PMM news

PRACTICE MANAGEMENT AND MARKETING NEWS IN PEDIATRIC DENTISTRY VOL. 10, NO. 6, December 2001

To Review

In this issue, we are completing our series regarding the business numbers and typical statistics in pediatric dentistry. Many of you have called or e-mailed to say thanks for this information. Comments have been along the line of, "Though it is tedious to plow through, this is data I have needed for a long time in order to better manage my practice." For this, I thank you since such comments are great to hear.

Incidentally, if you need copies of the June, August and October issues of *PMM News*, all of which contain aspects of this numbers/statistics data, call the headquarters office so a copy can be mailed to you. The information would make excellent discussion data for staff meetings.

Understanding Goals (continued)

A well-managed dental practice may have a menu of goals, including production, collection, show rate (percent of appointments kept as made), recare system effectiveness, new patients per month, accounts receivable maximums, etc. Many of these were discussed in previous issues. Now we can resume the goal review with the subject of a daily scheduling goal.

Understanding Goals–Scheduling #'s per day

- $4,000/day collection goal
- 95% collection rate
- 85% show rate
- $4,000 ÷ .95 collection rate = $4,210/day production goal
- $4,210 ÷ .85 show rate = $4,953/day scheduling goal
  $4,953
  <u>$4,000</u>
  $ 953/day meltdown between dollars scheduled vs. dollars collected because 15% of what is scheduled never shows up and 5% of what is produced is never collected.

An example for instructing staff: You calculate the scheduling goal given these facts:

- Collection goal is $5,000 per day
- Collection rate is 97%
- Show rate is 80%
- Scheduling goal is_____
- Answer: scheduling goal is $6,443/day

Understanding Goals–Accounts Receivable (A/R)—

Fees for dentistry that have been done, but not yet collected (money owed the practice)

A. Goal - maximum A/R not more than 1 to 1 1/2 month's gross production.

B. Example:
- Average monthly production = $72,000
- $72,000 x 1.5 = $108,000
- Maximum A/R = $108,000

C. Aged A/R—once/month an aged A/R report must be generated. The report should be monitored by categories of aging:
- Current—50% to 60% of total A/R
- 30 days—less than 15% to 20% of AR
- 60 days—less than 10% to 15% of A/R
- 90 days—less than 10% of A/R
- 120 days+ —placed for outside collection action

D. Problems with A/R
- Failure to collect OTC (over the counter)—35% to 50% or more of monthly production should be collected OTC.
- Failure to get at least 1/3 of fee up front as treatment progresses or to get an exact co-pay amount if insurance profiles are kept so that an accurate co-pay is known.
- Failure to review payment procedures with parents at first visit.
- Failure to file insurance promptly.
- Failure to generate and follow-up on an "Outstanding Insurance Claim Report" at least once/month.
- Failure to get pre-estimates from insurance companies for large $ cases.
- Failure to collect fees for hospital cases up front in case of cash patient or to collect co-pay up front from insurance patients, whose treatment has been pre-approved by the insurance carrier.
- Failure to send statements regularly.
- Failure to correct patients' addresses promptly.
- Failure to offer parents the use of credit cards; 15 to 20% of monthly production collected by credit card is a reasonable goal.

Understanding Goals–Contracts Receivable (C/R)—Fees for orthodontic cases for which payment plans are made

A. Typically in a pedo-ortho practice, the total contracts receivable due from ortho patients may be twice or more the total A/R which is due for pedo patients. This is because ortho cases are higher dollar cases than pedo and most often are paid over time.
B. The down payment, if one is charged, should be entered as production and collection on the day of banding. Monthly fees are entered into production figures on a monthly basis.
C. Monthly contract payments kick into current C/R as due. On any given month, the collection rate on those ortho accounts should be 97% or better as recommended for pedo A/R.

