THE MGE

GUIDE TO COMPREHENSIVE CASE ACCEPTANCE

MGE management experts

7 STEPS TO COMPREHENSIVE CASE ACCEPTANCE

By **Gregory A. Winteregg, DDS**

We dentists are an interesting breed. Mechanically inclined, we are actually "engineers of the mouth." We have a tendency towards marked regimentation in our procedures, and once we figure something out we don't like change.

If I had to pick a subject that the majority of us have difficulty with, I'd say it's getting patients to *accept dentistry they need*. When we hit resistance, we often acquiesce and compromise our treatment plans to fit within the "insurance allowance," in an attempt to avoid patient upsets and at least do some dentistry. Unfortunately, this attempt at conciliation potentially creates a perception with our patients that the initial diagnosis wasn't really needed or even necessary! Lack of a set system which smoothly progresses from diagnosis, to presentation (and acceptance) can not only be frustrating, but also costly and in some cases…embarrassing.

Lost in the exasperation of doing "only what insurance covers" and the resultant drop in professional satisfaction and practice revenues is what really matters: ineffective case presentations leads to patients receiving "phased" or less than ideal treatment. **What suffers most in this scenario is your patient's dental health.**

The remedy? I recommend a seven-step approach to case acceptance. Will it work every time? Absolutely not. But if you develop this approach and adapt it to your style and personality, you'll most likely succeed more often than not.

Keep in mind as you read this: you are the one who is going to have to apply it in your office, not me. So, do it in a way that works for you. Experiment a bit and adapt it as needed, but I'd recommend that you don't skip any steps. And with that, let's start with step one:

STEP 1: PERFORM A COMPREHENSIVE EXAM.

Do an exam that you are happy with. It *must be complete* in order to provide the information you'll need to create their treatment plan. During the exam, I used to avoid most dental terms (e.g. "crown," "root canal," "extraction," etc.). I used a series of abbreviations with my dental assistant. I found that throwing various dental terms around could either a) scare a patient away or b) confuse the patient (e.g. buccal, distal, etc.).

The other factor to consider is that you have no idea if a patient has a negative experience or concept of "crowns," "root canals," or "extractions." In some cases just *hearing* the term can be enough to prevent them from coming back for treatment or even a consultation. So I developed a simple code of abbreviations for my office for each dental term e.g. 'cr' for crown, "ext" for extraction etc. I also prepared my patients for this prior to the exam, e.g. "Jenny and I are going to use abbreviations for what I find today to help make the exam go more quickly. I will explain everything to you and give you your options and how much it will cost before I do any treatment." Now you ABC, XYZ, 123 your way around their mouth. When you're done, you haven't "triggered" anything with a specific term. They don't know what they need, but they do know you'll be explaining it afterwards.

At some point (preferably early on) in the exam ask every patient:

"Do you want to keep your teeth?"

Why? Well, this serves up an immediate indication of this particular patient's attitude towards restoring their teeth. Their answer of "absolutely", "just the front ones" or "I just want them all pulled" provides a window of insight as to what you are facing when it comes time to present treatment.

Initially, when I began asking my patients this question I assumed that one third or less would unequivocally state "Yes! I want to keep my teeth!" I resigned myself to having to roll up my sleeves and work hard to convince the other two-thirds to make their dental health a priority. To my surprise, roughly three-fourths of my patients came back with some version of a "yes" answer. And it was an excellent foundation on which to build comprehensive case acceptance.

STEP 2: BE SURE YOU HAVE ENOUGH TIME TO DO THE CASE PRESENTATION BEFORE YOU START.

Doctor-stress-and-clock3Ideally, we could do an exam, diagnose, treatment plan, present, arrange payment and start treatment all in the same day. And this will happen on occasion but for most this is the exception rather than the rule. Often patients have to come back for a consult/case presentation. This might be in conjunction with a prophy, or other minor or routine procedure, or it might be a consult on its own.

Note: currently, you might be doing all of this in one visit for every case, but not having a lot of success as a result…keep reading.

During the exam you should also be evaluating the patient's attitude towards dentistry. For example, if a patient doesn't view dentistry as a priority or is inordinately nervous/anxious, you'll know immediately that their consult appointment will take longer than usual. It's similar to treating a nervous/anxious patient. You'll normally schedule more time, allowing for more time to explain, breaks, etc. It will definitely take longer to "close" the scared or anxious patient on their treatment plan than a patient who is comfortable with the dentist and dental treatment.

