Ep #5: Integrating New Procedures into Your Practice

Full Episode Transcript

With Your Host

Dr. Tarun Agarwal

T-Bone Speaks with Dr. Tarun Agarwal

Ep #5: Integrating New Procedures into Your Practice

Welcome to *T-Bone Speaks* with Dr. Tarun Agarwal where our goal is to change the way you practice dentistry by helping you achieve clinical, financial, and personal balance. Now, here's your host, T-Bone.

T-Bone: All right, welcome back to another episode of *T-Bone Speaks*. I'm T-Bone and I'm here with…

Chuck: Hey, it's Chuck.

T-Bone: Chuck, it's been a little bit of time. I feel bad that we've missed a few episodes here. I feel like we're slacking off.

Chuck: This was my biggest concern when we started this. It is hard to stay on top of this. Let's tell everybody why we had to take a little bit of a break. What happened there?

T-Bone: Well, I went on vacation. Then you went on vacation. I think you went on vacation first. Then I went on vacation. Then my practice got in the way. Your territory got in the way. Then I couldn't do lunchtime anymore because it didn't work for you and me both. Then we tried an evening and we stayed here until 9:00 at night one night and then our wives got mad at us. Then the next thing you know we tried to Skype and I fell asleep while we were recording.

Chuck: That was a disaster.

T-Bone: It was a disaster. So obviously that episode never made it up.

Chuck: It was hard to take you serious when I could see you sitting on your couch with your snuggle. What do you call that thing? A snuggly you had on?

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T-Bone: It's a blanket, dude.

Chuck: Well you had that thing pulled up super tight. The other thing, we ran into some editing issues.

T-Bone: Yes. To make my life easier I hired a virtual assistant that flaked on me. Oh, god.

Chuck: That's a concept I don't quite understand. What is truly a virtual assistant? Is that a person? Talk to me about that.

T-Bone: I think it's a person. It could be a robot for all I know. But the one I had hired was a lady out of Brazil who I would upload using Dropbox, I would send her our episodes. She was in charge of editing it to bleep out my curse words.

Chuck: Right.

T-Bone: And make the sound a little bit better and also write some show notes and stuff for us. She promised me she'd get the first one done in the first week. Four weeks later, I still haven't heard back from her now.

Chuck: So moving forward, our goal is to have one a week, about 30 minutes. So this week we'll upload this one Monday, right? Yeah, Mondays.

T-Bone: So I have a quick question before we get started, Chuck. Are you on Facebook yet?

Chuck: No. I'm still not there.

T-Bone: So we're two months in and you're not on Facebook yet.

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Chuck: I feel like it's phasing out and I'm just trying to wait that out right now for the next big thing.

T-Bone: Okay.

Chuck: What's your thought there?

T-Bone: Well, there probably is a next big thing but by the time that comes around you will have more grey hair than you have now.

Chuck: I was happy to have grey hair. I've moved on to white hair. One thing, you're talking about being busy and it getting in the way. That's just one more thing for me right now. We're trying to find time to get this podcast in and if I had Facebook—I'm just giving you an excuse. Just give me time. I'll be there.

T-Bone: Right, you know I'm going to keep asking you and making fun of you.

Chuck: So what's on your mind tonight? Our whiteboard is full of stuff. Gosh, there's been—have you had many questions and things people have been asking you about as of late?

T-Bone: We have, but I don't want to kind of get into those tonight.

Chuck: Okay.

T-Bone: I want to encourage everybody to continue to submit questions, info@3D-dentists.com or visit www.TBoneSpeaks.com. You can submit your questions.

But today, I want to talk about something that's probably pretty close to me right now. That is integrating new procedures into your practice. Kind of how that looks and

how that works and ultimately my thoughts on that. When I say new procedures, I'm talking about going beyond general dentistry. You know I'm a big proponent of practices going beyond general dentistry. I mean, if you think about it, if you were to be honest with yourself and say, "Hey, if my patient walks into my practice today, what are they going to get?"

It's one of essentially five things, right? You're going to get a filling, a direct restoration, a crown or an indirect restoration, you might get a root canal. You might get some oral surgery to have a tooth taken out. That's pretty much it, right?

Chuck: That pretty much covers the mix.

T-Bone: So your patients are going to get one of four things essentially. Oh, they'll get an exam. So, one of five things or a cleaning. I'm a big proponent that we've got to go beyond that. We have to absolutely go beyond that.

