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Dr. Ravi Nanda: Yes, Pat, I have noticed a keen interest in biomechanics by the orthodontic specialty in recent years. We are more and more curious about how our appliances work and what we can do to improve them. The specialty is moving away from technique-oriented approaches that treat, for example, all Class II, division 1 patients with wire “X” and extraction cases with wire “Y.” Now we want to know the “guts” of a wire, loop or a spring, such as magnitude, moments, constancy, direction of force, as well as side effects and methods to prevent and reduce them.

I have always said that we orthodontists...
often spend half our time treating patients' problems and the other half correcting the problems we create, often due to inadequate mechanics. Such examples include loss of anchorage and faulty root inclination of incisors and posteriors. If we apply sound mechanics, side effects can be minimized, treatment time shortened, and chair time saved, not to mention the benefits of peace of mind.

Since Edward Angle invented the edge-wise appliance, there have been few, if any, revolutionary advances in mechano-therapy. Most of our progress has been made through improvements in and variations on bracket design and the clinical application of new wire alloys. Yet, 100 years later, we are still vexed by the same problems as our forefathers. Anchorage control, predictable and precise results, stability and compliance are still confounding difficulties in orthodontics. Many clinicians have offered solutions by making refinements in the appliance itself. The tremendous number of bracket prescriptions and orthodontic techniques advocated by the leaders in this field are evidence of our focus on the appliance. Perhaps the problems are not in the appliance, but in our analysis of its use. Incorporating biomechanical concepts into everyday patient care may be where we are headed and the source of the next generation of clinical advances.

Dr. Turley: A lot of clinicians find biomechanics difficult and too theoretical. Why?

Dr. Nanda: This has had a lot to do with us – educators, researchers and orthodontists active in the area of biomechanics. We did not describe principles and appliances in a user-friendly way. The terminology associated with learning biomechanics probably has limited the clinician's understanding. Sometimes simple ideas seem complex because of the language and terms used. Another problem is the quantitative nature of the field: the mathematics used to demonstrate the concepts often seems to intimidate the learner. But for the most part, the mathematics is simply based on high-school level geometry. The more exotic analysis, such as finite element analysis, are used more in the engineering of appliances than in clinical practice. This is changing fast.

One should remember that biomechanics is not a technique. It is applicable to all the orthodontic techniques – any wire, spring or loop which delivers a force when ligated into the brackets. So a basic understanding of biomechanics is essential for all orthodontists in order to understand what forces we are applying and what sequelae to expect. We would not expect our internist to prescribe a drug without telling us the dosage, the frequency and the duration of intake. In orthodontics, we apply a force on teeth with only a minimal idea of that force, its moments or its side effects. So the first order of business for all orthodontists should be to take a step back and try to understand from the standpoint of biomechanics what is working and what is not working and how to fix it.

With an understanding of biomechanics, we'll find that simple loops, cantilevers and a small bend at the right place in the wire are all that is necessary to improve our favorite technique. Simple, sound principles of biomechanics can be applied to any technique.

Dr. Turley: Why isn't biomechanics a bigger part of all orthodontists' training?
Dr. Nanda: A good question, Pat. Our basic problem in this area has been a huge gap between the classroom and clinical practice. The students are taught all the details of forces, moments and couples, but in the clinic, there is little application of biomechanics. Many clinical approaches follow specific wire sequences or are taught as if there are “magical” properties incorporated into the bracket. The student becomes more concerned with the technical aspects of care and forgets about how the appliance is working. There is good news, however. Orthodontic departments are spending more time in educating their students about biomechanics, and several schools are moving away from technique-based approaches to orthodontics.

I must add that we at the University of Connecticut have contributed significantly by providing educators in various programs who can link biomechanics to clinical practice. Out of our 100+ graduates in the last 25 years, 20 are in full-time teaching, 20 are in part-time teaching, and four are department heads.

Dr. Turley: What are some examples of biomechanically oriented appliances?

Dr. Nanda: The best example is the intrusion arch. Although the name implies that it only intrudes, it can simultaneously correct Class II molar relationships, especially in adolescents. The same wire with a simple variation can close anterior spaces, flare incisors, correct occlusal planes or, if ligated upside down, extrude anterior teeth. On top of that, you know how much force you are using, what moments you are generating and what measures you have to use if you do not like the side effects. And this appliance can be used with any treatment approach. Actually, all appliances are biomechanically oriented; we just do not look at them that way.

As several chapters in our book *Biomechanics in Clinical Orthodontics* reveal, only three to four types of wire designs accomplish almost all types of tooth movements. A given wire may look the same from the standpoint of its shape in the mouth, but a different placement of a bend or loop would deliver a completely different type of tooth movement.

Dr. Turley: What are the advantages of using biomechanically oriented appliances?

Dr. Nanda: The #1 advantage is that you can go from point A to point B in a straight line. Let’s take a look at an example. In extraction patients with biomechanically oriented space closure, you can retract all six anterior teeth into the extraction site with minimal anchorage loss, excellent root alignment of the posterior teeth and ideal axial inclinations of the incisors. On top of that, you only have to activate the appliance once during treatment. The maximum force you need for space closure ranges from 300 to 350 grams, and you lose only 25 to 30 grams of force with each millimeter of tooth movement. Compare this with sliding mechanics: There you have unknown force values, continual elastic changes, uneven forces due to fast drop-off in force, force reactivation each time – I can go on and on.

Applying the principles of mechanics to appliance design and selection increases creativity and innovation in solving our patients’ problems. How many times have we faced the perplexing problem of one of our patients not responding well to treatment? When we are dependent on “cookbook” techniques, these problems may never be solved. With careful analysis from a biomechanical perspective, unique solutions may be found.

In a nutshell, biomechanics allows you to design an appliance that will give you a predictable tooth response without guess-work.

Dr. Turley: Why should an orthodontist care about the specifics of forces and moments if a particular technique is clinically successful from an empirical perspective?

Dr. Nanda: Orthodontists should care about specifics of forces and moments. Orthodontics is little different, let’s say, from driving a car and knowing the mechanics of an automobile. In our specialty, we deliver the forces, so it becomes imperative that we must know what we are doing.

I concede that 60 to 70 percent of the adolescent patients in our practices probably do not need specialized mechanics. The problem comes with patients who have complex problems such as open bites, deep overbites, midline discrepancies, asymmetric molar occlusion, moderate to severe crowding, critical anchorage, crossbites, etc. A simple straight wire and chain elastics are not going to solve these problems. These patients need a comprehensive treatment plan with a mechanics plan to achieve results. Use of biomechanically oriented appliances in these patients will help achieve tooth movement compatible with soft tissues, facial bones and jaw function. Let’s face it. No one has perfect results every time. We love to show off our successes, but it’s when we come up short that we lose sleep. When problems arise, for instance, when our tried-and-true approaches are failing, we must develop alternatives. Understanding biomechanics and applying these principles aid our problem solving.

Dr. Turley: What are some examples of commonly held beliefs in clinical orthodontics that make little sense from a biomechanical perspective?

Dr. Nanda: Simple examples would be the use of straight wires, step-ups and step-downs or reverse curve of Spee wires to correct deep bites. You often hear orthodontists say that they have intruded the incisors to correct the deep bite. Actually, all these wires correct the deep bite by extruding the posterior teeth and/or flaring the incisors. These approaches may result in bite opening, but predictable intrusive tooth movement may or may not occur. Unless you use specific intrusive mechanics, it is difficult
to achieve intrusion.

