Newsletter of the Louisiana Academy of General Dentistry

Winter 2008

The Pelican's Pouch

Janet Steward will be presenting a seminar for the LAGD Feb. 29. This is one meeting you won't want to miss. This is a must for your whole staff to attend. Janet entertains audiences and readers with a delightful variety of professional and personal experiences. She has an easy, out-going style that her audiences and consulting clients alike find refreshing. Janet is a dynamic speaker, consultant and a published author having just co-authored *What do Dentists* Really *Want?* with her husband and business partner, Lawrence Steward, MBA.

She is a Certified Professional Behavior Analyst and holds memberships to the Academy of Dental Management Consultants, the Academy for Professional Speaking, the Speaking Consulting Network, and the Institute of Management Consultants.

Call Brenda at 1-800-277-8356 to register!

See page 5 for Janet's article on Intraoral Cameras.

Presidents' Message

Welcome to the first edition for 2008 of our Pelican's Pouch Newsletter. I hope you find it informative as you discover what's new with our Louisiana AGD. Our editor, Scott Kogler DDS MAGD, and his wife Melissa impressed us last fall with their first effort of producing an excellent Pelican's Pouch and this edition is equally terrific!

I look forward to serving my second year as your LAGD President. The LAGD and our national AGD organization continue to be a positive force to promote the interest of General Dentist. This extends not only to the public but also to our State legislature and Federal Congress through our strong advocacy efforts.

To keep the AGD on the right track, our LAGD constituent will be meeting February 8, 2008 in Mississippi with the rest of our Region 12 friends. At this meeting we will discuss our strategy for the upcoming national AGD meeting in Orlando which will be July 16-20, 2008. Besides the excellent CE offered and the beautiful Orlando area to enjoy, we will try to positively influence the policies of the national AGD to keep our organization one of the best representatives for us as General Dentist.

Speaking of the national AGD meeting this July, you should know that in addition to being an excellent CE venue, you can take your staff as well because their meeting tuition is free. I think my staff will enjoy the meeting and I encourage you and your staff to join us as well!

See you in Orlando!

For more information
On the National AGD Meeting in Orlando
July 16-20, 2008
Visit:
http://www.agd2008orlando.org/

COMMUNICATION – KEY TO REFERRAL IN DENTISTRY

By Dr. Chip Simon
Drs. Simon, Bond and Corbett
2051 Silverside, Suite 208
Baton Rouge, LA 70808
(225) 766-3061 (225) 933-9101
chip@geauxendo.com

The practice of General Dentistry in 2008 presents unique challenges regarding referral of patients to specialists. Advancing methods of communication, including digital images and e-mail have made immediate feedback possible. Relationships between Generalists and Specialists are based on open, honest and complete communication. There should be no surprises when the patient arrives at the Specialists office. Obviously, most communication can occur between the administrative staff of the individual offices involved. However, there are certain cases when Doctor to Doctor communication is necessary. If the reader senses a theme of communication, then the message is being accurately conveyed. Every Specialist has referral "slips" for the Generalist to send with the patient. It is important that the referring Generalist keep a copy of this communication "slip". It serves as a tangible reminder of all the information relayed to the Specialist. This can be accomplished via paper or computer. As we transition to the digital office, more of these correspondence will be electronic.

Minimally, the communication should include the name, age, gender, and medical history (if applicable) of the patient. Pertinent dental signs and symptoms and complicating factors that stimulated the referral should also be included. During these times of insurance and other third party payments, any information that will allow the patient to maximize their reimbursement should also be shared. Much of this information can be garnered directly from the patient, but quality care and exceptional service would allow for most of this information to be conveyed between the administrative staffs of the respective offices. Again, the more information gathered prior to arrival at the Specialists office, the smoother the transition for the patient.

