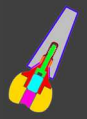
Vancouver Implant Maxicourse



Implant practice management

May 1st 2026
8am - ~3pm PDT
Dr. Bill Holden

In our little centre we…

- Stock and place 8+ different systems
- Restore both our implants and implants from around the world, incl primordial implants
- Manage and maintain older-style cases
- Manage tourism dentistry disasters
- Deal with complications every day, from all over northern BC, AB, SK, and NWT
- Manage an implant lab, teaching centre, and have several research projects on the go

The point is, this is what we do every day.

My goal for today is to help you guys take what you have learned in the Maxicourse, and implement it in your office.

Course schedule for today:

1. Setup and implementation in your office
   Configuring your environment for surgery, checklists, resources for auxiliaries
2. Inventory
   What and what not to stock, inventory control, dealing with vendors, knockoff parts, IPC
3. Infection prevention and control, instrument management
4. Paperwork
   Informed consent, chart records, surgical reports, implantable device records, sterilisation records, etc.

-lunch-

5. The filthy lucre $
   Fees, codes, insurance, billing, payment plans, payments for associates
6. Preventing/managing the unhappy patient
   Managing expectations, documentation, when to refer, support networks
7. The "S" word
   Selling implant therapy to patients, marketing dos and don'ts
8. Your support network
   Specialist support, when to ask for help, getting the most from your lab
9. The future—implant professional development
   Orgs, journals, credentials, CDE/study club options, resources, what to do next

...plus lots of other fun stuff, and a final exam too!

1. Setup and implementation in your office

Your first cases in your office

1. Patient selection and pre-op records

   Do you need a CBCT scan?
   Do you need a medical consult?
   Do you need a surgical guide?
   Do you need sedation?

Choose slam dunk cases for the first few in your own office!!!

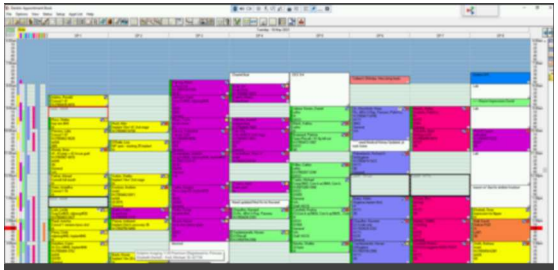
Your first cases in your office

1. Patient selection and pre-op records
2. Fees and paperwork established
3. Book adequate time…and lead time
4. Choose an operatory
5. Review the checklist
6. Case planning
7. Involve your rep early!

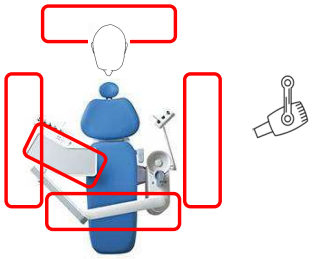
Book adequate time

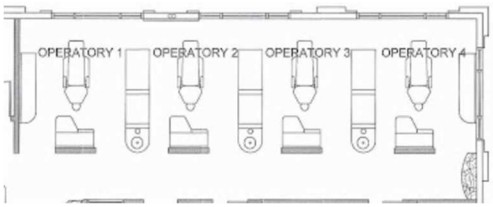
Homework: tell your staff

- Only book one implant placement per half day at first (or maybe better yet, just one per day)
- Surgery can't be double-booked—yes that includes beside recall examinations
- Give you fair warning when they book implant placements for you to double-check inventory
- How long is your implant placement appointment???



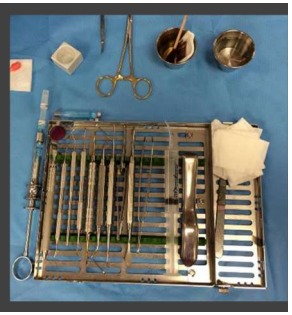
Pro tip: give your reception staff a cheat sheet when you implement implants.





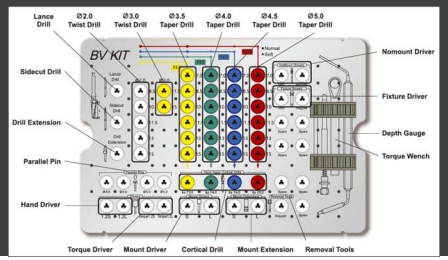
Typical instrument kit

- XCP or whatever radiographic holder you prefer
- Air-water syringe tip
- Your typical exam kit—mirror, explorer, probe, cotton pliers, articulating paper forceps if desired
- Needle driver and Scissors
- Scalpel handle with millimetres marked
- Anaesthetic syringe
- Minnesota retractor
- Molt 2/4 curet
- Periosteal elevator, small to medium in size
- 60 cc irrigation syringe, Monoject 412 works well
- Ceramic dish for bone, a dappen dish or old Alvogyl jar will work to start
- Iodine cup for saline, or two if you want to toss used small parts into saline
- One additional instrument to keep clean for handling saved bone, use an old Hollenback or any old instrument you have laying around



Surgical kits are just a starting point

We add and subtract items from all of our kits



Suggested adjustments to a NobelReplace surgical kit

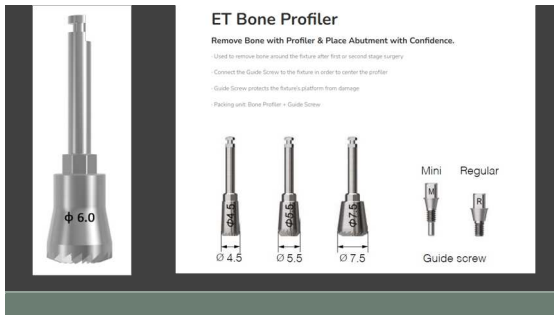
- Add one long guide pin 32112
- Add lance drill (“Precision drill” or similar)
- Buy 4.3 +/- 3.5 5.0 cookie cutters, but bag separately
- Remove dense bone drills and bag separately
- Add one Lindemann or Kirschner bur
- Buy NP and RP bone profilers, bag separately

