Directors Committee Meeting Agenda
combined meeting with the Coordination Committee, with invitations also extended to the Practitioner Executive Committee, Study PIs, and regional Practitioner Advisory Committees
(in place of the usual monthly Directors Committee meeting initially planned for August 21st)

held face-to-face in the
La Cantera Hotel (La Sierra and Palo Duro Ballrooms)
and by Zoom conference for some attendees

Tuesday, August 27, 2024
8:30 AM - 5:00 PM Central time
Join Zoom Meeting: https://uthealthsa.zoom.us/j/92855757685
Call-in: +1 346 248 7799 US; Meeting ID: 928 5575 7685; Passcode: DCf2f2024!

Anticipated attendees

Western	Midwest	Southwest	South Central	South Atlantic	Northeast	NCC	Specialty Node	NIDCR
Jeffrey Fellows	Brad Rindal	David Cochran	Gregg Gilbert	Valeria Gordan (PREC/PTC Director)	Cyril Meyerowitz	Mary Ann McBurnie	Sath Allareddy	Dena Fischer
			Joana Cunha-Cruz (C&D Director)		Victoria Thomas (2024 Coord. Cmte. Chair)	Michael Leo		Margaret Grisius
			Muna Anabtawi (Natl. Pgm. Manager)			Danyelle Barton		Lorena Baccaglini
						Suzanne Gillespie		
						Lisa Waiwaiole		

Attendance not anticipated
As shown above and below (if applicable) ~~with strikethrough~~

Assistant Regional Node Directors (Joana Cunha-Cruz, Dorota Kopycka-Kedzierawski, Rahma Mungia) and Regional Managers (Sarah Basile) are invited to attend as non-voting representatives.

Once each quarter (January, April, July, October), members of the Coordination Committee are invited to join the Directors Committee meeting.
Potential attendees include:
Western Regional Node: Chris Catlin, Chalinya Ingphakorn, Sweta Mathur
Midwest Regional Node: Sarah Basile, Chris Enstad, Amanda Gillesby, Kim Johnson, Heather Weidner
Southwest Regional Node: Caitlin Sangdahl, Ashley Spencer
South Central Regional Node: Brittni Ball, Aleena Potluri
South Atlantic Regional Node: Danny Johnson, Brenda Thacker
Northeast Regional Node: Kathy Bohn, Rita Cacciato, Pat Ragusa, Victoria Thomas
National Coordinating Center: Danyelle Barton, Phillip Crawford, Ellen Funkhouser, Tamara Lischka, Celeste Machen, Sweta Mathur, Kim Stewart

Once each quarter (January, April, July, October), Study PIs are invited to join the Directors Committee meeting (attendance not required).
PIs of studies still in data collection: Nicolaas Geurs; George Kotsakis; Sandra Japuntich
PIs of recent studies with completed data collection: Blake Berryhill; Jenna McCauley; Nathan Culmer; Todd Smith; Muhammad Walji

Other anticipated attendees
Members of the National Dental Practitioner Executive Committee are invited to the annual face-to-face meeting of the Directors Committee, as are members of regional Practitioner Advisory Committees (Michael Bates, Cheryl Davis, Sridhar Eswaran, Thomas Linton, Sara Mahmood)

Key objectives for this annual meeting

- *Once each year, we have a combined face-to-face meeting of the Directors Committee and the Coordination Committee. We also invite members of the Practitioner Executive Committee, Study PIs, and members of the regional Practitioner Advisory Committees. This is planned as a face-to-face meeting, to provide an opportunity for all team members to meet and/or get to know each other better, and to facilitate longer, broader discussions.*
- *The location of this meeting rotates each year from one region to the next.*
- *In addition to the 'meet and greet' opportunity, a high priority is to enable 'big picture', strategic planning discussions, as well as topics that benefit from longer discussion with input from a broader group.*
- *A next-level priority is to address time-sensitive matters of these committees, given that this single meeting replaces the regular meeting of these committees.*
- *This meeting also provides an opportunity to inform and update a broader range of personnel in the network, about matters in which they are not directly involved. With time constraints, these may not be discussed as part of the formal agenda. If not, these are usually addressed as "Information Items" by including summary documents in a large agenda packet. With a large number of personnel involved in a very broad range of activities, it is easy to have situations where folks feel uninformed or 'out of the loop'. The 'information items' are designed to address some of that. For the meeting packets for these annual meetings, we tend to err on the side of comprehensiveness instead of parsimony. This is the one opportunity each year to ensure that everyone is informed about the numerous activities of the network. Because no one is on all committees, some of the documents you may be seeing for the first time.*
- *Sometimes the routine business of these committees is discussed, given that this single meeting replaces the regular meetings of these committees, but usually any discussion of routine business is displaced by topics that are 'big picture' or more time-sensitive.*

We will project the agenda on a screen and sometimes refer to agenda files on another screen. You may want to bring with you a printed version of the agenda packet. This is because we may need to go back and forth between the agenda and the files used to support the agenda, instead of relying on projections. Printed versions of the packet will *not* be provided at the meeting.

This annual meeting allows for strategic, in-depth, preferably in-person, large group discussions that bring together the input of the various teams within the National Dental PBRN. Please review this agenda packet prior to the meeting and come prepared to add value to the discussion**.**

We will convene promptly at 8:30 AM Eastern time, so please be in attendance by that time. This is an expensive meeting for the network to hold, so we need to make good use of our time. ***For this meeting, we will be more-rigid than usual about abiding by the allotted times*** *for each agenda item*, because some attendees will join via Zoom only at specific time slots. See agenda item #12 below for what happens if more time is needed for an agenda item.

Continental breakfast from 7:30 AM – 8:30 AM
Palo Duro Ballroom and Terrace

1. Welcome and roll call (Gregg Gilbert) [8:30 AM - 9:15 AM]
Objective: To introduce ourselves.
Anticipated time: 45 minutes.
Preparation: Please be prepared to tell us your favorite hobby.
Outcome: Getting to know others in the network better.

For face-to-face meetings, we like to provide an opportunity to get to know our network colleagues better. This is much more time than is typically allotted for this agenda item, but not so for the once-a-year meeting. We have an exceptionally talented network team, with a very broad range of talents and expertise, from a broad range of backgrounds. 'Doing science,' especially clinical science, is still a 'people business.' Therefore, time spent getting to know one another better is important, especially because we must function as a highly collaborative team in order to be effective. Some participants are new to the group, so we will introduce

ourselves.

We will go around the room and "Zoom table" and introduce ourselves. We will do so by stating our name and network role, followed by stating our favorite hobby. In previous years, we revealed our favorite beverage, favorite animal, favorite musical instrument, favorite movie, etc. We will start with the end of the left side of the U-shaped table, then toward its middle, ending on the right side of the table, and then to those who are attending via Zoom.

2. Update of funded studies and lessons learned for the future (Mary Ann McBurnie and Gregg Gilbert) [9:15 AM - 10:15 AM]
Objective:

- To review study timelines and progress, envision resources planning needed for upcoming studies.
- Discuss lessons learned (successes and challenges) and consider suggestions for CQI.

Anticipated time: 60 minutes
Preparation:

- Please also review the attached study-specific reports about practitioner recruitment and patient recruitment.
- Please come prepared to offer your perspective and recollection about lessons learned.

Outcome: Improved workload and study recruitment planning and ideas for CQI.

Before proceeding to the next study, for each study we will:

- Remind ourselves of the key study objectives, study design, and number of practitioners and patients involved
- Discuss any problems encountered during the study development or study implementation, and whether any solutions were proposed and acted upon
- Discuss any lessons learned, with an eye toward recommending Continuous Quality Improvements (CQI) for the future

In development or no data collection yet

- none

Data collection in progress

- Geurs/Implant Registry (UH3)
- Japuntich/FrESH RCT (UH3) [MW and NE Regions only]
- Kotsakis/PAAS (UH3) [SW, SC, and Western Regions only]

Data Collection complete (n = 14)

- Walji/POPS (UH3)
- Culmer/MSDP (X01)
- McCauley/SUDS (X01-like)
- Chavis/CADTAPS (X01)
- Xiao/eHygiene (X01)
- Fellows/CARAD (X01)
- Elad/TOP-AC (X01)
- Jurasic/DCRS (X01)
- Fellows/CORE1, CORE2 (X01)
- Feldman/COVID PREDICT (X01)
- Kwon, Durkin1, Durkin2, Amili (X01s)

Since 2005, a total of 58 studies have been conducted by the Network, or are in progress, the full list of which is located at https://www.nationaldentalpbrn.org/recruiting-ongoing-upcoming-completed/.

List of attachments included for this agenda item

- Overview of studies included in the report (pages 8-9)
- FReSH study status reports (pages 10-17)

- DIRR study status reports (pages 18-25)
- PAAS study status reports (pages 26-31)

Break from 10:15 AM – 10:30 AM

3. Coordination Committee updates and lessons learned for the future (Victoria Thomas) [10:30 AM - 11:00 AM]
Objective:
- To review lessons learned and problems solved regarding Cycle 3 practitioner recruitment and study readiness.
- Perspectives on lessons learned and problems solved from study development and data management for the PBRN setting

Anticipated time: 30 minutes
Preparation: Review the Lesson Learned slides in the agenda packet (pages 32-33).
Outcome: Improved awareness of lessons across all network personnel and ideas for CQI.

4. Update on activities of the Communications & Dissemination Component (Joana Cunha-Cruz) [11:00 AM – 11:30 AM]
Objective: Provide an update on C&D activities and plans.
Anticipated time: 30 minutes
Preparation: Review the C&D information items included in this agenda packet (pages 34-35).
Outcome: Network staff are familiar with current C&D activities and plans and can offer suggestions for Continuous Quality Improvement, such as ideas for the dissemination of study results and for maintaining engagement with members when we do not have studies active.

5. Third-cycle Publications and Presentations Committee activities and plans (Brad Rindal) [11:30 PM – 12:00 Noon]
Objective: Provide an update on P&P Committee activities and plans.
Anticipated time: 30 minutes
Preparation: Review the attached report. Also, please come prepared to share any interactions that you have had with study teams regarding manuscript planning and questions about the policy.
Outcome: Network staff are familiar with P&P activities and can help remind study teams of these benefits.

List of attachments included for this agenda item
- Table of analytic datasets and first manuscript (pages 36-37)
- P&P metrics report (pages 38-39)
- Current P&P Policy (pages 40-47)

Lunch/rest break from 12:00 Noon – 1:00 PM
Palo Duro Ballroom

6. De-centralized clinical trials (Suzanne Gillespie) [1:00 PM – 1:30 PM]
Objectives: To educate us all about de-centralized clinical trials.
Anticipated time: 30 minutes for presentation and discussion.
Preparation: None. Suzanne anticipates projecting a slide presentation during the meeting.
Outcome: Improved awareness and understanding of de-centralized trials.

7. Results from the POPS study (Muhammad Walji) [1:30 PM – 2:00 PM]
Objectives: To educate us about findings from the POPS study. Its data collection ended on April 30, 2024. The date of the analytic data set is pending.
Anticipated time: 30 minutes for presentation and discussion.
Preparation: Review the POPS slides in the agenda packet (pages 48-53).
Outcome: Improved awareness and understanding of POPS study results.

8. Results from the SUDS study (Jenna McCauley) [2:00 PM – 2:30 PM]
Objectives: To educate us about findings from the SUDS study. Its data collection ended on October 16, 2023. The date of the analytic data set is pending.
Anticipated time: 30 minutes for presentation and discussion.
Preparation: Review the SUDS slides in the agenda packet (pages 54-58).
Outcome: Improved awareness and understanding of SUDS study results.

9. Factor analysis results from the CARAD study (Jeffrey Fellows) [2:30 PM – 3:00 PM]
Objectives: To educate us about findings from the CARAD study. Its data collection ended on August 31, 2021. Its analytic dataset was delivered to the Study PI on June 27, 2022.
Anticipated time: 30 minutes for presentation and discussion.
Preparation: Review the CARAD slides in the agenda packet (pages 59-61).
Outcome: Improved awareness and understanding of CARAD study results.

Break from 3:00 PM – 3:15 PM

10. Results from the MSDP study (Todd Smith) [3:15 PM – 3:30 PM]
Objectives: To educate us about findings from the MSDP study. Its data collection ended on August 28, 2023. Its analytic dataset was delivered to the Study PI on April 25, 2024.
Anticipated time: 30 minutes for presentation and discussion.
Preparation: Review the MSDP slides in the agenda packet (pages 62-65).
Outcome: Improved awareness and understanding of MSDP study results.

11. Results from a recent Quick Poll about Network participation (Rahma Mungia) [3:30 PM – 4:00 PM]
Objectives: To educate us about findings from a recent Quick Poll.
Anticipated time: 30 minutes for presentation and discussion.
Preparation: Review the Quick Poll results slides in the agenda packet (pages 66-67).
Outcome: Improved awareness and understanding of recent Quick Poll results.

12. Open time [4:00 PM - 5:00 PM]
Open time to finish discussion of the agenda items above or other items if needed. If this time is not sufficient, the discussion will be completed at the next meeting of the relevant committee(s).

We will keep to the appointed times for each agenda item listed above. However, if an agenda item takes longer than planned, it will be moved into this time period and considered for continuation. Priority will be based on how time-sensitive the agenda item is.

If time is still available, we will close by discussing any questions about the Information items listed below in agenda item #14.

13. Assignment of new Action Items from today's meeting, if applicable (Gregg Gilbert)

14. Information items:
- Update on the Specialty Node (Sath Allareddy) [page 68]

Each year NIDCR hosts a meeting (F2F or virtual) to discuss the annual reports provided by the ARC, NCC, and Study PI personnel. This year's meeting was on June 11-12, 2024. Presentations are often given. Some of this year's presentations are listed below and are included in this agenda packet as information items. Slides from the C&D update and Specialty Node are not included because more-recent updates are included elsewhere in the agenda packet for today's meeting.
- Update on the PREC/PTC Component (Valeria Gordan) [pp. 69-76]
- Update on activities related to the National Dental PBRN Central IRB (Muna Anabtawi) [pp. 77-78]
- Update on activities related to the Practitioner & Patient Compensation System (PPCS) (Muna Anabtawi) [pp. 79-81]

Dinner at 6:30 PM
La Sierra Private Dining Room

NEXT MEETING:
Wednesday, September 25, 2024

FUTURE MEETINGS: ***(please make sure that all of these are on your calendar!)***
Wednesday, October 23, 2024
Wednesday, November 27, 2024
[no mtg in Dec]

ACTION ITEMS	Assignee	STATUS		
		In Progress	Complete	Recurring
Items from 2024-07-24 meeting				
Assess if NCC can support recruitment if the FreSH study patient enrollment extends past September 15th, after Michael Leo does an updated assessment of whether 1,200 patients are still required as a sample size, given new information from actual study data (ICC and missing data estimates).	Mary Ann McBurnie	X		
Recurring items from previous meetings				
Consider updating the Orientation Handbook and comparable documents on an annual basis.	Director's Committee			X

Charge: The Directors Committee (DC) is responsible for optimizing and monitoring overall Network performance, prioritizing Network-wide tasks, and approving study administration policies and procedures. It also reviews study coordination across nodes and makes decisions about practitioner recruitment, training, and engagement. Its main activities comprise discussion and decisions, and to make sure that all team members are working in unison toward the same goals. The highest-priority items are those that are time-sensitive or those that require discussion so that a decision can be made, or consensus obtained. Although these meetings almost always have to do with planning, coordination, and inter-regional communication, and typically function by consensus, a rare vote regarding policy is needed. Within this committee, consensus decision-making is sought, but when needed, each member contributes one vote. NIDCR will advise the DC, as appropriate, on the following: decisions regarding study development, study sequencing, and study implementation; budget/financial/resource allocation decisions; planning the timing and activities of Network face-to-face meetings that are attended by NIDCR personnel; discussion of changes in NIH policy that may affect Network operations or priorities; and proper reporting to NIDCR.

Meeting Frequency: Monthly via conference call and annually face-to-face. Once each quarter (January, April, July, October), members of the Coordination Committee and members of Study Teams are invited to attend the Directors Committee meeting.

Meeting Time: All Directors Committee meetings are held at 1:00 PM – 2:00 PM Eastern time; 12:00 Noon - 1:00 PM Central time; 10:00 AM – 11:00 AM Pacific time, unless they are a face-to-face meeting.

Voting members:

ARC (all voting members, one vote per individual)
National Network Director (Gregg Gilbert); Node Directors (Sath Allareddy, David Cochran, Jeffrey Fellows, Gregg Gilbert, Valeria Gordan, Cyril Meyerowitz, Brad Rindal); C&D Component Director (Joana Cunha-Cruz); PREC/PTC Component Director (Valeria Gordan); National Program Manager (Muna Anabtawi)

NCC (all voting members, one vote per individual)
NCC PI (Mary Ann McBurnie); NCC Biostatistician (Michael Leo); NCC Technical Director (Kim Funkhouser); NCC Co-Administrative Directors (Suzanne Gillespie, Lisa Waiwaiole)

2024 Coordination Committee Chair (voting member, one vote per individual)
Victoria Thomas

NIDCR (ex officio)
Dena Fischer; Margaret Grisius; Lorena Baccaglini

Study Short Name, PI, Study Description	Study Type	# Practitioners	# Patients	Regions
FreSH, Japuntich	UH3, clinical trial	**~55**	**1200**	**Midwest & Northeast**
Cluster randomized clinical trial. **Primary objective:** Assess the effectiveness of Ask-Advise-Refer (AAR) + Nicotine Replacement Therapy Sampling compared to enhanced usual care (AAR + electric toothbrush) on 6-month biologically verified 7-day point prevalence abstinence from combusted tobacco.				
DIRR, Geurs	**UH3, registry**	**~200**	**2000 implants**	**All**
Prospective, observational study (registry). **Primary objectiv**e: quantify the incidence of biologic and prosthetic complications amongst patients receiving dental implant therapy in a practice setting. Characteristics, mucosal and prosthetic characteristics, and radiographic images are obtained from patients at Baseline. Follow-up clinical data and radiographic images are collected at 1, 2, and 3 years after implant placement.				
PAAS, Kotsakis	**UH3, clinical trial**	**37**	**544**	**Southwest, Western & South Central**
Randomized patient-level clinical trial. **Primary objective:** assess the effectiveness, as determined by changes in site-level periodontal probing depth, of scaling and root planing with adjunctive antibiotics compared to placebo in patients with periodontitis, from baseline to 6 weeks and 12 months following non-surgical periodontal therapy.				

NCC Anticipated Effort, Cycle III Years 5-7

Year		2024																	2025												2026				
Activity	**Timeline**	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
*POPS**	*8/1/2021-7/31/2025*																																	
*FReSH**	*8/1/2022- 5/31/2026*																																	
DIRR*	*2/01/22-5/31/2026*																																	
*PAAS**	*8/1/2023-5/21/2026*																																	
Administration and Operations	through 5/31/2026																																	

*** NCC STUDY SUPPORT ACTIVITIES**

- **System development/modification, maintenance, trouble shooting; data security**
- **Data collection, cleaning, routine reporting**
- **Oversight monitoring reports**
- **Analysis requests/analyses**
- **Public dataset creation/documentation**
- **Study managment, logistics, closeout**

Study Implementation

Study Closeout

FreSH (N106)

Study Status Report by Node

Midwest and Northeast Nodes

As of 11AUG2024

Status	Midwest	Northeast	All Nodes
Target # of Participants Consented	600	600	1200
Actual # of Participants Consented	489 (81.5%)	379 (63.2%)	868 (72.3%)
Actual # of Participants Completed **Baseline Survey**	482 (98.6%)	378 (99.7%)	860 (99.1%)
Actual # of Participants Completed **After Visit Survey**	423 (86.5%)	336 (88.7%)	759 (87.4%)
Actual # of Participants Completed **1M Followup Survey**	330 (96.2%)	262 (96.0%)	592 (96.1%)
Actual # of Participants Completed **3M Followup Survey**	217 (94.8%)	208 (98.1%)	425 (96.4%)
Actual # of Participants Completed **6M Followup Survey**	128 (96.2%)	67 (95.7%)	195 (96.1%)
Actual # of Participants Withdrawn	15 (3.1%)	12 (3.2%)	27 (3.1%)

Footnotes:

Consented percentages based on Target counts. Baseline, After Visit Surveys, & Withdrawn percentages based on actual consented counts.

1,3, & 6 Months Follow-up surveys based on those consented, eligible in each respective window and their follow-up window is closed.

Completion is based off REDCap completion status for each form.

FreSH (N106)

Study Status Report by Treatment Arm

Study Status Report by Treatment Arm

As of 11AUG2024

Status	ET	NRT	All Arms
Target # of Participants Consented	600	600	1200
Actual # of Participants Consented	498 (83.0%)	370 (61.7%)	868 (72.3%)
Actual # of Participants Completed **Baseline Survey**	492 (98.8%)	368 (99.5%)	860 (99.1%)
Actual # of Participants Completed **After Visit Survey**	439 (88.2%)	320 (86.5%)	759 (87.4%)
Actual # of Participants Completed **1M Followup Survey**	345 (96.4%)	247 (95.7%)	592 (96.1%)
Actual # of Participants Completed **3M Followup Survey**	257 (96.6%)	168 (96.0%)	425 (96.4%)
Actual # of Participants Completed **6M Followup Survey**	106 (95.5%)	89 (96.7%)	195 (96.1%)
Actual # of Participants Withdrawn	11 (2.2%)	16 (4.3%)	27 (3.1%)

Footnotes:

Consented percentages based on Target counts. Baseline, After Visit Surveys, & Withdrawn percentages based on actual consented counts.

1,3, & 6 Months Follow-up surveys based on those consented, eligible in each respective window and their follow-up window is closed.

Completion is based off REDCap completion status for each form.

FreSH (N106)

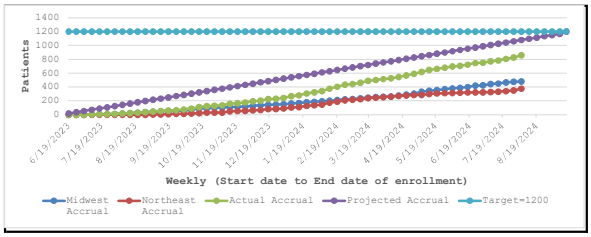
Recruitment Yields

Midwest and Northeast Nodes

As of 11AUG2024

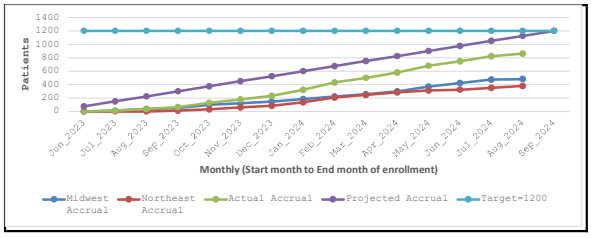
Week	Midwest	Northeast	Total	Midwest Accrual	Northeast Accrual	Actual Accrual	Projected Accrual	Target=1200
6/19/2023	1	0	1	1	0	1	18	1200
6/26/2023	0	0	0	1	0	1	36	1200
7/3/2023	0	0	0	1	0	1	54	1200
7/10/2023	4	0	4	5	0	5	72	1200
7/17/2023	3	0	3	8	0	8	90	1200
7/24/2023	0	0	0	8	0	8	108	1200
7/31/2023	4	0	4	12	0	12	126	1200
8/7/2023	6	0	6	18	0	18	144	1200
8/14/2023	7	0	7	25	0	25	162	1200
8/21/2023	5	0	5	30	0	30	180	1200
8/28/2023	6	0	6	36	0	36	198	1200
9/4/2023	8	2	10	44	2	46	216	1200
9/11/2023	6	2	8	50	4	54	234	1200
9/18/2023	3	5	8	53	9	62	252	1200
9/25/2023	0	3	3	53	12	65	270	1200
10/2/2023	9	2	11	62	14	76	288	1200
10/9/2023	11	4	15	73	18	91	306	1200
10/16/2023	17	4	21	90	22	112	324	1200
10/23/2023	5	8	13	95	30	125	342	1200
10/30/2023	4	1	5	99	31	130	360	1200
11/6/2023	4	2	6	103	33	136	378	1200
11/13/2023	7	17	24	110	50	160	396	1200
11/20/2023	4	4	8	114	54	168	414	1200
11/27/2023	6	4	10	120	58	178	432	1200
12/4/2023	9	6	15	129	64	193	450	1200
12/11/2023	7	3	10	136	67	203	468	1200
12/18/2023	9	15	24	145	82	227	486	1200
12/25/2023	1	3	4	146	85	231	504	1200
1/1/2024	7	6	13	153	91	244	522	1200
1/8/2024	10	14	24	163	105	268	540	1200
1/15/2024	6	7	13	169	112	281	558	1200
1/22/2024	10	16	26	179	128	307	576	1200
1/29/2024	8	9	17	187	137	324	594	1200
2/5/2024	8	10	18	195	147	342	612	1200
2/12/2024	8	27	35	203	174	377	630	1200
2/19/2024	10	17	27	213	191	404	648	1200
2/26/2024	12	18	30	225	209	434	666	1200
3/4/2024	4	7	11	229	216	445	684	1200
3/11/2024	9	9	18	238	225	463	702	1200
3/18/2024	10	17	27	248	242	490	720	1200
3/25/2024	6	5	11	254	247	501	738	1200
4/1/2024	7	7	14	261	254	515	756	1200
4/8/2024	4	8	12	265	262	527	774	1200
4/15/2024	12	8	20	277	270	547	792	1200
4/22/2024	13	8	21	290	278	568	810	1200
4/29/2024	16	7	23	306	285	591	828	1200
5/6/2024	27	1	28	333	286	619	846	1200
5/13/2024	16	13	29	349	299	648	864	1200
5/20/2024	7	9	16	356	308	664	882	1200
5/27/2024	13	3	16	369	311	680	900	1200
6/3/2024	13	5	18	382	316	698	918	1200
6/10/2024	8	1	9	390	317	707	936	1200
6/17/2024	11	5	16	401	322	723	954	1200
6/24/2024	20	3	23	421	325	746	972	1200
7/1/2024	6	0	6	427	325	752	990	1200
7/8/2024	17	3	20	444	328	772	1008	1200
7/15/2024	8	4	12	452	332	784	1026	1200
7/22/2024	14	9	23	466	341	807	1044	1200
7/29/2024	10	12	22	476	353	829	1062	1200
8/5/2024	6	25	31	482	378	860	1080	1200
8/12/2024							1098	1200
8/19/2024							1116	1200
8/26/2024							1134	1200
9/2/2024							1152	1200
9/9/2024							1170	1200
9/15/2024							1200	1200

* Accrual is cumulative



Month	Midwest	Northeast	Total	Midwest Accrual	Northeast Accrual	Actual Accrual	Projected Accrual	Target=1200
Jun_2023	1	0	1	1	0	1	75	1200
Jul_2023	9	0	9	10	0	10	150	1200
Aug_2023	26	0	26	36	0	36	225	1200
Sep_2023	17	12	29	53	12	65	300	1200
Oct_2023	44	19	63	97	31	128	375	1200
Nov_2023	23	27	50	120	58	178	450	1200
Dec_2023	26	27	53	146	85	231	525	1200
Jan_2024	38	51	89	184	136	320	600	1200
Feb_2024	39	72	111	223	208	431	675	1200
Mar_2024	31	39	70	254	247	501	750	1200
Apr_2024	42	35	77	296	282	578	825	1200
May_2024	73	29	102	369	311	680	900	1200
Jun_2024	52	14	66	421	325	746	975	1200
Jul_2024	51	25	76	472	350	822	1050	1200
Aug_2024	10	28	38	482	378	860	1125	1200
Sep_2024							1200	1200

* Accrual is cumulative



FreSH (N106)

Patient Baseline Characteristics*

Midwest and Northeast Nodes

As of 11AUG2024

	Midwest	Northeast	Total
Count of Enrolled* patients	482	378	860
Sex			
Male	187 (38.8%)	151 (39.9%)	338 (39.3%)
Female	293 (60.8%)	227 (60.1%)	520 (60.5%)
Unknown/Not reported	2 (0.4%)	0 (0.0%)	2 (0.2%)
Age			
Age (Mean)	48.5	46.9	47.8
Age Range	(20-84)	(20-88)	(20-88)
Ethnicity			
Of Hispanic/Latino origin	10 (2.1%)	53 (14.0%)	63 (7.3%)
Not of Hispanic/Latino origin	468 (97.1%)	317 (83.9%)	785 (91.3%)
Prefer not to answer	4 (0.8%)	8 (2.1%)	12 (1.4%)
Race			
American Indian or Alaska Native	7 (1.5%)	5 (1.3%)	12 (1.4%)
Asian	7 (1.5%)	7 (1.9%)	14 (1.6%)
Native Hawaiian or Other Pacific Islander	0 (0.0%)	1 (0.3%)	1 (0.1%)
Black or African-American	31 (6.4%)	81 (21.4%)	112 (13.0%)
White or Caucasian	410 (85.1%)	239 (63.2%)	649 (75.5%)
Multiple races	11 (2.3%)	12 (3.2%)	23 (2.7%)
Other	0 (0.0%)	0 (0.0%)	0 (0.0%)
Prefer not to answer	16 (3.3%)	33 (8.7%)	49 (5.7%)
Dental Insurance			
No dental insurance	37 (7.7%)	34 (9.0%)	71 (8.3%)
Private insurance (e.g. employer sponsored, commercial, HMO, etc.)	228 (47.3%)	125 (33.1%)	353 (41.0%)
Public/government insurance (Medicaid, military or veterans benefit, etc.)	121 (25.1%)	137 (36.2%)	258 (30.0%)
Other	74 (15.4%)	53 (14.0%)	127 (14.8%)
I don't know	10 (2.1%)	15 (4.0%)	25 (2.9%)
Prefer not to answer	12 (2.5%)	14 (3.7%)	26 (3.0%)
Missing	0 (0.0%)	0 (0.0%)	0 (0.0%)
Education			
Less than high school diploma	15 (3.1%)	20 (5.3%)	35 (4.1%)
High School diploma or GED	140 (29.0%)	93 (24.6%)	233 (27.1%)
Some college/Associate degree	186 (38.6%)	138 (36.5%)	324 (37.7%)
Bachelor's degree	58 (12.0%)	40 (10.6%)	98 (11.4%)
Graduate degree	14 (2.9%)	41 (10.8%)	55 (6.4%)
Prefer not to answer	11 (2.3%)	5 (1.3%)	16 (1.9%)
Missing	58 (12.0%)	41 (10.8%)	99 (11.5%)
Self-reported Community Type			
Urban	72 (14.9%)	127 (33.6%)	199 (23.1%)
Suburban	165 (34.2%)	140 (37.0%)	305 (35.5%)
Rural	172 (35.7%)	41 (10.8%)	213 (24.8%)
Prefer not to answer	15 (3.1%)	29 (7.7%)	44 (5.1%)
Missing	58 (12.0%)	41 (10.8%)	99 (11.5%)
Number Living in Household			
1	71 (14.7%)	73 (19.3%)	144 (16.7%)
2	154 (32.0%)	97 (25.7%)	251 (29.2%)
3	73 (15.1%)	56 (14.8%)	129 (15.0%)
4	57 (11.8%)	47 (12.4%)	104 (12.1%)
5	34 (7.1%)	25 (6.6%)	59 (6.9%)
6	15 (3.1%)	10 (2.6%)	25 (2.9%)
7	3 (0.6%)	2 (0.5%)	5 (0.6%)
8	1 (0.2%)	0 (0.0%)	1 (0.1%)
9	0 (0.0%)	0 (0.0%)	0 (0.0%)
10 or more	2 (0.4%)	1 (0.3%)	3 (0.3%)
Missing	72 (14.9%)	67 (17.7%)	139 (16.2%)
Annual Household Income			
Up-to (less than or equal to) $25,000	64 (13.3%)	71 (18.8%)	135 (15.7%)
$25,001-$50,000	95 (19.7%)	82 (21.7%)	177 (20.6%)
$50,001-$100,000	134 (27.8%)	91 (24.1%)	225 (26.2%)
Over $100,000	70 (14.5%)	45 (11.9%)	115 (13.4%)
Prefer not to answer	61 (12.7%)	48 (12.7%)	109 (12.7%)
Missing	58 (12.0%)	41 (10.8%)	99 (11.5%)

*Only includes patients who completed the Demographics/Baseline Form.
Excludes withdrawn participants. Missing values are for those patients who have not yet completed the after visit summary (AVS).

