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All-In-One Marketing and Risk Management for All Staff: The Eight Step Discipline

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The 8 Step Discipline  
with 4 Core Reports  
and 28 Marketing Opportunities

Step 1: Creating Referrals

**Concept:** Use education as a tool to market your practice: relevant to referring Doctors, team members, and patients. Helps build trust & understanding.

**Check List: Do you...**
1. Maintain proactive C.E. program?
2. Educate referring Drs. and team members to your philosophy?
3. Have a thorough mechanism to educate pts/parents?

Step 2: First Office Contact

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

**Check List: Do you...**
4. Have mission statement reflected in the Administrative Assistants’ skill set?
5. Is the practice mission part of “shared vision” of doctors and team members?
6. Follow-up with welcome letter, brochure, etc.? Is your welcome genuine and shared?

Step 3: First Doctor Meeting

**Concept:** Significant amounts of information are exchanged at the first office visit. This initial interaction has a written component (health history, brochures, etc.); a verbal component (question and answer session); and a non-verbal component (time spent, body language, sincerity, feelings of trust established).

**Checklist: Do you...**
7. Provide a thorough review of the health history and the chief complaint?
8. Spend time educating the parent/patient with your initial thoughts about a tentative treatment plan, fee estimate, treatment time?
9. Send a letter to the DDS and to the patient/parents with a summary of preliminary plan?

Step 4: Treatment Planning Conference / Report

**Concept:** Patients and parents have a keen interest in their treatment plans and most have already done some research through friends, other professionals and the internet. This appointment is an opportunity to present your caring doctor and team members all of whom can educate the patient about the problem, the need for the treatment, and what can be expected during and after the treatment process.

**Checklist: Do you...**
10. Review records?
11. Illustrate possible outcomes in a consistent way?
12. Review consent form?
13. Treatment Plan report to DDS/Specialists, to patient with patient/parent signature of approval?
Step 5: Progress Conference / Report

**Concept:** Time goes by very quickly and patients and parents are curious about the progress and success of treatment. This is another opportunity to inform the patient/parent and general DDS about the unique features of their particular case.

**Checklist:** Do you…

14. Take a panoramic x-ray about two-thirds of the way through treatment on every patient?
15. Send a Progress Report to the DDS (including x-ray) with a copy to the patient/parent?
16. Have educational materials to help patients understand options such as implants, timing of implants, retention modalities for missing laterals, plasties, gingival grafts, Class III growth &/or jaw surgery?

Step 6: Retention/Stabilization Conference / Report

**Concept:** After appliance removal, it is helpful to have a formal conference to review the original treatment plan and to emphasize the importance of the orthodontic after care (retention). Direct the patient back to their general dentist, discuss limitations of treatment, restorative options, and include a discussion of relapse risk factors.

**Checklist:** Do you…

17. Have patients complete a questionnaire assessing their orthodontic experience?
18. Provide the patient/parent with a post-treatment report with a copy to their dentist?
19. Celebrate the patient’s accomplishment? Present before and after photos?
20. Discuss specific issues that require future attention?

Step 7: Completion Conference / Report

**Concept:** There are several areas of interest to most patients who are about to “graduate” from their orthodontic treatment program: 1) Stability; 2) Third molar decision; 3) Jaw growth; 4) Duration of retainer wear and concerns about long-term impact of fixed retainers

**Checklist:** Do you…

21. Take a panorex (or obtain from DDS) to evaluate 3rd molars and document your recommendations?
22. Take a wrist film when mandibular and/or vertical growth excess is a factor?
23. Evaluate growth vectors to inform patients of growth imbalances?
24. Review a Treatment completion Report to answer most frequently asked questions? Send a copy to DDS; give copy to patient/parents?

Step 8: Team Members Review of Patient Feedback

**Concept:** Health care practices in the future will struggle with the issues of quality versus quantity (volume). To provide the highest quality care, mechanisms of periodic review are needed to both refine and to improve procedures and to help the doctor and team members to continue the quest for excellence. Affirmation and encouragement comes from patients and referring dentists who express appreciation for the excellent service that has been provided to them.

