MICRODENTAL
a dti laboratory

DUBLIN·CALIFORNIA

Improving Case Acceptance

Mark T Murphy DDS FAGD
mmurphy@dtidental.comm

Step 1 - Review or develop Vision & Mission

Step 2 - Business and operation analysis (SWOT Analysis)

Step 3 - Develop and Select Strategic Options

Step 4 - Establish Strategic Objectives

Step 5 - Strategy Execution Plan

Step 6 - Establish Resource Allocation

Step 7 - Execution Review

- Money
- Time
- Health
- Friends
- Patients
- Fulfillment
- Meaning
- Philanthropy
- Volunteer

Circumstances
Temperament
Objectives

The Revenue Formula

$$GR = NP \times FP \times AAP$$

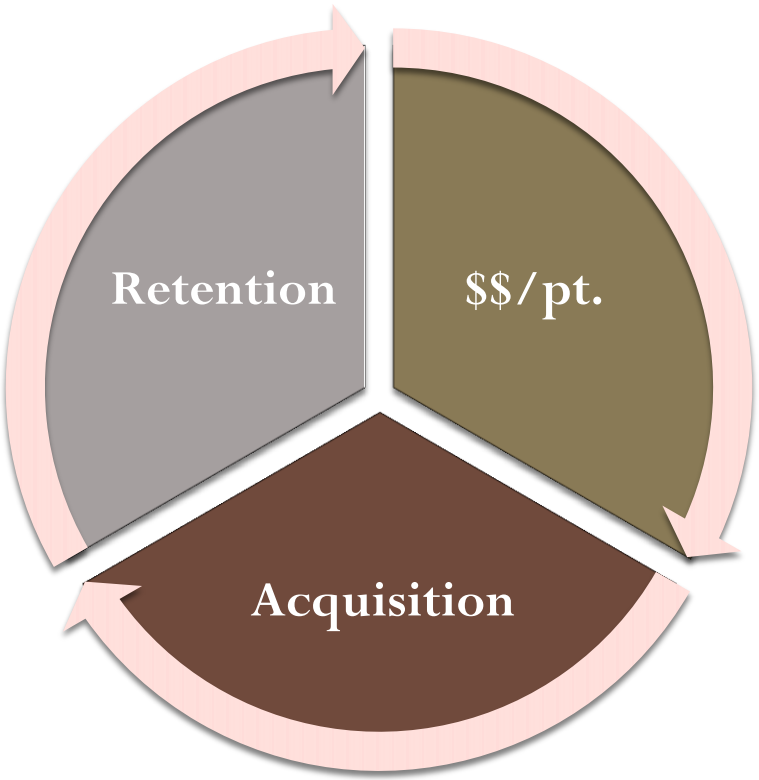
GR = Gross Revenues

NP = Number of Patients

FP = Frequency of Purchase

AAP = Average Amount of Purchase

Customer Equity
Patient Value



- Conversion
- Penetration
- Retention

Normal Trackers

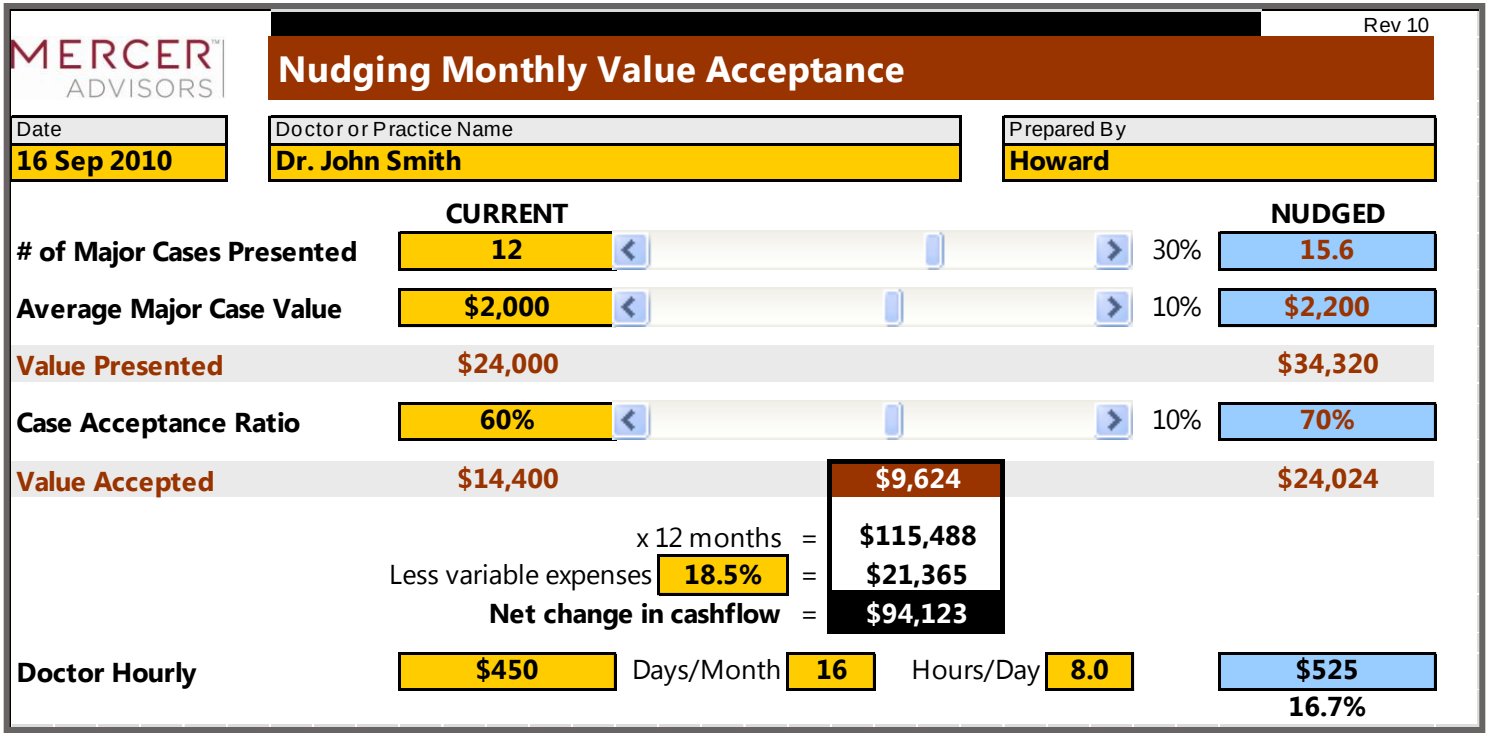
- Diagnosis → Do you diagnose comprehensively?
- Present → Do you present complete treatment?
- Accept → Level of acceptance? (over $?000)
- Appoint → Clinical appointment maintenance?
- Bill → Bill for the full fee?
- Collect → Collect the full fee?

Improved Case “Behaviors”

- Diagnosis →.
- Present →.
- Accept →.

- Appoint →.
- Bill →.
- Collect →.

