Ep #47: Being Intentionally Intentional In Your Practice with Dr. Mark Murphy

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With Your Host

Allison Watts, DDS

Practicing with the Masters with Allison Watts, DDS

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Welcome to *Practicing with the Masters* for dentists with your host, Dr. Allison Watts. Allison believes that there are four pillars for a successful, fulfilling dental practice: clear leadership, sound business principles, well-developed communication skills, and clinical excellence. Allison enjoys helping dentists and teams excel in all of these areas. Each episode she brings you an inspiring conversation with another leading expert. If you desire to learn and grow and in the process take your practice to the next level, then this is the show for you. Now, here's your host, Dr. Allison Watts.

Allison: Welcome to *Practicing with the Masters* podcast. I'm your host, Allison Watts, and I'm dedicated to bringing you masters in the field of dentistry, leadership, and practice management to help you have a more fulfilling and successful practice and life.

All right, hello everybody. Thank you so much for being here, spending your evening with us. I'm going to go ahead and officially introduce Mark. Some of you guys know him, some of you guys have heard him before on here. Thank you for coming back, Mark.

Mark: My pleasure. Thank you for having me.

Allison: Always nice to talk to you and always nice to learn from you. Mark Murphy is the lead faculty for clinical education at MicroDental and DTI Dental Technologies Incorporated. He also serves as an adjunct faculty at the University of Detroit Mercy School of Dentistry and the Pankey Institute where he also serves on the board of directors.

He practices general dentistry on a limited basis in Rochester, Michigan and lectures internationally on leadership, practice management, communication, case acceptance, planning, occlusion, and TMD.

Mark is also the principal of a web-based application, Funktional Tracker. It is a behavior-tracking app marketed towards dentists who wish to improve their practices. Through a combination of daily user inputs and data synchronization with office management software, the app let's small practice owners track and correlate desirable behaviors of their staff a.k.a. Key Behavioral Indicators with Key Performance Indicators that measure the success of their practice.

One of Mark's favorite quotes is, "When the student is ready the teacher appears."

Mark: Because it's true.

Allison: He believes that when we're ready in life—yeah it is. When we're ready in life, no matter how many wonderful people you're running around, when you are ready, you're going to hear things you didn't know before. That's when incredible transformation begins and that's what we're here for tonight.

Those of you who were here last time, I know we got a lot of good information, and Mark, like I said, I'm really excited that you've agreed to come back. I know we enjoyed last time and we got a lot of good info and we also had a lot of great conversation and great questions. I know you and I talked for quite a while after the call.

Mark: We did.

Allison: We were saying like, "Oh my gosh, we didn't even get to finish."

Mark: No, we really didn't. So that's why I really appreciate you having me back. Because when you asked if I'd come back, I said that would be great because it will give me a chance to do what my wife always yells at me about not doing sometimes. That's when I'm teaching or lecturing, sometimes I get caught up in the 10,000 and 20,000 foot level looking at something and I

don't always finish up talking about what are the specific things you can do to achieve that.

So I felt like when we got done last time, we had some great conversations and a lot of great questions people were coming up with and it led us on some tangents and down some rabbit holes. It was all great stuff. I mean, I loved it. I wouldn't change it for the world but I felt like we didn't get a chance to send people home with stuff that they could do Monday morning in their practices to make a difference. So I appreciate that.

Allison: Yeah. And you don't even know this but when I first started doing these calls, I asked every single speaker, and I don't think I asked you for this. I used to say, "I want everybody to walk away from this call with something actionable, something that they can take back Monday morning and do to change their practice."

You know what, they may have gotten some stuff from that conversation but we weren't so intentional about it.

Mark: Correct.

Allison: Yeah.

Mark: So you said my favorite quote. Intentional, at least the last couple, three years has probably been my favorite word.

Allison: Oh yeah.

Mark: Favorite word.

Allison: It's my work in progress this year to be more intentional in everything that I do.

Mark: Same here.

Allison: Yeah, so you mentioned to me there's three things. Right?

Mark: Yeah, and that's a lie because there's 300 things of course. Or there's 30 things. But to keep it simple so that in a small amount of time like we have, the question I'd ask myself, and the question you and I talked about afterwards last time is, what would I send somebody with after this?

Probably one great thing you can do in three different categories. So here's three things, one from each of the main drivers of practice growth and success and improvement that would allow us to be more successful or a little bit better in our practices, and so I thought that would be a good way of framing it.

Certainly each one we could take off on tangents, go down rabbit holes, but we'll try not to do that tonight. Instead I would talk about the three things that I would consider doing in a practice if I wanted to improve things.

Allison: Okay, perfect.

Mark: So the thesis for this is a very important article that I read a long time ago in *Harvard Business Review.* It was about banks. It was a case study about banks and how they spent a lot of money on marketing to try and get more new clients. What the case study did is they spent about 25 percent of the original budget, instead of trying to get more new clients, in retaining their existing business.

Then they spent another 25 or 27 percent on trying to sell more to their existing customers. In a bank, that means instead of you just having a checking account, could they come and sell you a savings account? Could they sell you a mortgage? A home equity line of credit? A car loan, etc.

If they just worked on those two things, and quit trying to go out and get more new clients, it turns out the bank grew more than

it had ever grown before. I found that fascinating about the banks, but that didn't interest me. What kept interesting me is it sounded to me like they were talking about dental practices.

Because what I heard in this *Harvard Business Review* article was if we focused on retaining our existing clients and selling them more of the dentistry that they need, that's a horrible way to say it, selling dentistry. So let's phrase it as, if I helped more of my patients make better choices about optimal health, and I got to do more of the dentistry that lit my fire and floated my and my team's boat. Then oh by the way, we might make more money.

