REED'S INTERNATIONAL LETTER

2999 North 44th Street ❖ Suite 650 ❖ Phoenix ❖ Arizona ❖ 85018 ❖ 602/952-1200

In the paradigm shift dentistry is experiencing, our team has decided to file with the SEC to initiate a public company for practice management in dentistry. The activities of my professional practice, lecturing, seminars and the pentathlon event we call "Pentegra," an international affiliation, are included in this new project as a most logical next step. Thence cometh Pentegra Dental Group, Inc. . . . PDGI.

Pipeline

Seventy-seven doctors from 18 states are the founders of this new corporate project.

PDGI is continuing the focus of strategic planning in two very critical factors of dental practice . . . the team and the monitoring of practice function.

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The Pentegra, Ltd. team has provided a financial planner, an accountant, an on-site team person, a dental team (in house: dentist, administrative, chair side, expanded functions hygienist), a person with extensive business training and computer experience, a legal secretary, a scheduler/facilitator, a business administrator and three persons who administer the Napili seminar system.

Team . . . As "counsel to" Pentegra members, our original onsite is the primary tool to acquaint our team with the member's team.

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That process weakens over time because the players in this game change, no longer sharing the initial experience and reason why this process started.

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As a *change agent,* I have observed the increasing degree of change that takes place as I am in contact with the dental marketplace; the first level, is the lecture series, next the Napili seminars and then the Pentegra involvement.

It is not surprising, with an increase in time, commitment, intensity and dollars, that the degree and frequency of change increases positively.

To me, the birth of Pentegra Dental Group Inc. is the logical *next step* for dentistry.

I believe that the necessary faith and trust involved with the PDGI partnership model will again accelerate the intensity of change and shorten its time line. The tactics that reflect our philosophy, vision and mission, strategy and structure are going forward in a uniquely created corporate design.

Sometimes, the participating members' attitude toward governance of change has **not** been implemented nor the rewards for these changes realized because the "testicular fortitude" to take the necessary leap of faith has not been chosen. The much-discussed growth and learning change that we know about, but have not implemented, remains solely in the hands of each of us in our professional corporations.

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I believe, since the direct reward from the applications of credible tactics are now more apparent (measurable and of individual benefit), the *"why is to know not to do"* question will be answered by positive action in a win/win formula that is fun, profitable, and has honesty and integrity at its heart and will do good for mankind over time.

For those of us new members/owners (indeed, founders) of a public company, we will now be monitored by the computer-linked infrastructure on a daily basis with the option of having our collected receivables *"gathered"* nightly into an interest-bearing account for our benefit.

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The value of a dental business is a paper entity, of no value to its owner other than to be listed on a net worth statement, a non-liquid asset. The sale of the

practice "on the street" ranges from 50-70% of gross, depending on one of many formulas available, the availability of a buyer, and the buyer's perception of the value of the practice.

Usually, again on the street, the buyer, after a small percentage down payment, "borrows" from the seller the time/money necessary for the payoff. During the time of the pay out, the seller usually stays in the business to keep it together in case s/he has to take the security (the practice) back.

The productivity left in the business over time by the seller is traditionally enough for the buyer to use this "seller's" money to buy the business.

Also, there is often a tendency for the buyer to cap the productivity time of the seller at the chair to provide the buyer with the critical cash flow necessary to live his lifestyle while he uses the energy of the practice to pay the seller.

In many cases, even in offices where the seller is the parent of the buyer, this has created personal and financial challenges.

Now comes a new way to create a critical mass of "seed money" for mathematical progression . . . which is the most certain way to accrue economic independence. Pentegra Dental Group Inc. converts the paper worth of the business to liquid assets, 20% cash at capital gains and 80% stock.

The net tracking formula of valuating the sale price of the practice favors overhead containment. At 55% overhead the practice valuation, or purchase price, equals 100% last year's gross . . . much better than any street formula.

The professional, for the first time, has a currency called stock and a little-understood energy called "a multiple."

The stock market over the last 50 years has continued to go up, corrections included. So the multiple provided to this equation gives the professional a multiplier to his "exit" strategy.

The formula for participation includes the participating practice continuing with PDGI for five years at 65% of net production. The records and business will be placed in a new PC with the doctor and business being the only inclusion.

All practice, professional and business decisions remain in the hands of the dentist.

At the end of a five-year agreement, my survey shows that most doctors will renew. Those choosing not to renew, although they have sold their practice and been paid in full at the front end, may now sell the PC to a replacement dentist. The replacement doctor will buy an "income stream" at 65% of net for a small fee compared to its business power . . . a win/win never previously available in the profession.

The 65% of net is far more powerful than the traditional associate monetary formulas, and with the encouragement of PDGI stock options provided by the seller over time, the new doctor in 20 years will be in a similar economic position as the selling doctor.

There is a fail-safe check list for all personal relationships and business transactions; the five points are that it must be fun, profitable, win/win, have honesty and integrity at its heart . . . and do good for humankind over time.

On careful scrutiny, the PDGI does just that.

PDGI will grow its value by new practice affiliations and with internal growth. Napili/Pentegra and Reed DDS, PC are inside PDGI as a sustainable competitive advantage. Internal growth, as experienced in the past years, is now offered and implemented only with the doctor and practice partnering in PDGI.

My lecture series, (90 days/year the last five years) Napili seminars (12 three-day workshops each of the last five years), and the Pentegra consultancy will no longer be offered to the general dental public, but continue only for the partners in PDGI.

A study of the five or six corporate "roll-ups" in the marketplace preceding PDGI, all managed care of one sort or another, shows remarkable benefits to their participants.

We have learned from our *predecessors* and retained our private, personal care vision.

This proven per capita profit exceeds managed care. PDGI has dentistry's first data-based quality assurance program. This QA is the platform from which PDGI participants can speak with statistical significance and honesty about their uniqueness in quality, efficacy and service (consumer satisfaction) in the marketplace.

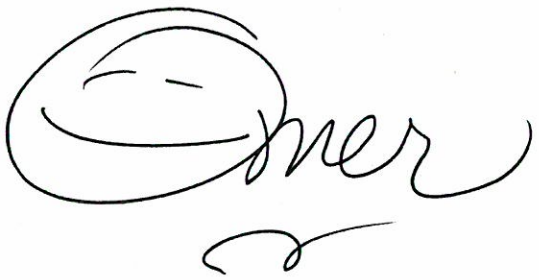
PDGI has practices in Canada, UK, Australia, New Zealand and South Africa, who are interested in this project, forming a global village dental service organization, with the person in the dental chair being our first concern, owned by dentists, governed by a Board of Directors, the majority by constitution are participating dentists, that I chair.

We are undergirded by an Executive Leadership Team (ELT) that have demonstrated their skill in dealing with Madison Avenue and Wall Street . . . as we in dentistry could not. We have in place a CEO, CFO, COO, Chief Acquisitions Officer and Chief of Dental Operations and in-house counsel.

This is a powerful marriage for growth and development. Most corporates on the street are "upside down," i.e., they are owned and operated by management with subservient dentists and last and least is the concern for the person in the chair . . . that's not our style. We have inverted this pyramid.

So we of PDGI are unique . . . on time and on target.

If you are not one of the founding corporate partners, I invite you to please personally respond to my invitation to study this new lifestyle and to seriously consider joining me in this new exciting adventure.



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"Let the games begin. . ." How appropriate with the current Olympic Winter Games in Nagano being our major focus on the television these days. . . well, next to the Teflon Man we have running our show here in this country.

Games People Play

It all began for me 30 years ago when psychiatrist Eric Berne uncovered this "game" behavior and his best selling book (still available in bookstores), *Games People Play*, explains that people play games to get attention, fill up time, if intimacy or productivity is not available, even stirring up negative attention (anger, outrage and hurt) which they find more gratifying that being ignored, being bored, being useless.

Games are emotionally rousing. Each one is a little drama that provides the opportunity to play roles. They enable us to interact with others without making ourselves as anxious or as vulnerable as we would be if we revealed our true selves.

Dr. Ken Olson often talked about this is. It's not good or bad, it's just the way things are. These games are also comfortably familiar because we have probably been playing the same games since childhood.

When adults want attention, they behave in ways they know will produce the desired reaction from others. When such behavior goes too far, the desired result is often not just the attention, but also manipulation.

When people repeatedly manipulate others through set patterns of behavior, they either meet continuing vulnerability with a game partner or are eventually met with resistance or other negative reactions in the equation. Psychologists refer to these behavioral patterns as games people play to get what they want.

Not good or bad, just the way it is.

Not infrequently seen in children, teenagers and, we forget, in adults as well. Such games are frequently not purposeful, they become part of the individual. Much like any other reflex, they become synaptically a part of who we are.

Once we understand the reason behind such behavior, we can take steps to avoid being trapped by our own vulnerability for playing games and in ourselves we can identify the games we play and modify our behavior.

I believe Berne's book to be required reading.

Another book, *Business Games. . . How to Recognize the Players and Deal with Them,* written by M. Groder, MD, Chapel Hill, North Carolina, who is a psychiatrist and business consultant, is available at Box 11401, Des Moines IA 50336. The text is $29.95 and is well worth it. Give it a try.

