

HOW ARE YOUR NEW PATIENT NUMBERS?

During the most recent 9-12 months I have noticed that many of our clients, and more than 75% of the non-clients whose numbers I have reviewed (roughly 500 doctors' statistics have been evaluated), have seen a decline in their new patient flow. In addition, every speck of feedback I have received from other consultants, from doctors' study clubs, from conversations at tradeshow, computer user's meetings, etc., shows that this decline in new patient flow is occurring throughout the entire dental/orthodontic profession, in every part of the country, but it is not occurring in every practice!

There are lots of reasons, good solid reasons, for this decline in patient flow. General dentists are seeing their own case acceptance and production per hour decline and therefore are referring less to specialists. The general public hears and reads that the economy is strong, that the recession is gone, that inflation is under solid control, the stock market is at an all-time high, etc., but these same patients notice they earn practically nothing on their savings, there's nothing much in their savings, they continue to pay more for all the things they need to buy yet their paycheck does not go up as much as all those things they need to buy, their employer is talking about expanding production, but in some Asian country, and in the mean-time has a freeze on hiring. The idea of putting Johnny into braces or getting that porcelain bridge just doesn't feel comfortable right now to a very large number of people.

Although even a short-term decline in new patient flow is of concern, this particular decline is more long-lived than those we have seen in the past during virtually every national and regional economic down-turn. Nevertheless, it is not time to panic. It is, however, well past time to do some quality marketing!

We believe that this new patient decline has hit 75%+ of the profession, but still many of our clients and other doctors we have spoken to have seen no decline in new patient flow. Some have enjoyed a relatively normal increase in new patient flow. A few of those with increases in new patient flow are new/young practices, starting from scratch, who tend to have, during the first few years, what we call "natural" new patient flow increases. That's easy to do when you start from 0! Most of these practices though are not young and are not new. Why then did they escape the decline that

has hit the majority of the profession? Are they just lucky? Is it because they are in a growing town? No, it is none of these. The doctors whose practices are seeing solid new patient flow, even in this "recession", are those who are aggressively and consistently pursuing high quality internal and external marketing!

So there is no problem with definitions – internal and external marketing is not advertising! It is not direct mail pieces that attract "B" and "C" patients to the practice and drive away the "A" patients in your community who wonder why you need to advertise that way. It is not coupon advertising, billboards, television or print advertising, and it is not putting a nice colorful ad in the Yellow Pages. It is not a splashy full-color magazine type piece that tries to convince potential patients and other doctors that you really were elected "Doctor of the Year." If you are an orthodontist, internal marketing is not doing "muffin runs" or other forms of solicitation to general dentists (ask your Treatment Coordinators if they would rather see a new patient referred by a patient or a patient referred by a dentist!). Internal and external marketing is sure as heck not signing up for a PPO or some other form of Managed Care!

Internal marketing is the work you do, within your office, to educate your patients and / or parents that you value their contribution to your practice and that you would welcome their referral.

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I have made it a point, in almost every one of my telephone calls during the past year, to ask each doctor about his marketing. My very favorite question to ask a doctor is: "During the most recent two working (patient) days, how many times have you personally heard a chairside assistant ask a patient or parent for a referral?" I am dismayed that the single most common response I receive to that question is: "I've never heard one of my chairside assistants ask for a referral!" Other questions we ask: "How often do you have good cooperation contests?" "How often have you let parents put their name in a bowl for a drawing for free orthodontics?" One of my general dental clients has two "Costume Days" a year where the doctor and the entire staff dress up and every patient who is seen that day who is also wearing a costume gets a

special prize. Stupid? Unprofessional? If so, why do these practices consistently have more new patients and more high quality new patients than most others?

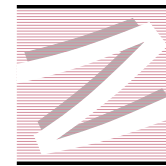
I could go on and on with internal marketing ideas, but what about external marketing? External marketing is the work you and your team do, outside your office, to educate your community that you are a quality practice, that you provide quality care and treatment, and that you would welcome those you come into contact with as new patients in your practice. For instance: How frequently do you or one of your clinical staff lecture to a Lamaze class? How often does the staff lecture to a grade school, middle school, or high school health class? How often have you bought every seat for a showing of a new Harry Potter or other kid's movie, and then given two tickets to each kid in the practice and encourage him to bring a friend? How many kindergarten or grade school field trips to your office do you host?

There are hundreds of quality marketing ideas such as these (we will discuss them in our October seminar) that doctors should be doing but almost universally, when I question doctors with declining new patient flow about these types of marketing, they tell me they do little of it and what they do is sporadic rather than consistent. It seems that these practices – these doctors – are sitting back and waiting for things to get better!

In fact, things are going to get better. The population's attitude about elective care is going to turn around and new patient flow will again be on the rise. However, those doctors who have learned the value of high-end internal and community marketing, those who know the difference between marketing and advertising, and those who understand that it is times like these when it is the most appropriate to spend time and money on marketing, on staff training, etc., will always be those who experience the briefest down-turns and the most long lasting up-turns. Those doctors will always be the most profitable and enjoy the highest quality of life within their practice as well!