FreSH (N106)

Patient Baseline Characteristics*

Midwest and Northeast Nodes

As of 11AUG2024

	Electric Toothbrush	NRTS	Total
Count of Enrolled* patients	492	368	860
Node			
Midwest	263 (53.5%)	219 (59.5%)	482 (56.0%)
Northeast	229 (46.5%)	149 (40.5%)	378 (44.0%)
Sex			
Male	196 (39.8%)	142 (38.6%)	338 (39.3%)
Female	295 (60.0%)	225 (61.1%)	520 (60.5%)
Unknown/Not reported	1 (0.2%)	1 (0.3%)	2 (0.2%)
Age			
Age (Mean)	47.8	47.8	47.8
Age Range	(20-88)	(20-84)	(20-88)
Ethnicity			
Of Hispanic/Latino origin	40 (8.1%)	23 (6.3%)	63 (7.3%)
Not of Hispanic/Latino origin	445 (90.4%)	340 (92.4%)	785 (91.3%)
Prefer not to answer	7 (1.4%)	5 (1.4%)	12 (1.4%)
Race			
American Indian or Alaska Native	4 (0.8%)	8 (2.2%)	12 (1.4%)
Asian	6 (1.2%)	8 (2.2%)	14 (1.6%)
Native Hawaiian or Other Pacific Islander	1 (0.2%)	0 (0.0%)	1 (0.1%)
Black or African-American	70 (14.2%)	42 (11.4%)	112 (13.0%)
White or Caucasian	364 (74.0%)	285 (77.4%)	649 (75.5%)
Multiple races	11 (2.2%)	12 (3.3%)	23 (2.7%)
Other	0 (0.0%)	0 (0.0%)	0 (0.0%)
Prefer not to answer	36 (7.3%)	13 (3.5%)	49 (5.7%)
Dental Insurance			
No dental insurance	29 (5.9%)	42 (11.4%)	71 (8.3%)
Private insurance (e.g. employer sponsored, commercial, HMO, etc.)	203 (41.3%)	150 (40.8%)	353 (41.0%)
Public/government insurance (Medicaid, military or veterans benefit, etc.)	155 (31.5%)	103 (28.0%)	258 (30.0%)
Other	72 (14.6%)	55 (14.9%)	127 (14.8%)
I don't know	17 (3.5%)	8 (2.2%)	25 (2.9%)

Prefer not to answer	16 (3.3%)	10 (2.7%)	26 (3.0%)
Missing	0 (0.0%)	0 (0.0%)	0 (0.0%)

Education

Less than high school diploma	15 (3.0%)	20 (5.4%)	35 (4.1%)
High School diploma or GED	143 (29.1%)	90 (24.5%)	233 (27.1%)
Some college/Associate degree	189 (38.4%)	135 (36.7%)	324 (37.7%)
Bachelor's degree	49 (10.0%)	49 (13.3%)	98 (11.4%)
Graduate degree	6.7 (0.0%)	6 (0.0%)	6.4 (0.0%)
Prefer not to answer	11 (2.2%)	5 (1.4%)	16 (1.9%)
Missing	52 (10.6%)	47 (12.8%)	99 (11.5%)

Self-reported Community Type

Urban	122 (24.8%)	77 (20.9%)	199 (23.1%)
Suburban	195 (39.6%)	110 (29.9%)	305 (35.5%)
Rural	93 (18.9%)	120 (32.6%)	213 (24.8%)
Prefer not to answer	30 (6.1%)	14 (3.8%)	44 (5.1%)
Missing	52 (10.6%)	47 (12.8%)	99 (11.5%)

Number Living in Household

1	88 (17.9%)	56 (15.2%)	144 (16.7%)
2	143 (29.1%)	108 (29.3%)	251 (29.2%)
3	82 (16.7%)	47 (12.8%)	129 (15.0%)
4	53 (10.8%)	51 (13.9%)	104 (12.1%)
5	32 (6.5%)	27 (7.3%)	59 (6.9%)
6	14 (2.8%)	11 (3.0%)	25 (2.9%)
7	4 (0.8%)	1 (0.3%)	5 (0.6%)
8	1 (0.2%)	0 (0.0%)	1 (0.1%)
9	0 (0.0%)	0 (0.0%)	0 (0.0%)
10 or more	1 (0.2%)	2 (0.5%)	3 (0.3%)
Missing	74 (15.0%)	65 (17.7%)	139 (16.2%)

Annual Household Income

Up-to (less than or equal to) $25,000	73 (14.8%)	62 (16.8%)	135 (15.7%)
$25,001-$50,000	104 (21.1%)	73 (19.8%)	177 (20.6%)
$50,001-$100,000	125 (25.4%)	100 (27.2%)	225 (26.2%)
Over $100,000	65 (13.2%)	50 (13.6%)	115 (13.4%)
Prefer not to answer	73 (14.8%)	36 (9.8%)	109 (12.7%)
Missing	52 (0.0%)	47 (0.0%)	99 (0.0%)

*****Only includes patients who completed the Demographics/Baseline Form.
Excludes withdrawn participants. Missing values are for those patients who have not yet completed the after visit summary (AVS).

FreSH (N106)

Practitioner Characteristics by Node

Midwest and Northeast Nodes

As of 11AUG2024

	Midwest	Northeast	Total
Count of Practitioners	49	32	81
Sex			
Male	20 (40.8%)	11 (34.4%)	31 (38.3%)
Female	29 (59.2%)	21 (65.6%)	50 (61.7%)
Unknown/Missing	0 (0.0%)	0 (0.0%)	0 (0.0%)
Age			
Age (Mean)	41.5	47.1	43.7
Age Range	(26-74)	(23-69)	(23-74)
Ethnicity			
Of Hispanic origin	1 (2.0%)	2 (6.3%)	3 (3.7%)
Not of Hispanic or Latino origin	46 (93.9%)	30 (93.8%)	76 (93.8%)
Prefer not to answer/Missing	2 (4.1%)	0 (0.0%)	2 (2.5%)
Race			
American Indian or Alaska Native	0 (0.0%)	0 (0.0%)	0 (0.0%)
Asian	8 (16.3%)	9 (28.1%)	17 (21.0%)
Native Hawaiian or Other Pacific Islander	0 (0.0%)	0 (0.0%)	0 (0.0%)
Black or African-American	2 (4.1%)	1 (3.1%)	3 (3.7%)
White or Caucasian	35 (71.4%)	18 (56.3%)	53 (65.4%)
Asian Indian/East Indian	2 (4.1%)	1 (3.1%)	3 (3.7%)
Middle Eastern	0 (0.0%)	1 (3.1%)	1 (1.2%)
Other	0 (0.0%)	1 (3.1%)	1 (1.2%)
More Than One Race	2 (4.1%)	1 (3.1%)	3 (3.7%)
Prefer not to answer/Unknown/Not Reported	0 (0.0%)	0 (0.0%)	0 (0.0%)
Primary Occupation			
In solo private practice	8 (16.3%)	5 (15.6%)	13 (16.0%)
In private practice, 2-4 dentists total	6 (12.2%)	5 (15.6%)	11 (13.6%)
In private practice, 5 or more dentists total	0 (0.0%)	2 (6.3%)	2 (2.5%)
Managed care or preferred provider organization	4 (8.2%)	0 (0.0%)	4 (4.9%)
Dental school, academic institution or faculty staffed by the dental school	0 (0.0%)	11 (34.4%)	11 (13.6%)
Corporate Dentistry	7 (14.3%)	0 (0.0%)	7 (8.6%)
Armed Forces	0 (0.0%)	0 (0.0%)	0 (0.0%)
Federal Government facility *e.g. VA, Public Health Service	1 (2.0%)	0 (0.0%)	1 (1.2%)
Public health practice , community health center, or publically funded clinic (but not federal facility)	1 (2.0%)	1 (3.1%)	2 (2.5%)
Hospital	0 (0.0%)	0 (0.0%)	0 (0.0%)
Dental Hygienist	20 (40.8%)	8 (25.0%)	28 (34.6%)
Dental Therapist	1 (2.0%)	0 (0.0%)	1 (1.2%)
Dental Assistant	0 (0.0%)	0 (0.0%)	0 (0.0%)
General Practitioner/Specialist			
Generalist	25 (51.0%)	18 (56.3%)	43 (53.1%)
Specialist	2 (4.1%)	5 (15.6%)	7 (8.6%)
Missing	22 (44.9%)	9 (28.1%)	31 (38.3%)
Specialty Training Categories			
Advanced Education in General Dentistry program (AEGD)	1 (2.0%)	12 (37.5%)	13 (16.0%)
Fellow of the Academy of General Dentistry (FAGD)	1 (2.0%)	4 (12.5%)	5 (6.2%)
Mastership in the Academy of General Dentistry (MAGD)	1 (2.0%)	2 (6.3%)	3 (3.7%)
General Practice Residency (GPR)	5 (10.2%)	12 (37.5%)	17 (21.0%)
Orthodontics & Dentofacial Orthopedics	1 (2.0%)	1 (3.1%)	2 (2.5%)
Orthodontics/Periodontics	0 (0.0%)	0 (0.0%)	0 (0.0%)
Oral and Maxillofacial Surgery	0 (0.0%)	1 (3.1%)	1 (1.2%)
Oral Medicine	2 (4.1%)	0 (0.0%)	2 (2.5%)
Orofacial Pain or TMD	2 (4.1%)	2 (6.3%)	4 (4.9%)
Dental Anesthesiology	0 (0.0%)	0 (0.0%)	0 (0.0%)
Dental Public Health	0 (0.0%)	1 (3.1%)	1 (1.2%)
Endodontics/Endodontist	0 (0.0%)	1 (3.1%)	1 (1.2%)
Oral and Maxillofacial Pathology	0 (0.0%)	0 (0.0%)	0 (0.0%)
Oral and Maxillofacial Radiology	0 (0.0%)	0 (0.0%)	0 (0.0%)
Pediatric Dentistry/Pediatric Dentist	1 (2.0%)	0 (0.0%)	1 (1.2%)
Periodontics/Periodontist	1 (2.0%)	3 (9.4%)	4 (4.9%)
Prosthodontics/ Prosthetics	0 (0.0%)	1 (3.1%)	1 (1.2%)

Race: may represent more than one category chosen

Speciality training: may represent more than one category chosen

FreSH (N106)

Practitioner Characteristics by Treatment

Midwest and Northeast Nodes

As of 11AUG2024

	Electric Toothbrush	NRTS	Total
Count of Practitioners	39	42	81
Sex			
Male	14 (35.9%)	17 (40.5%)	31 (38.3%)
Female	25 (64.1%)	25 (59.5%)	50 (61.7%)
Unknown/Missing	0 (0.0%)	0 (0.0%)	0 (0.0%)
Age			
Age (Mean)	45.1	42.4	43.7
Age Range	(23-74)	(26-69)	(23-74)
Ethnicity			
Of Hispanic origin	2 (5.1%)	1 (2.4%)	3 (3.7%)
Not of Hispanic or Latino origin	36 (92.3%)	40 (95.2%)	76 (93.8%)
Prefer not to answer/Missing	1 (2.6%)	1 (2.4%)	2 (2.5%)
Race			
American Indian or Alaska Native	0 (0.0%)	0 (0.0%)	0 (0.0%)
Asian	8 (20.5%)	9 (21.4%)	17 (21.0%)
Native Hawaiian or Other Pacific Islander	0 (0.0%)	0 (0.0%)	0 (0.0%)
Black or African-American	1 (2.6%)	2 (4.8%)	3 (3.7%)
White or Caucasian	25 (64.1%)	28 (66.7%)	53 (65.4%)
Asian Indian/East Indian	2 (5.1%)	1 (2.4%)	3 (3.7%)
Middle Eastern	1 (2.6%)	0 (0.0%)	1 (1.2%)
Other	1 (2.6%)	0 (0.0%)	1 (1.2%)
More Than One Race	1 (2.6%)	2 (4.8%)	3 (3.7%)
Prefer not to answer/Unknown/Not Reported	0 (0.0%)	0 (0.0%)	0 (0.0%)
Primary Occupation			
In solo private practice	6 (15.4%)	7 (16.7%)	13 (16.0%)
In private practice, 2-4 dentists total	7 (17.9%)	4 (9.5%)	11 (13.6%)
In private practice, 5 or more dentists total	1 (2.6%)	1 (2.4%)	2 (2.5%)
Managed care or preferred provider organization	1 (2.6%)	3 (7.1%)	4 (4.9%)
Dental school, academic institution or faculty staffed by the dental school	6 (15.4%)	5 (11.9%)	11 (13.6%)
Corporate Dentistry	0 (0.0%)	7 (16.7%)	7 (8.6%)

Armed Forces	0 (0.0%)	0 (0.0%)	0 (0.0%)
Federal Government facility *e.g. VA, Public Health Service	0 (0.0%)	1 (2.4%)	1 (1.2%)
Public health practice , community health center, or publically funded clinic (but not federal facility)	1 (2.6%)	1 (2.4%)	2 (2.5%)
Hospital	0 (0.0%)	0 (0.0%)	0 (0.0%)
Dental Hygienist	15 (38.5%)	13 (31.0%)	28 (34.6%)
Dental Therapist	1 (2.6%)	0 (0.0%)	1 (1.2%)
Dental Assistant	0 (0.0%)	0 (0.0%)	0 (0.0%)
Other	1 (2.6%)	0 (0.0%)	1 (1.2%)

General Practitioner/Specialist

Generalist	16 (41.0%)	27 (64.3%)	43 (53.1%)
Specialist	5 (12.8%)	2 (4.8%)	7 (8.6%)
Missing	18 (46.2%)	13 (31.0%)	31 (38.3%)

Specialty Training Categories

Advanced Education in General Dentistry program (AEGD)	5 (12.8%)	8 (19.0%)	13 (16.0%)
Fellow of the Academy of General Dentistry (FAGD)	3 (7.7%)	2 (4.8%)	5 (6.2%)
Mastership in the Academy of General Dentistry (MAGD)	0 (0.0%)	3 (7.1%)	3 (3.7%)
General Practice Residency (GPR)	6 (15.4%)	11 (26.2%)	17 (21.0%)
Orthodontics & Dentofacial Orthopedics	2 (5.1%)	0 (0.0%)	2 (2.5%)
Orthodontics/Periodontics	0 (0.0%)	0 (0.0%)	0 (0.0%)
Oral and Maxillofacial Surgery	1 (2.6%)	0 (0.0%)	1 (1.2%)
Oral Medicine	1 (2.6%)	1 (2.4%)	2 (2.5%)
Orofacial Pain or TMD	4 (10.3%)	0 (0.0%)	4 (4.9%)
Dental Anesthesiology	0 (0.0%)	0 (0.0%)	0 (0.0%)
Dental Public Health	1 (2.6%)	0 (0.0%)	1 (1.2%)
Endodontics/Endodontist	1 (2.6%)	0 (0.0%)	1 (1.2%)
Oral and Maxillofacial Pathology	0 (0.0%)	0 (0.0%)	0 (0.0%)
Oral and Maxillofacial Radiology	0 (0.0%)	0 (0.0%)	0 (0.0%)
Pediatric Dentistry/Pediatric Dentist	0 (0.0%)	1 (2.4%)	1 (1.2%)
Periodontics/Periodontist	2 (5.1%)	2 (4.8%)	4 (4.9%)
Prosthodontics/ Prosthetics	0 (0.0%)	1 (2.4%)	1 (1.2%)

Race: may represent more than one category chosen

Specialty training: may represent more than one category

Implant Registry (N108)
Study Status Report
All Nodes
As of 08/11/2024

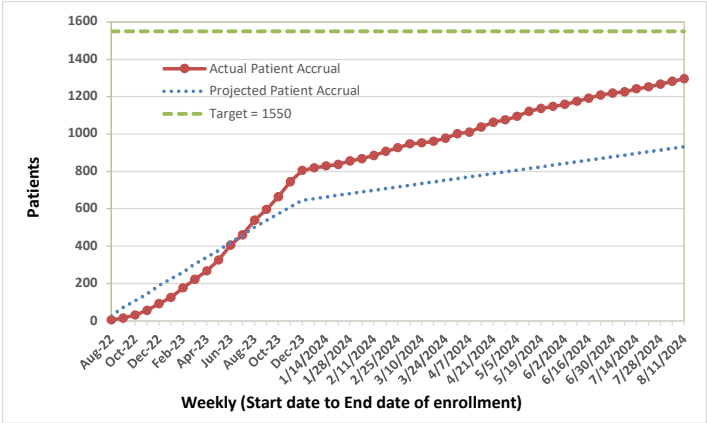
Status	1-Western Region		2-Midwest Region		3-Southwest Region		4-South Central Region		5-South Atlantic Region		6-Northeast Region		All Nodes	
	Baseline	Y1	Baseline	Y1	Baseline	Y1	Baseline	Y1	Baseline	Y1	Baseline	Y1	Baseline	Y1
Target # of Participants to Enroll (BL) Expected # of Participants to Enroll (Y1)	259	98	258	242	259	398	258	137	258	218	258	203	1550	1296
Actual # of Participants Enrolled (BL) or annual data collection has opened (Y1) (excludes fully withdrawn participants)	98 (37.8%)	50 (51.0%)	242 (93.8%)	125 (51.7%)	398 (153.7%)	176 (44.2%)	137 (53.1%)	37 (27.0%)	218 (84.5%)	52 (23.9%)	203 (78.7%)	93 (45.8%)	1296 (83.6%)	533 (41.1%)
Actual # of participants within data collection window	N/A	31 (62.0%)	N/A	71 (56.8%)	N/A	122 (69.3%)	N/A	25 (67.6%)	N/A	46 (88.5%)	N/A	50 (53.8%)	N/A	345 (64.7%)
Actual # of participants past data collection window	N/A	19 (38.0%)	N/A	54 (43.2%)	N/A	54 (30.7%)	N/A	12 (32.4%)	N/A	6 (11.5%)	N/A	43 (46.2%)	N/A	188 (35.3%)
Missed visits - actual # of participants past data collection window with no practitioner data entered	N/A	6 (31.6%)	N/A	15 (27.8%)	N/A	22 (40.7%)	N/A	8 (66.7%)	N/A	6 (100.0%)	N/A	11 (25.6%)	N/A	68 (36.2%)
Actual # of Practitioners completed Implant Survey (Baseline) or Completed Practitioner Annual Followup Visit (excludes fully withdrawn participants)	96 (37.1%)	21 (21.4%)	242 (93.8%)	60 (24.8%)	391 (151.0%)	67 (16.8%)	135 (52.3%)	11 (8.0%)	208 (80.6%)	15 (6.9%)	203 (78.7%)	47 (23.2%)	1275 (82.3%)	221 (17.1%)
Actual # of Participants Completed Baseline Visit or Completed Patient Annual Followup Survey (excludes fully withdrawn participants)	77 (29.7%)	33 (33.7%)	213 (82.6%)	92 (38.0%)	280 (108.1%)	107 (26.9%)	112 (43.4%)	22 (16.1%)	153 (59.3%)	25 (11.5%)	186 (72.1%)	70 (34.5%)	1021 (65.9%)	349 (26.9%)
Actual # of Participants Fully Withdrawn*	0 (0.0%)	3 (3.1%)	2 (0.8%)	1 (0.4%)	4 (1.5%)	16 (4.0%)	0 (0.0%)	0 (0.0%)	5 (1.9%)	0 (0.0%)	3 (1.2%)	2 (1.0%)	14 (0.9%)	22 (1.7%)
Target # of Implants to Enroll	334	126	333	308	334	540	333	281	333	300	333	257	2000	1812
Actual # of Implants Enrolled** (excludes fully withdrawn participants) **Baseline = Implant Enrolled **Y1 = # of Implants where Practitioner fully completed Practitioner Annual Follow up Per Implant Survey	126 (37.7%)	24 (19.0%)	308 (92.5%)	75 (26.9%)	540 (161.7%)	83 (15.4%)	281 (84.4%)	19 (6.8%)	300 (90.1%)	25 (8.3%)	257 (77.2%)	56 (21.8%)	1812 (90.6%)	282 (15.6%)

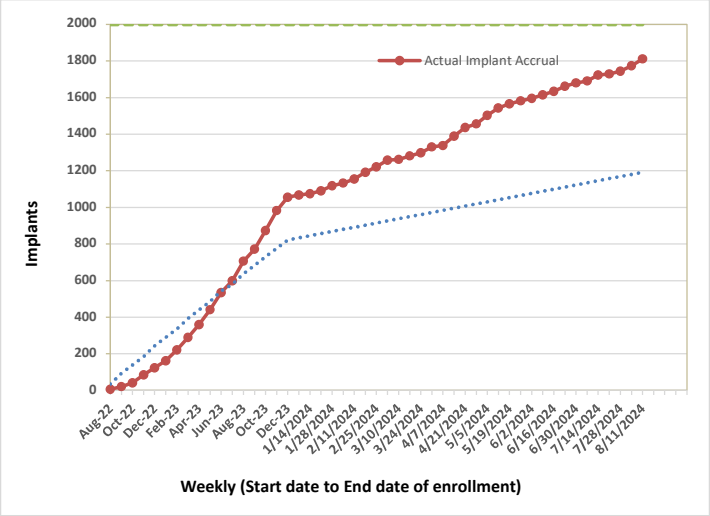
Implant Registry (N108)

Recruitment Yields

As of 08/11/2024

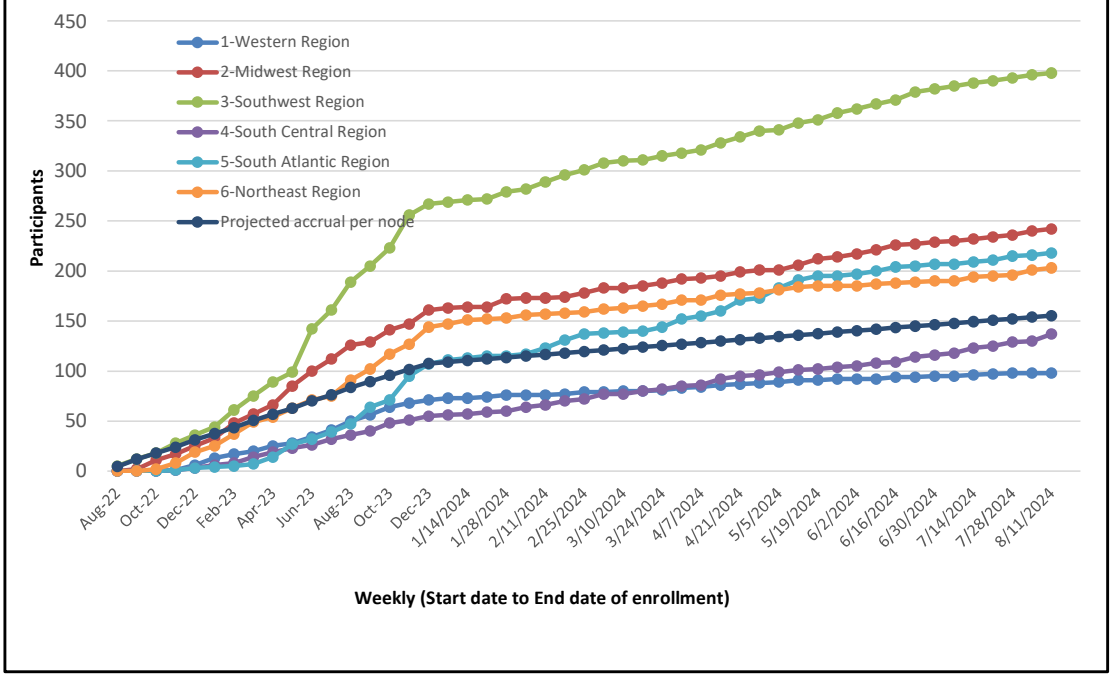
Date	Actual Patient Accrual	Projected Patient Accrual	Target=1550	Actual Implant Accrual	Projected Implant Accrual	Implant Target = 2000
Aug-22	5	27	1550	5	35	2000
Sep-22	14	72	1550	20	92	2000
Oct-22	31	108	1550	40	139	2000
Nov-22	56	143	1550	84	185	2000
Dec-22	92	188	1550	123	243	2000
Jan-23	125	224	1550	161	289	2000
Feb-23	176	260	1550	221	335	2000
Mar-23	222	305	1550	289	393	2000
Apr-23	267	340	1550	359	439	2000
May-23	325	376	1550	441	486	2000
Jun-23	405	421	1550	533	543	2000
Jul-23	460	457	1550	599	579	2000
Aug-23	539	502	1550	706	637	2000
Sep-23	596	538	1550	771	683	2000
Oct-23	664	573	1550	873	729	2000
Nov-23	744	609	1550	983	776	2000
Dec-23	805	645	1550	1055	822	2000
1/7/2024	819	654	1550	1067	834	2000
1/14/2024	829	663	1550	1075	845	2000
1/21/2024	836	672	1550	1091	857	2000
1/28/2024	855	681	1550	1118	868	2000
2/4/2024	868	690	1550	1133	880	2000
2/11/2024	884	699	1550	1155	891	2000
2/18/2024	906	708	1550	1192	903	2000
2/25/2024	926	717	1550	1222	914	2000
3/3/2024	947	726	1550	1258	926	2000
3/10/2024	952	735	1550	1262	938	2000
3/17/2024	961	744	1550	1281	949	2000
3/24/2024	977	753	1550	1299	961	2000
3/31/2024	1001	762	1550	1331	972	2000
4/7/2024	1010	771	1550	1338	984	2000
4/14/2024	1037	779	1550	1389	995	2000
4/21/2024	1063	788	1550	1436	1007	2000
4/28/2024	1076	797	1550	1456	1018	2000
5/5/2024	1094	806	1550	1504	1030	2000
5/12/2024	1121	815	1550	1543	1042	2000
5/19/2024	1136	824	1550	1566	1053	2000
5/26/2024	1148	833	1550	1582	1065	2000
6/2/2024	1158	842	1550	1596	1076	2000
6/9/2024	1175	851	1550	1616	1088	2000
6/16/2024	1192	860	1550	1635	1099	2000
6/23/2024	1208	869	1550	1663	1111	2000
6/30/2024	1219	878	1550	1681	1123	2000
7/7/2024	1225	887	1550	1691	1134	2000
7/14/2024	1242	896	1550	1723	1146	2000
7/21/2024	1252	905	1550	1730	1157	2000
7/28/2024	1267	914	1550	1745	1169	2000
8/4/2024	1281	923	1550	1774	1180	2000
8/11/2024	1296	932	1550	1812	1192	2000
8/18/2024		941	1550		1203	2000

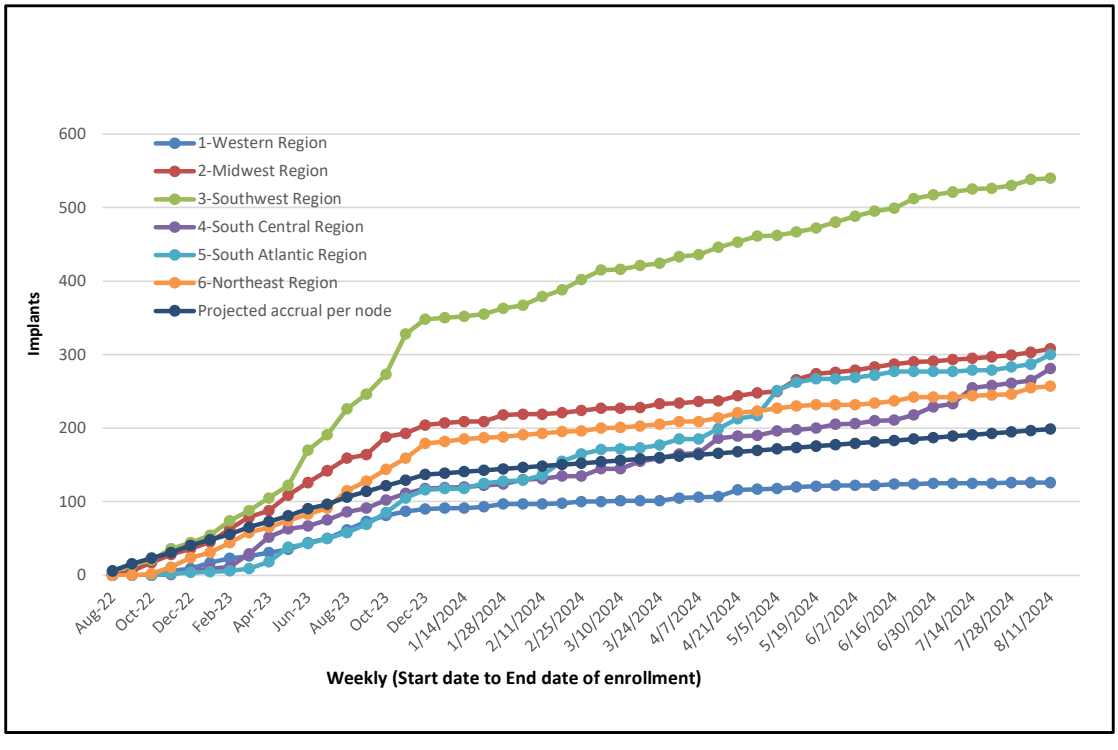




* Accrual is cumulative, and excludes participants who have withdrawn

Implant Registry (N108)
Recruitment Yields by Node
As of 08/11/2024





IMPLANT REGISTRY (N108)

