

ODA JOURNAL

VOLUME 99/ISSUE 10

SEPTEMBER 2008

The official publication of the Oklahoma Dental Association



Grow your Practice: Helpful Practice Management Tips for the Dental Office

pg. 10

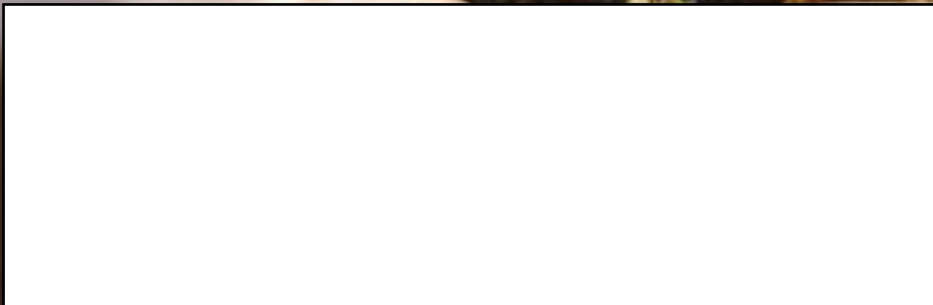
ODA Legislative Loop
Small Business
Legislation

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In Practice: How Going
Digital Will Affect the
Dental Office

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Removing the Shield
That Minimizes New
Patient Flow





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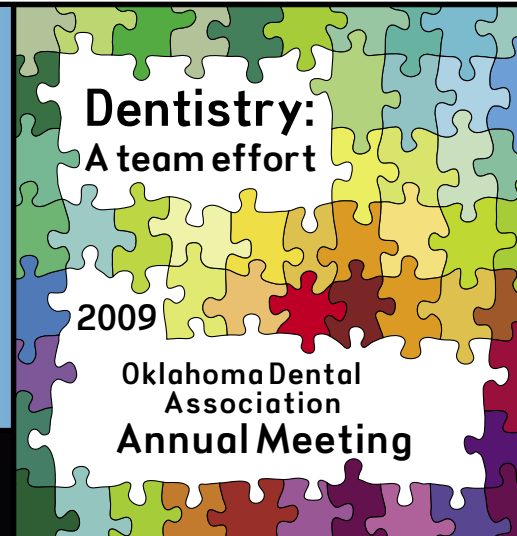
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From the Editor

Dr. Raymond A. Cohlmiya

Grow your Practice: Practice Management *Journal* Issue

Practice Management: A term that has certainly come into play in the last decade or two. Dental practices of a few decades ago allowed dentists to do specifically that: practice dentistry.

As they say, “the times, they are a changin’”. Recently, I attended a practice management course that compared the number of hours a dentist spends in clinical care with the number required to do “paperwork.” I was amazed! During the 1980’s, for every 35 hours of clinical practice a dentist spent less than one hour managing the practice. That equates to just under 3% of time used to control the production of the other 97%. Just twenty years later, management time had increased to 8%. Interestingly, the 2.5x increase in time allotted for business operations, resulted in an average of 24% increase in production. Yes, a dental practice is no longer just a practice; it is a hard-working business entity that requires much more than just creating wonderful smiles.

In the last issue’s editorial I made the statement, “You talk, we listen.” Many of your comments have requested that we provide additional articles and information on how to run our practices and discuss those issues that will affect the profession in upcoming years. This issue of your *Journal* addresses a theme that is often requested: Practice Management.

Your editorial staff and board have worked hard to bring you a diverse range of articles that inform

you on how to make better decisions in your practice operations, and that provide some vision for the future. Ultimately, we are all after the same thing; better care delivered to our patients using the most efficient methods with the fewest diversions.

In the last several weeks, I have had the opportunity to speak to many recent graduates who have been in practice less than two years. They all report the same thing. They love the clinical patient care, but get frustrated dealing with the business end of the practice. Federal mandates, escalating overheads, higher patient demands and stricter practice guidelines, just to name a few, continue to infiltrate our practices and will for years to come. As a result, efficient “practice management” is critical.

I hope you enjoy this practice management issue of the Oklahoma Dental Association *Journal*. I’d love to keep on writing, but I don’t have the time I need to get all my paperwork done at the office so I can see my patients next Monday.

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SEPTEMBER

- 1st**
> ODA Offices Closed
- 8th**
> ODF Mobile Dental Unit - Caring Hands/McAlester - 9:30 AM
- 9th**
> ODF Mobile Dental Unit - AK Verdigris Valley Community Center/ Porter - 9:30 AM
> OCDS Board Meeting - ODA - 6:00 PM
- 10th**
> Children's Oral Health Coalition Meeting - ODA - 10:00 AM
- 11th**
> OCDS Golf Tournament - 1:00 PM
- 12th**
> Leadership Summit Task Force - ODA - 9:00 AM
> Membership Task Force - ODA - 10:00 AM
- 15th**
> Retired Dentists Lunch - ODA - 11:30 AM
- 19th**
> ODA Council on Budget and Finance - ODA - 1:00 PM
- 20th**
> 12th District Pre-Caucus - Dallas
- 21st**
> 12th District Pre-Caucus - Dallas
- 26th**
> ODA Risk Management Seminar - OKC - 9:00 AM

OCTOBER

- 3rd**
> Adopt-a-Dentist Orientation & Lunch - ODA - 10:30 AM
- 8th**
> Children's Oral Health Coalition Meeting - ODA - 10:00 AM
- 9th**
> DentFest - OUCOD - 5:00 PM
- 10th**
> Adopt-a-Dentist Orientation & Lunch - ODA - 10:30 AM
- 13th**
> ODF Mobile Dental Unit - Caring Hands/McAlester - 9:30 AM
- 14th**
> ODF Mobile Dental Unit - AK Verdigris Valley Community Center/ Porter - 9:30 AM
> OCDS Board Meeting - ODA - 6:00 PM
- 15th - 21st**
> ADA Annual Meeting - San Francisco
- 20th**
> Retired Dentists Lunch - ODA - 11:30 AM
- 23rd**
> OCDS Spouse Night - 6:00 PM
- 24th**
> Annual Meeting Planning Committee - ODA - 1:00 PM

THE OKLAHOMA DENTAL ASSOCIATION JOURNAL (ISSN 0164-9442) is published ten times per year by the Oklahoma Dental Association, 317 NE 13th Street, Oklahoma City, OK 73104, (405)848-8873. Annual subscription rate of \$6 for ODA members is included in their annual membership dues. Rates for non-members are \$36. Single copy rate is \$6, payable in advance. Periodical postage paid at Oklahoma City, OK POSTMASTER: Send address changes to OKLAHOMA DENTAL ASSOCIATION JOURNAL, 317 NE 13th Street, Oklahoma City, OK 73104. Opinions and statements expressed in the OKLAHOMA DENTAL ASSOCIATION JOURNAL are those of the author and are not necessarily those of the Oklahoma Dental Association. Neither the Editors nor the Oklahoma Dental Association are in any way responsible for the articles or views published in the OKLAHOMA DENTAL ASSOCIATION JOURNAL.



**MEMBER PUBLICATION
AMERICAN ASSOCIATION
OF DENTAL EDITORS**



This month's spotlight on an ODA endorsed company

For more information on ODA's endorsed companies please call the ODA at 405-848-8873 or 800-876-8890 or visit www.okda.org

Dear Members:

You are probably aware there is an increasing trend of lawsuits and/or allegations stemming from practice-related Harassment, Discrimination, and Wrongful Termination. You can protect yourself with an Employment Practices Liability (EPL) insurance policy. Please allow me to introduce an ODA-endorsed EPL insurance policy I know will serve you and/or your practice well. But first, let's see how you handle a short quiz on insurance.

