

TO TREAT OR NOT TO TREAT: THE CASE FOR EARLY TREATMENT

There is a great debate in the orthodontic arena regarding the efficacy of early treatment. It is an ongoing discussion between doctors who view it as clinically unnecessary or inappropriate, those who believe it is unprofitable, and those who believe that the clinical benefits to the patient of early treatment are substantial and that, properly handled, early treatment is extremely profitable as well.

As a business consultant, I have the luxury of avoiding the debate on efficacy and choose instead to focus on the financial benefits that hinge on the decision to offer early treatment. What I know is this: Were I a doctor with the clinical skill to improve the orthodontic health of a patient by starting them early, I would not turn them away with only the promise of future help. After all,

“...doctors embracing early treatment have significantly better loyalty and satisfaction ratings, resulting in significantly better patient referrals and practice growth.”

in this world of instant gratification, what is keeping them from heading straight to the next doctor willing to offer assistance now and receive the profits that I have declined?

As a businessman and consulting professional, it is my responsibility to focus on the financial health of my clients, helping them achieve optimum practice growth, profitability, and quality of life within the practice. Zuelke & Associates' clients understand the economic impact of all the decisions they make, both financial and clinical. However, I stress that while I focus greatly on financial impact, there is nothing more important than maintaining diagnostic integrity in our profession. Above all, the doctor who provides early treatment must do so based not strictly on financial gain, but on professional standards and the best interest of the patient.

However, allow me to offer a few relevant business and economic facts for those who do not embrace early treatment:

1. Doctors doing “normal” amounts of early (Phase I) treatment always show better rates of case acceptance than doctors who put those same patients into Recall. At least three issues are at play here. First, many parents, upon being told their child will simply have to remain awkward or unattractive for some time, immediately leave to find another doctor who will treat their child now. Second, many children who have reached the age of awareness regarding appearance are highly motivated to get into treatment now. Third, parents whose children are in Recall are given the opportunity to move away, incur negative changes in personal finances, become divorced, or simply

grow comfortable with their child's appearance before the child reaches the point of needing full treatment. Obviously, none of these potential patients end up in treatment – at least not in the practice that put them into Recall. Combine with this the fact that many orthodontic practices have weak Recall systems and this problem of “lost” patients becomes worse.

2. Because they have better overall case acceptance rates (case acceptance on early treatment cases is typically well above 80%), doctors providing early treatment boast significantly better patient retention than practices that have put patients into Recall.

3. Because they have satisfied the expressed need of the parent and child, doctors embracing early treatment have significantly better patient loyalty and satisfaction ratings, resulting in significantly better patient referrals and practice growth.

4. As a result of greater patient satisfaction, loyalty and retention, doctors offering early treatment tend to have excellent Phase II start ratios. Since the combined Phase I and Phase II fee is normally 110% to 135% of a full start adolescent case fee, profitability is typically far greater than in practices operated by doctors who decide against early treatment.

It is apparent that providing early treatment produces enviable results, both in referrals and profitability, but also, according to the doctors doing early treatment, clinically as well. To enjoy the financial benefit, a “combined” fee should never be quoted because it is often overwhelming to the parent and damages case acceptance. The parent should be charged an early treatment (Limited/Phase I) fee and then, when it is time for Phase II to commence, a separate Phase II fee is charged. Please note, the Phase II fee is a separate established fee in the practice. It is not a regular full start fee that is discounted! At the time a Phase I or Limited case is started, the parent may ask the amount of the future Phase II fee. If asked this question, the parent should be advised of the most typical Phase II fee currently being charged, although inflation will change their fee by the time Phase II is needed.