Expert clinical care is expected from the Specialist, but the patient should not be given false hope prior to the referral if the prognosis is guarded. Once the clinical care is completed, then the communication burden is reversed. It is

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Communication—Key to Referral in Dentistry Continued…..

incumbent on the Specialist to relay on paper or electronically any diagnosis, treatment, or follow-up care necessary to allow for smooth transition back to the Generalist. It should always remain paramount that the patient "belongs" to the General Dentist. It has been stated that patients refer to their General Dentist as "My Dentist" and Specialists as "The Specialist". These comments are in complete concert with what we routinely encounter in our Specialty Practice.

I feel a scenario presentation can best describe the ideal referral and return proceedings. As an Endodontist, we are highly dependent upon high quality radiographs or digital images to assist in diagnosis and treatment planning. Conveyance of these documents prior to the visit will facilitate scheduling. Obviously, the Specialist will need to take their own images, but one cannot have too much historical information. Written documentation should include the reason for the referral, either treatment or diagnosis. The pain level or asymptomatic condition should be included along with the tooth number if the diagnosis is obvious. Additional information should include what type of "final" or "temporary" restoration is requested, and whether a buildup is required. Health history, especially latex allergy, significant anesthetic considerations, diabetes, or autoimmune condition should be relayed.

This is just an overview of the cascade of events which would lead to a smooth referral from Generalist to Specialists and back. Specialists must communicate all pertinent post-operative information in a timely manner. Please try to communicate with each other prior to some catastrophic event, as this will improve resolution of any issue. Remember, to quote Yogi Berra, "I really didn't say everything I said." This may apply to this article, but if anything I said is unclear, please contact me personally with any comments.

Congratulations to those LSU Tigers
BCS National Champions 2007!
G•E•A•U•X • T•I•G•E•R•S

DUST OFF THAT INTRAORAL CAMERA

By: Janet Steward

How many times a day is the intraoral camera used in your practice. Twenty? Ten? Never? You know the benefit of dramatically increased case acceptance. What was so clearly visible to only you is now visible to the patient as well and, as the saying goes, a picture is worth a thousand words. You are painfully aware of the cost. Intraoral cameras are not cheap. Many dentists would love to invest in having them in every treatment room but don't because those that they currently have are not being fully utilized. How frustrating is it when this expensive piece of equipment becomes a dust gatherer?

How do you get your team to use the camera on virtually every single patient? You could issue an edict instructing your assistants and hygienists to use the intraoral camera more often. The first day things are usually a little better. The second day they are not as good and the third day, your practice is back to the same old thing. People begin with good intentions; they really do. Sadly, the busyness in the day usually catches up with them and the best of intentions fall by the wayside.

What are you, the dentist, to do about it? You could fuss and gripe, moan and groan and try to bludgeon them into shape. This approach may work for a while until your ulcer starts acting up as all this micromanaging wears you down. Isn't there some system that you can put into place that you won't have to micromanage? Here are six steps you can implement today that will achieve 100% use of the intraoral camera, a dynamite wrap-up from the team at the end of each appointment and dramatically increase your case acceptance.

1. One of the traits of effective leaders is that they are crystal clear. It starts with a clear expectation from the doctor to the team that they will use the camera with every single patient. Every time you sit down to perform an exam, you should expect to have one or more intraoral pictures displayed on the monitor. If a patient does not have any restorative concerns, show periodontal concerns such as calculus buildup or bleeding. Take a picture of the crown you just seated on number 31 to show how great it looks and matches up with the tooth next door. Use it with children to show them the results of disclosing solution highlighting where they are having difficulty brushing.
2. The assistants and/or hygienists keep track of two things during the day: (a) the number of patients they saw, and (b) the number of times they used the camera. They give this information to the administrator at the end of each day. The administrator enters the data into a simple spreadsheet that tracks the percentages. You can create your own spreadsheet or send an email to janet@quantumleapdental.com for a complimentary one.

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Intraoral Camera Continued……..

