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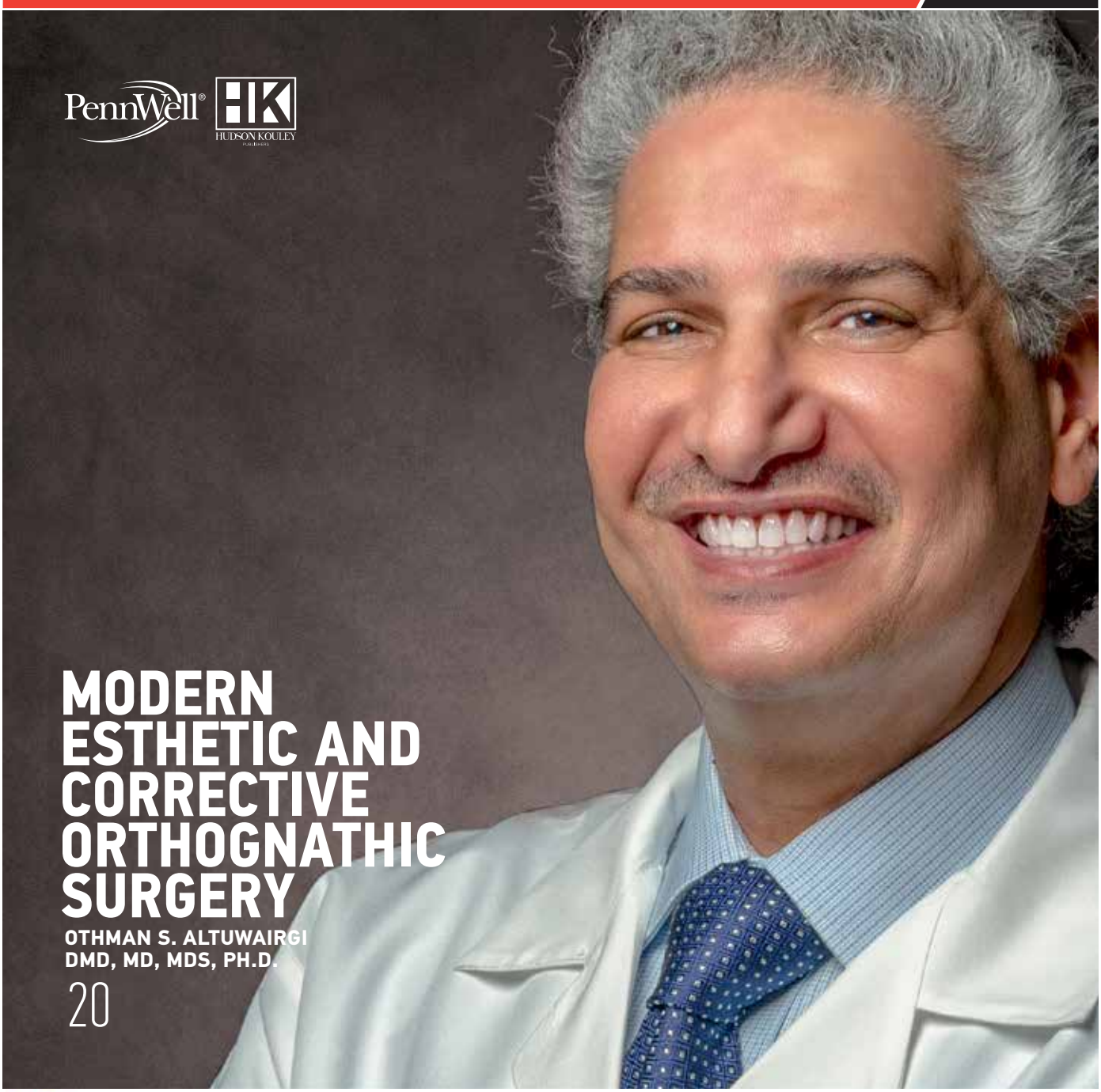

MODERN ESTHETIC AND CORRECTIVE ORTHOGNATHIC SURGERY

OTHMAN S. ALTUWAIRGI
DMD, MD, MDS, PH.D.

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COURSES:

- Emerging Concepts in Periodontitis and Overall Health
- A Review of Dental Caries Detection Technologies
- Building Bridges: Dental Care for Patients with Autism
- Abuse: Mandated Reporting for Dental Professions
- Clinical and Material Factors in Achieving the Ideal Impression
- Dental Erosion: Etiology, Diagnosis and Prevention
- The Business of Dentistry

Upon passing the 30 MCQ examinations, the Participant will receive continuing education credit as documented in the attached Verification of Participation Form AA

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Course ID: 04-3274-05006

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DR. KHALID M. KHALID

has taken and successfully passed the Continuing Dental Education Self Instructional-Visual course authored by William R. Watson Jr., DDS, MS, FAAOMP and entitled:

Achieving Predictable Success with Root Canal Treatment

on January 04, 2014 and verified by:

Craig Dickson
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Heather Hodges
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Dental Board of California: Provider 4827, course registration number: 04-3274-05006

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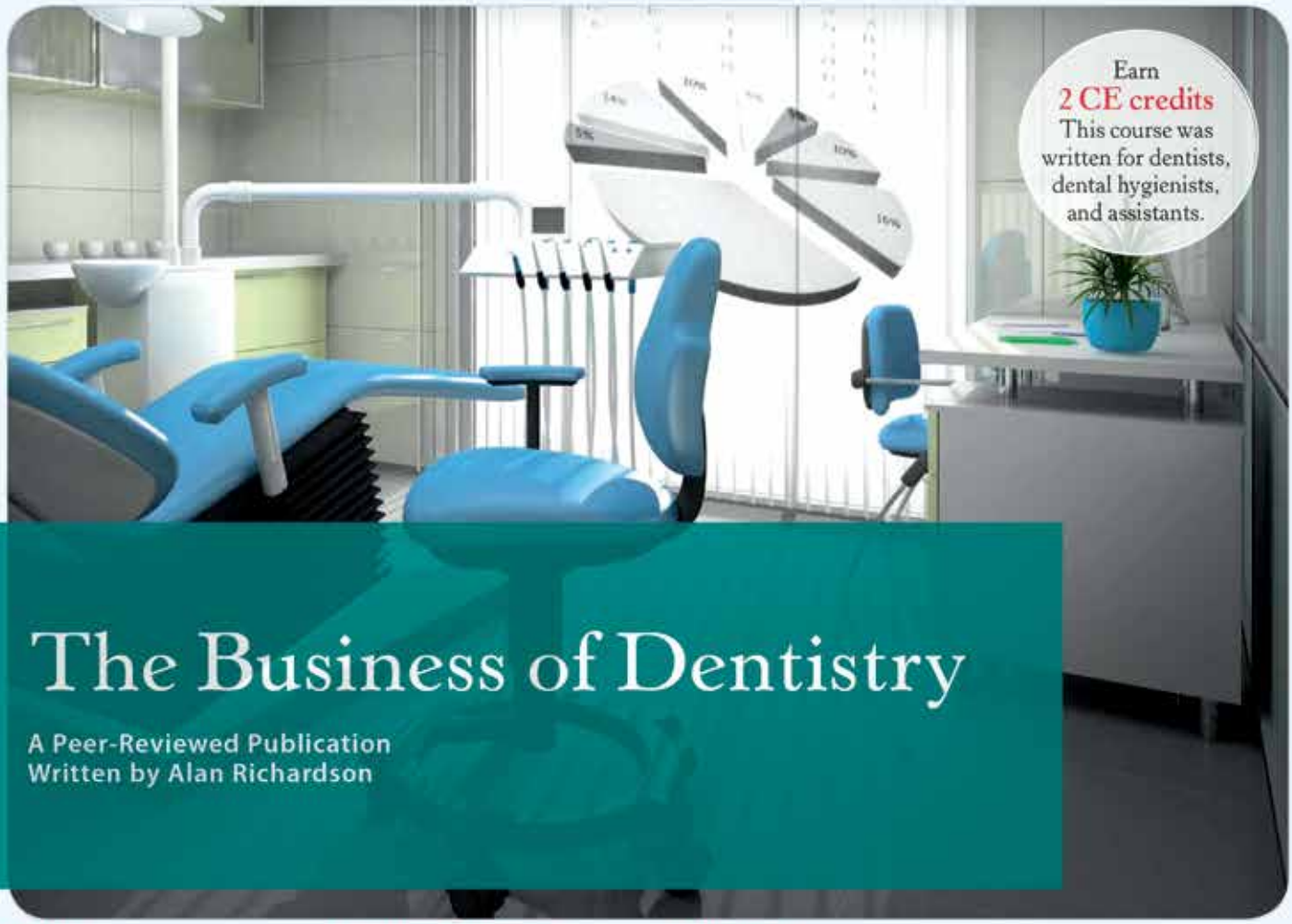


The Business of Dentistry

A Peer-Reviewed Publication
Written by Alan Richardson

Abstract

Basics of Business Success

You will learn what makes a dental office successful and profitable. The areas discussed in detail include; the importance of delivering high quality dentistry, providing exceptional customer services and understanding what makes the business work and be profitable, safeguarding the patient base as the most valuable asset by understanding continual care, the role of insurance, management of collections and receivables. Also discussed is the role of leadership to ensure the team is committed to common vision and goals, so the practice is a fun place to work, is productive, profitable and a place that patients enjoy visiting.

Educational Objectives:

At the conclusion of this educational activity the participant will be able to identify the following:

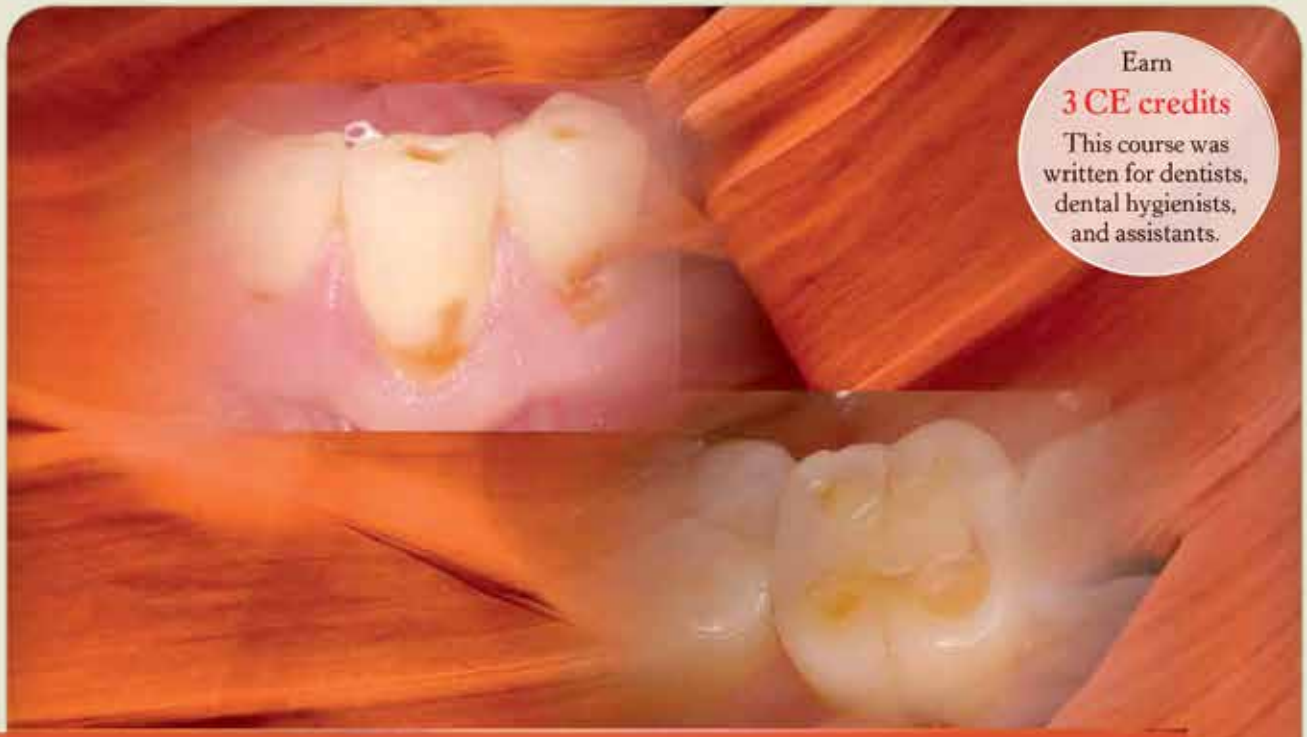
1. The importance of delivering high quality dentistry
2. The basics of practice profitability
3. The four primary areas to manage for success
4. The importance of exceptional customer services
5. The importance of leadership
6. How to minimize embezzlement

Author Profile

Alan Richardson, As a peak performance coach, Alan brings to the business of dentistry a refreshing, stimulating perspective based on more than 30 years experience in heavy industry and business management. As a Chairman and CEO of public companies and having lived and worked in many parts of the world, his insightful knowledge and experience adds a dimension unique to the field of dentistry ... a leader of large teams worldwide. Born in England and educated at King's College, University of London and the Imperial College of Science and Technology in London, his broad international experience adds vitality and energy to everything he does. A lecturer, writer and executive coach to many of North America's leading dentists, Mr. Richardson draws on his strategic strengths and experiences to coach dentists, both professionally and personally. Alan is the Chief Executive Officer of The Richardson Group, providing consulting and management services to the healthcare industry. His goal as a coach is to be a catalyst that moves people to action and achievement of their goals. He can be contacted at alan@richardsoncoaching.com or toll free 888-495-3623. www.richardsoncoaching.com

Author Disclosure

Alan Richardson has no commercial ties with the sponsors or providers of the unrestricted educational grant for this course.



Earn
3 CE credits
This course was written for dentists, dental hygienists, and assistants.

Dental Erosion: Etiology, Diagnosis and Prevention

A Peer-Reviewed Publication
Written by Yan-Fang Ren DDS, PhD, MPH

EDUCATIONAL OBJECTIVES

The overall goals of this article are to provide an overview of the causes, risk factors, diagnosis and prevention of dental erosion.

On completion of this course the reader will be able to:

1. List and describe the prevalence of dental erosion

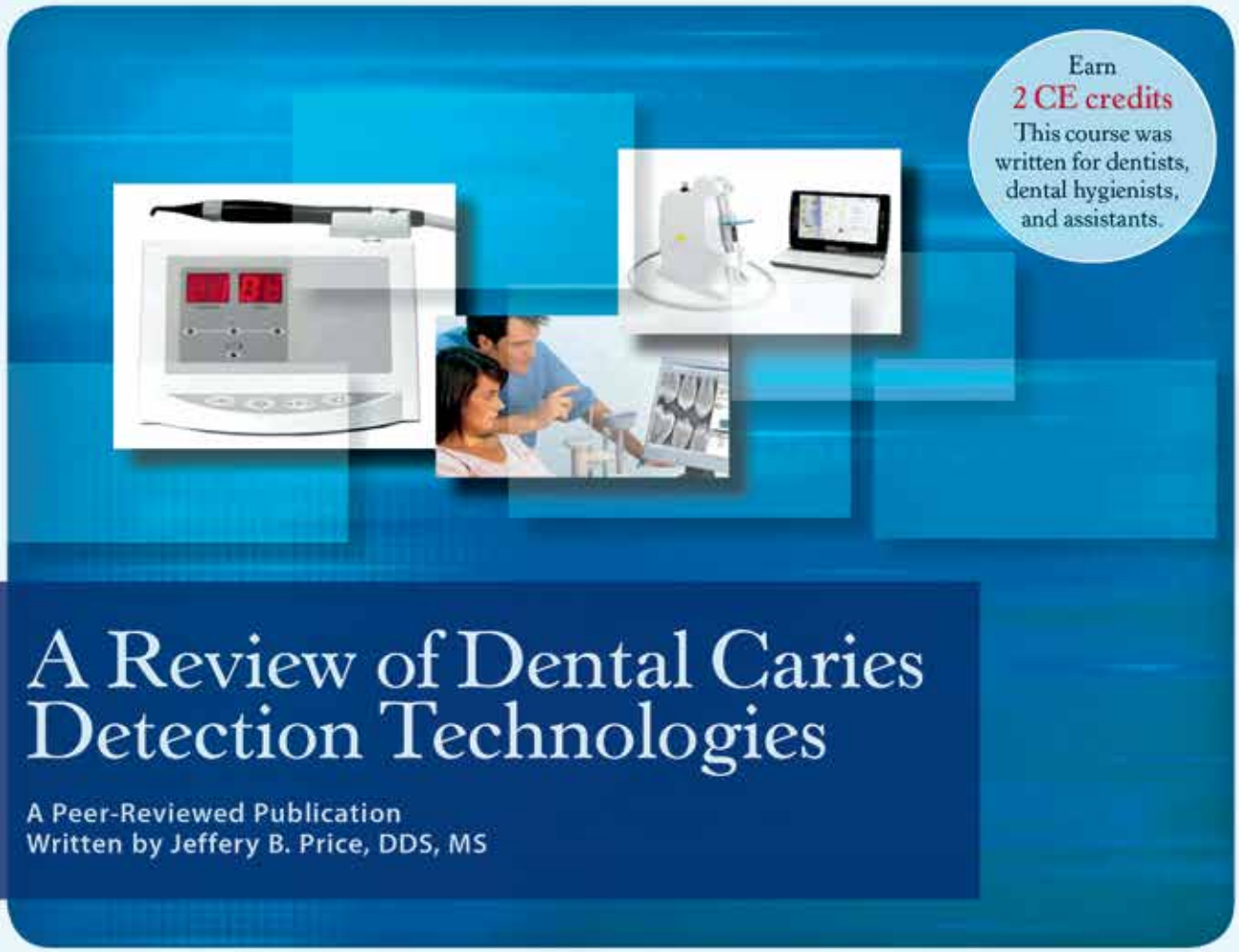
2. List and describe the etiologies of dental erosion

3. List and describe the signs and symptoms of dental erosion and the complicating factors associated with dental erosion

4. List and describe methods for the management and prevention of dental erosion.

ABSTRACT

Dental erosion is a prevalent condition that occurs worldwide. It is the result of exposure of the enamel and dentin to nonbacterial acids of extrinsic and intrinsic origin, whereby mineral loss occurs from the surface of the tooth. The most frequently affected areas are the palatal surface of maxillary incisors and the occlusal surface of the mandibular first molars in adolescents. Characteristic early signs of dental erosion include smooth and flat facets on facial or palatal surfaces, and shallow and localized dimpling on occlusal surfaces. Early intervention is key to effectively preventing erosive tooth wear. Effective prevention of dental erosion includes measures that can avoid or reduce direct contact with acids, increase acid resistance of dental hard tissues and minimize toothbrushing abrasion.



A Review of Dental Caries Detection Technologies

A Peer-Reviewed Publication
Written by Jeffery B. Price, DDS, MS

ABSTRACT: An editorial in the journal of American Dental Association (JADA) 6)143) June 2012 indicated that the majority of the 1 million dentists around the world still use G.V. Black caries lesion classification and disease management system that is more than 100 years old. The editorial concluded that "the system is unable to meet the needs and demands of our patients".

