President's Message: Gary R. Hartwell, D.D.S., M.S.

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From March 24-26, 2013, the Pulp Biology and Regeneration Group of the International Association for Dental Research held a symposium titled Pulp Regeneration: Translational Opportunities at University of the Pacific, Arthur A. Dugoni School of Dentistry’s San Francisco campus. I was fortunate to have the opportunity to attend this Symposium as a representative of the AAE and its Foundation (one of the sponsors of the event). The symposium brought together scientists and clinicians from all over the world to discuss the advances that have occurred to date in this field, and to identify questions and areas requiring further research.

I asked Dr. Anibal Diogenes, a participant and presenter at the symposium, if he would provide some insight into this important topic for this President's Message. Anibal is an AAE member, a past member and Chair of the AAE’s Research and Scientific Affairs Committee, and a faculty member at the University of Texas Health Sciences Center at San Antonio. His time and explanations are greatly appreciated.

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Important Dates and Deadlines
Visit www.aae.org/events for more information.

August 1
Late fee assessed for outstanding 2013-2014 membership dues payments

October 1
Deadline to pay dues and be included in the 2013-2014 Membership Directory

August 15
Corporate Community Conference

November 14 – 16
2013 AAE Fall Conference

August 16 – 17
2013 Department Chairs Educator Workshop

Communiqué Takes Gold

The redesigned Communiqué received a Gold EXCEL Award from Association Media & Publishing for Most Improved Newsletter. Nearly 1,000 entries were submitted to the 33rd EXCEL Awards, representing 83 nonprofit organizations and associations and honoring the best and brightest in association media and publishing.
Current Status of Pulp Regeneration:
An Interview with Anibal Diogenes, D.D.S., M.S., Ph.D.

Dr. Gary R. Hartwell – Anibal, I think it is important to differentiate pulp revascularization procedures from pulp regeneration procedures. Could you define the two terms and highlight the major differences?

Dr. Anibal Diogenes – There has been plenty of confusion and controversy regarding the uses of these two terms. Pulp revascularization is a term that has emerged from the dental trauma literature. It arises from the observation that immature teeth could become revascularized after disruption of their neurovascular bundle following a traumatic injury such as avulsion. In this clinical presentation, a native tissue is present, and it may regain its blood supply due to angiogenesis, and possibly anastomosis. This is a process similar to re-perfusion of ischemic tissues followed by repair. This term has been subsequently used since the initial reports of the regenerative endodontic cases. Although these cases share many features with the initial trauma reports, the pulpal tissue is no longer present due to liquefaction necrosis. Instead, a blood clot is brought into the root canal system to promote repair, or the formation of a vital connective tissue into the root canal.

Pulp regeneration procedures are procedures that use principles of bioengineering with the knowledge of stem cell biology in conjunction with harnessing local growth factors and the use of scaffolds. It has been demonstrated that regenerative endodontic procedures deliver a substantial concentration of undifferentiated stem cells into the root canal system. Thus, the biological processes that take place following these procedures are far more complex than simply the revascularization of an exiting tissue. Instead, it is likely to involve a balance between the proliferation and differentiation of stem cells, and the resolution of the infection and inflammation. In the past decade, we have gained knowledge on the interplay between stem cells, growth factors and scaffolds, the triad of bioengineering.

Contemporary regenerative endodontic procedures acknowledge the importance of the same principles. There is no question that these procedures are rapidly evolving with protocols and approaches being directed by information gained from translational studies. Thus, regenerative endodontic procedure is a term that best describes the goal of these procedures. This term does not exclude procedures previously called “revascularization” or “revitalization,” but also includes procedures being developed using the principles of bioengineering with the use of growth factor-containing scaffolds, for example.

GH – There was a great deal of discussion at the Symposium regarding the sources of pulp stem cells. Could you give us your opinion as to what you feel are the current best sources for these cells?

