THE HYGIENE FACTOR

Most dentists would like to think that our patients come to our practices to see us. That's just not true. Your patients bond to the office primarily because of the staff and this is particularly true when it comes to the hygienist. Hygiene is the hub about which most successful practices orbit and all really productive practices are driven by their incredibly strong recall systems and hygiene staff. In fact, I have never seen a well-run, super profitable dental practice without a stellar hygiene department. What has escaped most doctors is the importance of how successful practices integrate the hygienist and all the systems surrounding them in order to "stage" a perfect visit for our new patients and retuning patients of record. Get this wrong, and you will never realize your practice's full potential. Get it right and there is no limit.

My office was fortunate to have 9 of the best hygienists I have ever seen. Based on this as a foundation, added to the thousands of offices we have visited and coached over the last two decades, I would like to give you a brief description of how to integrate your hygiene department into the whole of your practice.

Let's begin with the end in mind. You are trying to create systems and hire staff that will inspire your patients to show up, pay for their treatment, and refer everyone they know. In a way, this defines success in the consumer driven business we find ourselves in. Your hygienists and all the systems that surround them are key to this process. **Hygiene is not a loss leader**. Your hygiene department is foundational to a profitable dental practice. Precision in these systems along with their application is a constant in my practices and every successful practice I have known.

Before jumping into this, I should point out that I'm primarily writing this as if I was speaking directly with a hygienist. If you are the doctor and you're reading this, be absolutely sure you have your hygienist(s) read it. In fact, everyone in the office should read it. That's the only way that you will ever incorporate a true ***system*** *into this, or any other, part of the practice.*

As a doctor, I am a little confounded when I ask staff what their job is. Seldom do they respond with the answer I am looking for. I say this so that the hygienists don't feel like I'm just picking on them. Almost every staff person thinks their job is what they do physically all day long. They are wrong, but it's not their fault. For several years during school, hygienists have been brain washed. You were told that success in hygiene depended on your ability to educate the patient and diagnose and treat soft tissue disease. Zero bleeding points, normal probing depths, and a patient educated in gum disease to a master's degree level is everything. The problem is that this is not your job. Yes, I expect that to get done, but what I'm paying you to do is inspire our patients. Just telling someone what they need will never get the patient or you to where you want to go. Doing a great cleaning is not what patients are paying for. They expect that. They can get that in every practice in town. To be a successful hygienist, patients have to own the problem, and want the solution. This happens when the patients feel the caring and compassion from a hygienist whose greatest assets revolve around their people skills. A hygienist who is lacking in excellent people skills has chosen the wrong profession. For the most part, if you lack great people skills you need to move on down the road. You will never be a successful hygienist or an asset to your practice. Consumers vote with their feet, and if you don't inspire them first, you will constantly see the back of their heads as they travel down the street to another practice that cares. Guess what? Only the patient decides whether or not their needs are being met, and you can't get better at giving patients what they don't want.

There are two types of practices in Dentistry: The Donor practice and the Recipient practice. The Donor practice has fine-tuned everything they do to drive patients away. They fail to meet the patient's needs and expectations, so the

patient tries another practice. Most Donor practices are clueless as to why patients don't find their practice attractive. You're a Donor practice if you have a significant number of cancellations and no-shows, patients need a second opinion, patients want to discuss the treatment with their spouses, there is high staff turn-over, you don't get at least 50-60% direct referrals, you are marketing driven to attract patients, and your recall is below 70-80%. The Recipient practice is the practice down the street with a 50-75 new patients per doctor, an 80% direct referral rate, two hygienists for each doctor, consumer hours, great staff, and a line of loyal patients waiting to get in and referring everyone they know. The strange thing about both of these is that often times the Donor or Recipient practices are unaware of what they are doing or why they get the results they get. In a way, there are also Donor and Recipient hygienists.

You, as the hygienist, are on the front line to make a good or bad impression. Every system and everything you do should be staged to meet your patient's expectations and in most cases exceed them. You are the face and the personality of the practice. Fall short as an ambassador and you have failed as a hygienist. In our office, 80% of the success of tying the patient to the practice was because of our hygienists. We respected each hygienist as a true professional and we expected great things from them and the systems that evolved around them. In addition to this expectation of certain results, we also rewarded them with bonuses, 401K, medical insurance, uniform allowance, and base pay derived from a commission of $80,000 - $150,000 per year or about 30% of their production.

What is the job of the hygienist?

We mentioned that while you clean teeth, take x-rays, gather clinical information, triage treatment modalities, and educate the patient on homecare, your real job is inspiring the patient. So how can a hygienist inspire a patient?

- **It starts with a call.** The most important piece of technology in the office is the telephone, and the most important person to a new client is the person who answers it. Remind your front desk that if they do not inspire that new patient with their voice, that you, the

hygienist, will not even get the opportunity to mess up the process. You get one chance and one chance only to get this right. Statistically you have 3 seconds to make this work when you answer the phone. That means that if you are the average office you will have 25 new patients a month and the first three seconds of a conversation sets you up to succeed or fail. 75 seconds a month to pay the bills and make a profit. This is do or die. If you find that you are struggling here, you either provide them with more training or you free up someone's future and hire someone that can get the job done.

- **It continues with a call.** Inspiring someone comes from doing the unexpected in a good way. Every patient that you have done extensive work on, like soft tissue and scaling procedures needs to be called by you the evening after that procedure. Taking this one step further, every new patient that you *will see the next day* deserves a call from you to just ask: *"This is _____. I was just calling to see if there was anything I could do to make your visit tomorrow go more smoothly?"*

- **The patient expects to be able to schedule a cleaning on the first appointment no longer than 2-3 days after the call**. Sooner would be better. Fail at this and your practice will fail to grow. You will notice that I said clean their teeth on the first appointment. If your policy is to never clean teeth on the first appointment, you have a death wish when it comes to growth. Start thinking TLC: **T**hink **L**ike the **C**onsumer. In addition to being seen within 2-3 days of their call, they also expect **to be seen during "peak demand times".** Any front desk person can tell you that patients only want to come in either early (7-9AM), or late (3-6PM) and on Saturdays. These are your "peak demand times". These are the times consumers want to come in. So it is not just within 2-3 days but also at a peak demand time within that period. If you cannot see a new patient in that length of

time, you will stop growing. You have encountered a blockage that creates an impasse that forces growth to a standstill. You can see that Monday-Thursday 8-5 will not cut it in today's environment. If you find yourself in this very limiting situation, it is time to expand the schedule and/or hire more hygienists. Nothing slows growth as quickly as the inability to give patients what they want.