Work Systems: A word to staff members about work systems

Consistency is a watchword in any well-managed practice, but it is an illusive goal. Although work system protocols may be decided upon and implemented, carrying them out in the heat of everyday pedo practice is a challenge, and often, darn near impossible on a day when almost every parent and/or young patient is "troubled." The secret to consistency is to forgive yourself if one of your responsibilities gets buried and slips by for one day, but make sure that does not happen two or more consecutive days.

Create forms you must turn in, set up times you are expected to report on certain systems or certain activities. In short, hold your own feet to the fire; *own* the systems for which you are responsible. Consistency with these and any other office systems you care to add to the list, brings rewards in the form of pride and self-esteem that comes from knowing *you can do it.*

- Budgeting and analyzing inconsistencies from planned income and projected expenses.
- Setting, monitoring and meeting production/collection goals, including delinquent account procedures.
- Raising fees regularly, at least once per year by almost double the inflation rate.
- Making financial arrangements.
- Block scheduling.
- Handling, welcoming, processing and educating patients/parents so they feel complete trust in doctor, staff, recommended treatment, treatment delivery and home care instructions.
- Updating patient/parent information—health status, address, telephone, employer, insurance, etc.
- Charting and proper recording of patient data and treatment notes.
- Handling/pursuing broken and canceled-not-reappointed appointments.
- Lab delivery system.
- Inventory control for both business and clinical supplies.
- OSHA training, record keeping and reporting.
- Emergency protocols for medical, fire and weather crises.
- Maintenance, cleanliness, tidiness of office.
- Personnel administration.
- Analyzing errors to learn to prevent repetition, *not* to place blame.

Staff Involvement in Fiscal Management

Learning more about why and how the business of the practice functions—things such as the importance of goals for production and collection, analysis of expenses and control of overhead, and why regular fee increases are necessary—helps staff members feel "ownership" of work systems. Some business gurus use the term "participative management" or the over-utilized phrase "empowerment" to indicate employee involvement in meaningful ways in the operation of the practice.

There are, in my opinion, appropriate ways to share numbers and goals with staff. For example, schedulers need to know per day production goals in order to understand that putting names into appointment slots with no consideration for treatment needed is *not* an acceptable way to schedule. One could fill an entire morning, for example, with appliance deliveries, checks, second opinion exams, quick-extractions, emergency visits, etc., so that doctor and clinical staff stay busy, but finish a five-hour morning with no more than a few hundred dollars in charges. On the other hand, if the schedulers have a target, a goal toward which to schedule, of perhaps $2,500 per five-hour morning, they understand the necessity of scheduling some heavy operative cases in addition to light treatment and quick appointments.

Business staff who collect fees must understand that a minimum of 97% collection rate is necessary, that is *at least* 97¢ must be collected on every $1 of production in order to meet payroll, purchase supplies, pay office rent, taxes, etc.

Clinical staff must be made aware of budgeted dollars for supplies, the value of time and efficiency in handling patients through the operatory, the importance of prompt delivery of lab cases, and the cost of repeating procedures or wasting supplies. By sharing this type of information, auxiliaries come to fully understand their important place

in the scheme of the office operation. If each auxiliary understands and is appreciated for her/his "ownership" of a set of responsibilities that really matter, staff commitment, enthusiasm and enterprise result.

I work with a number of practitioners who are reluctant to share with staff specific financial goals or dollar allotments toward various costs of running the practice. Their reasoning seems to be that if actual figures for production, collection, recare system costs *vs.* productivity, overhead and such are shared, staff may: (1) think doctor is "poor-mouthing" the business and income of the office; (2) assume all collections are going into doctor's wallet; (3) deem doctor is trying to turn patients into dollars rather than being focused on exquisite service to and care for patients.

Nothing could be further from the truth. Those dental teams who are allowed an insight into the income *and* the expenses in their office are the ones who help operate an excellent practice that reaches its potential. Incidentally, if the doctor prefers, financial goals can be monitored by a certain percentage growth over last month or last year. In other words, staff may be aware that an 8% increase in production and collections is the goal for this year or this month rather than a specific dollar amount.

