

Aesthetic Dentistry

TECHNOLOGY AND INNOVATION IN PRACTICE MANAGEMENT & AESTHETICS | VOLUME 18 ISSUE 2 • SUMMER 2019



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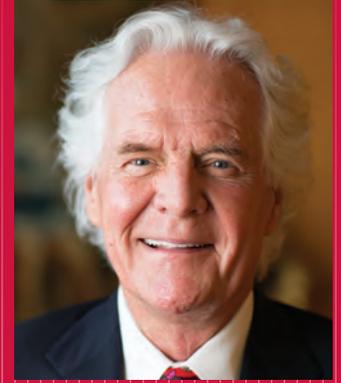
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The Unfinished Dentist

Ask, “What Kind of Dentist Do I Want to Be?”

I am often asked what the difference is between dentists who are productive and profitable compared to those who seem to struggle. My answer is simple—it's their mindset. The dentists who produce at the highest levels are generally practitioners of a philosophy I like to call “the unfinished dentist.”

Every year, new dentists receive their diplomas and embark into practice all across the nation. For many, graduating from dental school is seen as the completion of the bulk of their education as dental professionals. In truth, it is. However it shouldn't be viewed as the end of learning, but rather the beginning of an educational journey that lasts until retirement.

Simply showing up to work every day, doing the things that you learned in dental school, and just getting faster at them is not the same as having an active commitment to learning. Instead, it is a recipe for dental mediocrity that will rob you of your potential and your patients of the outcomes they need and deserve.

You might be thinking that this doesn't apply to you, but before you decide, answer a couple of questions. First, have you ever done a full arch reconstruction? If the answer is no, then

what is your goal to make this a reality in the next 12 months? Next, what advanced procedure or procedures currently make you feel uneasy or inspire within you a sense of fear?

Simply showing up to work every day, doing the things that you learned in dental school, and just getting faster at them is not the same as having an active commitment to learning.

The follow-up question is how do you intend to move past such feelings and start doing those procedures regularly, making sure to present the option to every patient who is in need of such treatment?

An unfinished dentist is a practitioner who is constantly learning and working at the edge of *(continued on page 42)*



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The Road to Success

From Dental School to an Expanding Practice in Five Years.

With this cover story, Aesthetic Dentistry magazine decided to highlight an emerging dentist and her team. We hope the tips that Dr. Cariappa's shares about her early success will be inspiring for other dental teams.

In 2014, I graduated from The Ohio State University College of Dentistry in Columbus, OH. Today, about five years later, I own a dental practice in Stonington, CT, and I am in the process of acquiring two additional practices in Rhode Island. Our goal is to build a small group practice.

Everyone on my team shares a paramount goal: to deliver the highest quality dental care in a holistic and personalized manner.

My team and I are often asked what the secret is to the early success of our practice and what motivates us to create a group practice. The simple answer is that our success is driven by the strength and unity of our team, and our desire to grow has been ignited by the passions and beliefs we have in common. Everyone

on my team shares a paramount goal: to deliver the highest quality dental care in a holistic and personalized manner.

EARLY MENTOR

Dr. Les Prasad, a family friend and dentist in Cranston, RI, guided me to the right path early in my career. He encouraged me to take several continuing education (CE) courses to build on the skills I had developed in dental school. While there, I did voluntary externships with Dr. Prasad. This provided me with initial exposure to high-end cosmetic dentistry, as well as a caring and personalized treatment philosophy.

After that experience, I knew the direction I wanted to take for my own career. On Dr. Prasad's advice, I enrolled in the New Dentist Program with the Dr. Dick Barnes Group (DDBG) in Salt Lake City, UT, even before I graduated from dental school.

After graduation, I moved to Rhode Island and became an associate with Dr. Prasad. I began to implement all of the skills and techniques that I learned from him and the CE courses I was taking.

In his practice, Dr. Prasad had already successfully implemented strategies for patient management and case presentation. Since he was using a



lot of the techniques I learned in the New Dentist Program, it was easy for me to follow in his footsteps and do the same. I am grateful to Dr. Prasad for his guidance and am very fortunate to have him as a mentor throughout my career.

FIRSTHAND EXPERIENCE

Since I was only working with Dr. Prasad part time, I got a second job with a nine-location group practice in Rhode Island. That experience was crucial because it gave me insight about how a group practice operates. I figured out what I liked, what I didn't, and how I wanted to run my own practice. It was also eye-opening to see the vast differences that exist among dental providers with regard to treatment philosophies, treatment planning, and execution.

Soon after joining the group, management encouraged me to lead the other dentists in the group and implement the practice methods that I had learned from the DDBG. I arranged for the dentists to take the Everyday Occlusion and Full Arch Reconstruction CE courses to encourage them to utilize better clinical strategies and techniques.

Senior management and I also attended the DDBG's Total Team Training course with the goal of inspiring the rest of the team members (both clinical and administrative) to implement this type of comprehensive dentistry.

During this time, we realized that, due to the varying levels of experience and skills among the 17 dentists in the group, a simplified course was needed. I worked with the DDBG and one of their clinical instructors, Dr. Jim Downs of L&D Downs Dentistry in Denver, CO, to create a specialized course called "Beyond the Basics." It focuses on mastering the basic principles of dentistry. The course was based on the premise that "you have to walk before you can run." The course was so successful, it was incorporated into the DDBG curriculum, and today I help teach the course with Dr. Downs. >

Aesthetic Dentistry

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Warning: Reading about techniques, procedures, and materials in this publication does not necessarily qualify you to integrate the new techniques and/or procedures into your practice. Exercise caution as you are solely responsible for specific treatments and options for your patients.

As exciting and wonderful as full arch and full mouth rehabilitations are, dentists must first master a single unit, bridge, or quadrant in the most efficient and qualitative way. The dentists in this group learned that there are better and more efficient ways to perform dentistry than those they had been employing for years.

A NEW PRACTICE

Within a couple of years, the group practice began to evolve into a dental service organization (DSO), with many changes that no longer aligned with my philosophy. Some colleagues in this group who shared the same philosophy and goals ended up leaving. Soon afterwards, I knew that it was also time for me to take a leap of faith and start out with my own practice.

Our group is based on the principle that treating patients and employees well leads to success. We focus on empowering the team.

Once my decision was made, I was presented with the opportunity to purchase a well-established practice in the idyllic town of Stonington, where high-end cosmetic dentistry was already being practiced. I knew this was the perfect fit for me, and I only needed the support of a great team to make my dreams come true.

THE DREAM TEAM

The first people I contacted about possibly joining my team were two former members of management from the group practice: Samantha Burnell, the former COO of the group, and her "right-hand woman," Amanda Kirwin, who oversaw personnel and operations.

When the group practice changed to a DSO, Samantha and Amanda left and started a dental consulting company. Since I, too, had decided to leave shortly after they left, we decided to team up. The three of us had already built a relationship based on our shared passion for patient-centric dentistry.

Having a strong team enables me to engage in guest lecturing, attend high-end CE courses, and expand my credentials.

Samantha's background brought invaluable skills to the team. She began her career as a dental assistant and gained experience in every dental specialty while she was studying to obtain a degree in dental hygiene.

Amanda is trained as a certified dental assistant, and has experience assisting in almost every specialty in the dental field. She is a front desk administrator who can perform all of the front desk and dental insurance duties, as well as manage our social media accounts and medical billing.

Samantha and Amanda were largely responsible for leading the group's acquisitions and transitions, and were instrumental in growing each practice. This experience gave them a great understanding of dentistry as well as business management.

Deciding to strike out on my own with the “dream team” was the best decision I ever made. As a team, we realized almost immediately that this was what we were meant to do. We got right to work, bringing in new technologies, expanding the treatments we could offer, and implementing transparent systems by utilizing cloud-based technologies on both the dental and business ends. Having our systems easily accessible allows everyone to check on what’s going on clinically and financially.

Today, Samantha and Amanda handle everything from human resources (such as hiring staff, writing policies and manuals, training team members, etc.) to bookkeeping, renovations, marketing, and social media—in other words, nearly all aspects of our operations. The only services we currently outsource are tax filing and IT support, which saves money and allows us direct oversight of all other aspects of the dental practice.

I focus the majority of my time and energy on dentistry. Having a strong team enables me to engage in guest lecturing,

attend high-end CE courses to expand my credentials, and look into new technologies and techniques that improve the patient experience. I am a recent Diplomate of the American Academy of Dental Sleep Medicine and am excited to offer those services to our patients.

We offer comprehensive treatment focused on best practices, rather than treatment dictated by insurance.

We have been fortunate to inherit other amazing team members in Stonington—Traci, Dale, and Nancy—who have supported our mission since the first day. Our team has expanded, and now three of our former colleagues—Kaitlyn, Amber, and Lisa—are current members of our team. Other former colleagues who know what we are trying to accomplish ▶



(Above, from left to right) Amanda Kirwin, Dr. Shanthi Cariappa, and Samantha Burnell. Their strong leadership has led their practice to early success.

have reached out, seeking to join our team. This has motivated us to expand our practice into a small group.

Our group is based on the principle that treating patients and employees well leads to success. We focus on empowering the team to continually learn and think independently. I want our hygienists and assistants to help me identify dental issues, find their causes, and understand and discuss the possible treatments and outcomes with patients.

For a dentist, being confident, believing in what you say, and not wavering are keys to case acceptance.

Many of my team members have been in the dental field longer than I have, so it would be a shame to not take advantage of their knowledge and experience. Getting the same information and advice from multiple providers gives patients better understanding and greater comfort, which leads to a ready acceptance of treatment suggestions.

Encouraging the team members to be involved motivates them to have an ownership mentality, which in turn creates a team spirit with everyone playing a role. We all understand that how well we do our part affects the rest of the team and our patients. This leads to individualized care, which our patients notice and appreciate.

PERSONALIZED TREATMENT

We offer personalized, comprehensive treatment focused on best practices, rather than treatment dictated by insurance.



“With a great team that functions at a high level, I’m able to focus on the dentistry.”—Dr. Shanthy Cariappa

Individualized treatment helps independent dentists stand apart from the dental corporations that are becoming commonplace.

Dental insurance has already become a “supplement” rather than true “insurance,” and many dentists have succumbed to the temptation to allow insurance companies to dictate the treatment they provide. Due to the increasing costs of health insurance, many employers are no longer providing dental insurance, and now it is not just retirees who are uninsured.

Because of this, our practice offers an in-office savings plan as an alternative for patients who do not have dental insurance. We offer this plan so that people can get the treatment they need and desire. Our patients have been saving thousands of dollars with the in-house savings plan, which we implemented immediately upon opening our practice.

Neither my practice nor my team are insurance-driven. We focus only on best practices and predictable outcomes to determine our treatments. We try to fully utilize insurance for our patients—it is difficult to move away from an insurance-driven mentality, and not every dentist can do it. We are fortunate that our patients truly value the services that we provide.

Most dentists get bogged down with everyday duties. It’s easy to obsess over such matters but they can distract a dentist from his or her true focus.

For a dentist, being confident, believing in what you say, and not wavering are keys to case acceptance. Sometimes doctors get into a negotiation with patients, but patients should never dictate treatment. That only causes them to “shop around.” As the doctor and the expert, the dentist should dictate treatment. Some of the tools we use to educate our patients include the following:

- **Utilizing proper verbiage to show value to patients.**
We learned this from the Total Team Training course.
- **Using both intraoral and extraoral photos.**
These help to educate patients on their situation and the possibilities for their future.
- **Using the American Academy of Cosmetic Dentistry (AACD) photo series.**
- **Showing before-and-after photos.**
We highlight similar cases to help patients understand the outcomes they can expect as a result of treatment.