The other factor to consider is how large the case will be. The larger the case the longer it will take to enlighten the patient on their individual treatment plan.

So with this logic, a large case on a scared patient who is not particularly excited about keeping their teeth will take longer to present than a routine procedure on a more relaxed patient who absolutely wants to keep their teeth. Schedule the consult accordingly. You will be making your best guess, but it's akin to leaving more time in the schedule for a molar endo than a bicuspid. It's an estimation of the difficulty factor as it translates into time.

For small procedures (i.e. a couple of fillings, etc.) the exam, treatment plan, presentation, finance and scheduling would normally be handled the same day. You could also apply this concept with a patient who views dentistry as a priority and also has a not-too-large treatment plan. In either of these cases, you won't really need a consult appointment.

And let's hit on this for a minute. Consults are normally reserved for "large treatment plans," i.e. ten-thousand dollar plus cases. So what happens with all of the routine "bread and butter" dentistry? Normally, the doctor tries to present it in five minutes at the end of the new patient exam (or recall appointment as applicable) or leaves it to the front desk to do it. Result: poor acceptance.

I don't really agree with this approach. I also don't agree with scheduling a consult for two occlusal composites. We're looking for a happy medium here.

First off, I'd build time into the schedule to present treatment. If you're looking for a place to start, begin by allocating the first half hour to forty minutes in the morning and the first half hour after lunch to present treatment. Why first thing in the morning? Well, you're undistracted – not in the middle of any patients yet. And as an added bonus, if you're productive morning procedure cancels or fails, you could present, get acceptance and START their treatment that day (if the patient has time)!

I'd suggest first thing after lunch in a similar vein. Even if you run through lunch, you can grab a quick sandwich and then do your consult distraction-free.

WHAT you put into these consult time slots is up to you. In forty minutes (or an hour if you'd

like) you could easily present routine cases – i.e. two implants, a four unit bridge, three inlays or crowns, etc. They're not HUGE treatment plans, but present a couple these a day and you'll have plenty of production on your schedule and healthier patients.

Which brings us to the most important rule in all of this:

DON'T START A CASE PRESENTATION YOU DON'T HAVE TIME TO FINISH OR "CLOSE."

This right away explains the failure behind most of these "five minute" comprehensive case presentations at the end of an exam. You know, you tell a patient what they need and run to the next patient. You ask the Front Desk about this later and find out the patient is "going to think about it." The patient is then added to the "incomplete treatment list," which as we all know is about as useless as a glass hammer when it comes to filling the schedule.

Here's the problem: **if you don't have time to finish the presentation, answer questions, etc. you leave the patient in a perfect position to blow the office off.** I've found it actually lowers overall office case acceptance.

So, keep if simple. **If you have time to present today (and the patient does as well), go right ahead!** Keep the rules in mind of how much time you need (i.e. patient attitude and size of case) in mind as you do this.

If you don't (or patient doesn't) have time, then bring them back during one of your preblocked consult spots.

And the last thing about this: do it FAST. The longer you make a patient wait, the greater chance you have of them not showing up. Ideally, they can come back tomorrow or the day after at the latest.

STEP 3: PRESENT THE OPTIMUM TREATMENT PLAN.

A compilation of information from a comprehensive exam should provide what's needed to arrive at what you'd consider an *optimum* comprehensive treatment plan. A workable mindset might be:

treatment planning as if you (or a loved one) were the patient with the same or very similar diagnoses. In other words, there are no reservations or considerations about what insurance will cover (or not), there's no thought about what this patient can (or cannot) afford. These are not even a part of the equation.

The rule I had was:

TREATMENT PLAN EVERY CASE AS IF THE PATIENT WERE YOU (YOURSELF) OR A LOVED ONE.

It can be both frustrating and time consuming to try to "guess" what a patient will accept. And even more important, what a patient will or won't accept has nothing to do, really, with what they actually NEED. And in this respect, modifying your treatment plan based on what you "think" a patient will accept borders on dangerous. Diagnose and present what a patient *needs*. Some need little treatment. Some need a lot. And not everyone will accept – no matter how good you are at case presentations. Obviously the better you are, the higher the percentage of people that will opt to move ahead. But even then, I've yet to see even the best get uniform, long-term 100% acceptance. And that's fine. Just make sure you don't allow economics or insurance concerns seep into your thought process as a clinician or modify the idea of creating and presenting optimum treatment plans.