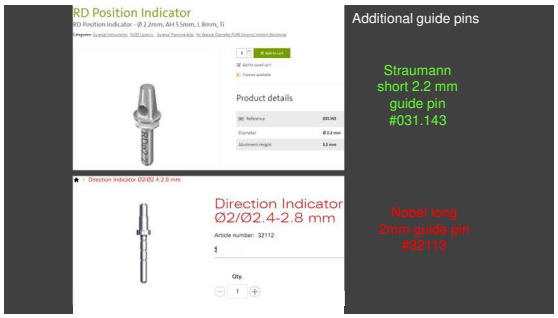
Suggested adjustments to a Straumman BLT (or BioConcept BC-BLT) surgical kit

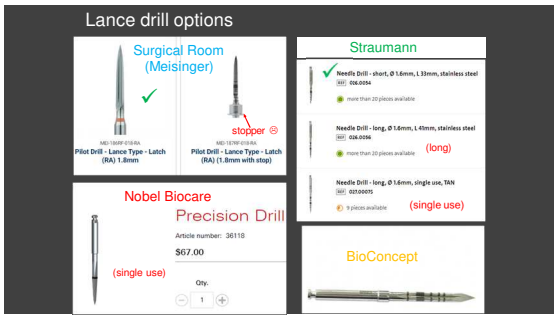
- Add one Straumann (or similar) short guide pin
- Add lance drill, Straumann calls it a needle drill 026.0054, or Meisinger from Surgical Room
- Buy 3.5 4.0 cookie cutters, but bag separately
- Optional: remove round burs and bag separately
- Add one Lindemann or Kirschner bur
- Buy bone profiler size 2 with guides, bag separately

Suggested adjustments to a BioConcept BV surgical kit

- Buy 3.5 4.0 cookie cutters, but bag separately
- Buy bone profiler size 2 with guides, bag separately







Tissue punches (cookie cutters) from Surgical Room or Henry Schein

Nobel also makes nice tissue punches but they are pricey.

Kirschner or Lindemann drill—Surgical Room or Henry Schein (make sure latch)

BioConcept sidecut drill

A great rep will…

- Make sure you have everything you need
- Unpack and setup surg kits and drill units
- Help your staff with operatory setup and infection control
- Be there to make sure everything goes smoothly
- Loan you any obscure parts or equipment
- *Possibly* bring donuts

Getting ready for your first patients in your own office

- Get your staff on board
- Choose good starting cases and BOOK them
- Use the implementation sheet to make sure you have everything you need on hand
- Involve your rep early
- Keep good records
- Ask mentors for help, and share your first cases with the group

Get your staff on board…

- Make an official announcement to all of them
- Make it about the patients, not the $$
- Spend time with your front end reviewing fees, codes, appointment lengths, and typical appointment sequencing
- Spend time with your back end explaining the procedure and what to expect
- Help at first with setup and takedown
- Consider sending an assistant to a training course
- Say Thank You! A lot!

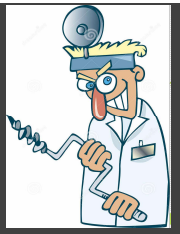
Set up for success

- Where should you store your implant stuff?
- Which is the best operatory in your clinic?
- Where will the tray, drill unit, etc. go?
- Do you have an assistant who is better at surgery? Likewise, is one better at ordering?
- What is the best time of day/week for implant placement appts?

Get going!

Make your first cases enjoyable through good case selection and preparation

Be a hero, not a goat.



2. Inventory

Inventory management

…is the difference between implant dentistry being a benefit or a drain on your business.

You can <u>always</u> order more later.

Common noob mistake: getting involved in more than one system. Don't do it! Just say NO!

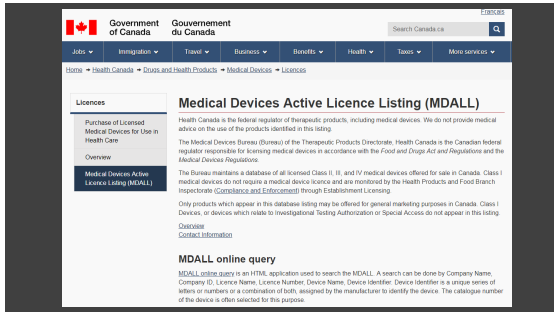
NO NO NO NO NO NO NO NO NO!

What you need to start out

Pro tip: create a separate expense line item for implant stuff

1. Surgical kit and drill unit
2. Hand instruments for placement
3. Projected implant and his "friends"
4. Selection of healing abutments & cover screws
5. Scalpel blades, sutures, saline, irrigation tubing
6. Drapes, gowns, hats, etc.
7. Impression copings, analogs, abutments, screws
8. Restorative kit and hand instruments
9. Bone and substitutes, membranes

"implant practice inventory"



When you have limited experience:

- Consider a repped, full service company
- Be careful with knockoffs until you have enough experience to know what you are getting
- Avoid items that are not licensed by Health Canada (exception is parts to treat existing implants)
- Do not buy stock from individuals, only from licensed vendors. Don't re-sell stuff either.
- A shared account is okay, and can be beneficial
- Never buy cheap, unlicensed crap on eBay or wherever, even later when you **do** have more experience!

Relationships with implant sales reps

- A great rep is worth their weight in gold
- Not <u>all</u> reps are great reps
- Treat them as a partner, not just a source of donuts, and they will make your life easier
- Turnover rate is high, and you need experience when you are starting out
- Ask for the best possible deal without grinding them
- Understanding how implant reps are paid

Startup packages

It's a big shell game, and deliberately confusing.

- In general, the lowest number of implants is what you want. The good news is you can trade for sizes with some companies. Watch expiry dates.
- Don't forget you will need healing abutments, cover screws, impression copings, analogs, etc.
- Every startup package can be customized.
- Ignore the fluff.

128

Another inventory concept:

What do we mean by
- warrantied
- dropped
- exchanged

dental implants?

Dr. Bill's recommendation:

Freeze dried mineralised cortical allograft

250-1000 um (.25-1.0 mm particle size)

Sold in a <u>dish</u> if possible

Short term collagen

- Collagen tape—plugs—barriers
- All perform similarly
- We treat as a medicament

Not considered an implantable device

Longer lasting collagen membranes

- Non-expanding!
  (Often branded as “flex” or “drapable”)
- Basic size is 15x20mm
  (Available in sizes 8x8 to 30x40)
- Regular, not “extend”, is most useful
- Considered an implantable device
- Native versus cross-linked

Non-exhaustive list of available collagen membranes for clinical use (n.d. = not declared).

