SPECIAL PCSO EDITION

ORTHO TRIBUNE

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Tooth decay more common in patients with cleft lip, palate

Patients with cleft lip and/or palate have a higher prevalence of tooth decay and cavities, also called dental caries, than their siblings without clefts, according to a report published in The Cleft Palate–Craniofacial Journal.

In this study, conducted at Damascus University of Syria, 53 patients with clefts ages 12 to 29 years were compared with 53 sex- and age-matched siblings without clefts.

Eighty-five percent of the patients with clefts exhibited a moderate or high dental caries score, compared with only 43 percent of the control subjects.

To read the entire article, visit *www2.allenpress.com/pdf/cpcj-46-05-529-531.pdf.* OT

Shooting straight about 3-D imaging

An orthodontist shares his views

By Bradford Edgren, DDS, MS

Studies on learning have shown that visual images provide 80 to 90 percent of the information that the brain receives. So it makes sense that in the dental office, details received from our radiological workups are imperative for precise diagnosis and communication with patients.

Now, cone-beam technology has brought 3-D imaging right into the dental office, expanding the scope of treatment for my patients as well as for other dental practitioners.

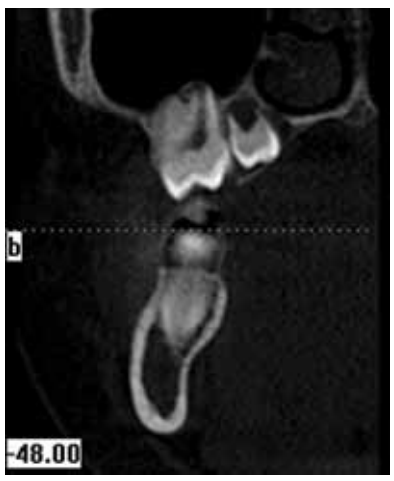

Fig. 1: Superimposed molars spotted on scan.

The greatest benefit of 3-D imaging is the amount of information obtained from each scan. The 360-degree scan of the entire head shows the maxillofacial complex in a format that can be rotated or sliced to achieve the best view of these structures.

For oral surgeons, periodontists or general dentists placing implants, the opportunity to view the dentition from any and all of these angles is of great benefit during diagnosis and planning.

→ OT *page 4*

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Check out how last year's winner, Dr. Brian Hardy, has grown his practice since he started the makeover process at *www.ortho-tribune.com.* OT

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Quality improvement via systems thinking

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

We are trained to treat malocclusions and growth and development problems. For the one-on-one relationship with our patients, most clinicians fulfill this job successfully. However, the traditional role of a doctor is carried out with a broader historical, organizational, social and political context — where the diagnosis and treatment of system failures can be as important as clinical interactions with the individual patient.

In order to improve health-care outcomes in our increasingly complex environment, clinicians must confront greater understanding to influence a wider framework. This progression can be achieved by meeting such constraints within the growing science of quality improvement.

Many orthodontists perceive providing high quality care not only as our professional responsibility but our *raison d'etre* — our reason for being! Our focus is first and foremost on the patient in front of our eyes and, occasionally, on similar populations of malocclusions, concentrating on clinical effectiveness, safety and frequently on wider proportions of treatment quality; this includes impartiality and fairness, patient-appreciation and patient-responsiveness, as well as access and synchronization with others.

As a profession, we are encouraged to advocate and espouse a standards-based approach and regard discrete phases of education as the mechanism by which these standards are delivered. We are trained as erudite scientists and, therefore, educated to regard a randomized, controlled trial as the gold standard of evidence; progress is then achieved by trial findings, outcomes and assessments.

In the business arena, the science of quality improvement is well established. As orthodontists, we strive for delivering high standards of care and recognize that we have two jobs regarding clinical effectiveness: improving how we perform and performing to our utmost ability. This requires commitment to (a) influence patients and populations, by accepting responsibility for other dimensions of quality; (b) standards, by influencing the systems within which care is provided, (c) bio-science, by consigning ourselves to continuous learning and to the creation of learning organizations, and (d) behavioral science, by understanding and accepting the strengths and weaknesses of different forms of evidence that apply to appropriate problems.

Quality improvement illustrates a variety of recognized scientific disciplines, the core feature of which is systems thinking. This requires acknowledgement of variation and recognition of behavioral sciences in order to glean a broader appreciation for what constitutes profound knowledge.