Patient Baseline Characteristics*

All Nodes

As of 08/11/2024

	Western	Midwest	Southwest	South Central	South Atlantic	Northeast	Total
Count of Enrolled* patients	79	214	283	112	154	187	1029
Sex							
Male	36 (45.6%)	102 (47.7%)	115 (40.6%)	50 (44.6%)	69 (44.8%)	79 (42.2%)	451 (43.8%)
Female	43 (54.4%)	111 (51.9%)	165 (58.3%)	62 (55.4%)	84 (54.5%)	108 (57.8%)	573 (55.7%)
Non-Binary	0 (0.0%)	0 (0.0%)	1 (0.4%)	0 (0.0%)	1 (0.6%)	0 (0.0%)	2 (0.2%)
Prefer not to answer	0 (0.0%)	1 (0.5%)	2 (0.7%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	3 (0.3%)
Age							
Age (Mean)	58.2	60.6	56.7	61.4	60.5	57.4	58.8
Age Range	(21-79)	(23-83)	(19-89)	(36-85)	(24-88)	(20-84)	(19-89)
Ethnicity							
Of Hispanic/Latino origin	17 (21.5%)	2 (0.9%)	26 (9.2%)	4 (3.6%)	19 (12.3%)	19 (10.2%)	87 (8.5%)
Not of Hispanic/Latino origin	62 (78.5%)	205 (95.8%)	253 (89.4%)	108 (96.4%)	134 (87.0%)	165 (88.2%)	927 (90.1%)
Prefer not to answer	0 (0.0%)	7 (3.3%)	4 (1.4%)	0 (0.0%)	1 (0.6%)	3 (1.6%)	15 (1.5%)
Race							
American Indian or Alaska Native	0 (0.0%)	0 (0.0%)	2 (0.7%)	0 (0.0%)	0 (0.0%)	2 (1.1%)	4 (0.4%)
Asian	4 (5.1%)	8 (3.7%)	30 (10.6%)	1 (0.9%)	11 (7.1%)	11 (5.9%)	65 (6.3%)
Native Hawaiian or Other Pacific Islander	0 (0.0%)	1 (0.5%)	2 (0.7%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	3 (0.3%)
Black or African-American	5 (6.3%)	19 (8.9%)	19 (6.7%)	8 (7.1%)	11 (7.1%)	15 (8.0%)	77 (7.5%)
White or Caucasian	62 (78.5%)	169 (79.0%)	211 (74.6%)	98 (87.5%)	126 (81.8%)	142 (75.9%)	808 (78.5%)
Multiple races	1 (1.3%)	1 (0.5%)	2 (0.7%)	2 (1.8%)	0 (0.0%)	2 (1.1%)	8 (0.8%)
Prefer not to answer	7 (8.9%)	16 (7.5%)	17 (6.0%)	3 (2.7%)	6 (3.9%)	15 (8.0%)	64 (6.2%)
Dental Insurance							
No dental insurance	14 (17.7%)	34 (15.9%)	47 (16.6%)	26 (23.2%)	57 (37.0%)	31 (16.6%)	209 (20.3%)
Private insurance (e.g. employer sponsored, commercial, HMO, etc.)	47 (59.5%)	120 (56.1%)	192 (67.8%)	65 (58.0%)	69 (44.8%)	117 (62.6%)	610 (59.3%)
Public/government insurance (Medicaid, military or veterans benefit, etc.)	4 (5.1%)	12 (5.6%)	10 (3.5%)	8 (7.1%)	2 (1.3%)	12 (6.4%)	48 (4.7%)
Private and Public/government(e.g., private plus Medicare)	10 (12.7%)	38 (17.8%)	18 (6.4%)	7 (6.3%)	15 (9.7%)	17 (9.1%)	105 (10.2%)
Other	1 (1.3%)	3 (1.4%)	7 (2.5%)	3 (2.7%)	9 (5.8%)	6 (3.2%)	29 (2.8%)
I don't know	0 (0.0%)	2 (0.9%)	3 (1.1%)	1 (0.9%)	1 (0.6%)	2 (1.1%)	9 (0.9%)
Prefer not to answer	3 (3.8%)	5 (2.3%)	6 (2.1%)	2 (1.8%)	1 (0.6%)	2 (1.1%)	19 (1.8%)
Education							
Less than high school diploma	2 (2.5%)	0 (0.0%)	5 (1.8%)	4 (3.6%)	2 (1.3%)	4 (2.1%)	17 (1.7%)
High School diploma or GED	5 (6.3%)	14 (6.5%)	23 (8.1%)	24 (21.4%)	24 (15.6%)	18 (9.6%)	108 (10.5%)
Some college/Associate degree	17 (21.5%)	59 (27.6%)	62 (21.9%)	35 (31.3%)	24 (15.6%)	47 (25.1%)	244 (23.7%)
Bachelor's degree	23 (29.1%)	67 (31.3%)	95 (33.6%)	28 (25.0%)	43 (27.9%)	42 (22.5%)	298 (29.0%)
Graduate degree	31 (39.2%)	70 (32.7%)	94 (33.2%)	21 (18.8%)	59 (38.3%)	72 (38.5%)	347 (33.7%)
Prefer not to answer	1 (1.3%)	4 (1.9%)	4 (1.4%)	0 (0.0%)	2 (1.3%)	4 (2.1%)	15 (1.5%)
Self-reported Community Type							
Urban	28 (35.4%)	51 (23.8%)	61 (21.6%)	12 (10.7%)	42 (27.3%)	28 (15.0%)	222 (21.6%)
Suburban	34 (43.0%)	122 (57.0%)	195 (68.9%)	57 (50.9%)	97 (63.0%)	147 (78.6%)	652 (63.4%)
Rural	17 (21.5%)	41 (19.2%)	27 (9.5%)	43 (38.4%)	15 (9.7%)	12 (6.4%)	155 (15.1%)
Number Living in Household							
1	11 (13.9%)	33 (15.4%)	49 (17.3%)	17 (15.2%)	23 (14.9%)	29 (15.5%)	162 (15.7%)
2	42 (53.2%)	122 (57.0%)	117 (41.3%)	62 (55.4%)	80 (51.9%)	78 (41.7%)	501 (48.7%)
3	9 (11.4%)	24 (11.2%)	50 (17.7%)	22 (19.6%)	24 (15.6%)	35 (18.7%)	164 (15.9%)
4	10 (12.7%)	20 (9.3%)	39 (13.8%)	9 (8.0%)	19 (12.3%)	28 (15.0%)	125 (12.1%)
5	5 (6.3%)	10 (4.7%)	17 (6.0%)	1 (0.9%)	6 (3.9%)	8 (4.3%)	47 (4.6%)
6 or more	2 (2.5%)	3 (1.4%)	10 (3.5%)	1 (0.9%)	2 (1.3%)	7 (3.7%)	25 (2.4%)
Annual Household Income							
Up-to (less than or equal to) $25,000	2 (2.5%)	3 (1.4%)	7 (2.5%)	4 (3.6%)	3 (1.9%)	5 (2.7%)	24 (2.3%)
$25,001-$50,000	4 (5.1%)	25 (11.7%)	18 (6.4%)	20 (17.9%)	14 (9.1%)	24 (12.8%)	105 (10.2%)
$50,001-$100,000	21 (26.6%)	50 (23.4%)	66 (23.3%)	32 (28.6%)	40 (26.0%)	36 (19.3%)	245 (23.8%)
Over $100,000	37 (46.8%)	90 (42.1%)	119 (42.0%)	33 (29.5%)	58 (37.7%)	88 (47.1%)	425 (41.3%)
Prefer not to answer	15 (19.0%)	46 (21.5%)	73 (25.8%)	23 (20.5%)	39 (25.3%)	34 (18.2%)	230 (22.4%)

*Only includes patients who completed the Demographics Form. Excludes withdrawn participants.

Implant Registry (N108)
Image Status Report
All Nodes
As of 08/11/2024

Baseline Visit Status	1-Western Region	2-Midwest Region	3-Southwest Region	4-South Central Region	5-South Atlantic Region	6-Northeast Region	All Nodes
# of Radiographs in Node Coordinator Queue *(NC Review or New Image Requested)*	0 (0.0%)	0 (0.0%)	7 (1.3%)	12 (4.3%)	9 (3.0%)	0 (0.0%)	28 (1.5%)
# of Radiographs in Study Team Queue *(Study Team Review or ST Review - No New Image Requested)*	0 (0.0%)	5 (1.6%)	2 (0.4%)	51 (18.1%)	1 (0.3%)	3 (1.2%)	62 (3.4%)
# of Radiographs in Image Repository *(Usable or Best Available)*	119 (94.4%)	303 (96.8%)	487 (89.7%)	164 (58.4%)	249 (83.0%)	241 (92.7%)	1563 (85.7%)
# of Unusable Radiographs	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (0.3%)	0 (0.0%)	1 (0.1%)
# of Implants without Radiographs	7 (5.6%)	0 (0.0%)	44 (8.1%)	54 (19.2%)	40 (13.3%)	13 (5.0%)	158 (8.7%)
# of Withdrawn	0 (0.0%)	5 (1.6%)	3 (0.6%)	0 (0.0%)	0 (0.0%)	3 (1.2%)	11 (0.6%)
All	126 (100.0%)	313 (100.0%)	543 (100.0%)	281 (100.0%)	300 (100.0%)	260 (100.0%)	1823 (100.0%)

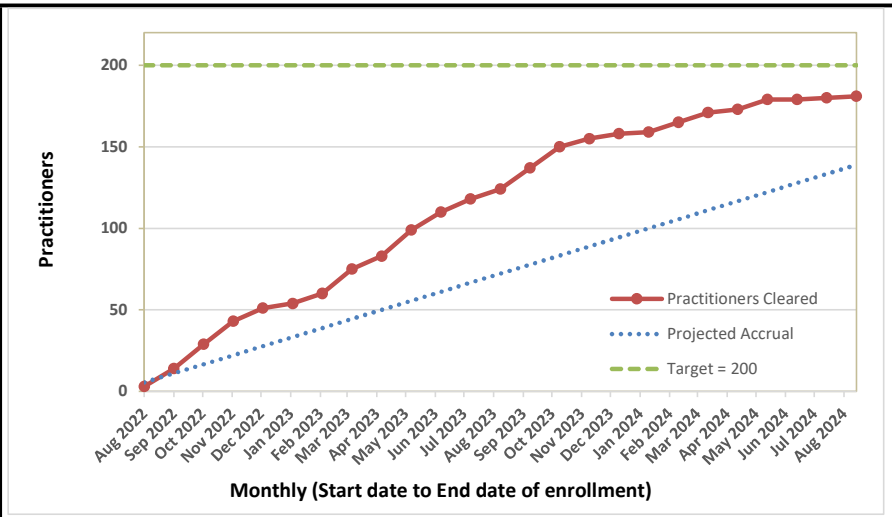
Y1 Visit Status	1-Western Region	2-Midwest Region	3-Southwest Region	4-South Central Region	5-South Atlantic Region	6-Northeast Region	All Nodes
# of Radiographs in Node Coordinator Queue *(NC Review or New Image Requested)*	0 (0.0%)	2 (2.7%)	3 (3.6%)	4 (21.1%)	3 (12.0%)	0 (0.0%)	12 (4.2%)
# of Radiographs in Study Team Queue *(Study Team Review or ST Review - No New Image Requested)*	0 (0.0%)	1 (1.3%)	5 (6.0%)	4 (21.1%)	2 (8.0%)	2 (3.6%)	14 (4.9%)
# of Radiographs in Image Repository *(Usable or Best Available)*	24 (100.0%)	69 (92.0%)	68 (81.0%)	8 (42.1%)	15 (60.0%)	35 (62.5%)	219 (77.4%)
# of Unusable Radiographs	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
# of Implants without Radiographs	0 (0.0%)	3 (4.0%)	7 (8.3%)	3 (15.8%)	5 (20.0%)	19 (33.9%)	37 (13.1%)
# of Withdrawn	0 (0.0%)	0 (0.0%)	1 (1.2%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (0.4%)
All	24 (100.0%)	75 (100.0%)	84 (100.0%)	19 (100.0%)	25 (100.0%)	56 (100.0%)	283 (100.0%)

Implant Registry (N108)

Practitioners Eligible for Recruitment by Month

As of 08/11/2024

Date	Practitioners Cleared for Data Collection	Projected Accrual	Target=200
Aug 2022	3	6	200
Sep 2022	14	11	200
Oct 2022	29	17	200
Nov 2022	43	22	200
Dec 2022	51	28	200
Jan 2023	54	33	200
Feb 2023	60	39	200
Mar 2023	75	44	200
Apr 2023	83	50	200
May 2023	99	56	200
Jun 2023	110	61	200
Jul 2023	118	67	200
Aug 2023	124	72	200
Sep 2023	137	78	200
Oct 2023	150	83	200
Nov 2023	155	89	200
Dec 2023	158	94	200
Jan 2024	159	100	200
Feb 2024	165	106	200
Mar 2024	171	111	200
Apr 2024	173	117	200
May 2024	179	122	200
Jun 2024	179	128	200
Jul 2024	180	133	200
Aug 2024	181	139	200



* Accrual is cumulative

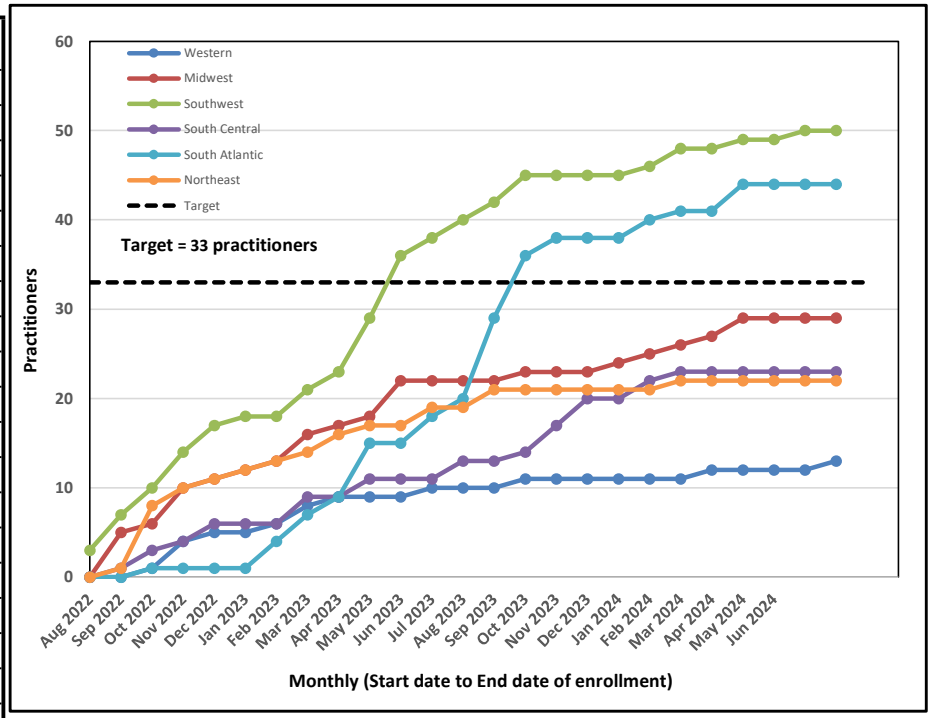
Implant Registry (N108)

Practitioners Eligible for Recruitment by Month by Node

As of 08/11/2024

Date	Western	Midwest	Southwest	South Central	South Atlantic	Northeast
Aug 2022	0	0	3	0	0	0
Sep 2022	0	5	7	1	0	1
Oct 2022	1	6	10	3	1	8
Nov 2022	4	10	14	4	1	10
Dec 2022	5	11	17	6	1	11
Jan 2023	5	12	18	6	1	12
Feb 2023	6	13	18	6	4	13
Mar 2023	8	16	21	9	7	14
Apr 2023	9	17	23	9	9	16
May 2023	9	18	29	11	15	17
Jun 2023	9	22	36	11	15	17
Jul 2023	10	22	38	11	18	19
Aug 2023	10	22	40	13	20	19
Sep 2023	10	22	42	13	29	21
Oct 2023	11	23	45	14	36	21
Nov 2023	11	23	45	17	38	21
Dec 2023	11	23	45	20	38	21
Jan 2024	11	24	45	20	38	21
Feb 2024	11	25	46	22	40	21
Mar 2024	11	26	48	23	41	22
Apr 2024	12	27	48	23	41	22
May 2024	12	29	49	23	44	22
Jun 2024	12	29	49	23	44	22
Jul 2024	12	29	50	23	44	22
Aug 2024	13	29	50	23	44	22

* Accrual is cumulative



Implant Registry (N108)
Practitioner Characteristics
As of 08/11/2024

	Western	Midwest	Southwest	South Central	South Atlantic	Northeast	Total
Count of Practitioners Eligible for Recruitment	13	29	50	23	44	22	181
Count of Practitioners with at Least One Active Participant	9	26	37	17	29	16	134
Sex							
Male	6 (66.7%)	15 (57.7%)	25 (67.6%)	12 (70.6%)	17 (58.6%)	5 (31.3%)	80 (59.7%)
Female	3 (33.3%)	11 (42.3%)	12 (32.4%)	5 (29.4%)	12 (41.4%)	11 (68.8%)	54 (40.3%)
Unknown/Missing	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Age							
Age (Mean)	48.1	50.1	47.7	50.6	45.9	53.4	48.9
Age Range	(34-69)	(33-72)	(28-73)	(24-73)	(28-66)	(41-65)	(24-73)
Ethnicity							
Of Hispanic origin	1 (11.1%)	0 (0.0%)	2 (5.4%)	0 (0.0%)	10 (34.5%)	1 (6.3%)	14 (10.4%)
Not of Hispanic or Latino origin	8 (88.9%)	26 (100.0%)	34 (91.9%)	17 (100.0%)	19 (65.5%)	14 (87.5%)	118 (88.1%)
Prefer not to answer/Missing	0 (0.0%)	0 (0.0%)	1 (2.7%)	0 (0.0%)	0 (0.0%)	1 (6.3%)	2 (1.5%)
Race							
American Indian or Alaska Native	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Asian	1 (11.1%)	2 (7.7%)	8 (21.6%)	0 (0.0%)	1 (3.4%)	4 (25.0%)	16 (11.9%)
Native Hawaiian or Other Pacific Islander	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Black or African-American	1 (11.1%)	2 (7.7%)	1 (2.7%)	2 (11.8%)	0 (0.0%)	0 (0.0%)	6 (4.5%)
White or Caucasian	6 (66.7%)	21 (80.8%)	25 (67.6%)	15 (88.2%)	24 (82.8%)	10 (62.5%)	101 (75.4%)
Asian Indian/East Indian	0 (0.0%)	0 (0.0%)	3 (8.1%)	0 (0.0%)	1 (3.4%)	1 (6.3%)	5 (3.7%)
Middle Eastern	1 (11.1%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (0.7%)
Other	0 (0.0%)	1 (3.8%)	0 (0.0%)	0 (0.0%)	2 (6.9%)	0 (0.0%)	3 (2.2%)
More Than One Race	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Prefer not to answer	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (3.4%)	1 (6.3%)	2 (1.5%)
Primary Occupation							
In solo private practice	5 (55.6%)	7 (26.9%)	19 (51.4%)	9 (52.9%)	14 (48.3%)	7 (43.8%)	61 (45.5%)
In private practice, 2-4 dentists total	3 (33.3%)	7 (26.9%)	13 (35.1%)	7 (41.2%)	4 (13.8%)	4 (25.0%)	38 (28.4%)
In private practice, 5 or more dentists total	0 (0.0%)	0 (0.0%)	1 (2.7%)	0 (0.0%)	1 (3.4%)	1 (6.3%)	3 (2.2%)
Managed care or preferred provider organization	0 (0.0%)	12 (46.2%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	12 (9.0%)
Dental school, academic institution or faculty staffed by the dental school	0 (0.0%)	0 (0.0%)	2 (5.4%)	1 (5.9%)	10 (34.5%)	3 (18.8%)	16 (11.9%)
Corporate Dentistry	1 (11.1%)	0 (0.0%)	1 (2.7%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	2 (1.5%)
Armed Forces	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Federal Government facility *e.g. VA, Public Health Service	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Public health practice , community health center, or publically funded clinic (but not federal facility)	0 (0.0%)	0 (0.0%)	1 (2.7%)	0 (0.0%)	0 (0.0%)	1 (6.3%)	2 (1.5%)
Hospital	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
General Practitioner/Specialist							
Generalist	9 (100.0%)	26 (100.0%)	33 (89.2%)	15 (88.2%)	24 (82.8%)	16 (100.0%)	123 (91.8%)
Specialist	0 (0.0%)	0 (0.0%)	4 (10.8%)	2 (11.8%)	5 (17.2%)	0 (0.0%)	11 (8.2%)
Missing	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Specialty Training Categories							
Advanced Education in General Dentistry program (AEGD)	2 (22.2%)	1 (3.8%)	7 (18.9%)	1 (5.9%)	6 (20.7%)	7 (43.8%)	24 (17.9%)
Fellow of the Academy of General Dentistry (FAGD)	1 (11.1%)	3 (11.5%)	7 (18.9%)	4 (23.5%)	3 (10.3%)	5 (31.3%)	23 (17.2%)
Mastership in the Academy of General Dentistry (MAGD)	1 (11.1%)	1 (3.8%)	4 (10.8%)	2 (11.8%)	1 (3.4%)	2 (12.5%)	11 (8.2%)
General Practice Residency (GPR)	2 (22.2%)	6 (23.1%)	3 (8.1%)	3 (17.6%)	2 (6.9%)	8 (50.0%)	24 (17.9%)
Orthodontics & Dentofacial Orthopedics	0 (0.0%)	1 (3.8%)	1 (2.7%)	0 (0.0%)	1 (3.4%)	0 (0.0%)	3 (2.2%)
Orthodontics/Periodontics	0 (0.0%)	0 (0.0%)	2 (5.4%)	1 (5.9%)	1 (3.4%)	0 (0.0%)	4 (3.0%)
Oral and Maxillofacial Surgery	0 (0.0%)	0 (0.0%)	1 (2.7%)	0 (0.0%)	1 (3.4%)	0 (0.0%)	2 (1.5%)
Oral Medicine	0 (0.0%)	1 (3.8%)	1 (2.7%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	2 (1.5%)
Orofacial Pain or TMD	0 (0.0%)	1 (3.8%)	1 (2.7%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	2 (1.5%)
Dental Anesthesiology	0 (0.0%)	0 (0.0%)	1 (2.7%)	0 (0.0%)	1 (3.4%)	0 (0.0%)	2 (1.5%)
Dental Public Health	1 (11.1%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (6.3%)	2 (1.5%)
Endodontics/Endodontist	0 (0.0%)	0 (0.0%)	1 (2.7%)	0 (0.0%)	0 (0.0%)	1 (6.3%)	2 (1.5%)
Oral and Maxillofacial Pathology	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Oral and Maxillofacial Radiology	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Pediatric Dentistry/Pediatric Dentist	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Periodontics/Periodontist	0 (0.0%)	0 (0.0%)	2 (5.4%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	2 (1.5%)
Prosthodontics/ Prosthetics	0 (0.0%)	0 (0.0%)	3 (8.1%)	2 (11.8%)	7 (24.1%)	0 (0.0%)	12 (9.0%)

Race: may represent more than one category chosen

Characteristics are based on practitioners with an active participant

PAAS (N114)
Study Status Report by Node
South Central, Southwest and Western Nodes
As of 11AUG2024

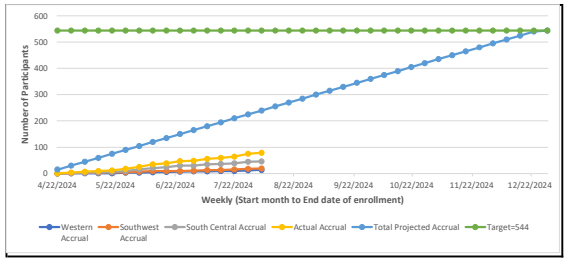
Status	Western	Southwest	SouthCentral	All Nodes
Target # of Participants Randomized	181	182	181	544
Actual # of Participants Consented **(Visit 0)**	15 (8.3%)	23 (12.6%)	48 (26.5%)	86 (15.8%)
Actual # of Participants who Consented into Plaque	10 (66.7%)	8 (34.8%)	0 (0.0%)	18 (20.9%)
Actual # of Participants Randomized	14 (93.3%)	19 (82.6%)	46 (95.8%)	79 (91.9%)
Actual # of Participants Completed Baseline (Visit 1A and 1B)	12 (80.0%)	15 (65.2%)	47 (97.9%)	74 (86.0%)
Actual # of Participants Completed Reevaluation Visit (Visit 2)	2 (13.3%)	8 (34.8%)	26 (54.2%)	36 (41.9%)
Actual # of Participants Completed Final Visit (visit 3)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Actual # of Participants Withdrawn Plaque Sample	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Actual # of Participants Discontinued Early	0 (0.0%)	4 (17.4%)	2 (4.2%)	6 (7.0%)

Consented (Visit 0) percentages are based on Target counts. All other percentages are based on actual consented (Visit 0) counts.
Completion is based off REDCap completion status for each form.