STEP 4: ENSURE YOU HAVE TIME (AND USE THIS TIME) TO ADDRESS AND HANDLE OBJECTIONS.

We often focus on how a patient will object to or provide reasons why they cannot accept or pay for full (complete) treatment plans. We can come to expect this. As sort of a "pre-emptive strike" many doctors try to avoid these objections by compromising their treatment plan in some way, especially with larger plans.

The most common forms this takes are:

1. Presenting a treatment plan in "phases," – i.e. we'll start with _____ treatment (without explaining that there is more). Or
2. Assuming that a patient would object to a more ideal form of treatment option and presenting only the alternative – i.e. patient has three missing teeth and the doctor presents a partial denture without mentioning any alternatives such as implants or bridge(s).

What's silly in many of these cases is that it's the doctor's own "sales" resistance that's creating this

issue. In many cases, these patients would probably have accepted the idea or complete treatment plan. The problem is the doctor "decided" for them – without giving them any opportunity to decide for themselves.

Which leads me to another rule:

IT'S VERY UNUSUAL FOR SOMEONE TO HAVE NO OBJECTIONS.

So get over it. They are going to object. Don't resist it. This is where the fun begins. This leads us to our next rule:

USE GOOD COMMUNICATION SKILLS TO DETERMINE IF THEIR OBJECTION IS FAULTY OR LEGITIMATE.

And what's the difference between a faulty and a legitimate objection?

Let's start by defining a "faulty" objection. By faulty we mean it's not the actual reason they don't want to proceed; it's just an excuse to get out of being "sold." This type of objection is usually given when there is no logical reason not to go ahead.

On the other side, some objections are "real," meaning a valid, logical reason to put off starting and/or paying for treatment. Being able to determine the difference between the two is a valuable skill. What to do when either comes up is even more valuable.

How to tell the difference between these two is covered in the next chapter of this ebook, *How to Effectively Handle Patient Objections*.

STEP 5: QUOTE THE FEE

If you're like 99.999% of the population, you want to know how much something costs before you buy it. The general consensus in the dental profession is that "Doctors aren't supposed to talk about money." As a matter of fact, when I was in practice, I asked an owner of a well-known consulting company, "What do I say when the patient asks me how much this will cost?" He said, "Look them in the eye and say—I don't know. Sandy handles all of that for me and she will go over it with you."

Yeah…that didn't work. I tried it once and felt foolish. If a business owner says they don't know how much their product costs you'd most likely think they are a) lying or b) not all that smart! So – my advice – don't do that! Tell them how much things cost. Don't run back to the lab and let your

Financial Secretary give them the "bad news."

Some doctors give some kind of prepayment or bookkeeping discount – i.e. 5% or something like this for payment in full. And it's not uncommon for any business to give some kind of discount to defer the costs of billing and follow-up, etc.

In any event, on this subject of fees and payment, the rule when presenting a treatment plan is:Dental Paying

THE DOCTOR SHOULD AT *MINIMUM* QUOTE THE FEE.

You can do more. You could take things a step further and discuss HOW the patient will pay and work this out – at least in general terms – prior to leaving it with your Financial Secretary or Treatment Coordinator. For example, if the fee for your treatment plan is $5,000 – you'd discuss how the patient would pay for it (check, credit card, patient financing and so on). There are a number of reasons why you'd do this, not least of which are:

1. Like it or not, the doctor's "word" carries more weight than anyone in the office. Patients tend to be more receptive and compliant when it comes straight from the doctor's mouth.
2. When you bring the financial issue up – you get an even better picture of the patient's mindset with regards to treatment. You'll see at once how serious (or not) the patient is about having the treatment done. From there you can address the situation accordingly.
3. One of the more common objections you'll hear is, "I can't afford that," or something along these lines. This might be covering for the fact that the patient is afraid of drills and needles, etc. Better to have this come up with the patient in the chair in front of you.
4. Lastly, whether you like it or not you are the "salesperson" in the office. A salesperson's job ends when payment has been received and services have begun. How can you possibly be effective at this job if finances are never discussed?