Little nudges…



MERCER ADVISORS

Rev 10

Nudging Monthly Value Acceptance

Date	Doctor or Practice Name	Prepared By
16 Sep 2010	Dr. John Smith	Howard

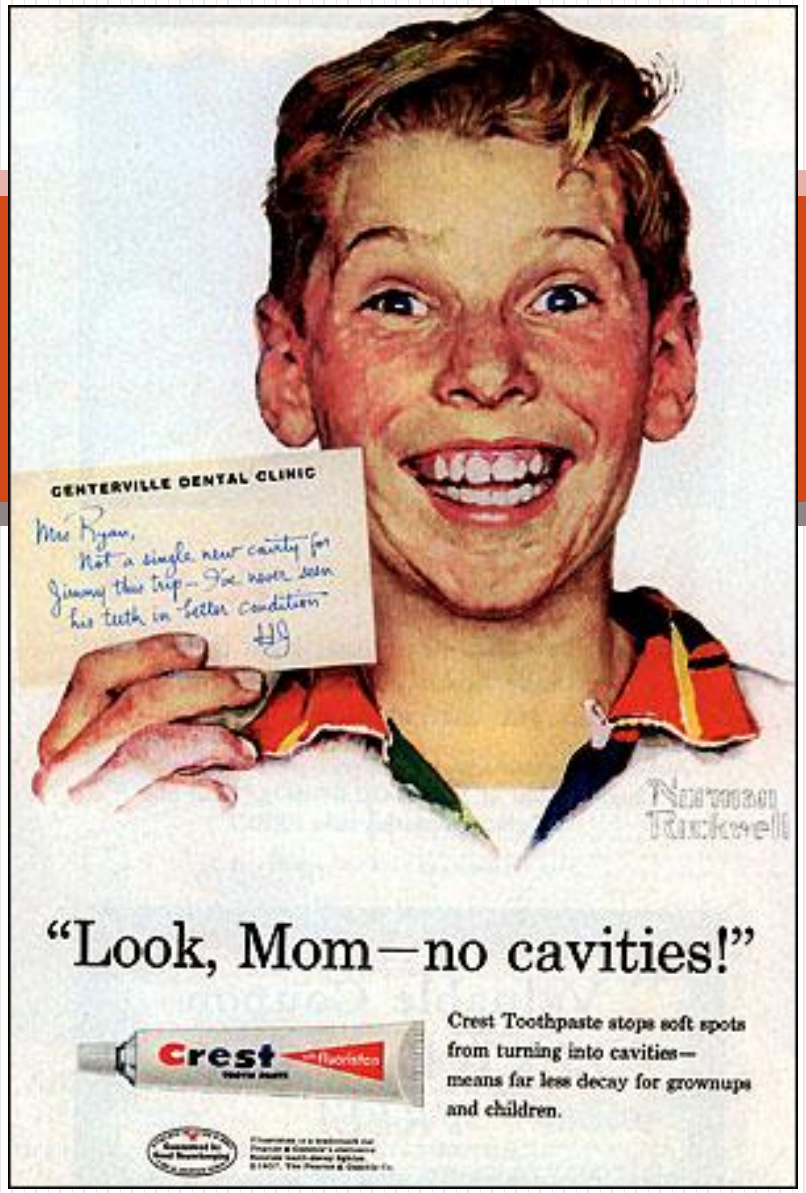
	CURRENT		NUDGED
# of Major Cases Presented	12	30%	15.6
Average Major Case Value	$2,000	10%	$2,200
Value Presented	$24,000		$34,320
Case Acceptance Ratio	60%	10%	70%
Value Accepted	$14,400		$24,024

		$9,624
x 12 months	=	$115,488
Less variable expenses 18.5%	=	$21,365
Net change in cashflow	=	$94,123

Doctor Hourly	$450	Days/Month	16	Hours/Day	8.0	$525
						16.7%

The Comprehensive

Curiosity Inducing Co-Discovery



New Patient Examination

Experience

signs/symptoms

Post Readers Digest Survey

- Educate the Patient
- Explain the Clinical Exam
- Advise of Current Conditions
- Phase Treatment
- Explain Fees
- Offer Payment Options
- Partner with the Patient
- Develop a relationship based on trust

80% of our waking time is spent communicating…

9 % Writing

16 % Reading

30 % Speaking

45 % Listening

Learning Ladder

The Three Most Important Steps to Case Acceptance

by Mark T. Murphy, DDS

I play Texas Hold'em poker and have had pretty good success at it. The math is easy enough when it comes to knowing the chances of making a better hand and comparing that to the pot odds that the bettor has created. There remain two intangibles in the game: one that is a learned skill, and one that is pure chance. Reading another person's "tells" helps players decide whether others are bluffing or representing a real hand. Reading people can be taught and become a skill that helps players make good poker decisions. Then comes the random distribution of the remaining cards. Even if you hold the strongest of hands before all the cards are played out, a chance exists that your opponent can beat you if he or she "draws out" a better hand than yours.