**Checklist:** Do you…

25. Ask your referring dentists if they are satisfied with the care that is being given to their patients.
26. Make changes if dentists or patients/parents have negative perception of the care provided?
27. Have a commitment to a discipline that is standardized and integrated with the mission statement of the practice?
28. System of rewarding the orthodontic team for excellence?
Phase I Orthodontic Treatment (Ages 4 - 12)

What is Phase I orthodontic treatment?
It is the first phase of a two-phase or multiphase orthodontic treatment process to improve function and the appearance of your child’s teeth. Phase I treatment incorporates principles of both dentofacial orthopedics (altering habits, muscle, and bony relationships) and orthodontics (movement of teeth).

What are the advantages of Phase I treatment?
- Younger patients usually adapt more easily to orthopedic appliance requirements and tissue response is better.
- Early improvement of the oral environment enhances self-esteem.
- Early intervention improves long-term stability.
- Patient will spend less time in full braces (Phase II treatment) during their teenage years.

NOTE: Not all 4-10 year old children with tooth malpositions require a two phase treatment approach. Your orthodontist will discuss the advantages and disadvantages of a multiphase treatment program for your child. Common Phase I case types are shown on this handout.

Open bite and contributing habits (*10%):
- Digit habits - sucking on thumb or fingers will cause adverse changes in teeth and growing facial bones.
- “Bite” habits - grinding and functional shifts can cause accelerated wear on teeth and joint strain with potential muscle fatigue and skeletal asymmetry.
- Mouth breathing habits - mouth breathing due to nasal obstruction and allergies can contribute to “open bites”.
- Tongue habits - improper positioning of the tongue during swallowing, habitually holding tongue between the teeth, or tongue sucking habits can contribute to open bite.

Lower jaw deficiency and/or upper dental protrusion (*30%): Referred to as Class II problems by dental professionals.
- Overjet -- A gap between the upper and lower front teeth:
  - due to overgrowth of the upper jaw and teeth;
  - due to undergrowth of the lower jaw and teeth;
  - due to a combination of the above.
- Phase I treatment reduces severity of the skeletal problem, improves chewing function and enhances facial appearance and self-esteem.
- Moving the teeth to their proper position can also prevent “sport trauma” to front teeth and subsequent dental injuries.

Open Bite Due to Habit

Before

With habit appliance

After habit corrected

After bicuspid extraction & braces

Lower Jaw Deficiency

Before with significant overjet

After orthopedics & braces

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Upper jaw deficiency with crossbite (*15%): 
Referred to as Class III problems by dental professionals.

- Anterior crossbite (also called “underbite”) is a reversal in the chewing relationship of the upper and lower front teeth. Lower jaw growth can become excessive.
- Frequently the patient may also have a posterior crossbite; a reversal in the chewing relationship of the upper and lower back teeth.
- These growth problems should be treated early to minimize trauma, avoid damage to the teeth that are out of place, and to improve facial balance.
- Early correction can minimize adverse effects on the growth of the jaws and facial bones.

NOTE: Severe jaw growth problems, while improved in Phase I treatment, may still require future surgery for complete dental correction, particularly true if genetic history.

Jaw constriction problems (*15%):

- When the upper jaw is too narrow, the molars and “eye” teeth can grow into a reduced perimeter resulting in crowding of the teeth.
- This problem is best corrected before the upper jaw growth is complete.
- Early treatment can provide an effective orthopedic response and can help to make room for crowded front teeth. This provides better esthetics and future periodontal health.

There are several other types of orthodontic problems that benefit from Phase I intervention. After examining your child, your orthodontist can advise you about the appropriateness of Phase I treatment for your child.

*Based on a 2001 study of 100 consecutively referred 5-10 year old patients.

