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Colorado Dental Manager’s Association

The CDMA Mission:
The Colorado Dental Manager’s Association is dedicated to dental office managers by providing an environment for education, networking, support and mentorship in a “workshop” environment for implementing new ideas and skills. The CDMA’s objective – to help office managers prepare for and welcome the challenges of managing and building a productive dental practice in today’s demanding market.

To learn more about the CDMA please contact Leigh Olson at 720-233-0574, leigh@novaconsultingllc.com or www.mycdma.org.

Since its inception three years ago, the Colorado Dental Manager’s Association has been privileged to have the following speakers address and lead “Round Table” discussions for many of Colorado’s finest Office Managers and Practice Administrators.

Leigh Olson
Owner, Nova Consulting
“Building the Right Team Around Your Vision”

Dr. Nate Reynolds
The Dentists Professional Liability Trust

Amy Kirsch
Amy Kirsch & Associates

Dr. Ray Shellburne
“Clinical Records That Prevent Criminal Records”

John G. Miller
Author of “QBQ!”
“Making Personal Accountability a Core Value”

Judy Holmes
President, The Compliance Clinic
“Prevent Costly Law Suits by Identifying Potential Problems”

Kim McGuire
Executive Chef, Fortune Management

Rita Zamora
Rita Zamora Connections
“Where to start and How to Skyrocket Your Social Marketing Results”

Linda Harvey
“Mastering the Art of Risk Management”

Marc Sitrin
POS Professional Office Services, Inc.

Caron Notarmuzi
Colorado Department of Revenue
“Cleaning up the Mysteries of Sales Tax for Practices in Colorado”

Roberta Sondgeroth
Auditor, Denver District U.S. Department of Labor Wage
and Hour Division
“To Exempt…or… Not to Exempt?”

Rob Pierce
Linford & Company
“Navigating Current HIPAA Requirements for Dental Practices”

Wendy Heckman
President, COPIC Financial Service Group
“Life and Disability”

Leigh Olson
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“Your communication through the lease renewal negotiations was excellent. The deal you were able to achieve FAR exceeded our expectations and really brought security to our practices. Thank you so much for the proper handling of the trust we put in you! Ever grateful…”

Michael Kevlyn, DDS
Westwood Dental
A Steady Diet of “Skinny” Plans? by Cal Utke, D.D.S.

Ethics, by Michael Diorio, D.D.S.

Medicaid, the Perspective of the Provider

Getting to the Root of Anthropology, by Richard Schilling, D.D.S.

Avoiding Absolutes When Selling a Dental Practice, by Susan Speak

Do I Need an Office Manager? by Judy Marcus and Gene Petersen, D.D.S.

Three Leadership Assumptions a Dentist Cannot Afford to Make, by Leslie Hilton, J.D., M.Sc., M.C.C. and Terri Tilliss, R.D.H., Ph.D.

Classified Ads
The landscape of healthcare and specifically dental benefit plans will be morphing and changing at an unbelievable rate over the next few years. Some of the recent changes within the dental insurance products, or more accurately dental benefit plans, may leave a bad taste in patients’ mouths and nausea in dental providers’ stomachs. Even though they come in a multitude of flavors, the basic ingredients remain very constant.

The changes are obviously the result of the horrid condition of our non-recovered economy, but also the looming impacts of the Affordable Care Act. There is a very finite “piece of the pie” that employers, corporations or companies will allocate to health benefits for their employees. Employers are already implementing “skinny plans” to drain resources out of dental wellness and place cost burdens on patients, their employees.

Every dental staff member of every dental office needs to understand this trend and be able to educate their patients about the employers’ and insurance company’s role in this movement. It is the dental staff who need to ensure that patients digest the real facts.

A skinny plan is one that will ONLY cover preventive services and basic diagnostics. The employer reduces their cost and the dental insurance company eliminates any actuarial risk or exposure. The real issue that will possibly require some Pepto-Bismol for the dental provider is that those patients, without any major or restorative coverage, will still fall under the contracted amounts or maximum plan allowance of that insurance network. The employer essentially gains a cash discount plan for their employees. Is that really insurance? That is hard to swallow!

