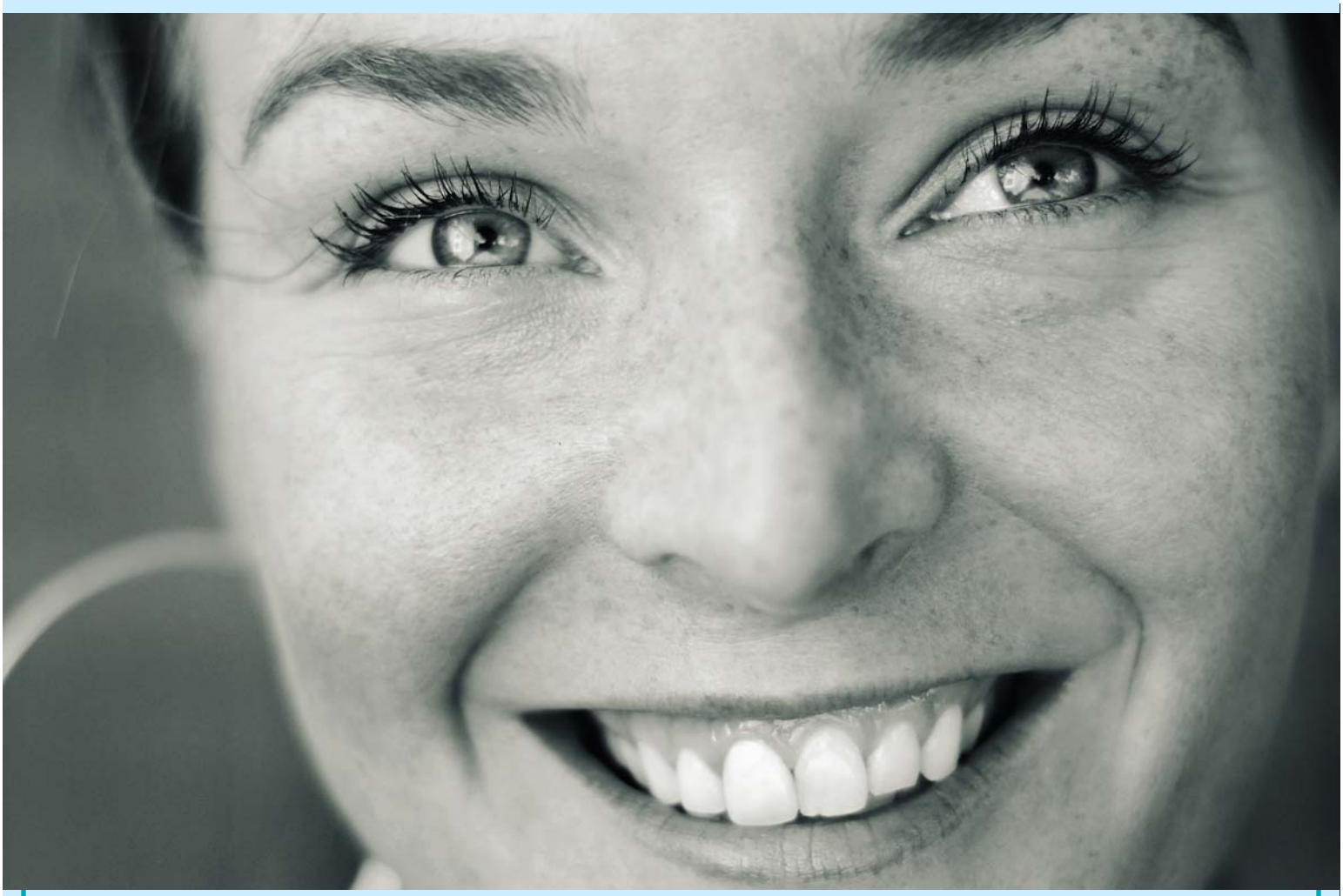


# Patient retention in a dental clinic

An examination of satisfaction and best practices

## Why do we have so **few** patients?

Staff turnover at the front end was high. Receptionists had been replaced every six to 12-months.