DENTISTRY INSURANCE 101 POP QUIZ

#1. Which claim statistics best describe Employment Practices Liability for Oklahoma Dentists?

- A. On average it cost \$14,483.45 to defend each claim reported over the past three years. Two claims have exceeded the policy limits. The number of claims reported has increased 100% since 2003.
- B. On average it cost \$12,508.68 to defend and indemnify each claim reported since 2003. A single claim has not exceeded the policy limits to date. The number of claims reported has increased 27% since 2003.

#2. Currently your Professional Liability Insurance policy with Alexander & Strunk provides what amount of Employment Practices Liability Insurance?

- A. \$1,000,000 each occurrence / \$3,000,000 aggregate with no deductible.
- B. \$25,000 of Defense ONLY with a \$2,500 deductible.

#4. Independent Contractor DENTISTS and/ or Employee DENTISTS can be held liable for Discrimination and Harassment.

- A. True
- B. False

#5. Patients and Vendors can hold you liable for Discrimination and Harassment.

- A. True (this is called 3rd party coverage)
- B. False

If your answers were A, B, A and A then you made a perfect score. Hopefully, these answers reminded you that you only have \$25,000 for defense coverage under your Professional Liability and the EPL type of claims are becoming more frequent.

The claim facts described in 1.A show a need for additional EPL insurance. Therefore, we have worked out an EXCLUSIVE plan with an "A" rated company to provide ODA members with limits up to \$1,000,000 with unlimited defense AND 3rd party coverage.

Our office will continue to recommend and offer you various types of insurance where we believe there is a need. I strongly encourage you to purchase EPL insurance as you continue to practice dentistry. Please call our office to discuss.

Sincerely,

Joe L. Strunk
 President
 Alexander & Strunk, Inc.

P.S. See our ad on page 13 and call us. Claim statistics shown in 1.B best describes Professional Liability insurance for Oklahoma Dentists.



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Insurance Professionals

ODA PATIENT'S PAGE

This message brought to you by your dentist - a proud member of the Oklahoma Dental Association

Wisdom Teeth

Wisdom teeth are the third and final set of molars that most people get in their late teens or early twenties. Sometimes these teeth can be a valuable asset to the mouth when healthy and properly aligned, but more often, they are misaligned and require removal.

Wisdom teeth present potential problems when they are misaligned – they can position themselves horizontally, be angled toward or away from the second molars, or be angled inward or outward. Poor alignment of wisdom teeth can crowd or damage adjacent teeth, the jawbone, and/or nerves. Wisdom teeth can lean toward the second molars making them more vulnerable to decay by entrapping plaque and debris. In addition, wisdom teeth can be entrapped completely within the soft tissue and/or the jawbone, or only partially break through or erupt through the gum. Teeth that remain partially or completely entrapped within the soft tissue and /or the jawbone are termed “impacted”. Wisdom teeth that only partially erupt allow an opening for bacteria to enter around the tooth and cause an infection, which can result in pain, swelling, jaw stiffness, and general illness. Partially-erupted teeth are also more prone to tooth decay and gum disease because their hard-to-reach location and awkward positioning makes brushing and flossing difficult.

Wisdom Tooth Extraction

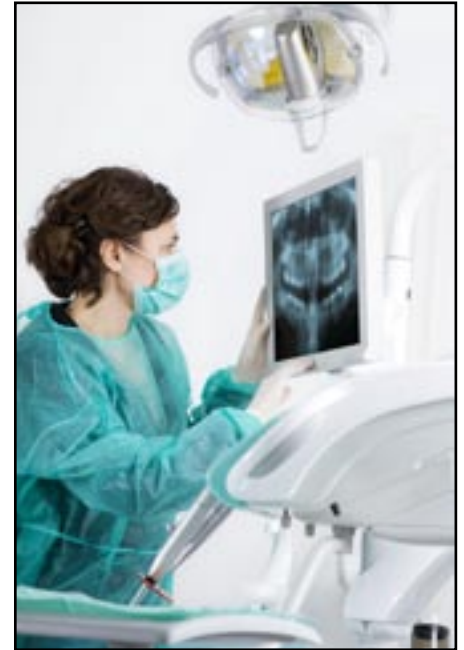
An oral and maxillofacial surgeon or your dentist can remove (extract) a wisdom tooth. The procedure can often be done in the dentist's or surgeon's office. You may have the surgery in the hospital, especially if you are having all your wisdom teeth extracted at one time or if you are at high risk for complications.

If you have an infection, surgery will usually be delayed until the infection has cleared up. Your doctor or dentist may have you take antibiotics to help heal the infection.

Before removing a wisdom tooth, your dentist will give you a local anesthetic to numb the area around the tooth. A general anesthetic may be used, especially if several or all of your wisdom teeth will be removed at the same time. A general anesthetic prevents pain in the whole body and will make you groggy or cause you to sleep through the procedure. Your dentist will probably recommend that you don't eat or drink after midnight on the night before surgery, so you are prepared for the anesthetic.

To remove the wisdom tooth, your dentist will open up the gum tissue over the tooth and take out any bone that is covering the tooth. He or she will separate the tissue connecting the tooth to the bone and then remove the tooth. Sometimes the dentist will cut the tooth into smaller pieces to make it easier to remove.

After the tooth is removed, you may need stitches. Some stitches dissolve over time and some have to be removed by the dentist after a few days. Your dentist will tell you whether he or she will need to remove your stitches. A folded cotton gauze pad placed over the wound will help stop the bleeding.



Ask your dentist about the positioning of your wisdom teeth. He or she may take an X-ray periodically to evaluate for the presence and alignment of your wisdom teeth. Your dentist may also decide to send you to an oral surgeon for further evaluation.

ODA Annual Awards

Do you have a colleague that should be recognized as Dentist of the Year? Do you know someone who has gone above and beyond the call of duty with his/her charitable and community work? The ODA will be recognizing members during the 2009 Annual Meeting Opening Session for outstanding achievement in the following areas:

Dentist of the Year –

The dentist selected as having made the greatest contribution to the advancement of dentistry in Oklahoma.

Young Dentist of the Year –

A new member dentist who exhibits an active interest in organized dentistry and the image of the dental profession. Candidates for this nomination should be a member of organized dentistry for five years or less.

Thomas Jefferson Citizenship Award –

A member dentist who has made significant contributions to community service and philanthropic works in the area of dentistry.

Robert K. Wynne Public Information Award –

A member dentist who has worked to advance the knowledge of dentistry and dental health through public education and public relations efforts.

Dan E. Brannin Professionalism Award –

The member dentist selected as having made significant contributions to the advancement of the principles and practice of ethics and professionalism in dentistry.

Richard T. Oliver Legislative Award –

A member dentist who has given outstanding effort and leadership in the Oklahoma legislative process on behalf of the Oklahoma Dental Association.

Nominations are now being accepted for 2009 ODA awards. **Nominations will be accepted until December 31, 2008.** Use the Oklahoma Dental Association Awards Nomination Form (on the adjacent page) to nominate an ODA member for an award. One form per individual nomination please. Nominations are only valid if the entire form is completed. Additionally, a letter of nomination describing the nominee's accomplishments for the award must accompany the nomination form. Nominations are not valid without this letter of nomination.