Commercial Name	Produced By/For	Origin	Cross-Link	Barrier Effect (Weeks)
Biomend	Collagen Matrix Inc.	Bovine Tendon	Yes	8
Biomend Extend	Collagen Matrix Inc.	Bovine Tendon	Yes	18
Copiov Extend	Collagen Matrix Inc.	Porcine Dermis	No	24–36
Osteoguard	Collagen Matrix Inc.	Bovine Tendon	Yes	26–38
Bio Gide	Geistlich Pharma Ag	Porcine Dermis	No	24
Mem-Lok RCM	Collagen Matrix Inc.	Bovine Tendon	Yes	26–38
Mem-Lok Pliable	Collagen Matrix Inc.	Porcine Peritoneum	Yes	12–16
Ossix Plus	Datum Dental Ltd.	Porcine Tendon	Yes	16–24
Creos Xenoprotect	Nobel Biocare	Porcine	No	12–16
Biocollagen	Bioteck S.P.A.	Equine Tendon Type I Collagen	No	4–6
Heart	Bioteck S.P.A.	Equine Pericardium	No	12–16
Cytoplast	Collagen Matrix Inc.	Bovine Tendon Type I	Yes	26–38
Collatape	Zimmer -Biomet	Bovine Collagen	No	1–2
Jason	MBP Gmbh -Botiss Biomaterials	Porcine Pericardium	No	8–12
Collprotect	Botiss Biomaterials	Porcine Dermis	Yes	4–8
Dynamatrix	Keystone Dental	Porcine Submucosa	No	n.d.
Ez Cure	Biomatlante	Purified Porcine-Based Type I And III Collagen	Yes	12
Conform	Ace Surgical Supply Company	Bovine Type I Collagen	Yes	12–16

Straumann Flex porcine membrane is “minimally cross-linked”, whatever that means.

You want to stock only one item for a longer lasting membrane. I suggest:

- Non-expanding (so probably porcine), 15x20mm, not “long-term” or “Extend”.
- You may possibly want a 20 x 30 later.
- A word about pericardium.
- A word about tacks and screws.

Bone and membranes inventory

Try to keep your stock down to three or four items

- A particulate bone material
  e.g. Mineralised cortical 250-1000um, 0.5cc jars
- Collagen tape and/or plugs
  e.g. Helitape or MaxxTape or ACE RCM Tape
- A longer lasting non-expanding collagen membrane
  e.g. BioGide, Straumann Flex, Maxxmem, 100 others

You can do any treatment in your first few years with this simple toolbox.

And all this stuff has expiry dates. ☹

One exception to the rule about not buying crap off of Amazon. Search “dental implant screwdriver”. Usually $80- $120. Occasionally as low as $45.

Sourcing surgical and IPC supplies

Your **local pharmacy** can order saline, drugs, syringes

Medical supply companies, e.g. **Canada Medical**, **Source Medical**, **Medi-Mart**, **Stevens**, and especially **Value-Med** (valuemed.ca) for dental

Implant supply companies such as Salvin or the Surgical Room are a great source

The "Holden Implant Surgical Packs" are put together by The Surgical Room out of Ontario.

Sourcing implant instruments and equipment

- Implant supply companies such as Salvin or the Surgical Room are a key source
- Most hand instruments are now available from regular dental supply companies, esp Schein
- The best price on irrigation tubing is usually either the implant companies themselves, or Precision Dental Handpiece out of Vernon BC.

Sourcing bone and membranes

We often bring in our bone grafting materials in large orders. This is not practical for your offices. The good news is that the implant companies, the Surgical Room, and Maxxeus now re-sell the simple products you will require.

Straumann and The Surgical Room both sell LifeNet Oragraft Min Cort 0.5cc

other sources are Community Tissue Svcs, Salvin, Citagenix, Maxxeus, BioHorizons, Rocky Mtn Tissue Bank, etc.

Note: in dishes

And the giant plastic organiser boxes that fit all the little sterilisation bags full of bits and parts…come from Practicon

Extra-tall 16 Compartment Tuff 'Tainer Box
Unbreakable all-purpose divider boxes organize, store, protect and transport smaller supplies

The multi-purpose **Extra-tall 16 Compartment Tuff 'Tainer® Box** stores, organizes and protects supplies from airborne contaminants. "Lock-in" grooves with removable dividers allow for an infinite variety of compartment combinations and sizes. Hinged lid snaps tightly shut with two locking clasps. Made in USA of tough, translucent polypropylene plastic. Surface disinfect only. Features built-in handle and feet for upright storage. Measures 15 5/8"L x 9 1/2"W x 3 1/8"H. Individual compartments are 3 3/4"L x 2 1/8"W x 2 7/8"H.

Ordering

You can get almost everything you need between your implant company, Valuemed, and The Surgical Room

The Cheat Sheet that explains where Dr. Bill's staff order stuff from is on your handout disk.

But it won't help your staff if you don't actually share it with them.

Again, what you need to start out is not a long list

1. Surgical kit and drill unit
2. Hand instruments for placement
3. Projected implant and his "friends"
4. Selection of healing abutments & cover screws
5. Scalpel blades, sutures, saline, irrigation tubing
6. Drapes, gowns, hats, etc.
7. Impression copings, analogs, abutments, screws
8. Restorative kit and hand instruments
9. Bone and substitutes, membranes

Take home message:

When starting out, your inventory of implants and related parts and sundries should be under $10,000.