Systems thinking can occur at the (a) practice level with our patients, and (b) national level with our leadership. Orthodontists are well versed in basic sciences and clinical application. By possessing the skills required to transform profound knowledge into practice, we bring together the expertise in a way that allows optimization of the working environment for the benefit of the clinician and patient. This evolution is called praxis. We must employ these skills and expertise to influence change in the local, state and national level.

Education, of course, is the answer to a lack of knowledge and the key to success for improving multi-level quality improvement. There are many approaches for developing initiatives of quality improvement, such as those presented in previous editorials (learning to look, systems thinking and scenario planning). We must have the desire to contribute at the level required to produce prolonged, system-wide improvements in quality. Education, incentives, leadership and revalidation are key ingredients for quality improvement to be omnipotent at all levels.

Quality improvement education differs from traditional dental education in terms of philosophy, culture, ethos, content and style. These are adult learning principles, highlighting active learning, experimentation, self-reflection and feedback. Existing educational programs must share and evaluate quality improvement in order to create effective evidence-based educational programs. Audits, outcome assessments and professional re-accreditation are important components for expanding and advancing the science of quality improvement; it is an explicit and integrated expression of *best orthodontic practice*.

Many general dentists, orthodontists and other specialists are only partially trained for future challenges, especially as our professional roles evolve within the system and our delivery of health care becomes more complex. In order to promote the science of quality improvement, systems thinking and appreciation for the praxis of theoretical explication and practical optimization are required to be applied. Academe, the profession and clinicians must rise to this challenge. OT

This editorial was inspired by an original essay: Hockey, P.M., & Marshal, M.N. (2009). Doctors and quality improvement. Journal of the Royal Society of Medicine, 102, 173–176.

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 Managing Editor Kristine Colker at *k.colker@dental-tribune.com*.

Image courtesy of Dr. Earl Broker.

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BPA WORLDWIDE BUSINESS

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PCSO, NESO focus on improvements, technology in their annual sessions

By Kristine Colker, Managing Editor

Orthodontists on the West Coast and the East Coast have a lot to look forward to during the next few weeks as both the Pacific Coast Society of Orthodontists (PCSO) and the Northeastern Society of Orthodontists (NESO) put on their annual sessions, both featuring a wide range of educational opportunities, social events and more.

The 73rd annual PCSO, which will take place Oct. 22–25 at the Phoenix Convention Center in Phoenix, Ariz., is focusing this year's program on "kaizen," the Japanese word for improvement.

Meeting organizers promise that this year's session will build on this theme by helping attendees explore new technologies and refine current techniques to achieve success in today's changing environment.

The meeting kicks off Thursday, Oct. 22 with a new and younger member program and reception, but the real action gets under way on Friday, starting with a joint doctor/staff lecture by Dr. Roger Levin. He will discuss what you should do to position your practice for the future.

Other speakers that day include Holly Armentrout on implementing current technology, Lori Garland Parker on new technologies and their applications in a busy practice, Dr. Lysle Johnston on orthodontic education and its current and future impact on the profession and an interactive panel discussion addressing TMJ, estradiol dysfunction and micro-implants.

Saturday's topics will focus on marketing, Web site development, patient care, mechanics, facial harmony, self-ligating brackets, soft-tissue lasers and mini-implants.

Sunday's staff portion features two lectures: Carol Eaton on the importance of the new patient experience and Jackie Dorst on TADS. The clinicians' program ends the weekend with more emphasis on technology and multidisciplinary topics as Dr. Claude Boutin lectures on the implication of the Internet on your practice, Dr. Jerry Nelson talks about multidisciplinary treatment at the University of California, San Francisco, and Dr. David Kennedy leads a discussion on early treatment.

In addition, attendees will have an opportunity during the weekend to attend alumni receptions, tour the exhibit hall and socialize with friends and colleagues at the Rawhide Western Town welcome party from 7–10 p.m. Friday.

In a re-created 1880s Western town with a steakhouse, saloon, shops and rodeo arena, attendees will enjoy staged shootouts, country music, a petting zoo, rock climbing, a sundown cookout and a marshmellow roast around a bonfire. Tickets are $75, and transportation is provided.

For more information on the PCSO annual meeting or to register, visit *www.pscoortho.org*.

NESO highlights

The NESO 88th annual meeting, taking place Nov. 13–15 at the New York Hilton in New York City, is centered around the theme "Something for Everyone."