A cold-hard fact of business is that if it isn't paid for, then it wasn't **sold**. In dentistry we have become way too casual in gaining treatment acceptance and getting paid. We routinely do thousands of dollars of dentistry, bill the insurance and then bill the patient. It's not uncommon to not get paid for sixty days or more. That is unacceptable from a business standpoint and I'm sure I'm not the only one that has noticed that the case that isn't paid for often times leads to a patient who complains more.

Therefore, I suggest that for any major service the patient makes some kind of deposit i.e. at least a third down to 'reserve' time in the doctor's schedule. This lets you know that they have effectively addressed any barriers or objections and you have a good chance that they will arrive and get the treatment. So come to an agreement with the patient of how they will pay and then go get Sandy to

finalize the financial arrangements!

STEP 6: TELL THEM THE OPTIMUM TREATMENT PLAN THREE TIMES BEFORE YOU GIVE UP.

Sometimes things have to be repeated before they "get through." Advertisers know this concept well. And it's actually a simple communication technique.

Let's assume the patient doesn't want needles and drills inside their mouth. You have asked questions and found out that their objection is faulty. Now what? Explain the treatment plan again—at least an abbreviated version of it. Then tell them again how much it will cost. And don't be surprised if they give you a different faulty objection. Simply repeat step 4 and 5 – not robotically of course, you might vary some of your points or focus. But do repeat the data.

The rule is:

GIVE THEM THE OPTIMUM TREATMENT PLAN AND FEE AT LEAST THREE TIMES BEFORE COMPROMISING.

STEP 7: SELL SOMETHING.

Unfortunately we live on planet Earth and not in Disney World. You aren't going to sell them all and the ones you do sell may not close on the first consultation. This is just how some folks make their decisions. This leads to the next rule:

SELL SOMETHING.

So you've told them three times and it's going nowhere. Well then, without compromising clinically, sell them something that will help them. Here's where "phased" care comes into the discussion. Sell two crowns instead of six – again, only if you can do this without compromising clinically. While they are getting numb for those two you tell them three more times why they need the other four. And when they come back for their prophy tell them three more times. Don't forget to keep asking them if they want to keep their teeth in between repeating the treatment plan. Simply by persisting they will eventually do the entire case. And again, this should be done with open and heartfelt communication – don't just repeat their treatment like a "robot."

You may worry that this will offend them and they will get upset and leave. By my own personal experience it will only be 1%-2%. And if you really have their best interest in mind and they leave the practice then I'm not sure they were being honest and sincere with you when they said they wanted

to keep their teeth. Move on and don't let it stop you from helping the other 98%. Welcome to Earth.

What I have tried to do is lay out a very simple and mechanical methodology of how to do a case presentation and include a few rules. I suggest you read this at least three times (sound familiar?) And if you really want to become a professional at case presentations, come to the **MGE Communication and Sales Seminars.**

HOW TO EFFECTIVELY HANDLE **PATIENT OBJECTIONS**

While there might be any number of objections you could hear from a patient, I have what I'd call my "top six." They are:

1. ***I have no money***
2. ***I only want to do what the insurance covers***
3. ***I have to check with my spouse***
4. ***I need to think about it.***
5. ***I'm really busy right now and have no time for this.***
6. ***File a pre-determination of benefits***

First thing to know: Some objections are faulty. And by faulty I mean it's not the actual reason they don't want to proceed; it's just an excuse to get out of being "sold." This type of objection is usually given when there is no logical reason not to go ahead.

On the other side, some objections are "real," meaning a valid, logical reason to put off starting and/or paying for treatment. Being able to determine the difference between the two is a valuable skill. What to do when either comes up is even more valuable.

Prior to becoming an MGE client, my treatment presentations were more of a lecture to a patient rather than a conversation. I would show them their x-rays and say something along the lines of:

"Here's what's wrong, and this is the best course of treatment if you want to keep your teeth. I know it's more than what you wanted to spend right now, but it's an investment in your health…"

Meanwhile, the patient sat there listening while I rambled on.

Early on in my MGE training, I learned an important lesson:

YOU HAVE TO GET PATIENTS TO TALK TO YOU AFTER THEY GIVE YOU THEIR FIRST OBJECTION.

The **MGE Communication and Sales Seminars** taught me that communication is a "two-way street." And the key factor in getting them to tell you exactly what's going on is persistence.

Now, the way to get someone to talk to you is to ask questions. Try this experiment: the next time

you are standing in line somewhere, look at a stranger and ask them a question, like "How about them Yankees (or whatever team)?" or "What do you think about the weather lately?" You can even get creative and ask a question about something they are wearing.

