Ortho Tribune

The World's Orthodontic Newspaper · U.S. Edition

September 2008 www.ortho-tribune.com Vol. 3, No. 9

Inside this issue

Ready for a change

As a teenager, Dr. Janet Stoess-Allen was inspired by her own orthodontist to enter the profession. Today, she is spreading the word about why all residents should learn more about neuromuscular dentistry and why being open to change is one of the most important things you can do in the field.

Page 4

Effective marketing in five steps

Is your current marketing plan not bringing in the patients you hoped? Don't give up. With the right coordinator, the right budget and the right game plan, you can keep your profits up even in these tight times.

Page 11

A second chance

When Demetria Slan was diagnosed with breast cancer, she had to put a lot of her life on hold, including getting the perfect smile she always wanted. But with the help of Orthoease, Phoenix charity Singleton Moms and one really generous orthodontist, Slan — now in remission — is getting her dreams after all.

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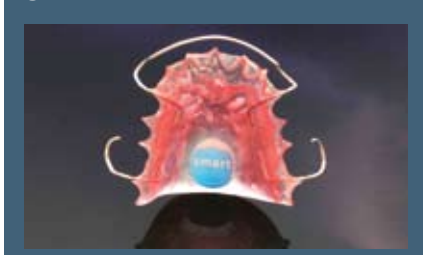
Helping patients get SMART



Ortho Tribune sits down with Scientic Compliance CEO Bill Longley to get the inside scoop on the company's SMART retainer, how it can help orthodontists and what 'Today' show host Matt Lauer has been saying about it.

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Industry Report

Invisalign Teen launches

By Joanna Farber

Align Technology, Inc. has welcomed a new addition to its Invisalign® product family. Invisalign Teen,™ designed for non-adult comprehensive orthodontic treatment, officially launched on July 29.

A pilot program involving top orthodontists in California, Arizona and Illinois began in February 2008, and was expanded nationally to top Invisalign orthodontists in June.

Invisalign Teen aligner with teen-specific features.

The orthodontists' key needs

Orthodontists participating in a 2007 nationwide survey commissioned by Align identified challenges common in teen treatment that held them back from using Invisalign on more of their younger patients — namely, patient compliance and the ongoing development of permanent dentition.

Invisalign Teen was specifically designed with the non-adult comprehensive market in mind, and it addresses the special needs of patients who have shed all their primary teeth and whose second molars have begun erupting.

Darrell Zoromski, Align's vice president of global marketing and chief marketing officer, said: "Teenagers are a significant portion of the orthodontics practice; patients aged 12 to 17 represent approximately half of all patient case starts in the United States each year.

"Until now, only a small number of doctors have treated their non-adult patients with Invisalign because of concerns such as patient compliance and the need to accommodate permanent teeth that are still coming in.

"We have addressed these issues with Invisalign Teen. Now orthodontists will have confidence that they can treat their teen patients successfully with Invisalign."

Teen

01 *see page 18*

The missing element to complete care

How orofacial myofunctional therapy can help the orthodontist

Part 2

By Joy L. Moeller, BS, RDH, COM
(Certified Orofacial Myologist)

Because most of our patients are in need of orthodontic treatment, if the patient was referred by a source outside of dentistry, we are certainly a great potential referral source for orthodontists.

Orofacial myologists can assist the orthodontist in many aspects of his or her practice to:

- Provide muscle patterns that promote a stable orthodontic result.
- Reduce the time spent in fixed appliances.
- Normalize the inter-dental arch vertical rest posture dimension, the freeway space.
- Identify and eliminate orofacial noxious habits that interfere with stable orthodontic results.
- Teach nasal breathing and remodel the airway through nasal cleansing and behavior modification.
- Reinforce compliance with wearing rubber bands, functional appliances and retainers.
- Develop a healthy muscle matrix and eliminate habits that contribute to TMD.
- Promote correct physiologic head and neck posture.

Myofunctional

01 *see page 5*

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Running an office utilizing human resources management

By Dennis J. Tartakow, DMD, MEd, PhD, Editor in Chief

Part I

At the end of a postgraduate orthodontic educational program, most orthodontists haven't the slightest idea about the business end of running an office unless he or she has had some business courses or possibly an advanced degree such as an MBA. This editorial is aimed at comparing our offices with that of formal organizations — theory, practice and structure; in essence, they are the same, so let us see what we can glean from understanding some basic principles of human resources.

In the realm of social sciences, the orthodontic office and its staff offer social arrangements that pursue collective goals. Social science researchers often examine organizational theory and practice from several different modalities, the most common of which are sociology, psychology, economics, political science, human resources management and communication.

For purposes of this article, we will discuss the orthodontic office as an organization in its relationship to human resources management (HRM) because the structure, function and productive ends are virtually the same. The organizational structure is directly related to the function and mission, as well as the rules and regulations for controlling activities in either a boutique practice or the larger offices. The organizational structure is a means to an end in order to achieve its goals and create focus on its objectives, which requires the effort of all employees.

When comparing our orthodontic offices to more formal organizations, the central theme is primarily in the lap of the staff and orthodontist, the chief executive officer (CEO). That is because all employees help to create and maintain the health of the organization. Both the organization and human beings are goal-directed unities that might be looked upon as two essential variables, which are important for considering the properties and functions of each, in order to predict results such as: (a) goals, (b) objectives and (c) missions that develop when all efforts work in concert with each other in the same direction in creating the whole.

In other words, in the organizational structure it is important to look at each member individually and how each person relates to each other individually and as a group, but each individual must also be aware of his or her place and function within the organizational structure.

