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September 5, 2003

Dear Colleague:

Re. ADA&C Practice Management Manual

The original ADA Practice Management Manual is now over five years old. I was responsible for about half of the Manual content (I understand most of the other half was provided by the American Dental Association). Although much of the information in the original Manual is still relevant, some things have changed over the past five years. The ADA&C Practice Management Committee decided in 2002 that it was time for an updated version of the Manual.

I reviewed the results of the 2001 ADA&C Dental Expense Survey and had discussions with your economic consultants. Although revenues have changed significantly, there is little evidence to suggest that key overhead ratios have changed much over the past five years. There have been modest changes in other surveyed items. I have updated all the reported statistics in the Manual, based on the results of the 2001 ADA&C Dental Expense Survey.

Also, since dental associateships are becoming more popular (over 15% of private practice dentists are now associates), and because dental practice transitions are becoming more complex and costly, a completely new section - *Dental Practice Associateships and Transitions* - has been added to the new ADA&C Practice Management Manual. I urge you to read this new section of the Manual, since most of you will be involved in a practice transition or an associateship at some point during your career.

The business of dentistry is becoming more and more complex. I commend the ADA&C for being proactive in helping its members to become better managers of their practices, and I wish you all the best for the future!

Sincerely,

H. Jack Stockton, DMD, CFP, MBA

Practice Management Manual

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Preface:

This publication of the Alberta Dental Association and College is intended to provide general background information on practice management issues and financial arrangements in a dental practice. It does not constitute policy or recommendations of the Alberta Dental Association and College, nor is it intended to provide legal, accounting, or financial advice. Appropriate professionals should be contacted for such services.

To be professionally responsible, dentists need and want a financially secure practice. In order to achieve it, they must have a clear understanding of how to manage the monetary aspects, set and collect fees and take the necessary steps to develop the proper financial support systems. Because of this, dentists need to view their dental practice as a business.

A dentist is the CEO, strategic planner, director of human resources and benefits manager in addition to being the health care provider.

The Alberta Dental Association and College gratefully acknowledges the invaluable contribution of Dr. H. Jack Stockton and the American Dental Association toward the development of the material in this manual. The Board of Directors also sincerely thanks the A.D.A. staff for their many hours of typing, editing, printing, and assembling this manual for the dentists of Alberta.

Dr. J.H. Brown
President

Section One

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Dentistry as a Business

by H.J. Stockton, D.M.D., C.F.P, M.B.A

Introduction

The practice of dentistry has changed dramatically over the past 30-35 years. In addition to the significant changes in the clinical practice of dentistry, there have been many changes concerning the business of dentistry. Some of the changes impacting on the business of dentistry include:

Significant Dental Manpower Changes

The number of dentists relative to the population of Canada has increased significantly over the past 30-35 years. For example, during the 1980's while the general population of Canada increased only nine per cent, the number of dentist's increased 28 per cent and total dental personnel increased 46 per cent. Although definitive data for the 1990's is not yet available, it appears that this trend has moderated in recent years.

Loss of Parts of the "Dental Pie"

Thirty-five years ago, dentists were the only licensed professionals allowed to make complete and partial dentures. Today, in most provinces, denturists are legally allowed to deal directly with the public, and they now account for a very high percentage of the complete and partial dentures made for the public. In addition, they are now making some bonded bridges and some of the prosthetic super-structures for implant cases. In some areas of Canada, dental hygienists are now dealing directly with the public.

Dramatic Decline in the Caries Rate

Thanks to fluoride and patient education, the caries rate has declined to only about half of what it was just 35 years ago. Many children today are caries-free.

Changes in Third-Party Coverage

Third-party dental coverage has increased from a very small percentage of patients 30-35 years ago, to a vast majority of patients today. However, the percentage of patients with third-party coverage has not increased in recent years and the quality of third-party dental plans has started to decline (witness managed care, flex-benefits, etc.).

The **bad news** is that there are now many dentists who are not doing well financially, and there are a few who have actually gone bankrupt. The **good news** is that there is a sizable group of dentists earning much larger real incomes than the top-earning dentists were 30-35 years ago. The net result is that the average real incomes of dentists have not declined and are in fact similar to those 30-35 years ago. Therefore, although many dentists today are suffering financially, the opportunity to do well has never been better.

The question arises: Why are some dentists doing so well financially while many dentists are having such a tough time making ends meet? It is the author's opinion that this dramatic difference in the financial fortunes of dentists does not relate to major differences in clinical skills; rather, this difference relates to dentists' understanding (or lack thereof) of the various aspects of the business of dentistry.

Technology and the availability of well-trained dental auxiliaries has allowed dentists who have gone to the trouble of learning about the various aspects of managing a small business to do very well financially while other dentists struggle.

Since most dentists today still practice solo or in small groups, the economies of scale are such that most dentists cannot afford to hire a competent business manager. Generally, dentists must be owner-managers. And, in today's high-overhead, competitive, complex business environment, to be successful they must understand and be able to apply many of the business principles which will be discussed in this Practice Management Manual.

Chapter One - Basics of Practice Finance

Dentistry as a Business

The goal of this manual is to demonstrate how understanding and implementing sound financial methods is critical to the success of the dental practice. You must begin by understanding dentistry as a business and applying general business principles to your practice.

Utilizing Financial Data

Having appropriate financial information allows a dentist to develop long-range plans, improve office systems for practice efficiency and manage practice costs. Understanding how to utilize and maximize this information works to ensure financial stability and planned growth. If your office systems do not allow you to gather and evaluate crucial information, you will minimize the opportunity for proper financial planning and only be guessing how to structure your practice development.

Financial Statements

Income Statements

An income statement is a summary of the office's fiscal activity over a specified period of time. It has three major elements:

- summary of revenues;
- summary of expenses;
- net income.

This statement displays all practice revenues and costs and further classifies those expenses by category. One category of the income statement is the revenue section which details the inflow of assets, such as cash and receivables resulting from the delivery of professional services.

The section on expense items contains the cost of dental supplies, facilities or services used for the purpose of generating revenue. Net income is the excess of revenues over expenses.

By analyzing expenditures and comparing this to previous years or quarters, trends can be established.

In ***Figure 1***, Dr. Mary Jones' income statement reflects a one-year period ending December 31, 2002.

Figure 1: Sample income statement

Dr. Mary Jones
Income Statement
Year Ending December 31, 2002

	Amount	Amount	%
Revenue			
Gross patient billings	$278,000		100.00
Less allowance for bad debts	(5,500)		(1.97)
Dividends	0		0
Interest income	1,500		0.54
Other income	0		0
Total revenue	$274,000	$274,000	98.57
Expenses			
Salaries (non-dentists)	$ 54,800		20.00
Dental supplies	19,500		7.12
Office supplies	7,250		2.65
Office rent expense	24,000		8.76
Laboratory charges	25,500		9.30
Interest on business indebtedness	5,600		2.04
Employee benefit costs	11,800		4.31
Uniform allowance	1,000		0.36
Depreciation expense	8,000		2.92
Marketing and promotion expense	4,300		1.57
Business taxes	3,900		1.42
Equipment repair & maintenance	1,500		0.55
Insurance			
Business and casualty	3,200		1.17
Professional liability	3,000		1.09
Telephone	2,100		0.77
Utilities	4,300		1.57
Legal & professional expense	2,500		0.91
Dues, licenses and subscriptions	2,750		1.00
Continuing education, travel & entertainment	3,250		1.18
Miscellaneous expenses	700		0.26
Total expenses	$188,950	$188,950	67.96
Net income (before taxes)		$85,050	30.61

When analyzing cost behavior, it is important to understand the effect that treatment volume has on cost. First, fixed costs are those that remain constant regardless of the level of treatment activity in the practice. Some examples of these are: utilities, rent, licenses, subscriptions, janitorial services and dues. Step-fixed costs are those that increase in certain steps as dictated by the practice volume. For example, salaries and benefits are a step-fixed cost. Once a person is hired, there is a step-up increase in fixed expenditures, which remain constant until the practice volume requires additional staff or when raises occur.

Finally, there are variable costs, which change in direct proportion to the level of activity in the practice. For example, the amount of local anesthesia used varies in direct proportion to the number of patients seen on a given day or on treatment volume. Other examples of variable costs are dental supplies, laboratory fees and billing costs.

Overhead is defined as the percentage of line item expense compared to total gross billings.

Balance Sheets

A balance sheet is shown in ***Figure 2*** and represents the financial position of the practice at a given point. In this respect, it is like a snapshot of the financial strength of the practice. Essentially, the balance sheet has three parts: assets, liabilities and shareholder's or owner's equity.

Assets:

Assets on a balance sheet are those items that a practice has acquired rights to or owns outright. As shown in ***Figure 2***, these might include cash, accounts receivable, land, buildings or equipment. Assets provide an economic benefit to the practice, because they have:

- purchasing power;
- ability to be sold and converted to cash;
- ability to offer services or rights to an owner, such as a building or dental equipment.

Liabilities:

Liabilities are the financial obligations of the practice. They may include debts owed to creditors; salaries and wages earned by employees, but not yet paid (known as salaries payable); mortgage payable; or supplies purchased on credit. Liabilities must be carefully watched. If a practice fails to pay its liabilities when due, it could result in significant credit problems and usually indicates a cash flow problem.

Shareholder's Equity:

Shareholder's or owner's equity is the excess of assets over liabilities as shown in this formula:

Assets - Liabilities = Shareholder's Equity

Shareholder's equity includes the value of any capital stock issued and the retained earnings. Retained earnings equals the accumulated net income and losses less dividends distributed to date.

Thus, the balance sheet portrays the financial position of the practice as at a certain date and is probably the best financial statement to assist in evaluating the practice's ongoing financial strength.

***Figure 2*: Sample balance sheet**

Balance Sheet for
Dr. John Smith
As at December 31, 2002

Assets		
Current assets		
Cash on hand and in banks	$ 7,000	
Certificates of deposit	$32,500	
Accounts & notes receivable	$92,000	
Merchandise/instruments inventory	$23,200	
Total current assets		$154,700
Long-term assets		
Real estate (office building)	$182,000	
Dental equipment & goodwill	$117,000	
Total long assets		$299,000
Total assets		$453,700
Liabilities		
Current liabilities		
Salaries payable	$9,200	
Accounts payable	$7,200	
Taxes Payable	$4,700	
Total current liabilities		$21,100
Long-term liabilities		
Notes payable (dental equipment)	$25,000	
Mortgages payable (office building)	$78,300	
Total long-term liabilities		$103,300
Total liabilities		$124,400
Shareholder's Equity		
Shareholder's equity		
Capital stock, 1,000 shares issued and outstanding	$300,000	
Retained earnings	$29,300	
Total shareholder's equity		$329,300
Total liabilities & shareholder's equity		$453,700

Ratio Analysis

The company profitability ratio includes information on how efficient the company is in meeting its profit objective. The most used ratio in this category is the profit ratio which is the relationship of net income to net sales:

$$\frac{\textbf{Net Income}}{\textbf{Net Sales}} = \textbf{Profit ratio}$$

For a dental office, it is the difference between 100 per cent and the commonly monitored number known as overhead. This number is easy to review both monthly and yearly. For example, if the overhead is 67 per cent, the profit ratio is 33 per cent. In proprietorships where the owner's salary or draw is taken from this profit margin, this number seems extraordinarily high and is really a combination of practice or business profit and salary for employment and management by the owner.

Solvency or liquidity ratios

The **current ratio** is a measure of the relationship between current assets and current obligations or liabilities. It is also sometimes referred to as the working capital ratio.

$$\textbf{Current ratio} = \frac{\textbf{Current assets}}{\textbf{Current liabilities}}$$

If the current ratio is 3:1 or 2:1, this indicates that the business is in good condition to repay its short-term debt. However, when the current ratio is less than 1:1, it indicates a deteriorating financial condition and a likely inability to pay current obligations.

The **quick ratio** is a measure of liquidity and is a more rigorous test of the ability to meet current obligations (that is, liabilities which are not long-term).

$$\textbf{Quick ratio} = \frac{\textbf{Quick assets}}{\textbf{Current liabilities}}$$

In the quick ratio, only the current assets that can easily be converted to cash are used in the calculation. These generally consist of cash, short-term marketable securities, accounts receivable and short-term notes receivable. Inventory is typically excluded, since it cannot be quickly converted to cash. A quick ratio of 1:1 has been used as a general rule of thumb.

The most commonly used ***activity ratio*** is accounts receivable turnover. Dividing the gross billings by the average net accounts receivable shows how many times the average receivables are collected or turned over in a period. The accounts receivable turnover is a measure of how efficiently the company collects its receivables and turns them into cash.

Most dental offices will compare their receivables with monthly productivity. Ratios of approximately 1.25:1 are considered average by most practice management experts; although, the recent ADA&C Dental Expense Survey (2001 Fiscal Year) indicated that the A/R ratio was only about 0.5:1.

$$\frac{\textbf{Accounts receivable}}{\textbf{Monthly production}} = \textbf{A/R ratio}$$

Finally, there are ***stability ratios***. The most common of these is the ***debt ratio***. A debt ratio is obviously much higher in a newly-formed and under-capitalized dental practice. Even though the acceptable debt ratio varies by industry group, dental practice debt ratios exceeding 75 per cent can, over time, suggest that the debt is too high. You may wish to review this ratio when contemplating major financing needs, such as purchasing new equipment.

$$\frac{\textbf{Total liabilities}}{\textbf{Total assets}} = \textbf{Debt ratio}$$

Chapter Two - Dental Practice Economics

by H. Jack Stockton, D.M.D., C.F.P., M.B.A.

Effective Financial Analysis and Planning

Many dentists do not have sufficient knowledge or understanding to effectively act as owner-managers of their businesses. Today it is critical that you are able to carefully monitor your practice performance, use the collected data to analyze the effectiveness of your practice, and then quickly make corrections to improve your practice performance. This section of the Manual should help you to accurately assess the financial performance of your practice and to make better business decisions.

Private Dental Practice Economics

As an introduction, and as background information for this topic, it will be useful to look at the economics of private dental practice in North America; i.e., both the characteristics of the profession as a whole, and the microeconomics of the individual practice.

First, in order to appreciate how your practice compares with other private dental practices, you should be aware of some of the economic statistics concerning private dental practice. Good published data are available for private dental practice in the United States, and it is the author's experience that the economics of private dental practice is similar in Canada. Some useful private dental practice facts are as follows:

- Average annual gross billings for general practice dentists in Canada appear to be in the range of $400,000 - $500,000; although, there are significant regional variations.

- Specialists' incomes appear to be significantly higher. Although good Canadian data are not available, specialists' gross incomes in the United States are 25 – 30 per cent greater than general practice incomes.

- The distribution of dental incomes is very wide and the distribution is skewed because of very large incomes for a small segment of the dentists. This has resulted in the mean income being greater than the median; i.e., there are more dentists below than above the average income.

- There is a distinct pattern for distribution of gross incomes, which is related to the number of years since graduation from dental school. On average, it takes dentists about 10 years in practice to reach the mean income for the profession. For the next 15 – 20 years their incomes are above average; then, after about 25 – 30 years in practice dentists' incomes drop below the average and keep dropping. Therefore, when comparing yourself to the norms for the profession, you should always take into account the number of years you have been in practice.

- As with gross incomes, there is a wide variation in practice overhead expenses. Average overhead for Canadian general dentists (excluding associate dentist compensation) is between 60 per cent and 65 per cent. Alberta practice overheads appear to be in the upper end of this range. The wide variation in practice overheads is illustrated by the fact that over 20 per cent of general dentists have overhead exceeding 70 per cent and nearly 20 per cent have overhead of less than 50 per cent.

- Generally, overhead for specialist practices is lower, with oral surgeons and endodontists having the lowest overhead ratios. Pedodontists and periodontists have the highest specialist overhead ratios.

- The average general dentist in Alberta works about 200 days per year (about 1,500 chairside hours plus an hour per day for administration). Again, there is a fairly wide distribution in the number of hours worked per year. However, it is interesting to note that a number of North American studies indicate that working more hours, on average, does not result in higher incomes. In fact, those dentists working significantly greater than the average number of hours per year have lower incomes than those working the average number of hours.

- An American study indicated that, on average, female dentists billed about two-thirds of what male dentists billed (this may or may not be true in Canada). The main reason for this difference is the fewer number of hours worked, on average, by female dentists.

- Average billings per patient per year in Canada are $300 - $400, although there is a very wide regional variation. This number is highest in Alberta, Ontario and British Columbia

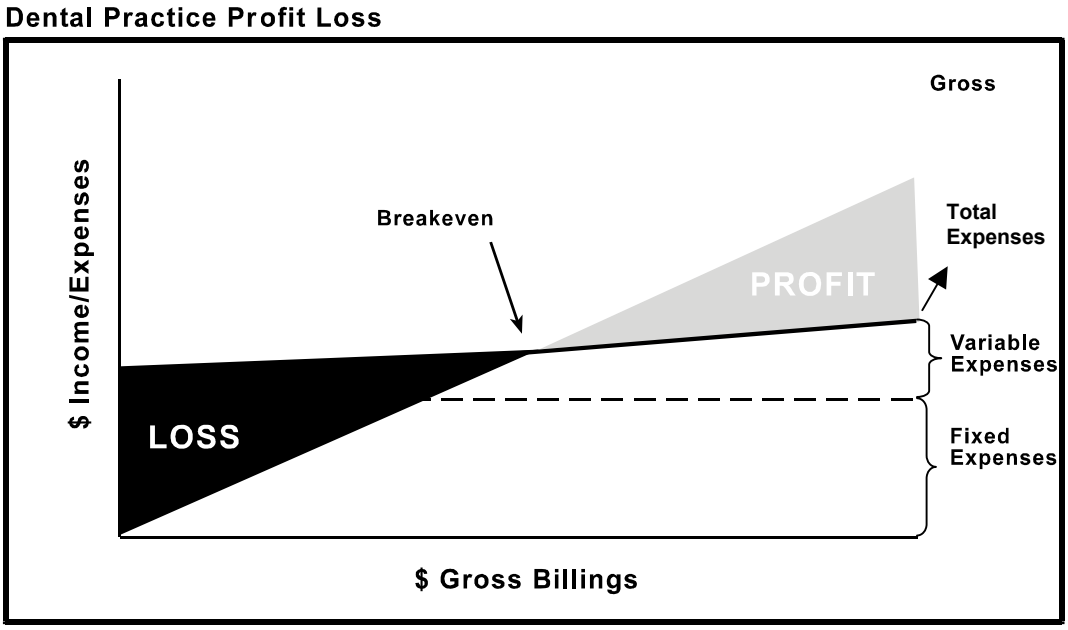
- Bad debts average only about one per cent of annual billings for Canadian dental practices (again wide variations). This is significantly better than the United States.

- Accounts receivable average about five week's billings in Canada and is generally below average in non-assignment offices. The 2001 ADA&C Dental Expense Survey indicated that in Alberta accounts receivable average only 2-3 week's billings.

Also, as a prelude to a detailed discussion of practice financial analysis, it will be useful to look at the unique microeconomics of the North American private dental practice.

High fixed expenses (overheads) and relatively low variable expenses today characterize private dental practice. This results in a high breakeven point, graphically illustrated in ***Figure 3***. In other words, substantial revenues must be generated before the costs of doing business are recouped, and your practice begins to produce a profit.

Figure 3: Graphical Illustration of Dental Practice Microeconomics



As can be seen in ***Figure 4***, the average variable expense ratio (variable expenses as a percent of total practice revenue) is only about 20 per cent, if compensation to the dentist is excluded. Therefore, once revenues reach the break-even point, each extra dollar billed adds about eighty cents to the bottom-line. In accounting jargon, the contribution margin is about 80 per cent. This is quite different from other businesses which have much higher variable expense ratios (e.g., restaurants) or other professional practices which have much lower fixed expenses (e.g., medical practices). Private dental practice can be considered a "highly leveraged" business.

Figure 4: Average Overhead Expense Percentages for Alberta General Dental Practices

REVENUE		
Dentist		70.0%
Auxiliary (Hygienist)		21.0%
Laboratory Fees		9.0%
Total Revenue		**100%**
EXPENSES		
Variable Expenses:		
Lab Fees		9.0%
Supplies - Dental		7.5%
Supplies - Office		2.0%
Bad Debts/Collection Fees		1.0%
Repair and Maintenance		0.5%
Variable Expenses Sub-total		**20.0%**
Wages and Benefits Expenses*		
Fixed Wages and Benefits	27.0%	
Variable Wages and Benefits		0.0%
Wages and Benefits Sub-total		**27.0%**
Fixed Expenses:		
Office Rent (all-inclusive)		5.5%
Other Fixed Expenses**		7.5%
Fixed Expenses Sub-total		**13.0%**
EXPENSES (excluding financing & depreciation)		**60.0%**
OPERATING INCOME (before financing & depr'n)		**40.0%**
Less, Financing Costs (net interest/lease payment)		1.5%
Less, Depreciation		2.5%
PROFIT		**36.0%**

Note:

- Expense percentages are the author's best estimate, excluding income taxes and after removing expenses not directly related to operation of the dental practice.
- (*) Wages and benefits excludes compensation to dentists (owners and associates) and above-market wages to family members.
- (**) Other fixed expenses include: Continuing Education, Conventions, Insurance Telephone, Professional Fees, Dues/Licenses/Subscriptions, Automobile, Business Tax, Advertising/Promotion and Miscellaneous.
- The average revenue mix, outlined above includes practices that do not employ a hygienist. For practices that do employ hygienists, auxiliary revenue accounts for 25-30% of total practice revenue; also, operating expenses are typically slighter higher for these practices.

In the strictest sense, all expenses are variable in the long run; e.g., a practice could be relocated once the lease expires and rent would change. However, most dental practice expenses can be easily categorized as fixed or variable over the short to medium term.

The variable expenses in a dental practice are typically dental supplies, office supplies, laboratory fees, bad debts/collection fees, and repairs/maintenance. On average, these variable costs are approximately 20 per cent of gross practice revenue; i.e., the variable expense ratio is 0.20 on average.

Fixed expenses include all costs that remain constant regardless of practice billings. Office rent, business taxes, utilities and licenses/dues are good examples of fixed expenses.

As mentioned by another author in the previous chapter, staff payroll can be considered a step-fixed expense. Also, staff wages can have a variable component in some practices (e.g., hygienists on commission), but this is the exception rather than the rule. Typically, in private dental practices, over the short-term most staff wages are fixed costs.

The percentages listed in ***Figure 4*** are for Alberta and are based on surveys of dental practice expenses and the author's extensive dental practice consulting experience. Expenses exclude income taxes, dentist compensation and expenses not directly related to operation of the dental practice. Variable practice expenses are similar in nearly all regions of Canada; but it appears that some regions of Canada have higher fixed expenses than others; e.g., staff wages as a percent of revenue seem to average about two per cent higher in Alberta than in Manitoba.

Data/Information Required to Assess Practice Performance and Make Management Decisions

One of the main reasons many dentists are not able to effectively assess practice performance and make rational business decisions is because they do not have adequate data/information. Or, if they have enough data/information, it is not organized in a manner which will allow them to easily identify specific practice weaknesses and then determine the corrective action, which should be taken.

For example, the only financial data many dentists have available to assess practice performance is last year's financial statements prepared by their accountants. And, many dentists do not accurately track new patients per month, recall patients per month, hourly production, staff turnover, etc. Nor do a large segment of dentists age their accounts receivable outstanding.

Without good data/information, organized in a useful manner, it is impossible to make good practice management decisions. A year-end financial statement prepared for income tax purposes (financial accounting), such as the Dr. Mary Jones Income Statement illustrated in ***Figure 1*** of the Chapter One is helpful to give a general idea of how the practice is doing. However, a detailed assessment of practice performance can not be done with this financial statement. Also, useful calculations, such as the break-even point and the percentage return on investment, cannot be easily done using only the year-end financial statements.

A few of the many reasons why year-end financial statements provide inadequate financial data for effective practice analysis and decision-making are as follows:

- Year-end statements are usually out-of-date by the time your accountant gets them to you;

- Most dentists implement tax-planning strategies using their dental practices, which is a good idea. However, this makes the financial information in the year-end financial statements non-reflective of the actual business operation; e.g., use of professional corporations and/or technical service corporations, wages to family members which are above or below market level, etc;

- Gross practice revenue is usually listed as one lump sum and is not broken down by source of production. For example, you must know the revenue mix for your practice to determine if the payroll expense for your particular practice is reasonable or not. This will be discussed later in this chapter;

- Fixed and variable expenses are not identified nor segregated. In order to do a break-even determination for your practice you must know the variable expense ratio for your practice. This will also be discussed in this chapter.

It is the author's opinion that, for a dentist owner-manager to do effective practice analysis and to make sound business decisions, another approach to financial record keeping must be taken for the dental practice throughout the year. At year-end, the accountant can simply reformat the financial data in order to prepare the required financial statements.

A useful financial record-keeping system should allow the dentist owner-manager to determine return on the capital invested in the practice, to assess the financial impact of contemplated practice changes, to accurately assess staff payroll and to pinpoint overhead expense trouble spots. Such a system should have the following characteristics:

- ***Data must be current.*** Monthly monitoring is best, but, at a minimum, performance should be reviewed immediately after each quarter. To be an effective owner-manager you must identify problems early and take corrective action quickly. Using year-old data to make management decisions is a recipe for poor practice management;

- ***Revenues must be categorized.*** Revenues must be segregated into at least three categories:
    1. dentist billings;
    2. hygienist/auxiliary billings; and
    3. laboratory billings.

  The revenue mix indicates the character of the practice, and changes in the revenue mix can be positive or negative and should be monitored. For example, a preventive-oriented practice typically has a high auxiliary (hygienist) billings percentage; whereas, a prosthetic-oriented practice usually has a high laboratory billings percentage. A decline in the hygienist billing percentage might be an early warning sign for problems in the recall system, or it might indicate that the loss of patients from the practice (slippage) has become greater than the gain

in new patients. A low laboratory billings percentage might indicate problems in the presentation and/or acceptance of comprehensive treatment plans for your patients. Also, as will be explained later in this chapter, it is impossible to know what a reasonable staff payroll for your particular office should be, without knowing the revenue mix for your practice;

- ***Staff payroll expense should be highlighted.*** Staff payroll is typically the largest dental practice expense item; therefore, you must very closely monitor staff payroll;

- ***Financial data must be adjusted to correct for tax planning and the use of corporations.*** The data you study must exclude artificial expenses and reflect economic reality;

- ***Consolidated revenue and expense data should be used.*** In those practices with affiliated entities, such as technical service corporations; the revenues and expenses must be consolidated in order to assess the overall operation of the practice. Arbitrary allocation of expenses between the entities will make proper assessment of practice performance very difficult, if not impossible;

- ***Depreciation/Amortization and financing costs should be isolated.*** Depreciation/Amortization claimed is arbitrary and often does not reflect economic reality; an adjustment is often required. And, financing costs (e.g., interest expense and equipment leases) typically reflect the personal financial situation of the dentist. It is not fair (or useful) to compare the operational efficiency of a self-financed practice with a bank-financed practice, unless financing costs are removed;

- ***Owner-operator fair market compensation must be estimated.*** In order to determine the return on your capital investment in the practice, you must deduct fair market remuneration to yourself for both your professional services and for your managerial effort in the practice. Fair remuneration for your professional services would be the fair market compensation to an associate dentist in similar circumstances. Typically, this is 30 – 50 per cent of the dentist's net collected billings (net of lab and hygienist billings). Estimating fair remuneration for your managerial effort in the practice may be a little more difficult. If you have a full-time paid business manager, your notional managerial compensation would be minimal; however, if you were a typical solo dentist, fair managerial remuneration would likely be about three per cent of total practice revenues. Up to six per cent of total practice revenues might be a reasonable estimate for dentists who spend an extraordinary amount of time on management tasks;

- ***All revenue and expense line items should be listed as a per cent of total professional billings as well as in dollars.*** It will be very difficult to compare your practice expenses and revenue mix to norms for the profession unless line items are listed in percent of total professional billings. Non-dental revenue items should be excluded (e.g., investment income and extraordinary items). The Dr. Mary Jones' Income Statement in ***Figure 1*** lists per cent as well as dollars; the author has found this to be the exception rather than the rule for prepared year-end financial statements;

- ***A managerial model should be used.*** The data should be organized in a "managerial" rather than in a "financial" accounting format. The Dr. Mary Jones Income Statement in ***Figure 1*** is prepared in financial accounting format. A managerial format segregates fixed and variable expenses.