- **Be on time, every time.** There is a double standard in dentistry that needs to go. We get upset when patients are late, but most of us are never on time. Not being on time demonstrates incompetence at scheduling and treatment planning. It is insulting to the patients when you do not value their time as much as you do your own. Not being on time is the number one complaint I hear from patients. Start on time and finish on time or find out why you can't and fix it. Use technology and the Internet to help the patients come in with all their records filled out. This is your arena. Organize and engineer your day for success. Just a note: Every hygiene operatory should be equipped with computers, two monitors, prophy jet, and piezo scalers, and intraoral cameras, and if possible, a "Rat" or "Florida probe". You cannot expect to maximize your day without the proper tools.

- **Start listening.** As a doctor, I need to know three things when I walk into the room to meet the patient, perform a check, and do a case presentation: *What do they want, what is their budget, and what is their dental IQ?* If you can help me understand this, you have set the stage for 100% case acceptance. This is how it would go: You would triage the patient by doing x-rays, full mouth probing, cancer exam and disclosing using a light system, take intra-oral photos, review of medical history, treatment planning in the computer, and recording existing restorations and needed treatment. Educate the patient by explaining what you are about to do, what you are doing, and what you just did. Identify points of blockage in any patient relationship

and make sure you are proactive in eliminating these confrontational barriers to treatment before they arise. Involve the patient in the process by "talking over" them the whole time you are performing your duties. Let them hear what you are thinking. Let them see what you see. Keep in mind that whatever you find will be "worse than they thought". Your ultimate goal is to help them *want* what they *need*. Patients gladly pay for what they want, not for what they need. The trick has always been to have them want what they need. While listening, you have to make a personal connection with them. Find out who they are and what they do, and about their family. You are bonding them to the practice. They will see you at least two times a year. They need to like you in order to return. If your office doesn't have an 80%+ recall rate, you are falling short of your goal. Find out why and fix it. Patients tell you how you are doing by what they do. Are you listening?

- **Start Talking.** I know what your doctor doesn't know: Hygienists are most upset with the doctor when they have to wait for them to get there, and when they have to wait for them to leave. There are a couple of things that you can do to eliminate several potential problems before they occur. This will keep you on time, inspire the patient, and make your doctor look caring and compassionate while maintaining a productive schedule. Once you have gathered all the clinical information, gotten to know the patient, and know why they are there, what they want, and what they can afford, signal your doctor that you are ready for a check. Don't wait until the very end of the appointment. Keep in mind that we are not checking you to be sure you cleaned their teeth well. By notifying the doctor 20 minutes or so into the appointment and prior to actually finishing the cleaning, you give the two of you a window of time for the patient to be checked. From the doctors perspective it allows him the opportunity to be on time for you, but also stage his exit from the

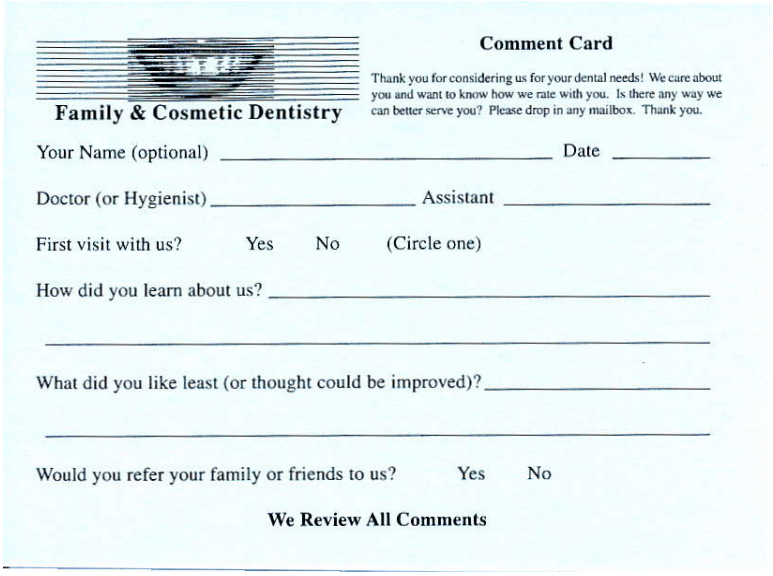
patient he is involved with in an efficient manner. When he arrives, introduce him but do not let him talk. Take this opportunity to brief the doctor on who the patient is, what they want, and what you found by using photos and technology to support the triage. It would go something like this: *"Dr. Abernathy, Mrs. Jones is new to us and came because her sister Mrs. Smith recommended us. She just moved to town to be closer to her grandkids and the rest of her family. Her husband passed away about a year ago and she just wanted to get back closer to her family. Her previous dentist had been keeping an eye on the lower right first molar, number 30. I took a photo and found a crack of the mesial buccal cusp. She says it is sensitive to pressure and a little sensitive to cold. I had her bite down on a Q-tip and only the mesial buccal cusp was sensitive. She* had the *old black mercury filling done 30 years ago. I explained that you would probably recommend a crown to cover the tooth after removing the old mercury filling and any decay or cracked tooth structure. I gave her a brochure about crowns and she would like to go ahead and set up an appointment to get this done. In addition, she would like to remove the old black mercury fillings on the two bicuspids in front of it at the same time. Her gums and soft tissue look good, and she has good home care. She does have a slight chip on the edge of tooth number 8 and I told her you would be glad to smooth it today, so I went ahead a set up a soft flex disc. I did take photos on the left side of tooth number 14 and 19.* (You pop up the photo so that the doctor and patient can see it.) *I told her that those teeth look similar to the lower right and that you would probably recommend crowns on these before they crack or break. She would like to wait until next year to do them. The x-rays and cancer screening look fine. Mrs. Jones was relieved that we offer nitrous oxide at no charge and I indicated that on her record. The health history looks good and has not changed and her blood pressure looks great".* (With this introduction to what you have seen, he now

