But whose evidence?

Why clinically derived research shouldn’t be ignored

By Larry W. White, DDS, MSD, FACD

It takes only a short time for some popular phrases to transform into cliché. Back in the late 1960s and early ‘70s, one such cliché that all commentators and writers with “gravis” used too frequently was “living life on the cutting edge.” This clearly implied that unless people engaged in unusual, risky and even unproven behavior, their lives lacked conviction and high purpose. Writers and speakers who favored and promoted this exciting call to action also suggested that those who failed to live life on the cutting edge had somehow sacrificed their God-given innovation and curiosity for intellectual and spiritual stupor.

But was this a fair assessment of more socially conservative people who lived comfortable, productive and somewhat predictable lives away from the so-called frontiers of progress? Of course not, and that general appreciation probably contributed to the phrase’s quick loss of potency and degeneration into a cliché that no longer holds much relevance.

Dentistry has recently coined a phrase that, for me, has quickly turned into a tired, impotent and overused slogan: evidence-based dentistry. This has evolved as a mantra of academia because scientists rule in this environment and have opportunity to engage in objective studies that limit the force of extraneous influences.

Professional journals and organizations have eagerly hoisted this new banner and dedicated entire issues and conferences to its primacy. But the implication remains that prior to this new dedication to evidence, dentistry operated by myth and magic. This impugns the integrity, dedication and usefulness of previous efforts to discover the truth of professional matters and denigrates the developments and applications of our collective experience.

Retention you can depend on

New Vivera retainers challenge traditional ways of thinking by offering four sets instead of one

By Joanna Farber

You have just spent approximately 18 months getting Jimmy’s teeth perfectly aligned. Now it’s time to work on retaining his beautiful smile for years to come.

Orthodontists are in wide agreement that effective retention is a critical factor in maintaining treatment results — so you know you need something that will really work. You could go with a traditional retainer and hope Jimmy wears it as directed. Or you could try something new.

Enter Vivera™ retainers. The subscription-based program introduced by Santa Clara, Calif.-based Align Technology, Inc. in late 2007 challenges the once-held theory that one retainer is enough to prevent relapse. With Vivera retainers, patients receive four sets of fresh retainers over time.

When Align Technology, makers of Invisalign aligners, explored the dental retainer field, its researchers found that retainer materials lose their ability to deliver force over time, and can fail or break down by warping, tearing and cracking after as little as two to three months of normal daytime use.

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Part 2

To briefly review the resources management dimension of any organization, which certainly can be applied to our orthodontic office management, an effective administrator must have three basic traits:

1. Technical skills for the mechanistic part of the job are often more applicable for larger companies (and/or offices) where the CEO has extensive competent assistance and experience, whereas the orthodontists, who are (a) supervisors, managers, and leaders who should be able to achieve high productivity with low cost, turnover and absence, as well as striving to gain the highest level of employee satisfaction. Such leaders often demonstrate a different pattern of management from those who achieve less impressive results, and (b) managers who are high-producers, sometimes deviating from existing theories by creating improved technical procedures and integrating individual principles into a management theory of practice.

2. Human skills in working with others, which are necessary for effective and cooperative relationships within a group. These human skills can be further subdivided into (a) leader-ship ability within the manager’s own unit, and (b) skills regarding inter-group relationships. Orthodontics as a whole, but often is accompanied by mediocre performance in the other.

3. Conceptual skills are necessary for recognizing the interrelationship of factors that led to taking all necessary actions for achieving the maximum good for the organization. This depends upon a specific way of thinking and involves: (a) emphasis and priority on conflicting objectives and criteria; (b) tendencies and probabilities, not certainties; and (c) correlations and patterns of elements, not clear cause-and-effect relationships.

These three skills vary with each administrative level of responsibility. In lower levels, technical and human skills are needed whereas higher levels require human as well as conceptual skills, and in top levels, conceptual skills are most important for successful administration.

These skill requirements also suggest that good administrators are not born, but develop and transform the need for identifying specific traits in order to provide a better way to visualize the administrative process. Identifying such skills that are required at various levels of responsibility can be useful in selecting, training and promoting executives.

In describing the resources management dimension of the typical orthodontic office, we, too, develop and provide a combination of managerial and CEO attributes. As orthodontists, we are (a) leaders, supervisors and managers, who should be able to achieve high productivity with low cost, turnover and absence, as well as striving to gain the highest level of employee satisfaction. Such leaders often demonstrate a different pattern of management from those who achieve less impressive results, and (b) managers who are high-producers, sometimes deviating from existing theories by creating improved technical procedures and integrating individual principles into a management theory of practice. Orthodontists are often aware of how our practices differ, but understanding the reasoning of such differences is what makes them successful.