AD – Mesenchymal stem cells can be found in a multitude of oral compartments such as in the apical papilla, periodontal ligament, dental pulp, inflamed apical tissues and others. All these cells have strong regenerative and reparative potential. Stem cells in regenerative endodontic procedures are likely derived from the apical papilla and the inflamed apical tissues. In most cases, dental pulp stem cells are not a potential source of stem cells since the tissue has been largely destroyed by liquefaction necrosis. In addition, the stem cells of the apical papilla (SCAP) are very abundant representing the most cell type in the apical papilla. This represents a much greater density of stem cells than present on the dental pulp. These cells have been shown to have greater proliferative and odontogenic potential than other cells such as dental pulp stem cells or bone marrow stem cells. Thus, I strongly believe that SCAP, followed by inflamed periapical progenitor cells (IPAPCs), are probably the main cells types involved in regenerative endodontic procedures in immature teeth.

GH – Pulp stem cells will require growth factors once they are implanted into the pulp canal space. Which growth factors are considered to have the best potential based on current best evidence?

AD – Undifferentiated stem cells require environmental “cues” to govern their proliferation, differentiation and spatial organization. These “cues” come from complex signals derived from growth factors and surface attachment molecules. There has been important research suggesting prominent roles of certain growth factors such as transforming growth factor beta-1 (TGF-beta), fibroblast-derived factor (FGF), and the potent chemotactic factor stromal-derived factor 1 (SDF-1), among others. Importantly, the pioneer work led by Dr. Anthony Smith has demonstrated that these important signaling molecules are present trapped within dentin. Importantly, it is very challenging to mimic this cocktail of growth factors that have been deposited within the dentin during development. Instead, we need to do a better job at harnessing the inductive potential of dentin. Thus, we are still charged with the role of disinfecting the root canal system, but we need to accomplish this while favoring the preservation, and the release of these dentin-derived growth factors.

GH – The cells also will need a matrix on which to grow within the pulp canal space. What is the status of current research with regard to scaffolding materials?

AD – This is a very active area of research that could potentially revolutionize...
regenerative endodontic procedures. There are a multitude of scaffolds currently used in bioengineering applications. Currently, we do not have a scaffold that is FDA-approved to be used in these procedures. However, hydrogel scaffolds seem like the most probable class of scaffolds that will eventually make into clinical practice. These scaffolds have the advantage of being injectable, and due to their fluid or colloidal consistency adapt really well to the conformities of the root canals system while keeping close contact with the dentin, an important source of signaling molecules. In addition, these hydrogels have other desirable features such as being tunable, biodegradable and bioactive. In an important study, Dr. Misako Nakashima and colleagues from Japan demonstrated that the pulp-dentin complex could be fully regenerated in an animal model (dog) using a hydrogel scaffold, selected dental pulp stem cells and growth factors. In another study, Dr. Kerstin Galler and colleagues demonstrated that dental pulp cells seeded within a peptide self-assembling hydrogel could differentiate into odontoblast-like cells in dentin disks implanted subcutaneously in immunocompromised rats. Therefore, there is strong potential of hydrogels to be translated into the clinic.

**GH** – Considering the current status of research efforts, could you summarize where you think we are and what we need to do for this procedure to become a clinical reality?  
**AD** – I think that we have gained tremendous knowledge in the past decade in several aspects of this procedure. We now know that there are a substantial number of stem cells delivered into the root canal system in these procedures. This is very important for the realization that these procedures are basically bioengineering procedures since there is a participation of stem cells, scaffold (blot clot or platelet rich plasma) and growth factors (present in dentin and plasma). Recently developed translational research has laid the foundation for a suggested treatment protocol from the AAE. Although this suggested protocol is based on the best current evidence, it is likely to change as the field evolves rapidly. Nonetheless, this protocol provides clinical guidance and allows for practitioner and researcher to compare outcomes. Indeed, the great diversity of treatment protocols makes comparisons across institutions and private practitioners nearly impossible due to the heterogeneity of the data. There is no question that these procedures have benefitted hundreds of children with very compromised teeth. The previously exiting treatment (apexification) is predictable and widely accepted. However, it does not promote root development or the formation of an immune competent loose connective tissue that resembles the dental pulp. A common feature of all the published regenerative cases is the resolution of signs and symptoms of disease, similar to that achieved by apexification procedures. However, in most cases, there is also appreciable root development and possibly positive response to vitality testing. In a recent retrospective study, Jerruphan and colleagues demonstrated that regenerative endodontic procedures promote greater root development and survival than apexification procedures. Although this study had limited sample size, and was not a randomized clinical trial, it was the first to compare across treatment modalities performed with standardized protocols. There is no question that randomized clinical trials, as I mentioned before, as still required to provide the highest level of evidence. Nonetheless, regenerative endodontic procedures have been shown to be a viable treatment alternative for these patients with previously very limited options.

