Dental Practice Transition

A Practical Guide to Management

David G. Dunning and Brian M. Lange

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David G. Dunning, Ph.D
Brian M. Lange, Ph.D

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Preface

As anyone who has ever edited or written a book knows full well, this book could not have been written without the untiring support of several key individuals. Our department office staff, Debbie Merritt and Marcia Bliss, not only tolerated our less–than–expert word-processing skills but also provided quick and efficient turnaround times on many tasks on many occasions. Our helper at Wiley-Blackwell, Shelby Hayes, similarly provided timely support.

This book is designed so that each chapter "stands" in essence on its own. This means that the chapters are complementary and may even cover in a few cases the same or similar content in varying degrees of depth. Each chapter is intended to address a topic in ample fashion without relying on other chapters. Readers will certainly and intentionally glean much more from the book by reading chapters with augmenting content. Still, instructors in practice management may assign chapters individually or in combination.

Profound market differences in dentistry and in cost of living typify the United States. For example, the value of dental practices may vary from 30% to 50% of average annual collections (or less) in sparse rural areas to well over 100% in highly competitive cities. Similarly, the personal budget provided in chapter 6 reflects a relatively high rent/mortgage expense that could be significantly less (or even higher!) in some areas. Internet sources may help understand some of the cost-of-living differences in various locations (e.g., www.bestplaces.net—Sperling's Best Places—and city-data.com).

We are very grateful to the chapter authors, all of whom have very busy schedules and thus basically participated in chapter writing "above and beyond the call" in normally hectic schedules.

We are also appreciative of our chapter reviewers:

Dr. Mert Aksu
Ms. Ronda Anderson
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Dr. Art Croft
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Mr. Stuart Spero
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Dr. David O. Willis
Dr. Steven Wolff
Dr. Terry Wostrel

These individuals donated their time, literally, in order to provide valuable input to improve the book chapters. As possible, writers were granted freedom of expression in writing style. Consequently, the reader will note variability in style from chapter to chapter. This is intentional on our part as editors.

This book is not intended to, nor does it provide, legal, financial, investment, or accounting advice. Readers are strongly encouraged to obtain the counsel of qualified attorneys, financial planners, accountants, and consultants for professional services.

Without God's grace, guidance, and blessing this project would not have been started or completed. Without support and encouragement from our families, especially our wives Kathy and Anne, this project would not have been accomplished.

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Dental Practice Transition

A Practical Guide to Management

Part 1
Overview

Chapter 1
Introduction and Overview

David Dunning and Brian Lange

This book is aimed at providing you with necessary concepts and perspectives for making practice transition decisions. The emphasis is on presenting good ideas in as fair and as balanced of a manner as possible. We are not trying to sell you anything other than information for decision making.

Assembling all that is necessary for practice transition in a single volume is a daunting task. More detail treatments are available for many of the topics addressed here (for example, see a partial list of American Dental Association [ADA] publications at the end of this chapter). Still, this book provides essential information not typically available in one book.

This chapter explores career choices, the current dental market and its implications for you, the “Bermuda Triangle” of practice transition, and the selection of key advisors for your practice transition and life.

Career Choices

The future you see is the future you get.

Robert G. Allen

The major career question has already been answered. You are in dental school or have already graduated. For those still in dental college, questions often center on what area of dentistry: a generalist, specialist, public health, military, dental educator, or are you one of the few that will join one or more of your relatives in “your” family practice? The ADA’s *Success Seminar Manual* (2005–2006), chapter 1, outlines many of the advantages and disadvantages of various career options. Our purpose here is not to duplicate that information but, rather, to take a step back and have you reflect on the process of making a career choice and some of the key issues in that process.

Most dental students in their first and second years are asking, now that I am in dental school, what is next? Questions begin to race through your mind. Where do I want to live? Or if married, where do we want to live? If I specialize, how does that affect where I can live? Do I want a metropolitan lifestyle, rural lifestyle, or something that allows a little of both? If you have or are

planning a family, you find yourself asking about the best educational and social opportunities for your children. What values do you want your children exposed to day by day? For those who follow a faith-based lifestyle, where does God want me to be? Can I get student loans repaid, and should this, based on interest rates, be a slow or a quick repayment process?

The questions listed above are by no means an exhaustive list. They are meant to get you thinking about the relationships between you, your family, the location of your practice, and the type of practice (general, speciality, etc.). The matrix in Table 1.1 is meant to give you a starting point for your decision-making process. You can list across the top all the issues you need to consider in making a decision about the type of dentistry you want to practice and then see which area of dental practice best meets most or all of your criteria. Approach the matrix (decision-making process) with the following in mind:

- Gather input from the people closest to you who will be affected by your decision.
- What seems like a good idea in your second year of dental school may not seem like a good idea in your third year of dental school. Be flexible; at times, life can take a sharp turn.
- It is called a decision-making process for a reason. Decisions, especially of the nature you are considering, take data or input that take time. Be patient.

A question that often arises when working with people making important decisions is, what if I do all the right things and I am comfortable in my decision, but after being in the practice I do not like it? This is a challenging and multi-dimensional question with both a simple and a complex answer. The simple answer is that you can always move, though this may take some time depending on your situation. There is a demand for dentistry in many places. The complex answer is based on a series of questions:

- What do you not like about the practice?
- What do you not like about the community?
- Can anything be changed that would make you more at ease?
- What would you do differently in choosing a practice?
- How does what you are experiencing differ from what you expected?

If you invest the time to go through the series of questions with family, and if you are in a position of working for (associateship) or with (partnership or buyout) another dentist, you may find out that you can resolve the issues causing your discontent. However, if you are not able to resolve the issues causing your discontent by answering the questions, you are better prepared to decide on what you will do next.

Some points to remember when making decisions, adapted from McDaniels et al. (1995):

Table 1.1. Decision matrix.

	Lifestyle We Want (e.g., rural area)	Values We Want	Loan Repayment	Educational Opportunities for Children	Close to Family	Housing We Want and Can Afford	List Other Important Considerations
General Dentistry							
Speciality Practice							
Military							
Public Health							
Dental Education							
Dental Service							
Management Organization							
Institutional Practice (Hospital)							

- Decisions are tentative; you can change your mind.
- There is usually no one right choice.
- Deciding is a process, not a static one-time event. We are constantly re-evaluating in light of new information.
- When it comes to a career decision, remember you are not choosing for a lifetime. Choose for now and do not worry whether you will still enjoy it in 20 years. Life is fluid and change occurs.
- There is a big difference between decision and outcome. You can make a good decision based on the information at hand and still have a bad outcome. The decision is within your control, the outcome is not. All decisions have an element of risk.
- Think of the worst outcome. Could you live with that? If you could live with the worst, then anything else does not seem that bad.
- Try to avoid either/or thinking: usually there are more than two options.

The Current Market and Its Implications for You

The dental market in the early 21st century presents some unique opportunities and challenges for dentists and patients alike. These exigencies have profound implications for you. Let us consider the platinum age of dentistry and the present market as representing both the best of times and the worst of times as a background for this book.

The Platinum Age

We stake no claim on being the first to call this the platinum age in dentistry. The term has been used since at least the first reference we could find, in the spring of 2000 (Takacs 2000). So, why *are* people calling this the platinum age in dentistry? Much of the rationale hinges on the numbers, most of which you have probably already heard and so we will only point out the most critical ones.

Our population is living longer and is more likely than a generation or two ago to have had relatively good oral health. With fewer missing teeth and more teeth and supporting structures to be maintained and restored, there is, plainly speaking, more work to be done. Simultaneously, the number of dental graduates is still significantly less than the number of dentists who will be retiring. As of this writing, a few new dental schools are in various stages of development. Still, the gap between retirees and new graduates will likely remain somewhere in the lower 4,000s, while the need is in the area of 4,650 (Chou 2006). Further, the number of dentists per 100,000 population is projected to decline from a peak of 59.5 in 1990 to 43 in 2020 (Valachovic et al. 2001).

In addition, according to Mark Maremont of the *Wall Street Journal*, as of 2005, general "dentists in the past few years have started making more money

than many types of physicians, including internal medicine doctors, pediatricians, psychiatrists, and those in family practice." This trend is likely to continue, if not be magnified. Granted, some physician specialists such as radiologists and cardiologists still enjoy incomes greater on average than that of general dentists and specialist dentists. However, remember that these medical specialists, like their counterparts in dentistry, have more years of education than general dentists before earning large incomes. So, the time value of money also has to be considered in understanding this as the platinum age of dentistry.

While this certainly seems to be the platinum age of dentistry for dentists, we would be remiss if we failed to mention that such is not the case for certain groups of patients. Patients lacking dental insurance, patients in some rural areas, and patients with lower incomes are all less likely to receive the care they need. So while this is the platinum age for providers, it is the stone age for certain patient groups. Since you will be receiving much, we hope you will consider giving back much in whatever manner you are led to help close the gap in access to care. Options are many but include state Medicaid programs, nonprofit clinics, Missions of Mercy (volunteer weekends for providing care for the poor), and even providing free or discounted care or negotiated care based on bartering.

The Best of Times, the Worst of Times?

A particularly astute and famous quotation from Charles Dickens's *A Tale of Two Cities* accurately describes the current transition opportunities for the general practice of dentistry: "It was the best of times, it was the worst of times, it was the age of wisdom, it was the age of foolishness, it was the epoch of belief, it was the epoch of incredulity." How do these literary observations relate to transitioning into private practice?

In so many ways, it is indeed the best of times. Student choices for entering private practice resemble a buffet: do I prefer Chinese food tonight, or perhaps seafood, or Italian instead? There are so many choices, in fact, that we have heard it said that it is very difficult to fail, for example, in buying an existing practice with healthy financial numbers. There is little doubt that in a myriad of dimensions in this platinum age of dentistry, this is the best of times.

However, it is also, ironically, the worst of times in a sense. Why? Because it is sometimes a struggle to choose what you really want from the buffet! Having to choose from two or more favorable options is still conflictive. There is a need, among other skills, to be able to objectively evaluate the options that are available in order to make an informed decision. Further, the word has now been widely broadcast: dental students will likely become wealthy in their lifetimes. This means that many individuals and corporations are, metaphorically speaking, circling above the heads of dental students, not waiting for them to die, but waiting for them to live out their careers and to share in the revenue stream! The need to be watchful regarding personal and business

insurance, regarding practice transition concepts and processes, and regarding investing has never been greater.

Amidst this best of times and worst of times, arguably some wisdom and strangeness have emerged, as well as some sense of total devotion to certain models and concepts and some sense of credulity (that there is no right way). We are, frankly, surprised at the way that some associateship arrangements and practice purchases are structured, particularly in this platinum age. Still, there apparently is room in the competitive market for contracts that seem to be heavily biased in some ways for the owner-dentist. Some very competitive market conditions give the owner-dentist incredible negotiating positions that, in such a context, may warrant many fewer advantages for an associate position and much higher prices for practices. Some consulting firms market and implement their business models of transitioning practices across incredibly variable market conditions, causing others to scratch their heads and wonder how and why.

One of the main purposes of this book is to provide for you some perspective of wisdom based on historically proven concepts so that you can sort your way through this best of times and worst of times, through the fog of strangeness. In the end, there may not be any absolutely and completely "right" way to structure an associateship experience or to purchase a practice. Nevertheless, there certainly are reasonable ranges within which these endeavors can be structured, and some of these will be more or less favorable to you. This, then, calls for you to be a wise consumer.

The "Bermuda Triangle" of Practice Transition

Transitioning from dental school or early career tracks (military or public health) into private practice represents a tenuous activity in which opportunities can readily disappear into oblivion. Hence, the reference in the heading to the infamous "Bermuda Triangle," where, according to folklore and myth, ships and planes have disappeared without a trace (see Figure 1.1). Regardless of the legitimacy of the Bermuda Triangle in history, as a metaphor the name helps us to focus on the particularly tender and easily tipped process through which recent dental graduates enter the business world by trying to start, buy, buy into, or become associates of dental practices.

The three-dimensional triangle in the practice transition model includes these parties/sides: the dental student/graduate, the owner-dentist(s), and the advisors for both parties (see the model itself). Inside the model are the particular dynamics and characteristics of the practice that, depending on how they "load" with each party, can also readily sink the deal. Outside the model are the external variables influencing the practice. For example, suppose a prospective buyer understood that the staff in a given practice would be staying after the purchase, only to discover that all the team members are leaving. Such information could easily sink the deal, as could discoveries related to the opinions of area dentists, overhead percentages, and so forth.

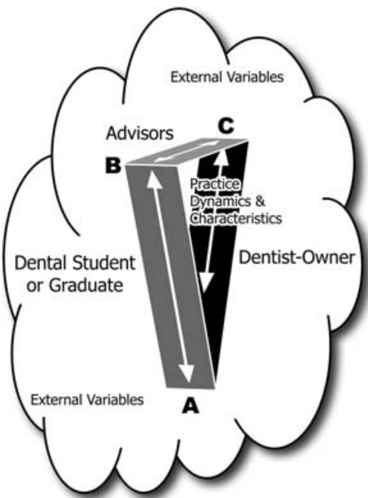

Figure 1.1. The "Bermuda Triangle" of practice transition.

Three specific principles undergird this model; principles that, admittedly, are themselves subject to debate.

Principle #1: *No single party in the transition process should retain all of the power or control.* We believe this principle is an equitable one. The dentist-owner, obviously, enjoys more "position power" than a prospective associate or buyer. Still, the interests of the latter simply cannot be shelved in favor of the dentist-owner. Some sense of balance and mutual interest must be preseved if a practice transition toward associating or purchasing is to be successful.

Principle #2: *Each party has competing interests, and thus this process requires some degree of negotiation, ranging from making minor adjustments to standardized employment agreements to developing unique contracts.* Sometimes individuals have interests and needs that, on the surface, appear somewhat strange. These may arise from personal history. Occasionally, for example, an associateship contract will contain some very specific provision regarding a rather obscure circumstance that presented itself in a previous associate's employment (for example, thou shalt not approve the purchase of any dental supplies).

Principle #3: *This process of negotiation can easily/readily "tip" or fall (sink into the ocean) if any party maintains an unreasonable bargaining position or an unreasonable stance.* We are of the opinion that practice transitioning needs to major in majors rather than get tipped by relatively minor issues. It seems unwise to walk away from an associateship contract because of a dispute about who pays for malpractice insurance for 1 year or because of a disagreement about whether the practice is worth $300,000 instead of $315,000. Fifteen thousand dollars buys a small car these days. Yet, it is our opinion that you do not walk away from a practice sale for $15,000 (though maybe for $50,000).

Let us explore the nexus of the triangle where competing interests meet. *At juncture "A" reside the relationships and interactions between the dental student (or recent graduate) and the dentist-owner.* How do the personalities mesh, the philosophies of practice, the values governing behavior, the type of dental services to be provided? Do these two parties agree on some fundamental concepts and principles to structure an associateship or a practice purchase?

At juncture "B" emerge the dynamics of relationships and interactions of the dental student with his/her advisors and the advisors of the dentist-owner. Importantly, note that advisors here may be both formal and informal. Formal advisors could include transition consultants/companies, attorneys, accountants, lenders, faculty, and so on. Informal advisors include parents, other family members, friends, and classmates. How well (if at all) are these basic understandings of the student communicated to the formal advisors? Does the consulting firm offer a flexible, efficacious business model to handle the transition if one is desired by the student? May the student hire independent advisors in addition to the ones in a consulting firm? Do spouses assert proper influence in the negotiation? We have seen cases where spouses exert incredible influence, potentially spoiling the "deal" for a few thousand dollars in valuation or applying models of understanding inconsistent with the dental market. Does a student agree with the philosophy/business model of the transition firm if one is involved? For example, some firms assert that they represent both parties (known as "dual representation"), and is the student comfortable with this? Should a student have to pay a fee up front to look at practices or an "earnest" payment to hold the final purchase until after graduation? Will the lender offer the money needed for the purpose?

The relationships and interactions of the dentist-owner with his/her formal and informal advisors and the student's advisors develop at juncture "C." Does the owner-dentist communicate clearly to transition consultants the previously agreed-to basic understandings negotiated with the student? We have seen many cases where this has failed, typically due to advisors who have a standardized contract or approach to transition inconsistent with what the student thought was going to occur based on extensive conversations with the owner-dentist. Do the student's advisors offer what is perceived to be reasonable positions with respect to valuations or contracts?

Inside the Triangle

Every dental practice has unique characteristics that make up the inside of the triangle. Some of the key "inside" variables include practice location, patient base (and its historical, current, and future dental needs), unique staff, the practice's office design (which can make life much easier or more difficult for the practitioner), technology, number of active patients (see Heller 2007), and financial information (see chapter 3 on dentistry by the numbers for an excellent overview by Dr. David Willis). This inside picture of the practice needs to be understood, especially by associates intending to buy and by potential

buyers. This is all part of due diligence. For example, a practice showing production of $510,000 and collections of $450,000 for the previous year creates a "due diligence opportunity" for you. Is this uncollected revenue, is this insurance "write-offs?" In a study published in 2007, Steward and Steward argue that it is very difficult for a dentist to produce the income and manage the practice once certain production thresholds are met. This requires a paradigm shift away from micromanagement to macromanagement if such practice characteristics exist and if the practice is to continue to grow.

Outside the Triangle

Outside the triangle are the external variables unique to the neighborhood, town/city, county, and state. Is the neighborhood older and established, deteriorating, or growing? Some friends of ours started a practice in extreme south Lincoln, Nebraska, in the late 1980s, when pheasants and foxes could be occasionally seen from their office. This area is now surrounded by miles of growing city. What is the general population of the city/county, and how many general dentists are in practice? This information can be researched through a variety of sources as well as purchased from certain firms. Is the dental market highly competitive for patients? If so, practices will likely sell for much higher prices, comparatively. Two states may be separated by a mile-wide river. Yet this may be a great divide representing two distinct markets: one essentially saturated with third-party payors; the other, primarily fee-for-service patients. These external variables cannot be overemphasized.

Some Common Pitfalls Causing the Triangle to Sink

In associateships:

- Compensation offers from owners and/or expectations of would-be associates below and/or above typical norms.
- Form of relationship: employee vs. independent contractor. The IRS has a rigorous test for dentist-workers to qualify as independent contractors (search www.irs.gov). As you probably know, an independent contractor must pay his/her own share of social security tax AND that of the employer (just over 15% as of 2007).
- Assignment of patients: is this fair and balanced? Does this match the compensation provisions of the contract to cover base pay or the "draw"? Patient assignment becomes particularly critical in practices with significant managed-care/third-party payors with resultant "adjustments" (reductions) in collections.
- Buy-in provisions/process (timing, procedures, etc.).
- Influence of third-party carriers on associate's compensation and on practice overhead and profitability.
- Insufficient practice revenue for adding another dentist?

- Allocation of dental hygiene income: does the associate receive any credit for hygiene exams?
- Restrictive convenant terms viewed as unreasonable.

Dr. Eugene Heller (1999) also details ten specific reasons for associateships failing; refer to his article listed in the references.

In purchases:

- Practice value unknown or viewed as unreasonably high by associate and/or advisors.
- Practice allocation of value seen as inaccurate (for example, a value of $2,000 for all equipment and supplies and a value of $300,000 for the goodwill or blue sky).
- Can the buyer secure enough financing? Some lenders may cap the lending limit of new graduates.
- Major change in the practice during the process of purchase (disability of owner, departure of staff, divorce of owner, etc.).
- Practice projections that appear too good to be true from a transition consulting firm.
- Undue and inappropriate influence of a key advisor (formal or informal).

Some Suggestions to Avoid Tipping the Deal

- Study the dental market in the specific area. What do associates tend to earn in salary and benefits? What methods are used to evaluate practices? What is the extent of third-party involvement and reimbursement in the area? What are typical overhead/profit ranges? What are some ballpark figures for which practices typically sell in terms of percentages of revenue?
- Identify your "non-negotiables," if any, in an employment arrangement and in a practice purchase. Are you willing to do prophies? What is your "bottom line" for income and benefits? How soon do you want to purchase the practice, and is this process in writing? What is the most you would be willing to pay for the practice?
- Identify your negotiable positions: compensation level beyond minimums, practice value within a certain range, how the transfer will proceed with respect to patients, staff, and so forth.
- Utilize a variety of advisors and weigh their input based on their expertise. It was Solomon who advised, "Refuse good advice and watch your plans fail; take good counsel and watch them succeed" (Proverbs 15:22).
- Make sure all items of importance are specifically documented in contracts and agreements. Part of the "code of the West," a term coined by Western writer Zane Grey, involved doing business on a handshake that was "more binding than a 100 page contract" (Wheeler 1996). That code served as a

great ideal of the burgeoning West. But, as you have heard in the 21st century, get it in writing.

Selecting Key Advisors

Before you start the process of selecting advisors to help you through the maze of decisions that end up with you practicing dentistry, you need to answer the question, which advisors do I need to seek out? The list of professionals that you need to find the best practice fit for you is rather extensive. Most certainly your choice of practice (associateship, partnership, ownership) will influence the number of advisors and type of advisors you will require. However, before we dig deep into purchasing the best possible advice, do not overlook the invaluable input of any family members or family friends, particularly those in business or in dentistry. Conversations about the practice of dentistry with practionioners, especially family, are most productive if you have a list of questions that reflect your goals. It is a good idea to cross-check information obtained about the practice of dentistry from family and friends with the views of your dental faculty.

Two of your best resources in dental school are the faculty who teach practice management and the faculty who practice in the community. For most dental schools, talking to part-time faculty who maintain a private practice is one of your best resources for issues that face a dentist in private practice.

Faculty who teach practice management should teach you about or have references that can help you decide which advisors you should contact to help you achieve your practice goals. Many schools maintain a list of practice opportunities and dental practices for sale. Most practices may be within the state and region in which the dental school is located, and many listed practices are owned by alumuni of the college. Nevertheless, your college's practices list is a good place to start.

Also, do not overlook the advice you can get from dental suppliers. Dental suppliers often know about dentists interested in selling their practices before the dentist goes to a broker or lists the practice. Most dental suppliers are happy to pass on information to prospective buyers in the hope of continuing to supply the new practitioner.

Remember to ask questions: advisors you hire work for you, with the obvious exception of consultants working for the practice owner. The number and type of advisors that you use will depend on the type of practice opportunity you are pursuing. For example, if you are pursuing an associateship without the option to purchase, your banking, accounting, and tax needs will be different than if you are pursuing a purchase of a solo private practice.

Let us examine in alphabetical order (see Figure 1.2) the advisors available to assist you in obtaining the practice environment of your dreams, or at least the practice environment that matches your goals. This is a basic list, not an exhaustive one. For example, architects are not discussed here.

Figure 1.2. The Unthank Design Group, Lincoln, Nebraska, is a planning architecture and interior design firm providing services exclusively to the dental professions. Since 1980, Dr. Unthank has designed more than a thousand dental and specialty offices throughout the world.

Look at the list below as a menu from which you need to choose the advisors who will help you accomplish your goals.

Accountant/CPA
Attorney
Banker
Insurance broker
Investment counsel
Practice broker

You may have the opportunity to get two advisors in one. Some accountants are also attorneys: see the American Association of Attorney-Certified Public Accountants (AAA-CPA) website (www.attorney-cpa.com); go to this website and click on the Find an Attorney-CPA link.

When looking for advisors, make sure they are skilled in working with small business/dental practices. If you use an advisor who does not deal with dental practices on a regular basis, you may end up paying to help educate the advisor and possibly pay again through lost income for outdated or inaccurate advice.

Selecting an Accountant

Consider, for example, what an accountant/CPA potentially has to offer:

- Prepare periodic financial statements and annual audit reports
- Assist you in analyzing your financial statements
- Help develop a budget and a system of monthly reporting so that you can regularly check on your financial transactions in relation to what was budgeted

- Prepare tax returns and assist with tax planning
- Set up a tax calendar and a system to help you comply with all filing requirements
- Help set up your accounting system
- Assist with determining loan or capital requirements
- Act as your advisor on financial and administrative matters
- Perform operational reviews to help you find ways to run your practice more efficiently
- Analyze profitability and break-even levels

The following suggestions are intended to help you find the right professional accountant, attorney, banker, CPA, practice broker, and so on. For the purpose of consistency, we will continue using the accountant in this example.

Determine the scope of work that you want an accountant to provide for your practice. Do you want someone to keep your books and prepare monthly financials? Are you looking for an annual audit? Are you looking for advice?

- Ask for referrals from other dentists in private practice.
- Set up interviews with two or three accountants so you can see which one you are most comfortable with.
- Keep interviews focused on whether you would be comfortable with and have confidence in the accountant. Questions you ask should be general in nature. Do not ask for accounting or tax advice in the interview process.
- Ask each accountant interviewed for two or three references.

The following questions should be covered in the interview (adapted from www.smallbusinessnotes.com; go to financial management, then click on selecting an account):

- What primary services do you provide to a dental practice?
- How will you charge for your services? Most accountants will establish a monthly retainer for recurring services like monthly or quarterly financial statements and charge by the hour for audits. Tax returns can be charged by the hour or by the form.
- What can I do to reduce your fees? Determine if you will be able to keep your accounting costs down using the tips provided.
- As my practice grows, how will you be able to help me? Ask them to describe services they provide to other dental practices.

You can keep your accounting costs down by:

- Finding out what you can prepare in advance to make the accountant's work easier. The easier it is for the accountant to read and understand the information you bring in, the quicker the work gets done.
- Choosing an accounting system, manual or computerized, that you can understand and that allows you or a staff member to do as much of the bookkeeping work as you have time for.
- Talking to your accountant and tax professional before making major decisions so you will know the tax implications ahead of time. This also allows

you to fill out all documents in a timely manner, thus saving the accountant time.
- Preparing and organizing for your meetings. Taking time to prepare for your visit can save money and time. Take notes so you will not have to ask questions a second time.
- Asking for a detailed bill that specifies the billing for each type of service, including time and billing rate. This will help give you some clues about what you can do to save money.

It is good to keep in mind that contracting out services that would take you a lot of time to learn can actually save you money. You can be far more productive doing dentistry than doing your own books, billing, or tax forms. There is a lot to be said for the quality of life: having time to spend with your family, enjoying your hobbies, and relaxing.

Selecting an Attorney

When selecting an attorney, it is important to determine the type of attorney you will need. If you are interested in becoming an associate or partner in a dental practice or are considering purchasing a dental practice, you will best be served by an attorney who specializes in small business contract law. If you are looking for an attorney who is also a CPA, you may be best served by contacting an attorney from the AAA-CPA.

In many localities, attorneys are permitted to advertise in the yellow pages for an area of specialization. Often the area of specialization is regulated by the American Bar Association. This association, like state dental associations, may require members to maintain a skill level that mandates the annual completion of additional study in the area of expertise under which they are listed.

The primary consideration in selecting an attorney should be how comfortable you are after your interview with a prospective attorney.

The suggestion list intended to help you find an accountant can and should be modified and used to find the right attorney. For example: determine the scope of work that you want an attorney to provide. Do you want the attorney to give you examples of contracts or review a contract you have been offered? If the attorney is reviewing a contract for you, know in advance what you want in the way of compensation, benefits, and overhead expenses.

The questions you ask of a prospective attorney should include (adapted from www.lawsonline.com/directories/attorneys/attyselection.htm):

- Does the attorney specialize in the area of law in which you are interested?
- Will you be charged for your first consultation?
- How much does the attorney charge per hour?
- How many hours does the attorney think it will take to complete the task?

- Are there any government licensing or filing fees involved?
- Are there any statutory guidelines for this type of work?
- Does the attorney provide the client with a written contract or letter confirming employment? If so, ask to see an example.
- Has the attorney ever had complaints filed against him/her?
- Does the attorney refer work to other attorneys in other areas of law where he/she is not an expert?

Throughout the course of your lifetime, you will need the services of attorneys to help you with issues like wills, trusts, and the sale of your practice when the time comes. Even if the attorney you have identified to work with cannot handle all of your needs, they can refer you to the expertise you require.

Selecting a Banker

How should you choose a bank or financial institution? The steps to choosing a bank or financial institution are very similar to choosing an accountant or attorney. Not all financial institutions are the same. Each institution establishes its own policies for

- Types of products and services that are offered
- Criteria for qualifying for a loan
- Minimum balances for accounts
- Interest rates
- Charges for account services

Your banker can offer you

- Assistance with cash management needs—for you and your business
- Investment products of varying maturities and varying risk
- Advice about qualifying for the loan that best meets your needs
- Special loan programs for small businesses

Compare financial institutions in order to find the one that serves you best. Do not overlook local banks. They tend to have more of an interest in the community, and the majority of their resources stay in the community. Start gathering information to help you select the best financial institution and identify a banker with whom you can build a relationship with for the future:

- Approach the decision as a long-term investment.
- Ask your accountant and attorney to introduce you to bankers with whom they are familiar.
- Check with your local Chamber of Commerce to find out which banks are active in the community.
- Look for a complementary personality—someone you are comfortable with.
- Introduce yourself to the banking center manager. If looking for a loan, ask to meet the loan officer who will be assigned to you.

- Tell them about your business so they can tell you what special products and services or restrictions might apply.
- Do not make a decision on pricing alone, but do compare interest rates on deposit accounts and basic consumer loans. Most business loans are negotiated. Also, you can get banks to negotiate charges for services. Do some comparison shopping (see www.smallbusinessnotes.com/operating/finmgmt/bank.html)

It is a good idea to establish a relationship with a banker before you need money. The right banker will be someone who understands your needs and the needs of your business.

Selecting an Insurance Broker

An insurance broker (agent) sources (brokers) contracts for insurance on behalf of his/her customers. Basically, there are two types of insurance agents: those who work for an insurance company, and independent brokers who work for their clients. Brokers who work for insurance companies can offer only the products and prices established by the company they work for. Independent insurance agents shop all insurance companies and try to offer the best coverage at the best price.

Your insurance needs will fall into the two broad categories of personal and business. Areas of your personal life that should be covered by insurance policies include but may not be limited to

- Household/renter's
- Automobile
- Life (you/spouse)
- Disability (may fall under your practice agreement)
- Umbrella policy
- Health (may fall under your practice agreement)

Areas of your professional life that require insurance coverage include but may not be limited to

- Malpractice
- Disability
- Health

If you are a partner in a dental practice or the owner of a solo practice, you will need to consider insurance coverage for

- Building and/or equipment
- Employee health
- Liability/personal injury
- Employee life

You may need to use more than one insurance broker, depending on your insurance needs. When looking for a broker to help you with selection and

coverage for your practice, you should follow the interview process as outlined for accountants, attorneys, and bankers. Seek a broker who is familiar with the insurance needs of a dental practice (see the article by Vogler and Lakamp [1988] in the references).

Please refer to chapter 21 on insurance needs as they apply to you and to dental practices.

Selecting an Investment Counsel

When it comes to investing your money for you and your family's future, whether children's education, new house, or retirement, you have basically three choices. First, you can do all the investing and manage your own portfolio. A second choice is to let someone else manage all your investments, or your third option is you manage some of your assets and someone else manages the remainder of your assets. Unless you have been trained as an investment counselor or have made investing a hobby over several years, going it alone can be risky, and not all the risk is in choosing poor-performing investments. If you are obligated to the practice of dentistry 35 or more hours a week and you have a family, little time remains that can be devoted to the study of investing.

Turning all or most of your investment money over to someone to manage should be done only after you have developed your investment goals, determined the level of risk you can tolerate, and established your investment philosophy. The process of developing your investment goals starts with the budgeting process. See chapter 22 on personal finance/investing. Once you have established a budget and your emergency fund and maintained your budget-driven lifestyle, you will have identified money for investments. Investment goals at the top of the list for most younger couples include

- Education for children/spouse
- New house/car
- Vacations
- Retirement

Once goals have been identified and the amount of money has been agreed upon, then it is time to determine your tolerance for risk; this is one question that an investment counselor should ask you. Basically, risk is defined in terms of rate of return on your investment. Usually, the higher the rate of return, the higher the risk. Bank certificates of deposit (CDs) and savings accounts are considered to have the least risk of losing your investment. However, it is possible to lose money on CDs and savings accounts. If your rate of return is 5%, and inflation is 3%, you are making a 2% return. But we need to figure that you will be taxed on your 5% return. Depending on your tax bracket, you could be losing money. Most investment counselors will suggest a mixture of investments (diversified portfolio), with percentages of your investment money being allocated to different investments. If you are in your thirties, you may

get a recommendation of 50–70% equities (stocks usually vs. mutual funds), 10–20% in bonds, and the remainder in foreign equities or cash.

The use of more than one investment modality is referred to as an "asset allocation." For a beginner's guide to asset allocation, diversification, and rebalancing, go to the U.S. Securities and Exchange Commission's website, www.sec.gov.

Investors who can tolerate high levels of risk and volatility may invest 90–100% in stocks. Their rationale is that from 1920 to 1999, the stock market has averaged an 11% return rate. However, there have been volatile days when the market dropped and people lost significant amounts of their investments. If you have the personality to ride out the bad days—and sometimes years—and you are in the right stocks and/or mutual funds, you will see good returns.

Next, you need to decide if your investments will be active (someone manages) or passive (stocks or funds that are reviewed once or twice a year). There will be fees and investment costs for either the active or passive approach to investing. The key to choosing an investment counselor is how he/she charges you. Pick financial advisors that charge an annual management fee. People who are paid only on up-front commissions have no incentive to watch your money and make suggestions as to when adjustments are needed.

For review purposes, your investment philosophy should include

- Allocation of assets
- Portfolio diversification
- Identifying and sticking with your investment style
- Active or passive management of your investments (wealthstrategies.com)

Selecting a Practice Broker

The role of a practice broker includes these and other functions:

- Listing of practices for sale
- Marketing listed practices
- Showing practices to potential buyers
- Writing offers to purchase
- Making sure all appropriate paperwork is signed

Choosing a practice broker is much like choosing an accountant or attorney. In addition to using the suggestions for finding an accountant or attorney, you will need to ask if the broker represents the practice owner or both the practice owner and you as the would-be associate/buyer. The latter is called "dual agency" and includes built-in ethical challenges. Is it really possible to represent both parties equitably and equally? Dual agents may be paid by both the buyer and seller. Theoretically, dual agents work for the best outcome for both

parties. If you are working with a broker who is a seller's agent (or with a dual-agency broker), you really should consider hiring an independent attorney or broker to represent your interests.

You will also want to ask how your earnest money will be handled. Typically, earnest money is deposited in an account and used toward the purcase price of the practice at closing. The amount of earnest money can be negotiated.

Another question you will want to ask is, what is the average length of time from acceptance of offer until close? The longer the wait, the more financial resources you will need to live on.

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Learning Exercises

Decision Matrix

Complete the decision matrix for the career path toward which you are leaning. Make sure that you involve your immediate family members.

Buy-In

You are just beginning your D4/senior year. Over the summer break, brief as it was, you found what you think is the ideal practice to purchase. An appraisal from 3 and a half years ago from a national consulting firm placed a value of $450,000 on the practice. In your initial discussions the current owner, Dr. Smith, indicated that he would sell you the practice for approximately @$375,000, in spite of increased practice revenues averaging $600,000 for the past 3 calendar years.

1. What can you do to facilitate this successful sale in order to make the deal mutually beneficial for you and Dr. Smith? In other words, how can you avoid “tipping” the Bermuda Triangle of practice transition?
2. What can Dr. Smith do to facilitate this successful sale in order to make the deal mutually beneficial for you and for him? How can he avoid “tipping” the Bermuda Triangle of practice transition?
3. Identify key advisors for you and for Dr. Smith.
4. Identify some practice information you would need to obtain and study as you pursue this purchase.

Chapter 2
Business Plans in Dentistry

Stuart M. Spero, Nader A. Nadershahi, and Lisa Itaya

Failure to plan is planning to fail.

Anonymous

When you have your own dental practice, you will not only be a practicing dentist but also a small business owner. As such, you will be responsible for managing all aspects of your practice, which requires much time, study, and effort. One key to your success as a business manager is to continually think about the future and not rely on good things to just happen. What do you want to do? When do you want to do it? How will you accomplish it? Success, then, is rooted in having a plan for its achievement.

After completing this chapter, you will understand:

1. The importance of management and the management process
2. The impact of planning on a successful practice
3. Why you should write a business plan
4. The key elements of a solid business plan.

Management and the Management Process

Management is the effective and efficient planning, organizing, leading, and controlling of limited resources in the face of a changing environment to achieve organizational goals.

This definition reflects four important concepts: (1) the effective and efficient accomplishment of goals; (2) the limitation of resources; (3) the constantly changing environment, both internal and external to the organization itself; and (4) the four basic management functions of planning, organizing, leading, and controlling.

Being *effective* means getting the job done—achieving your stated goal. Being *efficient* means using the fewest resources to accomplish that goal. For example, explaining a new procedure to each dental assistant one-on-one would be highly effective because you could ensure that each one fully understands it.

However, it would not be very efficient because of the total amount of time you would spend. In contrast, you could be very efficient and explain the new procedure in a group setting, but that might not be as effective as one-on-one because some people may be reluctant to ask for clarification. Your job as a manager is to balance the two without having a negative impact on your operations. The second concept, *limited resources*, recognizes that there is a finite amount of all resources. There are, for example, only 24 hours in a day, a finite number of dental chairs in your office, and only one of you. A *constantly changing environment* is a reality of life, both outside and inside your practice. The question is not whether things will change, but at what rate they will change. Externally, new dental procedures and technologies are discovered virtually every day. The economy can impact decisions to purchase new technologies or to move to a new location. Internally, hiring new employees brings new skills and new personalities to your staff. Your decision to implement a new administrative (office) procedure can be seen as positive or negative by different employees. Figure 2.1 illustrates how the *four basic management functions* of planning, organizing, leading, and controlling interact as a process.

Clearly, the management process must begin with planning. Without a goal, it is impossible to determine how to organize your practice, how to lead your team, or how to control your efforts. After establishing your goals and creating

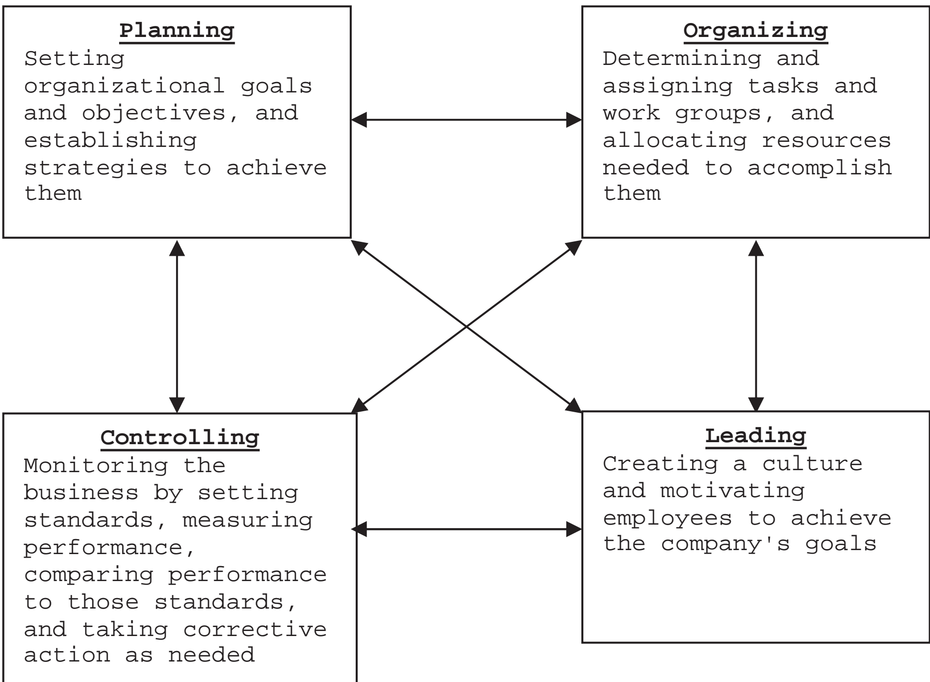

Figure 2.1. The management process.

a plan to achieve them, you must organize your practice and hire the right people so as to achieve those goals. You and your management team must then lead your staff by creating a positive, shared culture and motivating each person to achieve individual and practice goals. Finally, you must monitor employees' progress to ensure the effective and efficient accomplishment of goals, taking corrective action as necessary. In other words, the goals you established in the planning process become the standards against which you compare employee performance in the control process. If all is going well, your job is to encourage continued good performance. However, if goals are not being met, you must take corrective action. You must evaluate both the goal in question and the employees' performance. Your evaluation might determine that the goal is still valid and employee behavior must be corrected. However, you may determine that the stated goal is no longer valid due to a changing environment. For example, after you wrote your goals, you purchased new technology, or you hired new employees with different individual needs, or your patient load increased or decreased. As a result, you need to raise or lower the bar—that is, change the goal. So, even though everything begins with planning, all four management functions are interrelated and are ongoing, and any one can have an impact on any other one. Hence, it is called the "management process."

Why Is Planning Important?

Overall, the primary purpose of planning is to offset future uncertainty by reducing the risk of an event catching you completely off guard. More specifically, planning

Attracts potential lenders
Aids in attracting customers and employees
Helps enterprises succeed (but no guarantees)
Provides direction
Helps management cope with change
Contributes to the performance of the other management functions
Helps to evaluate your progress (the planning function becomes an integral part of the control function by acting as standards of performance)

Why Do Managers **Not** *Plan?*

Good planning is hard work.
Planning is long term, and we tend to be short-term oriented.
Planning is only one activity of many, and we are often too busy "putting out fires." Note the irony—perhaps better planning would prevent those fires from ever occurring.
You could be called to task if the plan does not work out, and failure is a concept we do not embrace.

What Is a Business Plan?

A business plan is a written document that describes and analyzes a proposed or current business and includes a marketing plan, a management plan, and a financial plan. While there are no guarantees of success, a well-written plan offers business owners a greater probability of success simply because it requires them to think about virtually every aspect of their business. A business plan is a roadmap for your dental practice. On the other hand, having a business plan, even one that is highly detailed, does not guarantee success. As that anonymous someone once said, “Poor management can cause even a McDonald’s to fail.”

Why Write One?

The main purpose for writing a business plan should be to allow the entrepreneur the opportunity to gain an in-depth look at the potential for the business’s success and what it will take to achieve that success. In other words, your primary audience should be yourself. However, many entrepreneurs write their business plan solely to obtain financing. Well-written business plans can help you answer many questions, including:

- What specific products (goods and/or services) do you offer?
- Is your target market large enough for the practice to be profitable, given the competition?
- How many support personnel will you need, and at what cost?
- Are the professional and support staff that are in the available labor pool qualified at the service level you desire/require?
- What level of revenues is required for you to break even in an average month?

In other words, given your proposed location and the services you plan to offer, a business plan can help you determine whether or not your practice has the potential to be successful. By putting together a thorough plan, you may discover that a change or changes might be warranted; for example, choosing a different location, offering different hours of operation, or partnering with another dentist or dentists (a second or third dentist in the same location only marginally increases the overhead costs).

How Long Should the Plan Be?

The short answer is, as long as it needs to be. The main body of most plans should be no more than 25 to 30 pages. Generally speaking, the higher the amount of financing you require, the more detailed the plan should be in order to justify the desired financing and to substantiate your ability to repay the lender/investor.

This is not a document you can expect to write over a free weekend while having a few glasses of wine (with cheese and crackers, of course). Nor should

you expect the first draft to be the final draft. As with any important paper, you should do your research (using your business plan outline as a guideline) and then put together the first draft. Put it down for a day or two, and then read it as if you were the investor, making notes of possible changes. Then, rewrite it and put it down for a day or two before re-reading it. Go through this process until you are satisfied it is complete—that it tells the whole story. Then, go back and make sure it is grammatically correct, especially your cover letter. Remember, people often write like they speak, but the rules for speaking are different than for writing. You do not want to lose a potential investor because of errors in your plan. That shows a lack of attention to detail that will not bode well for you as a manager (and a seeker of funding).

Another important point is to make sure that the end results—the numbers in your financial projections—are a result of your research, and not the other way around—that is, the "research" was developed to support the numbers that reflect a positive outcome. Making the numbers show a great cash flow and a large profit will often lead to difficulties later on. You might even be able to convince the banker that your plan is accurate, but you know the real story.

Business Plan Format

While every business plan is unique and should be designed and written for a specific purpose, certain elements are universal. Figure 2.2 provides one such framework and is the basis for this discussion. The sample business plan at the

I. COVER PAGE
  A. Business name, address, and phone
  B. Names of principals
  C. Date
II. TABLE OF CONTENTS
III. EXECUTIVE SUMMARY (not to exceed 2 pages)
  A. The company and its founders
  B. Market opportunity
  C. Financial projections
IV. MISSION
  A. Mission statement
  B. Goals/objectives
    1. What are your top short-term and medium-term goals or objectives?
    2. How does each one support your mission?
V. MARKETING PLAN
  A. Product description
    1. What services will you offer? Be complete, including maintaining changing technology

Figure 2.2. Business plan format.

2. How do your services differ from those of your competition; that is, what are your distinctive competencies?

B. Industry analysis
   1. What is the current status of the dental industry?
   2. What opportunities and threats do you face; for example, are there any new products, markets, trends, and so forth that might affect the business either positively or negatively, particularly in the proposed geographic area where you plan to practice?

C. Market definition (target market)
   1. Discuss primary market(s) and, if applicable, secondary market(s)
   2. Develop market demographics; for example, age and income
   3. How many potential patients are there?
   4. Given your competition (see "D" below) and the average percentage of the population that seeks your type of services, what makes this market viable (potential sales)?

D. Competition
   1. Who are your top competitors (due to specialty and/or proximity)? What is the dentist-to-population ratio?
   2. What are their strengths and weaknesses?
   3. How do *your* strengths and weaknesses compare to those of your competitors?

E. Place
   1. Where is your proposed location?
   2. What are its advantages and disadvantages?
   3. Will you be renting, building, or buying an existing structure? What are the up-front and monthly costs?

F. Price
   1. What is your pricing policy/strategy; that is, equal to, over, or below market average?
   2. What are your product costs?
   3. What will be your prices?
   4. What are your competitors' prices?

G. Promotion
   1. What are your advertising plans; for example, media, frequency, grand opening?
   2. Develop your advertising budget for the first year.
   3. Prepare a 3-month schedule of your promotional activities. Also discuss what will be done internally

VI. MANAGEMENT PLAN

A. Key management personnel (who may or may not be the owner[s]); for example, office manager, billing/insurance specialist
   1. What function(s) will each manager/company officer control?
   2. What background/qualifications will you seek in your managers?
   3. Identify your board of directors or advisors by qualification (for example, accountant, the business's CEO) and, if known, by name

B. Organization structure
   1. Prepare an organizational chart indicating who will perform what functions
   2. Understand that the same person may perform more than one function

Figure 2.2. *Continued*

- C. Personnel management
  1. Discuss such factors as recruiting, wage and salary structure, benefits, job descriptions, and so forth
  2. Indicate how many employees will be needed (include a typical work schedule)
- D. Policies
  1. Internal; for example, employee standards (that is, conduct and dress), financial controls, filing insurance claims
  2. External; for example, credit and collections, check cashing
- E. Insurance
  1. Identify the types and amounts needed
  2. What are the costs?
- F. Legal
  1. What will be the legal structure of your business? What are the start-up and ongoing costs?
  2. What other legal requirements might apply; for example, contracts, licenses, permits, lease/rent agreements?
  3. If not a sole ownership practice, discuss provisions for such things as profit/loss distribution, adding or buying out partners, and business termination

VII. FINANCIAL PLAN
- A. Turn-key costs
- B. Pro forma cash flow (first year, by month)
- C. Pro forma income statements (3 years)
- D. Pro forma balance sheets (3 years)
- E. Break-even analysis for an average month
- F. Proposed financing
  1. Summarize the total amount needed
  2. Indicate the proposed source(s) and use(s) of funds
  3. Indicate the security/collateral offered

VIII. APPENDICES
- A. Résumés of key personnel
- B. Letters of recommendation or endorsement
- C. Market research
- D. Historical financial data
- E. Other items

Figure 2.2. *Continued*

end of the chapter illustrates another format. Some of the topics in Figure 2.2 are not included, and some are not in the same sequence, location, or detail. Again, your business plan should be written to meet your needs. There is no "perfect" business plan format. The outline discussed here and the sample business plan appearing later in this chapter demonstrate this fact.

Elements of the Plan

Cover Page

The cover page identifies the name, address, and phone number of the business and the owner(s), as well as the date the plan was submitted. If you are requesting funds from more than one source, also include a copy number.

Table of Contents

The table of contents provides a concise overview of the plan's contents and should list, as a minimum, each primary and secondary heading with its starting page number. For example, a major heading would be "Mission," and a secondary heading would be "Mission Statement."

Executive Summary

This introduction to your proposal must capture the attention of the reader with a convincing message to read the entire plan. It is a brief synopsis (not more than 2 pages) that addresses the essence of your proposed business. Hence, even though it is the first thing read, it is the last thing written. While a lender might talk about having read, say, five hundred business plans, what the lender really read were five hundred executive summaries. Only a small percentage of those executive summaries successfully led to the full plan being read, so these introductory comments are critical and foundational.

Imagine that just you and a potential investor are in an elevator, and you have that person's undivided attention for maybe 1 minute. What would you say to convince this person that your proposal would be a great investment opportunity? The executive summary is simply a written version of an "elevator pitch" and should briefly describe the following:

- The company and its founders: describe your service, what is special about it, and what the qualifications of the owner(s) are.
- The market opportunity: describe the size and growth rate of your market and how it is currently being served.
- The key financial highlights. Summarize your sales and profit projections for at least the first year. Clearly state the total capital needed from all sources (including personal resources), what use will be made of each source's capital, and an anticipated repayment schedule. While you may not know the exact terms of the loan (such as the interest rate and length of the loan), you should make a reasonable estimate. For example, suggesting that a loan of $5,000 can be obtained at a 2% interest rate to be repaid over 5 years would not be reasonable. Lastly, include when your business practice will financially break even.

Mission

Mission Statement

A company's mission statement answers the question, why do I exist? It is a short statement (25 words or less) that tells employees, clients, and investors what you do and what you believe in. In other words, it gives direction to your practice. It is like your elevator pitch—you need to be able to summarize your proposal in about 1 minute. If you cannot summarize the essence of your business and what you stand for in no more than about 25 words, you probably do not have a handle on who you are and what you are all about.

Goals and Objectives

While the mission statement provides the broad overview of your business, goals and objectives are actually what help you achieve your mission. *Goals* are broad, long-range statements of what the practice would like to achieve. An example might be "to be the premier general dentist in Anywhere, USA." An *objective* is a very specific statement that is relatively short-term oriented and follows the basic formula "to do something, by a certain time, by some amount." For example, "to increase my patient base by 300 within 6 months" or "to reduce uncollectible accounts receivable by 2% by the end of the fiscal year." These goals and objectives give you and your practice a sense of direction and should, obviously, relate to your basic mission statement.

Marketing Plan

Having a well-designed marketing plan is crucial to your success in terms of both acquiring needed funding and having a viable practice. Indeed, it is your marketing plan that forms the basis of your financial forecasts. So, knowing your target market, defining your product, having an appropriate pricing strategy, selecting the right location, and developing a suitable promotion strategy are some of the most critical—and challenging—aspects of building your plan.

These four factors are commonly known as the "4 Ps" of marketing (product, place, price, and promotion), and, together with your target market, create an image for your practice. All five factors must blend together; otherwise, your marketing message will not be consistent. If you change any one of them, you change the image people have of your practice. For example, if you believe dental implants will be an important service in your practice, then renting a small office in an older structure on the "other side of the tracks" would not likely serve your best interests. Your location would be incompatible with the target market for dental implants.

Another important marketing concept is how you see, or relate to, the marketplace. Do you have a production orientation or a marketing orientation? A *production orientation* suggests that you already have a product, so you must

now find the target market(s). A *marketing orientation* suggests that you determine your target market(s) first, and then you determine what product(s) the people in your target market need or want. In other words, the production concept says that you already have a product that, of course, you believe is the greatest thing since sliced bread, but you must now find a market that thinks the same way you do—not always the easiest thing to do. The marketing concept says that you have selected a market you wish to serve, and now you must find a product they need or want. Conventional wisdom says that having a product and trying to figure out how to convince potential customers they should buy it (the production orientation) is much more difficult than determining what someone wants or needs and then making it available to them (the marketing orientation). Knowing your orientation suggests which is most important to you: your product or your patient.

As you begin the process of actually starting your professional career, you have likely already determined what area of dentistry you will practice. Does that mean you automatically are relegated to a production orientation? Absolutely not! As your client base develops, based on what services you do or do not choose to provide, you will gain a more in-depth understanding of their needs as well as an understanding of your own developing professional interests. As these needs converge, you will be able to fulfill more and more of your patients' needs.

Product Description

A product is a good, a service, or, most often, a combination of the two. A good is tangible; a service is not. For example, a routine semi-annual exam would be a service; the toothbrush you give to a patient would be a good; the preparation for and the seating of a crown would be a combination of the two (preparing the tooth and seating the crown are services, but the crown itself is a good). Other "product offerings" might include convenient hours, options for financing dental care, or the latest technology. Knowing exactly what your total product offerings are (and being able to describe them in terms the average layperson can understand) will govern many decisions. For example, what skills will you seek in hiring new staff members (or in retaining current ones)? What promotional activities will your target market most likely respond to? How will you price your products? (Virtually every aspect of your product offerings has an associated cost, and you must ensure your pricing covers all of those costs.)

It is also important to clearly understand and describe how your product differs from your competition's. That is, what is your *distinctive competency*—what sets you apart from your competitors—and how will that give you a competitive advantage? For example, as a general dentist offering orthodontic treatment, you might establish office hours so that your school-aged patients will not have to miss school.

Industry Analysis

Demonstrating an understanding of your industry tells the investor that you have an eye on the future. Briefly describe the current status of the dental industry. What opportunities and threats do you face (such as new products, markets, trends, etc.) that might affect the business either positively or negatively, particularly in the geographic area where you plan to practice? How do you plan to take advantage of those opportunities and overcome the threats?

Market Definition

The term "market" has both a geographic and a people component, which, combined, constitute your target market. The geographic component refers to the physical area you plan to serve, for example, the entire city or county, or the area of the city bounded by certain streets. The people component is the demographic description of your potential patients (such as age, income, specific types of dental treatment required). The major question you must ask (and answer) is, how many potential patients (the people component) live/work in my geographic area (geographic component)? That is, about what percentage of the population requires or seeks the services you plan to offer? On average, how often might an individual patient seek those services? Given your competition (see the next section), what percentage of the total potential patient load can you expect to seek those services from you as opposed to one of your competitors? Given your proposed pricing schedule, what, then, are your potential sales? Is that enough to cover your total business costs and still leave enough for your personal needs?

Competition

Understanding your competitors is especially important if you are starting from scratch. And even if you are buying out or buying into an existing practice, you should consider how many practitioners there are in your area and what demographic changes, if any, there may be since the practice first started. Are there still enough patients to support the current practices plus yours? What is the current dentist-to-population ratio? Might current patients of the practice you are purchasing value a practitioner's years of experience versus "the new kid on the block"? Who, then, are your top competitors due to specialty and/or proximity? What are their strengths and weaknesses? How do *your* strengths and weaknesses compare to your competitors'? In promoting your practice, you want to emphasize your strengths and your distinctive competencies and play down your competitors' strengths. For example, because you just graduated from dental school, you might emphasize your knowledge of the latest techniques. Your competitors have much more experience than you do, so your emphasis should be on other competencies.

Place

While place generally refers to your location, it actually encompasses more than that. A better word might be *distribution*, but “4 Ps” sounds better than “3 Ps and a D.” Certainly, your physical location, to include the physical structure, is a vital component of your business. However, the consideration is how you deliver your total product, both services and goods, to your customer. So, unless you have your own lab and fabricate your own crowns, for example, you must also include other businesses in your business plan. You may be able to choose from among several suppliers for various items. Which one(s) will you use and why? How will cost, financing arrangements, convenience, and quality play into your decision? While your banker may not necessarily want to know these details, you do. Choosing a supplier whose quality is less than you desire or whose turnaround time is slow can have a definite impact on your bottom line through the loss of patients. Remember, your patient does not really care that someone else made the poor-fitting crown or could not deliver it in the time promised.

Regarding the physical location, where exactly is it? What are its advantages and disadvantages, including, for example, age of the structure, available parking, room for expansion, proximity to clients? Are you going to rent or buy an existing structure, or will you build? What are the up-front and monthly costs?

Price

Your pricing structure, when multiplied by the number of the various procedures you can perform, will ultimately determine your total sales. While pricing and fees will be covered in detail in other chapters, the basic questions you must answer are:

- What is your pricing policy/strategy—that is, equal to, over, or below market average?
- What are your product costs?
- What are your fees?
- What are your competitors’ fees?

Promotion

Whenever non-marketing people see or hear the term “promotion,” they usually think of advertising. However, promotion is more than that. It also includes personal selling, specialty advertising, and publicity. We do not normally think about dentists and physicians engaging in *personal selling*, but that is what you do when you suggest elective procedures such as teeth whitening. How you and your staff interact with patients is also part of personal selling, in that you are constantly “promoting” superior service, which translates into satisfied customers who will remain loyal patients. The giveaway items with your name and logo on them such as pens and toothbrushes are called *specialty*

advertising. *Publicity*, sometimes thought of as "free advertising," is when your business (or you) is the subject of, or mentioned in, a story in the mass media such as a newspaper article. These references could be positive or negative. For example, a reporter may choose to write a story about the opening of your new practice or include the fact that your office had 100% participation in a blood drive. On the other hand, the fact that you or a member of your staff was involved in a single-car accident and alcohol was cited as a contributing factor would probably be seen negatively. Including a reference to you in the article was the newspaper's choice, not yours. And since you do not pay for publicity, you have no control over it. Conversely, *advertising* is space you purchase, which means you control, to some degree, what is said and where it is placed; for example, ads in the newspaper, on TV, or in the yellow pages of the phone book.

In this section of your business plan, you should include (1) your initial advertising plans (e.g., media, frequency, grand opening), (2) a 3-month schedule of all your promotional activities, and (3) your advertising budget for the first year. You will discuss any internal promotion in this section. See chapters 15 and 16 for an in-depth discussion of internal and external marketing.

Management Plan

Unlike the marketing plan, which has an external focus—your customers—the management plan has an internal focus—the structure of the business itself.

Key Management Personnel

What supervisory positions are necessary to ensure the efficient and effective operation of your practice, and, if known, who will fill those positions? Examples include an office manager or a billing/insurance specialist, positions that are not normally filled by an owner of the practice. Specifically, what will be the responsibilities of each of these positions? If there are multiple business owners, what function(s) will each owner control? What background/qualifications will you seek for each manager position?

Some forms of ownership require a board of directors—namely, corporations. Identify the members of your board by name if possible or, as a minimum, by qualification (for example, accountant and the business's CEO). If such a board is not required, you may wish to consider having a "board of advisors" whose function is basically the same as a board of directors.

Organization Structure

Preparing an organizational chart indicating who will perform what functions helps everyone to see how all of the various components of your practice interact. That is, it presents a clear picture of who does what and who reports to whom. Because some workers may have multiple responsibilities, especially in a small practice, one name will be in more than one "box."

Personnel Management

Arguably your most important asset, and one of your largest expenses, is your staff. If you are starting a new practice, you may need only two people, a dental assistant and a receptionist, for example. Those two names, along with yours, will fill all the boxes in your organizational chart. On the other hand, your practice may require several staff members. Indicate how many employees you need and in what positions. Also indicate if and when you plan to add additional staff. For example, when monthly revenues reach, say, $30,000, you will add a dental hygienist. Also include such factors as recruiting, wage and salary structure, benefits, and job descriptions. It may be useful to include a typical work schedule. See chapter 18 on staff.

Policies

Thinking about and establishing both internal and external policies at the outset can help you avoid making hurried decisions later on. Taking the time up front to consider *all* the pros and cons about situations that will likely occur on a regular basis will result in less stress for you and more consistent decisions later on. Examples of internal policies might include personnel issues (for example, coming to work late, use of alcohol, smoking, advances in pay) and financial controls (such as who collects payments, who makes deposits). External policies might include credit and collection (such as selling accounts over 90 days old to a collection agency) and check cashing (for example, checks drawn on local banks only).

Insurance

What types of insurance will you require and at what costs? While insurance is expensive, you want to make sure you have enough of the right kinds. See chapter 21 for a detailed discussion of insurance needs.

Legal

What will be the legal structure of your business? What are the start-up and the ongoing costs? If it is not a sole ownership practice, discuss provisions for such things as profit/loss distribution, adding or buying out partners, and business termination. See chapter 9 for an in-depth discussion of the various forms of business ownership.

In addition to the legal structure of your practice, what other legal issues are important and at what costs? For example, will the practice pay for any required licensing fees for your dental hygienist? What are the terms of a lease/rent agreement?

Financial Plan

The financial plan details your revenues and your expenses. It shows how they translate into a profit (or loss) and how (and when) the money flows into and

out of the business. It also shows the practice's assets and who "owns" them—you (owner's equity) or someone else (a liability). The financial plan is where the "rubber meets the road." In business terms, what's the "bottom line"? Virtually everything in your marketing and management plans must be quantified. What are your costs, when will you incur them, and when will you pay for them? For example, how many patients do you expect to see per month, and at what price (marketing plan—target market)? What are your advertising costs (marketing plan—promotion)? What are your legal, insurance, and personnel costs (management plan)?

The three financial statements that you should understand (not necessarily be able to create them, but understand them) are the *cash flow statement* (which includes *turn-key costs* for a start-up practice), the *income statement* (sometimes called a profit and loss statement, an operating statement, or a statement of earnings), and the *balance sheet*. See chapter 3 on dentistry by the numbers for an in-depth discussion of financial statements.

Cash Flow and Turn-Key Projections

The cash flow statement is considered by many to be the most important financial statement for any business owner. It shows when money actually flows into the business and when money actually flows out of the business, not when the sale is made or the expense incurred, as is often the case with the income statement. Say, for example, you provide a service on May 5 for which you charge $100, but you do not receive payment for it until June 10. Your profit and loss statement could show a $100 "sale" in May, but your cash flow statement will show the receipt of that $100 in June, not May. Similarly, if you order $100 of supplies in May, but pay for them in June, your profit and loss statement could show an expense of $100 in May, but your cash flow statement will show a $100 payment in June. In other words, the cash flow statement is like your checkbook. It is a month-to-month accounting of your actual deposits and your actual withdrawals. A cash flow statement should not be confused with a "statement of cash flows" or a "sources and uses of funds" statement, which are often produced by accountants. While the latter two statements can be useful for an overview of the sources of the cash and how that cash was spent, they do not show how your cash "cycles" through your business on a month-to-month basis. Basically, if your practice cannot maintain a positive cash flow, you will not need to worry about an income statement or a balance sheet because you will not be in business. Your business plan should include monthly pro forma cash flow statements for the first 12 to 24 months. These pro forma statements forecast expected financial outcomes (see Figure 2.3g as an example).

Turn-key costs are all of the costs you incur before "turning your key in the door" to open it for business; for example, construction or renovation costs, legal fees, purchase of equipment and supplies, utility deposits, and the like. Some of those costs can be paid for after you open your doors, but some may

require payment at the time of purchase. Ultimately, these costs will be reflected in the expense section of the income statement.

Income Statement

The income statement shows sales, expenses, and the resulting profit (or loss) for a specified period of time such as monthly, quarterly, or annually. Income statements can be on an accrual basis (when the sale or expense is incurred) or on a cash basis (when the money is received or expense is paid). As a minimum, your plan should include monthly pro forma income statements for the first year and an annual summary for year 2.

Balance Sheet

The balance sheet shows the total assets of the business and who "owns" them—either you (owner's equity) or someone else (liability). Because all assets are owned by someone, total assets must equal total liability plus owner's equity. The balance sheet is a reflection of a single point in time; for example, the end of your fiscal year. Your business plan should include *pro forma* (projected) balance sheets for opening day and the end of years 1 and 2.

Break-Even Analysis

An important question to answer is, what level of sales must I have to cover total costs for an average month? Knowing your *break-even point* is particularly critical when there is a gap between the date of the sale and the receipt of payment. You should also be aware of when during an average month you expect to reach that point—that is, when do you anticipate actually receiving payments to cover your costs? For example, say your break-even point is projected to be the 20th of the month. It is now the 15th, and your receipts are only half that amount. Knowing the situation, you are in a better position to plan what you will do before you come face-to-face with the "end of the month crunch."

Proposed Capitalization

Finally, itemize your total proposed capitalization from all sources, equity and debt. *Equity financing* is money that comes from the owner(s) and does not have to be repaid. It is called "risk capital" because the money could be lost if the business fails. *Debt financing*, on the other hand, is money that you borrow and must repay with interest. Indicate how the money from each funding source will be used, what security/collateral, if any, will be used, and your proposed terms of repayment. Financing your practice is covered in detail in chapter 8.

Appendices

Include as appendices (or attachments) anything that adds useful detail to your proposal. Examples include, but are not limited to, résumés of key personnel,

letters of recommendation or endorsement, market research, contracts, and historical financial data.

Resources for Business Plans

There is a vast array of resources available to assist and guide you in putting together your business plan as well as to provide information and education about the various aspects of managing your own business, such as understanding financial statements. These resources range from one-on-one individual assistance from consultants to books and self-help guides to attending classes and workshops. A small sampling of the various resources follows below.

Business Consultants

Business consultants are people who offer advice to others about how to better run a business. Some consultants specialize in a particular industry, and some are generalists. Check the yellow pages in your phone book for "business consultants." You might talk to your business attorney or accountant. It is not unusual for them to assist in putting together business plans. Some may even have "how-to" booklets for business plans. There is also the Academy of Dental Management Consultants. This academy has experience-based requirements for member-consultants (www.admc.net).

Federal Government (SBA)

The Small Business Administration (SBA) is the federal government's agency specifically designed to assist small business people in finding financial assistance. More to the purpose of this chapter, however, is the management assistance they provide small business people through the Service Corps of Retired Executives (SCORE) and through a network of Small Business Development Centers (SBDCs).

SCORE

SCORE is an organized group of retired business executives with a wide variety of backgrounds who provide free consulting to any small business owner. Not all industries are represented in each chapter, so be sure to ask for someone whose background is compatible with your needs. To find the SCORE chapter nearest you, check their website at www.score.org.

SBDC

The SBDC program is a cooperative effort of the private sector, the educational community, and federal, state, and local governments. Assisting with the development of feasibility studies (business plans for start-up businesses) is only one of the many services the program provides to anyone interested in

starting a small business or improving or expanding an existing one. For more information on their services or to locate the office nearest to you, go to www.sba.gov and click on Local Resources.

State and Local Agencies

Many states and local agencies offer a variety of assistance. Check out your city's chamber of commerce or economic development office for local information. Similarly, your state's economic development office will often have a myriad of resources and links to assist you.

Academic Institutions

Your local college or university may be a good source of assistance. First, some instructors or professors supplement their income by providing private consulting. Similarly, assisting in developing a feasibility study may be an excellent student project for a small business class or an internship. While the work is actually done by a student, it is supervised by the course instructor.

Books

There are literally hundreds of books on the market specifically designed to help put together your business plan. Some contain fill-in-the-blanks worksheets, some come with interactive CDs, and some simply give you the information. Check your local library or bookstore, or, for a more complete listing, check online with Amazon (www.amazon.com) or Barnes & Noble (www.barnesandnoble.com), keyword: business plans.

References and Additional Resources

Armstrong, Gary, and Kotler, Philip. 2004. *Marketing: An Introduction,* 6th ed. Upper Saddle River, NJ: Pearson Education, Inc.

Daft, Richard L. 2008. *Management,* 8th ed. Mason, OH: Thomson Higher Education.

Scarborough, Norman M., and Zimmerer, Thomas W. 2006. *Effective Small Business Management,* 8th ed. Upper Saddle River, NJ: Pearson Education, Inc.

McKeever, Mike. 2007. *How to Write a Business Plan*. Berkley, CA: Nolo.

Learning Exercises

1. Contact a dentist in your intended area of practice who recently began his or her practice (within the past 5 years) and who has the same type of business arrangement you plan to have; that is, either started or bought a single-practitioner office, or started or bought into a multiple-

practitioner office. Did he or she prepare a business plan before starting the practice? Why or why not? How detailed was the plan? How long did it take to complete it? Who, if anyone, assisted in the plan's preparation? Was creating the plan beneficial? Why or why not? If there was no plan, does he or she still agree with that decision? What advice does she or he have about writing a business plan?

2. Interview a local banker (or some other entity from which you might request a loan) and ask questions such as:
   A. How important is a well-prepared business plan?
   B. How important is being knowledgeable enough about the plan's content to discuss it with the banker, particularly the financial projections? How important is it to have a smooth presentation?
   C. What is a typical loan repayment schedule (about how many years to repay and approximately what interest rate) for the type and amount of loan you are seeking? (This is information you will need to know to prepare your financial projections.)

A Sample Business Plan

This business plan was prepared by Dr. Lisa Itaya under the supervision of Dr. Nader Nadershahi as part of a course in practice management. The plan details the establishment of a general practice in Foster City, San Mateo County, California. The plan demonstrates a slightly different organizational format than the one presented earlier in this chapter, illustrating that a business plan may be organized in various ways depending on the needs of the person developing the plan.

Confidential Business Plan

Lisa Itaya

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Executive Summary

Upon completion of graduation and State of California licensing requirements, Lisa Itaya intends to organize, establish, and operate as a limited liability corporation or professional corporation a private practice in general dentistry. The practice will be located in Foster

Figure 2.3. Sample business plan.

City, California, and serve a diverse base of patients throughout the metropolitan San Mateo County area.

This confidential business plan summarizes the nature of the practice to be established. Operations will commence after an initial funding of $75,000 is secured through private placement, bank loan, or access to Dr. Itaya's home equity line of credit. First year operations are summarized in Figure 2.3a.

Revenue	$188,500
Expenses	$227,566
Net Profit/(Loss)	($39,066)

Figure 2.3a. Summary of first year operations forecast.

The first year's net loss (before taxes) is largely attributed to the initial investment in equipment and supplies. Additionally, $35,700 is drawn from the annual operation for Dr. Itaya's initial salary. Although this plan only addresses the first year of operations, it is important to note that the operation is profitable beginning the eighth month and thereafter.

Location

Region and City Location

Dr. Itaya plans to establish a new private practice offering general dentistry services in Foster City, California. Incorporated in 1971, Foster City is a master-planned mostly white-collar community situated on the San Francisco peninsula midway between the metropolitan cities of San Francisco and San Jose. Foster City comprises a population of approximately thirty thousand persons and is conveniently situated to serve potential patients from throughout San Mateo County (population 691,500).

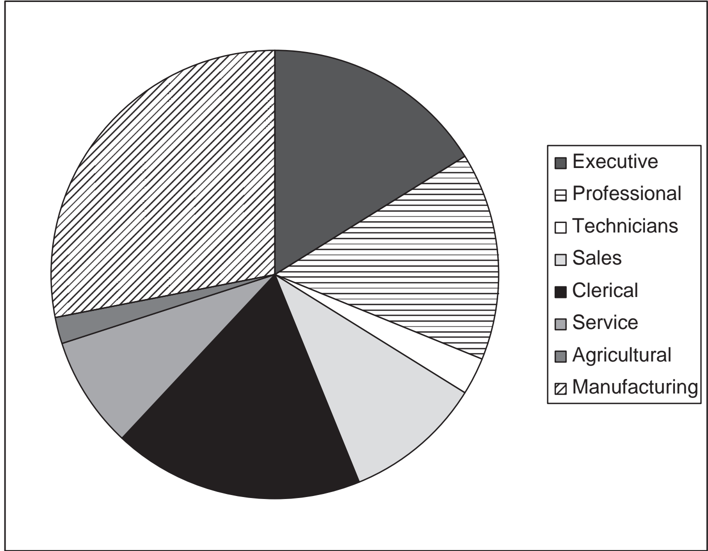
San Mateo County's cities are low in crime, and Foster City has one of the lowest crime rates in the entire San Francisco Bay Area. The county schools score among the highest in the state. The county has served as home to some of the richest residents in California and is home to many of the newest transplants to California. The county is one of the most desirable addresses in the state, owing much of its prestige to its history, its amenities, its topography, and its location. Foster City residences are mostly of newer construction, with the oldest structures only 30 years old.

Approximately six hundred businesses are located in Foster City, including a number of high-growth biotech companies and VISA (900 employees). EFI Corporation is currently building their new worldwide headquarters in Foster City. When fully occupied, this facility will bring several thousand additional daily employees to the community.

Regional and Local Demographics

About 91% of the county's approximately seven hundred thousand residents reside in twenty cities; they are Atherton, Belmont, Brisbane, Burlingame, Coma, Daly City, East

Figure 2.3. *Continued*



Source: 1990 Census.

Figure 2.3b. How San Mateo County earns its money.

Palo Alto, Foster City, Half Moon Bay, Hillsborough, Menlo Park, Millbrae, Pacifica, Portola Valley, Redwood City, San Bruno, San Carlos, San Mateo, South San Francisco, and Woodside. Each of these communities is within 15 miles of Foster City. In 1996, there was a net inflow of over six thousand new residents (licensed drivers) to the county, reflecting the continued and expected robust growth of this region.

According to the Association of Bay Area Governments (ABAG), Foster City residents enjoy an average household income of $89,600, while county-wide the average is a robust $77,800. As shown in Figure 2.3b, 49% of earned income is derived from so-called "white collar" professions (executive, professional, technical, and sales). These groups are expected to be more likely than others to be motivated to attain and maintain good oral health.

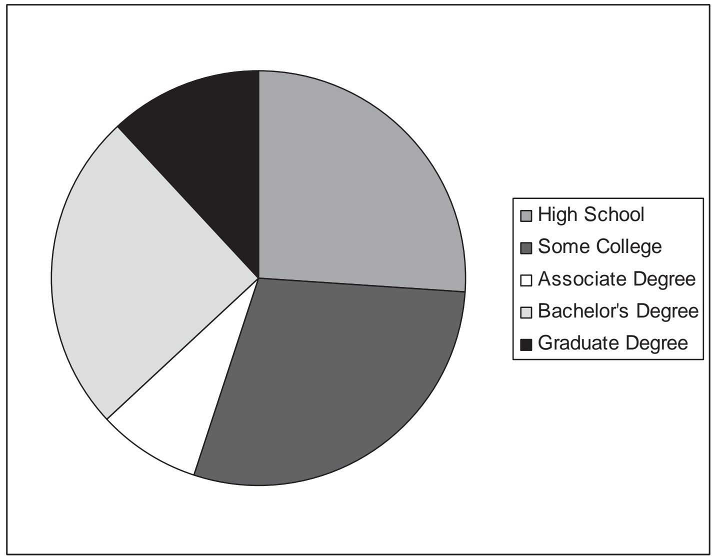
Moreover, the county's high level of adult education gives further evidence of a pool of potential patients historically predisposed to seeking regular oral care (see Figure 2.3c).

Finally, the balanced distribution of the target population indicates that a general dental practice can have broad appeal—the available market is not skewed to, for example, pediatric or geriatric patients (see Figure 2.3d).

Facilities

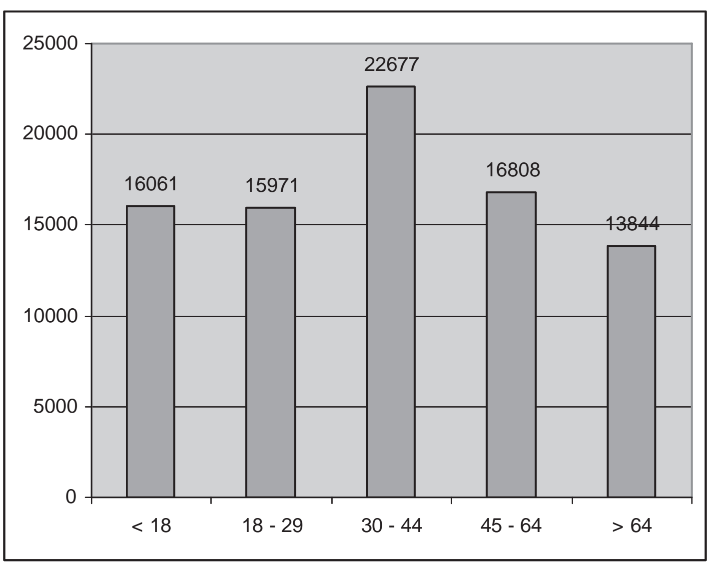
The practice will operate at 1289 East Hillsdale Boulevard. This mature two-story medical/dental building is convenient to the city hall, a major shopping location, and the vibrant Metro Center, a multiple high-rise building development housing many large and small companies. The office is a short drive from any location in the city, including residences

Figure 2.3. *Continued*



Source: 1990 Census.

Figure 2.3c. Education level of population age 18 and older.



Source: 1990 Census.

Figure 2.3d. General population characteristics.

and the site of the new headquarters for EFI Corporation, a high-technology company. This new construction will add several thousand workers to the target patient population next year. The building has more than ample parking and is directly accessible to patients in the county from nearby Highways 101 and 92.

Figure 2.3. *Continued*

Dr. Itaya is extremely fortunate in that the contemplated office suite has 700 square feet of useable space, including two operatories that are already installed. As detailed in the financial exhibits, the facility is available on a 3-year lease basis at $1,425 per month, including water, sewer, and garbage utility services.

Economics

Regional and Local Economic Profile

The San Francisco Bay Area in general, and San Mateo County in particular, have been consistently robust economic regions. Although high-technology companies represent an extremely large and visible slice of the economic pie, the region is by no means dependent on any one industry. In addition to high technology, the area has strong influences from airlines, biotechnology, agriculture, media, petroleum, and telecommunications companies.

ABAG forecasts that by the year 2020, (1) the area's over-60 population will nearly double to more than two million people, and one in four people will be over 60 years old; (2) the region's total population will grow by 1.4 million to 7.7 million; and (3) more than 1.4 million jobs will be added, bringing the regional total to 4.3 million. ABAG advises that cities with large senior populations will be required to provide more services with older people in mind, including health care. Clearly, there will be a growing need for geriatric dentistry, as the so-called baby boomers become a large aging population group.

East Palo Alto, a smaller community at the edge of San Mateo County and only 15 minutes from Foster City, is expected to be the fastest-growing job center of the region. According to the ABAG projections, that city's job base could grow by 6,000 in the next 20 years. This provides an excellent opportunity for dental education and to positively impact oral health in the community.

Industry Profile

According to the American Dental Association and the U.S. Department of Health and Human Services, the following points characterize the dental industry:

- Dentistry is the third most trusted profession in America. Dentists are highly rated in terms of honesty, ethical standards, interpersonal skills, and delivery of quality care.
- Dental offices are the third highest-ranking category of start-up businesses and most likely to survive.
- The average 1992 net income of general practitioners was about $98,000. For dentists under 35 years of age the average is $88,710. Dentists rank in the ninety-second percentile of U.S. family income.
- Fifty-two percent of American adults are covered by a dental insurance plan that pays for all or part of their dental expenses. Private dental insurance payments accounted for approximately 44% of U.S. expenditures for dental care.

Figure 2.3. *Continued*

	San Mateo County	Foster City
General Dentists	443	17
Pediatric Dentists	14	2
Total Dentists	457	19
Population	691,500	29,286
Penetration	1:1,513	1:1,541

Source: Pacific Bell SMART Yellow Pages and 1996 Census.

Figure 2.3e. Dentist-to-patient ratio.

- The success of preventive dentistry in reducing the incidence of oral disease has contributed to a growing older population that will retain their teeth longer and be even more aware of the importance of regular dental care.

Services

Type and Characteristics of Services

Dr. Itaya will establish a general practice dental office offering comprehensive care to patients of all ages. Based upon her experiences as a student at the University of the Pacific School of Dentistry, she expects to offer services that will be of special appeal to dental phobics, persons with disabilities, and the elderly.

Specialty services will include nitrous oxide sedation, cosmetic restorations, bleaching, emergency care, simple extractions, and dental implants.

In-office marketing programs (for example, a computer-generated silent commercial viewable in the reception/waiting area) will inform and educate patients about services of potential interest to them.

Competition

Although it has been suggested that the San Francisco Bay Area is saturated with dental practitioners, Dr. Itaya is optimistic that an active and profitable general practice can be established in Foster City. While there are 514 active private practitioners in San Mateo County, 21% limit their practices to specialties such as endodontics, orthodontics, and periodontics. Of the remaining 407 general practitioners in the county, 20% are over 55 years of age, and over 7% are more than 65 years of age, suggesting that there is opportunity for new practices to become established.

This analysis is corroborated by additional information (see Figure 2.3e). Compared to the national average of one dentist for every 1,700 residents, we conclude that there is still room for growth in the dental industry in both the Foster City and San Mateo County communities.

Figure 2.3. *Continued*

Marketing

Within the context of a professional dental practice, marketing refers to activities that ethically promote the services to potential new patients and encourage additional and recall services with existing patients. For planning purposes, the plan identifies two broad classes of marketing programs.

Internal marketing programs refer to practices and procedures implemented within the office to promote additional services and satisfaction with existing patients:

- Recurrent training to encourage office personnel to solicit referrals from patients as well as the employee's own family, friends, and associates.
- Availability of in-office printed material (brochure) describing the range of services (including aesthetic procedures)
- Referral bonuses to patients who refer new clients
- A posted mission statement that articulates the values of the practice (a promise of quality, excellence, and efficiency; a guarantee of workmanship; a commitment to a healthy environment by exceeding OSHA regulations with respect to infection control and waste management; a pledge to excellent oral health through clear communications, education, and community involvement)
- Morning staff "huddles" including informal ongoing technical and administrative education

External marketing programs include activities selected to increase community awareness of the dental practice and to acquire new patients:

- Advertising in San Mateo County telephone yellow pages
- Inclusion of business cards in all outgoing correspondence
- Patient referral bonus
- An internet presence on the world wide web
- Participation in 800-DENTIST
- A quarterly newsletter to all active patients featuring educational topics and news about the office staff
- Additional advertising as appropriate

Management Systems

Personnel

The practice will hire two essential regular employees at the onset of operations. There is high confidence that these positions can be readily filled from the local employment pool without the use of expensive recruiting services.

- One front office receptionist at $15.00 per hour. This person will greet arriving patients, answer the telephone, make and reconfirm appointments, collect and log payments, and print the daily operating schedules.
- One dental assistant at $12.00 per hour. This individual will greet and seat the patient, take and process x-rays, take and pour impressions, ensure sterilization of instruments, set up the operatory for planned procedures, and generally assist the doctor

Figure 2.3. *Continued*

with four-handed dentistry. This employee must have state certification to take x-rays.

This plan seeks to balance what is needed to support the doctor and serve the patients against reluctance to commit to ongoing fixed costs in advance of a sustainable revenue run-rate. Accordingly, the practice will add two additional employees when the indicated sustainable levels of production are achieved.

- One registered dental hygienist at $30.00 per hour. When office production reaches $25,000 per month, this licensed professional will join the team initially for 2 days a week to review patient medical history changes, perform prophylaxis and root planings, and carry out cursory hard tissue examinations. Before this hiring, Dr. Itaya will perform these procedures.
- One financial administrator. It is not yet determined when this individual will be required. It is planned that Dr. Itaya's husband, who has over 25 years of experience in new-business development, will advise the practice on marketing ("promotion") activities and will personally maintain the accounting books. These services will be provided without charge until the practice can sustain a part-time bookkeeper.

In general, hired positions will be subject to the following terms, which are typical of the industry and region:

- Positions are full-time and employment is "at will."
- Wages will be as noted above and paid semimonthly.
- Each employee shall earn 1 week of paid vacation after 1 year of service. Two weeks of paid vacation will accrue for 2–5 years of service, and 3 weeks thereafter.
- Employees will receive paid holidays for New Year's Day, Presidents' Day, Memorial Day, Independence Day, Thanksgiving Day (2), and Christmas Day. This policy is expected to be expanded as the practice grows.
- The practice will initially grant up to 5 sick days per year to each regular employee.
- The practice will seek to obtain group rates for medical and health insurance. Initially, these premiums will be fully paid by the participating employee.

Accounting Systems

Using the pro bono business consulting services of her husband, Dr. Itaya intends from the outset to exploit computer technology wherever possible in the practice. This has the immediate advantages of reduced employee requirements, low recurring costs, and efficient operation, and eliminates costly and labor-intensive conversions from manual systems in the future.

Commercial software packages will be evaluated to select an accrual basis accounting system that could eventually be integrated with the dental-specific functions of appointments, insurance claims processing, and patient records.

Income statements and profit and loss statements will be compared against the annual budget at the close of each month of operation. The reports will be analyzed by Dr. Itaya and the business consultant to manage the ongoing operation. Monthly income and cash flow projections for the first year of operations are included as Figure 2.3g in this plan.

Figure 2.3. *Continued*

Patient Systems

As noted above, a software system will eventually be selected to permit the complete electronic recording and retrieval of patient records. Initially, costs will be minimized through utilization of traditional paper-based patient records.

The receptionist will have the responsibility to ensure that a patient's next appointment is secured before the patient completes his or her current office visit. The receptionist will also be responsible for reconfirming upcoming appointments.

Patient recalls will be semiautomatic through the above-described procedure and/or a reminder postcard with follow-up. The automated patient record and tracking system can easily alert the receptionist to patients who have unscheduled recalls coming due.

Supply and Vendor Channels

There are several high-quality dental labs in the San Francisco Bay Area. Availability of technicians to provide quality product with efficient turnaround times is not an issue. Dental supplies can be ordered and fulfilled from multiple reputable dental supply vendors. The practice does not expect to have any risk from depending on any particular vendors.

The practice will rely heavily on computers to automate the tracking, patient scheduling, and accounting information. Systems will be selected not only for computing power but also for their serviceability. Only the most flexible and reliable software programs will be selected for integration into the business. Dr. Itaya's earlier background in the computer industry will help to ensure that this process goes smoothly.

Implementation

Timeline of project

Event	Completion Date
Obtain State of California license	August 1998
Secure start-up financing and bank relationship	September 1998
Commit to office space	October 1998
Assume tenancy	December 1998
Purchase office equipment and start-up supplies	December 1998
Open for business	January 1999

Figure 2.3f. Summary of key milestones.

Pro Forma Income Statement/Cash Flow

Figure 2.3. *Continued*

		Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Year 1
		Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	**Projected**
REVENUES														
Dental Service Collections		5,000.00	6,000.00	7,500.00	9,000.00	10,800.00	13,600.00	15,400.00	18,800.00	21,200.00	23,600.00	27,600.00	30,000.00	**188,500.00**
Total Revenues		5,000.00	6,000.00	7,500.00	9,000.00	10,800.00	13,600.00	15,400.00	18,800.00	21,200.00	23,600.00	27,600.00	30,000.00	188,500.00
EXPENSES														
Variable Expenses														
Dental Supplies	8%	400.00	480.00	600.00	720.00	864.00	1,088.00	1,232.00	1,504.00	1,696.00	1,888.00	2,208.00	2,400.00	**15,080.00**
Laboratory Fees	9%	450.00	540.00	675.00	810.00	972.00	1,224.00	1,386.00	1,692.00	1,908.00	2,124.00	2,484.00	2,700.00	**16,965.00**
Total Variable Expenses		850.00	1,020.00	1,275.00	1,530.00	1,836.00	2,312.00	2,618.00	3,196.00	3,604.00	4,012.00	4,692.00	5,100.00	**32,045.00**
% of rev		17%	17%	17%	17%	17%	17%	17%	17%	17%	17%	17%	17%	**17%**
Fixed Expenses														
Accounting		2,000.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**2,000.00**
Advertising		1,500.00	1,000.00	1,000.00	1,000.00	1,000.00	1,000.00	1,000.00	1,000.00	1,000.00	1,000.00	1,000.00	1,000.00	**12,500.00**
Continuing Education		0.00	0.00	0.00	0.00	0.00	105.80	0.00	0.00	0.00	0.00	600.00	0.00	**705.80**
Dues and Subscriptions		100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	**1,200.00**
Insurance-Disability		400.00	400.00	400.00	400.00	400.00	400.00	400.00	400.00	400.00	400.00	400.00	400.00	**4,800.00**
Insurance-Health		800.00	800.00	800.00	800.00	800.00	800.00	800.00	800.00	800.00	800.00	1,200.00	1,200.00	**10,400.00**
Insurance-Malpractice		900.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	**6,400.00**
Insurance-Workers' Comp		350.00	350.00	350.00	350.00	350.00	350.00	350.00	350.00	350.00	350.00	350.00	350.00	**4,200.00**
Legal		2,000.00	400.00	400.00	400.00	400.00	400.00	400.00	400.00	400.00	400.00	400.00	400.00	**6,400.00**
Office Supplies		13,365.00	250.00	250.00	250.00	250.00	250.00	250.00	250.00	250.00	250.00	250.00	250.00	**16,115.00**

Figure 2.3g. Pro forma.

		Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Year 1
		Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	**Projected**
Payroll Taxes	8%	603.20	603.20	603.20	603.20	603.20	603.20	603.20	603.20	625.60	625.60	723.20	723.20	**7,523.20**
Postage and Delivery		75.00	75.00	75.00	75.00	75.00	75.00	75.00	75.00	75.00	75.00	75.00	200.00	**1,025.00**
Rent		1,425.00	1,425.00	1,425.00	1,425.00	1,425.00	1,425.00	1,425.00	1,425.00	1,425.00	1,425.00	1,425.00	1,425.00	**17,100.00**
Salaries-Staff		4,320.00	4,320.00	4,320.00	4,320.00	4,320.00	4,320.00	4,320.00	4,320.00	4,320.00	4,320.00	5,040.00	5,040.00	**53,280.00**
Salaries-Doctor		3,220.00	3,220.00	3,220.00	3,220.00	3,220.00	3,220.00	3,220.00	3,220.00	3,500.00	3,500.00	4,000.00	4,000.00	**40,760.00**
Taxes & Licenses		644.00	618.00	696.00	670.00	644.00	670.00	670.00	670.00	670.00	644.00	670.00	696.00	**7,962.00**
Telephone		300.00	250.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	**2,550.00**
Travel, Meals, Entertaining		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	600.00	0.00	0.00	**600.00**
Total Fixed Expenses		32,002.20	14,311.20	14,339.20	14,313.20	14,287.20	14,419.00	14,313.20	14,313.20	14,615.60	15,189.60	16,933.20	16,484.20	**195,521.00**
% of rev		640%	239%	191%	159%	132%	106%	93%	76%	69%	64%	61%	55%	**104%**
Total Operating Expenses		32,852.20	15,331.20	15,614.20	15,843.20	16,123.20	16,731.00	16,931.20	17,509.20	18,219.60	19,201.60	21,625.20	21,584.20	**227,566.00**
% of rev		657%	256%	208%	176%	149%	123%	110%	93%	86%	81%	78%	72%	**121%**
NET INCOME (LOSS)		(27,852.20)	(9,331.20)	(8,114.20)	(6,843.20)	(5,323.20)	(3,131.00)	(1,531.20)	1,290.80	2,980.40	4,398.40	5,974.80	8,415.80	**(39,066.00)**
% of revenue		–557%	–156%	–108%	–76%	–49%	–23%	–10%	7%	14%	19%	22%	28%	**–21%**
Bank Loan (Interest Rate)	10.00													
Principal	75000.00	675.89	675.89	675.89	675.89	675.89	675.89	675.89	675.89	675.89	675.89	675.89	675.89	**8,110.72**
Total Bank Loan		675.89	675.89	675.89	675.89	675.89	675.89	675.89	675.89	675.89	675.89	675.89	675.89	**8,110.72**
% of rev		14%	11%	9%	8%	6%	5%	4%	4%	3%	3%	2%	2%	4%
CASH FLOW CHECK		–$28,528.09	–$10,007.09	–$8,790.09	–$7,519.09	–$5,999.09	–$3,806.89	–$2,207.09	$614.91	$2,304.51	$3,722.51	$5,298.91	$7,739.91	**–$47,176.72**

Figure 2.3g. *Continued*

Appendices

A. Curriculum Vitae (withheld from sample plan)
B. Personal Balance Sheet
C. Personal Living Budget
D. Sources of Information

Appendix B: Personal Balance Sheet

ASSETS	
Cash	$500.00
Bank Accounts (Checking/Savings/Money Market)	$0.00
Securities (Stocks/Bonds/Other)	$0.00
Accounts/Notes Receivable	$0.00
Life Insurance (Cash Surrender Value)	$0.00
Auto(s)	$7,650.00
Real Estate	$0.00
Pension/Retirement Plan (Vested)	$17,000.00
Personal Property (Art/Jewelry/Furniture/Etc.)	$25,000.00
TOTAL ASSETS	**$50,150.00**
LIABILITIES	
Accounts Payable (Credit/Revolving Accts/Etc.)	$0.00
Contracts Payable (Installment Payments)	$0.00
Notes Payable (Auto, etc.)	$0.00
Real Estate Loan Principal Balances	$0.00
Student Loan Principal Balances	$144,000.00
Other Liabilities	$0.00
TOTAL LIABILITIES	**$144,000.00**
NET WORTH (Total Assets—Total Liabilities)	**–$93,850.00**

Figure 2.3h. Personal balance sheet.

Figure 2.3. *Continued*

Appendix C: Personal Living Budget

PERSONAL MONTHLY BUDGET	
Regular Monthly Payments	
Rent or Mortgage	$1,300.00
Automobile Loan	$300.00
Appliances	$0.00
Personal Loans	$0.00
Educational Loans	$1,903.00
Auto Insurance	$100.00
Other Insurance	$122.00
Miscellaneous	$0.00
Total Regular Monthly Payments	**$3,725.00**
% of Total Expenses	65.12%
Household Operating Expenses	
Telephone	$50.00
Utilities	$190.00
Other Household Expenses	$0.00
Total Household Operating Expenses	**$240.00**
% of Total Expenses	4.20%
Meal Expenses	
Dining at Home (Groceries)	$125.00
Dining Out	$150.00
Total Meal Expenses	**$275.00**
% of Total Expenses	4.81%
Personal Expenses	
Clothing, Cleaning, Laundry	$130.00
Pharmaceuticals	$15.00
Medical/Dental	$10.00
Charitable Gifts and Donations	$110.00
Travel	$100.00
Subscriptions	$25.00
Auto Expense Fuel/Maintenance/Parking	$340.00
Other Spending Allowances	$250.00
Total Personal Expenses	**$980.00**
% of Total Expenses	17.13%
Tax Expenses	
Federal and State Income Taxes	$500.00
Property Taxes	$0.00
Other Taxes	$0.00
Total Tax Expenses	**$500.00**
% of Total Expenses	8.74%
TOTAL MONTHLY EXPENSES	**$5,720.00**
Non-Business Income (Significant Other/Spouse/ Investment)	$2,500.00
NET MONTHLY PERSONAL CASH NEED	**$3,220.00**

Figure 2.3i. Personal budget.

Figure 2.3. *Continued*

Chapter 3
Dentistry by the Numbers

David O. Willis

Banks and other financial institutions use several standard types of statements to assess the financial health of a business. Understanding how to develop these statements, what each component is, and what they show is important. A bank may require the borrower to develop each of these forms when requesting a loan for practice purchase or start-up. The information on these forms can then be used for planning and analysis of the practice.

Types of Financial Statements

1. The *statement of financial position (balance sheet)* shows what someone owns (assets) and what they owe (liabilities) at a specific point in time. The general formula for a statement of financial position is given in Table 3.1. The balance sheet is a "snapshot" of a financial position. It will be different tomorrow, as assets change value and loans are paid off. Bankers and financial planners like to examine changes in the balance sheet to decide how well someone is doing financially. (Total net worth should be growing.) Net worth can grow in two ways. One, assets can increase by savings or through increasing the value of an asset. Two, liabilities can decrease by paying off debt. Borrowing and then using the money to purchase an asset leaves the net worth unchanged. This happens when a new dentist buys a dental practice. He or she takes on debt but also now owns an asset of equal value. The total net worth remains unchanged. As he or she pays down the debt or the value of the practice increases, net worth becomes more positive.

   It is possible to have a negative net worth. This happens to young professionals who have significant educational debt and few assets. Their total liabilities (educational and other debts) are more than the total of what they presently own (assets). While not an enviable position, it is frequently encountered.

   Bankers often require borrowers to develop a personal balance sheet, and/or a balance sheet for the practice. Generally, if the borrower is a sole proprietor, he or she will use a personal balance sheet (since all assets and

Table 3.1. Balance sheet formula.

Statement of financial position (balance sheet)

ASSETS – LIABILITIES = NET WORTH

ASSETS
- Cash/cash equivalents
- Business assets
- Invested assets
- Personal use assets

LIABILITIES
- Short-yerm
- Long-term
  - Mortgages
  - Notes

debts are personal), including the practice as an asset on the statement. If the practice is incorporated or has multiple owners, each of the owners may need to develop two statements, one for the practice and the other a personal statement of financial position. Often banks have specific forms to complete. These are usually their particular versions of the generic balance sheet.

