Treatment Planning
A Systematic Approach

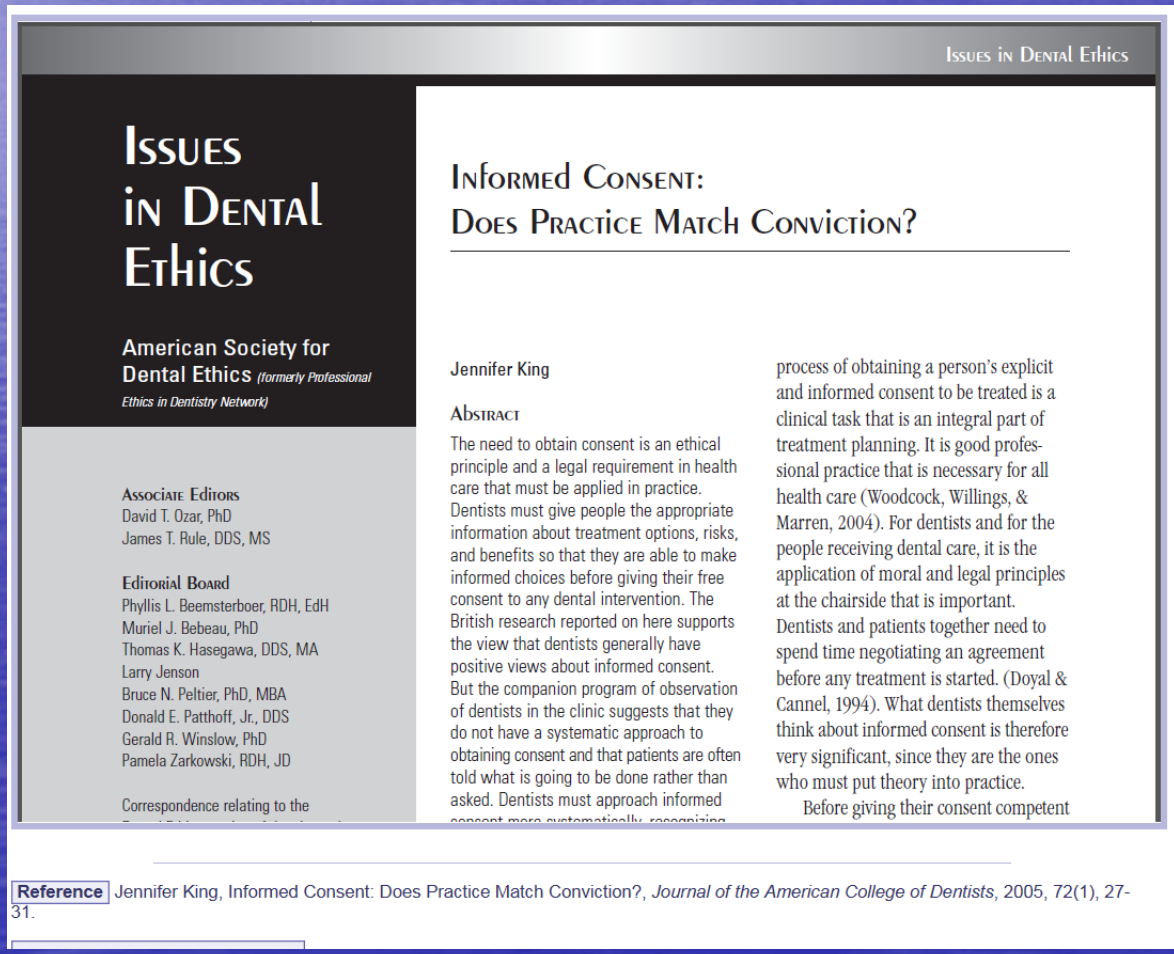
Discussion of Risks, Benefits, Costs and Alternatives

D4/ID4 Seminar Series

Joel White, DDS, MS

July 22, 2016

Quiz questions based on reading https://www.dentalethics.org/coursematerial35.htm, Jennifer King, Informed Consent: Does Practice Match Conviction?, *Journal of the American College of Dentists*, 2005, 72(1), 27-31.



Issues in Dental Ethics

American Society for Dental Ethics (formerly Professional Ethics in Dentistry Network)

Correspondence relating to the

Informed Consent: Does Practice Match Conviction?

Jennifer King

Abstract

The need to obtain consent is an ethical principle and a legal requirement in health care that must be applied in practice. Dentists must give people the appropriate information about treatment options, risks, and benefits so that they are able to make informed choices before giving their free consent to any dental intervention. The British research reported on here supports the view that dentists generally have positive views about informed consent. But the companion program of observation of dentists in the clinic suggests that they do not have a systematic approach to obtaining consent and that patients are often told what is going to be done rather than asked. Dentists must approach informed

process of obtaining a person's explicit and informed consent to be treated is a clinical task that is an integral part of treatment planning. It is good professional practice that is necessary for all health care (Woodcock, Willings, & Marren, 2004). For dentists and for the people receiving dental care, it is the application of moral and legal principles at the chairside that is important. Dentists and patients together need to spend time negotiating an agreement before any treatment is started. (Doyal & Cannel, 1994). What dentists themselves think about informed consent is therefore very significant, since they are the ones who must put theory into practice.

Before giving their consent competent

Reference Jennifer King, Informed Consent: Does Practice Match Conviction?, *Journal of the American College of Dentists*, 2005, 72(1), 27-31.

"The need to obtain consent is an ethical principle and legal requirement in health care that must be applied in dental practice."

True or False?

True

"Before giving their consent competent adults must have appropriate information that they understand so that they are free to decide for themselves whether or not to accept a particular treatment."

True or False?

True

"Before touching someone else, it is morally important to ask for their permission. This respects patients' privacy and their rights as human beings to be in control of what happens to any part of their own body."

True or False?

True

"Observation of dentists in the clinical setting suggests that they do not have a systematic approach to obtaining consent and that patients are often told what is going to be done rather than asked."

True or False?

True

Which of the following are component stages in the process of obtaining consent?

A. Making introductions
B. Exploring the problem
C. Outlining treatment procedure and options
D. Explaining risks and benefits.
E. All of the above

All of the Above

Which of the following are component stages in the process of obtaining consent?

A. Explaining cost and time involved
B. Inviting questions and checking understanding
C. Reaching agreement
D. Obtaining explicit consent
E. All of the above

All of the Above

Honesty/Ethics in the Professions- How do Dentists Measure Up?

www.gallup.com/poll/1654/honesty-ethics-professions.aspx?version=print

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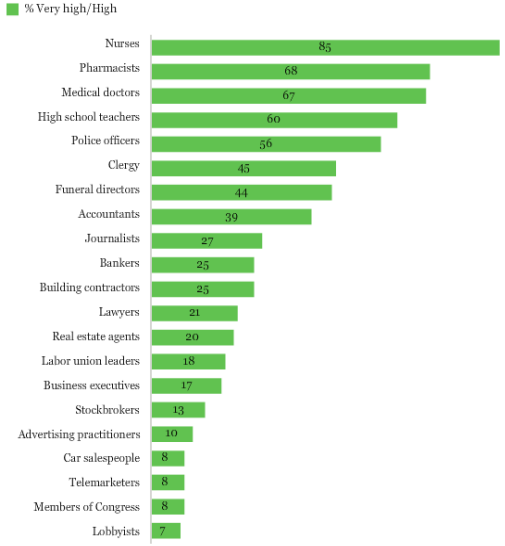
Honesty/Ethics in Professions

Please tell me how you would rate the honesty and ethical standards of people in these different fields -- very high, high, average, low or very low?

Dec. 2-6, 2015



GALLUP

Dentists

	Very high	High	Ave-rage	Low	Very low	No opinion	Very high/ High
	%	%	%	%	%	%	%
2012 Nov 26-29	11	51	33	3	1	*	62
2009 Nov 20-22	12	45	35	5	2	1	57
2006 Dec 8-10	10	52	34	3	1	*	62
2003 Nov 14-16	11	50	34	3	1	1	61
2001 Nov 26-27	11	45	38	4	1	1	56
2000 Nov 13-15	9	49	35	5	1	1	58
1999 Nov 4-7	8	44	41	6	1	*	52
1998 Oct 23-25	8	45	41	4	1	1	53
1997 Nov 6-9	9	45	37	5	2	2	54
1996 Dec 9-11	8	45	38	5	2	2	53
1995 Oct 19-22	9	45	38	4	2	2	54
1994 Sep 23-25	9	42	41	6	1	1	51
1993 July 19-21	6	44	40	7	2	1	50
1992 Jun 26-July 1	7	43	42	4	1	3	50
1991 May 16-19	8	42	41	5	1	3	50
1990 Feb 8-11	8	44	41	3	1	3	52
1988 Sep 23-26	10	41	39	5	2	3	51
1985 July 12-15	10	46	37	4	1	2	56
1983 May 20-23	8	43	41	3	2	3	51
1981 July 24-27	10	42	38	6	1	3	52

GALLUP

Reader's Digest SPECIAL FEATURE

How Dentists Rip Us Off

by William Ecenbarger

From behind a door comes the whine of a high-speed drill. When my name is called, I am ushered into an examining room and welcomed with a nutcracker handshake by the dentist, a graying-at-the-temples man.

Soon I am staring toward the white cork ceiling while my teeth are probed, poked, tapped and tugged. The numbers of my teeth are called out to an assistant, who jots the information on a chart: "No. 11, crown; No. 13, M-O-D; No. 14, M-O ..." A few minutes later comes the verdict: I need 11 crowns, plus other work. It will cost $8347.

"Do this and you will have no worries about your teeth for the next 30 years," the dentist purrs. Somehow I doubt that. Then he adds, "You and I are going to become great friends."

Somehow I doubt that too. I was there in Dayton, Ohio, as part of an assessment of the consistency and fairness of American dentistry. Since Americans spend about $42 billion a year on their teeth, it seemed like a reasonable assignment: visit 50 dentists, show them your teeth and a set of X rays, and ask each what needs to be done.

Four months, 50,000 miles and 50 exams later, I concluded that going to the dentist is nothing to smile about. Dentistry is a stunningly inexact science. Even expecting that different dentists would have different, yet valid, opinions did not prepare me for the astounding variation in diagnoses I received. Some wanted only $500 to bring me up to good dental health. Others wanted ten, 20, even 50 times that amount. Surely they could not all be right.

I randomly selected the dentists from the Yellow Pages in 28 states and the District of Columbia.

At each of the offices I told the same story: I was moving to the area and wanted to become a patient; I had recently come through successful gum surgery; my dental expenses were covered through a direct-reimbursement program with my employer; I was interested in maintaining good oral health and was satisfied with the appearance of my teeth. Because I said I was in a direct-reimbursement program, I got a written treatment plan and a cost-estimate from each dentist.

Reader's Digest SPECIAL FEATURE

Appendix

Following are the locations of selected dentists and a description of their recommendations and estimates. Six dentists listed thought Ecenbarger needed 11 or more crowns, including 4 dentists who thought he needed 21 or more.

Location of dentist	Number of crowns (C) and/or fillings (F)	Total estimate
Madison, WI	5C, 3F	$3,110
Davenport, IA	5C	$2,555
Moline, IL	4C	$1,980
Tarrytown, NY	2C, 1F	$1,952
Dayton, OH	6C, 2F	$3,410
Englewood, OH	11C, 5F	$8,347*
Indianapolis, IN	4C	$2,617*
Memphis, TN	3C	$1,735*
Hernando, MS	3C	$1,395
Memphis, TN	28C	$13,440
Seattle, WA	17C	$10,735
Albuquerque, NM	22C	$14,445
Salt Lake City, UT	28C	$19,402
Washington, DC	7C, 4F	$5,275
Philadelphia, PA	3C, 1F	$2,540
Cambridge, MA	1C, 4F	$1,220
Lansing, MI	2C, 1F	$1,197
St. Louis, MO	5C	$4,550
Minneapolis, MN	2C, 1F	$1,240
New York, NY	21C	$29,850

*Includes additional miscellaneous charges.

Be cautious about dentists who recommend elaborate treatment plans. In 1996, a reporter on assignment for the Reader's Digest visited 50 dentists in 28 states and found that their fees, examinations, and recommendations varied widely. The visits cost from $20 to $141. The reporter brought along his own x-ray films and told the dentists he had ample insurance coverage. Before embarking on the study, the reporter was checked by four dentists who agreed that he had only one immediate problem (one molar needed filling or a crown), and that work on another tooth might be advisable. Only 12 of the dentists agreed with this appraisal, and 15 failed to note a problem with the molar. One dentist recommended crowning all of the reporter's teeth, at a cost of $13,440. Other estimates ranged from $500 to $29,850. The reporter also visited a dental school clinic where the student and a department chairman independently recommended capping both teeth, which would cost $460 [5].

In 1997, ABC-TV's "Prime Time Live" conducted a similar investigation in which, after evaluation by an expert panel, two patients with completely healthy mouths were examined by six dentists. One patient was given estimates for $645, $1175, $1195, $2220, $2323, and $2563, The other received proposals for $2135, $2410, $2829, $3140, $3190, $3700, $4061, and $7960. No program was broadcast, but the figures were made public by one of the review panel members [6].

These investigations indicate that when extensive dental work is advised, a second opinion is often a good idea, preferably a dentist who is affiliated with a dental school. No practitioner should fear or resist having you get a second opinion. If a treatment plan is sound, particularly a major and/or expensive one, it should hold up to scrutiny by others.