In dentistry, I've explored the important role that games play in the office where people use them to exercise power, deal with risk and manage inter-personal relationships.

I certainly feel that the "doctor/patient" relationship, a "game" we play, is sadly diminishing in medicine. (Note enclosed addenda.)

Games operate at cross-purposes on occasion. In the office, the pleasure of games often moves people to distract others from productivity and in some departments and even in entire companies, games can replace work altogether.

When games are used positively and become a part of work, then work becomes fun and the office gets to be a place where "Hot dog! I get to go. . ." when we get out of bed in the morning.

It's clear to me that spotting the games that others play and those that I play can be crucial to our social wellness, our mental health. . . and even our economic survival. Dr. Groder rattles out some of the games for us.

"See what you made me do." In this game, a person in the office who considers him/herself to be a manager, who has lost the motivation to succeed and is failing, frequently asks subordinates for suggestions on how to execute a project or solve a problem. When the suggestions fail to produce the desired results, or backfires, the managing type person blames the subordinate.

In the family when a parent or spouse becomes irritated by interrupted when performing a task such as cooking or balancing a checkbook, the parent or spouse blows up at the person who "made" him/her slip up. This game is played so the player can vindicate himself.

Feeling victimized puts the player in a morally superior position of power as opposed to having to recognize his/her own personal failure.

How do we stop such a game? Instead of falling into the trap, firmly refusing the provide suggestions unless you're empowered to act on them.

There's another game in Berne's text called "Now I've got you, you S.O.B." In fact, he calls it "NIGYYSOB." This is played by someone who seems to be engaged in meaningful activity but who's real aim is to trap others when they slip up.

In the office the player is often heard to proclaim that no one does anything right around here. In relationships that can lead to physical abuse, why is this game played? It allows the player's rage to be justified. The player can righteously vent his/her anger.

You can stop this game if you scrupulously contract with the player and perform your part. If you err, quickly take all the responsibility and contract for an immediate and acceptable correction. At the offset, make the rules and obligations explicit. . . who's responsible for what and by when . . . and strictly adhere to prior agreements.

This is the kind of contractual behavior we'd expect in an office any way, isn't it?

There's a game called "kick me" and in this game the player behaves in a way that others find obnoxious, irritating and arrogant. The negative response by others always arouses a hostile reaction by the player and is often followed by an injured wail of "why does this always happen to me?"

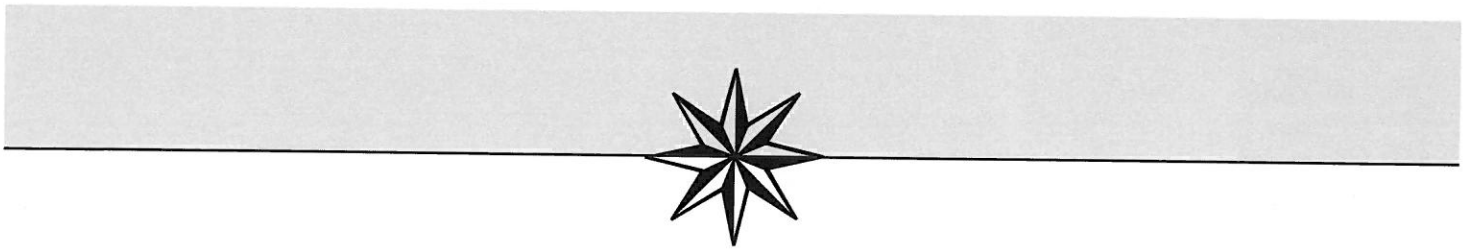
This player is like a person who walks into a room with a sign on his back that says "kick me."

Why does this game get played? The player enjoys watching others lose control while he remains calm. He enjoys being victimized while feeling superior.

You can stop this by not rising to the bait. Don't kick the player. Instead, point out the unnecessary provocation and indicate a willingness to work with him or don't work with him further at all.

There's a game called "I'm always late, but that's too bad for you." Persons who are constantly late for work, late for meetings, dinner dates, miss deadlines or take forever to return phone calls may be playing this game. They always do what they're supposed to do, but insist on being irritatingly late.

Why is the game played? The player is seeking control and resents being controlled by others. He may well deserve and may have earned the right of being at the "top of the pile." Yet, he is insecure and of low self-



esteem to the degree that he cannot risk receiving this position as deserved and so chooses to play this game. He takes the upper hand by determining the pace of his life, and yours, without open rebellion.

It can be stopped by being reasonable in assigning work loads and deadlines. Discuss the problem openly, make it clear why a promise is vital to the business and negotiate mutually acceptable limits. Hold the player to those limits. In some situations, flex time is the solution. . .or do not accept the invitations that create the game.

There's a game called "What do you think? Thanks, but I disagree." In this game the player complains about a problem, usually to a group of friends or a co-worker and fends off every suggestion that would resolve the issue; thereby explaining why it won't work. This game could go on indefinitely.

This game is played because it provides the player with reassurance. The player assumes the role of a child and his listeners are transformed into sage parents, giving him the benefit of their wisdom, and he can feel superior to his failed rescuers.

Remember that the player isn't looking for a real solution. React with sympathy, not advice. Offer suggestions such as "That's a difficult problem, what will you do about it?" Turn the tables.

If you must speak. . . ask questions.

I find that there are lots of positive applications to the above games with the person coming to you for dental care and certainly as you now listen to the person's primary complaint, you will have more insight.

Reflect on your personal experiences socially, familially and in the business world. It's likely that the next time you feel the energy of a raised voice, a sharp question, or an antithetical comment, you will smile inside, having sensed a game being played.

And now you have the opportunity to quietly identify the nature of the game. As Frankl would say. . . "You are not a victim as long as you have choices."

You now proceed to choose the desired outcome and proceed with your own game.

In light of all this "games that we play" opportunity, and I consider it to be exactly that, simply because I know you'll be referring to the two references I've included and will have a lot of fun with this, over time, please know that we can do more than we think we can and we're doing less than we think we are.

We must choose the games that produce the desired result.

What are we trying to do?

Are we getting the job done?

And, of course, the final question. . . does it produce the desired result?

I think there's a real shocker in that the people on the team actually think for themselves. Games and all.

Most of us are using only half of the collective brain power on the team and frankly, we don't seem to care. Recent studies show that we've created a critical thinking crisis in our organizations. Quin Spitzer, CEO and Chairman of the Princeton, New Jersey consulting firm, Kepner-Tregoe, conducted the study.

We must acknowledge that thinking is a core business and that quality thinking has to occur. . . and be shared throughout the team.

My last reference of the day is Spitzer's book (co-authored and titled, *Heads, You Win! How the best companies think.*) It's a Simon-Schuster publication for $23. Worth every dime of it.

It says that the best teams recognize the four fundamental skills of business success. And don't kid yourself for a minute, these are games people play.

These four skills are being able to assess complex situations, solve problems, make decisions and anticipate potential opportunities and threats.

Critical thinking is necessary for all of these, notes Spitzer.

"To promote widespread critical thinking, you must first decide on a common process for tackling issues. . .a checklist (does that sound familiar to some?)."

Take decision-making: "The key," says Spitzer, "is to make one decision at a time. Break down the bigger issues. . . we want to implement a plan". . . into little decisions. Put the *who* before the *when* decisions or however you want to approach it.

You also have to identify your objectives before you start throwing around options. If you're trying to decide where to expand your market, for example, first lay out your wish list. (The cost of real estate, the high concentration of young families.)

Now, prioritize these objectives.

This thinking process, Spitzer says, is not really our natural response. "Our culture rewards people for quick action. We reinforce behaviors that are not conducive to critical thinking." As a person who is a leader, you need to be as concerned with the thinking behind the team member's recommendation as you are with its bottom line implication.

"Run through how s/he came to the decision" suggests Spitzer. "That's how you can build behaviors that are profitable."

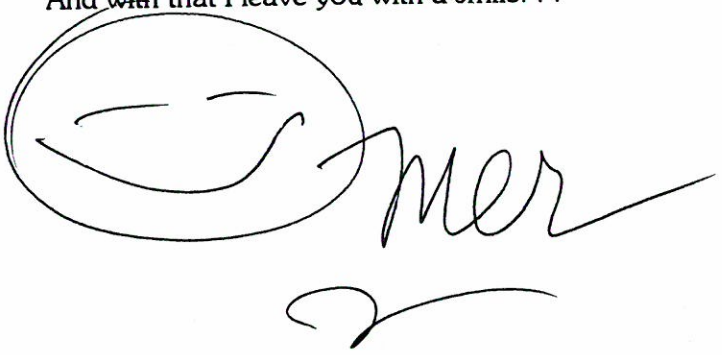
In regard to the games people play references in the first two texts, this one is a real winner. Look at it with great care.

Now, as a closing thought, let me share something with you that I believe to be critically important and *pregnant* to the entire operation. Oftentimes we get an emotional overload, in fact, isn't it true that the key words in life are "overload, overload, overload"?!