Please return your nomination form(s) to the ODA:

405.848.8875 - Fax

or mail to: Oklahoma Dental Association

317 NE 13th Street, Oklahoma City, OK, 73104

What you don't (and do) say can hurt you! Do you have a health literate practice?

Oral Health Literacy Symposium: Communication, Ethics and Risk Management

The American Dental Association's Council on Access, Prevention and Interprofessional Relations (CAPIR) will host this free pre-conference workshop to address health literacy and oral health (CE hours: 8.5). This interactive course, led by experts in the field, will focus on health literacy and implications for dental practice, including professional liability, communication by the dental team and ethical responsibility. The course will provide practical solutions based on the best available information on health literacy.

Wednesday, October 15, 2008, 9:00AM – 5:00PM

Thursday, October 16, 2008, 3:00PM – 5:30PM


at the Henry B. Gonzalez Convention Center, San Antonio, TX

Register today at www.ada.org/goto/session



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Oklahoma Dental Association
2009 AWARDS NOMINATION FORM
DEADLINE FOR NOMINATIONS IS DECEMBER 31, 2008.

NOMINEE INFORMATION (please print clearly or type)

Name: _____ Award Nomination for:
_____ Dentist of the Year
Current Address: _____ _____ Young Dentist of the Year
_____ Thomas Jefferson (Citizenship)
City: _____ _____ Robert K. Wynne (Public Info)
_____ Dan E. Brannin (Professionalism)
State: _____ Zip: _____ _____ Richard T. Oliver (Legislative)

Phone: _____ Fax: _____ ODA Member Since: _____

Date of Birth: _____ Email: _____

NOMINATED BY

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____ Fax: _____

NATIONAL, STATE &/or LOCAL POSITIONS HELD

Organization/offices held: (please use additional pages as necessary)	Year
_____	_____
_____	_____
_____	_____
_____	_____

List all dental-related work experience in chronological order with dates: (please use additional pages as necessary)

Please attach letters of recommendation, references and other documentation as necessary.

Submitted by: _____ Signature: _____

DEADLINE FOR NOMINATIONS IS DECEMBER 31, 2008.

Please use a separate form for each award nomination. Photo copies of this original form will be accepted. A letter of nomination must accompany each nomination describing the nominee's accomplishments and other contributions.

Submit to: Oklahoma Dental Association, Attention: Member Awards, 317 NE 13th Street, Oklahoma City, OK 73104



By: State Senator Glenn Coffee

Small Business Legislation



**R-Okla. City
Co-President
Pro Tempore
Oklahoma
State Senate**

After the 2006 elections, the Senate ended up in a tie: 24 Democrats and 24 Republicans. This resulted in a historic power-sharing agreement between the two parties, and marked the first time that Senate Republicans have ever had a say in running the chamber and setting the legislative agenda. While many pundits predicted gridlock in the Senate, I'm proud that the senators defied expectations by working together to do the people's business.

My brother, Dr. Logan Coffee, is a dentist and a member of the ODA. He makes sure that I have an intricate understanding of dentistry issues. While a variety of health care issues are important to dentists, small business issues are also important.

Thankfully, the Legislature has made some progress on business issues in the past few years. We reformed the franchise tax to exempt businesses with a liability of less than \$250. We are phasing out Oklahoma's death tax, which will be completely eliminated by 2010. Senate Republicans will continue to push for more tax reforms to help small businesses when the Legislature reconvenes in 2009.

In 2007 the State Senate successfully passed a meaningful, comprehensive lawsuit reform bill for the first time ever. (The trial lawyers have

historically been able to block all lawsuit reform legislation in the Senate.) These common sense reforms also passed the House, but the bill was vetoed by Gov. Henry. Lawsuit reform will be on the Senate's agenda again in 2009, and I am hopeful we'll be able to enact meaningful reforms.

Concerns about the high cost of workers compensation remains a high priority at the Legislature. Unfortunately, we've had some setbacks with the reforms passed in 2005, as the courts have stricken parts of the 2005 law. Workers comp continues to be a burden on Oklahoma businesses, so more reforms will be considered in upcoming legislative sessions.

The Legislature has funded the Oklahoma Dental Student Loan Repayment Program for three years in a row, as well as providing state assistance for the Mobile Dental Care Program. These programs are important to Oklahomans' dental health.

Finally, let me offer a special thank you to Oklahoma dentists and your staff for promoting dental health in our great state.



ODA members join to present Representative Sullivan a campaign contribution from ADPAC. Forty dollars of your DENPAC dues support ADPAC to help support our friends in Congress.



Dr. Jim Torchia, Dr. Pamela Low, Representative Sullivan, Dr. Richard Haught and Dr. Steve Hogg.

Doctor, would you like:

- A sound annual financial plan for your practice based on 'real' numbers?
- Your staff meetings and huddles to be more productive?
- Your staff members to learn great verbal skills?
- How to present treatment plans that get patients to say "Yes!"?
- A full appointment book?
- A rock-solid payment arrangement system?
- A recare system that really works?
- Leadership training, or one-on-one coaching for you or your staff?



If the answer to any of these questions is yes, please call me today. The solutions are easier than you think!

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\$150

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State: _____

Zip: _____

Check (make checks payable to DENPAC)

Visa MasterCard Discover American Express

Card No: _____

Expiration Date: _____

Signature: _____

Thank you for your donation!

Please return this form and your contribution to:

DENPAC
317 NE 13th Street
Oklahoma City, OK 73104

Or fax to: 405-848-8875

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Introducing

ODA JOURNAL PROFILE: Dr. Jana Winfree, Our New State Dental Health Director

Who & What



Jana Winfree received her Bachelor's degree in Zoology from OU in 1981. She is a 1985 graduate of the OU College of Dentistry and has practiced dentistry in Oklahoma for more than two decades. Dr. Winfree grew up in Ada, OK, and often returns there to visit family. She is

the mother of three: two sons who are university students and a daughter entering 7th grade.

Although Dr. Winfree has worked in a variety of dental positions over the last two decades, the common thread is a sense of public health. Highlights of this experience include 11 years at Neighborhood Services Organization, many years at Rose State College teaching community dentistry and clinical instruction to dental hygiene students, several years in nursing homes and residential facilities with a mobile dental unit, and as a dentist with the Cleveland County Health Department. Even though Dr. Winfree says there was never a grand plan in mind, she now feels fortunate that all these public health experiences prepared her for her new position as Chief of Dental Health Service for the State of Oklahoma.

ODA: What do you hope to accomplish first as the new State Dental Director?

JW: My first order of business is to establish good working relationships with other program service areas at the Oklahoma State Health Department. WIC, SoonerStart, Maternal and Child Health, Family Support and Prevention, Child Guidance and Community Health Services can join forces with us and together we can be great partners. Very soon, I'd like to see dental education as part of the goals of these organizations. They reach out to and serve such a large group of people in the state; I know together we can do much more than any one of us can do alone.

ODA: What are your long-term goals in this new position?

JW: The state already has some fantastic ongoing programs and my long-term goals are to enhance and expand this work. Dental educators provide lessons to schools, daycares, nursing homes and many other community venues throughout the state and I want to make sure that this dental education reaches all vulnerable populations. Also, we now have recent dental school graduates that work in "in-need" counties for two years and receive a benefit of having portions of their dental school loans paid off. This kind of work serves at least 30% of Medicaid patients, so it is a win-win model for dental graduates and citizens that can certainly be replicated. Lastly, I see adding more county dental clinics that serve the uninsured scattered across the state (which is how I became aware of my new position). This is a critical public health issue that we must keep our eyes on as we look to the future.

