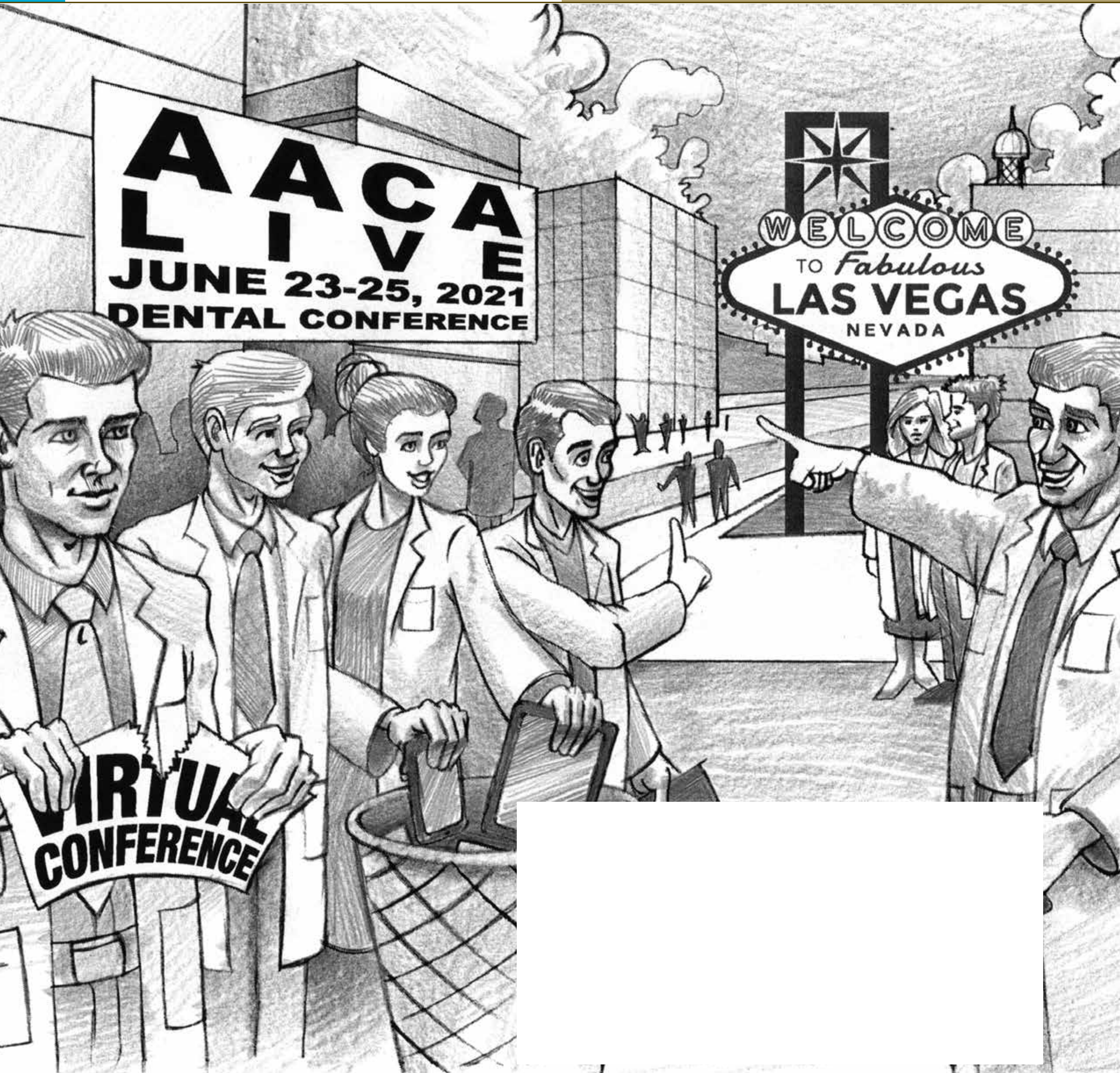
ISSN 2372-0808 (Print); ISSN 2372-0816 (Online)

SPRING 2021

the Journal

American Academy of Clear Aligners

The Academy for Clear Aligner Therapy



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the Journal
American Academy of Clear Aligners

Editorial

What's New in the AACA?

As the Academy grows, so do member benefits.

Members are encouraged to visit the www.aacaligners.com website frequently for the latest on bad reviews and legal assistance; ClinCheck training videos; form letters; assistance from ClinCheck "cowboys" and "cowgirls"; WhatsApp chatrooms; and the newest, exclusive-to-members AACA savings and deals.

Additionally, there are important innovations that deserve your attention.

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Every Wednesday at 9:00 PM ET, the Academy offers free, 1-hour Continuing Education courses. All participants, via Zoom, receive CE credit. Past webinars have attracted over 300 dentists, and have featured a range of topics such as:

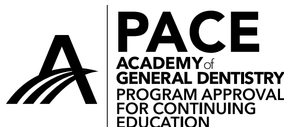
- Can Snoring Kill You?
- Invisalign Changes for Class II Malocclusions
- Say "Goodbye" to Open Bites and Refinements
- Presenting an iTero Scan for Case Acceptance
- Invisalign's New G8 Innovations Explained in English
- Change Your Mind, Change Your Life

AACA Fellowship Award
Members who have attained high levels of achievement in Clear Aligner Treatment deserve to be recognized, and this year's annual AACA convention (June 23–25) will honor the very first class of AACA Fellows.

Members who have qualified for the award will be recognized at a special convocation ceremony during the AACA convention, receive a handsome diploma suitable for display in their offices, and be entitled to write "Fellow of the American Academy of Clear Aligners" on their office stationery and literature.

We look forward to reuniting at the Wynn Hotel, Las Vegas, this June!

Dr. Jeffrey Galler
Editor



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the Journal
American Academy of Clear Aligners

Article is Peer Reviewed

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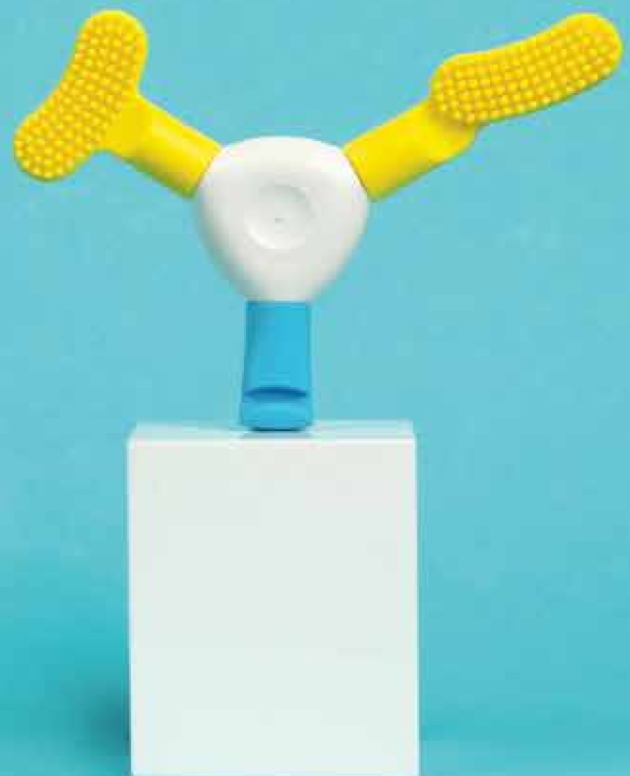

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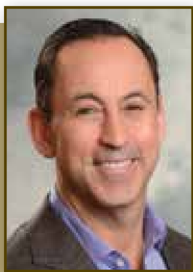
Case Reports

Isiah's Multi-disciplinary Restoration

by Steven Glassman, DDS, Frank Celenza, DDS, and Ryan Wagner



Dr. Steven Glassman reached the level of Invisalign® Elite Advantage Provider in 2005 and has been treating Invisalign patients since 2003 at the prestigious New York City practice he owns with his wife. In addition to being a successful practitioner, Dr. Glassman has published several articles on Invisalign technology, implants, and restorative and laser dentistry in well-regarded publications, including *Inside Dentistry* and *Contemporary Esthetics Magazine*. He has been invited to lecture about Invisalign Clear Aligner Therapy at hospitals and universities across the country. Dr. Glassman won the Invisalign Case Shoot-out in 2005 at the GP Summit. He is a proud graduate of Brandeis University and the Columbia University School of Dental and Oral Surgery. In 2018 he was named to the Zimmer Biomet faculty, adding to the digital workflow of aligners and implants. In 2020, he received the faculty award for 15 years of service.

Abstract

This case will demonstrate the use of Clear Aligners to

1. achieve proper setup for the restoration of the patient's "peg" lateral (tooth #7) and congenitally missing lateral (tooth #10), and
2. treat the malocclusion, specifically lower left first bicuspid (tooth #21) crossbite, upper spacing, and lower crowding.

This case will also showcase digital planning for final restoration that includes minimal restorative treatment involving a crown on tooth #7, and implant restoration, abutment, and crown on tooth #10 (**Figure 1**).

Materials and methods

One of the most important challenges to this case (**Figure 2**) would be to ensure the parallel, if not divergent, root alignment of the upper left central incisor and cuspid (teeth #9 and 11), to

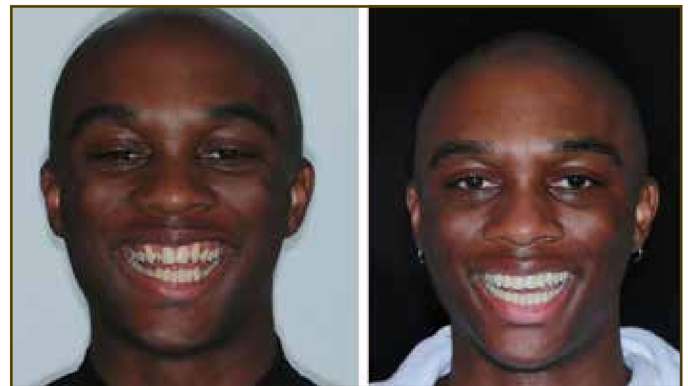


Figure 1: before and after treatment.

allow proper implant placement and restoration for the missing lateral incisor. Since these are the longest-rooted teeth in the arch, and given the limitations of removable appliances for controlling root alignment, the design of the appliance and its proper implementation would be critical to success.

Of primary importance was the design of the attachments. Although the dual-spike attachment is designed to facilitate root control and is the default attachment for this purpose, greater surface area was needed to effectively distalize the cuspid and ensure that the movement did not incur tipping.

Further, throughout the course of treatment, it was necessary to monitor progress via periapical radiograph, as merely relying upon clinical crown position can often be misleading. This last point cannot be overstressed (**Figure 3**).