(equipment is separate)

Tip: consider a separate expense line item for implant stuff

3. Infection control and instrument management

For starters, we need to understand what is a…

- Critical item
- Implantable device
- Class 5 indicator
- A biologic monitor, or "BI"

Patient Care Items – Modified Spaulding Classification

Category	Description	Management	Examples
Critical Items	Penetrates soft tissue or bone	Items that are not single-use disposable must be sterilized and stored wrapped until point of use. Single-use disposable items must not be re-processed.	Air/water syringe tips Anaesthetic syringes Endodontic instruments, including files (hand and rotary), reamers, and broaches Gauze for surgery Handpieces Instrument trays Metal Matrix Bands Mouth mirrors (when used during a procedure where tissue is cut or manipulated) Orthodontic Bands Periodontal instruments including ultrasonic tips Polishing cups, points and mandrels Restorative / operative instruments Rotary burs and diamonds Rubber dam clamps Scalers Stainless Steel Crowns Surgical instruments Surgical suction tips
Semi-Critical Items	Touches intact mucous membrane or non-intact skin	Items that are not single-use disposable, must be sterilized, may be stored unwrapped in a clean, dry, covered area and handled with clean hands or forceps. Single-use disposable items must not be re-processed. Heat sensitive items must receive high-level disinfection between patient use.	Articulating ribbon holder Cotton rolls Crown removing instruments Gauze for non-surgical procedures Impression trays Lab burs Mouth mirrors (when used for examination only) Mixing spatula Nasal hoods Orthodontic pliers Rubber dam frame Rubber dam and rubber dam clamp forceps Suction tips other than for surgery Wedges

Source: ADA&C IPC Standards of Practice

ISO 13485 2003
PLAIN ENGLISH DEFINITIONS

Implantable Medical Device

An *implantable medical device* is a medical device that:

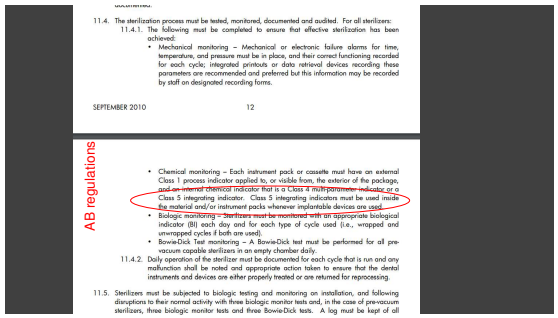
- is partly or totally inserted into the human body or a natural orifice and is expected to stay there for 30 days or more, or
- is used to replace an epithelial surface or the surface of the eye and is expected to stay in use for 30 days or more.

Surgical or medical procedures are used to insert or apply implantable medical devices and surgical or medical procedures must be used to remove them

Class 1 monitors only confirm that a given item has gone through the steriliser system. The most obvious example is tape.

Chemical indicators

Class 5 monitors measure multiple parameters of sterilisation (e.g. temperature AND pressure AND time), and can conclude a package has been sterilised.



AB regulations

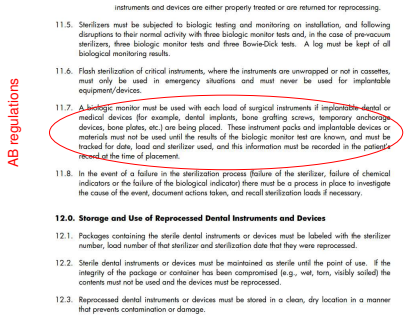
11.4. The sterilization process must be tested, monitored, documented and audited. For all sterilizers:
11.4.1. The following must be completed to ensure that effective sterilization has been achieved:
- Mechanical monitoring – Mechanical or electronic failure alarms for time, temperature, and pressure must be in place, and their correct functioning recorded for each cycle; integrated printouts or data retrieval devices recording these parameters are recommended and preferred but this information may be recorded by staff on designated recording forms.

SEPTEMBER 2010 12

- Chemical monitoring – Each instrument pack or cassette must have an external Class 1 process indicator applied to, or visible from, the exterior of the package, and an internal chemical indicator that is a Class 4 multiparameter indicator or a Class 5 integrating indicator. Class 5 integrating indicators must be used inside the material and/or instrument packs whenever implantable devices are used.
- Biologic monitoring – Sterilizers must be monitored with an appropriate biological indicator (BI) each day and for each type of cycle used (i.e., wrapped and unwrapped cycles if both are used).
- Bowie-Dick Test monitoring – A Bowie-Dick test must be performed for all pre-vacuum capable sterilizers in an empty chamber daily.

11.4.2. Daily operation of the sterilizer must be documented for each cycle that is run and any malfunction shall be noted and appropriate action taken to ensure that the dental instruments and devices are either properly treated or are returned for reprocessing.

11.5. Sterilizers must be subjected to biologic testing and monitoring on installation, and following disruptions to their normal activity with three biologic monitor tests and, in the case of pre-vacuum sterilizers, three biologic monitor tests and three Bowie-Dick tests. A log must be kept of all



AB regulations

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11.6. Flash sterilization of critical instruments, where the instruments are unwrapped or not in cassettes, must only be used in emergency situations and must never be used for implantable equipment/devices.

11.7. A biologic monitor must be used with each load of surgical instruments if implantable dental or medical devices (for example, dental implants, bone grafting screws, temporary anchorage devices, bone plates, etc.) are being placed. These instrument packs and implantable devices or materials must not be used until the results of the biologic monitor test are known, and must be tracked for date, load and sterilizer used, and this information must be recorded in the patient's record at the time of placement.

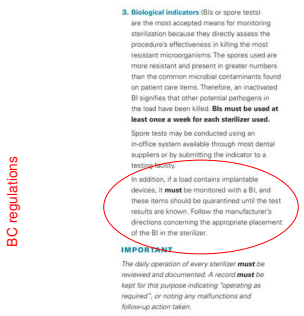
11.8. In the event of a failure in the sterilization process (failure of the sterilizer, failure of chemical indicators or the failure of the biological indicator) there must be a process in place to investigate the cause of the event, document actions taken, and recall sterilization loads if necessary.

12.0. Storage and Use of Reprocessed Dental Instruments and Devices

12.1. Packages containing the sterile dental instruments or devices must be labeled with the sterilizer number, load number of that sterilizer and sterilization date that they were reprocessed.

12.2. Sterile dental instruments or devices must be maintained as sterile until the point of use. If the integrity of the package or container has been compromised (e.g., wet, torn, visibly soiled) the contents must not be used and the devices must be reprocessed.

12.3. Reprocessed dental instruments or devices must be stored in a clean, dry location in a manner that prevents contamination or damage.



BC regulations

3. Biological indicators (BIs or spore tests) are the most accepted means for monitoring sterilization because they directly assess the procedure's effectiveness in killing the most resistant microorganisms. The spores used are more resistant and present in greater numbers than the common microbial contaminants found on patient care items. Therefore, an inactivated BI signifies that other potential pathogens in the load have been killed. **BIs must be used at least once a week for each sterilizer used.**

Spore tests may be conducted using an in-office system available through most dental suppliers or by submitting the indicator to a testing facility.

