

Scheduling Efficiently A Profitable Resolution for the New Year

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Let's examine what appears to be a very successful solo dental practice as we enter the 21st century:

- The doctor works a four day week – approximately 35 to 36 hours of patient care.
- The doctor is scheduled four to six weeks ahead.
- There is a considerable amount of comprehensive and cosmetic dentistry being performed.
- A talented support team is in place.
- Two full time hygienists work each day the doctor does.
- The doctor and staff regularly update their knowledge through continuing education.
- The physical plant is adequate.
- Collections and accounts receivable are reasonable since financial arrangements are executed properly.
- The hygiene practice is healthy with a nice mix of soft tissue management.
- Fifty to sixty percent of the patients are covered by some form of dental insurance.
- The practice welcomes twenty to twenty-five new patients per month.

What could be better? What could be improved? As a management consultant, I have worked with over 100 practices that exhibit the above characteristics. Believe it or not, they share some serious problems:

1. In busy practices, treating lots of patients, there is a great deal of stress in trying to maintain a timely schedule. And we know that patients respect our time in direct proportion to the way we respect theirs. So timeliness is key.
2. Often times the doctor thinks an associate is needed to help process the volume of patients.
3. The doctor feels successful, yet at the same time is concerned that patients have to wait five to six weeks for an appointment. There is no flexibility in the doctor's schedule because of this backlog of patients. The doctor feels a loss of control over his or her life. This is certainly not ideal customer service.
4. There is a tendency to postpone definitive dental treatment because there is such a long wait for an appointment.
5. The doctor feels maxed out and can't seem to find a way to get to the next level of profitability other than working more hours.
6. The problem of how to control capacity is constant. Should fees be raised, should

hours be expanded, should the facility be expanded or changed.

Notice that I haven't categorized or sized this practice by gross production dollars. No philosophical discussions about amalgam vs. non amalgam. Insurance dependant or non insurance dependant. Accepting assignment of benefits or not accepting assignment. Those are all important issues, but have little relevance to the topic of how to schedule efficiently.

The most important management system in a dental practice is scheduling, because the only thing we have to sell is our time. Yet most practices are terribly inefficient in scheduling, wasting two to four hours of time virtually every day. I didn't say they weren't busy – I said they weren't efficient. There is a huge difference between being busy and being profitable. I believe that when an effective scheduling system is introduced into a practice:

- the stress level of everyone can be significantly reduced.
- the appointment backlog can be cut in half.
- the need for an associate is often eliminated.
- production is increased dramatically without raising fees or altering the mix of the practice.
- every hour in the practice becomes a productive hour no matter what procedure is being performed.

Every scheduling system that I have ever heard about, read about, or seen promoted by the national practice management gurus is a variation on what is called BLOCK scheduling. Save certain blocks of time everyday, some in the morning and some in the afternoon, in order to begin major dental treatment. The rest of the day is saved for smaller procedures, crown inserts, and exams. According to block scheduling, if you follow these guidelines, you are guaranteed to produce your target production number for that day. Those target numbers are fictitiously (in my opinion) created by charging out the full fee for the procedure when it is started. This is done so that insurance forms and statements can be generated.

The big problem with this type of scheduling is that nobody ever explains to the scheduling coordinator how to finish the procedure. So I often see try in visits of crowns, bridges, partials and dentures condensed into very short appointments so they won't take up very much of the doctor's time. You see, the scheduling coordinator is supposed to schedule each day to a certain target dollar amount. And the computer tells her that the second and third and fourth visits of prosthetic treatment have no value. Why? Because they were already charged out at the initial visit. So these procedures get squeezed into the wrong place with inadequate amounts of time so that the MOD amalgam can get scheduled. At least, says the scheduling coordinator, that has a dollar value, even if it may only be \$90. So if I squish enough of these \$90 appointments in, I have a chance to reach my target production goals.

My scheduling system is totally different.

1. Every hour of the entire day should be profitable, not just the blocks where "major"

work is scheduled. Major treatment can be scheduled all day long.

2. Through a comprehensive analysis of every procedure performed by the doctor, the fee charged for that procedure, and the time it takes to perform that procedure, a dollar value per hour or half hour can be established for every procedure.
3. Based on the hourly and daily production goals that each practice sets for itself, certain procedures will be categorized as productive and others will be classified as non productive.
4. Those procedures categorized as productive are arranged one after the other in an appointment schedule on the left side of the page. These are prime time appointments because of the dollar value assigned to them.
5. Any procedure that doesn't meet the valuation criteria for productivity is placed on the right side of the page in a time slot that doesn't interfere with the profitable procedure scheduled on the left. These side booked appointments are further categorized into "doctor required" or "non doctor required." Examples of doctor required would be small fillings or emergency treatment. Non doctor required could be alginate impressions, re-cementing temps, X-rays, etc.
6. A set of eleven scheduling rules that I have developed covers every contingency as to what procedures can be scheduled opposite each other. For example, doctor required right side appointments **can not** be scheduled when on the left side you are performing operative, endo, prep temp impression visits for crowns and bridges, or final impressions for removable prosthetics. Doctor required right side appointments **can** be scheduled when on the left side you are performing try – in visits for crowns, bridges, partials and dentures. Non doctor required visits can be scheduled anytime there is an available room and an available dental assistant.