FOCUS ON DENTISTRY

Most dentists get bogged down with everyday practice management, human resources, finances, accounting, and data analysis—none of which are taught in dental school. It’s easy to obsess over such matters, but they can distract a dentist from his or her true focus.

As a clinician, you should be focusing on patient care. I am able to do just that because of the great people I work with. I trust and respect my team members. In addition, we have set up

simplified, transparent systems with checks and balances so that it is easy for me to monitor everything.

Seeing team members who are happy at work every day, and who feel rewarded both emotionally and financially, is another main reason why we believe that growing our group is the right thing to do. With our team in place, I can feel confident that even as we expand, I can stay focused on dentistry, mentor new dentists who join our group, and collaborate with other like-minded colleagues.

Our goal is to build a group of professionals who share our philosophy and ideals so that collectively we can provide high-quality dentistry to an ever-growing patient base. Whether we achieve that by growing our group, or by providing consulting services, we want to do what we can to keep the practice of dentistry in the hands of skilled and caring service providers. With each patient we treat with our patient-centric philosophy, we inch closer to this goal. ■



Dr. Shanthi Cariappa was born and raised in Cincinnati, OH. It was her dream to become a dentist, and she wasted no time in pursuing that goal. Dr. Cariappa earned a Bachelor of Science degree from Adelphi University in Garden City, NY, and graduated in 2014 from The Ohio State College of Dentistry in Columbus, OH. Since then, she has been an associate in private practice in Rhode Island, and now has her own dental practice in Stonington, CT.

Dr. Cariappa has taken extensive continuing education courses not only in cosmetic dentistry, but also in sleep apnea diagnosis and treatment, full mouth rehabilitation, aesthetic removable prosthesis, dental anxiety treatments, and many other areas. Her goal is to provide the most comprehensive dental care for the whole patient, and not just their teeth.

Dr. Cariappa is a proud member of the American Dental Academy, the Academy of General Dentistry, and the American Academy of Cosmetic Dentistry, and is a Diplomate of the American Academy of Dental Sleep Medicine. Being an active member of these organizations is important to her, because she has a commitment to her patients to continue learning and growing, and to always be at the forefront of the ever-changing field of dentistry.

COVER STORY PHOTOGRAPHY

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Slowing Down to Speed Up

Taking the Time to Get Things Right on a Smile Makeover.

I first met Daniel in December 2017. His wife had been a patient in our practice for eight years, but we hadn't treated Daniel. She had wanted him to come in for some time, but he's a busy guy who owns his own company. It had been a long time since he'd visited a dentist. His teeth had been giving him problems for a while but taking care of them wasn't a priority. Eventually, it got to the point where the timing was right and he decided to take care of his teeth.

In the initial consultation, we discussed Daniel's concerns and how I could help him. I asked him how his teeth had gotten into their condition. He said that he had a history of not taking care of his teeth and even abusing them somewhat—including everything from generally neglecting them to using them to open bottles and cans, and grinding them at night.

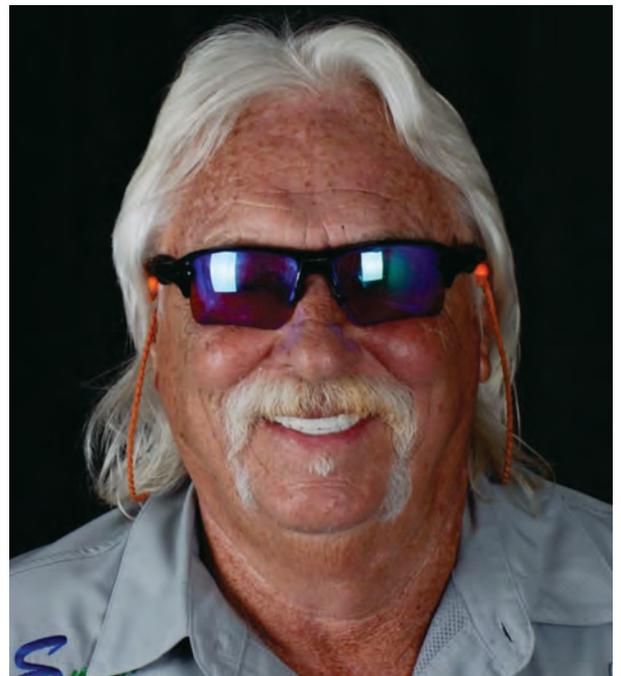
He had a history of not taking care of his teeth and even abusing them somewhat—including everything from generally neglecting them to using them to open bottles and cans, and grinding them at night.

Now Daniel was motivated to get his teeth fixed. Initially, because his teeth were so broken down, I was considering giving him a hybrid denture or something similar, but he was not interested in that. He wanted to keep as many of his natural teeth as possible.

I considered doing some posterior implants in the molar areas of the mandible, but he had been missing teeth so long that

the bone was severely atrophic. There was not enough room above the inferior alveolar nerve to comfortably place implants. He had tooth numbers 20 through 29 in the mandible, and he had tooth numbers 2 through 11 and 15 in the maxilla. But tooth numbers 2 and 15 were non-salvageable.

With the denture option off the table, I talked to Daniel about visiting a periodontist to get his gums healthy. I explained



(Above) Daniel after his full mouth smile makeover.



(Above) Before, retracted view, frontal angle, teeth together.



(Above) After, retracted view, frontal angle, teeth together.

that if he wanted to keep as many teeth as possible, he would need crown-lengthening surgery. He was fine with that.

After the initial consultation, I brought him back for a comprehensive exam where we took photographs (a full mouth series of X-rays), performed a soft tissue exam, did initial charting, took impressions, made a facebow record, and took a centric relation bite utilizing a leaf gauge. Once we got his case mounted in centric, I could tell that we probably had some room to get decent-sized teeth for him.

PREPARATORY WORK

After our initial diagnostic work, Daniel went to the periodontist. There was no way to place temporaries on his teeth in their current condition because they were so short. All I could do was refer him out to try to get some more tooth structure to work with.

I asked the surgeon to give Daniel 2 millimeters of ferrule for each tooth so that I could restore them with crowns. He did 360-degree crown lengthening on tooth numbers 6 through 11. Other areas were treated with scaling and root planing.

The periodontist had to remove two teeth that were not in function and non-restorable—tooth numbers 2 and 15. He also performed a sinus lift and placed implants in the 12 and 13 positions. Daniel also had to visit an endodontist to have root canals on tooth numbers 3 and 9.

CASE EXECUTION

It was about three months before Daniel was ready for me to start working on his restorative dentistry. My top priority was seeing how he would function in temporaries. I like doing temporaries chairside because they are not as rigid as the ones from the lab. It may seem counterintuitive, but the chairside temporaries reveal a lot of important information. I view them like the canary in the coal mine—if there's a weak point in the occlusion, it will show in the chairside temporaries.

The case was mounted in centric relation and I sent it to Arrowhead Dental Laboratory in the greater Salt Lake City, UT, area for the White Wax-Up. When it arrived it looked beautiful.

I wanted to give Daniel the appearance that he wanted along with the function he needed. Once his mouth had healed, we prepped his teeth.

At the first appointment, we prepared the maxillary arch. The next day, we prepared the mandibular arch. The temporaries were fabricated from Luxatemp and we cemented them with Temp-Bond™ Clear.

I told him he would need crown-lengthening surgery. He was fine with that, as long as he could keep his teeth.

There was a minor hiccup with the temporaries. They did not line up with his preparations. So I took impressions of the preps on both arches and sent those off to Arrowhead to have new wax-ups made. In the meantime, I patched together what we had so that he would be able to function with it.

When I mounted his case, I noticed that Daniel was hitting on his premolars. Tooth number 4 touched tooth number 29 in centric relation, but the moment he applied any pressure on it or postured forward, his teeth came together in the anterior. That had been going on his entire life.

The moment he applied any pressure on it or postured forward, his teeth came together. That had been going on his entire life.

Centric relation is a great place to start working from, especially if dentists don't have any information to go on—as was the circumstance with this case. Initially, trying to put Daniel into centric relation wasn't natural. I tried to give him a little bit of overjet, and it ended up being too much. He kept breaking the temporaries between tooth numbers 6, 7, and 8. He came in multiple times to have it repaired. >

Once I got the new wax-up, I made Daniel a new set of temporaries, reducing the height of the teeth, but he still kept breaking them between tooth numbers 6, 7, and 8.

I had to do some problem-solving to figure out how to prevent this from happening. I concluded that I had given him an envelope of function that was too steep, and he had adapted to a more down-and-forward posture. That's where he was comfortable.

I re-did the temporaries, making them a little shorter and a little shallower. This gave Daniel more freedom to move, which worked out much better for him.

I re-did the temporaries, making them a little shorter and a little shallower. This gave Daniel more freedom to move, which worked out much better for him. He finally felt comfortable after this fourth attempt at the temporaries, and he didn't experience pain or feel entrapped.

TAKE YOUR TIME

Many patients think that a smile reconstruction can be a one-day process and they can get a dramatic makeover really quickly. But it pays to take your time and make sure you're doing it right. Daniel's case is a good example of proceeding slowly and strategically.

Acrylic temps are stiff, hard, and durable, and they are typically splinted together. If I had used such temps, Daniel might not have broken anything due to their durability. I may not have discovered the overall problem until I had switched to individual crowns.

To get things right, I had to do more than shorten the temporaries, because Daniel didn't have freedom of movement. Again, his envelope function was too steep, and that's why he was breaking them.

So instead of just making them shorter, I also had to flatten or make the lingual side of the teeth shallower in order to give him better guidance. Otherwise, Daniel would have kept breaking his temporaries.

Daniel had no joint pain. If he had come in with a sore jaw or if I had made temporaries and he had reported jaw soreness, that would have been a different story.

I also changed his vertical dimension of occlusion (VDO) because he was over-closing. His premolars would hit, and then he would slide down and forward, and that's why the teeth would come together in the anterior. I put him back to where he was before his front teeth got destroyed. Over time, he had various teeth taken out in different areas and was left with no posterior support, so he was always functioning on his front teeth.



(Above) Before, retracted view, frontal angle, teeth apart.



(Above) After, retracted view, frontal angle, teeth apart.

Many patients think that a smile reconstruction can be a one-day process and they can get a dramatic makeover really quickly. But it pays to take your time and make sure you're doing it right. Daniel's case is a good example of that.

Despite such issues, Daniel reported experiencing no joint pain. If he had come in with a sore jaw or if I had made temporaries and he had reported joint soreness, that would have been a different story. But there was no reduction of his ligament, no clicks, no pops, and no tears. That knowledge helped in determining the direction of the case. If he had temporomandibular joint (TMJ) issues and the temporaries had made them worse, that would've been extremely problematic.

Daniel was in various sets of temporaries for a total of about five months, living with them and getting a sense of how he functioned in them. He was in the final set for about a month. Those were the ones that ended up working the best and that he was in the longest without any issues. Knowing that the final temporaries were working gave me confidence that I had achieved a comfortable, functional position for him.