In addition, if a load contains implantable devices, it **must** be monitored with a BI, and these items should be quarantined until the test results are known. Follow the manufacturer's directions concerning the appropriate placement of the BI in the sterilizer.

IMPORTANT

*The daily operation of every sterilizer **must** be reviewed and documented. A record **must** be kept for this purpose indicating "operating as required", or noting any malfunctions and follow-up action taken.*

So in addition to your regular IPC practices…

1. Recognition of single use items
2. Cleaning drills and surg kit
3. Surgical gloves, PPE, and drapes
4. Sterile irrigant and tubing
5. Increased steriliser monitoring requirements

1. Single use items

"A single-use device is designed to be used on one patient for a single appointment and then discarded, not re-processed for use on that same patient at a later date, or on another patient (e.g., cleaned, disinfected or sterilized).

"Examples of single-use or disposable devices include syringe needles, prophylaxis cups and brushes, implant parts, temporary anchorage devices, bone grafting materials and certain orthodontic brackets. Single-use materials and devices are often marked with the following symbol:

What does all this affect?

- Many restorative burs
- SOME implant drills, notably the Nobel Precision and 2mm Pilot
- All healing abutments, cover screws, temp abuts, Locator abuts

- Cookie cutters are okay
- Items "tried in" are okay
- Items replaced in pt are okay
- Some (not all) impression copings, scan bodies, and analogs are ok

be used if commercially available; those sections that cannot be sterilized must be processed according to manufacturer's instructions between patient uses.
(b) Clean and reprocess through disinfection or sterilization reusable critical, semicritical, and noncritical dental equipment and devices according to manufacturer instructions.
(c) Clean and reprocess reusable dental equipment according to the manufacturer instructions.
(d) All disposable and single-use items, as labeled by the United State Food and Drug Administration, must be discarded after use on a single patient.
(i) Single-use items that need to be tested for size are not considered used unless cemented in the mouth. Single-use items can be cleaned or reprocessed (disinfected or sterilized) when following manufacturer's instructions.
(ii) If a single-use item is not used, but is contaminated or exposed to aerosols during the appointment by being placed on a surface ready to use, it may only be sterilized if the process of doing so does not compromise the efficacy of the item including, but not limited to, anesthetic carpules.
(2) Bag or wrap contaminated instruments in packages, containers, or cassettes in preparation for sterilization.
(a) Store sterile instruments and supplies in a covered or closed area.
(b) Wrapped packages, containers, or cassettes of sterilized instruments must be inspected before opening and use to ensure the packaging material has not been compromised.

RULE-MAKING ORDER PERMANENT RULE ONLY
CR-103P (December 2017) (Implements RCW 34.05.360)
CODE REVISER USE ONLY
DATE: December 23, 2020
TIME: 10:01 AM
WSR 21-01-214
[4]
OTS-9086.12

When do we replace our implant drills?

When they are dull. Well, duh. Number of uses does not correlate with dullness. However some drills, including Nobel pilot and lance, plus ALL NobelActive drills, are single use.

What about healing abutments?

Healing abutments are single use.

What constitutes a "use"? What about items tried-in but not used, can they be re-processed? Not made clear, but our interpretation is if sent home with pt.

2. Cleaning instruments and surg kit

- Make life easier: place all used bits & parts in dish of saline
- Everything that comes out of surg kit must be scrubbed +/- run through the ultrasonic
- Remember Nobel requires syringe to clean hollow drills
- Items should be clean enough to use before sterilisation
- Always re-sterilise loaner kits, etc., in your own office
- Items that can be taken apart, take them apart (e.g. torque wrenches, some 20:1 handpieces
- And yes, piles and piles of biologic monitor$

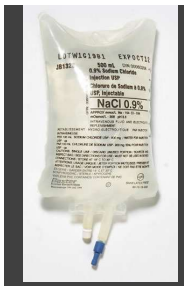
3. Surgical gloves, PPE, and drapes

- Surgical gloves required for dentist
- Don't fool around, get them for intra-oral assistant as well
- Consider sterile towels to dry hands
- What do you do if pt is latex allergic?
- Gowns: none vs isolation vs surgical
- Stylish hats

We use a blue towel as our pt drape.

Remember that the CSR wrap on your surgical cassette can become your table cover.

ALL of these items have back order issues. ☹



4. Sterile irrigant & tubing

Saline shortages are a real thing.

500cc bags are lots.

The price of tubing is outrageous.

What about for refilling dishes, rehydrating grafts and media, etc.?

5. Steriliser monitoring

1. Each implant pack must have a class 5 (or 6) strip inside it, and a BI in the same load, and the load quarantined until the BI test passes
2. The result must be recorded in the chart including the load #
3. No flashing of instruments
4. You can't fight city hall

Suggested IPC protocols for implant placement

1. Double CSR wrapped surg kit and instrument pack with CI 5 indicator, BI in load, record load # in chart
2. Separate sterile pack of disposables: gauze-Qtips-suctions-needles-drape-gowns-monoject, etc. Simplest to buy pre-fab pre-sterilised packs.
3. Clean out and double wipe operatory
4. Sterile irrigant and disposable irrigation tubing
5. Sterile table drape to work from—can be the inside of the instrument pack CSR wrap

Suggested IPC protocols for implant placement

6. Sterile barrier protection to light handle and implant handpiece, plus tray/table if used
7. Patient drape of some kind, swab face and surgical site with disinfect or rinse with chlorhexidine
8. DDS and RDA to wear isolation gowns, scrub and wear sterile surgical gloves; head cover is optional
9. All staff need to be clear on where sterile field is on work surface; all additions (implant, blade, suture) dropped in

Paperwork

Implant paperwork includes:

A. Your regular chart w medical history

Implant paperwork includes:

A. Your regular chart w medical history
B. Surgical consent form
C. Surgical report
D. Post op handouts, medication handouts
E. Implantable device record
F. Steriliser load records to chart
G. Steriliser test/mtce log
H. Laboratory prescriptions

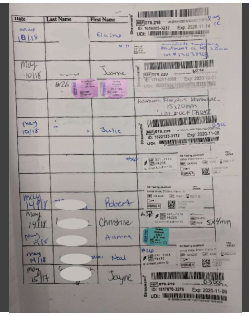
A. Patient chart

- Graphic charting on some kind of odontogram
- Medical history WITH updates
- Periodontal probing
- A written diagnosis is helpful in complex cases
- Treatment plan and estimated cost
- Notes for <u>every</u> patient contact
- Pre, intra, and post operative radiographs
- Photographs are golden
- Never adjust chart entries, but you can append them

E. Implantable device record

- We STRONGLY suggest you keep a separate duo-tang or binder for this purpose
- Pt name, date, and 2nd sticker from vial or package
- One sticker goes in the patient chart, the other goes in the record book
- If paperless, sticker goes on the paper consent form prior to scanning into the computer "chart"
- If you move, a copy goes with you

Remember, what is an "implantable device"?