In 1967, Dr. Rensis Likert published “The Human Organization,” describing (a) how to understand the difference in styles of various companies, and (b) how these styles affected the bottom line. He coined the term “organizational climate,” and this was later revised as “culture.” According to Likert, the most important behavioral issues in all organizations are supportive relationships and making sure the people involved have self-fulfillment. When not fulfilled, people will avoid doing their jobs. For example, a company that is not successful may be successful in his or her department, but the overall result may not be as good for the organization as a whole. The same principle applies to the practice of orthodontics.

Dr. Peter Senge’s “Five Disciplines” are basic to understanding all individual communities or groups, and apply to the orthodontic office:

1. Systems thinking — the corner-stone of organizational learning: the ability to comprehend and address the whole, as well as to examine the interrelationship between the parts, provides both the incentive and the means to integrate all disciplines.

2. Core disciplines — four component technologies, or a series of principles and practices that we study, master and integrate into our lives as one of three levels: (a) practices — what you do; (b) principles — guiding ideas and insights; and (c) essences — the state of being a leader with high levels of mastery in the discipline (Senge, 1990, p. 575).

3. Mental models — deeply ingrained assumptions, generalizations or even pictures and images that influence how we understand the world and how we take action (pp. 9).

4. Shared vision — the position that if any one idea about leadership has inspired organizations for thousands of years, “... it’s the capacity to hold a shared picture of the future we seek to create. Such a vision has the power to be uplifting — and to encourage experimentation and innovation.” (p. 9).

5. Team learning — the process of aligning and developing the capacities of a team to create the results its members truly desire, building on personal mastery and shared vision. People must act together in concert, not only for the best interest of the organization or office, but those same individuals will develop into better employees much more rapidly (p. 10).

In describing the resources management dimension of organizations, Dr. James Caraway stated that the “Sixth Discipline,” known as “relational reality,” added a necessary dimension to Senge’s “Five Disciplines,” being basic to the outcome, sine qua non, for greater understanding of individuals, communities or groups, or even our own personal practices. It brings the assurance that the individual-in-relation and the organization as a whole are dialectically understood, both the individual and the organization are understood as necessary and necessarily related partners. The sixth discipline confirms the importance of the individual and personal fulfillment within the group or community.

According to Caraway, Senge observed: “The five disciplines now converging appear to comprise a critical mass. They make building learning organizations a systematic practice, rather than a matter of happenstance. There will be other innovations in the future ... perhaps one or two developments emerging in seeming unlikely places or styles, and lead to a whole new discipline that we cannot even grasp today” (Caraway, 2005, p. 87).

(For more, read Part 3 in November’s issue of Ortho Tribune.)
AAO confronts crisis in education

ST. LOUIS — Through its Task Force on Recruitment and Retention of Faculty, progress is being made in the American Association of Orthodontists’ (AAO) quest to seek long-term, sustainable solutions to the crisis in orthodontic education.

“We are beginning to realize our goal of putting realistic and lasting solutions in place to address orthodontic faculty recruitment and retention,” Task Force Chair and AAO Past President Donald R. Joondeph, DDS, MS, said.

First steps

The Task Force’s first initiative, implemented in the AAO’s 2006-2007 fiscal year, was disbursement of $2 million to augment salaries of full-time faculty at accredited post-doctoral orthodontic programs in the United States and Canada. One-time awards of up to $50,000 were distributed to 142 orthodontic faculty members in recognition of their contributions to the specialty and as an incentive to remain in orthodontic education.

More measures implemented

AAO efforts during its 2007–2008 fiscal year secured commitments for more than 60 years of teaching through a new initiative: full-time faculty teaching fellowships. Eleven faculty members received two- or three-year fellowships. Fellows receive $50,000 for each year of the fellowship and must commit to teaching a number of years equal to the length of the fellowship. Two-year fellows must teach a total of four years. Three-year fellows must teach a total of six years. The 2008 AAO House of Delegates extended this initiative for new fellowships that will range from two years to five years, yielding four to 10 years of teaching per fellow.

The Task Force is launching a clearinghouse on faculty job opportunities on the AAO’s member Web site, AAOmembers.org, to make these positions known to a wide audience. A presentation on academic careers was developed for orthodontic students and residents as they consider their post-graduation options.

In addition, the AAO Foundation (AAOF) has made significant contributions to orthodontic education for more than a decade. Since 1994, $6.9 million in endowment earnings from the AAOF’s “A Case for the Future” campaign have been awarded to support orthodontic faculty, teaching fellowships and research. The AAOF has made it possible for many educators to remain in the classroom.

(Source: AAO)

OSAP winners announced

ANNAPOLIS, Md. — The Organization for Safety and Asepsis Procedures (OSAP) announced the winners of its I See IC Contest during a red-carpet event at the OSAP Symposium in Palm Springs, Calif., on June 13.