The development of the individual in our culture is omnipotent. It is hypothesized that the development of the human personality, in our culture, pursues direction and dimension. Therefore, in considering the HRM dimension of the organization, growth of the individual, group or structural component of an institution is neither black nor white, but rather a matter of degrees.

This concept postulates that each dimension for any one individual is a continuum that can be plotted at any particular time and which does not take for granted that the adult human is self-centered and interested in only his own growth. However, one characteristic of an adult in our society or culture being predisposed to a mature end of the continua simultaneously allows others to do the same. Each person's wholeness is derived from interactions with others.

An adult never assumes that he or she will be independent, have control or be completely active and not inhibit the growth of others. Self-actualization does not mean happiness, or a state where there is no tension and everything is going OK; tension might provide motivation for growth and might also be healthy.

According to Plato, individuals typically strive to become ideal, perfect and complete. Ideals are, in that sense, a motivating force. In fact, he identifies the ideal with God and perfect goodness. God creates the world out of materia (raw material, matter) and shapes it according to his "plan" or "blueprint" — ideas or the ideal. If the world is not perfect, it is not because of God or the ideals, but because the raw materials were not perfect!

Plato applied the same dichotomy to human beings: There's the body, which is material, mortal and "moved" (a victim of causation). Then there's the soul, which is ideal, immortal and "unmoved" (enjoying free will). The soul includes reason as well as self-awareness, ethics, and moral sense. Plato said the soul would always choose to do good if it recognizes what is good. Rather than bad being sin, it is considered a matter of ignorance. Therefore, when someone does something bad, he or she requires education, not punishment.

If we assume that this is correct, then there is no reason to think that such phenomena present a threat to the general view that motivational states such as desires always aim at the good or to the view that we only desire to do the bad under the species of the good (sub species boni).

In describing the resource management dimension of organizations, an effective administrator has three basic traits in common: technical, human and conceptual skills:

1. *Technical skills* for the mechanical part of the job, which might be possible only for larger companies where the CEO has extensive staff assistance, as well as competent, experienced technical operators in the organization. Older companies typically have operational momentum that affords a new CEO to concentrate on strategic issues and planning.

2. *Human skills* in working with others as an effective and cooperative member of a group. These skills can be further subdivided into (a) leadership ability within the manager's own unit, and (b) skill in inter-group relationships. Outstanding capability in one role often is accompanied by mediocre performance in the other.

3. *Conceptual skills* for recognizing the interrelationships of factors that led him or her to take action to achieve the maximum good for the organization. This depends upon a specific way of thinking and involves thinking in terms of (a) emphasis and priority on conflicting objectives and criteria, (b) tendencies and probabilities, not certainties, and (c) correlations and patterns of elements, not clear cause-and-effect relationships.

(For more on the similarities of ortho practices and human resources management, read Part 2 in October's issue of Ortho Tribune.)

OT Corrections

Ortho Tribune strives to maintain the utmost accuracy in its news and clinical reports. If you find a factual error or content that requires clarification, please report the details to Kristine Colker, Managing Editor, at k.colker@dtamerica.com.

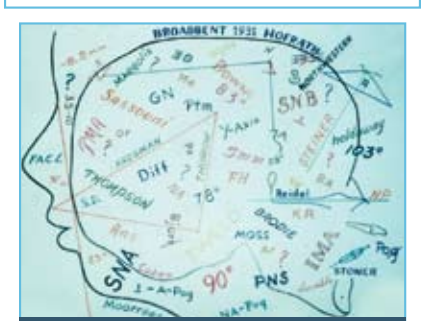

Image courtesy of Dr. Earl Broker.

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ORTHO TRIBUNE
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Publisher
Torsten Oemus, t.oemus@dtamerica.com

President
Eric Seid, e.seid@dtamerica.com

Group Editor
Robin Goodman
r.goodman@dtamerica.com

Editor in Chief Ortho Tribune
Prof. Dennis Tartakow
d.tartakow@dtamerica.com

International Editor Ortho Tribune
Dr. Reiner Oemus
r.oemus@dtamerica.com

Managing Editor/Designer Ortho Tribune
Kristine Colker
k.colker@dtamerica.com

Managing Editor Endo Tribune
Fred Michmershuizen
f.michmershuizen@dtamerica.com

Managing Editor Implant Tribune
Sierra Rendon
s.rendon@dtamerica.com

Product & Account Manager
Humberto Estrada
h.estrada@dtamerica.com

Product & Account Manager
Greg Anderson
gregory.anderson2@comcast.net

Advertising & Event Coordinator
Anna Wlodarczyk
a.wlodarczyk@dtamerica.com

Marketing & Sales Assistant
Lorrie Young
l.young@dtamerica.com

Director E-publishing & E-learning
Ovidiu Ciobanu, PhD, MBA, DMD
ovidiu@doctor.com

Design Support
Yodit Tesfaye
y.tesfaye@dtamerica.com

Dental Tribune America, LLC
213 West 35th Street, Suite 801
New York, NY 10001
Phone: (212) 244-7181, Fax: (212) 244-7185

BPA WORLDWIDE BUSINESS

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Last chance to win Levin Makeover!

Entries due Sept. 30

Dreaming of explosive growth for your orthodontic practice? Dream no more. Or at least one lucky practice will dream no more.

Levin Group, in conjunction with Ortho Tribune, is in search of an orthodontic practice that is ready to reap the rewards of a free* year-long orthodontic practice management consulting program.

