



ATTI PRACTICE GUIDE

The Value-First Presentation Framework

Why sound treatment plans get declined — and the four-part conversation that changes the answer.

P PROBLEM

C CONSEQUENCE

S SOLUTION

B BENEFIT

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THE PATTERN

I've Watched Thousands of Exams. They Almost All Sound the Same.

I've been in hundreds of dental practices. I've observed thousands of exams. The thing I see most often isn't a clinical miss. It's a conversation problem.

The doctor finds something and names it, then names the fix. Finds the next thing, names the fix. Problem, solution. Problem, solution. Problem, solution. Ping-pong down the arch until we reach the last tooth and ask if there are any questions.

It's fast. It's accurate. It's also the reason so many good treatment plans end with "Let me think about it."

We're describing what we found and what we'd do. We're never describing the value we bring.

The Value We Never Say Out Loud

Here is the thing every one of us knows and almost none of us says: **every dental problem gets worse over time**. As it gets worse, it gets harder to fix, more expensive to fix, and the end result is never as good as it would have been.

That fact is so obvious to us that we skip right past it. It is not obvious to the patient. They have no way to know it. Nobody has ever explained it to them, because everybody assumes somebody else already did.

And you cannot expect a patient to buy value that was never described.

This guide is about one small change in sequence — and the very large difference it makes in what your patients understand, and therefore what they decide.

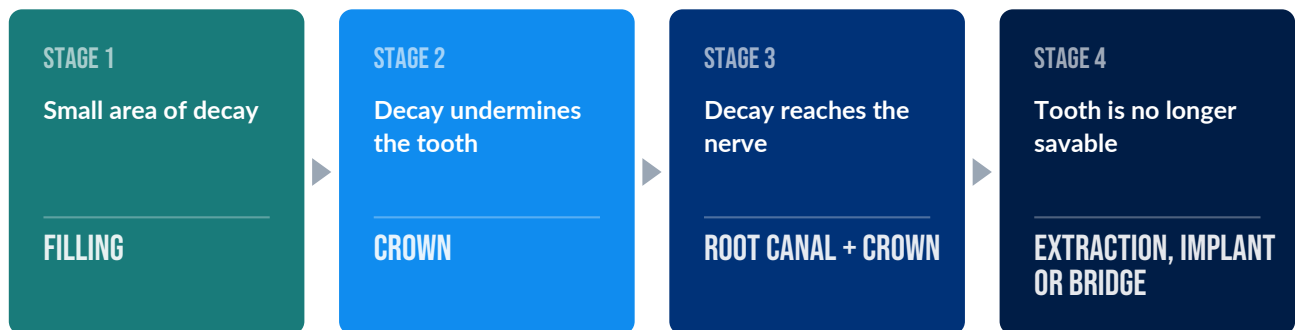
WHAT THE PATIENT HEARS

“Small Cavity” Sounds a Lot Like “Later”

Tell a patient they have a small cavity and they hear the word *small*. Small means minor. Minor means it can wait until after the holidays, or the next bonus, or whenever life settles down — which it never does.

They aren't being difficult. They're making a reasonable decision with the information they were given. What they were not given is the road map.

The Road Every Untreated Problem Travels



COST, COMPLEXITY AND CHAIR TIME increase at every stage → ...and the tooth you end up with is never as strong.

Not one step on that road is a surprise to you. You've watched it happen hundreds of times. Every step is a surprise to the patient. They are comfortable waiting because no one has ever walked them down it.

The same road exists for periodontal disease, for a cracked tooth, for a failing restoration, for the missing molar that lets the opposing tooth drift. Different findings, same physics: it doesn't hold still, and it never gets cheaper.

Waiting is a treatment decision. Most patients don't know they're making one.

THE FRAMEWORK

PCSB: Put the Consequence Before the Solution

The value-first framework is a small change in order with a large change in outcome. Instead of jumping from problem straight to solution, you put **what happens if we don't treat this** in between. Four steps, in this sequence, every time.



Why the Order Matters

When solution follows problem, you're a person recommending a purchase. When solution follows consequence, you're a person offering a way out of something the patient now wants to avoid. Same finding. Same recommendation. Same fee. Completely different conversation.

Everything in this framework lives or dies on the second letter. Skip C and you're right back to ping-pong — accurate, efficient, and declined.

THE WHOLE FRAMEWORK IN FOUR SENTENCES

"Here's what I see. Here's where it goes if we leave it. Here's what I recommend. Here's what that gets you."