So if I kept more of my patients and didn't have to find as many new patients, and I did all the dentistry that they needed to have done. I got them to want that. I probably wouldn't need any new patients. I'd probably have so much dentistry to do that I'd be busy for the next two or three or four years.

That thesis is correct because most practices come to talk to us and say, "Man, I need more patients." I can only tell you story after story of finding out that somebody is averaging 15 new patients a month, which is 180 per year, which is 360 new patient hygiene visits needed next year and that's 45 eight-hour days.

Allison: Wow.

Mark: So I say to them, "So 15 new patients a month, right?" They go, "Yeah." Well I go, "That doesn't make any sense. You need more new patients?" They go, "Yeah, I got holes in my schedule. My hygiene is down half the day."

I go, "Well how many patients is that a year?" I make them do the math. "Then if they all came in twice, how many is that?" I make them do the math. Then I have them divide it by eight,

that's how many full days of hygiene that should have added to their schedule, 45 eight-hour days to accommodate a 180 new patients if they had a 100 percent retention.

Allison: Right.

Mark: Now, nobody has 100 percent retention. But even if you get half of that, and you added 45 four-hour days, 45 half days of hygiene. So I typically say to practices and dentists who tell me they need more new patients, I work them through their own math and I say, "You know, I don't think you have a new patient problem. I think you've got a retention problem."

It changes their perspective. They have an almost instantaneous paradigm shift. So the very first thing that I would categorize about the three things is I would say one of the things should be associated with how do we retain more of our existing patients?

Then just like in *Harvard Business Review* article, the second thing I would focus on and say, okay, on those patients that are staying with us and coming in every six months for their cleaning. Am I getting the opportunity to do all the dentistry that they need or are they playing that "I just do what insurance covers" game? If they are, I'm frustrated. And things keep breaking out down in their mouth and they keep having emergencies and I don't feel satisfied. They don't feel satisfied. My team doesn't feel satisfied because they're driven by this insurance entitlement mentality.

If the first thing is retaining more of my patients, the second thing is getting them to say yes to more of the dentistry. Then oh by the way, once in a while, yes, once in a while, especially in younger, newer practices, you probably do need a few new patients. Even if you had a solid base of new patients, there's times when want to grow or you're getting closer to transitioning

your practice in such a way that you want to bring in an associate. So there's plenty of times in a practice cycle, in the lifecycle of the practice that you might want more new patients.

So the three categories that drove me to say three things is, what could we do as the most significant driver of retention in a practice? Then what could we do to improve case acceptance so that we got to do more of the dentistry that our patients needed? Then what can we do to get more new patients?

So those are the three things that I want to talk about. Does that make sense from an organizational standpoint?

Allison: Totally. Yeah, I love that. It's very clear.

Mark: All right. So with those three topics and the thesis, because we don't have slides or anything, which I kind of like this format, we don't have slides. I would ask you to try to remember those three categories and think of it as a matrix. So on the left-hand side of the piece of paper you could have hygiene retention, you could have case acceptance, then you could have new patients. Those would be three things.

Then across the top, as you went from left to right across the page, you could have what are your Key Performance Indicators now? How are you doing now? Then what would you like it to be? What are your goals? Then what are the behaviors you would choose? So what are the Key Behavioral Indicators? What are the tools? What are the things you're going to do differently to change those numbers to what you want? Then finally what will that cost?

Now you've got a matrix that you can use that's very intentional about how you want to create more success, more growth, do more of the dentistry you want to have. Help more of patients

have healthier mouths. You've got a matrix where you can focus on those three driving components.

Then you can measure how successful you are by looking at both the Key Behavioral Indicators and then measuring the behavior, not just the performance. You'll have Key Behavioral Indicators, you'll have Key Performance Indicators, you'll have goals and objectives. Then you'll figure out if it's going to cost you some money.

But for example, simply, if you're see ten new patients a month and your goal is fifteen, what are you going to do to get five more? You're going to ask patients for referral. We'll talk about that. Maybe you're going to put an ad in the newspaper. You're going to go on TV or the radio. You're going to go door to door and hand out handouts, I don't know.

Whatever you're going to do, some of those things have budgets and costs, some of them are time intensive, they have different success ratios. If I decide to go on television and in the newspapers, it's going to cost me a lot of money. If I decide to put out coupons, I might get the wrong kind of patients.

So now you can at least have some fairly objective way to design and then measure those things that you're trying to do and accomplish. See we don't learn that in dental school because in dental school they're teaching us in four years as much as they can about fixing teeth. We should have really gone to business management school, get an MBA, marketing school, or something like that and it would have changed how we thought about running a practice.

That's how I would ask us to think. An easy way to remember that is the terminology in the business world would be conversion, percentage of business, and retention. So the initials would be C, P, and R. Conversion of prospects to new

clients. Penetration or percentage of share or percentage of work or percentage of wallet, share of a wallet. There's a number of different terms. So it'd be a C, P, and R. The P would be, I usually think of it as percentage of business. The percentage of mouth that we get from that patient. How much of the dentistry we get to do.

Then finally, retention. Keeping more of those patients. You can remember CPR as this life-saving acronym but it's also a life-saving acronym, if you will, for your business. So it's kind of easy to remember. In our case, it's hygiene retention is retention, case acceptance is your percentage of work that you get to do, and certainly new patients are conversions from prospects to new clients.

So let's start with the most important one, that's hygiene retention. When a friend of mine who did have 15 new patients a month was crying about more new patients and I ran through that math, remarkably he said, "Well I never thought of it that way." I said, "That's great. You know why?" He said, "Why?" I said, "Because we went to dental school and not business school."

