The treatment of deep anterior overbite in adults is a real challenge. It is important to know the different etiological factors and their influence on the malocclusion. In general, these patients have the lower third of the face diminished and a tendency to have a concave profile with good lip closure.

The presence or absence of growth is another issue to take into account when deciding the treatment plan. When there is a potential path of growth, the results are more controlled and effective; this is the reason why treatment in mixed dentition or early permanent dentition is recommended.

Deep overbite can be observed in Class I, II or III patients, but is most common in Class II Division II brachyfacial patients.

One of the most frequent characteristics is the presence of an increased interincisal angle.

By Dr. Julia Harfin

Symposia, ortho day at Greater N.Y. Dental Meeting

Symposia, ortho day at Greater N.Y. Dental Meeting

The New York University College of Dentistry and NYU Orthodontic Alumni Society will jointly present their third annual full-day orthodontic seminar on Wednesday, Dec. 5 at the Greater New York Dental Meeting (GNYDM).

Featured speakers include Drs. R.G. “Wick” Alexander, Anthony Gianelly, Lionel Sadowsky and Jack Fisher on such topics as “When Does A Non-Extraction Orthodontist Extract?,” “Evidence Based Analysis of Current Controversies,” “Avoiding Orthodontic Errors and Management of These Errors” and “The Use of Temporary Skeletal Anchorage in Orthodontics.”

The GNYDM is the largest dental meeting in the United States and has included a number of orthodontic programs for the orthodontist specialist.

The NYU program has been particularly successful and this year promises to be well attended as well.

Six C.E. credits will be awarded to attendees of this program. The full program and a registration form (look for course 6060) are available at www.gnydm.com. For more information, contact Elliott Moskowitz at typodont@aol.com.

Discover new specialties
This year, Dental Tribune America has partnered with the GNYDM organizers to offer four days of symposia in various areas of dentistry. Each day will feature a variety of lectures on topics, which will be led by experts in that field. The afternoon sessions introduce attendees to Dental Tribune America’s educational concept of “Getting Started in ...”.

By Dr. Julia Harfin

Stop running scared
The economy is down. We know that. But instead of panicking and making classic business mistakes with your practice, there are four tips you need to understand.

Doing it his way
Dr. Barry Matza sits down with Ortho Tribune to talk about the events that led him to orthodontics and interdisciplinary dentistry.

Figs. 1a, 1b: A 58-year-old patient was sent by the prosthodontist to the orthodontic department in order to improve esthetics and normalize the position of the upper incisors to make room to reconstruct the labial side of the lower anterior incisors.

Figs. 2a, 2b: A 26-year-old who wants a change in the position of her upper left lateral incisor.

American Tooth reveals its new bracket and Amazing Animation shows off its newest cell that will look good in every orthodontist’s office.

By Dr. Roberto Justus

Dr. Roberto Justus kicks off the morning session of Orthodontic Specialty Day with a presentation of treatment options for the anterior open bite during the 2007 Greater N.Y. Dental Meeting.
Running an office utilizing human resources management

By Dennis J. Tartakow, DMD, MEA, PhD
Editor in Chief

A ccording to Dr. James Caraway, differentiating between person-centered and task-intensive organizations, and between I-Thou and I-It relations, the Sixth Discipline provides guidance for the discipline that members can assess, separately or collectively, to the extent that the group or community is functioning for the individual’s welfare. That includes all workers from the temporary worker to the CEO or Board of Trustees member.

Thus, the Sixth Discipline — “Relational Reality” — is more than an effort of a “fit” among workers, tasks or even the organization and refers to the best possible fit of management. It consistently confirms the primary resource of any organization is its people; the organization only exists to provide some good to the individual.

Relationships are the basis for reality. The Sixth Discipline explains: (a) the two types of individual relationships — the I-Thou relations of At-onement and the I-It relations of estrangement; and (b) the two types of organizational relationships — the community and the collective.

The importance of “Relational Reality” is that it relates to something we can study, master or accomplish. According to Dr. Caraway, Martin Buber said that 25 centuries of philosophy were wrong — we have always experienced relation — never experienced aloneness; we philosophers were wrong — we have always experienced relationship. Buber said that 25 centuries of philosophy are wrong — we have always experienced relation — never experienced aloneness; we philosophers were wrong — we have always experienced relation — never experienced aloneness.

According to Dr. Caraway, Martin Buber said that 25 centuries of philosophy were wrong — we have always experienced relation — never experienced aloneness; we philosophers were wrong — we have always experienced relation — never experienced aloneness. At the same time, we can reflect on our own concepts, realizing the collective nature of thinking and language itself.

Collective learning is the basis of team learning and has three basic conditions: (a) all people must suspend their assumptions, (b) all people must look at each other as colleagues, and (c) a facilitator must be included to maintain the context of dialogue.

Therefore, in the realm of social sciences, the orthodontic office has been referred to as an organization by its relationship to human resources management and communication.

For purposes of this discussion, the orthodontic office has been referred to as an organization by its relationship to human resources management and communication. The structure of the office is structured to function and produce ends virtually the same. The organizational structure is directly related to the function and mission, as well as the rules and regulations for controlling activities in either a boutique practice or the larger office. Therefore, the office structure is a means to an end in order to achieve its goals and create focus on its objectives, requiring the effort of all employees.

Summary

1. Organizations are the strategies of individuals created to achieve certain objectives, and they require the effort of many individuals. Most organizations follow a particular strategy whose roots are found in military theory, industrial economics, public administration or scientific management.

2. The strategy from these roots lead to a pyramid-shaped, formal organization that can be defined by such principles as a chain of command, span of control or task specialization. If the strategy works as intended, the analysis would end here. However, the formal organizational strategy typically hits some snags due to the human influence.

3. Mutual adaptations occur when an organization changes the individual’s personality and the individual in turn modifies the formal organization, which become part of the organization.

4. A total organization is more than the formal organization. The concept is that as a behavioral system, it might be concluded that the organization is a composite of four different but interrelated subsystems that have behavior that results from the formal organizational demands, (b) demands of the informal activities, (c) individual’s attempt to fulfill his idiosyncratic needs, and (d) pattern for each organization of the three levels above.

5. In the organization’s resources management dimension, it is relationships that permeate all organizations and institutions.

6. The development of the individual in our culture is the most important factor for all offices or organizations.

References are available from the publisher.
Applications in for Levin Makeover contest

This past summer, Levin Group and Ortho Tribune embarked on the first Levin Group Orthodontic Practice Power Makeover contest. Applications streamed in until the Sept. 30 deadline. The response was overwhelming with just over 100 applications from orthodontists all vying for the chance to win a free year-long Levin Group Total Ortho Success management and marketing consulting program. Check out next month’s issue of Ortho Tribune to find out the winning practice!

The applicants ranged from orthodontists just starting their own practice to seasoned veterans. One message came through loud and clear: A makeover will be necessary at different points during the life of your practice. Evaluating your practice on a regular basis to determine strengths, weaknesses, opportunities and threats is critical to a practice’s ability to reach its growth potential. It is important to take a close look at your systems and make sure they are helping the practice run efficiently and profitably. Every orthodontist wants to reach financial independence, and your practice is the best investment to get you there. The Levin Group Orthodontic Practice Power Makeover applicants recognized the need for a makeover and shared their reasons for wanting one.

Many had interesting stories to tell. Some were experiencing serious challenges. One orthodontist is the new guy in town. He bought the 25-year old practice from someone who did very little to help him establish relationships with his best referral sources. Competition is fierce, and he is seeing an alarming decline in new patients coming through the door. Another doctor discovered his office manager had embezzled money from the practice for a full year, forcing him to borrow money just to keep the practice going. Now he is concerned his practice is at risk of completely falling apart.

A number of orthodontists with concerns over family friction in the practice applied for the makeover. A father and son or daughter working together to build a practice can be a wonderful experience, but it also poses challenges. Others who applied are doing quite well, even enjoying practice growth, but as one doctor eloquently put it, “We are an example of doing all of the right things the wrong way.” Another high-powered practice says it has a great team but is “stuck” in a smaller practice model inherited from the practice’s previous owner.

Across the board, the applicants listed the following as their top goals of the makeover:

- practice growth and increased profitability
- less stress
- more cohesive team
- higher conversion rate

Stay tuned for continuous coverage on the Levin Group Orthodontic Practice Power Makeover in Ortho Tribune. In addition to regular updates on how the winning orthodontic practice progresses over 2009, we also will share some of the common threads as noted on the applications as well as Levin Group’s Total Ortho Success strategies for jumpstarting your own makeover.

‘Marvelous Mouth’ reveals tooth truths

Discover the wide world of braces, brushing and beautiful teeth in a hands-on exhibition targeted to pre-teens at the National Museum of Dentistry on the campus of the University of Maryland Baltimore. Marvelous Mouth explores how to take care of braces, how mouth guards protect teeth during sports, how tobacco use can lead to tooth trouble and what careers are possible in the world of dentistry.

The exhibition features a central interactive computer station where visitors can explore the Marvelous Mouth animated game guided by a friendly tooth who takes on the guise of a game show host, stealth Mission Impossible spy and hazmat crew member to illustrate the world of pre-teen oral health care.

