Ep #38: Saving Your Lost Patients with Joy Millis

Full Episode Transcript

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.

Tonight we have Joy Millis. Joy is actually an expert in the business of implant dentistry, with a unique combination of specialty and general dentistry practice expertise. She is a professional speaker and consultant with more than three decades of hands-on clinical and business experience in the field of implant dentistry.

Joy helps dentists grow their practices, train their teams, and influence patients to do the right thing, accelerating the incorporation of implant dentistry into their services provided. She is also on the visiting faculty of Georgia Regents University and the University of Texas, where she teaches the business of implant dentistry.

Joy has earned the National Speakers Association's highest designation of Certified Speaking Professional, an accomplishment achieved by less than 10 percent of speakers in the world. I've heard you speak, Joy, and I enjoyed every minute of it. It was funny, it was inspiring, it was not just all about implant dentistry. So if you're on this call and you heard

me introduce her, we don't have to talk just about implant dentistry, right Joy?

Joy: That's right. In fact, you asked me tonight to talk about patient retention. I was all ready to talk about implant dentistry but it's very refreshing to talk about patient retention which is my other favorite topic to talk about. So thank you. Thank you very much for inviting me.

Allison: Absolutely. We're happy to have you. I'm thrilled and I know the audience is. Joy, I don't know where exactly you want to start. I know when you came you did talk mostly about patient retention and I loved a lot of what you said. I know for me, one of the things you hear dentists always talking about how we need more patients, more new patients, more new patients.

Especially after listening to you, realized that we really don't make a lot of effort to keep people in our practice. We think we already know why they're not coming back. I don't know what that is, but what you started with with us was teaching us the value of the different levels of patients and how much value a lost patient—or basically a lost patient base could bring. Do you want to start by talking about that? Then we can just go with the flow?

Joy: Certainly. One of the things that happened to me years and years ago, I was very curious while working in a practice and coordinating care for patients that sometimes patients would not accept treatment. I thought, "What's wrong with them?" They come into the office, they go through a comprehensive evaluation.

The doctor puts together a lifetime plan of good dental health for them, presents it to them. And they do nothing. Sometimes they come back for hygiene and then do nothing else. Sometimes they get caught in the loop of doing just hygiene and nothing else.

I thought, “What’s wrong with them?” So I started investigating and started giving patients calls and saying, “Did you have any questions? What questions do you have about what we recommended?” Or, “Did I not schedule an appointment for you the last time you were here?” Just trying to figure out what is going on.

To my surprise, some of them were waiting for my phone call. Some of them were confused about treatment. Some of them were thinking they had to do everything or nothing at all. Some of them were afraid to ask the doctor questions but were not afraid to ask me questions. So the first time that I launched out on making phone calls to lost patients, not just recall patients, not just calling telling them they're due for a checkup, but patients who actually heard the good news about what we could do and then did nothing. I called them.

The first time I did that, I called 16 patients and was able to schedule $43,000 worth of treatment. I thought, “Hmm, maybe this is a good use of my time.” The next thing that happened is I began to start consulting and working with practices specifically in the area of implant dentistry and complex restorative care.

I was very fascinated that doctors would hire me to help market their services. I would go in to see how effective they were with their internal marketing, you know, talking to the patients they have, communicating care to them, moving patients forward into treatment and would find that as I evaluated the records of patients, patients were not accepting treatment. 50 percent of what they considered their active patients were filed and forgotten. And of course now with computers, invisible, out of sight and then out of mind and were not accepting treatment and were gone.

So I would go to the doctors and ask, “Do you really want to market, make the phone ring, get some new patients in here for

you to just disappoint them and lose them and not have them receive care?" So, I was curious. What in the world has happened? How did we lose these patients? Can we get them back?

Many times, hygienists will tell me, and I'm so glad we've got some hygienists on the phone call tonight. Hygienists would tell me, "I've got too many to call and I don't have time to call. We leave it up to the postcard. We hope they come back. We can't make them come back. We can't make them accept treatment."

Doctors would say to staff members, "I'm going on vacation. Why don't you guys while I'm gone get on the phone, call some of these patients who need treatment, who need to come back. We've got holes in the schedule. Give them a call." Doctors would leave the office and the staff members would look at each other and say, "What a waste of time. If they wanted to receive care, they would have been here. This is crazy. This is stupid. I don't want to call them. Do you want to call them?"

Then maybe one would call them and say, "Do you want to come back?" Patients would not respond necessarily positively and the next thing you know we're pushing the archive button or we're getting boxes to put charts in and patients are being made inactive.

This sparked a curiosity in me to see what if we could get them back and what if we could stop the losses? Now I'm telling doctors all the time, "What if you never got another new patient? Could you thrive and survive with the patients you have?"

In looking at the value of the patient, insurance companies think they're on average valued at about $1,000 in value each year. Then the American Dental Association says that the average utilization of dental services is, right now, it's around $500. So if the patient is worth $500 to $1,000 based on the numbers that

we're hearing reported, then what do we lose when we lose a patient? That's a lot of money if you think about it.