<u>Implantable device record</u>

Implants, bone, dermis

Does not include screws, tacks, or collagen

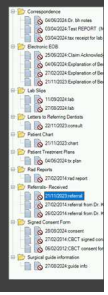
Remember, second sticker goes here

A copy follows you for your whole career

Other random *implant* paperwork

- incoming and outgoing referral slips
- incoming and outgoing letters
- radiology or other reports
- pt medication lists
- drawings from consultation appointment
- treatment plan/estimates
- surgical guide printouts
- insurance correspondence
- copies of pt texts and emails
- WHMIS, MIFU, RPB, IPC, EIEIO

"if in doubt, scan it in"



Also: start a spreadheet of every CDE course you take/teach

Lunch →

Would you prefer:

a. The full scheduled 1 hr lunch break

b. Shorter break and you chew while I talk (not rude at all ☺)

Concept 1: First molar occlusion as a treatment goal

- Second molars are more challenging sites
- Patients with at least one functional molar in each quadrant do well
- Treat the WHOLE CASE, properly, or don't do implants…they will overload and fail
- Beware the pt with "Less Syndrome"

Shortened dental arch (SDA)

- Research tells us second bicuspid occlusion is still functional
- W.H.O. says this is the minimum
- More appropriate for the older patient
- Lower bicuspids take more wear, not clear why
- Option to drop to single bi + molar

Concept 1: First molar occlusion as a treatment goal

Whenever we see a patient who is missing one or more teeth, our starting point should be

"How can I get this patient back to first molar occlusion?"

Concept 2: Implants are only one of several options

- Remember: denture-bridge-implant-nothing
- Dental implant placement is an elective procedure
- No guarantee your implant will succeed
- Neither implants, nor teeth, are forever
- Forward compatibility is important
- Aside from bone loss, a denture or retainer doesn't burn any bridges

Concept 3: Dental implants are second stage therapy

and should be placed after stage one (disease control) therapy is complete, including cleaning, minor restorative, extractions, and endodontic treatments.

Orthodontics, cast partials, crown and bridge, most appliances…also stage 2.

Concept 3:
Dental implants are second stage therapy

- Titanium is part of a complete ~~breakfast~~ treatment plan
- Get the damned teeth cleaned first. Yeesh.
- Restorability of other teeth needs to be known as well
- Placing implants when other infection present increases failure risk
- Complete treatment plans include **both** arches

as

Concept 4: (a quick one)
Implants stand alone

Implants are best

NOT splinted to teeth

esp while you are learning.

We will do so sometimes in very specific cases.
For you uys, for now, just say no.

Concept 5:
Restorative-driven treatment planning

- A bit of a cliché, but still an important philosophy
- The implants need to go where they can support the prosthesis
- Implants were not always done this way; sometimes still aren't
- Implant cases that can't be properly restored are failures, even if the implants are properly integrated and healed
- All cases in dentistry need a "quarterback"

So our five general treatment planning concepts are:

First molar occlusion as a treatment goal

Dental implant treatment is only one of four+ options

Dental implants are second stage therapy

Implants are not splinted to teeth

Restoratively driven treatment planning

And remember: implants are not for everyone

- This is elective treatment
- Some patients are contraindicated
- Some patients are just not good candidates
- An implant is not always our treatment of choice

No one ever got in trouble for declining to treat.

5. The filthy lucre

27205

Crown ceramic/porcelain

Restorative Permanent Implant

Common implant codes:

	Code	Fee
Implant placement	79932	
All ceramic crown on implant	27205	
PFM crown on implant	27215	
Full gold crown on implant	27305	
All ceramic bridge retainer on implant	67205	
All ceramic pontic	62502	
Outside lab	99111	

Make up a quick cheat sheet for your receptionist!

Other handy implant codes:

Full lateral sinus lift	79352
Internal sinus lift ("bump")	79355
Remove hybrid or bar	66211
Insert hybrid or bar	66301
Flap and clean around implant	42421
Mini implant	79951
Implant removal simple	79961
complex	79962
Fixed hybrid upper	69811
lower	69812
Stud overdenture (e.g. Locators)	51701/2
Replace Locator males (each)	55101/2
Ridge preservation graft, when charged	72421
Minor graft, with or without membrane	74401
Major grafts or requiring fixation	77402
Ridge split graft	77604/5

Dental insurance plans

- Myth: "insurance won't touch implants"
- More than 50% of dental plans cover some portion of the implant procedure
- In some cases, alternate benefit clause applies
- Note the GWL adjacent tooth rule
- Note that some plans will not pay for the implant placement until the crown is in ☹

Assignment of benefits

- Never a great idea to accept assignment
- Especially risky with implants
- Will put you in a bad position if there is a disagreement between patient and their insurance carrier

Payment plans

- Implants have a "built-in" payment plan!
- We offer three monthly post-dated cheques
- You are not a bank

What if you are an associate?

- Who buys the start-up package?
- Who carries the inventory?
- Is a typical 40% associate split fair?
- Who is handling maintenance and re-dos if/when the associate leaves?
- Remember: copy of IDR goes with you if you move on.