A slight change in the recipe for the additional skinny plans will be created under the state exchanges that will provide a children’s benefit mandated by the Affordable Care Act. These plans are expected to cover an extremely limited CDT code group with prevention, diagnostics and very minimal (one-to-three teeth) restorative coverage per year. The real skinniness comes from the fact that many of the insurance companies are expected to place these embedded plans as a “closed panel” within their lowest fee level reimbursement network group. In other words, the patients will be restricted on choice of their providers, because they have to see a dentist on a list to gain any benefits at all! That is contrary to the intent and efforts by the state exchanges to ensure maximum participation and access.

The prevailing question that always seems to be missing from the menu of discussion points is dental insurance carriers and how they establish a relationship with their dentist clients. Can one continually provide services to patients at reimbursement levels that don’t cover the basic operational costs of those treatments/services? That is the reality of any provider (private, large group, corporate, public health, FQHC, non-profit, etc.). The compromise of the standard of care will occur, insidiously. Even on a diet, one needs to bring in a minimum number of calories to sustain life and not destroy the muscle (that gets all the work done) or the organism, in general, will shut down.

What if the menu choices started from the provider’s perspective since we are the advocate for our patients? Would all the other groups in the equation (insurance, employers, government) stomach their 30%–55% reduction in revenues, yet be required to still maintain a sound and sustainable business model, take care of their employees and still meet requirements and expectations of their constituents, some of which are mandated by law? Are the patients or dentists the only ones who must pick up the dinner tab or should a sense of fairness prevail?
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Right now, for many reasons, is a great time to be a dentist. There is an abundance of amazing services we can provide to our patients. The materials and techniques that we utilize everyday in the office continue to improve. There are esthetic options available that were not around when a lot of us, “seasoned veterans,” started our practices.

The public’s trust of dentists is at an all-time high. In the Gallup poll from November 2012, 62% of those surveyed rated dentists’ honesty and ethical standards either high or very high. That places us fifth on the list. Nurses were first with 85% and physicians were third with 70%. This rating ties the highest that dentists have received since the inception of the poll in 1981. Dentistry also had a 62% rating in December 2006.

All professions have individuals of the highest ethical standards, and all professions have those who, shall we say, are lacking. Ethics are a topic of every profession. A lapse in ethical thinking and behavior, however, can take a professional’s good image around a corner at high speed to the verge of plummeting off a long steep embankment. So why am I sounding the alarm when all seems well, especially from the public’s perception?

My concerns come from general observations, discussions with peers and conversations with current and former patients. Ethically challenged providers have always and will always be around in any practice model. As single, unrelated “weeds,” they have not significantly compromised the integrity of our lush green dental lawn. They also seem to be somewhat self-limiting and have minimal impact on the overall landscape.

“Weeds” with a common root system have a greater potential to take over our lawn.

The delivery of care model for general dentistry is always in flux, adapting to changes from both internal and external forces. A current trend is an increase in the number of dentists who are employees in a practice rather than owners. Another trend is the market share that corporate group practices have acquired.

Dentistry is a business and needs to run as one. The business of dentistry is different though, in that we are treating people and must always place ethics and compassionate care over financial gain. Appropriate and ethical treatment recommendations, and high quality work can bolster our patient’s view of dentistry. Conversely, less than appropriate treatment recommendations and inferior quality of care can greatly diminish the trust we have gained.

No matter how each of us practices, we must all follow a Code of Ethics. Consider the following incidents that have peaked my interest in professional integrity:

A long standing patient in my office left because she chose a more affordable dental plan that we chose not to participate in. She selected an office from the plan list. After visiting the dentist, she became concerned when the restorative options offered to her were either “plastic” (resin) fillings that she was told “might last a year” or (more costly) porcelain fillings that “would last 20 years.”

