role, but in reality I believe the system had finally absorbed all that it could, and simply hit a wall. Government, employers and consumers simply could not pay any more and something had to give. Where was dentistry in all of this? First of all, you have to put dentistry into perspective with respect to total healthcare costs to understand why we went largely unnoticed. Our $100 billion industry is hardly detectible in a healthcare system of nearly $3 trillion dollars. If we take a closer look at our history of spending, however, it tells almost the same story. Projections in 2007 were that by 2020 we would be a $170 billion industry growing at 6% or more annually. What really happened, however, is that dental spending also plateaued after 2008 and has remained flat at around $110 billion in inflation-adjusted dollars ever since. 2002 through 2008, and we have actually

experienced slightly negative annual growth rates from 2008 through 2012, while medicine has experienced a modest 1.4% positive annual growth

During these same decades the population was growing, and another perhaps more valid way of looking at dental spending is on a per capita basis. Per capita spending plateaued around 2007 at about $345 per person, but the bend in the growth curve actually started occurring back in 2002 when per capita spending was at about $315. This demonstrates that the changes we have seen cannot be entirely blamed upon the economic downturn. To get closer to home, you can also analyze spending on a per-patient basis. Here we can see that per patient spending actually peaked in 2008 at about $683 per patient and has since been slowly declining to about $660. The patterns of patient spending are strongly influenced by human behavior, and the number one driver is out-of-pocket costs. If you compare the year-to-year variation in patient spending, individuals with private insurance average the highest per patient spending at about $730, with year-to-year changes being fairly small as insured are better insulated against the influences of the economic environment around them. Uninsured patient spending averages about $630, with a high degree of year-to-year volatility as consumers react to the economic environment. Patients on government funded programs have the lowest per patient spending at about $400, and almost no year-to-year volatility as they have the lowest level of out-of-pocket obligation and react least to their economic environment.

Another important thing to analyze is who is paying the dental bills. Looking back since 1990 the largest payer overall has been private insurance at about 48% of total expenditures, and this has only varied by a few percentage points. Out-of-pocket expenditures currently make up about 42% of the total, and have gone down from 48% in 1990. The payer that has shown growth has been in government programs, which have grown from about 2% of the total in 1990 to more than 8% today. Most of this growth has been in children's dental coverage, with the expansion of Medicaid and CHIP programs.

The truly concerning projection, however, is presented by the ADA Health Policy Institute on projected growth in dental spending over the next 25 years. These projections have been made on a most conservative, least conservative and middle conservative scenarios and project that by the decade of 2030-2040 we could be looking at essentially zero growth. Their overall conclusion is that we have entered an era of a "new normal" of dental spending.

There are many drivers that impact this scenario, such as the growth in consumerism, changes in the dental workforce, and changes in the business models for dental delivery. One of the big factors is a change in utilization of care. The Health Policy Institute published historic utilization data for different age cohorts that showed children and older adults have been fairly constant in their rate of seeking annual care, but use among adults age 19-64 has been steadily declining since about 2002. A Harris Poll survey done by the ADA looked at reasons for this decline, and found that cost was the overall biggest driver for adults deciding not to seek care followed by the perception that their mouths were healthy, and not in need of care. What was interesting with these results, however, was the fact that when they broke this adult population down to looking at only higher income adults, the overwhelming reason for not seeking care was the perception of good oral health. Younger adults also had a greater perception of good oral health as their reason for not seeking care. Clearly the improvement of oral health is having an impact on patient behavior to seek care.

When looking at a population of approximately 1.5 million insured individuals the picture is a bit different. Among the insured population we see an increase in the annual utilization across all ages,

though the increase is smallest for middle-age adults. This large difference in adult utilization between the ADA data and insured data, therefore, is primarily due to the influence of the uninsured and publically insured populations. These two populations constitute the main driver for this slowdown.

Another driver for the dental economy is the mix of services being provided. In the insured population preventive services are trending upward over time with the greatest increase being seen in children 19 and under. Children utilize about three times more preventive services than adults. The trends in restorative service utilization are just the opposite, with all ages declining over time and again, children 19 and under showing the greatest decline. In this case, however, it is adults that use about twice as many restorative services as children. To see if this decline has any relationship to disease trends this data can be broken down into the proportion of single surface to all restorations as a measure of early disease treatment. The results over 7 years show a rapid decline in the number and proportion of single surface restorations for the age 19 and under cohorts, as well as a decline for younger adults below age 40. Similar declines in root canals and other disease-related services, such as pulp capping reinforce the fact that these younger age cohorts are experiencing a declining disease burden that is requiring fewer and less complicated treatment. The utilization of crowns over this same 2007-2013 time period also show an overall decline in per-patient utilization, but the trend is tied much closer to economic conditions with a steep decline coinciding with the 2008 economic downturn, followed by a short period of recover in 2012 and 2013. The result of all of this is a time-dependent shifting of the age-cost curve. The peak dental costs that occur for patients in their early teens are declining and the upward ramping of costs with age that occurs in adults is shifting towards older ages. The result will be that for privately insured patients, average per-patient revenue will continue to decline for younger patients while older adults will grow to be the population with the greatest need.