Morale among the receptionists and clinic manager was low and a somewhat adversarial relationship was maintained with the lead dentist.

Many administrative tasks remained unperformed. Several undeposited charge card chits and unsubmitted insurance claims were discovered.

The level of accounts receivable was high, most of the accounts were over 90-days old, and an analysis of the financial statements over the past three years revealed that all the original capital of the clinic had been lost to bad accounts receivable.

About two-thirds of the light bulbs in the reception area were burnt out.

The sliding wall-type retail door of the clinic remained half-closed during mall opening hours due to an apparent draft from the ventilation system.

## Introduction and Methods

A dental clinic, which was part of a chain, was experiencing a problem with low patient retention and low numbers of new patients. The lead dentist had determined that a "chart audit" was required in order to address the problem. An arrangement was made for this to be performed. (A chart audit is a procedure designed to determine which patients in the practice are eligible for a recall appointment and then schedule such an appointment for them. A recall appointment is one where the recommended semi-annual cleaning and check-up procedures are performed.)

During the performance of this audit, however, the above-mentioned observations were made.

Following completion of the chart audit the following additional investigations were performed:

- An analysis of the chart audit data,
- A patient survey,
- A review of the literature on patient retention in dentistry, and
- An interview with the office manager of a successful clinic.

## Results

Analysis of Chart Audit Data

Information obtained from the chart audit allowed a defection rate to be determined. Patients who had indicated they would not be returning when contacted were asked to indicate why and their reasons recorded. These patients amounted to 14% of the practice over the pasts six months.

Twenty-seven percent of the patient population could not be reached during the chart audit. It is possible that an effective ongoing recall system would result in these patients becoming scheduled for a recall visit. However, the 11% of the patient population who: 1) Could not be reached, 2) Remained loyal, and 3) Would not schedule when prompted, suggested that other factors are involved, especially when interpreted in the context of this figure representing two-thirds of patients who were contacted. Such a rate of reluctance to schedule an appointment when prompted casts doubt on the ability of a recall system to achieve better results with the same method of a single prompting.

Patient Survey

Data describing the image and perceived level of service of the clinic were collected. Patients were asked to rate the clinic on the attributes of "professionalism of dental staff," "overall organization of the clinic" and "service provided by reception staff." A scale of 1 to 5 was used.

The resulting mean scores indicated perhaps respectable, or at least acceptable, image and level of service. However, the resulting ranges indicated that at least some patients disagreed. Of note was the small difference between the rating of the back-end, "professionalism," and the front-end, "service provided by reception staff." A high score on the back-end is consistent with the 5% verbalized dissatisfaction rate obtained from the chart audit: Four percent "found another dentist" and 1% indicated poor relations with the dentist. However, a high score on the front-end is not consistent with the observations of the clinic listed by this author earlier.

Further results of the survey, combined with details from the chart audit, allowed a retention or return profile of certain patient groups to be identified. Patients who were members of a family unit had a return rate of 89% compared to one of 70% for their single counterparts. Furthermore, patients who were a member of a family unit where other members also attended the clinic had a return rate of 93%. These results indicated a higher natural return or retention rate with members of family units and families themselves and suggest that retention may be increased by simply targeting these groups.

However, for the purposes of compiling these data, "return" was defined without respect to elapsed interval of time. Charts of survey respondents were scanned for appointment dates over the past three years. In other words, the return rates presented are not necessarily regular return rates where "regular" is defined as semi-annually. The regular return rate for the patient population over the previous six months was 25%. In order for the benefits of customer or patient retention to occur, it is believed that patients must return regularly. For the clinic in question, the retention challenge would be to close the gap between the weighted average return rate of 86% and the regular return rate of 25%.

