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WINTER 2022

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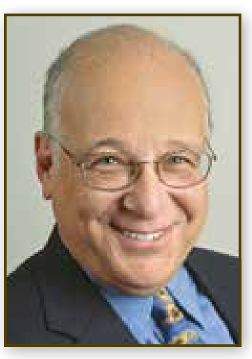


Editorial

Fellowship

One hundred sixty eight thousand, four hundred and twenty eight.

As you read this, there are, right now, 168,428 dentists who are certified to offer Invisalign to their patients. In this increasingly competitive market, how can dentists distinguish themselves from the pack, and show prospective patients that they are not only Invisalign providers, but also Invisalign superstars?

Being an AACA member certainly helps. The AACA is dedicated to helping members increase their proficiency by means of Continuing Education courses, ClinCheck training videos, ClinCheck Theater Thursdays, Wednesday Webinars, ClinCheck Cowboys-Cowgirls-Marshals, free case reviews, local study clubs, and, of course, this highly respected, award-winning Journal.

And, our members are certainly self-motivated to attain excellence! Note how, as of this writing, Dr. David Galler's next 6 Reingage courses are completely sold out and only 17 spots remain open for the May courses.

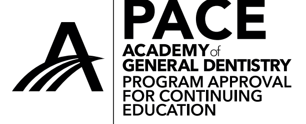
Being recognized as a Fellow in the AACA can further demonstrate your excellence and proficiency to prospective patients.

The **AACA Fellowship** program launched last year. Our first 32 dentists completed the rigorous accreditation requirements, and were honored at our June 2021 convention. Since publicizing their new status, all of these doctors have reported the best 6 months of their Invisalign history.

AACA Fellowship cannot be gamed or fixed. It is independent of office size, current tier status, location, and whether you speak or lecture. It can be achieved only with time, hard work, talent, and a desire to create beautiful, healthy smiles.

AACA VP Dr. Phil Gaudin has announced that the 2022 application process for Fellowship is now open. Will you be part of the 2022 AACA Fellowship class (**https://bit.ly/3sauBhk**)?

(For criteria on attaining Fellowship, continued on page 6)



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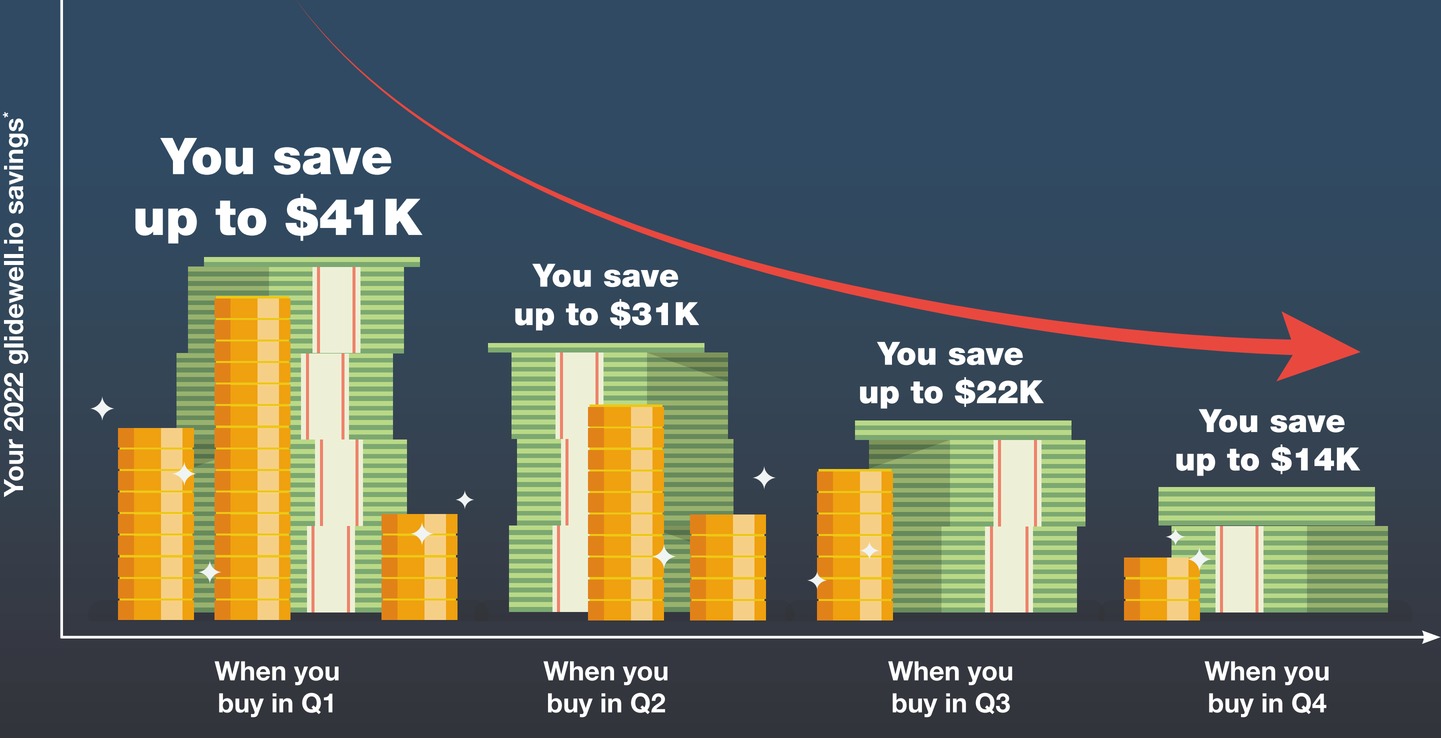

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Case Reports

Marci Was Amazing. No IPR and No Refinements

by Rob Herron, DDS

This case was a Golden Aligner finalist at GRC 2021 and a Semi-Finalist at the 2021 Invisalign Summit.

Dr. Rob Herron has been serving the Southeast Kansas community for over 30 years as a general dentist. He is a graduate of Creighton University School of Dentistry, class of 1989, earning his DDS. Dr. Herron has spoken at the annual American Academy of Clear Aligners Convention and at the Invisalign Summit. He is the lead triage dentist at the annual Kansas Mission of Mercy project. Outside of dentistry, he enjoys spending time with his family, including his 4 grandchildren, as well as taking care of his hobby farm.

We first saw Marci in April of 2019 as an Invisalign consult. She and her mother had tried in vain to find a dentist who would treat Marci with Invisalign. Every dentist and orthodontist they visited told them that she was not a candidate for clear aligners. They had heard that we treated teen patients and accepted more difficult cases. We were their "last hope" to avoid bands and brackets.

At 15 years old, Marci had little to no skeletal growth potential remaining. This was not a concern, since she presented as a dental Class I. Her Angle classification was confirmed by a traced cephalometric image using the Sassouni-plus method. (In our office, all aligner patients 16 years old or younger must have a traced ceph to begin treatment. That helps avoid unpleasant surprises.)

Records, including the ceph, digital images, and an iTero scan, were completed at Marci's first visit. We take full records at the consultation appointment. If patients don't immediately start treatment, they can call later and accept. We have everything we need to send off the case, and the patient doesn't need to come back into the office. This allows us to conserve chair time and removes a barrier to starting a case.

Challenges

Marci presented with several challenging aspects to her treatment (**Figure 1**). Her upper right canine (tooth #6) was "high" in the arch. This was most likely caused by premature deciduous tooth loss. Many times, this results in mesialization of the first molar that then requires a distalizing adjunct appliance. Fortunately, in Marci's case that did not occur. Instead, her maxillary bite collapsed, creating the high canine and the crossbite of the lateral (tooth #7). Also note the half-tooth shift in the midline.

Marci's aligner delivery appointment was on June 4, 2019. She was placed on weekly aligner changes. We emphasized that to achieve the large amount of expansion in the maxillary arch that would be needed to successfully complete her case, compliance in wearing the aligners would be paramount. We prescribed a regimen of 22 hours a day wear and use of a red Munchie every time the aligners were placed. With an anterior crossbite, many times patients are told to eat in their aligners; but this was not part of the protocol we gave Marci.

Completion

Marci returned monthly until her trays were completed on January 14, 2020, for a total of 7 months in active wear. She bleached her teeth for 2 weeks to achieve the shade she desired. On February 4, 2020, a cosmetic bonding was placed on tooth #8 for an esthetic finish (**Figure 2**). We took final photos and scanned her for Vivera retainers

The takeaways on this case to me are:

- **Patient compliance:** Marci was dedicated to getting rid of her "can opener" tooth.
- **Red Munchie:** This is the acceleration I use on every case. I will sometimes switch to the Munchies VIBE on more stubborn movements.

