The Entrepreneur’s Children’s Dental Practice: A Ten Step Plan for Success!

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About the Author

Roger G. Sanger, DDS, MS

Dr. Roger Sanger, is a founder of a multimillion dollar, multi-office, multi-doctor (both pediatric dentists and general dentists for children) dental group serving infants, children and teenagers in the six county region of the central coast of California. In its 25th year, the group provides comprehensive dental care to all socioeconomic categories of patients funded with governmental programs, insurance industry programs, and private parent funding with a unique medical model delivery system. Incorporated into this group practice is in-office surgicenters, off site hospital based operating suites, and off site orthodontic alliances. With a staff of over ten doctors and 150 employees, the group is modeled more after a large business and incorporates modern management techniques to sustain high profitability.

After graduating from the University of Southern California with a D.D.S., Dr. Sanger received a Certificate in Pediatric Dentistry and a M.S. degree in health care education and business. After that, he had a career in academic health care at both U.S.C. Children’s Hospital of Los Angeles and the University of Colorado Medical Center where he held numerous teaching and administrative positions and authored numerous clinical textbooks, textbook chapters, and journal articles.

Dr. Sanger has been a consultant to many national practice management companies including Quest and Dentist Development Seminars as well as being a Contributing Editor for Dentistry Today. In 1985 he formed The Sanger Group with his wife, Kathy, a practicing dental hygienist, and together they produced nine practice management workbooks and related seminars on Marketing, Selling, Scheduling, Production, Collection, Insurance, Dental Hygiene, Team Building, and Profitability. Dr. Sanger has also served in various positions in organized dental societies and worked extensively with non-profit foundations.

This book encompasses Dr. Sanger’s work experiences in academic health care centers, the dental practice management industry, and private clinical practice. He has maintained not only a managing partner role in his practice but also an active clinical practice role as well. Dr. Sanger’s creativity in blending business acumen with dental practice continues to push his group to new levels in both technology and profitability.
Preface

The contents of this book will assist the pediatric dentist and/or the general dentist for children in establishing a children’s dental practice that achieves the following:

1. A comprehensive demographic patient/parent mix that accepts all levels of dental care through professional marketing and parent education.

2. An advanced pharmocodynamic and medical treatment scheduling model different from the traditional behavioral based dental treatment model where maximum productivity in dental delivery systems is the goal.

3. A treatment planning program that is dentist productivity based where cosmetic and minimally invasive care is limited and sound traditional restorative care is promoted in a high caries population.

4. A staff utilization program where trained auxiliaries coordinate patient diagnosis, treatment planning, parent education, financial contracts, appointment scheduling, and treatment delivery thus allowing the dentist to concentrate on actual restorative productivity.

5. A multi-office, multi-doctor practice plan to accommodate all segments of the socioeconomic patient/parent mix.

6. A doctor utilization program where both pediatric dentists and general dentists for children can practice to the greatest of their ability, experiences, and education.

7. An off site orthodontic care program with financial incentives and advisor mentor/monitor program where profitability evaluation and strategic planning is continually performed.
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Chapter 1:
So You’re an Entrepreneur —
Apply it to a Dental Practice!

Step One

My father was dead set against me going into the business world where he had toiled long hours ascending the corporate ladder in the American retail industry. He moved his family every year going to different parts of the U.S. to learn the demographic influence of America in the retail trade. Every time came a promotion. Every time came a new challenge. He never went to college but moved from floor sweeper to a vice president for an international retail discount chain in his 47 years with this same company. He rarely saw his family. He was up and out before sunrise and never home before sunset. 24/7 was standard operating procedure. He had watched his parents fight off poverty after the depression of the late 1920’s and vowed never to let that happen to his family.

But one thing predominated his career – he loved retailing and he loved to try new ideas. On the job trial and error was his education, not some M.B.A. from an Ivy League school. He had fear. He also had passion. He never looked back because someone was always trying to overcome him and his next promotion.

Today the business books would describe him as a pioneer and an entrepreneur. He would describe himself as just trying to stay ahead of the game. Once when asked by someone if he was a four year letter man in high school sports, he said yes – W O R K.

So, why not have his son follow in business? He felt that by getting an education in a profession one could secure a better life – more time for family, more leisure time, less dependence upon a corporation, better chance to control your own destiny, etc. He felt that a professional career and
certainly one in the health care industry would be immune to the pressures faced in the corporate world. He felt that the solo professional practice in health care would eliminate the corporate ladder climbing he had to do to get ahead in the retail business world. He equated a professional career as above a career in the business world. After all, you would be a doctor – a person held in high esteem by the community. A doctor would never be without a job. People always had diseases. A doctor would never have to worry about BUSINESS or BUSYNESS.

So, my decision was to be a dentist. I knew a neighbor who was a dentist. He never worked as hard as my father. He enjoyed a great family life, was involved in the community, was a member of the local county club, did a little part time teaching at a local dental school, traveled for pleasure, attended professional meetings in beautiful places, etc. In short, he had a hell of a life and one I perceived without business stress. So, I thought my father was a very smart man to have guided me into a health care profession.

Fast forward to today. I realize that I made a choice to follow only part of my father’s advice. I chose a professional career in health care but I also chose a career in business.

When did I realize this? After dental school, a residency in pediatric dentistry, a postdoctoral degree in health care education and business, and a career in academic health care, I realized that watching my father’s passion and entrepreneurial activities in the world of business made me crave the same in health care.

Health care was changing in the early 1970’s as I graduated from dental school. Gone were the “golden years” when insurance was a minor player in the game and patient appointments were booked months in advance. The federal government was supporting the establishment of numerous new health care campuses to alleviate the shortage of doctors. More doctors meant more competition was on its way. The government hoped that this would lower prices and increase access. Insurance carriers entered the marketplace by the thousands. Employees wanted health care benefits often in lieu of a salary increase. What was once a “cottage” industry between doctor and patient became a national industry between doctor, staff, patient, insurance carrier, and the government. The pressure on the provider was just starting.

Beginning in the mid 1970’s dentistry experienced an explosion of business consulting firms, seminars, and books. New trends entered the industry – marketing, selling, patient scheduling programs, expanded auxiliary utilization, production technology, financial credit, insurance management, computer systems, and profitability advancement. All in response to the need by practitioners for information not received by either predoctoral or postdoctoral education.
Learning how to “double” your practice or more was soon as important for many doctors as was the latest information in dental materials or restorative techniques. Business education was becoming just as important as professional education for the practitioner that wanted to succeed in the business of dentistry. Journals devoted exclusively to the business of dentistry – *Dental Economics, Dental Management, Dentistry Today*, etc. – became standard reading for the success oriented professional.

Today a variety of consulting firms, seminars, books, and journals still serve the profession. Many have become more niche oriented focusing upon the business of specific dental topics – cosmetics, implants, perio, hygiene, etc. New internet technologies have made it possible for the dentist to access not only dental practice management information but also information in other areas of business.

Most dentists have entered the business style of the new millennium. Some have even specialized into the business of these new niches in an effort to stand out from the masses and to highlight their practice. Entrepreneurism has hit dentistry and those practices that “think out of the box” have become wildly successful.

Spending on dental care was reported by the American Dental Association to be $86.6 billion in 2005 with 94% of this spending from the private sector. They predict that total dental spending will rise at an average annual rate of nearly 7% through 2015. In comparison, health care spending in 2005 approached $2 trillion with about 4% attributed to dental care. Did I say “Big Business”?

Webster defines an entrepreneur as “one who organizes, manages, and assumes the risks of a business or enterprise”. The word comes from the French word “entreprendre” to undertake. Notice the key words: organize, manage, assume, and risk.

Entrepreneurs are not born. They are made. They are self made. As kids they are selling lemonade, mowing lawns, washing cars, walking dogs, babysitting, delivering papers, selling tickets for the scout fundraisers, painting fences, etc. In high school and college they are working in restaurants, retail stores, grocery chains, construction, agriculture, auto industry, and a variety of businesses. They are experimenting with ideas to make money on their own by either providing a service or making a product – a computer program to make signs or a music compact disc, etc. As adults they are starting new tech companies, opening popular franchises, expanding service sectors, establishing new product lines, etc.

So, why can’t you be an entrepreneur in dentistry? What’s stopping you? Fear of work? Fear of failure? Like your present comfort zone? Don’t want to take risks? Or, maybe you just don’t know where to start. Maybe you just don’t know how and where to be entrepreneurial in dentistry. After all, many

Remember the Babe Ruth story. He struck out at bat more times then he hit home runs. He was in the batting cage more than he was in the dugout. He was a star in the batting zone but mediocre in the field.

Fast forward to Tiger Woods. He’s won numerous golfing championships, but he’s lost them also. He is on the driving range, at the putting green, playing in the dark, practicing in the rain, competing while sick, exercising while in pain, etc. He has also brought that same championship ethic to the world of golf business and philanthropy. His endorsements in the sports industry bring him more income than golf competition. Babe Ruth — Baseball Legend. Tiger Woods — Golf and Entrepreneur Legend.

Why isn’t Babe Ruth remembered for more than just his baseball records? Why wasn’t he an entrepreneur in sports business like a Tiger Woods? The answer is found in the times each lived in. In Ruth’s time, baseball was just baseball- the favorite past time of America. It was not a multifaceted, multibillion dollar industry that it is today.

In Wood’s time, golf has become an international phenomenon. The communication and computer industries have propelled golf into the world of sports industry giant. Entire industries “piggy back” on golf- clothing, accessories, travel, equipment, golf course design and construction, internet products, television, books, magazines, etc. Woods and his business advisors have made him a business in himself. He has become both world champion golfer and world class entrepreneur. But first he was a child golfer, then high school golfer, then college golfer, then amateur golfer, then professional golfer, and now world champion golfer. First he was a young man out of college, then he was a golfer, then he was a winning golfer, then he was a businessman, then he was a successful businessman, then he was “the” business: Tiger Woods and Tiger Woods, Inc.

Can you see the parallels in dental practice? You can have a dental practice. It can be like one of the many thousands of solo practitioner dental practices in America. It can have the most modern facility and equipment, the best trained staff, the latest in dental technology, etc. It can be a success. It can provide you and your family with a comfortable lifestyle. Or, it can go beyond all of this in your wildest dreams. It can be the practice that stands out as not only financially successful but also highly entrepreneurial. You can be a successful dentist and a business entrepreneur. You can apply the Tiger Woods story or for that matter the Bill Gates story, or the Oprah Winfrey story, or the Billy Graham story, etc. to your practice.

Remember the famous saying “if it’s been done before, it’s probably possible“. Well, entrepreneurism has been done in dentistry, numerous times
for that matter. Other dentists have done it. You can also.
But, remember the stories. First, be great at what you do – dentistry. Next,
decide that you want to be an entrepreneur and great at the business of
dentistry. Then, find the coaches, advisors, consultants, etc. that can help
you achieve this greatness. Finally, do it.

“Doing it” is as important as “starting it”. A true entrepreneur will “start it”,
“do it” and “continue it.”

From experience I can tell you that starting a successful project will require
the continuation of it as well. Otherwise, the project will eventually fail.

Ever heard the saying: “he can sure talk a good talk, but he can’t walk a
good walk”? Walking-the-walk requires follow through from dream to plan
to action to continuation. It requires attention to the big stuff and the little
stuff.

Whoever said: “Don’t sweat the small stuff” was not an entrepreneur. He
was a dreamer. There is a difference. An entrepreneur will make the dream a
reality. A dreamer just dreams. He never achieves.

Now you may be wondering. What’s the reward for being an entrepreneur in
dental business? It’s financial. That’s a no brainer. You will work hard and
you deserve the financial reward. It’s also fun. It allows you to be creative
and build something that very few people have done.

Many dental entrepreneurs will tell you that the financial reward becomes
secondary to the fulfillment of their creativity. Seeing their practice grow to
a large business providing jobs for many staff members and serving
hundreds of patients is often more satisfying than counting the profit dollars.
Helping other younger professionals to become entrepreneurs in the practice
instead of just partners or associates is very gratifying. Becoming more
involved in your community because of your entrepreneurial basis brings
new meaning to our profession.

So, let’s help you apply entrepreneurism to your practice. Okay?

If you said let’s go for it, congratulation on making the right decision. You
have taken the First Step.

Let’s recap some important points.

- In today’s economy the dental practitioner is in a service business. The
  second must compliment the first.

- We are in an age where business success means more than being great “at”
your business. You must be great “in” your business as well.
Entrepreneurs are not born. They are self-made. They take risks. They achieve. They get rewards. They take risks. They fail. They still get rewards because they are learning how to succeed. They have coaches, advisors, etc. — people that help make them be more successful.

Entrepreneurs in dentistry have revolutionized everything from equipment, techniques, materials, etc. to computer systems, delivery modalities, staffing utilization, interdisciplinary coordination, etc. It’s been done before and it’s possible.

The solo dental practice of today can be the entrepreneurial group practice of tomorrow. It can serve more people – you, your staff, your patients, your community, etc.

Everything starts with a decision to “go for it”. Make a goal. Set a plan. Achieve the results you want. Take Step One. Be an entrepreneur in dentistry.

Don’t be afraid to fall. Just make sure you fall forward. Many a runner has fallen forward in a track event as he/she crosses the finish line on the way to winning the event by a “nose”. Stick your nose out! Fall forward!

I want you as a dental entrepreneur to get to a place where you have no one else to compare yourself with. I want your entrepreneurial children’s dental practice to get to a place where it has no other practice to compare itself with also. That’s what entrepreneurs dream of achieving – the no comparison phenomenon.
Chapter 2: The Boutique Car Wash or the Auto Collision Center – Pick Your Demographics Carefully!

**Step Two**

Demographics or information on people according to address, occupation, recreation, marital status, dependents, rent or own, primary language, number of cars, pets etc. is extremely helpful in deciding what sector of parents/patients you want to serve in your practice. A prestigious address may look good in your alumni directory but it doesn’t guarantee practice success and profitability.

Psychographics or information on how people shop, pick a church, select a school, choose a hobby, etc. are just as important as the demographics of the same sector of people. The needs, wants and desires of people influence greatly what they spend, where they buy, when they buy, why they buy, and how they pay.

Deciding where to locate a practice must be based on market analysis (What type of demographic and psychographic sector of people do I want to serve?) and market penetration (Who is already serving them?). The entrepreneur will pick a location that has an appropriate market and low penetration of that market.

“Blue collar will make you green and white collar will make you scream”. An old business saying that reflects the type of customers and the ease or difficulty in doing business with them.

Wal-Mart doesn’t open a store in an affluent neighborhood. They go to the “blue collar” or “working” neighborhoods. Conversely, a boutique high end women’s fashion apparel store doesn’t open in a middle class neighborhood. They go to where the “white collar” professional or upper class neighborhood is located.

Both stores have picked locations based upon specific demographic and psychographics of the market they want to serve. Both stores can be entrepreneurial. One can do so much easier than the other. Guess which one?
If you picked Wal-Mart, you were correct. Why? Well, they know that their customers will be price and value conscious more than brand conscious. They can offer a “look alike” off brand with good quality, low price and sell dozens to the masses. Wal-Mart generates huge corporate profits by achieving small profits on mass selling.

The boutique has to stock a popular brand, in popular today’s colors, with a celebrity endorsement, offer all sizes, and hope that a few customers will want to buy the item at a high price because it is fashionable now. Often left with high priced inventories, they resort to “sales” to generate sales. Some may resort to internet liquidation to be able to go on to the next “shopping trend”. The boutique generates small corporate profits by achieving large profits on minimal items.