Imagine having the leading orthodontic management consulting firm working with you and your staff for an entire year to catapult your practice into the next level of growth, productivity and fulfillment. No more days of inconsistent starts, chaotic schedules, staff conflicts, flat or declining growth, no-shows or daily stress. With Levin Group's expertise and guidance, the winning orthodontic practice will experience improvements in every aspect of running the practice. This management makeover will be a customized approach based on the selected orthodontic practice's unique needs, goals and potential.

As orthodontists, you know the importance of having the right business systems in place. So ask yourself, when was the last time you took a close look at your practice's systems? It may be time to re-evaluate and replace outdated business systems. Orthodontists in every phase of their career can benefit from improving the management of the practice. Growth is always within your reach — even in this weak economy. The Levin Group Orthodontic Practice Power Makeover may just be the answer to achieving your dream practice!

Levin Group Orthodontic Practice Power MAKEOVER

All Ortho Tribune readers will benefit from the Levin Group Orthodontic Practice Power Makeover as the winning orthodontic practice's 12-month journey will be profiled throughout the entire process. Updated articles every few months will highlight how the Levin Group consultants and the orthodontist work together to achieve the desired results. These articles will get you thinking about ways you can start on your own ortho practice power makeover!

How do you enter to win this opportunity of a lifetime? Visit *www.levingroup.com* and click on Levin Group Orthodontic Practice Power Makeover on the homepage to access the online entry form. Deadline for entries is Sept. 30. Good luck!

** Winning practice receives a free, one-year Levin Group orthodontic management consulting program. Travel expenses for the Levin Group consultants and orthodontist during the year-long program are the responsibility of the orthodontic practice.*

AAO elects new officers

The American Association of Orthodontists (AAO) elected officers for 2008–2009 and installed a new member of the Board of Trustees at its 108th Annual Session held in May in Denver.

Raymond George Sr., DMD, of Lincoln, R.I., was elected the AAO president. Dr. George is in private practice in East Providence, R.I. and South Attleboro, Mass. He has been active in organized dentistry and orthodontics for many years, serving local, state, regional and national dental and orthodontic organizations. He is a past president of the Rhode Island Dental Association, the Northeastern Society of Orthodontists, the American Association of Orthodontists Foundation and the College of Diplomates of The American Board of Orthodontics, among others.

Robert J. Bray, DDS, MS, of Somers Point, N.J., was elected president-elect. Lee W. Graber, DDS, MS, MS, PhD, was elected secretary-treasurer. Dr. Graber also represents the Midwestern Society of Orthodontists on the AAO Board of Trustees.

Nahid Maleki, DDS, MS, of Washington, D.C. was installed as the new Trustee on the AAO Board of Trustees. She will represent the Middle Atlantic Society of Orthodontists (MASO).

AD

‘Keep your mind open to learning’

Dr. Janet Stoess-Allen talks to Ortho Tribune about her love of orthodontics and why she thinks all residents should learn about neuromuscular dentistry

By Dennis J. Tartakow
DMD, MEd, PhD, Editor in Chief

Please introduce yourself to our readers and tell us about your background in orthodontics.

I went to the University of Louisville Dental School and completed my orthodontic residency program at New York University. After finishing my residency, I moved to Florida and purchased my first practice in Delray Beach where I practiced until 1995. After getting married, I moved back to New York where I have practiced for the past 15 years. My current solo practice is on Park Avenue in New York City, where I have been for the past 10 years.

What motivated you to become an orthodontist?

As a teen, I was treated by an orthodontist in Louisville, Ky., where I was born and raised. I always looked forward to my appointments with my orthodontist, Dr. Robert Coomer, for several reasons. He always appeared very happy doing his job, which I found very comforting and positive. I found the whole process of tooth movement fascinating and wanted to understand how it was possible to move teeth without damaging them and the bone around them. There was also a very nice lab technician who worked in the practice where I was treated; I used to watch him make appliances, which I found interesting. The whole atmosphere was always pleasant and inviting, and everyone there seemed happy.

When and how did you open your orthodontic practice?

I purchased my first practice from a retiring orthodontist in Florida. When I moved back to New York, I worked as an associate in a few practices outside of Manhattan for a few years. I always dreamed of having a practice on Park Avenue, and ultimately that dream became a reality. In 1999, I purchased my cooperative space on Park Avenue, renovated it and the rest is history.

What special areas of education, research or clinical activities are you most interested in and why?

As an orthodontic resident and in my early years of practice, I struggled with mandibular positioning — in the vertical and horizontal planes. I never agreed with forcing a patient’s jaw into centric relation and treating to that position simply because it was “reproducible.” After searching unsuccessfully for some time, and seeing many patients in my practice who had been orthodontically

Dr. Janet Stoess-Allen with the staff of her private practice in New York.

Dr. Janet Stoess-Allen with her husband, Lowell, and son, Zachery.

treated and were subsequently having symptoms of TMD, I was very fortunate to stumble upon a very brilliant neuromuscular dentist by the name of Dr. Jay Gerber. I studied under Dr. Gerber and actually spent time shadowing him in his practice in West Virginia. He answered many of the questions I had and ultimately changed my life as an orthodontist. I felt I finally had some answers to questions that would help me tremendously in my career as a practitioner. Very simply, it taught me to work with the natural positioning of the mandible with the condyles symmetrical and centric in the glenoid fossa — in a physiological rest position. As it was explained to me, by attaining this position, it allowed the muscles to rest with minimal electrical activity and to perform their functional activities with a strong bilateral symmetrical activity, which is healthy.

