Case acceptance in complex-care dentistry

Dr. Paul Hamby

I enjoy seeing the articles in complex dentistry in which clinicians recount their creation of art through digital restorative dentistry. In most of the case studies, I see that the patient fees reach well over US$15,000 or more.

Let me ask you this: what percentage of your patients whose fee is US$15,000 or more are ready to start care immediately after you present your treatment plan? I have directed this question to thousands of my dental practice members over the last decade and the overwhelming response is “fewer than 5 percent.” Yes, most patients do not understand dentists’ treatment recommendations. It is only once we have fit them into their budgets? Chances are that both these apply.

As dentists we are pretty good at helping patients understand our treatment recommendations. What we are not good at is understanding our patients and the manner in which our treatment recommendations fit into their lives. If you have heard it once, you have heard it a thousand times: the key to case acceptance is patient education. Go to dental seminars, read journals, listen to consultants, most of it sounds the same—educate, educate, educate. Now let me ask you this: is it true? Is patient education the solution to case acceptance?

If it is, then why do many new patients who have been thoroughly examined, educated and offered comprehensive treatment plans leave your practice and never return for care? Is it that you did not educate them sufficiently? Or is it that in the challenge of case acceptance, patient education is not the only answer.

Let’s consider the new patient process and case presentation and learn when patient education works for us and when it chases patients out the door.

Inside-out versus outside-in

How do we get patient education right? How do we make the distinction between an inside-out versus outside-in approach? A traditional new patient process is inside-out. It begins by studying the history of the patient’s mouth—the examination, diagnosis and treatment plan. It is after this inside look that we educate the patient with regard to all the hows and why’s: how we/he/she got them and what we can do about them, for example case presentation. After case presentation, we quote our fees and discuss financial arrangements. It is only once we have gone through our inside processthat we discover what is happening outside the patient’s mouth—his/her budget, work schedule, time and significant life issues. The flow of conversation starts with inside-the-mouth conditions and ends with outside-the-mouth issues. I label this traditional way of managing the new patient inside-out process (Fig. 1).

For patients with uncomplicated dental needs—fees of US$5,500 or less—inside-out approach with appropriate patient education works well. Here’s why:

First, patients with minimal clinical needs are often unprepared for complex care dentistry. Patients with conditions such as periodontal disease, asymptomatic periapical lesions, and incipient carious lesions must be made aware of them and educated about their consequences. Patient education is the driver of case acceptance when patients are unaware of their conditions.

Next, the inside-out process works well for patients with fees of US$5,500 or less because the outside-the-mouth issues—time, treatment and life issues—are such that most patients can proceed with their treatment without undergoing hardships or inconveniences. Dental insurance reimbursements, patient payment plans such as CareCredit and credit cards usually soak the sting of fees for US$5,500 or less. Fees at this level are not insurmountable and usually do not anger or embarrass patients out of your office. But, if you present complex dentistry for more than US$5,500?

Let’s suppose your fee is US$10,000 and it involves multiple long appointments and your patient would lose time from work? Do outside-the-mouth issues get in the way of case acceptance? Yes, they do. Does patient education make the unaffordable affordable? No, it does not. How do I know? Have you proven it, have you not?

It is with the patient whose fee is greater than US$5,500 that I recommend an outside-in approach. Employing an outside-in approach involves initiating your new patient procedures with conversations—telephones, initial office new patient interview—that focus on understanding what is happening outside the patient’s mouth, such as significant life outside-the-home issues. Once you settle on the broad outside-the-home issues then, and only then, does it make sense to begin discussing the detailed inside-the-home issues, such as room size, carpet and tile selection, lighting, etc. Good estate agents discover what the suitability factors of homes buying are (price, down payment, monthly payments, location, etc.) before they get into the inside details. In other words, the flow of conversation is outside-in.

Now imagine you and your spouse go to the estate agent, but this time she is a former dentist and uses the traditional inside-out process she used as a dentist. As soon as you sit down she begins educating you on the inside-of-the-home issues, and where you want to live. What would you think? You would think about finding another estate agent, would you not?

Here’s why: First, patients with complex needs often come into your office with a specific complaint—embarrassment about their appearance, aggravation by their dentures or fear of losing their teeth. They do not need to be educated about their chief complaint. They may not be aware of all their conditions, but it is most likely that they have lived with the complaint that brought them into your office for a long time.

Next, many complex-care patients have heard the patient education lecture about plaque, pockets and sugar many times before. It’s old news and thus the estate agents have blown patients out of the water— and out of your practice.

Fit versus change

The earlier influencers in my dental career emphasised that a significant part of being a good dentist is to get patients to change. Change the way they clean their teeth, change what they eat and how they prioritize in their life and put dental health at the top. It took me ten years and thousands of patients to realise that patients change when they are ready, not when I tell them to.

I learned to replace the concept of change with the concept of fit. Instead of telling patients they need to change to accommodate my treatment plan, I learned to accommodate my treatment plan to fit their life situation. Patients, especially those who have been complex care patients, have complex fit issues. These include finances, family hassles, work schedules, special current events, travel, stressors, health factors, significant emotional issues; in short, any issues dominating the patient’s energy and attention. When you present complex dentistry, it has to fit into the patient’s life.