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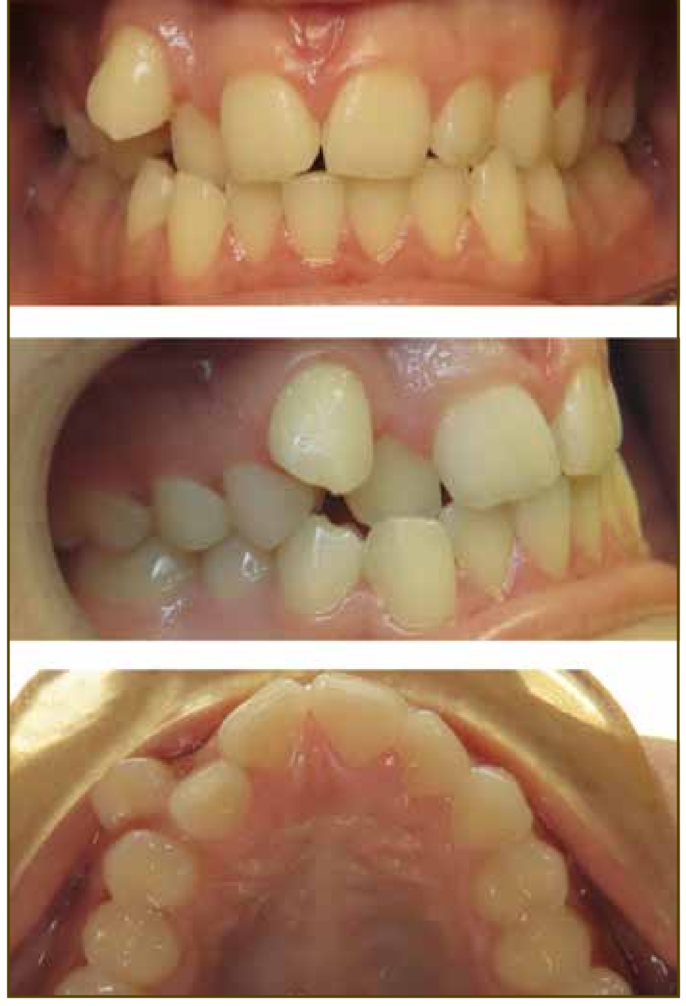

Figure 1: pre-treatment. Note maxillary arch collapse, "high" right canine, crossbite of right lateral, and mid-line shift to the right.

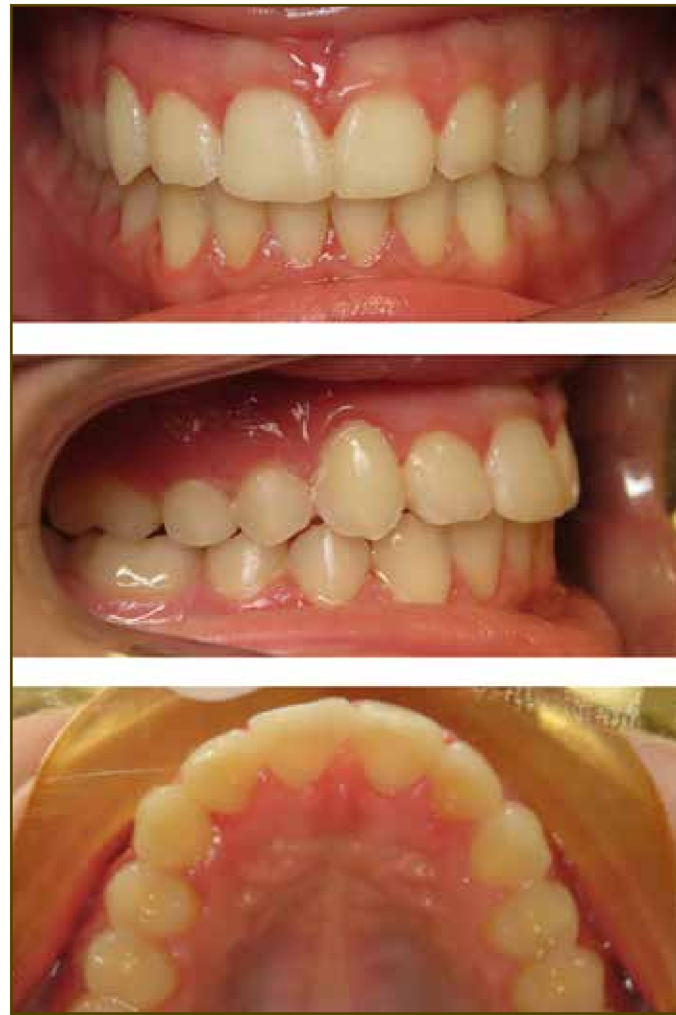

Figure 2: after treatment.

- **No IPR:** This was a pure expansion case. I avoid using IPR by prescribing more expansion in most of my cases. This is especially true with younger patients.
- **No Refinement:** With a compliant, motivated patient and a proper ClinCheck plan, no Refinements are the goal, even in more difficult cases.
- **Midline shift:** Through nothing more than the expansion of the maxillary arch, the midline shift exhibited at the beginning of treatment was corrected when the mandible was released from its restrictions.

I encourage the reader to consider taking on the more straightforward teen cases, as this seems to be a future market for clear aligners, and no longer the niche that it's been for so long. ■

(Editorial—continued from page 1)

Criteria for fellowship award:

1. AACA membership for 12 months
2. Lifetime completion of 100 clear aligner cases
3. Presentation (with photos and case write-ups) of 5 of those cases
4. Passage of a written multiple-choice exam
5. 50 hours of documented Clear Aligner Continuing Education

Are you special enough to join the 32 AACA Fellows? The dentists who qualify will be presented with their Fellowships on June 29, during the GRC 2022 meeting in Las Vegas.

Dr. Jeffrey Galler
Editor

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Case Reports

Optimizing Clear Aligner Tooth Movement Outcomes With Digital Occlusion Technology

by Julia Cohen-Levy, DDS, MSc, PhD, FRCD(C); Jeremy Saranes, DMD Candidate; and Robert B. Kerstein, DMD

Clear aligners have become a commonplace, modern-day computer-era method for patients to undergo orthodontics. Digital planning software can simulate dental displacements in 0.1-mm increments, anticipating changes in arch shape and in dental mass disharmony (Bolton discrepancy), while prognosticating future functional contacts.

Whether brackets or aligners result in better occlusal contact outcomes is still unclear. Some comparison studies concluded that aligners produced less adequate contacts,[1] possibly related to occlusal coverage that may improve spontaneously during retention with settling.[2,3] However, recent settling studies indicate that occlusal balance does not always follow orthodontics.[3-7] It was reported that a marked right-left occlusal force imbalance (right-left > 50 % ± 10%) can persist in some cases that appear to be in "good occlusion," even after 6 months of retention.[8]

Dr. Julia Cohen-Levy is an assistant professor in clinical orthodontics at the Faculty of Dentistry, McGill University, Montreal. She graduated in dental surgery at the University of Paris 7 in France, and followed two residency programs in orthodontics (Paris and Montreal) to become a certified orthodontist in these 2 countries. She defended a doctoral thesis (PhD) on obstructive sleep apnea syndrome, and she has several ongoing research projects on sleep-disordered breathing, temporomandibular dysfunctions, and computerized occlusal analysis.

The T-Scan™ Novus™ Digital Occlusal Analysis system (Tekscan™, S. Boston, Mass., USA) is a precise, reproducible,[9-11] and innovative technology[12] that records relative occlusal force levels dynamically.[9-11] It detects heavy contacts and imbalanced force distribution during the course of orthodontic treatment (with either aligners or conventional fixed orthodontic therapy), when case-finishing, and during retention. The color-coded occlusal-force and timing data sets of T-Scan graphically guide an orthodontist to isolate and adjust high force and time premature contacts. Its digital data optimizes the occlusal force balance and individual contact force concentrations, to higher-precision outcomes than what tooth movement alone can accomplish.[3-7] The T-Scan eliminates the subjectivity of interpreting occlusal contact quality that is employed when visually inspecting the patient or casts, and when using non-digital occlusal indicators like articulating paper, wax, or shim stock.[13-18]

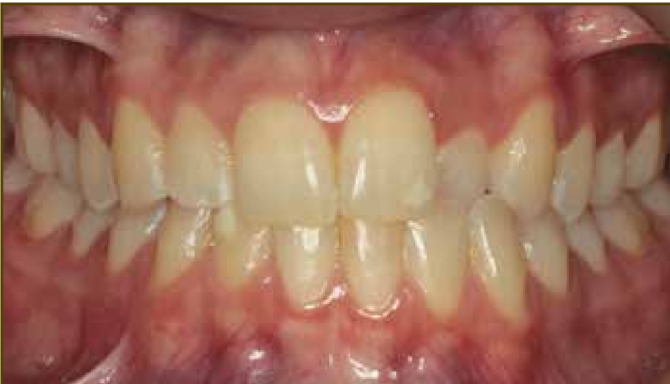


Figure 1: The initial patient presentation showing incisor enamel hypoplasia, mild anterior crowding, localized anterior crossbite, and lingually inclined posterior segments.