Mouth breathing, tongue thrusting, incorrect swallowing and other myofunctional habits cause MALOCCLUSION and POOR FACIAL DEVELOPMENT. Research has proven the T4K™ can effectively develop arch form and alleviate crowding by correcting these habits. Used by Orthodontists and Dentists in over 60 countries.

Across the board, the applicants listed the following as their top goals of the makeover:

- practice growth and increased profitability
- less stress
- more cohesive team
- higher conversion rate

Stay tuned for continuous coverage on the Levin Group Orthodontic Practice Power Makeover in Ortho Tribune. In addition to regular updates on how the winning orthodontic practice progresses over 2009, we also will share some of the common threads as noted on the applications as well as Levin Group’s Total Ortho Success strategies for jumpstarting your own makeover.

Discover the wide world of braces, brushing and beautiful teeth in a hands-on exhibition targeted to pre-teens at the National Museum of Dentistry on the campus of the University of Maryland Baltimore. Marvelous Mouth explores how to take care of braces, how mouth guards protect teeth during sports, how tobacco use can lead to tooth trouble and what careers are possible in the world of dentistry.

The exhibition features a central interactive computer station where visitors can explore the Marvelous Mouth animated game guided by a friendly tooth who takes on the guise of a game show host, stealth Mission Impossible spy and hazmat crew member to illustrate the world of pre-teen oral health care.
‘Timing in life is everything’

Dr. Barry Matza talks about the events that led him to orthodontics and interdisciplinary dentistry

By Dennis J. Tartakow, DMD, MEd, PhD
Editor in Chief

Please introduce yourself to our readers and tell us about your background in orthodontics.

I graduated from Tufts University, School of Dental Medicine in 1975 and worked as a general dentist for a maxillofacial prosthodontist. While teaching at Tufts the following year in the Oral Diagnosis Department, I met Dr. Everett Shapiro, chair of postgraduate orthodontics, and two years later received a certificate in orthodontics.

What is the name of the institution with which you are affiliated?

Nova Southeastern University, School of Dental Medicine, Department of Postgraduate Orthodontics, where I am an adjunct assistant professor.

What motivated you to become an orthodontist?

When I was in dental school, my first interest was in oral pathology as a result of being fortunate to have an exceptional teacher, Dr. Gerald Sklar.

However, I wanted more patient contact, and my next thought was specializing in oral and maxillofacial surgery. I spent a week of my spring vacation at Boston City Hospital and decided that this was not for me either.

I then pursued a career in orthodontics and enjoyed the challenge immensely: the age of the typical orthodontic patient, the thought process requiring biomechanics as an integral part of treatment and the challenge of “full mouth reconstruction in enamel on every patient.”

Oclusion has always interested me. In my opinion, the complexity and variability of the stomatognathic system is a lifelong pursuit of the knowledge, and applying its principles to treat a patient’s malocclusion really appealed to me.

When and how did you open your orthodontic practice?

After working a couple of years in New England, I moved to South Florida and opened my office in Boca Raton in 1979. I specifically remember the patient who paid for treatment up front as it was the first month I was able to pay the rent without drawing on my loan. This took five years, and as the saying goes: Patience is a virtue!

What special areas of education, research or clinical activities are you most interested in and why?

Although the interest in children motivated me to pursue orthodontics, timing in life is everything. When I first opened my office, the referral patterns did not allow me to build the adolescent patient referral. I was getting adult patients more and more. This forced me into an arena I knew little about as I had not treated many adults during my training.

I was later introduced to the Seattle Study Club Network where my interest in interdisciplinary dentistry began. After practicing orthodontics for 10 years, I began to interact with restorative dentists and the other dental specialists in a different manner. The adult dentition that was worn, mutilated and in need of a team approach became my focus.

It was 15 years after graduating dental school, and now I had the need to re-educate myself. I began taking courses that had little to do with orthodontics. If I was to communicate with my dental colleagues, I needed to learn and communicate in their language as well as understand current concepts of reconstruction.

Prior to teaching at NSU, I became involved with the craniofacial team at the University of Miami School of Medicine, where I was a clinical instructor in the Department of Plastic Surgery.

I had the privilege to be on the craniofacial team with Dr. Ralph Millard. I spent 10-plus years on that team and had the opportunity to learn the orthodontic needs of the craniofacial patient.

Not only did I get back to treating the adolescent, but I was taking impressions on infants to fabricate appliances in order to move alveolar segments in patients with cleft lip and palate deformities prior to the initial surgery to close the cleft.

As an educator, what are your most important educational responsibilities to your postgraduate orthodontic residents?

My role as educator has changed over the past 10 years at NSU; I review the literature with the orthodontic residents in adult treatment, periodontics, smile esthetics, interdisciplinary treatment, aligner therapy and craniofacial anomalies.

In your opinion, is there a need to change the way higher educational programs in this country educate their orthodontic residents?

We need more educators. However, in order to attract them, the pay scale needs to be attractive, especially today with the debt incurred by a new dentist as soon as he or she graduates.

As an educator and clinician, what orthodontic techniques do you teach?

I teach with a bidimensional edgewise technique. However, it is not the appliance that makes a case excellent; it is the diagnosis and implementation of a treatment plan using sound biomechanical principles, as well as understanding how the face grows and how that differs from the non-growing patient, that is omnipotent.

Regarding the American Board of Orthodontics Certification, in your opinion:

• Will more certified orthodontists benefit the specialty, the patient or both?
• What are some positive and/or negative effects of these changes?
• Is American Board Certification as important today as it was in the past?

For me, becoming board certified was a very positive learning experience. The process of reflection on treated cases was enlightening and made me become a better orthodontist.

Looking back at your career, would you do anything differently?

I have been extremely fortunate. “I’ve done it my way!”

Do you have any final comments for our readers?

Orthodontics is a great profession in our patients’ lives. What a pleasure it is to go home at the end of the day when a patient thanks you for your help and you can say to yourself, “A job well done.”

Contact

Dr. Barry Matza is an adjunct assistant professor in the Department of Postgraduate Orthodontics, Nova Southeastern University, College of Dental Medicine. His professional accomplishments and academic appointments include: diplomat, American Board of Orthodontics; clinical instructor, Department of Diagnosis, Tufts School of Dental Medicine; consultant, South Florida Cleft Palate Clinic, University of Miami, School of Medicine, Division of Plastic Surgery; clinical attending instructor, University of Miami, School of Medicine, Department of Oral and Maxillofacial Surgery, and Department of Plastic Surgery; and visiting lecturer, Post-Graduate Department of Orthodontics, Tufts University, School of Dental Medicine. Dr. Matza is a graduate of Tufts School of Dental Medicine and its postgraduate orthodontic residency program (DMD and Certificate). He has a private practice in Boca Raton, Fla.

info@bmatza.com
Flossing and braces. Right.

Now there's an easier and more effective solution for Mr. Non-Compliant.

Clinically proven more effective than floss for cleaning around braces

With a new ergonomic design that's perfect for kid's hands and a patented orthodontic brush tip, the Ultra Cordless dental water jet is the ultimate braces cleaning machine.

Goodbye threaders. The Ultra Cordless is so easy and so effective that your patients will enjoy using it every day. So if you have patients who struggle with flossing around their braces, recommend the new Waterpik® Ultra Cordless. But be prepared. You might just win over Mr. Non-Compliant.

Waterpik® ULTRA Cordless

The lower incisors lose the stopper on the palatal side of the upper incisors and continue growing until they reach the gingival palatal tissue. Because of the retroinclination of the upper and lower incisors, a shortening of the arches is observed but is more common in the upper than in the lower arch. In general, the arches are more square in shape because of the influence of the muscular pull (Fig. 1a).

In addition, the labial mental sulcus is very pronounced, and the lower lip covers the middle third and often the upper third of the upper incisors. The lips can appear retrorgnostic.

Another important issue is to determine if the deep overbite is located in the anterior region, in the posterior region or in both.

In general, these patients come to the office looking for an esthetic improvement in order to normalize the position of the central and lateral incisors. Others are recommended by prosthodontists to normalize the position of the anterior teeth in search of more room for a normal restoration (Fig. 1b).

Usually in these patients the muscles are very well developed and the occlusal plane is altered with a very pronounced Spee’s curve. The normal path of mastication would be changed.

Because they are non-growing patients, no orthopedic alterations can be expected. The treatment is limited to an orthodontic correction with or without orthognathic surgery.

It is very important to observe the presence or absence of a gingival smile because this issue determines the biomechanics that will be employed.

When the upper incisors are not visible during normal speech, the solution is to intrude the lower incisors in order to correct the deep overbite. If not, the result will be the typical smile of an older person.

In these cases we must consider the option to extrude the lateral sides or intrude the lower incisors.

Some patients will need temporary reconstruction of the occlusal surfaces in the posterior region, and on the palatal and labial surfaces in the anterior region, during treatment. At the end of the orthodontic treatment, a definitive reconstruction is necessary in order to maintain the results achieved.

