“Establishing realistic treatment objectives for adult patients”

Goals of presentation

I. Describe uniqueness of adult ortho patients

II. Clarify the meaning of “realistic treatment objectives” for 21st century orthodontics

III. Describe a standardized method of communication that helps patients and providers achieve their objectives

IV. Reduce risks of adverse legal action and at the same time enhance internal marketing

2. In your experience with adult IDT patients which of the following interdisciplinary treatments result in the least predictable outcomes?
   a) Orthodontics and restorative
   b) Orthodontics and Orthognathic surgery
   c) Orthodontics and periodontics
   d) Orthodontics, periodontics, & restorative
   e) Orthodontics, periodontics, restorative and orthognathic surgery
   f) Any combination of the above and TMJ symptoms at treatment start

3. For your answer to question #2, what do you think is the most likely cause of outcome deficiency?
   a) Lack of IDT teamwork among doctors
   b) Lack of IDT teamwork among office staff and treatment coordinators
   c) Frequency of unexpected complications
   d) Lack of insurance coverage resulting in treatment compromises
   e) Patient “burn-out” as they go through the treatment process
   f) Other___________________________________

4. Which of the following technologic advances have allowed reduction in treatment limitations of your adult IDT patients?
   a) Additional diagnostic information from 3-D cone beam radiographic assessment
   b) The use of removable aligners (Invisalign, Clear Choice, etc.)
   c) Utilization of TADS to provide more predictable anchorage and control
   d) Utilization of methods of accelerated tooth movement (Wilkodontics, Surg Facilitated Ortho Tx, etc.)
   e) IDT study club meetings in which each specialty is represented
   f) Other, Please list_____________________________________________

5. In your treatment of complex, IDT patients, what specific measures have you taken to minimize limitations of treatment outcomes?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Survey answers from experienced orthodontist at end of presentation.
Cases and concepts

"Perio and too old for treatment"

"Only way to treat is w/ jaw surgery"

"25 and considering dentures"

"Two stage surgery? Cost and coverage?"

"Previous tx, but unhappy!"

Significant variation in adults challenges “adult label”

**Adult orthodontic patients— 19-80 yrs.**

**Age/social factors**
1. 19-29 still in transition to independence
2. 30-39 pressure, pregnancy, stress, $$, TMJ
3. 40-49 time for self; before it's too late
4. 50-65 use insurance, prepare for retirement, other health issues— “stay younger longer”
5. 65-80 preserve and restore; role of implants!

**Intrinsic factors**

- Periodontal
- Skeletal
- Dental
- Neuromuscular
- Psychological
- Financial—2007—2014 and beyond
- Capacity to commit to tx duration & plan

**Biologic System/Patient**

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Case #1--70 y old Female:

What is her chief concern? What are her kids chief concern?
What is your/your patient’s concept of acceptable treatment goals?

- **Function (Optimal)**
- **Reliable/Realistic**
- **Esthetic/Economic**
- **Stability/Satisfaction**
- **Health—dental/physical/mental**

Who determines which goal is prioritized? 
**Examples**

1. Is function more important than facial esthetics? i.e. canine rise vs. flattened upper lip and accelerated facial “aging”?
2. Is total cost of treatment a consideration—eg. missing laterals—space opening or closure?
3. Surgical risks, costs, coverage and borderline surgical cases?
4. Is it acceptable to push boundaries of stability to achieve a more esthetic outcome?

For adult orthodontic patients, **realistic treatment objectives**.....

1. ...are determined through a thorough diagnostic process and thoughtful conversation;
2. ...most important objectives are the primary treatment goals of the patient;
3. ...are sensitive to the age of the patient and realizes that ideal goals that are possible may not be desirable;
4. ...more that 75% of the time require interdisciplinary teamwork to achieve reliable outcomes.

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III. **Describe a method of communication that helps patients and providers achieve their objectives**
Interdisciplinary dentofacial therapy (IDT):

Missing posterior teeth:

- Counter periodontal problems and adults have more missing and damaged teeth. However, adult orthodontic patients cooperate better than children. The jaw structure of adults is no longer growing which limits correction of certain types of bite problems. Additionally, adults are more at risk for degenerative joint disease.

Yes, the jaw structure of adults is a part of a complex genetic interaction of teeth and bones. In about 15% of the population, severe jaw and chin deficiencies exist.

Why is jaw surgery part of some orthodontic treatment plans?