A Useful Financial Model

Figure 5 illustrates a simple, versatile financial model, developed and utilized by the author, which can be used to effectively monitor and analyze dental practice financial data. It is also a convenient format for preparing a dental practice budget.

The basic model illustrated in ***Figure 5*** is for a typical solo dentist employing one hygienist. You may find this basic model adequate for your practice, or you may wish to make a few modifications and/or adjustments as necessary when there are multiple producers and you want to compare the relative effectiveness/efficiency of each producer. However, these types of modifications are simple, logical extensions of the basic model. For example, in group practices with multiple producers, in addition to analyzing the practice as a whole, each producer's efficiency could be assessed by individually allocating pro-rata expenses.

As mentioned previously, it is important that dental practices which are organized as multiple, related businesses be consolidated for monitoring and analysis purposes (e.g., a technical services corporation, a management company an/or a holding company operating in conjunction with the professional practice/corporation). For tax planning and year-end reporting purposes, adjustments and reformatting should be relatively easy if good communication is maintained with your accountant. The fine details of the management model format to be used should be decided upon in consultation with your accountant. If your general ledger is automated, year-end adjustments and reformatting for reporting purposes should be relatively simple.

Figure 5: Managerial Dental Practice Financial Model

DENTAL PRACTICE FINANCIAL MODEL

REVENUE	Dollars ($)	Percent (%)
Dentist	$	%
Auxillary (Hygienist)	$	%
Laboratory Fees	$	%
TOTAL REVENUE	$	100 %
EXPENSE		
Variable Expense:		
Laboratory Fees	$	%
Supplies – Dental	$	%
Supplies – Office	$	%
Bad Debts/Collection Fees	$	%
Repair and Maintenance	$	%
Variable Expense Sub-total	$	%
Wages and Benefits Expense:		
Fixed Wages and Benefits	$	%
Variable Wages and Benefits	$	%
Wages & Benefits Sub-total	$	%
Fixed Expense:		
Office Rent (all inclusive)	$	%
Other Fixed Expenses (*)	$	%
Fixed Expense Sub-total	$	%
TOTAL EXPENSE (excluding financing and depreciation)	$	%
OPERATING INCOME (before financing/depreciation)	$	%
Less Financing Costs (Interest/Lease Payments)	$	%
Depreciation	$	%
PROFIT	$	%
Less Dentist Remuneration	$	%
Management Remuneration	$	%
RETURN AFTER OWNER REMUNERATION	$	%

(*) - Other fixed expenses includes: Continuing Competence, Insurance, Telephone, Professional Fees, Dues/Licenses/Subscriptions, Automobile, Business Tax, Advertising/Promotion, Miscellaneous.

Dental Practice Analysis and Planning Techniques

Once you have collected and organized current financial data for your practice, as described previously, you are ready to analyze this data to determine if there are any practice problems, to make managerial decisions and to plan for the future. There are a number of analytical and planning techniques that can be very useful to the dentist owner-manager, including the following:

A. Comparing your practice with revenue and expense norms for the profession;
B. Break-even analysis;
C. Assessment of profitability (i.e., return on invested capital);
D. Analysis of staff payroll;
E. Income projection;
F. Preparation of a practice budget.

Now that you understand how to collect and organize current financial data for your practice in a managerial format, the application of each of these analytical/planning techniques will be discussed in turn:

A. Comparing Your Practice with Revenue and Expense Norms

Once financial data for your practice is adjusted and organized as previously discussed, one of the simplest and most useful analytical techniques which you can use to pinpoint practice problems is to compare the revenue and expense data for your practice to norms for the profession.

Comparing financial data for your practice for the most recent period to norms for the profession is very useful; however, it is equally important to observe trends for your practice over a number of reporting periods. You should look at each line item in the reformatted Income/Expense Statement to identify significant variations from the norms for the profession and to note trends in the data over time. However, some items are more significant than others.

The most important line item concerning practice overhead expenses is “Expenses (excluding financing and depreciation)” in other words, operating overhead. If the operating overhead percentage for your practice is above the norm (about 60 percent in Alberta), then further investigation is warranted. The most important overhead expense items to assess are staff payroll, supplies and rent. Together with lab fees, these items usually account for more than three-quarters of practice operating expenses. Analysis of staff payroll will be discussed in detail later in this chapter.

An above-average overhead percentage for dental supplies should be investigated further since it could be caused by any of the following: sloppy dispensing of expensive materials, poor inventory control, buying fad items which are not used, poor shopping for price, theft of supplies, etc.

Rent is a fixed expense and cannot be easily reduced. A high overhead percentage for rent usually indicates that the facility is underutilized. Revenue must increase to reduce the

overhead percentage for rent. If your practice is a new, rapidly growing practice this is not of too much concern. But, if your practice is well established this is of considerable concern, since a rapid increase in billings is unlikely to occur. In the latter case, it is sometimes worthwhile to consider bringing another dentist with his/her own patient base into the office to cost-share and make better use of the facility; or, you might consider relocation when the lease expires.

Lab fees are both an expense and a revenue item and merely reflect the character of your practice. The level of lab fees are not of concern, unless a very low lab fee percentage indicates a lack of comprehensive treatment for your patients.

As an example, it might be worthwhile to look at Dr. Mary Jones' income/expense data as reported in ***Figure 1*** in the previous chapter. ***Figure* 6** shows the expense data reformatted into a more useful managerial format. The revenue mix is not reported in the Dr. Jones Income Statement, as is typical of year-end financial statements. Since staff wages are modest, we shall assume that Dr. Jones does not employ a hygienist.

The first thing to observe when comparing the Dr. Mary Jones practice **(figure 6)** to norms for the profession in ***Figure 4***, is to note that Operating Income is only 35 per cent of gross billings, compared to the norm for Alberta practices of about 40 per cent. In other words, Operating Overhead Expense for Dr. Jones is 65 per cent. A five per cent variation from the norm is significant and should be investigated further.

As can be seen when comparing line items in ***Figure 6*** with the norms in ***Figure 4***, variable expenses are similar to the norm. Also, at first glance, wages and benefits are below the norm; however, a more detailed analysis of staff payroll is required (discussed later in this chapter).

The main overhead problem for Dr. Jones lies with rent and other fixed expenses. Rent and other fixed expenses are about one and one-half times the norm for the profession (19.4 per cent compared to 13.0 per cent). This indicates a very much under utilized facility. For a start-up practice this may not be a long-term problem, if billings increase rapidly. But, for an established practice, this is not an easy problem to solve since the solution is to either significantly increase billings or to reduce the cost of the facility. As an owner-manager, Dr. Jones must make some decisions and take action; e.g., implement an aggressive marketing campaign, have another established dentist join her and cost-share, etc.

Dr. Jones should also look back at the financial results for previous periods to observe any significant trends.

Although the solution to Dr. Jones' problem is not simple, unless she is aware of the specific nature of the problem, she will not know what types of corrective action to consider. This is the plight of many dentist-owners today…they know something is wrong, but they are not exactly sure of the problem. This type of practice analysis and monitoring should help you to identify specific problems at an early stage. Once you know exactly what the problem is, you can then formulate a plan for corrective action, which will deal with the specific problem.

You should realize that the norms listed in ***Figure 4*** are the averages for the profession;

and, on average, dentists are not terrific business managers. The author is familiar with a number of modern, ethical, well-managed dental practices which have a typical revenue mix and which have operating overhead more than five per cent below the norm for the profession. Therefore, your management objective should not necessarily be, to just achieve the norm for the profession. Rather, you should set aggressive, but realistically achievable goals and objectives for your practice.

Figure 6: Dr. Mary Jones Overhead Expense for the Year Ended 2002 Reformatted in Managerial Format

REVENUE	**Dollars ($)**	**Percent (%)**
Gross Patient Billings	$ 278,000	100.0 %
EXPENSE		
Variable Expense:		
Laboratory Fees	$ 25,500	9.2 %
Supplies - Dental	$ 19,500	7.0 %
Supplies - Office	$ 7,250	2.6 %
Bad Debts/Collection Fees	$ 5,500	2.0 %
Repair and Maintenance	$ 1,500	0.5 %
Variable Expense Sub-total	**$ 59,250**	**21.3 %**
Wages and Benefits Expense:		
Fixed Wages and Benefits	$ 67,600	24.3 %
Variable Wages and Benefits	$ 0	0.0 %
Wages and Benefits Sub-total	**$ 67,600**	**24.3 %**
Fixed Expense:		
Office Rent (all inclusive)	$ 28,300	10.2 %
Other Fixed Expense (*)	$ 25,700	9.2 %
Fixed Expense Sub-total	**$ 54,000**	**19.4 %**
EXPENSE (excluding financing and depreciation)	**$ 180,850**	**65.0 %**
OPERATING INCOME (before financing/depreciation)	**$ 97,150**	**35.0 %**
less Financing Costs (Interest/Lease Payments)	$ 4,100	1.5 %
Depreciation	$ 8,000	2.9 %
PROFIT	**$ 85,050**	**30.6 %**

Note: - It is assumed that all wages are fixed expenses.
It is assumed that the practice does not employ a hygienist.
Dr. Jones performs the hygiene treatment herself.

B. Break-even Analysis

The break-even point in business is when total revenue exactly equals total expense; in other words, the point at which there is neither a profit nor a loss. Determining the break-even point can be very useful for managerial decision-making in private dental practices. The business application of break-even analysis in a dental practice will be discussed shortly.

If you refer back to ***Figure 3*** you will see the break-even point for a dental practice graphically illustrated in its simplest form. The broken horizontal line represents the fixed practice expense, which over the short run does not change for a dental practice regardless of whether a patient is treated or not. The gradual-sloped solid line, which starts at the fixed expense level and rises as gross billings increase, represents the variable expense plus the fixed expense (i.e., total expense).

The difference between the fixed expense line and the total expense line is the variable expense. As can be seen in ***Figure 3***, the slope of the variable expense line is very gradual. This is typical for the average dental practice if remuneration to the dentist is excluded; i.e., relatively low variable expense and relatively high fixed expense. However, if fair remuneration to the owner-dentist is included as another variable expense, then the slope of the variable expense line would be much greater and the break-even point would be higher. If estimated remuneration to the owner-operator is included as an expense, the break-even point would then represent the point at which there is neither return nor loss on the capital investment a dentist has made in her/his dental practice.

The break-even point is where the gross billings and total expense lines cross. There is a simple formula for calculating the break-even point, which is very useful for the owner-manager of a dental practice.

$$\textbf{Break-even Gross Billings} = \frac{\textbf{Fixed Expense}}{\textbf{1 – Variable Expense Ratio}}$$

Note: Accountants refer to “1 – Variable Expense Ratio” as the “Contribution Margin”. The Contribution Margin is the portion of each dollar of revenue which “contributes” toward fixed expense or profit.

There are a number of applications for break-even analysis, which can help the dentist-owner-manager. **Two very useful applications are as follows:**

A) To determine the break-even point in advance when you are considering the addition of another fixed practice expense, such as lease payments for the acquisition of a major capital asset for the practice (e.g., laser, intraoral camera, panographic X-ray unit, etc.) or the employment of another salaried staff member (e.g., a second dental assistant). As a rational businessperson, it is prudent to know in advance how much additional revenue is required to at least break-even on such an expenditure;.

B) To be aware of the daily/hourly break-even point for the practice based on a target annual net income to the owner-dentist. This will allow you to prepare an annual budget for the practice based on your income needs; and, in turn, you will then be able to clearly communicate the practice production targets to the staff.

We will again use examples involving Dr. Mary Jones (***Figure 1 and Figure 6***) to illustrate these two applications of break-even analysis:

Example A:

Let us assume that Dr. Mary Jones is considering the addition of a second full-time dental assistant (it appears there are currently two full-time employees, a receptionist and a dental assistant). Wages and benefits would total $2,000 per month for the new dental assistant. How much additional revenue would the practice have to generate to at least break-even?

There are two ways to look at the break-even point in this case:

(i) What is the break-even point assuming that Dr. Jones is willing to work for free; i.e., no personal remuneration for her additional professional and managerial effort required to produce the extra revenue?

(ii) What is the break-even point assuming that Dr. Jones wants to be fairly remunerated for her additional professional and managerial effort?

If you refer back to ***Figure 6***, you will see that the variable expense ratio for Dr. Jones' practice, exclusive of her personal remuneration, is 21.3 per cent (0.213). And, if we assume that fair remuneration to Dr. Jones for her professional services is 40 per cent of gross billings net of lab (40 per cent of 90.8 per cent = 36.3 per cent of gross billings), which is equivalent to fair associate dentist compensation in the community. And, if we assume that fair remuneration to Dr. Jones for her management effort in the practice is three per cent of gross billings. Then, the variable expense ratio for her practice is:

(i) excluding personal remuneration = 21.3 per cent (0.213)
(ii) including personal remuneration = 21.3 per cent + 36.3 per cent + 3 per cent = 60.6 per cent (0.606)

Now, determining the break-even revenue for the addition of a second dental assistant at $2,000 per month is simply a matter of plugging the numbers into the break-even formula below:

$$\textbf{Break-even Gross Billings} = \frac{\textbf{Fixed Expense}}{\textbf{1 – Variable Expense Ratio}}$$

(i) Excluding personal remuneration:

$$\textbf{Break-even Gross Billings} = \frac{\$2{,}000/\text{month}}{1 - 0.213} = \$\ 2{,}541/\text{month}$$

(ii) Including personal remuneration:

$$\textbf{Break-even Gross Billings} = \frac{\$2{,}000/\text{month}}{1 - 0.606} = \$\ 5{,}076/\text{month}$$

In other words, if Dr. Jones hires a second full-time dental assistant, even if Dr. Jones works for free, the practice would have to generate $2,541/month of additional revenue to break even (i.e., not lose money). If she expects to receive fair remuneration for her personal effort in treating the extra patients and generating the additional revenue, then the practice must generate $5,076/month of additional revenue. This would produce no return on the capital investment she has made in her practice; it would simply recover her additional costs and pay her a fair wage for her additional effort.

Conclusion: If the likelihood is high that the addition of a second dental assistant would result in significantly more than $5,076/month of additional practice revenue, then Dr. Jones should proceed to hire a second dental assistant. But, if it is unlikely that this staff addition would result in even $2,541/month of additional revenue, then Dr. Jones should definitely not hire another dental assistant, since after working harder she would have less take-home pay. If the expected additional revenue was between $2,541 and $5,076 per month, then hiring a second dental assistant would only make sense if she is prepared to work for less than fair remuneration.

Example B:

Let us consider that Dr. Mary Jones is having trouble making ends meet at home and would like to increase her Net Income (Profit) to $100,000 for the next fiscal year, from $85,050 during the past year. Also, she only wants to work 200 days next year (1,400 hours). Since it is important that she meet this Net Income target of $100,000 for next year, she would like to have a staff meeting and communicate clearly to her staff the daily and hourly production targets for the office. She plans to give each of her two staff members a $1,000 bonus at year-end, if the practice meets an annual billings target which would produce $100,000 of Net Income while working only 200 days. In preparation for the meeting with her staff, she needs to know – what are the annual, daily and hourly revenue targets which should assure a $100,000 Net Income for the practice?

The way to determine Dr. Jones' revenue target is another application of break-even analysis. In this particular case, her Net Income Target of $100,000 becomes another fixed expense, which must be met to break-even. The break-even formula would then be:

$$\textbf{Break-even Gross Billings} = \frac{\textbf{Fixed Expense + Target Net Income}}{\textbf{1 – Variable Expense Ratio}}$$

The appropriate Variable Expense Ratio to be used in this case would exclude Dr. Jones' personal remuneration, since Dr. Jones is treating her personal remuneration as an additional $100,000 annual fixed expense to be met. The appropriate Variable Expense Ratio to be used is therefore 21.3 percent (see ***Figure 6***).

As can be seen in ***Figure 6*** the practice fixed expense for the last fiscal year, including financing costs and depreciation, was $133,700 ($67,600 + $54,000 + $4,100 + $8,000). If inflation is projected to be three per cent for the next year, we can reasonably assume that the fixed expenses will increase by three per cent to about $137,700 for the next fiscal year. Determining the practice gross billings required to achieve Dr. Jones' target Net Income for the next year is now simply a matter of plugging numbers into the modified break-even formula; i.e.,

$$\textbf{Break-even Gross Billings} = \frac{\textbf{Fixed Expense + Target Net Income}}{\textbf{1 – Variable Expense Ratio}}$$

$$\textbf{Required Annual Gross Billings} = \frac{\textbf{\$137,700 + \$100,000}}{\textbf{1 - 0.213}} = \textbf{\$302,000}$$

Therefore, if $302,000 is the total practice revenue required next year for Dr. Jones's to achieve her Net Income target of $100,000; then, the daily and hourly practice gross billings targets to be communicated at the staff meeting are as follows:

$$\text{Daily practice gross billings target} = \frac{\$302,000}{200} = \$1,510 \text{ per day}$$

$$\text{Hourly practice gross billings target} = \frac{\$302,000}{1,400} = \$216 \text{ per hour}$$

C. Assessment of Profitability (i.e., Return on Investment)

It has been the author's experience that most dentists are unaware whether they are earning a fair return on the capital investment they have made in their dental practices. In other words, the typical dentist is unaware whether his/her practice is a profitable business. This is partly because many dental practices are operated as unincorporated businesses where the owner's remuneration for his/her personal effort in the business is included in the practice Net Income. And, in Alberta, where professional incorporations are allowed, the management salary paid to the dentist owner-operator has little relationship to the dentist's personal effort in the business. The salary paid to the owner-dentist is typically based on income tax considerations. Therefore, without some effort and a few calculations, most dentists have little idea how much (if any) return they are receiving on the substantial investment they have made in their practices.

In the corporate business world, one of the key measures of business profitability is **Return on Investment**. This is one of the best measures to assess operational efficiency and management effectiveness, and it is a very good measure to be used by dental practice owner-operators to assess their management effectiveness.

Return on Investment is often calculated in two ways: (1) **Percentage Return on Assets** and (2) **Percentage Return on Equity**. It is a good idea to calculate return on investment both ways. Percentage Return on Assets is the best measure of how effectively the assets of the business are being utilized in the business operations. Percentage Return on Equity also takes into account how effectively debt is being used to finance the business operations, and it should be greater than Percentage Return on Assets since there is a greater business risk when debt is used to "leverage" the business.

Conceptually, Percentage Return on Investment is a straightforward calculation. You simply divide the business Net Income (Profit) by the Investment in the business. The difficulty in determining Percentage Return on Investment for a dental practice arises for the following reasons:

- Dental practice Net Income usually includes some or all of the fair market compensation for the owner-operator's personal effort in the business;
- Some expenses in the dental practice year-end financial statement often do not reflect economic reality;
- Many dentists are unaware just how much capital they have invested in their dental practices.

In order to determine Percentage Return on Investment for a dental practice, one must adjust reported Net Income to exclude fair remuneration to the dentist owner-operator and to fairly reflect the true business expenses. Also, the fair market value of the dental practice must be estimated. Once these things have been done, the calculation is simple.

Examples:

We will continue to use Dr. Mary Jones' dental practice for our examples. We will make some assumptions and then calculate pre-tax Return on Investment for her practice in two ways:

A. Percentage Return on Equity; and
B. Percentage Return on Assets.

It is simpler to use the reformatted Income/Expense data in ***Figure 6*** for Dr. Jones' practice to determine Percentage Return on Investment, than to use the accountant's year-end statement in ***Figure 1***, although either can be used. In Dr. Jones' case, let us assume that, except for wages and benefits, all the expenses are true business expenses, which reflect economic reality. For purposes of this example, we shall assume that reported wages and benefits expense includes wages and benefits to Dr. Jones' daughter which are $22,000 in excess of market; therefore, adjustment must be done to make practice expenses reflect fair market expenses. Also, fair remuneration to Dr. Jones for her professional services and management effort must be estimated and deducted from reported Net Income (Profit) to determine the return on investment.

Fair remuneration to Dr. Jones was previously estimated, in application A of our break-even analysis, at 39.3 per cent of gross practice billings (36.3 per cent of her professional services and three per cent for her management effort in the practice). Therefore, a fair estimate

of her personal remuneration for helping generate the practice gross billings of $278,00 would be $278,00 x 39.3 per cent = $109,250.

To calculate Percentage Return on Investment one must estimate the fair market value of the practice assets. To get a reasonable idea of how profitable and well-managed the practice is, an approximate fair market value of the practice assets is all that is necessary. Most dentists, with a little help from their dental supply company representatives and their accountants can make a reasonable approximation of the fair market value of the practice assets. A professional dental practice valuator could give a more accurate estimate; however, that degree of accuracy is not really necessary in order to provide a dentist owner-manager with an understanding of whether a reasonable return is being earned on his/her invested capital.

Dental practice assets typically include the following:

- Major dental equipment, office equipment and furnishings;
- Dental instruments;
- Supplies inventory;
- Leasehold improvements;
- Accounts receivable;
- Goodwill.

Dental practice liabilities typically include the following:

- Bank overdrafts and loans;
- Accounts payable.

Since no information is provided in Chapter I regarding the fair market value of Dr. Jones' various practice assets and liabilities, we shall assume the following asset and liability values:

Assets:

• Major dental equipment, office equipment & furnishings =	$ 60,000
• Dental instruments =	$ 5,000
• Supplies inventory =	$ 5,000
• Leasehold improvements =	$ 20,000
• Accounts receivable =	$ 30,000
• Goodwill =	$ 70,000
Fair Market Value of All Practice Assets	**$190,000**

Liabilities:

• Accounts Payable =	$ 5,000
• Bank Loan (net of bank account) =	$ 50,000
Total Practice Liabilities	**$ 55,000**
Dr. Jones' Net Equity in Dental Practice	**$135,000**

Example A. - Percentage Return on Equity

To determine Percentage Return on Equity we simply:

a) Adjust reported Net Income to reflect economic reality by adding back the excess wages and benefits paid to Dr. Jones' daughter;
b) Deduct from adjusted Net Income the fair market value of Dr. Jones' personal effort in the business;
c) Divide the Return after Owner Remuneration by Dr. Jones' equity in the business.

Therefore,

Reported Net Income	$ 85,050
(a) add, Excess Wages & Benefits to daughter	$ 22,000
Adjusted Net Income	$107,050
(b) less, Fair Remuneration to Dr. Jones	(109,250)
Return (Loss) on Equity	($ 2,200)

(c) Percentage Return on Equity = ($2,200) / $135,000 x 100 = **(1.6%)**

Example B. - Percentage Return on Assets:

To determine Percentage Return on Assets we simply:
(a) Adjust reported Net Income to reflect economic reality by adding back the excess wages and benefits paid to Dr. Jones daughter;
(b) Adjust reported Net Income to reflect a debt-free (no liabilities) practice by adding back the net interest expense paid by Dr. Jones';
(c) Deduct from adjusted Net Income the fair market value of Dr. Jones' personal effort in the business;
(d) Divide the Return after Owner Remuneration by the fair market value of Dr. Jones' practice assets.

Therefore,

Reported Net Income	$ 85,050
(a) add, Excess Wages & Benefits to daughter	$ 22,000
(b) add, Net Interest Expense	$ 4,100
Adjusted Net Income	$111,150
(c) less, Fair Remuneration to Dr. Jones	(109,250)
Return (Loss) on Assets	$ 1,900

(d) Percentage Return on Assets = $1,900 / $190,000 x 100 = **1.0%**

The bottom-line is . . . analysis of return on investment for Dr. Jones' practice reveals that profitability is very poor; and, unless this is a new, rapidly growing practice, a plan of action should be developed to correct the problems.

Discussion re: Return on Investment

In Dr. Jones's case, the Return on Equity is negative. In other words, after compensating herself for her personal effort in providing professional services and managing the practice, Dr. Jones is losing money on the $135,000 she has invested in her dental practice. If this continues, she would be better off financially to sell the practice, invest the proceeds in a lower-risk investment that has a positive return and then work as an associate dentist.

Return on Assets, although positive, is very low (1.0 per cent). This again indicates that the assets of the practice are not being utilized very effectively. For a dental practice with this asset mix (i.e., about 35 per cent goodwill), a pre-tax Return on Assets of less than 15 per cent should be considered inadequate. In fact, if Dr. Jones' practice was reasonably well managed, the pre-tax Return on Assets should be over 20 per cent.

A standard investment principle is that the greater the investment risk, the greater the expected rate of return. Therefore, the rate of return on goodwill (a very risky asset) should be greater than the rate of return on tangible assets. Hence, owners with a higher proportion of the practice value as goodwill should have a higher overall rate of return on the practice assets. Similarly, practices which have fewer potential purchasers are more risky (e.g., rural and specialty practices) and should earn a higher rate of return. Owners of rural or specialty practices, or practices with a large proportion of goodwill (over 50 per cent of the practice asset value) should expect an overall pre-tax return of at least 25 per cent on the practice assets.

D. Analysis of Staff Payroll

Note: The payroll percentages discussed in this section **exclude** management salaries to the dentist(s), associate dentist compensation, and wages in excess of fair market (e.g., to family members).

Staff payroll is, by far, the largest expense item for most North American private dental practices. Typically, staff payroll accounts for 20 to 30 per cent of gross practice billings, or one-third to one-half of all practice expenses. Therefore, a dentist owner-manager must look very closely at staff payroll. In the majority of cases when a dental practice is having overhead expense problems, staff payroll is one of the expense problems that must be addressed.

Unfortunately, assessing your dental practice staff payroll is not simply a matter of comparing your staff payroll to the overall "average" for the profession. This simplistic approach to assessment of staff payroll can be very misleading because in reality there are few average practices. As a result, the author has developed a method of assessing staff payroll that takes into account the differences in "revenue mix" that exist between practices. Using this method, the normal expected payroll expense percentage for a practice could vary from under 20 per cent to over 30 percent (assuming similar management effectiveness). In other words, a practice with a staff payroll of 20 per cent of total billings may be no more effectively managed than a practice with a staff payroll of 30 per cent; it depends on the practice revenue mix.