Corrected deep overbite in adults requires an individualized treatment plan, especially in the vertical plane. A bite plane is effective in retaining the overbite correction, and long-term use is recommended. As brachyfacial patients have more tendencies to relapse than mesofacial ones, the same type of retention is not possible.

Figures 2a and 2b show a 26-year-old patient who came in search of a second opinion regarding a change in the position of her upper left lateral incisor. She had been treated twice before, between ages 8 and 10 with a removable appliance and between ages 14 and 16 with fixed appliances. She admitted she hadn’t used the retention appliances as was indicated.

When we observed the facial photograph, we could see that the chin was slightly deviated to the left. She had a gingival smile, and the gingival line was not parallel to the lower lip as was described by Björn Zachrisson some years earlier.

The overbite was nearly 100 percent at the central incisors. She presented a Class I canine and molar on the right side and a Class II on the left side. The right first molar was in crossbite and the midline was slightly deviated (Figs. 5a–5c).

The overbite was nearly 100 percent at the central incisors. She presented a Class I canine and molar on the right side and a Class II on the left side. The right first molar was in crossbite and the midline was slightly deviated (Figs. 5a–5c).

The major objectives of the treatment plan were to correct the position of the left lateral upper incisor, normalize overjet and overbite, achieve a Class I molar and canine and improve her smile (Figs. 6a, 6b).

Looking at the lateral X-ray, we can confirm the magnitude of the deep overbite in the anterior region (Fig. 5).

The major objectives of the treatment plan were to correct the position of the left lateral upper incisor, normalize overjet and overbite, achieve a Class I molar and canine and improve her smile (Figs. 6a, 6b).

0.022-inch pre-programmed esthetic brackets with a metal slot were used with a 0.016-inch NiTiCu wire to begin the alignment.
Orthoease
The most intuitive practice management software program yet!

Featuring:
- Paperless Charting
- Comprehensive Imaging & Analysis
- Ready-To-Use Scheduling Templates
- Automated Data Backup
- World Class Support
- Industry’s Best Financial and Management Reporting

Improve your case acceptance and manage your practice with ease.

www.orthoease.com
1-800-217-2912
Overbite

Fig. 11a-11e: Three years later, the results continue to be stable, not only from the occlusal point of view but at the gingival tissues.

Fig. 12a-12f: This is a 42-year-old patient who was in search of a second opinion regarding the correction of his anterior deepbite.

Fig. 14a-14e: Ten months after placing 0.022-inch esthetic pre-programmed brackets with an esthetic 0.016-inch SS wire with a closing loop.

Fig. 15a, 15b: Some triangular elastics are used in order to maintain Class I molar and canine on the left side while Class III elastics on the right side are recommended to complete the mesialization of the upper right second molar.

Fig. 16a-16e show the results at the end of the treatment. The anterior deepbite is completely corrected. The Class I canine and molar are maintained, and on the right side the second molar occupies the space where the first molar originally was. The third molar is in the position of the second molar. Lower anterior crowding is totally corrected, and a fixed retention wire is recommended for a long period of time.

Figure 17 shows the panoramic X-ray at the end of the treatment just before debonding.

Three years later (Figs. 18a-18d), the overjet and overbite continue to be stable, but a little diastema between the upper central incisors is visible. The lower canine and molar are maintained, and the lower retention wire is still in place.

Conclusion

The treatment of deepbite in adult patients requires a careful diagnosis, prognosis, treatment and retention plan. The type of biomechanics we decide to use is determined according to the labiodental relationship the patient has when he or she is speaking and smiling.

In order to achieve objectives ahead of time, the use of new types of alloys should be considered. The amount of periodontal attachment is another determining factor when the treatment objectives are planned.

The maintenance of the results is

After the alignment of the upper arch was completed, the brackets on the lower arch were bonded with a NiTi reversed curve in order to correct the retroinclination of the lower incisors (Figs. 7a–7d).

After eight months of treatment, and when the alignment and leveling of the arches was attained, full-time Class II elastics were recommended in conjunction with 0.016-inch by 0.022-inch stainless steel (SS) wires.

Some over-correction of the deep overbite is advisable. After that, triangular elastics with a Class II component on the right and left side were suggested with individualized SS wires.

Figures 8a–8f and 9a and 9b show the results at the end of 20 months of active treatment. The midline is corrected, and the overjet and overbite are normalized. The occlusal plane is parallel to the gingival line. Class I molar and canine are obtained. The gingivo-periodontal tissues are almost normal.

To maintain the results, a fixed retention was recommended on the lower arch and a Hawley appliance with a bite plane was suggested for the upper arch. It is advisable that the patient uses them for a long period of time.

Figure 10 shows panoramic and lateral X-ray at the end of the treatment, just before debonding, where the normalization of the incisal inclination and the occlusal plane are evident.

Three years later, the results continue to be stable (Figs. 11a–11e), not only from the occlusal point of view but at the gingival tissues too. At night the patient continues to use the bite plane.

We have to remember that the normalization of the position and inclination of the upper and lower incisors are critical when we have to treat these patients. To obtain a normalized anterior and posterior disocclusion, it is fundamental to maintain a healthy and long-lasting stomatognathic system.

Of course, the type of biomechanics depends on the patient’s problem. It is completely different when you have to intrude the upper incisors versus the lower ones or extrude the molars in your treatment plan.

Figures 12a–12e show a 42-year-old patient who was sent in search of a second opinion regarding the correction of his anterior deepbite. He had a Class I molar and canine with 5 mm of crowding in the lower arch. His dentist advised him to have the upper right first molar extracted because it had problems with the root canal.

The overbite at the anterior region was nearly 95 percent. No gingival problems were present, and the oral hygiene was fair.

The lateral X-ray (Fig. 13) showed extrusions of the upper and lower incisors.

The treatment plan included not only the normalization of the overjet and overbite, but also the closing of the space of the upper right first molar that was extracted two months before the orthodontic treatment began.

0.022-inch esthetic pre-programmed brackets with an esthetic 0.016-inch SS wire with a closing loop to begin the mesialization of the molar were placed to begin phase one of treatment (Figs. 14a–14e).

Ten months later, a rectangular 0.016-inch by 0.022-inch SS wire with an omega loop was placed in the upper arch while pre-programmed SS brackets were placed in the lower arch.

Some triangular elastics were used in order to maintain a Class I molar and canine on the left side while Class III elastics on the right side were recommended to complete the mesialization of the upper right second molar (Figs. 15a, 15b).

Figures 16a–16e show the results at the end of the treatment. The anterior deepbite is completely corrected. The Class I canine and molar are maintained, and on the right side the second molar occupies the space where the first molar originally was. The third molar is in the position of the second molar. Lower anterior crowding is totally corrected, and a fixed retention wire is recommended for a long period of time.

Figures 8a–8f and 9a and 9b show the results at the end of 20 months of active treatment. The midline is corrected, and the overjet and overbite are normalized. The occlusal plane is parallel to the gingival line. Class I molar and canine are obtained. The gingivo-periodontal tissues are almost normal.

To maintain the results, a fixed retention was recommended on the lower arch and a Hawley appliance with a bite plane was suggested for the upper arch. It is advisable that the patient uses them for a long period of time.

Figure 10 shows panoramic and lateral X-ray at the end of the treatment, just before debonding, where the normalization of the incisal inclination and the occlusal plane are evident.

Three years later, the results continue to be stable (Figs. 11a–11e), not only from the occlusal point of view but at the gingival tissues too. At night the patient continues to use the bite plane.

Figures 8a–8f and 9a and 9b show the results at the end of 20 months of active treatment. The midline is corrected, and the overjet and overbite are normalized. The occlusal plane is parallel to the gingival line. Class I molar and canine are obtained. The gingivo-periodontal tissues are almost normal.

To maintain the results, a fixed retention was recommended on the lower arch and a Hawley appliance with a bite plane was suggested for the upper arch. It is advisable that the patient uses them for a long period of time.

Figure 10 shows panoramic and lateral X-ray at the end of the treatment, just before debonding, where the normalization of the incisal inclination and the occlusal plane are evident.

Three years later, the results continue to be stable (Figs. 11a–11e), not only from the occlusal point of view but at the gingival tissues too. At night the patient continues to use the bite plane.
directly related to the fulfillment of the retention plan. The musculature plays an important role and affects the stability of the results.

Event though the treatment of deep overbite malocclusion in patients without growth is a challenging one, excellent results can be achieved when an individualized treatment plan is considered.

References are available from the publisher.
Demystifying early treatment of malocclusions

By German Ramirez-Yañez, DDS, MDSc, PhD

Early treatment of malocclusions is still a matter of controversy in orthodontics. Although some professionals discourage early treatment, arguing there are no benefits, the current evidence may not provide any evidence-based guidance to discourage such an approach of treatment.1 Conversely, there are sufficient studies encouraging early treatment of malocclusions and demystifying some statements spread around with no scientific support. Thus, it is the purpose of this paper to discuss a couple of those myths built with no scientific support. Thus, it is the purpose of this paper to discuss those myths built with no scientific support.

Myth: Most malocclusions present at early ages self-correct and therefore will not be carried over into permanent dentition.