Doctor’s Comments:

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**PHASE I MILESTONES (AGES 4 - 12)**

<table>
<thead>
<tr>
<th>Evaluation (1-3 mos)</th>
<th>Appliances in Place (12-18 mos)</th>
<th>Observation (6-12 mos)</th>
<th>Periodic Recall (18-24 mos)</th>
<th>Phase II (12-24 mos)</th>
</tr>
</thead>
</table>
| • Orthodontic records | • Growth & treatment response monitored (patient cooperation is essential) | • If favorable progress, go to stabilization program | • Continue growth guidance & monitor dental development | • Evaluate for new problems 
• Full braces to complete bite correction 
• Additional orthopedics possible |

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Adolescent Orthodontic Treatment (Ages 12 – 20)

What is Adolescent orthodontic treatment?
Adolescent treatment involves the orthodontic management of a patient who has all or nearly all of their adult teeth. At this time, the patient is rapidly growing due to the adolescent “growth spurt”. Treatment during this phase involves the correction of adult tooth position to maximize the bite. More severe orthodontic problems involve skeletal disharmonies with jaw deficiency or jaw excess. These growth imbalances (sometimes with genetic etiology) can often be best corrected during this rapid skeletal growth phase using growth to our advantage.

Severe Crowding
Before                                     After

Tooth size / jaw size discrepancy:
- With the replacement of the primary dentition (baby teeth) to adult teeth, tooth size / jaw size problems can become apparent
- The canines can become ectopic (out of position) either showing up high like “fangs” or impacted (stuck in the jaw) due to lack of space
- Treatment would involve analysis of study records to determine the cause of this problem
  - Tooth size excess with normal jaw size may be treated with permanent tooth extraction and braces
  - Jaw underdevelopment with crowding can be reversed with expansion and braces
- **Note:** The problem of severe crowding can be diagnosed early and early intervention can reduce the need for tooth extraction that is frequently required if not treated until the adolescent years. Phase I intervention also enables a decrease in the duration of treatment during adolescent correction.

Adolescent Class III
Before                                     After

Mandibular excess/maxillary deficiency:
- Anterior crossbite (under bite) may become more apparent during this growth phase due to the rapid skeletal growth of the patient
- Most cases (80%) involve upper jaw size discrepancy which can be managed with palatal expansion and forward traction with elastics
- **Therapeutic diagnosis:** More severe skeletal disharmonies are managed with expansion and traction of the upper jaw to assess the skeletal response after initial treatment and elimination of tooth interferences (crossbite)
- Severe jaw growth problems may require surgery to complete bite correction when growth is complete
- Diagnosis and treatment planning is important to quantify problems, predict future growth, and allow timing of treatment decisions to be made
Congenital absence / traumatic loss:

- Missing teeth frequently have a familial/genetic factor
- Lateral incisors are the third most common missing tooth after wisdom teeth and premolars—missing lateral incisors occur in about 5% of the general population
- Due to the missing tooth, the arch collapses to close some of the space on the affected side and the midline will shift to that side
- Treatment often requires reopening of the space and correction of midline with braces followed by replacement of the missing tooth
- Treatment planning decisions take into account skeletal relationship, shape and color of canines (eye teeth), and bite relationship
- Replacement is often favorable to canine substitution because of better aesthetics, function and stability
- Replacement options include—resin bonded bridges, traditional bridges or implants
Note—Implants cannot be placed until growth is complete

Failure of eruption / impaction:

- Occurs when a tooth becomes wedged or stuck so that no further movement is possible
- Can be caused by lack of space, displacement of developing tooth due to trauma, or genetic factors
- Alignment and arch perimeter needs to be reestablished as well as space required for the impacted tooth
- Treatment involves full braces, possible arch expansion, and surgical exposure with orthodontic traction into the arch
- An open surgical procedure with an apically-repositioned flap is preferable to “closed eruption” due to easier evaluation of progress, faster progression and increased patient comfort (less pain on activation)
- Early orthodontic evaluation can often detect eruption problems which can be redirected with arch expansion, space creation and guided eruption to avoid surgical exposure at an adolescent age