An example balance sheet is shown in Table 3.2. This shows that John and Mary Doe own assets that total $570,830 in value. These assets have been grouped according to their financial use (cash, personal, business, investment) Mary's dental practice has been valued at $300,000. John and Mary owe a total of $344,070. These debts are categorized by when they will pay them. Short-term liabilities will be paid within a year. Long-term liabilities are loans used to purchase assets that last many years, such as houses, autos, and dental practices. Mary still owes $250,300 on her dental practice, so she has just less than $50,000 of value, or equity, in the practice. The difference between what they own and what they owe is the couple's net worth, in this case $226,760. This means that if the couple sold everything they own and paid off all their loans, they would have $226,760 in cash remaining.

2. Another statement, called a *profit and loss statement*, an *operating statement*, or an *income statement*, shows income and expenses and the resulting net income or net loss. The general formula for a profit and loss statement is given in Table 3.3. This statement shows a summary of the taxable income and expense items over a specific period. The period may be a day, month, quarter, year, or any other period that gives meaningful information. If the money that flows into the practice is greater than the money that flows out, a profit results. If the outflows are greater, there is a loss. The office checkbook register, whether a manual or computer system, should group expenses according to type. The office management computer system will have income information.

Table 3.2. Example balance sheet.

Statement of Financial Position			
John and Dr. Mary Doe			
As of December 31, 200X			
ASSETS			
Cash/Cash Equivalents			
Checking Account	3,050		
Credit Union Savings	4,000		
Money Market Account	7,500		
Life Insurance Cash Value	8,000	22,550	
Personal Use Assets			
House	135,000		
Automobiles	28,000		
Personal Property	52,000	215,000	
Business Use Assets			
Dental Practice	300,000	300,000	
Investments			
Stock Portfolio	7,800		
Mutual Funds	6,500		
SEP/IRAs	18,980	33,280	570,830
LIABILITIES			
Short-Term Liabilities			
Credit Card Balance	950	950	
Long-Term Liabilities			
Auto Notes Balance	4,920		
Home Mortgage Balance	87,900		
Dental Practice	250,300	343,120	344,070
NET WORTH			226,760

Table 3.3. Profit and loss statement.

Profit and loss (income) statement

INCOME – EXPENSES = PROFIT (LOSS)

INCOME
- Collections

EXPENSES
- Practice costs
- Business taxes
- Depreciation

Profit and loss statements may be arranged in two ways, according to their use. (Both contain the same information; they are simply organized differently.) Expenses may be listed alphabetically, which is the same as the format for the tax form Schedule C (Profit or Loss from Operating a

Table 3.4. Example profit and loss statement (Schedule C format).

Profit and Loss (Income) Statement Mary Doe, DDS For the Year Ending December 31, 200X		
Income		
Production	337,470	
Collections		327,346
Expenses		
Advertising	1,854	
Auto Expenses	1,928	
Commissions	0	
Depreciation	23,047	
Employee Benefit Program	3,640	
Insurance	2,650	
Interest Expense	12,487	
Legal and Professional	1,790	
Office Expense	3,817	
Pension/Profit Sharing Plan	3,048	
Rent or Lease	18,000	
Repairs and Maintenance	270	
Supplies (Office)	4,082	
Taxes and Licenses	10,108	
Meals, Travel, and Entertainment	139	
Utilities	10,955	
Wages	65,950	
Other Expenses		
Temporary Services	340	
Bank Charges	120	
Office Cleaning	3,055	
Dental Supplies	23,584	
Dental Lab	33,754	
Dues and Publications	2,050	
Continuing Education	3,492	
Postage	690	
Total Expenses/Costs		230,850
Profit (Loss)		96,496

Business). Others organize the information by categorizing items of expense. This format makes it easier to do financial analysis on the practice because similar costs (staff, facility, etc.) are grouped together.

Examples of both types are presented in Tables 3.4 and 3.5. Both show a summary of the income and expenses Mary Doe had in her dental practice for the year ending December 31, 200X. These statements show that Mary produced $337,470 of dentistry during the year. Her practice collected $327,346 in cash, checks, and credit card payments for the year. She uses

Table 3.5. Example profit and loss statement (categorized format).

Profit and Loss Statement Mary Doe, DDS For the Year Ending December 31, 200X			
Income			
Production	337,470		
Collections			327,346
Expenses			
Staff Costs			
Commissions	0		
Employee Benefit Program	3,640		
Pension/Profit Sharing Plan	3,048		
Wages	65,950		
Temporary Services	340	72,978	
Office Space Costs			
Depreciation	23,047		
Rent or Lease	18,000		
Repairs and Maintenance	270		
Utilities	10,955		
Office Cleaning	3,055	55,327	
Office Expenses			
Insurance	2,650		
Office Expense	3,817		
Postage	690	7,157	
Marketing Expenses			
Advertising	1,854	1,854	
Bank Expenses			
Interest Expense	12,487		
Bank Charges	120	12,607	
Variable (Production) Expenses			
Dental Supplies	23,584		
Dental Lab	33,754		
Office Supplies	4,082	61,420	
Professional Expenses			
Legal and Accounting	1,790		
Taxes and Licenses	10,108	11,898	
Owner's Expenses			
Auto Expenses	1,928		
Meals, Travel, and Entertainment	139		
Dues and Publications	2,050		
Continuing Education	3,492	7,609	
Total Expenses			230,850
Profit (Loss)			96,496

this number (collections) as the starting point for her profit and loss statement. Her expenses are summarized by item in both forms and grouped by categories in the categorized form. The total cost of $230,850 leaves her a profit of $96,496 for the year. If she had shown a loss for the year, expenses would have been more than income, and the number for the loss would be in parentheses.

3. The *cash flow statement* is primarily a business statement, although we may adapt it to personal situations. The general formula for a cash flow statement is given in Table 3.6. It is similar to a profit and loss statement, with a few important differences. This statement shows the cash receipts and cash disbursements for a specific period and the resulting cash balance changes. The cash flow statement represents changes in the checkbook. The cash flow statement shows the cash changes. The income statement shows tax items. Some transactions involve tax events, but not cash. For example, the income statement lists "depreciation" as an expense. The dentist never wrote a check for depreciation, although he or she claimed it as a tax expense. Some transactions involve cash transfers, but not tax events. For example, if a dentist borrows cash and puts it into a checking account, the dentist has made a cash transaction, although this is not a taxable event. (The dentist does not pay tax on borrowed money. Likewise, when he or she pays back borrowed money to a lender, the principal portion is not a tax deduction, only the interest portion.) Some outflows (such as savings) actually go to you. In reality, savings are an asset that increases on the balance sheet. This improves overall financial position.

   Cash flow statements are often used to decide if there is enough money flowing through the practice to make recurring mortgage and other loan payments or other expense items, such as payroll or supplies. We must cover any cash shortage from savings or borrowing. Therefore, cash flow statements must "balance." That is to say, cash inflows must equal cash outflows.

   An example of a projected practice cash flow statement is shown in Table 3.7. It shows the projected (estimated) production, collections, and costs by month for the first year of a practice. It includes a mortgage payment each month and a draw or salary for the owner's living expenses. The line "Monthly Net Cash Flow" shows the anticipated cash flow for the month. The line "Cumulative Cash Position" shows the running total cash excess or shortage. Since the cash inflows must equal cash outflows, this statement shows that the dentist buying into or starting this practice would need to borrow cash to pay the bills until month #9, when monthly net cash flow becomes positive. At this point, there should be enough cash coming through the practice to pay monthly expenses. The maximum amount of cash needed (as working capital) is estimated to be $53,569 in month #8, the largest negative "Monthly Net Cash Flow." After this point, estimates show the excess cash flow that can be used to pay down the accumulated cash borrowed.

Table 3.6. Cash flow statement formula.

INFLOWS – OUTFLOWS = NET CASH FLOW
CASH INFLOWS
Collections
Withdrawal from savings
Loan proceeds
CASH OUTFLOWS
Office expenses
Loan payments
Taxes
Additions to savings
Owner's draw (salary)

4. A *budget* is a statement of how money was spent in the past, and an estimate of future income and expenses. The general formula for a budget is given in Table 3.8. As such, a budget becomes a target for day-to-day financial living. Budgets are based on historical evidence. They are used for planning the financial needs of a family or business by setting expected goals for income or expense and by explaining and evaluating spending patterns. The professional budget will help secure professional (office) cash reserves and provide information for expansion or purchase decisions.

   Budgets are often used when a family is having a financial problem. They help set targets for spending and let everyone know why spending is being limited in one area or another. A budget can help coordinate savings and improve living standards by identifying areas of waste. A banker may request a family budget to be sure that the practice can support personal income needs without jeopardizing office cash flow.

   An example of a family budget is displayed in Table 3.9. The family in this example budget came very close to their predicted income and spending patterns. Mary's income from the practice was slightly higher than expected, which offset her husband's lower income. Fixed expenses were as expected, because these expenses are preset. Variable expenses were also close to projected. The family had enough money for the month that they could have made a larger savings or investment than planned and still been very close to budget. In future months, they may plan to increase savings. The final chapter of this book also provides information on family budgeting.
5. *Pro forma statements* are projected statements. They can be any of the four types described above. The essential element of a pro forma is that it is an educated guess of what the statement will be at a given time in the future. For practice statements, this requires estimates of numbers of patient visits, average charges, numbers and pay rates of staff, and many other items of expense. Obviously, a pro forma statement is only as accurate as the

Table 3.7. Example cash flow projection.

	Month 1	Month 2	Month 3	Month 4	Month 5
Doctor Production	7,621	8,764	10,079	11,590	13,329
Hygiene Production	1,732	2,078	2,494	2,993	3,591
TOTAL PRODUCTION	9,353	10,842	12,573	14,583	16,920
TOTAL COLLECTIONS (CASH RECEIPTS)	4,676	7,946	11,084	12,855	14,912
Dental Laboratory	842	976	1,132	1,312	1,523
Clinical Supplies	561	651	754	875	1,015
Office Supplies	187	217	251	292	338
TOTAL VARIABLE COSTS	1,590	1,844	2,137	2,479	2,876
Staff Wages	5,265	5,265	5,265	5,265	5,265
Employment Taxes	684	684	684	684	684
TOTAL STAFF COSTS	5,949	5,949	5,949	5,949	5,949
Office Rent/Lease	1,500	1,500	1,500	1,500	1,500
Utilities	800	800	800	800	800
Repairs	100	100	100	100	100
TOTAL OFFICE SPACE COSTS	2,400	2,400	2,400	2,400	2,400
Office Expenses	317	317	317	317	317
Insurance, Business	416	416	416	416	416
TOTAL OFFICE EXPENSES	733	733	733	733	733
Bank Charges	50	50	50	50	50
Mortgage Payment (Practice)	3,041	3,041	3,041	3,041	3,041
TOTAL BANK EXPENSES	3,091	3,091	3,091	3,091	3,091
Marketing and Promotion	583	583	583	583	583
TOTAL MARKETING EXPENSES	583	583	583	583	583
Management Consulting	0	0	0	0	0
Accounting	200	200	200	200	200
TOTAL PROFESSIONAL EXPENSES	200	200	200	200	200
Draw	4,000	4,000	4,000	4,000	4,000
Personal Insurances Paid	300	300	300	300	300
Continuing Education	50	50	50	50	50
Professional Dues and Journals	83	83	83	83	83
TOTAL OWNER'S EXPENSES	4,433	4,433	4,433	4,433	4,433
TOTAL EXPENSES	18,979	19,233	19,526	19,868	20,265
MONTHLY NET CASH FLOW	–14,303	–11,287	–8,442	–7,013	–5,353
CUMULATIVE CASH POSITION	–14,303	–25,590	–34,032	–41,045	–46,398

Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Year #1
15,328	17,627	20,271	23,312	26,809	30,830	35,455	221,015
4,310	5,172	6,206	7,447	8,937	10,724	12,869	68,553
19,638	22,799	26,477	30,759	35,746	41,554	48,324	289,568
17,304	20,086	23,322	27,088	31,473	36,580	42,531	249,857
1,767	2,052	2,383	2,768	3,217	3,740	4,349	26,061
1,178	1,368	1,589	1,846	2,145	2,493	2,899	17,374
393	456	530	615	715	831	966	5,791
3,338	3,876	4,502	5,229	6,077	7,064	8,214	49,226
5,265	5,265	5,265	5,265	5,265	5,265	5,265	63,180
684	684	684	684	684	684	684	8,208
5,949	5,949	5,949	5,949	5,949	5,949	5,949	71,388
1,500	1,500	1,500	1,500	1,500	1,500	1,500	18,000
800	800	800	800	800	800	800	9,600
100	100	100	100	100	100	100	1,200
2,400	2,400	2,400	2,400	2,400	2,400	2,400	28,800
317	317	317	317	317	317	317	3,804
416	416	416	416	416	416	416	4,992
733	733	733	733	733	733	733	8,796
50	50	50	50	50	50	50	600
3,041	3,041	3,041	3,041	3,041	3,041	3,041	36,492
3,091	3,091	3,091	3,091	3,091	3,091	3,091	37,092
583	583	583	583	583	583	583	6,996
583	583	583	583	583	583	583	6,996
0	0	0	0	0	0	0	0
200	200	200	200	200	200	200	2,400
200	200	200	200	200	200	200	2,400
4,000	6,000	6,000	6,000	6,000	6,000	6,000	60,000
300	300	300	300	300	300	300	3,600
50	50	50	50	50	50	50	600
83	83	83	83	83	83	83	996
4,433	6,433	6,433	6,433	6,433	6,433	6,433	65,196
20,727	23,265	23,891	24,618	25,466	26,453	27,603	269,894
–3,423	–3,179	–569	2,470	6,007	10,127	14,928	–20,037
–49,821	–53,000	–53,569	–51,099	–45,092	–34,965	–20,037	

Table 3.8. Budget formula.

PLANNED – ACTUAL = VARIANCE
ACTUAL (HISTORICAL)
Income, practice profits
Fixed expenses
Variable expenses
Borrowing, loan payments
Taxes
PLANNED
Income, practice profits
Fixed expenses
Variable expenses
Borrowing, loan payments
Taxes

Table 3.9. Example family budget.

Mary Doe, Family Budget
For Month ••

	Planned Amount	Actual Amount	Variance Amount	Variance Percent
INCOME				
Practice Income	8,000	9,012	+1,012	+13%
Spouse's Income	3,000	2,500	–500	–17%
Other (Investments)	500	625	+125	+25%
Total Income	11,500	12,137	+637	+6%
Expenses				
Fixed expenses				
Taxes	3,500	3,500	0	0%
Housing	1,541	1,541	0	0%
Auto Note Payment	794	794	0	0%
Insurance Payments	958	958	0	0%
Student Loan Pmts	604	604	0	0%
Variable Expenses				
Utilities	453	582	+129	+28%
Medical/Dental	627	657	+30	+5%
Food, Groceries	362	301	–61	–17%
Clothing	150	82	–68	–45%
Household Expenses	80	39	–41	–51%
Gifts/Contributions	250	250	0	0%
Entertain/Recreation	200	352	+152	+76%
Vacations	250	250	0	0%
Savings/Investment	500	0	–500	–100%
Miscellaneous	300	247	–53	–18%
Total Expenses	10,569	10,157	–412	–4%

educated guess about the future. Often, banks will ask borrowers to develop a pro forma cash flow (to assess whether there is adequate cash to meet expected expenses) and an income statement (to determine your expected income and tax situations).

Using Financial Statements

Financial statements have several uses. These include

1. Meeting the needs and desires of creditors, required either by contract or to secure funds (borrowing)
2. Providing information that may be required by law, such as income tax returns (compliance)
3. Developing information to be used in control of the practice (analysis)
4. Providing information to be used in planning changes in the practice (planning)

Borrowing

Bankers are in the business of lending money. However, they want to lend to people that they believe will repay their loans in a timely manner. So the banker will gather extensive information to "qualify" a new dentist for a loan (or to decide whether he or she is a good loan risk). Borrowers should show the banker that they know what they are doing from a business perspective so that the banker will be more comfortable with the loans. Borrowers should approach the first meeting with a budget, cash flow analysis, and business plan, rather than asking what the banker needs for a loan. Bankers may have specific items (for example, tax returns from the past 3 years) that they want in addition, but being prepared at the initial contact will help to convince the banker that the borrower is worthy of a loan. (Two other chapters of this book relate to borrowing—business plans [chapter 2] and financing a practice [chapter 8]).

At larger banks, professionals usually deal with a bank employee in the private banking section. Private banking is the division of the bank that works with low-risk clients. Most professionals are considered low-risk clients since very few practices file bankruptcy, and very few professionals default on loans. Private banking is much more personal than public banking. The bank assigns a specific loan officer to each case. The professional then works with the loan officer if cash flow or tax problems develop in the practice. Some banks extend additional credit for the purchase of a home or other consumer purchases through private banking. In return, the bank may expect that the borrower will maintain personal and professional accounts with that bank.

Many issues discussed in this chapter are negotiable. That is to say, the lender has a certain amount of discretion in setting the rate, term (payback

period), and conditions of the loan. However, the banker must also gain approval for the loan from the bank's loan committee. This is a group of senior bank officers who act as a supervisory board, deciding whether a loan is acceptable from the bank's point of view. Since the banker must represent the borrower in this meeting, borrowers should provide the banker with as much positive information as possible. The banker might ask the borrower to develop pro forma financial statements, or a complete business plan. Other times the loan application process may be a mere formality. For example, if the new professional is buying into the practice of a family member who is a long-standing, excellent customer of the bank, he or she may only need to complete a few forms to qualify for a loan.

The borrower might negotiate specific conditions of the loan. It is common practice to negotiate "interest only" for the first 6 months to a year. This means that the borrower only needs to pay interest on the loan, or even let the interest accumulate on the loan. This decreases payments in the first, critical portion of the loan, when start-up costs are high and the cash flow may be at the lowest. (The cash flow projection will show if this is needed.) If the borrower does not purchase accounts receivable, he or she will probably need to negotiate a line of credit for "working capital." The borrower may also negotiate variable rates, a longer term, or even lower interest rates. Strength of the bargaining position depends on individual history with the bank, and how much the bank wants to gain the borrower as a long-term customer. If the loan request and application have been presented to other banks or financial institutions, the borrower might even be in the position of having one bank match or exceed another bank's offer to gain its business.

Compliance

Financial statements form the basis of business and personal income taxes. Depending on the form of business entity, the practitioner may be required to develop an income statement and a balance sheet, showing changes in financial position for the year. The accountant will develop these tax forms. The professional needs to understand that they can also be used for analysis of the practice.

The profit and loss statement is the basis for determining federal income taxes. The items placed on a business profit and loss statement are the same ones that are tax items. A sole proprietor reports tax items on the IRS's Schedule C, which is nothing but a glorified P&L statement. Other forms of business ownership have different requirements and forms, but most involve some form of a profit and loss statement and balance sheet calculations.

Financial Analysis

Financial statements provide the raw numbers to analyze the financial health of a dental practice. This data is used in several ways. A given practice may

be compared with other similar practices to detect areas where the practice exceeds or falls short of benchmarks. The analysis can look for changes by comparing data over time (monthly, quarterly, or yearly). The practitioner may set his or her own internal standard and use data to decide how well the practice met these specific goals.

While some data may be used in raw form, other data needs to be converted into financial ratios in order to be most meaningful. (To say that someone weighs 200 pounds is meaningless unless we relate that weight to the person's sex, height, body frame, and previous weight.) Financial statements provide the numbers that are then used to compute these ratios for analysis of the practice.

Dental Office Financial Analysis

The basic source for financial analysis is the profit and loss statement. It starts with the revenue produced, takes away all costs, and results in spendable profit (or loss) for the practitioner. The basic P&L statement breaks down into specific elements as in the following sections.

Dental Practice Revenues

Total collections (gross practice revenues) result from the number and type of procedures that the office does, the fee that is charged for each of those procedures, any adjustments granted from full fee, and the collection ratio shown by the office. If collections are low, any of the four factors may be at fault. The following formula describes this relationship:

Collection = (Procedures × Fee) − Adjustments × Collection Ratio

Collections are the amounts of money (cash, checks, and credit cards) that crossed the receptionist's desk for the period. Some of this may be from production for this month, while the rest of it may be for dentistry performed several months ago but just now being paid. Individuals, insurance companies, or government programs may make payments.

Production is the total amount of dentistry produced by the office for the period, before any discounts or adjustments. Production levels vary with the number and types of *procedures* done, and the *fee charged* for those procedures. Production numbers are obviously very important for a dental practice, for without production, no money flows through the office.

Adjustments are the amounts of money that the office "wrote off" for discounts because of payment plans (such as managed care), requirements, marketing efforts, or professional courtesies. The practice may decide to track particular types of adjustments to detect the impact that plan has on the office finances.

The *collection ratio* is the percentage of accounts that have historically paid in full for the services provided. Uncollectibles are the monies that the office has given up trying to collect. At some point (120 days, 6 months, 1 year) the

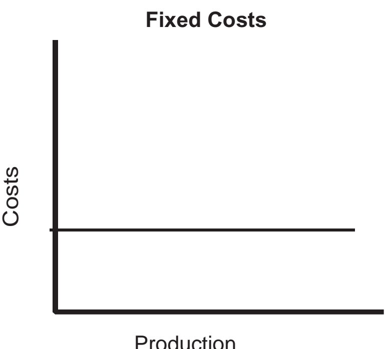


Figure 3.1. Fixed costs.

office decides that the person who owes this money isn't going to pay, and the account is "written off" and deemed uncollectible.

Dental Practice Costs

Dental practice costs fall into three basic categories: fixed, step-fixed, or variable.

Fixed costs do not change with production. Whether the office produces $3,000 or $30,000 per month, fixed costs are constant. Examples include rent, dental association dues, and malpractice insurance premiums. These remain constant, regardless of how much production is done. (While these are not exactly the same from month to month, they are generally consistent.) Fixed costs are depicted graphically in Figure 3.1.

Fixed costs consist of the following:

Office space/equipment consists of all costs associated with operating the physical space and equipment of the practice, including rent payments and utility, tax, or repair charges associated with the occupancy of the building. Depreciation expense for office and equipment is included, since this represents wear and tear on those assets. The cost of a practice buy-in or equipment replacement program also represents an office space cost.

Other fixed costs include bank charges, office insurances, advertising, and legal and professional expenses.

Step-fixed costs vary with production, but only in discrete steps. The existing staff will work harder as production increases. Finally, the load becomes too great, and another staff member must be hired to help the office run efficiently. Costs jump in a discrete step when we hire the new person. Staff members are hired as entire people (or increments of people). These costs are considered "fixed" over their range, so that when another person is hired, a new set of fixed costs is established. Unless a staff member is hired or leaves, staffing costs will be relatively constant or "fixed" in the range of our analysis. Step-fixed costs are depicted graphically in Figure 3.2.

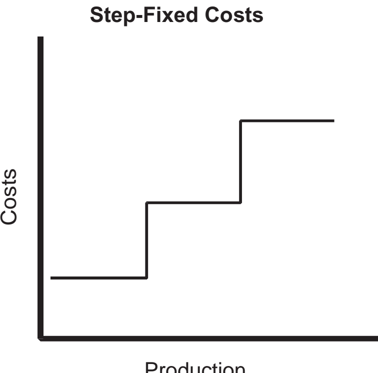


Figure 3.2. Step-fixed costs.

Staff costs include direct wages, benefits, payroll taxes, retirement plan contributions, hiring and training expense, and any other costs that are direct results of employing staff for the office. Labor costs can be divided into clerical (front office), hygiene, and chair-side assisting personnel.

Variable costs change directly with the production level. If the office produces $30,000 of dentistry 1 month, then the cost for dental supplies will be approximately 10 times more than a month with $3,000 in production. If the office has no production, then theoretically there will be no variable costs. Variable costs change with production, not collections. The office must still purchase supplies for procedures that they discounted or did not collect. Variable costs should be tracked separately. Variable costs are depicted graphically in Figure 3.3.

Dental lab costs are associated with contract laboratory work. The costs of laboratory supplies in the office (stone, waxes, etc.) are considered dental supplies. If the office employs a laboratory technician, all costs associated with the laboratory operation (salary, benefits, supplies, lab space rent, etc.) are included in this category.

Dental supplies are the materials used when doing dentistry. They include expendable supplies (cotton rolls, anesthetic, alloy, composite material) and small instrument replacement.

Office supplies are the costs associated with materials for the front desk operation. This includes paper products, computer program fees, postage, magazine subscriptions, pencils, and other items used in processing patient visits.

Total costs are the sums of fixed, step-fixed, and variable costs. Likewise, the diagram for total costs is the combination of these various types of expenses. Total costs are depicted graphically in Figure 3.4.

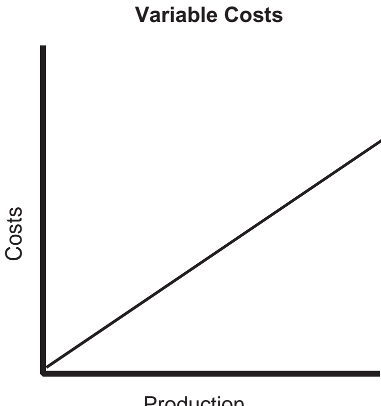


Figure 3.3. Variable costs.

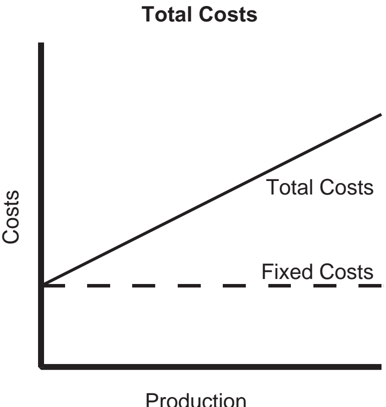


Figure 3.4. Total costs.

Ratio Analysis

Ratio analysis uses the "numbers" of the practice as given on financial statements to maximize profit from the practice. The financial control process can be simple or complex. The possibilities for gathering data are endless. An office computer system can generate so many reports that the problem is deciding which reports and analyses are truly useful. Try to remember the acronym "KISS" (*K*eep *I*t *S*imple, *S*tupid). Do not inundate the analysis with information; keep it simple. Look for major problem areas first. Start with some basic ratios (production, profitability, and collection ratios), and look for problems in these areas. If there are no problems, there probably is no need to do any in-depth analysis. Conversely, your practice may be having problems in one

Table 3.10. Keys to practice success.

1. Office production
2. Generate patients for the practice
3. Maintain collections
4. Control managed care
5. Control costs

certain area that needs particular, additional attention. Other areas may be functioning well and only require periodic monitoring. Table 3.10 summarizes the key areas where financial ratios can help determine practice success. Each key to practice success is provided in the list below, along with one or two common ratios used to assess accomplishment of the key. You can use these ratios either in assessing a practice to make it more efficient or to determine whether the practice is a healthy practice for a buying opportunity.

Most people only think of costs when they look at financial control. However, the revenue side is equally important. Since both output (revenues) and input (costs) help to set productivity, we obviously must control both to be productive.

1. Office production: *Office production per month* tracks the total amount of dentistry done by the entire office for the month. Assuming a solo practitioner, production should remain steady or rise each month. (Obviously, if the owner takes a week off, then production will be down for that month.) Many dentists set production goals for the office. This then becomes the production measure. In order to do production, the office must be adequately scheduled. "Adequately scheduled" does not just mean being busy. Instead, you need a good mix of highly productive procedures (such as crown and bridge) and preparatory procedures (such as restorations).
2. Generate patients for the practice: Since new patients present with most of the large cases in an office, *new patients per month* keeps track of this statistic. Each practitioner should see at a minimum twenty new patients per month (or about one per day) to keep the practice adequately busy. "New" patients implies comprehensive care patients, not emergency or episodic care patients.

   Recall effectiveness measures the percentage of patients due for recall in a month who were actually seen for recall visits. This ratio examines how effective the practice is in encouraging patients to return for periodic maintenance visits. In established urban practices, production resulting from the "recall" visit and subsequent findings accounts for 60–75% of the total production. Managing the recall program is obviously a very important component of overall practice management. Some patient attrition can be expected as people move from the area or find different reasons to switch dentists or forego dental treatment. Practices should strive to see 90–95%

of the patients who are due for the month. If they fall short, the front office person or hygienist (whoever is responsible for recall management) should begin procedures to increase recall acceptance. (This is also, in part, a scheduling issue.)

3. Maintain collections: The *accounts receivable amount* shows the proportion of production that you are not collecting. A raw amount for accounts receivable (for example, $30,000) is meaningless. Was that from a practice that grosses $25,000 per month or one that grosses $80,000 per month? Accounts receivable will be larger for larger practices, all other things being equal. This indicator says that for any practice, about 1 to 1 and a half times the average month's production is acceptable as an accounts receivable amount, perhaps less in our electronic age. Your credit and collection policies will have an obvious impact on this indicator. Easy credit policies will generate higher accounts receivable (A/R); stricter policies, lower. Practices that process a large amount of insurance (greater than 60–70% of patients) will also have a larger A/R as they wait for insurance companies to process and mail checks. Immediate fee-for-service practices are on the low end of this range.

   The total *collection ratio* should be at or above 97%. Ideally, everyone should pay you. Most dental offices collect between 95% and 99% of the billable amount. (Since you do not really expect to collect adjustments, these amounts are not included in this ratio.) A lower collection ratio may suggest problems with collection procedures or a temporary surge in production, resulting in an increase in accounts receivable and potential cash flow problems. A very high collection number may suggest a credit policy that is too strict, discouraging patients from accepting large treatment plans. This may be a particular problem in younger, growing practices.

4. Control managed care: *Managed-care percentage* looks at the portion of your practice production represented by managed care. There are two options for this measure. Number one, if total managed care production exceeds 20% of total practice production, then managed care is simply too great a part of the practice. Not only are you losing a lot of money but you are also losing control of the schedule, as managed care patients replace full fee-for-service patients. The practice may be seen to be in a "risky" position if the programs change reimbursement schedules or cancel provider contracts. An alternative measure is to look at managed care adjustments. They should represent no more than 8% of the total office production. This takes into account the efficiency of all of the plans (in total) you are working with but does not assess an individual plan. Both measures give similar results. The first is a bit easier; the second, more accurate.

   Managed-care efficiency determines the level of reimbursement for each individual plan. It asks the percentage of charges returned compared to a similar, full fee patient. This way, you know how much of a discount is

implied with each plan. To calculate this measure, take the total collections from each plan (including any capitation payments) and divide by the full fee value. You need to track this regularly, as plan administrators change their reimbursements and rules, often without telling you.

5. Control costs: Many people consider that any cost (or overhead) is bad. In fact, there is a cost of doing business, and that is overhead. Any cost that improves profitability is a "good" cost; any cost that decreases profitability is a "bad" cost. The key is to decide which is which. To accomplish this, most management experts compare a practice to norms, or "average" practices of a similar type. These may come from surveys published in the dental press or from proprietary information gathered by management or accounting firms. For example, every dentist has a cost associated with rental (or purchase) of office space. If the "average" dentist pays 6% of his or her production for rent and you are paying 9%, then some of your rent may be decreasing the profit of the practice. As another example, suppose a dentist hires a new staff member, paying him or her $15 an hour. That staff member allows the office to produce an additional $50 per hour. That is money well spent (or invested), a "good" piece of overhead. However, if the office does not increase production enough to make up for the additional costs, the additional money spent on the staff member would be "bad" overhead. This is simple in concept. The problem is trying to decide which costs are wasted and which contribute to the practice's profitability. That is what financial analysis is really about.

The *overhead ratio* (OH ratio) rearranges the information contained in the income statement to give a very general cost ratio. Rather than showing how much profit the office makes, the overhead formula shows how much it costs for a given amount of work. It answers the question, what percentage of production went to pay the bills? This shows, in a rough way, the percentage of every dollar generated that pays the costs of the practice. The inverse (1–OH%) represents the profitability of the practice. The profitability ratio then answers the question, what percentage of production was left as profit? If the overhead is 70%, then the profitability of the practice is 30%.

In general dental practices, overhead (and the OH ratio) fall into ranges—more than 65% is high; less than 55% is good; and 55–65% is about average. This ratio balances for different parts of the country. High fee areas are also generally high-cost areas. If overhead falls into the "good" range, you may be satisfied, realizing that the trouble of additional analysis and control may not produce enough return to worry about. Conversely, you may want to maximize the potential profit from the practice and continue the analysis to detect areas to increase profitability further.

If overhead percentage is out of line compared with other practices, there is a need to look further at the practice's numbers. Generally the problem is that the OH ratio is too high, but it may actually be too low. This happens when

Table 3.11. Specific costs.

Typical Dental Office Cost Breakdown	
Category	Percentage of Collections
Staff Costs	22–30
Wages, Benefits, Taxes, Insurance	
Variable Costs/Supplies	12–22
Lab, Dental Supplies, Office Supplies	
Facilities	8–10
Rent, Utilities, Depreciation	
Miscellaneous	9–14
Legal, Acctg, Adv, Taxes, Ins, Interest	
Owner's Expenses	8–10
Dues, Subscriptions, Auto, CE, Retirement	
Profit	35–45

the office is understaffed, when the analysis does not account for all costs (such as working spouses), if collections surge because of anomalies in the collection pattern, or if the office does not purchase adequate supplies, equipment, and material to keep up to date. Specialty practices have different acceptable ranges due to the different character of those practices. This also assumes that the practice does not use tax avoidance strategies (for example, renting space from yourself or hiring family members at an unusually high level of compensation) that can skew results.

The overhead (OH) ratio depends upon the point at which the practice is in the practice cycle. In a start-up phase (with few patients and relatively high debts and expenses), the OH ratio will obviously be very high. New practitioners are often paying off buyout or start-up loans. The interest and depreciation expenses represented by this outlay are additional costs that established practitioners generally do not have. New practitioners in a buyout situation often must replace or update equipment, supplies, and materials at an additional cost. Finally, many new practitioners simply cannot do the volume of dentistry that established practitioners do. This may be from the need to increase their patient pool or the new practitioner's clinical inexperience. Regardless, if production is less than a comparable established practitioner, then the OH ratio, and most other ratios, will appear to be out of line. New practitioners can expect an additional 5–8% overhead for debt service and other start-up costs while paying off loans. They may even run at a loss (more than 100% overhead) while building their patient pool.

Specific cost control looks at the same thing as the overhead percentage but begins to break it into specific units. There are typical ranges of costs for each area of cost allocation. These are shown in Table 3.11. These standards

attach values to various components of the expenses of operating a dental practice. Most are related as a percentage of collections. When using these numbers, you are comparing your practice to the "norm" or other similar practices. You can compare every cost if you want, but that is not a good use of time. Concentrate on the areas where a change can make the most impact.

Planning

Break-Even Analysis

Proper allocation of costs gives a much more accurate understanding of practice costs than the simple traditional "percentage overhead" figure. A valuable tool for putting this information to use is through the "break-even analysis" technique. This financial analysis technique relates the office's costs to the production and profit of a practice. While, as its name implies, it can determine the point of zero profit and zero loss (the "break-even point"), it has a much wider use by providing insights into the cost behavior of the practice and the riskiness of many courses of action. The basic equation used in the break-even technique is:

Collection – Variable Expenses – Fixed Expenses = Net Income

The equation brings mathematical sense to an intuitive concept; namely, that all the money you collect, minus all your expenses (fixed and variable), leaves a profit or loss. If you know any three of the numbers, you can substitute in the equation to find the fourth number.

The break-even analysis can also be depicted graphically (Figure 3.5).

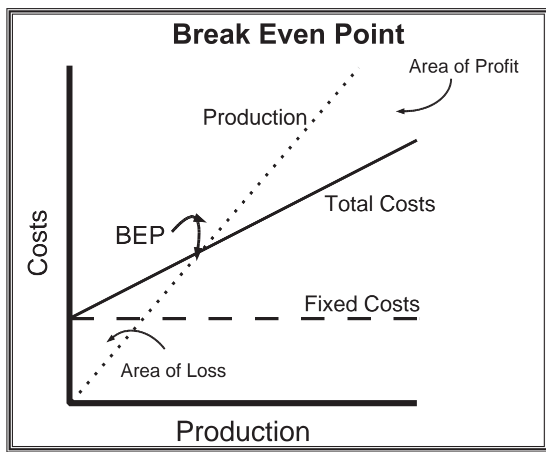


Figure 3.5. Break-even point.

Essentially, this is the cost structure diagram superimposed on a production diagram. The point of intersection between the revenue (collection) line and the total cost line is the "break-even" point. Any production above this point results in profit; any production below this point results in a loss. You can also see that production above the break-even point is "more profitable," since the fixed costs have been paid and you now incur only the lower variable costs. This also happens when a dentist takes an associate or in other ways offsets hours with another dentist. Fixed costs have already been paid; only step-fixed and variable costs remain. Any additional dentistry produced is on a better margin for the owner-dentist. The incremental cost of producing more is small in comparison to the initial cost ratio. This is also critical to understanding managed care or other reduced payment third-party plans. If there is slack chair time, then the only costs associated with the production are the variable costs, since fixed costs have already been paid. However, if these patients replace traditional, fee-for-service patients, then the cost must also include the loss from the foregone production on those traditional patients.

As an example problem, assume that our dentist, Dr. Mary Doe, wants to gain a better understanding of her office finances. She has asked her accountant to prepare an income statement for the previous year so that she can use the results for a more detailed analysis of the practice finances. From that statement, she allocated costs into the various categories and arrived at the following financial outcomes for the past year in her office:

Category:	**Amount:**
Production	$337,470
Collections	$327,346
Fixed costs	$96,452
Step-fixed costs	$72,978
Total fixed type costs	$169,430
Total variable costs	$61,420 (18.2% production)
Total profit	$96,496
Traditional overhead	71.5%

In our example, Dr. Doe produces $337,470 per year ($28,123 per month). She collects 97% of production. Using the formula and previously given cost data, her income for the year would be:

Collections − Variable Expenses − Fixed Expenses = Net Income
(.97 × Production) − (.182 Production) − 169,430 = Net Income
$338,372 − 61,420 − 169,430 = Net Income
= $96,496

Dr. Doe netted $96,496 (before personal taxes) by producing $337,470 of dentistry, collecting 97% of accounts, and paying all fixed and variable expenses. Her actual production "break-even" point, where net income is zero, can also be found:

Collections − Variable Expenses − Fixed Expenses = Net Income
(.97 × Production) − (.182 Production) − 169,430 = 0
(.788 × Production) = $169,430
Production = $215,013

That is to say, if Dr. Doe produced $215,013 of dentistry this year ($17,918 per month), she would pay all the bills but not take a dime home, having a net income of zero ($0).

Dr. Doe may decide that to buy a new house and join the local country club, and thus would require a net pretax income of $150,000. What production level corresponds to this net income level? Again the break-even analysis can be used:

(.97 × Production) − (.147 Production) − 169,430 = Net Income
(.97 × Production) − (.147 Production) − 169,430 = 150,000
(.788 × Production) − 169,430 = 150,000
(.788 × Production) = 319,430
Production = $405,368

Dr. Doe would need to produce $405,368 of dentistry per year ($33,781 per month) to "clear" the target income of $150,000. Can this be done given the existing staff, facilities, and fee structure? That decision is the essence of strategic practice planning and control. If not, then she should modify plans and reconfigure the estimates of fixed and step-fixed costs for the new configuration and repeat the analysis.

Once you understand and chart the cost and revenue structure of the practice (that is, once you develop a model), you can then look at various growth opportunities from a financial standpoint by asking the question, what if? What if I hire a hygienist and expand the office? What if I join the new capitation plan that is in town? What if I raise my fees by 10% and lose 5% of my patients? Applying the mathematical model of the practice can answer all of these questions from a financial standpoint. Many dentists have the ability, through computers and spreadsheet programs, to develop practice models that are very sophisticated. However, they can develop a good working model of the break-even approach that uses a pencil and handheld calculator. Fortunately, even these now primitive tools can give good results with a minimal amount of time and effort. A blank form is included for doing "what if?" analysis in Table 3.12. Several example problems are also provided as guides for using this financial technique.

Table 3.12. "What if?" analysis form.

Problem: ______________________

Assumptions:

	EXISTING	CHANGE	PROPOSED
REVENUES			
A Production	________	________	________
B Collections (____% of A)	________	________	________
COSTS			
C Fixed Costs	________	________	________
D Step-Fixed Costs	________	________	________
E Total Fixed Costs (C + D)	________	________	________
F Variable Costs (____% of A)	________	________	________
G Total Costs (E + F)	________	________	________
H PROFIT or (LOSS) (B – G)	========	========	========

Conclusion:

References and Additional Resources

Books

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Websites

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www.sba.gov. Small business administration, steps for starting a business.
www.store.yahoo.com/. General information on small businesses.

Learning Exercises

The following are several examples of putting the "what if?" technique into practice. Obviously, these estimates are only as good as the numbers used in the assumptions. These scenarios are based on Dr. Doe's practice numbers. Your practice numbers will surely be different, but by examining the process, you should be able to easily adapt this technique to your office planning.

1. Dr. Doe is considering expanding the practice and adding a half-time hygienist. She estimates that production would increase by $8,000 per month, in part because of the additional procedures done by the hygienist, and in part because of her time being freed up from doing prophies and exams. An additional operatory would cost $854 per month for 3 years. This is the cost of a loan for all the costs, including equipment and the cost of renovations. Hygienists in the area are presently making about $28 per hour, base pay, with an additional 13% payroll taxes and expenses. (See Table 3.13.)
2. Dr. Doe has been considering joining a preferred provider organization (PPO) that is trying to become established in town. She estimates that her patient base will increase by 10%, leading to an additional 10% more production. That increase will be PPO patients. The PPO pays approximately 67% of the UCR for the area. (Dr. Doe's fees are at the average for the area.) She would need an additional operatory (with the same costs as in #1 above) to see the additional patients. She would also need to hire an additional half-time chair-side assistant. Assistants in the area are currently making about $15 per hour. (See Table 3.14.)
3. Dr. Doe is considering raising her fees. She plans to raise them 10% and estimates that she might lose as much as 5% of her patient base. (See Table 3.15.)

Table 3.13. "What if?" example, Dr. Doe problem #1.

Problem: Adding a part-time hygienist

Assumptions:
Production will increase $96,000/yr ($8,000/mo)
Operatory costs $10,248/yr ($854/mo)
Hygienist costs $31,640/yr (50 weeks × 20 hrs × $28 × 1.13)

	EXISTING	CHANGE	PROPOSED
REVENUES			
A Production	337,470	+96,000	433,470
B Collections (97% of A)	327,346	+93,120	420,466

Table 3.13. *Continued*

COSTS			
C Fixed Costs	96,452	+10,248	106,700
D Step-Fixed Costs	72,978	+31,640	104,618
E Total Fixed Costs (C + D)	169,430	+41,888	211,318
F Variable Costs (18.2% of A)	61,420	+17,472	78,892
G Total Costs (E + F)	230,850	59,360	290,210
H PROFIT or (LOSS) (B – G)	96,496	+33,760	130,256

Conclusion:
Adding a hygienist increases costs by $59,360 per year, but the production increases ($96,000) will more than offset those changes in costs. This strategy results in an increased profit of $33,760 per year. After 3 years (when the operatory is paid off), profit increases by an additional $10,248 per year.

Table 3.14. "What if?" example, Dr. Doe problem #2.

Problem: Join a PPO?

Assumptions:
Patient visits (and production) will increase 10%
Collections increase by 67% of the production times .97
Operatory costs $10,248/yr ($854/mo)
Staff costs increase $16,950/yr (50 weeks × 20 hrs × $15 × 1.13)
Variable costs increase with production

	EXISTING	CHANGE	PROPOSED
REVENUES			
A Production	337,470	+33,747	371,217
B Collections (97% of A)	327,346	+21,932	349,278
COSTS			
C Fixed Costs	96,452	+10,248	106,700
D Step-Fixed Costs	72,978	+16,950	89,928
E Total Fixed Costs (C + D)	169,430	+27,198	196,628
F Variable Costs (18.2% of A)	61,420	+6,142	67,562
G Total Costs (E + F)	230,850	+33,340	264,190
H PROFIT or (LOSS) (B – G)	96,496	–11,408	85,088

Conclusion:
Collections increase less than production because of the managed-care discount. Because Dr. Doe needs to add an operatory and staff, joining the PPO would lead to increased costs and a decrease in income. If she could hold required cost increases to less than $21,932 per year (additional collections), then it would be profitable.

Table 3.15. "What if?" example, Dr. Doe problem #3.

Problem: Raising fees

Assumptions:
Lose 5% of the patient visits (production decreases to $320,597, 95% of original)
Raise fees 10%
Production increases 10% to $352,656 (110% of $320,597) from fee increase
Variable costs will decrease by $3,071 (5% fewer patient visits)
Fixed and step-fixed costs will not change

		EXISTING	CHANGE	PROPOSED
REVENUES				
A	Production	337,470	+15,186	352,656
B	Collections (97 % of A)	327,346	+14,731	342,077
COSTS				
C	Fixed Costs	96,452	0	96,452
D	Step-Fixed Costs	72,978	0	72,978
E	Total Fixed Costs (C + D)	169,430	0	169,430
F	Variable Costs (18.2 % of A)	61,420	–3,071	58,349
G	Total Costs (E + F)	230,850	–3,071	227,779
H	PROFIT or (LOSS) (B – G)	96,496	+17,802	114,298
		============	============	============

Conclusion:
Dr. Doe is working less hard, making more money. Practice growth may slow. If Dr. Doe is not in a competitive market area, or if she has a well-established, excessive patient pool, this strategy will work. If she is in a competitive market or if she is trying to expand the patient base, this alternative is less attractive.

Part 2
Ownership

Chapter 4
Understanding Practice Valuation

C. Steven Wolff

Introduction

The subject of business—and more specifically, dental practice valuation—consumes many textbooks and is the focus of both undergraduate and postgraduate programs. We cannot within the confines of a single chapter expect to cover this entire subject but hope instead to provide the reader with enough information about the terminology and techniques to allow entry to more detailed study on the topic. We have no doubt that at some time during the course of your career you will need to have some idea how a dental practice is evaluated.

It would be convenient if the Internal Revenue Service's definition of fair market value—what a willing buyer will pay and what a willing seller will accept when neither is under any compulsion to act and both have been advised of all information needed to make a decision—would allow parties to always arrive at some mutually agreeable price. However, the market does not always work that way, and consequently, an appraiser should be retained to determine the starting point for negotiation between the parties.

Before we get too far down the road concerning the process and techniques, let's clarify a common misunderstanding. The terms "appraisal" and "evaluation" (or perhaps more precisely, "valuation") are frequently used interchangeably when in fact they have significantly different meanings. A valuation is used primarily to determine an appropriate asking price for a practice placed on the open market. After collecting and reviewing practice and financial data, the valuator may recommend a narrow range of value (sometimes based on the perceived urgency of the sale), but the ultimate decision regarding the asking price lies with the seller. In the case of a true appraisal, the valuator will present a document to the client specifying a dollar value, and as a result of his or her experience and credentials, would be prepared to defend that number. That defense might be given to a potential buyer with counsel, a financial institution, or in litigation. As you might expect, this appraisal document involves considerable time and expense. In our office, we do market valuations at about a 20 : 1 ratio to true appraisals.

Process

There are four distinct steps leading up to the revealing of a specific or range of valuation numbers depending on the nature of the assignment. Each step is vitally important to the credibility and accuracy of the project and demands considerable effort on the part of both the valuator and the client.

First, the purpose and scope of the assignment must be determined. Is the work being done to place the practice for sale on the open market, or is it being done because of litigation between two partners? What is the effective date, and to whom will this information be revealed? Does the client understand the fee for these services, and what are the time constraints for the completion of the project?

The second step involves the collection of all necessary financial and demographic data regarding the practice. The client is asked to complete a questionnaire about the practice and to provide statistical and cultural information about the area in which the subject practice is located. In addition, we will need a current profit and loss statement, as well as business federal tax returns for the last 3–5 years, along with all supporting schedules. We normally schedule a complete physical inventory at this time and guide the client through a hands-on count of instruments, handpieces, and patient records.

In the third step, we spend a considerable number of hours processing the data in order to use it in subsequent valuation computations. We determine the in-place, functional, and productive value for all equipment based on our experience and familiarity with the market. Be advised that this number will not be the same as the retail, wholesale, "book," or liquidation price and in most cases will amount to less than 35% of the total value of an ongoing dental practice.

Another significant step in the processing phase is referred to as the "normalization" of the tax returns. While doctors and their tax preparers may have taken great pains to find as many legitimate deductions from gross income as possible, our job is to separate necessary operating expenses from the perks of business ownership in order to determine the true cash flow and profitability. In addition, certain noncash items and expenses that would disappear at closing must be filtered out.

Let's divide these expenses subject to normalization into three categories: doctor's personal expenses, judgment calls, and disappearing items.

1. Doctor's personal expenses: These are sometimes referred to as lifestyle expenses or perquisites. To give an example, a trip to Hawaii for an 8-hour continuing education course is allowable as a legitimate business expense and is deducted from the gross income of the practice. Those 8 hours of training could also be had from various online study courses at a fraction of the cost. While continuing education is a necessary expense for the ownership of a dental practice, a standard has to be determined by the

valuator, and adjustments are made accordingly. Other personal expenses may include

   A. Auto expense
   B. Contributions
   C. Insurance
   D. Retirement contribution
   E. Travel and entertainment

2. Judgment calls: There are recognized industry standards for certain overhead categories. If the practice varies too far from these guidelines, we investigate and adjust accordingly. Be advised that the adjustments can be both up and down in nature.
   A. Supplies
   B. Telephone
   C. Payroll
   D. Lab
3. Disappearing items: All of the disappearing items are adjusted to zero. In the case of interest expenses, it is assumed that all assets of the practice are being transferred free and clear and that the buyer's only interest expense will be for the practice mortgage and any subsequent capital improvements.
   A. Depreciation
   B. Interest
   C. Amortization

There are probably as many variations in tax returns as there are accountants preparing them. Careful analysis of the return is necessary in order to give an accurate picture of the funds available to pay overhead, taxes, living expenses, and debt service. You will benefit in understanding these valuation issues by studying chapter 3 on dentistry by the numbers.

Now the process of applying the various methods of valuation begins. These methods, which we will discuss in great detail shortly, range from purely mathematical computations to very subjective techniques based on the experience of the appraiser. Some, all, or perhaps even a weighted combination of several methods may be used to arrive at a conclusion. While a strict, by-the-numbers technique would probably be most appreciated by our dentist clients, the fact remains that most appraisers are going to use some combination of art, science, and mathematics to come to their conclusions.

The fourth step in the process involves the writing of a report either as specified by the requirements of a true appraisal or to advise a prospective seller/client about placing the practice on the market. Whereas a report to a prospective seller may be in letter format, the appraisal document is generally printed in multiple copies and bound.

The letter of opinion will review the comparisons made by the valuator of the target practice to other similar practices. Based on his or her experience in the market, a market price will be recommended to the client. The urgency of

a sale may have considerable effect on the final decision regarding the listing price.

In the case of a true appraisal, the final report will be presented in several bound copies and will go into considerable detail about the qualifications of the appraiser, the methods of valuation used, the "weight" of those methods, and finally, a specific number that represents the valuator's professional opinion as to the value of the practice.

Appraisal Methods

As mentioned earlier, the methods of appraisal range from pure mathematics to the valuator's instincts. We also discuss a frequently used term in business valuation and how it may or may not apply in dentistry. The most common methods used to determine the value of a dental practice include summation of assets, comparable sales, capitalization of earnings, and its first cousin, the excess earnings to retire debt calculation. Let's discuss them individually after laying down a few ground rules. For the course of this matter we will confine our discussion to the valuation of single-owner practices selling assets and not stock and expecting to get cash at closing. Variations on that theme will be discussed later in the chapter.

Summation of Assets

Being familiar with the market and having previously determined the value of the tangible assets, the valuator performs a build-up of values based on the comparison of the subject practice to a model practice. This scoring includes items such as location, staff experience, equipment, hygiene efficiency, patient counts and demographics, cash flow, and profitability as they relate to a statistical norm.

Comparable Sales

All qualified appraisers will have access to a variety of databases that will suggest what similar practices with similar revenues have sold for in similar markets. While accepting the fact that all dentists are unique, and consequently their practices are unique, five or more data points in two or three different databases can be very convincing in determining a practice's place in the market. We frequently use the real estate analogy: if you knew what fifty homes with 1,500 square feet of living space, three bedrooms, and two bathrooms on one half of an acre in a suburban neighborhood of a city sold for, you could probably come very close to knowing the market value for the fifty-first such home.

Capitalization of Earnings

This method utilizes a computation based on a calculated rate of return on the practice's profits. This rate of return is referred to as the cap rate and involves a variety of factors outside the scope of this chapter including present dollar values, risk of the market, fixed securities return, and so forth. For now, let's think of the cap rate as the rate of return on the "excess earnings" of the practice. Excess earnings are defined as cash available after overhead is paid, after the owner receives a fair compensation for producing dentistry, and after a fair return is made on any cash invested in the practice and some allowance is made for capital improvements. If those earnings are known as a result of the work done to normalize the tax return, an appraiser can use that derived cap rate to work backward into the value of the practice.

Let's simplify this by using the example of a certificate of deposit of unknown value. Pretend that you just received a notice from your bank that you have been credited with the annual proceeds from a long-forgotten CD in the amount of $6,000 at 5% annual percentage rate. By using the following formula, you could determine that the value of the CD is $120,000.

$$\text{Value} = \frac{\text{Excess Earnings } (\$6{,}000)}{\text{Cap Rate } (5\% = .05)} = \$120{,}000$$

Don't let the example mislead you, however, as historically the cap rate for dental practice earnings is several multiples of 5%.

Excess Earnings to Retire Debt

This calculation uses an amortization schedule in reverse to calculate how much debt our previously determined excess earnings could support using industry standards for acquisition financing. As an example, let's suppose that our calculations resulted in excess earnings of $70,000. Given an interest rate of 8% and a loan amortization/length of 7 years, the buyer could service a loan amount of almost $375,000. Since most buyers will also need to have some operating capital to fund the practice's expenses until the revenue stream begins, the sales price will have to be 10–15% less than the total loan amount. This test is sometimes referred to as the "sanity test" to check the validity of the numbers derived from the other methods.

Other Methods

Sometimes appraisers will make a value determination based on what costs could be avoided by purchasing the seller's practice. While this avoided cost method is frequently used in relation to the physical plant, it may also be used in conjunction with a pro forma (refer to chapters 2 and 3 for more information on pro forma financial statements) to determine the income differential between

two scenarios or even perhaps as a means of controlling a market. The national average cost of a three operatory build-out and start-up is currently in excess of $350,000. Thus, serious consideration is sometimes given to what costs the buyer could avoid by purchasing and moving to another office that—while lacking adequate cash flow for typical valuation methods—may have some inherent value just because it already exists and is ready to go.

A simplified version of the summation of the assets method depends on access to a national database that tabulates the value placed on the intangible or soft assets, which include "blue-sky" or "goodwill," a covenant not to compete, a trained and available work staff, and a recognizable ongoing business concern. This database, known as the Goodwill Registry, expresses the allocation of intangible value as a percentage of the most recent year's gross revenues. The resulting amount can then be added to the known hard asset values for equipment, furniture, instruments, and supplies to give a valuator another indicator of the practice's value.

Rule of Thumb

Another frequently discussed idiom in this industry is the rule of thumb. No less of a resource than the ADA's *Valuing a Practice* refers to multipliers that are based on 5 years of data. These multipliers are used in conjunction with gross revenues and net income. These data, while interesting, can be very misleading to both buyers and sellers. Let me use the following examples to illustrate the need for caution. If you stand a 5 foot 2 inch, 100-pound dental student next to a 6 foot 4 inch, 220-pound student, a rule of thumb would claim that all dental students are 5 foot 9 inches and 160 pounds. Obviously that is not the case. A more on-point example should further illustrate the need to look beyond this method in determining a practice's value. Let's assume the Smith and Jones practices each have gross revenues of $600,000. Would the practice values be the same given these details?

1. The Smith practice was fee-for-service, and the Jones practice was 50% Medicaid.
2. The Jones practice had a solid below-market-rate 7-year lease, and the Smith practice was going to be relocated due to an eminent domain proceeding.
3. The Jones practice had a 20-year history in the community with steadily increasing revenues, while the Smith practice had peaks and valleys due to numerous associate doctors with varying skills.
4. The Smith practice had a long-term, well-trained staff, and the Jones practice had been plagued by constant turnover.

It should be obvious from these extreme (and yet very real) examples that these practices could not have the same value. In the last 12 months, we have seen practices sell for as little as 25% and for almost 85% of gross revenues. We're told that practices in some areas of the country sell for over 100% of

revenue. Our advice would be to use rule of thumb as a check mechanism to examine the reasonableness of an appraisal, asking price, or offer.

Factors Affecting Practice Value

We would not pretend to be able to create a complete list of all of the factors that can influence the value of a dental practice. We would only need to wait for the next transition to find a new one. However, there are some key variables that have been consistently shown to affect both the price and marketability of a practice. Certainly the most important is cash flow and profitability. Businesses are purchased for the purpose of making money. If a practice does not produce adequate revenue to pay overhead, a fair wage to the producer, some return on investment capital, and to service the debt, it will have less than hoped-for value. The longer the history of adequate revenues, the less risk to the potential buyer, and therefore, a higher value can be placed on the practice. Likewise, the more transferable the revenue stream is to the new owner, the higher the value.

Probably the next most important factor in practice value would be location. Location factors considered in a practice analysis would include metro versus rural, placement and visibility within a trade area, and patient demographics of the area.

The number of active patients of the practice, a favorable lease, new patient development, the availability of a trained staff along with the overall curb appeal of the office, and equipment are all important issues that can have a dramatic influence on a practice's value. Even issues such as fees, procedure mix, and the percentage of preferred provider organization (a type of managed care) contracts have to be considered. We will blend all of these and many other issues together in a valuation exercise later in this chapter.

We have been asked if there is some discount factor that needs to be taken into consideration with regard to patient retention. It has been our experience that a well-orchestrated transition will result in little if any patient loss above and beyond the normal attrition rate of a practice. Patients move, die, or just aren't compatible with the personality of the practice. Assuming the practice has a long history of new patient flow, the net loss will not likely even be noticeable. Since the market has already accounted for any consideration that might be given to this issue, there is no further discount factor.

Historical Performance and Future Earnings

Practices are appraised on the basis of performance over a period of time. While cash flow projections can be an effective marketing tool in attracting a buyer, they would figure only marginally in the process of evaluating a practice. It is certainly of some comfort to a potential buyer and his or her lender that there is a long-standing history of positive and adequate cash flow. That

history implies a reduced risk of losing that cash flow and, therefore, a higher value. Just as most other investments carry a disclaimer that states that past performance is no guarantee of future earnings, however, the same can be said for investment in a dental practice. The buyer has to show up, do the work, and run the business in order to enjoy the benefits that were available to the previous owner.

All this being said, there are always opportunities for buyers who recognize the potential for growth and additional profit in an existing practice. Sharp population growth, reduced competition, or the ability to expand the procedure mix may indeed make for a good buying opportunity. These factors are very hard to quantify and consequently are outside the scope of both an appraisal and a market valuation.

Other Issues in Practice Appraisals and Sales

As mentioned earlier in this chapter, most of our discussions have centered on the premise that the target practice involved a solo owner/operator buying or selling assets and not stock and who expected cash to be exchanged at closing. We are further biased by the fact that all of our work has been confined to the Midwest. Obviously there is room for a discussion of market variations throughout the country.

We would first point out that comparable sales data can vary significantly from one part of the country to another. Population density, competition among recent dental graduates, and cost of living variables can make for vastly different prices for similarly sized practices. Likewise, in our work we notice the differences between metropolitan and rural practices in spite of the fact that the office environment and equipment may be identical and that profitability may be higher in the rural office. As a general rule, metropolitan practices will appraise for a higher value. Always be sure that the appraiser who has been retained has recent experience in the specific market of the target practice.

The discussion of stock versus asset sales is nearly moot because the overwhelming majority of transactions are conducted as asset sales. If it is at all possible, we suggest this approach because it results in a much cleaner transaction that is more financeable and tax-friendly. Stock sales generally involve large group practices and the acquisition of a new partner. While recognizing that this type of a transition is relatively rare, please do not overlook the need for qualified counsel to assist in the process.

While such was not the case only a decade or so ago, most practice appraisals and valuations are based on a “cash at closing” value. With the current attitude of capital lenders, sellers are seldom expected to carry back any or all of the purchase price in the form of a note (loan). If sellers were so required, the certainty of full payment would involve more risk, and since risk equals reward, the higher the risk the higher the return. Consequently, the value of the practice

may have to be increased. Payment in full at closing removes that risk of future payment and may reduce the appraised value.

The last item for discussion in this chapter involves the valuation of nonmajority interest in a dental practice and the subsequent discount applied to that value. Any ownership percentage less than 51% (or any fractional number over 50%) results in a lack of control. Several factors now come into play. Financing of a minority ownership interest is more difficult, as the lender may not be able to have an adequate collateral position to support the loan. Non-majority owners cannot exercise the same control over their destiny as can the majority or solo owner. Every circumstance would have to be closely examined, but it may not be unreasonable for the discount to be as high as 25%.

Valuation Exercise

Just for fun, let's see if we can place a listing price on a hypothetical four operatory general practice located in the Midwest. Rest assured that there will be no absolutely right or absolutely wrong answers, as there will be too many unknown variables. As a matter of fact, we're going to violate one of the fundamental rules of practice valuation by not being able to make a physical inspection of the facility. The way an office looks, feels, and smells can have a tremendous impact on its price and marketability. All that being said, let's look at the practice numbers and description and see if we can arrive at a projected asking price.

The subject practice was built in 1981 in a professional building that was at that time on the outskirts of the city. The city's growth has left this location about halfway between "downtown" and the outer borders of the metro area. The office has four nice-sized operatories in 1,700 square feet, along with a lab, darkroom, sterilization center, and employee lounge. In addition, the doctor has a nice-sized private office that is plumbed and could be converted to a fifth operatory. The equipment was upgraded in 2000 and is very well maintained. The office uses conventional x-ray techniques and paper charts. A recent redecorating effort with contemporary colors and materials leaves the office looking very up-to-date and comfortable.

The four-member staff is a mixture of long- and short-term employees, with the receptionist having the longest tenure, at 12 years, and a recently hired chair-side assistant having been with the practice less than 6 months. The receptionist is probably at the top of her pay range. The patient base of almost 1,800 "active" patients has grown older with the seller, and over half are about the age of 50. The practice has only a small preteen component. (Note: Active patients are defined as those patients who have been in the office for a billable visit within the last 18 months and are not known to have moved away or died.) The hygienist sees between 30 and 35 patients during a 3.5-day work week. The doctor and remaining staff work 4.5 days per week.

The gross receipts for 2008 totaled $612,000, which was about $40,000 more than 2007. In fact, the practice has always had steady annual revenue growth of 3–5%. Normalized expenses for 2008 were $343,000, which resulted in a gross profit of $269,000. A salary of 28% would allow excess earnings of approximately $97,600. (Note: We would use a salary allowance of 30% if the doctor was working without a hygienist.) The seller recently signed a new 3-year lease with two options of 5 years each. The rate seemed to be comparable to other properties in the neighborhood. Due to the presence of a couple of large employers in the area, the office does participate in three different PPO plans. The office does not accept Medicaid or any other discount services plan.

All in all this is a very attractive practice that would most likely do very well on the market. It is not without issues, however, as just about every potential listing has a few warts. We have mentioned numerous items that need consideration regardless of whether we are referring to this practice or others. In this case, is the location still vital or is the neighborhood declining? The equipment is now nearly a decade behind the curve—will immediate upgrades be needed for the buyer to perform comfortably? Can you or can you not afford to pay a receptionist at the top of her salary range? Will the practice struggle if she is no longer there to greet patients? Although the overhead seems well controlled, will the buyer be able to do a comparable procedure mix that will maintain the current level of profitability? Will the age range between the new doctor and the majority of the patients be an issue? Will the landlord be agreeable to a lease transfer, or will he see this as an opportunity to make a dramatic increase in the terms? What if all of the custom cabinetry was configured for a right-handed dentist and the potential buyer is left handed? All of these plus many other questions will have an effect on the final results, whether building up a summation of assets value or performing a strictly financial analysis.

Since the reader will not have access to computer models or statistical databases, we will provide the following numbers for this exercise.

Summation of assets: $412,650
Comparable sales: $358,000 (the average of five similarly sized and located Midwest practices)
Excess earnings capitalized: $390,400 (25% cap rate)
Excess earnings to retire debt: approximately $520,000 (7 years @ 8%)

Given these numbers, what would be your asking price for this practice?

Remembering that there is no absolutely right or wrong answer, we would probably recommend that this practice be offered to the market somewhere between $400,000 and $420,000. We would guesstimate the most probable selling price to be between $380,000 and $410,000. We would expect this practice to be on the market less than 1 year. Assuming all else besides market comparables being equal, the sales price would probably be less in a rural area and much higher on either coast. The high value for excess earnings to retire

debt is a function of the practice's well-controlled overhead and subsequent profitability. Had the excess earnings resulting from a 61% overhead been used instead of a 56% overhead, the resulting debt service number would only be about $360,000. This is another example of why overhead control is so important.

The intent of this exercise is not to make you an expert appraiser but (rather), to further expose the vast number of issues that must be taken into account in order to establish a working value for a practice. Please do not forget that we are working with a Midwest bias and that markets are different in other parts of the country. The methods used to calculate value are important, but every method may not be useful in every case. Curb appeal is still a strong component of a buyer's motivation and is difficult to quantify. The valuator must blend his or her experience with both objective and subjective information in order to ensure a fair price and successful transition.

Conclusion

Dental practice transitions and appraisals can be very delicate assignments. Seen by lenders as "mom and pop"–sized businesses, the owner/seller is placing his or her life's work on the line and consequently may have an emotionally inflated opinion about its value. Too high of an asking price results in frustration as the practice lingers on the market while the seller's motivation to keep the practice vital and productive wanes. Buyers may see the seller as being potentially unreasonable in other matters of the transition if they feel the asking price is too high. Too low of a value results in a reduced estate for the seller. The young buyer may have never purchased anything more costly than a second-hand car and cannot understand how a room full of used dental equipment can be worth much at all. The appraiser must maintain as objective of an opinion as possible about the value of the practice based on sound financial calculations, thorough research, and knowledge about the local market.

References and Additional Resources

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Learning Exercises

1. Determination of excess earnings
   A. Let's assume that the practice grossed $624,500 in collections in the last calendar year. The adjusted overhead was 57.4%. The practice has a hygiene staff that accounted for 30.5% of total revenues.

   What was the amount of excess earnings?

   B. The practice had gross revenues of $425,000 and the adjusted overhead was 61%. The doctor worked without a hygienist.

   What was the amount of excess earnings?

2. Normalization of expenses
   A. Which of the following would most likely NOT be adjusted to $0.00 in the process of normalizing a profit and loss statement or tax return?
      a. Depreciation
      b. Donations
      c. Interest
      d. Continuing education
   B. Which of the following may be adjusted by the evaluator to conform to industry standards?
      a. Dental supplies
      b. Lab
      c. Property taxes
      d. All of the above
3. Excess earnings to retire debt (the sanity check)
   A. If a practice had gross revenues of $550,000 and an adjusted overhead of 58% without a hygienist, how much debt could the excess earnings support if we assume a 7-year loan at 8.5% interest?
   B. If the same practice increased revenues by $100,000 and reduced overhead to 56%, how much debt could be supported assuming the same loan terms?

Answers

1. A. Excess earnings
   Income: $624,500
   Overhead @ 57.4%: $358,463
   Net income: $266,037
   Dr. salary @ 28%: $174,860
   Excess earnings: $91,117
   B. Excess earnings
   Income: $425,000
   Overhead @ 61%: $259,250
   Net income: $165,750
   Dr. salary @ 30%: $127,500
   Excess earnings: $38,250
2. A. Normalization of expenses
   d. Continuing education
   B. Normalization of expenses
   c. Property taxes
3. A. Sanity check
   Income: $550,000
   Overhead @ 58%: $319,000
   Net income: $231,000
   Dr. salary @ 30%: $165,000
   Excess earnings: $66,000
   Debt @ 8.5% for 7 years: $347,500
   B. Sanity check
   Income: $650,000
   Overhead @ 56%: $346,000
   Net income: $304,000
   Dr. salary @ 30%: $195,000
   Excess earnings: $109,000
   Debt @ 8.5% for 7 years: $573,500

Chapter 5
Dental Equipment

Mike Wacker and Dan Wacker

Tips on Buying New Equipment

This section addresses tips on purchasing what is considered large, and the more expensive, pieces of equipment for the dental practice. These items consist of patient chairs, doctor's and assistant's seating, dental units, patient lights, sterilizers, intra-oral x-rays, panoramic x-rays, x-ray film processors, digital x-rays, air compressors, and vacuum systems.

When it's time to purchase new dental equipment, there are some obvious factors to consider, such as what fits your needs and/or budget. There are some often overlooked or less obvious factors such as ergonomics, ease of use, operating expenses, and equipment maintenance to consider as well.

In some cases a piece of equipment you currently use may have a specific function or feature you feel you must have when purchasing a replacement. Be sure to discuss this need with a dental equipment supplier in order to avoid any disappointment with your purchase.

Seating

One area of dental equipment that has received much-needed manufacturer attention is seating ergonomics for the doctor, assistant, and patient. There is a history of neck and back discomfort associated with practicing dentistry over an entire career, and manufacturers have worked diligently to revamp seating to help eliminate this problem.

It is advisable to select doctor's seating that has an adjustable seat and back. When the seat is properly adjusted you will keep circulation flowing in your legs. An adjustable seat back, when properly adjusted, will keep your back and neck from being hunched over. When purchasing doctor's seating, keep in mind that one size does not fit all, so be sure to try out seating at a dental equipment supplier showroom or trade show.

The same is true for assistant's seating regarding neck and back pain over an entire career of dental assisting. Assistant's seating consists of a seat and upper body support. If your practice usually performs lengthy procedures, the

purchase of assistant's seating with an optional backrest is recommended to help eliminate back and neck fatigue.

Ergonomics has also had an effect in the development of the patient chair for the benefit of the doctor and patient. When you try out patient chairs, you should place the chair into your working position (with someone in the chair if possible) and see if you can get close enough to the patient without straining your neck and back. Also, check the accessibility of the patient chair controls while you are in the working position. Patient comfort is also important when considering the purchase of a patient chair. If the patient chair is too short or too narrow; has poor arm, lumbar, or shoulder support; or if the upholstery is too firm, the patient will become restless and tense. That in turn slows you down and affects your productivity. It is recommended you try out patient chairs at a dental equipment supplier showroom or tradeshow before making the purchase.

Dental Units

The dental unit is available as over-the-patient, orbit (also called left/right) unit, side delivery (wall or cabinet mount), and 12 o'clock (cart, wall, or cabinet mount). If you are undecided as to which to purchase, here are some things to consider that will help narrow down the choices. For example, if your practice has both left- and right-handed doctors and hygienists, you might want to consider the orbit (left/right) dental unit, cart with the left/right feature, 12 o'clock wall-mounted unit, or 12 o'clock cabinet with the left/right dental unit option. These units easily convert to left- or right-handed dentistry by simply rotating the unit from side to side.

Over-the-patient units, by contrast, are attached to either the left- or right-hand side of the patient chair. In order to convert the unit to the opposite side of the patient chair, the unit must be removed from the chair. The steel arm, known as the chair adapter, attached to the patient chair must be removed and re-configured, or in some cases a new chair adapter must be purchased. The chair adapter and dental unit are then reinstalled onto the opposite side of the patient chair. Keep in mind that there are labor and possible parts costs associated with this conversion.

If you practice four-handed dentistry, you can choose from the cart, 12 o'clock wall-mounted unit, or 12 o'clock cabinet with dental unit. It is recommended that you visit a dental equipment supply showroom or a dental tradeshow to see examples of these items.

Patient Lights

Another area with multiple choices is the patient light. These are available as ceiling-mounted, track (ceiling-mounted), wall-mounted, cabinet-mounted, orbit (also called left/right), chair-mounted, and unit-mounted. The ceiling-mounted patient light is permanently attached to the ceiling on either the left-

or right-hand side of the patient chair and requires extra ceiling support or framing above the finished ceiling. The ceiling-mounted light is not recommended if you are using the orbit (left/right) dental unit. The track light is also mounted to the ceiling and has a patient light mounted to a trolley that can be rolled toward the toe or head of the patient chair. This style of light can be used for left- or right-handed dentistry. Track lights also require extra ceiling support or framing above the finished ceiling. The wall-mounted patient light attaches to a side wall, and the side depends on if you practice left- or right-handed dentistry. The wall must be sturdy enough to mount this style of light. This style of light is not recommended if you are using the orbit (left/right) dental unit. Cabinet-mounted patient lights are mounted into a center island cabinet (center island cabinets are used in open concept style dental offices) and can be used with orbit (left/right) dental units. Orbit (left/right) patient lights are attached to the patient chair and can be rotated from side to side around the toe end of the patient chair. This style of patient light is recommended when a practice has left- and right-handed dentists and hygienists. Chair-mounted patient lights are attached to either the left or right side of the patient chair. The same left/right conversion procedure applies here as outlined in the over-the-patient dental unit. The unit-mounted patient light attaches to the over-the-patient dental unit that is attached to either the left or right side of the patient chair. The same left/right conversion procedure applies here as outlined in the over-the-patient dental unit. It is recommended that you visit a dental equipment supply showroom or a tradeshow to see examples of these items.

Sterilizers

There are three types of dental sterilizers: dry heat, chemical, and steam. Dry heat means the sterilizer uses only heat and no chemicals or water. Chemical sterilizers use heat and chemicals for the sterilization process. Steam sterilizers use heat and distilled water for the sterilization process. There are two types of steam sterilizers: recirculating and non-recirculating, offered as either manual or automatic models. The recirculating steam sterilizer reuses the distilled water each time a cycle is run. This type of sterilizer requires a frequent maintenance schedule. The non-recirculating steam sterilizer uses the distilled water for only one cycle. At the end of the cycle, the water is purged from the sterilizer into a container or a drain. This type of sterilizer has a higher distilled water usage but requires less maintenance.

Another version of the steam sterilizer is the “dry-to-dry” model. It is offered in the recirculating and non-recirculating versions as well. With this model, the instruments and/or handpieces are dried after the ultrasonic/disinfecting process, and then placed into the sterilizer. The items inside the sterilizer go through an entire sterilization process, including a drying cycle, before the sterilizer door opens. This type of steam sterilizer is more costly compared with other sterilizers and the sterilization process is longer due to the drying

cycle. However, the contents are dry when the door opens at the end of the cycle.

After you have determined which type of sterilizer you want, you need to determine an appropriate size and whether you need more than one sterilizer. For example, if you use instrument cassettes, you will need a larger sterilizer. If you use sterilization pouches for instruments and/or handpieces, they should be laid in a single layer on the tray. If you use a cassette-style sterilizer, the pouches should be laid in a single layer on the bottom of the cassette. If pouches are multilayered, the middle layers will not completely sterilize, and if you have a dry-to-dry sterilizer, the middle layers will not dry. Also, multiple layers can shift and slide off to the side and touch the sterilizer chamber wall. This will result in burnt pouches and possible cycle failure. It is recommended that you have a larger sterilizer for larger loads and a smaller sterilizer for quick turnaround items (that is, handpieces, specialty instruments, etc). This also gives you a backup if one unit breaks down.

Intra-oral X-ray Units

Intra-oral x-ray units produced today are capable of either film or digital x-ray imaging. When using film the exposure time is increased, resulting in a longer radiation exposure. In contrast, digital x-ray requires a lower exposure time, resulting in a much lower radiation exposure.

When setting up a new office or clinic, costs and cost savings are always an issue. Intra-oral x-rays can be set up in an x-ray room, one x-ray per operatory, in a pass-thru cabinet, or mounted on a center island. Consequently, the most expensive setup will be one x-ray unit in each operatory, and the use of an x-ray room will be the least expensive to set up. There are, however, other things to consider. Depending on the size of the practice, an x-ray room could cause a slowdown in productivity due to waiting for the room to become available. The pass-thru or center island option utilizes one x-ray unit mounted between two operatories, which will reduce costs. While this option will help reduce equipment costs, keep in mind that if that x-ray unit breaks down, two operatories will be unavailable for taking x-rays.

Panoramic X-ray Units

Panoramic x-ray units produced today are capable of either film or digital x-ray imaging. When using film exposure time is increased, resulting in a longer radiation exposure. In contrast, digital x-ray requires a lower exposure time, resulting in a much lower radiation exposure. If you purchase a film-based panoramic x-ray with intentions of upgrading the unit to digital in the near future, be sure to inquire whether a conversion will be possible for that unit. Also, it may be more cost-effective to purchase a digital panoramic unit instead of purchasing a film-based unit then doing a digital conversion at a later date. The panoramic x-ray is the one mechanical piece of equipment that has the

ability to pay for itself and continue to generate a significant income for the practice. Two key things to consider here are your current and future needs; then purchase the unit that best fits both. To keep costs down, do not purchase a unit that can be upgraded for things you will not use. For example, if you plan to take only panoramic x-rays, try to purchase a unit that will do only panoramic x-rays. This unit will have a lower purchase price because it will not have the extra internal components necessary for the addition of a cephalometric. If you think in the near future you want to have the ability to take cephalometric x-rays also, then purchase a unit that has the ability to add the cephalometric option. This type of unit will have the necessary internal components for a cephalometric upgrade but will also have a higher purchase price.

X-ray Film Processors

X-ray film developing can be accomplished manually with the use of dip tanks, or automatically with the use of an automatic film processor. The dip tank method requires manually handling films through the entire developing, fixing, and rinsing process before exiting the darkroom. The automated film processor allows you to feed the films into the film processor, and once they are completely inside the machine, you can exit the darkroom. If a darkroom does not exist, the film processor can sit on a stand, cabinet, or countertop where space allows and will require purchasing an optional daylight loader. This is a small compartment that attaches to the film entry end of the processor for the handling of films without exposing the film to light.

Automated film processors are offered in an intra-oral only version and an intra-oral/extra-oral version. Intra-oral automatic film processors develop only intra-oral x-rays. These units are smaller, require less space inside the darkroom, and are less expensive to purchase than the intra-oral/extra-oral models. If you have a panoramic or panoramic/cephalometric x-ray unit, you will need the larger automatic film processor that will develop both intra-oral and extra-oral films. Automatic film processors can be purchased as a plumbed or stand-alone unit. The plumbed model is hooked up to a cold water supply line and a drain. The stand-alone model is totally self-contained. These models use pumps to circulate the chemicals and water from containers into the automatic film processor, then back into the containers. The stand-alone unit with a daylight loader offers the flexibility of placing an automatic film processor virtually anywhere within the dental practice. They are, however, more expensive than the plumbed automatic film processors.

The film-based x-ray process has a significant ongoing operating expense in the form of x-ray film, processing chemicals, and cleaning chemicals. Also to be taken into account is the staff time required for the frequent maintenance of automatic film processors.

Lastly, the purchase of duplicating film and a film duplicator is necessary in order to send film(s) to another dental practice, insurance company, and so

forth. Duplicating film is another item to be added to the list of ongoing operating expenses. The film duplicator will require a space in the darkroom.

Digital X-ray

There are two forms of digital x-ray available to the practitioner: phosphor plate technology and digital sensor technology. Determining which one is best for your practice means understanding what each one has to offer.

Phosphor plate technology uses a phosphorus plate that is the same size and shape of an x-ray film. Preparing to take an x-ray has the same set-up steps as that of an x-ray film-based process. Once the image is captured on the phosphorus plate, it is placed into a light-proof container and carried to the scanner. The plate is removed from the container and placed into the reader. The reader is connected to a computer and monitor, and you can watch the image coming up on the monitor as it is being read. Processing a phosphor plate image is quicker than film-based processing but longer than digital sensor processing. Digital x-ray software offers numerous features that allow you to manipulate images in a variety of ways as well as send images electronically. Phosphor plates are available in intra-oral and extra-oral sizes. Phosphor plate technology eliminates the need for duplicating film, a film duplicator, processing chemicals, cleaning chemicals, and the need for staff to perform routine maintenance. Care must be taken with the phosphor plate to avoid scratching or bending it. Phosphor plates are not repairable and do have a limited lifespan.

Digital x-ray uses a digital sensor with a wire coming out of the sensor that is connected to a computer to capture and show images. Once the x-ray is taken it is available for viewing within seconds. The sensor is much thicker than film or phosphor plate and can be uncomfortable in smaller mouths or the posterior region. Digital x-ray software offers numerous features that allow you to manipulate images in a variety of ways as well as send images electronically. This technology replaces the use of x-ray film, a film processor, duplicating film, a film duplicator, and darkroom. Digital x-ray has a greater start-up cost but a considerably lower ongoing cost compared to its film-based counterpart.

Air Compressors

Air compressors are available as both lubricated and lube-free units, and both offer various sizes of units that are then matched to the number of users. Dental air compressors have built-in filtering systems in order to provide clean and dry air into the oral cavity. The lubricated models are quieter and usually less expensive than the lube-free models. On the other hand, the lube-free models do not require annual oil changes, and there is no risk of compressor oil ever getting into the air lines and dental unit(s).

When purchasing an air compressor, consideration must be given to where the air compressor is placed within the facility and the decibel level generated from the unit. It might be necessary to purchase an optional sound cover that will help to reduce the decibel level.

Vacuum Systems

Dental vacuum systems are offered in two versions known as "wet-ring" or "dry." Both systems are sized based on the number of users. The wet-ring version is available as a single pump or dual pumps. Because of the compact size, especially the single pump, this system will fit into very small areas. A cold water supply line must be run to the pump(s), and the water is then injected into the operating pump(s). These pumps are offered in a water recycling version that reduces water consumption to approximately one-half (or less) of the non-recycling versions.

The dry vacuum systems use an electric motor to drive a pump to create suction. While they use no water to create suction, they are larger and are more difficult to fit into confined spaces.

In terms of purchasing and ongoing costs, the wet-ring vacuum systems are less expensive to purchase than the dry vacuum systems. In contrast, the dry vacuum systems have no impact on water bills, especially in cities that impose a high user surcharge.

What to Look for in Used Equipment

This section provides you with important information if you're in the market for used dental equipment. As with anything used, it is important to know what questions to ask and what to watch out for. While there is some very good used dental equipment offered for sale, there is also some very old and obsolete equipment for sale.

Your Needs

There is always used dental equipment for sale, but in order to make a smart purchase you must first determine what your needs are. If you are unsure of your needs, you can use the "Tips on Buying New Equipment" section as a guide. The various types of dental equipment are explained and can help you determine your needs. It is very important to take time to carefully consider your equipment needs and not let yourself "settle" for something you may regret purchasing.

Age of Equipment

When considering the purchase of used dental equipment it is to your benefit to research its age. If it is newer equipment, there may be the balance of a factory warranty still in effect. If it's older equipment, some parts or the entire unit may be obsolete. Do not hesitate to ask the seller if he or she can produce documentation showing the purchase date. If the seller is unable to provide proof of the purchase date, the next step is to get the item's model and serial number, manufacturer name, and where applicable, model name. With this information, a dental equipment supplier should be able to give you at least a general idea of the manufacturing period. If you have at least a manufacturer

name, model name (if applicable), and model number, the internet is another helpful tool. With this information you should be able to learn the general manufacturing period. In some cases, having the serial number(s) during your internet research could also provide you with the year and month of manufacture.

Condition of Equipment

There are a number of things you can do to determine the condition of dental equipment. The most obvious is looking at the equipment's appearance. Look for missing or broken parts. If it's upholstered, is it discolored or torn? Dips in seat backs and seat cushions could indicate breakdown of the foam padding. If the surfaces are painted, look for discoloration, chipping, and flaking. If the surfaces are laminate, look for discoloration and chipping. Other red flags are sounds like squeaking, grinding, snapping, rattling, leaks, or a loud electric motor hum. In some cases a squeak might be nothing more than a part needing to be cleaned and lubricated. A grinding or snapping sound might indicate a fatigued part or parts that could lead to costly repairs. Some equipment has been very well maintained but just needs some updating. An example of this is patient chairs, doctor's seating, and assistant's seating that has outdated or worn upholstery. Before you make a purchase, you should check with a dental equipment supplier on the availability and price of replacement upholstery packages. Another area in which to exercise caution is with dental equipment that is, or has been, stored in a non-temperature-controlled storage in a freezing weather climate. If dental units and wet-ring vacuum pumps do not have the water purged with air before going into storage, the freezing temperatures will rupture water lines and crack vacuum pump housings. Needless to say, these are costly repairs, and in some cases the cost of parts and labor far exceeds the value of the unit. If you purchase used dental equipment and intend to do some refurbishing, be aware of your total investment in the project. Remember, you are most likely refurbishing what is known to need attention. All other parts could still be original equipment. After an initial purchase and refurbishing you could end up putting as much as one-half (or more) of what new would have cost, and yet the used item is not completely refurbished and has no warranty. Something else to consider is the image your practice presents to your patients and prospective job applicants. Let's say you have one operatory you're going to equip with used dental equipment. You end up purchasing doctor's seating, assistant's seating, and a patient chair from three different sellers and also end up with three different upholstery colors. There is also a good chance some or all of these upholstery colors may not match your operatory decor. Some new upholstery packages could make these items look as good as new for considerably less than purchasing all of these items new. Providing quality dental work to the patient is first and foremost. However, a neat, clean, updated facility and equipment are extremely important in creating a positive impression with patients, job applicants, and staff.

Red Flags

Obsolete dental equipment is knowingly and unknowingly offered for sale. In the "Age of Equipment" section of this chapter, tips were given for determining equipment age. A product is deemed obsolete when a manufacturer decides to stop producing it or if a manufacturer ceases to exist. Once the manufacturer's parts inventory is depleted, that source for parts is now gone. The next option would be checking for after-market parts companies that offer new replacement parts for a number of different equipment brands. However, not all parts are manufactured in the after market due to high manufacturing costs, low demand, or exclusivity to the original manufacturer. If you should happen to purchase obsolete dental equipment and new parts are not available, you can always shop the internet for replacement parts. Remember, the part you are looking for is probably going to be used and as old as the part you are replacing. Other red flags are poorly performed repairs, air leaks, and fluid leaks. Look for electrical wires that have been taped. This could be covering bare or broken wires, and if this is part of a wiring harness it could be a costly part(s) and labor repair. If you are looking to purchase a dental unit and the dental unit and junction box are still hooked up and in use, listen for air leaks and look for water leaks. When looking at a wet-ring vacuum pump, if at all possible try to hear it run because a loud squealing sound and/or water leaking indicate needed repairs. If you are looking to purchase a used sterilizer, run one cycle from a cold start (first run of the day), and as soon as that cycle has finished, immediately run another cycle. On both cycles, note if the sterilizer reaches sterilization temperature or if it took a lengthy amount of time reaching sterilization temperature. Also check for leaks around the door or cassette and drips under the unit. If any or all occurs, the unit requires repairs. Older hydraulic patient chairs are susceptible to hydraulic fluid leaks over time. Hydraulic hoses can split, and hydraulic cylinder seals can fail, which allows hydraulic oil to leak onto the chair base and/or floor. If parts are available, parts and labor costs range from moderate to expensive. Air compressors also require a close inspection. They can have obsolete parts, rusty tanks, faulty electrical components, and slow recovery times. Lubricated compressors can have oil consumption issues that will allow oil to saturate filters and drying systems. This can also cause contamination of air lines and damage parts inside dental units, as well as emit oily-smelling air from the handpieces and the air side of the syringe.

Valuation of Dental Equipment

It is difficult to place a value on used dental equipment. The seller, who probably purchased the equipment new, remembers that it was very expensive when it was brand new. Even though the item might be 10 years old, the seller feels it's in great condition for its age, so it should be worth at least one-half

(or more) of the new price. Another technique a seller may use is to ask a dental equipment dealer how much a like item costs today, then place his or her own value on the item. A buyer looking at the equipment may have a totally different opinion of the condition and value, and the result could be a no sale.

Determining Fair Market Value

Because a used dental equipment price guide does not exist, a number of factors are considered in trying to determine a fair market value. The considerations are age, condition, parts availability, popularity, colors, and the cost if purchasing a like item new today. Oftentimes a buyer has already shopped the new equipment market prior to turning to the used market. The point here is, as a seller, to have some idea of what a fair price is but be willing to settle for what the market will bear. As a buyer, once you find what you're looking for, do your research before making an offer. Whether you are the buyer or seller, it is to your advantage to utilize available resources as a guide in determining a reasonable value for used equipment. One resource is your ADA chapter. They distribute a newsletter that includes a "for sale" section that always has used dental equipment listed. Another resource is internet auction sites.

Individuals wanting to sell and companies that refurbish used dental equipment often post on auction sites. In either case you can't actually see the item(s) in person, so ask for photos from various angles and don't hesitate to ask questions. Keep in mind that in addition to the winning bid amount, you will most likely incur shipping and insurance expenses. Always cover yourself by asking for a written return and full refund guarantee in the event the item has missing parts or does not work upon receipt. This is especially important when purchasing any equipment with circuit boards and used x-ray equipment. Replacement circuit boards, if still available, are quite expensive. The filament in used x-ray tube heads is very fragile, and rough handling can ruin the tube head. If the tube head can be repaired or replaced, the repairs are extremely costly and in most cases will far exceed the value of the x-ray unit. One other resource for guidance on used dental equipment is a dental equipment supplier. They might be able to provide you with approximate time frames of production, tips on what to look out for, information on reliability issues, and parts availability.

Maintaining Equipment

How to Maximize the Life of Your Equipment

Dental equipment requires a significant financial investment, so you will want to perform the necessary maintenance in order to maximize its life. As with anything mechanical, periodic maintenance is necessary, and it's simply a

matter of getting a routine schedule set up and sticking to it. Because of the demands that will be placed on your time, you should assign equipment maintenance tasks to staff members. Additionally, ask that your staff note and inform you if they hear air leaks or see water leaks, or if normal operating sounds change (that is, handpieces, air compressor, vacuum pump, etc.). Oftentimes air compressors and vacuum pumps are placed in small closets or share a space with the furnace and water heater. Most of the time these rooms are not temperature controlled, so heat and humidity can be very high, especially in the summer. This causes the air compressor filtering system to become saturated with moisture, which will necessitate more frequent maintenance and increased maintenance costs. It is recommended to have a heating/air conditioning duct run to this space, with the duct open in the summer for the cold air. The duct should be closed for winter in order to keep additional heat out. Air leaks can be another source that will cause unnecessary stress and an early demise of your air compressor. Air leaks are most commonly found in the junction box where the dental unit connects to the plumbing and in the delivery unit. Air leaks are also possible where air-operated accessories are connected and within the accessory itself. Air leaks will cause your air compressor to run more frequently, causing unnecessary wear and tear. If you own a lubricated air compressor, the oil level should be checked monthly. There is a sight glass on the side of each compressor head with a "FULL" indicator line next to the sight glass. To obtain the most accurate reading of the oil level you should check it in the morning before the compressor is started. Checking the oil level when the compressor is cold will ensure all of the oil has drained down. Over-filling the air compressor with oil can cause damage. Each month when the oil is checked you should also check for moisture in the tank. This is accomplished by slowly opening the valve at the bottom of the tank a few turns. Water (and sometimes air) may leak out. If water is coming out, let it drain completely then close the valve tight. Failure to tighten the valve will result in an air leak.

The patient light is another item that when not cared for properly will result in costly repairs. The lens shield and the reflector should be cleaned with only water and a soft cloth. Glass cleaners or all-purpose cleaners will ruin the coating on the reflector, and paper towels will scratch the lens shield and reflector. You should never attempt to clean a patient light reflector that was just in use. The glass will be extremely hot and will crack if touched with a damp towel. Replacement reflector prices vary, but even the least expensive reflector will cost several hundred dollars. Handpieces should never be placed in the ultrasonic cleaner or be doused with spray disinfectant, as this also causes expensive repairs. Handpieces should be wiped down with a two-by-two dampened (not soaked) with alcohol prior to sterilization. Handpieces with fiberoptics should have the exposed fiberoptic lens wiped with alcohol prior to sterilization. Any debris not removed prior to sterilization will be baked, possibly permanently, onto the handpiece and/or fiberoptics. There are some duties that need to be performed but that are not part of the manufacturer's

recommended maintenance schedules. The next section will cover setting up maintenance calendars for various manufacturers' equipment.

Some of the following duties are day-to-day duties and should be included on those calendars. If you have a chemical or steam sterilizer, at the start of the business day, you should check the fluid level in the reservoir. If the level is low, fill the reservoir to the "FULL" mark. If you use water bottle systems to supply water to delivery units and air/water syringes, fill the bottles with distilled water at the start of each business day. This will help to avoid running out of water during a procedure. If you have a plumbed-in nitrous system, turn the system on and check the gauges on the nitrous and oxygen tanks for pressurization and tank levels. Turn the air compressor on and check in the operatory, at the dental unit, for air to the handpieces and air/water syringe. Turn the vacuum system on and check in the operatory for suction to the assistant's utilities. At day's end, a vacuum line cleaner should be run through all saliva ejectors and high-volume evacuators (HVEs), which will disinfect the vacuum lines. Change or clean the solids collector in the operatory at day's end. There is a simple test you can perform semiannually that can tell you if there are air leaks that may be causing your air compressor to work harder than necessary. To perform this test requires a minimum of one hour and a time when dental units and air-operated accessories are not in use, so a lunch hour is ideal. After the last patient is seen just before lunch, run some handpieces and air syringes until the air compressor starts. Place the syringes and handpieces back on the dental unit and leave the dental units, any air-operated accessories, and the air compressor on. For the next hour listen to see if the air compressor starts up, and if so, note how many times it starts within that hour. If the air compressor starts at all during this hour there are definitely air leaks that must be serviced in order to maximize the life of the compressor.

Manufacturer's Maintenance Schedules

With the purchase of any new equipment, you will receive a manual that covers use and care instructions. Oftentimes some pieces of equipment with specific maintenance requirements will have a separate maintenance document that can be posted near that unit as a reminder to perform maintenance. It can't be stressed enough to always follow the manufacturer's recommended maintenance procedures. Documented maintenance is critical in the event of a repair during the warranty period. By following the manufacturer's maintenance schedule, you will maximize the life of the equipment. Because each piece of equipment might be on a different maintenance schedule, you should set up a maintenance calendar to keep track of the various schedules. Air compressors have an annual maintenance (under normal operating conditions). Annual maintenance for a lubricated air compressor is an oil change and filter(s) and drying system maintenance. Annual maintenance for a lube-free air compressor is filter(s) and drying system maintenance. Wet-ring vacuum pumps should have the solids collector cleaned (or replaced if using a disposable

solids collector) each week at week's end. The sterilizer door gasket should be checked daily for proper fit and for any cuts or tears. The gasket and chamber opening surface should be checked for debris. A worn, cut, or dirty door gasket and/or chamber opening surface will cause the sterilizer cycle to fail before the instruments and/or handpieces are sterilized. If you have a recirculating sterilizer (the distilled water is used over and over), you will need to perform a thorough maintenance procedure after several cycles. The use and care guide will provide you with the specific number of cycles you can run before this maintenance must be performed. Failure to comply will result in an extremely dirty-looking chamber and water reservoir and in premature failure of some of the internal components and costly repairs.

Upholstery Care and Maintenance

Doctor's and assistant's seating upholstery, as well as the patient chair upholstery materials, today are offered in vinyl or ultraleather. While both materials are very durable, vinyl has a stiffer feel to the touch while ultraleather has much softer feel. A patient chair with ultraleather upholstery is very appealing and relaxing to the patient. There are some things you will want to do to get as much life as possible from your upholstered items. Before seating the patient in the patient chair, try to notice if any sharp objects are in their back pockets. There are numerous horror stories about sharp objects in back pockets that puncture a hole in the patient chair upholstery. Ink pens are a double threat because they can puncture or cause ink stains. Also be watchful for leather apparel that has been freshly dyed, as this has been known to stain upholstery as well. As for cleaning of the doctor's and assistant's seating upholstery and patient chair upholstery, avoid disinfectants with high alcohol content. Repeated use will discolor and crack upholstery and will significantly reduce the useful life of the material. Many dental offices now use a plastic barrier on the patient chair, which eliminates using harmful chemicals. The barrier is discarded after each patient, and a new barrier is placed on the patient chair before the next patient.

On a final note, most new doctor's and assistant's seating upholstery and patient chair upholstery has a 1-year warranty against manufacturing defects.

Helpful Hints

The "Tips on Buying New Equipment" section covered purchasing new equipment. If you plan on acquiring more than one bid for dental equipment, make sure bids are for the exact same equipment. One dental equipment supplier may have brand "X." Another dental equipment supplier may not have brand "X" but have brand "Y" and may tell you it's just like brand "X." If brand "X" is what you really want, try to find another dealer that carries that brand.