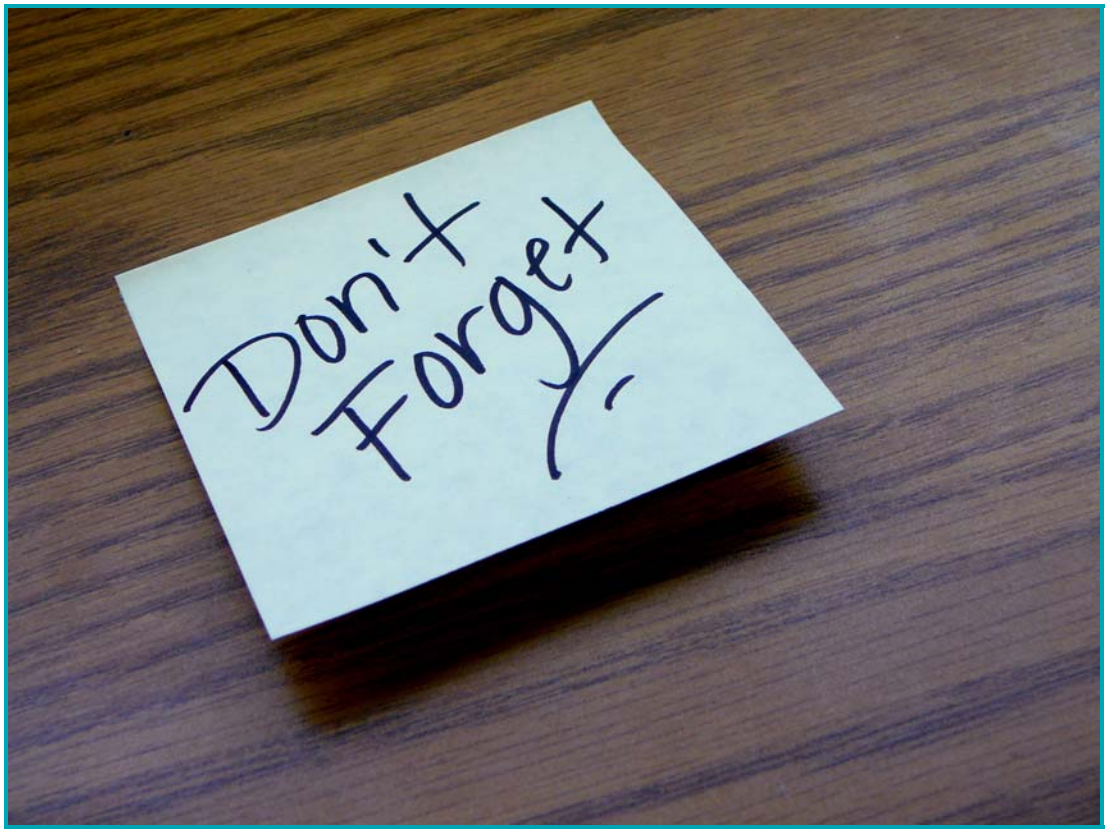
Once again, with the defection rate described earlier and the reluctance of about two-thirds of patients contacted to schedule a recall appointment, it is unclear whether an effective ongoing recall system by itself could close this gap. It is possible that other factors are involved in the low rate of retention or that other efforts could be instrumental in increasing it.

| | |
|---|---|
| Singles | 70 |
| Family members | 89 |
| Family attendees | 93 |
| Regular | 25 |

Table 1: Patient return rate (%, by group)

## Review of Literature

A total of 56-abstracts and three journal articles were reviewed. Approaches used in the research included attempts to identify patient determinants of quality and satisfaction in health care services, in general, and dentistry in specific, as well as simply identifying which attributes of the services provided are considered important by patient consumers. A few studies did, however, link retention to satisfaction but a clear picture of the determinants of satisfaction did not emerge. Perhaps this is due to the divergence of attributes studied or which were mentioned by consumers on survey. It did become clear, though, that health care consumers in general, and dental ones in specific, attempt to evaluate both the back- and front-end service components of the experience.



