Case acceptance in complex-care dentistry

Dr Paul Himmel

I enjoy seeing the articles in continuing dentistry in which clinicians recount their creation and evolution of art through digital restorative dentistry. In most of the case studies in these articles, 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 dentist colleagues over the last decade and the overwhelming response is “fewer than 5 per cent.” Is it that first patients do not understand dentists’ treatment recommendations or that they cannot fit it into their budgets? Chances are that both apply.

As dentists we are pretty good at helping patients understand us and 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 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 to make the distinction between an inside-out versus outside-in process? The traditional new patient process is inside-out. It begins by studying the inside 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 outside-the-mouth issues. Then, you, the dentist and sometimes a dental hygienist, tell them about the restorative treatment options. Then, if the patient is interested, you schedule an appointment. The patient may or may not be aware of all the dental conditions and treatments and may or may not have the financial ability to make decisions. The patient may not have the knowledge of what is available and how long it will take to complete the treatment. The patient may not have the time to think about it and make their decision. The patient may not have the ability to change their lifestyle to accommodate the treatment plan.

On the other hand, the outside-in approach is different. The first conversations we will have with the patient are about discovering and understanding their outside-the-mouth issues, to see how they fit. The question to ask is: do they have outside-the-mouth issues? If the answer is yes, then the dentist will need to qualify the issues and educate the patient on how these can effect their dental care. The questions to ask are: do they have a US$10,000 treatment plan that needs to be paid off by 5 per cent? Is the treatment plan going to result in the loss of teeth? Is the treatment plan going to cause stressors in their life that will affect their health and lifestyle?

Inside-out versus outside-in

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 the inside-out process (Fig. 1).

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

First, patients with minimal clinical needs are often uninterested in learning about the disease process. They may not understand periodontal disease, asymptomatic periapical abscesses 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—fees, time in treatment and life issues—are such that most patients can proceed with their treatment without undue hardships or inconveniences. Dental insurance reimbursements, patient payment plans such as CareCredit and credit cards usually sooth 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 what 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. Do you know? I have proven it, have you not?

It is with the patient whose fee is greater than US$5,500 that we see the need for an outside-in approach. Employing an outside-in approach, you initiate your new patient procedures with conversations—telephone calls, office offer new patient interview—that focus on understanding what is happening outside the patient’s mouth, such as significant life issues, budget and work obligations. Later in this article, I’ll show you how.

After we have an understanding of outside-the-mouth issues, we do our examination. Then, during the post-examination conversation and case presentation, we link our treatment recommendations to the realities of their outside-the-mouth issues. Let me show you how.

The flow of conversation starts with outside-the-mouth issues and ends with inside-the-mouth treatment recommendations. I label this an outside-in process (Fig. 2).

An excellent example of an outside-in process is the purchase of a home. Imagine you and your spouse decide to buy a new house. You go to a real estate agent and, just a few minutes into the conversation, you talk about price range, neighbourhood, schools, proximity to work, financing and down payment. These are all big picture, outside-the-house issues, such as location, price range, and the suitability conversations. You probably aren’t very interested in how the inside of the house looks. But if the real estate agent talks about the difference between cement versus gravel base foundations and vinyl siding versus brick exteriors. She goes as far as to recommend another appointment with her so she can show you how to clean a house clean before you buy one. She does all this before she has any idea of what you can afford and where you want to live. What would you think? You would think about finding another estate agent, wouldn’t you?

How many of your complex-care patients, after experiencing your inside-out process, find another dentist for the most likely reason that you spent a bunch of time educating them on inside-the-mouth details before you had any idea what was suitable for them? You educated them right out your door.

An outside-in process works best for complex-care patients. Here patient education is not the driver of case acceptance. This is 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 not a subject that distinguishes them. For many patients, patient education efforts bounce off like BB’s fired at icebergs. Expecting to influence them into a US$10,000 treatment plan that does not fit into their budget by showing them how tall this was naivety.

Let me be clear at this point: we are going to spend some time on the patient education process with complex-care patients, it is just not one of the first conversations we will have.

The first conversations we will have with complex-care patients are about discovering and understanding your outside-the-mouth issues. Would you think the patient would like the suitability conversation with the estate agent. The outside-the-mouth issues of dental needs are often unaware of them.”

Trends & Applications

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 exercise the priorities 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 the 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-care dentistry, it has to fit into the patient’s life.

Think about it. If you offered 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...
For the third year in a row, the DTSC hosts its annual CE Symposia at the GNYDM, offering four days of focused lectures in various areas of dentistry. Find us on the Exhibition Floor in Aisle 6000, Room # 3.

Each day will feature a variety of presentations on topics, which will be led by experts in that field. Participants will earn ADA CERP CE credits for each lecture they attend. DTSC is the official online education partner of GNYDM.

PLEASE SEE PROGRAM DETAILS UNDER WWW.DTSTUDYCLUB.COM/GNYDM

FREE FOR REGISTERED GNYDM ATTENDEES, BUT PRE-REGISTRATION IS RECOMMENDED.