References and Additional Resources

Some Manufacturer's Websites

A-dec: www.a-dec.com.
Belmont: www.belmontequip.com.
Brasseler: www.brasselerusa.com.
DentalEz: www.dentalez.com.
Marus: www.marus.com.
Midmark: www.midmark.com.
Pelton and Crane: www.pelton.net.
Premusa: www.premusa.com.
Dental manufacturers by name, location, and product: www.ada.org.prof/resources/pubs/dbguide/index.asp.

Some Supplier Websites

Dental Health Products, Inc.: www.dhpi.net.
Goetze: www.goetzedental.com.
Patterson Dental: www.pattersondental.com.
Sullivan-Schein Dental: www.henryschein.com/us-en/DENTAL/default.aspx.

Other Sources

Internet auction sites.
State dental associations.

Learning Exercise

Assume that you are going to purchase your own dental practice. You have a building with a favorable lease, but the existing dental equipment is in need of replacement. Now you are in the process of making the decision to buy equipment. Identify the decision-making process that you will employ. The following is a partial list of questions you need to answer. How much can you spend? What equipment will you need? Will someone help you decide or recommend what to replace? Will the replacement equipment be new, used, or a combination of both? How will you price the equipment? What type of service agreement will you need? Will you remodel? How long will it take to redo the office? Do you replace the units one at a time or all at once? What other issues need to be addressed?

Chapter 6
Buying/Buying into a Practice

Nader A. Nadershahi and Stuart M. Spero

> Business, more than any other occupation, is a continual dealing with the future; it is a continual calculation, an instinctive exercise in foresight.
>
> Henry R. Luce

For most dentists, the choice of purchasing a practice is one of the top three largest decisions you will make in your life. This is true if you take the perspective of how it can affect your quality of life, finances, or professional satisfaction. This is exactly why it is important to spend the time necessary to make a well-informed decision based on a thorough evaluation of each opportunity.

In this chapter, we explore two of the most common paths of entry into dental practice. The first path we discuss is buying a dental practice where the owner sells the entire dental healthcare service business to the buyer. The second path is buying into a practice where the owner is selling a share of the business to the buyer, who will become a partner or shareholder.

Our learning objectives are that after reviewing this chapter, you should understand:

1. The different variables that should be considered in choosing the location of practice
2. The difference between buying and buying into a practice
3. What to look for in each transaction
4. How to work with other professionals to protect your interests.

> In modern business it is not the crook who is to be feared most, it is the honest man who doesn't know what he is doing.
>
> William Wordsworth

Choosing the Right Location

This section is intentionally placed first in the chapter because it is a critical part of the decision-making process in the purchase of a practice but is often overlooked. If you find the best opportunity in an area that does not provide the elements that will allow for a happy personal and professional life, it is not

the right opportunity for you. Whether you decide to buy a practice or buy into a practice, the first decision should be to find the general area where you want to live and work.

Quality of Life

With some of the changes that are occurring in licensure in the United States, such as larger regional examinations and reciprocity between states, a doctor is not locked into one location as much as in the past. What you must do is to start globally and begin to narrow down the area where you want to establish your professional roots. There are many questions to consider as you make this quality-of-life decision.

1. Do you want to be near certain friends or family members?
2. Do you and your family like living in a rural area, the suburbs, or a big city?
3. What recreational outdoor activities are you interested in, such as snow sports, water sports, or hunting?
4. Do you want to have access to certain cultural activities like the opera, theater, or sporting venues?
5. Are you looking for an area to live where there are certain schools or other options available to you?

These and many other questions pertaining to the quality of life you will have are critical in narrowing down your options of where you will start your search for a practice to buy or buy into.

Professional Environment

After you have decided on some specific areas and communities that meet your personal needs, it is time to consider the professional environment. A specialist will want to locate a practice in an area where there are sufficient general practitioners and an appropriate population to maintain a healthy referral practice. As a general dentist, you would like to ensure that there are other professionals that you can work with to create a provider team as necessary for your patients. For example, if you do not feel comfortable with doing any surgical procedures or choose not to have them as part of your practice, you should ensure that there are an adequate number of oral and maxillofacial surgeons or periodontists whom you can work with to complete the treatment needs of your patients.

You will also want to make sure that there is access to other professionals who may be valuable in the treatment of your patients or as a source of referral and support for your practice.

Business Environment

The next area of evaluation is the business environment. The environment in business can be divided into the internal and external business environments.

We touch on the internal environment in other areas of the book as we discuss issues associated with employees, systems, and other internal aspects of a dental practice. The focus of this section is the external business environment.

When choosing the right location to practice, you should look at all of the stakeholders in the business environment that have some effect on the practice of dentistry. In *Business and Its Environment*, Baron (1996) describes the external environment as the "market environment" that would include effects on your production, relationship and response to your patients, innovation, and incorporation of new procedures and techniques into your practice. The "nonmarket environment" is the interaction with public institutions that are not driven by the private markets. Nonmarket influences have slowly increased in the demands they place on the management of a practice. Examples of nonmarket influences include environmental protection (EPA), health and safety (OSHA), other regulations (HIPAA, radiation safety, etc.), public responsibility, and ethics.

It is important to make sure that you have an idea of what regulations and forces would affect your dental practice and to ensure that there are no regulations or forces from the external environment that would make it difficult to succeed in your small business. For example, some cities or towns will be more welcoming of professional businesses, and others create regulatory obstacles and costs that would discourage you from maintaining a practice in that location.

Alignment with Goals

Finally, as you narrow down your decision of where to practice, you want to make sure that the location will allow for a practice that is aligned with your personal and professional goals. This step would arguably be the first to consider, but all of the items discussed in this section hold equal weight in the decision-making process.

As we discuss in chapter 2, planning and goal setting are key components of success. You may have heard someone describe a study conducted at Yale University on the class of 1953, where researchers surveyed the seniors and found that only 3% of them had specific written goals. After 20 years the researchers found that the 3% with specific goals had accumulated more financial wealth than the other 97% of the class combined. Now whether this story is true or not (most likely not, since several articles have been written challenging the veracity of this story including Tabak [1996/1997] in *Fast Company*), setting goals is an important step toward personal and business success.

If you have not done so already, you should consider having some goals that you set for yourself with both short- and long-term time horizons. These goals can be broken down into 1-year and 3-year ones and then separated into personal and professional.

Your personal goals may include health, family, retirement, travel, or recreation. Then the professional goals may include some quantitative items such

as number of new patients seen, revenue, or size of staff. They may also include some qualitative goals such as practice image, range of services provided, how much time you will devote to providing care for the underserved in your community, or who your target market will be.

Choosing a location that will allow you to achieve as many of your personal and professional goals as possible will create a shorter path to a successful practice career. If you intend on providing care for pediatric patients, you should avoid areas that have a population demographic that shows a continued growth in the older age ranges with little growth of children, new families, and new schools. On the other hand, if you intend to have a practice that is geared toward comprehensive prosthodontics, implants, or aesthetic dentistry, you will need to make sure that all of the demographics and the professional environment will support such a practice.

Deciding to Buy out or Buy into a Practice

In this chapter we are assuming that you have chosen not to start a practice because of financial or personal reasons. Of course the alternative—starting from scratch—includes taking on more risk initially with a potential for much larger rewards in your ability to build a practice exactly how you want, and to grow the business and equity more quickly. Practice start-ups will be covered in more detail in chapter 7. Many individuals will choose the path of entering a business that is already a going concern so that there is a built-in cash flow on day 1, as opposed to starting from scratch and building the cash flow. That is what we focus on throughout the remainder of this chapter. There are several broader issues to consider in making your decision that we discuss initially and then compare and contrast some specifics about each type of transaction.

Opportunity Cost

Buying a practice, buying into a practice, and starting a practice from scratch are the three most common forms of practice entry. Practice valuations are discussed in chapter 4, and financing a practice in chapter 8. All of these discussions usually focus on the actual cost or how much we are paying out of pocket or through the attainment of a private, commercial, or federally backed small business loan. Another concept of cost that is commonly overlooked in the dental practice marketplace is opportunity cost. In the text *Essentials of Corporate Finance*, Ross et al. (1996) describe opportunity cost as “the most valuable alternative that is given up if a particular investment is undertaken.” In other words, when you are deciding to buy a practice, you should look at what other options you are giving up for that dollar amount. What other options exist in the marketplace for a buy-in or practice start-up for that same $500,000 that you are planning on paying for a practice purchase? Another

example would be if you already have an established practice and are looking at another that is for sale. What is the cost of everything you are giving up in your existing practice? Will you choose to sell your practice, the equipment, and the patient charts, or move some of your assets to the new location? An understanding and assessment of opportunity cost will allow you to evaluate all other alternatives as you strive to make the most informed choice when selecting a buyout or buy-in transaction.

Solo Practitioner or Partner

Another very important decision to make early in your decision process has to do with the type of practice that you want. Do you want to work in an office by yourself as the only doctor, or do you want to be in a setting where there are other general practitioners and/or specialists? This decision should be made based on your personal style and professional interests.

A solo practitioner has the flexibility of making all of the decisions and serving as the leader in the practice. He or she will create the vision, mission, and goals for the practice, and then create an environment where those goals can be achieved. The solo practitioner also owns all of the responsibility when it comes to the management of staff, practice systems, finances, and all other aspects of the business operation.

A partnership or group practice will give a practitioner the ability to focus more on performing the dentistry and less on the management of the business operations. A partnership or group practice may also create a built-in professional support system for the practitioner. The business management responsibilities and leadership roles may be shared or divided in a way that allows for each individual to take advantage of his or her personal strengths and focus on what he or she is interested in doing in the practice. Being in a partnership or a group does, however, require that you come to a consensus or compromise about important business decisions such as major purchases or employee issues. There also need to be clearly delineated roles for each doctor to avoid confusion among the partners or the staff in the practice about how decisions are made and work is completed in the office.

Now that you have decided whether you choose to be a sole proprietorship or a partnership after the buying or buying-in transaction, you need to consider the type of business that already exists in the practice and what business entity you want to establish after consultation with your accountant and attorney team. The most common forms of business structure for a healthcare practice in the United States are as a sole proprietor, a partnership, a limited liability company, or a corporation. Details about these options are discussed further in chapter 9.

Transition Considerations

Your decision on which transition route to choose may have to do with your current situation or options. You may have the opportunity to become, or may

already be working in a practice as, an associate, and this would lead to a partnership or a buyout. If this is the case, then you will need to have a clear understanding of what that transition period will look like. You and the current practice owner should discuss the details and create a written agreement or memorandum, with legal advice, that is attached to your employment contract. This memorandum will prevent any misunderstandings on the part of either party as time passes. Items to include in this memorandum include but are not limited to the length of time before a purchase option is available, how and when a value will be determined, details of how the purchase will be paid off, what the business entity will be after the transition (partnership, sole proprietor with or without an associate, corporation, etc.), and what the role of the selling doctor will be in the practice after the purchase has occurred.

Other Doctors Who Will Remain in the Practice

If the practice that you are considering buying or buying into has other doctors who work in the office, there are several questions that you will need to consider.

1. What is the configuration of the employment arrangement? Are these doctors employees or independent contractors? There are several considerations here that have different tax and legal implications, so you will want to make sure you have the proper advisors as you review this information. Table 6.1 describes some general differences between an employee and an independent contractor.

Additionally, you will need to ensure that there is an employment agreement with each associate or employee and that it is transferable to you as appropriate. For example, if you are paying for a practice with the production of associates used as part of the determination of a final price, you will lose equity immediately if the covenant not to compete does not transfer to you and the associates take their patients and production to another office.

2. What is the relationship between the seller and these doctors? It is a good idea to assess this relationship and determine why this individual or

Table 6.1. General comparison of employee vs. independent contractor.

Employee	Independent Contractor (IC)
Paid by employer on formula or flat rate	Pays employer on formula or flat rate
May receive benefits	No benefits
Employer pays taxes	Employer pays no taxes
Employer hires staff	IC hires staff
Employer responsible for equipment and supplies	IC responsible for equipment and supplies
Employer has control	IC has full control

individuals did not purchase the practice. Maybe they were not interested because of some problems that you have not noted yet, or maybe they are sore that the selling doctor did not give them the opportunity to buy in or buy the practice. You will have to manage that relationship after you take over.

3. What is the contact between the remaining doctors and the patients? The evaluation here would be to see whether these doctors have been seeing the patients in the practice on a regular basis and determine whether there is a greater chance that the patients would want to see them instead of you after the selling doctor is out of the practice.

Due Diligence

Due diligence is a noun and has to do with the process that a reasonable person will use to avoid harm financially and personally as he or she collects and evaluates all of the necessary information before making a business transaction. In the purchase of a dental practice or buying into a dental practice, you will need to consider several things in your due diligence process. The following sections discuss in more detail the cash flow considerations, operational systems, facilities and equipment, and personal considerations related to the selling doctor or other partners.

Cash Flow Considerations

In real estate, we know that the three most important considerations are location, location, and location. Well, in business, the three most important considerations are cash flow, cash flow, and cash flow. Now, we understand that this is a simplistic view of a healthcare practice and that there are many other considerations, not the least of which being the oral health of the patient and the public. However, if you do not manage the cash flow of your business, you will not be able to provide your great services to anyone in your community.

In any transaction to buy or buy into a practice, you will want to closely review the financial status of the practice and create a forecast or pro forma income statement. These tools will allow you and your accountant to make some informed decisions on the likelihood that the practice opportunity you are evaluating will be able to support the practice overhead, service the debt you may incur on the practice, and provide you income to meet your personal living budget.

You will want to ask the selling doctor for several financial items to review as you are evaluating any purchase transaction: the last 3–5 years of financial statements (income statements and balance sheets), tax returns for the same period, bank statements to reconcile with the financial statements, an accounts receivable report including aging, and copies of any leases that are in force.

Let's discuss each of these items and what you are generally looking for with each.

Financial Statements and Tax Returns

When you review the financial statements and tax returns from the last 3–5 years, you should first look at any trends that are displayed by the practice. For example, has the production decreased over the last few years, or have expenses suddenly increased? You will need to dig a little deeper and find out the reasons behind such changes and then decide if they are acceptable to you in making the final transaction. You and your accountant can also look at some bank statements if the seller is willing to review them with you to ensure that the financial statements, tax returns, and bank statements reconcile with one another.

Let's look at a few examples and discuss the kind of information you would request in addition to what is provided.

Practice A (see Table 6.2) is located in a large suburban city that has seen great growth and rising income levels. The selling doctor has been in this practice for 15 years and is retiring from dentistry to focus on family and other interests. The patient base is made up almost entirely of employees from a transistor design and fabrication company. The existing doctor does minimal marketing and is only working with one preferred provider plan and other indemnity-type insurance plans.

The good points about this practice are the sustained growth of the area and the fact that the growth has translated to increased productivity with minimal resources put into marketing. However, there are two areas where you will want to go deeper for more information.

First, as you can see from Table 6.3, once you do the calculations of net income, the practice has become less profitable over the years despite the growth of revenues. As a matter of fact, the expenses have grown at a rate of 15%, where revenue has only grown at a rate of 9% annually. You will want

Table 6.2. Sample Practice A.

	2007	2006	2005	2004	2003
Revenue	$698,733	$641,039	$588,110	$539,550	$495,000
Expenses	$647,132	$562,724	$489,325	$425,500	$370,000

Table 6.3. Sample Practice A with net income.

	2007	2006	2005	2004	2003
Revenue	$698,733	$641,039	$588,110	$539,550	$495,000
Expenses	$647,132	$562,724	$489,325	$425,500	$370,000
Net Income	$51,601	$78,316	$98,785	$114,050	$125,000

to see if this is a trend that you could have any control over changing or if it is due to the rising cost of salaries and rent, which would be difficult for you to affect with closer management. The second area of concern is when you go into an area where the growth and patient base are related to only one major employer. You need to assess the risk of this semiconductor company going out of business, downsizing, or sending its fabrication business offshore. Any of these actions could have a significant impact on your ability to maintain a viable dental practice because the large majority of patients come from this business.

Practice B (see Table 6.4) is located in a rural area that has seen little growth and stable income levels from farming.

The selling doctor has been in this practice for 12 years and is selling to move her family to a different state. The patient base is made up of employees and residents in a 50-mile radius from the practice. The existing doctor does minimal marketing and is compensated by cash payment or indemnity insurance payments.

In this example the first thing you will notice is that the productivity has been somewhat erratic, with a significant drop in 2005. When you complete the calculations for net income you will see in Table 6.5 that the practice actually suffered a loss during that year. So although this practice started in 2003 and 2004 with the identical financial pattern as Practice A, there was a large change in 2005. When you ask more questions you find that this doctor suffered a personal injury in 2005 that she was not comfortable revealing in the early phases of disclosure. She has shown good growth again since the injury, so this may be a good opportunity for you to pursue further.

In these two examples, you see some variations from the usual steady growth in profitability that occurs with many practices, but they illustrate the fact that you need to review the financial statements and use them as a source to continue a deeper evaluation of the practice you are considering.

Table 6.4. Sample Practice B.

	2007	2006	2005	2004	2003
Revenue	$540,250	$495,642	$359,250	$539,550	$495,000
Expenses	$466,475	$405,630	$420,219	$425,500	$370,000

Table 6.5. Sample Practice B with net income.

	2007	2006	2005	2004	2003
Revenue	$540,250	$495,642	$359,250	$539,550	$495,000
Expenses	$466,475	$405,630	$420,219	$425,500	$370,000
Net Income	$73,775	$90,012	–$60,969	$114,050	$125,000

Accounts Receivable

The accounts receivable (A/R) report will help you obtain a better understanding of the efficiency of the office and the systems that are in place for the financial management of patient accounts. The first item to evaluate in the A/R report is the quantitative aspect, which is the size of the A/R. For example, if the practice has an average production of $35,000 per month and the A/R report shows a total A/R of $100,000, there are some red flags about the collection processes and financial arrangements that are made in the office. An A/R of almost three times the monthly revenue is not a healthy number for an office to maintain, and this places a huge strain on the cash flow of the practice. You will want to look for a number that is closer to an A/R to revenue ratio of 1. The following examples illustrate what we are talking about:

A/R = $100,000
Revenue = $35,000
A/R / Rev = $100,000/$35,000 = 2.86
A/R = $35,000
Revenue = $35,000
A/R / Rev = $35,000/$35,000 = 1.00

Next you will want to make a qualitative assessment of the A/R. You should receive an A/R aging report, which gives you the A/R by the length of time since that receivable was accrued or when the treatment was posted to the patient's account.

Let's look at the example of Practices C and D (see Tables 6.6 and 6.7). Both practices have monthly revenues that average $46,000 and A/R of $88,000, giving us a slightly high A/R / Rev ratio of 1.91. On the surface, these two practices would look the same. However, as you look at the A/R aging report, you will see that Practice D is doing a really good job of collecting in the first 3 months, but there is a history of bad debt that is over 90 days old. Practice D has almost half of its A/R tied up in the over-90 category, which is much harder and less likely to be collected than the shorter-term receivables. This may be due to a change in financial policies in the practice, or a new staff

Table 6.6. Sample accounts receivable aging report for Practice C.

	<30 days	30–60 days	60–90 days	>90 days	Total
Accounts Receivable	$45,000	$23,000	$8,000	$12,000	$88,000

Table 6.7. Sample accounts receivable aging report for Practice D.

	<30 days	30–60 days	60–90 days	>90 days	Total
Accounts Receivable	$38,000	$10,000	$0	$40,000	$88,000

member who has come in and cleaned up the accounts. It is unlikely that you would want to purchase this A/R from the selling doctor, as you have only a small chance of getting a few pennies on the dollar with debt that goes out that far without more extensive collection processes, which you do not want to have as a new owner in the practice.

Existing Equipment Leases

The final item we mentioned above that you would request from the selling doctor is information on any existing equipment leases. In this case, whether you are buying or buying into the practice, you should understand how the business is committed to these leases and if you are going to take over the responsibility of such leases. We do not recommend this as a first option, but you must discuss that as part of your negotiation of the purchase price. For example, you have agreed that the equipment has a value of $180,000, and the dental units and a CAD CAM machine are included in that price. These items have another 8 years of payments remaining, so your first choice would be to make sure those obligations are paid off as part of the transaction, or you can work with your accountant and come up with a value that would account for the depreciation and the net present value of the remaining payments. This can become complicated, so it is in the best interests of all parties to pay these leases off as the transaction comes to a close.

Financial Forecasting

After you have obtained and reviewed, to your satisfaction, all of the financial information and reports from the selling doctor, the final step in performing your due diligence as it relates to the cash flow is financial forecasting. This is another area where your accounting professional can help you with his or her experience. One financial forecasting document that is created for a business is referred to as the pro forma income statement. This is basically the same as a standard income statement except for the fact that it is an educated guess of the forecast income, expenses, and profit or loss based on the historical information that you have at hand. This exercise of developing a pro forma income statement will help you evaluate the financial return potential of different purchase opportunities. It is also one of the financial documents that any lender will require if you are asking for a business loan. Figure 6.1 below is an example of a pro forma income statement for a fictitious practice showing that this specific practice purchase would cover the personal living budget of the doctor in Figure 6.2 and break even in the fifth month of this projection. (This is the first month that shows a positive net income.)

Operational Systems

The first and arguably most important management system has to do with staffing. As you evaluate the practice, you should review the number of staff

		Month 1 projected	Month 2 projected	Month 3 projected	Month 4 projected	Month 5 projected
REVENUES						
Dental Service Collections		45,000.00	45,000.00	45,000.00	45,000.00	50,000.00
Total Revenues		45,000.00	45,000.00	45,000.00	45,000.00	50,000.00
EXPENSES						
Variable Expenses						
Dental Supplies	8%	3,600.00	3,600.00	3,600.00	3,600.00	4,000.00
Laboratory Fees	9%	4,050.00	4,050.00	4,050.00	4,050.00	4,500.00
Total Variable Expenses		7,650.00	7,650.00	7,650.00	7,650.00	8,500.00
% of Rev		17%	17%	17%	17%	17%
Fixed Expenses						
Accounting		1,500.00	150.00	150.00	150.00	150.00
Advertising		500.00	500.00	500.00	500.00	500.00
Continuing Education		0.00	0.00	0.00	0.00	0.00
Dues and Subscriptions		150.00	150.00	150.00	150.00	150.00
Insurance-Disability		200.00	200.00	200.00	200.00	200.00
Insurance-Health		400.00	400.00	400.00	400.00	400.00
Insurance-Malpractice		400.00	400.00	400.00	400.00	400.00
Insurance-Workers Comp		450.00	450.00	450.00	450.00	450.00
Legal		2,000.00	0.00	0.00	0.00	0.00
Office Supplies		400.00	400.00	400.00	400.00	400.00
Payroll Taxes	8%	1,941.92	1,941.92	1,941.92	1,941.92	1,941.92
Postage and Delivery		250.00	250.00	250.00	250.00	250.00
Rent		2,500.00	2,500.00	2,500.00	2,500.00	2,500.00
Salaries-Office		4,864.00	4,864.00	4,864.00	4,864.00	4,864.00
Salaries-Assistant		3,040.00	3,040.00	3,040.00	3,040.00	3,040.00
Salaries-Hygiene		6,000.00	6,000.00	6,000.00	6,000.00	6,000.00
Salaries-Associate		0.00	0.00	0.00	0.00	0.00
Salaries-Doctor		10,370.00	10,370.00	10,370.00	10,370.00	10,370.00
Taxes and Licenses		500.00	500.00	500.00	500.00	500.00
Telephone		50.00	50.00	50.00	50.00	50.00
Travel, Meals, Entertainment		150.00	150.00	150.00	150.00	150.00
Total Fixed Expenses		35,665.92	32,315.92	32,315.92	32,315.92	32,315.92
% of Rev		79%	72%	72%	72%	65%
Total Operating Expenses		43,315.92	39,965.92	39,965.92	39,965.92	40,815.92
% of Rev		96%	89%	89%	89%	82%
NET INCOME (LOSS)		1,684.08	5,034.08	5,034.08	5,034.08	9,184.08
% of Revenue		4%	11%	11%	11%	18%
Bank Loan (Rate %)	10%					
Principal ($)	575,000.00	5,181.85	5,181.85	5,181.85	5,181.85	5,181.85
Total Bank Loan		5,181.85	5,181.85	5,181.85	5,181.85	5,181.85
% of Rev		12%	12%	12%	12%	10%
CASH FLOW CHECK		–$3,497.77	–$147.77	–$147.77	–$147.77	$4,002.23

Figure 6.1. Pro forma income statement.

Month 6 projected	Month 7 projected	Month 8 projected	Month 9 projected	Month 10 projected	Month 11 projected	Month 12 projected	Year 1 projected
50,000.00	50,000.00	55,000.00	55,000.00	55,000.00	60,000.00	60,000.00	615,000.00
50,000.00	50,000.00	55,000.00	55,000.00	55,000.00	60,000.00	60,000.00	615,000.00
4,000.00	4,000.00	4,400.00	4,400.00	4,400.00	4,800.00	4,800.00	49,200.00
4,500.00	4,500.00	4,950.00	4,950.00	4,950.00	5,400.00	5,400.00	55,350.00
8,500.00	8,500.00	9,350.00	9,350.00	9,350.00	10,200.00	10,200.00	104,550.00
17%	17%	17%	17%	17%	17%	17%	17%
150.00	150.00	150.00	150.00	150.00	150.00	1,200.00	4,200.00
500.00	300.00	300.00	300.00	300.00	300.00	300.00	4,800.00
0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
150.00	150.00	150.00	150.00	150.00	150.00	150.00	1,800.00
200.00	200.00	200.00	200.00	200.00	200.00	200.00	2,400.00
400.00	400.00	400.00	400.00	400.00	400.00	400.00	4,800.00
400.00	400.00	400.00	400.00	400.00	400.00	400.00	4,800.00
450.00	450.00	450.00	450.00	450.00	450.00	450.00	5,400.00
0.00	0.00	0.00	0.00	0.00	0.00	0.00	2,000.00
400.00	400.00	400.00	400.00	400.00	400.00	400.00	4,800.00
1,941.92	1,941.92	1,941.92	1,941.92	1,941.92	1,941.92	1,941.92	23,303.04
250.00	250.00	250.00	250.00	250.00	250.00	250.00	3,000.00
2,500.00	2,500.00	2,500.00	2,500.00	2,500.00	2,500.00	2,500.00	30,000.00
4,864.00	4,864.00	4,864.00	4,864.00	4,864.00	4,864.00	4,864.00	58,368.00
3,040.00	3,040.00	3,040.00	3,040.00	3,040.00	3,040.00	3,040.00	36,480.00
6,000.00	6,000.00	6,000.00	6,000.00	6,000.00	6,000.00	6,000.00	72,000.00
0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
10,370.00	10,370.00	10,370.00	10,370.00	10,370.00	10,370.00	10,370.00	124,440.00
500.00	500.00	500.00	500.00	500.00	500.00	500.00	6,000.00
50.00	50.00	50.00	50.00	50.00	50.00	50.00	600.00
150.00	150.00	150.00	150.00	150.00	150.00	150.00	1,800.00
32,315.92	32,115.92	32,115.92	32,115.92	32,115.92	32,115.92	33,165.92	390,991.04
65%	64%	58%	58%	58%	54%	55%	64%
40,815.92	40,615.92	41,465.92	41,465.92	41,465.92	42,315.92	43,365.92	495,541.04
82%	81%	75%	75%	75%	71%	72%	81%
9,184.08	9,384.08	13,534.08	13,534.08	13,534.08	17,684.08	16,634.08	119,458.96
18%	19%	25%	25%	25%	29%	28%	19%
5,181.85	5,181.85	5,181.85	5,181.85	5,181.85	5,181.85	5,181.85	62,182.17
5,181.85	5,181.85	5,181.85	5,181.85	5,181.85	5,181.85	5,181.85	62,182.17
10%	10%	9%	9%	9%	9%	9%	10%
$4,002.23	$4,202.23	$8,352.23	$8,352.23	$8,352.23	$12,502.23	$11,452.23	$57,276.79

PERSONAL MONTHLY BUDGET		
Regular Monthly Payments		
Rent or Mortgage	$2,500.00	
Automobile Loan	$600.00	
Appliances	$0.00	
Personal Loans	$0.00	
Educational Loans	$2,000.00	
Auto Insurance	$150.00	
Other Insurance	$0.00	
Miscellaneous	$0.00	
Total Regular Monthly Payments	**$5,250.00**	
% of Total Expenses		50.63%
Household Operating Expenses		
Telephone	$70.00	
Utilities	$200.00	
Other Household Expenses	$0.00	
Total Household Operating Expenses	**$270.00**	
% of Total Expenses		2.60%
Meal Expenses		
Dining at Home (Groceries)	$150.00	
Dining Out	$100.00	
Total Meal Expenses	**$250.00**	
% of Total Expenses		2.41%
Personal Expenses		
Clothing, Cleaning, Laundry	$75.00	
Pharmaceuticals	$50.00	
Medical/Dental	$175.00	
Charitable Gifts and Donations	$0.00	
Travel	$0.00	
Subscriptions	$100.00	
Auto Expense: Fuel/Maintenance/Parking	$200.00	
Other Spending Allowances	$0.00	
Total Personal Expenses	**$600.00**	
% of Total Expenses		5.79%
Tax Expenses		
Federal and State Income Taxes	$2,500.00	
Property Taxes	$1,500.00	
Other Taxes	$0.00	
Total Tax Expenses	**$4,000.00**	
% of Total Expenses		38.57%
TOTAL MONTHLY EXPENSES	**$10,370.00**	
Non-Business Income (Significant Other/Spouse/Investment)	$0.00	
NET MONTHLY PERSONAL CASH NEED	**$10,370.00**	

Figure 6.2. Personal budget.

members in each position and decide if the office is over- or understaffed. For example, if the one-doctor practice you are looking to buy has three people working at the front desk, but the revenue and activity in the practice only support one position, this may be an area where you could decrease expenses in the future. The opposite may also be true with a general practice that has a need for more staffing to maintain growth.

Another staffing consideration is if there is a family member of the selling doctor or a partner working in the office. This may create some conflicts or loyalty issues that should be considered and addressed in the beginning of the negotiation process. The turnover of staff is also important to note. Staff who have been in the office for a short period of time will not have the same connection with patients, and an entirely new team of doctors and staff may lead to a larger-than-normal attrition of patients after the transition. Staff who have been with a doctor for many years will take longer to develop a relationship of trust with the new owner as well. Finally, you should ensure that there is a good employee policy manual. This is important to outline some of the policies and procedures for the office and also to meet some of the nonmarket environmental regulations we discussed earlier. The bottom line with staff will be that they are the ones who help you succeed and you need to understand them, build a relationship with them early, and empower them to help you.

The computer system in the office will also provide you with some other valuable office systems information to review. You can look at the fee schedule in the office and make a decision on the appropriate nature of those fees. You can also review reports such as demographics on where patients are coming from and the types of procedures that are most commonly performed by the office to ensure a fit with your professional goals. The computer can also provide information on the number of new patients seen, cancellations, no shows, and the continuing care frequency and efficiency. All of this information will be important for you to understand how carefully patients are followed up and the growth of the practice through new patients.

Facilities and Equipment

Now that you have reviewed most of the information that can be obtained before visiting the office, it is time to go to the facility if you have not already spent some time there. You can start by getting a feel for the neighborhood and look for things like growth in housing, new schools, crime rate, and businesses in the area. Are there any issues with the lease or changes planned for the zoning of the area that may interrupt your business? You should also evaluate the actual structure from the outside and inside. Is there adequate parking for patients and staff? Is this the place you would love to get up and go to every morning? It is a good idea to take your digital camera and take a few photos or digital videos so you can remember the details and go back to them as needed. Another consideration is room to grow, if that is part of your future plans.

Next, look at the equipment. What is the condition of the equipment, and how has it been maintained? You want to make sure that you are not paying a high price for equipment that you will have to replace in a few short years. You also want to make sure that the equipment you will need is available for the treatment that you plan to provide for your patients. Do you need to have a computerized office with digital radiography? Do you need a CAD CAM machine or lasers? As you become serious about the transaction, you will also require an independent appraisal of the equipment value. Also, as discussed previously, ensure that there are no outstanding leases on the equipment that would remain after the transaction.

The charting system is also a critical evaluation. There are several things to look for here. Does the office use paper or digital charting? Make sure there is adequate notation and charting available that will not create a legal problem for you later. What are the referral patterns? What is the quality and thoroughness of the charting? Are there adequate radiographs of good quality for each patient? What kind of work has been completed on the patients? For example, are most patients fully restored, so you will have no work remaining on existing patients, or are most patients being monitored or patched and may see your treatment plans as aggressive? Another important part of this chart audit and evaluation is to actually make a count of active charts. This is an important step that also shows the health of the practice. There is no one right answer to this, and many varying opinions, but a one-doctor practice would be in a good position with 2,000 active charts, defined as patients seen in the last 2 years.

Evaluate how OSHA compliant the office is with the proper documentation manuals, material safety data sheets, and stickers warning of any hazards that may reside in the practice. Your visit to the office should give you a good sense of how well the office will fit with your personal style and goals.

Selling Doctor or Partners

Finally, you will want to look at the qualitative fit you will have with the selling doctor if buying the practice, or the selling doctor and remaining doctors if buying into the practice. A big mistake that can be made in this area is going into a practice where your personal style clashes with what the practice is used to. For example, you are relatively introverted and quiet and tend to concentrate with little chitchat while you are providing treatment for a patient. You buy a practice from a doctor who was well known by the staff and patients as someone who was extroverted and would never stop talking. He would tell stories and jokes throughout the entire appointment and sometimes run over because of this characteristic. It is possible that after you go into the office, you will start losing patients because they had come to expect and look forward to the banter with the selling doctor, or they suddenly think you do not like or care about them and that is why you are being so quiet. This same dilemma may occur if you are buying into a practice where you may lose patients to

other partners or never gain the support of the staff. As trivial as this may seem, it is an important part of considering which opportunity you choose.

You should also attempt to understand why the doctor is selling the practice and make sure it does not have to do with the decline of the business. You can also assess his or her interest in negotiating a price. Most doctors will want to be fair and come up with a transaction that will maintain the health of their patients and create a real win-win transaction for the buyer and seller.

Common Transactions

Buying into a Practice

When you are buying into a practice there will usually be two or more practitioners who remain in the office. You may be buying a share of an existing practice and creating a new partnership or buying out an existing partner who is leaving the group. You will have some form of a legal entity created after the transaction. The practice you are buying may exist as a sole proprietorship, limited partnership, general partnership, C or S corporation, or a limited liability company or partnership. After the purchase, you would go into the practice as a new shareholder, general partner, or limited partner depending on what structure you choose with your advisory team. See chapter 9 for a discussion of various forms of ownership. In most cases, there will be a shared patient base and shared liability. Solo-group and space-sharing agreements are not true partnerships, so they will most likely not be part of the final transaction.

Buying a Practice

When you are buying a practice, you will usually replace the existing doctor in the business. Unlike the buy-in option above, the final formulation of the business may include the sole proprietorship option as well.

Contracts

The purchase agreement for a healthcare practice is subject to several rules and regulations, so any time you are reviewing and signing a contract, you should obtain the appropriate legal advice from the team of professionals you establish as part of your business support group. You should also take care not to use the same attorney or accountant as the selling party, since your goals in some cases will be in direct conflict with one another. Some of the federal and state laws that will affect your transaction include but are not limited to those in the following list (Johnson 2002).

1. The state dental practice act and any other laws regulating the type and manner of ownership allowed for a healthcare practice in your state

2. Confidentiality laws such as the U.S. Department of Health and Human Services' Health Insurance Portability and Accountability Act of 1996 (HIPAA) that affect the privacy of patient information
3. State domestic property and divorce laws affecting the rights of a spouse to interests in the dental practice
4. Laws governing the covenant not to compete and liquidated damages
5. Statutes that relate to patient abandonment that could affect the transition process between treating doctors and how the patients are notified
6. Laws affecting the purchase of securities on the state or national level
7. Malpractice and professional liability laws and regulations
8. Laws affecting antidiscrimination at the state and federal level that could involve any portion of the transaction that relates to gender or ethnicity issues

Buying into a Practice

Buying into a practice will have some slight differences from buying a practice. The contracts for both will include the negotiated sale price, which will be a bit more complicated if you are already in the practice and growing it for the other owner(s). Some of the general contents of a practice buy-in or partnership agreement include

1. The offering will outline what you are buying and what portion of the business and profits will be attributed to you. The calculation of profit will need to be outlined clearly to include any income based on production and separation of net income or expense beyond that.
2. The management of A/R as it is accrued and collected.
3. Management responsibilities and a clear understanding of who is responsible for the management of staffing issues, marketing, operations, and expenses.
4. The allocation and calculation of expenses, benefits, payment, and taxes.
5. Insurance needs to limit the liability of each individual should be explored and defined so that everyone is covered in case of any unforeseen events.
6. Finally, as with any good partnership agreement, there should be a plan for dissolution so in a time of stress or conflict, the steps have already been clearly defined when everyone was cooperating at the beginning of the relationship.

Buying a Practice

Purchase agreements will have several formats and include a great deal of detail. Some of the general contents of a practice purchase agreement include

1. Financial terms: Although there are numerous articles and opinions about the financial terms and valuation of a practice opportunity, this topic is discussed in another section of this book, and we will not cover it in detail here. The important note here is that the financial terms of the transaction

should be negotiated in advance and clearly included in the agreement to buy or buy into the practice. Such terms would include the price, what is included in the price, and when and how it will be paid.

2. Purchase price and breakdown: This breakdown includes such items as equipment, A/R, supplies, furniture and fixtures, covenant not to compete, charts, tenant improvements, and goodwill. The important note here is that as you negotiate this breakdown of price, both parties should have the input of their tax advisors. The seller will generally want to place more value in items that will produce long-term capital gain and therefore be taxed at a lower rate, such as goodwill. The alternative for the seller is to pay tax on the items as ordinary income, which will be at a much higher rate, usually double, from 15% to 35%. The buyer, on the other hand, wants to have as much as possible in items that will be depreciated faster on his or her tax return like supplies, instruments, and A/R that are generally deducted in 1 year. The other options would be to depreciate the item over a longer period, such as equipment that would depreciate over 5 years or goodwill and covenants not to compete that depreciate over 15 years. Again, please consult your tax advisor, as these are only generalizations.
3. Assets/warranties: This section describes the assets being sold and any warranties made in relation to those assets. Usually all of the existing furniture, fixtures, and equipment will be included in this section.
4. A/R: This section covers whether or not the A/R are being purchased and how much they will be purchased for. For example, will you be paying 80 cents on the dollar or some other discounted rate due to the aging of the accounts? If you are not buying the A/R, then are you going to have a nominal collection charge that you will charge the seller for the resources used to make that collection?
5. Re-treatment: This section describes the way to handle any treatment completed recently by the selling doctor that the buyer would need to replace. Details of this should include time since placement, types of procedures, how the costs for replacement will be recovered, and other such related items.
6. Insurance: This section of the contract addresses any insurance-related matters such as how each party would include the other in malpractice insurance as appropriate. Chapter 21 of this book provides a discussion on insurances.
7. Custodian of records: This portion of the contract commonly identifies the buyer as the custodian of records for the seller, defines the records, and stipulates the length of time that he or she would need to retain those records.
8. Hold harmless: This section outlines the manner and extent to which each party would hold the other harmless in the event of any future action.
9. Contingencies: This section could cover any contingency on the contract from either party that would keep the contract from being completed and not place the individual in breach of contract.

These are some general comments on the more common aspects of a purchase contract and do not serve as legal advice.

Another contract that you will see often in a purchase transaction is the lease agreement. These agreements usually include some of the following sections:

1. Square feet and terms: This section describes the total square feet of space that you will be renting and the general terms.
2. Additional costs/NNN: Any additional cost or NNN fees that you will be responsible for such as common area maintenance will be outlined in this section.
3. Usable vs. rentable square feet: There may be a difference between the space you are paying for and what you actually have access to use.
4. As is or TI allowance: This section describes the allowance, if any, the landlord will give or has given for leasehold or tenant improvements.
5. Options: This is an important section to understand when going through a purchase agreement since you will want to have some options to renew your lease so you are not stuck having to pay for a move if the lease is due to expire soon. Many lenders will also require that the term of the lease and options will cover the length of the loan.
6. First right of refusal: This section will give you the right of refusal either for other dentists entering the building or for the first right to choose to purchase the building if it is going up for sale.

We hope that after reviewing this material, you are better prepared to make an informed decision on where you would like to work, what type of practice you will enter, and what you need to review and prepare before deciding to buy or buy into a dental practice. Practice purchase is one of the most important decisions you will make, and we wish you the best of preparation and opportunities.

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Learning Exercises

1. Identify the following as fixed or variable costs:
   A. Dental laboratory
   B. Staff salaries
   C. Credit card processing fees
   D. Rent
   E. Telephone
   F. Dental supplies

2. Calculate the net income for this practice (Table 6.8) and comment on how interested you would be in pursuing this opportunity to purchase the practice.

Table 6.8. Calculation of net income.

	2007	2006	2005	2004	2003
Revenue	$459,356	$567,000	$588,110	$583,000	$525,000
Expenses	$422,560	$438,250	$489,325	$425,500	$370,000
Net Income					

3. Please identify the following as components of a lease contract or a purchase agreement:
   A. Tenant improvements
   B. Accounts receivable
   C. NNN costs
   D. Covenant not to compete
   E. Custodian of records
   F. Options to renew

Answers

1. A, C, and F are fixed costs. B, D, and E are variable costs.
2. See Table 6.9.

Table 6.9. Answers for calculation of net income.

	2007	2006	2005	2004	2003
Revenue	$459,356	$567,000	$588,110	$583,000	$525,000
Expenses	$422,560	$438,250	$489,325	$425,500	$370,000
Net Income	$36,796	$128,750	$98,785	$157,500	$155,000

This would not be an interesting practice because there is unstable income that trends down over the last 3 years of data and the expenses have not been controlled. There may be an opportunity here to make the practice more efficient, but it is a risky proposition.

3. A, C, and F are lease contract items. B, D, and E are purchase contract items.

Chapter 7
Starting a Dental Practice

David Dunning, Steve Jacobs, Brad Alderman, and Jesse Neal

> The link between my experience as an entrepreneur and that of a politician is all in one word: freedom.
>
> Silvio Berlusconi

This chapter describes some of the critical variables and steps related to starting a dental practice. While the chapter is not exhaustive in its discussion of a practice start-up, you will find that most of the issues are presented, including specific step-by-step do-lists for starting a practice.

"I Want to Be My Own Boss"

Applicants for dental college are routinely asked, so, why do you want to be a dentist? or some variation on this question. Answers to this query often embrace references to caring for people and to "lifestyle" (a code of sorts referring to a relatively high income and freedom of work schedule). Another commonly heard and honest reply is, I want to be my own boss. The truth is that dentists tend as a group to be very independent people who enjoy calling the shots (no pun intended). This tendency often does not lend itself to being told what to do by others or to being an ideal employee who spontaneously abides by the wishes of an employer. Clearly, some individuals take the path of a practice start-up (or a practice buyout) simply because they are wired to be their own bosses. This "I want to be my own boss" mentality may also reflect in some dentists a more deeply abiding spirit of entrepreneurship.

Are You an Entrepreneur?

Exactly what is an entrepreneur? The Online Etymology Dictionary indicates that this concept originated from the French language, defining entrepreneur as "one who undertakes or manages." J.A. Timmons (1994) formulated this more precise definition: "Entrepreneurship is the process of creating or seizing

an opportunity and pursuing it regardless of the resources currently controlled."

Historically, entrepreneurship, like leadership, has been understood in terms of personal characteristics and skills. Here is an incomplete list: money-conscious, competitive, risk-taking, professional, self-control, self-confident, a sense of urgency, ability to comprehend complexity, realism, emotional stability, social networker, a high need to achieve, positive "can-do" attitude, ability to anticipate developments, results-oriented, technical knowledge, a hard worker, disciplined, a focus on profits, total commitment (BusinessTown.com 2007; Byers et al. 1997; Di-Masi 2007; Gaebler.com 2007; Tucker 2007; University of Alabama 2007).

You can get a glimpse, albeit perhaps not scientifically, of your entrepreneurial tendencies by doing an internet search for "entrepreneur quiz" and "entrepreneur test." A search in the summer of 2007 uncovered several such tests at these locations: bizmove.com, bcd.ca, bankrate.com, davincimethod .com. Use these with caution—the results may not be accurate for you, though you will likely get a sense of your inclination toward being an entrepreneur.

Your Sense of Efficacy: Do You Believe?

One newer approach focuses on an individual's entrepreneurship self-efficacy (ESE; Chen et al. 1998). That is, do you have a deep and abiding sense that you can achieve in this particular role, particularly along these five dimensions: marketing, innovation, management, risk taking, and financial control? This formal assessment of entrepreneurship seems to represent a distinct construct and also appears to have some capability of distinguishing entrepreneurs from others. A study in 2005 (Zhao et al.) showed that ESE helps to explain individual tendencies toward entrepreneurship and intentions to become an entrepreneur. The authors of this text are not aware of the general availability of the ESE assessment instrument.

So, what do the definition of entrepreneur/-ship, the admittedly incomplete list of entrepreneur characteristics, and the concept of entrepreneurial self-efficacy have to do with you? *Simply this: you are like the little engine in the children's classic story that "thought it could." If you think you can, you are much more likely to succeed. If you think you cannot, you are much more likely to be unsuccessful.* As applied to starting a dental practice, you really have to do a major "gut check." Even though you may have some doubt, you better believe deep down in your soul that you "can" do this before launching this adventure.

What Special Competitive Advantage Can You Leverage?

We are now going to contradict ourselves, at least partially. The definition cited previously about entrepreneurship included, "creating or seizing an opportunity and pursuing it *regardless of the resources currently controlled*" (italics added). It has been our experience that most successful dental practice start-ups involve

some special resource. The entrepreneur leverages this resource in order to make the practice start successful (namely, profitable) in a relatively short amount of time, perhaps weeks or months. Here is an incomplete but representative list of these types of resources: having an incredible level of energy to work 80–100 hours a week (this seems a bit more than being a hard worker from the earlier list); benefiting from the sage wisdom of a relative (grandfather/grandmother, parent, sibling, cousin, etc.) with business experience, particularly in dentistry; enjoying the obvious benefits of a parent who is a general contractor and who will build-out lease space or build a gorgeous facility at or near cost; locating the practice in an area in which you have unparalleled strategic and/or financial advantage. Examples of the last scenario would include a rural area with a population of 3,500 and no competing dentist within 25 miles; and start-up incentives from state or local government or community programs that might involve no or low-interest loans, property tax waivers, student loan forgiveness programs for practicing in designated shortage areas, and so on. Some of these unique leveraging opportunities might be able to be "stacked" or added on top of each other by creative entrepreneurs.

We, of course, are not saying it is impossible to start a practice from scratch without a competitive advantage such as those listed above. We are saying that such resources offer incredible assistance in launching a practice.

Other Considerations

Special Marketing Ideas

For a much more thorough treatment of marketing issues, please refer to the chapters on internal marketing/customer service (chapter 15) and external marketing (chapter 16). Our purpose here is, obviously, not to review the discipline of marketing but, rather, to convey a couple of successful approaches to marketing used by people who have started dental practices. Ted Turner is quoted as saying, "Early to bed, early to rise, work like hell and advertise" (Shapiro 2004). This aphorism has some application for practice start-ups. One of the coauthors of this chapter went literally from door-to-door in the surrounding neighborhoods to market himself and his practice. While a unique approach, especially for a professional services business, meeting and greeting hundreds if not thousands of potential patients provided a direct method for communicating with the public.

Another dentist we know opened a practice in a small town in the Midwest and utilized an existing facility from a previous dentist. His advertising strategy included a distinctive series of black and white contrast newspaper ads. He purchased a portion of a page that featured a simple image of a molar. Beginning with a small molar, the tooth "grew" with each weekly issue of the paper. After several weeks, with the community talking about what in the world the tooth was all about, the dentist then utilized the same page space

and announced the opening of his practice and the availability to schedule appointments. The simple and relatively inexpensive strategy worked effectively.

Special Real Estate Issues

A practice start-up raises concerns related to buying or leasing a practice facility. These parallel similar decision-making variables involved in buying/buying out a practice. However, with a start-up, the entrepreneurial dentist has no reliable patient cash flow and no accounts receivable. In all likelihood, a line of credit from a lender or some other revenue source (a spouse with steady and sufficient income) will have to fill the gap when the doors open in order to cover all the overhead expenses plus a minimal draw if needed as a living wage for the dentist.

Given this tenuous situation, the decision about buying or leasing a facility may be a sticky one. Monthly cash flow is one variable—that is, what it will cost to lease and what will be the monthly cost to make a mortgage payment plus insurance, real estate taxes, and upkeep. In most areas, it is more cost-effective to lease, especially when money is tight. This, however, is not always the case.

Dr. Gene Heller (2005), national director of Sullivan-Schein's Transition Services, identifies three criteria in deciding to buy real estate for a dental office: (1) if replacement cost is 50–75% (or less) in comparing the building/office to new construction, (2) if the building is anticipated to be in a good location for 7–10 years or more, and (3) if the building is large enough for the practice or can be expanded to be large enough. So, in addition to issues of cash flow and affordability, these three criteria need to be examined in making the decision to lease or buy real estate for a dental practice.

In addition, some people have more of a "renter" mindset and prefer to avoid the hassles of "ownership" (leaky roofs and plumbing leaks, for example). It does not appear obvious to us that a person starting a practice from scratch would tend to side one way or the other on this particular issue. Still, it must also be considered. One entrepreneur might prefer to focus on producing dentistry instead of a building. Another with superhuman energy levels and construction skills might relish fixing roof and plumbing problems.

Financing is another issue related to real estate. Recent graduates may have to push the tolerances of lenders in starting a practice due to the expenses of building-out lease-hold space and purchasing cabinets, chairs, equipment, technology, and supplies. While real estate in some sense involves less risk to a lender (given a building to resell if necessary), there may be limitations on the total amount to be borrowed in a more risky start-up venture. Thus, inability to get financing to purchase a practice facility may render moot the issue of buying a facility.

Finally, there exist some rare and lucrative opportunities, especially in rural areas, in which towns, cities, or owner-dentists may have some unique incen-

tives involving real estate for practice start-ups. We know of situations where a student has purchased a practice, in essence, for only the cost of a building (with older but serviceable equipment considered part of the price of the building). Obviously, not having to pay for any goodwill or blue-sky could readily "tip" the scales and make the purchase of a building a smart business move.

Equipment Issues

Chapter 5 provides detailed information about equipment issues within the context of practice ownership. We simply would like to remind anyone who starts a dental practice to have any used equipment inspected and maintained. Further, it is vital to have a trustworthy relationship with someone who can readily make a service call for "down" equipment. A fledgling dental practice being sustained in part by cash flow can ill afford to have a compressor fail and lose the income that would have been produced for, potentially, several days.

It is also vital to pay fair market value for any used (or new) equipment purchases for a start-up. If necessary, an independent appraiser can inspect and value used equipment.

One other comment related to equipment is noteworthy here. As nationally acclaimed registered architect-dentist Dr. Mike Unthank warns (and this is a paraphrase), any piece of equipment that says "dentist" on it, literally or figuratively, will cost more money (Unthank 2007). This may particularly apply to cabinetry. So, as always, be a wise consumer of what you purchase.

Business Plans and Financing

We believe a metaphor is helpful in understanding the importance of business plans and financing in starting a dental practice: you have to build a bridge over the span of a river to reach the other side of profitability. The bridge consists of all of your business decisions, your skill-set, and your indispensable staff. The river to be spanned consists of all the market forces and overhead expenses with which you must contend in building a practice. Depending on the source with whom you talk, and depending on market forces and overhead expenses, it may take from a few months to a year or more to "span the river"/ build the bridge to profitability. In other words, it is likely to take months before you can pay for your overhead AND earn a profit. For the initial months of start-up, you will likely need a line of credit from which you can borrow to pay for your living expenses, unless you have some wonderful support (such as a spouse with a solid income).

Chapters 2, 3, and 8 cover business plans, dentistry by the numbers, and financing a practice in great detail. The bridge to profitability reinforces the vital importance of these topics for a start-up situation. Your business plan can be augmented by building upon software programs such as Business Plan Pro and Matsco's Practice Success Series, which includes an interactive practice

planner to help establish expense and income projections. Make sure that your business plan includes available loan money, probably a line of credit, for spanning the river.

As far as financing a start-up, our advice is to persevere, persevere, and persevere. The lending industry seems to ebb and flow in mysterious and unpredictable ways with market nuances. In other words, it is sometimes relatively easier and more difficult to obtain loans for start-ups. In any case, if you are turned down by one lender, especially a bank, we encourage you to go to another, and to another, and to another if necessary.

The Step-by-Step Process for Starting a Practice

> You cannot overestimate the need to plan and prepare. In most of the mistakes I have made, there has been this common theme of inadequate planning beforehand. You really cannot over-prepare in business!
>
> Chris Corrigan

Two of the coauthors of this chapter prepared "start-up" checklists in beginning their practices. Dr. Steve Jacobs, whose wife, Trista, is a certified public accountant, created the first list (Table 7.1) based originally in part on the third list (Table 7.3), which Matsco generously allowed us to reproduce here. Accordingly, there is some redundancy in comparing Dr. Jacobs's list and Matsco's list, but enough unique points warrant inclusion of both lists. Dr. Brad Alderman then built upon Dr. Jacobs's detailed list (Table 7.2). Together, we believe that most of the critical steps you need to accomplish to start a dental practice are covered in the three lists. The lists have demonstrated their indispensable value over the years with many students.

The lists provided by Drs. Jacobs and Alderman, combined with the comments by Dr. Neal, offer perspectives from different markets. The first market is a small city in the Midwest with relatively favorable demographics for a start-up. The second is a city in the Midwest with a relatively competitive market. The third is a very small town in the rural Midwest in desperate need of a dentist. It might be possible, though admittedly more challenging, to start a practice from scratch in a market more competitive than that entered by Dr. Alderman, as described below. Importantly, if you are considering a start-up in a larger metropolitan area, please study Dr. Itaya's business plan (chapter 2) for a practice start in the San Francisco Bay Area county of San Mateo (with a population at the time of this writing of approximately seven hundred thousand residents).

The American Dental Association has also developed a "New Practice Checklist." It is available for members at www.ada.org. It lists thirty-six items in twelve categories, detailing some of the key issues involved in opening a new practice. Categories include licensure, regulations, insurance, infection control and OSHA, and staff.

Table 7.1. Dr. Steve Jacobs's new dental practice start-up list and timeline.

Task	Time Frame		Done by Steve (S) or Trista (T)
	Begin	End	
Develop overall marketing plan (see chapters 15 and 16 for assistance with ideas)	10/1/2001	10/31/2001	S
Complete an annual projected budget of expenses	10/1/2001	10/31/2001	S
Decide whether to lease or buy building	10/1/2001	10/31/2001	S
Find a good attorney (network as needed for this)	10/1/2001	10/31/2001	S
Complete paperwork for business loan	10/1/2001	11/30/2001	S
Look at equipment in Brookings	10/1/2001	12/31/2001	S
Look at equipment from used dealer	10/1/2001	12/31/2001	S
Make a list of equipment to purchase new	10/1/2001	12/31/2001	S
Study and purchase disability insurance	10/1/2001	12/31/01	S
Develop job description for each position	11/1/2001	1/31/2002	T
Create list of interview questions for each position	11/1/2001	1/31/2002	T
Research local rates of pay	11/1/2001	1/31/2002	S
Document salary/hourly rates and benefits to offer each position	11/1/2001	1/31/2002	T
Network for hiring staff	11/1/2001	5/31/2002	S
Hire receptionist	11/1/2001	5/31/2002	S
Hire assistant	11/1/2001	5/31/2002	S
Hire hygienist	11/1/2001	5/31/2002	S
Identify local major employers' insurance plans and decide whether to join them	12/1/2001	12/31/2001	S
Evaluate pros and cons of membership in managed care plans and decide which, if any, to join (capitation, PPOs, etc.)	12/1/2001	12/31/2001	S
Be aware that one in seven dentists is embezzled and have safeguards in place to discourage attempts	12/1/2001	12/31/2001	T
Possibly get special local license/permit	12/1/2001	12/31/2001	T
Make a due date list of all tax forms to be filed (payroll, income, sales, property)	12/1/2001	12/31/2001	T
Design office with supply representative (or architect)	12/1/2001	1/31/2002	S
Renovate facility	12/1/2001	3/31/2002	S
Obtain loan approval	1/1/2002	1/31/2002	T
Create consents	1/1/2002	1/31/2002	S
Have supplier representative appraise used equipment	1/1/2002	1/31/2002	S
Order equipment, office, and dental supplies	1/1/2002	4/30/2002	S
Post staff openings at schools	1/1/2002	5/31/2002	S
Place newspaper ads for staff openings	1/1/2002	6/30/2002	S
Have systems in place to comply with OSHA and HIPAA guidelines and requirements	2/1/2002	2/28/2002	S
Arrange for equipment storage, if necessary	2/1/2002	2/28/2002	S
Start a list of patients to recruit (friends, neighbors, nearby businesses)	3/1/2002	3/31/2002	S
Make a policy on accepting insurance assignment benefits and whether to bill insurance for patients or not	3/1/2002	3/31/2002	S

Table 7.1. *Continued*

Task	Time Frame		Done by Steve (S) or Trista (T)
	Begin	End	
Outline ideal day so that there will be a balance of small restorative, large procedures, new patient exams, and hygiene	3/1/2002	3/31/2002	S
Preblock a portion of daily schedule for significant treatment to meet production goals	3/1/2002	3/31/2002	S
Select dental software system	4/1/2002	4/30/2002	S
Write practice vision/mission statement identifying ideal patient, the quality of care to provide, and type of practice environment to create	4/1/2002	6/30/2002	S
Train on computer software	5/1/2002	5/31/2002	S, T
Get a telephone number (after becoming licensed)	5/1/2002	5/31/2002	T
Get business cards and plan for use	5/1/2002	5/31/2002	T
Develop procedures for daily data back-up disks to be made with weekly updates to a disk set stored off-site	5/1/2002	5/31/2002	T
Arrange for payment options like credit cards, healthcare credit cards, ATM, etc.	5/1/2002	5/31/2002	T
Arrange to file electronic claims from office dental software	5/1/2002	5/31/2002	T
Have a manual or computer new patient log to track names, referral sources, amount diagnosed, amount accepted/appointed	5/1/2002	5/31/2002	T
Get DEA license from U.S. Department of Justice	5/1/2002	5/31/2002	T
Register with South Dakota Division of Public Health to prescribe controlled drugs	5/1/2002	5/31/2002	T
Order laboratory prescription pads from South Dakota Dental Association	5/1/2002	5/31/2002	T
Study and purchase malpractice insurance	5/1/2002	5/31/2002	T
Study and purchase workers' compensation insurance	5/1/2002	5/31/2002	T
Study and purchase general business liability insurance	5/1/2002	5/31/2002	T
Study and purchase personal property insurance	5/1/2002	6/30/2002	T
Get dental license	5/1/2002	7/31/2002	S
Have equipment delivered	6/1/2002	6/1/2002	S
Have personnel policies in writing and ready to be distributed to employees	6/1/2002	6/30/2002	T
Document standard operating procedures for my office (or buy off-the-shelf model)	6/1/2002	6/30/2002	T
Ensure that billing statements to patients list a specific due date	6/1/2002	6/30/2002	T
Develop cancellation policy with financial penalties for repeated appointment failures and sample patient warnings and dismissal letters	6/1/2002	6/30/2002	S
Have x-ray equipment examined and licensed by South Dakota Department of Health	6/1/2002	6/30/2002	T
Get South Dakota tax license	7/1/2002	7/31/2002	T

Table 7.1. *Continued*

Task	Time Frame		Done by Steve (S) or Trista (T)
	Begin	End	
Get certificate of incorporation from South Dakota Secretary of State	7/1/2002	7/31/2002	T
Prepare to do hygiene until a full-time hygienist can be afforded	7/1/2002	7/31/2002	S
Draft articles of incorporation	7/1/2002	7/31/2002	T
Open bank account in corporation's name	7/1/2002	7/31/2002	T
Get Employer Identification Number	7/1/2002	7/31/2002	T
Obtain nitrous license	7/1/2002	7/31/2002	S
Network: physicians, pharmacists, nearby business owners, real estate agents, specialists, beauty/nail salons, plastic surgeons, community activities, sports teams, etc.	7/1/2002	7/31/2002	S
Develop a script for asking patients for referrals and plan to practice these skills with staff	7/1/2002	7/31/2002	S
Make bank deposits daily after checking a day sheet	7/1/2002	7/31/2002	S
Preappoint all hygiene patients for their next prophy	7/1/2002	7/31/2002	S
Reduce hygiene cancellations by use of reminder postcards as well as confirmation calls sent 2 days in advance	7/1/2002	7/31/2002	S
Develop system to track delayed or unaccepted treatment and actively urge patients to complete needed treatment now	7/1/2002	7/31/2002	S
Use computer or manual reports to track at least the following statistics: monthly/year-to-date production (dr. or hygiene), collections, new patient numbers, adjusted production due to managed care, total monthly expenses, and accounts receivable	7/1/2002	7/31/2002	T

It is critically important to recognize the value of other information in this book when reviewing/studying these lists for starting a dental practice. Virtually all of the other chapters inform, affect, or clarify these lists of steps, from chapter 2, to chapter 3, to the chapters related to staffing, to the chapters in the money management section, to the chapter on various insurance needs you will have.

Dr. Jacobs's Steps for Opening a Practice

Dr. Jacobs refurbished an existing but unused dental office space in Brookings, South Dakota, a small city with a population of approximately twenty thousand and a market area of approximately twenty-five thousand. He opened his practice within weeks of graduation. This practice was not ideally located. Instead, alley access was necessary to enter the facility.

Table 7.2. Journey to succeed: Dr. Brad Alderman's dental practice start-up guidelines.

X	Task
	Buy existing practice or start my own.
	Visit other dental offices—ask questions!
	Complete paperwork for business loan.
	Location, location, location—find the right one!
	Shop for business loans—start with local bank, be tough, and don't take "no" for an answer!
	Find an attorney.
	Look early for used dental equipment—might find great deals.
	Meet with dental equipment vendors—don't be oversold—you are the customer!
	Network for hiring staff—look to the dental community.
	Start your office manual—be thorough but remember that it will change over time.
	Research local rates of pay.
	Hire staff—be picky—they represent you!
	Start a marketing plan—think outside the box!
	Decide whether or not to be a preferred provider for insurance companies, accept Medicaid, etc.—you do not have to be a PPO just because you're slow!
	Find accountant—call dentists in the area for suggestions.
	Office design can be done by equipment representative or an architectural design group such as Unthank Design Group (www.unthank.com).
	Order equipment, office, dental supplies.
	Start a list of patients to recruit.
	Announce opening of dental office—I couldn't advertise my name without a license, but I hung a sign that said "Dental Office—Open June."
	Select dental software.
	Train on dental software with all employees.
	Obtain a telephone number—ask for a number that will be easy to remember (5555).
	Get business cards for myself and staff to use.
	Think about financial policies for the office/put financial policies in writing—sign up with third-party financing (care credit), do not be a bank!
	Get DEA license from U.S. Dept. of Justice, www.dea.gov.
	Find malpractice insurance.
	Find office overhead insurance.
	Get dental license.
	Develop cancellation policies for the office.
	Have x-ray generating equipment licensed by Nebraska Dept. of Health.
	Get Nebraska tax ID number.
	Get articles of incorporation from attorney.
	Walk through "typical" day with employees.
	Advertise yourself—ask for referrals, carry business cards, beat the streets!
	Send W-9 to insurance companies so you can submit claims.
	Develop continuing care systems.
	Make sure every patient is scheduled for his or her next appointment prior to leaving.
	Collect all of patient's portion of payment the day service is rendered.
	Strive for portion of daily schedule to be used for productive treatment to meet production goals—tough to do when first starting out.
	Excellent customer service training for all employees.
	Employees trained on emergencies that could arise in the office.

Figure 7.1. Dr. Brad Alderman's reception desk in Coddington Dental, Lincoln, Nebraska.

Dr. Brad Alderman's Additional Steps

Dr. Brad Alderman built out lease space in a very tight dental market in Lincoln, Nebraska, starting his practice in a location with few if any closely located competitors. Lincoln is a city of approximately two hundred fifty thousand and is perceived by many to have more dentists than it needs, in large part because the University of Nebraska Medical Center's College of Dentistry is located there. Like Dr. Jacobs, Dr. Alderman opened his dental practice within weeks of graduating from school (Figure 7.1). Dr. Alderman enjoyed so much success in starting a practice from scratch that, 3 years later, he helped his wife, Dr. Katherine Alderman, start a practice after graduation in another strategic location in Lincoln's competitive market (Figure 7.2).

Thoughts from Dr. Neal about Starting a Practice

Dr. Jesse Neal completed a general practice residency in the first year after graduation. He then served a year as faculty at the residency, and then a year as a staff dentist in a dental college. At the same time he also was an associate in private practice for 2 and a half years 1 day a week. He then renovated space in a former dental office, which had been closed for 5 years, in the small town of Alma, Nebraska, and opened his office. Here he shares his reflections based on the previous information in this chapter and his experiences.

"Starting a dental office from scratch does require that you are an entrepreneur: It is a strenuous and stressful endeavor. However, I have found it to be very rewarding. The best foundation you can build on for your office is starting with a vision. During 3 years of residency, being an associate, faculty, and

Figure 7.2. Dr. Brad and Katherine Alderman's North Star practice in Lincoln, Nebraska.

visiting dozens of potential offices to purchase or join, I began to develop a very clear picture of what type of practice, office, and dentistry I wanted to provide. Having a vision is important to developing the practice that will allow you to achieve your personal and professional goals.

"What all should be included in that vision? First and most important is what type of dentist you are going to be and what type of dentistry you are going to provide. Dr. Jacobs's list aptly advises you to look at your ideal day and your ideal patient; both exercises are wonderful tools in aiding you in developing your vision. You should also start thinking about your office design, staffing, technology, and where you see the practice in 5, 10, or 20 years. There are many variables to consider when starting from scratch, and it can begin to get overwhelming. There are no existing procedures or protocols, and establishing them demands extra work and time from you to develop; however, it also gives you a wonderful opportunity to do it the way you want. Taking the time to use or develop lists and checklists like the ones present in this chapter help you get a wonderful start and relieve much of the anxiety. The more time you take to work on your vision will make all the steps and decisions much easier along the way for all your decisions. In my office, the employee manual, patient forms, new patient exam, and many other things were all fluid documents and processes that changed many times in the first year until I was comfortable and satisfied with the right forms and procedures. There are many wonderful resources available that provide you with general documentation and procedures. Mine were taken from a mixture of sources and then tailored to fit my specific needs.

"My practice's mission statement captures some of the vision I had for my office, which guided me through all these steps: *Alma Family Dentistry desires*

to provide excellence in the field of dentistry. We seek our patient's trust, and are committed to meeting their short- and long-term comprehensive oral health care needs, while encouraging and supporting overall patient wellness. Having a vision and really taking the time to set goals for yourself and your practice will help guide and direct your practice both now and in the future. The time spent to do this is worth the effort because it always gives you a point of reference as to what is important to you when changes or opportunities present themselves.

"Along with a vision, you also want to find a core group of consultants you trust who are looking out for your interests and desire to be an advocate for you (see chapter 1 for information on selecting key advisors). This group is an invaluable resource that can aid in helping you avoid many common pitfalls.

"Visiting dental offices and talking to dentists who have been through the start-up process also can be valuable. It does take time, but the more practices you are able to visit, the more quickly you will realize your style and how you want to develop that style. Do not just look at how fast a dentist performs a crown prep, or how many patients he sees in a day. Look at how the office runs; look at the flow and layout of the office, and how the staff interacts as a whole. Ask yourself questions such as, do I want rear or front delivery systems? and how much and which technology do I want to incorporate into my office? These may sound like simple questions, but I have found many young dentists focus on how fast they can do a procedure rather than looking at other areas that affect efficiency. Speed will come with time. Remember, it is always faster doing it right the first time. Everyone's situation is unique, and one method that worked for somebody does not apply to every situation.

"I was able to start with an all-digital, completely paperless office, with all new equipment (Figures 7.3 and 7.4); however, I went to a rural area where a state loan repayment program was in place, and I also received help from the

Figure 7.3. Dr. Jesse Neal's Alma, Nebraska, practice before remodeling.

Figure 7.4. Dr. Jesse Neal's Alma, Nebraska, practice after remodeling.

community in providing a building in which they provided the leasehold improvements. With this advantage, I was able to invest in the equipment I wanted—not everyone will have this advantage. I also want to make clear that with all the diversity in practices and situations, many of the guidelines and principles found in this chapter and book will still apply to a majority if not all situations. These guidelines are a great help when visiting with other dentists, for not all advice is sound advice. I started in a community of 1,200 people with a surrounding population of 3,900. The nearest community with dental care available was 25 miles away. Statistics show that these are favorable numbers for a start-up practice, which they have proven to be in my case. However, I remember a handful of dentists telling me it was too rural of an area and too much of a risk. In fact, with no previous office in the area, the bank could not compare or see historical numbers, which made it somewhat difficult to secure financing. I was told financing would be no problem as a young dentist with experience and great credit history, so I was surprised no local bank was willing to finance the project without a substantial down payment or a co-signer. Therefore, we chose to go with one of the national lenders specializing in dentistry. We needed no money down and no co-signer; however, we are paying for these conveniences through fees, a slightly higher rate, and with a contract that does not allow the loan to be prepaid.

"Supply representatives and equipment specialists are another area that can provide a lot of help during a start-up. A key point to remember is that this is a business relationship, and these individuals are sales people. You want to convey your goals and objectives very clearly with these people to ensure complete understanding. I made the mistake of not communicating clearly and faced some problems because of it. While securing financing, I was only given broad estimates for supplies and small equipment that I was 'told' I would

need. I did not establish a list for myself, nor did I compare prices. Consequently, my supplies and small equipment did not turn out to be the 'ideal' purchases I specifically would have chosen. In the end, all that 'little stuff' added up to much more than anticipated, forcing me to use some working capital to purchase supplies, and subsequently sending less important equipment back. Remember, you have a budget and usually limited financing, so having a vision helps weed out many of the items or equipment that would be nice, but practically speaking, may be purchased at a later date. I also purchased three different chairs. However, out of the three, two were new, one being a higher-priced chair, the other in the middle of the price spectrum. The third was a used chair with new upholstery. With large variations in price, my patients never comment on, nor do I believe, notice a large difference between the chairs. Looking back it would have been a more economical decision to start with needs and add to as you are able to cash flow. This is all advice I received but did not fully appreciate until now.

"One other thing I did in my first year that proved to be very beneficial was to make continuing education a priority, along with the decision to join a local study club. I found that any time you invest in yourself through continuing education or study clubs, you are investing in the overall health of your practice and patients. It is especially difficult to leave a new practice because of all the demands to be there to build it up and make the money you need to sustain it. Still, do not allow this to dictate whether or not you can attend continuing education. An opportunity for you to become a better clinician is well worth the time and can become a positive return on investment by producing better skills and patient care. The fact that my CE (continuing education) was located in beautiful St. Petersburg, Florida, helped me to reflect on the direction my practice was going and to relax. The study club, which also takes time, has helped me develop valuable relationships with other dental professionals in the area.

"In summary, I have experienced a full range of emotions from excitement to disappointment. I must say, though, I enjoy dentistry and have generally enjoyed my start-up experience. My wife has stated many times she wishes we would have started this process 5 years earlier or later. During the start-up we had three very young children (three under 3 years), and starting your own business can be a very time-consuming, busy, and intense process. In the beginning I allowed it to take more time from my family than I should have. Work is never-ending when you have your own business; there is always something to work on. I could spend 80–100 hours a week at the office and still feel the burden of unfinished work. Just like you need a vision, goals, and great counsel in your business, do not forget your personal life. Take the time to set goals and make time for yourself and your family. One great lesson I have learned is to leave work at work, and I am trying to live my life in the order that I state my priorities are in. Dentistry is a wonderful profession, but it is not the only part of our lives.

"To all those considering start-ups, I wish you all the best and hope that I have given you some valuable insights for you to consider and apply."

Table 7.3. Matsco's start-up checklist: checklist for dentists starting a new practice.

		Done and Acceptable	Done and Not Acceptable	Not Yet Done	Not Applicable
I.	Staffing				
	1. I have a plan for hiring my staff through networking, newspaper ads, and posting my openings at local trade schools/colleges	☐	☐	☐	☐
	2. I have job descriptions for each position for which I plan to hire	☐	☐	☐	☐
	3. I have a list of powerful questions to use to interview candidates for staff openings	☐	☐	☐	☐
	4. I am prepared to do hygiene as well as restorative treatment on my patients until I can justify and afford to pay a hygienist	☐	☐	☐	☐
	5. I have researched local rates of pay and have documented the salary or hourly rates and benefits I will offer for each position in my practice	☐	☐	☐	☐
	6. Personnel policies are in writing and ready to be distributed to every employee	☐	☐	☐	☐
	7. I have documented standard operating procedures for my office (or purchased off-the-shelf models)	☐	☐	☐	☐
II.	Marketing				
	1. I have written a practice vision/mission statement identifying my ideal patient, the quality of care we will provide, and the type of practice environment we will create	☐	☐	☐	☐
	2. I have started a list of patients I ideally would like to recruit for my practice (friends, neighbors, nearby businesses, former patients [without violating any noncompete covenants], etc.)	☐	☐	☐	☐
	3. I have a plan to announce my new practice	☐	☐	☐	☐
	4. A marketing plan has been written, or at the very least I listed monthly activities I will conduct to market my new practice	☐	☐	☐	☐
	5. I have budgeted for monthly marketing costs tied to the overall marketing plan	☐	☐	☐	☐
	6. I plan to network with: physicians, pharmacists, other nearby business owners, real estate agents, specialists, beauty/nail salons, plastic surgeons, community activities, sports teams, etc.	☐	☐	☐	☐
	7. I have a script for asking patients for referrals, and I plan to practice these verbal skills with my staff so that we will ask a patient for a referral daily	☐	☐	☐	☐
	8. I have business cards and a plan for me and each staff member to use them to network	☐	☐	☐	☐
III.	Computer				
	1. I have selected a dental software system and have been trained to operate it	☐	☐	☐	☐
	2. I have a set of procedures for daily data back-up disks to be made with weekly updates to a disk set stored off-site	☐	☐	☐	☐

		Done and Acceptable	Done and Not Acceptable	Not Yet Done	Not Applicable
IV.	Cash Flow Plan				
	1. I have completed an annual projected budget of expenses	☐	☐	☐	☐
	2. I have arranged for payment options like credit cards, ATM, etc.	☐	☐	☐	☐
	3. Billing statements to my patients will list a specific due date, not just "upon receipt"	☐	☐	☐	☐
	4. I have a policy on accepting insurance assignment benefits, and whether we will bill insurance for my patients or not	☐	☐	☐	☐
	5. I will file electronic claims from my office software	☐	☐	☐	☐
	6. I have identified local major employers' insurance plans and decided whether to join those plans or not	☐	☐	☐	☐
	7. I have evaluated the pros and cons of membership in managed-care plans and made a decision (capitation, PPOs, etc.)	☐	☐	☐	☐
V.	Appointment Scheduling				
	1. I have outlined my ideal day so that there will be a balance of small restorative, large procedures, new patient exams, and hygiene	☐	☐	☐	☐
	2. I will preblock a portion of my daily schedule for significant treatment to meet production goals	☐	☐	☐	☐
	3. A cancellation policy is in place with financial penalties for repeated appointment failures and sample patient warning and dismissal letters	☐	☐	☐	☐
IV.	Embezzlement Safeguards				
	1. I am aware that one in seven dentist is embezzled and have safeguards in place to discourage attempts at embezzlement	☐	☐	☐	☐
	2. I will make my own bank deposits daily after checking a day sheet	☐	☐	☐	☐
VII.	Continuing Care				
	1. We will preappoint all hygiene patients for their next prophy	☐	☐	☐	☐
	2. We will reduce hygiene cancellations by use of reminder postcards as well as confirming calls sent 2 days in advance	☐	☐	☐	☐
	3. We have a system to track delayed or unaccepted treatment and will actively urge patients to complete needed treatment now	☐	☐	☐	☐
VIII.	Numbers Tracking				
	1. A manual or computer new patient log will track names, referral sources, amount diagnosed, and amount accepted/appointed	☐	☐	☐	☐
	2. I will use computer or manual reports to track at least the following statistics: monthly/year-to-date production (doctor and hygiene), collections, new patient numbers, adjusted production due to managed care, total monthly expenses, and accounts receivable	☐	☐	☐	☐
IX.	OSHA Guidelines				
	1. I have systems in place to comply with OSHA guidelines and requirements	☐	☐	☐	☐
	2. I have assigned OSHA officer duties to one of my staff members.	☐	☐	☐	☐

Matsco's Start-Up Checklist

Matsco's practice start-up checklist is reproduced here with permission. The Matsco start-up checklist is available at www.matsco.com. Click on New Dentist, then Planning Tools. The checklist appears in the resource book entitled *Start-Up Primer.*

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Learning Exercises

Practice Start-Up Case #1: Rural Midwest

You grew up in the rural Midwest and are considering starting a practice from scratch in a county that the state has designated as a “shortage” area. The small town you have your eye on has a population of 1,100 and the county a total population of 2,000. The nearest dentist is a 30-mile drive from the town in another county. The total population of the four adjacent counties is 6,000 with three dentists, one of whom is 70 years of age and practices about 20 hours a week.

As you contemplate this possibility in the spring of your D-3/junior year of dental school, what are some of the key variables that need to be considered/managed?

Some Key Variables and Questions to Consider

Do you have an inclination toward being an entrepreneur? Do you have entrepreneurial self-efficacy?
Do you anticipate anyone else competing in this larger market in the next several years?
What resource can you leverage to maximize your chances of success?
Will the community, county, or state provide any special financial assistance?
What strings are attached to any such assistance?
What is the general and projected health of the local economy?
Are there any major employers in the area?
What is the income profile of the population? Its dental IQ?
Is there any insurance coverage for some of the population?
What are the reimbursement rates?
What space is available to renovate? Building a new facility may be a challenge financially and practically.
What assistance can a dental supplier provide for you?
What kind of advisors will you need, and when?
What will it cost to renovate space and to buy needed equipment and supplies?
What kind of financing will you seek? What kind of a business plan will you need to develop, and how will you develop it?
Are qualified staff available to be hired? Are you willing to practice for a time without a hygienist? It may be difficult to recruit one to the area.

Practice Start-Up Case #2: Front Mountain Range of Colorado

You grew up in Quite Lovely, Colorado, and would like to start a practice from scratch there. Quite Lovely's population is growing at about 5% per year and currently is 80,000. Other growing communities are within 15 miles of Quite Lovely, but you anticipate that nearly 100% of your patients live in or very near Quite Lovely.

There are thirty-five general dentists in Quite Lovely, eight of whom are over 65 years of age and could possibly retire in the next 5 years or so. The practicing community appears to be quite "closed," meaning that practitioners seem reluctant to share information about their practices and are somewhat skeptical about the need for another dentist. In fact, even your childhood family dentist told you, "I'm not sure you can start a practice from scratch here and succeed. I'm not sure we need another dentist right now."

As you contemplate this possibility in the spring of your D-3/junior year of dental school, what are some of the key variables that need to be considered/managed?

Some Key Variables and Questions to Consider

Is your family dentist correct about the need for another dentist? How confident are you about the market and the need?

Is there someone looking to sell an existing practice or perhaps would be interested in an associate-to-buyer transition in the next 2 years? How might you try to discover such opportunities?

Do you have an inclination toward being an entrepreneur? Do you have entrepreneurial self-efficacy?

Do you anticipate anyone else competing in this market in the next several years?

What resource can you leverage to maximize your chances of success?

What is the general and projected health of the local economy?

Are there any major employers in the area?

What is the income profile of the population? Its dental IQ?

Is there any insurance coverage for some of the population?

What are the reimbursement rates?

What space is available to renovate? Building a new facility may be a challenge financially and practically.

What assistance can a dental supplier provide for you?

What kind of advisors will you need, and when?

What will it cost to renovate space and to buy needed equipment and supplies?

What kind of financing will you seek? What kind of a business plan will you need to develop, and how will you develop it?

Chapter 8
Financing a Practice

Judy Jennings

Introduction

Many new dentists worry about obtaining essential first-time financing through a commercial loan. Although most have acquired a student loan, many new doctors are not prepared to approach a commercial lender. They are understandably concerned that they will not meet the basic requirements for approval. This chapter seeks to demystify the lending process in dental acquisition.

Financing Dental Transitions—The State of the Industry

In today's commercial lending environment, dental transition financing can cover up to 100% of the purchase price and can also include additional working capital. The most likely lender will meet underwriting criteria specific for dentistry and will have a portfolio or group of past loans from which inferences have been drawn and risk mitigated.

Other sources of lending for new dentists include seller financing, local or community bank financing, and loans secured by the U.S. Small Business Administration (SBA), in association with another lender. In general, all lenders are looking for borrowers with demonstrated ability to manage debt, as evidenced by a satisfactory review of personal credit.

Few other start-up small businesses have access to this type of 100% financing. Dentists have an attractive record of paying their commercial loans in full and on time. Their default rate is low. Whether this is due to favorable demographics or ethical character and professionalism, or both, lenders do favor doctors with good personal credit and allow them to finance a qualified practice at 100% with favorable terms. The specifics of achieving such financing will be explored throughout this chapter.

Historical Perspective

Only as recently as the 1980s did the dental industry accept that practices had a value (outside of their equipment) that could be transferred. Most doctors in

the 1970s had only the options of working for another doctor (which few did) or "hanging out a shingle" and starting from scratch.

When appraisal and evaluation of "goodwill" became accepted, few lenders could get comfortable with these "blue-sky" transactions. If a practice was sold, the seller would have been the only option for financing available to the new doctor.

Many of these internally financed loans had their pitfalls. Sometimes the loan might hinge on the seller's staying on as an employee. If the relationship did not work out, it was hard to fire the practice "banker." Some of these transactions lacked the due diligence necessary to determine whether the buyer could afford or had sufficient cash flow to take on the practice loan. Without the lender's objective input, such analysis never occurred. Without the analysis, the buyer did not know if the practice's cash flow would support his or her lifestyle. The results could be painful.

Sellers also disliked the risks associated with being the bank for their buyers. At a time in their lives when they were trying to leave dental practice responsibilities behind, sellers found themselves still bound to the practice for income. As a result of these problems and the availability of external financing through specialty lenders, fewer and fewer transactions are being financed by the seller. Today we estimate that less than 15% of dental transitions across the country are exclusively financed by the selling doctor.

Preparing for a Practice Acquisition Loan

Commercial Loan vs. Consumer Loan

Banks make a distinction between commercial and retail (that is, consumer) products. Frequently, commercial and retail loans are handled by different banking departments. Some banks focus on retail lending and have few resources devoted to commercial lending. Student loans, home mortgages, car loans, and credit cards are considered retail lending. New doctors who seek commercial financing are venturing, usually for the first time, into the commercial departments of the bank.

In general, commercial loans are granted based on the strength of the borrower and on the business opportunity they represent. They are typically secured by the assets of the business. The typical business loan is structured over a 5- to 10-year period. The loan's interest rates may be fixed or floating, and there may be conditions that relate to the business (for example, a lease on the property where the business will reside) and to the borrower (for example, insurance requirements, personal guarantee). Of primary importance is the doctor's personal credit profile.

Assessing the Borrower's Personal Credit

The first step in preparing for practice ownership is monitoring and maintaining good personal credit. It is easy to do; it can be done quickly and carries

considerable weight in determining eligibility and the terms of a practice financing loan.

Lenders and other vendors access personal credit information by requesting a credit report from at least one of the three nationwide credit agencies: TransUnion, Equifax, and/or Experian. These bureaus gather data on each consumer and provide a report that includes a list of accounts, timeliness of payment, and public information such as tax liens or judgments. The bureaus also employ statistical modeling of this data so that through the borrower's past performance they create a credit score on each consumer. This score helps lenders evaluate how reliably the borrower is likely to repay the loan promptly. Credit scores range from 300 to 850; the higher the score the better.

A credit score over 730 is considered excellent and will garner the borrower the best rates and terms available. Scores below 625 will significantly narrow the number of commercial lenders interested in a financing project. If such projects can be approved at all, a low score will result in a higher rate and more rigid terms.

Credit scores are influenced by the following factors (by priority):

- Timeliness of monthly payments
- Amount of debt
- Type of debt
- Inquiries from outside vendors

Experian, one of the major consumer bureaus, advises consumers to maintain good credit by paying bills on time, seeking out credit only as needed, and monitoring credit annually to guard against errors and identity theft.

The Federal Trade Commission (FTC) has excellent information on managing personal credit. Its website is www.ftc.gov. The FTC advises consumers to check credit through a website that was set up through the Fair Credit Reporting Act (FCRA), which mandates that all three bureaus give consumers access to a free credit report annually. That website is www.annualcreditreport.com.

Experience in evaluating the credit reports of new doctors has revealed several common but easily avoided problems. Sometimes student loans that are in deferment show up on the credit report as late payments. These "late pays" can and should be disputed and eventually removed from the report. Similarly, small medical bills, unknown to the doctor, are reported as collections accounts. Since students move frequently, a delayed medical bill may be sent to a past address. The young doctor may have no knowledge of the lateness, but it ends up as a collection account—arguing against the doctor's claim of prompt payment history. Although these accounts cannot be disputed, they can be neutralized by time. Annual credit reviews or credit reporting services that report changes as they happen can alert borrowers to these oversights, allowing quick payment and resolution. After such bills have been paid, the credit score may have time to recover, minimizing the negative effect of late payments.

Assessing Your Income Requirements

Before buying a practice and applying for a business loan, it is essential to know the amount of money necessary to run the borrower's household. Income requirements are basic information every doctor should know before considering a particular practice purchase.

Although there are many ways of estimating personal income requirements, one method is examined in Table 8.1. In this example, the doctor determines

Table 8.1. Example of estimating personal income.

Expenses		Commitment	Outstanding	Mo Pmt
Housing:	1st mortgage	$200,000	$157,936	$1,385
	2nd mortgage	$0	$0	$0
	Cost of home	$240,000		$0
	Mkt val home	$0		$0
Total Housing:		$200,000	$157,936	$1,385
Installment Loans:		Commitment	Outstanding	Mo Pmt
1	Car payment 1	$19,885	$7,155	$250
2	Car payment 2			
3		$0	$0	$0
4		$0	$0	$0
Total Installment Loans:		$19,885	$7,155	$250
Credit Cards/Revolving:		Commitment	Outstanding	Mo Pmt
1	Chase	$5,000	$1,000	$200
2	Capital One	$2,000	$400	$40
3	Wells Fargo	$5,000	$500	$60
Total Credit Card:		$10,000	$0	$300
Student Loans:		Commitment	Outstanding	Mo Pmt
1		$100,000	$84,153	$631
2		$0	$0	$0
3		$0	$0	$0
Total Student Loans:		$100,000	$84,153	$631
TOTAL REVOLVING		$10,000	$0	$300
TOTAL INSTALLMENT		$119,885	$91,308	$881
Total Monthly Obligations:				$2,566
Total Loan Outstanding:		$329,885		
Living Expense				
$300 a month per family member				$1,200
Total Monthly Expenditures				$3,766
20% "Hedge"				$753
Total Income Requirements				$4,519

his or her monthly expenses based on a review of monthly obligations coupled with a monthly expense allotment per family member.

The doctor lists his or her mortgage total and debt (or rent payment) as well as installment debt (usually automobile debt, but it could be any installment debt that is unrelated to school debts). Next, credit cards and lines of credit are accounted for. Minimum payments on credit cards are used as the monthly expense in this exercise. Finally, student debt payments are listed. Expenses other than monthly debt obligations can be estimated by multiplying the number of family members by $300. This accounts for most day-to-day expenses. In this example the doctor needs a bare minimum of $1,200 a month to cover basic living expenses for a family of four. Unusual or other specific obligations (that is, alimony, child support, special investments) should be accounted for and added to monthly obligations.

In looking at income requirements, many doctors ask if it is appropriate to include an accounting of spousal income. If the spouse's income is needed to make the deal work, many lenders will in fact ask for the spouse's personal guaranty. If the practice cash flow is sufficient without the spouse's income, then the lender may not ask for the guaranty.

Once a doctor has a good understanding of his or her family expenses, projecting income requirements becomes easy. It is recommended that a doctor take these basic expenses, add a small hedge of about 20% on top, and use this final number as a monthly income requirement. In Table 8.1 the doctor in question needs $4,519 per month to comfortably continue his or her lifestyle after the practice purchase.

Preparing a File for a Commercial Lender

An easy task to be done ahead of time is to prepare a file of financial information for the lender. It's recommended that a potential borrower have the items below handy when applying for a loan. All lenders will require the first three items. The other items are useful in telling your story. Start immediately to gather this information, as it eliminates much of the stress associated with applying for a commercial loan.

These items should be ready for the lender:

- 2 years of personal tax returns
- CV or résumé
- Dental license
- Production reports from current associateship (if available)
- Life insurance and disability policies (if available)
- Personal financial statement (list of assets and debts)—see Table 8.1 for an example
- Income requirements (personal budget)
- Copy of self-obtained credit report
- Any appropriate references (especially if you have a short work history)

Understanding the Commercial Lender

Many doctors are confused at the array of commercial lenders who seem interested in doing business with them. In this section we explore the two overarching credit philosophies that are used in making these decisions. We also examine the type of lenders available and the benefits and challenges of each.

Two Credit Philosophies

In general, lenders can be divided into two categories: asset-based and cash-flow-driven. As the term implies, an asset-based lender looks first at the collateral or hard assets of the business to secure the loan. Equipment, furnishings, inventory, and work in progress are examples of hard assets. Most community banks and large, nonspecialized banks would look to cover most of the loan proceeds with this kind of asset base. Dental practices as a rule do not have this collateral base.

Cash-flow-driven lenders tend to be specialty oriented. These lenders make their decisions based on the historical performance of the business, that is, its ability to generate enough profit to fund the debt while allowing the owner to maintain his or her lifestyle. These lenders may not expect that collateral (assets) will protect the loan. Rather, they base loan approval on sufficient practice cash flow and their knowledge of the dental industry.

Therefore, doctors who approach only community banks or large banks with no dental specialization for a practice acquisition loan may be frustrated by these lenders. There may be exceptions, however. Occasionally, a local bank will choose not to follow its asset-based lending approach and provide a loan program that resembles that of a specialty lender. It is more common, however, for the local bank to proceed within its traditional philosophy and use other methods to shore up its collateral coverage (which will be discussed below).

Types of Lenders

Understanding how each type of lender is prone to react to acquisitions empowers loan seekers to find the right loan for their project. It will also help identify exceptionally good “deals.”

The likely types of lenders encountered are the seller, the local bank, the SBA, the specialty lender, and the loan broker. The benefits and challenges of each will be discussed.

Seller Financing

As discussed earlier, seller financing can benefit the buyer in several basic ways. The seller may offer more favorable terms than the commercial lender. In the event that the buyer is unable to get outside financing (such as due to a poor credit history), seller financing may be the only option. Finally, if the

transaction has a particular challenge such as a large practice being bought by a new, financially unproven dentist who needs mentoring, the seller might carry a small loan in addition to outside financing. In this manner, the seller in effect shares some of the risk in the transition.

The biggest challenge of seller financing is that it simply may not be available. After all, sellers do not have to finance practices. In a competitive situation, holding out for a seller-financed loan can result in failure to win the practice. If seller financing is available, the relationship pitfalls mentioned must be avoided. It is important for the buyer to make sure he has a competent and experienced dental-focused advisor who can thoroughly review the transactions. The lender will not be there to analyze cash flow, with the aim of protecting the buyer.

Local Bank

Recall that local commercial lenders tend to be generalists with asset-based lending philosophies. However, some local lenders can, at times, vary this for dentists in some markets. The benefits are that the borrowing dentist can centralize his or her banking into one institution. Rates are usually favorable and might be 0.5–1% lower than some specialty lenders.

Typically, however, local banks have difficulty offering 100% financing. They may require a co-signer for the loan or look for liens on personal residences to shore up their collateral position. Frequently, a local lender will require the practice to maintain a business account and sometimes to agree to a minimum balance in that account.

This type of lender may have trouble finalizing a loan decision because the loan request is unusual. The borrower may not meet the lending criteria. So the bank may ask for a co-signer or guarantor on the note (that is, a parent with a positive balance sheet). More often than not, a local bank or large, nonspecialized lender will offer a young doctor an acquisition loan that uses the SBA guarantee to shore up its collateral position.

SBA 7a Loans

The Small Business Administration was established in 1954 with the mission of helping small business continue to flourish in the United States. Its mission is to “start, build and grow business by providing aid, counsel, assistance and protection insofar as possible.” One of the services the SBA provides is a guaranty loan program. Since 1991, the SBA program has guaranteed small business loans totaling $94.6 billion. In 2006 alone, the program provided loan guarantees of $12.3 billion.

Many banks and finance companies participate in this loan program. Lenders provide the loan according to SBA guidelines, and the SBA provides a guarantee of 75% on the loan proceeds. This allows traditional, asset-based lenders a significant collateral position. It is what many local, nonspecialty lenders will offer dentists seeking to buy a practice.

The program offers favorable terms and requires only a 10% down payment (rather than 20%). It is also useful if a real estate loan is involved in the transaction, as it is very rare to find a commercial real estate loan without a 20% down payment among any lenders. The SBA is tailored to small business owners with no other avenues for capital.

Dentists with good personal credit are not in this position. They have other choices. The challenge of an SBA 7a loan (the one used most for practice acquisition business loans) is that terms and conditions on these loans are not as favorable as doctors can get from lenders who do not require an SBA guarantee.

There is a significant SBA fee that must be charged, which usually averages around 2.6% (depending on size of the loan). The loan requires a 10% down payment. There is a prepayment penalty in most SBA loans if the loan is prepaid within the first 3 years. And finally, the interest rate is usually no better than the doctor can get with other lenders who have lower fees and more favorable terms.

Specialty Lenders

Historically, specialty lenders in the dental industry were privately owned. While they offered 100% fixed-rate financing, their rates were significantly higher than local banks and had restrictive terms including significant prepayment penalties. Today there are several large banks that have dental specialty lending divisions. They and some regional lenders make up the majority of specialty lending in the dental industry. They benefit doctors by providing 100% fixed-rate financing, usually with minimal fees and flexible terms for prepayment. Specialty lenders should have complimentary services that help the project come together or help the doctor should problems arise in the practice. Although these services in no way take the place of competent advisors (that is, accountant, lawyer, and consultant), they do augment and make the lender an informed member of the doctor's team.

These loans should be evaluated very thoroughly because the details vary widely. Rates are likely to run about 0.5–1% higher than traditional lenders in most cases. However, sometimes fees and advance payments can be manipulated in ways that distort the real cost of financing. It can be higher than it appears on the commitment letter. Some fees may be hidden. It is important to have a competent dental advisor's assistance (for example, an accountant) in evaluating terms and conditions.

Loan Brokers

Loan brokers bring borrowers and lenders together, but it is important to know that they do not underwrite the loan or keep the loan long term. Also, brokers do not add value in a market where lenders are already present and active. However, brokers can be of great value in situations when a loan is difficult to place. They can streamline the process for the borrower and find a "home" for a difficult loan.

Brokers are likely to be the highest-cost loan source in the market, since the broker must be paid in some fashion, either by fees or by increased interest rates. Finally, since the broker is not the underwriter, he or she cannot provide other services to remedy problems the doctor may experience along the way.

Frequently, doctors do not realize that they are not working with the primary source until the loan is already in progress. They may feel it is too difficult to start the underwriting process over again and settle for a lender they know little about. If you ask the right questions up front, it is easy to avoid this problem.

Questions to Ask Potential Lenders

The following questions will help you understand if a prospective lender is interested, has knowledge of dental acquisitions lending, and whether or not they are the primary lender for the loan.

- What markets does your bank serve?
- Does your bank provide commercial loans for new professional practices?
- Do you offer 100% financing for business loans?
- Do you have other dental clients? May I speak with one of them?
- How does the loan decision get made? How long does it usually take to get a decision?
- Who will fund the actual loan?
- Who will service the loan long term?
- If I have problems, who do I call?

Analysis of the Buyer

When a lender prepares to evaluate the loan applicant's credit in connection with a practice acquisition, the process involves an analysis of the buyer's situation, the practice, and the deal itself. The evaluation is based on the parameters discussed earlier in this chapter.