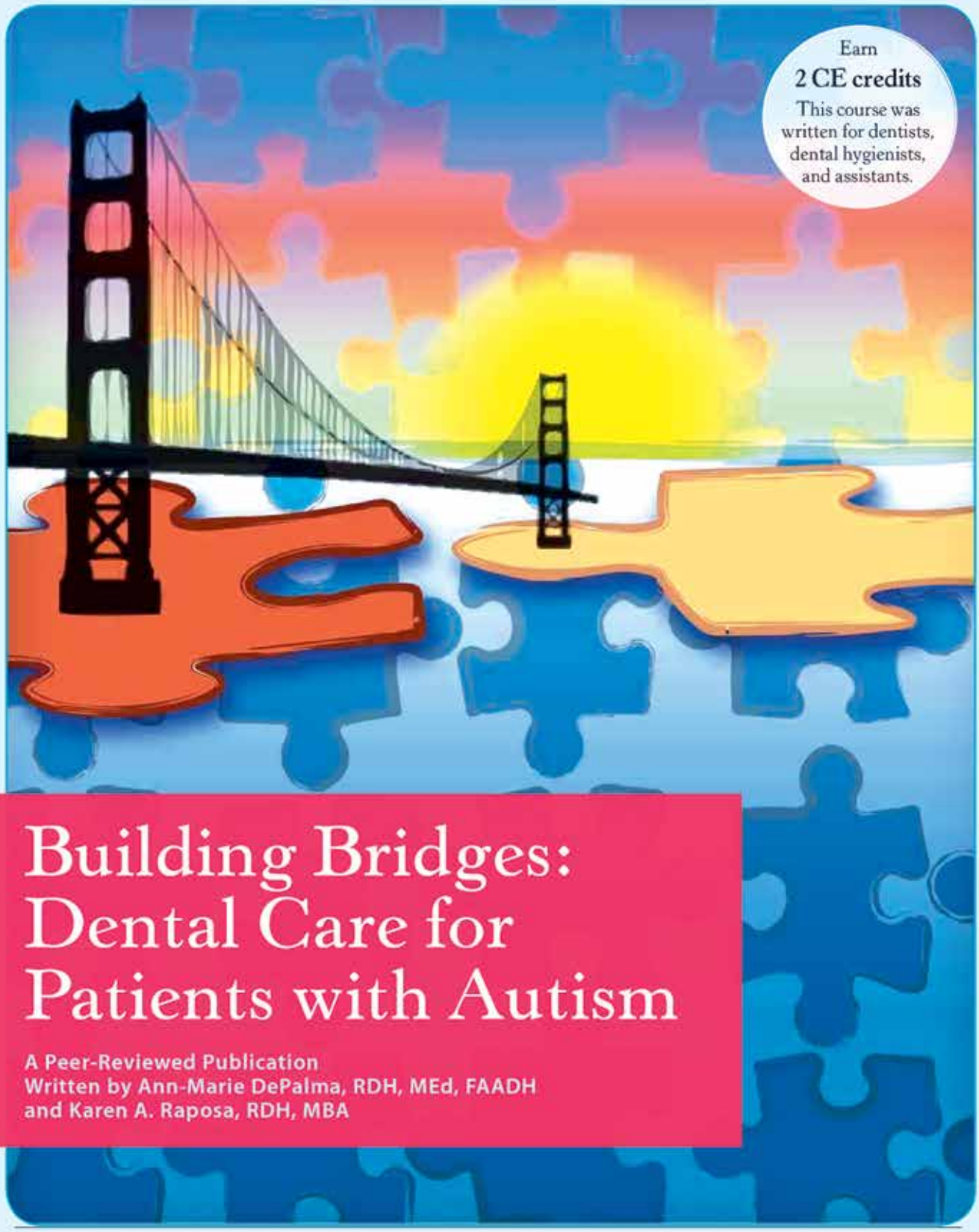
Dental caries can be stopped thru prevention and health promotion measures.

The preventive measures against dental caries begin with early disease detection and early diagnosis which inturn depends principally on caries classification.

This article deals with dental caries detection and lesion evaluation method. Starting with the simplest detection method "visual examination" to the most technologically advanced such as quantitative light-induced fluorescence, computer aided diagnosis and frequency-domain laser technology.

The 2012 international caries detection and assessment system (ICDAS) offers a six stage, visual-based systems for detection and assessment of coronal caries. It has been thoroughly tested and has been found clinically reliable and predictable. A major limitation with bitewing radiography is its reliability and predictability in caries diagnosis is especially interproximal caries.

Although have excelled in the clinical treatment test, the dental professionals do not excel at diagnosing dental caries, especially interproximal caries using bitewing radiography. The ICDAS will enhance accuracy in detection and the improvement of Oral Health case.



Building Bridges: Dental Care for Patients with Autism

A Peer-Reviewed Publication
Written by Ann-Marie DePalma, RDH, MEd, FAADH
and Karen A. Raposa, RDH, MBA

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2 CE credits
This course was written for dentists, dental hygienists, and assistants.

Abuse

Mandated Reporting for Dental Professionals

A Peer-Reviewed Publication
Written by Cynthia N. Yellen, LCSW, MSW, MBA, RDH, BA

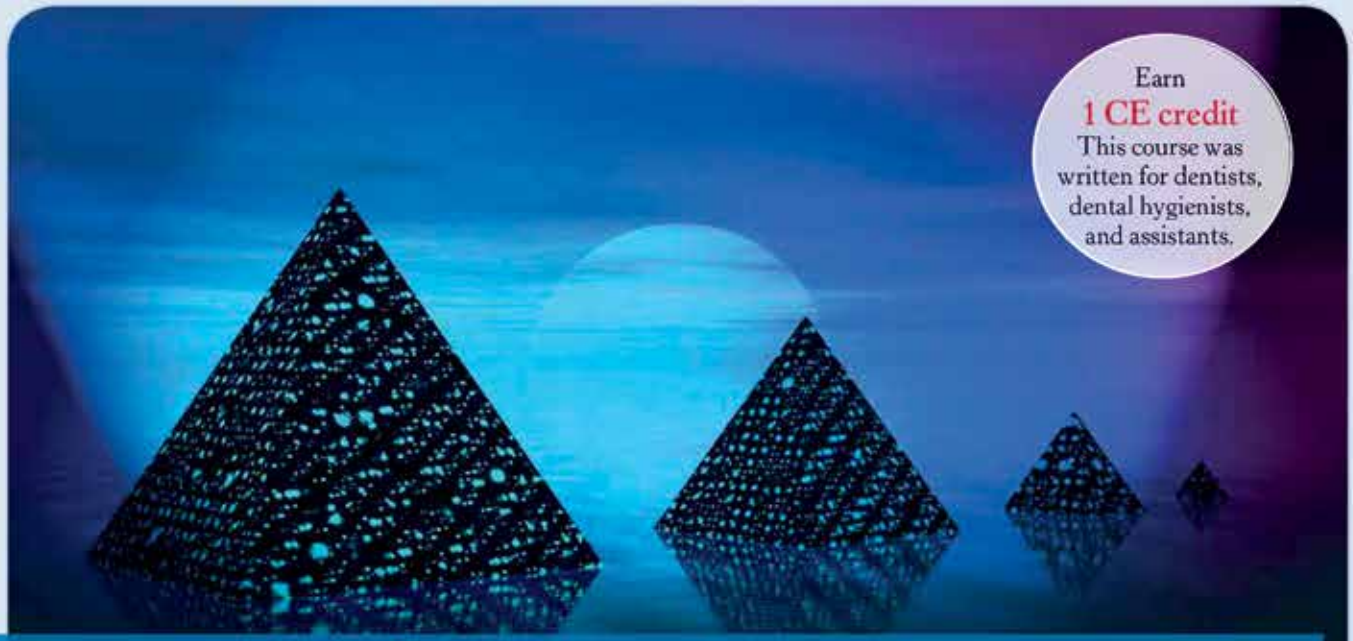
ABSTRACT: Dentists and Dental Hygienist may encounter types of patient that are in need for dental care, but require special management and documentation. They are:

1. Patients experiencing problems related to the use of alcohol and illegal drugs.
2. Patients experiencing actual dental problems related to trauma caused by physical abuse thru domestic violence.
3. Patients experiencing dental problems related or caused by neglect.
4. Patient's not experiencing pain, but have creating problems to deceive doctors by faking pain, in order to get pain medications.

Dental professional must be knowledgeable in the signs and symptoms of abuse in all of its types. The consequences and health effects of many of the alcoholism, drug addictions and abuse problem manifest in the oral cavity. Therefore, are easy to identify and detect early if these patients are seen in the dental office. The majority of the cancers of the mouth, larynx and pharynx, sialosis, glossitis, gingivitis are disease and oral manifestation related to heavy alcohol use. The "methmouth" with severe caries, teeth destruction are conditions related to drug usage.

CONTENTS:

The rise of dental professional in identifying suspected abuse



"Emerging Concepts in Periodontitis and Overall Health"

A Peer-Reviewed Publication

Written by Dianne Glasscoe Watterson, RDH, BS, MBA

Abstract

This course examines the evidence surrounding various systemic diseases and their interrelation with periodontitis. The course begins with a historical view of the focal theory of infection. Next, the seven study designs and the strength of evidence with each design are discussed. The reader is given some guidelines to use when evaluating studies. Finally, these systemic diseases and their association to periodontitis are discussed: cardiovascular disease, diabetes mellitus, respiratory disease, pregnancy factors, prostate cancer treatment, osteoporosis, rheumatoid arthritis, and head and neck cancer.

Learning Objectives:

1. To learn the latest information about the association of periodontal disease and non-oral disease
2. To weigh the evidence surrounding various oral/systemic associations

Author Profile

Dianne Glasscoe Watterson, RDH, BS, MBA is an award-winning author, speaker, and consultant. She has published hundreds of articles in various professional journals, including two monthly columns in Dental Economics and RDH magazines. Dianne has also authored several textbook chapters in Foundations of Periodontics for the Dental Hygienist and has published two books: Manage Your Practice Well for dentists and office administrators and The Consummate Dental Hygienist: Solutions for Challenging Workplace Issues. Dianne was honored by Dentsply® as a "Distinguished Dental Professional" in 2005 and Colgate® in 2009 and 2010 as a "Key Opinion Leader." Dianne has been chosen as a "Top Clinician in Speaking and Consulting" by Dentistry Today every year since 2006. Please visit her website at www.professionaldentalmgmt.com.

Financial Disclosure

This work was not funded by any agency or commercial enterprise. The author, Dianne Glasscoe Watterson, relates no conflict of interest that would compromise or have an affect on the manuscript's content.

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FROM THE EDITOR

The publication of this issue coincides with the launch of CEArabia.com, an online dental continuing education destination available in both Arabic and English. The first release of CEArabia.com features seven peer-reviewed courses prepared in collaboration with the PennWell Corporation. All CEArabia's online courses are recognized by the American Dental Association's Continuing Education Recognition Program (ADA CERP) and the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE). We hope you review these courses at www.CEArabia.com and appreciate your feedback.

In this issue of DE MENA, modern aesthetic and corrective orthognathic surgery is featured through a comprehensive interview with Dr. Othman Al Tuwairgi, a pioneer in maxillofacial surgery in Saudi Arabia. The interview covers a wide range of issues, and Dr. Al Tuwairgi reveals his opinions and insights about the status of the oral maxillofacial specialty, and the changes and current practices of orthognathic surgery. The information presented is important to educate patients with maxillofacial deformities who need to know the options they have available. It has been my experience with such patients that neither cosmetic dentistry nor orthodontics can realign skeletal deformities, nor do they restore the physiologic functions they have lost or the esthetics they have always dreamed of.

In this letter, I have selected a few articles to share with you. Dr. Stacey Simmons' article "What I learned from firing my first employee" is an informative yet delightful story of a recent dental graduate and a dental receptionist who was nasty to the patients and practice staff, yet always nice to the doctor. I am sure many of us can relate to what Dr. Simmons has gone through.

Dr. Jim Philhower's advice on the morning huddle in "Increase your production in 15 minutes or less" clearly outlines one of the best practices to involve all the dental practice staff and make them efficient and more accountable.

There are three more articles that may help us assess our leadership, communication, and management skills. Dr. Rick Workman considers "Level 3 communication," the ideal level to fully communicate with clarity, confidence, and dedication. You are not afraid to be direct and sincere when you share ideas. In Amy Morgan's "Finding your leader's voice" she writes that "hiding behind a façade and remaining detached, your voice will fall on deaf, cynical ears." Finally, Desmond Clancy reminds us of eight common mistakes that could mess up our leadership: Not deciding, not delegating, not providing feedback, not setting goals, not listening, hiring too fast, firing too slowly, and treating employees as a group not as individuals.

I have assessed myself and sadly found that sincere leadership and open communication could frustrate and even disconnect us if others do not reciprocate with the same values. Therefore, I will probably continue to err and learn, and remember John C. Maxwell's statement, "A man must be big enough to admit his mistakes, smart enough to profit from them, and strong enough to correct them."

I hope you like what we have prepared for you. Please email or contact us.

Thank you,

Marwan AbouRass
DDS, MDS, PhD
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PUBLISHED BY:
HUDSON KOULEY PUBLISHERS FZE
CREATIVE CITY-MEDIA FREE ZONE
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LICENSE 4503/2014

PRINTED IN THE UAE BY:
MASAR PRINTING & PUBLISHING

Dental Economics Mena® is published 6 times a year by:
Hudson Kouley Publishers FZE®
P.O. BOX 4422
Fujairah, United Arab Emirates
The magazine is available on a controlled, complimentary basis to qualified practicing dentists and dental faculty and other Dental professionals by special arrangements.

- Annual Subscription
  Printed & Online
  156 USD
- Monthly application
  13 USD
- Print Copy
  13 USD

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SELL THAT SMILE!

JANET HAGERMAN, RDH, BS

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WHAT I LEARNED FROM FIRING MY FIRST EMPLOYEE

STACEY L. SIMMONS, DDS

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THE 7 DEADLY SINS OF ONLINE PRACTICE MARKETING

GLENN LOMBARDI, BA

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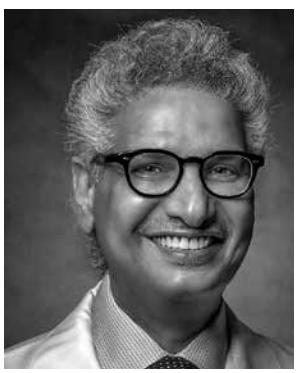

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JANET HAGERMAN RDH, BS

Coach, Fortune Management.

CREME DE LE CREME

THIS COLUMN INCLUDES A COLLECTION OF SELECTIVE STATEMENTS AND QUOTES EXTRACTED FROM THE VARIOUS ARTICLES PUBLISHED IN EACH ISSUE. THEY INCLUDE IMPORTANT AND INTERESTING THOUGHTS AND BEST PRACTICES. PLEASE CONTINUE TO THE MAIN ARTICLE FOR MORE.

FINDING YOUR LEADER'S VOICE

▶ When you hide behind a façade and remain detached, your voice will fall on deaf, cynical ears. When you communicate authentically, others will hear you and be moved.

▶ I used to advise dentists to "empower" their teams. I have, however, seen so many dentists claim they are empowering staff, when they are actually micromanaging or abdicating their leadership roles, that I now consider "empowerment" a tainted word. I now prefer "emancipation," because staff who are not allowed to find their own self-leadership will feel like slaves.

THE 7 DEADLY SINS OF ONLINE PRACTICE MARKETING

▶ It's 2014, and all of us are far more Internet-savvy than we were even five years ago. Nevertheless, a surprising number of dentists still seem to think that a website is the end-all-be-all to online success. Once upon a time, this was true. But those days are long gone. The Web is now so enormous that any site, no matter how good it is, will get lost in a crowd if it is not part of a comprehensive and carefully maintained Web presence. To ensure success, your online footprint will need to be much, much larger.

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REACHING LEVEL 3 COMMUNICATION

▶ Confronting conflict without stress -- If conflict occurs when communicating with others (and it naturally will), you have to handle it correctly. Becoming angry and going into attack mode or completely closing your mind might be natural responses, but they're not the right responses. When confronting conflict, it's important to remain calm, open, and focused.

▶ Mastering nonverbal communication -- Another important component of the "It's not what you say, but how you say it" idea is nonverbal communication -- your tone and body language. If you have a negative and uncaring body language and tone, that's how others will perceive you, no matter what you say. Be positive, upbeat, and encouraging, and you'll make a much better impression.

HOW TO PROFIT FROM COSMETIC DENTISTRY: ACHIEVING PROFITABILITY WITH AESTHETIC DENTISTRY

▶ The physical environment of the office should elicit patient's questions and desires about how they can improve their appearance with an enhanced smile. This can be accomplished with before and after photo books, beautiful smiles and faces as artwork on the office walls, or even screen-savers that morph from before to after pictures.

▶ One of the greatest ways to create value is the concept of "practicing what you preach." When the doctor and the team members have had their own smiles enhanced with aesthetic dentistry, this escalates the value, durability, and safety of the specific procedure. Most of the successful cosmetic-dental practices have a doctor and several of the team members who personally have had a smile enhancement with porcelain veneers or orthodontics.

MODERN ESTHETIC AND CORRECTIVE ORTHOGNATHIC SURGERY

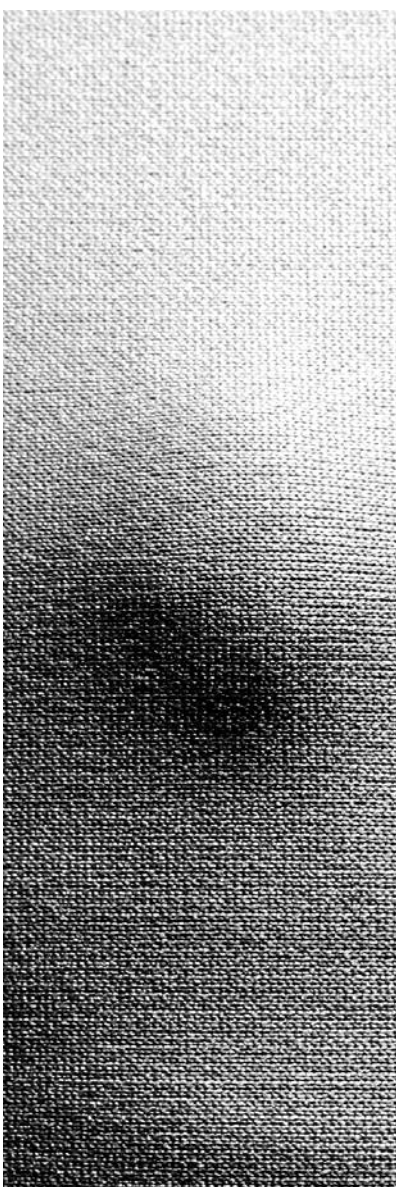
▶ The OMFS standards of care, whether in the private or public sector, are well defined and require that all patients be treated and cared for according to these standards. Unfortunately, the care many patients are receiving in some tertiary care hospitals do not comply with the acceptable standards of care of the OMFS specialty.

▶ I am very concerned about the status of dental education in KSA today. There is a steep decline in the quality of the academic and clinical skills of the recent graduates of the current Saudi dental schools including the three universities mentioned above. Unfortunately, I do not see my veteran colleagues and pioneers actively involved in the discussions and planning of the future of dentistry in Ksa.

▶ Improvements in techniques and materials have made the surgery much safer and simpler than in the past. I remember back in the 1980s, the patient was kept in the ICU intubated overnight for recovery from anesthesia. Patients also used to get blood transfusions as the routine. Today, the surgery requires on average 1½–3 hours depending on case difficulty. After recovery from anesthesia, patients are transferred to their hospital room and discharged from the hospital within 24–48 hours after the surgery.

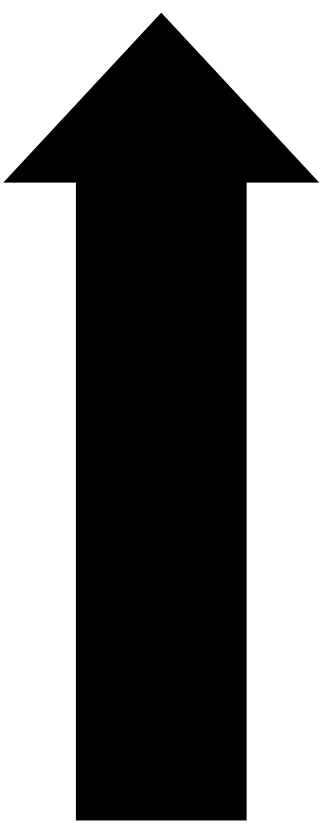
SELL THAT SMILE!

Giving your patients enough information to make a well-informed decision. Then let the patients make their decisions, not you! The challenge is to sell whitening, or any dentistry, in an elegant manner that creates value for your patients, without feeling like you are selling. None of us likes to "be sold," but we all like to buy!



