17. Playing Both Sides of the Fence

Not knowing what direction orthodontics is going to take has left many orthodontists in the middle. . . or, maybe in a muddle. They are afraid not to join the HMOs because of their potential clout, but don't want to give up fee-for-service. They want to have their cake and eat it too -- sort of an orthodontic hip-hop. **This debases orthodontics**. To have a patient who is paying full fee sitting next to one that is paying half-fee (HMO) lacks integrity. Do you really think they won't ultimately know? It destroys what are supposed to be the advantages of each system. To further inflame the problem, many HMO orthodontists are playing bait and switch with fees. They proclaim that, "Yes, the HMO fee covers basic services, but it doesn't cover retainers, loose braces, post retention care, additional appointments, etc." Do you really think the HMOs won't ultimately know? I understand pragmatism, but playing both sides of the fence will only denigrate the patient's view of who we are. It may work out economically in the short run (and some even doubt that), but we are passing on a poor legacy to the next generation of orthodontists. Just as Neiman Marcus and Sears wouldn't work well in the same space, fee-for-service and HMO orthodontics make poor partners. The end does not justify the means.

What are some of the answers to these challenges? How can we be more proactive about our future? Are there reasons to be optimistic? How do we position our practice?

1. Do Your Homework - Strategic Inflection Points

When I have addressed groups of orthodontists about managed-care issues, their body language (and sometimes their verbal language) shows they are caught in a belief system or maybe better, a system of disbelief. I quite often see knee-jerk reactions to many of these concepts based on insecurities and preconceptions more than on actual fact. I have absolutely no problem with those who take a different tack from me on this issue as long as they've done their homework. Kudos to those who teach about practice transition, kudos to those who lobby for legislative change, kudos to those who preach zero-defect efficiency, and kudos to those who actively engage our future.

Perspective: Andrew Grove, C.E.O. of Intel Corporation, talks about "strategic inflection points" that are caused by large-scale changes in the business environment. He maintains that individuals or companies that fail to recognize inflection points often wither and die. He refers to the Internet as being one of these inflection points. Intel initially saw no real value in the Internet (in terms of telecommunications), and his on-board advisors demonstrated as many positives as negatives in the future for this enterprise. Grove maintains that is exactly when the inflection point occurs, when there are as many positives as there are negatives in any endeavor. Because you work inside your own skin, it is often difficult to recognize these junctures. **You want to stay doing business as usual, in a vertical plane, when the changes are really occurring in a horizontal plane.** Once this inflection point is realized, Grove says, **"The only way you'll know how to engage it is not sitting and speculating, but getting involved and working with other people who don't see the world the same way you do." Inflection points precede a change in the paradigm.**

Get involved in focus groups and political action committees, e-mail your buddies and do your homework before taking a rigid stance. Heck, call your congressman for the first time in your life. Tell him how you see things. This is a simple problem as long as you don't care about it and are myopic. When you care about something, it can get complex awfully fast. Knowledge is knowing facts; wisdom is knowing what to do with them.

2. Zero-Defect Efficiency

Efficiency in treatment is a greatly misunderstood concept. I suppose because many management gurus talk about the financial rewards of efficiency, we are left with the impression that money is the only reason to be efficient. Of course, I understand the financial benefit of being efficient, but ***in my view, the #1 reason for efficiency is quality.*** This quality is expressed in many ways:

- Patients' perception of your skills
- Less patient trauma - less overtreatment
- More predictability in treatment -- time and results
- Less need for patient compliance
- Makes practice more competitive -- lean and mean
- Increases staff confidence
- Prevents burnout and reduces overhead

Efficiency means one thing: doing the requisite task in the simplest, most efficient and predictable manner. **If there are any extra motions or if the task is done incorrectly, quality deteriorates.** Those who believe efficiency equates to sloppiness are sorely missing the point. It is the exact opposite. Although the time working on the task may be reduced, everything is done absolutely correctly. That is why there is so much effort in truly efficient practices to keep things **simple through system.** This is referred to

as **zero-defect management and can occur only at the highest levels of technical and management expertise.** It is the only level in management hierarchy where the total focus is on one thing, quality. I don't want to imply that I'm always working at that level, I'm not. But I do know what that level is and have been there at times. It guides the focus of my energies.