If three patients, potential patients, call us in a day and one schedules, we've gained about $500 to $1,000. And of course the doctors I work with in the field of implant dentistry and complex restorative care, it's much more than $500 to $1,000 that's gained if one patient out of three schedules. But if two patients out of three don't schedule, or they come in, have an exam, don't accept treatment. The loss is significant.

I look at the value of a patient and I think, you know, we experience loss in the profession but what does the patient lose? I think their loss is great as well. If we're not good at communicating with them about the value of the dentistry and moving them forward into care and we don't have systems in place to stop the losses from occurring, then everyone loses. Everyone does.

Allison: Yeah. I love your conversation about the communication piece and how you positively state your verbiage. I thought that was very interesting and very different than what I've heard before. I don't know if this is the place to talk about that but I know that you come to the conversation—you mentioned that the staff would call and maybe the patient wouldn't be interested. When I hear that I think it all depends on how you come to the conversation.

Joy: I know that one thing I used to do is answer the phone to stop it from ringing. It was an interruption. That's not the reason to answer the phone. The reason to answer the telephone in the dental office is to schedule an appointment, generate a new patient, and retain an existing patient. If the telephone is a nuisance, and many times answering the phone is given to the newest employee that hasn't had any training, it's just stop it

from ringing. That's what they'll do. So we lose new patients because we answer the phone to stop it from ringing.

When they call, if I don't schedule them, I want to know what I did wrong in the process. Many times it's simply we ask them, "Do you want to schedule an appointment" instead of saying, "The best thing I can recommend is let's go ahead and reserve an appointment for you. That way we can tell you exactly what can be done for you, what the fees will be, and how much time is necessary. Let's go ahead and do that." Recommend the appointment. Move them forward into the appointment instead of lazily saying, "Do you want to?"

When a patient walks in the door and has the initial evaluation, if it's exactly the way it went at a previous doctor's office that they sit, they wait, we're not jumping over the counter enthusiastically greeting them, welcoming them to the practice. We're shoving a clipboard in their face with forms to fill out. We're having them serve themselves. Bring them back to us when you're done. I mean if their experience is just like it is in every other office, we're going to lose them.

If when we talk to them the only thing we schedule is hygiene and don't move them beyond hygiene, we're going to lose them or they'll just get caught in the loop of just doing hygiene. If when we're talking to them about money and they say, "Oh, it's just too much money. There's no way I can afford that" and we end the conversation with, "Well, that's it. They're done." And we don't figure out how can we move them forward regardless of the cost, regardless of the insurance limitations, if they have insurance. If we don't figure that out, we lose them.

Insurance certainly interferes. It creates a roadblock. But in the profession, we've gotten in the habit of stopping at the max, of planning treatment around the insurance in many offices, of believing patients won't receive care unless insurance covers it.

So we lose them then. Patients start treatment, stop treatment, and we don't have someone to follow up on them to get them going again. We lose patients at that point.

Also, if we refer a patient to another dentist for some reason, either a surgeon or a periodontist or an orthodontist, if the patient leaves the practice and we don't make sure they made the trip and also make the trip back to our office, we lose them in that cycle.

Our recall system doesn't always work. We leave it up to a postcard and there's no one designated to follow up on the patient to keep them in the loop. We don't preschedule. Many times people think that if we preschedule they won't keep the appointment but my opinion is that the patient without an appointment is not a patient in the practice. Patients who see the value of coming back for continuing care will schedule that appointment in advance and keep that appointment.

When they say, "I don't know what I'll be doing in six months." I say, "I do. You're going to be right here and here's why." We don't want to lose those patients who are in recall because those are patients who often need additional care and they could experience additional loss and be at risk if they are lost just because we leave it to a postcard.

Patients are filed and forgotten. It's fascinating that now because many offices are going to electronic records, many of them have the hybrid system where it's charts and electronic records. I see that the easy button in the dental office has become the archive button. Before, we would give patients about a three-year survival rate in the office. We'd put clever little date stickers on the chart so that we would know when it was time to get rid of them and put the chart in a box. If they haven't been in in the last three years it was very clever to do that and it made it easy for us to get rid of patients.

Now we can't take those patients for granted. But now when I go into an office, I'm finding that dental offices are just pushing the button and archiving patients every year. So they only survive a year. But in my research, especially with implant dentistry and complex care, sometimes it takes a patient a full year to make the decision to go forward. It takes a patient a full year to plan their time and their finances so they can go forward. If we're quickly getting rid of them, they lose, we lose. It's very sad.

Sometimes we just purge automatically. We have a system for getting rid of them and it's so sad. And of course, the other group of patients we lose are the patients that could be referrals because we don't ask for referrals. It's so easy to ask but if you don't ask, you don't receive those patients.

All of our language needs to be proactive. For example, if a patient walks in the door and they're late for an appointment, what I used to say is, "You're late. I'll have to see if we can still see you." We lose patients because of the way we approach them with our language saying, for example, "You're late." Instead we could say, "You're here. Let me see what we can still do."

