Issue 14
Jan/Feb 2021

ENDO INC
ROOT CANAL SPECIALISTS
NORTH SHORE

A publication of Drs. Maloff, Makkar, and Tsai

www.endoincrootcanal.com

be LEAN and PROFITABLE without being CHEAP and MISERABLE

by Kevin Coughlin

When it comes to building a more profitable dental practice, cutting corners will often cost you a lot more than investing in the processes and procedures that really drive business growth.

Finding and trimming fat is a necessary part of running any small business. Make no mistake; your dental office is a service-based small business.

But reducing costs can only get you so far. Cutting back on something like staff hours you're likely to see costs spike because an understaffed operation cannot run at peak levels when employees, who deal with patients, are miserable and stressed out.

If you think your patients won't notice, you're kidding yourself. The team members in any dental office are even more important than the dentist. That's because team members have the most one on one interaction with patients – from answering phones, to booking appointments to greeting people as they walk in the door. So if they are not happy, it's going to show. And that will, in turn, result in less referrals and even the loss of clients as patients move to practices where the levels of service are higher.

Over the course of my career, I built not one, but 14 very successful dental practices that are lean and profitable without being cheap and miserable.

We did this by putting in place processes and procedures that increased efficiencies in the operation while increasing customer service and satisfaction. Best of all, we were able to replicate this success multiple times.

At the core of this system is a very simple acronym that will help you make your practice **SPECIAL**.

Scheduling
Production improvements
Employee or team member management
Collections improvements
Internal controls
Associates and accounts receivables as a tool for growth
Liabilities and asset management

Scheduling Tips:

What is your patient's chief complaint? How immediate is the need to get it fixed? Obviously if there is a chronic pain issue, it must be addressed. But if you can "triage" patients and determine how long your procedures will take, then you can schedule treatments more effectively and have less downtime throughout the day. This will allow you to schedule more patients throughout the day, which in turn leads to increased profitability! In the end, your scheduling coordinator must know two very important things.

1. Is your patient a **1**, **2**, **3**, **4** or **5**?
2. Is your patient prior approved through a soft credit check?

Production:

The first thing I do with any patient is to assign them an administrative number between 1 and 5.

1. *Patients with no insurance.* These patients are great because it cuts out all the middlemen. Their credit card to your balance sheet!

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2. *Patients over the age of 65.* Most patients in this cohort are retired and are now in a position to take care of themselves. The house is paid for and the children are out of college and on their own. More importantly, you can schedule them at off peak times such as 9–11AM and 2–4PM. I suggest you try to discourage weekends, because this group in most cases have very flexible hours.
3. *Patients with insurance.* These are only slightly less valuable than those without insurance who are paying you directly. But you know the bill is going to be paid. With this group of patients you can balance bill their dental insurance.
4. *Patients are on State health insurance or Medicaid.* These patients will reduce your fees by 60–75% and only certain treatments are covered, in most cases only fillings and extractions and hygiene appointments. However, if scheduled and managed correctly, they may be able to help your practice.
5. *Patients with insurance, but who's insurance only pays to a certain fee schedule,* meaning many times you cannot balance bill or only balance bill to what the patient's dental insurance allows and this will reduce the value of your billable work.

After determining if the patient is 1, 2, 3, 4, 5 and determined the nature of the complaint, you should have an excellent idea on how long the appointment should be and with whom the appointment should be scheduled with.

You should be looking for who in your practice does the treatment best and quickest with least number of issues. In most cases the senior doctor will meet this criteria, but not always.

Your front desk coordinator should accurately determine the estimated production of each appointment to make sure it coincides with your hourly, daily and weekly and monthly goals. For non-group practices I often see less productive appointments filling the schedule and more productive appointments waiting to be seen.

Employee Management:

Employees are the lynch pin to any successful practice. I've even started using the work TEAM as an acronym in my training programs to mean "Together Employees Achieve Mastership." Don't hire just anyone. Your brand and your business is on the line, Background checks, personality profiles and experience will determine the likelihood any employee will succeed and stay with you or not. Look for signs and be smart about who you hire and how they fit in with your existing team.

Collections:

The best patient is the one who puts down a credit card at the end of their treatment. No fuss, no muss. But it's always good to know if a new patient has had a soft credit check by Care Credit. If they have and are already approved you know you're going to get paid for your services. However, if the soft credit check, which should be done before scheduling, indicates the patient is not pre-approved you can be pretty certain there are other financial issues at play and maintaining a 100% collection standard may be in jeopardy.

Internal Controls:

Run your practice based on information to find out where your strengths lie and what improvements must be made in order to become more profitable. Things you need to know include:

- How many new patients are you getting per month and where are they coming from?
- How many patients are leaving your practice each month and why?
- How many procedures are you doing every month in the following categories: root canals, extractions, periodontal surgeries, root planing, orthodontic band and brackets or MTM or Invisalign, crowns, bridges, implants, dentures and partials, biopsy, night guards, sleep appliances or MAD (mandibular advancement devices).

This will determine where your strength and weaknesses are. Next evaluate your AR's or accounts receivables. Who has not made a payment for 60 days or more? These patients have a clinical issue, service issue or insurance issue. Whatever the issue is, it must be addressed.