Chuck: When you say that, why is that? Why do we need to go beyond that? If you have a great practice, you're really efficient, a couple units, a crown, a bridge a day and you have a decent perio program.

T-Bone: If you're 70 that's okay.

Chuck: Okay.

T-Bone: Because you won't live long enough to see the change necessarily.

Chuck: I see a lot of successful people in their own minds and they're content with that.

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T-Bone: So yeah, that's a good point, Chuck. Listen, I don't want to tell anybody that they're not successful in not going beyond general dentistry. But ultimately, I believe that it boils down to three things. We either need more money, we need more time, or we need more professional satisfaction, okay?

If you don't get up and love what you do and love going to work, you need more money. You need more time. Or you need more professional satisfaction. I get zero professional satisfaction from MODing a patient or buccal pitting a patient. Zero satisfaction from that. In fact, I had to do two composites today that ruined my day quite honestly.

Chuck: I see that often too. I kind of tee that up because I see a lot of burnout. We're going to talk about burnout in another episode but I do see a lot of young dentists. When I say young dentists, you know 43, 44 years old, you know managed care and PPOs have made it difficult. We've talked about increased overhead and decreased fees along the way and it's really creating a high rate of burnout. So I think folks, to your point, they're having to work 30 percent harder to make the same income. Does that play into the factor for you a little bit?

T-Bone: Of course. The other thing is also that I believe general dentistry has a ceiling. In other words, with a root canal, you can only charge so much. With a filling, a direct restoration, you can only charge so much. Certainly if you're like me, in the PPO environment, you can only charge so much. If you want to do more or make more, you just have to do more of that. To me, it's counterintuitive. Why would I want to take an eight-hour

day and double my patient load to make more money? I mean it doesn't make any logical sense to me.

So to me, what I'd prefer to do is add a procedure that raises the ceiling of what my production can be on a per-patient or per-hourly basis. That to me is why we need to go beyond general dentistry and also because it's satisfying. You can help someone. You can change their life. You can make your life easier. You can extend your career. I think we take that for granted. I certainly, I took that for granted. Not that I'm old yet, I turn 40 this year.

But I can see the difference. I'm not the same person I was when I was 25. I don't have the patience. I don't have the physical presence for that. I don't have the mental aspects for that. So I'm different. And what I'm looking for professionally is very different right now. Listen, I was just happy to find a patient who let me do two crowns on them when I was 25. Now, and I say this, with some level of honesty is that if I have a patient with just two crowns I'm like, "Well, okay." Not that I don't like it. Not that I don't want to do it. Not that I'm not financially helped by that. But it doesn't really do anything for me professionally.

Chuck: When you're choosing a new procedure, you know, we've got a lot of different things you guys are doing here. With me, as a Patterson rep, I have checklists I have to go through. I have four things that are very important to me when I'm helping a client. First thing is, it has to benefit the patient first. It has to be ultra conservative to the patient first. Third, it has to help the doctor. If it helps the doctor, patient first, doctor third. Secondly, is Patterson. The very last thing is Patterson, and then myself, right? So I have this whole checklist.

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So when you're choosing a new procedure like I know you've integrated several things over the last couple years. What's your thought process there? Is it what's hot, a trend, or it is something…?

T-Bone: A lot of it's driven by trends certainly. I've always been very fortunate that I've been on the leading edge of the trends of procedures. In the early 2000s, when I started my practice I was into the cosmetic dentistry thing and that was kind of hitting its stride then. Then we certainly saw that change.

Then in the early 2010s I was hitting my implant stride and we've seen that change. Now in the 2015-2016, we're starting to hit our sleep apnea, TMD, medical billing, we're hitting into that stride. We'll see that pick up in the next two to three years then that will have its lifespan of eight to ten years and something else will come about. So certainly that's part of it.

Also, I think everything has a certain life story to it. We've gotten into sleep apnea much more because of my personal—I mean I post pictures all the time of me sleeping. I've got my own hashtag #TBoneSleeps. So it's a personal story for me, right? We're getting more into TMD because a good friend of ours and a couple of teammates of ours are suffering from TMD issues and we're able to help them and you see the difference it can make and all of that, so those are kind of personal issues.

It certainly does help that it is financially rewarding and it also helps that it allows me to slow down. I set a goal for myself. My goal for 2017—I mean, think about this. My

goal in 2015 was set for 2017. My goal was in 2017 I want to stop doing fillings.