To see the impact of these changes on a dental practice we need to compare what happened inside an average practice in 2008 to one in 2013. In 2008 the average practice provided 73.5% of its services as diagnostic and preventive, and 15.5% of services were restorative. By 2013 the diagnostic and preventive made up 76.2% of services, while restorative dropped to 14.9%. While this change may seem small, one must also take into account that the 14.9% of restorative services made up 39% of total revenues, while that 76.2% of preventive and diagnostic services made up another 39%. What this implies is that a small shift in the proportion of restorative services will have a much larger impact on the bottom line than the change in diagnostic and preventive. If these trends continue, it may require a different business model to facilitate both the delivery of this mix of services, and to provide the efficiency needed to retain profitability.

We have already seen changes in the dental marketplace with models such as corporately managed, corporately owned, large group, and even employer-based practices. We will continue to see the marketplace evolve as change is inevitable, and consumers will ultimately determine which of these business models survive. Dentistry remains a more than one-hundred billion dollar industry that isn't going away. During this transition, however, it is up to us as a profession to establish and maintain the quality of care we deliver.

Joan Matis Retires from Operative Academy Journal

Joan started working for the Operative Dentistry journal in May of 1999. At that time subscription information was kept on 3x5 cards and a single excel spreadsheet. Joan started, right away, to move to electronic record keeping and by the end of 1999 all subscriptions and mailing information was in the computer.

Manuscripts were handled all by hand and it was Joan's responsibility to receive the manuscripts by mail and prepare them for Dr. Cochran to assign to review. Preparation of the manuscripts was difficult and time consuming. All author identifying information had to be redacted by hand and 4 copies of the manuscript prepared for review. After the Editor assigned reviewers, the manuscripts had to be prepared for mailing to those assigned. Each manuscript took, on average, 2 hours to process at that time. Joan found all this processing time unproductive, and began searching for ways to improve the process.

Joan decided that with the rapidly developing use of the computer, and increasing world-wide accessibility to the internet and email, it would be beneficial to move to an online presence; this was done one small step at a time. Joan sought out assistants that would help her with the technical aspects of this process, and eventually hired her son Kevin to help accelerate the process. In 2003 the office went paperless (for the most part), and by 2004 all of our archives were digitized and available on CD/DVD. In 2005 we made a significant pricing structure change to accommodate our upcoming online presence. This price increase did not affect the academies, which we were very pleased with, but did generate significant additional capital that was needed to fund the future expansion of the journal.

In 2006 we added the RV Tucker Academy as a sponsoring academy, Joan's desire to reach out and find other academies that might benefit from access to the journal was a catalyst to this addition. As a natural progression to manuscripts submitted online, Joan and her office staff finalized a long-term project that began offering the full journal online. In 2007 Joan continued to push the boundaries of the journal and we added Virtual Network as a subscription option – now institutions could access the journal world-wide, and in 2008 all online archive content became searchable.

Never one to rest on her laurels, Joan continued to facilitate the expanded presence and impact of the journal - making online content older than three years freely available to everyone, adding online early for accepted manuscripts, and making bound volumes available, as well as a host of other things.

Joan was always trying to find better ways to handle the everyday work in the office, ways to increase the subscriber base, and working with her many assistants through the years, has been diligent in keeping all of the journal balls in the air at the same time. The successes in the office though pale in comparison to what she has always considered one of the best things about working for the journal, that was, "getting to know the academy members and working with so many of them".

Joan has been an indispensable part of Operative Dentistry for so long, that it has been difficult imagining what the journal will do without her. We thank her for her 15+ years of dedication and talent that she has devoted to the journal. We hope she enjoys her new "freedom" to visit her kids (5), her grandkids (13) and her great-grandkids (1 and counting)!

Good luck, and best wishes in your future.

Orthodontic Extrusion of Severely Damaged Teeth

Dr. Richard D. Tucker

The restorative dentist is often faced with the situation where a patient wishes to keep a tooth which, either through fracture or decay has insufficient coronal tooth structure remaining for restoration even with the addition of a post and core. Or perhaps one cusp is broken far below tissue level, compromising tissue health if it is restored to this depth. When radiographic examination of the tooth reveals a root of sufficient length, surgical crown lengthening might be considered to expose additional sound tooth for restoration. However, this resection of soft tissue and bone can give a less than satisfactory esthetic result, as well as detract from the health and support of the adjacent teeth. The problem actually facing the dentist is not one of too much bone, but rather one of too little coronal tooth structure. If the remaining root is of sufficient length, then all that is necessary to solve this problem is to pull the tooth out of the supporting tissues a few millimeters. In most cases, the addition of three or four millimeters of sound tooth structure can transform a very difficult or impossible restorative situation into a relatively routine treatment situation. The concept of orthodontically extruding a tooth to gain additional sound coronal tooth structure for restoration is not new. However, the following technique is of considerable value to the general dentist for its simplicity and lack of requirement for special orthodontic materials.