There will be discussions on the latest technology, including reports on intraoral scanning, computer-aided brackets and other new developments; discussions on when to treat children, with opposing points of view presented and debated; and in a special joint session given by Dr. Bill Arnett, there will be discussions on making soft tissue your primary focus.

In addition, staff sessions will focus on communication and conflict resolution, digital trends and risk management.

When not attending the educational programs, attendees will be able to have lunch in the exhibit hall so they can visit with the exhibitors and see what's new for their practice.

On Friday night, Nov. 13, the president's reception will give attendees the opportunity to meet and greet friends, classmates and colleagues before heading out on the town.

For more information on the NESO annual meeting or to register, visit *www.neso.org*. OT

←OT page 1

My cone-beam system has even revealed supernumeraries, cysts and foreign objects hidden within standard radiographs.

When evaluating for implants, 3-D imaging allows the clinician to determine the height and width, as well as the quality, of the bone in the implant area. Moreover, 3-D provides the ability to precisely evaluate the distance and angulation between roots of adjacent teeth to avoid damaging said teeth during implant placement.

Because implants are generally the preferred restoration for the missing single tooth, an orthodontist can scan a patient prior to debanding to determine exactly how the teeth are aligned within the bone and make any necessary corrections. It would be very disappointing for a patient to anticipate receiving an implant and crown only to realize later that the orthodontist didn't create enough space for the implant.

Three-dimensional imaging provides for more precise measurements than 2-D panoramic radiographs, which can be unreliable because of distortion and superimposition. Cone beam offers true 1:1 anatomical measurements, eliminating geometric errors of projection and supporting accurate linear measurements.

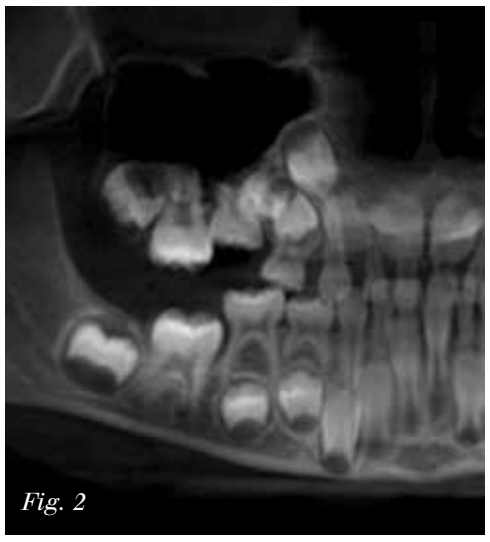
Fig. 2

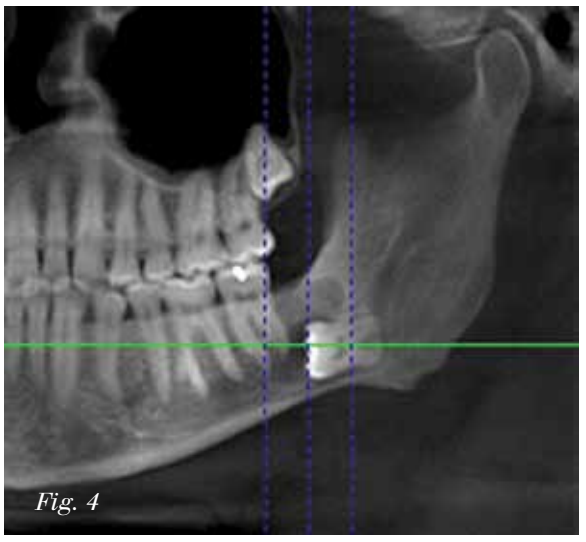
Fig. 4

Fig. 2: Scan saves the patient unnecessary surgery.

Fig. 3: Precise position of an impacted central incisor.

Fig. 4: Patient educated on pathology.

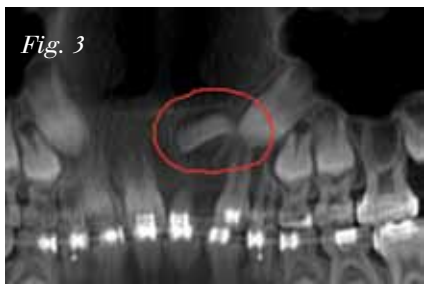
Fig. 3

All of this improves surgical predictability for orthognathic surgery cases. With 3-D, I don't have to calculate for magnification errors when determining the amount of surgical correction on these cases.

