PMM news

PRACTICE MANAGEMENT AND MARKETING NEWS IN PEDIATRIC DENTISTRY VOL. 11, NO. 3, June 2002

To Review

In the February and April issues, two articles by Dr. Gayle V. Nelson about patient records were reprinted. Dr. Nelson's information, originally published in *Pediatric Dentistry* is still pertinent, practical and valuable, even in today's technologically advanced offices. The pediatric dentist preparing for board examinations will find these articles in the must-read category. And the new-to-practice or established practitioner considering new charts or training staff members about the intricacies of charting should read and save them.

Why Hire an Associate?

Pediatric dentistry provides the most fun and excitement of any type of practice. It can also present the most stress and frustration. You readers are well aware that one day may be totally enjoyable with cordial, polite parents who compliment your work and well-behaved children who open wide and say, "thank you." The next day is on the far side of awful with parents and patients you wish were any place but in your office. Such a yo-yo effect wears heavily on most pediatric practitioners so that well before retirement age, many sense the need to bring in an associate to share the load.

Another reason many pediatric dentists seek associates is "over-busyness." The American Academy of Pediatric Dentistry, regional, state and local pediatric dental organizations, residency programs, other health care agencies and individual pediatric dentists have done an excellent job in the last 10 to 15 years of raising public awareness about infant oral health and dental care for children. In short, more parents are knowledgeable about pediatric dentists, the specialty and its benefits for their children. For the majority of you, increased demand for your services has meant more patients than you can handle alone in a timely way. Hence, an associate(s) is (are) needed.

As costs of producing dentistry have continued to increase, spreading overhead costs between two or more practitioners has become a consideration. An associate allows the office to be used more days and longer hours, and this can mean increased profitability if other aspects of the practice are managed soundly.

Other criteria for employing an associate:

- 4,000 to 4,500 or more active pediatric patients.
- 3,000 to 3,500 or more active pedo patients if 25% or more of your practice is devoted to full orthodontics.
- Restorative appointments unavailable for six weeks to two months or longer *even* if you are block scheduling for greatest efficiency. (See the August and October 2000 issues for an explanation of block scheduling.)
- Recare appointments delayed, resulting in seven, eight or nine-month cycles.
- Senior dentist is within five years of retirement or chooses to reduce workdays to three or fewer weekly.

Questions and Concerns for the Senior Dentist Prior to Taking an Associate

Do you need an associate? Can you instead change to block scheduling, add a hygiene assistant or second hygienist and thus, delay hiring another dentist? Will personalities and styles of senior dentist and associate combine well? Are treatment philosophies and modalities compatible?

Very important considerations:

1. Is patient load and appointment management sufficient for another dentist?
   - Recare rate – at least 80% effective.
   - Allotment of hygiene fees – does associate get percentage of exam only or exam and x-rays, not prophy and fluoride?
   - Show rate – at least 80-85% in pedo; 85-95% ortho.
   - Case acceptance rate – at least 85-90%.
   - Number of active patients sufficient for two dentists?
   - Booked ahead (giving each patient the next appointment, not a series of appointments) more than six to eight weeks?
2. Can management systems handle an associate? Consider the following:

- Accounting method for associate's production/collections
- Billing and aged accounts receivable system
- Insurance processing and follow-up
- Appointment scheduling
- Recare system
- Supply/inventory system
- Sterilization/OSHA
- Telephone system
- Trained staff
- Computer capacity
- Good idea – separate bank account for his/her collections if associate is paid as an independent contractor

3. Disposition of current accounts receivable (A/R) before associate begins.
4. Is facility size adequate? Is growth possible?
5. How will shared patients be allocated?
6. Distribution of new patients?
7. Total charges last 2-3 years; total collections; collection percentage rate (recommended 97% or more after adjustments for Medicaid, other managed care, etc.)
8. Total current overhead percentage? Adjusted overhead (less owner's compensation – average is 55% to 61% in pediatric dental practice).
9. Projected financial outcome for owner and associate – return on investment?