The “revenue mix” for a practice is calculated by determining the total practice billings for each of three categories:

- Dentist billings;
- Hygienist (or other auxiliary) billings;
- Laboratory fee billings.

The average revenue mix for all general dental practices is roughly 70 per cent for dentist billings, 20 per cent for hygienist billings and 10 per cent for laboratory billings (i.e., 70:20:10). This average revenue mix **includes** practices where the dentist performs some or all of the hygiene procedures. Please note that the 70:20:10 revenue mix is simply the average for the profession, and variations from this would have nothing to do with the efficiency of the practice; rather, it would reflect the different character of the practice. For example, a prosthetic-oriented practice would typically have a higher percentage of lab billings and lower percentage of hygienist billings than would a preventive-oriented practice. And, if practices where the dentist performs some or all of the hygiene procedures were excluded when determining the average revenue mix for general dental practices, then the average revenue mix would be approximately 65:25:10.

Wages and benefits associated with hygienist billings in Alberta appear to average about 50 per cent of these billings (40 per cent hygienist wages plus 10 per cent indirect administrative wages). Whereas, wages and benefits associated with dentist billings average only about 24 per cent of dentist billings (since dentist remuneration is excluded). And, laboratory billing revenue is a flow though item, which has no associated staff wages (laboratory billings revenue equals laboratory expenses). Using these numbers, and the revenue mix for a particular practice, it is possible to establish a ‘normal’ weighted wages percentage that can be used as a guideline in determining the expected staff payroll percentage for that particular practice, assuming average management effectiveness. ***Figure 7*** provides this information for numerous revenue mix possibilities.

***Figure 7*: 'Normal' Alberta Staff Payroll Percentages for Various Revenue Mixes**

Dentist Billings Percent	Hygienist Billings Percent	Laboratory Billings Percent		'Normal" Weighted Wages Percent
70%	21%	9%	=	**27%**
70%	25%	5%	=	**29%**
70%	28%	2%	=	**31%**
90%	0%	10%	=	**22%**
85%	0%	15%	=	**21%**
80%	0%	20%	=	**20%**
75%	0%	25%	=	**19%**
65%	25%	10%	=	**28%**
65%	30%	5%	=	**31%**
60%	30%	10%	=	**29%**
60%	35%	5%	=	**32%**
55%	40%	5%	=	**33%**
52%	45%	3%	=	**35%**

Wages as a % of billings for each component of the revenue mix is as follows:

- **About 24% for dentist billings;**
- **About 50% for hygienist billings;**
- **0% for laboratory fee billings.**

Figure 7 should allow you to assess the staff payroll for your office, taking into account the particular revenue mix for your practice. If the staff payroll for your practice (as a percentage of total revenue) is significantly higher or lower than expected, it should be investigated.

If staff payroll is higher than expected, it could be the result of many things; e.g., too many staff, excessive wage levels, or ineffective delegation of duties. If lower than expected, it could also be a problem. Very low staff payroll may be due to inadequate delegation of duties to staff (e.g., the dentist does not delegate enough lower level duties) which would limit revenue potential for the practice. Or, if individual wage rates are too low, it may result in excessive staff turnover that is very costly in the long run.

Example:

Again, as an example of staff payroll analysis, we will assess Dr. Jones' practice. If you refer back to ***Figure 1*** or ***Figure 6*** you will note that total staff payroll expense (salaries + benefits + uniform allowance) was $67,600, or 24.3 per cent of gross patient billings. Since Dr. Jones did not employ a hygienist, hygienist billings were nil. Laboratory billings/expense was $25,500, or about nine per cent of gross patient billings. Therefore, the "revenue mix" for Dr. Jones' practice

was 91 per cent dentist billings, zero percent hygienist billings and nine per cent lab billings (91:0:9).

If you refer to ***Figure 7*** you will note that Dr. Jones' revenue mix is very close to the 90:0:10 revenue mix listed in ***Figure 7***. The 'normal weighted wages percent' expected for a 90:0:10 practice in Alberta is 22 per cent. In other words, a general dental practice with a revenue mix similar to Dr. Jones' practice, and with average management effectiveness, would be expected to spend about 22 per cent of total gross billings on wages and benefits. However, Dr. Jones is spending 24.3 per cent, which is over two percent more than expected. In her case, that amounts to about $6,000 more than expected was spent on staff payroll during the past year.

Staff payroll does not appear to be Dr. Jones' most serious problem, but $6,000 per year is $500 per month. This is enough to be concerned about and should be investigated. If Dr. Jones had not taken the particular revenue mix for her practice into account, she may have incorrectly concluded that her staff payroll was well under control, since her staff payroll was significantly below the overall 27 per cent (***Figure 4***) average for Alberta dental practices.

E. Income Projection

Once practice expense data has been reorganized into a managerial format it is very simple to project Net Income for Various "what if" scenarios for the next year. To project next year's Net Income for your practice for various different levels of gross billings, you first determine two numbers based on last year's expense data (i) the practice variable expense ratio (which is usually quite stable from year to year) and (ii) the expected fixed practice expenses for next year (usually by simply adjusting last year's fixed expenses based on your estimate of the inflation rate for next year). You then plug these two numbers into the basic net income formula for various levels of gross practice billings; i.e., Net Income = Gross Billings – Total Expenses.

The restated Net Income formula is as follows:

Net Income = Gross Billings - [Fixed Expense + (Gross Billings X Variable Expense Ratio)]

Example:

As an example of how to project next year's net income we will again use Dr. Jones' practice (***Figure 1*** and ***Figure 6***).

Last year her gross professional billings were $278,000. Suppose she would like to know what her net income would be next year if she were able to increase her production. She feels her patient base is quite large and her gross professional billings could easily be increased to $300,000 or $325,000 if she just worked a little harder; i.e., she wants to know what her net income would be next year if she billed (a) $300,000 or (b) $325,000.

From ***Figure 6*** the variable expense ratio is 0.213 (excluding owner remuneration) and last year's total fixed expenses were $133,700 ($67,600 + $54,000 + $4,100 + $8,000). And, let us assume that next year's inflation rate is expected to be about three per cent, resulting in expected fixed expenses of about $138,000 for the practice next year.

Therefore, to project practice Net Income for next year we simply plug the number into the Net Income Formula:

Net Income = Gross Billings - [Fixed Expense + (Gross Billings X Variable Expense Ration)]

(a) If the practice bills $300,000 next year, the projected Net Income is:
Net Income = $300,000 – [$138,000 + ($300,000 x 0.213)] = about $98,000

(b) If the practice bills $325,00 next year, the projected Net Income is:
Net Income = $325,000 – [$138,000 +($325,000 x 0.213)] = about $118,000

F. Preparation of a Practice Budget

The **next** chapter on Cash Management, prepared by another author, provides some good information on budget preparation for your practice. The five steps listed in the next chapter are:

1. Identify Objectives;
2. Examine Previous Year's Results;
3. Update for Expected Conditions;
4. Monitor Performance; and
5. Review and Revise the Budget.

A sample Cash Flow worksheet is included in that chapter.

However, if you plan to use a consolidated managerial format for monitoring practice performance throughout the year, as discussed in **this** chapter, then you might find ***Figure 8*** a more useful format for budget preparation and financial monitoring.

Figure 8: Consolidated Practice Budget/Monitoring Form

	ALBERTA NORM %	200X BUDGET	%	RECENT MONTH	200X YR. TO DATE	%	BUDGET VARIANCE %
REVENUE:							
Owner dentist (net of lab)	70%	$	%	$	$	%	
Associate dentist #1 (net of lab)		$	%	$	$	%	
Associate dentist #2 (net of lab)		$	%	$	$	%	
CDAs		$	%	$	$	%	
Hygienists #1	21%	$	%	$	$	%	
Hygienists #2		$	%	$	$	%	
Lab Fees	9%	$	%	$	$	%	
REVENUE	100%	$	100%	$	$	100%	0.0%
EXPENSES:							
Bad Debts/Coll fees	1.0%	$	%	$	$	%	%
Supplies - Dental	7.5%	$	%	$	$	%	%
Supplies - Office	2.0%	$	%	$	$	%	%
Laboratory	9.0%	$	%	$	$	%	%
Repair & Maint.	0.5%	$	%	$	$	%	%
Var Expense Sub-total	20.0%	$	%	$	$	%	%
Salaries/Benefits - Receptionists		$	%	$	$	%	%
Salaries/Benefits - Assistants		$	%	$	$	%	%
Salaries/Benefits - Hygienists		$	%	$	$	%	%
*Salaries/Ben. Expense Sub-total	27.0%	$	%	$	$	%	%
Rent - all inclusive	5.5%	$	%	$	$	%	%
Insurance	1.0%	$	%	$	$	%	%
Continuing Ed./Conventions	1.0%	$	%	$	$	%	%
Professional Fees	1.0%	$	%	$	$	%	%
Telephone	1.0%	$	%	$	$	%	%
Auto	0.5%	$	%	$	$	%	%
Travel, Lodging, etc.	0.0%	$	%	$	$	%	%
Advertising & Promotion	0.5%	$	%	$	$	%	%
Bus. Tax, Dues and Memberships	1.5%	$	%	$	$	%	%
Misc. Fixed Expense	3.0%	$	%	$	$	%	%
Fix Expense Sub-total	13.0%	$	%	$	$	%	%
EXPENSES	60.0%	$	%	$	$	%	%
PROFIT (before depr & finance)	40.0%	$	%	$	$	%	%
Interest Expense	0.5%	$	%	$	$	%	%
Equipment Leases	1.0%	$	%	$	$	%	%
Amortization/Depreciation	2.5%	$	%	$	$	%	%
PROFIT	36.0%	$	%	$	$	%	%
less,							
Associate compensation		$		$	$		
Owner-dentist remuneration		$		$	$		
Owner-manager remuneration		$		$	$		
****RETURN ON INVESTMENT**		$		$	$		

Notes:
- (*) Excludes spousal wages/fees in excess of FMV
- (**) Return after remuneration to all dentists (including associate dentists).

Please note that the ***Figure 8*** Consolidated Practice Budget/Monitoring Form is for preparation of an Income Budget; whereas, the Worksheet included in the next chapter is for a Cash Flow Budget. Income and cash flow are similar, but not exactly the same. Income is what dentists must report on their tax returns, using the "accrual" method rather than the "cash" method of accounting. Differences between the two methods include reporting revenues as billed rather than when collected, and reporting expenses when incurred rather than when paid. Non-cash expenses such as depreciation and amortization are excluded when using the cash method.

Although dentists must report on an accrual basis, sometimes practice cash flow is of more concern. For example, if your concern is whether you will be able to make your loan payments and make ends meet, then cash flow is more important. But, if you are analyzing practice data in order to assess practice performance and make related managerial decisions, then accrual data is more useful. Depending on your circumstances, you may want to prepare both, an income and a cash flow budget.

Chapter Three - Cash Management

Principles of Cash Management

Cash management is the anticipated cash flow available for planning and debt control. By controlling the rate of incoming and outgoing cash, you control the accounts receivable and the accounts payable. A positive cash flow allows you the security of having enough money to pay bills in a timely fashion.

Cash flow budgeting bridges the gap between cash excesses and deficits. The goal is to identify periods of time annually when there are oversupplies or undersupplies of cash. It will help identify problems in your credit system such as a lax collection policy. Not only is close scrutiny of the office collection policy vital, but the enforcement of it is one way to improve cash flow. Adjusting patient payment alternatives and collection practices can mean the difference between meeting salaries and supplier obligations with borrowed money or paying those amounts with well-timed cash inflows. Avoiding interest charges on borrowed funds is one of your best mechanisms to assist cash flow. In short, borrow money for the right reasons and be prudent about overextending credit to patients.

A cash flow budget begins by identifying objectives. What would you like to do with the money coming into the practice? Analyze the income statement and balance sheet to set goals and establish plans for the future. By examining last year's results, you can find:

- expected annual income;
- any anticipated changes in annual income;
- identification of revenue and expense sources.

Another consideration is to budget for your own regular salary as part of the cash flow plan, rather than taking whatever monies are left over. This forces you to plan your personal budget accordingly and should help alleviate personal cash shortages.

Using the cash flow budget to anticipate income is also critical in determining the volume and timing of major expenditures. Many dentists find that when it is time to fund a pension or tax deferred savings plan, insufficient cash is available. Planning for a major expenditure early in the year allows you to construct an appropriate cash flow budget.

Cash management has many facets. Aside from the planning and budgeting process, effective cash management encompasses maintaining the security of cash by the establishment of internal controls and office systems.

Step One: Identify Objectives

The first step of the budgeting process is identifying objectives. The objective may be the purchase of new equipment, retirement of long-term debt or consistent positive monthly cash flow.

Step Two: Examine Previous Year's Results

To develop a budget requires an opening balance sheet and the previous year's results in as much detail as possible. By estimating the expected income for the current year, based on the income level experienced in the preceding year, you can identify both revenue and expenses in specific months of the year.

Anticipated income is a critical factor in preparing the entire budget, because it invariably determines both volume and timing of expenditures. By working backward from the income for each month, you can determine the outlays required to meet that level of income.

Step Three: Update for Expected Conditions

Even though you use the previous year's budget, you must change this information based on future conditions that you anticipate. For example, you must assess seasonal fluctuations in volume or additional output for new employees. In projecting expenses, you must allow for possible increases in salary expense, supplies, and other overhead expenses or for any new capital expenditures, such as added equipment or expanded facilities.

Seasonal fluctuations also require attention to expenses related to marketing, utilities, maintenance and vacation costs. Interest and income taxes must be developed monthly because of their direct relationship to bank advances and earnings.

Figure 9 is a sample worksheet that can be used to develop a cash flow budget.

Step Four: Monitoring Performance

The completed budget gives a monthly projection of revenues, expenses, and account balances in enough detail that you can measure actual performance. Variations from expected receipts and expenditures can indicate a change in market conditions or operational costs that might otherwise go unnoticed. Reasons for variances, whether favorable or unfavorable, should be analyzed, so that the consequences can be addressed effectively.

Step Five: Reviewing and Revising the Budget

When the monthly reports show significant changes, consider whether to revise the total budget or continue with the basic budget and make the short-term adjustments

to deal with the variance. You may find it more useful to make new projections for the balance of the year. As a reflection of the financial objectives of office goals, the budget remains a useful tool for keeping operations on course.

Figure 9: Cash Flow budget Worksheet

PROJECTED STATEMENT OF MONTHLY CASH FLOW

Date prepared _____
Prepared by _____
Reviewed by _____

		MONTH _____/_____/___
	CASH RECEIPTS	_____/_____/___
A.	Receivables	_____/_____/___
B.	Mortgage loan	_____/_____/___
C.	Other	_____/_____/___
	• Bank loans	_____/_____/___
	•	_____/_____/___
	•	_____/_____/___
D.	TOTAL CASH RECEIPTS (Lines 1-3)	_____/_____/___
	CASH DISBURSEMENTS	_____/_____/___
E.	Salaries	_____/_____/___
F.	Payroll taxes	_____/_____/___
G.	Rent	_____/_____/___
H.	Insurance	_____/_____/___
I.	Property taxes	_____/_____/___
J.	Professional fees	_____/_____/___
K.	Taxes and Licenses	_____/_____/___
L.	Interest	_____/_____/___
M.	Employee benefits	_____/_____/___
N.	Supplies	_____/_____/___
O.	Income taxes	_____/_____/___
P.	Utilities	_____/_____/___
Q.	Repairs and Maintenance	_____/_____/___
R.	Fixed asset additions	_____/_____/___
S.	Long-term debt repayment	_____/_____/___
T.	Other	_____/_____/___
	• Bank loan repayment	_____/_____/___
	•	_____/_____/___
	•	_____/_____/___
U.	TOTAL CASH DISBURSEMENTS (Lines 5-20)	_____/_____/___
V.	CASH OVER (SHORT) (Line 4 minus 21)	_____/_____/___
W.	CASH BALANCE, BEGINNING	_____/_____/___
X.	CASH BALANCE, END (Line 22 minus 23)	_____/_____/___
	BANK LOAN, BEGINNING	_____/_____/___
	Bank loan receipts (Repayments)	_____/_____/___
	BANK LOAN, END	_____/_____/___
	BANK SECURITY	_____/_____/___
	Accounts receivable (previous month)	_____/_____/___
	Net change acct. rec. this month	_____/_____/___
	New accounts receivable balance	_____/_____/___

Improving Cash Flow

The first step in the collection of receivables is preparation of a statement. Obviously, the more promptly a patient is billed for services rendered, the sooner payment may be received. This is a simple but often overlooked fact.

Many health care practitioners are now requesting cash payment upon delivery of services, and this is certainly one means to increase office cash flow. This method of obtaining payment is accomplished by making specific financial arrangements prior to the beginning of treatment. If a policy requiring payment upon delivery is not desired, another method is to establish a due date for payment and to indicate that date clearly on the invoice.

The number of days receivables that are outstanding should be monitored and an aging of receivables prepared monthly. Most computer billing software has this feature. Collection should be pursued aggressively, but tactfully, including reissuing invoices. It may even become necessary to curtail non-emergency services to patients with past-due accounts. You may use your aging of receivables report to evaluate the appropriateness of the office's credit policy.

Maintaining Cash Security

An integral aspect of cash management is maintaining the security of cash while it is in the system. Since cash is a highly liquid asset, it is important to establish controls over its recording, maintenance and disbursement to prevent embezzlement. Responsibility for these duties may be assigned to different staff members, where possible, so that no one person has control over all aspects of the cash function. For example, the person responsible for reconciling bank balances to account balances should not be assigned functions relating to receipt or disbursement of cash or preparation or approval of payment vouchers. If this is not possible, the dentist may wish to share in alternating the various processing aspects of cash management with staff.

A monthly reconciliation of bank balances must be performed. This will assure recognition of all items recorded in the accounts. The reconciliation procedure should include examining cheques for appropriate signatures and endorsements and reconciling bank transfers.

While it is impossible to quantify, it is estimated that about one in 10 dentists will have money stolen from his or her practice. It is extremely important that office systems are designed to prevent this crime from occurring. Here are several suggestions that you may wish to implement:

- have your canceled cheques mailed to your home address and review them yourself;
- check new employee references diligently;

- consider bonding insurance on your employees;
- require employee vacations;
- rotate personnel who handle cash transactions;
- monitor accounts paid with cash;
- be knowledgeable of the office financial affairs, by reviewing the day sheet or the computer summaries;
- make deposits daily;
- sign all your own cheques;
- retain authority for balance "write-offs";
- stamp cheques with "for deposit only";
- review the monthly billing statements;
- interrupt the accounting cycle chain;
- use external CA, CMA, or CGA review on a regular basis;
- balance the total of the ledger accounts with the accounts receivable running balance.

Chapter Four - Dental Practice Monitoring - Non-Financial Data

by H.J. Stockton, D.M.D., C.F.P, M.B.A.

Chapter Two involved a detailed discussion about monitoring and assessing practice performance using practice financial data. In addition to financial data, there are other practice statistics which a well-informed dentist owner-manager should keep and monitor. This chapter will discuss additional practice data which you should collect, monitor and assess, if you are to make good business decisions concerning the operation of your dental practice. Again, the discussion in this chapter will be focused mainly on the private general dental practice. Specialty dental practices would want to keep similar but more specialized data.

Additional Important Measures of Practice Performance

The following non-financial measures of practice performance are key indicators of practice health and should be monitored on a regular basis by effective dentist owner-mangers:

- new patients per month;
- recall patients per month;
- patient slippage (loss of patients) per month;
- staff turnover.

It has been the author's experience that a majority of dentists do not monitor the above-mentioned measures of practice performance on a regular basis. These non-financial indicators are often early warning signs of future practice problems. Changes in these practice statistics will usually appear before the dentist notices significant changes in the financial data. Let us now discuss each of these indicators in turn:

New Patients Per Month

New patients per month is a very important dental practice performance criterion, but it is one of the most difficult criteria to determine what the required performance level should be. Required new patient flow depends on many factors, such as: the type of practice (e.g., pedodontic practices need more patients), the dental IQ of the patient bases (patients who are dentally aware generally demand more dental services per patient) and the mobility of the community population (e.g., Calgary practices need more new patients than Winnipeg practices). However, to maintain an average dental practice over the long-term, most practices, regardless of type or location need a minimum of 10 new patients per month. Most "successful" growing practices need to see at least 20 new patients per month. Practices seeing over 40 new patients per month should grow quite rapidly.

You should segregate new patient data into (1) new patient examinations and (2) new patient emergencies. New patient exams per month is really the important statistic to track. Emergency patients are an excellent source of new patients, but until they have a complete examination they should not be viewed as patients of your practice. When emergency patients return for a new patient examination, they can then be counted as new patients to the practice.

Although the absolute number of new patients per month is important, a significant change in this number over an extended period of time (i.e., the trend) is even more important. Often the first indicator of future practice problems is a significant decline in new patients. In a busy practice it may take a few years for this decline to show up in the financial data. Changes from month to month are typical; however, a declining trend in new patients over many months should be of considerable concern. The cause for the decline should be determined and corrected as soon as possible.

Recall Patients Per Month

The number of recall patients per month is also an extremely important statistic to monitor closely. There are a couple of different ways that dentists track recall patients per month. Those dentists who have all their recall patients seen by the hygienist often keep track of the number of hygiene visits per month since it is a very easy number to track. Technically, the number of recall visits and the number of hygiene visits are not the same. However, if hygiene visits per month are consistently tracked, in most cases it is a reasonably good proxy for recall visits. In order to be more accurate, a few dentists track the number of recall examinations per month (usually on computer using the recall exam code). If your hygiene department has a lot of multiple hygienist visits for individual patients, or if the hygienists are seeing a lot of patients for services other than preventive hygiene, then you might want to track recall examinations rather than hygienist visits.

There are two important things that can be identified by monitoring recall patients per month. First, an increasing or decreasing **trend** for number of recall patients per month is an important indicator concerning the underlying strength of a practice. A healthy, growing practice will see the number of recall patients per month steadily increasing. Whereas, a declining number of recall patients per month is another early warning sign for future practice problems.

Second, the absolute number of recall patients per month, relative to the total number of active practice patients, is a measure of the effectiveness of the practice's recall system. The average general dental practice does not have a highly effective recall system. Only 50-60 per cent of the active patient base is on regular recall in the typical practice. **Note**: There are a number of definitions for "active patients"; here we shall define "active patient base" as the number of patients who have had an appointment at the practice within the past two years. This definition is a reasonably

good estimation of the number of patients who consider themselves patients of that practice. Very few general practices have over 75 per cent of their patients on regular recall. Therefore, although it sounds poor, a practice's recall system could be considered "successful" if over 50 per cent of the patients are on regular recall.

To determine the effectiveness of the recall system for your practice, first, estimate the "active patient base" (i.e., count the number of charts for patients you have seen within the past two years). Next, determine the average number of recall patient visits per month and multiply that number by the average recall interval for your patients (recalls per month X recall interval = number of patients on active recall). And, finally, divide the number of patients on active recall by the number of active patients in your practice to determine the effectiveness ratio for your recall system. For example, if you have 2,000 active patients, are seeing 160 patients per month on recall and your average recall interval is seven months, then the effectiveness of your recall system is 56 per cent (i.e., [160 X 7]/2,000 = 0.56).

Patient Slippage

A successful dental practice would have more new patients coming to the practice than patients leaving the practice. Therefore, a practice could be seeing a large number of new patients per month; but, if more are leaving through the back-door (slippage), the practice would be considered unsuccessful. Again, as with new patient flow, an acceptable level of slippage is difficult to determine because of the wide variation in types and locations of practices. Zero slippage is unrealistic to expect, since a few patients will die each year and some will move to another community. Experience indicates that the average practice likely has slippage of about 10-12 per cent of the patient base per year, although this average varies from community to community. Therefore, every practice needs a certain number of new patients each month, just to maintain its patient base. Practice growth will only take place when the number of new patients to a practice exceeds slippage.

The most accurate way to determine patient slippage is to first count the "active patient base" both at the beginning and the end of a time period, and thus determine the change in the active patient base. Then, the patient slippage can be calculated by subtracting the change in the "active patient base" from the number of new patients attracted to the practice over the same period of time. For example, if during the past year the "active patient base" increased by 120, and during the same period 216 new patients were attracted to that practice; then, patient slippage during the past year was 96 (216 - 120 = 96). In other words, eight patients per month left the practice during the past year. If the practice had an "active patient base" of 1,000, then patient slippage was 9.6 per cent (96/1,000).

Assuming the effectiveness of your recall system is stable, a simpler method can be used to determine the change in the "active patient base". You simply determine the growth (or decline) in the practice recalls per month and gross that up, based on the effectiveness of your recall system. For example, if the effectiveness of your recall

system has been consistently about 60 per cent (0.60), and if the number of patients on regular recall increased by five per month. Then, the increase in your "active patient base" was just over eight per month (5/0.60), or about 100 over the past year.

Staff Turnover

Staff turnover is an often overlooked dental practice performance criterion, but most successful practices have low staff turnover. Staff turnover is inversely proportional to the average number of years of service for your staff. In other words, practices with low staff turnover have a staff that, on average, has many years of service. High staff turnover causes many practice problems. Dentists operating offices with high staff turnover are often frustrated, stressed-out and relatively unproductive.

High staff turnover is also very expensive. Various practice management articles have quantified the total cost of having to replace a single dental staff member at anywhere from $5,000 to $50,000 or more.

Studies indicate that the average term of employment for dental office staff is dismal, at about 3 years. Well-managed dental practices certainly should have better-than-average staff turnover. Practices whose staff average more than five years of service have staff turnover under control.

Chapter Five - Effective Recall Systems

by H.J. Stockton, D.M.D., C.F.P, M.B.A.

Patients on regular recall are the core of your dental practice. They are usually the most dentally-fit; they are the most loyal to your practice; and, they refer the most new patients to your practice. Moreover, when you eventually decide to sell your practice, practices with strong recall systems are more valuable and command higher selling prices. Therefore, it is important to organize and operate a strong recall system for your practice.

Details on how to assess the effectiveness of your current recall system were previously discussed in Chapter Four. As was mentioned, the effectiveness of most general practice recall systems is not as good as you might have expected. You may want to refer back to "Recall Patients per Month" in Chapter Four to review assessment of recall system effectiveness.

This chapter will discuss some of the key principles and strategies which have been used by dentists to organize strong, effective recall systems. Generally, dentists would view a successful recall system as having met most of the following objectives:

- the highest possible percentage of the practice's patient base is on regular recall;
- the hygiene recall part of the practice is very profitable;
- missed and cancelled recall appointments are minimized;
- the recall system is simple and easy to manage;
- the recall system is very flexible.

Unfortunately, the author has found that no recall system can totally meet all of the above-mentioned objectives. For example, a recall system which maximizes the number of patients on regular recall may not be the most flexible and may not have the fewest missed appointments. Therefore, as owner-manager, you have to priorize the objectives for your recall system. The discussion in this chapter assumes that the five objectives listed above are listed in order of priority for your practice. If the priority of your objectives is different, you may not want to blindly follow all of the recommendations in this chapter.