The contest was designed to promote infection control and safety by inviting dental professionals to create attention-getting videos and photos. A DVD is being created that will include the finalists’ entries and additional material.

Winners for the contest were:

• Best Comedy: “Beauty Pageant for Gloves,” submitted by Leslie Canham
• Best Drama: “Infection Walks Loose,” submitted by Joab Montes Garcidueñas
• Best Infection Control Message: “Proper Placement of PPE,” submitted by Philip Kim and Jasrit Pahal
• Most Creative: “A Long Journey,” submitted by Piedad Hernandez Ramirez

In addition, $1,000 in cash was given to the best video and the best still photo. The award for Best Overall Video went to “Are Both the Same,” submitted by Rene Rodriguez Romero. The award for Best Still Photo went to “Her Highness,” submitted by Sharon Beans.
The missing element to complete care

Part 3

By Joy L. Moeller, BS, RDH, COM
(Certified Orofacial Myologist)

(In Part 2, we discussed how oro-
facial myologists can assist the ortho-
dontist, and we delved into detail
about a habit elimination therapy. Here is a look at four other types of therapy.)

The Mini-Myo program for the young child

Many times, young children can benefit from doing exercises to develop positive growth factors and eliminate negative growth pressures. The young child program has to be fun and fast in order to achieve success. Because the bones are soft, the changes can be remarkably fast. I use a variety of rewards and behavior modification techniques. Parental support at home is essential. The young child program lasts about three to six months and can make a major life enhancing change.

Goals of the Mini-Myo program are:

• encourage nasal breathing,
• develop a lip seal,
• encourage bi-lateral chewing,
• work on proper sleep posture as well as eating posture,
• introduce the “bite, sip and swallow back” motion,
• keep hands and objects away from the face.

Orofacial myofunctional therapy

This is my standard program for children 7 through 97. It consists of a year-long program of therapy exercises of the facial muscles and includes:

• noxious habit elimination,
• many different therapy exercises to stretch, tone and develop proper neuromuscular proprioception of the facial muscles,

• introduction of the proper chewing and swallowing patterns,
• development of proper head and neck posture,
• habituation of the new patterns.

The first eight weeks of treatment is the intensive period, followed by habituation of the new pattern.

Special-needs patients and TMD

These patients need an individualized program based on their physical limitations, pain factors and ability to cooperate. The treatment plan always needs to be individualized for the best result possible. The goals would be the same as the other programs, but the methods are customized to meet the needs of the patients. The patients really appreciate this help that no other specialty has been able to provide. Some patients with special needs afflicted with incorrect muscle patterns would present:

• TMD,
• autism,
• cerebral palsy,
• Down syndrome,
• attention deficit disorder,
• Bell’s palsy,
• orthognathic surgery,
• trauma-induced muscle abnormalities,
• Sturge Weber syndrome.

Cosmetic muscle toning for facial fitness

With age, orofacial posture changes. There are about 40 facial muscles that work in group function. This allows for facial expression. If the patient presents with chronic non-nutritive facial muscle habit patterns, inadequate orofacial postural patterns, orofacial muscle function patterns or orofacial muscle integration patterns, then the overall cosmetic appearance will be compromised in spite of cosmetic surgery or orthodontics.

Plastic surgery patients are tired of having their face cut, burned, injected, creamed and acid etched only to have gravity pull the muscles down again. The more effective way to achieve desired results would be to develop tone and fitness in the facial muscles by changing muscle patterns, habits and postures by a trained orofacial myofunctional therapist and work with both the surgeon and orthodontist before and after surgery.

A personal trainer will tell you that you have to stretch, lift weights and do cardio three to four times a week in order to be fit. Why not exercise your face as well? I feel this type of treatment will be the way of the future for orofacial myofunctional therapists.

Orofacial myofunctional courses, certification

For speech and language pathologists, dental hygienists, physical therapists, registered nurses and other allied health care professionals, there are four or five post-graduate courses available to become an orofacial myofunctional therapist. Certification is available through the International Academy of Orofacial Myology, For more information, check out the IAOM Web site, www.IAOM.com.

Practicing OMT guides patients to make major life-enhancing changes, which affect their entire body. After 50 years of practicing and teaching courses in OMT, I view the profession of OMT as a specialty of its own, working parallel with orthodontic treatment and being the critical missing element to complete care.

(Both the reference list is available from the publisher.)

About the author

Joy Moeller is a certified orofacial myofunctional therapist and a licensed registered dental hygienist. She is in private practice in Pacific Palisades and Beverly Hills, Calif. Moeller is a former associate professor at Indiana University School of Dentistry and an ongoing guest lecturer at USC, UCLA and Cerritos College. She attended the Myofunctional Therapy Institute in Coral Gables, Fla., and the Coulson Institute in Denver, Colo., and studied with Dr. Mariano Rocabado, Santiago, Chile, on head and neck posturing. She is a founding member of the Academy of Orofacial Myofunctional Therapy and has taught courses at USC, the Gutenberg University and Freiberg University, both in Germany, among other locations.

