Introducing a treatment coordinator: The Bridge to case acceptance

By Lina Craven, UK

You might think that in financially challenging times the last thing you need is a new member of staff. For a practice to thrive and prosper in a difficult financial climate, however, it has to become more efficient, more competitive and more profitable. One way to do that is to introduce a treatment coordinator (TC) into the team or if you already have one then to offer appropriate training. This is a relatively new role to the European market, but in the US, where the role is a central part of any practice, it has proven to dramatically add value to the patient experience, reduce in chair time and increase case acceptance.

The introduction of a well-trained TC will change your entire approach to new patient care, as well as increase profitability. While many practices know how to attract patients, their case acceptance rate is often low. The first contact, first visit and follow-up are the most important elements of the new patient process, yet they frequently represent a wasted opportunity because of a lack of skill, focus, time or all three.

In my experience, a major downfall of practices is the unwillingness of practitioners to delegate the new patient process to staff, or what we call the TC role. This is often due to a wide range of factors, including the practitioner’s perception that the patient wants communication on his or her treatment to come from the practitioner, the perception that patients pay to see the practitioner, a lack of trust to empower staff or time to train staff, and the financial implications of introducing the new role.

Relinquishing new patient management to well-trained staff is not a new trend, although its applicability has been limited in Europe. However, patients’ expectations, competition for private work and the team’s demand for career progression and job satisfaction are key drivers for introducing the TC role.

The TC concept

A TC is someone in your practice who, with the right skills and training, will facilitate the new patient process. He or she bridges the gap between the new patient, the practice and the staff. The TC promotes and sells the practice and its services by demonstrating their true value to prospective patients, frees up the practitioner’s time, increases case acceptance ratios and, resultantly, increases practice profits.

Consider the time spent by the practitioner with the new patient and calculate how much of that time is non-diagnostic. A TC can often reduce up to 60 per cent of practitioner-patient time. Rather than being a barrier to patients—which is indeed what many practitioners perceive to be the case—in my experience, patients actually feel much more at ease with the TC and therefore better informed. Doctor time is not always doctor time. As a typical example: if an new patient appointment is 30 minutes, but the clinical part is actually only 15 minutes, there is potentially 15 minutes still available. Think about the impact an additional 15 minutes for every new patient in the appointment diary could have.

A good TC will manage all aspects of the patient journey, from referral to case start, and potentially increase your case starts. He or she is the first point of contact. People buy from people, so the development of a relationship and establishing of rapport between the TC and the new patient are crucial to the success of your conversion from referral to start of treatment. The TC informally chats to the new patient prior to consultation. This helps not only to foster rapport but also to gain a better idea of the patient’s needs and wants.

I recommend to all my TCs to be present at the consultation to listen and understand clinically what is and is not possible in order to allow the TC to determine how he or she will conduct a top-notch case presentation.

The TC carries out the case presentation, reiterates the treatment options available to the patient, discusses these, answers any questions the patient may have, and clarifies proposed treatment. He or she also discusses the informed consent, shows before and after photographs of similar cases, and addresses any barriers or concerns the patient may have.

The TC also explains the financial options and determines the most suitable payment method for the patient’s needs, as well as prepares the walk-out pack. The value of a walk-out pack should not be underestimated and should reflect the values of the practice, including all information the patient needs, the finance agreement or contract, diagnostic report, photographs of the patient (an excellent marketing tool), informed consent and anything else the practitioner feels adds value to the consultation.

There are no hard and fast rules. It depends upon the size and aspirations of your practice and the qualities of existing members of your team. If you have an individual who fulfils the characteristics of a TC and he or she wants the challenge, then the answer is yes. Keep in mind that you may well need to fill that person’s current position.

Some practices streamline job descriptions allowing them to create the new role without having to hire another staff member. Whether it is a full-time role or not depends upon various factors, including the size of the practice, the number of practitioners, chairs and patients; and the profit aspirations. Many practices implement the role and monitor its progress and impact. This often helps the team to accept the change and gives the practitioner the opportunity to assess any training needs of the TC and to access how remuneration will be affected.