Friends, don't surrender leadership to the problem. Do you remember Hans Selye's concern about stress being necessary for life and his coining of the word *eustress* as being creative and *distress* as being destructive. Remember the three C's . . . commitment, control and challenge. They belong.

For those who care to, look at Isaiah 40:37. I think you'll find it critically important to this discussion.

And with that I leave you with a smile. . .



W. Scott Richardson, M.D.

Silent crisis plagues medicine

On any given day, most national newspapers will announce several crises in the world of medicine. Escalating costs, falling corporate competitiveness, malpractice, the uninsured, the AIDs epidemic, the rise of HMOs, the fall of HMOs are but a few. There is also a silent crisis in medicine, not discussed in public; an insidious force that threatens medicine in a very fundamental manner. Most physicians are aware of this crisis instinctively. Some have articulated its effects on them, others have ignored it. The architects of health policy seem to cheer this crisis on, while patients are, perhaps, the ones who are best beginning to understand its significance.

The silent crisis is the ripping apart of the doctor/patient relationship. The doctor/patient relationship derives from the basis compact that has existed from the time of Hippocrates. The doctor commits to care for the patient in exchange for a reasonable fee. This is a profound commitment that promises unlimited support in future unknown crisis. This includes support during illness as well as during death and dying. A recent National Public Radio special on dying concluded that one of the most important components in making a terminal illness meaningful, indeed positive, was a strong physician/patient relationship. With the advent of managed care, the compact between the doctor and patient has been replaced by two contracts:

1. The payor/client contract and
2. The payor/provider contract.

Not only is there now no doctor/patient contract, there is no doctor and no patient — only a provider and a client. The relationship between the payor and the doctor is even more treacherous. The payor agrees to pay the provider under a variety of complex rules, the bottom line of which encourages minimization of care in order to lower costs.

There are a variety of destructive forces inherent in this relationship. All of these forces reward the physician who ultimately delivers the cheapest care regardless of quality, and without regard for the doctor/patient relationship. In this new order, the physician's commitment to the patient is indirect, and really only promises community "standard of care," which is essentially a technical service.

Since there is no longer a true contract or a bond between the patient and the physician, the emotional commitment implicit in that relationship has disappeared. The physician is no longer judged according to the complex assortment of skills re-

quired in a doctor/patient relationship: compassion, ability to understand the patient as an individual, technical skills, fund of medical knowledge, and ability to synthesize family dynamics. His contract is no longer with the patient. The patient is, therefore, no longer the judge of his success. His judge now is his payor, whose primary interest is in the cost effectiveness of his economic performance, with lip service to superficial questionnaires as to quality.

The fact that the patient and the physician no longer have a contract between them has profound implications. For it is in the doctor/patient relationship that the true rewards of medicine are to be found. It is the source of satisfaction that keeps physicians interested in medicine and more importantly keeps young people entering medicine.

In the past, economic hard times, political turmoil, the malpractice crisis, have all been weathered because of one fundamental principle: no matter what the reward system, no matter what the hassles, medicine was always fundamentally, personally rewarding. It is for this reason that young people are still entering medicine in high numbers.

However, as the destruction of the doctor/patient relationship is fully appreciated, not only will there be an exodus of established physicians from the profession, but the younger generation will be forced to realize that medicine is no longer medicine, but a technical, bureaucratic position devoid of the personal rewards that have always characterized the field. The criteria for excellence are no longer skill at the bedside or in the operating room, and the judge is no longer the patient or community. Success is determined by cost reduction, and the judge is a businessman in a boardroom far away. When that lesson is fully appreciated, medical schools will see a radical change in their applicant pool.

Physicians currently practice medicine in multiple different structures. We are salaried, we are in managed care plans, we are in private practice, and we are competing against each other in a myriad of ways. To survive, we think we must accept the business paradigm, so we allow ourselves to be put in compromised positions. But it does not have to be so.

"Each of us has to apply pressure where we can so that, as the system evolves, there will be restoration of the basic compact between doctor and patient. If we do not, there will be no doctors in the future, only cost efficient technicians and entrepreneurs moving clients quickly through the system."

Physicians around the country are refusing to participate in managed care plans where the economic incentives impair the delivery of appropriate care. In some cases, physicians' anger is motivated solely by reimbursement considerations and is therefore a subject for marketplace discussions. But just as frequently, at least in our community, physicians are withdrawing for ethical reasons.

Outright rejection of the plans is not the only option. Many physicians are employed, many are in advisory positions where they can effect change from within. Indeed many executives are physicians who must, in quiet moments, see the flaw in the system.

Change can only come with pressure. Each of us has to apply pressure where we can so that, as the system evolves, there will be restoration of the basic compact between doctor and patient. If we do not, there will be no doctors in the future, only cost efficient technicians and entrepreneurs moving clients quickly through the system.

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The value of a dental business is a paper entity, of no value to its owner other than to be listed on a net worth statement, a non-liquid asset. The sale of the

practice "on the street" ranges from 50-70% of gross, depending on one of many formulas available, the availability of a buyer, and the buyer's perception of the value of the practice.

Usually, again on the street, the buyer, after a small percentage down payment, "borrows" from the seller the time/money necessary for the payoff. During the time of the pay out, the seller usually stays in the business to keep it together in case s/he has to take the security (the practice) back.

The productivity left in the business over time by the seller is traditionally enough for the buyer to use this "seller's" money to buy the business.

Also, there is often a tendency for the buyer to cap the productivity time of the seller at the chair to provide the buyer with the critical cash flow necessary to live his lifestyle while he uses the energy of the practice to pay the seller.

In many cases, even in offices where the seller is the parent of the buyer, this has created personal and financial challenges.

Now comes a new way to create a critical mass of "seed money" for mathematical progression . . . which is the most certain way to accrue economic independence. Pentegra Dental Group Inc. converts the paper worth of the business to liquid assets, 20% cash at capital gains and 80% stock.

The net tracking formula of valuating the sale price of the practice favors overhead containment. At 55% overhead the practice valuation, or purchase price, equals 100% last year's gross . . . much better than any street formula.

The professional, for the first time, has a currency called stock and a little-understood energy called "a multiple."

The stock market over the last 50 years has continued to go up, corrections included. So the multiple provided to this equation gives the professional a multiplier to his "exit" strategy.

The formula for participation includes the participating practice continuing with PDGI for five years at 65% of net production. The records and business will be placed in a new PC with the doctor and business being the only inclusion.

All practice, professional and business decisions remain in the hands of the dentist.

At the end of a five-year agreement, my survey shows that most doctors will renew. Those choosing not to renew, although they have sold their practice and been paid in full at the front end, may now sell the PC to a replacement dentist. The replacement doctor will buy an "income stream" at 65% of net for a small fee compared to its business power . . . a win/win never previously available in the profession.

The 65% of net is far more powerful than the traditional associate monetary formulas, and with the encouragement of PDGI stock options provided by the seller over time, the new doctor in 20 years will be in a similar economic position as the selling doctor.

There is a fail-safe check list for all personal relationships and business transactions; the five points are that it must be fun, profitable, win/win, have honesty and integrity at its heart . . . and do good for humankind over time.

On careful scrutiny, the PDGI does just that.

PDGI will grow its value by new practice affiliations and with internal growth. Napili/Pentegra and Reed DDS, PC are inside PDGI as a sustainable competitive advantage. Internal growth, as experienced in the past years, is now offered and implemented only with the doctor and practice partnering in PDGI.

My lecture series, (90 days/year the last five years) Napili seminars (12 three-day workshops each of the last five years), and the Pentegra consultancy will no longer be offered to the general dental public, but continue only for the partners in PDGI.

A study of the five or six corporate "roll-ups" in the marketplace preceding PDGI, all managed care of one sort or another, shows remarkable benefits to their participants.

We have learned from our *predecessors* and retained our private, personal care vision.

This proven per capita profit exceeds managed care. PDGI has dentistry's first data-based quality assurance program. This QA is the platform from which PDGI participants can speak with statistical significance and honesty about their uniqueness in quality, efficacy and service (consumer satisfaction) in the marketplace.

PDGI has practices in Canada, UK, Australia, New Zealand and South Africa, who are interested in this project, forming a global village dental service organization, with the person in the dental chair being our first concern, owned by dentists, governed by a Board of Directors, the majority by constitution are participating dentists, that I chair.

We are undergirded by an Executive Leadership Team (ELT) that have demonstrated their skill in dealing with Madison Avenue and Wall Street . . . as we in dentistry could not. We have in place a CEO, CFO, COO, Chief Acquisitions Officer and Chief of Dental Operations and in-house counsel.

This is a powerful marriage for growth and development. Most corporates on the street are "upside down," i.e., they are owned and operated by management with subservient dentists and last and least is the concern for the person in the chair . . . that's not our style. We have inverted this pyramid.

So we of PDGI are unique . . . on time and on target.

If you are not one of the founding corporate partners, I invite you to please personally respond to my invitation to study this new lifestyle and to seriously consider joining me in this new exciting adventure.

REED'S INTERNATIONAL LETTER

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"Let the games begin. . ." How appropriate with the current Olympic Winter Games in Nagano being our major focus on the television these days. . . well, next to the Teflon Man we have running our show here in this country.