knows what she wants, what she can afford, and you have done an incredible job of handing off the patient. All the doctor has to do is "meet and greet" while studying the information you have laid out before him. Following this he restates what you said in an abbreviated form to reinforce the fact that he was listening to what she wanted and closes by handing the patient back to you in this fashion.) He turns to you while touching the patients shoulder and says: *"Sandy (the hygienist), make sure that you get Mrs. Jones in as soon as possible. I do not want this tooth to break and require a root canal or the loss of the tooth. You tell Cathy (the receptionist) to get her in within the next 24-48 hours even if she has to move someone".* The doctor then turns back to the patient and adds this short postscript: *"We will do our best to maximize your insurance and fit any additional costs into your budget. If you need anything just give me a call. Between now and the time you come back be sure not to eat anything on that tooth until we get it fixed. We don't want to take the chance of making it worse."* This technique of staging the transition and handoff guarantees the doctor will be in and out as effectively and efficiently as possible while keeping you on time. It has the added benefit of making the doctor look caring and competent by setting the stage for a successful case presentation. An additional benefit will be that if you have associates or junior doctors working, this strategy makes sure that their diagnosis or inability to diagnose and present treatment will be minimized while keeping production up and handling the patient perfectly. The short script about not eating on the tooth and turning to you to make sure you get her in as quickly as possible creates *urgency* to the whole process while making for a flawless handoff.

- **Keep talking some more.** There is a fallacy or myth in dentistry that alludes to the supposition that if you take care of the patients, they will refer their friends to you. Some will, but most will not. You must

have a structured, scripted referral based system that you consistently use on every patient. Bottom line: You have to ask for referrals. Every patient on every day needs to be prompted to refer their friends and family. No exceptions.

- **Only the consumer gets to vote on how you are doing.** Included here is what we call a "comment card". It is given to every patient you see and you must ask for their feedback. You will notice that it also asks for referrals in the body of the card. It is postage guaranteed and can be anonymous with its response. This card works ten times better than software solicitation for feedback. Patients know that you will capture their email with the digital response but feel that the card hides their identity. Use it, and alter your systems based on the responses you get. In fact, we always assumed that if we got one bad comment about some staff member or situation, that there were another 100 patients that said nothing and will probably move on down the street. This is serious and we need to carefully consider the feedback we get from our patients and act quickly.



Comment Card

Thank you for considering us for your dental needs! We care about you and want to know how we rate with you. Is there any way we can better serve you? Please drop in any mailbox. Thank you.

Family & Cosmetic Dentistry

Your Name (optional) _____ Date _____

Doctor (or Hygienist) _____ Assistant _____

First visit with us? Yes No (Circle one)

How did you learn about us? _____

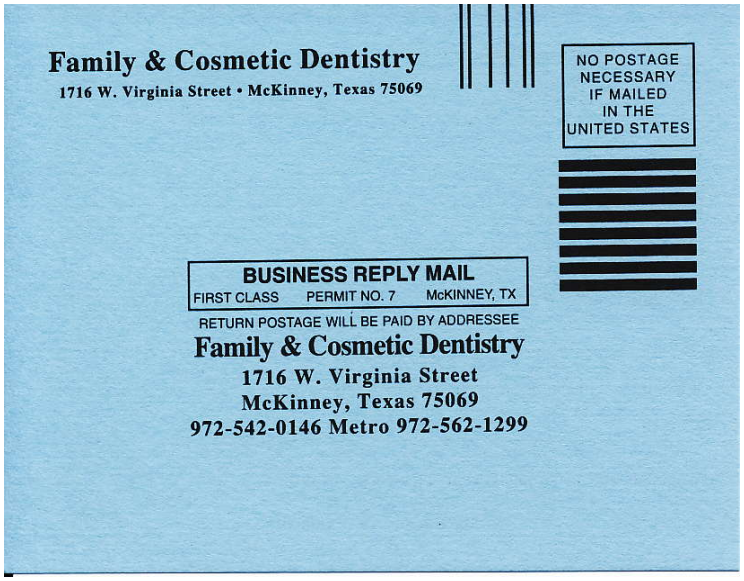
_____

What did you like least (or thought could be improved)? _____

_____

Would you refer your family or friends to us? Yes No

We Review All Comments



- **Learn the art of the handoff.** In every track and field competition, they finish with the relays. Four people run varying distances and pass a baton between them in a handoff. The race is won or lost on how well the handoff is made. A dental office is the same way. Patients pass from a phone call to a schedule, from a receptionist to a hygienist, from the hygienist to the doctor and back again, to a financial secretary to a receptionist and it starts all over again. Even if every person performs perfectly except one, the patient will never return. 98% of dissatisfied patients will fail to return or no-show and cancel when they are not inspired by the staff and doctor. The biggest problem is that they will never say a word to you. They will tell everybody else not to go to your office, but you will be clueless as to how they felt while they were there. Welcome to the Donor practice. Your relationship with your patients hinges on the handoff. It needs to be seamless.

Successful Hygiene Steps:

We need to consider the tricks of the trade to make you both efficient and effective in dealing with other staff members, patients, and the doctor. These points will delve into the philosophy and techniques of daily hygiene that will guarantee success.