First and foremost, the lender will assess whether the buyer's personal credit history shows his or her ability to secure and manage credit. If in preparation the buyer has handled each of the tasks listed earlier to review and improve his or her credit standing, the analysis should be easy for the lender, resulting in optimal financing terms.

Similarly, the lender will review the buyer's personal assets and liabilities to clarify the resulting cash flow available. One key factor will be the buyer's income requirements. Those buyers with modest income requirements are better positioned to "afford" the practice.

Beyond financial analysis, the lender will evaluate the practical work experience of the buyer. An experienced lender will be concerned that the clinical skills and interests of the buyer match the practice. For example, if the doctor is relatively new in practice but has a history of being able to generate strong production, a favorable production report from an associate position would bolster the lender's belief that the operation will succeed. Perhaps the practice currently outsources all in-house endodontic or oral surgery procedures, but the buyer can bring the advantage of that expertise into the new acquisition. This type of subjective information can aid in the analysis and support the buyer's case.

Lenders may seek other subjective information that helps evaluate the buyer. For instance, if the doctor plans to be somewhat involved in the community, that seems to predict some measure of success. Dentistry is a community-based business. Doctors who live in and are invested in the particular area in which their practice resides tend to do better than doctors who buy a practice simply because it is a "job" with no community connection. Doctors' plans for marketing, staffing, and other business planning issues are important and weigh on the analysis of the opportunity.

Analysis of the Practice

Cash flow analysis of the practice is imperative. Regardless of other analyses done by appraisers or other advisors, all lenders must and will insist on performing their own analysis of the practice's cash flow. Insufficient cash flow will prevent loan approval.

Two years of corporate tax returns (or Schedule C and expenses, if the owner is sole proprietor) and current-year profit and loss statements are essential to this analysis. The lender will evaluate both time periods and the interim year (if that applies) to check for trends. For instance, a practice with a declining revenue base or declining profitability alarms the lender, a "red flag" that will require acceptable explanation.

The analysis is performed by taking the net income of the practice and "addback" expenses that the new owner can use to cover debt and personal expenses. Examples of common "addbacks" include

- Owner's compensation
- Pension relating specifically to the owner
- Associate's salary (if the buyer will be able to do that production without an associate)
- Depreciation expense
- Extraordinary expenses

Other "addbacks" to cash flow that pertain to choices the buyer can make about expenditures (that is, travel, car, and staffing) can be added back if appropriate.

After the objective analysis has convinced the lender, subjective factors become relevant. The lender will review the demographics of the area, the clinical makeup of the practice, staffing, marketing, and "pay mix" (a combination of preferred provider organizations, health maintenance organizations, private pay, and Medicaid). The lender will assess the size of the physical space, hours of operation, and availability of a suitable lease. Characteristics and factors that need to be carefully matched to the buyer's needs and abilities become obvious.

Putting It All Together

Key to an approval is putting together the objective and subjective analysis of the practice and the buyer. If the above essentials are supplied, the lender has everything needed to come to a decision.

Cash Flow Analysis

Basically the analysis follows the process outlined in Table 8.2.

The cash-flow analysis mentioned earlier is performed using the following:

- The practice's tax forms from 2 years past
  Some lenders will require 3
- The current year interim statement, also called
  Profit and loss statement (P&L statement)
  Income statement
  Revenue – expenses = net income

An experienced lender is needed to fully appreciate the complexities of a transition, which questions to ask, and what expenses to add back to cash flow.

Table 8.2. Lender's analysis process.

	Net Income of the Practice	
+	Addbacks	
	+	Depreciation expenses
	+	Owner's compensation
	+	Owner's pension
	+	Extraordinary expenses
	+	Misc. addbacks
=	Total Cash Flow Available for Debt	
	–	Loan payment
	–	Personal expense of buyer
	+	Other income available after sale
=	Net Cash	
	Is there a sufficient hedge?	

Note the item under "Total Cash Flow Available for Debt" on Table 8.2, "other income available after sale"—this could be related to associating income of the buyer (rare in acquisitions but required in start-up financing) or to income provided by a working spouse. It can bolster an analysis that shows marginal cash flow.

Lenders will also require that there is cash left over after all business and personal bills are paid. This is the "net cash" bottom line on Table 8.2. This reassures the lender (and buyer) that there will be sufficient cash even if, after the buyer takes possession of the practice, unexpected things occur. As with the exact analysis of personal expenses and addbacks, this "cash flow coverage" requirement varies from lender to lender. Many would require the buyer to show capacity to cover, at a minimum, all debts, even if they have increased by 20–25%.

Subjective Analysis

Matching the subjective elements of the practice to the buyer is vital to long-term success. An experienced lender will be watching for obvious practical problems during transition to the new practice. The lender may ask the buyer to do further analysis to clarify and resolve any problems. One of the most striking problems would be where a new buyer has purchased a practice that emphasizes clinical competence the buyer lacks, such as high-end cosmetic dentistry. In some cases, the seller has been unwilling to sign a sufficient covenant not to compete. Perhaps the seller's office manager has always been the seller's spouse so that the transition, while successful, also involves losing (and replacing) the office manager. These problems can be dealt with, but they must be recognized and handled as a part of the transition plan. One subjective factor that works against approval might be inability to obtain a lease with renewal options that ensure the new buyer can depend on a place to practice for at least 5 years. It is helpful to remember and hardly surprising that the buyer's key advisors (accountants and lawyers with expertise in dental transitions) would raise the same concerns as experienced lenders. After all, both are invested in the success of the transition.

Loan Terms, Rates, and Typical Conditions

Terms, rates, and conditions will vary from time to time and from lender to lender. This chapter discusses terms as they exist today.

The Proposal Letter

The lender's proposal letter is designed to help the borrower assess what a lender is likely to offer in advance of the exhaustive underwriting process. Therefore, it is standard practice for the lender to draft a letter proposing rates, terms, and conditions for the loan transaction. The proposal might be issued

after a simple review of personal credit, or sometimes after a more thorough evaluation. However, since a true in-depth analysis has yet to take place, such a proposal is not to be interpreted as the lender's approval. The proposal letter merely details the terms and conditions the lender can offer. It is not a commitment to do so.

The proposal letter should contain the following rate and term information:

- The name of the entity who is borrowing the money and the guarantor (the borrower).
- An outline of the purpose of the financing, such as an amount for purchasing the practice and an amount for working capital.
- The term of the loan (typically 7–10 years). An experienced lender will provide a 3-month deferral so that the borrower doesn't make payments until month #4.
- The interest rate of the financing. This must be very clear. It could be fixed for the entire term of the note or variable (priced around prime). It may be fixed for a number of years and then "float" until the end of the term. Generally, 10-year fixed-rate financing is preferable.
- The expiration date should be clear. Most proposal letters have a time limit or some way to increase or decrease rate over a period of time. Usually a lender can fix the proposal letter's rates and terms for 30 days.
- Fees should be clearly stated. A small documentation fee (around $350) is common, but other fees and points may be included (points are fees amounting to 1% of the total). In SBA financing, additional fees can be as high as 3%, or 3 points. If the loan amount is high, some fees might take the form of advance payments on the loan, increasing the real cost of financing. These should be noted.

The next section of the proposal letter should contain the standard approval conditions that will appear on the loan. At the proposal stage, it is too early for the lender to anticipate the necessity of adding more conditions. However, there are standard conditions that appear on every proposal letter, and it is reasonable for a lender to supply these. Sample conditions include but may not be limited to the following:

- Evidence of a professional license
- Evidence of a legal entity in good standing (corporation or partnership), if one exists
- Satisfactory review of a buy/sell agreement that includes a list of equipment and documented evidence that the buyer is protected from competition with the seller
- An office lease that shows the doctor can practice at the site for a minimum of 5 years
- A provision stating that the lender may secure a first security interest in the practice (blanket lien)
- Available funds to be used for business purposes

It should be noted that SBA or banks without a dental specialty may ask for additional conditions such as a lien on a home, a parental guarantee, and so forth.

Other items on the proposal letter may relate to insurance requirements. At larger dollar amounts ($300,000 and above), many lenders will ask for the borrower to have life insurance, disability, or business overhead insurance. These insurances are prudent in terms of any new business owner. There is no particular advantage when a lender waives the insurance requirement, since they will be required in any case. In these types of situations, all lenders will require property insurance/hazard insurance.

For some borrowers a prepayment requirement to comply with a lender's policies poses a serious problem. For that reason, the lender's prepayment policies should be clearly stated in a proposal letter. Many specialty lenders do not clarify their prepayment policies because they are unfavorable. Careful review of prepayment policies before proceeding with a lender can prevent difficulties.

Finally, the proposal letter should outline the next steps for submission into underwriting, where the credit decision will be made. At that time, the lender should request all outstanding documents or forms. To proceed to the next steps, the potential borrower should indicate acceptance of the terms and conditions in the proposed offer, sign the letter, pay any conditional fees, and submit everything to the lender.

The Commitment Letter

After the credit underwriting (analysis) is complete and the loan is approved, the lender will issue a commitment letter. In most respects, this letter should match the proposal letter. However, the commitment letter will also state that the application for the loan has been approved. Upon receipt of this letter, it is essential to have an advisor review it to confirm the terms and conditions are clear and consistent with the buyer's needs. The loan rate, basic terms, insurance requirements, and prepayment policies should not have changed. Fundamental changes to these factors may raise questions about the reliability of the lender.

There will be an easy explanation for some changes that appear in the commitment letter, however. Normal processing may result in a change to the loan's dollar amount and/or conditions. For example, cash-flow analysis may have indicated that the requested loan amount is unrealistic and cannot be supported. In these cases, the lender may return a counteroffer and approval of a reduced loan amount. In another example, cash-flow analysis may indicate that the lender must declare a maximum on the monthly lease amount. The lender may decide to require an additional guarantor, and such a condition would appear on the letter.

The commitment letter will also have an expiration date that must be heeded. Commitments can be withdrawn after this date, and rates can no longer be guaranteed.

Comparison of Lenders through Proposal and Commitment Letters

As indicated above, it is wise to retain an advisor to evaluate a lender’s proposal and commitment letters. Some new borrowers make the mistake of focusing only on the rate in the proposal, not realizing that fees, advanced payments, and terms that stunt the growth of the practice (5 year vs. 10 year, for example) significantly change the offer in real terms. An advisor such as an accountant with experience in the dental industry can help arrive at an “apples to apples” comparison.

Due Diligence and Closing

After the commitment letter is signed, the closing process begins. At this time, the buyer must perform the due diligence activities that will protect the new practice. A buyer should perform his or her own chart audit of the practice. For other important steps, Matsco’s Practice Success Series includes a workbook that discusses the practice’s due diligence issues. The first step of the series, the Practice Acquisition Primer, can be ordered from www.matsco.com.

A lien search will be performed on the seller and the buyer. All liens on the seller’s practice must be cleared up, either with available funds or proceeds from the loan. Loan documents including a note, security agreement, personal guarantee, and corporate guarantee must be reviewed and signed. A competent lawyer versed in dental practice transitions is important to the buyer at this time. The lender will follow up for all the items requested as a condition (license, buy/sell agreement, evidence of insurance or that applications have been made, etc.). Wiring of payment instructions will be requested so that the funds are available on the day of the closing. Most lenders will not be present at closings; their work is done ahead of time.

How to Maintain an Excellent Relationship with a Lender

Expectation of the Borrower

After the sale is complete and the loan is in place, the borrower should expect timely and accurate bills. A good service center should be available to handle problems and prevent errors. Should the borrower have additional lending needs, it is reasonable to expect the lender to provide advice and assistance. Specialty lenders such as Matsco also supply relevant data and assistance in operating the practice itself. For marketing information, referrals to other dental professionals in the industry should be available, as well as information on how the practice is doing vis-à-vis industry standards. These services are not usually supplied by general industry-based lenders.

Expectation of the Lender

Lenders expect timely payments. This is essential to maintaining a good relationship with any lender. It follows that a new buyer who is having difficulty paying promptly must make a priority of informing the lender. There are tools and resources available from experienced specialty lenders, but only if they have been informed of problems with time enough to put them to use. Frequently, the lender can restore stability to the practice and resolve difficulties. However, the worst situation for the lender and for the buyer occurs when a bad situation is hidden until the practice is near default and time is growing short. At that point the lender has few alternatives and little flexibility to work with the doctor to save the practice.

Fortunately events that threaten the life of the practice are rare in dentistry. An experienced lender and an educated borrower can develop successful transitions and keep practices healthy far into the future.

References and Additional Resources

Federal Trade Commission, Bureau of Consumer Protection, Division of Consumer and Business Education. 2006. *Building a Better Credit Report.* Available at www.ftc.gov/bcp/edu/pubs/consumer/credit/cre03.shtm.

Small Business Administration. www.sba.gov.

www.adamemberadvantage.com/dentists/prac_prafinancing.asp.

Learning Exercises

1. What is the difference between a collateral-based lending philosophy and a cash-flow lending philosophy? Give examples of each.
2. Go online to annualcreditreport.com and do the following: (1) identify the three major credit bureaus; (2) select one bureau and order your credit report from that bureau; and (3) after reviewing your personal credit, identify if you have any delinquencies or “late payments.”
3. What are the major advantages and disadvantages of a seller-financed practice acquisition loan?
4. Name four items that should be in a file you take to a commercial lender.
5. In evaluating a practice for purchase, what are some of the subjective factors to consider?
6. What are appropriate practice expenses that can be “added back” to net income to give a realistic assessment of cash flow?
7. How is a proposal letter different from a commitment letter?

Chapter 9
Business Entities

Arthur S. Wiederman and Ross L. Crist

The type of business entity a general dentist uses to operate his or her dental practice can have significant financial, legal, tax, and operational effects during a professional career. Whether to start a practice from scratch, to purchase a practice, or to operate with other dentists, the model of business entity or form chosen is a decision that requires thought and planning prior to the initial opening or purchase of the practice and throughout the course of time the business remains in operation. The expertise of an accountant and an attorney who have experience in working with dentists can be invaluable when they are consulted prior to establishing or purchasing a dental practice.

In this chapter, we discuss the operational, tax, and management aspects of the four most common entities that are used to operate a dental practice: sole proprietorships, corporations (both S corporation and C corporation), partnerships, and the limited liability company (LLC).

Sole Proprietorship

Description

The sole proprietorship is the least complicated of the available business entity forms. As a sole proprietor a business is simply operated under an individual's name (for example, John Smith, D.D.S.). A sole proprietorship may also use a specified title, or a "doing business as" name (or d.b.a.)

Necessary Documentation

Unlike the other entities to be discussed later in this chapter, with the sole proprietorship, other than one's professional license, there generally are only a few business application forms necessary to local, state, or federal government agencies to establish this business entity. Typically, the practitioner only needs to obtain a business license from the local jurisdiction (city, county, etc.), a state dental license, and federal and state drug prescription licenses. The

owner sole proprietor will need to secure a federal tax ID number for employment tax purposes. Some states may also require a special tax license. Although a dentist may use his or her individual name and title (for example, John Q. Smith, D.D.S.), the business may also operate under a d.b.a. name. In the case of a d.b.a., John Q. Smith, D.D.S. could use as his d.b.a., Lincoln Avenue Dental. He may choose to do so for unique marketing and/or identification purposes because the practice is located on Lincoln Avenue. But in order to do this, Dr. Smith is typically required to post notice in the local newspaper for a period of time (usually a month or 2), or file the assumed name with the local county government prior to the opening of his business. This serves as legal notice to others who may have a similar name, to be made aware that Dr. Smith intends to use Lincoln Avenue Dental as his d.b.a., and if others have a conflict with Dr. Smith's d.b.a., they have adequate time to legally contest the use of Dr. Smith's d.b.a. business name.

Operational and Management Aspects

To begin operating as a sole proprietorship, one needs to go to a bank (typically a local bank) and open a business bank account. Usually a checking account is the first account established. This account is opened under the name of John Smith, D.D.S., or his d.b.a. The account, even though used for business purposes, is treated as a personal account of Dr. Smith, and Dr. Smith is personally and legally responsible for all activity on the account, just as he would be for his personal checking account.

As the owner, all deposits or income of the dental practice are placed into this account and are used to pay office expenses. Additionally, the practitioner may also decide to open a business savings account for the practice. But again, the savings account, while used for business purposes, is still considered a personally guaranteed account of the practitioner. Personal income from the business to the dentist is usually taken from the business account in the form of a draw or check. This can be any amount and may be taken at any time, depending on available funds. While some dentists may choose to pay personal bills such as mortgage payments, home utility bills, and so forth from their business account, it is not recommended. If personal bills are paid from the business account, they must be treated as personal draw checks or personal income. This may create confusion regarding business expenses versus personal expenses in calculating true business overhead and in paying the correct taxes at year's end. Instead, most dentists take a periodic monthly draw, transfer it to their personal bank account, and use their personal account to pay personal bills. This allows clear delineation of business versus personal expenses. Draws taken from the business account will obviously depend on the cash flow, or income and expenses, of the business. As collections and overhead expenses in a dental practice can be variable from month to month, draw checks also vary as to amount and as to when they are taken for personal use.

Again, we do not recommend that you pay your personal bills from the business account. By taking a periodic, and preferably a set monthly, draw from the business, a personal as well as business "budget" can easily be established. This in turn will allow for the accumulation of more money both personally and in the practice, which over time can provide a means for larger equipment purchases, retirement planning, and so forth. Paying all personal bills through a business account makes it harder to save money and meet goals in both the business and in personal life.

Income Tax Issues

As a sole proprietor, earnings from a dental practice are reported on the practitioner's individual income tax return. Business gross income and allowable business expenses are reported on Schedule C of Federal Form 1040. The net income of the practice is shown at the bottom of Schedule C and then is transferred to page 1 of Form 1040. Thus, business income is reported just like any other type of income on a personal tax return.

Example: Dr. Smith's dental practice collected $600,000 for the current tax year. His deductible business expenses (staff salaries, lab, supplies, depreciation, etc.) for the year were $400,000. Dr. Smith will report income on his individual income tax return of $200,000 for the year.

When starting dental practice, it is possible to incur a loss of income (and is most likely in the first few months or perhaps years of operation). This loss is tax deductible if the individual's personal investment in the practice is what is called "at risk." For example, if a practice that is started on October 1 collects a total of $40,000 for the months of October, November, and December, and during that same period the expenses of the practice are $55,000, there would be an operational loss of $15,000. If money to fund the $15,000 loss is borrowed from the bank and the dentist is personally liable for the loan (which is typically the case with bank loans), then the dentist is considered "at risk" for the $15,000 loan and is permitted to deduct the loss on his or her personal tax return.

For purposes of allowable tax deductions, now is a good time to discuss the concept of depreciation. As a dentist, the sole proprietor typically operates on what is referred to as the cash basis of accounting. This requires the practitioner to report receipts (income) as collected and deduct all expenses as paid. The one exception is for fixed assets (like equipment, furnishings, or fixtures) purchased for the business. For tax deduction purposes, fixed assets are allowed to be depreciated, or expensed to offset taxes, over time. This means that instead of taking a full tax deduction the same year equipment is purchased, the individual is allowed to depreciate or deduct a portion of the cost of that equipment over a period of several years.

Example: Assume Dr. Smith buys $100,000 of dental equipment. Federal tax law says that he can depreciate dental equipment over a period of 5 years, however, it takes 6 calender years to fully depreciate a 5 year asset. So the

doctor's allowable tax deduction each year for this purchase equipment is, according to current tax law, as follows:

Year 1 (20%)	$20,000
Year 2 (32%)	$32,000
Year 3 (19.2%)	$19,200
Year 4 (11.52%)	$11,520
Year 5 (11.52%)	$11,520
Year 6 (5.76%)	$5,760
Total Depreciation	$100,000

Note: There is an exception or provision that was put into law several years ago regarding the depreciation of newly purchased fixed assets. This tax law provision is referred to as Internal Revenue Code Section 179 and allows for the full deduction of expenses for equipment purchased in the same year it is placed into service up to specified total or maximum, which currently is $125,000. This tax provision has been created as an incentive for small business owners to expand their businesses. This in turn is intended to help stimulate the U.S. economy. So with the Section 179 provision, a small business like Dr. Smith's is allowed to expense or deduct the cost of all the equipment in 1 year instead of depreciating it over a 5-year period as shown in the example above. There are no restrictions for the sole proprietor, other than the total amount per year, in taking this deduction, and this deduction can create a loss on the practitioner's Schedule C for the year, as long as the individual is "at risk" (as previously discussed) in the investment or cost of that equipment. Remember, no matter how the equipment is paid for, whether through a bank loan, dental specialty lender, or from private resources, such as a family loan, and regardless of when the loan is paid off, the cost of equipment is deductible in the year it is *placed in service*.

Example: Dr. Smith opens a new dental office the first day of October. He has worked the first 9 months of the year, earning $100,000 as an associate in another office, where he intends to continue to work a few days a week as an associate until his new practice is busy enough for him to quit the associate position. He will earn an additional $20,000 for the last 3 months of the year as an associate; thus, he will have total income from the associate position of $120,000.

For the first 3 months of his new practice (October, November, December), Dr. Smith's office collections are $40,000, while the operational expenses (before depreciation) are $55,000, leaving a loss of $15,000. Assuming Dr. Smith purchased $100,000 of equipment and furnishings to start the new office, and that these were placed in service on October 1, the day he opened the office, he can elect to use Section 179 to deduct all or any part of the $100,000 equipment and furnishings purchased and can increase his deductible loss on Schedule C to as much as $115,000 ($15,000 operating loss plus $100,000 Section 179 equipment expense). This $115,000 loss would almost totally offset the $120,000 in

salary from his associate position and would result in Dr. Smith paying little or no taxes for the year.

As you can see, there is significant tax planning that should be done, especially in the first year of a new dental practice. Again, consultation with an accountant with experience in this area is critical.

With regard to payroll taxes, all persons who work as employees and receive W-2 wages not only pay income taxes but are required to pay into both the Social Security and Medicare systems. An employee, like a dental assistant, pays 6.2% of wages up to an annual limit in Social Security tax, and the employer matches this amount. The employee will also pay 1.45% of wages in Medicare tax (there is no income limit on Medicare withholding), which is again matched by the employer.

As a sole proprietor the owner is not only liable for employer taxes on employee wages (Social Security and Medicare as mentioned above) but also for what is known as the self-employment tax for the practitioner's earnings. Because a sole proprietor is earning income (draws) and thus is not likely receiving a true payroll check, the government created the self-employment tax, which is computed on an individual's tax Form 1040 (Schedule SE) each year. A sole proprietor is in essence both the employer and employee and must pay both halves of the Social Security and Medicare tax each year based on calculations from the tax Form 1040 Schedule C profit. This is something that must be taken into account in planning taxes. Self-employment tax can and often does run into five figures annually, and without proper advanced tax planning, many sole proprietors find themselves financially challenged when it is time to pay their self-employment taxes.

Finally, the sole proprietor is not allowed some of the same tax deductions that a C corporation is allowed. These include things such as deduction of long-term disability insurance premiums, medical reimbursement plan contributions, child care plan contributions, cafeteria plan contributions, and so forth. This will be discussed further in the corporation portion of this chapter.

Liability Issues

One of the disadvantages of operating a business as a sole proprietorship is that the practitioner's personal assets are subject to creditor claims in the event of a lawsuit stemming from the operation of the business. Other types of business entities, yet to be discussed, can provide personal liability protection against such suits. In the event of a lawsuit against a sole proprietorship, creditors can seek compensation in the form of personal property, that is, real estate, vehicles, and even personal investment accounts. However, insurance can protect against general and professional liability judgments.

Example: Dr. Smith operates his business as a sole proprietorship. He owns a home and three pieces of rental real estate and has personal investment accounts. In his third year of business, he terminates the employment of the front office manager, Julie, who in turn sues Dr. Smith and wins a civil judg-

ment in court for $75,000 for wrongful termination. Because he is operating the business as a sole proprietor, Dr. Smith is personally liable for this $75,000 judgment to the former employee. If he does not have the cash to pay this former employee, she can go after his home, real estate, and investment accounts to secure and settle her judgment against Dr. Smith's business.

Again, consultation with an attorney who works with dentists in the matter of liability of a sole proprietorship is absolutely critical before choosing this business model.

Advantages

The advantages of operating as a sole proprietor begin with the simplicity of this form of doing business. There are few government submission requirements, no need for the owner to take salary and withhold taxes (sole proprietors, however, usually plan for and pay their income taxes using quarterly estimated tax vouchers), and no annual state or federal filings that are commonly required of corporations, partnerships, or LLCs. It is simply the least complex business entity for operating a business.

Disadvantages

There are two major disadvantages to operating as a sole proprietor. First, the liability issue as discussed above (this issue alone in many cases steers the decision of business entity away from the sole proprietorship). Second, experience shows that Schedule C sole proprietorships have a higher rate of being selected for IRS tax return audit than do corporations, partnerships, or LLCs.

Corporations

An Overview

For dentists entering practice ownership, forming a corporation has many advantages and a few disadvantages that will be discussed. As mentioned in discussing sole proprietorships, business owners are strongly motivated to form corporations by the liability protection it offers for their personal assets. Done correctly, forming a corporation will in most cases protect personal assets, such as homes, cars, and investments.

However, incorporating requires that the business owner follow certain formalities, which include taking income or salary just like other employees (paying regular income taxes through payroll deduction vs. self-employment tax) and having to file certain government forms throughout the year. While providing a method of insurance against personal liability, the corporation can also provide certain income tax benefits. Characteristic differences between C corporations and S corporations will be delineated and are generally differences in taxation.

Description and Necessary Documentation

A corporation is a legal entity typically formed by submitting a fee and a state-specific application. The business owner typically creates the corporation when he or she transfers money or other property (that property being dental equipment, furniture, fixtures, and other practice assets) to pay for, or in exchange for, stock in the corporation. In dentistry, most corporations are typically started for a transfer or cost (known as capitalization) of between $1,000 and $5,000.

It is strongly recommended that an attorney be employed to submit the necessary paperwork, such as articles of incorporation and bylaws, to the secretary of state or other agency responsible for forming corporations in the state in which the corporation is to be formed. Following the legal formalities to form a corporation is critical. If a corporation is not formed correctly, and thus is not in good standing with the state, another party could "pierce the corporate liability veil" if a lawsuit occurs. A lawsuit can be catastrophic to the stockholder if the corporation is found not to be a legal entity because the shareholder is personally liable for the lawsuit judgment (just like the sole proprietor).

Once the state approves and returns the articles of incorporation and bylaws, a corporate seal or stamp is created. This seal may be created by the state or may need to be done with the assistance of an attorney. Next, with the help of a local bank, a corporate bank account can be created. For legal purposes, banks will oftentimes require copies of the articles of incorporation, the bylaws, and the corporate seal in order to establish a corporate business account. In addition, the corporation will need to obtain a federal employer number or tax identification number, also known as a TIN. This number is needed to file corporate tax returns and to send claims to insurance companies for the dental services provided to patients of the practice.

Dentists desiring to operate their business entity in the form of a corporation, whether at the start of a new practice or when purchasing an existing practice, will normally transfer some cash to the corporate account to purchase the stock, and also to provide working capital to the corporation. The dentist/shareholder can then acquire a loan from a bank or a specialty dental lender in the name of the corporation. For example, say Dr. Susan Jones is operating her dental practice as a corporate entity (Susan Jones, D.D.S., P.C.) and decides to borrow the funds to buy another existing practice that costs $400,000. In purchasing the existing practice, the assets of that business are allocated among equipment, furnishings, supplies, goodwill, and probably a covenant not to compete. All of these assets will become assets of her corporation. The corporation is actually buying the practice and will be liable for the debt. So the corporation will have $400,000 in assets and $400,000 in bank debt. Dr. Jones is simply the stockholder of the corporation.

However, issues are much more complex for a dentist who has operated his or her practice as a sole proprietor for many years and then decides to

incorporate. Before incorporating, it is very important to consult with an accountant to determine how much in assets and liabilities the sole proprietor has immediately preceding the proposed incorporation. This determination is critical due to the potentially onerous tax provisions of Internal Revenue Code Section 357.

When a sole proprietor incorporates, if the sole proprietor transfers liabilities (what is owed) in excess of the basis (original cost) of assets to the newly formed corporation, the excess, or difference, of liabilities over assets is considered taxable income to the dentist (that is, the sole proprietor "on paper" is gaining income from forming the corporation). Accounts receivable (what is owed to the business) and accounts payable (bills the business needs to pay) are excluded from this calculation.

Example: Dr. Jones has been operating her sole proprietorship for 4 years. She decides to incorporate as of January 1. The assets of her practice have an original cost of $250,000, and due to accelerated depreciation and Section 179 deductions (discussed earlier in this chapter), Dr. Jones has taken $200,000 in depreciation as a sole proprietor. For this reason her depreciable basis in her assets is the original cost of $250,000 less accumulated depreciation of $200,000, or $50,000. At this same time, she still owes the bank $200,000 for the original build-out expense of the office. If Dr. Jones incorporates, she has $150,000 of taxable income (which is the $50,000 of basis of assets less the $200,000 of debt transferred to the corporation).

The reasoning behind this rule in the example above has to do with the fact that Dr. Jones has received income tax deductions of $200,000 in depreciation as a sole proprietor but has only paid off $50,000 of her debt. So she has really received $150,000 in tax deductions without having to pay cash out. Thus, when the assets and liabilities are transferred to the corporation, the theory is that Dr. Jones is being relieved of personal debt of $150,000 (indirectly receiving income).

There are three ways of avoiding this tax while still incorporating:

- First, Dr. Jones can transfer up to $50,000 of her bank debt to the corporation and not transfer the other $150,000 of debt to the corporation. This would mean that she will transfer assets of $50,000 and liabilities of $50,000 to the corporation, so there is no debt forgiveness or taxable income to her personally. Under these circumstances, Dr. Jones has to pay off the $150,000 personally to the bank, with after-tax dollars. This may make more sense than incurring a taxable gain of $150,000, since she has already received personal tax benefits, from accelerated depreciation, as a sole proprietor. However, the bank may have difficulty agreeing to split the total $200,000 debt between the corporation and the individual and still may require a personal guarantee.
- Second, Dr. Jones can transfer the $50,000 of net assets and the $200,000 in debt to the corporation. In so doing, she then can execute a promissory note to the corporation for $150,000 and pay it back to the corporation with a

fair rate of interest. This loan must be a bona fide loan over a reasonable period of time. This will allow her to pay back the corporation with after-tax dollars.

- A third way to handle this is for Dr. Jones to keep the equipment in her name, retaining the title to the capital equipment personally to in turn lease the equipment to the corporation. She will receive lease payments as an individual and file a Schedule C for the leasing income and pay the debt from this income.

In the authors' experience, these types of taxable-event issues occur often and are many times overlooked in establishing corporations. If a sole proprietor dentist changes his or her business entity to a corporation without proper income reporting and then is audited by the IRS, not reporting income correctly can create a significant amount of taxes, interest, and penalties.

Operation and Management

Once a corporation is set up and a bank account is established, the business essentially operates in a similar fashion to the sole proprietorship.

The major difference between operating a business as a sole proprietorship and as a corporation is that, as a sole proprietor, the owner is not an employee of the business. As a sole proprietor, the collections minus the deductible expenses is the net amount of what the individual (owner) pays personal income taxes on. When the business is incorporated, the dentist becomes an employee of the corporation and will usually take a regular salary, with regular income tax deductions. His or her salary is reported on a W-2 form issued by the corporation at the end of the year, just as it is for other employees or staff. Income taxes are paid based on the salary received and are reported on the individual's income tax return. How salary is, or should be, taken depends on whether the business is a C corporation or an S corporation. We provide more detail about C and S corporations, in this regard, later in this section.

Liability Issues

One of the biggest advantages to forming a corporation is what is known as limited liability. The corporation can be sued, but the personal assets of the stockholder are protected from the suit. In a sole proprietorship and in a partnership, if the owner or partner is sued, his or her personal assets are at risk, as discussed earlier under sole proprietorships. The plaintiff (person suing) can win a judgment against the sole proprietor in court and then collect by procuring the dentist's personal assets. However, as a corporation, the stockholder/owner's personal assets are protected from a liability judgment.

Generally, when it comes to malpractice suits, dentists are not protected by the corporation entity. Since the malpractice suit is based on a contractual agreement between the dentist performing services and the patient receiving those services, that agreement is considered a personal contract with the dentist,

and thus the corporate veil generally does not protect the individual dentist. However, dentists should have trustworthy malpractice insurance that protects against malpractice judgments.

Obviously, different states can and do have different laws, so it is critical to discuss the liability as well as malpractice protection issues with a qualified attorney.

Tax Issues

There are two different types of corporations, C corporations and S corporations. The differences between C corporations and S corporations are strictly tax related.

C Corporations

All corporations when formed are automatically C corporations. To become an S corporation an election must be made (see later). The C corporation is a taxable entity, and the owner of a C corporation annually files a Federal Form 1120 reporting the gross receipts and expenses. In a C corporation, if the gross receipts of the corporation exceed the deductible expenses, the corporation will have a taxable profit and will pay a corporate or business tax. The corporation is allowed to deduct a reasonable salary to the owner.

Many years ago, Congress required that any taxable income of a C corporation considered to be a "personal service corporation" is to be taxed at the highest maximum tax rate from the first dollar of income. As of this writing, this currently is 35%. Dental corporations are personal service corporations. This can be very expensive for the C corporation owner.

Example: Dr. Jones collected $600,000 in her dental practice in the current calendar year. Her deductible expenses for the year, including a $150,000 salary to Dr. Jones, were $580,000. Therefore, Dr. Jones's C corporation has a taxable income of $20,000. Since she is a C corporation, she has a corporate tax due of $7,000 ($20,000 corporate profit × 35% tax rate). This is compounded by the fact that the $7,000 when paid is not deductible to the corporation. Because it is not deductible, it automatically creates $7,000 of "phantom" taxable income for the next tax year when she again pays tax. This can cause additional tax problems going forward the following year.

Once the shareholder pays the corporate tax, he or she then also has to pay a second tax when taking the remaining corporate profit. So in the example above, Dr. Jones had a profit of $13,000 (left after paying the $7,000 corporate tax on the $20,000 profit left in the corporation). When she takes out the remaining $13,000 in profit, she will pay personal tax at her personal tax rate. This is called double taxation and is a huge disadvantage of a C corporation.

For this reason, it is imperative that the C corporation owner "zero out" the corporation each year. This requires detailed annual planning to ensure that the C corporation owner pays additional business expenses at the end of the year, such as taking a salary bonus or contributing the year-end corporate

profit to a qualified corporate retirement plan, so that no profit is left in the corporation that would be subject to tax.

Example: In the above illustration, Dr. Jones could have used the $20,000 profit to either pay bills at the end of the year (such as January's rent, or lab and supply bills that she owes on December production, etc.), she could take a $20,000 salary bonus, or she could contribute $20,000 to the company retirement plan. By doing so, there is no end-of-year profit left in the corporation, as it is "zeroed out" for the year and owes no taxes.

In general, C corporation owners take a reasonable salary from the corporation to pay their personal expenses, and it is this salary that offsets profit from the corporation. In the example above, Dr. Jones is taking a salary of $150,000, which represents most of the business profit for the year. Dr. Jones will pay Social Security and Medicare tax on this salary like any other employee. If the corporation were to have an extra $75,000 of profit at the end of the year, she could then take a year-end bonus, or she could contribute this amount to the company retirement plan to "zero out" the corporation. As we show later in this chapter when we discuss S corporations, there also may be a Medicare tax saving opportunity for dentists earning higher net incomes by operating their practice as a corporation.

C corporations also benefit from certain income tax deductions that sole proprietorships, S corporations, partnerships, and LLCs are not entitled to.

C corporations are the only business entities that are permitted to deduct long-term disability insurance premiums of their owners. For an owner age 50 or older, this can be a significant deduction. Importantly, however, the major disadvantage of paying long-term disability premiums through the corporation is that if the owner becomes disabled and receives benefits from the policy, the benefits are taxable to the recipient as an individual. We generally recommend that long-term disability premiums be paid personally, so that benefits are not taxable when received.

C corporation owners can also establish medical expense reimbursement plans, or MERPs. These are written plans established to pay for medical expenses that are not covered by the corporation's medical insurance policy, such as deductibles, copayments, excluded procedures, and perhaps prescriptions. A medical expense reimbursement plan, however, must be provided on a non-discriminatory basis to all employees of a dental practice. If it is not, the benefits are considered a dividend to the owner and, while not taxable to the owner, are nondeductible to the corporation.

The corporation can also include the C corporation owner in a "cafeteria plan" of the corporation. This is a plan that provides a series of personal expense benefits (such as medical, child care, group legal, etc.) to the participant (hence the name "cafeteria"). Here again, the cafeteria plan must be made available to qualified employees.

As far as insurance is concerned, the C corporation can pay for the owner's health insurance (again, the corporation must provide insurance to eligible employees of the practice), as well as long-term care insurance. The C

corporation does not have to provide long-term care insurance for employees—this is an exception to the general rule that employees have to be included as part of benefit programs.

Finally, one significant disadvantage of the C corporation is double taxation upon liquidation. Prior to 1986, Internal Revenue Code Section 337 allowed for a corporation to sell the business, distribute the cash to the shareholder, and pay one capital gains tax on the sale.

The Section 337 provision, known as the General Utilities Doctrine, after the court case that upheld this tax treatment, was repealed in 1986. Now, upon the sale of corporate assets, the shareholder not only has to pay the corporate tax but also has to then pay personal income tax when any remaining cash of the corporation is distributed.

Example: Dr. Jones sells her practice for $300,000. The basis in her stock is $1,000. She pays a corporate tax on $299,000 that is approximately $100,000, leaving $200,000 for distribution to Dr. Jones. She then pays personal income tax on the $200,000, so she essentially, as the stockholder, pays double tax.

A recent United States Tax Court case, *Norwalk v. Commissioner of Internal Revenue Service*, gives dentists a way around the double taxation issue by providing that the goodwill portion of a dental practice is actually owned by the dentist as an individual and not by the corporation. This removes a large part of the sales proceeds from the corporation and, in turn, allows for the more favorable single capital gains tax treatment on the goodwill portion.

This particular court case specifically dealt with a group of CPAs, so there are not yet court-tested cases on this issue directly relating to dentists. Therefore, a dentist operating as a corporation needs to discuss this case as a reference authority with his or her professional advisor when selling an incorporated dental practice.

S Corporations

The biggest difference between the C corporation and the S corporation is this: while the C corporation is a taxable entity and pays tax on any profit left inside of it, the profit of the S corporation is allowed to "flow through" directly to the shareholder's personal tax return. As an S corporation, it is not necessary to "zero out" the corporation like the C corporation at the end of the year to avoid taxes. The S corporation is not subject to the possible onerous corporate tax rate of 35% on every dollar of corporate profit.

Example: Using the same example cited earlier (under C corporations), if Dr. Jones has a $20,000 profit after paying her salary and business expenses, instead of paying the $7,000 of corporate tax as a C corporation shareholder, the $20,000 will "flow through" to Dr. Jones' personal tax return. Dr. Jones takes $20,000 out of the corporation in the form of what is called a distribution, and it is tax-free to the corporation. Dr. Jones pays personal taxes on the $20,000 distribution.

The S corporation files a Federal Form 1120S each year to report income and expenses. In order to convert to an S corporation from an existing business,

the shareholder(s) must file a Federal Form 2553 within 75 days of the beginning of the tax year. When dentists incorporate at the start or purchase of a practice, the election to form an S corporation must be made within 75 days of the date the corporation is formed. For example, if you start a new practice or incorporate an existing sole proprietorship on March 15, you have 75 days from March 15, or until May 29, to make the S election. If you do not make the election within 75 days, the election will not become effective until the next year. Recently, Congress has provided generous rules if you miss the deadline and you still want to be an S corporation for the current year. For the current laws, this should be discussed with an accountant and attorney.

Another loophole in the law that Congress has threatened to change for years but has not done so to date applies to the Medicare tax. As a shareholder of a C corporation, Medicare tax is paid on any and all salary taken out of the corporation. There is no limit on the amount of Medicare tax, but there is a limit on Social Security tax. The Social Security tax currently applies only up to a salary maximum of $102,000 as of this writing. As mentioned above, any profit taken out of the S corporation can "flow through" to the shareholder, and this "flow through" profit is not subject to the Medicare tax (and may not be subject to Social Security tax if the shareholder's salary is under the Social Security wage base for the year).

Example: Dr. Jones's net profit before her salary is $200,000 for the current year. If Dr. Jones is operating as a C corporation, she can take out a salary of $200,000 to zero out the corporation and pays 2.9% in Medicare tax, or $5,800.

If Dr. Jones is operating as an S corporation and she takes $120,000 in salary and then takes the remainder of the $200,000 (or $80,000) total compensation in the form of distributions, she only pays Medicare tax on $120,000. Therefore, she would save Medicare tax on $80,000, which results in a 2.9% or $2,320 personal Medicare tax savings for the year. For dentists who earn larger incomes, this Medicare tax savings can be significant. However, the practitioner needs to be aware that some states charge state tax on S corporation profits. For example, California charges a 1.5% tax over the minimum tax on S corporation profits. This state tax can mitigate some of the Medicare tax savings discussed in the example above.

One disadvantage of using the S corporation is the requirement of complying with what are called the basis rules. Basically, in a sole proprietorship or partnership, if the owner borrows money from the bank and is personally liable on the debt, he or she is considered "at risk" and has "basis" to deduct a loss or to take a large depreciation or Section 179 item. However, the rules are different in the S corporation arena.

Let's take a simple example. Dr. Smith buys a practice and pays $400,000 for the practice. For the current year ended December 31, Dr. Smith collects in his new practice $100,000 in gross receipts and has $90,000 in overhead expenses before depreciation and loan amortization. He takes depreciation and amortization expense of $50,000 on the assets purchased. This creates a loss of $40,000 ($90,000 overhead expense plus $50,000 depreciation, less $100,000 gross

receipts). As a sole proprietor or a partnership, there would be no question as to whether or not he could personally deduct the $40,000 loss against his personal income. But if Dr. Smith elected to be an S corporation when he bought the practice and he wants to have the loss “flow through” to create a loss on his personal taxes, he must have “basis.”

For further discussion, assume that Dr. Smith worked as an associate for the first 9 months of the year and bought the practice on October 1. As an associate he earns $120,000 in the first 9 months, and he wants to use the $40,000 loss from his S corporation to offset the $120,000 of W-2 salary he earned as an associate. Without basis he cannot do this.

If Dr. Smith had the S corporation borrow the $400,000 to buy the practice, the tax code DOES NOT give Dr. Smith basis when operating as an S corporation. Basis is created in one of two ways:

- Dr. Smith creates stock basis by making a contribution of cash into the corporation.
- Dr. Smith loans the corporation money (it must be a bona fide loan with payback provisions).

Therefore, in this example, Dr. Smith can contribute $40,000 of his own money into the corporation, thereby creating stock basis. He then can take a $40,000 deduction against the $120,000 of salary. The other option is he can make a loan of $40,000 to the corporation and create loan basis that allows him to then be able to take the deduction. But the disadvantage of creating loan basis is that when Dr. Smith’s corporation pays back the loan to Dr. Smith, the repayments are considered taxable income to him personally.

These provisions are very complex, and how they apply in specific circumstances requires consultation with a competent CPA or tax attorney.

Finally, there are significant tax ramifications when selling a practice and liquidating an S corporation. Congress, in 1986, put into the law for S corporations what is known as the built-in gains tax. This tax is very complex and generally doubles taxes to S corporation shareholders on any profit that existed on the date they elected S corporation status. This built-in gains tax basically provides for or results in a double tax upon the liquidation of a corporation.

However, this tax is easily avoidable for S corporations. If an S corporation status is elected for on the same date you incorporate, the S corporation is not subject to this tax. Also, if the practice is not sold for 10 years after electing S corporation status, the tax does not apply.

Advantages of C Corporations and S Corporations

C Corporations

The advantage of the C corporation is the allowable deduction of fringe benefits such as disability insurance, medical reimbursement plans, and cafeteria

plans for 2% or more shareholders. Still, as previously stated, it may not be advisable to take disability insurance premiums as tax deductions because future claims would be taxable income for the recipient.

S Corporations

The S corporation allows the shareholder to pass through profits each year without being subject to a double tax, as in the case of a C corporation. There is also an opportunity to save Medicare taxes on S corporation profits.

Disadvantages of C Corporations and S Corporations

C Corporations

The C corporation has to be "zeroed out" each year, or it is subject to double taxation on any profits taken as salary. There also is the disadvantage of double taxation upon liquidation. Finally, Medicare tax has to be paid on all salary paid to the shareholder(s).

S Corporations

The only disadvantage of the S election is the loss of deductibility of certain fringe benefits, as discussed above. The authors generally recommend that if an S corporation is going to be formed, it is best to elect upon forming a corporation (to avoid double taxation issues). If the owner has significant fringe benefits to pay, a C corporation may be better.

Partnerships and Limited Liability Companies: An Overview

A partnership is defined in the law as two or more persons doing business as co-owners for profit. For many years dentists and other professionals were hesitant to operate their businesses as partnerships due to the lack of liability protection. However, with the advent of the LLC, which is a combination of a partnership and a corporation (to be discussed later in this chapter), the use of the partnership form of practice entity offers the dentist advantages over the corporation. The advantages mostly occur in the way profits are split among partners. With more flexibility than the corporate structure, the partnership-LLC has become more popular than in years prior.

As compared with corporations, partnerships can specifically allocate profits and losses based on the agreement of the partners. This can be very appealing for the partners where different partners work different hours and days than one another. The partnership and LLC models also make it much easier to bring on additional partners and can make it easier to buy out partners who relocate or retire.

General Partnerships

Description and Ownership

A partnership is established by two or more dentists deciding to operate a practice together. All of the receipts are collected and expenses paid out of a single bank account. The partnership generally will use the name of the partners (for example, Smith & Jones Dental Partnership), as many states require the dentists to use their names as the partnership name. However, a partnership may use a d.b.a. (doing business as) title to identify itself for marketing purposes. For example, the partnership name could be Smith & Jones Dental Partnership d.b.a. Wilson Street Dental. The d.b.a., as with the sole proprietorship, needs to be published in the local newspaper so that legal notice is provided to other businesses and to the public.

A partner owns what is called a partnership interest. This means that the partner owns a percentage of all of the assets (and liabilities) of the partnership. Many partners, especially partners starting a new practice, will be 50/50 partners. This is the easiest form of partnership, as all income and expenses are split 50/50 or "down the middle."

One important distinction that has to be made in a partnership is the differentiation between ownership of the assets of the partnership and the splitting of profits. In most professional partnerships, profits are split based on the percentage of work done by each partner. For example, if Dr. Smith produces 65% of the revenue in the Smith & Jones Dental Partnership and Dr. Jones produces 35%, Dr. Smith receives 65% of the profits and Dr. Jones receives 35% of the profits. But regardless of the profit distribution percentages, as 50/50 partners in ownership of the partnership, if the practice were to be sold each partner would receive 50% of the sales proceeds.

Necessary Documentation

Whereas a corporation is formed by registering with the state in which it operates, a partnership has no such requirements. A partnership is formed by the creation of a partnership agreement. The agreement can be verbal, but that is generally not a good idea. Like other legal documents, the purpose of the partnership agreement is to memorialize the agreement between the partners. The agreement will generally have the following covered:

- The name and term of the partnership is in the agreement. The partners can agree that the partnership will be for, say, 50 years or until the partners retire.
- Allocation of profits and losses are also outlined in the partnership agreement. We will discuss this at length in the next section, regarding operational/management aspects.
- Ownership of the partnership assets is covered also. For example, say one dentist has an existing practice and the other dentist does not. If Dr. Smith has the existing practice and brings all of his practice assets into the new

partnership, and the equipment and furnishings are worth $100,000, the partnership agreement might state that upon sale of the total practice, or if Dr. Jones buys out Dr. Smith in the future, Dr. Smith is entitled to an additional $100,000 (beyond his appraisal share) for his initial contribution of assets into the partnership. So if they are 50/50 partners and the practice sells for $700,000, the partnership agreement says Dr. Smith receives the first $100,000, and because they are 50/50 partners the remaining $600,000 would be split equally ($300,000 each).

- Buyout provisions typically are covered in the partnership agreement. This comes up in three specific instances: first, where one partner wants to leave the profession, move out of the area, or retire and the other partner is to buy out the partner who is leaving.

  For example, say Dr. Smith and Dr. Jones are forming their partnership. They will negotiate terms as to what happens should either doctor leave the practice (other than for reasons of death or disability). While there are numerous ways to structure this, a typical scenario is for the two doctors to agree to engage the services of a qualified dental practice appraiser (many times this is a dental practice broker in the area with experience in preparing appraisals). The partnership agreement states that both doctors agree on a particular appraiser, or more typically that each doctor will get his or her own independent appraisal. If the doctors agree on a particular appraiser and he or she is still appraising practices when one of the partners leaves the practice, then they agree to accept the value of the practice as appraised by that appraiser. Under the other scenario, each doctor engages a qualified dental practice appraiser, and each appraiser establishes a value for the practice. A typical agreement might say that if the two values arrived at by the appraisers are within 10% of each other, then the two appraisals are averaged and that average is the buyout value. If the two appraisals are not within the 10% benchmark, a third appraiser is then utilized, and his or her value is used.

  Once the value is established, the agreement states that the partner remaining with the practice has the right to buy out the partner who is leaving based on the agreed-upon appraisal. If the remaining partner agrees to buy out the departing partner, then partnership agreements typically also provide for terms regarding down payment, interest rate, and so on.

  For example, say Dr. Jones decides to retire. Dr. Smith as his partner has the first right to buy him out at the appraised value of the practice. If this value is $700,000, the agreement might say that Dr. Smith is to make a 10% down payment ($70,000) and Dr. Jones is to carry the balance over 7 years at the current prime interest rate. Of course, as with most legal agreements, these provisions can be altered to be anything the two partners agree upon.

  In the case of death or disability (the second and third instance of a partnership buyout), the partnership agreement provides for buyout provisions that are usually covered through life or disability insurance benefits.

This is generally the most cost-effective way for a partnership to provide the mechanism to buy out a partner who becomes disabled or who unexpectedly dies during the term of the partnership. If one or both of the dentists are not able to obtain insurance (generally for health reasons), usually a reduced total buyout value is agreed upon and is structured over a period of years. A reduced value is used because, without insurance benefits available, if one of the doctors dies or becomes disabled, the value of his or her partnership practice is reduced dramatically as word of the dentist's death or disability spreads in the community.

- The partnership agreement outlines responsibilities and duties of the partners. It states that each partner is expected to devote his or her full-time professional effort to the operation of the practice. It also states whether or not one of the partners will be the managing partner (this is a responsibility that is usually rotated between partners unless the partners agree that one partner has more expertise and should be the managing partner). The managing partner will likely be paid a management fee for his or her services.

Operational and Management Aspects

When the partnership is formed, all of the gross receipts of the practice are deposited into the partnership bank account, and all of the expenses are paid out of this account. For example, Dr. Smith and Dr. Jones form a partnership. They agree to split profits equally, as they are both working the same number of days each week and expect to produce about the same amount of dentistry. Additionally, they decide to split management duties equally.

Dr. Smith and Dr. Jones expect to gross $400,000 in the first year of the partnership, and their business plan shows overhead of $250,000 for the first year, leaving an expected profit of $150,000. Each doctor needs to take a draw from the partnership to cover personal living expenses and taxes. Because they do not want to deplete all of the partnership funds from the bank account, they each agree that they will take a monthly draw of $5,000 and leave the $30,000 balance of funds ($150,000 profit less $120,000 or $60,000 times two partners' draw) in the bank for purposes of working capital and future equipment purchases.

Dr. Smith and Dr. Jones will maintain what are called "capital accounts." Capital accounts are very important because a capital account is a running accounting of how much profit each partner earns and how much draw each partner takes out of the partnership. Capital accounts are used to determine how much of the remaining profit exists in the partnership attributable to each partner. These accounts are valuable in calculating a buyout of a partner deciding to leave the partnership. These accounts are also used if a partner needs to take additional personal draws. The capital account tells each of the partners if the other has "overdrawn" or "underdrawn" his or her capital account.

Table 9.1. Drs. Smith and Jones capital account example.

	Smith	Jones	Total
Capital Account: Beginning of Year 1	0	0	0
Capital Contributed	10,000	10,000	20,000
Profit Earned During the Year	75,000	75,000	150,000
Draws Taken by Partners during the Year	–60,000	–60,000	–120,000
Capital Account: End of Year 1	25,000	25,000	50,000

For example, using the above example of Drs. Smith and Jones, that the partnership earns $150,000 in year one. Each partner takes out $60,000 in draw leaving $30,000 in the bank. Let's also say that to open the partnership, both doctors contributed their own cash of $10,000 each. Table 9.1 shows what the capital account would look like after year 1.

In this simplistic example, each partner has $25,000 in the capital accounts and the partnership has $50,000 in the bank at the end of year 1. If the partners decided to end their partnership at the end of year 1, each partner would receive a final draw of $25,000, which would give them back their original capital contribution of $20,000 and distribution of undistributed profits of $30,000. From a practical standpoint, partners receive capital account adjustments for other items, such as liabilities of the practice, depreciation, purchase of fixed assets, and so forth. When determining the correct capital account amounts, a qualified CPA needs to be engaged.

Tax Issues

Despite the fact that the partnership section of the Internal Revenue Code is probably the most complex section of the tax code, operating as a partnership (or now as an LLC—see discussion below) has major tax advantages over the S and C corporations.

As discussed in the corporation section, in order to take tax losses in excess of basis, a dentist must be able to create basis by either loaning or contributing money to the corporation, which in many cases is not possible.

In the area of partnerships, as long as the dentist is personally liable on debt, basis is created. This can provide a huge tax advantage for a dentist who recently set up a practice and earned a large income from his or her associate position earlier in the year.

Example: Dr. Moss has worked from January through October for a private practice dentist and earns 1099 income of $150,000 (1099 is an IRS form). On November 15 Dr. Moss and his new partner, Dr. Jeffries, open a new dental office. In the first year (a month and a half), the Moss & Jeffries Dental Partnership purchases $200,000 of dental equipment and furnishings. Additionally, they generate revenues of $40,000 and expenses, not including depreciation, of $80,000 ($40,000 operating loss).

For the new partnership, Drs. Moss and Jeffries took out a loan from the local bank for $500,000, which paid for the $200,000 in equipment and furnishings, $200,000 in leasehold improvements, and $100,000 for soft costs and working capital. Both Dr. Moss and Dr. Jeffries are personally liable on the debt to the bank.

When Drs. Moss and Jeffries send their information to their CPA, they are informed that they are entitled to the $40,000 operating loss, plus $50,000 depreciation of assets (leasehold improvements), plus $100,000 of Section 179 deduction. Therefore, the loss on their individual K-1 (tax) forms is $45,000 each ($40,000 operating loss plus $50,000 depreciation, divided by two). Each also receives one-half of Section 179 deduction ($100,000), or $50,000 apiece. In total each will receive an allowable deduction of $95,000 (the $45,000 loss on the K-1 plus $50,000 in Section 179 expense).

The entire $95,000 loss is deductible on Dr. Moss's tax return and can be used to directly offset his $150,000 in 1099 income from his associate position. This is a huge advantage for Dr. Moss, as he can limit his tax liability while building his practice.

Each doctor in a partnership receives a K-1 form, which is an attachment to Federal Form 1065. All of the net income or expense is allocated to each partner based on his or her percentage interest in the partnership, which is found in the partnership agreement.

The partnership also allocates on the K-1 what is called separately allocated items, which have other limitations in the tax code. These items in a dental practice are generally Section 179 deductions on equipment purchases, charitable contributions, interest income, and other items in the tax code. These items are then put on the partner's Form 1040.

Another advantage of operating a business as a partnership is the ability to specially allocate income and deductions. For example, say Drs. Moss and Jeffries from above choose to have three locations. The partnership agreement says that the partnership owns the three locations, and that the income from location #1 is specially allocated 80% to Dr. Moss and 20% to Dr. Jeffries, location #2 allocates income equally, and location #3 is allocated 70% to Dr. Jeffries and 30% to Dr. Moss. As long as (pursuant to Internal Revenue Code Section 704[c]) the allocation has "substantial economic effect," meaning that the percentage allocations per the partnership agreement are how the profits are distributed, then the allocation will be respected by the IRS for tax purposes.

As with sole proprietorships, income allocated by a partnership to a general partner (all dental partnerships are general partnerships, which means that the general partner has unlimited liability as a partner) are subject to Social Security self-employment tax.

Liability Issues

One of the big disadvantages of operating as a partnership is that partners in a dental partnership are personally liable for any lawsuits filed against the

partnership. This could include wrongful termination, sexual harassment, age or sex discrimination, slip and fall, and so forth. Unless the dentist has an umbrella liability insurance policy, the dentist who is a partner when a partnership is sued can lose his or her personal assets, such as the family home, savings and brokerage accounts, and so on. This is why most dentists who form partnerships first individually make professional corporations (our recommendation is an S corporation), which then become partners of the partnership.

Limited Liability Company

The limited liability company (LLC) is an entity that is frequently used instead of the general partnership. A limited liability company allows dentists wanting to be partners to form this new entity and have it taxed under the partnership tax rules, while also having the liability protection of a corporation.

Prior to the LLC, when partners set up a partnership, each partner would set up a corporation that became the partner of the partnership. By doing this, the dentist would not be subject to the personal liability discussed above. The LLC basically makes it unnecessary to set up a partnership of professional corporations.

The LLC with more than one member (owners of LLCs are called members) files the same federal tax form as the partnership, which is a Federal Form 1065. As noted above, the federal tax rules are exactly the same for LLCs as they are for partnerships, but dentists need to check the LLC tax rules for each particular state. California, for example, has a limited liability tax of $800 per year and a limited liability fee that is based on gross income (as of this writing it is being challenged in court as being unconstitutional).

The IRS has made it easier for tax filing for single-member LLCs. If you are the sole shareholder of a dental corporation, you have to file a corporate tax return, which requires double entry accounting (income statement and balance sheet), as well as paying a CPA to prepare that return.

With the single-member LLC, the IRS considers it a disregarded entity. Therefore, if a dentist practices as a single-member LLC, the dentist does not have to file a partnership tax return and simply treats the business as a sole proprietorship for income tax purposes and reports all income and expenses on Schedule C of Form 1040, just like the sole proprietorship discussed earlier.

Advantages and Disadvantages of Partnerships and LLCs

The biggest advantage of the partnership is the ability to split profits any way the partners desire as long as the allocation has substantial economic effect. Also, the partnership offers huge flexibility in bringing in new partners, and there is no double taxation on sale of a partnership interest.

The biggest disadvantage of the partnership is the liability of the partners. As noted above, this can be easily eliminated by using the LLC.

The LLC has very few disadvantages and provides the advantage of using the favorable tax rules of partnerships, the limited liability afforded to corporate shareholders, and the use of the disregarded entities that eliminates partnership tax return and associated costs for the single-member LLCs.

What Is Right for You?

Hopefully the information in this chapter has given you some ideas as to which entity is best for you. Much depends on whether you are operating as a single dentist or with partners. The best thing to do is to put your thoughts together on paper as to what your long-term vision is for your dental practice and to meet with your CPA and attorney, who will generally give you the pros and cons of each option and will provide sound advice in order to make the decision appropriate for your situation.

References and Additional Resources

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Hill, Roger K. 2006. *Transitions: Navigating Sales, Partnerships, and Associateships in Your Dental Practice.* Chicago: American Dental Association.

McGill Advisory Newsletter. E-mail: info@bmhgroup.com.

Learning Exercises

1. When would you use a C corporation form of business as opposed to an S corporation form?
2. What are the advantages of the limited liability company over the corporate form of business?
3. When would it be appropriate to use a sole proprietorship, and what are its pitfalls?

Part 3
Business Systems

Chapter 10
Dental Practice Fees: What Do You Charge and Why?

Mert Aksu

Introduction: Dental Fees—What Do You Charge?

Fees for dental services are based on many factors, including practice location, local economy, insurance participation agreements, and personal practice philosophy. In medicine the patient pays, based on procedure, a lab fee and facility fee in addition to the professional fee. For the most part, the fees patients pay for dental services include all of these costs. There are wide variances in fees among North American dental practices, many of which are identified in fee surveys that are stratified by the practitioner's location. These fee surveys provide a perspective on the usual and customary fee at various percentiles for a broad range of procedure codes (example: the National Dental Advisory Service Pricing Program). The cost of dental care for any particular patient is based on the American Dental Association (ADA) procedure codes and the practice's usual and customary fee for the procedures performed. The "usual and customary fee" is in a sense the "list price" for that particular procedure.

Within a particular location, the prevalent factor affecting this is most evident when comparing practices that accept a variety of dental insurance plans versus practices that limit the number of insurance plans. Office amenities and staff compensation rates contribute to increased overhead and higher costs. While in many instances there is a close relationship between practice fees and the practitioners' wage on a per hour basis, practice overhead can often erode any potential profit from high fees.

The fees charged for procedures are an important consideration for many practitioners. While there are numerous annual surveys that report on average fees for various procedures, many practitioners are unable to articulate the basis for setting fees. In addition, the relationship between the fee, time allocated for a particular procedure, and expenses associated that procedure are often not in direct proportion to each other. Essentially, for the practice of dentistry, the practitioner's wage is determined by the net sum of all fees collected minus the expenses. Many practice managers and practice management consultants work with practice owners to help improve their ability to increase reimbursement per procedure and increase the number of billable procedures

delivered within a given time. These are two unique strategies. In order to increase fees, the practitioner must be able to convince the patient (purchaser of the service) that the service is worth the higher fee. This is often done by patient education, marketing, or changing the practice philosophy and physical amenities within the office. Many times this occurs when a retiring dentist sells his or her practice to a new dentist. The new owner-dentist redefines the practice image and purchases new "state-of-the-art" equipment to improve the level of services performed. Ultimately, he or she hopes to increase fees and annual collections.

The ultimate fee charged for any given procedure, and therefore the practitioner's income, is determined by simple economic principles. These economic principles are the basis for patient behaviors as consumers and for practitioners' behaviors as producers of dental services. This is because dental services are considered to be an economic good that patients purchase. Any patient's decision to purchase a particular good or service is determined by whether that good or service gives the patient satisfaction equal or greater to the satisfaction of the dollars paid for that service—dollars that the patient could spend on other goods or services. In addition, the "total cost" of the procedure from the patient's perspective also includes the value of lost wages, the cost of commuting to the practice, and any cost for other miscellaneous items such as child care.

Basic Healthcare Economic Principles

The law of supply and demand economics says that within a given marketplace, the price of any good or service will equal the equilibrium point price where supply equals demand. This point is defined by what economists call the intersection point between supply and demand curves. The supply curve of a particular good or service is determined by surveying the willingness of suppliers to provide a certain good or service at various prices. These points, when graphed, will produce a line. The slope of the supply curve shows how the supply of a good or service increases with increased price. Similarly, the demand curve for a particular good or service illustrates the willingness of consumers to purchase that good or service at various prices. The slope of the demand curve illustrates how fast demand will decrease as price increases.

When measured across large groups, dentists and patients have supply and demand curves for various dental procedures that intersect at a point that is deemed to be the economic equilibrium price. There are a number of factors that affect this; however, for the most part, the fee for a particular service is determined by the dentist's willingness to provide the service at that fee and the patient's willingness to purchase the service at that fee. A sample supply and demand curve is in Figure 10.1.

There are a number of things that affect the supply and demand curves. Patients who are given the chance to have dental insurance will consume

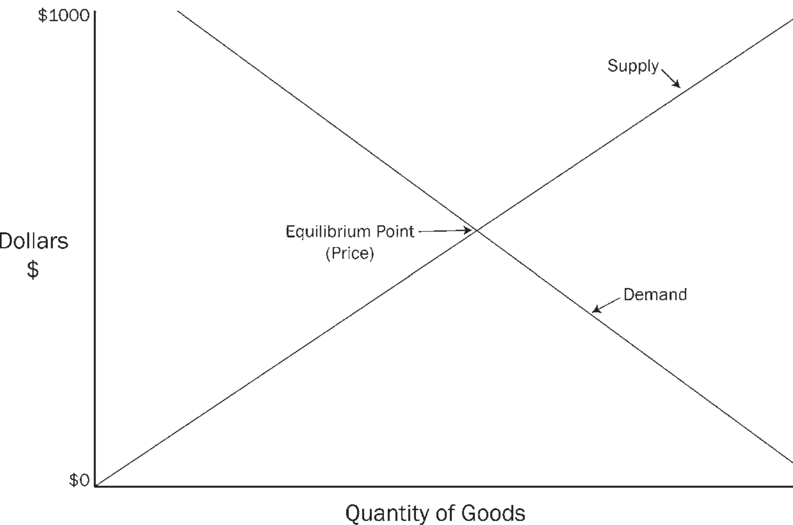

Figure 10.1. Basic economics of supply and demand.

dental procedures at a different rate when compared with similar patient populations without dental insurance. The actual cost of the procedure to patients decreases, and they demand more of the service than they would otherwise demand. So, the demand for the procedure increases in the presence of third-party reimbursement. Similarly, advertising campaigns and events in the media that portray the desirability of dentistry will also increase the demand for services. However, if the equilibrium point is not prepared to meet the increased demand, the dentist as a supplier of services will respond to the increased demand by increasing fees. The insurance carriers, on the other hand, will control reimbursement by placing ceilings on reimbursement and capping reimbursement, usually below the new equilibrium point. Figure 10.2 illustrates the effect of insurance on supply and demand.

Based on what we have seen so far, it seems that the secret to being able to charge higher fees is to get the patients' demand curve to shift so that the demand for services increases at the higher fee. Advertising, marketing, and patient education all cause the demand curve to shift. This is because if the patient perceives an increased value to the dental services provided, he or she will be willing to pursue treatment that would otherwise not be purchased. Figure 10.3 illustrates the shift in the demand curve caused by advertising and patient education.

This effect of advertising is particularly true for patients who view dental services as elective procedures. Of course, nonelective dental procedures, such as emergency exams and extractions, would have a different slope to the demand curve. The demand for these services would be more resistant to changes as the fee increased. That is, the demand for emergency procedures to

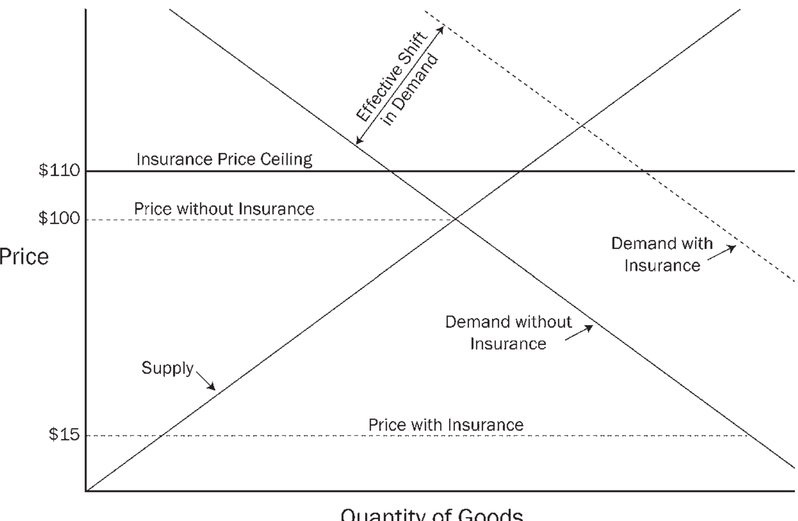

Figure 10.2. Effective shift in demand with insurance.

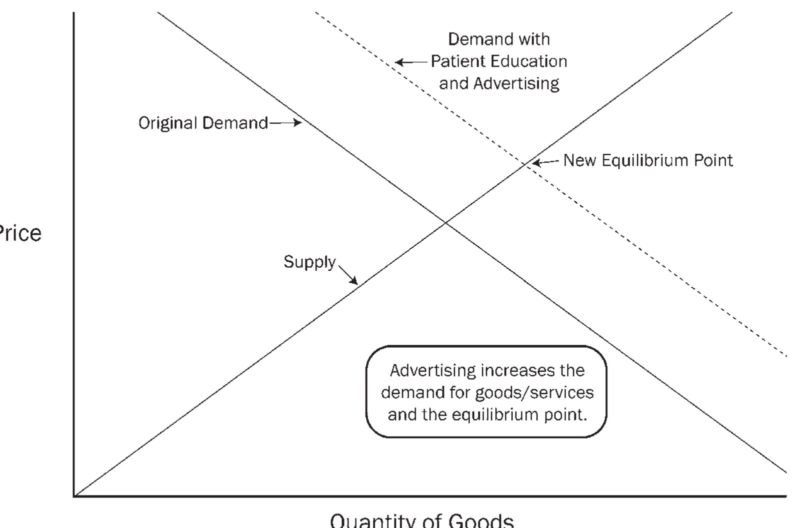

Figure 10.3. Effective shift in demand with patient education and advertising.

relieve pain would not demonstrate the same decrease as price increases relative to dental prophylaxis procedures or routine dental exams. For many the "annual dental check-up" is an elective procedure. These type of procedures are responsive to marketing, and therefore many dental societies have advertisements to encourage the public to see their dentist regularly.

Improvements in technology that make it easier to perform a particular procedure and the ability to delegate procedures to dental auxiliaries will

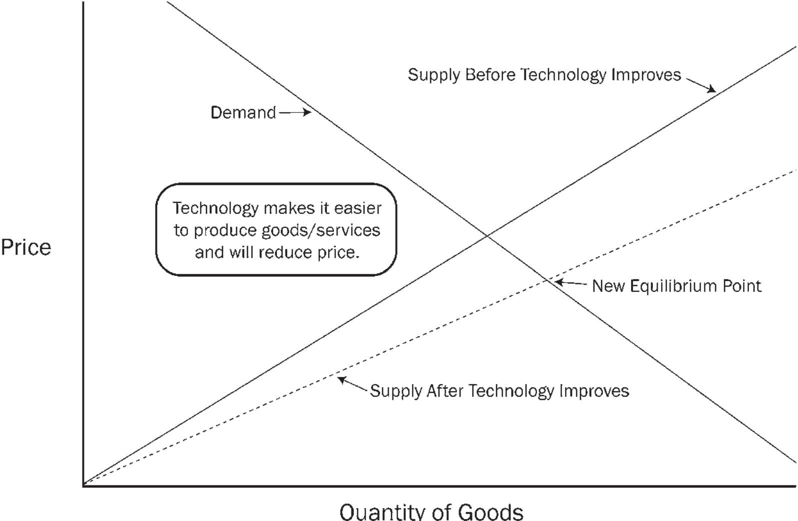

Figure 10.4. Effect of new technology and improved efficiencies on price of goods/services.

cause the equilibrium price point to fall by shifting the supply curve. Similarly, economists will predict that changes in the dental practice acts permitting the use of expanded duty auxiliaries will result in lower fees. Dentists will be more willing to perform these procedures at lower fees than they would otherwise be willing to do without the technology or ability to use auxiliaries. Figure 10.4 illustrates the effect on improvements in technology.

There are some procedures whose consumption decreases when the local economy improves. In economic terms these products are termed to be "inferior products." That is, if the income of the patients in the practice increases, the consumption of economically "inferior" services decreases. An example of this in the dental setting is extractions. An example of this in the consumer marketplace is macaroni and cheese. As the average income of any practice increases, patients elect to have endodontic treatment and crowns instead of extractions. Another example would be posterior amalgams or composites versus inlays or crowns. So the fee any dentist can charge for these services is in many ways related to the economic well-being of the patients of record.

In economic terms, two procedures can be substitutes when the price of one increases relative to the other, the demand for the other increases. In dentistry, a three-unit bridge and an implant are economic substitutes. One way to increase implant case acceptance and demand is to increase the price of the three-unit bridge. Merely increasing the fee for the three-unit bridge will cause an increase in the demand for single tooth implants. Another example of this economic principle is posterior amalgams versus posterior composites. Patients are willing to pay a premium for composites, however, and as the price

differential increases when composite fees increase, the demand for amalgams will eventually increase and patients will substitute amalgams for composite.

In summary, dentists and patients behave in the marketplace in accordance with basic economic principles. It is important to understand these basic principles in order to understand the consumer-oriented behavior of patients as they make their decision to purchase (or not to purchase) dental services.

Cost-Based Fee Structures

From an accounting perspective it is important for every practitioner to understand the costs associated with running a practice. For most solo-practitioner general dental practices, the overhead costs run 50–65% of gross collections. Factors affecting this percentage include number of hours worked, staff salaries, numbers of staff, rent/mortgage payments, supplies, lab fees, and other miscellaneous office expenses. As a rule, the fee for procedures that incur lab fees is often three to four times the lab fee.

One method of setting fees is to analyze the practice and the mix of procedures performed. The costs associated with each procedure can be calculated by determining the average time spent on each procedure and actuarially assessing a portion of the fixed costs of the practice to that procedure. In addition, variable costs associated to that procedure can be added into the equation. Fixed costs are defined as costs that do not increase when additional procedures are performed. These costs are incurred whether a practice sees one patient a day or a hundred patients a day. In general, the costs of rent, insurance, basic office staff, property insurance, and most utilities (heat, basic phone, and internet connectivity) are considered to be fixed costs. The incremental additional costs associated with particular procedures are considered to be variable costs. These costs can be plotted against the number of procedures performed. Alternatively, these costs can be plotted against the number of hours worked, in order to provide a general sense of the effect of fixed and variable costs. Also, on this graph, the average revenue per procedure or, alternatively, the average revenue per hour worked can be plotted. The intersection of these graph points gives the accountant an ability to understand the practice's break-even point and gives the dentist a net marginal revenue for the practice after the break-even point. Figure 10.5 shows a typical cost graph.

The net marginal revenue is defined as the incremental additional revenue that the practice earns minus expenses for every additional procedure or hour worked. This also defines the practice profit and profitability for any dentist contemplating increasing hours or increasing the numbers of procedures performed. Figures 10.6 and 10.7 illustrate the principles of fixed costs, variable costs, break-even point, marginal revenue, and profit.

For most owner-dentists, the profitable practice is achieved through a combination of controlling costs and maximizing revenue while wanting to mini-

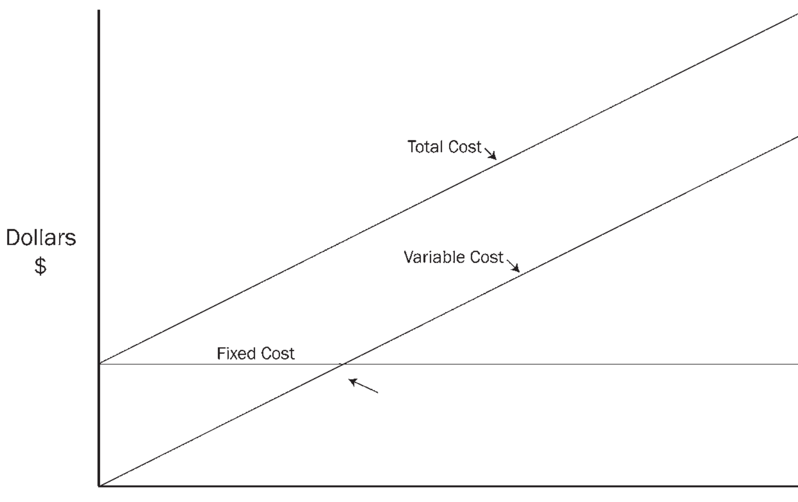

Figure 10.5. Practice costs: fixed, variable, and total cost.

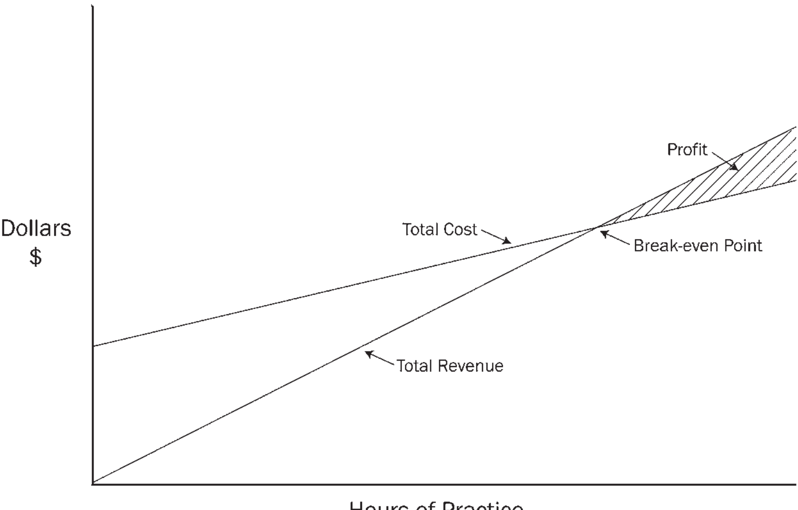

Figure 10.6. Break-even point.

mize the numbers of hours worked. This is an ever-increasing challenge. For many practices, patients are being pressured into managed-care insurance plans in order to reduce the cost of insurance premiums. Dentists are facing the decision of participating in various insurance plans or the risk of losing patients. The real question that dentists as producers of services need to consider is, what is the effect of managed care going to be on my bottom line? For some the answer may be no effect. However, for a large number of dentists,

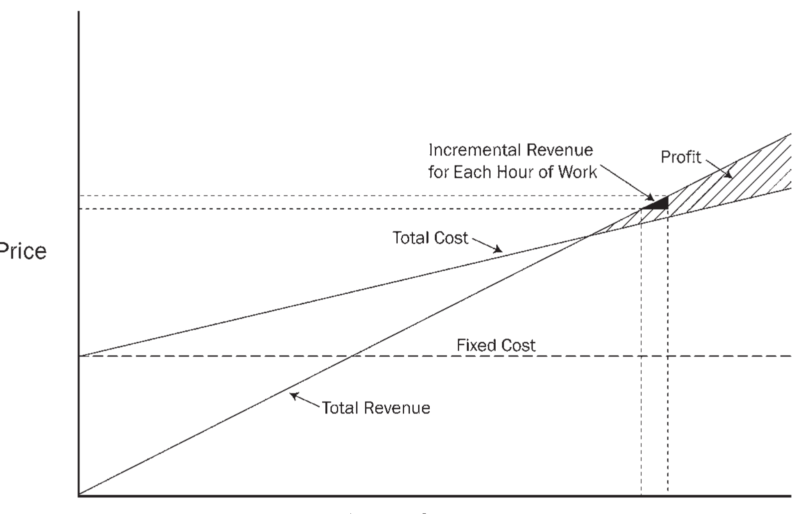

Figure 10.7. Marginal revenue.

the answer is that the participation in managed care will probably reduce reimbursement for some if not all procedures. So what effect will a 3% or 10% decrease in reimbursement have on your bottom line?

For illustration: Presume your practice has a $500,000 annual revenue and expenses of 60%. That means that the net taxable income is $200,000 and expenses are $300,000. Now, let's presume that the patients switch to a managed-care plan that results in a 5% reduction in revenue for the practice. Gross expenses are still the same: the owner will still have the same number of employees and will still use the same dental labs, still consume the same amount of supplies and utilities, and will pay rent that is the same or higher. So, the owner will have $300,000 in expenses on what is now $475,000 in revenue. The net effect of this is that as owner of this practice, your taxable income decreased by $25,000 or 12.5%—wow.

So what does the owner do? Work longer, work faster, use less expensive labs and less expensive materials, raise the fees for noninsurance patients. This is often a difficult decision for many. No single answer fits all situations. Discounting care affects the break-even point, because the average revenue per procedure or per hour decreases and the dentist has to either perform more procedures or work longer hours to produce the same net profit. See Figure 10.8 for the effect of discounted care on practice income.

The decision to accept plans that reimburse below the practice's usual and customary fees is usually only acceptable when the practice has open chair time. The practice that decides to accept reduced fees from a third-party plan intends to increase practice activity without displacing any of the practice's existing patients. The decision to accept a reduced third-party payment program is also done often with the hope that these new patients will also refer

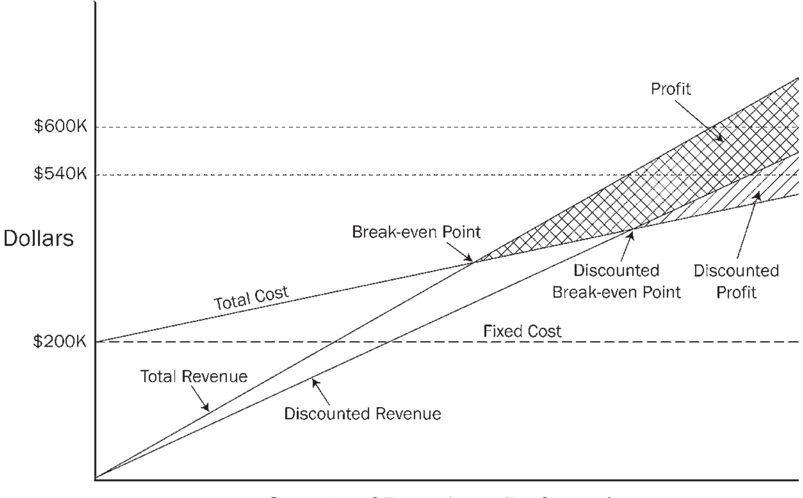

Figure 10.8. The effects of discounted care on practice income (10% discount).

friends and family who then may not be constrained by the managed-care plan. That is, there is a possibility that the managed-care patients may refer fee-for-service patients, who will improve the practice's payer mix.

Insurance companies control shifts in the demand curve with price ceilings. When a patient's out-of-pocket cost for a particular service is only a fraction of the cost due to the fact that the patient has insurance, the demand for services will increase with insurance due to the economic principles of supply and demand. Dental insurance companies will set maximum allowable fees for all procedures in order to counteract the effect of the shift in the demand curve with insurance. These limits are termed "price ceilings." In an economic sense, the resultant outcome is that the equilibrium price is below what the demand curve would otherwise dictate. In a practical sense, the decision between a large amalgam and a crown may be different when a patient has insurance than when a patient does not have insurance. Understanding that both procedures are performed for "medical necessity," however, the fee affects the decision-making process.

Dental Reimbursement Mechanisms: Third-Party Payment Programs vs. the All Cash Practice

Financial freedom in private practice is often spoken of in terms of the practice's ability to free itself of the constraints of third-party reimbursement. While the advent of dental insurance has increased the percentage of the population who regularly sees a dentist, the insurance industry has also been associated with cost controls, utilization controls, and quality controls that some practi-

tioners find to be overly burdensome. Despite this, most practices accept some form of third-party payment, and based on overhead averages, most practices could not survive without the population of insured patients.

While there are a number of different reimbursement mechanisms, the term "fee for service" describes patients that pay the practice's stated fee. Even if the patient is reimbursed by his or her employer through a "direct reimbursement" program, patients who pay the usual and customary fee of the practice are deemed to be "fee-for-service" patients.

There are "fee-for-service" third-party payment indemnity programs; however, these programs will have the usual price ceilings, utilization controls, and claims submission protocols, including the practitioner's agreement to participate in quality assurance reviews when requested. Many dental insurance companies have a "fee-for-service" insurance product that is sold to employers; however, this product is usually the most expensive when compared with other dental insurance products with the same annual maximums and same patient co-pays.

A "co-pay" is the insurance term for the patient's financial responsibility for any given procedure. Some patients may also have a "deductible," which is an amount that the patient must pay before any insurance benefit will start. Deductibles are usually calculated on an annual basis and are usually in the amount of $50 to $100. The purpose of the deductible is to provide checks and balances in the utilization of dental services. By making the patient personally responsible for the first $50 or $100 in any given year, the patient must make a personal financial sacrifice in an economic sense before the insurance shifting demand curve takes effect.

A dental PPO—or "preferred provider organization"—is a third-party managed-care plan that gives the patient an opportunity to get better coverage if the patient only seeks care from a certain list of "participating" provider dentists. Dentists can become participants by agreeing to accept the PPO's fees as the usual and customary fee for the PPO patients. The intent of PPOs is to provide a better level of benefits at a lower cost to the patient and the purchaser of the dental insurance—the patient's employer. The dentist participating in the PPO will be reimbursed according to the PPO's fee schedule. In an attempt to control costs, the PPO will often have fees at the 50th to 60th percentile. The implication is that in any particular Zip code or geographic region, 40–50% of practices will have usual and customary fees higher than the PPO's fee schedule. Similarly, 50–60% of practices will have lower fees. Participating providers will be required to accept the PPO's fee schedule for PPO patients regardless of what the particular office charges. Dental providers become participating providers by signing preferred provider agreements. These agreements often require the provider to complete a credentialing process and document licensure and minimum levels of professional liability insurance, and in some cases agree to background screening. The providers are required to sign a contract, binding the provider to the PPO for a certain period of time, with an opportunity to withdraw with written notice. In exchange, the provider will be listed

on the PPO's marketing materials as a preferred provider, and the PPO usually will make referrals to providers based on PPO members who inquire about the availability of local providers.

Another form of reimbursement is capitation. Capitation is a dental reimbursement mechanism that pays participating providers a certain amount of dollars per month for each enrolled patient, regardless of whether the patient is seen in the practice. The practice signs a written agreement to accept a certain number of capitation members and agrees to provide for all of the members' required basic dental needs without any further reimbursement, with the exception of the patient's insurance co-payment. The goal with capitation is to shift the risk for dental service costs to the provider, and in exchange, the provider has the possibility of financial reward if the enrolled patients need fewer services once they are under the care of the participating provider. Because the participating provider receives the capitation payment regardless of utilization, capitation programs often have certain benchmarks to ensure that patients are being seen for routine procedures and that patients receive the appropriate level of care. Capitation practices were much more popular in the mid 1980s, especially in the auto manufacturing regions, where many of the unionized workers were offered capitation plans. The capitation market was hurt by reports that patients were not able to get access to practices because of over-enrollment. The capitation market was also hurt by reports of patients not receiving appropriate care; for example, capitation patients would receive large amalgams rather than crowns, which the fee-for-service patient would receive. The practices that participated in capitation plans were guaranteed a certain per-member per-month payment (PM PM), and such arrangements were good catalysts for practitioners wanting to start practices "from scratch." Such financial arrangements were beneficial to practices that were able to establish a patient base that was able to maintain a certain level of dental health such that its treatment needs were less than the monthly payments for the capitation plan. The successful practice still needed to track procedures and costs so that the relative value of the provider's production could be tracked in relation to the payer mix of the practice. Twenty years since the implementation of the capitation model, enrollment in capitation dental plans continues to fall.

Looking at Practice Numbers

For the average dentist, every practice should have production goals and targets. These targets should be tracked on a daily, weekly, and monthly basis. The dollar value established as the target will be based on the number of providers, the geographic region of the practice, the operating hours, and the mix of services provided. The practice should be looking at production and collections simultaneously, as both numbers are a reflection of the practice's financial health. Every procedure should be reflected in the practice ledger, even procedures that the practitioner ultimately decides to provide at a reduced fee or

without a fee. The usual and customary fee of the practice should be reflected for every procedure. Only when this is done does the practitioner have a sense as to the size of the practice write-offs and the dollar value of care provided as a "professional courtesy."

In an accounting sense, dental practices are a cash basis business. In that sense, the practice will have tax liability based on the collections and not on the production. As a result, while the dollar value of the write-offs is not a deductible expense, every office should have a record of such write-offs and the reasons for them. The reason for write-offs can include family/employee discounts, insurance participation write-offs, and write-offs for remakes, bad debt, and so forth. The amount of write-offs can significantly impact practice profitability if left untracked.

The dollar value of accounts receivable should typically not exceed more than 1 month's production. This is particularly true in practices that use electronic claims submission and electronic claims payment programs.

How to Get Higher Fees for What You Produce

As previously discussed, there is often wide variance in fees among practices—even in the same geographic area. This most directly relates to the particular practice's ability to induce demand at the higher fees. While most patients do not report that they choose a dental practice based on the fees, most patients will say that the decision to pursue a particular treatment will be influenced by the fee. The reputation of the doctor and the practice attracts the patient, and once in the practice, fees do come into consideration when making treatment decisions. Patient education and most patients' desire to sustain a youthful and healthy smile are strong motivators when patients elect to pursue treatment.

The successful practice needs to have a consistent image and message to its patients. The practice that tries to "be all things to all people" will struggle with case acceptance. A practice's ability to sustain consistent fees will be related to its ability to sustain a consistent image. The practice that markets for "coupons" will attract patients interested in discounted dental services, and when the patient realizes that the advertising campaign is inconsistent with the image of discounted care, the patient will most likely leave the practice. Only if the patient finds some other extrinsic feature in the practice will he or she continue and pursue treatment with the practice's usual and customary fees.

Each practice should have consistent payment policies in order to minimize accounts receivable and the risk of uncollected/uncollectible debt. Accordingly, every attempt should be made to accurately calculate the patient's insurance benefit at the time of service and collect the patient portion of the fee, if any is due at the time of the appointment. The doctor needs to understand the "net present value of money" (NPV) and the effect that uncollected debt and

payment plans will have on the practice's financial strength. Financial planners and accountants often speak of the NPV, which is a calculation of the value of accounts receivable if they were paid immediately rather than over time. The NPV of money discounts all future payments to determine their present value, if paid in full immediately. The NPV depends on the duration of time predicted to collect accounts receivable and the prevailing interest rate for debt. A typical practice grossing $800,000 with an accounts receivable of $150,000 and with aging account average of 45 days will be losing value based on NPV calculations. In response, many practices promote credit cards and the use of personal credit accounts with third parties to improve cash flow and reduce the accounts receivable. These third-party personal credit accounts are also promoted to increase case acceptance. Many of these personal credit programs will provide immediate payment to the practice and allow the patient a period of time to make interest-free installment payments. Practice management consultants often point to the effect these programs have on improving case acceptance; however, these types of financing options will often cost the practice 8% or more of the total fees charged.

Last Thoughts

It is difficult if not impossible to quantitatively formulate the basis for the fee any individual practice charges for a particular procedure. Regardless of how the fee is established, practices cannot set the fee based on the patient's insurance status. The American Dental Association states, "It is unethical for a dentist to increase a fee to a patient solely because the patient is covered under a dental benefits plan" (*ADA Principles of Ethics and Code of Professional Conduct*). Practices also cannot waive any insurance co-pay or deductible as part of the collection policy. The ADA sets forth in its *Principles of Ethics and Code of Professional Conduct* ethical duties that are binding on its members, and in this document it is stated that "A dentist who accepts a third-party payment under a copayment plan as payment in full without disclosing to the third party that the patient's payment portion will not be collected, is engaged in overbilling." The practice must consistently collect the patient co-pay and deductible. Failing to collect these patient portions may subject the practice to legal action and even criminal prosecution. However, fees can be adjusted based on case complexity.

The Federal Trade Commission (FTC) restricts dentists from comparing fees and engaging in activities that are substantially likely to discourage competition. FTC control is wide-ranging and is designed to protect the public from unfair business practices. Dentists who conspire to refuse to submit dental x-rays to insurers along with patients' insurance claim forms are engaging in illegal activities prohibited by the Sherman Antitrust Act. The dentists unsuccessfully argued that they should be permitted to engage in activities to protect the health and well-being of the patient. The insurance companies provided

evidence that the decision to withhold x-rays limited its ability to review claims and implement cost-containment mechanisms (*Federal Trade Commission v. Indiana Federation of Dentists*, No. 84-1809). Because of the wide range of activities that can be construed to be unfair business practices, the FTC often releases advisory letters in response to specific inquiries of business practices. In this manner, the FTC has commented that surveys that are not likely to have an anticompetitive effect may be conducted, and as a result, numerous consulting firms have been able to collect data on the usual and customary fees for various procedures. The FTC Antitrust Division routinely cautions against fee surveys that are viewed to reduce independent pricing of dental services and competitive market. Dentists are routinely cautioned against comparing fees with their local colleagues, in that this may be portrayed as anticompetitive action.

The issue of dental fees has received a lot of attention. The *New York Times* reported that "In real dollars, the cost of the average dental procedure rose 25 percent from 1996 to 2004. The average American adult patient now spends roughly $600 annually on dental care, with insurance picking up about half the tab" (Boom times for dentists 2007). The issue of dental fees will continue to be discussed, particularly as the population of underserved continues to grow.

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Learning Exercises

1. As a new owner of a dental practice, you realize that half of the patients are members of a dental HMO and that the old owner discounted the fees by an average of 33% for these patients as compared to the remaining patients of the practice. You are trying to decide whether you can afford to discontinue the participation with this

HMO. Please discuss the overall impact on revenue if you drop the HMO and lose 75% of these patients. Assume the practice produces $600,000 worth of dentistry and collects $300,000 from the "fee-for-service" portion of the population and $200,000 from the HMO patients.

2. You just bought a rural practice. Many patients need crowns, but most have not expressed an interest in crowns. Discuss in an economic sense why these patients have not elected to pursue these needed crowns.

Answers

1. For 50% of the practice you are discounting your fees 33%. For this portion of your practice you realize that half the procedures are discounted by 33%. Even though half the procedures are HMO patients, the revenue from this portion of your practice is 40% of the total. You only collect 67% for half of your work. The other half of your collection rate is 100%. The HMO care equals 40% of your revenue. If 30% of these patients stay and begin paying your regular fees, your new gross will be $390,000. The 30% of the HMO patients who stay with the practice will return 15% of the previous gross production (the percent of the patients that stay) multiplied by (the percent of patients that were HMO patients) multiplied by (the total gross production) = 30% × 50% × $600,000 = $90,000 added to the previous collection from the non-HMO patients.
2. The total cost of the crown (noneconomic and economic cost) may exceed what the patient is willing to pay. The patient's demand curve may be such that the equilibrium point is above the point at which the patient would "consume" this treatment option. The dentist could increase demand with patient education, reducing the fee for crowns, or encouraging patients to secure insurance if not already insured.

Chapter 11
Fees, Fee Setting, and Financial Policy: A Practitioner's Perspective

Robert D. Madden

Introduction

Dental fees are the lifeblood of a dental practice. They are the single most important tool the dentist has to generate income and to offset the cost of doing business. The primary goals of a fee schedule are simple: generate profit and growth for the dental practice. Fees and fee increases are part of the normal process of conducting a dental practice. Fees need to be high enough to permit the business to accomplish the following objectives: (1) cover the expenses of the business, (2) permit reinvestment in the business, and (3) provide a respectable rate of compensation for the owner. On the other hand, fees need not be so high as to price oneself out of the marketplace.

Dental practices have a tremendously high overhead. Historically, overhead will range from 60 to 65% of production for a general dentist (*McGill Advisory* May 2007b). Lab fees, dental supplies, equipment, facility costs, staff salaries, and taxes are just a few of the items that contribute to overhead. The doctor often has to be content with the amount that is left over after all the bills are paid. The amount can vary from practice to practice. It can be as little as 9% and as much as 35% of collections. The point is, the doctor does not get anywhere near all that is collected (Glasscoe 2000).

Practices with low fee schedules and thus low profit margins are frequently subjected to complaints from staff members about low wages. This in turn can lead to a high staff turnover rate. It can also lead to an inordinate amount of stress for the doctor having to deal with an overhead that is out of control and the financial difficulties associated with failing to recognize a profit. Dental practices with healthy, well-maintained fee schedules are rarely subjected to these financial and managerial problems.

How much is a professional service worth? Ask ten different people and you are likely to get ten different answers. In dentistry, we frequently talk about professional fees being based on care, skill, judgment, overhead, and expected revenues per hour. Ideally, fees should be derived with these considerations.

In reality, dental fee schedules are established in a variety of ways. Some dentists use survey data, others use tables of allowances from indemnity insurance plans, others use relative value tables, and some opt for using inherent cost of procedures in establishing fee schedules. For the most part, fees in the dental industry are determined like those in other consumer-driven entities. That is to say, prices are market-driven. The range of price has been set by the marketplace. Various fee surveys reveal the range and percentile that have been established for a service in a particular geographic area. These surveys add credibility to the fact that the majority of dental fee schedules are derived in such a manner. That being the case, it makes no financial sense to charge any less than what has been established in a given geographical marketplace. Pricing established in such a fashion is referred to as "target pricing." Target pricing is defined as being a mechanism wherein prices are set based on market penetration or price points rather than building from standard costs (12manage, The Executive Fast Track).

The insurance industry uses this pricing model to build fee schedule profiles on its providers. It is also a means by which usual, customary, and reasonable (UCR) fee tables of allowances are determined as well as preferred provider organization (PPO) fee schedules.

Fee Schedules and Definitions

Ethically, your practice should have only one fee schedule. The fee schedule in your office represents what you would normally charge for each procedure performed in your office and is referred to as your *usual fee schedule*. State boards and other regulatory agencies frown on practices that have multiple fee schedules. That is to say, you cannot have one fee schedule for insured patients and another for noninsured patients. The usual fee schedule in your office represents your full fee for a given procedure and has nothing to do with the amount of money contractually reimbursed by a patient's dental benefit plan.