PROCEDURE

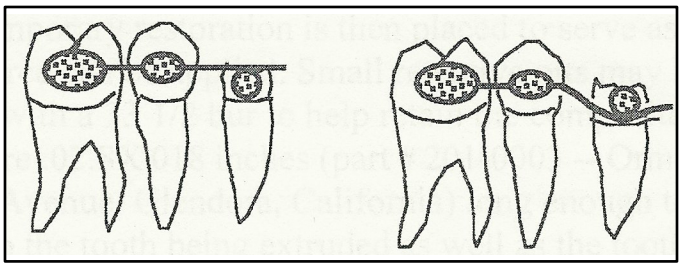
The first step is to remove all decay and loose tooth fragments from the root to be saved. A composite temporary restoration is then placed to serve as a point upon which the extruding force can be applied. Small retentive pits may be placed in the periphery of the tooth with a 33 ½ bur to help retain the composite. A length of braided rectangular wire .02 SX .18 inches (part #201-003—Ormco Corporation 1332 South Lone Hill Avenue, Glendora, California) long enough to cover two teeth mesial or distal to the tooth being extruded as well as the tooth itself, is cut off and laid aside. The two anchor teeth are etched, primed, and a thin even layer of composite is placed over the wire to bond it in the middle 1/3 of the buccal surfaces of the two teeth. The end of the wire next to the tooth to be extruded in depressed 2 mm, and a button of composite is bonded above the wire. The composite button should extend over the wire at least ½ the width of the wire to keep it from slipping off the button. Once the button has been formed, the wire is again checked to insure that it is free to move under the button. The wire must be able to move as the tooth erupts or else the tooth will not move. The provisional restoration is checked to be sure that there is a 2 mm clearance in centric occlusion, and the patient is instructed to return in two weeks for adjustment of the wire and a circumferential supercrestal fiberotomy.

When the patient returns after two weeks, a small amount of anesthetic is infiltrated into the tissue on the buccal and lingual of the moving tooth. The occlusion is checked for clearance, and the wire is tightened either by bending with a “rod and trough” wire bending pliers, or by adding more composite to the composite button. The anesthetic should have taken effect by this time so the fiberotomy can be accomplished without discomfort. A thin bladed instrument such as the half Hollenback carver (#104 Carver from Suter Dental Manufacturing Co, Inc. Chico, California) is inserted into the sulcus along the root. The blade is carried completely around the tooth, and apically to the crest of the alveolar bone below the sulcus. This detaches the gingival fibers from the root surface, so that the gingival tissue does not follow the tooth up as it is extruded. A sharp explorer is then used to scrape the surface of the bone below the sulcus to disturb any developing osteoid, thus preventing the growth of bone on the alveolar crest as the tooth extrudes. Finally, a flat sided instrument can be used to gently press the gingival tissue down apically to help it stay behind as the tooth erupts. The patient is dismissed with instructions to return in three weeks for another wire adjustment and fiberotomy. Following this appointment, the patient is instructed to again return in three weeks.

At this time, the tooth will have moved a sufficient amount for the restoration, so the wire is not adjusted, but it is left in place for retention. The final fiberotomy is performed and an appointment is scheduled for the patient not sooner than 4 weeks, for the restoration of the tooth. The four weeks time is required for the tissue to heal sufficiently to resist careful manipulation encountered during the restorative procedures. It is not necessary to bury the labial margin of the restoration deep in the sulcus for future esthetic requirements, because the tissue level is quite stable.

DISCUSSION

This technique gives the operator sufficient sound tooth structure so that s/he can properly restore a tooth that might otherwise have been lost. In addition, the gingival architecture will not have been destroyed as in a resective procedure such as a gingivectomy and/or osseous recontouring. The periodontal health will be improved if there was moderate pocket depth initially, because the bottom of the periodontal pocket is raised coronally as the tooth is extruded, resulting in a reduction in pocket depth. The economic and biologic cost to the patient of this treatment option is much less than the cost of tooth replacement by fixed prosthesis or implant. One final benefit of this technique is that it is self-limiting in that as soon as the tooth has moved 1-2mm and the wire has straightened, all further extrusion stops until the wire is adjusted at the next appointment. This eliminates the danger of accidentally orthodontically extracting the tooth.



Associated Ferrier Study Clubs Annual Meeting

Seattle, Washington, May 8, 2015

Back row, left to right: Dr's. Margaret Webb, Warren Johnson, Chris Hacker, Barry Evans, David Thorburn, Bob Murray, Rick Nash, and Richard Tucker

Front row: Marty Anderson, Jody Brennan, Tasha Bollerman, Darcie Morris, Elizabeth Lee-Johnson, Wendell Foltz, and Murielle Arsenault

Dr. Rick Nash presents the Presidents Award to Dr. Tasha Bollerman. Tasha is also the AAGFO Clinician of the Year for 2915. She will receive the award at the Annual Meeting in Pensacola, Florida.

Dr. Wendell Foltz Retires

Wendell and Gloria Foltz with the new owners of his McMinnville Dental Practice, Dr. Ryan Hunt and his wife Tanya. Now we need to convince Dr. Hunt to get involved with the AAGFO.