The next four pages take each step one at a time: what it is, what it sounds like, and the specific way each one tends to go wrong.

**STEP ONE – PROBLEM****Show Them What You See**

Don't just tell them. **Show** them. Intraoral camera, radiographs, AI-assisted imaging, the scanner, a hand mirror — whatever you've got. Put it on the screen and put your finger on the spot.

A patient who *sees* the fracture line behaves differently than a patient who *hears* about the fracture line. Seeing turns your finding into their finding. That shift is most of the work.

Then describe it in language a person actually uses. No tooth numbers, no surfaces, no lingo.

"Distal-occlusal caries approaching the pulp" communicates nothing. "The decay has worked its way close to the nerve" communicates everything.

WHAT IT SOUNDS LIKE

"Let me put this up on the screen so you can see what I'm looking at. See this dark shadow, right at the edge of that silver filling? That filling has been in there a long time, and decay has gotten in underneath it. That dark area is the part of the tooth that's breaking down."

Watch out for: tooth numbers and clinical terms; narrating the image before the patient has actually looked at it; moving to the next finding while they're still studying this one. If they haven't seen it, you haven't done step one.

A Quick Test

Ask yourself whether the patient could describe the problem to their spouse in the car on the way home. If the answer is no, it wasn't shown plainly enough — and the spouse is very often the second half of the decision.

DRILL IT IN THE HUDDLE

Pull up an image of a finding you see every week. Have each person on the team describe it out loud in fifteen seconds, in plain English. No tooth numbers, no clinical terms. Go around the room until everyone can do it without flinching.



STEP TWO – CONSEQUENCE

Show Them Where It Goes

This is the step almost everybody skips, and it is the one carrying all of the value. It answers the question the patient is silently asking: **what happens if I wait?**

So walk them down the road. Name the cascade in order — this becomes that, that becomes this — and be specific about what each step costs them in money, in visits, and in how strong the tooth ends up being. You are not predicting doom. You are handing them the map you’ve had in your head the whole time.

WHAT IT SOUNDS LIKE

“Right now, this is a filling. Decay doesn’t stop and it doesn’t reverse, so if we leave it, it keeps growing. Once it takes out enough of the tooth, a filling won’t hold and we’re into a crown. If it reaches the nerve, we add a root canal on top of that crown. And if it goes far enough, the tooth isn’t savable at all and we’re talking about replacing it. Every step down that road costs more, takes more visits, and leaves you with a tooth that isn’t as strong as the one before it.”

Watch out for: hedging it into mush — “that could potentially become an issue down the road ” — which tells the patient it’s optional. And the opposite error: inflating it. Say what is true, in the order it actually happens.

This Is Not Fear. It’s Information.

Some people hear “consequence” and worry they’re being asked to scare patients. You’re not. Fear requires exaggeration, and we don’t do that — ever. The honest truth about a cavity is already compelling enough. Our obligation is to make sure that when a patient chooses to wait, they are choosing it with the same information we have.

Withholding the cascade doesn’t protect the patient. It just leaves them to find out the hard way, eighteen months from now, in more pain and for more money.

DRILL IT IN THE HUDDLE

Take your three most common findings and write the cascade for each, in plain language, as a team. Then say them out loud until everyone tells the same story.

S

STEP THREE – SOLUTION

Now Recommend the Fix

Once the patient understands the problem and where it leads, the solution stops sounding like a purchase and starts sounding like a way out. That's why it goes third and not second.

Keep it short. Name the treatment, roughly what it takes, and be clear that it is your recommendation — not a list of things a person could theoretically consider. Patients came to you for a professional judgment. Give them one.

WHAT IT SOUNDS LIKE

"What I recommend is a filling on that tooth. It's one visit, about forty-five minutes, and we catch it while it's still just a filling."

Watch out for: presenting three options with no recommendation attached. That isn't respect for autonomy — it's handing the patient a decision they have no training to make. Recommend first, then discuss alternatives if they ask.

Say It Like You Believe It

Watch for the qualifiers that creep in when we're uncomfortable talking about treatment: *we could maybe think about possibly doing something with that at some point*. Every hedge you add subtracts from what the patient thinks is at stake.

You already did the hard part. You showed them the problem and you showed them the road. A clear, calm, one-sentence recommendation is the least confusing thing you can offer them next.

DRILL IT IN THE HUDDLE

List the five treatments you recommend most. Write one sentence for each: what it is, how long it takes, and why now. Read them aloud and strike every "maybe," "kind of" and "at some point" you find.