Most dental practices accept dental insurance benefit plans. As a result, your practice may accept several different *tables of allowances*. Tables of allowances should not be confused with your usual dental fee schedule. Tables of allowances are dollar amounts representing the total contractual dollar obligation on part of the dental benefit plan. They have nothing to do with your usual fee schedule.

Some dental benefit plans reimburse for specific dental services based on a *maximum allowance*. Typically these plans reimburse up to 100% of a predefined dollar amount. The dollar amount of reimbursement is based upon the financial strength of the plan as defined by the contract with the purchaser, not the insurance company (Limoli 2007). Dentists who participate in such plans cannot collect their full fee from patients covered by a maximum fee schedule, as they are contractually bound.

Frequently, dentists and patients alike are confused by the difference between the terms "maximum allowance" and "maximum fee" as they relate to a practice fee schedule. Regardless of the payment schedule, your usual fee schedule is not taken into consideration. With maximum allowances, the patient is responsible to your office for any balance due on your usual fee. With maximum fee scheduled plans (i.e., PPOs), *participating dentists* cannot collect their usual fee should a balance exist after payment. On the other hand, should a patient with a maximum schedule have work done with a *nonparticipating* dentist, balance billing is permitted.

Why Do Dental Practices Need to Increase Fees?

The world would be a happy place if one never had to raise the price for a particular good or service. Unfortunately, we live in an imperfect world. We live in a world subjected to economic forces that change the outlook for everyone on a daily basis. Fees charged for dental services are subjected to the relative prices of other goods in our economy. Inflation is the primary reason you must raise fees on a periodic basis.

Inflation is defined as the increase in the price of some set of goods and services in a given economy over a period of time. It is measured as the percentage rate of change of a price index (Wikipedia).

In the long run, inflation is generally believed to be a monetary phenomenon, while in the short and medium term, it is influenced by the relative elasticity of wages, prices, and interest rates (Federal Reserve Board 2004). It is generally agreed among economists that a small amount of inflation does carry a positive effect on our economy. There are many reasons for this justification, the principal one being that it is difficult to renegotiate prices in a downward direction. One such example would be an attempt by management to lower employee wages. Modest inflationary pressure means prices for a given good or service are likely to increase over time. This trend helps to keep the economy active, as it encourages spending, borrowing, and long-term investment. It is for this reason that dentists must keep informed about inflation and keep pace with inflation by periodically raising fees. Our economy is not stagnant, and neither should be a dental professional's fee schedule.

Disturbing Trends

It is important to stay abreast of inflation in raising fees and also to pay attention to what is happening to your profession. As recently as 2004, some disturbing trends have started to emerge in the dental profession. Unfortunately, most dentists in this country are not operating at or near full capacity. In a survey conducted by the *McGill Advisory* in 2006, it was reported that 83% of dentists are not as busy as they would like to be. The reported statistic showed no

improvement over a previous survey conducted in 2004. What has led to this lack of busyness is a combination of factors that merit discussion.

It was previously anticipated that by 2000 there would be an increase in the number of retiring dentists. Recent surveys conducted by various consulting groups, as well as the American Dental Association, show this is not the case. The lack of retirement by dentists has been primarily due to the lower net asset values and investment incomes of doctors. The lack of retirements has helped increase the competition within the dental industry. While this is of concern, an even bigger concern is the shrinking portion of consumers' disposable incomes.

Fueled by rising gas and energy costs, inflation, the mortgage crisis, and higher short-term interest rates, consumers' disposable incomes have lagged behind the rate of price increases in the general economy. With less disposable income available to consumers, dentists find themselves competing for the limited disposable dollars available to consumers. For the majority of dentists in our country, this has resulted in fewer new patients and fewer procedures being performed.

Operating costs of a dental practice have continued to mount in recent years. Dentists have traditionally relied on an increasing number of units of production to sustain net income and practice growth. Survey data have shown that dental office productivity has been increasing at a rate of approximately 1.5% per year (Beazouglu et al. 2002). With the number of units of production in decline, dentists can no longer rely on productivity alone to sustain net income and practice growth. Fee increases are inevitable, even with disturbing economic news. Unfortunately, for those dentists participating in discounted fee dental benefit programs, fee increases to offset costs have not occurred due to contractual constraints by the benefit programs. Dentists participating in these programs have seen their practice profits erode and overheads skyrocket.

The ability of dentists to increase office production in the future as a means to maintain or expand their net incomes will depend on an increasing demand for dental care by people with the resources to pay for that care. The downward pressure on the utilization of services in dental benefit programs will make growth more difficult. Once viewed as an effective stimulus for the demand for dental services, dental benefit plans may be seen by some as becoming a less effective stimulus because of the downward pressure they exert on utilization and fees. Dental benefit plans can also lead to stagnation in the maximum annual benefit level (Guay 2005).

Adding to the woes of the consumer is what has been happening in the insurance industry. There has been a marked decrease in dental caries. Public fluoridation and preventative oral health programs have done their job. That being the case, consumers have opted toward more cosmetic procedures, many of which are not covered by dental benefit plans. With decreasing levels of disposable income, even these heavily marketed cosmetic procedures have been difficult for consumers to afford.

Employers wishing to control the ever-rising cost of dental insurance premiums have switched from indemnity policies to managed-care plans. Currently, 60% of the dental benefit programs are of the discounted fee type. The result for many dentists has been to willingly or unwilling become discounted fee providers. The really bad news is that annual fee increases associated with discounted fee products only permit increases of up to 1% or less (*McGill Advisory* May 2007a). If inflation is occurring at the rate of 3–4% a year, it will not take long for dentists to notice a marked decrease in profit and an increase in the overhead required to run the practice. Unfortunately, many dentists, fearing a lack of busyness, willingly or unwillingly opt for becoming preferred providers. Such action only adds to the problem. Practitioners, seeing their profits shrink and overheads swell, are left with only one viable solution: Raise fees to all present and future patients not on a discounted fee program, to cover the costs of those receiving the discount. From a societal standpoint, one might ask, is this fair and ethical treatment?

Doctors who do not raise fees at least annually resign themselves to higher overhead costs and lower profits over their remaining career, since it is difficult to implement large (makeup) fee increases. Also, doctors participating in managed-care plans must submit fees annually for approval. Most of these companies do not allow doctors to "catch up" with larger fee increases in a later year, so their fees remain lower permanently (*McGill Advisory* 2006).

Factors that Influence Pricing

How often should I increase my fees? How much do I raise my fees? These are frequently asked questions by young dentists. It is recommended that you review your fee schedule at least once a year. Fee increases can vary from the percentage of inflation up to whatever the marketplace will tolerate. It is a good business practice to pay attention to the consumer price index, the producer price index, and the employment rate in order to assure oneself of having a profitable, balanced, and reasonable fee schedule. Additionally, it is important to stay abreast of economic developments in one's community. While it is important to periodically increase fees, one must pick and choose the times that are most opportunistic for the success of the business. Obviously, you would want to think twice before subjecting your practice to a fee increase when local economic conditions fail to support this business decision. For the most part, fees and fee setting need to be reflective of economic conditions at the local, national, and international levels.

When to Raise Fees

Is there any particular time of the year that it is better to raise dental fees? The answer is yes and no. From a budgetary standpoint, it is generally agreed that you raise your fees effective the first month of the calendar year. By doing so,

you are able to properly position your practice fees in order to ensure greater profitability in the coming year. By having a consistent time of the year for fee increases, you also can better construct practice comparisons and growth indices with previous calendar years. That having been said, should economic conditions make fee adjustments necessary, you should act immediately so as to ensure profitability of the practice. One such example would be an increase in the price of gold. Drastic price changes in an upward direction of this commodity will lead to higher dental laboratory costs for the practice and will affect profitability.

How to Raise Fees

In order to raise fees, you must first determine where your practice's fees are positioned relative to other practices in the same geographic location. This process is easily accomplished using fee survey information. Recommended surveys include Dr. Charles Blair's comprehensive "Peace of Mind" Revenue Enhancement Program, the UCR Dental Fee Report, and the ADA Survey on Economic Research on Dentistry. Frequently, dental practice brokers will construct fee surveys on communities in which they operate. You may want to locate practice brokers and fee survey information by utilizing the internet.

Doctors cannot properly set fees without first determining where their fees are positioned in the marketplace. Failing to do so can cost thousands of dollars in the course of a career. Insurance companies have access to data from companies such as the Health Insurance Association of America. The insurance companies use the data to establish fee reimbursement schedules. As a dentist, you need to have access to this information to help position your practice fees in the marketplace (*McGill Advisory* 2006).

The second step in the process is determining where in the marketplace you wish to position your practice. Positioning should take into account and be reflective of the practitioner's expertise, time, skill, and judgment. Overhead associated with the practice is also an influencing factor. In short, prices should be reflective of the quality of care. It is interesting to note that many patients do not equate fees with the quality of care. Patients generally rely on the newness of the equipment, the perceived aesthetic appeal of the practice, customer service, and personal interaction issues in judging the quality of care (*McGill Advisory* 2006).

Once you have decided on which percentile is reflective of the practice, you should raise all fees up to that desired percentile. Raising some but not all fees results in an unbalanced fee schedule, sending an inconsistent message to the patients of the practice and to insurance carriers (*McGill Advisory* 2006). Ultimately, such action results in an unbalanced fee schedule.

The third step in the process is maintenance of the fee schedule. Paying attention to what is happening with inflation and the general economy is extremely important. Armed with this information, it is recommended that the

doctor continue to raise fees across the board each year thereafter to maintain market position. According to practice management consultant Dr. Charles Blair, 89% of doctors follow this approach to maintaining their fee schedules. The other 11% elect to raise some but not all of their fees on an irregular and inconsistent basis.

In general, doctors fear negative reactions by patients when raising fees. Change can be difficult, especially for the new dentist. Having to confront conflict with patients over fees is even more trying. It has been my experience and that of many of my peers that the perception of fear is much worse than the reality.

How Much to Raise Fees

Economists estimate that on average, our economy experiences a rate of inflation ranging from 3 to 4% annually. If you are to recognize a profit at this level of inflation, you must raise your fees a minimum of 5% across the board to keep pace or increase practice profitability. Once again, pay attention to the annual rate of inflation as it is reported in the economic indexes. The rate of inflation as reported by the Consumer Price Index (CPI) is a primary determinant in raising fees.

Economic Indexes that Influence Fee Setting

Consumer price index: The CPI is the most recognized measure of price inflation in retail and service goods. The CPI is composed of eight different groups, each of which is weighted in the calculation of the CPI: housing 42.4%, food and beverage 15%, transportation 17.4%, medical care 6.2%, apparel 3.8%, recreation 5.6%, education/communication 6.0%, and other goods and services 3.5% (Baumohl 2005). These eight groups represent over 200 categories of goods and services whose price changes over a period of time are used to measure and calculate the CPI. The CPI uses an index number versus a dollar figure. This permits one to gain a historical perspective on how inflation has performed over a various time frames. For example, assume at the end of 2000 the CPI index was 200. Measured 6 months later the score is 202, or a 1% increase in inflation for the first 6 months. Annualized, it would represent a 2% increase in inflation.

Dr. Albert Guay, in his article "Dental Practice Prices, Production, and Profits," states the following: "Nonetheless, dentistry functions within the general economy of the United States and its healthcare system, and it is influenced directly by conditions operating in those sectors. It is important for all—from health planners to individual practitioners—to understand dentistry's economic relationship to the general economy and the healthcare system, as well as how changes in both sectors are reflected in changes in the dental

care system at all levels." His article points out the strong relationship between the CPI and dental fees charged in the United States. The trend is to parallel one another (Guay 2005).

Producer price index (PPI): The PPI measures the changes in prices paid by businesses during various stages of production. The index is composed of three price indexes, each representing a stage in the production cycle. Thus, the index for crude goods, immediate goods, and finished goods composes the PPI. Established in 1902, the PPI is the oldest measure of inflation for our economy (Baumohl 2005). From the standpoint of a practicing dentist, it is wise to pay attention to this index. A rise in this index implies the dental products we use in dentistry are increasing in cost, hence signaling to dental practitioners the need to increase fees.

The employment rate: It represents one of the most influential economic indicators of the U.S. economy. The employment news of our economy details conditions in the job market and household earnings. The information in the rate of employment report is important when forecasting future economic activity. The employment rate is announced the first Friday of each month and reports on the month just concluded (Baumohl 2005).

From the standpoint of a practicing dentist it is nice to know what is happening both locally and nationally with employment. A rise in unemployment signals to providers of dental services that consumer spending is tending to drop off. Thus, one can expect his or her practice to notice a drop in production as well as collections. With this information, one might put on hold any elective office improvements and watch spending on inventory more closely. Most economists agree an ideal unemployment rate would be in the range of 4.5–5%.

From the standpoint of dental fees, an increase in unemployment may cause one to think twice about instituting a fee increase. On the other hand, if the CPI is increasing at a rate of 4–5%, one would have no choice but to increase fees just to keep pace with inflation, the rationale being that you will produce less, but at a higher fee to maintain a profitable business margin. As you can see, it is a must to keep an eye on inflation as well as what is happening to the employment rate when increasing fees. Unfortunately, most dentists, when confronted with rising unemployment rates, sit tight on their fees, fearing they will lose patients and thus production. The result of such action means less overall income, greater overhead, and less profitability for the practice and the dentist. If this type of activity occurs over a period of 3–4 years, the dental practitioner who failed to increase fees will be playing catch-up when economic conditions improve. Playing catch-up means fee increases beyond those of practitioners who have kept pace with inflation. This is not wise from the standpoint of maintaining patients in the practice or managing a profitable business.

I recommended that you subscribe to economic-related periodicals such as *Business Week* or the *Wall Street Journal* to become familiar with the economy and its economic indicators. Reading such publications will give you a sense of what is happening in the local, national, and international economies.

Understanding what is likely to happen economically can only help you make intelligent business decisions in regard to fee setting and general practice management.

Practice Purchase and Fee Schedule

What happens if you purchase an existing practice and are unhappy with the fee schedule? First, how long has it been since the fees were increased in this practice? If it has been some time, over a year or 2, you should definitely entertain the idea of a fee increase. Generally, we as dentists do not like change and are reluctant to make changes to a fee schedule in a practice that is in transition, for fear of losing patients. If the fee schedule is not to your liking, then change becomes a necessity and you should proceed with making the change. Choosing to not do anything is a grave mistake.

Most practice brokers generally agree that fee schedules of most practices in transition tend to be too low. There are two schools of thought in regard to making changes to a practice fee schedule for a practice that is in transition. The first line of thinking would recommend an incremental increase in fees. That is to say, raise some but not all fees, and do so in two to three phases during the next 12–18 months. Start with items that are paid by insurance carriers, exams, x-rays, and cleanings by raising fees to the medium-high or high percentile. Radical changes in any aspect of an existing practice made by a new owner can and may initiate problems. Once fees are at an appropriate level, fee increases should be implemented on a yearly basis. The second school of thought is to raise all fees 3–5% or more depending on where the practice fee schedule falls demographically and where you choose to position the practice in the marketplace. It should be emphasized that low fees described above may also have other related problems initially overlooked during the purchase phase of the practice. One such problem may be the lack of a written and well-communicated financial policy.

If the fee schedule of the practice has been raised on an annual basis and is still below the prevailing price range for the geographic area in question, what should you do? The knee-jerk reaction is to raise fees across the board to bring them into line with what is being charged in the community. Though this is the correct action to take, it merits more thought than merely increasing the fee schedule. Prior to becoming the new owner of the practice, you should take time and question the selling doctor on the philosophy of his or her fee schedule. It may be that the seller never felt really comfortable raising fees to the level that prevails in the community. This should be a red flag to the prospective purchaser of the practice. It can be difficult to institute fee increases for practices with historically low fee schedules without a lot of conflict with the practice clientele. Additionally, practices with low fee schedules tend to have higher overhead rates, higher levels of employee turnover, and lower levels of profitability.

Discounting Practice Fees

The decision to discount your usual fee is a personal business decision, and there is really no right or wrong answer. When allowing discounts it is always nice to remember that someone is paying for that discount. With this in mind, the decision is up to the owner of the practice as to whether or not discounting of a fee is permitted.

In today's marketplace people are always looking for ways in which they can get the best price. Patients of a dental practice are no different. Patients will often approach the dentist or the practice financial/accounts manager and ask for a discount of the fee. Many reasons may be cited by the patient. The request for a fee reduction should come as no surprise to the dentist. In situations like this, the practice must have a clearly defined, well-communicated philosophy when it comes to discounting fees. It is extremely important that the philosophy be followed on every case in which a discount is given. It is recommended that payment for services that are discounted be made at the time of service. Payment should be made either by cash or check. Credit cards have processing fees associated with them, so it is not recommended that you accept credit cards for payment when discounts are given. As far as the amount of discount given, that is up to the dentist/owner, as he or she will most likely be the one absorbing the cost or loss as a result of giving a discount.

Discounting of Fees and Dental Benefits

The question that is becoming more frequent is this: I have an opportunity to become a preferred provider for a particular dental benefit program. The agreement states that I must use their fee schedule or discount my fees 20%, and whichever fee schedule is less is the one I will be reimbursed by. The agreement also states I cannot balance bill the patient for what the insurance company does not pay. What is the impact of participation in discounted fee programs on my fee schedule, my practice, present and future patients, and access to care?

To answer this question, one needs to take an in-depth look at what is happening as a result of discounted fee dentistry. Insurance companies have developed discounted programs, for example, PPOs, to combat the rising cost of dental benefit premiums. The premiums paid by employers of PPO benefit programs are less expensive and thus are more attractive to businesses than indemnity plans. By offering this type of program to companies, the insurance company can maintain or expand its market share and provide a product that is actuarially sound at a lower premium price. Companies electing to purchase this type of benefit program are happy because PPO premiums are less expensive and thus decrease costs and increase profits. What about the recipients of the program? What happens to them? Frequently, they must find a new dentist, one who is in the PPO's network of preferred providers—a dentist who is willing to discount his or her fees in exchange for becoming a network pre-

ferred provider. The preferred provider list is then marketed to those individuals who have a specific PPO benefit plan. In essence, a "preferred provider" is agreeing to discount his or her fees in exchange for having his or her practice marketed by the insurance company as a preferred provider. If the patients refuse to change dentists, they will receive less financial benefit from their benefit program. More out-of-pocket cost to the patient is the net result of not participating with a preferred provider.

The "preferred provider" dentist is also affected by agreeing to discount his or her fees. The cost of procedures does not go down by becoming a preferred provider. The cost of care is the same for all patients regardless of the type of benefit plan they have or may not have. Costs of providing care are very real. They do not go away. You can deny and try to launder these costs, but they do not go away. Someone always has to pay. Who is that someone? It can be the provider, or it can be the present and future patients of the practice who do not receive the benefit of a discounted fee schedule. If the provider fails to shift these costs in the form of higher fees to non-discounted fee patients, the provider incurs a loss by being a preferred provider. Since costs do not go away, the overhead of the practice increases and the profit margin of the practice decreases. If the provider elects to pass these costs on to the present and future patients of the practice who do not receive a discount, those patients will be subject to increased fees beyond that needed to account for inflation and profit. The increases in fees by the provider are then passed on (assuming they have dental benefits) to the insurance companies of those patients who have dental benefits. The insurance company notes an increase in fees charged and more payout costs and thus raises its premiums to the companies it markets its products to. The companies that provide the benefit to the employee then have a choice: pay a higher premium price for a benefit program or eliminate the benefit altogether. As you can see, the only way one party benefits from discounted fee dentistry is at the expense of a subsequent party. Michael Porter and Elizabeth Olmsted, in their book *Redefining Healthcare* (2006), call this "zero sum competition." Ultimately, fee discounting and the accompanying cost shifting result in higher costs for everyone. Less access to care is the final burden passed on to society.

An issue to be addressed in this scenario is the ethical considerations of having people who do not have dental benefit programs or have indemnity benefit policies pick up the costs for those who have discounted fee policies. As of today, the American Dental Association has taken a hands-off approach to this ethical issue. It is a business decision on part of the dentist whether or not to participate in discounted fee programs and cost-shifting activity.

Impact of Fee Increases

An annual increase of fees is an economic necessity if you wish to keep pace with inflation and the ever-increasing cost of running a dental practice. Costs in the dental industry continue to climb as a result of competition for quality

employees, technology, OSHA requirements, marketing, discounted fee dental benefit programs, and an increase in energy costs.

Fee structure and annual fee increases represent the quickest means available to dentists to decrease practice overhead and increase profitability. The number one deterrent to practice profitability is the discounting of fees as a result of participation in discounted fee dental benefit programs. From a business standpoint, fee discounting results in less profitability for a dental practice, and ultimately higher healthcare costs for *all patients* in a given practice. It is for this sole reason that participation in discounted fee programs should be discouraged, insofar as this is a veliable option in the marketplace.

What Is UCR?

UCR stands for "usual, customary, and reasonable" as it pertains to fees. UCR is an acronym created by the insurance industry; it appears at the bottom of explanation of benefit forms and checks supplied to providers of dental services by insurance companies. The UCR is created by the following methodology: The insurance companies record the fee numbers as submitted by practitioners on dental claims. The insurance companies sell the numbers (fees) to a company, such as the Health Insurance Association of America (HIAA). Since HIAA is not an insurance company, it can compare and analyze fees without worrying about "restriction of trade" litigation. HIAA then "sells" back the data to the insurance companies. The insurance companies then have an entire range of fees from which to compose their very own UCRs (Webb 1999).

There is no such thing as a universal UCR fee. Rather, there exists a range of fees based on percentiles.

What Are Percentiles?

In simple terms, percentile means, how many out of 100 did you beat? For example, the 80th percentile is that number or fee for which 80% of all fees fall below and 20% fall above (Webb 1999). Understanding percentiles will permit you to better position your practice fees with those in the same geographic or Zip code region.

A Benefit Provider Says My Fees Are Too High—Are They?

On occasion, you may receive notification from an insurance carrier stating that your fees are higher than the UCR for the geographic area. The question arises, are my fees really out of line with the UCR for my geographic area?

The answer is no. In reality, UCR varies from company to company and from policy to policy. Insurance companies generate these notices based on the *premium paid by the employer* for that particular policy. The lower the premium, the lower the table of fee allowances, thus assuring the insurance company that the policy sold is actuarially sound. It is the responsibility of the dentist and his or her staff to educate the patient on insurance reimbursement and coverage as it relates to policy coverage and fee-level reimbursement bought by an employer for an employee. Depending on the premium paid, the fee allotted as UCR may or may not be represented by one's fee schedule. A good quotation to have available to patients when the above scenario presents is the following: "This action is not an attempt to establish a fee or to discuss the propriety of the provider's charge, but the expression of the obligation accruing under your plan. Please refer to your plan booklet for further information" (Webb 1999).

Relative Value Unit Pricing

Just what is relative value pricing? Relative value unit pricing at this point in time is rather foreign to most dentists. This type of pricing model has been in place in medicine for over 10 years. With the strong possibility of national health insurance confronting our profession, you need to become familiar with what relative value unit (REV) pricing is all about.

Historically, providers of healthcare services have fee schedules based on the UCR format. The shortcoming of this form of fee schedule is the diversity in the fees charged for the same service within the same geographic area. With exploding healthcare costs in the 1970s and 1980s, serious cost containment needs for medical and dental services prompted investigation into alternative reimbursement methodologies. The relative value pricing model seeks elimination of the wide variances in fees for the same service within the same geographic area. The pricing model is an attempt to standardize fees charged to patients.

The REV Model

A relative value scale (RVS) ranks services according to "value," where that value is defined with respect to a base value. All services are assigned a unit value, with more complex, more time-consuming services having higher unit values and vice versa. Values are then multiplied by a dollar conversion factor to become a fee schedule (Ingenix 2008).

Since its inception, the REV model has been modified. In 1996, the Resource-Based Relative Value Scale (RBRVS) was developed using the results of a Harvard University studies team that first identified three distinct components affecting the value of each procedure:

1. Provider component
2. Overhead component
3. Liability component

REVs are assigned to each component, and the sum of these composes the total value of each service (Ingenix 2008).

REV pricing is likely to be in the future of most dentists. You should understand that it is an attempt to standardize the cost of healthcare delivery to the patient.

Definitions

The following is a list of definitions that may be of help in understanding fees and various forms of fee schedules and allowances.

Customary fee: The fee level determined by the administrator of a dental benefit plan from actual submitted fees for a specific dental service to establish the maximum benefit payable under a given plan for that procedure.

Fee schedule: A listing of charges for services rendered and agreed upon by the dentist of a particular practice.

Maximum allowance: The maximum dollar amount a dental program will pay toward the cost of a dental service, as specified in the program's list of provisions.

Maximum fee schedule: A compensation arrangement in which a participating dentist agrees to accept a prescribed sum as the total fee for one or more covered services.

Reasonable fee: The fee charged by a dentist for a specific dental procedure that has been modified due to the nature and severity of the condition being treated. This fee may be different from the dentist's usual fee or the insurance company's customary fee.

Table of allowances: A list of covered services with an assigned dollar amount that represents the total obligation of the benefit plan with respect to payment for such services. The table of allowances does not necessarily represent the dentist's full fee for that service.

Usual fee: That fee which the dentist most frequently charges for a given service within the practice.

Collection and Payment Policies

To own and operate a dental practice you must be a skilled clinician and businessperson. The goal of any business is not to break even but to register a profit. It is rather simple: without a profit, there is no practice. It is not only important to have a balanced fee schedule but also important to have a system to collect the money owed to the business. Collections of fees for provided care are the lifeblood of the practice and a necessity if the practice is to remain a going

concern. Overhead is traditionally high in dentistry, and bills must be paid on time. Additionally, you deserve to be compensated for professional services. Unfortunately, dentists have traditionally been overly sensitive to the financial needs of their patients. By placing the financial needs of the patient first, far too many dentists have found that financial problems have become the norm and practice failure a reality. To avoid this set of unfortunate circumstances it is important to have a written, well-communicated financial and collection plan. A payment policy needs to be in place prior to starting the practice of dentistry.

How to Get Started

New patients and all current patients of the practice, upon their arrival, should be given two forms to complete, the first form being a medical/dental health history, the second being an account registration form. The account registration form should include the following for patients with or without dental insurance:

Account registration form components:

1. Person responsible for the account
2. Driver's license number
3. Address information
4. Phone number
5. Insurance information
6. Preferred payment option

Payment options for patients without dental insurance:

1. Cash or check at time of service
2. Pay by credit card at time of service
3. Apply for extended payment plan

Payment options for patients with dental insurance:

1. Pay estimated portion at the time of service with cash or check
2. Pay estimated portion at time of service with a credit card
3. Apply for extended payment plan

The components of this form communicate two clear messages to the patient. The first is that payment is going to be addressed regardless of insurance status. The second implies that if payment is not going to be made at the time

of service, the patient must make application for the privilege of not paying at that time.

The information from the account registration form then becomes a part of the patient record. The hardest part of any payment policy is the follow-up and holding of all patients of the practice to the established rules. If not strictly adhered to and audited every month, the policy becomes worthless.

Importance of Cash Flow

A survey conducted by American Express of healthcare professionals asked what the most important management priorities for the next 6 months were; 32% of dentists surveyed put managing cash flow at the top of the priority list (Langwith 2005). In order to improve cash flow, payment policies need to be enforced. Payment involves more than just stating to the patient that payment will be made by cash, check, or credit card. It starts by having a written and well-communicated treatment plan.

The components of the treatment plan should include the items to be addressed, cost, priority, treatment options, estimate of dental benefits, and the number of appointments required. The patient should be consulted about the treatment plan and asked if he or she has any questions. The patient is given a copy of the treatment plan, and financial arrangements are made with the office accounts manager. A comprehensive treatment plan enables the accounts manager to become more familiar with the treatment, sequencing of treatment, and associated fees prior to making financial arrangement with the patient. By handling treatment in this fashion you can avoid performing treatment the patient did not expect or for which he or she was unaware of the cost. In private practice, the best surprise to the patient is no surprise when it comes to cost of care.

How Much Can One Afford to Finance?

While financial arrangements are important, you must ask who is in control of the process. Patients want arrangements that are affordable and advantageous for their personal budgets. On the other hand, patient financing is a liability to the dental practice.

Acceptable financial arrangements are those in which risk to the practice is minimized. The first step in the process to minimize risk is to know the overhead of the practice. The overhead percentage is the key if one is to have an in-office financing program. As an example, if the overhead of the practice is 60%, the practice can only afford to finance 40% of the patient's expected bill. By not financing the variable cost of the treatment, your cash flow remains intact, and risk is minimized. Bills associated with treatment are covered by not financing more than the profit margin of the business. The idea of financing

is to be flexible enough to oblige the patient but strict enough not to put the practice at any undue risk.

Once the financial policy has been established, it is extremely important that follow-up on the arrangements is carried forth by the accounts manager. This step is frequently left to lapse in many practices. If you expect to collect what you have produced, it is an absolute necessity that this step not be ignored.

Credit Cards

Part of a good financial policy is accepting credit cards for services provided. The use of credit cards allows for a strict payment policy simultaneously with keeping the widest range of patients. Recent estimates show that 144 million Americans carry at least one general-purpose credit card (Langworth 2005). Surprisingly, many dental offices today still do not accept payment by credit card. The primary objection to credit card payment is the associated cost of establishing and maintaining a credit card system. When you consider the benefits—payment, out-of-the-office financing, ease at which business can be transacted—it seems imprudent not to have this service available to patients.

Utilizing Collection Agents

In spite of efforts to have and administrate a good financial policy in your practice, bad accounts still occur. There are two schools of thought with regard to utilizing a collection agency. One line of thought centers around the fear of getting sued by the patient if the account is turned over to a third party collection service. It is interesting that people cannot find the money to pay their dental bill but they always have enough money to pay to an attorney to file a lawsuit against a dentist trying to collect for professional services. Nonetheless, fear results in no action and a financial loss to the practice. The downside of such an approach is your practice gets a reputation in the community of being “soft” on financial issues. The saying “birds of a feather tend to flock together” really holds true if you have a soft hand with regard to those people who are delinquent on their accounts.

The second school of thought is to use a collection agent when all in-office attempts have failed to result in payment of a delinquent account. It is important to be aware of state and federal standards governing the use of collection agents. You should take the time to interview and discuss with the third party collector policies and adherence to state and federal law. Hiring a collection agency with a good reputation and adherence to state and federal law is of utmost importance if you are to avoid litigation. Whether you attempt to collect accounts in-house or via a third party agent, the Fair Debt Collection Practices Act (FDCPA) governs issues on to how to communicate with debtors and how payments must be processed. The FDCPA became law in 1978 and prohibits

any harassment or abusive conduct and the use of false or misleading statements in the collection of patient debt by third party debt collectors. The provisions of this act do not apply to businesses that collect their own debt. However, the act does apply to collection agencies, lawyers, and other third party agents who in the regular course of their business collect debt for others (Abdullah 1996). A word of caution when you choose to collect accounts in-house: state law can be stricter than federal law when it comes to collection of delinquent accounts. Adherence only to the FDCPA guidelines may not protect you from litigation. You should consult an attorney prior to starting the collection process to ensure that you are in compliance with laws of your state.

When turning an account over to a third party collector, it is your responsibility to ensure information about the person and the account is correct. Additionally, the collection agent cannot use any prohibited acts as stated in the FDCPA to collect a delinquent account. Violations by the collection agent can result in federal litigation should the patient file a complaint and a violation of the FDCPA is noted. As a result, dental practices using third party collection agencies face the very real risk of countersuits.

Summary

A fee schedule is the primary tool available to a dentist to generate income to help offset the cost of doing business. Our economy is influenced by a number of factors that cause it to be in a constant state of flux and impact a dentist's fees. Economic indicators help us measure these changes and help us understand our rate of inflation. Inflation is the primary reason why fees need to be increased on a periodic basis. Discounting of fees has a tremendous negative impact on the cost of doing business and the level of profitability recognized by the business.

To ensure your fees are acceptable to the patient, the treatment plan and financial policy (including your fees and collection polices) need to be communicated clearly.

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Learning Exercises

1. You have recently purchased a dental practice in which the fee schedule appears to be competitive within the geographic area. The practice broker reaffirms the fact that the fee schedule has been well maintained and is competitive. You notice the collection production ratio of the practice is in the low 90% range, and the overhead of the practice is higher than the national average. What are the possible reasons for what is going on in this practice? What can you do to resolve this problem? What areas of practice management would you investigate?

2. A disgruntled patient tells you that your fees are too high. What do you tell this patient? What can you do to possibly prevent this situation from happening again? Should the actions of this patient concern you? Why or why not?

3. How does managed care impact fee setting? Do you think it is unethical to participate in cost shifting? Why or why not? Do you think the ADA should take have an ethical statement concerning cost shifting?

4. Why does increasing fees offer more benefit to those practices with higher overheads?

Chapter 12 Appointment Scheduling Strategies

Dunn H. Cumby and Rosita Brown Long

Appointment Scheduling Policy and Philosophy

Appointment scheduling is the foundation of a dental office. All production and revenue generated by the practice result from patient fee for services. These fees result from the effective and efficient use of time. Dentistry can be described as a service business that sells time. This time is broken up into units that are used to assign patient appointments into daily scheduling. How this time is allocated and managed first depends on the number of hours available to the dental office.

The typical dental office is not open for business every day of the calendar week. Most dental offices use a 4-day workweek. In addition, by providing 7 holidays and 2 weeks of vacation each year, the average dental office may be open for production a total of 196 days per year. Most offices can count on the dental providers losing other production days due to personal or family illness or other emergencies. Time away from the office must also be allowed for professional continuing education. In large practices, time units are also lost to staff meetings and strategic planning and/or facilities maintenance. All of this means that out of a typical year (365 days), the dental office may be open for business about 50% of those days.

Since time is the most valuable product for sale in the dental practice, the best use of this resource is accomplished by establishing a scheduling policy and philosophy that allows for the effective use of this resource. The policy, along with its philosophical principles, should be written, implemented, maintained, and periodically reexamined to verify that it remains relevant within the desired context and will provide the desired results. The document should be kept in the office in a place where all the staff have access to it and can refer to it on a daily basis, as necessary. Some offices refer to this as a "recipe or system strategy" for scheduling. But whatever name is given to it, it should be a documented systematic approach to appointment scheduling that works for a particular office as long as the logic and steps are followed.

Many scheduling strategies exist among dental offices. Generally, these strategies are rooted in philosophical principles. Unless an office has scheduling principles from which an appointing strategy can be implemented, the true potential of the dental office will not be achieved. In addition, the office will not come close to receiving its highest return on investment while simultaneously providing scheduled patients with excellent care. Whoever schedules the appointments in a dental office is like the conductor of a symphony. If an appointment is not scheduled, production cannot be realized, and if appointments are not scheduled properly, office production will never reach the fullest potential. No scheduling strategy will work if there is a lack of commitment by the doctor(s) and staff. In other words, for the scheduling system to work, it must *be* worked. A scheduling system is worked by the consistent application of the principles involved in its management. Any decision to change the system should be decided collectively. Two of these philosophies are briefly discussed.

The first of these principles results from a relatively simple philosophy: *Just keep the doctor busy and everything will work out in the end. Keep all the chairs full during office hours.* Offices using this philosophy generally schedule several appointments within the same time slot just in case one or more of the patients scheduled do not show up or cancel the appointment at the last moment. The doctor, then, may also be scheduled in two or more treatment rooms at the same time. The type of treatment procedures planned for the time slot is not taken into consideration when these appointments are made. The philosophy is to just keep the doctor busy. These are the kind of scheduling philosophies found in clinics where the patients expect to wait for extended periods of time and usually only very basic types of dental treatment are provided. Another way to understand this philosophy is to view it as similar to an emergency room at a local hospital, where patients are treated on a first-come-first-served basis. This principle is to do *something* for each patient and to do more only if time allows.

On the other hand, some offices "orchestrate" time slot utilization. This orchestration is based on production goals, finely tuned and timed procedures (systems), disinfection and preparation time needed before and after each treatment procedure, the doctor's time to perform each procedure, and the preferences of doctors and patients. The principles in this type of scheduling can be relatively simple or extremely complex. Some doctors prefer to schedule more complex treatment early in the day, while others prefer to schedule this treatment in the middle of the afternoon or at the end of the day. Some doctors prefer to appoint children early in the morning rather than late in the afternoon. These schedules require the complete coordination of clinical and clerical staff as well as provider staff to maintain smooth office workflow.

Either of the philosophical approaches to scheduling will work in a variety of dental settings. There are, however, many other types of scheduling that fall somewhere between these two. For the purposes of this chapter we focus on

the merits and challenges involved in the principles of orchestrating an appointment scheduling system.

Types of Appointments

In order to orchestrate appointments, thought, purpose, and intent must be used to schedule all appointments before they are written in the appointment book. Appointment time increments in dental computer software are usually broken down into units of either 10 or 15 minutes. The daily appointment objective is to maintain a productive flow of patients in the practice day. Scheduling and production efficiency are critical to patient wait times. Appropriate scheduling with low no-show rates results in a most effective and efficient patient-satisfying practice. Additionally, appropriate scheduling is more likely to meet daily provider production goals. As scheduling is discussed in this chapter, consider an ideal small clinic or practice to have three chairs (operatories) and two assistants per dentist. Also consider the ideal larger practice as a six-chair (operatory) dental clinic with two dentists, four assistants, and one hygienist.

There are many strategies to developing and using scheduling blocks. Many offices have successfully used quadrant dentistry by scheduling one or two patients per hour per dentist, classifying an appointment as either exam or operative (child or adult) or emergencies (or walk-ins). Many others have used the physical operatory as the scheduling block. Some use the open access method of appointment scheduling by appointing daily call-ins and seeing call-ins the same day of the call. Some leave blank time intervals in the schedule for potential emergencies that are filled as emergencies or when new patients call in for appointment times either the same day or the next day. Providers or assistants may elect to schedule next appointments from the chair based on treatment evaluation, and suggested follow-up time intervals requiring a later reconciliation with the front desk scheduler. There are advantages and disadvantages to any strategy chosen. Provider preferences and the target market served generally dictate the best strategy for managing scheduling blocks.

Appropriate scheduling blocks and sequencing of procedures are important to the efficiency of the practice as well as to establishing patient goodwill. Time demands, scope of the treatment plan, patient requests, and treatment sequencing are aspects of scheduling that are impacted by the type of procedure provided to the patient. In other words, all aspects complement one another, and none are stand-alone considerations. Other aspects to consider along with the procedure itself include office staffing availability, provider absences, other office facilities and equipment availability, style and philosophy of the provider, and the proficiency of the dentist or provider complementing the individual need of the patient to tolerate particular treatment demands. In this section, we do not incorporate or address these aspects specifically, though we do acknowledge their existence. Instead, we refer the reader to other sections of the chapter.

Table 12.1. Ten-minute appointment book interval.

Time Units	Dr. Zip	Dr. Dip
8:00 a.m.	Ms. Happy (child exam)	Mr. Loner (emergency)
8:10 a.m.		
8:20 a.m.		
8:30 a.m.	*Open slot*	
8:40 a.m.	*Open slot*	
8:50 a.m.	*Open slot*	

Table 12.2. Fifteen-minute appointment book interval.

Time Units	Dr. Zip	Dr. Dip
8:00 a.m.	Ms. Happy (child exam)	Mr. Loner (emergency)
8:15 a.m.		
8:30 a.m.	*Open slot*	
8:45 a.m.	*Open slot*	

Units of Time

There are many ways to utilize time to get the best production from providers and to most efficiently utilize operatories. Time units can be scheduled in 10- or 15-minute intervals. An example of a 10-minute interval appointment book is shown in Table 12.1. A 1-hour time block can comprise as many as six appointments for each of the doctors, as shown on the appointment book in Table 12.1.

An example of a 15-minute interval appointment book is shown in Table 12.2. A 1-hour time block can only comprise as many as four appointments for each of the doctors as shown.

Consideration must be given to doctor preferences and the most frequently delivered treatment procedures prior to selecting time intervals for a practice.

Operatory Availability

An example of a 10-minute appointment interval using operatory scheduling is shown in Table 12.3.

Operatory appointment booking allows for doctor, space, assistants, and facility use to be included in planning for the appointment. Each operatory is assigned an assistant, in this case Assistant W and Assistant Y. Some time slots shown on Table 12.3 indicate assistant functions where the doctor is *not* involved and present in the operatory. These may or may not be included in an actual appointment book. These slots are prep and seating, dismissal of the

Table 12.3. Operatory appointment booking.

Interval	Operatory #1/ Assistant W	Operatory #2/ Assistant Y	Appointment Name/Op#	Dr. Zip
8:00 a.m.	Prep & seating	*Open*	Crown—Ms. Sad/OP#1	*Open*
8:10 a.m.		Open		*Open*
8:20 a.m.	Dr. Zip	*Open*		OP#1—Asst. W
8:30 a.m.	Dr. Zip	Prep & seating	Crown—Ms. Glad/OP#2	OP#1—Asst. W
8:40 a.m.	Dismiss			*Open*
8:50 a.m.	Decontaminate	Dr. Zip		OP#2—Asst. Y
9:00 a.m.	*Open*	Dr. Zip	*Open time*	OP#2—Asst. Y
9:10 a.m.	*Open*	Dismiss		*Open*
9:20 a.m.	*Open*	Decontaminate		*Open*

Operatory #1 (OP#1)
Operatory #2 (OP#2)
Assistant W (Asst. W)
Assistant Y (Asst. Y)

patient, and disinfection of the operatory. The dental assistant is primarily responsible for these required functions.

Preparation (prep) of the operatory may include the assistant reviewing a checklist of items that are needed for the appointed procedure and subsequently ensuring that those items or supplies are available prior to the doctor's entry into the operatory. In addition, "seating of the patient" ensures that the patient and his or her chart are brought to the appropriate operatory and the patient is greeted, made to feel comfortable, and draped for the procedure. The assistant may also preliminarily converse with the patient and generally address today's treatment event. Also of interest in this demonstration is that the time slot is unavailable when the operatory is being disinfected, in spite of the fact that the patient is not physically present in the operatory.

The patient appointed to the time slot and the procedure planned is included under the fourth column in Table 12.3. Ms. Sad's treatment is planned as a crown preparation and final impression. She has been scheduled in operatory #1 with Assistant W. A 1-hour total operatory time slot has been allotted to this procedure. Dr. Zip has been given only 20 total minutes to complete the procedure. The amount of time required for this treatment procedure (by this doctor) can only be known by the scheduler and/or doctor through trial and error over a period of several months. As an example, an additional 10 minutes could be made available to him by decreasing the amount of prep and seating time required for this patient and/or procedure. Ms. Sad, however, may be elderly with comorbid conditions requiring several blood pressure readings or more time to prepare her for the procedure. In this case time must be made up in the dismissal and/or disinfection time slots or through the doctor's increased efficiency. A doctor could also alternately make up time through efficient use of the second operatory.

The opportunity to make up time through use of another operatory makes operatory scheduling more desirable, given a flexible and efficient staff. Notice the staggered scheduling required in order to effectively utilize the provider's time between two operatories. Whenever both an operatory and a dentist are shown to be *open in the same time slot*, there is an opportunity for another appointment to be inserted. However, the amount of *open time* available dictates the procedure that can be performed within that time frame.

Disinfection and Preparation Time

The procedure determines the amount of preparation time and disinfection time that it takes to prepare a treatment room between patients. Hygiene procedures are the simplest and fastest types of dental treatments to prepare for in setting up an operatory and in disinfecting a treatment room. Hygienists use the same instruments on most all procedures. They have two basic trays: one for prophylaxis and one for deep scaling and curettage. Dentists, on the other hand, have many different types of treatment procedures requiring different instrumentation and equipment, as well as different time frames to complete these functions.

Root canal treatments have become very sophisticated when rotary instrument systems are used instead of hand instrumentation. Many of the rotary files can only be used once, and those that can be recycled must be monitored with each usage and inspected for damage before being used for the next procedure. Some practices that offer implants and other surgical procedures have specially designed rooms to be used specifically for those types of procedures. It may take up to 20 minutes to properly set up a room for an implant procedure. If they have the space, for efficiency, some practices use other rooms for patient sedation before moving the patient into the surgical treatment room. Documentation of the specific manufacturer and brand name of implants used in the procedure must be recorded. Sometimes it takes longer than was allotted in an appointment time slot to provide proper sedation for the patient. When this happens the doctor or hygienist has to wait and try again. All of this takes time that may or may not have been planned.

For every procedure performed in a dental office, the proper time needed to set up and disinfect before and after the treatment should be factored into the time that the treatment room is not available to any other procedure. These functions also occupy the assistant's time both before and after the treatment procedure. Care should be taken when using operatory scheduling to consider procedure type, especially when scheduling a patient for treatment that requires the presence of both the assistant and the doctor. Some appointments, like denture adjustments and healing checks, do not require an assistant.

There are hundreds of different dental procedures that can be provided to patients. The doctor or assistant uses a basic exam instrumentation setup (mirror, explorer, and cotton pliers) for many of these procedures. Some offices

use a tray and tub system in which all the materials and instruments are placed on a tray and all the supplies and equipment are placed in a tub that is either color coded or labeled for use with a particular procedure. Other offices stock each operatory with the basic supplies and only bring the necessary instruments from the sterilization room into the operatory. The tray and tub systems are broken down and disinfected away from the operatory. Those offices that stock supplies in the operatory treatment room must take the time to restock each room periodically, in addition to disinfecting after each use of the operatory.

Time Units by Procedure

The time it takes to set up and disinfect an operatory is easier to gauge than the time a particular doctor needs to perform a specific procedure. This is especially true of new doctors or even an experienced doctor who has incorporated a new procedure into the practice. Just remember that with every new thing there is a learning curve. Repetition leads to efficiency, and efficiency leads to decreasing the time needed to perform different dental procedures. An excellent idea is to periodically record the time doctors and hygienists need to perform different procedures.

The more information the scheduler has concerning a particular appointment prior to the appointment time, the more likely the appointment will be scheduled within the appropriate time slot. The specific tooth number, the surfaces to be treated on each tooth, and the total number of teeth to be treated at the next visit are “minimal information.” No scheduler will ever complain about being given too much information about the dental visit being scheduled. Typically doctors err on the side of giving too little information to the scheduler about the next appointment. This is not a desirable behavior.

Ten-minute time units allow for more flexibility in scheduling an appointment. When 10-minute time units are used in scheduling, it is much easier to salvage time over the course of a normal workday. “Ten-minute cultures” must be established over time in the dental office. Much of appropriate appointment scheduling is orchestrating a practice/patient rhythm. Procedures can be measured in terms of 10-minute time units. Hygiene appointments can be used as a basic example. Some offices schedule one hygiene appointment per hour. Not all prophylaxis take the entire hour to accomplish, but even if finished before the hour is over, the hygienist must wait until the next patient arrives for the next appointment. If, however, the hygiene appointments are scheduled every 50 minutes or five “10-minute” units of time for each appointment scheduled, 10 minutes are saved with each appointment. If appointments are scheduled on the hour, using the 50-minute time for cleanings, the next appointment will be scheduled for 10 minutes before the hour, the following appointment will be scheduled for 20 minutes before the next hour, and so on. For every eight appointments, eight units of time are saved (1 hour and 20 minutes in

potential production time by the end of a typical 8-hour day). This will allow the hygienist to see nine patients instead of eight and have two units of time to "spare" at the end of the day.

Let us take this hygiene example and put some numbers with it. If the average hygiene appointment is a $100 production, the hygienist can treat five more patients over the period of 1 week. That increased production accumulates over a 1-year period to 300 more patients treated. Using these very conservative figures, an additional $30,000 in production could be scheduled for the year. These "spare units" can be thought of as "spare change," which adds up to increased production, as well as efficiency in utilizing the resources of the practice.

Scheduling by Provider

This section includes a discussion of the four basic dental aspects that impact scheduling (type of procedure, order and sequence of procedures, variability of provider work habits, and patient preferences).

Patients form opinions about the dental office at all these levels, starting with their first contact with the office, whether it is on the phone, in person, or on the internet. Attention to details in all these levels of sequencing is critical. The recurring question that must be constantly asked at all levels is, how can we do this better? We must always look to the patients for the answers because all that we do is under their continual scrutiny.

Creating an efficient and productive schedule is similar to accomplishing successful dental treatment. There are certain principles that need to be honored, and there are systems that need to be followed. Schedulers must first be taught how long it typically takes each provider to do the different procedures that will be scheduled. They must be educated as to the setup and disinfection time it takes for particular procedures. It helps if this person has a working knowledge of the different procedures, but if not, the level of understanding of the procedures from a time standpoint can be taught. Not to have this working knowledge of the dental procedures limits the scheduler's potential to achieve excellence in this area.

Type of Procedure

Procedures can be classified in many ways. Separate consideration of appointment time units can be given based on classes of dentistry. These class divisions could be made based on the following: examination and consultation, prophylaxis (with dentist review), diagnostic (referral to specialists), episodic treatment (hurting), simple restorative, cosmetic, evaluation of previous treatment effectiveness, treatment follow-up, and implementation of comprehensive long-term treatment plans. There are other ways to classify dentistry with regard to appointments, and remember, our concern is with our commodity—time.

Classes of dental appointments can be viewed strictly from the time requirements. There are long, intermediate, and short procedures. The long procedures would be those that require at least 1 hour of the doctor's time. Intermediate appointments would require 30 minutes of the doctor's time, while short appointments only require 10 minutes of the doctor's time. An example of a long procedure could be a root canal, crown and bridge (preparation and final impression), or an implant procedure. An intermediate procedure could be fillings, extractions, or impressions for dentures or partial dentures. Short appointments are healing checks, denture adjustments, or hygiene and treatment planning exams.

Dentistry can also be classified according to the dollar amount of production for the different procedures. Using the cost of a crown as the basis for production, we divide these classes into primary, secondary, or tertiary. Primary procedures are procedures that use the cost of a crown or above. Secondary procedures are those that are about half the cost of a crown. Tertiary appointments are procedures that have no out-of-pocket cost to the patient at that appointment. In other words, the exam may simply be a follow-up exam or check-up to assess healing from a previous treatment.

Examples of primary procedures are partial dentures, veneers, implants, root canals, or completing several fillings during one appointment. Examples of secondary procedures are fillings, some surgical procedures, extractions, and teeth bleaching. An example of a tertiary appointment is a healing check exam. It is very important that when appointments are scheduled, these appointments are translated into production dollars by the scheduler. If the scheduler is not very conscious about these differences, a very busy schedule will be created, but if slots are filled with mostly tertiary appointments, there is no dollar value to the day's production.

Dental consultant Cathy Jameson of Jameson and Associates refers to primary, secondary, and tertiary appointments as rocks, pebbles, and sand, using complementary definitions of each, as provided previously. She recommends preblocking the schedule for the placement of primary appointments in the schedule, with the daily goal to have at least half of the production scheduled in primary appointments and then building secondary and tertiary appointments around the primary appointments. This is an excellent system that makes primary appointments a priority for the scheduler and helps prevent being busy but not being productive. This sometimes requires negotiation skills on the part of the scheduler to gain patient acceptance in scheduling a primary appointment on a day and in a time slot that may be less desirable from the patient's viewpoint.

Sequence of Procedures

Before an efficient and productive schedule can be sequenced properly based on the treatment required, the person scheduling the appointments must have a working knowledge of dental treatment procedures. Sequencing is the understanding of the steps necessary for treatment completion and how these steps

integrate with appointment scheduling. For example, scheduling appointments involved in developing a patient denture includes an understanding of when the treatment sequence requires an appointment and what steps must be completed by the laboratory before the next appointment can be scheduled relative to this treatment procedure. Consider the following sequences in the development of a patient's denture:

1. An appointment is required to take oral cavity impressions (models are created)
2. No appointment is needed to send models to the laboratory, but wax rims must be returned prior to the next appointment
3. An appointment is required to establish vertical relationships and dimensions and to take measurements for teeth
4. No appointment is needed to send these articulated models to the lab so that teeth can be set in wax
5. An appointment is required for try-ins; however,
6. No appointment is required to send the try-ins back to the lab for processing and finishing
7. An appointment is required for delivery when laboratory finishing is complete

Many dental offices do not have schedulers with dental backgrounds. Schedulers must be educated in this area. There are certain principles that need to be honored, and there are systems that need to be followed in order to accomplish successful scheduling. Let's deconstruct components of a crown procedure resulting from a previous *diagnostic* patient visit. For the current visit (treatment follow-up), the patient will be greeted by the assistant and prepped while seating. The dentist will apply a topical anesthesia and develop the operative model. The dentist spends time on tooth preparation to include taking the final impression. The assistant, depending on state rules, can complete the temporization of the prepared tooth. After the temporary is prepared the dentist returns and examines the temporary that has been fabricated for the tooth, makes any needed adjustments, and cements it. For this procedure, an hour has been allotted on the appointment book to accommodate the way Dr. X and Assistant Y work together. This procedure may require 30–40 minutes of doctor-devoted time. However, Dr. Z and Assistant W may require less or more time depending on their speed and efficiency.

Notice on Table 12.3 (operatory availability) that the dentist is not involved in all of the time that was allotted for the patient on the appointment book. This means that if the doctor works two operatories (side by side), another patient can also be seen during this time period. If the second patient is also a primary procedure (like the crown procedure), then staggering the appointment time by starting the first patient on the hour and the second patient on the half hour would allow the dentist to walk away from the first patient to the second patient and complete them both in about an hour's time. However, without two assistants this would not be possible.

Let's deconstruct components of an examination for a 6-year-old child. The first dental visit should be allotted a full 30 minutes. This allows time for the assistant to make both the child and the parent comfortable and then seat the child, describe prophylaxis techniques, expose a panoramic radiograph of the child's teeth, and determine how the child will respond to the examination. The panoramic should be completed and available for the dentist to review prior to his or her entering the operatory. The dentist primarily spends time explaining the panoramic results and developing a plan of action, if necessary, for the child's next visit. Within this 30-minute appointment interval, this examination procedure may require only 5–10 minutes of doctor-devoted time. However, over time each provider establishes his or her ease in interacting with child patients. Some dentists may require more than 10 minutes to establish the relationship and conduct the examination. Others require less time.

Comprehensive treatment plans can be difficult to schedule and sequence. The patient should be informed during the consultation of the total number of appointments that will be required, as well as the total estimated length of time it will take to complete the whole treatment. If this is a treatment plan that involves perio, oral surgery, fillings, implants, and crown and bridge, the sequence of the appointments is critical to the timely completion of these appointments. This is where the philosophy of the doctor is critical. The traditional way to treat these types of cases is to start out by getting the foundation healthy. This approach requires that the gums and tissue be treated first. Whenever possible the teeth that need to be extracted need to come out very early in the treatment so that as these sites are healing, other treatment can be accomplished. After the foundation is healthy, the remaining teeth are restored and then the missing teeth are replaced. What you do not want to happen is that the treatment is interrupted over periods of time while you are waiting on something to heal. Sometimes this cannot be avoided, but every attempt should be made to keep the treatment moving forward toward its completion as soon as possible. Every attempt should be made to get as much treatment accomplished as possible at each appointment. One of the major challenges in dealing with comprehensive long-term treatment plans is keeping the patient informed and motivated to complete the treatment.

Variability of Provider's Work Habits

How examinations and consultations are coordinated can vary tremendously by provider. The variation is dependent on how inclusive the doctor wants the patient's information to be prior to initiating treatment, as a reflection of the philosophy of the doctor. Comprehensive exams usually refer to exams conducted for patients new to the practice. Comprehensive appointments consist of hard and soft tissue examinations with x-rays taken of all the teeth and surrounding structures. A complete medical history and evaluation, which can also include intra-oral and extra-oral photographs, is usually taken at this time. Diagnostic impressions can also be taken during this time, as indicated. Another

philosophy would be to conduct limited examinations. These exams are usually conducted on established patients or on patients having specific problems to resolve at the time of the visit. These exams are limited to a particular part of the oral cavity and can be as specific as a particular tooth. Emergency examinations can be simple and straightforward, or they can be rather complex and time-consuming if the cause of the emergency is obscure. An example of this is a patient presenting with referred pain. The cause of the pain is perceived by the patient as coming from a particular tooth when in fact on thorough examination, it is discovered that the cause is from another part of the mouth, the jaw, or the sinus cavity.

Some doctors want fully orchestrated consultations for their patients, requiring separate appointments, while others want the patients to have simple time-conservative consultations done immediately after all the necessary information is obtained from the patient either at chair-side or in a separate consultation room. These orchestrated consultations may be scripted for the staff, as are scripts used by the doctor. All the bells and whistles are used at this time because part of this process is "selling the treatment plan and closing the deal." Some consultation rooms in the high-tech offices are the most elaborate rooms in the dental office, and they take on the appearance of a multimedia room. No matter what the philosophy is regarding consultations, after consultations are conducted, the patient or responsible party must agree to the financial arrangements before treatment begins.

The work habits of each provider are different. Some prefer a fast-paced, high-volume practice day, while others prefer to concentrate on a few patients. Some prefer a variety of treatment procedures, while others would be perfectly happy to have similar schedules day in and day out. Some providers are perfectionists, while others are production driven and try to save time whenever possible. Both hygienists and doctors vary in this area. Some providers are time conscious, while others do not even wear a watch. This provider's only concern is doing the very best for each patient no matter how long it takes. This may drive the entire staff crazy, and there has to be a conscious effort on the part of the staff to keep the provider aware that a schedule even exists, especially if the staff want to go to lunch or get home at a reasonable time. This difference in work habits can be very problematic in group practices. The scheduler is required to take into consideration the work habits of each provider in the practice as the patients are scheduled.

Some providers are morning people and are at their best early in the morning, while others do not get fully focused until midmorning, after the third cup of coffee. Some providers are very personable people and must be given time to visit with their patients, while others would prefer to limit this type of interaction.

Dentistry is a profession with a plethora of new toys and gadgets. If the dentist is not careful, he or she may end up buying every new gadget that comes out, and supply sales people will love to call on that office. The disruption to the office caused by sales people calling on the provider may contribute

to inefficiency and ineffective workflow in the practice workday. Any interruption that is not a part of the planned appointment workday can create a backlog in the day that is never resolved. The dental provider must protect the time commodity by insisting that sales people call at the completion of the day or by appointment only.

Patient Preferences by Provider

Every dental student has an ideal practice that he or she envisions while in dental school. After the student has been out of school for a few years, this ideal is integrated and blended with reality and shaped into a new or similar vision. One of the reasons that many people are attracted to dentistry is that the profession offers such a variety of practice models. There are cosmetic practices, which are very popular with many dentists today. In order to have this type of practice, dentists must be able to attract enough of the right kind of patients who can afford what they have to offer.

Other providers may be more community-oriented and simply want to offer a variety of services to a diverse population. This is known as a "blue collar" model that is usually insurance dependent. This model treats a large volume of patients, but a much smaller dollar per patient is generated when you compare this model to the cosmetic model.

Whatever practice model the doctor chooses, relationships are built with the patients. The more loyal the patients are to the doctor, the more they do not want to be treated by anyone other than that particular doctor. This makes it difficult for the schedulers. The busier the practice gets, the less appointment availability there is. Patients want to continue to be seen by the doctor in the customary way as when the practice was not as busy. The more a doctor successfully delegates to the staff, the more patients can have the same level of satisfaction at the appointment and not occupy as much of the doctor's time.

This works especially well if the staff have been with the office for long periods of time. The patients get to know them and form relationships with them. This allows a practice to "get large and remain small at the same time." The patients do not feel neglected because as the practice has grown the staff have filled in some of the time that was spent with the doctor. This allows the office to provide the same type of "one-on-one" treatment as it has grown. The patients still feel like kings and queens when coming to the office.

This preference of a particular provider creates some challenges when the office brings in a new associate. Many of the patients do not want to see the *new* doctor. Patients want to see "their" doctor. This requires a well-thought-out, scripted transfer of value from the old doctor to the new doctor by the staff, as well as by the old doctor. Both have to literally sell the new doctor to the old doctor's patients in order to make this work. It helps when both the old and new doctor share treatment responsibilities for these patients during this initial period. As hard as the doctor and staff try to make this happen, some people will leave the practice and go somewhere else if they are

not allowed to see "their" doctor. Those patients who simply refuse to see the new doctor are labeled as such and their wishes are respected, although some may have to wait longer for appointments. It is prudent for the staff to always offer the availability of the new doctor in an attempt to decrease appointment wait time.

Integrating Appointment Scheduling with Other Business Systems

Appointment scheduling is only one of the systems needed for a dental business to function like a well-oiled machine. There is a dependent relationship that exists among all the systems that make up the business. The dental business is a system of systems applied within a constantly changing context. Because of the constant changes, the systems used to run the business must be dynamic and adaptable to keep the office current.

The first task in systematizing the dental office is to identify all the generic business and clinical systems that must be either created or improved, and then create a systems development plan for the office that will serve as a road map for this process.

The system starts with the patient calling on the phone for an appointment or physically walking into the office and being greeted by the business staff. Scripting of telephone conversations is used to get the new patient to schedule an appointment. Asking the right questions to determine what type of appointment to schedule is important. At this point, a working knowledge of the various dental procedures that are available in the clinical area is a must. The sequencing of processes to create a patient chart and corresponding documents that collect all pertinent information will save time and be invaluable to the clinical and business staff later. Determining how the perceived dental services will be paid for and by whom must be handled in a very sensitive way so as not to alienate the patient and make a bad first impression before the patient ever meets the doctor. The ability to give the patient as much information as requested without attempting to diagnose the condition for which the patient may have originally sought an appointment is also dependent on a working knowledge of treatment procedures. Most of the time, a checklist is a valuable tool for the business office staff to use to ensure that all the necessary processes are complete before the patient is allowed to enter the clinical area.

The appointment sequencing occurs once the patient is brought from the clinical area to the business area. There must be a checklist of processes to follow before the patient is allowed to leave the office. The procedures that were delineated during the clinical part of the visit should be repeated, along with the corresponding charges for the procedures. Again, a working knowledge of dental procedures is a must to communicate this to the patient. Insurance benefits for today's appointment should be explained again, if necessary. Any payment due for today's procedures should be collected at this time. All

these procedures need to be scripted and evaluated for their effectiveness. Finally, the patient should be reappointed for his or her next appointment and dismissed.

Well-Balanced Patient Load

A well-balanced patient load consists of a good mix of first-time appointments, children, cash and emergencies, and filler appointments. These are all categories of patients that are welcomed into the dental office and should be tracked for evaluation purposes. Well-balanced patient loads do not just happen. Systems should be set up with these groups of patients in mind. User-friendly, patient-centered systems will facilitate the attraction and maintenance of the desired group of patients.

How does one determine a well-balanced patient load in terms of scheduling? The practice should determine by policy the maximum number of new patients that can be seen on a particular day given the number of total patients scheduled. If children pose a problem for the practice, then children should be limited to certain times of the day and/or limited to a certain percentage of the total patient load on a given day.

Emergency patients should not make up more than 10% of the number of patients scheduled for appointments in a practice. Some solo practitioners may want to keep that number even lower. For example, if 5% of the thirty patients encountered in 1 day in a solo practice were emergency patients, this would mean that one or two patients the doctor plans to treat would require at least an hour of his or her time, whereas the average time planned per patient might be 30 minutes. Even if only one emergency patient was encountered, total time added to the workday schedule could be 30 minutes, but if two emergency patients were encountered, total time added to the workday schedule would be closer to an hour.

First-Time/New Patient Appointments

One very important piece of information that should be noted in patient charts is the way that contact was made with the dental office for the first time. This will give the office valuable information on trends in the market about which mode of communication is growing or decreasing. Patients should also be asked how they wish to be contacted by the office in the future. An office cannot have too much information in a patient's chart about how to get in contact with them.

First-time patients and patients of record who have not had an appointment for a period of time are primary sources for scheduling patient appointments. When these patients call in for appointments, the first thing that the scheduler must do is to categorize the appointment as an emergency or nonemergency.

If it is a nonemergency appointment, then it needs to be classified as a problem-specific appointment or a general evaluation appointment. If it is a problem-specific appointment, as much information about the problem as possible should be gathered and passed on to the clinical staff. This information will help the clinical assistants and the doctor as they prepare for the appointment.

The scheduler should not attempt to diagnose the patient's problem before the doctor examines him or her. As an example, a patient calls and states that he or she needs a tooth pulled. The scheduler should pass this information on to the clinical staff but should not schedule the patient for an extraction based on the request of the patient. It may turn out that the tooth, after examination, can be saved with a simple filling, or it might require a root canal and crown.

If this first-time patient wants a general evaluation, then he or she is appointed for what many offices call the "new patient experience." New patients are the future of the dental practice. Because you only have one time to make a good first impression, the manner in which new patients are serviced is of utmost importance to the dental practice. When the new patient arrives in the office the receptionist should greet the new patient by acknowledging the fact that this is the patient's first time in the office and that the entire dental team has been looking forward to meeting him or her. The patient can be given a limited tour of the office on the way to the treatment room and be introduced to as many members of the dental team as possible. The entire team needs to make sure that this is not viewed as just being a routine procedure. The new patient is treated like a guest who enters your home for the first time and who you had been looking forward to meeting. Business systems are put in place to properly service new patients and convert them into loyal returning patients and sources of new patients.

One barrier to an excellent new patient experience can be the wait time. What happens if the new patient calls in for an appointment just to have an oral prophylaxis? The office will have to establish a policy on how to integrate the "new patient experience" with the prophylaxis appointment. Decisions will have to be made as to who sees the patient first, the doctor or the hygienist. This is where the systems used by the hygienist and the doctor will have to be integrated.

Children

Children bring diversity to the office. They provide rewarding and healthy challenges to the dental office. Their presence paints a different color on the flow of the day in a most positive way. It is rewarding to have the privilege to work with children and watch them grow and develop. Dentistry can place the dentist in a very influential position in the life of a child to serve as a mentor or role model.

There can, however, be a downside to treating children and adults together. Sometimes children are difficult to manage, and this can really challenge the doctor or hygienist to stay on schedule. For example, if a practice decides that the maximum number of children that will be treated in a normal day is six and two of those six children take an extra 30 minutes to treat due to management problems, that requires an extra hour of the doctor's time to treat these children. This means that other patients will have to wait and the staff may have to work through part of their lunch or work late. An ill-behaved, uncooperative child can stress the entire staff as well as other patients in the office.

To minimize disruptions that can be encountered when treating children, blocks of time during certain parts of the day can be used. Screening techniques for predicting behavioral problems during the initial visit can be used to decide how to properly schedule the child for clinical visits. This approach can also be used to decide if it is best to refer this child to a pedodontist. One of the worst things that can happen in the office is to have one of these challenging children ill-behaving while new patients are in the office. Even with these downsides to treating children, the benefits outweigh the liabilities.

Cash and Emergencies

Cash and emergency patients can have a devastating effect on the schedule, especially if there are no provisions made for them in the daily schedule. But they also provide an excellent opportunity to provide care for patients who are in pain. Care must be taken when deciding how much treatment to provide these patients. The objective of treating emergency patients is to get them comfortable and then reappoint them when the schedule permits if there is not enough time in the current day's schedule to treat them. This is easier said than done because doctors are trained to help people, especially when they are hurting.

This is where many offices get in trouble with a schedule while they are treating cash and emergency patients. Here is an example of what can happen. A cash and emergency patient comes in with a toothache. The doctor diagnoses the problem and recommends that the tooth be extracted. Then the business manager makes financial arrangements with the patient and the doctor proceeds to extract the tooth. At first it appears to be a simple extraction, but the tooth breaks off and the doctor ends up having to do a surgical extraction. It takes an hour to complete the extraction. By the time everything is finished and the room is disinfected, the operatory has been tied up for 2 hours. To make matters worse, when the patient is informed that the doctor had to do a surgical extraction, the patient informs the business manager that he or she is not able to pay for the treatment just rendered. In the meantime, two of the scheduled patients reappoint and the doctor and the clinical assistant end up not having lunch. A better way to handle this would be to make the emergency

patient comfortable, have the patient pay cash for the visit, and reschedule for the next available appointment to receive additional treatment.

Filler Appointments

Filler appointments are patients who have indicated that they can possibly come into the office for treatment on very short notice. This kind of appointment is available to some people who have flexible work schedules or live short distances from the dental office. These appointments are worth their weight in gold if they can actually come in on short notice. When a patient is 5 minutes late for an appointment there should be someone on the phone calling that patient to see if they are going to keep the scheduled appointment. This means that someone in the office must be time conscious and aware of patient arrivals and delays. In some offices this may be the doctor's clinical assistant or some other designated person at the front desk.

Filler appointments are schedule savers when offices have no-shows, last-minute cancellations, and rescheduled appointments. Every patient who is scheduled for a restorative or hygiene appointment should be asked if they could be called on short notice to fill in open slots in the schedule. If patients can be used as fillers, they should be placed on a call list with their contact information and planned treatment procedures. Care should also be taken to make sure that the patients on the filler or short call list do not have outstanding account balances. The object is to replace lost production with good production and not to increase the accounts receivable.

Over-the-Counter Follow-Up Appointments

When a patient is dismissed from the clinical area and is at the checkout counter, there should be a list of the treatment planned for the next few visits. The goal of all the activities that occur with patients standing at the counter is to get them rescheduled for their next appointment. This is an opportune time, when the patient is physically present in the facility at the same time the doctor and the hygienist are in, just in case their input is needed for scheduling the next appointment.

Getting It on the Books

It is an excellent idea to begin the rescheduling process with an explanation to the patient as to what procedures were accomplished during the current visit and what treatment remains to be completed. The scheduler will then discuss with the patient what treatment the doctor has recommended to be scheduled next and how long the procedure will take. At this time the cost of the planned procedure should be discussed with the patient. If the patient has dental insur-

ance and the planned procedure is covered, the patient's co-pay can be discussed. The patient should know what will be done at the next appointment, how long it will take, and the amount that will need to be paid. If a treatment plan has been presented and financial arrangements have already been made with the patient before the treatment was started, this discussion serves only as a reminder to the patient and should be a very quick process.

Scheduling this appointment can interface with several aspects of the appointment system. For example, the next appointment listed in the patient's treatment plan calls for a crown preparation and final impression. The patient wants to schedule the appointment for the following Tuesday. On observation the scheduler notes that the doctor has four major procedures already scheduled for that day. It is the policy of the office to not schedule more than four major procedures in a typical appointment day in order to maintain a well-balanced patient load. The scheduler now has to negotiate with the patient for an alternative day where another major procedure can be accommodated and one that fits the patient's schedule. It is always a good idea to present the patient with at least two alternative dates, giving him or her a sense of some control over the appointment. The scheduler may have to sell this appointment day and time to the patient. The doctor and the hygienist could also help assist the scheduler in negotiating the appointment time that bests fits into the office scheduling system.

Understanding Patient Behaviors

While all these activities are going on it is the task of the check-out person to observe the patient's behavior. This can be done by watching and listening. Systems should already be in place to gather information about the scheduling preferences of a patient. Does the patient prefer morning or afternoon appointments? Does the patient prefer to pay by cash or credit card? Does this patient get agitated when he or she has to wait at the counter for a short period of time? Does the patient prefer a certain provider? This is especially important in a group practice where there are multiple providers. Matching the appointment with the provider time needs to be negotiated with the patient. A patient's preferences must be factored in as part of the process.

The scheduler must motivate the patient to reschedule for further treatment. This is especially true when a lengthy treatment plan is being followed. This is the juncture where scripted conversations are useful. The scheduler as part of the initial training process must practice scripts, and periodic retraining must be completed. The scheduler must serve as both a motivator and a concierge to help get the patients to do what is needed in order to complete the recommended treatment. The next appointment is scheduled with an explanation of what will be done and how much it will cost. The patient is then given a reminder card with the date and time of the next appointment, is thanked, and is then dismissed from the office.

Telephone, E-mail, and Internet Appointment Scheduling

The telephone is still the main artery supplying life to the dental practice. E-mail and internet scheduling are rapidly expanding and should be used to supplement and leverage the effectiveness of the telephone. Many people use cell phones as their primary—and in many cases their only—phone service. This is a part of the information that should be noted in every patient's chart. E-mail addresses are very helpful in contacting patients because many people check their e-mails during normal business hours.

One of the advantages of having a well-developed website is the information you can allow the patient to access. Directions to the office can be obtained from the website. Many websites are able to take the viewer on a virtual tour of the office as well as introduce the staff. Potential patients and current patients can ask questions through the website.

Confirmations

Confirmations are an ongoing challenge to the dental staff. First the office must establish a policy about just what is considered a confirmation. Is it just leaving a message on an answering machine? Is the confirmation done at the time that the appointment is made? Does the staff actually speak with the patient, or is talking to the patient's spouse enough? Do the same rules apply to hygiene recall appointments that apply to appointments to see the doctor? These are just some of the considerations that have to be sorted through when patients are confirmed.

E-mail and the internet can serve as tools to leverage the communication capabilities between the office and the patient/households. One of the most dynamic usages of the internet is remote access to the computer by the doctor or staff. One of the most effective ways to confirm a patient's appointment is to call the patient after regular business hours during the evening. This can be accomplished by simply subscribing to a remote access company. GoToMyPC is one of the larger companies, but there are several. These companies will establish a link to your computer that will allow total access to a designated computer that is left on at all times. Doctors can thus review patients' charts and x-rays (if they have digital x-rays) while away from the office.

Recalls

In an office without a hygienist on staff, the doctor must perform recall appointments. If recall blocks are not limited, the scheduler can fill up the doctor's time with recall appointments and leave no room for restorative appointments. This type of scheduling will not allow the practice to meet its daily production

goals. To complicate things even more, the insurance eligibility dates for recall on prophylaxis must be factored into these negotiations.

In well-established practices that have hygienists, time for the doctor to examine the hygiene patients must be factored into the schedule. Offices will have to establish systems and procedures for the doctor to examine the patient in an efficient and timely manner. Time can be lost in hygiene production when the hygienist is waiting on an exam by the doctor before he or she can dismiss the patient and turn the room around before seating the next patient. The placement of the proximity of the doctor's treatment rooms with the hygiene rooms should be taken into consideration in designating operatories for hygiene treatment. The closer the doctor's chairs are to the hygienist's chairs the more time will be saved in both the doctor's and the hygienist's schedule.

Patient Account Balances

The office financial policy spells out in detail how the office will collect money from the patients for the services rendered. It is strongly recommended that dental offices do not finance dental treatment. There are companies that specialize in financing dental procedures. There must be a written financial policy in the office. Financial policies need to be objective and clear. Any decisions to make exceptions to the financial policy must be cleared with the doctor. This is not a decision that should be made by the staff if it deviates from the policy. There should be a written sequence of activities (systems) to collect these unpaid balances incorporated in a progressive time that tells the staff exactly what to do about an account balance as it ages. Patients with outstanding balances cannot continue to be rescheduled for more treatment until the balances are cleared up.

Laboratory and Preparatory Results

Most dental offices may use more than one dental lab. Each lab has a different time line to finish a case and return it to the office for delivery to the patient. The clinical staff must work closely with the scheduler to coordinate the patient's return appointment to have a crown or a partial denture delivered. The patient should not be scheduled for an appointment to have a crown delivered before the lab finishes the crown. This is a waste of production time, not to mention the impression that it leaves with the patient when treatment cannot be completed on the day agreed upon.

Some dental offices have the technology to make crowns and deliver them on the same day that the teeth are prepared for the crowns and the impression is taken. Patients should not be asked to wait more than 2 weeks for crowns. As a general rule, no dental treatment that involves lab work should take more than 2 weeks to deliver. This includes dentures and partial dentures.

Who Is Responsible for Scheduling?

In most offices scheduling is centralized in the business area. The key to effective scheduling is to have a scheduling system. Those who are not familiar with the system should *not* be allowed to schedule because they will create more problems than they will solve by scheduling improperly. There should be one person in the office who is ultimately responsible for all scheduling. Even though that person does not actually make every appointment, he or she has the responsibility of coordinating the schedule and making sure that the system is being followed. This person is constantly monitoring the schedule, making sure that production goals are being met and coordinating with the clinical staff on the status of all laboratory cases ready for delivery on an appointed date. Any decentralized scheduling must be limited and strictly coordinated or it will cause problems.

Computerized and Paper Appointment Schedules

Dental offices are moving away from paper appointment schedules and incorporating computerized appointment schedules. In addition to simple web-based appointment scheduling systems there are many dental software developers that have included appointment schedule modules in their practice management software packages. Converting from a paper appointment system to a computerized one is simply a matter of selecting start and stop dates and beginning the demographic data conversion process. Once the computerized software has been installed and personnel trained, staff can begin to appoint into the computerized software. As time permits, appointments from the paper appointment book are simply moved to the computerized system until all appointments have been converted. Simultaneously, new appointments are not put in the paper system and are entered directly into the computerized scheduling software application.

Computer Interactive Scheduling/Web-Based

Web-based appointment systems are new innovative ways of empowering the patients to make their own appointments. While the use of web-based systems has not become commonplace in the dental practice business, the technology creating the possibilities for a web-based appointment scheduling system are well defined. Like web-based accounting systems, all of the appointment scheduling data are maintained at the host server site unless the dental practice has the expertise to be responsible for maintaining the web-based system (data) for both software and hardware. Some of the risks associated with privacy issues for medical and dental providers have not been resolved to the satisfaction of many providers. This may be one of the main reasons web-based scheduling has not been adopted more quickly.

Most of these systems are organized in much the same way as paper appointment systems from the user's perspective. Most are designed to take the user through a series of questions that, when answered, lead to an appointment being placed on the system. Patients using the system are generally established patients of the practice as opposed to new patients, since medico-legal releases and consents, as well as web-site access permission, must be obtained prior to utilizing the web-based system. Demographic documents used by the dental practice office staff can also be placed on the web-based system so that patients can complete much of this information prior to coming into the dental office for the appointment.

In addition to a web-based appointment scheduling systems, many dental offices elect to use practice management appointment scheduling software. The advantage of using practice management software is the ease of integration with other business system applications, which are usually developed by the same company. Each company has its own set of modules comprising the practice management software. In contrast to practice management systems, web-based appointment scheduling systems are generally stand-alone but can be connected to other office software so that the data collected through web access can be downloaded and used with other office applications.

Components of the scheduling application generally include a comprehensive system of interactive modules that share patient, household, treatment, and financial information. The computerized schedule can enable staff to list all patients due into the office that day by operatory room along with the name of the chosen providers and notes or medical alerts pertinent to the appointment. Information about the treatment procedure such as tooth number and surfaces may also be included. Unlike what is available using a paper appointment schedule, a large amount of data can be collected, manipulated, and stored for various uses in the dental practice. The collection of this amount of data for a particular appointment enables staff to quickly review and understand patient needs for the day's appointments.

A computerized appointment system is also critical for the dental recall system. Using the computer, office staff are able to classify patients by the number or type of recall notice and print personal or generic messages on each or all of the notices. Address or responsible party labels can be printed at the touch of a few buttons, as opposed to paper systems that must be manipulated and re-manipulated to get the necessary information for sending correspondence to patients or households. The complexities and intricate workings of the recall system are not as burdensome when computerized since basic inquiry parameters are set and can be reset as needed and the computer quickly executes those parameters. Staff can run missed appointment reports and conduct patient tracking as necessary. Tickler files can be used and confirmation and/or end-of-day callback lists can be printed quickly and easily. The use of the computerized short call list can substantively increase achievement of practice production goals, maximize practice revenue, and contribute to increased patient satisfaction by getting patients in to see the doctor sooner. Effective use

of this list and the quick and easy generation of it through the computer may justify the expense involved in purchasing and using practice management appointment scheduling software.

Completing an Appointment Unit

Appointment scheduling is involved at patient check-out, over the telephone, and at walk-in. Completing an appointment unit varies by whether a patient is new, established, or an established or new patient emergency. For brevity, we use the perspective of an established patient physically present at check-out as the prototype for explaining the process involved in completing an appointment unit in an appointment scheduling application software. This prototype is likely to represent the most inclusive procedure and the most frequently encountered patient type.

At checkout, the patient has completed a treatment procedure in the back office and likely has a router or other document with instructions for follow-up from the back office. The scheduler or front office staff review the physical router/document (some offices may utilize a computer screen router that never becomes paper). The patient's account history and medical alerts are also reviewed. Front office staff must balance the patient's financial responsibilities to the practice with the need to get the treatment completed while at the same time negotiating a future appointment.

Front office staff explain the time interval suggested by the doctor for the return appointment. The patient is asked whether a certain day of the week is better and whether a certain time of the day is better than another. After obtaining the patient's response, the front office staff review available appointment days and times with the appropriate doctor in the scheduling system to determine a match with any of the days and times preferred by the patient. The appointment system can quickly display the schedule for the requested time interval and the days and times available for that particular doctor. If there is no match, the patient is provided a day and/or time that is closest to the preferred time.

The appointment is physically entered into the system, blocking off the estimated amount of time needed to deliver the planned treatment, assigning the operatory and doctor, and ensuring that a current phone number is available for the patient so that the confirmation call can be made. The patient may be asked if it is acceptable to receive a confirmation call at the number provided. Other financial information is given and received from the patient at this time. Minimum information needed for most offices to complete an appointment time unit within a computerized system could be patient name, contact phone number, ID or account number or date of birth, date and time of the appointment, estimated treatment time block, planned treatment procedure with information about tooth/surfaces and so forth, operatory or doctor, premedication instruction/alerts, and how the treatment cost will be paid.

One of the most vexing decisions for front office staff in the checkout process is the patient's need to complete treatment in consideration of the fact that the patient may have an outstanding balance from previous treatments and may not have made appropriate financial arrangements for full payment. Placing the appointment on the schedule becomes a difficult process when the practice has difficult patients with regard to bill payment history. When this is the case, office policy must be referenced by the staff to ensure that patients are treated alike with regard to this process. Many times, the front office staff must get special permission from the manager or doctor to forego making a future appointment until financial arrangements for full payment of previous charges are made. In this case, notes are made in the computer system as to the disposition of the patient with regard to the future appointment. It is important to add a tickler so that when the payments have been made, the computer can alert the scheduler to call the patient so that the treatment appointment can be made.

Chair-Side Scheduling

Chair-side scheduling is another innovative dental practice showing promise for increased production goals. It requires that the dental office be equipped with computers in the patient operatories and consultation rooms. Through these connections, integration of other technologies such as digital radiography, intra-oral cameras, digital photography, and patient education videos or tutorials can be established. It also requires that back office staff (doctors, hygienists, and assistants) be trained to use the scheduling application software. The extent of the training for doctors and other back office staff, however, can and should be limited to very rudimentary aspects of inquiring, viewing, and entering an appointment.

Computerized appointment scheduling allows for back office interaction with the activities of the scheduler and checkout staff. Back office staff can view any and all appointments previously scheduled for the patient to include no-show and cancellation activities. Staff can also quickly view any future appointments already scheduled with family members or the patients themselves to increase coordination of household activities. With appropriate training back office staff are able to enter follow-up appointments.

Many times, not enough information has been supplied from the back office staff on the encounter form or router for the scheduler or front office checkout personnel to determine the time interval for the next appointment based on the procedures completed today. Back office staff generally have more knowledge about the length of time that may be required for a particular patient to heal and/or information about how the patient will respond to treatment. Back office staff are in the best position to set a follow-up appointment time interval for evaluation of treatment progress while the patient is available and able to contribute to the follow-up appointment time interval negotiation

process. When the patient observes the doctor setting the next appointment, emphasis is placed on the importance of the follow-up examination to treatment progress from the patient's perspective. One disadvantage of chair-side scheduling is that most offices do not and should not get back office staff involved in patient financial matters that may be connected to future appointments. Most of this can be accommodated through policy and computerized security levels.

Accessing and Monitoring Schedules

Appointment schedules are monitored throughout the day by most all of the dental office staff, which includes the doctor, the assistant, and the hygienist as well as the scheduler and front office staff. The schedule is the backbone of the dental practice and on forms the foundation for operation of the business. Since the front office staff create the schedule (even in a paper scheduling office), the back office can usually only receive the information secondarily. Accessing and monitoring appointment schedules by the back office staff is dependent on timing and on front office staff completing the necessary paper documents to make the schedule available either physically or through the computer. In many cases, a day's schedule is dynamic; that is, write-ins for added appointments and deletions for no-shows and cancellations could make the paper schedule convoluted and hard to read. In addition, back office staff must constantly coordinate with front office staff to ensure that up-to-date information has been placed on the paper schedule. Computerized appointment scheduling with back office staff access to the operatory scheduling module of the software enhances this process. There is increased capability to utilize a dynamic schedule without much of the inefficiency of constant coordination between front and back office staff with regard to the living document—the operatory schedule.

Back office staff can use the computer screen to constantly view the operatory schedule and any changes made to it by the front office staff or the scheduler. Added appointments could be color coded for the back office staff as an alert; cancelled appointments could be similarly coded. Some applications also allow for alerts for patient arrivals and treatment completion so that most coordination between the front and back office staff can be simply viewed on the computer screen, as opposed to the walking and verbal coordination necessary with paper systems.

For dental offices that want to monitor patient arrival-to-treatment wait times and other intraoffice time management components, appointment scheduling software applications are the ideal solution. Software applications enable the practice to monitor other evaluation measures as well. These may include no-show rates, cancellation rates, number and dollar amount of treatment plans initiated or completed, operatory and provider production forecast by treatment codes, number of recall notices sent, and so forth.

Appointment Scheduling Maintenance

All recall systems begin with the doctor. The doctor's philosophy for having a recall system is the driving force that determines what resources of the practice are allocated and how those resources will be managed. Some doctors set up recall systems and hire hygienists as profit centers in the practices. Some doctors set them up so that they will be able to dedicate more of their time to other procedures that bring more income into the practice. Some doctors view them strictly as referral sources for restorative treatment. Some doctors view them as the only way to offer patients comprehensive care, while others see them as the means to never having to clean teeth again in this lifetime.

Recall System

The traditional approach to scheduling patients for recall (prophylaxis) appointments will be discussed in this section. This traditional recall system is based on a 6-month recall plan. This plan begins with scheduling a patient for his or her next appointment as the patient checks out of the office after having a prophylaxis. The appointment is set up for a specific date at a specific time 6 months from the current date. The paper process to this recall plan is described. At this appointment a recall card is made with the patient's name and address on the front of the card. The card is filed 6 months from the date of the current appointment. For example, if a patient has a prophylaxis in January, the card is put in the July section of this recall system file. Six months later all the cards in that current month are pulled from the file and the cards are mailed to the patient as a reminder of the appointment.

Since these cards are already addressed it makes mailing a matter of simply placing a postage stamp on each card and dropping them in the mail. Some offices have the patients address their recall cards to themselves as an attention-getting device. When they unexpectedly receive mail addressed to them in their own handwriting, they are pleasantly reminded. These cards are typically followed up with a phone call to confirm the appointment with the patient. This 6-month recall system can also be accomplished by using a computer. In some of the more technically advanced offices these notices are sent in either text messages or e-mails to the patients.

Each office must track the effectiveness of the recall system used to determine if it is giving them the results expected. No matter which system is employed, any system is better than none. The systems, if properly developed and maintained, will allow the office to leverage ordinary people and reap extraordinary benefits. The more successful an office is in keeping patients, the more successful the business. The rate of return of recall patients is a good measure of sustainable growth and maturity of a practice. It is also a good way to measure the customer satisfaction of patients.

A recall patient list can also serve as a mailing list for newsletters as well as Christmas cards or any other mailings that the office decides to make a part

of its overall marketing plan. Some offices offer special incentives to patients who have a prophylaxis every 6 months. An example of such an incentive would be to guarantee a crown or a partial for 5 years if a patient never misses a 6-month recall appointment during that period.

No-Shows, Last-Minute Cancellations, and Reschedules

No-shows, last-minute cancellations, and reschedules are schedule breakers and a scheduler's nightmare. No-shows and last-minute reschedules must be tracked, and a policy should be established as to what happens on the first, second, or third time. Some offices automatically send a letter to the patients who no-show telling them no-shows are reason for dismissal from the practice. The patient is reminded of how committed the office is to providing excellent dental care for them. The letter also states that continued competent care cannot be provided if appointments are not kept. This is a very positive approach that initially has no consequences to the patient, but if no-show rates are high, then office policy should outline a strong plan of action for staff.

Some offices try to control the patient's behavior using negative enforcement. Patients are charged and sent a bill for not showing up for the appointment. The rationale is that the office had reserved that specific time for them and as a result could not schedule anyone else in that time. Because the patient did not show up, the office lost production time and the patient was sent a bill. Another approach is to have the patient put a down payment on the next appointment before he or she is rescheduled. Some simply do not reschedule the patient in the near future. Patients are made to wait for a period of time before rescheduling.

Treat the first scheduled patients of the day with special care and educate them so that they understand the importance of showing up for their appointments. When possible, appoint these time slots with patients who routinely keep their appointments. These can be time slots that the scheduler intentionally sells to patients who keep their appointments routinely. The fact that the patients will not have to wait at all if they are the first patients is a good selling feature. Never schedule patients who have a history of missed appointments for any reason in the first time slots of the morning or afternoon sessions. Time lost is potential production lost, and once it is lost it cannot be recovered.

Replacing Rocks with Pebbles

A well-orchestrated schedule is a thing of beauty. There is an easy workflow and spacing between patients. Even though the schedule does not look busy, the production numbers are excellent. The daily schedule results in production goals reached or even exceeded. The downside of having only a few patients scheduled is that it only takes one of the major production appointments to reschedule or not to show for the appointment to turn the day into a disaster, which leaves everyone in the office hustling, just trying to salvage the day. Any production is better than none is the attitude that prevails at this point.

Offices that try to schedule a percentage of their production in primary appointments (rocks) must decide when they will let these appointments go if they are not filled within a certain time interval. If this plan is used, these time slots must be closely monitored by the scheduler. This gets even harder to monitor if more than one person schedules appointments. The scheduler needs to have a very clear understanding about the profitability of the different procedures in the dental office. Several small but very profitable procedures (pebbles) in a time block may produce more net income in the office than one major procedure that carries with it a small profit margin.

Late Providers and Late Patients

Most patients usually are very understanding when the doctor is running a little late. There is that unspoken understanding that if the doctor was with me and it takes longer to complete my treatment, I expect the doctor to stay as long as it takes to finish the job and do it right. The motto for the appointment is "it's over when it's over." However, if this is the norm rather than the exception, patients will grow tired of this and go somewhere else for their dental treatment.

Offices need to create a culture that time is valuable. The patients should be kept informed if the doctor is running behind. This sends a message to the patient that the office is concerned about honoring the appointment time.

We have discussed adding filler appointments to salvage production. There is also a need to condense an appointment time slot in order to get back on schedule. If the doctor gets behind in the morning or evening, the work flows into the lunch hour or late work hours. This produces stress and tension in the staff. Some patients may prefer to reschedule if the wait time is excessive.

In a group practice, the doctors can help keep each other on schedule by helping out with each other's patient load until the partner gets back on track. The same is true for multiple hygiene practices. The added number of producers adds flexibility. It also allows for expanding an appointment if the partner is not busy and can see some of the doctor's patients while the patient's appointment is being expanded to do more treatment. Even if the patient prefers to wait on the doctor with whom they are scheduled, the ability to offer such a choice is a valuable resource.

On the other hand, how does an office handle late patients? This is extremely critical in hygiene. The appointments are set on the half hour or hour. Time has been allocated to accomplish a precise number of procedures during that time. If a patient is late, the hygienist has to decide whether or not to treat him or her. If the patient is treated and given all of the scheduled procedures, there is a guarantee that the next patient will also finish late even if he or she shows up on time.

It is a very difficult thing to refuse to do any treatment on patients who come in late because of all the effort that it takes just to physically keep an appointment. The issue then becomes, how late are they? If 45 minutes late for a 1-hour appointment, the hygienist does not have much time to get anything done.

However, if the patient is only 10 minutes late, most of the scheduled treatment probably can be accomplished.

If an office refuses to treat a late patient, what happens the next time the doctor or hygienist is late? What options are the patients given? A practice that refuses to treat late patients creates negative goodwill with its patients. Staff and doctors are also late from time to time, and the schedule seldom proceeds without some adjustments. The scheduler must be an excellent negotiator. If the doctor is late coming back from lunch or arriving in the morning, the scheduler must quickly inform the patient and inquire of the patient how the appointment should proceed. The scheduler is working to accomplish two outcomes simultaneously. The first outcome is to produce the major treatment production goals for the day. The second outcome is to be able to treat the patient who was late or who was made late by the doctor without a major disruption to other patients on the schedule.

The principles involved in appointment scheduling for late patients and late providers vary based on whether the schedule becomes 10, 20, or 30 minutes late. If the schedule is delayed 10 minutes, major time units may not be affected. However, if the schedule becomes 30 minutes late, then major treatments planned will affect the production goals for the day. The principle is to deliver the major treatment planned to preserve the achievement of the day's production goals. The scheduler must observe time units and treatment types planned for the remainder of the day's schedule, make some preliminary decisions about preferred outcomes, and then talk to one or more patients about the doctor's lateness or need to reschedule. If the scheduler is able to accomplish the scheduled day within a reasonable time frame by continuing the planned treatment for all patients, including the late patient, then that is the preferable outcome for which the scheduler negotiates.

The practice should recognize, however, that patients must be given options as to how their time is to be used. If the lateness delays the majority of patients on the day's schedule, each of them must be notified immediately and given the option to reschedule or continue with the planned time units. Sometimes patients are willing to deal with a longer wait to get the planned treatment completed, preventing the need to return on another day. Also, there are some treatment procedures that the doctor may provide as easily during the next appointment, saving valuable time in the day's schedule. These time unit savers are sometimes invaluable to a scheduler's ability to negotiate.

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Learning Exercises

1. Dr. Powell's office has a yearly production goal of $350,000 per year. There is only one doctor and one hygienist in the practice, and 25% of the production is hygiene. The gross collection rate for this practice is 95%. Using a 4-day and a 5-day workweek, 5 holidays, and 2 weeks of vacation time for each producer, what must the daily production be by provider in order to produce the yearly production goal?
2. Go online and choose three remote access computer companies like GoToMyPC and compare what services each offers and the cost of the service.
3. Obtain demo discs from three dental software programs and compare the dental appointment scheduling pros and cons of each.

Chapter 13
Compliance with Government Regulations

Ronda Anderson

There are several government regulations in the dental office that you will deal with on a regular basis and that will affect your practice on a daily basis. The Occupational Safety and Health Administration (OSHA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Centers for Disease Control and Prevention (CDC) are the specific areas of regulation addressed in this chapter. Obviously, these areas are not exhaustive within the scope of government regulation. For example, employment law is covered in another chapter in this book, and amalgam waste management is not addressed here (refer to the American Dental Association website listed in the references section). Government regulations in the areas of OSHA, HIPAA, and the CDC have changed how dentists practice and will continue to do so in the future.

What Is OSHA?

The basic answer: OSHA was created to oversee compliance with the Occupational Safety and Health Act passed by Congress in 1970. This is a worker safety law. Before this law, as an employee you were left to the goodwill of your employer as to whether your workplace was safe or not. For example, when building San Francisco's Golden Gate Bridge, the engineer insisted that it be a safe workplace. He insisted on tethers for all workers working on the high wires and even built a net under the entire bridge to catch anyone who fell. Even with these precautions, eleven men died during the construction. These workers were lucky. Brooklyn Bridge workers were not so fortunate. Twenty to thirty men died during its construction—the number being uncertain because records were not kept with any consistency. Because of this law, many lives are saved on a daily basis across many industries.

Many people in healthcare sometimes lose sight that OSHA is a worker safety program and not a patient safety program. In fact, most of the subparts of the OSHA law have nothing to do with healthcare-specific items, and even those sections can apply to any industry. This law has to be broad because it applies to *all* employers who have employees.

We discuss the subparts of this law and the specific applications to the dental office. It is your responsibility to provide a safe workplace for any employee. This is not only the right thing to do, it is the law.

Subparts

Walking and Working Surfaces

This, like many of the subparts, is common sense–oriented. It has to do with safety requirements for aisles and passageways, guardrails, and the use of ladders. Basically it requires you to keep all passageways clear of debris or any obstacle that would prevent safe travel in that area. This could include a wet floor, a rug that causes tripping, or storage of inappropriate items in these areas. The ladder portion refers to the act of making sure the ladder is in good condition and that another person holds the ladder for the person climbing it. This subpart should be easy to comply with.

Means of Egress

This subpart states that you must provide an unobstructed means of exit from any place in the office. OSHA requires you to place a map of the office with the exits, fire extinguishers, smoke detectors, fire alarm, and sprinkler systems located on the map. These should be placed in areas where the employee can easily view them in case evacuation of the facility is necessary. This subpart also requires you to create an emergency action plan for your office. This should include a fire prevention plan that lists any fire hazards in your office and provides training for employees on the fire hazard of materials located in the office. The emergency action plan also includes a list of any employee who has medical or first aid training, and the location of the first aid kit. Emergency evacuation directions should also be included. The scenarios should include in case of fire, chemical spill, and weather-related emergencies such as hurricanes, tornadoes, blizzards, and floods. One of the most important features that should be included is a meeting location in case the facility is evacuated so all employees can be accounted for. This subpart sometimes is neglected because people don't think it will ever happen. However, when it does, you will be happy you have rules in place.