A straight wire or a flat wire placed in a crowded arch or one with a deep curve of Spee will invariably level the teeth by the process of extrusion and flaring. This has serious implications for a patient with a long face, a large interlabial gap and gummy smile. The straight wire will align teeth very well, but it will increase vertical dimension problems. This brings me back to your earlier question as to what is "clinically successful."

Another example is the description orthodontists use for incisor torque. A hundred years ago, torque was described in degrees. Now, we have been to the moon and are moving on to the next millennium, and we still describe incisor root movement in degrees. Degrees is not the way to describe force magnitude. A twist in a rectangular wire can deliver significant stress at the apex, but we still use it without any idea of magnitude of force and moments.

Finally, all techniques are limited by Newton's laws of motion, perhaps the most important being that for every action there is an equal and opposite reaction. This means for every distal force, there must be a "balancing" mesial force, or vice versa. Many times tooth movements are described without regard for the reactive forces. Distalization of molars with intraoral anchorage may often produce a reactive mesial movement of the anchorage teeth. In other words, there are no free lunches, the laws of physics apply to all our techniques.

Dr. Turley: In the book you recently edited, Biomechanics in Clinical Orthodontics, Class II treatment receives a lot of attention. Why?

Dr. Nanda: We had a symposium in Connecticut in 1993 on the correction of Class II malocclusions and another in 1995 on biomechanics. I invited speakers from the two symposiums to contribute chapters for this book. Leaders in the field of biomechanics and orthodontics such as Drs. Bantleon, Burstone, Dermant, Gianelly, Graber, Kuhlberg, Kusy, Lindauer, Melsen, Mulligan, Ram Nanda, Fancherz, Pearson, Shroff and Statkowksi have all contributed excellent chapters to this book. The emphasis of the book is on Class II, division 1 treatment as it relates to biomechanics. However, the principles described in the book are applicable to every aspect of clinical orthodontics. We have deep bite, anchorage problems, extraction and nonextraction mechanics, etc., in all types of malocclusions. Overall, emphasis of various chapters has been to correct specific problems, rather than to describe a malocclusion on the basis of the molar occlusion.

Dr. Turley: Can these principles be applied to Class III treatment?

Dr. Nanda: Yes, Pat, you can apply the very same principles. As you and I have been active in improving methodologies to correct skeletal Class III in grow-

Illustrations from Biomechanics in Clinical Orthodontics courtesy of W.B. Saunders Company
by Michael W. Scott, D.D.S., M.S.D.
Longview, Texas

In a previous issue of Clinical Impressions, I stated the list of my personal practice goals. That list of goals has remained one of the foundations of my practice for years and consists of:

• Producing consistent, predictable, high-quality orthodontic results
• Practicing with great efficiency
• Starting all the cases I care to start
• Making a reasonable profit
• Having fun

It is with the first two goals in mind that I would like to present an orthodontic problem that, at least for me, poses a treatment planning dilemma virtually every time it is encountered.

An eight-year-old patient is referred to your office by her general dentist. The patient's dentist is concerned that the maxillary permanent lateral incisors have not erupted and wants your evaluation. You take a panoramic radiograph and discover that the laterals are congenitally missing. In addition, the primary lateral incisors show significant root resorption, even though there are no succeeding permanent teeth. As you begin your explanation to the parents that “the patient is missing her maxillary lateral incisors,” before the word missing is completely off your lips, the question is posed by the parents, “What are you going to do, Doctor?”

The answer to the question, of course, depends on myriad factors. In some cases, the missing teeth are ultimately replaced by a removable partial denture, a fixed bridge or an implant. In other cases, it is best to close the spaces by orthodontically moving the teeth.

The latter situation will be the focus of this article:

• A patient presents with missing maxillary permanent lateral incisors.
• The primary lateral incisors are either missing or will be extracted due to root resorption or other considerations.
• After all factors are considered, a decision is made to close the spaces by moving the permanent cuspids, bicusps and molars mesially.
• The cuspids will be cosmetically bonded after orthodontic treatment.

The numerous factors involved in the diagnosis and treatment planning are not the subject of this article. How one arrived at the decision to close the spaces is immaterial to this paper.

When tooth movement is the elected procedure, there are several ways to approach it. I will describe a method that I feel greatly increases my ability to achieve the goals of consistency, predictability, quality and efficiency. My experience has been that mesial movement of the cuspids, bicusps and molars can be a very time-consuming, unpredictable and inefficient process. A solution to this problem came and bit me on my backside several years ago when, by chance, one of my facemask patients was seated next to a patient with missing maxillary lateral incisors. (You know where this is going,

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don’t you?) To make a long story short, I began to use the A.D. Protraction Facemask™ in many cases where the treatment plan called for closing spaces.

The orthodontic application of orthopedic force systems is not a new idea. One example is the use of headgear to distalize maxillary molars. I can think of much better ways to accomplish that, i.e., Lokar™ Molar Distalizers, but that is what is often proposed.

Clinical Case Presentation
Patient S.A. The patient presented to my office in March 1989. At that time she was 7 years, 6 months of age. Summer was referred by her pediatric dentist for the evaluation and treatment of missing maxillary lateral incisors. Her mother was also concerned about a large diastema between Summer’s maxillary central incisors. Pretreatment facial and intraoral photographs are seen in Figures 1-5. The pretreatment panoramic radiograph is shown in Figure 6. A summary of significant findings from diagnostic records revealed:

• Balanced facial appearance in both frontal and profile views.
• End-on Class II molar relationship.
• Overjet of 4 mm.
• Missing maxillary permanent lateral incisors.
• Mild mandibular crowding.
• Maxillary and mandibular mid-
lines were coincidental.
- Skeletal Class II. ANB = 6°,
  NA - APo = 9°.
- Maxillary midline diastema.
- Roots of the maxillary primary lateral
  incisors were resorbing.

The principle concern was the long-
term management of the missing lateral
incisors. Summer and her mother were
both very hesitant about placing implants
or bridgework in her mouth. Secondary
concerns were the crowding of the
mandibular anterior teeth and the maxil-
lary midline diastema.

The diagnostic data, along with the
concerns of the patient and parent, led to
the decision to close the lateral incisor
spaces over the course of time. A phase of
early treatment would be undertaken to
address the mandibular crowding and
the maxillary midline diastema. Phase 1
treatment consisted of the following:
- Maxillary 2 x 2 to close the diastema
  and align the central incisors
cosmetically.
- Lip bumper to relieve the mild
  mandibular crowding.
- Mandibular lingual arch after lip
  bumper.
- Selective extraction of primary teeth
  over time.
- Bonded lingual retainer for upper
  1-1 posttreatment.
- The skeletal Class II and overjet were not
  addressed in Phase 1. No headgear
  was used because of the decision to
  move the maxillary posterior teeth
  mesially as time passed.

Phase 1 treatment was initiated in May
1989 and completed in May 1990.
Summer was then seen every four months
to monitor the integrity of her lingual
arch. The lingual arch was removed in
July 1991, upon the eruption of the
mandibular cuspids.

Facial and intraoral photos taken in
October 1991 are seen in Figures 7-11.
A progress panoramic radiograph taken at
the same time is shown in Figure 12. Note

The panoramic radiograph taken January
1994 is seen in Figure 13.