Once the doctor has determined the appropriate fee for a combined Phase I and Phase II plan (which should be 110% to 150% of a full start adolescent fee), 55% of that total fee becomes the Phase I fee and 45% of that fee becomes the Phase II fee. Let me reiterate: The Phase I fee is greater than the Phase II fee! We do not want our clients charging token early treatment fees and suffering the discouraging case acceptance rates associated with then charging a full adolescent treatment fee at Phase II! Neither do we want our clients to forget

that they are not charging for wires, brackets, and other “things” that are put in their patients' mouths. Doctors charge for the value inherent in their ability to diagnose and treat what is necessary for the best possible orthodontic care for each patient! There is nothing an orthodontist does for a new patient in early (even Limited) treatment that is not worth a minimum of \$1,000! It is our belief that a Phase I treatment plan of 12 months or so is worth no less than \$3,000.

While we embrace the concept of early intervention for the many benefits it brings in profitability, let me address the other side of the coin. The fact remains that there are many doctors (our data suggest about 20% of the profession) who simply do not enjoy early treatment or who truly believe that it is clinically inappropriate. Fortunately, this is not an issue of right or wrong, no matter how badly some doctors want to make it so. It is a matter of personal choice. So while we tout the many benefits associated with early treatment, we also believe that no doctor who believes that early treatment is improper should provide it simply because it is a moneymaker. Whatever your beliefs, stick to your guns because, while there is absolutely no question that providing early treatment is the more profitable way of operating a practice, it is justified only if you also believe you are properly serving your patients.



Paul D. Zuelke
President, Zuelke & Associates, Inc.

Ortho as CEO Conference

Paul will be lecturing at the “Orthodontist as a CEO” conference in New York City this year on November 14th and 15th. His first lecture on the 14th titled, “The Business of being an Orthodontist” is a presentation showing doctors how they can use their fee schedule, diagnostic style, and patient financing policies, to dramatically increase net profitability. Paul's second lecture, on the 15th is titled “Marketing in Today's Economic Environment.” Paul will explain the differences between Marketing and Advertising, why an orthodontist should never Advertise, and why proper Marketing is so successful in building a high volume practice of high quality patients. During this presentation Paul will also present more than 100 specific Marketing ideas that all practices can use with great success. Register online at www.aomembers.org for this outstanding learning experience.

Zuelke & Associates, Inc. Corporate Purpose: To make a fundamental change in the nature of the health care profession by teaching that through risk identification, risk management, and accounts receivable control, our clients will have not only optimum growth, cash flow and profitability, but most importantly, an impeccable quality of life!

ADDRESS SERVICE REQUESTED

West Linn, OR 97068
P. O. Box 201
Zuelke & Associates, Inc.



Zuelke & Associates' clients are located in the following cities:



Pre-Sorted
First Class
U.S. POSTAGE
PAID
Portland, OR
PERMIT NO. 2263

Need/Want an Associate or Partner?

One of the tougher decisions a doctor in private practice makes is whether or not to bring on an associate or partner and, if the decision is to do so, choosing the right timing. On the surface perhaps such decisions don't seem to be that tough, but in the 28 years Zuelke & Associates has been in the consulting business we have seen more poor decisions on these subjects than good! Invariably the poor decisions resulted in great financial cost to both doctors and these same decisions often wreaked havoc among the practice team and often caused major declines in productivity, relations within the referring doctor and patient community, etc. We are not transition specialists but in many years of tracking more than 1000 doctors practice statistics we have learned a few things about the subject.

Over the years, our clients have quoted a number of different reasons for bringing on an associate or partner. One of the more common – and the one that most frequently fails – is to bring on an associate or partner to help “build” the practice. Although we have seen exceptions, adding an associate/partner rarely results in building the practice, at least nowhere near in proportion to the increased overhead associated with the new doctor. Net income almost always declines! The best example I can offer is that our average single doctor practice produces and collects 30% to 40% more than our multi-doctor practices – on a \$ per doctor basis. Considering the additional staffing required in a multi-doctor practice and the additional doctor(s) salary, the primary doctor is virtually always taking home less (even though it may be a larger overall practice) then before the associate was hired.