Chuck: Right.

T-Bone: So I said to myself, how much production did I have in 2015 from fillings? I said if I want to stop doing fillings I either have to take a pay cut or I have to replace that production. I chose to replace that production because I'm not in a position to want to or be able to take a pay cut. So I looked at it and I said, "Well what can I replace it with?" For me, it's sleep apnea and now we're starting our TMD journey because sleep apnea and TMD certainly go hand in hand together.

So what I'd like to do is let's talk about my thought process, Chuck. Ask me some questions. Let's go through it and let's figure it out. So let's set the story. Let me set the story, okay?

Chuck: Sure.

T-Bone: So, hey, you know, I peaked clinically in my practice. I'm doing my five services and I finally decided that it's time to add the sixth service, something that goes beyond general dentistry. Things like for example sedation. Things like for example tissue surgery, grafting. Things like for example even bone grafting. Things that are new to us in that sense. Things like TMD treatment. Things like sleep apnea. Things like medical billing. Things like dental implants. Things like complex dental implants.

Maybe now you've been doing singles, onesies, twosies, and now you're ready to step into the removable implant game or the fixed hybrid implant game. So those are the

things—I'm not talking about adding a new technique for root canals. I'm not talking about adding a new bonding agent. I'm talking about something that legitimately is a new procedure to your practice and to your patients.

Chuck: Let's back up one quick thing. When you say, "I'm replacing fillings." Okay, we bring that up a lot. When you say, "I'm replacing fillings," let's be very clear. You're still doing those. Your practice is…

T-Bone: My practice is still doing them.

Chuck: Okay. So most of the time your associate—and I know your associate very well.

T-Bone: My associate/partner. We don't call him an associate, he's a partner. Partner/associate at our practice.

Chuck: Talk to us real quick about that, associate/partner.

T-Bone: Yeah, because I'm trying to cultivate that partnership mentality, that you're an owner. That when I'm not here, you lead the team meetings. You lead the morning huddle. You know, you own your success. When I'm talking to other patients, when you say "my associate" it connotates somebody that's underneath you, right? When you say "my partner," that connotates somebody that's part of you, right?

My patients, I saw that my patients were more receptive to me maître d'ing them to my associate, quote/unquote an associate, when I refer to him as my associate/partner in the practice. That word partner, it sent a different message to our patients.

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Chuck: Okay. One of the things so often I see a lot of side bars, I have a lot of side bars with different team members from different offices. Doctors come back, they've taken just a small CE. Maybe it's on something like sleep apnea or maybe it's on something like TMD.

I've seen some really interesting devices people have bought along the way and I'll have team members pull me aside, "Do you really think this is going to work? Do you really really see us drawing blood here and making our own membranes? Or do you think this is just going to pass? I mean, what is he thinking?" Or, "What is she thinking?"

I'm like, "Look, this is really neat. I've seen a couple people doing it." So it's important, a lot of your team members across the board talk to the reps about that.

T-Bone: Are my team members asking you asking questions? Because I want to fire them if they are.

Chuck: I think your team, they're not surprised by anything anymore. So they don't know from week to week what's going to happen.

T-Bone: By the way, I want to apologize to our listeners. I have a little bit of an allergy, cold, something, a man flu. I like to call it the man flu. So let's talk about that.

Chuck: So that's buy-in, right? Let's talk about, that's buy-in.

T-Bone: Well, that's part of it. I mean I think buy-in is not just… [police sirens in background] I think they're coming to get you, Chuck. The police are here to get you, okay?

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I hear it too much that people are not successful with something and they totally give up and they don't look to that procedure anymore. So what I always say is I don't think that that something doesn't work. Like I'll give you the number one thing I hear, okay? And probably the same thing with you because I know you're out talking about it these days is, "Oh, I've tried medical billing and it just doesn't work."

Chuck: Right.

T-Bone: Right? And it couldn't be further from the truth. I wouldn't use the word it "just" doesn't work. Sometimes it doesn't work but I would say that we haven't set ourselves up for success and that's really what this is really about for me. It's about setting ourselves up for success.

Chuck: What will happen often when I hear that, this falls in right into everything. I always ask, "Why doesn't medical billing work?" This is just an example, "Well we had a patient come in," and it's usually a teenager who's been hit with a baseball bat or hit with a baseball and we all know that's trauma. We know that should be billed as medical.