The Phase 2 treatment plan was as
follows:
- Band/bond the maxillary arch.
- Bond the maxillary cuspid brackets in a
  position slightly more distal than
  normal to help rotate the teeth into
  more favorable positions for future
  cosmetic bonding.
- Bond the maxillary cuspid brackets
  upside down (Figure 14) to produce
  more favorable lingual root torque,
  because these teeth would ultimately
  be made to resemble laterals.
- On an .016 S.S. upper archwire, use
  sliding hooks distal to the cuspids and
  begin elastic traction from the sliding
  hooks to a facemask (Figure 15).
- Once the cusps are forward, position
  the hooks distal to the 2nd bicuspids
  and slide both the 1st and 2nd bicus-
  pids mesially at one time (Figure 16).
- The .016 S.S. archwire would be
  constructed with omega loops and be
  tied back to the 1st molars.
- Band/bond mandibular arch soon after
  facemask started.
- Class III elastics if needed.
- Cosmetic bonding of the maxillary
  cuspid posttreatment.

Cuspid brackets as opposed to lateral
brackets were used on the cusps simply
because of the better fit.

Summer was instructed to wear her face-
mask 12 hours per day. Ormco Ram (1/4
inch, 6 oz.) or Impala (3/16 inch, 6 oz.)
elastics were used for traction, one on
each side. The facemask was adapted to
the patient exactly as it would be used in
maxillary protraction. (Please refer to my
1, 1993, and Vol. 2, No. 4, 1993.) The
only exception is the direction of pull of
the elastics. Instead of pulling downward
continuing on page 11
Figures 7-12. Photographs and progress panoramic radiograph taken in October 1991. Evaluation led to the decision to remove upper B’s, C’s and D’s, after which patient was seen every 6 months for observation.

Figure 9.

Figure 13. Panoramic radiograph taken in January 1994.

Figures 14-16. Phase 2 treatment plan included:

Figure 14. Maxillary cuspid brackets bonded upside down to produce more favorable lingual root torque. Note that the “dot” (usually positioned distally and gingivally) is positioned mesially and occlusally.

Figure 15. Sliding hooks distal to cuspids used for elastic traction to facemask.

Figure 16 (right). After cuspsids were moved forward, hooks were placed distal to 2nd bicuspid to slide both 1st and 2nd bicuspid mesially at one time.


at a 45° angle, as in maxillary protraction, the direction of pull should follow the plane of occlusion.

Once the maxillary cuspids and bicuspids were forward, the maxillary 1st molars had to be moved. This was accomplished by wearing Class III elastics (Ormco Ram) from an .016 x .025 S.S. mandibular archwire to an .016 S.S. maxillary archwire without omega loops. The maxillary 2nd molars were not banded and followed very nicely.

Progress intraoral photographs taken 20 months into treatment are shown in Figures 17-19. Note the buttons placed on the lingual of the upper 2nd bicuspids. These were used along with power chain to maintain rotational control of the bicuspids as they were moved mesially.

Treatment proceeded well with the exception of six missed or canceled appointments over the course of treatment. Three of the missed appointments occurred in the first year of treatment and accounted for 25 weeks of excess time between visits. That might not be that critical in today’s world of 35°C Copper Ni-Ti™ archwires. However, when you are in the 1994 world of braided D-Rect®, it makes a huge difference! The other three missed appointments accounted for nine weeks of excess time between visits.

Summer’s treatment summary is as follows:

- Total treatment time = 29 months.
- Total number of visits to complete treatment = 19.
- Total time wearing facemask = 5 months.
- Total time wearing Class III elastics = 4 months.

Due to the explosion in archwire technology, the archwire sequence I used is not relevant. It is amazing how much has changed in less than three years. Intraoral photographs taken posttreatment are shown in Figures 20-22. These photographs were taken prior to cosmetic bonding. Final facial and intraoral photographs taken after cosmetic bonding are shown in Figures 23-27.

Conclusion

As can be seen in the previous clinical example, the use of the A.D. Protraction Facemask as an orthodontic force delivery system can be a valuable tool in specific situations such as the one described. In considering how the use of this force system has impacted my practice goals, I have reached several conclusions. The results that can be expected from the use of this force system are predictable and consistent. The quality of the final result achieved in Summer’s case was greatly improved by the fact that she was spared the need for major posttreatment restorative work. I feel that I delivered extremely high-quality orthodontic care to a 12-year-old patient by providing her with the ability to go through life with an occlusion composed of all natural dentition. The use of the facemask helped to close a 10 mm space excess in the maxillary arch that would have otherwise posed significant mechanical challenges. This was also accomplished very efficiently in that the facemask was only worn for five months. This efficiency of mechanics resulted in the case being more profitable. Only 19 appointments were needed to complete treatment.

As you consider the treatment and results achieved in this case, I hope you will agree that the orthodontic application of orthopedic force systems truly adds more ammunition to your operatory!

The A.D. Protraction Facemask – Designed with Patient Compliance in Mind

The A.D. (Adjustable Dynamic) Protraction Facemask™ provides dynamic movement in the forehead rest while allowing the chin cup to slide vertically along the main frame. This means maximum patient comfort while sleeping, talking or any time the jaw is moving. Since the movement of the softly padded chin cup and forehead rest involves much less sliding contact with tissue, irritation is reduced and comfort is improved. Increased patient compliance equates to more efficient orthopedic and orthodontic therapy.

The A.D. Protraction Facemask is fully adjustable, so one size fits all patients. The horizontal arm for elastic hookup can also be positioned inside or outside the vertical bar to modify forces and vectors. In addition to the standard facemask design, a modification is now available for the Asian patient. The Asian Profile Protraction Facemask has a more flattened forehead rest, a flatter and broader chin cup and less curvature in the vertical bar profile. Some orthodontists prefer the new design for their non-Asian patients as well. Both types are available as a complete package containing a choice of blue or lavender masks, three chin and three forehead replacement pads and a hex key for adjustments. Order information is provided on page H of the Center Section.
A couple of years ago, Dr. Marvin Zatts, a dental consultant for The Prudential Insurance Company, and I made separate presentations to the Middle Atlantic Society of Orthodontists in Wilmington, Delaware. Later in the day, Dr. Zatts and I served on the same panel. At one point during the panel discussion, Dr. Zatts abruptly stopped defending all dental managed care plans and gave some advice to his audience. Dr. Zatts said, “The way for dentists to respond to bad managed care plans is simply not to sign up for them.” When I had a chance to respond, I observed that Dr. Zatts’ “don’t sign up” proclamation was one of the best arguments I had heard in defense of the Alabama Patient Choice Law (APCL).

In essence, the APCL allows individuals in managed care plans to seek care from any provider they choose, even if the provider is not under contract with the patient’s health plan. If the noncontract provider’s fees are higher than the contract allowance, then the patient, not the plan, is required to pay the difference. The contract payment allowance can be assigned by the patient to the noncontract provider.

How does Dr. Zatts’ “don’t sign up” advice substantiate the need for the APCL? Obviously, dentists have the option of not signing up for managed care plans that they feel are, in Dr. Zatts’ words, “bad plans.” But what about the patient who is an employee of company XYZ? Rarely are employees allowed any input into the selection of their company’s health plans. So what is the employee’s option if the company plan is a bad one? Without a law like the APCL, there is obviously no option. The dentist may elect to eschew “bad plans,” but the employee must acquiesce to the employer’s decision or pay for care out of his or her own pocket.