- **Becoming the Team member that everyone wished you were.** This is a touchy subject and would readily apply to most doctors, too. There is a difference in a "team" and a "group" of people that work together. I would have to say I find far more "groups" than "teams". As an aside, I would recommend that you and the rest of the office take the time to read and study a short book by Patrick Lencioni called "The Five Dysfunctions of a Team". This book is the best of its kind. It will quickly point out the areas where you fall short as well as how to fix them. Without a strong team you will never have a stellar practice. In respect to the hygienist and even the doctor, I most often see an elevated sense of value or worth for no apparent reason. Evidently there are jobs and duties that fall beneath the dignity of a hygienist or doctor to do. That is as far from the truth as East is from West. Yes, you went to school longer, we're paid better, but in the realm of a team member you need to put on an attitude of "whatever it takes". You assist if you are asked and have the time. You call patients to confirm if there is a cancellation. You look at and worry about your schedule. Bottom line: Stop being the "I'm too good for that" employee seen far too often in the average dental office. This attitude seems to drip off some hygienists, leaving a bad smell and an attitude of disregard for fellow team members. Enough said, just check your attitude or superiority at the door, and put on your big girl panties and deal with being a valuable team player. As for the doctor, I was always the first person there in the morning and the last person to leave at the end of the day. I was often the person sucking fluid through the vacuum line, emptying trash, or bagging instruments for sterilization at the end of the day because my staff was busy "inspiring" ***our*** last patient. You will notice I did not say "*my*" last patient. The business, the patients, and the results we got were always

accomplished with a "*we*" attitude. Our offices were always "Purpose Driven, Doctor Led, and Staff Owned". The attitude of "*our*" kept us all thinking like owners. This directly accounted for an average staff employment of over 14.5 years. It also was the reason that each and every staff member shared in a bonus that meant an extra $2,000-$3,000 for each and every staff member each and every month while still maintaining a total practice overhead that hovered around 50%.

- **Patients say yes to their emotions, not your logic.** New doctors and hygienists seem to revert back to what is most comfortable for them: A classroom. If you've read our article "100% Case Acceptance", you've seen the scripts and systems we use to compensate for this tendency and take advantage of the patient's tendency to make buying decisions based on emotions. That means throwing away the Dentistry 101 lecture, forget using dental words, and stop trying to logically convince your audience that gum disease will kill them, or justify your fees. It's all about getting that emotional response. If you can touch their emotions they will own the problem. Fundamentally most patients walk in thinking that you are going to "fix" them. They think it's just a matter of having someone do something for them to be fixed, and this is all wrong. Whether you are the doctor or the hygienist, you have to help them "own" the problem. There is nothing you can do for them that they can't undo between visits. You are not fixing them. It is their problem and they have to own it. They got there all by themselves and they need to understand that they will have to make changes in order to correct where they find themselves now. You will only be able to get them to a place where they have a chance of maintaining health. You can't do it for them. In the process of presenting your findings, you have to understand that anything you find is going to be worse than they thought. The process of helping patients "want" treatment begins with the first phone call, and continues through the actual treatment. With this in mind, you must continue to involve the patient in the discovery process by talking to them about what you are going to do and what you

find as you find it. Use your technology to involve them mentally and visually. Most of us are visual learners, so if you are not using an intraoral camera on each and every patient you are not going to succeed in 100% case acceptance. If I come into the room to check a recall or new patient there had better be lots of photos that the patient has already seen and been able to ask questions about and get answers that satisfied them. I want every patient presold and staged in such a way that the answer will always be yes. The only point that will not be completed is fitting it into their budget. Financial secretaries see this all the time and I will bet each of you have seen this, too. You tell the patient nothing in the triage and wait for the doctor to "diagnose" the patients and do a case presentation, or as we say: Drop the bomb on them. The doctor goes through the Dental 101 speech, turns to the patient and asks: *"Do you have any questions?"* Which is quickly followed by the patient answering: *"No, not really",* followed by an even quicker exit by the doctor. The minute the doctor leaves the patient turns to you and asks: *"What is he going to do about _____and about _____?"* If this is happening, you are not doing your job. Think about it. The patient doesn't feel qualified to ask a question of the doctor. They also feel like his or her diagnosis is dependent on how much the doctor's new car payment is. They are far more comfortable asking you questions than they are of the doctor. They feel as though you have no reason to present them with anything other than what is really needed. You have no ulterior motives in case presentation. So pre-close the patient by listening to what they want. Assure them that your office will start with their primary concern, and take the time to point out other areas of need while helping them emotionally understand what needs to be done prior to having the doctor in to check your patient. Do this and the patient will feel cared for and the doctor will be in and out much quicker while appearing not to pressure the patient to follow through with treatment. Your goal is to have the patient show up, follow thru, pay for treatment, and refer everyone they know.

- **Recall.** Every office has a recall system and most are broken. The average dental office has a 42% recall. Take the time and run a program that gives you all of the patients that have not made it back in 6-12 months. If the normal hygienist works around 200 days a year, and sees about 6-8 patients a day (your cancellations and no-shows would lower the number of patients seen per day), you would need a new hygienist every year in order to just see the 300 new patients (25 x 12) that an average practice receives and see them each twice a year. Knowing this, why do you still just have one hygienist? This says volumes about whether you are inspiring your patients or not. If you really had your house in order, your recall would be in the mid 80th percentile. Marketing brings patients in, but if our message and methods don't meet or exceed the patient's expectations, you will have a situation where this happens. Consider that marketing opens the front door of the practice, while how you take care of them closes the back door. Most of you run off more patients than you attract, otherwise you would need that additional hygienist and doctor every couple of years. Let's look at how you are doing recall now. Most offices utilize their computer to print, sort, and distribute some form of recall card. It is this system that is causing you to languish in mediocrity when it comes to hygiene recall. This is going to sound a little old school, but the best way to do recall is to use an oversize post card that is larger than a legal envelope. Have the patient fill it out at the cleaning appointment so that when they actually receive it in 6 months, they recognize the writing, pause, read it, and not automatically throw it out with all of the other junk mail they receive. In addition, you need to take the time to write some personal note that includes some fact or item that the two of you discussed about their lives and then sign it. It might say: *"Can't wait to hear about your niece's fist year as a cheerleader. Marcie."* This card will be put in a four week/month card file system so that it will go out 2 weeks in advance of the scheduled appointment. Imagine your patient getting that recall card. They can't miss it because it colorful and larger than most of their mail. She looks at it because she recognizes her own handwriting, and she

reads the personal note. She thinks you wrote the note the day it was mailed, and is very surprised and impressed that you remembered what the two of you spoke about 6 months ago. Follow the card with a call about 3-4 days before, and a final confirmation 24 hours before the appointment. Email and text messaging are also very effective reminders for some patients. You should be "customizing" the appointment reminders on a patient-by-patient basis. Do "whatever it takes" to be sure the appointment is confirmed. Even doing all of this, there will still be some patients who no-show. Do yourself a favor: Stop putting these people back on the schedule. Either put them on a last minute call list (you call them when you have an opening) or have them pre-pay for the appointment.

