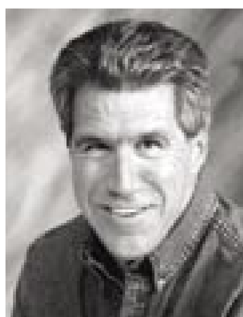
Advocacy and Case Acceptance



by Paul Homoly, D.D.S.

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It's the middle of what has been a tough week. On Monday you were slammed—emergency patients, broken temporaries, staff members out sick. Now, two days later you're sitting on your hands, fuming over a last-minute cancellation of a two-hour appointment that's left your whole afternoon a bust. Then, out of the blue, in walks Mrs. McCash, the lady with rings on every finger, to whom you presented a complete-care plan a year-and-a-half ago (she told you she needed to "think about it," then disappeared from your practice). Now in she walks, waving your treatment plan, and says, *"I'm ready now!"* and you think, *"Thank goodness!"*

Has this happened to you? I'm sure it has. Why do patients who've been gone for many months, sometimes years, come back to you when they're ready? They do because in some way they see you as their advocate—one who is on their side. Having a patient return to your practice after a long absence is not accidental or random. In fact, a patient returning to your office for complete care when they're ready can be a predictable event. Creating an advocacy relationship with the patient is at the heart of case acceptance for complex care, and a cornerstone in the leadership issues surrounding case acceptance.

ADVOCACY

The word *advocate* comes from the Latin *advocatus*, meaning "to call" as a witness or advisor. The modern meaning of the word outside the legal realm is "one who acts as a supporter or one who encourages." Think of advocacy as the experience patients have when they realize you're on their side. Another way of thinking about it is that when you and your team adopt an attitude of advocacy, it communicates to your patient that treatment acceptance is not a condition of your continuing good relationship, and that treatment can pro-

ceed when she's ready. It's easy to be a patient advocate when the person is ready for care; I hope to convince you that it's even more important to be one when the person is not.

A few years ago Dr. Phil Potter of San Clemente, California, and I were teaching together on the topic of case acceptance. Dr. Potter told the group of dentists, *"Be the patient's advocate, not adversary, when presenting care."* I really liked this distinction and since then the spirit of his statement has evolved into an important leadership dialog within the case acceptance process—the "Advocacy Dialog."

Structure

The Advocacy Dialog links what's going on in the patient's mouth to what's going on in the patient's life. This dialog typically occurs immediately after a complete examination, but can be delivered at any time during the initial appointment by the dentist or any team member.

To understand the Advocacy Dialog, you'll need to understand a few other concepts. The first concept is "fit." Fit is the suitability of complex dental care relative to the patient's life circumstance (budget, work schedule, family issues, current events, etc.). Complex treatment must fit into patients' lives.

Another concept integral to the Advocacy Dialog is "disability." Disability is how the patient's dental conditions affect his or her life (embarrassment, worry, lack of confidence, etc.).

The generic structure of the Advocacy Dialog looks like this:

"(Patient name), *I know you're concerned about* (fit issues) *and I also know that you're concerned about* (your disability). *At our next appointment we'll talk about your choices, but let's find the best way to fit fixing your teeth into what's going on in your life. Is now a good time to talk about that?"*

Notice that the Advocacy Dialog ends with a question: *"Is now a good time to talk about that?"* This question opens a conversation about how best to fit complex dental care into the fit issues of the patient's life. This is the conversation you want to have *before* you present your treatment plan your patient; you want the patient to go home and think about financial issues after the initial appointment, not the consultation appointment.

Addressing the Patient's "Inner Dialog"

Do you remember watching cartoons when you were a kid, and the character in the cartoon would have an angel on one shoulder and the devil on the other, whispering good and bad things in each ear? Well, patients are listening to "little voices," too. Patients walk into your office with their own inner dialogs going on. For example, your new patient Jack has two children starting college this fall. Jack's inner dialog is whispering in one ear: *"Two kids in college, two kids in college, two kids in college."* Whispering in his other ear is you: *"Golden proportion blahblahblah, centric relation blahblahblah."* Think about it: *"Two kids in college"* versus *"Centric relation… golden proportion."* The patient will have a hard time listening to you unless you address his or her inner voice first. The intention of the Advocacy Dialog is to reassure the patient that their issues of fit will be respected; this therefore addresses and soothes their inner dialogs.

Ultimately, the conversation that results from the Advocacy Dialog addresses the inner dialogs and answers the patient's questions:

- What is the "big picture" of my clinical needs?
- What is the ballpark fee and total time in treatment?
- How can I pay for it?
- How much will my insurance help?
- How much do this dentist and team care about me?