We know that in most cases, most had four to six root canals due to that. Over time, we've usually done a CBVT and then they ultimately have to have all those teeth crowned. So everyone says, "Well let's bill this through your medical." Most of the people tell me, "I've never done this before."

T-Bone: Well how do you expect to be successful if you've never done it before?

Chuck: Exactly.

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T-Bone: I mean it's like the stupidest thing I've ever heard, Chuck. Look, I'm writing an article right now talking about are you a professional. To me, my good friend Samir used to always say, "If you're going to be a bear, be a grizzly bear." So you can't dabble in things. You can't dabble in TMD. You can't dabble in sleep. You can't dabble in medical insurance. You can't dabble in gingival grafting. You can't dabble in these things, right? You've got to be committed and you've got to make it happen.

Because I know we only have 14 more minutes and we promised them we're going to get to something, okay? So I think the first thing that I did, let me go back to the first new thing I introduced to my practice. I think this was 2004. I was one of the five things—actually back then all I did was direct restoration, indirect restorations. I didn't even do root canals and extractions and things then.

The first thing I introduced to our practice that was new was sedation. So we did oral sedation and I was scared out of my mind to try it. I figured my patient would die. I'm like, "Okay, what if I have to go do a hygiene check?" You know, all these things cross your mind. Or you know, what's going to happen?

So it was then that—I don't know if it was by accident or if somebody else told me—I said, "Why don't I just have a sedation day?" For me, my sedation days, back in 2004, 2005, I was working four days a week. So my sedation day was Friday. I chose one Friday per month and that was a sedation day. That way mentally we were prepared for that to be sedation day. We had no hygienists there so I could focus totally on the sedation. We had nothing else going on. We could totally focus on workflow,

understanding the sedation, getting the care done, and all of those things.

What happened was we had four months of one sedation day per month. The next thing you know, suddenly it showed up on another day in the schedule and it went like clockwork.

Chuck: I hear that often. If you want build the ideal practice, start with the ideal day first. Schedule that one day a month and then once you start booking out one day a month, then let's work for two. So you're telling me so when we're integrating a new procedure, you're like, "Pick one day and let's make this that procedure day."

T-Bone: Right and you know, even if it's ortho for example, right? Whatever it may be, when you get right in to start, because you don't know what you're doing yet. You may have been to the classes but you haven't really done it. It's like an orchestra at the end of the day. It's a bunch of instruments working together.

There's front office people. Are they getting the consents? Are they getting the ride home? Are they finding out where the patient's ride is going to be? The assistant, are they monitoring them? Are they going on? Are they drinking? Whatever is going on, right? How are we going to take them out the door? How are we going to get them into the car? How are we going to follow up with them? Me, the dentistry. How I'm administrating medication and doing dentistry?

There's so many things going on with the various procedures that we don't need any distractions at the

beginning. So we did a few days a month, one day a month for a few months. Then we knew what we were doing. We were comfortable with what we were doing. We weren't experts certainly but we were comfortable with the flow. We knew, everybody knew, our front office people knew, my back office people knew, I knew what was going on. We were ready to take it to, "Okay, this can be an everyday procedure within our practice."

Chuck: So when we're doing that, I know we're talking about sedation, we're talking about potential bone grafting and implants and this is probably a little bit of a loaded question, would you say setting the room up, getting the patient ready, would you say it usually takes about six or seven, eight, nine, ten times before you feel like you're in a little bit of a rhythm with a new procedure particularly?

T-Bone: Yeah, I would say maybe even more than that because certainly some procedures have a lot more things going on with them. Like implants for example, there could be bone graft, there could be extractions, there could be membranes, there could be blood drawn, there could be so many different things. I would say that it takes probably, my experience has been 10 to 15 times before I'm really comfortable with making that, "Hey, I can do that in a normal day with hygienists."

I base everything on: can I do it with hygienists? Because I've got to get up once or twice per hour to check hygiene. So can I integrate this procedure during that time period?

Chuck: You were talking about checking hygiene. That is a whole podcast within itself. I don't know what it is here lately and maybe it is because the folks that you and I work closely

with are doing some very big complicated procedures and I'm starting to see a bottleneck there. So staying on task here, do you believe your first few that you should discount? Dentists seem to really like to discount really quick? What's your thought on that?