Let’s see how this can apply to a children’s dental practice.

The caries rate is exploding in the children from lower to middle income families – the so called “blue collar” or “working class” population. Recent U.S. Centers for Disease Control and Prevention studies found that more than 4 million preschoolers are affected by caries, a leap of more than 600,000 children in a decade. In children ages 2-5 the caries rate was 24% between 1988 and 1994. It jumped to 28% from 1999 to 2004. It increased more in the lower to middle income families. These studies indicate that the suggested decline in caries in young children was false. These studies also noted that three times as many children in the age range 6 to 11 (12%) from families below the federal poverty line had untreated caries compared with children above this line (4 %). In another study nearly half of US children ages 2-9 have untreated caries. The National Institute of Health reported that 80% of caries is found in 25% of the population – usually in low to middle income families. In some geographic areas, dental caries is the single most unmet health care need in children. Dental problems often account for the majority of elementary school absences for health reasons. In 2007, two deaths were reported in children from untreated dental abscesses.

In this population both parents often work to support the family. They rely upon other care givers to supervise their children. Both these care givers and the parents over indulge these children in high sugar content liquids and foods. If they can’t give them their time, they can sure as well give them sweets. So, the caries rate escalates. Besides, dental care is now often covered by either government or employment based dental insurance benefits, so the out of pocket expense for dental care is no longer a penalty for poor diet or lack of home care. Getting access to care is now becoming more difficult than funding for this care.

These are alarming findings for the health care epidemiologist, and interesting findings for the health care entrepreneur. Do you see any parallels with Wal-Mart?
All children’s dental practices are not similar. They differ night to day. Just because they serve a children’s market, don’t be confused into thinking they are alike.

Some are small boutique low caries type practices. I call these “boutique car wash” practices. They are usually in an upper middle class to upper class neighborhood, have appointments mostly for exams, x-rays, cleanings, and sealants and offer some interceptive orthodontic services. Parents usually want a “real” orthodontist to do more complex procedures. Since caries rate is low in this patient population, restorative procedures are usual minimal and may involve only composites and cosmetics. The doctor talks to attractive mothers usually in sports attire (some don’t even come in themselves but send in the nanny) with an attractive staff performing hygiene procedures. These “prophy palace” practice are usually successful, but because hygiene services often have much lower fees than restorative procedures these practices tend to have lower profitability because rent, staff salaries, etc. in affluent areas are higher. Insurance is minimally encountered but many people pay privately and want to be billed after the services not at the time of services. The office often caters to the parent in payment procedures, scheduling, etc. These practices tend to be solo doctor. The doctor is often not appreciated by the parents who want numerous second opinions for minor treatment. The parents only want to see one doctor. These practices operate at a high stress level trying to please both child and parent. Appointments are often parent/patient centered around social, sports, school activities, etc. The doctor owner often wants to live in this affluent area and be recognized as a “doctor”. The location, décor of the office, high tech gadgets, and the likes, are more important than office systems.

Others are larger sized high caries type practices. I call these “auto collision center” practices. They are in lower to middle class neighborhoods, perform a multitude of diagnostic, preventive, hygiene, and restorative procedures, refer all ortho out because they are too busy with higher profit restorative procedures, often use a surgery center or hospital for larger caries cases on young children, and perform more major restorative care (pulp therapy, crowns, amalgams, etc.) The staff performs most treatment plan explanations, financial arrangement, insurance determination, scheduling activities, etc. while the doctor performs restorative procedures. Use of expanded function auxiliaries is mainstreamed. Insurance programs are very popular and co-payment is expected at the time of service. Billing is kept to a minimum. These practices are very successful and have a higher profitability because not only are diagnostic and preventive services performed but also higher fee restorative care. Practice expenses maybe lower for rent, staff salaries, and other overhead items due to location. Practice policies are enforced and accepted readily by the parents. These practices tend to be group doctor. The doctors are very much appreciated and their opinions are respected. Parents are more accepting of seeing numerous doctors. Appointments are more jointly centered around both
parent and practice needs. These practices operate at a lower stress level because of this appreciation and respect. The doctors may or may not live in the area and recognition as a “doctor” outside of the office is not important. Office systems are vital to the practice in its service.

I have experienced both types of practices. Our group’s first practice location was in a “blue collar” agricultural based town and in the height of the “satellite” practice “rush” in dentistry (mid 1980’s) I and my second partner at that time opened a small “office sharing” practice in an affluent adjacent resort town with an orthodontist. Parents in this affluent town didn’t keep their appointments, often had a nanny come with the patient, didn’t want caries treated for fear of hurting their precious child, wanted us to cater to the child and aberrant behavior, didn’t want to pay at the time of service, didn’t want to pay their bills on time after a statement was sent, etc.

Needless to say, that experiment was a good lesson in doing your research with demographics and psychographics before opening a satellite. Our first experience with being an entrepreneur had failed. But, the experience was invaluable in having our young group solidify what market we wanted and what market we didn’t want. The next two satellites were in areas just like our first. Both were successful. So, you see a mistake is not the end of being an entrepreneur. It helps you be a better one!

You must decide which sector of parents you want to serve. This choice will ultimately determine practice market, practice size, success, profitability, stress level, etc. Don’t be hung up on the address that will appear in the dental association or dental school alumni directory. Be hung up instead on your bank account and your retirement plan.

My advice? Pick the “blue collar” practice. Pick the high caries practice. You don’t need to live near your office as long as the community knows you care. Remember, “People don’t care much you know until they know how much you care.”

Next, let’s look at the time economics model of high caries patients from low to middle families and compare it to low caries patients from middle to upper income families in a children’s practice.

In the high caries, low to middle income practice model the dentist is faced with treating patients on governmental assistance programs, preferred provider private insurance programs, or low fee scale private insurance programs – all having lower fees than your UCR (usual, customary and reasonable) fees for your area. However, when the dentist performs the restorative dental care on a child from this population segment, the dental practice will usual have a higher profit margin per time period (chair time) when compared to the same period (chair time) when treating a child from the low caries, middle to upper income population.
Why? Because when the dentist compares the profit margin based upon chair time, the child having the greatest restorative needs will necessitate the dentist performing more complex restorative procedures even at reduce reimbursed fees than the child having minimal restorative needs necessitating the dentist to perform minimally invasive procedures even at fully reimbursed UCR fees.

Example: A competent, experienced dentist with a well trained auxiliary staff can perform therapeutic vital pulpotomies and stainless steel crowns on teeth K and L in the same amount of chair time as he/she can perform interproximal composite or amalgam restorations on teeth K and L of a similar child. Even with a lower reimbursement on the former patient (high caries, low to middle income) assuming the patient is on a governmental assistance program, preferred provider insurance program, or lower fee scale insurance program, when the dentist compares the billable and collectable amount with the lower restorative care procedures rendered on the latter patient (low caries, middle to upper income) even with higher reimbusables, the profit on the former patient is greater per chair time block.

Simple. The lower reimbursable combined fees for two pulpotomies and two stainless steel crowns is often greater than the than fully reimbursable combined fees for two interproximal restorations. This is basic economics applied to a dental practice in time units. Forget profit per procedure. Think profit per unit of time. Quit tripping over dollars on your way to picking up pennies!

As you saw from my biography, I practice in California. California leads the US in amount spent on children’s dental care for the low to middle income families through various governmental (federal, state, and counties) entitlement assistance programs. Unfortunately, it leads the US in the number of children covered by these programs.

Result? California is one of lowest reimbursement states for dental care to children on these programs. In the Medicaid program alone, the reimbursement is often lower than 30 % of our UCR fees. Plus, this program has not had a reimbursement fee increase in almost ten years.

If the time economic model works in our group practice with low reimbursement rates, it can work even better in those states where the practice reimbursement rates approach 70%. Remember, look at the profit not just the reimbursement rate. Don’t be fooled by the “practice management gurus” that say that with expenses approaching 60 % in a dental practice, that practice is loosing money when it performs care reimbursed below their expense rate. This is simply not the case as I have proven not only in the example above but in my group practice as well. Don’t accept the gurus’ nonsense!
Don’t accept the boasting of your colleagues that say they never accept patients who are on third party reimbursement programs that don’t pay 100% of their UCR. I have colleagues that say this and then wonder why there practice continues to experience increased expenses with decreased patients number, decreased restorative procedures, and decreased profitability.

Remember, larger practices must realize that “profit amount” is more important than “profit percent”. As our group practice has grown to a multimillion dollar revenue business, we have focused less on the percentage of profit from collections and more on the amount of profit from our production. So many dentists get concerned about their profit percent and not their profit amount. You can’t spend your profit percent! It’s a non cash asset. But, you can spend your profit amount. It’s a cash asset and cash is great! No, it’s not great. It’s phenomenal! Concentrate on increasing your profit amount and less on increasing your profit percent. Your banker and retirement specialist worry about the profit amount. Your accountant and practice consultant worry about your profit percent. Which one do you worry about? I hope you answered “profit amount”. You can spend an amount. You can’t spend a percentage.

So, decide which type of practice you want? The small “boutique car wash” style practice or the larger “auto collision center” style practice? You know which one I would pick. How about you?

If you choose the high caries practice, I think you made the right choice. You have taken the Second Step.

Let’s recap some important points.

- Practice style and market must be considered in making a determination of practice location. Often times when I ask a doctor what style of practice, type of market, where they would like to practice, etc., all I hear is “I want to live (fill in the blank with beach, mountains, beautiful city, etc.)” Remember you can live anywhere you want, but there maybe only a few specific locations that will match your decision on your practice style and market. Don’t be fooled by a prestigious address. Be impressed with a bigger bank account!

- Demographics and psychographics will define a market. Market penetration will determine the saturation of the services in that market. Define the market. Identify the penetration. Pick a “blue collar” market with high needs and with low market penetration of your type of services.

- It is easier to apply entrepreneurism to the “blue collar” or “working class” than the “white collar” or “professional class“.
Profitability will be greater in a practice that delivers high caries restorative care with doctors performing restorative procedures. Dentists are better trained and more efficiently used in performing restorative care whereas dental auxiliaries are better trained and more efficiently used in performing preventive care, treatment plan coordination, clerical duties, etc. You don’t bill your time for talking; you bill your time for doing dental restorative care. Remember, D.D.S. means Doctor of Dental Surgery. You degree wasn’t D.D.P. – Doctor of Dental Psychology. Look at your time economics model closely. Don’t get caught up with the “I’ve got to be reimbursed my full fee or I won’t see that patient or do that procedure.” Get off of it. Check your ego at the back door! Stop thinking fee for procedure and start thinking profit per chair time block.

Again, make a decision. Make a goal. Set a plan. Achieve the results you want. Be an entrepreneur in dentistry. Take Step Two.
Chapter 3:
The Medical Treatment Model – Stop Being a Psychologist and Start Being A Surgeon!

Step Three

Ask any one of our medical colleagues in the ENT (ear, nose, and throat) specialty and they think dentists that treat children are crazy. We perform micro surgery on hard tissues in the oral cavity under local anesthesia, sometimes with minimal consciousness altering drugs (i.e.: nitrous oxide analgesia), and oftentimes with parental interference. Why? Because we were taught in dental school that “we” need to “modify the child’s behavior” to accept dental care. Forget the fact that the child’s behavior has been established at home with adults most of whom have never had formal instruction in parenting. “We” are supposed to change all of this and have the parent and child “love” us. Yes, “we” are crazy.

Survey pediatric dentists and general dentists for children and you will find a number of them boast about a “drug free practice”. No nitrous oxide analgesia is administered. No sedative drugs are prescribed. Injectable local anesthesia is limited. They even condemn those that do the opposite.

Yet, it was a dentist that discovered general anesthesia. Go figure that out. Why have we become a non-pharmacodynamic discipline? Why do we have to “modify” a child’s behavior and act as a psychologist and behavioralist when we are a surgical medical/dental discipline? Often times it is the academics that didn’t practice in the real world that first forced this concept on us. They can afford to “bring” the child back to the dental school numerous times performing “show, tell and do” until the child is supposedly exhausted with boredom and allows the dentist to place an instrument into their mouth. They devised the assertive voice control and “hand over mouth” techniques that were supposed to help with behavior modification. These have all been eliminated (thank God as they were an illegal assault on the child) but other “behavior modification” theories still exist today. The public is accustomed to “behavior modification” practices so much so that they expect the dentist to perform miracles on a child with normal disruptive behavior.

Maybe our profession became this way when a long time ago it was customary for a child to go to the dentist and “tough it out”. In today’s
parentally permissive society that doesn’t work anymore. The child now rules the parent and other adults (teachers, coaches, etc.); and they are the ones that are supposed to “tough it out”. I don’t think so. NOT ME!!

I refuse to practice this way. I didn’t have the child! I didn’t cause the cavities! I didn’t raise the child with their behavior! Why should I be the one to deal with this under less than ideal conditions for me? I refuse to be a psychologist! I am not a behavioral modification expert. I refuse to practice “drug free”. I practice my discipline as a dental surgeon! I practice my discipline with modern, safe, and effective pharmaceutical techniques.

This does not mean that the doctor and staff are tyrants. Chairside manor is, above all, friendly, courteous, and kind. But if a child’s behavior can’t be managed with analgesia (nitrous oxide) and pain managed with local anesthesia in my office, then I don’t plead, promise, threaten, perform magic, put on a costume or mask, use assertive voices, do hand over mouth, etc. I am not an actor nor a clown!

I perform dental procedures on the child under consciousness altering drugs in either a surgicenter or a hospital. I don’t allow myself to be talked into doing it any other way. “Oh, doctor, my child will be better next time, I want you to try to treat him with just being patient with him and using that “laughing air”.

NO! Remember, that nitrous oxide analgesia will only make a good child happier; it won’t perform magic on a child with disruptive behavior. Be assertive. Be the expert. Know what will work and what won’t. Don’t let a child and parent run your practice. Don’t dread practicing dentistry because you have become a psychologist. If you want to be a psychologist, quit dentistry and go back to school to be a psychologist and open a child psychology practice.

So, STOP being a dental psychologist or behavioralist. Start being a dental surgeon. If a restorative or surgical procedure can be performed in-office under nitrous oxide analgesia and local anesthesia with minimal stress on you, your staff, and the child, that’s great. If not, don’t do it. Do it in a behaviorally controlled environment in a surgicenter or hospital.

Likewise, when I encounter a young child with extensive caries and exhibiting good behavior on the initial exam appointment but the treatment will require very invasive procedures (pulp therapy, crowns, etc.) and numerous in-office visits, I know that the last few visits will deteriorate with management problems. Again, I recommend that these children be treated under consciousness altering drugs in a surgicenter or hospital.

The same is recommended for a child coming from long distances to our offices. Nothing will cause a good young child to become unmanageable
more than a long ride to the dentist’s office thinking about the fear of dental care.

Same holds true when a good young child has been “predisposed” to fear by an older sibling.

My advice is to assess the family situation, child behavior, distance to office, sibling interaction, medical history, etc. just as much as you assess oral findings.

Next, let’s see what this medical style of practice does to your practice.

First, it will reduce stress on you. No more playing psychologist but practicing as a surgeon. You will love it!

Second, it will increase your productivity and profitability. No more bringing a child back numerous times for “behavior modification” that didn’t work and no treatment was performed. Oh, I know some of you were told by the academics that you should bill for “behavior modification”. In the real world, many of you do not. “But, doctor you didn’t do anything on my child”. I don’t think I should have to pay for that. I’m going to another doctor who can treat my child.” Again, you will love it.