Consequently, the attachments used for both the central incisor and the cuspid were long vertical boxes, beveled toward the edentulous site. This ensured that an additional ledge of surface area was offered to the aligner to exert force for space opening (which in this case was largely the distalization of the cuspid). As a case like this one unfolds, the clinician must observe the engagement of these attachments by the aligners at every appointment, and if it is noted that the attachment is no longer intimately engaged, a Refinement is indicated immediately to recapture the intended movement.

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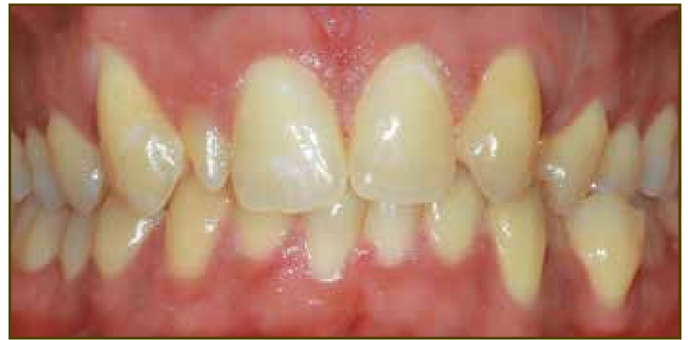
Moreover, anticipating that challenges to the desired movements might be incurred, we included other features in the design from the very outset. This included the provision for a left side Class II elastic, by virtue of a precision cut at the cuspid and a button cutout at the lower left first or second molar (**Figure 4**). Additionally, our design called for the movements of the central incisor and cuspid to be overcorrected by 5 to 10 degrees of root tip, as the aligners might not fully express. However, although we designed these features in from the outset, as the case unfolded we chose not to implement the Class II elastic, as the movements proceeded satisfactorily without it.

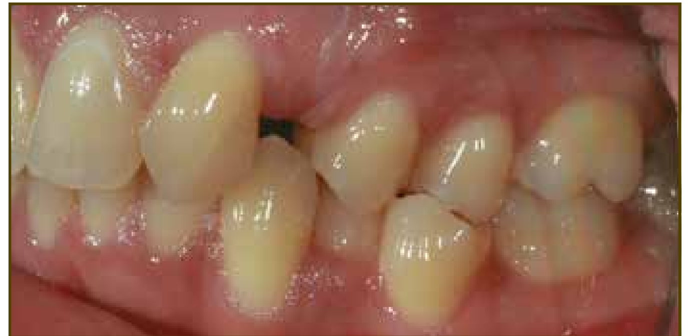
In cases such as this, when the space opening for the lateral incisor is judged to be sufficient, the clinician can proceed with implant placement. This requires that

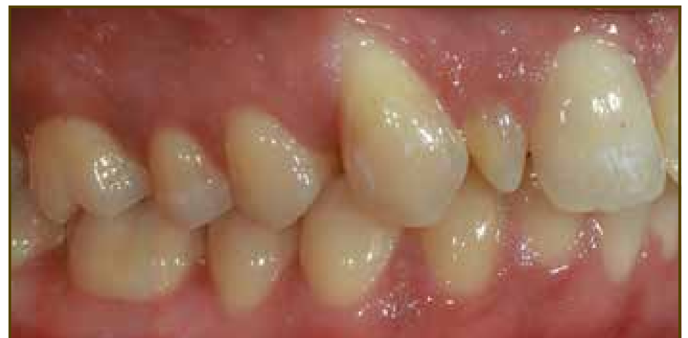
- the midlines are coincident,
- the left cuspid is in a Class I relation, and
- the roots are observed to be parallel, if not divergent, as observed radiographically.

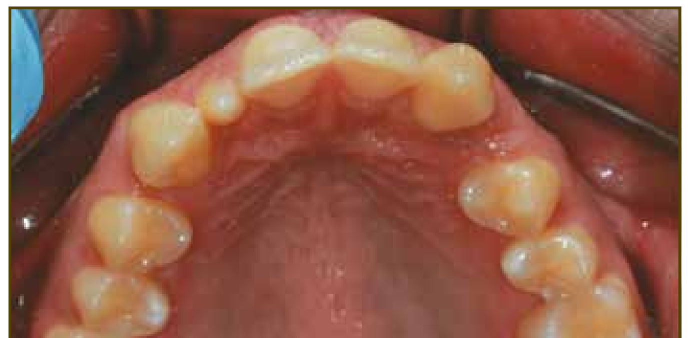
Further details in other areas of the dentition need not be completed if these goals are achieved. Implant placement (and osseointegration) can proceed as the last details of the orthodontic sequence are accomplished simultaneously with implant management. In other words, therapy of various specialties can be overlapped, and it is not necessary to complete each modality before initiating the next. This makes it possible to complete the case faster.

We achieved further expedition of the case through acceleration technology. The patient applied micropulsation









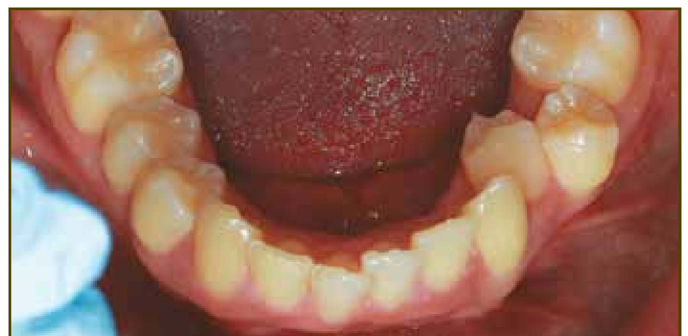


Figure 2: before treatment. Note peg-shaped #7, missing #10, crossbite #21, upper spacing and lower crowding.

Dr. Frank Celenza is a second-generation dentist, son of an internationally acclaimed teacher, author, and speaker in the field of prosthodontics. Dr. Celenza Jr. is uniquely dual-certified in both orthodontics and periodontics.

This dual specialty positions him to a deeper appreciation and understanding of the adult dentition, from treatment planning to treatment execution. He has been involved in postgraduate teaching for over 20 years, is widely published in the dental literature, and has written many textbook chapters. Dr. Celenza has pioneered techniques and innovations in his field, and his work combining implant dentistry with orthodontics was groundbreaking.

Outside of dentistry, Dr. Celenza is passionate about motor sports, cycling, and bass guitar. He was raised on Long Island, New York, resides in New Jersey, and has 3 children.

Dr. Celenza has offices in New York City and Westchester County, New York.

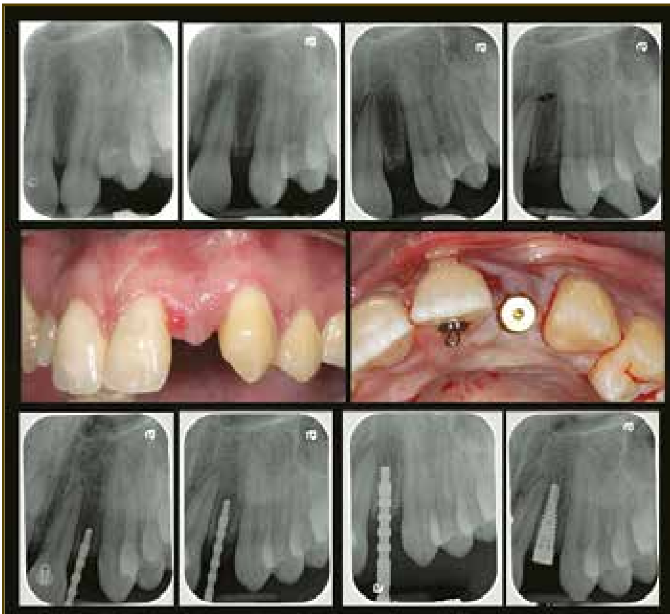


Figure 3: creation of sufficient space and placement of implant #10. Note the importance of radiographic monitoring as the space develops. Merely relying upon clinical crown position can often be misleading.

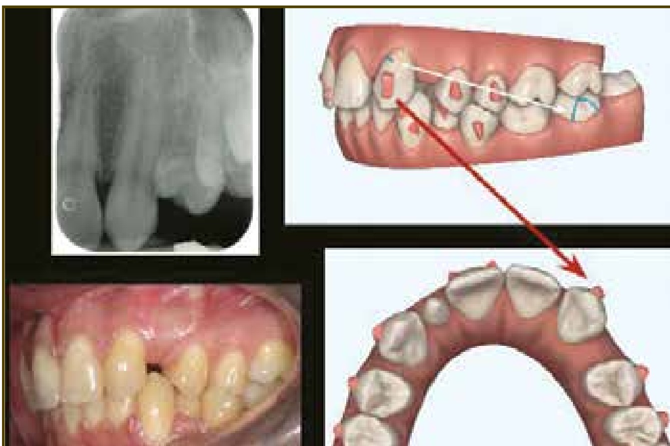
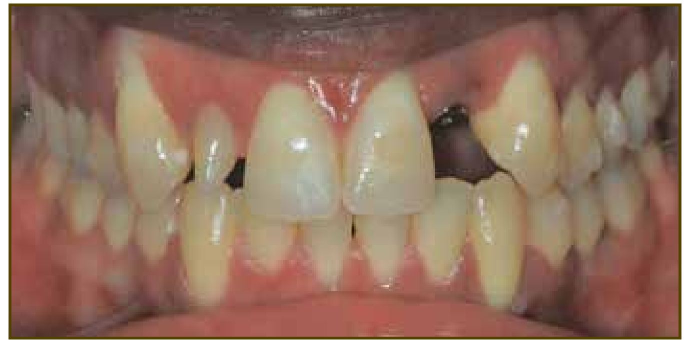
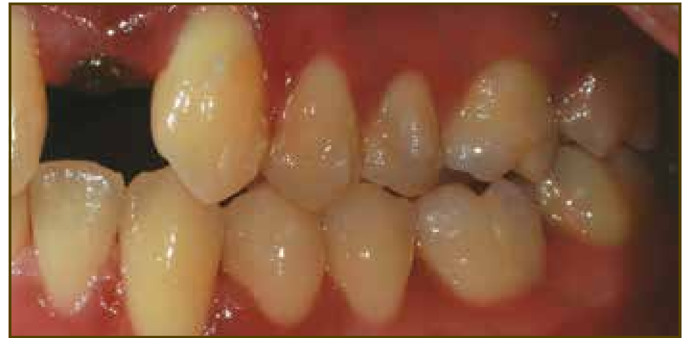


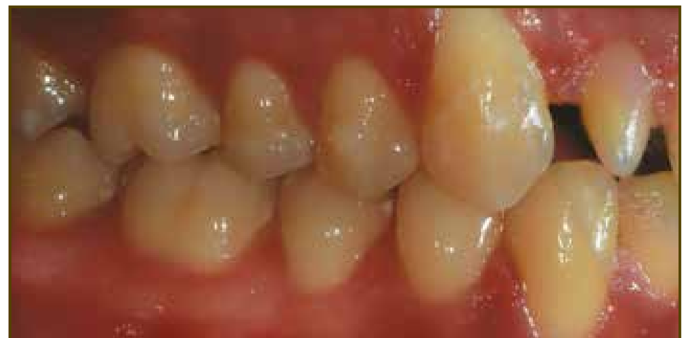
Figure 4: provision for a left side Class II elastic. Movements proceeded satisfactorily without it.