Associates:

Associates are needed when you are thinking of retiring or slowing down, or when you want to jump start your business. In most cases large overhead expenses such as rent, mortgage and wages are fixed costs. So think about your associates as potential revenue center rather than an expenditure. If managed correctly your associates will not only increase your money-in potential, but also allow you to enjoy more time away from a very profitable practice!

Liabilities:

Keep your overhead below 65% only purchase what you know will give you a return on investment. Understand the difference between internal business liabilities and personal liabilities.

Liabilities such as rent, mortgage and salaries are generally fixed. So it's best to extract as much value from each. One suggestion is to offer expanded hours and better scheduling. Consider split shifts such as 7:30AM to 1PM and 1PM to 8PM. The fixed costs stay the same but your practice has more time to see patients - and may even be more convenient for most patients. In essence your monetizing more hours and reducing your bricks and mortar liability.

As you can see, there is nothing here that can't be implemented in every dental practice. With improvements in place you are positioning your business to be more competitive, productive and ultimately more profitable without affecting client care or customer service levels.

For more information on this topic and many others visit AscentDental-Solutions.com. Kevin Coughlin DMD, MBA, MAGD has been practicing General Dentistry since 1983; he owns 14 dental practices in MA. He teaches practice management at Tufts School of Dental Medicine. He has written three books on the business of dentistry and has been lecturing on MSO's and DSO's Friend or Foe? He also has over 60 podcast and webinars available on his website. Dr. Coughlin can be reached at 800-983-4126.

The Magic Lockbox

by Dr. Steven M. Katz[2]

Frequently, in our role as practice coaches, we are called on to solve conflicts and resolve turmoil in the practices we work with. We are faced with anger, misunderstanding, resentment and accusations. The combatants often blow the disagreement out of proportion, allowing their emotions to overwhelm their sensibility to the point that even complete resolution of the conflict leaves residual hard feelings.

When my wife and I were married, 38 years ago, one of the most curious gifts we received was from my wise Great-Aunt, Ruth. Aunt Ruth's gift was a small lockbox. The instructions that accompanied it were that the box was not to be opened unless Regina and I found ourselves in the predicament of not being able to resolve a dispute.

Though Regina and I have had an incredible run of love and cooperation, there have been times when we disagreed. In the early days, it was arguing over who would do the dishes. Then there were differences of opinion in where we would live and whose family we would spend holidays with.

Later there were more globally significant conflicts over careers and parenting. However, we never once got even close to cracking open the lockbox, for fear that we would lose the opportunity to open it if and when we "really" needed it. We were reserving the possibility that it would be the cure-all for **"the"** worst of arguments, whenever it arose.

Recently, Regina and I have come to realize how incredibly compatible we are. It has been years since we have had a serious argument and even minor disagreements are fewer and far between.

On our anniversary a few years ago, we decided, out of curiosity, to open the lockbox. We could not imagine what earth-shattering information made up its contents. As we opened it, we were shocked to find very little in the box. It contained two envelopes. The first was addressed to me and it contained an "I'm Sorry" card and a $50 bill paper clipped to the business card of a florist and instructions on how to order a dozen roses. The second envelope was addressed to Regina and it contained an "I'm Sorry" card and a list of phrases, including "I love you," "I appreciate you," and "I want to see how we can compromise."

Brilliantly, Aunt Ruth had proven that the tools to overcome turmoil are not something that we can receive, but they are totally within all of us. We had found the resolve to settle many disagreements prior to opening the box. With slightly more resolve and determination, we all possess the ability to resolve even the most difficult conflicts. To do this we must:

1. Look beyond the person confronting you. The source of the problem is rarely an individual, but rather a challenge or a situation. Focus on these contributing factors instead of the person and try to understand why it is upsetting to each other.
2. Identify the source of the problem. Often it is not the situation, but a perspective on the situation that causes anger to fester and leads to exaggerated conflict. The ultimate source of the conflict may have been something minor that happened in the past, but its persistence led to greater frustration.
3. Request solutions. After understanding the "other" viewpoint, it is important to discover how "we can make things better between us." As disputants stop fighting and begin to attempt cooperating, the discussion moves away from finger pointing and toward ways of resolving the conflict.
4. Look for common threads of agreement. Break down thoughts on the conflict to areas where you may be able to agree. It's not all black or white. Embrace the grays and then find smaller parts of the issue that can be tolerated in compromise. If we remove some of the selfishness that we all have, sometimes looking at the issue from the practice's perspective can lead to broader compromise.
5. Re-embrace each other's positive qualities. It's not enough to just agree to agree. Reemphasize how each person matters to you personally and in the context of the practice. Apologize for emotions that surfaced spontaneously in the moment and commit to keeping the good of the practice and others in perspective.
6. Create your own lockbox. Create a lockbox for your practice that contains the first five steps in the instructions above, describing the lockbox as the last resort. May the specter of that lockbox give you the resolve and remind you of the commitment to wanting to resolve conflicts without creating turmoil.

