

Aesthetic Dentistry

TECHNOLOGY AND TRENDS IN PRACTICE DEVELOPMENT

ISSUE 2 • SUMMER 2016

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Visions for Leadership

Lessons from My Years in Practice.

In July 2016, the Dr. Dick Barnes Group and Arrowhead Dental Laboratory will be hosting a 40th Anniversary World Symposium in the scenic mountains of Park City, Utah. During the seminar, dentists from around the world will spend two days learning from many of dentistry's most influential thought leaders about leadership and how it relates to building a more productive and satisfying dental practice.

As many of you know, I have been in the dental industry for 50 years. During that time, I have seen and learned a great deal. Recently, I received a call from a former patient who now lives in Kansas. When this woman went to her last dental appointment, she was sent home with a clean bill of health and no additional work needed. The dentist asked her, "Who did your original dental work?" She responded, "Dr. Dick Barnes!" She generously called to thank me for dental work that has served her well for 40 years and counting.

Today, the forces of change are working to shape the future of dentistry and it is important for us to strive to become increasingly better dentists. It's also a critical time for dentists as leaders.

We are seeing a vast expansion of corporate dentistry. Technology and patient attitudes are changing at an exponential rate and are reshaping the vision of dentistry's long held value proposition of quality. If dentists don't become the guiding influence in helping to chart the future course of our profession, we may find ourselves mere passengers on this journey.

There isn't anything magical about leadership. It simply requires someone who will start doing things differently. Throughout my career, I have found some principles that have helped me teach dentists to become more effective leaders. Here are some of my favorite principles of leadership:

- **All leaders should be firm in principle, flexible in procedure.** Success is easy—just copy it. Find someone who is successful and follow their principles. But always be flexible and adapt those principles to your particular needs.

- **Good leaders listen.** In team meetings, the leader should primarily let others talk. As soon as the leader says something, everyone else is quiet. You will learn much more about what's going on in the practice if you let others speak.

- **Surround yourself with the best possible people.** As leaders, dentists should hire the best people for their jobs. To continue their progress, make sure they are trained by the best trainers in practice development. Don't try to do everything yourself—hire the highest-quality team members.

- **Good leaders lead and get out of the way.** After hiring good people, dentists should get out of the way and let the team members do what they're good at.

- **Good leaders delegate.** In an ideal practice, the team members are responsible for their own jobs, and the dentist is free to be "just the dentist" and a leader who shows direction.

- **Leaders should be open to new ideas.** Once, in my office, a chairside assistant suggested that we reorganize some of the instruments, color-coding trays and correspondingly color-coding the instruments for different procedures. This idea saved our office a lot of time by having things organized, identifiable, and ready to go. She remained responsible for her own ideas.

- **Leaders take risks.** An introvert by nature, I took a risk early on by being more assertive and outgoing. All leaders need to take risks to get themselves and their practice to a new level.

- **A good leader shows direction.** Many times, we get trapped doing what's comfortable. To avoid this, ask yourself,

Be the kind of leader who ensures that dentistry remains a vibrant and fulfilling profession.

'Why am I doing things the way I'm doing them?' If your answer is, 'Because I've always done it that way,' then it's time to take another look.

- **A leader knows his or her strengths.** If we dentists don't stick to doing what we are trained to do, we could be "jumping over dollars to save nickels." You should look for "undone" dentistry!

- **A leader earns respect.** Once a dentist earns the respect of staff members, they will trust the dentist when he or she presents comprehensive dentistry to patients. Patients will make financial sacrifices when they understand the value of comprehensive dentistry.

If you follow these principles, you can transform your practice. Your patients will be grateful that you were their dentist and provided services that were meant to last.

I hope that as you look to the future, you constantly ask yourself what dentistry can and should be. Once you have established that vision, commit yourself to becoming a leader who not only achieves success for yourself and your practice, but also ensures that dentistry remains a vibrant and fulfilling profession. ■

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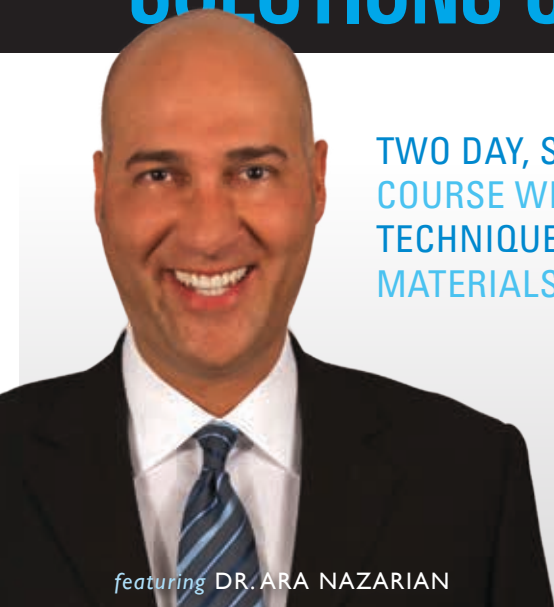
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A Learning

A Second Full Arch Reconstruction with the Latest Technology.

A portrait of Roy L. Petersen, a man with short brown hair and a mustache, smiling. He is wearing a brown button-down shirt. The portrait is positioned on the left side of the page, partially overlapping the main title and the sub-header.

The expression “the third time is the charm” isn’t always true. Sometimes, you only need one or two attempts to succeed. I’ve had not one but two full arch reconstructions. While the first reconstruction wasn’t a failure by any means, the second full arch reconstruction truly gave me the smile I’ve always wanted.

Unlike many patients who want a full arch or full mouth reconstruction, I didn’t experience any major health problems or unbearably painful complications because of my teeth. I wasn’t teased about my smile as a kid, I didn’t suffer from headaches or other pains, and I wasn’t looking to repair damaged dental work. I was motivated to undergo a full arch reconstruction because I was just dissatisfied with the overall appearance of my teeth.

I also have a unique perspective because my job is working on other people’s teeth. Since 1995, I’ve worked for Arrowhead Dental Lab in Sandy, Utah. I started work as a dental technician (in the model and die department), and for more than 20 years, I’ve worked in just about every department at Arrowhead. For the past nine years, I’ve managed the ceramic department. In my current job, I oversee training for more than 60 ceramists and teach them how to create the best quality restorations.

Although I originally had my teeth reconstructed in 2002, the materials and techniques have advanced since that time. Therefore, I was anxious to upgrade to the latest materials and techniques that dentistry could offer.

NEW AND IMPROVED

When I first had my teeth done, Dr. Jim Downs from Denver, CO, was planning on teaching a full arch reconstruction course with the Dr. Dick Barnes Group and he needed a patient. Because I had some discolored teeth (they were yellower than I wanted), I volunteered. I became the patient for the course so I could get some veneers over my upper teeth and make them whiter. Then last year, 13 years later, Dr. Downs worked on my teeth again. I had a second full arch reconstruction because the materials had improved significantly and I wanted a new upgrade for my smile.

Experience

Originally, I had my teeth done with Finesse® restorations, which were made from all-ceramic porcelain. It is an aesthetically pleasing, but somewhat weaker, material with a higher fracture rate than more recently developed materials. When Ivoclar Vivadent launched the IPS e.max® system, which is stronger in the mouth, I wanted to change my restorations. IPS e.max® offers a more aesthetic porcelain combined with a stronger material that typically lasts longer.

Because I am a bruxer and grind my teeth, I had some fractures with the original Finesse® restorations. Once one broke, the others started breaking—so I decided to remake them all. The Finesse® restorations wouldn't hold up to my bite, so I really needed something stronger.

During the most recent full arch reconstruction, I had the Finesse® restorations removed and I redid everything out of the stronger IPS e.max®. My entire upper arch was reconstructed again with the new materials. Dr. Downs put Snowcaps (see article, "Expedition Snowcaps: Discover the Multi-Purpose Case Solution," *Aesthetic Dentistry*, Fall 2015) on my posterior lowers, and we plan to finish the lowers in the near future.

For my second full arch reconstruction, I was the seat patient during a full arch reconstruction seminar for the Dr. Dick Barnes Group in Denver, CO. I flew to Denver and Dr. Downs took off the Finesse® restorations, and then I flew back to Utah where he seated the restorations later during a bonding course.

As a dental technician, I am acutely aware of the teeth in my mouth. Most patients aren't so attuned to every little nuance, but I notice every little defect. As a technician, it's hard to imagine how small changes to the tooth will impact the feel in the mouth. But as the patient, I could see and feel every minor defect—things I didn't realize were there until they were put in my mouth.

With a second chance, I was able to fix some of the original flaws. In addition, with the knowledge that I had gained throughout the years, I had a lot more experience and skill with the second set of crowns, so they were not only more functional, but they were also better looking.

After my first full mouth reconstruction, I noticed quite a few things that I wanted to change in the original crowns. For the second set, I wanted to dial in the occlusion and function even

more, and I wanted to put different translucencies and effects into the crowns that were improved from the previous ones.

I was anxious to upgrade to the latest materials and techniques that dentistry could offer.

Additionally, after noticing the fractures on the original restorations (which I had to fix repeatedly), I really wanted something stronger. Because of my work with IPS e.max®, I had noticed how pretty and strong it is, and I really wanted to switch to e.max®. The fracture rate on e.max® is much lower than with Finesse®. The strength comes from a material called *lithium disilicate*, which is a well known type of glass ceramic. The strength of lithium disilicate (measured in megapascals, MPa) is far superior to many other restorations.

According to a March 2009 article in *Dentistry Today*, "The strength of ceramic material is about 80 to 100 MPa for metal ceramics, approximately 100 MPa for veneered zirconia, and 150 to 160 MPa for lucite glass ceramics. However, for the pressed lithium disilicate, the strength is in the range of 360 to 400 MPa."

I made my own teeth for the restorations, so I know they will last. I didn't put a lot of porcelain in the occlusion. I kept it all ingot, which makes it much stronger. Every time you add porcelain, ▶



(Above, top to bottom) Roy, before first full arch reconstruction in 2002; after first full arch reconstruction in 2006; after second full arch reconstruction in 2015.

Aesthetic Dentistry

EDITORIAL DIRECTOR: Dr. Dick Barnes, D.D.S.

EXECUTIVE ADVISOR: John Bauer, D.D.S.

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ACQUISITIONS EDITOR: Matthew Cook

ASSISTANT ACQUISITIONS EDITORS: Debi Evans
& Peggy Nelson

COPYWRITERS/EDITORS: Diana M. Thompson,
Michelle Billeter-Maxfield, Gavin Glover

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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.

the reconstruction is only as strong as that porcelain. Aesthetically, using ingot instead of porcelain is a bit of a compromise, but just a bit. It still looks good. The porcelain adds depth and translucency, but most people don't see the occlusion. I wasn't too worried because most of the "pretty" stuff is on the front where people see it.

I've been living with the new reconstruction for a few months now and haven't had any problems at all—they seem to be holding up well. I haven't noticed any problems or any issues. The difference in my smile is subtle enough that others don't really notice it—the change was mostly for my own personal benefit.

For doctors and technicians to do their best job and be on the same page, there needs to be clear communication.

Changing reconstructions from one material to another doesn't account for a dramatic difference, as far as appearance is concerned. There are some translucency differences, but the differences are noticeable more often in the small details—the things you can't see, but you can feel. I know that the teeth in my mouth are better than the ones I had before.

JUST DOING MY JOB

I now have firsthand experience with what patients go through during large-case dentistry, and this experience helps me in my work. That's

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why some doctors decide to get their own teeth done—so they can experience what their patients feel. Hopefully that level of understanding will lead to better diagnoses and doctors can better understand their patients' needs and wants. It's hard to completely understand what patients go through without having a reconstruction done.

The most surprising thing to me about the process (after the first reconstruction) was my occlusion. My first crowns had a nice, bumpy anatomy and looked natural. But in the mouth, natural teeth are actually slightly worn. Teeth don't have that "virgin" anatomy—they are worn down every single day from use. As a result, the manufactured teeth felt unnaturally bumpy and sharp, and I always felt like I had "stuff" in my teeth.

For the second set of crowns, I made the teeth much smoother. They still have a nice, detailed anatomy, but they're more smooth and functional. As a technician, learning to contour comes with experience, and learning such things as the Curve of Spee and the Curve of Wilson are critical to job performance.

As technicians, we're taught (at least in our lab) to stack the anatomy in (which means to include the bumps and crevices similar to what is found on natural teeth). All the bumps and anatomy that techs include look pretty, but when they put it in the teeth, sometimes it doesn't feel as pretty as it looks. If something is a bit off, it's like having a sesame seed in your tooth—it may be small (almost imperceptible to the naked eye), but you can really feel it.

When we were stacking in the anatomy the second time around, I had learned about all of the things that felt uncomfortable or just a bit "off" in my mouth. Therefore, I learned what things can cause discomforts for patients and I learned to change up the techniques and adapt to this new knowledge.

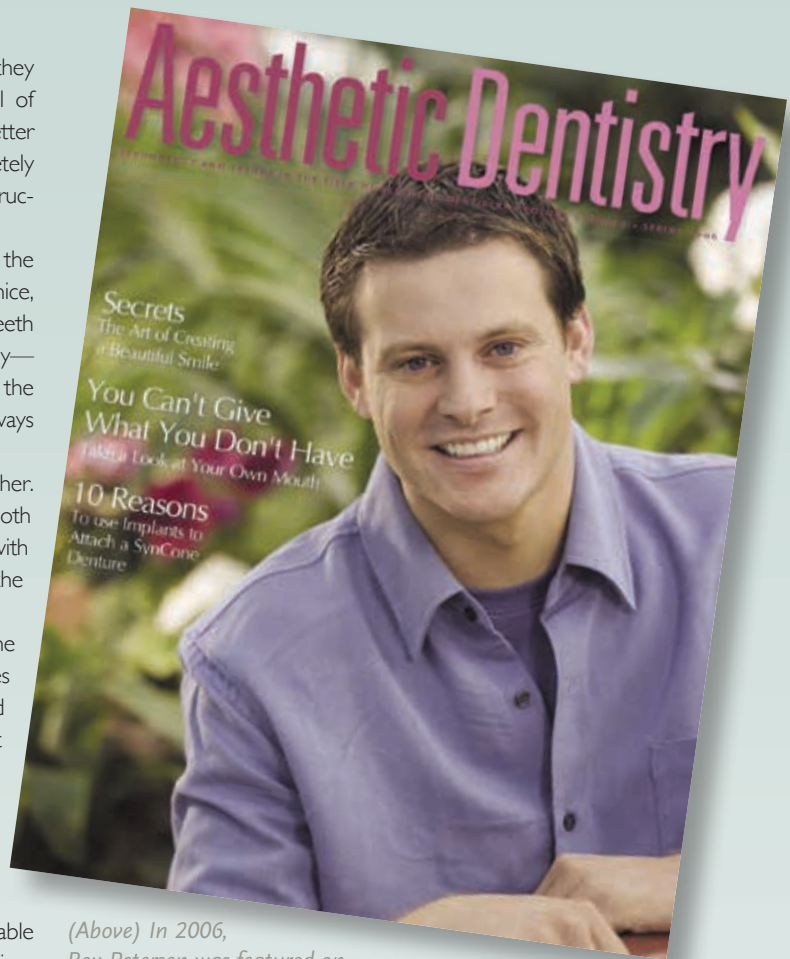
PATIENT-TECHNICIAN ADVICE

After undergoing a full arch reconstruction twice, the biggest thing I have learned is that for doctors and technicians to do their best job and be on the same page, there needs to be clear communication. Doctors should provide technicians with study models, shade tabs, and pictures. Technicians need those tools to make the tooth or teeth match the patient's and doctor's expectations.