Several authors have found that consumer satisfaction effects subsequent buying behaviour (Bennett and Mandel, 1969; Beardon and Teel, 1983; and Peterson, 1988; as quoted in Peyrot *et al.*, 1993) and intention to reuse the provider (Andreasen, 1979; Singh, 1990; and Woodside and Shinn, 1988; as quoted in Peyrot *et al.*, 1993). One group of authors have apparently documented the positive effects of patient satisfaction "on the bottom line" of health care practices (Brown *et al.*, 1993; as reviewed by Jennings, 1993). A further group of authors reported that continued patronage of physicians and dentists is determined by "the actual interactive nature of the service encounter" but did not elaborate on this expression beyond relating it to the "demeanour and interpersonal skills" of the provider (Crane and Lynch, 1988). No other studies were found discussing patient retention *per se*.

On the issue of patient satisfaction, several studies emerged and presented a plethora of attributes upon which health care and dental patients evaluate the experience with respect to it. The most frequently cited factor was quality / quality of care and in an attempt to identify determinants of this factor a further large number of attributes emerged. The results of these studies will be reviewed briefly in an attempt to relate satisfaction to elements of the service experience perceived by patients.

Peyrot *et al.* (1993) found that satisfaction is related to general perceptions of quality. Barnes and Mowatt (1986) found that after the initial selection of a dentist is made, quality of care is the major evaluative criteria. Quality was further found by McAlexander *et al.* (1994) to be based on "provider performance," while Coates and Willans (1992) reported that quality was perceived by dental patients in terms of reassurance and a caring image, rather than technical competence. Peyrot *et al.* (1993) also stated that patient impressions of procedure effectiveness may be based on physical sensations.

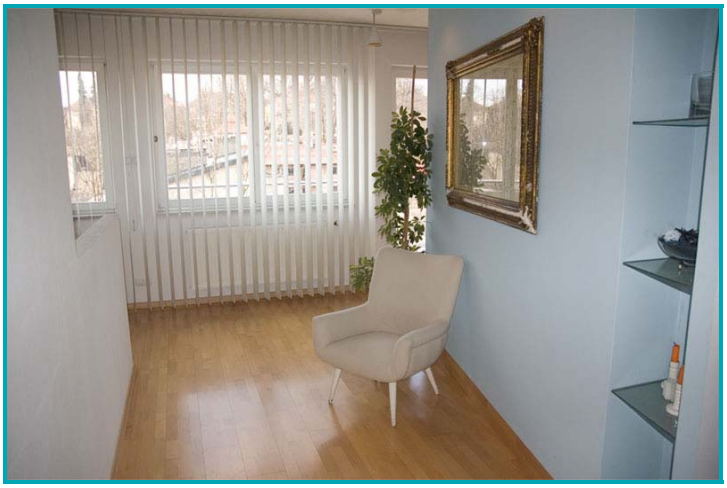
| | |
|---|---|
| Quality<br>Provider performance<br>Reassurance<br>Caring image<br>Impression of procedure effectiveness<br>Waiting time for appointment | Waiting time at office<br>Pain management<br>Willingness to discuss treatment<br>Prevention<br>Neat and clean office<br>Sensitivity to children |
| Expectations met (which were a function of experience, needs, and communication) | |

Table 2: Determinants of patient satisfaction.

Returning to determinants of satisfaction beyond quality, Gopalakrishna and Mummalaneni (1993) reported that satisfaction in dentistry was influenced, in order, by waiting time at the office, waiting time for an appointment, and then by pain management. Barnes and Mowatt (1986) found that after quality, the next most important determinants of satisfaction were the dentist's willingness to talk about treatment, prevention, a clean and neat office, and sensitivity to children. Brown *et al.* (1993, as reviewed by Jennings, 1993) stated that satisfaction is a function of expectations, not necessarily quality care on a technical level, and that expectations were a function of experience, needs, and communication. And finally, Peyrot (1993) reported that satisfaction is determined by the socio-emotional aspects of the encounter.