T-Bone: I think this is part two of things we want to talk about there, is one, I think we should have realistic goals, okay? So like how many times, Chuck, have you talked to one of your clients who, for example, go to a sleep seminar and they come back all gung ho, "I'm going to make my practice a sleep practice."

Chuck: Right.

T-Bone: No offense, but I mean that's unreasonable. I mean, it's unrealistic. That's pie in the sky dreaming. Listen, I want people to dream and I want them to dream big but we've got to be realistic, right?

Chuck: Well it can't be reckless at the same time. You've got to remember what got you where you are and what feeds this monster as well.

T-Bone: Yeah, so for me, I set realistic goals. So for example, with sedation I wanted two sedations one Friday per month. When I started implants, I wanted two implants per month. When we started sleep appliances, I just wanted to do two sleep appliances per month. So I set a realistic goal that I could achieve and that I could easily measure.

So when we hit two a month it was like, "Okay, great. We're hitting our goal." Then once I consistently achieved that goal, then we have to up the goal. Then we have to go from two a month to four a month. Then we have to go

from four a month to six a month or whatever it may be. So you have to have realistic goals. Now, part of getting realistic goals is also spreading the word, right?

So to me, you've got to get some evangelists. You've got to get some patients out there that will spread the word and you also have to get your ducks in a row. So I remember specifically with dental implants, I said to my team, and again, we need to get into the team part of this, is I said to my team, "I'm committed to doing ten implants at $1500 start to finish, including the restoration. And I need you to find me ten implants and we have four months" whatever the number is to get that done.

So what it did was one, I didn't have this feeling that why would a patient pay me full price for me to fumble around and experiment. Not experiment like I don't know what I'm doing but at least experiment on how does an impression coping fit? How does a digital impression coping fit? How do I take a digital impression? Stuff like that, right?

Then it also allowed me to get ten patients that would go out there and talk in my community. So you set a goal and I budgeted that. I budgeted, "Hey I want to do ten." Number one, I wasn't doing any of them anyway, right? And $1,500 covered my costs, certainly my material costs of doing that. And it allowed me to get, again, experience in that procedure.

Chuck: Something that's really important to understand is that when you pull out those numbers, that's not a pie in the sky number. There's math behind all of these procedures. We know in a million-dollar practice, a million-dollar general practice yields about 35 implants, 20 of which

most GPs feel comfortable doing, 15 of which they may need to refer out. We know that one in 15 patients have already been diagnosed with sleep apnea, am I correct?

T-Bone: Sleep apnea, diagnosed and undiagnosed.

Chuck: So we know those numbers are there so realistically, we know how many through the course of months, so when you're setting those goals and you're taking your courses or you're doing your research, try to understand that you're not just pulling this number out of the air, you already know what the math is. We know that…

T-Bone: Well, it's realistic to expect to do one of something.

Chuck: That's correct.

T-Bone: I mean, why would you learn something—I didn't mean to interrupt—by why would you learn something to not even be able to do one of it or two of it, right?

Chuck: Well I'll tell you a great story I heard just last week from a good friend of ours, Dr. Folden Lee, and something he said, he said, "Look," he was talking to his associate. His associate had brought up, "You do a lot of implants." He's only been out of school about a year, very sharp guy.

He's like, "How is it you do so many?" In their team huddle, you know what he asked everyone, he said, "How many people did you see wearing a red shirt today?" And no one—everyone went and said, "None." He said, "Tomorrow, tell me how many people you saw wearing a red shirt." His point to that was, when you're looking for things, you see things differently.

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T-Bone: Well, it's about awareness, right? You make people aware of a red shirt. It's like how many Mercedes did you see driving here?

Chuck: Just your wife's.

[Laughter]

T-Bone: It wasn't here today, okay? But when my kid's in the car I say, "Let's play the Mercedes game" or "Let's play the Honda game or the Toyota game." Then it's amazing how many of those things you see.

Chuck: The other thing with your team, this is something that has really worked great here. When you guys were integrating implants here, the biggest thing I think has been a great secret here is you guys have a consolidated fee schedule. No matter what it is, your team knows—from the person who answers the phone to your hygienist to your assistant—everyone knows the fee for an anterior implant and a posterior implant.