ODA: What do you envision your toughest challenge in your new position will be?

JW: Changing from clinician to administration and learning all that it entails. I'm having to think differently and see things from another perspective. I need to see the State of Oklahoma as my patient, rather than each individual. I've got a lot to learn and the first step is taking time to listen. The second challenge is my wardrobe! All I've worn to work for the past 23 years has been scrubs and athletic shoes, so it's been an adjustment to get up in the morning and put on professional business clothes. I think I can handle it.

ODA: What are some ways ODA members can assist the State Health Department's dental health mission?

JW: These words in our mission statement "... help protect and promote good oral health for Oklahoma citizens" will resonate with a lot of ODA members. Volunteering time and dental expertise in the communities in which they live and work is a tangible way to make a difference. Also, ODA members can support state legislation to help meet our dental goals.

Don't let a lawsuit ruin your practice.



Whether it comes from staff, patients, vendors or contractors, a lawsuit could cause severe damage to your practice. No matter how frivolous the claim, your current Professional Liability Insurance Policy will only cover a fraction of the costs and you will be left to make up the difference. With limits up to \$1,000,000.00 and unlimited defense and third party coverage, adding the ODA exclusive Employment Practice Liability plan will alleviate this threat and protect your practice.

Call our office for more information, question and concerns.



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Dentistry: A Team Effort

2009 ODA Annual Meeting CE Preview

Deborah Dopson-Hartley, RDH

Ms. Dopson-Hartley is known as the ‘real thing’ of dental hygiene and for being one of the most profitable hygienists ever in both producing revenues and promoting treatment. Her extensive professional experience spans three decades as a full-time practicing hygienist, dental assistant, patient care coordinator, business office administrator, author, speaker, industry advisor and the former developer and co-editor-in-chief for a reality publication that evaluated and rated hygiene products in the dental industry. She is currently the Hygiene Professional Manager for Zenith Dental.

The Business of Dental Hygiene

Six (6) Hours of CE Available

Friday, April 24, 2009

8:00 am – 11:00 am and 2:00 pm – 5:00 pm

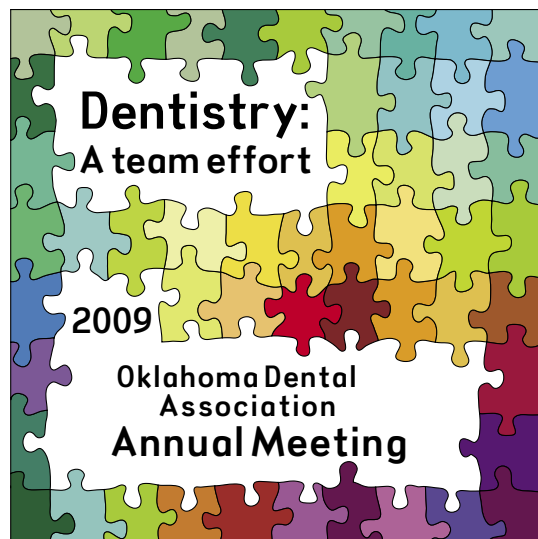
Lecture format

Recommended for dental hygienists

When you see this title, what comes to mind? Perhaps a treadmill where high volume and financial reward are the focus? Or possibly, a hygiene department where quality patient care and profitability are congruent, operating with systems that would not allow one to compromise the other? A thriving hygiene department has a major influence on the overall success of the practice. Not only are hygiene services important to overall patient health, they're essential in terms of referral-generating potential, pure sales power, patient retention and practice growth. Also, a profitable hygiene department allows dental

practices to afford the equipment and supplies needed to deliver the quality care. Learn the costs associated with the daily operations of running the hygiene department and patient care. After completing this program, the dental professional should be able to:

- Develop a productive hygiene department where quality patient care and profitability are congruent, operating with systems and protocols that would not allow one to compromise the other.
- Increase compelled target patient referrals while building the active recall list without increasing the doctor's workload or overhead.
- Implement and work a practical, effective, realistic and successful soft tissue management program for today's patient-focused, real world.
- Increase hygiene net profits \$70,000 to \$100,000 per year.



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Professional Practice Associates is the dental practice transition specialist who helps you achieve your dreams! We understand that buying or selling a dental practice can be overwhelming, but we draw from our years of experience to make the transition as smooth as possible.

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In practice

How going digital will affect the dental office

Allan G. Farman, BDS, PhD, DSc, MBA; Claudio M. Levato, DDS, FACD; David Gane, DDS; William C. Scarfe, BDS, MS, FRACDS

Digital imaging is not simply the display of filmless radiographs. More importantly, the images are captured in a computer and can be displayed almost instantaneously, facilitating operative procedures that now can be image-guided.

Digital radiographic images do not need to stand apart from film radiographs; in fact, many practitioners use both. There is nothing wrong with this hybrid solution. The first commercial digital intraoral systems were developed for operative procedures rather than as a replacement for film. Because the original sensors were bulky and the active area was small, they were not practical replacements for conventional film-based full-mouth series.

With advances in digital technology, however, the surface areas of sensors can be identical to their film counterparts in the case of storage phosphor systems, and they are similar in dimension for solid-state devices. Although a hybrid approach made the most sense in the early stages of digital imaging, an entirely digital approach now is a practical option. For two-dimensional (2-D) transmission x-ray imaging, the quality of digital systems generally has been found to

ABSTRACT

Background and Overview. The impact of digital imaging on dental practice depends upon the degree of planning conducted before implementation. Digital technologies have the potential to improve diagnosis; facilitate patient treatment procedures; and streamline storage, transfer and retrieval. These technologies also provide for secure backup of patients' image data, critical to re-establishing the practice should fire, flood or earthquake occur.

Conclusions. The decision to invest in digital radiographic equipment should be a simple one for dental practitioners. Although digital x-ray sensors have long equaled analog film for diagnostic tasks, they have several advantages over film radiography, including immediate image production with solid-state devices; interactive display on a monitor with the ability to enhance image features and make direct measurements; integrated storage with access to images through practice management software systems; security of available backup and off-site archiving; perfect radiographic duplicates to accompany referrals; security mechanisms to identify original images and differentiate them from altered images; the ability to tag information such as a patient identifier, date of exposure and other relevant details; and interoperability of the Digital Imaging and Communications in Medicine file format.

Clinical Implications. Most clinicians should contemplate integrating, at a minimum, intraoral digital x-ray sensors and a digital panoramic system into their practices.

Key Words. Dental radiography; Digital Imaging and Communications in Medicine; digital imaging; interoperability.

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be equivalent to film in terms of diagnostic yield.¹⁻⁶ However, with regard to record keeping, backup, transmission of images and integration with the practice management system and other digital diagnostic inputs, digital radiography outperforms film. Digital radiographic and photographic visible light images are the building blocks that eventually will take the dentist from the role of freehand artist to that of an architect of dental care. The computer is the major enabling technology.