That is not true. Sagittal, vertical and transverse problems can be diagnosed in the primary dentition, indicating that a similar or worse problem can be present in the mixed and permanent dentition. Sagittally, 80 percent of Class I malocclusions present at an early age will not improve from primary to permanent dentition, and furthermore, 76 percent of Class II and 89 percent of Class III malocclusions increase their severity from primary to permanent dentition.2 This also was confirmed by other studies,3 which reported that the overjet observed in the primary dentition remains through the mixed and is present in the permanent dentition. The same occurs with the vertical relationship, the overbite. That overlapping of the upper incisors onto the lower incisors tends to increase approximately 2 mm from the primary dentition to the mixed dentition.4 In other words, when a deep bite is present in the primary dentition, it may be worse in the mixed dentition. In addition, once the overbite is established in the mixed dentition, it remains constant to adulthood.5

Transversely, it has been shown that patients with crowded primary incisors will have crowded permanent incisors.6 Additionally, it has been reported that 67 to 69 percent of patients with no spaces in the primary dentition will have permanent incisors crowding.7–9 This is further supported by another report showing that 75 percent of the malocclusions present in the permanent dentition were previously present in the primary dentition.8 Thus, crowding in the adult dentition can be predicted from the available space in the primary dentition.9,10 Therefore, the literature supports that malocclusions observed in the primary dentition involving sagittal, vertical or transverse relations will remain through the mixed dentition and will be present in a similar pattern or even worse in the permanent dentition. So why not treat those malocclusions early and prevent or intercept the malocclusion from being possibly worse in the permanent dentition?

Myth: Cases treated at early ages are not stable and will relapse, requiring a more complicated treatment in the future.

Studies after four years of treatment of the development of occlusion in children younger than age 6 treated with functional techniques have shown that the percentage of relapse (12.5 percent) is significantly lower than those cases with no relapse (61.6 percent), and the percentage of performed treatments that may require treatment for other complications (26.1 percent) also is significantly lower.11 Furthermore, it has been demonstrated that treating at an early age reduces the risk of relapse,12 contrasting with another study reporting that 90 percent of cases with incisal crowding treated with four premolar extractions and fixed appliances relapsed.13 Several clinical studies have reported that when the first permanent molars are maintained at the original erupted position, incisors are easier to align and will produce wider dental arches.14,15 Another interesting finding is that treating before the apical closure of the root will reduce the risk of relapse as periodontal ligament fibers will develop after straightening the teeth.16,17 Furthermore, uncalled predentin is not attacked by resorbing cells, reducing the risk of root resorption and crowding relapse.18–21

Final discussion

The literature reviewed in this paper strongly supports early treatment of malocclusions. Thus, malocclusions diagnosed early will remain through the various developmental stages of the human dentition. Furthermore, studies encourage early treatment of malocclusions as it appears to produce less secondary effects because orthodontic treatment, such as root resorption, produce better results.22–24 Therefore, the dental profession should reconsider the common sayings regarding early treatment of malocclusions and base its decisions on scientific concepts when observing a malocclusion at an early age. Some patients may argue that treatment referenced here is not recent. This is due to a lack of research on this matter during the last decades. Although some reviews have been published recently, they are not able to contradict the results of the studies presented here, and most of them concluded there is no scientific evidence to support the treatment of malocclusions,25 whereas treating early may facilitate treatment and have financial benefits.26 In the second part of this article, more literature will be reviewed to continue demystifying common arguments against early treatment of malocclusions, and furthermore, those concerns about using preformed or prefabricated functional appliances also will be discussed.

References

3. Silver E. The dentition of the growing child, 1959:
Handling problem employees

By Scarlett Thomas
President, Orthodontic Management Solutions

Problem employees: Their performance is unsatisfactory. They consume your time and create dissatisfaction. They show little commitment to the job. Employee entitlements interest them more than the team goals. Counseling sessions always end in the same manner — they agree to change but don’t follow through.

Some problem employees can be helped through coaching or training to correct performance shortfalls. Others can do the job, but for one reason or another, they need constant supervision and reinforcement to perform at an acceptable level. Whatever the situation might be, the key to handling employees with behavior problems is strong and effective communication skills.

Make sure that work expectations and performance objectives are clear. The only way to verify the existence of a performance problem is to state the expected level of performance and measure the employee’s actual performance against it.

Review all the details before you have a meeting with the employee. Evaluate all your previous records including job descriptions, notes and documented conversations that relate to the specific behavior. Don’t try to wing it!

Give the person advance notice and specify the issue or concern. For example, for a person who is consistently late for work, you might say: “I’d like to speak with you tomorrow regarding your starting time.”

At the time of discussion, start the conversation off in an upbeat manner. Doing so will set the tone for a productive meeting. You can express your concerns in a friendly manner without being overbearing.

Describe the problematic behavior and its impact on you and the staff. For example: “You’ve been coming to work a half-hour late several days a week for the past month. This is making it difficult for your coworkers to get their work done. And I’m very concerned it’s starting to set a bad example for everyone else.”

Refer to the history and reoccurrence of the problem. “This is not the first time we’ve had to talk about this. According to my records we discussed this issue six weeks ago, and once more prior to that in March, and yet the problem continues.”

State the actual effect the employee’s behavior has on you and the staff. For example: “I recognize that you make up the missed time by either staying late or working through lunch, but that’s not a solution. Because we operate as a team, having one person unavailable can create major disruption.”

Listen actively to the employee’s response. Don’t get distracted with thinking about what you’ll say next. Be open to what the employee says.

Make a suggestion or a request to change the behavior. For example, “What I’d suggest is that you rearrange things at home so you can be punctual.” Then check to make sure the person understands your suggestion. For example, “Do you understand why I’m insisting you be on time?”

Make sure the employee is committed to the change. For example, “So you agree that you’ll be here at 9 a.m. every morning?” Keep a record of what was said and any agreements that were made. Have the employee sign the agreement and pick a future date to revisit the discussion and any improvements that may or may not have taken place.

At some point in your career, you will have to dismiss an employee. To do it right and in a professional manner, make sure you’ve done your homework with respect to legal issues, written documentation of the employee’s performance or behavior and the steps you’ve taken to help. You want to feel confident that dismissing the person is the right thing to do — for him or her, for your team and for your practice.

To learn more about top-notch management skills, you are invited to attend the Orthodontic Training Workshop from March 6–7, 2009, in San Diego. Discussion will focus on management skills, ways to increase your case acceptance, marketing your practice and building a successful schedule. You can find out more information about the workshop by visiting Orthoconsulting.com.
Time to give marketing another look

By Pat Rosenzweig

Let's face it. Even though we all look back longingly at the days when all an orthodontist had to do was open an office and wait for the patients to start calling, those days are long gone. Especially in the current economy, marketing is a necessity for all offices—even the more established ones. The truth is that some really nice practices out there are starting to languish due to lack of marketing, and they'll ultimately be worth a lot less than they should be when the orthodontist is ready to retire.

We're living in a society that has become accustomed to letting marketing assist with all its decisions, including dental care, and every new orthodontist who opens or purchases a practice knows he needs to get on the marketing bandwagon and ride it indefinitely if he wants to succeed. The reluctance of some of our more established practices to return to, or even begin, a marketing campaign is causing them to lose more patients than they can spare to all the new offices opening around them.

Let's take a look at some of the forms of marketing to consider and evaluate where and how they work the best.

Internal marketing

In my opinion, internal marketing begins at the very first phone call. This is probably the least expensive form of marketing, but it does have a price tag. The cost of this marketing comes in hiring someone who can really "wow" your patients at the first call rather than just hiring the body who will answer the phone when it rings. Spending a few extra salary dollars on this first impression will translate into more future patients. Patients who feel welcomed and special in an office are a lot less likely to shop around for a few dollars off treatment fees or for a location that's slightly closer to home.

Other inexpensive forms of internal marketing have to do with how we present our physical space and attitude to our patients. One simple marketing tool comes in the form of a coat of paint and a carpet cleaning. Spending a few dollars on a regular basis to keep the spit and polish shine on your office will really impress a new patient; not doing so is almost guaranteed to drive him or her down the street to your competitor.

Also, while we sometimes joke and grumble about office games and contests, they're fun, and fun is what it's all about for kids of treatment age. Our patients and their parents don't have to settle for a stuffy "all business" office. They can go to a few doors over and enjoy a game, a contest and a brighter, happier attitude. It takes very little investment of both dollars and time to make the office a much more inviting place for parents and children.

The final form of internal marketing that I'd like to touch on is much less obvious but becoming more and more necessary — accepting insurance assignment. There was a time when I advised all my orthodontic clients to remain "fee for service." Almost all orthodontic insurances will pay out of network, and by staying out of network, you avoid unreasonably low caps set by some insurance providers. The problem with this is that patients and parents are becoming more and more insurance savvy and less loyal to any particular office.

Parents are aware that while they'll still get the same $1,500 to $2,000 benefit in or out of network, they'll pay less in network because of caps and write offs. They also don't really care if older sister or brother had a good experience in an office; they want an orthodontist who accepts their insurance coverage.