Additional Information on Dental Choices

- How Dental Restoration Materials Compare

References

1. Friedman JW and others. Complete Guide to Dental Health: How to Avoid Being Overcharged and Overtreated. New York, 1991, Consumer Reports Books.
2. Clinical guideline on the elective use of conscious sedation, deep sedation and general anesthesia in pediatric dental patients. American Academy of Pediatric Dentistry, revised May 1998.
3. Policy statement on the use of deep sedation and general anesthesia in the pediatric dental office. American Academy of Pediatric Dentistry, May 1999.
4. How to choose a dentist. Consumers Research, March 1997, pp. 2024.
5. Ecenbarger W. How honest are dentists? Reader's Digest, February 1997, pp 50-56.
6. Dodes J. Coverage questioned (letter to the editor). ADA News, Sept 15, 1997.

www.dentaleconomics.com/articles/print/volume-87/issue-3/features/your-reply-to-readers-digest.html

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Your reply to Readers Digest

The magazine article made us look bad, but our response can be a public relations coup.

Roger Levin, DDS

If you haven`t read it by now, you`ve certainly heard about it. Maybe your patients have called about it. Perhaps a conscientious few have even sent you a copy of it. Yes, I`m talking about, "How Honest are Dentists," a self-described expose published in the February 1997 issue of Reader`s Digest.

This article is the proverbial bombshell - and it just exploded a few feet from every dental office in the nation. However, you can emerge unscathed if you defuse it properly.

This is called crisis management. And this, among many other things, is my business. If you want to continue to prosper in these increasingly challenging times, it will become part of your business, too.

What's the Legal Risk?

- Duty-

"The dentist owes his or her patient that degree of skill, care, and judgement possessed by a "reasonable" dentist.

- Breach of Duty-

"The breach of the duty owed is a negligent action defined as failing to do something that the ordinary, prudent person would do or conversely doing something that the reasonable and prudent individual would not do in the same or similar circumstances."

72 The Treatment Planning Process

DOCTOR-PATIENT RELATIONSHIP AND PROFESSIONAL LIABILITY

Malpractice claims for damages are civil suits based in tort law. To be successful, claims must satisfy four elements. First, the defendant must owe a duty to the plaintiff and second, the defendant must breach that duty. Third, the breach of the owed duty must result in damage to the plaintiff, and finally, the breach of duty must be shown to be the proximate cause of the damages. Malpractice claims usually allege negligence or fault by the dentist as the breach. The negligent act may arise from either the commission of or the omission of an act during treatment. The plaintiff must provide a preponderance of credible evidence that the alleged wrong occurred, thereby meeting the burden of proof. Each of the four elements must be addressed through evidence; failure to address and to prove each element can result in the case being dismissed in the defendant's favor.

Duty

The dentist owes his or her patient that degree of skill, care, and judgment possessed by a "reasonable" dentist. This is the benchmark against which an alleged negligent act is judged—in other words, the standard of care that must be established by expert testimony. Courts have cited the greatly increased opportunities for communication and education in the dental field as the foundation for a national or prevailing standard of care. In many jurisdictions, a plaintiff cannot use the testimony of a *specialist* to establish the standard of care for a *general* dentist. On the other hand, specialists have long been held to a national standard of care. In addition, general dentists who hold themselves out as specialists (and in some jurisdictions, even those who do not) are held to the national standard when performing treatment that clearly falls into the realm of the specialist. In essence, the courts require all dentists to properly diagnose disease.

The duty to treat arises from the doctor-patient rela-

actual treatment. If the treatment plan is not agreed to for any reason, both the dentist and the patient must clearly understand the next steps to be taken. It is important to realize that even if the relationship is properly severed, the dentist may still owe a duty to arrange for the opportunity of continuing treatment, including providing referrals and a referral source, and making copies of records available.

Breach of Duty

The breach of the duty owed is a negligent action defined as failing to do something that the ordinary, prudent person would do or conversely doing something that the reasonable and prudent individual would not do in the same or similar circumstances. A mere bad result or an unforeseen result does not constitute negligence *per se*. Negligence is established by one of two general methods. The first and perhaps the easiest is through a doctrine known as ***res ipsa loquitur*** in which the deviation from the standard of care is so obvious that expert testimony does not need to be offered to prove the departure. For example, a patient who sustained injury because of a radiographic unit toppling over or because a dental instrument was dropped in the patient's eye need only show that the injury occurred. It is commonly understood that such injuries are not the normal expected results of a dental visit. The extraction of the wrong tooth would also fall into this category of claims, although the services of a dental expert may be required to comment upon the extent of the injury suffered. It is important to note that in this type of case the burden of proof shifts to the defendant dentist to show by a preponderance of the evidence that negligence did not occur. The accompanying *In Clinical Practice* box discusses one such example.

The great majority of cases, however, require a demonstration of the standard of care from which the defendant is alleged to have deviated negligently. The degree of skill, care, or judgment required of the defendant dentist is that of the reasonable and prudent practitioner.

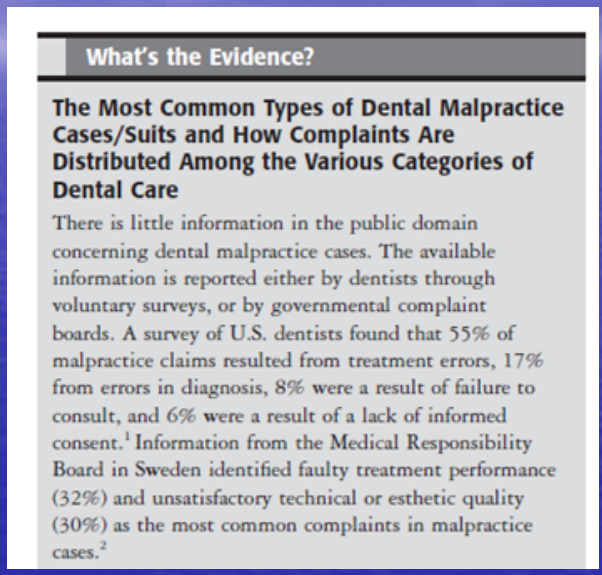
What's the Consequence?

Malpractice (Legal)

55%	Treatment
	28% Oral Surgery
	24% Restorative
17%	Diagnosis
8%	Failure to Consult
6%	Lack of Informed Consent

Disciplinary Actions (Boards)

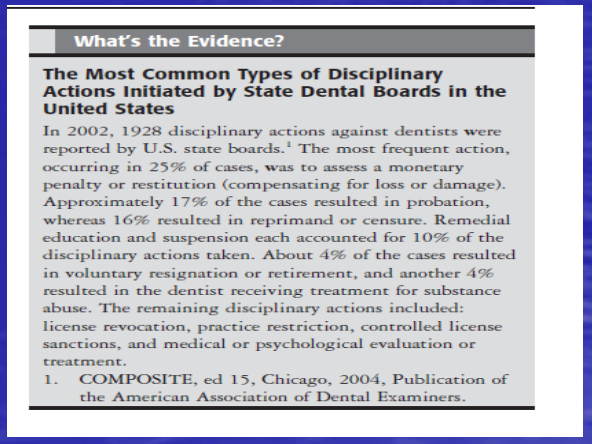
25%	Monetary/Restitution
17%	Probation
16%	Reprimand/Censure
4%	Resignation/Retirement
4%	Substance Abuse Tx



What's the Evidence?

The Most Common Types of Dental Malpractice Cases/Suits and How Complaints Are Distributed Among the Various Categories of Dental Care

There is little information in the public domain concerning dental malpractice cases. The available information is reported either by dentists through voluntary surveys, or by governmental complaint boards. A survey of U.S. dentists found that 55% of malpractice claims resulted from treatment errors, 17% from errors in diagnosis, 8% were a result of failure to consult, and 6% were a result of a lack of informed consent.[1] Information from the Medical Responsibility Board in Sweden identified faulty treatment performance (32%) and unsatisfactory technical or esthetic quality (30%) as the most common complaints in malpractice cases.[2]



What's the Evidence?

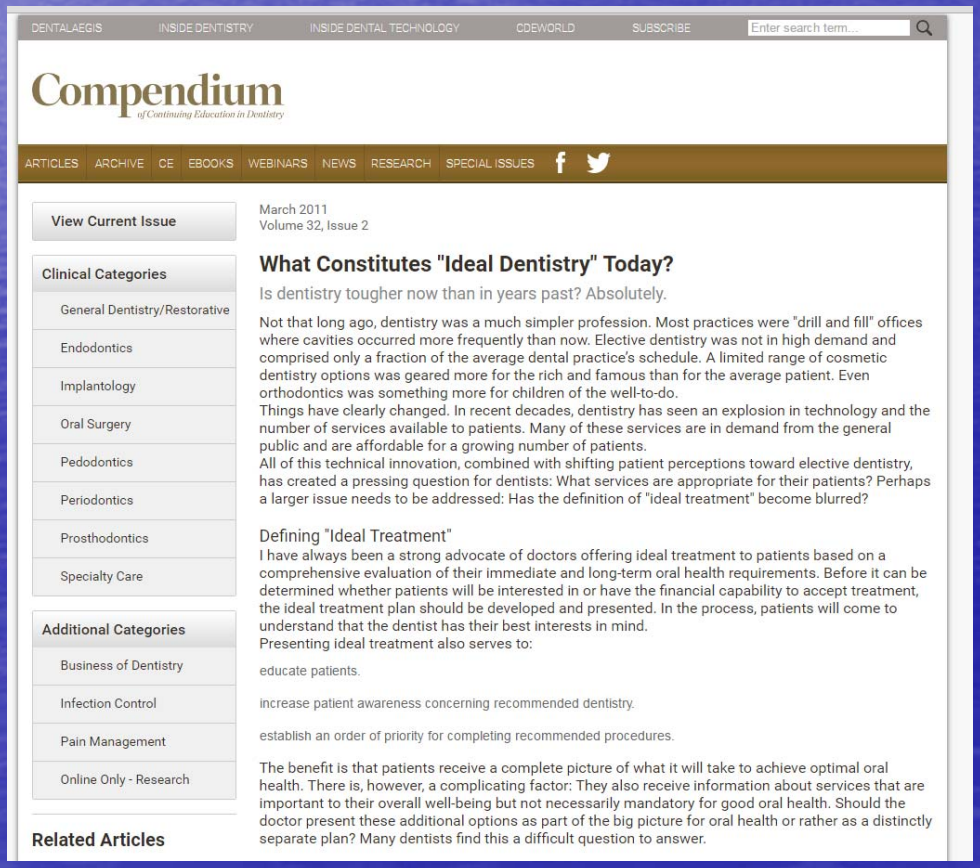
The Most Common Types of Disciplinary Actions Initiated by State Dental Boards in the United States

In 2002, 1928 disciplinary actions against dentists were reported by U.S. state boards.[1] The most frequent action, occurring in 25% of cases, was to assess a monetary penalty or restitution (compensating for loss or damage). Approximately 17% of the cases resulted in probation, whereas 16% resulted in reprimand or censure. Remedial education and suspension each accounted for 10% of the disciplinary actions taken. About 4% of the cases resulted in voluntary resignation or retirement, and another 4% resulted in the dentist receiving treatment for substance abuse. The remaining disciplinary actions included: license revocation, practice restriction, controlled license sanctions, and medical or psychological evaluation or treatment.

1. COMPOSITE, ed 15, Chicago, 2004, Publication of the American Association of Dental Examiners.

Definition of “Ideal” Treatment Plan

- What is the definition of ideal treatment, as you have learned?



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March 2011
Volume 32, Issue 2

What Constitutes "Ideal Dentistry" Today?

Is dentistry tougher now than in years past? Absolutely.

Not that long ago, dentistry was a much simpler profession. Most practices were "drill and fill" offices where cavities occurred more frequently than now. Elective dentistry was not in high demand and comprised only a fraction of the average dental practice's schedule. A limited range of cosmetic dentistry options was geared more for the rich and famous than for the average patient. Even orthodontics was something more for children of the well-to-do.
Things have clearly changed. In recent decades, dentistry has seen an explosion in technology and the number of services available to patients. Many of these services are in demand from the general public and are affordable for a growing number of patients.
All of this technical innovation, combined with shifting patient perceptions toward elective dentistry, has created a pressing question for dentists: What services are appropriate for their patients? Perhaps a larger issue needs to be addressed: Has the definition of "ideal treatment" become blurred?

Defining "Ideal Treatment"
I have always been a strong advocate of doctors offering ideal treatment to patients based on a comprehensive evaluation of their immediate and long-term oral health requirements. Before it can be determined whether patients will be interested in or have the financial capability to accept treatment, the ideal treatment plan should be developed and presented. In the process, patients will come to understand that the dentist has their best interests in mind.
Presenting ideal treatment also serves to:

educate patients.

increase patient awareness concerning recommended dentistry.

establish an order of priority for completing recommended procedures.

The benefit is that patients receive a complete picture of what it will take to achieve optimal oral health. There is, however, a complicating factor: They also receive information about services that are important to their overall well-being but not necessarily mandatory for good oral health. Should the doctor present these additional options as part of the big picture for oral health or rather as a distinctly separate plan? Many dentists find this a difficult question to answer.