The better that doctors and labs communicate, the better the results will be for the patients.

Some doctors will send a shade and say, "A1," and then it's left to the technicians to guess the rest. At times, the majority of the technical work is guesswork. But for a doctor to be extraordinarily successful and to have fewer problems and frustrations, the technician needs to have study models, shade tabs, photos, the patient's profile, and the patient's expectations in advance. It's extremely helpful for technicians to know what that patient's expectations are for their restorations.

The better that doctors and labs communicate on such issues, the better the results will be for the patients—it makes it easier for doctors and the lab to deliver a slam-dunk case. Otherwise,



(Above) In 2006, Roy Petersen was featured on the cover of *Aesthetic Dentistry* after his first full arch reconstruction.

doctors are just hoping for the best, and are letting someone else determine what the patient is going to look like.

My teeth perfectly matched my expectations because I worked on them! They were exactly what I wanted. The biggest difference from the original restorations (besides the material) is that I lengthened the teeth somewhat. They're the same size and shape, so there wasn't a lot to get used to. I didn't make many changes to them, except for the incisor translucencies and effects.

My smile makeover gave me a greater understanding of what patients go through, and now I am able to perform my job better. I think every cosmetic dentist should consider having his or her teeth done at some point, because it opens up a whole new perspective. Doctors can't completely understand their patients until they do it. But once they do, it's a whole new world of understanding! ■

COVER STORY CREATIVE TEAM

AESTHETIC DENTISTRY: **Dr. Jim Downs**, Denver, CO

PORCELAIN RESTORATIONS: **Roy L. Petersen**, Arrowhead Dental Laboratory, Sandy, UT

PHOTOGRAPHY: **Justin Grant**, JustinGrantPhotography.com

HAIR AND MAKE-UP: **Janelle Corey**, Salt Lake City, UT

Oral Cancer Screenings

Early Detection Can Protect Patients.

In 2002, Bruce Paltrow, an acclaimed television and film director and producer, died after suffering for years from complications due to oral cancer. He was 58 years old. After Paltrow's death, Blythe Danner (an accomplished actress and Paltrow's wife), partnered with the Oral Cancer Foundation (OCF) to raise awareness for early screening of the disease. In 2006, Danner told *ABC News*, "Because [the tumor] was hidden way back in [his] throat, it was hard to detect. [If he had] stage I or stage II, he'd still be with us, I think." Danner emphasized the need for early detection of oral cancer. She said, "Early detection, prevention, it just has to be out there much more, and it hasn't been out there in the mainstream media."

The Oral Cancer Foundation reports that fewer than 25 percent of those who regularly visit a dentist routinely receive an oral cancer screening.

Dentists can play key roles in making screenings of oral cancer as common as mammograms and colonoscopies. With massive advertising campaigns in the past few decades, mammograms and colonoscopies have become household terms. The Centers for Disease Control and Prevention (CDC) reports that about 66 percent of women aged 40 and over have had a mammogram in the last two years and 65 percent of adults aged 50 to 75 have had a recent colonoscopy. In contrast, the OCF reports that fewer than 25 percent of those who regularly visit a dentist receive an oral cancer screening. Your patients are likely unaware how pervasive oral cancer is and that you can help them with early screenings. Here are some important facts and risk factors for you to know.

ORAL CANCER—THE FACTS

Oral cancer (any cancer that originates in the mouth or throat) is the sixth most common cancer worldwide. Oral cancer includes mouth cancer, tongue cancer, tonsil cancer, throat cancer, and cancers in the middle part of the throat behind the mouth (the oropharynx). For 2016, the American Cancer Society estimates that about 48,330 people will get oral cavity or oropharyngeal cancer.

More than 8,500 Americans die from the disease each year. The OCF reports that "the death rate for oral cancer is higher than that of cancers which we hear about routinely such as cervical cancer, Hodgkin's lymphoma, laryngeal cancer, cancer of the testes, and endocrine system cancers such as thyroid, or skin cancer (malignant melanoma)."

When caught early, the five-year survival rate for oral cancer is about 83 percent. This number drops to just 32 percent when the cancer is not discovered until its later stages, after it has begun to spread.

According to the OCF, the death rate for oral cancer has been historically high because it is usually not discovered until late in development. In the early stages, when the cancer is more easily treatable, it is typically painless and symptomless. By the time a patient begins noticing symptoms, the cancer has often spread to the lymph nodes in the neck, and has grown deep into the tissues where it began. At that point, the prognosis is significantly worse.

The key to prevention and successful treatment of oral cancer is early detection. Changes in tissue that signal the beginnings of cancer can be easily seen and felt by a trained medical professional. The best way to screen for oral cancer is a thorough visual and tactile exam. Because an estimated 60 percent of Americans visit dental practices once a year, dental professionals

are in a great position to detect early signs of this cancer. Every person who enters a dental office represents an opportunity to catch oral cancer in its early stage.

With shifting at-risk populations, it is now more important than ever to screen as many people as possible. On its website, the OCF reports that, "opportunistic screening of ALL patients must become the norm if the death rate is to be reduced."

COMMON RISK FACTORS

When completing a patient's health history form, it may be helpful to ask patients about lifestyle choices that may increase their risk for oral cancer. While some factors are out of a patient's control (such as age and genetics), lifestyle choices are often the biggest factors in increasing the risk of oral cancer. Knowing a patient's history can help dentists determine whether patients should be screened annually or even more frequently.

1. Tobacco

Tobacco usage tops the list of risk factors. In the past, about 75 percent of people aged 50 years and older who were diagnosed with oral cancer were tobacco users. Today, the Cancer Treatment Centers of America (CTCA) reports that "About 80 percent of people with oral cavity and oropharyngeal cancers use tobacco in the form of cigarettes, chewing tobacco or snuff." Even exposure to secondhand smoke increases the oral cancer risk. A 2009 study in *Cancer Epidemiology, Biomarkers & Prevention* reported an 87 percent increase in oral cancer risk for people who had never smoked but had been exposed to smoke at work or at home.

2. Alcohol

Heavy use of alcohol, particularly when combined with smoking, also increases the risk of developing oral cancer. The CTCA reports that "About 70 percent of people diagnosed with oral cancer are heavy drinkers."

3. Diet

According to the National Institute of Dental and Craniofacial Research, diet may also play a role in increasing cancer risk. A diet low in fruits and vegetables may be a factor in cancer development.

4. Sun Exposure

Sun exposure is also a major risk factor, particularly for cancers that appear on the lips. With increased use of sun protection in recent years, the incidence of this particular oral cancer has decreased. But this risk factor may still apply for individuals who spend a lot of time outdoors for work or recreation.

5. Age

Age is also a risk factor; the average age for an oral cancer diagnosis is 62 years old, and two-thirds of those diagnosed are over

than the age of 55. Oral cancer is also more common in men than women.

6. Human Papillomavirus (HPV) Infection

The demographic statistics for oral cancer are beginning to shift. In recent years, younger, non-smoking patients are the fastest growing segment of the oral cancer population. This change is due to a newly emerging risk factor: HPV.

When completing a patient's health history form, it may be helpful to ask patients about lifestyle choices that may increase their risk for oral cancer.

Many strains of HPV are harmless, several cause warts, and a few are linked to cancer. One strain, HPV16, is linked to oropharyngeal cancer. In 20- to 30-year-old men and women, cases of oral cancer caused by HPV16 are beginning to replace cases of cancer caused by tobacco products.

Additionally, while men have historically been diagnosed with oral cancer six times more often than women, in recent years the gap has shrunk dramatically. Men are still twice as likely to have oral cancer as women, but the statistics may continue to change as HPV-related cancers rise.

THE DENTIST'S ROLE

Currently, most patients report feeling symptoms (pain, a mass, bleeding, otalgia, or dysphagia) *before* receiving a screening from a dentist or a doctor. But often, once symptoms appear, it's too late to treat the cancer easily.

A screening takes just a few minutes, and can reveal abnormalities that could develop into cancer long before symptoms appear. With the main cause of oral cancer shifting to HPV16, it is difficult to determine which populations are at greatest risk. ➤



(Above) Dentists should use a mirror to examine all surfaces of a patient's mouth for suspicious lesions.

The dentist's first responsibility is to educate his or her patients about oral cancer—particularly the risk factors and any early signs and symptoms. Alongside raising awareness, “the dental community is the first line of defense in early detection of the disease,” according to the OCF. To fulfill this role, the OCF recommends that dentists add routine cancer screenings to their regular exams, at least on an annual basis. Patients who are at a higher risk should be screened more often, if possible.

Oral cancer screening is quick, painless, inexpensive, non-invasive, and effective. Therefore, offering oral cancer screenings is a great way to add value to a dental practice and build trust with patients. Patients get peace of mind about a growing cancer threat, and the confidence that their dentist cares about their overall health.

CONDUCTING A SCREENING

Dental professionals do not need any special training or qualifications to perform oral cancer screenings. As in all dental procedures, patients should feel comfortable and informed about the process. Explain to patients what you plan on doing and why you are doing it—not only to put them at ease but to provide them the tools to conduct basic self-examinations as well (which further increases the chance of detecting any abnormalities

Dental professionals do not need any special training or qualifications to perform oral cancer screenings.

early). Encourage patients to perform a brief self-examination at least once a month, looking for any abnormalities (you can find directions for oral cancer self examinations online through the American Dental Hygienists' Association). When conducting an exam on patients, the OCF suggests that it is important to *listen*, *look*, and *feel*.

Listen

Ask patients the following questions:

1. Have you noticed any changes in swallowing? Do things seem to stick or catch in your throat when you swallow? (*Difficulty swallowing can indicate the development of oral cancer at the base of the tongue.*)
2. Have you had any chronic hoarseness? (*Hoarseness lasting more than two weeks may indicate something more than an ordinary infection.*)
3. While putting on makeup or shaving, have you noticed or felt any small lumps on the side of your neck? (*Many people ignore painless lumps, but they may indicate the spread of cancer from the inside of the mouth into the lymph nodes.*)
4. Have you had any earaches that seem to persist, particularly unilateral ones?
5. Have you or any of your friends noticed a change in your voice? (*Oral cancer can subtly affect nerves that control the movement of the tongue, causing changes in voice and speech.*)

While patients answer these questions, listen not only to the answers but also the sound of the patient's voice. Is it hoarse and

raspy? Changes in the voice can indicate growths in the throat or base of the tongue.

Look

While talking with patients, take note of facial asymmetry, masses, skin lesions, facial paralysis, swelling, or temporal wasting. It may be helpful to have a baseline photograph of the patient to compare, to make it easier to notice changes over time.

Feel

As you examine the oral cavity, mouth, and throat, it is important to feel each area to look for masses or abnormalities.

KEEP RECORDS AND FOLLOW UP

A cancer screening is only as good as the records you keep. Use a mouth map to document areas that seem abnormal in any way. In the record, include the size, shape, color, surface texture, consistency, location, and any previous trauma of the area in question. Any area that seems suspicious should be monitored for two weeks. If it persists for longer than two weeks, refer the patient to an oral surgeon or another specialist for further testing.

DIAGNOSTIC AIDS

No device or diagnostic test can replace a thorough visual and tactile exam performed by a dental professional. However, when used as adjuncts to an exam, certain tools may be helpful, depending on the needs and scope of each individual dental practice. Diagnostic aids are just that—aids. The devices are intended to help dentists and other specialists in analyzing and interpreting test results.

Toluidine Blue Staining: Toluidine blue staining uses a blue dye that is supposed to stain cancerous oral lesions, making them easier to spot. In studies, its effectiveness is mixed, and it has a high rate of false positive results.

Tissue Reflectance: Tissue reflectance uses an acetic acid rinse that patients swish for one minute to remove the glycoprotein barrier. The dentist then activates a light stick containing hydrogen peroxide to produce a blue/white light source. Under this light source, normal tissue appears blue while abnormal tissue appears white with brighter and sharper margins. This is intended to make it easier to identify abnormal tissue. However, studies so far have not shown that tissue reflectance is any more effective than the naked eye.

Narrow Emission Tissue Fluorescence: This technique uses only light, without a rinse. It requires a specialized machine that uses a blue light to highlight abnormal tissue. Initial results using this technology are promising, but studies are limited.

Brush Cytology: If an abnormal area is found, brush cytology can evaluate the area. Cells from the suspect area are gently scraped and tested for malignancy. Brush cytology cannot provide a definitive diagnosis, but it may help dentists determine whether to refer a patient to an oral surgeon or another specialist for a biopsy based on the results.

INSURANCE

Most dental insurance plans cover some level of oral cancer screening as part of a routine dental examination. In some cases, a medical insurance plan may cover the screening since cancer is considered a medical condition rather than a dental one.

Screening for oral cancer is an important part of the dental professional's responsibility to her or his patients. Conducting a thorough cancer screening typically takes less than five minutes, and has the potential of adding years to a patient's life. ■

For more information and support, including sample marketing materials and downloadable fact sheets, release of liability forms, and referral forms, go to www.oralcancerfoundation.org.

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Diana M. Thompson graduated magna cum laude with a bachelor's degree in English from Utah State University in Logan, UT. For the past 10 years, she has worked as a copywriter and editor for the natural products industry. She has written for several newspapers and edited a variety of full-length books and booklets. She specializes in nonfiction literature, particularly for the healthcare industry. Diana can be contacted at dianamaxfield@gmail.com.



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Trading Places

Part One

The Dentist as Patient and the Patient as Dentist.

For the past 40 years, the Dr. Dick Barnes Group has offered seminars to thousands of dentists. The following article was written after a Clinical Hands-On course taught by Denver-based dentist, Dr. Jim Downs. The four-day course, held over two weekends, is designed to give dentists the highest level of training in advanced cosmetic techniques through a clinical, hands-on experience. During the course, a full maxillary arch is reconstructed—from prepping to seating.

In 2014, two dentists who attended the course were also the volunteer patients for the course. The participants were Dr. Michael B. Beeler, a dentist from Tennessee in practice for about 40 years, and Dr. Ashley Blattner, a dentist from Missouri in practice for about six years. Both dentists shared their perspectives on the experience with Aesthetic Dentistry. Here are highlights:

Dr. Michael B. Beeler, D.D.S.

