Welcome to the third installment of Office Visit, where we visit a Townie’s office and profile their equipment, design or unique practice philosophy. If you would like to participate, or nominate a colleague please send me an e-mail at tom@dentaltown.com.

This month we visited Dr. Chaim Wexler’s practice located in a Manhattan apartment building. His compact three-operatory practice has a unique philosophy that is influenced by his office manager, Marcia Meyers, MBA.
Equipment List

Computer System:
• Computer network in all operatories, paperless office

Software:
• Dentrix – www.dentrix.com

CAD/CAM:
• Sirona CEREC 3D – www.sirona.com

Digital Radiography:
• Schick Dental Technologies CDR – www.schicktech.com
• KODAK 8000 Digital Panoramic System – www.kodak.com
• Planmecca, Inc. Dixi 3 – www.planmecca.com/EN

Laser – Operatory:
• ADT DioLase ST
  6.0 watts (current model Biolase DioLase Plus) – www.biolase.com

Laser – Diagnostic:
• KaVo America DIAGNOdent – www.kavousa.com

Handpieces:
• NSK Technologies Ti-Max 400 EL – www.nsk-nakanishi.co.jp
• Kinetic Instruments – www.kineticinc.com

Endodontics:
• J. Morita USA Dentaport ZX (current model is Root ZX II) – www.jmoritausa.com

Magnification:
• Seiler Revelation – www.seilerinst.com
• Kerr Orascoptic 2.5x Galilean – www.orascoptic.com

Miscellaneous:
• Isolite dryfield illuminator – www.isolitesystems.com

Q: When did you decide that having an office filled with high-tech equipment was an important goal?
A: I have never considered myself a technology junkie as such. In fact, most of my career was spent trying to avoid anything more than completely necessary to run my small solo practice. I was convinced that the approach to success was to spend as little as possible on any equipment. I believe that my original interest in newly available technologies came as answers to weaknesses in my office and not as something to set myself apart. For example, our small office was constantly having problems getting x-rays developed and filed in a timely and organized manner. Also, we noticed that if we had to call a patient in for a second appointment to review the x-rays, many times they would not reschedule or put off treatment. When I saw the demo of digital x-ray technology, I realized right away that this would be a tremendous benefit for our small office.

This same pattern is part of what my criteria are for deciding on new technologies. Primarily, any device should function to answer a pressing need in my office. If it has a "wow" appeal to the patient, even better; but that should never be the driving force for acquiring new products in my opinion.
# Chaim's Top Five

<table>
<thead>
<tr>
<th>Equipment</th>
<th>Earliest Date of Purchase</th>
<th>Reasons for Purchase</th>
<th>Equipment Replaced</th>
<th>Procedures Added to the Practice as a Result of This New Technology</th>
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<tbody>
<tr>
<td>Sirona CEREC</td>
<td>June 2000</td>
<td>To produce ceramic inlays onlays and crowns.</td>
<td>Nothing replaced.</td>
<td>We have added so many new procedures and techniques. Some of them are: one-visit root canal and crown, one-visit implant placement and final crown, one-visit quadrant dentistry, posterior inlays and lower anterior crowns.</td>
</tr>
<tr>
<td>KODAK 8000 Digital Panoramic System</td>
<td>September 2005</td>
<td>The x-rays are available right away and always labeled and dated correctly.</td>
<td>An older analog pan. Pans were lost and misfiled from time to time.</td>
<td>Pans on all patients to replace full-month x-rays. The quadrant pan allows me to expose only certain portions of the mouth.</td>
</tr>
<tr>
<td>J. Morita Dentaport ZX (current model is Root ZX II)</td>
<td>November 2004</td>
<td>To improve our rotary root canal system.</td>
<td>Early rotary root canal systems.</td>
<td>Ability to do almost all root canals in office.</td>
</tr>
<tr>
<td>Magnification: Seiler Microscope/Kerr Orascoptic lenses and light</td>
<td>2003 and 1999 respectively</td>
<td>Magnification and light are the two most essential elements of good clinical care.</td>
<td>N/A</td>
<td>It has made treatment of quadrant dentistry for CEREC practical and easy. It has made performing root canal on broken teeth relatively straightforward. It frees the dental assistant from sitting chairside.</td>
</tr>
<tr>
<td>Isolite dryfield illuminator</td>
<td>2004</td>
<td>This aids in all treatments.</td>
<td>Rubberdam, in most cases.</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Q: How would a dentist in your community describe your office?
A: I have always said “dentistry is local.” My office is in a middle-class area of Manhattan. Our patients have literally thousands of dental practices to choose from within a short distance. Like many city dwellers, they have high expenses from housing and other things, and do not always wish to spend a lot on dentistry. Like myself in my earlier incarnation, my colleagues for the most part, view some of the technology that I use as unnecessary frills and an unneeded increase in overhead. They have not yet grasped fully that technology actually cuts overhead drastically.