T-Bone: Yes. You know, and I would say that when you're introducing a new procedure in the beginning certainly I'm an advocate of making it a discounted fee, I call it an educational case, is how I sell it to the patient. I say, "Listen, I want to write an…" I mean, sometimes it's a fib, okay? "I want to write an article about your case. It's a great case. I want to take some pictures. Document it. In exchange for that extra time and allowing us to utilize that, we're going to give you an educational discount on the case."

But we brought our team into that fee process. So like we know in our office a posterior implant is $3,500 start to

finish, includes the guide, includes the abutment, whatever type of abutment it is. It includes grafting at the time of placement and we know that an anterior implant is $4,000 from start to finish, includes all those things plus a provisional. Then everybody knows that.

Same thing with our sleep appliances. We know in our office a sleep appliance is $2,595, all in. That includes everything. That includes all the adjustments. Includes the titrations. All of those things to make sure that it's correct. I think that is also part of getting acceptance to these new procedures is making it easy. Making it easy for the team to talk about it. Making it so it's not just about making it easy, Chuck. It's about making it just roll off the tongue.

Chuck: Just less confusion, right?

T-Bone: Well it's about rolling off the tongue, okay? If I asked you how much impression material was, it would probably roll off your tongue, right?

Chuck: Right.

T-Bone: Okay and when it rolls off your tongue, what message does it send to me?

Chuck: It's simplified.

T-Bone: Well you know what you're talking about, right?

Chuck: Right.

T-Bone: It's simplified. You know what you're talking about. You've done it before. If somebody asks me how much something cost and I have to say, "Well let me figure it

out." The first thing I'd be like, "Have you ever done any of these? Do you not know what things cost?" So I think things should just roll off your tongue, whatever the fee is. Whether it's $10, $100, or $50,000. The number should roll off your tongue because it sends a message subliminally to your patients.

Chuck: I'll tell you, on that note, I've watched a lot of dentists over the years who do a lot of implants, who do maybe even a lot of cosmetic cases, a lot of veneers. The dentists who do a lot of the big procedures, you know one thing I've really noticed, specifically with implants, you know what their secret is? And they will all tell you this, they keep it simple.

It seems like there's about a $2,500 threshold with dentists. When you hit that threshold, you feel like you're having to justify because you feel guilty what you're about to charge. So you got to start talking and you start talking and you start talking and guess what happens? The patient is overwhelmed. We're going from a simple implant to somebody thinking they're getting a hip replacement.

That's something I heard somebody say a long time ago about implants, "Let people know, this procedure, it's going to take me about 25 to 30 minutes. I feel a little bad that I've got to charge you $3,500 but understand I've had a lot of training to do this. The parts and pieces cost a lot. The exam costs a lot. The CT costs a lot. But the procedure is really easy, you're probably going to take a couple Advil the way I do it."

So when you simplify things, patients aren't as overwhelmed. Then it's going to be quick and easy. Most of the time it's going to be painless.

T-Bone: It's about confidence, right?

Chuck: Absolute confidence.

T-Bone: At the end of the day, it's that confidence. I think people buy confidence and patients buy confidence. I mean if I needed brain surgery, god forbid I hope I don't, do I want the guy that says, "Well, it might work. It might not work." Or do I want the guy saying, "Hey, I've done this before. We've gotten great results. I think we're going to get a great result here."

Chuck: Yeah. Or how about this, "During the surgery, did you know that you're going to be awake the whole time? We're going to talk. It's really actually kind of cool. I get to talk to you during my procedure."

One of the things too, this comes up very, very often, especially with the implant world. A lot of general dentists will jump in, they'll get eight or nine or ten under their belt in the first six months and then guess what we have? Two or three failures. At what point when you're enrolling somebody and you're jumping into new procedures and you're integrating new procedures, things just go wrong because of you. Because you don't know what you're doing or you're uncomfortable. At what point do you see people giving up or shouldn't you give up?

T-Bone: I see people give up too early.

Chuck: Too early.

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T-Bone: Yeah. Failure is a part of life. I don't care what procedure you do, there's failures. Now all you can do in my mind is did you do a good job? Did you follow typical protocol? Did you give it your best effort? Did you do everything you possibly could do? With implants, you have failures. And it's unbelievable to me, they come in rashes. We'll have a month we're I have like five failures and then we'll go six months without any, right?