Third, parents will love you. By treating an unmanageable child in one visit at a surgicenter or hospital it will save the parent loss of work time, the child loss of school time, and if coming from long distances, transportation expenses will be reduced. The treatment got done on the first and only visit. No aborted appointments when the behavioral modification didn’t work. You’re a hero! Again, you will love it.

Fourth, your staff will love it. No more explaining why the appointment did not work out (they want to tell the truth – the kid’s a brat). No more making another appointment and giving the parent hopes that this one will work (they know it won’t). No more frustrated chairside assistants who have to put up with your disappointed behavior (they also are dreading the next aborted visit). Again, you will love it.

Am I getting your attention? Let me see. Everyone will love it, you will practice like a surgeon, and you will make more money.

Okay, now for the details on practicing like a surgeon! Let’s set up a facility and system that allows you to practice like a surgeon by performing surgery (restorative and surgical care) in a controlled behavior setting – the in-office surgicenter.

Surgicenters have become very popular in today’s health care delivery models. They are frequently used in outpatient diagnostic and surgical procedures when sedation or general anesthesia is required for patient
management and comfort. Gone are the days when overnight hospitalization is required for elective minimally invasive procedures.

Surgicenters can be owned by hospitals, groups of doctors, or part of one practice only. They can be accredited by a national accrediting body thus allowing the center to bill for center use, etc. or non-accredited and merely a facility to be used for analgesia, anesthesia, diagnostic and/or surgical procedures, pain control, etc. For instance, a hospital or group of doctors may have an accredited surgicenter with anesthesiologists performing procedures outside the hospital operating room complex in a facility designed for groups of doctors to perform diagnostic or surgical procedures which do not need the full support of the hospital. An example would be a gastroenterologist performing a colonoscopy.

One doctor or a group of doctors in one practice may have an unaccredited surgicenter as part of their office facility for the express purpose of performing their specific diagnostic or surgical procedures within their office facility but under the design of a surgicenter. Analgesia, anesthesia, IV sedation, or oral sedation may be performed by either an anesthesiologist or the operating diagnostician or surgeon. An example would be a radiologist performing a minor ultrasound test or a plastic surgeon performing a minor facial surgery.

In the mid 1990’s, our pediatric dental group was the first in California to build an adjacent office surgicenter as part of one of our offices. It was used exclusively for oral conscious sedation (OCS) administered by the pediatric dentists in our group or for IV sedation administered by anesthesiologists. Children and teenagers treated here were often done so for behavioral issues. They were generally over age two with normal medical histories, and normal weight, small tonsil size, etc. Care was rendered under OCS for young children and IV for older children and teenagers. Children and teenagers that received dental care in the OR at the hospital tended to be those under age two or those exhibiting remarkable medical histories, developmental delay, mental retardation, obesity, large tonsils, etc.

Our statistics revealed that only one in ten cases requiring conscious altering procedures required general anesthesia in the OR at the hospital. Of those receiving care at our surgicenter, approximately 99 % are done under OCS by the pediatric or general dentist for children.

What is the economic advantage of using a surgicenter and OCS administered by the dentist over either IV sedation administered by an anesthesiologist in the surgicenter or general anesthesia administered by an anesthesiologist in the hospital? The answer is substantial to both dentist and parent.

The dentist can treat more patients and perform more care in a given time period because pre-op and post-op time in the surgicenter with OCS is
greatly diminished over IV sedation or general anesthesia. Use of quick onset oral conscious sedation drugs is faster and safer than IV or general anesthesia procedures.

The parent has less financial payment since no anesthesiologists and hospital facility/staff are used. And, since the surgicenter is owned by the practice there is not a facility usage charge as would be the case in an off-site non-practice owned facility.

How does the in-office practice owned surgicenter differ from the off-site non-practice owned surgicenter? There is very little difference. The in-office practice owned surgicenter can be designed, equipped, and supplied specifically for dental care on children. Monitoring systems can be more customized for children. Emergency systems can be more specific for children. Staff can be trained especially for the dental surgicenter. The in-office practice owned surgicenter does not have to go through any national organization or governmental accreditation process since the practice generally bills for the dental care and OCS care and not the facility usage.

What happens when the in-office practice surgicenter is not in use, usually afternoons? Since most OCS or IV sedation is performed in the mornings due to the NPO status of the patients, the surgicenter can be used for normal dental appointments in the afternoon.

In our group the dentist that does OCS in the morning generally does diagnostic procedures in the afternoon on new and/or returning patients. Again, since the surgicenter is dentally designed this switch from morning to afternoon is very easy. Morning surgicenter hours for OCS are 6:45am to 12:15pm. After a lunch break and reorientation of the surgicenter for diagnostic procedures, the afternoon hours are from 1:30pm until 4:00pm. Both doctor and staff enjoy this dichotomy of work in a given day. Restorative care under OCS in the morning; diagnostic and preventive care in the afternoon. In early, out early.

In other parts of the office, other doctors are performing a regular work day with both diagnostic care and minimal restorative care on well managed children and teenagers all day. Dentists rotate in and out of the regular day and surgicenter day. The surgicenter like the regular office is open five days per week.

So, decide how you will practice on the high caries population — as a behavioralist or as a pharmacodynamic surgeon? You again know which one I would choose. How about you?

If you chose the pharmacodynamic surgeon with in-office surgicenter, I think you made the right choice. You have taken the Third Step.
Let’s recap some important points.

➢ Stop being a psychologist and start being a surgeon.

➢ Stop being a behaviorist and start being a dentist using conscious altering pharmacodynamics.

➢ Stop allowing parents and their children’s behavior management to stress you and your staff.

➢ Set up an in-office surgicenter and use it to perform dental care on children and teenagers whose behavior is not ideal, whose dental care is complex and very invasive, or who come from great distances and don’t wish repeated appointments.

➢ Achieve greater production, increased profitability, better parent satisfaction, and more appropriate patient treatment in your practice with the medical model and use of an in-office surgicenter.
Chapter 4: Restorative Choices - Don’t Let the Cosmetic, Metal-Free Hype Raise Your Stress and Lower Your Profits!

Step Four

The cosmetic and metal-free hype has generated countless new products and procedures. Competition amongst dentists has elevated this hype even more. Every dentist is going after the cosmetic, metal-free market as the older and middle age populations want to look younger. They want whiter, brighter, straighter, and prettier teeth. They want metals replaced with composites for a number of cosmetic and quasi-health reasons. Periodontists and oral surgeons are fighting in the implant surgery arena. Oral surgeons are challenging plastic surgeons in the facial reconstruction market. General dentists are performing more adult orthodontic procedures with invisible techniques.

I went to a recent dental school graduation where the young graduates were asked what careers in dentistry they would choose. Overwhelmingly the response was “cosmetic dentistry”, “spa dentistry”, “smile dentistry” “metals-free dentistry”, “biological dentistry”, etc. Yet, when asked about children’s dentistry, amalgams, crowns, etc. their facial expression suggested the question “what’s that”. Some dental schools are in areas that don’t have children with caries.

The cosmetic and metal-free hype has even hit some pediatric dental practices. Upscale parents want their children to have white baby teeth – no silver fillings or silver crowns. Some pediatric residency programs have even stopped teaching amalgams and stainless steel crowns. The rush is on for anterior and posterior composite restoration as the treatment of choice.

The yuppies want the “gadget” children’s practice also. They want to be the first to tell their friends that their children go to the dentist that has (you name the new gadget). Remember Lasers handpieces? Remember the pumice pressure cutting handpieces that supposedly removed carious tooth structure without anesthesia? What about the non-injection method of local anesthesia? All gadgets gone by the side of the road.

Forget the fact that insurance carriers will pay for only amalgams and crowns. The yuppie parent will pay the difference in price from the lower fee
amalgam or crown to the higher fee composites. If the composites won’t last as long as the amalgam or crown, that’s ok. It must be the dentists fault for poor material selection not the child’s fault for the recurrent caries rate. It’s ok because the parent will still pay again even if the insurance carrier won’t. They’re not happy with the dentists. But, they still will pay. Remember, this is the age of permissive parents where it’s never the child’s fault.

Caries in the young child from lower or middle class populations is on the increase. Water fluoridation, fluoride varnishes, caries immunization, anticaries mouth rinses, fluoridated toothpastes, systemic fluoride supplements, etc. have not stopped this increase. Despite a national movement by both the American Academy of Pediatrics and the American Academy of Pediatric Dentistry for more infant oral evaluation by dentists, early childhood caries is exploding in these populations. I used to think when I started practicing in the early 1970’s that caries would be diminished in my lifetime. Boy, was I wrong.

Birth rates are up. These are primarily in the minority populations of Hispanic, Black, Asian, etc. They are up in the lower and middle class. They are up in certain regions, counties and towns. While school districts in affluent areas are closing schools, those in the lower to middle class can’t open them fast enough.

The cosmetic and metal-free hype has not gone into the lower and middle class populations. They still seek value in longevity over extravagance in cosmetics. They still care about what their insurance will cover and not cover, replace or not replace. For example: They may want a primary posterior stainless steel crown over a large composite build up. The crown may not have the best esthetics but it has the best durability, has a fee that is covered by their insurance carrier, and is easily replaceable.

Do you enjoy doing anterior primary interproximal composites? How about one on the mesial and one on the distal of the same tooth? Now how about doing these on all four anterior primary maxillary incisors? Oh, I know you use eye magnification and small rotary burs. But, wouldn’t it be easier to do crowns? You don’t want to do stainless steel crowns? How about stainless steel crowns with resin facing? Oh, I know you favor composite crowns over stainless steel crown with resin facing for better esthetics. But, ever notice that they are more difficult to place and make fail because of color change, fracture due to trauma, warpage due to age, etc.

Understand why I ask these questions?

Multiple interproximal anterior primary composites are cosmetic based not caries recurrence based. Anterior interproximal composites on primary teeth are susceptible to recurrent caries, color change, and breakage. An anterior stainless steel crown with or without resin facing on the same tooth is susceptible to only lost requiring recementation.
Now, which is easier to do — the anterior interproximal composite or the crown on a primary tooth? That’s easy. It’s hands down for the stainless steel crown.

Now, which one is faster to do? It’s hands down again for the stainless steel crown.

Same question and response will hold true for posterior restorations on primary teeth. Stainless steel crowns are easier than multisurface amalgams are easier than multisurface composites.

Remember, the cosmetic, metal free hype can drive the bus. But, do you want to be on that bus?

Go back to Chapter Two and review what we discussed with respect to the saying: “Blue collar will make you green and white collar will make you scream”. Again, pick your demographics carefully. Next, pick your restorative philosophy just as carefully.

Picking a restorative philosophy that is not driven by the cosmetic, metal free hype will do two things for your practice.

First, it will reduce your stress in restorative procedures on primary teeth.

Second, it will restore your profitability in your restorative procedures on primary teeth.

The day our practice developed the treatment restorative philosophy that for anterior caries on primary teeth it was either a composite for small facial caries or it was a stainless steel crown with or without the resin facing, was the day all of the doctors reduced their restorative stress considerably. Conversely, in the long run the parents were much happier because retreatment and repayment was reduced to nothing. The practice profitability was significantly enhanced as well. It was a win-win for both practice and parent.

Similarly, in the posterior primary dentition pick your treatment philosophy carefully also. The same exercise that applies to anterior restorations applies to posterior restorations.

Do you see how this chapter is linked with Chapter Two and Chapter Three? If you are an entrepreneur you will spot the opportunities by:

A. Picking the high caries type demographic practice.

B. Picking the medical treatment model and have an in-office surgicenter.
C. Picking the restorative treatment philosophy that builds on low operator stress, treatment longevity, and financial rewards for both doctor and parent.

So, decide the treatment philosophy for your practice. Do you want to have a high stress, low profitability cosmetic, metal free restorative practice or a low stress, high profitability traditional restorative practice? You again know which one I would choose. How about you?

If you chose the traditional restorative practice, I think you have made the right choice. You have taken the Fourth Step.

Let’s recap some important points.

- Don’t be fouled by the cosmetic, metal-free hype of the yuppie generation. Tried and true restorative dental materials are easier to place, quicker to place, last longer, favored by insurance carriers, and still the choice by many parents and dentists that perceive value in their usage.

- Caries rate is way up in certain populations and in certain regions. If you want a high profit restorative practice, find these areas. Similarly, birth rates are way up in certain populations and in certain regions. Finding a high caries rate in a high birth rate area will be an entrepreneur’s dream.

- Combining high caries rate, high birth rate, traditional restorative philosophy, and the medical model discussed in Chapter Three will assure an entrepreneur’s successful start.
Chapter 5:
The Multi-Doctor, Multi-Office Model – It Works! Do It!

Step Five

By now you are asking yourself this: How can a solo practitioner practice be an entrepreneur serving the lower to middle class families, using the medical model, and performing traditional restorative care in a high caries population? The solo practitioner and small staff can’t. Multiple doctors will be needed.

So, does that mean that I need associates or partners and a larger staff? Correct. And, here is where your next entrepreneurial opportunity comes. You get to select other dentists and staff that can share your vision and follow your lead in this new entrepreneurial venture.

Notice I said, “share your vision and follow your lead.” Your vision is the genesis to your entrepreneurial venture. Your leadership is its continuation. If you need help in establishing and sharing your vision and in leading its successful destiny, then stop and get assistance in both. Visionaries are not born; they are made. Leaders are not born; they are made.

The next chapter (Chapter Six) will address getting you this assistance. But, let’s assume for now that you have your vision and you are a leader. Let’s look at how your vision can be implemented with the right doctors, staff and offices.

Remember the medical model had you treating high caries young children in an in-office surgicenter in the morning while another dentist was performing routine care in another part of your office. It would cause productivity and profitability to be compromised not to have the regular part of your office operating at peak efficiency also. So, to start, you will need two dentists in your start-up entrepreneurial office—you and an associate.

Does the associate have to be a pediatric dentist? Do you have to be a pediatric dentist? We will discuss that in the next chapter (Chapter Six). For now, let’s just say that the dentist performing oral conscious sedation in the in-office surgicenter must have the training and skills to evaluate candidates for sedation management in the surgicenter, administer oral conscious sedation medications, monitor sedation results during dental care, handle medical emergencies that might arise, and perform the necessary dental care
on young children with a high caries rate under sedation. Also, if you are planning on using an off-site surgicenter or hospital, one of the dentists must be able to have operating privileges at these facilities.

So, the first associate you hire must share your vision. In some practices this associate could become a partner or remain an associate. This decision is yours. Some multi-doctor groups are owned by one dentist, while others admit associates as partners after a period of time with a buy in arrangement. My personal preference is that if you find someone who can share your vision and exhibit leadership style, then why risk having this person leave and start the search all over again. It costs a lot of your time and monies to recruit and train an associate. A typical transition would be that you hire your first associate and after a period of time sell this associate a part of your practice retaining a larger majority share. Then, when growth dictates another associate, start the process again with another associate. But, remember if you are the entrepreneur and took all the risks, then never give up your majority share unless someone of equal or greater talents wants to be a partner. Because your practice grows in productivity and profitability, the smaller share of the practice that you now own after admitting one or more associates as partners will be worth more. Although your share of the “pie” got smaller, the “pie” got bigger also.

Ok, now you have your associate/s. What’s next?

Let’s consider more offices. But let’s consider that not every office has to be the same. Don’t confuse office location with office purpose.