It is my opinion that the current clinical procedure is far from ideal, and much more research needs to be done. Most animal studies and published human histology from regenerative endodontic procedures demonstrated ingrowth a connective tissues that are richly vascularized and innervated, consistent with a pulp-like tissue. On the other hand, in most studies, the mineralized tissue formed along the dentinal walls does not resemble dentin, but cementum or osteodentin. Also, there are often islands of mineralized tissues embedded in the connective tissue, not necessarily in contact with the dentinal walls. Thus, it appears that we have not reached the desirable level of tissue organization at the histological level. Although it is highly desirable to have a tissue that fully resembles the native pulp-dentin complex, the effect of the histological findings on the clinical outcome is largely unknown. As I mentioned before, the complete resolution of symptoms and signs of disease could be considered a clinical success by our traditional definition of clinical success regardless of the histological status.

I feel optimistic that, as the field of regenerative endodontics evolves, we will not only enjoy great clinical success but will also observe better tissue organization at the cellular level. This is what we should strive for as a specialty. Certainly, there is still a lot of research and development to happen in this young field of regenerative endodontics.

To read the rest of this interview, including comments on the AAE’s role in regenerative endodontics and for a full list of regenerative endodontic resources, scan the QR code with your smartphone or tablet or visit www.aae.org/communique.
A New Look at Marketing:

Keys to Growing a Successful Endodontic Practice

By Albert “Ace” Goerig, D.D.S., M.S.,
Cofounder of Endodontic Practice Mastery

Over the past few years, many endodontists have seen a significant decline in endodontic referrals. They have trouble filling their days with patients and worry about the future of our specialty. Most of them have done little to change the way they have practiced over the years. To survive and flourish in today’s environment, we need to take action, looking with fresh perspective on our practice philosophies and modifying our marketing techniques.

There is an old marketing adage: “Those that need to market should not, and those that don’t need to market should.” Before you spend your time and efforts to market, make sure your office is a warm and inviting place to send patients. If it is not, you will have spent a great deal of time and money turning patients and referring doctors away. Once you lose a referring doctor, it’s very difficult to get him or her back. Here are some ideas to revitalize your practice and improve your marketing.

**Be a full-service endodontic practice.** Do not give referring doctors an excuse to send their patients anywhere else. It is best to be available five days a week, and that is why I am a firm believer in having associates. Even if you’re a solo practitioner, you could have a staff member available to answer the phones five days week. To make endodontics easy and affordable for patients, offer them a variety of payment options. Payment plans such as Care Credit enable patients to accept treatment without stressing their household budget. It’s also important to be a provider to those insurance companies used by your best referring offices if they pay a majority of your fee. Lastly, have nitrous oxide available for your patients and incorporate conscious sedation into your practice. I highly recommend the DOC’s conscious sedation course.

**Incorporate surgery into your practice.** You cannot be a full-service endodontic practice unless you perform apical surgery. I would recommend taking a course in this, such as Dr. Syngcuk Kim’s course in Philadelphia. He is always up-to-date and provides an excellent hands-on surgical course. Learn to do simple extractions on teeth with vertical root fractures to include osseous regeneration procedures. Always check first with the referring office for their permission. Implants will probably be the wave of the future. Endodontics is the best specialty to do implants because we can give the patient an honest choice in treatment options.

