Informatics and IT in dentistry: a look forward

Recently, Dr. John O’Keefe, the editor of the Journal of the Canadian Dental Association, interviewed Dr. Titus Schleyer, associate professor and director of the Center for Dental Informatics, University of Pittsburgh, about the development of health information technology in the context of the dental profession.

Dr. O’Keefe: What are the main developments you see in the areas of informatics and information technology (IT) as applied to dental practice?

Dr. Schleyer: We have gone through a tumultuous period of change and development in informatics and information technology over the last 15 to 20 years, so I think many of these trends will continue to be important. For instance, the Internet has influenced dental practice and life in general. I think we have seen changes that we could barely imagine 20 years ago.

The trends in how we use electronic technology in our lives and in managing information have emerged with the stark realizations, and I guess they will continue to mature and generate new surprises. In terms of concrete examples, we see that data and information are much more accessible and available than previously, and they are much better connected. We see patients having access to their medical records, looking at what physicians write about them and what they diagnose, and sometimes arguing about it, and thus taking a much more active role in their care. I think that is a development that will definitely influence dentistry.

We also have almost ubiquitous information access. There are dentists who access their practice schedules through their Blackberries, cell phones and other devices. Some physicians write prescriptions from their hand-held computers. So I think ubiquitous information access will be a strong trend in the future.

Another big development I see accelerating is the move toward paperless practices, paperless being somewhat of a euphemism for “mostly computerized practices.” Paper never really goes away, even “mostly computerized practices.”

When you look at how the United States conceptualizes electronic health record as some implicate the electronic patient record, and is there a difference between that and the electronic dental record?

Typically, people consider the electronic health record as something global that has everything related to a patient’s health in it. An electronic patient record is often used in specific reference to a health care area, for instance, as in an “electronic medical record” and an “electronic dental record.” I prefer the term, “electronic dental record,” for us because that identifies the dental component of the patient’s health. In general, the impact of electronic health records will be very significant.

As you know, the United States is targeting 2014 as the year when most Americans are supposed to have access to electronic health records. This now has been the stated goal of two successive presidents from different political parties, no less. Through this national goal and mandate, so to speak, we will come to a much more transparent way of managing patient information.

As I mentioned earlier, patients now do take a look at their own health records and sometimes argue with the physicians about what’s in them. They detect errors that are in them, and I think that will have a big impact. I think we will move away from patient records as incidental documents that we mainly create in order to protect ourselves from lawsuits. In the future, they will be a central tool that informs and guides how we care for patients.

When you look at how the United States conceptualizes electronic patient records, we’re not pursuing that concept as a goal in itself. The idea is to fundamentally improve patient care, as several reports from the Office of the National Coordinator for Health Information Technology have described. How do we do this? Number one, you give caregivers who need access to patient information the ability to access it. Number two, you connect personal health information with evidence-based resources in order to make sure that patients get the most appropriate care. And third, as I mentioned, you get the patients involved in their own health care through electronic access to their data.

So I think dentistry is a little bit behind here, but that is not necessarily a bad thing. However, we shouldn’t wait until a wave of patients washes over us when people march into our offices and demand the same kind of access to dental records that they have to their medical records.

Do you think that the patients having access to an electronic health record would have any impact on the relationship of a particular patient with a particular provider? Would it make patients more mobile?

In theory, patients’ mobility will be enhanced by easy access to their health information. But of course, we have to temper that view by asking whether, and to what degree, the difficulty and effort in obtaining records influences a patient’s decision to move to another dentist right now. Typically, if people are unhappy with their dentist, they’ll “pack up and go” to a new dentist. Maybe that will be slightly easier for them if they do not have to worry about getting their radiographs or particular pieces of their patient record to their new dentist. But I’ve never really felt that patients I talked to who switched dentists were particularly inhibited by the fact that they had to get a copy of the latest radiographs, for instance. So in the grand scheme
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Five of the top 10 reasons why associations fail

By Eugene W. Heller, DDS

The “American Dream” is still to own a home. The “Dentist’s Dream” continues to be the ownership of a practice. Thirty years ago, the dream was to graduate from dental school, buy equipment, hang out a shingle and start practicing. Today the road to ownership is a little different.

Due to extensive debt, most new graduates enter practice as associates to improve their clinical skills, increase their speed and proficiency, and learn more about the business aspects of dentistry. Most hope the newfound associateship will lead to an eventual ownership position. Instead, many find themselves building up the value of their host dentist’s practice, only to be forced to leave. The result of a non-compete agreement when the promised buy-in/buy-out doesn’t occur.

The following reveal the first five of the top 10 reasons many associateships fail to result in ownership or partnership.

Reason No. 1: purchase price

If the purchase price has not been determined before the commencement of employment, the parties find themselves on different ends of the spectrum as to what the practice is worth and what the buy-in price should be.

When purchase price is established before the commencement of employment, three out of four associateships lead to the intended equity position. Conversely, if the purchase price has not been determined, nine out of 10 associateships lead to termination without achieving the ownership intended or promised.

Reason No. 2: the details

The more items discussed and agreed to in writing beforehand, the better the chance of a successful equity ownership occurring as planned.

The written instruments should be two specific documents — an Employment Agreement detailing the responsibilities of each party for employment and a Letter of Intent detailing the proposed equity acquisition.

Reason No. 3: insufficient patient base

Approximately 1,000–1,200 active patients are required per dentist in a dental practice. If the junior dentist does not intend to restrict or cut back on his/her number of available clinical treatment hours, then the transition from a one-dentist to a two-dentist practice requires an active patient base of approximately 1,400–1,800 patients and a new dentists’ flow of 25 or more new patients per month.

Many senior dentists count their number of active patients by counting the number of patient charts on a wall. However, the best way to estimate the active number of patients involves utilizing the hygiene recall reports.

Insufficient numbers of patients and/or an insufficient new patient flow signals that all expenses relating to the new dentist are coming directly out of the bottom line. The practice then begins to experience financial pressure.

Creation and maintenance of a patient base is an extremely important aspect of the business. If the senior dentist is nearing retirement with the intent that, within one to two years, the senior dentist will turn over total ownership of the practice and intends to cut back shortly after the beginning of the second dentist’s employment, this problem is not as critical.

Reason No. 4: incompatible skills

The incompleteness in clinical skills between practitioners may include the possibility of one practitioner having different skill levels than the other. This situation might emerge in a practice that is evolving to a two-dentist practice; one dentist having different skill levels than the other. This might result in the resignation of practitioner A after two years, before the practice is ready to achieve an ownership status.

Reason No. 5: timeframe

The failure to identify when the buy-in or buy-out is to occur and when to execute it can result in failure to achieve an ownership status. The Letter of Intent may have stated that the buy-in was to occur in one to two years, but certain behaviors and signs during the continuance of employment relationship might give an indication that the senior doctor is having difficulty honoring the intended buy-in or that the associate does not feel ready to contribute to the transaction. The original outlined timeframe. Either position might result in the demise of the buy-in as involved parties lose patience over such delays.

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