Booking Systems

Although there are many different variations in booking systems, there are two basic approaches which can be taken:

Book-ahead systems. These systems follow the key principle that "a patient never leaves the office without an appointment". In other words, when the current hygiene recall visit is completed, a specific appointment time is booked for the next recall visit before the patient leaves the office.

Reminder systems. These systems typically identify the approximate time when the next recall visit should take place; and, a month-or-so in advance of that date, the patient is contacted to book the specific appointment time.

It has been the author's experience that practices which employ a "book-ahead" system generally have a significantly higher percentage of the patient base on regular recall. This is likely due to the greater sense of patient commitment when they have already booked an appointment. However, this system is not as flexible, it can be a little more complex and you may experience a few more missed appointments.

With a book-ahead system you have to plan much further ahead. You need to keep time open to accommodate new patients; and, you need to plan your work schedule about a year in advance in order to avoid, as much as possible, rearranging appointments.

A book-ahead system may also be a little more complex, since more appointments have to be rearranged. What's more, you are likely to have a few more missed appointments, since there will be a few patients who booked recall visits six to nine months in advance and now cannot be contacted to confirm their appointments.

For most dentists, the benefits of a larger percentage of patients on regular recall - resulting in better dental health for the patients, a more profitable recall system and greater practice value - more than offset the disadvantages mentioned. But, if appointment book flexibility is a high priority, a book-ahead system may not be the best choice.

Reminder Systems

If you use a "book-ahead" booking system you must remind the patient of the recall appointment which they made months ago, and if you use a "reminder" booking system you must contact the patient to book the recall visit. Therefore, it is imperative that you have a highly-effective method of contacting patients to book and/or remind them of their appointments.

Most who have studied the various reminder systems have come to the following conclusions:

1. telephone contact is much more effective that mail, but mail is less costly;
2. both telephone and mail can be used to advantage;
3. multiple reminders are required to minimize missed and cancelled appointments
   (patients are more likely to miss or cancel a hygiene recall appointment than an appointment for treatment with the dentist).

For those who use a "book-ahead" booking system, the most effective reminder system seems to be as follows: Phone the patient about four weeks in advance of the

booked recall appointment to confirm the appointment (or to rearrange a more convenient time, if the pre-arranged time is no longer good). Then, one or two days prior to the recall appointment remind the patient once again by phone.

For those who use a "reminder" booking system, the most effective booking/reminder system similarly seems to be as follows: Phone the patient about four weeks in advance of the target recall date to arrange the recall visit appointment. Then, one or two days prior to the recall appointment remind the patient once again by phone.

Reminder cards by mail can be used as a low cost alternative or when the patient cannot be contacted by telephone. The type of reminder cards which are the most effective are those where you had the patient fill out the reminder card in his/her own handwriting when they were in the office.

Patient Education

In addition to using a book-ahead booking system and a multiple-call telephone reminder system, other things need to be done to maximize the percentage of your patients on regular recall. One of the most important things which must be done is to educate your patients. Your patients must understand and appreciate the value they will receive by regularly returning to your office for their recall visits. This is especially important now that many third party plans are reducing benefits for preventive recall visits. When patients must pay a larger portion of their dental bills themselves, they will want to be certain that they are getting value for their hard earned money.

Patient education can be done through institutional education (e.g., Dental Association advertising, Dental Health Month, etc.), and through individual-practice education. Each dental practice can improve the patients' appreciation of regular recall visits by using any and all of the following patient education methods: practice newsletters, brochures, in-office videos and one-on-one discussions with the patient by staff and/or dentists. Dentists must take advantage of every available opportunity to educate their patients. Patients must understand and appreciate the importance of good dental health. That it is much less expensive to prevent problems than to have to treat them later.

Staff Selection and Training

Good staff are critical to the success of your recall system. In particular, the hygienist(s) and the administrative staff must be caring, capable and friendly. In-office training and staff meetings are important but staff selection is equally important. It has been said "you can't make a silk purse from a sow's ear"; in other words, the basic character and traits of people cannot be changed. Therefore, selecting staff with the appropriate inherent personality and talents is very important.

The hygienist (or the dentist, if a hygienist is not employed) is the most important staff member influencing the patient's desire to return for regular preventive recall visits. Characteristics of a good hygienist who patients will want to return to see is a combination of many characteristics. A friendly, outgoing personality is important. And, the right blend of thoroughness and gentleness is critical. Patients often will not return for their recall visits if they sense that the hygienist was not thorough enough; but, on the other hand, if the hygienist was rough and the patient's experience was very uncomfortable or painful, the patient will often avoid returning. A good hygienist will have a very gentle way of being thorough. Also, patients do not like to be scolded or lectured to. There is a fine line between good patient education and embarrassing the patient over his/her lack of good oral hygiene. A good hygienist should be able to provide patient education in a tactful manner.

Patients very often develop a long-standing, trusting relationship with the hygienist. Patients who develop this type of relationship with the hygienist tend to be very regular recall patients. In fact, when a hygienist leaves one dental practice and joins another, it is not uncommon for some patients to follow the hygienist to the next dentist's practice.

Therefore, the dentist owner-manager should try to select good hygienists and keep them long term. Also, in practices with multiple hygienists, one should always try to book patients with the same hygienist whenever possible. Although this may not be the most efficient booking method, it should be more effective over the long-term since it will help to maximize the number of patients on regular recall.

Staff Compensation

There is considerable controversy over whether incentive compensation systems will motivate dental practice employees to be more productive. If there is any merit to using an incentive compensation system for dental staff, the dental hygienist is the one employee where such a system might encourage higher productivity.

Most compensation experts agree that for an incentive system to be effective, the employee must have considerable direct control over achievement of the objective(s) which will result in the additional compensation. Every situation must be looked at separately to see if extra compensation can be linked directly to the key objectives to be achieved. For example, if the hygienist has little control over his/her productivity, then an incentive scheme would be of little value.

Incentive compensation for hygienists is not wide-spread. A small minority of dental practices use incentive compensation for hygienists. For those practices that do attempt to motivate their hygienists with incentive compensation, some of the most popular methods are as follows:

- a minimum hourly wage, or a percentage (usually 30-40 per cent) of hygienist billings, which ever is greater;

- a straight commission, typically 30-45 per cent of hygienist billings;
- a reduced hourly wage, plus a percentage of hygienist billings;
- a reduced hourly wage, plus so-much per patient seen;
- a normal hourly wage, plus a year-end or month-end bonus if a certain production target is achieved.

In developing a compensation system for your hygienist(s) it is useful to know compensation norms for the profession. On average, hygienists/ wages and benefits are about 40 per cent of hygienist billings (excluding professional examinations, but including X rays exposed by the hygienists). The median hourly wage for hygienists in Alberta for fiscal 2001 was $36 per hour.
** The author's understanding of market conditions is that the median hourly wage now exceeds $40 per hour (late 2002)

Short-Notice Lists

Since even a well-managed hygiene recall system can expect five per cent or more missed and/or cancelled recall visit appointments, a short-notice list should be maintained. The staff person responsible for the recall system should keep a current list of all patients who would like to come in sooner for their recall visit if an appointment became available. The patients on this list should be classified by how much notice they need to come in for an appointment. Those who live or work close to the office and who can come in on very short notice should be highlighted. Due to the high fixed expenses for dental practices, those practices with hygiene recall systems that are able to fill cancellations quickly are more profitable.

Additional Comments

Statistics (in addition to those discussed in Chapters Two and Four) which you may want to keep, and which should help you to better manage your recall system and identify problem trends are the following:

1. Number of missed recall appointments per month;
2. Number of cancelled, but not filled, recall appointments per month;
3. Number of available recall appointments not booked per month;
4. Each hygienist's wages and benefits as a per cent of their billings.

Good recall systems can be either computerized or manual. Computers allow things to be done more quickly and more accurately; however, remember the computer motto "garbage in, garbage out".

Chapter Six - Developing Your Fees

Fee setting is a very important component of financial administration for dental offices. There are no specific rules or guidelines to determine the exact fees that are correct for your practice. Fees must be based on expenses, volume, time, skill, responsibility, education and risk.

Fee Surveys

Many dentists review fee survey data on various procedures. This can be helpful for the dentist who is just starting out to determine how his or her calculated fees compare to provincial surveys. The Association conducts regular fee surveys.

These surveys are conducted and reported periodically to the professional in an attempt to investigate the economic factors affecting dental practice. The fees charged by an individual dental practice should be established by that dental practice on the basis of the economic factors which affect it and from a determination of the fee ranges which will make the practice competitive.

Insurance Company Profiles

Some practices attempt to use insurance reimbursement profile levels as a starting point in their fee setting. Some even use the insurance companies' reimbursement schedules as their own fee schedule. However, insurance companies or third parties set fees based on factors that are not necessarily related to the financial management considerations of your dental practice. In other words, their reimbursement may have no relation to your expenses. Furthermore, different companies use varying formulas, parameters and less than current information to determine the reimbursement schedule for each practice.

These plans often pay a certain "percentile" of the Usual and Customary Reimbursement (UCR) rather than a "percentage". Percentile is that mathematical point, in the range of all responses, where the number of data entries fall at a specified percentage. For example, the 75th percentile of UCR is the point where 75 per cent of the submitted fees are below that number and 25 per cent of the responses are above it. It is based purely on the relative ranking of the submitted fees compared to others and is not 75 per cent of the average of UCR. Many dentists erroneously believe that the 75th percentile is 75 per cent of UCR. **Thus if the carrier reimburses at the 75th or 90th percentile of UCR, the reimbursement amount will never change unless UCR itself changes by dentists submitting new or different fees.**

Occasionally, patients may be contacted by the third party carrier regarding the disparity between their reimbursement level and the dentist's fee. This puts the dentist in an awkward position of trying to explain to patients the limitations of the patient's coverage.

One way to deal with these issues of disparity is to educate patients about their plan's coverage. ***Figure 10*** illustrates a letter which describes for the patient how there may well be a difference between their dental benefit plan reimbursement and the service fee for the treatment. This letter can be reproduced on your own stationary in the event that patients receive such third party communication or a similar letter sent to all patients to educate them regarding this fact.

Figure 10: Sample letter to patients explaining UCR

To my patients:

During the past three decades, dental benefits plans have become an integral part of health care planning for many families. Dental benefit plans are made available to employees or members, through companies, unions, and associations and may vary considerably from one plan to the next.

The range of benefits depends solely on what the plan purchaser wishes to offer to employees or members. Some plans may cover as little as 30 per cent or as much as 100 per cent of the fees for dental services, with most falling in the 50 to 80 per cent range. Some plans exclude certain types of services, such as orthodontics, while other plans will cover a full range of dental services.

Some plans base the amount of benefit on a chart or schedule of fees arbitrarily developed by third party payers. For this reason, you may receive a lower percentage of the reimbursement level indicated in your dental plan. For example, if your plan states that it will pay 80 per cent of the cost of dental treatment, it means 80 per cent of the fee charged by me.

As the number of patients covered by dental benefits plans has increased, certain assumptions have become evident. I would like to make the principles of my practice, as well as the type of service and care I provide my patients, very clear:

- *My fees are based on the overhead involved in my practice, the treatment plan selected, and the time it takes me to provide you with the necessary dental care. I do not believe it is in either of our best interests for me to compromise my recommended treatment, in order to accommodate a dental plan's maximum benefits that may be considerably less than optimal. However, I am more than happy to discuss a treatment plan's advantages and disadvantages with you, in order to involve you, not the third-party payer, in the health care decision-making process.*

- *The type of treatment you need and receive from me is based upon my professional judgment, and not on whether you are covered by a dental benefits plan.*

- *As a courtesy to you, my staff will complete the dental portion of the claim form. To expedite processing, make sure that your part of the form is filled out completely and accurately.*

- *If your dental benefits plan requires a "pre-determination" or "prior authorization," I will submit a treatment plan for review by the third-party payer. However, please remember that the financial obligation for dental treatment is between you and this office. The third-party payer is responsible to you and not to this office.*

- *If you receive communication from the third-party payer suggesting that my fee is over and above the usual and customary for the services provided to you, please do not accept this as fact without first discussing the matter with me. The third-party payer's fee data may be extremely out of date. It may not take into account local factors pertaining to _____(city/town) in establishing its schedule and its geographic area may include the entire country.*

- *If, after our discussion, you believe that the dental benefits provided by your plan are inadequate, you may want to discuss the matter with your employer, union, or association, so that appropriate alternatives can be investigated.*

- *I will help you in filing your claims, handling third party queries, processing follow-ups, lost claims, etc. No question is too small for you to ask, whether it is about your treatment, benefit plan or statement. Stop in, or call, any time you have a question. I am here to help you.*

_____D.D.S. and staff

Inflation

It is important to be aware of how inflation is part of your underlying discussion about the cost of your dental services. The CPI is the country's principal measure of consumer price change. For example, it is used as an indicator of inflation to evaluate the impact of government economic policies, as a deflator to adjust other economic data indicators like the Gross National Product (GNP), or as a monitor of how well incomes are keeping up with the cost of living to mention a few. Keep in mind that the CPI is a price index, not a cost-of-living index.

Cost of Doing Business Method

Dentists can use various other methods to set fees, but the most business-like manner is to assess the cost of doing business as it relates to patient visits or hourly production. In this method, the dentist calculates the total number of productive hours worked per year and divides this number into the sum of all fixed, step-fixed, variable and owner's compensation costs. The dentist reviews each treatment procedure and

determines how long it typically takes to complete. The fee for the service is then based principally on a time and hourly expense rate.

While this method has great value to help determine how much it costs to run the office, strict adherence to a fee determined by time designations may not be an accurate representation. For example, if it costs $135 per productive hour in the office, a procedure that takes two hours would be calculated at $270, plus laboratory costs, if any. The procedure may be quite complex though, and command a much higher fee. On the other hand, patients typically schedule continuing care appointments on a regular basis and it may not be appropriate to charge the $135 hourly rate for this service. Also, most dentists tend to under-price routine and preventive services, since it is to the patient's benefit to access these treatments, reinforcing their regular care habits and oral hygiene instructions. ***Figure 11*** illustrates a worksheet that you can use to help estimate these calculations for your office.

Summary

Setting an appropriate fee for a procedure should be a combination of service complexity, time, experience, risk, responsibility and office expense. When considering all these variables, it is NOT unusual to see a wide range of fees throughout a community. Since highly personal dental services are delivered, it is incumbent on dentists to understand that fees are a reflection of their value to patients and the value the patient places on their service. It is through clear communication to the patients regarding service fees that dentists help to clarify the treatment costs and prevent misunderstandings.

Figure 11-1:

Time Allocation in the 2001 Calendar

	2001 Median
Days worked in 2001	200
Weekend days not worked	104
Statutory holidays	12
Vacation days	20
Sick days	0
Professional development days	6
Other days not worked	8
Average hours per day booked	7.5
Average hours worked per day	8.5
Total hours worked in 2001	1,686

***Figure 11-2*:**

Average hours and hourly salaries of support staff for the 2002 fiscal year

	Median hours per week 2002	Median hourly $ 2002
Chairside Assistants: No Formal Training	26	14.17
Chairside Assistants: RDA I	30	16.00
Chairside Assistants: RDA II	32	18.00
Dental Hygienist	24	36.00
Office Manager	31	23.60
Receptionist	35	17.50
Office Clerk (insurance, Computer secretary)	31	17.00
Others	16	10.82

Alberta Dental Association and College Expense Survey form including hours worked after (2 pgs.)

Expense Survey

How to determine the cost for a single 15 minute unit of production time:

(a) If you are a solo practitioner (no hygienists)

Total expenses = Cost per 15 min. Production Unit
Total hours x 4

(b) If you have hygienist(s)

- 40 per cent of expenses are related to hygienist;
- 60 per cent of expenses are related to dentist.

Hygiene Cost per 15 min. Production Unit:

$$\frac{\textbf{Total expenses x .40}}{\textbf{Total Hygiene hours x 4}} = \textbf{Cost per 15 min. Hygiene Production Unit}$$

Dentist cost per 15 min. Production Unit

$$\frac{\textbf{Total Expenses x .60}}{\textbf{Total dentist hours x 4}} = \textbf{Cost per 15 min. Dentist Production Unit}$$

(c) If you have an Associate, deduct their portion of expenses before beginning these calculations.

Chapter Seven - Communicating Financial Policies to Patients

Dental practices may consider having a well-defined financial and patient credit policy that offers payment options reflecting the demographics of the practice. The effectiveness of this policy will only be of value if it is clearly communicated to patients. An understanding of payment expectations should be established as part of the new patient introduction process.

Discussions concerning money matters can elicit strong emotions. Therefore, the psychology of handling financial arrangements is critical. Some factors concern when and how to discuss your policy, in what environment and who will be explaining this information to the patient.

If your practice does not have a written financial policy, you may consider developing one and deciding if it will be mailed or given to every patient in the practice.

Financial policy statements could include:

- a clear description of when payment is to be made;
- the payment methods suggested such as cash, cheque or credit cards;
- if payment plans are available, discuss when they are to be established relative to the treatment appointment and who has the authority to establish the payment plan;
- office policy with respect to penalties for late payments.

Office Brochures

The first step in communicating the office financial policy begins with an office brochure. The brochure could contain information relating to the scope of the practice, such as hours, emergency telephone numbers and services offered by the practice. It is also important to include a section regarding the office financial policy. It should have the following characteristics:

Directness

The financial policy statements should be direct. Use other parts of the brochure to demonstrate warmth, caring and concern for patients;

Ease of Understanding

Be sure the statements are easily understood by all patients. The financial statement should be clear and leave no room for confusion or misinterpretation;

Breifness

Make the statements brief. Lengthy explanations or justifications of the financial policy are not necessary and only serve to confuse readers.

Be sure that all patients have had the opportunity to become familiar with the office financial policy. Even for current patients, it is a good idea to present them with your brochure and request in a tactful manner that they review the financial policy section. New patients can be familiarized with the financial policy at their initial appointment or with a pre-appointment welcoming mailing which outlines the office policies, hours and procedures. Further, if you contemplate a large treatment plan and wish to offer the patient financial options, you may choose to draft a personal letter about your policy. The letter in ***Figure 12*** can be used to illustrate the options to patients.

***Figure 12*: Example of financial policy statements for office brochure**

A. *Payment for services are normally due at the time of the visit unless other arrangements have been made. Patients with a dental benefit plan normally take care of payment at the time of treatment. We will complete all dental claim forms on your behalf to insure prompt payment to you from your plan server. We will be happy to discuss any special needs in the handling of your account. We accept cash, cheques, or credit cards (identify).*

B. *Our office financial policy is to bill patients for all services rendered. We appreciate payment at the time of the visit. If this is not possible, we will arrange to mail you a monthly statement. Payment for all balances are due within 30 days after receiving the financial statement. We accept cash, cheques or credit cards (identify). A late payment charge of one and one-half (1 1/2) per cent will be added to overdue balances monthly until the balance is paid. Please discuss any special needs in the handling of your account with the office financial secretary prior to the treatment appointment.*

Implementing the Financial Policy

Once the financial policy is established and incorporated into a practice brochure, it is advisable to apply it routinely and consistently. Miscommunication can lead to conflicts which could be avoided if the policy is applied equally and fairly.

Suppose the practice has Financial Policy A written in ***Figure 12***, and intends to collect all monies due to the practice by patients at the time of the visit. If the appropriate staff member does not request payment or allows patients to leave without paying for services rendered, then the policy is rendered ineffectual. The infrastructure of office management is jeopardized when staff members arbitrarily choose which policies and rules to follow. Instead, your staff member can use standardized statements to follow through on your office policy, such as:

"Your visit today included two amalgams and composite bonding. The total is $130. Would you like to use cash, credit card or cheque?"

"Today's visit completes your periodontal scaling and root planning. Since this is your fourth visit and the total was $400, your balance for today is $100. Will you be using a cheque again today?"

This reinforces the existing policy and obligates the patient to make a choice as directed. If the office uses Financial Policy B, then the conversation may go as follows:

"Here is your statement for today's visit. We will bill you at the end of the month. All balances are due within 30 days of the billing date. For your convenience we accept cash, credit cards or cheques."

or

"Here is a computer printout for today's treatment. How would you like to take care of this account?"

Financial Policy Discussions

The time to discuss fees and payment arrangements is before treatment begins. The following are guidelines to consider in patient financial discussion:

- Discussions should be held in a private area where you will not be disturbed. The more comfortable the setting, the more relaxed the discussion;
- Discuss your financial policy in a straightforward manner as most patients are rarely embarrassed if this is handled tactfully;
- Review and discuss the patient's dental benefits plan coverage, deductibles and remaining balance, if applicable;
- Payment plans and arrangements should be fully explained and any supporting materials provided (i.e., office brochure and/or written financial policy);
- Provide an opportunity for the patient to ask questions;
- Your patients' care will be enhanced when you arrange credit and collection matters with businesslike efficiency, tactfulness and consideration.

Overdue Accounts

Before taking steps to collect on these accounts, review the statement for possible billing errors. If everything is correct, then a highly specific system of letters and phone calls may be started to prevent the account from becoming uncollectible. If full payment is not received at the time of service, the following steps may be considered:

Step 1:

Start by mailing a reminder statement 15 days after the initial billing statement is sent.

Step 2:

If an account shows up as 30 days overdue, then a simple reminder letter may be sent (See Figure 13). The letter includes a new date for payment and offers assistance as needed.

***Figure 13*: Sample letter to patient over 30 days past due**

Date

Dear_____,

Perhaps you overlooked our recent billing statements that were sent on June 1 and 15, 1997..

We offer billing as a special convenience to our patients and would appreciate your payment of the balance on the enclosed statement by July 15. If for any reason you are unable to pay the balance or have any questions, please call me as soon as possible at 555-1212.

If you have already mailed your cheque, please disregard this request.

Thank you,

Nancy Smith
Financial Secretary

Step 3:

If the account is not paid after sending the first letter, the office should consider a telephone call to inquire about the status of the account and whether the remittance was simply overlooked. Start with a pleasant telephone call. The conversation may go as follows:

> *"Hello. How are you today? This is Nancy from Dr. Jones' office. I am calling about your account balance and perhaps this is merely an oversight, but we had expected your account balance to be paid last week. Is there any problem or misunderstanding?"*

Step 4:

If the account is not paid by the date requested in the letter or after the initial phone call, then a stronger worded letter may be needed such as the one in ***Figure 14***. At this point the patient is almost 60 days overdue and the likelihood of collecting the amount in full is declining. It is suggested that you have a red stamp that can be used to stamp the envelope with a phrase such as: "PERSONAL AND CONFIDENTIAL;" IMMEDIATE ATTENTION NECESSARY;" or "IMPORTANT." Many patients who are not disposed to timely payments will discard your office envelopes without ever opening them. By personalizing the envelopes and using an attention getting color such as red - you may add a sense of urgency to the billing statement.

***Figure 14*: Sample letter to patient between 31 - 60 days**

Date

Dear _____,

You were recently sent a third statement regarding your balance due. At this time your account is almost 60 days old and it is imperative that payment be made within 10 days.

If you cannot send a cheque or utilize a credit card to clear this balance within 10 days, please call me immediately. We look forward to resolving this delinquency as soon as possible.

Thank you for you cooperation.

Sincerely,

Nancy Smith
Financial Secretary

Step 5:

Once an account reaches 60 days overdue, it may be necessary to contact the patient again by telephone. The major problem with collection phone calls of accounts that are this far overdue is that they can be unpleasant due to the inexperience of the financial secretary and the delinquency of the patient.

The collection phone call is not made to embarrass or scold the patient. Instead, the phone call should be looked at as a solution call, not a problem call. To accomplish this, the conversation may go as follows:

"Hello. This is Nancy from Dr. Jones' office. How are you today? It has come to our attention that your account is 60 days overdue and that there has been no response to our letters. Is there any special problem with your account (Assume no problems)? In that case, we would like to take care of your balance using a Visa or MasterCard. Which would you prefer?"

If the patient will not or cannot use a credit card, then decide on a specific date when the payment will be received by the office. The financial staff person should note that date on a collections calendar. If a payment has not been received, then a second phone call is made:

"Hello. This is Nancy from Dr. Jones' office. We were expecting your payment of_____ to be received by today but did not receive it. Is there some way that we can help you resolve this matter? In that case, I am only authorized to offer you another 15 days to clear your balance or our accountant will turn the account over to a collection service."

Step 6:

Follow up with a final letter as shown in Figure 15. This letter informs the patient of their extreme delinquency and of the action that you plan to take. A third phone call to stress the urgency of payment is also suggested. This call is much harder to make and you should be prepared with documentation about charges, dates and previous contacts.

***Figure 15*: Sample letter for accounts 61 - 90 days overdue**

Date

Dear _____,

Your account with this office is seriously overdue. We have contacted you on _____ and _____ by letter and on _____ and _____ by telephone. Each time, you agreed to pay and did not. On the advice of our attorney, we intend to turn this account over for collection unless we have payment in full by _____. Please contact my office immediately at 555-1212 to discuss this matter with our financial secretary.

Regards,

Dr. _____D.D.S.

"Mrs. Jones, this is Nancy from Doctor _____'s office. We've sent you letters on _____ and _____ and called on _____. Each time you promised to pay the overdue account. The last payment was on _____. What measures will you follow to clear up

this account before we are forced, by our office policy and outside advisors, to turn this account over for collection?"

Step 7:

Follow up with a collection agency or legal action.

Chapter Eight - Collecting Patient Revenues

No financial subject may be more relevant to the success of a dental practice than that of collections. Without a sound method to collect monies to pay for salaries and other office expenses, the practice cannot achieve long-term stability. The financial policies of the practice must be clearly understood by the staff person responsible for making financial arrangements, as well as other staff members and patients, to be effective. If the policy is too restrictive, patients may refuse treatment. If it is too lenient, it may result in a large accounts receivable, many of which may result in being totally uncollectible. The following factors may be considered in the creation of a sound office financial policy.

Cash Flow Needs of the Practice

The accounting practices for any dental office should provide enough money to be collected by the practice to pay debts and obligations. If money is owed interest free to the practice and the practice cannot pay its debt, borrowed money will then be needed with interest payments owed to the lender. A lack of sufficient cash may also restrict practice investment in new equipment, supplies, staff salaries or continuing education.

With this in mind, the selection of effective business office staff should be most carefully considered. In particular, the business office personnel should have background experience in handling financial arrangements with the public, or, at the very least, have them attend appropriate classes and/or seminars.

Credit Worthiness of Patients

You can also base payment plans on how long a patient has been active in the practice, history of payment, personal knowledge about a patient, and the amount of the initial payment prior to treatment.

Treatment Plan Acceptance

Many practices have increased treatment plan acceptance rates by allowing patients to gradually pay their entire bill in pre-established increments that are reasonable for the dentist and manageable for the patient. Another option involves the increasingly accepted use of credit cards for payment. Using these methods allows credit-worthy patients, who are unable to pay all at once, to accept needed or desired care.

Third-party Payers

It is preferable to collect full payment from the patient. It is important for patients with dental plan benefits to realize that treatment services are rendered and charged to

them and not to the third party. The dental office should do everything necessary to assist prompt payment to their patient from his/her carrier.