Determining What's in the Best Interests of the Patient

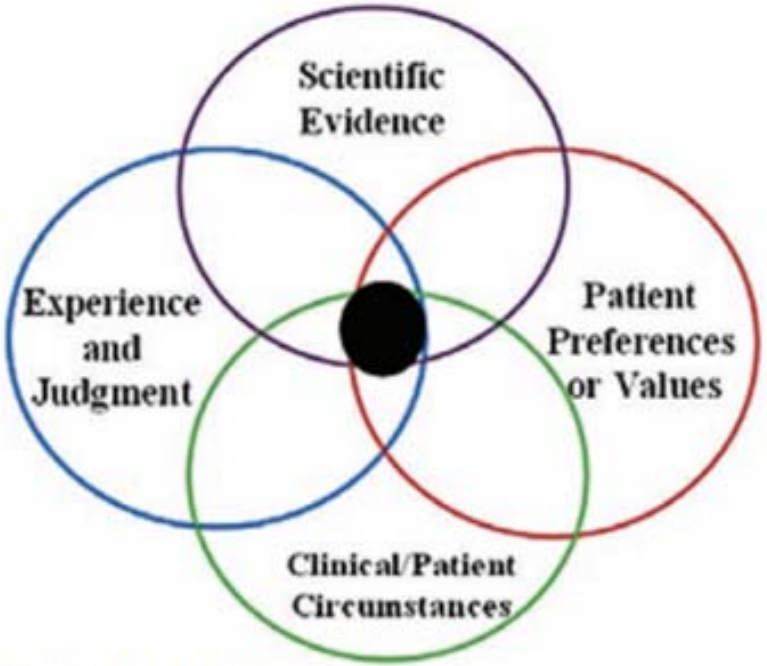


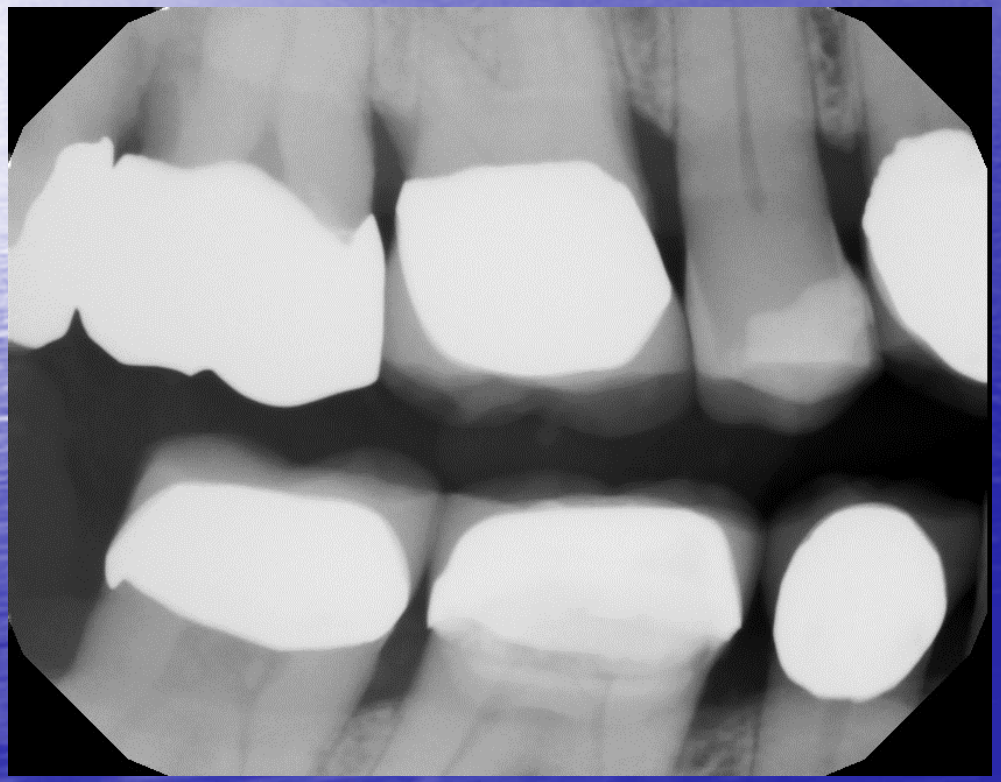
Figure 1. EBDM Process

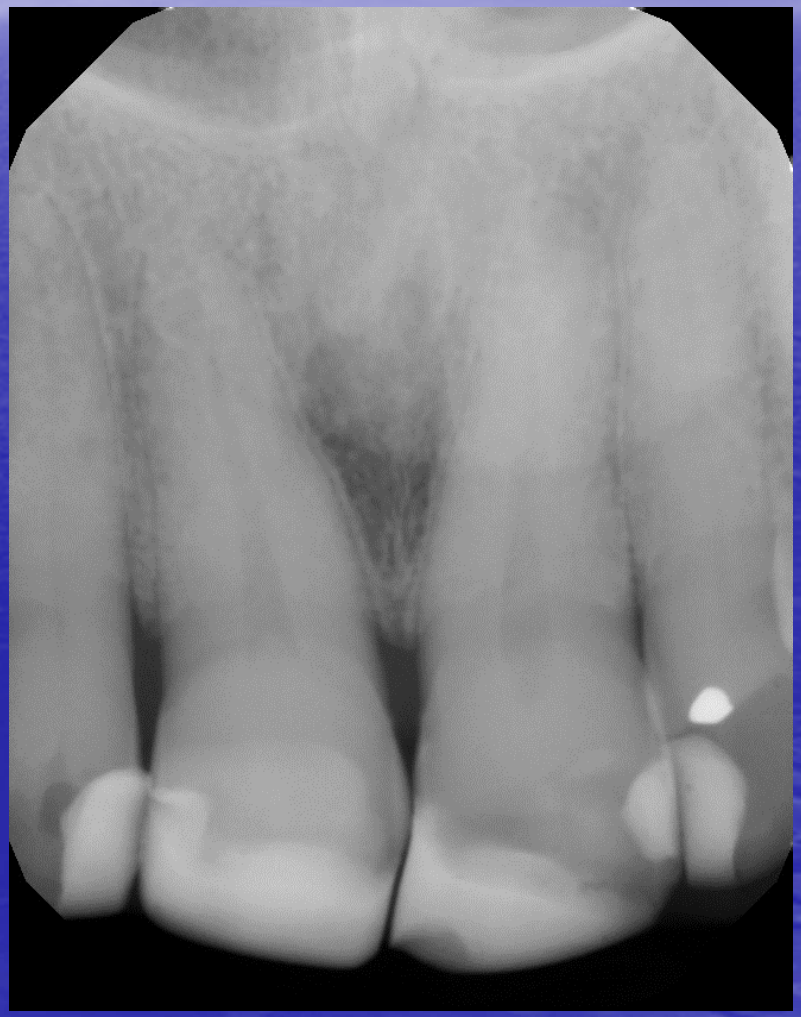
How to Gain Informed Consent

"Although the dentist ultimately is responsible for recommending a course of treatment, the patient would not be expected to know and understand all of the factors to be taken into account in the process."

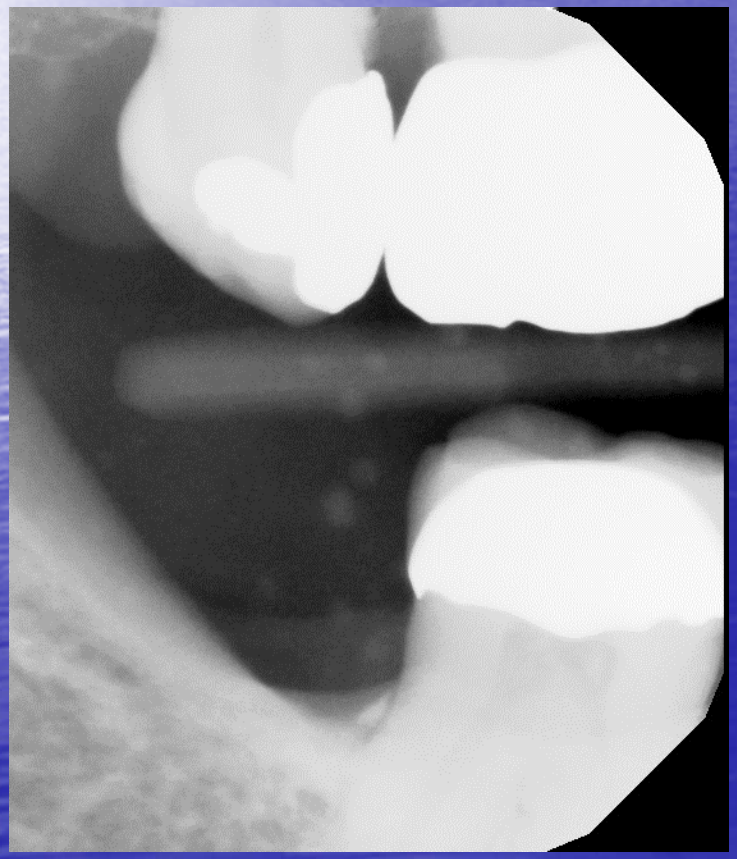
"To fulfill this duty, the dentist must disclose all risks and benefits or the proposed treatment, including any complications that might reasonably be expected to occur, any alternative (including the alternative of no treatment) to the proposed course of treatment, and the risks and benefits (if any) of non-treatment."

Case Study- Middle Aged Women “Second Opinion”





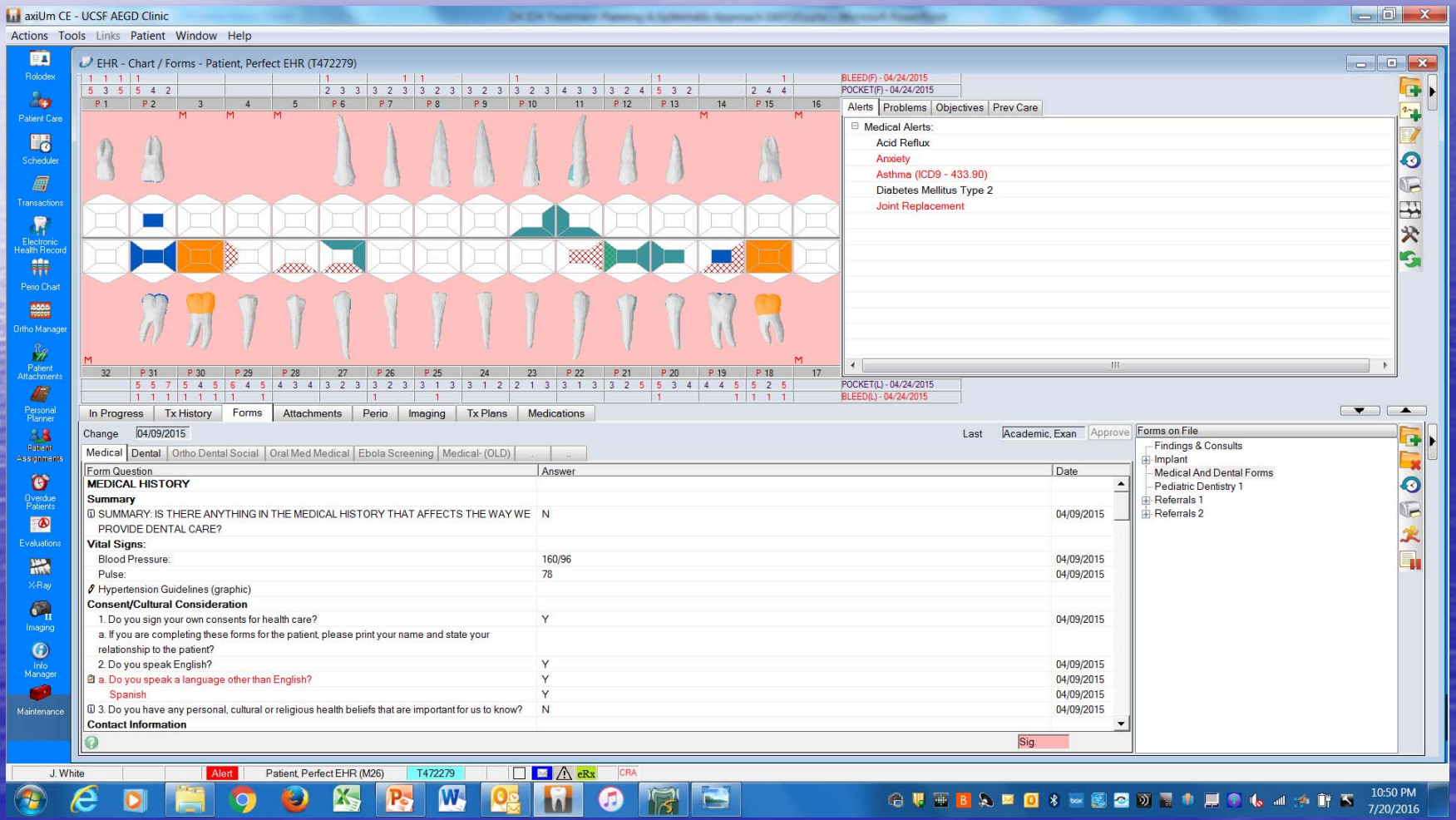
Look in the mouth!
Diagnosis Driven Profession!