Perspective: The value of creating simplicity in your personal and business endeavors is almost immeasurable. A trait that is common to the *masters* of any discipline is their uncanny ability to take something complex and make it simple. My wife rides horses and has worked for years with a competent trainer to improve her riding skills, as she wants to compete at a high level. However, her trainer is constantly adjusting, releasing, tightening, fussing and frittering with the horse all in the name of "doing it right." She has no clear system in her training regimen and, in short, makes this discipline a complex endeavor. When my wife transferred to a world-class trainer (a master), her skills improved dramatically overnight. When I asked her what he did to accomplish this miracle, she said: "He just made everything so simple. He doesn't waste any time or energy on unimportant things. Riding can be pretty complex but it sure doesn't seem like it with him. I think even my horse understands this simplicity and responds to it without resistance." **We all need to learn to become masters. Simplicity is the key to efficiency, and efficiency is the key to quality.**

Zero-defect efficiency means we set our standards a little higher for our practices and quality is the benefactor. What do you do with the extra time this efficiency buys you? You can see more patients, catch more fish, play more golf or **you can use that time to grow and improve your practice through communication.** I have often used the adage "delegate, don't abdicate" to express the conviction that time with the patient can be much more productive overall if you are efficient in your procedures. It gives you time to communicate to the patient, to the parents and to the staff. It is the time you convey the value of your services. It is the time you differentiate yourself and your practice. Why place brackets three times when only one should do? Why use three wires when one wire will do? Why treat a patient over 36 months when the same result can be accomplished in 20 months?

Efficiency driven profit is a graphic way of demonstrating the economic advantages of being efficient. Those who lecture about it are attempting to entice you to the advantages of zero-defect management in the most dramatic way - your pocketbook. I am not denying that improved efficiency doesn't translate to an improved bottom line. It does. It allows you leeway. **When you can make a profit at almost any price point, you are a very competitive entity indeed.** This way of thinking about orthodontics will ultimately be one of the primary forces for competing with HMOs while still maintaining quality -- but we are a long way from objectively understanding what the most efficient treatment is, given today's technology. It is a moving

target because as technology improves, so should efficiency. **Your ability to be efficient is an intimate byproduct of your ability to change.**

Perspective: I have always liked the quip about the oral surgeon who had just deftly removed an impacted tooth in less than five minutes. His patient angrily queried, "I had to pay $350 for that? It only took you five minutes to do the job." To which the oral surgeon replied, "I'm sorry, sir. Next time I'll do it much slower so you'll get your money's worth." Efficiency has its greatest value when you can communicate its benefits to the patient.

The last seven years, I have been focused on a mode of treatment I refer to as **noncompliance therapy.** True noncompliance therapy **can be** the most efficient treatment available. It can be very cost effective and bottom line productive. But first and foremost, it must provide exceptional quality. If it cannot do as good a job as other approaches, both efficiency and quality are squandered.That is the benchmark. It must be as good or better, or faster doesn't count.

3. Take a Stand

We must stand for something or we may fall for anything. There are those who advocate that if we just keep to knitting as usual, managed care will not affect us. Stay quality. Stay fee-for-service. Just focus on patient needs. Serve patients well. Perhaps they are right. Time will tell. However, don't confuse fee-for-service with ethics. Those who would have you believe that fee-for-service automatically means an ethical approach to service are sorely mistaken. We (as a profession) have proven that not to be the case too often in the past. Competition and ethics make strange bedfellows.