Think about it. If you offer most patients a US$10,000 treatment plan, something in their life has to happen. People need to wait to receive their tax refund, wait for a child to graduate from college, become
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10:00 - 11:00 Howard Glazer, DDS, FAGD
BEAUTIFIL: GO WITH THE FLOW - COURSE: 3020
11:20 - 12:20 John Pucek, DDS
LIGHT CURED ADHESIVE DENTISTRY - SCIENCE AND SUBSTANCE - COURSE: 3030
1:20 - 2:20 Martin Goldstein, DMD
A SIMPLIFIED APPROACH TO MULTI-LAYER DIRECT COMPOSITE BONDING - COURSE: 3040
2:40 - 3:40 Jay Reznick, DMD, MD
3D IMAGING AND CT-GUIDED DENTAL IMPLANT SURGERY - 3050
4:00 - 5:00 Leon Malamcher, DDS, MA, GAG
TOTAL FRACTURE ESTHETICS FOR EVERY DENTAL PRACTICE - COURSE: 3060

MONDAY, NOVEMBER 29
10:00 - 11:00 Mr. Neil Badami, DDS
ECO-FRIENDLY INFECTION CONTROL UNDERSTANDING THE BALANCE - COURSE: 4130
11:20 - 12:20 Gregory Kurtzman, DDS
INTEGRATING NEW ADVANCES IN DENTAL MATERIALS AND TECHNIQUES INTO YOUR RESTORATIVE PRACTICE - COURSE: 4130
1:20 - 2:20 Damien McMillan, DDS
OPTIMIZING YOUR PRACTICE WITH 3D CONE BEAM TECHNOLOGY - COURSE: 4140
2:40 - 3:40 Edward Katz, DDS
IMPROVING PATIENT CARE WITH 3D CONE BEAM COMPUTORIZED TOMOGRAPHY - COURSE: 4150
4:00 - 5:00 George Freedman, Fay Goldstep and Edward Lynch
SOFT TISSUE LASERS AND CARIES DIAGNOSIS - COURSE: 4160

TUESDAY, NOVEMBER 30
10:00 - 11:00 George Freedman, Fay Goldstep and Edward Lynch
SOFT TISSUE LASERS AND CARIES DIAGNOSIS - COURSE: 3110
11:20 - 12:20 Greg Diamond, DDS
LASERS IN PERIODONTAL THERAPY - COURSE: 5120
1:20 - 2:20 Ovary Almog, DMD
INTRODUCTION TO CONE BEAM CT (CBCT), ESPECIALLY AS IT PERTAINS TO PREVENTION OF FAILURES IN ORAL IMPLANTOLOGY - COURSE: 5130
2:30 - 3:30 Maria Ryan, DDS, PhD
DETECTING CORONARY HEART THROUGH PERIODONTITIS AND PERIMPLANTITIS - COURSE: 5140
4:00 - 5:00 Dwayne Katschew, DDS
CONTEMPORARY CONCEPTS IN TOOTH REPLACEMENT: PARADIGM SHIFT - COURSE: 5150

WEDNESDAY, DECEMBER 1
12:00 - 1:00 Mr. Al Duke
BEST MANAGEMENT PRACTICE, WASTE MANAGEMENT FOR THE DENTAL OFFICE, AND OSHA COMPLIANCE - COURSE: 6060
1:10 - 2:10 Glenn van As, DDS
HAND AND SOFT TISSUE LASERS - COURSE: 6070
12:45 - 1:45 Dr. Bobbi Smith, Dr. David Lambert, Dr. Jeffrey Hess, Dr. Dwayne Katschew, Dr. Enrico Menoyo, Dr. Ethan Paradis
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THIS PROGRAM IS SUBJECT TO CHANGE.
I am very good at helping patients fit their dentistry into what is going on in their life."

Whether you are using an indirect fit-chat or a direct approach to discovering fit issues, I know I can help. What I do not know is whether this is the right time for you. You mentioned you travel a lot and your company is in the middle of a big reorganization. Do you go abroad with your treatment now? Do we wait until later? Or do we do it over time? Help me understand how I can best fit your treatment into everything that is going on in your life."

This advocacy statement leads to a conversation about the patient's fit issues. This conversation reveals what treatment fits and what does not. You will find that this approach results in many complex-care patients doing their treatment over time, allowing them to stay within the limitations of their fit issues. This is a good thing. I would rather treat two patients for US$5,000 each than no patients for US$10,000. It also yields lifetime patients for you. Patients will exhibit fierce loyalty to you when they experience advocacy.

The decision to educate
The decision when to educate and when to advocate is situational. Figure 5 demonstrates that the impact of patient education on case acceptance is highest when the complexity of the care (and its associated fee) is minimal. Patient education is the driver of case acceptance when a patient's conditions and fees are minimal. However, when the complexity of care increases, the role of advocacy takes over. Advocacy is the driver of case acceptance when the patient’s conditions are complex and fees are high. Copy Figure 5 and keep it in your patient's life.