Then I said, "It sounds like you've got more of a retention problem." Then I waited. Then I waited for him to say, "What do we do about that?" Because when the student is ready—thank you for that quote by the way—when the student is ready, the teacher appears. So I can tell him the right answer but it's more important that he wants to hear the right answer.

So sometimes you have to wait just a second with patients. Sometimes you have to wait with your team. Sometimes you have to wait when you're teaching a dentist, when I'm teaching out at Pankey or anywhere that I'm lecturing. So sometimes that sort of pause and not saying anything, that uncomfortable

little silence is where some of the best learning ever gets a chance to occur.

Then I said to him, “I think you’ve got more of a retention problem.” And I waited. He said, “So how do you fix that?” I said, “How awesome.” I said, “Well…”

Allison: “I’m glad you asked.”

Mark: Yeah. “Thank you for asking.” That’s right. “I’m glad you asked.” So I’m not certain how I would solve it, it would depend on how your problem arose and what we could do about it but I go, “First I need some more information.” He said, “What would you need?”

I go, “Thank you for asking again.” So I said, “First, I’d want to know how you were doing at the single most important thing that drives how you retention.” He said, “What’s that?” I said, “How many of your patients today when they come in to get their teeth cleaned are leaving with their next hygiene appointment set up, time and date, six months or three months, whatever, the recares.”

It was great because his eyes dropped and he went, “Oh, I don’t think we’re very good at that.” I go, “Well how not very good at that do you think you are?” He goes, “I bet it’s only about maybe 85 percent.” So I had him go back and check. I had him go back to his practice, draw a line down a sheet of paper, look at the first and last months.

It’s February now, so from the first of January and on the left-hand side of the paper, put a tick mark, go to the first day that you worked in January and put a tick mark on the first day you worked for every patient that came to get their teeth cleaned. Then look them up in the computer to see if they have an

appointment, time and date specific setup six months down the road. If they do, put a tick mark on the right-hand side.

Then go to the next day that you worked, tick, tick, tick, tick. How many tick marks on the right? The next day that you worked. Until you get to 100 patient visits on the left-hand side. When you do, stop, and then count up the tick marks for the patients that have an appointment six months out on the right-hand side and that will give you the exact percentage with a pretty large in, 100. The percentage of patients who are leaving with a next hygiene appointment.

Also, in the average practice, when I was with Mercer, I looked at probably, I don't know, well over 1,000 practices, data forms. The average practice, hygiene retention, patients leaving with their next hygiene appointment was just under 70 percent. Now the difference between 70 and 90 percent, where it should be, is $50,000 or $60,000 or $70,000 in hygiene services in a dental practice.

And it's a lot of time, effort, and energy to try and fill those appointments six months down the road when you didn't fill them today.

Allison: Right.

Mark: So it's time, it's effort, it's energy, it's the kind of phone calls nobody wants to make trying to fill the schedule. All because we rolled over and played dead sometimes when we said to the patient, "So is this generally a good time of the day for you? You want to setup your six-month recare?" And I said, "I travel a lot, just send me a card."

Instead of using strong verbal skills and good communication and selling the benefit first, why it's good for the patient, instead of doing that, we just said, "Okay." And we send them a

reminder card. Then we've got to try to fill that appointment six months down the road. A lot of them slip through the cracks, don't they? That's the issue.

Allison: That is still happening, huh?

Mark: Pardon?

Allison: That's still happening today?

Mark: Oh my god, yes. Absolutely right. Oh yeah. The last few practices we started up as consulting projects, we measured two in the 50s, one in the 70s, we did have one in the 80s, we had about an 82 or an 83. The only practices, I don't think there's an exception to what I'm going to say, the only practices I've ever measured that were 90 or above are practices that had already heard me speak and began measuring it and changing things about it before we started working with them.

Nobody is in the 90s unless you're consciously measuring that and working on it. And here's another, warn ya. So some of you might be sitting there thinking, "Oh, my practice is great. We do that much than that." Well, I thank you for thinking that. I'm sure you're right from a perceptual standpoint but just to appease me, go measure it.

Allison: Yeah.

Mark: And be prepared to find out that the number that you think it is probably going to be higher than what it really is. That's okay. In fact, if it is 90 or 95, you probably can't do much to improve it much more. We get 96s, 98s, but 92, 94, that's about as high as you're going to get it. It's not worth the time, effort, energy to try and get much higher than that. In fact, if it is 60. If it is 70, celebrate. That's awesome. Why is that awesome? Think of the potential.

Allison: Oh yeah.

Mark: Right? You're getting by on paying your bills now and if there's that kind of opportunity and you could find $50,000 or $60,000 or $70,000 worth of hygiene to do, guess what? For every dollar of hygiene that you find, there's another $2 or $3 of dental work that comes out of those hygiene appointments.

So if you found $50,000 in hygiene opportunity, there's another $100,000 in dental opportunity. That's $150,000 delta in terms of what you've got now and what you could have down the road. Don't think of it as money, think of it as that many more patients having a healthier mouth.

That much more dentistry that you get to do that's fun to do. And, oh by the way, that turns into money. So the money part is just an outcome, a way of measuring, doing the right thing that's in our patient's best interest.

Allison: Yeah.

Mark: So how do we change that? Well when a patient says, "Well gosh, can't you just send me a reminder card in six months?" What I would coach somebody to say is something like this, I'd say, first I would go to right to where they are and be present with them in their response. Then I would use some sort of a strong verbal skill, a bridging comment, to take them to an action that I'd like them to do, that we agree to do together. Then I would offer a solution that makes sense.