When the APCL legislation was being considered in 1994, lobbyists for Blue Cross and Blue Shield of Alabama (BCBSA) told legislators that the passage of the APCL would result in the demise of managed care in Alabama. Legislators did not buy BCBSA’s arguments, and the bill was eventually passed by an overwhelming majority of both the House and Senate and signed into law by then Governor Jim Folsom, Jr.

BCBSA’s next step was to file suit in Federal District Court seeking to have the APCL overturned. The BCBSA challenge to the APCL was assigned to Federal District Judge Seybourn Lynne. Due in part to some serious health problems that Judge Lynne experienced shortly after the lawsuit was filed, the Birmingham Federal Judge did not issue his ruling in the case until January of last year. The decision was in favor of BCBSA.

Although the defendants (seeking to uphold the APCL) in the suit immediately determined that Judge Lynne’s order would be appealed to the Eleventh Circuit, the formal filing of the appeal proved to be a legal marathon. It now appears that a three-judge panel of the Eleventh Circuit will hear oral arguments regarding the APCL in either spring or early summer of this year. In addition to the briefs already submitted to the Eleventh Circuit by the attorneys representing the defendants, both the American and New Jersey dental associations have submitted written arguments supporting the defendants’ position.

The case before the Eleventh Circuit involves a number of complex legal issues. In essence, however, the court will review two facets of Judge Lynne’s earlier decision: first, that ERISA (self-insured) plans are preempted or exempt from complying with the APCL and, second, that the APCL is not applicable to any BCBSA plans.

Wayne McMahan has been the executive director of the Alabama Dental Association for the past 17 years. Prior to his current position, he worked for eight years as the executive secretary to a former governor and lieutenant governor of the state of Alabama. Mr. McMahan is also currently serving as the president of the American Society of Constituent Dental Executives. He resides in Montgomery, Alabama, with his wife and two children.
Each staff member represents you and your practice in each and every interaction with a patient. With patient service being so inextricably tied to the perception of your clinical care, it seems curiously uncharacteristic of you (who fusses over tooth movement measured in fractions of millimeters) to leave critical communications to happenstance. One alternative is scripting.

Make Sure We’re All Reading from the Same Sheet of Music

Scripts are working documents, not meant to have everyone marching in lockstep, but flexible models that provide key words and, more importantly, key philosophies about how to deliver specific messages or answer critical questions. Like mission statements, much of the value in developing scripts is the discussion that goes into them. Such discussion encourages buy-in from your staff. It also helps them internalize your philosophies by getting a clear understanding of the importance of key phrasings. With scripts, you and your staff will weave your individual brands of humor (“Retainers are pajamas for your teeth”) and your chairside charm (“So, Christy [age 12],... continued on following page
Just Say It!
continued from page 13

did you come with your husband today?”) with proven patient relations techniques. When they become second nature, you can just say it and know that the wording you’ve shaped will support and clarify the message you purposely mean to deliver.

“Restating problems in terms of challenges and opportunities with a solution approach encourages partnership in care.”

Your Relationship is Showing
There are at least two aspects to every communication: the content and the relationship. The relationship between people colors every aspect of the content. It’s why a good friend can say something rude and you chalk it up to a bad day. It’s why a person whom you distrust can give you a compliment and you wonder what they want. We often convey how we feel about someone through how we look at others. We find it easier to communicate with people who are on our side. The relationship between our philosophies and our language before the conversation needs to escalate.

No Buts About It
Ever been given a compliment only to have it taken away in the same breath? “Hey, Doc, nice job, but that space between these two back teeth always collects food.” What message did you hear? Certainly not the compliment.

A staff member is doing a particularly good job in one area. We’d like the approach modified for a particular aspect of the job, so we say something like this: “Cindy, I like the way you’re giving the tour, but I wish you’d give more emphasis to the sterilization area.” What does the staff member hear? Certainly not the compliment. She hears nothing except what is said after the but.

Why do we sandwich a but between a compliment and a criticism? Who knows? (Maybe we picked up the idea from Blanchard’s One Minute Manager.) It’s a skill. We learned it. We can unlearn it. If you truly want to compliment an individual, do so without the but. If the compliment is a well deserved one about important accomplishments and the constructive criticism is a trifling thing, you end up sounding picky. If someone is doing a good job in one area except for certain aspects, build on successes to change behavior in another way.

Compare: “David, you’re doing a great job wearing your elastics. That means you might get your braces off sooner. You’re missing a lot of areas between the brackets and your gums.” With: “David, you’re doing a great job wearing your elastics. It means you might get your braces off sooner. Won’t that be super? Being a World Class Elastics Wearer, I know you can handle brushing with braces – getting between the brackets and the gums. Let’s have Jenny give you some tips on becoming a World Class Tooth Brusher, too.”

Jenny then follows up the discussion with: “You know, David, if you’ve got elastics down pat, you’ve done the really hard part. Now you can focus on a couple of tricky areas that your toothbrush seems to miss. Easy stuff for the Master of Elastics.”

Compare: “Jenny, you’ve really impressed me with having picked up so many essential chairside assisting skills in the short time you’ve been here, but I’d like to see more detail in your treatment cards.” With: “Jenny, you’ve really impressed me with having picked up so many essential chairside assisting skills in the short time you’ve been here. Way to go! You know what I’d like your next challenge to be? Detail with treatment cards. Let me get Marcy to review with you what’s expected and why, so that by this time next week, you’ll have mastered that as well.” Not only have we built on Jenny’s successes to challenge her to the next level, we’ve also made our language more specific, making our expectations clear with a goal and a time frame.

Note: If you have a persistent performance issue, keep the message clean. Mixing messages about substandard performance with a compliment is misleading and unfair to your staff.

Patient Focus Starts with You
When you deliver a message from the perspective of listeners (e.g., McDonald’s slogan, “You deserve a break today”), you help yourself see things from their vantage point. You will more likely, then, deliver the message with a patient-centered or staff-centered focus, reinforcing the emphasis on meeting their needs. Introductory patient letters and
brochures, for example, are peppered with *we, our, I and my staff and I* (e.g., “We are pleased to have the opportunity to explain the benefits of orthodontics,” or “We appreciate the trust you have shown by selecting us to help with your orthodontic needs.”). Anytime you can replace these pronouns with *you*, do so (e.g., “Your initial visit is a time for us to get to know you and what you want to accomplish,” or “Your decision to take advantage of the benefits of orthodontics is an investment in your child’s future.”). The *you* perspective helps focus on the patient’s needs and can often keep you from speaking platitudes. Work the *you* perspective into your case presentation verbiage. It’s a good way to differentiate yourself. And it’s a theme that works with staff, too.

Note: Want to try an interesting exercise? Have everyone refrain from using the words *I* or *we* for ten minutes at your next staff meeting. It provides insight into the paradigm within which we all operate.

**Pose Problems as Challenges to Focus on Solutions**

Problems point out what’s wrong. Challenges position issues in terms of what can be done. Restating problems in terms of challenges and opportunities with a solution approach encourages partnership in care.