I have found that when our group practice choose to serve lower and middle class families, use the medical model, and perform traditional restorative care in a high caries population two things happened.

First, our group became more of a regional practice serving people from great distances. Why? Because other dentists either couldn’t or didn’t want to serve them.

Second, our group became more involved in numerous governmental programs, preferred provider insurance networks, non-profit foundation contracts, etc. Why? Because the parents that weren’t being served usually were on reduced fee government programs or controlled contractual insurance programs.

Both of these occurrences lend to our multi-office approach to both regionalization and diversity in dental care funding. Multi-offices were and still are being established to expand our service region (location) and to expand our funding base (purpose).

Let me explain “purpose”.
One of our offices provides dental to children from low income families on the various local, state and federal governmental assistance programs – what you would refer to as indigent care or welfare service programs. This office receives funding from not only the fee for service reimbursement from these governmental programs, but additional funding from other philanthropic organizations that supplement this governmental funding. This office, although part of our total group of offices, has a separate distinct name for marketing and self identity purposes. So, in addition to other private offices, some with in-office surgicenters, our group has a separate office with a separate name providing indigent dental care.

The media and philanthropic organizations are reticent to notice endeavors where the indigent are served unless there is a special place or name attached to them. So, by establishing a separate office and program to serve the needy, our group received much more community support and financial assistance than had our group simply combined the service to these patients in our regular private practice offices. If the parents move up the economic ladder into jobs that provide insurance funding than these patients are transferred into a private practice office thus creating room for more patients at the indigent care center.

Now, let me explain “location”.

One of the reasons why parents don’t bring their children to the dentist is transportation. In the affluent population this means they want less time in transportation and shortness of distance. These people want to be close to an office, mall, restaurant, etc. because they don’t want to be inconvenienced with travel, traffic, etc.

In the lower and middle class populations it means they still want less time in transportation and shortness in distance but for different reasons. As working people taking time off from work or having the care giver perform transportation costs money – money they can’t easily afford.

Why do you think McDonalds has the “golden arches” every so many miles in a “blue collar” area? Because they want to attract the people that have little time to eat. These people can’t afford a long distance and a time consuming drive to eat. They don’t have the time. They also perceive value in low priced, convenient food service or “fast food”.

So, with our group in a medium sized “blue collar” agricultural based town, we have found it more beneficial to our productivity and to the parents’ time if we have more than one location in the one town. Instead of one giant office, we established more than one medium sized office.

Remember, one circle can only draw so far from its center. But more than one circle overlapping in some parts of the circle allows for greater market
penetration because you are using more than one strategically placed offices in that town. Like the McDonald’s concept.

Is this the satellite approach that was popular in the late 1980’s? Not really. There you would have one large office with smaller “satellite” locations. The new multi office concept of the 2000 millennium has multi-offices of the same size offering full services in each but attracting a larger population through the McDonald’s overlap “circle” approach.

Our group has found that two medium sized offices both with in-office surgicenters have great productivity and higher profitability than one mega office. For this reason, we are continuing to open more medium sized offices in the overlapping “circle” approach.

So, decide on a multi doctor, multi office model. Remember, bigger doesn’t always mean better. But, sometimes getting bigger can lead to expanded productivity and increased profitability. You again know my choice. How about you?

If you chose the multi doctor, multi-office model, I think you made the right choice. You have taken the Fifth Step.

**Let’s recap some important points.**

- The high caries, medical model, traditional restorative children’s practice must have a multi doctor multi office approach to deliver regional dental services.

- The entrepreneurial dentist must attract like minded associates that may transition into partners.

- The addition of other offices may be for additional locations or additional purposes.

- It is beneficial for additional offices that have location penetration to be aligned by “circle” penetration to establish a regional presence for this market penetration. It is important that this market penetration be similar to the existing market.

- Mega offices with satellites have been replaced with medium sized full service offices for better regional market penetration.

- Special purpose offices can attract not only a particular segment of a population, but funding specific for that population.
Chapter 6:
Pediatric Dentist versus General Dentist for Children – What The Future Holds!

**Step Six**

The child population is exploding. But, the number of specialists in pediatric dentistry is not. What does that tell you? The use of general dentists to treat children in the future will be a necessity.

In the early 1960’s, the American Dental Association declared that to be a specialist in one of the specialties of dentistry recognized by the ADA, a dentist must be a graduate from an ADA accredited postdoctoral program. The days when a dentist could declare a specialty by nothing more than a preceptorship or self education ended. Dentists that did so prior to the ADA ruling were called “grandfathers” in the specialty. Many states even instituted specialty exams for licensure if a dentist intended to practice as a specialist in that state.

New postdoctoral programs were started but they never keep up with the demand in certain specialties. Fast forward to today and we find that we have a shortage of pediatric dentists. Fast forward to today and we find that many pediatric specialists have stayed in the larger metropolitan areas leaving the smaller to mid size towns facing an even greater shortage. Fast forward to today and we find that women who have entered the dental professional in massive numbers have gone into the pediatric dental specialty but because of family obligations have left the profession. Fast forward to today and we find that dentists graduating from dental school are older and have already started families. Stressed with an already high debt they often can’t afford the luxury of continuing into postdoctoral education. Fast forward to today and we find that the military once a supplier of specialist with their own postdoctoral programs have ended many such programs as the military has downsized. Fast forward to today and we find that the number of applicants for one postdoctoral position in pediatric dentistry sometimes approaches one hundred.

So, what does the general dentist do when he/she graduates from dental school but finds that for any number of reasons cannot fulfill the ADA criteria for being a specialist in pediatric dentistry? They either forget about that desire and enter regular general practice or they try to enter a children’s practice or clinic that hires general dentists. In essence they receive “on the
job” training. They may continue with their education through a number of CE courses or seminars at professional meetings.

Is this sort of a preceptor type of education? Sort of?

Many general dentists if they continue treating children exclusively simply state ethically to the public that they are “general dentists for children”. They never state to either the profession or the public that they are specialists. Many may leave their “preceptor” practice or clinic and establish children’s dental practices of their own usually in areas or populations underserved by pediatric dentists. Many find associateship and partnerships with pediatric dentists who have had difficulty finding other pediatric dentists to become associates or partners. Many do a great job of service to children.

Recently, the American Academy of Pediatric Dentistry (AAPD) invited the American Association of Dentistry for Children (ASDC) to join its academy. Now many of the general dentists that were members of the ASDC can be associate members of the AAPD and attend meetings, CE course, etc sponsored by AAPD.

Is this an indication that a movement is under way for the AAPD to recognize the need to include more of these associate members? Maybe. Will this recognition lead someday to a formal preceptor program leading to full status as a specialist? Maybe. At least the AAPD is starting to address the issue of workforce shortage.

In our group, we have recruited both pediatric dentists and general dentists for children. All started as associates. Some left our practice to start their own practices. Some returned to advanced postdoctoral programs. Some stayed as associates. Some continued up the ladder to become partners.

None of our general dentists are “second class” professionals. None of the general dentists are listed on signs, letterheads, etc as anything but “general dentists for children”. In our practice one GP associate established a “teen” program and has become our teenage in-office expert on teenage dental conditions and their treatment. He has become a partner. Another has remained an associate but supervises a dental office the group established for indigent care.

Do I see a trend in children’s dental practice with these professional workforce changes? Yes. I see the future will have children’s dental practices where there may or may not be pediatric dentists as partners or associates. I see many children’s dental practices where there will be general dentists for children as partners and associates. I see the latter first appearing in the underserved areas of our country.
Can pediatric dentist/s form a children’s dental group with just pediatric
dentist/s? Yes! This will be determined based upon where the practice is
located and what focus that practice established.

Can pediatric dentist/s form a children’s dental group with general dentist/s
for children? Yes. Again, this will be easier in recruitment based upon
practice location and focus.

Can general dentist/s form a children’s dental group with general dentist/s.
Yes. Again, this will be easier in recruitment based upon practice location
and focus.

The key to the success of the group is not in whether they are pediatric
dentist/s or general dentist/s for children. The key is to have the
professionals have the training to perform at the same level of care no matter
what the designation as specialist or generalist. That means that the
generalist must continually seek to attain the educational level as that of a
pediatric dental specialist.

Are there any administrative drawbacks with having a general dentist for
children in a children’s practice? Yes, there are a few.

First, many government and private insurance program reimburse at a lower
rate for a procedure performed by a general dentist compared to a pediatric
dentist.

Second, a hospital or off-site surgicenter may require formal continuing
education in hospital dentistry before it grants operating privileges. The
general dentist may need to have additional proctoring by an existing dentist
on staff for a number of initial cases.

Third, some states have various licensure requirements for a dentist to
administer in-office oral conscious sedative drugs. If the dentist has not had
formal training in the patient selection, administration of medication, vital
sign monitoring, emergency preparedness, and other qualification of oral
conscious sedation, then such training maybe a prerequisite for application.

Finally, referrals may be less likely to come to a children’s dental practice
where no pediatric dentist is present. Pediatricians, school nurses, family
practitioners in both medicine and dentistry, etc. may feel they are risking
their reputation if they refer to a non-specialty children’s dental practice
and/or the treatment is not to the standard that is achieved by a specialist.

So, decide on the workforce of pediatric dentists and/or general dentists for
children or a combination of both. You again know my answer. If you
decided that if pediatric dentists cannot be recruited for whatever reason and
if you decided to recruit a general dentist for children who can perform to
the same standard of care, then you have taken the Sixth Step.
entrepreneur pediatric dentist and/or general dentist will need then to recruit other pediatric dentists and/or general dentists for children to a growth oriented children’s dental practice. All dentists in a children’s dental practice regardless of formal specialized training or preceptor self training must attain and maintain the highest level of proficiency in both the diagnostic and therapeutic techniques of dentistry for infants, children, and teenagers.

Let’s recap some important points.

➢ There is a continual birth rate increase each year in many of the ethnic populations and certain geographic areas in the U.S. However, there is a continual shortage of pediatric dentists.

➢ The trend will favor using more general dentists to treat children.

➢ General dentist for children is an ethical distinction of a general dentist that is not a specialist in pediatric dentistry but is a generalist treating children exclusively.

➢ Pediatric dentists and general dentists for children can be very synergistic is a children’s dental group.

➢ With the distribution of pediatric dentists more prevalent in the larger metropolitan areas, general dentists for children will practice in children’s dental practices in areas where there is a shortage of pediatric dentists.
Chapter 7:  
**Manage Your Practice Like a Big Business – Forget the Dental Trend!**

*Step Seven*

“I went into dentistry because I didn’t think I was cut out for business.”  
Well, guess what? You are in business!

“Doctor, can I talk with you after work. I’ve got something I need to discuss with you.” You’ve heard this question addressed to you before, haven’t you? It starts the cold sweats. “My best front office person wants to talk with me. I don’t know what’s it about, but I don’t like it. Is she going to quit, asking for a raise, telling me some office gossip, informing me she’s pregnant, getting a divorce, etc.?” It really makes your entire day. You worry about pleasing your patients. You worry about the overhead. Now, you have to worry about a staff problem. It can’t be good. It’s a trend in most dental practices. It’s been around for ever. It will never go away.

Well, I’ve had those days. But, once I developed a management style that was more big business oriented and less dental office oriented things changed a lot. I broke this trend.

Big corporate business. Just the name invokes Board of Directors, Chairman of the Board, CEO, President, CFO, COO, Vice Presidents of Human Resources, Facilities, Marketing, Sales, Manufacturing, Customer Service, etc., etc. Divisions run by managers making decisions after committee research and discussion.

Dental business. Now that name implies the opposite - solo practitioner dealing with all the same problems on a much smaller scale with the usual staff structure of office manager, receptionist, and chair side assistants. Decisions are made by one person, the dentist, often with very little research or discussion — “just flying by the seat of one’s pants” as they say.

So, if you have established an entrepreneurial group practice you will have the necessity and the luxury of having a big business structure applied to a children’s dental practice. In the multi-doctor, multi-office children’s dental group practice you will find like I have that a big business management system will free you up from the administrative duties often performed by a corporate business type person. This will allow you to be the COB and CEO of your dental company. Decisions will be made by you but after careful
research and discussion by the group administrative personnel with you. You won’t deal with a human resource problem because you will have an administrator hired and trained to do just that.

You mean I won’t hire and fire? Someone will do that for me? Correct. This is just one example of how you will be relieved of the duties that someone can do better than you but with your direction.

So, where do you start?

Let’s assume that you have been entrepreneurial and chosen an appropriate demographic area for your children’s dental practice. Let’s assume that you have chosen the medical model. Let’s assume that you have chosen the traditional restorative practice style. Let’s further assume you have chosen to be a group practitioner.

Let’s start with some simple basics in dental practice management.

The mistake many dental practitioners make is that they don’t establish the proper systems in their practice. They’re great on choosing the technical stuff, but poor on choosing the administrative stuff.

Let’s first set up the proper systems and monitors to judge the performance of those systems. A system without a monitor is like a car without a dashboard. You know your car is running; you just don’t know how it’s running. Well, the same is true with your dental practice.

The most common mistake dentists make is that they hire staff without any systems for them to manage. Systems must be established before you hire the staff to run the systems. So, if you’ve done this backwards, let’s go back and get the systems established and see if your staff can run these systems. If not, you might need to retrain or adjust your staff.

The Five Key Systems in a Dental Business

1. Marketing

Every business needs a marketing system. In the service business that means that you need customers/clients that want to buy your services. Once you attract these people, you want to keep them. I call that “open the front door, but close the back door and bar the windows”. In a dental practice you want a great marketing system to attract new patients and a sure proof recall program to retain them.

Marketing must be both external and internal.

Let’s look at the difference.
External marketing includes such things as: direct mail to homes, radio and television advertising, telephone book advertising, doing an exhibit at a health fair, doing preschool dental screening, joining a community philanthropy organization, etc.

Internal marketing includes such things as: asking about siblings of a new patient, asking patients for referral from friends, neighbors, coworkers, etc., asking staff for referrals, etc.

Monitoring of the marketing system would include such things as: monthly stats on number of new patients, age, place of residence, referral source, etc. Monitoring would also include stats on external activities such as: numbers of radio and television commercials, number and type of screenings, etc.

The recall program must include such things as: a preappointment six month plan, a computer based report on patient recall needs, purging of existing charts for missed recalls, review of all sibling charts when a patient is at office for any type of visit, etc.

Monitoring of the recall program would include such things as: monthly stats on number of recalls, etc. It should also measure the efficiency of the recall program by comparison of recalls that should be appointed to actual recalls performed.

2. Sales

Next, if you have the customer/client in your business, the business must sell them something. It does little good to have a customer/client come into a business and leave without ever buying a service or product.

The same is true in a dental practice. Parents bring their children to a dental practice because they perceive their child needs dental care. It can be as simply as an examination with radiographs and tooth cleaning or major caries control treatment. In either case, they are buying a service – dental health service.

So, a sales system, or as it is called in certain high end educational circles, a parent/patient education system, must follow your marketing system. This system includes such things as: preappointment telephone questions when a new parent calls to screen for their needs, questioning of a parent at time of examination visits as to needs, having a parent “co-diagnose” caries by visual examination of the mouth with doctor, use of various patient education materials, etc.

Monitoring of the sales system would include monthly stats on such things as: treatment plans presented, treatment plans accepted, extent of treatment plan accepted, etc. Why have parents bring their children to your practice if they don’t buy anything?
Your sales system must be as good as your marketing system. Don’t spend the money on a marketing system and have a poor sales system.