As an educator, what are your most important educational responsibilities to your post-graduate orthodontic residents?

I am not currently affiliated with a teaching institution. I do, on occasion, lecture with my friend and colleague, Dr. Neil Zane, who practices neuromuscular dentistry. We currently treat many patients who are suffering from TMD, following the guidelines of neuromuscular positioning. Our methods of treatment are constantly changing and evolving in response to each individual patient’s needs. In our lectures, we share the treatment plans and results of our mutual patients.

In your opinion, is there a need to change the way higher educational programs in this country educate their orthodontic residents?

I would like to see more emphasis, especially in two areas. First, there should be a very strong focus on mandibular/condylar placement in orthodontic treatment and the beneficial effects on the relationships of the head, neck and facial muscles. Second, there should be a much stronger focus on each individual patient and his or her overall dental needs. In most cases, a team of dental specialists and general dentists should be spending time treatment planning each case together so that all the dental needs of the patient are met and in the proper sequencing.

What changes would you make if you could and why?

In all orthodontic residency programs, and even in the undergraduate dental school programs, I believe that neuromuscular dentistry should be introduced so that students have a better understanding of the whole patient, taking into consideration the relationship of the jaw, teeth and muscles and how they work together optimally at their most relaxed, efficient state.

In your opinion, what changes do you foresee in orthodontic education in the near future?

I feel that change is very slow coming and that the changes I would like to see in the area of neuromuscular positioning from an orthodontic standpoint is very misunderstood or often unknown. I hope the field will be investigated by orthodontic educators and, in time, change will come. It is a very gratifying area as we help people feel better with an improved quality of life.

Looking back at your career, would you do anything differently?

For the sake of my patients in the past, I wish that I had known then what I know now with respect to neuromuscular positioning. However, I feel that you can’t look back and regret but rather be grateful for the knowledge you now possess. I would really do nothing differently as the evolvement that I have been so fortunate to enjoy has been such a true learning experience and positive addition to my life.

Do you have any final comments for our readers?

My greatest words of wisdom are to keep your mind open to learning and change. The fields of medicine and dentistry are ever changing and improving. It is very sad for me to hear from colleagues that they are practicing the very same way that they always did simply because it is easy and it works for them. It may work for them but still be wrong for their patients or, even if it isn’t wrong, it might be better. We can always improve and provide better patient care if we are willing to listen, be open-minded and take chances. If we don’t listen and really hear our patients, we will never adequately treat them appropriately.

OT About the doctor

Dr. Janet Stoess-Allen received her BS (with honors) from the University of Kentucky, her DMD from the University of Louisville and her postdoctoral certificate of orthodontics from New York University. She has practiced orthodontics in Delray Beach, Fla., Hauppauge, N.Y, Southampton, N.Y., and New York City. Dr. Stoess-Allen has received a grant and Thesis Award for “Cleft Palate — TMJ Dysfunction” as well as a first place award for her table clinic on “Oral Cancer — Soft Tissue exam.” Her hospital appointments include Mount Sinai Hospital, New York, N.Y., and Bethesda Hospital in Boynton Beach, Fla. She resides with her husband, Lowell, and their son, Zachery.

OT Contact

Janet H. Stoess-Allen, DMD
935 Park Avenue, Suite 102
New York, NY 10028
Phone: (212) 452-2777
E-mail: Drstoessallen@aol.com

Myofunctional

OT *from page 1*

The best time for the orthodontist to refer the patient to an orofacial myofunctional therapist is before the braces go on or before the braces come off, depending on the patient's facial structure and motivation. We can work together to help the motivated patient achieve amazing results.

To elaborate on the importance of the working relationship between OMTs and orthodontists, I have reached out to some of my esteemed colleagues for commentary, which follow below.

According to Dr. John Kishibay, an orthodontist from Santa Monica, Calif., and a professor at USC School of Dentistry: "Orofacial myofunctional therapy must be part of the treatment plan from the beginning. This way the patient understands from day one that the muscle adaptation is important for long-term stability.

"Especially important would be the orthognathic patient. The patient must learn to use the new space in an ergonomic manner, in both a functional patterning and habit elimination awareness."

Dr. William Hang, an orthodontist practicing in Westlake Village, Calif., believes that OMT problems are one cause of poor facial development. He claims: "Stability will continue to be an elusive, unachievable goal with poor facial balance frequently being the norm of the post-orthodontic result. Myofunctional therapy must become the first line of defense in the quest for proper facial development rather than the rescue squad when the orthodontic result is going up in flames. When orthodontists embrace myofunctional therapy, they stop treating symptoms and begin to focus on treating the cause of poor facial development (altered rest oral posture)."

Dr. Jerry Zimring, a practicing orthodontist for 44 years in Los Angeles, believes that attaining proper occlusion is a state of balance between the teeth, the muscles and the bones. He states: "Both my daughter and my grandson were treated with myofunctional therapy with excellent results that would not have been possible without this valuable treatment. I feel strongly that myofunctional therapy should be part of every orthodontic practice."

Dr. Richard L. Jacobson, a Diplomate of the American Board of Orthodontics who has been in the exclusive practice of orthodontics in Pacific Palisades, Calif., for the past 28 years, stated: "We know that form follows function and function can follow form. Therefore, it is vital to identify those patients who need myofunctional therapy. In these patients, myofunctional therapy by a specialist is essential. Treatment is effective and orthodontic stability is enhanced."