*Compare:* “Mrs. Jacobs, I’ve got a problem with David’s poor elastic wear. He’s not progressing as quickly as he should, and I know he’s going to be frustrated if we can’t take his braces off when we originally planned. He just needs to understand how critical wearing his elastics is to his progress.” Here the doctor owns the problem, is focused on attitude (understand) rather than behavior and has expended considerable breath without yet being directed toward a solution. *With:* “Mrs. Jacobs, we’ve got a challenge to help David improve his elastic wear so he’ll be able to get his braces off when planned. David mentioned that he forgets to put his rubber bands back on after lunch. Is there some way we can help him remember – maybe by packing these Ormco Z-pak elastics in his lunch box? Or maybe he could wear his elastics on his little finger while he’s eating? Think either of these ideas could help? Or maybe you have another suggestion?” Now the discussion is oriented away from the problem and toward the challenge of finding possible solutions, focused on behavior rather than attitude and on shared ownership of the challenge.

**What’s in It for Me?**

Translating features into benefits. It’s a primary tenet of every case presentation and marketing course given. If the patient is still asking “So what?” after you’ve bragged about some aspect of your practice, you may still be focusing on a feature, assuming that your patients can translate features into benefits on their own. Don’t leave this to chance.

Feature: “We use the most advanced wire technology available.”

Benefit: “Because we use the most advanced wire technology on the market today, appointment times can often be scheduled eight to ten weeks apart rather than monthly as we did only a couple of years ago. This means less time away from school for Kristin and from work for you. And then there’s the comfort. These new wires move with so little force to do the same job as traditional stainless steel wires that Kristin should be quite comfortable throughout treatment.”

**How You Get Started**

Psychologists tell us that it takes 21 days to develop a new skill. If changing your team’s language is something you consider worthwhile, work in increments. Choose one script or one general language change on which to work. Concentrate on that change for three weeks or until you feel comfortable with it, then move on to another change. Make a game of it. Every time someone works creatively to eliminate an unnecessary *but,* ante up $1 for pizza.

**Scripts: Ten Easy Steps to Power Talk**

1. Brainstorm to identify every situation where communications are critical (e.g., recurring patient “compliance” discussions, your most unpopular policies, situations in which you know you tend to preach rather than partner).
2. Prioritize the top three.
3. Brainstorm all the ideas you already use (not judging them at this point).
4. Develop one or two scripts for each situation.
5. Check your phrasing against the do’s and don’ts listed here, using other techniques you know work well.
6. Rephrase where appropriate.
7. Role play using the script, putting the expressions into your own manner of speaking, adding humor.
8. Incorporate one script every three to four weeks.
9. Share results and alter where necessary.
10. Choose the next three priorities and repeat the process.

**Just Say It!** is a course offered through Ormco’s 1997 Practice Development Seminar Series that Ms. Brunner will conduct in Minneapolis, Minnesota, June 20, 1997, and Vancouver, British Columbia, August 29, 1997. For more information about this course, contact your local Ormco representative or an Ormco customer service representative at (800) 854-1741, Ext. 7001.

**Tact is the Language of Strength**

Almost every time we open our mouths to speak, we are attempting to influence another human being. These language skills are centered around tact. Tact is the language of strength. Exhibiting tact requires that you continually monitor what you are about to say, given your listener’s perspective and your relationship with that listener. It’s the art of making a point without making an enemy. As Zig Ziglar aptly puts it, “It’s difficult to offend people and influence them at the same time.”
Developing and Implementing an Effective Marketing Plan for Your Practice

by Jerry R. Clark, D.D.S., M.S.
Greensboro, North Carolina

In the previous article*, we discussed the importance of getting all your practice’s systems in place prior to initiating the development of a marketing plan. This process is essential to providing such a wonderful experience for your patients that they will want to tell everyone they know about your practice. Only after all the appropriate systems have been established is it time to aggressively market the practice, to develop a strategy to increase the number of individuals who will demand your service. The plan, which will be outlined, is similar to the sophisticated marketing plans used by major corporations like McDonald’s. You, too, can attract more customers just like they do and do it in a manner consistent with the highest levels of ethics and professionalism. There are three basic steps in developing the actual marketing plan:

• Positioning
Positioning (differentiation) involves the analysis of the determining factors, or as they are called in the marketing field, “influencing conditions,” which cause consumers to choose one product or service over another.

• Development
Development of the marketing plan involves using those influencing conditions to develop goals and strategies to reach and attract patients through the use of specific internal and external marketing efforts.

• Implementation
Implementation of the plan involves the establishment of a marketing calendar and a budget for the marketing efforts. Staff members and the doctor are assigned specific responsibilities to make sure the marketing strategies are carried out as planned.

Positioning (Differentiation)
The decision of a consumer to choose one product or service over another is a complicated issue. However, that process or those influencing conditions can be analyzed by using statistical research to provide the doctor a much better grasp of why people might choose his or her practice. This involves:

• Practice Analysis
• Geographic Analysis
• Competitive Environment Evaluation

From this analysis, conclusions are drawn and strategies developed to maximize the effectiveness of the plan and to allow the plan to be implemented in a cost effective manner. We will illustrate this process by developing an actual plan compiled for a practice by Orthodontic Management Group to show how the information gathered is used to mold and develop the plan. To be effective, accurate statistical data must be obtained and appropriate market research must be performed. The eventual marketing plan will be no better than the research information obtained, so take the time to do your research carefully, otherwise, you are probably wasting your time.

Practice Analysis
Evaluate the practice by thoroughly analyzing all aspects of the practice and benchmarking the practice at one point in time. These include the following:

Statistical Analysis – Involves the tracking of meaningful information about the practice over a period of time to determine trends. See Figure 1 for an actual statistical analysis of a practice.

• New-Patient Growth – The number of new patients is growing nicely and indicates a positive trend.

• Seasonality – The practice reaches its peak season during June, July and August. People usually are not interested in spending money on orthodontics in December.

• Start Rate – There is a dramatic rise in patients getting ready to start treatment. This is an extremely favorable trend.

Conclusions: Continue to increase the

*See article by Dr. Jerry Clark, “Developing an Effective Marketing Plan for Your Practice,” Clinical Impressions, Vol. 6, No. 1, 1997
number of new patients by implementing a strong marketing plan. Do not concentrate on external marketing during the summer months or December. Investigate the new-patient exam and recall procedures and discuss any improvements which can be made.

Procedural – Based on the statistical information, many procedures which are already in place seem to be working well. However, some improvements can be made.

Conclusions: To improve current new-patient procedures:
• Make the new-patient “experience” more comprehensive and informative (minimum 30-minute exposure).
• Ask the new patient his or her primary concern and focus on it.
• Inform new patients of sterilization procedures.
• Give a thorough office tour before the new-patient exam.

To improve the consultation:
• Shorten consultation and make it more relevant to the patient.
• Begin the consultation by addressing the patient’s concerns.
• Use visuals – photographs, models, imaging.
• Provide the patient with a vision of completed treatment.

Image – What image does the practice present to potential patients? What is their perception of the office, doctor and staff members? How does the community view the practice? These are all assessed and evaluated.

Internal
• Physical facility – Has been completely remodeled and redecorated; grounds, parking lot and signage are very good.
• Staff appearance – Excellent, professional; projects warm, caring attitude.
• Office atmosphere – Excellent and professional, yet light, friendly, warm and caring.

External
• Correspondence – Excellent; all brochures, letters and correspondence are professional in appearance and comprehensive, yet brief; everything is coordinated and is highlighted by an attractive, professional, distinctive logo.
• Positive outside perceptions – Very positive, good treatment, competent, friendly staff, patients seen on time, a fun place for patients to be treated.
• Negative outside perceptions – Too expensive, doctor is often out of the office, doctor is perceived to be too tough on patients and parents for noncompliance.