### 3. Scheduling

Next, you’ve got to have a scheduling system. Often parents want to dictate appointments. Everyone wants after school. Develop an office policy as to when young children, special needs children, etc. are to appointed and why. Determine when the doctors do certain procedures and why. Establish time amounts for restorative procedures. Adhere to a cancellation, tardiness and failure policy.

Just because a schedule is “full” doesn’t mean it’s productive or profitable. Establish a policy for scheduling doctor time with highly productive and profitable procedures that only a doctor can do. Don’t schedule the doctor with procedures that a dental auxiliary can legally do.

Monitoring of the scheduling system would include such things as: monthly stats on number of days worked, number of patient visits, daily procedures and production goals, patient cancellation and failure rates, etc.

### 4. Production

Next, the children’s dental practice must have a superb production system. Adequate staffing is critical to achieve maximum productivity. Dental materials, supplies, sterilization techniques, procedure tray set ups, etc. must be supportive of this productivity. Being effective is one thing, being efficient is another. Performing procedures in the shortest amount of time with the best results can turn an effective day into an efficient day. More patients can be seen with less stress to doctor and staff and greater satisfaction to parents if the practice is both effective (got the job done) and efficient (got the job done with reduce stress and time).

Monitoring of the production system would include such things as: monthly stats on daily production, number of procedures performed, etc. Actual production to actual scheduling should be evaluated to evaluate change of treatment requests by patients to more minimal care.

### 5. Collection

And finally, you must collect for what you do. The collection system is paramount for the profitability of your practice. Start at the beginning with an infallible office financial policy. The policy must have an internal component for your staff and an external component for your parents. Both must be in written form. The first is in an office manual and the second in a patient brochure.
Start the parent financial discussion when a new patient visit is made. Review what governmental and private insurance program will cover specific to the patient. Encourage parents to bring any plan description with them to the office.

After treatment plan presentation, a financial presentation must be completed. Both treatment plan and financial plan must be signed before any treatment commences.

Use of credit cards and specific dental charge cards should be encouraged. Remember, you are not a bank. If the credit card companies or other financial institutions deny credit, why shouldn’t you? Adhere to a co-payment policy. Accept assignment of benefits but consider charging for insurance processing since it takes staff time to do so and then you wait for your money.

Never start a dental procedure unless you have two agreements in writing. Informed consent is the first. Financial arrangement is the second.

Monitoring of the collection system would include such things as: monthly stats on daily and monthly collections, collections by different programs, collection as a factor of production, accounts receivable and their aging analysis, etc.

Let’s do a quick review. The five key systems in your dental practice are marketing, sales, scheduling, production, and collection. Dentists spend time in dental school and other postdoctoral programs learning only one – production. Somewhere they must learn the other four to survive.

Okay. Now you have the five key systems set up for your practice. What’s next?

Your systems are only as good as the people that perform and manage them. Don’t let a great system fail because of the poor performance of a person. You must have a people oriented, customer friendly staff to successfully manage your patient oriented, patient accepted systems.

**Team Building**

You’re the quarterback with weak lineman and strong back field. Where does that leave you? Sacked most of the time. You don’t have a chance to get out of the back field because the line could not hold the opposition.

Every position on the team must be filled. Everyone on the team must be the best. No exceptions! A missing link is just as damaging in performance as a weak link.
Ever play back yard football? You don’t have the luxury of a full professional squad. Your small squad must be multi talented and vastly diverse, playing both offense and defense.

It is the same with a small dental business. This staff must be able to perform and manage more than one system. They must be both versatile and creative.

As your business grows and it becomes a multi-doctor, multi-office practice, your team will enlarge and you will have the luxury and necessity of having specialists on your team. Often times a generalist staff on your team will become a specialist staff.

**Systems and People Management**

Like any other business the most important asset of a dental business is the people. I say again that the systems are only as good as the people that perform them. So, the people must be trained and motivated first before the systems can be managed.

Traditional vertical authoritarian management must yield to a more powerful and enrolling style of networking management with self responsibility and horizontal support. The latter must reward innovation, problem solving, creativity, and goal orientation. The latter will result in a more competitive management style where management is an activity not an entity.

Leadership of the dental practice must involve creating the purpose of the business, establishing the goals of the practice, and translating these goals into action and success. Leadership must set goals, establish standards of performance, monitor this performance, evaluate this performance, recognize performance trends, reward performance achievement, and correct and redirect results where necessary.

Performance is a factor of both behavior (I can do it!) and action (I did it!). Enhancement or improvement of performance is a factor or training (I can do it better if you teach me!) and repetition (I did it again but better each time!).

It is essential that you have the systems management and people management in place before you hire your first associate dentist. An associate dentist is both staff associate (a person on your team) and dentist associate (a doctor on your team). The associate must possess leadership skills as both staff and associate. The associate must be a leader in some key systems such as internal marketing, recall programs, sales, scheduling, production, etc. Don’t let your associate be a weak link in a strong leadership oriented practice.
Applying Big Business Structure to the Dental Practice

I can tell you when our group decided to apply a big business structure to our practice. It was when we decided to differentiate office management from practice administration in our multi-doctor, multi-office model. It was a financial stretch but it entailed making two key decisions. First, we committed to a practice administration staff. Second, we committed to a practice administration facility.

Let me explain.

A dental practice has the usual front office staff and back clinical staff. In the course of growth, an office management person is designated for the office and might have a variety of responsibilities including marketing, human resources, accounts payable and receivable, etc. This person is often limited in patient contact. This person may have an assistant as practice growth progresses.

Similarly, both the front office staff and back clinical staff may grow to include more specialists in both areas such as insurance coordinator, financial agreement specialist, etc. in front and clinical coordinator, treatment planning specialists, etc. in back. File clerks and sterilization technicians are brought on the team as well.

You get the picture.

However, when our group established a multi-office model, it first became necessary to have an over structure of administration for office management. Each office had office managers and their respective team leaders in both the business and clinical areas. But, the next level of management had to oversee individual office management at a higher level. Thus, the practice administrator was needed. Over time with continued practice growth, other assistant administrators were needed. Assistant practice administrators are responsible for such things as external marketing and outreach, human resources, grant and contractual agreements, facility maintenance, OSHA coordination, etc.

Next, it secondarily became necessary to establish a facility or office to allow these administrators to function without being in one particular office. We started our first administrator in one of the offices. The first two assistants were also housed in the same one office. It became readily apparent that a practice administration team housed in one of the offices did not allow that office management team the autonomy it needed to function independently. So, our practice administration team has a separate office of its own.
So, applying big business structure to the dental practice takes both the commitment for an administrative staff and an administrative facility. It is team commitment. It is a financial commitment. No direct patient revenues are achieved by this staff and office. I know that this is hard for a dentist to accept, but it’s necessary to achieve autonomous oversight practice administration.

However, what does this team and office allow the dentists to do?

First, it allows all the dentists to practice clinical dentistry uninterrupted by administrative and management duties.

Second, it allows the partner dentists to be structured in a corporate type model. In our group, one is Managing Partner, others are Supervising Office Partners, Chairperson of the Marketing Committee, Chairperson of New Office Growth, Chairperson of Community Affairs, Chairperson for Political Action, etc. In the true corporate world the Managing Partner would be the COB and CEO with the other partners would be the Vice Presidents, etc. Different titles, but the same purpose.

Third, it allows the partner dentists to meet with various practice administrative and office management teams to review practice stats by office according to the practice management systems described previously.

Now you can see why I don’t hear the question: “Doctor, can I meet with you after work?” It’s not in my job description. It’s in the job description of the assistant administrator for human resources.

So, decide to commit to a practice administrative plan to compliment your office management plan. Again, you know what I have done. By doing the same you will have taken the Seventh Step.

Let’s recap some important points.

- Practice growth will allow the entrepreneur dentist to transition the small dental business into a large more corporate oriented big business.

- The dental business has five key systems – marketing, selling, scheduling, producing and collecting. They are active systems and must have monitors to measure results.

- The five key systems must have the right staff to perform and manage these systems. People management is just as important as system management.

- Generalist staff is very important in the start of a dental practice but as practice growth occurs these generalists will become more specialized.
The application of big business structure to a dental business at the right time in practice growth allows for tremendous opportunities for the entrepreneur dentists to concentrate on more growth oriented models for the practice.
Chapter 8:
Advisors – Get Away From the In-Office Divas and Can’t Do Dentists That Teach!
Hire the Pros!

Step Eight

Ever notice that the most successful business executives often write best selling business books? From CEOs of Fortune 500 companies to self made millionaires their books are often on the best seller lists. Many are used at the prestigious graduate business school where potential MBAs devour them in the hopes of following in their author’s footsteps.

Ever notice that the reverse is true in Dentistry?

You rarely hear from the most financially successful dentists. You routinely hear from the technique gurus that roam the country on every lecture circuit. You routinely hear from the organized dental proponents that expound on the virtues of getting involved with organized dentistry. You routinely hear from the in-office divas with their continual regurgitation of the same old practice management forms and techniques. You routinely hear from the legions of retired, academic, public health or disabled dentists that don’t practice in the real world but want to tell you how.

You routinely read from the many practice management journals that come free each month about office design, income generation from cosmetic, perio and other “hot” topics, staff issues, retirement issues, fee surveys, financial planning, etc. Nice, but not quite edge of your seat issues on entrepreneurial practice growth by the leading financially successful dentists.

Why don’t we routinely hear or read from the financially successful entrepreneurial dentists? They’re out there. They’re the ones with successful groups. They’re the ones with multi-offices. They’re the ones that have done innovative programs with governmental, philanthropic, insurance, and private sector agencies/companies.

Why? Two reasons.

Financially successful entrepreneurial dentists are continually improving their practice, growing it more, and don’t have the time or the interest in getting on the lecture or book circuit. They’re making more money in a day
than the circuit gurus make in a month. Their egos are satisfied differently. Often making money becomes secondary to making their business grow.

I suspect that the other reason is that the dental leaders in continuing education, annual meetings, media and dental consulting don’t want to be embarrassed. These dentists and dental consultants want the profession to remain the same cottage industry it has been for years. Any successful deviation would question their decision as to what is good for the profession. After all, the dentist can make a comfortable living not an outrageous one. The entrepreneurial dentists are often looked upon with suspicion. You can’t be good clinical dentists and be entrepreneurs at the same time. You can’t be good clinical dentists and make a lot of money.

Wrong. You can. But, you’re not going to get much help from your colleagues in dentistry or the professionals in continuing education, annual meetings, media, dental consulting, etc.

So, where does one go for help in becoming a financially successful entrepreneurial dentist?

First, start by reading the same books on business, leadership, motivation, creativity, self help, etc. that the MBA candidates read. Look at what’s on the best seller list by the movers and shakers in big business, the management gurus to the Fortune 500 companies, the motivational experts, etc. Look at the many journals that are on the newsstands like *Forbes, Fortune, Business Week, Economist*, etc. Look at the business newspapers like *Wall Street Journal, Barons, Investors Daily*, etc. Review some of the classic business books of our time by Tom Peters, Ken Blanchard, Jack Walsh, Jamie Walters, James Collins, John Kotter and others.

Second, supplement continuing dental education with business education. Look at business seminars, motivational seminars, leadership seminars, etc. Larger cities will often attract multi-day symposiums by private groups of speakers on business topics. Universities often offer guest lectures from business experts.

Third, seek out those dentists that have done what you think you want to do also. Investigate the various organizations of dental group practices. Seek out the founders of large dental groups. Look for entrepreneurs in children’s dental groups. Interview them if possible.

Finally, get the right advisors. Again, I am not referring to the in-office divas or the dentists that have quit that small solo practice, left a dental school faculty, gotten an on-line life experience business or financial “degree”, etc. I mean find the business consultants that have a list of impressive clients in the health care industry. They may be accountants, attorneys, business professionals, etc. Many have nationwide reputations with vast regional
experiences. Many are affiliated with other consulting companies in human resources, marketing, law, accounting, real estate, philanthropy, etc.

Remember, the entrepreneur thinks “outside the box”. Don’t rely on the usual. Seek the extraordinary.

Did you think I was going to give you a list of persons to interview? It doesn’t work that way.

An entrepreneur is never “spoon fed”. An entrepreneur “digs” for information in a variety of ways – being creative and resourceful to the highest level.

I can’t tell you which expert to hire, whose brain to pick, what questions to ask, how much it will cost, how long it will take, where it will lead, etc. What I can tell you is that the ideas, advise, counsel, contacts, etc. you will get from these experts will be invaluable. They can shorten your learning curve and reduce the monies wasted on the in-office divas or they can’t do dentists.

If you find the right advisor/s that suits your needs, stay with that person or group. Coaching is a continual process; not a one time event. The right coach knows when to let go and let the player practice. The right coach knows when to get the player back for more instruction.

Find your coach. Find your continuity.

If the right advisor/s is/are found, expect to pay premium rates because the person or group should also be financially successful entrepreneur/s. If they are not, why hire them? You get what you pay for.

Find your entrepreneur/s. Pay the price. Success doesn’t come cheap.

Experiment on your own with new ideas. Look for parallels in other industries. Become your own best critic.

So, do you want to find the correct information and hire the best advisors? Do you want the best coaches? Again, you know what I would do. What about you.

If you decided to find the best information and hire the pros, congratulations you have taken the Eighth Step.

**Let’s recap some important points.**

- Don’t expect much help from traditional dental education or consulting on your road to entrepreneurial success.
➢ Get a self education in business by reading the classic business books by the recognized business gurus that have been in the “trenches”. Take courses in business at universities, private seminar companies, etc.

➢ Find the right advisors that can “coach” you not “spoon feed” you. Find the pros in coaching.

➢ Coaching is a continual process. Even Tiger Woods has coaches and continually uses them both in golf and in business.
Chapter 9:
The Ortho Opportunity — Why It Can Be A Win Win Deal!

Step Nine

Let’s see how this old scenario plays out. The young child comes to the children’s dental practice with the parent. Over the years the child returns for biannual examinations. Each time the dentist comments on the child’s occlusion and any genetic or environmental influences that affect its condition. At an appropriate time in the child’s growth and development if a malocclusion has occurred, the dentist refers the child and parent to an orthodontist. The orthodontist recommends treatment consistent with the malocclusion which often involves two or more years of treatment at a cost of thousands of dollars. The dentist gets a nice note of thanks. Throughout the treatment the dentist gets updates. The orthodontists send the dentist and the staff the usual food baskets, candy, flowers, etc. at all the usual holidays.

Sound familiar to you? Are you in this movie?

Ever feel used and unappreciated? Ever feel that it is not a win win between you and the orthodontist? You have established a relationship with the parent over the years, performed numerous low profit examinations, talked endlessly about growth and development, answered all of the parent’s questions, and made the referral, etc. And all you get is a card and candy. The orthodontist steps into an already primed parent ready for ortho and all you get is a cheap gift while he gets thousands of dollars of treatment. Oh, by the way, the parent also decides that it is time for the parent to get some orthodontic treatment. You get nothing here. Not even a thank you this time. You didn’t do anything? Right?

As the old movie used to say, “I’m mad as hell and I ain’t going to take it any longer.”

For years orthodontists used to think that the only marketing that they needed to do was take dentists to lunch. Get enough dentists on your referral program and you were set. Orthodontists were the spoiled child of dental specialists.