Because we're excited to see them, "You're here. We were worried about you. Is everything okay? Let me see what we can still do." They will feel better about showing up because the fact of the matter is many times in dental offices we're late seeing them. Our language is important.

Allison: Yeah.

Joy: I went on there and said probably more than you wanted me to say right there but our language is important.

Allison: No, that was great. That was a perfect example. That was one that I really appreciated that you gave us at our meeting as

well. I want to go back to something you said a little while ago. If anybody has any questions, you're welcome to push *2 and jump in.

When you were talking about that people answer the phone because they just want it to stop ringing and that really one of the things we need to work on is that we need to figure out how we can move them forward regardless of cost, regardless of insurance, whatever. I'm curious how you do that. Not just maybe what your thinking is, but when you're thinking, “How can we move them forward?” Does that mean…?

Obviously you want to keep them active in hygiene. But you're saying to begin to have a conversation about what’s keeping them from moving forward and then figure out a way to break treatment down into bite-sized pieces. What does that look like when you're doing that? When you're trying to figure out a way how we can help a patient move forward?

Joy: Over the telephone obviously the first thing we want to do is move them into an appointment. Many people answer the phone not just to stop it from ringing but we answer the phone, answer questions, and hang up without attempting to earn their business or earn them as a patient. We don’t act interested. We just answer their questions.

“How much is a crown?”

“Well, I can't tell you that over the telephone because there are many different types of crowns.” That’s what I would say before.

Then one day I got phone call from a dentist down the street. He said, “Joy, thank you for the referral.” I said, “What are you talking about? We don’t refer to you.”

He said, “Joy, a man called you, wanted to know how much is a crown. You wouldn’t tell him. Told him you had to see him for a thorough evaluation before you could tell him. The man just

wanted to know how much money to bring. He paid us before we seated him. Thank you very much for the referral. We're prepping it now."

It suddenly occurred to me, people are calling and asking questions that they ask other people. Like how much is that doggy in the window? If we sell many doggies, we probably know the price and certainly we can't diagnose and treatment plan over the phone but we can answer questions better to better help them move forward into treatment.

For example, in implant dentistry, someone would ask me, "How much is an implant?" I would want to say, "You idiot. I can't tell you that over the telephone. We need to see you first. We need to know how much bone you have, the bone width, the bone height, the tissue integrity. We need to know how many you need. It's not just an implant per tooth. We need to know more, stupid."

I wouldn't say those words but that's what I was implying. "I can't answer your question." So I wouldn't answer their questions so they'd call someone else who could. Suddenly I realized maybe they've seen other dentists and maybe they know what type of implant they need. So I would say instead of saying, "I can't tell you that over the phone." I'd ask them a question, "Can you tell me what type of implant or implants you need?" Then they'd say, "Oh no, I don't have any lower teeth." And I'd say, "Oh, how did you hear about implants?"

Then I'd get into the discussion about implants are the best thing that's happened to dentistry. "I'm so glad you called our office. That's what we do in this practice." Then I would just get excited about hearing their story, hearing their challenge. That we could help them. We could provide the solution for the problems. "We've had many patients who have had that very same problem. The best thing I can recommend is let's reserve

an appointment for you so we can tell you exactly what can be done for you." So I would move them into an appointment.

When they're in the office, many times they have never heard the good news or the big story. In implant dentistry, often you will hear a patient say, "No one ever told me that." Or, "Why didn't my other dentist recommend this?" Or, "I had no idea I needed all this."

One of the errors I believe that we make in dentistry many times is we put together the treatment plan and then the next thing we do is we have the list of fees on the treatment plan and we put all this information in front of the patient. Not only are they overwhelmed by all the treatment they need, but the focus gets diverted into the price of that treatment that they need.

That's when many times they're lost. Because it's overwhelming. No one has ever gone this far with them. They've locked in at that, "What will insurance cover?" Or them paying their copay and "Let's do what we can based on your insurance limitations." We don't move them into more comprehensive care.

When a patient says, "I don't know if I can afford this," their focus is on the price. We want to move the price away and focus on the value of the treatment. I recommend to many doctors to put the treatment plan in front of them and discuss it certainly. But don't have the price on the same page when they're talking about the treatment or the patient's eyes will never leave the price. It's like a menu at a fine dining restaurant. Many times they don't even put the price on there.

If the price is there, we're trained, just psychologically we just glance at the price and that's sometimes where the patient's eyes lock. So talk about the value first. When they ask how much, I'm not embarrassed talking about fees with patients. When we quote the fee, if it's overwhelming to them, depending

on their reaction, many times we're able to say, "What did you plan on spending for your dentistry?"

If they say, "There's no way I can do this," one thing I jump to the conclusion now about is they can't do it right now because they haven't planned on it. They haven't saved up for it or they had no idea it would be this or whatever. So there are two words that I used: when and what. When will it be appropriate for you to have this done? Because I figure just because they don't have the money today, maybe they'll have it tomorrow. So I say when.