- **Keeping Score.** We at Summit feel that every position in the office should have some way to measure performance. It is called the "Hawthorne Effect": What gets measured gets done. We try to identify the two or three most important things you need to get done daily and then we measure them and compare to a goal. Complete these top two or three things and it will be a great day. In hygiene we measure your production on a weekly basis, the number of crowns you present, and the number of scaling and root planing cases you begin on a weekly basis. Each will have a goal marked in red on a graph. You, the hygienist, will plot the numbers on a weekly basis. As long as the graph is improving and going up, we don't need to have a conversation. If it is going down or you are struggling, we will need to talk, retrain, or come up with a strategy for improvement. Day to day we need to always try and schedule about 15% more treatment than your goal for the day. A productive hygienist should produce about $1,100-$2,500/day. A point to remember is that with the increase of managed care and the deep discount that they exact on hygiene, these production numbers are based on gross production, not adjusted production. With a well written job description, thorough training, a way to measure your results, and consequences for not meeting the agreed upon results, you will see a marked improvement in both focus and results.

- **Subtleties in Scheduling for Hygiene.** It's not my intention to try and teach you everything about hygiene scheduling, but allow me to give you an overview and some very important tips that are very often overlooked. NOTE: There are no "difficult cleanings". There is no ADA code that applies. It is either a regular cleaning or it is perio. If it really takes you 60 minutes to clean someone, it is probably a soft tissue or periodontal case. There have always been differences between one hygienist and another when it comes to diagnosis of soft tissue, but we need to agree that if a certain length of time to perform the prophy is exceeded, or if there are bleeding points and periodontal pockets, the appointment constitutes something more than a cleaning, and this needs to be addressed with the patient. In the next section, I will go over the system and actual scripts to use, but for now, we need to agree that there should be no difficult cleanings. When we look at scheduling, it is almost laughable that we continue to see one hour long appointments for recall. If you were on commission or really engineering your schedule, you would find varying appointment times based on each patient's needs. It's almost as if some hygienists build in coffee breaks and down times. I assure you that if the staff had an ownership mentality and were paid based on their results, the schedule would look all together different. Let's take a worse case example of a schedule filled with nothing but hour long recall patients for a typical eight-hour day. That's eight patients all coming in for a cleaning and maybe a bitewing or two. The national average for cancellations and no-shows is somewhere around 15%+ per day. That means at the end of the day you could expect 1-2 people not to show on this schedule causing a possible 25% loss of productivity. If the hygienist could just lessen the time from 60 minutes to 50 minutes, you would have at least 80 more minutes that day or maybe a couple of more patients that if we did great on eliminating cancellations we might see a 40-50% increase in production from hygiene. If the hygienist was paid a commission and we could maintain that pace throughout the month, she might realize an increase in take home of 20% or more. This is a win/win for both the doctor and hygienist. The hygienist

has unlimited earning potential and the doctor has mitigated his risk of having to pay for staffing with no corresponding production. It means both parties have some bacon in the fire. The ripple effect of this is that with a couple of more patients per day, the doctor would also see an increase of about 30% on his schedule when you consider that 67% of all the work on the doctor's schedule comes thru hygiene recall, not new patients. Throw in some soft tissue, and new patients and you can literally double a practice in no time. If you increase your recall, and inspire the patients to refer, you get another bump and before you know it you will need more hygienists and doctors. This is what a great practice looks like. Your goal each day should be to pre-schedule at least 90% of your patients in the future. There is an overlooked strategy that we need to discuss. *You should never book more than 70% of any one day in the future with these recall patients*. The reason for this is so that you will have the capacity to see new patients and schedule your soft tissue treatment in a timely fashion. Think back to when we were discussing peak demand times: 7-9AM and 3-6PM and all day Saturday. These are the times that everyone wants to come in. They are also the easiest to fill. Most importantly is that they are the only times a new patient will want to come in. So your job will be to guard these peak demand times for substantial productive cases and new patients. Secondly you want to try and guide the patients who already know and love you into coming in during non-peak demand times (9-3). Even if you get only 1 or 2 per day to do this, it means that you will have about 32 places in that month to put these new patients. Now what do you do about the 30% you did not schedule on that day in the future? They go in another column on that day knowing that they can be used to fill a cancellation or failing that if the day is full, you will hire another hygienist. These would be younger patients who would not be upset seeing a different face for a cleaning. *Note: If you do not have peak demand times available, you should not market or try to increase new patients*. This is a blockage that has to be fixed in order for any practice to grow. For a hygiene schedule to be effective and productive, 60% of the day has to be in substantial cases.

These are things other than just a normal recall. Things like soft tissue, impressions for night guards, interceptive orthopedics, quadrants of sealants, etc. To facilitate this, your front desk should check every patient's insurance that is coming in the next day and summarize what is available for the hygienist or doctor to work in. This could be sealants on adults, fluoride treatments, and diagnosed but unfinished treatment. One step you should incorporate on both the hygiene and doctor's schedule is a pre-appointment call for all new patients. You call, introduce yourself, and ask: *"Is anything I might do or any question I might answer that would make tomorrows appointment go smoother for you?"* This is huge. No one will no-show after this. They have never had a doctor or hygienist call and ask anything to make their visit better. It separates you from the Donor practice down the street. This is the level of "WOW" that creates a lifetime patient and a raving fan that will refer everyone they know.

- **Fees, Coding, and bundling.** We have to keep our fees comparable to the usual fee found in your area. You should review these every couple of years. In addition you should raise your fees 1-4 percent every year. We generally did this every January and July in smaller increments equaling about a 2-4% increase for the year. If you have not done a fee review, just email us your zip code and we can forward this to you. You should keep your fees between at about the 80th percentile. The next area you need to become an expert in is maximizing each patient's insurance benefits. Coding for the best benefit along with the most reimbursement is so important. I recommend that your office subscribe to Insurance Solutions Newsletter and also buy Charles Blair's book "Coding With Confidence". The last area is bundling. How you present treatment along with how you bundle the fee can add thousands to the bottom line. If you happily give patients what they want, and tell them what they need, you can raise case acceptance to almost 100%. If you have not read our article about "100% Case Acceptance" let me know and I will send it to you. It should be

considered a prerequisite to reading this article. They will complement each other and allow you to get the maximum result.