One study (Chakraborty, G. *et al.*, 1993) simply asked dental consumers to state the most important attributes perceived by them for dental services. Analysis revealed the most important factor to be the dentist's sensitivity to pain and fear, followed by ability to see the assigned dentist, the appearance of the office, and the attitude of the staff.

If the results of the review of literature do not converge to form a manageable understanding of the attributes of satisfaction for dental patients, the results do describe attributes from both the back- and front-end of health care and dental practices. In other words, patients attempt to evaluate both the front- and back-end components of the service experience, all be it on different and rather varied criteria. Unfortunately, the literature does not indicate the relative importance of the two components. However, it implies that patient retention is a function of satisfaction, and that satisfaction is based on attributes from both components. In fact, Brown *et al.* (1993, as reviewed by Jennings, 1993) state explicitly that satisfaction is defined as clinical quality plus service quality. It would, therefore, seem that patient retention is a function of being satisfied with both components and that dissatisfaction with the level of front-end service may result in lowered retention.



Interview with Manager of Successful Clinic

The office manager of a successful dental clinic was interviewed. They were asked to discuss the importance of front-end service for both the success of the clinic and patient retention. The reception area was observed to be large, clean, spacious, well-lit, and tastefully-decorated. It was separated from the mall by a complete glass wall with two glass doors for traffic. The receptionist on duty was observed to be attentive, polite, helpful, and busy. The back-end was not observed.

Following is a summary of the comments made by the office manager on the subjects of front-end service and patient retention:

- Front-end service is "very important,"
- The role of receptionist is critical because:
  - They are the first person patients meet, and
  - The role includes that of being a professional promoter: the receptionist, basically, has to "sell" the clinic, at least until the appointment is made,
- The role of receptionist is more knowledge-intensive than expected: both administrative details, such as fees and payments, and clinical ones, such as symptoms and procedures, must be familiar and discussed with ease,
- Good receptionists require competitive wages to recruit and premium ones to retain,
- Effective communication with patients regarding costs and the proportion covered by insurance is also critical: a misunderstanding on the part of the patient can result in a service failure, an extremely difficult recovery in the absence of a refund, and ill will circulated. Clinic staff must be proactive and, basically, assume responsibility for communication of the details of each patient's insurance coverage in an attempt to avoid service failures,
- Front- and back-end staff must work as a team in the interests of communication and service. "If one slips the other will fall." Service is a "complete" job and not divided into back- and front-end components,
- The cost of a computer is recovered many times over,
- Patient education is a factor in return and retention,
- Level of service can make the difference between the volume of two clinics side-by-side, and
- Dental patients can, and will, migrate in the event of errors with accounts, insurance processing, or other tasks delegated by them to the front-end staff.

The results of the interview with the office manager may be interpreted as containing three themes:

1. The position of receptionist, and level of service provided, are critical to the success of a dental clinic,
2. In reality service may not be compartmentalized into back- and front-ends, and
3. Patients can, and do, migrate in the event of an unrecovered service failure, or when service level fails to meet their expectations, no matter how unreasonable or uncommunicated those expectations are.

Furthermore, results of the interview indicate that level of service provided is a *bona fide* factor in patient retention and one that is independent of the effectiveness of a recall system.

## Conclusions

It was determined that modification of the recall system of the clinic in question was required. The system was revised, errors were corrected, and the staff was re-trained. As well, replacement of the paper based system by a computerized one was highly recommended due to the former being data-intensive and having a large requirement for staff compliance. The recommendation, however, was not accepted by the lead dentist; the cost was considered too high.

The poor appearance and possible employee problems of the front-end likely contributed to low patient retention and low numbers of new patients. High staff turnover was associated with patients having to forge a new relationship with the receptionist on each visit. Often this required re-completion of one time forms, re-discussion of insurance benefits, resubmitting insurance claims and appointments being cancelled due to requirements for pre-medication not being made known to the receptionist.

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