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*Exclusively to Clients and Friends
of Advanced Practice Management*

BULLETIN

- **DENTAL DOW 2015 WRAP-UP**
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- **HOW GOES IT WITH PHYSICIANS?**

DENTAL DOW JONES: 2015 WRAP-UP:

Comparing 2015 to 2014 statistics for the mature area practices sampled, we found that practice production was up 6% and collections were up 4.8%.

Total patient flow was up 3% with New Patients being up 7.3%. The average production per exam was up 3.2%.

Metro Area Fees were up 1.3%. Outstate Area Fees were up 1.7%.

Production Increase Percentages

<u>2009</u>	<u>2010</u>	<u>2011</u>	<u>2012</u>	<u>2013</u>	<u>2014</u>	<u>2015</u>
0.5%	1.4%	2.5%	3.3%	3.3%	4.2%	6.0%

Collection Increase Percentages

<u>2009</u>	<u>2010</u>	<u>2011</u>	<u>2012</u>	<u>2013</u>	<u>2014</u>	<u>2015</u>
0.4%	0.4%	1.6%	3.5%	2.2%	3.1%	4.8%

As you can see, this is the most growth in **7 years**.

Our Dow, a sampling of both Rural and Urban practices, shows an average collection percentage of 84% - down a percentage point from last year. The Collection percentage has slipped by around 1 point per year for the past five years. Doctors are raising fees but, of course, PPO Participation is affecting Collections.

TIME TO RECALIBRATE YOUR INCENTIVE:

Most incentives need to be adjusted each year taking into account factors like:

- Additional staff
- Raises given to staff
(Both of the above items change the Overhead landscape and therefore the incentive targets)
- New practice goals & projects
- Upcoming performance reviews



Bill Rossi

So call us and we will help you retune your bonus targets.

About a third of area practices have their staff on an incentive. If the conditions are right, we highly recommend incentives. It

gives the staff a stake in the practice success. However, sometimes incentives get to the point where they are no longer stimulating performance. They go from being a “nice bonus”, to being expected, to being taken for granted and a “right.”

Sometimes it makes sense to discontinue an incentive that’s no longer helping to foster a harmonious and productive team and that extra edge of performance that we are always looking for. This is best done in conjunction with performance reviews because you can “buy-out” from an incentive by awarding increases and then change the game according to the practice’s situation – or just let it lie fallow for a while.

Productive Performance Reviews: As many of you have heard me say, I feel that a productive performance review should not be a bureaucratic “grading” process. Everybody hates that.

Instead, I feel that a performance review should be a cross between a “Wedding Anniversary” and “Let’s Make a Deal.” That is, the employee should be thanked and honored for their contributions for the past year. Recognition matters to high performing employees. So when you give a raise, it is helpful to give it with praise – in a bouquet. Then you’ll get more of what you want (happy employees). The “Let’s Make a Deal” part is where you outline 3 to 5 concrete things for the employee that you want their help with,

“So Debbie, I am very happy with how you’ve gone beyond the call to increase your skills this year, are flexible in working hours, always willing to lend a hand and always cheerful. That’s why I am giving you a 4% raise this year...”

Now, for the coming year, here is where I need your help...”

Then outline to your employee what you’d like them to do. Examples:

- Get the Continuing Ed to add to their skills (for example, the front desk to learn more about QuickBooks or the Practice Management software)
- Flexibility in working evening hours
- More use of the intra-oral camera
- Better front desk collections
- Be more punctual

Be very specific and concrete. Note the requests and then the next year, if they've made progress in those areas, **thank them.** In fact, don't wait until next year! Tell them right away if you see a change in behavior (or don't!).

As practice owners, you have an automatic "incentive" program. You know your career, your livelihood is at stake. Employees are a step or two removed from the harsh realities and from the rewards. You don't need anyone to motivate you to grow, to get better, etc. Create an environment so good employees can flourish. Valuable team members are always adding to their skills, always helpful, pleasant and hardworking. If you don't recognize those qualities in an employee, they will go somewhere where they can be recognized!