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Evidence

This insinuation also diminishes other clinicians’ ability to formulate evidence, because reductive research processes, so useful in the laboratory, prove difficult in clinical settings. One must invoke objective evidence as the raison d’être for our professional beliefs and practices can prove harder than its zealous advocates realize. And this provides opportunities for clinicians to add valuable experience to any debate.

Consider the studies of shear bonding strengths of various luting materials. Some researchers found composites to be stronger bonding materials, while others found resin-in-reinforced glass ionomer cements equal or superior. Whose evidence should clinicians accept?

At this point, clinicians can certainly lend credibility and clarity to the evidential process by trying them in their own environments. In fact, clinical experience provides the ultimate confirmation doctors need for deciding whether to use a particular product or process. All other evidence assumes a secondary role.

Clinical applications certainly contain fallacies, and many therapies work in spite of themselves rather than because of their efficacies. One need consider only the countless remedies published regarding temporomandibular dysfunctions. Even a cursory examination of many of those cures will reveal the specious physiological and anatomical bases for their applications.

Nevertheless, the profession needs to recognize that not every valid and useful progression has to evolve from an academic research facility. Clinicians, along with dental supply companies, have much to offer, and we need to acknowledge those efforts. Never-theless, we must also acknowledge the roles clinicians and corporations play, and we must promote more cooperation while foregoing exclusion simply on the basis that one doesn’t have sufficient statistical evidence.

Bertrand Russell said, “There is an unbridgeable gulf between knowledge by description and knowledge by acquaintance and no way of going from one to the other.” (i.e., there is no substitute for experience.)

I agree with Russell, and in orthodontics, the clinician supplies the knowledge by acquaintance. (The reference list is available from the publisher.)

Recently, the Journal of the American Medical Association sanctimoniously demonized some technologies and the companies that develop them, further declaring industry-sponsored research untrustworthy and unpublishable unless written by an academic researcher who will take responsibility for it. An editorial from the New York Times also advised physicians to exercise a cautious skepticism about any industry-backed studies. These messages could not have a clearer meaning: Health professionals can trust scientific researchers to display a selfless devotion to discovering the truth, while corporations will devote their efforts to enriching themselves at the expense of those who prescribe and use the products.

However, in a Sept. 8, 2005, article in the New England Journal of Medicine, Dr. Thomas Stossel reported, “No systematic evidence exists that corporate sponsorship of academic research contributes to misconduct, bias, public mistrust or poor research quality.”

In orthodontics, no one has a clearer reason to fear that patients and doctors need more than clinicians, and that accounts for a preponderance of the diagnostic and therapeutic processes to be driven by them through corporations. Clinicians have developed every popular treatment planning protocol orthodontists use today, e.g., The Tweed Triangle, The Stein Analysis, The APO Line, The Visualized Treatment Objective, The Radney Line and The A Line. Practically every therapy ever developed has had a clinical genesis or collaboration, e.g., headgears, bands, brackets, adhesives, functional appliances and elastics.

I don’t offer this screed to excoriate academia — far from it, because I belong to an orthodontic department faculty. All of us profit from the discoveries made in universities, and we need to support those efforts. Nevertheless, we must also acknowledge the roles clinicians and corporations play, and we must promote more cooperation while foregoing exclusion simply on the basis that one doesn’t have sufficient statistical evidence.

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...
Structuring dynamic meetings

By Scarlett Thomas
President, Orthodontic Management Solutions

Take your practice to the next level of success by working on the practice, not just in it. If you no longer have staff meetings because of complaints (“We’re too busy,” “Nothing was ever prepared,” or “The meetings were just gripe sessions.”), see what a little structure can do.

Meetings are the most efficient way of making sure that everyone is on the same page. Productive meetings can be used to resolve issues, implement new ideas, minimize gossip, encourage staff to take a more proactive role in the business, engender buy-in for practice values and, generally, make coming to work each day more enjoyable.

There are five meeting types — morning huddles, evening huddles, goals and budget reporting, training and business development. Because everyone is responsible for practice success, everyone should attend all meetings to understand where the practice is headed and areas that may need improvement.

Each meeting must have a facilitator and someone who takes notes. Facilitators develop meeting agendas and run meetings. One week prior to meetings, facilitators should type agendas based on topics the staff and orthodontists submit. During meetings, note takers document major ideas and decisions on flip charts so everyone can agree to the outcomes.

