

The Triple-Win Interdisciplinary Experience™

Improving Patient Quality of Care and Practice Productivity

How to improve interdisciplinary dentistry is an issue that dentists and specialists have struggled with for years. Many groups and organizations have attempted to create an effective methodology to advance patient care through an interdisciplinary process, with little success. Interdisciplinary treatment is an often complex and time-intensive process that requires a high level of communication between the dentist, specialist and patient. For this reason, creating a standardized approach has been extremely challenging for most doctors.

The Triple-Win Interdisciplinary Experience™ focuses on a systemized methodology that can be employed by any specialist or restorative doctor to enhance patient results, clinical quality and practice productivity. The goal is to focus on the total patient experience—both clinical and non-clinical—to create a “triple-win” experience for the patient, specialist and restorative doctor.

Challenges to Interdisciplinary Care

To fully understand the current state of interdisciplinary care, Levin Group recently surveyed hundreds of specialists and restorative doctors on the most difficult challenges they face in the area of interdisciplinary dentistry. The top 10 challenges reported by restorative doctors are:

1. Front desk staff in the specialty office is non-responsive
2. Specialty practice took too long to see patient
3. Insufficient communication
4. Specialist proposes bigger case than patient expected
5. Treatment makes restorative phase harder
6. Patient doesn't come back to restorative office
7. High fees for specialty treatment
8. Patient had a “less than desirable” experience

9. Availability of specialist for questions or follow-up
10. GP is left to fix problems created by specialist

The top 10 greatest challenges reported by specialists are:

1. GP is “under-educated” in a specific discipline
2. GP trying to be an expert in all areas
3. Only sending complicated or “problem” cases and patients
4. GP practice sending little or no information about patient or case
5. Patient is not fully aware of why he or she was referred
6. Weak endorsement of specialist with referral
7. Front desk staff at GP office doesn't understand specialty
8. Patients who have no money (insurance, cash poor, etc.)
9. Referring doctor cannot handle case
10. Patient does not understand case

These lists indicate that many of the challenges for specialists and restorative doctors are based on high expectations not being met by dental colleagues. A primary cause of interdisciplinary challenges seems to be the nature of the specialist-general dentist relationship.

The majority of procedures performed in a specialist's practice involve some form of interdisciplinary treatment. The same can't always be said for a general dental practice, where the majority of procedures (hygiene, amalgams, etc.) are performed in-house. These different perspectives must be taken into account when designing an effective collaborative process.

Keys to Interdisciplinary Success

The goal should be for the specialist, restorative doctor and patient to have the most positive experience resulting in excellent clinical care. After interviewing an extensive number of doctors in multiple specialties and general practices, we have identified seven key steps in the process:



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1. GP refers patient
2. Patient appoints in specialty practice
3. Specialty practice consult
4. Specialty practice communication with patient and GP
5. Specialist discusses case as needed with referring doctor
6. Specialist informs referring doctor post-treatment
7. Referring doctor completes case

These steps focus exclusively on the practice management components of interdisciplinary care—not the clinical aspects. The actual treatment itself is rarely the issue, but rather it is the patient’s experience before and after interdisciplinary treatment where the greatest challenges lie.

1. GP Refers Patient

Each practice needs to standardize the referral process. For example, answer the following questions:

- Does the patient make the appointment or does the referring practice make the appointment?
- Does the referring doctor strongly endorse the specialty practice to ensure that the patient will make an appointment and present for examination and consultation?
- How does the specialty practice handle the scheduling of the referred patient—what is the time frame for the consultation and treatment appointment?
- What is the confirmation process for the patient in the specialty practice?
- Does the patient present for treatment?
- Does the patient accept treatment?

Each question must be answered and then systemized in a step-by-step documented process. Patients are often lost in “the hand-off” from one practice to the other. For example, our studies indicate that 35 percent of patients referred to specialists for implant consultations never make an appointment. These results mean that more than one-third of referred edentulous patients will fail to improve the quality of their lives through implant treatment. When the interdisciplinary experience breaks down at the earliest stage, it also signals that the referral process needs to be overhauled.

2. Patient Appoints in the Specialty Practice

What do patients experience when they contact the specialty practice? How soon can they be seen? Do they feel welcomed when they call? If the general practice calls on behalf of the patient, are specialty staff members accommodating?

Based on the earlier-mentioned survey, many front desk staff members at general practices experience difficulties making convenient appointments for referred patients. GP practices often feel as if the specialty practice staff is overwhelmed, busy or indifferent. To create the most positive experience, practices must view their referral partners—not just patients—as customers. All too often the patient receives the “nicer” communication from the specialty office, but practices do not treat each other in the same regard. Attitude can be affected by training, verbal skills, busyness, frustration, stress level or even the referring practice’s relationship with other specialty practices. Scripting and training can improve the customer service experience for both specialty and general practices.