Conclusions: Concentrate on changing the outside perceptions of the practice from negative to positive. Address each issue in a strategic manner.
• Too expensive – Convey to patients at the new-patient appointment that orthodontics is expensive. However, it is the responsibility of the practice to make sure that treatment is affordable and will be made so through flexible financial arrangements. Flexible arrangements should be provided only to those individuals who have demonstrated financial responsibility in the past, i.e., good credit rating. If the rating is good, provide sufficient options for payment to facilitate treatment acceptance.
• Doctor is often out of office – Doctor needs to inform staff of exact plans, and staff conveys to patients that the doctor is out of the office for legitimate reasons. Example – “Doctor is attending a continuing education seminar. He is constantly going to programs to allow him to keep abreast of all the latest developments in orthodontics.”
• Doctor is too tough on patients and parents for noncompliance – In the future, the doctor will only give positive feedback and leave it to the staff to discuss compliance issues. The staff will

Continued on following page
discuss hygiene and noncompliance with patients/parents and keep the doctor out of the “fray.” If treatment is being extended due to noncompliance, the treatment coordinator will discuss, well in advance, the potential for increased charges or early appliance removal before treatment completion.

Current Referral Status – See Figure 2 for an example of patient referrals to a practice. From this information, important conclusions can be drawn that will guide you in the formulation of the strategy for marketing to referring doctors.

<table>
<thead>
<tr>
<th>No. patients referred of total into practice referrals</th>
<th>Doctor referrals</th>
<th>Friend/family referrals</th>
<th>Previous orthodontist</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>174</td>
<td>47</td>
<td>128</td>
<td>35</td>
<td>14</td>
</tr>
<tr>
<td>15</td>
<td>4</td>
<td>15</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>53</td>
<td>53</td>
<td>53</td>
<td>53</td>
<td>53</td>
</tr>
</tbody>
</table>

One hundred thirty referrals came from 16 doctors while the other 35 doctors referred only 44 patients. Seventy-five percent of the doctor referrals came from approximately 30 percent of the doctors.

Conclusions: The referring doctors should be divided into two tiers.
• Tier 1: The 16 doctors providing the largest percentage of referrals. The practice should also choose five doctors not in the current Tier 1 level and concentrate on bringing them into Tier 1 over the next year. Market this group aggressively.
• Tier 2: The doctors who only occasionally refer to the practice. Should receive only minimal marketing efforts at little or no expense to the practice.

Current Patient Base –
• Adults, 33 percent
• Children, 67 percent
Practice should concentrate on fulfilling the wants and needs of both patient bases.

Adult
• Needs: orthodontic treatment, affordable treatment.
• Wants: constant information on what is
happening to them; communication on progress toward completion; encouragement; “don’t waste my time;” want to know you care.

Children
• Needs: orthodontic treatment.
• Wants: to have fun; “How much longer?” (information); encouragement (compliance).

Conclusions: Provide ongoing information and encouragement about treatment and treatment progress that does not back the doctor into a corner of promising the exact time treatment will be completed. Make sure children have fun every time they come in for an appointment.

Fees and Financial Arrangements –
Fees must be fair for both the patient and the doctor. The entire patient experience must be one of excellence, not just the treatment being performed. After all, aren’t the beds at Ritz-Carlton the same as the beds at Days Inn? The difference in what these two companies charge for a night’s stay has nothing to do with why you are staying there (the bed) but everything to do with the experience (customer service and quality of the facility).

Conclusions: Establish your fee structure according to the experience, not just the treatment. Financial arrangements must be made affordable for patients to accept treatment. Several specific payment options should be presented to allow the patient to choose the most suitable. An example of financial options can be found in Figure 3. The doctor must also determine the practice’s discount policy. Are any individuals offered treatment at reduced fees? Clergy? Physicians? Dentists? Staff? This policy must be established and discounts given only to those predetermined to be eligible.

Current Marketing Plan – Figure 4 illustrates a marketing plan previously used by a practice.

Conclusions: Many marketing approaches are currently being directed toward patients and referring doctors. Ensure they are organized in a fashion to produce maximum productivity and cost effectiveness. Omit some of the more expensive things such as T-shirts, water bottles and tooth erasers. Give away only coupons that can be obtained at no expense to the practice. A thorough and complete analysis of the practice is the most essential step in determining the final marketing plan. When diagnosing a case, your treatment can be no better than the quality of the diagnostic records and the research performed in devising a treatment plan. Similarly, your marketing plan will be no better than the initial research to devise that plan.

Geographic Analysis
The type of information shown in Figure 5 can be obtained from various information services such as your local chamber of commerce or a state department involved with census information. This will provide valuable information on how to target the age groups.

Conclusions: The natural demographics and economics indicate the population will not be growing. To increase the number of younger patients, the practice should provide information and education outside Office
• Visit patients in the hospital
• Annual advertising in school yearbooks
• Sponsor softball team
• Speaking engagements

Referring Doctors
• Luncheon meetings
• Golf tournament
• Thanksgiving letter
• Gifts at Christmas
• Conferences to discuss difficult multidisciplinary cases

Figure 4

For remainder of the ‘90s, all age cells under 30 will be decreasing while the 30-40 age group will be increasing as a percentage of the population.

Economic Analysis:
According to the chamber of commerce, there are no plans for any major business moves either in or out of the area.

Demographic Analysis – County Population % by Age

<table>
<thead>
<tr>
<th>Age</th>
<th>Current</th>
<th>Year 2000</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>6.29%</td>
<td>5.36%</td>
<td>down</td>
</tr>
<tr>
<td>5-9</td>
<td>7.01%</td>
<td>5.98%</td>
<td>down</td>
</tr>
<tr>
<td>10-14</td>
<td>6.55%</td>
<td>5.82%</td>
<td>down</td>
</tr>
<tr>
<td>15-19</td>
<td>6.80%</td>
<td>5.99%</td>
<td>down</td>
</tr>
<tr>
<td>20-24</td>
<td>7.18%</td>
<td>6.22%</td>
<td>down</td>
</tr>
<tr>
<td>25-29</td>
<td>6.82%</td>
<td>6.56%</td>
<td>down</td>
</tr>
<tr>
<td>30-34</td>
<td>7.12%</td>
<td>7.41%</td>
<td>up</td>
</tr>
<tr>
<td>35-39</td>
<td>7.90%</td>
<td>8.14%</td>
<td>up</td>
</tr>
</tbody>
</table>

Figure 5
Competitive Environment

There are currently 11 practicing orthodontists. The top four competitors are listed below along with their positive and negative perceptions in the marketplace.