Noise Exposure

The requirement for the employer to provide hearing protection is based on the exposure time equal or in excess of an 8-hour time-weighted average of 85 decibels. This is a very rare situation in a dental office. The sound of a sander is measured at 85 decibels. Since we are rarely exposed to something that loud and should never be so exposed for an 8-hour period, this is not applicable to the dental office. Nevertheless, you should be aware of the requirements.

Ventilation

Fortunately, there are not many items that we use in a dental office that require ventilation, but there are some. In the lab, work with monomers can be very overwhelming. Also, if you grind many models, dust particles can be a problem. A ventilation hood or fan should be provided in this area. The darkroom is another place of importance: cleaning the processor ventilation is necessary. This is another good reason to go with digital x-rays to eliminate this concern. The last item is an autoclave that uses chemicals instead of steam to sterilize instruments. These should have filters attached if you continue their use. Because of this, steam sterilizers predominate the market today.

Nonionizing Radiation

This pertains to radiation originating from radio stations, radar equipment, and any other source of electromagnetic radiation. This section does not apply to the dental office.

Hazardous Materials

This applies to several items in the dental office. Bulk oxygen is one of them; if you have central nitrous available in your office, you must comply with storage regulations for the large tanks. Hazardous materials are another—check with your state regulations on disposal of certain items in your office. Examples include amalgam, developing solutions, and any other hazardous chemicals you may use in your office. Proper training of employees in handling and storage of these items is essential. Make sure you have procedures in place in case of any accidents involving these items, including proper protective wear and notification in case of spills.

Personal Protective Equipment (PPE)

In the dental office we consider the following items our PPE: warm-up jackets (long sleeved, high necked, fluid resistant), masks (high filtration), protective eyewear (must have side shields), and gloves (latex or nitrile for dental procedures, heavy duty gloves for cleaning). These items should be provided to the staff members in order to protect them from possible contamination from body fluids or chemicals. Warm-up jackets should be worn during dental or cleaning procedures *only* and changed daily or when penetrable blood is present. Jackets should not be worn in break rooms or out of the office. The employer is required to launder this item in the office or have it laundered by a professional service. This is the largest protective item we wear. It is also the most exposed. Keep this in mind when training employees about the exposure this item has received throughout the day. Safety glasses are another item that is extremely important but not always worn. Challenge those employees who choose not to wear provided safety glasses to wear them just 1 day and see all the material that accumulates on them. This should be an easy reminder of how important

wearing this item is for their safety. The following is the proper sequence to put on and take off PPE:

Put on:

Jacket
Mask
Eyewear
Gloves

Take off:

Jacket
Gloves
Eyewear
Mask

Wearing PPE is one of the easiest ways we can prevent exposure. As an employer it is your obligation to train employees on the proper use of these items.

Medical and First Aid

Because we work in a healthcare facility, we usually think that much more is required in this area than is actually necessary. OSHA requires that you provide a basic first aid kit that includes bandages, a one-way valve for CPR, and a compression bandage. You must also provide an eyewash station for employees. This should be properly maintained by checking it on a monthly basis to make sure it is working correctly. Make sure everyone knows the location of the first aid kit and the proper use of the eyewash station. It is also a great idea to post important phone numbers such as those for the hospital, police, fire, and poison control. Also list the name and phone number of all staff members who have special training. Don't forget to put the number and address of your facility on this list so it is easily found in case of an emergency.

Fire Safety

Do you have a fire extinguisher? This should be the first question you ask yourself regarding this subpart. Many of the fire safety items were discussed in the Means of Egress subpart. However, having, maintaining, and training your employees on the proper use of the fire extinguisher are the main components of fire safety. You should have the extinguisher inspected on a yearly basis and consult with your local fire station regarding training of your employees on its proper use.

Electrical Safety

This is, again, common sense. Check all cords for frays. Do not alter plugs. Do not overload outlets. Check with manufacturer recommendations on certain equipment items regarding the use of dedicated outlets or circuits. Take care when plugging in items that are near water. Make sure all electrical connections are tight. These should be regular safety practices that we use in our own homes.

Employee Records

Employee records should be kept for the duration of employment plus 30 years. This may seem like a long time, but doing so is in your best interests. These records should include medical and employment histories. Remember that even though your employee may be a patient, this OSHA record should be kept separate from an employee's individual patient files. Make sure the health histories are kept current. This is to the employee's advantage in case of an accident. Other items that should be included are the results of medical examinations or lab tests, medical opinions or diagnosis, record of first aid, and employee medical complaints. Employees can request a copy of these records, and you are required to give them a copy within 15 days of such a request.

Ionizing Radiation

This is the radiation that pertains to x-rays. Each employee using such equipment should be properly trained on its use and should employ monitoring devices such as a badge as your state law requires. Badges are available to monitor employee exposure to radiation. Modern x-ray devices are fairly safe to use. Be wary of any pointed cone x-rays that are still in use.

Bloodborne Pathogens

This is the subpart that most healthcare workers focus on and is a very real concern in the dental office. This pertains to all employees that are exposed to blood and other potentially infectious materials. Saliva exposure during dental procedures is on this list. The most serious viruses are HIV and hepatitis B, although other hepatitis strains such as A and C are becoming more prominent in the population.

The Exposure Compliance Program is an important part of this subpart. This includes providing all employees with the hepatitis B vaccination. If they choose not to receive this protection, they must sign a declination form. Also, it is necessary to provide care to any employee that might be exposed during work. This could include a needle stick or instrument poke. Instrument pokes are more common and should not be treated lightly. You must send any employee who is exposed to the proper healthcare facility. Check your area for facilities specializing in worker issues. Also, you must receive proper follow-

up from that facility. Record keeping is vital during this situation. Refer to the flow chart provided on the American Dental Association website www.ada.org/prof/resources/topics/osha/flowchrt.asp for specific details.

Infection control is the best way to prevent exposure incidents from happening. Work practice controls such as hand washing, patient history, use of proper PPE, and employee training are one of the best ways to avoid incidents. The other is engineered controls such as needle recappers, sharps containers, and cassettes. These items are made to eliminate your chance of exposure. Again, training on the proper use of these devices is crucial. Lastly, cleaning, sterilization, and disinfection of the work area and instruments are vital to stop exposure. Please keep in mind the following areas that exist in your office:

Critical: An instrument that is used to penetrate soft tissue or bond *must* be sterilized. This critical category includes anything that goes in the mouth.

Semicritical: Instruments that come into contact with mucous membranes, but do not penetrate, must at least receive high-level disinfection. This disinfectant must be able to kill hepatitis B and should be left on the recommended time to do so. This area is approximately a 3-foot area around the mouth.

Noncritical: If there is no contact or penetration with any mucous membrane, but an item used in the treatment of patients, it must receive intermediate-level disinfection. A household disinfectant is sufficient for this purpose. This area is the rest of the operatory.

Please keep in mind that in cleaning and sterilizing instruments, ultrasonic cleaners are considerably more effective than hand scrubbing and alleviate the risk of exposure.

This subpart may be the most important one for any healthcare facility, but it is not the only one. Remember, OSHA is for worker safety, not patient safety. It is a positive outcome that our patients are safer because our workers are safer.

Hazard Communications

Chemical inventory is your first step in compliance with this section. This is simply an alphabetical list by product name of all products requiring an MSDS (material safety data sheet) used in your office. Ask your supplier representative to help you with this. This list should be posted for all employees. Next is the MSDS book. This is the most misunderstood item in the office. It is simply a copy of each MSDS for each item listed on your chemical inventory. It should be arranged the same way: in alphabetical order by product name. Use your chemical inventory list as a table of contents. Remember that with both the chemical inventory list and the MSDS book, discontinuation of a product does not mean it is removed from the list. You must maintain your MSDS sheets for 30 years. Each item you purchase that requires an MSDS sheet will be sent to you with a copy of the sheet. You need only keep one copy in your book.

Make sure the one you have is current and discard the old one. However, if the chemistry has changed you must maintain both. This can be overwhelming to an office that does not keep its book current. However, if you keep it current from day 1, it should be a simple matter requiring minimum time. When you introduce any new products into your practice, you should post the MSDS sheet for your employees to review. Make sure all employees know how to read the MSDS sheets. They vary in the way they look for each manufacturer but are required to include the same information. The sections of an MSDS should include identification, hazardous ingredients, physical/chemical characteristics, fire and explosion data (this should be rated 0–4, 4 being the most flammable), reactivity data, health hazard data (this includes the routes of entry), precautions for safe handling, and control measures. It is a good idea to look at several different MSDS sheets and become familiar with these sections.

Labeling is another area that is widely misunderstood. You must label anything that is not in its original container. In most offices the main items that require labeling are the cold sterile container, the ultrasonic machine, and the film processor. I recommend that for any surface disinfectant you use manufacturer-labeled spray bottles. Labels are available from most dealers and are easy to use. A simple tip is to make a copy of the first label you make and keep it with your MSDS book, and then when that label is destroyed you don't have to look up the information again.

This is the most overwhelming part of OSHA for most dental offices, but if kept up it can be simple and not as time consuming.

Workplace Violence

This is not a new part of the standard and is advisory in nature. Each industry faces different risk. As an employer you should be aware of this as a part of OSHA and should provide a violence-free workplace.

Sexual Harassment

This is a serious problem in the workplace and should not be taken lightly. You should consult a training manual on this for your office. It can happen to anyone at any time. Sexual harassment is related to OSHA and to equal employment law (see chapter 17). As an employer you should be knowledgeable about and prevent sexual harassment.

OSHA Compliance and Inspections

Following the recommendations in the above subparts should go a long way in making any office compliant. It is recommended that you purchase an OSHA book. These are available through the American Dental Association (www.ada.org), the Dental Resource Center (http://drcdental.com/index.asp,

then click on View All Titles), and various other organizations. Make sure when you purchase one that it is as complete as possible. Many of the available OSHA books provide forms for incident reports, emergency action plans, and so forth. It will save you a lot of time and headache to use these forms instead creating them yourself. Why reinvent the wheel? Proper state and OSHA forms must also be posted in your office. These forms are available from the same OSHA books (and probably also from governmental agencies).

Inspections from OSHA in the dental industry are rare but do happen. You could face substantial fines for noncompliance. Inspections can be triggered by some of the following situations: imminent danger present, catastrophes and fatal accidents, employee complaints, and programmed inspections. OSHA uses the "worst first" system of inspections. This is not meant to scare anyone, but you should always make sure your facility is compliant.

Yearly training of all employees is the biggest component to OSHA. All existing employees should attend OSHA training on a yearly basis, and new employees should be trained upon starting employment. Training should consist of review of all subparts. This can be done by an outside source, you, or an employee whom you have designated as the OSHA officer in your practice. However you decide to provide it, this training is required and is part of your compliance.

Further questions and information on the OSHA regulations can be answered at www.osha.org.

What Is HIPAA?

With the increase of electronic data interchange within the healthcare industry, lawmakers needed a way to protect patient privacy and security of patient records. Because of this HIPAA was created. There are three main standards involved in HIPAA: Electronic Transactions Standard, Privacy Standard, and the Security Standard. This law applies to any health plan, healthcare clearinghouse, and healthcare provider that transmits any health information in electronic form.

Your first step to compliance is to assign a HIPAA coordinator in your office. In a small office this person may also take on the responsibilities of transaction compliance officer, privacy officer, and security officer. As the practitioner, you should remain the practice executive unless your office is quite large.

Electronic Transactions Standard

This provides for safe transfer of patient information through the computer to clearinghouses used in electronic claim submission. It also includes information sent over the internet to another physician's office. Sending electronic claims can eliminate cost and increase productivity in your office. Many of the

functions of this standard should be handled by your practice management software. Check with the vendor to make sure the system is HIPAA compliant. One of the features of HIPAA is standard code sets. CDT-4 is for dental services procedures and nomenclature. Also, make sure any organization you exchange information with is compliant. To eliminate fraud, the government issued Employer Identifier Numbers for all employers, since they provide most healthcare plans, and a National Provider Identifier (NPI) for all healthcare providers. The NPI is a 10-digit number that will be used with any correspondence to healthcare plans.

Privacy Standard

This standard serves several purposes: to protect the rights of patients and to provide them with access to their protected health information (PHI), to improve the quality of healthcare by restoring trust in the healthcare system, and to improve the efficiency of healthcare delivery. The patient's PHI can only be disclosed as follows: directly to the patient; to carry out/provide treatment, payment, or healthcare operations, generally accompanied by a consent form; in compliance with a patient authorization form; upon informing a patient in advance of proposed disclosure, when the patient can agree or disagree; when disclosure is required by law or for public health reasons. Service contracts should be obtained by anyone outside the facility or not included on the HIPAA compliance list. This may include accountants, attorneys, business consultants, computer consultants, or temporary employment agencies. A form for consent and authorization should be signed by the patients so they understand the law and reasons that their information would be used or transferred.

The greatest practical implication for staff regarding this standard is this: limit access to patient records by not leaving them unattended, not discussing PHI outside the office, not removing files or patient records from the office, restricting employee access to records except for assigned business needs, and storing historic records similarly. Some activities that may be affected by this law are sign-in sheets (names only are allowed), schedules that contain anything other than patient names, and oral communication of PHI. A special effort to provide privacy for each patient should be enacted.

Security Standard

This standard relates to the safety of electronically stored and transmitted PHI. Each facility should do a risk assessment based on its capabilities. As far as electronic submittal, you should check with the entities involved to ensure compliance. Also, the backup of your computer is essential, but any tapes or servers should be tracked if removed from the facility. Logons and automatic logoffs for your practice management software are also a great way to ensure safety. Workstation use should also be a consideration, and the uti-

lization of screen savers or monitor shields is vital to the protection of patient records.

Failure to comply with HIPAA regulations can trigger fines up to $250,000. Most computer software companies are fully aware of HIPAA rules and regulations and make compliance seamless. Your hardware provider should also be familiar with the regulations to help make storage easy. The main implication for your office is to train employees properly and make sure all the proper forms are signed by your patients.

Latest CDC Guidelines

From time to time, the CDC issues updated guidelines for dentistry to help stop the spread of disease. Unlike OSHA, these are guidelines, not laws. However, compliance with these guidelines also helps provide a safe workplace.

The latest guidelines for dentistry were released in December 2003 and are as follows:

1. Developing written comprehensive policies and programs
2. Not refilling your soap bottles without washing and drying them first
3. Using sterile gloves with surgical procedures
4. Keeping fingernails short, and no artificial nails or extenders
5. Changing masks between patients
6. Allowing packages to dry before they are handled to avoid contamination
7. Designating a central processing area into distinct areas: receiving, packaging, sterilization, and storage
8. Transporting instruments in covered containers
9. Using chemical indicators on the inside of the bag
10. Wrapping of all instruments that are not being used immediately
11. Examining wrapped packages of sterilized instruments before opening them to ensure the barrier wrap has not been compromised
12. Avoiding the use of carpeting and cloth-upholstered furnishings in dental operatories
13. Meeting Environmental Protection Agency regulatory standards for drinking water (500 CFU/mL) for routine dental treatment
14. Advising patients to not close their lips tightly around the tip of the saliva ejector

Government Agencies Unraveled

In the end, the best approach to any regulatory agency is to analyze it piece by piece and make it work for you. Many people are overwhelmed by the idea

of OSHA or HIPAA, but when you break down the compliance issues, they are entirely manageable. Compliance can even make your practice better. By providing a safe workplace for your dental team, you are more likely to retain them. Given the average, short duration dental assistants tend to stay in a practice, retention of staff remains very important for practical and economic reasons.

References and Additional Resources

Health Professions Training Consultants. 2001, 2006. HIPAA Unraveled. Available at http://drcdental.com.

———. 2003. *OSHA Compliance Manual.*

www.ada.org. ADA (American Dental Association) website; (www.ada.org/goto/hipaa, www.ada.org/prof/resources/topics/amalgam.asp).

www.osha.org. OSHA (Occupational Safety and Health Administration) website.

Learning Exercises

1. Use your current classroom and create an emergency evacuation map.
2. Find and analyze at least two MSDS sheets for items you use in the clinic.
3. Create a label for one of the items you found the MSDS sheet for. Use http://its.unm.edu.labels.html for example labels.

Chapter 14
Incorporating Technology

Scott A. Trapp and Gregory G. Zeller

Background on Information Technology in Dentistry

The history of information technology in dentistry has mirrored that of other functional components of the U.S. economy. Prior to the introduction of the personal computer in the early 1980s, very few dental practices utilized computers to automate business and clinical functions. This was due primarily to the high initial cost of the investment in this equipment and was further exasperated by the high recurrent costs associated with programming and operation.

The introduction of the personal computer helped to remove the barrier of high start-up costs, but programming and computer operation continued to be a barrier. The adoption of the Microsoft Windows operating system as the de facto standard in the business environment led to the development of dental practice management software that was easier to use and reduced the costs associated with training and ongoing maintenance.

As the information technology market matured, the need for ease of use and off-the-shelf software was fulfilled by new entrants to the dental informatics market. This influx led to a number of varying dental information management systems on the market by the beginning of the 1990s. Many of these systems were developed by small start-up companies that did not have the market base nor the capital required to develop a significant level of market penetration to maintain viability. Thus, by the end of the 1990s, very few of these dental practice management systems were still being supported by their developers, and by the middle of the first decade of the 21st century, the dental practice management system industry had consolidated to a handful of major companies. This, in turn, led a number of dentists to reinvest in new practice management systems at a significant cost. Unfortunately, these systems have still failed to standardize their databases on a single patient-centric electronic dental/ health record, which has inhibited effective communication between the various providers the patients see.

Benefits of IT in Dental Practice

Advantages

The proliferation of information technology in healthcare has led to great gains in patient prevention and disease management programs. Dental management systems first began as systems designed to manage the dental hygiene recall systems by alerting the practice when a patient was due for his or recall, then generating reminder cards. These systems have now evolved to the point where they can actually make reminder follow-up phone calls. The practice management systems soon moved beyond the administration of the recall systems and started building dental charting capability. The creation of the electronic dental chart shaped the ability for the dental practice to more effectively manage patient treatment plans to completion. Through the use of data mining techniques, the dentist can now seek out patients who may have not followed up with recommended treatment and encourage these patients to complete their recommended dental care. The business side of the dental practice management systems started out as simple monthly statement generating systems. Today these systems have the ability to interface with third-party benefit providers to determine levels of coverage and co-payments required, often in real time. This level of service has led to great improvements in communication not just between the dentist and the patient but also between the dentist and the third-party payer.

Unfortunately, despite the establishment of consensus-based transaction standards for this type of communication between the dentist and the third-party payer, a large number of third-party payers have failed to implement the systems necessary for this level of improved communication. The implementation of dental practice management systems has allowed the more effective management of a larger patient base while improving the level of service within the dental practice. This has given those who have these systems a distinct competitive advantage over those who have not upgraded their management systems.

Disadvantages

While the advancement of information technology into the practice of dentistry has produced a number of advances in the management of patient care, it has also presented a number of challenges. The high rate of change in technology related to both the hardware and software platforms has led to shorter product life cycles. Dentists have grown accustomed to capital budgeting expenditures that are often in the 10- to 15-year upgrade range. However, rapidly changing technology requires planning for new information technology hardware and software upgrades that may be in the 3- to 5-year range. This rapid turnover in technology also comes with an education and training cost. Currently our workforce has an information technology gap. There are a great number of

individuals who are still uncomfortable using computers. This is mostly due to their education and training background. As the segments of our workforce that were not exposed to computers early on in their careers reach retirement, this gap will continue to decrease. In the meantime, dentists need to be aware of this gap and make efforts to utilize the vast knowledge possessed by those who may have a limited exposure to computers. If there is a need to have the dental office computer systems connected to the internet, there is the constant requirement to ensure the security of the patient's records. Safeguards must be in place to monitor for potential intrusions into the computer system through the use of firewalls and virus protection. The connection to the internet may be a further limitation depending upon the location of the dental office. There are still a number of rural areas that lack broadband internet access. The reliability of computer systems has improved dramatically, although these systems may still experience downtimes greater than that of other equipment in the dental office. Safeguards can be implemented through the use of uninterrupted power supplies and real-time backups that can ensure a high level of reliability. Table 14.1 presents the advantages and disadvantages associated with use of current information technology.

Return on Investment

Dentists are trained to provide the latest and most advanced treatments possible to their patients. This is through the use of the latest and most improved techniques, materials, and equipment. This mindset often discards the need to evaluate these new technologies in a cost-effective manner. There are a large number of examples of dentists who have thousands of dollars of discarded equipment in storage and have never recouped the cost of their investment. When a dentist is making any purchasing decision, he or she must also understand that dentists are business people and must make purchases that will provide a return for their investment. The concept of return on investment and payback period should also be used to make the decision to upgrade to a new technology within the office. In the field of finance, the types of calculations that aid in the purchasing decision process are referred to as "capital budgeting." There are generally three techniques that are useful in the capital budget-

Table 14.1. Advantages and disadvantages of information technology.

Advantages	Disadvantages
Improved communication	Constant learning curve
Improved efficiency	Security
Improved service	Reliability
Ability to mine health data	Infrastructure
Improved patient management	Product life cycle/upgrades
Competitive advantage	

ing process: the payback period, net present value, and internal rate of return.

Payback Period

The payback period is the time period, usually expressed in years, that it takes to recover the original investment. This technique is useful in evaluating the differences between two items or projects. For example, if the decision to upgrade to a new computer printer has been made, one can evaluate the recurring costs between the existing printer and the replacement. If the new printer has an initial cost of $200 with a cost per page of $0.02 and the practice prints 50 pages per day with a 220-day work year, this would give a recurring printing cost of $\$0.02 \times 50 \times 220 = \$220$. If the old printer is costing the practice $0.03 per page, that would give a yearly recurring cost of $330. Subtracting the recurring cost of the old printer from that of the new printer, $330 – $220 = $110, gives a cost savings by upgrading to the new printer. The payback period would then be calculated as the original investment cost of $200 divided by the cost savings of $110, giving a payback period of 1.8 years. A good rule of thumb is to compare the payback period to the depreciable life span of the equipment under consideration. (Consult with an accounting professional for depreciable life spans.) If the payback period is less than the depreciable life span, the decision would be to make the purchase.

Net Present Value and Internal Rate of Return

The use of payback period is a good basic capital budgeting technique but fails to account for the time value of money. We know that a dollar today is worth more than that same dollar 1 year from now, if we can earn interest on our money. The capital budgeting technique of net present value and internal rate of return takes into account the time value of money. A detailed discussion of net present value and internal rate of return is beyond the scope of this text. The main concept to understand is that your sales representative should be able to provide this information to you for major purchases. The decision to make the purchase would be made only when the net present value is positive and the internal rate of return is acceptable for the use of your money. The key with the internal rate of return is that your investment in the technology must exceed the rate you can expect to receive in other investments.

Whenever evaluating an information technology project for its ability to improve dental office operations, there are a number of factors to consider beyond those of just cost. There is a benefit derived from improved accuracy and error reduction. This can be difficult to quantify in terms of dollars. One method is to look at the costs associated with an error and calculate the costs of the time spent correcting the problem. Another factor to consider is the time savings gained from the investment in the technology. For example, if one was to consider an investment in digital radiography, there would be a time savings by being able to display the image instantaneously versus waiting 5 minutes for the film processor to develop the image.

Standards

Why Standards Matter

Standards ensure desirable characteristics of products and services such as quality, environmental friendliness, safety, reliability, efficiency, and interchangeability at an economical cost. When products and services meet our expectations, we tend to take this for granted and are unaware of the role of standards. However, when standards are absent, we soon notice. We soon care when products turn out to be of poor quality, do not fit, are incompatible with equipment that we already have, or are unreliable or dangerous. When products, systems, machinery, and devices work well and safely, it is often because they meet standards. The organization responsible for many thousands of the standards that benefit the world is the International Organization for Standardization (ISO) and its American counterpart the American National Standards Institute (ANSI).

What standards do are to

- Make the development, manufacturing, and supply of products and services more efficient, safer, and cleaner
- Facilitate trade between countries and make it fairer
- Provide governments with a technical base for health, safety, and environmental legislation and conformity assessment
- Share technological advances and good management practice
- Disseminate innovation
- Safeguard consumers, and users in general, of products and services
- Make life simpler by providing solutions to common problems

Whom Standards Benefit

For businesses, the widespread adoption of national and international standards means that suppliers can develop and offer products and services meeting specifications that have wide acceptance in their sectors. Therefore, businesses using standards can compete on many more markets around the world. For innovators of new technologies, standards on aspects like terminology, compatibility, and safety speed up the dissemination of innovations and their development into manufactured and marketable products.

For customers, the worldwide compatibility of technology that is achieved when products and services are based on international standards gives them a broad choice of offerings. They also benefit from the effects of competition among suppliers. For governments, international standards provide the technological and scientific bases underpinning health, safety, and environmental legislation. For trade officials, international standards create “a level playing field” for all competitors on those markets. The existence of divergent national or regional standards can create technical barriers to trade. International standards are the technical means by which political trade agreements can be put into practice. For developing countries, international standards that represent

an international consensus on the state of the art are an important source of technological know-how. By defining the characteristics that products and services will be expected to meet for export markets, international standards give developing countries a basis for making the right decisions when investing their scarce resources, and thus avoid squandering them. For consumers, conformity of products and services to international standards provides assurance about their quality, safety, and reliability. For everyone, international standards contribute to quality of life in general by ensuring that the transport, machinery, and tools we use are safe. For the planet we inhabit, international standards on air, water, and soil quality; on emissions of gases and radiation; and on environmental aspects of products can all contribute to efforts to preserve the environment.

Standards in Dentistry

The American Dental Association (ADA) is an ANSI-accredited standards-developing organization. ADA specifications have been approved as American national standards by ANSI, and thus they are designated as ANSI/ADA specifications. These specifications are developed through two committees: the ADA Standards Committee on Dental Products (SCDP) and the ADA Standards Committee on Dental Informatics (SCDI).

ADA Standards Committee on Dental Products and Standards Committee on Dental Informatics

The ADA SCDP develops specifications for dental materials, oral hygiene products, infection control products, dental equipment, dental instruments, and more. ANSI/ADA specifications for dental materials, instruments, and equipment are formulated by working groups of the ADA SCDP. The committee has representation from all interests in the United States in the standardization of materials, instruments, and equipment in dentistry. The scope of the committee is, "Nomenclature, standards and specifications for dental materials, except those recognized as drugs or dental radiographic film. Nomenclature, standards and specifications for dental instruments, equipment and accessories used in dental practice, dental technology and oral hygiene that are offered to the public or the profession. Orthodontic, prosthetic, and restorative appliances designed or developed by the dentist for an individual patient are excluded" (http://www.ada.org/prof/resources/standards/products-about.asp).

The ADA SCDI develops informatics specifications and technical reports to assist the dental profession with hardware and software selection, digital photography, interoperability, data security, and more. The scope of the SCDI is, "To promote patient care and oral health through the application of information technology to dentistry's clinical and administrative operations; to develop standards, specifications, technical reports, and guidelines for:

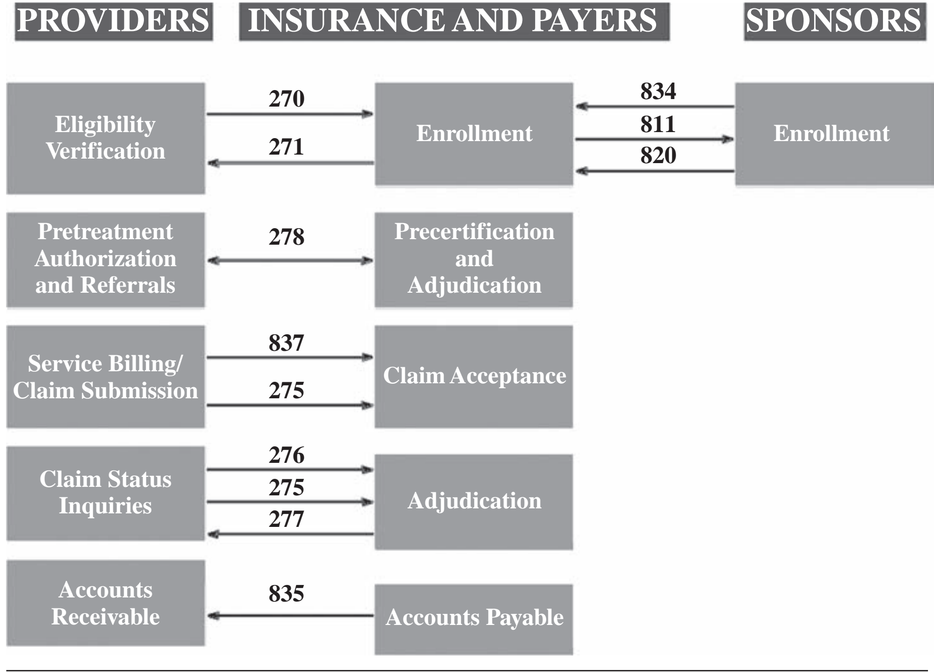
components of a computerized dental clinical workstation; electronic technologies used in dental practice; and interoperability standards for different software and hardware products which provide a seamless information exchange throughout all facets of healthcare" (http://www.ada.org/prof/resources/standards/informatics-about.asp).

Accredited Standards Committee X12

The Accredited Standards Committee (ASC) X12 is a membership-based not-for-profit organization chartered in 1979 by ANSI to develop uniform data standards and specifications for cross-industry electronic exchange of business transactions. ASC X12 has developed the standards identified in Table 14.2, which allow for effective commerce between the dental office and third-party

Table 14.2. ASC X12 standards.

270/271: Health Care Eligibility/Benefit Inquiry and Information Response
276/277: Health Care Claim Status Request and Response
278: Health Care Services Review—Request for Review and Response
820: Payroll Deducted and Other Group Premium Payment for Insurance Products
834: Benefit Enrollment and Maintenance
835: Healthcare Claim Payment/Advice
837: Healthcare Claim: Dental



carriers as designated under the Health Insurance Portability and Accountability Act.

It is the implementation of these standards that will allow for a complete electronic solution to handling a patient's dental insurance in a manner similar to that used by us daily by swiping our ATM card or credit card. Unfortunately, the slow adoption of these standards by third-party payers has delayed an electronic solution to the efficient handling of dental insurance within the dental office.

Other Standards Development Organizations

In addition to the ASC X12 there are several other standards development organizations for healthcare devices and healthcare informatics; these include Health Level Seven, the National Council for Prescription Drug Programs (NCPDP), the American Society for Testing and Materials and the Institute of Electrical and Electronics Engineers. These organizations have contributed to the development of standards and specifications related to dentistry.

Business Management and Electronic Commerce

Dental practice management systems are composed of a number of integrated components. The components include business management, scheduling, communications, clinical management, and radiography. The business management component of dental practice management systems is primarily designed to give the dentist the information needed to effectively and efficiently run his or her practice. These components include:

- Patient billing management
- Insurance information management
- Productivity analysis

Patient billing management allows the dentist to track the charges, payments, adjustments, discounts, refunds, write-offs, and finance charges. This can be done based upon the provider of the dental care, such as an associate or dental hygienist. For those with dental insurance, the dental practice management system should have the capability to submit dental insurance claims in accordance with ASC X12 transaction standards, as previously discussed. For those carriers that do not support electronic commerce, the system should support and have the ability to print the ADA Standard Claim Form. For tracking purposes, dental practice management systems have the ability to age and audit insurance claims as submitted, paid, nonsubmitted, or resubmitted based upon date of transaction. In order to aid the dentist in managing the patient's insurance benefits, these systems have the capabilities to display

coverage breakdown per policy, employer, or company, which contains coverage information, deductibles, maximums, and percentage for each category of dental service performed.

Most dental practice management systems have developed similar productivity analysis reports. These include items such as:

- Day sheet generation for balancing the deposits and viewing billings for the day
- Aging and combined aging by provider, insurance company, contracts, and so on
- Report showing collection/production ratio
- Current ADA Procedure Code Listing
- Open item accounting for insurance billing and tracking
- Open item insurance estimation
- Employer tracking of employee's benefits and office utilization (sort reports by employer)
- Missed payment report
- Production and collection comparisons to previous periods
- Health maintenance organization/preferred provider organization/capitation billing, processing, and productivity analysis reports indicating patients seen, production, collection, and capitation income compared to office fee for similar services
- Quantification of the number of active patients using the practice description of active patient (for example, a patient who has had a periodic exam in the last 12 months or as defined by practitioner)
- Goals comparison in scheduling, production, new patients, and so forth

There is an increasing need for dentists to provide not only a high level of dental care to their patients but also a high level of customer service. Increasingly, practice management systems are adding functionality that allows their systems to interface with off-the-shelf third-party software such as the Microsoft Office Suite, phone dialer systems, and text messaging through the internet. This has allowed the dentist to communicate items such as appointment reminders to the patient. This becomes a win-win for both the patient and the dentist. The patient is more likely to seek and follow through on preventive dentistry, thus reducing his or her out-of-pocket expenses. For the dentist, this improved communication can reduce the office broken and failed appointment rate. See chapter 12 on appointment scheduling. Practice management systems are currently in the very early phase of integration with business accounting packages. The business accounting packages are used to handle items such as payroll and accounts payable. The full integration of these two systems will lead to the ability of the dentist to implement activity-based accounting. Activities-based accounting will then allow the dentist to better determine and evaluate the true costs of each of the services delivered to his or her patients.

Clinical Management Systems

Scheduling Systems

A robust scheduling system is critical to an efficiently run dental practice. The management of the dentist's schedule is a complex job that requires the individual to consider a large number of input parameters. For example, a dentist may have the ability to manage the patient dental care in multiple operatories simultaneously, but there are those procedures or patients that require one-on-one care. The clinical scheduler or the scheduling system must have the ability to handle these exceptions and give warnings if attempts are made to override these requirements. The most efficient of the scheduling systems integrates the patient's treatment plan. This is done at the treatment planning appointment, where the dentist, in addition to planning the required treatment, also note, the number of appointments required for treatment plan completion, the time required for each appointment, and the equipment or instrument resources need at each appointment. Once these appointment parameters are set, the scheduling system will then have the ability to search for the most effective and productive time to place this appointment. The main goal from the business perspective is to ensure there is not a great deal of variability in the production from day to day. This will in turn even the cash flow of the practice, lessening the impact of income changes from month to month. In turn, the dentist has a greater ability to control his or her overhead. The system, in performing the search function, may consider items such as daily productivity, convenience to the patient, and dental office scheduling rules.

One of the best features the scheduling system can have is the ability to integrate with the dental office communications systems. This allows the dental office to send out appointment or recall reminders to the patient in a variety of forms such as an automated phone call, e-mail, or text message. In addition to the management of day-to-day appointments, the scheduling systems have the ability to manage a patient's recall. These systems are highly customizable by the recall needs of the individual patient and may go as far as managing the recall needs of families and integrating those needs with the third-party payer requirements.

All scheduling packages should have a tight integration with the business management subsystem's insurance management database. This can prevent costly miscommunications between the dentist and the patient. For example, if a patient's third-party payer has rules that will not pay for more than one periodic exam within a 6-month period, the dentist will need to be conscientious not to schedule the patient on exactly the 6-month date but rather on 6 months plus 1 day.

The final component of the scheduling system is that of the reporting mechanism. The reports that the schedule management system generates will give the dentist insight as to how this portion of the dental office system is running.

These reports will generate items as simple as broken/failed appointment rates and tracking of the time used to perform procedures. The dental office can then use this information to make changes to its schedule to better accommodate its patient base.

Clinical Charting

The core element to any practice management system is its ability to allow the dentist to efficiently document his or her clinical finding. Additionally, these systems should have a user interface that is not only easy to navigate for the dental staff but also comprehendible to the patient, so that the dentist can actively engage his or her patient in the treatment planning process. Charting systems currently allow the dentist to chart the procedures he or she recommends rather than the underlying problem or diagnosis associated with the recommended treatment. More robust systems allow the dentist to chart the patient based upon his or her diagnosis and then pass on a set of suggested treatments to resolve the pathology. This set of procedures linked to the diagnosis should be configurable by the individual dentist. This in turn can be linked to a treatment planning module that will allow the patient and dentist to plan a recommended course of care by considering factors such as type and severity of the disease, area of the mouth, and cost factors. As treatment is rendered, the dentist must be able to document the patient visit. Most charting systems have the ability to document progress notes, and the more robust systems will allow the dentist to develop his or her own templates of notes that will allow for a more rapid way to document the visit while still customizing the entry for an individual visit.

An area under rapid development is the electronic health record. This record will allow the practitioner to view all the necessary health information on a patient. The goal of this record is to move from our current system of one patient with many records to a system of one patient with one record. Once implemented, this system will provide the dentist with a clearer picture of a patient's true health status. Until a fully integrated electronic health record becomes available, the current systems should be evaluated based upon their ability to develop electronic health history forms or scan-in paper forms. Since paper is a necessary part of doing business, there is going to be the need to scan these documents so that they may be stored electronically.

Electronic Prescriptions

Electronic prescriptions are an emerging technology that can be of great benefit to the dentist. Electronic prescription programs are based upon the National Council on Prescription Drug Programs (NCPDP) standard for electronic prescriptions. When evaluating dental practice management systems, one should inquire as to the system's ability to handle electronic prescriptions or their plans to build this capability.

Digital Radiography

Digital radiography is nearing a point that it will become the de facto standard for dental radiology. Most clinical charting systems have the capability to manage a patient's imaging. This is done through their own built-in program or through a bridge linking to a digital imaging program. These digital imaging programs have a number of features common among the various manufacturers. The most critical element in evaluating the interoperability of imaging programs is the standards by which the image is stored. Through the consensus process, the dental and medical industry has agreed that the Digital Imaging and Communications in Medicine format will be the standard.

Common Practice Management Software Systems

As mentioned earlier, only a few software systems currently dominate the market share. In no particular order, and with no intention of endorsement, these systems include Dentrix (www.dentrix.com), Eaglsoft (http://patterson.eaglesoft.net/index.htm), and Kokak PracticeWorks (www.kodakdental.com/en/productsForDentists/index.html?pID=2173/2423). You are encouraged to obtain demonstration DVDs/CDs of these and perhaps other software systems. Then evaluate these systems against the features of software systems previously outlined.

Patient Education

Software systems are also currently available for patient education. These can enhance case presentation as well as case acceptance. Two prominent educational software systems include, again in no particular order and without an intention of endorsement, CAESY (www.caesy.com) and Orasphere (www.orasphere.com). These systems provide animated descriptions and explanations of patient treatment options. For example, a crown preparation is described in terms of each major step, including animation of the tooth preparation.

Need for Integration and Expert Support

In spite of all the efforts to standardize technology, issues of incompatibility commonly arise when hardware and software are combined. Therefore, it is essential to have sound advice and consultation from information technology experts in selecting and updating hardware and software. Dental supply companies often can provide assistance in this area.

Future Direction

In 2004 President George W. Bush issued an executive order that set into place the foundation for building the National Healthcare Information Infrastructure (NHII). This executive order calls for a fully interoperable patient-centric electronic health record by 2014. The key to accomplishing this is for the industry to come together and build their systems based upon a set of industry-based consensus standards for information technology. Once these standards are identified, organizations will be able to certify health and dental record systems and their levels of compliance to standards. Once a fully interoperable health and dental record becomes the norm, the next step will be the development of decision support systems that will aid the practitioner in selecting from a series of potential treatments given the selected inputs. The decision processing will be based upon an integration of the system to the most current research. These systems will provide the dentist with the ability to continually evaluate the quality of the services performed and give suggested methods for improvement. Specific to dentistry, an area of quickly advancing technology is that of CAD/CAM technology, utilizing digital prescriptions. There are currently systems being developed that allow the dentist to take a visual light impression, similar to scanning a piece of paper. This digital impression is then transmitted to the dental laboratory for prosthesis fabrication. As this technology moves forward, it offers the promise of lower cost to both the dentist and the patient, with a faster turnaround time from the dental laboratory.

Overall, the use of information technology in dentistry can be a great asset, but one must caution against putting too much emphasis on this technology. Information technology is just another instrument in the dentist's armament.

References and Additional Resources

ADA ANSI Accredited Standards Committee MD 156 Task Group on Dental Informatics. ADA Technical Report No. 1004: Computer Software Performance for Dental Practice Software. Available at www.ada.org/prof/resources/standards/informatics_reports.asp.

www.ada.org. American Dental Association.

www.ansi.org. American National Standards Institute.

www.iso.org. International Organization for Standardization.

Plus, software websites listed earlier in the text.

Learning Exercises

1. What are the advantages and disadvantages of information technology, and how can they be used to the dental office's advantage?
2. What are the key components of practice management systems?
3. Obtain demo discs from three dental software programs and compare the pro and cons of their charting and billing software.

Part 4
Marketing

Chapter 15
Internal Marketing and Customer Service

Amy Kirsch and Karla Gunner-Barringer

Marketing your practice in today's tough marketplace is challenging. Many practitioners are confused about what kind of marketing (internal, external, and/or advertising) will work for them. In our experience as consultants throughout the United States, it is rare to meet a dentist who is "closed" to new patients. Even the busiest of practices still needs new patients to meet production, collection, and cash flow goals.

As we all know, the best new patients are those who have been referred to us by others. With a focus on internal marketing and customer service skills, you and your team will be able to separate yourself from other practices and ensure a healthy new patient flow every year. Our goal in this chapter is to give you techniques and communication skills to

- Increase quality internal referrals as a result of the "WOW" factor
- Implement and enhance the internal marketing program in your practice
- Implement high-level customer service skills
- "WOW" each and every patient from the initial phone call through the greeting, treatment, and dismissal
- Learn skills to make sure each patient is treated like a "guest" in your practice, not a bother in your workday

Marketing and Customer Service: How Do They Relate?

Where does marketing end and customer service begin? Marketing (internal or external) is the way we retain and attract patients to our practice. Customer service skills are part of the marketing plan. Marketing and customer service skills in dentistry are closely intertwined. Without customer service skills, the marketing plan will fail. Without a marketing plan, the customer service skills may not be a priority for all of the team.

Interestingly enough, most of us in dentistry have not received any specific training or education on marketing or customer service skills. If you worked for a high-end bank, restaurant, or retail store, you would receive extensive

training in customer service skills before working directly with the public. Not so in dentistry.

As in any service industry, we distinguish our practices in how we communicate and how we deliver our services. To your patients, the best marketing you can do is internal marketing by providing a high level of customer service. It is low cost and has the biggest impact on patient retention, treatment acceptance, and referrals

It is very important to be able to deliver what you promise. If you talk "quality service," you need to be able to back it up with your communication skills, facility, and technical skills. Inconsistency between your promises and the product you deliver can lead to low trust as well as decreased patient referrals and poor patient retention. Many practices that struggle with adequate new patient flow have not spent enough time on the internal marketing and customer service side of the practice and have many dissatisfied patients who do not refer and often leave the practice.

Internal Marketing

As we have discussed, many of the best patients in your practice have been referred by other patients. They already have a certain level of trust in you and your team. This trust is based on the recommendation of a friend or family member they trust. They have a higher level of treatment acceptance and retention because they were referred to your practice and did not pick your name from a list or from the internet.

Although you may need to belong to a reduced fee dental plan or have a direct mail campaign to help your practice grow, you will be able to reduce your costs and time spent recruiting new patients with a strong internal marketing plan in place. You want all patients, regardless of their referral source, to experience a high level of service, so they in turn will refer patients to the practice. A good internal marketing program has the following marketing ideas in place:

- Greet the patient (by name if possible) as he or she enters the office. If you have not met the patient before, shake hands and introduce yourself. You may come around the counter to collect any forms or insurance information from the patient.
- Eliminate any sign-in sheets you may have at the front desk.
- Be honest with your patients and let them know how long they may have to wait if there is a delay in getting them seated. Always check back with them after 10 minutes so they will not feel neglected. If you checked them in, you are responsible for following up if the clinical team is running late.
- Try to address patients by Mr., Mrs., Ms., or Dr. until they give you permission to do otherwise.

- To speed up the patient checkout, the paperwork should be completed prior to escorting him or her to the business area.
- If a team member is busy checking out another patient, the clinical staff member should go the next staff member for the patient dismissal; no patient should ever be standing in line for a checkout if there is a business staff member available. It does not matter what anyone's job description is; if there is a patient who needs to be dismissed, whose payment needs to be collected, or who needs to be scheduled, any business staff member should help.
- The "90-10" rule: God gave us two ears and one mouth for a reason! We should be listening to our patients and letting them talk 90% of the time, and we should only be talking about ourselves 10% of the time.
- Use the "second question technique" to keep the patient talking. The more the patient talks, the more you get to listen. The more you listen, the more trust you build. Example: "Tell me about your trip to Hawaii. What islands did you visit? Would you go there again?"
- If you have kept a patient waiting, always say, "Thank you for your patience. I know that your time is valuable."
- Wear nametags 100% of the time. Your patients want to know your name!
- Always be on the same eye level with the person with whom you are speaking. That means not talking to patients when they are reclined or when you are behind them.
- Utilize "quality statements" about the doctors, referring doctors, and other staff members. Examples: "Jenny is an expert at dealing with insurance. Let me go get her for you." "Dr. Hite is a perfectionist and an artist when it comes to his cosmetic dentistry." "You will love Dr. Cleeves. He is an excellent oral surgeon and has a very warm personality."
- Each team member should have his or her own business card and give it to a few patients each day. Each team member should also carry several business cards and give them out in the community to friends and family.
- Weekly, each team member should write a thoughtful note on the office card stationery to a patient he or she felt a connection with or felt should receive a card for an occasion (retirement, death in the family, graduation, illness, birth of a baby, etc.).
- So that everyone can give the patient his or her full attention, no cell phones should be on at work. Personal phone calls from family and friends should be limited, and internet usage should be limited to business issues.
- The doctor should write a handwritten thank you note to referring patients.
- Gift cards should be sent to patients who refer more than one new patient into the practice.
- Document all referrals in the patient charts (who has referred them and who they have referred).

- Complete a telephone information slip for each new patient.
- Send a “welcome packet” to each new patient prior to his or her first appointment
- Document personal comments on each patient chart.
- 100% postop calls for difficult cases/appointments should be made by the doctor or hygienist.
- Each team member and doctor should target a quality patient and asks him or her to refer to the practice.
- Tell each and every patient, “It was a pleasure seeing you today.”
- Have lunch with one specialist (or general dentist) per month to develop a better professional relationship and to increase referrals.

The Three Levels of Patient-Friendly Customer Service

In any service industry, there are three common levels of service: minimum service, exceeding standards, and outstanding standards. For example, think of a large “box” store where you have recently shopped. You probably received (and expected) minimal service. This trip probably involved buying some basics for the office or your home, did not cost very much, and was a quick trip. You chose this store primarily because of cost and convenience and probably had low expectations for service. You were satisfied because your needs in shopping there were met. This is the level of minimum service.

In a dental practice, by providing minimum patient service and by meeting the patients’ basic needs and expectations, patients get what they expected and are not disappointed. However, it is not a “WOW” experience. This patient will return but probably will not refer friends and/or family. As a matter of fact, patients may leave at some point because of a change in insurance, location, or one “bad” appointment. They feel no loyalty to the doctor or the team because they probably chose your office based on cost or convenience.

Here are some of the basic examples of a practice that is providing minimal patient service:

- Clean facility
- Running on time
- Good telephone techniques
- Smooth-running appointments

Now think of a hotel where you have stayed that exceeded standards. It was probably a “chain” hotel at a moderate price range. They may have had chocolate on your pillow, fluffy towels, and room service. It cost more than the motel down the street, but you were comfortable paying more because you were getting more. You chose this hotel based on quality and maybe some convenience, but not solely on cost. You expected a higher level of customer service and quality and were willing to pay for it. This is an illustration of the exceeding standards level of service.

In a dental practice, the middle level of patient service is exceeding standards by anticipating the patients' needs. The dental team starts to go beyond what is expected when caring for the patient. During the morning huddle and throughout the day, the team discusses and anticipates the patients' needs, even those needs that are unexpressed by the patients. This involves the Golden Rule: "Do unto others as you would have them do unto you." This means putting yourself in the patients' shoes and looking for ways to delight them.

Here are a few of the ways in which to exceed standards and to start building loyalty from the patients in your practice:

- Appointment availability through preblocking the schedule
- Taking the time to actively listen and build rapport with your patients
- Up-to-date with technology and continuing education
- Strong emphasis on patient education
- Cohesive team
- Complaints are handled quickly
- 100% postop calls for difficult cases/appointments are made by the doctor or hygienist

Lastly, what is the nicest restaurant you have ever been to? It may have been on your anniversary, your birthday, or another special occasion; hopefully, you had a "WOW" experience. They anticipated your needs even before you did. It was not cheap, you had planned to be there a while because of the experience, and now you cannot wait to go back. This is an example of the outstanding standards level of service.

In the highest level of customer service of outstanding standards, the dental team is creating loyalty by anticipating the patients' needs and wants. This high level of patient service is based on focusing entirely on the patient instead of on ourselves. This relationship style of customer service is rewarding for the patient and results in an overwhelmingly positive response from your patient. The patient feels valued and will actively refer to your practice.

To create patient loyalty, the team offers special and unique benefits to make the patients feel comfortable in the practice:

- Warm face cloth
- Coffee, juice, water
- Relaxing, up-to-date facility
- Professionally dressed doctor and team
- Documented personal comments in the charts
- Recognition and rewards for referrals
- Thorough and comprehensive new patient exam
- Uninterrupted time with the doctor to establish rapport and discuss dental needs

Now how does this apply to your dental practice? What level of service is your practice offering?

Excellence in Communication Skills

Another way patients judge the quality of care in the practice is how we communicate with them. They cannot judge the quality of the crown or the hygiene prophylaxis, but they do know how they were treated. How we communicate and the words we choose can make the difference in establishing patient loyalty and satisfaction. Here are some of the most important customer service skills to use every day in your practice:

- "I apologize . . ." not "I am sorry . . ." (for placing a patient on hold, keeping a patient waiting, etc.)
- "It would be my pleasure . . .," "It is my pleasure . . .," "It was my pleasure . . .," "My pleasure . . .," not "No problem," "You bet," "No big deal"
- Say "absolutely" to patient requests
- Avoid the word "policy"; you have "procedures" and "arrangements"
- You have "fees," not "prices"
- Never say "no" to a patient. Always say, "I wish I could, however . . ." or "I would love to be able to, however . . ."
- No discussion of sex, drugs, politics, or religion in the office
- "Discomfort" not "pain"
- No lecturing or placing blame on the patient (respect-based communication versus shame-based communication)

Asking for Referrals

When was the last time a patient called and asked your business team member, "Are you accepting new patients?" (It was probably last week.) It is surprising to all of us how many of your existing patients do not know that you are gladly accepting new patients. Why is this? It is probably because we have not communicated this well to our patients. After all, our reception room is usually full, they wait 10–15 minutes to be seen, and they cannot get an appointment with your hygienist for 6 weeks.

Many businesses (realtors, beauty salons, insurance agents) are comfortable asking clients to refer, but most dentists and their teams are not. It feels like you are begging or that you are desperate for new patients. The key in asking for referrals is targeting who to ask for a referral, when to ask for a referral, and developing the communication skills to ask for a referral. Team members who regularly ask quality patients to refer to the practice see an average of a 20% increase in internal referrals. Here are the four steps in asking a patient for a referral:

Step 1: Solicit a compliment or receive a compliment from a patient. "Thank you for letting me know about how comfortable your injection was today. I will make sure to let Dr. Thompson know." "I am so glad that your cleaning

with Julie was so thorough. Thanks for letting me know." "How was your new patient exam with Dr. Thompson?"

Step 2: Statement about the quality or the philosophy of care in your practice. "I am so glad that you let me know how much you like your new bridge. Dr. Thompson is such a perfectionist and an artist with his dentistry. He always strives to make his bridges look as natural as possible." "Thanks for the feedback about your new patient exam today. It is very important to Dr. Thompson that he gets to know you and your mouth before he starts any treatment." "I am glad you liked your cleaning today. It is important to me to be thorough but also gentle at the same time."

Step 3: Transitional statement. "Occasionally, we see patients who were surprised how painless dentistry can really be." "You would be surprised how many patients did not know that a dental procedure could be so comfortable."

Step 4: Asking for referral. "If we are not already seeing your husband we would love to have him as a patient in our practice." "If you know of anyone else looking for this type of dental practice, we would appreciate you referring them to us." "As you probably know, we do not advertise for new patients. Our new patients are referred to us from existing patients. If you work with anyone who is looking for a quality dental practice, we would love to see them."

First Impressions Count

Is your phone answered within three rings by a friendly, unrushed team member? Does he or she have a "smile" in his or her voice? We have all heard the adage, "You only have one chance to make a good first impression." The new patient telephone call is the first opportunity to impress the patient.

Some of the goals in this important phone call are to impress the caller with your organization and professionalism, to gather pertinent information, to complete a telephone information slip, and to have the patient schedule an appointment. The business team member should follow a script but be flexible enough to answer most of the patient's questions concisely. Here is a typical script for a new patient phone call:

Team: "Good morning, Dr. Smith's office. Jeanne speaking. How may I help you?"

Pt: "I would like to make an appointment to see Dr. Smith."

Team: "I would be happy to make that appointment for you. How long has it been since you have seen Dr. Smith?"

Pt: "Actually, I have never seen Dr. Smith before."

Team: "So you are a new patient? Welcome to our practice! So that I may properly appoint you, do you mind if I ask you a few questions?"

Pt: "No, not at all."

Team: "Tell me what kind of an appointment you feel you need."

Pt: *"Well, I just moved here a few months ago and I am overdue for my regular check-up and cleaning."*

Team: "So you would like to have your teeth cleaned on the first visit to our office?"

Pt: *"Yes, that would be great."*

Team: "I would love to schedule that appointment for you. In our office, we have five different kinds of cleanings and we work with two different hygienists. To save you time and money, Dr. Smith would like to meet you first, complete a thorough examination, and then make a recommendation for the type of cleaning that is best for you. How does that sound?"

Pt: *"It sounds good. Can I have my teeth cleaned at that visit also?"*

Team: "Absolutely! Just a few more questions before we schedule your appointment. Has any dentist or doctor told you that you needed antibiotics prior to a dental visit?" (You may need to explain the reason you have asked this question.) "Can you tell me when you last had dental x-rays taken? What kind of x-rays were they?" (You may need to explain the different kind of x-rays.) "Where are they located? Can you call and have them transferred to our office, or will you be bringing them in with you?" (Note: If the x-rays are over 2 years old, they may need to be updated.) "To provide you with a thorough exam, Dr. Smith would like to have some new x-rays. We can take those at the first appointment also. Let's go ahead and schedule an appointment for you to meet Dr. Smith and to have a thorough examination of your mouth and teeth. We will also take the necessary films and schedule an appointment with one of our great hygienists. I have an opening on Monday, April 12, at 8:30 a.m. or Wednesday, April 14, at 11:00 a.m. Which one will work better for you?" (Notice the patient chooses from 2 options given.)

Pt: *"Monday at 8:30."*

Team: "Do you have any dental benefits that will be helping you with your treatment? Do you mind sharing that information with me?" (Note: If you are not a participating member of their insurance: "I wish we were a participating member of ______. However, the good news is that we accept all dental insurance benefits. Do you know if you can see a dentist out of your network? Normally, there is slight cost for the patient to see a dentist out of network. We have a lot of patients who come to see us even though we are not on their list." [Note: Why your doctor is not a participating member: "I wish we could participate with the ______ plan. However, we have found that to provide our patients with the highest level of care, the doctor is uncomfortable with an insurance company influencing the kind of care he provides to his patients."]) "Who may we thank for referring you to our office?"

Pt: *"Maggie Jones, from my church."*

Team: "Maggie is great and sends us the nicest patients. We will be sure to thank her. So that I may mail our welcome packet and additional infor-

mation about our practice to you, may I have your address and phone number? Is there a cell number or work number that you would like to give us?"

Pt: *"Sure. My address is 155 Main Street, Parker 80111. My phone at home is 303-796-0098 and work is 303-798-7763. I do not use my cell phone very much."*

Team: "Is there anything else you feel I need to know before we see you next week?"

Pt: *"Yes, I am kind of a chicken when it comes to dentistry. Is Dr. Smith gentle?"*

Team: "Yes, he is very gentle and a good listener. Please feel free to share any concerns or fears with him when you see him. He wants you to be comfortable. Thank you for calling our office. We look forward to meeting you next week. In the meantime, if you have any questions or concerns, feel free to give me a call."

The Welcome Packet

The welcome packet is your second opportunity to impress your new patient with your organization and image. The goal is to allow patients the opportunity to complete their paperwork at home and encourage them to keep their appointment. This packet is mailed to new patients in advance of their appointment; the contents should be placed in a large folder with your logo attached to the front. The welcome packet includes

- Welcome letter (see Figure 15.1)
- Patient registration form
- Medical history form
- Map to the office
- Appointment card
- Magnet

Do not include your financial policies, HIPAA forms, hours, or scheduling guidelines. These can be become objections to keeping the appointment and may be reviewed after the new patient exam.

After the new patient exam has been completed, a second patient letter should be sent. The intent of the letter is to thank and encourage your new patient. See Figure 15.2.

Morning Huddle

An important part of internal marketing and customer service is preparing for your day with a 15-minute meeting prior to the start of the day. This all-team meeting allows the team to problem solve, to discuss the schedule for the day, and to follow through with the marketing goals for that day.

Date
Patient Name
Street Address
City, State, Zip
Dear (Patient Name),

A very warm welcome to you. The entire team would like to thank you for selecting our office to care for your dental needs.

Our goals are to provide you with the highest quality dental care in a gentle, efficient, and pleasant manner, and to strongly encourage prevention of future dental problems.

Generally, the first visit will include a thorough examination and necessary x-rays for proper diagnosis, followed by a consultation of your dental needs (unless you have a particular dental problem requiring immediate attention). Treatment costs will be discussed, and financial arrangements can be made.

Please complete both sides of the enclosed health questionnaire and bring it with you for your first visit. Also, so we may assist you in filing any claims, if you have dental insurance, please bring your completed and signed forms.

Should you have any questions, please call at your convenience. Our team is looking forward to meeting you.

Welcome!

Figure 15.1. Welcome letter #1.

Date
Patient Name
Street Address
City, State, Zip
Dear (Patient Name),

We are delighted to welcome you to our practice, and we are pleased that you chose us to serve your dental needs. It was a pleasure meeting with you on Thursday, February 15, 2008.

We are serious about providing superior dental care, and we are proud of our dedication to our patients. Our goal is to help you feel and look your best through excellent dental care. We look forward to seeing you on a regular basis.

Sincerely,

Figure 15.2. Welcome letter #2.

The best huddles are facilitated by a business team member who follows an outline. All team members are on time and have reviewed their charts and patients for the day. The huddle also includes a motivational statement to ensure that the day starts on a positive note. Read more about staff meetings in Chapter 19. Here is a typical outline for an effective morning huddle:

- Identify emergency and catch-up times
- Identify patients who have a medical alert or who should be premedicated
- Verify lab/implant cases
- Discuss challenging patients and procedures
- Discuss any changes from routine
- Identify and discuss patients with outstanding restorative needs
- Yesterday's schedule: What went right and wrong?
- Today's schedule: Are there any problem areas?
- Next available major appointment
- Next available minor appointment
- New patient information
- Emergency patient information
- Financial information
- Marketing information
- Yesterday's productivity
- Daily production goal for today: Has it been reached?
- Motivational statement

Periodically you need to evaluate your morning huddle by asking yourself and writing down the answers to the following two questions:

- What is working well with our morning huddle?
- What do I need to do to improve effectiveness of our morning huddle?

Portraying a Professional Image

How important is the appearance of your office? Do the patients really care and do they even notice? Since patients cannot personally judge the quality of a dentist's care, they often use other criteria to measure the practice, the dentist, and the team.

Patients will judge the appearance and location of the facility. If the carpet is stained, they may feel the treatment rooms are also not clean. If the lamp in the reception room is 20 years old, they may feel that your clinical skills are also not up-to-date.

Patients like to be in a professional, warm, and inviting office. They also want to be associated with a successful practice. This does not mean you should have an over-the-top, high-end, or expensive-looking office. However, it does need to reflect the quality of your care and your commitment to a professional up-to-date practice.

Clutter needs to be reduced in the business office, the clinical rooms, and even in the doctor's office (if patients see it), so as to reflect an organized and professional environment. Posters need to be replaced with artwork, charts need to be taken to the storage room, and the consultation room may need to be spruced up. Maybe a fresh coat of paint and new reception chairs

will make a big difference. When was the last time you updated your office?

Another way patients judge the quality of your practice is by the way you and your team are dressed. As a rule, the doctor and the business team need to be dressed one level higher than the average patient. For the male dentists, this usually means nice khaki pants, a starched shirt, and sometimes a tie. Do not overlook the nice shoes, socks, and watch (but not an expensive one!). Many doctors wear lab coats over their business causal clothes.

For a female dentist, it is very important to dress for success. Because there are typically many women in a dental office, the female practitioner needs to distinguish herself by dressing differently than the staff. Again, business casual is the recommended style with a lab coat.

For a higher case acceptance, and to be able to gain respect and trust with patients, it is highly recommended for all doctors not to wear scrubs unless they are in a hospital setting.

Business staff members should wear business casual clothes because they are dealing with patient financing and scheduling. They are influential members of the team and need to dress the part.

The clinical team should wear matching uniforms or scrubs with lab coats. Patients love the look of a clinical team when team members are dressed alike.

Guidelines for Dental Dress for Success

Business staff should wear coordinating business attire in the business area of the office. You are a representative of the practice. You deal with patients' finances, treatments plans, and scheduling, and therefore you need to demonstrate a successful and professional appearance.

When there are more than two business staff people, it is recommended that the office manager arrange for the staff to meet with a designated sales person at one or two stores. The staff will be directed as to the appropriate styles that would then be approved by the manager (and/or doctors). Recommended:

- Coordinating jacket, sweater sets, skirts, and/or pants
- "Classic" look and classic colors are preferable
- Closed-toe shoes (dress boots are acceptable)
- Appropriate undergarments (no lingerie showing at any time)
- Hose, tights, or knee highs
- Skirts no shorter than 3″ above the knee
- Shirts must be tucked in
- Conservative jewelry
- Tops and jackets must cover top of the arm
- Appropriate makeup
- Clean, attractive nails

Not acceptable:

- Tank tops or bare arms
- Low cut blouses (or showing cleavage)
- Short skirts (shorter than 3″ above your knee)
- Sandals of any kind
- Denim of any kind
- Cargo pants
- Corduroy
- Five-pocket style pants
- Sweatpants or sweatshirts
- Jumpers (unless you are pregnant)
- Midriff showing
- Visible tattoos
- Excessive jewelry (one ring per hand, no more than two earrings per ear)
- No tongue piercing or other visible piercing (other than ears)

The Significance of the Team to the Patient

We all know that the dentist's best asset is his or her dental team. The dental team is on the front line with customer service and internal marketing implementation. Team continuity is more important to patients than dentists realize. Staff continuity is a valuable indicator in predicting high patient retention and referrals. Hiring individuals who have the willingness and ability to deliver is also vital to an effective and profitable practice. Many dentists hire staff based on skill versus personality and fall short in delivering the best in customer service.

By working with team members in dental practices for many years, we find that the most committed team members are people who are motivated by the following:

- A chance to do something well
- A chance to change the way things are
- A chance to do something that makes them feel good about themselves as people
- A chance to do something worthwhile
- An opportunity to develop new skills
- The amount of freedom that they have at their job
- Peers letting them know they did a job well
- Manager letting them know they did a job well
- Patients letting them know they have given them a great service
- Being compensated well for a job well done
- Appreciation for a job well done
- Being in control of their area or of a certain situation
- Having specific goals
- Having rewards when expectations have been met

Definitions of Patient Service

- The point is to not only satisfy your patients but delight them.
- Do unto others as you would have them do unto you.
- Total quality in the services you provide and how you deliver them.
- What feels right to the patient.
- Giving the patient what he or she wants.
- Involves willingness to see the practice from the patients' point of view.
- Eagerness to move swiftly.
- Everyone working together while keeping the patient in focus and the #1 priority.
- Overlooking personal needs for those of the patient.
- Commitment to accuracy, follow-through, and details with all the key systems in the practice.

References and Additional Resources

King, Larry. 2004. *How to Talk to Anyone, Anytime, Anywhere.* New York: Random House.

Timm, Paul R. 2002. *50 Powerful Ideas You Can Use to Keep Your Customers*, 3rd ed. Franklin Lakes, NJ: Career Press.

Williams, Bryan. 2004. Lecture comments, "Legendary Service at the Ritz." Denver, CO, April.

Learning Exercises

1. List five areas of customer service and internal marketing you and your team could implement in the next 30 days.
2. List five areas of customer service and internal marketing you and your team could implement in the next 12 months.
3. Customer service skills "fill in the blank:"
   A. Say ______________________ not "I'm sorry."
   B. Say ______________________ to patient requests.
   C. Say ______________________ not "pain."
   D. You have ______________________, not "prices."
   E. Say ______________________ not "no problem."
   F. Never say "no" to a patient; always say ______________________ or ______________________.
4. List five areas you could improve in your facility to enhance the image of the office.
5. How can you ensure your patients have a good first impression of the office?

Chapter 16
External Marketing

Terry L. Wostrel

Building a Brand for Your Practice

When you hear the word "brand," most people think of large companies such as Coca-Cola, Nike, or McDonald's. The mere mention of these company names or sighting of their logos triggers an emotional response in the heart of the consumer that is consistent and predictable. These companies have long-standing developed brands that are essential to each company's position in the marketplace and the profitability of the company. A well-developed brand such as these commands premium pricing in the marketplace due to the immediate recognition of the brand and the predictability of the product or service represented by the brand. However, brands and branding are not limited to large companies.

Is branding relevant to dental practice? Absolutely. It is an emotional connection between your patients (and potential patients) and your practice. It is the cultivated identity of who you are and what you do, and your reputation in the community. It is the predictable service in the minds of consumers that is relevant to their daily needs.

You are already branded simply by graduating from dental school. Earning a D.D.S. or D.M.D. degree creates an emotional connection between the community and its perceived notion of who you are and what you do. Historically, most consumers thought all dentists were the same and offered the same services. Times are changing, though. Consumers realize that there is a difference and they do have choices to make. In a large city, they may look in the yellow pages and have hundreds of potential dental providers to choose from. It is your job to "brand yourself" and help them in their selection process. This will help consumers find the practice that is right for them and help you to attract the desired patients to your practice.

The problem with the simple D.D.S. brand is that the public perceives you as Dr. Generic, D.D.S. This may not be what you want to be. Do you want to be known for outstanding technical skills, outstanding customer service,

convenient before and after work appointments, the place for outstanding cosmetic dentistry, low prices, or a myriad of other features? If you do not want to be Dr. Generic, D.D.S., you must decide how you want your practice to be viewed in the community and take proactive steps to position your practice as such.

As you are developing your brand or identity, it is important to understand patients and consider how and why they make buying decisions in dental care. Ongoing research at the University of California–Los Angeles (received in a private communiqué from Eddie Facey, M.B.A., president of New Patients, Inc.) reveals the relative weighting of factors in making buying decisions in dental care as follows:

Price: 34.7%
Technological adoption: 18.6%
Geographic convenience: 12.2%
Familiarity of the dentist through referral or advertising: 9.9%
Office amenities: 6.8%
Dentist of the same ethnicity/culture as the patient: 6.2%
Years of experience: 5.8%
Suitable specialization as a family or cosmetic dentist: 5.8%

Many dentists operate general practices where they attempt to be all things to all people. This is the most difficult type of practice to brand and market effectively, as there is little to differentiate this type of practice from the rest of the dental community. A decision to develop a subbrand within these general practices may be indicated. Two of the most common subbrands are cosmetic dentistry and dental implants.

The most successful cosmetic dentistry brand execution that I am aware of is by Dr. Larry Rosenthal of New York City. His practice markets itself as creating "The Most Beautiful Smiles in the World," and his clientele is a virtual who's who of the business and entertainment world. The office staff includes a personal concierge to make travel, hotel, and dining arrangements for his clients. This outstanding customer service linked with extreme technical excellence creates a powerful brand. Your patient base may not include Donald Trump, but you can learn a great deal about cosmetic dentistry and customer service if you participate in the Rosenthal Institute Continuum at New York University College of Dentistry.

With regard to dental implants, a dentist could offer "dentures that won't slip." This would apply to an implant-retained denture, which has vastly improved function over a traditional full denture. This could be quite effective if you practice in an area with a large number of potential patients over 50 years of age.

Neither cosmetic nor implant dentistry would have to be the exclusive focus of your practice. You could continue to be branded as a general practice, but with a subbrand area of expertise.

After you have decided on your brand, you must consider if your market will support your aspirations. That is, will a town of 5,000 in rural Nebraska support a purely cosmetic practice, or do you need a larger market to build your dream? Or, does the metro market in Phoenix have room for another practice focusing on cosmetics?

While in the process of establishing your brand in the community, you must honestly consider the value of your brand and whether the community places enough value on it to pay a brand premium for your services. For example, people will pay more for Coca-Cola then generic cola. In dentistry, people will pay more than $3,000 for a bonded porcelain restoration placed by Larry Rosenthal in New York City, but only $750 for the same restoration placed by Dr. Generic, D.D.S., in Anytown, U.S.A. What is your market? Will patients pay a premium for your brand? Have you considered the concept of brand premium when establishing the fees for your services? If you have inadequate demand for your brand, are you overpriced? If you are overrun with patients demanding your services, are you underpriced?

What is a "tagline"? This is a single line that conveys your brand image. Timex Watches used the tagline "takes a licking and keeps on ticking," while DeBeers Diamonds used "diamonds are forever." Both created an emotional image of what the company was trying to convey.

Does your dental practice need a tagline? Only if you want a successful branding campaign. Some examples for various types of practices are

- General dentist: "Personalized and comfortable"
- Cosmetic dentist: "Smiles to die for"
- Laser dentist: "For those tired of the drill"
- Sedation dentist: "Sleep through your dental visit"
- Implant dentist: "Dentures that won't slip"

The opportunities are only limited by your imagination.

You need to decide on what you want to be known for and convey this message to your community. You cannot rest until approximately 90% of your community knows of your brand. When this occurs, you will have reached a critical mass of growth, where you will be receiving referrals from people you have never treated, simply because they are familiar with your brand. This familiarity in your community comes at a cost though.

Your Marketing Budget

Prior to opening your doors, you should have created a business plan that considers potential income and expenses for at least the first 3 years of practice. You will benefit by studying the chapter 2 on business plans. You should consider your personal lifestyle costs first, and then add in your practice expenses to create a model of what revenues your practice needs to generate to pay your lifestyle costs, pay all business expenses, and position your practice to grow.

There are various opinions as to how much money you should spend to grow and develop your practice. Most experts say you should spend between 3% and 7% of your practice revenues on marketing. You would spend less if your practice reaches a plateau and you are comfortable with this. You would spend more if you were a new start-up practice and desired rapid growth. You must have the production capacity to accommodate this growth. What I mean by this is that the marketing is only cost-effective for you if you have adequate space, equipment, and personnel to service this growing portion of the practice. You do not have adequate production capacity if your schedule is booked several weeks in advance and you cannot see a new patient for 2 or more weeks. Many practitioners continue to market the practice and crowd out patients of record because they have not added the space, equipment, and personnel to take care of the growing demand. The bottom line is this: you should have more space, equipment, and personnel than it currently takes to service your demand; then spend 5% of what you want your practice revenues to be on marketing, not 5% of what your current practice revenues are.

What should you expect from this marketing investment? All you can realistically expect is for your telephone to ring. After that it is up to you and your dental team to reach out to the caller and schedule a prospective patient, provide a service that at least meets or preferably exceeds the expectations of the patient, and convert this patient into a referral source in your community.

Most business consultants will talk about marketing and return on investment (ROI). The gold standard on ROI in dentistry is 3:1. This means that for every dollar that you spend on marketing, you would expect to produce $3 of services over the first year. But dentistry is a recurring revenue business. This means that the patients generated by your marketing will continue to invest money for oral health in your practice, referring others after this first year. Therefore, after 2 years, the production generated by this initial pool of patients may have doubled, yielding you an effective ROI of 6:1. After another year this may have doubled again, resulting in an effective ROI of 12:1. I challenge any of you to find another investment that generates a 1,200% return over 3 years. Invest in yourself and the marketing of your practice.

Understanding the Difference Between Internal and External Marketing

Both internal and external marketing are crucial to the long-term success of a dental practice. However, for either to be effective, you must have accomplished the basic prerequisites of having a reasonable level of consumerism in your practice. The previous chapter emphasized internal marketing and customer service. The four Cs reinforce the points made in the previous chapter.

These four Cs must be successfully addressed/covered in your practice. They are:

Cost: Your fees must not be unreasonably high. You will start to get price resistance if your fees are over the eighty-fifth percentile unless your brand value is extremely high.

Comfort: You must make every effort to make patients comfortable during their visits. This includes both emotional and physical factors.

Convenience: You must have a location that is accessible and office hours that work for your marketplace. If you are in a commuter community, you must provide before and after work clinic hours. You might start at 7:00 a.m. some days and work until 7:00 p.m. on other days.

Control: The patient makes the ultimate buying decisions. You must present treatment in a way that the patient "gets it." Patients must understand what their dental health needs are, what caused these, what treatment you recommend, what they need to do to enjoy optimum oral health, and what will happen if they do not receive the recommended treatment. They must feel that you have their best interests at heart. They then must find a way to work the treatment both into their schedules and into their budgets.

Once you have introduced systems to handle the issues of cost, comfort, convenience, and control, you are ready to begin marketing your practice.

Internal marketing is promoting your practice to your patients of record and making sure that their experience is consistent with your branding effort. Since you already have varying degrees of trust with these individuals, they will be more likely to refer if asked or given the opportunity. The bottom line of this is that you need to make sure that you exceed the expectations of your patients, give them the opportunity to refer, and then reward the act of referring. The most important of these is to exceed the expectations of your patients. Make absolutely sure both that their "wants and needs" are met and that they view both the doctor and team as being caring and genuinely interested in them as people and in their health. If you can accomplish this, the rest of internal marketing is straightforward.

How do you give patients the opportunity to refer? That may be as simple as asking whether a spouse or children have a dentist. You may also give the patients a brochure to take with them and share at their office. You may thank them for patronizing you for their care and give a small gift on the completion of treatment. If you are a cosmetic dentist, you may give the patient before and after photos. The opportunities are endless.

When patients do refer, you should reinforce this behavior. It may be a simple handwritten thank you note, a set of movie tickets, or a gift certificate to a local restaurant. The bottom line is that you should have a system in place to reward the referral process so that it is repeated. If a new patient spends $1,500 in your practice during the first year, it is certainly a great return on investment to spend $25 to thank patients for this referral.

External marketing is getting your brand message out to the individuals in the community who have no knowledge or emotional ties to your practice. The purpose of this marketing is to get your telephone to ring. At that point, skilled team members must reach out over the telephone and establish the emotional bond, confirm your brand message, and portray themselves as unrushed team members who genuinely care. You must have exceptional telephone skills present in your office, or your marketing effort may prove ineffective. You must not allow your front office to erect barriers or have hoops the patient must jump through to see the doctor. The telephone must be answered during real people hours. Most working people consider 8:00 a.m. to 6:00 p.m. (Monday through Friday) to be regular business hours. If your telephone is not answered on Fridays you are missing out on 20% of your potential new patients. If a new patient gets an answering machine on Fridays, the chances that he or she will call back on Monday are low. Many communities have 70% of dentists closed on Fridays. This is a real opportunity for the 30% who are open.

Examples of external marketing could include direct mail pieces (not just to new move-ins, but the entire community), yellow page advertisements, newspaper advertising, press releases about new training and services, radio or television advertising, and of course, the website, which is especially important in this day and age.

The website should be the cornerstone of your marketing effort. Unlike mailers and brochures, the website has an unlimited amount of space for you to store information about your brand, services you provide, and healthcare in general. The website should be easy to use, meet the visitor's expectations, and communicate visually. All of your other marketing should drive people to and encourage them to use your website. Statistics show that only 9% of dentists nationwide have a website. Just having one will give you an advantage, but potential patients need to be able to find it. Many dentists do not maintain the website with current information, and most dentists do not pay attention to the positioning of the website and the available search engines. Getting your website to be in the first five sites identified by the search engine is a huge external marketing advantage. Also, for a fee you can use the Google or Yahoo pay-per-click feature and position yourself above the regular search engine results. What this means is that you bid to have certain keywords entered into the search engine bring your sponsored ad up. For example, you may bid for the word "crown." If a potential patient enters this search work and your ad is brought up, this is an exposure. The prospective patient will see it, but you will only pay if the prospective patient clicks on your ad. You will be charged $2 or more depending on if other dentists in your community have bid for this word. What is it worth to you to have your ad at the top of the list? Only you can decide.

Two cost-effective options for developing a business website are Microsoft's Small Business Office Live (http://smallbusiness.officelive.com) and Costco's web service (www.valueweb.com/Costco/).

External Marketing Strategies

You may use many marketing vehicles to covey your brand and message to the community. You want to get your message out frequently and to as many potential patients as possible. *Reach* is the number of people who receive the message, and *frequency* is how often they are exposed to it.

One of the most cost-efficient and predictable means of getting the message out is direct mail. As with any medium, people need to see it multiple times before the message is familiar and ingrained. Potential patients may need to see your message 8–10 times before it evens triggers an awareness response. Considering your marketing budget, you may want to use a frequency of receiving the message four times a year, with your reach being the number of households you can afford to mail to four times a year. You can develop a mailing list by age group, household income, or many other factors. You would not market children's dentistry if your reach area was primarily senior citizens; instead, you would probably market implants and dentures.

Do not expect immediate results. Stay committed to mailing for at least 2 years at the quarterly frequency. At that point, you will begin to own your market. Your reach may be 10,000 or more households (which would be 25,000 people at 2.5 people/household). You can implement an effective direct mail campaign for less then 50 cents per piece. The direct mail piece should be attractive, appeal to women, and convey your brand and tagline. You would do well to hire a dental advertising agency to handle this for you.

Figures 16.1 and 16.2 depict a direct mail piece I utilized in my office. Figure 16.1 is the cover page; Figure 16.2 is the back page. Another page from the mailer, which included the address, postage, and the return address (with the practice logo, a photograph of the practice, and a map to the practice), is not reproduced here. This direct mail piece was designed by Phoenix Practice Marketing in Smithville, Texas.

When using direct mail to promote your practice, the question of whether or not to use a coupon often arises. Should you offer a coupon for a discounted cleaning or free exam? This could be an insert in a Val-Pack or Money Mailer mailed out every few months to your marketplace. Opinions differ, and varying results have occurred across the country. In a start-up dental practice, coupon advertising can generate a short-term gain by getting a large number of patients through the door and allowing you to get patients in your community talking about your practice. However, "discount dentistry" is probably not the branding effect that you desire for the long term. It is estimated that up to 70% of prospective dental patients have some type of dental insurance that covers their examinations and cleanings. This reduces the appeal of a discounted cleaning to only 30% of the marketplace. The coupons can give your patients a sense of increased purchasing power for the short term, but they may also communicate the perception of poor service. This, in turn, can have a damaging effect on your practice for the long term. You need to consider your

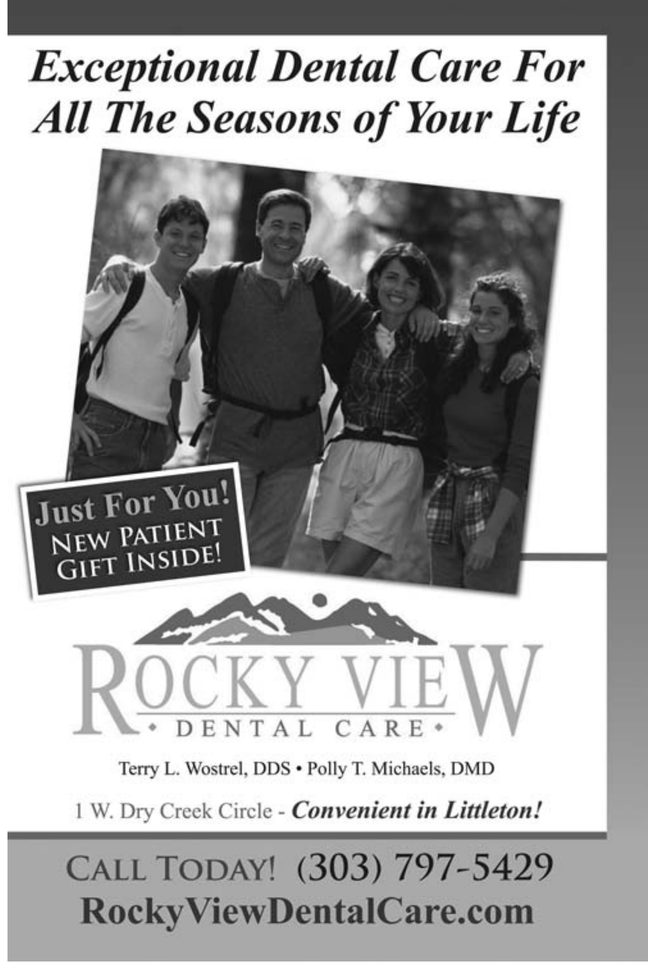


Figure 16.1. Direct mailer cover page for Dr. Wostrel's office.

branding effort and your marketplace to determine whether coupon advertising is for you.

What response rate should you expect from direct mail? This varies depending on the dentist-to-population ratio. On average, most communities have a dentist-to-population ratio of about 1:1,500. Some very competitive areas such as urban San Francisco may have a ratio of 1:750. Other areas, such as rapidly growing Phoenix in the 1980s or Las Vegas in the 1990s, may have a dentist-to-population ratio of 1:5,000. On average, you can expect to schedule twenty to forty new patients per ten thousand pieces of direct mail. But this can vary widely, with a higher return in areas with a more favorable dentist-to-population ratio. A commitment to stay the course in a direct mail campaign

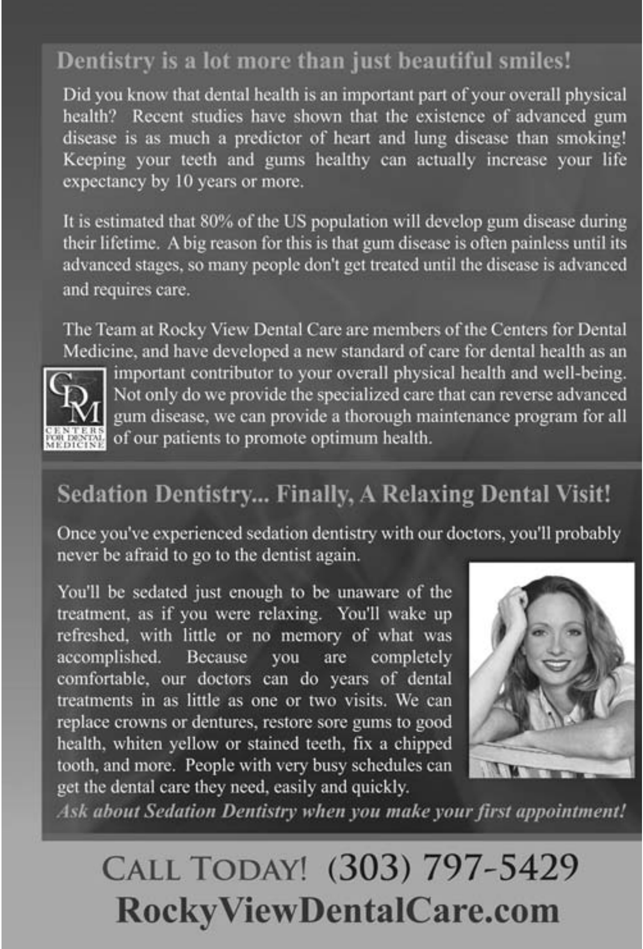


Figure 16.2. Direct mailer back page for Dr. Wostrel's office.

would be well advised. It is all too common for a dentist to think he or she is getting a poor return and stop the campaign prematurely.

Another very common marketing vehicle is the yellow pages. When dental advertising first became legal in the 1980s, this was the first marketing tactic of most dentists. As time went by, an advertising dollar became more and more diluted as many dentists purchased large display ads. In a larger market, there may be 50 or more pages of yellow page ads, with each dentist paying several thousand dollars a month for these ads. If you are not in the first few pages of the directory, your message will be lost and your dollars wasted. Also, many younger people no longer use the yellow pages and instead gather information about dentists from the internet. If you are in a market that is heavily

represented in the yellow pages, you may do well to save your money and apply your marketing dollars to a more cost-efficient medium.

Newspaper print ads or newspaper inserts are another effective means of communicating your brand to the community. However, over time younger people are getting more of their news from the internet. In fact, statistics show that 80% of the readership of daily newspapers is over the age of 50. Newspaper ads may do better in marketing implant and cosmetic services compared to family dentistry, due to the demographics.

Radio and cable television marketing may be possible in your market. However, either of these will command a hefty investment. Dentists nationwide have had success promoting sedation dentistry over the airwaves. However, what makes this work is the large case size that these patients generate. It is not unusual to have $10,000–15,000 of dentistry performed in a single visit with these high-fear patients who have avoided dentistry for years. You should probably not consider these media unless you have a specialized niche market and your practice is very established. You will also need to make sure that your telephone is answered during all hours that the radio or television advertising is run.

External Marketing to Women

While women make up only 51.2% of the population, but they influence or buy 80% of the products sold in America. When Home Depot bills itself as a "friendly, attractive, non-macho hardware store that women will love," we know that some of the marketplace has shifted toward women and the needs of women.

Historically, middle-aged women have made 80% of all healthcare decisions. What are they looking for, and how can we accommodate them in this process?

While men often prefer a quick, concise solution to their problems, women value a one-on-one relationship with a true emotional connection and want to be certain that they have made the correct decision for their family's healthcare needs. This requires us to structure our practice atmosphere to focus more on relationships, communication, and joint problem-solving time for our female patients. The days of "this is what you need, take it or leave it" are long gone. In any branding campaign, there are five key elements that must be addressed to have maximum appeal to women. They are:

- *Respect:* Women are well informed. They research products and services more than men before buying. This needs to be acknowledged and information given that meets the emotional needs of the woman, so that she feels certain that she has made the appropriate healthcare decision for her family.

- *Individuality:* She may manage a career, a family, and a household and does not want to be talked to from a narrow perspective. She wants us to develop the relationship to fully understand her needs before making any specific recommendations.
- *Stress relief:* In numerous studies stress has been shown to be a woman's #1 enemy. Women are overwhelmed by their increasing responsibilities both in the home and in the workplace. Offer solutions that relieve worries and stresses of everyday life.
- *Connection:* Some people base their decision making on emotion rather than rationality. Information needs to be presented differently to women than men. Men may like facts and statistics, but women need to feel that the solution is best for them personally.
- *Relationship:* Women want interaction, not just a solution. Women are likely to see themselves as nurturers of themselves and others. If a relationship confirms the fact that she has made the best healthcare decision, you have won the heart. If a brand represents something that is important in her life, she will be loyal to the brand. Trust in the brand is of paramount importance.

Finding out how to create a loyal female consumer is probably the best investment a brand could ever make.

How do we gear our marketing to women? As we have learned, women must feel that the healthcare decision is correct for them. They may require a lot of information that is relevant to their individual needs. Women tend to use the internet more for gathering information, while men are more likely to be surfers and browsers. Having a website that is easy to use and that caters to the informational needs of women will be of great value to your practice. In today's busy world, women may search for information late at night after your practice has closed. The 24/7 availability of the website is a plus for women. A recent survey by Northstar demonstrates that women gather more buying information from the web than from newspapers, television, radio, and even their friends. You cannot afford to be without a highly visible and informative presence on the web.

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www.businessplanpro.com.

www.NewPatientsinc.com.

Learning Exercises

What are the core values of your practice? What brand message do you want to convey? What portion of your personal values and treatment philosophy do you want to convey to your patients? And how is this relevant to your patient's needs?

1. Will your brand command premium pricing? Why or why not? How could you develop your brand to command premium pricing?
2. What part of your marketplace do you want to own? How many and what type of patients will it take for you to build the practice of your dreams? How will you get the message out to your community? What marketing vehicles will you use? Are you willing to create and fully implement a dental branding and marketing campaign? Will you use an advertising agency? If so, will you use one that that specializes in the needs of dental practices?
3. Patients will not magically appear at your door and stay a lifetime without being reminded of what is in it for them. What are you willing to do to stay relevant to the healthcare needs of your community over the 3 decades or so that you will practice?

Part 5
Staffing

Chapter 17
Employment Law

Pamela Zarkowski and Mert Aksu

Introduction

Consistent with the goals of any employer, owners of dental practices seek to hire competent, ethical, and an empathetic dental staff. Additionally, the employer-owner seeks to create a work environment that legally protects the employer and the employee. All phases of the employer-employee relationship, from initial hire to possible termination, are influenced by federal and state laws, as well as local jurisdictions.

Hiring Process

A dental office, depending on the size and services provided, will often have many employees, including associates and support staff. An important first step in the hiring process is to outline a job description for a particular position. In drafting the job description, it is critical to be familiar with the legally defined scope of practice. This strategy assists in recruiting, interviewing, selecting, and hiring the right employee. Following the drafting of the job description, an applicant pool must be generated. Specific staff positions can be advertised using local newspapers; professional association publications or websites; dental, dental hygiene, and dental assisting schools; or word of mouth. "Help wanted" advertisements are a reasonable method to reach a significant number of potential applicants. It is important to carefully phrase an advertisement to reduce the possibility of an accusation of discrimination. Similarly, word of mouth may limit the applicant pool because employees or others advising friends or relatives about a job opportunity often speak to those of the same race and/or gender. It is suggested that applicant résumés are requested to allow the dentist or individual delegated to review the applicant pool to determine whether credentials, licenses, and experience criteria necessary for the position are satisfied. Chapter 18 on staffing has sample position/job descriptions as well as sample advertisements.

Key to the selection of an employee is the interview. If the applicant pool is large, a review of résumés will reduce the pool to a manageable number.

Some employers use initial telephone interviews to screen applicants for suitability. It may be helpful to develop a written plan or schedule that details the steps included in the selection process. The process should be communicated to all the employees who are involved in screening the applicants being considered for employment; for example, the dentists in the office, as well as the office manager. An office will benefit by developing a set of standard or core questions that are used with all potential employees. The questions should seek to expand on the information provided in the résumé, as well as provide an opportunity for the applicant to present him- or herself in a one-one-one situation. Although an interview may be perceived as an opportunity to "get to know the applicant" better, on a more personal level, an employer must be cautious about the nature and type of questions that are asked. In many states, specific questions about age are unlawful. For example, one can ask an applicant if he or she is 18 years or older, but not the year of birth. In most jurisdictions the following questions can be part of the interview:

- Full name and whether the applicant has ever worked under a different name
- Address
- How long an applicant has lived in the city or state
- If the applicant is 18 years or older
- If the applicant was ever convicted of a crime, and if so, when, where, and the nature of the offense (felony or misdemeanor), or if charges are pending. (But not if she or he has ever been arrested.)
- If the applicant is a U.S. citizen. If applicant is NOT a U.S. citizen, you can ask:
  Country of citizenship
  Whether naturalized or native born
  Date citizenship acquired
  Whether applicant's parents or spouse has U.S. citizenship
  Require him or her to produce naturalization papers
- If applicant is NOT a U.S. citizen, after hiring you can ask:
  Does him or her intend to become a U.S. citizen
  Authorized to work in the United States
  Authorized to permanently stay in the United States
  Intend to stay in the United States
- Educational background
- Employment history and names and addresses of former employers
- Seek to find out if the applicant can perform the essential duties of the job, with or without accommodation
- Organizations the applicant is involved in if you exclude those that involve race, color, religion, national origin, and ancestry
- Names of relatives currently employed by employer
- If a noncompete clause was signed with a former employer

A recommended guidepost for questions is that if an inquiry has little to do with the job or is not critical to determining whether the applicant can perform the responsibilities associated with the position, do not ask it.

To protect the office, and not be subject to an allegation of discriminatory hiring practices, an interviewer should NOT ask the following questions:

- Place of birth
- Height or weight (in some jurisdictions)
- Religion
- If the applicant is pregnant, has children, or plans to have children
- Race or national origin
- Marital status
- Sex
- Age or date of birth, or other dates indicating age
- Arrests that did not include conviction
- Physical or mental condition, unless related to the job
- Maiden name, or original name if changed by court order
- Prior work injuries or if ever filed a workers' compensation claim
- Garnishments
- Clubs, societies, or lodges
- In addition, no photograph can be required

State guidelines may have a similar or modified list of legal and illegal inquiries in an effort to protect the civil rights of state citizens. The state guidelines provide additional topics or questions that are illegal to ask, such as marital status or sexual orientation. The local or state civil rights office can provide printed or online materials that will assist an employer in determining lawful versus unlawful questions. Chapter 18 on staff management includes sample interview questions and suggestions for interviewing.

Reference Checks

It is important to exercise due diligence in the employment process, especially related to the applicant's background. One should not hire an employee because of an impressive résumé or a "good feeling" from the interview prior to conducting a background check and references. Employers should always ask an employee for a list of references. Due to a concern about lawsuits, past employers frequently provide neutral information when a reference is sought. Potential employers can request that an applicant sign a release form allowing the employer seeking to hire an individual to contact previous employers. The authorization should include language that waives any potential legal action against the former employers for responding truthfully to reference checks. Without permission, an employer is able to confirm only the position and dates of employment. Once obtained, the waiver form can be faxed to a previous employer with a cover sheet that explains the request for a reference

and indicates that a telephone call is forthcoming to discuss the applicant. The waiver assures the previous employer that they are protected from being sued for defamation if they say anything negative. However, some states consider an employer's statements as "qualified privilege." This means that an employer cannot be held liable if they provide information unless that employer knew it was false or reckless. If an employer is going to conduct reference checks, the waiver form, either for references or background checks, should be reviewed by an attorney to assure that it is appropriate for the particular state.

Background Checks

Background checks are an additional mechanism to gain important information about an employee that assists in appropriate evaluation. A simple background check may include confirmation of an applicant's educational credentials, professional licenses, and previous employment. Some states require that healthcare professionals have more comprehensive background checks. Background reports can range from a verification of an applicant's Social Security number to a detailed account of the potential employee's history and acquaintances. There is even some evidence that employers are now searching popular social networking websites such as MySpace and Facebook for the profiles of applicants.

Some areas that may be included in a background check are:

- Driving records
- Social Security number
- Bankruptcy
- Property ownership
- Past employers
- Education records
- Character references
- Military records
- Credit records
- Court records
- Criminal records
- Worker's compensation
- Medical records
- State licensing records
- Incarceration records
- Drug test records
- Sex offender lists

Since staff responsibilities within a dental office vary, specific information may be more critical depending on an individual's roles and job responsibilities. For example, an employee that handles financial transactions may also

require a credit report. An employer can obtain information about an employee's credit history under the Fair Credit Reporting Act (FCRA), 15 U.S.C. sect. 1681 et seq. Obtaining a credit report requires an employee to give written permission to the employer, and as with other checks, should occur only after the job has been offered. There is discussion by some states to require background checks for all healthcare professionals applying for or renewing professional licenses.

Pre-employment Testing

Pre-employment testing is used by some employers as a screening tool. Under Title VII of the Civil Rights Act of 1964, it is "unlawful for an employer to refuse to hire any individual, or otherwise discriminate against any individual with respect to his . . . employment, because of race, color, religion, sex, or national origin."

Pre-employment testing is addressed specifically in Section 703(h) of the act, which provides that "notwithstanding any other provision of this subchapter, it shall not be an unlawful practice for an employer . . . to give and to act upon the results of any professionally developed ability test provided that such test . . . is not designed, intended or used to discriminate because of race, color, religion, sex, or national origin." Obviously, Title VII does not prohibit employers from the use of intelligence, skills, or integrity tests in the workplace. However, the statute is applicable when (1) an employer uses tests to *intentionally* discriminate against protected groups, or (2) the tests have an adverse impact on minorities *and* are not job-related for the position.

The safest practice for an employer is to administer the same pre-employment test to *all* applicants for a particular position, providing reasonable accommodations when necessary, (for example, a larger computer terminal for someone who is visually impaired, etc.). This is the first step toward a fair and equitable selection process. An English language test can only be required if the position requires superior English language skills. Similarly, if an aptitude or psychological test is required, all applicants must receive the same examination. The test cannot be used to reveal any psychological disorders or impairment. The aptitude or psychological test may be used to screen out less qualified applicants, group applicants by ability level, or hire applicants with the most appropriate scores.