PAAS (N114)
Recruitment Yields (Participants)
Western, Southwest, and South Central Nodes
As of 11AUG2024

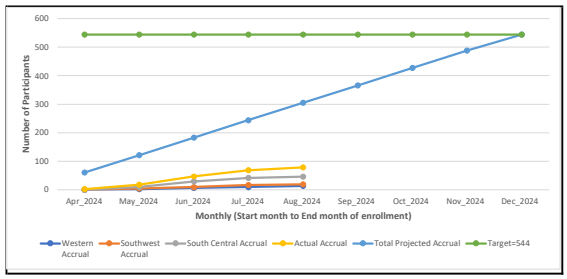
Week	Western	Southwest	South Central	Weekly Total	Western Accrual	Southwest Accrual	South Central Accrual	Actual Accrual	Total Projected Accrual	Target=544
4/22/2024	1	0	0	1	1	0	0	1	15	544
4/29/2024	0	1	2	3	1	1	2	4	30	544
5/6/2024	0	2	1	3	1	3	3	7	45	544
5/13/2024	0	0	2	2	1	3	5	9	60	544
5/20/2024	0	2	1	3	1	5	6	12	75	544
5/27/2024	2	0	4	6	3	5	10	18	90	544
6/3/2024	0	2	5	7	3	7	15	25	105	544
6/10/2024	2	2	6	10	5	9	21	35	120	544
6/17/2024	1	0	3	4	6	9	24	39	135	544
6/24/2024	1	1	6	8	7	10	30	47	150	544
7/1/2024	1	1	0	2	8	11	30	49	165	544
7/8/2024	0	2	5	7	8	13	35	56	180	544
7/15/2024	1	1	2	4	9	14	37	60	195	544
7/22/2024	1	1	2	4	10	15	39	64	210	544
7/29/2024	2	3	6	11	12	18	45	75	225	544
8/5/2024	2	1	1	4	14	19	46	79	240	544
8/12/2024									255	544
8/19/2024									270	544
8/26/2024									285	544
9/2/2024									300	544
9/9/2024									315	544
9/16/2024									330	544
9/23/2024									345	544
9/30/2024									360	544
10/7/2024									375	544
10/14/2024									390	544
10/21/2024									405	544
10/28/2024									420	544
11/4/2024									435	544
11/11/2024									450	544
11/18/2024									465	544
11/25/2024									480	544
12/2/2024									495	544
12/9/2024									510	544
12/16/2024									525	544
12/23/2024									540	544
12/30/2024									544	544

* Accrual is cumulative



Month	Western	Southwest	South Central	Weekly Total	Western Accrual	Southwest Accrual	South Central Accrual	Actual Accrual	Total Projected Accrual	Target=544
Apr_2024	1	1	0	2	1	1	0	2	61	544
May_2024	2	4	10	16	3	5	10	18	122	544
Jun_2024	4	5	20	29	7	10	30	47	183	544
Jul_2024	3	7	12	22	10	17	42	69	244	544
Aug_2024	4	2	4	10	14	19	46	79	305	544
Sep_2024									366	544
Oct_2024									427	544
Nov_2024									488	544
Dec_2024									544	544

* Accrual is cumulative



PAAS (N114)

Baseline Characteristics for the Randomized Patients by Node

South Central, Southwest and Western Nodes

As of 11AUG2024

	Western	Southwest	SouthCentral	Total
Count of Enrolled* patients	14	19	46	79
Sex				
Male	7 (50.0%)	11 (57.9%)	19 (41.3%)	37 (46.8%)
Female	7 (50.0%)	8 (42.1%)	27 (58.7%)	42 (53.2%)
Non-Binary	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Prefer not to say	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Unknown/Not reported	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Age				
Age (Mean)	60.7	56.9	57.5	57.9
Age Range	(40-78)	(40-71)	(40-86)	(40-86)
Ethnicity				
Of Hispanic/Latino origin	1 (7.1%)	3 (15.8%)	4 (8.7%)	8 (10.1%)
Not of Hispanic/Latino origin	13 (92.9%)	15 (78.9%)	42 (91.3%)	70 (88.6%)
Prefer not to answer	0 (0.0%)	1 (5.3%)	0 (0.0%)	1 (1.3%)
Race				
American Indian or Alaska Native	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Asian	2 (14.3%)	0 (0.0%)	4 (8.7%)	6 (7.6%)
Native Hawaiian or Other Pacific Islander	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Black or African-American	1 (7.1%)	6 (31.6%)	13 (28.3%)	20 (25.3%)
White or Caucasian	7 (50.0%)	11 (57.9%)	24 (52.2%)	42 (53.2%)
Multiple races	2 (14.3%)	0 (0.0%)	1 (2.2%)	3 (3.8%)
Other	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Prefer not to answer	2 (14.3%)	2 (10.5%)	4 (8.7%)	8 (10.1%)
Dental Insurance				
No dental insurance	3 (21.4%)	3 (15.8%)	5 (10.9%)	11 (13.9%)
Private insurance (e.g. employer sponsored, commercial, HMO, etc.)	5 (35.7%)	10 (52.6%)	33 (71.7%)	48 (60.8%)
Public/government insurance (Medicaid, military or veterans benefit, etc.)	2 (14.3%)	2 (10.5%)	2 (4.3%)	6 (7.6%)
Private and Public/Government (e.g, private plus Medicare)	3 (21.4%)	1 (5.3%)	3 (6.5%)	7 (8.9%)
Other	1 (7.1%)	2 (10.5%)	1 (2.2%)	4 (5.1%)
I don't know	0 (0.0%)	1 (5.3%)	0 (0.0%)	1 (1.3%)
Prefer not to answer	0 (0.0%)	0 (0.0%)	2 (4.3%)	2 (2.5%)
Missing	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)

Education

Less than high school diploma	1 (7.1%)	0 (0.0%)	0 (0.0%)	1 (1.3%)
High School diploma or GED	3 (21.4%)	2 (10.5%)	7 (15.2%)	12 (15.2%)
Some college/Associate degree	5 (35.7%)	4 (21.1%)	9 (19.6%)	18 (22.8%)
Bachelor's degree	4 (28.6%)	5 (26.3%)	10 (21.7%)	19 (24.1%)
Graduate degree	1 (7.1%)	6 (31.6%)	15 (32.6%)	22 (27.8%)
Prefer not to answer	0 (0.0%)	2 (10.5%)	5 (10.9%)	7 (8.9%)
Missing	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)

Self-reported Community Type

Urban	5 (35.7%)	8 (42.1%)	21 (45.7%)	34 (43.0%)
Suburban	7 (50.0%)	8 (42.1%)	20 (43.5%)	35 (44.3%)
Rural	2 (14.3%)	3 (15.8%)	4 (8.7%)	9 (11.4%)
Prefer not to answer	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Missing	0 (0.0%)	0 (0.0%)	1 (2.2%)	1 (1.3%)

Number Living in Household

1	0 (0.0%)	1 (5.3%)	10 (21.7%)	11 (13.9%)
2	6 (42.9%)	7 (36.8%)	18 (39.1%)	31 (39.2%)
3	6 (42.9%)	3 (15.8%)	8 (17.4%)	17 (21.5%)
4	0 (0.0%)	3 (15.8%)	1 (2.2%)	4 (5.1%)
5	0 (0.0%)	2 (10.5%)	3 (6.5%)	5 (6.3%)
6	2 (14.3%)	0 (0.0%)	1 (2.2%)	3 (3.8%)
7	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
8	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
9	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
10 or more	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Missing	0 (0.0%)	3 (15.8%)	5 (10.9%)	8 (10.1%)

Annual Household Income

Up-to (less than or equal to) $25,000	3 (21.4%)	1 (5.3%)	1 (2.2%)	5 (6.3%)
$25,001-$50,000	2 (14.3%)	3 (15.8%)	6 (13.0%)	11 (13.9%)
$50,001-$100,000	2 (14.3%)	6 (31.6%)	11 (23.9%)	19 (24.1%)
Over $100,000	7 (50.0%)	5 (26.3%)	10 (21.7%)	22 (27.8%)
Prefer not to answer	0 (0.0%)	4 (21.1%)	18 (39.1%)	22 (27.8%)
Missing	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)

*****Only includes patients who completed the Randomization Form (Randomized patients).

PAAS (N114)

Practitioner Characteristics by Node

Western, Southwest and South Central Nodes

As of 11AUG2024

	Western	Southwest	South Central	Total
Count of Practitioners	10	11	12	33
Sex				
Male	6 (60.0%)	7 (63.6%)	3 (25.0%)	16 (48.5%)
Female	4 (40.0%)	4 (36.4%)	9 (75.0%)	17 (51.5%)
Unknown/Missing	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Age				
Age (Mean)	51.4	45.9	44.7	47.2
Age Range	(39-68)	(33-62)	(24-66)	(24-68)
Ethnicity				
Of Hispanic origin	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Not of Hispanic or Latino origin	10 (100.0%)	11 (100.0%)	11 (91.7%)	32 (97.0%)
Prefer not to answer/Missing	0 (0.0%)	0 (0.0%)	1 (8.3%)	1 (3.0%)
Race				
American Indian or Alaska Native	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Asian	4 (40.0%)	3 (27.3%)	1 (8.3%)	8 (24.2%)
Native Hawaiian or Other Pacific Islander	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Black or African-American	0 (0.0%)	1 (9.1%)	2 (16.7%)	3 (9.1%)
White or Caucasian	5 (50.0%)	4 (36.4%)	9 (75.0%)	18 (54.5%)
Asian Indian/East Indian	0 (0.0%)	3 (27.3%)	0 (0.0%)	3 (9.1%)
Middle Eastern	1 (10.0%)	0 (0.0%)	0 (0.0%)	1 (3.0%)
Other	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
More Than One Race	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Prefer not to answer/Unknown/Not Reported	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Primary Occupation				
In solo private practice	4 (40.0%)	4 (36.4%)	5 (41.7%)	13 (39.4%)
In private practice, 2-4 dentists total	3 (30.0%)	6 (54.5%)	1 (8.3%)	10 (30.3%)
In private practice, 5 or more dentists total	1 (10.0%)	1 (9.1%)	0 (0.0%)	2 (6.1%)
Managed care or preferred provider organization	2 (20.0%)	0 (0.0%)	0 (0.0%)	2 (6.1%)
Dental school, academic institution or faculty staffed by the dental school	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Corporate Dentistry	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Armed Forces	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Federal Government facility *e.g. VA, Public Health Service	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Public health practice , community health center, or publically funded clinic (but not federal facility)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Hospital	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Dental Hygienist	0 (0.0%)	0 (0.0%)	3 (25.0%)	3 (9.1%)
Dental Therapist	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Dental Assistant	0 (0.0%)	0 (0.0%)	1 (8.3%)	1 (3.0%)
Receptionist or other office staff	0 (0.0%)	0 (0.0%)	1 (8.3%)	1 (3.0%)
No longer practicing dentistry/retired	0 (0.0%)	0 (0.0%)	1 (8.3%)	1 (3.0%)

General Practitioner/Specialist

Generalist	8 (80.0%)	8 (72.7%)	3 (25.0%)	19 (57.6%)
Specialist	2 (20.0%)	2 (18.2%)	3 (25.0%)	7 (21.2%)
Missing	0 (0.0%)	1 (9.1%)	6 (50.0%)	7 (21.2%)

Specialty Training Categories

Advanced Education in General Dentistry program (AEGD)	1 (10.0%)	1 (9.1%)	1 (8.3%)	3 (9.1%)
Fellow of the Academy of General Dentistry (FAGD)	0 (0.0%)	4 (36.4%)	0 (0.0%)	4 (12.1%)
Mastership in the Academy of General Dentistry (MAGD)	0 (0.0%)	1 (9.1%)	1 (8.3%)	2 (6.1%)
General Practice Residency (GPR)	4 (40.0%)	4 (36.4%)	2 (16.7%)	10 (30.3%)
Orthodontics & Dentofacial Orthopedics	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Orthodontics/Periodontics	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Oral and Maxillofacial Surgery	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Oral Medicine	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Orofacial Pain or TMD	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Dental Anesthesiology	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Dental Public Health	0 (0.0%)	1 (9.1%)	0 (0.0%)	1 (3.0%)
Endodontics/Endodontist	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Oral and Maxillofacial Pathology	0 (0.0%)	1 (9.1%)	0 (0.0%)	1 (3.0%)
Oral and Maxillofacial Radiology	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Pediatric Dentistry/Pediatric Dentist	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Periodontics/Periodontist	2 (20.0%)	2 (18.2%)	3 (25.0%)	7 (21.2%)
Prosthodontics/ Prosthetics	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)

Race: may represent more than one category chosen

Speciality training: may represent more than one category chosen

Lessons Learned

In the National Dental PBRN

U19-DE-22516

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Lessons Learned with **Network Membership Recruitment**

- **Prioritize** practitioner meetings focused on live interactions
- **Target** academic settings: faculty & graduate students
- **Mailings** were productive in previous cycles
- **CE courses** yield survey use – gateway to studies?
- **Strategically** spaced survey studies
- **Regional experiences**
- **Retention strategies** active engagement plan? Enrollment data?

2

2

Lessons Learned with **Study Recruitment**

Coordinators' Perspective

- $250 research ready remuneration – some variation in success per region
- Increased study remuneration for practitioners was influential in study participation
- Complexity of study logistics impacted practitioner recruitment
- FreSH - participant perceived stigmas impacted recruitment and compliance
- Regularly scheduled practitioner meetings are necessary for successful recruitment, retention, and engagement

3

3

Lessons Learned about **Patient Recruitment**

Practitioners' Perspective

- Overall patients continue to be very interested and receptive to study participation
- FreSH recruitment has been slightly challenging - more patients vaping and some very resistant to any quit attempt
- DIRR implants tend to come in spurts
  - An extended deadline helped recruitment
- POPS was well received by patients due to ease of contacting the dentist
  - Beneficial way for the dentist to communicate with patients
  - Positive patient feedback
- Studies aren't as office friendly as previous cycles because data entry systems are not customized to dental practice setting and workflow

4

4

Lessons Learned in **Study Protocol Training**

Coordinators' Perspective

- Involve practitioner, patient, coordinator stakeholders in study planning phase for feasibility and to better customize data entry processes in dental practice setting
- Study timeline accuracy: practitioner and patient recruitment efforts exceed estimates = over enrolling
- Standardized study protocol training videos
- PI interactions with NC

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5

Lessons Learned

Practitioners' Perspective

- ClinCard challenges for practitioners
- Streamline tasks in becoming research and study ready
- Complicated study logistics – including REDCap security limitations; multiple log-ins, system timeouts
- PEC meetings frequency
- Members miss the regional meetings and feel less connected to their involved colleagues
- Disappointment in lack of annual practitioners' meetings
- "Should guide the academician PI's to develop a better practice-based approach with our studies, as they are not as office friendly as in previous cycles"

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Lessons Learned from **Study PI - SUDS**

Successes:
- Great team
- Consumer feedback from PEC and content-specialists strengthened survey
- Effective/efficient recruitment- Node staff
- Thoughtful analysis plan fostered non-duplicative initial publications
- Creative REDcap programming

Challenges:
- Budget constraints impacted recruitment/sample size
- Sample size based on previous study rates

Moving forward:
- Smaller initial sample size if navigating capped participant count
- Option to recruit in additional waves prn

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7

Lessons Learned from **Study PI - FreSH**

Successes:
- High practice enrollment
- Streamlined consent/enrollment process via iPad
- Study team proficient in tracking data

Challenges:
- Non-English participants enrolled
- Underperforming sites contributing to distribution logistics

Moving forward:
- Caution against stratified randomization
- Allow for a range of enrollment across different sites
- Introduce stopping rules for underperforming sites
- Add comprehension questions to surveys to exclude data from non-English speaking participants
- More time at beginning and end of study to accommodate delays

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8

Keeping the Network in the Spotlight

IDEAS:
- More social media posts presence
  - Metrics on previous strategies – what worked, work didn't
- Social media post ideas
- Network uniformity on different platforms
- Highlighting Network practitioner in State or local dental association newsletter
- Free Institutional CE department advertising

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Evaluating Y2023 Slide "Suggestions for the Future"

- Gather additional feedback from NCs (not just from the single PNC), as early as possible in the study development process
- To offer more network swag for the offices
- Staff who help with studies deserve some type of incentive
- Engage more predoctoral students, as well as dental students
- Re-visit REDCap outages and automatic error messages when the system is down

10

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Suggestions for the Future

Practitioners would like Network to explore the following:

- Digital dentistry (e.g. use of facial scanners, denture processes etc.)
- AI in dentistry, (e.g. txt planning, caries dx., relationship to between AI in younger and older dentist populations)
- Dental AI and what insurance covers
- More studies on Implant failure (e.g. free handed v/s guided technique and unrestorable due to angle)

NCs would like Network to have NCC direct more IT resources to produce/support more efficient workflows for practitioners and NCs

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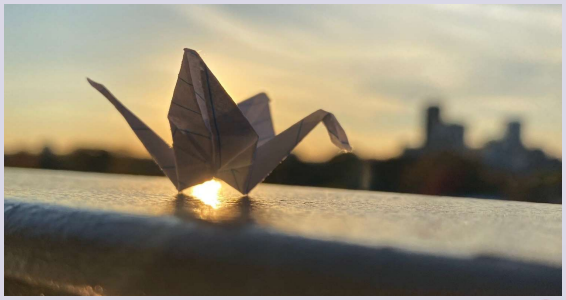
Whimsy from 2023 Face to Face



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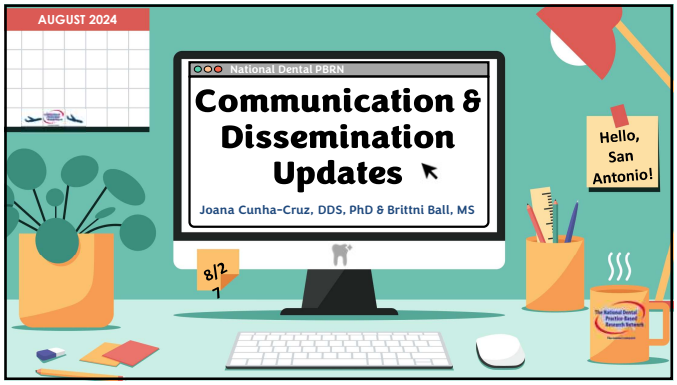
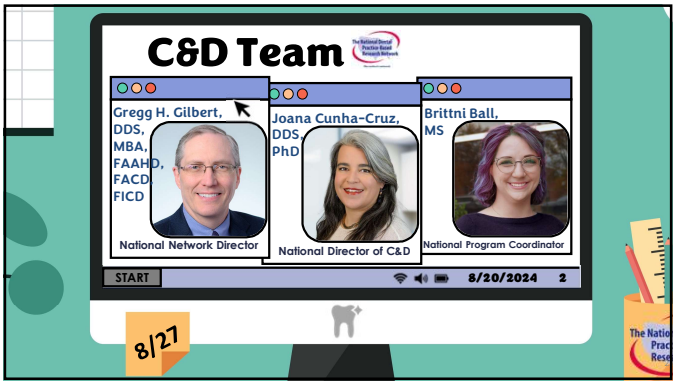
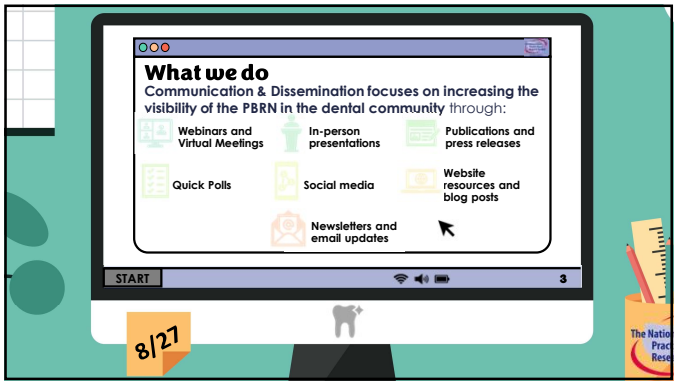

AUGUST 2024
National Dental PBRN
Communication & Dissemination Updates
Joana Cunha-Cruz, DDS, PhD & Brittni Ball, MS
Hello, San Antonio!
8/27

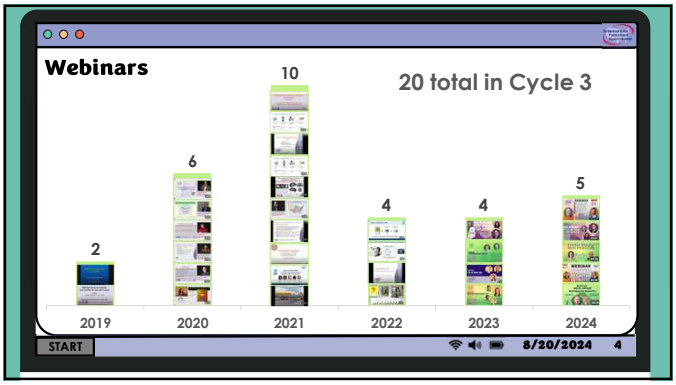
1


C&D Team
Gregg H. Gilbert, DDS, MBA, FAAHD, FACD, FICD
National Network Director
Joana Cunha-Cruz, DDS, PhD
National Director of C&D
Brittni Ball, MS
National Program Coordinator
START
8/20/2024
2
8/27

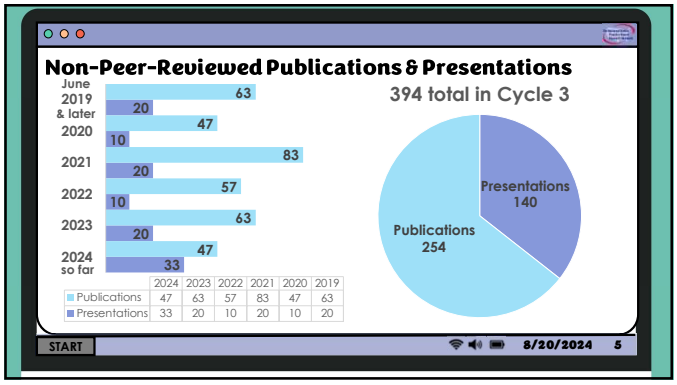
2


What we do
Communication & Dissemination focuses on increasing the visibility of the PBRN in the dental community through:
Webinars and Virtual Meetings
In-person presentations
Publications and press releases
Quick Polls
Social media
Website resources and blog posts
Newsletters and email updates
START
3
8/27

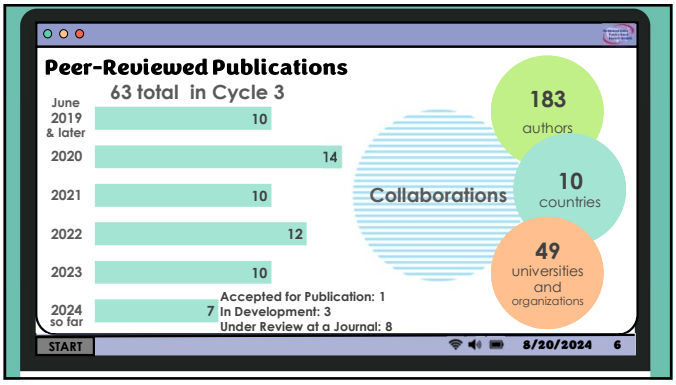
3


Webinars
20 total in Cycle 3
2019
2020
2021
2022
2023
2024
2
6
10
4
4
5
START
8/20/2024
4

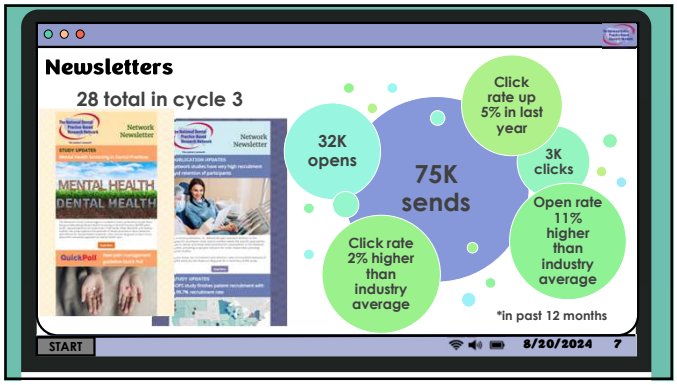
4


Non-Peer-Reviewed Publications & Presentations
394 total in Cycle 3
June 2019 & later
2020
2021
2022
2023
2024 so far
63
20
47
10
83
20
57
10
63
20
47
33
Presentations 140
Publications 254
START
8/20/2024
5

5


Peer-Reviewed Publications
63 total in Cycle 3
June 2019 & later
2020
2021
2022
2023
2024 so far
10
14
10
12
10
7
Collaborations
183 authors
10 countries
49 universities and organizations
Accepted for Publication: 1
In Development: 3
Under Review at a Journal: 8
START
8/20/2024
6

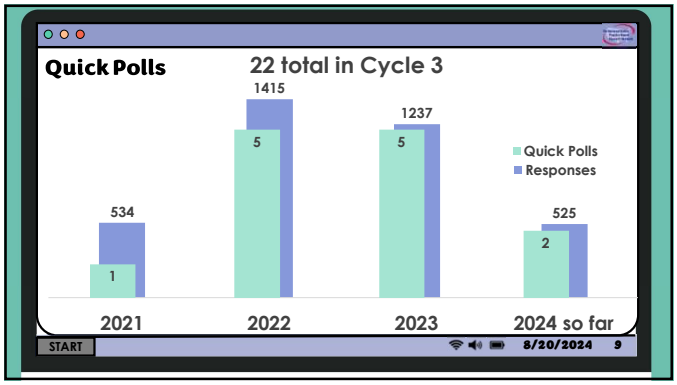
6


Newsletters
28 total in cycle 3
32K opens
75K sends
Click rate up 5% in last year
3K clicks
Open rate 11% higher than industry average
Click rate 2% higher than industry average
*in past 12 months
START
8/20/2024
7

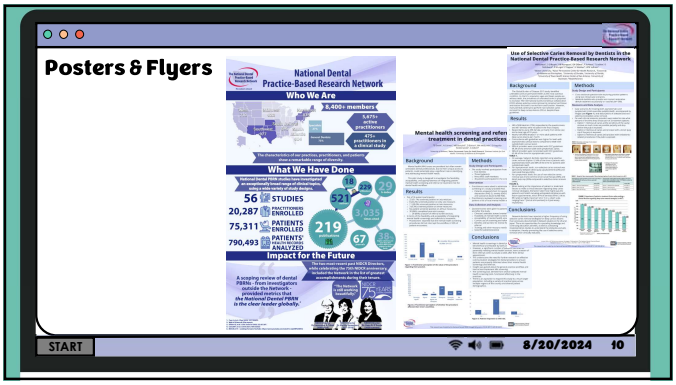
7


Website & blog posts
60 total blog posts in Cycle 3
Website redesign in 2022
7.1K
9.4K
51K
17K
20
24
16
2022
2023
2024 so far
START
8/20/2024
8

8


Quick Polls
22 total in Cycle 3
534
1
1415
5
1237
5
525
2
Quick Polls
Responses
2021
2022
2023
2024 so far
START
8/20/2024
9

9


Posters & Flyers
National Dental Practice-Based Research Network
Who We Are
What We Have Done
56 STUDIES
20,287 PATIENTS ENROLLED
75,311 PATIENTS ENROLLED
790,493 PATIENTS ANALYZED
219
Impact for the Future
START
8/20/2024
10

10


AUGUST 2024
National Dental PBRN
Thank you!
Goodbye, San Antonio!

11

Table of analytic datasets and first manuscript

There is a combined NCC/ARC meeting most Mondays. The agenda packet for that meeting includes a table of analytic dataset delivery and first manuscript status. Studies that have already met those milestones are removed from the table once the milestone has been met. Those still in process appear in the table.

Pasted below is the table from the August 5, 2024 meeting. Highlighted in yellow in the table are studies that are not in compliance, or soon will be, with the National PBRN Publications & Presentations Policy excerpt that reads:

5. Timeline for Manuscript Completion

A timeline for completion of each proposed manuscript should be provided by the study PI or lead author. All manuscript(s) that present the main findings of a network study should be submitted no later than 2 years after the final dataset has been provided by the National Coordinating Center to the study PI. Non-adherence to timeline beyond 2 years may result in the P&P Committee assigning a new lead author so the manuscript can advance in an acceptable timeframe.

Purpose of table: time to Analytic Dataset delivery & first manuscript status					
Study	**Data collection complete**	**Analytic Dataset Delivery to PI**	**De - Identified Dataset delivery to ARC**	**NCC did analysis**	**Manuscript status**
Fellows / CORE (X01—Type 1)	7/19/2021	10/14/2021	DONE	Y	8/5/2024 – Jeff is focusing on the CARAD paper at the moment.
Elad / TOP-AC (X01—Type 2)	8/24/2021	12/15/2022	TBD	Y	7/22/2024 – Mary Ann emailed Sharon but has not received a response since 2/16. Cyril reported that she is working on three manuscripts.
Fellows / CARAD (X01-Type 2/3 Hybrid)	8/31/2021	6/27/2022	DONE	Y	8/5/2024 – CARAD attitude paper update: working to complete the results section for sharing (today/tomorrow) the methods (written) and results tables/text with the team for discussion. Target journal is JADA.
Chavis /CADTAPS (X01 – Type 2)	5/16/2022	12/14/2022	TBD	Y	8/6/2024 – Sydnee shared the manuscript draft with the study team for review.
McCauley/SUDS (X01-like)	10/16/2023	In progress	TBD	Y	8/5/2024 – The Naloxone manuscript was not accepted by the journal, and the PI is working on edits. They are also working on another manuscript.

Culmer & Smith/MSDP (X01 – Type 3)	8/28/2023	4/25/2024	7/2/2024	Y	7/22/2024 – resubmitted the manuscript.
Walji / POPS (UH3)	4/30/2024	6/19/2024	TBD	N	8/5/2024: Alfa presented the POPS findings during the NCC Biostat call on 7/22.

**Raw data, not an analytic dataset*

KEY METRIC UPDATES ABOUT NETWORK PUBLICATIONS AND PRESENTATIONS

As of August 15, 2024, the network has published a total of **227 peer-reviewed scientific journal articles**. The full list is regularly updated at https://www.nationaldentalpbrn.org/Peer-Reviewed-Publications/.

The full list of **68 different peer-reviewed scientific journal titles** in which the network has published is also regularly updated at https://www.nationaldentalpbrn.org/Peer-Reviewed-Publications/#1589322198976- c295e5c0-8c1c. *This large number of different titles is a manifestation of the broad range of clinical research topics which the network investigates*.

In addition to publications, we also regularly update our network's list of…

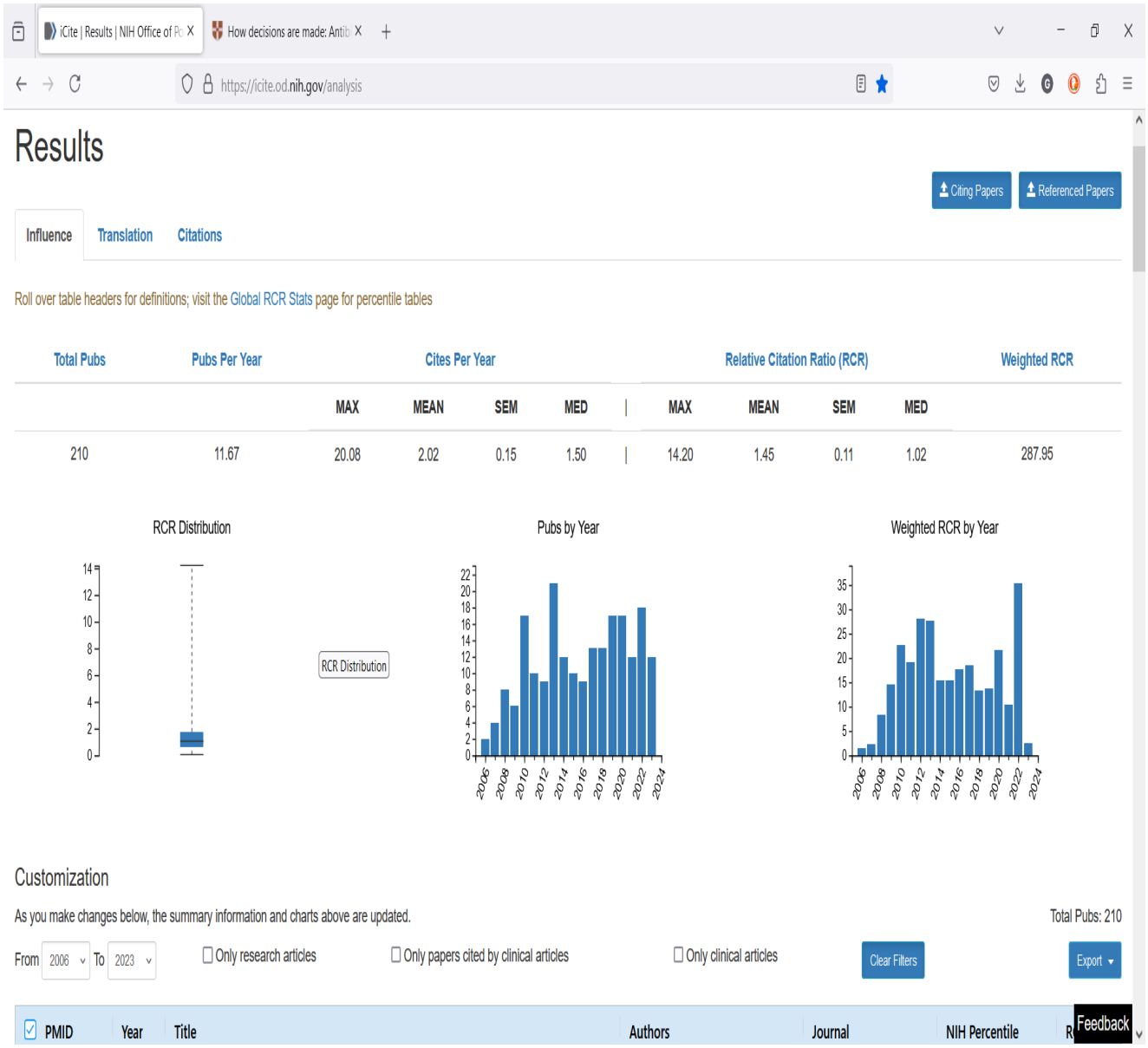
- 259 peer-reviewed abstracts and presentations at https://www.nationaldentalpbrn.org/peer-reviewed-presentations/
- 1,495 non-peer-reviewed publications and presentations at https://www.nationaldentalpbrn.org/non-peer-reviewed-publications-presentations/

The network uses the NIH iCite tool to estimate mean citations per year and Relative Citation Ratios (RCR). The ICite tool uses PMID numbers to estimate the ratio of an article's citation rate to its expected citation rate, adjusting for the average and expected citation rates for the field for equivalent time periods. The RCR was developed to quantify the influence of a research article that is article-level and independent of the scientific field. RCR represents the field-normalized and time-normalized citation rate. It is benchmarked to 1.0 for a typical (median) NIH-funded paper in the corresponding year of publication. This benchmarking process ensures that a paper with a RCR of 1.0 has received the same number of citations per year as the median NIH-funded paper in its field, while a paper with a RCR of 2.0 has received twice as many citations per year as the median NIH-funded paper in its field. The weighted RCR is the sum of RCRs for Network articles, which weights the article count by their influence only relative to NIH-funded articles.