To my surprise through the years, patients have blown me away at how they have it sooner than I thought they would. You know, "It's after the wedding. It's after the kids get back in school. It's after the holidays." It's after this. It's, "I don't have it now but my mother's got it and I'll see her next week." So it's not right now and they're blown away today but that doesn't mean that tomorrow won't be just perfect. So the first thing I ask is, "When will it be appropriate for you to have this done?" And they tell me based on their budget.

Then if they say, "I don't think I can ever get this done," then I ask them, "What had you planned on spending for your dentistry?" I've discovered that patients don't save up for dentistry just like people don't save up for divorces, but they need dentistry. They don't necessarily need a divorce but they're blindsided by the cost sometimes. So patients did not plan on what it was going to cost. Insurance has, with our help, patients have been led to believe insurance pays 100 percent. "I've got insurance." They think it covers everything.

In dentistry, it's like, "Give us 20 percent and we'll fantasize about the rest." They kind of began to believe insurance is going to pay for everything. Now we have to teach them that it has limitations. That there is a maximum allowable. That we

want to work with you so you can receive care. So let's plan this out.

When they tell me what they've budgeted for their dentistry, many times they'll say, "Oh, about half that." I've heard that so many times it's amazing. "About half that." Then I'll say, "Great. Well let's go ahead and put together a progressive treatment plan for you so you can get this done. Let's talk to the doctor and figure out exactly what the priorities are with you, what should be done first. Let's plan your treatment so you can get this done.

"If you can't do it all now, which would be the best thing to do because of time and finance and so on, it would be the best to get it done, everything now. But if that's not appropriate for you, if you can't do that let's put together a plan so you can get this done." I want to assume that patients want the best of care without compromise.

Allison: Yes, me too. You're just helping them get that. You know, some people would feel like that's pushy but I actually think that's really nice. I think it's a really nice thing to do what you're saying.

Joy: Many times speakers and consultants will say, "Let the patient make up their own mind." I think that's well and good if the patient knows as much as we do so they can make an informed decision. I think that many times we get into the habit of putting so many alternatives in front of a patient that the alternatives confuse a patient and they end up doing nothing. I ran into that when I started calling patients. "I was so confused when I left. It's like I didn't know what to do."

I teach risk management and one of the things that you're required to do is inform the patients about the alternatives of care. But I think that's more a part of informed consent which can occur very close to the consultation about care. But what

has gotten confused is that doctors will go into a case presentation with at least three alternatives already outlined. It's treatment plan number one, treatment plan number two, or treatment plan number three.

In the mind of the patient, the only difference between those three treatment plans is the price. I tell doctors if every one of those options is as good as the other, put the same price at the bottom of each column. Then the patient will make a decision based on value. They'll be forced to look up on the page to see the value that's listed instead of just focusing on the price at the bottom of each column.

You want to move patients forward into doing the right thing instead of just doing the cheaper thing, the alternative that many times is just what insurance will pay for. I would rather a patient wait until tomorrow to do the right thing then to simply do the cheaper thing today or what the insurance will pay for today.

Insurance has limitations and it doesn't always help the patient receive the best of care. Insurance is not bad, it just has limitations. I see so many patients who were underserved and not cared for with life-changing care because the focus is on the price instead of on the value.

If treatment coordinators working in a dental office can work with a patient, with the doctors hand holding as far as what the priorities are, if the treatment coordinators can work with that patient to move them forward to receive the best of care instead of compromised alternative care, I think it's a better idea.

I recommend alternatives in time versus an alternative in treatment. It's easy to sell something cheaper. You have to work to help the patient understand and see the value of something better. But when I've worked with peer review committees or boards of dentistry, one of the things that I'm told

is that the reason doctors get in trouble is when they compromise. When a patient talks them into doing something cheaper. When a patient talks them into not doing something that's necessary.

Something as simple as x-rays or images, doctors get talked into not doing them all the time. One of my clients told me she would never allow a patient to refuse necessary x-rays or now certainly the images that are used. She would not. I said, "Why not?" She said, "Because I had a patient die because I'd been chewed out by a general dentist because I took a full series of x-rays on a patient that had been referred to me. The general dentist just chewed me out for doing that."

But this was a periodontist. She said, "I felt it was necessary and I did what was necessary. The referring doctor had not done any images and I just did it to do a complete periodontal evaluation and he chewed me out.

"The next patient as a young periodontist that I saw," she said, "said that I don't think I want x-rays." She said, okay, then. And she didn't do x-rays. If she had taken the images for that patient, she would have seen that starburst that was in the mandible that was—what is that, a blastoma?

Allison: I don't know. I don't know my oral pathology that well. That sounds right.

Joy: Cancer. The woman ended up dying. So she said, "I wish I had not compromised and let the patient talk me into that." But I'll go into offices and they'll have stacks of forms for patients to sign saying, "I don't want the images. I don't want the x-rays. I don't want this." The easy thing to do is not do that. My belief is that do the right thing. If it means taking extra time to educate and inform the patient, then do that. Do that. Do what is necessary.