So I might say something like, "Oh, Allison, I know exactly how you feel. Sometimes I don't know what I'm doing in six months. But let's do this, let's go ahead and set up something in six months but don't worry about it, if you get near the date and you find you've got a scheduling change, you're going to be out of town, no problem at all. Nothing whatsoever. No sweat. Just

give us a call and we can switch that to another day or another time. But it's way easier to change that appointment when you already have one than if you're not in the books at all."

You know, that sounds like it makes sense. It's not how we schedule. If somebody calls up, we find them hour. If they have an hour, it doesn't really make it any easier than finding them a different hour but it sounds like if I have a one hour appointment, I could trade it for another time.

Allison: Right.

Mark: It's not like if we have an auction. "Yeah, I've got a Tuesday at 2:00." [Speaking like an auctioneer] "I've got a Wednesday at 2:00. I've got a Wednesday at 2:00, 2:00, 2:00. Do I got a 2:30?" We don't do that. But it sounds like it makes sense when you say it. And guess what? If you say that 20 times, 18 people go, "Okay."

Now that's not the magic. Here's the magic. The magic is some of those people, not all of them, some of those people, it doesn't have to be all of them. Just some of them schedule around that for the next six months.

So when Allison is getting out there five months and two weeks and somebody calls you up and says, "Hey, I'm going to be out of town next week, can we reschedule?" You go, "That'd be great. How about Tuesday afternoon?"

"Now, I can't Tuesday."

"Why not?"

"I have a dental appointment. Could you do Wednesday?"

See, some of those people will put it in their book and if they don't have that out of town conflict, or something else, they'll book around it. So now your real schedule when you get out

there six months down the road, is fuller than it would have been and more of those patients show up and you get an opportunity to have patients with healthier mouths and you get to do more of the dentistry that they need and everybody wins. That flat out works.

Allison: It's simple.

Mark: Yeah. And the best part is this, if you go back to your practice and you measure that next hygiene percentage like we talked about. Then you walk away and you tell them, "I'm going to measure this again in a month," and you don't do any coaching on verbal skills like that. Guess what? It will get better. As soon as people know you're measuring it, it will improve. On average about eight points. Then you coach them on some of the verbal skills and it goes up again. Then you continue to coach them and practice that and it continues to go up again.

When the father says, "Oh, you know I've got three kids in today getting their teeth cleaned. You've got to call my wife, she sets up those appointments." I heard a hygienist say to the father, "I know exactly how you feel. I wouldn't want my husband making those appointments either but I've got a great idea." She says, "Let's go ahead and set something up. You take the cards home. Don't even let them out of your hand. Walk through the door, say to your wife I made you make these and if they work for her, you're a hero, and if they're not, she can call and change them."

The prospect of the guy being a hero when he gets home and everything that that might carry with it that for that evening is worth taking a shot. I know, because I've been married to my high school sweetheart for 38 years and I would definitely run with that.

Allison: That's cool.

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Mark: When we call and confirm patients, we can confirm them with intentionality. We can say something nice on the phone like, “I was just calling to confirm your appointment for Tuesday at 2:00 for your cleaning. See you then. Thank you so much.”

Or we could say, “Allison, I was calling to confirm your appointment for Tuesday at 2:00 with Linda. She’s looking forward to seeing you.” Now, that just changed it from another appointment with a procedure attached to it to an appointment with a person. Now I can’t say that unless you know Linda. I can’t say that unless you like Linda. I can’t just say it arbitrarily. It’s not a script. It’s still a thinking-person’s game. But we can do things like that, we can confirm our appointments with cards and letters that we send out.

We used to use handwritten ones, remember that in the old days? I mean, I think for my dad who’s 93, I think I’d still have them handwrite one. I don’t think he wants to get a generic postcard and he certainly doesn’t want an email or a text because he wouldn’t know how to answer that. But if we can individualize the form of communication with each of our patients when we’re confirming their appointments, we’ll stand a better chance of those people coming in.

So see there’s behaviors that we can change and we can measure and track them, that’s the kind of stuff that our software does. And it’s not how you track that’s important. It’s that you track. But if we track these behaviors in real time, the outcomes change and the schedule is fuller and the production is better. Pretty soon I’m not crying about wanting more new patients. That flat out works every single time.

But once you get to about 90 or 92 or 94 percent, quite trying to improve it, that’s about as good as it’s going to get. Nobody can get to 100 percent. I see months where we’ve had a 100

percent. I've seen months where we had two or three months in a row of 96, 98, but 92, 94 that's about the end. There's always going to be a couple patients. So once you…

Allison: What did your friend up scoring? The one that thought he was at 85?

Mark: Oh, thank you. I didn't finish that piece.

Allison: I think I took you off track because I asked you a question.

Mark: So he thought he was 85. He went back, he was 60.

Allison: Oh, wow. Okay.

Mark: He told his staff that, he told them he was going to measure it again. They jumped to 75 in one month. Then we coached them and they've been at or around 90, 92, sometimes they dip to 85, 87. But they've never been below that. That's a big deal. That's a big deal.

Allison: That is a big deal. That a huge improvement.

Mark: So now those patients are coming back in. Your schedule is fuller. Then you want to get better case acceptance and there's lots of stuff we could talk about in terms of case acceptance. Probably the primary thing I'd really want to talk about but it would take us all evening is talk about how to create real, true curiosity and co-discovery in that new patient experience. So that patients come to want what we know they need.

But that's, that's a long discussion. That's a challenging behavioral discussion. But there's a tool out there that most of us have in our practices that we could use every single day that we don't use as often as we could or we should, that makes a huge difference.