Daily morning huddles
Convene morning huddles 10 to 15 minutes prior to the start of business. Have each staff member report on assigned items related to that day’s activities, e.g., delinquencies, cases overdue in treatment, difficult patients, medical alerts, starts and consultations scheduled, scheduling availability and lab appliances due. Having everyone report on an item keeps staff members interested.

Daily evening huddles
Convene evening huddles immediately after patients leave. Reflect on the day’s challenges and achievements. Cover charting, new patient starts, received delinquencies, number of care calls that need to be made, how problem patients were handled, daily production and collection activity, etc.

Twice-monthly training meetings
Hold separate training meetings twice monthly for front office and clinical staff. The front desk should review patient service policies, proper phone protocol, return call timeliness, ways of managing difficult parents and scheduling, etc. The back office should continually review proper impression taking, radiography, photography, and bonding techniques and wire sequencing, etc.

Monthly goals and budget meetings
Hold this meeting for roughly two hours during the first week of each month. The first part is for information sharing: the previous month’s success versus goals and the current month’s goals, including departmental budgets, collections, production, case acceptance, new patient starts, referral sources, etc. Transition the meeting to idea-generating to address challenges. Deliver bonuses and awards during this meeting.

Quarterly business development meetings
Business development meetings should cover all major issues. Hold them quarterly and use their outcomes as the game plan for continued achievement. Topics should cover marketing, patient service, new equipment, team-building, remodeling, systems implementation, consulting services needed, fees and upcoming conferences.

Conclusion
Keeping everyone in the practice apprised of how the business is doing is the best way to ensure continued practice viability. Involving staff in problem solving puts everyone’s experience to use and helps create loyalty and dedication.

To learn more about how to structure meetings or implement effective practice systems, attend Orthodontic Management Solutions workshop Nov. 7-8 in San Diego. Visit www.orthoconsulting.com for more information and to register.

AD

Scarlett Thomas is an orthodontic practice consultant who has been in the field for more than 23 years, specializing in case acceptance, team building, office management and marketing. As a speaker and practice consultant, she has an exceptional talent to inform, motivate and excite. Contact her by phone at (858) 435-2149 or by e-mail at scarlett@orthoconsulting.com.

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The right way to market an ortho practice

By Roger P. Levin, DDS

How do you know if you are implementing the right ortho marketing strategies? Could you be doing more? In today’s sluggish economy, how can you maximize your efforts?

Talking with a new client, I was dismayed to learn he’d spent several years and tens of thousands of dollars on external marketing efforts that generated only minimal results. The proper program, along with excellent management systems, can predictably increase practice production by 50 percent or more. By marketing to referring doctors and patients, you can attract new patients and experience unprecedented growth.

Case study

Jim was a 11-year-old orthodontist who had been in practice for four years. He had engaged a general marketing firm to create his corporate identity through business cards, stationery and a practice brochure. The firm also provided advertising and direct mail services and charged the right identity through business cards, stationery and a practice brochure. Jim had done absolutely nothing in regard to meeting or getting to know his referring doctors and was attempting to build his practice strictly on corporate identity, direct mail and advertising. I immediately explained to him that I doubted the approach was going to be completely effective. Here’s why:

- Corporate identity marketing doesn’t work by itself. The development of a corporate identity — business cards, stationery and a brochure — is necessary, but will almost never attract patients. I have always contended and still believe that the simplest logo in the world will attract almost the same number of patients as the one that costs $10,000 and takes six months to design specifically.

- Am I saying you don’t need a corporate identity? Of course not. These materials are a necessity for any orthodontic practice, but they repre- sent a passive approach to marketing and should be used in conjunction with more active forms of marketing, especially referral marketing.

- Direct mail is ineffective. Direct mail firms will tell anyone that there is a 1.5 percent or greater return on direct mail and that the customers will gain a return on investment. While that sounds good, in the last 25 years, I have seen most of these campaigns in orthodontics fail. Direct mail also can be extremely expensive in terms of design, printing, address lists and postage costs. And still, after spending a lot of money, there is no guarantee you will achieve the coveted 1.5 percent response rate either, which still means 98.5 percent of your marketing efforts are being wasted.

- For orthodontic practices, direct mail is a risky way to attract new patients and can waste a great deal of time and money.

- No referral marketing was being done. Jim was not doing any marketing directed at his referring doctors. The one, almost guaranteed approach to building orthodontic practices is marketing to referring doctors combined with marketing to patients. When I use the term “referral marketing,” I am referring to using proven strategies in a consistent marketing program managed at all times by a professional relations coordinator (PRC).

- Predictable marketing, dependable results

Orthodontics is different from other types of businesses. Companies such as L.L. Bean and Land’s End live and die by catalogs and Internet marketing. Orthodontists, on the other hand, depend on referrals from doctors and patients.