Games People Play

It all began for me 30 years ago when psychiatrist Eric Berne uncovered this "game" behavior and his best selling book (still available in bookstores), *Games People Play*, explains that people play games to get attention, fill up time, if intimacy or productivity is not available, even stirring up negative attention (anger, outrage and hurt) which they find more gratifying that being ignored, being bored, being useless.

Games are emotionally rousing. Each one is a little drama that provides the opportunity to play roles. They enable us to interact with others without making ourselves as anxious or as vulnerable as we would be if we revealed our true selves.

Dr. Ken Olson often talked about this is. It's not good or bad, it's just the way things are. These games are also comfortably familiar because we have probably been playing the same games since childhood.

When adults want attention, they behave in ways they know will produce the desired reaction from others. When such behavior goes too far, the desired result is often not just the attention, but also manipulation.

When people repeatedly manipulate others through set patterns of behavior, they either meet continuing vulnerability with a game partner or are eventually met with resistance or other negative reactions in the equation. Psychologists refer to these behavioral patterns as games people play to get what they want.

Not good or bad, just the way it is.

Not infrequently seen in children, teenagers and, we forget, in adults as well. Such games are frequently not purposeful, they become part of the individual. Much like any other reflex, they become synaptically a part of who we are.

Once we understand the reason behind such behavior, we can take steps to avoid being trapped by our own vulnerability for playing games and in ourselves we can identify the games we play and modify our behavior.

I believe Berne's book to be required reading.

Another book, *Business Games. . . How to Recognize the Players and Deal with Them,* written by M. Groder, MD, Chapel Hill, North Carolina, who is a psychiatrist and business consultant, is available at Box 11401, Des Moines IA 50336. The text is $29.95 and is well worth it. Give it a try.

In dentistry, I've explored the important role that games play in the office where people use them to exercise power, deal with risk and manage inter-personal relationships.

I certainly feel that the "doctor/patient" relationship, a "game" we play, is sadly diminishing in medicine. (Note enclosed addenda.)

Games operate at cross-purposes on occasion. In the office, the pleasure of games often moves people to distract others from productivity and in some departments and even in entire companies, games can replace work altogether.

When games are used positively and become a part of work, then work becomes fun and the office gets to be a place where "Hot dog! I get to go. . ." when we get out of bed in the morning.

It's clear to me that spotting the games that others play and those that I play can be crucial to our social wellness, our mental health. . . and even our economic survival. Dr. Groder rattles out some of the games for us.

"See what you made me do." In this game, a person in the office who considers him/herself to be a manager, who has lost the motivation to succeed and is failing, frequently asks subordinates for suggestions on how to execute a project or solve a problem. When the suggestions fail to produce the desired results, or backfires, the managing type person blames the subordinate.

In the family when a parent or spouse becomes irritated by interrupted when performing a task such as cooking or balancing a checkbook, the parent or spouse blows up at the person who "made" him/her slip up. This game is played so the player can vindicate himself.

Feeling victimized puts the player in a morally superior position of power as opposed to having to recognize his/her own personal failure.

How do we stop such a game? Instead of falling into the trap, firmly refusing the provide suggestions unless you're empowered to act on them.

There's another game in Berne's text called "Now I've got you, you S.O.B." In fact, he calls it "NIGYYSOB." This is played by someone who seems to be engaged in meaningful activity but who's real aim is to trap others when they slip up.

In the office the player is often heard to proclaim that no one does anything right around here. In relationships that can lead to physical abuse, why is this game played? It allows the player's rage to be justified. The player can righteously vent his/her anger.

You can stop this game if you scrupulously contract with the player and perform your part. If you err, quickly take all the responsibility and contract for an immediate and acceptable correction. At the offset, make the rules and obligations explicit. . . who's responsible for what and by when . . . and strictly adhere to prior agreements.

This is the kind of contractual behavior we'd expect in an office any way, isn't it?

There's a game called "kick me" and in this game the player behaves in a way that others find obnoxious, irritating and arrogant. The negative response by others always arouses a hostile reaction by the player and is often followed by an injured wail of "why does this always happen to me?"

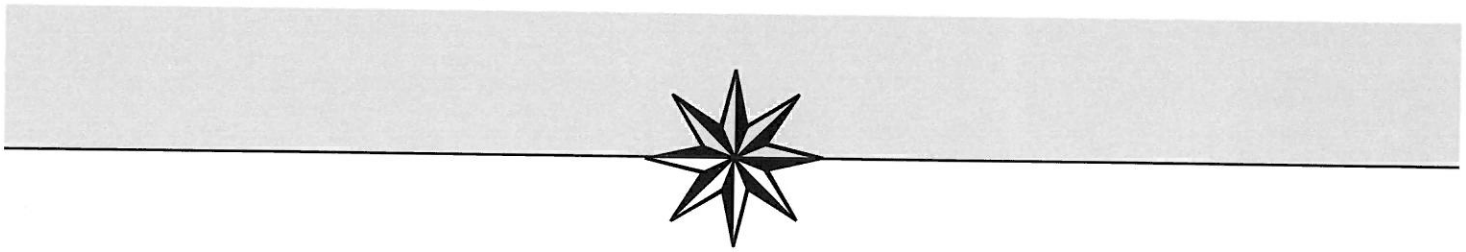
This player is like a person who walks into a room with a sign on his back that says "kick me."

Why does this game get played? The player enjoys watching others lose control while he remains calm. He enjoys being victimized while feeling superior.

You can stop this by not rising to the bait. Don't kick the player. Instead, point out the unnecessary provocation and indicate a willingness to work with him or don't work with him further at all.

There's a game called "I'm always late, but that's too bad for you." Persons who are constantly late for work, late for meetings, dinner dates, miss deadlines or take forever to return phone calls may be playing this game. They always do what they're supposed to do, but insist on being irritatingly late.

Why is the game played? The player is seeking control and resents being controlled by others. He may well deserve and may have earned the right of being at the "top of the pile." Yet, he is insecure and of low self-



esteem to the degree that he cannot risk receiving this position as deserved and so chooses to play this game. He takes the upper hand by determining the pace of his life, and yours, without open rebellion.

It can be stopped by being reasonable in assigning work loads and deadlines. Discuss the problem openly, make it clear why a promise is vital to the business and negotiate mutually acceptable limits. Hold the player to those limits. In some situations, flex time is the solution. . .or do not accept the invitations that create the game.

There's a game called "What do you think? Thanks, but I disagree." In this game the player complains about a problem, usually to a group of friends or a co-worker and fends off every suggestion that would resolve the issue; thereby explaining why it won't work. This game could go on indefinitely.

This game is played because it provides the player with reassurance. The player assumes the role of a child and his listeners are transformed into sage parents, giving him the benefit of their wisdom, and he can feel superior to his failed rescuers.

Remember that the player isn't looking for a real solution. React with sympathy, not advice. Offer suggestions such as "That's a difficult problem, what will you do about it?" Turn the tables.

If you must speak. . . ask questions.

I find that there are lots of positive applications to the above games with the person coming to you for dental care and certainly as you now listen to the person's primary complaint, you will have more insight.

Reflect on your personal experiences socially, familially and in the business world. It's likely that the next time you feel the energy of a raised voice, a sharp question, or an antithetical comment, you will smile inside, having sensed a game being played.

And now you have the opportunity to quietly identify the nature of the game. As Frankl would say. . . "You are not a victim as long as you have choices."

You now proceed to choose the desired outcome and proceed with your own game.

In light of all this "games that we play" opportunity, and I consider it to be exactly that, simply because I know you'll be referring to the two references I've included and will have a lot of fun with this, over time, please know that we can do more than we think we can and we're doing less than we think we are.

We must choose the games that produce the desired result.

What are we trying to do?

Are we getting the job done?

And, of course, the final question. . . does it produce the desired result?

I think there's a real shocker in that the people on the team actually think for themselves. Games and all.

Most of us are using only half of the collective brain power on the team and frankly, we don't seem to care. Recent studies show that we've created a critical thinking crisis in our organizations. Quin Spitzer, CEO and Chairman of the Princeton, New Jersey consulting firm, Kepner-Tregoe, conducted the study.

We must acknowledge that thinking is a core business and that quality thinking has to occur. . . and be shared throughout the team.

My last reference of the day is Spitzer's book (co-authored and titled, *Heads, You Win! How the best companies think.*) It's a Simon-Schuster publication for $23. Worth every dime of it.

It says that the best teams recognize the four fundamental skills of business success. And don't kid yourself for a minute, these are games people play.

These four skills are being able to assess complex situations, solve problems, make decisions and anticipate potential opportunities and threats.

Critical thinking is necessary for all of these, notes Spitzer.

"To promote widespread critical thinking, you must first decide on a common process for tackling issues. . .a checklist (does that sound familiar to some?)."

Take decision-making: "The key," says Spitzer, "is to make one decision at a time. Break down the bigger issues. . . we want to implement a plan". . . into little decisions. Put the *who* before the *when* decisions or however you want to approach it.