ADVANTAGES OF DIGITAL RADIOGRAPHY

The decision to invest in digital radiographic equipment should be a simple one for dental practitioners, even though the capital costs may be high. While digital x-ray sensors have long equaled analog film for diagnostic tasks, they have several advantages over film radiography, including the following:

- immediate image production with solid-state devices such as a charge-coupled device (CCD) and a complementary metal-oxide semiconductor (CMOS);
- interactive display on a monitor with the ability to enhance image features and make direct measurements;
- integrated storage, providing access to images through practice management software systems;
- security of available backup and off-site archiving;
- perfect image duplicates to accompany referrals to other practitioners;
- security mechanisms to identify original images and differentiate them from altered images;
- ability to tag information such as a patient identifier, date of exposure and other relevant details;
- interoperability of the Digital Imaging and Communications in Medicine (DICOM) (National Electrical Manufacturers Association, Rosslyn, Va.) file format, which enables practitioners with different equipment and software to view and enhance the same images.

Most dental practitioners should contemplate integrating, at a minimum, intraoral digital x-ray sensors and a digital panoramic system. These are important, irrespective of specialty. Orthodontists and maxillofacial surgeons need a cephalometric system to obtain images of the patient's entire head. They should decide whether their practice would benefit by converting from tradi-

tional x-ray film to 2-D digital images versus the three-dimensional capabilities of cone beam computed tomographic (CBCT) x-ray systems. CBCT is rapidly becoming the standard of care for such procedures as dental implantation.⁷⁻⁹ The figure shows the possible components of an integrated digital dental office.

Levels of integration. The level of integration will depend on the desire and capability of each practitioner. Practitioners have four distinct choices regarding digital x-ray imaging integration.

- **Analog only:** Stay with analog radiography using silver halide film. The advantages are no immediate outlay of capital. The disadvantages are that practices experience none of the benefits of digital technology and face the likelihood of eventual obsolescence.
- **Hybrid:** Combine the strengths of digital systems and analog film. The advantages are a decreased immediate investment. The disadvantages are decreased access to the benefits of digital technology and the continued costs of maintaining an analog system.
- **Completely filmless (digital imaging, but not integrated with a digital practice management system):** The advantages include having a greater ability to manage the radiographic component of the practice and the benefits of digital radiology applications. The disadvantages are the lack of a completely digital practice record and the capital costs and ongoing maintenance costs.
- **Completely digital:** This is the integrated digital practice. The advantages are improved efficiency and management of all clinical, administrative and communication practice applications. The disadvantages are the capital costs and ongoing maintenance and training costs.

Practical applications of a fully digital environment. Starting with the acquisition of data and including the use of electronic charting, digital radiographic images, photographic images and dictated or typed progress notes, the practi-

ABBREVIATION KEY. **CBCT:** Cone beam computed tomography. **CCD:** Charge-coupled device.

CMOS: Complementary metal-oxide semiconductor.

CRT: Cathode ray tube. **DICOM:** Digital Imaging and Communications in Medicine. **PSP:** Photostimulable phosphor plate. **RAM:** Random access memory.

RF: Radio frequency. **TCP/IP:** Transmission control protocol/Internet protocol. **2-D:** Two-dimensional.

USB: Universal serial bus.

tioner now has a complete dental record that is secure and accurate. He or she can share any part of this record internally with staff members or externally with insurance companies and/or dental laboratories, as well as use this record for referrals.

One of the most powerful outcomes of integrated technology is the potential to organize the pertinent data in a format that is readily available to educate the patient in real time. Use of the patient's own images helps accelerate his or her acceptance of dental care. When the practitioner combines this visual information with available electronic patient education programs, he or she has provided a credible second opinion on the same day as the consultation.

With digital technology, the dentist can read radiographs and plan treatment in any location that has a workstation. This allows the dentist to take advantage of any open time and provides him or her with immediate access to the patient information. Using multiple windows, monitors and/or a laptop computer connected to the network facilitates multitasking for the dentist. Specifically, it allows the dentist to work with multiple images, as well as charting programs and treatment planning programs, thus greatly reducing the time needed to create treatment options for patients. If the practitioner is connected to the Internet, this also enables him or her to share information with a colleague who may need to be part of the patient's care.

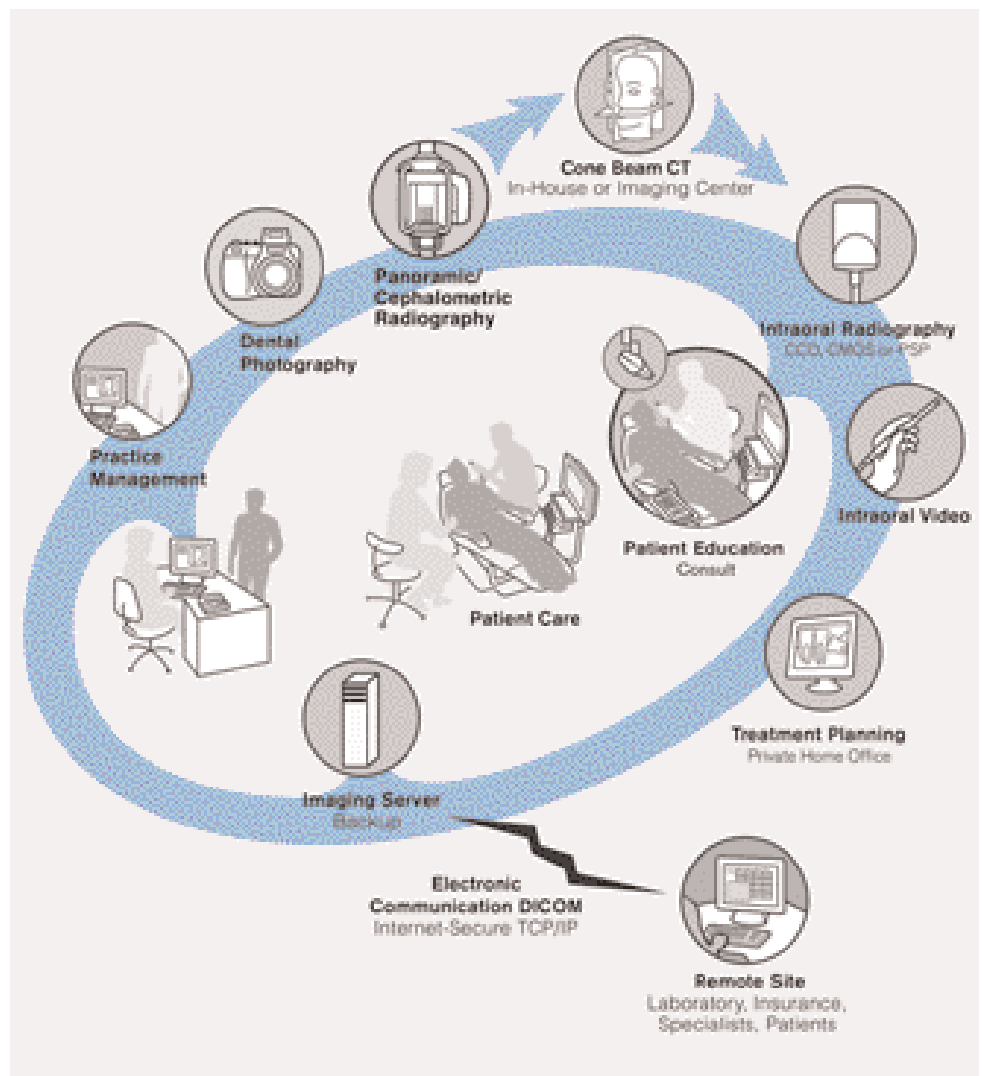


Figure. Possible components of an integrated digital dental office. CCD: Charge-coupled device. CMOS: Complementary metal-oxide semiconductor. CT: Computed tomography. DICOM: Digital Imaging and Communications in Medicine (National Electrical Manufacturers Association, Rosslyn, Va.). PSP: Photostimulable phosphor plate. TCP/IP: Transmission control protocol/Internet protocol.