I wish there was some kind of a green/yellow/red light on every patient's forehead indicating their level of preparedness to move to the next level in discussions when presenting treatment plans. I would be able to tell if they had become aware and interested in my educational component and then gauge their trust in me and commitment to move forward with the actions I would recommend. In fact, those are the six steps of the learning ladder (illustrated at left).

I often lecture about striving to achieve "total case acceptance" and use this very valuable tool that was given to me in 1985 at the Pankey Institute by Dr. Don Absjornson of Lincoln, Nebraska. It has six distinct steps that we can use to guide a conversation and case presentation, but in reality, we can only control some of these steps and the rest are a bit like playing poker. If we understand the entire process that leads to case acceptance and develop our skills to improve our chances, it might still "seem" like poker, but the odds of winning will be squarely in our favor.

continued on page 46

continued from page 44

What I have observed over the years is that two of these steps are easy to do, and one results from the success of the others… that leaves three "variable" steps that are *key* to gaining case acceptance. Moving a patient from unaware to aware is second nature to us. As dentists, we have become adept at educating our patients and have many resources that we can call upon to help. Models, charts, interactive software and our own explanations help a patient become more aware than they might have been about their present condition. When a patient is truly committed to doing something to improve his or her health, function and aesthetics, the movement to action is a foregone conclusion. At that stage, it become important to have tools on hand to help execute on the decision to act, such as patient financing, staged treatment planning and clear expectations. Overcoming those impediments are relatively easy. CareCredit, for example, provides a multitude of payment options that help overcome the financial barriers to treatment more easily than we could ever design on our limited resources and platforms.

It is the other three steps, interest, trust and commitment, that present the greatest challenge for us. Like playing poker, the better we can learn to set these steps up and read our patients, the higher our case acceptance will be. Look at each of these steps and find out how we can apply them on a daily basis.

"Awareness does not imply interest. Interest develops when someone begins to see the value for them."

Interest

Awareness does not imply interest. I wish it did, because I would have been more effective with patients in my early years. Interest develops when someone begins to see the value for them. "What's in it for me?" is the question we should focus on to move a patient from being made aware of a periodontal, restorative or occlusal situation, to getting them interested. It can mean "what is in it for me if I don't" do something about the situation at hand as well. The key here is that *they* must realize the interest for them; we cannot prescribe it or simply tell them about the consequences. It is more about *asking* questions to guide their thinking than it is about *telling* them. We have to have the patience to let them co-discover with us what we are observing. If we do an exam and just *tell* patients what we're seeing, chances are slim we'll create any real interest. If we have the patient examine with us and stay in the questions about our own observations, they will have a better chance of becoming curious and interested as they co-discover what we see. For example:

"Mrs. Jones, can you see this area here where the filling is chipped and broken? This restoration fills more than half of the entire tooth and is barely holding on. I am curious, how was it that you decided to place this large of a silver filling in that tooth when you had it fixed?"

Patients often respond by saying they really didn't decide; the dentist did. We now have an opportunity to ask them if they would value being involved in the choice of materials when we get ready to talk about how that tooth can be restored. This generates curiosity, and yet we have not gone anywhere near solutions or presenting treatment. We are just staying in the question and discussing the problem or concern we have. We are letting them know there are choices. You will be able to read patients' verbal and non-verbal communication in relation to the level of interest generated. As they ask their follow-up questions or stare at the monitor or mirror to better see what you have described, you know they have stepped up the learning ladder with you.