Study OMT

Joy Moeller will teach an IAOM-approved, five-day course on orofacial myofunctional therapy Oct. 19–23, 2008, in Philadelphia with Barbara J. Greene, COM, and Licia Coceani-Paskay, MS, CCC-SLP, COM.

Moeller also will teach a seven-day course Feb. 11-17, 2009, and June 24-30, 2009, in Los Angeles. The course includes two days of internship.

For more information, contact Greene at bgreene@tonguethrust.com or call (805) 452-4302.

Types of therapy programs offered

I have been practicing orofacial myofunctional therapy for 30 years and have treated thousands of patients.

My son had this problem when he was 7 years old, and I witnessed the positive change in his teeth, headache pain and Attention Deficit Disorder (ADD) and Temporal Mandibular Dysfunction (TMD) issues. The dramatic results motivated me to study everything available in OMT.

I began a private practice in OMT in addition to my dental hygiene practice in 1978. I love the challenge of helping improve the quality of my patients' lives.

I have five different programs I offer to my patients:

- habit elimination therapy,
- Mini –Myo program for the young child,
- orofacial myofunctional therapy,
- TMD and special needs therapy,
- and cosmetic muscle toning for facial fitness.

Habit elimination therapy

My program for habit elimination treatment is three to five visits. I work with thumb and finger sucking, nail biting, hair chewing, tongue and lip sucking and/or chewing, and many other oral habits with a 95 percent success rate.

Rosemarie A. Van Norman, an expert in the field of thumb sucking, has determined:[6]

Myofunctional

OT *see page 6*

AD

HOW

[Discover your potential]

WHO

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Myofunctional

OT *from page 5*

Before (left) and three months after successful thumb sucking therapy

- 60 percent of malocclusion is caused by prolonged digit sucking.
- 10 percent of 6- to 11-year-olds suck their digits.
- 85 percent of digit suckers exhibit an open bite.
- Many times, open bites lead to TMD due to lateral movements of the jaw in order to chew food.
- 49.9 percent of orthognathic surgery patients with open bite relapse.
- 59 percent of digit suckers experience atypical root resorption.
- 40 percent of digit suckers have

learning and behavior problems in school.

Infants are born with only a sucking skill, which enables them to survive. Usually, at age 9 months to 3.5 years, the child self-weans and starts drinking from a cup and eating more solid foods and transitions from suckling to sucking, which is supposed to be used in only a few situations such as using a straw. However, many times a pacifier is used or the child finds his or her thumb or another object, and the suckling habit is extended and continued.

At this point, the tongue is unable to rest and swallow correctly, leading to an open bite, cross bite or some other type of malocclusion.

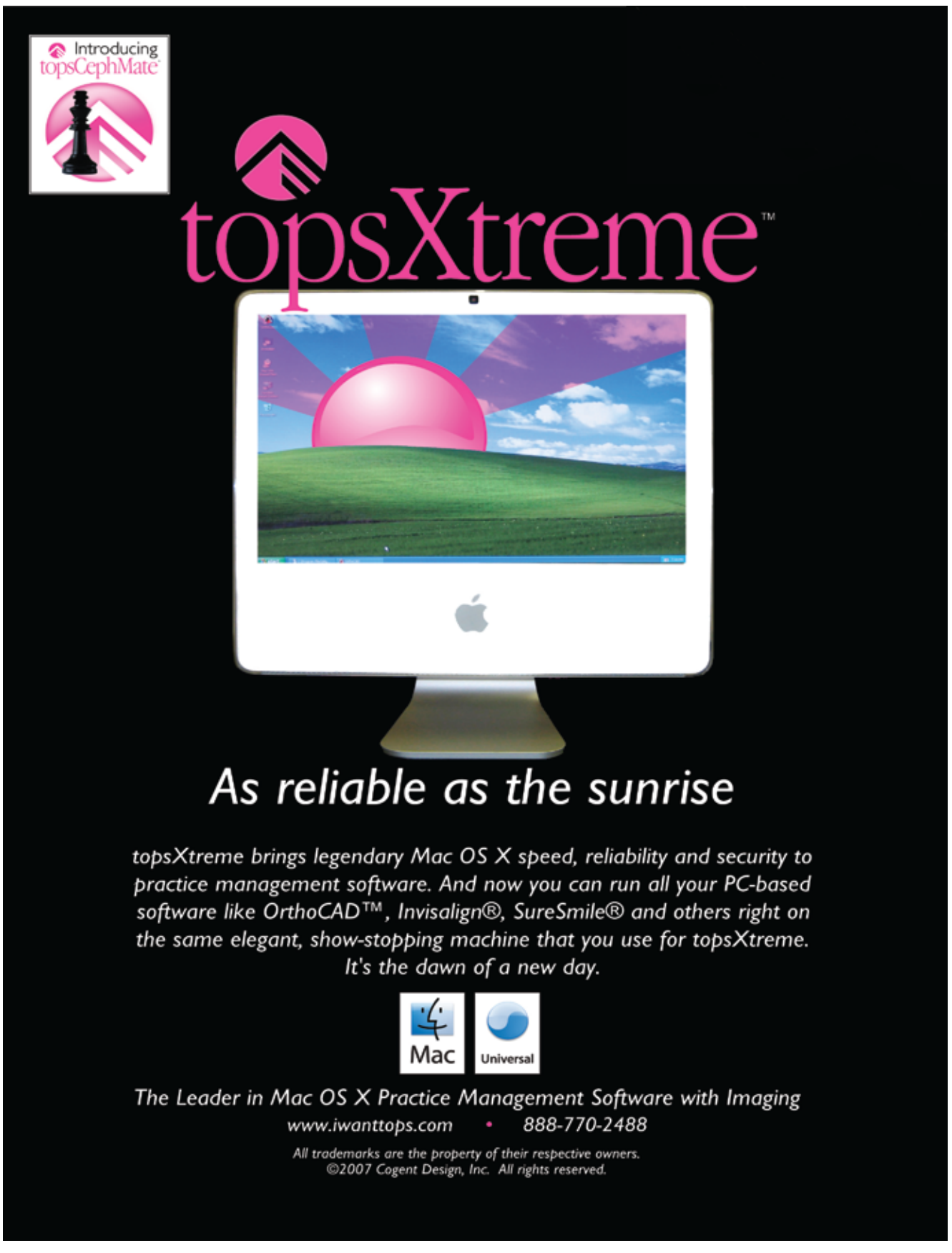
The program I follow uses behavior modification and positive reinforcement. The patients feel so proud to have ceased the habit once and for all.