In the past several years, I have taken Over the Shoulder™ courses on cosmetics, implants, occlusion, and the Total Team Training course with the Dr. Dick Barnes Group. I've also used Arrowhead Lab for crowns and veneers for my patients. So after contemplating “remodeling” my mouth, I volunteered as a patient for the Clinical Hands-On course with the Dr. Dick Barnes Group.

I called Peggy Nelson at Arrowhead, and she asked me to send photos, radiographs, and study models of my teeth and mouth, to determine if my case met the course requirements. In addition to volunteering as a patient, I also wanted to participate as a dentist. I hoped that another dentist and I might take turns as patient and dentist for a full arch reconstruction.



(Above) Dr. Michael B. Beeler at Masterpiece Smiles, in Clinton, TN.

After a few months, Arrowhead called to tell me that they found a dentist, Dr. Ashley Blattner, who wanted to take the Clinical Hands-On course, but she needed a patient. Dr. Blattner had graduated from dental school about three or four years prior and was practicing in Missouri.

It worked out great! During the course, I volunteered as Dr. Blattner's patient for a full upper arch reconstruction and Dr. Blattner was my patient for a full upper arch reconstruction.

HOW IT BEGAN

Prior to the course, Peggy suggested that Dr. Blattner and I call each other to discuss the procedures. After a couple of emails and phone calls, Dr. Blattner and I met in October 2014

For the first time, two dentists who attended the course were also the volunteer patients for the course.

at Dr. Jim Downs's office in Denver, CO, just prior to the course. An additional five or six dentists attended the course with their respective patients.

I wasn't worried about anything because Dr. Downs is an experienced dentist and I knew he would guide the procedures. In addition, another esteemed dentist, Dr. Brian Britton, from Arlington, TX, assisted Dr. Downs with the course. Both dentists are great teachers, mentors, and leaders in our profession.

THE PATIENT EXPERIENCE

Day One (First Weekend): On the first day, I was the patient. Everything was a breeze! I had some old anterior crowns on my upper incisors and gold inlays on my molars. I also had some recurrent decay underneath some of the old dental work.

Dr. Blattner went to work and shaped precise preparations using "prep guides" from Arrowhead Lab, and then used the DENTA™ 2 laser (micro-pulsed CO₂) to contour my gingiva and "frame my new smile." She made and finished the most beautiful temporary crowns possible using great materials, modern technology, and Arrowhead Lab's technique.

As a patient, I experienced absolutely no postoperative pain from the lasing, the injections or the preps, or from holding my mouth open for several hours. I took no pain medication, and I felt great with my new smile! There were no surprises with my temporaries because they looked exactly like the wax-ups that had been fabricated before the procedure. Day one was great!

BEFORE—DR. BLATTNER



AFTER—DR. BLATTNER



Dr. Blattner expressed a feeling of accomplishment and some relief that she had prepped and temped a big case.

THE DENTIST EXPERIENCE

Day Two (First Weekend): On the second day of the seminar, it was my turn to work on Dr. Blattner. At the time, Dr. Blattner was four months pregnant, so naturally, she was somewhat concerned about having extensive dental work done. Dr. Blattner's obstetrician gave the "okay" for her to have dental work done and Dr. Blattner's only request was that we only use local anesthetic without epinephrine. I thought, 'No problem.' But I was wrong.

Shortly after beginning the procedure, I became concerned because Dr. Blattner's teeth were sensitive and she had difficulty staying numb for more than about ten minutes. It was a big case and I was becoming frustrated about getting behind schedule.

Dr. Downs reminded me that when a woman is pregnant, it is normal for the body to more quickly metabolize anything that it might perceive as foreign in order to better protect the unborn baby and the mother.

The "over-the-patient" delivery system and the control buttons on the chair were different from ones at my office. I wasn't in the familiar comfort zone of my "behind-the-patient" delivery system and I actually began to get nervous about finishing Dr. Blattner's preps in a timely fashion. I had only brought

Dr. Blattner expressed a feeling of accomplishment and some relief that she had prepped and temped a big case.

with me 2.5X loupes, and 3X or greater are really needed for this kind of precision dentistry. I was the oldest dentist there, I had completed hundreds of full arch cases, and I felt that I should have managed my patient's comfort level better because of my experience. (However, you are never too old to learn!) It seemed as if I could never get into a rhythm and I have a renewed respect for epinephrine in local anesthetic.

Dr. Blattner had several old composite restorations that needed to be replaced. She also had old bonding that was ▶

BEFORE—DR. BLATTNER



AFTER—DR. BLATTNER



done to close diastemas in between her centrals, and bonding to enlarge small lateral incisors. In addition, Dr. Blattner had an overjet of 5 mm, was slightly overclosed, and is a tongue thruster—therefore, she was not a typical wear case.

Dr. Blattner's Shimbashi was 15 mm. We needed to improve on her zenith, and therefore planned to end up at a tissue-adjusted Shimbashi of 17 mm. The treatment plan consisted of

Throughout the process, both Dr. Blattner and I were under the watchful eyes of Dr. Downs and Dr. Britton.

a full arch reconstruction and future lower arch reconstruction. A wax-up was completed (for more information on wax-ups, see Dr. Jim Downs's article, "White Wax-Up 101," *Aesthetic Dentistry*, Spring 2016).

CASE PREPARATION AND EXECUTION

Other than the sensitivity, everything went smoothly with the prep design. We were able to stop the lingual margin on the

she was doing. Dr. Blattner said that she was doing just fine. She was excited about her beautiful new smile and was looking forward to getting her permanent veneers, crowns, and onlays.

SIX WEEKS LATER

Day One (Second Weekend): The second part of the course took place six weeks later. On the first day, Dr. Blattner removed my temporaries and put in my new crowns. Dr. Downs checked the fit and they were all perfect! After cleaning the excess cement, my bite was very close to perfect—enough so that I comfortably waited until the next day to check my bite with the T-Scan®.

I was so impressed with the results of my beautiful smile and how my own bite felt that as soon as I got back to my office, I ordered Orascopic's wireless adjustable 3X/4X/5X loupes, the DENTA™ 2 CO₂ laser from GPT Dental, two curing lights from Ivoclar, and the T-Scan® so that I could immediately incorporate them into patient care.

Day Two (Second Weekend): The second day of the course was spent on seating and using the T-Scan® to check our occlusions. Both our cases needed minor

pre-molars and first molars about 1 to 2 mm shy of the gingiva. The second molars were prepped for porcelain onlays, as requested by Dr. Blattner. The Sil-Tech® stent, made from her wax-up, was used to fabricate her temporary restorations, and they looked great. After adjusting her bite, she seemed very pleased.

Throughout the process, both Dr. Blattner and I were under the watchful eyes of Dr. Downs and Dr. Britton. As I prepped Dr. Blattner (and re-anesthetized her every ten minutes or so), I noticed she was becoming fatigued and I was becoming discouraged.

About the same time, Dr. Downs came to the rescue. He re-contoured the preps (as needed) and his highly skilled and experienced dental assistants (Yvette, Casey, and Ciara) helped with the impression taking and fabrication of beautiful temporaries.

On the Monday after the course, I followed up with a phone call to Dr. Blattner's Missouri office to see how

(continued on page 42)

Trading Places

Part Two

The Dentist as Patient and the Patient as Dentist.

Dr. Ashley Blattner, D.D.S.

Our situation was unique because we started case-planning before I met the patient (Dr. Michael B. Beeler) in person! Like myself, the patient is a dentist who had legitimate concerns about his dentition and genuinely wanted to improve

his smile. After talking with him on the phone, I knew Dr. Beeler would be great to work with on a full arch rehabilitation case.

THE DENTIST EXPERIENCE

Day One (First Weekend): On the first day, I was the doctor. Dr. Beeler's case was fairly straightforward. He presented no health concerns, and was comfortable with the prospect of extensive dental work. He wanted to fill his buccal corridor and improve the overall appearance—including shape, shade, and zenith—of his existing teeth and restorations.

After reviewing his models, we decided that improving his buccal corridor would require restoration of the entire upper arch. Dr. Beeler also had several gold onlays/inlays in the posterior that needed to be replaced due to wear, decay, and appearance.

Dr. Beeler was not a typical wear case. His Shimbashi was 16 mm, which complimented his face well. We needed to improve on his zenith, and planned for the goal of a tissue-adjusted Shimbashi of 17 mm. The treatment plan consisted of a maxillary full arch reconstruction and future lower arch reconstruction. A wax-up was completed.

CASE PREPARATION AND EXECUTION

For prep day, I reviewed Dr. Beeler's wax-up and checked to make sure we had the proper ▶



(Above) Dr. Ashley Blattner at Bennett Family Dentistry in Cape Girardeau, MO.

BEFORE—DR. BEELER



AFTER—DR. BEELER



Shimbashi measurements. I also checked the contour and smile design to make sure it was what the patient desired. I made certain that we had a prep guide, bite registration, and stent. Arrowhead Dental Lab and Dr. Downs were great in coordinating the entire treatment and making sure these items were in place on prep day.

Dr. Beeler's case was fairly straightforward. He presented no health concerns, and was comfortable with the prospect of extensive dental work.

I was amazed by how smoothly everything went with the prep guide, bite registration, and stent. I was as conservative as possible with the prep design. I was able to stop the margin on the pre-molars on the occlusal surface, and therefore preserve the entire lingual cusp. When removing the gold onlays,

I encountered some decay, but was able to excavate it and restore the areas without difficulty.

As I moved into prepping the maxillary anterior, I removed the permanent existing crowns, and soon realized that there was more tooth structure present on tooth number 7 than initially thought. We made Dr. Beeler aware of this, but we decided to move forward with a full coverage crown on this tooth (see "Challenges of Dr. Beeler's Case" on page 19).

Once the preps were completed, I completed his temporary crowns. I was amazed at how easy the Sil-Tech® stent (made from the wax-up), was to fabricate from the temporary restorations. Not to mention how amazing they looked!

THE PATIENT EXPERIENCE

Day Two (First Weekend):
On the second day of the first weekend, it was my turn to be the patient. I had decided to get my teeth done both for the professional experience and because I really wanted to change my smile. I'd had a lot of wear, but if you look at

my "before" smile (see page 16), it wasn't awful. I also had some composites and a lot of wear on my posterior teeth.

I had previously attended one of Arrowhead's Over the Shoulder™ courses where Dr. Downs had rehabbed a young guy—he was a medical student. I looked at his mouth and thought, 'Oh my goodness. My mouth looks a lot like his!'

So I started thinking about getting my work done. I knew I needed some posterior crown work and I thought, 'If I'm ever going to do this, now is the time—before I need those crowns.' I knew at my age, if I didn't do something, in 20 years I would definitely have issues as far as posterior wear and possibly teeth chipping. I was already having some headaches, and I was clenching and grinding in the evenings and overnight.

On day two, being a patient was somewhat complicated due to the fact that I was four months pregnant. But the only real complication was with the anesthesia—it wore off really quickly. Plus, it was just tiring for me! I think I was in the chair for nine hours! I learned that it was really important to take breaks. Also, just hearing the drilling can sometimes be a bit nerve-racking.

But it was great to hear positive reinforcement while I was in the chair. During the treatment, everyone was really positive—the doctors, the lab, the technicians, and Dr. Beeler. It really helped me get through it.

CHALLENGES OF DR. BEELER'S CASE

Day One (Second Weekend): Bonding day was exciting, yet stressful. It was imperative that everything was lined up and ready to go. Dr. Beeler's case looked fantastic—I was beyond impressed with the Elite porcelain crowns fabricated by Arrowhead Dental Lab. The quality and artistic ability that went into each one was unmatched.

We removed Dr. Beeler's temporary crowns fairly effortlessly, except for one issue with tooth number 7. When we removed this piece of the temporary acrylic material, the tooth had broken at the gumline.

Inside, my heart skipped a beat, but I knew calmness was key, and it was nothing that the Arrowhead instructors (or any general dentist, for that matter) had not encountered before. Again, I was extremely glad that we pre-framed the possibility of such an occurrence to the patient at his prep appointment.

We continued cementing the entire arch and waited until the end to address the issue of tooth number 7. It was apparent that the tooth had a poor prognosis and would likely be best treated with an extraction and implant placement in the future.

In the meantime, we needed a tooth! We were able to fit a post into the tooth and retrofit the crown. It is not likely this will last a great length of time, but it allowed the patient to see the final aesthetic product and it bought us enough time to get an implant consult.

REFLECTIONS

It was a long day, not only for myself as the clinician, but also for Dr. Beeler as the patient. He was an ideal patient, and I gained great insight on the amount of time it takes to achieve an excellent outcome.

From the experience, as a clinician and a patient, I am now able to better prepare my own patients for what they may encounter with a full arch reconstruction. "Pre-framing" patients and telling them what they may expect is key. And what better way to do this than to tell them that you have been through the same process yourself?

The experience also taught me the importance of compassion. I have always prided myself on putting my patient first, but

Case Presentation Details — Dr. Beeler

- Natural smile design.
- Full coverage crowns on teeth, numbers 2 to 15.
- Tooth number 2 and tooth number 15 were full gold restorations due to increased strength, and to create a good posterior stop.
- We retained the lingual cusps of the pre-molars. Decay was not present, and there were not any fracture lines or decalcification present. We were not able to save the cingulums on tooth numbers 7, 8, 9, and 10 due to these teeth already having full coverage.
- Patient has existing full coverage crowns on teeth, numbers 7, 8, 9, and 10—he had trauma on tooth number 7 and had previous root canal therapy completed years ago with silver points. The patient had that crown come off and explained that there was not a substantial part of the tooth remaining. He completed a consult with a local endodontist who was unable to remove the silver points. However, there was not any sign of radiographic or clinical infection on the tooth. The main concern was the extremely short clinical crown.
- Tissue contouring: 1 mm from teeth, numbers 4 to 13. Corrected the zenith and added slight length to Shimbashi. One of my main concerns in tissue contouring was to add symmetry.
- Dr. Beeler and I both felt aesthetics would be improved by lightening the shade of his dentition.
- His incisal plane was fairly ideal.

I really had no idea what it felt like to sit in a chair for nine hours with my mouth propped open and having my entire maxillary dentition drilled on. It is emotionally and physically draining.

Therefore, as the dentist, it is important to keep the patient excited and focused on the end result. Patients can sense a doctor's frustration. I discovered that little breaks lightened the mood and gave the patient time to regroup. Positivity is truly contagious—it is important the entire dental team is on board with creating a fun, relaxing environment.