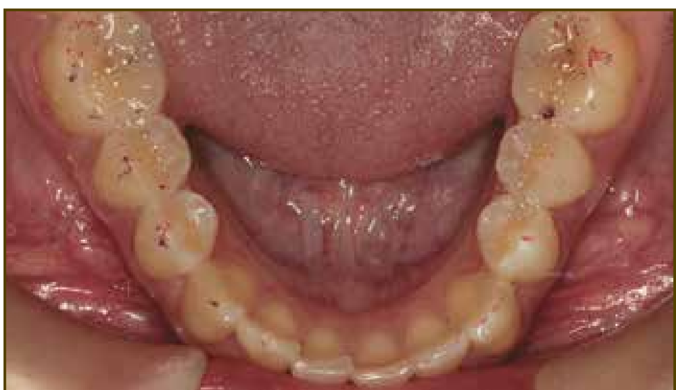


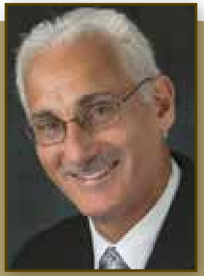
Figure 2: Despite slight anterior crowding, there was harmonious mandibular arch form. But thin periodontium with limited keratinized tissue was present in the mandibular left quadrant.

The following case report illustrates how the T-Scan Novus with v10 software was used following aligner therapy, to improve the occlusal force profile and the right side–left side occlusal balance.

Case report

A 21-year-old female seeking smile improvements presented with her maxillary lateral incisor (tooth #10) lingually positioned in crossbite, uneven maxillary central incisors, and mandibular anterior crowding resultant from a 2-mm anterior mandibular excess Bolton discrepancy (**Figures 1 and 2**). Cephalometric and panoramic radiographs confirmed that the patient presented with a Class I skeletal and dental malocclusion

Jeremy Sananes received a Diploma of College Studies, Science program, in 2017 from John Abbott College. He then went on to complete the Dentistry Preparatory Qualifying Year at McGill University before entering McGill's undergraduate dentistry program. Jeremy is currently in his final year of the DMD curriculum and will be pursuing a General Practice Residency at the Jewish General Hospital in Montreal beginning in July 2022.



Dr. Robert B. Kerstein received his DMD in 1983 and his prosthodontic certificate in 1985, both from Tufts University School of Dental Medicine. From 1985 through 1998, he maintained an active appointment at Tufts as a clinical professor teaching fixed and removable prosthodontics in the Department of Restorative Dentistry.

Dr. Kerstein has conducted original research regarding the role that occlusion and lengthy disclusion time play in the etiology of chronic myofascial pain dysfunction syndrome. His now 38 years of research with all versions of the T Scan Digital Occlusal Analysis System have made him a leading author and researcher in the field of computerized occlusal analysis. Dr. Kerstein has been published in the *Journal of Prosthetic Dentistry* and more than a dozen other journals. Additionally, Dr. Kerstein has published 2 research handbooks about the T-Scan technology.

For many years now, Dr. Kerstein has lectured both nationally and internationally, about prosthodontics, implant prosthodontics, digital occlusal analysis, and treating muscular temporomandibular dysfunction with Disclusion Time Reduction Therapy.
www.drrobertkerstein.com

with normal vertical and transverse relationships, and both Temporomandibular Joints within normal limits.

Aligner therapy represented a good treatment option aimed at uprighting the posterior teeth, increasing the arch perimeter, and compensating for the Bolton discrepancy, by using Interproximal Reduction (IPR) between the mandibular canines without proclination. The #10 lateral incisor would be

Figure 3a: The initial arch forms and existing occlusion visualized in the ClinCheck software, with the locations and amounts of the Interproximal Reduction (IPR) required in the mandibular arch (1 = 0.1 mm IPR; 3 = 0.3 mm IPR).

Figure 3b: The final prognosticated setup in ClinCheck, showing the transverse arch expansion that will upright the Curve of Wilson, and the 0.3 mm of IPR aiding the #10 lateral incisor crossbite correction. Attachments (in red), Power Ridges, and Bite Ramps (in blue) will apply the mechanics to the teeth without utilizing interarch elastics.

buccalized after adequate space was created in the maxilla (**Figures 3a-b**).

The final orthodontic outcome was very similar to the prognosticated plan, with improved arch coordination, the crowding corrected, and the #10 incisor no longer in crossbite (**Figures 4a-b**). This outcome required 20 initial aligners and 7 Refinement aligners. Then, bonded retainer wires were placed lingually on the maxillary (not shown) and mandibular anteriors.

Despite the improved visual alignment following aligner treatment, the patient reported feeling some "discomfort" that she could not locate precisely, together with some muscular tension and mild left Temporomandibular Joint pain, especially in the morning, consistent with a diagnosis of sleep bruxism. The tooth movement outcome was then assessed with the T-Scan for the occlusal contacts' quality and distribution, and for any occlusal force imbalance.

The initial T-Scan recording detected an imbalanced force distribution (58.9% right - 41.1% left), with opposing right 1st and 2nd molars concentrating 36.2% of the total right-side force, and opposing left 2nd molars concentrating 22.0% of

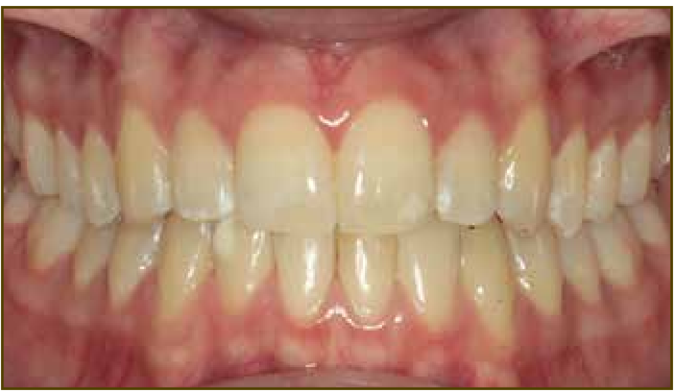


Figure 4a: Frontal view of the aligner treatment outcome.

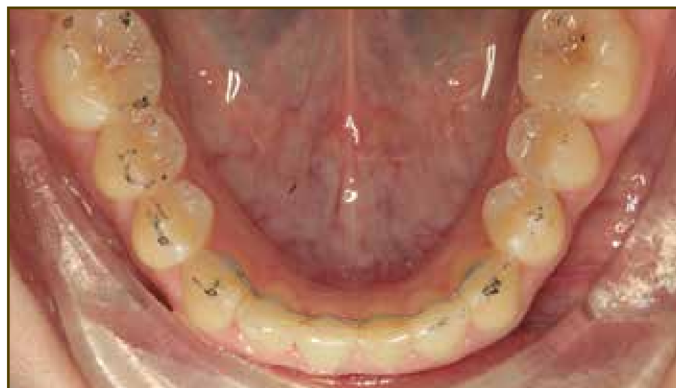


Figure 4b: After aligner therapy, fixed retainers were installed. The articulating paper markings suggest there are widespread occlusal contacts.

the total left-side force. This imbalance was visualized by the non-centered Center of Force (COF) icon (red/white diamond within the target), which pointed toward the overloaded right posterior teeth (**Figure 5**). Excessively forceful contacts are often found on the palatal cusps of upper premolars and molars following transverse arch expansion, because buccal crown torque is difficult to achieve with aligners.

To effectively optimize an orthodontic result by correcting areas of excessive occlusal force concentration, a series of T-Scan-guided occlusal adjustments are performed on very precise contact points, using an oval multiblade tungsten carbide bur, combined with thin articulating paper (Accufilm, Parkell, Farmingdale, N.Y., USA). Repeated T-Scan recordings guide additional adjustments until a widely uniform, low-moderate force profile is created, with a centered COF indicating bilateral occlusal force equality.

Figure 6 depicts the final occlusal force distribution after five T-Scan–guided corrections were made to the differing occlusal contacts where excessive force was sequentially detected. The COF was located very close to the arch midline, and the right-to-left force distribution is 48.1% right - 51.9% left. Importantly, teeth #2 and #3 concentrated 12% less force than pre-T-Scan treatment (24.4%), while cross-arch teeth #14 and #15 concentrate a nearly equal force percentage (25.2%).