Prior to 3-D imaging, my orthodontic diagnostic records always included panoramic X-ray and lateral and frontal cephalograms. Now, with one scan, I gain the panoramic, lateral and frontal images, as well as everything in between. Skeletal asymmetries that may not be clearly visible on 2-D head films are more evident with a cone-beam scan. 3-D makes it easier to determine the buccal, lingual and vertical position of impacted teeth.

Cone-beam imaging also helps with informed consent. 3-D scans reveal pathologies that may have become lost in 2-D images because of distortion, magnification and the superimposition of anatomical structures. I discovered a horizontal root fracture on a patient and subsequently referred him to an endodontist for evaluation. This patient needed to be aware of the likelihood that the tooth could be lost because of previous trauma. Without this insight, foreshortening of the root, or even tooth loss, may have been blamed on the orthodontic treatment.

For TMJ disorders, with one scan that takes just a couple of minutes, I get panoramic, frontal and lateral views as well as corrected tomographs that would have taken me an hour or more with 2-D methods.

After implementing cone beam, I discovered some interesting cases. In one case, we were waiting patiently for the second permanent

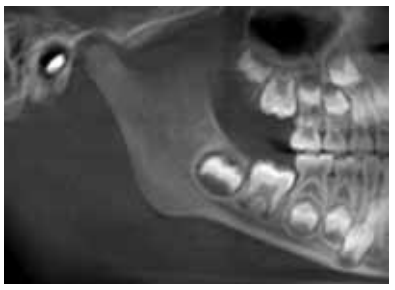

Fig. 5: Mysterious hearing issue solved.

molars to erupt prior to initiating phase II treatment. After the other three second molars had already erupted, as part of progress records, the i-CAT® scan showed that an impacted third molar was impeding the eruption of the maxillary right second molar (Fig. 1).

On previous "standard" pans, the fourth third molar was perfectly superimposed with the second molar, and was not evident. This second molar may never have erupted, or worse yet, may have been presumed to be "ankylosed."

In another example, a patient was referred from an oral surgeon for an i-CAT scan. The referring oral surgeon wanted to clarify diagnoses made at another office, based upon previous digital pans, including a supernumerary, odontoma, failure to erupt and/or ankylosed deciduous second molar.

On the scan (Fig. 2), it was evident that it was just an ankylosed deciduous second molar, eliminating the need for a previously planned exploratory surgery. This patient also owes her future nice occlusion to 3-D imaging and diagnosis.

Our cone beam also gave us a great view of another patient's horizontally impacted maxillary central incisor (Fig. 3). When treatment started, the i-CAT machine aided the oral surgeon in exposing and placing a gold chain on the central incisor for guided eruption. Her impacted canine, detected on the previous scan, has also since been brought into place.

Regarding patient education, an oral surgeon referred a patient for an i-CAT scan to verify the position of the mandibular canal in relationship to the impacted third and dentigerous cyst prior to extraction (Fig. 4). This helped the patient visualize the extent of the third molar impaction and appreciate the size of the cyst. The patient was so impressed with the i-CAT scan that he consequently set his daughter up for orthodontic treatment.

One of my most unusual cases involved a young patient who came in for braces, but after the i-CAT scan left with some clues that led to an ENT solving the mystery of her hearing loss (Fig. 5).

While some of these cases show hidden pathologies, it is no secret that 3-D imaging sheds light on our more difficult cases and, no matter what our specialty is, adds a new dimension to our practices. OT

OT Online

To register for and view Dr. Edgren's complete Webinar on 3-D imaging, including a discussion of these cases and others, check out the online archives section of the brand new Ortho Tribune Study Club at *www.OTStudyClub.com*.

OT About the author

Dr. Bradford Edgren earned a doctorate of dental surgery from University of Iowa, College of Dentistry and a master of science in orthodontics. He is certified by the American Board of Orthodontics, is a diplomate of the American Board of Orthodontics and is a member of the College of Diplomates of the American Board of Orthodontics. He is also a member of the American Association of Orthodontists, Rocky Mountain Society of Orthodontists, Colorado Orthodontic Association, The Edward H. Angle Society of Orthodontists — Southwest Component, American Dental Association, Colorado Dental Association and Weld County Dental Association.

What kind of impression is your practice making?

By Scarlett Thomas
President, Orthodontic Management Solutions

So my girlfriend calls me the other day. Her son has been a patient of a particular orthodontic practice for many years. Her relationship with this practice has always been pleasant, but nothing special.

