

To Review

If you have not yet read and shared with your staff the August 2001 issue, I urge you to do so. Included in that newsletter: (1) standards and guidelines for compensating staff, ratios between staff productivity and personnel costs; (2) recommended expense guidelines, each expressed as a percentage of collections; (3) averages, medians and goals for production, collections, accounts receivable, patient flow, recare systems, etc., in private pedo practice; (4) a *Monthly Practice Monitor* form listing must have management data; and (5) a brief summary of the stages of pediatric dental practice development.

This information provides the nuts and bolts data any well managed practice must record, analyze and apply to guide the practice much as a rudder steers a ship. In fact, when I consult my beloved, well worn dictionary, the word rudder has a secondary definition beyond the obvious connections to a boat and an airplane that says, "Something that controls direction; a guide." Numbers are the rudder for the practice. Long gone are the days, in my opinion, when a practice could be run following hunches, maybes and seat-of-the pants management style. Numbers, standards, hard measurable data is necessary now to assure a profitable, efficient practice that endures and serves well its owners(s), employees and, most of all, its patients.

I feel so strongly that you MUST have the statistics given in the last *PMM* news, that I will make you an offer—if you have lost or tossed the August issue, call the headquarters office and a copy will be mailed to you.

Practice Statistics

After almost 22 years of working with hundreds of pediatric dentists in private practice, academics and faculty practices, hospital and public health clinics and Federal Services facilities, I have to say that as a group you are exquisitely trained, technically superior, infinitely patient, and unbelievably generous with your time, energy and money. All in all, you are a fantastic group of human beings, far above any verbal or written descriptions I have ever heard or read discussing attributes in the finest of people.

On the other hand, I must also chide some of you—you seem aware of only the bare minimum about the business of your practice. You may be cognizant of some statistics, set a few goals, worry about how fees are collected and where the money goes, and juggle various personnel issues, but you have never tried to dissect and truly comprehend what the numbers/standards/goals should be and where they are in comparison, at any given time, to your wish-they-were-at-this-level list.

At the risk of boring you with more of "that dull number stuff," let us look at setting, counting and comprehending practice business statistics. It is time you and your staff become more aware of the business side of pediatric dentistry.

How to Set, Count and Understand Practice Numbers

New Patient Examinations (NPE)

A. Goals

- Pediatric dental practice—60 to 75 or more/month, realizing attrition occurs; a multi-doctor practice may have 40 to 50 NPE's/month per doctor.

- Orthodontic practice—25 to 35 or more/month, realizing not all go into treatment immediately.

B. Count of NPE's

- Count ADA code D0150 per day and per month.
- Count reduced-fee NPE's (welfare, other managed care) patients separately in order to make certain that the number of reduced fee patients stays within an acceptable percentage of total NPE's seen. NPE's in these categories can be easily counted if given different provider codes.
- Count D0140 (evaluation for a specific problem such as acute infections, trauma or other emergencies) separately. Often these patients present for an emergency only, not returning for a comprehensive oral evaluation that would lead to their enrolling in the recare system. Count them as a NPE if they return for a comprehensive exam, code D0150.

C. Calculating the average

- Because types of patients seen in a dental office vary from day to day, we must make daily counts that make it quick and easy to figure monthly totals and averages.
- Goals for NPE's are monitored as monthly averages. The average of three months' total NPE's provides a satisfactory number for running calculations; 12 months' totals used to calculate an average is even better.

Example:

January	76 NPE
February	84 NPE
March	65 NPE
Average:	76
	+84
	+65
	225 NPE ÷ 3 months = 75 NPE/month

3 month average:

April	87 NPE
May	80 NPE
June	91 NPE
July	63 NPE
August	111 NPE
September	69 NPE
October	84 NPE
November	67 NPE
December	25 NPE
	929 NPE ÷ 12 months = 77 NPE/month
	12 month average

D. Planning new goals

- 5 percent to 8 percent growth per year in patient numbers, production and collections in a practice more than eight to ten years old is acceptable; not outstanding, but sufficient to maintain a viable practice. Annual growth of 8 percent to 10 percent is above average; 10 percent to 15 percent or more is outstanding.
- If your practice wants 10 percent growth in NPE's for next year, calculate:

77	NPE. month average this year
$\times .1$	desirable growth rate
7.7	additional NPE/month next year (round up to 8 NPE/month)

77

+8

85 NPE/month goals for next year

- Note: setting new goals for next year in any area of the practice operates on the same principle. Decide the percent growth desired and calculate new goal numbers based on this year's data. Share new goals with staff members responsible for achieving them.

Recare System

A. Importance

The recare system is the golden rope that ties patients to a practice, allowing doctor and staff to provide optimum care and typically generating 65 percent to 75 percent of practice income from the actual hygiene fees plus restorative work and orthodontic treatment diagnosed in recare patients. If a patient drops out of the Recare system, chances are 80 percent or better that he/she will not return to the office except, perhaps, for an occasional emergency.

B. Goal in a fairly stable community

80 percent or more of active patients returning regularly for recare.