SUDDEN IMPACT' TO BOOST PRODUCTION

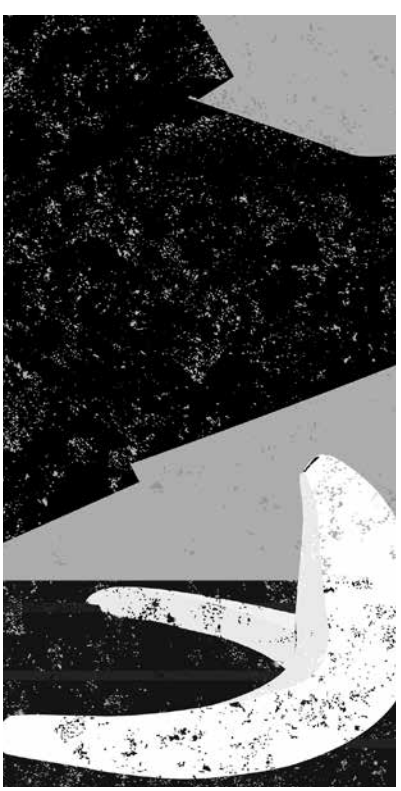
Introduce changes incrementally by phasing them in gradually during the annual plan. Achieve great things by proceeding in small steps. Rather than arrive like a bull in a china shop to topple the established office routine and to overwhelm the Dr. and his staff, our approach was more subtle, leading to a Corollary Pride Concept: Do not try to change all of the systems and staff behaviors at once. Instead, make one or two fantastic improvements in the practice. These first successes enable everyone to accept management improvement as possible and nonthreatening. We call this quick dose of easy-to-swallow medicine a "sudden-impact plan." for example : boosting production.



8 COMMON MISTAKES MADE BY DENTAL PRACTICE OWNERS/ MANAGERS

Also as a manager, you should be "friendly" with members of your team, but being close friends with them can make things difficult. While socializing with your team is a good idea, seek balance in how much time you spend doing so. Once you become their friend, it makes it difficult to be their boss.

Take your time and hire the right person for your team. You and the rest of your team deserve to get the best person, not the first person. Another mistake managers make is taking too long to end someone's employment. Terminations are the most difficult part of the job, but also one of the most important.



WHAT I LEARNED FROM FIRING MY FIRST EMPLOYEE

When one individual is not doing his or her part or causing contention, then the whole operation, and subsequently the financial health of the practice, is affected. How? Staff communication and interaction affects, albeit subtly, patient motivation and comfort level. If patients are not at ease, they won't or will be less inclined to schedule another appointment or be willing to come back to your office. Patients read body language!

Firing an employee is not a decision to be taken lightly. Several factors equate into such a verdict, but let's be realistic - it happens, and it will happen with all of us at one point or another. Resistance to change the status quo is difficult; we are all human! Yet, as small-business owners, tough decisions have to be made ... and tag, you're it!

Don't make the same mistakes I did. If you are going to let someone go, then do it and do it quickly with no strings attached. You will be better off, your staff will appreciate your leadership, and your practice will benefit in more ways than you realize.

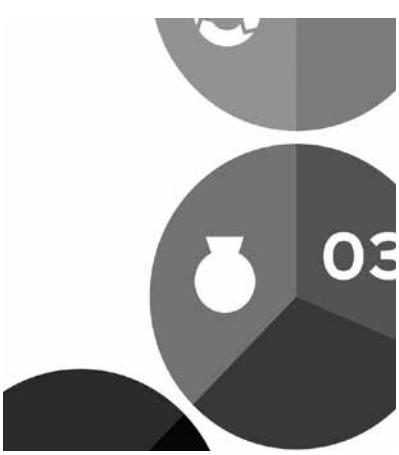
DEFINING AND MEASURING SUCCESS

Measuring your success

Educating patients about all of your products and services is the first step in boosting production per patient. A hectic pace does not always indicate a productive practice. A dentist who sees a full schedule of patients from open to close may feel successful because it seems the practice cannot handle any more patients. But if the practice does not track average production per patient, it is difficult for the dentist to determine whether the practice is as profitable as it could be.

The more financial options practices give patients, the greater the opportunity to increase case acceptance, especially for cosmetic and elective services. In today"s image-conscious society, many patients are interested in improving their appearance.

The right financial options, combined with other case presentation strategies, can help make a more beautiful smile and an enhanced appearance a reality for more patients.



FIVE SEO BEST PRACTICES TO HELP YOUR PRACTICE ATTRACT AND ACQUIRE NEW PATIENTS ONLINE

Consumers searching online almost always click on the first results they see -- 87% of all clicks from organic search engine traffic goes to the first five results. To capture the attention -- and clicks -- of prospective patients, a practice's website must secure these top spots in relevant searches for specific keywords.

If your webpages are frequently updated with fresh content, search engines will deem them more important, increasing the chances they make the first page of results. Update your website monthly if possible. Focus on creating content that site visitors will value since this type of content also tends to help with search-engine rankings. Updating a link or two in the navigation bar is unlikely to help your search rankings, but adding a new blog post or new site content might.

MODERN ESTHETIC AND CORRECTIVE ORTHOGNATHIC SURGERY

AN OPEN AND INFORMATIVE INTERVIEW WITH
OTHMAN S. ALTUWAIRGI
DMD, MD, MDS, PH.D.

Oral and maxillofacial surgery (OMFS) is a recognized specialty of dentistry. The designation of oral and maxillofacial surgery was adopted by the ADA House of Delegates in 1977 from the previous specialty designation of "oral surgery" to be representative of the procedures performed by oral and maxillofacial surgeons. The ADA definition of the specialty states:

"Oral and maxillofacial surgery is the specialty of dentistry that includes the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects involving both the functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial region."

The theme of "Ask the Professor" column, in this issue, is modern orthognathic. Featuring Dr. Othman S. Altuwairgi who is considered one of the pioneers in OMFS specialty and is first GCC countries dentist to be certified in the OMFS American board in 1996. Following graduation from King Saud University (KSU) in 1988, Dr. Altuwairgi went to Boston, where he spent a decade and a half in advanced academic studies, research, clinical practice and teaching at the universities of Tufts, Harvard, Boston and Antiqua. Dr. Altuwairgi is licensed in dentistry and medicine and holds a doctorate degree in craniofacial biology. He is currently a visiting professor at Maryland University, USA and Associate Professor at the Al Faisal University, Saudi Arabia.

The interview revealed Dr. Altuwairgi's opinions about the status of the OMFS specialty and the teaching of dentistry in Saudi Arabia, and provided valuable detailed information about the changes and current practices of esthetic and corrective orthognathic surgery. Dental Economics-MENA is pleased to bring this comprehensive, educationally and clinically informative content to the interested dental and medical health professionals, and to the patients who are in need for advice and guidance.

1- Please tell us about your personal professional vision, values, and the people who influenced your career the most.

My interest in OMFS started when I was a dental student back in the 1980's, my vision to be the best clinician became an obsession. I learned how medical negligence can destroy a person's life and make him/her permanently handicapped because some dentist did not detect precancerous oral lesions, missed the diagnosis or did not grant the patient the right to be referred to a specialist.

I have always believed that the best way toward professional excellence is through specialty education. I have inherited all my professional values from my mentors with whom I spent my advanced studies, mentors as: Professors G. E. Ghali at Louisiana State University, Philip L. Maloney, Larry M. Wolford, H. Chris Doku, Maria Papageorge and Lonnie Norris at Tufts and Boston Universities, and Johan P. Reyneke at Baylor University. These men and women have taught me the values of "giving" and "sharing" the true meaning of the value of "excellence." They taught me how to cope with the heavy burden of "professional responsibility". That when a patient grants me the authority to operate, he or she is also giving me the highest levels of trust and in return expects the "highest levels of care".

The best way to meet patients expectations is through the value of "commitment" to quality care regardless of the difficulties and obstacles we face. I have learned since returning from the US, that through "perseverance" to values and principles, all the hardships will disappear and the reward will come. The reward is the ever shining, glimmer of happiness I see in the patients' eyes and the tones of hope I hear in their words, which make me look forward to the next patient to give him/her the same happiness and hope.

2- Having spent a decade and a half in the U.S. and witnessed the changes of the specialty from oral surgery to oral and maxillofacial surgery, please discuss the status of the specialty in Saudi Arabia in comparison to the United States.

In the past, the scope of oral surgery (OS) was limited to the management of pathology and trauma. Today, the scope of OMFS has expanded to include the functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial region. Figures 1, 2, 3 and 4.

Currently, the numbers and severity of oral and maxillofacial trauma cases we are treating are much less than in the past. Nevertheless, there is a significant increase in basic surgeries such as implant placement localized oral bone augmentation, and orthognathic esthetic and corrective surgery.

I believe that the scope of the OMFS specialty is not well defined in either the minds of the kingdom's OMFS specialists or the minds of medical professionals, such as the Ear, Nose & Throat (ENT) and plastic surgeons. It seems that most OMFS specialists in Saudi Arabia are still practicing the traditional dentoalveolar, surgery scope plus the placement of dental implants. Elective and reconstruction procedures are receiving little or no attention. The majority of general practitioners do dentoalveolar surgeries and either place dental implants or refer to periodontists. Some general dentistry clinics are even providing facial fillers and Botox services to their dentistry patients. If this trend continues, future OMFS specialists will be operating only in tertiary care hospitals.

What has been taking place in Saudi Arabia is no different from what has happened in the U.S. back in the 1980s when physicians, ENT and plastic surgeons considered OMFS specialists no more than general dentists, the way many Saudi surgeons view us today.

It is very important to realize that the OMFS specialty was not easily developed. I have been told of the stories of struggle and hard politics that the early OMFS pioneers had to go through to establish the specialty

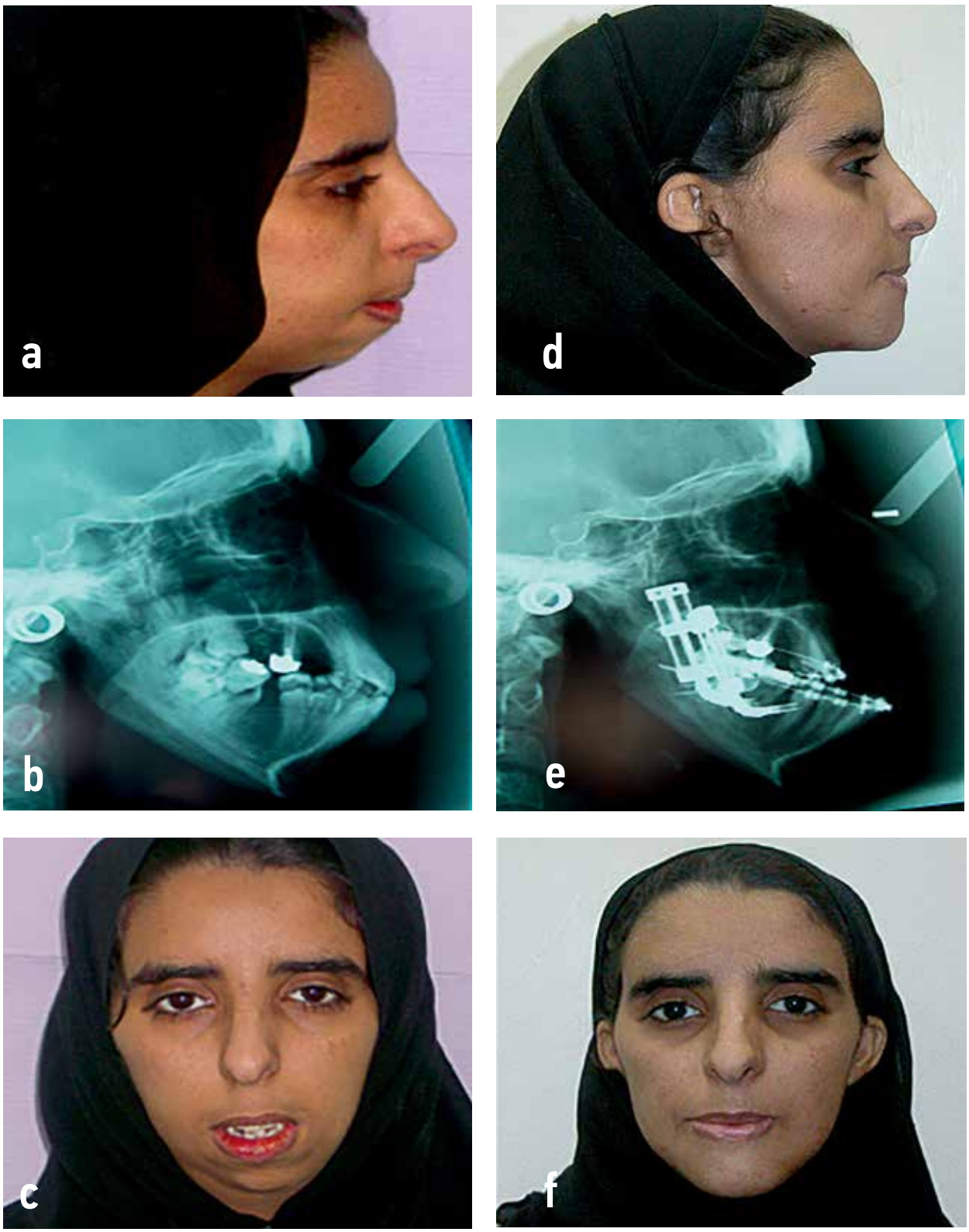


FIG. 1 (A,B,C) pre-operative and cephalometric radiographs showing, facial harmony loss and airway collapse due to severe mandibular retrognathic problem caused by condyle resorption. Fig. 1 (D,E,F) post-operative regaining of facial harmony by mandibular distraction osteogenesis followed by double jaw orthognathic surgery.

we enjoy today. Some U.S. oral surgeons spent their life campaigning for OMFS political recognition. Others spent their years in clinical work, research and teaching. None of this is happening in Saudi Arabia, none of these activities are being done to build a well-organized and respected Saudi OMFS specialty.

It seems that the few of us who have been trained have no vision for the future of our OMFS specialty. OMFS specialty in Saudi Arabia is at a crossroads. There is a need for progressive leadership that will revitalize the specialty and lead it into the 21st century, especially with the increased number of dentists in the country and the increased demands of the public for quality dental and esthetic health care. If we do not lead, then the specialty will be leading itself and drift to loss and more mediocrity.

3-It seems that you are not pleased about the organizational aspect of the specialty, what about the quality of the oral and maxillofacial surgery treatments that you have seen in your practice?

True, my thoughts in this regard are based on the fact I work in both the public and the private sector. In the private sector, patients tend to shop for the best doctor. They compare between plastic, ENT and OMFS surgeons. They investigate the surgeon's background, quality and personality, they ask questions about risks, results and complications. On the other hand, patients of the public health sector have no choice but to accept what the public hospital is offering. Although public health sector patients do not ask many questions, they do expect treatment to be equal in outcomes to that of the private practice sector.

The OMFS standards of care, whether in the private or public sector, are well defined and require that all patients be treated and cared for according to these standards. Unfortunately, the care many patients are receiving in some tertiary care hospitals do not comply with the acceptable standards of care of the OMFS specialty.

“The OMFS standards of care, whether in the private or public sector, are well defined and require that all patients be treated and cared for according to these standards.”

4- What about the differences that you have personally experienced, between the US and Saudi Arabia, in terms the standards of patient care, research, and teaching.

This is a very important question as it relates to my answer concerning the specialty status. In Boston, a large segment of my time was spent working with the oncology team, which included an oncologist, radiologist, radiation therapy specialist, pathologist, an ENT surgeon, a maxillofacial prosthodontist, and even a speech therapist when needed.

This kind of team participation and care is scanty in our hospitals. This made me focus on the treatments that require the professional assistance of the orthodontist and other dental specialists to prepare the patients for orthognathic surgery. As to the teaching and research, in Boston I was involved and collaborated with oral cancer clinical care and research teams. Unfortunately the values of cooperation, behaving, sharing, commitment, responsibility and perseverance, which we discussed earlier are difficult to find in our hospitals and educational institutions which forces the individual to depend on his or her personal efforts.

5-As OMFS is considered a dental specialty, and your opinions have been so frank and revealing, I would like to hear your opinion regarding the status of dental education in Saudi Arabia.

The future will show that the early dental graduates of the universities of KSU, KAU and KFU were the best dental professionals in the history of Saudi dentistry. The knowledge and clinical skills of the majority of these universities early graduates were comparable to the highest American Dentistry Standards.

Many of these dentists are now in their fourth and fifth decades and have spent a long time and effort preparing to serve the country as dental administrators, teachers, researchers and clinicians.

I am very concerned about the status of dental education in Saudi Arabia today. It seems as if there is a steep decline in the quality of the academic and clinical skills of the recent graduates of the current Saudi dental schools.

Unfortunately, I do not see my pioneer colleagues actively involved in the discussions and planning of the future of dentistry in Saudi Arabia. It seems that there was a sense of urgency when new dental schools were opened within a period of two to three consecutive years. It is estimated that the current 34 Saudi dental colleges will be graduating 1,200 dentists every year. I believe that the quality of dental education being given in many of the 27 public and 7 private dental schools do not meet the standards of the Commission on Dental Accreditation of the American Dental Association, which I feel is the best in the world.

The published and Internet portfolios of these schools' curricula are often copy-paste documents of American dental education standards which is highly misleading. The realities of teaching and learning do not meet the minimum standards of acceptable dental education because there is a serious lack of the most important elements: professors of dental specialties, associate and assistant professors, competent instructors, clinical demonstrators, certified dental hygienists, certified expanded duties dental assistants and para dental support of dental technicians and administrators, just to name a few.

If the purpose of opening these new colleges is to accommodate high school graduates, then the country should expect and be prepared for huge numbers of unemployed Saudi and non-Saudi dentists in the near future.

6- Therefore, you are not against the establishment of these dental colleges, rather you are complaining about the quality of the education in these colleges and specifically their student admissions standards?

Very true, dentistry is a health profession, which goal is to provide the most optimal oral and dental health care to the society through the different dental specialties. I am very concerned that this goal is not clear in the minds the decision makers or the minds of today's dental graduates.

Let me explain what I mean. Back in 1996, after two years of hard work in preparation, documentation of clinical cases and recommendation letters to support my application for OMFS American Board certification, I was told by the examiners that the privileges to practice on the people of the state of Massachusetts and other states, are granted only if I have two personal traits: I was fit to practice safely on patients and I was fit to belong to the specialty's community.

One of the most important lessons I learned in my early practice years was to recognize the normal and abnormal, such as precancerous oral lesions. As a

“ It is estimated that the current 34 Saudi dental colleges will be graduating 1,200 general dentists every year. ”

surgeon, I have seen many patients who lost their lives or became handicapped because some dentist did not detect the abnormality, misjudged or ignored the abnormality, or refused to refer him to a specialist. This is the moral safety I am talking about. It is the national health security and the dental profession reputation is what I'm talking about.

I consider it an immoral and unethical treatment, when a dentist extract treatable teeth in order to place dental implants, or crown all the patient's teeth in order to cosmetically resolve the problem of esthetic skeletal and dental-facial malocclusion. We have seen many patients whose teeth and jaws bones were destroyed because of the pathologic, functional, and esthetic complications caused by such substandard and unethical treatments.

> "I have seen many patients who lost their lives or became handicapped because some dentist did not detect the abnormality, misjudged or ignored the abnormality, or refused to refer him to a specialist."

7- Let us now focus on the clinical aspects of oral and maxillofacial specialty. Could please give examples and statistics of the procedures you do?

I would estimate that my practice includes the following averages:

- 65%-70%: correction of orthognathic deformities, mainly orthognathic surgery
- 15%-20%: filler, Botox and facial tightening
- 10%: dentoalveolar and implant with/without bone grafting
- 5% face lift and rhinoplasty
- 3% TMJ non-invasive procedures

8-Since 65%-70% of the treatments you do are the correction of orthognathic deformities through Orthognathic surgery, I would like to focus on that aspect of your expertise by asking: What is an orthognathic deformity?

You will find in the literature and dental textbooks that orthognathic surgery is indicated to correct dental malocclusion. This is incorrect.

Malocclusion is a dental term used to describe misalignment of the dentition at the bony base. Because the jaws are part of the face, it is safe to conclude that the majority of facial deformities are bony and caused by congenital or growth problems. Examples of such dento- facial esthetic deformities are:

- facial asymmetry
- gummy smile
- protrusion of upper or lower jaw
- open bite

Patients with such problems often have difficulties in pronouncing certain words. They usually have complaints like :

"I don't like my profile,"

"my lower jaw continuously moves backward"

and "I have a long face."

Personally, I consider malocclusion a skeletal anatomic dysfunction. To say that orthognathic surgery is performed to correct malocclusion is inappropriate because occlusion denotes only the functional aspect of the surgery and disregards anatomic facial structures that give people their looks.

The surgery's purpose is to correct facial deformity by repositioning parts of the jaws back to normalcy. In addition to this aesthetic purpose, corrective orthognathic surgery restores oral physiological functions of mastication, breathing and pronunciation.

9- What are the most common orthognathic deformities in Saudi Arabia that require surgery?