You also have to identify your objectives before you start throwing around options. If you're trying to decide where to expand your market, for example, first lay out your wish list. (The cost of real estate, the high concentration of young families.)

Now, prioritize these objectives.

This thinking process, Spitzer says, is not really our natural response. "Our culture rewards people for quick action. We reinforce behaviors that are not conducive to critical thinking." As a person who is a leader, you need to be as concerned with the thinking behind the team member's recommendation as you are with its bottom line implication.

"Run through how s/he came to the decision" suggests Spitzer. "That's how you can build behaviors that are profitable."

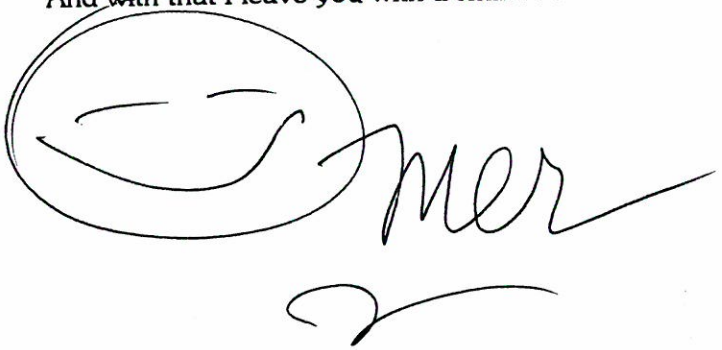
In regard to the games people play references in the first two texts, this one is a real winner. Look at it with great care.

Now, as a closing thought, let me share something with you that I believe to be critically important and *pregnant* to the entire operation. Oftentimes we get an emotional overload, in fact, isn't it true that the key words in life are "overload, overload, overload"?!

Friends, don't surrender leadership to the problem. Do you remember Hans Selye's concern about stress being necessary for life and his coining of the word *eustress* as being creative and *distress* as being destructive. Remember the three C's . . . commitment, control and challenge. They belong.

For those who care to, look at Isaiah 40:37. I think you'll find it critically important to this discussion.

And with that I leave you with a smile. . .



W. Scott Richardson, M.D.

Silent crisis plagues medicine

On any given day, most national newspapers will announce several crises in the world of medicine. Escalating costs, falling corporate competitiveness, malpractice, the uninsured, the AIDs epidemic, the rise of HMOs, the fall of HMOs are but a few. There is also a silent crisis in medicine, not discussed in public; an insidious force that threatens medicine in a very fundamental manner. Most physicians are aware of this crisis instinctively. Some have articulated its effects on them, others have ignored it. The architects of health policy seem to cheer this crisis on, while patients are, perhaps, the ones who are best beginning to understand its significance.

The silent crisis is the ripping apart of the doctor/patient relationship. The doctor/patient relationship derives from the basis compact that has existed from the time of Hippocrates. The doctor commits to care for the patient in exchange for a reasonable fee. This is a profound commitment that promises unlimited support in future unknown crisis. This includes support during illness as well as during death and dying. A recent National Public Radio special on dying concluded that one of the most important components in making a terminal illness meaningful, indeed positive, was a strong physician/patient relationship. With the advent of managed care, the compact between the doctor and patient has been replaced by two contracts:

1. The payor/client contract and

2. The payor/provider contract.

Not only is there now no doctor/patient contract, there is no doctor and no patient — only a provider and a client. The relationship between the payor and the doctor is even more treacherous. The payor agrees to pay the provider under a variety of complex rules, the bottom line of which encourages minimization of care in order to lower costs.

There are a variety of destructive forces inherent in this relationship. All of these forces reward the physician who ultimately delivers the cheapest care regardless of quality, and without regard for the doctor/patient relationship. In this new order, the physician's commitment to the patient is indirect, and really only promises community "standard of care," which is essentially a technical service.

Since there is no longer a true contract or a bond between the patient and the physician, the emotional commitment implicit in that relationship has disappeared. The physician is no longer judged according to the complex assortment of skills re-

quired in a doctor/patient relationship: compassion, ability to understand the patient as an individual, technical skills, fund of medical knowledge, and ability to synthesize family dynamics. His contract is no longer with the patient. The patient is, therefore, no longer the judge of his success. His judge now is his payor, whose primary interest is in the cost effectiveness of his economic performance, with lip service to superficial questionnaires as to quality.

The fact that the patient and the physician no longer have a contract between them has profound implications. For it is in the doctor/patient relationship that the true rewards of medicine are to be found. It is the source of satisfaction that keeps physicians interested in medicine and more importantly keeps young people entering medicine.

In the past, economic hard times, political turmoil, the malpractice crisis, have all been weathered because of one fundamental principle: no matter what the reward system, no matter what the hassles, medicine was always fundamentally, personally rewarding. It is for this reason that young people are still entering medicine in high numbers.

However, as the destruction of the doctor/patient relationship is fully appreciated, not only will there be an exodus of established physicians from the profession, but the younger generation will be forced to realize that medicine is no longer medicine, but a technical, bureaucratic position devoid of the personal rewards that have always characterized the field. The criteria for excellence are no longer skill at the bedside or in the operating room, and the judge is no longer the patient or community. Success is determined by cost reduction, and the judge is a businessman in a boardroom far away. When that lesson is fully appreciated, medical schools will see a radical change in their applicant pool.

Physicians currently practice medicine in multiple different structures. We are salaried, we are in managed care plans, we are in private practice, and we are competing against each other in a myriad of ways. To survive, we think we must accept the business paradigm, so we allow ourselves to be put in compromised positions. But it does not have to be so.

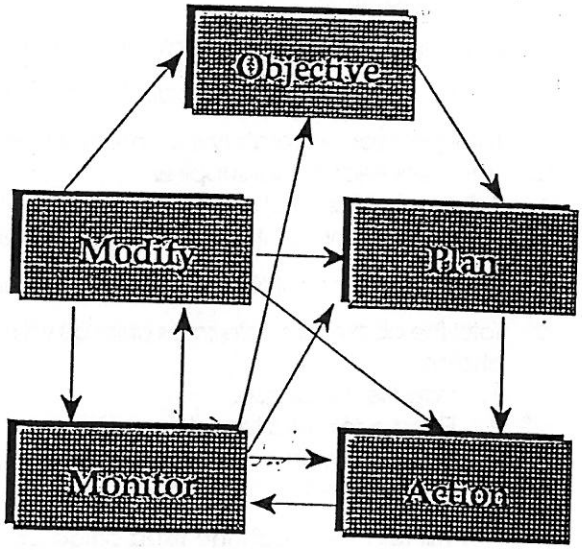
"Each of us has to apply pressure where we can so that, as the system evolves, there will be restoration of the basic compact between doctor and patient. If we do not, there will be no doctors in the future, only cost efficient technicians and entrepreneurs moving clients quickly through the system."

Physicians around the country are refusing to participate in managed care plans where the economic incentives impair the delivery of appropriate care. In some cases, physicians' anger is motivated solely by reimbursement considerations and is therefore a subject for marketplace discussions. But just as frequently, at least in our community, physicians are withdrawing for ethical reasons.

Outright rejection of the plans is not the only option. Many physicians are employed, many are in advisory positions where they can effect change from within. Indeed many executives are physicians who must, in quiet moments, see the flaw in the system.

Change can only come with pressure. Each of us has to apply pressure where we can so that, as the system evolves, there will be restoration of the basic compact between doctor and patient. If we do not, there will be no doctors in the future, only cost efficient technicians and entrepreneurs moving clients quickly through the system.

MONITOR



Basic information needed to begin to think of monitoring your practice as a business includes knowing last year's gross, cost, and net for your office; divide these three figures by the total hours scheduled by your team last year for the gross/hour, cost/hour, and net/hour.

Once this is established, last year's potential chair hours for your office are calculated by multiplying the number of operatories you have by the days and the hours per day available; i.e., 365 minus 52 Sundays, or 313 days time 12 hours/day, or a total of 3,756 hours; 3,756 times operatories equals PCH/year. (Potential Chair Hours.)

Subtract last year's actual chair hours scheduled to determine the "church/pew" syndrome of your office, i.e., unused chair hours. (Convert to percentage figure). Divide last year's gross by the potential chair hours you have available to determine the "wind chill" factor called potential chair gross/hour last year . . . *humbling!*

The real punch line comes for dentistry when we insist that the net figure has the Return on Invested Capital (ROIC) subtracted before the figure is divided by the doctor's hours worked; to determine the doctor's true dollar/hour pay before taxes — a figure far below the number necessary to amortize the investment made.

Is the doctor at risk and/or does he have invested $200,000 - $300,000 - $400,000? Is it reasonable to expect 10% minimum or at a high risk/high return then 20% ROIC on this amount? Twenty percent on $400,000 invested would be $80,000. Subtract $80,000 from the net before dividing it by the hours worked — per hour before taxes — to see doctor's actual salary — frightening for some.

Question: Does the room in which the dental assistant provides auxiliary delegated services for your clients generate enough gross charges to the person cared for to cover the calculated costs (fixed or variable) and generate a true profit, or by stop watch and actual measure is the procedure of delegation in the red?