<table>
<thead>
<tr>
<th>Competitors</th>
<th>Positive</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Dr. Galackowitz</td>
<td>Great doctor</td>
</tr>
<tr>
<td>2. Dr. J</td>
<td>Great staff</td>
</tr>
<tr>
<td>3. Dr. Jeckell</td>
<td>Excellent sterilization/high tech</td>
</tr>
<tr>
<td>4. Dr. Livingston</td>
<td>Lots of community involvement</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Galackowitz</td>
<td>Not flexible with payment plans</td>
</tr>
<tr>
<td>Dr. J</td>
<td>Long waits for appts., up to 20 mins.</td>
</tr>
<tr>
<td>Dr. Jeckell</td>
<td>Throws things and yells</td>
</tr>
<tr>
<td>Dr. Livingston</td>
<td>Lots of staff turnover</td>
</tr>
</tbody>
</table>

Future Marketing Plan

<table>
<thead>
<tr>
<th>Estimated Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescent Patients</td>
</tr>
<tr>
<td>Birthday cards</td>
</tr>
<tr>
<td>Contests</td>
</tr>
<tr>
<td>Skating party</td>
</tr>
<tr>
<td>Adult Patients</td>
</tr>
<tr>
<td>Birthday cards</td>
</tr>
<tr>
<td>Christmas party</td>
</tr>
<tr>
<td>Contests</td>
</tr>
<tr>
<td>Parents</td>
</tr>
<tr>
<td>Cookies</td>
</tr>
<tr>
<td>Carnations</td>
</tr>
<tr>
<td>Thanksgiving treats</td>
</tr>
<tr>
<td>Luncheon</td>
</tr>
<tr>
<td>Christmas gifts</td>
</tr>
<tr>
<td>Referring Doctors</td>
</tr>
<tr>
<td>Treats – cookies, fruit, pizza, candy, apples, etc.</td>
</tr>
<tr>
<td>Golf outing</td>
</tr>
<tr>
<td>Cruise on private boat</td>
</tr>
<tr>
<td>Birthday cards</td>
</tr>
<tr>
<td>Appreciation luncheon</td>
</tr>
<tr>
<td>Referring Staff</td>
</tr>
<tr>
<td>Treat same as above</td>
</tr>
<tr>
<td>Your Staff</td>
</tr>
<tr>
<td>Trip to AAO</td>
</tr>
<tr>
<td>Trip to dental society meeting</td>
</tr>
<tr>
<td>Trip to district orthodontic society meeting</td>
</tr>
<tr>
<td>Birthday lunches</td>
</tr>
<tr>
<td>Barbeque dinner</td>
</tr>
<tr>
<td>Appreciation dinner</td>
</tr>
<tr>
<td>Community</td>
</tr>
<tr>
<td>Special Olympics participation</td>
</tr>
<tr>
<td>Christmas gifts to families</td>
</tr>
</tbody>
</table>

TOTAL | $21,310

* $12,000 was budgeted; therefore, asterisked items were eliminated

Demographic Breakdown of Dental Community

<table>
<thead>
<tr>
<th>Age</th>
<th>&lt;35</th>
<th>35-44</th>
<th>45-54</th>
<th>55-64</th>
<th>65+</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP</td>
<td>22</td>
<td>46</td>
<td>21</td>
<td>33</td>
<td>9</td>
<td>131</td>
</tr>
<tr>
<td>(%)</td>
<td>17</td>
<td>35</td>
<td>16</td>
<td>25</td>
<td>7</td>
<td>100</td>
</tr>
<tr>
<td>Ortho</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>13</td>
</tr>
<tr>
<td>(%)</td>
<td>15</td>
<td>31</td>
<td>23</td>
<td>23</td>
<td>8</td>
<td>100</td>
</tr>
</tbody>
</table>

Figure 6: Competitive Environment

Figure 7: Demographic Breakdown of Dental Community

Figure 8: Future Marketing Plan
Marketing Calendar

<table>
<thead>
<tr>
<th>Month</th>
<th>Adolescent</th>
<th>Adult Parents</th>
<th>Referring Patients</th>
<th>Referring Doctors</th>
<th>Staffs</th>
<th>Community</th>
<th>Your Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan</td>
<td>Birthday cards throughout year</td>
<td>Birthday cards throughout year</td>
<td>Birthday cards throughout year</td>
<td>Birthday lunches all year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feb</td>
<td>Groundhog contest</td>
<td>Valentine cookies</td>
<td>Contest</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mar</td>
<td>Easter egg contest</td>
<td>Contest</td>
<td></td>
<td></td>
<td></td>
<td>Bowling lunch</td>
<td></td>
</tr>
<tr>
<td>Apr</td>
<td>Best mom contest</td>
<td>Contest</td>
<td></td>
<td></td>
<td></td>
<td>Appreciation lunch</td>
<td></td>
</tr>
<tr>
<td>May</td>
<td>Smile contest</td>
<td>Mother’s Day carnations</td>
<td>Contest</td>
<td></td>
<td></td>
<td>Participate in Special Olympics</td>
<td></td>
</tr>
<tr>
<td>Jun</td>
<td>Olympic contest of USA gold medals</td>
<td>Contest</td>
<td></td>
<td></td>
<td></td>
<td>Barbeque at doctor’s house for staff &amp; family</td>
<td></td>
</tr>
<tr>
<td>Jul</td>
<td>Trivia contest</td>
<td>Contest</td>
<td></td>
<td></td>
<td></td>
<td>Attend district ortho meeting</td>
<td></td>
</tr>
<tr>
<td>Aug</td>
<td>Trivia contest</td>
<td>Contest</td>
<td></td>
<td>Golf outing</td>
<td></td>
<td>Collect gifts for Christmas</td>
<td>Collect gifts for Christmas</td>
</tr>
<tr>
<td>Sep</td>
<td>Back to school skating party</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Appreciation night</td>
<td>Secret Santa gift exchange</td>
</tr>
<tr>
<td>Oct</td>
<td>Candy corn contest</td>
<td>Contest</td>
<td></td>
<td></td>
<td></td>
<td>Collect gifts for Christmas</td>
<td>Collect gifts for Christmas</td>
</tr>
<tr>
<td>Nov</td>
<td>Christmas contest</td>
<td>Thanksgiving treat</td>
<td>Contest</td>
<td>Thanksgiving letter</td>
<td>Deliver treats</td>
<td>Collect gifts for Christmas</td>
<td>Collect gifts for Christmas</td>
</tr>
<tr>
<td>Dec</td>
<td>Christmas contest</td>
<td>Christmas party</td>
<td>Christmas gift</td>
<td></td>
<td></td>
<td>Secret Santa gift exchange</td>
<td></td>
</tr>
</tbody>
</table>

Figure 9

regarding the benefits of Phase 1 treatment. To take advantage of the increase in the older age cells, the practice should continue to aggressively market to adult patients, especially parents of children already in treatment.

**Competitive Environment Evaluation**

This is one of the most interesting aspects in the development of a good marketing plan and the third and final method of positioning your practice. Gather and compile information on all competitive practices. Talk to staff members, patients and former patients, parents and dentists. Use surveys to obtain the impression or perception people have of your competitors’ practices. This data is then compiled as is shown in Figure 6. (The names have been changed to protect the doctors’ privacy.) In all cases, fees were comparable and perceived to be “high.”

**Conclusions:** Provide services the other orthodontists are lacking. Address all the negatives of the other practices and make them your positives. In this case that involves:
- Flexible payment plans.
- Zero waiting time.
- Friendly environment.
- Consistent pricing; explain value of orthodontics.

Also, since age plays an important role in referral patterns (you are generally referred to by dentists within ten years of your own age), it is important to know the breakdown of referring doctors by age. Figure 7 presents such a breakdown.

**Conclusions:** Gear the marketing plan to doctors in the 35-44 age segment. They have the more mature practices and the greatest number of child patients. Educate them concerning Phase 1 treatment. Also market older dentists but concentrate on adult treatment and the benefits of preprosthetic orthodontics in complex restorative cases, periodontal considerations, surgery and esthetics.