The orthodontic studies conducted at King Saud Univesity to develop orthodontic norms for the Saudi population indicate that the population's most common facial functional and esthetic deformaties, as shown in Fig. 2, and caused by problems such as:

- Class III malocclusion – mandibular prognathic
- Bimaxillary protrusion (especially the upper jaw)
- Gummy smile
- Open bite
- Facial asymmetry
- Retruded mandible
- Sleep apnea
- Post-trauma facial asymmetry

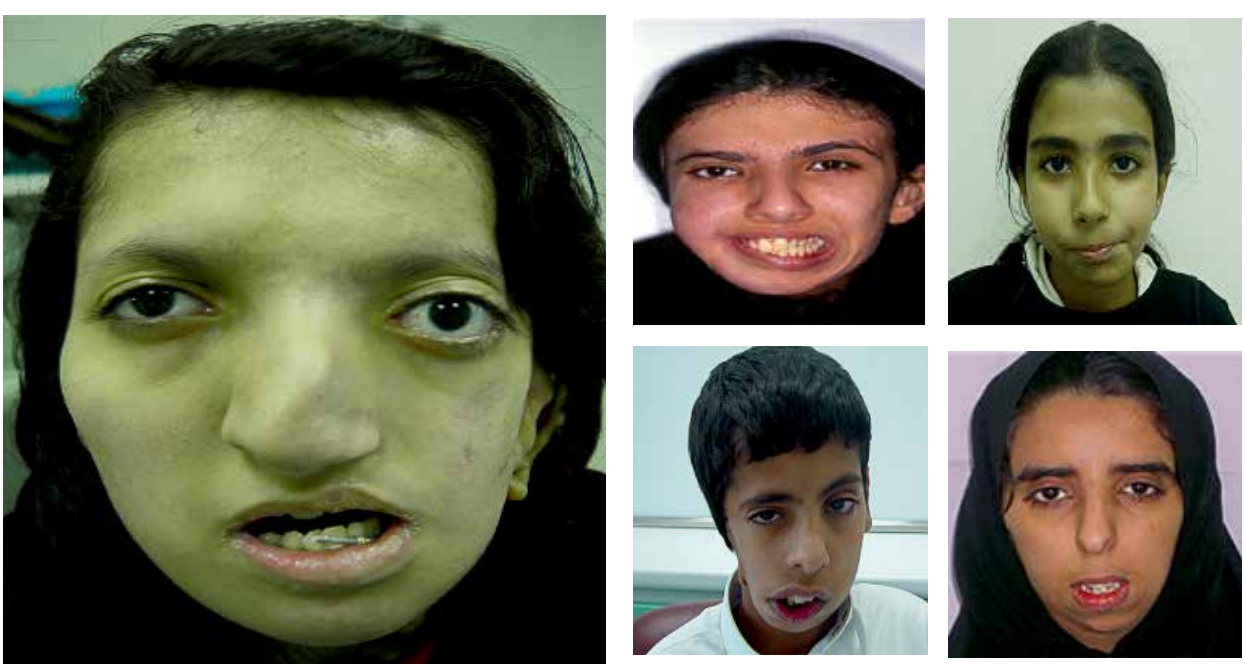


FIG. 2 : YOUNG PATIENTS WITH FACIAL ASYMMETRY PROBLEMS: It is recommended that such problems be treated early in life (before the complete maturation of facial structures) to give the patients harmony and facial symmetry before entering school age, where the social, mental and psychological effects of the school environment are harsh and unforgiving.

10- Is surgery the only approach to treat orthognathic deformities? What about preventive measures or early age corrective interventions?

We can modify the growth patterns during early age to correct deformities. For example, a mild case of hemi facial microsomia (type I – II) can be approached early around 5–7 years of age and can be corrected (80% of the time). Such maneuvers are being introduced through the development of the small distractors that enable intervention early in life.

Mild dentoalveolar skeletal deformities, such as wide open bite due to thumb sucking or tongue thrusting, can be corrected with orthodontics. As early intervention produces good, but not excellent results, patients in their early teens have better and stable results with corrective surgery.

11- Who are the patients of orthognathic surgery, and what are the steps and the procedures involved?

The majority of my patients are females from the age of early teens to the forties. I suggest that the corrective surgery be performed before school age in order to eliminate or reduce the psychological effects of facial deformity at this age. Furthermore, I believe that the recent advances in Osteodistraction techniques have made early surgical interventions more beneficial and predictable treatment for the correction of the facial deformities at early age. There is no need to wait for skeletal maturation.

Another significant advantage of the early surgery intervention is the benefit gained from expanding the soft tissue of the face along with the hard tissue, thus minimizing the possible problem of relapse and soft tissue defect. (Fig. 1)

12- Could you please describe the clinical and preparatory details of the Orthognathic surgery.

The main objective of orthognathic surgery is to give the patient the most optimal facial esthetics and symmetry, and to restore normal physiologic functions. Fig. 3 (E, F, G and H) To accomplish this, the patient must go through extensive clinical and radiographic examinations and assessments of his/her facial, oral and dental profiles to determine the types and amounts of technical

“I suggest that the corrective surgery be performed before school age in order to eliminate or reduce the psychological effects of facial deformity at this age”

corrections needed. Fig. 3 (A, B and C) Orthognathic treatment begins with lengthy orthodontic treatment to normally align and correct the position of the teeth in the dental arches. Fig. 3 (D) Orthodontic treatment should precede the surgery. Although there are cases that can be treated without orthodontics, the results are not as predictable. On average, about 6–12 months are required for the orthodontic treatment.

It is also very important to mention here that many of my patients are young men in their third decade who tried to have their facial deformity problems corrected through dental treatments, such as orthodontics, cosmetic restorations or prosthodontic treatments, but that ended with disastrous Periodontic and endodontic complications. These problems must be addressed through strict comprehensive assessments to assure that the periodontium and Endodontium tissues of all teeth are free from pathologies or substandard dental treatments before the orthodontic or surgical intervention.

All orthognathic surgical procedures are performed through intra-oral surgical access, whereby through osteotomies, the maxilla or the mandible jaw bones are

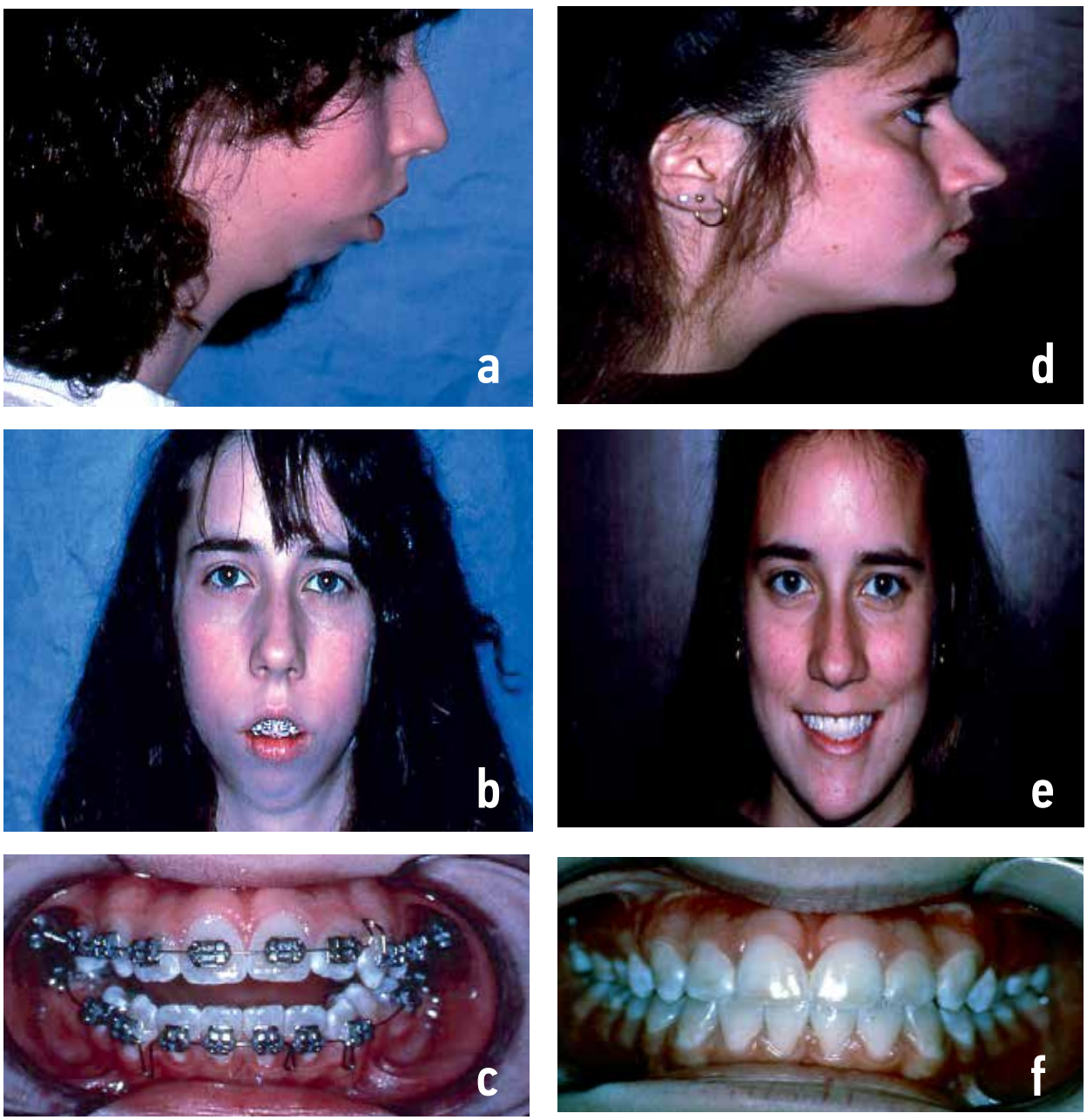


FIG. 3 (A, B and C) : loss of mandibular projection, severe mandible rotation and facial harmony secondary to condyle resorption and collapsed airway. (C) : Orthodontic treatment phase, please observe the patients open bite, loss of posterior vertical height (mouth breathers).
(D,E and F) : post-operative views of regaining of facial harmony by counterclock rotation of facial structures with mandibular projection . Post-operative intraoral showing class I canine guided occlusion with correct occlusal plane and restoring normal airway. (courtesy of Prof. Wolford)

repositioned in harmony with the already anatomically functioning and esthetically aligned teeth.

Because of advances in osteotomy techniques and mat erials, it is no longer necessary to wire the upper and lower teeth together after the surgery, as done in the past.

13- What are the steps that a patient has to go through in orthognathic surgery?

There are five pre-operative steps and five post-operative steps.

PRE-OPERATIVE STEPS:

1. Primary consultation to collect the necessary medical history, and a physical evaluation for data and to answer questions

2. Orthodontics consultation

3. Patient education and orientation regarding achievable results

4. Patient-to-patient interview to give the patient a chance to interview another patient who has had the surgery

5. Pre-surgical interview

POST-OPERATIVE STEPS:

1. Immediate, post-operative surgery radiographs. At this step, the surgeon may uncover serious surgical problems which may need a second intervention (first week)

2. Intermediate/post-operative surgery swelling evaluation (3 weeks)

3. Orthodontic/reevaluation and initiation of final orthodontic treatment (6 weeks)

4. Late follow-up (8 weeks)

5. Finalization of treatment and removal of the orthodontic appliance (3–6 months)

14- What are the possible risks and complications?

In terms of the risks, the elective procedures are performed on healthy ASA I / II patients for whom risks are extremely low. On the other hand, for trauma and birth defect surgeries, risks and complications are higher and depend on the severity of the case's problem and patient age.

Improvements in techniques and materials have made the surgery much safer and simpler than in the past. I remember back in the 1980s, the patient was kept in the ICU intubated overnight for recovery from anesthesia. Patients also used to get blood transfusions as the routine. Today, the surgery requires on average 1.5-3 hours depending on case difficulty.

After recovery from anesthesia, patients are transferred to their hospital room and discharged from the hospital within 24–48 hours after the surgery.

In terms of complications, it is important to know that a less than 1% complication incidence rate is not worth mentioning, unless the complication is serious enough to change the patient's lifestyle, such as facial nerve injury. Of course there are the common complications of swelling, edema, and bruising, temporary asymmetry of the face, temporary numbness, drooling and the rare complications of bleeding, infection and loss of teeth or bone segment.

Finally, during the first post-operative visit, examination and radiographs may uncover some surgical problems causing the patient concerns or dissatisfaction. This will be managed by a second surgery at no cost to the patient. Minor problems will be radiographically and clinically observed until resolution.

15- If the results of the surgery are not acceptable to the patient, what do you do?

Fortunately, dissatisfaction with the surgery results is extremely rare in my experience. If the patients are well informed and psychologically prepared before the surgery, the majority will wait for all swelling to subside before making judgments, which may require three months.

The initial results of maxillofacial corrective surgery will not show until all the swellings and edema have subsided, which may require 6–12 weeks.

The final results of healing of the operated jaw bones, face bones and oral soft tissue may require 6–12 months to stabilize. This biologic guideline makes me believe that patients who judge and complain about the surgery results in the first or second week after the surgery must have either a hidden agenda or unrealistic expectations or both, and these are impossible patients to treat.

16- What do you mean by hidden agenda and how do you define and recognize patients with unrealistic expectations?

It is important to mention that most of the dissatisfaction with the treatment results comes from patients who have had negative past experiences or unsatisfactory results from previous treatments.

Patients with hidden agendas are patients who are under the misconception that the results of the orthognathic surgery will fix more than their jaws and holding teeth problems. As to the patients with unrealistic expectations, they are easy to recognize as they come to the practice a picture of an actor or actress, expecting surgery will make them look the same.

Others may be very demanding to have the treatment completed in the shortest time. If the surgical results were not up to their expectations, instead of blaming themselves, they will blame the surgeon. This is most detrimental in a close-knit society like ours.

Unfortunately, friends and relatives do not hesitate to criticize others in the total absence of facts or background. They make a mountain out of mole hill.

This will make the already difficult patient more difficult to deal with. Such patients should be avoided, or the surgeon should lengthen the time between the assessment interview and the operation in order to carefully document every detail.

> “I REMEMBER BACK IN THE 1980S, THE PATIENT WAS KEPT IN THE ICU INTUBATED OVERNIGHT FOR RECOVERY FROM ANESTHESIA. PATIENTS ALSO USED TO GET BLOOD TRANSFUSIONS AS THE ROUTINE.”

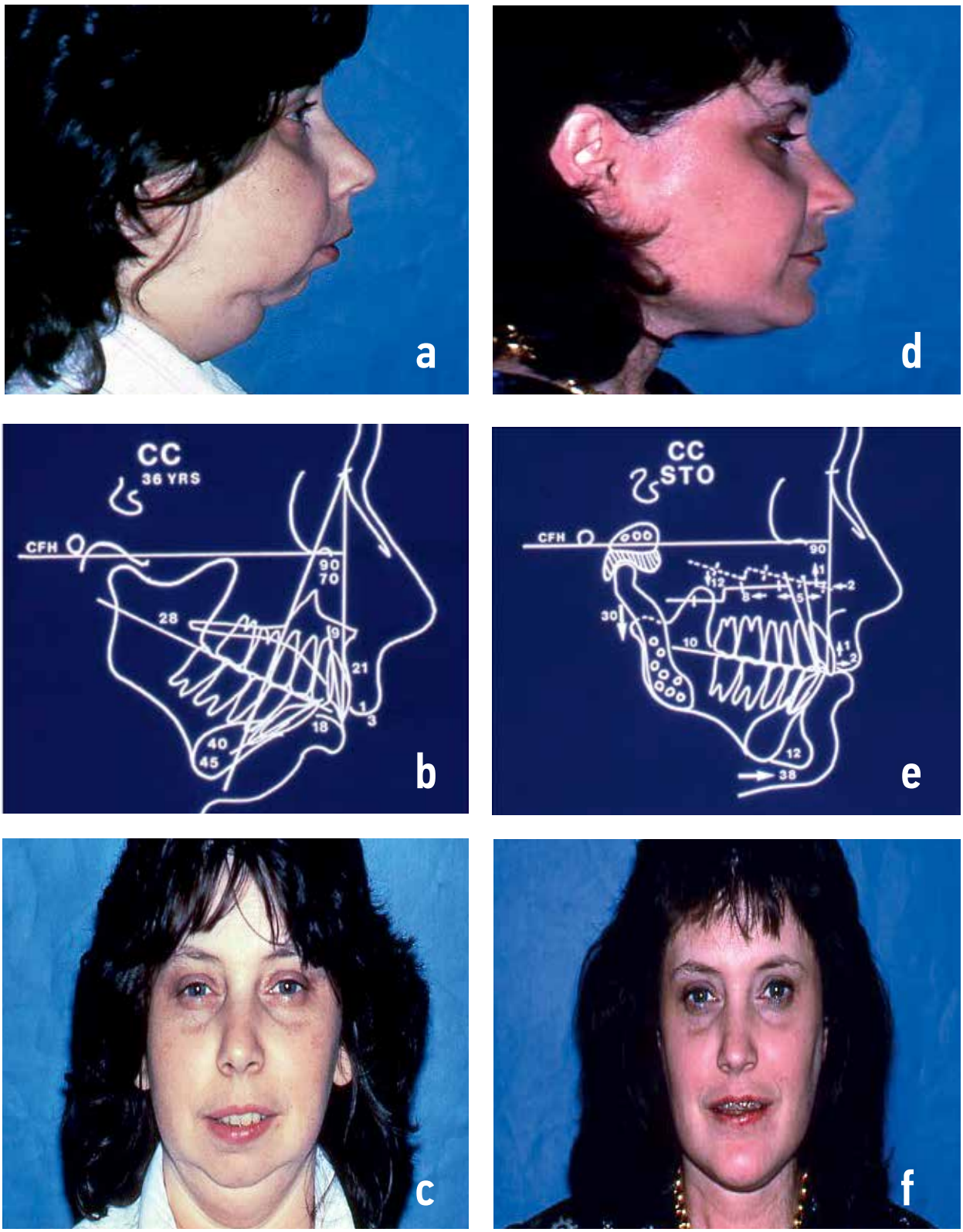


FIG. 4 (A, B and C) : loss of facial projection and backward rotation of the facial structures secondary to condyle resorption and collapsing of the airway space causing sleep apnea. Fig. 4 (D, E and F) : post-operative views showing the regaining of facial projection, forward rotation of facial structures and opening of the airways. (courtesy of Prof. Wolford)

WHAT I LEARNED FROM FIRING MY FIRST EMPLOYEE

STACEY L. SIMMONS, DDS

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In a nutshell, this is how a business should be run. Easier said than done, but let's admit, once we took that plunge into the real world after dental school, we were forced to learn as we went along. Sometimes the mistakes we made taught us our best and most valuable lessons.

I admit I have made mistakes in several areas of what I thought was competent staff management. "Jane" was hired on to work as a front desk employee, and she had been with me for three years. She was pleasant with patients (from what I observed), seemed to be productive, and appeared to get along with the other staff members. All seemed well, and I was happy that my office ran so smoothly.

There was my first mistake. I assumed all was well, and I let my contentment fog the view. What I didn't know was that slowly, over time, extreme tension built up among the individuals working up front, which overflowed to the back of the office. I did some discrete surveillance and realized that what I did not hire Jane to do was ignore coworkers or talk abruptly to them, be insensitive to patients' needs, and essentially collect on the accounts only when she felt like it. It was ugly.

I had a discussion with my office manager and brought Jane into my office. I told her what my concerns and expectations were, and said she had three months to make it right or she would be let go. I typed all this up on fancy letterhead, had her read over it, and then asked her to sign it. Her review date was given, and the stage was set.

BIG MISTAKE. Why in the world did I give her three months to change? To be honest, I did not want to fire her because that meant I would have to find another front desk worker, one of the most difficult positions to fill! That meant putting out an advertisement, interviewing someone, training that person, and then hoping it all would work out. Since I did not spend much time up front, I was content, to some degree, with the status quo (even though I knew what was going on!). I was actually putting the inconvenience of hiring a new person before the needs of my other team members and the health of my practice. My argument and justification for such stemmed from the simple question: Why can't they all just get along?

Furthermore - and I hate to admit it - I did not want to hurt Jane's feelings by firing her. She needed a paycheck and outside of dentistry, the relationship was satisfactory. Mistake No. 3! I let my emotions dictate a pure business decision that ultimately gave way to

"A MAN MUST BE BIG ENOUGH TO ADMIT HIS MISTAKES, SMART ENOUGH TO PROFIT FROM THEM, AND STRONG ENOUGH TO CORRECT THEM."