Cost Analysis:

1. a. Determine total expense for period of time being evaluated (one year) (month, week, day, hour).
   b. Subtract all salaries.
   c. Subtract laboratory and dental supplies expense (variable cost).
   d. Divide this adjusted expense by the number of months being evaluated (12).
   e. Divide this average monthly fixed overhead cost by the number of operatories (even if unequipped). Divide this figure by number of weeks worked, days or hours worked per year, or weekly, daily or hourly.

   This will give the raw fixed overhead expense per room, per month (etc.)

2. a. Total administrative salaries (front desk).
   b. Divide the administrative total by number of operatories.
   c. Divide by 12 for monthly (number of weeks, days or hours).

   This will give the administrative salary cost per room.

3. a. Total invested capital in:
      1. Equipment.
      2. *Good* accounts receivable.
      3. Leasehold improvements.

   b. Compute interest on capital investment, amount you'd expect to have returned on your best investment.

1. Principaltimes current time interest rate times interval (the time interval in fraction of a year or one if for a whole year).

c. Divide the interest by the number of operatories, months, weeks, days or hours.

This will give the return on capital cost per room, per month (etc.)

4. a. Total prior year laboratory expenses for period of time being evaluated (variable costs)
   b. Total prior year dental supplies.
   c. Add and divide total number of operators being evaluated.
   d. Divide by 12 for months, weeks, days, hours, etc.

This will give the total variable office costs per month (etc.)

5. a. Total the above four categories and you will have your own dollar costs per operatory/time unit of your choice.
   1. Raw fixed expense.
   2. Fixed administrative salary costs.
   3. Fixed return on capital costs
   4. Variable costs

This will tell how much the fixed office costs per month before non-administrative salaries.

$$\text{Break-Even Point} = \frac{\text{Fixed Cost}}{\frac{\text{1.0 - Variable Cost}}{\text{Gross}}}$$

Per Chair Hour Cost Accounting - Dental Hygiene

1. a. Total salary for interval being evaluated. If hygienist has an assistant this salary would also be added.
   b. Divide the number of months in interval.

This gives the average monthly salary costs (weeks, days, hours)

2. a. Add: Cost of room per month and average monthly salary.

This gives the total cost of the hygiene program per month.

3. a. Divide the total cost by the number of hours for which the hygienist is paid.

This will give the cost per chair for use of dental hygienist.

Subtract this from total hygiene charges for department profit or loss.

Per Chair Hour Cost Accounting - Doctor

1. a. Total salaries for interval being evaluated, include:
      1. Doctor, total dollars taken from practice.
      2. Assistant(s)
   b. Divide by number of months in interval (weeks, days, hours)

This will give the average monthly salary.

2. a. Add: cost of room per month and average monthly salary.

This will give the average cost of the dentist per month.

3. A. Divide the total of cost by the number of hours the doctor works.

This will give the cost per chair time per hour for use of doctor.

Assets: Any owned properties or rights having money value to their owner or which are available for the payment of obligations.

Balance Sheet: A balance sheet is a statement of the financial position of a company on a given date. The balance sheet presents, in dollar amounts, three classes of information: assets (what the company owns), liabilities (what the company owes to outsiders), and stockholders' equity (the capital of the owners).

Assets: Assets are listed on the left-hand side of the report, and liabilities and stockholders' equity is listed on the right-hand side of the report. The total of each side equals the other; i.e., the sides are "in balance."

Earnings: The net profit after taxes for the period.

Income: Revenue less costs and expenses. Net income is the same as earnings.

Invested Capital: The money supplied to run a business. These monies come from ownership (equity) and formal (interest bearing) debt.

The average invested capital is the arithmetic average of the beginning and ending balances of the capital accounts for a specific period.

Liability: Any claim against the company or an obligation of the company. Examples are accounts payable, salaries and wages payable, accrued taxes, bonds, and bank loans. Of these, the latter two are forms of formal debt since they are interest bearing.

Net Worth: The total value of the equity (ownership) in the business represented by the sum of capital stock and surplus accounts.

Profit and Loss (Income Statement): A financial summary of the operating activities of a company during an accounting period. It encompasses all of the revenue and all of the expense, and the resulting net income or loss of the company for the period. It is sometimes called an earnings report.

Profit Rate: The earnings (net profit after taxes) divided by the sales for the period.

Return on Invested Capital (ROIC): The ratio of annualized earnings generated in a business to the average invested capital used by the business.

Revenue: All receipts of the business. Examples are receipts from sales of products or services (generally called sales) and interest from investments or rents from properties.

Sales Forecast: A statement of expected future levels of business expressed both in units and dollars.

When planning either an ongoing business or a new business venture, this forecast is key to planning the nature and amount of capital, material, and human resources; i.e., the capacity of the plans to produce the product.

Turnover: Annualized sales divided by average invested capital. One way to think of this term is sales in dollars that can be generated per dollar of capital used in the business.

Worker Productivity: This is the number of units of product produced per worker in regular time over a period of time.

What should an administrator administrate?

a. Short range views of managing sales, production, finance, engineering, or personnel; is only a means to an end.
b. Ultimate view, all dentists, as managers, have same common goals - *management of invested capital.*

What is invested capital?

a. Very simply, the money that people supply to run the business.
b. Nature of equity capital (ownership).
c. Nature of debt capital (loans.)

How is capital used?

a. To acquire (buy or lease) land and buildings.
b. To purchase tools and equipment.
c. To purchase raw materials.
d. To pay for labor and expenses.
e. To provide working capital.
f. In summary — to provide assets.

How is capital paid for?

a. By interest, on borrowed capital.
b. By earnings, on equity capital (paid as dividends or retained).
c. By total earnings on total capital.

How much should profits be?

a. Commensurate with *risk*.
b. For the average business, minimum of 10% after taxes on capital or 5% on sales.

How is profit on capital measured?

a. First determine profit:

Charges to patients	2000
Expenses	1800
Pretax Profit	200
Taxes	100
Net Profit	100

b. Next, determine invested capital

Equity Capital:	
Common Stock	400
Retained Earnings	600
Total Capital	1000

c. Earnings of 100 divided by capital of 1000 = 10% return on total capital

d. Can be expressed another way: $\frac{\text{Patient charges of 2000}}{\text{Total capital of 1000}}$ = Turnover of 2

$\frac{\text{Earnings of 100}}{\text{Patient charges of 2000}}$ = Profit rate of 5%

How can turnover be managed?

a. Any combination of patient charges and capital:

Patient Charges	divided by	Capital	=	Turnover
2000		1000		2

b. By increasing patient charges:

Patient Charges	divided by	Capital	=	Turnover
2000		1000		2.0
2500		1000		2.5

c. By reducing capital:

Patient Charges	divided by	Capital	=	Turnover
2000		1000		2.0
2000		800		2.5

How can profit on sales be managed?

a. Increase volume/unit time
b. Raise prices.
c. Reduce costs. Any one, or a combination of the three.

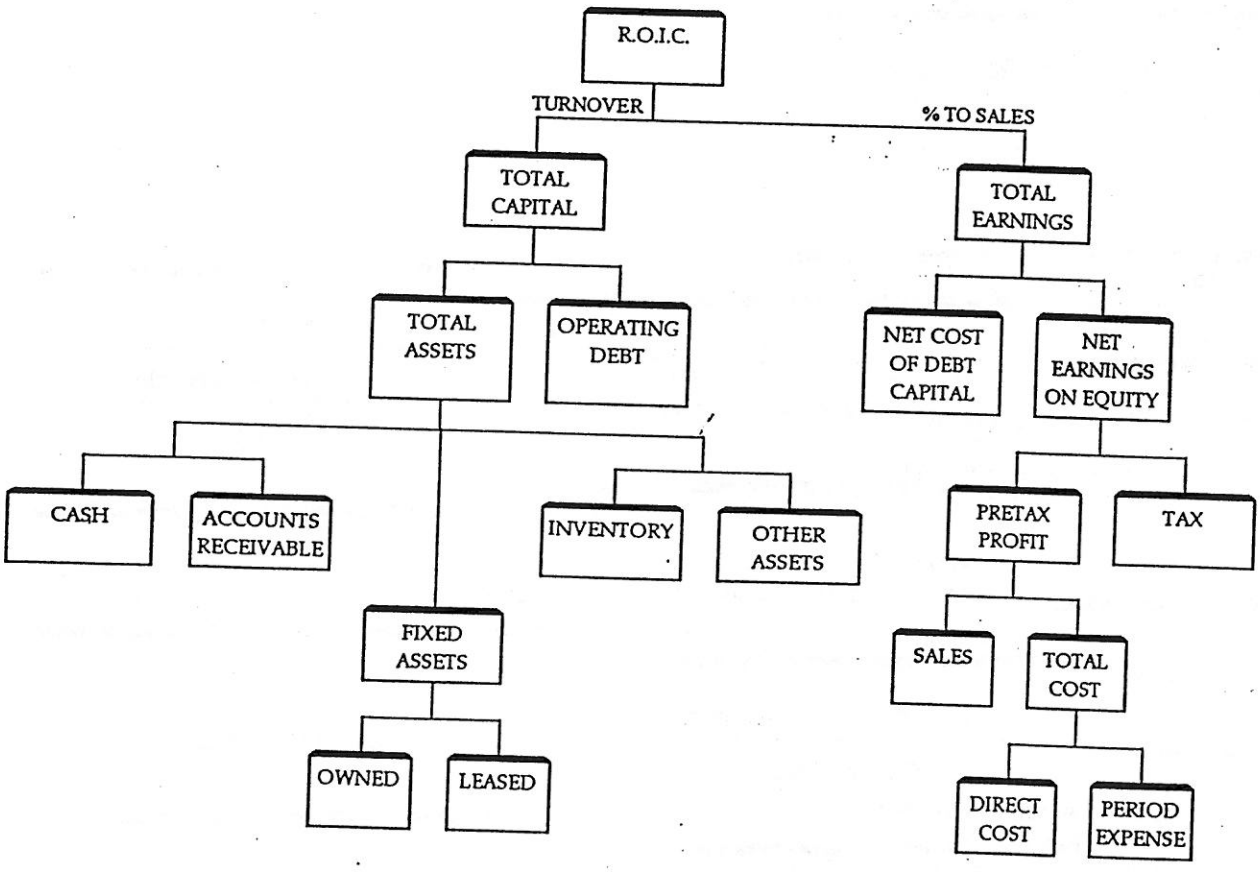
How does capital affect profit? Profit, capital?