TREATMENT CASE — Treatment Plan

DATE	VISIT	TH	SURF	CODE	PROV	DESCRIPTION	FEE	PAT	PRI INS	SEC INS
05/13/2015	1	2		D2740	DDS4	Full Porcelain/Ceramic Crown	1400.00	737.50	662.50	0.00
05/13/2015	1	2		D2950	DDS4	Core Buildup w/ Any Pins	380.00	76.00	304.00	0.00
						Visit 1 Totals:	1780.00	813.50	966.50	0.00
05/13/2015	2	2		0001	DDS4	Cement Crown	0.00	0.00	0.00	0.00
05/13/2015	2	6	F5	D2330	DDS4	Anterior Resin Composite 1s	255.00	255.00	0.00	0.00
05/13/2015	2	7	F5	D2330	DDS4	Anterior Resin Composite 1s	255.00	87.50	167.50	0.00
						Visit 2 Totals:	510.00	342.50	167.50	0.00

Putting it all together
Robust Work Up



Perfect Patient

1	1	1	1	1											1		0	1	1	0	0	0	0	PLAQUE
1	1	1	1												1					1	1			BLEED
5	3	5	5	4	2										2	3	3	3	2	3	3	2	3	POCKET
-3	0	1	1	0	3										2	0	-1	-1	0	-1	-1	0	-1	GM-CEJ
2	3	6	6	4	5										4	3	2	2	2	2	2	2	2	CAL
	0			1																				FURCA
																								FREMITIUS
	0			0												0			0			0		MOBIL
	1			2			3			4			5			6			7			8		
1	1	1	1																					BLEED
1	1	1	1	0	0										1	0	1	1	0	1	1	0	1	PLAQUE
5	5	5	5	3	2										2	2	3	3	2	3	3	2	3	POCKET
2	2	2	2	2	2										2	0	-1	-1	1	-1	-1	0	-1	GM-CEJ
7	7	7	7	5	4										4	2	2	2	3	2	2	2	2	CAL
0		0	0		0																			FURCA

0	0	0	0	0	0	0	0	0	0	0	0	0	0	0				0	0	1				PLAQUE
			1									1								1				BLEED
3	2	3	3	2	3	4	3	3	3	2	4	5	3	2				2	4	4				POCKET
-1	0	-1	-1	0	-1	-1	0	-1	-1	0	-1	-1	0	2				2	0	2				GM-CEJ
2	2	2	2	2	2	3	3	2	2	2	3	4	3	4				4	4	6				CAL
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																								FREMITIUS
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	9			10			11			12			13			14			15			16		
	1											1	1	1				1						BLEED
1	0	1	1	0	1	1	0	1	1	0	1	0	1	1				1	1	1				PLAQUE
3	2	3	3	2	3	3	2	3	3	4	5	5	2	3				3	3	4				POCKET
-1	0	-1	-1	0	-1	-1	0	-1	-1	0	1	2	1	2				2	0	2				GM-CEJ
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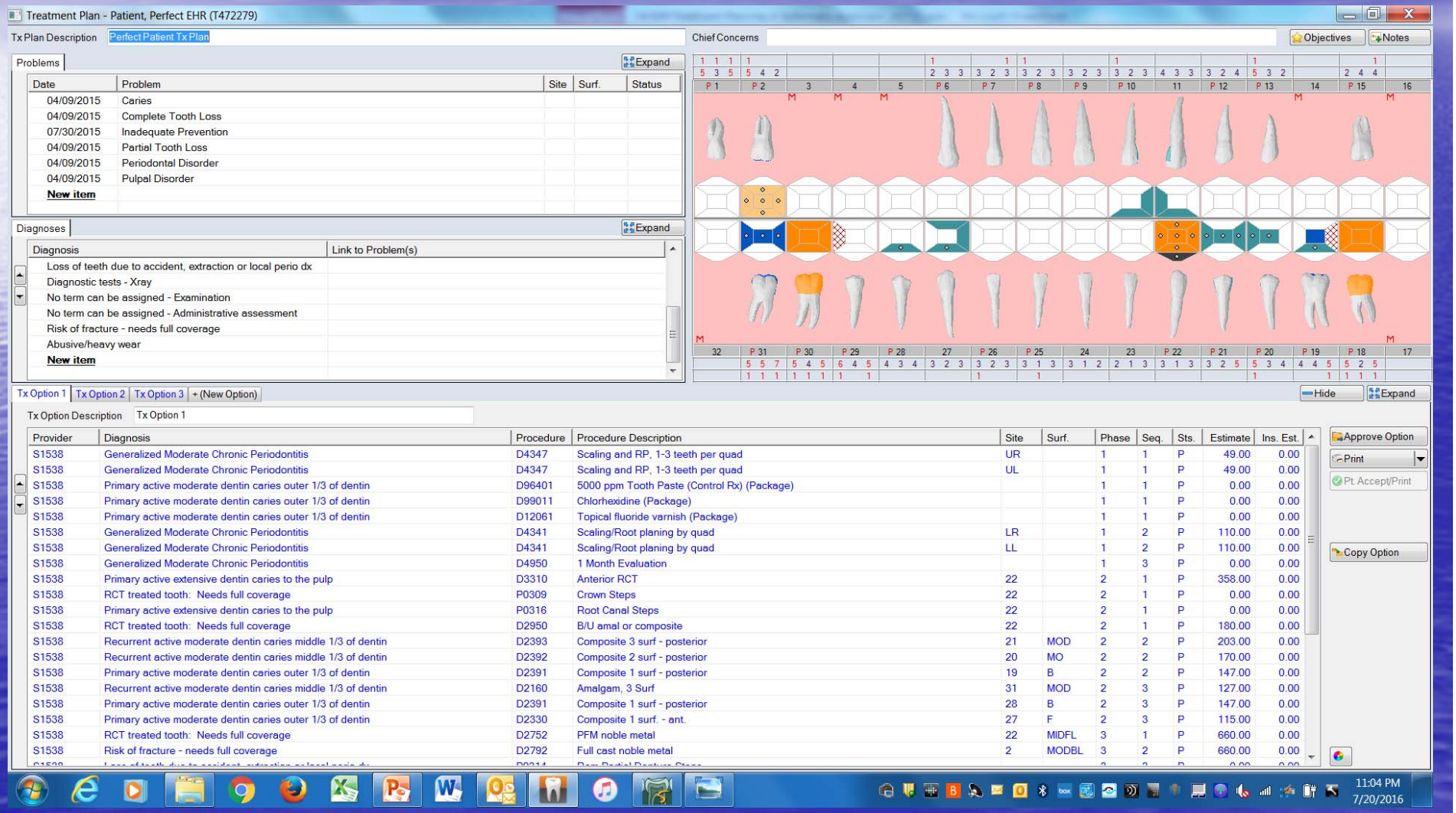
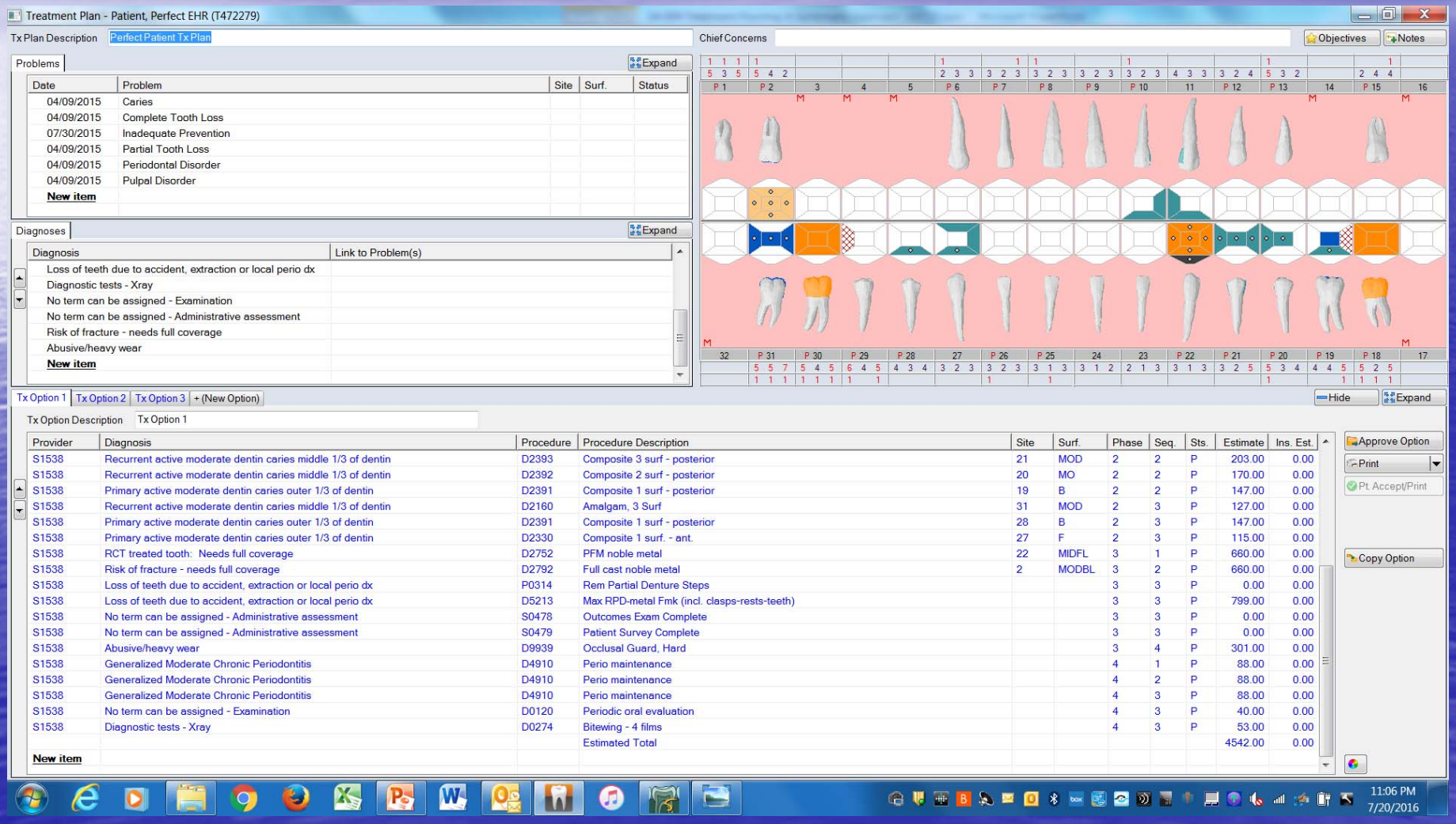
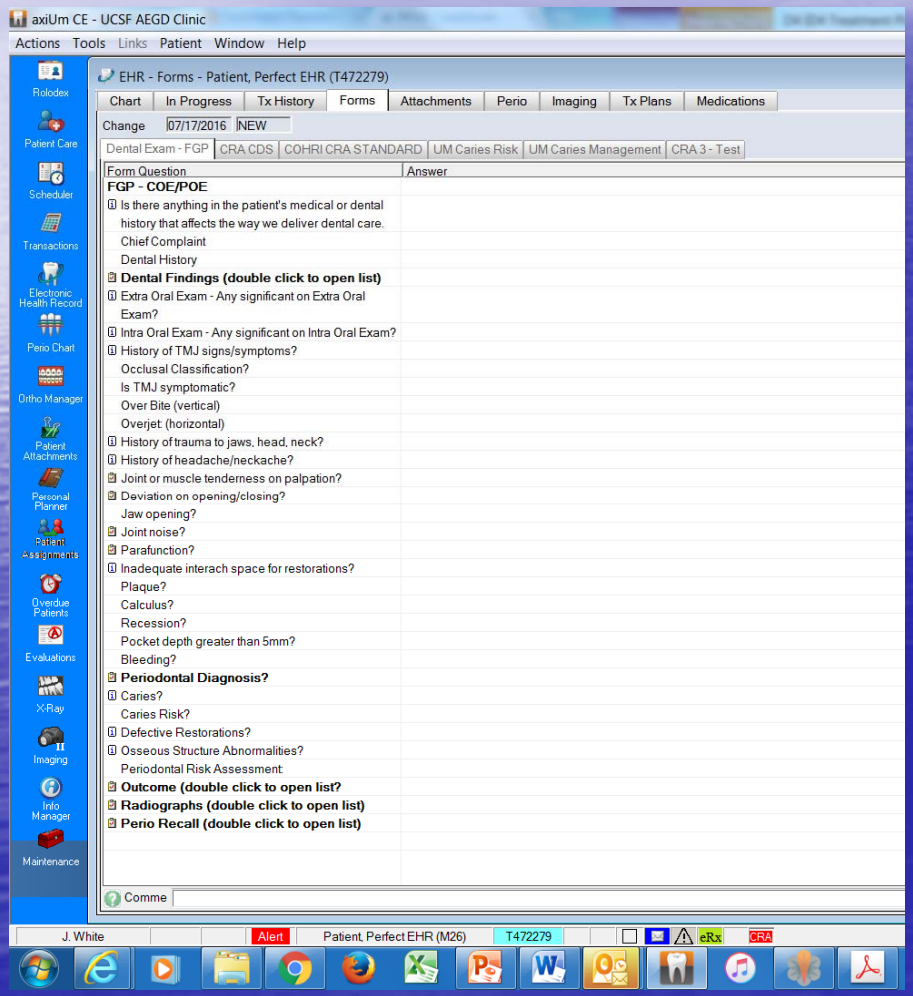
Perfect Patient- Tx Plan