– JOHN C. MAXWELL

> **“THERE WAS EVIDENCE OF LESS-THAN-IDEAL WORK PERFORMANCE, AND ANY ATTEMPTED CHANGE WITH COWORKERS WAS SUPERFICIAL.”**

three months of torment and continued false fronts, desperation, and staff members looking at me with questions in their eyes inquiring, “Why are you making us go through this?!”

It was clear that after two weeks, it was not going to work out. There was evidence of less-than-ideal work performance, and any attempted change with coworkers was superficial. My fourth mistake was that I did not realize that the crux of the problem was with Jane’s personality and inability to cohesively interact with the other staff members. I acknowledge that when all this started, I was ignorant to the fact that when I was around, she put up a front for her benefit and my scrutiny.

By this time, I become conscious of the painful fact that I had backed myself into a corner with only myself to blame. My three-month “improvement” contract letter came back to haunt me. I wanted to let Jane go immediately. However, after inquiry into the state law, I was bound. If I prematurely let her go and broke the contract, I could face legal issues and a very angry individual who would no doubt wave that paper in front of my face. This was a headache I wanted to avoid. So I did the only thing I could do - wait it out.

I made another mistake in this process - yes, another one! During the course of time while this employee was under my hire, I did not document all conversations, meetings, and observations. In the eyes of the law, if it is not documented, it did not happen!

When all was said and done, I fired Jane. I gave my reasons, cited examples, and was firm in my belief that the correct decision had been made. I did not go away from that meeting rejoicing, but in all honesty, I felt I had taken a big step in the world of being a business owner, having shouldered the responsibility of my decisions.

The first day in the office after Jane’s dismissal, it felt as if a cloud had cleared the entire building. Up until that point, I had not realized what a negative impact her presence had had and how it affected the entire aura of the office.

In a nutshell, here’s where I went wrong:

1. **I assumed all was well.**
2. **I gave Jane time to change.**
3. **I let emotions dictate business decisions.**
4. **I did not realize the true problem at hand.**
5. **I did not document.**

I would not be human if I looked at that list and didn’t question my ability to be a boss and business owner. Nonetheless, I will submit that the acknowledgement of failure on my part has resulted in my ability to reevaluate my position and give me determination to strengthen my resolve to adjust to a better execution of said expectations.

With that being said, correcting my multiple faux pas has been an ongoing process; some things have been easier than others. For example, it is simple to bring a staff member into my office, have a conversation about a concern or recommendation, and then not document it with the team member’s signature. In my mind, I think the maturity level and competence of those who work for me would/should not require me to do that. I admit I have lacked in that area, but I have improved!

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One of the best things that has come of this is that the trust I put in my staff is now reciprocated. If my team has any apprehensions, they are comfortable enough to come to me and discuss their concerns. I have found that I am able to consider their varying points of view, despite how they may intimidate my comfort. I appreciate that, and I am sincere when I tell them.

How can we profit from our mistakes, especially when firing someone? I like cars, so let's use a car analogy. A car has multiple parts that work together collectively. Each component has an important role that directly or indirectly affects the overall performance. If one of those parts is not working properly, the effect can either be subtle or drastic.

The same can occur in the dental office. Each employee has his or her responsibility. Collectively, everyone works together for the benefit of the patient and the health of the practice. We expect and assume there are things that are beyond our control (illness, family commitments, etc.) - those we manage without too much difficulty. However, when one individual is not doing his or her part or causing contention, then the whole operation, and subsequently the financial health of the practice, is affected. How? Staff communication and interaction affects, albeit subtly, patient motivation and comfort level. If patients are not at ease, they won't or will be less inclined to schedule another appointment or be willing to come back to your office. Patients read body language!

In addition, we can all agree that motivation in any area of life is what drives us daily. If coming to work dampens or hinders that motivation, then we might find ourselves asking why work hard when our efforts are not appreciated? When dissatisfaction occurs, we may also be more prone to make communication errors with insurance, scheduling, phone calls, and patient care. Quality and quantity levels factor into work performance and, in turn, affect production.

I noticed that once I got my team back on track, our entire office ran much more smoothly. The corner tête-à-têtes ceased, production and collection increased, and the overall atmosphere improved tremendously. It is true that bringing a diversified collage of personalities together and hoping that the collective skills and dynamics present among everyone will somehow mesh together so we can all be one big, happy family is arduous! But we must have the courage to perfect what is not and make adjustments in light of less-than-ideal circumstances.

Firing an employee is not a decision to be taken lightly. Several factors equate into such a verdict, but let's be realistic - it happens, and it will happen with all of us at one point or another. Resistance to change the status quo is difficult; we are all human! Yet, as small-business owners, tough decisions have to be made ... and tag, you're it!

Don't make the same mistakes I did. If you are going to let someone go, then do it and do it quickly with no strings attached. You will be better off, your staff will appreciate your leadership, and your practice will benefit in more ways than you realize.

“PATIENTS WHO COMPLETE THEIR TREATMENT COMFORTABLY AND ON TIME WILL BE MORE SATISFIED WITH THEIR TREATMENT, AND WILL BE MORE LIKELY TO REFER FRIENDS AND FAMILY”

INCREASE YOUR PRODUCTION IN 15 MINUTES OR LESS

JIM PHILHOWER

What is the number one thing you can do to increase production, efficiency, and communication in the dental office? Have an effective morning huddle! A morning huddle sets the tone and pace for the day and provides an opportunity to uncover potential production that otherwise might have been missed. Unfortunately, less than 10% of dental offices have a good morning huddle - a powerful tool that takes very little time and costs almost nothing.

Once you establish an agenda and routine, the morning huddle should take no more than 15 minutes. To keep everyone focused and involved, team members should take turns running the huddle. Before turning the meeting over to the day's leader, the doctor should begin the huddle with a positive comment about the team member›s performance or personal achievement. The huddle is not a time for complaints, policy and procedure discussions, or debates. Save those topics, as well as any constructive criticism, for the weekly or biweekly team meetings. Limit your morning huddle agenda to information pertaining to yesterday, today, and tomorrow.

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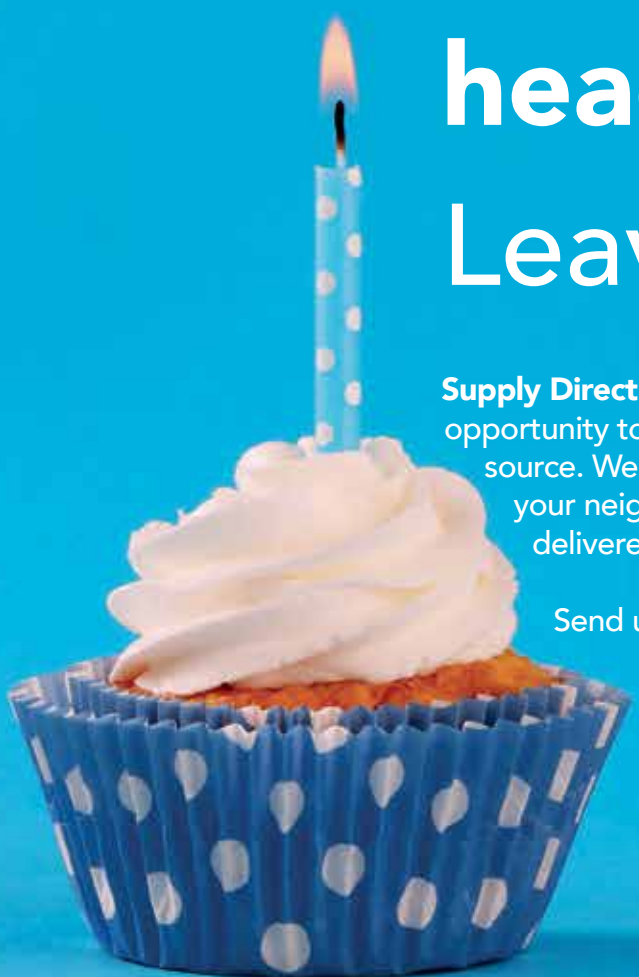

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YESTERDAY

Every huddle should begin with the question, "Did we meet our production goal yesterday?" Next, the team should discuss the highlights from the previous day, covering what went right, as well as what went wrong.The discussion of what went right and what went wrong should be brief; add any items that need further discussion to the agenda for the next team meeting. Review yesterday›s case acceptance rate as a team, and set a goal to increase that rate today. **Did the team meet the collection goal yesterday? If not, why?** End the discussion of yesterday with a review of the follow-up phone calls made to patients, noting any updates of which the rest of the team should be aware.

TODAY

Start the discussion of the current day›s schedule with the question, "Are we scheduled to meet our production goal?" If not, the team should discuss opportunities to add production to the schedule with same-day treatments. If any patients are scheduled who have been under watch for restorative work, for example, the team should review openings in the doctor›s schedule to determine whether those patients might be able to stay longer or come back later in the day for the doctor to begin the restorative work. Identify patients who are candidates for scaling and root planing (SRP) treatment, if home care has not improved their periodontal health. Just four additional quadrants of SRP per week could add $50,000 to your annual production.

The next topic for today›s huddle should be radiography and hygiene. Are all scheduled patients up-to-date with the doctor›s standard of care in these areas? One missed pan or FMX per day can equate to $25,000 in annual lost revenue for the average practice. When reviewing patients› hygiene history, check their family hygiene history, as well.

Spend time discussing the new patients on the schedule today. Who are they? Who referred them? What does the team know about them, including where they work or live? Ideally, you should be able to find at least three unique «touches» to create a special welcome to your practice. For example: "Ms. Smith, I see you are friends with the Jones family, and they referred you here. Bill and Mary are delightful! We will be sure to thank them. How long have you been friends?" A new patient with a positive experience is likely to tell others about the practice.

"WHO ARE THEY? WHO REFERRED THEM? WHAT DOES THE TEAM KNOW ABOUT THEM?"

The last topic for today›s huddle is referrals. Use the morning huddle to identify at least two patients to ask for referrals. The team member who has the most rapport with each patient should be responsible for requesting the referral from that patient. For example: "Jen, we talked about you in our meeting this morning, and we just love seeing you in the practice. If you have any friends or family members who are as nice as you are, we would enjoy welcoming them as patients, as well!"

TOMORROW

Finish your morning huddle with a discussion about what the team needs to do in order to prepare for the next day. **Is the office scheduled to meet the production goal? Are there openings in the schedule that need to be filled? Have the lab cases arrived yet? Have all of the patients who will be coming in confirmed their appointments? Do any of the patients on tomorrow›s schedule have special needs?** This part of the morning huddle is also the time to review any new patients on the schedule for tomorrow.

Running a successful morning huddle is one of the easiest and least expensive things a dental office can do to increase profitability and efficiency every day. Use these suggestions to create your own morning huddle agenda, and remember to start with yesterday.

8 COMMON MISTAKES MADE BY DENTAL PRACTICE OWNERS/MANAGERS

DESMOND CLANCY

I was initially going to direct this article at "new" business owners by capturing some of the mistakes they make and distilling them down to the most common mistakes. I shared what I wrote with a number of people whose input I value to gather their feedback, and as expected, their feedback was great.

However, a piece of advice from one of my peers stood out — "Remove the word 'new' from the headline." What a wonderful suggestion! The mistakes new managers make are identical to those that managers make later, even after years of experience.

I was also reminded that there are an infinite number of ways to "mess up" as a manager. But for the sake of simplicity and brevity, I compiled this list of 8 common mistakes made by small business owners and managers.

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#8 FAILING TO MAKE TOUGH DECISIONS

As the leader of your business, there are many people counting on you. There are some problems that only you, as the leader, can solve, and they simply will not get better until you address them; in fact, they will likely get worse. You owe it to your team to take action. Perhaps the deadliest of all leadership sins is inaction. Dealing with conflict, managing employee performance, and managing through tough economic times necessitate timely and decisive leadership.

Making a quick decision without knowing all the facts can make the problem worse, as can overanalyzing the problem and letting it drag out. One must find balance in making informed and timely decisions. Create a process to solve the problem, but don't let the process become the problem.

#7 LEADING THE GROUP

A common mistake managers make is assuming they can lead the group. Leading the group is certainly the outcome you're working toward, but to **build your leadership strategy based on economies of scale is a mistake.** Leadership is about creating one-on-one connections with every member of your tea. While leadership appears as group leadership, it is really about inspiring individuals. Inspired individuals tend to gather around the person who inspires them. If you can inspire every member of your team, you will find yourself leading the group. To connect with every member of your team, you need to understand what each person values in his or her employment relationship. I refer to this as motivation. Rewards, personal growth, security, and teamwork are just a few universal motivators. Each member of your team lives in a unique set of circumstances, both professionally and personally. The better you understand that uniqueness, the more likely you are to inspire that individual.

#6 HIRING TOO QUICKLY, FIRING TOO SLOWLY

As busy as you are, having the "right people on the bus" is important to your business. A common mistake managers make is acting too quickly regarding hiring decisions based on the need to fill a spot on their roster. If a manager fills a role too hastily at the expense of hiring for the appropriate cultural fit, it can lead to disastrous results. Having insufficient resources to manage your business is a challenge, and it is very easy to give in to the temptation to hire the first qualified candidate.

However, it is far more challenging to undo the mess that a bad hire can create. Take your time and hire the right person for your team. You and the rest of your team deserve to get the best person, not the first person. Another mistake managers make is taking too long to end someone's employment. Terminations are the most difficult part of the job, but also one of the most important. Managers are forced to make tough decisions and have difficult conversations with employees. If you have well-documented justification to terminate someone, you should act quickly. Failing to take swift action can have a significant and sometimes irreversible impact on the culture of your business.

#5 CREATING THE PERCEPTION OF FAVORITISM

As a manager, you will connect with some employees better than others. While this is perfectly natural, these connections can lead to friction with other members of the team, as they may create the perception of favoritism. As a manager you must learn to influence the perceptions of your team members. Being aware of how and how often you interact with members of your team is important in managing these perceptions. While you will not treat every member of your team the same, you must treat them all fairly. **Any perception of favoritism can be heightened during conflict,** and it is possible to appear as though you are choosing sides based on a personal relationship. Also as a manager, you should be "friendly" with members of your team, but being close friends with them can make things difficult. While socializing with your team is a good idea, seek balance in how much time you spend doing so. Once you become their friend, it makes it difficult to be their boss. You may find yourself making a difficult decision about an employee or having a difficult conversation with them, and if you're too friendly the employee may take it too personally, or may simply dismiss you, taking advantage of your relationship.

#4 FAILING TO SET GOALS AND EXPECTATIONS

It's simple — when people don't have an accurate understanding of their goals and expectations, they are less productive. Research tells us that approximately 80% of performance issues are due to poorly communicated expectations. If you have not clearly set goals and expectations with your team, they have no reason to meet them. Employees who do not have this clarity of purpose typically muddle through each day, acting cautiously and without conviction. They struggle to prioritize the "to do" list effectively, which often leads to work being completed in the wrong order or behind schedule. Every employee should know what they are supposed to do and in what order (goals). Equally, they need to know how to go about doing so (expectations). Lastly, they should know why they are doing it and what their contribution means to the business (vision). If you can clearly communicate to your team what they need to do, how they need to do it, and connect that to why their contribution is critical to the success of the business, you will find yourself surrounded by motivated, engaged, and committed people.

#3 NOT DELEGATING

One of the biggest challenges for leaders is **"letting go"** of tasks and responsibilities that could be more efficiently handled by members of the team. **As a business owner and/or manager, you are always managing scarce resources: time, money, and people.** One resource that many managers fail to manage properly is themselves. Every minute you spend on a task that could be delegated to a member of your team is a minute you are ignoring a critical task that cannot be delegated. Creating vision, setting goals, strategic planning, eliminating barriers to productivity, and communication are just a few of the tasks that may suffer if you do not delegate often or effectively. Most importantly, delegation frees you up to develop your team, which will ultimately alleviate some of the pressure on you. Give your team the autonomy and empowerment to get their jobs done, even if it means they'll make a few mistakes. Your job is to be there to help them learn from it. People want to know how they are doing. People want to be recognized for performing their job well. They also want corrective feedback, when appropriate, delivered with tact and professionalism. Feedback is the portal to self-awareness, and if you fail to acknowledge poor performance it will likely go uncorrected. After acknowledging underperformance, if you fail to recognize improvement and effort, you may extinguish team motivation. As a manager, you must be able to recognize and capitalize on the teachable moments in which well-executed feedback can shape behavior. The challenge is getting people to consider the impact their actions will have on their work and/or personal lives, whether positive or negative

#2 LACK OF FEEDBACK

It is imperative that you consistently provide feedback to your team. People want to know how they are doing. People want to be recognized for performing their job well. They also want corrective feedback, when appropriate, delivered with tact and professionalism. Feedback is the portal to self-awareness, and if you fail to acknowledge poor performance it will likely go uncorrected. After acknowledging underperformance, if you fail to recognize improvement and effort, you may extinguish team motivation.

As a manager, you must be able to recognize and capitalize on the teachable moments in which well-executed feedback can shape behavior. The challenge is getting people to consider the impact their actions will have on their work and/or personal lives, whether positive or negative.

#1 FAILING TO LISTEN TO YOUR TEAM

Effective managers listen to their team members. As a mentor of mine once said, **"Use everyone's brain, not just yours."** As a manager, it is imperative that you seek out and consider your team's feedback, always remembering that they are often closer to the problems and the opportunities than the manager. Great managers create a culture in which team members feel they are free to speak openly about any topic, even if they are the voice of dissension. Great managers encourage team members to express concern, share ideas, and even disagree. Consistently seeking out your team's feedback and unique perspectives can yield the missing piece of the puzzle that gives managers the clarity we need to make a sound decision on behalf of our business, our team, and our customers.

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DEFINING & MEASURING SUCCESS

ROGER P. LEVIN, DDS, MBA

Levin Group recommends that clients use Key Performance Indicators (KPIs) as tools to measure goal achievement. All practices have 12 to 15 KPIs that accurately reflect the practice's health. KPIs provide a statistical snapshot of practices during a set period and allow dentists to accurately track daily, weekly, and yearly production goals. Using this data, doctors can make adjustments to potential problem areas. Here are eight of the most critical areas that KPIs measure:

- PRODUCTION
- COLLECTIONS
- OVERHEAD
- NUMBER OF NEW PATIENTS
- AVERAGE PRODUCTION PER NEW PATIENT
- AVERAGE PRODUCTION PER PATIENT
- CASE ACCEPTANCE RATIO
- PROFITABILITY

PRODUCTION

Increasing production is critical to the practice's long-term financial health, but high production does not necessarily result in high profitability. Examining KPIs will reveal potential opportunities to increase production. For example, if the majority of practice production is single-tooth treatment, the doctor should emphasize the benefits of comprehensive dentistry through a variety of internal marketing and case presentation strategies. In addition, unmanaged production can create numerous problems that have a negative effect on profitability, including scheduling overruns, stress, and poor patient care.

COLLECTIONS

Many practices feel uncomfortable requesting payment at the time of service. Dentists have to instill a payment mentality in patients. Signs, brochures, and employee scripting are all part of an efficient collections system. Levin Group recommends practices collect more than 90 percent of payments at the time of service and 8.5 percent within the next 30 days. All other monies due should be collected within 60 days. Practices need to get paid for the work they perform. It's a simple concept but one that some practices have trouble implementing successfully.

When you schedule a patient for treatment, you block out a set amount of time, be it 20, 40, or 80 minutes, for that patient. At the time of service, the practice incurs all the labor and overhead costs associated with treatment. When the fee goes uncollected, you lose the revenue for that procedure, the costs of providing the service, plus the revenue you could have made by delivering dental services to a paying patient. In essence, the loss of revenue from dentistry that goes uncollected is far more detrimental to the practice than simply the amount of the lost fee. When a patient does not pay all or part of a fee for dentistry performed, there are collection efforts required, which limits practice profitability.

OVERHEAD

Overhead is a necessary part of running a practice, but eliminating unnecessary expenses can ensure the financial health of the practice. Many dentists and their teams fail to look at overhead as an opportunity to reduce costs and improve financial performance. As the practice owner, the dentist should know how much it costs to turn on the lights every day. Does the current budget accurately reflect practice expenses? Does the production schedule take into account the operational costs of the practice? Without an accurate financial picture, the doctor could be incorrectly setting fees. If a practice underprices its services, the dentist will be working harder for diminishing returns. If the fees are overpriced, the practice will end up driving away existing patients and turning away new patients.