One day she walked in for her son's regular monthly appointment to find things just didn't go well for seemingly no good reason. She became extremely frustrated and, as soon as she walked out the door, she called me and in a stronger-than-normal voice said, "I really dislike those people."

This was a practice she had been loyal to for many years, but because of one negative exchange in a handful of minutes, the relationship and years of working together quickly turned sour. In a moment, the entire practice was reduced to "those people." Because of one person, she now disliked them all.

Perhaps someone called in sick and the rest of the staff was running behind. Maybe the staff was training a new employee or possibly had just received bad news regarding a particular situation.

Who knows?

But at that moment, she realized she no longer wanted to do business with that orthodontic practice anymore. She was ready to end a long-term affiliation because of a brief encounter over nothing significant. It was at that moment I realized how fragile orthodontic patient relationships really are.

The problem was that the orthodontic practice had not worked to establish a strong emotional connection with my friend and/or her family. It was just a group of people in a building going through the motions of handling daily affairs. The situation was simply a generalized indifference, but when the relationship was tested, it had no significant strength to support it.

In business and in life, we too often minimize or forget the impact we really have on others. Our reach is deeper and wider than most of us realize. Unfortunately, it can take losing a valued patient to understand this.

'No job is insignificant or exempt from making an important and impressive impact on the value and experience an orthodontic practice delivers to its patients.'

Let this be a reminder to you that your orthodontic practice, your staff and you personally have a far greater effect on your patients than you could ever image.

No job is insignificant or exempt from making an important and impressive impact on the value and experience an orthodontic practice delivers to its patients.

To help your team understand its individual effects on your practice and patients, you must get specific. Training, role-playing and communication are keys to a successful business. Just saying, "You play an important role," won't tell the employees what they need to do or do differently every day.

Every decision, action and activity presents an impression. They must understand that what they do every day has a meaning far greater than the tools they use, the items they handle and the paper they deal with.

In fact, your staff may be the very reason patients do business with your practice and/or the very reason they don't. This being said, before the members of your team can embrace the impact of each of their respective actions, they must understand the impact they have on the practice as a whole.

They must be trained how to communicate with patients. They must operate with constant mindfulness about their ability to build or destroy relationships in a heartbeat.

I recommend having regular meetings to discuss the following:

- What is the real impact your staff has on the well-being of your patients?
- What recent negative situations have come to the surface concerning your patients?
- How were these situations handled?
- What could have been done differently to resolve the issue?
- What effect on the patient does it have when things go right? Or when things go wrong?
- What does the staff need to know and do regularly to make a great impression with your patients?

Every staff member needs to be focused on the impact he or she has on the practice and the patients. It is a key factor in the greater success of your practice.

To learn more about the impact employees have on your business, please join the "4 Keys To Orthodontic Success" Webinar series. You can register and find out more information by visiting orthoconsulting.com *and checking under events and seminars.* OT

OT About the author

Scarlett Thomas is an orthodontic practice consultant who has been in the field for more than 23 years, specializing in case acceptance, team building, office management and marketing. As a speaker and practice consultant, she has an exceptional talent to inform, motivate and excite.