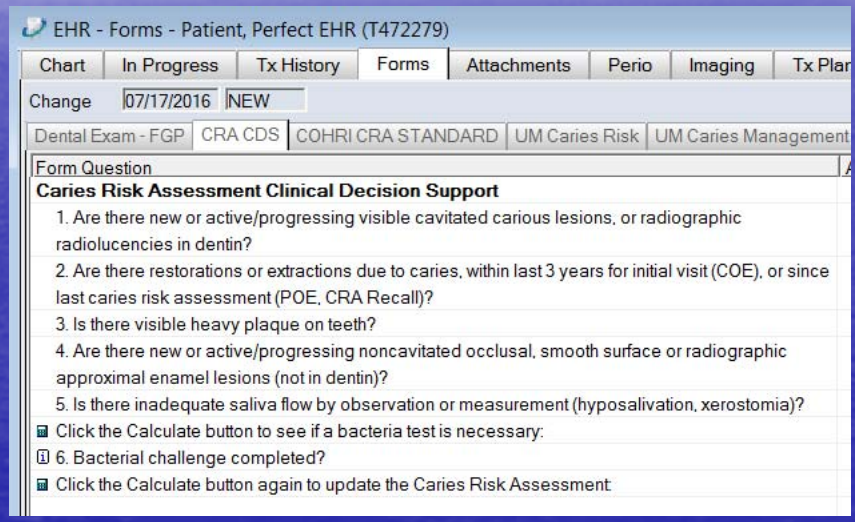


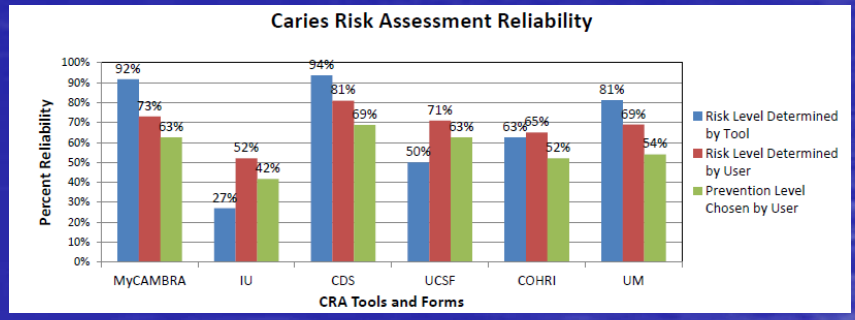
Putting it all together
Prevention and Maintenance



Putting it all together
Advanced FGP/AEGD







Frame of Reference

PCC 139: Informed Consent & Evidence-Based Dentistry Exercise

Learning Objectives:

1. Demonstrate critical thinking and clinical reasoning that is consistent with the best available evidence.
2. Communicate effectively and respectfully with patients, students, staff, and faculty.
3. Demonstrate understanding of informed consent.
4. Formulate patient-centered treatment plans based on diagnoses, risk profile for caries and periodontal disease.
5. Formulate patient-centered oral home care preventive regimens according to risk profile for caries and periodontal disease.

Part 2b: Worksheet

Upon approval of the group and topic, use this worksheet to guide your literature worksheet to the CLE by the due date to receive credit for Part 2.

Approved Topic	
Team Member Names	
Define PICO Question Patient/Population- Intervention- Comparison- Outcome See EBD Parts I and II	
Sources Searched Cochrane Library ADA EBD website PubMed See EBD Part II	
Keywords Used for Search	
Articles Reviewed + Appraisal of Literature Citation list of all articles (at least 6) List strengths, weaknesses, and conclusions of each resource cited. See EBD Parts II and III	**Citation:** **Type of Study (e.g. RCT, case-control):** **Strengths:** **Weaknesses:** **Conclusions:**

Part 3: Worksheet for Patient/Dentist Resource (Brochure or Video)

Use this worksheet to put your evidence into a usable format for describing risks, benefits, alternatives, cost, and timeline for patients. You might consider starting this part while you are reviewing the literature for Part 2b. This worksheet should reference the articles and textbooks you reviewed, but the brochure/video you create for patients should not use jargon. To receive credit for Part 3, upload *this and the brochure/video* in by the due date.

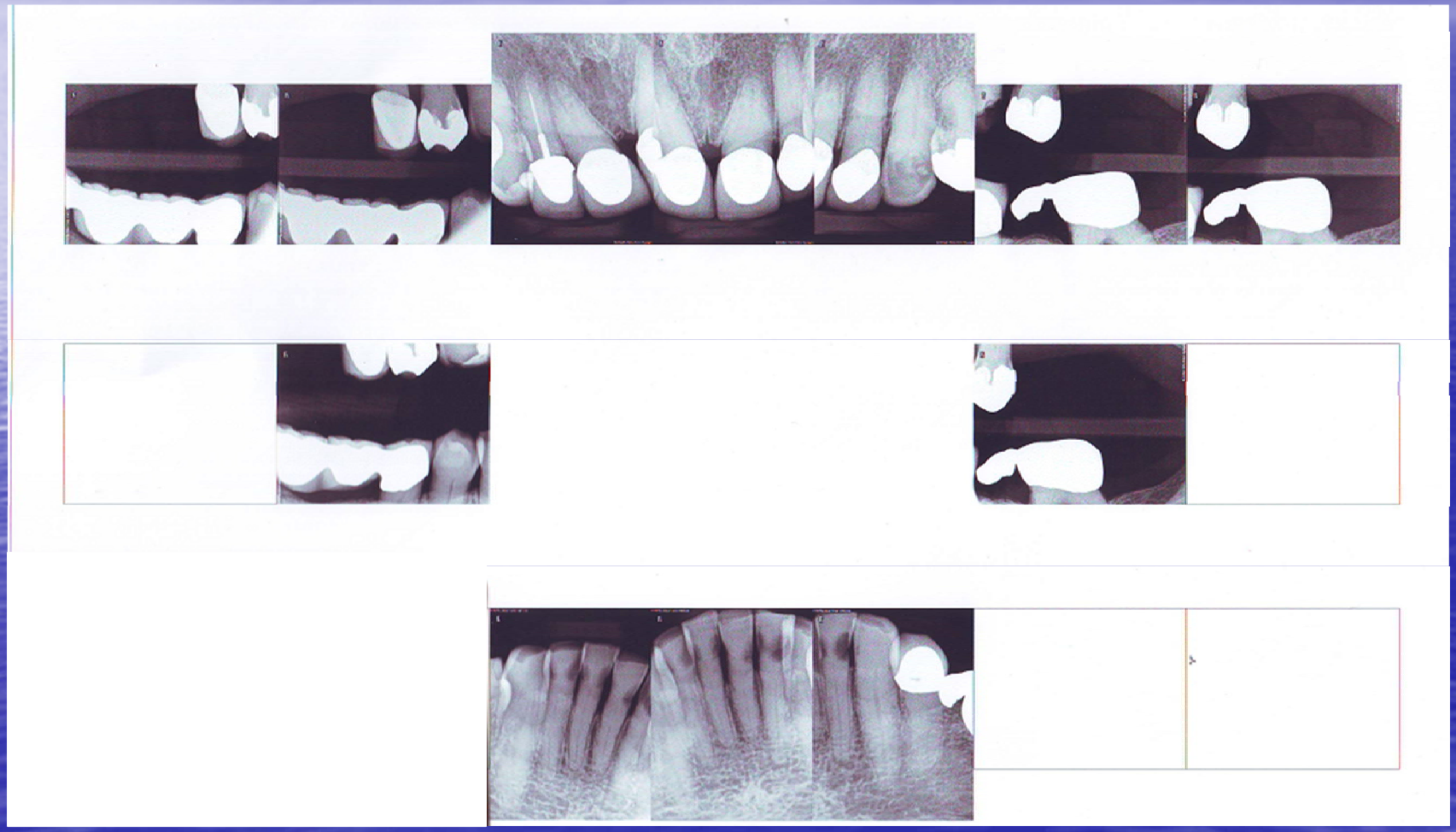
Team Member Names (must be same as Part 2):

_____

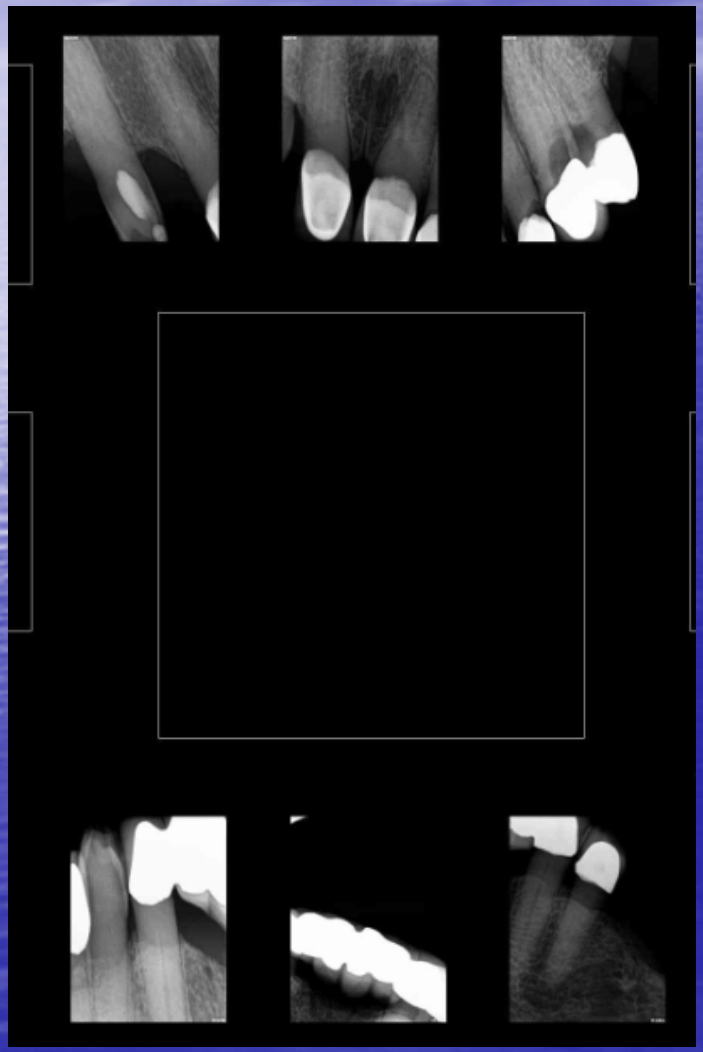
_____

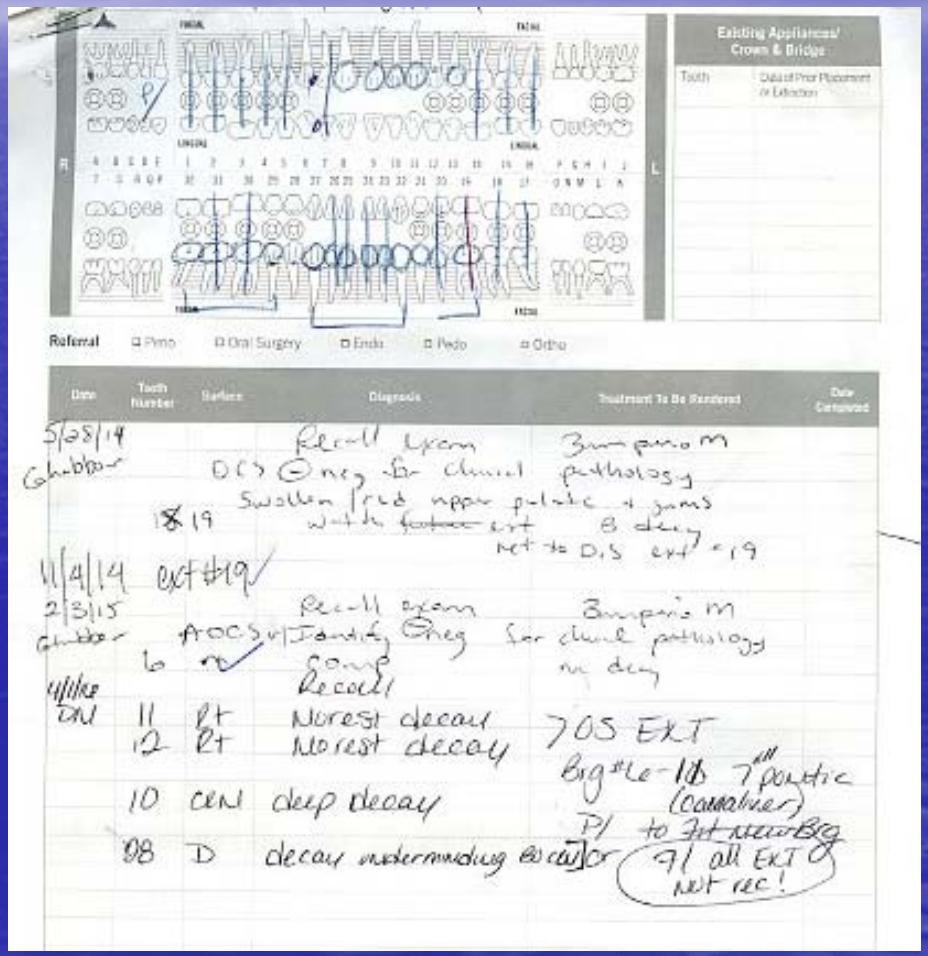
	Risks	Benefits	Alternatives	Cost & Timeline
Option 1 _____				
Option 2 _____				