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An interesting phenomenon!

Over the past 3-4 years we have noted an increasing number of occurrences that perhaps have always happened over history but we are only now noticing because of the fairly large number of clients who are nearing retirement age. What is happening is that doctors are bringing on young doctors as associates and partners with the intention of transitioning out of the practice as the time for retirement comes. That part is normal. The change we are noticing is that the senior doctors are allowing their new young partners to make practice changes, changes in policy, changes in staffing, changes in methods of marketing. Even this may be interpreted as a normal part of a transition but the changes I am concerned about often result in abandoning policies that are working well and changes to policies that the senior doctors long ago learned, usually the hard way, were damaging to the well-being of the practice.

In the most recent six months alone, we have seen these young doctors sign up for PPO's, start charging for records, decide to require consults on all patients, stop diagnosing early treatment, switch from 6-month recall to 12-month recall, require auto-debit, require fixed down payments, etc. I can probably cite at least another 6-8 additional examples of policy changes made by new, young doctors in mature practices that will eventually cause the practice grievous harm.

A young doctor starting his own practice can be forgiven for making mistakes such as these because there is no guiding presence to teach him or her otherwise. But what about these senior doctors who have already been subject to the problems associated with these policies and have learned, again, the hard way, that there is a better way of doing business? Why are they passively standing by watching their young partners make these mistakes?

I had one of my clients, only a year or so away from his retirement say to me: "I am going to let him do what he wants. By the time these policies cause significant damage to the practice, I'll be gone and he can learn what works and what doesn't the same way I did, by trial and error."

These young doctors are walking into exceptionally clean, delinquency free, profitable, and high quality of life practices. Cases are being finished on time, patients are keeping their appointments, brushing their teeth and sending their friends and relatives in to be new patients as well. Not having had any other experience, the new doctors simply learn and believe that is the way it is in the orthodontic business. They believe that their "new and modern" ideas will make things even better. Unfortunately, most of these "new and modern" ideas are not new at all! They are the same techniques, policies, and procedures that long ago were abandoned by the senior doctors as being barriers to building the type of quality practice that they have today.

I suppose there is some value in learning through the school of hard knocks, and maybe it is true that the new doctors will simply have to learn the hard way, but it seems to me that these senior doctors could save their young "protégés" a lot of grief by being a bit more assertive, providing proper guidance about the reasons for and value of current practice policies and not allow them to travel a path that the senior doctors long ago abandoned.

Delta Participant?

In 1982, or thereabouts, I was in a General Dental client's office in Minneapolis who asked me what I thought about his participation with an "insurance company" named Delta. I knew almost nothing of Delta in those days but noted that while Delta allowed him to charge whatever he wished, he had to pay what I recall was a 2% "administrative" fee for every procedure he did on a patient insured with Delta. I questioned why he would want to give up 2% of his fee, which was probably 8% to 10% of his net! His answer was the answer that has become standard and increasingly common today: "I'll be listed as a doctor on their plan and I will get more new patients." I told him I did not think that was a proper way to get new patients and promptly forgot about the issue.

It was not much later that I was in an Orthodontic office. The doctor asked me an identical question. In this situation, there was no administrative fee and he also was free to charge what he wished – but he was required to submit his fees for "approval." A quick review of his contract with Delta showed that Delta had the potential ability to reduce his fee structure. I did not think that sounded right to me and told him so.

We all know, of course, what has happened since. Managed Care "invaded" the dental and orthodontic professions with many doctors participating because they naively believed that the fee restriction would be insignificant relative to the new patients that the Managed Care plan generated for the practice. Of course, it did not work out that way!

It was only a few more years and a few dozen "plans" were now at work around the country. By this time we had a few hundred orthodontic clients and were continually being asked our opinion on participation with Delta (CDS in California). The comment or justification was always the same, "we will get lots of new patients and they don't restrict our fee." Because the potential to reduce the fee was there, we were adamant that our clients not participate although much to our disappointment, a number of doctors failed to take our advice.

About five years ago, in a couple of low population mid-US states, Delta started restricting the orthodontic fees of a few of our clients who were "participating." Then, about three years ago, Delta started restricting fees to some of our higher fee California and Washington clients. Today, Delta plans are restricting orthodontic fees all over the country and the fee restriction is no longer limited to the higher fee practices. The average fee reduction today seems to be about 5% to 7% of the typical fee which in most offices is 10% to 15% of the profit. Still, many participating doctors foolishly believe that this fee restriction will somehow remain stable at the current level and that they can simply choose to get off PPO's someday if the fee restriction becomes untenable. In another five years, doctors participating with Delta and other PPO's will most likely be giving up 50%, or more, of their profit! These doctors will see 30% to 50% of their new patients being on the plans and doctors will be unable to get off without huge declines in production and income.

Wake Up! Get off of the Delta (and all other PPO) plans now, while you still have a reasonable chance. More than half of all potential patients in this country have no insurance at all and significantly less than half of those that do have insurance are on Managed Care plans. Learn how to market effectively and attract the right type of patient to your practice.