All in all this experience was exceptional! As both patient and clinician, the insight I gained was second to none. I love my new smile, and believe it was the best practice-builder I have done thus far. It has already opened conversations and opportunities with patients to improve their own smiles. Wear cases are difficult and a bit intimidating, but with a great lab and the confidence that comes with restoring full mouth reconstruction cases, they can actually be fun and so rewarding! The only regret I have about the process is that I did not do it sooner. ■



Dr. Ashley Blattner resides in Cape Girardeau, MO, with her husband, Trevor, and their family. Originally from Kansas City, MO, she completed her B.S. in Dental Hygiene and practiced dental hygiene for two years. Then she decided to return to the University of Missouri-Kansas City Dental School and earned a Doctor of Dental Surgery (D.D.S.) in 2010. For three years, Dr. Blattner practiced general dentistry in Baltimore, MD, before returning to Missouri in 2013. While in Baltimore, Dr. Blattner had the opportunity to advance her training in complex cosmetic and occlusion cases, dental lasers, and dental implants.

Today, Dr. Blattner enjoys working at Bennett Family Dentistry, where she can be part of a practice that is focused on enhancing patient care by staying up-to-date with both technological advances and continuing education opportunities. She takes great joy in helping others, and her compassion for patients has a positive impact on the dental experience.



TECH TIPS ■ AESTHETIC DENTISTRY EDITORS, WITH TRACEY FOLAU, LESLIE R. LAB, JAY NELSON, ROY L. PETERSEN, AND CHRIS WALLEY

Hybrid Zirconia Restorations

The Requirements and Benefits of Hybrid Zirconia Restorations.

Aesthetic Dentistry recently spoke with Arrowhead Dental Lab's hybrid zirconia restoration team to learn more about this unique appliance. Members of the team include: Tracey Folau (TF)—CAD Technician, Leslie R. Lab (LL)—Implant Technical Support Specialist, Jay Nelson (JN)—CAD/CAM Department Manager, Roy L. Petersen (RP)—Ceramic Department Manager, and Chris Walley (CW)—Ceramic Training Specialist. Together, they shared their insights regarding best practices for hybrid zirconia restorations and how to ensure success for doctors and patients.

AD: WHAT IS A HYBRID ZIRCONIA RESTORATION?

LL: This restoration is an aesthetic hybrid (a full zirconia bridge on a Ti-base) with implants. There are two main variations of the hybrid zirconia restoration: a monolithic approach, where it's made out of a block of zirconia and stained by an expert for aesthetics, and a second approach for a higher aesthetic outcome, where IPS e.max® crowns are individually created and cemented to the zirconia bar. For

both restorations, the technicians at Arrowhead Dental Lab start with the implant, design the zirconia frame, stack the zirconia, and then build the pink porcelain on it. If requested, we make the entire unit screw-retained (see image on page 21, top right).



(Above) A hybrid zirconia restoration, made by Arrowhead Dental Lab, is a highly aesthetic restoration. This restoration (made with individually placed IPS e.max® crowns) is great for edentulous patients and others with badly damaged teeth.



Generally, the best way to make it is on multi-angled abutments—non-engaging fixtures that can add some tissue height or angle correction within the design of the frame.

AD: WHY SHOULD DENTISTS USE A HYBRID ZIRCONIA RESTORATION?

CW: It's a more robust restoration, versus a standard denture on an abutment. Also, it's more aesthetically pleasing. The full zirconia restoration is milled out of a zirconia puck and then sintered. It's a solid piece of zirconia, with the exception of the pink porcelain (an aesthetic embellishment on top of the zirconia). Because it's a monolithic restoration, it's incredibly durable. They're tough! However, a standard denture is still a great option for patients on a more limited budget.

AD: WHICH PATIENTS SHOULD CONSIDER THE HYBRID ZIRCONIA RESTORATION?

LL: It's specifically designed for an edentulous (or soon-to-be edentulous) patient whose case fits within specific parameters—primarily, he or she needs sufficient room in the vertical. In an ideal situation, we ask for at least 15 millimeters per arch (that's also for the posterior). The doctors should work closely with their patients and the lab to determine the best direction in order to establish the vertical.

Patients who are unable to open comfortably to accommodate a zirconia hybrid restoration can still be restored with an acrylic denture hybrid instead. But for the hybrid zirconia restoration, it's important that the patient has enough room in their arch. In some cases, a doctor or surgeon can reduce some of the bone to make enough room for the implant restoration.

AD: WHY WOULD A DOCTOR USE THIS RESTORATION INSTEAD OF A STANDARD DENTURE?

JN: It's really for a dentist who wants to deliver high-end dentistry, and who wants the best aesthetic and functional outcome for their patients. This is a highly-customized, aesthetic product that will return the patient to as close to full function as any product on the market.

CW: Overall aesthetics are superior with this restoration. Tooth placement, zenith, arch form, Curve of Spee, and Curve of Wilson—all appear more natural with the full hybrid zirconia.

With standard dentures, there's usually a fixed format (pre-made designs) to save costs. For certain patients, dentures are great because they still get improved function and aesthetics at a lower price point.

However, with the hybrid zirconia restoration, patients and doctors can choose a smile design, a tooth shape, tooth height, and tooth width—just about anything that the patient or doctor desires. If the patient wants flat incisal edges, we can do that. If the patient wants oval, youthful teeth—it's all achievable. A hybrid zirconia restoration is the most aesthetic, functional, and durable option available for edentulous patients. It's truly a customized outcome.

AD: WHAT CAN PATIENTS EXPECT IN TERMS OF MAINTENANCE WITH STANDARD DENTURES?

LL: Standard dentures generally require more maintenance than hybrid restorations. Typically, standard dentures eventually wear down and they have to be replaced. Also, patients have to visit the dentist more often for cleanings and repairs. ➤



(Above, top to bottom) Before-and-after images of a patient with severely damaged teeth who received the monolithic hybrid zirconia restorations. In the next issue of *Aesthetic Dentistry* magazine (Fall 2016), read more details about this case by Dr. Ara Nazarian of Premier Dental Center in Troy, MI.



(Above) A close-up view of the hybrid zirconia restoration shows the realistic detail and aesthetics of the design.

AD: IS OVERALL MAINTENANCE DECREASED WITH A HYBRID ZIRCONIA RESTORATION?

LL: Yes. With the hybrid zirconia restoration, which can be screw-retained, the dentist has the ability to remove the prosthesis and give it a thorough cleaning. However, the patient still should be extremely conscientious and diligent with daily dental hygiene. All patients with these restorations should purchase a Waterpik® to flush underneath the appliance, in addition to having good hygiene habits. These hybrid restorations will not have a full seal, especially on the lowers, and poor hygiene can lead to buildup on the original abutment.

Periodontal problems typically cause patients to become edentulous in the first place, and the issues that caused the periodontal disease don't magically go away with these restorations. In addition to good dental hygiene, patients should visit their dentists for regular cleanings and maintenance. When they do, the dentist will take the screws out to clean the device and then replace the screws with new ones.

There is really no limit to the aesthetics with these restorations. It's truly a customized outcome.

Many patients experience increased function with these restorations (compared with standard dentures). If someone has a traditional denture, even if it's held in place with paste or locators, certain food—particularly food that requires a grinding motion to break down—just cannot be consumed.

AD: IS THIS RESTORATION RECOMMENDED FOR PATIENTS WHO HAVE LOST THEIR TEETH DUE TO AN ACCIDENT OR OTHER PROBLEMS?

RP: Yes. We received a case for a young woman whose teeth were severely damaged (see *before-and-after photos on page 21*).

Dr. Ara Nazarian of Premiere Dental Center in Troy, MI—a dentist with an emphasis on comprehensive and restorative care—removed all the young woman's natural teeth and put in six upper and six lower implants. The hybrid zirconia restoration gave the patient the best possible outcome for the long term. It restored proper function.

AD: CAN YOU DESCRIBE THE PROCESS OF FABRICATING THESE RESTORATIONS?

RP: For the highest aesthetic hybrid restoration, we build the crowns one-by-one and bond them to the zirconia. The advantage of doing that is if a patient breaks one tooth, we don't have to remake the full restoration. If a patient were to chip it, a doctor could take it out of the patient's mouth, and re-prepare that one tooth or send it in to the lab for us to re-prepare that tooth. Then the doctor could place that crown back onto the restoration. As mentioned earlier, we can also do a one-piece monolithic restoration (which has a different fabrication process). Each hybrid zirconia restoration case is going to be different because we can customize it for a specific patient.

TF: Once the model work is completed, the case is sent to Arrowhead's CAD/CAM team, where the upper and lower models are scanned and correlated. A CAD technician then designs the restoration according to instructions given by the dentist in the prescription. Before the restoration is milled, an

5 Tips for Success

WHEN SENDING IN A HYBRID ZIRCONIA RESTORATION CASE, PLEASE INCLUDE THE FOLLOWING:

1. **SURGICAL GUIDE**
2. **PHOTOS**
3. **TISSUE SHADE**
4. **SMILE DESIGN**
5. **IMMEDIATE DENTURE (IF POSSIBLE)**

expert ceramist checks the design and may suggest any improvements. When the ceramist is satisfied with the design, it is milled out of a zirconia puck. The milled restoration is then given to a ceramist who refines embrasures and surface textures as needed.

Next, a staining specialist gives it a natural shade and translucency. The restoration is then seated to the model and pink porcelain is applied. Any needed adjustments are made to the occlusion or intaglio surface before the restoration goes through the final stain and glaze process. Afterwards, a final quality check is completed and the restoration is shipped to the doctor.

AD: WHAT CAN PATIENTS EXPECT IMMEDIATELY AFTER TREATMENT FOR A HYBRID RESTORATION?

LL: After the initial surgery, patients should eat a soft or liquid diet for the first two weeks. That's generally how long it takes for the implants to assimilate. After that, patients should continue on a soft diet while slowly introducing harder foods (when the patient is wearing temporaries or immediate dentures). By the time the patient gets the full zirconia restoration, he or she should be able to eat foods that might be difficult or impossible to consume with a standard denture.

AD: HOW SHOULD A DENTIST CASE-PLAN FOR THIS RESTORATION?

CW: The dentist should closely collaborate with the lab. Every restoration is so customized, if we only get an impression (which we see a lot) without additional details, we frequently have to go back-and-forth with the office.

LL: Yes, as with all restorations, the better the planning, the better the outcome. To emphasize again, it's critical to have the vertical dimension dialed in. The patient has to be comfortable with the vertical. If the dentist opens it up too wide, it can be problematic for the joints and muscles.

Often, it's best to do an immediate denture if the patient isn't wearing one. The lab can make a clear duplication of the immediate denture, which becomes a tool for setting the bite. With it, we can see exactly where the bite is (versus working off of wax bite rims where the mid-line is marked and we're guessing at where the bite should be).

In addition, surgical guides are highly recommended. We have a team at Arrowhead Dental Lab that can take cone beam images, work with the surgeon with CAD design, and pick the proper sizes and the specific brand for the doctor. The surgical guide takes a lot of the guesswork out of the process and makes the entire process easier for doctors.

RP: It's helpful to have photos, tissue shades, and a smile design up front. This helps technicians dial in the aesthetics so that the patient's smile is naturally beautiful.

JN: When we first started fabricating hybrid zirconia restorations, Arrowhead formed a team in which each team member specialized in a particular facet of the case. When we receive a new case, the team gathers to discuss what we see, whether there are issues, and then we communicate all these things to the doctor. Each case is customized and comes with unique challenges. Our team helps doctors case-plan and creates hybrid restorations that are as unique as each patient.

TF: It's critical to get the vertical right. It's important that the bite is verified before we move on to the design process. Once we verify the final design with the dentist, we can then mill out a design in a temporary material and have the doctor check it to make sure everything fits properly. Alternatively, we can send digital images (which show how the bite looks—including

the aesthetics and the function) to the doctor prior to milling to make sure that everything appears the way they want it.

Each case is customized and comes with unique challenges. Our team helps doctors case-plan and create hybrids that are as unique as each patient.

Digital images are helpful tools for good communication between dentists and the laboratory. We want to make sure everything looks right before we fabricate the final zirconia restoration.

AD: HOW CAN DOCTORS FEEL MORE COMFORTABLE DOING THIS KIND OF HIGH-END DENTISTRY?

TF: At Arrowhead, we've created an organizational structure built around the hybrid zirconia restoration process. If we need to make changes to the design or to the fabrication process,



(Above, back row—left to right) Jay Nelson, Roy L. Petersen, Chris Walley; (front—left to right) Tracey Folau, Leslie R. Lab.

everybody involved in the process is available to make sure that all the bases are covered for the best outcome.

It's really a manifestation of Arrowhead's commitment to help doctors become better at what they do and also help them deliver a level of dentistry to their patients that far exceeds what is commonly available on the market. For a doctor looking to stand out and practice dentistry at a whole new level, this is an incredible product! ■

For information on other implant-retained options, look for the Tech Tips article in the Fall 2016 issue of Aesthetic Dentistry, available in November. In the article, we will highlight the benefits and uses of the following restorations: Overdentures with Locators®, bar-supported overdentures, immediate fixed hybrids, and directly veneered fixed prostheses. Coming soon!

Going Forward

Creating Opportunities for Success.

Creating opportunity is taking action, which results in positive outcomes. Opportunities can be created by adopting behaviors that lead to being hired or promoted, or otherwise opening new doors for success. Regardless, the intended

My first opportunity was just being friendly on the phone. I thought it would be easy. I also thought, 'I can easily schedule patients for appointments.'

outcome is success. What it is not is fortuity—a lucky chance. Positive outcomes are not a coincidence. When you create an opportunity, you take advantage of a good situation to meet or exceed expectations. Sometimes, as in my personal experience, the outcome was much more than I could have ever anticipated.

MY STORY

I was asked to write this article about creating positive opportunities in my own career. It's not always easy writing about oneself; however, I agreed to try and include some examples.

My beginnings in the dental industry started in 1984, when I began work as a receptionist for a dentist in Fort Smith, Arkansas. I was always a motivated person, and on the first day, I decided that nobody was ever going to answer the phone any better than me. I was always going to do my best.

I had to figure out the things that worked for the dental practice by trial and error. At the time, it was a very small dental practice. My first opportunity was just being friendly on the phone. I thought it would be easy. I also thought, 'I can easily schedule patients for appointments.'

However, it wasn't as easy as it seemed (I don't mean the friendliness part). I didn't know that I should identify my office by announcing my name and saying, "This is Tawana. How may I help you?" Instead, I just said, "Dental office." One day, a caller asked, "Are you the building? Are you the office?" I was so embarrassed! I said, "No, I'm Tawana." On that day, I learned that there was a better way to answer the phones.

GETTING STARTED

During the early days, our hygienist only worked two days a week, so I asked her why she didn't work every day (which

was about sixteen days a month). She said, "I don't have enough patients. If we figure that out and get people in here, then I can work every day."