Once we got the right shape and size of restorations and Daniel was tolerating them, we impressed the temporaries for the final restorations. When those restorations arrived, Daniel came in and I seated both uppers and lowers in the same appointment. It took about three hours.

There were a lot of factors to consider, including how his teeth had deteriorated, and how we could prevent the same thing from happening to the restorations.

I chose aesthetic zirconia for the final restorations because I wanted something stronger than e.max and also more aesthetic than full strength zirconia. We used RelyX™ Ultimate for the cement and Scotchbond™ Universal as the bonding agent.

After seating, I immediately checked Daniel's occlusion to get him comfortable and then he went home. I brought him back the next day to again adjust his occlusion. One week later, Daniel visited our office and I used a T-Scan by Tekscan® to digitally check his occlusion and protrusive movements. The T-Scan helped to make the adjustments easier. Today, Daniel uses an occlusal night guard. We see him regularly for hygiene appointments, and he seems compliant with wearing it.

CASE OUTCOME

Daniel was thrilled with the results. His wife was at the seating appointment, and she was very emotional. As you can see in the photos on pages 13 and 14, it was a dramatic change. Patient happiness is always the most important outcome—and also the most rewarding.



(Above) Closeup photo of aesthetic zirconia crowns.

Daniel's case wasn't an easy, straightforward one. There were a lot of factors to consider, including how his teeth had deteriorated, and how we could prevent the same thing from happening to the permanent restorations.

I had to proceed slowly and understand that this was not a simple case where I could prepare him, top and bottom, temporize, take a full arch impression, and then send it in and say, "Go ahead and make the permanent ones," knowing it would work out fine. I had to take time to work things out for Daniel.

Because we worked methodically through all the issues, I didn't have a lot of surprises with the case. The work that the periodontist did turned out great. The implants were in a good position. The endodontist did his job. Working with the different temporaries helped us get everything into the right position.

In addition to fixing the problems Daniel was having, I wanted to prevent such problems from happening again. Using zirconia restorations helped because they are so strong. But in addition to that, keeping regular hygiene appointments, alternating between

In addition to fixing the problems Daniel was having, I wanted to prevent such problems from happening again. Using zirconia restorations helped because they are so strong.

the periodontist and my office to make sure there are two sets of eyes on him, wearing the occlusal guard at night (a must for him), and simply not using his teeth as a tool to open things are all important to the future success of Daniel's new smile.

I did my best to plan in case anything were to fail. Daniel has one area where there is a bridge—tooth numbers 3 and 4 are splinted, and tooth number 5 is a pontic to 6. Everything else >



(Above) Before, smile.



(Above) After, smile.

is an individual unit, so if one of them were to fail, he could easily have an implant placed.

I tried to make sure Daniel's occlusion was protected and that he would be able to function well with it. I can't predict if he is going to get decay, but as long as he keeps up his hygiene, it should be fine. Decay wasn't really a huge issue for him in the past. His main problem was wear and tear.

WHAT I LEARNED

Working on Daniel's case has taught me the importance of taking the time to get it right. Daniel was great because he did not rush me on this case. He did not give me a deadline of when the work needed to be done.

When I said I wanted him to stay longer in the temporaries, he was fine with it. He never said, "Let's get this done. I want to finish this." Whatever the process was, he was "in."

Dentists can get into trouble when a patient needs to get a case done by a certain date. If it's a complicated case like Daniel's, rushing can compromise the outcome.

When I said I needed more time and I wanted him to stay longer in the temporaries, he was fine with it. He never said, "Let's get this done. I want to finish this." Whatever the process was, he was "in."

I also learned how important it is to understand how the patient's teeth got to their current condition. Even if a patient isn't forthcoming with details, there are things dentists can deduce that will help the overall results.

Before Daniel, I hadn't really worked on a case that was this badly broken down. I had done cases where it was a functional fix rather than an aesthetic fix, but nothing as severe as this case. It was a bit overwhelming at first. His was a multidisciplinary case, utilizing both a periodontist and an endodontist to achieve such outstanding results, and everybody had to work and communicate well together.

I think the case turned out so well because we took our

time and made sure we got things done right. Sure, making the temporaries four times was not necessarily ideal, but it was worth following that process in order to achieve the absolute best placement.

The positive outcome was due in large part to the planning. If Daniel had refused to do crown lengthening, I could not have done this case. There just wasn't enough tooth structure. I knew that the periodontist would give me more tooth structure, and that the patient was on board with everyone's recommendations. It gave me a boost of confidence that helped the process along.

The timing was right for Daniel, and I'm glad that he was open to doing the process the right way, including going to all the specialists and spacing out the treatment over several months. He was able to keep most of his natural dentition in the process, and since then, he hasn't stopped smiling. ■



Dr. Jeffrey Skupny received a bachelor's degree in exercise science from Florida State University in Tallahassee, FL, and a Doctorate of Dental Medicine degree from the University of Florida College of Dentistry in Gainesville, FL. He is also a proud member of the Academy of General Dentistry, the International Team for Implantology, and the American Academy of Cosmetic Dentistry.

Dr. Skupny has participated in extensive continuing education, including courses at Spear Education, The Dawson Academy, and the over the shoulder Full Arch Reconstruction course twice with the Dr. Dick Barnes Group.

Dr. Skupny is also a Diplomate in the International Congress of Oral Implantologists. He is a past president of the Collier County Dental Association, as well as a member of the ADA, FDA, and West Coast Dental District. Dr. Skupny has been practicing in the southwest Florida area for 12 years, and resides there with his wife and son.



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ARROWHEAD

Pitfalls Can Happen

10 Ways to Avoid Pitfalls in Full Mouth Reconstructions.

When attempting a full mouth or full arch reconstruction (FAR), mishaps can happen. To improve as practitioners, dentists should learn to recognize any pitfalls before they occur. This is a critical skill that helps reduce the number of problems associated with each case.

To improve as practitioners, dentists should learn to recognize any pitfalls before they occur.

Rather than jumping immediately into a FAR with a patient, doctors must first get all the diagnostic information and form a strategy for putting the patient in the best position for the long-term enjoyment of their teeth. With good diagnostics, dentists can develop a plan of action for preserving a patient's teeth for functional aesthetics and for support of the temporomandibular joint (TMJ). After years of performing numerous full arch and full mouth reconstructions, I've compiled a list of the top 10 pitfalls that dentists may encounter:

1. NOT CONSIDERING VDO

With FARs, a common pitfall is not determining whether the patient has lost vertical dimension of occlusion (VDO). To help determine VDO, dentists should look at the measurement from the cementoenamel junction (CEJ) on the maxillary central incisors to the CEJ on the mandibular central incisor. This measurement helps dentists to be aware of whether or not an occlusal height problem might exist.

The norm I prefer with this measurement for a class I dentition is 16 to 18 millimeters. If the patient's measurement is around 14 mm and the doctor begins a restoration, he or she may not have enough clearance to do the appropriate restorative dental work.

The quandary with this particular pitfall is determining how much to open the VDO. Not opening a patient's vertical enough can exacerbate muscle problems, causing muscle tension and headaches. I advise using panoramic X-rays, a full mouth series of X-rays, or 3D X-rays to determine if the crown-root ratio is favorable or unfavorable.

Choosing an arbitrary number to decide how much to open the bite often leads to problems. For example, a doctor may choose to open a patient's bite 5 mm without looking at other diagnostic information like root length and stability, and end up creating an unstable crown-root ratio.

The rule of thumb is to maintain, on average, a 2-to-1 ratio, meaning two lengths of the root in the bone to one above. I liken this to building a fence and determining how deep to put the fence posts. If you don't put them deep enough into the ground and a strong wind hits, they'll come loose and topple over.

If you put a 10-foot fence post 5 feet into the ground, that's a one-to-one ratio. But if you take that same fence post and put it 7 feet down into the ground, it will be anchored and solid.

The human jaw is an "anchoring point" for the teeth. If a patient's teeth have shorter roots, the dentist must be careful about how much to open the vertical. Some doctors open it too much, not knowing that the crown-root ratio can't handle it, and the result is that the teeth become mobile.

GOOD DIAGNOSTICS HELP DENTISTS DESIGN OPTIMAL SOLUTIONS



If the crown-root ratio is a one-to-one ratio and the dentist opens up that bite, he or she is going to put undue stress on the individual root complex, and mobility can ensue. In such circumstances, the practitioner may consider splinting teeth together to aid in transferring occlusal pressures.

Another diagnostic issue that doctors may forget to account for is sleep apnea. The Epworth questionnaire is a simple test that can help prevent this pitfall. The test has seven questions about snoring and other sleep issues. A patient who answers yes to a majority of those questions should consult with his or her general practitioner about having a sleep study done.

2. THE DEGREE OF TOOTH LOSS

Dentists who pass the hurdle of VDO may run into another pitfall: nonuniform tooth loss throughout the mouth. Every millimeter of tooth loss in the posterior region means a 2 mm collapse in the anterior region, creating the “wedge effect” of the dentition. A simple diagnostic test is to feel for fremitus of the anterior teeth at closure—a tap test in centric occlusion (see explanation in section 3. *Entrapment Issues*).

One way to test for this is to evaluate the jaw’s range of motion. How wide can the patient open? There are common

ranges for males and females—typically 40 mm for females and 50 mm and beyond for males. Anything below such measurements can mean restricted movements, in which case a dentist should not proceed with treatment until it is clear what is causing the restriction. Be sure to address the functional hindrance with orthotic therapy before fast-tracking the restorative phase.

3. ENTRAPMENT ISSUES

Recently, a doctor attempting to do a FAR ran into a pitfall. Once she had the patient in provisional temporaries, the patient started to have jaw joint and muscle problems due to anterior

Knowing how to avoid pitfalls is a critical skill that helps reduce the number of problems associated with each case.

entrapment. This problem does not always become apparent when the patient is in the temporaries, but if it happens, it can lead to muscle instability and result in headaches and joint pain. ▶



The doctor didn't realize that she had basically locked the patient's bite with anterior entrapment. Anterior entrapment is defined as a timing and force bite relationship that is not harmonized for the envelope of function, a situation in which the anterior teeth will hit first before the posterior teeth come into contact. This leaves no way for the muscles of mastication to relax.

A simple solution in this case was to relieve the anterior timing occlusion so the back teeth hit first and the front teeth last—in other words, long centric. If the patient's VDO is 11, the interior teeth can create a deep overbite.

Every dentist should have a T-Scan™.
It is an occlusal analysis system, and it can
tell dentists about timing vs. force.

Dentists can avoid this pitfall by testing the patient in diagnostics with the fremitus test. Using his or her finger, the doctor can test for vibration or movement of the anterior teeth as the patient bites into centric occlusion.

To do so, put a finger on the patient's central incisors and tap. If you feel those teeth touching, moving, or vibrating, it's a clear indication of entrapment.

Entrapment can and should be verified with a T-Scan™. Every dentist should have a T-Scan™. It is an occlusal analysis system, and it can tell dentists about timing vs. force.

In our dental practice, we do an initial scan, then we go through relaxation techniques with the patient and immediately do another T-Scan™. Using the two different bite scans, we

verify that the patient's bite is different due to issues with occlusal alignment.

Many doctors use occlusal paper to try to guess which tooth hits first based on a dot that's left on the teeth. They think that the biggest dot is the one that hits first. But dot size does not necessarily equate to intensity. It's the intensity that matters, and using the T-Scan™ to measure it can be a big paradigm shift for dentists.