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I lectured once at the Venetian in Las Vegas. I remember the location, the room, and I was talking about this and I asked the question to them, I said, “So how many of you have an intraoral camera in your practice?” There was about 600 people there, about 150 practices. Not every hand in the room went up but darn near every hand in the room went up.

I said, “Keep your hands up. Keep your hands up.” Everybody wants to put them down. “Keep your hands up, everybody. Keep your hands up. Close your eyes but keep your hands up.” I said, “If you use the intraoral camera at least once a day, keep your hands up. If not, put them down.” And I didn’t count because it happened too quickly but I’ll bet that 70 or 80 percent of the hands, maybe more, went down.

Allison: Went down, yeah.

Mark: Now just think about this. We have a tool called an intraoral camera that takes a picture of a tooth and puts it on a 16 or 24 or a 32-inch television screen in front of a patient and most people are visual. They like that visual image.

And we could show them something gnarly in their mouth, something horrible, bloody, puffy gum, or a big old gnarly filling that’s broken down, it’s cracked, or wear facets and craze lines. And we can just stare at it with them and go, “Look at that.” And say, “What do you think about that?” I mean, we could do that right? And instead…

Allison: Yeah, that’s awesome. I love it.

Mark: The average person doesn’t even use the intraoral camera once a day.

Allison: Right.

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Mark: It's because we get busy with other things and yet this tool is laying there. I don't want to shortchange the idea of the curiosity and co-discovery kind of examination. I'd love to come back and spend an hour just talking about that sometime. But if you just took an intraoral camera, picked it up, and used it more often, you would sell more dentistry. End of story. Of every practice they've ever done it in, if they increased the utilization of the intraoral camera, they increased the amount of dentistry the patients said yes to.

Most practice management consultants would say that you need to use the intraoral camera what percentage of the time would you guess?

Allison: Oh gosh.

Mark: That they would hope for.

Allison: 50 percent is the first thing that came into my head.

Mark: 50 percent is exactly what I'd like to see as an end result. Most practice management consultants say on every single patient. I think that's unrealistic unless you're looking at my mouth and you're showing me an area that I'm taking really good care of and your celebrating something, in which, okay maybe you use it on everybody. But I think a worthy goal, if you're using it once or less a day, is to work towards 50 percent by going in maybe 10 or 15 or 20 percent increments.

So if you're using an intraoral camera rarely now and you say, all right, you see eight or ten patients a day in hygiene. We should probably use that 20 percent of the time. 20 percent would be two times out of ten. Two. Then once you started meeting that goal, then I'd say "Let's go for the moon. Let's go for three." When we get to three, I'd say, "How about four?" And eventually we'll get to half, I'd probably quit.

But can you imagine the power of showing somebody unhealthy gum tissue and then when they got it and when they said, “My god, what do you think we should do about that?”

“Thank you. See this little stringy stuff? It’s called floss. Put it in your mouth.”

Right?

Allison: Yeah.

Mark: Magic. Magic will happen. So it’s getting the patient curious and co-discovering. Certainly it is by using the intraoral camera. My favorite example would be you take a picture of a gnarly old, big old molar with a big ole filling in it, it’s falling apart. It’s huge MOD. You put it up on the screen. You look at the patient, you say, “Well, what do you think?”

Let’s not talk about good patients. Good patients, they go running up the learning ladder and they go from on alert, to aware, to interested, to trusting you, to commitment statements. They ask you what do you think you ought to do. Forget about those.

Let’s talk about the patient that’s sighing [makes sighing sound] and they're looking away. You go, “Hey, what do you think about that?” And he goes, “Is that my tooth?” You go, “No, you idiot, it’s a picture of your ear. Of course, that’s your tooth. So what do you think about that?”

They go, “I don't know, what do you think?” Then I would say something smart aleck like, “Well I asked you first.” Once you finally get to engage them in conversation you say, “What do you see right there?” They go, “I don’t know, that’s the tooth.” You go, “Yeah.” You point to the enamel on the inside and you go, “Actually that part of the tooth there is called the enamel. You know anything about the enamel?” They go, “No.” I go,

“That actually happens to be the hardest material on the body. It’s even harder than bone.” They go, “Really?” I go, “Yeah.”

Then I come over here on the other side and they go, “That’s that enamel stuff again.” You go, “Exactly.” You give them some positive reinforcement. Make them feel like they're learning and responding well. “Well what about in between?” They go, “Well, there’s a filling.”

“What kind of filling?”

Keep asking questions. Stay in the question, like Mary Osborne has taught us, right?

“So it’s a filling. What kind of a filling?”

“A silver filling”

“And what percentage of the tooth do you think it’s filling?”

“Well, it’s at least half I guess. Probably about 75 or 80 percent.”

Then I always say something smart like, “It’s funny that we call them fillings” and I wait. And they say, “Well why is that?”

“Well because fillings makes it sound like I’m putting it inside of something, like I’m filling a hole. Instead, this filling here is being the tooth. We should it the being, not a filling. You know?”

Patients get that. They get that. A filling means I’m filling a hole.

“Well, that’s not a hole. I'd be paving a whole road here. It’s not a pothole, it’s different.”

So then finally you say, “What do you see right here between the tooth and the filling there?”

“There’s a little space there.”

“Yeah, there’s a little crack with some decay in it but that crack keeps getting bigger. You know why?”

“No.”

“What did you have for breakfast?”

“What do you mean?”

“Because whatever you had for breakfast is down inside that little crack, we don’t even get to clean it out. There’s bacteria and germs that live down there. So what happens is those bateria and germs, they eat the waffle that you had for breakfast and they poop out acid. Now, when they do that the acid continues to eat away the tooth and eventually that crack is going to get bigger and wider until eventually that tooth breaks and you need a root canal or you lose the tooth all together.”

