

This is your practice on DHMO's

Any Questions?

Kathleen Johnson

The Problem with DHMO's

While the idea of dropping DHMO plans seems to be on the minds of many dentists throughout the country, and especially here in California, many offices are reluctant (seemingly unable) to actually drop plans. Based on a recent survey of its membership, the Association of Managed Care Dentists claimed that 73% of providers reported a drop or no increase in their personal income over the last 3 years; 58% reported that their personal income is down in spite of increased gross office revenues. It doesn't take a rocket scientist to discover that DHMO's (Dental Health Maintenance Organizations) could be at least partially responsible. Capitation rates and patient copayments are not sufficient to meet overhead and deliver a fair return for the dentist. Dental offices are addicted to DHMO's; consequently, patients as well as dental offices are hurting.

I began watching DHMO's back in 1982 and have seen the plans, which lurked on the outskirts of the market back then, wheedle into the system like drug dealers until dentists believed they could not survive without them, no matter how much income the plans gave away. A DHMO needs a provider panel before it can take a plan to an employer, so it lures dentists in with perks, such as subsidized lab fees and cap checks, then, in time, removes the perks, sending each office's overhead through the ceiling. What is equally disheartening is the discrepancies in the amount guaranteed to the dentists depending on the area in which they practice. Thanks to the internet, I have been able to communicate with dentists from various regions in the U.S.. I was concerned to find that one of the largest plans guaranteed \$120. per hour of chair time to a dentist in Northern CA, while dentists with the same plan in Southern CA received no guarantees. Let's face it, the DHMO's do not value their provider pan-

els, and the individual offices which make up these panels have to pay the costs—literally, since X-rays and prophylaxis are at \$0. copayments, and the copayment on root planings is extremely low.

The office environment suffers because of the reduced cash flow. Dentists and staff have to work in overdrive to see enough patients to barely stay afloat financially. Eventually, they start to feel that the kind of rushed treatment the DHMO's force them to give is ethically questionable. The schedule is stressed even further by the heavy volume of phone calls and conferencing that become necessary when the staff has to explain the copayment or optional treatment fee, first to the patient and then to the DHMO. Revenue is too low to offer either a bonus system or competitive wages, and, understandably, the moral of the entire office sinks. The atmosphere only becomes more negative and costly when the office inevitably begins to lose track of its fee-for-service patients in the face of all the added time and paperwork the DHMO patients involve.

Eventually, the additional stress brought by the DHMO plans reaches the patients as well. When the staff has to rush through treatment, an experience which is already frightening and confusing for many people only intensifies. Although the copayments and optimum treatment fees are so low as to create revenue problems for offices, many patients are misinformed and enter an office expecting to pay nothing. This kind of miscommunication leads patients to mistrust the dentists and staff members, especially when the DHMO questions the optimum treatment.

My desire in writing this article is to help dentists make sound business decisions like those I have encouraged my clients to make over the years. I have assisted my clients in dropping these preposterous plans and moving toward fee-

for-service practices. Since the relationship between a practice and a DHMO is like a drug addiction, such changes were neither implemented overnight nor without a clear plan for replacing the income. If offices in Southern CA can be successful without DHMO's, then I believe offices anywhere can.

A Step-by-step Proposal for Dropping DHMO's

1. Plan on terminating the relationship with the DHMO during open enrollment.

Know your numbers. Know the revenue generated as a result of the DHMO patient; this means: capitation check, copayments and optional treatment. Evaluate non-revenue production versus the income generated.

2. Evaluate patient retention.

Take the number of active FFS patients (patients seen within the last 12 months)—let's say the number of active FFS patients is 800.

The % of patients in a Periodontal Maintenance Program—40% or 320

The % of healthy patients on a 6 months continuing care—60% or 480 formula:

Periodontal Maintenance patient on a 4 mo. recall:

3 visits per year X 320 patients = 960 visits

Healthy patients on a 6 months recall:

2 visits per year X 480 patients = 960 visits

Total hygiene visits per year = 1920 visits

If the hygienist is seeing 9 patients per day, then you would divide 1920 patient visits by 9, and that means 213.33 hygiene days per year or 17.77 days per month are necessary to accommodate the active hygiene patients. If patients are not returning, then move on to the next step.

