# Goal-Oriented Management

## The 3 Aspects of Reaching Realistic Goals

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Many orthodontic practices set yearly goals and some even reach them, but what about those that don't? Are their goals unrealistic or ill thought out or are they just hoped for or ignored once set? The purpose of this article is to show the essence of goal-oriented management—setting, monitoring and attaining realistic goals. 2005 goals are based on 2004 numbers plus your ability to improve those numbers in 2005. The numbers used here are based on many practices over many years. Some practices base their goals on net income and work backward, but that doesn't usually work. You must first determine what is realistic and then decide what changes must be made to improve, if possible.

**1) Setting goals:** Setting goals should not be based on what we wish would happen, only on what can realistically happen; I find that setting in order the seven interrelated goals below, helps.

**Collections/month:** 2005 collections are simply equal to 2004 production (charges) plus/minus 1% to 2%. A crucial factor is % Initial Payments (total of all IP, PIF and 1st insurance check amounts divided by *total* charges). If the percentage (ideally between 25% and 35%) increases or decreases, collections will increase or decrease accordingly.

**Expenses/month:** There are a dozen expense categories, but for a typical 55% overhead about 43% is due to: Staff-related expenses (26% +/– 10%), Occupancy (9% +/– 6%) and Clinical Supplies (8% +/– 4%). While a complete budget makes us more aware of expense anomalies, controlling the above expenses is usually adequate. Staffing is crucial and the following may help, based on full starts/day (FS/D) (total Full+Ph-II starts per month divided by full Tx days per month). Per 1.00 FS/D you should have: 2.4 +/– 0.6 Clinical Staff and 1.9 +/– 0.6 Clerical Staff, totaling 4.3 +/– 1.2 total staff—thus, a 0.75 FS/D practice should have 3.2 +/– 0.9 team members and a 1.50 FS/D practice should have 6.4 +/– 1.4 team members. The percent *fixed* occupancy expense can be decrease with increased production, but the *variable* clinical supplies expenses can only be decreased with frugal purchasing. If using Invisalign, lab expense will be a significant expense factor.

**Tx Days/month:** Patients are typically treated in about 15 full (<5 hours is a ½ day) Tx-days/month averaging about 7.5-hours/day. Increases or decreases in days or hours will correspondingly increase or decrease production.

**Exams/month:** *New patient* exams are the life's-blood of a practice and minor to aggressive marketing can increase exams by 10% to 30%. Improved *internal* marketing programs (providing a *service* beyond what the patient expects) are best, since it also affects how effectively you produce treatment. *Dentist* marketing is effective as long as it is based on your team and the dentist's team working together for the patient. Other marketing such as ads, mailouts, etc., are also very effective, but starts from these exams are less fruitful. Bottom line, your exams won't increase unless you do something about it and do it well!

**Conversion Rates:** Increased exams won't increase production unless they start. An Exam conversion rate (total starts minus Ph-II starts divided by total exams) goal of 75% is realistic, but is highly affected by your OBS-recall conversion rate (all starts from OBS-recall divided by new exam patients placed on OBS-recall), which should be at least 65%—control your OBS-recall to increase your starts/production. A Ph-II conversion rate (Ph-II starts divided by Ph-I starts) goal of 75% is realistic and a good source of *extra* production, but if you do many Ph-I starts (Avg = 15% +/– 15% of *total* starts) it is crucial to take control of your Ph-II starts.

**Production/month:** On the average, about 85% of production (*after* adjustments and courtesies) comes from Full+Ph-II start charges, 10% from Ph-I/Limited charges and about 5% from miscellaneous charges. A 2005 production goal is 2004 production plus growth; a growth of 15% +/– 10% is realistic as long as you can make the changes necessary (i.e., a 20% increase in exams and/or 10% increase in conversion rates and possibly increased work days when sufficient exams are available)—also, a 3% increase in fees translates to a 2-3% increase in production, depending on growth.

**Full Starts/month:** Full+Ph-II starts statistics are accurately obtained from treatment contract charges and not from clinical statistics. A 2005 monthly goal is the 2004 full starts/month (total 2004 Full+Ph-II starts divided by 12) times the percent increase in production—a 10% increase in production goal is a 10% increase in the full starts/month goal.

## 2) Monitoring Goals:

You *must* report on accurate statistics to determine whether you are reaching your goals—awareness is half the battle. I collect and report on many variables to provide my clients with monthly Budget and Super Reports, but you can take control with the following minimal statistics: production, collections, expenses, exams, full starts and days worked, although knowing the Exam, OBS-recall and PH-II conversion rates and %IP, helps—the more reported on, the more information to determine *why* you didn't meet your goals; it also helps to compare 2005 to 2004. Below is a minimal monthly report example for March 2005, along with other helpful monitoring statistics.

| **March 2005** (3rd month to date) | ***Year-to-Date* Goals** | **2005** Year-to-Date | **2004** Year-to-Date | **2005 – 2004** Yr-to-Date Diff. | ***Monthly* Goals** | **2005** This Month | **2004** This Month | **2005 – 2004** Mo. Difference |
|---|---|---|---|---|---|---|---|---|
| **Production** | ***$ 249,000*** | **$ 238,000** | $ 233,000 | **$ 5,000** | *$ 83,000* | $ 74,000 | $ 78,000 | ($4,000) |
| **Collections** | ***$ 225,000*** | **$ 233,000** | $ 218,000 | **$ 15,000** | *$ 75,000* | $ 72,000 | $ 77,000 | ($ 5,000) |
| **Expenses** | ***$ 126,000*** | **$ 122,000** | $120,000 | **$ 2,000** | *$42,000* | $ 48,000 | $ 46,000 | $ 2,000 |
| **New-Pt. Exams** | ***66*** | **73** | 68 | **5** | *22* | 20 | 20 | 0 |
| **Full (+Ph-II) Starts** | ***45*** | **43** | 41 | **2** | *15* | 12 | 13 | (1) |
| **Tx Days Worked** | ***45*** | **45** | 44 | **1** | *15* | 15 | 16 | (1) |
| **Exam conversion** | *75%* | 74% | 71% | 3% | *75%* | 71% | 73% | (2%) |
| **OBS-recall conver.** | *65%* | 44% | 31% | 13% | *65%* | 32% | 28% | 4% |
| **Ph-II conversion** | *75%* | 54% | 46% | 8% | *75%* | 45% | 42% | 3% |
| **% Initial Payment** | *25% to 35%* | 30% | 28% | 2% | *25% to 35%* | 25% | 26% | (1%) |

## 3) Attaining Goals:

Your monthly reports indicate whether you attained your *Year-to-Date* monthly goals: just compare what you did with your goals. Don't worry about the first few month of the year *unless they are less than last year*—to meet your goals you have to do better than last year. Now comes the hard part, you have to actually do something to improve if a goal is not met. The basis of goal attainment is your exams and conversion rates; if these goals are not met your production goals won't be met. If your production and %IP goals are not met your collections goal won't be met; increase your initial payments if too low. When your exam goal isn't being met, improve your marketing programs; if your exam conversion rate is low improve your selling techniques and TC procedures; if OBS-recall conversions are low, apply more OBS-recall patient control. Whatever you do, do something!

**In conclusion:** practice growth and profitability is not a given, it is pro-active. Set realistic goals, accurately monitor and report on them, and take action to make changes to meet goals yet unmet.