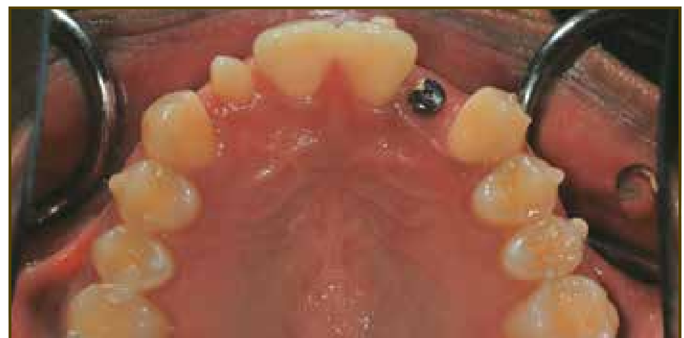
stimulus to his teeth on a daily basis throughout the treatment, using the AcceleDent device according to the manufacturer's direction.

We performed implant placement under local anesthesia, using a largely flapless approach, and again monitoring the procedure radiographically. Implant procedure is as follows: The first 2.5 mm diameter drill is introduced to the osteotomy site to 1/3 depth, and checked radiographically with a guide pin in place. This is followed by drilling to half depth and correcting for any directional needs, and again taking a periapical radiograph with a guide pin placed. If the clinician is confident that the angulation is correct, the osteotomy can be completed to full depth and diameter, and a tapered profile implant (Thommen SPI Contact RC Inicell 3.5 × 11.0) placed. Proper coverage (by healing abutment) is followed by any necessary tissue closure, and the aligner is checked to ensure that there is no contact with the head of the fixture. Further









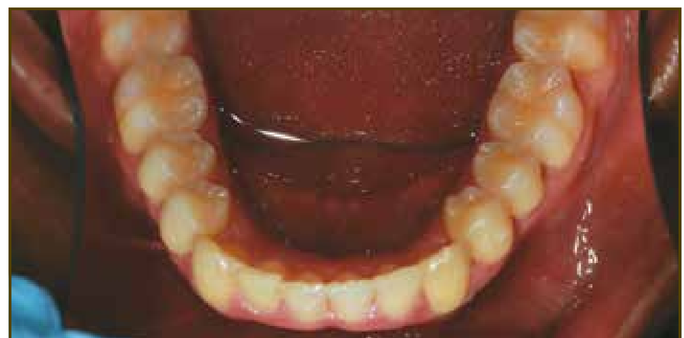


Figure 5: after Invisalign movement and after implant placement.

and finishing aligner treatment steps can ensue, as proper time for osseointegration is allowed to elapse. The time needed is a function of the bone quality, initial stabilization, soft tissue maturation, and other factors.

In this case we allowed 10 to 12 weeks. Following that time, we directed the patient back to the restorative dentist for restoration (**Figure 5**).

The orthodontic treatment required 44 sets of initial aligners, which the patient wore with weekly changes in conjunction with acceleration, for a total of 44 weeks. This was followed by 10 sets of Refinement aligners, for an additional 10 weeks.

Final restorative treatment

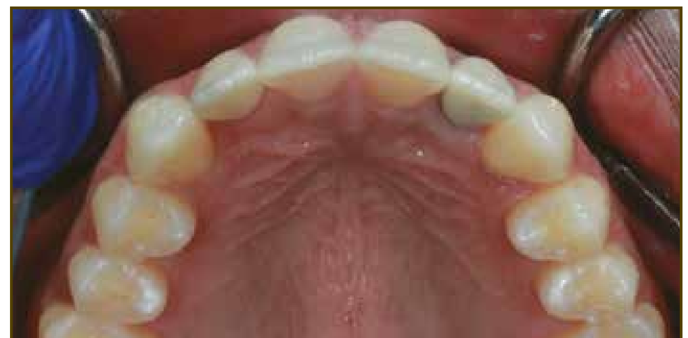
The patient returned to the general dental office after the implant had integrated and the Invisalign treatment was completed. After taking photos and an iTero scan, we worked the case up digitally through a dental lab that used the 3Shape software program to plan the restoration on the peg lateral (tooth #7) and the implant restoration (tooth #10). The laboratory printed a model from the designed case along with a clear matrix.

Ryan Wagner is a senior at Elon University in North Carolina, in pursuit of attending dental school in the fall of 2021. He has conducted behavioral research, tutored, and volunteered both at local clinics and in the greater Elon community. Ryan spends his free time traveling, painting, and participating in real estate renovation projects. He has honed his technical and personal skills working at Dr. Glassman's New York City dental practice, and is eager to join the wonderful profession of dentistry.

The patient returned a week later, and we prepared teeth #7 and #10 for the next step in final restoration. We anesthetized the patient and prepared #7 for a full crown. We used the temporary metal abutment at #10 to support a screw-retained bisGMA provisional restoration to develop the soft tissue for optimal soft-tissue esthetics.

We explained to the patient that we would continue to monitor the esthetics of the case and adjust the provisionals as needed. The patient also underwent in-office whitening at this point. Photos of the provisionals were taken and evaluated.

After 2 months, the patient returned for final evaluation. We took final scans of the prep on tooth #7 and (using a scan body) of the Thommen implant at #10. It was important to capture the developed gingiva and emergence profile of #10. iTero offers the ability to take a pre-scan of the provisional, which the



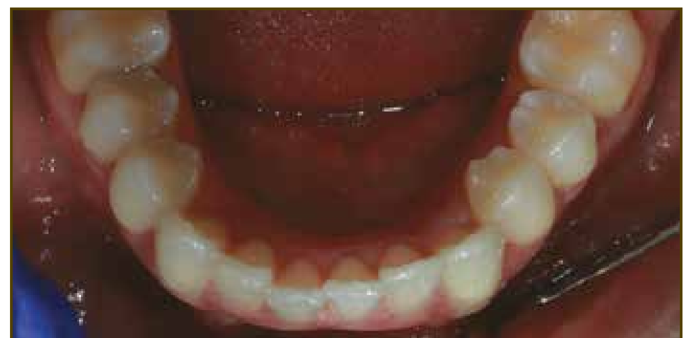


Figure 6: after treatment.

lab can use to determine the outline of the provisionals of the prepped teeth and soft tissue of the implant.

At this appointment, we discussed with the patient any possible changes from the provisionals to the final restoration, and also final color changes after the whitening. One of the challenges in making a natural implant restoration is masking any metal from the implant platform subgingivally so that a greyness will not show through the gingiva. The restorations we chose were lithium disilicate, with a gold-hue custom CAD abutment. The lithium disilicate crown would be cemented (using Improv cement) to the abutment. The patient then returned to the ortho/periodontist to be scanned for Vivera retainers (**Figure 6**).

Conclusion

The authors have presented the treatment of a commonly encountered case type: namely, a congenitally missing maxillary lateral incisor, which is frequently accompanied by a misshapen (or peg) contralateral incisor. A challenging treatment plan was carried out using modern digital technologies and planning strategies. The case was first set up orthodontically, using aligner appliances in conjunction with acceleration technology. The next phase was surgical implant placement, followed by digital restorative methodology. The clinicians attained a pleasing result both esthetically and functionally, in a very reasonable time frame, with no untoward side effects.

With the movement from analog to digital technology, this has become our mantra: "In order to plan, we must first digitally scan." ■

Case Reports

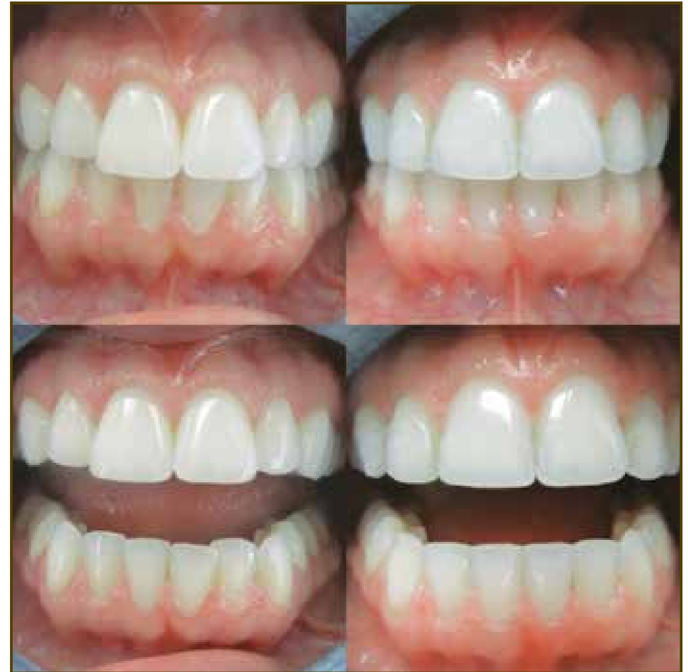
Solving Laterals With a New Approach

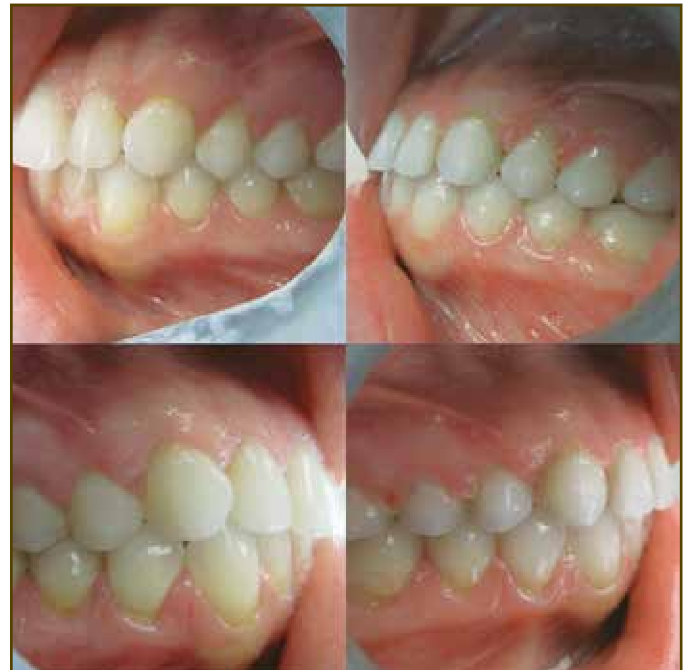
by Michael I. Wollock, DMD

Extruding maxillary lateral incisors requires 100% compliance. However, a lack of compliance is the first, second, and third reasons Invisalign movement can be ineffective, especially with difficult or technique-sensitive movements. Because of their small size and conical shape, extrusion of lateral incisors is a technique-sensitive movement. With the combination of a removable appliance and human nature, we will never achieve 100% compliance. But, by making it easier to comply, we can increase the odds for success.