a. Capital requires investment and earnings.
b. Earnings retained in the business increase the invested capital.
c. Higher capital requires higher earnings.
d. Earnings require more earnings.

What is the effect of a single decision in any segment of business?

a. No one action stands alone.
b. Effect spreads throughout business structure.
c. Action on capital effects profits.
d. Action on profits effects capital.

Financial Model for Managing Return on Invested Capital



Ratios used to determine liquidity of current assets & short-term paying ability.

1. Days' sales in receivables = $\dfrac{\text{Gross Receivables}}{\dfrac{\text{Net Sales*}}{365}}$

2. Accounts receivable turnover = $\dfrac{\text{Net Sales}}{\text{Average Gross Receivables}}$

3. Accounts receivable turnover in days = $\dfrac{\text{Average Gross Receivables}}{\dfrac{\text{Net Sales*}}{365}}$

4. Days' sales Inventory = $\dfrac{\text{Ending Inventory**}}{\dfrac{\text{Costs of Goods Sold}}{365}}$

5. Merchandise inventory turnover = $\dfrac{\text{Costs of Goods Sold}}{\text{Average Inventory**}}$

6. Inventory turnover in days = $\dfrac{\text{Average Inventory**}}{\dfrac{\text{Cost of Goods Sold}}{365}}$

7. Working capital — current assets — current liability

8. Current ratio = $\dfrac{\text{Current Assets}}{\text{Current Liabilities}}$

9. Acid test ratio = $\dfrac{\text{Current Assets - Inventory}}{\text{Current Liabilities}}$

$\dfrac{\text{Current Assets - Inventory - Receivables}}{\text{Current Liabilities}}$

10. Cash ratio = $\dfrac{\text{Cash + Marketable Securities}}{\text{Current Liabilities}}$

11. Pure cash ratio =

* Net sales figures can be improved by using net credit sales

** The inventory method (lower of cost or market, LIFO, etc.) will have direct bearing on the number and must be intelligently considered.

Ratios to determine long-term debt paying ability:

		Desired	Ratio
1. Times Interest Earned (Debt Service) =	$\frac{\text{Operating Income}}{\text{Interest Expense}}$	Higher	Better
2. Debt Ratio =	$\frac{\text{Total Liabilities}}{\text{Total Assets}}$	Lower	Better
3. Debt/Equity =	$\frac{\text{Total Liabilities}}{\text{Shareholder's Equity}}$	Lower	Better
4. Debt to Tangible Net Worth =	$\frac{\text{Total Liabilities}}{\text{Shareholder's Equity-Intangible Assets}}$	Lower	Better
5. Debt to Tangible Assets =	$\frac{\text{Debt}}{\text{Tangible Assets}}$	Lower	Better

In a study, ". . . Altman, Haldeman, and Marayanan used discriminate analysis to develop a model for predicting failure. The researchers studied a group of 53 failed companies and a matched group of non-failed companies for the period of 1969-1975. Combinations of 27 summary indicators were analyzed for predictive value. These indicators included six profitability ratios, seven coverage and similar ratios, four liquidity ratios, five capitalization ratios, three measures of earnings, variability, and two miscellaneous measures.

A group of seven variables was found to give the most reliable method for discriminating between failed and non-failed corporations. That method gave correct predictions for 90% of the sample one year prior to failure and 70% up to five years prior to failure. The seven variables were:

a. Overall profitability — earnings before interest and taxes to total assets.

b. Stability of earnings — measured by the variability of actual earnings around the stable trend.

c. Debt service — earnings before interest and taxes to total interest payments.

d. Cumulative self-financing capacity — cumulative retained earnings to total assets.

e. Liquidity — current assets to current liabilities.

f. Capital structure — equity to total capital.

g. Asset size — measured by the firm's total assets . . ."

Napili Business Projection (Desired Goals, etc.) Checklist

How much increase in net worth in the next 12 months _____%

How much increase gross production in the next 12 months _____%

Hold operating expenses under _____ % next 12 months.

Gross salary next 12 months _____ (before tax).

Profit-sharing next 12 months _____ ($) or (%) by whatever plan; i.e., tax free deferred.

Based on _____ working hours per year.
To recognize a gross $_____ per hour and a net $_____ per hour with a cost of $_____ per hour, based on $_____ per hour, per operatory, a monthly gross of $_____ per operatory, based on $_____ per operatory monthly net $_____ per operatory, per month.

Collection percentage improved from _____% to _____ % next 12 months. To have a _____ (number) of patient visits per month with a gross of $_____ per patient visit. (Calculate last 12 calendar months as current base, monitor weekly). Reduce broken appointment/cancellations by _____%. Reduce by _____% the number of lost patients over prior year.

To have _____ (number) of new patient visits next 12 months, monitored weekly. (Calculate last 12 calendar months as current base, monitor weekly.)

Savings program to accrue $_____ per month.

Improve assets and liabilities ratio by _____.

Reduce all outstanding non-constructive debt as soon as possible in order of highest priority. Prioritized on leaving constructive debt (that debt which measurably earns more than the debt costs.)

Establish emergency savings account of $5,000 cash.

Review insurance, particularly disability and million dollar umbrella liability policy as soon as possible.

Financial reporting system for monitoring, not less frequently than monthly, and must have a month-and year-to-date in dollars and percentages on that report.

Make conservative budget and live within it.

"Crunch" every other month.

REED'S INTERNATIONAL LETTER

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Quite a few of us are interested in the process of taking a look at what happens in business life to the accounting process. As is traditional, most of us talk in gross terms and the "bottom line" is usually on the bottom of the fourth page on the reports we get from our accountant. It seems that it would be appropriate if the bottom line, or the true net, were placed at the top of the first page.

The Bottom Line

Ownership expenses and rewards would be the next set of line items to be displayed. After all, for the capital invested, the risk taken and the care, skill and judgement delivered, what is our reward for owning the business? Isn't that the ultimate purpose of this "profit or loss" statement?

Further analysis would then be given to the personal net for the people on the team as they are the energy and the support that created the true net. The direct expense, facility and fixed expense would round out the analysis leading to the gross collections. And at the end of the report an analysis of the differences, (or discounts) would then show us how much more we worked than what we received in pay.

If forced to look through this window of the world, would not the entire project, then, be designed around supporting that net position rather than *fee minus cost equaling profit*?

Quite a few of us have a very accurate picture of our 1996 years, as it was used to great lengths with the Pentegra program. There is a strong need for us to seriously consider a program for 1998 that increases our net 40% over the 1996 net.

Unless we think about this in a way that's focused, it won't happen. So, since we become what we think about, let's think about it.

Going back through Pentegra records, I find that there are many areas where 10% has been achieved in the net as a result of a change made by one or more of the doctors (and the team) on continuum. So, let me review areas of focus to seriously consider as I strongly believe that a minimum of 40% net in 1998 over 1996 is not only essential but good stewardship.

1) The first 10%: Overhead containment that comes out of the economies of scale. Without question, the Pentegra group buying and the discounts that are available in hardware, software and expendable supplies can easily accrue to 10% net increase, so I'm anxious to get the IPO behind us and start on the project.

I know a number of Pentegra members on continuum, without the economy of group buying, who were able to achieve an increase in total net of 10% by the economy of scale purchasing, inventorying, bar-coding and tagging which created for them such a gain without strain within a calendar year.

At the very least, a careful review of inventory, supply, technique and usage would be the first area where net benefit is available. Review your vendor performance as well. Would you do better, cost-wise, at this time ordering more from one vendor? Is your vendor now offering assistance that you don't need or new services that would help you be more efficient?