Eighty percent of the time, something magical will happen: they'll give you an answer and you'll have something to talk about. This little exercise may take you out of your comfort zone, but I encourage you to try it. I did this on an airplane once and found that the person sitting beside me was the sister-in-law of a dentist I knew. It's actually fun!

HOW DOES THIS APPLY TO OVERCOMING OBJECTIONS?

For this, I'll give you a few examples using the first of my "top-six" list of objections above.

"I have no money"

Sometimes this objection is real; the patient truly can't afford it. But not if they just told you about their trip to Las Vegas or their new car. We don't believe they can't put it on a credit card or get approval for 3rd party financing—but we can't come outright and say that.

So what should you do – without running the risk of upsetting your patient? Simple:

GET THEM TO TALK TO YOU BY ASKING A QUESTION.

When they say, "I have no money," you might respond with, "I understand. Could you put that on a credit card?" Find out what's really on their mind by asking questions and getting them to talk to you. Do this in a friendly and comfortable way – don't challenge them, talk to them. I realize that this can be uncomfortable to discuss, but your dental office is your business and you have to be willing to talk about financial matters.

Once you get them talking, you can get what's actually on their mind. **And surprise, surprise – oftentimes money isn't really the issue.**

What is it, then?

Well, here's what we face in dentistry:

PEOPLE DON'T LIKE NEEDLES AND DRILLS INSIDE THEIR MOUTH!

The fact is: people who are afraid don't see things logically. When someone is afraid of needles and drills inside their mouth, they tend to withhold what is really going on with them. Of course they say they have no money—**if they admitted they did have money, they would end up with needles and drills inside their mouth!**

Most patients could put $3000 on a credit card if they wanted to. And with today's financing options, most would easily be able to qualify for that amount or more. If you ask if they can put the cost of treatment on a credit card, there's a great chance they'll say, "I can, but I don't want to." Now here is a critical point:

YOU JUST IDENTIFIED THEIR OBJECTION AS FAULTY (based on the definition above).

The patient isn't really sold on doing the treatment yet, and it has nothing to do with the money. The next action is too simple to believe it actually works.

EXPLAIN/REVIEW THE TREATMENT PLAN A SECOND TIME.

The patient probably wasn't listening to you the first time because of some "consideration" other than money, so tell them again. You might point out a few things you didn't the first time. The rule is:

TELL THEM WHAT THEY NEED AT LEAST 3 TIMES BEFORE COMPROMISING OR GIVING UP.

A miracle will happen at least 50% of the time—they will ask YOU a question, such as:

- "Am I going to get a shot?"
- "Are you going to grind all the enamel off of my teeth while making the crown?"
- "Mom has a crown that is still sensitive to hot and cold. Will that happen to me?"

Now we have true communication: they are asking you questions. You've had this happen before. You just didn't realize you found a gold nugget—the actual objection to treatment. It had nothing to do with the first six objections I mentioned at the beginning of the article.

I've personally found that the most effective way to handle patients' objections is to ask questions and get them to open up about *what's really on their mind*. To this end, you should come up with questions you are comfortable with.

REAL VERSUS FAULTY OBJECTIONS

How can you definitively tell the difference between these two types of objections? A couple of points that can steer you in the right direction:

1. A patient will "bounce around" with faulty objections. They'll tend to "stay put" with the real one.

With a faulty objection, the patient will tend to offer it up, you'll handle it and then they'll use another. Example: Patient says they need to think about it, then after talking to them a bit more, they bring up that they're very busy right now and so on. This person – most likely just doesn't want to be "sold" and you haven't found the real reason they don't want to proceed.

If it's real, they'll stick to the same one more or less. If they tell you they want to think about it, you might ask about this and they'll tell you that they never spend more than $2,000 (the treatment plan is, let's say, $4,000) without at least 24 hours to think about it or "cool off." Talking to them some more, you might find that they have done this every time since making a purchase they regretted 20 years ago. And while (believe it or not) we can teach you how to handle this too, for the most part, you'll have to give the patient their 24 hours to think. If it was the real thing, they'll probably call 24 hours later to schedule.