Then something happened. The orthodontic postdoctoral programs increased the number of orthodontists going into the workforce. The pediatric dentists and general dentists started to take weekend courses from practicing
orthodontists. New techniques and materials made orthodontic care less complicated. The pediatric dentists and general dentists for children started treating the less complex cases, etc. The general dentists in family practice started to do the same. They even started doing orthodontics on their adult patients. All of a sudden competition hit the orthodontists just like the rest of us.

Some orthodontists have changed the way they do business. This presents an opportunity for the entrepreneurial pediatric dentist and general dentist for children.

Those pediatric dentists and general dentists in a low caries children’s dental practice often resort to providing orthodontic care to supplement their production. They treat the simply stuff and refer out the hard stuff. Smart. If they can’t make the profit that a high caries practice can at least they can make it up by doing some ortho.

But, what about the children’s dental practice that has a high caries population, practices with the medical model, and performs traditional restorative dentistry? They don’t have time to do ortho. They can make a better profit doing restorative care than they can doing ortho. But do they want to refer out this profit center?

So, what should this practice do? Let’s look at some options for you to consider if you are in the latter situation.

**Option One:** You can refer out to the orthodontists all the ortho. And, with a multi-doctor, multi-office regional practice, you will refer out a lot of ortho. But, you will get the same referral thank you letters, the same candy, the same invitations to lunch, etc. Wow. I can’t wait. I don’t know about you but this scenario sounds like the same old broken record playing over and over again. You get nothing for all your work.

**Option Two:** You can do an office sharing arrangement with an orthodontist. The orthodontist would have a separate practice from yours, but you would share space like reception room, consultation room, etc. The orthodontist could practice in conjunction with your time or both of you could have different times of utilization. In this case, I strongly recommend that the orthodontist pay more of the total utilization expenses (rent, janitorial, utilities, etc.) since there must be a financial consideration to you for your referral of orthodontic care. At least you get something for your referral efforts.

**Option Three:** You can recruit an orthodontist to bring into your practice as an associate. With the abundance of orthodontists completing
advanced postdoctoral education, finding an orthodontist that has an interest in associating in a busy multi-doctor, multi-office practice is very likely.

The associate orthodontist may become a partner some day or remain an associate. The orthodontic program may be an integral part of an existing office or a separate office in an adjacent facility.

My preference would be an adjacent facility so that an office could be designed especially for orthodontics on children, teenagers, and parents. Remember, the multi-office concept applies to both additional location and additional purposes. In this case an additional office would be for the purpose of orthodontics. It is important that if the orthodontist associate becomes a partner this partnership we limited to the orthodontic practice.

Option Four: You can make a legal arrangement with an existing or new orthodontist for an additional office for the purpose of doing your referral orthodontics. Again, the orthodontist can be a partner with you but only in the orthodontic office, not in your children’s dental practice. Since the orthodontist has a separate office, he/she can also have their own practice and partner with you for only the orthodontic care on your referral patients.

Stop. Why wouldn’t you want the orthodontist to be a partner in your children’s dental practice? Because the profitability in a high caries, medical model, traditional restorative practice is greater than in an orthodontic practice. And, remember that the children’s practice is still performing the majority of the marketing for the orthodontic practice.

Years ago it was the “hot” idea to merge pediatric dentistry and orthodontics. Even some of the postdoctoral programs were combining the specialty training into a Pedo-Ortho program. Our group tried this with the first orthodontist in our group being a pediatric dentist that had also completed a separate orthodontic program. He was going to able to practice both specialties of pediatric dentistry and orthodontics. In the end, he wanted to practice only orthodontics with the group referring all the ortho to him. The orthodontic practice was not carrying its share of the total practice profitability plus the pediatric dentistry practice was doing all the referral work. This was definitely not a win-win partnership and was terminated. Needless to say, our group has moved on to other more favorable arrangements as discussed above.

So, decide if you want to refer to orthodontists and get nothing but the candy box. You know my decision. There are probably more options than the major ones presented above. An entrepreneurial children’s dental practice
will establish legal relationships with orthodontists to control the orthodontic profit center inherent within this practice.

If you choose to make the orthodontic opportunity a win-win for both you and the orthodontist, you have taken the Ninth Step.

**Let’s recap some important points.**

- The competition in orthodontic care is tremendous. Both pediatric dentists and general dentists have entered the marketplace. The number of orthodontists in the workforce and in training programs remains high. Starting a new orthodontic practice is difficult. Orthodontic franchises, multiple offices, discount clinics, etc. have all entered the scene.

- The referral pattern for orthodontists has changed. They are experiencing referrals but for more complex cases. The simply cases are being treated by pediatric dentists and general dentists. Both education and technology have allowed the pediatric dentists and general dentists more flexibility in treatment options. Profitability has decreased for the orthodontists as they spend more for their collection on marketing and complex case treatment.

- Referral of orthodontic care from a successful children’s dental practice can result in the loss of considerable profit from that practice. Long term relationships have been established with the children’s dental practice. So, why loose the profit from these relationships?

- A win-win situation can be established with an orthodontic association to your children’s dental practice.

- Numerous models can be explored and established to create this win-win situation.
Chapter 10:
The Job’s Never Done –
Monitor Your Results,
Evaluate Your Performance,
Make Corrections When Necessary!

Step Ten

Entrepreneurs never sit back and coast. They are always monitoring results, evaluating performance, and making corrections to have a better product or service. They are always in a “what’s next” mode. They are never content with the status quo. They are experimenting with new ideas and retesting old ones. That’s why they are called entrepreneurs.

Congratulations, by now the previous nine steps have brought you as a dental entrepreneur to a new level of practice for your children’s dental group. You have established a multi-doctor, multi-office group that serves the lower and middle income families whose children have a high caries rate. Your group treats children using a medical model with traditional dental restorative procedures. Your group has at least one in-office surgicenter. Your group utilizes an operating suite at a local hospital or affiliated surgicenter. Your group may have one or more special purpose offices (i.e. indigent care, orthodontic care, etc.) Your group has an administrative office.

You have found some like minded associates. Some have followed in your footsteps first as partner and then as entrepreneur.

You have established a win win relationship with an orthodontist/s.

So, what’s next? Well, a great entrepreneur never “takes his eye off the ball”. Tiger Woods doesn’t. Not in golf; not in business. A great entrepreneur will monitor results, evaluate performance, and make corrections when necessary. Enhanced performance comes from practice, perform, monitor, and improve on a continual basis.

In Chapter Seven we discussed monitoring the various systems in your office and the staff that run these systems. Now, we want to monitor individual offices and programs.
On a monthly basis you and your administrative team must review and evaluate the daily monitors for production, collection and profitability for each office and the people that manage these offices and their staff. Also, you must review and evaluate the monthly monitors for production, collection and profitability for programs such as: operating room care, in-office surgicenter care, etc. Evaluation should include a comparison with both the previous month and the same month of the preceding year.

Trends will develop when you monitor and evaluate. Making corrections will alter the effect of a down trend. These corrections can become part of the management plan for a particular system or office to lessen a down trend on a continual basis for that trend.

For instance, certain months of each year may yield lower than average results than other months. In the case of February, a shorter month, fewer days to be worked will result in a lower production result. Corrections can be made to insure that fewer days worked will not produce a down trend in production in February thus producing a down trend in collections in March. Production can be maximized by avoidance of doctor days off, scheduling of more productive days, purging of existing records to discover untreated care, etc.

Another example you might see is this. Certain offices may experience a down trend in new patient numbers during a particular month requiring more aggressive internal and external marketing during that month.

I think you get the picture. It is only by looking at historical data from thoroughly evaluated monitoring that a trend can be determined. It is only by studying this trend that causes can be identified and solutions proposed for correction of future trend occurrence. Then, monitor and evaluate the corrective action to make sure it was the right action.

So, your monitoring, evaluating, correcting, monitoring, evaluating, correcting, etc. becomes a continuous cycle in your strategic management. The entrepreneur never lets this cycle stop.

Don’t let analysis lead to paralysis. Don’t analyze, analyze, and analyze without ever determining the cause of a problem and instituting corrective action. Manage by analysis, not by guessing. The entrepreneur never lets data paralyze making a decision. If you stop making decisions because you think one could be the wrong decision, you will never succeed. Remember, Babe Ruth struck out more times at bat then he hit home runs. Tiger Woods still hits in the sand trap on his way to winning a championship.

Getting advisors to review your analysis and growth is paramount to the strategic planning of your practice. This should be done at least semi-annually. Involve them in the research and decision process. Advisors should be available by phone or email for instant feedback to prevent crisis reaction.
So, decide if you are going to continually monitor, evaluate, correct, monitor, evaluate, and correct your practice. You know my decision. If you choose the cycle of monitoring, evaluating, and correcting your performance you have taken Step Ten.

**Let’s recap some important points.**

- Performance of your systems, people, and offices must be monitored, evaluated, and corrected when necessary. Down trends must be identified, understood, and eliminated with constant problem solving.

- The process of monitoring, evaluating, and correcting is a continual cycle. It should never stop. When it stops, so does success.

- Don’t be paralyzed by analysis. Don’t hesitate to take corrective action for fear of making a mistake in the correction.

- Strategic planning should occur with outside advisors on a semi-annual basis.
Chapter 11:
Non Profits and Governmental Agencies – On your Side or Not!

A multi-doctor, multi-office children’s dental practice that serves the lower and middle income families will be approached by many non-profit foundations, non-profit health clinics, and governmental agencies. All want one thing. They want the families that they serve to be included in your service programs.

Let’s differentiate these non-profits and governmental agencies and see how they may fit into your group’s goals.

Your group has decided by now that their practice will serve the lower and middle income families in caring for children with a high caries rate in a medical model using traditional restorative procedures. What you will discover is that the children from these lower and middle income families are supported by governmental agencies and nonprofits in many areas – social, educational, financial, residential, nutritional, transportation, health care, etc. This support can help you or it can hinder you.

Let’s differentiate further these non-profits and governmental agencies in the distinction of help or hindrance.

Governmental Dental Programs and Social Assisting Agencies

Children from low and middle income families are often on various governmental assistance programs for dental care. These programs are often hybrid social entitlements involving federal, state, and county government legislation. Governmental funding is usually based upon federal and state income standards for eligibility, but administered locally within county government. Often times, a private insurance carrier will be the third party administrator of a program having contracted with the government.

Funding monies for these programs for dental care varies from state to state with some states setting higher reimbursements rates than others. Those states that have higher reimbursement rates for dental care naturally have a greater utilization of dental care because access to care is greater. The more the program reimburses the dentists for services, the more dentists accept patients from the program. The more dentists in the program, the greater the access by patients. The greater the access by patients, the less the county...
governmental social assisting agencies intervene to help families in finding dental care.

Specific governmental social assisting agencies may have specific guidelines for the provision of dental care to their recipients. The funding may come from a national, state and county government program but the specific social assisting agency may facilitate as mandated by law in helping recipients obtain health care. A good example is the national, state and county Headstart Program. All enrollees in the Headstart program must have a mandatory dental screening and completion of dental care within a specific period of time for the program to be a Headstart Program and receive funding.

Some county governmental social assisting agencies that are responsible for helping families in areas outside of health care may be of great assistance in accessing dental care also. For instance, a county nutritional program for infants may assist the families in dental home care and diet counseling for caries reduction. Or, a school program may provide dental screening for its students.

Social assisting agencies are of tremendous help to the children’s dental practice in accessing children. In counties that don’t have a large metropolitan base there are usual no county wide dental clinic facilities. So, these agencies rely heavily upon the private sector for dental care.

My advice? Get as much knowledge as you can on the various government dental programs in your state and the counties that you serve. Get to know all of the social assisting agencies in your region that help families in accessing dental care. These agencies usually have very motivated and dedicated employees. They are often very grateful when a dental practice wants to get involved with not only providing dental care to their children but also providing in-service employee education, dental screenings, patient caries and care statistics, parent seminars, etc. Assistance to parents may include such things as transportation provision, home care education, etc. I consider them a big help!

**Non Profit Foundations without Dental Clinics**

Children for low and middle income families either on governmental assistance programs or private insurance programs for dental care may receive assistance from non profit foundations, so called 501(c) 3 tax exempt charitable corporations. These entities may be specific to just one county or be a state or national entity with a local office in a specific county. Although these corporations have no dental clinic they often have a dental health component that serves as an advocacy for children to access dental care. They may assist in such things as transportation, co-payment, payment for non covered dental procedures, etc.
My advice? Get to know these non profits since they can be a source for patient transportation and financial assistance. They often hold fundraisers and will involve your practice in their philanthropic functions. These fundraisers are an excellent source of networking with both the social assistance professionals and community leaders, philanthropic public, and other care providers. I consider them a big help!

**Non Profit Foundations with Dental Clinics**

Now here is where I will have you proceed with caution. Notice I said “with dental clinics”.

A health clinic that provides services to the low and middle income families often operates as a non profit corporation with national, state and/or county subsidies. These clinics often have dental clinics. Or, a non profit foundation may establish only a dental clinic. Some can be stationary while others mobile. Some can be free standing, while others school based.

No matter what type of non profit dental clinic they are these clinics are often staffed with recent dental school graduates that are on some federal loan repayment program. As such, these recent graduates being new dentists often lack the experience in treating infants and children. They want to refer the more difficult treatment while retaining the easy stuff. They are often on a salaried position and not motivated with incentives as they would be in private practice.

Realize that these dental clinics must survive by not only receiving subsidies from public and private sources but also from providing dental care. Referrals are often based upon the latter. Keep the easy stuff. Refer the difficult stuff. Keep the patients on the higher pay programs. Refer the patients on the lower pay programs. If a non-profit dental clinic is mobile and school based, then the non profit entity can also keep the older children and refer the younger ones.

So, again I say proceed with caution on affiliating with non profit dental clinics. Don’t get in a situation where all your practice gets are the difficult young children on low reimbursement governmental assistance programs. This is where your negotiating skills will be tested. Insist on a mixture of children and funding assistance. They must have a place to refer their difficult children. You must have a balance in both children and funding. It must be a win-win. I consider them a help but with caution.
Chapter 12:  
What Organized Dentistry Misses – And Doesn’t Know It!

Organized dental associations, societies, academies, etc. have done a great job of enabling dentists to socialize, continue their education, discover the latest in technology, view new equipment, become involved in advocacy projects, travel, etc. In a profession where the majority of dentists are solo practitioners, these activities are essential for both professional stimulation and a sense of camaraderie. Dentists traditionally leave the dental school environment with enormous peer contact to a private practice with very little peer interaction. Organized dentistry allows dentists to continue peer relationships and participate in peer activities.

In the medical professions, similar organized entities perform the same functions. However, in the medical profession, hospitals often provide another level of interaction as most physicians are involved in patient care at both a practice office and a hospital. Organized medicine and hospital administration provide two outlets for physicians to continue peer relationships and activities. In hospitals physician participate in more health care business models both among peers and hospital programs (i.e.: cancer centers, heart centers, joint replacement centers, birthing centers, surgicenters, substance abuse programs, diabetes programs, etc.).

Physicians experience more entrepreneurial health care activities in their profession because of the private practice/ medical center joint cooperation. Dentists do not have this opportunity.

Ever go to a local dental meeting and hear the question: “How’s your practice?” The response is usually: “I’m a little slow right now. How about you?” The return response is: “I’m a little slow too, must be the time of the year. I think everyone is slow.” Both dentists are relieved to hear that they are normal as everyone is slow. Both start to roam the room to make sure everyone is normal. What a relief. Everyone is slow! Everyone is normal!