To avoid this issue, dentists need to know how to create long centric correction, avoiding anterior entrapment. Prep design is critical in properly pitching the axial inclination of the teeth.

4. CANINE PROTECTIVE OCCLUSION

Another pitfall deals with establishing canine rise. When patients slide their teeth laterally, they should run up on a canine, which discludes the posterior region (PR). If you can't see canine rise or enough to quantify it, the patient will once again have issues with clenching, which will lead to headaches and other problems.

Even after insertion visits, there can be a pitfall when a doctor thinks he or she is done and the patient comes back with pain and headaches. The problem might have been introduced by the dentist in the provisionals and then again in the finals. Often doctors are not aware that they possibly caused the problem by not recognizing the lack of canine rise or the interfering posterior teeth, and not discluding in a timely manner.

5. SKIPPING GINGIVAL CONTOURING

Unfortunately, doctors do not always take into consideration soft tissue design with FARs. The soft tissue is the framework for the picture, with the teeth being the picture. (*For more information on gingival contouring, see my article in the August 2018 issue*

of *Aesthetic Dentistry* magazine called “Framing the Picture.” Particularly in the aesthetic zone, dentists should make the anterior soft tissue look symmetrical left to right.

A front tooth should not be longer or shorter than the one next to it. If corrections can be done on the gingival heights and the zenith points, the doctor should mark it with a red pencil on the model so that the laboratory technician knows what to do when creating a White Wax-Up.

Another potential pitfall in this area is using an electrosurge and/or diode laser for contouring on prep day. Dentists should keep in mind that there must be six to eight weeks of recovery after electrosurgery/diode contouring before they can start prepping for reconstruction. Avoid thinking that all treatment can be done in a day with those modalities. Keep in mind, however, that the DEKA CO₂ laser is the best gingival contouring instrument that can be used at the prep appointment with certainty.

Let the lab know if you intend to lean any of the teeth a certain way to create more room in the upper arch so there aren't any entrapment issues—for example, buccal corridor expansion or anterior axial inclination changes.

6. INVOLVING THE TEAM

Continuing education (CE) for dentists is a great opportunity to learn new skills and advance the practice. However, some doctors run into an unnecessary pitfall by not sharing the excitement of what they learned at CE courses with their team members.

After attending a course, dentists should hold team meetings about what they learned and how they would like to implement it. In my practice, we have a weekly team meeting every Monday.

Team members are a big part of the diagnostic process. As the doctor, you rely on them to provide you with the proper information. If you are taking a full set of models on the uppers and lowers, it's imperative that the team member who does the impressions knows exactly what to capture before moving forward with a case.

Dentists may run into the pitfall of having issues with fit and occlusion if the team members do not capture the key anatomical features. The doctor must inspect what they expect.

I highly recommend using Border-Lock® impression trays to avoid this pitfall. These are semi-custom, moldable trays with no perforations, and are available from Henry Schein. Trays with perforations allow the impression material to ooze out and have the potential to warp and flex.

Dentists want a true hydrostatic press of material into the soft tissue vestibules and around the teeth. It's essential for capturing the necessary anatomical features. I also suggest using one of two types of impression materials—either AccuDent®, or any polyvinyl siloxane (PVS) impression material.

After attending a course, dentists should hold team meetings about what they learned and how they would like to implement it.

Be cognizant of the manufacturer's suggestion of the time-frames that these impressions require in order to eliminate distortions. If pouring stone at the office, make sure to use the proper ratios of powder to liquid to avoid expansion, because little details make a big difference.

Team members should be trained on properly positioning patients in the 3D X-ray units and panoramic units to ensure accurate measurements. Getting proper measurements allows dentists to place implants exactly where they want. If they use a surgical guide, accurate measurements mean that the guide is a correct representation for implant placements.

7. RUSHING TO TREATMENT

Fast-tracking a FAR case is a common pitfall. Patients often want the work done as soon as possible, but if the patient has jaw joint issues, headaches, and possibly sleep issues, fast-tracking the case may come back to haunt you.

Test the environment before attempting any restorative procedures so you know that the patient's comfort level is good, the muscles are comfortable, the jaw joint is stable, and the periodontal tissues are solid.

If you are increasing the VDO on a patient, then you have to take a specific bite registration to put that new VDO into function. Take a muscle-driven bite registration and use splint therapy. I prefer the type of splints that fit on the lower arch. Using an upper splint can again lead to entrapment in the anterior. The most common splints are the ▶



Gelb appliance (for deep overbite anterior cases), and the L&D appliance (to re-establish canine protrusive disclusion).

The patient needs to be in splint therapy for eight to twelve weeks. With splint therapy, patients undergo a type of physical therapy,

Every patient is different, and if we try to fit a round peg in a square hole, it typically doesn't work out so well.

retraining their muscles to be at the appropriate resting length. To be effective, the splint needs to be used constantly—not just at night.

One testing modality for figuring out the physiologic rest position of the muscles of mastication involves using something called a TENS unit. If a practitioner doesn't have that machine, there's a great mouthpiece called an Aqualizer® that the patient could wear for a few days to relax the muscle. This temporary appliance can be given immediately to the patient.

After the patient wears their orthotic for eight to twelve weeks and is symptom free, the dentist can transfer the new bite registration with the new vertical dimension to have the case remounted at the lab.

I prefer to do the mounting myself to avoid the risk of the upper and lower models being improperly mounted. But some doctors do not have the necessary equipment, such as an articulator.

8. COMMUNICATING WITH THE DENTAL LAB

In terms of communication, it may seem obvious, but always tell the dental lab whether you are doing a full arch or full mouth reconstruction. Let the lab know if the patient is able to have everything done at once or if you need help in segmenting out the case. With a full mouth restoration, always do upper arch reconstructions first.

Without good communication, a big pitfall occurs when the models are not accurately set up at the lab. On maxillary impressions, it's important to capture the anatomical features such as the

hamular-notch incisive papilla (HIP). This allows for hard tissue points of reference and a tripod relationship of the cranial base. Repeatable reference points are critical for lab communication.

Dentists should take a stick bite, giving a reference to a true horizontal behind the patient's face. Do this with the patient standing up, because the interpupillary line is not level on a majority of patients. Some doctors line their patients up to window blinds and think it is level, but I highly recommend buying a Symmetrigraph. It's not expensive and ensures better measurements.

When a patient stands against the Symmetrigraph, dentists may notice other structural issues, *(continued on page 40)*



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ARROWHEAD

Form and Function

The Art of Smile Design

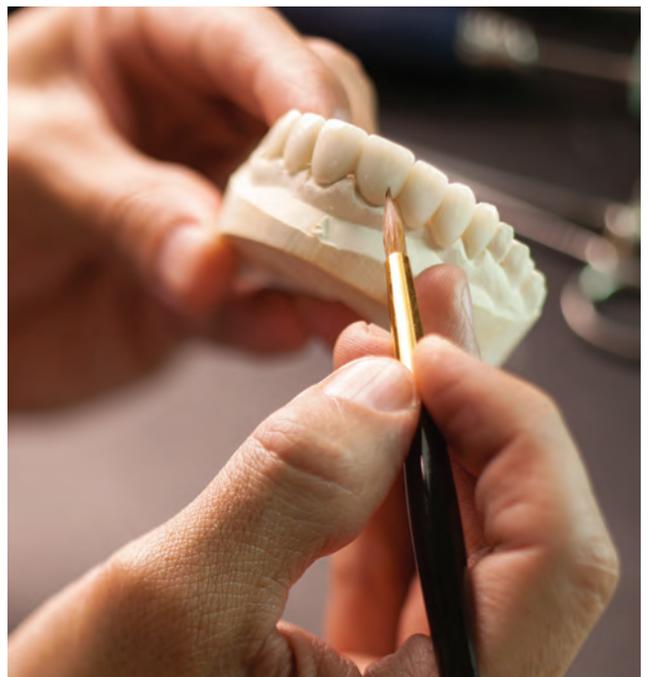
Get the “Wow!” Factor with Customized Smile Design.

We’ve all seen them: poorly made, ill-designed crowns. Because they are often opaque and non-symmetrical, they stand out in a person’s smile like a beacon that you can see a mile away. Unfortunately, sometimes crowns or veneers lack that “Wow!” factor

Customized smile design adds the extra touch that enhances the aesthetic outcome and generates the “Wow!” factor.

when a case is done. It is easy for anyone to see the difference between a poor case and a good case. But what is it that distinguishes a case that is merely adequate from one that is great?

Designing a customized smile is partly a technical and partly an artistic endeavor. The job isn’t all about aesthetics—any good case includes beautiful form as well as proper function. Tooth height, width, and length, plus shade, shape,





(Above) Attention to detail is crucial to the overall success of the case.

and texture, all contribute to a patient's new smile. Elevating a patient's smile to a higher level of quality always involves an artistic touch.

Customized smile designs are fabricated for individual patients rather than using a "cookie cutter" design with a standard size and shape. Whether it's changing the shape a little bit, or adding a little extra texture on a crown, personalized smile design adds the extra touch that enhances the aesthetic outcome and generates the "Wow!" factor.

It's the difference between driving a standard vehicle and driving a luxury car. The standard vehicle can be perfectly fine, but for someone who drives a luxury car, it's not just about the flash. There's a quality that is noticeably different.

Designing a smile that is customized takes a commitment to excellence and years of experience. Such customization is for discerning patients and high-end doctors who want to offer their patients the highest-quality restorations for superior outcomes.

QUESTIONS FOR THE PATIENT

Smile design patients primarily fall into two categories: patients who trust that the doctor knows what he or she is doing and therefore don't have any preconceived notions of what they want for their teeth, and patients who have very specific desires and know exactly what they want in their smile. Both types of patients can come with unique challenges when designing a custom smile.

Most patients generally want to look the way they did when

they were younger, only better. Almost every patient will say, "I want natural-looking, white teeth," and therein lies the challenge. What does that mean? Beauty, as they say, is in the eye of the beholder. What someone perceives as beautiful and natural may not be the same as another person's perception.

Our focus centers on quality craftsmanship combined with state-of-the-art technology and techniques that are refined from years of practicing the craft.

Natural-looking teeth are almost always anything *but* white, and they are often slightly misaligned. But to some, natural beauty may mean teeth as white as snow and straight like a fence. Both views can be correct. Understanding where a patient is on that spectrum is key.

To understand a patient's desires, doctors should ask all smile design patients the following questions:

- **Why are you getting the work done?** It's important to know if the work is restorative (due to decay), purely a cosmetic procedure, or a combination of both.
- **What do you like about your smile?** Dentists and technicians should not make assumptions because some patients may like a diastema between the centrals or the relative length of their teeth. >

- **What do you dislike about your smile?** Conversely, it's good to know if a patient *dislikes* a diastema between the centrals or feels like his or her teeth are too long or too short, etc.
- **How do you feel about color?** Most people want to see a brighter smile, but surprisingly, that isn't always the case. Also, dentists should find out if one or two shades brighter would suffice, or if the patient wants to go as white as they can.
- **What do you expect to see at the end of the treatment?** It's good to know if patients have any preconceived notions about the case results, or if they are trusting the doctor and technicians to determine the overall outcome.

Not only do such questions elicit important information, but they generate a conversation with patients. Getting to know a patient's personality can be very helpful. Understanding each person's unique story and a bit about their preferences helps dental lab technicians and dentists determine which direction to take in the overall design of the case.