Another long standing patient left my office for geographical reasons.
Historically, she had one small amalgam restoration placed through her entire life and was decay free with us for several years. Her new office recommended nine restorations. We provided a second opinion for her and the areas that were recommended for treatment included non-decayed stained areas, minor white spots and some small almost un-detectable enamel-only lesions visible on her radiographs. All of these, however, were presented as decay that needed to be restored.

We, as a profession, have worked hard to gain the public’s respect. Ranking in the top five is something to be very proud of. The dark side of this trust is the potential for abuse, to take advantage of the trust that we have earned and use it for financial gain. It takes time and effort to gain trust. Violating that trust and losing the respect of our patients could take a generation to restore.

What is to be done then? I see this as a great opportunity for organized dentistry to step forward and speak up for the patients and our profession. We need to look at educating the public about what is fair, ethical and appropriate. Inform them that it’s ok to seek a second opinion and not feel pressured into making an immediate commitment to an extensive treatment plan. Used car sales people were near the bottom of the Gallup poll and we should not be utilizing their hard sell tactics. Unfortunately, dentistry and how it is practiced is now on the radar of congress. Everyone is better off if we look out for our own profession. We must develop a plan to dispel any misinformation or outright lies that are being told to our patients.
Dr. Bob Benke is like many dentists in Colorado. He’s seasoned in his profession and rooted in his community, having invested some 30 years in his Greeley practice. As a small-business owner, he knows he must keep an eye on his bottom line to ensure his practice stays viable. That said, he’s also conscientious about the community’s less fortunate residents, and he finds ways to reach out and help them.

One of those ways is by treating patients covered by Medicaid. They represent only a small percentage of the 1,300 to 1,400 patients Dr. Benke sees in a year, but they are a regular part of his caseload nonetheless. A special focus for him has been children in foster care, who he calls “a great group of kids.” Many of these children are Medicaid-eligible.

“I see this as part of my service to the community,” said Dr. Benke, who spent his first few years as a dentist working on a South Dakota Indian reservation. “I’ve never had a large Medicaid practice, but it’s there for patients who need it.”

That’s why Benke welcomes a potentially game-changing initiative led by the Colorado Dental Association to encourage the state’s dentists to expand their ties to the Medicaid population.

The association’s “Take 5” pledge is a campaign that recruits and recognizes dentists who commit to provide dental care for Coloradans covered by Medicaid. The program asks dentists to accept a minimum of five Medicaid patients or families throughout the year. Participants receive training and support to work with the state’s Medicaid program and integrate Medicaid patients into their practices.

“The endeavor is intended to give new momentum to the association’s long-standing commitment to reaching underserved populations,” said Dr. Cal Utke, CDA president.

“Access to a dentist is critical to our state’s overall public health,” Dr. Utke said. “When struggling families can’t regularly see a dentist, they not only suffer as their health deteriorates, but the entire community eventually pays for it.”

He said ripple effects range from missed work to overburdened hospital emergency rooms – an expensive last resort for patients whose ailments could have been treated most efficiently and effectively by a dentist.
The Take 5 initiative coincides with another breakthrough in expanding access to dental care – a policy signed into law earlier this year by Gov. John Hickenlooper that, for the first time, extends limited dental coverage under Medicaid to adults. The effort is anticipated to launch in mid-2014.

Some Colorado dentists who already go the extra mile in serving Medicaid patients say an effort like Take 5 isn’t just the right thing to do – it’s also the smart and proactive thing to do for the future of the dental profession.

For rural southeastern Colorado dentist Dr. Carol Morrow, a Medicaid dental benefit for adults can’t come soon enough. She intends to accept the new adult Medicaid beneficiaries just as she now sees children covered by Medicaid.

The many financially strapped households in her community of Walsh, as well as surrounding areas, truly have no alternatives. Dr. Morrow and her semi-retired dentist father, Dr. Bob Morrow, are the only dentists in all of Baca County.

“If I don’t take them, they have to drive a substantial distance to find a Medicaid clinic,” she said. “Some people think there’s a sense of entitlement in this population, but for the most part, these are working families trying to make it work.”