NUMBER OF NEW PATIENTS

Practices need new patients to achieve growth. Dentists lose a certain amount of patients each year due to relocation. On the other hand, people are also moving into your area. How do you track patient turnover? Does the practice have a system in place to boost the percentage of new patients? When new patients come in for treatment, does the staff ask them how they were referred to the practice? What is your practice doing to actively increase its patient base?

A strong patient referral program can boost the number of new patients. For frequent referrers, small gifts and reduced fees for select services are excellent ways to say thank you and encourage continued referrals.

AVERAGE PRODUCTION PER NEW PATIENT

When a new patient becomes part of the practice, a new patient profile needs to be completed. This information, along with a medical and dental history, will be helpful in creating a long-term treatment plan. Your team should introduce patients to the full array of products and services the practice offers. Comprehensive care — not single-tooth treatment — should be your goal for new patients.

AVERAGE PRODUCTION PER PATIENT

Long-time patients present unique opportunities for boosting production. If the practice has added new services such as cosmetic dentistry, do team members promote these procedures to all patients? Even a small increase in production per patient can lead to a big increase in profitability.

Educating patients about all of your products and services is the first step in boosting production per patient. A hectic pace does not always indicate a productive practice. A dentist who sees a full schedule

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of patients from open to close may feel successful because it seems the practice cannot handle any more patients. But if the practice does not track average production per patient, it is difficult for the dentist to determine whether the practice is as profitable as it could be.

An effective practice maximizes opportunities by presenting comprehensive dentistry. A practice that sees 30 patients per day and averages only $125 of production per patient ($3,750) is not nearly as profitable as a practice that sees 20 patients a day, but averages $325 of production per patient ($6,500).

Consider for a moment that a daily difference such as this ($2,750) can mean an additional $550,000 per year for a practice operating four days a week. The dramatic difference in revenue and profit occurs because the "slower" practice has the time to present, sell, and deliver more comprehensive dental care.

CASE ACCEPTANCE RATIO

Often the biggest hurdle to case acceptance is cost. If patients perceive the procedure is out of their price range, then they will reject treatment. By building value for treatment and presenting a variety of financial options, practices can change patient perceptions of affordability. To maximize case acceptance opportunities, practices should present patients with these financial options:

- **Offer a 5 percent courtesy to patients who pay in full before the first appointment begins.**
- **Accept credit cards. Very few patients have the ability to pay out-of-pocket for significant dental procedures, but credit cards allow them to pay in full up front.**
- **Require half up front and half before the treatment is completed.**
- **Offer outside financing. A patient financing company that offers no-interest and flexible payment options makes treatment affordable for patients.**

The more financial options practices give patients, the greater the opportunity to increase case acceptance, especially for cosmetic and elective services. In today"s image-conscious society, many patients are interested in improving their appearance.

The right financial options, combined with other case presentation strategies, can help make a more beautiful smile and an enhanced appearance a reality for more patients.

PROFITABILITY

All measured goals should be geared toward boosting profitability. The more new patients the practice gains, the more profitable the practice should become. The more the average production per patient increases, the more profitability the practice should achieve. Of course, every KPI comes with its own challenges.

Boosting production will not increase profitability if the service mix does not contain enough high-profit services. Also, if the dentist attempts to increase production without having proper staffing in place, the practice could drive patients away and increase staff turnover due to poor planning.

A systemized approach works best to achieve practice growth and the doctor's vision, especially when systems are regularly monitored using KPIs.

To assess your performance and progress toward goals, it is critical to track each KPI on a monthly, weekly, and even daily basis. Possessing this kind of information will allow you to take immediate corrective steps if your actual performance falls short of your goals.

By evaluating your KPIs, you can also readjust your goals over time to reach your vision.

CONCLUSION

Your career is a journey, with success being your ultimate destination. Your vision and goals act as a map on the road to success.

KPIs are tools that can help you measure your progress. You will face challenges and obstacles along the way, but you have the power to make your dream practice a reality. Follow your vision, and it will lead you to ultimate success.

SELL THAT SMILE!

JANET HAGERMAN RDH, BS

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" I told my dentist my teeth are going yellow. He told me to wear a brown tie."

-Rodney Dangerfield

Have you ever failed to recognize a patient's emotional or social need, or turned a deaf ear to their seemingly trivial cosmetic concern? In an effort to focus on being clinically correct, do you sometimes overlook your patients' emotional and esthetic concerns as superficial (think of the 60-year-old patient)?

It's no secret that a person's smile is typically the first thing that gets noticed. Those of us in the dental industry are keenly aware of this, and studies show that this is true even of people outside the dental field. A great smile can light up a face. Conversely, a smile of crooked or discolored teeth can be so distracting as to take attention away from any message or communication that person is trying to convey. So why doesn't everybody have a great smile?

Madison Avenue "knows" that everybody wants and deserves a great-looking smile. Over-the-counter whitening products abound. And why shouldn't they? They are filling a marketing need and would not be on the shelves if they were not selling. If we, in the dental industry, can take off our "clinician's hat" for one moment, we can learn from Madison Avenue marketing.

Whitening has been called the window to cosmetic dentistry. Once your patients begin to care about their smiles, they typically become more open to many other dental services you offer. But you must lay the groundwork carefully. By carefully, I mean not just thoughtfully, but with the utmost care in mind for your patients.

Selling dentistry has gotten a bad rap. Is SELL really a four-letter word? Too often it is associated with negative connotations and an assumed lack of clinical care. But nothing could be further from the truth. The truth is, As a clinician, you and your team MUST learn to sell your services and products or you will not be successful

Here's why. If you don't, someone else will! Not only are our patients being educated — and sold — by mainstream advertising and the Internet, they are being informed by friends, family, and other dental offices.

"MADISON AVENUE KNOWS THAT EVERYBODY WANTS AND DESERVES A GREAT-LOOKING SMILE."

TWO CASES IN POINT

1 I was working as a temp for my friend, who happens to be a wonderful dentist. One patient had recently gotten beautiful veneers, which surprised me because I couldn't find any reference to this in her chart. She informed me that she'd had the procedure done in Florida. Her sister had gotten cosmetic work done by her dentist and was proudly displaying her beautiful new smile. My patient, mistakenly assuming that Dr. Wonderful didn't do these procedures (because no one had ever told her!), had her smile redesigned by her sister's dentist. My patient had never been told about the cosmetic procedures that were available to her from her own dentist, so she went elsewhere.

2 Another great dentist-friend of mine told me that he used to not offer implant options to patients who were just too old to make that kind of investment. (This example could easily apply to whitening cases.) How old is too old? Dr. Great almost lost a patient due to this implant philosophy. Dr. Great was reluctant to place implants on a 91-year-old patient until the patient insisted, saying if Dr. Great didn't do it, he'd find someone else who would. The case was successful! I learned this story while discussing implant options for my own 86-year-old mother, who, by the way, also got her teeth whitened!

Both of these cases involve selling, or the lack of selling, dentistry, and these cases could easily have involved whitening. Are you losing whitening opportunities to the local mall kiosk or another dentist?

Some call this selling. I call it giving your patients enough information to make a well-informed decision. Then let the patients make their decisions, not you! The challenge is to sell whitening, or any dentistry, in an elegant manner that creates value for your patients, without feeling like you are selling. None of us likes to "be sold," but we all like to buy! Great selling feels effortless and helpful.

HERE ARE SOME STRATEGIES FOR SUCCESS

BELIEVE in your product. Don't buy cheap products to entice new patients with free whitening, thinking you will up-sell them on more services and your office. You will lose credibility and the patient. Use quality products that work!

PERSONALLY try all you sell. Every member of your team should have sparkling white teeth with the product you sell/recommend

USE your new-patient form. The form should have a question that asks, "Would you like whiter teeth?" Upon patient review, ask your patients about this. Have they tried whitening before? Was it an over-the-counter product? Were they satisfied with the results? What results do they want? Use this question on your new-patient form to explore patient concerns, questions, and answers.

A SEPERATE smile assessment form can be a great tool to gauge how your patients value their present smile situation. You can create your own or, better yet, find an existing template to suit your practice.

DISCOVER your patients' values and hot buttons. Once again, use the new-patient form or smile assessment form, which should give you a plethora of information to discover what is important to each particular patient. You can then use this to relate to their dental and cosmetic concerns.

PREPARE the foundation for quicker case acceptance with the treatment triad. During the exam process,

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“AS A CLINICIAN, YOU AND YOUR TEAM MUST LEARN TO SELL YOUR SERVICES”

particularly the initial exam, prioritize treatment into these three categories: urgent, preventive, and cosmetic. As you examine a patient's mouth, dictate your findings aloud to your assistant to document with the following preface: “Mrs. Jones, as I examine your mouth today, I will look for three things: urgent treatment that must be completed ASAP to keep you out of pain, preventive treatment that should be done but could be completed over time to meet your budget, and cosmetic treatment that is not necessary but fun to consider.” This way your patients feel enlightened and educated, rather than overwhelmed, as they are introduced to cosmetic dentistry (whitening) along with needed restorative dentistry. I've had dental teams tell me that this simple treatment triad presentation method has doubled and tripled their treatment enrollment!

JUMP-START your whitening sales skills with the shade guide exam. This is done on the initial evaluation and every subsequent periodic exam. The hygienist or assistant can do this. Let each patient hold the shade guide, not you. This is critical to gain a patient's attention and interaction. Ask the patient to match the shade to his or her cuspid and tell you the corresponding shade number, which you will document in their chart. The conversation should sound like this: “As time goes by, our teeth tend to change color. We want to document that change.” Please use the phrase “as time goes by” and NOT “as we get older”! This simple step, the shade guide exam, opens up opportunities for questions and answers, and paves the way for patient interest in whitening.

STOP! Look! Listen! ... to your patient. Is your patient well groomed, paying attention to his or her appearance (for example, does a woman have manicured nails)? What are the patient's hobbies, business/job, and special life events (weddings/divorce)? How do these things change over time? This will give you even more clues to discover your patient's values, which you can then use to relate to his or her dental and cosmetic concerns.

As a dental health-care provider, it's your job to ask about and understand your patients' wants and desires about their smiles. What is the whitening trend in your office? Are your whitening services gaining in popularity and sales? Or is your whitening percentage the typical 25% or less? If so, why are you not serving your patients' wants? Why are they getting their whitening needs met at the closest kiosk? Maybe it's time to revisit your approach to whitening in your office.

Use these tools to become a master seller of whitening and dentistry, in an elegant manner that creates value for your patients. Implementing these “selling” strategies will bump you up out of that 25% category, and make you feel great about the whitening services you and your team can offer patients.

“DON'T BUY CHEAP PRODUCTS TO ENTICE NEW PATIENTS WITH FREE WHITENING, THINKING YOU WILL UP-SELL THEM ON MORE SERVICES AND YOUR OFFICE. YOU WILL LOSE CREDIBILITY AND THE PATIENT.”

FINDING YOUR LEADER'S VOICE

AMY MORGAN

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Leadership communication is not a monologue, but a dialogue. According to leadership expert Margaret Wheatley in her book Finding Our Way: Leadership for an Uncertain Time, "We often approach leading people like mechanics trying to fix machines." (I taught a class for senior dental students and one asked, "How do you make your staff enjoy their jobs?")

"When we allow no input from our staff," Dr. Wheatley said, "we must provide everything ourselves: the mission, values, structure, plans, supervision, and deterrents. This approach is like trying to pump energy into a lifeless mass; it exhausts the leader and employees, and causes burnout. Instead of assuming that employees have no capacity for self-creation, self-organization, or self-correction, we can learn to lead differently."

It's as if Dr. Wheatley were addressing dentistry and dental students directly. Dentists have been trained to look at what is wrong clinically and fix it, which leads to approaching people like mechanics fixing machines. Believe me, I've been searching for the pill to cure "people issues," but until it is discovered, we need to roll up our sleeves, clear our vocal cords, and start communicating with a leader's voice.

What is a leader's voice? It's a voice that pushes past cynicism and uncertainty, and allows the leader to speak the truth, create a compelling context, and challenge others to stand with him/her. That's easier said than done.

What easy first step will help you create your own leader's voice? Learn to communicate authentically. This is described in one of my favorite books, The Leader's Voice, by Boyd Clarke and Ron Crossland. The authors refer to a leader's authentic, honest, open communication as "leadership without wax."

No, this does not refer to a new hairstyle or study model. It harkens back to the sculptors of ancient Rome. A status symbol of that culture was displaying statues in the home. Two kinds of sculptors emerged. The bargain-basement kind camouflaged their mistakes with wax the same color as the real stone. This practice incensed the fine artisans, who proudly hung signs on their doors declaring that they were sculptors "sine cera," which means "without wax." The term "sine cera" is the origin of our word, sincere.

Leadership without wax is the proud sign of an authentic leader. If your nose falls off during a staff meeting, let it stay off. Too many dentists mistakenly believe that they must present themselves to the staff as all-knowing and all-powerful. It reminds me of the old deodorant commercial that declared, "Never let them

see you sweat." If you don't think it's difficult to break this mindset, say out loud, "I was wrong. I need your help." I'll bet some of you broke into hives just uttering the words.

Leadership without wax believes it is perfectly acceptable to let them see you sweat. For example, assume you decide to lead your staff through the implementation of digital radiography. If you present this project as an expert leader who knows all the answers and has no fears or misgivings, the staff will approach the project in the same unrealistic way. It is natural to embark on sweeping changes with some trepidation. Your staff will not be innovative or take risks unless you allow for potential failures, concerns, or fears. They will feel uncomfortable sharing their misgivings with a leader who seems impermeable. One of the best statements a dentist can make is: "I have fears and concerns, but I know we can accomplish this. That's why I need your help."

"THE FIRST STEP TO BEING AN EFFECTIVE LEADER LIES IN DEBUNKING THE MYTH NOTED BY KEN BLANCHARD – LEADERSHIP IS SOMETHING YOU DO TO PEOPLE, NOT WITH PEOPLE"

You may think such an admission is risky, but you cannot be a leader without wax unless you are willing to be vulnerable. In influencing others, both the leader and staff change, grow, learn, make mistakes, encounter obstacles, and have setbacks. You become more credible when you are vulnerable. And isn't that a more natural and human role to play? I've seen a lot of waxy build-up, and all it does is block the leader's message.

Another favorite book of mine, The Leadership Challenge, by James Kouzes and Barry Posner, explains the steps to help you gain your authentic leader's voice. Here are four of them:

1. MODEL THE WAY

2. INSPIRE A SHARED VISION

3. ENABLE OTHERS TO ACT

4. ENCOURAGE THE HEART

Let's see how you can carve a masterpiece of leadership using these tools.

MODEL THE WAY

Serving as a role model for others requires you to a) find your voice by clarifying your personal values, and b) exemplify what you say in action. People admire leaders who believe strongly in something and stand up for those beliefs. The principles and values that you choose to guide your actions cannot be faked, but must be chosen honestly. If you attempt to base your value system on what you think will please others, or on what will sound good in a marketing piece, if it doesn't reflect the real you, at the first sign of an obstacle, pressure or resistance, you will lose the will to persevere.

Having strong values does not mean they must remain unchanged during your career. The values that form your character, such as honesty, may not change, but the business values derived from your personal values, such as what you appreciate most and what you invest

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in, must change with time. For example, when a practice is in its growth phase, it had better have a business value called profitability, because it will be unable to deliver the best care and service with past due payables and large credit balances. When a practice is in its peak performance stage, we often see a value shift, such as a greater commitment to excellence, charity work, or family time.

To test the authenticity of your values, ask yourself: Am I truly passionate about this value? Am I willing to publicly affirm it? Am I prepared to act on it consistently? If the answer to any of these is "no," look for a greater value to support your investment and fuel your passion.

Once you have strong values that you ardently want to achieve, you need to exemplify them in your attitudes and behavior in order to inspire people. If the value you seek is excellence in customer service, it is important that you arrive for work on time and communicate with patients in the same manner you expect of your staff.

INSPIRE A SHARED VISION

A vision is a compelling, magnetic picture of a future outcome that you truly, deeply desire and that supports your business values. Whatever term you use, be it purpose, mission, dream, or calling, your vision is significant and gives you a sense of meaning and purpose. Without it, your practice becomes a series of tasks that feel like drudgery and lead to burnout.

Once you identify a vision that motivates you, the next step is to inspire the staff to share it. And there's the rub. One of my favorite quotes from The Leader's Voice is "The difference between a vision and a hallucination is the number of people who see it." How many of you have come home from a course excited about launching a new procedure, then three weeks and a few glasses of wine later, you discover that your vision was just a hallucination? You need to be able to communicate your vision in such a way that people will understand it, commit to it, care about its progress, and take appropriate action to accomplish it.

"NEVER LET THEM SEE YOU SWEAT."

The biggest problem with leadership communication is the illusion that it has occurred. Do you have a vision that is communicable to patients and staff? Can you describe your vision in the following terms?

- **The quality, service, outcomes, and results that you want to achieve in patient care**
- **The that you want to inspire in patients and staff**
- **The knowledge, skills, abilities, and behaviors of your team that personify the practice goals and benefits to the staff to align with your vision. Once you can share your vision in this compelling way, your staff and patients will see the horizon and help steer you.**

ENABLE OTHERS TO ACT

I used to advise dentists to "empower" their teams. I have, however, seen so many dentists claim they are empowering staff, when they are actually micromanaging or abdicating their leadership roles, that I now consider **"empowerment"** a tainted word. I now prefer **"emancipation",** because staff who are not allowed to find their own self-leadership will feel like slaves. For example, an appointment coordinator who has been given **"free rein"** to create an ideal template for scheduling will become frustrated when the dentist breaks the rules by talking trout-fishing with patients during the hygiene check and throwing everybody off schedule. This staff member will mistrust the leader's word. What does the dentist need to do to enable others to act? Trust the team by giving them true responsibility and accountability.

ENCOURAGE THE HEART

The most important step in establishing leadership without wax is to encourage the heart. Encourage means to inspire one with courage, and courage comes from the Latin word for heart, cor. You can think of the act of encouraging as driving heart into someone. Rather than giving your staff more logic, this step involves releasing and supporting emotions. How do you encourage enthusiasm, joy, and passion for a common goal? You need to pay attention to your team and show them how important they are to you. Staff members deserve to be valued. They walk around with neon signs on their foreheads that say, **"See Me," "Acknowledge Me," "Appreciate Me," and "Give Me an Opportunity To Grow."**

If you are clear about your standards, and you believe people can perform like winners, then you'll often catch them doing things right. Think about a growth conference or salary review you recently held with your staff. Did your words of feedback result in encouragement, strength, and commitment to excellence? If the answer is "no," then change your words. The most common complaint we hear from staff members is that the dentist only tells them what they did wrong, and never notices what they did right. The bottom line is: What gets acknowledged gets repeated.

How would you feel if an assistant accused you of not caring about your patients and staff, but only about your bottom line? Or an appointment coordinator charged that you only like your assistant, and that you don't care about the problems of the front desk? Would these criticisms give you reason to change, or would they simply sound like attacks and get your hackles up? This is how a steady diet of criticism without positive feedback can sound to your staff.

"HAND ME THE WRONG INSTRUMENT ONE MORE TIME AND YOU'RE TOAST!"

"SEE ME, ACKNOWLEDGE ME, APPRECIATE ME, AND GIVE ME AN OPPORTUNITY TO GROW."

There is a way to offer corrective feedback that preserves self-esteem by focusing on the behavior, not the person. Have you ever had an assistant who repeatedly gives you the wrong instrument, even after you've told her what you need? How can you communicate with your leader's voice so that you build her self-esteem and allow her to grow in her job? The wrong way is "Hand me the wrong instrument one more time and you're toast!" The right way may be "When we're setting up for a crown prep, I see that the tray still has incorrect instruments. What do you need from me as your leader to ensure the tray is always set up correctly?" Whatever the answer, you're leading the person to the self-discovery of a solution.

Being a leader without wax means being sincere and passionate about your values, inspiring others to share them, emancipating others to support your goals, and encouraging the best in people. When you hide behind a façade and remain detached, your voice will fall on deaf, cynical ears. When you communicate authentically, others will hear you and be moved. So the next time your nose slips off at a staff meeting, shine a spotlight on it proudly and say, "I made a mistake, and I need all of you to help." The results will be miraculous.