Trust

Honest, verifiable comparisons that you allow a patient to apply to your co-discovery process is a quick way to establish trust. If you show the health (especially in their own mouth) and then let them compare and score themselves in a diseased area, they are likely to begin to trust your opinion and observations because they can come

continued on page 48

continued from page 46

to the same conclusions themselves. In this way, you are not telling them what you see; instead, they are co-discovering again and understand the standards that we keep score with. They (not us) conclude that something is wrong and needs fixing. They believe and trust themselves and you for leading them this way:

"Mr. Smith, can you see this gum here? Can you see how it is pink and not red? See how it lays flat against the teeth and is not puffy? See how it comes up to a nice point in between the teeth not rounded or blunted? And see how the surface is rough like and orange peal, not swollen and smooth? This is really healthy gum. And when I try to measure the health of this gum with this instrument (perio probe), I cannot go deeper than this first line which is 3mm. There's no bleeding either. This is a healthy gum. Now let's take a look around all of your teeth and measure the health of the gum in six areas about each tooth. 31, 323, 313, 323, 557…! Take a look up here with your hand mirror. See how different that gum looks. It bleeds before I can even remove my measure. It's blunted, swollen and reddish-blue looking."

The patient comes to the same conclusion as we do, that something is wrong. The patient does not feel we are making something up or selling them something. We all understand the early detection of disease, and can come to conclusions ourselves when we have the standards (120/80 familiar to anyone?). We trust the results and the person delivering the information.

Commitment

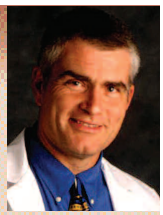
The toughest step to allow a patient to take is the commitment statement. When we hear, "Doctor? What can I do about that?" we have finally earned the right to *tell* the patient what we have observed that they need to solve their problems. All too often we lead with the solution instead of waiting until we are asked. Patients commonly move through trust and commitment together almost as one. When they are sure you are really acting on their behalf and with their best interest in mind, they know you are the right person and they want to know what to do. Just listen, they will ask. Sometimes they ask with their eyes or through body language, but usually they ask out loud and want to know what their advocate – you – would do.

"This flattening here and here, as well as on these other teeth is from the excessive force you can put on your teeth when sleeping. We eat with 45 pounds per square inch and our teeth only touch 20 minutes a day. When people clench and grind at night, they can apply up to 400 pounds per square inch and a lot longer than 20 minutes. Those forces can wear, crack, loosen or even break teeth. Eventually several more of your teeth will break like this one over here and you will need more crowns and maybe even a root canal like this one did."

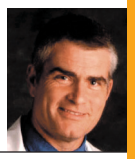
When patients have climbed up the learning ladder with you and have become interested and trusting, they will ask what they should do. Now you have earned the right to discuss a splint, occlusal therapy and restorative needs. This is a better way to have patients want what we know they need.

Reading patients' responses and being patient while we develop the relationship and let them climb the learning ladder will help us become more proficient at case acceptance. With the present condition, technical solution and behavioral riddles solved, we can turn our attention to the financial riddle. Patient financing options like CareCredit or phased treatment can help us get to the final yes. Will the learning ladder and our observations work 100 percent of the time? Of course not. But just like in poker, understanding patient behavior and observing them will help us win more often. You can bluff if you want to, but getting your money in with the best hand is the best way to win. Reading the signs that patients are moving along that ladder with us will make treatment plan acceptance much more predictable and profitable, for us and for the patient. I'm all in! ■

Author's Bio



Mark Murphy is a featured presenter for the National Dental Network and the National Lab Network, and lectures internationally on a variety of dental clinical and behavioral subjects. He practices part-time in Rochester Hills, Michigan, and teaches at The Pankey Institute in Key Biscayne, Florida, where he served full-time as the director of professional relations during 2005 and 2006. For more information or to contact Mark e-mail him at mmurphy@pankey.org or visit www.mtmurphydds.com.