- **Scheduling for productivity.** 60% of any hygiene day needs to be made up of "Substantial Cases". This would be procedures like quadrants of sealants, scaling and root planing, impressions for sleep apnea appliances, snore guards, bruxing devices, and new patient appointments. A day comprised of six-month recall will not allow for a productive day. As mentioned earlier, we expect a good hygienist to produce in the area of $1,100-$2,500/day, unassisted. A hygienist should produce at least 3 times what they are paid. If they make $300/day (and you would need to add in matching taxes, benefits, vacation, other benefits, etc.) they should produce a minimum $900/day to make this work. We always suggest moving to a commission basis of pay that creates unlimited earning potential for you, the hygienist, while sharing the risk of down times with the doctor. Most times we start with a hybrid where there is a base pay plus a commission. Take a hard look at your hygiene department and understand it is a profit center that needs to be based on sound business principles that both the doctor and hygienist understand.

- **The Silent Killer: Assisted Hygiene.** This is going to sound a little counter intuitive from someone who had nine hygienists and was always looking to improve the bottom line, but for 99% of the practices out there, I would not recommend assisted hygiene. There are several reasons. In its purest form, assisted hygiene has the hygienist doing only what she can do based on the dental practice act in your state. This means she scales and leaves. This means that getting the patient, all record keeping, all triage, pocket depths, patient education, photos, x-rays, etc., falls to the assistant. The problem is that this assistant has to the most valuable assistant in the entire office. It should be the assistant that has worked the longest with the doctor and knows his exact words and diagnosis traits. It would be that assistant that the doctor couldn't work without. Just the opposite happens. This is typically an entry-level position for a marginal, or at least unproven,

team member. Think about it. You are exposing your most valuable asset of recall and new patients to someone that you are depending on to form a relationship that will bond the patient to the practice. Assisted hygiene will increase hygiene production, but you will also see an increasing number of patients that don't follow thru with their treatment plan. Patients are concerned about money, time, fear, and trust. Using assisted hygiene almost always destroys the "trust" factor. If you are considering assisted hygiene or are already doing it, please consider limiting it to just children in your practice. Adult assisted hygiene can devastate an otherwise healthy recall and profitable practice.

- **The Soft Tissue Impasse.** Hygiene departments just can't make it on 100% recall. We need fresh bodies in the form of new patients. With new patients we have the potential of more soft tissue or root planning and scaling. Hygienists need to understand that if it takes you more than about 40-50 minutes to examine, prophy, and take bitewings on a typical recall patient, it is not a cleaning (01110). If bleeding points and exudates exist, your patient has an infection based on a periodontal disease pathogen. Later on we will discuss the scripts and how to handle patients to get maximum acceptance of treatment recommendations

- **The Oral Fitness Report.** While our offices are chartless, we do use paper that leaves the office but we do not track or keep a copy. The OHFR (Oral Hygiene Fitness Report) is a document that creates added value to the hygiene appointment by helping the patients understand that this is **not just a cleaning**. By using the OHFR you will find that patients have a new level of appreciation of what you do and how well you do it. I have included a copy for your review and use. Every hygiene patient leaves with this document. You do not need to keep a copy or track it in any way.

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Family & Cosmetic Dentistry

We're known for our smiles!

ORAL HYGIENE DENTAL FITNESS REPORT

PREPARED FOR _____ ON _____
The following was accomplished at your dental appointment today:

EXAMINATIONS and CLINICAL PROCEDURES

- ❑ Medical history update
- ❑ Oral Cancer Screening
- ❑ Blood Pressure Screening
- ❑ Plaque Index
- ❑ Necessary Radiographs
- ❑ Periodontal Therapy
- ❑ Sealants, Custom Trays
- ❑ Other Evaluative Procedures _____
- ❑ Hard & Soft Tissue
- ❑ Cavity Detection
- ❑ Periodontal Screening
- ❑ Oral Hygiene Instructions
- ❑ Dental Prophylaxis
- ❑ Antimicrobial Therapy
- ❑ Diagnostic Study Models

ORAL HYGIENE EVALUATION

❑ Good	Very little plaque, calculus, stain.
❑ Satisfactory	Some plaque, food debris, light bleeding.
❑ Needs Improvement	Plaque, calculus, stain present; tissues are bleeding, pockets with inflammation.

DISPENSED THE FOLLOWING

- ❑ Toothbrush
- ❑ Medicaments
- ❑ Oral health aids
- ❑ Mechanical toothbrush
- ❑ Dental Floss
- ❑ Toothbrush
- ❑ Irrigator
- ❑ Fluorides
- ❑ Cleaners
- ❑ Patient Education Materials, Other _____

TREATMENT RECOMMENDATIONS

- ❑ Maintenance therapy at 3 months, 4 months, 6 months _____
- ❑ Daily home care maintenance with attention to specific areas _____
- ❑ Please maintain your dental appointments _____
- ❑ Periodontal therapy intervention _____
- ❑ NEXT APPOINTMENT _____

Thank you for choosing our dental office. We hope that you will continue to recommend our personalized dental care to your family and friends.

Michael P. Abernathy, D.D.S. • James H. Rhone, D.D.S. • Marvin W. Berlin, D.D.S.
1716 W. Virginia Street • McKinney, Texas 75069 • (972) 542-0146

Transitions to more comprehensive soft tissue treatment. For those of you who have not read our "100% Case Acceptance", I included a small excerpt outlining the actual steps in case presentation. Each step should be incorporated into your hygiene system. Some of the steps need to be done by the doctor, but most should be utilized by the hygienist.