2. A patient will open up about a real objection. They won't with a faulty one.

Faulty Objection:

Doctor: *I'd like to get this treatment started as soon as possible.*

Patient: *I can't afford it.*

Doctor: *We have some excellent financing options available*

Patient: *I don't have money right now. I'm also very busy.*

In this case, the doctor hasn't discovered WHY the patient doesn't want to proceed.

Real Objection:

Doctor: *I'd like to get this treatment started as soon as possible.*

Patient: *I know I need it and wish I could, but I can't afford it right now.*

Doctor: *We have some excellent financing options available*

Patient: *Yeah, I was thinking about that, but I'm in the middle of refinancing my house. I can't spend money or apply for credit. I have it available on a credit card, and I also might take you up on your financing, but I have to finish the refinancing first. We should be done in a month.*

Do you notice how in this example the patient is TALKING? Informing you of what's actually going on? That's real! While the patient may have to wait in this scenario, I can more or less guarantee they would be more likely to follow through than in my first "faulty" objection scenario!

EXAMPLES

Here are a few examples, using numbers two through six from my top-six list of patient objections:

"I only want to do what the insurance covers."

This is an interesting one. Let's take a broad look at how people in society feel about teeth and dental insurance:

Some people have their teeth more important than their insurance plan and some have their insurance plan more important than their teeth.

When someone says this, you have to find out which category they fall into. Then you will know how to proceed. So my suggestion in how to respond is to ask them 'Do you want to keep your teeth?'

If they say "Yes," then it probably has nothing to do with what the insurance will cover.

"File a pre-determination of benefits for me"

"Do you want to keep your teeth?"

"I need to talk to my spouse."

You could ask something along the lines of: "What do you think they will say about it?" You could also ask: "If it were only up to you, would *you* go ahead with the treatment plan?" If anything, you'll get some indication as to where *they* are at with regards to moving ahead.

This is one of the trickier objections because you're not just dealing with one person. In some cases, it's the real deal: the patient has to speak with their spouse before going ahead. In others, it's the patient not wanting to be "sold." Every relationship is different; some people have an agreement that they make no major purchases without a discussion. Some have one person in-charge of the finances and the patient in the chair may not be the one!

If you run into a scenario where a spouse needs to be consulted, the patient may wish to give them a call or better yet, I'd recommend having the patient back in WITH their spouse for a free consultation. Why? Your patient just sat through your treatment plan presentation and understands why they need the treatment along with the cost. Their spouse doesn't. When your patient

goes home to explain it – the one thing you can guarantee the spouse will understand is the cost! But not having seen *why* the treatment is needed, they won't be able to make an educated decision.

Bringing the spouse in for a consult to explain it again will allow them to see why it is needed. Worst case scenario, you'll meet the spouse and it will still be a "no." Best case, the spouse may not already be your patient – so you could not only "close" the treatment plan, but also end up with a new patient in the bargain!

And as I said, relationships are different. You may ask for the patient to come back with their spouse and they reply, "It's not a problem – he/she won't have any problem with me doing it," or something like this. They go home, discuss it and schedule the next day.

In any event, the key is communication. The better the quality of the communication with your patient (meaning they are asking questions too), the easier it is to determine the right way to go about handling this objection.

"I need to think about this."

"Is there something I didn't explain very well?" You may also ask: "Is there something about the treatment plan that you have a question about?"

"I'm very busy right now."

"Do you want to keep your teeth?" You could also ask "How important is it to you that you keep your teeth?"

SUMMARY

Remember one thing – you're not going to "close" them all. If you're running at around 80% "close" rate – that's just fine. Some people are ready to go right away – others may have to wait. It all depends on the person. Although if you know your business with treatment presentations, I'd bet you'll find that many of the people who would have put treatment on "hold" in the past (for no good reason) will decide to move ahead. If you want to master this skill, attend the MGE Communication and Sales Seminars!

I know some of what I've written about goes against what you've heard from seminar speakers and consultants. We are taught to be cautious and afraid and never do anything like this. I say BE BOLD! Engage the patient so that they communicate with you.

As dentists we have a valuable service that people NEED. It's time we bring our communication skills up to be more in line with our clinical! Patients need to understand what's really going on. And what you'll find is that when they do, most are happy to get their treatment done!