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Allison: When you're talking to a patient about ideal treatment and you want to do the informed consent properly, are you saying, basically present to them the best treatment plan?

Joy: Right.

Allison: Then go back and forth to try to move them forward doing the best thing for them. Then right after that, you just need to mention that there are alternative plans. What does that look like?

Joy: Obviously you get to know the patient. Every doctor has a different interviewing process finding out what are you looking for, what type of care are you looking for? If you could change your life in some kind of magical way how do you see dentistry helping you do that? That sort of thing.

You get to know the patient and find out what they're looking for as far as their dentistry is concerned. Are they just after emergency care? Just stop the pain? Are they after, “I’m tired of this. I’m sick of living like this. I’m sick of looking like this.” You get to know them.

Then you treatment plan the best of care based on what you would do for yourself, your mother—if you love your mother. You treatment plan that. You sit down. You recommend that treatment, not with three alternatives pre-prepared. I tell the doctors I work with that’s the ultimate form of judging a patient. That they don’t want the best of care. You treatment plan all these alternatives in advance. That I have a problem with.

So go in there. Tell the patient what your best recommendations are. That’s what they want to hear in my opinion. When they say, “That sounds great. That’s what I want to do. I wish my other dentist had told me that,” then you move into informed consent.

The beginning process of letting the patient know, “I am required to inform you that there are alternatives. For example, one alternative is doing nothing, which I don’t recommend. Because if you do nothing, here’s the loss that you might experience. You could lose this or that or the other thing.”

That’s what I mean by present the best of care then when they say yes to that, move into, “I am required to inform you about these things.” There are about 12 different things in consent that need to be covered but this is another step in preoping a patient and certainly I work in the field of implant dentistry, we want to make sure there are no questions at all before we do treatment.

There’s more complete informed consent, which if you get used to doing consent you want to make sure you cover all the bases without having questions after the fact. Just answer the patients’ questions. When they say, “How much?” Then tell them what the fee is. When they say, “That’s great. I thought it was going to be much more,” then you move them into treatment after you’ve gained consent, make financial arrangements, do all that sort of thing.

When a patient says there’s no way, then you look at, “There’s no way today to do this, when will it be appropriate?” If they say, “There’s no way I can do all that.” Then you find out what had they planned to spend. Then you give them an alternative in time. “We’ll do this now and then we’ll do that next.”

I worked with a delightful office manager out in California who was a client, I spoke for their study club. They also had a Seattle study club. I spoke for their study club. This delightful office manager, Luanne, 70 years of age, still managing a practice, said to me, “I don’t like the word ‘phases.’” Dentists are always saying, “We’ll do your treatment in phases. Phase one is this and phase two is that,” and so on.

I said, “What word would you use instead, Luanne?” She said, “I love the word progressive.” I said, “Well use it. Use it in a sentence for me. How do you say that to a patient?” She said, “We’ll put together a progressive treatment plan so you can get this done.” I love that language. So you can get this done. It’s not, “Well, okay, well your insurance doesn’t cover it. You say you don’t have the money.” Then we do nothing for patients.

Many times we file them, we forget them. Or we say, “Well just call us if you change your mind.” Or, “Just call us.” Or, “You just think about it and let us know when you're ready.” We do that and then the patient gets lost, filed, forgotten. Nobody follows up. We wouldn’t know what to say if we did follow up. So they’re lost. They’re lost. So move them into something.

I was in an office where the doctor told me, “Patients are only doing hygiene.” They hear the good news, they hear the full treatment plan then they schedule hygiene. I evaluated his records in the office and sure enough everybody was scheduled for hygiene but they weren’t moving into the other necessary care. So I evaluated their exam process.

The hygienist was involved in the consultation, certainly answering questions and talking about hygiene. Then the hygienist would take the patient to the business office for a financial conversation and scheduling. On that walk from the consultation to the business office, on that walk many times patients would say, “Ugh, I had no idea I needed all that. There’s no way I can do this.”

The hygienist would say, “Well let’s go ahead and schedule your hygiene appointment. You do that while you're thinking about the rest of the treatment.” The patients would schedule the hygiene appointment but there was nothing in place to move the patient from hygiene into treatment.

So I suggested a simple fix there. “And while you're here for that appointment, we’ll reserve some time again for you to sit down, it can be with either the doctor or a treatment coordinator to answer your questions and to make a decision about what’s next.”

One of my clients said her office manager came to her and said, “You blow these people away. They're blown out of the water. You tell them all this treatment they need and they're totally blown out of the water. Yes, they need it all but they're blown out of the water and they don’t schedule anything because they're just so overwhelmed.”

Suddenly it was agreed that we need to tell them, “I recommend you do this first.” Then when they do that, “I recommend you do this next.” Keep them moving and they will be more likely to receive care. If they get caught in the loop of just coming back for continuing care without completing care, they’ll be a hygiene patient forever.