Collection Policies

The office credit and collection policy information should be clearly written and appropriate personnel trained regarding its implementation. Most dentists are not typically involved in the day-to-day financial and collection policies since their time is better utilized in performing treatment. However, the actual policy must emanate from the dentist as the practice leader, with input from accountants, attorneys, financial advisors and staff.

Without realizing it, credit and financial policies are reviewed each week or month when the profit and loss statement is generated and accounts receivable information is noted. However, you may consider reviewing the actual wording and administration of the office credit policies at least semi-annually to determine if modifications are needed. To help in reviewing office policy, the periodic financial report may include, among other items, the following:

- total production;
- total collections;
- total adjustments to accounts;
- total accounts receivable;
- change in accounts receivable (+/-).

Collections from the Patient's Perspective

As previously stated, the financial collection policy will influence patient case acceptance behavior. Many patients who want good dental care can only afford it on a credit basis. If you insist on cash up front you may experience lower treatment plan acceptance rates. A.D.A. survey data show that the average independent dentist collected 99 per cent of all billings. If your percentage is below 99 per cent, you may need to fine tune your policy and review your credit arrangements.

Assignment of Dental Plan Benefits

Based on dental plan reimbursements, dental offices have the opportunity to have the carrier pay the practice directly. Whether or not to accept assignment is up to you. If assignment is accepted, the patient must know that they are still responsible for the entire fee regardless of the amount of dental plan coverage.

It has become commonplace in many, if not most dental practices in Alberta, to have patients assign the benefits of their prepaid dental plans to their dentist when they present for dental care. Assignment of benefits is a practice that is common in other industries/professions where third party companies have traditionally sold their products and, indeed, is generally viewed as a tool to enhance and market their business.

It has also become obvious that this practice, while easing the up-front costs to patients, has influenced some dental practitioners to “treat the dental plan”, ignoring the actual needs of their patients. In addition, some third party carriers are now adopting the attitude that they are the actual “customer” - not the patient - as the carriers make payment directly to the dentist in the vast majority of the claims that are submitted to their offices. Because the third party views itself as the “customer”, and being a good “customer” of that particular office (any office), they then begin to make demands with respect to the price being charged for a given procedure.

However, there are several convenient methods whereby a dental office can accept payment directly from their patients without seriously hurting business and, in fact, promote more comprehensive care to the public.

The first step in removing “assignment” from your practice must involve a face-to-face, sincere dialogue with each patient or person responsible for paying the account. Let them know that you are changing your billing methods to be more responsible as a business person and to be more responsive to their oral health needs. Eliminating third party interference between the dentist and patients does build a closer relationship between parties which will lead to confidence and acceptance of treatment plans when they are presented. Let your patients know that you are being pressured to accept a payment schedule and other onerous demands which will inevitably compromise their care and you will not be party to such promotion.

The following methods of payment have been shown to work well when presented with a very sincere commitment to long-term care for patients:

a) the use of post-dated cheques, which allows for payments to be made over a predetermined time frame. This also allows time for patients to receive benefits from their dental benefit plan, further decreasing the up-front financial burden;
b) the use of MasterCard or Visa allows the dentist to receive payment immediately, while again allowing time for patients to collect from their third party company before the payment deadline on their credit card is reached - this should result in no interest charges, if the dental office will agree to delay submission of charges for a few days when the occasion calls for it.

Credit Card Payments

Typically regarded as a commercial payment method, credit cards have become a popular payment option in dental practices. **(In one survey nearly two-thirds of consumers said they would have used a credit card to pay for the care if they had known it was available).** Many patients prefer to charge their dental services and have the flexibility of paying the credit card as they can. Credit card transactions offer the patient a record of expenses for tax considerations and can help with dental benefit plan claims. While credit card usage will decrease expenses due to lower billing costs, it may be offset by the discount to the credit card company for processing the

reimbursement. Using credit cards typically results in an increase in collections because authorization of a proper credit card charge virtually guarantees payment. Also, payment from the credit card company usually occurs in a matter of days, which in turn provides the dental practice with more available cash.

Patient Payment Plans

For those patients needing additional time to pay, payment plans can be established. The payment schedule should be clearly communicated and agreed upon by both parties. A precise system of tracking payments must be carefully established to avoid collection problems.

It is advisable to develop and use a written schedule of usual and customary fees and to have all staff familiar with this schedule. Financial data is not germane to diagnosis and treatment planning. Financial records may be kept in the patient's file as a separate document.

Specifics of Collection Policies

After deciding which collection policy is best suited to your practice, it is necessary to implement the policy. See Chapter Seven for more information. Keep in mind that selected credit flexibility can be used, but it is still important that the financial support staff know the general policy. There are several options for specific collection policies that can act as a framework for a final customized policy to fit your unique practice.

Payment at Time of Service

This is the most efficient and least costly method for the practice. The dentist writes the fees on a financial communication form and the financial staff will present the bill to the patient immediately following treatment. It is important that the financial staff be available to request payment. In order to do this, staff must have the information available in advance of the patient check-out to be efficiently prepared to present an invoice. The office policy may be communicated through an office brochure or a copy presented to the patient by the office financial manager before non-emergency treatment begins. The timely presentation of your office policy will help to facilitate its implementation. In a service-oriented business, this is a courtesy to the patient.

In addition, it is a good idea to display a sign in your office that tactfully explains your policy. Through these and other efforts, the patient will know what is expected and will not be surprised when the policy is enforced. It is important to be polite and firm in communicating your policy.

Walk-out Statements

This collection policy allows patients the option of payment at the time of service or to receive a walk-out statement showing the services rendered and the balance due with a specific payment plan discussed. By presenting patients with a walk-out statement, you are essentially requesting that they mail a cheque for the balance within a pre-designated period of time, which you may cite to them as they are about to leave. The expectation is that a timely payment will be made and the office will not have to mail an additional bill. To accomplish this, give the patient a printed, return envelope for them to remit the payment. You may even wish to have this envelope printed with a postal permit number whereby you pay the return postage.

Monthly Billing

The most expensive form of collection is to bill patients monthly. This process results in time and expense for personnel, postage, printing, and uncollectible accounts. Even with computerization, billing is an expensive process compared to the previous policies described.

Aging the Accounts Receivable

One way to monitor who owes the practice money and what the amounts are is to age the accounts receivable.

The aging report is produced by listing which patients are under 30 days, 31-60, 61-90 and those that are 90+ days overdue. Remember though, an increase in accounts receivable does not necessarily mean that patients, as a whole, are taking longer to pay bills. This is why it is recommended to age accounts monthly for analyses purposes.

Practice management experts believe that anything over 90 days has a very high likelihood of going uncollected. The following table illustrates the estimates that are made for the value of accounts receivable based on their age:

Account age	Potential value
Current	85-95%
31-60 days	75-84
61-90 days	50-74
Over 90 days	0-49

A good rule of thumb is for the accounts receivable not to exceed five weeks of billings. Conversely, if the total receivables is less than 1/2 month's production, your credit policies are probably too restrictive.

Changes in the Aging of Accounts

The totals for the various aging categories are important to control and should be reviewed monthly. If an increase in any of these time frames is noted, as compared to previous periods of analysis, it may be helpful to investigate why and to correct the process as soon as possible. Delays in collections:

- reduce available cash to pay bills;
- reduce the opportunity to invest monies and gain accrued interest;
- may suggest internal office problems or inefficiencies;
- often lead to patient conflicts over amounts due.

A signal of longer collection periods sends a message to examine the cause(s).

Chapter Nine - Managing Patients' Dental Plan Benefits

The dentist determines the treatment for the patient and charges accordingly. The third-party payer decides the payment it will make, based on its agreement with the patient's employer; the third-party does not, however, determine the treatment or the dentist's fee. The patient is responsible for full payment, regardless of the amount of assistance received from the benefit program.

It is important to understand that a dental benefits plan represents an agreement between two parties, often an insurance company and an employer, in which the carrier agrees to cover a percentage of costs for services based on preset conditions.

There is an extensive array of third-party contract agreements that exist between third parties and employers or the carriers and benefit parties. Dental benefit plan agreements are highly variable, often creating difficulty for dental practices to establish an efficient system of dealing with them.

The Third Party Claim Process

One of the key elements in properly managing the claim process is to understand how third parties handle claims for specific diagnostic and treatment procedures. Each carrier has its own system for processing claims, but there are some general conditions that will help facilitate the claim process.

For example, suppose a patient receives routine prophylaxis and examination. According to the dental plan contract, the patient will receive some percentage of coverage twice a year as long as the prophylaxis appointments are at least six months apart. A review of the patient record indicates that it has been six months since the previous prophylaxis and examination. In a manual system, the claim is then submitted to the carrier company and received by a first level representative. This individual examines the claim, notes that the patient has the coverage described above and that it has been six months since the last prophylaxis and examination. At this point the representative has the ability to authorize payment for the prophylaxis and examination without consulting anyone else. Theoretically, this should be a relatively short process, since only one dental plan representative is involved in the process of authorizing payments.

Suppose, however, that the treatment plan calls for six anterior crowns in order to improve a patient's occlusion and to restore strength to these teeth. This treatment data is then placed on a third party claim form using universal codes, mailed to the carrier, and received by the first level representative on the same day. After reviewing the claim, that individual will immediately recognize that he or she does not have the authority to evaluate the claim or authorize payment. The claim will then be reviewed by one or more higher level individuals and if necessary by a dental consultant of the third party to evaluate:

- if the treatment is deemed "necessary" by the dental consultant;
- if the patient has coverage for this type of treatment under this specific plan;
- what percentage of the procedure(s) is covered by the plan;
- whether or not additional information such as radiographs, casts, or a narrative about the case is required to help the dental consultant make a final determination in regard to financial coverage.

This second claim process may possibly require a longer period of time for several reasons. The individuals who are assigned to review this claim may have other work which needs their attention prior to the time that they will be able to review this specific claim. The dental consultant may require additional information from the dental practice in order to make a final assessment about the claim. Analysis of whether or not the patient's specific dental plan policy covers the services provided in this claim may demand a more in-depth review of the dental plan contract.

The point of the above examples is that each claim is processed differently and each third party handles these claims in its own manner. The mechanism of how a third party processes claims will affect the length of time until a decision is made about payment and what percentage of the service is covered. This places a burden on dental practices because variations in the response of carriers can create difficulty in establishing and maintaining an efficient third party monitoring system within dental practices. As the number of policies and variations of benefit plans continues to grow, this process will become increasingly complex and require more specialized staff. While the following definitions will facilitate an understanding of claims processing, third party payers typically refer to this process as predetermination.

Pre-authorization

Statement by a third-party payer indicating that proposed treatment will be covered under the terms of the benefit contract.

Predetermination

An administration procedure that may require the dentist to submit a treatment plan to the third party before treatment is begun. The third-party usually returns the treatment plan indicating one or more of the following: patient's eligibility, guarantee of eligibility period, covered services, benefit amounts payable, application of appropriate deductibles, co-payment and/or maximum limitation. Under some programs, predetermination by the third party is required when covered charges are expected to exceed a certain amount, such as $600.

Electronic Submission of Claims

Claims submitted directly through the computer are processed and usually paid faster and with greater ease. One of the most important principles of computer facilitation is that all information need be entered only once.

Some dental benefit carriers encourage the submission of dental claims and pre-authorizations through electronic transmission. The third party's time to process a paper claim is based on the human review of each claim and the time it takes to enter this information into their computers. Since the third party's administrative cost per claim does not vary appreciably by the dollar size of the individual claim, many carriers would prefer to automate, if possible.

Predetermination

One way to determine in advance the specific coverage provided for a patient when a defined service is performed is to send a predetermination query to the third party. Predetermination is the process of submitting all the necessary information about proposed services to the carrier. Thus the carrier can determine if services are covered under the contract and at what level of reimbursement.

For many practices, the process of predetermination appears to create inefficiency because it uses the staff time inappropriately and has a response time that can often take weeks or even months. In the meantime, a patient who may be ready to accept treatment may not want to begin until a response from the third party is received. It is important to note that just because a treatment plan has been submitted and the third-party has issued their predetermination, there is no guarantee of payment by the third-party.

Certain dental benefit plans or contract organizations may retain the right to set a maximum fee which dentists can charge for specific services. If you are a participant in one of these plans, then the percentage covered by the third party will represent a percentage of a maximum allowable fee. Even if your fee is normally higher than that allowed by the third party, you may only be permitted to charge the maximum fee determined by the carrier. In this situation, a predetermination will advise the practice as to the total dollars available to perform specific services. If the fee charged by the practice does not exceed the maximum limit, then there should be no problem. However, if you have entered into a contractual agreement, and the fee charge exceeds the third party's maximum limit, you may be restricted in charging your allotted fee.

Although a complete discussion of dental benefit policies and practices is beyond the scope of a single chapter, it is important to be aware of some of these principles when managing benefit plans.

Another aspect of predetermination is that it requires staff time, delays patient treatment, and may necessitate another patient consultation to finalize the financial arrangements. The following suggestions can help expedite the process:

- create a file or a list of third parties or policies that require pre-authorization. Many computer software programs can enter in specific plan coverage information which allows you to respond to patient inquiries much faster;
- predetermine any unusual treatment;
- always clearly state the proposed treatment;
- send accompanying radiographs of procedures that require them;
- clarify the reason for treatment in a written narrative when necessary to explain why certain procedures are being performed. For example, the fee for a diagnostic wax-up may not be covered unless a letter is sent explaining the reason why the wax-up needs to be done. Letters can make a difference in many cases. Remember the purpose of the pre-authorization is to find out what is covered and what is not;
- depending on the case, send appropriate photographs as pictorial indications of why treatment is necessary. This is especially helpful in cases that border between restorative dentistry and aesthetic enhancement. A restorative case may be covered, while an aesthetic case may not. Photographs can help the dental consultant reviewing the case to assess the reason that proposed services are to be provided;
- send study casts or diagnostic wax-ups only if a specific request is made. A set of casts can be extremely beneficial in case evaluation.

The main point is that sending pertinent information will facilitate the predetermination process. It saves time that may be lost if additional data is requested by the carrier to enhance the review process. Each third party's dental consultant typically has some flexibility within the structured company guidelines. The more information provided to clarify the need for the services, the more likely the dental consultant is to understand the need for treatment. The predetermination process allows the carrier to ascertain whether or not coverage is to be applied to each specific case. Many dentists view third parties negatively, because they believe that they dictate treatment. Their role should not be to determine or suggest appropriate treatment, but only to assess if that service is covered in the patient's contract.

Do not be encouraged by patients to begin treatment unless they have agreed to pay the entire fee in the event that the carrier denies payment for any reason.

Section Two

A Dentist's Guide to Managed Care Marketplace Information

Contents

Preface

One of dentistry's successes is the result of its long-term emphasis on the prevention of disease.

Questions of participation in a dental managed care plan are now challenging dentists on a broader scale than ever before. In fact, managed care has become the health care buzzword, offered as tonic for all the burdens of an increasingly expensive health care system. Dentistry has not been left untouched by this growing phenomenon.

Those dental benefit plans that emphasize prevention and early detection of oral disease have helped keep dental costs down.

The effect of a well designed dental plan will be to promote oral health through cost-effective treatment and patient participation.

Dentists want and need information about these plans, how they work, typical contractual requirements and the possible economic consequences. This manual will help dentists understand the changing practice marketplace and assist them in making an informed decision regarding whether or not to participate in managed care.

The Alberta Dental Association and College does not endorse the managed care concept for the following reasons:

- It limits the patient's ability to choose their own dentist;
- There could be a reduction in the quality of care for patients covered under these plans due to restrictions and controls that the terms of contracts may place on the provider and the ability of the provider to offer their normal standard of care at the discounted fee level.

Golden Rule: **It is prudent that dentists signing contracts should consult an accountant and a lawyer to ensure they understand their obligations and that they comply with legislation.**

Introduction

The purpose of this section is to provide dentists with an overview of managed care and discuss the implications for individual dental practices. Certainly, there will be changes in dentistry if managed care continues to grow. The changes, may be the result of economic forces, some of which are already occurring in the dental care environment.

Possible Changes in the Dental Marketplace

- Increase in the number of people with dental benefit coverage;
- Change in the types of services covered;
- Downward pressure on dental coverage if global budgeting is adopted;
- Loss of patient freedom of choice in selecting a dentist;
- Reduction of practitioner influence in the marketplace;
- Formation of provider networks to compete in the marketplace;
- Control of health care expenditures;
- Shifting of financial risks from purchasers to dentists;
- Pressure for greater administrative efficiency; and
- Increased segmentation of the dental market.

Participation in managed care plans is a complex and serious decision and each provider must take time to determine how participation will affect his or her practice.

Part One - Managed Care Plans and Models

What is managed care? The term managed care refers to a cost-containment system that controls the utilization of health care benefits by:

- restricting the type, level and frequency of treatment;
- limiting access to care; and
- controlling the level of reimbursement for services.

The foundation of a managed care dental plan is the contractual relationship between the benefit plan and the dentist.

There are generally two major vehicles for managed care dental plans: Capitation programs and their various hybrids and Preferred Provider organizations (PPOs) and their various hybrids. Both are concepts for financing dental care. Capitation typically places the dentist at financial risk, partially or fully, and reimbursement is controlled. PPOs may require dentists to offer discounts on usual fees and typically subject dental practices to organized utilization review and control.

Types of Dental Benefit Plans

Essentially dental benefit plans are simply a means of providing patients with assistance in paying for predictable dental treatment.

Direct Reimbursement

Direct reimbursement is an approach to self-funding employee dental benefits. It is a cost-effective way to provide a dental plan for employees while protecting their right to be treated by the dentists of their choice.

Under a direct reimbursement plan, the employee and covered dependents pay the dentist's bill directly to the dental office. The employee is reimbursed for all or part of the expense, depending on the benefit levels of the plan. Reimbursement is based on dollar expenditures rather than on services provided. Unlike conventional plans, there are typically no exclusions and few if any limitations on specific treatment or services.

Administrative Services Only Plans

These are a type of self-insure plan where the employer sets aside a predetermined dollar sum for each employee and dependents for their dental care. The employer contracts an "outside" agency to administer the plan.

There are generally no treatment restrictions on A.S.O. plans except the yearly maximum. There is no choice of dentist limitation. Profiling of individual practitioners is still done by the administrative agent.

These plans offer flexibility, cost containment, predictability, and accountability.

Traditional Indemnity Plans

Traditional Indemnity Plans are a method of reimbursement in which a third party provides payment for an amount of specific services. Reimbursement is made to the patient for all or part of the dentist's usual fee.

Traditional indemnity plans are agreements between the patient and the plan purchaser (usually an employer). Some of these plans are beginning to use some of the techniques of managed care plans such as utilization review. Thus, it is important to distinguish "managed care principles" from "managed care plans."

Certain cost containment mechanisms are used in traditional plans. For example, these might include pre-authorization of treatment, co-payments, limitations on services (e.g. two prophylaxes per year), claims review and utilization review programs through which dentists' treatment patterns are monitored.

In a traditional indemnity plan the patient is responsible for the entire fee charged by the dentist.

Preferred Provider Organizations (PPOs)

PPOs offer discounted fees in accordance with a contract between the PPO and the dentist. This discount may act as an incentive to patients to "prefer" a participating dentist over a non-participating dentist.

PPOs require a contractual relationship with participating dentists who agree to discount their fees to the plan's subscribers. Although PPOs are promoted to dentists on the basis that the plan will result in an increased patient base, this increase is not usually guaranteed by the plan, nor is it usually made a part of the contract.

Utilization review (UR) is a major control mechanism in PPOs. In those instances where dentists' utilization of a procedure goes above the "norm" established by the insurer, the dentist might be notified by the insurer regarding performing more of one type of procedure than other dentists in the area. Thus, utilization review may have an impact on clinical care.

Capitation Plans

Capitation plans finance and provide an agreed upon set of dental maintenance and treatment services to a defined population for a prepaid, fixed amount of money. The defined services are reimbursed by a fixed, usually monthly, payment based on the number of enrolled participants regardless of whether they ever see the dentist or how often they visit the dentist.

The practice receives a predictable cash flow and income source. The trade-off is that when a dentist contracts to a capitation plan, the dentist assumes the financial risk of the cost of the patient's care. To stay in business, capitation plans are constantly challenged to reduce the cost of care delivered but still keep people healthy while attempting to maintain the quality of care delivered.

Part Two - Tools of Managed Care

Quality Control

Credentialing is a popular method used by managed care organizations for evaluating the competence of the dental professional or for enrolling a dentist. Credentialing often requires:

- licensure;
- liability insurance;
- prior acts review;
- institutional affiliation;
- specialty training and board certification;
- periodic re-credentialing; and
- continuing education.

Treatment facilities may be judged on:

- sterilization techniques and infection control;
- adherence to infection control guidelines;
- staff training and in-service education;
- emergency preparedness;
- automation/computerization; and
- accessibility for handicapped persons.

The quality of patients' dental records may be based on:

- completeness;
- legibility;
- treatment plans; and
- detailed records of treatment.

Information on patient satisfaction is usually solicited through written questionnaires or patient focus groups and is determined by:

- patients' perceptions of the value and quality of services;
- treatment of patients by dentist and dental office staff;
- access to, or convenience of care;
- hours of the dental office, including early morning, evening and weekend appointments; and
- costs.

Utilization Review

Utilization management is an important tool of managed care plans because the rates of utilization of services directly affect the total cost of care and thereby the financial status of the plan.

It is important to remember that regardless of the plan's utilization management, liability for treatment decisions typically falls on the dentist.

Dentists joining managed care plans should consider how utilization management may influence their practices.

Utilization review may require dentists to obtain prior approval for non-emergency services, and it may involve retrospective reviews to determine if the services or care provided were over or under utilized. It might also be a thorough office audit where facilities, charts and procedures can be reviewed in a quality assurance process.

Utilization Rates

While utilization rates may give the dentist a sense of how he or she compares to other practitioners, raw views of these utilization data do not necessarily lead to conclusions about over or under-treatment of patients.

Referral Rates

The data often are used to compare dentists according to the conditions for which referrals are being made and might be used in an attempt to reduce the number of referrals.

Procedure Utilization Rates

Procedures are often assessed by measuring the number of times a procedure was used per 1,000 patients.

Preventive Service Rates

When limited insurance dollars are available, it makes sense to focus them on prevention. However, many managed care plans limit the utilization of preventive procedures.

Member Satisfaction Rates

Many managed care programs use surveys to assess patients' satisfaction with individual dentists and dental groups.

Clinical Protocols and Practice Guidelines

Dentists may be assessed based on their compliance with practice guidelines that are specified and defined in the managed care contract.

Part Three - Issues Related to Managed Care (MCO)

Prior to contracting with an MCO, dentists might ask themselves the following questions:

1. How will an MCO affect the quality of clinical care I am able to provide?
2. What are my business objectives?
3. How will an MCO affect my style of practice?
4. What are the ethical considerations in dealing with an MCO?
5. Is the plan economically feasible?
6. What are the legal implications if I join?
7. Will this affect my hospital affiliation?
8. What added costs and revenue can I expect?
9. Will I lose patients if I don't join?

Practice Objectives

Two fundamental components of a successful dental practice are customer service and patient relations.

Dentists rank extremely high in honesty, integrity and trustworthiness.

Dentists have been held in high public esteem for many years and they spend a considerable amount of time developing a professional relationship with their patients. It is through this trusting service relationship that patients are taken to higher levels of oral health awareness and care.

Providing expanded customer service usually requires increased time and commitment to each patient.

When profitability in managed care plans is based on the assumption that increases in productivity can be accomplished, expanded attention to customer service may be difficult to maintain. Attention to increased customer service and increasing volume are often opposing business objectives. Mass delivery of health care may lead to less time spent with each patient. Over the long run, this may be detrimental to the nurturing of the doctor-patient relationship.

Ethical Considerations

Dentists who enter into managed care agreements may be called upon to reconcile the demands placed on them to contain costs with the needs of their patients. Dentists should not allow these demands to interfere with the patient's right to select an appropriate treatment option based on informed consent. Nor should dentists allow anything to interfere with the free exercise of their professional judgment or their duty to make appropriate referrals if indicated.

Primary Care Versus Specialty Care

This can raise issues in managed care arrangements, some of which have rules relating to referrals. These rules may take the form of prior authorization, a requirement that general dentists refer only to someone on the MCO's list of participating specialists or financial disincentives to referral.

A dentist contemplating participation in a managed care arrangement is well served by finding out what rules, if any, apply to referrals before they sign up and making sure that whatever rules do apply are consistent with the dentist's practice choices legally and ethically.

The number of referrals to specialists may decline slightly because pressure may exist for general practitioners to provide treatment that they normally would refer in a non-managed care practice. The liability, however, generally remains the same.

Business Goals

With respect to capitation plans, a large influx of patients who have not had access to dental treatment could present a major financial investment by the dentist in bringing these patients to a maintenance level. Since there is no guarantee that these patients will remain in the practice, dentists may never recover this investment.

As the percentage of revenue from contractual plans grows, there is a greater likelihood of a financial impact on the practice if the terms of the contract suddenly change.

Part Four - Evaluating Managed Care Organizations

Common Questions Regarding Managed Care Programs

A. ***What is the management style of the managed care organization?***

- Who will make decisions about consultations and referrals?
- Do your patients need your approval before contacting other providers?
- Will you receive reports from other dentists and maintain the patients' complete dental record?
- Are referrals to dental specialists limited to those who participate in the plan?
- When and how will I get paid?
- How often are reimbursement levels reviewed? What determines any reimbursement changes?
- Do dentists play a prominent role in the management of the MCO?
- Is the information being given to the dentist the same information being given to the purchasers and the plan subscribers?

B. ***Are the MCO's expectations regarding clinical decisions reasonable?***

- Can the dentist balance the plan's cost-containment requirements with quality of care?
- Will the MCO's principles of cost-containment affect clinical decision-making?
- Does the plan require adherence to treatment guidelines for dentistry? If so, who establishes these guidelines?
- Are the MCO's clinical guidelines and rules clear and acceptable? Are they spelled out in the contract? Are they consistent with ethical obligations?
- Are dentists involved in reviewing the clinical reasonableness of treatment decisions?
- Can the range of services be provided in a cost-effective manner?

C. ***What are the terms and conditions of the managed care contract?***

The contract is the document that specifies the relationship between the dentist and the managed care organization.

- How many new patients will the managed care organization actually bring to my practice?
- What is the demographic mix and dental health of the patients enrolled in the plan?
- What claims reporting documents will be required?
- What records will be required?

- Will contracting with an MCO place additional burdens on dental staff?
- Will existing office procedures or appointment schedules have to be changed?
- What revenue will the plan generate for the practice?
- What current revenue will be lost by the practice?
- What are the payment mechanisms and frequency of payment?
- What new financial risks or liabilities will this contract impose?
- What are the conditions that constitute a breach of contract?
- Under what conditions may I terminate the contract?
- Under what conditions can the MCO terminate the contract?