Impact of eruption / impaction:

- Occurs when a tooth becomes wedged or stuck so that no further movement is possible
- Can be caused by lack of space, displacement of developing tooth due to trauma, or genetic factors
- Alignment and arch perimeter needs to be reestablished as well as space required for the impacted tooth
- Treatment involves full braces, possible arch expansion, and surgical exposure with orthodontic traction into the arch
- An open surgical procedure with an apically-repositioned flap is preferable to “closed eruption” due to easier evaluation of progress, faster progression and increased patient comfort (less pain on activation)
- Early orthodontic evaluation can often detect eruption problems which can be redirected with arch expansion, space creation and guided eruption to avoid surgical exposure at an adolescent age

Adolescent Treatment Milestones (Ages 12-20)

<table>
<thead>
<tr>
<th>Evaluation (1 – 3 mos)</th>
<th>Appliances in Place (18-36 mos)</th>
<th>Retention / Observation (12-18 mos)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Orthodontic records:</td>
<td>• Growth &amp; treatment response monitored (patient cooperation is essential)</td>
<td>• Observe tooth “settling” &amp; completion of growth</td>
</tr>
<tr>
<td>• Diagnosis / Treatment plan</td>
<td></td>
<td>• Monitor retainers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Final panorex to evaluate wisdom teeth (3rd molars)</td>
</tr>
</tbody>
</table>
Adult Orthodontic Treatment (Ages 20 – 75)

Is there anything special about adult orthodontic treatment?
Yes, 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 periodontal problems and adults have more missing and damaged teeth. However, adult orthodontic patients cooperate better than their adolescent counterparts and as a result their time in orthodontic treatment is frequently shorter.

Missing Posterior Teeth

Missing posterior teeth:

☐ Loss of molars and congenitally absent posterior teeth contribute to jaw “over closure”
☐ Jaw over closure is also called “bite collapse” and can accelerate progressive tooth loss through incisor trauma which is secondary to over closure and to an anterior deep bite
☐ The most predictable correction is accomplished through:
  ☐ Reversal of the “bite collapse” with tooth movement (orthodontic treatment)
  ☐ Periodontal re-evaluation of tissue response
  ☐ Reopen spaces in preparation for restoration
  ☐ Stabilization with tooth replacement—implant if possible to preserve bone and to reduce crown preparation

Interdisciplinary Treatment

Interdisciplinary dentofacial therapy (IDT): 80% of adult patients require dental teamwork:

☐ Tooth loss and wear allow dental migration
☐ Dental arch collapse requires “reversal” (uprighting) through orthodontic treatment
☐ If adequate bone exists—implants will replace roots and crowns will replace the top portion of the tooth
☐ Restored function, health and esthetics are achieved
☐ Dentofacial “aging” is reversed
Tooth size / jaw size discrepancies:

- Some crowding and spacing situations requires orthodontic intervention
- In some cases, “strategic extractions” are required to align teeth and optimize bite
- Anchorage appliances may be necessary to allow efficient movement
- Improved function, periodontal health and esthetic are achieved
- Treatment of crowding has as favorable a prognosis for adults as it does for adolescents

Congenital absence / traumatic loss:

- Optimal replacement frequently requires space modification and re-angulation of roots
- Orthodontics moves neighboring teeth to make room for implant (root) and crown
- The implant (root) is placed when adequate room is available to allow for bone integration to occur
- Implants can often be placed prior to orthodontic completion
- Crown (cap) placement usually occurs approximately 4 months after implant placement

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I. CLASSIFICATION AND DIAGNOSTIC DESCRIPTION OF MALOCCLUSION:

[ ] Class I with skeletal balance  [ ] Class II (skeletal/dental) maxillary excess/mandibular deficiency
[ ] Class III (skeletal/dental) maxillary deficiency/mandibular excess