Dr. Andre Gillespie, who sees many children covered by Medicaid in his Aurora practice, says serving Medicaid patients demonstrates that Colorado’s dentists are willing to step up to the plate for the state’s most vulnerable families. That fact alone, he says, matters now more than ever in response to those who advocate for letting alternative practitioners perform complex dental procedures for at-risk populations – lowering the standard of care.

“Everyone deserves access to quality dental care,” said Dr. Gillespie, a Denver native who spent some of his youth in the neighborhoods he now serves, which makes the commitment personal.

“As a kid, I was on Medicaid,” Dr. Gillespie continued. “That’s something I now want to give back.”

Dr. Gillespie is a graduate of Denver’s East High School and the University of Colorado’s School of Dental Medicine. Some of the families he grew up with are now among his patients. He sees some 4,500 patients each year and estimates that 60%-65% are covered by Medicaid.

Dr. Morrow acknowledged the challenges of taking Medicaid recipients, notably the extra paperwork and often-inadequate reimbursement rates for dental procedures.

Both she and Dr. Gillespie also stressed that a lot of the conventional wisdom about Medicaid patients doesn’t hold true. The children in each of their current Medicaid caseloads often come from hard-working families that simply are struggling to make ends meet and need a hand.

Dr. Morrow emphasized the potential impact on public policy when dentists step forward as a profession to serve the Medicaid population.

“If we don’t show that we care, then there will be pressure to bring in other kinds of providers, and that’s just not good for our patients,” said Dr. Morrow, who also now serves as the secretary of the CDA.

Take 5’s pledge to treat at least five Medicaid patients or households per year is a modest commitment. Dr. Benke, Dr. Morrow and Dr. Gillespie all agree that its financial impact on the typical dental practice is likely to be negligible given that most dentists already do this type of work gratis for select patients, and that the initiative holds great promise for expanding access to care.

“Any small bit will make a huge difference if everyone does it, and this is a great place to start,” Dr. Morrow said. She continued to explain that many dentists are altruistic and want to help but also are concerned about keeping their practices financially sound and stable. She believes that Take 5 strikes the right balance.

Dr. Benke agreed, noting that Take 5 essentially asks dentists to help an at-risk population in need but seeks a manageable level of participation.

“This program is not going to impact our bottom line,” he said, adding that dentists who are seeing Medicaid patients for the first time “will find it rewarding.”

“We are in a helping profession,” Dr. Benke concluded. “And part of that is part of who we all are. This is an easy way to do a little bit more without putting a burden on anyone.”
To begin, I must inform the reader that this is not a scientific paper. I am totally responsible for any inaccuracies that you may find due to my limited knowledge of archeology and anthropology. I am submitting documentation from my own observations, and for the purpose of opening a dialog regarding the tracking of the prehistoric migration of humankind into the Western Hemisphere from Asia.

I have practiced dentistry for over 50 years. I have been a dental volunteer for the past 20 years, working on five continents. My story begins in 1995 at the Pine Ridge Indian Hospital in South Dakota where I served with the medical relief organization, Remote Area Medical Corps. During my stay, I found that a number of mandibular first molar teeth extracted from the Sioux Indians demonstrated a distinct third root originating on the buccal surface between the bifurcation of the mesial and distal roots. I thought this was strange, but at the time my only concern was that I had not overlooked a retained, broken third root.

In 1996 and 1997, I provided dental care to the indigenous people of remote villages in the Siberian Arctic. The Eskimo people in the villages are of the Yupik ancestry and hunt whale and walrus for a living. Another segment of the society is descendant of Mongols, and today migrates with reindeer herds. My work was supported by World Medical Mission, Inc. and consisted of both restorative and surgical care. What I found there startled me – many of the indigenous people had the same three-rooted lower first molars that I first noticed in South Dakota. I was beginning to become very interested in the anthropological similarity.

