How do you recommend compensating a hygienist?

The simple answer is: pay them on commission. But of course this “simple answer” leads immediately to more questions. What is the percentage number? Is this a percentage of production or collection? Gross or net? What do you include? What do you exclude? If the office has a bonus plan, does the hygienist participate in addition to the commission based pay? And on, and on, and on.

So I’ll try to answer as many of those common questions as possible. First, let’s look at some hygiene basics. Ideally, hygiene department revenue should be one third of total practice revenue. I define “hygiene department revenue” as consisting of everything that gets done in the hygiene operatory. For example, I consider the doctor’s exam as hygiene department revenue. Keep in mind also that the 33% figure is for a typical general practice. Sometimes the percentage will be lower if the practice (doctors) are performing a lot of “big case” dentistry (cosmetics, implants, sedation, etc.).

Another factor to consider is that one third of the hygiene production should be from perio procedures (scaling and perio maintenance). No hygienist will ever reach a substantial daily goal doing only prophys (just like no doctor would ever reach a substantial daily goal doing only fillings). You must insist that there will be no “difficult cleanings” in your practice. This has to clearly defined so that the non-assertive hygienist is forced to confront the patient with the truth. An adult who supposedly needs an hour every 6 months should have the recare appointment interval shortened to 3 or 4 months. If the patient improves, then, and only then, do you return to 6 months. If not, then you do not clean; you start soft tissue management with education and multiple appointments to make the infection go away and help the patient own the problem.

In addition to a strong perio program, there are four other factors that are found consistently in practices with outstanding hygiene department production:

1. **Someone at the front desk is assigned to keep the hygienist(s) productively busy (the person’s primary responsibility)**. Someone must be held accountable for keeping the schedule full. Be sure you are on a 10 minute increment schedule (not 15). This alone will increase productivity by 20%. The person responsible for the hygiene schedule will be “engineering” the schedule for productivity and will work closely with the hygienist(s) to insure success.

2. **The doctor(s) must make checking hygiene an absolute priority (no waiting)**. This can be a major stumbling block to making hygiene commission based work well --- or fail.

3. **Each patient receives a customized appointment time based on individual needs. Everyone does not get one hour**. Very, very few adults should ever get an hour. Shortening adult recare appointments by just 10 minutes will create time in the schedule for at least one additional patient to be seen each day. Take the average income from one more patient seen each day in hygiene and multiply by 200 (4 days per week and 50 weeks per year). You’ll probably find that to be at least $25,000 extra per year --- per hygienist. Children should never be more than 30 minutes.

4. **Hygienists are paid 100% on commission**. When I look at a hygiene schedule from an office I’ve never been to, I can always determine whether or not the hygienists are being paid on commission or paid a salary. Hygienists paid on commission will schedule different length appointments for different types of procedures and patients. You’ll find that they actually care about whether or not the patient was reached reached on the confirmation call and will actually be upset if the patient doesn’t keep the appointment. Offices where the hygienists are paid on commission always have a lower cancellation/no show rate. You should also have the
hygienist(s) keep a graph to track and measure their performance versus their goal (the Hawthorne Effect --- what gets measured gets done).

Let’s tackle the pay issue. It is much simpler to pay the commission based on production. Of course, that is net production, after any discounts, write-offs, etc. The appropriate percentage is going to be 28-30%. I know a lot of practices go with 33%, but if the hygienist is participating in the overall office bonus (and they should), plus any other benefits (vacation, insurance, 401k, etc.) then paying this higher percentage will have a negative effect on the overhead. The best way to transition from hourly or daily pay to commission is to have a “trial period” where you track the production, calculate what the pay would be if based on the percentage, and then pay the hygienist the percentage or the hourly rate for the pay period, whichever is greater. This creates a “safety net” and assures the hygienist that her income will not suffer as a result of moving to commission. This trial period should be specified and will typically be 3 or 4 months. At the end of the trial period, the “safety net” is removed and the hygienist is paid strictly on commission. Once fully embraced, this system usually results in a revenue increase from your hygiene department of 20 to 30%.

What about discounted fees, especially advertised discounts designed to attract new patients? My answer to this has always been to pay the percentage based on the discounted fee. Most perio procedures will be diagnosed on new patients (as will most restorative dentistry, but that’s a whole different discussion). So what the hygienist might “give up” in the discounted fee, she should more than recoup in the larger fee perio procedures. What if you advertise the “$1 exam” to attract new patients? If the hygienist actually sees a patient for the $1 exam, she would get the agreed upon percentage of the $1. But this should be rare because the intent of the $1 exam is for the dental assistant to handle most of it. Free bleaching would earn the hygienist the agreed upon percentage of zero --- so zero. Again, the easiest way to think of this is that if it happens in the hygienist’s chair, she earns a percentage of it --- whatever the fee is. So yes, even x-rays and exams. If you have the right person and she is appropriately trained, she will actually be talking to the patient and writing down everything she learns and observes. The doctor, whether it is you or an associate, will spend very little time on the exam --- about 2 to 4 minutes. Since the hygienist is actually doing the bulk of the work, she should get paid for it. As I tell doctors all the time, I’ve never seen anyone get rich and retire early based on income earned from hygiene exams. You get rich and retire early from having patients who come to your office over and over for many, many years. It is this “lifetime value” that should always be the main focus of your thought processes. And if patients like the office and come routinely and follow the treatment plan presented and pay their bills and are happy, they will refer other people who will do the same. This pretty much defines a successful career in dentistry. If and when you do hire an associate, just explain to them that a hygienist who is really good will earn the exam fee, will develop a relationship of trust with the patient, and will sell a lot of restorative dentistry that the associate WILL get paid for.

If you have further questions about moving to commission based hygiene pay, just give me a call. The number is 214-762-3117. (MG)