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Q: Which pieces of equipment have provided the fastest return on your investment (ROI)? What factors made this possible?
A: The fastest ROI by far has been the digital x-rays and digital pan. These items have a relatively low investment, but pay dividends immediately. They improve diagnosis and patient education. They allow even the most disorganized office to access and retrieve x-rays immediately at every operatory. As the first piece of technology that the patient encounters, it gives them the initial impression of an up-to-date, technology savvy office.

Q: You are an early adopter of CEREC technology. How did you decide to select this technology, and what is the impact on your practice?
A: CEREC again answered a growing need and I admit, again, a weakness in my practice. By the late ’90s I saw more and more patients were demanding non-metallic posterior restorations. It finally dawned on me that instead of explaining for the millionth time that amalgam was safe and approved by the American Dental Association, I should be giving the patients what they desire.

The impact of CEREC on my practice and lifestyle has been enormous. It revived my passion for dentistry. For the first time, I traveled to dental meetings and conventions. I developed a desire to share my knowledge with others, especially young students. That is how I began teaching at Columbia dental school and developing its CEREC program there. I also became involved in a fledgling online forum with a funny name called Dentaltown, where a lot of interesting characters were putting in their two cents several times a day. I became a regular, and soon after that an addict.

Perhaps the main impact of the CEREC was that patients sensed my passion and commitment dentistry. They may not understand what I was doing, but they realized I cared deeply and that I was very focused on their care. This alone had a profound impact on the way my practice was perceived in the community.

Q: Which pieces of equipment are most appreciated by your patients? Why?
A: The most appreciated piece of equipment is the CEREC as it allows them to get their treatment finished in a very small amount of time. Most of our patients work, and even those who are retired prefer to be elsewhere. Although they might not “appreciate” it directly, our patients also are happy that their root canal treatments are being done fast and effectively with rotary root canal systems. Some might not appreciate the Isolite dryfield illuminator, but they like the fact that their jaw is supported during treatment and that their work is done quickly and safely.

Q: How do you work with three operatories? Describe your schedule and thoughts about having more space – do you want more or is three a great size for your style of practice?
A: Three operatories is more than adequate for our needs at this time. We are in an urban environment where every square foot of space comes at a premium. The style of practice is seeing patients sequentially rather than many at a time. We often utilize the downtime of the milling process of CEREC to see another patient in the second operatory. Cleanings, adjustments, whitening and consults can be done in the third operatory when the other two are in use. We also have a part-time dental associate and hygienist who mainly do cleanings.

My schedule at this time is quite hectic. For the last few years, I have been directing the CEREC program at Columbia University dental school. That entails a commitment of at least two days a week away from the office. I find the teaching rewarding on all levels, except financially. This means I still work a full four-day-a-week schedule at my private practice.

Q: What is your philosophy regarding office technology? What misconceptions do your colleagues have about technology?
A: Like myself in my earlier incarnation, my colleagues for the most part, view some of the technology that I use as unnecessary frills and an unneeded increase in overhead. They have not yet grasped fully that technology actually cuts overhead drastically.
A: My philosophy is that the technology should answer a pressing need in our office or open up a new area of clinical practice for our patients. Ideally, these devices should pay for themselves.

Some colleagues think that we buy the technology just to set our office apart. This could not be further from the truth. We buy these things to make our lives easier. Colleagues also think that these products are expensive frills. With few exceptions, these new technologies have saved us money through increased practice efficiency and diminishing other expenses.

Q: Is it difficult to incorporate new technology into your daily routine? What is your approach to integrating new technology into your practice?

A: I have no difficulty at all incorporating new technology into our routine. I won’t buy a product unless I have a clear understanding and conception of how this will be employed in our daily clinical routine. My approach is to read the instructions or talk to the sales rep and start using the technology immediately. If I have any trouble, I put a post on Dentaltown.com and the answers are posted in a few minutes!