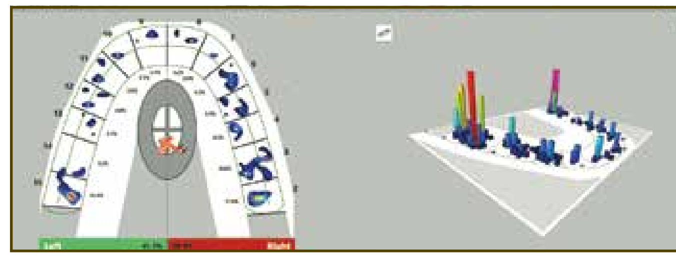


Figure 5: After aligner tooth movement, the T-Scan detected a 58.9% right - 41.1% left occlusal force imbalance, with the Center of Force (COF) icon pointing at the right posteriors where excessive occlusal force was concentrated (opposing 1st and 2nd molars = 36.2% of the right side occlusal forces).

Figure 6: After T-Scan-guided adjustments, there are only low-moderate closure forces present, with the computer-refined result exhibiting ideal occlusal balance (48.1% right - 51.9% left).

Summary

Computer-guided occlusal adjustments with the T-Scan system with v10 software represent a definitive advance in orthodontic case finishing. Measured occlusal force levels are targeted with precise occlusal adjustments, with articulating paper marks only employed as locators of the contacts, and not as predictors of what the differing contact force levels may be. The T-Scan data sets guide the clinician's contact selections to precisely treat the contacts that truly require force optimization, thus removing the subjectivity that non-digital occlusal case finishing procedures rely upon.

Disclosure

The third author is a clinical consultant for Tekscan, Inc., S. Boston, Mass., USA, and receives no compensation for sales of any Tekscan products.

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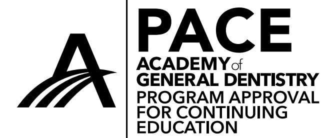

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Case Reports

Demystifying Molar Intrusion With Clear Aligners

Intruding Molars to Achieve Restorative Goals

by Jeremy Kurtz, DDS

When I graduated dental school over 20 years ago, molar intrusion was a trick that could only be achieved by wizards, sorcerers, and some very dedicated orthodontists and equally motivated patients. With the advent of Clear Aligner Therapy, molar intrusion can be done predictably and with relative ease. This is an extremely useful tool for restorative dentists to have in their armamentarium.

Dr. Jeremy Kurtz is a graduate of the University of Toronto School of Dentistry. He is a general dentist who maintains a unique private practice in Toronto that focuses exclusively on Invisalign and dental implant therapy. Dr. Kurtz is a guest lecturer at various Invisalign and implant study clubs in Toronto. He is a Diamond Plus (previously called Top 1%) Invisalign GP provider and enjoys making his patients smile with Clear Aligner Therapy.

The need for molar intrusion is quite commonplace in the dental office. The most common scenario involves bruxers who have worn down their molars over time. Exposed areas of dentin become sensitive, and patients complain of sensitivity when biting. When the dentist attempts to cover or restore these areas, there simply is not enough room, because the opposing tooth has erupted to fill the void. The dentist is then faced with the decision either to reduce the tooth further to make room for the filling material or to reduce the opposing tooth. In these scenarios, fillings often break or fall out, and the cycle repeats itself.

Another common scenario is that of the "missing molar," in which the opposing tooth has overerupted, making it difficult or even impossible to restore the missing tooth without significant reduction or even removal of the opposing tooth.

What if, instead of "shaving down" an already compromised sensitive tooth, we could create 1 to 2 mm of space by intrusion, allowing the tooth to be restored without reducing the tooth further? This truly would be a dream come true for the conscientious dentist. But can this actually be achieved? How predictable is this movement, how long will it take, and which molars can be intruded—maybe only maxillary molars or only one molar at a time?

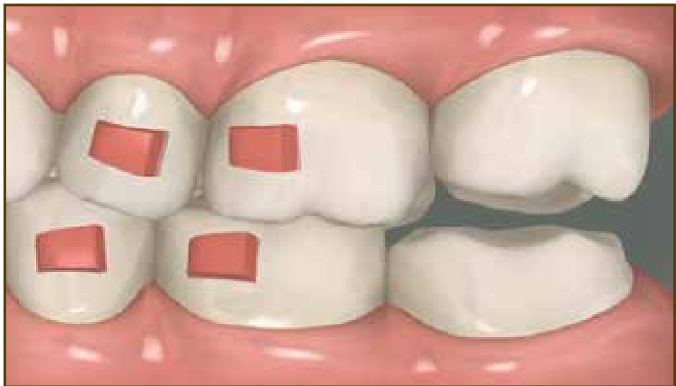

Figure 1: for intrusion of terminal molars, place horizontal rectangular attachments on the 2 adjacent teeth.

Figure 2: if intruding a first molar (with second molar present), place horizontal rectangular attachments on the adjacent teeth when feasible.

With Clear Aligner Therapy, molar intrusion can be achieved with confidence. I would argue that clear aligners are the appliance of choice for intrusion, especially compared to traditional braces, for several reasons:

1) Clear aligners are "pushing" appliances (whereas braces are pulling appliances); this is the exact force needed for intrusion.
2) Clear aligners cover the entire occlusal surface of the teeth (compared to braces, which only make point contact).
3) The occlusal forces of the opposing tooth bite into the plastic (and can be directed to do so), further enhancing the efficacy of the intrusion. (Generally, we try so hard to prevent posterior open bites with Clear Aligner Therapy, but we can actually make the trays create one when we need it!)

Here are the general guidelines for molar intrusion.

- It's generally easier to intrude a maxillary molar than a mandibular molar, because the bone is softer.
- It's easier to intrude one molar than two adjacent molars.

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Figure 3a: molar wear from years of bruxism has exposed dentin, causing sensitivity.

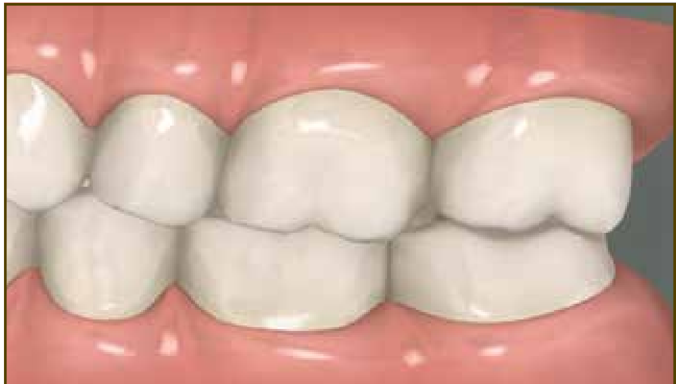


Figure 3b: molar wear from years of bruxism has exposed dentin, causing sensitivity.

- You need to have sufficient anchorage to achieve intrusion.
- Some clinicians reduce the rate of velocity for intrusion to 0.125 mm per tray (but I have successfully intruded molars without such reduction of velocity).
- I would generally avoid intruding third molars.

In summary, the greatest success of intrusion will be with terminal maxillary molars.

Here are a few scenarios and general guidelines for the attachments required to achieve the intrusion. These have worked well in my practice. More intrusion can be achieved with more perseverance and/or the use of temporary anchorage devices (TADs).

1) Terminal molars (second molars, maxillary or mandibular): place horizontal rectangular attachments on the 2 adjacent teeth (first molar and second premolar) (**Figure 1**).
2) If intruding a first molar (with second molar present), place horizontal rectangular attachments on the adjacent teeth (second molar and second bicuspid) when feasible (**Figure 2**).
3) For mandibular molars, 1 mm of intrusion is predictable; for maxillary molars, 1.5 mm. Hence in the case of a worn-down second molar, the clinician can intrude the mandibular second molar 1 mm and the maxillary second molar 1.5 mm, creating a total of 2.5 mm of space.

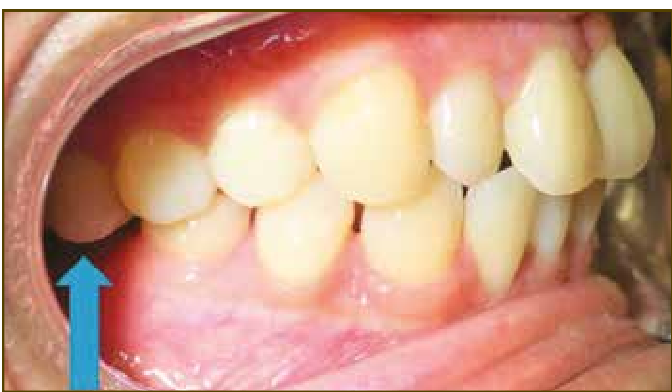


Figure 4: significantly overerupted tooth #3 made it impossible to add an implant and crown for tooth #30.