**The most important concern of your referring doctors is availability.** They want their patients to be seen that day. Always leave space in your appointment schedule to see emergencies and schedule enough time to complete the root canal in that appointment. For demanding offices that want their patients seen immediately, tell them to send them right over. Upon arrival, figure out a diplomatic way to put them exactly where you want them in your schedule. Single-visit endodontics is another way of differentiating yourself. Patients and referring doctors prefer to complete treatment in one appointment.
Incorporate new technology to provide high-quality, consistent results. As endodontists, we need to provide high-quality, consistent endodontic results, and it’s important to incorporate new technology that facilitates excellent outcomes. Not only do the microscopes, digital radiography and CBCT scans improve your diagnostic and clinical skills, your referring dentist expect you to have these technologies. Have a great website. PBHS provides an inexpensive but highly effective website just for endodontists.

Develop relationships with your referring doctors. To ensure that patients come back to the referring doctor with glowing reports of your office, I would recommend three ideas: 1. Compliment the quality of the referring doctor’s work; 2. Support their treatment plan; and 3. When the patient compliments you or your office, ask him or her to tell the referring dentist that you took good care of them. When they respond with, “Yes I will,” there is a high chance that they will sing your praises when they see their dentist.

As Dicky Fox said in the movie “Jerry Maguire,” “The key to this business is personal relationships.” According to AAE research the most important reason why dentist refer to a specific office is based on relationships. Many endodontists resist taking their referring doctors to lunches. The most important job you have at these or similar face-to-face meetings is to develop a deeper relationship. It is better to be liked than heard. This is best done by asking questions about the doctor, as well as asking for their help. It may be asking them who is the best banker in town, where they go fishing, where they get their dental supplies, or where they took their last vacation. Not only will you learn a lot—you will connect with them on a whole new level. When they help you, they become committed to your success. The most important question that you ask is, “What will it take for me to be your endodontist of choice?”

Among the most important relationships are those developed between the staff at our front desk and the referring office. You need someone who is loving, caring and can connect on a personal level with the staff of your referring doctors. I believe it is important to have a marketing coordinator with these same skills that also works at the front desk. The role of the marketing coordinator is to track all referrals on a monthly basis, come up with various marketing ideas, coordinate monthly lunches for your best referrals and bring gifts of appreciation to your top offices each month.

To survive and grow in these difficult times, you and your team need to be continually changing and reinventing yourself and your practice. These changes are built on good marketing systems and the development of strong personal relationships.

Dr. Goerig teaches endodontists the business of dentistry while helping them to love their practice, and has been in private practice for 22 years in Olympia, Wash. He can be reached at doctorace1@gmail.com or via his website, Endomastery.com.
Sunshine Law Goes Into Effect: Payment Disclosure Law

By Andrew R. Van Haute, J.D., associate general counsel at the Advanced Medical Technology Association

Beginning August 1, 2013, medical and dental device manufacturers are required to report certain payments to physicians and dentists under the so-called “Sunshine Law.” The Sunshine law does not restrict interactions or collaborations but requires disclosure. While health care providers do not need to file any reports, it is important for them to understand that their names will be reported to a database annually if they have interactions that trigger reporting requirements.

AdvaMed is a trade association that represents 80 percent of medical/dental device manufacturers, and all of our members will be required to comply. Our members view health care providers as critical partners in advancing quality of care for patients through innovation, training and education. Our members are committed to helping AAE members and other providers understand required disclosures.

What is reportable under the law?
Reportable items under the Sunshine Law include payments for consulting, education, serving as faculty or as a speaker for continuing education, honoraria, research and grants – as well as other transfers of value such as gifts, meals, travel and entertainment – if they are worth $10 or more (or even items worth less than $10 if the total for a doctor adds up to $100 in a given year). The law also requires reporting of ownership/investment interests by covered providers.

How often is this data reported?
The data will be reported to the Centers on Medicare and Medicaid Services on a calendar year basis, and reports are filed on March 31 the following year. For 2013, the March 31, 2014 report will include payments made between August 1, 2013 and December 31, 2013.

Will I know if a manufacturer reports a gift/payment to me?
Providers can access their own data once it is made available by CMS on a secure online portal-sometime in mid-2014. However, you will need to register with CMS to view payments. The details of when and how to register have not been determined yet, but the AAE and AdvaMed members will be providing this information to you when it is available. Once annual payments are posted on CMS web site, providers will have 45 days to review data submitted under the Sunshine law to ensure that it is correct or to initiate disputes before it is made public.