Most recently in February 2013, I was in Bolivia aboard the Ruth Bell River Boat providing medical and dental care to the people of the upper regions of the Amazon watershed, traveling upstream on the Rio Mamore and Rio Isaboro tributaries of the great river. As we progressed farther, I found Bolivian villagers exhibiting dental anomalies of the early migratory people. It was at the terminal end of the voyage that I extracted the lower first molar for a young man in a remote jungle village and was again amazed to observe a three-rooted tooth.

In each of these three groups, I observed the distinct, fully-formed third root. This tooth anatomy is distinctly different from the anomaly that is occasionally observed of mesial molar roots, which have bifurcated into two smaller roots.

**Scientific Studies Support Observations**

I contacted Professor Marco A. Versiani, D.D.S. M.S., Ph.D., an esteemed Brazilian endodontist, who pointed...
me to research on dysmorphic root anatomy by Calberson et al. They reported that mandibular molars can have an additional root located lingually (the radix entomolaris or RE) or buccally (the radix paramolaris or RP). The presence of a separate RE in the first mandibular molar is associated with certain ethnic groups. In Mongoloid traits (such as the Chinese, Eskimo and American Indians), reports have noted that the RP occurs with a frequency that ranges from 5% to more than 30%.

**Practical Applications**

It is important to make a careful radiographic diagnosis prior to an extraction or endodontic treatment. Traditional radiology produces a two-dimensional image of a three-dimensional object, making detection of supernumerary roots difficult. The cone-beam computed tomography (CBCT), when available, is an important tool for diagnosis of complex anatomies. Cogulu and Evans state that it is still easy to miss an additional root due to its slender dimensions.

**Conclusion**

I believe I have seen the “tooth marks” of the ancestral migration of Asian people across the Bering Land Bridge into the land that is now the Americas. About 13,000 years ago, they traversed melting sheets of the Cordilleran ice sheet; and over centuries, they migrated south through western Canada and the U.S. Migration did not stop here, but continued through Meso-America into the western regions of South America, eventually reaching Monte Verde, on the southern coast of Chile 14,800 years ago.

My observations are of only passing interests to anthropologists. They have already documented this migratory pattern with modern science and DNA testing. However, I have found this anatomical similarity to be fascinating. It has been astounding to me to be able to observe the physiological and dental anatomy that supports the Land Bridge hypothesis.

**Dr. Richard Schilling** is a dentist and artist who left private practice in 1992 to follow his desire to be a missionary dentist. In 2005, he and two visionaries created the Smiles Without Borders Foundation, which establishes portable dental clinics in Latin American schools. He has served in Kenya, Honduras, Russia, Nicaragua, Mexico and Bolivia. Dr. Schilling has lectured to physicians who work in remote areas of the world on the subject, “What to do When There is no Dentist.” He has written three books and has contributed articles on art and dentistry for national magazines. He is a life member of the International College of Dentists and the American Dental Association.

**References:**

3. K. Kris Hirst, “Bering Strait and the Bering Land Bridge.” About.com Archaeology.

**A Look at History**

Above the Bering Strait is a submerged landmass called the Bering Land Bridge (BLB) or Beringia. K.K. Hirst indicates that whenever the sea level drops about 164 feet below its present position, the land surfaces. Since the BLB is currently below the surface of the water, it is difficult for archeologists to study it. However, over time they believe the landmass became exposed and then submerged beneath the surface with rising sea levels. Pollen studies seem to indicate that there was a solid land bridge by which immigrants would have traveled to North America between 13,000 and 18,000 years ago.

**Additional Reading:**

AFTCO is the oldest and largest dental practice transition consulting firm in the United States. AFTCO assists dentists with associateships, purchasing and selling of practices, and retirement plans. We are there to serve you through all stages of your career.

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Kim McGuire and Fortune Management provided guidance and sound practice management techniques to help bring my struggling practice into a position of well being. I worked hard, had great patients, but never felt as if I was in control of my business. The Fortune Management program allowed my practice and my staff to achieve an amazing level of peak performance. A performance those years later has produced a stable, successful practice. I look forward to going to my practice every day, as well as, love working with my staff to bring quality service to our patients; providing an environment in which, we all strive to be one of excellence in our dental service.