Intelligence tests are not the only pre-employment testing that may occur. Drug tests are acceptable if given to all applicants. The applicant must be notified that once offered the position, drug testing will occur. If the test is positive, a second test must be given. Similarly, physical exam requirements cannot occur until a job offer occurs. The physical exam must be consistent for all employees and must be based on "business necessity," that is, the focus is related to the ability to do a job. Chapter 18 on staffing includes some testing recommendations for dental staff.

Employment Relationships

At-Will Employment

Specific employment relationships impact the working relationship and, in some situations, the appropriate protocol for termination. An at-will agreement is one in which there is an undefined duration of the relationship. The employer/employee relationship occurs at the will of either party. The employment can be terminated by the employer at any time and for no reasons, or an employee can quit at any time. There is no written or formal employment contract that indicates start and end dates. There is no obligation to provide notice of termination. However, there are exceptions important to the at-will relationship. A public policy exception exists in some states. The public policy exception prohibits an employer from firing an employee if it would violate the state's public policy or a state or federal statute. Key federal statutes are discussed later in this chapter.

Some states also recognize an implied contract as an exception to the at-will employment arrangement. Under the implied contract exception, an employer may not fire an employee if an implied contract exists, even if there is not written or express agreement documenting the employment relationship. Proving the terms of an implied contract is difficult. The burden of proof is on the employee to prove that one existed. Implied employment contracts are most often found when an employer's personnel policies or handbook indicate that an employee will not be fired except for good cause or specify a process for termination. If the employer fires the employee in violation of an implied employment contract, the employer may be found liable for breach of contract.

Contractual or Term Relationship

In a contractual relationship, either expressed or in writing, there is a defined duration to the relationship; for example, employment is contracted for July 1 through June 30 of the following year. This employment relationship may be referred to as a term relationship as well. In addition, there are guidelines for termination by either the employer or employee. For example, language in the contract may state that termination must occur in writing with at least 3 months notice on the part of either party. Contractual relationships are frequently in writing so that the terms are clear to all parties involved.

The following is a list of basic components found in employment contracts. Employers interested in a written contractual agreement should have the agreement reviewed by an attorney to ensure that it is in compliance with state laws and includes pertinent sections important to the relationship.

- Parties: The name of the employer and the entity (that is, corporation, partnership, or sole proprietor), as well as the name of the employee.
- Time and place: When the employee is to be present and where.

- Duties: General and specific responsibilities, including scope of practice if appropriate.
- Term and conditions of employment: States the time period of employment and the effective date. States any extension options; for example, if there is an automatic renewal on the same terms unless one of the parties gives notice to terminate. May also have language concerning maintaining licensure and consequences if there are any violations of the dental practice acts or negligence is alleged.
- Compensation—salary: Any salary, percentage of production, or collections; payment relating to capitation or PPO plans; bonus pay; sick leave; vacations; malpractice insurance; professional membership; or continuing education.
- Benefits including disability, medical, life insurance, or retirement plan participation.
- Access to records: After employment termination and in the event of malpractice or other legal action.
- Noncompete or restrictive clauses: Consult an attorney to determine the appropriate language and guidelines.
- Termination provisions: Should include disability, death, end-of-term, and at-will or for cause provisions outlining grounds for termination and the effect termination may have on continuity of care or for any owed compensation.
- Dispute resolution: May have language that requires the use of mediation or arbitration for some defined disputes.

Independent Contractor Relationship

An additional employment option is an independent contractor. There are three general areas that are considered characteristics of the independent contractor relationship: behavioral control, financial control, and the relationship of the parties. Table 17.1 highlights the twenty points established by the Internal Revenue Service to determine whether someone is an independent contractor. Both parties interested in an independent contractor relationship should use the twenty points in reviewing the working relationship and consult with an employment attorney.

Compensation

An individual who provides services on behalf of an employer is considered an employee. Various arrangements exist for compensation of employees. Some staff will be paid on an hourly basis. Other options include a salary that is a fixed amount that allows an employee the advantage of planning his or her personal income accurately. In this relationship, there are defined work hours and also responsibilities. However, there may also be expectations on

Table 17.1. 20-point test for independent contractors.

1. Must the individual take instructions from your management staff regarding when, where, and how work is to be done?
2. Does the individual receive training from your company?
3. Is the success or continuation of your business somewhat dependent on the type of service provided by the individual?
4. Must the individual personally perform the contracted services?
5. Have you hired, supervised, or paid individuals to assist the worker in completing the project stated in the contract?
6. Is there a continuing relationship between your company and the individual?
7. Must the individual work set hours?
8. Is the individual required to work full time at your company?
9. Is the work performed on company premises?
10. Is the individual required to follow a set sequence or routine in the performance of his or her work?
11. Must the individual give you reports regarding his or her work?
12. Is the individual paid by the hour, week, or month?
13. Do you reimburse the individual for business/travel expenses?
14. Do you supply the individual with needed tools or materials?
15. Have you made significant investment in facilities used by the individual to perform services?
16. Is the individual free from suffering a loss or realizing a profit based on his work?
17. Does the individual only perform services for your company?
18. Does the individual limit the availability of his or her services to the general public?
19. Do you have the right to discharge the individual?
20. May the individual terminate his or her services at any time?

In general, "no" answers to questions 1–16 and "yes" answers to questions 17–20 indicate an independent contractor.

the part of the employer concerning job responsibilities or production/billing expectations. Production-based compensation gives the employee the income he or she "produced." Lab charges and other direct charges must be discussed so that it is clear who bears the costs. Collection-based compensation systems allow the dentist-owner to compensate an associate or dental hygienist with a percentage of his or her monthly collections.

The frequency and method of compensation is determined by the employer. Compensation payments can occur weekly, biweekly, or monthly. An employer must keep written records of payment and taxes withheld. If benefits are offered to one employee, they must be offered to others in the same classification, full-time or part-time. The workweek is considered 40 hours in length. The IRS definition of full time is 32 hours, thus, full-time benefits must be offered to those working over 32 hours. Lunch hours and breaks over 20 minutes are not part of the paid workweek. Overtime must be paid if there is an excess of 40 hours worked. The rate is 1.5 times the hourly rate; however, salaried employees are not paid overtime. If an employer requests that work

must be done, the employee must be compensated. Compensatory time off may not be given in place of overtime; the employee must receive pay.

Forms, Forms, Forms

The use of forms may begin with the employment application, or signing of waivers for references. Additional forms important to the employee must also be completed. The IRS Form W-4 must be completed by the employee for the employer to determine the appropriate level of federal income tax to withhold. The form is available online at www.irs.gov. The Employment Eligibility Verification Form (I-9) is required by the U.S. Immigration and Naturalization Service. It assists in proving that an employee is legally entitled to work in the United States. The form is available at the U.S. Citizenship and Immigration Services website (www.uscis.gov). An Employment Eligibility Verification Form (I-9) must be completed and kept on file by the employer. An employee is required to produce original documentation verifying eligibility to work. Other forms that may need to be completed include enrollment forms for benefit plans.

Employee Training and Safety

New employees may require training in areas such as OSHA or HIPAA. There are online courses as well as manuals available. Some state dental associations offer opportunities for staff training. State dental practice acts may also require training for noncertified staff, such as an office-trained assistant who must take an approved radiography course. It is important to be familiar with the state dental practice act and scope of duties allowed, as well as training required.

Employee safety must be addressed as well. Employees should be encouraged to have a hepatitis B virus vaccine and if they refuse, must indicate that refusal in writing. Additional training may include infection control protocol, emergency procedures, and the employee's rights within federal and state laws. Chapter 13 on government compliance offers more details on OSHA and HIPAA.

Job Descriptions and Employment Manuals

As noted earlier, complete job descriptions are important in the employee recruitment process. They are also helpful as part of the office's documentation outlining policies and procedures. Recommended sections may vary based on the nature of the dental office. Table 17.2 outlines areas that should be considered. The manual can be available both in hard copy and online, password

Table 17.2. Recommended sections for an office/personnel manual.

Acknowledgment of Receipt and Form
Introduction
Goals, Values, and Beliefs—Statement of Philosophy
Ethics and Confidentiality
Equal Opportunity Statement
General Policies
Personal Records/Files
Attitude
Attendance/Tardiness
Confidentiality
Personal Grooming, Dress, and Appearance
Lunch and Break Periods
Phone Calls
Personal Computer Use
E-mail Use
Safety and Accident Rules
Substance Abuse Policy
Sexual Harassment
Performance Reviews
Termination—Employment-at-Will
Snow Days/Emergency Closings
Compensation
Payroll
Work Hours and Reporting
Wage and Salary
Overtime
Holidays
Vacations
Paid Time Off (PTO)
Leave of Absence
Family Medical Leave
Sick Leave and Workers' Compensation
Maternity Leave
Funeral Leave
Jury Duty
Military Service
Benefits
Group Health Insurance
Short-Term Disability
Life Insurance
Continuation of Medical/COBRA
Dental Benefits
Workers' Compensation
Retirement Plans
Tuition Assistance/Continuing Education Courses
Employee Assistance Program
Compliance and Regulatory Requirements
Licensure/Certification
OSHA (Occupational Safety and Health Administration)
HIPAA Training (Health Insurance Portability and Accountability Act)
CPR Certification
Immigration Law Compliance
Disclaimer
Effective Date
Conclusion

protected, if the office environment is conducive to more than one method for communication. All staff should acknowledge that they have received and read the manual with a signed form placed in their personnel file.

Statutory and Case Law Impacting the Employer/Employee Relationship

Federal and state laws have been written to protect employees from discriminatory practice and serve as guidelines for employers in hiring and termination. Federal laws frequently require a minimum number of employees for a lawsuit to be filed. Most states have passed legislation similar to federal laws protecting civil rights and other employee benefits. State laws may only require the employment of one individual for a lawsuit to be filed. Employers should be aware of state employment law and civil rights protections afforded to employees.

Federal laws were passed to protect specific classes of individuals. Title VII of the Civil Rights Act of 1964, later amended in 1991, 42 U.S.C. sect. 2000e et seq. prohibits discrimination in hiring and discharge and in employment, compensation, terms, conditions, and privileges based on an individual's race, color, religion, sex, or national origin. Title VII covers employers of fifteen or more employees working at least 20 weeks of the year. Individual states also have state laws that protect the civil rights of their citizens. State law may be "stricter" than federal law but can never conflict with the federal laws. For example, a state law aimed at protecting civil rights, in addition to prohibiting discrimination based on the qualities outlined in Title VII, may also include protection against discrimination based on height, weight, or marital status, for example. Following passage of the Civil Rights Act, additional federal legislation occurred to protect classes of individuals.

Sexual Harassment Prevention

An important protection offered by the Civil Rights Act of 1964 is protection from sexual harassment. Two forms of sexual harassing behaviors are protected. *Quid pro quo* includes unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature or submission to them that is the basis for hiring, firing, or advancement. *Hostile environment* occurs when any type of unwelcome sexual behavior creates an offensive or hostile environment. The harassment does not have to result in tangible or economic job consequences. The dental office is an environment that is characterized by working relationships in which humor or inappropriate comments or behaviors, intended to be humorous, may result in allegations of creating a hostile environment. Examples of behaviors that could contribute to a hostile environment include

- Unsolicited or unwelcome flirtations, advances, or proposals
- Ill-received jokes or offensive gestures
- Intrusive questions about an employee's personal life
- Suggestive facial expressions
- Abuse of familiarities or diminutives such as "cutie," "my girl"
- Unnecessary, unwanted physical contact such as hugging or touching
- Suggestive comments about clothing
- Questions about sexual fantasies, sexual preferences, or sexual activities

Pregnancy and Pregnancy Leave

An amendment to Title VII of the Civil Rights Act that makes it illegal to fire an employee based on pregnancy, childbirth, or related medical conditions is the 1976 Pregnancy Discrimination Act. An employer cannot force a woman to quit her job because she is pregnant, nor can a woman lose her job because she has an abortion. Pregnancy must be covered in an employer's medical plans like any other medical condition. Pregnancy leave must be treated like any medical condition, with similar allowances for absence or short-term disability. There is no obligation to grant a lengthier pregnancy leave for an employee. However, if the employee's medical status requires additional time off for work, the absence must be treated as any other request for a medical leave would be by the employer.

American with Disabilities Act

The American with Disabilities Act of 1990 impacts employers with fifteen or more employees working at least 20 hours a week. Titles I and II ban discrimination against disabled persons in the workplace and mandate equal access for the disabled to certain public facilities. Title III protects patients. A person is considered disabled if he or she has a physical or mental impairment that substantially limits one or more major life activities. Physical impairment includes any physiologic disorder, condition, cosmetic disfigurement, or anatomic loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory (including speech), cardiovascular, reproductive, digestive, genitourinary, hemic, lymphatic, skin, and endocrine. Mental impairment includes any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities. Major life activities include walking, breathing, seeing, hearing, speaking, learning, and working. Examples of impairment that can limit major life activities include multiple sclerosis, asthma, diabetes, osteoporosis, bipolar disorder, dyslexia, and HIV infection. There are three categories of employees afforded protection under the ADA: (1) A person who has a physical or mental impairment that substantially limits one or more major activities of that person, (2) a person who has a record of such an impairment, and (3) a person who, while not actually being disabled, is regarded as disabled.

Legislation is not only focused on preventing discrimination. Health and safety are protected by the Occupational Safety and Health Act of 1970. This law was passed to ensure safe and healthy working conditions for employees.

Wage and Benefit Protection

Wage and benefit protection are also important to an employee. Continuation of health benefits following termination is protected by the Consolidated Omnibus Budget Reconciliation Act. The Equal Pay Act of 1962 guarantees comparable pay for men and women with similar skills and experience, not to be influenced by gender.

Family Medical Leave Act of 1993

The Family and Medical Leave Act (FMLA) was instituted to allow for the care of children, adult children, and personal health problems that affect the employee, spouse, or parents. The act applies to employers with fifty or more employees. Thus, practices with multiple offices may be subject to providing this benefit. The FMLA allows leave for up to 12 weeks if an individual has been employed for more than 1 year and worked at least 1,250 hours. Under the FMLA, the leave can occur for the following reasons:

- Because of the birth and care of a newborn child
- Because of the placement of a child for adoption or foster care
- In order to care for an immediate family member (spouse, child, or parent) with a serious health condition
- Because of a serious health condition that makes an employee unable to perform the necessary function of his or her position

The act does not allow for care of in-laws or unmarried partners. An employer is not required to pay an individual who takes an FMLA leave but must pay benefits. The employer is required, upon the return of the employee, to offer a comparable position.

Age Discrimination in Employment Act of 1967

The Age Discrimination in Employment Act of 1967 prohibits discrimination based on age against any employee or applicant for employment that is at least 40 years of age; this law applies to employers with twenty or more employees.

State Laws

State legislatures are committed to protecting the state's citizens. Employers should seek advice about legislation important to the employer/employee relationship. A state may have a Whistleblower's Protection Act that protects employees from reprisals by an employer because the employee, or a person

acting on behalf of an employee, reports, or is about to report, verbally or in writing, a violation or suspected violation of a law of a state, political subdivision of a state, or the United States. There are usually guidelines or limitations as to the length of time someone can file a lawsuit, based on a whistleblower's protection, such as 90 days after the occurrence.

Termination

Employees are subject to termination on many levels. An employer may determine that an employee is incompetent and placing patients at risk. Or an employee may have demonstrated inappropriate behavior such as physical or verbal abuse with colleagues or patients. Dentists should utilize appropriate diligence in evaluating employees, providing feedback and progressive discipline documentation, and making the proper decisions if termination is appropriate. If a decision is made to dismiss an employee, certain strategies are helpful during the process to protect the employer and employee. The meeting to discuss the termination of an employee should be limited to 10–15 minutes. One should provide a simple and concise statement indicating that the dismissal is occurring on a specific date (preferably on the same day as the meeting to terminate or soon thereafter), the severance pay, and benefits coverage, and request that the employee sign a release from further liability. The employer needs to explain the policy on references. In addition, keys, credit cards, and so forth are to be collected. Passwords for computers and telephone messaging should be changed if the employee had access to information that was protected by passwords.

Resignation

If an employee indicates he or she is interested in resigning, a written resignation and explanation is advised. The reason for the documentation is to make it clear that the employee was not fired or forced to quit. Frequently in an office manual there is a notice requirement for resignation.

Layoff

Businesses have the right to terminate employees for economic reasons. Using seniority as basis for layoffs is the simplest method. Dilemmas occur if the most senior employee is one who would not meet the needs of an office in the downsizing. Performance reviews are useful for documenting situations in which a higher seniority employee is laid off, resulting in less chance of litigation. In instances where an employee is going to be laid off, consultation with an attorney is advised to prevent allegations of discrimination. An employee is entitled to unemployment compensation if he or she is fired or laid off. If an

employee quits, and there is not allegation of sexual harassment or other wrongful employment behavior, an employee is not entitled to unemployment compensation. An employee must have worked at least 13 consecutive weeks to qualify for unemplolyment compensation and may have a right to 26 weeks of maximum benefit in any year. To be eligible for the benefit, the employee must be actively seeking employment and physically able to work. Benefits are reduced if the employee is employed.

Conclusion

An employer seeking to recruit, hire, and retain employees must be sensitive to the laws and policies governing the employment situation. In most instances, seeking legal counsel is important. An employer must be aware of the administrative rules and regulations governing the practice of dentistry in a particular state, which assist in providing information about scope of practice for various dental personnel. Hiring and firing practices must follow the legal guidelines outlined by federal and state statutes. Employers must be clear about practices that do not hint of discrimination or bias. Office manuals and policy and procedures should be reviewed and updated on a regular basis for clarity and accuracy.

References and Additional Resources

http://www.ada.gov. Information about the Americans with Disabilities Act.

http://ada.org/prof/prac/tools/software/index.asp. Practice management software list available from the American Dental Association.

http://www.irs.gov. Forms such as the W-4 and information on independent contractors.

http://www.dol.gov. Department of Labor website that provides information about employment protections; for example, FMLA.

http://www.eeoc.gov. Information about federal laws prohibiting employment discrimination; for example, pregnancy discrimination.

http://www.osha.gov. Information about OSHA.

Pollack, B.R. 2002. *Law and Risk Management in Dental Practice*. Chicago: Quintessence.

www.ftc.gov/os/statutes/031224fcra.pdf. Provides information about the Fair Credit Reporting Act.

Learning Exercises

1. Conduct a mock interview. Role-play the various roles, serving as interviewer and candidate. Include both legal and illegal questions.
2. Find a copy of your state dental practice act (most likely available online) and review it. Identify the scope of practice for the dental assistant and dental hygienist in your state.

3. Consider your current practice or identify a future practice where you are the owner. Identify the sections you would include in an office/personnel manual.
4. Plan an orientation for a new employee. Outline what key information you would provide verbally and what “sections” of the personnel handbook you would direct the new employee to read.
5. An allegation of sexual harassment occurs against a patient. Role-play what you would say to the patient and the staff person and “next steps.”

Chapter 18
Managing Staff

Karla Gunner-Barringer and Amy Kirsch

Managing staff effectively is one of the biggest challenges dentists face in their practices. As we all know, motivated and well-managed staff may improve productivity, profitability, and patient care. In this chapter, we discuss how to hire the right people, how to motivate them, and how to evaluate them effectively.

Before You Hire Anyone; What You Must Know

When hiring a quality employee, you must first know and be clear about who *you* are and what kind of team you need to surround yourself with to practice effectively. The most successful practices we work with are great students of their behavioral style and know how to use it in selecting and working with staff members.

In the early 1970s, the Carlson Learning Company (www.carlsonlearningcompany.com) described four major behavioral styles (DISC):

- Dominance
- Influence
- Steadiness
- Conscientiousness

Are you a "dominance" style? This is the visionary leader who loves challenge and change. You wear your heart on your sleeve and need followers who will implement your ideas for you. Having too many direct styles in a practice is like having too many cooks in the kitchen.

If you are an "influence" style, you prefer working with people and motivating them. You have fun and love the people side of dentistry. However, if you hire a whole team of influencing individuals, you will have lots of fun but rarely run on schedule and may have issues with implementation and follow-through.

The "steadiness" style craves order, works and thinks about systems, loves harmony, and dislikes change and conflict. If you have too many steadiness

styles on the team, you will be a low-key, happy group, but change will be difficult for you.

The "conscientiousness" style of individual is the detail-oriented, analytical individual who loves research and working alone. If you have too many conscientiousness staff members on the team, you will have a very organized practice with lots of rules and regulations, but not enough people-skill individuals with high customer service skills.

What is your behavioral style and what behavioral style would best complement you in the practice? Most of us are a combination of some of these. We need to be surrounded by others who have other strengths than we do. Many staff and doctors spend too much time trying to change other people's behavioral style, and it rarely happens. There is one factor that will not change: you are the dentist and the owner of the business. Your behavioral style will most likely remain the same for the duration of your career.

Therefore, hire staff based on their strengths and behavioral style, not just their skill set. Learning effective clinical and business systems is easy if you have a person with ability and willingness and a great training program. However, basic behavioral styles rarely change. Recruit and select staff members who complement you and your style.

An additional important point to consider when you hire someone is to trust your instincts. If there are red flags in the interview, you can almost count on wild forest fires when the person is hired. So often we have a gut feeling about an individual and ignore it, but after hiring hundreds of employees over the years, our instincts are almost always right.

How to Locate and Recruit the Best Staff for Your Practice

The best candidates for your position are not necessarily looking for a new job, so you will need to network to find the "right" person. The best place to start your networking is with your existing patients of record. Are any of your patients a good candidate for you? Perhaps one of their friends could be the team player you are looking for in your office. Let your patients know about the position open in your practice. Involve your staff in the hiring practice by offering them a "finder's fee" if they refer an applicant and you hire that person for the job. Most staff members are motivated to refer their friends to your practice and will be more vested in their long-term success and training. Do not overlook the importance of placing a creative, descriptive, and exciting ad in the newspaper and on the internet. (See sample ads below.) You want to set your practice apart from the others on the internet and in the newspaper so you will attract the "cream of the crop."

When evaluating a candidate in today's competitive marketplace, quick response time and good interview skills are very important. The candidate should fax or e-mail his or her résumé and be screened initially over the telephone by a competent staff member or the doctor to determine experience, job

responsibilities, and salary needs. If the candidate appears to be qualified for the position, ask him or her to come in for an interview. If the candidate's résumé or application demonstrates good job experience and longevity, set up an interview with the doctor as soon as possible.

In the interview, ask interesting questions and listen more than you talk. Look for a person with a positive attitude and willingness to take on a challenge. Remember to trust your instincts! Ideally, the right candidate would be available for a working interview as soon as possible to assess his or her abilities and experience. The last part of the interview process would include a lunch meeting with the staff. After all, they will be intimately involved in the training and success of this individual, and you need their feedback and support in the hiring process. Please refer to chapter 17 for a more complete discussion on employment law.

Questions to avoid:

1. Marital status
2. Names and ages of spouses, children, dependents
3. Nationality, ancestry, lineage descent
4. If the applicant is pregnant or plans a family
5. Age
6. Race or color
7. Does he or she rent or own home
8. Religion
9. Dates of attendance or completion of school
10. Height or weight
11. Provisions for childcare
12. Who he or she resides with
13. General medical condition, state of health, or illness
14. Receipt of workers' compensation
15. Physical disabilities or handicaps
16. Organizations, clubs, societies, lodges
17. Military service, either foreign or national
18. Economic status
19. Refusal or cancellation of bonding
20. Name and address of relative to notify in case of emergency
21. How spouse/parents feel about person working
22. Sexual orientation

Sample Employment Ads

Growing, quality-oriented professional office desires enthusiastic, mature team member as Patient Coordinator. Outstanding work environment and benefits. Three days/week/ Aurora. Fax résumé to ______ or e-mail to ______.

Full-time Practice Administrator for a small quality-oriented professional office. If you are a highly motivated people person with exceptional organizational skills and would like to be a member of our progressive team, please fax ______ or e-mail ______.

Happy, high-quality, team-oriented dental office is seeking enthusiastic Financial Administrator to help our family of patients properly handle their accounts and schedule their appointments. Dental experience required. If this sounds like you, please fax or e-mail ______.

Are you an enthusiastic, motivated dental person looking for a new opportunity? We have a leadership position for the right individual to take over the front desk responsibilities. Part-time or full-time. Please contact: ______.

An opportunity for a caring, enthusiastic person with a progressive professional office as Appointment Administrator. Please fax ______ or e-mail ______.

Appointment Administrator needed for a quality-oriented downtown professional office. If you have a high level of energy, excellent verbal skills, and people skills please fax ______ or e-mail ______.

Downtown dental office requires full-time Patient Coordinator. If you are self-motivated, enthusiastic, and have good communication skills, please call Elaine _____ to become a member of our quality team. Benefits program offered.

Full-time position in a small professional office. Fantastic opportunity for an organized people person who is creative and detail oriented. To become a valued member of our fine team, please call fax ______ or e-mail ______.

Downtown area. Two-doctor restorative practice seeking mature-oriented individual with good verbal skills and an eagerness to learn.

Would you enjoy working in a cheerful, exciting, and professional atmosphere? Well, we're in need of an enthusiastic and caring person to join us in our quality-oriented practice. Experienced preferred, but not required.

Full-time position in professional office. Wonderful opportunity for an organized people person who is detail oriented. Excellent benefits. Englewood area. Dental experience preferred.

Would you like to be appreciated? Dental Hygienist needed for caring, progressive family practice. Great pay with benefits is offered for an enthusiastic individual with appropriate skills.

Our high-quality practice is looking for an energetic and organized Dental Assistant committed to excellence. 34 hours/wk. Coal Mine and Wadsworth. Experience required.

Our progressive dental team is seeking an experienced EDDA to help provide quality dental care. This full-time position comes with complete fringe benefits package and negotiable salary.

Progressive Cherry Creek general practice looking for that special Dental Assistant who loves working with people, enjoys multitasking, and is interested in personal growth and long-term commitment. Outstanding salary and benefits.

Young, progressive dental practice in a new facility seeking enthusiastic, self-motivated person to be full-time Dental Assistant. Experience preferred, but will train the right person.

Seeking an outgoing people-oriented team member who likes a challenge for position of EDDA in a caring office. If you are looking for this type of position with a good benefits package . . .

Telephone Screening

The following questions are examples of questions that you can use to determine if a telephone screening interview should be offered.

1. "What about our ad prompted you to respond?"
2. "Tell me about your dental experience."
3. "Generally speaking, what is most important to you about your current position?"
4. "Have you dealt with the public in previous positions, and how have you felt about it?"
5. "What do you like most about your current job?"
6. "The hours for the position are ______. How does that work for you?"
7. "Before we continue our discussion, let's make sure we are in the same ballpark on salary. What kind of salary are you looking for?"
8. "What would you say are the main responsibilities of ______?"
9. "What do you think are important characteristics of a good ______?"
10. "Ideally, what are you looking for in your next job?"

First Interview

Questions to ask to determine a person's willingness, ability, values, and goals can include the following.

Questions about his or her most recent position:

1. What circumstances led to your employment at ______?
2. What most influenced your decision to work there?
3. What are (were) your day-to-day responsibilities?
4. What are (were) the most important dimensions of your position?
5. What are (were) the key responsibilities and/or objectives?
6. Describe the kind of client contact you have at ______.

7. Which of your responsibilities have you performed particularly well?
8. In what ways could your performance be improved?
9. What steps have you taken to improve in these areas?
10. What aspects of the position do you enjoy the most?
11. What aspects do you enjoy the least?
12. What do you consider to be a stressful situation in your current position?
13. Why are you seeking to make a career change at this time?
14. What types of people do you work best with within your current position?

Questions about his or her other work environments:

1. Of the businesses you have worked for in the past, which did you like the most?
2. Which did you like the least?
3. Which positions/duties have you liked the most?
4. Which positions/duties have you liked the least?
5. Of the various environments in which you have worked, in which were you most productive?
6. Which of your past positions have best prepared you for this job?

Questions about his or her personal effectiveness:

1. How would you describe yourself?
2. What do you consider to be your greatest strengths?
3. In what areas could you improve?
4. What was the worst mistake you ever made in a position, and how did you handle it?
5. Where do you see yourself career-wise in 3–5 years?
6. How does the position we are discussing today pertain to these career aspirations?
7. If you could create an ideal job for yourself, what would that job look like?
8. Why are you attracted by this position we are discussing?
9. What attracts you to a career in dentistry?
10. Define for me what you think constitutes “patient service” in a dental office.

Second Interview/Working Interview and Lunch with Staff

The purpose of the second interview is to assess the competency or skill levels of the applicant on a different day in a different situation, and to communicate more about values and the job itself. Always check skill levels. Also, you may need to consult an attorney to ensure compliance with employment/selection law.

When checking for competence or skill levels, use three tools: Question philosophies about why specific skills are used or necessary for the position. Test whatever professional skills the applicant possesses. Role-play scenarios that the applicant is likely to encounter in the position.

Questions about philosophies:

1. What is the most important role of the ______?
2. Describe your infection control procedures.
3. Describe your sterilization techniques.
4. Describe your philosophy of periodontal care.
5. What is your philosophy of helping build the practice?
6. Give an example of how you can support the team.
7. What is your role in influencing patients to have (prediagnosed) dentistry?
8. How do you document financial arrangements?
9. What role do you perceive yourself having in staff meetings?
10. What role do you feel that appointment scheduling plays in the overall success of the practice?
11. Tell me what you would do to incorporate the philosophy statement into your day-to-day responsibilities here if you were hired. (You previously gave the applicant a copy of your philosophy statement on the first interview.)

Tests

Tests for Hygienist

Perform a quadrant or two of prophylaxis (on the doctor, or on a team member if doctor wants to observe technique). Another method is to have the hygienist work for a half day in the practice at a flat hourly rate as an independent contractor. Communication skills and empathy toward the patients can be observed.

Place/take/develop bite-wing x-rays on a staff member or doctor.

Tests for Dental Assistant

Place/take/develop bite-wing x-rays on a staff member or the doctor.

Test generalized chair-side technique, test applicant's four-handed dentistry skills, have applicant set up operatory, disinfect operatory, follow process through with sterilization of instruments and tray.

Tests for Financial Administrator/Appointment Administrator

Compose a thank you note for a referral and a welcome letter to a new patient on either the typewriter or word processor to check for composition, spelling, punctuation, and so forth.

Mathematically figure financial arrangements on a fictitious case with proper documentation.

Role-Play Scenarios

Role-Play for Hygienist

The hygienist must tell an established patient that he or she sees signs of periodontal disease and that the patient may need to see a specialist.

The hygienist is aware that a patient has been delaying getting a crown for 2 years. Have him or her talk to the patient about going ahead with it.

The hygienist sees another staff member disregard an important practice policy. What would the candidate do about it?

Role-Play for Dental Assistant

When the doctor leaves the room the patient turns to you and says, "Do you think I really need that crown?" How would the assistant respond?

When the doctor is not in the room, the patient bursts into tears. What would the assistant do?

When the doctor leaves the room the patient says, "I think I need a second opinion." How would the assistant respond?

He or she sees another staff member disregard an important policy. What would the assistant do about it?

Role-Play for Financial Administrator

Present a patient with financial arrangements for a large case.

Handle an emotional patient who did not realize what the fee for a procedure would be.

Role-play a collection call (follow up on a financial arrangement) on an account over 30 days. Then, do the same thing for the account after it reaches 60 days.

The financial administrator sees another staff member disregard an important practice policy. What would the candidate do about it?

Role-Play for Appointment Administrator

Collect an over-the-counter fee.

Schedule an appointment.

Schedule an appointment for a preblocked morning time when the patient "wants to come in after work."

The patient wants to call later to schedule his or her next appointment. How should the appointment administrator respond?

The appointment administrator sees another staff member disregard a practice policy. What would the candidate do about it?

Welcoming Your New Employee to Your Practice

Celebrate the decision to work for your outstanding team by sending the new employee a plant or flowers with a note welcoming him or her to the practice. Have the entire team sign the card. On the first day of work, make sure a staff member is assigned to the new employee and available to greet him or her and give a brief orientation. It should include where to park, where the lockers are, a tour of the office, lunch and break time suggestions, and an introduction to all the staff members.

Have a specific training program for the new employee for everyone to follow. The most successful team members are clear on their job responsibilities and what is expected of them. All staff members should also be aware of where the new employee is in the training process and what their role is in the training.

One last thought to remember: you are in control of setting the tone in the practice by hiring individuals who can follow through with your goals and vision. Hire well!

Job Descriptions

Clearly defined job descriptions and responsibilities are the backbone of the success of an employee and of the practice. A job description should outline the duties of the position as clearly as possible. The documented job description includes the standards for the position and qualifications for the position. It serves as a guideline for hiring, interviewing, and future training. The job description also sets the groundwork for performance evaluations and managing the employee effectively. Table 18.1 provides sample job descriptions for

Table 18.1. Position descriptions.

Financial Administrator Job Description
Overall responsibilities:
- Responsible for administering the day-to-day financial activities of the practice; accounts receivable; insurance; back up the appointment administrator

Maintain an accounts receivable system:
- Enter patient activity in computer
- Maintain accounts receivable activity
- Maintain a financial record for each patient
- Complete insurance claim forms as needed for each patient
- Prepare bank deposits
- Prepare statements for patients
- Follow up insurance claims
- Follow up delinquent accounts
- Arrange payment schedule with patients

Table 18.1. *Continued*

Insurance:
- Submit treatment plans for predetermination of benefits
- Prepare claim forms for patients with dental insurance
- Organize supporting materials for claim forms, such as radiographs or written narratives
- Electronically submit claim forms daily
- Assist in the resolution of problems with third-party payers

Billing:
- Send statements to patients each week, divided evenly by the alphabet
- Prepare and mail overdue account letters on the 15th of each month
- Call patients with overdue accounts
- Post checks received each day

Appointment Administrator Job Description
Overall responsibilities:
- Responsible for maintaining appearance and order of dental office, patient scheduling; patient management and correspondence

Office management:
- Open the office and turn on the lights at least 15 minutes before the first scheduled appointment of the day
- Ensure the reception room is neat and has a professional appearance
- Check the day's schedule for accuracy
- Facilitate the morning huddle

Scheduling:
- Establish and maintain a recall system
- Confirm patient appointments 2 days in advance by phone or e-mail
- Schedule according to the daily production goal
- Preblock the schedule according to procedures
- Maintain a tickler file for patients with delayed and undone treatment

Patient management:
- Manage recall system each month with the hygienist(s)
- Prepare and send out recall care cards 3 weeks in advance of patient appointments

Welcome patients and greet all patients by name
- Accurately record patient dental, medical, and insurance information
- Accurately file patient information
- Collect money from patients at time of treatment
- Arrange patient charts and radiographs for the next day's appointments
- Assist in the treatment rooms as needed

Correspondence:
- Sort, organize, and distribute mail
- Prepare and send out welcome packets to new patients and referral thank you letters to patients
- Send out the weekly marketing note

Dental Assistant Job Description
Overall responsibilities:
- Responsible for assisting the dentist in the clinical treatment of patients

Table 18.1. *Continued*

Clinical management:
- Check to ensure that units are ready, stocked, and clean at the beginning of each appointment
- Oversee cleanliness of treatment rooms
- Help in other areas of the office when necessary (answering phones, filing, assisting the hygienist, etc.)

Patient management:
- Go into the reception room and greet patients by name
- Seat patients in the treatment room and have proper setup for procedures
- Try not to leave the patient unattended in the chair
- Anticipate and assist dentist's needs at all times
- Perform clinical procedures as delegated by the dentist
- Document the date of service, services rendered, all charges, and what procedure is to be completed at the next visit
- Give patient instruction and demonstrate where necessary, as directed by the dentist
- Update patient's health history and patient information semiannually
- Notify the appointment administrator if a patient should be called in the evening after a difficult appointment
- At all times show care and concern for patients
- Escort patients from the treatment room to the business area

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Dental Hygienist Job Description

Overall objective:
- Responsible for providing hygiene treatment to patients

Equipment management:
- Before each appointment, check hygiene room for cleanliness
- Clean hygiene room at the end of the day; turn off equipment
- Maintain a supply inventory for hygiene treatment
- Review, select, and submit orders for patient education materials for the practice

Patient management:
- Gather and review patient charts for the day and the following day
- Work closely with the appointment administrator to keep the hygiene schedule full and productive
- Carefully review patient medical and dental history forms and update as necessary
- Accurately chart each patient's periodontal and restorative health at each visit
- Provide thorough and gentle prophylaxis to patients
- Provide periodontal therapy as needed to designated patients
- Provide radiographs for patients as prescribed by dentist
- Provide topical fluoride applications for designated patients as prescribed by dentist
- Communicate with patients in an understandable and professional way
- Provide appropriate patient education to each patient and distribute the proper patient education material
- Preappoint 90% of the hygiene patients for their next hygiene appointment
- Strive to achieve your daily and monthly goals
- Perform other tasks assigned by dentist

Table 18.1. *Continued*

Infection Control Job Description
- Properly discard all disposable items from each visit
- Assemble soiled instruments and place in sterilization area
- Clean treatment room surfaces with disinfectant solution
- Presoak soiled instruments in a disinfectant
- Process instruments in ultrasonic cleaner tank
- Rinse and soak treatment trays in disinfectant
- Sort and package instruments by tray for proper sterilization
- Load, activate, and vent the sterilization unit according to the manufacturer's directions
- Store instruments and trays in appropriate places

these positions: financial administrator, appointment administrator, dental assistant, dental hygienist, and an infection control person. Qualifications are not listed in these example job descriptions.

Buying a Practice with Existing Staff

One of the most challenging situations a dentist may find him- or herself in after purchasing a practice is establishing rapport with the "inherited" or existing staff. Many staff members are reluctant to have a new leader and are unsure of their future in the practice. To ensure a smooth transition for the doctor, staff, and patients, we recommend building rapport and opening the communication lines with the staff as soon as possible. For example, here are five key questions to ask the existing staff in a 15-minute initial interview:

1. Tell me about yourself.
2. What part of your job do you like the most?
3. What part do you like the least?
4. What do you currently like the most about how this office runs and what would you change?
5. What do you need from me (dentist) in regard to leadership and communication?

In this short interview, the dentist, as the new owner of the business, is looking for ways to motivate and meet the employee's needs. He or she is hoping to uncover the employee's "hot buttons," what motivates the employee, and what he or she likes and dislikes about the job. It also allows the dentist to establish whether he or she has the "right" person for the job and to make any changes in personnel. This type of interview also gives the staff members an opportunity to view the new dentist as a leader and begin to build trust.

Training Employees

The success of an employee often depends on the quality and quantity of the training program. Many skilled staff members have become frustrated and left

a position when they were not able to perform their jobs effectively due to the lack of training. Every position in the practice needs to have a complete and accurate job description that becomes the basis for the training program.

After hiring the "right" person for the job, the dentist, office manager, or supervisor should meet with the employee to review his or her job description and responsibilities and specific training chart. The training chart (Table 18.2) is completed and reviewed with the employee. Depending upon the job and the new employee's skill level, many staff members may be involved in the new employee's training.

The goal of the training chart is to determine:

- Who will train
- When they will train
- How they will measure the training
- What kind of training

Table 18.2. Training chart.

Date: ______________________________

Trainee: ______________________________

Position: ______________________________

	Tasks	Who Will Train	Type of Training*	Date of Training	Progress**
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					

*Type of training
A. One-on-one
B. Group training
C. Outside source
D. Peer training
E. Self-study

**Progress
Example responses:
Supervision needed
No supervision needed
Task mastered
Can train others

To ensure the training is effective, the trainer and the new employee need to have uninterrupted training time. Depending upon the nature of the training, they may need 15 minutes or over an hour. One of the worst mistakes many trainers make is training the new employees on too many tasks at one time and not allowing them to become proficient before moving on to the next task. Good trainers do the following:

- Set aside specific uninterrupted training time
- Describe the task to be learned
- Tell why this task is important
- Show how the task is done
- Have the employee do the task with supervision

Obviously, it is important for the employee to take notes and ask questions during and after the training. The training chart is reviewed with the dentist weekly for an update of the training progress.

Employee Evaluations

Employees need and want feedback on how they are doing in their jobs. This promotes excellence and reduces conflict when they know what is expected of them. If employees do not know how they are doing, they may continue to make mistakes and feel confused about their responsibilities. Performance reviews are based on the responsibilities outlined in the job descriptions and help determine raises, probation, and termination of employment.

Each employee should receive a formal appraisal once a year on his or her date of hire or at another specified time. New employees should receive a formal performance review after 3 months of employment. Future reviews for the new employee may then be conducted on an as-needed basis.

The dentist or supervisor reviews the employee's job description and completes the evaluation form (Table 18.3). Note that the staff member also completes a self-evaluation. Then, the employee and the dentist/supervisor discuss the employee's strengths and weaknesses. Together they establish the objectives for the next time period. All individuals sign the evaluation form, and a copy is place in the personnel file.

Raises

Raises in the practice should be based on two factors: merit of the employee and the health of the practice. Salary reviews should occur on a specific schedule each year. Salary reviews should not be tied to the employee's performance reviews, although performance reviews are a consideration in giving a salary increase.

Table 18.3. Employee evaluation.

Performance Evaluation
(Filled out by doctor or office manager)
Date: ______________________________
Employee name: ______________________________
Position: ______________________________

Characteristic and Performance Rating:
Rate each aspect of work performance on a scale of 1 to 5.
1: Exceeding the job requirements
3: Meets the job requirements
5: Unsatisfactory or unacceptable performance

Circle one per category	Excellent			Unsatisfactory		Comments
Punctuality	1	2	3	4	5	________
Attendance	1	2	3	4	5	________
Attitude	1	2	3	4	5	________
Communication skills	1	2	3	4	5	________
Self-starter	1	2	3	4	5	________
Flexibility	1	2	3	4	5	________
Quality of work	1	2	3	4	5	________
Speed	1	2	3	4	5	________
Telephone techniques	1	2	3	4	5	________
Computer skills	1	2	3	4	5	________
Charting	1	2	3	4	5	________
AR management	1	2	3	4	5	________
Insurance	1	2	3	4	5	________
Appointments	1	2	3	4	5	________
Radiography	1	2	3	4	5	________
Sterilization	1	2	3	4	5	________
Equipment care	1	2	3	4	5	________
Treatment procedures	1	2	3	4	5	________
Continuing education	1	2	3	4	5	________
Prophylaxis	1	2	3	4	5	________
Patient education	1	2	3	4	5	________
Preliminary diagnosis	1	2	3	4	5	________

Employee's Action Plan

Goal:

Target Date:

Goal:

Target Date:

Goal:

Target Date:

Signatures

Table 18.3. *Continued*

Performance Evaluation Form
(Filled out by the employee)
Date: ____________________
Employee name: ____________________
Position: ____________________

Characteristic and Performance Rating:
Rate each aspect of work performance on a scale of 1 to 5.
1: Exceeding the job requirements
3: Meets the job requirements
5: Unsatisfactory or unacceptable performance

Circle one per category	Excellent			Unsatisfactory		Comments
Punctuality	1	2	3	4	5	________
Attendance	1	2	3	4	5	________
Attitude	1	2	3	4	5	________
Communication skills	1	2	3	4	5	________
Self-starter	1	2	3	4	5	________
Flexibility	1	2	3	4	5	________
Quality of work	1	2	3	4	5	________
Speed	1	2	3	4	5	________
Telephone techniques	1	2	3	4	5	________
Computer skills	1	2	3	4	5	________
Charting	1	2	3	4	5	________
AR management	1	2	3	4	5	________
Insurance	1	2	3	4	5	________
Appointments	1	2	3	4	5	________
Radiography	1	2	3	4	5	________
Sterilization	1	2	3	4	5	________
Equipment care	1	2	3	4	5	________
Treatment procedures	1	2	3	4	5	________
Continuing education	1	2	3	4	5	________
Prophylaxis	1	2	3	4	5	________
Patient education	1	2	3	4	5	________
Preliminary diagnosis	1	2	3	4	5	________

Accomplishments
List areas of work in which you have performed especially well. Give examples.

Performance Improvement
Describe any performance area that needs improvement. (Think of specific tasks or behaviors.)

Motivating and Appreciating Employees

Employees are any doctor's best asset and marketing tool. Motivated employees who know the difference they make are invaluable to the success of a practice. Dental practices that have high employee morale have many things in common:

- Shared values
- An environment of mutual respect
- Good communication between doctor and staff
- Teamwork
- No gossip or backstabbing
- A sense of ownership
- Challenging job
- Appreciation from the leader

Motivated staff enjoy a "family" atmosphere and a doctor who is committed to the long-term success of his or her team. Staff members like to have clear expectations and the freedom and autonomy to do their jobs. Many doctors feel the employee's salary and benefits should be enough appreciation for their team. In our combined 35 years of interviewing team members in dental practices throughout the United States, many employees crave and want the following from their employers:

- Be a good listener
- Say "please" and "thank you" often
- Give fair salaries and benefits
- Have spontaneous rewards for a job well done
- Remember birthdays and anniversaries in the practice
- Praise in public and criticism in private
- Give honest and direct feedback in a kind way
- Be a good role model

Many staff members have reported they feel they are underappreciated by their doctors. Great leaders recognize the value of communicating their honest appreciation by sincerely complimenting the staff in front of patients. Patients love this, and so does your team. Other team recognition ideas include:

- Quarterly team outings (with a budget) planned by the different departments in the practice (bowling, shopping, manicures, baseball game, theater, laser tag).
- Spontaneous rewards are just as motivating as monetary rewards. Bringing staff a Starbucks latte to the morning huddle, giving them a $20 bill, or ordering a pizza for delivery to their home buys you a lot of motivation and positive attitude.
- Two round-trip tickets for the best "marketing" idea of the year.

- Having a masseuse come to your office and give staff a 15-minute shoulder and neck massage.
- Giving staff 5-, 10-, and 15-year loyalty gifts (watches, jewelry, bed-and-breakfast gift certificates).
- Schedule a staff meeting for 3 hours and surprise them with a shopping trip instead. Give them $200 and meet them for coffee at the end. Anything they do not spend they need to give back to you.

One of the most important keys to staff motivation is hiring motivated people. You cannot motivate a negative or unmotivated individual for very long. Keep your staff motivated by involving them in the practice decisions, providing regular feedback, and giving them challenging work.

Many practices have turned to a bonus incentive plan to help motivate and reward employees. If properly set up and administered, a bonus incentive plan can be a great motivator for staff. However, some bonus incentive plans are hard to track and may actually create a negative environment when the bonus is rarely achieved.

We have found the most effective bonus incentives programs are based on a 3-month rolling average of collections (not production!) and are achieved approximately 50–75% of the time. The bonus amount is determined by the percentage of staff salaries to collections and is distributed monthly. The individual amount is based on the number of days or hours worked.

Sample Bonus Incentive

1. Doctor commits to give staff a certain percentage of collections in the form of salary and/or bonus incentive. This percentage is based on the previous year's gross staff salaries in relation to collections. Usually ranges from 21% to 28%.
2. Bonus incentive is based on *collections*, not production.
3. Bonus incentive is based on a 3-month rolling average of adjusted collections.
4. Monthly gross salaries to be deducted from the predetermined percentage should include contract labor costs but not include spouse salary, staff benefits, or payroll taxes.
5. Formula and example:

   Step 1: 3-month adjusted collection average

Jan:	$68,000
Feb:	$64,000
Mar:	$66,000
Average:	$66,000

   Step 2: Monthly gross salary: $18,363 *(Based on May profit and loss statement. This will change each month based on the gross payroll and contract labor that is paid in that given month.)*

   Step 3: $66,000 × 28% (example) = $18,480

Step 4: $18,480 – $18,363 = $117
Step 5: $117 to be split among employees (based on hours or days worked)

6. Examples at 28%:
$67,000 × 28% = $18,760 – $18,363 = $397
$68,000 × 28% = $19,040 – $18,363 = $677
$69,000 × 28% = $19,320 – $18,363 = $957

How to Handle Challenging Staff Members: Focus on the Behavior, Not the Person

Most dentists want to perform dentistry and do not want to deal with staff performance concerns and conflict issues. Unfortunately, as a business owner, you will at some time in your career experience these challenging situations. After many years of handling conflict and having successful outcomes, here are some tips that we have found helpful:

C: Communicate within 24 hours
O: Out of area
N: Neutral
F: Facts
L: Listen
I: Investment
C: Conclusion
T: Trust the movement

C—Communicate within 24 hours: Address the situation as soon as possible, but when your emotions are in control. It is best to do this before the end of the day so that you will not take this problem home with you.

O—Out of area: When a situation is noticed or brought to your attention, make sure that you address it behind closed doors.

N—Neutral: It is your responsibility to remain neutral and nonjudgmental, especially when there is more than one individual involved. Remember, there are three sides to every story: yours, theirs, and the truth.

F—Facts: Stick to the facts. It is important to discuss the specific concerns related to this situation. At times, previous situations will be mentioned that may have no relevance to the resolution of this matter. The more factual you can keep the matter, the better.

L—Listen: In order to gather the facts, you must first listen. Remember that you have two ears and one mouth for a reason.

I—Investment: Your employees are an investment. Your primary goal is to resolve and move forward with any conflict situation. It is much harder and more costly to replace an existing employee than to hire and train a new one. However, if the problem continues, it is more costly to keep this individual.

C—Conclusion: As the dentist and owner, it is best to challenge the employee to think about the possible solution. Whether you are addressing a concern with an employee or an employee is coming to you with a concern, it is best for the individual to come up with a possible solution. Your goal is to have employees work out situations on their own. In the event they do come to you, they may have already solved the problem. When you need to address an employee, ask what *he or she* can do to improve the situation. This often leads to ownership and a higher level of accountability.

Lastly, document these situations in the employee's personnel file. Verbal situations could turn into written forms of communication down the road, which could lead to possible termination. One can never document too much.

T—Trust the movement: This is an old saying, but it remains true to this day. Trust what people do, not what they say. Actions speak louder than words. This age-old cliché will keep your business thriving and will help create a great place for all of you to work.

Disciplinary Process Leading to Staff Dismissal

As an employer, one of the more stressful tasks is managing an employee who is not performing at the level required in his or her job. It is important to have a disciplinary process in place to reduce the likelihood of wrongful discharge litigation and also to allow the employee an opportunity to improve performance. There are some standard steps in the progressive disciplinary process:

1. A verbal warning with written verification placed in the employee's personnel file
2. A written warning detailing the exact problem, what the employee is expected to do, and within what time frame
3. A probation period when the employee is put on notice and given a time frame to change or improve the behavior or risk other disciplinary measures
4. Possible suspension without pay
5. Termination

All of these steps should be well documented and signed by the dentist and the employee. A copy of all written documents is placed in the personnel files. Each dentist should be aware of state and federal guidelines prior to dismissing any employee. Refer to the section on termination in chapter 17.

References and Additional Resources

Moawad, Karen, and Bender, Lynne Ross. 1993. *Managing Dental Office Personnel: A Management Tool for Structuring and Administering Personnel Policies in the Dental Practice*. Tulsa, OK: Penwell Books.

www.ada.org. American Dental Association (ADA) (especially, *Basic Training II and III, Employee Office Manual*, *Fast-Track Training: The Basics for Dental Staff*, and *Smart Hiring: A Guide for the New Dentist*).
www.dol.gov. U.S. Department of Labor (DOL).
www.eeoc.gov. Equal Employment Opportunity Commission (EEOC).
www.pathways-to-performance.com. Pathways to Performance, Inc.

Learning Exercises

Discover Your Behavioral Style

1. Answer the following questions and circle the answer to decode your behavioral pattern.

Are you active/outgoing (DI) or more reserved (SC)?
If you circled "active/outgoing," are you a relater with others (I) or a director of others? (D)
Are you more concerned with persuading or impressing others (ID) or getting the results you want (DI)?
If you circled "more reserved," are you more concerned with how you are to complete a task (S) or the quality of the task (C)?
Are you more accepting of others (SC) or assessing of others (CS)?

2. Do an internet search on "behavioral styles" and compare your answers to what you discover on the web. The only limitation to this exercise is the accuracy of the observer him- or herself—a limitation that can be easily overcome by additional information from others who work with you.

Conflict Case Studies

Case Study #1

An employee barges into your office and breaks into tears. She proceeds to tell you about another employee who has been mean to her. How do you gain control of the situation, become a fact finder, and ultimately have the employees resolve the situation themselves?

Case Study #2

Sally, your dental assistant, is not following OSHA protocol. When and how do you approach her? What conflict solution should you use?

Case Study #3

Margie, your long-term dental hygienist, is upset about her schedule and wants to add another 20 minutes to each appointment. What conflict strategy should you follow?

Case Study #4

Last month, your accounts receivable was very high, especially in the over 90 days category. In your last meeting with Virginia, your office manager, she assured you the money is in the mail and she is confident the AR will be under control next month. In reviewing this month's AR report, the AR over 90 days has crept even higher. What is your plan of action with Virginia? What conflict principle do you want to use?

Chapter 19
Staff Meetings

David Neumeister

Staff Meetings = Empowered Team = Delighted Patients

Every dental office has a unique current that runs through it, like a river. It has a temperature and a movement that can be felt as you first wade into the flow. A river's current is the energy force that guides every drop of water, just as the office spirit of camaraderie creates an aura for the actions of every single staff member. The energy field in the office also determines the satisfaction level and the sense of security for every patient. The current of supportive enthusiasm is established by the dentist and can be multiplied by every staff member at every moment of patient contact.

A healthy office current cannot be forced onto a group of people by a benevolent dentist. Neither can it be conjured up by everyone taking a course or reading a book. Nor can it be easily altered once the flow is moving. It develops its own momentum as it moves through the day: new patterns and behaviors take a long time to be nurtured and become a smooth part of the flow.

Your patients can feel the unique current when they walk through your front door. They sense the pace and energy in the reception room, in the hygienist's chair, when you come in to provide the clinical exam, and when they take out their checkbook to pay for their care. They respond to the diagnosis and recommendations in your office according to a subconscious sense of trust, quality, and energy in the office. Patients can feel tension: they can be intuitively aware of hidden agendas, and they will express their reaction by delaying treatment, saying "no," or even taking their records to another office. Some of their judgment is based on your new equipment and your clinical expertise, but their excitement to act now is based on a sixth sense of comfort and peace that comes from the feeling of ownership and security exhibited by the team of people that had an impact on them. It is critically important that you grow and motivate the team you have selected.

Practice success is not just about fixing teeth. Teeth do not have emotions, people do. Teeth are easy.

How do you create a healthy, patient-focused aura in a dental office? It begins with the dentist defining personal success very clearly and moves on to building a team of dedicated, motivated professionals who carry that energy

and commitment into everything you do as a dental professional. Every successful dental team needs to learn, grow, bond, share, and support your mission as a dentist.

Whether you see three patients a day or thirty, whether you have four or twenty-four individuals working in the same building, you need staff meetings. In fact, the busier you are, the more patients you see, the greater is your need to regularly stop, sit down, look into the eyes of your work friends, and learn how to define mission, collaborate, and build the daily energy necessary for prolonged success.

You can attempt to teach or will this motivation onto your staff. You can buy some allegiance with bonuses or force dedication, for a time, with sheer willpower. But, if you are to raise the ceiling on patients wanting extraordinary quality services and if you are to grow your monthly production, you have only two choices: you can either work faster or you can empower your team.

You do not develop a team just because the king rules the kingdom. If a commitment to serve the patient is not enlivened by your team members, you do not have a team. Unless they understand the vision, believe in the dedication required, and are willing to hold each other accountable for defined outcomes, you do not have a team. Staff meetings are foundational to the success of a team. Remember, effective staff meetings are absolutely essential both to the success of the team and your dental practice. Figure 19.1 captures a moment in a meeting in the staff lounge of a dental practice.

Dental team: A group of people with different background skills and abilities working together toward a common goal for which they hold themselves accountable, and for which they are held accountable as a group.

Figure 19.1. Staff meetings: Creating expectations for shared responsibility and shared success.

It is not instinctive for a young dentist to regularly set aside productive chair time in order to gather everyone together to share and learn. In many average and below average dental offices, staff meetings are not held at all or are regularly postponed in favor of more important things. In some cases, staff meetings are grudgingly held and barely tolerated by the dentist or the staff in the practice. “I do not have the time for staff meetings,” “I have never experienced one really valuable staff meeting in my life,” “I have enough trouble getting the work done now, why would I want to call a meeting and waste valuable time?”

Dentists often believe success is a matter of knowing the technical material, learning the business skills, and surrounding themselves with an honest, diligent staff. It is true that you need technical and business expertise. Equally valid is the necessity for a talented, devoted support team, but it does not stop there. To be successful, day after day, year after year, you need to continuously motivate, train, reward, and challenge your team to understand and value your devotion to your patient’s oral health and your team-shared vision of quality service.

The difference between average and excellent in any organization is the difference between common knowledge and daily application at every moment of public contact. Being successful every day absolutely requires focused, productive, and regular gatherings of your work group.

You will do more to improve your happiness and success as a professional by regular, focused team meetings than you will by taking a full week of the best dental education course in the country! Let me tell you why that is true.

You know your stuff. You graduated from a good dental school and have passed your boards. You have your license in hand, and now you have a dental practice. You have a setting to work your gifts in the public arena and actually get paid for it. All the patients in your community do not realize yet how good you are, but that will happen soon enough. You assume the key to your success as a dentist is literally in your hands.

But success is NOT in your two hands. Contentment at night when you are in bed waiting to fall asleep is not about your technical skills. Being able to do the dentistry is just the beginning. Contentment is found in knowing the patient with an old loose bridge who called today can fit in the schedule tomorrow morning without upsetting your other patients or your dental assistant. Contentment is found in knowing this: when the local school principal is first told she needs four quadrants of scaling and root planning, she does not get angry and ask why no one ever told her she had periodontal disease before today. Contentment is found in knowing this: when you leave the operatory and the patient quietly asks your assistant why root canals cost so much, your assistant has practiced an answer that builds confidence and security in the patient’s decision to have this service provided today. That is the contentment that allows you to fall asleep with a smile on your face as you look forward to your professional decision to work every day to help people keep their teeth for a lifetime of health.

How do you get a group of unique, gifted, and dedicated people to rise above their differences?

How do you motivate these individuals to work as a team? How do you encourage them to value service to the patient the way you do?

How do you build a sense of responsibility within a group of people who each came from different life experiences, with different personalities and different personal needs?

What types of meetings are necessary for a successful office?

- One to start each day and establish congruency of focus.
- One to share personal successes and celebrate victories.
- One to share basic business information of the office.
- One to bring new staff members into the family and experience your office philosophy.
- One to learn of changes in dental techniques, materials, and office systems on a regular schedule.

This can all be productively accomplished with just two meetings: a morning huddle before the start of each day and a team meeting once a month for a few hours. The total time required might vary from 3 to 5 hours a month, which is carefully devoted to allowing each person to understand, connect, and contribute to his or her own success and the success of the dental office.

Successful meetings: How would you know if you had one?

1. The participants would predictably look forward to coming.
2. The time would be productive and accomplish growth and improvement in office systems.
3. Everyone would feel like they, personally, made a difference in the process of making a decision.
4. The team would want to think and act more effectively as a result of participating in the meeting.

If we use these points as criteria for success, imagine what has to be in place to accomplish our goals. First, we have to agree on what makes a group of people a team. There are many settings where a group of people get together and act but no one would confuse the group with a team. There are established restaurants where it feels like the staff members do not talk to each other. Questions are repeated and you are left alone at the table for long periods. You sense that no one is in charge, and you have either been ignored or, if served, concluded that they really do not care if you come back for a second visit.

Sometimes it seems as if the waitstaffs in some restaurants do not even like each other. Very quickly the service falters and next your perception of the

quality of the food diminishes and you wonder why you came here in the first place. It does not take long to decide you are not coming back. Have you ever experienced a dental office like this?

Conversely, you have also been in restaurants where everything is seamless. The greeter tells you who your waitperson will be and he or she arrives quickly. Everyone seems devoted to making sure you have whatever you need. They actually look for ways to be responsive to your questions and desires. They can tailor the menu to meet your dietary needs, and they smile as they ask if there is anything else they can do to be helpful. And, no surprise, the food is terrific also.

What makes the difference? How does a group of people, each with a different background and experience, become an integrated unit that is capable of meeting the needs of a single customer, a couple on a date, a family with children, or a large group celebrating a wedding anniversary? Each visitor has a unique expectation and a unique perception of that particular restaurant. A successful restaurant finds that people return again and again because the experience was predictably warm and responsive. The food was well prepared, but food alone would not make this a return experience. Quality food is important, but quality food is not enough.

Quality dentistry is important, very important, but it is not enough to make a successful dental practice.

Agree on Success—Order without Control

Definition of success for the team: the entire staff enjoys, participates, takes away lessons, and improves service to the patient and to each other. Definition of success for the dentist: you develop rapport, educate, challenge, affirm, and grow a team of people to expand your ability to help patients make better choices about oral health.

You have an orderly pattern to your office systems without having to control or dictate the daily patient encounters in the delivery of oral health services in your office. Involve your entire staff in the process of patient service. Their confidence and authority to act comes from shared goals and common expectations for success. You can focus on direct patient care while your team demonstrates the attentiveness and service you would want if you were a patient in a dental office.

Team meetings must be:

Regular but team-driven
Focused but flexible
Fun but productive

In order to become regular, team meetings need to be scheduled at a definite time with no opportunity to change the date or shorten the length of the

meeting. The staff should know this time is as indispensable as lunch and the day the paychecks arrive. Everyone, including part-time team members, should make a dedicated effort to be present for the entire meeting, every time. Staff members are paid for the full time of the meeting, and any food or incidental costs are paid for by the dentist.

Morning Huddle: 15 Minutes before the Start of Each Day

Just as the daily schedule is the itinerary for the day, morning huddle is the GPS device to get you there efficiently. Huddle is held 15 minutes before the start of each day. The goal of the huddle is to indelibly connect the daily expectations of each person in the office. It is an opportunity to share information that is usually known only by one team member but for which whole-team awareness is important to establish congruency in delivery of service. Figure 19.2 portrays the activity of a morning huddle. The dentist needs to know there is a difficult patient who needs anesthesia coming into hygiene at midmorning, and the assistant needs to know that the front office staff will call the one o'clock patient to be sure she has taken the required prophylactic antibiotic that was forgotten last time. The person handling financial arrangements wants the hygienist to have the mother of both children this afternoon stop at the desk to make the insurance co-payment. The dentist may want the receptionist to ask the guardian to stay in the office at 4 o'clock to approve the necessary care for a special needs child.

This daily exchange of unique information makes the day start to flow harmoniously for everyone. It is part of how the patient begins to perceive the office energy currents that intuitively inform them that this office is well

Figure 19.2. Morning huddle: Come prepared; this moves quickly.

managed. Patients reflect the confidence, warmth, and assurance they witness within the office.

Each person must come to morning huddle prepared. Some staff members may come to the office 20 minutes early that morning to prepare, and some may stay a little late on the day before. If you have a hygienist who starts at 9:00 a.m. every day, s/he would need to prepare the afternoon before and give the information to someone else to report for her/him. If each person expects to participate three or four times at different points in the fixed agenda, a great deal can be accomplished in just 15 minutes.

The business office comes with information about overnight schedule changes, patients having financial arrangements to make, or payments due today. They may also have information about special insurance requirements for a patient or have knowledge about the family of a new patient coming in today. They may know of a patient who must be seen exactly on time this morning because of a previous scheduling problem. The hygienist will know who needs x-rays, who has pending dental treatment as yet unscheduled, which patients need dental exams, and who in today's schedule might need a treatment plan/plan of care, or a new comprehensive exam. The dental assistant will know which patients need special precautions, what set-ups will be needed for each patient, and which rooms will be used. The dentist is responsible for knowing which patients may need special care and which ones may have recently completed treatment by a specialist. The dentist must also help the scheduling coordinator know which time in the day is appropriate to see an emergency patient if someone should call and need to be seen today.

Every team member is also encouraged to bring news of special happenings they have learned about patients. Who, on today's schedule, has recently been in the newspaper, had an anniversary, been in the hospital, or graduated from school. Huddle is also the time when anyone can offer news about any patient of record who has had a significant milestone such as a wedding or birth of a baby. These patients might get a congratulatory card, with sentiments from multiple team members. Huddle is the time when a specific person would put a congratulatory card on the staff table so it can be signed during the day and mailed that evening.

Huddle is one more way you can create the expectation that each individual is responsible for the success of every other team member. Each person has an opportunity to be the one who satisfies the expectations of the patients visiting your office today. The quality of this meeting sets the tone and pace for the day. This allows patients to routinely leave the office glowing with praise for the congruency and professionalism of your office.

When everyone comes to this huddle prepared, you can begin to develop today's current of energy with a motivated, healthy team of individuals each possessing a desire to contribute to the whole. There must be a routine list of business office, hygiene, assistant, and dentist responsibilities that is used each day. If you do not start with common information and shared expectations, you will not feel linked throughout the day when the inevitable emergency

Table 19.1. Huddle agenda.

Start by 7:45 a.m., end by 7:55 a.m.
- Announcements for the entire office
- Schedule changes for today
- Business
  - Patients who may need help opening the front door
  - Patients who need to make or confirm financial arrangements
  - Hand off patients
  - New patients
  - Next preblock time for hygienist and dentist
- Hygiene
  - Patients who need medical history updates at the front desk
  - Patients with outstanding treatment
  - Patients who need an FMX, treatment plan, or conversion exam
  - Patients who need a dentist check
- Assistants
  - Patients who require extra time or have special needs today
  - Patients who require follow-up from yesterday
  - Emergency time today
- Gift ideas for patients
- Equipment or supply needs
- Thought for the day

call comes in or the important patient arrives twenty minutes late. Morning huddle starts promptly 15 minutes before the start of the day and can be completed in 10–12 minutes.

Table 19.1 provides details for a huddle agenda.

Team Meeting

The entire office gathers monthly on a firm date and at a known time, no excuses. These meetings should eventually be off-site so there will be no interruptions and so it is obvious to the team that you are making an independent commitment to time and space for focused discussion and personal connections to enhance your daily work. There is a safe narrative that will lead to an orderly, patient-focused, and emotionally satisfying gathering that every person will look forward to every single month.

Early in a dentist's career staff meetings are called only when there is a crisis. They are seen as a time to fix what is wrong. The topics are often critical issues that require urgent action, and there is little discussion about long-range issues that impact your practice harmony. When dentists have greater experience, there is more planning and more time allowed for issues at a staff meeting. Still, staff meetings often remain a negative, complaint time controlled by whomever has the biggest problem or the loudest voice. This is not an experience anyone is willing to have a second time.

Table 19.2. Dental team meeting.

Location: ____________________
Moderator: ____________________
Record keeper: ____________________
Evaluator: ____________________
Start time: __________, end by __________

Meeting Agenda
Rewarding experiences—personal and professional
Action list
Reports
  Hygiene
  Dentist
  Supplies
  Gift account
Housekeeping list
Education topic
Evaluation

Six parts to predictably successful team meetings:

1. Rewarding experiences
2. Action list
3. Reports: hygiene, dentist, supplies, gift account
4. Housekeeping list
5. Education topic
6. Evaluation

Table 19.2 provides the basic organizational structure for a team meeting.

Rewarding Experiences

During the rewarding experiences portion of the meeting, everyone will share at least one personal and at least one professional experience that has occurred in the last month.

This time is devoted to a leisurely sharing of experiences by each person clockwise around the room. After one person starts, the sharing moves calmly around the circle giving each person an opportunity to tell his or her story. This allows a friendly, relaxed, and unhurried opportunity for people to demonstrate through words who they are both personally and professionally. They can first tell the group what brings them satisfaction and reward outside of the office environment. Some dental colleagues find it not only easy but necessary to share home experiences. Some team members would have shared these personal highlights even if it meant bringing a photo or a personal memory to work during a busy day. Other team members will be less open about their lives outside of work, and that is fine. This process is not about revealing con-

fidences. However, everyone *must* have a couple things that have happened each month that brought them special satisfaction. If one team member hesitates to offer an experience, offer her or him an opportunity to wait until the last person in the circle has had a chance to share and then come back to the less talkative team member.

No one is allowed to skip over sharing personal rewarding experiences. It is important to connect with each person as an individual and know a little about what makes them unique.

As leader of the team you can support your quieter team members—and there will always be some reluctant individuals—by following up privately by asking more questions about their interests and strongly encouraging them to do more sharing at the next meeting.

Each person should express one or two personal rewarding experiences that have occurred in the last month. Figure 19.3 illustrates a rewarding experience portion of a team meeting held in the home of a staff member. This could be an award a child achieved in scouts, an activity successfully accomplished at church, or a vacation experience including some photos of this special trip. This allows both the effusive and the less secure person a predictable time to tell the group a little more about who he or she is and what subtleties that person contributes to your team. This is part of connecting as humans on a social and emotional level so that work life has the potential to become a support network. It is easier to work effectively with friends who know and understand your family life, your hobbies, and the life experiences that make you a unique individual. These social connections enhance professional responsibilities and build a depth of empathy for the day when someone is sick or the sterilization area overflows. Those days will happen.

Figure 19.3. Rewarding experiences: What lights your fire each day when you drive to work?

This rewarding experience time also allows opportunity for sharing a couple of experiences that have been professionally rewarding to each team member during the last month. Celebrate why you enjoy coming to the office each day. Tell one another what is working well for your patients. These experiences should involve named patients and other staff members. It is meant to cheer the successful patients and to affirm the behaviors and actions of fellow team members.

This rewarding experience time also provides a vehicle by which the business office and the treatment providers can elaborate on the interconnectedness of everything that occurs in a good office. The hygienist can thank the scheduling coordinator for moving patients on the day her daughter got sick and she had to leave on short notice. The assistant can thank the hygienist for encouraging a patient to complete her whitening experience before she had the bicuspids crowned, allowing the shade to match more perfectly. The dentist can affirm the person who takes new patient phone calls because of all the detailed information she collects on the phone, facilitating a better first visit experience.

The subtle message infusing this rewarding experience time is that we are all human beings with a home, with a circle of friends, and with unique life experiences. We also happen to share similar values in this dental office with an opportunity to make a difference in the lives of our patients and in the lives of our fellow teammates. The emphasis during this first item on the staff meeting agenda is on leisurely sharing.

Action List

During this part of the meeting, employees will follow up activities from past meetings.

The second item on every meeting agenda is the action list. Through this section you demonstrate that decisions that are made by the team at a staff meeting are either put into action immediately or require more research and are returned to a future meeting for a more complete discussion.

Table 19.3 is an example outline of an action list.

An example of topics on this list might be the specific technical definition of an insurance code for periodontal maintenance visits. Someone might volunteer to research that definition and report back at the next team meeting. That item, requiring follow-up reading, would be placed on the action list for reporting at the next meeting. Another example of an action list topic might be the dates and cost of the regional continuing education meeting scheduled next summer. An individual might be asked to get all the information, post the list of speakers and dates in the staff room, and then place the topic on next month's action list for a decision about members of the team who might want to attend.

Perhaps someone in the business office receives questions about implants and asks if he or she could learn more about this service. The group might then

Table 19.3. Action list.

Post on Monday following staff meeting

Action	Who is doing it	By date certain
__________	__________	__________
__________	__________	__________
__________	__________	__________
__________	__________	__________
__________	__________	__________
__________	__________	__________
__________	__________	__________
__________	__________	__________

decide to invite a local oral surgeon to come to a lunch meeting in your office and discuss advancements in implant treatment modalities. The team members could determine which surgeon they want to learn from, and someone could be asked to make a contact for a lunch session.

You might even find more referrals from that oral surgeon after he or she discovers the quality of your office and your staff. If a decision is made by the group, that item would go on the action list for reporting at the next team meeting.

One objective of this list is to affirm to everyone that suggestions that are supported by the group are followed up and completed. A second objective is to make sure good ideas are not lost. Within days of your team meeting, this list should be posted in the office so it is visible to every staff member during the month between gatherings of the team.

Reports: Hygiene, Dentist, Supplies, Gift Account

What reports are important, what data do you track, and who does the tracking? First, the dentist must establish the vision for success in patient care, hygiene services, financial payments, and all other office systems. This creates the outcomes to be measured and discussed by your team. In this way you encourage a shared vision for exactly what constitutes "order without control" in your office. Once the vision is understood and valued by the team, it is the dentist's responsibility to have a staff member in charge of tracking every essential, team-selected outcome. Agree, in advance, to the desired target for success in each of these business areas and determine who in the office is primarily responsible for tracking and achieving the desired outcome. If any of these numbers are significantly outside the desired target range, the person in the office known to be primarily responsible for that outcome should be prepared to discuss possible solutions and help set in place an action plan for improvement. The dentist may sometimes check the data during the month, and the dentist will certainly build support for achieving success; however, the

dentist is not presenting the report and is not the first one to comment on the report. This staff meeting is a team-driven model, not a dentist command model.

After months of tracking and evaluating office outcomes, it becomes easier for the staff member in charge to report on the successes and the weaknesses of your chosen outcomes. If your objective is to have office supplies at 6% of production and you have made one person responsible for ordering supplies, that person can budget purchases to stay in the selected range. If the monthly results are unusually high, the responsible person can explain what purchases were necessary and how the total can be averaged down in the coming months. Eventually the most rewarding role for a good leader-dentist is to act as cheerleader for the empowered team, whose members act as if they are responsible for the success of the dental office.

There is a delicate but necessary balance between your real need to focus on specific results to be fully successful in the business of dentistry and still allow the individual team members to take responsibility for their actions and their results.

This part of the meeting is devoted to sharing selected office information with everyone. A team supports actions and decisions more fully if its members understand the "why" behind a decision. People do not argue with their own data.

Hygiene report: During the report section of the meeting there would be a summary of the activities on the hygiene side of the practice. This report is essential whether you have one part-time or a mixture of part-time and full-time hygienists. This data is useful for the team today and are useful for you as your practice grows and you track changes in the flow of patients and staff over the life of your career. This report might include the number of patient visits, number of sealants, number of quadrants of scaling and root planning, number of periodontal maintenance visits, dollars per hour produced, and number of broken appointments in the last month as a percentage of total hours available.

Dentist report: There would also be a report of the dentist's new patient numbers, production success, future preblocks scheduled, insurance billing, and accounts receivable tracking.

The necessity of strong dental leadership cannot be overemphasized. Determine your indices for success, monitor the level of achievement, celebrate your good numbers, and determine, as a team, how to improve your weak numbers. The targets you choose to track will slowly evolve as your practice experience grows. You may start out tracking production and collection numbers and move on to separate the dentist numbers from the hygienist numbers. You may track accounts receivable over 90 days and then realize that a better number to track is percentage of daily production collected at the front desk each day. There are no perfect data set for your office. As your collaborative abilities increase, so will your awareness of the subtle pieces of information that influence your desired outcomes. The critical element is that

you, as a group, decide what measures success for your dental office and that you, as a team, determine how to achieve your chosen definition of an effective dental practice.

Supplies report: Another report that should be a regular part of the shared information at your staff meeting is the supplies report. It should be given by the individual on the team who is responsible for ordering, purchasing, and tracking supply costs. The target for supply expense might be 6% of your office monthly production. Your actual cost for supplies is compared to the target, and a report is given by the person who orders supplies for your team. The supply expert would report monthly success and year-to-date success. You could even report hygiene supply cost, goal versus actual, as well as dentist supply cost, goal versus actual, to give you a better idea where your expense was in variance. The objective is for the entire office team to feel ownership in the process to stay under a specific overhead target each month and to share that information in a way that allows input for improvement.

Gift account report: The gift account is a reporting of small gifts that have been given to patients since the last meeting. One person is in charge of sending cards and prepurchased gift certificates to patients who, for example, celebrated an anniversary, who received an award, or who were admitted to the hospital with an injury. Any staff member at any time can suggest that a gift be sent. One person in the office is designated as gift officer to have cards and certificates on hand and to be the person to send messages whenever appropriate. Any one staff member could sometimes sign the card, or multiple staff members might sign the card, as appropriate. There is no need to notify the dentist when it is decided to recognize an individual. The gift officer has an allowable monthly maximum to work from, and within that parameter, he or she is free to send gifts anytime during the month. Announcement of the recipient's name and the gift is made at the gift account section of the agenda. For some in the room, this is the first time they may realize that recognition was given.

The objective of the gift account is to provide every staff person an opportunity to recognize some of the special people who have entrusted their care to your team. Each person in your office should feel a personal responsibility for remembering and rewarding your patients. Staff recognition antennae should be on alert all the time. Imagine the buzz in the community when flowers and a card from two or three staff members arrive at the hospital for the new baby. Or just imagine the number of friends who might learn of the gift certificate to a local bookstore that is received with a signed personal card from your office when a student in your care was inducted into the National Honor Society.

Housekeeping List

In this part of the meeting, discuss any nonurgent ideas or questions that came up since the last team meeting.

Table 19.4. Housekeeping list.

Post immediately after last staff meeting

Item to discuss	Who	How much time
___________	______	______
___________	______	______
___________	______	______
___________	______	______
___________	______	______
___________	______	______
___________	______	______
___________	______	______
___________	______	______

A blank sheet headed “housekeeping list” is posted in the staff area at the beginning of the month. It has space outlined for the topic of interest, the name of the person who wants to raise the issue, and the approximate time required to allow group discussion. Every staff person is encouraged, during the month, to put any original idea he or she has or any question that arises on the list. Anything placed on the housekeeping list does not require urgent action and would generally benefit from some consensus building before an action is taken. If the air conditioning is not working, for example, that needs attention immediately and would not be added to the housekeeping list. If, however, you are wondering about having a cleaning service come in three times a week instead of the current two times, that question should be placed on the housekeeping list. It is a question that could be answered spontaneously by the dentist on the day your assistant had a concern about something on the carpet. Or, it could just be forgotten or ignored by a team member. However, if this question is placed on the housekeeping list by the individual who recognized the problem, at any time during the month, it will lead to a staff meeting discussion and understanding of all the issues surrounding office cleanliness. An office conversation will acknowledge the desire of the team member to have a very attractive office. It will also allow every team member to appreciate the consequences of cleaning his or her own work area, the cost of current vendors, and public perception of cleanliness in your office.

Table 19.4 is an example outline for a housekeeping list.

By putting this and similar topics on the housekeeping list, posted on the staff room wall, it encourages every team member to think, every day, about ways to improve the office. Their input and advice and questions are encouraged. This is part of empowering your team to take responsibility for the success of the practice.

Using a housekeeping list takes a staff question out of the realm of the dentist or office manger being a one-person, autocratic, problem solver. The staff

member may wish someone could just go out and buy different magazines for the office, but this is a good time to pause and ask for the issue to go on the housekeeping list for the next month. Then the whole group can have a discussion about patient reading habits and marketing to specific patient interests, and after this, you may give a staff member a budget to be responsible for all patient reading material. This is a situation when the best action is to not just say something but, rather, to help others get involved in the solution as well. It also allows you, the dentist, time to think about an issue and obtain more background information before the full team discusses the concern. Most important, this type of sharing is part of allowing everyone to be part of the learning and decision-making process.

Decisions that are owned by the team are more likely to be valued and implemented as a team. Individual team members do not argue with a decision that was developed as a group. Putting a question that is not urgent on the housekeeping list for full discussion will, by itself, lead to dramatically diminished back office chatter about who makes decisions and how they are made.

There are definite concerns that ultimately fall to the dentist alone to make the decision. This housekeeping list activity does not transfer all leadership responsibility to the group. If there is a patient care decision to make regarding the choice of dental laboratory, or if the cost of some suggestion is prohibitive or the timing is inappropriate, it will be up to the dentist to make the decision. A housekeeping list during staff meetings is not one step toward absentee leadership. This is the highest form of leadership, creating a real-life experience of shared responsibility toward a shared team vision of an ideal oral health environment.

The staff and the office will have benefited even in situations where the dentist encouraged full discussion and the group's choice cannot be immediately accomplished. Examples might include adding another front desk staff member, purchasing a new piece of equipment, or remodeling of the building. First, they benefit by feeling that they are a valued part of a team working in all ways to make the office better. Second, they will have a fuller understanding of all the factors contributing to the perceived problem. Remember the cleanliness problem that was raised earlier? It could even be that each person does more end-of-day cleanup in their respective area, thereby eliminating entirely the need for a third day of cleaning. Third, they will witness the leader—the dentist—seriously listening and valuing and affirming the input of a group of dedicated and empowered team members.

Empowerment is not a matter of giving your staff power. They already had power in the talents and skills they possessed when you invited them to join your practice. Your role as leader is to grow that ability and release that power in a focused way. *Leadership is the ability to create an environment where it is easy for people to succeed and feel better about themselves in the process. Remember, our goal is order without control.*

Other items you might find on the housekeeping list could include such things as the scheduling of the floating holiday around the Fourth of July each

year. Having a housekeeping list discussion lets the team decide which adjoining day to take, either the day before the Fourth or the day after. Other examples of housekeeping list subjects might be a question about the appropriate background music or air temperature for the office. There may be a concern about the repeated denial of insurance claims by one specific insurer, or a change in insurance definitions in the CDT Manual.

There will be five to fifteen items on this list each month. Most items will be discussed, consensus developed, and action taken that day. A couple of items will require the moderator to ask for volunteers to act as a short-term task force to obtain more information or write up some possible solutions. In this case the item will be added to the action list schedule for a specific future meeting. Regardless of outcome, you have established that ideas for success are encouraged, heard, debated, and decided upon, and an action taken.

When a dental assistant asks you why you use a specific brand of whitening material, you might simply tell her your reason. There are times this would be most appropriate. You might also suggest that she put it on the housekeeping list and let the whole office reflect on the myriad choices of whitening materials. You might find that there are newer products that another staff member knows about that are even more effective.

Bringing this topic to a full staff meeting discussion demonstrates that you value the opinion of every member of your team on this subject. Front desk staff, assistants, and hygienists should all learn about the best whitening materials for your patients. Everyone—even the business office staff, who is also asked about whitening materials—will have a better understanding of the range of materials available and the benefits of the products you endorse. Most important, you also make real your commitment to empowering everyone to become an expert. A team is only as strong as its weakest link.

Housekeeping is not only a way to involve your team in problem solving; it is additionally a way to educate your entire office on the narrative behind some actions that may be taken for granted. This is particularly true for newer team members. Very importantly, it is also a way to model a behavior you want your whole team to emulate. If you demonstrate the respect that comes from truly listening to the emotion behind the words and concerns of your team members, they will give their fellow teammates the same respect. If you ask sincere questions, you will be more certain you have all the information necessary before a decision is made. Then you respect the will of the group and, finally, are certain the chosen action is implemented. The individual team member will expand his or her sense of ownership and commitment to the office. This establishes the foundation that allows each person to feel personally responsible for what happens each day in your office. If the results of that patient visit or that teammate encounter were not healthy, you want that business office person, that assistant, or that hygienist to take responsibility for initiating an action to achieve a different result.

If you, the dentist and leader, demonstrate integrity to the process of really being present and listening to your employees, they will learn how to do this

with your patients. They will be more willing to do this with each other, and they will come to model this behavior outside the office as well. They just may become better spouses, better community members, and better citizens because they work in your office.

This is difficult to accept for most dentists: sometimes when a problem arises the best solution is not to provide answers. Instead, the preferred action is to ask questions to help the individual discover a solution based on the questions you asked, leading him or her to think about the problem differently. Having staff meetings like this will make some decisions take longer to achieve, but the long-term implementation will be much better. Team decisions are thick decisions that infuse actions and decisions of every person every day. This creates the energy and comfort that your patients feel at every moment of contact.

Education Topic

The education topic is a unique learning opportunity each month that can be done internally or externally. Staff members are engaged in an education topic at a team meeting depicted in Figure 19.4.

Have fun with this portion of the meeting. This item should be scheduled last on your agenda, but the topic should be planned and scheduled for every meeting. This is a critical section that is often omitted from dental team meetings. Every team gathering is an opportunity for internal systems growth or external subject learning.

Internal systems growth: Internal systems ideas for the education topic section might be new dental materials, causes and treatments for bruxing, when to do implants, your new patient experience, verbal skills, dental office emergency procedures, OSHA training, insurance coding and tracking, or production

Figure 19.4. Education topic: Continuous learning involving everyone.

goals and equipment maintenance. You also need to occasionally revisit and fine-tune all the assumptions and actions about what is required to be a successful dental office. Your team meeting is also an opportunity to educate your staff and yourself about the changes and challenges of a modern dental practice. You want to make your office a full-time learning organization.

Use the educational topic portion of the meeting to introduce or expand new ideas and services to the team. You could provide the educational session yourselves by doing a thorough review of whitening techniques or the effects of and treatments for temporomandibular joint disease.

External subject learning: The education topic section often involves bringing in an outside speaker to add depth to your knowledge and add breadth to the staff. Invite, in turn, each of the specialists you refer to and ask them to come and explain why they got into dentistry or what they particularly enjoy doing in their specialty field. Some of your team may not even have met these people, and they will benefit intellectually and also have a more convincing answer when the patient asks what it is like to have wisdom teeth removed by this surgeon. Imagine the goodwill created when orthodontists can come to your office and explain why they enjoy repositioning teeth. They will bring successful case models and photos to help your team understand treatment options and referral time frames. This opportunity is especially appreciated when new specialists move to the area. They are anxious to meet all the referring dentists and to connect with the staff. This introduction time will be remembered by the specialist and by your staff many years into the future. Every few years it is helpful to have a guest return for a second or third visit, as treatment protocols change or new health risks become more of a topic of public discourse. It also creates quite a buzz among your staff members when they can tell their colleagues that they heard, at their office, a lecture by the local periodontist or oral surgeon a few weeks ago.

There are many other community members who have important background information that would expand your ability to help your patients. Many of these topic experts would relish the opportunity to see your office and visit with your staff. They just might also refer their clients and friends to your office because you take the time to be very thorough in educating your whole staff.

Imagine the benefit to your patients and your staff if the diabetes counselor from the community hospital could come and tell you about what he or she advises patients regarding oral health and the oral-systemic implications of diabetes.

Creativity and willingness to risk are the only limitations to the number of informative and successful learning opportunities available to your team. How about inviting a hospice trainer to come talk about listening to a patient who might have recently lost a loved one? Other good hour-long topics would include a pharmacist, a counselor for eating disorders, a tobacco cessation expert, or a drug and alcohol counselor.

In this era of ubiquitous information sources with a blizzard of confusing claims and recommendations, how can you possibly read enough, learn enough

to be informed? And then, how do you keep your staff informed? One way you can do this is by having 1 hour of every team meeting devoted to office education.

Why would you provide an hour every month for an education topic with the entire office team?

1. It ensures that your patients receive more complete healthcare. This develops a level of empathy and awareness that patients can see and feel. This will be a unique experience for many of your patients, who are accustomed to being rushed through the model of healthcare that says "time is money."
2. It grows the skills and confidence of every team member. Your senior certified dental assistant and your newest front desk trainee will benefit from these education opportunities. Each person will learn firsthand new background to procedures, new words to explain, and new ways to be helpful to every patient seen. Your patients will benefit, team interaction will be enhanced, and each employee will take home a new awareness that provides an enhanced level of personal satisfaction.
3. It allows you to put more responsibility for treatment descriptions and patient trust building on your highly informed and motivated team members. When the person who answers the new patient phone call knows the consequence of a diabetic with periodontal disease, he or she speaks with a confidence that bonds immediately. When the hygienist knows the laboratory sequence involved in making an all-ceramic crown, he or she has a much more convincing answer to the patient who wonders why a simple crown costs so much. When your assistant has met the surgeon and talked with and seen photos of multiple implant cases, he or she has not only the words but also the sensitivity to help the anxious college student who has just suffered a serious fall and lost a front tooth.

You can also use this education time to maximize the benefits of attending a continuing education course as a team. What if you asked each person, in advance of a full-day course away from the office, to come to the next meeting prepared to list three new things learned during the day and two things to do differently as a result of what has been learned? Imagine how much more engaged your staff would be if they had to report at next month's meeting. Imagine the outcome if someone takes notes and posts the "two things I will do differently" list on the staff bulletin board so anyone can go by and check the results of the commitment a few weeks later.

You could use the education time to write an office mission statement, draft #1, and then 2 months later you could go back and fine-tune your chosen outcomes. At a future meeting, during the education topic section you could then set up criteria for measuring progress toward your mission. Each person might be asked to identify things he or she could personally accomplish that would have the greatest impact on the newly defined dental office mission. Post these impact statements so that each person is self-linked to actions that help achieve a higher level of participation.

Your imagination is the only limitation to the growth that is possible during this regular section of team learning.

Evaluation of Meeting

This section of the meeting involves a discussion of criteria for success each month. Evaluate every team meeting to help bring the group to consensus on the chosen outcomes for every meeting.

You could identify the "how would you know?" criteria for a really perfect team meeting. List the specifics of "ideal" in advance so everyone knows what success looks like. Possible criteria could include

Start on time, 8:00 a.m. or 1:15 p.m.
Did everyone participate?
Were all subjects covered to the satisfaction of everyone?
Did everyone learn new things?
Was it fun?

Have everyone rate their responses on a scale of 1–5, with 5 being terrific and 1 being terrible.

Length and Frequency of Team Meetings

When do you have these meetings, how often are they held, and how long does all this take? Once you get over the fear of losing control of a group conversation and you decide the risk/reward balances in favor of having these meetings, these are natural questions.

Table 19.5 presents a sample staff meeting schedule.

Table 19.5. Staff meeting schedule.

Permanently posted in staff room

Month	Host	Notes	Moderator	Evaluator	Guests
January	Shirley				
February	Heidi	Shirley			
March	Jackie	Heidi	Shirley		
April	Tom	Jackie	Heidi	Shirley	
May		Tom	Jackie	Heidi	
June			Tom	Jackie	
July				Tom	
August					
September					
October					
November					
December					

Successful team meetings are a lifelong journey whose destination expands as you travel.

Start simply by having these meetings in the office, at the start of your day, 1 day a month. Begin by setting aside 2 full hours when you are fresh in the morning and let everyone build comfort with the process. After 6 months of growth, go to 3 hours and maybe eventually take a half day every month to build your team. Developing confidence and trust in a process of openness and sharing is more important than any one result. Early success is just getting everyone to speak up and being clear about building group decision dynamics. Early in the learning there are no wrong answers, and the only fault is a lack of involvement by individual team members.

Moderator for the Staff Meeting

For the first few meetings, have some senior staff members moderate the meeting. The agenda provides order to the process, so the moderator only has to keep the discussion moving, close topics when consensus is reached, and end at the appointed hour. The moderator is not the expert with the answers but, rather, a facilitator of conversations to build a harmony of result. The moderator does not call for votes or rule on opinions. The objective is openness of ideas and group consensus. “Are we agreed that Susan and Bill are going to post the sterile area schedule by Friday and everyone will select their day to be responsible so the system can start on the first of the month?” This is the role of the moderator.

One other significant obligation of the monthly moderator is to draw in the quieter team members. When the subject of discussion naturally involves a person who is known for his or her reticence, it is an expected part of the process that the shy person will speak up. It is also the responsibility of the moderator to draw them in to the conversation. “Martha, you work with this every day, what do you feel about the discussion we are having?”

Eventually, every single person in the office should be the moderator. If there are six people in the office, then each person will be moderator of the office staff meeting two times each year. Even the new dental assistant, just a few months in your office, is placed in the schedule so he or she can confidently step right in and facilitate the meeting.

Getting Started: What to Do if You Do Not Already Have Staff Meetings

1. Select a regular day of the week each month for a 2-hour meeting, like the third Wednesday of the month at 8:00 a.m. Do not change this date or time; do demonstrate your absolute commitment to meeting and growing regularly. A few months later, expand the time set aside to 3 hours, and perhaps

eat at 11:00 a.m. that day and work from noon until the end of the day's schedule.

2. For your first staff meetings, start simply. Establish a rotating schedule for just two people, perhaps moderator and note-taker, for the balance of the year. To make an easier transition to regular focused staff meetings, you might have only two or three sections instead of the full six. Perhaps start with an educational topic, reports, and rewarding experiences. I urge you to always include the rewarding experiences section and be leisurely about this section, allowing individuals to share themselves. You might have only office rewarding experiences for a few months to focus on successful patient experiences. It is easy to ask your staff to share success stories that involve three or four team members, and it encourages a focus on what is working well in your office. You can always expand the rewarding experiences section as time permits. I suggest you always do the rewarding experiences section first. It sets the tone for the balance of every single meeting. It elevates enthusiasm and reinforces the importance of a team working together for the rest of every meeting. Always start with rewarding experiences, whether you allow 2 hours or a full day for your gathering. Some easy education topics for your first meetings might include some of your referring specialists. They enjoy sharing some interesting cases, and everyone learns more about personalities and referral patterns.
3. As your success grows and the team learns that staff meetings are not just filled with the dentist complaining about the most recent crisis, you can expand the agenda and the time allowed for meeting. You could add the meeting evaluation responsibility and add a housekeeping list so more ideas could be generated between meetings.
4. Ask for suggestions of topics that staff would like to learn more about during future staff meetings. Give them some ownership of what new learning will occur. You may have a couple of subjects like whitening and implants that you feel the need to explore early in the process. The education focus will attract considerable positive interest, while the idea of closing the office, buying bagels, and paying your team to share ideas for improvement will probably raise some early uncertainty for everyone.

Dentists naturally favor consistency over creativity, but this is a growth opportunity that begs for a fresh spirit of energy and challenge. Most dentists are highly perfectionist personality types. Dentists also are fearful of starting anything new unless they know exactly how the process will turn out. As a rule, dentists would rather not attempt something new than risk the possibility of making a mistake. This is not about allowing yourself to do something you may regret. It is about beginning a journey for all of you. This is an evolving process and a personal journey that is its own reward.

If you dare to dream of smiling each day as you drive to work; if you think patients can be grateful and send appreciative notes when they find an emotional match in your office; if you can imagine a team of people whose members

are individually motivated to do well and who are comfortable encouraging each other to do well, you desperately need staff meetings. Your entire team will benefit on a daily basis when they join in the shift to greater personal success and practice success as you grow people through motivating staff meetings.

If you have ever experienced the inner peace that comes from a healthy, positive current of energy as you blend your talents with the gifts of your workmates, you know the value of an authentic team. If you can surround yourself with gifted people and establish an orderly process for the journey together, you will enjoy your dental profession to the fullest. You made your own good fortune, and you made theirs too.

Other Ideas for Staff Education Topics

- Learn about behavioral styles and personality styles by finding someone to give a self-scored inventory to your whole office. Post the results so everyone on the team can see how unique communication styles complement others to make a complete team. The options that grow out of this include learning how to use behavioral styles to help patients and learning how to use this information when you hire new team members.
- Ask each staff member to come to the next meeting with "the most difficult question you get asked." Put all the questions in a box and have a staff member draw a question out of the box and offer a good response. Then ask the whole team to brainstorm other possible answers and write out for the meeting notes some better answers to the question. Continue this until all the questions have group-developed comfortable responses. This may require two meetings to complete, but your verbal skills will improve dramatically. At the same time, the group is learning practice values and dental terminology.
- Invite a communications professor from a nearby college, a family health therapist, the infection control expert from your hospital, a stress management counselor, the local rescue service, the fire safety expert, the owner or hostess of a fine dining establishment, or a marketing expert for some other service business.
- Identify what you do well in patient relations by asking everyone to come with a list of their five or ten favorite patients and have each person tell the group why the patients they chose are special. What are the common themes of these patients, and how can you build on these positive feelings? What can you do to attract more of this type of person to your office?
- Give each person $50 and ask him or her to use it to have a real quality customer service experience before the next staff meeting. At the next meeting, allow each person to describe what exactly made the event go well or not so well. Keep a list of the qualities and feelings necessary to have an emotionally satisfying experience. Then you can brainstorm how

your individual team members can do more of this quality service in your office. Stop and ask each person to write down three things he or she can personally do to improve the quality of the patient visit. Post the list and then, next month, ask each person to report on how it is going. What do your employees see that tells them it is making a difference in the patient perception of quality in your office?

- Invite an independent financial planner to discuss life insurance needs and retirement planning to your staff.
- Ask your staff for ideas and be creative. This is fun for everyone and part of the energy that makes your office a special place to enjoy each day.

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Learning Exercises

1. Imagine that you have purchased a dental practice in which staff meetings were rarely held. How would you begin the process of adding a morning huddle? What are reasons you would give to make your staff look forward to setting aside this time? In the beginning what would your agenda include?
2. Now imagine you want to add a regular staff meeting to discuss broader topics. What are easy topics you could include in your first few meetings? What would you do to be certain the staff understood the importance you place on everyone helping to improve your office?

3. Picture your staff after a year of monthly meetings. You can see they value the learning that occurs and all would agree there is a greater sense of community in your office. The problem you experience is that some staff members dominate the meeting and others are reluctant to speak up. What things could you do to draw in the quieter people? What things could you do to increase the sense of enthusiasm and anticipation for your regular meetings?
4. What are some of the possible topics you could have on the agenda that would increase the staff knowledge about developments in dental materials or new technology?
5. How do you plan a staff meeting so everyone can be present from the start and there are few interruptions?