Approach to integration. Regardless of how the dentist decides to approach technology integration, he or she needs a plan.^{10,11} For an existing practice, a gradual approach is acceptable. For example, the dentist can begin with one sensor attached to a solitary personal computer, which can be used for operative procedures. This approach permits a relatively inexpensive trial of the technology and minimizes the learning curve while stimulating the attention of the dental team. For a new facility or an office that is to undergo a complete renovation, we advocate total networking. For a newly opened general practice, the clinician might consider replacing a traditional film full-mouth series with digital

panoramic images in addition to bitewings and selected periapical radiographs. As with any new technology, developing competency in digital imaging involves a learning period for the practitioner trained in film radiography. However, in our experience, students who have been trained in both analog film and digital x-ray systems find the latter to be easier to learn.

Before buying. Digital radiography is not inexpensive. Hence, clinicians should “test drive” several systems to determine which sensor and software fulfill the needs and style of the practice. The appropriate place to evaluate such systems is the dentist’s own office, where he or she can compare products in a standardized manner with images that are not preselected. This usually is possible while the vendor’s representative is present. In addition, it is important to work in one’s own office environment to determine whether the existing x-ray generators are acceptable or should be replaced. Only in the dentist’s own office environment can he or she examine the ergonomics of using the system and plan integration.

HARDWARE CONSIDERATIONS

Sensor type. *CCD and CMOS.* The scientific literature reveals little difference between the CCD and CMOS chips for solid-state imaging in terms of physical image properties.¹² The CMOS chip, however, requires less energy, so it is possible to connect it directly to the computer via a universal serial bus (USB) rather than needing an additional external signal amplifier. Furthermore, CMOS technology has permitted the development of wireless sensors. However, the latter will involve the additional cost of disposable batteries. Solid-state sensors typically range in cost from \$5,000 to \$8,000 each, with wireless sensors costing up to 50 percent more. Solid-state x-ray sensors produce an almost immediate radiographic image.

Photostimulable phosphor plate. An alternative to solid-state technology is the photostimulable phosphor plate (PSP). The advantage of this technology is that the sizes of the phosphor plates are almost identical to those of traditional film radiographs. The disadvantages include a propensity of intraoral sensors to degrade owing to scratching, the time needed to prepare and package the plates, and the time needed to scan with a laser the exposed plates to process the latent image. Producing an image with PSP is not immediate. The cost of PSP plates varies from

tens to hundreds of dollars depending on the size of the plate.

Number of sensors. In deciding the number of intraoral solid-state sensors to purchase, the dentist should factor in the need for cold disinfection of sensors between patients, the flow of patients through the office, and the various sizes and shapes required for patients of different ages and sizes. Clinicians need not buy all of their sensors from a single vendor as long as the systems are DICOM-conformant and the images produced are interoperable.¹ It is always prudent to insist that the vendor, as a condition of purchase, integrate the selected system into the existing practice management system. For PSP devices, clinicians should purchase at least twice the number of plates as the practice uses in a given period to allow sufficient time for them to be erased and repackaged before reuse. They also should purchase additional plates to replace those damaged by wear and tear.

Sensor specifications. Most, if not all, current systems are adequate in terms of contrast and spatial resolution. When it comes to diagnostic quality, the clinician should trust his or her own eyes.

Physical connection to computer. Clinicians can choose between wired and wireless sensors for solid-state technology (CMOS using radio frequency [RF] transmission) and for PSP. If a wire is used to attach the sensor to the computer, ensure that the length of the wire is sufficient for the working environment. If the practice is using a wireless system, however, it is important to make sure that the permitted range of a wireless RF or Bluetooth system is adequate. Placement of the wire also is important, as it can have implications for the types of exposures that can be made. If, for example, the dentist wants the instant image feature of a solid-state intraoral sensor and also wishes to obtain vertical bitewing radiographs, he or she should use a sensor with the wire attached at the back; otherwise, it is acceptable to use a sensor with the wire attached at one end.

Sensor sizes. When evaluating different systems in the office with patients during vendor demonstrations, dentists should make sure that the range of available sensor sizes is acceptable. In our experience, sensor sizes no. 2 and no. 1 are useful, whereas size no. 0 is of limited utility. Regarding the thickness of CCD and CMOS intraoral sensors, we find that slightly thicker sensors are easiest to place, as they do not cut into the patient’s tissues.

Sensor positioning devices. The positioners are not much different from those used with intraoral film radiography.

Computer requirements. In general, if a computer is more than one year old, it is probably worth upgrading the computer system when investing in digital imaging. Dentists should not try to skimp on random access memory (RAM), read-only memory or speed. As a rule of thumb, 4 gigabytes of RAM is optimal. The processor speed of the central processing unit should be at least 3 gigahertz. A terabyte of storage is not excessive for the server, and mirrored storage drives are desirable. In a networked environment with a dedicated server, workstations do not need much storage capacity, so a hard drive of 500 GB is adequate. Extra slots and USB connections are always useful.

Storage. Digital file storage need not be expensive. Dentists can purchase a terabyte of storage capacity for less than \$500. All data should be backed up both locally (by using mirrored drives—two drives that contain the exact same information) and at a secure remote site several miles from the practice. A simple means of backup is a removable drive that can be copied to the secure remote system on a daily basis. Keep in mind that the practice is the patient data, not the physical equipment. The dentist can replace physical equipment readily, but he or she must carefully protect unique patient data.

Monitor selection. The physical specifications and settings of the monitor ultimately will determine the appearance of any digital image, as well as the image of the practice to patients. Flat panel monitors look modern, cathode ray tube (CRT) monitors look like antiques. Flat panel monitors are economical with regard to space, while CRT monitors are inefficient. Clinicians should purchase a high-resolution monitor with a wide grayscale contrast capability. In most cases, an upper-end nonmedical-grade monitor is sufficient for administrative or nonclinical locations. In the operatory, we recommend medical-grade flat-plane monitors that have sealed nonglare glass fronts. This is most consistent with infection control protocols, permitting disinfection along with the rest of the operatory between patients.

Printer. It is not essential to have a printer if practitioners and other third parties to whom the dentist transmits images can handle digital images transmitted as DICOM files. The printed

image invariably is of lower quality than the originally displayed image, and clinicians should not consider it to be diagnostic.

Networking. To achieve a fully integrated practice, we prefer a hard-wired network over a wireless network. However, depending on space requirements and accessibility, the practice can use a combination of both. Keep in mind that wireless applications are more susceptible to electrical interference, are less secure and are slower in transmitting larger file sizes (such as images from high-end digital cameras or volumetric radiographic images). The maximum wireless data transmission speed is 55 megabits per second, while the maximum speed of a hard-wired category 5E cable is about 350 Mb per second and that of a category 6 cable is 1 gigabit per second.

The quality of the diagnostic image depends on the weakest link in the imaging chain. Clinicians should consider this when deciding whether or not to upgrade the x-ray generator. Typically, they should replace x-ray units that are more than 10 years old, but newer units also should be replaced if the timer is incapable of making reproducible short exposures or if the image quality is suboptimal.

