Clinical calibration

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by Bill Rossi

In every practice, a gap exists between what dentists can do for their patients and what the patients choose to do. This gap can lead to frustration, compromised patient care, and cost tens of thousands of dollars or even hundreds of thousands of dollars per year in lost practice income.

As a management consultant, I work with doctors whose clinical opinions span the spectrum. I'm a businessman, not a clinician, so it"s not appropriate for me (or any consultant, in my opinion) to talk with doctors about what percentage of crown and bridge, perio, or any other treatment they should have. The statistics can beg the question, but the answers lie within each practice.

Countless articles have been written about case acceptance: how to set up and plan consults, sales techniques to use, and even scripted dialogue. It's been my experience that none of those things work as well as creating a strong ethical foundation. This is where clinical calibration comes in.

to find practices that have meetings about the following simple and very important question:

• What do we really feel is best for our patients?

To this end, I suggest you and your staff schedule a "Clinical policy summit." In your clinical policy summit, address every type of treatment you deliver from adult fluorides to X-rays. Use the "three-minute brainstorming" technique. First, pose a question such as:

"What conditions warrant recommending a patient be treated with a crown?"

Then, for the next three minutes, everyone should keep silent and list all the conditions that come to mind. The staff should be using their own value systems, not what they think you think. You want everyone's honest opinion.

When three minutes are up, have each person discuss one condition on his or her list. The doctor should go last. List all the conditions on a board for everyone to see. Then, sort through the responses and seek to clarify each one. Test your thinking.

If a staff person says, "A tooth with a fracture," ask, ***"Would it have to be symptomatic or just present?"*** Or, if someone says, "A large filling," you might ask, ***"How large? What if a filling is doing fine — does there have to be deterioration on the margins?"***

Develop concise written statements on every type of treatment — statements that are so clear and straightforward that a temporary hygienist could read them and know what you feel is best for your patients.

you treat and when you refer, who are good implant candidates, and when to do a composite vs. a crown — is more important than the written guidelines. Sometimes discussion will spur research on your part to see what the gurus and institutions you respect are currently recommending regarding new procedures or materials.

Once you've discussed and clarified your beliefs, then you have the ethical foundation to close the gap. ***You don't need to rely on scripts, because if you get to the truth, the words will come naturally.*** You'll get great case acceptance!

Moreover, any technology or techniques you use to increase case acceptance will work better. For example, your hygienists are more likely to use the intraoral camera. In fact, I find it's much more important to clarify when and why you recommend treatment than to buy new technology to show patients treatment options that you and your staff haven't thought through.

"Mission" over "Production"

Most dental staff and doctors have a sense of mission with patients. Most hygienists are much more in tune with patient care than their production per hour. It doesn't usually work well when you appeal to a staff's sense of money or "percentage of crown and bridge." It almost always works well when you appeal to their sense of professionalism!

In daily practice, it's easy for patients to bring your expectations down. Instead of trying to lead them to better case acceptance, they can lead you to complacency! Then you'll hear yourself and your staff say, "It's not us, it's the economy," or, "Patients just don't get it. They have no dental IQ or appreciation."

relate much better to the numbers (crown and bridge production, perio treatment, etc.) if they know it"s a reflection of their belief systems instead of arbitrary statistical quotas.

The following are some other simple clinical calibration and treatment tracking exercises. None of them cost anything or take much time, but they will add more to your bottom line than almost anything else that you can do.

Crown counting

This is a clinical calibration exercise in which the doctor and the hygienist look at every exam patient"s mouth and note how many crowns could be done (that aren"t being done) if that mouth was in their heads. Note your findings on the day sheet and have the hygienist do the same (the doctor should take the left side and the hygienist should take the right). After two weeks, tally your findings. The purpose of this experiment is twofold:

1. To see the amount of dentistry available to your patients if they only understood and valued it to the same degree you do.
2. To determine how closely you and your staff"s clinical policies match.