Dr. Michael I. Wollock graduated from the University of Medicine and Dentistry of New Jersey, class of 1996. In the U.S. Air Force, he received the Commendation Medal for Meritorious Service. In 2001, he became a Fellow of the Academy of General Dentistry. In the same year, he opened his practice in the Philadelphia metro area. As of 2021, he was on pace for 700 cases a year, achieving over $3.4M annually in collections even in a pandemic.

He currently serves as a board member for the American Academy of Clear Aligners (AACA) and president of the Aligner Empire chapter. The AACA has been the biggest provider of Invisalign in the world, and within the AACA, Dr. Wollock has been the biggest producer every year for the past 4 years. He is a founding member of the High Rollers, made up of some of the highest-producing Invisalign dentists around North America. He serves as an educator and consultant for Align Technologies. Now he is sharing his vast Invisalign knowledge through his Diamond Club Makers course: www.DiamondClubMakers.com





Kelly, before and after treatment.

Over the past 4 to 5 years, with over 1,000 patients, I have had most eat with trays in. These patients wear aligners 24 hours a day, taking them out only to clean. This change in protocol has significantly increased compliance. As well, it has decreased common pitfall moments—such as patients taking trays out at lunch and forgetting to put them back in until driving home that evening, or any of the dozens of other examples of noncompliance we hear so often. As a bonus, lost trays have virtually ceased. It turns out to be impossible to lose a tray when it's in your patient's mouth.

It is not only the increased time of wear that benefits movement. It is also the masticatory forces working with tray movement, rather than potentially against it, that enhance outcomes. After the first week of patients being committed to the idea of doing Invisalign better (and as a side effect, quicker), they find it easier to comply with wearing trays "24 of 24" than eating without them in. Of course, we have them remove the trays after every meal to rinse the trays and their mouths, as well as brushing (and flossing) twice daily.

In addition to eating with them in, I have patients change trays every 7 days as a matter of routine. This will automatically take

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the average 20-tray case from a standard 10 months down to 5 months. In most cases that take over 6 months, even with a dedicated patient, compliance drops significantly, resulting in increased rates of failure, especially with difficult and technique-sensitive movements.

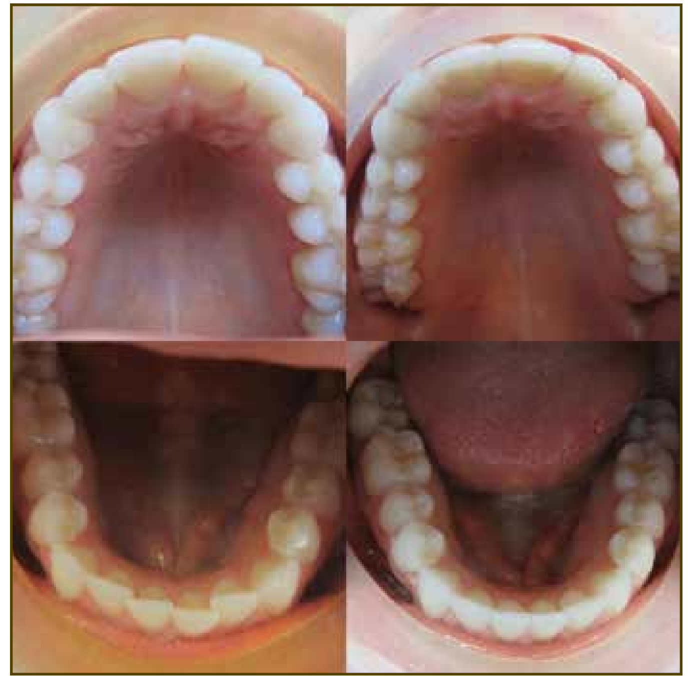
The fourth, fifth, and sixth reasons movement fails and cases head to Refinement are things that we program into tray movement and are within our control. This is where failure of lateral extrusion can also originate.

Successful lateral incisor extrusion requires understanding the causes of failure and then compensating for such. As a patient wears a tray over the course of 7 or even 14 days, most if not all of the movement from the tray happens in the first 2 to 3 days. Ask your patients how long they feel any pressure from a tray; they will confirm this. If correct, the tray has become inactive for its remaining use. And likely, that tray stretches and deforms over that remaining inactive time. Try having a patient wear a treatment tray for a year after completion and see how well it works to retain teeth. After that year, it may fit well where the teeth are, but those teeth are no longer where you left them upon completion. So, we know trays stretch over time.

Now, imagine a tray extruding a lateral incisor for 3 days. Assuming we normally have patients change trays every 14 days, that tray sits around the lateral for another 11 days, inactive and probably deforming/stretching. That lateral ever so slightly rebounds or shifts out of the exact predicted position owing to the current tray stretching. As a result, the next tray doesn't fit perfectly because that tooth is no longer in the ideal predicted position. Then repeat that scenario on the next tray, and the next, and beyond. Now, each tray fits less and less perfectly until it no longer engages the tooth. As a result, extrusion stops. Then we order more trays for a Refinement and try it again, and again, and again. Unprofitable chair time accumulates. Patients and providers become frustrated. Now we are headed toward Refinement hell—unless we try a new approach.

For lateral extrusion, I purposely slow the tray movement from the standard 0.25 mm each tray, down to 0.125 mm, changing trays every 4 days, with a simple extrusion attachment on the laterals. This is not rocket science, or witchcraft, or specialized orthodontic wires/rubber bands. This slower movement but faster tray change protocol results in more consistent, predictable movement of the lateral while mitigating the deforming potential of a tray. With this new tray protocol in combination with wearing "24 of 24," the odds of success significantly increase. Profitability rises, along with patient happiness, and we are enjoying building a more successful Invisalign practice within our general dental office. Note: this works best when not combining with other movements such as rotation.

The case of Kelly is one simple example of many that demonstrate how effective and predictable maxillary lateral extrusion can be with a new approach (**see Before and After photos**).



Kelly, before and after treatment.

Kelly's treatment, from first to last tray, took 25 active treatment trays at 0.125 mm per tray, totaling less than 4 months.

The real measure of success is the chair time required to achieve the patient's goals. This case took 2 hours and 50 minutes of scheduled time: a 10-minute video consult with me, 30 minutes of data collection by my team, a 10-minute ClinCheck review with me, and 2 hours of treatment time (1:50 of team time and only 10 minutes of my time). In total, 30 minutes of my time and 2 hours 20 minutes of team time.

The patient was happy and left an amazing review, which can only help to generate more Invisalign cases for my office.

This is just one small tip that is part of a larger review of my entire high-producing Invisalign program that I share in my Diamond Club Makers course: www.DiamondClubMakers.com. ■

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WEDNESDAY—JUNE 23

12:00 pm: Registration
12:00 pm: Convention Floor Open
3:00 pm: Opening Session—ToGetHer(e)
4:30 pm: Convention Floor Re-opens
9:00 pm: Award Ceremony
Comedy Show
Featuring Dr. David Galler
and Special Guest
Celebrity Star

THURSDAY—JUNE 24

7:00 am: Breakfast
7:00 am: Convention Floor Open (till 7pm)
8:00 am: Breakout Sessions (at the top of each hour)
12:00 pm: Lunch
2:00 pm: Breakout Sessions (at the top of each hour)
7:30 pm: Private Party at Stratosphere (need badge for entry)

FRIDAY—JUNE 25

7:00 am: Breakfast
8:00 am: Workshops
12:00 pm: Convention Ends

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Treating the Dreaded Black Triangle: Bioclear Hands on —**David Clark, DDS**

You Snooze, You Lose... HealthyStart Addresses SDB With More Permanent and Profitable Orthodontic Solutions —**Jill Ombrello, DDS**

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Feature Article

What's Up With "Axial Angle of Tooth Inclination"?

by Perry E. Jones, DDS, MAGD, IADFE

Dr. Perry Jones is a graduate of Virginia Commonwealth University School of Dentistry, where he served as Director of Continuing Education/Faculty Development, as well as Adjunct Faculty, Associate Professor, in the Department of Oral Maxillofacial Surgery and the Department of General Dentistry. He is a Master of the Academy of General Dentistry and served as Director of the Virginia Academy of General Dentistry, Master-Track Program. One of the very first Align Technology GP education speakers, Dr. Jones has lectured extensively, having given some 300+ Invisalign and iTero presentations. He is the co-founder of the AACA. Currently, Dr Jones maintains a private practice in Richmond, VA.

Introduction

Positioning teeth to help create healthy, esthetic, and functional relationships for a lifetime of oral health should be the common goal for practitioners. The axial angle of tooth inclination and angle of tooth angulation are an important component of esthetics, as well as a critical factor in proper tooth function.

Consider the gears of a transmission: when the gears do not align properly, excessive wear, material fatigue, breakage, etc., can occur. Similarly, teeth and surrounding structures such as bone and soft tissue may exhibit abfraction, excessive wear, tooth breakage, gingival recession, and even bone loss. Terms such as receding, chipping, thinning, shifting, and wearing are used to describe the effects of improper tooth alignment. The problem list gets longer when we add to improper alignment the tremendous potential forces of bruxism, grinding, and clenching. Improving axial inclination can improve tongue space and airway volume and have positive impact on airway issues. The issue of proper alignment also applies to restorative/

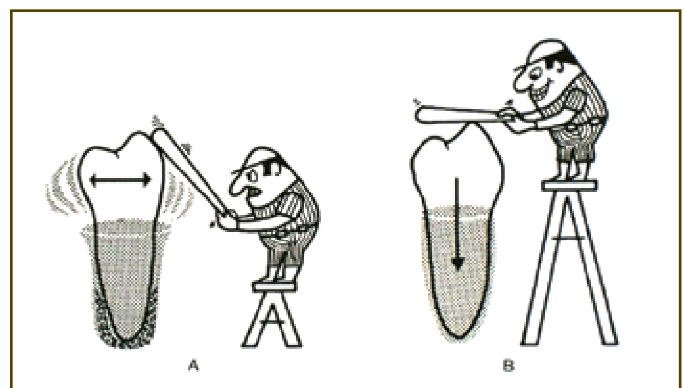


Figure 1: Horizontal vs. vertical.