Hygienists that I interview, and thank you, Jill, for being on this call. The hygienists that I interview tell me that on average everyday they’ve got at least two patients who had been diagnosed needing treatment that had not done the treatment but continue to come back for hygiene. So we've got to figure out how to move them forward into treatment instead of having them get caught in doing nothing. They get stuck.

Jill: I did have a question. How do you feel about when people refuse x-rays and the doctor says, “Oh, it’s okay” and they sign a form? That form really is not legal is it?

Joy: That’s a great question, Jill. The attorneys that I work with say that if you have a patient sign the form, the doctor okays that, that the doctor is agreeing to neglect. What will happen when you go to court on a case like that is they will say to you, the patient’s attorney will say, “What if you had taken this x-ray?”

What if you had gotten this image, doctor? You just let the patient sign that away."

The attorneys will say that the doctor is agreeing to neglect. Negligence is the omission of reasonable precaution or carelessness. When I see stacks of forms in operatories and hygiene rooms for the patients to sign saying they refuse the images, it becomes a habit.

My sweet husband went to the dentist, the hygienist said, "Eddie, do you want x-rays?" He said, or he asked, "Do I need x-rays?" She said, "Well, we can just get them next time if you want." My response to that quite frankly, Jill, is lazy hygienist.

Allison: Yeah.

Joy: You know, does he need them or not? Let me tell you the rest of the story. That year, had a minor stroke. I flew him out to Spokane, Washington, The Heart Attack and Stroke Prevention Center. While I was there, one of my clients is a fabulous periodontist in Spokane, I said, "Is there any possible way…" She's booked up six months with four hygienists. "Is there any possible way that you could work him if you have a change in the schedule, if it works while we're here." We were there for a week. I said, "If there's any possible way, get him in."

Her hygienist did a comprehensive exam with the doctor. They found a 5mm and a 6mm bleeding pocket on one tooth. He's been seeing a hygienist every six months for the last 28 years. Every six months. More faithful than I am. They did the bacteria test to determine what type of bacteria was living there. The bacteria had the indicators for stroke or heart attack. So do we want to be lazy or do we want to stop and educate and inform these patients about—you know, maybe this time we won't do it, but let me show you some things.

I tell doctors to collect images of what you could not see with the naked eye. Collect images. Show them the blown out bone. Show them what's in between teeth. Collect images and put it up on the screen. Take a picture of the tooth, what you can see without the images. Then take a picture of the tooth with the, whatever the disease is, or whatever is in the mandible or maxilla.

Take pictures and save those so when a patient refuses, say, "I'm concerned. Here's what I'm concerned about. Let me show you something." I didn't think it was that big a deal until I started seeing these things and recognizing that this is an issue. Did I answer your question, Jill?

Jill: Yes, I'm sorry. I got disconnected so I kind of caught the last end of that.

Joy: I tell doctors if they've got a stack of forms sitting there for patients to sign, they are agreeing to neglect. They should take those forms and put them in the furthest corner of the office so they have to take a long, slow walk and think about the consequence of taking the risk and putting the patient at risk of experiencing unnecessary loss.

It is a choice that a doctor makes but I think it's high risk not to do the right thing. Doctors don't probe. "We don't have time." Jill, you know from experience what you find if you do. I went into an office one time that didn't even have a perio probe, I asked the hygienist, "How do you know that this patient has periodontal disease?" She said, "Usually if the tooth is loose."

Allison: Oh, god.

Joy: You know? So I think we get lazy. We don't tell the patients what they need to hear. Now of course, I've worked in implant dentistry now for 37 years. The thing about working in implant dentistry is I see the patients that have been thrown away from

the mainstream. They've been told it's bad, all these teeth have to go. Or maybe the teeth are even gone. "This is a bad and that's bad."

These patients walk in with their hands clasped against their mouth. They have their lips locked around their teeth. They don't want anybody to see their teeth. They're dentally disabled and they're basket cases. I look at them and I think, "This was unnecessary. This is negligence and it's not always the patient's fault." If someone didn't get them excited, you know, someone just criticized them and they couldn't take it anymore.

I tell hygienists, find one clean tooth please. Make a big deal about it. Show them what stippled tissue looks like. Get them excited about how they did a great job here. Say, "I know you probably know how to brush your teeth. Let me show you how I do it." Educate them. Spend time with them. Show them good technique and good methods.

Some offices I work with that have multiple hygienists actually encourage the patients to go from hygienist to hygienist to hygienist so that they learn more different techniques so they can figure out what works for them because hygienists use different techniques. Different educational techniques even. Different methods for getting to this spot or that spot. It's kind of nice for patients to pick up on what works for them.

So do the right thing. Just do the right thing. Always question, am I taking the easy way out? Am I taking the habitual way out? "Just sign here and then when we're not responsible." We are responsible if the patient experiences loss. We might not be called on the carpet for it but we are responsible. Just do the right thing.

Jill: I totally agree.

Joy: Thanks, Jill.