Who else can see the payments?
Starting September 2014, patients and other important stakeholders will be able to see these reported payments and transfers of value on a searchable public CMS web site.

Because this is a new reporting program, there may be glitches as it is rolled out. However, it is important that AAE members who receive these sort of payments or transfers of value be aware of the program and that these payments will be a matter of public record.
From My Side of the Chair:
An Office Manager’s Look at the AAE

By Lynda L. Davenport, R.D.A.

Managing an endodontic practice, I am always reading, listening to webinars, searching for podcasts, attending seminars and working with consultants. But I usually end these events sifting out all the useless points and longing for information that specifically addresses the practice needs tailored to the endodontic specialty. As I thought about where to go for the most applicable and pertinent information, the Janet Jackson song “What Have You Done for Me Lately” made me think about what the AAE has done for me.

Free Employee Orientation
How can we give new employees in an endodontic practice accurate, consistent and current information when we are already understaffed and stressed for time during the workday? Training and education is the key to successful integration of a new employee as a valued staff member. The Patient section of the AAE website is a free resource and should be part of every clinical and administrative staff training process in your office. The website explains why a patient needs to see an endodontist, leads into a description of an endodontic office visit, reviews post-treatment care, explains dental insurance, clarifies myths associated with root canal treatment and answers frequently asked questions about several common endodontic procedures. It costs you no time and no money, so be sure to use this complimentary resource for new employee orientation.

Free Education for My Patients
Connect your patients to the most up-to-date information about the root canal procedure by using AAE website resources. Add a link on your practice website to AAE Patient Information web pages, or offer a kiosk or tablet in your office for patients to access the website and learn while they are waiting to be seen. The more information that the patient can access, the more prepared they are for the procedure!

Improving Support for My Practice
It is worth a $35 membership to make qualified staff a member of the AAE. Membership will give them access to other Auxiliary staff (administrative and clinical) through the Online Directory and the Professional Staff Forum.

Your staff can use the Online Directory to help a patient locate an endodontist in another city or state, or engage in discussion with other endodontic offices in your state about handling CE or state-specific OSHA requirements, etc.

Staff can use the Professional Staff Forum to pose questions to peers about team-building activities, their success using social media in an endodontic practice, or any other feedback that will help your team find resources and suggestions from practices that have faced similar situations. The Forum can be a wonderful resource for discussion and support for management in the endodontic office.

Best Networking and Information Available
It costs time and money for a practice to invest in staff to attend the AAE Annual Session, but the benefits gained when the staff is able to meet and share success and failure stories on many different topics such as hiring, training, team building, team harmony, software, social media, record keeping, X-ray techniques, patient care and more are hard to measure.

There are two parts of the meeting that will benefit your staff: 1) the networking activities where they build their contacts face-to-face (and that can always be a resource for your practice), and 2) the only education sessions that are specifically tailored to endodontic clinical and administrative staff – which makes it more valuable than any state or regional meeting.

Endodontic Training Online
The Live Learning Center is a $50 investment for Auxiliary staff to add to their membership. It is the only continuing education center that is specifically targeted for the endodontic office. If your staff is unable to attend the Annual Session, it is a great investment in quality CE that you know will be tailored to promoting their knowledge of the endodontic specialty. Even if your staff attended the Annual Session, they may want to listen to sessions that they missed due to schedule conflicts.

What Has the AAE Done For Me Lately? A Lot!
At any level that you choose to rely on the AAE, these resources are at your fingertips and will save you time, money and will help you grow your practice.

I manage an office for seven endodontists, so I realize how important it is to promote the practice and the specialty with scientific, accurate and consistent information. There is no better resource than your Association and no better investment than opening that door for your staff.

Want to locate an endodontic staff member? Follow these steps:

2. Select the state in which you want to search.
3. Select “Auxiliary” in the Membership Type menu.
4. Click “Search” to find AAE professional staff members.
To Contract, or Not

Considerations Before Signing an Insurance Contract

A practice’s decision to participate as a contracted dental provider is an important business decision. It must be made based on the market where the endodontist practices, referral relationships and overall practice economics. The key is determining whether participation helps build and sustain a financially healthy practice.