Case Study- 2011 “Aunt Ruth” Octagenarian

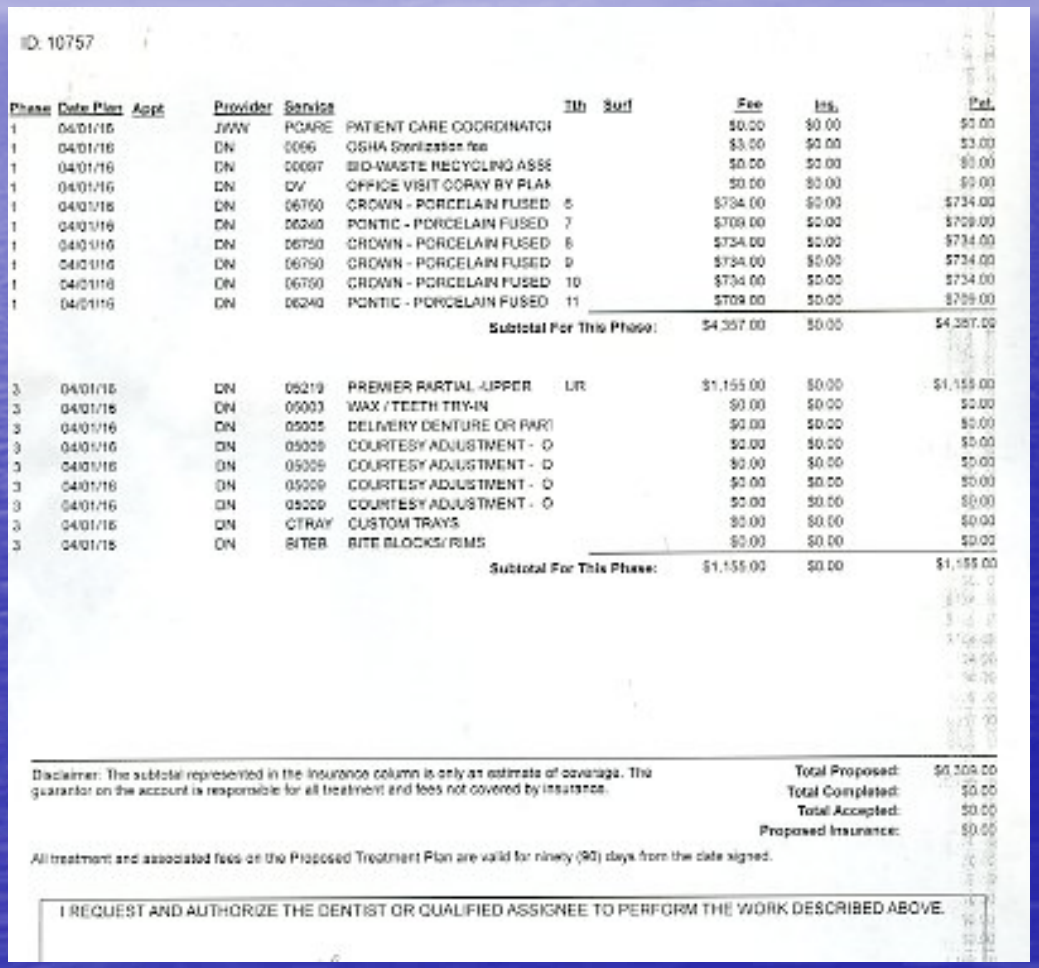


Case Study-2016 “Aunt Ruth”





Case Study- Tx Plan “Aunt Ruth”



ID: 10757

Phase	Date Plan	Appt	Provider	Service		Tth	Surf	Fee	Ins.	Pat.
1	04/01/16		JWW	PCARE	PATIENT CARE COORDINATOI			$0.00	$0.00	$0.00
1	04/01/16		DN	0066	OSHA Sterilization fee			$3.00	$0.00	$3.00
1	04/01/16		DN	00097	BIO-WASTE RECYCLING ASSE			$0.00	$0.00	$0.00
1	04/01/16		DN	OV	OFFICE VISIT COPAY BY PLAI			$0.00	$0.00	$0.00
1	04/01/16		DN	06750	CROWN - PORCELAIN FUSED	6		$734.00	$0.00	$734.00
1	04/01/16		DN	06240	PONTIC - PORCELAIN FUSED	7		$709.00	$0.00	$709.00
1	04/01/16		DN	06750	CROWN - PORCELAIN FUSED	8		$734.00	$0.00	$734.00
1	04/01/16		DN	06750	CROWN - PORCELAIN FUSED	9		$734.00	$0.00	$734.00
1	04/01/16		DN	06750	CROWN - PORCELAIN FUSED	10		$734.00	$0.00	$734.00
1	04/01/16		DN	06240	PONTIC - PORCELAIN FUSED	11		$709.00	$0.00	$709.00
					Subtotal For This Phase:			$4,357.00	$0.00	$4,357.00
3	04/01/16		DN	05212	PREMIER PARTIAL-UPPER	UR		$1,155.00	$0.00	$1,155.00
3	04/01/16		DN	05003	WAX / TEETH TRY-IN			$0.00	$0.00	$0.00
3	04/01/16		DN	05005	DELIVERY DENTURE OR PAR			$0.00	$0.00	$0.00
3	04/01/16		DN	05009	COURTESY ADJUSTMENT - O			$0.00	$0.00	$0.00
3	04/01/16		DN	05009	COURTESY ADJUSTMENT - O			$0.00	$0.00	$0.00
3	04/01/16		DN	05009	COURTESY ADJUSTMENT - O			$0.00	$0.00	$0.00
3	04/01/16		DN	05009	COURTESY ADJUSTMENT - O			$0.00	$0.00	$0.00
3	04/01/16		DN	CTRAY	CUSTOM TRAYS			$0.00	$0.00	$0.00
3	04/01/16		DN	BITER	BITE BLOCKS/ RIMS			$0.00	$0.00	$0.00
					Subtotal For This Phase:			$1,155.00	$0.00	$1,155.00

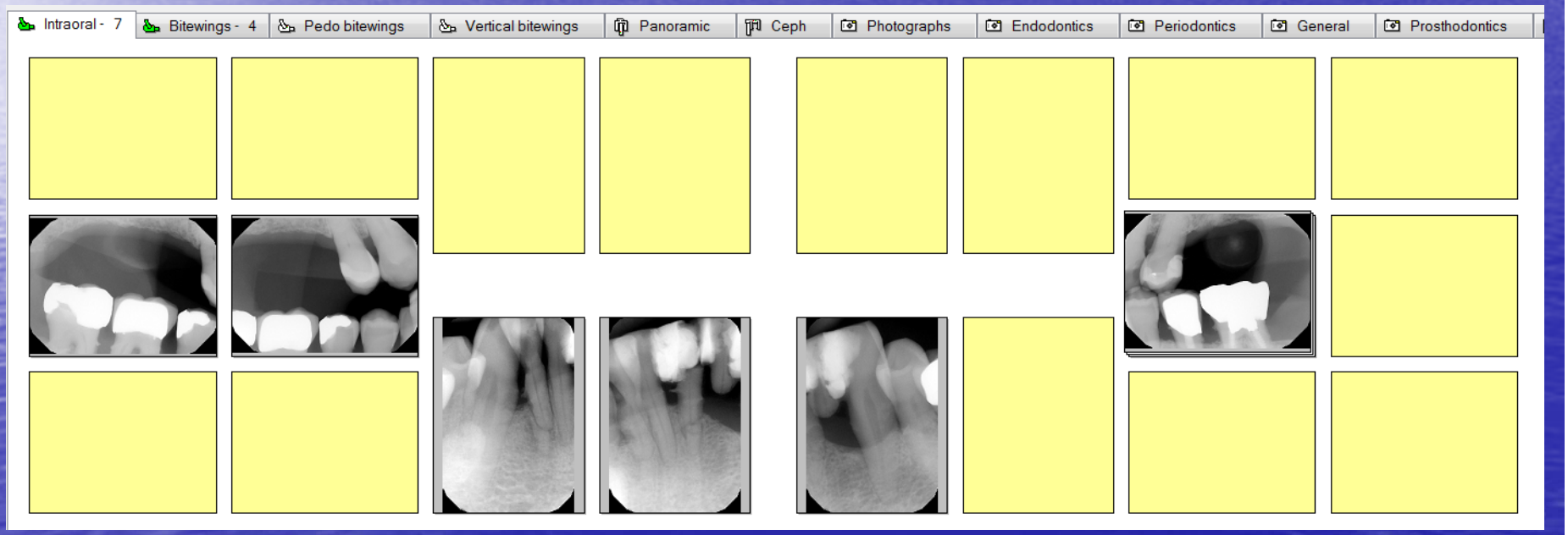
Disclaimer: The subtotal represented in the Insurance column is only an estimate of coverage. The guarantor on the account is responsible for all treatment and fees not covered by insurance.

Total Proposed:	$5,309.00
Total Completed:	$0.00
Total Accepted:	$0.00
Proposed Insurance:	$0.00

All treatment and associated fees on the Proposed Treatment Plan are valid for ninety (90) days from the date signed.

I REQUEST AND AUTHORIZE THE DENTIST OR QUALIFIED ASSIGNEE TO PERFORM THE WORK DESCRIBED ABOVE.

Case Study- Mr. K 92 yr old from San Diego-Venture Capitol Scientific Advisor



Case Study- Mr. K 92 yr old

TIME 1:35 PM

Date: 1/15/2016

[redacted]

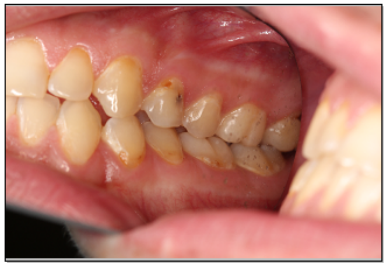
Planned Services Information

Services	Appt Date	Tth	Surf	Status	Prov	Planned Date	Comp. Date	Fee	Est Ins	Pat
05811-Interim, Complete Lower		22-2		Proposed	BLB	1/15/2016		$913.00	$456.50	$456.50
00360-3D Cone Beam				Proposed	XRU	1/15/2016		$315.00	$0.00	$315.00
06057-Custom Abutment, Implant		22		Proposed	BLB	1/15/2016		$573.00	$286.50	$286.50
06057-Custom Abutment, Implant		26		Proposed	BLB	1/15/2016		$573.00	$280.00	$293.00
06068-PC Implant Retainer		22		Proposed	BLB	1/15/2016		$1,378.00	$0.00	$1,378.00
06068-PC Implant Retainer		26		Proposed	BLB	1/15/2016		$1,378.00	$0.00	$1,378.00
06245-Bridge Pontic- All Porcelain		23		Proposed	BLB	1/15/2016		$1,389.00	$0.00	$1,389.00
06245-Bridge Pontic- All Porcelain		24		Proposed	BLB	1/15/2016		$1,389.00	$0.00	$1,389.00
06245-Bridge Pontic- All Porcelain		25		Proposed	BLB	1/15/2016		$1,389.00	$0.00	$1,389.00
02393-Comp, Post, 3 Surf		12	MOD	Proposed	BLB	4/9/2010		$344.00	$0.00	$344.00
02331-Comp, Ant, 2 Surf		27	IL	Proposed	BLB	1/15/2016		$349.00	$0.00	$349.00

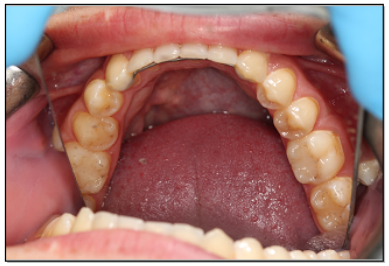
Total Proposed/Posted to Walkout:	$9,990.00
Total Accepted:	$0.00
Total Completed:	$0.00
Total Referred:	$0.00
Total Estimated Insurance:	$1,023.00
Total Discount:	$0.00
Total Patient Portion:	$8,967.00
Total Plan:	$9,990.00