Jill: My phone stopped and I had to call back. I don't know, I was getting another call or something and my phone cut out. But anyway, how much does it cost a practice really to take the x-rays, the necessary x-rays, and not charge the patient?

Joy: Not much at all.

Jill: Yeah. But you need that not only for just them and their purposes but legally too.

Joy: Yeah. Jill, that's another great question. There's a lot of controversy in the industry right now because of cone beam technology which I absolutely love. It's amazing to be able to see three-dimensional images. I love love love that. Well some doctors are using the cone beam as a marketing tool and they're not charging for that in order to get the patient, in order to be able to do the evaluation.

Other doctors get real upset. "I paid a lot for this machine. I think I need to charge for this." So there's a lot of dialog going on about, do we charge? What do we charge? Well they're not charging that much and we're charging. So there's dialog going back and forth and a lot of controversy there. That always peaks my interest.

I have to ask, and this is to your point, Jill, that who are we taking the x-rays for? Who are we taking that image for? Who are we doing that for? Is that for the patient or is that so we can better diagnose and treatment plan what needs to be done? We're doing it so that we do the right thing. Now certainly the big question comes up, how do we bill for it? How do we bill insurance for it?

Quite frankly, I think we do it so we do the right thing. In my opinion, that can be kind of the loss leader that we do so we do a better job. So we do it so we do the right thing for the patient.

I always suggest that you have a token standard fee for the initial evaluation and it depends on how covered up you are.

You know, if you do free evaluations, there's no perceived value. They think, "I don't really have to make it. They're just trying to get me in there." Then a lot of patients get real upset if you're telling them on the phone there's no fee and then they come in and doctors say, "To really be able to tell you, we need to do this big image and that's going to cost this and that." So patients get mad and they don't come back then.

So I say decide on a fee. Make it a fair fee that covers everything in order to provide you with a very thorough evaluation and recommendations for treatment. You decide what that is. Then make sure that it includes what you need to do in order to be able to determine what the patient really needs. You can't guess work complex restorative care. You just can't do that.

Whether you eat part of the cost or you recognize that I'm doing this so I can do the right thing and absorb that part, or whether you charge for it, depending on the demand. I have worked with clients to determine what they need to charge based on how many new patients can they even handle.

If a percentage of those patients are accepting treatment, how many cases can they start and finish in a month? Determine how many new patients you need that way. Then you can determine what kind of fee we need to charge in order to manage that load. So I would do the images for us.

Jill: Yeah, that's what I've been used to recently.

Joy: One of the challenges with that, Jill, is going to be that the word gets out. Where you didn't charge my friend and now you're charging me. It's like years and years ago there was a little fad of giving a flower to a patient when they would leave the

appointment. Funny thing that happened then was that the flowers didn't arrive and a patient didn't get a flower, then they would get mad. So it worked against us.

So whatever you want to do for one, you want to do for another. You want to make sure that you're being fair. The way I look many times at insurance is, is it really right for us to discount the fees for one group and not discount the fees for another?

Jill: What I've been saying to patients recently is your insurance is like a coupon. Some people that come in, they have insurance. Some people come in that don't have insurance. You have to be fair, I understand that. So where do you draw the line on what you're going to charge or not going to charge? You want to give the patient a full comprehensive exam and you can't do that without the necessary x-rays.

Joy: I agree with you on that. You just have to decide how can you charge for that. There's a whole analysis that needs to be done with regards to insurance, that's a whole other topic. There are many times when I go into an office, if practices are participating with insurance, we look at what are the doctor's fees compared to what the reimbursements are? What are the write offs? Is it cost effective to work with this insurance company or that insurance?

I don't think insurance is bad. I just think that it can quickly take over a practice and all of a sudden you start recognizing it's costing you more to treat the patient than the payoff is. It's all of a sudden the nature of practice changes and it's all insurance driven. Just like giving things away can become a habit. It's the same thing, the same truth with insurance, treating insurance patients.

The challenge with insurance, one more thing about that, the challenge with insurance is it has limitations. Patients are less likely to receive comprehensive care if the focus is on the

insurance. Just like patients are less likely to receive comprehensive care if the focus is on the price.

You want to turn the focus to the value of the care, the benefit the patient will receive. Why they need to have this done. Patients don't buy what they need. They buy what they want. So you need to switch that into this is something they want because whatever that benefit would be to them that far outweighs the price.

Jill: Got ya. It's a fine line because I don't deal with insurance or things like that. I mean, I know a little bit about it but the doctor wants the x-rays. Period. I don't usually have too many people but there are those people that refused x-rays but then you can't treatment plan, or the doctor cannot treatment plan properly without them.

Joy: I have seen doctors walk in and when the staff members would say that the patient doesn't want x-rays, doctor walks in and says, "Well I guess I won't need these glasses either. I can't see what needs to be seen in order to be able to treat you without compromising on the quality of care. We need this in order to be able to see."

They just need to be educated. I think many times seeing is believing so showing them examples of what could not have been seen is important. It's important. Well it looks like we only have about five more minutes on this phone call.