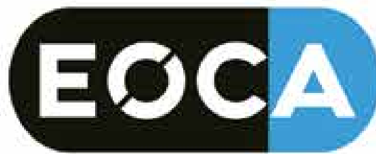
prosthetic solutions, from the simplest to the most complex. Improved occlusal alignment may also serve to benefit function and health of the TMJ.

A simple understanding of applied forces tells us that teeth can best function when forces are directed vertically. Horizontal forces are unwanted destructive forces that can result in abfraction, excessive wear, weakened attachment apparatus, and other consequences (**Figure 1**).

Tooth alignment has been established as important for healthy function.[1] Orthodontic educators from the past have provided important occlusion concepts still used today. For example, Andrews lists "6 keys to normal occlusion."[2] One of these 6 keys is crown inclination in the labiolingual plane. Tooth movement terminology uses the term "axial angle of tooth inclination" to describe this feature.[3]

Using tooth movement terminology, there are 2 different planes in space within which the axial angle is commonly measured.

- The axial angle of *inclination* refers to the axial angle in the buccolingual (B-L) plane. Axial angle of inclination is usually referenced as an angular measurement of the position of the long axis of the tooth.
- Crown *angulation* refers to the crown position in the mesiodistal (M-D) plane. The angle of angulation is an



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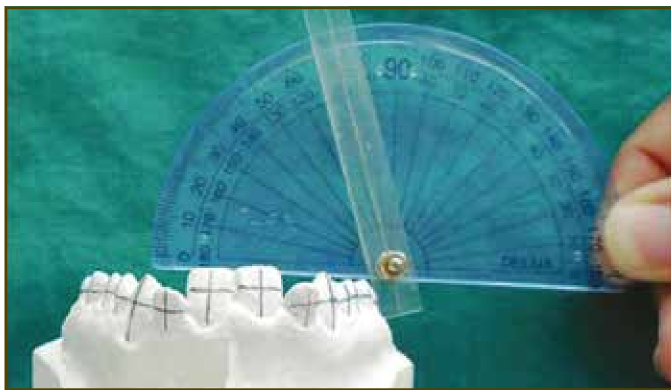

Figure 2: Manual technique for measuring axial inclination.

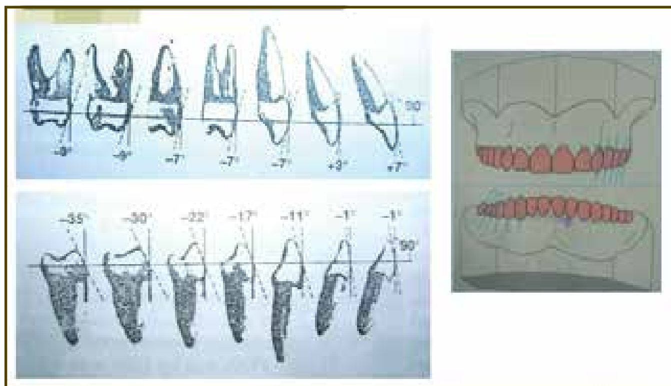

Figure 3: CBCT scan technique for measuring axial inclination.

angular measurement of the crown position of the tooth, commonly termed tip.[3] This term describes the angle the crown "tips" toward adjacent teeth.

Various methods have been used in the past to measure the axial angle of inclination.[4] This angle is especially difficult to quantify with conventional 2D imaging, as for example, a panoramic radiograph does not clearly depict the labial/buccal angle of crown "lean" (axial inclination).

Advances in technology with 3D cone beam computerized tomographic (CBCT) imaging and associated software have made it easier to measure tooth inclination with high reliability and accuracy.[5,6]

Discussion

There are many different tooth position values that can be helpful in identifying problems and in choosing solutions that produce well-defined finished tooth positions. Relationships such as interincisal angle, [buccolingual] axial angle of tooth inclination, [mesiodistal] crown angulation, Curve of Spee, and Curve of Wilson are examples of relationships that have been used to help define orientations of tooth position within the arch as well as between arches.

Although there are many important measurements, the focus of this article will be limited to the axial angle of inclination. This important value is usually expressed in degrees.

Methods of measurement

As noted, there are many different methods of axial angle measurement, as well as many different defined landmarks used as reference.[4] This article will focus on 2 common measurement techniques:

1. A manual technique used on a dental model (stone, 3D printed, or milled) with a tooth inclination protractor (TIP) (**Figure 2**)..
2. Three-dimensional (3D) software that derives the measurement using intraoral digital scan data and/or Digital Imaging and Communications in Medicine (DICOM) data from a CBCT scan (**Figure 3**).

In the case of the manual method of measurement, the axial angle of inclination is an angle measured between a line perpendicular to the occlusal plane and a line parallel to and tangent to the facial axis of clinical crown (FACC) at its midpoint facial axis (FA) point. Note that this is a measurement of angle of crown inclination; it is not the inclination of the central axis of the crown relative to the occlusal plane.

When using 3D data, the measured angle uses the intersection of the central long axis of the target tooth to a common point with the occlusal plane. Note that software can also be used to replicate the manual method of measurement (line tangent to FACC).

Note that many published collections of data include certain "mean" standards for the axial angle of inclination. As these data may have been derived using different methods for measurement, these angular measurements are best used for relative comparison purposes rather than as "absolutes."

This means that measurements for the axial angle of inclination can differ. Most commonly, 3D software is used to define a horizontal plane as passing through the most occlusal/incisal points. This then establishes the horizontal occlusal plane. Digital 3D data can also be used to mimic the "manual" measurement method by creating a FACC tangent line and a line perpendicular to the occlusal plane, in order to measure the axial angulation.

Data sources

CBCT

CBCT technology provides a simple method of determining the axial angle of inclination in any plane in space. Commonly the axial central angle of inclination is measured in the buccolingual plane.

In my office we use two different CBCT systems to acquire records data: a mobile van using a NewTom VGi CBCT 3D imaging unit and a floor-mounted PreXion CBCT unit. Each scanner uses the smallest focal spot (0.3 mm) for optimal accuracy and resolution. The software can be used to measure the various angles of data as desired.

iTero Element Scan data

A second source of 3D imaging data used in my office is direct

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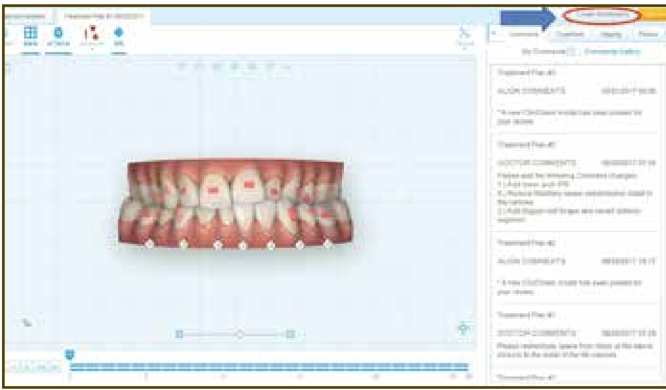

Figure 4: ClinCheck Pro software "Create Modification" selection tab.

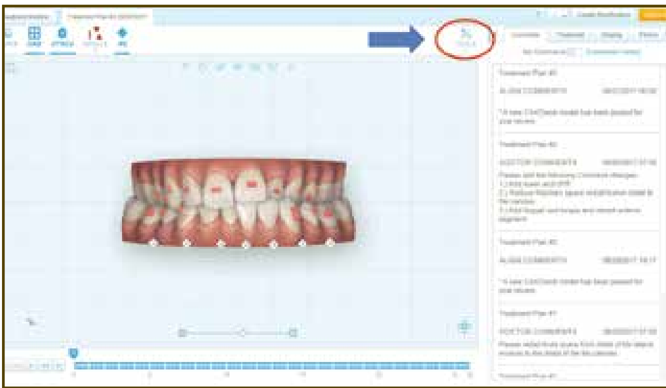

Figure 5: ClinCheck Pro software "Tools" selection tab.

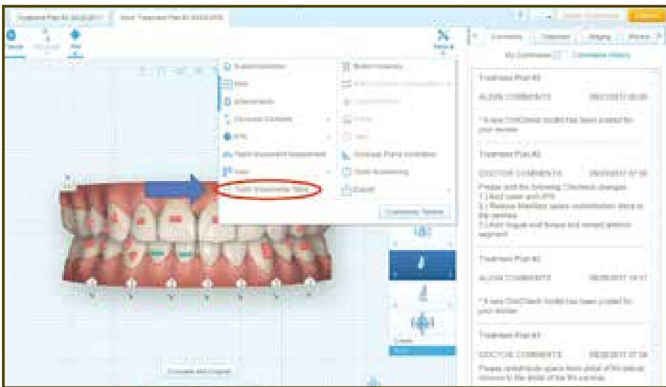

Figure 6: ClinCheck Pro software "Tooth Movements Table" selection tab.

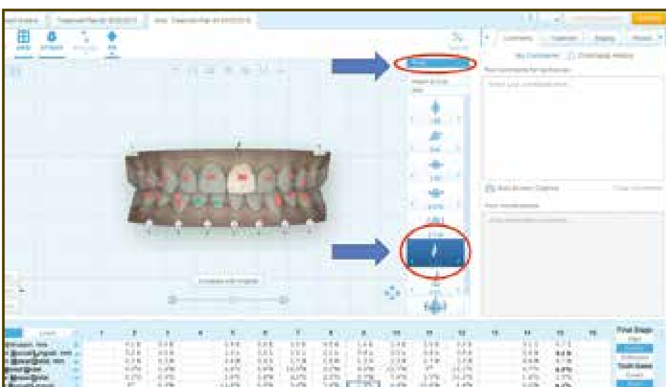

Figure 7: ClinCheck Pro software "Tooth" selection tab.

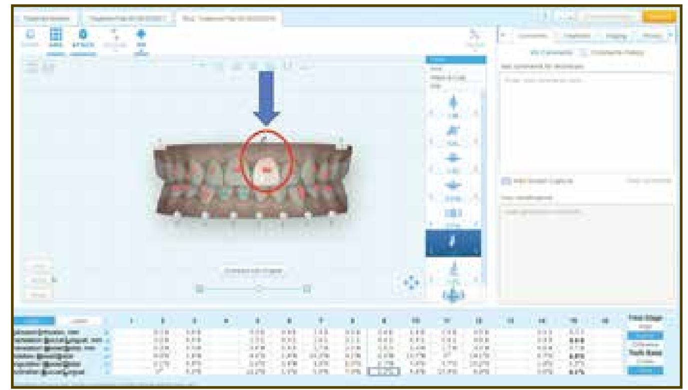

Figure 8: ClinCheck Pro software Tooth selection to highlight tooth "Root" movement feature.