TePe®
We care for healthy smiles

IT'S THE LITTLE THINGS THAT COUNT!

SANDY ROTH

The devil, as they say, is in the details. Consistency with your patients over seemingly insignificant matters makes the difference for patients and staff alike I stress to dentists and their teams that everything they do matters. When you are in a good mood and others know it, it matters. If you are feeling crabby and it shows, that matters as well. When you strive to be knowledgeable and informed, it matters. However, when you fail to do your homework and that omission contributes to a problem that might have been avoided, it makes also a difference.

Every team member influences the success or decline of the practice. Behaviors, attitudes, spirit, functions, performance — they all add up to either a team that takes advantage of each opportunity or one that misses the mark consistently.

When you handle opportunities or deal with problems sooner rather than later, it helps your co-workers turn their attention to other issues that matter as well. When your team wastes energy and effort on interpersonal strife, it robs the group of resources that rightly belong to the practice for patient care.

Most of what I refer to involves significant, substantive issues. But the little things matter as well, for they represent the standards that govern your performance. Let's turn our attention to some of those "little things."

Many teams have begun to look at adding little touches that "add value" to their patients' experiences. You needn›t go far to find a plethora of ideas: Hot towels; massage and heat pads for the dental chairs; headsets for listening to music; spa dentistry; perfumes and lotions in the washroom; water bottles engraved with your office logo; birthday cards and flowers; movie passes; and dinner gift certificates.

A practice could easily spend thousands of dollars on these niceties each year, and many do. In the last few years, I have heard several speakers use an entire three-hour program reviewing an array of ideas, gimmicks, and gadgets that promise major returns. And while I think there can be value in many of these ideas for some patients under some circumstances, I also am absolutely confident that no gimmick is compelling enough to overcome more significant omissions. A free water bottle can't mollify a patient who doesn't don't feel heard, understood, and respected. Yet little things can make a difference. Even in the most competently skilled practices, patients leave because those little things are overlooked.

So how do you make a distinction between trivialities and the significant little things that make a difference? What "little things" enhance the patient experience in an already solid practice — and could easily dislodge a good relationship if taken too lightly?

HERE ARE MY LITTLE THINGS THAT MATTER:

GETTING DETAILS RIGHT — Details do matter. Patients easily can worry about your clinical abilities if details like appointments, accounts, and other issues are not handled competently. Patients pay attention to cleanliness, clutter, and other signs that indicate attention to detail. They have a personal interest in the care that goes into the handling of their affairs. You and your team must continuously review the details and ensure that paperwork is handled accurately, accounts and insurance are processed with care, and that other aspects of patient service are managed with precision.

PROMTPT ACKNOWLEDGEMENT Just last week, I entered an airport sundry store to buy a newspaper. The clerk kept me and several other customers waiting while she engaged in a personal phone call. While she halfheartedly apologized afterwards, it didn't erase the aggravation we felt.

It may not seem like a big thing, but why should a patient ever have to wait for a simple acknowledgment of their presence? It takes so little to acknowledge a person's arrival — and it costs so much when that acknowledgment is withheld. I often wonder what's behind this type of behavior. Is it a power play? Is the employee frustrated or angry? Again, the team must be vigilant to ensure that this "little thing" does not come to define the quality of care and service for patients.

STAYING ON TIME — One of the biggest complaints I hear from team members about their dentist is the tendency to run late. Few things incur a patient's anger more than a doctor's tardiness. This little thing is one that can quickly mushroom because it's disrespectful to the patient. Do whatever it takes to keep your practice on time consistently. Certainly, there will be exceptions, but never allow your practice to accept lateness as ordinary or acceptable.

QUOTING ACCURATE FEES AND STICKING TO THEM — Too many practices take a cavalier approach to fees and financial arrangements. Sometimes it is because team members shy away from financial discussions with patients. At other times, it's because there are no systems that ensure patients have the respect that comes from full disclosure of fees and financial expectations. Patients are entitled to know the full range of financial possibilities so they can authorize treatment.

Remembering what you promised — If you don't write it down, you will likely forget it. If you don›t write it down, others won›t know what you have promised. If you don't write it down, they won't know what to do. The biggest detail is writing every one of the other details down so no one is confused or runs the risk of letting a patient down. Enough said.

"IF YOU CHOOSE TO PROVIDE A SERVICE, MAKE SURE YOUR SYSTEMS PROVIDE A WAY TO DO IT REGULARLY AND CONSISTENTLY. IT MATTERS."

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REACHING LEVEL 3 COMMUNICATION

RICK WORKMAN, DMD

When looking at successful businesses and individuals, several traits can be observed. More than likely they possess strong leadership skills, expertise in their fields, and adaptability. Another shared trait I guarantee you will commonly see among them is effective communication, which may be the most valuable trait of all.

No matter who we are or what we do, we all communicate with others every day in some manner. If you work in a business office, you›re constantly communicating with coworkers and relying on them to work as efficiently as possible. The same can be said if you're a dentist -- you're constantly communicating with team members to streamline your schedule, as well as communicating with patients. Because it's such an important element of leadership, effective communication isn't optional; it's essential.

In his courses at the Bell Leadership Institute, Dr. Gerald Bell discusses three levels of communication, with each progressing in effectiveness. Level 1 communication is very surface oriented, and it lacks trust, commitment, and honesty. At Level 2, you begin communicating with more openness and truth, and you become more unguarded with others in the process. At Level 3, the ideal level, you fully communicate with clarity, confidence, and dedication. You are not afraid to be direct and sincere when you share ideas, and you are not closed-minded when receiving ideas from others. In addition, Dr. Bell describes seven essential skills that will help you reach Level 3, including:

LISTENING EFFECTIVELY

Communication is not one-sided. Listening well to the thoughts and ideas of others is as important

> **“EFFECTIVE COMMUNICATION, WHICH MAY BE THE MOST VALUABLE TRAIT OF ALL.”**

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as effectively sharing your own thoughts and ideas. Listening to others shows respect, helps build relationships, increases your own knowledge, generates ideas, and creates loyalty.

DELIVERING IDEAS CLEARLY AND POWERFULLY

When delivering your message unclearly or without enthusiasm, the point of that message can become lost on others. You may have revolutionary ideas, but if you can›t effectively communicate them, no one will ever know.

CONFRONTING CONFLICT WITHOUT STRESS

If conflict occurs when communicating with others (and it naturally will), you have to handle it correctly. Becoming angry and going into attack mode or completely closing your mind might be natural responses, but they're not the right responses. When confronting conflict, it's important to remain calm, open, and focused.

BEING OPEN TO FEEDBACK AND CRITICISM

We'd all like to be perfect, but we›re not. We›re human beings who are constantly learning. None of us likes receiving criticism, but it›s essential for the learning process, and it›s how we advance ourselves. Instead of becoming negative when you receive criticism, look at it as an opportunity to grow.

ENRICHING YOUR SENSE OF HUMOR

Used appropriately, incorporating humor into your communication keeps others engaged and helps you sound relatable and natural. Since conflict and stress are common in certain circumstances, savvy communicators will cultivate appropriately timed humor as a means of reducing tension and frustration.

ENHANCING YOUR PRESENTATION SKILLS

This goes back to delivering your message with clarity and enthusiasm. It's not all about what you say, but how you say it. Be clear, concise, and genuine, and your audience will respond.

MASTERING NONVERBAL COMMUNICATION

Another important component of the "It's not what you say, but how you say it" idea is nonverbal communication -- your tone and body language. If you have a negative and uncaring body language and tone, that's how others will perceive you, no matter what you say. Be positive, upbeat, and encouraging, and you'll make a much better impression.

Once Level 3 communication is reached within a company or dental office, a perfect application is developing a "mastermind" approach. Walter Hailey, a past mentor of mine, taught that **whenever two or more minds are joined together in harmony, a "mastermind" is formed**. When applying a mastermind outlook, everyone in that company or office works toward the same goals with no competing interests. Some of the largest, most successful organizations on the planet operate as "open-book" entities, where critical information is widely available. This transparency creates the proper environment for growth, innovation, and advancement.

“DR. BELL DESCRIBES SEVEN ESSENTIAL SKILLS THAT WILL HELP YOU REACH LEVEL 3”

BEFORE A MASTERMIND approach can be created, Level 3 communication must be reached. The difference and impact from progressing from Level 1 to Level 3 is immense, and is something Heartland Dental continues to value. Establishing an open, collective atmosphere where everyone gives and shares selflessly, without fear or distrust, has been a huge reason why our team has been able to achieve so much.

"SUDDEN IMPACT" TO BOOST PRODUCTION

JAMES R. PRIDE, DDS
AND **AMY TUTTLE-MORGAN**

Half of any equation in a dental practice represents the patient's clinical needs and the primary reason for being a dentist. The other half represents the business needs of the practice, because it is difficult to provide the appropriate care if the needs of the enterprise are not being met. The tool that sets the business goals for the year and directs everyone's actions is the annual plan. Without goals, which become finish lines, dental team members never know if they have done enough.

The proper approach to annual planning is to budget the year's expenses as if making a "wish list" of things you'd like to have, then develop a challenging, but achievable, annual plan to meet them.

The Concept is to produce what is needed for both business and living expenses. "This is what I'll need to live the way I want to, and here's what I have to produce to do it." This new para digm stretches the limits of the possible.

Another Con cept is: Intro duce changes incrementally by phasing them in gradually during the annual plan. Achieve great things by proceeding in small steps. Rather than arrive like a bull in a china shop to topple the established office routine

and to overwhelm the Dr. and his staff, our approach was more subtle, leading to a Corollary Pride Concept: Do not try to change all of the systems and staff behaviors at once. Instead, make one or two fantastic improvements in the practice. These first successes enable everyone to accept management improvement as possible and nonthreatening. We call this quick dose of easy-to-swallow medicine a "sudden-impact plan." for example : boosting production.

FEE INCREASE. Raising fees to the 80th percentile for the area. Be careful not to increase fees too much at one time, as this could be detrimental to the practice.

PREBLOCKING. Preblocking the schedule. Schedule treatment procedures with high fees. The total income generated from these procedures should match the clinic daily goal of income target. Preblocking avoids schedules in which the doctor performs new-patient exams all day, with very low production, as well as days in which the doctor performs difficult procedures all day, which are both physically and mentally exhausting.

IDEAL-DAY SCENARIOS. In order to teach the staff members how to schedule to the production goal, we asked them to compose "ideal-day scenarios." These were sample schedules of various procedure mixes that filled the preblocks and met the daily goal. The scenarios were the staff's finish line. Another Pride Concept: Always create a finish line. Often we find no goal line in a practice. So, even on high-production days, the staff lacks a feeling of achievement. We wanted to avoid that by clearly defining goals for success. Notice that the staff - not the doctor or consultant - created the scenarios. Empowering the team is essential to management improvement.

DECREASING NEW PATIENTS. We preblocked for new patients to reduce their number from 27 to 15 per month. We aimed for quality, not quantity, by targeting a patient profile that fit the doctor or the clinic's vision. This vision called for patients who wanted long-term care and agreed to a comprehensive exam, rather than episodic treatment. This is not easy to do and can only be fully achieved if the staff develops superior listening skills and an exceptional interviewing process for new patients.

Doctor's production rose with fewer new patients, because needed treatment was already diagnosed in the practice. At this point, we did not change the doctor's new-patient exam or case presentation, although they needed improvement.

> "THE BALANCED SCHEDULE IS IDEAL BECAUSE IT MEETS GOALS AND AVOIDS THE PROBLEMS OF UNDERPRODUCTION AND OVERPRODUCTION. THE PRIDE CONCEPT IS: PREBLOCKING NEEDS TO OCCUR EACH AND EVERY DAY, WITHOUT EXCUSES."

PRIDE CONCEPTS

- Produce what is needed for both business and living expenses.
- Introduce changes incrementally by phasing them in gradually during the annual plan.
- Do not try to change all of the systems and staff behaviors at once.
- Preblocking needs to occur each and every day, without excuses.
- Always create a finish line

HOW TO PROFIT FROM COSMETIC DENTISTRY

ACHIEVING PROFITABILITY WITH AESTHETIC DENTISTRY

DAVID S. HORNBROOK DDS, FAACD

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The practice of clinical dentistry is at its finest moment — in terms of profitability and economics — since the early 1960s. The public's increased awareness of the benefits of modern dentistry has never been higher. The desire for "wants-based" dentistry frequently replaces "needs-based" dentistry as the reason a patient seeks dental treatment. This increased awareness, coupled with the overall desire of the public to look and feel better and younger, has created an entirely new arena in dentistry that was much less explored prior to the new millennium.

The media's attention on dentistry's entry into providing positive changes in people's appearance has resulted in a prolific number of articles in leading national beauty and glamour magazines. These articles cover topics such as bleaching, bonding, veneers, and orthodontics. This increased awareness by the media has had a profound effect on one group of patients — the ones who seldom visited the dental office because of its association with unpleasantness and pain. Dentistry now has established itself near the forefront of delivering self-image-enhancing services, along with providing and maintaining excellent oral health.

When combined with the proliferation of new materials and techniques that simplify the clinician's ability to provide patients with aesthetic procedures, the number of dentists providing and, in many cases, focusing their practices on aesthetics is incredibly high. However, success in the delivery and execution of aesthetic dental procedures is based on predictability. With higher patient expectations and demands, providing beautiful, functional dentistry — without sensitivity or premature failure — is determined by effective communication skills, understanding the applications and limitations of the new materials, clinical confidence in the new techniques, and an excellent relationship with your ceramic laboratory.

PREDICTABILITY WITH COMMUNICATION

Excellent communication skills are equally as important as clinical skills in delivering predictable aesthetic dentistry. The ability of the doctor and team to create value for aesthetic dentistry can only be achieved by creating an environment where the patient knows what is available and what can be done. Creating and establishing value frequently begins with the simple statement, "Is there anything you would like to change about your smile?" or "If you could wave a magic wand, what would you like to change about your smile?" Unfortunately, few clinicians and their teams actually take this easy, first step and, as a result, they miss out on countless opportunities to provide their patients with beautiful smiles. Although the patient may have heard about new techniques in dentistry, few truly understand exactly what is available and the miraculous results that can be achieved in a very short time. Listening to the patient's goals and desires about their

smile then becomes the next step. Frequently, just handing patients a large, hand-held mirror and asking them to describe what they do and don›t like about their smiles will elicit responses that will result in treatment acceptance.

Increased treatment acceptance is usually a result of the enthusiasm of the doctor and the team in describing the treatment and the results that can be obtained. Since most patients are going to accept treatment based on an emotional response or need, rather than on the clinical merits of a specific material or technique, this enthusiasm establishes credibility that the patient's desires will be met ... and possibly even exceeded! Those clinicians and teams that are most successful in obtaining case acceptance are the ones that are able to effectively infuse excitement and enthusiasm into the treatment plan and the final outcome.

Creating value through visual communications is as important as verbal communications. The physical environment of the office should elicit patient›s questions and desires about how they can improve their appearance with an enhanced smile. This can be accomplished with before and after photo books, beautiful smiles and faces as artwork on the office walls, or even screen- savers that morph from before to after pictures. Since the aesthetic-based dentist is in the business of enhancing smiles, anything that can be placed within the patient's view that promotes awareness of beautiful smiles will help in establishing the correct environment for increased treatment acceptance.

One of the greatest ways to create value is the concept of "practicing what you preach." When the doctor and the team members have had their own smiles enhanced with aesthetic dentistry, this escalates the value, durability, and safety of the specific procedure. Most of the successful cosmetic-dental practices have a doctor and several of the team members who personally have had a smile enhancement with porcelain veneers or orthodontics. It is difficult for the patient to see the value when the doctor and team aren't walking advertisements for what can be achieved with aesthetic dentistry.

PREDICTABILITY WITH THE NEW MATERIALS

The materials and techniques used in aesthetic dentistry are changing at an alarming rate. It is difficult — if not impossible — for the average clinician to try to keep up with all of the changes. The importance of understanding what is available, as well as the applications and limitations of the new materials is paramount in providing patients with state-of-the-art, predictable dental care.

Since most of the new techniques are not discussed in dental school, post-graduate continuing education becomes even more important for the aesthetic dentist. Success in eliminating post-operative sensitivity, premature failure, and obtaining the optimal results is determined by the use of the most ideal materials and an understanding of the techniques utilized to place them. Many clinicians have stopped using excellent materials because of a lack of understanding of the proper techniques. The successful aesthetic-based clinician is one who attends numerous hours of continuing education and stays abreast of the latest literature. Another important asset is to seek out and follow a mentor who has the ability and time to investigate the various materials as they are introduced to the dental community by the manufacturers. The pinnacle in post-graduate education is to attend a live patient, hands-on program where leading clinicians actually treat patients using the latest techniques in aesthetic, restorative dentistry. There is no substitute for this infusion of hands-on experience, and many clinicians have stated that these types of programs are responsible for propelling their clinical self-confidence to a new level.

This acquired clinical self-confidence is another key ingredient in increased case acceptance. When the doctor and the team express confidence when describing the options — and ultimately the results — the patient can sense this

confidence and case acceptance is enhanced. It is the doctor›s lack of confidence, usually based upon lack of clinical experience, that results in the patient's concerns about the final results and the overall treatment experience.

YOUR CERAMIST AND PREDICTABILITY

Once the value for treatment acceptance is established and the clinical skills are acquired, the desired results can only be obtained with the use of an artistic ceramist. Artistic skills alone, however, are not enough to yield the most ideal result. The artistic ceramist must be allowed to follow a set of blueprints based upon a design process established by the clinician. The concept of "designing the smile" is one in which the variables of the smile are addressed with the patient by the clinician and then transferred to the ceramist through the laboratory prescription. The smile design addresses such things as tooth length and shape, surface anatomy, incisal edge translucency, shade, and functional concerns. Frequently, these criteria are developed using photographs, models, or, ideally, an intraoral resin mock-up. Placing a flowable resin of the patient's pre-existing teeth to determine ideal length, profile, central and lateral relationships, smile line, and contour allows him or her to express their own preferences on the final design. This mock-up can then be impressed and used to fabricate the provisional restorations. The provisionals, in turn, can be used as a working diagnostic model. The ceramist then duplicates and uses the model to fabricate the definitive restorations.

Usually the relationship between the clinician and the ceramist begins and ends with the prescription. It is a one-way dialogue that inhibits the preferred interaction between the two. Successful clinicians are those who have established a consultatory relationship with their ceramists. The ceramist becomes a peer in the design process, whether it be the discussion of the materials used, or even the design of the smile itself. Optimal aesthetics and patient satisfaction can only be achieved when this kind of relationship exists.

PREDICTABILITY AND PERCEPTION

Dentistry can be an incredibly rewarding and satisfying profession. For many clinicians, it has become a hobby at which they have been able to make an excellent living. The ability to have a positive role in helping other people improve their self-image and self-worth is an honor that is limited to very few professionals. Aesthetic dentistry has taken away the stigma of just relieving and/or causing pain and created, in its place, a profession that is associated with beauty and enhancement. It is a profession that individuals can turn to when they want to improve the quality of their lives.

“ THE CONFIDENCE THAT YOU CAN DELIVER THE RESULTS PREDICTABLY. IT IS THIS CONFIDENCE, ABOVE ALL ELSE, THAT WILL CHANGE THE PERCEPTION OF YOUR PATIENTS, YOUR TEAM, AND, ULTIMATELY, YOUR OWN. ”

THE 7 DEADLY SINS OF ONLINE PRACTICE MARKETING

GLENN LOMBARDI , BA

Year after year, the Web continues to provide new marketing opportunities for dentists. But as time goes by and more practices compete for online success, building a competitive Web presence is becoming more difficult. It's still possible to do. In fact, it's altogether necessary. So if you are looking to improve your Web presence this year, here are seven pitfalls you will want to avoid.

1 ASSUMING A WEBSITE IS SUFFICIENT

It's 2014, and all of us are far more Internet-savvy than we were even five years ago. Nevertheless, a surprising number of dentists still seem to think that a website is the end-all-be-all to online success. Once upon a time, this was true. But those days are long gone. The Web is now so enormous that any site, no matter how good it is, will get lost in a crowd if it is not part of a comprehensive and carefully maintained Web presence. To ensure success, your online footprint will need to be much, much larger.

2 BEING UNPREPARED FOR MOBILE TRAFFIC

Mobile websites were a novelty back in 2007. Then again, so was the iPhone. Seven years later, it's time to catch up. Ninety-one percent of all people on the planet have access to a mobile device, and 56% of these people have a smart device. That makes a mobile website a basic necessity. Without one, half of your potential mobile customers will see someone else's website before yours.