D. ***What services will you be required to provide?***

- When will dentists refer patients to other dental professionals? Who pays for such referrals?
- Will the dental office be required to provide 24-hour care, including telephone consultation? If so, for what services and at what fee?
- Will the dentists need to provide coverage from a participating dentist when out of the area?

Part Five - Economics of Managed Care Compensation

Financial Risk Issues

There is a risk associated with agreeing to provide certain health care services to a given population for a fixed or pre-negotiated amount, without the ability to raise prices to offset external factors.

Capitation represents a frequency risk that is not applicable to PPOs. In return for a flat fee, the provider assumes treatment for patients. It is unknown how many participants in the plan will seek care, what the nature of their oral health care needs will be, or how long they might be enrolled in the specific plan with you as the dentist. Moreover, dentists may have a limited idea of the extent of the enrollees' oral health care needs depending on whether the group has ever had coverage before. This is referred to as intensity risk.

Discounted PPOs often carry significant price risk, in that the discounted charges must be sufficient to cover normal overhead charges. Therefore, it is important for the dentist to fully understand the expenses of the dental office and analyze the monthly profit and loss statement, procedures rendered, and fee schedule prior to entering into a contract. It is prudent to factor in the financial implications of various contract requirements.

Practice Economics and Break-Even Points

It is important for dentists to understand their practice financial situation when presented with a managed care plan. The point at which collections equal both variable and fixed costs is the break-even point for the practice before net revenue to the dentist.

Marginal Cost Pricing, Excess Capacity and Chair Hour Reimbursement

In economic theory, the cost of producing the next unit, after fixed expenses are covered, is known as the marginal cost (MC). Respectively, the revenue from the next unit sold is the marginal revenue (MR). Marginal cost pricing means that the last product produced will be priced directly at the cost to produce it, (variable expense), in other words, priced at the marginal cost.

Chair hour reimbursement then assumes that the only expenses to provide care for the new managed care patients are the variable costs to deliver this new care. Under this theory, any revenue received by the dentists from these new patients would potentially enhance profits, since the fixed costs are covered by established patients.

A variation of this concept is sometimes used by managed care organizations to entice providers whose practices are not being utilized at full capacity to grant price concessions for the managed care patients. This approach assumes that the office is not working up to 100 per cent capacity, again something that is difficult, if not

impossible, to achieve. In looking at chair hour availability, it assumes that each chair can be, and should be full at all times. However, this may not be a realistic way to look at chair availability.

Dentists may be told that, since the fixed costs of operating a dental practice are being paid by existing patients, any new patients that can be added to the practice are, except for the small increase in variable costs, such as supplies, generating pure profit. The “real price,” in this instance, is the marginal price.

In this scenario, the pricing strategy assumes cost shifting, which means that the fixed costs of operating the dental practice be borne by other patients rather than those of the contract being considered. This tends to suggest that price discounts can, or should be, offered only to certain groups in return for volume. However, in the long run, all patients may need to share in the fixed costs of operating a dental practice, because there is no assurance that those paying their share of the fixed costs will tolerate discriminatory pricing for very long; that is, they may demand marginal cost pricing for themselves. When every one desires marginal cost pricing, the fixed costs are not borne by any patients and could lead to decreased profits or insolvency.

Profitability is not best viewed by solely comparing the marginal price to the marginal cost. Profitability is prudently viewed by comparing average price and average cost.

Managed Care Financial Modeling for Capitation

One method to estimate how a capitation plan may affect a practice economics is to develop a model based on average costs per patient visit. In theory, knowing how many patients would be seen under the capitation plan and the average cost per patient visit in an office, a comparison can be made to the proposed monthly capitation reimbursement level.

Step 1.

Determine the average office expense per current patient visit. To do this, divide the total office expenditures by the total number of annual patient visits.

Step 2

Determine the plan’s patient utilization rate. This is needed to determine how likely the proposed patient pool will be using the plan. The administrator of the plan can be asked this value. If this number is not available from the plan, you may wish to estimate this at approximately 57 per cent.

Step 3.

Multiply the average utilization rate times the average number of visits per patient per year.

Step 4.

Multiply the average expense per patient visit by the number of patient visits per year to determine the total yearly dental expense per patient.

Step 5.

Divide the total yearly expense per patient by 12 to calculate the monthly break-even capitation rate needed to meet expenses.

Step 6.

Compare the proposed capitation rate per covered patient to the calculated office monthly expense per patient. Herein lies one of the great issues with any capitation health care arrangement; profits grow dramatically with decreased utilization, for whatever reason.

Managed Care Financial Modeling for PPOs

When reviewing a PPO offer, you can use the break-even analysis outlined earlier to estimate the amount of revenue change to the practice. The following case study shows three different practice assumptions to help you understand the financial analysis needed to review these plans. One assumption calculates the financial effect if the doctor chooses not to participate, the second shows the effects of joining, but receiving no new patients. The third assumes a 10 per cent new patient flow into the practice.

Example:

Discounted PPO Case Study

Dr. Mary Jones
Year ending December 31, 2002

Total Revenue:	$274,000
Fixed Expenses:	
Office Rent	24,000
Interest on Business Debt	5,600
Depreciation	8,000
Marketing	4,300
Business taxes	3,900
Insurance	
Business	3,200
Liability	3,000
Telephone	2,100
Utilities	4,300
Legal and Professional	2,500
Continuing Executive Director.	3,250
Dues, Licenses	2,750
Total Fixed Expenses	$66,900
Variable Expenses:	
Salaries (non dentists)	$54,800
Employee Benefits	11,800
Uniform allowance	1,000
Dental supplies	$19,500
Office supplies	7,250
Laboratory	25,500
Equipment repair and maintenance	1,500
Miscellaneous	700
Total Variable Expenses	$122,050
Total Expenses	$188,950
Net Income (before taxes)	$85,050

Dr. Mary Jones is presented with the option to contract to a Preferred Provider Organization at a 20 per cent fee discount. She is concerned that she may risk the loss of patients, as 25 per cent of her current patient volume would be subject to this new plan. Dr. Jones believes that signing would increase patient volume by 10 per cent. How would signing this contract affect her income under the following three assumptions:

1. possible loss of 25 per cent of her patients by not signing
2. no new patients, but a 20 per cent discount in fees from signing the contract
3. an increased patient flow of 10 per cent by signing contract, with a 20 per cent fee discount

Dr. Jones is also interested in determining the level of production necessary to return her current income of $85,050 if she joins the PPO.
NB: The following calculations are based on the long term results with each assumption.

Assumption 1. Loss of existing patients, no fee change

Current gross income	$274,000
Loss of 25 per cent to PPO	(68,500)
Revised gross income	205,500
Fixed expenses	(66,900)
Variable expenses (75 per cent x 122,050)	(91,538)
New net income (before taxes)	$47,062

Assumption 2. No new (the same) patient flow, 20 per cent fee discount

Current gross income	$274,000
Revised gross income (20 per cent reduction)	219,200
Total expenses	(188,950)
New net income (before taxes)	$30,250

Assumption 3. 10 per cent increase patient volume, 20 per cent fee discount

Current gross income	$274,000
10 per cent increase in gross income	301,400
Revised gross income (20 per cent fee reduction)	241,120
Fixed expenses	(66,900)
Variable expenses (10 per cent increase)	(134,255)
New net income (before taxes)	$39,965

Economically Dr. Jones is better off not to sign the contract, even if she were to lose 25 per cent of her patient volume. To regain her income of $85,050 at the 20 per cent fee discount, Dr. Jones would have to do 57 per cent more dentistry than she is currently doing. If she were practicing 7 hours per day now, she would need to practice 11 hours per day with the discount plan to maintain the same income.

Current gross income	$274,000
57 per cent increase in patient volume	430,180
Revised gross income (20 per cent fee reduction)	344,144
Fixed expenses	(66,900)
Variable expenses (57 per cent increase)	(191,619)
New net income (before taxes)	$85,625

Part Six - TERMS & CONDITIONS OF MANAGED CARE CONTRACTS:

When you sign a contract, you make promises that are legally binding on you. If you fail to do what you promise, the other party may initiate legal action against you. It is, therefore essential that you and your lawyer carefully review and understand the contract before you sign it.

Understand what you are promising to do by signing the contract. Are you willing and able to live up to these promises? What can you do if something goes wrong?

The information below is not to be construed as legal advice, and **dentists are strongly advised to seek their own legal counsel before signing any agreement**.

Remember any part of a contract is negotiable; refusal to negotiate should be a sign of trouble ahead.

A. **Documents**:

- Most contracts refer to other documents such as appendices, schedules, exhibits, policies etc. Be sure you have acquired, read, and understand these documents.

- If the contract is subject to change, determine how and when you will be notified and what say you will have in the change if it is going to adversely affect you. .Avoid clauses that force you to automatically agree to modifications.

Rule: Before you sign anything, obtain, and carefully review with your lawyer all the documents that form the contract.

B. **Term and Termination**:

- What is the term or length of the contract and is it negotiable?
- When can you terminate the contract? Any time? Once a year?
- How much notice is required by you? How much notice is required by the Insurer?
- Can the contract be terminated for any reason (without cause) or must there be a reason (with cause)? What are these reasons and are they the same for you and the Insurer?
- Do you have obligations after termination, (eg. completion of treatment in progress) and will you be paid?
- Some contracts have non-competition clauses that prevent you from signing with other networks for a period of time and over a specified geographic area. Be sure you are aware of these limitations.

C. **Liability**:

- Who is responsible for liability arising out of the contract?
- Is there a "Hold Harmless" clause that shifts liability from the third party to you? For example:

"The dentist promises to indemnify and hold the company harmless from any and all claims, lawsuits, and actions arising out of any dental treatment provided by the dentist."

This means that you promise to hire legal counsel and pay for any losses incurred by the company because of claims or lawsuits brought against the company because of dental treatment provided by you.

Hold harmless clauses create obligations for you that you would normally not be responsible for. Normally you must pay for your own negligence, but a hold harmless clause may mean that you have to pay for someone else's negligence also.

These created obligations are "contractually assumed", meaning in all likelihood you did not have these obligations before you signed. Liability insurance does not normally cover contractually assumed liabilities.

Rule: Never sign a contract with a Hold Harmless Clause without first consulting your legal counsel and your malpractice insurer.

- Is there a "Sole Responsibility" clause that shifts liability from the third party to you? For example:

"The dentist is solely responsible for all dental treatment provided under the contract."

In this situation if the contract controls treatment protocol or restricts referrals to specialists, a patient may think there is evidence of malpractice arising out of this situation. If you are solely responsible then you accept full liability.

Rule: Contract obligations must not alter the standard of care which the dentist owes to all patients. Consider carefully whether the contract will interfere with your high standard of practice before you sign it.

D. **Referrals**:

- Does the network use a closed panel of specialists? This means that you must refer to specialists signed to the plan.
- Who are the specialists on the closed panel?
- Can you refer to a specialist outside the panel? Are you financially responsible for the referral; that is, are you liable for payments to the specialist?

Rule: You have an obligation to your patients to make sure that treatment is not compromised, regardless of any restrictions in the contract.

E. **Utilization and Peer Review**

- All PPO arrangements control plan costs by:
  - negotiating fee discounts with providers
  - controlling utilization (referred to as Quality Assurance, Utilization Review, or Review Committee)
- Will you be subject to utilization review or external audit?
- How will it be conducted and who will do the review? (What are their qualifications?)
- What standards will be used and who sets them?
- Will you be required to participate in a peer review process?
- Who will do the peer review and by what standards?
- Will you have to peer review other dentists?
- Is the peer review binding or is there an avenue of appeal?

Rule: Will the utilization/peer review process influence or control the way in which you practice dentistry? Will it compromise your professional judgement?

F. **Insurance**:

- Would you need extra insurance for the contract plan and what are the additional costs?
- Does the company have the right to approve your carrier?

Rule: Contracts, by their nature, set up special situations. Understand whether you need to purchase extra insurance or change carriers. Protect yourself while the other party is protecting itself.

G. **Grievances and Arbitration**:

- Who can use the grievance system? Can a patient use it to complain about the quality of your care?
- By submitting disputes to the company grievance system, are you waiving your right to have them resolved in a court of law?
- Does the contract contain an agreement to arbitrate? The arbitrator's decision is almost always final; there is no right to appeal.
- Who pays for arbitration?

H. **Compensation and Covered Services:**

- A PPO will require you to agree to a schedule of fees for a list of covered services.
- You must have a clear understanding of the income your practice generates, the overhead structure, and the types of services you normally perform, before deciding whether to join a PPO.
- You should determine whether you can balance bill for the difference between their fee schedule and your usual and customary fee.
- Remember your earnings are what is left after the expenses are paid. If your overhead is 70% and earnings 30%, then a 10% reduction in your usual and customary fee will translate into a 33 l/3% reduction in your personal earnings.
- How will dual coverage's be handled?

I. **Delegation**:

- Can you delegate your duties under the contract to an associate?
- Can the agency transfer its rights and obligations under the contract to another company? If so, you may find yourself in a contractual relationship with an unknown party. Does the agency need your consent to transfer the contract?

J. **Further Considerations**:

- Will you be required to give all other patient groups and organizations the same price differential given to the PPO?
- Beware of "liquidated damages" clauses. If the dentist breaches the contract and the company terminates the contract, a liquidated damage clause will identify a predetermined lump sum that must be paid by the dentist.

Rule: Most contract obligations belong to the dentist. It is not that difficult to breach the contract. You must protect yourself against any liabilities that could be imposed on you and be certain your professional liability insurance will protect you.

- Determine how your patients will be handled if you are sick or take a holiday. What responsibility do you have to ensure they are treated? If they see another dentist who has different fees, who will pay the difference?

Golden Rule: Always seek the advice of your legal counsel before signing any agreements.

Experience in the United States is:

- Companies initially market plans with simple contracts involving only a few conditions that appear quite innocuous at first glance.
- Contracts soon evolve into very comprehensive and complex agreements with steeper fee discounts as the number of dentists signing and their dependency on the plan grows.
- Terms, controls, restrictions, and the discounted fee structure in the contract eventually make it impossible for you to offer your normal standard of care.
- The percentage of discount quickly moves to the 20% to 30% range.

Section Three

Dental Practice Marketing

Marketing

by H.J. Stockton, D.M.D., C.F.P., M.B.A.

Introduction

Dentistry has changed over the years, and today very few dental services are directly related to the elimination of pain and suffering. Therefore, for the most-part, the public can choose to spend or not to spend their hard-earned dollars on dental services.

In today's business climate, where consumers have so many choices as to how they will spend the limited number of dollars they have available, good marketing of dental services to the public is essential for our profession. All successful businesses use marketing. However, many dentists put little money or effort into marketing because of misconceptions concerning the marketing of dental services to the public. For example, many dentists believe that marketing is simply advertising, and advertising is unethical. As will be explained shortly, advertising is only a small part of marketing, and advertising dental services is not necessarily unethical. Also, many dentists believe that the demand for dental services is directly related to the need for dentistry. As will be explained, this is not true. Just because the caries rate has declined dramatically does not necessarily mean that the demand for dental services will decline; or, just because today's seniors have many missing or broken-down teeth does not necessarily mean that there will be a strong demand for fixed and removable prosthodontics.

This chapter will attempt to help the dentist owner-manager understand basic marketing concepts used in business, and then, how these marketing concepts can and should be applied to the dental profession.

What is Marketing?

Marketing is almost anything a business could do, either directly or indirectly, to increase the demand for its **products** (note: products can be goods or services). Therefore, marketing is much more than advertising. Marketing is very broad and includes all strategies and tactics involving the so-called four Ps of marketing. The four Ps of marketing are:

- **Product**
- **Promotion**
- **Place**
- **Price**

In other words, anything a business can do - to improve its **product, to improve the promotion** of its products, to improve its **place** (its facility or the distribution of its products), or to **price** its products better- is marketing.

Advertising is only one part of promotion. For retail businesses, advertising is a large component of marketing; but, for dental practices, advertising is typically a minor part of the marketing mix.

For a business to be successful in marketing its products, those responsible for developing the marketing strategy must understand what makes a market for a product. The marketing manager (in our case, the dentist-owner) must understand the difference between: (a) the **"need"** for a product, (b) the **"want"** of a product, and (c) the **"demand"** for a product.

Just because someone "needs" a product, does not mean there will be demand for the product. In fact, there is very little relationship between need and demand for a product. For example, most people do not need to smoke cigarettes, eat candy bars or buy lottery tickets; however, many people need to eat healthy food and/or have treatment for periodontal disease, but they choose to spend their money on other products for which they have little need.

What's more, just because someone "wants" a product, does not mean there will be a "demand" for the product. Many people want to own a Mercedes automobile, but only those with plenty of money can purchase such an expensive vehicle.

The point is: demand for a product requires that people (i) want a product and (ii) have the ability to pay for the product. Good marketing requires that a business determines what people want and then targets its marketing effort toward those people that have the ability to pay for the products they want. Dental professionals should have much higher ethical standards than business people and should only consider marketing products that patients need. Therefore, restated for the dental profession, dentists who want to be effective in marketing dental services should:

- determine people's need for dental services;
- educate and motivate people to want the dental services which they require;
- offer the dental services which people need and want to those who have the ability to pay for them (either directly, or indirectly by third parties).

Classifying the Marketing of Dental Services

Before we discuss how to develop and implement a marketing plan for your practice, we should categorize the marketing of dental services to facilitate discussion of the various topics in an organized manner.

The broadest classification would divide marketing of dental services into:
(A) institutional marketing and (B) individual practice marketing. And, for convenience, individual practice marketing is often subdivided into (i) external and (ii) internal marketing.

External marketing refers to those marketing strategies and tactics used outside the dental office and, as expected, internal marketing refers to those marketing strategies and tactics used inside the dental office.

Another classification separates marketing strategies into two overall groups:

(1) those strategies which attempt to increase the size of market for dental services; and
(2) those strategies which attempt to increase the practices' share of the market.

Institutional Marketing

In the long-run it will be best for dentists to increase the size of the market, since simply increasing a practice's share of the market means that another dental practice will lose market share. It is in dentists' best interest to support their professional associations financially and otherwise, since the most cost effective way to increase the size of the market for dental services, would be to have the professional associations (e.g., Alberta Dental Association and College, Canadian Dental Association, Orthodontist's Society, etc.) market for dental services to the public. Examples of institutional marketing by the dental profession include:

- Dental association advertising to improve dentistry's image, to inform and educate the public about dental services, to motivate the public to visit a dentist, etc.
- Dental association promotion such as Dental Health Month.
- Lobbying government to act in the dental profession's best interest concerning issues such as taxation of dental benefits, limits on denturists/hygienists, etc.

Individual dentists cannot afford to mount an effective television, radio or newspaper advertising campaign. Effective media advertising requires hundreds of thousands of dollars. If each dentist contributes a few hundred dollars per year toward association marketing, it is possible to increase the size of the market. Previous association advertising campaigns in provinces and states such as Ontario and California have reportedly been very effective in increasing the dental "participation rate" (the percentage of the population visiting a dentist within the past year).

Developing a Marketing Plan for the Individual Dental Practice

Most dentists do some marketing of their dental practices, but many dentists have no overall marketing plan. A dentist may decide to put a display ad in the telephone book one week, then next week start a practice newsletter, and then the following week begin sending birthday cards to all of the practice patients. Although some of these marketing tactics may be helpful, what is really required is an overall marketing plan, developed in an organized way, customized for that particular practice, and implemented in a cost-effective manner.

A well-designed marketing plan starts with establishing the practice mission statement and finally results in choosing marketing tactics which should be cost effective for that particular practice. Please refer to Figure A which outlines the **"marketing decision-making hierarchy".**

Figure A

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You may have heard the saying "you can please all of the people some of the time and some of the people all of the time, but you can't please all of the people all of the time". This saying applies very well to developing a marketing plan for a dental practice. Before choosing specific marketing strategies and tactics, you must decide on the focus for your practice and what groups of people you would like to have as patients in your practice . . . you cannot be all things to all people!

For instance, effective marketing strategies and tactics for a practice which focuses on discriminating individuals who want the best dentistry has to offer, may be ineffective (or even counter-productive) for a practice which focuses on individuals who want convenient, accessible, low-cost dental services. Therefore, the first thing you must decide on is what type of practice you want to have; in other words, first you must establish the mission and goals for your practice.

The mission and goals, by their very nature, are general, fuzzy statements. Once the practice mission and goals have been established, the practice direction is then more clearly defined by setting specific, measurable objectives. For example, the practice mission may be to provide the best dentistry possible to those individuals who are discriminating and demand the best. One of the practice goals might be to focus the practice on high-quality, comprehensive, reconstructive dentistry; and another goal might be to earn an above-average practice income. Specific practice objectives defining these goals might be: to have more than 40 per cent of the dental practice revenue generated from crown and bridge procedures, and for practice pre-tax net income to be at least $200,000, within five years time.

Once the practice mission, goals and objectives have been set, the next step is to look at the population and divide it into various segments; e.g., by age, by sex, by income, by education, by postal code, etc. Then, you select the segments of the market which have the most suitable potential patients for your practice. These selected segments of the population become your **"target market".** In other words, the people in your target market are the individuals who should prefer the type of practice you plan to operate and who, as patients in your practice, should allow you to achieve your practice goals and objectives. For example, you may decide that - to achieve the above-stated goals and objectives -you will need to target affluent, discriminating individuals, between the ages of 40 and 60, with post-secondary education. Note: Statistics Canada collects this type of demographic information, usually by postal code.

Once you have selected your target market, you must then decide on a **"positioning strategy".** In other words, how should you position your practice in relation to other dental practices in your community? To decide on a positioning strategy you need to research your competitors and the consumer trends in your community. One positioning strategy would be to choose to do the same things as your competitors . . . only better - much like McDonald's might choose to set up right across the street from A & W. If the other dentists in your community have not kept up to date and are near retirement, this may be a good strategy. However, if your competitors are very capable, competent practitioners, this may not be such a good plan. A more effective positioning strategy might be to find a "niche" in the market which is not being served well, rather than going head-to-head with your competitors. For example, if none of the dental offices in your community are offering evening or

week-end appointments, or if sedation (nitrous-oxide and/or intra-venous) is not offered, these are voids in the dental market which you might be able to fill using a niche positioning strategy.

Once you have selected your target market and your positioning strategy, you can start to get into some of the details of your marketing plan. You can then intelligently choose which of the marketing elements to emphasize, and strategically and tactically how you want to develop each element of the marketing mix.

Consumerism

Shortly we will discuss specific tactics which you can use to implement your marketing plan, but first you should attempt to understand today's consumer. The typical consumer is much different today than 30 or 35 years ago. The rise of consumerism, even over the past 15 to 20 years, has been dramatic. If you are going to be-successful marketing dental services, you must understand what today's typical consumer wants and how that is different from a few years ago. Although the various segments of the population will have somewhat different consumer characteristics, the general characteristics of today's typical consumer are as follows:

- ***Wants convenience*** - Today's consumer wants convenient access, free parking and office hours that will not require time away from work or school. This is why mall locations and evening/week-end hours have become very popular.

- ***Wants it "now" and no waiting*** - If something is not in stock at one store, the consumer will typically go to another store rather than order it for future delivery. Dentists must be able to offer appointments the same day for emergencies and within a week or two for regular treatment, or risk losing the patient.

- ***Informed and wants to be more informed*** - Consumers are much better informed than they were in the past and they want to understand the features of the products they purchase. In particular, patients are not willing to accept the recommendations of physicians and dentists without fully understanding the proposed treatment. If they do not receive a full explanation, they are likely to seek a second opinion. Dentists must educate and fully inform their patients of the various options available, then let their patients choose the treatment they want. Note: the courts have entrenched this consumer trait by making informed consent before treatment a legal requirement today for health professionals.

- ***Cost-conscious*** – Conspicuous consumption of the 1980's has given way to greater frugality in recent years. It is now considered fashionable to be a "penny-pincher". Although fee level is not the most important factor when an individual chooses a dentist, it is more important than it used to be.

- ***Wants personalized service*** - There is a growing segment of the population that wants personalized service and is willing to pay for it. Exclusive specialty shops have been proliferating in recent years. This consumer trait will be more or less important, depending on your target market.

- ***Wants choice variety*** - Ice cream parlors which offer only two or three flavors, like they did 30 years ago, will not make it today. Twenty or thirty different flavors must be offered. Notice how popular the different-flavored fluoride gels and the different colored orthodontic appliances are with younger patients.

- ***Prefers the holistic, preventive approach to health, and is environmentally conscious*** - The “amalgam scare" is closely related to this shift in consumer attitude, and many patients want to know exactly what metals are in the casting alloys we use. This consumer shift has opened up the opportunity for dentists to expand their range of services into areas such as nutritional counseling, halitosis treatment and prevention, etc.

- **I*s very concerned about sterility and infection-control*** - The public is very aware of news items discussing the possible spread of AIDS, hepatitis B. hepatitis C, etc. in dental offices which do not follow proper infection control procedures. Not only must you practice infection control, your patients must perceive that you have a very high standard of infection control. Many dental offices are finding that it is effective to make their sterilization areas highly visible to their patients. Some offices now take all new patients on an office tour, emphasizing their state-of-the-art sterilization facilities and procedures.

Although consumer attitudes are changing, one characteristic of dental consumers which is still very significant today, even though it has moderated a bit over the years, is fear and anxiety toward dental treatment. Many surveys have been done to determine what causes people the most fear and anxiety; and, a visit to the dentist is still near the top of the list, along with public speaking and having a baby. Dentists who can allay fear and anxiety in their patients should have little trouble keeping their appointment books full.