Dr. Katz's practice was destroyed by a series of life tragedies 18 years ago. He systematically rebuilt it to become a multi-milliondollar practice with an emphasis on relationships and customized care. Dr. Katz is a Master in the Academy of General Dentistry and a Fellow in the International College of Dentists.

He has been the Team Dentist for the New York Jets Football Team and a Dental Consultant to Channel 5 Fox News in New York. He was the owner of Smiles On Broadway Dental Care in Malverne, NY and the Founder of Smile Potential Dental Practice Coaching. He can be contacted by phone at 516-599-0214 or by email at drkatz@smilepotential.com, www.SmilePotential.com

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BIOFILM: Are You Treating It Properly? - Part 1

by Patricia A. Worcester, RHD, BS[7]

Biofilm has been studied for more then 300 years. In this time span, we have learned how these micro organisms work in our mouth and their deliberate attack on our oral health. One definition of biofilms is that they are made up of heterogeneous composites of bacterial communities within a non bacterial protein, polysaccharide, and glycol-protein matrix of bacterial and salivary origin. The matrix allows for a "circulation" of nutrients and bacterial metabolites between communities and the environment outside the biofilm. There are extreme variations in oxygen levels ranging from highly aerobic areas within fluid channels to almost completely anaerobic areas in micro-colonies.

This article will address biofilm in the oral cavity and what a clinician must do to successfully remove the biofilm. The importance of this is a direct relationship between biofilm and periodontal diseases.

Periodontitis is not profoundly different from any other chronic biofilm-mediated disease.[1] In 1978 Costerton and his colleagues renamed plaque as biofilm. However, plaque is a term still used in popular culture. We hear plaque on television commercials and read about it in school textbooks. But for the duration of this article, the term biofilm will be used exclusively.

Biofilm is found supragingival and subgingivally. The gingival sulcus presents a very unique living condition for bacteria. In our sulcus, the bacteria cling to its non-shedding surface, the only place in our body where this occurs. Our gingival sulcus is a protected microhabitat for bacteria to multiply. Our mouth contains over 500 different bacterial species. At the end of the day, our mouth has over 7 billion bacteria, and if you have the genetic gene for periodontal disease, your mouth will have over 28 billion bacteria. No wonder the American Association of Periodontology's Classification for gingival diseases consists of 8 categories and 72 subcategories and periodontal diseases consists of 8 categories and 67 subcategories.

The new model of periodontal disease is dependent on the resistance of the host, in other words, your patient's risk factors. Risk factors can be local or systemic in nature. Local factors can include both, anatomic or iatrogenic which facilitates bacterial biofilm, and therefore, calculus. Systemic diseases and lor conditions are also contributing factors for periodontal disease.

"P. Gingivalis and A. Actinomycetemcomitans are two exogenous periodontal pathogens that are resistant to eradication by scaling and root planing. "Because their persistence in high numbers after mechanical therapy is associated with continuing periodontal deterioration, the eradication of these and endogenous periodontal pathogens is viewed as major success criteria for successful periodontal therapy. The use of systemic antibiotics as adjuncts to mechanical periodontal therapy to reduce the levels of periodontal pathogens below detectable levels."[2] "Biofilm disruption must be employed at the beginning of antibiotic therapy to maximize the effectiveness of the chosen systemic antibiotics. Intact biofilm acts to protect the most pathogenic bacteria from antibiotics." [3,4,5,6]

The special feature of the infected sulcus is the presence of crystalline calculus, which protects the biofilm and acts as a foreign body for additional biofilm formation, so that the calculus must be removed before the biofilm can be controlled. Even minor roughness like scratches or grooves of less than a micrometer on the root surface will facilitate the adhesion of bacteria. In root irregularities and grooves of only a few micrometers the first traces of bacterial re-colonization start in less than 24 hours after biofilm disruption. Scratches and grooves have been shown to enhance biofilm formation and to protect extant biofilms from mechanical cleaning. Clean smooth surfaces colonize biofilm at only a 10% rate compared to scratched or grooved surfaces.[7]

Therefore, as hygienists, we must spend more time during our SRP/RDT appointments to remove the root irregularities and biofilm in order to arrest periodontal disease. By removing all the calculus, biofilm, and root irregularities, any adjunctive chemotherapeutic agent or systemic antibiotic that is used will be effective.

1. Donlan RM, Costerton JW. Biofilms: survival mechanisms of clinically relevant microorganisms. Clin Microbiol Rev 2002;15(2):167-193.

2. Serio FG, Hawley CE. Nonsurgical Therapy. Manual or Clinical Periodontics: Chapter 6:61.

3. Serio FG, Hawley CE. Nonsurgical Therapy. Manual of Clinical Periodontics: Chapter 6:69.

4., 5., 6. Schaudinne, C, Gorur, A, Keller D, Sedghizadeh, P, Costerton, Jw. Periodontitis An archetypical biotilm disease: JADA, Vol. 140 August 2009 (980).

7. Costerton JW, Schaudinn, C, Melrose Diane. DENTAL BIOFILMS in the ORAL CAVITY: Dimensions Digest or DENTAL HYGIENE; January 2011(18-20).