2) The second 10%: Productivity scheduling. Scheduling against the last best average of our time, with stop-watch studies, can easily increase our productivity per unit time by 10% in any given calendar year. In fact, this is a small number for what

some have achieved. Check to see if you haven't allowed the work to expand into the time available. . .then, check again. This is truly an area that rewards through consistent monitoring.

Look, as well, at new procedures or techniques that you have adopted or learned over the course of the last year or so. Have you overcome the learning curve? Did you schedule conservatively for corrections that you no longer need to make? Monitor how interruptible you are while performing these new procedures as the absence of the focus required as a skill is developed may have allowed too many spurious activities.

3) The discipline of single chair scheduling (and a frontdeskless practice) at the best last rate of our productivity is wise to consider at this time. Are you really doing well, efficiency and cost/fee wise in multiple chairs? Do you know your "real time" chair cost? Quality assurance must be associated with our practice, too. Because we are here to do the very best we can, the Mayo wellness protocol is the least of that which we must achieve. In accord with some of the suggestions that follow, are your standards, results, costs and fees better served by a careful delivery in a single chair at an appropriate fee?

4) Is the standard of care upgrade you set out to achieve fully in place? If we, post-emergency, invite people to become *members* of our practice and we adhere rigorously to a co-interview, co-discovery, co-diagnosis, co-treatment planning and co-discovery of a fair fee, with case presentation as our unconditional commitment, a 10% increase in the net has been done, so it's probably possible. ***Been there, done that*** . . . check again, good doctor! Remember?

5) The fifth one is case presentation and closing. We let a lot slip through without closing the sale and doing our case presentation properly. Check the technique and results of your presentations. Have a team member role play or listen in to mid-course correct slippage into the old *"If they know what I know they'll do what I tell them"* syndrome. This is poor stewardship and not in the best interest of the person coming for care . . . Need, Answer, Source, Time and Cost . . . don't forget it . . . and S.P.I.N. the tough ones. Ten percent is a minimum from this activity!

Look to see if you've been worn down by the crowd. Look at last year's treatment plans, acceptance and performance records. Are you presenting as careful and complete a plan as you did last year? Did all of them accept and perform? If not, why not? How will you go back and retrieve the "lost souls?" Can you improve to lose fewer of the new ones?

6) Ten percent in perio/hygiene is important, the retention of people in the dental practice is less than 50% in the United States. Shoot for 90%. Small businesses do better retaining their own people. It's less expensive and more productive to retain than to "buy" new market. Market penetration means going after the people who are in your records and a 10% increase in retention gives you a 30% net equivalent. So, let's go for it.

Hygiene is usually 10% of gross, 15% at most. Let's make 35% the minimum and you'll see that 10% drop to the bottom line immediately. Check your healthy hygiene capacity against actual performance. If each of the persons coming for care (on average) were healthy and saw you four times a year to stay that way, at your standard hygiene maintenance fee (is that a cost plus profit fee?), what would your hygiene revenue be?

If this calculation is more than you did in hygiene last year, you know you have plenty of work to do. If this calculation is the same as last year's hygiene revenue, check to see if they're all healthy, or if they're all staying that way. Rarely do we fully appreciate or perform against the available hygiene treatment plans. While you're looking . . . if they're all healthy, why don't they refer? To what other treatment plan are they ready to graduate? What are you willing to do to acquire this newly discovered revenue and net?

7) A cost-related fee structure must be the baseline against which you design cases to be presented. Getting rid of the piecework fee schedule, which is very subjective, and going to the true cost in real time. . . add to that the profit that you believe you deserve. Let's stick to it, and be unconditionally committed to that process.

Remember, this works in conjunction with "feed forward" scheduling. Kelly calls it "daymation". . . ensuring that each day tight compartment in your next calendar year is packed right and water tight. I call it decimation. Regardless of the periods (weeks, months, 1/10th of a year, or quarters) look to ensure that the cost and fee correct treatments are in place to achieve your economic goals and objectives.

If the next segment has a day that doesn't honor the cost associated with having the office open, fix it now. Move events from subsequent days forward to close out the segment. Once a day hits target, seal it off and do not allow emergency or poorly planned dentistry to leak in and spoil the mix. Remember, too, this creates the free time to be fresh and focused on the days you do work.

8) Practice Purification and Referral. Ten percent at the bottom line is a small addition for getting the lower third of your practice out of the red. (One-third of what you do has less fee/hour than your total cost/hour. Check and see if you doubt it.), dismiss them. Increased market penetration will occur (accepted presentation) when the top third that has been carrying the lower third deficit can be priced more affordably.

As you sort, recall the ones, by profile, with which you have the most success and actively create and follow a program of attracting more "like kind" referrals to the practice. It is simple and important to remember to ask those who come for care for referrals.

9) And now, manage by attrition. . .team enhancement and utility. . .a care pair function with a frontdeskless practice and proper use of the computer will very easily accrue to fewer people being necessary for the productivity that we currently have or indeed the same people with an increase in productivity brought about by the care pair function and single chair scheduling.

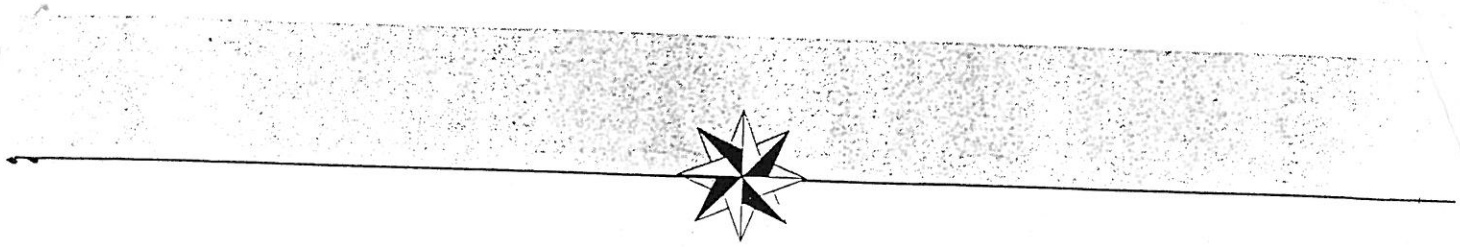
Review the tasks being done day-to-day. Are they necessary? Are they congruent with your standards? Would some team time be available for purification, marketing, recare and for those valuable chores if we had less paperwork, less *busyness*? If a team person leaves, is it necessary to replace that person to get the job done? We've discovered, on some teams, that this process garners fantastic results . . . meaningless tasks discarded, existing team and tasks enhanced . . . greater satisfaction and greater results all around.

10) Insurance purification. Take a look at the added overhead created by the insurance process. Yes, insurance may be like gravity in your neck of the woods! If you believe it is. . . it probably is!

Even so, look at the firms and the insurance policies that are particularly ineffective in your practice. If an insurance company or policy is traditionally a 90-day-plus wait, constantly avoiding payment by asking for additional overhead-producing documentation, letters, X-rays, etc., consider discontinuing the acceptance of that plan, or at the very least dropping any assignment or co-pay relationship and agreeing to send in the form after payment has been made.

If another group rarely performs a treatment plan or perio/hygiene recommendation, and is constantly your "emergency of the hour," consider a change in that relationship, especially if it assists the bottom third of the practice to vacate.

Streamline the "pre-estimate" (only you and the patient can truly authorize work) system for only those firms or groups where appropriate treatment plans can be carried out in cooperation with the policy. Encourage patients to continue with necessary



treatment beyond what the insurance company will co-pay.

Remember as you look at the process (overhead, stress, and esteem involved in being driven by the insurance process) that the benefits for dental insurance have been about $1,000/year for the last 30 years. That is zero percent growth. Remember that the premiums and your overhead march on at inflationary rates at a minimum. To whom to we owe what?

11) Personal assurance and esteem issues, although perhaps in order of importance, should be considered the primary boosters of productivity, clear thinking and net increase. Take a moment to take stock in where you stand. What is your net worth, is your estate in tact, are you properly insured, is your money working as hard for you as you did for it? Are you building the nest egg necessary for economic independence? Is your life in order? Do you exercise, vacation, spend time with family and hobby as much as you'd like?

It is remarkable that this can be one of the most accelerating factors at work in the membership and among those who have participated in Napili.. Take the time to rework the Napili Three/four workbook, get your financial planner, your professional and lay advisory boards together to review and re-organize.

You'll be amazed at the "juice" you'll have in the practice when you know the rest of your world is in order. Simply, the extra time and "head space" available from not having to worry about personal matters at work will be *manna*.

Faith, trust and courage are the primary factors that get us where we need to go. (Re: Joel Barker of *Paradigm* and *Vision* fame.)

Let's monitor the decimated year so we can have *free time any time* instead of looking up at our overhead.

We must be certain that we don't give permanent reality to temporary concepts, events or things.

We must have a *passion*. . . a comprehensible necessity to life's journey. Passion is an undeniable force that "fills the cup."

In our time some people work for money, a leader, a cause. The weight of these three differs. A leader motivates more powerfully than money. A cause motivates more powerfully than a leader. And in Pentegra, the over arching purpose is our cause. . . private, personal, self-pay dental care. It really unites us.

We are a seamless team and now let's move forward with passion.

RSVP ad lib.