SOFTWARE CONSIDERATIONS

Operating system. The operating system must be compatible with the digital imaging system, and it also must be compatible with other software used on the same computer or network.¹³ At the time of purchase, the dentist must be assured that the vendor will update the digital imaging system to be compatible with future modifications made to the computer operating system.

File format. The American Dental Association¹⁴ has resolved that interoperability should be established according to the DICOM standard.¹⁵ DICOM is a standard of the International Organization for Standardization.¹⁶ Dentists need to make sure that the system they purchase conforms with the DICOM standard and permits the export and import of DICOM files. File interoperability protects patients' data and the dentist's investment so that he or she cannot be "held hostage" by the proprietary file formats of an individual vendor.

Ergonomics. The digital imaging system should require a minimum number of keystrokes and preliminary screens. The dentist and staff members should be sure that they have no problems using the software.

Integration. Ideally, digital images are acces-

sible via the practice management software. Leading practice management software systems provide for the importation of images in DICOM format. The DICOM image file tags can populate new patient information, saving staff members' time and reducing the likelihood of making errors.

MAINTENANCE

Warranty. Digital imaging systems are a fairly expensive investment. Thus, the manufacturer's warranty is important. Practitioners should read the small print carefully to ensure that their investment will be protected adequately.

Hardware service contract. We recommend that dentists obtain a hardware service contract. For intraoral solid-state sensors, this should provide for overnight replacement. In our experience, hardware failure is unusual; however, when it does occur, immediate replacement is needed.

Software service/update contract. A software service contract, including upgrades, is needed, and it should include support when the computer operating system or practice management software is upgraded.

Before purchasing a system, the dentist should call technical service to make sure that someone answers the telephone. Continued technical support should be part of the warranty and maintenance contract.

Several companies have been in the dental digital radiography business for more than one decade. Such long-term survival suggests that customers are satisfied. While past performance is no guarantee of future results, it certainly is a factor in determining the company with which to work.

Costs. To determine the total costs of going digital, the dentist needs to consider the following:

- capital costs of hardware and software;
- continuing costs of disposable items (for example, plastic wraps for sensors);
- costs of secure data backup;
- maintenance costs;
- initial and ongoing training costs.

Dentists also should consider the costs that would apply if they decided not to go digital. These include film, processing solutions, processor maintenance, darkroom space, film mounts and storage of film radiographs.

CONCLUSION

We have given a brief synopsis of the factors involved in going digital with regard to dental imaging. Certainly, practice prestige and work flow ergonomics can be enhanced greatly by careful integration of digital imaging systems. The key to success is to assess the needs of the individual practice and to observe, in the practice setting, demonstrations of the systems under consideration. Digital intraoral radiography is a mature industry, with many vendors having survived one decade or more. Survival in the business is a good sign that consumers are happy with the products being marketed. ■

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Are We Really Doing Anything About The Future Of Healthcare?

By: Dr. Raymond Cohlmia

That is the \$64,000 Future Healthcare Question! If you can answer that one then you're ahead of the curve. But because there are so many related topics, we cannot even phrase the question properly. If we take a proactive position on the subject, we can be a part of the question itself...and of the answer as well.

So how do we take a proactive stance? Your American Dental Association House of Delegates took that position last year with Resolution 58H-2007 which states: That the ADA lobbying efforts emphasize that government dental programs prioritize resources for those most in need, and be it further, resolved, that a task force be appointed by the ADA President to include but not be limited to the Council on Dental Benefits Programs; Council on Dental Practice; Council on Government Affairs; Council on Access, Prevention and Interprofessional Relations; Council on Communications, and relevant consultants for the purpose of:

1. Defining the role of the ADA in the development of future universal healthcare programs
2. Developing goals and strategies to guide the Association's advocacy efforts as it relates to potential universal healthcare
3. Reporting to the 2008 House of Delegates with recommended action items.

When delegates were surveyed during a discussion prior to the HOD meeting, a few key questions were asked. The first was "How likely will there be some sort of universal coverage program by 2012?" Secondly, "What is your prediction of the impact of universal healthcare coverage on dentistry?"

As you might suspect, 32% said it is very likely that a program would be in place by 2012. But 58% felt it would have a negative impact on dentistry. Thus, the position we take on this future healthcare coverage is paramount and emphasizes the need for this important task force.

What are the initial considerations of this task force? We received a presentation from Dr. Charles Smith, 6th district trustee and task force chair, at the 2008 ADA National Dental Benefits Conference. Among his points were the following:

- Whatever the American Dental Association recommends, it must also provide direction with the flexibility for negotiation.
- We must acknowledge that the ADA cannot enter into the debate with the same position as with the 1990's effort (Dentistry: Healthcare that Works).
- Discussion must be reframed from the oral health perspective for the ADA to be considered the leading advocate for the profession.
- Both the public and the policy makers are much more attuned to the issue of access to dental care.
- Work should be centered on a framework and concepts that are less rigid so that the ADA is able to maneuver and negotiate.

All these bullets say the same thing: It is a new battle. The strategy plan of a decade ago most likely will not apply to our approach today. A rigid position in the face of political dynamics is not likely to work to the best interest of all entities involved.

The mission statement of the task force addresses these bullets and statements very well; "Define the role of the ADA and dentistry in the development of future universal (and other) health care programs, and develop goals and strategies to guide the ADA's advocacy efforts in this arena".

It is important to note that the House of Delegates has not yet approved all of the task force's findings presented here; these findings will be considered at the upcoming national meeting for changes and/or approval.

Oral Health Care is Essential to Overall Health

- *Healthcare is a shared responsibility.* No law, regulation, or mandate will improve the oral health of the public unless policy makers, patients and dentists work together with a shared understanding of the importance of oral healthcare and its relationship to overall health.
- *Prevention pays.* The key to improving and maintaining oral health is preventing oral disease. Community-based preventive initiatives, such as community water fluoridation, school-based screening, and sealant programs are proven and cost-effective measures. These should be integral to oral health programs and policies, and will provide the greatest benefits to those at the highest risk of oral disease.
- *Improving Oral Health Literacy Makes Patients Better stewards of their own health.* Patients, parents, care-givers and others need to understand the importance of good oral health, oral hygiene fundamentals, diet and nutritional

guidelines, the need for regular dental care and, in many cases, how to navigate the system to get dental care.

- Patients need a dental home. All patients should have an ongoing relationship with a dentist with whom they can collaboratively determine preventive and restorative treatment appropriate to their needs and resources.