The role of your TC should fit in with your practice’s culture and aspirations for patient care. However, you choose to implement the role, the only guarantee is that you will benefit enormously. Augmenting your team with a well-trained TC can reap tremendous rewards for you, the team and your patients. A TC’s tailored and personal approach to care, follow up and communication with patients fosters trust and increases patient satisfaction and retention.
BDA calls for radical action to lower Britain’s sugar intake

By DTI

LONDON, UK. Lately, there have been increasing efforts to curb Britain’s high sugar consumption. Although the British Dental Association (BDA) has welcomed Tesco’s recent announcement that it is banning high-sugar drinks from its shelves, the association has called for action that goes further than “symbolic” concessions and urged government to follow through on the recommendations of the report by the Scientific Advisory Committee on Nutrition (SACN).

Finally, we’re seeing big retailers waking up to the sugar crisis. That’s progress, but these symbolic gestures should not disguise the fact that supermarkets are still banking on the nation’s sweet tooth.”

D’Mick Armstrong, Chair of the BDA, said.

Tesco’s plans echo recent recommendations in the Carbohydrates and Health Report, published by SACN in July, which advises reducing the daily energy intake of sugars from 10 to 5 per cent. The report also recommends that consumption of sugar-sweetened drinks be minimised and of fibre be increased.

According to the health experts, 5 per cent of daily energy intake is the equivalent of 19 g or five sugar cubes for children aged 4-6, 24 g or six sugar cubes for children aged 7-10, and 30 g or seven sugar cubes for those aged 11 and over, based on average diets.

The SACN findings, established by a group of independent experts that advises government on matters relating to diet, nutrition and health, offer the first wide-ranging look at the relationship between sugar consumption and health outcomes in the UK since the 1990s.

Other national statistics have shown that British children especially are consuming unhealthy amounts of free sugars—the nutrient-free refined sugar added to products such as sweetened drinks—in their daily diet. At 30 per cent, soft drinks accounted for the majority of sugar in the diet of 4- to 10-year-olds, the 2014 National Diet and Nutrition Survey found.

Soft drinks and juices are especially harmful to the teeth, since they tend to be very acidic, which makes the teeth particularly vulnerable to both dental decay and tooth erosion. Aside from posing oral health risks, a diet rich in free sugars has been linked to obesity and Type 2 diabetes, among other conditions.

With reference to the SACN recommendations, the BDA has called for radical measures to cut Britain’s sugar intake, including lowering the recommended daily allowance, and action on marketing, labelling and sales taxes. The BDA has launched an online petition addressed to Prime Minster David Cameron, inviting both health professionals and patients to lend support to SACN’s proposals at Change.org.

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The case report by Burgess, titled “Rare case of amnesia linked to root canal treatment”

By DTI

LEICESTER, UK. In March 2005, a 58-year-old British soldier stationed in Germany lost his ability to form new memories after undergoing a regular root canal treatment. To this day, he is unable to remember anything for longer than 90 minutes, although his brain is completely intact and he suffered no trauma that could have caused the amnesia, according to his doctors.

“I remember getting into the chair and the dentist inserting the local anaesthetic,” the man, who wishes to remain anonymous, told the BBC. “Since that moment, he remembered nothing. Every morning, he wakes up thinking that he is still a soldier stationed in Germany in 2005, waiting to visit the dentist for root canal surgery.

The German dentist only realised after the treatment, which was without complications, that something was wrong with the patient. He was pale, disoriented and struggled to stand up. As his condition did not improve, he was brought to hospital where he stayed for several days. In the beginning, he was not able to remember anything for longer than a few minutes.

The doctors’ first suspicion was that a bad reaction to the anaesthetic had caused a brain haemorrhage. However, they could not find any evidence of injury. Finally, the patient and his family returned to England, where Dr Gerald Burgess, a clinical psychologist from Leicester, took over the case.