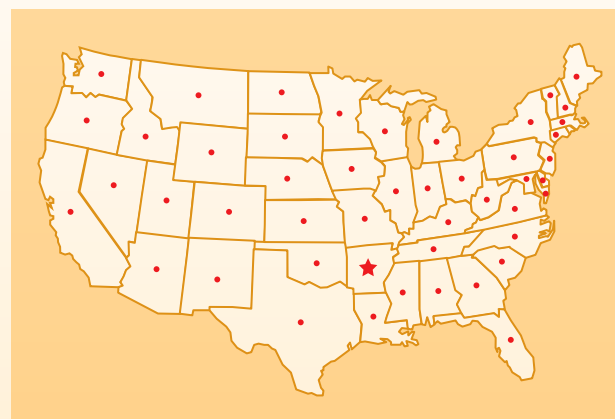
As every dentist knows, you can't just pay a hygienist, or anyone else for that matter, to show up without work to do—you must have patients. So the hygienist and I implemented a system that built up our hygiene clients until she was able to work every day.

That experience was an early taste of success. After that, I felt confident that we could succeed in the future, because I already had a small victory under my belt. Together, the hygienist and I had created something that didn't exist, and we caused it to happen as a result of our actions. We implemented a recall system that I still believe in today. (*For tips on setting up a recall system, see the article, "The Untapped Power of Your Recall System," Aesthetic Dentistry, Spring 2015.*)

NEXT STEPS

After working six years for this dentist, Dr. Kendall Roberts bought the practice. When Dr. Roberts bought us out, I considered moving on to another career. At that point, I didn't feel completely challenged. I'm a goal-oriented person and I wanted to create something. I didn't understand the potential of dentistry.

The building where we worked was not large enough to accommodate two doctors and two hygienists, so we moved into a different building at a new location. At the time, I asked



(Above) Beginning in Fort Smith, AR, Tawana Coleman's career eventually took her to all 48 contiguous states.



Dr. Roberts if I could be his office administrator and he agreed. There was no raise involved, however, I was moving forward.

In my new position, there were new challenges—issues I didn't know anything about—such as last-minute cancellations, broken appointments, and high accounts receivable. I've come to learn that these are typical concerns in dental practices today.

To help out, Dr. Roberts sent me to a consultant. In response to the problem of patients not paying for their accounts, the consultant suggested, "Just smile and look patients in the eyes and ask, 'Will that be cash, check, or credit card?'"

Unfortunately, that response didn't always produce the desired result. Patients said, "Oh, I don't ever carry a credit card." Or, "I don't have enough cash with me today." Or, "My checkbook is in the truck. I'll go get it." And then I saw brake lights pulling out of the parking lot! There had to be a better way.

Our practice was struggling, and I was struggling too. However, I'm not one to give up. It's never been my M.O. to quit when things are down. I thought, 'I don't know how, but we're going to succeed.' We tried so many things, it would just make your head swim, but unfortunately, we never stuck with anything.

In September of 1994, Dr. Roberts sent me to a front-office training seminar presented by Arrowhead Dental Laboratory and Dr. Dick Barnes. After that seminar, we immediately started to have success. The first thing I noticed (after doing it right for 60 days) was that patients were paying. Also, we didn't have broken appointments anymore in the doctor's schedule. It was the most amazing thing!

MAKE IT HAPPEN

When implementing a new structure into your practice, it helps to have a leader who believes in where he or she is

going. In my circumstances, I felt like I couldn't ask anybody to do anything that I was not willing to do first. It wasn't that I was perfect; other people came along who could ultimately do a better job than I ever did in certain capacities. However, you can begin by saying, "Doctor, we're not getting the results that we want. Let's do this." Why not? Try out the Dr. Dick Barnes structure for 60 days, because good habits will be formed during that time.

Dentists are typically looking for the next best thing, whether it's clinical or in practice management. If they don't get success quickly, they'll move on. In Dr. Roberts's office, I knew that if we did not get measurable successes early on, we would give up and not continue with this structure.

Our practice was struggling and I was struggling too. However, I'm not one to give up. I thought, 'I don't know how, but we're going to succeed.'

A key indicator that something needs to change (and the way to get a doctor on board with changing their current structure) is to take action when a dental practice is struggling. When it's struggling, the team members know that something needs to be done.

At that time, it usually isn't difficult to encourage doctors to make a change. They'll be on board because they've been waiting for *someone* in their practice to take a new direction. At that point, the doctors realize that perhaps they can "just be the dentist," as Dr. Dick Barnes suggests (which simply means ►

that the team members are responsible for their own jobs and the dentist can focus on providing life-changing dentistry for the patients).

After we implemented this new structure, I continued to work for Dr. Roberts for nine more years. Positive changes happened and it was very rewarding. After that time, I became

When attempting to accomplish something that you've never done before, you won't have confidence in it until you succeed at it. Success comes first.

an employee of Arrowhead Dental Lab full-time as a practice development consultant. I left the dental practice not when things were down, but when things were up! When I discovered how dentistry could indeed change the lives of patients, it was exciting to think about doing it on a wider platform.

CONFIDENCE VS. SUCCESS

Today, in the dental practices that I train, I ask, "Which comes first, confidence or success?" When I ask that question, people are quick to say, "Oh, it's confidence!" But actually, it is not—success comes first. When attempting to accomplish something that you've never done before, you won't have confidence in it until you prove it. Success comes first.

To start implementing change, there's no time like today! American industrialist Andrew Carnegie (1835–1919) said, "You cannot push anyone up the ladder unless he is willing to climb a little." Along those same lines, in his book *The Power of Leadership*, leadership expert John C. Maxwell (1947–) wrote, "No one can succeed for you. Success isn't a gift to be given away."

Success is something that each individual must do. When I consult with dental offices, I look for someone who will rise to the occasion and say, "Let me do that. I know I can do that part."

You can't make people do what they don't want to do. You can give them tasks, and often they'll get the tasks done. However, to make a huge change—a fundamental paradigm shift—someone typically rises to the forefront and says, "Let me do that. I will make a difference, and I'll be good at that one particular thing."

At first, it may start with simple memorization. For example, when answering the phones (whether scheduling, confirming, or answering shopper calls), it's good to memorize key phrases. (See my article, "Using the Words That Work," *Aesthetic Dentistry*, Spring 2016.) Set a goal to get a certain amount of new patients through the door. You can't just let those patients call your office and then hang up. That's not serving the patient or building a good relationship.

It gives me great joy when offices call me to report their successes after a training. I want every office to be successful immediately—and I've seen it happen!

I recently received an email from an office just one week after I visited them. The email said, "Tawana, it's been a great first week. We are all seeing success with the newfound verbiage, we have met with and started building relationships with several new patients, plus we are setting up diagnosis financial arrangement appointments to close on recommended treatment. Attached are the number of crowns and missing teeth that have come through hygiene appointments this week that you asked for. We are still going strong." That's success!

Did they believe me that all this would work? They wanted to believe it. They didn't have the confidence early on. It's very important to recognize when someone steps up and says, "Please let me be the person to make this happen." Dr. Roberts gave me that same opportunity and it opened up additional opportunities for me throughout my career.

FOCUS ON URGENT TASKS

It's true that everything that you do in a dental practice is important. However, some things are more urgent than others. I was in an office a little while ago and an employee said, "I want to do what you suggest, but I've got to get all these other things done." Setting priorities can be challenging.

I felt her pain. After I attended the Dr. Dick Barnes training for the first time, I met with my doctor and asked for permission



(Above) Tawana Coleman teaches a Total Team Training seminar in Kansas City, MO, in 2016. In the seminar, Tawana teaches dental practice team members that opportunities for growth are everywhere.

to focus my energy on the urgent things, assuring him that I would get everything else done. I knew that if I couldn't focus on the urgent matters, we would never see change.

You have to analyze what's most important to your practice. Certain people are more task-oriented than problem-solvers; turn over more of the daily tasks to them. Then ask questions within your practice such as, "Who wants to get this job done?" Or, "Who is willing to cause something new to happen?"

I have witnessed this strategy succeed in offices—the team members separated the "urgent" tasks from the "important" ones and acted on those things first. Identifying and prioritizing the tasks in a dental office can make a real difference.

When describing job responsibilities, the words you use matter. Once, I met an office manager who used these words: "I can't get the girls motivated to answer the telephone. *All they've got to do is just answer the phone.*" I suggested that it's not just answering the telephone. I said, "It is the first impression for anybody who calls the office." Everybody wants to feel and know that what he or she does every day is important and can make a significant difference.

OVERCOME ROADBLOCKS

Keep in mind that roadblocks sometimes turn up along the path to success, and some practices set up their own roadblocks. One of the biggest is procrastination. Dental offices should start implementing new strategies *immediately*—because otherwise it will never happen. Whenever I do a Total Team Training, I always give the office suggestions of things to begin working on immediately, so they have a starting point.

After the training, I call to check in on the practice's progress. Sometimes I hear, "We're going to have a staff meeting, and we'll get this figured out later." In one office, I revisited the practice after a year and they had not implemented any changes. They still had the same scheduling problems they had been struggling with on the initial training. The hygienists were frustrated and the office was wasting a lot of time by overbooking the doctors. Just start making changes today!

Often a roadblock is just a failure to begin. As Lucius Annaeus Seneca (5 BCE–65 CE), a Roman statesman, observed, "If a man knows not what harbor he seeks, any wind is the right wind." You have to have a purpose. Life is not an accident. Somebody who creates their own opportunity makes things happen. When you encounter roadblocks, don't panic. If the pressure is on, just keep on keeping on!

Small glitches are sometimes perceived as roadblocks. I have clients tell me that the structure didn't work for them on a particular patient. I usually respond, "But that was one out of how many?" Instead of looking at the successes, they focus on the "one-percenter" who it perhaps didn't work for.

Instead, focus on the positive. Don't let one failure stifle you. At our dental practice, I was determined to succeed. I decided, "I won't let any of those situations discourage me." I told the doctor, "I called twenty people today. And I'm not looking at the three patients who I didn't get scheduled, I'm looking at the seventeen patients who did."

Don't listen to the naysayers—just dwell on the successes! When doctors see your successes, they can't help but say, "It

does work!" The morning huddle is a great time to share some of your successes with the office. It's important to let others know when changes are working.

LIFE-CHANGING DENTISTRY

My experience working in the dental industry has taught me that every person within the practice can have a significant part in changing the lives of patients through the world of dentistry. Years ago, Arrowhead asked me to speak to the technicians in the dental lab. I told them, "That case that you're working on right now—it's not just teeth. It's not just veneers. It's not just crowns. It's somebody's mother. It's somebody's wife. It's somebody's daughter. It's somebody's son. You are contributing to patients' lives in such a positive way. Their lives are never going to be the same again because of you."

As I mentioned earlier, life takes you in directions that you can't even imagine sometimes. Before I started working in the dental industry, I dreamt of being a teacher. Today, as I look back on my career, I'm grateful that Arrowhead offered me the

You are contributing to patients' lives in such a positive way. Their lives are never going to be the same again because of you.

opportunity to teach a structure and deliver a message that has impacted the lives of many people. Because of my work, I've also had the opportunity to travel to all 48 contiguous states in the United States, and I've been to Europe nine times!

I didn't set out to travel the world and impact the lives of thousands of people—I just wanted to do the best job that I could. I always kept my focus on others—helping facilitate the best possible care for patients and supporting dentists so they could treat comprehensively. As a result, the opportunities presented themselves along the way and the outcome has greatly exceeded my expectations. I always tell participants in the Total Team Training seminar, "To love what you do and feel that it matters—how could anything be more fun?"

Opportunities are everywhere. They exist for you, and for the people in your dental practice today. What part are you going to have in creating something positive and something new? The possibilities are limitless. Go and create your own opportunity today. ■



Tawana Coleman has been a practice development trainer with the Dr. Dick Barnes Group for more than 20 years. She has worked with thousands of dental practices. The structure that she teaches has empowered dental practices across the country to dramatically increase production. For any questions, email Tawana at rtcoleman@cox.net.

Which Price Is Right?

Managing PPO Memberships and Associated Agreements.

Today, dental insurance companies are working aggressively to expand their network footprints to include more dentists and more locations. According to the Life Insurance and Market Research Association (LIMRA), a worldwide association of insurance and financial services companies, dental insurance is the third most requested employee benefit, after health insurance and retirement.

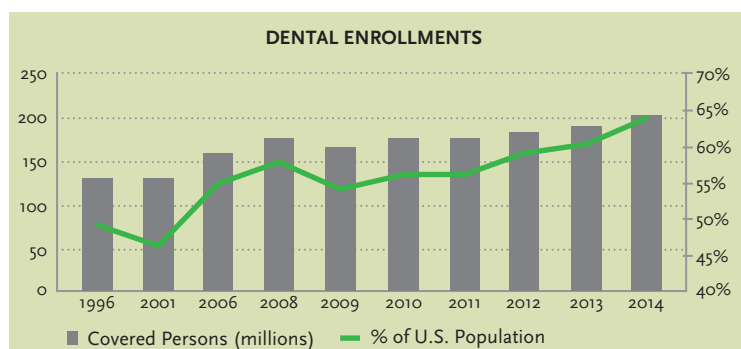
In addition, the American Dental Association (ADA) reports that in 2015, nearly 73 percent of all dental patients had a dental benefit. This statistic shows that more people have dental benefits than

Dentists no longer control pricing power to the extent previously exercised, and margins are under siege.

ever before. The chart, below right, shows the growth in dental insurance enrollments, as well as the percentage of the United States population with dental insurance coverage. Both enrollments and coverage are at an all-time high.

As the number of people with dental benefits has increased, insurance participation has grown in popularity among dentists. Most dentists now participate as a preferred provider in at least one dental network. In fact, more dentists participate in more plans than ever before.

According to the Delta Dental Plans Association, "Nationally, about 80 percent of dentists participate in one or more Delta Dental Programs."



Recent data from NetMinder, a tool that analyzes data and is powered by the healthcare consulting group, The Ignition Group, suggests that participation is increasing widely. The chart to the right shows the increase in the number of locations, providers, and access points among the top dental networks. The data in the graph suggests that more dentists are in networks, more dentists are part of more plans, and more dentists are contracted at more locations.

The growth of Preferred Provider Organizations (PPOs), such as Delta Dental®, and their heightened importance within most dental practices has resulted in one of the most dramatic changes in the history of the profession: *Dentists no longer control pricing power to the extent previously exercised, and margins are under siege, based on insurance reimbursement schedules.* As this trend advances, it is important to realize that insurance companies continue to evolve their cost-containment tactics.

Dental plans are structurally designed to subsidize the cost of care within the confines of the total amount of premiums collected. Because of this, most aspects of a dental plan are designed to contain costs. Common cost-containment tactics include downcoding to an alternate benefit, waiting periods, and frequency limitations on visits. While PPO participation remains a viable way to attract and retain patients, dentists need to be increasingly aware of the ever-changing strategies that PPOs use to contain costs.