What someone perceives as beautiful and natural may not be the same as another person's perception.

After listening to patients and learning what they want in their smile design, doctors should follow several rules to help elevate the design.

RULE #1: TOOTH MORPHOLOGY SHOULD BE DETERMINED BY SKELETAL AND ROOT STRUCTURE

In the dental business, we often throw around words like "feminine" and "masculine" to describe certain shape characteristics of teeth. The terms apply to a "softer, rounded shape," or a more "aggressive, angled shape," respectively. Does that mean a female patient is limited to soft shapes, or that a male patient can only have squared angles? Of course not.

Understanding each person's unique story helps technicians determine which direction to take in the overall design of the case.

No one can determine the gender of a patient merely by looking at the shape of his or her teeth. If a dentist puts a rounded, "feminine" tooth in the mouth of a patient with a squarer, "masculine" morphology, the outcome may not be what is desired.

With a central tooth restoration, there are three shape options: square, oval, and triangle. The morphology is determined by the skeletal and root structure, and if it is unintentionally changed, the results may not look quite right.

If a patient naturally has more triangular-shaped teeth, and a dentist tries to put a round or oval crown in his or her mouth, it may look okay, but it might not look like the patient's natural teeth. It's a subtle detail that can truly make a difference.

Such details take crowns to the next level, and it's where



the artistry comes into consideration. To achieve a high-level outcome, the patient, dentist, and technician must all be on the same page.

RULE #2: LISTEN TO WHAT THE PATIENT WANTS—IT MAY NOT BE WHAT YOU EXPECT

I recently met with a patient who was having her maxillary arch restored. I use the term “restored” because, as she explained it, when she was 14 years old, a dentist had shortened and rounded her teeth. Originally she had two square, prominent centrals that were about .75 mm longer than the laterals. She liked her smile and hadn’t asked for the change.

After the dentist modified her teeth, he told her that a girl’s teeth were “supposed” to be small and round. The dentist may have preferred it that way, but the patient did not. She thought that her teeth no longer looked like they belonged to her.

The patient is now in her twenties, and with the help of photographs and an interpretation of her natural morphology, we were able to restore her smile to something very close to what she expected to see in the mirror.

This patient wanted a very customized smile. She had specific parameters that she expected to see. However, such parameters didn’t fit into what would traditionally be done for a young woman. She wanted more of a “dominant,” “masculine” smile because that is what she had before.

It’s easy to improve a little and go from adequate to good. But it’s worth the effort to take it to an even higher level.

After speaking with the patient and understanding her story, it became clear that a “cookie cutter” approach would never yield the results she hoped for. As dental professionals, we must think and plan beyond the everyday, mass market tooth design in order for the optimal results to be achieved.

Beauty, as they say, is in the eye of the beholder, and standards of beauty can change from person to person. One of our German clients wanted restorations that were completely different from the typical American ones. He said that in Europe, they think that American teeth look silly because they are “unnaturally” white and too straight. So we worked on a “European” tooth design to satisfy this patient’s desires that were “outside the box.”

When deciding which shade is appropriate for a patient, it can be helpful to look at a patient’s sclera (the whites of the eyes) and pick a shade that complements that color.

RULE #3: DON’T GET IN A RUT AND PRESCRIBE THE SAME SMILE FOR ALL PATIENTS

As clinicians and technicians, we often use smile catalogs to communicate shape and characterization of teeth. Some have numbers or letters to identify each design, and some have memorable names, such as “Hollywood” or “Enhanced.”

Many doctors and technicians tend to have their favorite

QUESTIONS FOR SMILE DESIGN PATIENTS:

- **Why are you getting the work done?**
- **What do you like about your smile?**
- **What do you dislike about your smile?**
- **How do you feel about color?**
- **What do you expect to see at the end of the treatment?**

designs and often prescribe them repeatedly, regardless of the patient’s morphology. Most of the time, the results of that choice will meet or even exceed the patient’s expectations. But can we do better? Have we gotten that “Wow!” factor?

The key to elevating the outcome is knowing what the patient likes or dislikes about his or her smile. After questioning, a patient may reply, “Well, I’ve always liked how my two >



(Above) It’s the artist’s touch that makes a high-end restoration look like a tooth instead of a crown.

front teeth are a bit longer than the rest.” That’s great information because it’s a detail that technicians can either eliminate or accentuate, customizing for each patient.

Occasionally, a doctor’s personal preferences dictates the smile design and it can be tempting to prescribe the same look for everyone. If every case looks the same (the same shade, smile catalog selection, and translucency), then the unique character of the smile and the patient can get lost.

During the smile design process, we never sacrifice function for the sake of artistry.

Don’t be satisfied with merely doing what needs to be fixed for your patients. Instead, think about what special qualities and characteristics you would like to preserve in the process.

RULE #4: ALWAYS LOOK AT A PATIENT’S FACIAL STRUCTURE AND PRE-OP INFORMATION

The cases that have the “Wow!” factor are the ones in which the dentist studies a patient’s facial structure, sees the pre-op, and matches what he or she had before. With that knowledge, the dentist can improve what he or she wants to change, fix what was damaged or decayed, and still keep the same shape and general appearance that most patients don’t even realize they have. It’s a delicate process.

Once in a while, doctors encounter a patient they don’t know how to help. Such “problem” cases are a great opportunity to deliver an outstanding outcome. A lab with the proper experience can help discover what the patient is hoping for and what is possible with a patient’s physiology.

Facial shape and skeletal structure are probably the most overlooked part of this process. Sometimes labs don’t get access to information about the patient’s facial shape and instead only get information about the teeth. If dentists take the time and

A key part of successful smile design is paying attention to the individual characteristics of the patient. Here are several considerations to keep in mind:

- Lip lines
- Skin tones
- Facial shape
- Gingival contouring
- The color of the sclera (whites of the eyes)
- The aesthetic zone (doing more than just the “social six” for a big, Hollywood smile)

submit such information, like the complete American Academy of Cosmetic Dentistry (AACD) photo series, it is extremely useful in helping the lab elevate the overall design.

Some patients think they want “straight” teeth, but teeth aren’t naturally completely straight. So if a patient wants a natural smile and straight teeth, it can be up to the dentist and technician to find a balance and accurately reflect what the patient really intends.

To find that balance, technicians must be confident in their skills and in the pre-op information. Once patients realize that dentists understand their desires and what’s possible, they are more relaxed. All patients want a confident diagnosis.

It’s important to listen closely to what the patient says and offer advice based on his or her facial structure and desires, and the dental laboratory’s past experience with successful smile designs.

RULE #5: NEVER SACRIFICE FUNCTION FOR FORM

Throughout the process, we never sacrifice function for the sake of artistry. A patient’s teeth should be shaped according to what his or her jaw is doing. Sometimes there has to be a compromise between what the patient wants and what is appropriate for function. We try to accommodate the patient’s desires as much as possible, but the shape of the tooth is always dictated by the function of the jaw.

It takes attention to detail and a focus on quality to produce a smile that makes patients say, “Wow!”

Similarly, the function of the jaw is influenced by the way the teeth are shaped. It’s a constant give and take. If patients are bruxing, their teeth are going to be very flat. If patients have a jutting overbite, their teeth are going to be shaped differently than if they’ve got an open bite. Function problems should always be the number one consideration.

As part of functionality, it’s important to address spacing issues by asking, “Is there a lot of room on one side and not enough on the other? Does a lot of tooth structure need to be removed to accomplish the goal? Or not very much at all?”

RULE #6: USE THE WAX-UP AS A DIAGNOSTIC AND SALES TOOL

Arrowhead’s White Wax-Up provides the tools for doctors to prep just the right amount of tooth structure. We provide a clear mold that dentists can place on the tooth and see how much reduction to do. Also included is a Sil-Tech matrix, which allows for chairside temporaries to be quickly fabricated that represent the final restorations. With the temps, doctors can make refinements to the smile design if needed.

With the right assessment, many issues are eliminated from the outset. Case-planning must be done before building the restorations. The process proceeds more smoothly when all of the details are provided up front.



(Above) Focusing on the smallest details guarantees quality and leads to a successful outcome.

Ideally, the lab should get a mold of the patient's mouth before the case starts so technicians can see what is going on. Then the lab makes a diagnostic White Wax-Up where we show what is possible with the smile design.

The White Wax-Up is a diagnostic tool—it's not just a selling tool. Often doctors use the wax-up to show a patient how pretty his or her teeth could be, and that's great. But the wax-up can also be used for troubleshooting and dialing in on those key questions to find out what the patient wants.

Maybe a patient has flat teeth because of grinding. Using the White Wax-Up, the doctor can explain that in order to give the patient more youthful teeth, he or she must fix the teeth that have been damaged by bruxing.

The diagnostic wax-up can tell doctors if there are issues that need to be addressed. It also gives the lab a chance to see any potential problems.

RULE #7: CONTINUALLY LOOK FOR WAYS TO IMPROVE PATIENT OUTCOMES

Smile design can be a bit like looking at a daisy—initially you may think every petal is the same. But if you look closely, you'll see that one petal is twisted to the side, and another one's a little shorter. Most people perceive it as symmetrical and flawless, but rarely is it ever that way.

There are many options and natural variations in a person's smile. Everyone has unique characteristics in his or her smile that make it beautiful. It's important to stay open-minded when designing a smile.

It takes attention to detail and a focus on quality to produce a smile that makes patients say, "Wow!" Dental professionals can always be looking for a way to improve, to change, and to develop their skills even more to continually improve on smile design.

Taking smile design from good to great is the hardest thing to do. It's easy to be satisfied with "good," but finding the "Wow!" factor requires effort and constant improvement. The smile of a satisfied patient makes it all worthwhile. ■



Ben Biggers has worked at Arrowhead Dental Laboratory in Salt Lake City, UT, for 20 years. In high school, he was selected for an apprenticeship in dental ceramics after an art teacher noted his artistic ability.

He then went on to work in another dental laboratory before joining Arrowhead in 1999. Ben was part of the original team of Elite technicians at Arrowhead, and he now works with doctors and patients on custom smiles. In his free time, Ben is a musician and enjoys playing the clarinet and the saxophone.

Finding the Money, PART 2

Helping Patients Pay for Dental Treatment.

In the November 2018 issue of Aesthetic Dentistry magazine, Tawana Coleman, the Total Team Training instructor for more than 20 years, wrote Part 1 of this article. Below, Hernan Varas, M.B.A., the current Total Team Training instructor, continues on the subject that Tawana started, and offers additional advice for doctors and team members.

Dr. Dick Barnes has always said, “People don’t have money, they have access to money.” To explain what he means, let me share a personal story with you. A few years ago, it was time to get a new car and I knew what I wanted. I wanted a Mercedes because I liked the way it made me feel. Truth be told, I didn’t have the money to buy it, but a salesperson showed me how to get it anyway.

At first, he counseled with me about how I could fit the car payments into my budget. Next, he gave me information about a third-party financing company, and they approved my loan on the spot.

To gain an understanding about a patient’s finances, a team member must conduct a new patient interview.

I drove that car out of the parking lot with a big smile on my face, looking and feeling great. I didn’t have all the money needed for that car, but as Dr. Barnes said, “I had access to the money.” Today, I am still happy with my purchase.

This service is very similar to what a financial coordinator in a dental practice can provide. If he or she understands the value of the treatment for patients—how much they want it, and how important it is for them to get the work done—he or she will find the money because it changes patients’ lives. Patients will be healthy and keep their teeth for a lifetime.