Consider the following important questions before signing a provider contract:

What is the fee schedule for the procedures you commonly perform?
Endodontists use a limited set of CDT codes, and the plan should be able to provide a fee schedule by CDT code so that you can determine whether total payment under the contract is adequate to cover overhead and a reasonable profit market.

Is participation important to maintain and build your referral and patient base? Does it provide a marketing advantage?
Patients build practices.
In endodontics, referrals from general dentists are key to building and maintaining a practice. General dentists who contract as in-network PPO providers are usually required to refer to in-network specialists.

In a market where one or more dental PPO plans serve a significant number of potential patients, the advantages to being in-network may outweigh the disadvantages. This scenario is more likely in markets where there are one or two dominant employers.

Ask the dental benefit plan’s provider relations representative for the following information:
• What are the major businesses in the area who use the PPO plan?
• How many “lives” does the plan cover?
• What are the standard design limitations and exclusions?
• What are the pre-authorization requirements?
• Already in-network? Monitor performance under the contract.

Most provider contracts are “evergreen,” meaning that they automatically renew every year unless one of the parties terminates the contract. For that reason, your practice staff needs to keep an eye out for contracts that may be more trouble than they are worth. For example, does staff spend too much time addressing plan problems or administrative requirements relative to the economic value of the contract? Are the plan’s payment policies hurting your bottom line by, for example, bundling procedures into a single code?

An endodontic practice is a small business, and decisions on whether to continue contracts should be based on whether they are good for the bottom line so that you can provide the best care to your patients.

Find additional resources to navigate dental insurance at www.aae.org/practicemanagement, including the Dental Benefits Kit.
Work in Washington: Updates on Dentistry Legislation

By Susan L. Wolcott, D.D.S.

Since completing my endodontic residency several years ago, I have become increasingly interested in issues and policies that affect not only endodontists, but dentistry as a profession. I became involved in organized dentistry in Colorado, where I first practiced as a specialist, and have continued my involvement since moving to Santa Fe, N.M. In February, the New Mexico Dental Association hosted a “legislative day” in Santa Fe, our county seat. It was a wonderful opportunity for local private practice dentists to speak with our state’s members of Congress about the issues that concern our profession at a state level. At that time, I was also introduced to Dr. Tom Schripsema, chair of the NMDA Council on Governmental Affairs, Michael Moxy, NMDA director of communication and governmental advocacy, and Joe Menapace, NMDA’s legislative advisor. This trio has been making the trek to Washington, D.C. as part of the ADA’s Washington Leadership Conference for several years to advocate for the NMDA and the ADA. When asked if I would be interested in joining them, I thought that it would be a wonderful learning opportunity to see, first hand, how the legislation process works.

To prepare for the leadership conference in May, we met several times to discuss our local issues. Once in D.C., the ADA held a symposium on the first day of the conference to inform all Action Team Leaders of what was happening in Congress in terms of legislation impacting dentistry. It was very informative; four ADA lobbyists and a panel of dentists walked us through the details of each of the three pieces of legislation we would lobby our Congressperson on and why. They emphasized the importance of all delegations communicating a consistent message in a concise manner.

After this initial introduction, the ADA “unleashed” all of the Action Team Leaders on Capitol Hill to meet with members of Congress and/or their staff to explain our positions on the legislation. Because New Mexico has just two senators and three representatives, our task was less daunting than some of the larger states. Our delegation was able to meet with all of our representatives, or at least a staff member, in one day, and had the opportunity to educate our legislators not only about the recent concerns of the ADA, but also about the issues that impact our state dental association.

I feel strongly that as endodontists, we need to have a seat at the table and be active participants in local and national issues affecting dentistry as a whole. Far too often, I think as specialists we do not see that the “issues” impact us, because it is rarely a direct impact. It is essential for all of us to keep in mind that anything that affects our referring doctors is going to affect us eventually. Their issues are our issues.
Advocacy Issues During Hill Visits

• Arizona Representative Dr. Paul Gosar introduced the bipartisan “Dental Insurance Fairness Act of 2013,” H.R. 1798, that will help consumers receive the full value of their dental coverage by amending the Employee Retirement Income Security Act to allow all self-funded health plans that offer dental benefits to provide uniform coordination of benefits and permit patients to assign the payment of benefits directly to their dentists.

