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 realization, 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 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 in the most highly computerized settings. Our research has shown that we seem to be standing at the beginning of a rapid acceleration of computerization of dental practice with respect to pretty much everything: patient records, supply ordering, electronic communication with patients, and so on. Based on historical trends, we expect that there will be a rapid acceleration of dentists who will adopt these technologies in the future. You can either sit on the fence or jump off. I think times are right for more people to take the leap and jump into the fray of computer-based patient records in their practice.

What do you think are the main implications of 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.

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 dentists 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 other 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 of 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 to existing health 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 bad. 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.
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Five of the top 10 reasons why associateships 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 when that practice is the result of a non-competitive 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 senior dentist does not intend to restrict or cut back on his/her number of available clinical treatment hours, then the conversion from a one-dentist to a two-dentist practice requires an active patient base of approximately 1,400–1,800 patients and a new patient 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 counts.

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.

Often the senior dentist brings in an associate dentist as the answer to increasing business. A practice with insufficient new patient flow that experiences the addition of a new practitioner may result in termination of employment for the associate.

Reason No. 4: incompatible skills

The incompatibility in clinical skills between practitioners may include the possibility of one practitioner having different skill sets than his associate. This might result in the demise of the buy-in/buy-out if the associate does not feel ready to contribute to helping practitioners evolve to a two-dentist practice; mainly at a one-dentist practice but it may also include different practice philosophies. On the surface, it would appear that having different skill sets and/or philosophies might be desirable. In reality, the patient base available to the younger practitioner may not lend itself to various types of dentistry.

Reason No. 5: timefractions

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 continuing employment relationship might give an indication that the senior doctor is having difficulty honoring the intended buy-in/buy-out or that the associate does not feel ready to contribute to the transaction. A timeframe is a necessary tool to avoid the original outlined timeframe. Either position might result in the demise of the buy-in as involved parties lose patience over such delays.

Summary

This article has been aimed primarily at a one-dentist practice evolving to a two-dentist practice; however, the issues apply equally to larger group practices. One-to-two-year associateships with the senior dentist retiring at the end of the associateship and a three-to-five-year partnership ending with the new dentist purchasing the remaining equity position of the senior dentist at the end of five years can also benefit from the insights provided in this article.

Unfortunately, nothing can guarantee a successful outcome will occur. However, by identifying the potential pitfalls at the beginning of the relationship, chances of success can be greatly improved.

Look for the remaining five reasons in the next edition of Dental Tribune.

About the author

Dr. Eugene W. Heller is a 1976 graduate of the Marquette University School of Dentistry. He has been involved in transition consulting since 1985 and left private practice in 1990 to pursue practice management and practice transition consulting on a full-time basis. He has lectured extensively to both state dental associations and numerous dental schools. Heller is presently the national director of Transition Services for Henry Schein Professional Practice Transitions. For further information, please call (800) 730-8885 or send an e-mail to hsfs@henry Schein.com

Contact info

Titus Schleyer, DMD, PhD
Associate Professor & Director
Center for Dental Informatics
School of Dental Medicine
University of Pittsburgh
5501 Terrace Street
Pittsburgh, PA 15261
Tel.: (412) 648-8886
Fax: (412) 648-9960
E-mail: titus@pitt.edu
Web site: www.dental-pitt.edu

www.dental-tribune.com

of things, I think there will be only a minor effect.

You might think this is a leading question but, could it make it easier for you to be seen independently by a dentist and an independent hygienist?

I guess it could if the independent hygienist had access to the full record and would have less work in doing the work-up and all the data collection. It would probably make that easier, but I think one thing to think about is that this capability could enhance overall efficiency of our dental care system. Right now, we spend a lot of time duplicating information that’s already somewhere else in the system. Also, I think with this more transparent access, we’ll focus on hopefully more important things and we’ll start from information that’s already there. We might update it, we might verify it, but we don’t have to spend 25 min-
utes going through the whole health history again from scratch.

When you look out five to 10 years, what are practical applications of the trends you see now for the dental office of the future?

Well, we’ve discussed the impact of informatics and IT a little bit in terms of what it means for patients and practitioners already. I’m hoping to see that when computers can contribute to helping practitioners keep up-to-date more than that is currently the case. Currently, computers don’t help much, in my opinion, because you as the practitioner have to do all the work. In order to update yourself on a topic or look up a clinical question, you may sit down at a computer, you have to search Medline or Google, or you fire off a message to an Internet discussion list. I’m looking for computers to do more of this for us. For instance, you could tell the computer the topic you’re interested in, and it would retrieve and sift information for you.

This form of information retrieval is not that hard computationally.

What is hard is that we have to separate the chaff from the wheat. We have to separate valid from invalid information. And, that’s a job that humans and dentists are very well qualified for, but I think a lot of the grunt work should be done by computers and there’s no reason why we can’t make them do that. Also, for dental offices, it means that the sophistication with which people look at the computer infrastructure has to rise significantly. One thing that we have to acknowledge is that dentists are the “chief information officers” for their businesses. They are in charge of managing all information technology, whether they do it themselves or outsource it. But most dentists don’t have that much training in that and the number of dental schools who provide that training is relatively small.

Look for part two of this interview in the next edition of Dental Tribune.