Allison: I know, that was what I was just noticing.

Joy: I don't know if there are any other questions. Thank you, Jill, for those questions.

Jill: Thank you, I didn't mean to take up all your time.

Joy: Oh no, it was great. Thank you.

Allison: Yeah, that was great. Thank you. I did have a question but I think it is too long for you to answer.

Joy: Then let me make a couple of suggestions, Allison.

Allison: Yeah, that would be great.

Joy: Since we're talking about patient retention, we can't talk about that without also saying something about how to get patients back once they've been lost. A few things that I want to mention, quickly, briefly. The best way not to lose a patient is to schedule an appointment for the patient before they leave.

The best way to schedule an appointment for the patient is to schedule the appointment for the patient before they leave the clinic. The further away they get from the clinical chair, whether it's the hygiene chair or the doctor's chair, the further away they get from that chair in that long walk to the front desk, to the business office, during that walk they get lost.

So when they're in the clinic, we can also talk to them without being concerned about privacy, HIPAA considerations. We can talk to the patient about what loss they might experience if they don't do this, if they don't schedule this. So I'm suggesting, keep them in the clinic. Don't have those private conversations in the business office about why it's important for them to schedule and not walk out and schedule an appointment.

Next thing is schedule beyond hygiene. I briefly discussed this early in our conversation. Schedule beyond hygiene. If a patient needs hygiene, schedule that and the next thing, or, and at the same time something else. Or, and a consultation to sit down and decide what's next. Schedule beyond hygiene.

Another thing is stay in touch with a patient. My uncle taught me to fish. I love to go fishing. One thing that he taught me is never let the line go slack. If there's a lapse of time, there's a loss of interest. You want to make sure you stay in touch with

these patients. Have a method for staying in touch with these patients and contacting them.

Then of course, bring them back. Make the phone calls. Give them a call. Say something like, “I’m concerned. I was worried about you. Did I not schedule an appointment for you the last time you were here?” Schedule an appointment if they somehow got away without scheduling an appointment.

In an office, a practice can take about two years to recover all the lost patients. About 50 percent of the active patients are lost. They're not scheduled. They're filed. They're forgotten. They're invisible on the computer. About 50 percent of the active patients are lost.

There are far more lost patients that have been archived, put in boxes, and about to implode the doctor’s attic or something. About 50 percent of the active patients are lost and they can be recovered easily if it’s been within three years since they were there. They're probably thinking you forgot them.

My friend Bobbie said, “Joy, you still work with dentists?”

“Yes.”

“Well I've got a new dentist.”

“Really?”

“Yeah, I went to a dentist for 25 years but I've got a new dentist now.”

“What happened? Why’d you change?”

“I got a coupon.”

“What do you mean you got a coupon?”

“I got a coupon from a new dentist. I get 20 percent off.”

“20 percent off of what?”

“I don’t know, but I’m getting 20 percent off.”

“You left a dentist you were with for 25 years because you got a coupon?”

“That’s right. My other dentist didn’t give me anything. They would send me a card telling me when I was due and it was up to me to call and schedule. They didn’t do anything to try to keep me so I guess they won't miss me now that I’m gone.”

That’s exactly what she said. And she’s not alone in that thinking. If we don’t care enough to call or if we don’t say, “I’m worried about you, are you okay?” Wrong reasons to call are because the doctor told us to or there are holes in the schedule or we don’t have anything else to do or the doctor needs the money or the doctor is on the vacation. Those are the wrong reasons to call.

The reason to call is because that would be the right thing to do. Follow up on them. Say, “I was worried about you. Let’s go ahead and reserve an appointment for you now.” Get them back in and practices will thrive and survive.

One of my clients who fully implemented my lost patient system told me recently, she said, “Joy, we’ve had to back off on calling these people.” I said, “Why is that?” She said, “Well we call it the treasure chest now.” She is booked up six months in advance with all the hygienists that she has as well as six months in advance with surgeries that she does. Six months in advance.

So now the lost patients are actually what she might call the treasure chest. Just there, available, if they need to fill in here or fill in there. Isn't that amazing? Isn't that wonderful to have that in this economy with what’s going on in this country? It’s just absolutely amazing that if you care about the patients enough to stay in touch with them, to schedule them, to not let

them leave without an appointment, and grieve about them if they're lost.

Take responsibility for that loss and not blame them. What could I have said? What could I have done? What word could I have used that would be different? Instead of saying, you're late—you're here. "Oh, we were so worried about you." Just caring about these people and valuing them as a patient. Then they will receive the life-changing care that we can provide them.

Allison: Awesome. I wish we had time for more.

Joy: Well thank you so much for including me in this conversation. I appreciate it.

Allison: Thank you. I appreciate your time and your energy and your willingness to be on here.

Thanks for listening to *Practicing with the Masters* for dentists, with your host, Dr. Allison Watts. For more about how Allison Watts and Transformational Practices can help you create a successful and fulfilling practice and life, visit transformationalpractices.com.