For more information, please contact Julia E. Wehkamp, C.E. Director, Dental Tribune Study Club
Phone: (416) 907-9836, Fax: (212) 244-7185, E-mail: j.wehkamp@DTStudyClub.com

SUNDAY, NOVEMBER 28
10:00 - 11:00 Howard Glazier, DDS, FAGD
BEAUTIFUL: GO WITH THE FLOW - COURSE: 3020
11:20 - 12:20 John Flicks, 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 Remnick, DMD, MD
3D IMAGING AND CT-GUIDED DENTAL IMPLANT SURGERY - 3050
4:00 - 5:00 Lewis Malamcher, DDS, MAGD
TOTAL FACIAL ESTHETICS FOR EVERY DENTAL PRACTICE - COURSE: 3060

MONDAY, NOVEMBER 29
10:00 - 11:30 Ms. Nan Baw-Baw-Baw
ECO-FRIENDLY INFECTION CONTROL UNDERSTANDING THE BALANCE - COURSE: 4130
11:20 - 12:20 Gregol Kurzman, DDS
INTEGRATING NEW ADVANCES IN DENTAL MATERIALS AND TECHNIQUES INTO YOUR RESTORATIVE PRACTICE - COURSE: 4130
1:20 - 2:20 Damien Meltzer, DDS
OPTIMIZING YOUR PRACTICE WITH 3D CONE BEAM TECHNOLOGY - COURSE: 4140
2:40 - 3:40 Edward Kao, DDS
IMPROVING PATIENT CARE WITH 3D CONE BEAM COMPUTORIZED TOMOGRAPHY - COURSE: 4150
4:00 - 5:00 George Friedman, Fay Goldstep and Edward Lynch
SOFT TISSUE LASERS AND CARRIES DIAGNOSIS - COURSE: 4160

TUESDAY, NOVEMBER 30
10:00 - 11:00 George Friedman, Fay Goldstep and Edward Lynch
SOFT TISSUE LASERS AND CARRIES DIAGNOSIS - COURSE: 4110
11:20 - 12:20 Greg Diamond, DDS
LASERS IN PERIODONTAL THERAPY - COURSE: 5120
1:20 - 2:20 Ov Almog, DMD
INTRODUCTION TO DENTAL 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 PERI-IMPLANTITIS - COURSE: 5140
4:00 - 5:00 Dwayne Karsdrew, DDS
CONTEMPORARY CONCEPTS IN TOOTH REPLACEMENT: PARADIGM SHIFT - COURSE: 5150

WEDNESDAY, DECEMBER 1
10:00 - 11:00 Mr. Al Duke
BEST MANAGEMENT PRACTICE, WASTE MANAGEMENT FOR THE DENTAL OFFICE, AND OSHA COMPLIANCE - COURSE: 6060
11:20 - 12:20 Glenn van As, DDS
HARD AND SOFT TISSUE LASERS - COURSE: 6070
12:45 - 2:45 Dr. Benjamin Belsicher, Dr. David Hunter, Dr. Jeffrey Hess, Dr. Dwight Karsdrew, Dr. Trudy Karsdrew, Dr. Ethan Panaeza
THE FIRST ANNUAL 3DUB UNIVERSITY SUMMIT: IMPLANT DRIVEN DENTISTRY - COURSE: 6046

THIS PROGRAM IS SUBJECT TO CHANGE.
Discovering fit issues

Your team often knows what is going on in the patient’s life. How do they know? They talk— they chat— with the patients and they make friends. Another purpose of chat-chat is to learn about those fit issues in your patient’s life impacting their treatment decision. When chat-chat is intentional, I call it fit-chat—an indirect way of discovering patient fit issues.

When you fit-chat, be curious and listen more than you talk. Listen to the manner in which patients spend their time and what they are not doing in their life— health, money and/or family issues. If they mention something you believe may influence a treatment decision, be curious, listen attentively and encourage them to talk more about it. Through indirect fit-chat, you’re going to discover what’s going on in patients’ lives.

Some patients do not fit-chat well. They are simply not talkers. I am that way. When I get my hair cut, the last thing I want is a chatty experience. When you hold good eye contact, listen attentively), your conversation leads to a conversation about the patient’s fit issues. This conversation reveals what treatment fits and what does not. You will find the best 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 area where you will see it often. Then, right before you go into case presentation, look at it and ask yourself: does this patient need education or advocacy? Let the situation guide you. When you do, you will discover how to keep from educating your patients out the door.

I know I can help. What do I 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 re-organization. Do you do abroad with your treatment now?

An absolute prerequisite to a good first conversation is for you to have a connected communication style. This means you hold good eye contact, listen carefully and patiently; you maintain a conversational tone of voice and your speaking rate is relaxed. Be sure to pause long enough to let what you are saying sink in.

If you attempt to use a direct approach to fit issues but have a disconnected style (do not look the patient in the eye, speak too quickly, do not listen attentively), your conversation may be perceived as being in- appropriate, unprofessional and seeking to diagnosis their problem sneakily.

Advocacy

Advocacy is the experience of patients when they realise that you are guiding them towards and not selling them into dental health. To be an advocate is to be a guide. To guide patients into complex care effectively you need to take the fit circumstances of their life into account. 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.

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