• The ADA voiced support for the repeal of the medical device excise tax through passage of the “Protect Medical Innovation Act of 2013,” H.R. 523. Essentially, the medical device tax is a manufacturer’s excise tax, which would require dental equipment, materials, and supplies purchased by a dentist to be taxed.

• The “Competitive Health Insurance Reform Act of 2013,” H.R. 911, also introduced by Representative Dr. Paul Gosar, would bring health insurance companies in line with the rest of the American business community by eliminating the special treatment granted to them almost 65 years ago with passage of the McCarran-Ferguson law.

• The “Coordination of Pro Bono Medically Recommended Dental Care Act,” S. 466/H.R. 963, would create a grant program that supports national volunteer dental programs which coordinate medically recommended dental care for low income individuals. The legislation is needed because Medicare, which does not cover routine dental services, will not pay for the coordination of medically recommended dental care.
The American Association of Endodontists proudly announces the District Director candidates for the 2014-2017 term. Members will approve the nominees by casting their votes at the 2014 General Assembly in Washington, D.C., on Friday, May 2.

The AAE Board of Directors is responsible for and maintains the authority over all matters concerning the Association. The Board includes two representatives from each of the seven districts. Each year, the AAE district caucus nominating committees elect nominees to fill upcoming vacancies on the Board. In addition to the directors, the Board is comprised of six officers, the executive director, the Journal of Endodontics editor and the AAE Foundation president.

**District Director Nominees Announced for 2014 Election**

**Following is the slate of nominees that will be voted on at the 2014 General Assembly:**

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<th>District I</th>
<th>District VI</th>
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<td><strong>Nominee:</strong> Michelle L. Mazur-Kary, Auburn, Maine</td>
<td><strong>Nominee:</strong> Kimberly A.D. Lindquist, Duluth, Minn.</td>
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<td><strong>Nominating Committee Chair:</strong> Tevyah J. Dines, Wellesley, Mass.</td>
<td><strong>Nominating Committee Chair:</strong> David C. Funderburk, Greeley, Colo.</td>
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<th>District VII</th>
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<td><strong>Nominee:</strong> Maria C. Maranga, Aquebogue, N. Y.</td>
<td><strong>Nominee:</strong> Nava Fathi, San Jose, Calif.</td>
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<td><strong>Nominating Committee Chair:</strong> Richard L. Rubin, Fairport, N.Y.</td>
<td><strong>Nominating Committee Chair:</strong> Joseph H. Schulz, Oakland, Calif.</td>
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<td><strong>Nominee:</strong> Mark A. Odom, Cary, N.C.</td>
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<tr>
<td><strong>Nominating Committee Chair:</strong> Henry H. Hancock III, Raleigh, N.C.</td>
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Additional nominations for all District Director positions are welcome and may be made in writing to the District Caucus Nominating Committee chairs. All nominations must be made with the approval of the nominee and accompanied by a petition that includes the printed names and signatures of 25 voting members of that district. To be eligible, the nominations must be received by the District Caucus Nominating Committee chair no later than October 15, 2013.

The AAE thanks the following directors, who are completing their terms on the Board of Directors in April 2014: Drs. Tevyah J. Dines, District I; Richard L. Rubin, District II; Arthur L. Cole, District III; Bruce C. Justman, District VI; and Alan H. Gluskin, District VII.

For more information on the district director nomination process or AAE governance visit www.aae.org/governance, or contact Trina Andresen, assistant executive director for governance, at 800/872-3636 (North America) or 312/266-7255 (International), ext. 3030, or by sending an email to tandresen@aae.org.

New Members

**Associate**
Evan L. Novick, Boston, Mass.
Brett W. Hill, Etna, N.H.

**International**
Pietro Carli, Venice, Italy
Pablo Alejandro Rodriguez, Buenos Aires, Argentina
Hiroshi Takahashi, Yokohama, Japan

Visit www.aae.org/events for more information.