That month that I had five failures, it will totally eat me up inside. Totally eat me up inside. Then we'll go six months without it. It's unbelievable if you step back and take a look, what's different? Well maybe I didn't change out the drills. Maybe it's time to get new, sharper drills. Maybe our saline bags were bad. Or maybe it was a bad batch of saline. Maybe it was, you know what, maybe I wasn't irrigating enough. You know, any number of things if you retrospectively take a look at it.

The other thing I want to talk about, Chuck, is how do you get your team involved in new procedures? I think the biggest mistake I see, the biggest mistake by far when it comes to team members and new procedures is you don't bring them to the CE. You've got to bring them to the CE. You've got to get them engaged. You've got to delegate to them. You've got to give them the opportunity to have ownership.

Who better than to have somebody who has ownership of that department within your store? Within your practice? It's not like if you go to let's say Target, for example. There's somebody in charge of the electronics department, right?

Chuck: Right.

T-Bone: That person ultimately is responsible for that. So in my practice, I look at it that way. For example, in my practice Devon is in charge of our sleep department. That doesn't mean Devon is the only one that can do sleep but Devon is in charge of the sleep department. She owns that.

Chuck: And she loves it.

T-Bone: She does. And she wasn't doing that before. Liz is in charge our implant department. She owns that. That doesn't mean she's the only one that does implants but she owns that. She knows when I go to implant CE, she goes with me. When we have meetings with our implant reps, she goes with me. When the implant rep comes in, she's right there with me, you know? She owns that. She's a part of my department of that part of our practice.

It changes the mindset. I've seen—it's funny, I've seen tremendous growth in our team members. When I see growth in our team members, I see growth in our practice. I see growth in their relationship with the patients and I see patients proud of our team members. What that makes them is proud of me. They're like honored that I would care so much.

For example, we have a medical biller at our office, like dedicated person to medical billing and she owns that department. So when we go to medical billing education, she's there. When we have a conference with a company about a new product, she's there to ask them, "What are the codes? How does this work? What is the insurance

reimbursement?" Because those are the things that are important to her.

You know, she came to me, and you know, she's been here about nine months now. We sat down. Well actually almost a year now. We sat down and talked a few months back, about the nine month mark. I said, "XYZ, well how do you like it here?" She said, "This is the first place where my employer has ever asked me what it is that I want to do. How can you be a better part of our team? Where can I help you grow to? What is your ultimate goal?"

Because I think if you don't answer those questions for your team members, they'll leave and you'll be stuck with a mediocre team for the rest of your life.

Chuck: Listen, team is important. That is something I've noticed a lot in the last ten years is there are a lot of folks who are content just doing those few things and who don't want to grow.

T-Bone: And that's okay.

Chuck: But be careful and don't let those folks hold you back from growing, okay? So first of all, when you have team members who really aren't on board with something you're passionate about, let's try to do everything we can to maintain them, coach them up. If they just aren't quite getting it, let's maybe reassign them to another role first but it's important with your team, and listen, it doesn't happen overnight. But it's important to empower your team. It's important to have a team that wants to get better.

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T-Bone: Yeah. Chuck, we've got a few more minutes here and I want to kind of button this up a little bit. I really enjoyed talking about this. I want to kind of button it up. So too often I think what happens is we go into something with ill-defined goals and unrealistic expectations. How many of your customers have said, "I want to build my practice as an implant practice?" How many of them have said that?

Chuck: I don't have anyone who specifically wants to do just implant, but I will tell you 50 percent want implants to be a large part of what they do.

T-Bone: Okay, so a large part. Define large part.

Chuck: A large part is about 25 percent.

T-Bone: Okay, define 25 percent.

Chuck: I want to come in every day and at least have an implant, if not one a day, one every other day.

T-Bone: So your doctors can define that they want one every other day. So to me, one every other day means you want to do 90 implants a year.

Chuck: That's correct.

T-Bone: Okay, so they define that.

Chuck: That's correct.

T-Bone: Then they work backwards. When do they want to get to that? Today? Tomorrow? One year from now? Five years from now?

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Chuck: You know, what I hear often is, “I want to get to that point.”

T-Bone: When is that point?

Chuck: Exactly. So I don’t see a lot of timelines. I’m just impressed that they're trying to dial in their dream day. If I can have an implant in the morning, at least once or twice a week, that’s a monumental task to have. At least we’re thinking that way, and that’s important.