NETWORK-SHARING AGREEMENTS

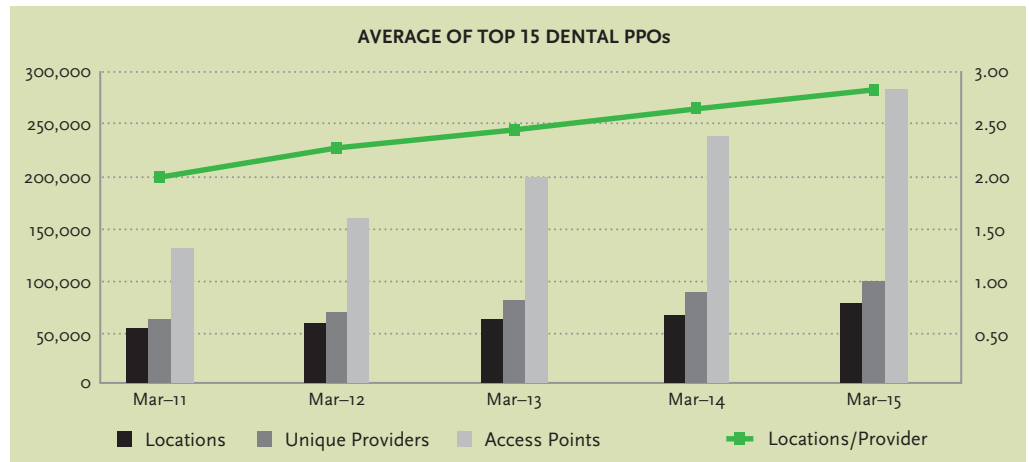
One of the more creative ways that insurance companies have evolved their methods for managing costs is the introduction of network-sharing agreements. A network-sharing agreement is an agreement that allows a dental network access to dental providers from another network, thereby increasing the number of “in-network” providers who are available.

Over the past few years, insurance companies, dental networks, and third-party administrators (TPAs) have partnered together to multiply the size of their dental networks. The most common example is GEHA (Government Employees Health Association) Connection Dental® Network. By joining Connection Dental®, dental providers can participate as in-network providers for over 60 insurance associations, TPAs, etc.

As insurance company network-sharing agreements proliferate, it is becoming increasingly difficult for office staff to communicate to patients whether or not they are in-network. Furthermore, it is difficult to estimate patient payments when offices don’t have a strong understanding of which fee schedule they will be paid from.

THE BEST INTEREST OF THE MEMBER

To complicate matters further, several carriers have started to change the way they administer dental plans. These carriers base their payments on the *lowest* of the partner fee schedules.



Despite a signed contract based on a specific fee schedule, several insurance companies pay according to partnership agreements if the fee is lower.

You may wonder how insurance companies can legally justify this action. However, most insurance carriers have language in their contracts with each provider that allows them to make changes that are in the best interest of the member (a member is simply a person with insurance). Reimbursing the provider at a lower fee benefits the member.

In the hypothetical example below, a dentist is contracted with the insurance company Ameritas®, as well as participating in Connection Dental®. Historically, a direct contract resulted in a claim being paid according to the directly contracted rate from Ameritas® (see *scenario A*). This fee was confirmed via claims in February of 2015. In 2016, however, Ameritas® paid out claims according to the lower Connection Dental® fee schedule (see *scenario B*). The result is that the doctor’s net collection is \$100 less than what was contracted directly with Ameritas®. ➤

SCENARIO A—Direct with Ameritas®	
	D2750
Office Fee	\$1,000
Ameritas® Fee	\$800
Patient Pays	\$400

SCENARIO B—Direct with Ameritas® and Connection Dental® (Network-Sharing Agreement)	
	D2750
Office Fee	\$1,000
Ameritas® Fee	\$700
Insurance Pays	\$350
Patient Pays	\$350

Difference Between Scenario A and Scenario B	
Patient Overpayment Difference	\$50
Doctor Collection Difference	(\$100)

IS THIS A BIG PROBLEM?

There are several problems with this strategy. First, the dentist makes less money than anticipated due to differences between the insurance company fees. Second, the dental office is likely not collecting the appropriate patient portion in light of the reimbursement differences. In the example provided, the patient saves \$50 in out-of-pocket costs between example A and B. In many other circumstances, the difference is often much less noticeable. Therefore, the office may be writing off small balances created by this change or have more credits to issue than normal. The reimbursement difference for a D0120 (periodic evaluation) in our claims study was \$1. However, if you multiply these small write-offs across the entire practice, you are potentially dealing with a significant amount.

Network-sharing agreements (also called leasing agreements) have advantages and disadvantages for dentists. Here are a few:

ADVANTAGES

Access to potential patients

Deciding to participate in-network with a company and its leased partners expands access to a larger membership base. More people with a PPO will find you in-network as a result of shared network agreements. This creates the potential for practices to better attract and retain patients.

Compensation differences

Compensation for services might be higher in a particular leased network than would be available by contracting directly. Evaluating this difference is critical to making informed choices about network participation. Five Lakes Professional Services, the company I started and lead, uses this strategy situationally to

Deciding to participate in-network with a company and its leased partners expands access to a larger membership base.

increase reimbursements for clients. We call it contract optimization—when a company has multiple partnerships that generally offer a higher fee schedule than what you can get by contracting directly. Through network-sharing agreements, offices are not considered in-network for 100 percent of a practice's membership, but the resulting improvement in reimbursement rates may present an attractive alternative. In my experience, very few dental offices employ this tactic, and in so doing, leave potentially large sums of revenue unrealized.

Simplified practice administration

Contracting across multiple plans with a single point of contact and a single fee schedule simplifies insurance management in the dental practice.

DISADVANTAGES

Compensation differences

Just as network-sharing agreements may present an opportunity to participate in higher reimbursing fee schedules, providers



can also lose money when they become contracted through network-sharing agreements unexpectedly. This happens for two main reasons. First, the existence of and extent of network partnerships is still largely unpublished (more on lack of transparency in the next section).

Second, several insurance companies have started using the lower of their partners' fee schedules to reimburse participating providers. Therefore, the existence of more network partnerships may one day result in carriers finding the lowest common fee schedule and moving to payment from that schedule.

Lack of transparency

As previously mentioned, many insurance companies simply don't know (or don't disclose) all the details of their leased arrangements. For example, when you contract in Guardian® dental insurance via a network-sharing agreement with DenteMax (a PPO network), DenteMax representatives do not know or may not disclose the specific Guardian® plans or groups that are provided access through the DenteMax network.

Connection Dental® provides the following disclaimer on their payor list, "Not all dental offices participating with the Connection Dental® network will be considered in-network for all groups listed. Please contact them to verify participation."

Maverest Dental Network, formerly under the direction of Dr. Cheryl Lerner, has made a tremendous effort to create transparency around their partners. However, most carriers still provide only limited information.

Ultimately, this means that providers may join a network without necessarily knowing it, thereby bringing patients in-network unintentionally.

Lastly, leasing often creates overlap. Leasing a network is when "Network A," for example, has a network-sharing agreement to access "Network B's" unique providers. This occurs when a network like Guardian® group dental insurance establishes multiple lease partners. When there is network overlap, a proprietary set of rules determines in many cases how the partners will identify your relationship.

Billing and patient communication confusion

As mentioned, many insurance companies have extensive reach within their leased partners, creating confusion about contracting status and fee schedules. Determining when to bill in-network, what to tell patients, and how much to collect for the patient portion becomes more difficult in many leasing arrangements.

As a dentist, evaluating the pros and cons of network-sharing agreements is an important step in developing and managing your insurance participation strategy. *(continued on page 43)*



Hope Gordon, Elite Full Arch Reconstruction by Dr. Jim Downs, 2013.

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Taking a Closer Look

The Benefits of a SWOT Analysis.

When was the last time you analyzed your practice from a business perspective? If you haven't done it lately, now is a good time. A simple and fast way to analyze your practice is with a SWOT analysis. This analysis is a tried-and-true way to assess your business and its potential. Simply stated, a SWOT analysis is done by analyzing the **strengths (S)**, **weaknesses (W)**, **opportunities (O)**, and **threats (T)** of your business. If looking at your practice from this perspective makes you nervous, don't sweat the SWOT. We'll help you get started.

SWOT HISTORY

Although scholars debate the history of the SWOT, many researchers credit Albert S. Humphrey (1927–2005), an American management consultant at the Stanford Research Institute, with creating the technique in the 1960s and 1970s. At the time, Humphrey reportedly used data from several different companies and evaluated them in terms of four categories—Satisfactory, Opportunity, Fault, and Threat. Eventually, the term

BEST PRACTICES

Every successful practice should take time to evaluate its business—so that they are not just reacting to challenges but thinking proactively about what opportunities are available. A SWOT analysis is a good, simple way to start identifying areas of growth for your practice.

To get the most out of a SWOT analysis, it's best to have a specific goal in mind. The challenge with a general SWOT analysis (without a clear goal in mind) is that the team will often focus on challenges or perceived weaknesses, and it may turn into a therapy session instead of a business analysis.

If you have a specific goal in mind, every strength, weakness, opportunity, and threat is related to the goal you want to achieve. Once that goal is identified and articulated, the team can see the vision of something bigger—they will see how a specific SWOT characteristic fits within the context of the broader goals for the company.

Team members who are not connected to the goals of the practice tend to perform the minimum amount of work required for their jobs. But once team members know how their role contributes to the goals of the practice, they often perform “discretionary effort”—meaning they are motivated to perform beyond what is required of them on a daily basis. Defining the goals for the practice can transform your business.

Examples of specific goals for a SWOT analysis may include the following:

1. How can we optimize our efforts to get new patients to our practice?
2. Are we retaining new patients?
3. Do we have a strong recall system?
4. Do we have a low cancellation rate?
5. Are we closing on large treatments?
6. Are we following through with pending treatments?
7. Do we have collections that are below 98 percent?

Every successful practice should periodically take a bit of time and evaluate their business—thinking proactively about what opportunities are available.

“Satisfactory” evolved into “Strengths,” “Fault” evolved into “Weaknesses,” and the first SWOT analysis was born.

According to ProvenModels, a web-based library of management models, “The SWOT framework was first described in detail in the late 1960s by Edmund P. Learned, C. Roland Christiansen, Kenneth Andrews, and William D. Guth in *Business Policy: Text and Cases*.”

Focus on one opportunity, one strength, or one weakness at a time; otherwise all the information can be overwhelming to the team. Also, it's important to include members of your team in the process, because when team members are involved, they add unexpected insights and honest feedback.

In Nicole Fallon Taylor's article, "SWOT Analysis: What It Is and When to Use It," (*Business News Daily*), Andrew Schrage (founder and CEO of *Money Crashers*, an online finance community) recommends doing a formal SWOT analysis. Schrage said, "Some small business owners make the mistake of thinking about these sorts of things informally, but by taking the time to put together a formalized SWOT analysis, you can come up with ways to better capitalize on your company's strengths and improve or eliminate weaknesses."

ON THE ROAD

For more than a decade, I have traveled with Dr. Dick Barnes, visiting practices and building relationships with doctors and their teams. At Arrowhead Dental Lab, our goal from the very beginning has been to help dentists become better and more productive. Dr. Barnes has a genuine interest in knowing how each practice is performing, and part of his philosophy is sharing what contributed to his success with his colleagues.

When we visited each practice, Dr. Barnes inevitably asked each dentist, "How is your practice doing?" It's amazing how that simple question led to great conversations and sharing of experiences of successes and failures.

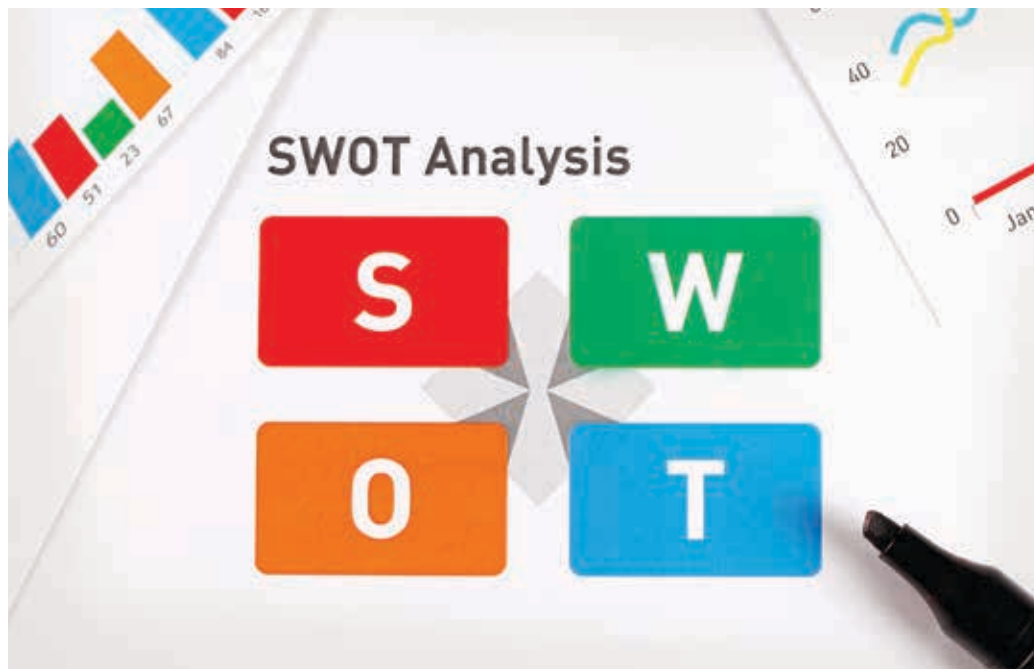
These discussions generated ideas on how to increase new patient flow, increase patient retention, and improve case acceptance—all topics necessary for a dental practice to be a healthy, thriving business.

Dr. Barnes mentioned in his article, "Visions for Leadership" (see page 3) that in the situation of a practice not doing well, or performing below expectations, he always asked, "Why are you doing things the way you're doing them?" If a doctor didn't know how to answer that question, or if the answer was, "We do it that way because we've always done it that way," then the response was remarkably simple: "No great discoveries come about unless we break from traditional thinking." It is time to take another look at your business.

A SWOT analysis is a tool to start thinking strategically, and to break from traditional thinking. And you will discover all the possibilities that are waiting for you.

SWOT RULES

Every SWOT analysis should follow some basic rules. Keep reading for five rules to consider:



1. Have a Specific Goal in Mind.

As mentioned, be as specific as possible with the goals for the SWOT analysis. Make sure your team members all understand the goals and how the questions that you ask the team (see *SWOT analysis worksheet, page 35*) contribute to achieving that goal. It is important that all participants know not only what they are doing, but why they are doing it.

2. Involve Your Team Members.

Getting input from the entire team is critical and will inevitably drive discretionary effort. Everyone feels involved. You will sometimes find that what one person sees as a strength, someone else may view as a weakness. For example, one person may look at the practice's website and think it's great. However, others may look at it and say, "We have too much information on the website. Can we streamline the information to make it easier to understand?" Team members may offer insights on things that the dentist isn't aware of or didn't realize were strengths or weaknesses. It's a good opportunity to listen and learn.