B**STEP FOUR – BENEFIT****Tell Them What They Get**

Close the loop. One or two sentences that tie the solution back to the consequence you described. The benefit is nearly always the same shape: **you avoid the road we just walked down, and you get something you can count on.**

This is the part that gets dropped most often, usually because we're already mentally in the next operatory. Without it, the exam ends with the patient holding a diagnosis, a fee, and no reason.

WHAT IT SOUNDS LIKE

"Take care of it now and you keep your own tooth, with your own nerve, and you never have to travel that road at all. That's the kind of fix you don't have to think about again."

Watch out for: generic benefits that could apply to any patient and any tooth — "it'll be great for your oral health." Tie it to the specific consequence you just described for this specific person.

Then Stop Talking

When the benefit is delivered, ask what questions they have and let the silence sit. Most of us fill that pause with more explanation, which almost always waters down what we just said. The patient needs a few seconds to catch up. Give them the seconds.

Hand Off the Same Story

The conversation doesn't end when you leave the room. When the treatment coordinator picks it up, the first thing out of her mouth should be the consequence you described — not the fee. A patient who hears the same road map twice hears a practice that agrees with itself. A patient who hears the cascade from the doctor and a number from the front hears a sales handoff.

DRILL IT IN THE HUDDLE

For each of those five recommendations, add a second sentence that ties back to the consequence. Two sentences total. If it takes more than two, it isn't a benefit yet — it's another explanation.

SIDE BY SIDE

Same Findings. Two Conversations.

Nothing on the right is more aggressive than what's on the left. It's the same diagnosis and the same recommendation — reordered so a person who didn't go to dental school can follow it.

THE USUAL WAY

"Number 30 has recurrent decay under the amalgam, so we're looking at a build-up and a crown there. And 14 has a crack we should keep an eye on. Any questions?"

HOW IT ENDS

"Let me think about it and check with my husband."

Everything here is accurate. None of it is understandable to a person who has never seen a radiograph.

THE VALUE-FIRST WAY

P "Let me show you. See that dark shadow under the silver filling? Decay has gotten in underneath it."

C "That won't stop on its own. It keeps growing until a filling can't hold, and then it's a crown. If it reaches the nerve, it's a root canal too. Far enough and the tooth can't be saved."

S "What I recommend is a crown now, while there's still healthy tooth to build on."

B "You keep the tooth, you keep the nerve, and you're done with it."

HOW IT ENDS

A patient who understands the decision in front of her — and usually makes it today.

The left column takes about eleven seconds. The right column takes about forty. That extra half-minute is the single highest-return time you will spend all day.

MAKING IT STICK

How to Put This to Work Monday

01

TEACH IT TO THE WHOLE TEAM

Hygienists, assistants, treatment coordinators, front desk. When the hygienist describes a consequence one way and the doctor describes it another, the patient hears disagreement and defaults to waiting.

02

DRILL IT OUT LOUD

Ten minutes in the morning huddle. Pick one common finding and have each person run all four steps out loud. It feels awkward exactly twice, and then it's yours.

03

BUILD A CONSEQUENCE LIBRARY

Write out your ten most common findings and the plain-language cascade for each one. Agree on the wording as a team so every patient hears the same road map.

04

AUDIT YOURSELF

After each exam, four questions. Did they see it? Did I tell them where it goes? Was my recommendation clear? Did I tie it back to what they get?

05

WATCH WHAT MOVES

Same-day treatment acceptance moves first. Then unscheduled treatment and reappointment rates. Track them before you start so you can see the change.

THE FOUR-QUESTION SELF-CHECK

- ☐ Did the patient **see** the problem?
- ☐ Did I describe **where it goes** if we wait?
- ☐ Did I make a **clear recommendation**?
- ☐ Did I tie it back to **what they get**?



Keep Going

PCSB is one piece of a much larger picture. A practice that presents beautifully and schedules poorly still loses the case. The Team Training Institute works with practices on the whole system — clinical communication, hygiene productivity, scheduling, leadership, and the numbers that tell you whether any of it is working.

If this framework changes a conversation in your practice this week, use it. That's what it's for.

ABOUT THE AUTHOR

Dr. John Meis, DDS, FAGD, DICOI is a fourth-generation dentist, national speaker, and best-selling author with four decades in dental practice leadership. He is the co-founder of The Team Training Institute and the CEO of a multi-location group practice.

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