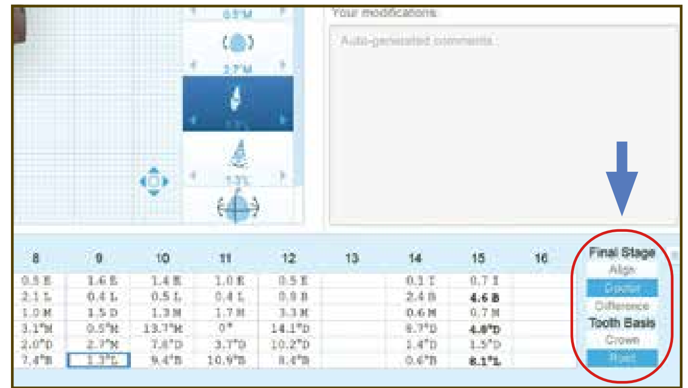

Figure 9: ClinCheck Pro software close-up of "Root" selection tab.

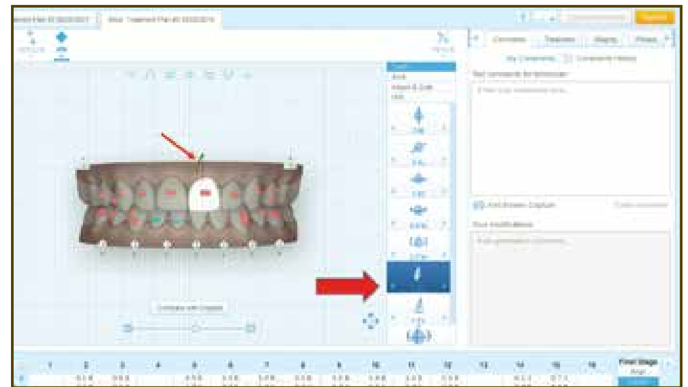

Figure 10: ClinCheck Pro software illustration to show tooth movement/ root selection/B-L inclination numerical axial angle value location.

intraoral digital scanning. We currently obtain intraoral digital scan data using the iTero Element intraoral digital scanner. Acquired digital data can be used as stand-alone surface morphology information to produce a virtual 3D image, or as a data source to merge with CBCT DICOM data for finer-resolution surface morphology information. The clinician sends the scan data to Align Technology for Invisalign submission. A virtual representation of tooth movements, known as ClinCheck Pro, is developed and returned to the provider for evaluation. The ClinCheck Pro software has some 30+ measurement features that can be used to evaluate tooth position. One of these is a measurement tool called "axial angle of tooth inclination" or "Inclination Buccal-Lingual." This tool can be used to show the changes between the initial axial measurement and the final position as forecast by the ClinCheck Pro.

After much discussion with knowledgeable ClinCheck developers, I understand that the reference line for the ClinCheck's "axial angle" is the central axis of inclination in the buccolingual plane, not the labial tangent line (as used with the FACC tangent in the "model" method described earlier). The initial and final values are meant only as a differential reference, not as a final optimal or mean value position. Thus, ClinCheck's axial inclination value must be used for differential comparison reference only, not as an absolute value, and should not be compared to reference tables of optimal or ideal norms. With that said, the measurement remains a valuable one. The next segment will describe where to find the ClinCheck measurement tools and how to use them.

ClinCheck is the virtual representation of tooth movement on a computer screen. The ClinCheck depicts only the crown portion of teeth, but the movement tools can project an interpolated long axis for the tooth. The software uses a generated occlusal plane, to which an angle can be generated using the "interpolated long axis" to create a measurable angle.

In the case of CBCT DICOM information, software can create transaxial slices, or axial slices in the buccolingual plane, that can then be used to define a line that represents the long axis of the tooth. Using the line of the long axis of the tooth, and its intersection with the horizontal occlusal plane, a point of intersection is created. Using this point, a line perpendicular to the occlusal horizontal plane can be created. An angle is created with the perpendicular line and the common intersection point of the buccolingual plane line that is the long axis of the tooth. This is a different measurement line from the facial tangent line described above in the "model" method of measurement. Published studies have compared the manual method with the 3D software used to replicate the "crown inclination" FACC tangent method, and found that the two methods produce similar results.[4]

ClinCheck tools

We will use only the "Inclination Buccal/Lingual" tool of ClinCheck Pro as the focus of this article.

Review of steps to use ClinCheck:

1. Open the ClinCheck Pro using your Invisalign Doctor Site (IDS).
2. Click the "Create Modification" tab on the upper right-hand side of the page (**Figure 4**).
3. Click on the "Tools" tab above the upper right corner of the image (**Figure 5**).
4. Click on "Tooth Movements Table" (**Figure 6**).
5. You will see a vertical list of options. Choose "Tooth." Drop down to highlight "Root Torque Buccal/Lingual." Hover over the choice to see the selection. Select the axial inclination movement icon (third from the bottom) (**Figure 7**).
6. Select a tooth on the model (**Figure 8**).
7. At the far right of the "Tooth Movement Table" (bottom of screen), note several choices:

   Final Stage: Align/Doctor/Difference

   Tooth Basis: Crown/Root

   Let's look at Root under the Inclination Buccal/Lingual row (**Figure 9**).
8. There are several ways to increase or decrease the "inclination" value (**Figure 10**).
   a. Left-click the target tooth and right-drag over the cursor pad to move the green arrow.
   b. Left-click to highlight the target tooth and use the vertical column dropdown for "Root Torque." Use the left or right arrow to alter the inclination value.
9. After alteration of the values, you may send the new values to Align using the Submit Changes tab on the far right of the ClinCheck screens.

There are many different valuable tooth position measurement tools. This article has focused only on the Inclination Buccal/Lingual tool of ClinCheck Pro.

Case example

The following case (**Figures 11-20)** demonstrates a problem list of issues including abfraction, excessive wear, and tooth fracture. We chose Invisalign as the tooth movement solution to help address the observed problems. With Align's ClinCheck Pro software, we were able to identify problems, such as axial angle of inclination, and using a virtual platform to manipulate the tooth movements, Align Technology manufactured a series of removable, invisible, comfortable clear aligners.

Function and proper final tooth position are important parts of finishing Invisalign cases. After aligner wear was complete, very small increments of occlusal adjustment were performed to achieve a final tooth position that helped optimize vertical loads of occlusal forces and thereby helped achieve long-term oral health. Clear thermoplastic aligners were fabricated in house and delivered.

This case demonstrates the relationship between occlusal function/tooth alignment, abfraction, and tooth wear/fracture. Invisalign was used to expand the narrow arches and better

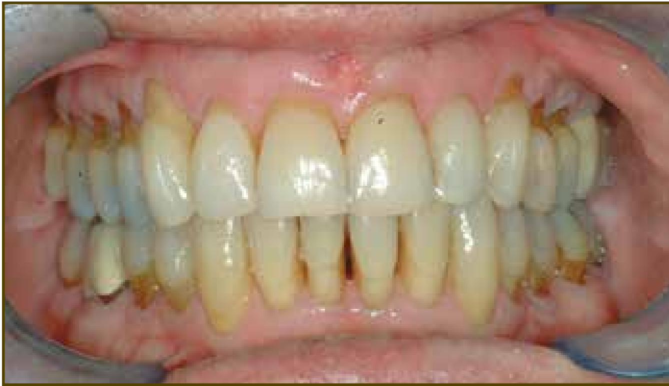

Figure 11: Example case pre-Invisalign Anterior View.

Figure 12: Example case post-Invisalign Anterior View.

Figure 13: Example case pre-Invisalign right Buccal View.

Figure 14: Example case post-Invisalign right Buccal View.

Figure 15: Example case pre-Invisalign left Buccal View.

Figure 16: Example case post-Invisalign left Buccal View.

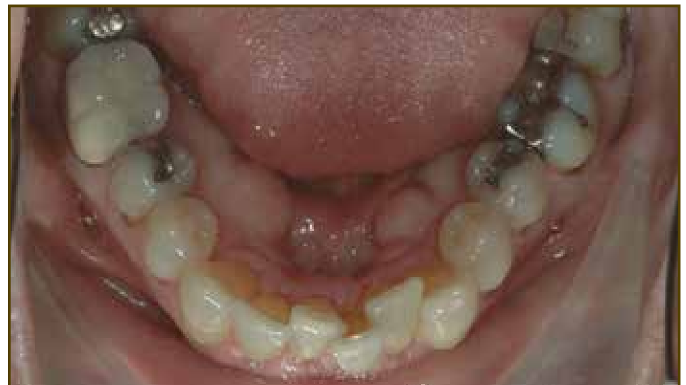

Figure 17: Example case pre-Invisalign mandibular Occlusal View.

Figure 18: Example case post-Invisalign mandibular Occlusal View.

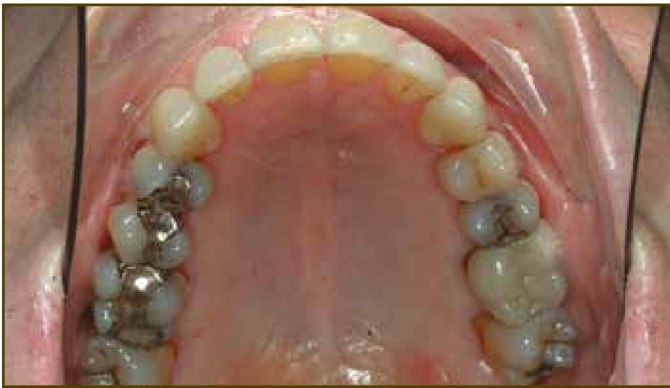

Figure 19: Example case pre-Invisalign maxillary Occlusal View.

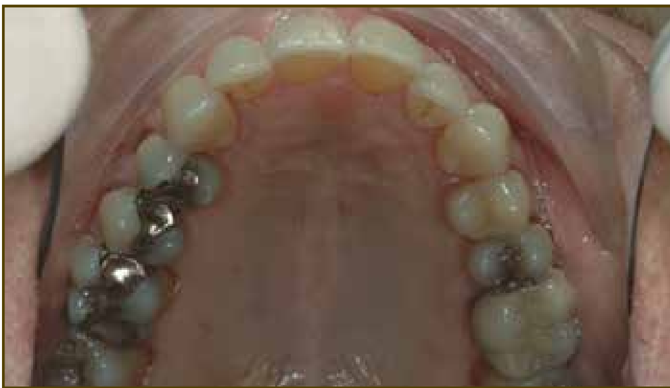

Figure 20: Example case post-Invisalign maxillary Occlusal View.

align the axial angle of inclination, with the objective to create a better occlusal alignment. The ClinCheck Pro axial inclination feature can be used as outlined above to help adjust the axial angle of inclination and achieve better vertical loading of the teeth. As we have illustrated, Invisalign offers measurement tools that can help achieve tooth movement goals. The movements for this case were predictable movements and played to the strengths of Invisalign, giving us excellent results and a very pleased patient.