LEFT SIDE	RIGHT SIDE	TOTAL	
1 st visit 2 hours prep temp Imp	\$1050	#####	\$1050
2 nd visit 1 hour metal frame	\$ 525	Small filling \$90	\$ 615
3 rd visit 1 hour biscuit bake	\$ 525	Small filling \$90	\$ 615
4 th visit 1/2 hour try in #30	\$ 200	Insert bridge NC	\$ 200

I teach doctors and staff the details of this system in a six hour seminar, so it would be impossible to describe anything more than a few examples in the format of a short article. Notice that production for all four of these appointments is between \$400 and \$615 per hour. I am not suggesting that you change your current system of charging out everything at the first visit. I am merely suggesting, that for scheduling purposes, you understand the dollar value for each appointment time. Just as it is unrealistic to credit production of \$2100 for the first visit of the three unit bridge, it is just as unrealistic to assign no dollar value for the next three visits required to complete that bridge.

Requirements:

1. Two full time dental assistants who are highly trained, people-oriented, and artistic. Delegation to these dental assistants to the full extent of your state dental practice act.
2. A minimum of two equally equipped dental treatment rooms (even better with three) available to the doctor at all times exclusive of hygiene.

Benefits of this scheduling system:

1. By understanding the true value of each block of time, it now becomes possible to **expand** the time allowed for multi-visit procedures (like try-ins), and still have a very profitable visit. The stress level is greatly reduced when the doctor is not performing "doctor intensive" procedures all day long.
2. Each hour of every day has the potential to be profitable based on your hourly target production goals that relate to your fees and your clinical pace.
3. The backlog is reduced by as much as fifty percent within three to four months because now you have a system of moving non-profitable half hour visits (small fillings, a simple extraction, etc.) into a right side visit that will accommodate them.
4. The profitability of each hour increases because of your ability to schedule right side visits in the appropriate slots where they don't interfere with the main left side production. The average practice, as described in the beginning of this article, with national average fees, will increase production minimally by \$100,000 in the first 12 months of using this system.

No scheduling system will work if the doctor abuses the system. The day can be designed perfectly by the scheduling coordinator, but it will totally fall apart if the doctor does definitive therapy for emergency patients, gets trapped in the hygiene room with a treatment presentation, or unrealistically decides that more treatment can be done in an inadequate time block.

Here is how to evaluate your current scheduling efficiency. Calculate how many hours the doctor worked in 1999. Divide the number of hours into the total doctor production and that will give you the actual dollars produced by the doctor per hour. Now I want you to do an exercise. Focus on the 15 or so most commonly performed procedures like anterior composites, posterior composites, amalgams, endo, posts, crowns, bridges, partials and dentures. When evaluating operative, think in terms of quadrant dentistry. In this exercise, calculate how long it would take for the doctor to perform each procedure if these three ideal criteria existed:

1. The patient is completely anesthetized when the doctor begins the procedure.
 2. A dental assistant is assigned to that room for the duration of the procedure.
 3. Nobody bothers the doctor – no phone calls or other distractions from front desk.
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For example, how long would it take to do the actual dentistry for a quadrant of amalgams, or two complex posterior composites, or a prep, temp and impression for a single crown if the patient was totally numb, a dental assistant was at your side for the entire procedure, and nobody interrupted the procedure. It may be hard for you to imagine this set of ideal circumstances if they rarely happen in your office. But I guarantee that when you now evaluate your production by dividing the dollar value of the procedure by the time it takes to perform the procedure, the production per hour will be increased by \$75 to \$100 over the 1999 totals. Why?

The difference between what was produced per hour in 1999 and what should have been produced is the measurement of the inefficiency of your current scheduling system.

And when you add up the number of hours worked in a year (typically 1700 to 1800), you can easily see that scheduling inefficiency is costing at least \$100,000 per year.

As the old saying goes, if you continue to do what you've always done, you will continue to get what you've always got. Doing the same thing you've always done, day in and day out, week in and week out, and expecting to get a different result is my definition of insanity. Perhaps it is time for a major re-evaluation of your scheduling system.