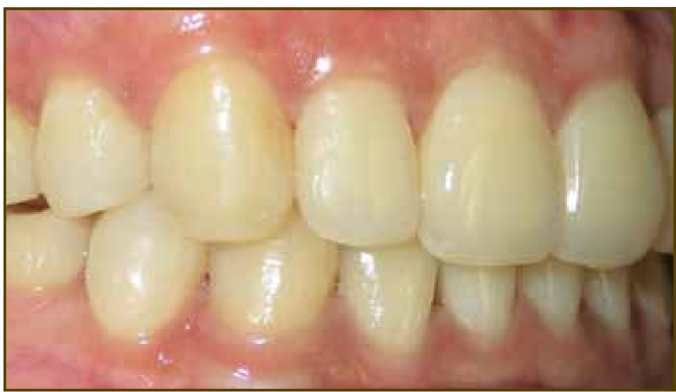


Figure 5: by intruding tooth #3, we made room for an implant and crown for tooth #30.

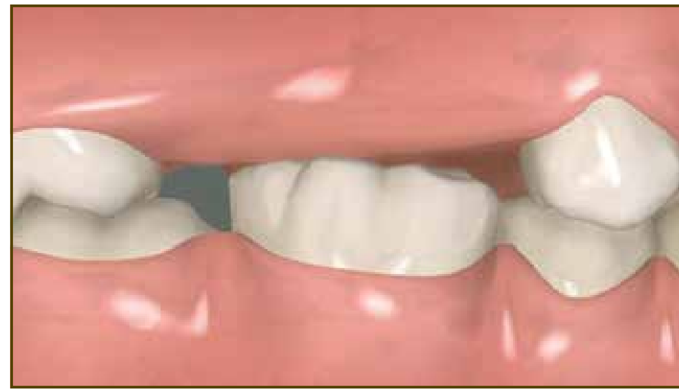
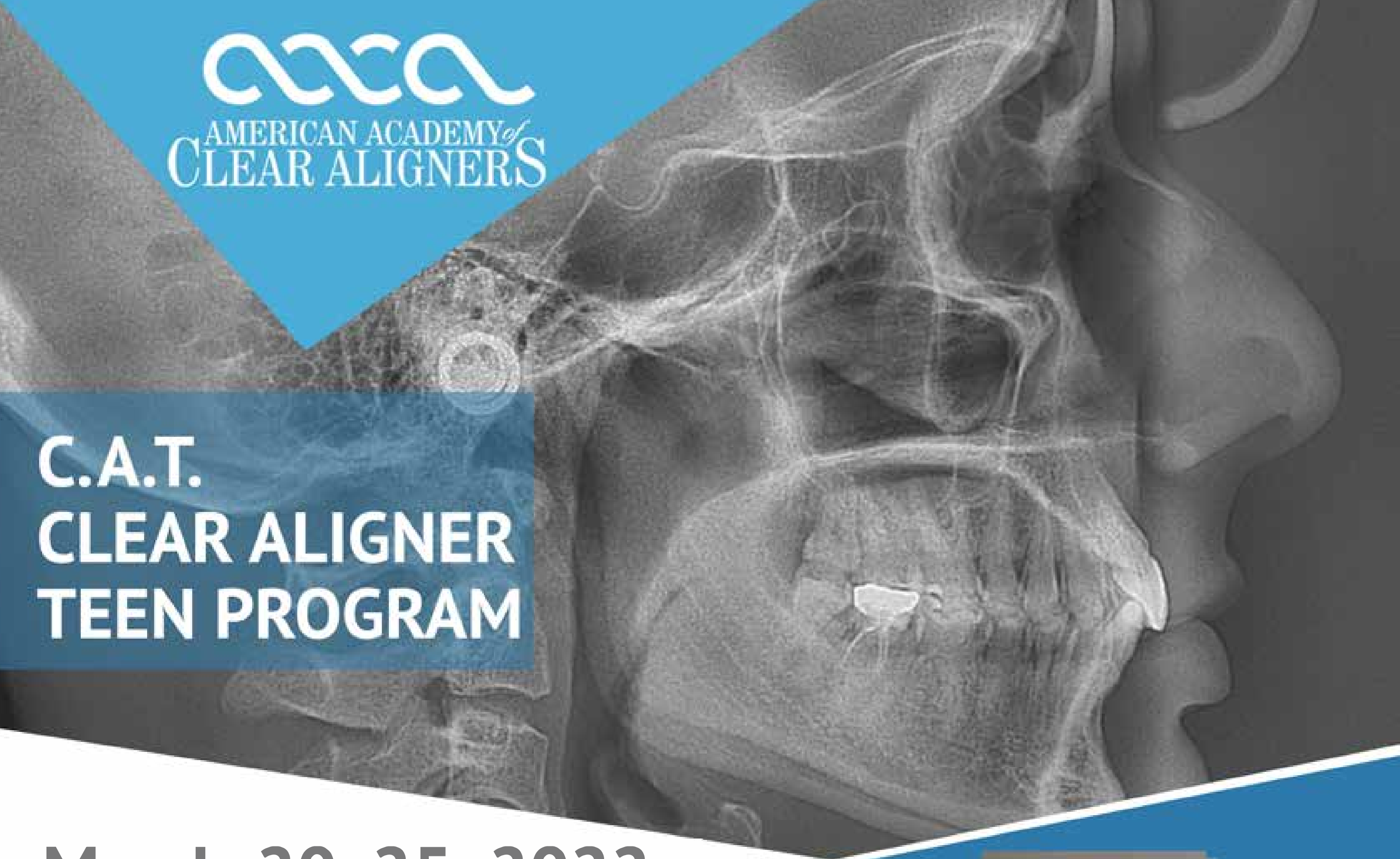


Figure 6: overerupted mandibular molar #30.

4) Some overcorrection may be warranted, but avoid excessive overcorrection movements for these intrusions.

Some clinical case examples:

1) A 40-year-old patient, Dee, complained of sensitivity when biting. Her dentist advised her that her molars were worn down by years of grinding. The dentin surfaces were exposed, causing sensitivity. Unfortunately, the dentist was unable to restore the teeth without further reducing the teeth and removing more tooth structure. This scenario is far too common (**Figures 3a and 3b**). We were able to intrude teeth #15 and #18 by 1 mm each (using a total of 12 trays). This provided room for the teeth to be restored with



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Dr. David Ostreicher

Dr. Ostreicher received his dental degree and Certificate of Specialty in Orthodontics, along with his master's in Nutrition and Public Health, from Columbia University.

- Professor emeritus at Columbia University and the University of New Haven
- President of the New York State Dental Association
- Published author
- Speaker for the National Bone Health Alliance
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composite material, resolving sensitivity and preventing further wear. Note how teeth #15 and #18 were successfully intruded, so as to allow space for occlusal resin (**Figure1**).

2) Another patient had tooth #3 significantly overerupted, making it impossible to add an implant and crown for tooth #30 (**Figure 4**). Over a period of 18 months, using clear aligners alone, we intruded tooth #3 significantly, a full 3 mm (which is considerably more than what could predictably be expected!), allowing for an implant and crown to be placed in the tooth #30 location (**Figure 5**). No TADs were required (although they were initially considered). This was achieved even though there was no opposing biting force to aid in intrusion.
3) A case that is still in progress features intrusion of an overerupted mandibular molar #30 (**Figure 6**). As mentioned above, mandibular molar intrusion is more challenging, yet to date, after 10 trays, we have started to achieve some degree of intrusion (**Figure 7**).

In summary, single molar intrusion can be predictably achieved with Clear Aligner Therapy, allowing for resolution to multiple restorative challenges. Now, you can be a magician too! ■

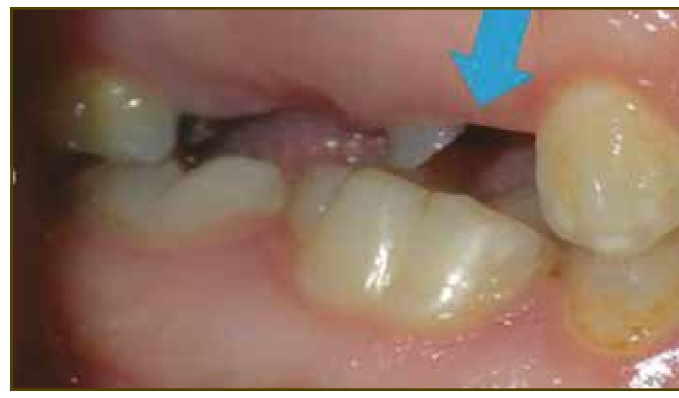

Figure 7: intrusion of overerupted mandibular molar #30 in progress.