Notice the emphasis on sharing with staff, information about *expenses,* as well as information about production and collection goals. An excellent method for sharing costs with staff is to break expenses into a daily, or even hourly total. How can this calculation be made? Follow these steps:

1. Divide your office expenses into seven categories:
    - Personnel—group total, *not* individual's wages or benefits
    - Occupancy
    - Administrative
    - Equipment, furnishings and contingency fund
    - Clinical supplies
    - Lab
    - Marketing
2. Total the amount spent in each category within the last six to 12 month period.
3. Divide each total by the number of days worked during that same period.
4. The quotient will be the per day cost in each category. One may choose to calculate per day costs of specific items under each category, for example, telephone, postage, taxes, insurance, etc.

   Note: This per day cost does not include any doctor compensation or profit. Those items, plus, depending on the accountant's advice, debt service, are *not* included in such a per day breakdown. And staff should be told that fact: "This amount per day is necessary to operate the office. It does not include doctor's compensation, profit on his/her investment in the practice" (and "debt service," if this is the case).

The per day costs are often astounding for the doctor and, certainly, for staff members. Breaking relatively large monthly, quarterly or annual expenses into realistic daily or hourly costs to which staff can relate is enlightening. It helps them understand the reasons for tasks such as setting financial goals, chasing broken appointments, controlling costs and raising fees.

The one piece of financial data I am absolutely opposed to sharing with or among staff members is individual salary information. Whether for a particular staff member or for the doctor(s), an individual's compensation is private and *must*, in my opinion, remain so. I have witnessed great problems created when staff members confide wage, benefit or salary increase information to each other.

An Invitation and a Thought

If either you or your staff have questions regarding practice numbers, goals, averages, etc., please call me at 800-959-9509 or e-mail *agriffin@practicon.com*.

As each doctor and her/his staff members wrestle with the business of the practice, initiating new systems, scheduling regular reporting sessions and making necessary adjustments may seem an insurmountable amount of work. Keep in mind that the dread of new systems and changes is almost always worse than the actual tasks. The first step is often the most difficult as one waits for a day or week that is not so busy, a new staff member to start work or a move to a more spacious office. There are always reasons we can invent to avoid implementing more extensive, effective management of our offices.

The following vignette may bring a smile and also cause one to think, "It is time to get off dead center and implement changes we have only talked about."

> "Six months after the owner of a small crossroads store was appointed postmaster, not one piece of mail had left the village. When deeply concerned postal officials investigated, the local postmaster explained, "It's simple; the bag isn't full yet."

Think about it. Do not wait for the bag to be full to begin, even in small steps, implementing the new and improved management systems that will help your practice reach and maintain its full potential.

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Time for an Associate?

Several times weekly, I get calls from pediatric dentists asking, "When can I tell if it is time for an associate? It feels like I need one now!" There are no hard and fast rules for making this decision. There are some general guidelines that experience has taught me. Consider an associate when:

- You have over 4,000 to 4,500 active patients. If ortho is a significant (25% or more) part of your practice, you may need an associate sooner, perhaps around 3,000 to 3,500 active patients.
- Block scheduling (See *PMM News* August and October2000 for an explanation of block scheduling) is utilized, yet restorative patients must be scheduled two months or more into the future. Another sign, recares must be delayed to seven, eight, or nine month cycles.
- You are within about five years of retirement or reducing your workload to three or fewer days weekly.

Also remember, it is OK for you to choose to work until you fit the description, "Doctor will work until he/she falls over at the chair." Just because most of your contemporaries are bringing in associates and making extensive retirement plans, you do *NOT* have to follow suit. You may prefer to remain fully involved in your practice until the day of sale at which time you will leave without the interim step of reducing work days by hiring an associate.

Preview

There are many aspects involved with associateship/partnership arrangements. In the June 2002 issue, we will explore these. In the February and April issues, I have received permission to reprint a pair of articles about patient charts written for the AAPD Journal in 1989 by Gayle Nelson. Dr. Nelson's information is still pertinent today and will, I believe, be helpful to new and experienced practitioners.

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