Loyalty to a particular provider has been replaced by economic reality, and the way to keep a family as patients is to make the office as economically attractive as possible. I never encourage participating in every insurance plan that's available, but if I do strongly suggest doing your homework, finding out who the predominant carriers are in your area and getting signed on with two or three of the big insurance companies. As one of my clients so succinctly put it, "Write offs beat empty chairs any day of the week."

External marketing

When we start talking about external marketing, there are a myriad of products available, and the trick is choosing the right ones for your office and your area. I've listed some of the marketing tools you may want to use and briefly discussed where we can expect each product to produce the most interest.

Brochure marketing has become very popular here in Colorado, where our company is based, and it has been very successful for many offices. There are, however, limitations to the types of areas where it works best. By and large, brochures or mailers have the best success in areas that have a great deal of new population growth. New residents are looking for new practitioners and are more open to mailer marketing.

There also are good inroads to be made with mailers in neighborhoods that are in strong transitional phases — areas where older homes are being sold to younger buyers and/or general gentrification of the area is in progress. Older more established neighborhoods are less likely to give a good return on mailers.

Newspaper ads are still definitely a good way to go, especially in smaller towns where the local newspaper is a real "back fence" type of information periodical for the community. I suggest smaller communities because while newspaper marketing will get some results in larger communities, your ad can get lost in a large urban paper. Television and radio also have some good response in smaller markets, but they can also get lost in the AM programming in the larger areas.

Obviously (and I use that word cautiously), the best external marketing you can have is the orthodontist getting out into the community and meeting general dentists, pediatric dentists and other specialists. The reason I use the word obviously so cautiously is because some practitioners have a real aversion to going out to lunch or an afternoon of golf with potential referral sources. To these shy, gentle folks I say as politely as I possibly can, and with only good intentions, "Get out there, and get over it!" You not only want to be taking your referrals out to lunch and golf, but you want to come prepared with notes to discuss how their patients are doing in your practice. Send regular gift baskets to their staff and plan regular meetings for the full staff and practitioners with your good referrals to keep them pleased with your practice as a whole. No matter how excellent your clinical skills may be, the whole package has a lot to do with why they refer to you.

Finally, think outside the box for your marketing. If you're in a good-sized medical/dental building with a large parking lot, talk to building management and the other tenants and get a health fair going for the community. Have fun activities such as face painting, a computer study machine, etc. for the kids and informational booths on all the offices in the building for the parents. People come because it's good, free entertainment, and you get some face time with parents. It's a real win/win situation for you and the community.

Another good thought, especially in smaller towns, is an office field trip. Invite local teachers to bring their classes and set up stations with healthy snacks, a free digital photo opportunity, hand impressions, etc. so they can have fun as they learn about the orthodontist. End their day with a certificate of completion with their photo on it and you'll have some happy kids and their teachers telling area parents about your "awesome" office.

We've only touched on a few of the many forms of marketing, but there are as many other creative, fun ways to set your practice apart from the rest as there are practices in your town, city and state. I encourage you all to get creative and get marketing. Your potential patients have a lot of options for good orthodontic care, and you want to be the office they choose.
OrthoEase
Manage your practice with ease

Practice Management System
Imaging, Ceph Tracing & Analysis
Patient Education & Case Presentation

16 years of service and innovation

Increase your case acceptance.

www.orthoEase.com
1-800-217-2912
How you can thrive in a down economy

By Roger P. Levin, DDS

I have to let you in on a little secret — I get concerned when I listen to orthodontists talk about surviving the economy. Just asking does “surviving” mean anything? Does it mean simply minimizing losses? I’m sorry, but you want to do a lot more than that. And you can!

Having worked with so many ortho practices over the years, I know for a fact that most offices operate as much as 30 percent below their capacity. I have watched ortho practices that were convinced they had maxed out their production growth exponentially. Consequently, I get a little frustrated when practitioners are content to sigh and accept the loss of revenue and write it off as solely the economy’s fault. The truth is that you can increase production — yes, even now!

Thriving — not merely surviving — needs to be your objective in the current economy. Accept nothing less!

It’s impossible to ignore the economy, but don’t be overwhelmed by it. It’s worth noting that this slow economy may last longer than any we have experienced in the last 75 years. We have dealt with the housing crisis, which is a major reason for our current difficulties, but energy prices, inflation and unemployment also are contributing to our troubles.

What are the possible ramifications for orthodontists? For one, some orthodontics practices may begin to perform more orthodontics at their practices as they seek new income sources. Second, other orthodontists in the area may change their practice, from general dentists to orthodontics. In a very real sense, general dentists who traditionally have not offered orthodontics in the past, may offer orthodontics to their patients. It is not uncommon for orthodontists to refer patients to other orthodontists who may be more experienced and able to handle their cases.

As mentioned, many orthodontists have made this mistake. You operate as much 30 percent below their potential and are very representative of what’s prevalent in financial circles, I have always been concerned about the economy affecting ortho practices if they have the correct management and marketing systems. Most practices have potential that orthodontists haven’t even begun to tap. Once they do, it’s smooth sailing even though the sky looks threatening in the distance.

Metaphorically speaking, you have a unique sailing vessel that allows you to outrun the worst storm, provided you trim your sails and you know how to chart your course correctly.

Yes, the economy will eventually improve. But it could take awhile. Why sustain lost production for whom knows how long when you don’t have to? I urge each orthodontist to act now. Protect what you have, plan for the future and accept nothing less than the steady growth of your ortho practice — right now!

Don’t let the economy put a dent in your ortho production. Ortho Tribune readers are entitled to a special complimentary eBrochure from Levin Group entitled “10 Tips to Recession Proof Your Ortho Practice.” To receive your eBrochure, email customerservice@levingroup.com with “10 Ortho Tips” in the subject line.

Update your management systems. Most practices arrive at Levin Group that had made this mistake. You operate as much as 30 percent below their potential because of outdated systems. Ineffi- cient systems lead to loss of produc- tion and stress for you and your staff. The longer you operate this way, the greater the loss and higher the stress.

The Levin Group Method for Total Ortho Success™ has helped hundreds of orthodontic practices reach their full potential. As you get your management systems back on track, your objectives should be to:

• increase starts,
• boost per day production,
• reduce overdue debond patients,
• keep more patients’ siblings active in the practice,
• increase the effectiveness of your orthodontic treatment coordination systems,
• spend 98 percent of all your in-office time on direct patient care.

Implement a consistent referral marketing program. During a recent seminar for orthodontists, I presented the Ortho Life Map — a Levin Group client activity that helps practitioners plan each year of their careers. In the course of the exercise, orthodontists determine the major steps they will take to grow their practice, the advisors they will consult with and their practice productivity and marketing goals. After going through the exercise, many of the orthodontists were surprised to learn that marketing requires a continuous annual effort. You need a top referral marketing program with at least 15 strategies in place that focus on your referring doctors.

Both the Levin Group and orthodontists believe referrals are more important in orthodontics than many other specialties, dentist referrals should account for approximately 30 percent of orthodontic production. We’ve all heard about the housing crisis, which is a major reason for our current difficulties, but energy prices, inflation and unemployment also are contributing to our troubles.

Yes, ortho practices are growing!

Obviously, many practices are facing significant challenges in this uncertain economy. For example, in just the last month alone, we have seen three new orthodontic practices arrive at Levin Group that are very representative of what’s happening to ortho practices every- where these days. One practice was flat and taking action to immedi- ately increase production and profit. Another orthodontist was down 3 to 4 percent and felt that this was enough of a decline to warrant tak- ing steps for ensuring growth rather than decline. The third doctor had dropped a shocking 14 percent in the last six months. A big contrib- uting factor was the fact that two new orthodontists had opened in his area. Can all of these practices be turned around? Absolutely! It’s all about systems. Improv- ing your management and market- ing systems will mean significant growth. Many of our clients are performing at the highest levels of increased production we have seen in 25 years. How are they accom- plishing results like this?

Because they are refining their systems in response to the changing economy. When the economy was better, ortho practices could oper- ate far below their potential and get away with it. It is no longer pos- sible to just coast along in today’s economy. You have to be proactive to stay on top.

Fortunately, there are three steps you can take to grow your ortho practice in good times and bad.

Three ways to grow your ortho practice

It is no secret that orthodontists depend on referrals from general dentists and patients, especially in a down economy. Although patient referrals are more important in orthodontics than many other specialties, dentist referrals should account for approximately 70 percent of orthodontic production.

In a very real sense, general den- sists are the purse strings to your practice. Many orthodontists don’t like to admit this, but it’s a fact of life. The secret, then, to growing your orthodontic practice is to expand your referral sources.

That sounds simple enough.

The thing is, you now face two distinct challenges. First, you have to actually get more referring doc- tors. That’s not automatic. You have to take a strategic approach to getting referrals, and you must know how to find your self-structure when the economy improves because the referral land- scape may change dramatically.

To spur orthodontic practice growth, your objectives should be to:

• increase starts,
• boost per day production,
• reduce overdue debond patients,
• keep more patients’ siblings active in the practice,
• increase the effectiveness of your orthodontic treatment coordination systems,
• spend 98 percent of all your in- office time on direct patient care.