Sheila Dashkow DDS
There are many important lessons we learn in a lifetime, but one lesson that everyone should consider is that absolute thinking limits the opportunity to explore new solutions to old problems. Dental professionals are bombarded with absolutes everyday so it makes sense that viewing practice transitions in absolute terms is just another way to form closed opinions. These absolutes, however, can limit the opportunities to experience practice transitions that are both positive and rewarding.

The following are just three examples of absolutes that may not always apply to every situation:

**Don’t plan to work in the practice after closing.** Staying on after a “direct sale” (seller sells all of his/her assets and is paid out for the business) is not possible for the majority of dentists selling, but it is not an absolute. The most common factor that determines the option for the seller is whether or not the practice can afford to have the owner dentist stay (usually part-time) after the sale. If financial limits are not an issue, it can be done successfully. It takes special effort on behalf of both the seller and the buyer to work out the issues of the transition process. The seller must fully understand the changes he/she most likely will experience, invest in the relationship to help ensure its success, and the parties must work together for a positive outcome. Many dentists successfully stay on with the practice for a period of six months to even a few years after a direct sale. Their commitment is limited to a part-time schedule, working within the financial needs of the practice and having a real exit strategy. There are many benefits to the new owner including learning from the seller’s experience and creating a more seamless experience for patients.

**Sell accounts receivable to the buyer at closing.** Selling the accounts receivable is one of the easiest ways to manage the process. This can be the best option for the buyer when the seller has healthy receivables. Although initially the buyer pays for the receivables, he/she is reimbursed through collection of the receivables at a discounted price. The buyer actually makes money on the investment. However, what if the buyer doesn’t want to purchase the receivables or if the seller has to take too much of a discount in order to make the sale of those receivables an option? There is a fair and reasonable alternative. One option is to pay the buyer a processing fee (5% of the receivables) to collect those receivables on the seller’s behalf. Specifically outline how the collection reimbursement will be handled and determine a timeline for collection of the receivables in the transfer agreements. All receivables owed to the seller are paid to the seller first before the new owner can collect on those same accounts. This process works and has been implemented by dentists for decades.

**Only agree to a full cash payout at the time of sale.** Selling a larger than average practice (collecting over $1M annually) or selling an office building at the same time of the practice sale, may mean that a buyer cannot get full funding on the acquisition and the seller will have to carry a portion (commonly 10%-15%) in a Promissory Note (known as “seller carry back”). In this case, the seller has a legal binding agreement with the buyer that helps to ensure the seller will be paid. In addition, the lending marketplace changes with the upturns and downturns of the economy and may affect how the sale is structured. If all practices and potential buyers met the lender’s criteria, and all underwriters saw each transaction the same way, and the economy always stayed the same, then it would not be necessary to be flexible. However, that is not realistic. A portion of the funding of a practice sale in a “seller carry” can also lower the tax burden by spreading out the compensation over time. Many dentist sellers actually choose to carry some of the purchase price as part of their future financial plan. If the seller is insistent on always cashing out, then this absolute may mean he/she may not be able to sell.
These are only a few examples of absolute thinking that can prevent a seller from achieving his/her true goals when selling a dental practice. T.S. Eliot once said, “There is no absolute point of view from which real and ideal can be finally separated and labeled.” To assume that there is only one way or only one “right” way to accomplish a successful practice sale is acting without knowledge.

Susan Spear is a practice transition specialist/broker business intermediary with SAS Transitions Dental Practice Brokers.
Among dental practices nationwide there exists every level of success, from practices struggling to keep their doors open, to hugely successful practices that produce well above their expected potential.

What makes the difference between a struggling practice and a successful one? What does it really take for a practice to perform as it should? It goes without saying that the practice has to be able to provide quality clinical care — yet some practices have still failed as businesses, even when that factor was not in question.