T-Bone: Yes. So ultimately they’ve got to pick, you know, when do you want to get there? Because you can't work toward something if you don’t know the goal and if you don’t know the endpoint and you can't expect unbelievable greatness in a second.

The other thing that I see is, I see people that don’t map out their CE. So let’s go back to this implant example for example. If I want to get to 90 implants a year, can I legitimately do that doing single units, molars, without any grafting?

Chuck: Absolutely not.

T-Bone: Right, you can’t. Right? So if you want to get to 90 a year, what does it take? What does it look like? What does it take to get to 90 a year? What’s the breakdown? See the problem is if you don’t think these things through, you’ll never ever get to 90 a year. So to me, 90 a year looks like, okay, I’ll probably do probably 30 to 40, let’s call it 30 posterior implants without grafting. That will probably look like 20 to 30 immediate placement implants. That will probably look like 10 moderate grafting implants. And that will probably look like two or three fixed hybrid implants.

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Chuck: And a few sinus bumps.

T-Bone: Okay, right, that's part of the grafting there. So I mapped out what it looks like to get to 90 implants. Now how many of your customers, and I'm not trying to say—but how many of them have laid their path to get there? Or are they just hoping and praying that they're going to get there?

Chuck: I think with the majority of folks that are probably listening who are general dentists who are placing implants, I think most would probably fall into the category of 25 to 30 slam dunks that are guided.

T-Bone: Okay, so then how are you going to get one every other day?

Chuck: So the port to that is, do we jump into a Pikos course, right?

T-Bone: Whatever it may be, right?

Chuck: Whatever it takes.

T-Bone: You know, do you go to the Dominican? Do you go to Mexico? But you've got to map it out. See, the other problem is, and I'm learning this since we're in the education business, right? I'm learning this that you can't put a course on next month a month from now because people have mapped out their life.

If somebody had to take a day off from work a month from now, what do they have to do? They have to cancel their patients, their hygienist's patients, they have to make babysitting arrangements, or they've got to ask a spouse

or somebody, “Can I leave?” What does it look like? Do we have family obligations? There’s so much going on. So you have to map out the CE. CE isn’t free. In fact, good CE costs money. You’ve got to map out and budget that.

So I would say that too often people are mapping out where they want to go and they're not mapping it out because they don’t have an ultimate goal of what they want to do and they haven't taken that ultimate goal and backed out, what does it take to get to that goal? It’s not more patients necessarily, right? It’s the breakdown.

Like for example, I want to do five sleep appliances a month. Okay, I can do five from hygiene. Quite honestly, we can do five from hygiene. But what happens if I want to get to ten? Now that means I have to get into some more advanced cases, maybe people that have TMD and sleep. Maybe I have to deal with patients that are on CPAP and oral appliance. Maybe I have to deal with CPAP failures then.

So now I have to start going to the sleep labs and getting referrals. Maybe I need to work with a neurologist. Maybe I need to work with medical billing to make it more affordable for my patients. I can probably find one or two patients a month who are willing to pay $2,500 for an appliance but I can't find ten a month that will do. So then I've got to look at medical billing.

Mapping that CE is about not just the implant procedure or the sleep apnea procedure but the auxiliary procedures that go with that, the medical billing, the teamwork flow. All those things that are a part of that. The equipment, the

materials. Maybe I need better equipment. You know, I went to Hu-Friedy Instruments and Paradise, PDT instruments, to make my life easier, to have a rep that will put together cassettes for me and look at my kits and say, "This would be a better instrument." Instead of me having to walk through the show floor and figure it out, right? That's bringing those people in.

So really there's a lot that goes into it. I would say you've got to block a day, you've got to block for success, you've got to get a team member to own it, and you've got to have realistic goals that set the stage, and you've got to map your CE to achieve those goal realistically.

Chuck: And simplify billing like we've talked about. The money is always the hard part. Keep it simple.

T-Bone: Time for your money.

Chuck: Time for your money.

T-Bone: Your patient's number one question. Chuck, we have, like usual, gone over a little bit. I want to thank everybody for listening. Again, if you have any questions, please visit www.TBoneSpeaks.com.

On behalf of Facebook friend, T-Bone, and non-Facebook friend, Chuck, I want to thank you guys for listening and we look forward to seeing you on our next episode.

Thanks so much for listening to *T-Bone Speaks* with Dr. Tarun Agarwal. Remember to keep striving for excellence and we'll catch you on the next episode.