An analysis of 210 Network publications with a publication date of 2023 or earlier, done on July 24, 2024, showed a mean RCR of 1.45, a median RCR of 1.02 and a weighted RCT of 287.95. A highly influential set of articles will have a higher Weighted RCR (288 in the case of this analysis) than the number of total publications (210 in the case of this analysis), while a set of articles with below-average influence will have a lower weighted RCR than the number of total publications.

Our RCR shows that our Network articles are above the 50th percentile, which is in comparison to other NIH-funded articles only!

See the next page for a screenshot of the graphic summary of the analysis.


iCite | Results | NIH Office of
How decisions are made: Antib
https://icite.od.nih.gov/analysis
Results
Citing Papers
Referenced Papers
Influence
Translation
Citations
Roll over table headers for definitions; visit the Global RCR Stats page for percentile tables
Total Pubs
Pubs Per Year
Cites Per Year
Relative Citation Ratio (RCR)
Weighted RCR
MAX
MEAN
SEM
MED
MAX
MEAN
SEM
MED
210
11.67
20.08
2.02
0.15
1.50
14.20
1.45
0.11
1.02
287.95
RCR Distribution
Pubs by Year
Weighted RCR by Year
RCR Distribution
Customization
As you make changes below, the summary information and charts above are updated.
Total Pubs: 210
From 2006 To 2023
Only research articles
Only papers cited by clinical articles
Only clinical articles
Clear Filters
Export
PMID
Year
Title
Authors
Journal
NIH Percentile
Feedback

National Dental PBRN Publications and Presentations Policy

Forward:

The National Dental PBRN policies regarding publications and presentations are intended to encourage the expeditious dissemination of findings from Network-related projects. These policies are founded on three guiding principles underlying all Network research and reporting, and are designed to promote the branding of the Network as a leading source of oral health practice-based evidence. These three guiding principles emphasize engagement, team science, and high ethical standards.

***Engagement**:* A characteristic of successful PBRNs is that network practitioners are engaged as highly valued collaborators who offer important practical clinical expertise. If practitioners provide input on the design, conduct, and/or analysis of studies, and receive feedback on these ideas, practitioners are more engaged in the research, and the network is more successful. Success is enhanced if the tangible application to their practice is evident, patients realize improved outcomes, and practitioners disseminate their improvements to colleagues.

Team science: Team science has real and potential advantages, such as the ability to address important research topics from multiple perspectives. Team science enables the network to include data from multiple sites with diverse populations to address important scientific questions. This collaboration is key to conducting practice-based research, yet the expansion of research teams has implications that include the need for an expanded authorship list and more diverse study teams (e.g., see Fontanarosa P, Bauchner H, Flanagan A. Authorship and team science. *J Am Med Assoc* 2017; 318(24); 2433-2437).

***High ethical standards*:** High ethical standards include declaring all conflicts of interest, assessing whether co-authors meet criteria for authorship, ensuring appropriate acknowledgements in the manuscript, acknowledging funding sources, taking steps to ensure data accuracy and quality, addressing human subjects protections, and following guidelines for accurate and complete reporting of research.

Policies:

1. Publications and Presentations (P&P) Committee

The P&P Committee monitors Network publications and presentations activities. The committee's purpose is to encourage and facilitate prompt preparation and submission of manuscripts, abstracts, and presentations. To this end, the committee periodically reviews the publication activities and plans of all active Network research projects. In addition, lead authors are encouraged to submit drafts of manuscripts and abstracts to the committee for review and comment. Membership of the committee is described in Appendix 1. The Committee conducts its business either by conference call or email on an as-needed basis, with a goal of acting on any request within two weeks. PIs and other authors will be invited to participate if their work is to be discussed during the call.

2. ***Early Planning***

Ideally, principal and secondary manuscripts and abstracts should be planned at or near the beginning of the project. Early planning will help ensure that all data eventually required for the planned reports are acquired. Just as importantly, unmet authorship expectations are less likely to arise due to misunderstanding and miscommunication. At a minimum, planning for each manuscript and abstract should identify the specific topic/study outcome to be reported, the lead (first or responsible) author, potential co-authors, and the target journal/meeting for each manuscript or abstract. To assist in this process a document entitled "publication log" should be completed once the study launches (Appendix 2). The document should be updated annually until data collection is complete and then up to quarterly, with updates sent to the publications committee following receipt of the committee's request. In addition, the "Publication Checklist" (Appendix 3) should be reviewed to acquaint authors with expectations for the publication process, which are summarized below.

3. ***Broad authorship encouraged in the interest of team science objectives***

Lead authors are expected to consider including practitioners who participated in the study and Network investigators and staff who made significant contributions. All individuals who agree to participate as co-authors should be made aware of International Committee of Medical Journal Editors Guidelines for authorship (http://www.icmje.org/), as well as any additional expectations of the lead author. Appendix 4 entitled "Process to Identify Practitioners & Network Staff for Manuscripts" contains a suggested process for identifying potential Network co-authors early in the process as well as a summary of the ICMJE guidelines.

4. ***Corporate authorship***

The National Dental PBRN encourages team science, so it is important that collaborators be recognized if they are not named co-authors. Lead authors should collectively acknowledge practitioners, network investigators, and staff personnel involved with data collection or other significant aspects of the study who are not a named author by listing an author in corporate form as "the National Dental PBRN Collaborative Group" (i.e., last author, second to last author). These individuals will be listed at (http://nationaldentalpbrn.org/). Another option for practitioners and network staff who made significant contributions to the study and provided feedback on the manuscript that did not rise to the level of authorship is naming them in the acknowledgements section.

5. Timeline for Manuscript Completion

A timeline for completion of each proposed manuscript should be provided by the study PI or lead author. All manuscript(s) that present the main findings of a network study should be submitted no later than 2 years after the final dataset has been provided by the National Coordinating Center to the study PI. Non-adherence to timeline beyond 2 years may result in the P&P Committee assigning a new lead author so the manuscript can advance in an acceptable timeframe.

5. ***Data verification***

Network publications must reflect accurate and scientifically sound data analyses and results. It is strongly recommended that approximately one month prior to submissions, draft manuscripts be submitted to the P & P committee, for National Coordinating Center staff to verify that the most-recent version of the database was used, that all methods and exclusions are accurately described, and that the reported results match those obtained by the National Coordinating Center (NCC). A submission form for manuscript verification is shown in Appendix 5. The form should be submitted in conjunction with the Publication Checklist (Appendix 3).

6. ***Manuscript/abstract/presentation tracking***

The Network needs to keep track of all accepted publications and presentations based on Network data for annual reporting purposes, as well as to satisfy requirements of the NIH public access policy. Thus, it is important that:

1) the Publication Log reflect manuscript and abstract acceptances,
2) copies of accepted manuscripts and abstracts be supplied to the P&P Committee, and
3) the P&P Committee be notified of each presentation you or a co-author make related to any of your abstracts or papers.

7. ***Manuscript/abstract/presentation NIDCR and National Dental PBRN acknowledgement***

All network publications, invited papers and presentations, and peer-reviewed abstracts based on network data should acknowledge NIDCR support by listing the following grants: U19-DE-28717 and U01-DE-28727. The following disclaimer is also required for manuscripts: *Opinions and assertions contained herein are those of the authors and are not to be construed as necessarily representing the views of the respective organizations or the National Institutes of Health*. Please consider including the words "National Dental Practice-Based Research Network" or "National Dental PBRN" in the title of the manuscript or abstract. Including these words in the title facilitates a literature search seeking to identify publications that utilized data from the network.

8. ***Suggested presentation/poster format***

To help establish a "brand" for the Network, a slide template and a logo have been developed. It is recommended that oral and poster presenters use these formats to promote familiarity with the network. A PowerPoint slide template slide and logo are available at: (http://nationaldentalpbrn.org/publications.php). If institutional guidelines require a different format, please consider using the network logo on an introductory image.

Appendices

Appendix 1: P&P Committee Membership

The P&P Committee member consists of at least one Network practitioner, an equal number (up to three each) of representatives from the NCC and the Administrative and Resource Center (ARC), and one *ex officio* representative from the National Institute of Dental and Craniofacial Research (NIDCR). A Chair for the P&P Committee will be designated by the Directors Committee from among the P&P Committee membership. Appointments will be made by the respective PIs for the ARC, the NCC, and the Network Project Officer for the NIDCR. Committee membership and contact information is listed at (https://www.kpchr.org/ndpbrn-hub/Committee/Committee/Detail/8).

Appendix 2: Publication Log

The Publication Logs are formatted as Excel spreadsheets, one for manuscripts and the other for abstracts. The Lead Author enters information into columns with the headings shown below. The log can track several manuscripts or abstracts, with each occupying a separate group of rows. The development status column records the current stage of the publication preparation.

Manuscripts
Projected starting date:
Study short name:
Manuscript topic/title:
Target journal:
Planned submission date:
Lead author:
Co-authors:
Development Status:
- Planned
- In progress
- Submitted to journal
- Accepted/rejected
- In press
- Published

Abstracts
Date:
Study short name:
Abstract title:
Association/meeting:
Submission deadline:
Lead Author:
Co-authors:

Appendix 3: Publication Checklist

Abstracts:

Study Short Name:

Title of Abstract: _____

Meeting/Association: _____

Submission Cutoff Date: _____

D Named authors have reviewed and approved the text

D Additional contributing authors are acknowledged using the Corporate Authorship *"The National Dental PBRN Collaborative Group" (recommended)*

D Title includes *"National Dental PBRN" (recommended)*

D NIDCR grants acknowledged *"U19-DE-28717 & U01-DE-28727"*

Manuscripts:

Study Short Name:

Title of Manuscript: _____

Target Journal:_____

D Named authors meet ICMJE criteria

D Additional contributing authors are acknowledged using the Corporate Authorship *"The National Dental PBRN Collaborative Group" (recommended)*

D Data, methods, and Results have been verified by The National Coordinating Center

D Title includes *"National Dental PBRN" (recommended)*

D NIDCR grants acknowledged *"U19-DE-28717 & U01-DE-28727"*

D Disclaimer placed in Acknowledgements "*Opinions and assertions contained herein are those of the authors and are not to be construed as necessarily representing the views of the respective organizations or the National Institutes of Health*"

☒ Citation, when published. Please send to: CHR-NationalDentalPBRN-Pubs@kpchr.org

Note to authors: When your manuscript is accepted for publication, you are responsible for submitting a copy of the accepted manuscript (not the published version) to PubMed Central. If you wish the National Dental PBRN to do this for you, please send an electronic copy to Terri Jones at the above address as soon as the manuscript has been accepted. The NIH policy states: "*NIH-funded investigators are required by Federal law to submit (or have submitted for them) to the National Library of Medicine's PubMed Central an electronic version of their final, peer-reviewed manuscripts upon acceptance for publication, to be made publicly available no later than 12 months after the official date of publication.*"

Appendix 4: Process to Identify Practitioners and Network Staff for Manuscripts

The node directors have agreed to assist PIs and lead authors in the process of identifying co-authors from their region. These potential co-authors include practitioners and network personnel who have participated in the study and have an interest in contributing to a manuscript. The lead author or PI will contact appropriate nodes directors when a draft outline of the proposed manuscript has been prepared. The node director will discuss potential practitioners with their respective node coordinators. After potential practitioners and network personnel are identified, the node director will contact them about their interest and discuss expectations for co-authorship. When interested practitioners/personnel are identified, the node director will connect them with the lead author. This process should be completed within two weeks. Once the manuscript has been completed, the lead author determines if the contributions of prospective warrant co-authorship or acknowledgement. The ICMJE recommends that authorship be based on the following 4 criteria:

- Substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work; *AND*
- Drafting the work or revising it critically for important intellectual content; *AND*
- Final approval of the version to be published; *AND*
- Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

Appendix 5: Manuscript verification request form

Request Date: **Anticipated Submission Date:** **Target Journal:** **Study Name/Number:** **Manuscript Title:** **Lead/Corresponding Author:** **Statistical Analyst:**	**NCC Analyst:** **Completed verification date:**

Introduction: Independent verification of the data management and statistical analysis for manuscripts to be submitted to peer reviewed journals is commonly accepted best practice. The goal of manuscript verification is to review and confirm that the most-recent version of the database was used, that all methods and exclusions are accurately described, and that the reported results match those obtained by the National Coordinating Center (NCC).

Process: The lead author, working with the study analyst (e.g. biostatistician), should submit this form to the Publications and Presentation Committee for manuscript verification by the NCC approximately one month prior to submission to a journal. The NCC will assign a biostatistician to review both the analytic work performed and how results are abstracted and interpreted in the manuscript. The biostatistician will work closely with the lead author and local analyst to resolve any questions that arise from the verification process. In addition to the manuscript verification request form, the following supporting documents and files should be provided to the NCC:

1. **List of data file(s) used. Datasets should also be provided if the NCC does not have them.**

2. **List of inclusion and exclusion criteria.**

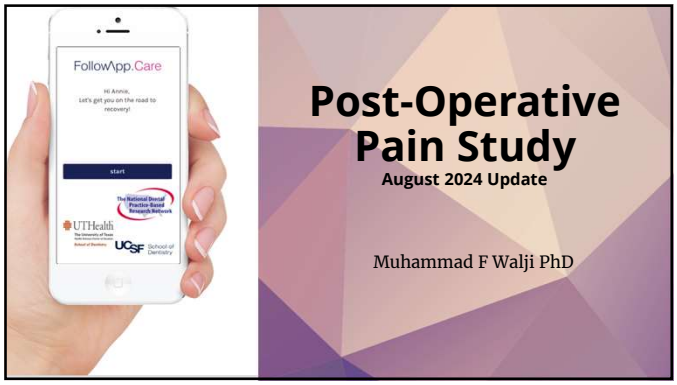
3. **A penultimate version of the manuscript (including all tables and figures intended for publication), the analysis plan (including plan for handling missing data) and software code.**

4. **Definitions of derived variables (i.e., analytic variables computed from raw data).**

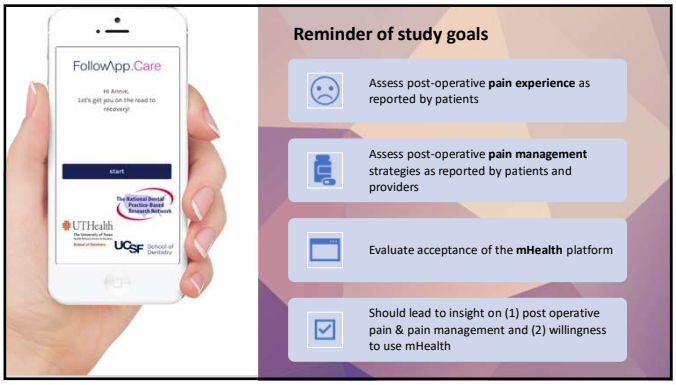
5. **A listing of numbered statistical models in the order that results appear in the text or tables. For example:**

Text, page 3:
Model 1: Logit (y) = x1 + x2 + ...

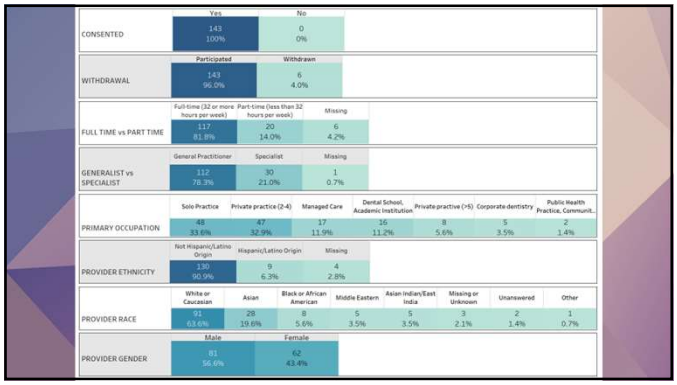
Table 3
Model 2: cox (y) = x1 + x2 + ...
Model 3: Model 2 + effect modifiers


FollowApp.Care
start
Post-Operative Pain Study
August 2024 Update
Muhammad F Walji PhD

1


FollowApp.Care
start
Reminder of study goals
Assess post-operative pain experience as reported by patients
Assess post-operative pain management strategies as reported by patients and providers
Evaluate acceptance of the mHealth platform
Should lead to insight on (1) post operative pain & pain management and (2) willingness to use mHealth

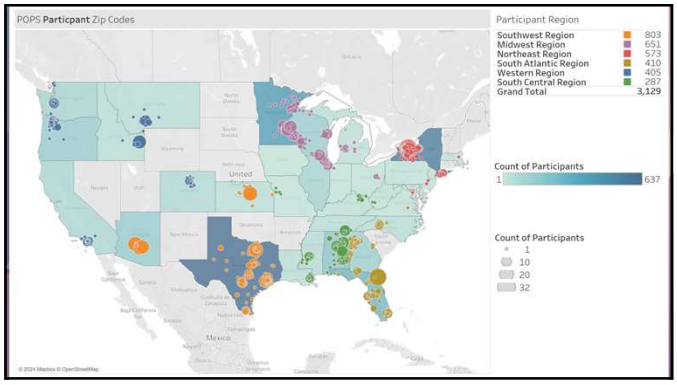
2


CONSENTED
Yes 143 100%
No 0 0%
WITHDRAWAL
Participated 143 96.0%
Withdrawn 6 4.0%
FULL TIME vs PART TIME
Full-time (32 or more hours per week) 117 81.8%
Part-time (less than 32 hours per week) 20 14.0%
Missing 6 4.2%
GENERALIST vs SPECIALIST
General Practitioner 112 78.3%
Specialist 30 21.0%
Missing 1 0.7%
PRIMARY OCCUPATION
Solo Practice 48 33.6%
Private practice (2-4) 47 32.9%
Managed Care 17 11.9%
Dental School, Academic Institution 16 11.2%
Private practice (>5) 8 5.6%
Corporate dentistry 5 3.5%
Public Health Practice, Communit... 2 1.4%
PROVIDER ETHNICITY
Not Hispanic/Latino Origin 130 90.9%
Hispanic/Latino Origin 9 6.3%
Missing 4 2.8%
PROVIDER RACE
White or Caucasian 91 63.6%
Asian 28 19.6%
Black or African American 8 5.6%
Middle Eastern 5 3.5%
Asian Indian/East India 5 3.5%
Missing or Unknown 3 2.1%
Unanswered 2 1.4%
Other 1 0.7%
PROVIDER GENDER
Male 81 56.6%
Female 62 43.4%

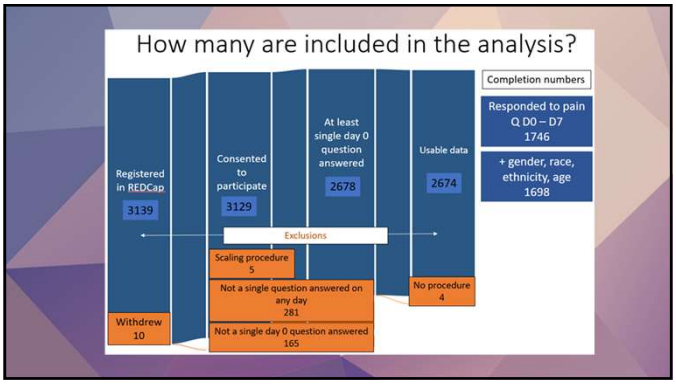
3


Patient Demographics
Average Age: 49.8 SD: 17.4
Average Household Count: 2.87 (med =2), SD: 2.08
GENDER
Female 1,489 47.9%
Male 1,171 37.7%
Missing 444 14.3%
Other 5 0.2%
RACE
Caucasian 1,843 59.3%
Missing 480 15.4%
African American 395 12.7%
Asian 151 4.9%
Prefer Not to Answer 119 3.8%
Multiple Races 73 2.3%
Native American Alaska Native 31 1.0%
Native Hawaiian Other Pacific Isla... 17 0.5%
ETHNICITY
Not Hispanic/Latino Origin 2,271 73.0%
Missing 456 14.7%
Hispanic/Latino Origin 339 10.9%
Prefer Not to Answer 43 1.4%
INSURANCE
Private Insurance 1,562 50.2%
Missing 519 16.7%
Public/Government Insurance 489 15.7%
No Dental Insurance 436 14.0%
I Don't Know 69 2.2%
Prefer Not to Answer 34 1.1%
INCOME
Over $100,000 714 23.0%
$50,001-$100,000 699 22.5%
Prefer Not to Answer 474 15.2%
Missing 470 15.1%
$25,001-$50,000 461 14.8%
Up to $25,000 291 9.4%
NEIGHBORHOOD
Suburban 1,438 46.3%
Urban 704 22.6%
Rural 487 15.7%
Missing 480 15.4%
EDUCATION
Some College/ Associate's Degree 857 27.6%
High School Diploma/GED 659 21.2%
Bachelor's Degree 601 19.3%
Missing 465 15.0%
Graduate Degree 432 13.9%
Less than High School Diploma 95 3.1%

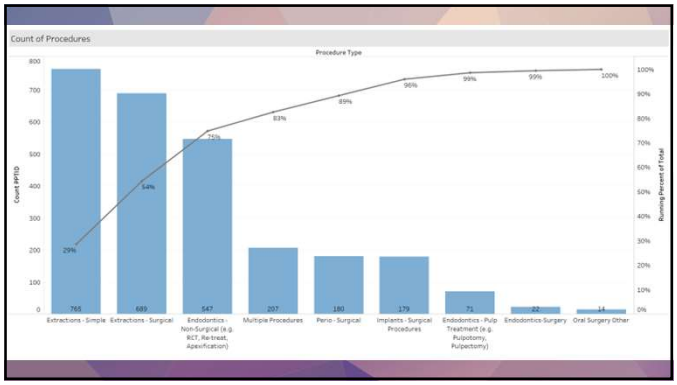
4


POPS Particpant Zip Codes
Participant Region
Southwest Region 803
Midwest Region 651
Northeast Region 573
South Atlantic Region 410
Western Region 405
South Central Region 287
Grand Total 3,129
Count of Participants
1
637
Count of Participants
1
10
20
32

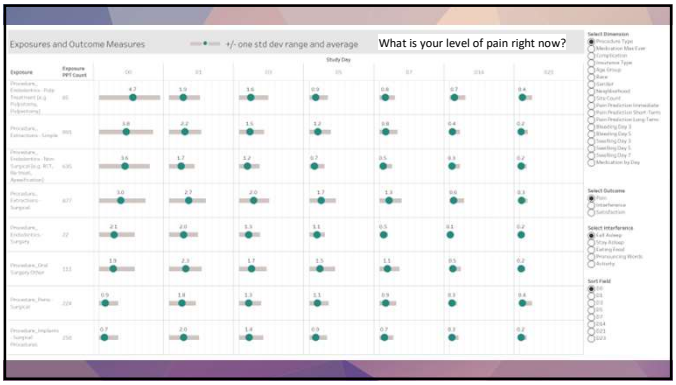
5


How many are included in the analysis?
Registered in REDCap 3139
Consented to participate 3129
At least single day 0 question answered 2678
Usable data 2674
Completion numbers
Responded to pain Q D0 – D7 1746
+ gender, race, ethnicity, age 1698
Exclusions
Scaling procedure 5
Not a single question answered on any day 281
Not a single day 0 question answered 165
No procedure 4
Withdrew 10

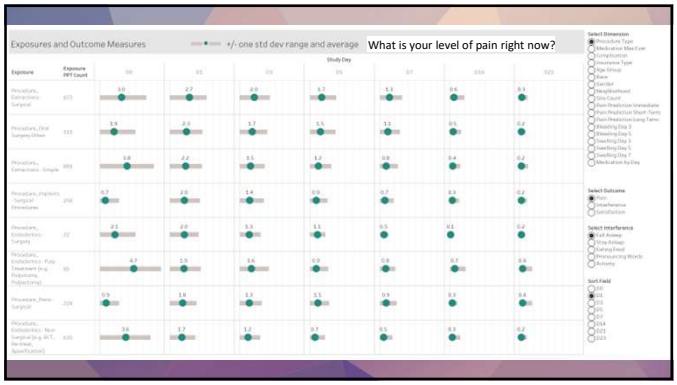
6


Count of Procedures
Procedure Type
Count PPTID
Running Percent of Total
765
689
547
207
180
179
71
32
14
29%
54%
77%
83%
89%
96%
99%
99%
100%
Extractions - Simple
Extractions - Surgical
Endodontics - Non-Surgical (e.g. RCT, Re-treat, Apexification)
Multiple Procedures
Perio - Surgical
Implants - Surgical Procedures
Endodontics - Pulp Treatment (e.g. Pulpotomy, Pulpectomy)
Endodontics-Surgery
Oral Surgery Other

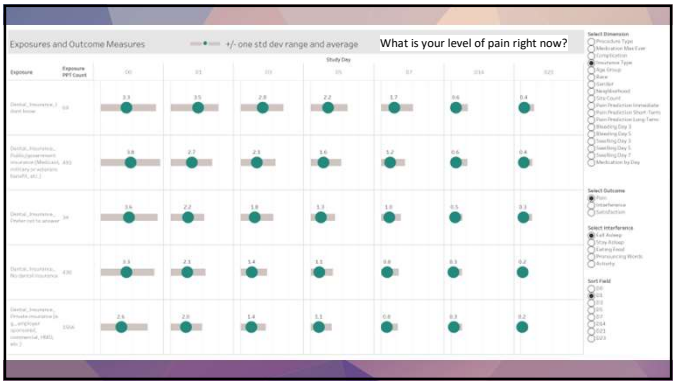
7


Exposures and Outcome Measures
+/- one std dev range and average
What is your level of pain right now?

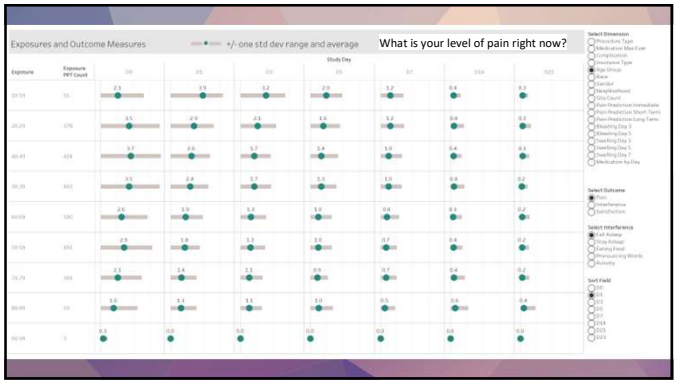
8


Exposures and Outcome Measures
+/- one std dev range and average
What is your level of pain right now?

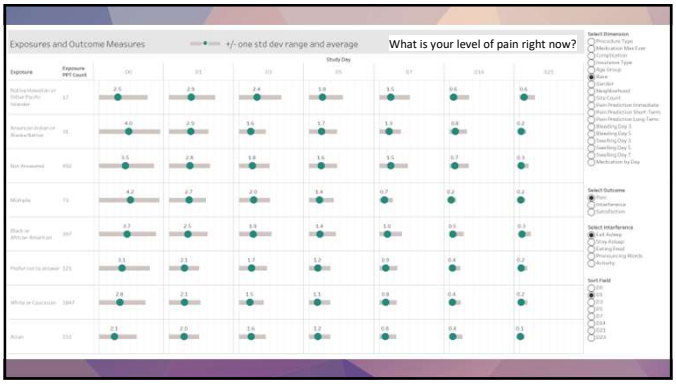
9


Exposures and Outcome Measures
+/- one std dev range and average
What is your level of pain right now?

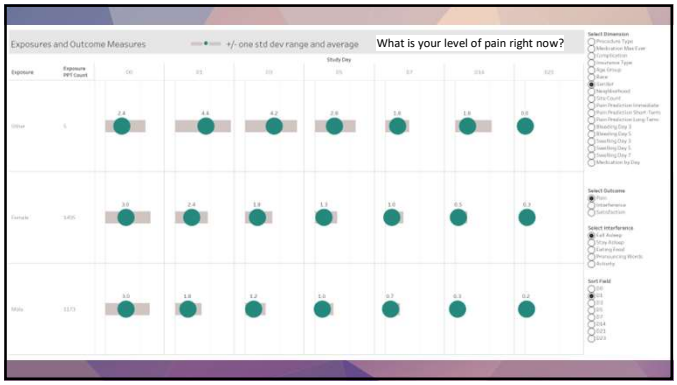
10


Exposures and Outcome Measures
+/- one std dev range and average
What is your level of pain right now?

11


Exposures and Outcome Measures
+/- one std dev range and average
What is your level of pain right now?