The dental meeting just described probably had a speaker after dinner talking about a new cosmetic technique, or a new area for the dentist to consider like biological dentistry, or maybe a topic on staff communication, etc. You would never hear about entrepreneurial business topics.

Why? Because the leadership of the dental meeting wants nothing controversial discussed. Let’s not “rock the boat”. Everyone in the room will be solo practitioners. Everyone wants to hear about their dream - the
cosmetic, metals free, insurance free, small boutique practice. The problem is that very few can ever achieve this type of practice. But, let’s dream about it anyhow.

The leadership of dental meetings doesn’t want to have a successful entrepreneur from a dental practice discuss business experiences. Gosh, jealousy may become apparent. The dentists that are slow will be offended. Besides, a great clinical dentist cannot be a wealthy dentist. If you are going to get rich in dentistry, you must have to herd patients in like cattle and do poor restorations.

Yet, in medicine the opposite is true. You routinely can encounter at a medical meeting a physician affiliated with a hospital or surgicenter discussing the latest concept in “center” based treatment – joint replacement center, cancer center, facial reconstruction center, etc. These topics are often discussed with both treatment innovation and financial success in mind. The successful surgeon and the high profile hospital or surgicenter are not looked on with distain but admiration. A great surgeon is expected to be a financially successful surgeon. A high profile hospital or surgicenter is expected to be a regional site for entrepreneurial health care.

Why can’t you and I go to a dental meeting and expect to hear the most successful dentists that have done the most innovative entrepreneurial business models in the various areas of dentistry?

Well, I think I explained why. But I still get upset that organized dentistry doesn’t recognized that they are excluding an entire block of successful entrepreneurs in dental practice that could share their knowledge.

So, I discuss this topic because you as an entrepreneur will have few places to go to share your ideas and get ideas from others. You will need to seek out your fellow entrepreneurs yourself. You won’t find them as speakers at dental meetings I am sorry to say.

Use the dental meetings to socialize. You will find that by seeking out like minded entrepreneurs through a social setting will provide you with more insight into entrepreneurism than anything else in dentistry. More on this networking in Chapter 14. But, for right now, don’t expect too much from organized dentistry no matter how noble your entrepreneurial intentions are.
In the previous chapter I mentioned how important the large hospitals and medical centers were for physicians in exposing them to entrepreneurial activities. Unfortunately not all of our dental schools and postdoctoral programs have on site affiliation with a major medical center. This results in a deficiency in the education of dental students and postdoctoral students in health care entrepreneurism.

In medical education, medical students and postdoctoral residents are surrounded by enormous health care business stimuli in the medical centers. Drug therapy with private multinational pharmacology corporations, joint and organ replacement therapy with major medical device and bioengineering companies, new advances in cancer chemotherapy with start up biogenetic laboratories, etc., all expose students, residents, fellows, etc. to new entrepreneurial joint ventures in health care. Institutes, centers, special programs, off-site hospital affiliation, etc. emphasis the interdisciplinary model approach to promote access to care.

In dental education, dental students and postdoctoral residents are sheltered from the enormity and stimulation of health care. Interaction with the medical centers is often diminished as these students become more entrenched in the practice of dentistry being outside of mainstream health care.

In medical education, both at the medical school and medical center, the faculty is often comprised of nationally ranked researchers and clinicians responsible for global advances in medical research and therapy. It is not too uncommon to find surgeons whose intramural practice puts them in the top echelons of subspecialty surgery in the world.

In dental education, the faculty is quite different. Few maintain an intramural practice that even approaches the real world of health care. Many are cloistered in academia because they have no interest in health care issues. Affiliation with medical centers is often relegated to only the oral surgeons.

I think you get the picture. The new physician is exposed to a multitude of health care models in addition to solo practice. The new dentist is exposed to very little. No wonder the new dental graduates want to be a “spa dentists”.

Chapter 13:
What Academic Dental Centers Don’t Teach – And Never Can!
So, don’t expect the academic dental centers to expose dentists to entrepreneurship in health care. Unless the dental schools and postdoctoral programs become integrated into the medical centers and expose dental students and postdoctoral students to the entrepreneurial activities found there, the young predoctoral or postdoctoral student will have little chance to view the exciting world of entrepreneurism in health care.

I don’t see this trend changing in the future. So, don’t look for the new breed of dentists and dental specialists to be any different from the older generation of practicing generalists and specialists. Far sighted leaders in dental education have proposed the merging of dentistry and dental education back into medicine and medical education. Unfortunately these visionaries have been silenced by the wave of faculty members whose existence would be threatened by such a merger. I suspect that even in the organized dental “towers” this proposition threatens the many practicing dentists that have spent years “ascending the organized dental chairs” on the old road to power and continued isolation.

So, realize your background. Make a correction in the approach to your own destiny. Look at what is happening in medicine. Be entrepreneurial in finding what in medicine can be applied to dentistry. Don’t let the dental isolation keep you from creating your ideas in bringing entrepreneurism to dental practice.
Chapter 14:
Continuing Education – Stop the Social Dancing and Get to Real Networking!

Continuing dental education has many facets. Organized dental associations offer the dentists numerous opportunities to advance their education. They provide annual meetings with seminars, offer separate courses, publish journals, produce audio programs, etc. Dental schools with both full time and part time faculty aggressively market their continuing education programs. Seminar and consulting companies offer an array of both business and clinical programs.

So, why can’t the entrepreneur in dental practice find programs that will stimulate and not regurgitate? I suspect the answer can be attributed to the fact that the programs just mentioned cater to the masses of dentists – the solo practitioner. Because of leadership decisions in organized dental association, faculty decisions in dental schools, and owner decisions in consulting companies, most continuing dental education programs are unprepared and unwilling in offering entrepreneurial topics often regarded as controversial and profit motivated.

Where does that leave you to start and continue your education in entrepreneurial dental business?

If you are like me, you get disenchanted attending the programs listed above. You go to get CE credit for your relicensure. But, you’re bored. You go for the social or travel experiences only.

What I started doing when I went to a national or state dental meeting or seminars was to seek out like-minded individuals. Find the other entrepreneurs. Arrange to interact with them at these meetings. While others go to do social or recreational events, do your networking with the other entrepreneurs. Share your experiences. Enquire about their experiences. Again, think out of the box. Don’t stop going to dental meetings frustrated with the lack of relevant programs. Force yourself to seek out those individuals that want to network on models appropriate to your situation.

Networking for the entrepreneur is one of the most powerful tools for research and implementation of new ideas. Make it your most powerful tool also.

Networking can start with just one other entrepreneur. Then it builds by recruiting other entrepreneurs into the network. Finally the network becomes
a structure for its own continuing education. Advisors in many of the areas of business consulting are great guests to bring into the network. Sharing of business articles, audio programs, etc. can be invaluable for continuing education.

So, don’t give up but get smart. Build your own network. Get away from the “study club” mentality. Instead, advance into the “entrepreneur’s network” activity.
Chapter 15:
Where to Start –
A Business Plan is Essential!

Well, congratulations on making it this far. If you have followed the Ten Step Plan for Success for the Entrepreneur’s Children’s Dental Practice at least in theory, you should now be ready to put this book aside and “go for it”.

If you are the entrepreneur I think you are (because you stayed with me on this book) I think it is time to start some action. All would be entrepreneurs start with a vision, a goal, an idea, etc. The true entrepreneurs follow through with a business plan.

So, let’s go back to the Table of Contents and review the Ten Steps.

- **Step One:** Be an entrepreneur in your children’s dental practice.
- **Step Two:** Locate your children’s dental practice in an area to serve the high caries patients from low and middle income families.
- **Step Three:** Establish the medical model for the treatment for patients.
- **Step Four:** Provide traditional restorative procedures.
- **Step Five:** Transition into a multi-doctor, multi-office group practice.
- **Step Six:** Utilize both pediatric dentists and general dentists for children in your practice.
- **Step Seven:** Manage your practice like a big business.
- **Step Eight:** Hire the professional advisors.
- **Step Nine:** Establish an orthodontic component to your practice.
- **Step Ten:** Establish programs to monitor, evaluate, and improve performance of both office systems and staff.

Developing a business plan for the entrepreneurial children’s dental practice will take research, consultation, and decision. Let’s look at these closer.
Research the geographic location that best meets your vision of treating high caries children from low and middle class families. Oftentimes, these locations are in suburban and rural areas that are underserved by the dental profession. Use modern demographic and psychographic analysis to find these locations. Determine if an area can sustain a regional multi-doctor, multi-office group practice.

Research the specific medical models in other surgical specialties with similarities to pediatric dentistry such as Otolaryngology, Plastic Surgery, etc. in an area.

Research the addition of your specific medical model in an area.

Research the various governmental and private insurance dental funding programs as it relates to reimbursement for traditional restorative dentistry in an area.

Research the workforce issues in this desired location. Research the feasibility of attracting pediatric dentists and general dentists for children.

Research the various model in big business as applied to large medical, dental, law, architecture, etc. businesses. Exam the management structure of these companies. Research the application of these models to this practice.

Research the national professional consulting companies specific to health care. Research those with emphasis on dental group practice management, practice transition, practice growth, strategic planning, etc.

Research the orthodontic practice opportunities in the location you are analyzing. Research the feasibility of attracting orthodontists.

Research various monitoring, evaluating and performance improvement systems for a large dental group practice.

Research the governmental agencies and non-profit foundations in an area. Research the feasibility of these governmental agencies and non-profit foundations assisting in patient care support.

Consult with professionals that you have hired for review of the information that your research has discovered. Obtain a variety of opinions.

Develop a master business plan. Have your professional advisors review this plan. Be creative. Be an entrepreneur.
I have indirectly mentioned in other chapters some of the consequences of
the success of an entrepreneurial children’s dental practice. Obviously, the
financial implications are significant to partners, associates, and employees.
But, let’s look at some non-financial ones.

1. **Employment of Large Workforce.** A multi-doctor, multi-office
children’s dental practice will employ a large workforce in the
community. This will also have a reverberating effect in the community
since the support necessary for this workforce would also be significant
such as banking, accounting, human resourcing, etc. What a nice feeling to
know that your group helps many employees and their families in job
security and wage earnings.

2. **Upward Mobility of Workforce.** A large workforce practice will give
many entry level employees the opportunity for upward advancement.
Again, what a nice feeling to for your group to experience the
occupational growth of an employee. Many of our management team
started in our practice as entry level clerical or chairside assistants. Many
of our associates have become partners involved with managing systems
and building staff teams.

3. **Support of Community Businesses.** A large dental practice will require
the support of other businesses in such areas as printing, OSHA
compliance, dental supplies, dental equipment maintenance, janitorial,
anesthetic gases, computer support, etc. Again, what a nice feeling to
know that your group is responsible for the existence and growth of other
community businesses.

4. **Access to Care.** A regional group practice serving the children from low
and middle income families will increase the access to dental care. What a
great feeling to know that your group is providing care to many children
that would otherwise have limited or no access to comprehensive dental
care.

5. **Community Involvement.** Because your group will improve access to
care it will receive the attention of many governmental agencies, non
profit foundations, and philanthropic civil groups. Your group will be
recognized for leading the efforts in your region in improving the dental
health of thousands of children. What a great feeling to know that your
group is responsible for a solution to a significant health issue.
6. **Time Management.** With a large workforce it is possible for both doctors and staff to plan on personal time away from the practice without creating staffing issues. With multiple doctors and numerous staff cross-trained in a variety of areas, planning of personal time away from the group is enhanced. What a great feeling for both doctors and staff to be able to take personal time away from the practice for such things as vacation, medical, pregnancy, family, education, etc without concern for jeopardy of job position or concern for guilt that one is causing stress to fellow employees because of a vacancy.

7. **Transition of Doctors.** With multiple doctors a large group can create a transitional plan allowing for the ascension of associates to senior associates to junior partner to partner. A retirement succession plan can be created for senior partners as younger partners are added to the professional workforce.

Now, notice in the chapter title, I said “mostly positive”. Here are some not so positive consequences.

1. **Colleagues.** Your professional colleagues at local, state, and national levels in organized dentistry won’t exactly welcome you with open arms. Suspicion about a successful multi-doctor, multi-office children’s dental group will always be there. The solo practitioner is often threaten by and jealous of the successful entrepreneur in dental practice. It’s fine in medicine, but not in dentistry. The actuality that great clinical care can be given and still be financially successful seems to allude their thinking.

2. **Volunteerism.** The governmental agencies, non profit foundations, and philanthropic civic groups will want members of your group to serve on numerous committees, participate in various fundraisers, help write grants, etc. Don’t confuse flattery with reality. While many of these entities are well meaning, politics abound even in these organizations. Make sure the people managing these entities realize that your practice already donates considerable resources by accepting less than full reimbursement for your services on some governmental and private insurance programs. Your practice should not be expected to donate services as well as funding for many social programs.

So, I feel that the financial and the non-financial rewards as a consequence of your group’s success are extremely positive. The few that aren’t are a minority. Don’t feel embarrassed by your success. Be proud that your group is leading the entrepreneurial achievement necessary in dental practice to improve access to care for millions of children.
As I write this book in 2007, I celebrate the 25th anniversary of our group practice. I have been fortunate to have partners that have shared my entrepreneurial vision as both associate and partner. Another founding partner has been very entrepreneurial in community involvement that has allowed me to focus upon practice administration, office management, systems development, and team building.

Not all associates have made partner. Some have left the practice after the discovery that being in a children’s group practice dedicated to serving the high caries dental needs of children from low and middle income families with a multi-doctor, multi-office approach using the medical model and with traditional dental rehabilitation can involve very difficult physical and mental work. Those that stayed and became partners have enjoyed the mentorship of those that preceded them on the entrepreneurial path to growing a financially successful children’s dental practice.

Our current Managing Partner is a former associate that has proven invaluable in “carrying the torch” of practice creativity and growth. He is passing on his passion to other associates that have become partners. This succession of mentorship has been the “cornerstone” of our foundation. It has allowed the more seasoned and experienced partners to step back and let the newer breed of entrepreneurs in our group “spread their wings”.

I can tell you that two key decisions have influenced our group’s success.

First, our practice was never going to be a “one owner” group. We always strived to find associates that wanted to share our vision. That meant that like a marriage there had to be agreement of issues because other partners were owners. To get agreement of issues involved extensive research, long discussions, negotiated compromises, and constant reevaluation of decisions. If that doesn’t sell you right there I don’t know what will. An entrepreneur is never a “control freak”, but rather an “includer”.

I personally think that the pluses more than out weight the minuses on one owner group versus multi-owner groups. I have studied both. Ours is the latter. The plus for me is that I have gotten enormous amounts of personal time away from the group as I have entered my “senior” years as a “founder”. I have for the last number of years taken off during the summer and early fall months to be at our second family home in one of the western mountain states. I stay in touch by email but have the luxury of being gone for this extended time knowing that the group is managed expertly and continues to be financially successful. Another selling point — It’s called a built in transition plan.
Second, our practice has always utilized expert advisory consultation from one of the top advisors in the country. He has challenged us. He has agreed with us. We have disagreed with him. We have agreed with him. We have disagreed with him. He has been “partner counselor”, “partner negotiator”, “idea bouncer”, “team builder”, “strategic planner”, “transition expert”, etc.

He has pushed us far beyond where we would have pushed ourselves and beyond our comfort zone. He has made us both “reach” and “hold back”. He has been both “optimistic” and “pessimistic”. His bill has been gladly paid. We have gotten more profit and saved more time because of his advisory talents.