COMPREHENSIVE CASE ACCEPTANCE IS A **TEAM ACTIVITY**

Comprehensive case acceptance is far easier when the entire team is on board. And by that I mean you want one and all aligned with the mission of providing your patients with the best possible care to help them live healthier, longer lives. With this in mind, there are five critical roles pertaining to case acceptance which can easily break down if everyone doesn't carry out their part of the process. They are:

1. Appointing Patients

Whoever answers the phone and schedules new patients must be able to "sell" the patient on coming in for an exam to see the doctor. Admittedly, handling the phone properly could be its own article but this staff member must be able to get through "Do you take my insurance?", "How much is it for a crown?", "Do you have Saturday hours?", etc.

Whoever handles these calls in your office must be drilled and drilled to the point where they could handle anything a prospective new patient throws at them without having to "think" about it. Ideally they should be able to get a prospective new patient to schedule and come in at least 70% of the time.

As in all sales, it's unrealistic to close everyone, but a log book, spreadsheet or some type of record must to be kept to reflect all new patient calls and show the result of each one. Doing this will not only record your level of success but will also point out patterns of troublesome objections that the staff can be taught how to handle.

2. Doctor as Diagnostician

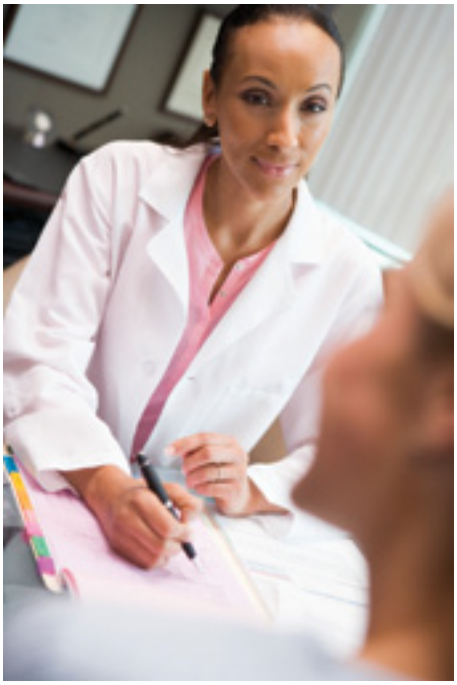
The patient is in the chair. Now it's critical to diagnose exactly what the patient needs with no regard for their insurance coverage or apparent financial situation. We have fallen into a bad pattern in dentistry of inspecting the insurance plan before inspecting the mouth. We are trying to

diagnose the patient's attitude about dentistry or their finances before diagnosing what they need in order to have a healthy mouth. We then let that affect how much dentistry we diagnose and treatment plan.

It is critical that the doctor examine each patient as if they were a close friend or relative. Forget about insurance coverage or lack of apparent finances. Diagnose the patient sitting in front of you for what they need to restore their mouth to optimal health. Without a comprehensive diagnosis there is no chance of them receiving an optimum treatment plan. We'll worry about getting them through their objections or barriers next.

3. The Case Presentation

At MGE, we teach our clients that the doctor is best at handling the patient's objections. They are, after all, the authority and the one who created the treatment plan. But whether it's the doctor or a staff member presenting treatment, handling objections should be done by someone who has a clear purpose and truly believes that every patient should receive optimum dental care. This should be the underlying purpose behind the case presentation. Patients live longer if they have optimum dental health so this process can't be undertaken flippantly or rushed.



If it's a staff member presenting the treatment (i.e. Office Manager or Treatment Coordinator, etc.) they should be instructed to go get the doctor if the patient wishes to change the treatment plan or wait (or not do it at all). Staff should not be making these decisions as that's the doctor's job. Faced with this, when the patient balks, a simple, "I understand. Let me go get the doctor," can work wonders with case acceptance. In many cases the patient might just come off of their objection and move ahead or when the doctor comes to talk with them, he or she finds an underlying concern or question which was never addressed.

For the doctor, I'd recommend a) presenting their full treatment plan and b) trying to help patients through their barriers so that they accept their full treatment plan. At the very least, if they won't do the whole thing, get their agreement to return for at least the first part of what was diagnosed. Then add ten or fifteen minutes onto that next visit to discuss the balance of the treatment plan. Not many patients like having needles and drills inside their mouth, so be patient with them. They may need to hear the treatment plan several times and become more comfortable with you as their dentist before they finally agree to having all necessary work completed.

4. Payment

This is a critical part of the process—not because you're after their money but because once they pay, you have a ninety-nine percent chance that they will return and have the necessary treatment

completed. In business, nothing is sold until it's paid for. We've fallen into a bad business practice, in dentistry, of doing thousands of dollars of dentistry and then counting on the Financial Secretary to chase up a large accounts-receivable so the bills can be paid.