Root canal is a powerful word. People don’t want root canals. By the time you say that, they go, “Holy crap.” Then I pat them on the shoulder and say, “See you in six months.” Well of course not, they stop you and they say, “Oh, dude, what are we going to do about that?” No as I much as I just want to tell them that tooth needs a crown, they made me work so hard to get them to want to hear the answer that I’m going to play hard to get.

So when they say, “Well what should we do about that?” I say, “Well, that really depends. Allison, we’ve got a lot of different materials and a lot of different ways we can fix teeth. So I need a little bit more information from you before I can answer your question. First, when we fix that tooth, we can use materials that are going to last several years or we can use materials that might even last you the rest of your lifetime. Do you have a preference?”

Well what do you think most people pick? Lifetime.

Allison: Lifetime. Yeah.

Mark: Yeah. I go, “Then we also have a choices in materials that are tooth colored, there’s silver metal, or the gold metal, do you have preference there?” Most people choose tooth color.

Allison: Tooth color.

Mark: Yeah. So without ever saying the word “crown.” Without ever saying the word porcelain, the patient just told me they want a tooth-colored restoration that might even last the rest of their lifetime. And that’s a crown, a porcelain crown.

Now, what I just did is instead of—listen to these words really carefully—instead of telling the patient what they needed, I asked the patient what they wanted. I said to the patient, just like if I was a good marketer and I'd been to business school instead of dental school, I asked the patient what features, what advantages, and what benefits would you like in the choices of restorative materials that we have.

I didn’t tell them what they needed. I asked them what they wanted. When they described the features, advantages, and benefits that they preferred, then I could match that up by going, “Hmm, that sounds like a porcelain crown.” Now we can have a discussion of what that would cost, how they’ll pay for it. But they're going to probably find the money because once people want things, they usually figure out a way to pay for them.

That’s why in this country we spend more money on alcohol, tobacco, and gambling than we do on dental care. That’s ridiculous but people want that stuff. People want nicer cars and so they’ll pay for the added value of their next car but try to

ask them to do something that's not covered by dental insurance and they blow a gasket, right?

But that's because we taught them to think that way. Well guess what. If we taught them to think insurance entitlement, just do what's covered, and it's taken us decades, it's taken us generations to do that. Since 1956, was the first year that we had dental insurance, Washington State Dental Association—Washington State Dental Services—I'm sorry, the first out there. That was 60 years ago.

So we've had dental insurance for 60 years. That's taken us generations of dentists to teach them to be insurance entitlement minded. We can unteach them. Not overnight. Not in three years. But over the next generation or two of dentist-patient relationships, instead of continuing to move towards worse and worse reimbursements and PPOs, we could actually turn that tide by having different kinds of conversations with patients. That would be a fun tangent too to go into, how do we get rid of PPOs?

Allison: That would be a fun tangent, yeah.

Mark: Oh man, I got some ways of looking at that. I've got some calculators that help you figure out what impact it's having on your practice, what lists you need to be thinking about. Oh, we have some fun stuff to do with that. But, enough said.

So now, I'm trying to stay on track. Now, I've got more of my patients are staying at my practice. More of my patients are coming every six months. Now I'm using this tool that I've had in my practice for a long time and I'm getting more and more of my patients to say yes. Oh my gosh, I'm having a blast.

Well, I'm a young practice, I'm only working two days a week but at least those two days are full and I still want to grow to

three and four days. I want to get out that associateship. I want to get rid of some of these PPOs, whatever it might be. So maybe you do still need some new patients. There's lots of good ways to get new patients and most of us know about the difference between thinking about internal marketing and external marketing.

I guess I do know quite a bit about external marketing but I'm not very enthused about it or passionate about it. I've seen a few good approaches to external marketing but most of the time I think the things we do, they get lost in some noise. I think with the internet we can differentiate a little bit, you know, with the kind of reviews and the things that we get on that. But it's hard to differentiate yourself in an external marketing piece. It's really a lot easier when a patient gets a chance to experience something different.

When they do, they become a very strong missionary for you. I told you that in that banking example, they grew more than they'd ever grown before by just focusing on retentions and percentage of business that they were getting from their banking clients. What I didn't say is they also got more new customers referred by existing customers than they had in the past because when the customers are so happy that they stay and so happy that they're buying other products, they also tell their friends how happy they are.

So the single greatest driver of new patients for most practices when we talk to them is word of mouth referrals from their existing clients. So if that's true, we should simply push that button. So if the first thing is measuring hygiene next visits, the second thing is using the intraoral camera more, the third thing is I would start to track how often have you asked a patient to send you a friend.

And I don't think it's a very high percentage, maybe one out of ten patients a day. Maybe in the huddle you identify one person or two that today you'd think you'd feel comfortable having a conversation with them about referring a new patient.

The time this takes you might go something like this, like maybe they paid you a compliment or maybe you came in to do a hygiene check and you said, "Hey Allison, it's good to see you. How have you been? How's the husband? How's the kid? Is everything good?"

"Yeah, great."

"Hey, by the way, how's all that dentistry doing that we did for you?"

"Oh, it's doing great. The teeth feel like my own, the implants. I don't even about them."

"That's great."

Then that's the opening in the door. So if they paid you a compliment or you went fishing for a compliment. The door's open and now you can say, "Well Allison, thanks. It's always nice doing work on people like you. So much more fun. In fact, Allison, can I ask your help with something?" And Allison of course, will say yes because you like her, she likes you. The doctor-patient, you're comfortable with each other.