What’s the best way to gain new patients? Identify current and potential referring doctors in your area and begin marketing to them. As I discuss in my Total Ortho Success Seminars, the secret of referral marketing lies not only in the quality of marketing but also in its quantity. Most referring doctors do not respond to one or two attempts to gain their referrals. Instead, it’s a gradual process of attracting doctors over a six-month period.

The potential for dynamic growth

Jim, the doctor in our case study, had been wrongly advised by another orthodontist to not bother with referring doctors. He was told referring doctors are uninterested, unap-
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On Sept. 15, I spoke with a doctor from Westchester County, N.Y., and he was one of several persons who mentioned the Lehman Brothers investment bank collapse. He told me his practice is in the heart of Lehman country, and he is preparing his practice to weather the storm.

I wanted to tell this doctor that everyone is in Lehman country, but I knew he was on the front lines of this particular crisis and he deserved special consideration.

With the failure or near failure of three storied financial institutions (Bear Stearns, Merrill Lynch and Lehman Brothers), the U.S. economy is now struggling through the most significant financial crisis since the Great Depression.

In truth, everyone I talk with is feeling the effects of the tightening of credit and the loss of consumer confidence. One large orthodontic supplier reported its volume is down 20 percent this year to date, while another multi-practice executive reports that doctors who once had August and July net sales of $50,000 per month were in a cash crisis this year without enough money to pay their overhead.

Today's economy is taking a toll on all procedures consumers consider "elective" or "optional." The impact comes from two primary issues: 1) consumer's concern for their financial future — we don't spend money on "optional procedures" when we have financial insecurity; and 2) the lack of available credit or the inability to borrow money on terms that are acceptable.

So what can you do and what should you do to protect your practice during these tough times? Here are a few specifics.

Make sure your cash position is solid

Remember cash is not just king, it is everything. Businesses fail (no matter how successful they have been) because they run out of cash.

Have a cash plan. Too many doctors are in the habit of spending cash when it is available in their bank account, and they don't do a great job of planning for their future needs. If you don't like managing money, get help now.

Review your monthly expenses for the past 12 months — list payroll, office overhead (rent, utilities, etc.), supplies and other fees. See if there is a pattern (Increasing? Decreasing?) and if there are certain months of the year when expenses are higher or lower. Use this information to create an estimate of the cash you will need for the coming year (month by month).

Open two banking accounts — an operating account where you will deposit revenues and keep enough cash to pay one month of expenses (including your salary), and a second savings or money-market account where you'll keep enough cash to meet your operating needs for three months. This second account should be an interest-bearing account.

Review your cash position every month. If your cash exceeds your planned need, feel free to pay yourself a dividend. If your cash on hand is less than you'll need, react quickly to increase cash by:

- Increasing the discount you offer patients who pay in full.
- Encouraging more of your patients to finance their procedures via a third-party financing company.
- Offering your accounts a discount for paying off their balance early.

In June, our children's dentist offered us a 20 percent discount for paying off our balance early — I showed up to the next appointment with a check in hand.

Have a back-up plan. Apply for a business line of credit before you need it. Too many practices wait until they are in a cash crisis before they apply for a line of credit. The best time to get a line of credit is when you don't need it.

Increase new starts by focusing on patient-friendly financing

As times get tough, your patient
financing options have a greater impact on your ability to win new cases. Your competitiveness is not just other doctors and their payment options, but often you’re competing against the patient’s financial fears that encourage them to not start “elective” procedures now.

**Money is never an issue**

Nevada dentist Dr. Jed Feller of Las Vegas has built a practice that has been virtually recession proof. After six months of owning his practice, his monthly production grew by more than $100K. By the end of the first year, his monthly production was up $200K. Today his practice produces more in two months than it did the entire year before he purchased it. Dr. Feller used no marketing — he didn’t even purchase a yellow pages ad. What did he do? He made his patients think “money is never an issue.”

Of course money is an issue. The one question that is foremost on patients’ minds during the whole process you want and need?”

Sometimes money is never an issue. And yes, “elective” procedures now.

**Talk solutions.** Make sure the person presenting fees for your practice understands his role — not to talk money but rather to talk solutions. He needs to understand he is there to help the patient (or parent) get what he or she wants — excellent treatment.

**Always gather credit information** (a credit report or, even better, an A+ credit grade) so if your patient is one of the 70-plus percent of the population that will pay their bills if extended payment options or one of the 30 percent who are likely to leave you wondering you had never trusted them.

I have met many doctors who say “I’ve been successful for years, and I’ve never used credit reports.” I simply remind them we are in one of the toughest economies in recent history, and banks who have done great business for more than 100 years are now gone.

**Be transparent about your fees and payment options.** If you don’t show them your “cards,” the patients feel like they are in a negotiation and they act accordingly. For most people, open and honest, non-manipulative dialogue will win clients now and strong patient advocates in the future.