Both practices need to be on the same page throughout the entire process. For example, when referred patients appoint in a specialty practice, they should feel that the two practices work together regularly and have a strong relationship. Unfortunately, many general practices simply give patients the specialist’s business card without a strong endorsement. These patients often don’t fully understand why they are being referred. Once again, scripting every patient interaction during the interdisciplinary process will create value for the proposed treatment and highlight the positive relationship between the two practices. When both practices pro-actively manage the patient experience from the start, patients feel confident about moving forward through the interdisciplinary process and will more likely agree to recommended treatment.

Finally, if a question arises as to a referred patient’s financial capability, it should be discussed between the two practices. While it is not the responsibility of one practice to handle the fee arrangements for another, it is important to share relevant information between practices as part of the interdisciplinary process. For example, is this person a long-term patient of the restorative practice, one who has regularly been able to handle financial obligations, does this individual have any behavioral or notable

personality issues, etc.? In many cases, specialty practices receive little information about referred patients other than an x-ray and a treatment recommendation. Such incidents put specialty practices at a huge disadvantage when it comes to providing exceptional interdisciplinary care.

3. Specialty Practice Consult

The following protocols should be discussed and agreed upon between the referring doctor and the specialist:

- Will there be a pre-conference between the two doctors?
- What patient information is needed for each doctor?
- Will the new patient be seen by the doctor or a treatment coordinator?
- Which services necessitate one consult and which necessitate two or more?
- Will there be full disclosure to the patient of all findings even if they stand beyond the purpose of the referral?
- Depending on the proposed treatment, will other specialists be involved?
- How quickly can the patient be seen if agreeing to treatment?
- What are the financial options available in the specialty practice and restorative practice?
- Does the specialty and/or restorative practice have patient financing available?

The above questions should be worked out between the two practices. While some offices believe these matters should be handled on a case-by-case basis, there is still a chance of missed expectations and miscommunication. As the protocols and procedures between the two practices become standardized, then true interdisciplinary treatment starts to become a reality. When patients are managed case-by-case using the continually changing law of common sense, then specialists, restorative doctors and patients all end up with a less-than-optimal experience.

4. Specialty Practice Communication with Patient and GP

Specialists need to know how the restorative doctors prefer to receive information. E-mails are more convenient than letters, but some

doctors still prefer the “official” feel of letters. While phone calls may seem inconvenient at times, they are still a necessity as e-mail and letters do not always convey complete information. Furthermore, certain information may be more appropriate to communicate verbally than in writing. Specialists and restorative doctors need to agree to a communication plan; keeping in mind that the triple-win experience occurs where everyone benefits and the ultimate result is excellent patient care.

5. Specialist Discusses Case As Needed with Referring Doctor

These discussions occur on an as-needed basis. However, they are critical inter-practice communication that enhance communication, facilitate decision-making and build stronger relationships. Following each patient consultation (Step 4), the specialist should determine:

- Is there a need for the specialist and restorative doctor to communicate directly?
- What are the goals of this communication?
- Are there any obstacles in designing a treatment plan for this patient or meeting the expectations of the restorative doctor?
- What is the final treatment plan that is in the best interest of the patient?
- How receptive is the patient to the recommended treatment?

6. Specialist Informs Referring Doctor Post-Treatment

The specialty practice must inform the referring doctor post-treatment. The most prevalent method for doing so is to send letters. While post-treatment letters may be required from a medical/legal standpoint, they are not necessarily the most effective means of communication.

As mentioned in Step 4, specialists should communicate with referring doctors to determine their preferred method of communication for the final report. Specialty practices should also consider scheduling patients back in the general practice to ensure that they are seen for their final restorative care or post-treatment hygiene appointment. As always, specialists should offer any level of support needed by patients to successfully transition back to the general practice.

The Interdisciplinary Ladder™ - General Practice

Level	Name	Description	Practice Potential
6	The Triple-Win Provider	<ul style="list-style-type: none"> Refers all specialized care w/complete systems. Extraordinary level of teamwork w/in practice. Requires communication with specialty practice. Highly solicited by specialists. 	0 – 20% untapped potential
5	The Educated Selector	<ul style="list-style-type: none"> Refers almost all specialized treatment. Builds value w/patient for the specialty practice. Appreciates, but does not expect, communication with specialty practice. 	15 – 30% untapped potential
4	The Pick & Chooser	<ul style="list-style-type: none"> Refers regularly, based on case complexity. Typically all difficult or unusual cases. Selectively develops interdisciplinary relationships. 	30 – 50% untapped potential
3	The Mindless Referrer	<ul style="list-style-type: none"> Rarely refers. Desires little follow-up and no documentation. No direction to the patient beyond “Here’s the number of someone I know that might help you.” 	50 – 70% untapped potential
2	The Last Resort Referrer	<ul style="list-style-type: none"> Refers only in extreme emergency. Refers when “stuck” or unable to complete case. No communication with specialty practice. No non-essential communication with patient. 	60 – 80% untapped potential
1	The Do-It-Yourself-er	<ul style="list-style-type: none"> Does not refer. Does not recognize the value of interdisciplinary care. Only presents cases he/she can complete. 	70 – 90% untapped potential

Figure 1

We also recommend that specialists endorse the restorative doctor even though the patient is a regular participant in that practice. The more confidence patients have in their dentist, the more likely they will comply with post-treatment recommendations, resulting in a higher level of clinical care.