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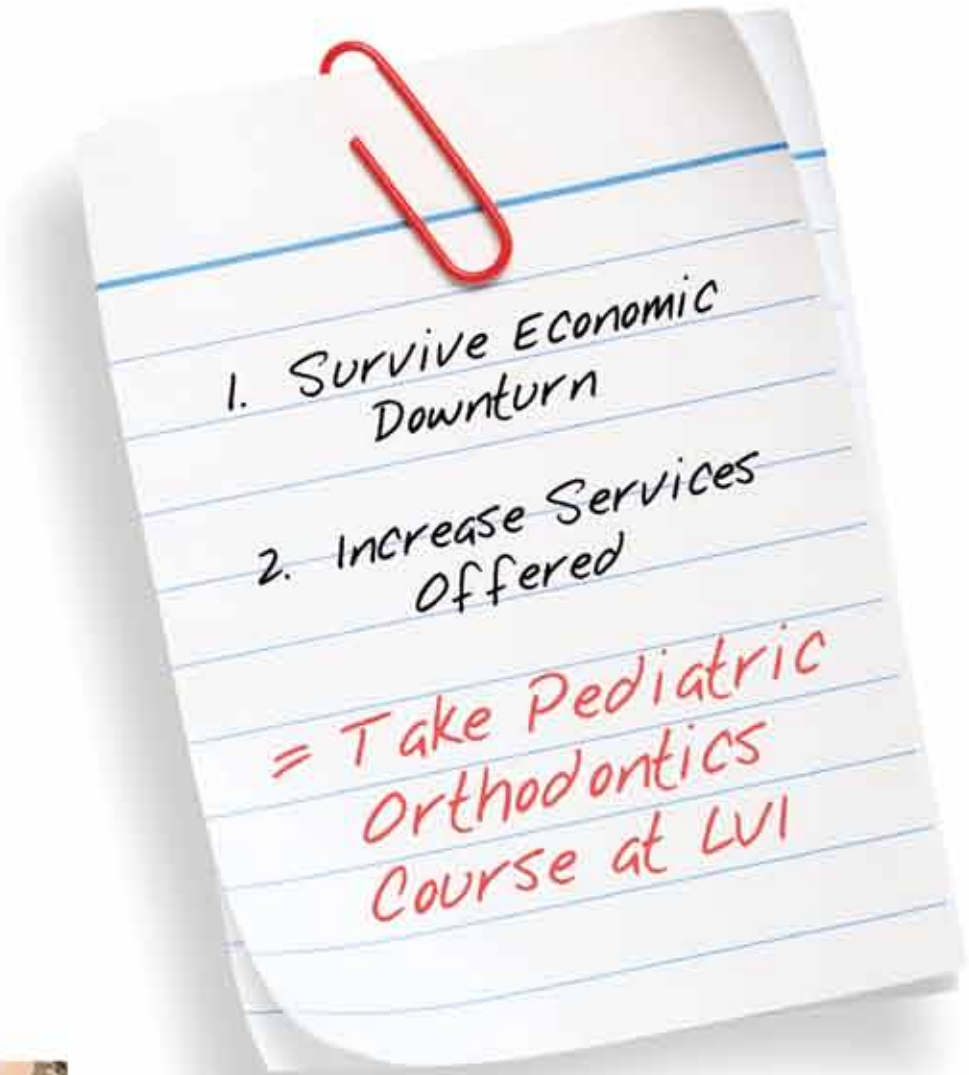

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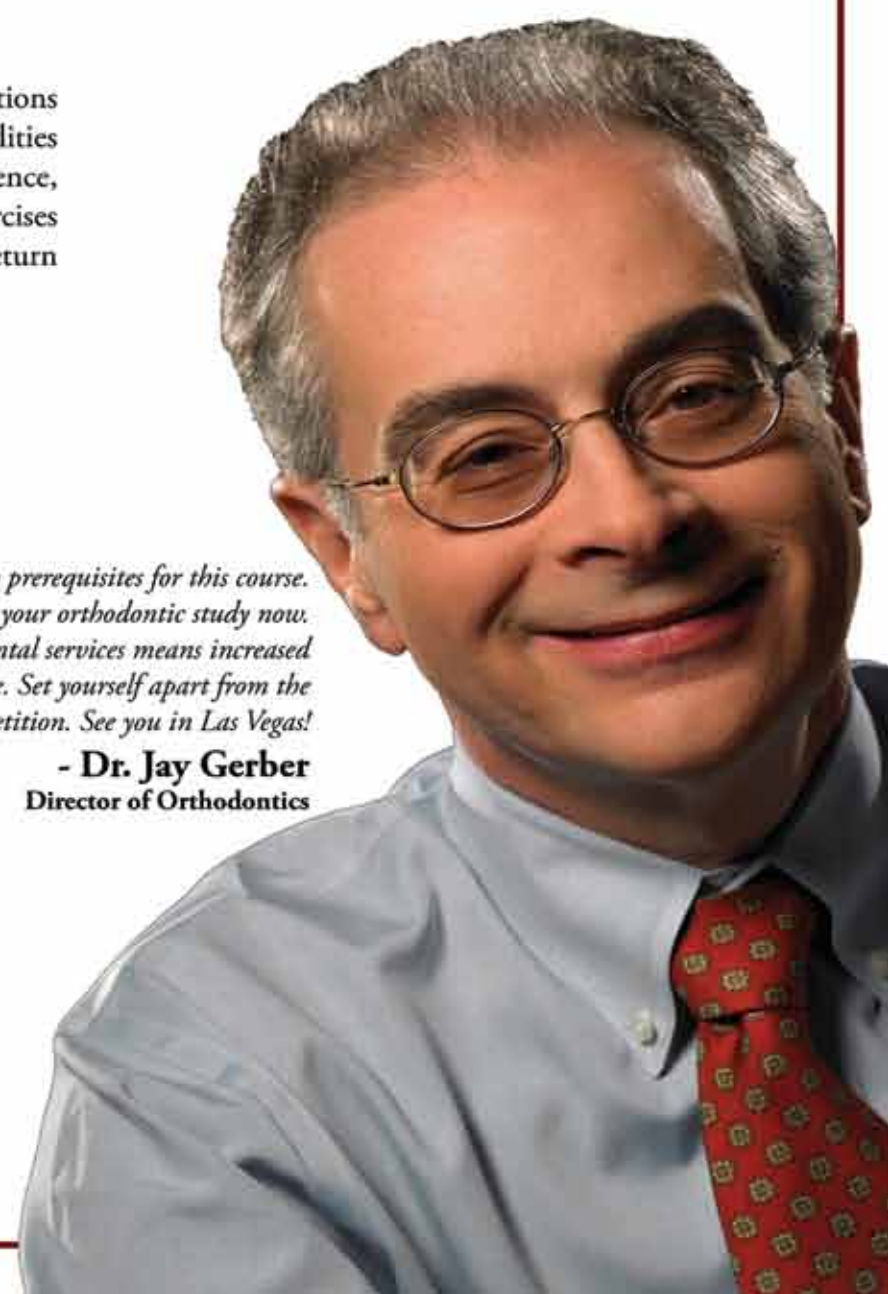
- Dr. Jay Gerber
Director of Orthodontics