As I said in the book, make your learning curve short and cheap. In business, time is money. And, remember, we are in BUSINESS.

I have enjoyed doing this book. I hope you have enjoyed reading it. I hope it has stirred your entrepreneurial thoughts. Good luck in your journey.

Don’t hesitate to network with me and our advisor, Randy Berning, who has encouraged me to do this book. Our hope is that we can team up to assist others in establishing other entrepreneurial children’s dental groups.

Remember, an entrepreneur has no age distinction. They can be young. They can be old. Entrepreneurism is a factor of mental determination not physical stamina. The brain is only as good as it is exercised by mental challenges.
Sanger’s Ten Bonus Points
(They’re Free)

As my biography indicated, since the late 1970’s I have been consulting in the practice management arena either with other practice management and seminar companies or my own. This has enabled me to analyze hundreds of general and specialty practices all over the United States. Whether or not you follow my model for the successful entrepreneurial children’s dental group practice, here are some bonus points for you to review for your practice improvement. They’re free, so why not enjoy them!

**BONUS POINT ONE:**
The outside of your office makes a first impression. You don’t get a second chance to make a good first impression. Make the first one count! Don’t blow it. The inside of your office makes a second impression. You can’t afford to blow two in a row. Do like the airline pilots do. Make an inspection of the plane before ever take off.

**Facility – Outside**
1. **Every morning park in your parking lot.** Get out and inspect the lot. Is the landscaping fresh? Well cared for? Or, are there dead plants, broken tree limbs, overgrown bushes, trash in plant beds, animal litter, debris on surface lot, poor pavement, etc.? Is your sign a sense of pride or old and illegible? Does your building look modern? Or, is the exterior looking tired, paint old, windows covered, roof dilapidated etc.? Is the trash receptacle area hidden and sheltered? Are all outside lights modern and functional? You get the picture. A dirty parking lot, poor landscaping, old sign, outdated building, etc. is an indication to your patients that you don’t care about being neat, clean, modern, organized, etc. Why should they trust you with their oral care if you can’t even care for your office?

2. **Don’t drive an expensive car to your office.** Don’t have a personally marked space. Showing off an expensive car for all the staff and patients to see is sending another message. All you care about is you and your gratification not the best interest of your office. Ever heard a person say, “I guess I’m helping Dr. ___ pay off that expensive car outside his office.”? Don’t let that happen to you. Park your ego at home, not in your parking lot!

**Facility – Inside**
1. Same morning but now go inside your office. Don’t go in the back door, but start at front door. Look at the door. Is it clean? Well maintained? Now go into the reception room. Look at the carpet and paint. Are they modern, inviting, clean, etc.? What kind of pictures are on the walls? I hope pictures of you and your staff and some information of each. Maybe some awards from your community,
profession, church, etc. Don’t put pictures of your travels, vacations, toys, etc. Your patients don’t want to think they are paying for your travel, hobbies, etc. What about the magazines? Are they current? Are they appropriate? Don’t put magazines that are not for the general public. Just because you like flying, doesn’t mean your patients care about aviation. Don’t have bad news magazines like the latest issue of Time or Newsweek with the latest war pictures, How about National Geographic, Parents, or sports magazines, cooking magazines, home magazines, etc. Are there dying plants or flowers? Is the furniture old, tired, and dirty? Is the design conducive to patient comfort and openness with your business staff? Again, why should a patient trust you with their oral care if you can’t even care for them in a place that they are received?

2. Now proceed to the reception greeting area where your business staff sits. Does this give a feeling of welcome? Is there clutter? Look beyond the greeting area. Is it clean and open? Or, is there junk taped and stapled to walls, doors, etc.? What pictures are on this wall? What about the workspaces of the employees in the business office. Dirty coffee mugs, soda cans, water bottles, etc.? Does the equipment look up to date?

3. Now go to the patient restroom. Is it clean, modern, fresh smelling, well supplied, etc.? Is there a baby diaper changing table, air freshener spray, toilet lid covers, tissues, etc.

4. Now go to the treatment area. Is it clean, modern, fresh smelling, etc.? Does your equipment look up to date? Are there appropriate pictures on the walls? Are the paint and/or wall coverings fresh and modern?

5. Ever consider a theme to your entire office? Tropical? Sports? Outdoor Recreation? Etc.? Remember, going to the dental office is not number one on people’s list. At least make it a place where their mind can be pampered with more than just dental health care.

6. Spend the money for a professional cleaning crew that comes to your office daily. Same for regular gardening and building maintenance. Your staff was not hired to be janitors, landscapers, building superintendents, etc.

7. Get rid of the big private office for the doctor. This is usually a place that is littered with months of unread dental journals, stacks of “hot, get rich quick” proposals, and sports equipment. The walls are usually a testimonial to the doctor’s education, sports interests, family involvement, travel junkets, etc. All this while the office manager and business staff are cramped and need more room to better serve your patients and increase practice profitability. You never make a dollar of production in your private office. In fact, I don’t even have a private office. I have a cubicle where I place my briefcase and laptop computer. Your staff can use your private office space better than you can.
**BONUS POINT TWO:**
Don’t get talked into owning your own office by your accountant or real estate broker. Your office may need either an expansion or relocation for practice growth. Be careful. Practice dentistry first and be a real estate investor second. Don’t discount commercial real estate. Just don’t lock in your practice growth by tying it to your own building. If you think commercial real estate is where you want to invest, do it in other ventures not tied to your prime dental business. Owning your own office to control your rent can stifle your growth. Approach with caution.

Facility – Owning Versus Renting
1. I have seen too many practices diminish their growth potential because the doctor owned the office and couldn’t or wouldn’t expand. Nor would the doctor consider selling the office and buying a larger one. The practice was doomed to stagnation.

2. I have also seen too many practices where the initial location where the doctor bought the office had changed dramatically for the worst but the doctor couldn’t or wouldn’t sell and relocate to a better area. These practices not only stagnate, they sometimes die.

**BONUS POINT THREE:**
Hire the most people oriented people you can find. Look outside of dentistry. You can teach dental skills, but you can’t instill people skills. People skills are nurtured over the lifetime of an individual. Some have them. Some don’t. Some of those that don’t will never have them. Pick the ones that have them now. Reward the talented people with profit sharing. Money talks long after the lunch, travel, gift, etc. Be professional, look professional, think professional, and talk professional. Practice, practice, practice verbal skills. Keep relationships with staff strictly professional.

Staff – Hiring
1. Ever seen a Christmas card from a dentist where all the staff were good-looking females? Ever notice that some dentists only hire attractive women? They think that by only hiring attractive women patients will flock to their office for cosmetic care. Wrong. Hire your staff based upon their human interaction, interpersonal, and communication skills. Remember, the key systems in a dental practice of marketing, selling, scheduling, production, and collection are all dependent upon the right people – not physically but mentality. Go for brains! Go for people skills.

Staff – Benefits
1. People love to work for money. People love to be bonused with more money. I have seen too many practices where the staff got a lot of bonuses (lunches at meetings, CE courses, travel programs, etc.) but never the benefit of salary and/or retirement bonuses. You can offer all the benefits to your staff you want, but don’t forget the one that is most important – money. Bonus on profitability for the ultimate in benefits. Profit sharing should not be a concept only in corporate business. Put it in your dental business as well.
Staff – Attire and Appearance

1. I like uniforms. Uniforms convey team spirit. I like to see a front staff in a business uniform, not scrubs or street attire. If they are business staff, then they should look like business staff. I understand that the clinical staff must be attired in scrubs but they can all dress the same with a team oriented theme with the scrubs. Make sure all uniforms fit correctly and are updated periodically. Use of name tags should be mandatory. Personal appearance should be professional.

Staff – Verbal Skills and Role Play Training

1. It is essential that all staff receive training in verbal skills. Role playing and communication practice sessions are essential for your staff. Whether it is answering the telephone, discussing a treatment plan, presenting a financial agreement, confronting a dissatisfied patient, etc. communication must be positive, supportive, and professional.

Staff – Fraternization

1. I have seen too many practices destroyed by fraternization between doctors and employees. Employee jealousy is the cancer of fraternization. Don’t be fooled into thinking that a staff member can keep a secret. Don’t play favorites. Don’t bring your personal family relationships into the office. Marriages can be ruined when spouses and children are brought in as employees. I don’t care what the tax benefits, I don’t like spouses and children working in the office.

2. Office parties should be on neutral grounds. Not in the office. Not in the home. Preferably during the day. Night time fraternization and alcohol consumption can lead to staff spousal issues and legal consequences. A summer family day picnic outing at a local park. An office holiday party on an afternoon at a hotel meeting room with catered food. A celebratory office lunch at a local restaurant. All of these examples are appropriate.

BONUS POINT FOUR:

Make a decision. Establish a policy. Put it in writing. Put it in a manual. Get the policy agreement signed by the person agreeing to the policy. A signed agreement is the basis for a strong negotiation position by the person that established the policy if there is a question or issue of disagreement by another person. Be a leader that confronts the issues with decisions instead of a player that assigns them to consensus study. Be respected first and loved second.

Office Policies and Manuals - Management

1. “Let’s see what the manual says about that!” “Let me review with you our office policy on that.” “I know you are a friend of the doctors, but our office has a policy on …..” Whether it’s a staff question or a patient question, you are in a losing battle if you haven’t agreed upon an answer to a hypothetical question and written it down. Policies are decisions you have made as the leader of the practice regarding all the possible questions that will confront you as a leader. Policies are
placed in a manual. Personnel manuals are essential for the leadership oriented practices. Office policies manuals are essential for the patient managed practices.

2. The doctor owner negotiates from a position of strength when there is a predetermined policy concerning an issue with a staff, patient, etc. A written policy has already established the doctor owner terms of agreement. Having an employee sign that they read and agree to the terms in a personnel manual or having a patient sign that they have read and agreed to the financial arrangements for treatment, creates enormous power for the doctor owner if negotiations and compromises are requested.

3. The leadership in a dental office should be vertical not horizontal. In other words, it is not leadership by consensus. Decisions are made by the leader (vertical) with input from the staff (horizontal). Policies and manuals help with the vertical leadership process. Years ago there were numerous self help communication seminars (EST, Transactional Analysis, etc.). All expounded on horizontal relationships. Most failed in business because leadership management was replaced by consensus management. People want leaders. Don’t confuse love with respect. A well liked leader is often one that is not respected. Making tough decisions sometimes means making decisions that are not popular. My motto is: “you don’t have to love me, but you must respect me!” Don’t confuse the two!

**BONUS POINT FIVE:**
When a patient makes an emotional buy don’t explain it away with stupid logic. Be thankful. Be complimentary. Exit and turn it over to the best closure staff member in your office. And, remember, a sale is not closed until the financial agreement is signed. Both marketing and sales should be emotional and people oriented.

**Marketing and Sales**

1. People buy based upon their needs, wants and desires. They buy from emotion more then they buy from logic. People buy from other people. So, make your sales system one that is people oriented to their desires. The most successful sales encounter whether it is face to face or face to web site, telephone, mail, etc. is always the one where emotion by both buyer and seller are considered over logic. Ever hear the saying: “I don’t need it, I don’t necessarily want it, but I just have to have it. I just have to. There’s no explaining why!”

2. Your marketing must concentrate on this emotion prior to the sales encounter. Market for need. Market for want. Market for the desire. But don’t forget the emotion of desire.

3. The doctor is usually the worst marketer and salesman in a practice. The doctor will often “explain it away with technical terms”. Not content when the patient says “yes” to a treatment plan, the doctor instead of shutting up will explain away the desire elicited by the patient with verbal technicalities. The doctor wants to apply logic but the patient wants to hear emotion. When a patient says “yes” the
doctor should be complimentary of the decision and not become explanatory of the logic behind the decision.

4. Don’t forget that when people buy there is often post sale buyers remorse. After a sale, contact the patient to reassure them that their emotional decision was a great decision.

**BONUS POINT SIX:**
Even the best leaders need coaching. Use a multitude of great advisors. Advisors don’t make decisions. They should give you various analyses of issues and projections of possible solutions. They should help you analyze the past but plan for the future.

**Advisors**
1. Avoid advisors that are purely historical and general. Use a team of advisors that can be historical, futuristic and specialized. An accountancy advisor may be great to produce historical data. A financial planning advisor may be better to analyze this data into projection trends and strategic planning. A real estate broker or leasing agent may be great at bringing you a purchase or lease deal. An attorney specializing in real estate law may be better at objectively analyzing this deal with your best interest in mind for the future. An in office practice management advisor may be great at helping establish a personnel manual. A human resource attorney may be better at ensuring all policies are legal and protect your interests.

2. Search for the best advisors you can find. Don’t stay within a certain geographic area. Look national. Don’t hire someone you can’t fire. Don’t hire friends or relatives. Hire advisors that can network with other advisors. Hire advisors that can work as part of a team.

**BONUS POINT SEVEN:**
Giving it 99% is not winning. It’s loosing. Winners give 100% and more. Whoever said that success is achieved by just showing up was wrong. Success is achieved by working hard and working smart 100% of the time. If you want to be in the stands or on the bench, then don’t give it 100%. If you want to be in the game, give it more than 100% ALL THE TIME. Winning is being in first place. Loosing is being everything after first place.

**Hard Work But Smart Work**
1. I have never met a successful dental practitioner that didn’t work hard. Whatever it takes to be successful that is what these practitioners did. There were never excuses like “I don’t work Fridays.” “I never take work home.” I don’t work well under pressure.” etc.

2. All of these successful dental practitioners not only worked hard they worked smart. They shortened their learning curve and made it cheaper. They learned quickly from their mistakes and never repeated them again. They took constructive
criticism without regard for ego deflation. They sought help from advisors, mentors, and peers that pushed them to their limits and beyond.

**BONUS POINT EIGHT:**
Share the wealth of your success. Do it tastefully. Be discrete. You’re not a celebrity. Stand out for your excellence in dental care and community involvement not for your “toys”.

**Success**
1. Don’t show off your success. I have seen too many practitioners “wear there success on their sleeves.” Fancy cars. Hugh house. Expensive vacations. Country club lifestyle. Lavish perks. Vacations homes. Planes. Boats. Etc. At the same time they are “cheap” with their staff and their practice. Share your success with your staff through profit sharing plans. Share your success with your practice through improvements.

2. Be involved with philanthropy in your community.

**BONUS POINT NINE:**
Pick the brains of the people that have similar practice experiences. Seek mentorship. Seek new ideas. Open your mind to new possibilities. Seek out opportunities.

**Networking**
1. The successful dentists have established their own network of colleagues that continually strive to better themselves.

2. A network can be local, regional or national. It must be serious with no social, travel, recreational, etc. goals. The goal must be focused on practice improvement.

**BONUS POINT TEN:**
No matter how old you are, plan for practice transition and retirement now. Don’t wait until it is too late. According to the ADA, less than 5% of dentists age 65 can retire. Don’t be a consumption addict. Be a prudent saver and an intelligent investor. Dentists are the biggest suckers for the get rich quick schemes. Be steady and stay the course with saving and investing. If it’s too good to be true, then it’s a lie.

**Practice Transition and Retirement Strategies**
1. It’s never too early to plan for practice transition and retirement strategies. The most successful dentists are the ones that have attained their critical mass of wealth early in their life and have the luxury of practicing for creativity and challenge.

2. Practice transition should be a dynamic not a stagnant activity. It should be continually evolving as the life of the practice and dentist grows.