Case Study- 20 yr old male

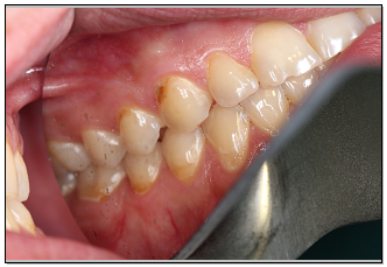
Lateral right



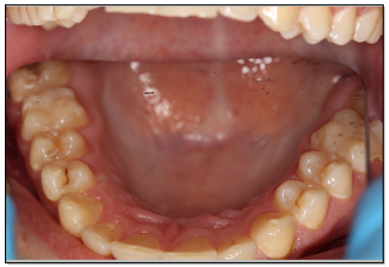
Occlusal maxilla

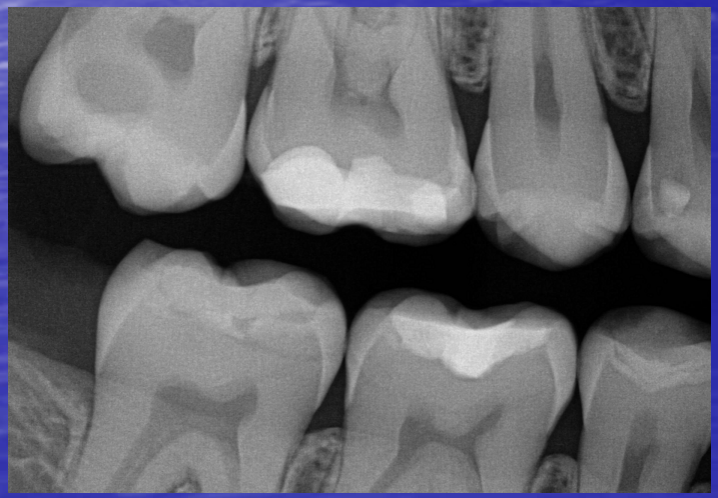


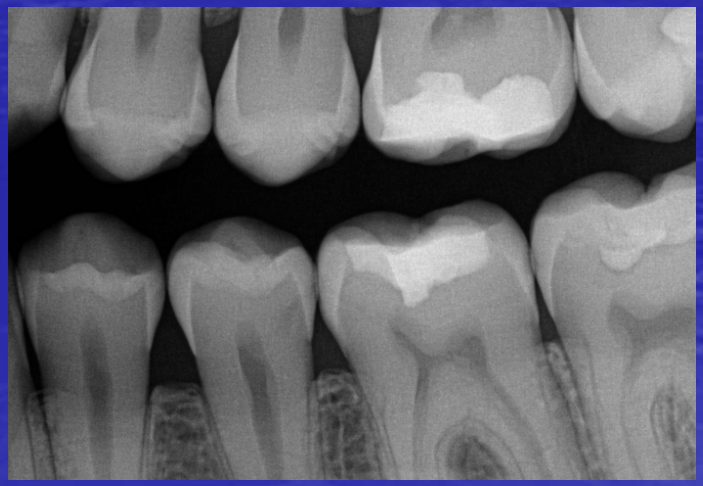
Lateral left



Occlusal mandible







Case Study- 20 yr old male 12K tx plan

Phase	Date Plan	Appt	Provider	Service		Tth	Surf	Fee	Ins.	Pat.
	11/06/2014		TD	FLUOR	Fluoride NSF- Paste			$21.00	$0.00	$21.00
	11/06/2014		TD	05986	Fluoride Trays			$200.00	$0.00	$200.00
					Subtotal for This Phase:			$221.00	$0.00	$221.00
1	11/06/2014		TD	02950	Buildup core, Inc. Pins	2		$283.00	$0.00	$283.00
1	11/06/2014		TD	02740	Crown, porc/ceramic	2		$1,533.00	$0.00	$1,533.00
1	11/06/2014		TD	02393	Resin 3+ surf,posterior	4	DOB5	$543.00	$0.00	$543.00
1	11/06/2014		TD	02393	Resin 3+ surf,posterior	5	DOB5	$543.00	$0.00	$543.00
					Subtotal for This Phase:			$2,902.00	$0.00	$2,902.00
2	11/06/2014		TD	02335	Resin, 4+ surfaces, anterior	7	MIDL	$543.00	$0.00	$543.00
2	11/06/2014		TD	02331	Resin, 2 surf, anterior	9	IL	$459.00	$0.00	$459.00
2	11/06/2014		TD	02330	Resin, 1 surf, anterior	11	F5	$355.00	$0.00	$355.00
					Subtotal for This Phase:			$1,357.00	$0.00	$1,357.00
3	11/06/2014		TD	02393	Resin 3+ surf,posterior	12	DOB5	$543.00	$0.00	$543.00
3	11/06/2014		TD	02394	Resin Comp-4+ Surf Post	13	MODB5	$543.00	$0.00	$543.00
3	11/06/2014		TD	02950	Buildup core, Inc. Pins	15		$283.00	$0.00	$283.00
3	11/06/2014		TD	02740	Crown, porc/ceramic	15		$1,533.00	$0.00	$1,533.00
					Subtotal for This Phase:			$2,902.00	$0.00	$2,902.00
4	11/06/2014		TD	02393	Resin 3+ surf,posterior	18	MOB5	$543.00	$0.00	$543.00
4	11/06/2014		TD	02393	Resin 3+ surf,posterior	19	DOB5	$543.00	$0.00	$543.00
4	11/06/2014		TD	02393	Resin 3+ surf,posterior	20	DOB5	$543.00	$0.00	$543.00
4	11/06/2014		TD	02391	Resin, 1 surf, posterior	21	B5	$355.00	$0.00	$355.00
4	11/06/2014		TD	02391	Resin, 1 surf, posterior	22	F5	$355.00	$0.00	$355.00
					Subtotal for This Phase:			$2,339.00	$0.00	$2,339.00
5	11/06/2014		TD	02391	Resin, 1 surf, posterior	27	F5	$355.00	$0.00	$355.00
5	11/06/2014		TD	02391	Resin, 1 surf, posterior	28	B5	$355.00	$0.00	$355.00
5	11/06/2014		TD	02392	Resin, 2 surf, posterior	29	OB5	$459.00	$0.00	$459.00
5	11/06/2014		TD	02393	Resin 3+ surf,posterior	30	DOB5	$543.00	$0.00	$543.00
5	11/06/2014		TD	02393	Resin 3+ surf,posterior	31	MOB5	$543.00	$0.00	$543.00
					Subtotal for This Phase:			$2,255.00	$0.00	$2,255.00
					Subtotal:			$11,976.00	$0.00	$11,976.00

Common Themes from Case Studies?

Rational for a Systematic Approach?

Risks, Benefits, Costs and Alternatives?

Oral Health Status

Outcome

Put teeth in 3 piles

Keep, Extract, ???

Phases of Care

Prevention and maintenance

From no treatment, minimally invasive, ...

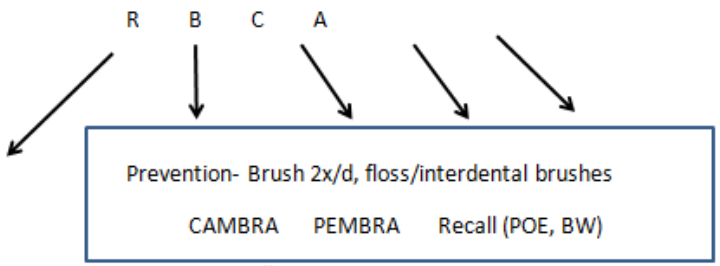
Oral Health Status
(graphic)

Keep for Sure	Outcome
???????	Keep Teeth
Extract for Sure	Keep Most/Some Teeth
	Lose Teeth it is only a matter of time

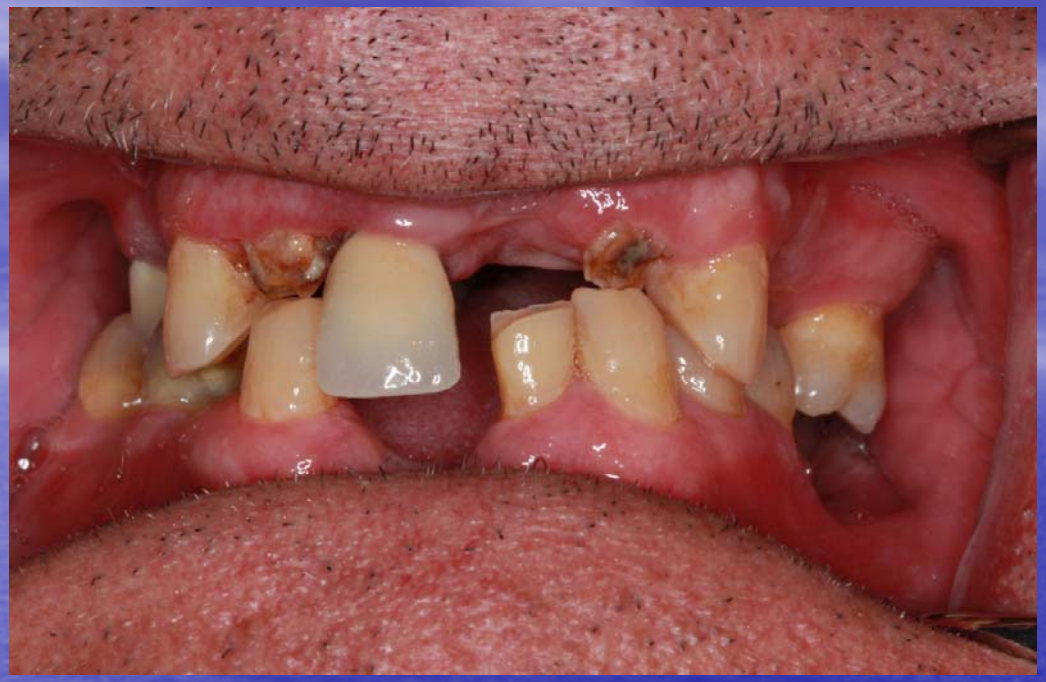
Must do Should do Could do

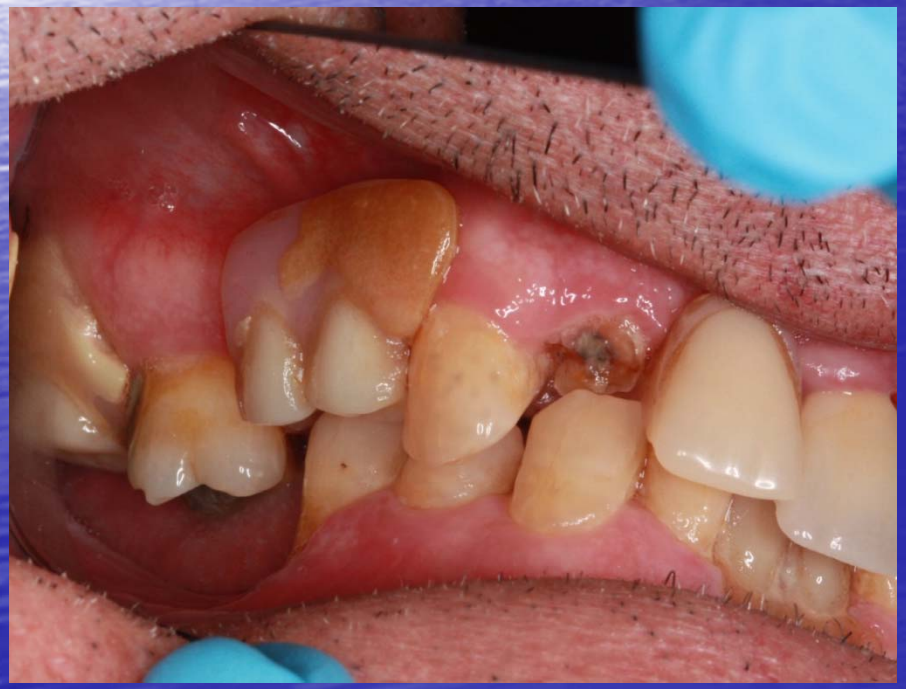
Phase I Phase II Phase III Phase IV

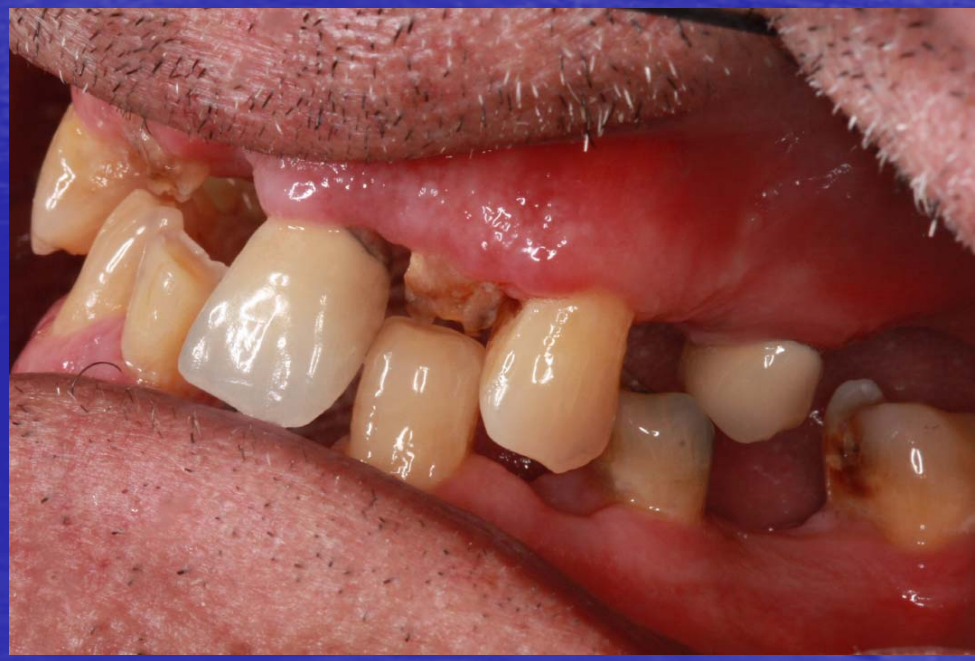
Reasonable Expectation of 5 years to life longevity vs heroics