Perspective: Oral surgery gives us a glimpse of how quickly things can change in a specialty. In 1991, I treated 38 patients with orthognathic surgery. In 1996 I treated 5 (based on the same general case load). Did the need for orthognathic surgery just go away? Did our diagnostic acumen change? Not at all. In 1996 I had just as many cases that needed surgery as I did five years ago. Insurance companies have simply decided not to cover these problems or to refer them to alliances of oral surgeons who are willing to live with their fee structure. It is very difficult for the patient to cover the surgical costs out of pocket. This forces orthodontists to either severely compromise treatment or to dissuade the patient from treatment at all. Oral surgery practices that were dependent on orthognathic surgery as an vital part of their economic base have been greatly compromised, and the quality of orthodontics in this spectrum of patients has been set back 20 years.

Having looked closely at all the issues, it is my perception that we cannot stand pat. It will take a more active roll on our part to effect change. I have no argument with someone who takes a stance and defends it

vigorously. The golden era of orthodontics is not over. Not by any means. It's just on temporary hiatus. Unfortunately, it's on hiatus during our turn at the helm. We need to swing the pendulum back the other way. **If you don't have an agenda, by all means, get one!**

I would encourage the mid-range orthodontist whose practice is thriving, where growth is occurring and patients are embracing fee-for-service and quality care, to stand pat. Keep doing what you're doing, adopt new concepts as they become available (some are mentioned here) and emphasize your competitiveness - become more budget, service and efficiency oriented. However, I would also encourage that orthodontist to keep his or her ears to the rail, as changes can come about very rapidly. The defenders of fee-for-service need to remain stolid and focused during this time of rapid change in our specialty. If you are going to stay "business as usual," you cannot afford vicissitude.

4. Management Service Organizations (MS0s)

By now almost everyone is aware of Orthodontic Centers of America (OCA). OCA is a management service company that purchases the assets of orthodontic practices in a complex buyout agreement. It, in effect, owns the orthodontic practice and is responsible for its management and economic viability. The orthodontist is paid a base salary and incentives for practice growth and productivity. At this time, OCA has gone public in an initial public offering (IPO) and is a stock-issue public corporation that has done surprisingly well. Many startup MSOs are in the works and they merely reflect a willingness of venture capitalists to invest in the future of orthodontics (and many other health-care related specialties). Once again, free enterprise. Will they work in the long run? No one can say for sure. They are businesses just like any other and they will live or die by management competence and trends in the marketplace. **They are very complex economic entities that have vast potential positives as well as vast potential negatives. My only concern is whether quality orthodontics can be sustained in this management environment.** Many would say no. They would say that to try to harness the skills of salaried orthodontists is like trying to herd cats. That it destroys the very entrepreneurial spirit that got them there in the first place. **However, if a public company can meet the needs of a certain segment of our profession, it will survive. If it cannot, it will fail.** One thing is sure. This current trend in orthodontics must run its course and either prove to be a viable entity or evolve into something

different. It is healthy to look at these start-up efforts with a jaundiced eye, but don't discount them until they have a chance to prove their worth. Believe me, if they don't work, Wall Street will be the first to let them know. It is the purpose of management service companies to take over the day-to-day management of the orthodontic practice and increase profitability.

Among other things, their areas of influence can include:

- Management information systems
- Activity-based costing systems
- Flexible patient financing systems
- On- and off-site training for both staff and doctors
- Career and retirement planning
- Marketing plans
- Inventory control and purchasing
- Accounts payable
- Payroll and insurance management
- Point-of-care database systems (time and motion studies)

5. No Fee for Initial Examination

There is distinct dichotomy among orthodontists about charging an initial examination fee. Those who do charge argue that the patient only perceives value when they are paying for it. Ergo, if they perceive no value, the information that they receive must be of no value. They would also argue that charging a fee for examinations discourages shoppers and encourages patient commitment. They feel that the orthodontist does a better job of communicating when there is remuneration for their services: **all valid points.** Those who don't charge maintain that they would like a shot at every patient. You only get one chance to make a good first impression. This is a chance to influence patients' thoughts about the value of orthodontics. **In today's competitive orthodontic environment, not charging for the initial examination makes sense, especially if you are adept at selling your services.** It should be considered the cost of doing business or as a promotional fee and all of your referral sources should be aware that you don't charge for this service.