Summary

Tooth position is an integral part of good oral health. Teeth should be oriented properly such that occlusal forces are transmitted vertically between opposing teeth, with horizontal forces minimized or eliminated. The axial angle of inclination in the buccolingual plane can be used to determine angles of orientation to a horizontal plane, and these values can be a help in determining optimal tooth position. Align's iTero Element intraoral digital scanner produces measurement data to help compare these angles using the Invisalign ClinCheck Pro tools. 3D imaging with CBCT systems, such as PreXion and NewTom VGi, offers powerful imaging and software tools to quickly quantify values such as axial angle of inclination.

Use of these technologies has opened the door to the future, allowing dentists to use tooth movement to produce better oral health care! ■

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The 80/20 Rule

by Terri Pukanich, DDS

Dr. Terri Pukanich graduated from the University of Alberta Dental School in 2002. She bought her first and only practice in 2003 when she was just 25 years old.

Since that time she successfully grew her practice from a 4–treatment room, 1-doctor office to a 17–treatment room, super-GP group practice—all in a small rural town of 7000 people. She is a Platinum Plus Invisalign Provider.

She is the founder and CEO of Dental BossLady—an online platform she created to help women excel in practice ownership.

She is also a Key Opinion Leader for the American Academy of Clear Aligners.

The journey to a successful practice is not without its challenges. My goal for this article is to help shave 5 to 10 years off your learning and income curves by teaching a few key principles.

Let's start with the 80/20 rule in dentistry. The Pareto principle states that, for many events, roughly 80% of the effects come from 20% of the causes. In your dental practice, this can be applied in a number of ways:

- 20% of your patients provide 80% of your revenue.
- 20% of your procedures provide 80% of your production.
- 20% of your efforts provide 80% of your results.

Now you just need to figure out what the 20% is.

Vision, systems, and metrics: these are three buzzwords in dentistry right now.

Why? Because they are the 20% you must focus on. Exquisite execution of these three things in your dental practice will bring you the majority of your success.

Following the Pareto principle—and based on my personal experience of building a multi-doctor, 17–treatment room office—implementing a clear, well-defined and inspiring vision; having the right systems; and tracking a few important metrics will bring you 80% of your success.

As dentists, we often get mired in details and overwhelmed to the point of paralysis on where to start. It can all seem overwhelming.

I'm here to tell you that it's simpler than you think—not easy, but simple.

Knowing and implementing are two different things, and that's why it's critical to understand the most effective things to focus on and implement.

It all starts with having a clearly defined vision. Whereas a mission and core values are vitally important to give you and your team an overall purpose, a vision should be the thing that gets you out of bed in the morning.

It keeps you excited and invigorated during your day. It inspires you to stay the course when things are not running smoothly. If your vision doesn't do this for you, it's time for a new vision.

Vision is also the key to keeping, motivating, and training our teams. They too need to understand their purpose in the practice. Without vision they are relegated to the philosophy of "it's just a job." Not only do you need to have a compelling vision; you need to be relentless in sharing it with your team.

In my office we have a credo card, just like the Ritz-Carlton. It is a six-panel business card with our vision, mission, core values, and the essential rules of our practice. We review one panel every day. It serves to remind everyone why we're there that day. It provides the mindset that we all need to start the day with the right attitude. It can often spark great conversations about interactions with patients or other team members.

Everyone knows that systems run practices. Systems are ways we can easily and efficiently make changes in our practices to make day-to-day operations more effective.

Better results. Comfortable patients. That's a winning situation.

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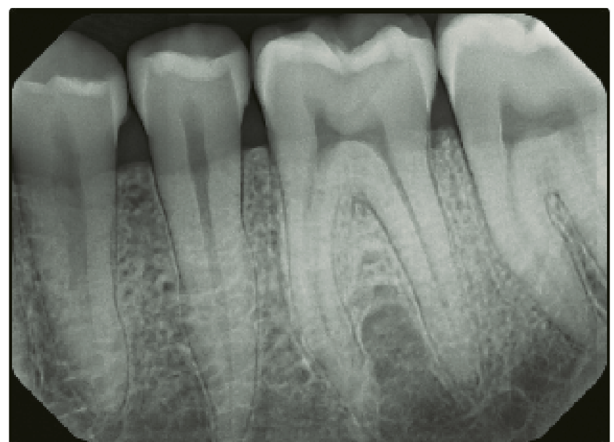

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But which systems? How many do you need? Which ones do you start with? How do you implement them? It may surprise you, but we run our 17-operatory, 3-doctor, 25-staff practice on 6 Critical Success Factors—and 20 systems total. Figuring out the systems that provide the most bang for the buck is instrumental to practice success.

These critical systems include the following:

Exit strategy—Having a system for how patients leave your practice after their appointments are completed is crucial. Having an exit-strategy system ensures you achieve 90% of next visits booked and increase your case acceptance. Please do not simply let your patients wander out of your operatory down the "amnesia hallway" to your front desk to look dazed and confused.

Chart reviews—Every person on your team (including you, Doctor) needs to know everything he or she can about the patients coming through your doors. What are their preferences for treatment? Do they require anything special or extra? Are there any medical conditions? Is it their birthday? Does anyone in their family need any dentistry? And probably most important: what happened last time they were in your office, what exactly are you doing this time, and what is the patient's next step in your office? Doing daily, detailed, systematic chart reviews will ensure you are maximizing the amount of dentistry you do in a day. It should add thousands of dollars to your same-day dentistry totals—which is key to hitting daily production goals.

Scheduling algorithm—This could be the most important system of all. Without a clear scheduling algorithm in place, you will have an extremely hard time using your practice management software to its potential. You won't be able to search for appointments and follow up with patients. By scheduling correctly, naming appointments correctly, utilizing blocks and having "rules" around your schedule, it will ensure you have days that are balanced and productive, avoiding the roller-coaster ups and downs in treatment. It should also provide you with your ideal days doing the dentistry that you love. Our goal every day is a fun, efficient, and profitable schedule.

Overdue treatment strategy—I'm sure you've heard it before: Most dentists have millions of dollars in dentistry sitting in the charts. It's diagnosed but not done. Constant contact and follow-up is vital to keeping your schedule full and making your office profitable. What is your system for follow-up on all that dentistry that was diagnosed but not completed? These patients are what marketing gurus would call your "warm leads," and they must be nurtured. Oftentimes I will see 4 to 10 touchpoints of communication, all documented in our PMS, with a patient before the patient actually schedules. For many patients in my experience, one phone call simply isn't enough.

Phone etiquette—Answering inbound phone calls correctly and efficiently can make or break an office. Whoever answers the phone in your office is making the first impression. These team members must be happy and confident and know their number one purpose: selling appointments. Using telephone strategies and making sure whoever is answering your phones is a superstar are key to creating a successful practice. I'll even give you the very first step: just get the phones answered during all business hours—and yes, even during lunch! Make answering the phone a priority.

Focusing on the big picture and big result items just makes sense.

Don't get overwhelmed by the details. Remember the 80/20 rule: pick the 20% of the systems that will make the biggest impact and then knock those out of the park!

Lastly, it's imperative you understand that we are in the metrics business. Simply put, metrics matter and you must know your numbers.

As Marcus Lemonis from *The Profit* is fond of saying, "if you don't know your numbers, then you don't know your business."

Anything you track will go up. Want your hygienists to preschedule more? Track it. Want more new patients? Track it. Want higher case acceptance? Track it. Want more profit? You get the idea.

I have 10 key practice indicators for my dental business that have evolved for me over time. Every dental business is unique and will develop its own best practices, but the key is to at least start to track and learn your numbers.

One essential is knowing your "gap." You must know what your daily production goals are and then what is actually scheduled. If you are under the goal, that's the gap, and you need to strategize how you will make it up.

You and your team need to identify (through that chart audit system…) patients in your schedule today who may be good candidates for same-day treatment. Daily goals are easy for both you and your team to focus on and actually make you feel that you can make a difference!

Dental practice success really can be that simple if you focus on the things that truly matter—the coveted 20%! ■

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Hygienists: Become a Hero (and Irreplaceable)!

by Christopher Hart, DDS, RDH, BS, Diplomate ABDSM

Almost 25 years ago, I began my career in dentistry, not as a dentist but as a dental hygienist. Early in my hygiene career, I worked as a temp in dozens of offices in the Denver metro area. I met many hygienists and learned that there are as many ways to practice dentistry and dental hygiene as there are offices. I closely watched the most successful, most fulfilled hygienists, hoping to find what was different about the way that they worked and viewed their role. The amazing ones were loved and heroes in their practice. What I learned then and applied to my own practice philosophy affects how I practice dentistry to this day. Read on if you'd like to learn more, because these principles can make you a hero, too.

Dr. Christopher Hart obtained his DDS at the Indiana University School of Dentistry and his BS in Dental Hygiene at the University of South Dakota. Dr. Hart is also a diplomate with the American Board of Dental Sleep Medicine.

Dr. Hart is the owner of Hart Dental, Center for Modern Dentistry, and Hart Dental Sleep Solutions, in Mitchell, South Dakota. He is a Gold Invisalign provider and enjoys teaching about Invisalign and dental sleep medicine.

The joy of collaboration (a win for the doctor)

I saw that the most fulfilled, most successful hygienists were the ones that were engaging and working in tandem with the dentist and the dental team. They were not a lone ranger tucked away in their operatory, but rather a very specific and irreplaceable piece of the larger entity. Considering hygienists often spent more time with the patient than the doctor did, I observed that hygienists are in an ideal position to assist in identifying both oral and overall health problems for the patient.

A hygienist who participates in the diagnostic process and educates the patient not only saves the dentist time but also creates a smoother appointment and a better patient experience. If the hygienist identifies something that ends up being nothing to be concerned about, he or she is still a hero! Both the doctor and the patient are thankful for such a conscientious hygienist caring for them.

As a dentist, I've found that even in the very rare times I disagree with my hygienists' assessment, I appreciate them because I see they are taking the time to partner with me in looking out for our patient's best interests. So whether it's highlighting a concern on the med history or identifying destructive malocclusion, cosmetic opportunities, failing margins, or signs of obstructive sleep apnea, I am thankful to have a collaborator advocating for the patient and the practice.