1. **THE PERMISSION STATEMENT**: This was taken from Zig Zigler's book, Closing the Sale. The script goes something like this: *"Mrs. Jones, I feel like my job is to show you the finest dentistry I can provide. Your job is to decide whether you want to do some, all or none of the dentistry we propose. In other words, we want you to decide how quickly you get your mouth healthy*." This first part of the permission statement levels the playing field. It creates a non-confrontational setting for showing the patient what's going on in his/her mouth. It is almost as if this changes their body language from defensive to open. If you're a Star Trek fan, we just got them to lower their cloaking and photon torpedo shields. ***Remember: We are selling solutions to problems and good feelings. Buying is an emotional decision not a logical one. More education will not sell your dentistry. You are just trying to justify your fees. They want something that looks good, feels good, and lasts a long time.*** The next and most important step is to ask: *"How do you feel about this?"* You can't say: "*Is that OK" or any variation*. It is **ONLY *"How do you feel about this?"*** This statement and only this statement will result in the patient responding in a thoughtful manner. It keeps the shields down. It portrays you as a caring friend who, with them, is co-diagnosing their problems.
2. **INSURANCE**: This comes from Walter Hailey's Boot Kamp. This is the script. *"Mrs. Jones, I see you have dental insurance. I'm not sure whether you have "good insurance" or "bad insurance", but if we find something that your insurance does not cover or does not cover* 100%, *what would you like to do?"* This little statement will eliminate the confrontation regarding only doing what the insurance will pay. Address the choking points ahead of time and you will eliminate most resistance. The phrase *"I don't know if you have*

good insurance or bad insurance" plants the seed. For probably the first time ever the patient is beginning to look at insurance in a different light. They always think that all insurance is good. This opens a non-confrontational discussion into the limits of dental benefits. At the same time, asking the patient what they want to do encourages them to answer: *"I want you to tell me what is wrong and let me decide what I want to do".* This allows the patient to continue to feel "in control". For the non-assertive hygienist or doctor it removes the barriers to presenting ideal treatment. To the assertive doctor, it helps him/her step away from the "doctor turned time share salesman" perception and become a caring health care professional --- someone concerned about the welfare, and budget, of the patient.

3. **DIAGNOSIS AND COMPREHENSIVE EXAM**: Every exam should include: FMX, Pano, oral cancer screening, a co-diagnosing camera tour of the mouth, full mouth probing and charting, and time to ask questions and be given answers by a staff person along with accompanying literature to satisfy every personality type. The key to this exam is that the patient must understand, verbalize, and feel that it is **WORSE THAN THEY THOUGHT.** In the process of the hygienist triaging the patient, (NOTE: It is illegal for a staff member to diagnose. It is not illegal for them to record what they see and help the patient to see and understand the problems. This is called patient education. They are giving the patient options on what could be done if the doctor says so. They are assessing the patients dental IQ and their budget.) all of the patients questions and concerns should be addressed. Patients feel more at ease asking a staff member questions than asking a doctor. If this is done correctly, the doctor will not have to spend time doing it later.
4. **CASE PRESENTATION**: This should only take 2-4 minutes. Remember that your staff members have gone over problems, used the camera, answered all the questions, and provided literature to further confirm treatment options. When I walk into the room the hygienist opens her mouth first. She tells me what she and Mrs. Jones have found and discussed, while I look at the photos on the monitor, look at the treatment plan already filled in on the chart in the computer, and knowingly nod, grunt, and just look plain studious. I then re-tell

the patient what is wrong, what caused it, and what will happen if it is not fixed. I take a moment on each trouble area to tell them what I would recommend (it's real easy because the hygienist writes it down for me).

5. **I CLOSE WITH**: ***"Mrs. Jones, what would you like to do?"*** If done correctly, over 90% of your patients will say yes. The only thing holding them back will be money.

One difficulty that sometimes arises at this point is what to do with the patient who comes in wanting a cleaning, but is in need of soft tissue? You are now faced with a confrontational tipping point. How do you help them get better, while having them want the treatment they really need? It is usually compounded by the patient that walks in talking about their previous dentist who for 40 years has taken care of them and the last three generations of their family. He goes on to explain that "good 'ole Doc Neverlook" was a great dentist. He didn't use those little hygienist girls. He was a real dentist and did everything himself. You seat him and take one look and realize that the only thing holding in his teeth is a calculus bridge. In fact, every time he breathes the entire anterior dentition waves in the breeze. So what do you do? How can you build a bond with the patient and still move them in the direction of understanding that a "cleaning" is not what they need?

This set of scripts and system is called **"Blood and Pus".** It goes something like this:

1. You have used the permission statement and discussed their insurance just like we discussed in "100% Case Acceptance".
2. You have taken the x-rays and charted the mouth for existing conditions and restorations.
3. You explain about probing and show the patient the periodontal probe. You explain that the color-coded markings on the instrument are in two-millimeter increments, and that pocket depths of 2-3mm are normal but anything deeper (larger number) means the patient has a periodontal condition. You further tell them that any bleeding points or pus around any tooth indicates an infection.
4. Swing the monitor around and involve the patient in "co-diagnosing" their mouth. We always handed the patient the "mouse" and had them click it to save the probing depth while watching the monitor indicate green lines for a normal probing and red for anything over 3mm.

The moment you find a bleeding point, you stop and inform the patient that they have ***"blood and pus"*** around that particular tooth.

5. You take the mirror or, even better, the intraoral camera, and show them the bleeding site.
6. You then ask: "*How long have you had that infection"?* To which they will always reply: *"I didn't know I had an infection".*
7. You then say: *"We need to get the doctor in to see about this infection because you may need something other than a cleaning".*
8. I will be the doctor here so I walk in and before I say anything the hygienist will brief me on what has occurred. *"Dr. Abernathy, I called you in because Mrs. Jones has blood and pus around tooth number 30 and 31 on the lower right. I have not finished the entire probing because I knew you would want to be informed immediately."*
9. I then would turn to the patient and ask: "*How long have you had that infection?"*
10. Just as before she will respond with: *"I didn't even know that I had an infection until a few minutes ago".* (Keep in mind that before we ever began the probing and oral exam the hygienist had taken the time to explain about normal and diseased probing along with the fact that if "blood or pus" is present they have gum disease. We will always try to precede confrontational blockage points with explanations that preempt any push back from the patient. This insures that we don't surprise them with anything. Surprises will usually trigger a negative emotional response and cause the patient to be less likely to accept treatment.)
11. Then I ask: *"Does it hurt?"* At this point the patient leaps at the opportunity to make it very clear that it doesn't hurt at all. They do this because, like most of us, we think that if it doesn't hurt then there's not a problem.
12. I pause just a moment with a reflective, thoughtful expression and say: *"That's the problem with gum disease. It's kind of like cancer in that it never hurts till it is too late."* The use of the words "blood and pus" and "like cancer" creates a word picture (mental image) that the patient cannot ignore. They are now listening and own the problem.
13. At this point I suggest that we take a little more time today to diagnose the disease and that we will probably need to see them a few times to clear this up. I allude to the fact that the hygienist will get her more information about her condition and as soon as we completely finish our