Perspective: A good dental referral source of mine expressed this to me: "Jim, I certainly understand that you deserve a fee for your initial examination and it is a very fair fee. I have no problem with that. Can I ask you a favor though? Would you consider forgoing the initial examination fee for my patients? **It makes it so much easier to get them over to your office if I can tell them there is no charge. Don't do this for the patient, do it for me."** Those were the magical words. I do not charge an initial examination fee as a favor to the referral source whether it is a dentist or a satisfied patient. These people have spent some of their time convincing the potential patient that your office is the right one for them. No examination fee is an appropriate recompense for that trust.

6. Affirmative Recall Systems

The linchpin for efficiency driven profit is starting active treatment when it is most proficient (treatment timing). Notwithstanding the dichotomy in orthodontics about two phase therapy, approximately one quarter of patient starts should be coming from our recall rolls. Historically, many orthodontists have a casual attitude about their recall system. This is no longer prudent. **The recall roll should be treated as if it is an entire practice waiting in the file cabinets.** The techniques involved capitalizing on the recall rolls should be as sophisticated as any in the practice. The process of keeping potential patients from falling through the cracks is of paramount importance to the fee-for-service orthodontist.

7. Raise Fees

Brace yourself. Raising fees to stave off managed care seems contrary to common sense. However, it works in several ways. Patients who are not presently constrained by HMOs don't resent reasonable increases in professional fees, especially if service and care improve perceptively. Quality of service doesn't generally improve when profit is declining. **It is inaccurate to believe that fee-for-service orthodontics is competing with HMOs on a monetary plane. It's not.** Patients enrolled in HMOs don't matriculate to fee-for-service practices unless they are very disenchanted and by that time they are already prepared for a higher fee. It is important to raise fees to keep up with inflation and avoid the pinch in profitablity that inevitably occurs. *More importantly, even a small (5 percent) increase in fees greatly reduces the number of patient starts needed to maintain the same profit.* For example, a 5 percent fee increase means patient starts can be reduced by 16 percent (See addendum) without impacting the bottom line. In other words, the same profit that is attained treating 10 patients can be enjoyed by treating only 8 1/2. Conversely, lowering fees 5 percent means that 25 percent more cases need to be started to achieve the same profitibility. This is very

persuasive arithmetic. We like to think the decision to raise fees is rational and logical. In truth, it is more psychological and inconsistent: usually, what we think the traffic will bear. The realization that fees can be bumped slightly without severely affecting patient starts is a powerful driver in breaking the psychology of fee stagnation. The pool of available patients is increasing, especially given the current robust national economy. Orthodontics (on the whole) has been very equable in raising fees. Increasing fees moderately will demonstrate that the survival of managed care and fees escalation are not mutually dependent, as we are inclined to believe. If we increase service along with an increase in fees, it will widen the perceptive "quality" gap between managed care and fee-for-service orthodontics. I would suggest raising fees 5 percent immediately. You won't feel a blip. **L.D. Pankey asserted that the correct fee is one that elicits gratitude in both patient and doctor.** How simple, increase care, increase fee. That should be our barometer.

8. No Down Payment

I am convinced that what is keeping many patients out of our practices is their inability to afford orthodontics, especially the high initial payment. We have to do things that address this problem. It is not enough to keep repeating, "Orthodontics is an unbelievable bargain" and "The patient is spending their disposable income on other things of less value." I'm not sure we'll ever get needy or frugal patients (fee-shoppers) to understand these musings. Allowing the patient to start without undue costs and to spread the payment out over a longer period of time has the potential to bring patients in when it is most needed instead of when its most affordable. The simple fact is, patients with a good payment record should encouraged to start and the length of time it takes to receive your fee should be secondary. Today's technological advances require a small orthodontic investment (remember, we're no longer pinching bands) for initiating treatment. Using credit rating services when initiating treatment (instead of always demanding a high initial payment) is a prudent and effective procedure.