From a business viewpoint, a practice must accomplish three functions on a regular basis to reach its potential:
1. Effective marketing that brings in an adequate volume of new patients to the practice.
2. Proper patient education (case presentation).
3. Competent office management.

The ONE ELEMENT that makes these three functions consistently possible is hiring and training the right office manager.

Dentists sometimes ask, “Do I really need an office manager?” Some have concerns about allowing one of the staff to have a position of authority or seniority over the others, worried it will cause discontent among the employees. They believe it is better to give everyone equal status in the practice. Unfortunately, this equates to no leadership. As a business model, this is not workable.

In point of fact, without an effective office manager, the doctor becomes the office manager by default. If a practice is to produce to its true potential, however, the doctor doesn’t have time to run the office administratively. He/she needs to be delivering dentistry. If the doctor has time to run the hour-by-hour operations of the practice, the practice is definitely not producing what it can and should.

In this scenario, either the practice has too many hours of “down time” (no production occurring) or the doctor ends up spending his/her own personal time, outside of clinical hours, trying to keep up with the administration and direction of the practice. This can lead to burn-out and the frustration of feeling that reaching one’s practice goals without extreme personal sacrifice can’t be done. Nothing could be further from the truth.

The most productive practices have an office manager. This is the model that works. Even if the person is not given the title, if one looks at any practice that is maximally productive, there is someone directing and seeing to it that important non-clinical functions get done — and it is NOT the doctor. The doctor(s) in these practices have the life they envisioned when they decided to own practices. They come to work and do dentistry, and they spend minimal time on hour-by-hour management. They make a good living while working 32–36 hours per week. This is how it should be and how it can be.

Where a practice has found and trained the right office manager, it inevitably grows to the level that is desired by the practice owner. The above three functions can be implemented if there is an office manager to take care of them.

It is important to note, however, this does not absolve the dentist from his/her leadership responsibilities as the practice owner. Indeed, it is up to the practice owner to establish a competent office manager, see that he/she performs sufficiently (through direct observation as well as through the use of reports and statistics), develop and enforce practice policy, lead and inspire the staff to...
achieve the practice’s mission, and maintain financial and legal control over the practice. Adequate checks and balances must be implemented so the doctor can see the practice to the desired level of success.

**What are some of the personal qualities that make a great office manager?**

- First and foremost, an office manager is someone who wants the position and isn’t afraid of it.
- An office manager should be someone who is willing to represent the practice owner and act on the owner’s behalf in dealing with staff and patients.
- He/she should be someone who will respond to financial incentives that are based on growth of the practice.
- He/she must be willing to hire and fire personnel, and not be hung up on friendships or the desire to be friends with everyone in the practice.
- An office manager must have good communication skills and be able to grasp the importance of friendly and efficient service to patients. In addition, he/she must be very comfortable with discussing fees and payment with patients.
- It is important that the office manager believes in the value of dentistry and also has confidence in the clinical skills of the provider(s) in the practice.

Many “front desk” personnel possess these attributes and even assistants have gone on to become successful office managers. Training is always essential if someone has not held an office management position before, but it is still important to have a qualified candidate to start with.

Having a qualified and trained office manager is the key to seeing an adequate return on investment. Once a marketing strategy is in place that produces a sufficient number of calls into the practice, it is the office manager who makes the marketing succeed by seeing to it that these calls result in new patients actually scheduling and arriving in the practice. During appointments, the office manager serves as your practice’s ambassador to help patients feel comfortable and educated on future treatment.

Statistically, acquiring a qualified office manager and getting him/her trained can result in huge increases in production and collections, in some cases up to 300%. While it may take some effort to find the right person and fit for your practice, it is well worth the effort.

**Judy Marcus is the president of JR Marcus, Inc., with over 20 years experience consulting dental practices.**

**Gene Petersen, D.D.S., is a retired CDA member dentist who practiced 32 years in Boulder, Colo.**
Consider these comments from competent professionals in two different dental offices:

Dental Hygienist: “Every day is the same… for seven years now I’ve just shown up and tried to do my best as a dental hygienist. My dentist doesn’t seem to care much about what I do unless there’s a mistake, and nobody in the office seems to be that happy. I love my patients, but that’s all that keeps me there.”