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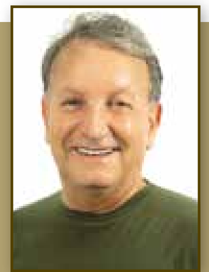
Feature Article

Munchies® Maintain

by David Penn, BDS, MBA



Dr. David Penn is the Head of the School of Aesthetic Orthodontics at the Postgraduate School of Dentistry in Double Bay, Sydney. Dr. Penn lectures and teaches extensively, principally in the areas of aesthetic orthodontics and clear aligners. He wrote the initial accreditation course for GP doctors for Invisalign® and has taught more than 1,500 postgraduate students in the use of sequential aligners and aesthetics. In January 2015, Dr. Penn wrote and gained accreditation for a government-accredited postgraduate degree qualification in aesthetic orthodontics. He is also responsible for the research and development of many unique dental appliances and devices, such as the Penn Composite Stent; the Atlas Cabriolet orthodontic retainer; and the acclaimed Munchies® series of orthodontic devices, including Munchies Vibe—the next generation of predictability enhancement.

Maintaining teeth in their corrected position following orthodontic treatment can be extremely challenging (**Figure 1**). Teeth have a tendency to move back toward the original position (**Figure 2**) as a result of periodontal, gingival, occlusal, and growth-related factors, but this can also occur as a result of normal age changes.

Clear aligner prescribers are generally unable to definitively predict which patients are at risk of relapse, which will remain stable, and the extent of relapse that may occur in the long term. Hence, clinicians need to treat all patients as if they have a strong propensity toward relapse.

Long-term retention should always be advocated, yet can require a significant commitment for patients, and so it is vital to make them fully aware of their responsibilities in committing to wearing retainers as prescribed.

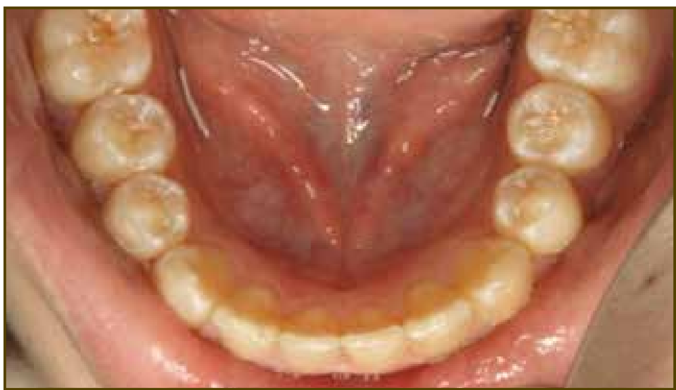


Figure 1: end of Clear Aligner Treatment.

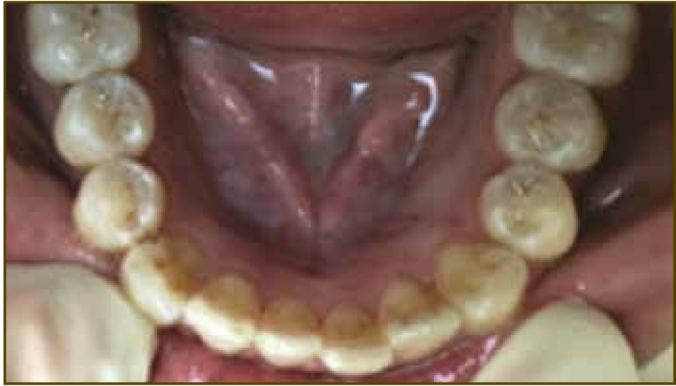


Figure 2: 4 months after completion: relapse has occurred.

There are a variety of ways of addressing this challenge:

- Fitting fixed retainers, which require careful maintenance and monitoring to check for unwanted side effects such as detachments, fractures, unwanted tooth movement, and periodontal complications secondary to plaque retention
- Asking patients to wear removable retainers, which require excellent long-term compliance and periodic replacement
- Securing patients' explicit acceptance that without adherence to a retention protocol in the long term, there will be an unpredictable amount of post-treatment tooth

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Figure 3: Munchies® Maintain engages the anterior teeth in the maxillary groove.

Figure 4: Munchies® Maintain EPS arm is engaged in premolars.

Figure 5: after wearing retainers for 22 hours per day, IPR, and use of Munchies® Maintain.

movement, which can either be accepted or corrected with orthodontic re-treatment

Most clear aligner patients are comfortable with the option of wearing removable retainers (although some less-compliant patients will benefit from the combination of fixed and removable options). Specific instructions on retainer-wear protocols should be explained and documented with every patient.

Optimal fitting of clear retainers not only maintains the post-treatment goals but also aids in providing remediation of minor relapse.

As clear retainers are generally 30% thicker and more rigid than aligners, intimate seating of the retainers can be more challenging. Munchies Maintain devices are specifically designed to provide adequate force systems to seat clear retainers.

Maintaining post-treatment position

As a daily regime for maintaining the position of the teeth after treatment, patients should insert their clear retainers before sleep, then engage the groove of the Munchies Maintain device into the anterior teeth (larger groove for maxilla, smaller for mandible) and bite down for 20 to 30 seconds on each against each opposing arch (**Figure 3**). Following this, patients should bite down on the ridged Enhanced Posterior Seating (EPS) arm of the Munchies Maintain on the posterior teeth for 20 to 30 seconds on both sides of the mouth (**Figure 4**). Patients will note that their retainers will fit more intimately within 60 seconds.

Minor relapse correction

Many patients are inconsistent with their use of their retainers, and minor relapse is a common sequela. If relapse is detected early enough and adequate space is available, the aberrant teeth can be moved back into the correct position with the use of clear retainers and the Munchies Maintain device.

The patients' contact points, adjacent to the relapse site, should be checked carefully to ensure that no collisions have occurred. The clinician may need to provide relief of these areas using an IPR strip.

The practitioner should then instruct patients to wear their clear retainers as they would their aligners, for 22 hours per day, and use Munchies Maintain each time the retainers are inserted. The rigidity of the retainers, and the optimization of fit with the Munchies Maintain, should enable the teeth to move back toward their post-treatment position (**Figure 5**).

Patients should maintain this regimen until the teeth have moved back into their post-treatment position. The health care provider should then check the teeth regularly and replace clear retainers as required.

Traditional approaches to retention have revolved around provision of fixed or removable retainers, with an acceptance that lack of retention will culminate in inevitable post-treatment change. While these tenets continue to apply, our approach to orthodontic retention is evolving thanks to improvements in our understanding of the propensity for post-treatment movement, as well as advances in the material science of retention options. ■

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Practice Management

Empower Your Team to Elevate Patient Experience

by Erin Cherry, DDS

Dr. Erin Cherry owns her office in downtown Denver, Colorado, with her husband Dan. Their practice recently hit Platinum Plus, and she was the 2021 winner of the AACA Golden Aligner Award. One of her favorite things about her job is watching her team experience personal growth and share her passion for exceeding patient expectations. Her favorite patient saying is: "I love coming here, which is weird because it's the dentist." Erin and her husband have 3 kids and 2 very large dogs. They love most things Colorado, especially skiing, and getting outside with the family. Her favorite place in the world is Lake Powell, Utah, because her cell phone doesn't work there.

What do your team members do when they encounter a problem? My team used to look to our leadership to fix it, or worse, complain to one another about it. That's changed over the last several years. Now my team is empowered to create change in our office, and everyone in our practice is dedicated to elevating the patient experience, which has led to personal and professional growth and satisfaction. A huge contribution to the change in our team culture has come from the implementation of "projects," and it's something any practice can incorporate into its culture.

For several years my team has set aside one day at the beginning of the year for an annual planning meeting. We celebrate the successes of the past year, reflect on the growth we've had, and set goals for the upcoming year. To help us meet our new goals, we end with a huge brainstorming session to come up with ways to provide a better experience for our patients. I used to compile all these ideas in a huge to-do list, go home, and try to figure out how to accomplish it all myself.

At some point, I realized that it didn't make sense to spend so much time away from patients coming up with great ideas to propel our practice to the next level, when there was no time to actually implement many of them. And so the idea of "team projects" was born.

Our planning event still consists of a mastermind session. We come up with a large list of great ideas that will continue to move our practice forward, always keeping the patient experience in the forefront of our minds. But at the end we tell the team members to look at the list and write down a few things that spark joy for them individually. And if they personally make one of those things happen, they're invited on a team trip.

Something amazing happens when you involve your entire team with the solutions. First, the huge to-do list starts to get done; but in addition to the original goal of making your annual planning fruitful, something far greater happens. The team learns to observe areas that need improvement and gains the power to approach challenges in a constructive and gratifying way.

Our leadership team has learned a lot in the process of managing the team projects to make them successful. Here are some of the things we have found important to the process:

Let it go:

We have a vision for our practice, and our job is to translate that vision to our team. When you hire people with similar values and properly articulate your vision, your team members should have autonomy to take on projects of their own without you micromanaging them. They won't always do things perfectly or exactly the way you would have done it, and inevitably, sometimes your team will create work for you to clean up their mistakes. This is where regular project check-ins are important to help support people where they need it. But ultimately, to empower your team, you have to let them go and learn from their own mistakes, which are not only allowed but encouraged.

