I in discussing documentation in our modern digital offices, let me be very clear that I’m a huge fan of the “paperless office.” I was a proponent of replacing the paper charts and X-ray chemicals with digital versions from the first time I saw the possibilities. However, as with every new tool in our office, we need to enjoy our exciting new products while maintaining our boring old standards of quality.

One of those old standards of quality is good solid documentation, and it’s beginning to slip in a serious way in many digital offices. Going to a “paperless” office is a big time saver and an excellent marketing tool, but it’s also become a way for sloppy documentation to creep into our office habits. Aside from making the office seem scattered and disorganized, a lack of documentation can have severe legal ramifications.

Let’s look at the places where we need to examine documentation in our offices.

The initial phone call

I think we can all agree that this initial contact with our office is vital to how patients and their parents. We hire people with excellent phone skills, and we train them to get all the preliminary information we need while creating a good first impression. Yet even when they do all this, a lack of documentation can trip us up.

It’s great the receptionist found out who the patient saw for a first opinion and what patient and parental concerns exist regarding treatment — but when our receptionist “keeps it all in her head,” we frequently never learn what we could be doing to wow this family.

We need to instruct our front desk staff to document anything interesting or informative from that initial conversation. We need to be sure they know how and where to make those notes. Documenting those comments for future reference gives us valuable insight into the concerns of a new patient and also lets our patients know we really care about what they have to say.

The health history

We sometimes tend not to consider the health history when discussing our shortcomings in documentation, but we should. Although the patient or parent fills it out (thus doing the documenting), the doctor needs to review it, discuss any pertinent health information and then sign or annotate it, showing that it has been reviewed.

With our new digital technologies, some histories are sent right from the patient’s desktop to our software, some are filled out on a tablet PC and all the rest get immediately scanned into the patient’s record. Whether the doctor sits and reviews the form before it’s scanned or brings it up and reviews it on a monitor, then signs off electronically, this signed or annotated documentation is essential to our patient record. A history that’s transmitted to us digitally and goes directly into the patient record is merely an existing history, not a reviewed one.

The initial exam

This is one area where good documentation is absolutely vital. We have great software that sets up a very detailed questionnaire for the treatment coordinator to populate as the doctor measures and diagnoses. This has proven to be a wonderful timesaver, especially appreciated by those of us who once worked strictly on paper.

However, all those little checked boxes don’t cover everything that gets discussed in the initial exam. The doctor may discuss extraction versus non-extraction and the benefits of each; jaw growth and its potential to help or hinder; need for a two-phase treatment; and any number of other issues relating to care or treatment options. If the treatment coordinator isn’t taking notes and maintaining a record of that conversation, it may as well have never happened.

The operatory

Our operatory staff also has been struck by the tendency to lean too heavily on digital documentation. All of our digital software has great drop-down menus where we can choose today’s procedures and create a plan for the next appointment. This is great stuff and an extremely useful tool, but it has to be coupled with attention to detail and diligence.

If we added a procedure that wasn’t planned, it needs to be documented. If we discontinued elastics or headgear, it needs to be documented. If the doctor or assistant had a conversation with mom to reassure her about a treatment concern, we need to document that as well.

Again, we have to remember both the impression we present and the legal ramifications. If we didn’t properly document today’s treatment, we risk making the doctor and assistant look incompetent at the next appointment as they fumble around because they set up for the wrong procedures. And when our legal record of treatment isn’t present, we have no proof the treatment was ever done.

The follow-up

Good patient follow-up is also an integral part of good documentation, and my advice is to continue documenting to the very end of your relationship with the patient.

There’s a tendency after “X” number of calls or recall cards to just let patients slip out of the system. A better format (after all other options have been exhausted) is to send an old-fashioned letter thanking them for coming in and letting them know you will de-activate their records in 30 days if you don’t hear from them. This not only provides you with an office archiving protocol, but it also gives you documentation when talking with the patients’ dentists that you did everything possible to get orthodontic treatment started.

This same type of letter should go out to patients who have been de-handled and then have subsequently gone missing. This not only provides archived closure, it also gives the office a back up if mom calls two years later and complains because “no one told her retention maintenance appointments were needed.”

We’ve always been sticklers about documentation in orthodontics, so let’s not let all our technological advances make us take a step backward in our due diligence. A doctor for whom I worked many years ago told me, “We have lots of paper; write down everything I say!” Let’s make our new caveat: “We have lots of memory; get it all documented!”

Pat Rosenzweig is co-founder of Mosaic Management Professionals, providing management and business consulting for orthodontic offices, as well as general dental and other specialty offices. Mosaic Management Professionals functions on a belief that every office is unique, with its own special dynamic and its own competing and systems needs. Mosaic is committed to creating an individual plan for each client that puts the office’s particular strengths into play to keep the office at the top of its game.

Practice Management

Economy

- “B” doctors — strong referrals: “B” doctors are your single highest potential growth group.
- “C” doctors = some occasional referrer: “C” doctors refer haphazardly and their patients often turn down treatment.
- “D” doctors — not currently referring: Don’t write off “D” referrers as unreachable. Make contact as a chance to further a relationship.
- “D” doctors = strong defenders of the status quo: They are resistant to change and don’t want to learn new things.

Once your referring doctors have been segmented, you need to create strategies for each of them. Levin Group’s Total Ortho Success — Referral Marketing program uses a statistically defined points system to ensure the right number of strategies is applied to the different segments of the referral base.

Conclusion

Despite the slow economy, ortho practices can still grow by 15–20 percent. While some practices have sustained losses, others continue to do well. Updated systems in all areas of the practice are one of the best defenses against a down economy. They allow your practice to grow by reducing inefficiency and unnecessary expenses.

Remember, the economy goes through up-and-down cycles. While this down period may be rougher and longer than previous ones, the good news is that improving your ortho practice management and marketing will stimulate growth.

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