**Development**

Now, and only now, a plan can be developed to effectively market the practice. This is analogous to the orthodontist’s treatment plan. At this point, it is imperative to establish the goals and strategies to be used in your marketing plan. However, if the practice analysis has been done well, this portion is easily accomplished because the entire marketing plan, both external and internal, has already been devised for you. It consists of the conclusions that were reached through the study of each area of practice analysis. Your research makes it very clear exactly what needs to be done; now it is merely a function of prioritizing and implementing those findings.

**Implementation**

Now it’s time to put all your research, continued on following page
Dr. Clark
continued from page 21

analysis and planning into action. The doctor should already have refurbished the practice facility so it is attractive and clean. The staff should now be thoroughly trained in the technical aspects of their job, as well as all aspects of quality customer service. Practice systems should all be in place so everything runs smoothly. The four steps to implementing a marketing plan are:

1. Decide what you want to do
2. Determine cost
3. Develop schedule
4. Delegate responsibility

Let's look at these one at a time:

Decide
You know what you've done in the past. What has been successful? What has not? Use a brainstorming session to record on a flip chart any idea to market the practice to adolescent patients and their parents, adult patients, referring doctors and their staff, the community and to your own staff. Then go back and eliminate duplications and ideas that are inappropriate, impractical, complicated or expensive. Narrow down the suggestions to specific ideas that all staff members feel good about and to which they can willingly pledge their involvement. The plan requires everyone's commitment and enthusiasm to make it work. Figure 8 provides an example.

Develop a Schedule
Establish a grid (Figure 9) with the months of the year in the left column and the seven major groups marketed across the top of the page. Now complete the agreed-upon marketing ideas and space them strategically during the year to keep the flow of new patients as level as possible. Build up the weak months and keep the strong months strong. The calendar allows you to space out your efforts so all marketing energy is not expended at one or two times during the year. Now your calendar should be in place and ready for the last step in implementation.

Delegate Responsibility
Just like major corporations, every practice should have a director of marketing to coordinate the marketing efforts, keep projects on schedule and hold people accountable for their marketing responsibilities. Analyze the entire marketing schedule and have people volunteer for the portions of the marketing plan for which they would like to be responsible. Everyone should share in this aspect of the practice in order to learn to appreciate the importance of continually building the name and reputation of the practice in the community. It is everyone's responsibility to help market the practice.

Conclusion
The implementation of an organized marketing plan, with the commitment of the doctor and total involvement of the staff, can have a dramatic impact on the growth of the practice, even a mature one. A well-conceived, properly orchestrated approach to marketing the practice will allow it to grow beyond your wildest dreams. It is not unusual for practices with which Orthodontic Management Group has worked to grow 20 to 50 percent the first year the plan is implemented.

As you can see, marketing does not necessarily mean advertising. Marketing a practice to increase patient flow can be done in an ethical, professional manner consistent with quality orthodontic care. As a matter of fact, advertising is the least cost effective way to market your practice.

Mr. McMahan
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The largest dental managed care plan in Alabama is operated by BCBSA in the form of a PPO. Statewide, approximately 50 percent of all practicing dentists are contract providers for BCBSA. A review of the BCBSA directory of “Preferred Dentists” reveals that participation in BCBSA's dental PPO is not uniform throughout the state nor is there widespread specialty participation except for oral surgeons.

For example, nearly 70 percent of the practicing dentists in Birmingham are listed as contract providers, while only two of 35 general dentists in Decatur are participants.

Orthodontists are one of the specialty groups that have basically elected not to become contract providers for the BCBSA PPO. Most of the dental plans offered or administered by BCBSA do not include any orthodontic benefits.

The failure of most of the BCBSA plans to adequately address orthodontic coverage is epitomized in a communication to some of BCBSA's insureds:

“Although Orthodontists and Periodontists are listed in the directory, they are covered only for routine Standard Option dental services.

“We hope you will find that your Preferred dental benefits are convenient and easy on your wallet.”

Well, to paraphrase Dr. Zatts, perhaps there is a solution for orthodontists who wish to become contract providers for BCBSA. They need to shift their focus from traditional orthodontics to setting up “prophy parlors.” Dr. Zatts was correct in saying that dentists have options regarding managed care plans. However, only if laws like the APCL are upheld by the courts and subsequently passed either by the Congress or state legislatures will patients enjoy a basic right to which they should be entitled – the right to determine who will provide their dental care.
ing patients, we are both well aware that biomechanics is extremely helpful in achieving predictable results. For example, I designed a reverse headgear bow to be used with a facemask to deliver force to the maxilla to achieve a predictable response. This replaces conventionally used elastics which cannot be biomechanically applied due to lip opening. We all know that elastics with protraction headgear often increase the vertical dimension of the face due to the extrusion of the teeth and cause the mandible to swing downward and backward, giving us an illusion that we have achieved forward displacement of the maxilla.

Dr. Turley: What about the “bio” in biomechanics? Do biomechanically oriented appliances give a more optimal biologic response for tooth movement than other types of appliances?

Dr. Nanda: Pat, “bio” is a big part of biomechanics. Indeed, biomechanics teaches us to use force values which deliver tooth movement in the shortest possible time with the least amount of nonreversible damage to the tissues. It also allows the use of appliances which have low deflection rates, are active for a long time and need small force values per millimeter of tooth movement.

Unfortunately, our understanding of mechanics is presently well ahead of our understanding of the biology of orthodontics. The physics of our appliance design is comparatively simple relative to the biological response of the tissues. But I think our knowledge of the biology of tooth movement (at the patient level) has been limited by our inability to precisely apply mechanical principles to treatment.

Dr. Turley: Can biomechanics be applied to innovations by manufacturers for improving our appliances?

Dr. Nanda: Orthodontic manufacturers play a major role in the field of biomechanics from the design of brackets to the development of new orthodontic wires. In recent years, wires such as nickel titanium and TMA® have allowed delivery of lower and longer activating forces. In the future, I see more precalibrated orthodontic springs, wires and loops which will deliver predictable orthodontic tooth movement.

Dr. Turley: Where is the field of biomechanics going in the 21st century?

Dr. Nanda: I feel market pressures will make it imperative for all orthodontists to understand the wires they put into the mouth. The future of biomechanics is very bright, especially in the area of orthodontic materials and development of new appliances. Even in this age of managed care, HMOs and increased practice efficiencies, I am confident the specialty will keep the quality of results always in the foreground.

Dr. Turley: Ravi, the last question, who are/were your mentors in this field?

Dr. Nanda: I have been lucky to be associated with leaders in the field of orthodontics. My brothers, Ram and Surender, come to the forefront as my mentors. Both have contributed tremendously to the specialty as researchers, educators and prolific writers. In the late ‘60s, I had the fortune of having Frans van der Linden as my teacher, and for a period, Allan Brodie, who was on sabbatical in Nijmegen, Holland. My last 25 years have been at the University of Connecticut, and I have had the fortune of being associated with Charlie Burstone, who is unquestionably the leader in the field of biomechanics. Needless to say, I also have had the opportunity to be a teacher and mentor of excellent orthodontic graduates who are now leaders in our field in their own right.

Dr. Turley: Thank you.

Dr. Nanda: I want to thank you, Pat, and at the same time, I want to congratulate you for your excellent contributions to our specialty.