NEW PATIENT INTERVIEW

Financial coordinators can’t help patients if they don’t know anything about the patient’s financial circumstances. To gain an understanding about a patient’s finances, a team member must conduct a new patient interview. This interview helps team





members build relationships of trust with patients. Another famous Dr. Barnes quote is, "Patients will do business with people they like and trust."

Building relationships of trust is critical, and it all starts with the new patient interview. To learn how to conduct a new patient interview, see Tawana Coleman's article, "Create an Uncommon Practice," from the November 2015 issue of *Aesthetic Dentistry* magazine.

In the article, Tawana writes that financial coordinators should give all patients a message of reassurance. They should say, "In our practice, we don't believe in surprises. You will always know about everything before we ever do anything. We have ways to help patients fit treatment into their budgets."

A CASE STUDY

Recently, I was visiting a practice and I conducted a new patient interview to show the team members how it is done. When I asked the patient, "Are you concerned about the finances required to return your teeth to excellent dental health?" the young woman said, "Yes, I'm concerned, because I'm employed part-time and I'm very concerned about how much money I have to come up with."

The financial coordinator is an advocate for the patient as well as for the practice.

She continued, "I'm pregnant and I want to make sure that my baby is healthy. I have no dental insurance. I'm broke. I don't know where I'm going to get the money from."

During her exam, the dentist discovered that she needed a

crown and had some decay and periodontal disease. The treatment was a little over \$2,000.

When we met again after the exam to discuss finances, I said, "I know things are a little tight financially for you, but if anybody can help you, this practice can. I know you want your baby to be healthy and this is a procedure that needs to be taken care of. Do you know anyone in your family or do you have friends who could help you?"

I guided her in a direction that saved her from potential embarrassment and provided her with the funds she needed.

She looked at me and said, "Actually, I think my grandfather can help me." I responded, "Would you like me to give him a call?" She replied, "No, I'll call him." She called her grandfather from the office and he agreed to help. We scheduled the treatment and she was able to get it done.

If I hadn't built a relationship with the patient from the beginning, I probably would have said, "Well let's try some of these financial-service companies and see if we can find ways to fit this into your budget. It's worth at least giving it a try." But after the interview I learned that she probably wouldn't be approved, so I guided her in a direction that saved her from potential embarrassment and provided her with the funds she needed.

Keep in mind that patients always ask, "What is my insurance going to cover?" Please be sure that all insurance benefits are already researched in advance for each patient with insurance, to maximize their benefits for them. >

When it comes to using third-party lending institutions, it's important to know the details about the different financing options. Financial coordinators must ensure that each company offers a win-win proposition for the patient and for the practice. The financial coordinator is an advocate for both.

If patients don't understand the terms of a financial agreement, they will likely blame the practice if something goes awry, because the practice advised them to use the financing. It is important to be clear and concise about what patients are getting, and details must be transparent.

Several financial institutions are available to help patients. The top three that I recommend are CareCredit®, LendingClub®, and Wells Fargo Dental Patient Financing. These companies have experienced trainers that can help guide financial coordinators on how to utilize the different resources they offer.



FINANCING GROUND RULES

All dental practices should establish some basic rules when engaging third-party financing for patients. *Note: If you offer printed brochures about such plans in your office, always include a disclaimer that reads, "Not all plans are available in all offices."*

1. **Understand the differences between plans.** Here are some of the most common plans, defined:

- **Deferred-interest plans.** Patients must pay off the full balance by the end of the deferred-interest period or they owe all the interest back to the original date of charge. Only offer 12-month plans because it costs the practice more after that time. For treatments under \$1,000, offer a same-as-cash plan.

Several financial institutions are available to help patients. The top three that I recommend are CareCredit®, LendingClub®, and Wells Fargo.

- **Same-as-cash deferred-interest plans.** Plans are 90-days or 6-months, and can be segmented into three or six payments.
- **Fixed-interest, long term, or extended payment plans.** The interest rate does not fluctuate during the fixed rate period of the loan. The discount rate tends to be less for practices and they are usually available as 24- to 60-month plans. Currently, CareCredit® offers 24- to 60-month plans at fixed-interest rates from 14.9–17.9 percent. LendingClub® offers similar plans, with up to a \$50,000 loan value, but it is contingent on what is approved for the individual patient and what their interest rate is based on a credit check. Interest rates are higher with this type of a plan, but it extends payment

options out so the patient can work this treatment into their monthly budget. Again, be the patient advocate by going over the plan's default rules.

2. **Stay away from companies that offer universal approval.**

In general, it isn't a good business decision to approve all patients for financing because the practice will take the risk on a patient who may not have the ability to pay. Don't make it a hardship for your patient.

3. **With deferred-interest plans, don't offer these higher-expense plans for treatments that are under \$1,000.** Why not? Because it ends up costing the practice too much. Again, look for a win-win situation.

It is possible, however, to offer same-as-cash deferred interest plans for 90 days or 6 months, and most patients can work them into their budgets.

4. **Be a patient advocate by reviewing default rules on all plans with your patients.** I call it "reviewing the small print." Some plans will apply interest to the origination of the loan at a high interest rate if a default occurs. Others may apply interest at the month in which the default occurred. Make sure the patient understands all the details.

5. **Consider cosigner or "In Behalf Of" loans for your patients.** According to MoneyCrashers.com, these are loans in which "a person agrees to pay a borrower's debt if he or she defaults on a loan." This is a great alternative for patients with less-than-stellar credit, or for patients who can't get approved on their own.

LendingClub® shines with their "In Behalf Of" loans, because the person named as the "In Behalf Of" receives the monthly statement and is responsible for payment. The patient is responsible to pay the "In Behalf Of" directly. So there is less risk of default that can ruin the credit of the person named as the "In Behalf Of," and he or she can monitor if the loan is getting paid.

CareCredit® offers cosigning loans but the bill is between the patient and CareCredit® (the cosigner is not directly involved in payments). If the patient defaults, it can ruin the cosigner's credit.

6. **It's important to understand the terms recourse and nonrecourse.** According to the Internal Revenue Service, a recourse loan holds the borrower personally liable. All other debt is considered nonrecourse.

In terms of dental practices, with a recourse loan, if the patient defaults on the payment or doesn't pay at all, the practice has to return the funds to the lending institution.

However, with a nonrecourse loan, the practice still gets the funds for treatment because the loan is strictly between the patient and the financing institution. Most offers of universal approval end up being recourse loans.

13 QUESTIONS TO ASK

There are several questions to ask each financial institution that you are considering for financing options.

1. What is it going to cost the practice to enroll? What is the financial responsibility of the practice?
2. Are there online support services? CareCredit®, LendingClub®, and Wells Fargo offer online support.
3. Is there an application fee for the patient or the practice?
4. Is there an in-office application option? Never send a patient away with information to fill out at home. Always fill out forms in the practice, because otherwise the patient might not do it.
5. Does the financial institution offer a "soft" credit check that doesn't affect the patient's credit score?
6. What is the discount rate for each time period?
7. What is the patient-approval rate? (Remember, don't use a plan that approves everybody, because there's usually recourse involved). Follow this question up with, "How does that work?" Asking this helps the practice to understand the terms of the loan. Sometimes dental practices won't collect money for treatment until the patient pays off the loan.
8. Once the patient is approved, do they get to choose which plan they will use? For example, CareCredit® will approve a loan amount and offer patients a choice of deferred-interest plans or fixed-interest plans.
9. Is there an interest-free option? If so, what does that cost for 6, 12, 18, and 24 months?
10. Is the credit line ever increased from the original amount approved? CareCredit® sometimes allows for credit increases if the practice calls to advocate for the patient.
11. What happens if a patient defaults on payment? Will there be financial penalties starting from the month of default, or from when the loan originated? Are there any late fees?
12. Make sure there is no pre-payment penalty (CareCredit®, LendingClub®, and Wells Fargo do not charge for pre-payments).
13. How soon does the practice receive payment? Within 24 to 48 hours?

After ruling out the obvious payment options of cash, credit cards, and maximizing insurance benefits, here are the best financing options to explore:

- Health Savings Accounts (HSA) or Flexible Spending Accounts (FSA)
- Outside financing from third-party institutions
- Local banks or credit unions
- Life insurance policies (cash value)

- Home equity loans (last resort)

In general, financial coordinators must be thoroughly prepared with several financing options to help patients find money for treatment if they need it. Be careful not to schedule the patient until after the financial arrangements are made.

A solid financial plan closes the deal and enables patients to proceed with the recommended treatment. Patients who are confident with the financing arrangements say, "Let's get it scheduled!" It's music to any financial coordinator's ears.

ALWAYS GIVE HOPE

If the above options fail, all is not lost. As you can see, dental practices have numerous options to help patients find money for treatment. In some instances none of the options work, and it's impossible to find the funds. As Tawana Coleman suggested in *Finding the Money, Part 1*, it's important to leave all patients with a sense of hope, even when circumstances seem bleak.

In general, financial coordinators must be thoroughly prepared with several financing options to help patients find money for treatment if they need it.

Everyone should continue to feel welcome in the practice, regardless of their current situation. Before sending a patient home, tell the patient, "We'll get there. It may be slower because of your circumstances; however, you never know when your circumstances will change. All is not lost." When patients feel welcome and respected, they will be loyal to your practice and will become your patients for a lifetime. ■



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Originally from Chile, Hernan attended Westminster College in Salt Lake City, UT, for a bachelor's degree in marketing and communications. Afterward, he continued his studies at Westminster and received a Master of Business Administration degree, with an emphasis in international management.

Since working at Arrowhead, Hernan has been mentored by and has visited thousands of dental practices with Dr. Dick Barnes—including every state in the contiguous United States. Hernan specializes in strategies and techniques for increasing productivity and case acceptance in dental practices.

To Join or Not to Join?

What to Do When Considering Participation with a PPO.

About 15 years ago, our practice, Nankin Dental Associates, in Quincy, MA, participated in a number of PPO programs. As most readers are aware, preferred provider organizations (PPOs) are networks of dentists who participate in the group's plan at lower-than-customary fees.

At the time, my brother and I were in practice together and we were trying to grow our business. When we signed up for the programs, the reimbursement structure was pretty close to what we were charging, and the fees seemed reasonable.

Fortunately, our practice had grown on its own over the years, and ultimately we decided to only participate with the two largest providers in Massachusetts.

Over the years, however, many of the fees had become significantly lower than our customary fees, so we stopped participating in several programs. Fortunately, our practice had grown on its own over the years, and ultimately we decided to only participate with the two largest insurance providers in Massachusetts.

A year or so ago, I decided to revisit our PPO participation. At that time, one of the two insurers that we worked with was looking to potentially reduce dental reimbursements by 25 to 30 percent off an already-discounted plan.

The proposed fee decrease was so significant, I knew it would not be worth our time (from a strictly monetary perspective) to

continue to treat patients with their insurance at the new rates. I decided to investigate whether options with other providers might be more advantageous.

Our practice was busy, but 35 percent of our patients were covered by this insurer, so we simply could not afford to lose those patients without finding a way to replace them.

I decided to proactively investigate other options because I wanted to remain busy and productive enough to maintain our profitability if the worst scenario happened and we lost 35 percent of our patients.