Improve your referral marketing systems. It is no secret that orthodontists depend on referrals from general dentists and patients, especially in a down economy. Although patient referrals are more important in orthodontics than many other specialties, dentist referrals should account for approximately 70 percent of orthodontic production.

In a very real sense, general den- sists are the purse strings to your practice. Many orthodontists don’t like to admit this, but it’s a fact of life. The secret, then, to growing your orthodontic practice is to expand your referral sources.

That sounds simple enough.

The thing is, you now face two distinct challenges. First, you have to actually get more referring doc- tors. That’s not automatic. You have to take a strategic approach to getting referrals, and you must know how to find your self-structure when the economy improves because the referral land- scape may change dramatically.

To spur orthodontic practice growth, your objectives should be to:

• increase starts,
• boost per day production,
• reduce overdue debond patients,
• keep more patients’ siblings active in the practice,
• increase the effectiveness of your orthodontic treatment coordination systems,
• spend 98 percent of all your in- office time on direct patient care.

Improve your referral marketing systems. It is no secret that orthodontists depend on referrals from general dentists and patients, especially in a down economy. Although patient referrals are more important in orthodontics than many other specialties, dentist referrals should account for approximately 70 percent of orthodontic production.

In a very real sense, general den- sists are the purse strings to your practice. Many orthodontists don’t like to admit this, but it’s a fact of life. The secret, then, to growing your orthodontic practice is to expand your referral sources.

That sounds simple enough.

The thing is, you now face two distinct challenges. First, you have to actually get more referring doc- tors. That’s not automatic. You have to take a strategic approach to getting referrals, and you must know how to find your self-structure when the economy improves because the referral land- scape may change dramatically.

To spur orthodontic practice growth, your objectives should be to:

• increase starts,
• boost per day production,
• reduce overdue debond patients,
• keep more patients’ siblings active in the practice,
• increase the effectiveness of your orthodontic treatment coordination systems,
• spend 98 percent of all your in- office time on direct patient care.

Improve your referral marketing systems. It is no secret that orthodontists depend on referrals from general dentists and patients, especially in a down economy. Although patient referrals are more important in orthodontics than many other specialties, dentist referrals should account for approximately 70 percent of orthodontic production.

In a very real sense, general den- sists are the purse strings to your practice. Many orthodontists don’t like to admit this, but it’s a fact of life. The secret, then, to growing your orthodontic practice is to expand your referral sources.

That sounds simple enough.

The thing is, you now face two distinct challenges. First, you have to actually get more referring doc- tor...
Orthocast™ mini
The mini tube that bonds like a band.

Orthocast™ mini tubes are easy to precisely bond on the mesial cusp of 2nd molars and provide a strong, secure bond that is unmatched in the industry. They provide the perfect solution for any patient with partially-erupted 2nd molars and are also a great choice for the 2nd molars of all other patients!

Patented laser-structured 3D base
Single piece tube with wide bonding base

Funnel design tube opening

Only $3.59 per tube

150% GUARANTEE
We guarantee that the Orthocast™ mini tube will provide better bond retention than your current 2nd molar DB buccal tube, or we will refund your purchase by 150% (Guarantee is limited to the first 100 tubes)

DENTAURUM USA
www.dentaurum.com  sales@dentaurum-us.com  800.523.3946
Growing your practice in a down economy

By Chris Roussos
President and CEO OrthoSynetics

There is no denying that times are tough: the market is down, credit is scarce and most Americans have lost value in their greatest source of savings — their homes. During these tough financial times most families are tightening their belts. Many businesses are following suit and also are cutting back.

While it is healthy for all businesses to do a periodic review to make sure they are spending their resources wisely, businesses need to be careful not to cut back on areas that could adversely affect their bottom line and future earnings just because the economy is down.

As the CEO of OrthoSynetics Inc. (OSI), a business service company in the orthodontic and dental industries, I see more and more doctors reacting to the worsening economy by making classic business mistakes. I have more than 20 years of management experience with top companies, such as PepsiCo and Newell Rubbermaid, and in the health care industry running national hospice, home health and outpatient physical therapy companies as president. From my early days as an Army Ranger to leading a national health care services company today, I have experienced a lot and know what works and what does not.

Bottom line: sound business and leadership practices work — whether the economy is strong or struggling. This is why OrthoSynetics has launched an aggressive education program to educate our orthodontists and practices — and the industry as a whole — on tips for running their businesses during a recession.

Here is what we are telling our customers:

- Understand the brutal facts of the current situation;
- Develop a plan and take decisive action to implement;
- Stay focused on your business plan; and
- Aim high.

Understand the brutal facts of the current situation

Fact 1: The current macroeconomic environment is bad and not expected to improve for the next couple of years. People are rethinking every financial decision they make. Before the current crisis, the cost of orthodontic treatment was perceived as expensive. Now, given the media’s sensationalizing of the current problem, consumers are getting nervous, scared and rethinking their every move.

I am a strong advocate for a well-rounded, educated business plan and respond-
Orthodontists have a second chance to own the technology their patients really care about and to prevent GPs from becoming the technology leaders

By Brett Blake, President and CEO, AccepX

I start with two disclosures: 1) I am not an orthodontist, and my arguments are made from a business and strategy perspective not a clinical perspective; and 2) I don't consult or sell for Align Technology. No one there asked me to write this article; in fact, no one there read it prior to publication. My writing this article not because I care about Align or its shareholders, but because I am genuinely concerned for the orthodontics industry and the practitioners I know in this industry.

This summer, my third child started orthodontic treatment, and even though my eldest two are getting their braces off before the end of the year, they were upset when they found out their younger sibling's treatment would be much shorter. Even though her teeth look worse than my eldest two when they started treatment, my youngest will be in braces just 12 months, compared to nearly three years for my oldest son and two for my oldest daughter.

The difference? My youngest will be treated with SureSmile and Damon brackets by a trained orthodontist.

Three years ago, my wife and I assumed the pediatric dentist with the largest orthodontics practice in town was, in fact, as qualified as any other doctor in town. I didn't learn until months later that a GP could put "orthodontics" on his or her door with little or no formal training.

Apparentely, I'm not alone. In fact, according to estimates made by Piper Jaffray, since 2005, more parents have gone to their GPs for orthodontics than to orthodontists. To add insult to injury, GP-performed orthodontics is growing rapidly, even as orthodontists are seeing a slowing and/or decline in the number of new cases they are treating.

The industry is changing and orthodontists will forever lose their market position if they don't recognize the impact of new technology and move quickly to take back the high-tech frontier.

What does technology have to do with the industry slowing? What does Invisalign Teen have to do with the answer?

Those of you who have been around a few years will remember that Align Technology wasn't always a large, publicly traded company. The company struggled to gain market share, and most orthodontists rejected the new technology as ineffective compared with metal braces (many practitioners still feel that way).

As I said earlier, I am not qualified or interested in arguing about the effectiveness of Align's treatments. This column is designed to raise business considerations and to provide a consumer's perspective. I also hope it helps orthodontists realize there is more to choosing technology than a clinician's assessment of the technology's relative effectiveness.

Align Technology initially held its technology exclusively for orthodontists — no GPs allowed. But orthodontists (as a whole) snubbed their nose at the treatment and, not recognizing the determination of Align's investors, hoped it would go away. It did go away — in part. Align went away from its ortho-only pledge and started to train and sell to GPs. Its technology made it easy for GPs to get into the orthodontic business and started a flood of GP competitors. For GPs, orthodontics is a much more profitable business (even with Align's lab fees) than the general dentistry business they were used to.

The rest is history. Year after year, month after month, more and more GPs hang an "orthodontics" sign on (their) door, and more and more parents (like me) ignorantly suppose they will find the same treatment inside. The frightening part of the whole story is the fact there is a disconnect between what parents and patients care about in terms of new technology and what doctors consider good and new technology.

When it comes to innovation in orthodontics, parents and patients care about two things — treatment time and the cosmetics of the treatment (they hate metal braces). However, practitioners know more, and they can analyze technology in terms of its effectiveness, its feasibility and its ability to deliver long-term quality treatment. Many orthodontists are using their criteria to reject new technology such as Invisalign or SureSmile and feel justified in doing so.

Here is the frightening truth: In the minds of the general consumer (your patients), orthodontists are giving up the treatment frontier to the GPs.

For now, history is repeating itself. Orametrics is trying to keep its technology exclusively for orthodontists, and Invisalign Teen has been introduced as an orthodontists-only technology. Orthodontists can ignore these technologies, but they will not go away — they will go to the GPs. If that happens, GPs will be left with two branded technologies that deliver on the two things patients and parents care most about — time and cosmetics.

My advice to orthodontists is not to abandon their commitment to quality, but to focus on improving these technologies in a way that they become a competitive advantage to the specialty. Find a way to keep them out of the hands of the GPs and to employ them in ways that provide high-quality treatment.

The shareholders of these two technologies will continue to invest and will spend what is required on advertising to drive their adoption. The shareholders have the resources to win the war of public perception and public education. The good news is both of these companies want to work with orthodontists. They want you to have exclusives, and they are willing to turn away from the tens of thousands of GPs who want to work with orthodontists.