Who Will Write the Associateship Contract? Recommended: Senior Dentist's Attorney.

Contract must include these provisions:

- Length of contract and renewal criteria.
- Who owns patient records?
- Where will patient records be maintained?
- How can records be accessed?
- If associateship dissolves, can records be duplicated? Can patients be solicited for future treatment?
- Completion of active cases, if associateship dissolves.
- Associateship does not constitute any ownership in practice.
- Staff of senior dentist cannot be recruited in case of dissolution.
- Restrictive covenant including time, geographic areas (distance from office), types of dentistry-related work, patient or staff recruitment.
- Structure of association?
  - ➢ Employee?
  - ➢ Independent contractor?
  - ➢ Solo group?
  - ➢ Compensation of associate?
    - Who pays whom?
    - Straight salary?
    - A percentage based on production or collection (collection recommended)?
    - Increase in associate's compensation over some production/collection threshold (i.e., bonus system)?
    - Compensation payment schedule?
    - Are expenses (lab, etc.), which are to be paid by associate deducted prior to or after calculation of percentage of compensation?
    - Is a salary review done? When?
    - Benefits (examples):
      - → Vacation
      - → Holidays, continuing education dues, licenses, etc.
      - → Insurance
        - ◆ Malpractice
        - ◆ Health
        - ◆ Disability
        - ◆ Other types of insurance
- Workdays and hours per day (total workdays per year)?
- Office policies and procedures; dress code; etc.
- Assignment of patients as associate begins? In case of separation?
- Management tasks for associate?
- Staff number, selection, training, supervision.
- Fee schedule – adherence to financial agreement and collection procedures used in the office.
- Emergency coverage and policies.
- Ownership and/or purchase of supplies and instruments.
- Equipment needs, use, responsibilities.

The initial contract may, but does not typically, include:

- Buy-in options?
- Method and timing of evaluation if and when buy-in begins?
- Will there be any adjustment of appraised value?

Senior dentist should ask potential associate to discuss:

- His/her one, three and five-year goals.
- Financial needs? Does associate need a draw for salary at first? How long? Does he/she prefer a percent of collections on his/her production?

- Who will be the associate's advisors?
  - Accountant?
  - Attorney?
  - Insurance agent?
  - Practice management consultant?
- How much authority does the associate want?
- If all goes well is the associate interested in becoming a partner (buying in)? Will the associate prefer a two-year or longer associateship?
- What strengths does the associate say he/she will bring to the practice?
- Time frame for acceptance of associateship offer?

More about associateships in the August issue. Now onto a new topic – an exciting study and published report about oral health in America.

What is Oral Health America?

Over the years, I am sure you have observed, just as I have, that the importance of oral health gets too little national attention, except perhaps for work through pediatric dentistry. Now, that all may be changing! Oral Health America is a nonprofit advocacy group that is working to inform the public of the fact that good oral health is paramount to overall health.

The article, "*The Disparity Cavity – Filling America's Oral Health Care Gap,"* published by Oral Health America offers a wealth of information and vital statistics on the importance dental health plays to overall essential good health. With permission from Oral Health America we have printed portions of the article below.[1] Consider sharing some of this information with staff and patients/parents.

The Disparity Cavity

Most of us brush and floss our teeth and have regular dental check-ups; but otherwise, we don't pay much attention to our gums and teeth unless there's a problem. Maybe that's why oral health gets so little attention in debates about health care coverage. It is common knowledge that 43 million Americans have no private health insurance, but how many know more than 108 million have no private dental insurance.

But oral health deserves better, for oral health should be a priority for us all. At the moment, it is a priority only for people who don't have it. Unlike medical care, which most people use only when they are sick, good dental care is always needed because good oral health is essential to good overall health.