C. Definition of active patient

- Pediatric dentistry - the number of individual patients seen within the last 18 months - NOT counting single visit emergencies.
- Note: count patients seen, not patient visits. For example, if one patient has had four appointments in the last 18 to 24 months, he/she counts as one patient.
- Do NOT count patients who came for single visit emergencies (code D0140), NEVER returning for a comprehensive examination as a new patient (code D0150).

D. Calculating Recare System effectiveness

- The effectiveness is calculated on a fairly accurate count of the number of ACTIVE PATIENTS, NOT how many recares were seen in a given month six months ago. If the number of recares due this month is based on the number seen six months previously, how can one adjust for holidays, vacations or other non-patient days or for NPE's seen in that month six months ago? An effective check must be based on the potential, i.e., how many active patients are due for a recare visit this month?

Example:

4,000 active patients ÷ 6 months = 667 recares/month for 100 percent effective system.

- Actually averaged 350 recares/month last year, counting EVERY hygiene patient who came for an appointment, including fill ins for cancellations.

- $350 \div 667 = 52$ percent effective

- Minimum goals = 80 percent

- $4,000 \times .8 = 3,200$ active patients

- $3,200 \div 6$ months = 533 recares/month for 80 percent effective system

- EFFECTS OF REACHING 80 percent effectiveness level

533 recares/month potential

-350 recares/month actual

183 more recares/month if maintain 80 percent effective system.

183 more recares/month

x \$105 average recare fee

\$19,215/month more production

x 12 months

\$230,580/year additional production on current patients if maintain 80percent effective system

- Calculating the average recare fee:

- In most typical pediatric dental practices, about 2/3 of the

patient population is under 13 years old; about 1/3 over 13.

"Adult" recare fees are charged once a patient is 13 years old.

Therefore, one must calculate an average recare fee by weighting the fees toward child patients, those younger than 13.

Formula:

$2(\text{fee for child w/o BX} + \text{child w/BX}) + (\text{fee for adult w/o BX} + \text{adult w/o BX}) \div 6 = \text{average recare fee.}$

Child - exam = \$40

pp = \$31

fl = \$18

\$89

2 BX = \$25

\$114

Adult - exam = \$40

pp = \$41

fl = \$18

\$99

2BX = \$25

\$124

Child: \$89

+ \$114

\$203 x 2 = \$406

Adult: \$99

+ \$124

\$223

\$406

+ \$223

\$629 ÷ 6 = \$105 average recare fee

- An example for instructing staff:

Question: You calculate the effectiveness of a recare system and the potential increased income for one year given these facts:

→ 5,000 active patients

→ averaged 550 recares/month for last year

→ minimum goal is 80 percent

→ Recare fees:

— exam = \$40

— prophy = \$31

— prophy adult = \$41

— fluoride = \$18

— 2 BX = \$25

Answer:

→ currently, system is 66 percent effective

→ 80 percent effectiveness goal = 667 recares/month

→ weighted average recare fee = \$105

→ potential increased income = \$12,285/month; \$147,420/year

Production/Collections

A. Goals—how to calculate

- Annual collection goal is the amount needed to:

- Pay practice overhead

- staff - occupancy

- supplies - lab

- administrative - marketing

- Compensate doctor(s) including wages/draw; taxes; benefits

- Retire debt

- Allow return on investment (profit) for the doctor(s)/owner(s)

- \$760,000 annual collection goal ÷ 190 work days = \$4,000/day collection goal

\$4,000/day collections @ 95 percent collection rate = \$4,000 ÷ .95 = \$4,210/day production goal

\$4,210 production/day @ 85 percent show rate = \$4,210 ÷ .85

- = \$4,953/day scheduling goal
- \$4,953/day scheduling goal
-\$4,000/day collection goal
\$ 953/day meltdown between dollars scheduled vs. dollars produced vs. dollars collected

B. Understanding goals—production & collections

- A dentist must know how much money is needed to cover overhead, compensate the doctor(s), service debt and provide a profit. If there is not enough money (collections) to cover the first three, the practice can flounder and fail. Without a profit, there is no return on investment or money for growth.
- In many offices, every dollar produced is NOT collected. Minimum collection goal is 97 percent (97¢ per \$1 produced) on private/insurance patients.
- In most cases, excessive “discounts” courtesies, and write offs are given. Opinion: never give more than a 5 percent book keeper courtesy allowance for cash/check payment in full up front on cases in excess of \$500-\$600. Give no allowance (discount) for credit card payments. Reason: the practice pays 2 percent to 4 percent or more of the charged amount as a merchant’s fee on top of the discount given to patients —too expensive! (Hint: shop and compare merchant rates. You should find a credit card service for around 2 percent to 2.5 percent or a fraction less.)
- Gross production (every \$ produced charged at regular fees) MUST be monitored.
- Net production (gross production minus write offs for charity dentistry, professional courtesy, managed care write offs including welfare adjustments) MUST be monitored.
- Gross collection is every \$ collected, recorded as paid.
- Net collection is gross minus bad debt, insufficient funds checks, and patient refunds. The net collection rate must be 97 percent or more of net production.
- To calculate collection percentage rate, divide collected dollars for a period (day, week, month, quarter, year) by production for that same period.
- Example:
 - \$65,000 collected/month
 - \$72,200 produced/month
 - $\$65,000 \div \$72,200 = 90$ percent collection rate/month
- An example for instructing staff:

You calculate the collection percent rate:

Annually

\$885,500 collected
\$912,900 production
_____percent collection rate/year
Answer: 97 percent collection rate

Monthly

\$73,525 collected/month
\$76,075 produced/month
_____ percent collection rate/month
Answer: 97 percent collection rate

Daily

\$4,325 daily collected/day
\$4,475 produced/day
_____percent collection rate/day
Answer: 97 percent collection rate

Note: Production on Medicaid and other reduced fee/managed care patients MUST be analyzed separately from private/indemnity insurance patients. One expects to collect 97 percent to 100 percent on private/insurance patients, but collections are significantly lower on reduced fee patients.

- Why must reduced-fee patients be limited?

Example:

- Overhead (cost to produce dentistry) = 60 percent (60¢ per \$1 of dentistry produced)
- \$1.00 of dentistry produced
.60 cost
\$.40 to compensate doctor(s), pay debt and provide ROI - (return on investment/profit)
- Reduced fee patients
 - Overhead remains 60¢ per \$1 of dentistry produced
 - Reimbursement rate = 40 percent to 50 percent = 40¢ to 50¢ per \$1.00 of dentistry produced
 - \$1.00 produced = 45¢ collected
- 60¢ overhead
- 15¢ (Loss of 15¢ per \$1.00 of dentistry produced)
 - \$0 to compensate doctor(s), service debt and provide ROI

C. Understanding goals - show rate

- A dentist and staff must know what percent of patients come AS APPOINTED so that there is some educated “guesstimate” about appointing to meet production /collection goals (and to keep doctor(s) busy). Unless the schedule stays close to full, there is no chance to meet practice expenses, much less make a profit. The airlines, restaurants, private schools, etc. do the same thing; i.e., take too many reservations, students, etc. knowing from past averages that a certain percent will not show up as expected.
- Calculating show rate:
 - Step 1 - Count the number of patients who come AS APPOINTED each day. DO NOT count last minute fill-ins or walk-ins, emergencies, etc.
 - Step 2 - Divide the number of patients who COME AS APPOINTED by the NUMBER APPOINTED to get the daily show rate.
 - The average daily show rate for three months (one quarter) can be used for estimating numbers of patients to schedule each day.
 - Note: calculating show rate is NOT a precise science. You are trying to calculate an average per day, month, quarter, year. Consistency is MOST important. If you count patients who are appointed as fill-ins several days prior, that is fine—just do NOT count fill-ins for that day or one day prior. Decide your method and make sure all staff members count patient appointments the same way.
- Typical show rates:
 - Pediatric dental practice - typically 70 percent to 75 percent show rate until an effort is made to address/stop broken appointments and last minute cancellations. 80 percent to 85 percent is good; 85 percent to 90 percent or better show rate is outstanding.
 - Orthodontic practice – 90 percent to 95 percent is typical.

Example:

65 patients are appointed for Monday
55 come as appointed
 $55 \div 65 = 85$ percent show rate for Monday
83 percent show rate Tuesday
90 percent show rate Wednesday
80 percent show rate Thursday

85 percent Monday
+83 percent Tuesday
+90 percent Wednesday
+80 percent Thursday
 $338 \div 4 \text{ days} = 85$ percent average show rate

Note: While one should avoid averaging percentages, choosing instead to average actual numbers, it is acceptable to use percentages in this calculation.

American Academy of Pediatric Dentistry

211 E. Chicago Ave – Suite 700

Chicago, IL 60611-2663

Presort Std.
U.S. Postage
PAID
Permit No. 81
St. Joseph, MI
49085

- An example for instructing staff:
You calculate the show rate given these facts:
59 patients are appointed for Tuesday
52 come as appointed
1 patient comes on short notice to fill in for a cancellation
3 emergencies are worked in

What is the show rate for Tuesday?

Answer: $52 \div 59 = 88$ percent show rate. Remember last minute fill-ins and emergencies do not count when calculating show rate.

Preview

In the December issue, we will analyze accounts receivable (A/R), contracts receivable (ortho A/R) and review a list of operating systems which must be established and run consistently in any well managed practice.

PMMNews

PRACTICE MANAGEMENT AND MARKETING NEWS IN PEDIATRIC DENTISTRY

Published six times a year as a direct membership benefit by the American Academy of Pediatric Dentistry, 211 E. Chicago Avenue–Suite 700, Chicago IL 60611–2663, 312-337-2169. Copyright©2001 by the American Academy of Pediatric Dentistry. All rights reserved. ISSN 1064-1203. aapdinfo@aapd.org, www.aapd.org

This publication is written by Ms. Ann Page Griffin, a nationally recognized author, lecturer, and consultant in dental practice management and marketing. Opinions and recommendations are those of the author and should not be considered AAPD policy.

Executive Director
Dr. John S. Rutkauskas

Communications Coordinator
Gina Sandoval

Graphic Designer
Cindy Hansen

Administrative Assistant
Susan McGuire