3. Start by Discussing Strengths.

Start a SWOT analysis by talking about strengths. When you identify strengths with your team, they'll give a lot of good feedback—such as having a great location, the kind of services you offer, the kind of technology you offer, a great team/patient relationship, the quality of people who work for you, and the products and services you provide.

Many practices are good at acknowledging strengths, but it can be difficult to identify (and therefore acknowledge) "weaknesses." Don't let that hold you back, though. Because through "weaknesses," you often discover strengths.

Try to keep your team focused on strengths, but if they start discussing perceived problems, don't take those criticisms personally. You have to identify a problem before you can offer a solution. ➤

Keep in mind that the categories in this analysis can be somewhat fluid because many things depend on circumstances and context. For example, having a surplus of new patients can be a perceived strength and also a perceived weakness. It may also become an external threat if you don't take care of your patients appropriately and they become detractors.

Usually, teams offer a lot of input. It's amazing how involved teams will get in this exercise. They will surprise you with how much they know.

4. Plan On More Than One Meeting.

To properly analyze the business, plan on about three lunch meetings (usually about one hour each) with your team. During the first meeting, explain the process and articulate the goals or specific focus of the SWOT analysis. In the second meeting, identify characteristics and ask questions (see *SWOT worksheet*

No great discoveries come about unless we break from traditional thinking.

on page 35 for suggested questions). The final (third) meeting is a strategic planning meeting to address the direction and goals for the practice.

In any business, team members can get caught up in everyday tasks, so it's difficult to think in terms of what's going on around you—what your competition is doing or what the guy down the street is doing. The SWOT analysis is a good opportunity for dentists to look at the bigger picture as well as to take a step back and analyze their practice internally.

5. Write It Down.

It's important not only to talk about these issues, but to write them down! Once you have these ideas on paper (or on a computer or whiteboard, etc.), you can refer to them and be reminded of what needs to be done. Also, assign activities in order to achieve your goals.

The purpose of the SWOT analysis is to develop a dialogue with your team members so they can be aware of what is going on with your practice as well as your competitors. This particular analysis is not a difficult project—it's especially easy when you follow a template (see *sample worksheet on page 35*).

With a SWOT analysis, you will look at internal elements (strengths and weaknesses) and external elements (opportunities and threats).



STRENGTHS

Strengths are positive internal resources and capabilities. Think about the following questions in terms of your practice:

- What do you do better than your competition?
- What unique services or skills do you possess?
- What sets your practice apart from others nearby?

- What are characteristics that make your business unique?
- Why do patients refer others to your practice?

The strengths of each practice will be different. For example, a practice may have a large patient base or the reputation of being gentle. Or perhaps a practice is staffed by experienced dentists. Another strength may be that the practice is located in a particularly good locale. Strong leadership is a great strength, as are flexible staff members who are open to improvements in technology and training. Strengths can also include practical elements—like the soothing or ergonomic design of your office.



WEAKNESSES

Weaknesses are any internal problems that keep you from achieving your goals. Strengths, such as having many new patients, can become weaknesses if they are not handled well. It's sometimes difficult to talk about weaknesses, but remember that every practice has room for improvement somewhere.

Defining your weaknesses helps you find areas to improve your practice. Consider the following questions:

- What does your competition do better than you?
- What areas could you improve in?
- Why do you lose patients?
- Have you noticed any problems during the daily schedule that keep recurring?
- Do your website and social media presence represent your practice well?
- Is cash flow a problem?
- Are your collections below 98 percent?

A few years ago I talked with a dentist who wanted to learn some new skills, but said that he couldn't take any extra continuing education classes because he had so many new patients. I responded that it was great to have a surplus of new patients, but I asked if he was presenting comprehensive treatments.

This dentist saw five to seven new patients every day but was stuck doing "drill-and-fill" dentistry. Under such circumstances, the dentist is so busy, he or she likely doesn't get to spend quality time with any patients.

With so many new patients, it limits the opportunities to discuss the comprehensive treatment that will help the patient avoid future problems. The dentist likely doesn't have time to develop a relationship with the patient so the patient can understand why larger comprehensive treatment may be necessary.



OPPORTUNITIES

Opportunities are external possibilities for the future. Use your strengths to identify opportunities. Consider the following:

- What trends and conditions could benefit your practice?
- How can you maximize the practice's strengths? ➤

SWOT Analysis Worksheet

A SWOT Analysis is a useful tool that can help you learn more about your practice and your competition, and will lead to greater insights into the marketplace. Remember that strengths and weaknesses are internal factors, and opportunities and threats are external factors. Tear out this perforated worksheet and use it to promote dialogue with your team members. Get started on a SWOT analysis today!

S

STRENGTHS

Some examples:

- The practice is in a great location.
- We have name recognition.
- We have highly trained team members.
- We have a good rapport with our patients.
- We offer advanced technology and comprehensive treatment.

Ask your team the following:

- What do we do better than our competition?
- What unique services or skills do we possess?
- What sets our practice apart from others in the area?
- Why do patients refer others to our practice?
- What are skills or characteristics that make our practice unique?

W

WEAKNESSES

Some examples:

- We have limited services (we don't place implants, etc.).
- We have a deficit of new patients/we have too many new patients.
- We have low new patient retention.
- No PPOs.
- Traditional hours (no early or late appointments, etc.).
- Poorly designed website.

Ask your team the following:

- What does our competition do better than us?
- In regards to competition, what areas can we improve in?
- Why do we lose patients?
- Have we noticed any problems during the daily schedule that keep recurring?
- Do our website and social media presence represent our practice well?
- Is cash flow a problem?
- Are our collections below 98 percent?

O

OPPORTUNITIES

Some examples:

- Lack of direct competition (we live in a small town).
- New services are available (we have expanded offerings).
- A new housing development is nearby (potential for new patients).
- Potential to add a new insurance plan to our offerings.
- Future community involvement.

Ask your team the following:

- What trends and conditions could benefit our practice?
- How can we maximize the practice's strengths and promote success?
- What does our practice offer that our competitors don't offer?
- What technologies are available in the dental industry that would help us?

T

THREATS

Some examples:

- Increased competition/cheap corporate dentistry nearby.
- General economic slowdown.
- Increase in insurance plan limitations.
- National healthcare policy.
- Increased overhead costs.
- Rapid changes in dental technology.

Ask your team the following:

- How do our weaknesses affect our practice?
- What external factors could hurt our business?
- What obstacles do we need to overcome?
- Is our office in need of updated technology?



“My practice is
more successful
than I could
have imagined!”

Dr. Valerie Holleman, Broken Arrow, OK

Arrowhead Dental Lab and the Dr. Dick Barnes Group offer a CE plan specifically designed to make new dentists more successful. Dr. Valerie Holleman was in practice for about eight years before starting the New Dentist Program with Arrowhead. Dr. Holleman said, “My advice? Do it now! It’s the best decision I ever made and the courses are life changing.”

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- What does your practice offer that your competitors don't offer?
- What technologies are available in the dental industry that would help you?

The greatest opportunity that a lot of people complain about is insurance. Dr. Barnes said that he “likes insurance and dislikes insurance.” He likes it because it is a great opportunity for patient acquisition. However, he dislikes it because insurance dictates the amount the dentist can charge for treatment. The opportunity is great, though, because as you build a relationship of trust with new patients, they will be loyal and accepting of treatment that may be above and beyond what their insurance covers.

Opportunities can come from anywhere. An overall growing economy can create opportunities for your practice. Your community (if it's growing or offers incentives of some sort) can also offer opportunities.

Keep in mind that sometimes opportunities can look like threats. It may seem like a threat to your business to have corporate dentistry coming in nearby and offering cheap products or cheap exams. But consider it a great opportunity! Corporate dental practices usually do standard dentistry—they offer the usual treatments and nothing more complicated than that. You can convert those patients to your practice—I see it happen all the time.



THREATS

Lastly, threats are external factors that can hinder an organization. Consider these questions:

- How do your weaknesses affect your practice?
- What external factors could hurt your business?
- What obstacles do you need to overcome?
- Is your office in need of updated technology?

As mentioned previously, threats can include corporate dentistry expanding to your neighborhood or the economy declining. Often, however, threats can be opportunities in disguise. Even a bad economy can be seen as an opportunity.

Dental practices should conduct a SWOT analysis once or twice a year, to help with setting yearly goals.

In 2008, when the economy was down and some areas of the country reported as much as 10 percent unemployment, Dr. Jim Downs of Denver, CO, said that the downturn was an opportunity to be positive—it was a temporary situation, and even with 10 percent unemployment, 90 percent of people were still working! Therefore, 90 percent of your patients likely still had jobs.

Other threats may be a lack of qualified people to hire, poor name recognition, and additional competition in your area. Sometimes new technology can be a financial threat—it may seem like you have to invest in technology because everybody wants a one-day crown, for example. But sometimes the threat is an opportunity to evaluate other options.

DON'T FORGET ABOUT IT!

Remember that a SWOT analysis has a limited shelf life, which is what I like about this particular analysis—you can't do it once and forget about it. Dental practices should conduct a SWOT analysis once or twice a year, to help with setting yearly goals. For example, at the end of 2016, assess how much

It should be very clear which items you need to work on and which ones to implement to take your practice to the next level.

production you're going to have as a goal for 2017. At the end of 2017, do another analysis and see how things have transformed! Work as a team to set priorities and decide which items to take action on.

As a result of a SWOT analysis, you will be able to find your niche and the best areas of your practice to focus on and highlight. You will also discover that your team wants to be involved in the success of the practice. This simple exercise will encourage discretionary effort among all your team members.

Additionally, you will have a heightened awareness of what you have as a business, and how you can take that business to the next level. You will also discover what additional services you can offer for your community. If you haven't done a SWOT analysis for your practice yet, tear out the worksheet on page 35 and get started today! ■



Hernan Varas is in Clinical and Practice Development with Arrowhead Dental Laboratory in Sandy, UT. Hernan has been with the lab for more than 15 years and has worked in the dental industry for more than 30 years. 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 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.

Active Leadership

Tips for Effective Leadership in Your Practice.

Recently, I conducted a seminar on leadership for six dental practices. During an exercise, we created a flowchart, diagramming the process of the new patient experience—how they are greeted, how are they brought back, what the examination includes (the diagnostic appointment), how treatment is presented, and finally, how and when the financial arrangement is made.

For this exercise, I assigned each participant into a small group. I mixed up the groups because I didn't want people from the same office sitting together—they needed to get out of their comfort zones. The assignment was to create the flowchart in a certain amount of time. I explained that there was a dentist and a leader at each table, but I didn't say who was the leader. It was interesting to see how some of the doctors led and some didn't.

The German philosopher Friedrich Nietzsche (1844–1900) said, “Out of chaos comes order,” so I figured that with the exercise, anything could happen. I watched some hygienists step

envision or even wants for the practice. Active leadership is more than going along with the group—it is purposefully setting the direction for your practice. The difficulty with leadership is

4 Stages of Training

1. FORMING PHASE—BE DIRECT
2. STORMING PHASE—REINFORCE EXPECTATIONS
3. NORMING PHASE—BE SUPPORTIVE
4. PERFORMING PHASE—PROVIDE COUNSEL

The difficulty with leadership is that there is not necessarily a “cookie-cutter” way to lead.

up and lead, as well as some front office people. At those tables, the human resources (H.R.) people and the dentists sat back and just went along for the ride.

When a dentist doesn't take a leadership role, he or she is relegated to procedures that may not be what the dentist

that there is not necessarily a “cookie-cutter” way to lead. Each dentist should analyze his or her particular weaknesses and strengths to determine what kind of leadership is required in certain situations.

Coming out of dental school, many dentists don't know how to lead. Leadership or management of any kind isn't something taught in school. The most common default for dentists is to

manage their team with a dictatorial “my-way-or-the-highway” approach. For most practices with a dictator at the head of the organization, turnover is a huge problem.

As I’ve mentioned previously (see *my article, “Goodbye, Gremlins!” Aesthetic Dentistry, Winter 2015*), I’ve learned valuable insights from author Ken Blanchard (*The One Minute Manager*, 1982). Blanchard, along with professor, scientist, and author Dr. Paul Hersey, developed the original theory of Situational Leadership®.

SITUATIONAL LEADERSHIP®

According to The Center for Leadership Studies (The Global Home of Situational Leadership®), “Situational leadership® . . . stresses flexibility and simplicity in execution.” In other words, the leadership style required depends entirely on the demands of each unique situation. The most successful leaders adapt to the needs of the task at hand.

My personal leadership style draws on the philosophy of Situational Leadership® as well as Bruce Tuckman’s philosophy as outlined in “Tuckman’s Stages of Development.” As noted in “Goodbye, Gremlins!” Tuckman identified four stages of group development: Forming (a new skill is learned), Storming (dentists begin implementing the new skill), Norming (the dentist becomes proficient at the new skill), and Performing (the dentist is an expert at the new skill).

When establishing him or herself in a leadership role (or trying to re-establish leadership that may have been lost or dormant), most dentists go through these four stages of development.

Today, you may be at different stages of development with different members of your team. And that’s precisely why this system works so well—it can adapt according to context and whatever phase you or your team may be at. It is a useful tool to develop active leadership skills as well.

TRAINING NEW TEAM MEMBERS

Here’s a practical example: When a hygienist who is new to your practice begins employment, the hygienist may not know how to use the specific equipment or software in your practice, or understand how your practice prefers to bring the patient back and check them out of the office.

During the first (forming) stage, the dentist’s leadership style has to be very direct. Most practices don’t have training systems to track who’s responsible for what tasks, and who’s going to

The leadership style required depends entirely on the demands of each unique situation. The most successful leaders adapt to the needs of the task at hand.

follow up. The dentist typically shoulders the responsibility of oversight, and often it “slips through the cracks” because he or she is busy restoring teeth and checking hygiene and doesn’t put significant administrative time aside to establish and follow up with training.