The success of this program will empower the patients to control many choices in their lives that feel good but that they know are wrong for them.

As a dental hygienist, I have learned that the value of pro-active therapy is to minimize or eliminate problems by treating early.

(For a discussion of the Mini-Myo, orofacial myofunctional therapy, special-needs patients and cosmetic muscle toning programs, read Part 3, appearing in the next issue of Ortho Tribune. The reference list is available from the publisher.)

AD

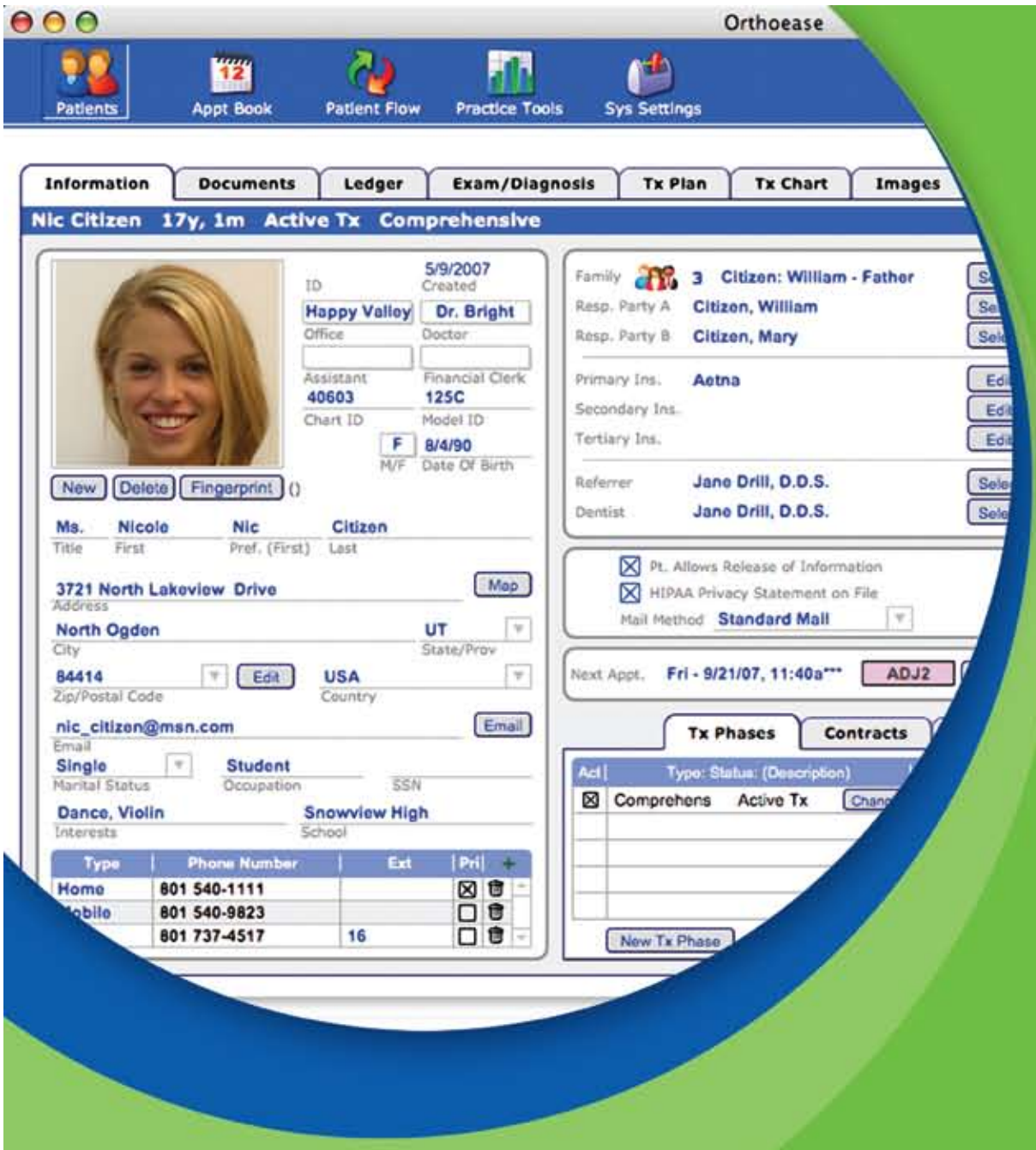


OT About the author

Joy Moeller is a certified orofacial myofunctional therapist and a licensed registered dental hygienist. She is in private practice in Pacific Palisades and Beverly Hills, Calif. Moeller is a former associate professor at Indiana University School of Dentistry and an ongoing guest lecturer at USC, UCLA and Cerritos College. She attended the Myofunctional Therapy Institute in Coral Gables, Fla., and the Coulson Institute in Denver, Colo., and studied with Dr. Mariano Rocabado, Santiago, Chile, on head and neck posturing. She is a founding member of the Academy of Orofacial Myofunctional Therapy and has taught courses at USC, the Gutenberg University and Freiberg University, both in Germany, among other locations.