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Make shoppers stop shopping

By Roger P. Levin, DDS

More than most dental specialties, orthodontics has always had shoppers. However, the down economy has made people even more sensitive to price. As a result, people are shopping around for the lowest fee more than ever. To turn ortho shoppers into starts, orthodontists must recognize that effective case presentation is essential to building patient trust.

Through our Total Ortho Success™ consulting program, Levin Group has demonstrated that case presentations by highly successful ortho practices share five common characteristics. All top-producing ortho practices:

1. *Use a dedicated treatment coordinator.* An orthodontic treatment coordinator allows the practice to provide a better experience for patients and parents without taking up too much of the clinician's time. A treatment coordinator can improve customer service and enhance case acceptance, but his or her performance must be measured against results to ensure optimal effectiveness.
2. ***Get to know the patient first.*** Asking questions about the patient's background is key to building a strong relationship. Subjects of interest can be school, athletics and extracurricular activities.
3. *Explain treatment.* And that means far more than simply mentioning the clinical details and the timeline for treatment. Emphasizing the benefits of treatment is critical to motivating parents (and patients) to commit.
4. *Answer questions and inspire confidence.* Questions from parents and patients are inevitable. It is at this stage that trust is built with the practice. The orthodontist should be perceived by patients and parents as knowledgeable and enthusiastic. Enthusiasm spreads to patients, which will create confidence. The more confidence patients have, the more trust they develop for the practice.
5. *Finalize with the treatment/financial coordinator.* Once questions have been answered, it is time for the orthodontic treatment coordinator or financial coordinator to handle financial matters. The clinician's time should be limited to treatment issues.

Conclusion

Why should patients and parents come to your office? By making an effective case presentation to patients, the practice has the opportunity to add sufficient value and gain case acceptance before the patient visits (or decides to visit) other offices.

When patients develop a sense of trust in your ortho practice, their shopping ends at your office!

Ortho Tribune readers are entitled to receive a 20 percent courtesy on Dr. Roger Levin's next Total Ortho Success Seminar being held Jan. 28 and 29 in Las Vegas. To receive this courtesy, call (888) 973-0000 and mention "Ortho Tribune" or e-mail customerservice@levingroup.com *with "Ortho Tribune Courtesy" in the subject line.* OT

OT At the PCSO

Don't miss Dr. Roger Levin speaking on "Achieve Total Ortho Success in A Down Economy" from 8:30–10 a.m. Friday, Oct. 23, during the PCSO.

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 Ortho Success™, the premier comprehensive consulting solution for lifetime success to orthodontists in the United States and around the world. A third-generation dentist, Levin is one of the profession's most sought-after speakers, bringing his Total Ortho Success Seminars 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*.