7. Referring Doctor Completes Case

The referring doctor will assess the treatment results to ensure that the final restorative case can be completed as originally planned. It is also critical to review the final treatment plan once again with patients so they understand all aspects of proper home-care.

In most cases when the restorative phase of treatment is completed, no communication is sent back to the specialty practice. In a true interdisciplinary experience, the restorative practice will inform the specialist of the final result as well as any challenges that took place in restoring the case. This level of communication provides closure for the case, but also serves as a learning opportunity if any challenges occurred

or changes need to be made. In addition, doctors will be better prepared in the future when cases of this type and scope are treated.

The Interdisciplinary Ladder™ for Restorative and Specialty Practices

To facilitate a triple-win experience, we have created the Interdisciplinary Ladder™ General Practice (Fig. 1), which depicts six types of general practices regarding interdisciplinary care. The goal is to reach level six, which is the Triple-Win Provider. In addition to the level, name and description, the illustration details practice potential (right column). There is a direct correlation between the level of interdisciplinary dentistry and the amount of untapped potential likely to exist in a practice. As you will see, the Do-It-Yourselfer Practice at level one may have a 70 to 90 percent growth potential. By working more closely with other practices through interdisciplinary dentistry, the practice can gradually move from level one to level six, achieving more and more of the office’s true growth potential.

The Interdisciplinary Ladder™ - Specialty Practice

Level	Name	Description	Practice Potential
6	The Powerhouse Educator	<ul style="list-style-type: none"> • Doctor is a Level IV Leader™. • Commitment and systems fully support all referral sources and every patient. • ITC runs all cases for all involved parties. 	0 – 20% untapped potential
5	The Effective Educator	<ul style="list-style-type: none"> • Understands ROI (time and money) of complete coordination with restorative practice. • Dedicates resources to expanding and supporting restorative practices. 	15 – 30% untapped potential
4	The Primitive Intentional Educator	<ul style="list-style-type: none"> • Dedicates time to work with restorative practices but lacks the systems to maintain consistency. • Will communicate if necessary. • Does not promote interdisciplinary care. 	30 – 50% untapped potential
3	The Unintentional Educator	<ul style="list-style-type: none"> • Leaves it to the GP to “figure it out” • Trains his/her staff but places little value on educating referring doctors and staff. • Makes no effort to communicate. 	50 – 70% untapped potential
2	The Ineffective Educator	<ul style="list-style-type: none"> • Does not discourage staff from attempting to coordinate care but commits no energy or vision. • Laissez-faire approach to interdisciplinary care. • Very poor communicator. 	60 – 80% untapped potential
1	The Lost Educator	<ul style="list-style-type: none"> • Lacks knowledge and/or understanding of the benefits of interdisciplinary care. • Sees no value in enhancing the skills and ability of referring doctor or staff. 	70 – 100% untapped potential

Figure 2

Figure 2 represents the Interdisciplinary Ladder™ Specialty Practice. While the same levels exist, there are different names for specialists from The Lost Educator at level one to The Powerhouse Educator at level six. Once again a full description is provided as well as the practice potential that exists regarding growth. Practices that are more involved in the interdisciplinary experience generally perform better regarding patient care, production and profitability than other offices. The reason for this is fairly obvious—the nature of interdisciplinary care and treatment requires practices to have better systems, enhanced communication and effective internal marketing. Without strong systems in place, it can be extremely difficult to maintain strong relationships with other doctors.

The goal is for each practice to identify its current level and then move to higher levels in the interdisciplinary relationship. As specialty and restorative practices progress through each level, these offices will ultimately realize more of their true growth potential, achieve a higher level of patient care, increase productivity and create greater profitability.

Conclusion

The Triple-Win Interdisciplinary Experience™ has the power to transform the specialist-referring doctor relationship from one of limited interaction to a partnership of mutual collaboration. This systemized approach to interdisciplinary treatment focuses on enhancing the entire patient experience—both the clinical care and customer service aspects—to achieve a triple-win for patients, referring doctors and specialists.

Dr. Roger P. Levin is Founder and Chief Executive Officer of Levin Group, Inc., the leading dental practice management firm in the United States. Levin Group provides premier comprehensive consulting solutions that deliver lifetime success to dentists and specialists in the U.S. and around the world. Levin Group is based in Baltimore, Maryland and has a second location in Phoenix, Arizona. For the past 23 years, Dr. Levin and Levin Group have embraced one single mission – To Improve the Lives of Dentists.