**Present fees in a way that puts the focus on payment options.** Make sure your patients know that these are “some of the options available to them,” and that your goal is to “find a payment plan that will work for them.” Then ask, “Which of these options is closest to the way you’d like to pay for treatment?”

**Start from that option and find out what needs to be changed to make that option work for them.** Acceptx stores rules and limitations for these discussions and allows the computer to be the “bad guy” when a patient asks for a payment solution that is beyond the limits allowed given the patient’s credit grade and the practice’s business rules. Without such a program, your staff should be coached to guide patients toward a win/win payment solution.

**Offer financing beyond treatment time for qualified patients.** Patients who have an “A” credit grade do not care if they are being treated or if they have been treated — they are responsible citizens and they pay their bills. If your practice can handle the cash flow challenges of extending payment beyond treatment time, do it. If not, find a third-party financing partner who will work, remember, most of us shop within a budget. Budget-minded patients are not always poor credit risks; in fact, they are often better risks because they are realistic about what they can afford each month, and they don’t stretch beyond their budget.

**Break up treatment.** If the patient can’t or isn’t willing to pay for the entire treatment at once, offer incremental treatment with “pay as you go” payment options.

These are tough times, but the factors driving consumer demand for your procedures are alive and well. In these tough times money matters like never before. Those practices that learn to manage their cash and that help their patients find solutions to their financial concerns will succeed — even as Wall Street banks continue to fail.

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**About the author**

Brett Blake is president and CEO of Utah-based Acceptx. He is also a partner in the Zuelke Lehrman Group Council. He earned an MBA from the Harvard Business School and graduated cum laude from Brigham Young University. Blake is available to lead study group discussion and can be reached at bblake@acceptx.com or (801) 797-8600.
Maria Merritt is the director of sales and marketing for DentalBanc and OrthoBanc, LLC. She has more than 20 years of experience in credit reporting and payment management.

What type of service does your company provide to orthodontists?
OrthoBanc provides risk analysis and payment management. Patient payments are electronically drafted from the patient’s checking, savings or credit card account. OrthoBanc also handles all patient contact regarding failed payments, expired credit cards, balance inquiries and special circumstances. OrthoBanc’s services are integrated with practice-management software companies to make it easy to set up accounts and post monthly payments. (OrthoBanc is currently integrated with Advanced Ortho Systems, Dolphin Management, IMS, MacBraces, Ortho II and topsXtreme.) OrthoBanc also offers online single payments through TeleVox’s T.LINK.

Do you have anything new to tell us about?
OrthoBanc recently introduced credit bureau reporting and collection service integration. This is something our customers have been asking about for a while, so we’re very pleased about the opportunity to meet that need.

Tell us how the collection service integration works.
Offices can select from three levels of collection services, and the collection follow up will be performed by a reputable third-party collection agency. If accounts are not paid within 30 days, they will be reported to all three major credit bureaus. Accounts are set up through the OrthoBanc Web site, making this an easy solution for our customers.

Is this an affordable solution?
For less than the monthly cost of a single credit bureau membership, orthodontists can report accounts and have them professionally collected. OrthoBanc charges a $50 monthly fee, which provides the integration with the agency, the ability to turn accounts over for collection, detailed reporting of collection activity and the ability to report accounts to the three credit bureaus. Collection rates for the three collection levels also are considerably lower than the rates charged by most collection agencies.

How do you think integrated collection services benefit an orthodontic practice?
This new OrthoBanc service encourages swift payment through demand letters from a collection agency. Credit bureau reporting also is very important because consumers know the importance of protecting their credit. Practices have been asking for these services, and OrthoBanc is excited about filling this need while offering discount collection rates exclusively for OrthoBanc clients.
Take Your Practice to the Next Level.

At Orthodontic Management Solutions, our philosophy is to treat your concerns as if they were our own. We will work hard to give you more than you expected, not only in the programs and services we offer, but in the results that these programs were designed to produce.

Whether you’re a new graduate ready to open your own office, or a seasoned orthodontist looking to improve systems within your practice, we have the tools to work with you.

- Increase Your Case Acceptance
- Train Your Treatment Coordinator
- Build a Successful Schedule
- Improve Your Management Skills
- Create Effective Systems that Work
- Market Your Practice for Success

What Our Clients Are Saying About Us

“As a result of Scarlett’s efforts and my decision to hire her as a practice consultant, my number of starts has improved, my production and collections have improved, my staff is more unified and most of all, I am having more fun as an orthodontist. If I could only convince her to work for me full time.”

Peter T. Kimball, DMD, MS

“Scarlett’s intimate understanding of every aspect of an orthodontic practice has impressed every member of our organization. The most impressive aspect of her many skills is to see how she trains staff, delegates responsibilities and puts into place the tools to monitor progress. Having great ideas is one matter, but having the ability to implement those ideas and consistently achieve the goals set is a priceless business asset.”