"So, can I ask you something?" She goes, "yeah." I go, "You know, I'm not trying to be the largest dental practice here in Rochester, Michigan. In fact, if everybody in the area decided to come see me, and that's like 70,000 or 80,000 people, I couldn't possibly see them.

"So whether or I want to or not, I have to be a little selective about who we see and what we do. What I know is that I like

working on people like you. So the favor I'd ask you is if you should happen to think of somebody that you think would be right for our practice…" You reach into your pocket and grab a couple business cards. "Would you give them one of these, one of my cards?"

Now here's what's interesting. When I was at Mercer, we measured that conversation. We had a large number of dentists talk to a large number of pretend patients. We rehearsed that role playing and that conversation. We got done and we asked the dentists after they'd each done about five of those conversations, "How did that feel?"

About 87, no, about 82 percent of the time, we got something in the answer that said something about it felt like they were begging. Might have been different words but the dentist said, "Well, I don't like asking them to take a card, if they'd tell this to friends. I felt like I was begging." I understand that. Well we also asked the pretend patients how they felt when they heard that conversation. And 87 percent of the time, they said something like, "I felt flattered."

Now this is where the rubber hits the road in the psychoanalysis of the dental mind. How in the world could we have had a conversation with a pretend patient where we felt like we were begging and they felt flattered. What is wrong with us? We should be comfortable asking patients who like us to send us to friends.

Allison: Yeah.

Mark: We didn't go to how to be a salesman school, how to ask for business, how to close business—we didn't go to that school. So we're not usually comfortable having those conversations. But I want to tell you. If you have one of those conversations a day, you'll get more new patients. And yeah, if you're asking the

right patients you'll get more of the right kind of patients that you want. It's phenomenal how that helps grow a practice.

I'm going to summarize. We talked about a matrix using an acronym CPR. Which talked about conversion, percentage of business, and retention. We said that it's really important to look at it in reverse order. When we thought about retention, the single most important thing we could do to impact the retention in our practice is to make sure more patients leave with a next hygiene appointment. To measure it. To set goals for improving it. And to change the behaviors that will impact those results. And that won't cost a dime.

Then we said to improve on the percentage of business we get from each patient, that's really like improving case acceptance. Most of us already have a tool that we're just not using. So that won't cost us anything to improve either. We just have to use it more. If we start to measure how many patients did we see and how many times a day did we use the intraoral camera, we can move that needle too.

Then finally, we see patients who think the world of us all the time. If every once in a while we identified one of them and asked for a referral, we will get more new patients. So with three really simple behaviors that we can change, that we can not only change but then we can measure. That we're really doing them in a new manner that will impact results that we wanted, we can have a profound impact on the income. We can have a profound on the impact on the type of dentistry we're doing. We can have a profound impact on the oral health that our patients get to enjoy.

Certainly in each one of those we could talk about many other things that impacted them. But to keep it simple and to give ourselves something we can do in 40 or 45 minutes, here's

three things that are easy. That will help make your practice better. Easy if you do them. The key to doing them is to hold yourself accountable and measure that you've changed that behavior. Whether you do that with a pencil and a piece of paper, you put it in an Excel spreadsheet, you celebrate the results. Whether you use software like I've got, it doesn't matter. It's not how you track, it's that you track.

Tracking behavioral changes in real time has a profound impact on the successful driving of outcomes in your practice. I am open for questions. And if there aren't any, I am open for beer and ice cream.

Allison: [Laughs] Awesome. You know what I'm going to do? I'm going to open the line and see if anybody has a question. How about that? Let's see, that's what I'm feeling inclined to do right now.

Mark: All right. You're allowed to that.

Kate: I have a question but I don't know if you guys can hear me yet.

Allison: I can hear you actually, I just unmuted you.

Kate: Perfect. This is Kate Dahl, a hygienist in Washington State. Hi Mike, I've seen you on Facebook. I am going to ask, so I love the intraoral camera and I actually as a hygienist do it at least every exam appointment for the doctor or if I want to show them something hygiene related so I just really like it.

But on our scheduling, I'm at a new practice, I mean, a new-for-me practice, and I want to say the doctor's owned it four years. She has two practices so she's commuting all over the state. Poor thing. But I'm new so I don't want to ruffle any feathers but the one thing that I'm really feeling like we're failing at, they don't let me schedule my own appointments.

The front office still insists on doing it but when patients really really like the hygienist, I feel like there's more of a commitment and I just didn't know if you had any suggestions over time that I might win them over with letting me help schedule more?

Mark: Great, great question because you didn't just say there's a problem. You said there's a problem and I think I see some avenues for solutions. That's a really good way of looking at something. So thank you for positioning it that way.

I agree with you totally. I think it's far more effective if the hygienist manages her own schedule. Both in terms of who she puts in there, how she schedules it, sequencing them. She can put down how much time she needs for everybody. It's just so much easier to do that without having that next communication step that you have to tell everything to the front administrator and then the administrator has to put that in. And then they're sometimes maybe moving a patient that wanted to see you or you wanted to see in another chair. Just so much more efficient to do that in the back. I totally, totally agree.

The challenge you've got though is you've got an office where it's being done in the front and you can see the possibility of doing it in the back. What I would look for is symptoms, signs and symptoms, just like we do in patients. Then I would offer tests of corrective actions.

So what I mean by that is if that system is working fantastically, then it's going to be pretty hard for you to argue your case. If the hygiene schedule is always full, if the administrator role in that office is not stressed by making those appointments, if patients are seemingly happy to be scheduled with whomever they put them with, then you're going to have a tough time saying your way is better to any of the other players in the game.