9. Third-Party Financing

Third-party or institutional financing has the possibility of creating further flexibility for patients who have good credit but are unable to afford large down payments or short payoff intervals. Normally the orthodontist will pay up to 7 percent of the fee for financing but payment is guaranteed and there are no attendant clerical costs. Also, the patient is aware that he or she is responsible to an institution rather than the doctor. The time value of money

makes this an acceptable alternative for the orthodontist in most cases. With those patients who are not creditworthy (or marginally so), the orthodontist can still treat the case but is liable for defaulted payments by the patient. **The great advantage of third-party financing is that it separates payment for services from the service itself. When the patient relates what was paid that month with what you actually did, efficiency can be stifled.** Third-party financing allows us to assign appointments at intervals that are most effective and apt. When a third party has dominion over financing, you are freed to treat in the most efficient manner because quality is equated to results, not time.

10. Accept Insurance Assignment

Half of all orthodontists presently accept insurance assignment. Those who don't generally contend that they do not want to be caught in the middle of an insurance dispute. They want the insurance company to be financially responsible to the patient and the patient to be financially responsible to them. The problem is: insurance communications that can be easily handled by the orthodontic office can be a logistic nightmare for the patient. Patients don't understand dental terminology and are often put off by the insurance carrier if they don't comply with established protocol. This can often delay the start of treatment. If they spend a lot of time resolving their insurance issues, there can be some ill will toward the orthodontist. An efficient, computerized insurance system allows us to aggressively pursue insurance payment with little difficulty. Most offices do most of the work anyway, and have to resolve patient insurance problems when they arise. By accepting assignment and simply considering it "the cost of doing business," it is a value-added benefit that helps improve the esteem of the office.

11. Create a Transition Plan

Currently there are more practitioners retiring than there are new graduates available to purchase their practices. It's a buyer's market. Unfortunately, most neophyte orthodontists don't have the resources to buy these practices nor the expertise to successfully cover the debt load that would ensue, let alone the expertise to make the practice thrive. A transition plan that allows the selling orthodontist to take time instead of money and doesn't put the graduate further in debt makes sense if a match can be made. Many orthodontists don't want to take the time or the risk to engage in this type of transition. An MSO that has the financial capital to buy the practice outright, train the graduate, take over sophisticated management entities and grow the

practice has a great deal of potential in this realm. To be successful, the retiring orthodontist needs to be able to take the equity out of the practice as part of his or her retirement assets, and the matriculating orthodontist needs to take over the practice without incurring more debt.

12. Assimilate Graduating Orthodontists

It is important that we find means of bringing new orthodontists into the field without increasing their debt load. Banks are unwilling to capitalize the purchase of most practices, especially the highly productive ones. New approaches are needed to allow this important transition to take place. Orthodontic supply companies, outside funding sources and MSOs all have potential to fund these activities. The goal: to keep most graduating orthodontists out of the clinics and HMO enviorns.

13. Activity-Based Costing System

Current technology enables us to analyze data to determine the true efficacy of our mechanics. Activity-based costing has the potential, for the first time, to reengineer the work flow, patient care, treatment costing and management processes. It is, in effect, a sophisticated time and motion study that determines the most effective approaches to certain kinds of problems. "Point of care" data entry systems using bar codes can define every motion of the assistant and the doctor and easily record and enter them into a data base. This approach is a way of taking the guesswork out of the overhead (cost) and treatment (production) entities. It has the potential of taking the "average" out of our treatment and replace it with more definitive time line and cost factors, not unlike the way supermarkets have refined pricing and overhead margins.

14. Orthodontic Alliance Groups

Groups of professionals forming together to increase purchasing power and clout with insurance companies are known as practice alliance groups. The best known in the general dental arena is Dental Health Alliance (DHA), which offers participating doctors an increase in patient pool if they are willing to treat for 80 percent of their standard and customary fees, with yearly increases indexed to inflation. There are start-up orthodontic alliances in California (California Partners in Orthodontics) and many other states that are in the process of negotiating with insurance companies and other providers. The advantage of these groups is their competitiveness as they

reduce the administrative and marketing expenses commonly associated with HMOs.