From our point of view, there are only three good reasons for bringing on another doctor.

1. The primary doctor wants more personal time off and he understands that he will have to pay for that time off via the increased overhead of another doctor. The benefit of the additional time away from the office must be worth the reduced net. If it is, then hiring or partnering with another doctor is a good idea.

2. The schedule is packed. New patient exams and case starts are both booked out 3+ weeks into the future. Working hours, the schedule, clinical and administrative staffing and job descriptions, etc. have been examined and there is no room for improvement. At this point, a single doctor practice is seeing more than 50 new patient exams each month and is starting more than 40 new cases a month! Hiring an associate or bringing on a partner is a reasonable choice in this situation because being booked out for exams and starts longer than three weeks sends entirely the wrong message to referring doctors and to the community.

3. The primary doctor is 1-3 years from retirement.

Again, we have seen many additional reasons for bringing on additional doctors but these three are the only ones we have seen that consistently generate the results desired.

“There are no problems we cannot solve together, and very few we can solve by ourselves.”

Lyndon B. Johnson

Credit Scoring?

Over the past couple of years, a number of orthodontists have signed up with certain companies that provide credit grades on patients. The service is fast, easy to use, inexpensive, - and it reduces your case acceptance! The problem is not with the companies providing the credit grade but rather with the credit scoring system that is used to generate the grade.

First, the credit scoring system was primarily designed to identify the risk of a potential bankruptcy. In the health care field, financial loss due to bankruptcy is relatively rare and a credit scoring system designed to identify the risk of bankruptcy is of limited value. While an understanding of this risk is useful to creditors, very few lenders will make a credit decision based on a credit score alone because of the significant weaknesses inherent in the scoring system that I will identify. A significant study we have done, reviewing thousands of Patient History documents, those patient's/parent's credit reports, and their credit scores, has shown that credit grades (A, B, C, etc.) that are assigned based primarily on a credit score (commonly called a FICO or Beacon score) invariably result in reduced case acceptance and lost patients because the scoring system is so conservative that patients/responsible parties are frequently graded much lower than they deserve.

Credit scores are of limited value to the health care profession for the following reasons:

- Credit scoring systems do not take into consideration the maturity and stability of the patient/responsible party. For instance, a married 45 year old with 15 years at the residence and 10 years at the job will have a similar credit score to a single 25 year old with 1 month on the job and 1 week at the address – assuming they have similar credit and bill paying histories.
- A \$10 medical collection, even when paid, lowers a person's credit score significantly – even though all other credit for the past 20 years may be perfect. We see many credit reports each month where an “A+” patient/responsible party, one with greater than 10 years on the job and at their residence, has 2-3 “Collections” reported by medical practices. These “A+” patients end up with very low credit scores! Most medical practices contract with outside collection services to handle all billing and collection on accounts once insurance has paid. These billing services are almost always licensed collection agencies as well. Once an account balance hits 60 days or 90 days aging, these services automatically report the account to the credit bureau. That person's credit report now shows a “Collection” and the credit score is significantly lowered – even when that collection is years old!
- A responsible party with an account balance at or close to their credit limit is downgraded by the credit scoring system. For instance, if a responsible party chooses to get a second mortgage, many banks create a line of credit, attached to a Visa or similar credit card, in the amount the person has requested. That instantly lowers the credit score because the account balance is close to the “credit limit.”
- Too many inquiries, by certain creditor types and within a certain time period, lower a person's credit score. Unfortunately, many people do not understand this and, especially with internet loan applications being so available, some people make the mistake of applying to 2-3 different creditors for the same loan. Even if they never actually borrow any money, their credit score has been damaged.
- If a patient's account has had delinquency in the past, but the creditor did not report how long ago it was delinquent, the credit score is damaged. For instance, a patient has an account with a bank that has been open and active for 10 years. Their credit with the bank is perfect but five years ago they had one payment that was 60 days late. The bank did not report to the credit bureau that the delinquency was five years ago. This patient's credit score is reduced as a result.
- A person who recently opened a couple of new accounts has a reduced credit score for awhile until those accounts have history (experience) reported to the credit bureau.