Let them go:

This concept only works with team members who want to be engaged. Bad attitudes about "extra work" are like a cancer on

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your team, and this is usually a good indicator that it's time to part ways. The good news is that you've now figured out who on your team wants to make the practice better and who just wants to complain.

Make the reward great and have fun with it:

While the ultimate reward is helping your team members create something they're proud of that positively impacts the practice, the team should be excited about the tangible reward they earn. This year our team is earning a trip to the Dentsply Sirona World Conference in Las Vegas. Big conferences are a great way to reward your team and also to have people "earn" their way. Spoil your team; they deserve it!

Create a timeline for accountability:

The timeline has been key to our team's success with projects. In addition to teaching project management skills, a timeline helps ensure accountability and communication within the team so that people can collaborate and avoid reinventing the wheel. It also allows the leadership team to provide redirection when needed.

We require everyone to bring a worksheet filled out each month and update the team on what they accomplished the month before. Here is how we've broken down our year, with the questions that make up each month's worksheet:

JANUARY—Annual planning meeting

- As a team, brainstorm ideas on what could be improved in the practice.

FEBRUARY—Identify a problem

- What is the root cause of this problem?
- Whom have you spoken to in finding the root cause of the problem?
- Is there a realistic resolution to the problem?
- What are several different ways in which this problem can be solved?
- What is the estimated cost for completion of the project?
- Do we have the resources to complete the project?
- Do you have enough time to complete the project?
- Who are the major contributors to this project?
- What might cause the solution to fail?

MARCH—Communication

- Whom have you discussed your solution with?
- What have you found out from your conversations?
- Do you have the support from the right people to complete your project?
- What steps are you taking to stay on target for your project?

APRIL—Gathering and building

- Here are the skills, items, or purchases that I have acquired to complete my project:
- The following outlines the budget for my project:

Figure 1: painting a mural for the waiting room.

Figure 2: Katie demonstrates the iTero.

MAY—Training and bug fixes

- I have trained the following people on how to utilize my solution:
- I have followed up with the following people to ensure they know how to utilize my solution:

JUNE—Go live

- The team started utilizing tools to execute my project on (date).
- I have followed up with the team members to ensure they are able to use the tools for my project in the following ways:
- The following challenges were presented upon going live with my project:
- I came up with the following solutions to these challenges:
- I will follow up with the team on (date) to ensure no additional challenges are encountered.

JULY—Earn your ticket

- Prepare a 5-minute presentation for the team describing your project and how it furthered the practice's core values. Name one thing you learned about project management and what you enjoyed most about seeing your project to completion.

We plan our trip for late fall, allowing enough time to book flights for those who earned it. While we don't have official projects that people work on in the fall and holiday season, the team members are now empowered to take things on when they see a need and also to start preparing ideas for next year's project.

I no longer come home from annual planning meetings feeling overwhelmed by the number of to-dos that fell solely on my shoulders. With team projects, there is power in numbers, and people come up with projects I'd never be able to do or come up with on my own. One of our more artistic team members painted a beautiful mural in our waiting room (**Figure 1**). Another created a partnership with a local yoga studio to trade yoga classes for dental cleanings. Lab instructions were laminated and attached to all the iTero machines so that scans are done correctly every time (**Figure 2**). Training manuals were created. Most importantly, our team members have so much pride in the things they've helped to accomplish that they're excited and empowered to find solutions to challenges we face, and they have the tools and support to implement them. ■

You're a Master Aligner: Now What?

How Refocusing on More Than Cavities and Cleanings Changed Me—The Children Are Our Future

by Sarah Pless, DDS

Chances are, if you've been around "The Game" for a while, your AACA experience involves the Invisalign journey from Silver to Gold to Platinum to Platinum Plus (and on and on). You might have made major career moves: opened a new practice or two or purchased five of them, or added associates to do the bread-and-butter stuff. You've met Ari Gold and Slater.

What next?

Understanding how malocclusion caused teeth to chip and ruin my best-intentioned dentistry was a game changer. For several years in my previous group practice, I had worked hard on earning the trust of inherited patients but always felt, as the "baby" dentist in a well-established practice, that any new services I'd recommend would be met with resistance.

Dr. Sarah Pless attended dental school at the University of Illinois at Chicago. Integrating a game changer like Invisalign after Reingage was a stepping stone to her solo practice, Renaissance Dental Studio, which she opened in 2018. Her new studio was featured in *Sidekick* magazine. She has presented at AACA study clubs on her experience staying innovative in practice, and at The Inspiration Lab on workplace culture, as well as contributed to *Dental Products Report* and *ProdPod* on how technology has revolutionized the dental patient experience.

Turns out, linking a procedure patients were largely familiar with—a crown after a tooth cracked—to a root cause—malocclusion—was not much of a leap for them. It was so invigorating to discover that a lot of patients were keen to hear about more than cavities and cleanings. Wellness in general was catching fire in a growing segment of the population.

So when I learned about HealthyStart at (where else?) an AACA event, having established Invisalign as everyday dentistry in my practice made me 100% up for the challenge of introducing a new service to my patients. Dr. Jill Ombrello showed me that things I'd "watched" my whole dental life (worn primary teeth, crooked kid teeth, foggy mirrors during kiddo hygiene checkups) were the precursors to all the malocclusion that I couldn't stop telling my adult patients about. I was floored.

And then my thoughts turned to my own 4-year-old Marin (**Figure 1**), who happened to be along and sleeping next to me

Figure 1: the author with her daughter and first HealthyStart patient.

in the hotel bed. Until that night, I'd had no idea that she was sometimes sleeping with her mouth wide open and snoring, and sometimes sleeping with her mouth shut and grinding her teeth; but I certainly had noted her increasing meltdowns during family outings and how she'd often wake up in the middle of the night crying, and I had no idea what we were going to do about it.

Dr. Jill explained that I had the power to intervene in my littlest patients' lives and rewrite their dental futures. HealthyStart appliances could help treat root-cause issues that we were largely taught in dental school to ignore but that likely wouldn't get better on their own. As the kids say these days, IYKYK (If You Know, You Know); there was no way to unsee this information.

If I'd found a way to introduce malocclusion talk to my adult patients, didn't I have to find a way to show parents these red flags during our hygiene conversations? Wouldn't they want to know that we have a proactive option that is noninvasive and gentle, and harnesses their child's own growth (**Figures 2a-b**), instead of waiting until all the baby teeth were lost to refer for traditional orthodontics and a lifetime of relapse? Forget this: Mama's got a brand-new bag!

For those that don't know, HealthyStart is a system of appliances, mostly worn at nighttime, that help guide a child's developing dentition and ideal oral habits (tongue posture, nasal breathing). These appliances have been around for 50+ years and have been used in over 4 million patients. The main barrier to entry for dentists to recommend this product to their pediatric patients is compliance. The kids have to wear the appliances as prescribed for the intended changes to occur. But if Reingage had given me:

- the courage to go all in on something "new" to my trusting patients
- the nuts and bolts to execute a new system (technology recommendations, consult verbiage, forms, fees)

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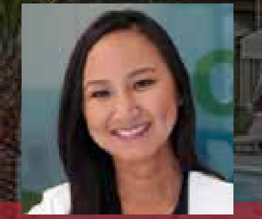

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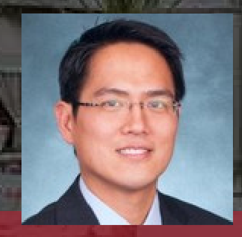

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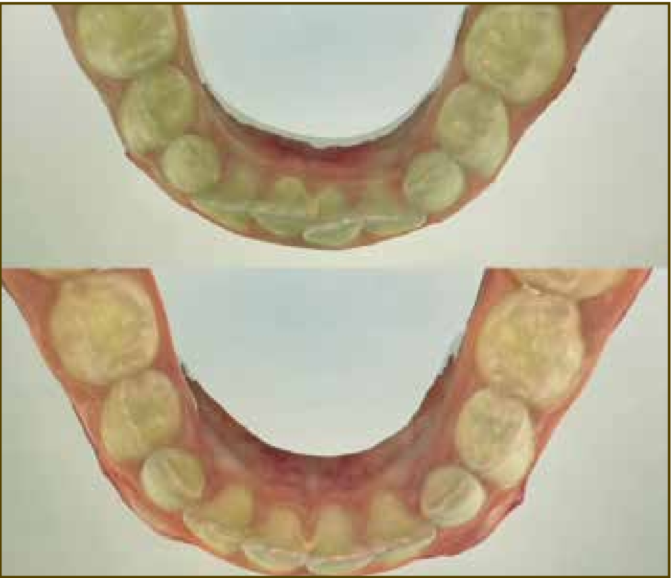

Figure 2a: mandibular alignment before and after HealthyStart.