Perspective: A recent article in the *Los Angeles Times* gives us a good look at the future of medicine. Minnesota, which started HMO plans and is conceded to be 10 to 20 years ahead of the national curve in health care reform, is embracing organized groups of physicians to meet health care needs. Groups of doctors (IPAs) are forming that say,"Why do we need the HMO intermediary? Too much is going to administration and advertising, leaving less for patient care." More interestingly, they indicate that HMOs **stifle competition and medical innovation.** Physicians are now taking back bargaining clout by acting in groups that can be competitive with the HMOs. However, physician groups need to prove that they can be price competitive with HMOs while increasing the quality of care. Initial indications are that they can. In 1997, the first year of the program, employers' premiums will drop 9 percent on average from the prior year (*Los Angeles Times,* front page 10/27/96: "Seismic Shift in Health Care Could Alter Industry Again").

15. Marketing: Stressing Quality and Value

Although to many the word "marketing" conjures up seedy and unprofessional conduct, marketing (both internal and external) offers something that organized orthodontics has not been able to achieve with any other method -- a way to tap into the huge resource of untreated patients. Although internal marketing continues to yield excellent results, external marketing, when subtly and professionally done, can also be very productive. The main focus of external marketing should be on reaching the potential patient pool that is not being referred by other patients or dentists. External marketing is very expensive (and potentially self-limiting) and best accomplished through MSOs and Orthodontic Alliance Groups where money can be allotted for these purposes. **My view is that marketing can be done professionally as long as its intent is to stress quality and value** and not blatant fee reduction or the "$19.95 deal" mentality. To this point, organized (AAO) marketing efforts have failed to access certain segments of our society into orthodontics. Orthodontics is often perceived as an optional, expensive or boutique service and external marketing efforts to dissuade that viewpoint are considered unprofessional. That mind-set is myopic.

Practice introduction videos, quality brochures and stationary and CD Rom educational progams are available and can be purchased for a reasonable cost. In addition, dynamic marketing programs that focus on referring dentists have great potential. These **systematic target marketing programs,** when pursued in a disciplined and committed fashion, yield predictable and assuring results. Outsource consulting resources that assist the orthodontist in this area are already available and have been extremely successful.

Perspective: It's easy to determine the cost of technical items. Much more difficult to determine is the cost of caring. In his article *Quality Work Doesn't Mean Quality Service,* management consultant David Maister states that "Because of the ambiguity that surrounds technical excellence (and the difficulty patients have in appraising it), personal relationships with clients take on great significance in every profession. Whether logical or illogical, sensible or not, even the most sophisticated client will focus more heavily on the quality of service that the quality of work. If the patient perceives service at a certain level but expected something more (or different), then he or she will be dissatisfied."

A simple formula is: Satisfaction = Perception - Expectation

16. Create Niches

Differentiation of services can be a powerful tool for the orthodontist who enjoys alternative treatment approaches. TMJ therapy, lingual orthodontics, complex adult and/or surgical treatment, myofunctional therapy, teeth bleaching and sleep apnea control (snoring) all help raise the esteem and profile of the fee-for-service practice. However, introducing treatment modalities you don't really enjoy or have expertise in can have devastating side effects. **After a short time, thinnly disguised contempt will abrogate the potential value of these niches. There is nothing worse than being a TMJ expert who hates treating TMJ cases.** Changing working hours, adding peripheral services and innovative scheduling techniques add niches that are much more comfortable and ammenable to modification.

17. Conversion - Commitment to Start Treatment

Giving patients information that they need to start orthodontics in a very timely and effective fashion is paramount. Traditionally, orthodontists have waited to communicate treatment modes until comprehensive records have been obtained. However, most clinically astute orthodontists appreciate what the patient needs to know to make a commitment after conducting a good clinical examination. This information should be imparted to the patient **immediately** in a plausible and polished fashion. This helps define the decision making process and gives the patient the clarity, confidence, and integrity they seek to go forward. In today's sophisticated world, where people are inundated with over 3000 commercials a day, the only messages that are heard are those that are delivered loud and clear and strike a responsive cord. Orthodontists needs to increase the available patient pool and assure the base that already exists.