OT Contact

Joy L. Moeller
15340 Albright St., No. 305
Pacific Palisades, Calif. 90272
Phone: (310) 454-4044
Fax: (310) 454-0391
joyleamoeller@aol.com
www.myofunctional-theraypy.com



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How an orthodontic practice experiences exponential growth

By Roger P. Levin, DDS

Many orthodontists have flourishing practices that lead to financial and personal success. They have made significant investments of time and resources to develop and refine their skills. Generally, all the effort pays off. After years of hard work, orthodontists wind up on the life path that leads them to financial independence on their terms. Or do they?

Let us examine the path of one Levin Group client who saw his orthodontic practice under-producing when he was getting closer to his retirement years. What did it take to turn things around? Let's find out.

Case study: taking an orthodontic practice from 'good' to 'great'

When Dr. Paul Smith[1] contacted Levin Group, he was relatively happy. He had been in orthodontic practice more than 20 years, lived in a nice community and was happily married with two sons in college.

He enjoyed a good income, but wanted more time to spend with his family. His life was good, but he knew it could be better. He decided Levin Group could get him where he wanted to be.

As it turned out, Dr. Smith's practice production over the previous two years grew only 3 percent. While his practice was successful, he knew he was not realizing his potential. Like many orthodontists, he was simply trying to get through the schedule, survive the after-school crunch and head home.

During an on-site visit, Levin Group identified issues that limited efficiency and practice capacity. Inefficient systems were having an adverse affect on the doctor, the team, patients and parents.

After Levin Group's on-site analysis and subsequent conversations with his consultant, Dr. Smith came to understand that implementing new systems or updating existing ones would reduce stress, improve performance and increase productivity.

He soon realized that implementing better systems and developing a more professional team would allow his practice to experience the profitability he wanted.

Dr. Smith's situation was not unusual. Many orthodontic practices put off redesigning their systems. It is very easy to do when things are going fairly well. Over the years, Dr. Smith took the position of, "We'll get to it." Now he realized he had to.

Something had to change. To get the most out of his practice and his life, Dr. Smith turned to Levin Group for the answers. He quickly found out that one of the most important elements to reach his goals was a Total Success™ Life Map.

Dr. Smith's Life Map — building the practice and creating more free time

A Life Map is a year-by-year blueprint of the orthodontist's professional and personal life, from the present through retirement. After creating hundreds of Life Maps for clients, we focus on key events that will affect an orthodontist's practice and life. A Life Map evaluates the doctor's age, financial position, spending habits, lifestyle, children, tuition needs and large financial events over a lifetime.

How does a Life Map work? Let's look at Dr. Smith's situation.

In 2003, Paul Smith was a 53-year-old orthodontist whose practice was producing $1.1 million. The practice was busy, and his numbers for starts were good. However, Dr. Smith wasn't reaching his growth goals and was working more days than he wanted.

Paul has been married to his wife, Nancy, for 25 years. Their two children at the time were 19 and 21. Putting his sons through college, along with personal retirement, was proving to be more difficult than anticipated.

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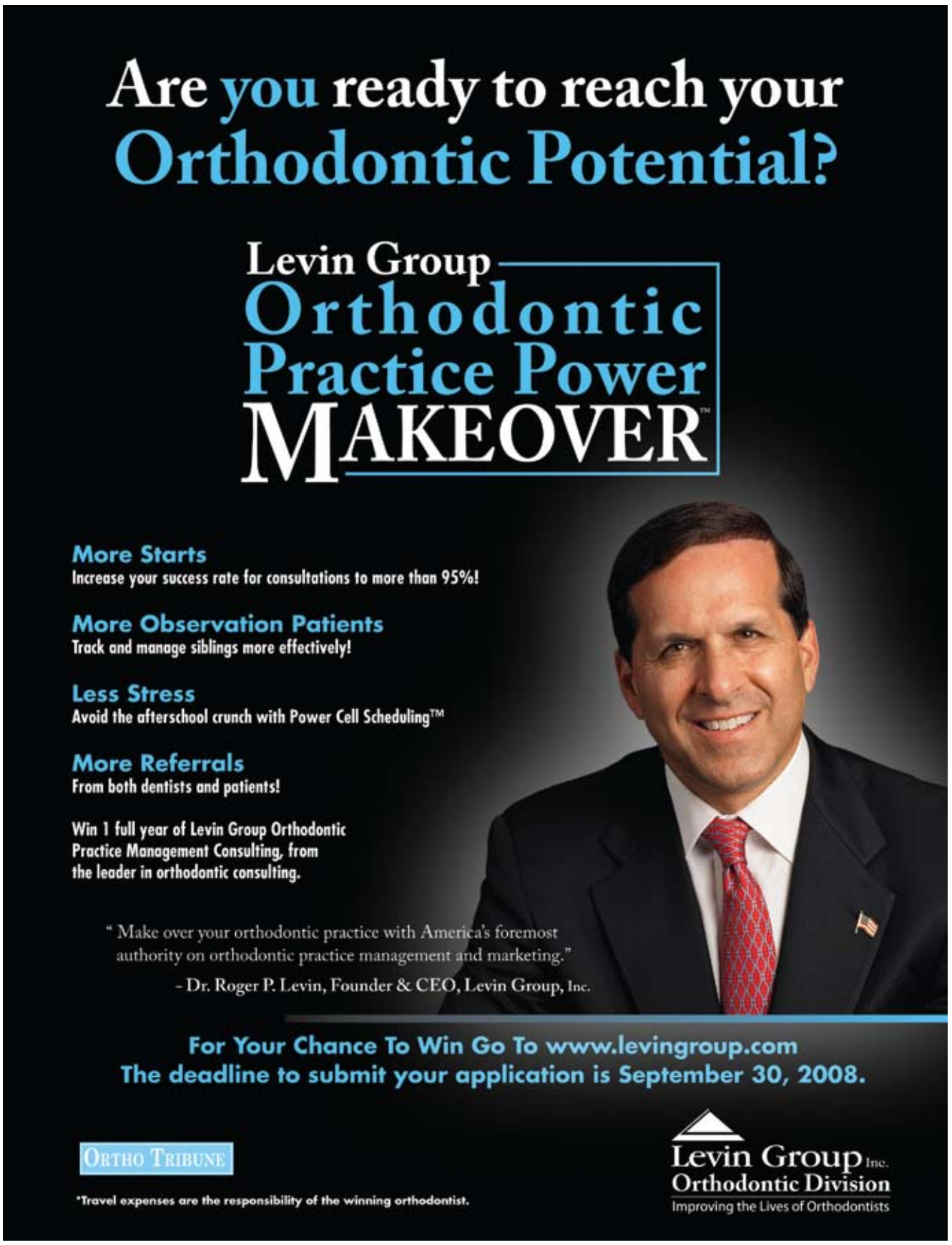