12



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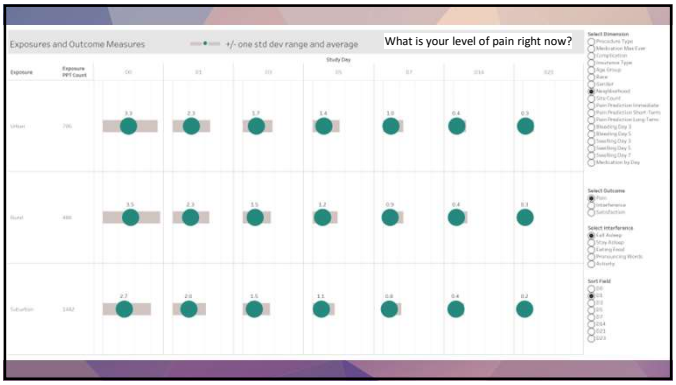

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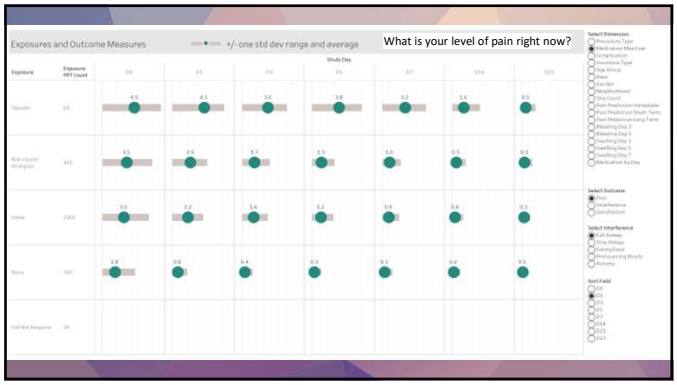

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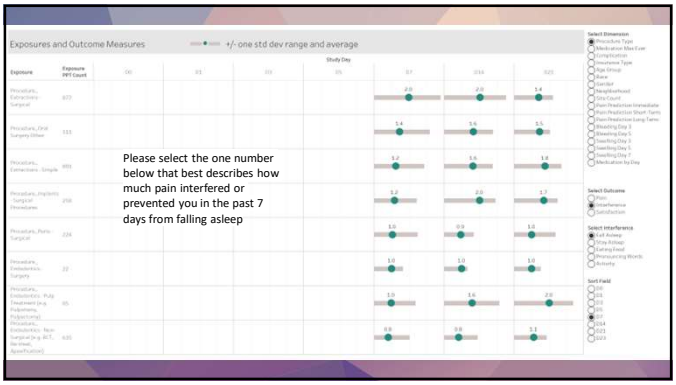

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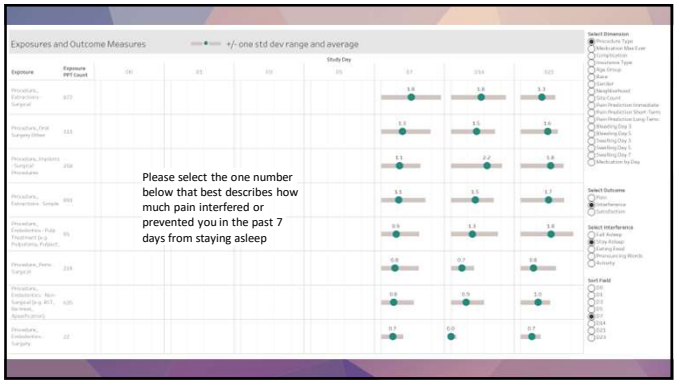

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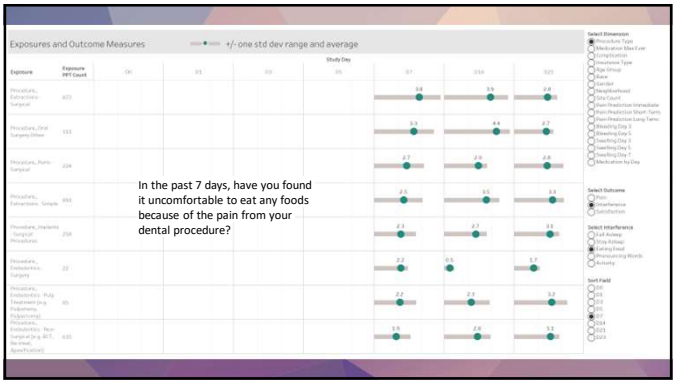

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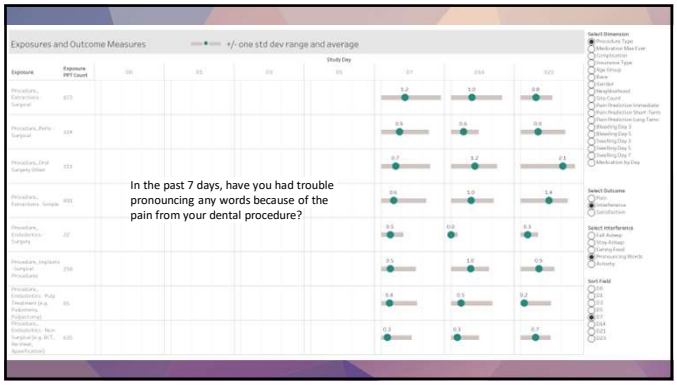

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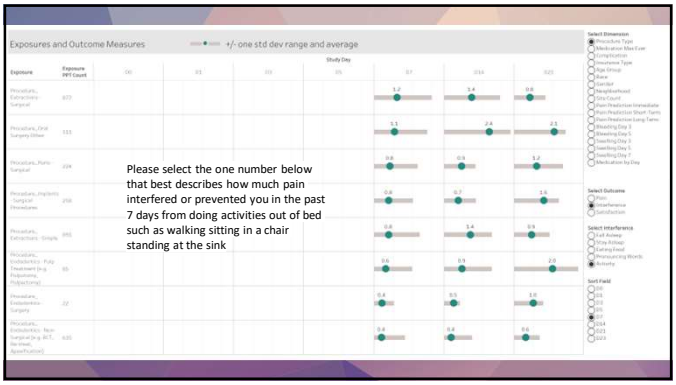

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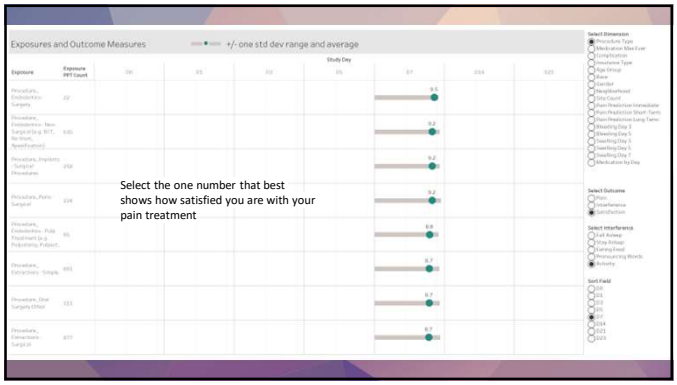

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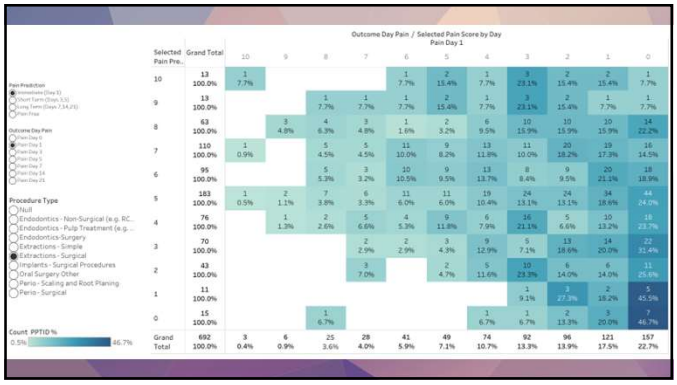

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Hypothesis 1
There is a significant difference in pain intensity measured over time and the dental procedure groupings after adjusting for pain management strategies and other complications. More specifically, are their significant variations in pain intensity due to different treatments after adjusting for:

a. pain management strategy (e.g., pain medications used, adherence to pain management strategy, the usage of non-medicine methods for pain)
b. other complications

Hypothesis 2
There is a significant difference in pain interference measured over time and the dental procedure groupings, after adjusting for pain management strategies and other complications. More specifically, are their significant variations in pain interference due to different treatments after adjusting for:

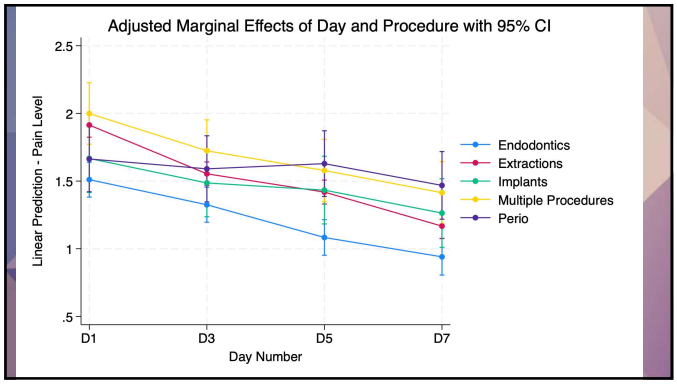
a. pain management strategy (e.g., pain medications used, adherence to pain management strategy, the usage of non-medicine methods for pain)
b. other complications

Hypothesis 3
There is a significant difference in patient satisfaction measured at the end of the 7-day period and dental procedure groupings, after adjusting for pain management strategies and other complications. More specifically, are their significant variations in patient satisfaction due to different treatments after adjusting for:

a. pain management strategy (e.g., pain medications used, adherence to pain management strategy, the usage of non-medicine methods for pain)
b. other complications.

Hypothesis 4
Reported technology acceptance metrics; performance expectancy (PE), effort expectancy (EE), social influence (SI), and behavioral intention (BI) will be consistent with high acceptance of the FollowApp.Care platform.

28



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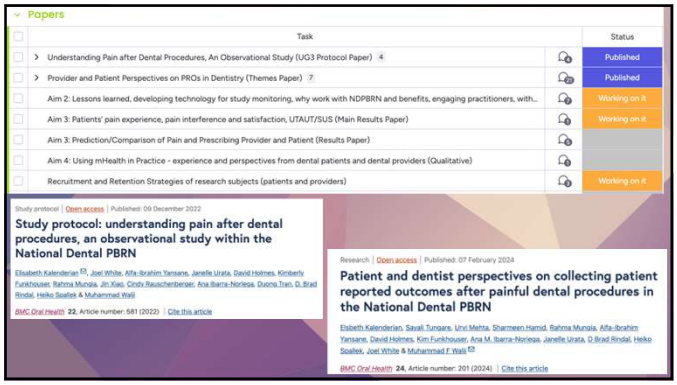
Timeline – On Track

MILESTONES

Task	Status	Inte..	Due Date	Timeline
Year 1: Finalization of data management system and processes	Done		Nov 1, 2021	Sep 1, '21 - Nov 1, '21
Year 1: Initiation and completion of Ramp-up study	Done		Apr 30, 2022	Sep 1, '21 - Jul 31, '22
Year 2: Activation of Full study	Done		May 9, 2023	May 9, '22 - Sep 30, '22
Year 2: Completion of Practitioner recruitment and training	Done		Jun 30, 2023	May 9, '22 - Jun 30, '23
Year 2: Enrollment of 40% of study participants	Done		Jul 31, 2023	Sep 1, '22 - Jul 31, '23
Year 3: Enrollment of 90% of study participants	Done		Jul 31	Aug 1, '23 - Jul 31, '24
Year 4: Enrollment of 100% of study participants	Done		Apr 30	Aug 1, '24 - Jul 31, '25
Year 4: Completion of data collection on all participants	Done		May 25	Aug 1, '24 - Jul 31, '25
Year 4: Completion of primary study analyses			Jul 31, 2025	Aug 1, '24 - Jul 31, '25

30


Papers
Task
Status
Understanding Pain after Dental Procedures, An Observational Study (UG3 Protocol Paper) 4
Published
Provider and Patient Perspectives on PROs in Dentistry (Themes Paper) 7
Published
Aim 2: Lessons learned, developing technology for study monitoring, why work with NDPBRN and benefits, engaging practitioners, with...
Working on it
Aim 3: Patients' pain experience, pain interference and satisfaction, UTAUT/SUS (Main Results Paper)
Working on it
Aim 3: Prediction/Comparison of Pain and Prescribing Provider and Patient (Results Paper)
Aim 4: Using mHealth in Practice - experience and perspectives from dental patients and dental providers (Qualitative)
Recruitment and Retention Strategies of research subjects (patients and providers)
Working on it
Study protocol: understanding pain after dental procedures, an observational study within the National Dental PBRN
Patient and dentist perspectives on collecting patient reported outcomes after painful dental procedures in the National Dental PBRN

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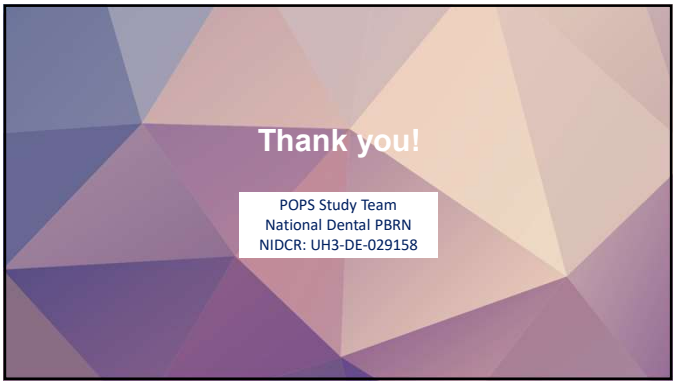

Thank you!
POPS Study Team
National Dental PBRN
NIDCR: UH3-DE-029158

32

SUBSTANCE USE DISORDERS SCREENING

August 27, 2024

1

Rationale for Current Study

- Commonality and far-reaching impacts of SUDs
- Availability of evidence-based treatments, but notable gaps in access to that treatment
- Dental settings offer opportunities to identify, intervene, and refer individuals for specialty care
- Existing literature has critical gaps
  - Most is dated
  - Predominant focus on alcohol and tobacco, emerging opioid focus
  - Broad definitions of screening
  - Very limited (no) focus on screening in adolescent populations

2

STUDY OBJECTIVES

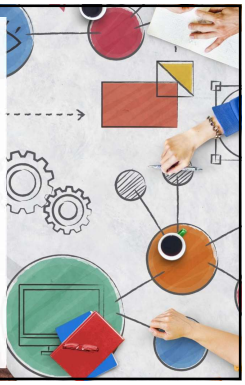
PRIMARY: Assess knowledge, attitudes, and current behaviors related to substance use screening implementation among adolescent and adult dental patients.

SECONDARY: Identify practitioner and practice-level facilitators and barriers of: (1) substance use screening implementation; and (2) early intervention and/or referral strategies when indicated among patients.

3

SURVEY DEVELOPMENT PROCESS

- Foundational literature review.
- Presentation of background and survey outline to Practitioner Executive Committee (PEC).
- Integration of PEC feedback regarding topics (and subtopics) for inclusion/key questions that should be addressed, response options for implementation barriers and facilitators items, survey format, and structure of key items.
- Iterative review and edits by the core study team.
- Content expert review: Smoking cessation
- Content expert review: Adolescent substance use
- National Coordinating Center Data Committee review
- NIDCR program review
- PEC Think Aloud review
- NIDA program review
- Integration of Feedback and Finalization



4

METHODS

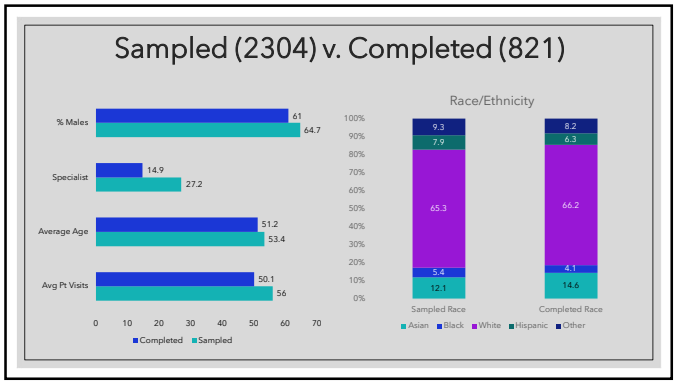
- Electronic Data Capture Survey
- Inclusion
  - Enrolled as Full or Limited Member
  - Licensed Dentist currently treating patients on recurring basis
  - Completed or updated Enrollment Questionnaire in cycle 3
- Survey Remuneration: $50
- Retest: n=50; Additional $50

5

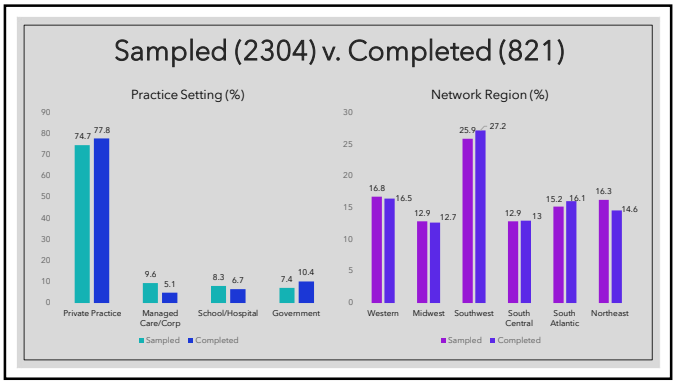
RECRUITMENT BY PROJECTWEEK

Week	Frequency	%	Cum. Freq	Cum. %
August 6	393	47.87	393	47.87
August 13	157	19.12	550	66.99
August 20	135	16.44	685	83.43
August 27	52	6.33	737	89.77
September 03	27	3.29	764	93.06
September 10	24	2.92	788	95.98
September 17	3	0.37	791	96.35
September 24	6	0.73	797	97.08
October 01	2	0.24	799	97.32
October 08	13	1.58	812	98.90
October 15	9	1.10	821	100

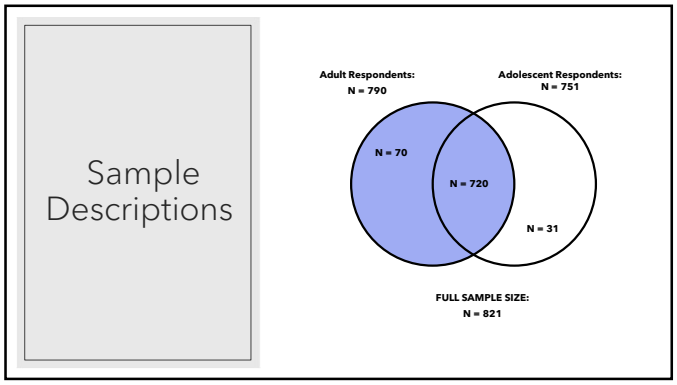
6


Sampled (2304) v. Completed (821)
% Males
Specialist
Average Age
Avg Pt Visits
Completed
Sampled
Race/Ethnicity
Sampled Race
Completed Race
Asian
Black
White
Hispanic
Other

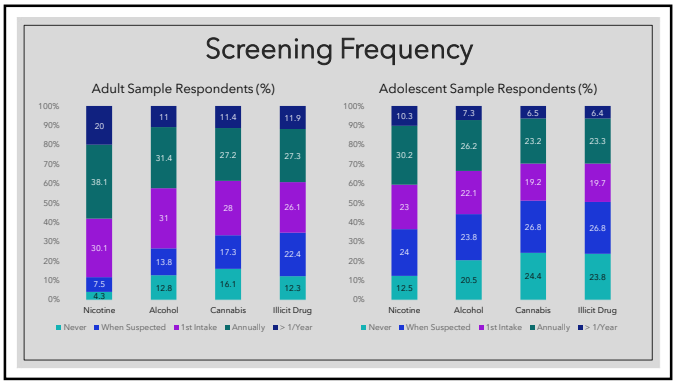
7


Sampled (2304) v. Completed (821)
Practice Setting (%)
Private Practice
Managed Care/Corp
School/Hospital
Government
Network Region (%)
Western
Midwest
Southwest
South Central
South Atlantic
Northeast
Sampled
Completed

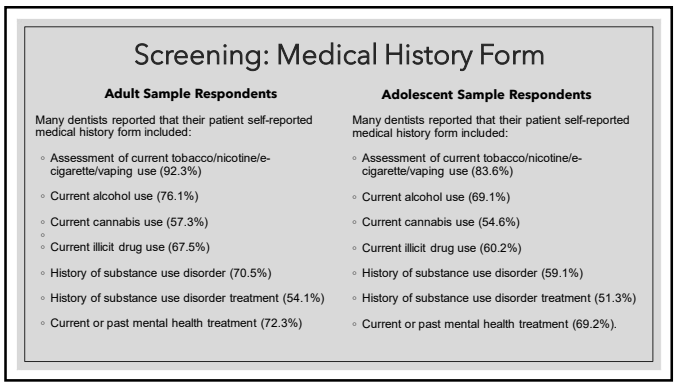
8


Sample Descriptions
Adult Respondents:
N = 790
Adolescent Respondents:
N = 751
N = 70
N = 720
N = 31
FULL SAMPLE SIZE:
N = 821

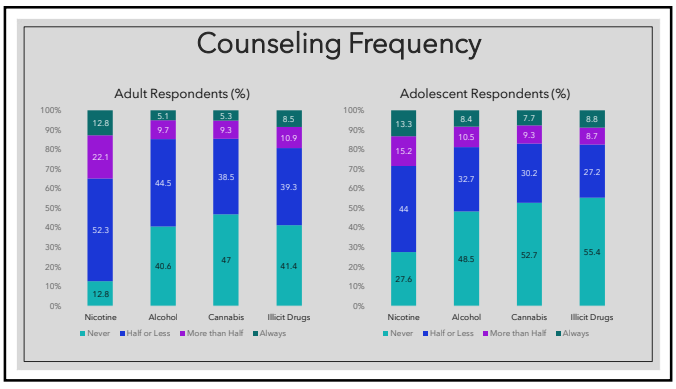
9


Screening Frequency
Adult Sample Respondents (%)
Adolescent Sample Respondents (%)
Nicotine
Alcohol
Cannabis
Illicit Drug
Never
When Suspected
1st Intake
Annually
> 1/Year

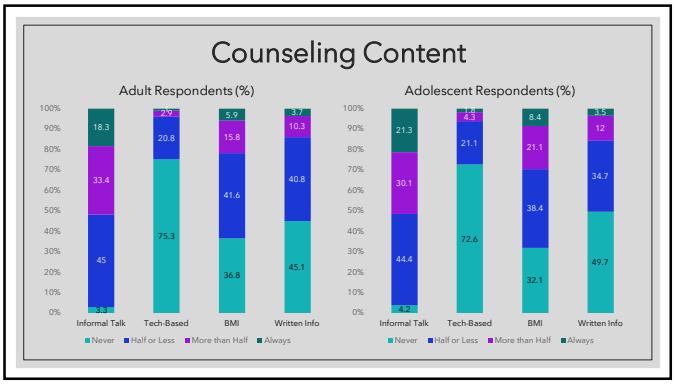
10


Screening: Medical History Form
Adult Sample Respondents
Many dentists reported that their patient self-reported medical history form included:
◦ Assessment of current tobacco/nicotine/e-cigarette/vaping use (92.3%)
◦ Current alcohol use (76.1%)
◦ Current cannabis use (57.3%)
◦ Current illicit drug use (67.5%)
◦ History of substance use disorder (70.5%)
◦ History of substance use disorder treatment (54.1%)
◦ Current or past mental health treatment (72.3%)
Adolescent Sample Respondents
Many dentists reported that their patient self-reported medical history form included:
◦ Assessment of current tobacco/nicotine/e-cigarette/vaping use (83.6%)
◦ Current alcohol use (69.1%)
◦ Current cannabis use (54.6%)
◦ Current illicit drug use (60.2%)
◦ History of substance use disorder (59.1%)
◦ History of substance use disorder treatment (51.3%)
◦ Current or past mental health treatment (69.2%).

11


Counseling Frequency
Adult Respondents (%)
Adolescent Respondents (%)
Nicotine
Alcohol
Cannabis
Illicit Drugs
Never
Half or Less
More than Half
Always

12



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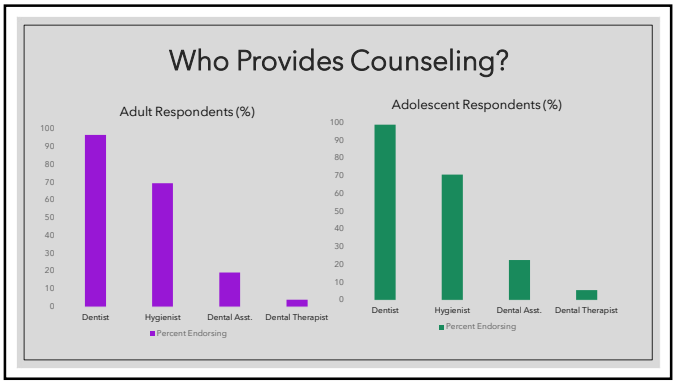

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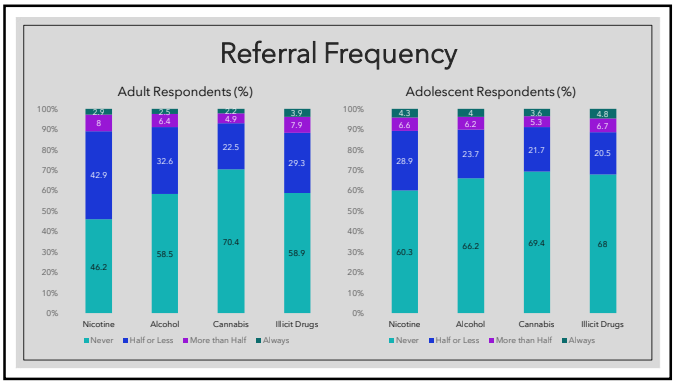

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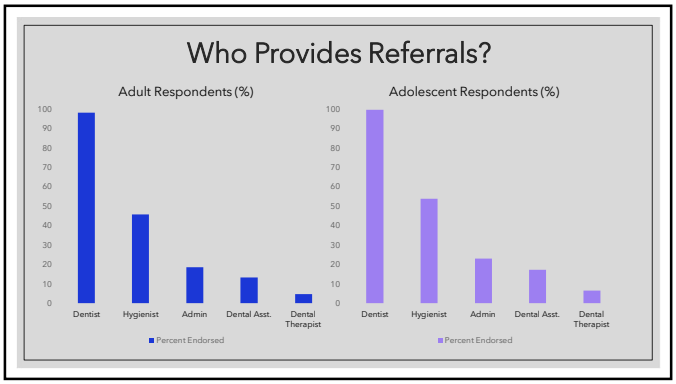

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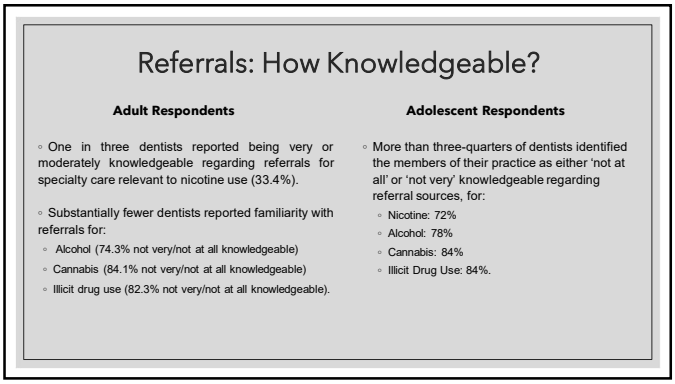

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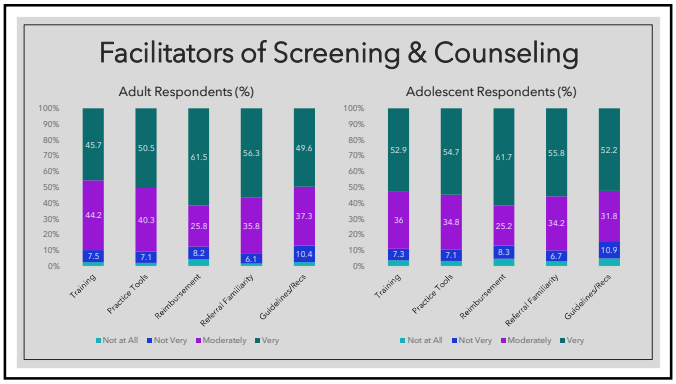

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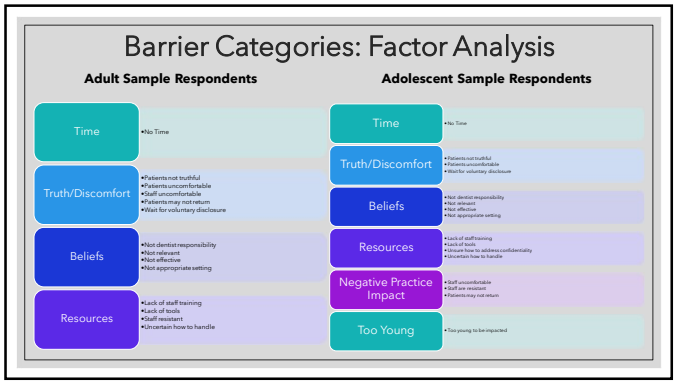

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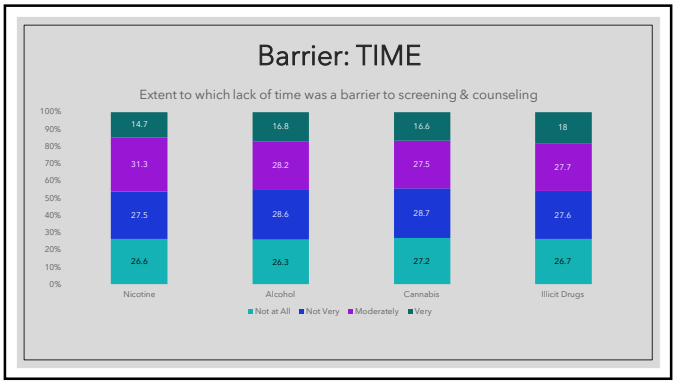

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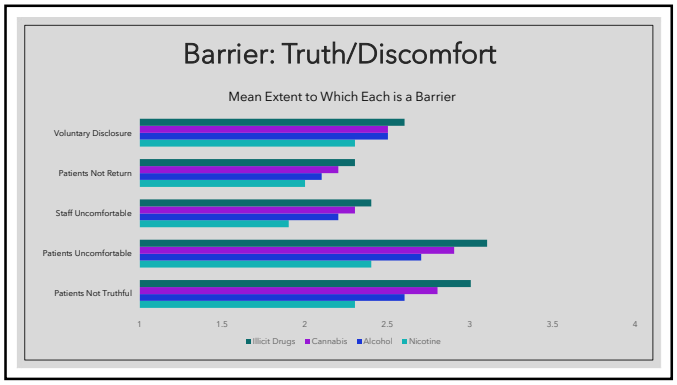

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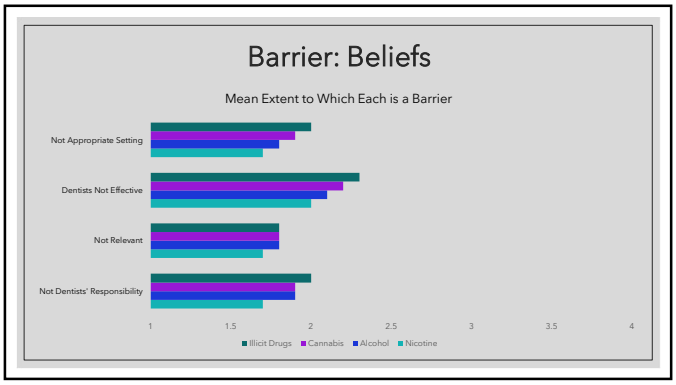

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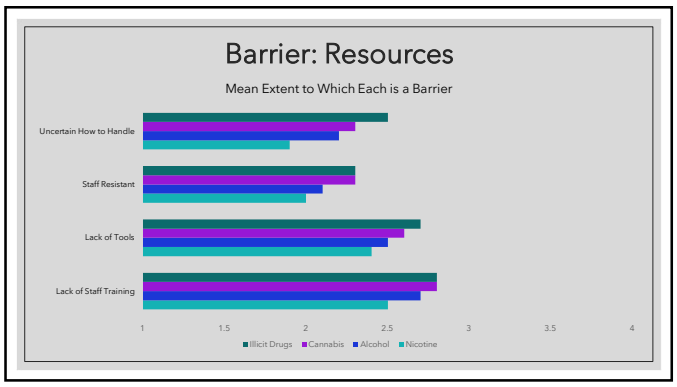

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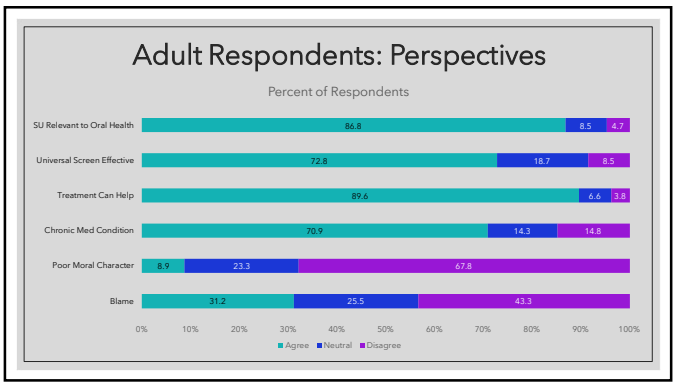


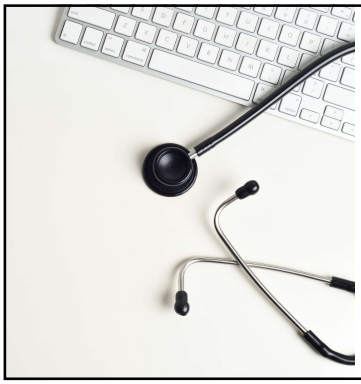
24

Adult Respondents: Correlations with Screening & Counseling

	Screen	Counsel	Refer	Time	Truth	Beliefs	Resource	Blame	Medical	Effective
Screen		0.395***	0.350***	-0.054	-0.292***	-0.314***	-0.222***	0.058	0.042	0.066
Counsel			0.545***	-0.056	-0.257***	-0.333***	-0.336***	-0.007	0.059	0.008
Refer				-0.015	-0.273***	-0.268***	-0.279***	0.010	0.068	-0.013
Time					0.277***	0.282***	0.342***	-0.021	-0.045	-0.060
Truth						0.472***	0.551***	-0.081*	-0.067	-0.082*
Beliefs							0.444***	-0.183***	-0.204***	-0.218***
Resource								-0.015	-0.062	-0.052
Blame									0.376***	0.219***
Medical										0.283***
Effective										

* p<.05, ** p<.01, ***p<.001.