MythBusters: dental insurance

For more on this topic, go to **www.dentaleconomics.com** and search using the following key words: *dental insurance, insurance reimbursement, access to care.*

The TV show "MythBusters" typically tests a popular myth that has become URBAN LEGEND OR FOLKLORE. Sometimes they bust the myth, and other times they prove it true. They design experiments, manufacture props, and use all kinds of scientific applications to simulate the reality needed to confirm or deny the myth.

I want to be perfectly clear before taking on the dental insurance goose that laid a golden egg. I am not opposed to dental insurance as a concept or as it is applied. However, I will challenge its limitations, language, and the dependence upon it that compromises our ability to do our best. Access to care is of the utmost importance in our world today, and we should do all that we can to improve it. I am just not convinced that what we have is working as well as it could.

"Dental insurance ... it's not really insurance at all." Insurance is defined as a third party taking the risk of a catastrophic loss. My wallet does not have $1,200 in it, and that is the annual limit of most dental insurance reimbursement. While we can agree that there is nothing "catastrophic" about $1,200, CareCredit and other third-party financing companies could help us with those out-of-pocket costs. It is a lot of money, to be sure, but it lacks the catastrophe that insurance was designed to protect us against. If you lost your home to fire, totaled your car, or had major medical surgery that required hospitalization, that would be catastrophic.

"If other insurances worked like this, we would revolt." If you totaled your new car and the insurance adjuster offered a $1,200 to $1,500 total settlement, you would call the state insurance agency, the Better Business Bureau, and your lawyer to complain. We have expectations of coverage for catastrophic losses that would be severely unmet. However, that is exactly how most dental insurance works.

"Call it what it really is … a maintenance plan." If your car insurance only covered oil changes twice a year, annual tire rotation and wiper blades, and a tune-up every three years, it would be useful to have, but it is not insurance. Dental insurance helps us keep our mouths in good health, but if something bad should happen that required an expensive fix, we are out of luck.

"If dental insurance kept up with inflation, it would cover $7,500." Depending on whether you start with $1,200 or $1,500 and use 3% to 5% inflation rates, dental insurance should cover $5,000 to $9,000 by now. Can you imagine answering a patient's often-asked question, "Will my insurance cover that?" with, "It will cover the first $7,500 ... and then we can use another $7,500 next year"? Wow, that would improve treatment plan acceptance.

"Our reliance on this entitlement has compromised recommending necessary care for patients." Not everyone or every time, but more often than not, dental insurance clouds the treatment planning process and makes it more difficult for us to do our best for our patients. The easiest way to achieve the coveted million-dollar practice is to treatment plan one crown and two cleanings a year on 1,000 patients. It does not require developing strong health-care advocacy relationships or comprehensive examination and treatment planning. You don't even need good communication skills or education. You simply have to point at a broken-down tooth and answer "Yes" to the "Does my insurance cover this?" question. It is an easy sell.

On the other hand, not many of us set out on this journey with the vision that we could do "one tooth at a time" or "insurance dependent" dentistry and find real meaning and fulfillment. We want to do and be our best. Choosing comprehensive care takes time and commitment.

At Pankey, I learned the people and financial skills that could support developing the practice style that would allow me to do my best stuff for and with people I like. But the siren's song of dental insurance sounds oh so sweet and smooth. That road travels easier than the rest. It is the path of least resistance. When we invented this reimbursement method and left it unchanged for 40 years, we chose the least resistant path. Maybe it is time for some of us to take the path less traveled. It may make all the difference for us and for our patients.

Freedom of choice is our greatest individual power. **DE**

I shall be telling this with a sigh
Somewhere ages and ages hence:
Two roads diverged in a wood, and I –
I took the one less traveled by,
And that has made all the difference.
— Robert Frost

Mark Murphy is a featured presenter for the National Dental Network and the National Lab Network. He lectures internationally on a variety of dental clinical and behavioral subjects. Dr. Murphy practices part time in Rochester Hills, Mich.. You may contact him by e-mail at mtmurphydds@gmail.com or visit mtmurphydds.com.