6. Preventing/managing the unhappy patient

…or "How to keep my patient's chart off Dr. Bill's desk"

☺ Keeping implant patients happy ☺

A. Implants are phase 2 therapy!
B. Implant are not for everyone
C. Written treatment plan and estimate
D. Under-promise and over-deliver
E. Beware "Less syndrome"
F. Refer-and-follow to learn from tough cases
G. Complications? Seek help early
H. Document, document, document, repeat

"Unfortunately Mrs. Jones, you will…"

-Hate your denture
-Struggle with speech
-Bite your cheek at first
-Sometimes have an implant that doesn't work on the first try
-Possibly have to be frozen to insert your crown
-Require 376 visits to construct your prosthesis
-Possibly not get your implant the first day
-Possibly not get a direct temporary crown
-Need your sinus floor repaired
-Be able to tell which is your crown from up close

"Pave your way with words"

Minimum pre-op records are:

- periapical or panoramic radiograph
- medical history incl medications list
- dental charting indicating an examination has been done
- something demonstrating informed consent

This is the absolute minimum.

Minimum post-op records are:

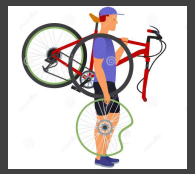
- periapical or panoramic radiograph
- chart notes reflecting implant size and position

Again, this is the absolute minimum.
We would expect more of a Maxicourse graduate.

When an unhappy patient arises:

- Seek referral support early, even if only a phone call or (secure) email. Document that you did.
- Be forthright with all parties
- Never refund patient without a signed release
- Review and gather notes
- Write a summary for yourself of the case
- Contact your insurer for advice
- Consider your own legal counsel
- Don't beat yourself up too badly. It happens.

You *will* have complications and failures



Common complications: their recognition and management

- Informed consent should include warnings of **reasonably foreseeable** complications
- You do have a legal and ethical obligation to recognise complications and either manage or refer
- If you work is within the standard of care, and the patient does not advise you of problems or does not return for recommended follow up (and you document this), you are not liable

How to get yourself in trouble with dental implants—a recipe:

1. Don't do a complete examination
2. Don't formulate a (written) treatment plan and estimate
3. Place the implants first
4. Treat one side/arch at a time
5. The "implant of the year" club

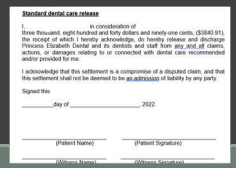
Again, beware of "Less Syndrome"

Your patient is unhappy. They might:

- say nothing but never return
- tell you/your staff about it, giving you a chance to address it
- tell all their friends, their regular dds, and post a negative review online
- file a complaint with the College
- begin legal proceedings against you

Let's talk patient refunds

Rare, but the cost of doing business.
Patients will not value your sunk cost.
Sometimes when you are in the right, still a good investment.
Never, ever, refund money without a signed release.
Cash/release exchange need not happen in your office.



Standard dental care release

I,
in consideration of
three thousand, eight hundred and forty dollars and ninety one cents, ($3840.91),
the receipt of which I hereby acknowledge, do hereby release and discharge
Princess Elizabeth Dental and its dentists and staff from any and all claims,
actions, or damages relating to or connected with dental care recommended
and/or provided for me.

I acknowledge that this settlement is a compromise of a disputed claim, and that
this settlement shall not be deemed to be an admission of liability by any party.

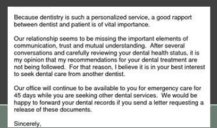
Signed this
_____day of _____ 2022.

_____ _____
(Patient Name) (Patient Signature)

_____ _____
(Witness Name) (Witness Signature)

Let's talk terminating (aka dismissing) patients

The best situation is when problem patients dismiss themselves
You have legal responsibilities around "patient abandonment"
Varies by state/province but usually 30 days emergency care
A registered letter used to be the standard, not so much now
Don't put anything negative in writing to the new office
Make it easy, send their records to a new office free of charge!
(with a signed release, of course)


Because dentistry is such a personalized service, a good rapport between dentist and patient is of vital importance.

Our relationship seems to be missing the important elements of communication, trust and mutual understanding. After several conversations and carefully reviewing your dental health status, it is my opinion that my recommendations for your dental treatment are not being followed. For that reason, I believe it is in your best interest to seek dental care from another dentist.

Our office will continue to be available to you for emergency care for 45 days while you are seeking other dental services. We would be happy to forward your dental records if you send a letter requesting a release of these documents.

Sincerely,

~~Malpractice~~
Professional Liability Insurance

- sources
- how much?
- when to call?
- adjustment process
- self-representation

7. The "S" word

Selling

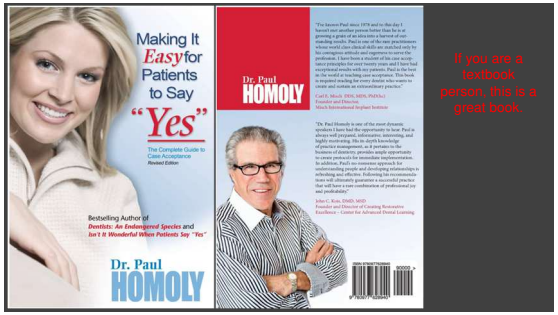
Marketing implant treatment in your office…

- Requires buy-in from all staff and dentists
- Requires you to invest time at recall examination, or even before
- Requires a confident "spiel" to explain treatment to the patient
- Requires preparation
- Is worth every bit of the time, $$, and effort required

The "S" word: Selling

- Is it a dirty word? (no)
- Are we really "selling" treatment, or are we educating patients about their condition and options? (hopefully b)
- Can you improve your skills for doing so? (yes)
- Are we doing it for us or them??? (hopefully both)

Whether we like it or not, everything we do is selling.



If you are a textbook person, this is a great book.

What motivates patients to proceed?

More important than any technical data about their condition, and the most important things in case acceptance are…

1. Establishing rapport
2. Showing patients that you care
3. Making patients feel better about themselves

A common mistake is to over-educate patients!

So how do we consistently accomplish all these things in our consult appointment?

- "Right-size" the amount of information
- Show the patient we care
- Make them feel good about themselves

You're going to need a "spiel".

Your spiel 

You need to develop a consistent, reproduceable spiel that you use to explain treatment to patients.

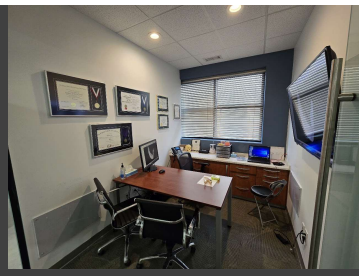
Scripts can give you guidance and ideas, but it has to be in your own words.