3. The third expectation is that the assistant and/or hygienists will display the pictures for the exam. In the beginning, the dentist may need to give a gentle reminder such as, "I can see you are not quite ready for me. Why don't I do my other hygiene check and come back when you have taken some pictures of that tooth?"
4. All this leads to an incredibly powerful wrap-up by the assistant and/or hygienist that you can easily track on the same spreadsheet. Things get hectic and the clinical team is often rushed. It is common for an assistant or hygienist to talk to the patient about their next appointment while they are gathering up the patient's chart, raising the back of the chair, removing the bib and ushering the patient to the front desk. Keep in mind that 55% of everything we perceive comes from body language, 38% from tone and pace and only 7% from the words we say. Talking to a patient about their next appointment while you are walking them up to the front desk looses a lot of its impact. Focus is a magical thing, takes hardly any time, increases case acceptance and reduces missed appointments. Here is how it works. When the doctor leaves the treatment room, the assistant or hygienist should sit facing the patient, eye to eye with their mask removed and ask, "What questions do you have about the treatment that Doctor recommended?" When any questions or concerns have been answered, the assistant or hygienist says something like, "I'm going to take you up to the front and Amy will schedule you for two appointments. The first one will be for your professional cleaning and the second will be for those three fillings on the left hand side." Then, and only then, do they remove the bib and escort the patient up to the front desk.
5. Tracking your results is the final component to this system. The numbers speak for themselves. While there may be some 'fudging' of the numbers, it can't be too far off or else you will know about it. Review the individual percentages during a staff meeting. Celebrate your success. Consider a $50 bonus for everyone if the practice as a whole achieves 95% compliance.

The results will speak for themselves. You, the doctor, will become the macro-manager instead of the micro-manager. The system runs itself. What a relief. We commonly find that practices that put this system in place go from 0-10% camera usage to 85-90% camera usage. Imagine what that does for your case acceptance when patients can see for themselves what their broken down tooth looks like. Imagine what it does for missed appointments. They are dramatically reduced because pa-

Anyone who has questions, comments, suggestions, or would like to submit an article for future newsletters, please e-mail Scott Kogler at skogler@eatel.net.

Michael J. Maginnis, D.D.S., M.S.
Board Certified Specialist in Removable Prosthodontics
7742 Office Park Blvd, Suite A-1, Baton Rouge, LA 70809
(225) 201-1000

Oh Alginate! How do I love Thee!
Let me count the ways……

Often, I'm asked, "What impression material do you use"?
I respond, "Alginate".
"That's fine for study models", says the dentist, "but, what about for complete dentures"?
I respond, "Alginate".
"And for partial dentures"?
Again, I respond, "Alginate".
And since I don't do fixed restorations any longer, I don't have to explain that I have done full crown restorations (quite well) with alginate – part of a test study – but alginate, none the less.

At this point, as a disclaimer, I should say that while alginate is used to construct my treatment dentures and partial denture frameworks, the final wash impressions for the dentures and corrected cast impressions for the partials are done with Microseal-Seal by AMCO (available through any dental supplier).

Why alginate? Why not? It's cheap, fast, easy to use and extremely accurate. When handled properly and poured immediately, it's as accurate as anything on the market.

Water::Powder Ratio vs. Water Temperature:

Don't mess with the W::P ratio -- this has a profound effect on accuracy. Variation in water temperature is different story. For the most consistent setting times year-round, use water that is room temperature. (We keep a large bottle with a pump dispenser on the counter and refill it every evening). Our office stays fairly close to 72^0 year-round – our tap water doesn't – it varies from 65^0 to 85^0 from winter to summer creating large variations in setting times. If your office is warm and humid, replace approximately 1/3 of the water in the measuring vial with ice water. This will give you a normal setting time on the muggiest of summer days.

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Oh Alginate! Continued…….