Product Life Cycle

An accepted marketing concept is the **product life cycle.** This concept states that all products, unless significantly changed or redesigned from time to time, will always go through four distinct stages or phases, as follows:

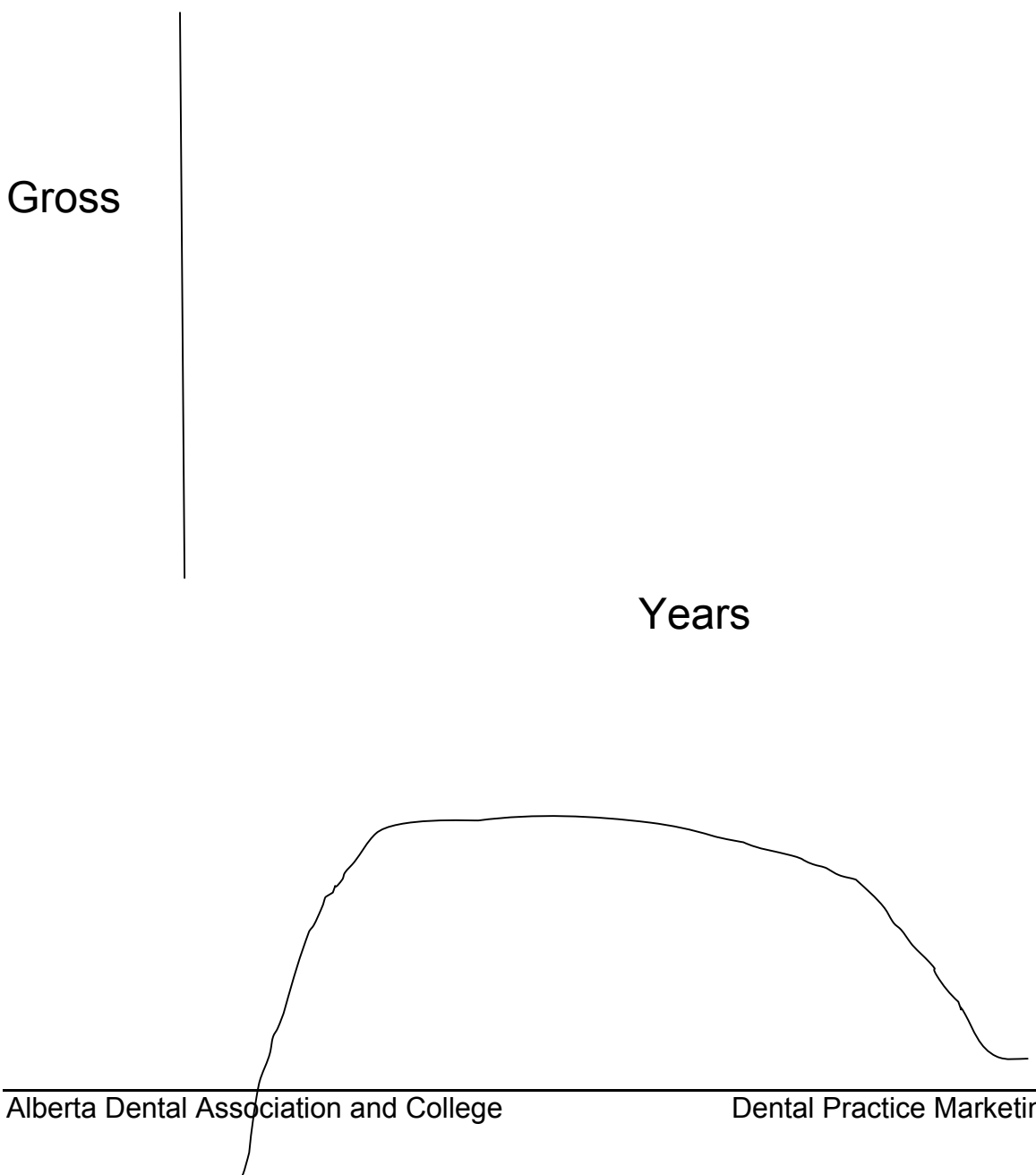
(i) introductory;
(ii) growth;
(iii) maturity; and
(iv) decline.

A dental practice, as well as the individual products it offers to the public, has a product life cycle. This is illustrated in **Figure** B.

Figure B

MARKETING

Product Life Cycle



The multitude of different products have product life cycles which vary dramatically in length, but they all have a life cycle. For example, amalgam restorative material has had a very long product life cycle, compared with many of the tooth-colored restorative materials being developed today which have very short product life cycles.

Some of the features of the phases of the product life cycle are as follows:

- ***The introductory phase*** - It is typically short and is characterized by expenses exceeding revenues for most products. Sales growth is often slow. The digitized X ray and the dental laser are examples of products still in the introductory phase.

- ***The growth phase*** - This is where sales start to grow very rapidly, typically after a critical level of market penetration. The offering price for the product during this phase can often have an abnormally high mark-up, until competitors notice the potential for high profits and also enter the market. For example, osseo-integrated implants are now in the growth phase.

- ***The maturity phase - This stage begins once more competitors enter the market. Growth*** slows and prices become more competitive. This is typically the longest phase of the product life cycle. For instance, the bonded orthodontic bracket has now moved into the maturity phase.

- ***The decline phase*** - Decline eventually happens for all products . . . unless significant changes are made to the product. During this stage sales and profits fall, since the market is extremely competitive and new products with better features are developed and introduced. The amalgam dental restoration is a classic example of a product currently in the decline phase. The gold foil restoration has almost reached the end of the decline phase. .. extinction!

The typical private dental practice also follows the product life cycle. The dentist owner-manager must understand that once revenues start to level off, changes must be made. If not, the practice will go into steady decline. The astute practice owner will make significant changes before it is too late. Practices that will soon move into the decline phase are those where the dentist has not kept up to date with changes in various areas such as: clinical techniques, management methods, facility design and equipment changes. Astute older dentists, who want to avoid practice decline, will often invite a younger dentist to join the practice. This change can result in the practice re-entering the growth phase rather than progressing into decline.

Market Research

In business, considerable funds are put toward market research. In the dental profession, only the dental associations have sufficient resources to afford sophisticated research; e.g., consumer preference studies, test marketing, etc. However, individual

dentists can and should use simple methods to gather marketing information. The following are inexpensive ways for the individual dental practice to do market research:

- Gather demographic information prepared by Statistics Canada in order to segment the market and identify your target market. Most of this information is either free or available at a very modest cost - at public libraries or from city, provincial or federal government offices.

- In-office suggestion boxes can be useful to obtain feed-back about your patients' level of satisfaction with the various aspects of the services you provide. This approach would be similar to the suggestion slips that restaurants ask you to complete.

- Surveys which you mail to your patients is a more costly but more effective method of surveying your patients than the simple suggestion box. Using this method, the questions can be more focused and the statistical results more reliable. Questionnaires with a few focused, simple questions using a five-point scale usually have the highest response rate. To be statistically valid, the surveys-should be-mailed to at least 100, randomly selected patients. In addition to the useful information you get from suggestion boxes surveys, there is a marketing benefit purely related to the process. The use of suggestion boxes and surveys implicitly says to your patients: "we care, we are concerned and we want to improve".

Marketing Tactics

Most dentists are aware of the various marketing tactics which can be used to increase demand for the individual private dental practice. Many articles have been written and many seminars have been presented, discussing marketing tactics which can be used by dentists. The problem is that many dentists do not know when to use which tactics.

The previous discussion concerning the marketing hierarchy and some of the basic principles of marketing should help you to understand when it should be effective to use the various marketing tactics.

The remainder of this section will discuss examples of marketing tactics which can be used by dentist owner-managers. The tactics which will be most effective will depend on your practice's objectives, target market and positioning strategy.

Numerous studies show that most practices attract the majority of their new patients through word-of-mouth referral. For general practices, most word-of mouth-referral is from the practice's patients, which is mainly related to internal marketing tactics. Although internal marketing tactics are the most important, external marketing tactics have become relatively more important with the recent rise of consumerism. Generally, the less discriminating the individual, the more effective the external marketing tactics.

External Marketing Tactics

Place :

- Location is very important today for urban dental practices. Typically, for general practices, the location should have high traffic flow past the office, should be highly visible, and should have convenient access and parking. An adjacent major draw such as a supermarket or a busy medical clinic is preferred. Ground floor locations are best.

- The image of the building should compliment the type of practice you are planning to develop, and it should meet the expectations of your target market. For instance, an upper-end practice located next to a thrift store would not be appropriate.

- Signage should be visible, professional and illuminated. The biggest mistake many dentists make with signage is not having it illuminated 24 hours per day.

Promotion:

- Paid advertising - such as yellow pages, newspaper and direct mail -is most effective for practices which are targeting non-discriminating consumers with low dental IQs. Paid advertising can be quite helpful in attracting those individuals who seek a dentist only when they have an urgent dental problem. But, practices targeting the upper end of the dental market may benefit very little from paid advertising, since discriminating individuals typical seek a dentist through word-of mouth referral.

- Unpaid media coverage - such as articles in the newspaper, guest appearances on radio talk shows, or TV clips about your practice is generally effective for all types of practices. Opportunities to let the media spread the word about you or your practice should be encouraged; just be careful not to offend your colleagues or your dental association.

- Other external marketing promotion tactics - such as holding an open house, joining service clubs, etc. - are listed in Figure C.

Product and price marketing tactics generally fall under internal marketing, discussed below.

Internal Marketing

Product:

Most of the marketing tactics which fall under the "Product" category are not thought of as marketing by many dentists. But, as mentioned, anything which increases the demand for your dental services is marketing. Therefore, any tactics which either (a) improve your products or (b) expand your product line would be considered as

marketing under the "Product" category. Examples of "Product" marketing tactics include:

- Investing in continuing education to improve your skills or to learn new skills; such as, acquiring the skills and knowledge required to provide an implant service at your practice

- Providing nitrous oxide or intravenous sedation at your office to attract new patients and/or avoid referring services out of the office.

- Having dental specialists come to your office to provide in-house services for the convenience of your patients. One-stop shopping is a growing consumerism trend.

- Purchasing high-tech equipment such as a digital xray unit or laser, to improve certain aspects of the service you provide.

- Adding trained personnel such as a lab technician or a hygienist to improve the quality or reduce the cost of services you provide.

Another product marketing tactic is the concept of product **"differentiation".** Product differentiation means - doing things to make your product unique and/or to be perceived as unique by consumers. If your product is unique, consumers cannot simply go to a competitor and get the same product at a lower price. The more you are able to differentiate your product, the higher the price you are able to charge. For example, prices are extremely competitive for undifferentiated products such as gasoline or milk; whereas, a painting by a famous artist is a highly differentiated product which can command a much greater price mark-up.

With a little marketing effort on the part of a dentist, his/her dental services can be differentiated from similar services by other dentists. For instance, your gentle manner or your "painless" injections can be perceived by your patients as being unique. If so, your patients are unlikely to leave your office on a whim and seek a new dentist. Aesthetic dentistry, in particular, is a product which can be easily differentiated. Patients seeking aesthetic dentistry are usually discriminating individuals who are prepared to pay a premium price to get the "best" result.

Price:

To date in Canada, price has been used very little as a marketing tactic for dental services; studies show that most dentists follow the published provincial fee guides. Although, this may change now that the published fee guide has been eliminated in Alberta. In most industries pricing is a very important marketing tactic, and in the United States price has been used effectively by some dental practices as a marketing tactic.

Dentistry is a profession, and as such, the use of price as a marketing tactic must be moderated compared with pricing tactics used in other businesses. While in

most businesses prices are ruthlessly adjusted to gain market share and to maximize profits, professional fees should be fair to both the consumer and the professional. However, since dentistry is also a business, which is gradually becoming more market-driven, you should understand some of the pricing tactics which are used in business.

The target market for a business is very important when developing pricing tactics. Certain segments of the population are very price sensitive and other segments are much less price sensitive. Generally there is a trade-off between time and money. The busier people are, usually the less price sensitive they are. Also, discriminating individuals are less price sensitive. As previously mentioned, discriminating individuals are prepared to pay a premium to get the best. Discriminating individuals are generally more affluent and better educated, but this is not always the case. For instance, multi-billionaire Warren Buffett is renowned for his frumpy appearance and penny-pinching spending habits.

Understanding the **"price elasticity"** of a product is important before deciding on pricing tactics. Price elasticity - is the sensitivity in demand for a product to the price for that product. A product such as gasoline, where small changes in price would significantly affect the demand for the product, would be considered to have very high price elasticity. Whereas, a product such as plastic surgery, where a small change in price would-not significantly affect demand, would have low price elasticity.

Compared to most consumer products, dental services are generally thought to have relatively low price elasticity. Although, good research on the topic is very limited, and there are conflicting opinions. Amongst the various dental services, logically, those services which are least differentiated and which are easiest to price-compare would have the greatest price elasticity. Recall hygiene visits and complete dentures likely have higher price elasticity than periodontal surgery, but there is little evidence to support such guesstimates.

Examples of business pricing tactics which have been used by some dentists are as follows:

- ***Loss leaders*** - The-idea-with this tactic-is to entice consumers into-the store by offering a product at a very low price (often below cost), in hopes that they will purchase other products. In dental practice, some dentists offer free or discounted examinations in hopes that the patients attracted to the office will need other treatment.

- ***Bundling services*** - The concept here is to increase the volume of sales by bundling products together at discounted prices. Furniture stores use this tactic frequently; e.g., if you buy a seven piece dining room suite, the total cost is less than if you buy the individual pieces separately. In dental practice, some dentists offer a recall "package" (e.g., scaling, polishing, exam, fluoride and bite-wing X rays) at a lower fee than if the services were purchased separately.

- ***High price = high quality*** - A large segment of the population believes that "you get what you pay for". In other words, if a certain product has a higher price than similar products, the quality must be better. Marketers capitalize on this consumer belief by using intense advertising, fancy packaging, etc. and then charging a higher price markup. Name brand blue jeans and special-occasion candy are sold with above-average price markups using this pricing tactic. Dentists, who are attempting to target discriminating consumers who want the best, may be more successful by raising than by lowering fees. If a dentist's fees are above-average, many of his/her patients will perceive the quality of the service as being superior.

Place:

The interior appearance of the dental office, and in particular the reception-business area, is very important from a marketing point-of-view. Perception is reality, and patients will very quickly make a judgment about your dental office based on the appearance of your reception-business area. It is extremely important to have defined your target market before you decorate your reception area. The reception room decor should very closely match the expectations of your target market. For instance, if you are planning to build a high-volume practice based on extended hours and discounted fees, a luxurious reception area would be counter-productive. Many of the patients in this target market would immediately assume that your fees are too high, even if they are discounted.

Although your leasehold improvements should meet the expectations of your target market, you should also be aware that some dental practice studies show that there is no correlation between the cost of the physical plant and the practice's gross income. In fact, there is a negative correlation between cost of the physical plant and net income. In general, it seems that patients are more concerned about the office being clean, neat, tidy, well-maintained and modern, than in how luxurious the leasehold improvements are. Spending huge amounts of money on fancy leasehold improvements may do more for your ego than for your business.

Promotion:

There are hundreds of internal marketing promotion tactics. Most dentists are aware of these tactics, but few-implement them. Please refer to Figure C at the back of this section for a listing of many of the internal marketing promotion tactics which can be used. Most are simple, logical things that are relatively easy to do.

The end result of internal marketing promotion, is to have patients leave your office believing that they got more than they expected. There are basically three types of patients who leave your office:

(I) Those patients who got pretty much what they expected - They will likely return and continue as patients in your practice, although they are unlikely to refer a large number of new patients to your office;

(2) Those patients who got less than they expected- Many of these patients will not return. They will seek a new dentist whose services will meet their

expectations. In the worst case, they may even spread bad rumors in the community about your practice;

(3) Those patients who got more than they expected- These are the patients you really want, since they will usually tell others about how great the service was at your office This group of patients typically refers many new patients to your office; some will become "missionaries" for your practice. You want to identify these patients and encourage them to continue referring new patients. This third group of patients are the ones who, in addition to the normal thank you letters, you should consider sending gift certificates to a nice restaurant, tickets to a hockey game, etc.

Remember, you cannot do everything yourself. Staff selection and training is extremely important if you are to be successful with internal marketing.

The Bottom-line

Planning is very important, but in the end, your plan will be useless if you do not take action. You must act and implement your marketing plan!!

Figure C

SUMMARY OF MARKETING STRATEGIES

Internal marketing to increase referrals from existing patients will be the most effective method of attracting new patients; for example:

- Top-notch telephone technique, particularly on initial contact, is extremely important.
- All patients must be treated with TLC (Tender Loving Care).
- Staff must concentrate on being "people-oriented" and on developing personal rapport with your patients. Development of a "people-oriented" office is extremely important. One example of this orientation is routinely knowing and using the patient's name in order to establish a strong bond with the patient. Also, name tags for staff will make it easier for patients to get to know your team members.
- Thank you notes and/or other tokens of-appreciation should be sent to those who refer patients to the office.
- A welcome letter, personally signed by you and your staff, should be sent to all new patients.
- End-of-the-day calls should be made to patients who have had major tx, to ensure that they are doing O.K.; e.g., following extractions, endo or bridge preps.
- Be sure you have a professional looking sign in the reception room stating "Your referrals are appreciated!". Some patients actually believe you are too busy to accept new patients.
- An introductory brochure could be considered for new patients outlining philosophy, policies, etc. The quality of any communication from your office is very important since it projects the image of your office..
- The use of suggestion boxes and patient surveys can be helpful in providing feedback of patient satisfaction.
- Mailings to patients of record can be useful; e.g., newsletters.
- Use of reply envelopes with your monthly statements is an effective method of speeding up collections and improving service to your patients.
- Regular staff meetings (including morning "huddles") can be useful for improving intra-office communication and building team spirit.

External marketing will not be as effective as internal marketing; however, some of the following might be considered:

- Your building signage should be made as visible as possible to passing motorists.
- Your phone number should be on all of your handout information.
- Special projects - e.g., office tours for school children, mouth guards for a hockey team, etc. can be effective in making the community more aware of your dental office.
- Letters can be sent to the patient's medical doctor confirming the patients medical condition. This may result in referrals from medical doctors.
- Evening and Saturday appointments appeal to today's consumers.
- Some dentists have been successful in attracting new patients by becoming involved in community activities; e.g., joining service clubs, helping with Brownie, Girl Guide, Beaver, Cub and Scout troops, coaching children's sports teams, etc.

Section Four

DENTAL PRACTICE ASSOCIATESHIPS AND TRANSITIONS (BUY-INS/BUY-OUTS)

Introduction

by H. Jack Stockton, DMD, CFP, MBA

This section on dental practice associateships and transitions has been added to the ADA&C Practice Management Manual due to the current popularity of associateships, and the growing complexity and financial significance of dental practice buy-ins/buy-outs. This section of the Manual will hopefully help members of the Alberta Dental Association and College better understand and deal with the business aspects of dental practice associateships and transitions.

Dental practice associateships generally refer to arrangements between dentists whereby a principal (an owner-dentist or Professional Corporation owned by a dentist) engages another dentist (the associate) to provide professional dental services at the principal's practice. Typically the principal provides most or all of the facilities, supplies and staff, and the associate provides professional dental services to the practice's patients. These business arrangements have many variations, which will be discussed later in this section.

Dental practice associateships have become very popular in recent years. Today, in Alberta and other regions of Canada, more than 15% of dentists in private practice are associate dentists. At present most new dental graduates choose not to establish or purchase a dental practice when first starting practice. In fact, more than 90% of new dentists begin private practice as associate dentists (some may first opt for dental internships or specialty programs before entering private practice). Also, a recent trend is that many senior dentists are choosing to sell their practices and become associate dentists during the latter part of their careers.

Dental practice "transition" refers to the process of transferring ownership of a practice from one dentist to another. In other words, it refers to buy-ins, buy-outs and the purchase-sale of dental practices. In recent years many of these transactions have become much more involved and complex than the simple purchase-sale of yesteryear. Also, the dollar value of these transactions has become very large – most involving hundreds of thousands of dollars.

Dental practice transitions can range from very simple (a straightforward purchase-sale) to very complex. The more complex dental practice transitions can involve some or all of the following steps:

- A dentist joins a practice as an associate dentist.
- The associate dentist makes a buy-in/buy-out commitment and becomes an “equity” associate.
- The associate buys into the practice and becomes a joint-owner.
- The senior dentist is bought out and then becomes an associate of the practice.
- The senior dentist retires and leaves the practice.

The cycle may or may not then start all over again with a new associate dentist. A complex dental practice transition can take 10 or more years to complete the first cycle.

This section of the Manual will discuss business aspects of dental practice associateships and transitions in some detail, and should benefit all dentists at some point during their careers. Even solo dentist-owners will eventually want to sell their practices.

A. Dental Practice Associateships

Types of Arrangements:

As mentioned, typically the principal provides most or all of the facilities, supplies and staff, and the associate provides professional dental services to the practice’s patients. However, some dental associates provide some of their own staff, equipment and/or supplies. The two main types of associateships are: (a) employee-employer arrangements and (b) independent contractor-principal arrangements.

The main differences between employee-employer and independent contractor arrangements relate to income tax consequences and liability issues. Generally it is to both the associate and owner-dentist’s benefit to have the associateship classified as an independent contractor arrangement, certainly from an income tax point-of-view. Also, the owner-dentist will usually have less liability for the actions of the associate with an independent contractor arrangement.

With independent contractor associateship arrangements the owner-dentist is not required to pay Employment Insurance premiums, make Canada Pension Plan contributions, nor withhold and remit income tax on behalf of the associate. The associate in turn, operating as a self-employed independent contractor, is able to deduct reasonable business expenses (such as auto, promotion and continuing education expenses). Also, independent contractor arrangements are not subject to the red tape associated with the provincial Employment Standards Act.

In the United States, where the Internal Revenue Service (IRS) has been very aggressive in attacking independent contractor arrangements, the majority of dental associateships are structured as employee-employer arrangements. However, the Canada Customs and Revenue Agency (CCRA) has been less aggressive and most dental associateships in Canada operate as independent contractor arrangements, to the benefit of both the associate and the principal.

To date the CCRA has not been too aggressive in attacking independent contractor dental associateship arrangements, although it has successfully attacked a few of these arrangements. Therefore, when structuring associateship arrangements it is critical that the associateship agreement not only state that the arrangement is an independent contractor agreement, but that the terms of the agreement fully reflect typical independent contractor arrangements. This is analogous to saying that if you call a bird a duck, it should walk like a duck, quack like a duck and swim like a duck.

Employee versus Independent Contractor – Criteria:

Many authors have discussed the criteria that the CCRA uses when determining whether a dental associateship is an employee-employer or an independent contractor arrangement. One of the most relevant articles was written by Dr. Robert Hicks and was published a number of years ago by the Canadian Dental Association for its members. This article states that the important criteria are: (a) control the principal has over the associate? (b) ownership of tools? (c) financial risk? and (d) is the associate an indispensable and integral part of the business?

No single criterion alone will determine whether the associate is an employee or an independent contractor; rather, one must look at all aspects of the arrangement to see on balance whether the associate qualifies as an independent contractor. Generally, the less control the principal has over the associate, the more likely the associate will be deemed to be an independent contractor by the CCRA. For example, if the principal examines all patients, develops the treatment plans, and directs the associate exactly how to perform the treatment, then the associate would appear more like an employee. If the associate provides some of the instruments or equipment, that arrangement would favor an independent contractor designation. Fixed associate compensation paid every two weeks would tend to make the arrangement look more like an employee-employer arrangement; whereas, a percentage commission paid once per month would be more typical of a compensation arrangement for an independent contractor. Also, if the duties of the associate were critical to operation of the practice, and if the practice could not function properly without an associate, that would favor an employee designation. Using this criterion, it would be difficult to argue that a receptionist was an independent contractor, but in most cases an associate dentist or a dental hygienist would not

be critical to the operation of the practice and could reasonably be viewed as an independent contractor.

Compensation Methods:

1. *Fixed salary or contract fee* – These arrangements, where the associate is paid a fixed hourly, daily, monthly or annual fee, are not very common in Canada. Although in recent years, with the more frequent use of "locum" dentists, this has become a more popular method of compensation (note: locum dentists are simply short-term associate dentists). Another group of associate dentists that are quite often compensated using a fixed salary or contract fee are associate orthodontists; they are often paid a per diem rate.

2. *Percentage commission* – This is by far the most common method for compensating associate dentists in Canada. Compensation is usually based on "net collected billings", meaning that compensation is based on collections net of laboratory and hygienist billings (the associate's laboratory bills are normally paid by the principal). Sometimes credit card transaction fees are also deducted in a similar manner to laboratory fees. Regarding billings related to recall visits with the practice dental hygienist - the professional examination fees are almost always included in the associate's "net collected billings", whereas the X rays (taken by the dental hygienist and interpreted by the associate dentist) are typically excluded from the compensation calculation. However, this is one of the many compensation issues open for negotiation between associate and principal, and sometimes these X ray fees are included in the calculation.

The percentage of "net collected billings" paid to associate dentists varies from 25% to 60% or more, but is typically in the 35-45% range. Generally, specialist associates are paid a higher percentage than general dentists, and typically associates in rural or remote locations are paid a higher percentage than associates in urban locations such as Calgary or Edmonton. As you can appreciate from the discussion concerning dental practice economics in Section One of this Manual, principals can afford to pay high-producing associates a higher percentage. Therefore, new dental graduates are often offered a lower percentage than more experienced dentists.

Example:
Let's assume that an owner-dentist decides to engage an associate dentist. They agree that the associate will be paid 40% of net collected billings (net of laboratory and hygienist billings). For a given month the associate's collected billings are $21,000 (including fees for professional exams at hygienist recall visits) and the associate's laboratory bills for the month total $1,000. In this case, the compensation calculation for the month would be as follows:

Collected billings for the month	$21,000
less, Laboratory expense	(1,000)
Net collected billings	$20,000

Commission percentage X 40%
Associate's compensation for the month =$ 8,000

Although not common, there are some combination arrangements. For example, an associate might be paid the greater of a fixed monthly fee or a percentage amount. When this type of compensation guarantee is included, the percentage amount might be lower than normal (again a point for negotiation).

Higher percentages are usually paid when the associate provides some staff, instruments, supplies or equipment. For instance, if the associate provides his/her own chair-side dental assistant, an extra 10% is typically paid.

The CCRA seems to have conceded that if an associate dentist is paid a percentage commission and is providing treatment for the principal's patients, then GST does not have to be paid. However, if it is really a cost-sharing arrangement, where the principal is simply providing facilities, supplies, staff, etc. to the associate dentist for a fee, and the associate is treating his/her own patients, then the principal would have to charge the associate GST on the services provided.

Associateship Contract:

The first issue to decide is whether the associateship contract should be in writing or not. Verbal agreements can be valid contracts, but if push comes to shove and a dispute arises, proving the terms of a verbal contract can be difficult. It is the author's opinion that all associateship contracts should be in writing, even for an associateship involving family members. Not only can there be disputes between the parties to the agreement, but the CCRA might choose to attack the independent contractor status of the associateship. An agreement in writing will make proving your case much easier.

Terms that could be important to *both the principal and the associate* include:

- Starting date and term?
- How can the contract be terminated?
- Can the contract be renewed? If so, how?
- Is there an option to purchase? If so, details.
- Confirmation of independent contractor or employee-employer status.
- The associate's work schedule – are weekends and/or evenings involved, how many hours per week, how many weeks per year?

Terms that are of particular importance to the *principal* include:

- A non-competition clause perhaps backed up by liquidated damages for breach (details to be discussed later in this section).
- A statement clarifying of ownership of patient charts and records.

- A requirement for the associate to carry adequate malpractice and comprehensive general liability insurance.

Terms that are of particular importance to the *associate* include:

- What is provided – space, staff, supplies, equipment, etc.?
- Compensation – how much and when? Any guarantees?

There are a number of *other considerations* that may or may not be included in the written agreement, but that should be discussed before the associate starts practicing at the principal's office:

- How are new patients assigned?
- Who sets the fees? Is the associate allowed to provide free services to relatives?
- Who controls selection of commercial laboratory services?
- Who provides coverage for after-hours emergencies? Is this shared?
- Is the associate provided with parking?
- What happens if some of the associate's work has to be redone following termination?

The principal should be certain that the associate has received competent, independent advice before signing the agreement. If not, the associate could later claim that he/she was unduly influenced to sign the agreement, which could be grounds for the associate to later have the contact voided.

Non-competition Agreements:

Given today's significant goodwill values for dental practices in urban locations, it has become very common for principals to insist that associate dentists agree to non-competition clauses in associateship agreements (note: non-competition agreements are also very common in dental practice purchase-sale agreements). These clauses are typically of two types:
(a) A *restrictive covenant* against an associate relocating within a certain geographic area for a defined period of time.
(b) A *non-solicitation clause* against an associate soliciting the principal's patients and/or staff following termination.