There's no shortage of companies that offer these programs—my practice constantly receives solicitations from PPOs. Once or twice a year, they reach out to say that a patient has requested that I participate in their insurance plan. It's a good way to find insurance companies that are looking to partner with dental practices.

Another company approached a colleague of mine, and he asked if I had ever talked to them. I reached out to the company to see if they were still looking to increase their network, and they were.

After looking at several PPOs, I have learned a few things that dentists can do to ensure that the arrangement is beneficial before entering into an agreement.

1. LOOK AT PRODUCTIVITY

When dentists consider participating in a PPO, they need to know what they're signing up for, and what the fees will mean to the financial health of the practice. PPO participation can provide great benefits to dentists, such as increased patient and referral



flow, but some PPOs may undercut a dentist's fees, which can cause the practice to flounder and lose money.

Before entering into a PPO agreement, analyze the overall busyness of your dental practice. If the practice is scheduled two to four weeks out with no openings, then it likely doesn't need to participate in network with an insurance company. A booked schedule means that the practice is able to stay busy while charging full fees, so replacing any of those patients with ones who have discounted PPO fees doesn't make sense.

However, if a schedule has "holes" in it and a PPO offers fees that allow the dentist to perform dentistry without compromising quality, it might be worth it. It won't be as profitable as having full-fee patients, but it is better than collecting no money and remaining idle. Dental practice overhead and expenses continue to mount up regardless of the schedule.

Dentists should be aware that filling a schedule completely with PPO patients might limit the time available for scheduling last-minute, full-fee patients. It's a balancing act that every dentist should consider.

2. KNOW YOUR NUMBERS

Once you have looked at the schedule and determined that the practice could use some new patients, look at your numbers to determine what kind of fees you need. To understand those numbers, you have to know the fixed operational costs for your practice—on an annual, daily, and hourly basis.

What are your daily overhead fixed expenses? Those include your occupancy cost (rent, lease, or mortgage payment), utilities, equipment leases, staffing, employee costs, insurance—anything

that continues to incur an expense whether you are seeing patients or not. Add up all these fixed expenses.

When you start to analyze your costs, you may discover that you need to raise your fees, based on operational costs. If your customary fees are too low, it affects your ability to negotiate with insurance companies because they know what your fees are. They know the fee schedule because either they receive claims with your usual fees on it, or they get that information from another insurance company (they share information). Not only do they know what you charge, they know what the common fees are in your geographic location by zip code.

If your customary fees are too low, it affects your ability to negotiate with insurance companies because they know what your fees are.

It's hard to ask an insurance company for \$1,000 for a crown if your customary fee is only \$900, and they know it. If your usual fees aren't high enough, you can't expect the insurance company to give you a pay raise. You may want to increase your fees a year or so before you even start to look at joining a PPO.

3. UNDERSTAND THEIR FEES

After determining your fees and reaching out to potential PPOs, the first thing to look at is their fee schedule. Look at fees for the procedure codes that are most commonly billed by >

your office. For our practice, that includes hygiene fees, cleanings, exams, X-rays, composites, and crown-and-bridge fees. If a PPO-insurer pays 100 percent of a fee for root canals, but you don't do root canals, that fee is meaningless.

The most commonly billed fee has the greatest impact overall. A small change in that fee over the course of a year can have a big impact.

4. LEGAL IMPLICATIONS

Fees are not the only factors to consider. Ask an attorney to analyze the contract before you sign it. Often, state dental societies have already done contract analyses. The lawyers on retainer for the dental society may have already performed a contract analysis that you can request.

When negotiating with PPOs, I've learned that, with the exception of the fee schedule, the standard insurance contract can't be changed. Therefore, be aware of what you're signing and understand exactly what that means to your practice going forward.

Fees are not the only factors to consider. Ask an attorney to analyze the contract before you sign it.

Evaluate fees and contracts independently. You may look at the fees and think they are acceptable, but then your attorney may advise against signing the contract for other reasons.

Another factor to be aware of is subcontracting ("selling your practice") to another insurance company. If that happens, you

may end up with a fee schedule that is different than what you anticipated, even though many times it doesn't change.

Some companies will disclose that you will be contracted with multiple companies, but other contracts may make that information more difficult to recognize. Every dentist should be aware that it's a possibility to be subcontracted to another insurance company, and should ask about it if it's not clear.

A small change in that fee over the course of a year can have a big impact.

Sometimes dentists think they're signing a contract with a particular insurance company, but they're actually signing with a third party who does the contracting for a number of insurance companies.

Another legal issue to be keenly aware of is the length of the contract. How long does it take to (without prejudice) get out of the contract? Is there a 60-day out or a 90-day out? Typically, contracts last a year and are self-renewing. But dentists can usually get out of any of these contracts within a specified amount of time.

5. OTHER CONSIDERATIONS

In addition to legal factors, there are other practical considerations. For example, if you're seeing full-fee patients who happen to have coverage with a PPO you are considering, those patients will likely be converted to PPO patients after you join the program. Investigate how many of your existing patients will be

CALCULATING THE EFFECTS

Many dentists don't realize that comparatively small increases or decreases in PPO fees can have a large effect on a dental practice's bottom line. Here's a simple way to understand the ramifications of fee changes:

To make the math easy, say you run a 60 percent overhead in a dental practice. If you collect \$100,000, then the dentist is left with \$40,000 (that's what's left after subtracting all the expenses). In dentistry, that number typically represents the dentist's salary.

If you're running a 60 percent overhead, and you increase your fees by 10 percent, that's a 25 percent increase in profitability. In this example, you would increase your fees to \$110,000. The overhead expenses are still \$60,000, but now you've gone from a \$40,000 profit to a \$50,000 profit, which is a 25 percent increase.

The corollary is that if you run a 60 percent overhead practice and you agree to take a 20 percent decrease in your fees, you've decreased your profitability by 50 percent. Instead of having \$40,000 left over from \$100,000, you're now only collecting \$80,000, and your overhead is still costing you \$60,000. So instead of a \$40,000 salary, the dentist is only left with \$20,000. That fixed costs remain the same, but the salary has been cut in half.

covered by any insurance plan you consider. It may seem worthwhile to accept lower fees in order to increase your patient base, but not if half your full-fee patients suddenly become lower-fee patients.

On the other hand, if you're not seeing any patients covered by a plan you are considering, joining that group may be a good way to grow the practice. A benefit from increasing your new patient flow is a corresponding increase in referrals. The more new patients that come into the practice, the more people who will refer their friends and relatives to you.

Another consideration is how many people an insurer covers in your area. It's not worth your while to sign up with a company that only insures a hundred people in your area—you probably won't see any new patients from such a small number of prospective patients.

On the other hand, if there's a factory next door that has 6,000 employees, signing up to accept the insurance they offer provides much greater potential for increasing business.

The number of participating dentists in your area is also an important consideration. If the potential number of patients is small, and the number of dentists who already participate with a PPO plan is large, you may not get many new patients.

You can learn which dentists in your area participate with a particular plan by logging onto the PPO websites. Many insurance companies offer a tool to find a participating dentist in a certain locale on their websites. If you know any of those practicing dentists, ask them about their experience with that particular insurer.

Also, consider whether the specialists you work with will take the prospective insurance plan. Will signing up with one provider

mean that you can't refer your patients to your preferred specialists?

At first glance, joining a PPO has more considerations than many dentists might think. Go through the process slowly. Learn how working with these PPO companies impacts your practice by adding one at a time, if that's what you want to do.

6. ASK QUESTIONS AND KNOW YOUR LIMITS

As I began researching PPOs, I was surprised to learn that some insurance companies are flexible with their fees. When the insurance company reaches out to you (rather than you reaching out to them), you have better leverage in negotiating for a better fee schedule. Typically, the people you talk to are customer service people who are trying to build their network of providers, and sometimes they are willing to negotiate. It doesn't hurt to ask.

If you're not seeing any patients covered by a plan you are considering, joining that group may be a good way to grow the practice.

After talking with several customer service agents, I learned that if I said I was interested but the fees were not high enough, I was often later offered two or three additional upgraded fee schedules. Sometimes those small, incremental changes were very significant. Other times, it still wasn't worth it.

As with any negotiations, you have to be willing to walk away if they don't offer what you feel is fair compensation. With one company, I was almost ready to sign up, but I asked them for an addition \$10 per cleaning. Initially they said they couldn't do it. I thanked them for their time and walked away. About two weeks later they came back and said they could do it.

Learn how working with these PPO companies impacts your practice by adding one at a time, if that's what you want to do.

If you know your numbers and you know exactly what you can and cannot accept in a fee proposal, it makes the process much easier.

7. BEWARE OF COST-CUTTING PRACTICES

The last thing to know is that PPOs sometimes deny treatment when you send in a claim because they recommend a lower-cost service for the patient. The amended treatment may indeed be less expensive to the insurance company and to the patient, but the quality of care may not be as high or as beneficial.

For example, you might place a crown for a patient, but the insurance company decides the crown was unnecessary and a filling should have been done instead. Even though you have already delivered the crown, the *(continued on page 43)*



Are You Doing Discount Dentistry?

Why It's Important to Offer High Quality Dentistry to Patients.

“Is there any way I can get a discount on that treatment?” Most dentists have encountered this question at some point in their careers. It's not uncommon for patients to ask for a reduced fee on proposed treatment, but the phrase “discount dentistry” still makes most dentists cringe. However, the question of what “discount dentistry” actually is goes beyond a fee-for-service conversation.

If dental practitioners are not offering the best level of care with finely honed skills and the best quality materials, they are practicing discount dentistry.

The concept of discount dentistry has two main components that must be fully understood in order to avoid the problems associated with it. The first component, and one most often overlooked by dentists, is the question of your skills as a practitioner. The second component is a conversation with patients about a fee for a service, and when or if a discount should be considered.

HIGH-END DENTISTRY

Most everyone has gone to what they thought was a high-end restaurant only to have a disappointing experience. The food may have been subpar, the service slow and unresponsive, and the ambiance far below expectations. At the end of the meal, the patron got a bill, the size of which suggested that he or she should have had a transformative dining experience.

Patients may experience a similar situation if they go to a dental practice in which the practitioner has not dialed-in his or her skills and operations. If dental practitioners are not offering the best level of care with finely honed skills and the best quality materials, they are practicing discount dentistry. They may still be charging full price for the treatments, but they are nonetheless discount dentists.

It's possible to be a discount dentist and not even know it. How? Because dentists may not even be aware that higher skill levels and materials are possible. This is an easy trap to fall into, and one that is not always easy to identify.

For me, the realization came when I attended the Full Arch Reconstruction course offered by the Dr. Dick Barnes Group. During that course, I learned that I had not been honing my skills as a dentist to the point where I could offer the absolute

best possible outcomes to my patients. Sure I was a good—or arguably even a great—general dentist, but I discovered that I could be offering even more to my patients.

In many ways, I was still doing the basic stuff that I had learned in dental school. I avoided techniques and materials that I thought were complicated or demanding, even though they offered the potential for a better outcome. It was a discount experience for patients, and one that I subconsciously admitted to by offering a limited, one-year warranty on the work.

I have since learned to offer only the best techniques and materials for my patients. This is easier said than done, because it requires dentists to take their skills to a whole new level.

It was a discount experience for patients, and one that I subconsciously admitted to by offering a limited, one-year warranty on the work.

Initially, I looked at complicated dental procedures such as large case dentistry, implants, complex occlusion, etc., and they intimidated me. But instead of staying in my comfort zone, I sought out instruction in those areas, and then I did the hard thing—I started doing them on patients. And not just once in a while.