comprehensive exam we can determine what needs to be done, how much time it will take, and what the cost will be. I always close by saying: *"We will maximize your insurance and make sure to help you fit anything that the insurance does not cover into your budget"*

So what about clients other than new patients? What about those patients that continually come in smelling like a toilet bowl and needing 50% more time to clean their teeth because they never brush or floss. You know the patients I'm talking about. You should have confronted them years ago about their periodontal condition, but somehow there was never a "right time". Let me say that when we begin to make changes, we always begin with the new patients. With the patients of record the easiest thing to do is tell them you have gone to some continuing education classes and these are the new standards of care. You can mention about the "oral systemic connection" and that how the health of their mouths indicates the health of their heart, circulation, hormones, and overall health. My suggestion is that with these patients you just advise them that you are going to shorten the length of time between this cleaning and the next one to 4 months instead of 6. At that time you will reevaluate their gum disease and if there are still bleeding points and pus that we will need to treat their periodontal condition. I would give them written literature including the periodontal handout from the ADA and your Oral Hygiene Fitness Report, and then make the appointment. Bottom line: You have to confront disease conditions and guide your patients into the proper treatment without pushing too hard.

- **Outline of a Hygiene/Patient appointment:**

NEW PATIENT WITH HYGIENIST

1. Pick up patient chart or open the digital chart and greet patient from reception area – introductions, etc.

2. Review paperwork and forms while escorting patient to operatory from reception area.
3. Be sure all required info is complete. It is not OK to leave blanks or have a partially filled out form.
4. Review medical history form – Ask patient specifically what Rx meds they take. (they have a tendency to not write these down)
5. Briefly discuss patient's prior dental treatment, etc.
6. Always ask if there is anything specifically they would like to ask the Doctor about.
7. Find out why they left their last doctor so that your office does not make the same mistakes the previous doctor or office made.
8. Seat the patient. Give a brief explanation of what you'll be doing today. Try to discover what they want, any phobias, negative prior experiences in dental offices, general dental IQ and/or concerns.
9. Ask if they are currently having any dental discomfort (NOTE: This is an entirely different question than #4 above – be sure to ask both.)
10. Take patient blood pressure.
11. Ask the patient if this is a normal BP for them and is their physician aware of this. Be sure to document if you suggest they consult a physician. All State Boards require base line blood pressure and a follow up any time dental work is done along with recording the reading.
12. Take FMX and Pano. (the Pano will not take the place of an FMX)
13. Begin x-ray processing if film or arrange digital x-rays.
14. This is a good time for the patient to work on any incomplete forms.
15. Full perio probing. Record on paper chart or computer. (all states require a full perio charting for new patients and patients of record every 5 years)
16. Before you probe, tell your patient any number greater than 3 or any points that bleed are areas of concern. Call your numbers out loud so the patient can hear.
17. Perform oral cancer screen.
18. Let the patient know you are looking for any "abnormal" tissue growth.
19. Consider using Visio system or other technology to be more thorough in your cancer screening.
20. Perform video exam with the I/O camera. Involve the patient in the process. Capture images. Print as necessary. No patient should be seen without recording at least one photo.

21. Retrieve and mount the FMX on view box or save digital x-rays in patient's digital chart.
22. Chart existing restorations and any obvious needs.
23. Every patient (unless they already have full anterior crowns or veneers) should be asked if they're interested in whitening their teeth. Assume that all patients are interested in cosmetic dentistry until they tell you otherwise – DON'T PREJUDGE. Many people who might not look like whitening or cosmetic candidates will say yes. You'll be amazed. The easiest way to do this is to ask: If there was anything you would change about your teeth, what would that be? You should always take a shade on every patient to elicit a question about what you are doing. This leads directly into discussions around cosmetics.
24. Fill out the treatment plan form (yellow sheet) or record any necessary treatment in the digital chart and discuss with the patient as you go about what was found and how it may need to be taken care of.
25. **NOTE: Throughout all of the above, be talking to the patient. Explain what you're doing and why. This is education time. Don't criticize their personal dental hygiene or their previous dentist and/or hygienist. This is relationship building time. You need to discover the patient's chief desire and or highest perceived need.**
26. DECISION TIME: Decide whether to:
27. perform prophy (A), or
28. recommend SRP (B).
29. If A:

Begin the prophy.
Call for the doctor.
Doctor arrives - introductions, etc.
Give a brief overview of what you found, what the patient wants, and other things that were discussed.
Exam is completed.
Treatment Plan is presented. Starting point is determined. Hygienist consults with financial coordinator to have FA prepared.
Doctor leaves.
Prophy is completed.
Recall appointment is made with the hygienist.
Give the patient the "Oral Hygiene Fitness Report"

Give the patient 2 business cards. Tell them one is for them to keep and one is to give to a friend if they were pleased with your service. (NOTE: This should be the hygienist's own business card, not the doctor's and not one generic to the practice. Some hygienists will even include their cell phone number and/or email address on their business card.)

30. If B:

Begin discussion and explanation of perio problem with the patient.
Call for the doctor.
Doctor arrives - introductions, etc.
Exam is completed.
Hygienist requests financial coordinator to prepare cost info.
Patient meets with financial coordinator to make FA.
Patient is scheduled at front desk for SRP.

Hygiene is all about relationships. It is the cornerstone of every great practice. Hopefully this will give you the insight to transform your hygiene department into a profit center for your dental practice.

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