This exercise usually stirs up discussion. Just doing it usually increases case acceptance. You start noticing what you"re seeing and not saying.

"Make Rounds"

In hospitals, Surgical Residents learn at the side of the Staff Surgeon. They go to a patient"s bedside, interview the patient, review the medical record and the test results. They retreat to the hallway and the Staff Surgeon asks, "All right, doctors, what is your diagnosis, prognosis, and treatment plan?"

when there are multiple doctors. Clinics with more than one doctor tend to have unspoken and unclear multiple clinical guidelines. This can be terrifically confusing for the staff and the confusion causes them to default to no substantial discussion or co-diagnosis with patients. It's not unusual to see doctors who have attended the same class — who even sat at the same bench — arrive at widely different philosophies, such as when to crown a tooth, use composites vs. amalgams, what materials or techniques are best, etc.

So, if you have an associate or partner, share some exams. Perhaps do this when doing exams on members of your staff, their relatives, or your relatives (or any patients who are willing). Say to the patient: "Dr. Smith and I are both going to examine you as an exercise we do together in clinical calibration. It helps us work together as doctors."

After the exam (or exams), compare your findings and treatment plans. Work through it. Again, the process will solidify your convictions. Your convictions will lead to good communications. Patients can sense when you really mean what you"re saying.

Here is another simple exercise: pull 20 charts of adult patients who were seen through hygiene the previous week (so they are somewhat fresh in your mind). Divide your staff into two teams. Go through the charts and note how many potential FMXs, whitenings, crowns, and fluoride treatments might have been done if the patient knew what you know. Have the two teams compare their findings. Talk through your thought process and arrive at a conclusion.

Action plans

his or her charts and noting when FMXs are due, so that an assistant or another hygienist can help or a little adjustment can be made in the schedule.

You (the doctor) are then aware of the problem and arrive promptly for exams so the hygienist avoids getting backed up. Where there's a will, there's a way! The end result is that your practice performs more of these services the very next week!

No patient ever wants to feel pressured, manipulated, sold, or judged. Most dentists and their staffs also don't want to pressure, manipulate, or put people down. Invest just a little bit of time into these clinical calibration exercises and you'll save yourself lots of time and aggravation — plus wasted investments in expensive presentation technology.

As you're doing these exercises, you"ll find yourself asking questions such as:

- "When we diagnose someone, are we looking for the most immediate problem and rushing to the next patient, or are we imagining what would be the best possible state of dental health for that patient and telling him or her what needs to be done to get there?"
- "Do we make it absolutely clear that we will respect patient choices so they never feel judged, manipulated, or ‘sold?'"

The odds of an OSHA inspection are exceedingly rare; the odds of a HIPAA fine are almost nil. Yet, every day in almost every dental office, patients decline treatment. Invest your energy and staff meeting times in areas where you can get the best return for your patients and your practice.

software, consultation rooms, scripts, before-and-after picture displays, etc.

All of these things can be very worthwhile, but you need first to decide to what end such tools can be used. Good case acceptance should not be a matter of betraying your core values. Indeed, it should be a matter of putting your core values into action in your everyday work. Leading yourself and your staff toward clarity is the surest way to move patients toward treatment.

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How much can you and your patients gain by closing the gap?

- Patients with recommended treatment will sometimes respond to the front desk"s effort to schedule by saying things such as, "I'll have to check my schedule" or "I have to check with my spouse" or, "I'll call you when I get back from vacation." Ask your front desk persons to keep track of all treatment so declined or put off during a two-week period. Simply note the date, patient name, and treatment that was delayed, derailed, or declined. Also note the stated reason why. Then tally the findings.
- It's not at all uncommon to have findings of more than 20 missed crowns in a two-week period. Or, a half dozen perio treatments, even fillings. Do it yourself. It's free and it will give you instant feedback. This shows the challenge and potential for you and your staff.