But let's forget about sound business practices for a second. The patient needs the diagnosed dentistry for the improvement of their health and the extension of their life. We know that no one likes needles and drills inside their mouth, so how do we help assure that they will follow through? Have them pay for it. It's a simple concept. Once they pay, it is evidence that they are ready to proceed. And while nothing is one hundred percent, once they pay, it's virtually certain they will return for the treatment. Until they've paid, fear can talk them out of it. Paying makes them braver. So help them out and have them pay.

5. Recall

How is this part of effective case acceptance? It's because no one "sells them all."

Now, I firmly believe and worked hard to get patients to agree to getting all active disease out of their mouth or they would have to find another dentist. While each patient had their own individual circumstances, if someone wanted me to be a "patch up dentist" and didn't care about their teeth, I referred them elsewhere. How could this translate into your practice? Well, this means that you shouldn't "watch" an obvious carious lesion, periodontal pocketing or periapical abscesses. You handle it….ASAP. It's definitely a "tough love" approach but we have sometimes gotten too afraid to tell the patient exactly what they need to get healthy. We unnecessarily worry about what they will think if we tell them that they have to leave the practice if they refuse to take X-rays or treat their disease. You're a doctor and you can't "supervise" disease.

But if they preventatively need six crowns and don't want to proceed immediately, I don't recommend you dismiss them. This is where an effective recall program comes into play. Get their agreement to return two, three or four times per year to maintain their oral health. At each of these visits you have another opportunity to enlighten them on why it would be prudent to do their preventive work. I would often do this at the new patient exam when explaining that I wanted them to keep their teeth the rest of their life and live longer.

A healthy practice is adding at least one day of hygiene every year—if not every six months. This should be a coordinated effort of all team members: the hygienist sets up the next visit when finished with the current visit, the assistant talks to the patient about their next recall visit when dismissing the patient after their last operative appointment, and all staff say goodbye with "See you in six months." This message, reinforced by each staff member, will make all the more real how important maintenance is and that the entire team is on the same page.

So, there you have it. Comprehensive case acceptance is a team activity. If everyone is on the same page, your patients and your practice will be far healthier.

"WHAT SHOULD I DO NOW?"

You have 3 options:

1. Give us a call today to speak with a consultant for free! (800) 640-1140

2. Attend one of our FREE 1-day CE Seminars:

The Art of Scheduling Productively Seminar

A proven system to make your schedule consistent and ultra-productive

The Real Solution to Cancellations & No-Shows Seminar

Cancellations & No-shows can cost the average doctor in excess of $100,000 a year. Learn how to fix this

The Effective Case Acceptance Seminar

Discover the secrets industry leading dentists use to get patients to accept and pay for full treatment plans

The ULTIMATE Internal Marketing Seminar

Revolutionary internal marketing techniques and an exceptional customer service system that create a flood of new patients into your practice

The Profitable Hygiene Seminar

You could be making 30% of your collections from your hygiene department... without changing anything clinically!

The Keys to Practice Profitability & Overhead Control Seminar

Powerful, yet easy-to-use information that every dentist should know to improve profitability in their practice

To register for any of these seminars or see the event callendar, give us a call at (800) 640-1140 or visit our website at www.MGEonline.com today!

3. ATTEND THE MGE **COMMUNICATION & SALES SEMINARS**

For over 20 years, thousands of health care professionals and their staff have used the **MGE Communication and Sales Seminar Program** as a vehicle to help their patients, boom collections and move case acceptance to the next level. Serving as a gateway to the MGE training program, the **MGE Communication and Sales Seminar Program** is one of the first steps MGE clients take on the road to a successful, profitable office.

Of course improving communication skill will boost your case acceptance – but there are also many side benefits – communication is used in every aspect of your life and work. So, these seminars are great for auxiliary staff as well. Having good communication within the office will help your staff tremendously to work well together as a team.

It's not uncommon for an MGE client to experience a **dramatic increase in their collections after just one seminar** – by helping their existing patients to accept the dentistry they've been avoiding. It's a win-win situation for both you and your patients – they get the treatment they need and you get the satisfaction of performing that needed treatment.

Call (800) 640-1140 for more information, or to speak with one of our consultants for FREE!