Utilizing credit grades to structure financial arrangements that match the risk the financially responsible party presents to the practice makes good business sense. It simultaneously increases case acceptance and production while reducing delinquency and financial loss. However, using credit grades that are based primarily on a patient/parent's credit score is a mistake that results in lower overall credit grades and reduced case acceptance.

Orthodontic Case Acceptance Improving!

In other articles, in this newsletter and elsewhere, I have mentioned the decline in new patient flow that has plagued the “elective” health care profession. Generally speaking, the rate of case acceptance, even in the practices without a decline in new patient flow (general dentists in particular), has declined as well. However, this is *not* the case with respect to orthodontics! Most orthodontists reading this have experienced a decline in new patient flow compared, for instance, to their 2006 numbers. Even the doctors who are doing the best have only experienced tiny increases in new patient exams over their 2006 numbers. It is interesting to note however, how many of these practices with declines in new patient flow have noticed no decline at all in their gross production and income. That's because the percentage of new exams that have started has improved!

Initially, I was a bit perplexed but it quickly became apparent what was going on. In a weak economy, or when there is a perception among the population that the economy is weak, those who are most impacted by the economy and those who have the lowest commitment to orthodontic care are those who choose not to come for an exam. Those patients and parents who are the least impacted by the economy and/or those who have the greatest commitment to getting their own or their children's teeth fixed still make and keep their exam appointments and continue to start into treatment just as they did before this economic issue took hold. Those “weaker” prospective patients who chose not to make exam appointments were often patients who would not have started treatment in the first place. The result? Better case acceptance statistics. The increase in case acceptance is not dramatic but it has been enough for many practices to avoid declines in production and income.

Dolphin Management announces the Zuelke Financial Expert!

For the past year, Zuelke & Associates has been working with Dolphin Management to develop a software product that will dramatically change – even revolutionize – the patient account management and the practice management capabilities of the Dolphin Management System. Historically orthodontic management (computer) systems have been designed by computer people – not by people who truly understand the day to day administrative management of an orthodontic practice. That has all changed!

There is no space in this newsletter to mention all of the features in this new Dolphin module but here are a few:

1. Statistical reports, for the day, week, month, - any period – that are easy to generate, easy to understand, and best of all, useful to the doctor and the staff to truly understand their practice performance numbers!
2. A delinquency control system, for both patient accounts and insurance accounts, that makes it far easier for the Financial Coordinator to identify, track, and conduct collection activity on past due accounts. The entire “Zuelke” delinquency control program, including our collection letter system, has been incorporated into this feature. All collection activity ever done, whether by letter or by telephone, is identified and tracked in this system. A patient whose payments are less than agreed to can be instantly identified. Patients' whose own delinquency or their insurance delinquency has been “adjusted” off the books or moved into future due (delinquency has been hidden) are easily identified.
3. Significantly improved electronic and manually generated patient statements – the “Zuelke” statement – that is much easier for patients to understand and more effective at reducing delinquency and reducing patient calls to have the statement explained.
4. Sophisticated, yet transparent, embezzlement controls.
5. A “Suspicious Balance” report that prints a list of accounts/patients/insurance contracts, etc. that have unusual or unacceptable provisions. For instance, a patient in treatment but the fee or contract has never been posted? How about a patient with a fee posted who has never started into treatment? How about a balloon payment of \$4000, due on the same day appliances are scheduled to be removed? A patient's account is declining by virtue of credit adjustments instead of payments? A patient whose account has been coded to have no payments roll into the due column? An insured patient who started months ago but whose insurance has never been billed. A patient's insurance has been billed but they have never started? This report will do much more than I have listed but this report alone can save a practice tens of thousands of dollars in just a few years of use.
6. Sophisticated tracking of referral sources so you will always know who your referral sources are, how many patients they send you, the percentage of those referrals who actually start – even the quality of each referral sources patients are identified.