But if any of those areas, and they're likely to be deficiencies in those areas, for example the occasionally patient complaint. For example, the administrator saying, “I don’t have time to do all this.” Or you look down the road and today’s schedule was perfectly full and you go six months down the road and it’s half full. Well, that shouldn’t be because today’s appointments should probably be in six months down the road, or close enough to that.

Then you could say, you know, one of the seminars I took, one of the consultants I heard talking, one of the gurus in whatever you wanted to say, suggested that hygienists make their own appointments and it does several things. It takes some of the stress off the admin team from having to do that. It lets the hygienist control her own schedule and manage it. Patients seem to be happier with it. And we’ll have fuller schedules.

Look at how much time, effort, and energy we spend if it’s true, keeping the schedule full when it gets here. I'd love to have a test where we tried for a few months having the hygienists book their schedules and see if that made an improvement in what the schedules look like six months out.”

Now you’d have a cause and effect, signs and symptoms, treatment recommendation, and everything like to try and solve the problem. It would be hard to argue against giving that a trial.

Kate: I like it. Do you have anything my doctor can read up on where it does, they get more committed scheduled patients when hygienist schedule or do we have anything like that?

Mark: I don’t have anything personally in my hand that I could just drop into an attachment on an email and send it to you. But I'd be willing to bet that if either one of us searched and Googled that right now, we’d find something on it.

Kate: Okay.

Mark: Whether that came from an RDH journal or whether that came from *Dentaltown* or from *Dental Economics* or something like that, it would surprise the heck out of me if somebody hadn't addressed that in an article somewhere.

Kate: Okay, I'll try it. Thank you.

Mark: A good place to go if that doesn't meet that solution, this is fixing the game a little bit, but if you went and had a conversation with anyone from Schein or Patterson or Burkhart or Benco or any of the dental supply companies, they want to sell equipment, right? They want you to computerize your rooms and to use them for everything.

So I'm willing to bet that any of those people who sell dental practice management software, Carestream, any of them, that they have white papers that say, "It's better to have a computer terminal in every room because…" and one of the reasons in the white paper would be it's better for they hygienist to make their own appointments.

Kate: Right. And we even have them. That's what's pathetic. I do everything on the computer.

Mark: Yeah, but now you have a white paper that says it's better for the hygienist to make the appointments. It's more effective.

Kate: Okay, yeah. I got you. Okay. I will try.

Mark: I do know that at Mercer that was the standard protocol because we'd seen in all our consulting when I was lecturing and consulting with them is that in every practice we always got better results when the hygienist was making the appointments.

Kate: Right. And one thing is sometimes they go in and there's lot of mistakes. Whether, let's say we had a high-maintenance

patient that loves me but she's nitrous and the whole nine yards, well you have to list that or else you look like an idiot when you see someone and you don't have it out. I just think it's better for also for patient retention like you're saying.

Mark: Absolutely right. I can't think of a single reason not to. I really can't and yet I work with several practices, in fact, I can tell you right now we work with a couple practices and one of them is a very wonderful practice, great dentist, fantastic dentist, very prestigious practice and everything like that. And I can tell you, this one practice I'm thinking of, they book all their hygiene up at the front and they're very high percentage of it and things like that.

Now they really only have one full-time hygienist so it's not really like who are they going to get booked with. They have one part-time, one day a week too but so it's not as big an issue but they do it all at the admin and the hygienist is much older and doesn't really want to learn computer systems, they don't want to do that. So there's all of that kind of cultural things going on in the office. So that probably works for them.

But that's probably not the norm. The norm today is we should be booking everything in the back, documenting everything in the back … in the back. We don't need charts anymore. I mean, it's a different world. It's a different world from how we do it.

Kate: I appreciate your input. I'm going to try it.

Mark: Okay, good luck.

Kate: Because I want help her be more successful. Thank you.

Mark: Good, thank you.

Allison: Thanks, Kate.

Mark: Cool.

Ep #47: Being Intentionally Intentional In Your Practice with Dr. Mark Murphy

Allison: I muted a couple of people because their lines were loud so if you have a question now, I'll have you push *2.

That was a great suggestion, Mark, to look for signs and symptoms. Man, you're just a smart guy.

Mark: [Laughs]

Allison: We could have several more phone calls if you're open to it at some point.

Mark: I'm always happy to do it. I like doing it. It's funny, you say I'm a smart guy and my wife says, "Man, you've done a lot of things wrong and you made them right the next time."

Allison: Well, there you go. That's why you're smart. Well that's what I mean, you've made a lot of mistakes and you've figured out how to do it differently. [Laughs]

Mark: For me, a big plus for me is that I worked with my wife and my mother-in-law. My mother-in-law was my office manager for 23 years so I had two people around me, and also my wife's best friend was my dental assistant. So I had three people around me really that would give me constant feedback, whether I wanted it or not.

Allison: Oh yeah.

Mark: They'd be very open and honest and candid with me. So I couldn't get away with snot. I couldn't have this big ego. I couldn't pull any of that crap because I had to be nice to my mother-in-law, I had to be nice to my wife's best friend, and hell, I wanted to sleep with my wife at the end of the day. So there's all these motivators for me to listen to them. They had great ideas but I was very fortunate to be in that kind of environment and have an opportunity to get feedback that I was going to have to listen to, not pretend to listen to.

Allison: Right.

Mark: I was lucky.

Allison: Well you did learn a lot of good stuff from out there too but that's true.

Mark: I did.

Allison: You were like a pearl.

Mark: It was fun.

Allison: You were being polished all day, every day.

Mark: Yeah.

Allison: I guess we don't have any other questions. I appreciate you keeping it short.

Mark: No worries.

Allison: I asked Mark to keep it short for you guys tonight and I'll open the lines.

Mark: I met that objective.

Allison: Yeah, that was perfect.

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