Oh, and one more thing, an important part of the performance review process is to ask the employee, **"What can I do to help support you in doing your job and in being happy at work?"** and then really *listen* to what they have to say. You don't have to grant everything that's asked for but if you take what they say under consideration, they'll know that. At the very least, you're less likely to be surprised by having someone unexpectedly quit.

Smart Wage Decisions: I believe it's best to take a look at staff wages as a percentage of collections at least once per year for the sake of determining how much will be available for wages and raises. If your total gross wages were running at about 25% of collections, for example, last year and they are 23.5% now (because your collections grew) then you are in a position to give raises. If staff salaries have crept up to 27% or 28%, then it's time to hold off until your practice revenue catches up.

Using this very simple method, you can keep the biggest part of your overhead (staff wages) under control.



Bill Sullivan

HOW DOES IT WITH PHYSICIANS?

For 33 years, Bill Sullivan has been the Executive Vice President of Dr. John Najarian's Medical Research Foundation. The Institute for Basic and Applied Research in Surgery (IBARS) provides additional funding support to the Department of Surgery at the University of Minnesota with an emphasis on Solid Organ Transplantation, Surgical Oncology and Cardio-Vascular Surgery.

As with Dental School, most physicians graduating from Medical School have a total debt load of approximately \$300,000.

Three "cataclysmic financial events" occur when many students graduate from Medical School. About one third marry another medical student, effectively doubling their tuition debt load. Next, Medical Students tend to buy homes they cannot realistically afford. And third, it is not at all uncommon for Medical Students to have a baby, effectively taking one of the wage earners out of the full-time practice of medicine.

Painfully, healthcare economists have calculated if a medical school couple assumes a "non-dischargeable" debt load of approximately \$1 million dollars, over the course of a 42 year professional career, there is "great likelihood" they will not be able to retire their tuition obligation.

The average income of a Mpls./St. Paul Family Practitioner is \$177,600, but new grads often earn less than \$100,000/year in their first 3 years.*

* *The mean income for a General Dentist in Mpls./St. Paul is \$189,000. The range for means throughout Minnesota is \$183,490 to \$224,830. Source: U.S. Bureau of Labor Statistics, 2014 data.*

This has resulted in the non-too-subtle self-segregation that is taking place between the ranks of the primary care physicians and the specialists. Recognizing the extraordinary costs involved, many students are gravitating to higher paying sub-specialty disciplines which, in turn, render the relative salary structure of the general practitioner to disproportionately fall behind.

THE 2012 AFFORDABLE CARE ACT (ACA)

Economists, political strategists, and business leaders have argued for years to expand the base of the insurance pyramid. Enrolling young, healthy candidates would help offset the exploding costs of health care costs today.

At the national level, this desired-for goal has not played out. In fact, young people remain reluctant to sign up for healthcare insurance. Even with a bitter pill of an annual Income Tax penalty assessed to those without healthcare insurance, many argue it is simply cheaper to "pay the penalty." What the nation has witnessed over the past two years is a disproportionate enrollment among young and middle-aged participants whose needs for healthcare are defined by a host of chronic medical problems.

While some states have done an aggressive job of moving many off of the Medicaid roles by offering healthcare insurance subsidies, the sad fact remains that too often young people today suffer a disproportionate number of problems related to obesity, diabetes, early onset heart disease; all problems typically associated with an older population.

A TWO (OR THREE) TIERED SYSTEM

- The "financially advantaged" will always be able to receive care, most likely from a concierge physicians' service. Painfully, 40% of physicians 55 years of age and older are opting out of Medicare participation and this number is growing. This is very bad news for aging Baby Boomers who are bound to need increased health care.
- The "financially disadvantaged" will receive care via Federal programs implemented at the State and Local levels.
- Sadly, the majority of Americans will fall into a system of quasi-rationing. Of course they will be treated, but there will be long lines of other patients ahead of them, "Justice delayed is justice denied!" and **"Healthcare delayed is healthcare denied!"**



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