Part 6
Associateships

Chapter 20
About Associateships

Richard S. Callan

The term "associate" can be used as a verb, adjective, or noun. As a verb it connotes the joining together of two previously separated entities. As an adjective it substantiates the connectivity of these separate entities while introducing the possibility of one being subordinate to the other. An associate (noun) is a fellow worker, a partner, or a colleague. It is important to recognize how all three forms of this word enhance our understanding of not only what an associateship is but how it is formed, how it functions, and if it can be considered a success.

For the purpose of this chapter, an associateship will be defined as simply the partnering of an owner-dentist with an associate-dentist. The associate, as implied by definition, is in some way subject to the owner, but the two are colleagues, with an agreement to work together in some way, shape, or fashion.

Types of Associateships

The types of associateships are categorized by the relationship between the owner-dentist and the associate-dentist. The associate is an employee, someone who will eventually buy into the practice, someone who will eventually buy the entire practice, or someone who is only renting space from the owner-dentist. It is important to note that these distinctions are made for the purpose of explanation and are not to be considered static positions. The employee may eventually buy into a practice or purchase the entire practice at some point in time. It is the initial understanding between the two parties at the time the agreement is made that is important to the "success" of the associateship.

Purpose for Associateships

The purpose of entering into an associateship agreement will depend greatly on the individual. Whether an associateship can be considered a success will

depend on how closely the purpose(s) match the needs and desires of those entering into the associate agreement.

Owner-Dentist

What are some of the factors that would motivate an owner-dentist to seek out an associate?

Too Busy

Many times the dentist is so busy he or she cannot see all patients in a timely manner. Patients are calling every day with no availability in the schedule. Emergencies are becoming increasingly more difficult to squeeze into an already overloaded schedule. This type of situation can have great potential for success.

Wants to Slow Down

Many dentists reach a point in their careers when they decide they want to slow their practice down to a less demanding pace, yet not lose the patient base they worked so hard to create. This may be a good time to bring in an associate, if only on a part-time basis. Once again, it is imperative for both the owner and the associate to understand completely the specifics of the proposed arrangement. The owner must consider the impact the decreased hours of production will have on his or her income as well as the number of hours it will take to manage the new associateship. The associate must be clear on the number of hours to be worked and realize his or her responsibility to be as productive as possible in the hours allotted.

Has Space Available

A dentist may have additional, otherwise unused space within the office and wish to bring in an associate to generate income in that space. An independent contractor relationship would exist when an associate-dentist rents that additional space from the owner-dentist. The associate dentist is responsible for and makes all decisions concerning this portion of the practice. Otherwise, this associate-dentist would normally have to be classified as an employee. The main consideration in this arrangement is the equitable division of the new patients coming into the practice. Other considerations are staff utilization, equipment and supply costs, and hours of operation.

Transition into Retirement

Similar to the dentist wanting to slow down, many owner-dentists planning for retirement will bring in associates to transition their practice to them. Although generally accomplished over a period of years, this arrangement should be thought through well in advance and put in motion at a predeter-

mined date. Depending on the desires of the owner-dentist and the needs of the associate-dentist, the associate may begin on a part-time basis and gradually increase as the patient load develops and/or the retiring dentist continues to decrease time spent in the office.

Mentorship

There are many dentists who have been practicing for a number of years and who desire to pass their experience and expertise on to the next generation of dentists. Their primary motivation for bringing in an associate is to do just that. The personal satisfaction they receive from assisting in the growth of the associate is in many ways greater than the monetary gain from their efforts.

Associate

Mentorship

A large number of new dental school graduates are looking for opportunities to become involved in a successful practice to hopefully learn from the experienced owner-dentist both technical skills and the art of operating a small business. As hard as dental schools try to work these skills into their curriculum, there is nothing better than on-the-job training guided directly by the tutelage of a private mentor.

Increase Speed/Confidence

If one lacks the confidence to strike out on his or her own immediately following graduation, it is a good idea to work within someone else's practice for a period of time to help develop the confidence and speed necessary to be a successful sole practitioner. No matter how fast a procedure is completed, if it is completed incorrectly or with poor quality, it has accomplished little.

Make Money while Planning/Building a Practice

The average student debt upon graduation from dental school continues to rise for both public and private schools. Coupling this with an ever-increasing cost of setting up a practice from scratch makes the option of an associateship ever more attractive. The ability to earn money through the associateship allows the associate-dentist to not only decrease his or her debt but also save money for future professional plans.

Future Practice Partnership/Ownership

It is not uncommon for an associate-dentist to enter into an arrangement with an owner-dentist with the hopes of eventually buying into a partnership with that dentist or eventually purchasing the entire practice outright.

Not Desiring to Own Their Own Practice

It may never be the desire of the associate-dentist to possess his or her own practice. Such individuals may be content to practice their chosen profession without the burden and responsibility of all that is encumbered with ownership of a practice. This may be an individual preference and one definition of success and is no less valued than any other.

Advantages

The items listed previously under "Purpose for Associateships," once accomplished, can at the same time be considered as advantages to both the owner-dentist and the associate-dentist.

Owner-Dentist

Increased Profitability/Expenses

By bringing an associate into an efficiently operating practice, the owner-dentist can expect an eventual increase equaling approximately 30% of the associate's gross collections. The addition of the associate should be considered an investment into the practice, and like most investments, may require some time before dividends are realized. A reasonable amount of time should be allotted so that the associate can acclimate into the practice, develop a patient base for the associate, develop speed, collect on treatment rendered by the associate, and provide time for mentoring. This increased profitability will not be immediate but should be forthcoming.

More Operating Hours/Overhead

Expanding the business hours can help attract additional patients to the practice, resulting in increased productivity and profit.

Fewer Vacation Closings

The office can now be open when the associate and/or owner is either sick, on vacation, or out for any other reason. The practice does not stop unless both doctors are gone at the same time.

Less Emergency Coverage

The more doctors there are in the practice, the fewer days each has to be on call for emergency coverage.

More Free Time/Continuity of Patient Care

Having the associate in the practice can permit the owner the opportunity to be away for periods of time and still have the needs of the patients met.

Opportunity to Specialize Care

The owner-dentist may want to concentrate his or her efforts on a particular area of dentistry without losing the patients who do not require that type of service. The addition of an associate to perform those other services can allow the owner to devote additional time to that endeavor. Care must be taken not to abuse the associate by not providing him or her the opportunity to learn all aspects of dental treatment the practice has to offer.

Consultation and Fellowship

Dentistry can be a very rewarding profession. It can also be a very lonely profession. The inclusion of an associate into a practice gives both the owner and the associate the opportunity for some fellowship with an individual of like mind and interests. Not only can this be beneficial as a second opinion for difficult cases but it also can as a sounding board in time of need.

More Efficient Use of Employees

Many of the functions in a dental office are routine in nature and must occur regardless of the number of operatories or providers of care. Having staff members who are cross-trained and able to function in various areas throughout the office can be a huge bonus when an associate is added to the mix.

Purchasing Discounts

An increase in the number of patients seen in an office will likely necessitate a greater utilization of supplies and equipment. Many dental supply companies and manufacturers are willing to offer a discount when things are purchased in bulk. An increase in supplies purchased to accommodate for the increased patient flow may actually result in a decrease in cost per item, without the concomitant problem of long-term storage.

Meet Growing Demand

Many practices are unable to meet the demands of their growing population. The addition of an associate can provide opportunity to see these patients in a more timely manner.

Potential Buyer (Death, Disability, or Retirement)

The owner-dentist will likely be comforted by the fact that someone already associated with the practice is able to take over without advance notice. This is one aspect frequently overlooked within associate contracts. What is to happen if either the owner-dentist or the associate were to unexpectedly become disabled or deceased?

Associate

Initial Income Potentially Higher

An associate in a practice can probably expect to make more money initially than his or her counterpart starting a new practice. The reasons for this are obvious. He or she has no immediate business overhead and should have a source of readily available patients. Although someone purchasing an existing practice would have a patient base and immediate cash flow, there is the expense of purchasing the practice and the overhead of the practice that accompany that option.

Little or No Risk

This statement is only partially true. While there is little financial obligation in being the associate, there can be substantial professional risk. There may also be contractual stipulations restricting the associate from practicing in the area outside of the office(s) of the owner-dentist. This can be a difficult situation once the associate and family are established in the community, schools, faith organizations, and so forth.

Little or No Capital Outlay

Generally speaking, the associate has little financial obligation to the practice. Under special circumstances there may be provisions for the associate to purchase certain equipment. This is with the understanding that this equipment be allowed to leave with the associate or considered appropriately if and when the purchase into the partnership or of the entire practice is consummated.

Learn/Build Self-Confidence, Quality Skills, Speed

Without the initial burden of operating a dental practice, the associate is permitted the opportunity to concentrate on developing the quality skills, speed, and interpersonal acumen required for a successful practitioner. The desire to continue to learn and grow is one that should be evident throughout one's entire career. In essence, associateships offer an "earn while you learn" opportunity. An associate may earn a living and at the same time see how the dentist-owner developed a practice that is successful enough to hire him or her.

Disadvantages

The dynamics within a dental office change considerably with the addition of a new associate, adding complexity to almost every aspect.

More Sophisticated Management

The addition of an associate into an already busy practice does not, in and of itself, make the practice run more smoothly. Metaphorically speaking, it is like

the circus performer balancing the revolving plates on top of thin wooden poles. The inclusion of each additional plate only makes the task more difficult for the performer. The importance of the need for organization and efficiency in the office prior to the addition of another provider cannot be overemphasized, lest it all come crashing down.

Autonomy/Decision Making

All decisions made within the practice must now factor in the impact they will have on both the owner and the associate. The freedom for either party to act independently is greatly diminished.

Delay of Building Own Practice

One obvious disadvantage for the associate committed to an associateship can be the delaying of the building of his or her own practice. One compromise that can in some instances be beneficial for both the owner and the associate would be for the associate to work part time for the owner while setting up a practice somewhere outside of the noncompete area specified in the contract. This way the associate can decrease the number of days he or she works in the owner's office as his or her own practice continues to grow. Honest, open communication is the key to making this sort of relationship successful.

Making the Connection

Making the connection between the owner-dentist and the associate-dentist can be a difficult task. How does an owner-dentist looking for an associate find just the right person for his or her practice? How does the associate-dentist locate the practice that best fits his or her needs? Beyond the obvious advertising in the local newspapers and the numerous internet resources, there are many other avenues in which this connection can be made.

Recruiting the Right Associate (Owner)

How does one find an associate once the decision is made? This can be a very difficult challenge. Whenever faced with a difficult situation, it is best to envision the perfect answer to the question. What does your perfect associate look like (be realistic)? Where can such a person be found? How can I make contact with this person? What will it take to get him or her to come to my practice?

Finding the Right Practice (Associate)

How does one find the right practice? This question is as difficult as the one asked by the owner looking for an associate. Let's try a similar approach. What does the perfect practice look like? Where can such a practice be found? How

do I get in contact with such a practice? What will it take to get into that practice?

The answers to these questions are quite similar for both the owner and the associate.

Dental Schools

A good place for an owner-dentist to begin looking for a potential associate is a dental school. This does not necessarily have to be the school nearest to the practice. As the clinical testing agencies expand their number of participating states and the expansion of states allowing for licensure by credentials continues to grow, many graduates are searching for opportunities beyond their state or region. Many schools handle such inquiries through their alumni affairs office. A number of schools have recently hosted dental job fairs where dentists are invited to set up booths promoting their practices to interested students. Through these meetings, acquaintances are made and conversations are begun that can potentially lead to the formation of an associateship arrangement.

Dental Supply Companies

Another popular method of making the connection is through the local dental supply companies. Many times these company representatives are the first to know of opportunities available in their area. The owner-dentist and associate-dentist both have access to this resource. The contact information for the prospective associate should be given to the owner-dentist so that a convenient time and place can be arranged for them to meet and discuss the potential associateship.

Practice Transition Specialists

The past few years have seen the emergence of the practice transition specialist. These individuals or companies promote their services to help make the connection and direct the transition of the owner to the incoming dentist, be they potential associates, partners, or purchasers of the practice. Recognizing the need for and the potential of this business opportunity, these specialists have evolved into providing services well beyond the simple matching of an associate to a practice. The range of services offered by these specialists differs depending on the expertise of the individual(s) and the desires of the dentist(s). These services may include the locating of the associate for the practice or the practice for the associate; the personality compatibility testing of the interested parties; the development of the transition plan into associateship, partnership, and/or sale of the practice; determining the value of the practice; the financial arrangements including purchasing, tax planning, asset protection, and retirement planning; and all the legal paperwork associated with each and every step of the process. The value of making sure these activities are handled in a fair and proper manner cannot be overstated. It is, of course, a cost-to-benefit consideration, and one should make sure he or she receives the benefit of what is paid for, as these services do not come cheap.

Define Success

Traditionally, the "success" of associateships has been defined more in terms of how long they have lasted, with the reported average of approximately 2 years, perhaps less. Time is just one of the factors defining the success of an associateship. The real success of such a relationship is better determined by the purpose(s) of the parties when entering into the agreement. It is therefore imperative that both parties are clear in their own minds about what they hope to achieve through this joining together of their professional lives. If the associate is interested in future ownership of a practice and the owner only wants someone to help increase revenue, this could be a recipe for an unsuccessful associateship. On the other hand, if the associate is looking for mentorship and an opportunity to increase skills and efficiency, and the owner is looking to mentor someone while at the same time decreasing his or her practice burden, this could be a highly successful associateship relationship. Both examples could last just 1 year, with one being considered a success and the other being a failure.

Figure 20.1 reveals the potential of success for varying associate relationships depending on the expressed purpose of both the owner-dentist and the associate-dentist. The pluses (+) indicate a higher potential for success, whereas the minuses (–) may be indicative of an associate agreement with a high likelihood of being considered a failure.

As Figure 20.1 indicates, associateships are most likely to succeed when the owner's and the associate's purposes match in the areas of the associate being an employee, building/earning equity in the practice, becoming a future partner, or eventually buying out the practice. Mismatching of expectations is likely to lead to a failed associateship.

Expectations

Associate

Owner	Employee	Equity	Partner	Buy-Out
Employee	+	–	–	–
Equity	–	+	–	–
Partner	–	–	+	–
Buy-Out	–	–	–	+

Figure 20.1. Expectations for associateships.

There are, of course, many other elements to consider beyond the purpose(s) when determining the success potential of the associateship, but without a clear understanding by both parties of each other's intended goal, the chance of success is greatly diminished. It is recommended that both the owner and the associate write down, individually, what they envision their successful associateship would look like. Include a timetable of perhaps 6 months, 1 year, 2 years, 3 years, 5 years, and so on. Nothing is written in stone at this time, and these are not binding contracts, but it does allow the opportunity for each to understand the direction in which the other is planning to go.

Win-Win

Once identified, it is imperative for both parties to recognize the need to fulfill the other partner's purpose or desire. Seldom does either party get everything he or she wants in a negotiation, but if both recognize the desire of the other to be fair and earnestly seek what is ultimately best for all involved, the chance for a win-win agreement is greatly enhanced. Any arrangement made in haste that ultimately benefits one side to a much greater degree than the other cannot be considered a win-win. This type of agreement will last only as long as the less favored partner can tolerate the abuse and almost never ends amicably. Seek the win-win.

Evaluation of a Practice

Numerous well-intended owner-dentists invite an equally motivated associate into their practices, only to have the associateship end in a premature separation. How can this happen? How can a dentist with a successful practice, desiring to mentor a new practitioner, have such a negative result with an associate? Diverging personalities notwithstanding, the problem could be that the practice could not support an additional dentist. There are many factors that need to be considered. The prospective associate-dentist would also do well to take these issues into consideration when deciding whether to join a particular practice or not.

1. Am I working as efficiently as I could? Before bringing on another practitioner, the owner-dentist should review the efficiency of his or her current efforts. There is great benefit to be gained by taking a good look at how one is scheduling patients. One might consider block scheduling if it is not already being utilized. If you find that you work better in the mornings than the evenings, then try to schedule the more intense procedures when you are at your best. Hiring an assistant for your hygienist or even an additional hygienist can have a marketed effect on office productivity. An additional assistant may enable you, the dentist, to do more of what your

license qualifies you to and less of what an auxiliary is permitted to do for you. Do you have your operatories, sterilization areas, labs, and so forth organized in such a manner as to maximize efficiency? Utilize the services of a practice consultant to help identify areas in your office that may be deficient or counterproductive. Many times an unbiased eye will pick up on items that go unnoticed to those intimately associated with the process.

This would be a good time to evaluate the amount of unproductive time spent in your office. Are you, or members of your team, talking on the phone to any appreciable degree? Are certain procedures being done during patient care time that could be accomplished during hours when patients are not being seen?

Even if you are in need of an associate, bringing one into a well-oiled machine will certainly improve the likelihood of success by maximizing the benefit of another provider.

2. Are there a sufficient number of patients to support the additional provider? Depending on the type of practice and the variance of procedures being performed, this number could vary greatly. A minimum of 1,200–2,000 active patients is required for the average private practicing individual dentist. In addition, an adequate supply of new patients is required to sustain that population. Although in most cases the incoming associate will not initially have the speed to immediately double the patient supply demand, a constantly increasing supply will be required to match the combined need of both providers. What are the current marketing efforts of the office, both internal and external? How can they be improved? It may be tempting to enroll in capitation plans in order to increase your patient pool, but be cautious. If you have not already done so, there was a reason you chose not to participate in these plans. Are you now willing to go against your better judgment in order to provide patients for your new associate, committing him or her to a practice model you decided was not best for you? Is this in keeping with your desire for a win-win relationship? If you are participating in these capitation plans, be sure to take this into consideration when computing the compensation for the associate. Otherwise you could be requiring the slowest operator in the practice to work at a pace he or she is not capable of (while simultaneously providing quality treatment) in order to make a living.
3. Is the facility adequate for the additional demands? Once the office is running to maximum efficiency, it must be determined whether it can support an additional provider. This consideration involves much more that just another operatory or two. There will be additional traffic flow due to the increased number of patients coming through the office (hopefully). Additional staff will most certainly be required. Both of these will demand an increased number of parking spaces that may or not be available at your current location.

Some of these problems can be accounted for by adjusting the office schedule and extending the hours of operation. This will work fine until the associate decides he or she is tired of working late afternoon, evenings, and Saturdays so that the owner-dentist can be home by 3:00 p.m.

If staggering of office hours is not the solution, then perhaps a renovation or addition to the existing office is in order. Ultimately a new facility may be required. Although having the associate purchase the necessary equipment for the expansion is something that might be considered (these can be retained by the associate if things do not work out), requiring the associate to invest in renovations, expansion, and/or a new building is unreasonable unless the appropriate arrangements have been formalized for future ownership, either part or whole.

4. Is my staff adequate, in both number and makeup? As indicated in the section on working as efficiently as possible, the appropriate utilization of auxiliary staff will also provide the associate the opportunity to be maximally productive. Again the speed and ability of the associate must be taken into consideration before the added expense of additional staff is incurred. As the practice continues to grow, it would be unreasonable to expect that additional assistants, hygienists, and front office personnel would not be required.

Compensation Package

How is the associate to be compensated for his or her effort? Should the associate receive a salary or be paid on commission or both? Is this commission to be paid based on production or collection? And what benefits should the practice provide to the associate?

The purpose of the associateship can be the deciding factor in how the associate is to be compensated. If the agreed-upon purpose of the associateship is for the associate to work a couple of years in the practice and then move on to something else, then perhaps the easiest solution to compensation would be to offer the associate a percentage of production, less a proportionate deduction for lab expenses. Market demands may dictate these percentages. Historically, the range can be from 28% to perhaps as high as 40%.

On the other hand, if the purpose is for potential partnership/ownership, then the compensation can become quite complicated. An initial base salary may then be offered with the inclusion of a portion going into an escrow fund to be used later as the down payment. There would be a matching amount placed in the fund by the owner-dentist as a gesture of mutual commitment to the agreement. Guaranteed base salaries vary widely by market and could be as little as $60,000 to over $100,000. These salaries may or may not be tied to production/collection incentive bonuses in which associate compensation surpasses the guaranteed base when production/collection goals are reached. In order for this to be a true and timely incentive, the production goals should

be monthly goals, not yearly. For instance, if an associate is guaranteed a base salary of $100,000/year, it would be better to calculate that on a monthly basis of $8,333/month. Any productivity over the $8,333 each month would be subject to the bonus provision, as opposed to waiting until the associate produced over $100,000 for the entire year before paying a bonus.

The possibilities are as numerous as the factors involved in the compensation decision. As an employee, the associate-dentist should be entitled to all that each individual employed in the office is entitled to, and under the same provisions. This could include items such as health insurance, disability insurance, malpractice insurance, retirement plans, profit sharing, vacation time, sick leave, association dues, continuing education opportunities; the list goes on. Each item should have a dollar figure associated with it and be considered in the overall compensation package offered the associate. As with all employees, it is important that the associate understand the total expense related to being employed in the practice. Do not forget to include the monthly unemployment check that must be paid and the matching Social Security, income, and state tax.

Failure

Why do associateships fail? For the purpose of this discussion, "failure" will be defined as the premature dissolution of the association agreement. What this means is that one or both parties did not accomplish what they had hoped through the associateship and is/are seeking to end the relationship.

Lack of Written Agreement

It has been suggested that the #1 reason for the failure of an associateship is the lack of a written agreement. The ability to seal a deal with a handshake has long since gone away. The English language is imprecise at best, as evidenced by the exponential increase in litigation in our country, and the memory of the individuals involved in the agreement is either conflicting or altogether lacking. It is hard to believe that professionals will enter into an associateship without a written agreement. Putting points of agreement on paper not only records the event but also helps to clarify the intent. Still, all things considered, the success of an associateship has more to do with the people involved than the words on the paper.

Unclear Expectations

The divorce rate in this country is now over 50% for first-time marriages. It would be safe to say that certain expectations were not clear at the time of commitment, and thus ultimately unmet. Why would one enter into an associate agreement without first being as specific as possible in expressing expectations? It is difficult for anyone to meet unknown expectations.

Unfair Expectations

Many associateships do not make it through the honeymoon period because of one or both parties not living up to the expectations of the other. The owner-dentist may expect the associate to have a positive financial impact on the practice from the first day. Depending on the individual practice and the investment required to bring the associate into the practice, it may be as long as 6 months before any real profit is realized. On the other hand, the associate may expect to be able to bring home as much money as the owner-dentist within the first couple of months of practice. This, too, would seem to be an unrealistic expectation.

Inability of the Practice to Support the Associate

Despite the good intentions of both parties, a practice that cannot support both the owner-dentist and the associate dooms the associateship to fail. The owner has not done his or her homework in determining the capacity of the practice, and the associate did not search for nor find the practice indicators that would warn him or her of impending failure.

Unwillingness to Adapt

Change is more difficult for some people than for others. Neither party involved in an associateship agreement should expect to remain unchanged. The ability of individuals to compromise is imperative to the success of any undertaking and is particularly important when considering going into an associateship agreement. When the owner is unwilling to accept some changes suggested by the associate or the associate is unwilling to adapt to certain mandates from the owner, the associateship will fail. One cannot think of everything when developing the agreement, but the more that is decided ahead of time, the greater the chance for success and the smoother the road to be traveled will be.

Inadequate Compensation/Inadequate Effort on Part of Associate/Lack of Mentoring

These topics could have been discussed, perhaps, under the previous "Unclear Expectations" section for why associateships fail. Still, these subjects warrant specific attention here. The total compensation package should be clearly defined before the associate begins to work in the practice. The expectations of the owner-dentist should also be spelled out in detail. What are the production goals for the associate, and when should they be met? Are they realistic? What are the extenuating factors affecting those goals (that is, patient assignment)? What are the consequences of not meeting those goals? These are all questions that should be answered during discussions prior to employment.

One of the advantages of an associateship mentioned for both the owner-dentist and the associate is the ability to mentor and/or be mentored. How

does the owner-dentist plan on becoming a mentor; what does that mean to him or her? What does the associate expect from a mentor? New graduates may accept a slightly less lucrative associateship with the expectation of a great mentoring experience. When this experience fails to materialize, the associates may leave, feeling not only disappointed but cheated as well.

Unfair Patient Assignment

The owner-dentist is cheating him- or herself when he or she does not maximize the potential of an associate. If the associate understands from the onset that his or her role in the practice is to see only Medicaid patients and/or those participating in capitation programs and is satisfied with the compensation received for these efforts, then so be it. Can we expect this type of relationship to be a lasting one?

Another aspect of unfair patient assignment is the type of patient assigned to the associate. The owner-dentist may instruct the front desk person to assign all crown and bridge patients to him or her, thus delegating the associate to the role of supporting cast. If the owner expects the associate to be a productive participant in the practice and to someday be a partner or future owner of the practice, then an equitable distribution of all types of patients represented in the practice is a must. To assign the associate a back operatory with the oldest equipment, working with the least experienced assistant, is not a recipe for success.

Not Part of Decision-Making Process

Not having the associate be part of the decision-making process of the office can lead to a sense of not belonging with the practice. This can work in both directions; the associate may wish to be part of the process and is not. Or, the owner may want the associate to be part of the process and he or she is not desiring to do so, thus implying a lack of commitment from either or both parties.

Unfair Compensation

Last, but certainly not least, on the list of why associateships fail is the subject of compensation. This is a topic that works in both directions: either the associate feels undercompensated for the work he or she does, or the owner feels the associate is overcompensated for the amount of work produced.

Associateship Contracts

A fair associateship contract is one that meets the needs and desires of both the owner-dentist and associate-dentist. The owner-dentist and the associate should spend many hours in preparation of their agreement (or at least points

Table 20.1. Components of a dental associate contract.

Date entered into
Owner name
Associate name
Services
Term
Duties
Restrictions
Compensation
Employer obligations
Employee obligations
Insurance
Fees
Records
Solicitation of employees
Vacation
Termination
Patient assignment and operations management
Status
Noncompetitition
Notice
Indemnity agreement
Purchase
Death or disability
Financial commitment
Mediation/arbitration
Fees and costs
Entire agreement
Amendments
Enforcement of agreement
Assignability
Severability of provisions
Counterpart signatures

of understanding) prior to obtaining legal council. Although this service is invaluable to the overall process, the basics of the agreement can best be determined by those directly involved with its results. The dentists understand the operations of a dental office, and only the individuals reaching the agreement know how important each specific element is to them, and thus how hard a line to hold on what issues. Once the particulars have been worked out, each dentist can enlist the services of a lawyer to review the proposed contract not only to ensure that its provisions are legal, but to advise them as to its shortcomings and potential risks. Every contract should, of course, identify those participating in the agreement, as well the length of time the agreement will be in effect. An outline of typical components of an associate contract can be seen in Table 20.1. The following sections, although not intended to be all-inclusive, list some additional provisions that should certainly exist within

every associateship contract. It should also be understood that the each contract is an entity unto itself, and the handling of each provision is up to the individuals making the contract, not to any prescribed "norm."

Owner/Associate Responsibilities

What the owner-dentist and the associate-dentist are responsible to provide should be clearly spelled out. It is not uncommon for the owner to supply the building, the signage, the telephone listing, the staff, the equipment, and the supplies.

The associate-dentist typically is responsible for his or her own insurance (malpractice, health, and disability), dues to professional associations, licensing fees, and payment for any continuing education courses. Some contracts may provide for one or more of these benefits as the market for associateships changes.

Patient Assignment

One of the first questions the prospective associate should ask when reviewing an associateship contract is, where are my patients going to come from? This question can be answered in many ways but needs to be precisely stated in the contract. Some owner-dentists require the associate to build his or her own patient base over time, through the recruitment of patients, while others are willing to share the current patient population with the associate. The owner-dentist may decide to give all new patients to the associate for a given period of time and then alternate the assignment of new patients. Many patients would prefer to be treated by the new dentist, whose schedule is not yet full, rather than waiting a longer period of time to fit into the schedule of the owner-dentist. However it is handled, both parties should be clear on its intent and be willing to live with the consequences.

Preferred Provider Organizations/Capitation/Medicaid

If the practice does participate in one or more managed-care plans, private or public, how these patients are to be assigned must be included in the contract. This is of particular importance when the associate is to be paid according to production. This subject was covered in an earlier section but is mentioned here specifically for its inclusion in the contract. Associates earning income based on collections may have their incomes significantly and negatively influenced by "write-offs" related to managed-care plans.

Work Hours

The hours to be worked by the associate should be part of the written contract. This should consist of not only the days of the week but also the hours of the

day. This protects both the associate and the owner-dentist. Any requirements for overtime, evenings, weekends, and emergency coverage should be included. Any vacation time and sick leave must be made available to the associate, within the guidelines provided to any other eligible employee. If the office is closed for a week over the Christmas holiday and everyone else is required to use that time as part of their paid vacation, then the associate is also obliged to do so.

Noncompete/Nonsolicitation

The true intent of a noncompete/nonsolicitation stipulation is to protect the owner from losing his or her patients and/or staff to the departing associate. Such provisions are not recognized by all states and thus are not included in the contract. In the states that it is permissible, it is typical for it to be included. The noncompete and the nonsolicitation inclusions are generally defined by both time and distance; one cannot work in a practice within a certain distance from a specified location for a specific period of time. In most instances it is more the possibility of the associate taking the patients and/or staff from the owner-dentist's practice that is the real potential insult or harm. It is important to note that some dentists may own several practices at different locations, and that this stipulation may be enforceable from any or all of these locations. It is also important to be specific when defining "practice." An associate may return to school to receive a specialty degree in hopes of returning to the same area to practice. Upon returning, he or she may still be prohibited from setting up practice at the desired location because of the confines written in the previously agreed-upon contract.

Where permitted, noncompete/nonsolicitation provisions are generally enforced. The enforcement of these provisions may be related to the reasonableness of their terms. A 10-mile radius may not be acceptable in a large metropolitan area but yet completely reasonable in a rural setting. Five years may be deemed too long a waiting period and thus unenforceable. Many contracts now include language addressing the enforceability of the stated terms. A contract can stipulate a buyout of the noncompete/nonsolicitation agreements. These buyouts are generally quite expensive, and justifiably so.

As an aside, similar noncompete/nonsolicitation stipulations should also be included in a sales contract, prohibiting the selling dentist from practicing within a certain distance from a specified location (or locations) within a given period of time. The reader is encouraged to study chapter 6 on practice buy-ins and buyouts.

Compensation

The means by which an associate is to be compensated for professional service to the practice should be explained in detail. Included in the explanation would be the handling of various associated factors, such as the lab bill, taxes, indi-

Lab Fees

Off the Top

$20,000
– 2,500
$17,500
.30
$5,250

Figure 20.2. Lab fees "off the top."

Lab Fees

After Percentage

$20,000
.30
$6,000
– 2,500
$3,500

Figure 20.3. Lab fees "after percentage."

vidually specific supplies or equipment, and any personal expenses incurred by the office. It may be helpful to include an addendum to the contract with an example representing a normal month's compensation calculations. Figures 20.2 and 20.3 show the difference in the bottom line when the lab bill is either taken off the total collections (Figure 20.2) or after the associate's percentage (30%) is already compensated for (Figure 20.3), the later method taking the lab bill out of the associate's percentage of income.

Obviously, it is in the associate's best interests to have the lab bill paid "off the top" of collections rather than "after percentage." In the example, monthly collections of $20,000 with a $2,500 lab bill result in an income difference of $1,750.

Hygiene

One of the seldom-discussed and somewhat controversial issues in associateships concerns what income if any associates receive for overseeing hygiene examinations and services. This would of course apply only in practices with hygienists. Most contracts are silent on the issue, meaning that, by default, in

almost all cases, associates receive no income related to hygiene production. This default position builds in considerable profitability for the dentist-owner if the associate is assigned oversight responsibility in the hygiene area. Some contracts specify that associates overseeing hygiene activity are to receive $10 per hygiene examination, or perhaps up to 30% of hygiene production. Other contracts may specify which dental care will result in associate income from hygiene (for example, credit for examinations but not for prophies). As with all other pivotal aspects in a contract, it is critical that the owner and the associate understand and agree upon this hygiene production issue from the outset.

Insurance

The type (claims made or occurrence) of malpractice insurance and the amount of coverage required by the associate should be established within the associateship contract. Provisions should also be stipulated for additional tail coverage if necessary.

Noncompliance

It is important to include statements pertaining to the consequences of noncompliance on the part of either the owner-dentist or the associate-dentist. This can be done for each item of the contract individually or for the contract as a whole, whichever is deemed most appropriate. What happens to the associate if he or she decides to take a week off with no notice? What happens if the owner changes the associate's schedule to 3 days per week instead of the agreed-upon 5? If the contract is subsequently dissolved due to such unacceptable action, is the noncompete/nonsolicitation provision also no longer in effect? The answer to that question would depend on who may be asked: the owner or the associate.

Termination

Many contracts include a description of certain offenses that, if committed by the associate, would result in immediate termination. The owner-dentist must have the ability to protect his or her practice and patients. I would recommend this section of the contract be looked at very closely and discussed to whatever extent is necessary to establish the specific intent of its meaning. "Action unbecoming a professional" is a broad concept and open to much interpretation. This should not be a vehicle by which the owner-dentist dismisses the associate simply because things are not working out as planned.

Death or Disability

Few contracts include provisions concerning the associate in the event of the death or permanent disability of the owner-dentist. Without such provision,

the associate may be forced to relocate his or her family and start all over again. A first right of refusal or first right to purchase for the associate for the purchase of the practice might be one suggestion. A term life insurance policy on the owner-dentist, sufficient to cover the cost of the practice, can be purchased on behalf of the associate. The cost of the premium for this policy could be split by the associate and the owner, with the assignment going to the owner's beneficiaries. There are many ways to manage this unfortunate possibility. The important thing is to plan ahead, be prepared, and pray it never happens.

Provide an Out

Every contract should provide a means by which the associateship can be terminated. It is wise to recognize the fact that all agreements do not always work out as planned. It is also wise to have a plan if your particular agreement does not work out.

Conclusion

Certain assumptions have been made in the writing of this chapter. One assumption is that the owner and the associate are being honest in their dealings with each other. A poor contract agreed to by honest individuals seeking what is fair to both parties has a greater chance of success than the best contract written contract made by dishonest, egocentric individuals. The other assumption is that the owner and the associate have sought individual counsel/representation before signing a legal document. It is difficult for anyone to give equal and fair consideration to two parties, particularly when being compensated, perhaps unequally, by both parties.

Student indebtedness upon graduation from dental school has reached an all-time high. Real estate and construction costs continue to rise. The percentage of female graduates, often less likely to open up their own solo practice, continues to increase. These and many other factors are contributing to an increase in the number of dental school graduates seeking associateship positions in the United States. The need for a clearer understanding of the mechanics of this dynamic relationship has never been greater. The appreciation of its complexity and respect for its importance are absolute requirements for the ultimate success of these relationships.

Acknowledgements

The information presented in this chapter represents years of knowledge gained from various sources. Much of the same information is shared between many of the contributors, making it difficult to site one particular source for its content. Many of these individuals I have spoken to personally and/or lis-

tened to their presentations, while others I have just read from their publications. Still, I am sure there are facts that were obtained from sources long since forgotten.

I would like to recognize the following individuals for their contributions to the content of this chapter:

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Learning Exercises

1. List four types of associateship arrangements.
2. List five reasons an owner-dentist may desire an associate.
3. What are five reasons a person may seek to be an associate?
4. List ten potential advantages the owner-dentist may realize by having an associate.
5. List five potential advantages the associate may realize by entering into this arrangement with an owner-dentist.
6. What are some potential disadvantages to an associateship arrangement?
7. How can you find the right associate (associateship)?
8. What is your definition of a successful associateship?

9. List four questions the owner-dentist should answer prior to bringing an associate into his or her practice.
10. Describe how the compensation package for the associate can vary depending on the purpose of the associateship.
11. List ten potential causes of a failed associateship.
12. List ten provisions that should be stipulated in every associate contract.
13. Describe the difference between the “non-solicitation” and “non-compete” provisions of an associateship contract. What are the determinants of their enforceability?

Part 7
Money Management

Chapter 21
Protecting Yourself with Personal and Business Insurance

Christine J. Insinger

Why Insurance Is Important

While working with young professionals during the past 18 years, it has been my experience that many of you have been trained and educated in your field of dentistry; however, when it comes to the exposures you will be faced with and the protection you need to cover these exposures there is a lack of education on the following topics: liability coverage, disability insurance, life insurance, and business insurance. These topics of protection can drastically affect your family and your business. Throughout this chapter it is my intent to educate you on how you can protect yourself and your family from exposures you may not know exist and to help assist you with the type of protection your practice may need.

Personal Liability

You want to make sure you protect yourself for any liabilities that may occur. First, the most important protection you should have is protection from lawsuits. You protect yourself by purchasing good malpractice insurance. Your coverage may be provided by your employer if you are an employee. If you own your own practice, you will need to purchase malpractice for yourself. Claims-made insurance policies will cover you for malpractice claims that take place and are reported to the insurance company during the policy period. The rates for this type of coverage will be lower in the first year and gradually increase every year for the first 5 years of coverage. Claims-made malpractice is the most widely used type of malpractice insurance across the United States. When terminating a claims-made policy it is recommended that you purchase what is called a "tail," or reporting endorsement, from your prior carrier. This may be required from your prior employer. Another alternative to purchasing

a tail or reporting endorsement is to negotiate with your new employer to pick up your retro date or purchase your tail coverage. If you are the employer it is highly recommended to purchase a tail or reporting endorsement and start over as a first year dentist again with first-year rates. By doing one of these actions, you are protected for any future claims that may arise related to the time period when you had the coverage.

Occurrence insurance insures for any claim that occurs while the policy is in effect, regardless of when the claim is filed. Occurrence policies are usually higher than claims-made in the first 5 years. However, with occurrence policies it is not necessary to purchase a tail or reporting endorsement.

This coverage can be somewhat confusing. Here is a situation that you may run into. Bill is a practicing dentist and is employed by XYZ Dental Associates and the year is 2008. He remains with the practice for the next 2 years. Bill then decides to move back to the state he grew up in and join a practice that already has three dentists. Bill will be an employee for the first 2 years at his new practice. His previous employer, XYZ Dental Associates, is requesting that Bill provide verification that he purchased tail coverage.

Because of the huge expense of this coverage, Bill decides to consider some other options. Instead of paying for the tail coverage out of his pocket, he could talk to the new practice he joined and ask them to pay his tail coverage. Or he could back up his retro date with his new malpractice coverage. By picking up this retro date, his malpractice coverage with his new employer would state that it is in effect from 2008, not 2010, when he joined the new practice. This is an example of picking up the retro date.

The second area of coverage regarding liability insurance is carrying a substantial amount of liability insurance on your auto and home insurance. A big mistake most professionals make is they carry a state minimum for liability insurance on their autos. These limits are usually too low. You must remember that you may get sued on future earnings. Ultimately you do not want to work to pay off a claim that could have been handled by having higher limits at a minimal cost. Passing this exposure over to the insurance company is the best way to protect yourself.

Initially homeowner's or renter's insurance is taken out to cover one's possessions. However, the exposure you would have should someone decide to sue you from getting hurt on your property is much greater. That is why I will recommend carrying a higher limit of liability insurance to protect yourself from this exposure.

Most homeowners recognize the need for homeowner's insurance because their lender will not lend money to purchase the home without it. However, when it comes to renter's insurance, those who feel they have no valuable assets usually will not purchase renter's insurance even though they should for the liability alone.

For example, George and Lori, as most young students do, rented a modest home while going to school. They had used furniture and personal belongings that did not amount to much. Therefore, they did not see the need to purchase

renter's insurance. Within this home they had a wood-burning fireplace they used frequently. One morning, after having a fire late the night before, Lori cleaned ashes out the fireplace and put them in a metal bucket by the back door. She did not put a lid on the bucket and did not notice that the wind had picked up. The ashes blew out and caught the backyard on fire. The damage amounted to $20,000 to the structure. George and Lori then received a call from their landlord's insurance company, which wanted to know if they had renter's insurance. Little did they know that if the landlord's insurance company could prove negligence on George or Lori, they would be responsible for the damage. This is why you want to carry renter's insurance. In this situation Lori was negligent, and her renter's insurance company would have been responsible for damages.

The fact that a friend or someone you know could come on your property, get injured, and sue you if the injuries are extensive is a very high risk. So having renter's insurance will again protect you from this exposure.

To go one step further, for extra protection it is highly recommended to carry a personal liability umbrella. This coverage will extend the liability limit of your auto and homeowner's insurance under one policy. The minimum recommended amount is $1,000,000 and may go higher depending upon your underlying assets. For example, if you have $100,000 liability limit on your homeowner's or renter's insurance and $100,000/$300,000 of liability limit on your auto, you can purchase an umbrella policy to extend the limits of your home and auto an additional $1,000,000 with one policy.

If you carry all your policies with one insurance carrier, you may receive a discount for having only one carrier. In fact, it may be hard to find a separate carrier to write an umbrella policy if they do not insure the home or the auto. If they will do it, this coverage is called an unsupported umbrella policy by the insurance company. It is best to use one of the carriers you have for your homeowner's, renter's, or auto insurance. You will typically find the most discounted rates if your homeowner's or renter's, auto insurance, and umbrella policies are with the same carrier.

We have discussed protecting you against lawsuits in many areas of liability exposure, and the next area of protection that you need to protect yourself for is a disability claim.

Disability Insurance

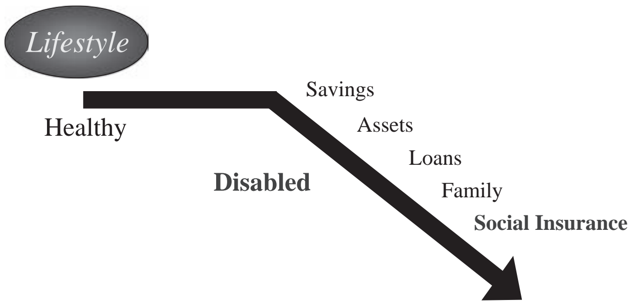
Buying disability insurance can be a very overwhelming task, and its importance is often overlooked. If I asked you what you consider your most valuable asset, I would probably get varying answers from different people. However, your most valuable asset is your ability to earn an income.

Take a look at Table 21.1 and find your potential income at different ages in life. You will see the amount of income you could lose should you become disabled. These figures do include an annual increase in income of 6%.

Table 21.1. Earning potential to age 55 with an annual 6% increase in earnings (annual income).

Age	$48,000	$100,000	$120,000
25	$7,430,400	$15,476,200	$18,576,000
30	4,347,200	11,143,500	13,368,000
35	3,796,800	7,905,800	9,492,000
40	2,635,200	5,486,500	6,588,000
45	1,766,400	3,678,600	4,416,000
50	1,118,400	2,327,600	2,796,000
55	633,600	1,318,000	1,584,000

Sources of Income Protection



"Where would the money come from?"

Figure 21.1. Sources of income protection.

With this amount of income at risk of being lost due to a disability, what would happen to your lifestyle? Where would your money come from? Who would provide you with money to pay your expenses? Refer to Figure 21.1 for more details.

Some of you would use your savings, some would sell your assets or try to take out loans. But who is going to loan money to a disabled person? One option might be to go to other family members. However, do you think your family members have your disability calculated into their budget? Some may be counting on Social Security, but at the rate this money is being displaced from our government plan, one should not be counting on this insurance. That is why you want to have a good disability plan.

There are different sources of income protection. First is group disability insurance that may be provided by your employer or by an association you belong to. Second is through individual insurance that you purchase on your own.

Group insurance through an employer or association is usually less expensive than an individual plan and may not require proof of insurability. An individual plan always requires proof of insurability unless offered on a guaranteed basis through your employer, but it usually it is not as comprehensive as an individual plan purchased on your own.

Most group plans offered through employers will have integration with certain benefits such as Social Security, some retirement plans, and workers' compensation. For instance, integration with Social Security means that you must apply for Social Security benefits and be turned down in order for your benefits from your group plan to continue coverage. This process may be required each year you are disabled and filing a claim for benefits. Social Security offset may just offset benefits you receive or could include all family members. If your spouse and children receive benefits from Social Security while you are disabled, this could offset the monthly benefit you receive from the disability carrier. Offset holds true also for workers' compensation and some retirement plans.

Group plans may offer a cost of living benefit, but in most cases they do not. Own specialty is another benefit that may or may not be offered within a group plan. Most group plans do offer partial coverage, but again this is an option left up to the employer.

One of the biggest advantages to group plans is the rates. These are usually low; however, they are not guaranteed for life. These rates are negotiated every 1, 2, or 3 years.

This is why one should consider, if healthy, purchasing an individual plan. This task may be a difficult one, especially if you have never had to purchase this type of plan. You may not know what benefits within a policy are right for you. There are several benefits that should be included in an individual plan. First and foremost is deciding on the monthly benefit amount that you are comfortable having, up to the limit the insurance companies will offer based on your income. Most companies are very close on the ratio of income to benefit they offer. Replacing lost income should be the foundation of your coverage. Once you have the benefit amount in place you need to make sure there are good definitions in the contract.

Benefit periods are the length of time the company pays the benefit while you are disabled. The most common are to age 65, 67, or 70; however, 2- and 5-year benefits are also available. Another term you should become familiar with is the elimination period. This is the time period that must pass while being disabled before the benefits from the insurance company start to pay. We refer to this as a deductible in days that must be met (for example, 90 days).

Next, you should determine what specialty definition you wish to have. The most important and the one most requested is the "own specialty" or "own occupation" definition. This definition of occupation could cover you 1 year, 2 years, 5 years, or for as long as the benefit period in your contract. This definition is known in the industry as "double dip own occupation." This means should you become disabled from your occupation and you choose to work in

another occupation, the income you earn will *never* offset your monthly benefit from the disability company. The other definition is considered a modified own occupation definition, which means should you become disabled and choose to work in another occupation, the income from the new occupation *may* offset your monthly benefit.

You will also want to make sure within the base level of coverage to include residual benefits. This benefit refers to partial disability. Should you become partially disabled you will receive part of your monthly benefit. Most companies will start partial benefits with a 20% loss of income and total benefits with an 80% loss of income. Some companies will pay total benefits at a 75% loss of income. Residual claims are often made when someone suffers an illness such as cancer. Individuals may gradually stop working throughout their treatment. Typically once they reach a loss of 80% of their income they would then be totally disabled.

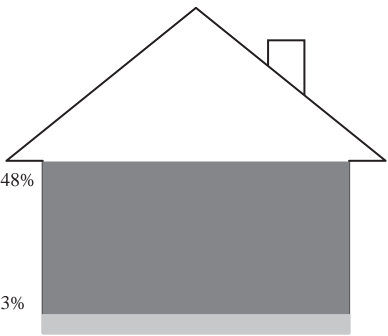
The next layer of disability coverage to have on your policy for young professionals is protecting your future insurability. Even though you may feel healthy today, you want to make sure that you are able to purchase more disability coverage in the future. Having a future insurability benefit will enable you to increase your coverage without proving good health in the future. These benefits and when you can execute them will vary depending on the company.

For some it may be difficult to understand why they would need to purchase this coverage while they are in school. Here is a situation that frequently occurs. Sidney is a young dental student who was healthy when she bought her first policy. She had an advisor named Tom who knew the exposures she could be faced with in the future. To protect her, Tom recommended that she purchase a future insurability benefit on her policy. Sidney's base coverage was $2,500 per month, which she purchased as a student. She also had the ability to increase her coverage an additional $5,000 per month.

Sidney was done with school and going out into practice with Carter Dental. They offered to pay for her disability coverage. She knew that she needed to increase her coverage; however, she was recently diagnosed with rheumatoid arthritis. She discussed this with her advisor, Tom, and he reminded her that they had a future insurability option to fall back on. She could increase her coverage up to $5,000 per month without answering any medical questions. This would give her a total monthly benefit of $7,500. Because of her arthritis she would not be able to qualify for more than this benefit, but she knew that if disability occurred, she would have this income to rely on.

The next important benefit to include on a disability policy is an inflation protection agreement. Guarding against the effects of inflation during a disability is very important. If you are young when you become disabled, inflation would slowly erode your monthly benefit over the years. If you had a 6% inflation benefit on your policy, your benefit would double in 12 years should you become disabled. This is referred to as the rule of 72. Divide the rate of inflation by 72, and this is the time period it takes for your benefit to double.

48% of all home foreclosures are the result of disability, while only 3% of all foreclosures result from death.



Source: The JHA Disability Fact Book, 2001 Edition, JHA, Inc.

Figure 21.2. Home foreclosures.

It is important to make sure the inflation benefit you have does not have a cap on it and does use compounding interest. For example, some companies stipulate that once your benefit has doubled they stop the inflation benefit. Also, some companies use simple interest instead of compounding.

Underwriting disability insurance, in my opinion, is the second hardest type of insurance to get coverage for, with health insurance being #1. At the same time it is also hard for young professionals to think they will ever become disabled; however, you are three times more likely to suffer a long-term disability than die during your working years (Society of Actuaries 1985).

If you had to depend on Social Security during a disability, you would need to be able to live off of $938 a month, the average Social Security disability income payment, which only replaces a fraction of current income. Two-thirds of American families live paycheck to paycheck; 70% of families can only afford to be without a paycheck for 1 month or less (Council of Disability Insurers 2005). Disability is the leading cause of personal bankruptcies and causes 48% of all mortgage foreclosures, compared to 3% by death (see Figure 21.2).

If I were to ask young professionals what would cause their disability, most would say an accident. However, the most common causes of long-term disability are musculoskeletal problems (22%), cancers (14%), circulatory system problems (10%), injuries/poisonings (10%), and mental disorders (9%) (JHA, Inc. 2002). Hopefully you see the importance of having a high-quality disability plan to protect you and your family.

Remember that when purchasing a disability policy you may not deduct the premiums as a business expense unless you are a C corporation. If you are and you deduct them as a business expense, the benefit paid to you once you are

disabled will be taxable upon receipt. If your employer pays for an individual policy or a group policy, the benefits are taxed upon receipt.

There are a couple of additional disabilities exposures you should have if you own your own practice or have other partners with whom you are in practice. This will be discussed later in the “Business Insurance” section.

Life Insurance

Simply stated, life insurance is a promise between a life insurance company and an individual. The promise is to pay a sum of money upon the event of the death of the insured to the named beneficiary. In order to better understand life insurance, there are a few key words I need to define.

First, the “insured” is the person named in a life insurance policy whose death triggers the paying of the death benefit. The “death benefit” is the amount of money paid at the death of the insured. The “beneficiary” is the person to whom the death benefit or face amount is paid. A trust may also be a beneficiary of the death benefit.

Another term that is important to be familiar with is the “owner of the policy.” The owner is the individual who pays the premium, or bill, for the life insurance policy. Usually, the owner is also the insured, but this is not always the case. For example, a grandparent may purchase a life insurance policy for a grandchild, a company may purchase a policy on a key employee, or a trust may be the owner.

The primary purpose of life insurance is to protect your loved ones in case of an untimely death. However, as you can see from the following list, there are many other uses.

Life insurances uses:

Income replacement
Charitable giving
Estate planning
Business protection
Retirement programs
College funding
Loan protection

People’s wants, needs, and goals are extremely diverse. Meeting those diverse needs requires a versatile tool. The uses of life insurance are only limited by your understanding of the benefits available.

Calculating the amount of coverage that a person needs in order to be adequately protected is quite complex. There are many different ways to calculate this. Most involve using the insured’s income (usually a percentage), additional income, assets, liabilities, and inflation. Because it is a complex formula,

there are many "human life calculators" or worksheets available. Many people will prefer to meet with a trusted financial advisor along with their accountant and/or attorney. An example web resource for determining life insurance needs is available at www.lifehappens.org. After going to this site, click on Life Insurance and then on How Much Do I Need?

Before I get into the specific types of life insurance, I will first discuss some terms that apply to the different types of life insurance. The first term is "mortality." Mortality is a measure of the likelihood of death. For example, a young person is less likely to die than an older person, so young people have a lower mortality rate. Mortality is studied over large groups of people so that trends can be seen and approximate predictions can be made about when a person will die. Insurance companies use mortality studies to determine how much premium to charge an individual. Because a young person is less likely to die than an old person, the amount the young person is charged for insurance will be less. Mortality costs, which are the paying out of death claims, are an expense that all products have built into their price.

In addition to what an insurance company charges to cover mortality expenses, they also charge for administration of the policy. Companies need to recover the administrative charges associated with keeping the policy in force, such as receiving premiums, sending out notices, and paying death benefits.

A final term that applies to some but not all types of insurance is "cash value." Cash value is an accumulation of dollars in a policy, but I will address this when we discuss permanent insurance.

There are basically two types of permanent insurance: whole life and adjustable or universal life. Figure 21.3 shows what happens in a permanent policy that has a cash value.

Cash Value

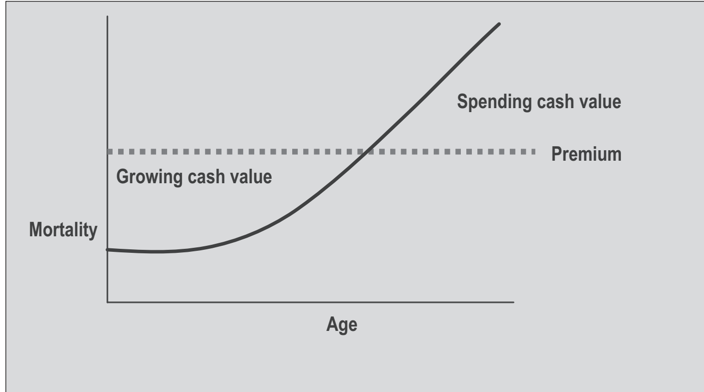


Figure 21.3. Cash value life insurance.

The vertical axis is mortality, the chance of death in any given year. This increases from bottom to top. The horizontal axis is age increasing from left to right. The curved line shows the effect of age on mortality. As you get older, your mortality increases. The straight line represents premium, which in a cash value policy is usually fixed. As you can see, in the younger years, the premium is higher than is needed to support the mortality costs of the policy. At this point, a cash value builds. This takes place so that as the insured gets older, the built-up cash value offsets the cost of the increased mortality in the older ages. This cash value allows premiums to remain level throughout the life of the insured.

Cash value does not just accumulate by putting more money into the policy. In some contracts it grows at a rate that the insurance company guarantees. Guarantees are based solely on the financial strength and claims-paying ability of the issuing insurance company. In other contracts, called variable, clients can choose different accounts to invest their cash value into variable subaccounts and then receive the return rate at which those accounts perform. Investments in variable subaccounts will fluctuate and may be worth more or less than the amount originally invested. Variable life insurance products contain fees, such as management fees, fund expenses, distribution fees, and mortality and expense charges.

There are many advantages of cash value life insurance. To begin with, it accumulates on a tax-deferred basis. Owners of these types of contracts can take advantage of this feature by putting more money into the policy beyond the premium to add to the cash value. Another benefit is that the cash value is usable by the owner of the contract. Although the primary focus of life insurance is the death benefit, the money can be accessed for anything that you would need it for. The options could include college funding, retirement, mortgages, home renovations, and so forth. Keep in mind that there may or may not be tax ramifications to this, depending upon how the owner accesses the money, how much he or she takes out, and what the current tax laws are at that time. Consult a tax advisor regarding your individual tax situation. Loans and withdrawals will also reduce your cash value and death benefit.

Whole life insurance is probably the kind of life insurance that most people think of when they think of life insurance. Just like the name implies, whole life insurance is coverage that lasts for your whole life. Whole life is cash value insurance, so the premium remains level throughout the life of the policy. Like term insurance, whole life is usually inflexible, and once the policy is purchased it can rarely be changed in any way.

Whole life insurance was the only kind of permanent life insurance until the 1970s and the development of adjustable and universal life insurance. Unlike term and whole life insurance, adjustable or universal life has built-in flexibility. These products were designed to allow clients to change different aspects of their policy at any time. Clients can increase or decrease premiums, increase or decrease death benefit amounts, and make a number of other changes.

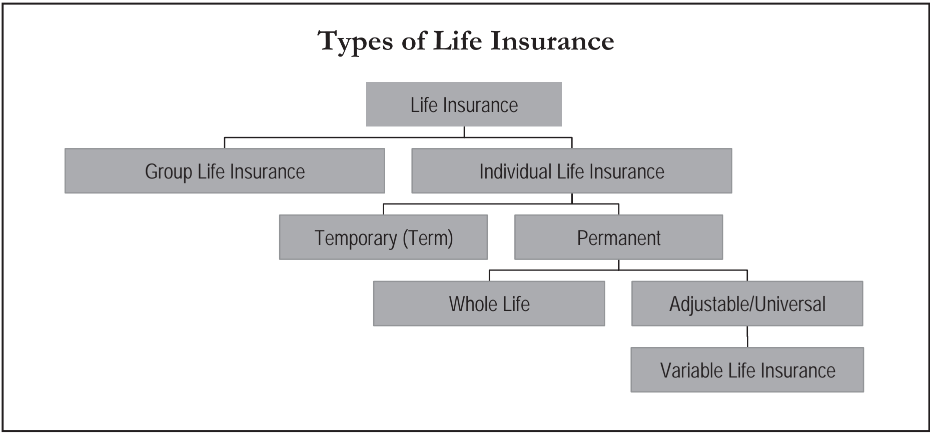


Figure 21.4. Types of life insurance. Life insurance has two main sources: group life insurance (for example, available through an employer or professional organization) or individual insurance (available through private insurance companies). Options for individual coverage include temporary or term insurance (for a specified amount of time) and permanent insurance (for the entire life span). Permanent insurance has whole life and adjustable/universal options. Variable life is a specific type under the adjustable/universal option.

This insurance is then referred to as variable adjustable life or variable universal life. This type of insurance also builds cash value, and it is in this type of insurance that a client can select to receive a variable return on his or her cash value.

With variable life insurance, an insured can choose various subaccounts to place cash value in. These accounts have a potential for a higher rate of return on this money, just like a stock has the potential to have a higher return than a fixed savings account. However, like a stock, there is also the potential to receive a lower or even negative rate of return than the guaranteed amount that the company offers. Because of this there is risk associated with this type of contract, and therefore it is only for those who are comfortable with possible volatility or fluctuations in their returns. It is important to know that your cash value, when redeemed, may be worth more or less than you originally invested. Figure 21.4 depicts the various types of life insurance available.

Term insurance is essentially a temporary coverage—that is, it covers your life for a specific length of time. Term insurance tends to be less expensive. However, on the down side, costs rise with age, and term insurance is basically inflexible. Some advisors advocate buying term insurance and investing the difference in the premium between term and other life insurance products. My strong recommendation is that you consult with your advisor to see which type or types of life insurance meet your needs.

Some individuals may ask, why do I need life insurance? Life insurance is an option, not a requirement. It is a gift of love given for someone or something. You might purchase it for financial protection for your family. When

deciding to purchase life insurance it is important to ask, what would happen to your family if you do not have it? Then, it is important to find a trusted financial advisor who can help you determine which type of coverage is best for you. Often it is a combination of term and permanent insurance.

Business Insurance

Many dental practices are faced with purchasing their own business insurance, and dentists do not know what kind to purchase and for what reasons they are purchasing this coverage. Now that we have protected you personally for different exposures, we must now protect your practice. There are going to be some claims that you will experience that are not related to you and the work you do in your practice. These claims fall under nondental exposures dealing with your practice, building, and advertising. This is why you should carry good liability coverage.

This coverage is usually sold in package form, generally called a professional office package. The main type of coverage found in this office package is general liability insurance. This protects you if you should have a patient come into your practice and fall in your office. If the patient is injured and sues you as a result of his or her fall, your liability coverage would cover it. This would not be a malpractice exposure but a general liability exposure. The minimum that I would recommend that you carry is $2,000,000. Some of the other exposures that are covered under a professional office package are coverage for the building in which you practice if you own it, your personal property in your office, business auto, and business interruption caused by a covered peril (that is, tornado or fire), which would pay a sum of money until the business was operating again. There are several other benefits that are not listed here. You want to make sure to work with an advisor in the property and casualty line in order to get adequate coverage for these exposures.

Workers' compensation is payment by employers for some part of the cost of injuries, or in some cases of occupational diseases, received by employees in the course of their work. Every state has its own legislation to determine the amount of benefit required. In 1908 the federal government was first to implement this benefit. Between 1910 and 1948 each state began to put into practice their own workers' compensation plan. You will need to become familiar with the laws for the state in which you are practicing.

Business Overhead

There are two types of disability policies that all businesses should consider. The first is a business overhead expense policy. This policy will cover the expenses of your practice should you experience a disability. One major difference between this and an individual policy is the individual policy is to

cover your family's living expenses, and the business overhead expense policy is to cover the day-to-day expenses of keeping your share of your practice operating. For example, some of the expenses that are covered under this type of plan are salaries for the employees or for a replacement for you and to assist the practice in taking over some of the patients' needs, insurance costs, utility costs associated with the practice, loans under the practice name, and rent or mortgage costs. This type of policy has shorter benefit periods. The most common benefit periods are 12, 15, or 24 months. After the benefit period, you would determine whether or not you are able to return to work. If you are not, then you must sell your share of the practice to your partners or to a new owner. The additional features you may add to this policy are residual and a future purchase option. The future purchase option would be highly recommended if you are in the start-up phase of your practice because you know your expenses will increase as your practice and patients expand. Therefore, if you were not insurable to add the coverage by proving your health, you could increase without providing evidence of insurability.

Now you have yourself and your family protected with an individual policy and your practice protected for a year or more for your share of the expenses. What if you were not able to return to your practice due to your disability and it was in your best interests to sell your part of the practice to the other partners? Would your practice have the funds to buy you out? In most practices where there is more than one partner there would not be enough funds to buy out the disabled partner. It has been my experience that most practices fund a buy/sell should one of the partners die, but not very many have taken the time to address a buy/sell in case of a disability. The type of policy to cover for this exposure is a business equity policy. This policy will provide the practice, usually after 1 year, the funds to buy the disabled partner out from his or her interest in the practice. Again, this policy offers a future insurability benefit that you should consider having on the policy, especially if you are young and know that the practice value will grow.

Group Benefits

Group benefits must be looked at with two different points of view, one the side of the employee and the other the viewpoint of the employer. Generally there is a requirement that an employee work a certain number of hours per week for a certain period of time to become eligible. These requirements are determined by the employer with the insurance companies. When we refer to employees, we are assuming those who are eligible for the coverage of the benefit.

There are two types of group benefits, mandatory and voluntary benefits. Mandatory benefits require all employees to participate. Voluntary simply means that the employees have the opportunity to participate and enjoy the benefits of a group rate, but they are not required. Most mandatory benefits

are paid in part (at times entirely) by the employer. The voluntary benefits are paid totally by the employee. The most common benefits you may want to offer are group health, disability, life, and dental insurances. Many times the benefits you offer may be viewed as equally important to the prospective staff as the salary.

Let me explain the different types of health insurance coverage. First, there is the traditional fee-for-service (FOS). This type lets you use any doctor or hospital but usually costs you more. There is usually a deductible before the insurance company begins to pay. Once the insurance company begins to pay, generally you will need to still pay a small percentage of the services, such as 20%.

A health maintenance organization (HMO) is a plan where as long as you use the doctors, hospitals, and other providers in the HMO network, the HMO pays for all covered services; however, you may have to pay a small amount when you get care. Most HMOs will ask you to choose a doctor or clinic to be your primary care provider (PCP). This PCP will take care of most of your medical needs.

Within an HMO can be a point of service option (POS). This will allow the participants to go to doctors outside of the HMO, but will give advantages, such as lower fees, for remaining in the HMO.

The final type of insurance plan is a preferred provider organization (PPO). PPOs are similar to traditional fee-for-service health insurance, except they have a network. PPOs give you the choice of using any doctor or other provider you want, or using one who is part of their network.

Group health insurance is typically the most important benefit you can offer to your employees. Many insurance carriers will require you, the employer, to pay for 50% or more of the premium for the single employee rate (if your employee has a family plan, you would only be required to pay the percentage of the employee's single rate portion, not a certain percentage of the entire family rate). You will need to determine which type of coverage you want. Remember, the benefits that you offer may be a strong incentive for hiring qualified employees and retaining them.

A minimal amount of group life is often time built into your health plans. You may want to offer additional coverage for your employees to purchase. In some cases, if the numbers of participating employees are large enough, you may qualify for guaranteed insurability, meaning the employee coverage is not dependent upon a physical examination.

Group disability insurance is a benefit that is often overlooked by many employers. This can be an area in which you may differentiate your practice from your competitors. Many companies will offer multilife discounts or even guaranteed insurability if the number of participants is great enough.

Group dental insurance may also be broken into the different types of coverage: POS, HMO, or PPO. However, many dentists will self-insure their staff and their staff's family by offering to meet their dental needs and charging a

nominal amount to cover expenses. This coverage can also be a leverage tool in recruiting and retaining your employees.

It is important for you to evaluate each of the insurance carriers prior to doing business with them. Cheaper is not always better. Many dentists will shift the burden of needing to research each company by using an insurance professional who will do this work and bring the solution to them.

Group insurance benefits can be a powerful recruiting and retaining tool. You must remember, though, that it is easier to add more benefits to your benefit package than it is to remove them. Each of these programs comes with a cost to you as an employer. I try to caution all new business owners to ease into their benefits plans. This way you are always improving them at a cost you can afford.

Summary

To recap, we have discussed the importance of having good malpractice insurance and the different types of malpractice insurance so that you can make an informed decision as to whether you want claims-made or occurrence coverage. Next we discussed the liability exposure that could occur with your home and auto and the purpose for umbrella coverage. This umbrella coverage will extend the liability under your homeowner's and auto insurance an additional $1 million, $2 million, and so on.

We now know that our most valuable asset is our ability to earn an income. We protect this ability by purchasing a high-quality disability policy from a company that is financially sound. It is important for the policy to have own occupation coverage, which will have a difference between "double dip" and "modified." It is important to have not only residual coverage but also a future purchase option benefit on your policy, especially if you see your income growing significantly over the years. You should carry a cost-of-living benefit on your policy, again especially if you are young.

We found that having disability insurance is not only important for your family but for your practice as well. In many cases your practice can stay functioning while you are disabled with a business overhead expense policy that will pay your business expenses while you are disabled for a short period of time. Also, you and your partners are protected should you not be able to return to work because of a long-lasting disability. With a buy/sell policy, the practice has the funds to buy you and your family out of your shares. This enables everyone to transition smoothly.

Life insurance can provide for you and your family and practice in the future. The amount of life insurance can be determined in a variety of ways to protect loved ones or a business.

Last, it is very important to have protection for your practice and employees with a professional office package that has good liability limits to protect those

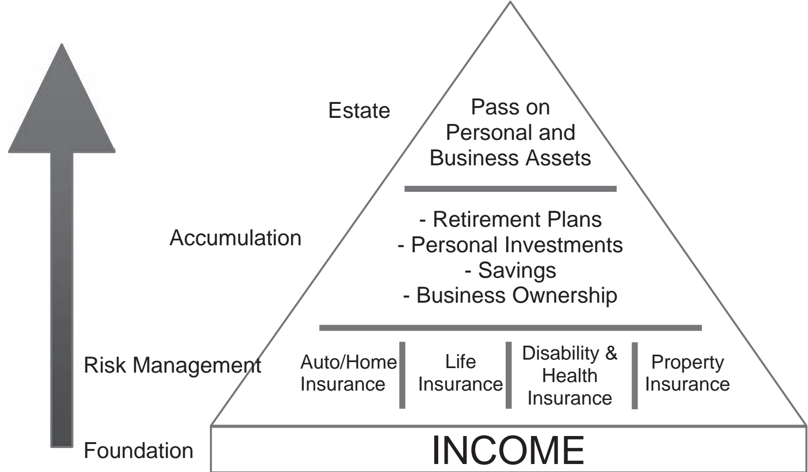


Figure 21.5. Steps to building wealth.

exposures not related to malpractice. Workers' compensation will protect some of this exposure. It is necessary to have coverage if you have employees.

I have often made mention of finding an advisor to work with you. Oftentimes you can find this person by word of mouth. I recommend that you interview two or three individuals and work with the person you feel most comfortable with. The following are some basic qualities you should look for:

- Trust and confidence
- Values the opportunity to work with you
- Wants to establish a long-term relationship with you as a friend and a financial advisor rather than just being a "number-cruncher"
- Takes the job and its responsibilities very seriously

The best advice that I can provide is to make sure to find an advisor who knows the exposures you are faced with as a young professional not only personally for you and for your family but also the exposures your practice will be faced with. It is important to make sure you have policies that offer you flexibility that will grow with you as you grow in your practice. See chapter 1 for detailed suggestions on how to select advisors.

The pyramid in Figure 21.5 shows the items discussed in this chapter. Your income or your ability to earn money is the foundation of all the items we have discussed. Without a solid foundation it is difficult to prepare for the future.

Insurance through Professional Organizations

Insurance coverage available as a benefit of membership in a professional organization presents unique opportunities. On the plus side, premiums may be less expensive and eligibility requirements may be less stringent. On the minus side, coverage may change over time, and options for coverage may be more limited. Again, consultation with your advisor is strongly encouraged before making a decision about any insurance product.

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Liability Insurance

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Disability Insurance

http://www.about-disability-insurance.com/.
http://www.disabilitycanhappen.org
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Life Insurance

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Learning Exercise

To determine the amount of life insurance needed, make sure you ask the questions, how much is tomorrow's income worth to your family? What is your human life value? If you are now making $200,000 and you want your family to have at least $100,000 per year at a 6% net after taxes, it will take $1,250,000–1,750,000 of capital to generate $100,000 annually.

Go to the website www.lifehappens.org and determine the amount of life insurance you need (or refer to similar website), or talk with a skilled advisor to calculate the amount of life insurance you need.

Chapter 22
Personal Finance, Investments, and Retirement Options

William "Dana" Webb and Brian Lange

Finance

Developing a Philosophy about Money

From many years of helping people build and maintain wealth, our firm has learned that most people do not have a philosophy about money. When asked about their philosophy, they usually develop a blank stare. The truth is that most people have never given it a thought. For this reason, it is important to first discuss the philosophy of money.

When you hold a dollar bill in your hand, you have three choices.

1. You can spend it. Most Americans know how to do this. With one of the lowest savings rates in the world, taking time to explain to Americans how to spend money is not time well spent. We will assume the reader has an understanding of this concept.
2. You can lend it. This is what most Americans do when thinking they are building wealth. The truth is no one you know has ever built or maintained wealth lending money. The term "lending" may be new to some readers. Let me give you examples. If you purchase a U.S. government bond or note, you are lending your money to the federal government. If you purchase a corporate bond, you are lending your money to that corporation. If you purchase a municipal bond, you are lending your money to that city. If you put money in a certificate of deposit or money market, you are lending your money to that financial institution. In other words, bonds, notes, CDs, money markets, fixed annuities, and so forth are lending instruments. You are lending your money and in return receive interest. Let us repeat: no one builds or maintains wealth lending money. But if you do the third thing, you will build and maintain your wealth even in retirement.
3. You can own things with it. Wealthy people own things. Think about it. Do you think Bill Gates is wealthy because he knows how to lend money? He owns a company. Do you think Warren Buffett is wealthy because he lends money well? He owns several companies. How about Donald Trump? He owns real estate. Throughout the pages of history, owners build and maintain wealth. While it is true that what is best to own changes from time to time, it has always been owners who build financial security. You

can build wealth owning real estate, your own business, stocks, or collectibles, just to name a few. What to own is up to you, but you must be an owner to build or maintain wealth.

One more thought. You should carry this philosophy with you the rest of your life. Most Americans think they should view their money differently during their retirement years. Remember: your money does not know how old you are. With interest rates at historic lows and people living longer, you must continue this philosophy into retirement to prevent outliving your money.

Being Committed to Your Financial Goals

It has been said that most people "want" to be rich, but those who build wealth are "committed" to being rich. In other words, those who build wealth are willing to sacrifice more than most people to attain their goals. Wealth builders understand that if they want a different outcome in their lives, they need to change the way they think, act, and react. Most people want a different outcome in their lives, but they do *not* want to change the way they think, act, and react. To build wealth most people need to make some fundamental changes in their character.

Be ready to spend more time focused on your wealth-building program. This is why it is very important for your spouse to share your goals. Many wealth-building trains have been derailed by a spouse not willing to allow the needed time away from the family to pursue this dream. It is so much easier with an understanding spouse, or better yet, one who can work alongside you to help you reach your goals.

Be ready to do without. You will not be able to keep up with your neighbor. They will be spending their money on the appearances of wealth, probably with too much debt. Wealth builders live way beneath their means. For example, most people think wealthy people drive expensive automobiles. The average age of a vehicle owned by a millionaire is 11 years old. In other words, those who build wealth rarely have an emotional need to keep up with the Joneses.

Be ready to use "good" debt when appropriate. Too many people do not understand debt. They either think all debt is bad or they have too much "bad" debt and not enough "good" debt. Good debt is debt against something that will probably go up in value over time. This would include mortgage and education debt. Bad debt is debt against things that go down in value almost as soon as you purchase them. This would be car debt and credit card debt. Have as much good debt as you can handle, but eliminate bad debt from your life for good.

Finally, more often than not, building wealth is a byproduct, not a main focus. Most wealthy people will tell you they were so busy doing what they loved, that the wealth was a side benefit. That is why so few wealthy people retire. They could financially retire, but they do not want to stop doing what they love. Find a vocation that you love and be the very best at it. Never stop learning. If you will read one book a year concerning your vocation, you will be light years ahead of most of your competition.

Saving Money vs. Saving Buying Power

One of the biggest myths when it comes to building wealth is that if you save money, you will build wealth. For most people this is impossible. If you want to build or maintain wealth you must save buying power, not money.

When Ford introduced the Mustang in 1964, the price was about $2,000. Today it is over $30,000. Most think the cost of the car has increased. NO!!! The dollar today is weaker than the dollar of 1964, so it takes more of them today to buy the same thing. Read the previous sentence again. Generation after generation teaches their offspring to "put your money in the piggy bank and save it for a rainy day." They teach their children to save money, an item that goes down in value every year. The child grows up, cannot figure out how to build wealth, and the parents scratch their heads. How can anyone build wealth saving something that goes down in value every year?

The problem is even worse for those who are retired. They have held the wrong definition of the word "safety" their entire lives. They believe safety is holding on to the dollars they have. Change your definition of safety now. Do not wait another day. Safety is not the preservation of principal, safety is the preservation of buying power.

Suppose one retired in 1964 and had $100,000. If he believed safety meant holding on to the principal, he might have invested in a long-term bond paying 5%. He received $5,000 per year, and when the bond matured, he received $5,000 plus the $100,000 back. He thought he was safe because he still had his principal. But he was not. When he received his first $5,000 in 1964, when the Mustang was $2,000, he could have purchased two and a half Mustangs. When he received his $5,000 in 2004, the Mustang was $30,000 and he could have only purchased one-sixth of a Mustang. Conclusion: if his definition of safety was to hold on to the principal, he was successful. However, what good did it do him? The standard of living continued to drop year after year as his purchasing power was eroded.

So, what mistake did this retired person make? He placed his money in a lending instrument and lost his buying power. Had he owned something with this money, his $100,000 would have had a better chance to have a rate of return high enough so that he would still have been enough to purchase the Mustang in 2004. In other words, to build or maintain wealth, we must be owners, not lenders, throughout our lifetime. But to do that we first need to create a budget and live within it.

Building Wealth

Making Decisions from the Revenue Side, not the Expense Side

There are basically two parts to every financial business model. Some people in the company are in charge of bringing in revenue. Others have the job of controlling expenses. Both are important. However, when a major decision is

made, it must be made from the revenue side. Too many businesses today make it from the expense side.

For years legendary CEOs (chief executive officers) would add new streams of revenue to their corporations to increase the value. This was done by creating new products or services to sell or by buying smaller companies and continuing to sell their products or services. Both increased corporate revenues.

Today, CEOs seem to be more CFO (chief financial officer) minded. They try to increase the value of a company by cutting expenses, not by increasing revenue. In the short term, this can work; in the long term it is usually a bad decision. Take the case of a widget company that moved jobs overseas to cut labor costs. The company even built a factory overseas to produce widgets between 8 a.m. and 5 p.m. But what really happened? The factory overseas produced the agreed-upon widgets between 8 a.m. and 5 p.m., closed down for 1 minute, then reopened again at 5:01 p.m. to continue to manufacture widgets for the bootleg market until 7:59 a.m. the next morning. How much can that company really save now that they have to cut prices on their own widgets to compete with the bootleg market widgets, which are produced 16 hours out of every 24-hour period? In other words, every day, twice as many illegal widgets are produced with the same quality as the legitimate ones.

We tell that story because we find most families and new business owners also make decisions from the expense side. When hurricanes swept through the Gulf Coast area, forcing gasoline prices higher, we could tell wealth builders from those who would never build wealth just by listening to their conversations. Most people were talking about how they were cutting expenses in other areas of their budget to pay for the increase in gasoline prices. In other words, they were making decisions from the expense side of the ledger. Wealth builders were talking about how they would need to increase their income to pay for the rise in gas prices. Hourly people asked to work overtime. Sales people focused on making a couple of extra sales per month. Retired people would talk about getting more aggressive with a portion of their investments. In other words, these people were focusing on increasing income, not cutting expenses.

People who build or maintain wealth make decisions from the revenue side. Successful businesses are built from the revenue side. Therefore, you must also think this way when building your dental practice while still managing overhead.

Investment Choices

Now that you understand you must be an owner to build or maintain wealth, what should you own? There are many things you can own; however, our advice would be to narrow the list to the following:

1. Own your dental practice. That may be tough to do at first, but make that one of your goals. This would be the business that you own.
2. Own the building in which your dental practice is located. This will be a longer-term goal for most dentists and would be the commercial real estate

in your portfolio. If you purchase or build a building with more square footage than you need, you can rent out the remaining square footage and have another stream of income.

3. Own what you invest in your retirement plan. This will give you a chance to own mutual funds. Make sure the mutual funds you own have all stocks in them with no bonds. Remember, bonds are a lending instrument. Your stocks, which represent ownership, will help you build more wealth over the long term.
4. Only after you have accomplished the first three items should you begin to own other things. At this point you may want to own single-family homes or apartment buildings to rent. You may wish to own individual stocks or another business that your spouse would operate. You will have many choices, but choose the investments that best fit your personality and character traits. For example, do not try to be a landlord if you lack the time or temperament to do it.

It should pointed out that the comments above are directed toward your business life. Do not forget your personal life. You should be an owner there too, and your first purchase should be a house. Most people should structure the purchase of this house with an 80% first mortgage, a 10% second mortgage, and 10% down. This should be your only personal debt. Always pay cash for your other purchases, including automobiles. Too many young people start their adult lives with car debt and credit card debt because they saw their parents do the same thing. Wealth builders have neither. This does not mean they avoid using a credit card. This means they pay the entire bill when it arrives and never let interest accumulate.

One final word of caution on this topic. We cannot tell you how many times newly retired people have told us they were so busy making money during their career that they failed to build wealth. We know you have studied hard to be a dentist, but never confuse making money with building wealth. If making money takes all of your focus, then hire a competent financial advisor to help you stay focused on your wealth-building plan. Doing this will be a good investment.

Retirement Plan Choices

There are basically three types of retirement plans: individual retirement plans, company-sponsored retirement plans, and self-employed retirement plans. This discussion will cover only the ones you will most likely consider in each category. Not every plan will be mentioned.

1. Individual traditional IRA: A tax-favored account that allows anyone under the age of 70 1/2 years, with earned income, to contribute annually. A nonworking spouse may do the same thing. Earnings are tax-deferred and contributions *may* be tax-deductible. Be aware of the income limits.

2. Individual Roth IRA: Contributions are not tax-deductible, earnings grow tax-free, and no taxes are due when you withdraw the money. Income limits apply here too, but no age limits apply.
3. 401(k): Allows employees of "for profit" companies to make pretax contributions through payroll deductions. Employers may contribute to the employee accounts, and that contribution would be a tax write-off for the company.
4. SIMPLE IRA: Businesses with 100 or fewer eligible employees can establish this plan. It resembles the 401(k), but with less testing and lower administrative costs. The maximum contribution an employee can make is much lower than the 401(k) allows. Employer contributions are mandatory up to 3.5%.
5. Profit-sharing plan: This offers companies considerable flexibility, allowing them to decide each year whether a contribution will be made and how much, up to 25% of each participant's pay. These plans can include provisions for loans and vesting schedules, like the 401(k). It does have a maximum dollar contribution limit.
6. Money purchase plan: This is similar to a profit-sharing plan. Contribution limits are the same, but the plan is not as flexible. A fixed percentage of pay must be contributed each year. That percentage is determined when the plan is established.
7. Defined benefit plan: Once your dental practice is established and your income is much higher, we recommend you switch to this type of retirement plan. It is like the old pension plans. In the other plans mentioned, the contribution is determined, but you have no idea how much money you will have in the future. This plan allows you to determine the benefit you want in the future, and an actuary calculates each year how much you will need to contribute to stay on track to achieve that benefit. Remember: a high income is needed to qualify for this plan.
8. Simplified employee pension (SEP) plan: This allows self-employed people and small business owners to make tax-deductible contributions of up to 25% of W-2 income or 20% of form 1099 income, up to a maximum dollar amount. It is very easy to administer; however, employers must contribute the same percentage of income to their employees' accounts as they do for their own account.

We cannot encourage you enough to seek professional help when deciding which plan is best for you and your employees. In most cases, the fees you pay to a good financial planner will be more than offset by the improved tax-deferred growth and tax savings.

College Funding Investment Programs

Should all parents put away something to help finance their children's college education? Most people would say "yes." Should they use one of the govern-

ment's designed savings vehicles for that purpose? Many people should not. There are two main programs to save for college.

1. The Coverdell Education Savings Account: A nondeductible cash contribution of up to $2,000 may be contributed each year, per child. The earnings grow tax-free. In certain circumstances, the account can be used to pay for elementary and secondary education as well. However, modified adjusted income limits may restrict your contributions.
2. 529 plans: These plans give you the ability to front 5 years of the annual gift exclusion (as of 2008, $12,000) per donor to each child. It is not a tax deduction, but the earnings grow tax-free if the money is used for higher education. This cannot be used for elementary and secondary education expenses. No income limits apply.

These are good plans for the right situation, but they are not for everyone. For example, the Hope Scholarship Credit and the Lifetime Learning Credit may not be claimed for the same expenses paid for by money withdrawn from these plans. For some people these credits are more valuable than the tax-free growth. Salespeople love to sell these plans because most people want to help their children save. Talk to a tax professional who does not sell these plans. He or she can give you an unbiased opinion on which is the best way for you to save for college.

There are many ways parents can fund college costs, which include student loans and borrowing against your house. Do not rule out any options until you have thoroughly discussed all options with a competent financial planner. However, remember: you can always borrow for education expenses, but you cannot borrow for retirement. Take care of your retirement first.

The Need for a Budget

A budget should be the money plan that determines your spending. A budget is the most effective financial management tool available, allowing us to control our financial resources, set and accomplish goals, and plan how our money will work for us. The purpose of a budget is to save money up front for known and unexpected expenses. The benefits of a budget are numerous and include but are not limited to:

1. A budget allows you to control your money rather than your money controlling you.
2. A budget organizes your funds into categories of expenses and savings, automatically providing records of all your transactions.
3. A budget helps you live within your means.
4. A budget can get you out of debt and keep you out of debt.
5. A budget enhances family communication by setting common goals.
6. A budget helps meet savings goals.

7. A budget assists in planning for unexpected expenditures and emergencies.
8. A budget creates extra money.
9. A budget shows areas of excessive spending, which allows you to refocus on your most important goals.
10. A budget that is followed allows you to rest better at night because you do not have to worry about how you will pay your bills.

Not all people are able to make budgets work the first time they attempt to establish financial order in their lives. The main reasons people fail to make budgets work are:

- Not understanding what a budget is and what a budget can do
- Setting unrealistic goals
- Giving up on the budget process

It is important to understand that the process of establishing financial order in your life is much like getting into and maintaining a physical exercise program. In a physical exercise program, you adjust the amount of exercise to accommodate to your physical condition and goals. You can expect to adjust your budget. You will have expenditures before all the money has been allocated for the expenditure (e.g., the clothes dryer breaks before enough money has been saved for a replacement). There will be times you or a family member purchase(s) an item on impulse. If you tell yourself you are in a learning process, the unexpected will happen and then you can get back to living on the budget. You can avoid the negative mindset and/or self-talks that lead to people giving up on the budgeting process by studying these sites: www.betterbudgeting.com/budgetformsfree.htm, www.soyouwanna.com/site/syws/budget/budget.html, www.youneedabudget.com.

Financial Goal Setting

Just as you had to set goals and develop and maintain positive self-talks to graduate from dental school, you will need to develop financial goals and maintain positive self-talks about living on a budget.

Your financial goals should reflect your values. For example, if it is important to give financially to help others, whether through your faith-based organizations or through nonprofit organizations that provide services for people in need, you should have a budget item for giving. If educating your children is important, you need a budget item for college. Professional money managers say that they can tell a person's priorities in life by looking at his or her checkbook and/or credit card bills. People spend on and save for things that are important to them.

It is a good idea to list your short- and long-term financial goals after analyzing your spending patterns and before establishing your budget. Keep in mind that goals are what you wish to achieve at the completion of your budget. You need to be prepared to adjust your goals, if necessary, to meet your financial target (www.utextension.utk.edu/publications/pbfiles/pb1454.pdf).

Budgeting Process

Step 1: Set Up Categories and Calculate Expenditures

How you start the budgeting process can set you up for success or disappointment. To maximize your success, keep all your receipts, or if married all your family receipts, for at least 2 months, preferably 3 months. Sort them by category as you accumulate them. At the end of the appointed time period, total each category. Now you have an idea of how much to budget for food, utilities, gas, lunches, coffee out, fishing, and so forth.

For periodic reoccurring bills such as car insurance and house insurance, consult your checkbook or credit card statements and budget monthly. Budget books are available at office supply stores, or you can purchase software that allows you to record your purchases and assists you with creation of your budget. Some personal computers come with software such as Microsoft Money. You can purchase other software programs such as Quicken or Microsoft Excel. Be sure to customize any budget worksheet you use. Add or delete categories to reflect your spending.

The important thing is to find a method that works for you and then use that method to record your expenditures. Table 22.1 provides an example of a personal/family budget.

Step 2: Matching Income to Expenses

The next step to successful budgeting is to take the summary of your 2- or 3-month spending patterns and compare the total monthly outflow to your monthly net (after taxes and deductions) income. If expenses run higher than income, you will need to make spending adjustments. The spending adjustments need to be severe enough to leave you with a surplus at the end of the month. Remember, the unexpected can and will happen, so put aside for the unexpected (see "Step 4: Setting up an Emergency Fund"). Savings should be a part of your budget. Savings should focus on your goals for retirement, investments, and vacations.

Step 3: Refine Your Budget

Look for ways to increase your buying power. You can increase your buying power by reducing expenses, increasing income, and taking advantage of unique opportunities.

Reducing expenses can range from cutting back on purchases, delaying purchases, or eliminating some purchases. On the positive side, reducing expenses can include buying in bulk items that you will need or timing sales (purchase next winter's coat in the spring). Many books and online sites are available to give good ideas on how to reduce expenses.

Increasing income can be accomplished without you or a family member seeking additional employment. Consolidating loans or paying off loans early

Table 22.1. Personal/family monthly budget.

Estimated take-home monthly income: ____________________

This assumes an emergency fund has already been funded. If not, fully fund this to last 3–6 months.

Automobiles (could do some through business)	**Monthly Amount**
Gasoline	________
Repairs/tires	________
Taxes/insurance	________
Leasing/loan payment	________
Car replacement savings fund	________
Clothing/shoes	________
Food	________
Nonfood (household cleaning supplies, shampoo, etc.)	________
Gifts and stamps/postage	________
Personal debt (credit cards, dept. stores, etc.)	________
School debt	________
Child care	________
House/apartment	________
Phone (local, long-distance	________
service, cell phone)	________
Water	________
Electricity	________
Natural gas/propane	________
Garbage (service provided via	________
city taxes in some cases)	________
House maintenance (repairs, etc.)	________
Mortgage/loan payment	________
Escrow for insurance/taxes	________
Cable/internet	________
Replacement funds (furnace, roof, carpet, furniture, computer, etc.)	________
Other insurance (life, liability, disability); could do through business but not recommended that you do so for disability insurance because of tax implications)	________
Entertainment (movies, eating out, etc)	________
Allowances	________
Vacation fund	________
Giving to charities	________
Health insurance, prescriptions, glasses, etc. (could do this through business depending on business entity and benefits offered)	________
Savings/retirement (beyond retirement plans through your business)	________
Pets	________
Miscellaneous (newspaper, magazines, haircuts, sports for children, children's school expenses, etc.)	________
TOTAL MONTHLY BUDGET	________

can increase income without substantially increasing taxes. Again, both your library and online sites have many useful resources to help you find ways to increase income.

Use credit cards (only if you can pay them off each month) to take advantage of money-saving offers such as free airline miles, discounts on gas, and points toward purchases. Make some of your necessary purchases online (only from reputable businesses with low or no handling charges). The cost of mailing may offset any reduced sales tax or gas required to purchase the same item locally. Again, many books and websites can help you find the bargains that best help you achieve your goals (www.utextension.utk.edu/publications/pbfiles/pb1454.pdf).

Step 4: Setting Up an Emergency Fund

With some or all of the cash you free up when you establish and live on your budget, you need to create an emergency fund. The purpose of an emergency fund is to sock away, in a safe, out-of-sight, out-of-mind account, 3–6 months of living expenses. An emergency fund not only can support you and your family in the interim between injury and disability insurance payments or the interim between changing practices but can also fund unexpected expenses such as the broken dryer or an expensive car repair. Emergency funds are an absolute necessity for financial security because they give you funds to fall back on. Without an emergency fund, you may be forced to incur credit card debt that could take you many years to pay off. You never want to be in the position where you have to buy daily necessities like food and transportation on credit.

If you do not have dependents, a 3-month emergency fund may be adequate. If you have dependents, you should set your goal for 6 months of emergency funds. The more people you support the more likely you will be to have unplanned or unexpected costs.

It is best to keep your emergency fund separate from saving accounts used for vacations or cars. Keeping it separate makes it easier to leave alone. While you would not keep your retirement funds in savings accounts, money market accounts, certificates of deposit, or short-term bonds, these are good places to stash cash you may need on short notice. These are the most liquid investments.

If you determine you need $6,000 in your emergency fund and you can afford $100 a month, pay yourself, put it away, and let it grow. Once you have reached your goal, keep investing the money but put it in a nonretirement brokerage account and watch your savings grow.

If you have your emergency fund money transferred from your paycheck to your emergency fund account, your temptation to spend it will be reduced. Remember, financial security comes over time. Do not get discouraged. Refer to http://financialplan.about.com/cs/personalfinance/a/emergencyfunds.htm.

Step 5: Passing on What You Have Learned

All the people affected by a budget should be involved in the budget as soon as they are old enough to understand the concept of money. Family budget meetings are excellent teaching opportunities for children and a good way to get the family working together on a goal or goals.

You will find many examples of budgets that give you a percentile range for how much you should be spending on housing, food, and so forth. The percentile ranges are based on average incomes. Consequently, if your income is lower or higher than average, the ranges will not be reflective of your spending patterns.

Remember that budgeting is a process that requires realistic goals and adjustments: adjustments to your goals, adjustments for unexpected expenses, adjustments in income, and so on. The more you scrutinize and understand your budget, the better the likelihood of achieving your financial goals. Stick to your budget and do not give up (www.msmoney.com/seminars/seminar4/htm/step2/create_a_budget.asp).

Exit Strategies

For Your Business

Should you structure your dental practice as a sole proprietorship, partnership, or limited partnership? What about a C corporation, S corporation, or limited liability company (LLC)? Chapter 9 addresses these organizational options in greater detail. We cannot advise you strongly enough to seek the help of a competent attorney-accountant team to help you decide which is best for you. Many times the decision is made based on which one offers the best tax situation or which best limits your exposure to a potential lawsuit. Sometimes the determination is made based on which has the least administrative costs. It is appropriate to consider all of these things. However, remember to consider something else. How will the structure I choose affect me when it is time to sell the practice? When first starting your practice, how it will be sold is probably one of the least important things on your mind. Even though this event is years away, give it some thought at the start.

For Yourself

You will die some day, a sobering thought for all mortals. How will you pass along your assets to your loved ones? Basically, it can be done in one of three ways.

1. Attach a beneficiary or transfer on death statement to everything you own. If you near the end of life with few assets, this may be all you need.
2. Use a will: Upon your death the executor will distribute your assets per your instructions. Probate court may be involved in some states and there-

fore the proceedings would be made public. The cost to probate a will can be substantial.

3. Use a trust: If you have considerable assets, a trust is probably best for you. It can shelter your loved ones from paying taxes needlessly. One need not die for the trust to be activated. A trust can actually start benefiting you while you are still alive. Since the trust does not go through a probate court, there are no proceedings to be made public. Your financial situation remains private. It costs more to prepare, fund, and manage a trust, but then you save by avoiding probate costs if all assets were held by the trust.

Make an appointment with a competent estate planning attorney. Professional guidance is very important.

Long-Term Care Planning

As we live longer, funding our care near the end of our lives is becoming a bigger concern. There are four ways to fund your long-term care expenses.

1. Long-term care insurance: It can be expensive and you will be paying regular premiums with no assurance you will ever use it. It is only as good as the company you buy it from. When the aging population starts making demands on these insurance companies, will they have enough money to meet these expenses? If not, the company goes bankrupt and you will not receive the benefits you were promised.
2. Medicare and Medicaid: Medicare is a federal program. Medicaid is a state program and therefore varies from state to state. Having federal and/or state programs pay for your longer-term care is designed for those who cannot afford to pay for it themselves. There are attorneys who specialize in designing programs to "give away" your assets so that you qualify for this support. More and more of these loopholes are being closed so that the wealthy cannot "beat the system." However, if you decide to pursue this, do not try to do it yourself. Hire a competent attorney who specializes in this area to handle the details. The process is very detailed and one minor misstep can derail your program.
3. Self-insured: Many people assume that only the very wealthy can afford to do this. Not so fast. Let us assume that the average cost of a long-term care facility in your area is $75,000 per year. If the average stay is 3 years, then one would need $225,000 to pay for it. Many dentists will have that much left in their retirement plans when they get to the last 3 years of their lives. Take the time to do the computations before you rule out this alternative
4. Relatives: Most people assume that this means financial support from a relative. That is one possibility. But what if you have a son, daughter, niece, or nephew who is a doctor or nurse? Can one of them take care of you and in return you leave that person some or all of your assets when you die?

So, how do you determine which of the four is best for you? First, decide whether or not you want to protect your assets for your children or loved ones. Some people plan to spend every dollar they have saved and enjoy life. These individuals are interested in protecting their assets for their spouse, but not for anyone else. We have heard many times, "I've told my kids the last check I write before I die will bounce." If this is your philosophy you will make different choices when it comes to paying for your long-term care than someone who wants to make sure his or her children inherit something. Keep in mind the reason you have saved your entire working life is to take care of you and your spouse in your final years. That is what the money is for. You did not save it to pass it along to the kids. However, some people want to protect it for that purpose. So, first decide whether or not you wish to pass along some of your assets to your children, then decide which way you will fund your long-term care.

Secondly, should you decide to purchase a long-term care insurance policy, be aware that not all insurance companies have strong enough balance sheets to have enough money to pay you when the baby boomers hit those peak years near the end of their lives. The drain on the assets of most insurance companies at that time will be enormous. Too many long-term care sales people focus only on the benefits of the policy they sell, which is important. But do not forget to explore the financial strength of the insurance company that issues the policy. This is best done by meeting with a competent professional who knows how to read profit and loss statements, balance sheets, and annual reports. Insurance companies are also rated by organizations. This information may also be helpful in evaluating companies.

Summary

If you decide to make financial independence and building and maintaining wealth a part of your way of life, then you will need to make a commitment as well as the necessary changes in attitude and behavior to achieve your goals. The changes in attitude and behavior will not be as difficult as your first year of dental school. In fact, if most people maintained their dental school lifestyle for a couple of years after graduation, they would make significant progress toward financial independence and building wealth. This assumes the money saved by not spending is wisely invested and/or used to pay-off "bad" debt.

The people who have achieved financial independence and accumulated wealth have left a trail to follow. All you need to do is follow the signs and do as they did:

- Develop an accurate philosophy about money
- Establish and be committed to financial goals
- Save buying power
- Make decisions on the revenue side

- Make informed investment choices
- Plan for the future (college, retirement)
- Develop and maintain a budget
- Develop exit strategies early in life

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Learning Exercises

1. Write out your philosophy on money.
2. Read at least two books on budgeting and develop your monthly budget.
3. Identify your financial goals for the next 5 years.

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