18. Direct Reimbursement - Flex Plans

Direct reimbursement shows great promise in maintaining fee-for-service orthodontics. These flex plans allow patients to put a predetermined amount of health-care monies aside in pre-tax dollars. The catch: they must use all these designated funds each year or forfeit them. This is very popular with patients, because it gives them a greater sense of control over how their health-care dollar is spent. The advantage: patients can choose their doctor (they like that) and use flex funds as they deem appropriate, while receiving a tax benefit. The AAO is to be lauded for the work they have done in this area. **Increasing options is the name of game** when it comes to orthodontic financing and flex plans create very positive options.

19. Outsourcing

Outsourcing has great possibilities in the orthodontic marketplace. Outsourcing means transferring redundant, inefficient, in-office management functions to outside sources, where they can be accomplished more economically. It is particularly valuable in terms of staff and doctor training, laboratory work, consulting services, computerization, payroll, database functions and activity-based costing. What is very appealing about outsourcing is that it can bring back pension plans (when pension plans have been rolled over into IRAs) and reasonable insurance coverage to staff. This is a function that is best accomplished through MSOs and dental alliances (with some potential participation by orthodontic suppliers), because it depends on a greater number of participants and excellent negotiating skills for its potency.

Perspective: The "*Blair-McGill Newsletter*" reported on a 1995 dental survey, stating that '95 was a very good year for dentistry. There was an increase in profitability and reduced overhead in every segment except orthodontics. In our specialty, there was reduced profitability and an increased overhead. While all segments of dentistry struggle to regain the profitability of the mid '80s, orthodontics has yet to realize the significance of controlling upward spiraling costs.

20. Ensure Consistent Quality Results - Exceed Expectations

Without a doubt, the biggest problem with any attempt to organize and focus resources by Management Service Organizations and Orthodontic Alliance Groups is to maintain quality. Those who are against these approaches maintain that the only defender of quality is the traditional fee-for-service practice. It is difficult to defend quality in the face of declining fees. **I do not espouse lowering fees without maintaining profitability.** I believe we can be more efficient, predictable and cost effective in our approaches. **Quality can be maintained using one simple yardstick. Every case that is started and finished by any orthodontist in these organizations is subject to peer review**. I don't mean a random or periodic audit. I mean every case. That is one of the advantages of technology.

Perspective: I have always been intrigued by the system that we use to define the quality of the orthodontic practitioner. A good example is the ABO clinical evaluation. This prestigious organization asks us to show ten of our very best cases for peer review by. **This is evaluation by exception - the heroism approach.** It basically says, "If you can treat ten cases perfectly, surely you must achieve good results in the other ten thousand." Not necessarily so. A much better barometer would be to show the results of 100 consecutively- treated cases. It is somewhat mendacious to show nothing but excellent results. The cynic in me would say that if you cannot find ten good cases out of several thousand treated, something is wrong. I think that in the past there would be difficulty in showing consecutively-treated cases due to the sheer mountain of data that this process would warrant. But this is changing and can be solved using digital cameras and data base technology. We now have the capacity to organize and transmit data anywhere in the world in a matter of seconds. Proper peer review systems should not intimidate. They should not be judgmental. They should enlighten and put a proper focus on the creation of quality.