25



Key Take-Aways

- While there is room for improvement in screening for alcohol, cannabis, and illicit drugs – outreach and **training related to nicotine/tobacco may serve as a good model**.
- Very few dentists are *never* screening (or counseling), meaning that there is already **some degree of buy**-in for these practices.
- **Stigma** was not associated with frequency of screening, counseling, or referral behaviors – this is good news.
- Keys to increasing screening and counseling practice behaviors may lie in providing **real-time resources** that both overcome staff training/resource barriers, as well as provide patients with confidential, meaningful methods of reporting use behaviors.

26

Planned Manuscripts

- Adult Patient Screening, Counseling, and Referral Practices (Including Barriers & Facilitators)
- Adolescent Patient Screening, Counseling, and Referral Practices (Including Barriers & Facilitators)
- Willingness to Distribute Naloxone (Brief Report)
- Dentists' Training Experiences Related to Screening and Counseling for Substance Use Disorders

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Questions for the Network

- DISSEMINATION OPPORTUNITIES?
- ADDITIONAL QUESTIONS OF THE DATA?
- NEXT STEP PROJECTS?

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THANK YOU

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Themes among dentists' attitudes about vaccines: factor analysis and regression modeling of CARAD study data

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The National Dental Practice-Based Research Network
The nation's network

NationalDentalPBRN.org

1

Background

- Vaccine hesitancy
  - Review – dentists' COVID-19 vax acceptance is high (81%) (Lin et al. 2022)
  - Higher among dental students (Lin 2022; Choi 2023)
  - HCW's hesitancy related to demog, perceived risk, safety, social factors, vaccine history, and distrust (McCready et al. 2023)
- Vaccine delivery
  - Dentist's value PH role, barriers include process mgt and payment regs (Gruβ et al. 2022)
  - Lack of knowledge, patient acceptance, clinic time, and relevance to practice were concerns (Naleway et al. 2018)
  - Indiana dentist survey (Shukla et al. 2022)
    - 58% would consider vax delivery if allowed (any type)
    - More support among academic, FQHC, and older dentists

2

Study purpose

- Assess dentists' attitudes about vaccines and vaccine delivery
  - Personal attitudes about vaccines
  - Professional attitudes about vaccine delivery
- Identify predictors of variations in attitudes
  - Dentist demographics (age group, gender, race-ethnicity)
  - Practice setting and patient type (adults only, includes children)
  - Practice location (region; urban/suburban/rural, HPSA)
  - Personal attitudes as predictors of professional attitudes
- All vaccine types are included (flu, HPV, Covid, etc.)
- Issue:
  - Simplify the regression modeling (16 attitude Qs)

3

Measuring dentists' attitudes about vaccines

- Personal attitudes based on 5C scale of vaccine hesitancy (Betsch et al., 2018) (7 measures)
  - **C**onfidence (3Qs: safe, effective, gov't trust)
  - **C**ollective responsibility (1Q)
  - risk **C**alculation (1Q)
  - **C**onstraints (1Q)
  - **C**omplacency (1Q)
- Professional attitudes developed by study team and NIDCR (9 measures)
  - Providing vaccines in office/community settings (4Qs)
  - Capabilities to manage vaccine delivery (2Q)
  - Importance of staff vaccination (1Q)
  - How practitioners can influence patient demand (2Qs)

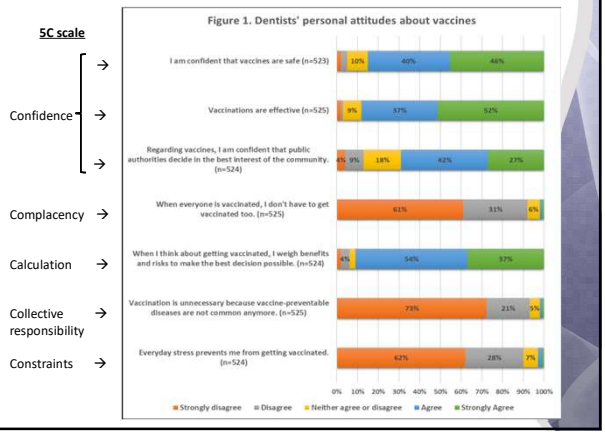
4

*Not part of the EQ questionnaire

Practitioner characteristics	Participants (N=537)	Eligible (N=2079)
Age, median (range)	51 (27-80)	51 (27-89)
Female	38%	38%
Hispanic/Latino	5%	7%
Race		
Asian	12%	12%
Black/African American	5%	6%
White	74%	71%
All other races	9%	11%
General dentist	95%	92%
Adult patients only	29%	NA*
Setting		
Private, solo	42%	41%
Private group	35%	35%
MC/PPO/Corp	9%	10%
Academic/Hospital	4%	5%
CHC/PH/Fed/Military	9%	9%
Location		
Urban	29%	NA*
Suburban	38%	NA*
Rural	15%	NA*
Health Professional Shortage Area	15%	NA*

Some column percentages may not equal 100 due to rounding.

5



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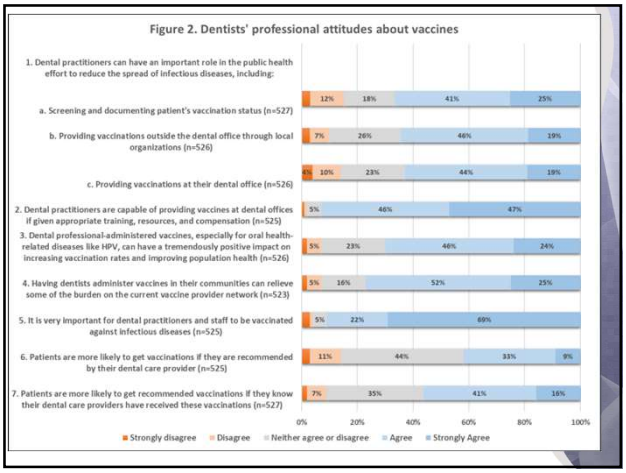


7

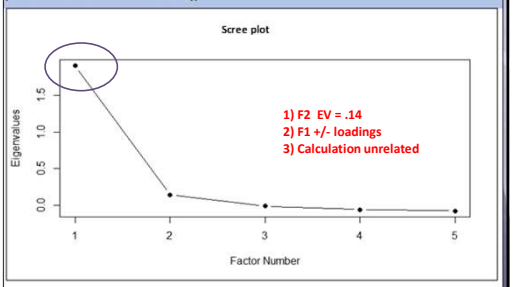
Explore attitudes with factor analysis

- Goals for factor analysis
  - Reduce the number of dependent variables
  - Identify underlying latent (unmeasured) themes btw measures
- Approach: principal axis factoring (PAF)
  - Extracts factors with shared variance
  - Unique & error variance treated separately
- Steps
  - Estimate corr matrix of communalities (shared variance)
  - Iteratively refine loadings → reduced stable factor structure
  - Calculate eigenvalues (variance explained by each factor)
    - Factors w/ EVs >1 retained (factor var > single measure var)
    - Scree plot useful (look for elbows in plot)
  - If > 1 factor, use **factor rotation** to clarify factors/min cross-loadings (we used Oblimin – account for correlated factors)

8

	Eigenvalue
1	1.90046502
2	0.14060197
3	-.01054392
4	-.05691785
5	-.07349306

Table 2. Scree plot and pattern matrix for factor analysis dentists' personal attitudes about vaccines (5C scale measures of vaccine hesitancy)



Pattern Matrix	Factor 1
Complacency: When everyone is vaccinated, I don't have to get vaccinated too.	.88
Constraints: everyday stress prevents me from getting vaccinated.	.65
Calculation: When I think about getting vaccinated, I weigh benefits and risks to make the best decision possible.	.07
Confidence: Vaccines are safe; vaccinations are effective; public authorities decide in the best interest of the community.	-.55
Collective: Vaccination is unnecessary because vaccine-preventable diseases are not common anymore.	-.64

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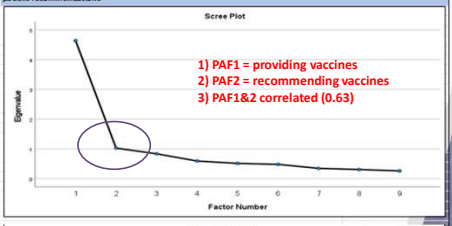
	Eigenvalue
1	4.638
2	1.027
3	0.836
4	0.593
5	0.513
6	0.480
7	0.346
8	0.307
9	0.260

Table 3. Scree plot and pattern matrix for factor analysis of dentists' professional attitudes about vaccine delivery and patient recommendations



Pattern Matrix[a]	Factor 1	Factor 2
Providing vaccinations at their dental office.	.88	
Having dentists administer vaccines in their communities can relieve some of the burden on the current vaccine provider network.	.82	
Dental professional-administered vaccines, especially for oral health related diseases like HPV, can have a tremendously positive impact on increasing vaccination rates and improving population health.	.78	
Dental practitioners are capable of providing vaccines at dental offices if given appropriate training, resources, and compensation.	.69	
Providing vaccinations outside the dental office through local organizations.	.69	
Screening and documenting patient's vaccination status.	.56	
It is very important for dental practitioners and staff to be vaccinated against infectious diseases.	.39	
Patients are more likely to get recommended vaccinations if they know their dental care providers have received these vaccinations.		.81
Patients are more likely to get vaccinations if they are recommended by their dental care provider.		.81

Extraction Method: Principal Axis Factoring.
a. Rotation converged in 4 iterations.

10

Predictors of dentists' vax attitudes

- Factor analysis = 4 dependent vars
  - Personal attitudes
    - 4C scale (6Qs)
    - Calculation (1Q)
  - Professional attitudes
    - Delivering vaccines (5Qs)
    - Recommending vaccines to patients (2Qs)
- Created unit-based factor scores
  - Means on 1-5 scale (str. disagree) to str. agree)
  - Component Qs using 75-80% rule
- Multiple linear regression models
  - Dentist demographic, practice, and location factors
  - F-tests for model significance
  - Report factor means and par. estimates (95% CIs)

11

4C scale
Measure of vaccine hesitancy

Model stats
F value: 1.56
Pr>f: 0.0487
N=515

Calculation
F value: 1.25
Pr>f: 0.196
N=513
Regression results not shown

Table 4. 4C scale score of vaccine hesitancy among National Dental PBRN dentists

Dentist characteristic	N	Mean (95%CI)	Estimate	95% CI	p-value
Age group					
27-34	57	4.5 (4.3, 4.6)	0.01	(0.01, 0.02)	0.890
35-44 years	124	4.4 (4.3, 4.5)	0.02	(0.01, 0.02)	0.856
45-54 years	112	4.4 (4.3, 4.6)	0.08	(0.07, 0.08)	0.376
55-64 years	131	4.6 (4.5, 4.7)	0.17	(0.16, 0.18)	0.032
≥65 years	96	4.4 (4.3, 4.5)	ref	ref	
Gender					
Female	198	4.5 (4.4, 4.6)	0.02	(0.01, 0.02)	0.773
Male	328	4.4 (4.4, 4.5)	ref	ref	
Race-ethnicity					
Hispanic	25	4.2 (3.9, 4.5)	-0.31	(-0.33, -0.30)	0.011
Asian	61	4.3 (4.2, 4.5)	-0.13	(-0.14, -0.12)	0.126
Black/African American	26	4.5 (4.4, 4.7)	0.14	(0.12, 0.15)	0.278
Other	40	4.4 (4.2, 4.5)	-0.12	(-0.13, -0.11)	0.219
White	369	4.5 (4.4, 4.5)	ref	ref	
Practice setting					
Private practice, solo	223	4.4 (4.3, 4.5)	ref	ref	
Private practice, group	186	4.5 (4.4, 4.6)	0.14	(0.14, 0.15)	0.015
MCO/PPO/Corporate	48	4.5 (4.3, 4.7)	0.16	(0.15, 0.16)	0.107
Dental school/hospital	21	4.6 (4.5, 4.8)	0.27	(0.26, 0.28)	0.046
CHC/public health/federal/military	48	4.5 (4.3, 4.7)	0.12	(0.11, 0.13)	0.232
Patients include children					
Children (≤18) or all ages	261	4.5 (4.4, 4.5)	0.00	(0.00, 0.00)	0.999
Adult patiets only	265	4.4 (4.4, 4.5)	ref	ref	
Network region					
Midwest	71	4.5 (4.4, 4.7)	-0.03	(-0.04, -0.02)	0.757
Northeast	101	4.6 (4.5, 4.6)	0.02	(0.01, 0.02)	0.865
South Atlantic	91	4.4 (4.2, 4.5)	-0.17	(-0.17, -0.16)	0.180
South Central	75	4.4 (4.2, 4.5)	-0.12	(-0.13, -0.11)	0.081
Southwest	101	4.4 (4.3, 4.5)	-0.06	(-0.07, -0.06)	0.457
Western	87	4.4 (4.3, 4.6)	ref	ref	
Practice location					
Urban	151	4.4 (4.3, 4.5)	-0.05	(-0.05, -0.04)	0.422
Rural	81	4.5 (4.4, 4.7)	0.08	(0.07, 0.08)	0.334
Suburban	294	4.5 (4.4, 4.5)	ref	ref	
Health Professional Shortage Area					
Yes	79	4.5 (4.3, 4.6)	0.01	(0.01, 0.02)	0.877
Don't know	77	4.4 (4.3, 4.6)	-0.02	(-0.03, -0.01)	0.799
No	370	4.4 (4.4, 4.9)	ref	ref	

MCO: Managed care organization. PPO: preferred provider organization. CHC: community health center.
Some categories had missing responses and were excluded.

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PAF1: Beliefs about providing vaccines

Model stats
F value: 7.49
Pr>f: <.0001
N=511
R^2= 0.28

Table 5. PAF1 score among National Dental PBRN dentists (draft title)

Dentist characteristic	N	Mean (95%CI)	Estimate	95% CI	p-value
Age group					
27-34	57	3.9 (3.7, 4.0)	-0.18	(-0.19, -0.17)	0.092
35-44 years	124	4.0 (3.9, 4.1)	-0.03	(-0.04, -0.02)	0.747
45-54 years	112	4.0 (3.9, 4.2)	0.03	(0.02, 0.03)	0.782
55-64 years	132	4.0 (3.9, 4.1)	-0.06	(-0.06, -0.05)	0.509
≥65 years	95	3.9 (3.8, 4.0)	ref	ref	
Gender					
Female	198	4.0 (3.9, 4.1)	0.05	(0.04, 0.05)	0.445
Male	328	3.9 (3.9, 4.0)	ref	ref	
Race-ethnicity					
Hispanic	25	3.8 (3.5, 4.1)	0.10	(0.09, 0.11)	0.464
Asian	61	4.1 (3.9, 4.3)	0.17	(0.16, 0.17)	0.074
Black/African American	26	4.3 (4.1, 4.6)	0.28	(0.27, 0.29)	0.038
Other	40	4.0 (3.8, 4.3)	0.14	(0.13, 0.15)	0.179
White	369	3.9 (3.9, 4.0)	ref	ref	
Practice setting					
Private practice, solo	222	3.9 (3.8, 4.0)	ref	ref	
Private practice, group	187	3.9 (3.8, 4.0)	0.01	(0.00, 0.01)	0.895
MCO/PPO/Corporate	48	4.2 (4.0, 4.3)	0.19	(0.18, 0.20)	0.069
Dental school/hospital	21	4.4 (4.2, 4.6)	0.32	(0.30, 0.33)	0.031
CHC/public health/federal/military	48	4.2 (4.1, 4.4)	0.42	(0.41, 0.43)	0.000
Patients include children					
Children (≤18) or all ages	261	4.0 (3.9, 4.0)	-0.01	(-0.01, 0.00)	0.882
Adult patients only	265	4.0 (3.9, 4.1)	ref	ref	
Network region					
Midwest	71	4.0 (3.9, 4.2)	0.06	(0.05, 0.07)	0.540
Northeast	101	4.0 (3.9, 4.1)	-0.02	(-0.03, -0.01)	0.855
South Atlantic	91	3.8 (3.7, 4.0)	-0.11	(-0.12, -0.10)	0.244
South Central	75	4.0 (3.8, 4.1)	0.04	(0.03, 0.05)	0.696
Southwest	102	3.9 (3.7, 4.1)	-0.10	(-0.11, -0.09)	0.294
Western	86	4.1 (3.9, 4.2)	ref	ref	
Practice location					
Urban	150	4.1 (3.9, 4.2)	0.03	(0.02, 0.03)	0.686
Rural	81	3.8 (3.7, 4.0)	-0.22	(-0.23, -0.21)	0.010
Suburban	295	4.0 (3.9, 4.0)	ref	ref	
Health Professional Shortage Area					
Yes	79	4.0 (3.9, 4.0)	-0.07	(-0.08, -0.06)	0.432
Don't know	77	4.0 (3.8, 4.2)	0.02	(0.01, 0.02)	0.824
No	370	4.0 (3.8, 4.1)	ref	ref	
Personal attitudes about vaccines					
4C score	–	–	0.54	(0.53, 0.54)	<.0001
Calculation	–	–	0.08	(0.08, 0.09)	0.010

MCO: Managed care organization. PPO: preferred provider organization. CHC: community health center.
Some categories had missing responses and were excluded.

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PAF2: Beliefs about influencing patient demand for vaccines

Model stats
F value: 3.06
Pr>f: <.0001
N=511
R^2= 0.14

Table 6. PAF2 score among National Dental PBRN dentists (draft title)

Dentist characteristic	N	Mean (95%CI)	Estimate	95% CI	p-value
Age group					
27-34	57	3.4 (3.2, 3.7)	-0.09	(-0.10, -0.08)	0.525
35-44 years	124	3.4 (3.3, 3.6)	-0.09	(-0.10, -0.08)	0.447
45-54 years	112	3.5 (3.4, 3.7)	0.01	(0.00, 0.02)	0.915
55-64 years	130	3.5 (3.3, 3.6)	-0.08	(-0.09, -0.07)	0.451
≥65 years	96	3.5 (3.3, 3.7)	ref	ref	
Gender					
Female	197	3.4 (3.3, 3.6)	-0.07	(-0.08, -0.07)	0.346
Male	328	3.5 (3.4, 3.6)	ref	ref	
Race-ethnicity					
Hispanic	25	3.4 (3.1, 3.8)	0.16	(0.14, 0.17)	0.351
Asian	61	3.6 (3.3, 3.8)	0.13	(0.12, 0.14)	0.273
Black/African American	26	3.9 (3.7, 4.2)	0.46	(0.44, 0.47)	0.010
Other	40	3.5 (3.2, 3.7)	0.07	(0.06, 0.09)	0.585
White	368	3.4 (3.4, 3.5)	ref	ref	
Practice setting					
Private practice, solo	222	3.4 (3.3, 3.5)	ref	ref	
Private practice, group	186	3.5 (3.4, 3.6)	0.06	(0.05, 0.06)	0.485
MCO/PPO/Corporate	48	3.5 (3.3, 3.7)	0.03	(0.01, 0.04)	0.848
Dental school/hospital	21	3.4 (3.1, 3.7)	-0.20	(-0.21, -0.18)	0.304
CHC/public health/federal/military	48	3.7 (3.4, 3.9)	0.16	(0.14, 0.17)	0.281
Patients include children					
Children (≤18) or all ages	260	3.4 (3.3, 3.5)	-0.15	(-0.16, -0.15)	0.036
Adult patients only	265	3.5 (3.4, 3.6)	ref	ref	
Network region					
Midwest	70	3.4 (3.2, 3.6)	-0.05	(-0.06, -0.04)	0.706
Northeast	101	3.5 (3.4, 3.6)	0.03	(0.02, 0.04)	0.800
South Atlantic	91	3.3 (3.2, 3.5)	-0.14	(-0.15, -0.13)	0.277
South Central	75	3.6 (3.4, 3.8)	0.10	(0.09, 0.11)	0.461
Southwest	101	3.5 (3.3, 3.7)	0.00	(-0.01, 0.01)	0.996
Western	87	3.5 (3.4, 3.6)	ref	ref	
Practice location					
Urban	151	3.5 (3.4, 3.7)	0.06	(0.05, 0.07)	0.492
Rural	81	3.5 (3.4, 3.7)	-0.01	(-0.02, 0.00)	0.927
Suburban	293	3.4 (3.3, 3.5)	ref	ref	
Health Professional Shortage Area					
Yes	79	3.6 (3.4, 3.8)	0.10	(0.09, 0.11)	0.422
Don't know	77	3.4 (3.2, 3.5)	-0.15	(-0.16, -0.14)	0.141
No	369	3.5 (3.4, 3.5)	ref	ref	
Personal attitudes about vaccines					
4C score			0.44	(0.43, 0.44)	<.0001
Calculation			0.02	(0.02, 0.02)	0.637

MCO: Managed care organization. PPO: preferred provider organization. CHC: community health center.
Some categories had missing responses and were excluded.

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Conclusions

- Personal support for vaccination
- Dentists have important role in vaccine delivery
- Less support for recommending vaccines to patients
- Factor analysis useful for simplifying Reg models
- 4C scale score strongly related to professional attitudes about delivery and recommending vax
- BAA Ds higher prof support for vax vs. white Ds
- Hispanic Ds lower person support for vax vs. white Ds

15

CARAD study team

- Jeffrey Fellows, PhD, PI
- Inga Gruss, PhD, Co-PI
- Mary Ann McBurnie, PhD, C-I
- Ning Smith, PhD, Biostatistician
- Ellen Funkhouser, PhD, Biostatistician
- Dea Papajorgii-Taylor, MPH, MA, Research Associate
- Reesa Laws, BS, Study/Data Manager
- Kim Stewart, Redcap Programmer
- Matt Hornbrook and Kelly Kirk, HUB Developers
- Phillip Crawford and Weiming Hu, Research Analysts
- Joe Cerizo, web designer
- Celeste Machen, Principal Node Coordinator
- Gregg Gilbert, DDS, MBA, Principal Node Director

- Michael Leo, PhD, Consulting Biostatistician

16

Mental Health Screening and Referral to Treatment in Dental Practices (MSDP)

Grant Number: X01 DE031105

Nathan Culmer, PhD
Todd B. Smith, PhD
Blake Berryhill, PhD

1

Scientific Overview – Purpose

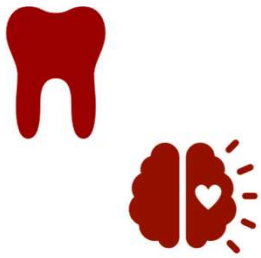
To collaborate with Dental PBRN affiliated practices to develop and test the feasibility of procedures for integrating mental health screening and referral to treatment procedures into dental care workflows.

2

Scientific Overview – Aims

- Aim 1
  - Qualitative cross-sectional study
    - Focus Groups
    - Barriers and Facilitators
  - Analyze and report data
- Aim 2
  - Development of screening and referral procedures
  - Small pilot to test feasibility in Dental Practices' workflows
  - Analyze and report data

3



Focus Groups

- Participants
  - 17 dentists
  - 10 hygienists
  - 5 dental assistants/office staff
- Major Questions:
  - Identifying patient concerns
  - Responding to concerns
  - Workflow implementation
    - Strategies
    - Barriers
    - Facilitators

4

Major Themes

Practitioners and office staff:

- Discover patient mental health concerns through record review, patient/caregiver disclosure, and patient observation
- Respond to patients' mental health concerns by making the patient more comfortable, documenting the concern in the patient's chart, and directly addressing the mental health concern
- Want a systematic process for mental health screening and referral to treatment in their dental office
- Recognize potential barriers in implementing health screening and referral to treatment processes
- Desire training on mental health matters

- Also, an overarching theme emerged: developing a trusting relationship with patients.

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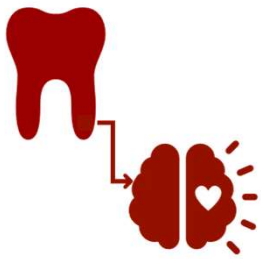


Pilot Study

- 5 Practices
- 18 practitioners
- Training began 05/16/23
- 36 patients
- Database locked 8/29/23

6

Clinical Screening Tools – The Study within the study

Questionnaire	Assesses	Questions
PHQ-2	Depression	2
GAD-2	Anxiety	2
C-SSRS	Suicide Risk	3-6
CAGE-AID	Substance Abuse	4

7

Pilot Study Results

- 5 practices
  - 5 dentists
  - 3 hygienists
  - 9 dental assistants/office staff
- 36 patients
  - 31 completed post-visit survey

8

Practitioner Demographic Characteristics

		Dentist N=5	Hygienist N=3	Staff N=9	Overall N=17
Sex (N)	Male	2	0	0	2
	Female	3	3	8	14
	Unknown/Missing	0	0	1	1
Age	Mean	57.8	51.3	32.1	43.8
	Range	41-68	42-61	20-60	20-68
Race* (N)	Black or African-American	2	1	6	9
	White or Caucasian	3	2	2	7
	Unknown or Not Reported	0	0	1	1

*No practitioners reported to be of Hispanic origin

9

Patient Demographic Characteristics

		Patients (N=36)
Sex N, (%)	Male	5 (13.9)
	Female	31 (86.1)
Age	Mean (Range)	45.17 (21-77)
Race N, (%)	Black or African-American	17 (47.2)
	White or Caucasian	18 (50)
	Asian	2 (5.56)
	American Indian or Alaskan Native	1 (2.8)
	Prefer not to answer	1 (2.8)
Highest Level of Education N, (%)	High school or GED	7 (19.4)
	Some college/Associate's degree	15 (41.7)
	Bachelor's degree	5 (13.9)
	Graduate degree	9 (25)
Annual Household Income N, (%)	≤ $25,000	4 (11.1)
	$25,001 - $50,000	6 (16.67)
	50,001 - $100,000	11 (30.56)
	> $100,000	11 (30.56)
	Prefer not to answer	4 (11.1)
Type of Dental Insurance N, (%)	None	8 (22.2)
	Private	18 (50)
	Public/government	4 (11.1)
	Other	5 (13.9)
	Prefer not to answer	1 (2.8)

*No patients reported to be of Hispanic origin

10

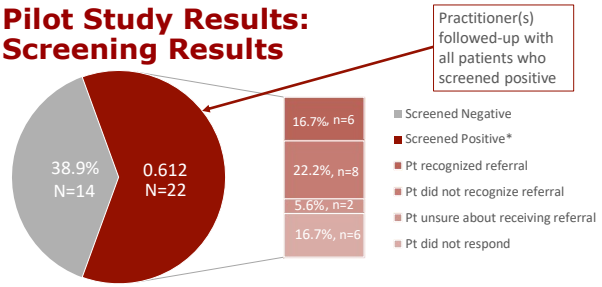
Participant Survey Process

Respondent	Survey	Questions	Content	Delivery
DOP	PBRN Survey	24	Demographic characteristics of DOP and their respective practices	Web-based, required for enrollment in Network
	Pre-Study Survey*	24	Current referral practices Attitudes toward mental illness	Web-based, prior to patient recruitment
	Post-Visit Survey	6	Time spent on patient screening and follow-up Potential workflow disruption DOP's perception of patient's response to the screening	Web-based, after each study-related patient encounter
	Post-Study Survey	35	Feasibility and acceptability of procedures Attitudes toward mental illness Perceptions of the process	Web-based, within 2 weeks of final study-related patient encounter
Patients	Demographic Survey	11	Patient demographic characteristics Type of dental insurance Type of health insurance	Tablet, at check-in after consent
	Mental Health Screeners	10-14	PHQ-2 GAD-2 CAGE-AID C-SSRS	Tablet, at check-in after consent
	Post-Visit Survey	12	Perceptions of referral process Receipt of referral Intention to act on referral Suggestions for improvement	Web-based, 1-7 days after visit, invitation sent within 24 hours

* NOTE: "Pre-study survey" was the term used to describe the survey given to DOP prior to the intervention. No participant took this survey prior to consenting to participate.