Whenever a patient presented in my office with a need that could be best met with advanced techniques, I presented that treatment as an option. I made sure that a lack of skills development did not limit the treatment options.

MATERIALS MATTER

I learned that in order to perform at a high level, dentists must use the highest quality materials. For example, you can't build a Formula One racing car by going to the local Pick 'n Pull and putting it together from scraps.

5 TIPS TO AVOID DISCOUNT DENTISTRY

- 1) *Take continuing education courses to ensure high-level skills.*
- 2) *Offer comprehensive treatments that go beyond the basics.*
- 3) *Always use the highest-quality materials.*
- 4) *Consider offering a warranty on the work.*
- 5) *Create a sense of value for the treatment.*

DISCOUNTS? NO WAY! *What is the real cost?*

Assuming an anticipated profit of 25% on selling price:

- **10% cut means a 67% increase in sales is necessary**
- **15% cut means a 150% increase in sales is necessary**
- **20% cut means a 400% increase in sales is necessary**

Source: Eastman-Kodak

I also learned that the best material isn't always the most expensive. Too often, high price is associated with high quality because it's easier than taking the time to understand the materials and how best to use them. A key part of enhancing one's skills is understanding the materials and how they can best be used in different situations.

Whenever a patient presented in my office with a need that could be best met with advanced techniques, I presented that treatment as an option.

Another major breakthrough for me was finding a dental laboratory that could help me progress as a dentist. Fortunately, I chose Arrowhead Dental Laboratory, a lab with sufficient skill and expertise to advise me as I began doing more complex cases. Especially in the early days, they helped me execute cases so that my learning process didn't compromise patient care.

It has been a long journey, but today I can offer high-end dentistry with high quality materials. I warranty all my work for five years, no questions asked. Some people might say this is a risky offer because I could get stuck with a lot of remake costs. But the truth is that I actually get fewer remakes than when I offered a one-year warranty.

By investing in continuing education, I worked at becoming an expert in proper prepping and bonding techniques. I am now able to address causes rather than symptoms. And because I am using the best materials, I don't have crowns failing or patients returning time and again to get issues fixed because they weren't done right the first time. This investment has paid off and set my practice apart from other so-called "discount dentists."

Avoiding the second part of the trap, in which dentists are constantly being asked by patients for discounts, is easy once the dentist is confident that he or she can offer patients the highest quality of care.

Because I have maximum confidence in the cases that I do, and because I offer a comprehensive *(continued on page 42)*



DENTISTS CAN
WORK AROUND
MOST POTENTIAL
PROBLEMS

such as their hips not being level or one shoulder being lower than the other. It may be good to advise the patient to visit a massage therapist, chiropractor, or osteopath to check their skeletal structure so that when you take the bite registration, it can be optimal and support his or her neck and back.

9. FAILING TO TRY IN

On prep day, doctors can get so nervous and excited that they may not take time to review the case and try-in certain features that were created to help them prep.

Doctors are often given a bite jig from the lab, and they should try it in and make sure that it fits properly. One pitfall may occur with the insertion of the bite jig. The posterior end on the bite jig can be over-extended and run into the musculature in the corner of the mouth.

Don't let the possibility of a mishap hold you back from moving forward with comprehensive dentistry.

Dentists need to recognize that and trim away some of the excess material around that second molar so that the bite jig seats fully. Verify the goal VDO with a Boley gauge and write it on the bite jig.

Doctors may also receive a prep reduction guide from the lab, which helps prevent over- or under-preparation of teeth.

This gives doctors a great understanding of exactly where the tooth needs to be prepped.

The last lab piece to try in is the Sil-Tech matrix. This is the matrix formed from the White Wax-Up to fabricate temporary restorations. Try it in to make sure it's not too bulky and to prevent it from pinching the musculature in the corners of the mouth when the patient opens or closes.

It may need to be thinned out so it seats fully. It shouldn't wobble when it is placed. The Sil-Tech is indexed to the opposing arch to reduce the pitch, roll, and yaw of the provisionals.

10. NOT BEING TEACHABLE

One of the most destructive pitfalls is when a doctor develops the attitude that he or she knows everything. Don't let your ego get in the way. Be open to possibilities. When doctors get dogmatic about a specific approach, they can't adjust if things go wrong. Every patient is different and if we try to fit a round peg in a square hole, it typically doesn't work out so well.

Mishaps can happen to anyone. Understanding common pitfalls in full arch and full mouth reconstructions can help dentists learn the most important things to incorporate into their restorative routines.

Don't let the possibility of a FAR mishap hold you back from moving forward with comprehensive dentistry. With a few thoughtful strategies, dentists can work around most potential problems. ■



Dr. Jim Downs received a D.M.D. degree at Tufts University School of Dental Medicine in Boston, MA. He is an expert in comprehensive restorative treatment and has completed numerous full arch and full mouth reconstruction cases. He maintains an aesthetic, family-oriented practice in Denver, CO. Dr. Downs is an instructor for several continuing education courses with the Dr. Dick Barnes Group seminars, including Implant EZ, Full Arch Reconstruction, and more.

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The Unfinished Dentist (continued from page 3)

their comfort zone—even on a daily basis. I have met dentists who have been out of school for more than 10 years and have never prepped more than four units in a single session.

I have also met dentists with more than a decade's worth of experience practicing dentistry who still take more than an hour to prepare a single tooth. Experience that isn't constantly building towards higher levels of skill is a manifestation of the conscious or subconscious belief that one has enough knowledge to "get by."

Even at this point in my career, I can proudly say I'm not finished. There are still many things to learn, and a great many things to be done.

The concept of the unfinished dentist refutes such a mindset in purposeful ways. The Aristotelian motto of "the more I know, the more I don't know" is the mantra of dentists who are truly dedicated to practicing the art of dentistry.

As a young dentist, I remember doing a full arch reconstruction on the wife of a good friend. The case turned out well and it was a vast improvement for the patient. Over the years, as I had the opportunity to visit with this friend and his wife, I could see in her smile things that could be improved because I had learned new techniques and approaches that would yield even better results.

During one of her checkups, I completed her exam and told her that I was going to redo her teeth at no charge. She looked at me and said that she thought her teeth were fine and she was happy with their current state.

I replied, "Now I am a better dentist than when I did your case. And because I want your smile to provide a lifetime of benefit, I want to redo it." And I did. For me, the goal for every case has been to continue the evolution of my skills in the service of my patients.

My invitation to you, regardless of where you are at in your career—and especially if you are just starting out—is that you become dedicated to the principle of the unfinished dentist. There are a number of ways you can do this, but above all else, you should commit yourself to always presenting the best option to your patients.

If there are times you have suggested a less-than-optimal treatment option because you feared doing a required procedure or technique, get the necessary training in that procedure. If you feel like your skills are not advancing as quickly as they could, find a mentor and be humble as you seek direction and guidance. Resolve to put into practice what he or she tells you needs to be done.

A great dentist isn't self-made, and it is that realization that is at the heart of becoming an unfinished dentist. Even at this point in my career, I can proudly say I'm not finished. There are still many things to learn, and a great many things to be done. ■

Are You Doing Discount Dentistry? (continued from page 39)

warranty, a patient requesting a discount is a very easy thing to address. When a patient asks, "What kind of discount can you offer?" I simply respond with, "What part of the case would you like me to discount—the quality of the dentistry and the materials that we use for your case, or the quality of the service that we provide?" Most often, the response is, "I don't want you to use a less-than-optimal approach or inferior materials. I want the best."

Once patients realize that they want the best, it's like a light bulb goes on and they start to understand what I am presenting in terms of value. It allows me to then speak to the fact that I use the best techniques and best materials, and that these will provide the best long-term solution.

THE ANSWER

The discount-dentistry conundrum is rooted in a scarcity mentality: scarcity of the skills and understanding of materials on the practitioner side, and scarcity of perceived value on the patient side. When practitioners know that they offer the best level of care and can articulate that through the experience and ongoing support of the patient's dental health, the expectation of a discount is easily handled. ■



Dr. Brian L. Britton has been practicing dentistry for 25 years, and for the past several years he has been integrating sleep dentistry treatments into his Arlington, TX, dental practice.

Dr. Britton is a graduate of Baylor College of Dentistry in Dallas, TX, a member of the American Dental Association®, and a member of the Texas Dental Association.

He has a fellowship in the Academy of General Dentistry and is the chairman of the Peer Review for a local dental chapter.

Dr. Britton has also completed a sleep residency with the American Academy of Craniofacial Pain. Over the course of his career, Dr. Britton has completed countless hours of continuing education, including the curriculum at the Dawson Center for Advanced Dental Study in St. Petersburg, FL.

He currently teaches the new Removables Simplified course, and the Airway Management and Dentistry course with the Dr. Dick Barnes Group seminars. Dr. Britton maintains a patient-centered, comprehensive practice in Arlington, TX.

insurance company says you are only allowed to collect a fee for a filling. Contractually, some of those plans have the ability to do that.

To find out if a particular PPO tends to approve lower-cost procedures after a higher quality of care has been provided, talk to colleagues who have partnered with that PPO and ask about their experience. Do your research on the policies of each company before you sign on the dotted line.

8. KNOW YOUR WORTH

For me, the bottom line is if compensation is so low that you start to think about cutting the quality of your care, then you shouldn't take it. That may sound silly, but it's not worth it to me if the PPO restricts my ability to provide the highest quality of care for people. Of course, it's possible to provide quality care even if you get grossly undercompensated, but you have to do it at a loss.

For me, the bottom line is that if compensation is so low that you start to think about cutting the quality of your care, then you shouldn't take it.

At the end of the day, dentists are running a business. You can't function at a loss in your business and take care of anyone. Part of taking care of your patients includes taking care of your team members. If you're not being compensated enough to be able to invest in your team members and have them grow professionally and personally, then you likely shouldn't do it.

CONCLUSION

After the threat of losing 35 percent of my patients, I was compelled to investigate other PPO options. Today, my practice participates in three PPOs. They offer reimbursement at levels high enough that I am comfortable taking them.

In the past three years, we have expanded our practice to include a third dentist, so there was room in the schedule for new business. The third PPO provider helped us to attract new patients we had never seen before.

I had prepared for the worst-case scenario by considering what would happen if we lost a lot of our patients due to a 25



to 30 percent decrease in fees. But that insurer was regulated by the state to only a 9 percent decrease in their fees, and we kept most of those patients. I plan to renew our contract with that provider, knowing I can change my mind in 90 days if it is not working. We now have enough alternatives in place to mitigate any potential damage.

When we dropped out of many of these programs 15 years ago, a lot of patients left our practice to go to another participant. But we learned that a huge percentage of them eventually came back because they realized they weren't being treated the same way that we had treated our patients.

When they returned, they came back as full-fee patients, not PPO patients. The most important thing is to provide the best quality dental care you are capable of providing, and make sure the practice earns enough to continue that legacy. ■



Dr. Gary Nankin received his bachelor's and D.D.S. degrees from Case Western Reserve University in Cleveland, OH. Dr. Nankin is an instructor for the APEX program of the Boston University School of Dentistry. He maintains a private practice in Quincy, MA, practicing with Dr. Barbara Nankin (his daughter) and Dr. Jonathan Ye. The practice focuses on aesthetic, restorative, and implant dentistry.

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