It is now possible and relatively simple to digitally record the results of every case treated and place it into a database within a circumscribed system (using on-line and Internet services). When you show consecutive cases, you show what you do on an everyday basis. We are trained to be superbly consistent competitors. We are not trained to be superbly consistent performers. We can be better at jumping through hoops than levitating in them. **That is where peer review has a niche. In order to ensure quality, you can't take an occasional glimpse; you need to take a hard, consistent and objective look.**

21. Engage

Perspective: One scene from a movie that always appealed to me was in *Top Gun* . Remember when Maverick lost his best buddy, lost his girlfriend, lost his confidence, lost his will to fight, lost his concentration and was asked to fly as wingman on a dangerous mission? When everyone (except the audience, of course; after all, this is Tom Cruise) thought he was going to cop out, one of his commanders yelled, **"Engage, Maverick, engage."** Of course he snapped out of it and won the day. This dramatic example says to me, "When you are most under siege, when things look the bleakest, when your future is on the line-that is the time to engage." It is an attitude, and although we may feel like we have little control over outside forces that influence our profession, we do have control over our attitude, and it is the single most important factor in initiating real change. Engagement in a manner that most presents your true position and perceptions is imperative. Your attitude determines your attitude.

The last, and perhaps most important, thing we must do is **engage the problems.** Strong reasons make strong actions. As I stated before, I am not against differing opinions that result in a productive dialogue. That is exactly what we should be doing. However, indifference on this issue will take us nowhere. Orthodontists need to reject the emotional finger-pointing that ignores the realities of our circumstance. I believe we must have more focus on "winning" and less on "not losing." Not losing can cause a bankruptcy of the spirit for us and those we serve

Conclusion

In short, I'm concerned about the future of orthodontics in this country. However, I must admit that I like the dialog that is going on. It shows we are paying attention. I don't care what position you take as long as you take one. Don't just be upset, be upset and do something about it. Idealism is good, but it is best when linked with a healthy dose of reality. Fighting for fee-for-service without fighting for free enterprise is a ruse. Fee-for-service can only survive in mainstream orthodontics if it competes successfully in a true market climate. HMOs will continue to be an important part of medicine. **HMOs will not work long-term in either dentistry or orthodontics. I have no question in my mind about that.** They will, however, create a lot of temporary turmoil. This turmoil will promote insecurity and indecision. **I have a sense that the tide has already turned in our direction.** We usually get most upset and apprehensive when a strategic inflection is at the height of the curve. For many reasons, the economic model of a dental HMO is flawed. HMOs will be used by young dentists as a means to gain a foothold in a startup practice and by mature practices where economic realities are fuzzy. **That does not mean there won't be major changes in orthodontics, there will be.** Perhaps they will be driven and fueled by this anxiety. We need to begin to deal with economic and treatment issues in

orthodontics in new and different ways -- ways that have not been clear to us in the past. These approaches will undoubtedly be innovative and unquestionably controversial. They will not be in the vertical plane where we are comfortable but will be in the horizontal plane where change is nebulous and uncomfortable. Orthodontics is not in bad shape. Not at all. It just needs a good reality check. I have a good feeling about the future of orthodontics but it is tempered by the vision of what we must do to recapture the sense of equilibrium we've had in the past. **For every crossroads of the future, there are a thousand self-appointed guardians of the past. We are at that crossroads.**

Addendum
On the Future of Orthodontics
Effect of Fee on Net Profit-Grummons

Assuming an anticipated profit of 25% on selling price, a 2% cut in that selling price means you must increase your volume of sales by 8.7% to make the same profit obtained before the price was lowered.

2% cut means a 8.7% increase in sales is necessary

3% cut means a 13.6% increase in sales is necessary.

5% cut means a 25% increase in sales is necessary.

7.5% cut means a 42.8% increase in sales is necessary.

10% cut means a 67% increase in sales is necessary.

15% cut means a 150% increase in sales is necessary.

20% cut means a 400% increase in sales is necessary.

3% increase means the same profit on 90% of sales volume.

5% increase means the same profit on 83.5% of sales volume.

7.5% increase means the same profit on 77% of sales volume.

10% increase means the same profit on 71.5% of sales volume.

15% increase means the same profit on 62.5% of sales volume.

20% increase means the same profit on 55.5% of sales volume.

If your fees are moderate or average in your practice, you can't afford to cut them because the amount of production that's needed to break even is astronomical.