- The most predictable correction is accomplished through orthodontic treatment. Braces are needed to prepare the teeth for surgical correction of the jaws. Braces usually precede the jaw surgery by 12 to 18 months. If adequate bone exists, the orthodontic braces are removed and the patient is scheduled for surgical correction of the jaw. The operation is followed by a period of orthodontics (approximately 6 to 12 months) to achieve the planned surgical correction of the jaw relationship (see milestones).

Dental arch collapse requires "reversal" (uprighting) to degenerative joint disease.

Restored function, health and esthetics are achieved with tooth replantation. If adequate bone exists, the orthodontic braces are removed and the patient is scheduled for surgical correction of the jaws. Braces usually precede the jaw surgery by 12 to 18 months. If adequate bone exists, the orthodontic braces are removed and the patient is scheduled for surgical correction of the jaw. The operation is followed by a period of orthodontics (approximately 6 to 12 months) to achieve the planned surgical correction of the jaw relationship (see milestones).

The "facial form" is part of a complex genetic interaction of teeth and bones. In about 15% of the population, severe jaw and chin deficiencies exist. The bite is characterized by a large overjet and severe overclosure of the lower teeth to the upper arch, causing a lack of room for the upper teeth. The lower teeth contribute to jaw "over closure." There is frequently an "underbite" and incisor trauma which is secondary to over closure.

Case #5: Skel Class III, spacing, impacted #11, perio, + attitude

Severe jaw and chin deficiency:

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The 8 Step Discipline

Step 2: First Office Contact

Concept: Good “first impression” is essential. Trust can be gained or lost during the telephone interview.

Check List: Will you...

4. Have mission statement reflected in the receptionist’s skills? Is the practice mission part of “shared vision” of doctors and staff?
5. Follow-up with welcome letter, brochure, etc.? Is your welcome genuine and shared by all of the staff?

The 8 Step Discipline

Step 4: Tx Planning Conference/Report

Concept: Patients & parents are curious about progress and have questions. This conference gives you chance to inform, & build trust. Reduce risk management issues.

Check List: Will you...

13. Take a panoramic x-ray + other needed records (?) about two-thirds of the way through treatment?
14. Send a Progress Report to the DDS (including x-ray) with a copy to the patient/parent?
15. Have educational materials to help patients understand options such as implants, plasties, exposures, gingival grafts, Class III growth & jaw surgery, verify restorative plan and future steps.
The 8 Step Discipline

Step 6: Retention/Stabilization: Report-JCO<16%

Concept: Formal conference to review original goals and the emphasize the importance of “after care” (retention). Also, discuss case limitations.

Check List: Will you...

16. Have patients complete a questionnaire assessing their orthodontic experience?
17. Provide the patient/parent with a post-treatment report with a copy to their dentist?
18. Celebrate the patient’s accomplishment & provide before and after photos?

Long-term fixed retainers are not without problems!

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IV. Reduce risks of adverse legal action while enhancing internal marketing

10 important tips from medical/defense attorneys:

1. Be selective in taking on new patients (Step #1; #2; #3)
2. Good communication—informed consent & tx plan; billing & finances (Step #2; #3; #4; #5; #6)
3. Document good care provided & comm w other providers (#4; #5; #6)
4. ALWAYS document informed pt refusals in detail
5. Do not allow patients to dictate care
10 important tips from medical/defense attorneys:
(continued)
6. Do not criticize the care of another provider to the patient.
7. Have a good system of standardized practices for tx plan, progress repts, emergency, reminders, etc. (All of 8 Step)
8. Acknowledge limitations to your expertise; refer to others when needed.
9. Treat staff and relatives in same manner as all other pts.
10. Maintain a team approach and good working relationship w other providers (#1, #2, #3—plus study club effort)

Case #5: Skel Class III, spacing, impacted #11, perio, + attitude

Achieving Objectives: Successes or Failures?
“...more logical to categorize patients as ‘responders (R) or non-responders (NR).’”
In addition, post-treatment relapse patients should be categorized as “adapters (A) and non-adopters (NA).”
Bell shaped curve—most favorable A and R at one end and most unfavorable NR and NA at the other end of a normal distribution curve. Ackerman, JL

Variables that made this person a non-responder: smoker, perio disease susceptibility, poor mechanics, no progress rpt

Outcome:
• All upper incisors were extracted
• Implants needed to replace
• $350,000 insurance settlement
• License suspended