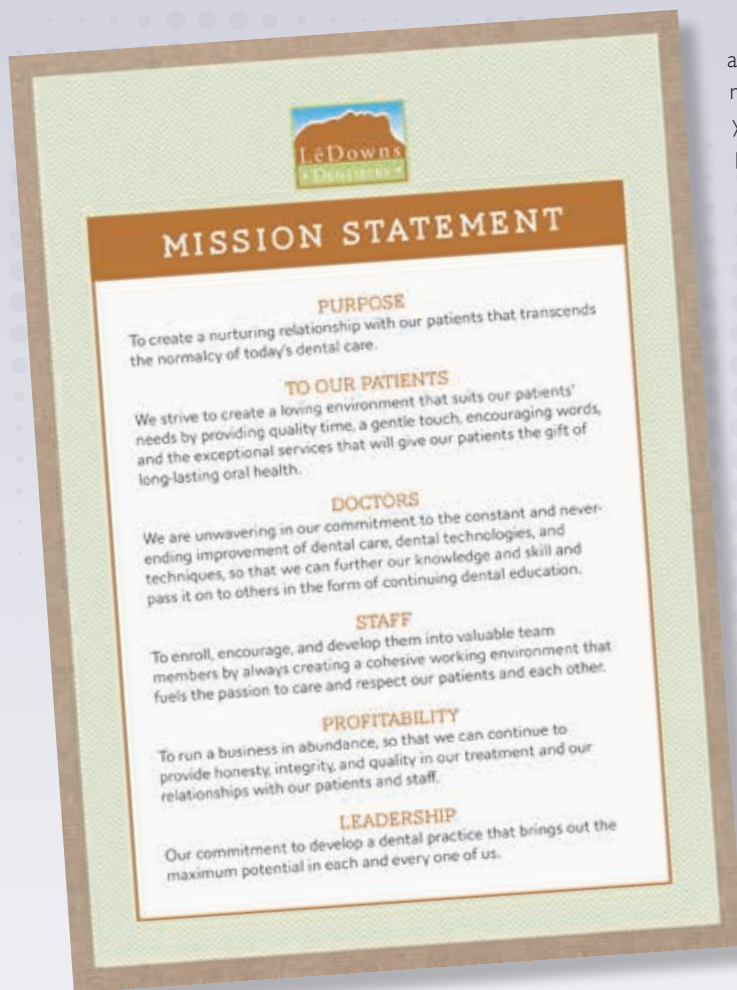
In my practice, we have training charts that detail the assigned duties, and how each employee should go about learning them. We have charts for everyone—from the chairside assistants to the front office team members. Clear and direct communication is important, and I’ve found that training charts provide helpful written confirmation of verbal expectations.

THE FIRST PHASE—BE DIRECT

During the forming stage of training, being direct helps prevent problems from developing in the future. With new team members, for example, the dentist should clearly communicate (either verbally or in writing) how he or she wants things done, >



(Above) The team at LêDowns Dentistry in Denver, CO. In the practice, more-experienced team members mentor new employees. Mentorship helps new employees learn the practice’s processes and reinforces those processes for the mentors.



(Above) At L&Downs Dentistry, we display a framed mission statement in the reception area that articulates the goals and philosophy of our practice.

how to do the tasks, why they do it that way, and whether or not veering from the protocol is permissible. Without clarification on why the dentist prefers the standard procedures, a direct leader can be mistaken for a dictator.

Don't confuse being direct with being mean—it's not the same thing. Everyone needs boundaries and parameters to work within. In the forming stage, there will be mistakes and a lot of questions. The dentist-leader should be patient while being direct. Direct leadership can stop problems before they occur.

THE SECOND PHASE—BE A COACH

The next phase is storming. As dentists move into storming (where the dentist acts as a coach), they should continue to reinforce expectations. The challenges in this stage are different from those in the forming stage. In keeping with the new hygienist example, as the new employee gains knowledge, he or she will discover what he or she doesn't know. The new hygienist will make mistakes (for example, breaking instruments), and the dentist's role is to coach the new team member.

During storming, the hygienist has a basic knowledge of the processes. Coaching reinforces this. A typical discussion may sound like this: "Let's review the structure. When you bring back

a patient, do their probings, get x-rays, see how the patient's medical health is, take a blood pressure reading, and then start your hygiene visit. Once you become comfortable with the process, your timing will get better. Let's start mastering this process today."

Along with coaching, continue to set and eventually increase expectations. For example, say, "Here's what I expect by next week: that you're on time with your schedule in cleaning your room and setup, and are getting in a rhythm." Show the hygienist efficiency steps or anything else that may be helpful. Once the hygienist is comfortable, he or she will establish a routine and you can move to the norming phase.

THE THIRD PHASE—BE SUPPORTIVE

In the norming phase, the main role of a leader is to be supportive. A routine has been established and the dentist provides support while continuing to teach the team members. This phase is different from the previous ones because it requires less involvement from the dentist.

Instead of actively coaching the hygienist, this phase requires involvement on an "as needed" basis. You might say, "I've noticed you're really staying on time and your cleanings are looking a lot better. You're doing great. Is there anything else I can do to support you?"

This leaves an opening for the employee to continue learning. They might respond, "Yes, you were talking about my hand positions and my ergonomics." Then you can set up a time to continue the education process. During this phase, the new hygienist has become a part of the team, and the next thing you know, they're moving to a performing stage.

THE FOURTH PHASE—BE AVAILABLE

During the final phase (performing), the dentist-leader is primarily there to provide counsel. In this phase, the team functions independently under the direction of the leader. Each person knows his or her role and performs it.

For example, the new hygienist now becomes the lead hygienist in the preventative department. He or she is proactive at looking at new instrumentation and new skill sets, and presents those ideas to the doctor.

Once the new employee has reached the performing phase, your work is done, right? Wrong! The reality is that no dentist gets to keep the same team for his or her entire career. You will inevitably bring on new people and begin the process again.

Your team members are at different levels of development at all times, so don't treat them all the same. Look at each employee individually and analyze how you can help them continue to move along the learning curve. The goal is to get all team members to a top-notch level where you can delegate to the team and they'll get the job done.

TAKING CHARGE

Training new employees is only part of a dentist's leadership responsibilities. A good leader learns to anticipate challenges and displays active leadership by putting systems in place to address the challenges that inevitably arise. It's important to build

relationships of trust throughout the training process so the team members will have confidence in the dentist when he or she needs to intervene in the inevitable conflicts.

One common issue in many practices is allowing gossip to consume the office. Gossip can be crippling to a practice. If you have a problem with gossip, deal with it directly and confront the individuals involved. Don't ignore the problem or it will continue to grow.

Without active leadership, when gossip happens, the dentist may not know how to handle it. Depending on his or her personality style, the dentist may completely avoid the issue, or alternatively, he or she might scream and yell at people. Neither tactic is particularly effective.

In my office, we have a 24-hour rule—we try to handle any and all problems within 24 hours. If not, the challenge can rear up again and it is usually an even bigger problem.

Another challenge in many practices is tardiness. If you have a team member who is habitually coming in late, the rest of the team will want you to confront the problem. Otherwise, they will perceive that you are a poor leader. Again, confront the issue directly by talking to the habitual offender and set clear expectations and consequences if the behavior doesn't change.

Being an active leader can simply mean offering support to your team members. Once, a new patient came into our practice and filled out all the necessary paperwork. A receptionist then asked to take the patient's photograph (we usually take pictures of all our patients so that we know who our patients are in the reception area). But this particular woman did not want her photo taken. Even after my staff assured her that it was not required, the woman stormed out of the office.

Afterward, the receptionists explained to me what happened. Instead of getting upset, I told the team members that they did everything correctly, just as they were taught. The support helped defuse a tense situation and gave the team members confidence in their roles. Team members look to the dentist to be authentic and supportive and support builds trust when something goes wrong.

IMPLEMENTING SYSTEMS

Setting up systems is a great way to set clear expectations and explanations for the processes and policies of your practice. As mentioned previously, in my practice systems are outlined in training charts. We also utilize a mentor system.

In addition to delineating procedures for tasks and timelines for accomplishing those tasks, the training charts specify a mentor (an existing team member) who helps the new team member accomplish their required duties. If the policies and procedures in our practice aren't explained and taught, the new person will be lost, or may fall back into habits of how things were done at their former offices. A bonus to the mentor system is that those who mentor get an even a deeper level of knowledge about what they're training. It's a win-win!

AUTHENTIC LEADERSHIP

An important part of active leadership is being authentic. I believe that leadership is something you do *with* people not *to* people. An authentic leader asks his or her team for input—and

listens to the responses. The leader should always help facilitate problem solving for the team.

A mission statement reminds everyone of the goals of the practice and keeps things progressing in the right direction (see *image, page 40*). In my practice, the mission statement is framed and displayed near the front desk, so when someone approaches, they notice it right away. I developed the mission statement with my team about ten years ago. We have reworked it a few times and now it is a part of what we do every day. The mission statement is a daily reminder of our priorities.

DEVELOPING GOOD RELATIONSHIPS

Good leadership cultivates good relationships—with patients as well as with team members. A good way to keep abreast of what is going on with your team members and your practice is to hold weekly meetings. My practice holds weekly "breakfast" meetings to build a strong relationship as a team. During the

Good leadership cultivates good relationships—with patients as well as team members.

meeting, we talk about everything—not just dentistry. I buy breakfast and it is a dedicated hour for us to be there as a team to talk and build relationships and fellowship. This meeting is in addition to our morning huddles.

If you think someone on your team is struggling, approach him or her and find out what is going on (if you've established a relationship of trust). I have conversations like this all the time: "Hey, this isn't like you. What's going on?"

CREATING BALANCE

Active leadership takes some time and effort. But once you have systems in place, it becomes much easier. One of the most important things you can do to create time for leadership development is to be organized. My schedule is already complete for the year 2016 and I know where I'm going to be every week and every weekend. I often say, "If it's not scheduled, it doesn't get done."

When you have organization, you can create time and space not only for your team, but for yourself and your personal life. Develop systems that establish or enhance your practice. Once such systems are in place, active leadership will become easier and you can enjoy the results of your work and enjoy your life. ■



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 mouth reconstruction cases. He maintains an aesthetic, family-oriented practice in Denver, CO.

adjustments. I was really amazed at how important the T-Scan® is in providing excellent patient care.

Dr. Blattner's case went well. Once again, she had some sensitivity due to local anesthesia constraints, and she had some mild bleeding due to pregnancy-induced gingivitis, but her case fit perfectly and her new smile is gorgeous!

My only regret is that I didn't take this clinical hands-on course ten years ago.

We removed Dr. Blattner's temp crowns fairly easily. However, her tissue was puffy and slightly inflamed due to her pregnancy, and controlling bleeding in the anterior region was a must. After trying in the crowns and veneers, we began the cementation process. At the try-in, all restorations fit perfectly. We used a rubber dam technique, and occlusal T-Scan® adjustments were minimal.

Dr. Blattner seemed very pleased with the final result. For over ten years I have prescribed Elite porcelain crowns, veneers, and cast restorations for my patients. The quality and artistic expertise that goes into each case is exceptional and always appreciated by patients. Of course, Dr. Blattner's restorations and beautiful new smile looked fantastic. The results made me proud to know that she had the best possible restorations using the latest materials and technology, all with the help of elite Arrowhead technicians.

REFLECTIONS

I have been in private practice for more than 40 years. After participating in the Clinical Hands-On course, I am more excited and invigorated than ever before about becoming a better dentist for my patients. My only regret is that I didn't take this course ten years ago.

Now, I plan on practicing dentistry for an additional ten years so that I can have ten more years of providing the best dentistry to my patients. I enjoy using my wireless Orascopic adjustable

After participating in the Clinical Hands-On course, I am more excited and invigorated about becoming a better dentist than ever before.

loupes, the DENTA™ 2 CO₂ laser, the T-Scan®, and two Blue-phase curing lights from Ivoclar, as well as utilizing the techniques that I learned to deliver a higher level of care to my patients.

Dentistry is one of the few professions in which we can visibly change and improve people's lives. Comprehensive full arch and full mouth reconstruction is not something that all of my patients necessarily need or want. However, it is something that I can now do more confidently and recommend for those patients who come to my office and choose me for their dental care.

I am now truly "invested." I am more confident and empowered, and I believe that the odds of me being a more successful dentist have increased dramatically as a result of this positive experience. Now I tell my patients, "Just look at my smile!" ■

Case Presentation Details — Dr. Blattner

- Natural smile design.
- Veneers on upper six (6) anteriors, tooth numbers 6 to 11.
- Crowns on premolars and first molars, and porcelain onlays on second molars. The prep guides were extremely helpful.
- Surprisingly, she had small amounts of decay under her old restorations that were not apparent on radiographs. After using conceptis, telio, etch, and bond, the decayed areas were "based" with flowable composite.
- Tissue contouring: 1 mm from tooth number 4 through tooth number 13, 2 mm on laterals. Corrected the zenith and added slight length to the Shimbashi. We determined that we could improve the aesthetics by lightening the shade of Dr. Blattner's dentition and by doing tissue contouring of her lateral incisors with the laser to improve symmetry and proper tissue height.
- Her incisal plane was fairly ideal.



Dr. Michael B. Beeler maintains a private practice in Clinton, TN, with an emphasis on restorative and rehabilitative dentistry. Originally from South Carolina, Dr. Beeler received a D.D.S. from The University of Tennessee Health Science Center: College of Dentistry in Memphis. Many notable dentists, including Dr. L.D. Pankey, Dr. Dick Barnes, and Dr. Payam Ataii have served as mentors to Dr. Beeler throughout his career. Dr. Beeler has received many professional honors, including Anderson County's Best Dental Office (2009–2015), the Knoxville News Sentinel award for East Tennessee Best Dentist (2012–2015), and many more. In his free time, Dr. Beeler enjoys photography and songwriting. Masterpiece Smiles, Dr. Beeler's practice, believes in "Improving people's lives, one smile at a time™."

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Which Price Is Right? (continued from page 30)

Successfully navigating insurance requires more and more frequent evaluation. Awareness of cost-containment behaviors like network-sharing agreements can better position your practice to provide quality care profitably. Knowing what data you need to access is critical in order to keep your patients happy and your fee schedules within the plans that pay at the highest levels of return.

FIVE TIPS TO STAY AHEAD

It's likely insurance companies will find the lowest fee schedule through which to reimburse a provider. Therefore, it is important for dental office management to take the following measures to avoid any surprises:

1. Verify benefits. Always check insurance benefits before treating a patient.

2. Understand your agreements. Ask questions and keep asking until there is a thorough understanding of what impact there might be on payments when changes occur to the provider's contracting status (as a result of a new partnership or other factors). As partnerships change, look at the positive or negative financial impact on your insurance portfolio.

3. Learn about potential effects. Be educated on the aspects of membership that have potential for contractual changes. Pay attention to external influences (such as legislation and market competition) that may result in carriers making changes to your plan's administration.

4. Take action! Equip yourself with knowledge and prepare to take action if something isn't adding up, or work with a professional PPO management firm to help oversee your PPO participation.

5. Develop, discover, and deploy. Several influential factors should be collected and monitored on a regular basis in order to maximize profitability in the various PPO plans that you participate in. Discover, develop, and deploy an insurance participation strategy appropriate to the goals of your dental practice. Properly managing such PPO plans can truly have a dramatic impact on the profitability of your P&L statement year after year. ■



Over the past seven years, Nicholas Partridge has established himself as a leader in analyzing the impact of dental insurance networks on the financial health of dental practices. As the president of Five Lakes Professional Services, Nick leads a team of nearly 40 team members who assist more than 1,000 dentists throughout the United States in developing an insurance participation strategy appropriate to the goals of their practice. More information on Five Lakes Professional Services can be found at www.FiveLakesPro.com.

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Michelle with IPS e.max

Dentistry by Dr. Jim Downs *American Academy of Cosmetic Dentistry survey December 2015
For more information, call us at 1-800-533-6825 in the U.S., 1-800-263-8182 in Canada.
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