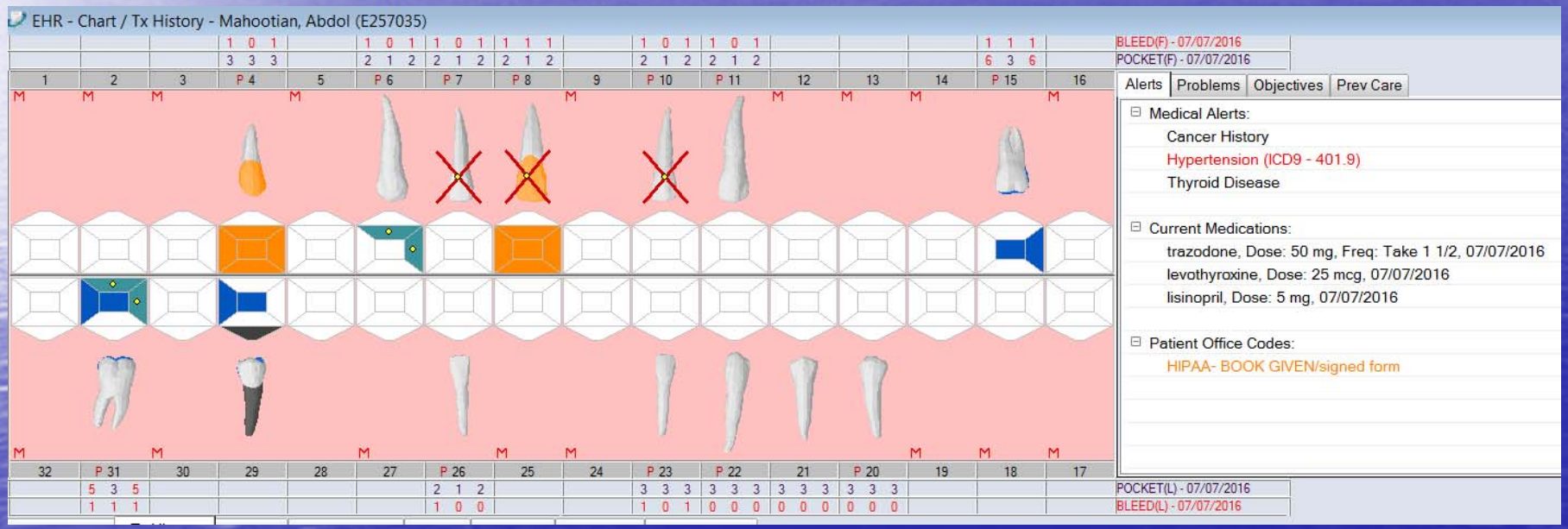


No Tx	Minimally Invasive	Most Invasive
Consequence	Least cost	Most Cost
Risks	Least visits	Most Visits

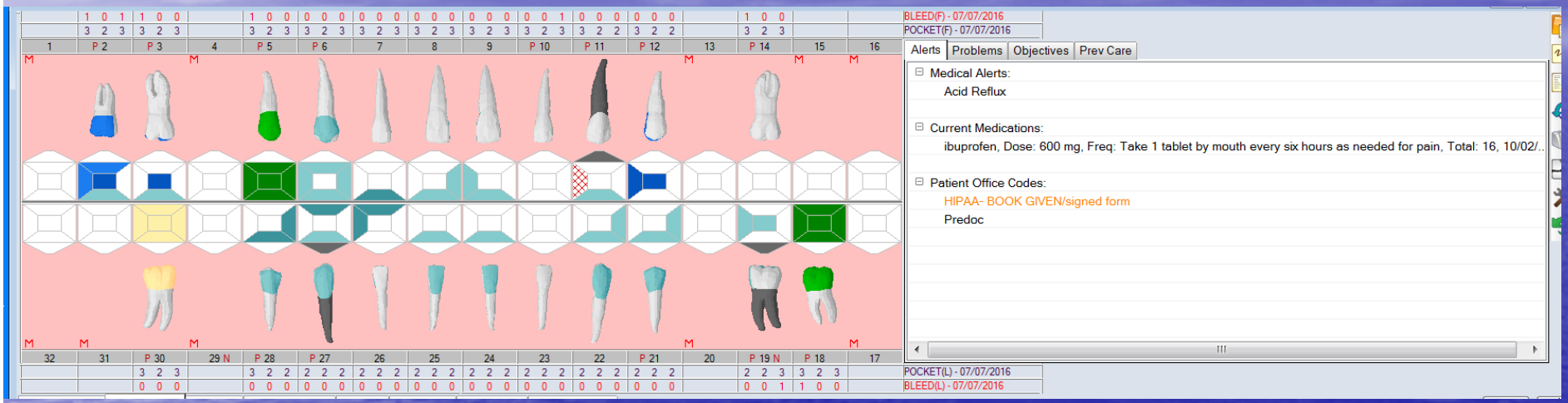


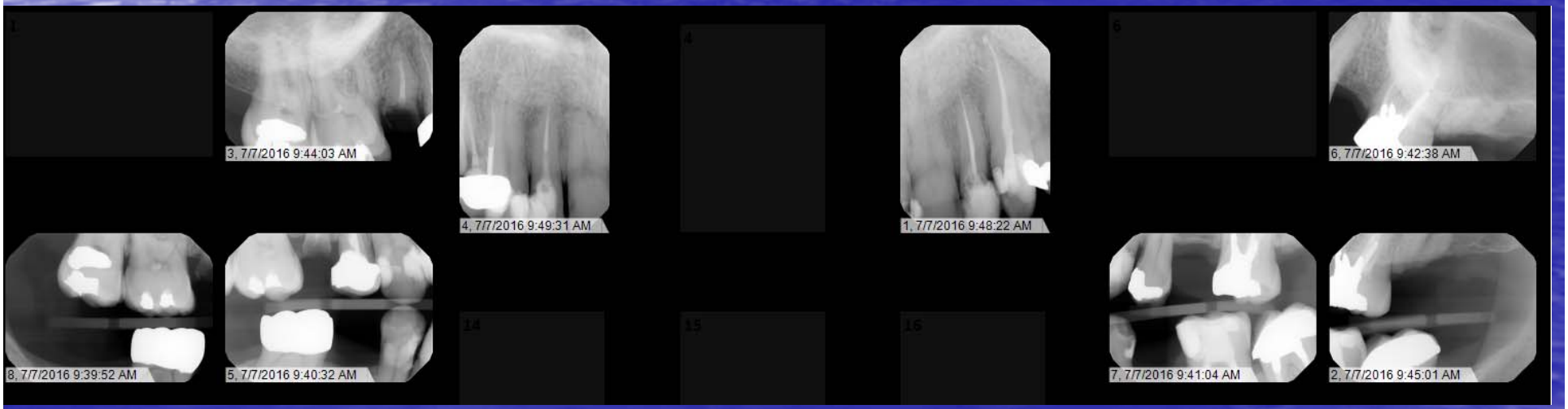




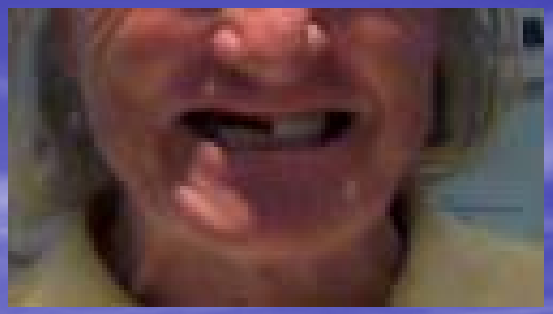

EHR - Chart / Tx History - Mahootian, Abdol (E257035)
BLEED(F) - 07/07/2016
POCKET(F) - 07/07/2016
Alerts
Problems
Objectives
Prev Care
Medical Alerts:
Cancer History
Hypertension (ICD9 - 401.9)
Thyroid Disease
Current Medications:
trazodone, Dose: 50 mg, Freq: Take 1 1/2, 07/07/2016
levothyroxine, Dose: 25 mcg, 07/07/2016
lisinopril, Dose: 5 mg, 07/07/2016
Patient Office Codes:
HIPAA- BOOK GIVEN/signed form
POCKET(L) - 07/07/2016
BLEED(L) - 07/07/2016

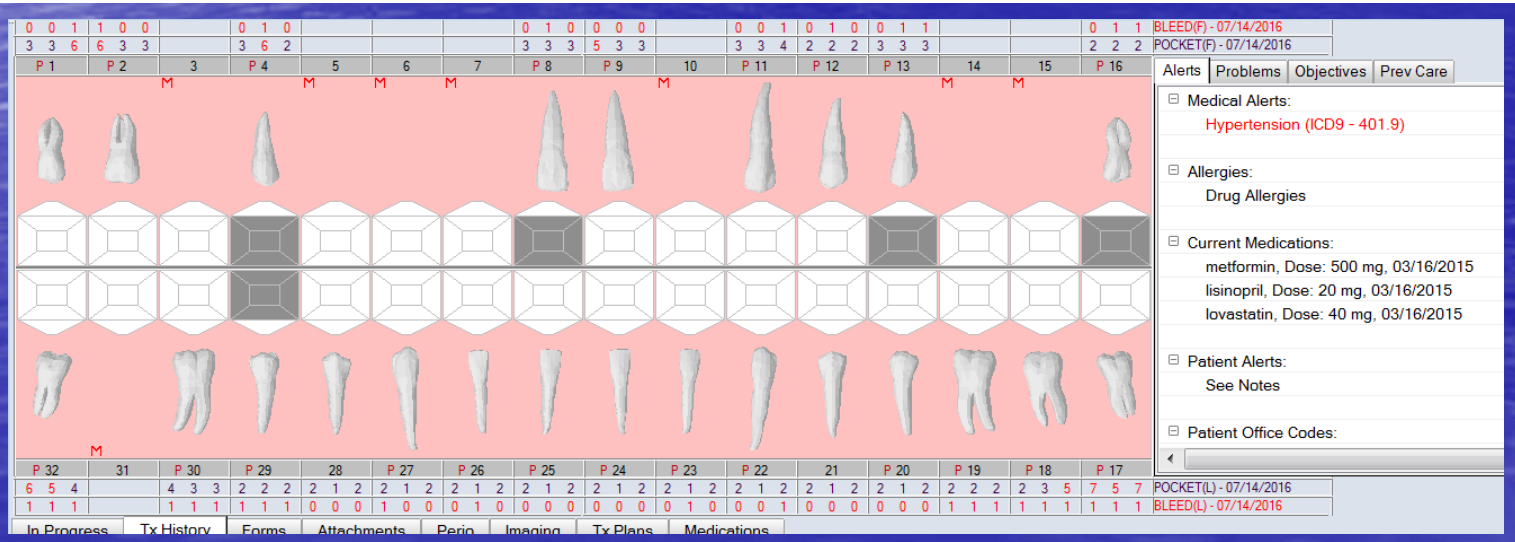
Case Study-Group Exercise



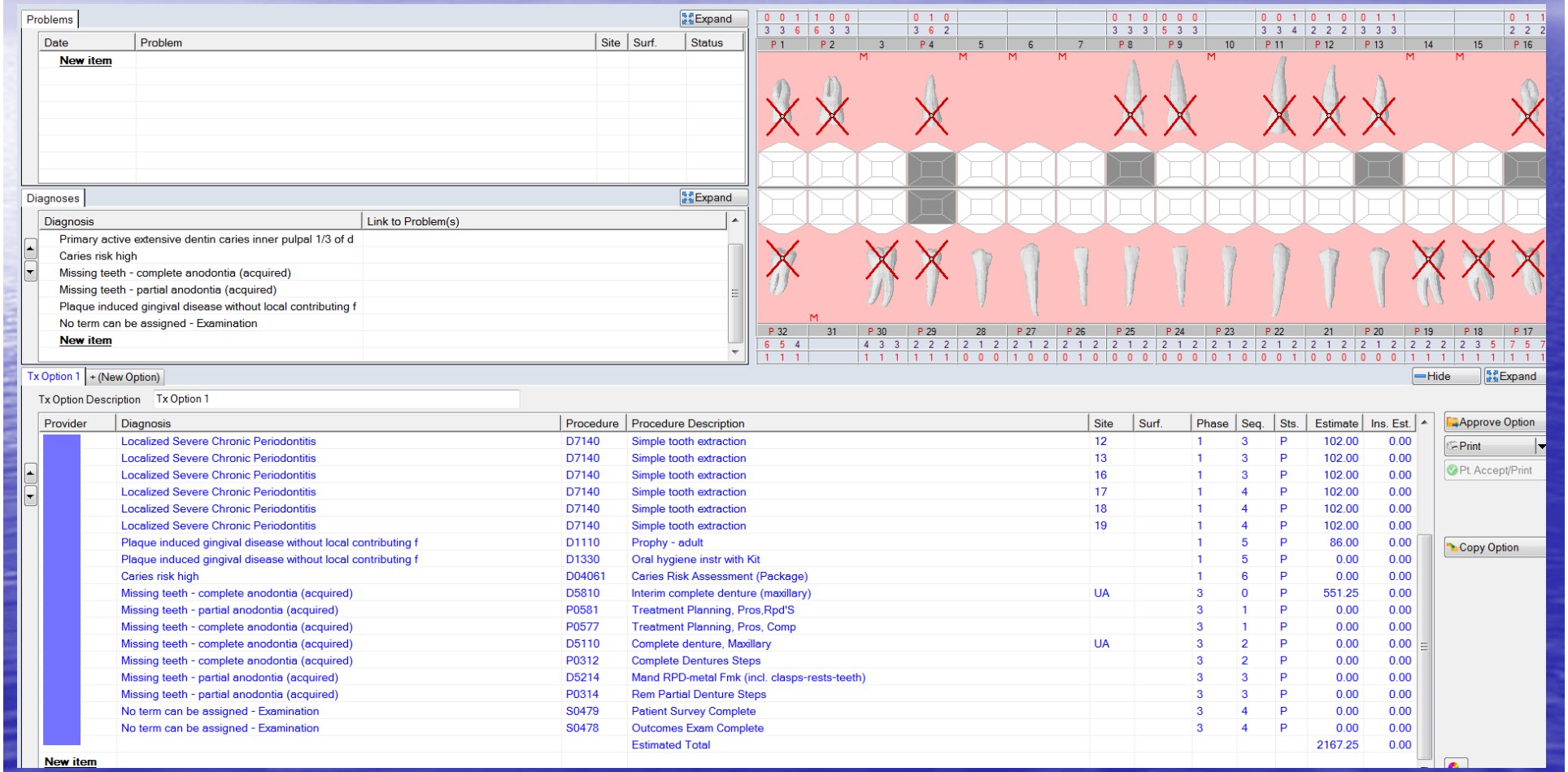


Case Study
Small Group Exercise





Tx Plan After R, B, C and A



Questions?
Comments?