According to Burgess, a form of antegrade amnesia would have been the most obvious explanation for the man’s condition. In this case, the hippocampus, the brain region responsible for the consolidation of information from short-term memory to long-term memory, are damaged so that memories can no longer be formed and stored correctly. Yet, the man’s brain scans showed no abnormalities. Thus, another possible explanation would have been a psychiatric illness. Burgess conducted detailed psychiatric assessments in order to determine whether the man had suffered any trauma. However, Burgess found that his patient was emotionally healthy and his wife confirmed that there had not been any traumatic events in the man’s life prior to his dentist visit in 2005. Burgess continues to research his patient’s rare case of amnesia, currently suspecting that the brain’s synapses might play an important role. Each time a memory is formed and transferred to long-term memory the synapses are rebuilt, which involves the production of new proteins. This protein synthesis can be blocked in cases of Burgess’ patient, keeping him from generating any new long-term memories. In order to further research his hypothesis, Burgess is examining five similar cases of mysterious memory loss without brain damage from the medical literature. These cases might provide an answer to why the root canal treatment appears to have triggered the man’s memory loss. All of the cases are in some way related to a period of psychological stress during a medical emergency: “It could be a genetic predisposition that needs a catalyst event to start the process,” Burgess told the BBC.

“One of our reasons for writing up this individual’s case was that we had never seen anything like this before in our assessment clinics, and we do not know what to make of it. But felt an honest reporting of the facts as we assessed them was warranted, that perhaps there will be other cases, or people who know more than we do about what might have caused the patient’s amnesia,” Burgess stated.

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By DTI

HUDDERSFIELD, UK: A University of Huddersfield researcher is harnessing the latest virtual reality technology to help oral and maxillofacial surgical trainees practise complex surgical procedures using Oculus Rift, a virtual reality head-mounted display.

Indian-born Yeshwanth Pulijala is a qualified dental surgeon. During his training, he was confronted with the problem of poor visualisation of dental procedures in the operating room. Being aware of these shortcomings in surgical training, as well as passionate about 3-D design and technology, he relocated to the UK to pursue postgraduate research on the use of advanced technology to improve health care.

During his master’s studies on 3-D medical visualisation at the University of Glasgow, Pulijala created a mobile app called SurFace that provides patient education in corrective jaw surgery. This inspired him to explore the potential of virtual reality for surgical education, using Oculus Rift. A commercial version of the device is expected to be released in the first quarter of 2016. However, Pulijala, who is currently studying for a PhD at the University of Huddersfield, was able to obtain the developer version for his research.

Learning through observation and hands-on participation is an important part of the education of surgical trainees, and medical and dental students, according to Pulijala. “During these sessions the trainees learn by observing the procedures in real-time,” he stated. “But the problem is that not everybody can see what is happening. This is especially the case in crowded operating rooms where surgical trainees perform multiple duties. Also in surgeries confined to oral and maxillofacial zone, as the structures are complex and densely enclosed in a confined space, it is very hard to observe and learn. Further, a reduction in surgical training hours is severely affecting the training of surgeons,” Pulijala pointed out.

As a result, he continued, four out of ten surgical trainees are not confident in performing a procedure. Therefore, he is developing a tool that enables them to participate virtually in an operation. His PhD project aims to provide trainee surgeons with close-up, unrestricted 360-degree views of a surgical procedure, yielding the potential to improve surgical training substantially.

“If you are a trainee surgeon, wearing an Oculus Rift, you will see the surgical procedure in an operating room environment and also be able to ‘touch’ the skull of the patient and interact with it,” Pulijala said. He is currently developing the project concept and producing working prototypes. In the longer term, he envisions a system that will enable surgical trainees to practice and perform virtual operations. “But at the moment it is about creating a high-quality visualisation, interacting with the patient’s data and seeing their anatomy in great detail,” he concluded.
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