II. LIST OF DENTAL PROBLEMS AND THEIR SEVERITY:

Periodontal:  [ ] Within normal limits  [ ] Tissue excess  [ ] Tissue deficiency  [ ] Inflammation  [ ] Advanced disease

Restorative:  [ ] Within normal limits  [ ] Decay control  [ ] Tooth replacement

TMJ Status:  [ ] Within normal limits  [ ] Disorder characterized by

Additional Orthodontic Considerations:

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III. ORTHODONTIC TREATMENT PLAN

Description

1. Preventive care with referring dentist at recommended intervals.

Provider

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Start Date:  
Est. Tx Time:  
Est. Retention Time:  

IMPORTANT NOTE:
Phase I (Interceptive Treatment) is designed to enhance proper dental development and to encourage proportionate jaw growth. GOOD PATIENT COOPERATION AND GOOD GROWTH RESPONSE ARE REQUIRED FOR GOOD PHASE I RESULTS. A second phase of treatment at age 11-14 is almost always needed to achieve an optimal result. Appropriate orthodontic records will be taken before Phase II to assess the need for further treatment.
Your patient was seen in our office today for an appointment/mini-conference to discuss: (☐ Parent Present)

☐ Progress panoramic radiograph (see enclosed x-ray) findings:
  ☐ Decay or Pathology
  ☐ Shape of Condyles and Symmetry
  ☐ Root Resorption
  ☐ Root Alignment/CEJ
  ☐ Third molars
(We typically make recommendations regarding third molar status during the retention phase.)

☐ Growth response to treatment:
  ☐ Not a factor in this patient’s treatment

Additional records to evaluate including:
  ☐ Cephalogram
  ☐ Hand/Wrist Film
  ☐ Cephalogram/Superimposition to evaluate “Growth Treatment Response Vector”

Comments: __________________________________________________________

☐ Compliance with treatment requirements:

<table>
<thead>
<tr>
<th>Appointments:</th>
<th>Excellent</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral Hygiene:</td>
<td>Excellent</td>
<td>Good</td>
<td>Fair</td>
<td>Poor</td>
</tr>
<tr>
<td>Cooperation with appliance instruction:</td>
<td>Excellent</td>
<td>Good</td>
<td>Fair</td>
<td>Poor</td>
</tr>
</tbody>
</table>

| Additional Comments: | ________________________________ |

☐ Treatment completion timeline:
  ☐ Treatment is on time (Brace removal estimated – Spring/Summer/Fall/Winter, ____________.)
  ☐ Treatment delayed due to _____________________________________________________________
  (New estimated debanding month is: ____________________________ )
Fixed orthodontic appliances were removed on _________; and _________ has been referred back to you with the following observations and recommendations:

I. RETENTION PHASE:

Estimated Retention Time: 12 months (visits included in fee; subsequent check-ups @ $55/visit)

Appliances Prescribed:
Maxillary: Ret LA
Mandibular: Ret LA

Frequency of Visits: Every 12 to 16 weeks

II. FUTURE TREATMENT CONSIDERATIONS:

Your patient, ________________, has been advised to make an appointment with you to be evaluated for the following:

☑ Routine post-orthodontic examination and caries check:
☑ Cleaning/fluoride:
☑ Radiographic survey (as you see fit):
☐ Periodontal Evaluation:
☐ Restorative Treatment:
☐ Equilibration Needed:
☐ Future Extractions: Evaluate third molars for extraction
☐ Others: JAW GROWTH—for girls who are 15 and younger and boys who are 21 and younger, studies have shown that 5-8% of persons in this age group experience “late-stage growth changes” that may effect the bite.

III. TREATMENT APPRAISAL:

Description of original problem and treatment objectives:

Limitations imposed by complexity of orthodontic problem:

Limitations imposed by patient cooperation:

Overall assessment and comments:

If there are any questions regarding this report, please call (XXX) XXX-XXXX, at your earliest convenience.

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Covey, Stephen: **First Things First.** Tells you how to “*connect with your mission statement*” Simon and Schuster; New York, 1994.

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