I hope not. The orthodontic industry has a rare opportunity to revisit a disastrous decision made just a few years ago. I hope it gets it right the second time around.
Management software transition and success

Yes, they can be used in the same sentence

By David Stephens
President, Merging Traffic, Inc.

I recall a teacher saying, “It’s easier to change a choice than a consequence.” I’ve thought a lot about that and have seen countless examples of its wisdom. We are in control when making the choice, but too often the result is high stress, ongoing frustrations, unexpected costs and compromised patient service.

Why are software transitions so difficult?

• It is an infrequent and unfamiliar process.
• It is complex, involving new hardware, software technology and a new mindset.
• Considerable additional effort is required of a staff already functioning at full capacity.
• There is an underestimation of the task at hand resulting in a lack of preparation.

Because of its nature, the typical transition is on a path to marginal results at best, unless the right choices are made to steer it to success.

Getting it right

There are many choices to make. They require effort and understanding. You must choose to take the lead on, be organized in and follow up in these key areas:

• Determination of practice needs and goals.
• Vendor evaluation and selection assuring necessary functions, usability and service.
• Vendor negotiation to insure timely delivery and promised performance.
• Adequate training and learning verification.
• Integration of hardware and software from multiple vendors.
• Accurate data transfer from the existing software.
• Effective utilization of new capabilities.

Your efforts will be an excellent investment. Imagine patients walking into your office the day after the transition. They are served by a confident staff accessing a new database with accurate data. Software and hardware components are working in harmony. Is it really possible? With correct choices, yes!

Tissue Care in the Maxillary Anterior: Ankylos — A New Paradigm

Catch Dr. DiGallionozzi’s lecture at the Dental Tribune Symposium during the Greater N.Y. Dental Meeting from 1:30–2:30 p.m. Dec. 1.
Is outsourced payment management right for you?

Answering the challenges of auto-drafting

By Marla Merritt

Let’s face it: Patient trends are changing. Whitening used to be just for the super-wealthy, and braces were just for teenagers. Today, the average American adult is willing to spend thousands of dollars to improve his or her smile. These changes in patient trends have allowed orthodontists to increase revenues by offering a wide variety of costly treatments to a new generation of appearance conscious consumers.

Just as patient care preferences are changing, so are patient payment preferences. Online and electronic payments are growing at accelerated rates. In 2007, the Electronic Payments Association (NACHA) reported that more than 18 billion in automated clearing house (ACH) payments, or checking and savings drafts, were made. That is a 12.6 percent increase over 2006 numbers.

Elliot McEntee, CEO of NACHA, reports, “ACH payment volume continues to double every five years with increases experienced across all transaction categories.” Orthodontic practices must position themselves to meet these changes in patient payment preferences.

Auto drafting obstacles

While auto drafting is the preferred payment method for many consumers, implementing this process into an orthodontic practice can be challenging. To provide the most flexible payment options for your patients, you need to make auto-drafting available via check or credit card. While most banks offer software to handle checking account drafts, this requires careful management.

Your staff will have to set up accounts in the software, remember to run transactions daily, weekly or monthly, and keep up with all failed transactions as they trickle in over time.

Failed transactions must be resubmitted. Doing so without first making contact with the patient can result in subsequent failures and bank fees that are costly both to the practice and to the patient.

Credit card processing has similar challenges.

i-CAT certified for compatibility with SureSmile technology

The Imaging Sciences International i-CAT, a leader in cone beam 3-D dental imaging, is the first cone beam system to be certified by OraMetrix, a leading provider of technology-based orthodontic care solutions, for seamless integration with the latest advancements in SureSmile technology, which transforms cone beam scans of the mouth and teeth into 3-D computer models for orthodontic treatment planning and treatment.

The SureSmile system is a doctor-driven digital therapeutic solution for the practice of orthodontics that replaces conventional manually-managed treatment.

Orthodontists now can take an i-CAT scan of the patient’s mouth, face and jaw and use this data in the SureSmile system for unprecedented control of treatment through virtual diagnostic simulations, instant quality grading tools, prescriptive planning capabilities and robotic arch-wire customization.

“The use of cone beam 3-D technology has enhanced the treatment planning success of our SureSmile technology for orthodontists,” says Charles Abraham, CEO of OraMetrix, Inc. “We have tested the Imaging Sciences i-CAT and found that using the detailed and anatomically accurate 3-D scans will help SureSmile customers deliver high-quality patient results. We look forward to working with i-CAT customers and orthodontists to show the integration benefits of these two innovative technologies.”

Orthosynetics is an orthodontic services firm that provides practices with business and administrative support. We define success by supporting our doctor’s goals and ambitions even in a tough economy.

How do you define success?

“Regardless of what the economy is doing, Orthosynetics helps inject a practice with a good dose of momentum. Their methodology delivers greater efficiencies and drives business to my practice. And they even leave me with time for golf. That’s saying a lot these days.” – Dr. Rick Herrschel Texas

Orthosynetics Services Include: Practice Consulting, Marketing and Advertising, Revenue Cycle Management, Purchasing and Much More!

Call Orthosynetics now

1-888-622-7645

You can also sign up for complimentary monthly Webinars at

www.orthosynetics.com

© 2008 Orthosynetics
A member of your staff must obtain credit card information from your patient and store it securely according to the Payment Card Industry guidelines. Then you must initiate the drafts on the date(s) chosen by your patient by hand-keying the information into your credit card machine.

Sometimes this process will require purchasing credit card authorization software. Once again, payment failures for overlimit cards, expired cards and lost or stolen cards must be handled by the staff, and the transactions resubmitted.

In addition, other considerations must be given. Familiarity with the rules governing auto-drafting is a must. These rules address adjusting payment amounts, moving draft dates, appropriate and allowable charges for NSF fees, etc. You must develop authorization forms that meet the guidelines for ACH and credit card recurring payments, and your office must decide how to handle weekends and holidays when scheduled draft dates fall outside of the work week.

While implementing auto-drafting into your practice is an important step, the obstacles mentioned above may keep offices from making the option available to their patients. Even worse, offices may implement auto-drafting and unknowingly be in violation of the guidelines, which are designed to protect consumers. Such violations can be very costly.

Is there a solution that provides the benefits afforded by auto-drafting that doesn’t present so many obstacles?

Overcoming the challenges

Outsourcing payment management may be the solution. Success stories abound from coast to coast. Delinquencies are down, staff productivity is up and practices are saving time and money. Companies such as OrthoBanc can help your practice meet the payment preferences of the savvy consumer while overcoming the obstacles of auto-drafting.

By outsourcing your payment drafting, your staff is relieved of creating coupon books, preparing monthly statements, handling payments received by mail, making bank deposit runs, processing manual credit card payments, answering questions about patient payments and posting payments into your practice management software system. You also are able to present your patient with the option of checking account draft or credit card draft without creating extra work for your employees.

Selecting a good outsourced solution

When choosing an outsourcing solution, select a company that takes responsibility for proper compliance with auto drafting rules and regulations — not one that merely automates the process while leaving you responsible for compliance. Also be certain to look for a company that manages your accounts. This means it handles all aspects of your payments including making contact with patients whose transactions fail, obtaining new expiration dates on cards and keeping your office informed of progress. Such management removes considerable stress from the staff and insures your payment plans are monitored and acted upon immediately when necessary.

Conclusion

If you’re still not auto-drafting your monthly payments, it is probably time to take that step. The process is made easier through companies that offer complete payment management. Your payments will be received on time each month, even if treatment is scheduled less frequently. With increased cash flow and fewer delinquent accounts, your team will have more time to build great patient relationships and provide excellent orthodontic care.
CHANGING PRACTICE MANAGEMENT SOFTWARE?

You’ve heard the horror stories... Don’t become one!

Avoid Mistakes
- Thousands in extra expense
- Selecting the wrong software
- Unfulfilled vendor promises
- Loss of software functionality
- Missing financial data
- Practice disruption and delays
- Unnecessary stress on staff and doctor
- Damaged patient relations

Plan for Success
- Approach the process with confidence
- Choose the right software for your practice needs and goals
- Control costs, meet deadlines and reduce stress
- Properly prepare and train staff
- Insure data conversion accuracy
- Increase software utilization
- Enhance vendor relations
- Protect your patient relations, practice and peace of mind

ATTEND THE SOFTWARE TRANSITION WEBINAR

Session 1
- Why you should be concerned
- The 3 reasons transitions go bad
- Mistakes that lead to disaster
- Do you really need to change
- Evaluating needs and goals
- Selecting the right software/vendor
- Getting beyond the dazzle of demonstrations
- Making the best of vendor references
- Gaining the most from a site visit
- Insuring fair pricing
- Vendor performance guarantees
- Protecting your practice today and tomorrow

Session 2
- Communication - the measure of progress
- Data conversion options and benefits
- Insuring data conversion success
- Maximizing training effectiveness
- Investing in equipment, software and networks
- Tying up the loose ends
- Integrations - making them work
- The day after – safeguards and warnings
- Cleaning up remaining issues
- Staying on the software company’s radar
- Maximizing software use
- Benefiting from good vendor relations

Webinar Schedule – Most Fridays – Check Website for Times
Fee - $295 - (includes both sessions)

Register Today at www.softwaretransition.com
or call 801-737-9372

About Merging Traffic
After observing market wide the difficulties practices experience with software transitions, David Stephens founded Merging Traffic, a software transition consulting company. With over 25 years experience in software sales, implementation and support, his services are designed to prevent the unnecessary suffering inflicted on the well being of practices when they change management software.