Here are some of the elements that were included in his Life Map:

2003

Faced with flat growth and profitability, along with an uncertain retirement date, Dr. Smith chooses to embark on both Levin Group's Total Ortho Success™ Management and Referral Marketing Programs.

Dr. Smith begins the goal-setting process during the management program and determines he needs a financial plan and elects to engage a certified financial planner.

His Levin Group consultant quickly identifies a problem. Dr. Smith tends to put more emphasis on patient referrals than GP referrals. In his referral marketing program, Dr. Smith begins to aggressively target GP referrals.

2004: production increase — 16 percent

The practice continues to experience significant growth in both number of new patients and starts.

Dr. Smith sets a goal of adding an associate to the practice and reducing the number of days he is chairside with patients.

Dr. Smith and Nancy would like to purchase a vacation home at the beach for weekend trips.

2005: production increase — 20 percent

Dr. Smith hires an associate. Beyond the immediate plan to reduce his time chairside, Dr. Smith hopes this person will become a partner and eventually buy the practice when he retires. He retains a legal consulting advisor with dental experience.

Dr. Smith reduces the number of days working in the practice to three days per week without lowering his share of the profit. He is able to focus on personal interests such as skiing and his love for fine wine.

Dr. Smith and Nancy acquire their dream vacation home, allowing for more quality time for family.

2006: production increase — 19 percent

Referrals continue to grow at an exponential rate. The practice is now far outpacing all previous growth.

Dr. Smith's associate requests a buy-in option. Dr. Smith's legal consultant facilitates the negotiation and draws up the agreement.

The Smiths update their financial plan.

2007: production increase — 18 percent

Dr. Smith reaches financial independence. He sets a plan to retire in 2011. To celebrate, he and his wife take a two-week vacation to Italy to explore the wine country.

A Life Map is vital for any orthodontist who seeks to grow professionally and personally. A Life Map helps orthodontists and their spouses identify short- and long-term goals and place them on a Life Map year by year.

Once the vision and goals have been determined, the appropriate actions and advisors help position the doctor for greater success. A Life Map begins with understanding the orthodontist's vision and goals, which change over time. In many cases, we see Life Maps help orthodontists reach for new goals they never thought possible.

Conclusion

What improves your quality of life? Is it what happens in your practice? Is it what happens outside of it? The answer is — both! As a result, all aspects of a Life Map are equally significant. The goal is not to grow rich at the expense of one's well-being. What's the point of accumulating a great deal of money if you can't enjoy your practice? As Dr. Smith found out, a Life Map helps you achieve comprehensive success in all areas of your life, both personal and professional.

Ortho Tribune readers are entitled to receive a 20 percent courtesy on Dr. Roger Levin's next Total Ortho Success Seminar being held Oct. 10–11 in Baltimore. To receive this courtesy, call (888) 973-0000 and mention "Ortho Tribune" or e-mail customerservice@levingroup.com with "Ortho Tribune" in the subject line.

[1] Case study based on actual Levin Group client information.

OT About the author

Dr. Roger P. Levin is founder and chief executive officer of Levin Group, Inc., the leading orthodontic practice management firm. Levin Group provides Total Orthodontic Success™, the premier comprehensive consulting solution for lifetime success to orthodontists in the United States and around the world. A third-generation dentist, Dr. Levin is one of the profession's most sought-after speakers, bringing his Total Orthodontic Success Seminar Series to thousands of orthodontists and ortho professionals each year. For more than two decades, Dr. Levin and Levin Group have been dedicated to improving the lives of orthodontists. Levin Group may be reached at (888) 973-0000 and customerservice@levingroup.com.

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