How to get what you want: an implant success story

By Roger P. Levin, DDS

Dr. Sherman Smock knew how much potential his periodontal practice had, but he wasn’t sure how to realise it. ‘I felt comfortable with my practice philosophy,’ he says, ‘but my office was still underperforming. I was working hard, but not achieving progress.’

He had made some effort to improve his business by developing better customer service models and writing out his vision and sharing it with his employees. The trouble was, neither he nor his staff was following through.

Dr. Smock needed to do something. He sought out the services of Levin Group’s Total Implant Success™ Management and Referral Marketing program. After a detailed practice assessment, Dr. Smock and his consultant identified three major areas on which to work: leadership, practice systems and communication. Dr. Smock has since been happy to see his production increase by 22 per cent and his referrals by 18 per cent.

Leadership

‘I was not in control of my practice,’ Dr. Smock admits. He had developed a practice vision previously but, as he says, ‘I didn’t have the time or the skills to make it a reality.’

‘One of my greatest challenges,’ he says, ‘was coming to terms with the fact that any change for the better would have to come through my actions.’ With the help and guidance of his Levin Group consultant, Dr. Smock began taking charge of his team, initiating marketing and customer service systems, leading by example the way to a brighter future.

Practice systems

At first, Dr. Smock wasn’t sure whether leadership or practice systems should take a priority in his practice overhaul. His Levin Group consultant helped him realise the practice could work on both issues at the same time, that they are really two sides of the same coin. The office began making changes to the practice marketing plan and the way the office communicated with referring offices, to the practice’s customer service models and to the way the practice handles competition with the area’s other periodontal office.

Referral marketing

Dr. Smock’s office had been providing up-to-date periodontal treatments in areas such as bone and soft-tissue grafts. The office had also started offering continuing education classes for referring doctors to promote implant referrals. However, marketing was not a priority, and relationships with referring offices were left mostly as is, with no concerted efforts to strengthen them.

‘Stress levels were high,’ Dr. Smock says, ‘because we weren’t following basic business requirements. We were making no consistent marketing effort. This began to change as Dr. Smock and his team followed the Levin Group referral-based marketing program – a consistent and ongoing set of 15 to 30 strategies customised for each type of referring office.

Customer service

‘In the past, when we’ve performed patient satisfaction surveys, we received good marks in clinical services,’ Dr. Smock says, ‘but now I see superior marks in all areas of the practice, as well as in clinical services.’

By following their practice plan, the business office has become more effective in handling insurance issues and has improved collections. Efforts by the professional relations coordinator have enhanced the practice’s image in the eyes of referring offices. In addition, current patients, thanks to internal marketing and strong customer service, are happy to refer friends and family to the practice on a more consistent basis.

Competition

In the town where Dr. Smock practices, there is currently one other periodontal office. In a bold move, Dr. Smock has begun partnering with that periodontist and has plans to develop a 7,000-square-foot office they can share. The office could even accommodate a third periodontal practice. ‘This process has restored my positive feelings toward dentistry as a profession and periodontics as a specialty,’ says Dr. Smock.

Communication

Dr. Smock understood that effective leadership requires effective communication. He began implementing a series of staff meetings. Once a month, the entire team meets, with emphasis placed on input from all team members. Dr. Smock also has a weekly meeting with each of his practice departments to discuss special problems or issues specific to those departments. Last, the whole practice holds a morning meeting. It begins 15 minutes before the first patient arrives.

“We trust each other more now,’ Dr. Smock says, ‘we communicate better, and we take our philosophy statement seriously.’ In other words, the entire team shares a vision for success.

Looking to the future

As Dr. Smock acknowledges, there remains much that he and his staff can do to improve their practice. Quality of life for the team has improved greatly, but Dr. Smock knows that things can, and will, get better. As he says, ‘There is a clear sense of commitment on the part of those who have gone through this program and have seen the benefits of the Levin Group Method.’

Conclusion

The changes Dr. Smock and his staff have made over a two-year period are remarkable. Production has skyrocketed 22 per cent, and referrals are up by 18 per cent. This should serve as an inspiration to any practice leader who recognises the possibility of greater success and professional satisfaction, but hasn’t yet figured out how to make it happen.

With the assistance of the Levin Group Method™, Dr. Smock has been able to focus on the integral areas of practice systems, communication skills and leadership, and the practice has grown.

As Dr. Smock knows, help is available, and hope is possible. In his own words, ‘We’ve gone from burnout to dreaming; survival to growth; aimlessness to direction; drudgery to joy; from a group of individuals to a team.’

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About the author

Dr. Roger P. Levin is founder and chief executive officer of Levin Group, Inc., the leading implant practice management firm. Levin Group provides Total Implant Success™, the premier comprehensive consulting solution for lifetime success to implant doctors in the United States and around the world. For more than two decades, Dr. Levin and Levin Group have been dedicated to improving the lives of implant doctors.