It will evolve over time, and that is a good thing.

If you are really, really terrible at it, maybe you need to delegate case presentation to a treatment coordinator.

First let's talk about consult rooms. A consult room:

- is less threatening to many patients
- cleaner, quieter, more private and professional
- a better space
- cost is a fraction (1/8?) of that of an operatory
- not helpful if nobody uses it, aka the "breastfeeding room"



Answering patient's concerns about proceeding

How long will I need to take off work?
How long will I be without teeth?
It all sounds painful. Will it hurt?
Do you have to put me to sleep for this?
Wow, that's more than I expected.
Where does graft material come from?
How long will the procedure take?
Do you have a payment plan?
I need to find out how much my insurance will cover first.

All patients can call with questions, or have a second consult at no charge. Many will have questions for your RDA after you leave.

Ten tips for selling this therapy 

1. Use physical models.
2. Show patients a dummy implant, and let them handle it.
3. Draw pictures. Lots of pictures!
4. Refer to quality of life, as opposed to clinical need.
5. Use flat fees to eliminate fear of the unknown.
6. Make sure everyone in your office is on board. And be confident.
7. Use testimonials.
8. Use the eyeglass analogy (or other prosthesis).
9. Emphasize that it is the best from a range of options.
10. Discuss forward compatibility!

Last few things to remember:

Patients will decide based on both
LOGIC and EMOTION

Caring and leadership trump information

The patient may not be ready today, & that's OK

If they decline treatment for now, it's not personal

8. Your support network

At one time the biggest challenge to dentists starting out in implant dentistry was poor lab support.

Today things are much better, at least for simple cases.

Still no guarantees for complex cases.

So how do I solidify the laboratory part of my implant practice?

1. Find a lab to work with.

-remember, you are a desirable account
-you need to be able to talk to them
-often a boutique lab is better than a factory
-this is a partnership!

So how do I solidify the laboratory part of my implant practice?

2. Decide what you are sending out.

-always place impr copings/analogs yourself
-consider pouring models in-house
-you may want to 3D print in-house
-you may want a vacuform in-house

how far away is the lab?

So how do I solidify the laboratory part of my implant practice?

3. Communicate regularly with your RDT!

-Meet them! Visit them! Talk regularly!
-fill out slips thoroughly
-send more than the bare minimum
-send videos and photos, incl post op

And say Thank You. A lot!

So how do I solidify the laboratory part of my implant practice?

4. Take an interest in the process

-visit the lab periodically
-ensure lab screws are being used
-ask about their infection control practices
-ask about their hazardous waste disposal
-learn their protocols
-confirm their preferred scan bodies!!!

So how do I solidify the laboratory part of my implant practice?

5. Be their favourite dentist

-allow enough time for quality work
-send good, organized information
-don't grind them on cost
-pay your bill on time
-be a partner, to all the lab staff
-most important of all, be kind!

Others in your support network

A. OMFS
B. Prosthodontists
C. Implant dentistry mentors
D. CBCT rad report service (radiologist)
E. Your dental implant company
F. Your peers!

Working with sales reps

Not just the sales rep, but your implant company's technical support team, training and education team, and their marketing team.

Involve your rep early. A great rep will…

- Make sure you have everything you need
- Unpack and setup surg kits and drill units
- Help your staff with operatory setup and infection control
- Be there to make sure everything goes smoothly
- Loan you any obscure parts or equipment
- *Possibly* bring donuts

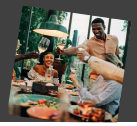
Understanding how reps are paid.

- Signing bonus for transferees
- Initial guaranteed income
- After that based hugely on growth
- Reps earn $ based on sales in their territory
- Ask for the best deal, but don't grind them

Dentistry is stressful and isolating.

Social media…can help…but is not enough.

You *need* to connect with your colleagues for your mental health and wellbeing.



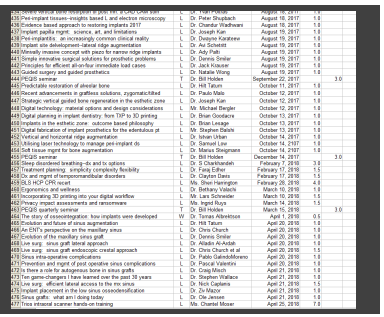
8. The future: implant professional development

Where do you go from here?

Organisations, journals, credentials, CDE/study club options, resources

Organisation		Sponsored Journal	Credentialing	Meetings
ICOI	Largest org, good parties, auxiliary training, not as professional, $$ driven	Implant Dentistry	Fellow, Master, Diplomate Not as well respected	One winter in USA, one annual which alternates USA/world
AAID	Oldest, most respected org, less glamourous	Journal of Oral Implantology (JOI)	Associate Fellow, Fellow	Western regional June every second year Annual meeting Sept or October (in Vegas this year)
ABOI	Board certifying body sponsored by AAID	N/A	Diplomate Most respected	in conjunction with AAID
AO	Science heavy org, resurgent in past few years	Journal of OMF Implants (IJOMI)	Certificate Doesn't mean much	Annual meeting March
ITI	Straumann-based, but good science and open to non-Straumann folks	ITI treatment guides	Fellowship More of a club really	Occasional world conferences (Singapore 2020)

Remember to start that CDE course spreadsheet!



What to do next???

Place some implants! Lots of implants!

You will get much more out of your next course if you already have a bunch of implants under your belt.

-Mini-residencies (we hate that term)
-One-off courses
-Study clubs, seminars, and continuae (incl CDITC)
-Conferences

ACTION PLAN

1. Get your staff on board.
2. Acquire a system, stock, and sundries.
3. Set fees, create paperwork.
4. Plan ideal appointment time, operatory, staff.
5. Book patients and treat them.
6. Repeat 5. above.

In closing…

Congratulations!
on tackling the Maxicourse.

Good luck!
on your AF exam. You will do fine.

Thank you!
for letting me share some of what we do. I am incredibly lucky to be involved in implant dentistry, and you will be too.

Our door is always open!
Feel free to visit our centre, or email me with any questions, any time.

Thanks!

Bill Holden
billholden@pedental.ca
Cell 780-721-1415