Of course, another point of view is that you can sign up with lots of plans, run a zillion patients a month through your practice, live with about 50% case acceptance, lots of clinical cooperation problems, lots of staff turnover, work your fingers to the bone, and live with a practice with all sorts of stress and upset. It's your choice!

Patient Statements

Sending statements (not bills!) to every patient with an account, even an insurance balance only, every month, remains the single best embezzlement control tool available to a health care practice. In addition, whatever level of patient delinquency you have today, that delinquency will be permanently reduced by at least 10%, and likely a bit more, if statements are sent every month to every account with a balance (whether due now or future due!). The increased income will be far greater than the increased costs related to additional labor, postage, etc. More importantly, patient satisfaction will be solidly enhanced!

"If you believe it will work out, you'll see opportunities. If you believe it won't, you'll see obstacles." Jon Alma

Primary Causes of Patient Delinquency

Eliminating delinquency in a health care practice can only be accomplished by first identifying and understanding what factors cause/allow a patient to get delinquent in the first place and then by utilizing a patient management system that is designed to encourage prompt payment and ensure that only a minimal number of patients ever become delinquent. Next, of course, a practice must have a solid system of delinquency control that not only collects the past due payments from those who do become delinquent but that also educates the patient/responsible party that continued delinquency is unacceptable. Finally, the practice must have a firmly and consistently implemented system that ensures that the chronic "unfixable" delinquents are removed (dismissed) from the practice, with their accounts written off, so they can cause no further damage.

We expect each of our clients to maintain their patient delinquency at 3% of open accounts. This 3% is not the amount of dollars delinquent! It is the number of open accounts that are past due 30 days or more. In addition, the annual bad debt write-off may not exceed one-half of one percent of annual gross revenue. Also, a patient whose account is delinquent remains included in the percentage of delinquency as long as it remains delinquent according to the terms of the original contract. Therefore a delinquent patient remains counted as delinquent, even though a new financial arrangement may have been made, until the account is either brought current according to the original financial agreement or is paid in full. In other words, "hidden" delinquency is not allowed!

If a practice has excessive (more than 5% of open accounts (not dollars!) delinquency, the problem can always be traced to one or more of the following "Top Ten" mistakes.

1. The credit risk inherent with a particular patient was not clearly identified before credit was granted.
2. Financial arrangements were made that were not appropriate to the risk.
3. A poor quality financial arrangement was made, ex. balloon payments on "B" and "C" patients.
4. Not allowing patients to choose their own preferred due date.
5. Statements not sent to all open accounts every month – even those with an insurance balance only.
6. Not charging (or routinely waiving) late charges on accounts 10+ days past due.
7. No appropriate balance between telephone and letter collection activity. No clarity on when to use one type or the other or when telephone must never be used.
8. Not using denial of progressive treatment (Maintenance) and "Dismissal" as collection levers.
9. Not recognizing that minor (15-30 day), but chronic, delinquency often causes greater damage than 90-120 day delinquency.
10. Doctor becoming involved in the delinquency control process.

Please note that the first five issues causing patient delinquency have nothing to do with actual collection activity. Said differently, half of what keeps your delinquency, your write-off, and your quality of life, at a healthy level is the process you go through to prevent delinquency in the first place!

"It is our attitude at the beginning of a difficult task which, more than anything else, will affect its successful outcome." William James

All-Stars

These doctors have practices with excellent case acceptance, perfect delinquency control, and overall practice numbers in outstanding health!

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Look Close to Home

As you can tell, much of this newsletter is about the issue of marketing, and the absence of quality marketing that we see throughout the profession. Too many doctors believe that the way to build their practice is to sign up for a program that basically teaches you nothing more than how to hustle your general dentists, or to sign up with a company that will help you do direct mail advertising, or to sign up with a company that will make you a pretty brochure, a fancy logo, nice letterhead, etc.

We know that each of these different "systems" will attract some new patients, and some will even attract enough new patients to generate enough starts to allow you to break even on the expense of the consultant, or the tuition, or the printing and mailing costs. However suppose one of those prospective new patients calls you and, when the telephone answers, they hear, "Dr. Smith's office, please hold!" What if when the new patient calls they are told there are no openings for new patients for three weeks? What if they are told you only see new patients in the mornings, or in the afternoon, or only on every third Tuesday – and then only if there happens to be a full moon that week? What if when they finally do come in for their exam you are 10 minutes late seeing them?

Not a day goes by when I or one of my staff do not call an office who answers as I described above. It's no wonder these same practices are hurting for new patients! My point is simple. You can have the greatest marketing program in the world, but if your appointment book, your practice policies, your staff verbal skills, your ability to be on time, and your telephone etiquette, are not in wonderful shape, all the marketing in the world will be of little value.

High Overhead?

You cannot repair a high overhead/low net situation by controlling staff salaries, supplies, and other expenditures. Virtually all practices with overhead rates of 45% and below have learned the three "secrets" to profitability: 1. Directed marketing programs that attract quality new patients. 2. Practice systems and procedures in place to ensure excellent case acceptance rates. 3. A healthy fee schedule and diagnostic style that ensures the practice's average fee per patient started is healthy.