As the nation's premier nonprofit organization dedicated to improving oral health, Oral Health America has initiated a 10-year Campaign for Oral Health Parity to make oral health a priority for everyone and increase access to care for 22.5 million Americans who want but cannot obtain oral health care.

Why Does Oral Health Matter?

Oral health means being free of disease. In a very real sense, the condition of the mouth mirrors the condition of the body. But good oral health also has an undeniable impact on well-being, because the way your mouth feels and looks affects how you eat and speak, how you smile, how you interact with other people, whether you sleep comfortably through the night, even whether you can make it through a day at work or school without being bothered by pain in the mouth.

Though the full impact is impossible to document, dental problems do affect work and school. A survey conducted in 1989 showed that children missed nearly 52 million hours of school, or an average of 1.17 hours per child, because of dental treatment and problems. That same year, more than 164 million work hours were lost, an average of 1.48 hours per worker.

Beyond the obvious problems, some researchers consider the mouth "the laboratory of the body," for its tissues reflect signs and symptoms of other problems. An examination of the mouth, for instance, can detect early signs of such disparate problems as diabetes, bone and joint disease, and cancer. In children, an examination of the teeth and mouth can detect signs of abuse and neglect. A dental exam also picks up poor nutrition and hygiene, growth and development problems, improper jaw alignment, and oral tumors. Literally hundreds of different kinds of bacteria and other microorganisms live in the mouth. Their presence is an important reason to maintain good oral hygiene, for some cause infection and disease.

For years, dentists have premedicated patients with heart valve problems or artificial parts because of the risk of infection. Beyond that, neither dentists, nor physicians for that matter, have paid much attention to the question of how the condition of the mouth might affect the rest of the body. A number of recent studies, though, suggest there may be links – nothing as definitive as cause and effect, yet – between gum disease and conditions such as heart disease, stroke, diabetes and premature delivery. Pregnant women are advised to have regular dental care since oral infections produce high levels of substances, known as prostaglandin, which can induce premature labor and the delivery of low birth weight babies. One study found the risk of premature delivery and a low birth weight baby was seven times greater in women with severe gum disease.

The new attention to possible links between oral heath and problems elsewhere in the body has ramifications that go beyond health. "There's increasing evidence that controlling mouth problems can have a major impact on physical well-being and lowering the costs of care," comments Dr. Garcia. "If keeping mouths clean can lower the risk of diabetes, heart disease and low birth weight babies, we can have a major public health impact with a minor investment in dental care."

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The Care Gap

Overall, American teeth are in better shape than they ever have been. But problems remain. According to the National Institute of Dental Research, dental caries is the most common, preventable disease in children. Problems start early. Healthy People 2000 reports 18 percent of 2 to 4 year olds have visible tooth decay, and the numbers keep climbing. More than half of elementary children have dental decay, and by the time they graduate from high school, it has risen to 84 percent. By the time they reach the age of 45, more than 99 percent of this population has had tooth decay.

Disparities in oral health care do not stop with decay. Gingivitis… is seen in half of high school students; 15 percent of adult Americans have advanced periodontal disease and are in danger of losing their teeth. Looking only at children, a recently published analysis of the National Health Interview Survey showed 7.3 percent of parents thought their children had one or more unmet medical needs. For 73 percent of those children, that unmet need was dental. That means, notes Dr. Edelstein, that one in every 20 American children has an unmet dental need. The need for medical care was runner-up.

Preview

The August issue will have more information on associateships and partnerships including a list of questions and considerations for the resident pediatric dentist/prospective associate to ask as he/she searches for a position. We will also provide more facts from the Oral Health America Report, which may surprise you, your staff and patients/parents.

1. "The Disparity Cavity," published by Oral Health America and the W.K. Kellogg Foundation (June 2000). Reprinted with permission from Oral Health America, 410 N. Michigan Avenue, Suite 352, Chicago, IL 60611, 312-836-9900, 312-836-9986 (fax), www.oralhealthamerica.org.

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

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