Q: How do you address staff training each time you add a new piece of technology?

A: Staff training is usually done with a rep or lunch and learn. We have a small and motivated staff. They are usually as excited as I am to learn about the new technology. I always bring the staff to dental meetings so they can see and learn about technology I am considering for the office. It is important that the staff be totally on your side when you get into any practice changing techniques.

Q: Which items from your list were purchased as a result of a recommendation on Dentaltown.com?

A: Dentaltown led me to the Isolite, OCO Biomedical implants, DIAGNOdent, Dentaport ZX, Seiler microscopes and many other products. Nowadays we won’t buy any equipment without first consulting what people on DT say about it.

Q: If your best friend from dental school called for a technology recommendation, which items would you insist that s/he purchase first? Why?

A: If a friend called, I would ask him what his most pressing problem that he sees in his practice. If he hates clinical work, I might ask him to try magnification and light. I would then follow-up to make sure that he has switched to digital x-rays and pans. If he wants more control of his treatment and less lab cases, I would recommend a CEREC machine.

Q: Do you have a technology budget each year, or do you evaluate each purchase based on return on investment (ROI)? What do you consider a “no-brainer” purchase? Give an example.

A: We have no budget for technology per se; however, we do look carefully and attend a dental trade show every year. I also closely monitor DT for any talk of new exciting things that are up and coming. If something interests me, I follow up on it and consider purchasing it. If it is a very expensive product the ROI is essential and I consult my accountant.

It Takes More than Technology to Run a Practice

An interview with Marcia Meyers, MEd, MBA, Dr. Wexler’s Office Manager

Q: How has your MBA and business background changed the operation of Dr. Wexler’s office? How is your management of the practice different from the “typical” dental office?

A: Since I don’t come from a dental background, I tend to look at a dental practice as I would other types of businesses. I look at overhead, staffing and equipment investments without a pre-conceived notion of what “it should be.” I tend to look at the production per hour of chair time rather than what each service should cost.

I also have educated the doctor on the need to spend money to make money. Dentists tend to focus inordinately on how much an item of technology will cost instead of looking at how this will facilitate growth and profitability of the office overall.

Q: Describe your approach to CareCredit? How do you use it in the practice (every patient, large cases, etc.)?

A: CareCredit is a great tool in our office. We offer a range of services including cosmetic dentistry, Invisalign, porcelain onlays, implants and other procedures that will require the patients to pay significant out-of-pocket expenses. Before each patient comes to our office, we do our utmost to know all his or her benefits, including what is and what is not covered. We use our practice management system (Dentrix) and experience to predict with great accuracy what the patient’s out-of-pocket expense will be. Even before presenting the treatment plan to the patient, we take advantage of CareCredit’s new pre-approval feature to see if a payment is likely to be granted. This allows our office to discuss various payment options before even taking a full credit history.

Q: Describe your patient mix (young/old, insurance/no insurance, working/retired, etc.). What are the top three sources for new patients in your practice?

A: We have a mix of young urban professionals either single or very young families. We also have a significant number of older patients. Families with older children tend to move away to the suburbs over time. When I first began, our referrals were mainly from insurance plans. Since joining the practice and placing the focus on our patient services and personalized care we have seen our fee-for-service business rise to 70–75%.

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Q: How did you add Invisalign to your practice? Do you do conventional ortho?
A: I have been doing my own conventional orthodontics for many years, but recently took a faculty course in Invisalign at Columbia. Invisalign Express, is a major, major improvement with more competitive pricing and short time span.

I have stopped placing bands and brackets on adult teeth. Most cases are stand alone Invisalign Express treatments. We are now experimenting with using Invisalign in our practice for older teens who are highly motivated to wear their appliances. Also, we have a handful of pre-prosthetic cases that we are in the process of treating.

Q: Describe your typical Invisalign patient. Is their case in conjunction with Restorative?
A: The typical patient is an adult from 25 to 45 years old who has always been a drop unhappy with their tooth alignment. Many are thrilled that they can correct something relatively fast and affordable.

I am always fascinated to discover the endless possibilities for the practice of general dentistry. Dr. Wexler’s practice is another example of the fact that you do not need a huge facility to be successful. Certainly, it’s no surprise that Manhattan office space is at a premium. With the right technology, a cozy office can be an efficient, productive practice. Please visit our message boards on Dentaltown.com to discuss Dr. Wexler’s practice.