The Zuelke Financial Expert can be seen, in its pre-release mode at the Dolphin booth at the AAO. Dolphin is currently taking pre-release orders for the module at \$1,995, a full \$1,000 less than the \$2,995 price of the module once it is released in late summer of this year. A \$495 deposit will reserve your copy! Call Dolphin at 800-548-7241 for further information.

“Excellence is not a spectator sport. Everyone's involved.”

General Electric

All-Stars

This issue's All-star awards go to the practices that, for the most recent 12 months, have enjoyed outstanding case acceptance (top 10% of our clients) and excellent health and balance with respect to all other practice management statistics. It is not a coincidence that almost all of these practices also enjoyed a solid increase in new patient exams during this period!

Drs. Arkwell & Schuler
Peoria, IL

Penny Berglund, DDS
Edmonds, WA

Christopher M. Brieden, DDS, MS
East China, MI

Drs. Carluhgh & Burzin
Clinton, CT

John DiGiovanni, DDS, MS
Laguna Beach, CA

James B. Donaghey, II, DMD, MS
Mobile, AL

Curtis K. Geyer, DDS, MS
Spencer, IA

Jene F. Jordan, DDS
Archdale, NC

Douglas C. Kallis, DMD
Griffin, GA

W. Blake Lane, DDS, MSD
Columbus, GA

Lee A. Mahlmann, DDS, MS
Richmond, TX

Russell McCabe, DDS, MSD
Columbus, IN

Drs. Peterson, Ryan, & Eaton
Williston, VT

David F. Proietti, DDS
Grand Junction, CO

Scott E. Prose, DDS, MS
Saint Charles, IL

If you would like more information on how you can become a Zuelke & Associates success story, call us at 800-845-4766.

Doom and Gloom?

In the Spring 2007 edition of this Newsletter, I wrote that the number of new patient exams have declined, throughout the profession. From 2006 to 2007 the decline averaged roughly 12%. For the 12-month period ending March 2008, the decline in new patient flow was reduced but was still down 6%-8% from 2007 numbers. However we saw solid improvement during those last three months – the first quarter of this year.

I also said in that newsletter: “. . . things are going to get better.” It is too early to say if that is happening yet. If we were to pay attention to the media, the media that is outraged at a .03% increase in unemployment to 5.1%, in a month (the same media that chooses not to report that inflation for the same month was 0%, that average wages increased, and that the 5.1% unemployment rate is still dramatically lower than it was four and five years ago), we would have to believe that we are in trouble and that our economic world is about to come to an end. I choose to believe that while the rest of this year will continue to be marginal with respect to new exams, the decline has been arrested and it is entirely possible that the improving trend has already started.

The best evidence to support my belief is that the first quarter of 2008 had new patient flow increases compared to the same quarter in 2007. Again, it is early, but better that our glass is half full. . . !

The first quarter of this year had other positive signs! Dozens of our clients had the best month in their history in January. Many of them had months so huge they could not put all of their “business” into January, and February ended up being better than even their best months during 2007. Much of this was due to flex plans, of course, and a point could successfully be made that much of that business was simply taken from earlier months. However, we had many single-doctor practices with January gross charges in excess of \$200,000 and a few that surpassed \$300,000! It was astonishing that we also had a few two and three-doctor practices doing \$400,000 to \$600,000 during January!

So, no more doom and gloom! Tighten the belts a bit perhaps, and focus on improved case acceptance with the new exams you have. Step outside the box and become heavily involved in quality internal and external marketing. Stay away from Direct Mail and the other forms of retail advertising that can ruin your practice. Use liberal and flexible financial policies to welcome your patients into your practice and make it easy for them to purchase what you have to sell. Ride out whatever remainder there is to this downturn. The very best is yet to come!