Faisal Naveed, CEO Orthoease

“After just one year of focused marketing, Scarlett has made our satellite office more productive than our main office! She has proven herself to be an asset to the practice. I would consider any office lucky to have her help lead their team.”

Victoria J. Lynskey, DMD, MSce

About Scarlett

Scarlett Thomas is an orthodontic practice consultant who has been in the orthodontic field for over 23 years, specializing in case acceptance, team building, office management and marketing. As a speaker and practice consultant, Scarlett has an exceptional talent to inform, motivate and excite.

After implementation of her concepts into your practice, Scarlett invites you to experience not only tremendous growth and increased income but a well-organized practice.
Since the foundation of the orthodontic profession, there has been one fundamental assumption: Malocclusion, in particular crowded teeth, is caused by lack of space for those teeth (usually anteriors) to align correctly.

From the initial expansion techniques practiced by Angle and even Tweed, there became a wave of extraction-oriented techniques prompted by Tweed and Begg’s theories in the 1950s. According to Angle, this shift to the “unethical practice of orthodontic extractions” was pushed forward in the quest to improve stability.

However, now in 2008, there is little evidence to verify this assumption was actually evidence based. Begg had an interesting theory of the cause of malocclusion based on the study of Australian aboriginal skulls and wrote extensive volumes to support this. If his theory was correct, then four bicuspid extractions would have provided sufficient space, and the remaining dentition could then spread out into correct alignment for life.

A study of extraction cases, now many years out of retention, would confirm crowding is as bad as, or perhaps worse than, pre-treatment in these cases. Certainly the Little studies are a thorn in the side of the “extraction equals stability” theory.

The popularity of removable expansion appliances promoted as an alternative to the great debate over the last three decades has prompted a renewed interest in non-extraction techniques. However, stability is still no better with GPs and orthos alike (with the self-ligating brackets) resorting to permanent retention for stability.

Glue is a very unscientific way of saying, “Maybe the teeth will be driven back to their original position,” whatever the skill of the orthodontists or the technology in the brackets.

Does the theory, “Malocclusion is caused by the teeth being too big for the jaws,” need scientific re-examination? If it were correct, the holy grail of stability would have been achieved on a consistent basis.

The new soft-tissue theory of malocclusion

What if the problem has nothing to do with the teeth and arch size at all? What if malocclusion emanates from an imbalance of the soft tissues that surround the very structures that so much research has been devoted to over the past century?

The dysfunctional forces of the tongue and lips drive the malocclusion and will perpetuate it until they are rendered functional.

Although retraining this soft tissue dysfunction has proven difficult in the past, when it is corrected, do we see a stable orthodontic result? The answer is an astounding yes.

Study of a normal occlusion indicates normal function is consistently associated. Severe malocclusion equally has severe oral habits. The author proposes we adopt a new theory of malocclusion based on soft, not hard, tissue and suggests we look objectively for the hard evidence.

We can no longer rely on the quality of bonding agent and longevity of retainers to hold together an outdated orthodontic theory. A future article will explore a clinical approach based on this new myofunctional theory of malocclusion. Testing the hypothesis objectives is the only scientific way forward.
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Agenda: Day 1

8:00am-12:00pm
Mastering The New Patient Exam
- The One Step Start
- How to Increase Case Acceptance
- Educating and Motivating the New Patient
- Scripting for the Entire New Patient Process
- Creating a Successful “Will-Call” System
- Having an Effective “Recall” System
- The New Patient Exam as a Team Approach
- Role Playing
- Presenting Fee’s
- The Importance of the Initial Phone Call

1:00pm-4:00pm
Top Notch Management
- The Hiring Process
- Employee Appraisals
- Addressing Collection Policies
- Effective Communication
- Creating and Managing Budgets
- The Importance of Delegation
- Motivating Staff
- Morning Meetings
- Staff Benefits

12:00pm-1:00pm (Lunch and Open Discussion)

Agenda: Day 2

9:00am-12:00pm
Effective Marketing That Works!
- Creating a Yearly Marketing Game Plan
- Determining a Marketing Budget
- Assigning a Marketing Coordinator
- Understanding the Market Trends
- Internal Marketing
- External Marketing

1:00pm-4:00pm
Building A Successful Schedule
- Building a Schedule for the Growth of the Practice
- The Build for Growth Formula
- Scheduling Doctor Time
- Assigning Procedures and the Benefits
- Emergency Appointments and How to Handle Them
- Building Production into the Schedule
- Scheduling Debend Days
- The Importance of Morning Meetings

12:00pm-1:00pm (Lunch and Open Discussion)

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“Your intimate understanding of every aspect of an orthodontic practice has impressed every member of our team.”
- David Stephens - Utah

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