Access is a Key to Good Oral Health

- Improving Oral Health in America requires a strong public health infrastructure to overcome obstacles to care. The current dental public health infrastructure is insufficient to address the needs of the disadvantaged groups. Efforts to improve access to dental care require investment in the nation's public health infrastructure. The ADA recognizes that community-based disease prevention programs must be expanded and barriers to personal oral health care eliminated, if we are to meet the needs of the population.
- Reimbursement Matters. Increased access to care for people covered by government-assisted dental programs depends on fair and adequate provider reimbursement rates. The vast majority of government programs are so seriously under-funded that dentists cannot recover the cost of materials used in providing care.
- Improving access in underserved areas requires extra market incentives. Federal, state, and local governments must develop financial incentives, such as student loan forgiveness, tax credits or other subsidies, to encourage dentists to locate their offices in areas that cannot otherwise support private dental practice.
- Patients with the greatest need must be first in line for care. Under-funded government programs fail to provide minimally adequate care to all they purport to cover. Funding should be prioritized so that those with the greatest need and those who will most benefit from care are first in line. For example, people needing emergency care and children needing diagnostic and preventive care should take precedence over other underserved groups.
- Cost-effective allocation of limited government funds is essential. The relentless upward spiral of health care spending heightens the fierce competition among policy priorities for public dollars. With very limited government resources, children, pregnant women, the vulnerable elderly, and individuals with special needs should also be covered. Limited government resources should allow for additional routine dental care coverage for all underserved populations as well as diagnostic and preventive for adults. With sufficient funding, complex or comprehensive care should also be covered.
- The government must fund public health benefit programs adequately. Programs such as Medicaid and the State Children's Health Insurance Program (SCHIP) must ensure that vulnerable children and adults with inadequate resources have access to essential oral health care. Programs such as Medicaid must cover dental benefits for adults. Children in low-income families who are not eligible for Medicaid must have access to essential oral healthcare through SCHIP. Eligibility should reflect regional differences in the cost of living and purchasing power.

We Must Build on Current Successes

- Open markets ensure competition and innovation. The dental private practice delivery system, which operates almost entirely separate from its medical counterpart, serves the vast majority of Americans well. While a fully functional public health infrastructure is essential, efforts to broaden access to care for people who currently are underserved would be best accomplished by bringing more people into the private practice system.
- Private dental benefits work. Independent companies selected in an open market should administer benefits. Experience in other countries has

Straight From The Members

“When looking at starting my practice I wish I had...”

“...opened my doors in a rural setting!”

- Kesa McConnell
Oklahoma City

“...done more observation at successful offices and their systems for patient flow and insurance, then incorporated pieces of each to customize what works for us best, instead of ending up there by trial and error!”

- Chris Bugg
Cushing

“...allotted for more storage space. But more importantly, I wish I had built separate thermostats for the business and clinical parts. We are always “freezing out” the team members in the front.”

- Thai-An Doan
Oklahoma City

shown that a single-payer system would stifle access, innovation, and reduce the quality of patient care.

- *Universal dental coverage mandates will not solve the access to care problem. Developing federal and state government programs that address not only funding but also non-economic barriers to care are necessary. The great majority of Americans already have access to dental care and millions can afford care without having dental benefits. The government can use tax policy to encourage small employers and individuals to purchase dental benefit plans in the private sector or develop cooperative-purchasing alliances for the segment of the population with privately funded care.*
- *Fostering the next generation of dentists must be a priority. Having a sufficient number of dentists to provide care to all who require it depends upon many critical factors, including sufficient government support of dental higher education, overcoming current faculty shortages, providing affordable student loan programs, advanced public health training and ensuring the financial viability of dental practices.*
- *Patients must receive care from a properly educated and trained oral health workforce. The U.S. dental delivery system owes much of its success to the team model, which includes dental hygienists and assistants working under the supervision of a licensed dentist. While many underserved communities might benefit from the addition of specially trained and culturally prepared dental support personnel, appropriate education, training, and dental supervision are essential to ensure quality dental care.*

The ADA and the ODA have come a long way in working toward the betterment of healthcare for all. One of the fundamental tenets of our profession is to advance the art and science of dentistry for all people everywhere. The task force is adhering to this tenet and will help insure that we continue to advance healthcare now and for years into the future.

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Removing the “Shield” that Minimizes New Patient Flow

By Dr. Richard Madow and Dr. David Madow

New patients are the lifeblood of dental offices. Successfully handling the initial phone call from potential new patients is critical to establishing these important relationships. Patients calling your practice for the first time may be dealing with numerous obstacles that are unknown to you. They may be fearful, or think the treatment will be too expensive, or perhaps they had a negative experience at another practice. It is your goal to put the patient at ease and address their concerns. Unfortunately, many practices put up an imaginary “shield” that prevents the patient from ever scheduling or keeping that first appointment.

How the “Shield” works

A “shield” is an unnecessary barrier or obstacle that causes practices to lose potential patients. Here are some examples of how a “shield” is used during a potential new patient call:

- Being inflexible in screening new patients. A potential patient calls and asks, “How much do you charge for a cleaning?” The dental team will not provide a quote over the phone, and instead, insists he/she come in for an exam and x-rays first. The potential patient only wants a cleaning, so the call is released. No appointment was made, the new patient is lost.
- Putting the caller on hold. The dental team is very busy. A potential new patient calls the office and is immediately placed on hold without

- an on-hold message, so they simply hang up. No appointment was made, the new patient is lost.
- Pre-judging a patient by his/her insurance. If the first (or second) question asked is the type of insurance the potential patient has, the patient might think the only thing the office cares about is being paid, rather than expert dental care. Or the potential patient might not have insurance or an insurance plan that is accepted by the practice, and gets embarrassed for having to admit this. No appointment is made, the new patient is lost.



Overcoming the “Shield” with the ALASKA System

In each of these situations, as during most telephone calls, there is a certain flow to the conversation. Correctly responding to that flow and using the appropriate communication techniques are important to handling the call successfully. We created the ALASKA System to teach dental

teams how to properly communicate with callers, helping to secure the maximum number of new patient appointments.

- A – Answer the phone quickly and correctly, and don’t immediately put callers on hold.
 - Answer within two rings. If the phone is ringing more than twice, it’s time to add another person to the front office team.
 - Try to answer the phone with: “Dr. Jones’ office, this is Linda speaking. I can help you.” Identify the office, give your name, and say that you can help them. This projects confidence.


- L – Listen to what the caller is saying.
 - Don't judge or predetermine need or try to quickly get off the phone so you can get back to more "important" tasks. Listen and respond to the person's needs.
- A – Analyze what they are saying to uncover hidden barriers or concerns.
 - Do they want an appointment but are fearful of pain? Are they concerned about the cost?
- S – Solve their problem-- this is your chance to shine.
 - If they call you with a problem, "I need a new dentist." – Help them set the first appointment.
 - If they call with a concern, "My last dentist said I need a lot of expensive work, but I don't have a lot of money." – Explain how your practice makes treatment more affordable by offering a no-interest payment program like CareCredit, and explain how it works.
- K – Kindness, say something nice to the caller
 - Assure them they've made the right decision, "You're going to love Dr. Jones. He is so gentle!" Treat them like a friend. Be nice and kind first, then professional and businesslike.
- A – Action, take action by asking them when they'd like to come in.
 - Offer several choices for appointment times and dates that are available, "Would you like to come

in today at 2:30? Or on Thursday at 1:00?" – Seize the opportunity to appoint the patient whether he/she has asked for an appointment or not.

Remember, when a potential patient calls, the dental office's main goal is to secure an appointment. Properly Answering, Listening, Analyzing, and Solving their problem will help that person feel important. Treating them with Kindness and taking Action by setting up their appointment will reinforce to them that they've made the right decision by calling you. Using the ALASKA System is a great way to help your patients feel good about their experience, and look forward to their first appointment.

Author Bio:

Drs. Richard and David Madow founded The Madow Group in 1989, an education and marketing company dedicated to helping dentists and their teams become more successful in their practices. They are internationally recognized by dental teams for their exciting seminars such as "How to Love Dentistry, Have Fun, and Get Rich," "TBSE (The Best Seminar Ever)", and "How to Love Dentistry, Have Fun, and Get Rich—Even More." The Madow Group can be contacted at 1-888-88-MADOW or www.madow.com.




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