3. Send a letter to the Dental Health Maintenance Organization advising

continued page 33

are asking others to do. If you want people to be on time, the leader needs to be on time. If you ask your team to work hard, then the leader should be the first person to arrive in the morning and the last to leave at night. A leader who asks his or her team to work hard, but spends all day complaining about having to treat patients and expresses a continuing desire to get out of the office as soon as possible to play golf will not inspire others toward the hard work ethic. A leader who demands that staff members not steal but commits insurance fraud will eventually discover embezzlement in the practice. A leader who asks the team to treat patients well, but treats the team members and/or patients disrespectfully will not have a practice with excellent customer service.

One of the major responsibilities of leadership is to do what you say you will do and be who you say you are. Once you take on the role of leader, people will be looking to you at all times for guidance. At the same time, they are always evaluating the leader to see if he/she really believes what they've said. At times, this may mean that you must have complete self-control to maintain the consistency of the leadership message. One of the reasons that this can occasionally break down is that the

dentist is the owner of the practice and is not necessarily accountable to the team for his/her actions—at least in the short run. In the long run, your actions will very much determine the reaction of your team to you as a leader.

Summary

Leadership is more of an art than a science. However, it does follow a few basic principles that will help you increase the respect by your team and galvanize all staff members to work in the direction that you desire. It will also help certain team members to decide whether or not they belong in your practice. Any individual who will not commit to the vision and goals of the leader once they have been explained should probably find another environment. You want to surround yourself with people who are willing to buy into your goals and to help the entire practice achieve what the leader has set forth.

Leaders help others to be winners.

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continued from page 22

them that the practice needs to close down to new patients.

This allows time to work on a patient reactivation campaign, as well as an internal and external (if you choose) marketing plan while you are continuing to receive your capitation check and copayments. This will terminate the influx of new DHMO patients while the office is completes the next step.

4. Conduct a telephone patient reactivation campaign.

Every FFS patient who has slipped though the cracks and has not been in for over 6 months must be called. The person calling must be caring and demonstrate an attitude of concern. The patient needs to hear that they were missed and that the entire office would like to see them back on the schedule. If the patient has uncompleted treatment and it's been over six months do not attempt to schedule them for the treatment. They will be more likely to return for a hygiene visit first, since most patients like getting their teeth cleaned. Once they are back in the practice, talk to them about completing their recommended treatment plan. Caution: A letter campaign will not reactivate patients as quickly or as effectively as a telephone campaign.

5. Next, send a notice of termination letter. to the DHMO

Most plans will want at least 90 days notice. Read the contract. This means all treatment that was begun before the termination date must be completed. It is also the time to inform DHMO patients of the decision to terminate the office's relationship with their plan. At no time should any staff member speak poorly of the DHMO in front of the patients. Simply let them know that under their DHMO plan the office can no longer afford to continue to deliver the quality of care to which they have become accustomed. Let the patient know that you would like to keep them in your family of patients. Ask the patient if they have any other coverage options open to them during open enrollment. Let the patient know that the office's insurance expert will be happy to assist them with their choices.

6. Send a letter to DHMO patients who are not scheduled to return during this process.

This letter should include the same information that I discussed above.

7. If you are a provider for any PPO plans do not drop them during this time unless you are comfortable with the progress.

8. Your internal marketing program

should include a new patient follow up call.

Did the entire visit meet their expectations? Do they have any questions with regard to their proposed treatment recommendations, etc.?

Additional Guidelines and Results

In conclusion, to rid yourself of a DHMO and become a fee-for-service practice, you need to have both the desire and a solid plan, but you and the staff must be totally committed to a "patient centered practice" as well. The patient's initial impression of you and your staff is even more crucial to treatment acceptance when a DHMO is not in the picture. Fee for service patients can choose to go anywhere they please. Why should they choose your office? What makes your practice different? Everyone on the staff must not just know, but truly believe, their answers to these questions. There are nine stages to a patient visit, starting with the telephone. You need to choreograph the patient visit, and the entire staff must role-play. It is imperative that all patients are treated as guests in your home.

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