The Advocacy Dialog and the resultant conversation answer your questions:

- Is this patient interested in the overall treatment recommendations?
- Is this patient comfortable with the ballpark fees, time estimates, and financial/insurance arrangements?
- Is this patient ready for complete care now?

In the absence of the Advocacy Dialog, the above questions usually are answered only *after* you've presented the treatment at the consultation appointment. Often, the treatment plan is presented without regard to fit/readiness issues, ignoring whether the care is suitable for the patient at that time. Too often, after the patient learns the fee and other details, the dentist/treatment coordinator have to pick apart the dentistry and figure out which parts fit, which ones don't, or if anything fits at all. This process is highly stressful and embarrassing; creates anger; wastes time; devalues the relationships; and is regarded as the low point by most dentists, team members, and patients. To avoid this, use the Advocacy Dialog and get the fit/readiness issues out on

the table before you treatment plan and present care.

CASE STUDY: MICHELLE—THE ADVOCACY DIALOG

"Michelle," during her initial telephone call and preclinical interview, was very clear about her chief disability: embarrassment over the appearance of her front teeth and some discomfort on her right side. From your team's conversation with her, you learned many of Michelle's fit issues—she owns a busy art gallery, she's in the middle of a remodeling project, she's training new staff members, she wants to look gorgeous for a black-tie affair she's hosting in three months, and she's traveling a lot on business.

During the examination, you noted the clinical conditions (large discolored composites and open contacts) responsible for her disability. During the post-examination discussion, you introduce the Advocacy Dialog, personalizing it for Michelle:

"Michelle, I know you've got a lot going on at your gallery right now. You've got carpenters remodeling your gallery, you're in the middle of training new staff members, and you're on the road a lot. I also know that you're embarrassed about the appearance of your front teeth and aggravated by some pain on your right side. At our next appointment we'll talk about your choices, but let's find the best way to fit fixing your teeth into what's going on in your life. Is now a good time to talk about that?"

If you were Michelle, what would your most likely response be to, *"Is now a good time to talk about that?"* Her first nonclinical questions probably would be about the cost, length of treatment and number of appointments, and whether her insurance will help. Let's look at these issues and think through some best responses.

BEST RESPONSES

You already know the number one question most patients have about complete care—*"How much does it cost?"* In the context of the Advocacy Dialog, you want to give a ballpark estimate with approximately a $5,000 range, preferably on the high side (it's very helpful to have your treatment coordinator in with you and the patient at this time). Along with the ballpark fee estimate, give estimates of total time in care, number of appointments, and the most affordable payment options, all in the same answer.

"Michelle, I'd say a good ballpark estimate of your care would be 15 to 20 thousand dollars. A case like yours typically takes us about two months to complete with about six appointments. Many of our patients enjoy starting care with no initial payments, and then make payments over time. I'd estimate monthly payments for you to be about $500 a month. Is this comfortable for you?" (Note: Make the monthly payment options available through a patient financial services provider such as CareCredit or Dental Fee Plan.)

The question, *"Is this comfortable for you?"* starts the negotiation process you'd normally have following case presentation at the consultation appointment. The big difference here is that you haven't invested hours of time and work treatment planning and presenting the case. Once you've asked the question, just listen. Remember, the intention of the Advocacy Dialog is to reassure the patient that you'll find a way to fit her dentistry into her life. Maybe she's comfortable with the ballpark estimates and can go ahead with complete care. If so, set her consultation appointment and look forward to starting her case.

If she's not comfortable with the estimates, guide her through some good choices for implementing complete care: patient financing, segmented treatments plans, holding plans, alternative plans, or maybe no treatment at this time. (I realize that there is no formal treatment plan at this time. My assumption here is that you're able to base your estimates on a quick visualization of the scope of her treatment plan.)

Keep in mind your role here is one of an *advocate*, not a salesman. The big distinction between the two is that with an attitude of advocacy, the patient senses that her treatment acceptance is not a condition of your continuing good relationship. Help the patient find a way to fit her dentistry into her life—now or later, a little or a lot, all or none. Your attitude of advocacy (*"…let's find a way…"*) is what answers the patient's unasked question, *"How much do this dentist and team care about me?"*

Advocacy and the Advocacy Dialog are everyone's responsibility. If you and your team do this well, chances are excellent that you will demonstrate to your patients an incredible amount of leadership, empathy, and common sense. They'll sense that they're welcome in your practice regardless of their level of treatment acceptance. And as a result of this, patients will bond with you and—even if they've moved out of your area—often will travel many miles to return to your office for care.

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