11

Pilot Study Results: Screening Results



12

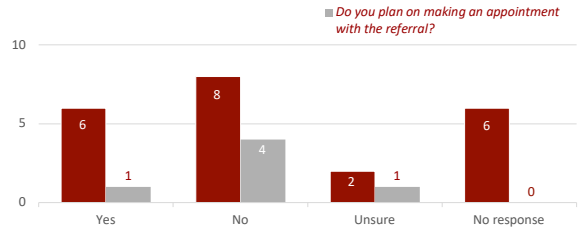
Patient Screening Results

Screenings	N (%)
Did not meet study follow-up threshold	14 (38.9)
Met study follow-up threshold on any measure	22 (61.1)
PHQ	15 (41.7)
GAD	18 (50.0)
CAGE-AID	4 (11.1)
C-SSRS	2 (5.6)

*Fourteen patients met study threshold on more than one measure

13

Patient Responses to Referrals



14

Level of Disruption and Average Minutes to Resume Workflow Across Encounters

	Number of Provider/Patient Interactions				Time to resume workflow (n=84)
The procedure disrupted my workflow (n=108)	Dentist (SD)	Hygienist (SD)	Staff (SD)	Total (%)	Ave. min. (SD)
Strongly agree					
Agree	4	1	1	6 (5.6)	10.8 (5.8)
Neither agree nor disagree	3	4	1	8 (7.4)	4.9 (3.7)
Disagree	20	12	16	48 (44.4)	7.3 (5.9)
Strongly disagree	9	3	10	22 (20.4)	2.5 (2.5)
No response		16	8	24 (22.2)	
Total Responses/Interactions	36/36	20/36	28/36	84/108	
Avg. min. to resume workflow (n=84)	5.3 (6.2)	7.4 (5.8)	6.1 (4.3)		6.1 (5.5)

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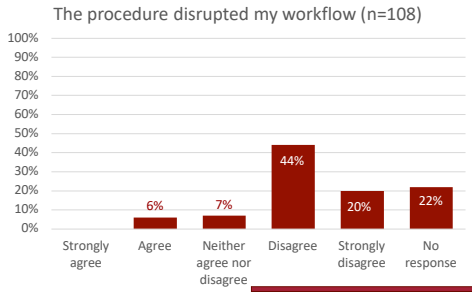
Practitioner Perceptions: Disruption

Procedure not disruptive in majority of encounters



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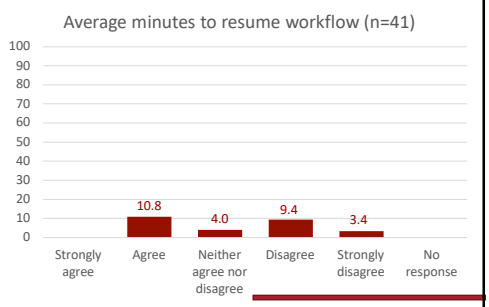
Practitioner Perceptions: Time

Procedure not disruptive in majority of encounters regardless of time till workflow resumed



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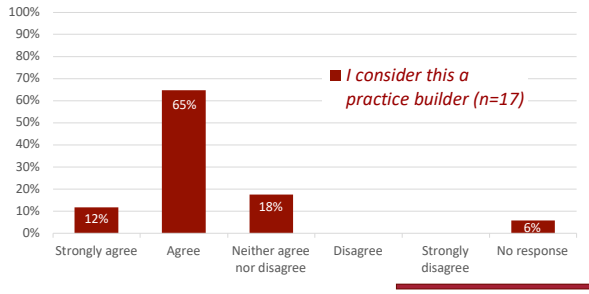
Practitioner Perceptions: Value



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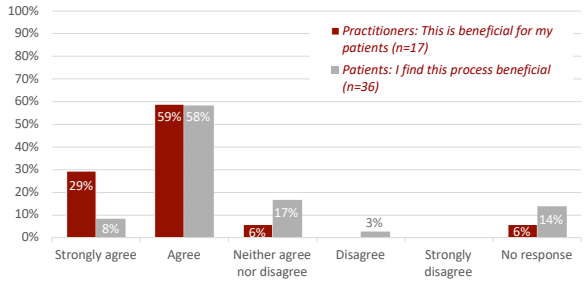
Perceptions: Practitioner and Patient



19

Publication – Focus Groups

Berryhill, M. B., Culmer, N., Smith, T., Kopycka-Kedzierawski, D., Gurganus, R., & Curry, G. (2024). Perceptions of mental health screening and referral to treatment in National Dental-Practice Based Research Network practices: A qualitative study. *Journal of Public Health Dentistry, 82*(2): 124-135.

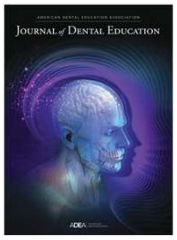
20

Manuscript – Feasibility Study

Smith, T. B., Berryhill, M. B., Culmer, N., McBurnie, M., Kopycka-Kedzierawski, D., Gilbert, G., Barton, D., & Machen, C. Mental Health Screenings in Dental Settings: Feasibility and Outcomes from a National Dental PBRN Study. *The Journal of the American Dental Association.* (revise and resubmit).

21

Additional Publications



- Culmer, N. P., Smith, T. B., Berryhill, M. B., Gurenlian, J., Simpson, L., Ogden, S., ... & Greenwood, C. (2024). Mental health screening and referral to treatment in dental practices: A scoping review. *Journal of Dental Education, 88*(4), 445-460.
- Culmer, N. P., Smith, T. B., Berryhill, M. B., Kopycka-Kedzierawski, D., Greenwood, C., Rengering, C., Howerton, A. A Review of Mental Health Curricula in Predoctoral Dental School Programs. *Journal of Dental Education.* (revise and resubmit).

22

Discussion

- More than 60% of participating patients (n = 22) met the study threshold in at least one of the screening measures
- DOP reported minimal workflow disruptions
- Need to clarify the word "referral," especially for patients
- More research needed on
  - Patient follow-up on referrals
  - Larger sample
  - Variety/diversity of workflows, settings, and screening tools
- Overall, a public health benefit, with early detection and intervention

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Thanks!

- NIDCR Support
  - Dena Fischer and Margie Grisius
- ARC Support
  - Gregg Gilbert, Muna Anabtawi, Patrice Harris, and Dorota Kopycka-Kedzierawski
- NCC Support
  - MaryAnn McBurnie, Reesa Laws, Danyelle Barton, and Celeste Machen
- Publications and Presentations Committee
  - Brad Rindal, lead; Valeria Gordan, Gregg Gilbert, Jim Bader, Mary Ann McBurnie, Michael Leo, and Paul Benjamin

24

Quick Poll
Your Voice Shapes the Network's Future

Motivations, Benefits, Challenges, and Future Directions in the National Dental PBRN Participation

1

Introduction

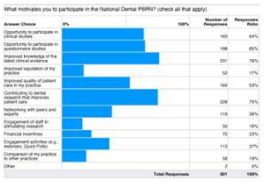
- **Brief overview of the National Dental PBRN.**
- **Importance of understanding motivations, benefits, challenges, and future directions for participants.**
- **Overview of the key findings from a recent survey of PBRN participants.**

2

Motivations for Participation

Top Motivators:

- Improved knowledge of the latest clinical evidence (76%)
- Contributing to dental research that improves patient care (75%)
- Opportunity to participate in questionnaire studies (65%)
- Opportunity to participate in clinical studies (64%)



Key Insight: The main drivers are the desire for up-to-date clinical knowledge and the desire to contribute to better patient care.

3

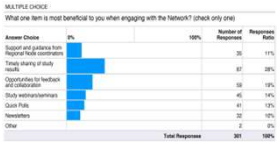
Most Beneficial Engagement Activities

Top Benefit:

- Timely sharing of study results (28%)

Other Notable Benefits:

- Opportunities for feedback and collaboration (19%)
- Study webinars and seminars (14%)



Key Insight: Participants value timely and actionable insights from studies.

4

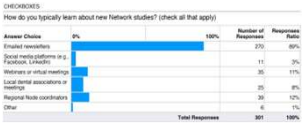
Learning About New Studies

Primary Source:

- Emailed newsletters (89%)

Other Sources:

- Webinars/virtual meetings (11%)
- Social media platforms (3%)



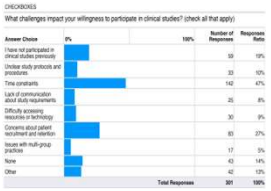
Key Insight: Email communication is the most effective way to inform participants about new studies.

5

Challenges in Participation

Top Challenges:

- Time constraints (47%)
- Concerns about patient recruitment and retention (27%)
- Unclear study protocols and procedures (10%)



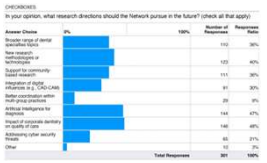
Key Insight: Time management and patient-related issues are the most significant barriers to participation.

6

Future Research Directions

Top Suggestions:

- Impact of corporate dentistry on quality of care (48%)
- Artificial Intelligence for diagnosis (47%)
- New research methodologies or technologies (40%)



Key Insight: Strong interest in exploring the impact of corporate practices and integrating AI into dental care.

7

Conclusion and Recommendations

Conclusion:

- Participants are motivated by improving patient care and staying updated on clinical evidence.
- Time constraints and recruitment challenges are key barriers.

Recommendations:

- Enhance communication through emails.
- Streamline protocols and provide clear guidance.
- Focus future research on AI, corporate dentistry, and innovative methodologies.

8

Q&A

- Open the floor for questions and discussion.
- Explore participant suggestions for further improvements and future research topics.

9

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August 7, 2024

Updates from Specialty Node (Information Item);

The Specialty Node is engaged in several activities and on the way to accomplish all the goals set for grant year 06. We have worked with the Restorative Dentistry department at University of Illinois Chicago (UIC) to be part of the Dental Implant Registry Study. The MSA has been approved and we are in the process of scheduling the practitioners for training. We expect over 50% of all implants enrolled at UIC to be from subjects who are traditionally underrepresented minorities. We are currently working on a Quick Poll on Craniofacial Microsomia. We have obtained feedback from the network and made changes to the quick poll.

We are scheduled to give the following talks in the next two months:

1. Min Kyeong Lee and Maysaa Oubaidin. Clinical Studies Conducted in the National Dental Practice-Based Research Network: Implications for Clinicians. To be presented on October 26th at Midwest Society of Orthodontists Annual Meeting. Rosemont.
2. Min Kyeong Lee and Maysaa Oubaidin. Overview and Updates from the National Dental Practice-Based Research Network. To be presented on October 10th at Dr. Thomas Graber International Symposium, Chicago.
3. Sath Allareddy, Maysaa Oubaidin and Min Kyeong Lee. Activities of the National Dental Practice-Based Research Network: How Can Residents Get Involved?. To be presented on September 9th at UIC Dept of Orthodontics. Chicago.

We have completed analysis of the Molar Hypomineralization Quick Poll and drafted a manuscript. It will be submitted shortly to Pediatric dentistry.

- Ahmed AT, Allareddy V, Avenetti D, Cunha-Cruz J, Gilbert GH and National Dental Practice-Based Research Network Collaborative Group. Management approach for newly erupted molars with molar hypomineralization: Preliminary findings from the National Dental Practice-Based Research Network.

We are continuing to analyze and publish data from the National Anterior Open Bite Study. We recently submitted a manuscript based on results from the National Anterior Open Bite Study to Angle Orthodontist.

- Greenlee GM, Collins JL, Leroux B, Allareddy V, Jolly C, Shin K, Vermette M, The National Dental Practice-Based Research Collaborative Group, Huang GJ. Treatment outcomes and stability in adult anterior openbite patients treated with or without extractions: a National Dental PBRN study.

Below article was published in American Journal of Orthodontics and Dentofacial Orthopedics –

- Greenlee GM, Lewandowski L, Funkhouser E, Dolce C, Jolley C, Kau CH, Shin K, Allareddy V, Vermette M, Huang GJ; National Dental Practice-Based Research Network Collaborative Group. Treatment acceptance in adult patients with anterior open bite: A National Dental Practice-Based Research Network study. Am J Orthod Dentofacial Orthop. 2024 Jul 8:S0889-5406(24)00233-6. doi: 10.1016/j.ajodo.2024.06.007. Epub ahead of print. PMID: 38980241.

PREC and PTC reports:

Practitioner Recruitment and Engagement Component
Practitioner Training Component

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Valeria V Gordan DDS, MS, MS-CI
Distinguished Professor and Associate Dean for Research, University of Florida
Director PREC, PTC, and South Atlantic region, National Dental PBRN

1

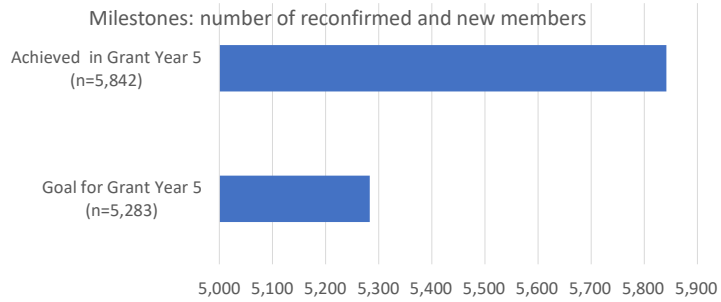
Network membership as of 6/02/24

Dental Hub Primary Occupation	Re-confirmed[1] and New Members[2]	Re-confirmed Members	New Members	Re-confirmed and New: Leve 3	Active[3] Practitioners who have not re-confirmed	Active Total
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Total	5842 (68.8%)	3573 (42.1%)	2269 (26.7%)	3122 (36.8%)	2653 (31.2%)	8495 (100.0%)

2

Strategic plans and activities for new members: GY5

- Milestones: number of new members enrolled in the network.
- Goal GY5: 5,067 reconfirmed or new members in the network (73% of cycle 2) and 72 new members per quarter.
- We exceeded that goal and revised the milestone to have 5,283 members at the end of GY5.
- 6/02/2024, **we exceeded the goal established for GY5, by having 5,842 reconfirmed and new members joining the network.**



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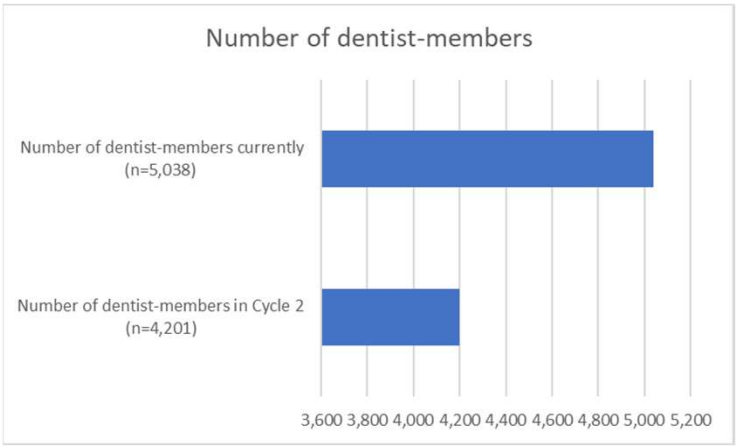
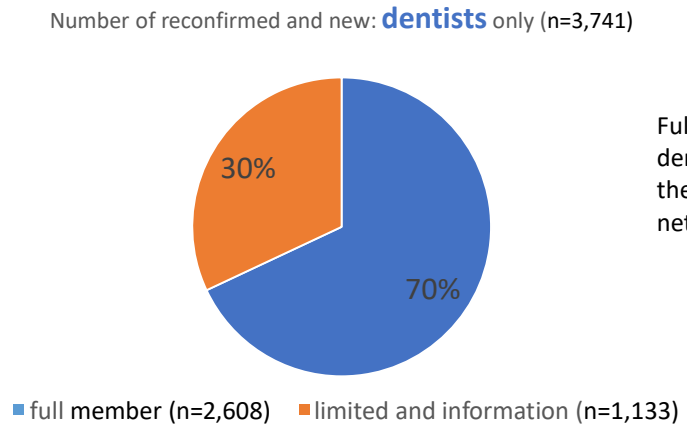
Dentist active membership



5,038 dentists who are active members (not counting hygienists + 1,736). This number **exceeded by 20% the number of dentists in cycle 2** (n=4,201 dentist-members February 2, 2019).

4

Recruitment of members at the full membership level:



Full membership enrollment of dentists in the past was ~60% of the dentists who enrolled in the network.

5

Goals and milestones for network membership for GY6:

Continue to recruit about 72 new members per quarter networkwide.

Maintain dentist's membership at least 50% at the full membership level.

6

Strategic plan and Activities for GY6 and beyond:

1) Mass electronic mailings from publicly available lists from state boards of dentistry and obtained as a result of our network collaborations with numerous dental associations.

2) Presentations and booths at local, state, and national dental association meetings (as funding allows).

3) Scientific presentations of network study results.

4) Newsletter announcements.

5) Webinars hosted by the Communications and Dissemination component as study results are available: at the end of each webinar the presenter will make a point to attendees and announce the benefits of joining the network.

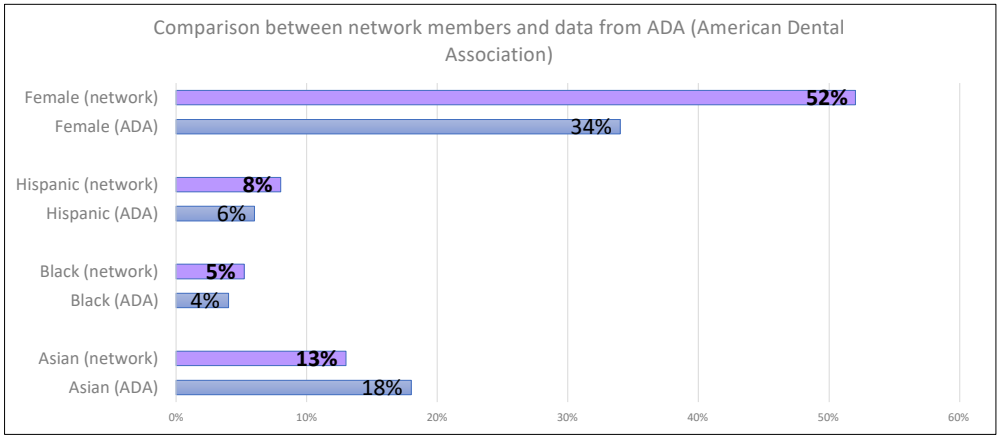
6) Node coordinators continue to follow up inquiries through the network's public website and network email address.

7

Milestones to increase diverse representation of network membership in GY6:

In GY5, we aimed to increase Asian membership by 2%. We exceeded that goal which would have resulted in 769 Asian members. We currently have 881 Asian members (active).

- **Increase the number of Asian members by 2%** or have 16 new Asian members, for a total of 897 Asian members.
- **Maintain the percentages** of other race, gender, and ethnicity for all active members **similarly or above** the percentage reported by the American Dental Association (ADA) for the dental profession in the USA.



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Other engagement activities: GY5

- A total of **2,662 members have participated in one or more** network studies in this grant cycle.
- **16 peer reviewed presentations** and **15 non-peer reviewed presentations** (n=31 presentations).
- **13 peer reviewed publications** and the **submission of another 9 peer reviewed manuscripts** currently under review (n=22 completed manuscripts).
- The network **issued 193 hours of Continuing Education credit** to participants for activities sponsored by the network.

9

Goals and milestones for network engagement for GY6:

Goal: Continue to work with the Communication and Dissemination Component on webinars, symposiums and meetings.

Milestone and metrics to improve the Practitioner Recruitment and Engagement component of the network:

1) Have at least three webinars in Grant Year 6.
2) Have one symposium at the American Association of Dental Oral and Craniofacial Research (AADOCR) meeting on March 12 2025 in New York, NY (led by NE region).
3) Have practitioner annual meeting hosted by at least three nodes (waiting for funding to define plans).
4) Offer Continuing Education credit for participants attending the above mentioned activities sponsored by the network.

10

Strategic plan and Activities for Engagement GY6 and beyond:

Member association presentations - Work with existing members (particularly at the full level) to engage them in presentations about study results at local, state, and national dental association meetings.

Annual practitioner meetings – plans are being defined for GY6. The topics discussed at the regional annual meetings and round-table discussions will be relevant and engaging to local members.

Webinars reporting study results.

Newsletter- Promote recognition of key participants, highlighting the event and the participation of the clinician speaker/presenter (with C&D).

Press releases - Work with the Communication and Dissemination and Specialty components on press release with study results and upcoming studies. Work with NIDCR, NIH, the ADA, and AGD as well as other outlets for further dissemination and engagement.

Symposiums held on research meetings- the AADOCR symposium will be held in New York on GY6.

Work with the Communication and Dissemination component and PAC (Practitioner Advisory Committee) members: As study results are available, engage PAC members on planning for dissemination of study results to patients, in "patient data briefs".

11

Practitioner Training Component:
Goals and milestones for GY5 and GY6

Maintain the amount of dentist-membership being **at least 50% enrolled at the full membership level**.

GY5: Have at least **330 dentists research-ready (n=415, Exceeded by 26%)**.

GY6: Have at least **477 dentists research-ready**.

Region	Research-ready by region on GY4	Research-ready by region on GY5. Cumulative (GY4+GY5)	Currently in process of research-ready	Total research-ready anticipated by region in GY6 (Cumulative+in process)
West	19	48	2	50
South West	54	78	23	101
Midwest	59	92	10	102
South Central	27	63	21	84
South Atlantic	43	71	2	73
Northeastern	35	63	4	67
Total	**237**	**415**	**62**	**477**

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Strategic plan and Activities for PTC GY6 and beyond

- Continue to learn from each other best practices for having clinicians become research-ready.
- We have to adapt as the landscape change and situations evolve.
- Strengths of the network: having creativity, resilience, team-work, and learning from its past experience.

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14

Engagement: GY5

1) 52 members participated on the webinar *"Post-operative Pain Study"* **November 10**
2) 22 members participated on the webinar *"Effectiveness of Nicotine Replacement Therapy Sampling in Dental Practices Study FreSH"* **January 30**
3) 120 members participated on the webinar *"Periodontal Adjunctive Antibiotics Study PAAS"* **February 14**
4) 57 members participated on the webinar *"Dental Implant Restoration Registry DIRR"* **March 26**
5) 58 members attended the 2024 Annual Meeting of South-Central Practitioners **April 5-6**

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National Dental PBRN Central IRB

Activities for Grant Year 05 (June 1, 2023 – May 31, 2024)
Plans for Grant Year 06 (June 1, 2024 - May 31, 2025)

Muna Anabtawi, DDS, MS
National Program Manager, National Dental PBRN
Department of Clinical & Community Sciences
University of Alabama at Birmingham, Birmingham, AL

NIDCR/PBRN Virtual Meeting of Directors and Key Personnel
June 11-12, 2024

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1

Overview of Grant Year 05 activity

Continued annual renewals of these IRB protocols

- Umbrella approval (general Network operations and Enrollment Questionnaire)
- Studies from the 2012-2019 funding cycle (TMD, PREDICT, AOB)
- CORE (phases 1 and 2) (Fellows)
- Deep Caries (Jurasic)
- TOP-AC (Elad)
- CARAD (phases 1 and 2) (Fellows)
- MSDP (phases 1 and 2) (Culmer)
- CADTAPS (Chavis)
- COVID PREDICT (Feldman)
- eHygiene (Xiao)
- POPS (Walji)
- DIRR (Geurs)
- FreSH (phases 2 and 3) (Japuntich)

New submissions in GY5

- SUDS (McCauley)
- PAAS (Kotsakis)

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2

Overview of Grant Year 05 activity

Other activities

- Numerous IRB Reliance Agreements and SMART agreements with non-Network IRBs who participate in Network studies
- Continued "Orientation to the National Dental PBRN Central IRB" sessions for new study teams
- Monthly meetings with the UAB IRB
- Numerous amendment submissions
- Local Context Review submissions
- South Central Region Individual Investigator Agreement submissions
- Protocol violations and deviations
- IRB audit requests

Other non-IRB activities

- Practitioners' Master Service Agreement (MSAs) submissions (approximately 675 MSA and MSA amendment submissions)
- Practitioners' MSA amendment submissions (e.g., apply payment increase to contracts)
- CE requests and tracking
- PEC contracts and payment requests

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3

Anticipated for Grant Year 06

Continue activities in the previous slides

Anticipated new submissions in GY6

- None; one UG3 award is still possible from the January 2024 NADRC Council

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4

Practitioner and Patient Compensation System

Activities for Grant Year 05 (June 1, 2023 – May 31, 2024)
Plans for Grant Year 06 (June 1, 2024 - May 31, 2025)

Muna Anabtawi, DDS, MS
National Program Manager, National Dental PBRN
Department of Clinical & Community Sciences
University of Alabama at Birmingham, Birmingham, AL

NIDCR/PBRN Virtual Meeting of Directors and Key Personnel
June 11-12, 2024

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Previous-year Milestones [*all completed*]

Milestone 1: Establish a system in the Hub that notifies the National Program Coordinator on a timely basis that a payment is ready to be made and initiate enhancements to the system's efficiency.

Milestone 2: The National Program Coordinator reports on a weekly basis the number of payments made and the number of payments made, by study.

Milestone 3: Establish a priority system for payments.

Milestone 4: To further enhance the system's efficiency, request of the NCC to enable the Hub system to meet certain specifications.

Milestone 5: Develop an electronic card payment system at UAB to make payments.

- Successfully addressed the iSupplier issue by implementing the Greenphire ClinCard system for practitioner payments for clinical studies.

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Grant Year 05 Milestones

GY5 Milestone 1: Regular monitoring to ensure that payments are made in a timely manner.

- The National Program Manager reports on a regular basis the number of practitioner payments made for clinical studies.
- The National Program Coordinator reports on a weekly basis the number of payments made, by study. Example of study-specific reporting by National Program Coordinator:

POPS					
Study	Date	Total payments needed	Total iSupplier# currently	Total payments submitted	Total payments to submit
POPS	6/3/2024	2788	2788	2788	0
POPS	5/27/2024	2751	2751	2750	1
POPS	5/20/2024	2751	2751	2713	38
POPS	5/13/2024	2751	2714	2713	38
POPS	5/6/2024	2714	2714	2697	17
POPS	4/29/2024	2714	2681	2681	33
POPS	4/22/2024	2681	2681	2656	25
POPS	4/15/2024	2681	2681	2643	38

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PPCS historical view of 2019-2026 funding period (as of Jun. 10, 2024)

Study Name HUB Payments	Individual Practitioner Payments	Group Payments	Patient Payments	Decline payment	Total Paid
CARAD	460	3	-	-	**463**
DCRS	303	3	-	-	**306**
TOP-AC	665	3		-	**668**
CADTAPS	380	3		-	**383**
MSDP (Qualitative)	30	-	-	1	**31**
MSDP (Pilot)	-	-	31	-	**31**
SUDS	756	4	-	-	**760**
eHygiene	-	-	104	-	**104**
POPS	84	11	2788	-	**2883**
DIRR	95	3	1044	-	1142
PAAS	-	-	0	-	**0**
FreSH RCT	7	-	0	-	**7**
Excel Sheet Payments					
Covid-PREDICT	-	-	74	-	**74**
ETW	35	-	-	-	**35**
FreSH - pilot	16	-	31	-	**47**
Research-ready payments	155	-	-	-	**155**
Total	**2986**	**30**	**4072**	**1**	**7089**

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Grant Year 05 Milestones

GY5 Milestone 2: Regular reporting on number of practitioners who complete research-ready tasks and provide evidence of behavior change due to this financial incentive of $250.

Node Coordinators continue to report that practitioners who received a research-ready payment often did these tasks in response to the financial incentive, and that they would probably have not become research-ready absent the incentive or would have delayed completion substantially.

Study Ready					
Research-ready	Date	Total payment needed	Cards sent	Total payments completed	Cards to process
Research-ready	6/3/2024	186	186	155	2
Research-ready	5/27/2024	184	184	151	4
Research-ready	5/20/2024	183	183	151	3
Research-ready	5/13/2024	180	180	150	1
Research-ready	5/6/2024	180	180	150	1
Research-ready	4/29/2024	180	180	149	2
Research-ready	4/22/2024	180	180	147	4
Research-ready	4/15/2024	178	178	146	5
Research-ready	4/8/2024	173	173	143	9
Research-ready	4/1/2024	173	173	142	10
Research-ready	3/25/2024	173	173	141	11
Research-ready	3/18/2024	172	172	141	10
Research-ready	3/11/2024	172	172	141	10
Research-ready	3/4/2024	171	171	139	9
Research-ready	2/26/2024	170	170	136	12
Research-ready	2/19/2024	165	165	135	15

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