MERGING TRAFFIC • www.softwaretransition.com • North Ogden, Utah • 801.737.9372
On Nov. 30, Dr. Gene Antenucci will kick the Symposia off with a session on CEREC 3-D CAD/CAM from 10 a.m.–1 p.m. At 1:30 p.m., Dr. John Schoeffel will discuss “Endodontic Irrigation via EndoVac.” Dr. Daniel McEowen will wrap up the day at 3 p.m. with his lecture on CBCT technology.

Dec. 1 starts with Dr. Neal Patel from 10 a.m.–1 p.m. presenting on 3-D imaging. After lunch, Dr. David DiGiallorenzo will present his lecture, “Tissue Care in the Maxillary Anterior: Ankylos — A New Paradigm.” At 3 p.m., Dr. James Jesse and Dr. Ron Kaminer will present “Minimally Invasive Dentistry in Rapid Fire Fashion.”

On Dec. 2, D4D will host a presentation on CAD/CAM technology at 11:30 a.m. At 1:30 p.m., Randall Donahoo’s lecture, “Enhancing Your Dentistry — Get out of Dentistry Alive!” will focus on the latest technology in magnified dentistry. The day concludes at 3 p.m. with Dr. Barry Levin on “Maximizing Implant Esthetics by Preservation & Regeneration of Alveolar Bone.”

The symposia sessions, which will continue Dec. 3, are free for registered attendees, but pre-registration is recommended in order to ensure preferred seating. The sessions not only offer C.E. credits but provide an invaluable opportunity to learn about a new field and how to integrate a variety of treatment options into your practice.

For registration and further information, please visit www.gnydm.com or send an e-mail to j.wehkamp@dtamerica.com.

The Logic bracket in a simplified application combines the use of a new, low-profile bracket design for the optimal use of the Slide ligature pads. It allows low-friction treatment in the initial alignment and leveling phases without the need for costly self-ligating brackets.

Logic brackets are available in the Step (MBT) and the Roth type prescriptions in both biomedical stainless steel and micro filled copolymer brackets.

Leone America, a division of American Tooth Industries

501 W. Van Buren, Suite S
Avondale, Ariz. 85323
Phone: (623) 927-2094 or (800) 242-9986
Fax: (623) 927-2342
E-mail: leoneamerica@americantooth.com
www.americantooth.com

Dental Tribune Symposia at the Greater New York Dental Meeting

Brought to you by

November 30 to December 3, 2008

The Dental Tribune Symposia at the Greater New York Dental Meeting offer an inspiring schedule of continuing education lectures in various dental disciplines. Each scientific lecture will provide an invaluable opportunity to learn about a new field and how to integrate a variety of treatment options into your practice.

We have developed a course schedule that is both diverse and engaging, and which also offers you the opportunity to earn C.E. credits. The symposia sessions are FREE for registered Greater N.Y. Dental Meeting attendees, but pre-registration is recommended.

Schedule

Sun., Nov. 30
10 a.m.–1 p.m.
CEREC CAD/CAM: The Power of Technology in Clinical Restorative Dentistry
by Dr. Eugene Antenucci and brought to you by CEREC - Sirona

1:30–2:30 p.m.
Endodontic Irrigation via EndoVac: Safety, Efficacy and Clinical Techniques
by Dr. John Schoeffel and brought to you by Dentsply - Smart Endodontics

1:30–2:30 p.m.
Tissue Care in the Maxillary Anterior: Ankylos — A New Paradigm
by Dr. David DiGiallorenzo and brought to you by Tulsa Dental Specialties

3–4:30 p.m.
High resolution Cone Beam with PreXion 3-D
by Dr. Daniel McEowen and brought to you by PreXion

Mon., Dec. 1
10 a.m.–1 p.m.
Using 3-D X-ray Imaging and Planning to Increase Patient Treatment Acceptance
by Dr. Neel Patel and brought to you by Galileos - Sirona

1:30–2:30 p.m.
Enhancing Your Dentistry: Get out of Dentistry Alive!
by Randy Donahoo and brought to you by MagnaVu

3–4:30 p.m.
Bone Preservation: One of the Keys to Esthetic Success in Immediate Implant Therapy
by Dr. Barry Levin and brought to you by A. Titan Instruments

Tues., Dec. 2
10 a.m.–1 p.m.
Enhancing Your Dentistry: Get out of Dentistry Alive!
by Randy Donahoo and brought to you by MagnaVu

1:30–2:30 p.m.
Enhancing Your Dentistry: Get out of Dentistry Alive!
by Randy Donahoo and brought to you by MagnaVu

Program details for Wed., Dec. 3 to follow shortly.

Attendee Registration

For registered GNYDM attendees, but pre-registration is recommended. For additional information and registration, please contact Julia Wehkamp:
E-mail: j.wehkamp@dtamerica.com
Phone: (414) 207-9280
Dental Tribune America LLC
213 West 36th Street, Ste. #810, New York, N.Y. 10001

Ortho Tribune | November 2008

I Will Not Bite the Orthodontist

Amazing Animation has announced the release of a new, hand-painted, limited edition cell from Warner Bros. Studios, “I Will Not Bite the Orthodontist.” The signed and numbered limited edition (only 250 pieces) measures 18 by 20 inches and is matted and framed.

Amazing Animation
(800) 536-7796
www.dentalcollectibles.com

Logic bracket

The Logic bracket in a simplified application combines the use of a new, low-profile bracket design for the optimal use of the Slide ligature pads. It allows low-friction treatment in the initial alignment and leveling phases without the need for costly self-ligating brackets.

Logic brackets are available in the Step (MBT) and the Roth type prescriptions in both biomedical stainless steel and micro filled copolymer brackets.

Leone America, a division of American Tooth Industries

501 W. Van Buren, Suite S
Avondale, Ariz. 85323
Phone: (623) 927-2094 or (800) 242-9986
Fax: (623) 927-2342
E-mail: leoneamerica@americantooth.com
www.americantooth.com

‘I Will Not Bite the Orthodontist’

Amazing Animation has announced the release of a new, hand-painted, limited edition cell from Warner Bros. Studios, “I Will Not Bite the Orthodontist.” The signed and numbered limited edition (only 250 pieces) measures 18 by 20 inches and is matted and framed.

Amazing Animation
(800) 536-7796
www.dentalcollectibles.com

Logic bracket

The Logic bracket in a simplified application combines the use of a new, low-profile bracket design for the optimal use of the Slide ligature pads. It allows low-friction treatment in the initial alignment and leveling phases without the need for costly self-ligating brackets.

Logic brackets are available in the Step (MBT) and the Roth type prescriptions in both biomedical stainless steel and micro filled copolymer brackets.

Leone America, a division of American Tooth Industries

501 W. Van Buren, Suite S
Avondale, Ariz. 85323
Phone: (623) 927-2094 or (800) 242-9986
Fax: (623) 927-2342
E-mail: leoneamerica@americantooth.com
www.americantooth.com
Introducing Invisalign Teen™
Clear, removable, and developed for orthodontists’ needs.

- Compliance Indicators
  Gauge approximate wear time.

- Power Ridge™ Technology
  For lingual root torque.

- Six Free Replacement Aligners*
  Reduce worries over lost aligners.

- Eruption Compensation
  To accommodate naturally erupting permanent teeth.

To learn more, call your local Align representative or log in to your VIP account today.

*Some conditions apply.
Orthodontic Training Workshop

MARCH 20-21, 2009  |  JUNE 26-27, 2009

Increase Your Case Acceptance

YOUR PATH TO GREATER SUCCESS BEGINS WITH IMPROVING THE SYSTEMS IN YOUR ORTHODONTIC PRACTICE. BETTER SYSTEMS INCREASE EFFICIENCY. EFFICIENCY REDUCES EXPENSES, PRODUCES HIGHER PRODUCTION, CASE ACCEPTANCE AND ULTIMATELY HIGHER FINANCIAL GAIN.

Agenda: Day 1

9:00am-12:00pm
Mastering The New Patient Exam
• The One Step Six
• How to Increase Case Acceptance
• Educating and Motivating the New Patient
• Scripting for the Entire New Patient Process
• Creating a Successful “Will Call Back 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
• Community Marketing
• Media/Direct Marketing
• Staff Marketing

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

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

Location
W Hotel
421 West B Street
San Diego, CA, 92101
619-398-3100

Tuition
$695 per person
Includes lunch both days, and course materials.

“Wow, what an informative, comprehensive meeting! You really know the formula to grow an orthodontic practice.”
Dr. Peter Kimball - California

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

Register online at www.orthoconsulting.com or call 858-435-2149

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.

13376 Poway Road | San Diego, California 92064 | Phone 858.435.2149 | Fax 858.748.5270
www.orthoconsulting.com