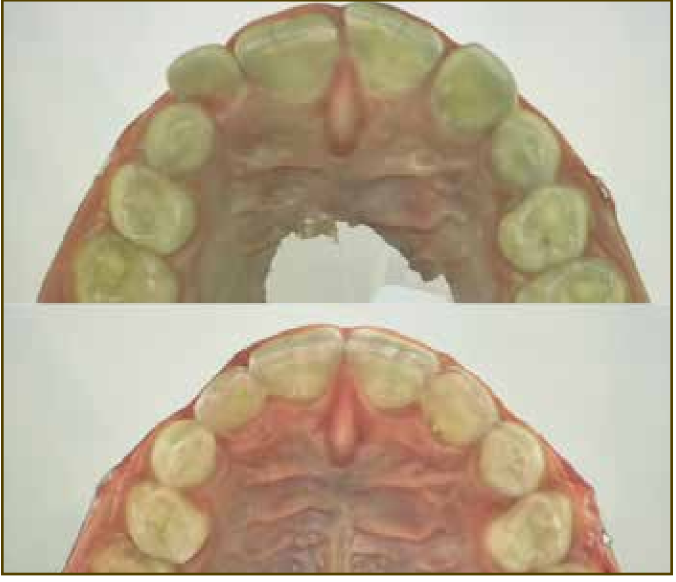

Figure 2b: maxillary alignment before and after HealthyStart.

- the most generous community that lets you ask all the questions as newfound situations arise

…what in the world was I waiting for? With AACA HealthyStart trailblazers like Janice Lo and Kristin Soileau, the vast experience of docs like Rob Herron, and HealthyStart's own John Gregorson on the WhatsApp chat literally every minute of the day, it was time to go for it.

Marin started wearing her first nighttime appliance, and it fell out, night after night after night. Hello, WhatsApp! Hmm, another AACA doc has tried a healthy "incentives" program (i.e. bribing) to get the kids on board. Bam! It worked and we haven't turned back since.

I've weathered the common parent challenges as a HealthyStart mom, and it's amazing to watch Marin sleep peacefully at night now, soundly breathing through her nose, able to make it through the whole day without needing a nap. My personal parental experience has only strengthened my professional resolve, and we have now started over 100 kids in HealthyStart appliances over the last 2 years.

I still get goose bumps watching parents connect the dots about their kids' symptoms and leaning on me, the DENTIST, to help. Watching a 7-year-old girl go from being bullied about her bucky front teeth, with Mom in tears recounting their history, to a complete change in her face with the resolution of her 8-mm overjet from wearing a soft plastic appliance overnight…it's changed my professional life. Composite fillings just don't quite hit that much anymore.

Since I was the only dentist in town offering this "new" service, a lactation consultant reached out to inquire if I'd be interested in joining their Tongue Tie Team locally. They'd been helping struggling moms and babies with TOTs (tethered oral tissues) find dentist providers who could release affected tissues negatively impacting breastfeeding.

Turns out, my second child Teddy is severely tongue-tied and has been since day 1. As a dentist or a mom, I had no idea how that could impact breastfeeding and other things too (speech); we certainly had a challenging experience. Some of my most upside-down days were after his delivery, trying to work out the mechanics of breastfeeding him after I'd had an OK time with Marin. If I could help even one mom with this issue, especially in my work life, I was all ears.

We had Invisalign: check. HealthyStart: check. Tongue-tie releases? Let's do it.

Swaddling a weeks-old infant and using a laser in its tiny mouth was a very similar feeling to accessing the pulp chamber for the first time in dental school. I woke up at 2:30 am the first day we held tongue-tie clinic in my office. My guts were in my throat. It was like that every Wednesday morning for a few months, but as the weeks ticked by and I'd see the moms at the weekly post-op checkups and hear how they'd had improvement in their latch pain and the baby was more content, Wednesdays became my favorite mornings at the office.

I have tongue-tie moms who now bring in their older children to be evaluated for HealthyStart since we've spent time talking about mouth breathing and snoring in babies—and HealthyStart moms calling when the newest addition is born, and breastfeeding is not going so well. Again, composite fillings are more and more in the rearview.

There's nothing like helping someone on their journey; what we do as dentists is no small task. Sometimes, it can feel humdrum, and tedious, and not very fulfilling as the years tick by, but what a gift Invisalign via Reingage has been to so many of our professional lives. For me personally, the supportive culture around the AACA has encouraged me to keep growing and keep pushing.

Just like Slater would say to Jessie Spano, "You got this, Mama." ■

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Jack's Corner

by Jack Von Bulow, DDS

Grit

Just when I needed inspiration, it came by way of a phone call. I'll explain a little later.

So, I've been a private dental practice owner since before LeBron was born, but I've never experienced anything like the last 18 months.

The leadoff 3 months or so was like spring break times 14 with a survival theme. Like Kwai Chang Caine in the old TV series *Kung Fu*, I spent my days walking the land (Pasadena)…and looking at worst-case-scenario spreadsheets. I hung by my hands from doorways while breathing deeply (checking my respiratory prowess) and found myself glued to CNN and the New York governor every morning, hoping I could remain "Rose City tough."

There's something happening here

When late June arrived, I began wondering if science could generate a vaccine for non-drug-related personality change reversal. Back in the '60s, Buffalo Springfield observed, "Paranoia strikes deep; into your life it will creep…" Hmmm.

And after ringing in the New Year watching a televised attempted coup d'état, I virtually attended a special winter meeting coming straight outta the Gaylord, just outside of Denver. And it wasn't just any seasonal meeting: it was the American Academy of Clear Aligners (AACA) Presidents/KOL gathering. FYI, the AACA is the top-producing Invisalign group in the world.

Our leader and founder, Dr. David Galler, is the foremost Invisalign educator on the globe. I wound up being elected as president of my group when nature called, and I returned to find 30 colleagues who couldn't make eye contact.

The winter meeting sets the tone for the new year and explores vision, goals, and purpose. And while dentistry and the rest of the world settled into a survival mode in 2020, the AACA vowed not only to survive but to thrive. While 2021 promised only uncertainty, we sought to stay in our bubble and manage only what we could control and how we could grow.

Playing well with others

The winter meeting also presents an opportunity for collaboration with other like-minded organizations and a chance for creating synergy and lasting relationships.

One of the presenting business owners was a registered dental assistant from San Francisco. Jannet Ly and her mom had started a business from the family kitchen. I hadn't heard of the PULTOOL.

Starting back in 2012, Jannet's device had rescued Invisalign patients from countless potentially fractured fingernails, streams of expletives, and future bad attitudes engendered by varying degrees of difficulty during the removal of orthodontic clear aligners. As she faced a sometimes-tough audience, Jannet's grit melted my heart…all the way from Colorado to the friendly stay-safe-at-home confines of Pasadena.

> *"I began wondering if science could generate a vaccine for non-drug-related personality change reversal."*

I later ordered removal tools and Fizz Me packets (the Fizz Me cleansers keep aligners fresh and clean). I noticed PUL had expanded beyond the removal tool to offer an array of super-helpful products.

Get up and do what needs to be done

As 2021 progressed, Dr. Galler (the heart and soul of the AACA) tasked presidents to stretch their responsibilities and look for passion as fuel for the missing fire. I wound up helping out with the AACA *Journal*, writing a quarterly column, and sharing inspirational quotes with close to 3,000 members Monday through Friday.

I pitched Galler the quotes because I was already opening our daily morning huddle with a quote…and hopefully, a message. I offered clues and even prize money for the first team member identifying the author. Actually, since returning in June 2020,

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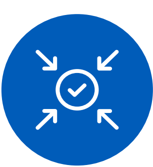

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I'd felt as though I was suffering from COVID-19 PTSD. I needed inspiration I could share with my team.

About a month ago, I saw a patient who hadn't managed to remove his locator-supported upper full denture in a year. I grabbed the PUL removal tool, and the patient had the appliance out in seconds. (We both jumped as if we'd just seen the same ghost.)

Later in the week, team leader Dani (also an RDA) left me a Post-it, asking for more Fizz Me packets. I conservatively ordered the packets and removal tools online. And within 10 minutes, I received a phone call…from PUL Founder/CEO/RDA Jannet Ly.

Jannet helped me order far more effectively. I shared my admiration for her determination. But I really didn't know Jannet's story until I tracked her down on LinkedIn.

In Jannet's article, titled "Nothing is Going According to (my) Plan" (**https://bit.ly/3f6p7OO**), she shares her story, including a definition of "grit" as "Courage and resolve; strength of character." And yeah, having read the article (published in April 2020 on the twentieth day of shelter in place), I learned Jannet does define grit.

"I shared my admiration for Jannet Ly's determination."

I'm still sharing morning quotes. And whenever my grit comes into question, I'm inspired by Jannet Ly. ■

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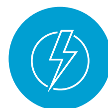

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