Listen, advocate, and create raving fans (a win for the patient)

Successful and fulfilled hygienists are not just assisting the doctor in identifying concerns; they are advocating for their patients' oral health and helping discover their goals. When a hygienist takes the time to ask what patients' oral health goals are and what their dream smile looks like, and truly listens, he or she creates the opportunity to educate patients on options available, letting them know these goals/dreams are achievable. I often hear "Since you asked, I want a beautiful smile, but I didn't know straight teeth were possible at my age."

The hygienist can make the doctor's exam as seamless as possible and showcase the expertise and life-changing treatment options that we offer. Whether the goals or dreams are big or small, a listening ear creates safety, openness, and loyalty.

Reap the reward (a win for you)

As a hygienist, you have the opportunity to be a part of taking your practice to the next level and improving the lives of your patients. By being a hero, you'll improve your own life as well.

Do not wait for someone to set the bar for you. Do not let someone (even yourself) minimize your role to just menial tasks. You have an amazing education, and you set your own limits on how productive, positive, and influential your role will be on your team. Establish your value through service to your patients, your team, and your doctor. Job satisfaction, compensation, and increased quality of life will naturally follow when you rise to what you are capable of.

So step into that leadership role. These heroic qualities will make you irreplaceable, a win for you and everyone around you. ■

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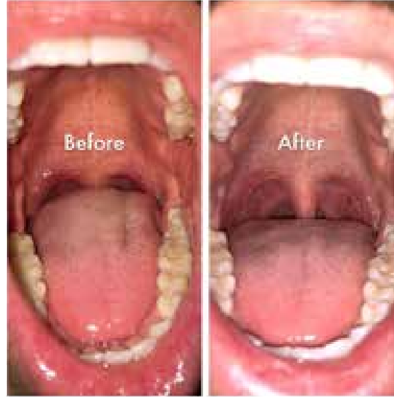

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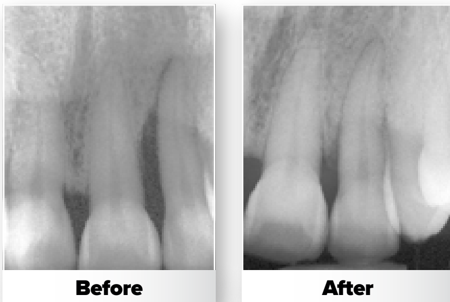

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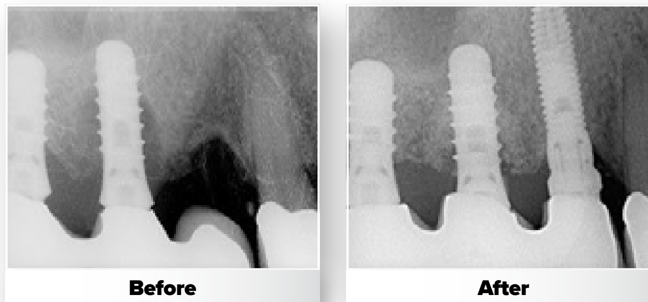

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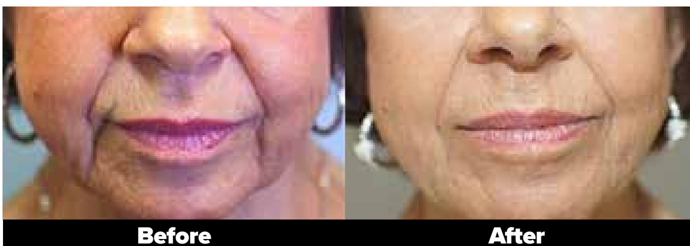

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Jack's Corner

by Jack Von Bulow, DDS

The Huddle

When I began my career just off Las Tunas Drive in downtown Temple City, Jimmy Carter was busy putting his peanut farm into a blind trust so that he could be president. Gas was 59 cents per gallon, a new home could cost you $43,400, and the year-end close for the Dow was 1,004.

My Dad passed away on March 6, a little more than 2 months into my start-up practice. I inherited Dad's awesome yellow Camaro with a black vinyl top (Dad had paid $4,500 cash and driven the hot rod off the lot). And without my mentor/hero by my side, I began serving about 50 patients I'd swiped after being an associate dentist in nearby Arcadia.

And when you were in your mid-20s and a dental professional back in The Day, it wasn't uncommon being caught alive wearing double-knit plaid bell-bottom pants with a flowered shirt. I refused to be uncool like dental school instructors who sported white belts and white shoes while not playing golf. I motored around shod in Sperry Top-Siders. No debate.

I knew close to zero about business, taxes, verbal skills, and systems. I was mildly content being just like my colleagues down the street. I figured they'd been around long enough to be peeps I could impersonate; should've known better. My dad and older brother were the only mentors I'd ever known (my brother was the marketing guy), and had they lived to be there and dish out advice during my early years, I'm confident that today, my second home would be a modest villa on the Amalfi coast.

For 20 years, I never left Los Angeles County for continuing education. Mostly, I read about and carefully tried out new stuff. I found the best dental materials guy in North America and waited for his annual Los Angeles 2-day drive-by downtown at the Bonaventure. The new materials were esthetic and lifelike; there was an opportunity to be creative and artistic. I stopped thinking about a second career. I loved serving people. Sometime in the mid-1990s, Dr. Ray Bertolotti suggested a course called Dental Boot Kamp. I hadn't been in an airplane since I was 12. Three of us, courtesy of Alaska Airlines, spent several training days in beautiful Canmore, Alberta, Canada. Changed my life.

As I was writing this, my amazing scheduling coordinator Denise (who has her own company, Next Level to Success) shared a quote: "Birds born in a cage think flying is an illness." And close to 20 years after founding Temple City Dental Care, I did some flying and found my first mentor not of Von Bulow DNA, Mr. Walter Hailey.

One of Walter's first lessons shared the concept of a daily morning huddle. Hailey was a millionaire from little Mesquite, Texas; he'd had three businesses go public after starting out as the low man on an insurance company totem pole. Walter started a CEO Boot Kamp, and on one great day in oral health care history, a dentist showed up.

I remember Walter looking out at us, attempting to see a figurative 10 out of 10 on any forehead—someone who could act like a 10, think like a 10, walk like a 10, and lead like a 10. He remarked, "Right now I don't think any of you could lead a morning huddle in silent prayer…but that's gonna change."

You guys (the public) may not know it, but today, any well-run, successful dental practice meets for a structured morning huddle. Important business numbers are presented, but, more significantly in my opinion, cultures are developed. Every day, a practice's core values and purpose are revisited, maybe off a whiteboard hanging on the wall. Our day is structured around serving one another and patients like family. It's much easier "making dentistry fun" when we start the day together with that purpose in mind with declared values like Family, Fun, Empathy, Appreciation, Represent (the community), Love, Enthusiasm, Service, and Support holding us accountable. The acronym is FFEARLESS. And if we're fearless, we'll be flying outta any cage limiting our growth.

Since 2015, I've been fortunate enough to be part of something special. The American Academy of Clear Aligners (AACA) is arguably the globe's leading Invisalign organization, but it's more. The AACA is the innovative product of fearless leader Dr. David Galler's vision, and it's become a growing family of colleagues building better lives for members and patients across the whole spectrum of oral and general health.

Declining Reimbursements? Need More New Patients?

Discover How To Double Your Production, Without Advertising Or Hiring More Staff

by Dr. John Meis

Have you seen the numbers?

Reimbursements really *are* shrinking. Proof: Independent GPs will lose 8.7% in reimbursements in 2019, according to Morgan Stanley Research. That's on top of a 6.7% loss since 2017!

What can you do? Especially if you're worried about getting more patients … or just want to keep your schedule from falling apart?

You'll find answers here.

Hi, I'm Dr. John Meis, a 4th generation Dentist. I was born to do dentistry. And my practice in Sioux City, Iowa was doing fine, thanks to long hours and hard work. But after a brush with death at age 28, I realized a painful truth -- *I couldn't afford to die!* My family depended 100% on my being at work every day. Without me doing all the work, my wife and 2 young children faced a future of financial hardships.

My health scare (a heart condition, now symptom free) was a wakeup call. It forced me to build a practice that ran on systems and teams … not on my labor. After 11 years of trial and error, I created what I call the *"Double Your Production System."* It took me to over $225k/mo. in personal production … yet I always made it home for dinner. It let me double and even triple production in any other dental practice I walked into. And since 2005, I've advised more than 4,439 dentists and staff in 12 countries.

The Strange Secret To Growth

What if everything you've been told about growing your practice was wrong? For example, *what if you don't have a new patient problem?* What if bringing in more new patients, like blasting water from a firehose into a leaky bucket, is actually causing your practice to fail? That's just one of dozens of unconventional success secrets you'll discover in my new book …

"The Ultimate Guide To Doubling Or Tripling Dental Practice Production"

Don't spend another dime on marketing or hiring a non-dentist "guru" before you get this book. In it, I reveal exactly how I learned to laugh at falling PPO reimbursements … as I built a $6-Million practice in little Sioux City … and how I've grown over 150 practices that I've been a partner in. Here's a sample:

- **Why "bad news" about insurance coverage leads to 80-95% case acceptance** (pages 24-25)
- The simple roadmap to $326,400 in new revenue, without advertising (page 126)
- **How to boost your production to $225,000 a month** by doing new patient exams in just 8 minutes -- without sacrificing care (pages 50-62)
- The #1 secret to case acceptance is an "E---------- C-------- Exam" (pages 55-60)
- How to double your production starting tomorrow (yes, *tomorrow*) pages 15-18
- Why "nesting" is stopping you from tripling production (and how to fix it). See pages 71-72
- **How to reclaim $102,952 in new revenue per hygienist** by "framing" (see page 29)
- How to replace your salary with profits that multiply, *while you do other things* (pages 119-120)
- **How to create $440,000 a year in production.** Hint: no more meetings!? (pages 87-88)

Free Book

Members of the Academy of Clear Aligners are entitled to a Free copy of this new book, while supplies last. Go to:

www.2xProductionStartingToday.com

Galler teaches Invisalign and leads the organization the way Jordan went to the hoop and Perlman plays the fiddle, making those around him better and doing it with a smile.

Somehow, when no one was looking (going on 6 years ago) I was selected president of Dr. Galler's first Los Angeles Reingage group; the 2-day training was accurately billed as "the course that changed everything." With the formation of the AACA, we presidents are now all board members. Recently, we shared some brainstorming sessions with the boss. What were we passionate about and what could we share to add value to the organization?

Looks as though, in addition to recruiting AACA journal contributors and writing a quarterly column, I get to lead a WhatsApp chat…about the morning huddle. Each working morning, I get to share a quote with my chat group. I'm thinking "Birds born in a cage think flying is an illness" might work for chat #1. ■

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