Levin Group, Inc.
3640 Owings Mills Boulevard
Owings Mills, MD 21117
E-mail: customerservice@levingroup.com
ADI launches dental implant mentoring database

Adrian Binney, the Welsh representative of the Association of Dental Implantology discusses the benefits of a new mentoring system for dental surgeons

We all see extensive adverts for dental implants in the dental press and patients continue to ask their dentists about the possibilities of dental implant restoration. As dentists, we all have to constantly update our knowledge and skill base in this field. The General Dental Council has been working for some time with interested bodies, including The Association of Dental Implantology, to clarify satisfactory training pathways for dental surgeons undertaking dental implantology. The ADI has been instrumental in helping to formulate these guidelines, which are available online at www.fgdp.co.uk

Essential components of dental implant training, which have been designed by the ADI are the online dedicated implant audit programme, ADIA, which is available live now as a free benefit for members. This fulfils the GDC guidelines regarding the necessity for audit of dental implant work. Additionally, an online postgraduate education programme will be available via a web-based learning programme.

Offering support
One of the main areas highlighted by the GDC and heavily emphasised, is the need to be monitored to ensure a dentist in training is guided appropriately. This has long been part of the dental education process, indeed as students our basic dental education was monitored carefully to ensure we progressed.

There are a number of postgraduate training courses widely advertised by the Universities, dental specialist practitioners, the dental implant companies and via The ADI. But the practicable day-to-day assistance in case assessment, planning and indeed surgical placement are difficult to arrange for the busy practitioner in a format that is suitable for the busy practice environment.

The Association of Dental Implantology has been aware of this and has been working towards providing for its members a selection of mentors who would be able to help in this phase of their dental implantology training. These are ADI members with experience in various systems and experience in a wide variety of dental implant procedures. The database is available via the ADI website. The mentors have been assessed and have all carried out a specific training programme in mentoring dental implantology training.

The database is offered to ADI members at no charge, another benefit of ADI membership. The mentors can be selected by geographic position, implant system or indeed an ADI member could seek out a mentor to help with a specific area of implantology or specific procedure. Once contacted the mentor will guide and advise the training of their colleague. The arrangement of how much or little is required, how and when the two should meet and what appropriate fees would be charged would all be arranged between the two individuals, mentor and trainee.

This is another phase in the development of dental implant training, at which the ADI is at the forefront. Visit the website at www.adi.org.uk.
Maxillary denture retention—
anatomical considerations

Achieving a well fitting upper denture can be quite straightforward and most of us achieve an acceptable result using our standard, tried and tested, technique.

Occasionally however the retention we, and the patient, are seeking is not achieved. This is the depressing moment when after fitting the denture you take your hand away and the denture fails to resist gravity, dropping gently to meet the lower arch.

This article addresses what we are actually trying to achieve when fabricating a well fitting denture base, potential warning signs and how problems may be resolved.

For a denture to fit optimally the following criteria are essential:
1. The denture base must extend properly over the maximum area possible without interference with the surrounding structures.
2. The occlusal plane must be at the correct height.
3. The teeth must be placed within the ‘neutral zone’ between the tongue and the cheeks.

Even if you achieve optimal denture base extension, there are still factors, which can compromise your retention:

1. CLOSE FIT
To be effective the denture base also needs to have a close fit to the underlying mucosa to maximise interfacial surface tension, or ‘capillary surface attraction’. (The viscous force between the denture base and the mucosa quickly reduces as the distance increases. This is a direct result of your impression technique and material used.)

2. SALIVA
The quantity and viscosity of the saliva affects its adhesive and cohesive properties.

3. BORDER SEAL
An effective ‘seal’ round the entire denture border, is essential as this creates retention due to ‘atmospheric pressure’ and the easily recognised ‘suction’ which is the resistance to dislodgement that we use to test retention of our dentures.

Hard palate – the basic support for the upper denture is the two maxillary and palatine bones. The keratinised mucosa over the midline is of varying thickness and critically is at its thinnest in the midline. In this area it is non-resilient and may need to be re-
resorption changes with time, and the pressure placed on it. For this reason the ridge is secondary in support to the hard palate. This can explain why dentures are liable to fracture in the mid-line, and why regular review and relining is so important.

Incisive foramen – Beneath the incisive papillae, this does not resorb and, as it is always positioned just behind the central incisors, gives an indication of the extent of resorption that has occurred.

Maxillary tuberosity – if the maxillary posterior teeth had been allowed to over-erupt prior to their loss there is a good chance of having a large tuberosity. It is not generally necessary to surgically alter these as they can provide significant resistance to rotational or tipping forces. It is, however, important to ensure that the occlusal plane is not compromised.

Lahial vestibule – these are either side of the anterior lateral frenum and running as far as the buccal frenum. It is often assumed that the form, and shape, of the lip is directly controlled by the shape of the lateral flange, this is not the case. It is the position of the necks of the teeth which should have most influence on the lip support, with the flange at its extremity being as thin as possible. Sufficient space needs to be made for the flange to navigate the lateral frenum (by manipulation of the lip during impression taking) as painful ulcers can quickly develop.

Buccal Vestibule – this is the area lying next to the tuberosity and extending from the buccal frenum to the hamular notch. Unlike the lateral vestibule the width of the buccal vestibule is critical. Correct recording of the buccal vestibule is often overlooked, it is however essential in creating the border seal. Problems are associated with recording the buccal vestibule because it changes size, in the same patient, depending on the contraction of the masseter and buccinator muscles and the position of the mandible. The distal portion of the buccal vestibule must be adjusted to accommodate the muscles, the ramus, and coronoid process during the impression. At rest the distal vestibule is at its widest and this is when it should be examined. When the mandible is moved forward or to the opposite side it reduces significantly through influence of the ramus and coronoid process. When the masseter contracts it is similarly affected.

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