These clauses can be backed up in the contract by agreeing to liquidated (pre-determined) damages in the agreement for breach and/or by agreeing that an injunction for breach is a reasonable remedy.

To be enforceable these clauses must be reasonable in the circumstances and must be required to protect a legitimate business interest. Even then, there is always some degree of uncertainty concerning whether the courts will enforce non-competition clauses in an associateship agreement. However, at the very least it will make an associate think twice before breaching the agreement, since he/she would be subject to a lawsuit. Even when a dentist wins a lawsuit he/she loses, because of the time lost and legal fees incurred.

A recent court decision in Ontario of *Lyons v. Multari*, on appeal, overturned the restrictive covenant clause but upheld the non-solicitation clause in an associateship agreement. This case involved oral surgeons, not general dentists, but it does point out that restrictive covenants can be overturned. Also, realize that it is rare for a judge to enforce an injunction for breach of a non-competition agreement. To enforce an injunction there would have to be special circumstances that made the awarding of damages an inadequate remedy.

In spite of the uncertainty, the author recommends that owner-dentists include restrictive covenants and non-solicitation clauses in associateship agreements whenever there is a significant business interest to protect. For a more complete discussion about restrictive covenants, readers are referred to an article published by the author in the March 1993 issue of the *Journal of the Canadian Dental Association*, “Restrictive Covenants – everything you wanted to know but were afraid to ask”.

Economics of an Associateship:

Many times associate dentists are engaged for non-financial reasons. But, if an owner-dentist is planning to make money by adding an associate dentist to the practice, then only certain situations will qualify.

Due to the high fixed costs associated with private dental practice, most associateships are only profitable for owner-dentists when the practice has excess capacity and an associate dentist can be added without any significant increase in fixed costs.

As well, there are a few other situations that can be profitable, such as:
(a) Adding an associate to a busy dental practice, which would allow the practice to continue to grow, resulting in increased market value of the practice owner’s goodwill.
(b) Engaging a very productive associate dentist who is able to cover both the fixed and variable practice costs, and still generates a return to the owner.
But, engaging an associate dentist makes the most economic sense when no additional space or equipment is required.

Many private dental practices have the potential to be open 65-70 hours per week. And, since a lot of these practices operate only 30-40 hours per week, there are numerous opportunities for owner-dentists to add an associate by expanding the hours of operation without having to expand the office or purchase additional equipment. Of course, in addition to underutilized facilities, the practice must also have an excess supply of patients available for the associate to treat. The following example illustrates the profit potential for an owner-dentist with underutilized facilities and an excess supply of patients.

Example:

Associate dentist net collected billings		$250,000
less,		
Associate compensation @ 40%	$100,000	
Dental assistant	30,000	
Additional administrative staff costs	20,000	
Variable expenses (supplies, etc.) @ 12%	30,000	
Total incremental expenses	180,000	180,000
Profit to principal		$ 70,000

In addition to the profit earned on associate billings, the addition of an associate dentist often results in additional revenue for the practice hygienist(s) and additional profit for the hygiene department. What's more, the additional practice revenue and profit should result in increased practice goodwill value when it comes time to sell the practice.

Note: For busy owner-dentists currently operating without a dental hygienist, the economics of adding a hygienist to the practice are generally more favorable than adding an associate dentist. However, given the recent upward spike in hygienist wages, adding an associate dentist has become relatively more attractive.

B. Dental Practice Transitions

As mentioned, the term "dental practice transition" refers to a practice buy-in or buy-out. The following discussion will address many of the business issues associated with the more complex dental practice transitions. Ordinary purchase-sale transactions will also be discussed, but they are much simpler and involve fewer steps. The goal for a dental practice transition should be to achieve a win-win-win arrangement . . . for the purchaser, the vendor and the patients.

Who Should Consider a More Complex/Extended Dental Practice Transition?

Most *purchasers* will benefit from a dental practice transition that extends over a reasonable period of time, especially if they are inexperienced. Having the opportunity to practice with the vendor for a period of time not only improves the chances of retaining the practice patients, but also gives the purchaser a chance to learn from the more experienced vendor.

Owners who should consider a more complex/extended dental practice transition include:

- Any dentists who own “saturated” practices; in other words, owner-dentists who are fully busy and are personally working as hard as they care to work. In this case a practice transition would allow for continued growth of the practice and a better selling price. Another attractive transition option for an owner with a saturated practice would be to have another dentist join the practice and then, rather than growing the practice, the owner could slow down and focus on his/her preferred treatment areas. For example, the owner could refer all children, endodontics, emergencies, etc. to the new dentist and concentrate on his/her favorite types of treatment.
- Any dentists who plan to retire from practice and want to maximize the selling price. A transition that extends over a reasonable period of time will almost always result in greater retention of practice patients, than a simple purchase-sale where the vendor retires from the practice the day the purchaser joins the practice. Greater expected patient retention results in a better selling price – often much better.

It is important for *both purchasers and owners* to be willing to compromise and share if they are to become involved in complex transitions, since they could be working together for a number of years.

The Most Important Factor in Achieving a Successful Transition:

Although many things help in achieving a successful (win, win, win) dental practice transition, the author’s experience has been that, by far, the most important success factor is that the parties must be compatible and willing to compromise. The longer the transition period, the greater the need for interpersonal compatibility and willingness to compromise. This means that the parties must respect one another professionally and personally, and their personalities must be compatible.

A lengthy and exhaustive search for the right purchaser or vendor is well worth the effort. Most dental practice transition failures (and there are a fair number) relate directly or indirectly to a failure of the personal and/or professional relationship between the parties.

Although there are many advantages to the more complex dental practice transitions, the author believes that some dentists simply do not work and play well with others, or are not willing to put in the effort required to make an extended transition work. Dentists who are not prepared to compromise, share, and contribute considerable effort to the process should stick to simple purchase-sale transactions.

Equity Associateships:

As described in the introduction to this section, one of the steps that can be involved in a complex dental practice transition is an “equity” associateship. This follows the initial, no-strings-attached associateship. An equity associateship is established when the associate decides to buy into the practice or buy out the owner, signs an agreement to do so, and makes a financial commitment toward the purchase.

The length of the initial, uncommitted associateship period varies considerably. It can be as short as a few months or as long as many years. It is the author’s opinion that the initial associateship should run at least six months, to allow enough time for the parties to determine if they are compatible. But, it should not run any longer than two or three years, since after an extended period of time patients will establish a bond with the associate. If the associate then leaves and relocates nearby, many patients could follow causing considerable damage to the owner-dentist’s practice. Remember: restrictive covenants are not foolproof!

The equity associateship step is usually taken when both parties agree that they are compatible and can work together for an extended period of time. Typically the associate has decided that he/she wants to be an owner in the practice in the near future, but is not quite ready to take on that responsibility.

The benefit to the owner-dentist is that once the associate makes a financial commitment the owner becomes more confident that the buy-in/buy-out will happen and can start making plans for the future (slowing down, retiring, transferring patients, etc.). Many owners have become frustrated with associate dentists who have joined their practices as buy-in/buy-out candidates, then left on short notice, often creating a new set of problems. The stability of an equity associate can be very reassuring to an owner-dentist.

The benefit to the associate dentist is that he/she knows what the terms of the buy-in/buy-out will be at closing, but can continue to learn more and become busier before taking on the responsibility of ownership. Many associates have become disillusioned with owner-dentists who, after having the associate help build the practice for many years, dramatically increase the asking price just prior to the buy-in/buy-out date. Committing to an equity associateship locks in the terms of the buy-in/buy-out for the associate and allows the associate to also confidently plan for the future, and to work hard to grow the practice prior to the closing date.

The most common arrangements to be made at the equity associateship stage are as follows:

1. The purchase-sale agreement is signed (buy-in or buy-out).
2. The associate makes a deposit, usually non-refundable, toward the future buy-in/buy-out.

3. The current associateship is renegotiated and extended to the closing date.
4. If a joint-ownership arrangement is planned (a buy-in, rather than a buy-out), then a partnership, shareholder or cost-sharing agreement is negotiated and signed. This governs the business relationship between the parties following closing.
5. If the vendor will be continuing on in the practice as an associate following a buy-out, then the terms of this associateship are negotiated and the agreement is signed.

As can be seen, the legal documentation (and the legal fee) at this stage is considerable; hence, the reason for an initial, no-strings-attached associateship, to ensure that both parties are compatible, serious and committed to the dental practice transition.

The amount of the associate's deposit is always a sticky point. The owner-dentist wants a substantial deposit, but typically the associate is a relatively new graduate with little or no capital and often with substantial student loans. Financial institutions are usually not keen on loaning money for a deposit on a transaction that may be a year or more in the future. Therefore, what often happens is that the associate makes as large a cash deposit as possible (usually only $10,000 or so) and agrees to make monthly additions to the deposit out of his/her earnings prior to closing (perhaps $1,000-3,000 per month).

Another, less common option to deal with the associate's financial commitment at the equity associate stage, is to reduce the associate's percentage compensation for the period prior to the closing date and to also reduce the buy-in/buy-out price. This is really a variation on the graduated deposit discussed above. But, it does have different income tax implications and it might not receive the CCRA's stamp of approval.

Buy-ins at Closing:

As part of a buy-in transaction, the former associate dentist and the owner-dentist will enter into a joint-ownership arrangement. There are two basic joint-ownership arrangements between dentists:

1. A cost-sharing arrangement between individual dentists and/or corporations.
2. A legal partnership or joint-ownership of a corporation.

Although these two basic types of arrangements can look very similar and often operate in a similar manner, the difference is very significant. In the first case (cost-sharing arrangement), separate practices are created. Legally, the practices are separate entities. Each practice bills its own patients. There is simply some agreement for sharing certain costs and this is typically outlined in a cost-sharing agreement.

In the second case, each dentist will own an interest in a common business. Depending on whether the business is a partnership or a corporation, the ownership interest is either a partnership interest or ownership of shares (or sometimes a combination). The ownership interest of the dentist-owners is usually equal, but can be unequal. In this ownership situation the “business” owns all the assets and earns a profit (or loss). There is an agreed method of distributing the profit (or loss); this is usually outlined in partnership and/or shareholder agreements.

Ownership can become quite complex. There can be proprietorships, partnerships, professional corporations, technical service corporations, corporate partnerships, etc. in various business relationships. For example, corporate partnerships can be structured in combination with technical service corporations. However, in the end, the business relationships will fall into one of the two basic categories listed above.

Because the two categories of joint-ownership are different, and can have very significant legal and financial implications, it is critical that the associate and the owner-dentist are very clear early in their transition negotiations exactly what the joint-ownership arrangement will be following the buy-in.

There will usually be at least two agreements to be executed for a buy-in: (a) a purchase-sale agreement and (b) an agreement to govern the ongoing business relationship following closing (cost-sharing or partnership/shareholder agreements). Needless to say, both owner-dentists and associates need good professional advice when negotiating and finalizing complex dental practice buy-ins.

Buy-outs at Closing:

Buy-out transactions are generally simpler than buy-ins, since in most cases only a purchase-sale agreement needs to be executed (perhaps together with an associate agreement for the vendor). However, if the associate is buying out an owner-dentist who is already in a joint-ownership business arrangement with other owner-dentists, then the required agreements are similar to those discussed under the previous buy-in heading.

Joint Ownership Issues:

For those dentists entering into a joint-ownership arrangement, there are many issues to resolve amongst the parties. The following list is not exhaustive, but should give you an idea of the various issues that need to be negotiated:

- Is this a cost-sharing arrangement or is it shared ownership in a common business entity (as previously discussed)?
- How will the banking be handled?

- Is there a common telephone number and/or practice name? If so, who retains ownership of these important assets should the joint-ownership arrangement terminate in the future?
- How are new patients/clients allocated?
- How are costs or profits (losses) shared?
- What restrictions/accommodations are there on transfer of ownership (e.g., in the case of a death or sale of an ownership interest)? For example, there could be a death buy-out provision funded with life insurance proceeds, or a right of first-refusal option for the remaining party(ies) when one of the owners decides to sell.
- Will there be a forced withdrawal provision for "just cause"?
- Will there be restrictions on associate dentists joining the practice in the future?
- Will there be a requirement for the parties to carry minimum amounts of various types of insurance (e.g., life, malpractice, office overhead, general liability, office interruption, etc.).

There are many issues to resolve concerning joint-ownership arrangements. All of these issues should be sorted out and agreed upon at the same time the purchase-sale terms are finalized. In the case of a complex dental practice transition, these issues are sorted out at the equity associate stage . . . *not* at closing.

Purchase-Sale Issues:

When a dental practice buy-in or buy-out is to take place there are a whole variety of issues that need to be addressed and agreed upon. In a complex practice transition, this also takes place at the equity associateship stage. Some of the issues to be resolved are simple and some are quite involved. The following is a list of the most common and most important issues to negotiate and agree upon:

- Who are the parties to the agreements? The parties could be individuals, corporations, or even family trusts.
- When is the closing date? This could be months or years in the future.
- What is the price and method of payment? How much is the deposit? Are there adjustments to be made at closing?
- Exactly what is being purchased/sold? It could include: shares, a partnership interest, and/ or various other tangible/intangible assets.
- If it will be an asset sale, how is the purchase price being allocated amongst the various assets? This is very important from an income tax point-of-view for both the purchaser and the vendor.
- Will GST have to be paid? If so, who will be responsible for payment of the GST? It is usually it is the purchaser who pays.
- Are patient charts being sold? If so, where will they be located and who will have access to them? The vendor may need access to his/her former patient charts for legal/tax reasons.

- Are the assets owned free and clear, or is the purchaser assuming practice liabilities, such as equipment leases, bank loans, etc.?
- Is the equipment to be in good working order?
- Is a letter of introduction to be sent to practice patients and/or referral sources? If so, who decides on the content of the letter and when is it mailed, and who pays the photocopying and postage costs?
- Is there a non-competition agreement? If so, what are the terms?
- Will the purchaser assume the current premises lease? Has the landlord's approval been obtained? Or, is a new premises lease to be negotiated?
- Are accounts receivable being purchased/sold? If not (which is common), will the purchaser assist the vendor to collect the receivables as a courtesy or will there be a collection fee?
- Who is responsible for compensation if a staff member is terminated without adequate notice? If the practice employs long-standing staff, this could be a major issue involving tens of thousands of dollars.
- Will the vendor promise to continue to operate the practice as a going concern right up to the closing date?
- How will retreatment of the vendor's work following closing be handled?
- What sort of indemnification will each party provide?
- Will there be any conditional clauses, such as:
    - Subject to arranging satisfactory financing?
    - Subject to graduating from a program of studies (undergraduate or specialty)?
    - Subject to obtaining visas or landed-immigrant status?
    - Subject to certain representations made by the vendor? For example, the purchaser may be relying on the representation that certain key employees or an associate dentist will continue on at the practice following closing.

There can be other issues to resolve, since each transaction is unique; however, the list above includes most of the purchase-sale issues to be negotiated by vendors and purchasers.

Dental Practice Valuation:

The sale prices for dental practices in Alberta and other parts of Canada have become very significant. It is not uncommon for dental practices in Calgary or Edmonton to sell for more than half a million dollars. Therefore, it seems prudent that dentists (both purchasers and vendors) who are considering a dental practice transition have a good idea of the fair market value of a practice before negotiating a buy-in or buy-out.

Since each dental practice is unique, accurately determining the fair market value (FMV) is not a simple matter. The author believes that a professional dental practice valuation should be obtained before the parties start to negotiate the buy-in or buy-out price. Although dental practice values usually do not change

much over short periods of time, the practice valuation should be as current as possible.

A dental practice valuation completed by an experienced dental practice valuator will usually be an *asset* valuation (as opposed to a share valuation). The practice assets included in the valuation are the tangible practice assets and the intangible "goodwill" asset. "Goodwill" is defined as the fair market value (FMV) of the practice assets in excess of the FMV of the tangible practice assets. The tangible practice assets included in the valuation usually include the following: equipment and furnishings, leasehold improvements, instruments, and supplies inventory. Sometimes accounts receivable and building/land are also included; bank accounts are excluded.

The valuator makes certain reasonable assumptions when completing a dental practice assets valuation. Common assumptions are as follows:

- The practice liabilities are excluded. The purchaser would receive clear title to the practice assets.
- The terms of purchase would be cash on possession.
- The practice would continue at its current location and a fair premises lease agreement/lease option for at least five years could be obtained.
- The vendor would make every reasonable effort to transfer the practice patients to the purchaser. This would usually include a letter of introduction to practice patients and/or referral sources, and transfer of the right to use the practice telephone number and practice name. But, the transition period (if any) would be short.
- The vendor would provide a strong non-competition agreement.

In order to give Alberta dentists a general idea of recent dental practice fair market values (FMVs), the author provides the following information, based on his consulting involvement in dental practice buy-ins and buy-outs in Alberta and other parts of Canada:

- The more popular the community as a place for dentists to work and live, the greater the FMV of dental practices. For example, Calgary and Edmonton practices generally have the highest FMVs in Alberta. Remote northern locations would typically have the lowest values.
- Today goodwill (an intangible asset) often accounts for a greater portion of the selling price than the tangible assets (equipment, leasehold improvements, etc.).
- Goodwill alone for *general* dental practices in Calgary (likely the most expensive market in Alberta), as a percent of gross practice revenue, has recently sold for an average of close to 40%. When the value of the tangible practice assets is added to the goodwill value, the total selling price in the most expensive markets can be considerable. However, goodwill for dental practices in some unpopular rural and northern communities could have no commercial value.

- Practices with similar gross revenue in the same local market can have wide differences in selling prices, below or above the market average. This is due to the unique characteristics of each practice, such as: strength of the hygiene recall program, number of active patients, number of new patients per month, mix of dental treatment provided, location, overhead ratio, accounts receivable control, practice trends, etc.
- As a percent of gross revenue, *specialty* practices typically have lower goodwill values than general dental practices.
- Practices in suburban, ground-floor locations have greater FMVs compared to similar practices in downtown, office building locations.
- Practices sold as share sales usually have the price discounted from the asset FMV. The discount is typically 10-20%, but can be higher or lower.
- When a dental practice sells for, what appears to be, an extremely high or low price there is usually some unusual or unconventional structure to the deal; in other words, it is not a straightforward cash transaction.

This should give you some general information regarding dental practice FMVs. However, since dental practice valuation is as much an art as a science, an accurate estimate of dental practice FMV is best obtained from a professional valuator who is familiar with the dental market.

Tax Considerations:

It should be noted that the various assets associated with a buy-in or buy-out are treated differently from an income tax point-of-view. Goodwill is taxed the most favorably for the vendor and provides the least tax deductions for the purchaser. If the vendor makes a gain on sale of goodwill it is taxed like a capital gain, but the purchaser only gets to write-off a portion of the goodwill spread over many years. On the other hand, tangible assets are taxed less favorably for the vendor, but provide much better tax deductions for the purchaser. In the case of an asset sale, the parties will often negotiate the allocation of the purchase price amongst the various assets for tax reasons.

Share sales (as opposed to asset sales) are becoming popular. A share sale is usually much more tax advantageous to the vendor since the gain on the sale of shares may be eligible for the $500,000 capital gains exemption. Again however, what is good for the vendor is not good for the purchaser. The purchaser will usually lose considerable tax shield when shares are purchased. Therefore, as previously mentioned, for a share sale a discount is usually negotiated from the fair value of the practice assets.

The tax considerations for a purchase-sale can be very complex and very significant. Good advice from a tax accountant should be sought before finalizing the price.

Financing Options - Dental Practice Transitions:

A purchaser without significant personal funds to invest will usually need two types of financing:

1) An operating line of credit to fund day-to-day cash shortfalls.
2) Capital financing to fund the actual buy-in/buy-out price.

A chartered bank usually provides an *operating line of credit*, although credit unions and other financial institutions have also been used. It is typically a demand loan with a maximum limit and a floating interest rate (based on the bank's prime interest rate). Since interest is only paid on the amount of credit that is actually drawn down, the purchaser typically will want an operating line of credit that is larger than the maximum expected operating cash shortfall. Practice accounts receivable will usually have to be pledged as collateral for this loan.

Capital financing for a purchase can be obtained from a variety of sources and can take different forms. In addition to personal funds (if available), the following are some of the different options for financing a buy-in or buy-out:

(a) Capital loans with financial institutions (floating or fixed interest rates).
(b) Equipment leases with banks or other financial institutions.
(c) Vendor take-back financing.
(d) Loans from friends or relatives.

The majority of practice purchases are financed with either bank loans, or a combination of bank loans and equipment leases. Generally vendors do not want to finance the buy-in or buy-out unless the purchaser cannot obtain adequate financing elsewhere; and, purchasers typically approach friends and relatives for financing only as a last resort.

Purchasers approaching financial institutions should be aware of the criteria that these institutions use when deciding whether to provide financing. Financial institutions look at the three "**C**s" when reviewing a loan application; namely,

1. **C**apacity/**C**ash flow – In other words, is it likely that the proposed project will have the capacity to produce enough cash flow to allow the borrower to make the loan and/or lease payments on a timely basis. The borrower must prove to the lender that the project to be financed is a viable business venture. A solid, well-documented business plan is required to convince the lender that the project has sufficient capacity/cash flow.
2. **C**haracter – The borrower will need to demonstrate that he/she is a responsible individual with a high degree of integrity. A good credit history, a good track record as a dentist, a professional demeanor and appearance, and some quality references will help convince lenders that a borrower-dentist has good character.
3. **C**ollateral – Lenders will always look to maximize collateral against a loan. In fact, they will take as much collateral as the borrower has and is willing to pledge. When a borrower has very little or no collateral, lenders will

typically try to have others (spouses, relatives and friends) co-sign or guarantee loan repayment.

Since most borrowers for dental practice buy-ins or buy-outs are young dentists with very little collateral, it is important for these borrowers to present a very strong and well-developed business plan, together with solid evidence to show strength of character.

Dentist-borrowers with very little collateral should be wary about having others co-sign or guarantee their loans . . . it may not be necessary. The author's experience has been that financial institutions generally view dentists as AAA credit risks. If strong capacity and character are demonstrated, it is not uncommon for chartered banks and other financial institutions to loan large sums of money toward dental practice purchases, even when the dentist-borrower has no collateral and is not able/willing to obtain a co-signer or guarantor for the loan.

When seeking financing for a dental practice purchase, it is usually prudent to present your proposal to two or three potential lenders. As negotiations proceed, realize that the interest rate is only one of many points to be considered. Dentist-borrowers typically focus too much on the interest rate. The financial institution offering the lowest interest rate may not necessarily be the best choice. The following other points should enter into negotiating the best loan for your needs:

a) The amount of the loan.
b) Repayment schedule.
c) Required security (collateral and guarantees).
d) Other fees or requirements to be met.
e) Convenience, service and rapport with the agent of the financial institution.

For example, if you are able to negotiate a higher loan amount, with an extended interest-only period, and no collateral required, it might be better to accept a slightly higher interest rate.

There is a never-ending debate over whether it is better to borrow-to-buy or to lease equipment. There is no correct answer, because it depends on the circumstances. In general the following comments can be made:

- It is easier to obtain 100% financing when leasing.
- The income tax consequences are different for leasing and buying; and, which is more tax-effective depends on individual circumstances.
- The interest rate is locked-in for the term of a lease, but can increase or decrease over the term of a floating interest rate loan, as market conditions change.
- The administrative costs built into the total financing costs are generally higher for leasing.
- When financing small purchases (e.g., one X ray unit) borrowing to buy is almost always less expensive than leasing. The larger the amount to be financed, the more competitive leasing becomes.

Vendor take-back financing is another option if the purchaser does not qualify for adequate financing to completely fund the purchase. Most vendors prefer not to get involved with vendor take-back financing. However, some vendors, in some situations, will consider providing some of the financing to allow the purchaser to complete the buy-in or buy-out.

Dentist-vendors most likely to consider financing a practice sale are those who will be continuing on in the practice after the sale, as an associate of the purchaser. In these cases, if the purchaser were to default on the vendor take-back financing, the former owner of the practice would be in a position to repossess the practice, and continue to operate the practice until a new purchaser was found. This is important since goodwill (an intangible asset) typically makes up a very large portion of the purchase price, and the tangible assets will usually have been financed by other lenders and assigned as security against their loans. In other words, the vendor will be financing the goodwill portion of the sale price.

In the case where a vendor had already retired from practice, and then the purchaser defaulted on his/her obligations to the vendor, it would be difficult if not impossible for the former owner to resume ownership of the practice.

Vendor take-back financing normally takes the form of a simple promissory note, but sometimes other arrangements are made.

Other creative arrangements have been used to bridge the financing shortfall for the purchaser. There are a variety of arrangements where the purchase price is reduced and the vendor earns additional compensation after closing. These alternate arrangements add more complexity to the practice transition. There are other things that need to be considered with these arrangements, such as: income tax and GST implications, obligations of the vendor following closing, and potential complications should there be pre-mature death or disability of one of the parties. Examples of alternate vendor take-back financing arrangements (when the up-front purchase price is reduced) include the following:

- *Consulting fees* - The vendor (or the vendor's spouse) is paid a consulting fee to help maximize the transfer of practice patients to the purchaser and to implement a smooth practice transition. The negotiated consulting fee can be a flat fee or a variable fee. If a variable fee is agreed to, it is typically based on certain aspects of practice performance following closing. The consulting fee is sometimes spread over a number of years following closing.
- *Higher associate fees for the vendor* – When the vendor continues on in the practice following closing as an associate of the purchaser, another way to provide additional compensation to the vendor is to increase the associate fee above what ordinarily would have been fair. For example, if the fair associate fee was 40%, the purchase price could be reduced by

$50,000 and the vendor could instead be paid 55% for two years following closing.

- *Hygiene fees paid to the vendor* – This is a variation on the previous example. In this case, the vendor is paid a percentage of the practice hygiene fees following closing. For instance, the purchase price could be reduced by $50,000 and as compensation the vendor could be paid 30% of the practice hygiene billings for 18 months following closing.
- *Higher rent on premises* – This arrangement can only be used when the vendor owns the practice premises and will become the purchaser's landlord following closing. In this case, the purchaser pays higher rent than would ordinarily be paid over the term of the premises lease. This arrangement compensates the vendor for a lower purchase price.

Note: The author in no way sanctions the above-mentioned arrangements, but is simply reporting examples of what has occurred in some dental practice transitions. Before considering any of these creative vendor take-back financing arrangements, be certain to obtain competent professional advice. These arrangements are complex and could be subject to attack by the CCRA if not structured properly.

As mentioned, the *last resort* is for a purchaser to approach friends and relatives to help finance a buy-in or buy-out. However, if it becomes necessary to borrow from friends or relatives to close the deal, then perhaps a good re-think should take place concerning the financial viability of the purchase opportunity.

Conclusion

Dental practice associateships and transitions are now very common, and can be very successful and financially rewarding arrangements for both owner and associate dentists. However, there are pitfalls and the arrangements can be complex. Hopefully this section of the ADA&C Practice Management Manual will help ADA&C members to negotiate and implement win-win-win associateship and buy-in/buy-out arrangements.