Interproximal Undercuts:

Alginate doesn't stick to alginate, so any place where tissue recession has led to open interproximal spaces, block them out on the facial with a small mix of alginate placed with a cement spatula. This "block out" mix will set by the time you prepare the main mix. This may produce an unsightly facial surface on the model, but a very accurate lingual surface – after all, this is the portion of the model that the partial framework or bite splint has to fit.

Mechanical vs. Hand-Spatulation:

For the best results, use a mechanical spatulator with vacuum – mine is located just outside the operatories. Short of this, I would recommend a Cadco or similar mechanical spatulator. It can be used chair side and produces a consistently smooth mix that is relatively bubble-free.

Custom Tray vs. Stock Tray:

Yes, I have made very nice impressions with custom acrylic trays that have been perforated and painted with alginate adhesive – usually in a situation where the patient has a very limited oral opening. Otherwise, I use perforated stock trays that have been altered with periphery wax (coated with tray adhesive) to make sure the alginate is carried out to the borders of the vestibules and down to the depth of the mylohyoid space and over the retromolar pads. The wax is also used to reduce the thickness of the alginate in the palatal vault – alginate works best at no greater thickness than 6mm (1/4"). Beyond this, it slumps, producing a denture with little palatal seal and a partial framework that stands away from the tissue. A 12cc disposable syringe can be used to inject a portion of the alginate into the vestibules and down into the mylohyoid space. A finger full of alginate is wiped across the palatal vault and onto the occlusal surfaces of the teeth. The impression is set one minute after the alginate no longer sticks to your glove.

Pouring the Impression:

Immediately, if not sooner, is my best advice. Upon removing the impression from the mouth, rinse with tap water, spray with algicide, wrap in a wet paper towel and let sit 5 minutes while preparing stone or plaster for mixing. Just prior to pouring, rinse again in tap water, blow dry, spray with debubblizer and pour model.

With apologies to Elizabeth Barrett Browning,

IMPLANTS MADE EASY REALLY!

On December 14, 2007, the LAGD had the pleasure of hosting a seminar with Dr. Leo Malin. If you weren't able to attend I think you missed an eye opening discussion of the latest modern possibilities of Dental Implants.

Dr. Malin hails from LaCrosse, Wisconsin and graduated from Marquette University in 1991. Over the years, he along with others have developed a system that can predictably place implants where they belong to optimize esthetics and occlusion.

He can accomplish this by utilizing surgical stents and CT Tomography. This technology is amazing in how it can guide you in the proper implant placement. Dr. Malin notes you can get a 3-D image of the Maxilla and Mandible to detect if a sufficient amount of bone is available to place an implant. Of course you can see the location of critical nerve pathways so you can avoid them as well.

This information can be carried over in fabricating a surgical stent which is used as a guide to place your implants. Dr. Malins' idea of "If you can drill a hole, you can do this" was proven once we covered this concept. His preferred implant system is the Ankylos system from Dentsply. The highlight of the day was a case presentation where Dr. Malin placed 28 implants and restored them within weeks. Although he lost one implant of Tooth #15, this was an incredible display of this systems' possibilities. We were very appreciative of Dr. Malins' expertise.

Mark Locantro DDS Memorial Award

At our annual meeting in December, the Louisiana AGD presented the Mark Locantro DDS Memorial Award to Dr. Jerry Tully. This award is given to a Doctor who has exhibited outstanding service to organized Dentistry. It is interesting to note this award may not be given annually; only when the LAGD board feels a deserving candidate has been nominated is the award presented. Dr. Tully has exhibited a long history of service to us in organized Dentistry, including his help with our Louisiana AGD and the LDA and by serving in various capacities in these organizations. He is also an LSUSD faculty member and has been instrumental in helping our school get back in the business of educating our new Dentist.

Marks' parents, Dr. Joe and Helen Locantro were on hand to present the award. It was great to visit with them as they too have been prominent supporters of organized Dentistry for many years. Afterwards we celebrated at Dr John Portwoods' home where we enjoyed gumbo and pralines... what a treat!