Dental Assistant: “I don’t think I’m going to be able to keep working here much longer. The drama between staff members is getting unbearable. I tried to address it with them, and I mentioned it to my doctor, but nothing ever changes. I left when this same thing happened in my last office. I don’t want to leave again.”

Why are these staff members who are excellent practitioners and exemplary employees so frustrated? Both work in situations with the need for stronger leadership from their dentist employers to create an appropriate work environment. Without it these dental practices will suffer with:

• Unmotivated employees
• Staff dissent evident to patients
• Expensive turnover
• Negative impact on practice referrals and profitability
• Dentist’s dissatisfaction from high stress and work/life imbalance

Situations like these are common but they don’t need to be. An overwhelming majority of dentists report staff-related issues as their number one stressor.1 A study of dental offices showed that it was dentists’ leadership and communication behaviors that had a significant impact on creating a team culture that led to increased overall productivity and improved team member satisfaction.2

There are three common assumptions that prevent dentists from experiencing success and professional satisfaction:

Assumption #1: Practice Management = Leadership

There are a myriad of management consultants and programs. However, sound practice management without effective leadership results in many of the problems identified above and reduces the return on the investment in practice management. Management and leadership are quite different from one another.

Management is about producing order through control. The main focus of management is systems, tools and processes for staffing, training, organizing workflows, service delivery and tracking practice performance. Management is concerned with efficiency and productivity throughout the patient acquisition, treatment and financial management cycle.

Leadership is about producing change, innovation and growth, and is focused on people – their development, motivation, engagement, teamwork, innovation and performance.3 An effective dentist-leader creates an office culture where all stakeholders are engaged in doing their best. Dentists who invest in sophisticated practice management systems, but are not effective leaders, will not realize the full return on their investment because it’s people who drive the return from systems and training.
High degrees of staff-related stress and are at a disadvantage, and experience leadership and communication skills fulfilled dentists. Dentists without ties of successful and professionally success are all leadership qualities. Providing opportunities for learning excellent communication, and motivating performance, demonstrating vision and direction, engaging and other team members. Articulating leadership cannot be deferred to an practice – the task of leadership is not an office manager.

A dental practice is organized around the skill, judgment and reputation of each dentist. In order to ensure excellence in patient care and practice performance, each dentist must demonstrate appropriate leadership with employees, patients and other team members. Articulating vision and direction, engaging and motivating performance, demonstrating excellent communication, and providing opportunities for learning and success are all leadership qualities of successful and professionally fulfilled dentists. Dentists without leadership and communication skills are at a disadvantage, and experience high degrees of staff-related stress and turnover. A dentist’s leadership style directly affects an office’s communication practices and affects the degree of team identity, interdependence and social dynamics among team members. Communication is a key leadership skill for dentists, and includes communicating expectations clearly, listening, giving and receiving positive and constructive feedback and recognition, coaching for performance and development, team-building, and conflict management. This dentist-leader will build a teamwork culture where staff and patients are motivated and enthused.

Assumption #3: Leadership = A Mission Statement

A task of leadership is to articulate a clear practice vision and a direction for achieving that vision. Too many dentists believe, however, that once they’ve hung a mission statement on the wall, the job of leadership is done. Effective dentists lead the way in making the mission statement a reality and inspire others to live up to the ideals of the shared mission statement. They model the same behaviors of listening, teamwork, positive communication, respecting others’ points of view, and optimism they want their employees and patients to exhibit. They make well-informed decisions, treat everyone with fairness and respect, keep their personal problems out of the office and give everyone the chance to succeed. They model quality, service, and professionalism with patients, employees, and fellow dentists.

Conclusion

Leadership skills can be learned. Strong dentist-leaders attract and retain the best employees and realize top return on their management investments. They have the competitive edge to create successful practices.

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