3 AVOIDING SOCIAL MEDIA

Facebook is not just for kids anymore. Like it or not, it's now prevalent enough that it's a big part of modern culture. This can be good or bad, depending on who you ask. But the facts speak for themselves. Every day 728 million people log into Facebook. Each user has an average of 303 friends. This means Facebook alone, not to mention other successful platforms such as Twitter and blogging, is the biggest, most immediate referral network at your disposal. It's a powerful tool, and your practice needs to use it.

4 GIVING UP ON ONLINE REVIEWS

Reviews on Yelp and Google can be both frustrating and fantastic. But regardless of which side of the fence your practice falls on, you need to keep up with them. This is because 85% of consumers say they read online reviews for local businesses before patronizing them. Seventy-nine percent say they trust reviews as much as personal recommendations. This means your online reviews are your reputation. They need to be monitored, tracked, and acted upon.

5 LEAVING GOOGLE UP TO LUCK

Google rules the Internet. "Google it" is a universally understood command. So what happens when your practice does not show up on a Google search for dentists in your area? Nothing. No new patients and stymied growth. Search engine optimization helps you appear prominently where people look for your services most often.

6 MAKING YOUR PATIENTS GO TO

WebMD for Information Your patients have questions. Make sure the answers come from you. You might not be available 24/7, but a patient education section on your website will be. It builds trust and keeps information-hungry patients on your site. That means that when they seek treatment as a follow-up action, they will already have your information at their fingertips.

7 WAITING AROUND, HOPING FOR IMPROVEMENT

How many of your patients delay basic treatment, only to return later on when the problem is much worse? Neglecting a weak Web presence is just like leaving a new cavity untreated. It's only going to get worse with time. If your problem can be fixed (and it can be), find a good company, find a good price, and get started.

All of these, in one way or another, can be prevented by following one golden rule: Stay current. Don't fall behind. You do not need to ride the very cutting edge of technology. You do not necessarily need to blaze new paths. Nor do you need to do anything so complicated that a smart person like you cannot understand it. But you do need to be up to snuff with the most basic online marketing competencies. If you have not already started, now is the time to get rolling before that cavity gets any bigger.

5 SEO BEST PRACTICES TO HELP YOUR PRACTICE ATTRACT AND ACQUIRE NEW PATIENTS ONLINE

DIANA P. FRIEDMAN **MA, MBA**

With 77% of people today seeking online health-care information starting their sessions at search engines, where your site shows up on search engines is a main determiner of how much traffic (and how many new patient calls) is generated from a website.

Consumers searching online almost always click on the first results they see -- 87% of all clicks from organic search engine traffic goes to the first five results. To capture the attention -- and clicks -- of prospective patients, a practice's website must secure these top spots in relevant searches for specific keywords.

Search engine optimization is the "process of improving the visibility of a website or a web page in a search engine's 'natural' or unpaid ('organic') search results. " The right SEO strategies, supported by the right website, will help a practice attract and convert more prospective patients. Here are five ways you can optimize SEO efforts.

1. PRIORITIZE FRESH WEBSITE CONTENT

If your webpages are frequently updated with fresh content, search engines will deem them more important, increasing the chances they make the first page of results. Update your website monthly if possible. Focus on creating content that site visitors will value since this type of content also tends to help with search-engine rankings. Updating a link or two in the navigation bar is unlikely to help your search rankings, but adding a new blog post or new site content might.

2. INCLUDE APPRORIATE KEYWORDS

Including the right keywords in website copy where appropriate will help a site rank higher in prospective patients' searches. Ask a few patients what search terms they used -- or would use -- when searching for a dentist online. Better yet, track your Google Analytics to evaluate what search terms are most often used by your practice website visitors. Then, weave these words and phrases into your website copy as appropriate.

"THE RIGHT SEO STRATEGIES, SUPPORTED BY THE RIGHT WEBSITE, WILL HELP A PRACTICE ATTRACT AND CONVERT MORE PROSPECTIVE PATIENTS."

3. OPTIMIZE YOUR SITE EXPERIEMCE FOR ANY DEVICE

By 2014, mobile Internet use will surpass desktops. Today's mobile devices come in many different forms. In order to rank highly on mobile searches, a practice's website must optimize viewing experiences for any type of device prospective patients might use, whether it be a smartphone or iPad. An optimized method (and one recommended by Google) exists to help a practice do this. This method, called responsive design, allows you to create a main website that looks and functions effectively across all devices and screen sizes. Responsive design makes it easier for search engines to index a website, improving its ability to be found in native search results. Just as importantly, providing visitors with an optimal viewing experience will improve new patient conversion.

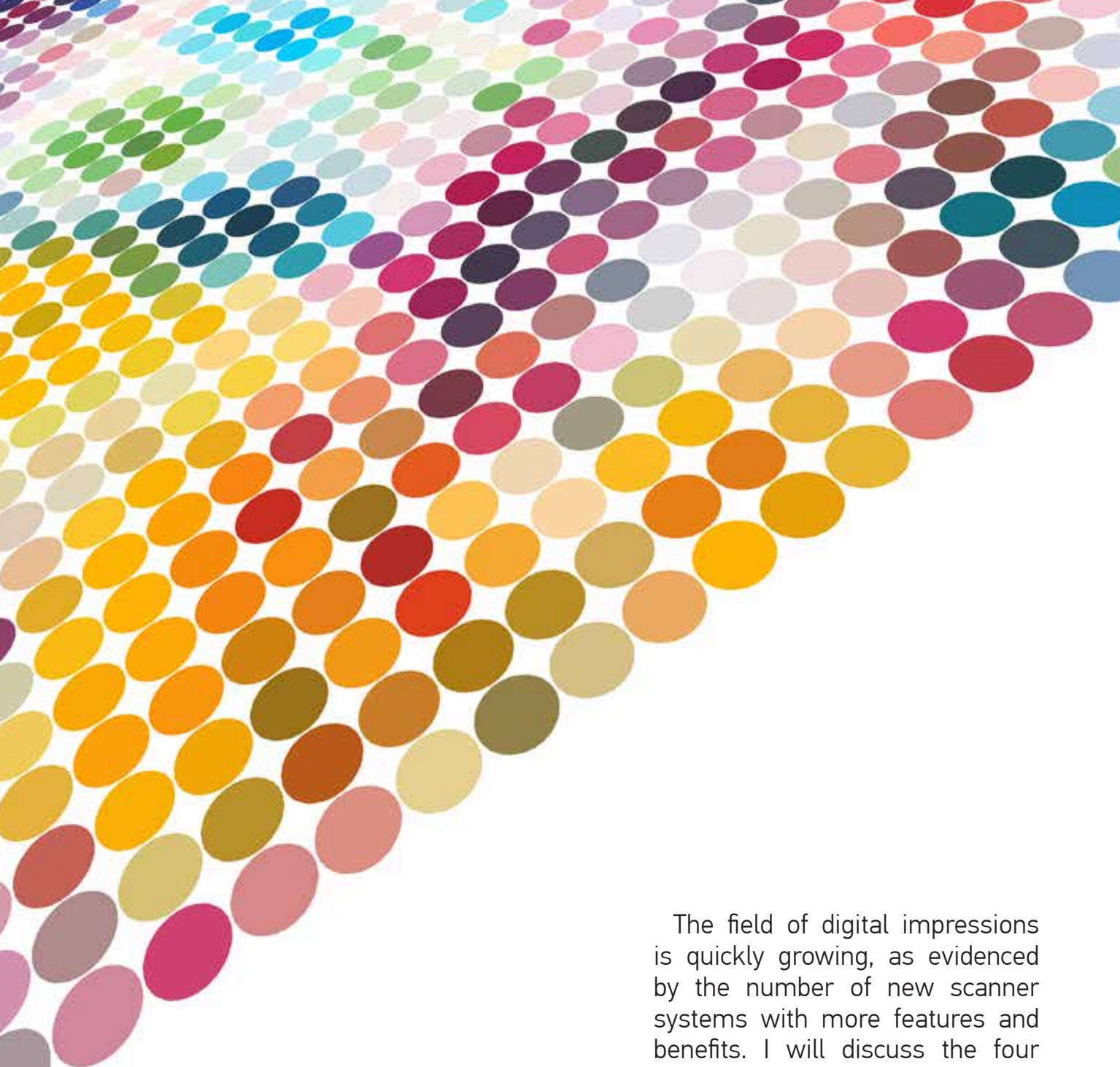
4. INCLUDE VIDEOS

Prominently displaying videos on a site will engage visitors and increase the chance that they will stay engaged. In fact, 46% of website visitors see video as a key reason to seek out more information on a product or service. Video content can also positively impact search rankings. Video content is proven to increase the amount of time a visitor spends on a website, which prompts search engines to increase relevance ranking.

5. MEASURE RESULTS

You won't know if your SEO efforts are working unless you have a way to connect these activities with site traffic increases and new patients. Website analytics programs such as Google Analytics let you identify exactly how many visitors arrive at your site via search engines during a given time period. This allows you to link increases in search-engine traffic to specific SEO activities. Tracking referral sources for every new patient will also help determine the connection between your SEO activities and new patient acquisition.

SEO helps websites get found by more prospective patients, ultimately allowing a practice to optimize its site as a tool for acquiring new patients.



The field of digital impressions is quickly growing, as evidenced by the number of new scanner systems with more features and benefits. I will discuss the four major systems on the market and others that should soon be available. I will also give cost comparisons of digital impressions vs. conventional impressions.

WHY DIGITAL IMPRESSIONS?

CURT MITCHEM, DMD

There are basically two types of scanners on the market today. There are systems that use blue LED (light-emitting diode). These systems are optical scanners that depend upon a reflective surface and require a contrasting medium or powder to acquire a representation of the tooth morphology. There are also systems that use laser technology to scan and measure distances from the tooth surface to acquire the image. They do not require powder.

The Cadent and 3M ESPE machines produce models that are sent to the lab to produce the restoration of choice. Sirona and D4D include milling units for immediate fabrication of the final restoration chairside.

The CEREC AC can be used for fabrication of a model-only system by purchasing it without the milling center. It uses a blue LED optical scanner and requires the use of powder. Dental anatomy created by Lee Culp, CDT, is used for the occlusal design.

E4D's system includes the interoffice milling center to produce same-day single crowns using Culp's database of dental anatomy as well. The difference is that E4D uses a laser scanner and does not require powder.

E4D offers what it refers to as TSS or three sources scanning. This allows the dentist to directly scan intraorally, take a conventional impression, and scan the impression or pour the impression, and then scan the model.

Cadent iTero

3M ESPE Lava COS

> “THERE ARE FOUR MAJOR SYSTEMS ON THE MARKET TODAY — CADENT ITERO, 3M ESPE LAVA COS, CEREC BY SIRONA, AND E4D BY D4D TECHNOLOGIES.”

Lava COS (chairside oral scanner) is a video-type format that uses the blue LED scanning system that requires powder. The downloaded scan information produces an SLA model that allows for fabrication of any type of restoration.

The iTero is an optically assisted laser scanner that does not require powder. The optics allow for real-time imaging. This allows seeing the model being built as you proceed through the scanning process. A milled model is produced, allowing for fabrication of restorative needs.

Glidewell has developed a scanning system that was introduced at the 2011 Chicago Midwinter Meeting. The system uses an optical scanning platform.

MODELING SYSTEMS

Two types of modeling systems are used, which are SLA or stereolithography and milling. SLA is a rapid prototyping technology that produces an accurate model.

Milled models are produced using a pre-cured urethane block that is placed in a milling machine to remove excess material to accuracies within 20 microns. SLA produces models for CEREC and Lava COS, while Cadent uses milling to produce its model.

The labs like the virtual impressions because the information can be downloaded directly to their milling units to produce CAD/CAM restorations, such as e.max crowns that require no models. All of the systems eliminate stone model work so there are no distortion issues and no bubbles.

Cleaner preparations, improved accuracy of the models with virtually no remakes, and restorations that fit and require little occlusal adjustment result in big cost savings for the lab and dental office.

Digital advantages: With milled models, you have a solid model. Dies are precision-fit in the model with no movement, and all dies are captured in one model. This gives greater accuracy when restoring multiple units, such as veneer cases. There is no contamination from the patient and no die spacer is required.

Conventional advantages: The technique has been used for years, allowing for better initial understanding and comfort with the system.

Digital disadvantages: At this time, there are only two implant systems on the market that allow scanning of fixture level implants — 3I and Straumann. Zimmer and Astra believe they will have scannable abutments on the market soon. It is still difficult to scan a prepped tooth for a crown to fit an existing partial. It is difficult to make a crown to fit an existing partial no matter what system is used.

Conventional disadvantages: Expansion and contraction of PVS material and poured models. The possibility of bubbles, pulls, tears, and distortion while taking impressions can be routinely found. There is also the fragility of stone models that require repours with less accuracy.

I use the iTero, which allows me to control monthly impression costs, as do the digital systems. With iTero, I have an annual subscription fee of $4,000 for scans and service of the equipment. A doctor who averages 20 cases per month pays $16.66 per case ($4,000/12 months/20 cases).

For comparison, I used Extrude PVS material from Kerr that costs $18.72 per cartridge. I get two quadrant impressions per cartridge, plus the cost of mixing tubes, intraoral tip, light body PVS, and Blu Mousse bite registration. This resulted in an average cost of $16.51, which is comparable if there are no retakes. More cases mean increased impression material cost. With digital impressions, you have a decrease in cost per case when doing more cases.

I found TIME to be the real savings! With a conventional impression, including prep for packing the case for the lab, we averaged 35 to 47 minutes. With digital impressions, again we have prep time, but then we take only four minutes to scan both arches based on a quadrant impression. This comes to a total of 12 to 14 minutes, a difference of 23 to 33 minutes.

My crown seat time for conventional impressions was 15 to

CEREC by Sirona

E4D by D4D Technologies

20 minutes. For digital impressions, it was 10 to 15 minutes — a savings of another five minutes. This adds up to 28 to 38 minutes per crown prep.

My assistants do some of these functions and this means they're not available to me for assisting. I admit I've become spoiled during the last 20 years and do not like to work alone. But anything that increases my efficiency and allows me to do more work in less time gets my attention.

This may not seem like much to some. So let's put this into dollar amounts.

My hourly goal is $500 per hour or $8.33 per minute. For 28 minutes in time saved multiplied by $8.33, we have $233.24 in increased production time. We average 500 crowns a year. Multiplying this number by $233.24 results in $116,620 in increased production for the year.

We would realize more with the 38-minute savings. What we actually experienced in the first year of using digital impressions was more than a $129,000 increase in production. This was due mostly from the time savings we experienced. Some was due to the marketing of goopless impressions, as well as being seen as a progressive office and staying on the cutting edge of technology.

Like any equipment purchase, there is an initial cost. For iTero, Lava COS, and the CEREC AC scanner-only systems, you will spend from $20,000 to $30,000. For CEREC AC with milling center and the Schein E4D systems, you will spend from $110,000 to $120,000.

> “THE MERGING OF INVISALIGN TECHNOLOGY WITH ITERO SCANS ALLOWS FOR QUICKER TREATMENT WITHOUT THE NEED TO TAKE CONVENTIONAL IMPRESSIONS. SIMPLY SCAN AND SEND THE DIGITAL IMPRESSION. THIS ALLOWS FOR VALUABLE PRACTICE GROWTH OPPORTUNITIES.”

If you compare any of the systems to the increased production I experienced, you would still have a return on investment in less than a year. In my book, this is one of the many positives for digital impression systems.

Other time savings include tray selection, material dispensing, disinfection, and cleanup of the impression guns. There is no model pouring of the opposing models or model trimming and no distortion from the Triple Tray. Also, there is no more packaging the impressions, writing the lab script, or shipping since online prescriptions are sent electronically with the digital impression.

After I give anesthetic, the assistants typically fill in the lab script and scanning sequence, scan the opposing arch, and have the impression taken for the temporary. All this is done while I am doing hygiene exams.

Upon my return, we go right to work prepping teeth. There is no wasted time on my part. Again, this results in increased production and efficiency. As I mentioned earlier, the true savings with digital impressions is TIME!

Open systems, such as iTero, allow for seamless integration of the digital impression with cone beam CT data for enhanced implant and orthodontic treatment planning. This allows for the development of surgical guides and same-day temporization with predictable results. CEREC merges with the Galileos CBCT to allow for case design.

All restorative options are available, from single crowns to full-arch restorations. Veneers, implants, inlays, and onlays are possible. I have used digital impressions for five years, and cannot imagine going back to conventional impressions.

COMPREHENSIVE DIGITAL DENTAL DIAGNOSTICS PROTOCOL

Marwan AbouRass, DDS, MDS, Ph.D.

The Problem

The American Academy of periodontology estimates that 73% of dental practices do not diagnose periodontal disease. The American Dental Association indicates that 50% of dental practices diagnosing periodontal disease do not probe on a regular basis. Although, whole mouth periodontal probing protocols are considered the gold standard in Periodontal Pocket Depth Measurement, they are not performed routinely. In most dental practices, periodontal probing is performed when there is a periodontal related emergency or periodontal problem. Unfortunately, except for abscesses of the Periodontium; all periodontal disease classifications are painless. Furthermore, whole mouth probing protocols are time consuming, stressful and financially unrewarding. The absence of whole mouth periodontal probing data from the patient dental records is considered professionally and legally below the acceptable standards of care.

The Proposed Solution

Introduce whole mouth digital periodontal probing as the central component of digital dental diagnosis protocol that focuses on comprehensive examination and assessment of the Endodontium and Periodontium of every tooth in the patient mouth. The digital dental diagnostics protocol s' appointment is an independent one hour procedure, scheduled and properly charged to serve as a base line foundation for preventive dentistry patient care programs, or as a prerequisite to comprehensive care dentistry, periodontal and implant dentistry, adult orthodontics and Orthognathic Surgery.

The comprehensive digital dental diagnostics protocol includes the following records, questionnaires and procedures:

1. Standardized medical, social and dental histories and general extra and intra oral examinations.

2. Standardized Digital FMX Periapical Radiographs

3. Orthopantograph

4. Documentation of Thermal dental Pulp Response Testing of all teeth

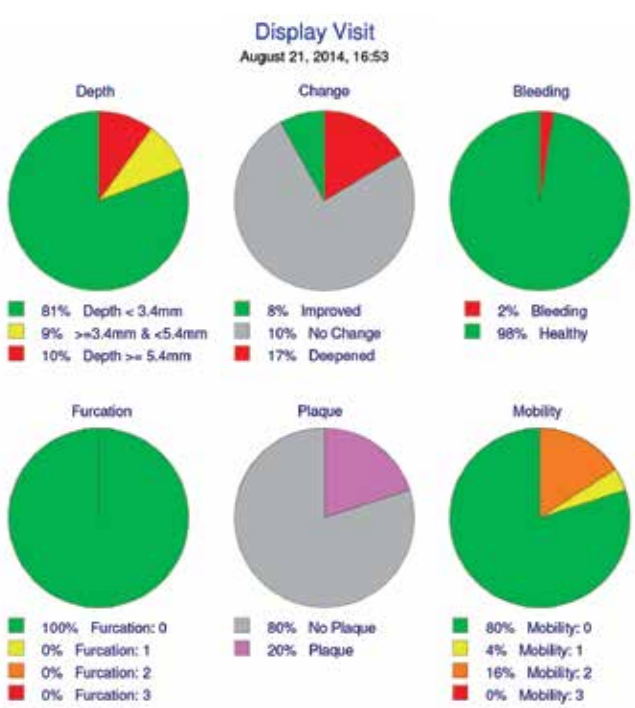
5. Standardized Intraoral and extra oral photographic record

6. Collect the Florida Probe Digital Diagnostics, which will provide computer-based documentation of the followings:

- Full Mouth Charting based on the data of the intraoral examination of the mouth and teeth
- Standardized Whole Mouth Periodontal Pocket Depth Measurements.
- Bleeding on Probing Index (BOB)
- Plaque Index (PI)
- Furcation involvement status.
- Tooth Mobility

7- Immediate patient feedback: The most significant findings of the above collected records and data are used to inform patients briefly about their oral-dental health condition.

8. Treatment Plan: A more structured presentation supported by visuals, radiographs and the Florida Probe graphs (see below) is organized according to the type and nature of the patient's problems and the criteria of standardized treatment planning case presentation.



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